# Documenting Patient Care: A Legal Perspective

Erin E. Meyers, Esq.

Partner

Zeigler Cohen & Koch
Attorneys at Law

# Documentation is Foundational

## Providers

-subsequent treating providers will need to know what has been done (or has not been done) and why

## Quality Assurance/Peer Review

-medical records to review, monitor, assess, correct, and improve patient care

-can also be used for discipline

## Billing/Medicare

-medical records are used to justify billing practices

## Litigation/Claims Resolution

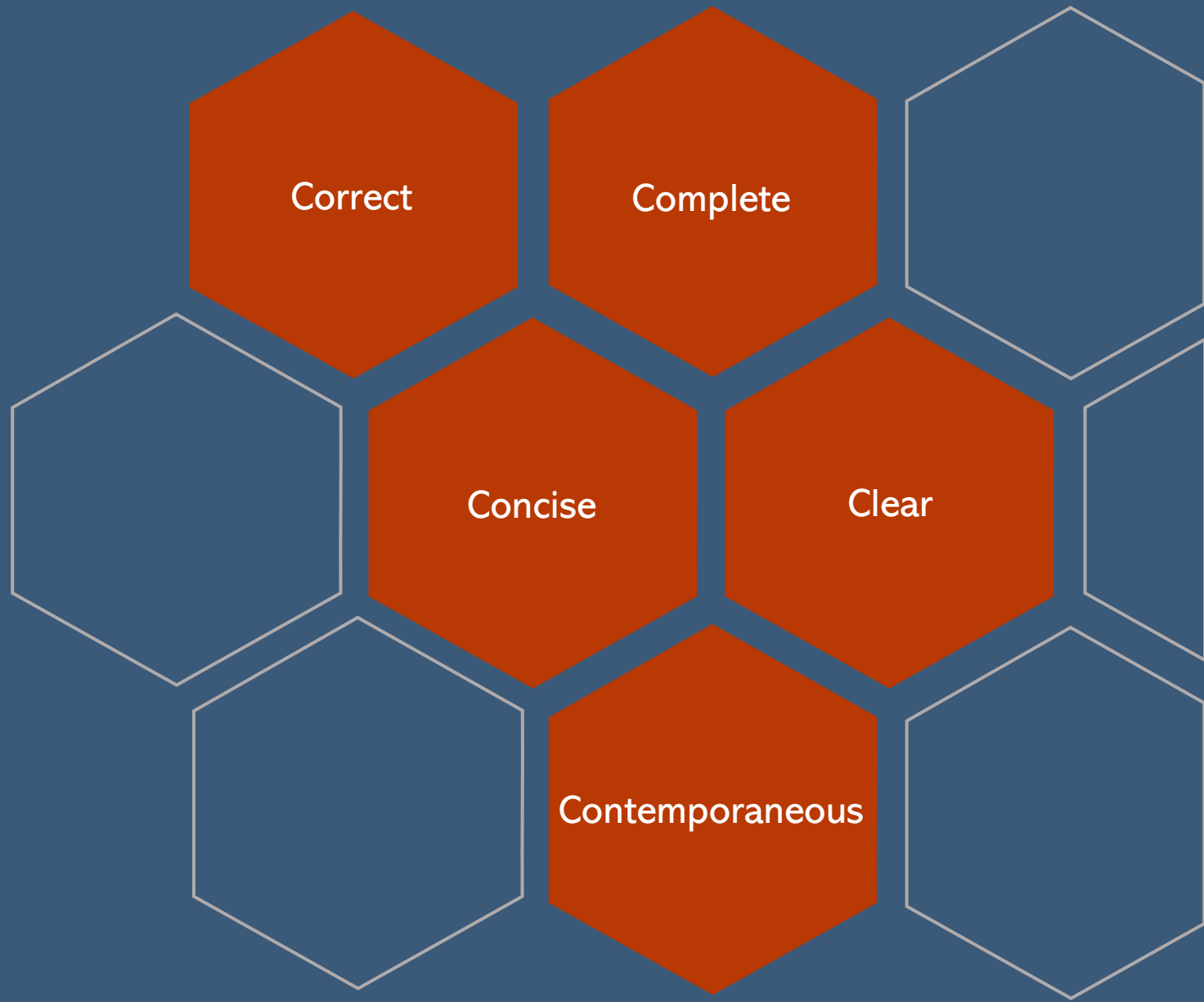
-The records form the basis of all we do

