STRENGTH. SERVICE. KNOW-HOW. VISION.

Documentation in the Electronic Record

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Objectives

- Elements of quality documentation
- Risks of poor documentation
- Authenticity of your records
- Identify strategies for ensuring quality documentation
- Examples of poor vs. good documentation

Legal Health Record

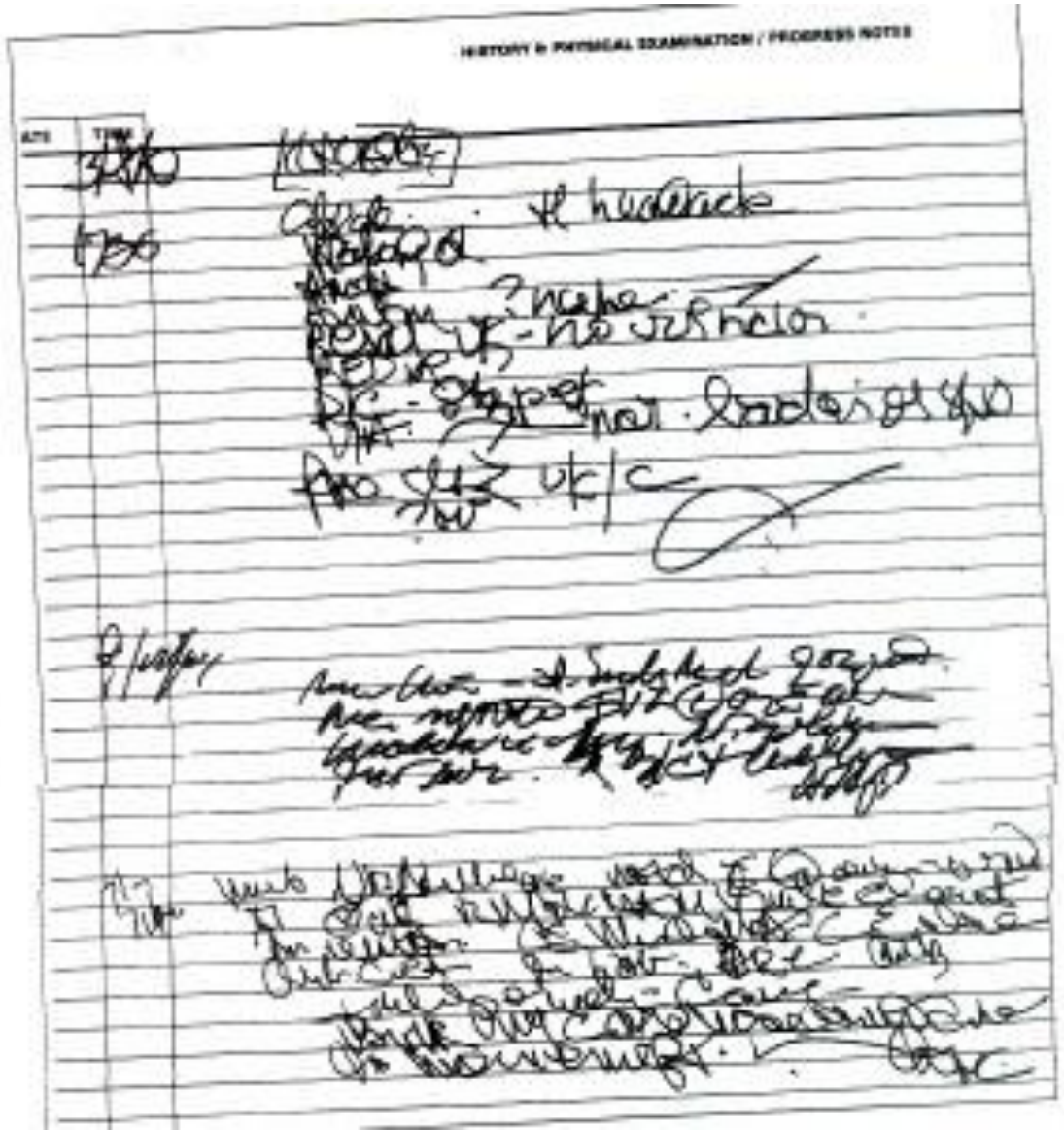
"Generated at or for a healthcare organization as its business record and is the record that will be released upon request"

