Medical Records Documentation & Liability

FTCA University, June 1, 2017
Iowa Primary Care Associates
3:45 - 4:25 p.m.

Christine Boyer, RN, JD, Esq.
KEPRO

HRSA Health Center Program

Objectives

- Provide general advice regarding best practices for medical records documentation
- Identify ineffective documentation techniques which frequently lead to findings of liability

Objectives (continued)

- **Review goals of effective documentation:**
  - Facilitate excellent patient care by:
    - Enabling effective provider to provider communication
    - Enabling effective provider to patient communication
- **Avoid a finding of liability stemming from improper or poor documentation**
- **Compliance – meeting state and federal requirements**

Documentation Topics

- How documentation is relevant to medical negligence claims
- Reasons to strive for improvement
- Factors affecting documentation quality
- Effective documentation

Polling Question 1

- **Do you believe that effective documentation has an influence on patient care and outcomes?**
  a) Yes
  b) No
  c) I don't often consider whether documentation influences patient care and/or outcomes

Negligence

Failure to provide a patient with the standard of care that a reasonably prudent healthcare provider would exercise in the same or similar circumstances.

- **Negligence can often be proven by poor/ineffective or absent documentation or disproven by effective documentation**
- **Poor documentation in itself is a breach in the duty to provide care meeting accepted standards**

Four Elements Required to Prove Negligence

Patient's attorney must prove all of the following:

- **Provider had a duty to render care meeting the accepted standard**
- **Standard of care was not met**
- **Causation – it was the failure to meet standard of care which caused the injuries**
- **Patient suffered damages**

Quality of Documentation

Ineffective – poor, inaccurate, untimely, unclear, illegible, incomplete

Effective – accurate, timely, clear, relevant, complete

Why is effective medical record documentation so critical?

Ineffective/poor documentation practices can lead to:

- **Provider to provider miscommunication**
- **Communication breakdown**
- **Weakened legal defense**
- **Increased risk and liability**
- **Patient harm**

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Why be concerned about improving documentation methods and practices?

Consequences of ineffective documentation:

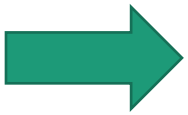
- **Incorrect treatment decisions**
- **Expensive, painful, and/or unnecessary diagnostic studies**
- **Unclear communication between consultants and referring physicians**

Possible patient harm and finding of liability if claim filed!

Why be concerned about improving documentation methods and practices?

Results of effective documentation:

- **Clear provider to provider communication**
- **Clear provider to patient communication**
- **Ability to prove standard of care was met**
- **Compliance – state and federal requirements are met**



- Decreases the risk of patient harm
- Increases likelihood of positive outcome
- Decreases likelihood of a finding of liability if claim filed

Confidentiality – Reminder

Medical records - confidential and protected by authority of HIPAA/HITECH

Protect patient-identifiable information:

- **Papers containing patient information not relevant to medical documentation must be shredded**
- **Avoid discussing patients or families in hallways, elevators, or in other public places**
- **Patient's consent is required for release of medical records**

Polling Question 2

- **In what forum have you received education or instruction regarding the principles of effective documentation that has been most effective for you, where you have been able to apply what you have learned?**
  a) During formal healthcare provider education process
  b) Upon employment at health center, during orientation
  c) Periodically with health center education/competencies

Challenges or Barriers to Effective Documentation

- Time constraints
- Lack of understanding
- Lack of education
- Lack of oversight and education

Goal of Effective Documentation

The goal is to foster quality and continuity of care. A complete and accurate record creates a means of communication:

- **between providers**
- **between providers and patients**

regarding health status, preventive health services, treatment, planning, and delivery of care.

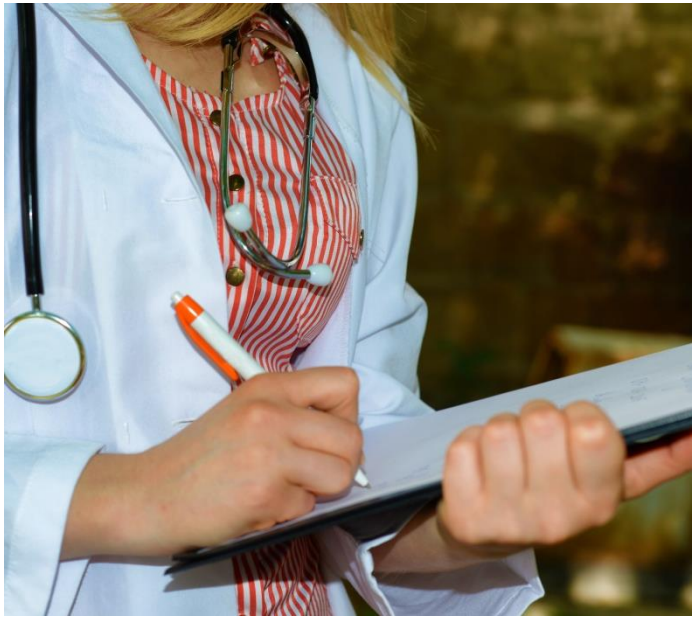
Key Components Of Effective Documentation