# Documentation is Protective:

1. Protects the Patient
2. Protects the Provider

# How To Ensure Protection?

## -remember the 5 C's



# Correct documentation

- Documentation must be accurate
  - Write down what you said, what you did, what you were told, and what you observed
  - Avoid future tense if possible
- Check dictation before signing
- Do not alter records

# Why Does Correct Documentation Matter to Attorneys?

## Implies Competence

- If providers are charting correctly, it also helps support the argument that the care was correct
- Incorrect documentation, conflicting reports, changing notes all imply lack of care and/or lack of attention to detail. When combined with a bad outcome, this may become difficult to defend.

## Reduces Need To Conduct Interviews / Depositions

- Saves the client $$$
- Streamlines litigation

## Avoids "Issues of Fact"

- Correct documentation is difficult to attack
- Incorrect documentation or conflicting documentation may give rise to a finding of "Material Issue of Fact" --a dreaded panel opinion

# Example of Incorrect Documentation

-Nurse documented test results that corresponded with radiologist's interpretation. Nurse relayed the results to an outside provider (and documented this as well) and the outside provider did not accurately document the results and failed to appropriately respond to the results.

-Later, outside provider changed the medical record, but not before plaintiff's attorney requested the medical record. Two different sets of records existed….that doctor had to settle. (Note: a lot of attorneys are requesting audit trails)

# Complete Documentation

-Great variation depending on role and setting but likely should include:

- -reason(s) for visit
- -relevant history (medical, surgical, family)
- -positive findings/pertinent negative findings
- -normal/abnormal test results
- -impression/differential diagnosis/diagnosis
- -clear management plan
- -treatment rendered/medications administered
- -documentation of communications with patient (e.g., complaints, non-compliance)
- -documentation of communications with others (patient/family/other providers)
- -informed consent (if applicable)
- -instructions and education

# Complete Documentation Includes Addenda and Attachments

-If new information is available, create an addendum and classify it as such

-Do not forget to mention and save: scanned records, printouts from monitoring equipment, photographs, after visit summaries, etc.

# Example of Incomplete Documentation

-Nursing documented pages, part of the physician conversation, and physician orders but never documented that the physician was bedside.
-Physician never documented one single time, but claims he was bedside.
-The patient died.  Panel members advised that perhaps they would have found “no malpractice” had the doctor documented the reasoning behind his orders.

# Concise Documentation

-Brief but comprehensive

-Subsequent treating providers need to be able to extract the most important information in a timely fashion

-Focus on just the facts relevant to the provider's specific involvement at that specific time

-Avoid copying and pasting past notes

-Avoid unnecessary comments that add nothing to the actual medical care and/or could offend the patient (e.g., judgmental commentary)

-However, if unsure, provide more information rather than less

# Clear Documentation

-Consider the SOAP method
-Avoid uncommon abbreviations and shorthand
-If multiple people are involved, describe who did what
    -e.g., a surgery with more than one surgeon involved, but only one surgeon entering an operative note
-List exact numbers instead of descriptive words (e.g., blood loss “minimal” or patient is “afebrile”)
-Describe people with particularity
    -consider “spoke with charge nurse” versus “spoke with Nurse Johnson”; OR
    -“received order to increase Lasix” versus “received order from Dr. Smith to increase Lasix from 20 mg PO once daily to 20 mg PO twice daily”)
    -”Dr. Smith called” versus “I called Dr. Smith” or “Dr. Smith called me”