American Health Information Management Association
www.ahima.org

Purpose of Health Record

- Legal record
  - Supports decision analysis
- Patient safety
  - Coordination / continuity of care
  - Quality review
  - Generate data for research – “best practices”
- Compliance
  - Regulations / credentialing
  - Reimbursement

What the EHR has Prevented



What the EHR Has Not Prevented

Documentation issues are among the most prevalent yet preventable causes of patient harm and malpractice claims

Documentation: A Significant Factor in Malpractice Claims

- Malpractice
- Patient communication
- Communication among the healthcare team
- System failures
- **Documentation**
- Informed consent

Documentation

"In court the medical record is the care rendered. If it isn't in the record, it didn't happen."

Documentation and Malpractice

- Quality documentation
  - Critical to defense
    - Malpractice cases are settled 2 – 5 years after the occurrence. Documentation refreshes your memory
  - Supports the care given and the decision making even when there was a negative outcome
  - Good documentation helps tell the story of events as they have happened

Quality Documentation

- The medical record is the primary vehicle for communicating among the healthcare team
- If documentation is poor, patient care is compromised
- Poor documentation leads to confusion

Quality Documentation

- Quality documentation reflects only pertinent medical care and treatment and uses only concise and professional language to reflect that care
- Factual documentation – refrain from inserting your personal opinions
- Refrain from jousting

Inadequate Documentation and Malpractice

- Increases the filing of claims
  - Attorney experts look for “red flags”
- Causes patient injury
  - Loss of communication, coordination and continuity
- Is the leading reason medically defensible malpractice cases are settled or lost at trial

“Red Flags”

- Medication/treatment ordered but not documented
- Lack of patient teaching or discharge planning
- Charting inconsistencies
- Lapses in time
- References to incident report or discussions with risk management
- Lack of informed consent

“Red Flags”

- Fail to monitor or fail to act when patient condition deteriorates
- Battles between health care providers
- Late entries that aren’t labeled as such or appear to be self-serving
- Fraudulent or improper alterations of the record
- Destruction of records or missing records – spoliation of evidence argument from plaintiff attorney(s)

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Trustworthiness

Integrity

- Changes
- Completion
- Version management
- Downtime documentation
- Audits

Authenticity

- What record is the original?
  - imaged documents
  - electronic documents
  - paper documents
- Assurance that electronic information hasn't been altered

Accuracy

- Validation of identity — each entry linked to specific ID
- Information from other systems
- Chronology

Authorship

- Authorized persons who may document in EHR
- Access level
- Unique ID
- Attester

Authentication

- Indicates authorship
- Attestation
- Multiple individuals
- Authentication of care by others

