Documentation: Write or Wrong

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Objectives

- Understand the overall purpose of proper documentation as it relates to medical malpractice claims.
- Define at least five common documentation pitfalls.
- Present five examples of proper documentation to reduce risk.
- Understand guidelines on how to fix common mistakes in medical records.
- Case Scenarios – Understand how documentation affected real world malpractice claims.

“The palest ink is better than the strongest memory”

Unknown Author

Documentation and Medical Malpractice

- The medical record is used both in and outside the court for settlement of such disputes as:
    - assessing extent of injury in accident cases; and
    - establishing negligence or otherwise of the health professional or hospital in the treatment of a patient.
- This assists in protecting the legal interests of the patient, hospital, and health professional.

(International Federation of Health Information Management Associations , 2018)

Documentation and Medical Malpractice

As a legal document, the record should have sufficient information to:

- identify the patient;
- support the diagnosis;
- justify the treatment; and
- accurately document the results.

(International Federation of Health Information Management Associations , 2018)

Documentation and Medical Malpractice

- Excellent documentation may protect a physician from liability during a malpractice suit, whereas poor documentation, although not clearly tied to worse outcomes, often leads to the commonly argued assertion, ‘‘if it wasn’t documented, then it wasn’t done,’’ which only supports a plaintiff’s case against a provider.

(Yu & Green, 2009)

Documentation and Medical Malpractice

- Health IT system hazards contributed to medical malpractice claims, representing $61 million, or about $415,000 per case. Incorrect information in the electronic record resulted in the most claims, or about 20% of the cases.
- A recent survey sent to members of the American Society for Healthcare Risk Management and the American Health Lawyers Association, the 369 respondents, asked to identify their EHR-related safety concerns, listed among them incorrect patient identification, incorrect selection from a list of items, and open or incomplete orders.

ECRI Institute, 2015

Documentation and Medical Malpractice

Don’t Trust Your Memory

- There is no adequate substitute for a detailed medical record. This is necessary to refresh your memory of the total patient history, physical findings, interactions with the patient, and your earlier thought processes. Complete records, when introduced as evidence, can offset patient allegations that a physician was negligent in making medical decisions and providing treatment.
- **Changes made to the medical records after learning of a lawsuit only raise questions about honesty, motives, and the quality of care.**

Documentation Pitfalls

General Pitfalls

- Non-transparency of the original, correction or addition to the medical record.
- As a record of professional activities, the record should maintain a professional tone.
- Objective data within the medical record is a must. Subjective “criticism”, “demeaning” or otherwise unprofessional tones can alter a jury’s perception of the healthcare provider.

(Guthell, 2004)

9 types of Nursing Documentation errors

Wolters Kluwer

Sloppy or illegible handwriting

Failure to date, time, and sign a medical entry

Lack of documentation for omitted medications and/or treatments

Incomplete or missing documentation

Adding entries later on

Documenting subjective data

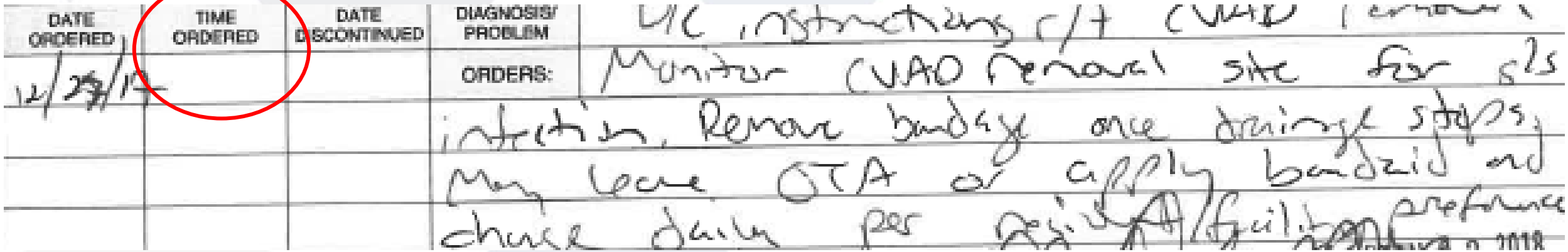
Not questioning incomprehensible orders

Using the wrong abbreviations

Entering information into the wrong chart

http://nursingeducation.lww.com/blog.entry.html/2018/02/22/nursing_documentatio-S5hF.html

