Documentation: Protect Your Patient/Protect Yourself

Presented by Laura Iding RN, BSN, MBA, CPHRM
Director Risk Management
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Objectives:

- Identify consequences of poor documentation in the courtroom.
- Discuss specific examples of inadequate charting and its impact on medical malpractice cases.
- Identify guidelines for medical charting in an electronic format to avoid medical malpractice litigation.
- Understand Consequences of a Criminal Negligence allegation.
Documentation: Why do we care?

- Example: Medical Malpractice Case
- Your documentation is the only way to validate the quality of nursing care YOU provided
- Your nursing documentation refreshes your memory
- All nursing documentation needs to tell the patient’s story
Documentation Do’s

- Nursing care at time provided
- Be concise, objective, and clear
- Record each phone call to provider. Include time, message and response
- Record enough, concise information to tell the whole story
- Consult your leadership if you are not getting provider engagement in the patients care
- Consult your leadership team if you are concerned if it is appropriate to document certain issues
- Utilize the chain of command if needed
- **Speak up to your peers if there are gaps in their documentation**
Documentation Don’ts

- Don’t write “Will continue to monitor”. Use “Continue plan of care”.
- Don’t chart assessments/reassessments without appropriate nursing interventions.
- Do not chart what someone else reported to you unless it is critical to the patient.
Documentation
Calling MD

- Document when you informed a physician about a change in condition or a critical value
- **WRITE THE PHYSICIAN’S NAME DOWN**
- Document when the physician sees the patient
- Document when there’s no change to the plan of care
- Do not write no response, do record the time you paged again
- Use Chain Of Command Policy
Documentation Guidelines
In an electronic age

- Legibility better than paper record
- Never share passwords
- Timeliness of entries
- Audit trails – Can help or hurt our case.
- Never cut and paste
Documentation
Event Reporting

- Document an Event objectively including anything that may have happened to contribute to the event (staffing, etc.)
- Give enough information that your leaders and risk can figure out what happened.
- Do not use negative terms related to your peers and/or providers.
- Don’t make reference to an incident or event report in the chart.
- All Event Reports are Peer Protected.
Documentation
Non-compliant patient

- Refusal of care and treatment
- Document explanation of consequences and refusal in medical record
- Document notification of physician
Results of poor charting in a medical malpractice claim

- Creates a question of fact about the care
- Your caregiver testimony will be questioned
- Your professionalism will be questioned
- The jury will make a decision on your credibility
- If the facts are not verified - increased liability
- Alterations in the record lead to allegations of fraud or “cover up”
Medical Records and National Malpractice Trends

- National Trends driving large rewards include:
  - Alleged altered records and late entries
  - Finger-pointing between doctors and hospital staff
  - Conflicting Documentation
  - EMR Audit Trails
  - Criminal Charges for Med Errors
Key Takeaways: Protect Your Patient
Protect Yourself

Documentation
- Should be clear, accurate, and concise
- Improves interdisciplinary communication
- Lends to quality outcomes and patient safety
- Is used for communication, regularity, coding/billing, evidence of provision of quality care
- Is used in the legal system/litigation
- Shows patients participation and understanding of their plan of care
- The whole story of the patient’s care during their encounter or hospitalization
- Risk Management is there to help support you and your practice.
Questions?