Practice Pointers For Improving Medical Documentation, From A Defense Lawyer's Perspective

Accurately Documenting Medical Records Is The Best Way To Minimize Malpractice Exposure

Purpose Of The Medical Record

- Plan for Patient Care
- Communication for the Health Care Team
- Provides Continuity
- Financial Reimbursement
- Used to Assess Quality of Patient Care
- Mandated to Maintain Accreditation Status
- Centerpiece of Litigation

The Importance of Medical Documentation

- Accurately document your conversations, assessment, and plan of treatment in patient files in a manner that can be easily read and understood by someone else.
- The Problem IS NOT that medical providers write too much in the file, it's that they write too little.

The Record Should Paint the Clinical Picture

Remember: Jurors typically DO NOT have any Medical Training.

The Centerpiece of Litigation

Use Plain Language to Paint the Clinical Picture
How To Improve Medical Documentation

The Basics of Documentation
- Be Careful
- Be Specific
- Be Clear
- Be Thorough
- Write Legibly
- Document Contemporaneously with the Event
- Carry a Clipboard

Essential Charting Tips
- Use Pen
- Date and Time All Entries
- Sign or Initial Each Entry (legibly)
- Hospital Accepted Abbreviations (JCAHO)
- Clearly label EKG’s & Monitor Strips
- If You Didn’t Chart It … It Didn’t Happen!

Some Examples of DO NOT USE Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Problem</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>U for unit</td>
<td>Mistaken as a zero or cc</td>
<td>Write “unit”</td>
</tr>
<tr>
<td>Q.D. or Q.O.D.</td>
<td>Mistaken for each other</td>
<td>Write “daily” or “Every other day”</td>
</tr>
<tr>
<td>H.S.</td>
<td>2 meanings: half strength or at bedtime</td>
<td>Write out “half strength” or “at bedtime”</td>
</tr>
</tbody>
</table>

Objective v. Subjective Entries
- Objective: Surgical incision healing- No signs of infection
- Subjective: Wound OK
- Objective: IV site clear, D5LR infusing at 125ml per hour
- Subjective: IV running well

Objective v. Subjective Entries (cont.)
- Objective: Half of breakfast taken
- Subjective: Diet taken fairly
- Objective: Dr. Smith paged x3, refused to see patient
- Subjective: Dr. Smith paged
Educate Your Patients

- Patient Education
  - Medication
  - Procedures
  - Environment
- Condition & Response

An Example of Educating the Patient...

Document ALL Communication

- Doctor – Doctor
- Doctor – Patient
- Doctor – Nurse
- Nurse – Patient
- Communication between Health Care Team Members
- Chain of Command

Document Communication (cont.)

- Lab Results
- Patient Noncompliance
- Family Visits and Social Documentation
  - Wife tearful at bedside
  - Patient Quotes
  - Red Flags

Shift Change

- Report Given To...
- Patient’s Condition
- Time of Assessments
- Shift Changes Are Always Critical Time Periods During Litigation

Good Habits

- Nursing Actions
- Safety Precautions
- Unusual Incidents or Omitted Treatments
- Attempts to Contact the Doctor
For the Doctors... Technology Is A Beautiful Thing

- Dictate your patient's assessment, plan, and any other important notes while you are in the exam room with the patient.
- Why? Because the patient will have an opportunity to hear any recommendations a second time, and correct any misunderstandings regarding their condition.

Stop Poor Documentation

- Incorrect Spelling
- Writing In The Margins
- Incomplete Entries
- Inaccurate Entries
- ILLEGIBLE Handwriting

Attention To Detail And Correct Spelling is Important!

Some Examples Of Sentences Found In Patients' Hospital Charts

- She Has No Rigors or Shaking Chills, but her Husband States She was Very Hot in Bed Last Night.
- Discharge Status: Alive but Without My Permission.
- Examination of Genitalia Reveals that He is Circumcised.
- The Patient Refused Autopsy.

Actual Sentences Found in Patients' Hospital Charts (cont.)

- Patient Had Waffles for Breakfast and Anorexia for Lunch.
- Occasional, Constant, Infrequent Headaches.
- She is numb from her toes down.
- Large Brown Stool Ambulating in the Hall.

Actual Sentences Found in Patients' Hospital Charts (cont.)

- Patient has Two Teenage Children, but No Other Abnormalities.
- She Stated that She Had Been Constipated for Most of her Life, Until She Got a Divorce.
- Both Breasts are Equal and Reactive to Light and Accommodation.
An Example of Poor Charting

- "Skin Warm and Dry"

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Good Charting

- Assess the wound
  - Measure size
  - Drainage
  - Redness
  - New skin growth
  - Odor
  - Etc.

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Another Example Of Bad Documentation

- Pt presents c/o pain. VS BP, P R T. Pt. uncooperative and family very demanding. Taken to bed 3.

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Good Documentation

- 3/4/04 - 2215: While Spanish speaking female presents to ER with family member, she is crying in pain and grabbing her abdomen. Per patient sister the pain is in the stomach, the patient was told by the Clinic she had gallstones. Attempting to calm patient while taking vital signs, BP, P, R, and Temp. The patient was transferred to bed 3 by Sue Smith, RN @ 2228. The patient's family was instructed to wait in the waiting room. Call placed to Medical Records for her Clinic chart.

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What The Bad Guys Look For

- Late Entries
- Record Alteration
- Time Discrepancies
- Editorial Comments (CYA)
- Charting Errors

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NEVER ALTER

- Should Not Edit After The Fact
- No Late Entries
- Do Not Obliterate
- Never Chart For For Someone Else
NEVER EVER ALTER

- If You Must Add Something To The Record, Use An Addendum
  - Date, Time, Initial

An Real Example Of Medical Record Alteration...

Do You Notice Any Changes?

Incident Reports

- Keep it Factual
- Confidential and Privileged
  - Do not refer to incident report in medical chart

After The Incident...

- All Important Information Must Be Documented In the Medical Record
- DO NOT Maintain A Journal or Diary

Patient Requests To View the Medical Records

- Always follow facility policy
- Only With Supervision
Medical Documentation Review

- Accurate and Concise
- Legible
- Sign and Date
- Chronological
- Avoid Bias
- Paint the Clinical Picture
  - Tell The Story

THANK YOU FOR YOUR TIME AND ATTENTION!

IF YOU HAVE QUESTIONS WE WOULD BE HAPPY TO ANSWER THEM AT THIS TIME?