Chart Examples



DATE ORDERED	TIME ORDERED	DATE DISCONTINUED	DIAGNOSIS/ PROBLEM	
12/29/17			ORDERS:	Monitor CVAD removal site for s/s infection. Remove bandage once draining stops, may leave OTA or apply bandaid and change daily per

Chart Examples

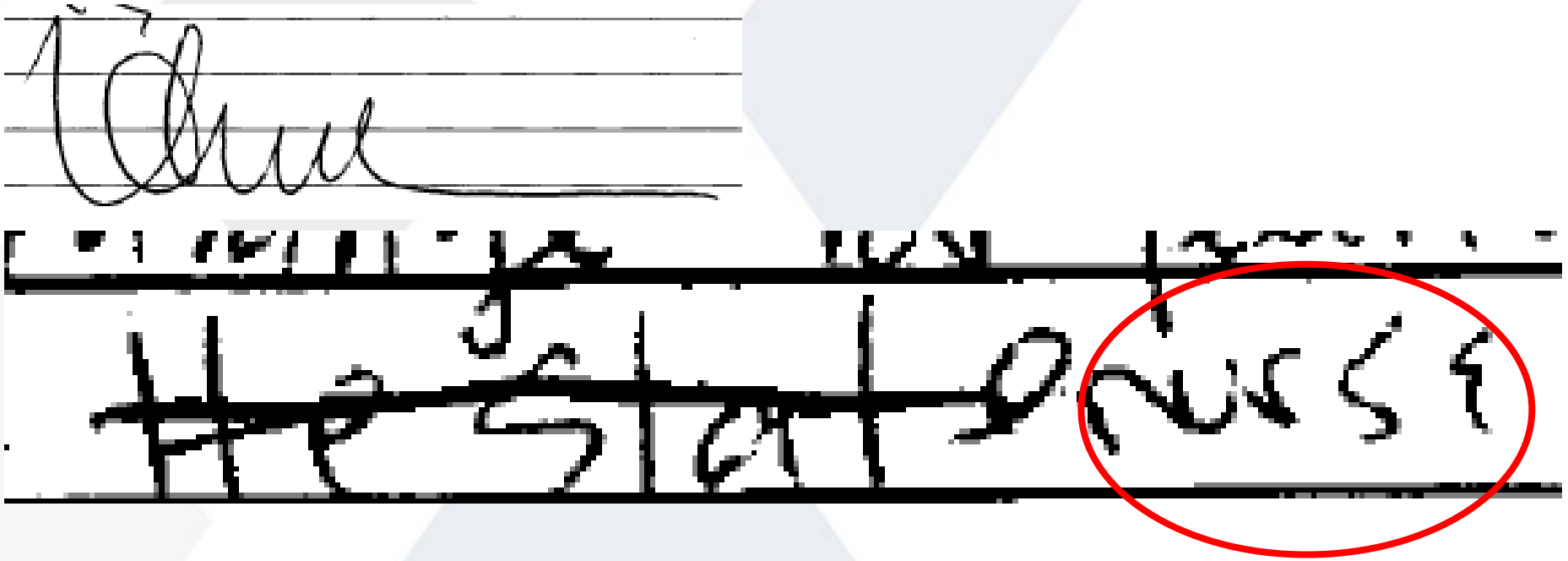


Chart Examples

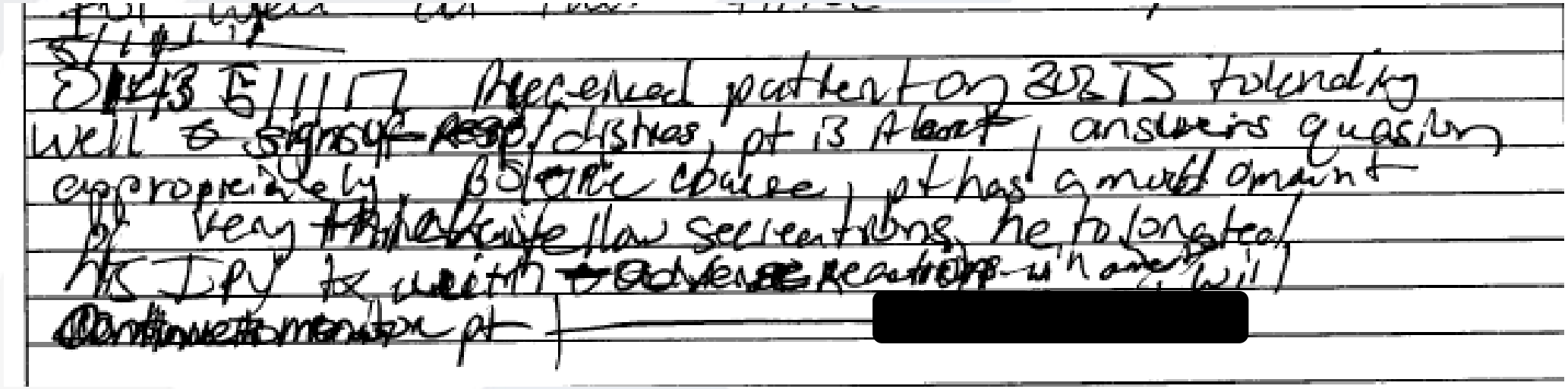


Chart Examples

DRAINAGE

5a. Type of drainage

- [ ] 1. None
- [ ] 2. Serous
- [x] 3. Serousanguinous
- [ ] 4. Bloody
- [ ] 5. Purulent
- [ ] 6. Brown

Serosanguineous is the proper spelling

memory problems

Resident recalls location of own room, staff names or faces, that they are in a nursing home, current season, person, place, time, situation