Amendment

- Correction
- Amendment
- Late entry
- Patient amendments

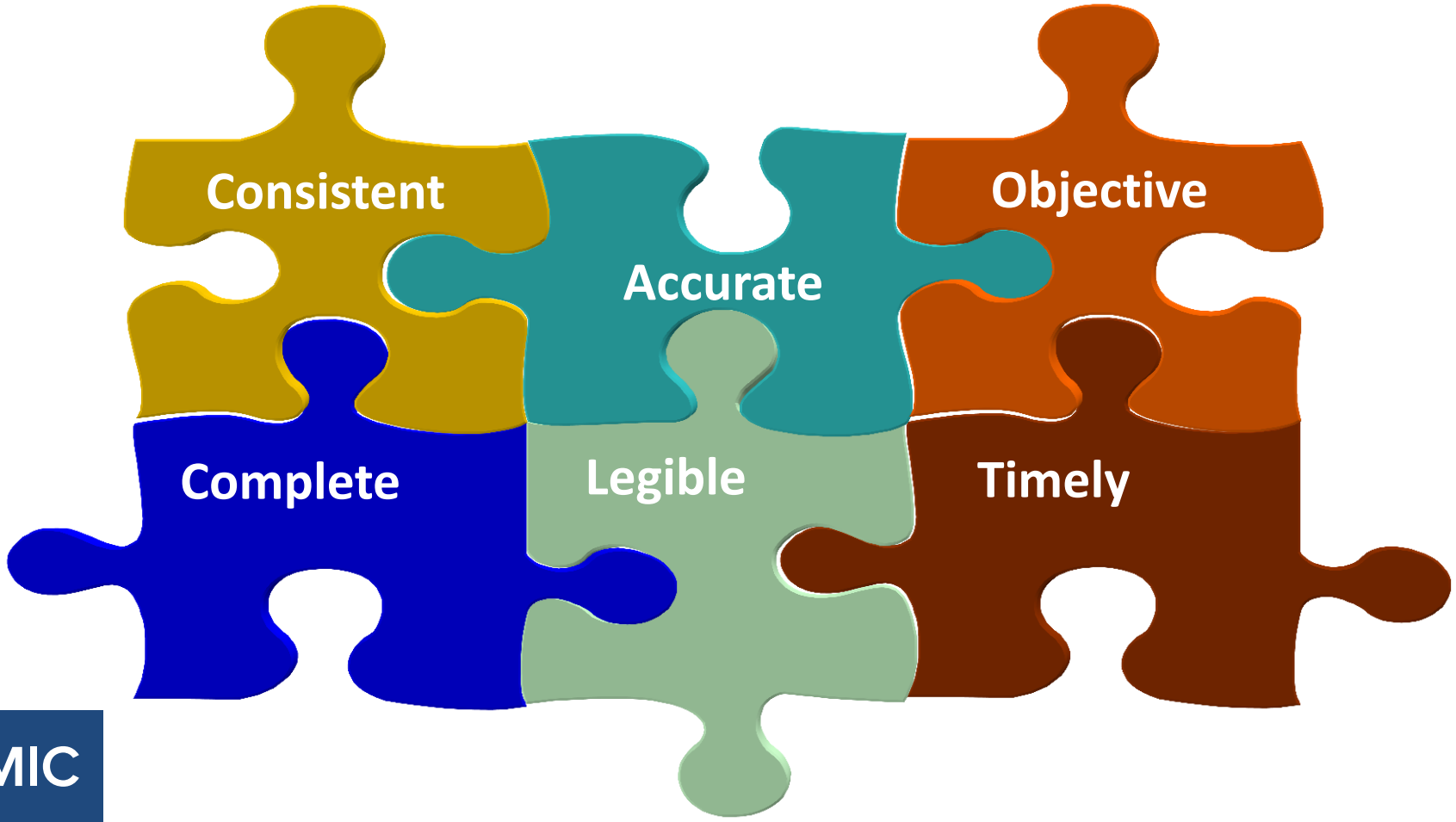
Alteration

- Intentionally
- Tampering
- Increases potential liability for the organization

Protecting Trustworthiness

- Develop policies
- Documentation standards
- Educate staff
- Update as necessary

Elements of Quality Documentation



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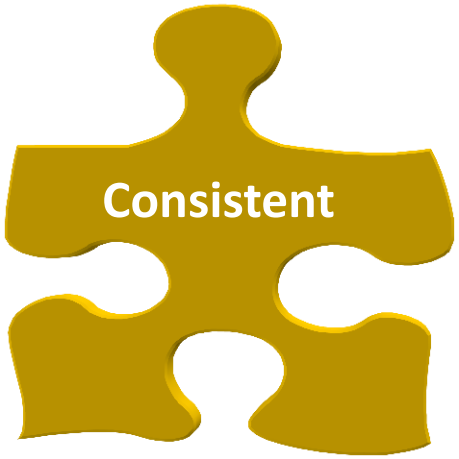
Consistent Documentation



- Format
  - Forms and flow sheets
  - Templates/boilerplates
  - Canned text (EHR)
  - Location in the medical record
- Leave no blanks- don’t skip spaces

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Consistent Documentation

- Sign every entry with name and credentials
  - Initials - flow sheets, medication and treatment records
- Follow facility documentation standards
  - Documentation system – narrative, charting by exception, etc.
  - Defines “normal”
  - Frequency

Accurate Documentation

- Double check patient name/secondary ID
  - Verify all reports, results and documentation
- Reread your entries
- Use only acceptable abbreviations
- Correct appropriately

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Inaccurate documentation: Review Entries

- Admitting note dated 10/28; first progress note dated 10/26
- Resident enters 4 y/o male; attending specifies 4 month old male
- ER note reads “fractured left hip” & admitting notes says “fractured right hip”
- “Call light in reach. Verbalizes no complaints. Pt comatose.”