- Completeness
- Relevancy
- Accuracy
- Timeliness

Frequently Identified Areas for Improvement in Documentation

- Resolution of medical problems from prior visit
- Informed consent discussions
- Patient non-compliance
- Provider attempts to manage the patient using alternative plans due to noncompliance
- Patient education
- Discharge instructions
- Return visit or follow-up advice
- Missed or canceled appointments

Frequently Identified Areas for Improvement in Documentation (continued)



- Unexplained cross-outs, write-overs or squeezed-in entries
- Date and time of any amendments to record

CAUTION - Never amend or correct a medical record after receipt of notice of a potential claim.

Additional Frequently Identified Areas for Improvement

- Unsubstantiated subjective remarks in progress notes
- Lack of objectivity in assessment – medical record entries should be objective
- Failure to acknowledge that a physical exam does not substantiate a patient's subjective complaints
- Non-objective/subjective documentation
- Failure to document objective evidence or behaviors

Additional Frequently Identified Areas for Improvement

- Failure to document patient condition at end of visit/appointment
- Failure to document all discharge instructions/education materials given to the patient and the patient's acknowledgement
- Failure to document failure to appear and canceled appointments in the medical record
- ***Failure to document attempts to arrange patient follow-up***

Additional Frequently Identified Areas for Improvement

- Failure to date and time notes
- Non-measurable phrases and language –“doing well”
- Failure to document a thorough history and physical
- Failure to document differential diagnoses, especially when diagnostics are ordered
- Naming the problem being treated when giving prescriptions, diagnostic testing orders, referrals, starting a new treatment
- Inadequate space on OB forms and emergency room documentation forms
- Failure to document prenatal risk evaluation

Alterations to the Medical Record

Medical record changes are appropriate for:

- **Correcting errors**
- **Clarifying a prior note**

All changes or additions to a medical record should:

- **Be accurate and true**
- **Include the date the change is made**
- **Include the writer's initials or signature**

Tips: Alterations to a Paper Medical Record

When altering the medical record:

- **Indicate what prompted the change or addition**
- **Do not remove the old entry**
  - Cross out the erroneous entry with a single line
  - Be careful not to obscure what is written
  - Add an asterisk to call attention to the correction

Coding and reimbursement issues can result if alterations are not made properly.

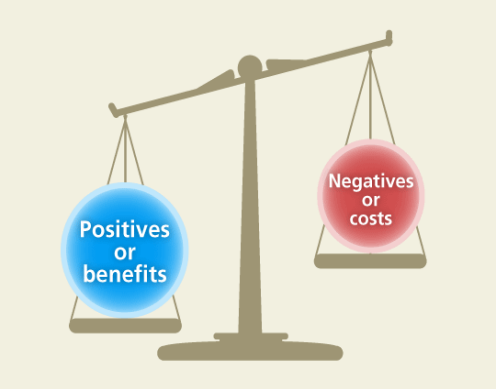
Tips: Making Alterations to the Medical Record

- Consult legal counsel before making a significant change to a medical record
- Avoid extremely late entries
- Do not alter a chart after notice of potential litigation

Effective Documentation for Physicians/Mid-level Providers

Record the risk-benefit analysis of important decisions in the clinical care of the patient.

- **Discuss benefits in addition to risks**
- **Discuss risks of declining recommended treatment**



Effective Documentation for Physicians/Mid-level Providers

DOCUMENT clinical judgment at critical decision points.

- **Clinical judgment is an assessment of the clinical situation and a response based on that assessment**

Who is your audience?