c. Describe what the reident can recall, if none, document none

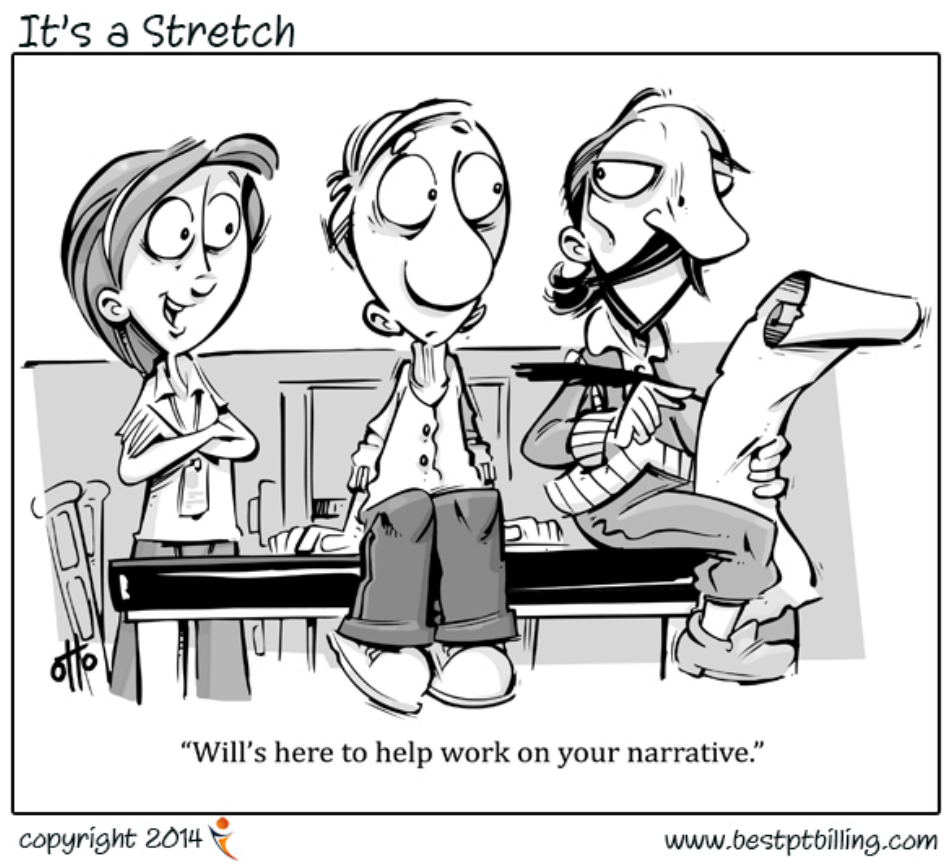
Copy & Paste

- The AHIMA position paper entitled *"Appropriate Use of the Copy and Paste Functionality in Electronic Health Records"* outlines the risks and challenges associated with the use of copy/paste in an EHR, including:
  - Inaccurate or outdated information;
  - Redundant information, which makes it difficult to identify the current information;
  - Inability to identify the author or intent of the documentation;
  - Inability to identify when the documentation was first created;
  - Propagation of false information;
  - Internally inconsistent progress notes; and
  - Unnecessarily lengthy progress notes.

- 15% of malpractice cases involved pre-populating/copy and paste as a contributing factor

(3M Health Information Systems, 2018)

Documentation Guidelines



Copy & Paste

- There are ways to minimize the risk of copy-paste errors through appropriate settings and tools in the EHR. For example:
  - Limit the type of content that can be copied from one record to another; and
  - Set the EHR to auto-populate lab results, test results and vitals from the most recent versions of these in the EHR, instead of having physicians copy-paste them.
- A healthcare practitioner should:
  - Review the information for every note to ensure it accurately reflects the care provided during the current encounter;
  - Remove information that is no longer applicable or clinically relevant; and
  - Remove information that has been ruled out during the current encounter.

(3M Health Information Systems, 2018)

General Recommendations

- Be objective and professional in all documentation.
- Avoid using slang or euphemisms. Reflect individualized care. Avoid complete dependence on generic, computer-generated documentation.
- Document only care provided by you.
- Use correct spelling and grammar.
- **Do not use abbreviations noted by your organization to be misleading.**
- Incomplete documentation may lead to a conclusion that it was not addressed by the healthcare provider.
- Document promptly. The longer the time lapse, the less reliable the entry becomes.
- Enter information only after the care is provided; **never pre-document.**
- Authenticate, date and time your entries.
- Use acceptable signature format.
- Control your passwords and logins.

General Recommendations

- Cancellations and “no shows” of patients’ follow-up appointments should be documented in the chart. The treating physician should then review the chart and, where appropriate, a letter or phone call should be made to the patient. **All efforts to communicate with the patient should be documented.**
- Refrain from documenting criticism of a previous provider's care.
- Be objective and document the facts.
- Place statements made by the patient in quotations. Note actions taken by staff/physicians and final resolution.
- Include emails/correspondence sent or received outside the medical record system.

General Recommendations

The healthcare provider [HCP] must document what they see or what the patient says to them, not the assumptions the HCP makes about the patient's condition or care. The HCP should avoid using words such as 'appears' or 'seems' and should write all observations in a descriptive manner. For example:

Don't write: the patient appears to be asleep;

Write: when observed the patient was asleep.

Or

Don't write: the patient seems to be drunk;

Write: the patient was walking in an unsteady manner, his speech was slurred and his breath smelled of alcohol.