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Inaccurate Documentation: Review Entries

- Large brown stool ambulating in the hall
- Dr. Blank wants to sit on her abdomen & I agree
- Patient has left white blood cells at another hospital
- She has no rigors or shaking chills but her husband states she was very hot in bed last night
- Patient has two teenager children but no other abnormalities

Inaccurate Documentation: Read Dictation

Transcribed as:

"Balony amputation"

Dictated as:

"Below the knee amputation"

Transcribed as:

"Had no carcinoma"

Dictated as:

"adenocarcinoma"

Transcribed as:

"Patient had a Papst beer today"

Dictated as:

"Patient had a PAP smear today"

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Accurate Documentation

- Use acceptable abbreviations
  - Avoid “never” abbreviations
  - Use only facility approved abbreviations
  - Use abbreviations only when the meaning is obvious
  - Question meaning whenever you are uncertain
- Never use abbreviations for diagnosis, surgical procedures or medications

Accurate Documentation

- Appropriately correct errors in paper record
  - Single line strike out and “error”, date and initials
  - Avoid masking, erasing, or overwriting

Accurate Documentation

- Late Entry / Addendum
  - Follow chronological order
  - Label as “late entry” or “addendum”
  - Appropriate Use
    - Correction of facts – persons involved, time of event, sequence of events
    - Addition of facts or clarifying information

Accurate Documentation

- Templates can add efficiency and consistency
- Template Risks
  - What is “normal”?
  - “Drift”
  - EHR Risks
    - Drop-down menu
    - Loosing pertinent data
    - Generic Templates

Objective Documentation

- Document what you see, hear, smell, count, measure, perform … be specific
- Signs and symptoms should be factually described using your senses
- Use “quotes” for verbatim statements from patients/families

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Avoid:

- Subjective statements (your assumptions or personal opinions)
- Generalizations and vague words
- Derogatory or discriminating remarks about the patient/family
- Staffing problems
- Alleged negligence by co-worker or statements regarding prior treatments

Document This, Not That

Subjective	Objective
"Slept all night"	Checked on rounds every 2 hours, eyes closed, respiration's regular
"Patient is nervous"	Patient is pacing and repeatedly asking questions about length of stay, expected pain, and required time off from work
"Drank fluids well"	Drank 1000 ml water past 8

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Complete Documentation

- Patient stated reason for seeking care
- Assessment factors/clinical observations/ baseline data
- Medications/treatments/education
- Response to interventions/medications/ testing etc.

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Complete Documentation

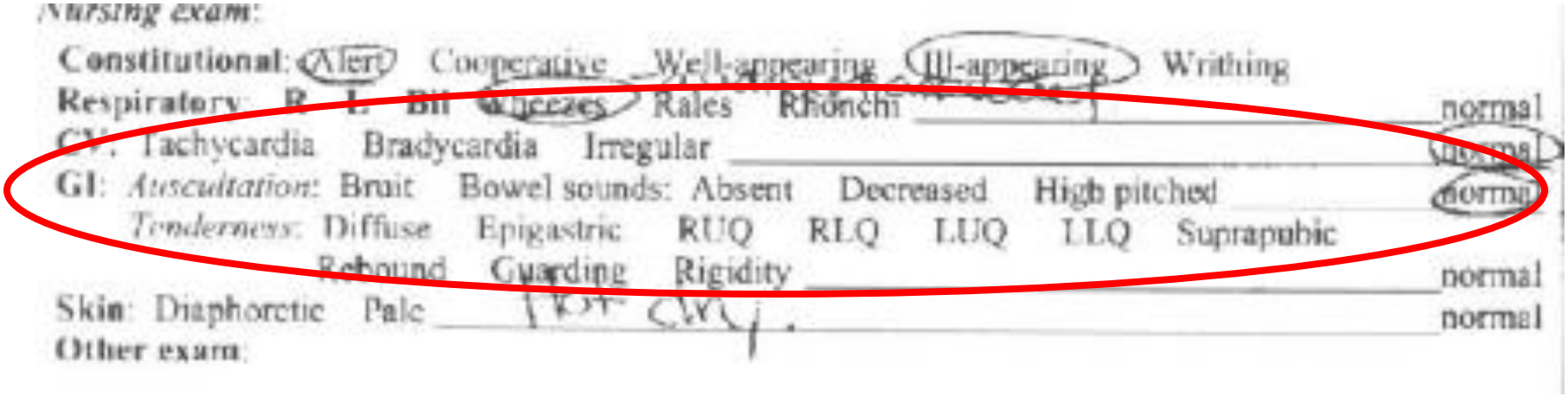
- Treatment plan/discharge plan
- All entries:
  - Dated
  - Timed
  - Signature