Keep in mind the audience for the medical record:

- **Other providers**
- **Nurses**
- **Utilization reviewers**
- **Professional standards review organizations (PSRO)**
- **Insurers, quality assurance reviewers, and similar review organizations**
- **The patient**
- **The plaintiff's attorney**

Audience awareness should guide your writing and result in documenting patient care and limiting liability.

Polling Question 3

- **Does your health center use electronic health records (EHR) for documentation of patient visits?**
  a) Yes
  b) No, but planning to implement within next year
  c) No, but health center has plans to use in the near future

EHR (Electronic Health Records) Advantages Related to Documentation

- Capture relevant details, provide an accurate and timely picture/story of events
- Can be user-friendly – ease of use for provider
- Can increase clarity, comprehensibility for the reader
- Reliable storage and access

EHR – Documentation Disadvantages

- Easy to overlook the need to update in real time
- Can be difficult to use
- Can be difficult to navigate for the reader
- In some instances, scribing or authenticating notes made by another person can be considered a fraudulent act if not properly acknowledged

Potential Risk Areas in EHR Related to Documentation

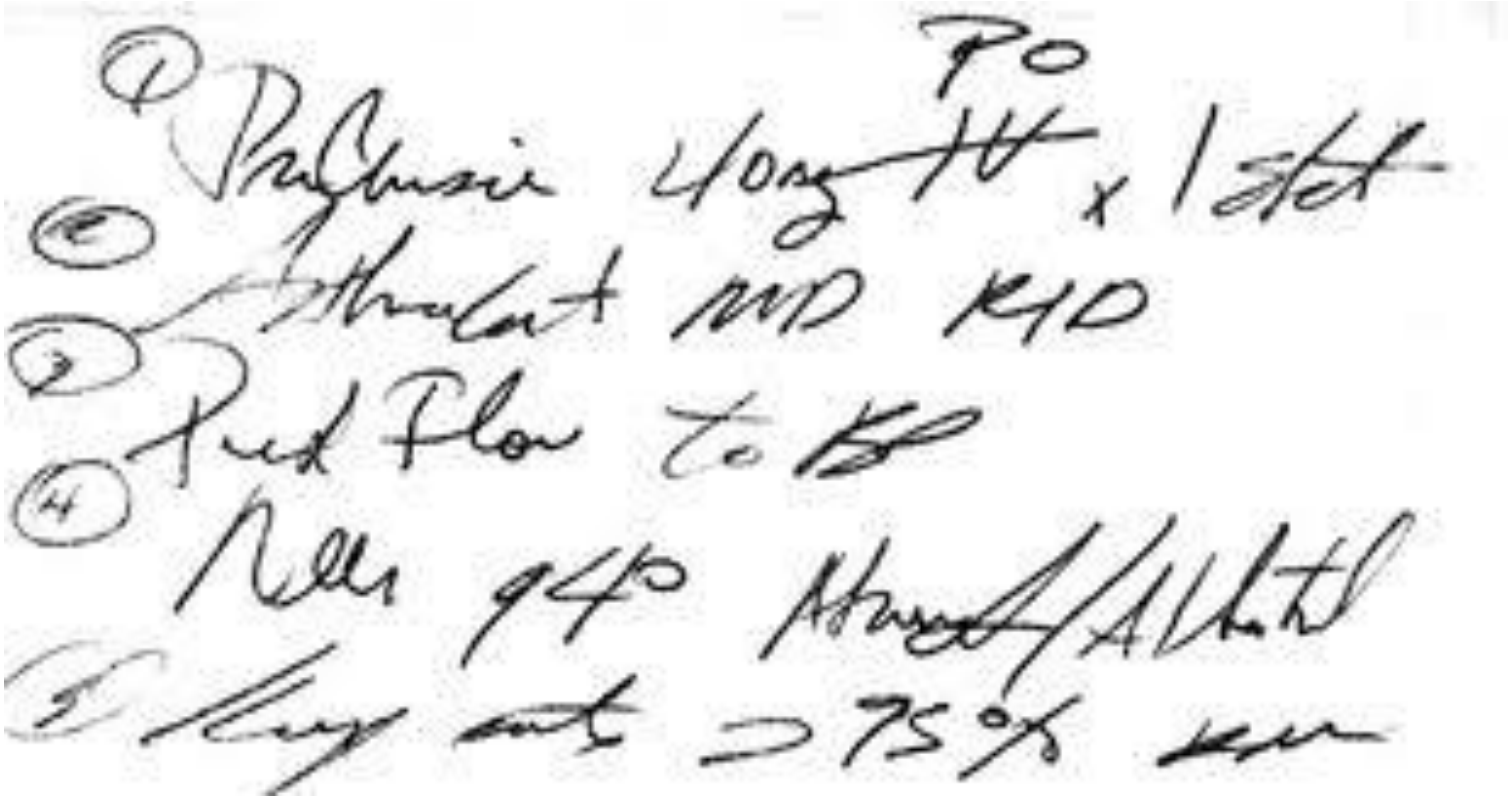
Documentation shortcuts are extremely tempting for busy clinicians with an EHR.