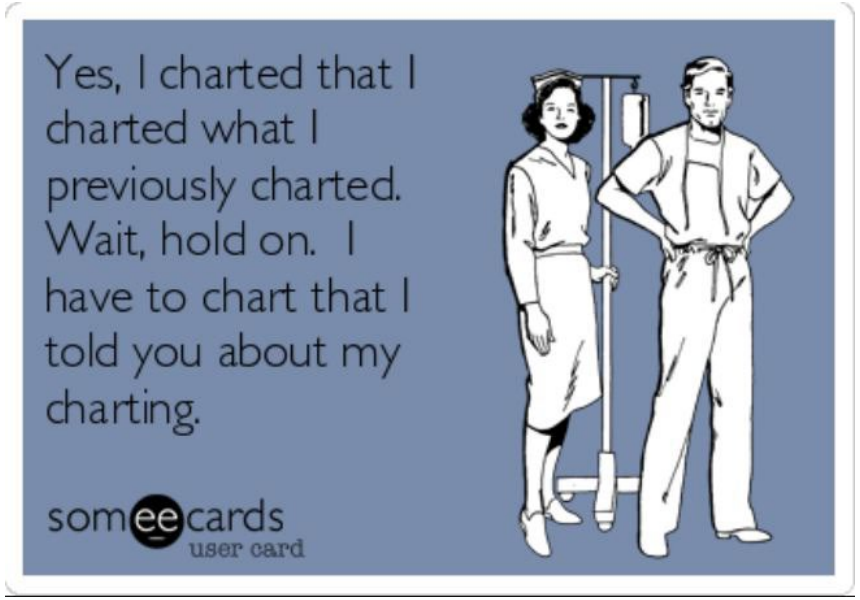
In each case, the first example represents an assumption the HCP has made about the patient, whereas the second example simply records what the HCP has observed.

(Jefferies, Johnson, & Griffiths, 2010)

General Recommendations

- The HCP should record events as they occur. If a HCP waits until the end of a shift to document the day's events, it can be difficult to recreate an accurate sequence of events. Documenting events as they occur guarantees important information about the patient's condition and care is not forgotten if subsequent events take place.

(Jefferies, Johnson, & Griffiths, 2010)



Transcription and Speech Recognition Technology

- Carefully review all transcribed documentation and edit and authenticate as appropriate.
- Prohibit notations that state dictated information was not reviewed. For example, notations such as "Dictated but Not Read" equate to "I take no responsibility for the quality and validity of the information in this document." **Only base clinical decision making on information that has been authenticated.**

Emergency Department

- **High-risk diagnoses**
- **Reevaluations**
- **Thought process**
- **Patient discussions**
- **Leaving AMA - A patient who signs out AMA does not leave the ED physician without risk**
- **Patient hand-offs**
- **Discharge instructions and follow-up**

(Yu & Green, 2009)

Proper Error Correction

- When an error is made in a medical record entry, draw a line through the entry (thin pen line).
- Make sure the inaccurate information is still legible.
- Initial and date the entry.
- State the reason for the error (i.e. in the margin or above the note if room).
- Document the correct information. If the error is in a narrative note, it may be necessary to enter the correct information on the next available line/space documenting the current date and time and referring back to the incorrect entry.
- **Do not obliterate or otherwise alter the original entry by blacking out with marker, using white out, writing over an entry, etc.**
- Correcting an error in an electronic/computerized medical record systems should follow the same basic principles. The system must have the ability to track corrections or changes to the entry once the entry has been entered or authenticated.
- When correcting or making a change to an entry in a computerized medical record system, the original entry should be viewable, the current date and time should be entered, the person making the change should be identified, and the reason should be noted. In situations where there is a hard copy printed from the electronic record, the hard copy must also be corrected.

(AHIMA, 2018).

Omissions in Documentation

- When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the medical record.
- **Identify the new entry as a "late entry."**
- Enter the current date and time – **do not try to give the appearance that the entry was made on a previous date or an earlier time**.
- Identify or refer to the date and incident for which late entry is written.
- If the late entry is used to document an omission, validate the source of additional information as much as possible (where did you get information to write late entry).
- When using late entries, document as soon as possible. The more time that passes the less reliable the entry becomes.

(AHIMA, 2018)

Addendums

- When making an addendum -
  - Document the current date and time;
  - Write "addendum" and state the reason for the addendum referring back to the original entry; and
  - Identify any sources of information used to support the addendum.
- When writing an addendum, complete it as soon after the original note as possible.