# Clarity Can Be Enhanced By Formatting

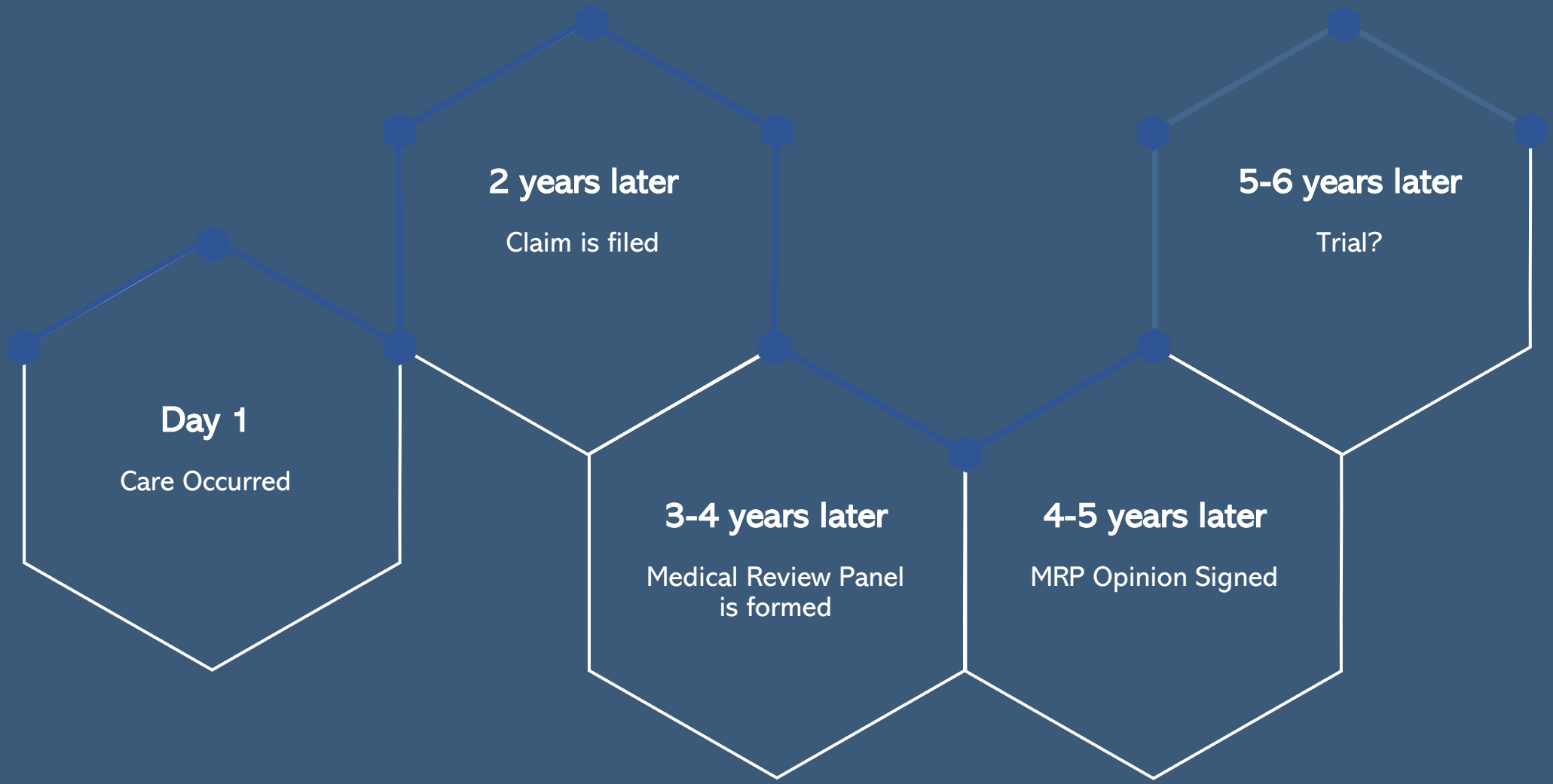
- Consider breaking apart paragraphs, using headers, and using bold text where emphasis is appropriate

- Ensure you are documenting in the correct location
  - e.g., labor and delivery flow sheets to document interventions and fetal monitor strip events, but some hospitals require documenting interventions on the strips themselves.  If so, ensure staff is scanning these into the EMR and that the medical records department is providing records in the media tab for your defense attorneys.