- **Re-use of previous documentation with a single click**
- **Use of copy and paste may be construed as fraudulent**
- **Compromised medical records**
- **Possible reduced credibility of record**

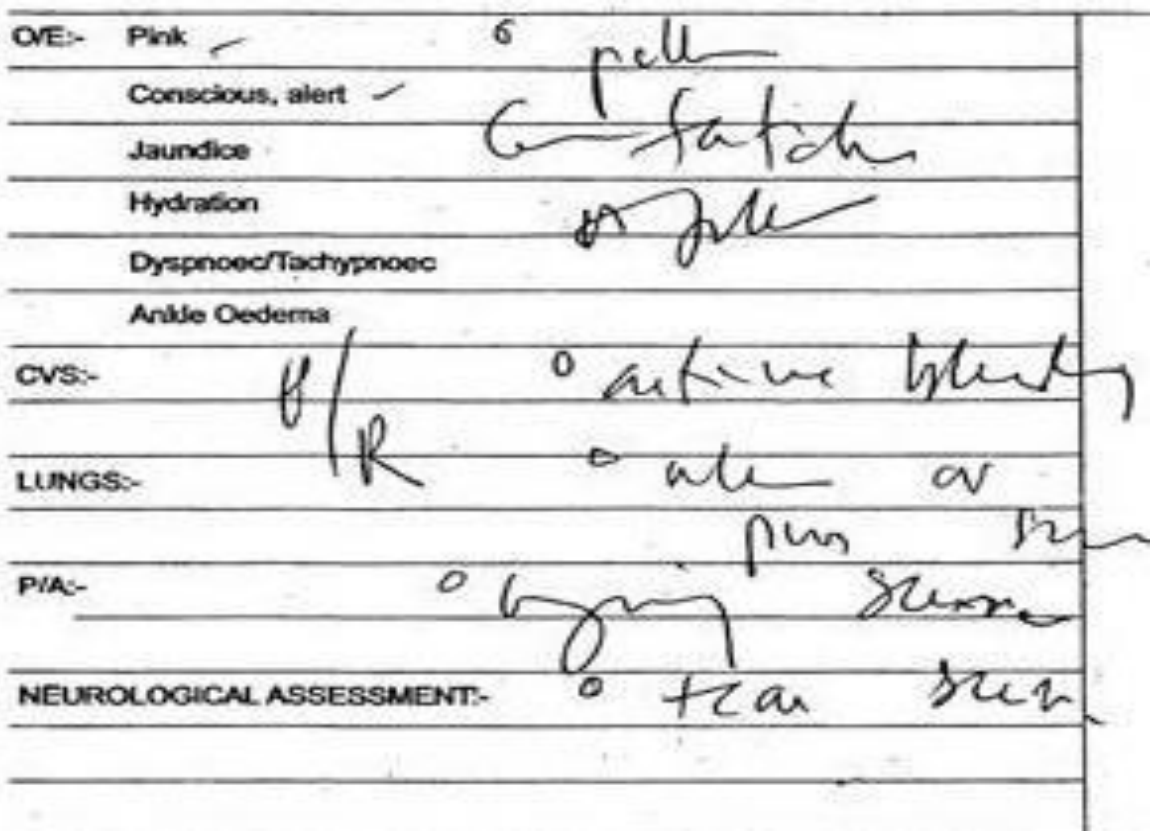
Legibility of Handwritten Records

- **Documentation should reflect professionalism and competence**
- **Illegibility results in:**
  - The appearance of shoddy provider care and management by the health center
  - Unclear communication between providers and staff – potentially causing patient harm
  - Problems created if the case leads to a legal claim which must be defended