(AHIMA, 2018)

Clarifications

- **A clarification is written to avoid incorrect interpretation of information that has been previously documented**. For example, after reading an entry there is a concern the entry could be misinterpreted. To make a clarification entry –
  - Document the current date and time;
  - Write "clarification," state the reason and refer back to the entry being clarified; and
  - Identify any sources of information used to support the clarification.
- When writing a clarification note, complete it as soon after the original entry as possible.

(AHIMA, 2018)

Omissions on Flowsheets

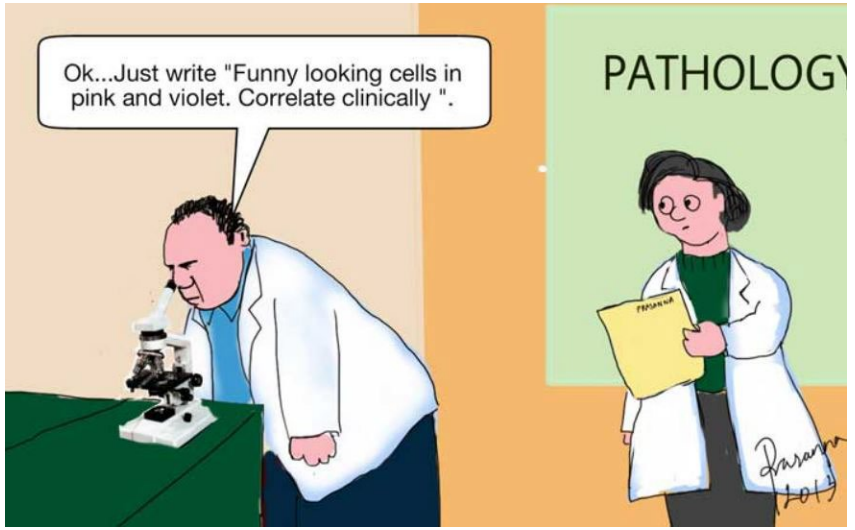
- It is considered **willful falsification and illegal to go back and complete and/or fill-in signature "holes" on medication and treatment records or other graphic/flow records in the medical record.**
- Facilities should use concurrent monitoring (self-monitoring, shift-to-shift review, etc.) to assure the documentation is complete and timely for all medications and treatments administered.

(AHIMA, 2018)

Documenting Care Provided by a Colleague

- Documentation must reflect who performed the action. **If it is absolutely necessary to document care given by another person, document factual information.**
- When the person returns to work, he/she should review your note for accuracy and countersign it.

(AHIMA, 2018)



Nursing Documentation

- The patient's own perception of their condition and their response to care should be the basis of the content of nursing documentation. This requires the nurse to record anything the patient might say to describe their condition or any observations the nurse makes about the patient's condition. An example of how these observations might be recorded is found in the following:
  - *Mr . . . complained that he had a headache all day and it was making his vision blurry. He asked that the blinds be closed in his room. It was observed that Mr . . . was shielding his eyes from the light with his hands.*
- This example brings together information from the patient and the nurse to describe the clinical context. Once this observation has been made, the nurse should **also document any intervention** such as reporting the symptoms to the medical officer or giving the patient analgesia. The nurse would also ensure that the **patient's response to this intervention be documented.**

(Jefferies, Johnson, & Griffiths, 2010)

