MODULE FIVE

BETTER DOCUMENTATION

OUTLINE

A. Introduction

1. "Document, document, document" causes more problems than it solves.

2. The patient is always more important than the chart.

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B. Documentation Myths

1. Myth #1
   Lawsuits are caused by poor documentation.

   a. Poor documentation never caused a lawsuit.

   b. Patients could care less about the chart. It is never the reason that they seek the services of an attorney.

   c. No physician has ever been sued by a chart.

   d. **TAKE HOME POINT:** Although documentation is important, the chart is never more important than the patient.

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2. Myth #2
   Physicians frequently lose malpractice cases because of poor documentation.

   a. Case Study: 35 year old woman in the ER with abdominal pain.

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   b. Documentation is inseparable from the reality of the care which was provided.

   c. **TAKE HOME POINT:** "Not done, not documented."

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3. Myth #3
When bad things happen, extra documentation can save you.

   a. Case Study: The Unexpected Result

   b. Trying to tie up loose ends and restate your case is a mistake.

      i. may contradict another note or lab result

      ii. decreases available options of defending the case

      iii. adverse effects of "heat of the moment"

   c. **TAKE HOME POINT:** When bad things happen, a little extra documentation will usually hang you.

4. Myth #4
You can cover yourself by blaming someone else.

   a. Case Study: The IV that runs all night.

   b. When something goes wrong, we're all vulnerable.

   c. **TAKE HOME POINT:** Because we all live in a medical-legal glass house, we need to be careful about casting stones.

C. How to Document

1. Legible, and give the appearance of an unemotional, professional approach.

   a. Big, block letters

   b. Any punctuation mark other than a period

   c. The medical record is not your diary

   d. Use, but don't abuse templates

D. What to Document

1. Every fact that is needed to convert the patient's complaints into the physician's assessment and plan.

    a. A clinician who did not see the patient must be able to read the chart and arrive at the same assessment and plan that you did.

    b. Case Study: A 30 year old man with headaches.

        i. Mentally construct a differential diagnosis.

        ii. Document our way through the differential diagnosis.

        iii. Record any significant past medical history, social history, medications and allergies.

        iv. Finish with, "No other complaints."

        v. **TAKE HOME POINT:** Document through the differential diagnosis, mention that the patient has no other complaints and sign your name.

2. The reason that we are unable to accomplish Plan A.

    a. Case Study: Patient who needs an MRI to rule out a brain tumor.

        "Neither patient nor insurance company willing to pay for MRI, will do CT."

    b. **TAKE HOME POINT:** When you abandon Plan A in favor of Plan B, document the reason. Otherwise, someone might say that you are the reason.

3. Our justification for doing something that looks unconventional.

    a. Case Study: An elderly woman with elevated blood pressure.

        The explanation for an unconventional approach must appear in the record.

    b. **TAKE HOME POINT:** When using an approach that looks unconventional, explain yourself in the chart. It may save you the trouble of to explaining yourself later.

4. Any warning that we issue to the patient.

    a. A warning downloads the risks of a situation to the consumer.

b A warning is appropriate any time we entrust someone with risks that they may not fully appreciate – virtually every patient at every visit.

c. Case Study: A 55 year old woman refuses to undergo a screening mammogram.

i. "Risks of refusing mammogram discussed."

ii. "Mammogram refused" is insufficient.

d. Case Study: A 44 year old man is referred to a cardiologist.

"Referred to cardiology, Importance discussed."

e. **TAKE HOME POINT:** A proper warning shifts the responsibility to the patient.

5. Anything that is needed to satisfy the various coding and billing requirements

E. Documentation Dilemmas

1. Making revisions or alterations to the medical record

a. Use a single horizontal line, sign and date the changes.

b Extended periods of time make a correction more suspicious.

c. Do not make corrections after a bad event occurs.

d. Do not make corrections after being sued.

2. Documenting medical errors

a. Case Study: A patient who receives the wrong antibiotic.

b. There are no magic words.

c. No amount of documentation can change what has already happened.

d. Attempted explanations merely draw attention to the matter.

e. **TAKE HOME POINT**: You are not required to incriminate yourself and should generally avoid doing so.

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3. Disagreement with another provider

a. Case Study: A disagreement over starting antibiotics.

b. Agreement is best for the patient and provides a unified line of defense.

c. We should always be working toward agreement.

d. **TAKE HOME POINT:** Collegial debate is both important and valuable, but it should not take place in the patient's chart.

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F. The Attorney-Client Privilege

1. Case Study: Where to document your thoughts.

2. Anything relevant to the patient's care can usually be discovered by the plaintiff.

3. "Confidential attorney client privilege" and "To my attorney:"

4. **TAKE HOME POINT:** Your thoughts as to the strengths and weaknesses of your situation should not be expressed outside of the attorney-client privilege.

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G. Conclusion

If you spend your time focused on the patient, most of the documentation will take care of itself.