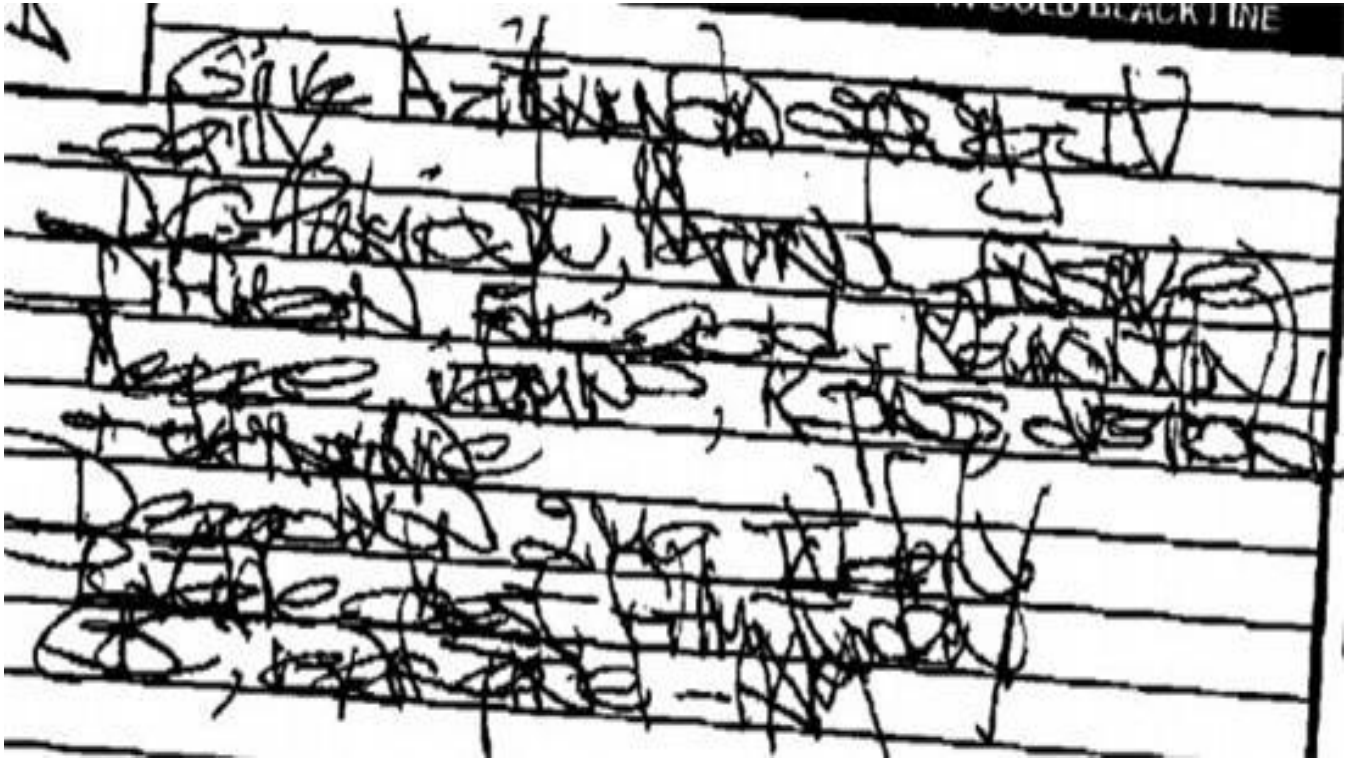
Example – Illegible Orders



Example – Illegible Progress Note



Example – Illegible Order



Practice Case 1

Health Center Visit March 2013

In early March 2013, a 53-year-old male with complaints of pain on the bottoms of feet for two months stated, "Just hurts, especially in the morning." Documentation of the assessment at this initial visit reflects feet were warm with brisk capillary refill, pulses present.

Patient had three more visits by health center providers.

Practice Case 1

Health Center Visit 10/09/13

CLINIC NOTE: This is an inmate who has edema to his left lower foot. He injured it two or three weeks ago and went to the doctor and was told that it wasn't broken. He says that it has been swollen and getting worse. He has never had gout that he knows of. He does have gout according to when he was checked in here two weeks ago.

PE: BP: 164/80. Pulse: 74. Throat is clear. TMs are clear. Neck is supple. Chest is clear. Abdomen is soft and non tender. Bowel sounds are normal. Skin is warm and dry.

CLINIC COURSE: He was given Toradol 60 mgs IM.

DX: Edema, left foot, probably gout.