Nursing Documentation

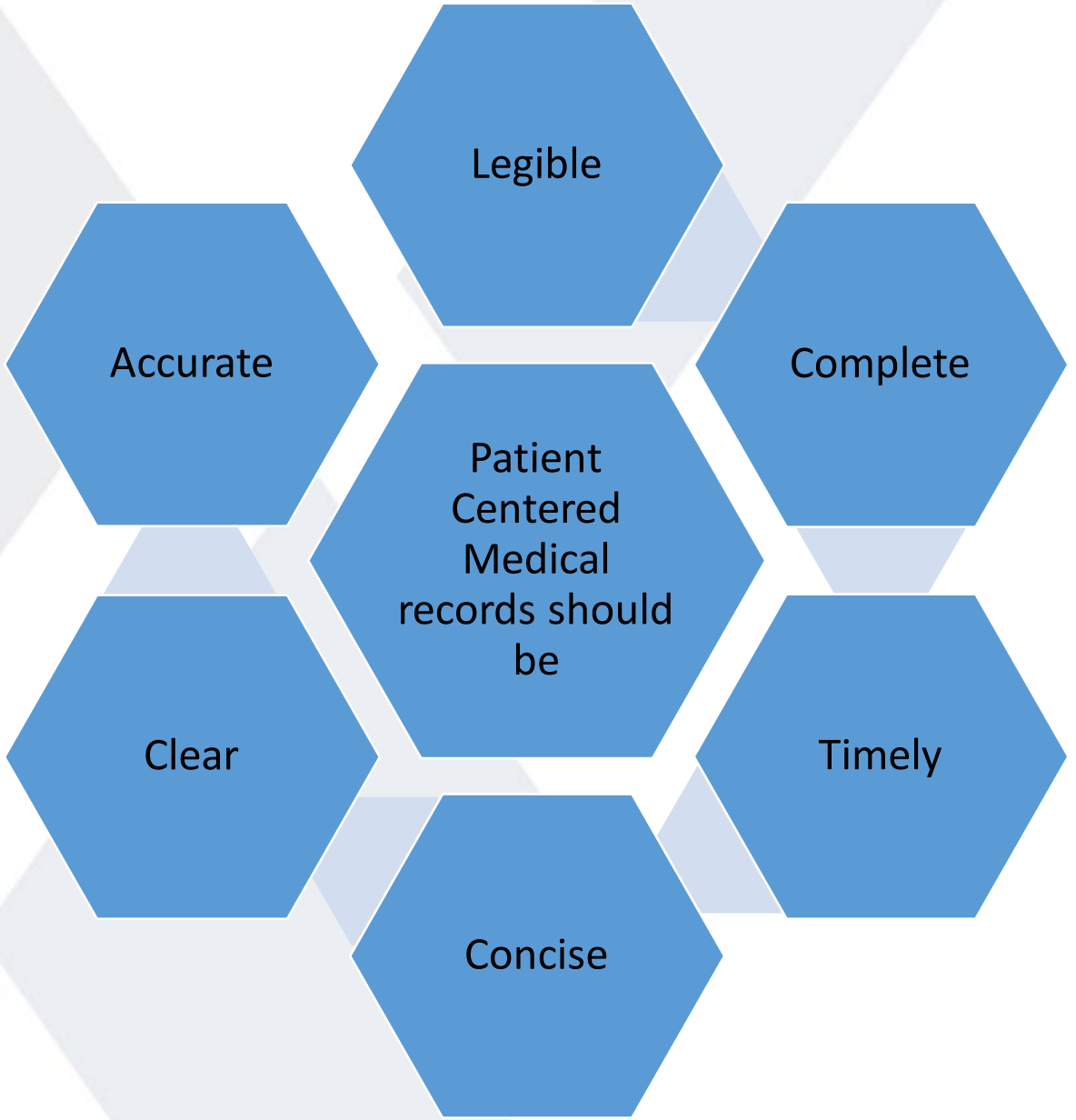
- Nurses must document their interventions in a manner that demonstrates their care of the patient.
- The oral, rather than written, culture of nursing encourages nurses to discuss their interactions and interventions with patients in a complex and sophisticated manner with other nursing colleagues. However, this information is rarely recorded in the nursing documentation.
- Nurses must be mindful they record all instances of psychosocial support or patient education to demonstrate how their work as a nurse has assisted the patient.
- Nursing documentation should be structured to demonstrate the benefit of these interventions, showing why such interventions were necessary, what was done and the outcome for the patient/client.

