Clinical Documentation

The Good
The Bad
And the Ugly

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Why Document???

- Most Important!!!
  - Assure high quality patient care
- Principles of quality documentation are not new and apply to EMR, paper or a combination of both
- Quality documentation:
  - Provides an account of the care delivered
  - Promotes continuity of care
  - Reduces redundancy
  - Supports billing (claims data)
  - May be your best defense or worst enemy in the event of legal action

Patient Medical Record

- "If you think of the medical record first and foremost a clinical communication that you documented carefully, you need not panic if the court subpoena's. If you think only of legal implications or document to protect yourself, your part of the medical record will sound defensive and tends to have a negative impact on a judge and jury."
  - Lippincott, williams and Wilkins, 2008

Major Purposes of the Medical Record

- 1. Vehicle for communication among **ALL** members of the healthcare team
- 2. Documents compliance with standards of care and standards of accrediting organizations
  - TJC
  - Department of Health and Welfare
- 3. Documents compliance with standards that must be met for reimbursement by third party payors.
  - Medicare
  - Medicaid
  - Private insurance
- 4. Documents that patient care meets safe, effective and legal requirements.

Common Errors

- Failing to record pertinent health or drug information
- Failing to record nursing actions
- Recording in wrong patient medical record
- Failing to document discontinued medication
- Failing to record drug reactions or changes in patient condition
- Transcribing orders improperly or transcribing improper orders.
- Incomplete records

- Nurses Service Organization, 2008

Examples

- Not Documented; Not Done!
- Injury due to IV extravasation: no nursing progress notes documented but site was checked every 30 minutes according to hospital policy. Nurse initialed in the flow sheet that she checked the site every 30 minutes but no findings documented related to site. Settled out of court in favor of the plaintiff.
  - Legal Eagle Eye, 2007
- Elderly patient is a resident of a skilled nursing facility. Patient suffers from Alzheimer's and fell with injury. Facility has a no restraint policy and a sound fall prevention program which includes hourly rounding by nursing assistants. Although protocol was followed it was not documented. Patient's family received an award of $500,000.
  - Legal Eagle Eye 2007

High Quality

Characteristics of STRONG Documentation

- Accessible
- Accurate, relevant and consistent
- Auditable
- Clear, concise and complete
- Thoughtful
- Timely and sequential
- Reflective of process
- Retrievable

- ANA, 2010

Financial Implications

- Present on Admission and Hospital Acquired
  - Beginning October 2008, CMS denied reimbursement for specific Hospital Acquired Conditions (HAC)

Some of the HAC's

- Air Embolism
- Blood incompatibility
- Falls with Trauma
- Retained Foreign Objects
- Manifestations of poor glycemic control
- Stage III and stage IV pressure ulcers
- Catheter associated urinary tract infections
- Surgical site infections following:
  - CABG
  - Ortho
  - Bariatric
- DVT
- Vascular catheter associated infection

EMR

- Many facilities have adopted an Electronic Medical Record. The hope was to be able to extract information in a more uniform manner and assist in communication across transitions of care. Not all EMR's communicate resulting in a need for Data exchanges or community clearing houses. Other dangers with EMR:
- Flow sheet and checklist formats:
  - Do not just click or initial, ensure you complete the assessment portion of your action.
  - Supplement flow sheets and checklists with your findings or interventions.
  - Ensure you follow up to interventions with patient response.
  - Charting by exception implies standards are met so ensure you have well defined standards

Bad Documentation????

- Is there such an animal as "bad documentation"?
  - Not documented, not done
  - Documented but . . .
    - Venting frustrations? Medical Record is not the forum
      - "Placed TEN calls in to provider with no response. When he does call, he doesn't listen"
    - Acronyms intended to be Humorous or Insulting
      - " I would call her husband to report her change of condition but he is such a POS"

Good Documentation

FACT Criteria

- F= Factual
- A= Accurate
- C= Complete
- T= Timely

FACTUAL

- Only information you see
- Describe, do not label
- State facts, not value judgments
- Be specific
- Use neutral language
- Avoid bias
- Examples:
  - Appears confused: Patient found in lobby, patient stated he thought he was in the airport
  - Medicated for pain, post med assess “reports relief”: Patient states pain at a 7, post medication states pain at a 2

ACCURATE

- Be precise and quantify wherever possible
- Clarify who delivered the care
- If countersigning, review the documents carefully.
- Examples:
  - Pedal pulses present: Dorsalis pedis pulse present bilaterally 2+/4+
  - Taking oral fluid well: Drain 1,000 ml between 0700 and 1200 on 10/5/17
  - Ate well: ate 100% soft diet at lunch

COMPLETE

- Condition change
- Patient responses, especially unusual, undesired or ineffective response
- You contacts and chain of command
- Communication with patient and/or family
- Fill **ALL** spaces, leave **NO** blanks. Place N/A in spaces that do not require documentation.

TIMELY

- When a medical record is examined in a med mal case, date and time are critical in establishing timely intervention
- Computers are automatically dated and timed so if your entry refers to event that occurred in different timing remember to note that time
- RESIST documenting at the end of the shift
  - You **WILL** forget details
  - Professionals in other disciplines will not have accurate and up to date information to manage the patient as the day progresses
- **NEVER** document in advance. This is illegal falsification of a medical record.

Other Issues

- Late Entries:
  - Ensure your document the time of the entry and within the body of the note indicate the time of the occurrence you are memorializing
  - Entering pertinent information is better late than never
  - The safest and most legally defensible way to practice is to document at frequent intervals and definitely after any emergency, unusual event or complication.
- Slander and Libel
  - Information shared that is irrelevant of with malicious intent
- Defamation (5 elements)
  - This is usually documentation about co-workers, physicians or other professionals

Risky words

- Accidentally
- Apparently
- Appears
- Assume
- Confusing
- Could be
- May be
- Miscalculated
- Mistake
- Somehow
- unintentionally

Documentation and the LAW

- Negligence
  - This is professional negligence and the most common of medical malpractice claims. There are required elements to prove the Tort claim of Negligence. These elements are:
    - Duty: duty of care owed to the patient as a reasonable prudent person would act.
    - Breach: in medical negligence standard of care is set by best practice and local standards
    - Injury: injury that resulted from the breach
    - Causation: If this then that. Res Ipsa Loquitor (but for)

What if **YOUR** documentation took the stand?

- Evidence in med mal cases frequently focuses on documentation of:
  - Timely vital signs
  - Reporting of changes in condition
  - Medications given
  - Patient responses to medications, treatment and interventions
  - Discharge teaching

Other Aspects

- Negligence is not the only possibility
- Reckless Endangerment
  - The conscious disregard of a known substantial likelihood of injury to a patient.

Incident Reports

- Usually not discoverable in a suit
- Business record exception
- Intended for improvement and courts don't want to hinder improvement

Let's Have Some Fun

- Examples and discussion!!!