Complete Documentation

- Education
  - Diagnosis – treatment options
  - Procedures
  - Medications
  - Discharge Instructions
- Verifying Informed Consent

Incomplete Documentation

- Assessment/observations/baseline data
  - Admitting diagnosis was abdominal tenderness


Nursing exam:

Constitutional: Alert Cooperative Well-appearing Ill-appearing Writhing

Respiratory: R L Bil Wheezes Rales Rhonchi normal

CV: Tachycardia Bradycardia Irregular normal

GI: *Auscultation:* Bruit Bowel sounds: Absent Decreased High pitched normal

Tenderness: Diffuse Epigastric RUQ RLQ LUQ LLQ Suprapubic

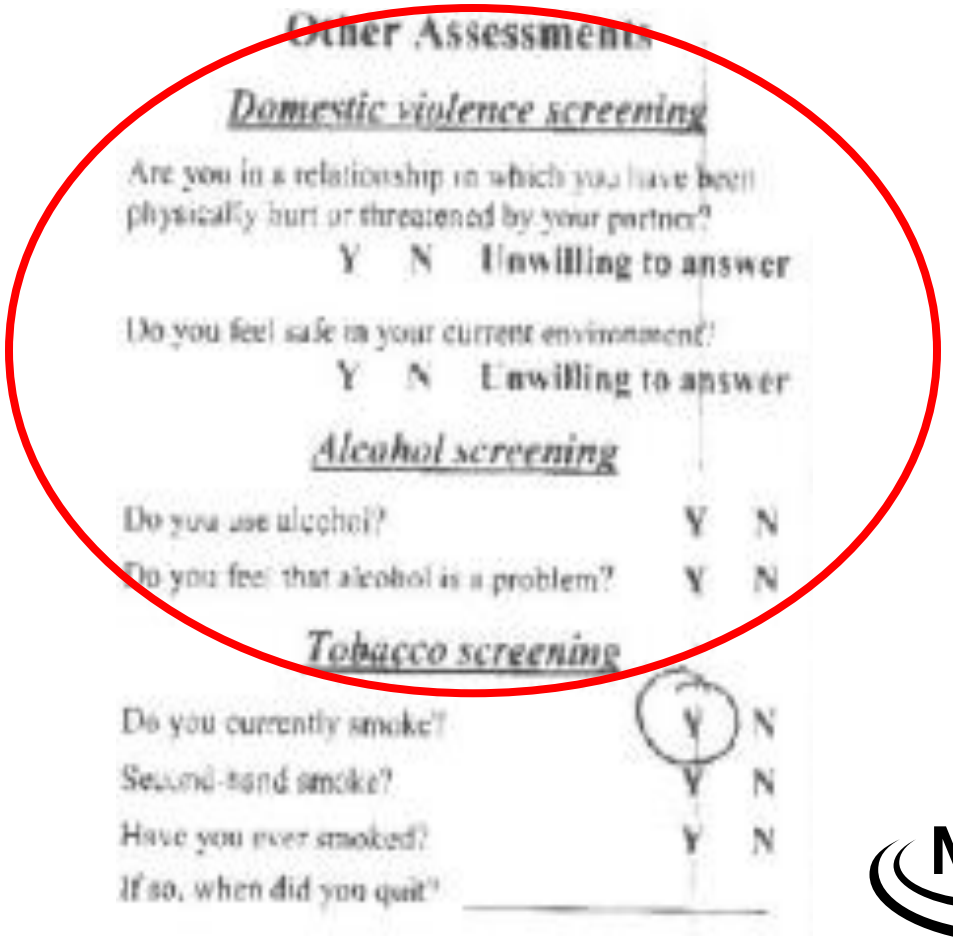
Rebound Guarding Rigidity normal

Skin: Diaphoretic Pale normal

Other exam:

Incomplete Documentation

- Assessment/baseline data
  - Leave no blanks



Other Assessments

Domestic violence screening

Are you in a relationship in which you have been physically hurt or threatened by your partner?
Y N Unwilling to answer