(Jefferies, Johnson, & Griffiths, 2010)

Nursing Documentation

- Document the patient's condition and care in a manner that explains why decisions about that care were made.
- Nursing documentation must be more than a list of tasks performed by the nurse. It must be sufficiently comprehensive to present a continuous narrative of the patient's experience to demonstrate how the nurse understood the patient's condition and how they dealt with any problems that might be evident.
- If nursing documentation gives an accurate, objective and sufficiently comprehensive record of a patient's condition and care, it will support the oral explanations a nurse might be required to give in a legal context. Nurses must also ensure the presentation of nursing documentation complies with legal requirements.

(Jefferies, Johnson, & Griffiths, 2010)


Legible
Accurate
Complete
Patient Centered Medical records should be
Clear
Timely
Concise

Resources for Clinical Documentation

- Association of Clinical Documentation Improvement Specialists (ACIDIS)
- American Health Information Management Association (AHIMA)
- The American Medical Association (AMA)
- Centers for Medicare and Medicaid Services (CMS)
- Elsevier mobile app
- The Joint Commission

Case Scenario #1

- There were two sets of ER nursing notes in a medical malpractice claim. We believe what occurred was that when the patient was transferred from the ER to the floor the ER nurse could not locate her notes so she recreated them. The content of the two versions was essentially the same. One was more detailed and reflects additional entries within the timeline of treatment. However, the appearance was that the nurse made a more detailed version after the patient's death.
- Also there was confusion with the multiple versions of records. There was a copy of the electronic chart and a copy of the original paper chart. Each version did not contain the exact same pages or ER nurse's notes.
- This case was settled due to the inability to find supportive experts and the appearance that records were altered by nursing staff after the bad outcome.

Case Scenario #2

- A case out of Canada revealed a physician ordering Gentamycin for a patient for the first time, who then subsequently suffered from Gentamycin toxicity. The prescribing physician was sued for failure to adequately warn the patient about risks, benefits, and other options. The physician claimed that this discussion took place with the patient however there was no documentation in the record to confirm.
- The physician testified he had ongoing discussions with the patient about the risks and side effects of Gentamycin despite the fact he kept no record of these discussions.
- During cross examination, the physician admitted he had a duty to document the discussions he had with the patient regarding Gentamycin and ototoxicity.
- The medical record also failed to show evidence to suggest there had been discussion about the risk and symptoms of ototoxicity and the urgency to report symptoms that correlated with ototoxicity to medical personnel.
- The physician was found to be negligent as the patient did not fully appreciate the urgency to report symptoms of toxicity.

From Borden Ladner Gervais, LLP in Canada

Questions?

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References

3M Health Information Systems. (2018, 12 17). Retrieved from 3M: http://multimedia.3m.com/mws/media/1048497O/3m-360emd-copy-paste-white-paper.pdf

AHIMA. (2018, 12 17). Retrieved from AHIMA: bok.ahima.org/Pages/Long Term Care Guidelines TOC/Legal Documentation Standards/Legal Guidelines

CMS Outreach and Education. (2018, December 17). Retrieved from CMS: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

ECRI Institute. (2015, May). Wrong Record, Wrong-Data Errors with Health IT Systems. *PSO Navigator, 7*(2), 1-10.

Guthell, T. (2004, November). Fundamentals of Medical Record Documentation . *Psychiatry*.

International Federation of Health Information Management Associations . (2018, December 17). Retrieved from IFHIMA: https://ifhima.org/wp-content/uploads/2014/08/module1the-health-record.pdf
White, A., & Danis, M. (2013, June 12). Enhancing Patient-Centered Communication and Collaboration by Using the Electronic Health Record in the Examination Room. *JAMA, 309*(22), 2327-2328.

Jefferies, D., Johnson, M., & Griffiths, R. (2010). A meta-study of the essentials of quality nursing documentation. *International Journal of Nursing Practice, 16*, 112-124.

Yu, K. T., & Green, A. R. (2009). Critical Aspects of Emergency Department Documentation and Communication. *Emergency Medicine Clinics of North America*, 641-654.