Reducing Risk

A Publication on Healthcare Risk Management from Princeton Insurance

Protect Your Practice with Your Pen: Documentation Tips

Introduction

The medical record is the primary tool for documenting the care provided to a patient, and for communicating among other healthcare providers about that care. Proper documentation in the medical record—which is a legal document—is an essential component of quality patient care and effective risk management.

Documentation that is absent, incomplete, improper, or illegible can negatively affect the quality and continuity of patient care, as well as the defense of a malpractice claim, even when the care given was appropriate. If a patient's care is called into question, the medical record is looked to as a primary source of information and, depending upon the quality of the documentation, becomes either an asset or a liability for defending a malpractice claim. It is a fact that the quality and content of the documentation contained in medical records often is a major factor in whether a malpractice suit is won or lost.

Essential Documented Content in a Medical Record

The goal for medical record documentation is to have complete, timely, factual, and accurate information that assists in diagnosis and treatment, and clearly communicates pertinent information to other caregivers. Documentation that is complete and legible will provide the best record that the patient care you provided was within the standard of care. To gauge the adequacy of your documentation, consider what you would want to know if you were assuming management of the care of a patient unknown to you.

The New Jersey Board of Medical Examiners regulations require that treatment records, bills and claim forms "accurately reflect the treatment or services rendered" including the patient complaint, history, exam findings, progress notes, orders for tests or consults and results, diagnosis or medical impression, treatment ordered such as medications and recommended follow-up, communication of test results, and documentation of the existence of any advance directive for healthcare with inquiry regarding same documented on an intake history form, and in other appropriate circumstances such as a serious illness. (N.J.A.C. 13:35-6.5)

All other information relevant to a patient's course of treatment and care also must be documented, including the following:

- Informed consent discussions
  Document the material risks, benefits, and alternatives that were discussed, the fact that patient questions were invited and answered, and that the patient consented to or refused treatment.
- Rationale for excluding a differential diagnosis or deviating from evidence-based standards of care
- Rationale for care provided or not provided when there is a discrepancy with the observations or recommendations of another practitioner:
  When dealing with conflicting matters between providers, such as a disagreement on a diagnosis or plan of care, review your notes and the other provider's notes and all other pertinent reports. Overlooked diagnostic reports, critical notes, and reports of consultations pointing to a different diagnosis or treatments that are not commented upon by the attending physician in the medical record may give rise to a malpractice claim for delayed or missed diagnosis.

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- Follow-up instructions
  Note or keep a copy of follow-up instructions given to a patient in the medical record. Identify any family or friends of the patient who were present when the instructions were given. Give specific instructions, e.g. "Check your temperature tomorrow morning and call me if it is 101 degrees or higher." This is opposed to a vague instruction such as, "Call me if you run a high fever."
- Patient education, including discussions, demonstrations and use of teaching aids such as models, pamphlets, videos, or internet resources
- Follow-up of referrals for a test or consult, particularly if a serious or life-threatening disease or condition is being ruled out
- Clinically pertinent telephone calls with notations regarding the caller, symptoms or complaints offered, prescriptions and instructions given, and any referrals
- Medication allergies and any adverse reactions to medications or contrast media
- Description of pertinent patient behavior such as missed appointments or failure to follow treatment recommendations
  Use language that is objective, not judgmental, or disparaging, e.g. "Patient did not return for recheck of BP," rather than, "Patient is non-compliant."
- Reports of tests and consultations dated and initialed upon review
- E-mail communications with patients, stored in either paper or electronic form

Inappropriate Content in a Medical Record

Documentation concerning matters other than the patient's health history, diagnosis, treatment, and response to care is inappropriate in a medical record. The following are examples of content that does not belong in a medical record:

- Event reports
  An event report is a separate document that is not part of a medical record. The reports and comments related to risk management issues, such as "incident report filed" or "malpractice carrier contacted" should never be noted in a medical record.
- Self-serving or accusatory comments regarding an adverse event or unanticipated outcome
  Document only the facts surrounding the occurrence and any subsequent care rendered as a result. Avoid documenting conclusions about events that were not witnessed, e.g., "Patient fell off exam table"; instead, document facts, e.g." Patient found on floor next to exam table."
- Subjective patient/family member statements regarding prior treatment or poor outcomes presented as fact
  Use quotes to record a patient's or family member's subjective impression of their condition, e.g., "Mother states child has cerebral palsy due to a birth injury."
- Criticism of care provided or perceived mistakes made by other practitioners
  Since all pertinent facts about prior care are rarely available, caution is advised in making judgments. If you disagree with a past or current caregiver, document a factual summary of pertinent clinical events and the rationale for your plan of care. Questions about prior care should generally be referred back to that provider.
- Derogatory comments about a patient or a patient's family member
- Arguments and conflict with other providers
  Finger pointing or argumentative remarks, especially after an adverse event, will only make the defense of a case much more complicated for all caregivers involved.

Documentation Mechanics

Errors in medical record documentation such as inaccuracies, omissions, illegibility, or incorrect methods to make a correction may cast doubts about the quality of the care that was provided, as well as the credibility of the provider. Incorrect or messy notes can convey the impression that a practitioner is careless or incompetent. Delays in making entries can be problematic for the defense of a claim when a note written after an adverse event appears to be defensive or self-serving.

Adherence to the following guidelines will help ensure that your documentation is proper and effective and convey the impression of a careful, competent practitioner:

- Use permanent black or blue ink, not felt pens or pencils.
- Write legibly. Print if your handwriting is not legible.
- The use of encounter forms, checklists, flow sheets, and computer-assisted documentation for high-volume activities can save time and may also reduce miscommunications and errors caused by illegible handwriting.
- Date, time and sign all entries with your name and professional designation. All entries should be in chronological order.
- Use only approved standard abbreviations.
- Do not skip lines or leave blank spaces between entries.
- Late entries should be identified as such. Record the date and time the late entry is recorded and note the entry being referenced.
- Never use liquid correction fluid or erase a notation. Incorrect entries should be corrected by drawing a single straight line through the mistake; write "error" above the line with your initials; and then write the correct word or statement.
- *Do not alter* or update existing medical record documentation or destroy or withhold elements of a medical record after an untoward event occurs or a legal claim is filed. Alteration of a medical record is a criminal offense. Even a minor alternation, once discovered, can greatly damage or destroy a practitioner's credibility.

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