Do you feel safe in your current environment?
Y N Unwilling to answer

Alcohol screening

Do you use alcohol? Y N

Do you feel that alcohol is a problem? Y N

Tobacco screening

Do you currently smoke? Y N

Second-hand smoke? Y N

Have you ever smoked? Y N

If so, when did you quit? _____

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Incomplete Documentation - claim

- Assessment/clinical observations
  - Whenever a change in patient condition, document what you did about it?
    - Notification – MD, supervisor, family
    - Action plan
    - Treatments / intervention
    - Monitoring

Incomplete Documentation - claim

- All pertinent information related to intervention
  - Documentation of site/mode
    - Injection of Demerol/Vistaril
  - Court ruled failure to document along with “other evidence” supported injury claim

Incomplete Documentation – claim

- Lack skin assessment
- Lack documentation of padding used in positioning
- Lack of documentation of efforts to reposition post-operative

Eight Common Charting Errors

- Failing to record pertinent health information
- Failing to record nursing actions
- Failing to record medications
- Recording on the wrong chart
- Failing to document a discontinued medication
- Failing to record drug reactions or changes in condition
- Transcribing orders improperly

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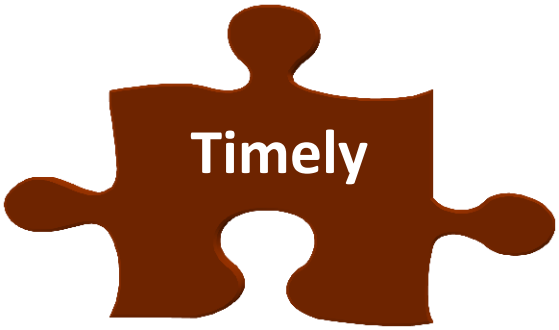
Nursing Staff Risks

- Failure to properly assess and monitor patient
- Failure to communicate changes in patient condition
- Failure to question orders
- Failure to perform according to policy
- Failure to properly administer medication
- Failure to document

Timely Documentation



- Chronological charting is preferred
  - More accurate, comprehensive, and precise
  - Keeps interventions/actions and patient outcomes in perspective
  - Real time charting enables you to have a better understanding of patient progress

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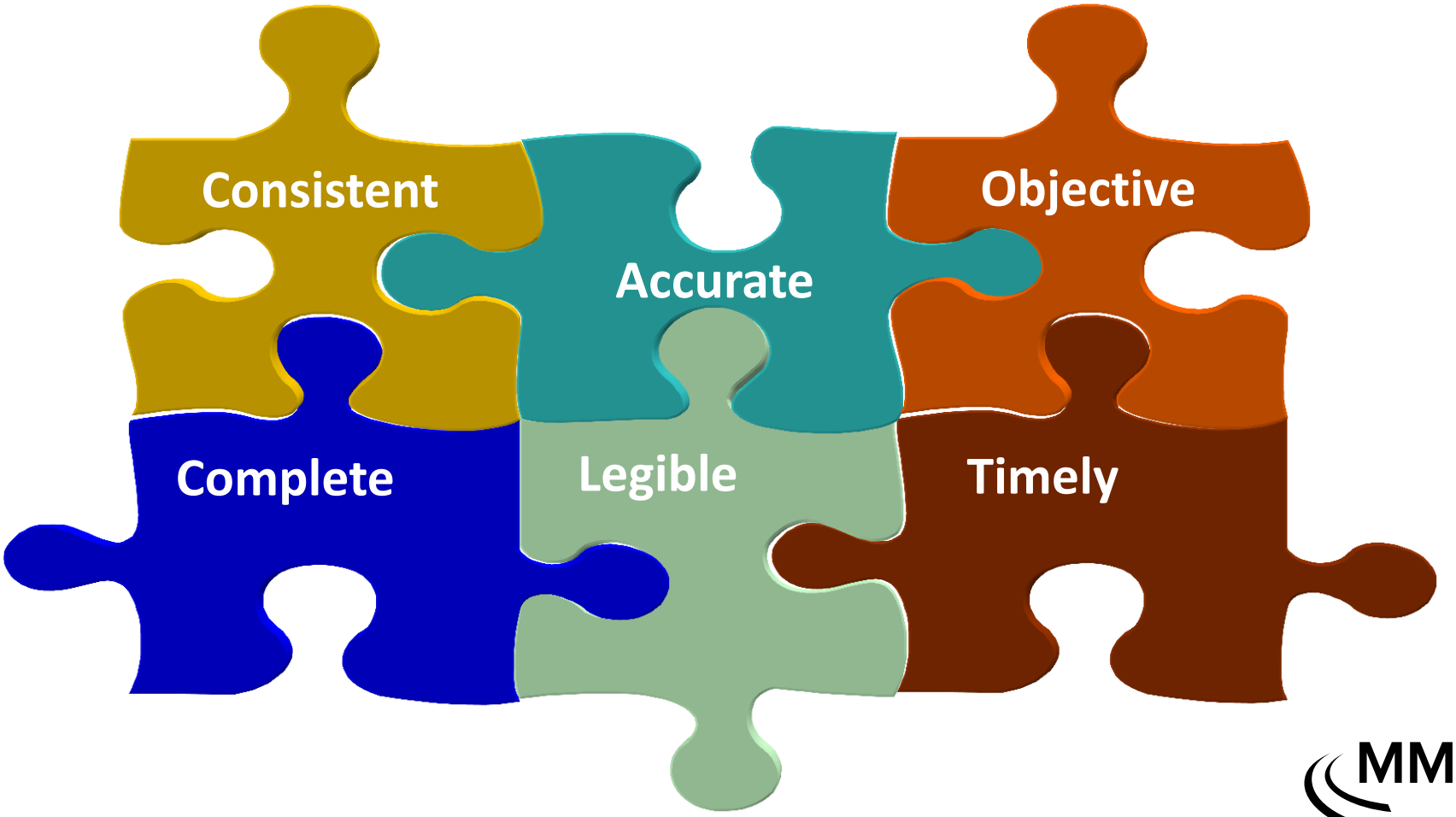
Timely Documentation