# Contemporaneous Documentation

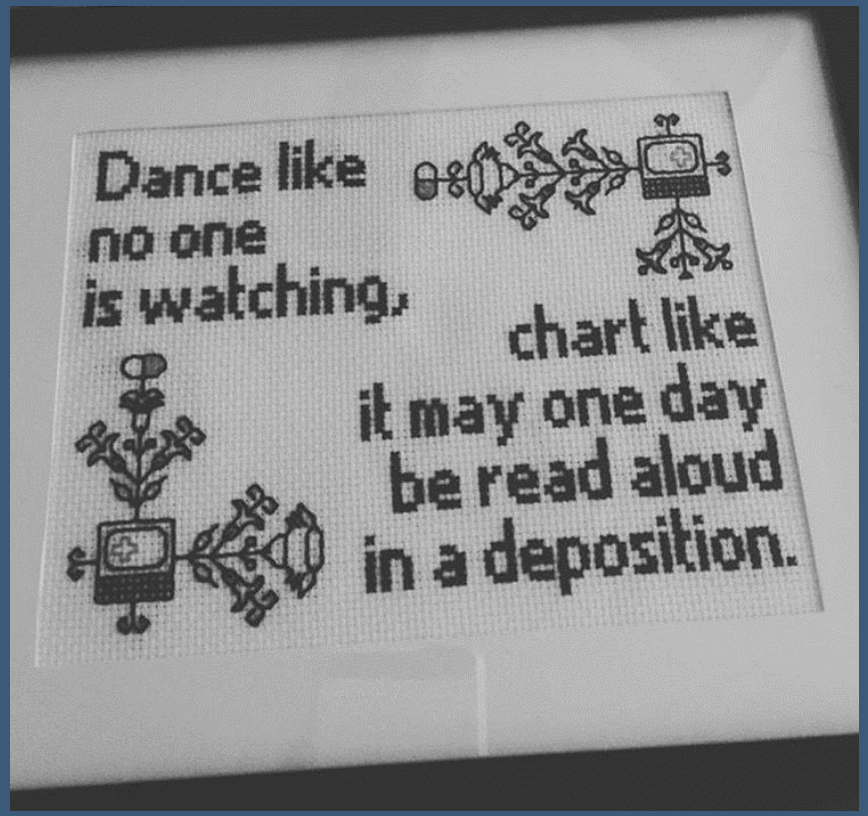
-Timeliness is imperative
-Critical for effective communication between providers
-Contemporaneous documentation is most reliable
-No charting should be done in advance
-Late entries are okay, but try to be objective
-Chronological order helpful for subsequent readers

# Typical Timeline of  Malpractice Claim



# Downstream Implications of the 5 C's

- Most legal cases involve bad outcomes and bad documentation
- Incomplete documentation can be rehabilitated, but it is difficult for it to appear anything other than self-serving
- Incorrect documentation typically cannot be rehabilitated
- Bad documentation can be amplified by a failure to comply with hospital policies and protocols



# Good Documentation Summary


**Anyone & Everyone**

Includes physicians, nurses, social workers, chaplains, pharmacists, etc.

**All Aspects of Care**

-Complete and Correct charting

**ASAP**

-Chronological and contemporaneous records are best

**It is Foundational**

-Basis of communication between providers AND basis of lawsuits

**Education, Training, & Practice**

-Clear and Concise

# Final Considerations

-Legal liability can be avoided, or is unavoidable, based upon what is documented.

-Make sure new staff (including locum physicians, travel nurses, etc.) are appropriately trained on documentation and the nuances of your specific EMR service provider.

-Offer in-services to refresh documentation skills.

# Thank you!


Contact information:

Erin E. Meyers

emeyers@zcklaw.com

317-844-5200