- Chart as you go — even though you are busy, the briefest of notes preserves credibility and increases accuracy

Timely Documentation

- Timed Entries
  - Treatments, interventions, medications etc.
  - MD notification
  - Supervisor, family notification
  - Transcription of orders – order entry
  - Securing consents, authorizations, releases etc.

Elements of Quality Documentation



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High Risk Documentation Issues

- Event/Incident/Occurrence
- Physician Notification
- Chain of Command
- Patient Education
  - Informed Consent/
  - Refusal of Care
  - Discharge Instructions

Physician Notification of Decline in Patient Condition

- Time/method of notification
- Time physician response
- Information given to physician
- Orders received – timed
- Orders implemented - timed

Chain of Command

- Physician, medical staff, administrative staff
  - Time/method of notification
  - Time/method repeated attempts
- Ongoing assessments of patient condition
- All orders/instructions received
- Actions
- Patient response

Malpractice Case Example - Discharge Instructions

- Fever 100.2 day of dismissal
  - Lacked documentation of physician notification
  - Lacked documentation of discharge instructions
  - Failure to act as patient advocate

Refusal of Care

- Document
  - Consequences of “refusal”; risks and benefits of care
  - Quotes – patient response
  - Nursing actions
    - Compromise – is there an alternative to reduce potential adverse effects of refusal
    - Notifications – MD, supervisor, family

Malpractice Case Example
- Refusal of Care

- Physician order for pulse oximetry
- “Informed Refusal” documentation absent
- Lack of assessment
- Failure to notify physician

Documentation Strategies

- Verify the document belongs to the right patient prior to entering data
- Never leave blank fields unless per policy
- Be consistent in documentation habits & data entry

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Documentation Strategies

- Be specific about your patient
- Read previous charting
- Document frequently
- Use only approved symbols & abbreviations
- Follow policy on correcting a documentation error, clarification or making late entries

Documentation Strategies – Perform your own "chart audit"

- Does it tell the complete story? Is it accurate?
- Are all entries legible?
- Is the meaning of all abbreviations obvious?
- Are there inappropriate comments regarding patient, family, other providers?
- Does medication administration record reflect physician orders? Treatments?
- Is patient response recorded?

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Facility Strategies to Improve

- Written documentation policies
- Standardized templates/forms/flow sheets
  - Routinely reviewed & updated
- Ongoing facility staff education
- Compliance program/chart reviews
  - Monitor, evaluate, feedback

Potential New Risks

- Emerging technology
- Information challenges
- Increased expectation
- Increased time and skills for physicians
- Corporate liability for inappropriate use

QUESTIONS