TX: (1) Prednisone 40 mgs daily for five days. (2) Colcrys 0.6 mgs b.i.d. (3) Ibuprofen 800 mgs b.i.d. (4) He is to recheck back in three days.

Practice Case 1

Health Center Visit 10/11/13

CLINIC NOTE: This is an inmate who has gout. I just saw him a couple of days ago. He is on Colcrys and Prednisone.

PE: BP: 152/95. Pulse: 72. The swelling is down quite a bit.

CLINIC COURSE: He was given Toradol 60 mgs IM. He was given Decadron 10 mgs IM.

DX: Recheck gout.

TX: Continue his other medications.

Practice Case 1

Health Center Visit 10/24/13

CLINIC NOTE: This is an inmate who has gout in his foot. He also has some foul smelling stuff between his fourth and fifth toes on his left foot.

PE: It looks like he has a fungal infection with secondary infection. It is foul smelling.

DX: Tinea pedis with secondary infection.

TX: (1) Antifungal cream b.i.d. (2) Keflex 500 mgs t.i.d. for ten days.

Practice Case 1

Health Center Visit 11/13/13

On November 13, 2013, patient was evaluated and admitted to hospital for gangrenous left foot/toe. He had a surgery for gangrene, which consisted of a left below-the-knee amputation.

Expert medical reviewing physician determined that standard of care was not met.

Practice Case 1

Was standard of care met?

- What was the applicable standard of care?
- Was there documentation of a proper evaluation of the patient's lower extremities?
- Did the physician order testing or referral for specialty consultation?

Practice Case 1

Standard of Care was Not Met

- The physician failed to evaluate and treat the patient's left foot pain
- Standard of care requires an examination of the affected area to help determine an appropriate differential diagnosis
- There was no adequate examination of the foot or leg documented
- Physician failed to refer the patient to a vascular surgeon or order imaging studies of the leg despite continued foot pain, swelling, discoloration, and worsening infection

Practice Case 2

- Patient was a 43-year-old female with minimal history
- Blood pressure at the initial health center visit was 217/141 and 208/110 a short time later
- No symptoms
- Not taking anti-hypertensive medication due to lack of insurance
- Anti-hypertensive medication was prescribed, patient instructed to return for follow-up in one month
- The patient found unresponsive at home 3 ½ weeks after initial visit, died from intracerebral hemorrhage

Practice Case 2

- **The HTN started in 2004 and is currently getting worse**
- **Risk factors include family history HTN and gout or CAD**
- **Pertinent negatives include chest pain, dyspnea, fatigue, headache, irregular heartbeat/palpitations, and visual disturbances**
- **Additional information: patient was previously on HCTZ – Lisinopril and stopped it in January after lack of insurance**
- **Reports medicine was controlling her blood pressure, and reports blood pressure is always higher in office**
- **Intake comments:**
  - Pap and mammogram are done and getting records
  - HTN for 10 years and needs established care

Practice Case 2

Vital Signs

Ht (In)	Wt (Lb)	BP	Pulse	BMI	Temp (F)	Resp	Pulse Ox	Pain Scale
64.33	170.40	208/110 217/141	89	28.95	98.7	16		0/10

Practice Case 2

Assessment/Plan

#	Description
1.	Encounter to establish care (V65.8). Requesting previous records including recent pap and mammo.
2.	Hypertension (401.9). Restart Lisonpril-HCTZ ($4 at Walmart). Declines flu vaccine today. Monitor BP at home - bring log to 1 month f/u visit. Please come fasting to this visit for screening labs. Advised patient to follow a low salt, low fat diet. Take medications as directed to prevent complications from high blood pressure such as heart disease, heart attack, stroke and kidney disease. An eye exam is recommended every 1-2 years. She is to schedule a follow-up visit 1 Month
3.	BMI 28.0 to 28.9 (V85.24). A healthy body mass index (BMI) ranges from 18-25. Excess weight can cause many health problems such as diabetes, heart disease, high blood pressure, back pain and knee pain. Eating a balanced diet consisting of more fruits and vegetables can help manage weight. Avoid soda. Decrease portion sizes. Exercise/walk for 30 minutes daily 5-7 times per week.

Practice Case 2

Was standard of care met?

- Was the verbal instruction to return to the health center in one month appropriate?
- What should have occurred?
- What was the applicable standard of care in terms of discharge instructions and/or referral to the emergency department for evaluation?

Practice Case 2

Standard of Care was Not Met

Expert medical review determined standard of care was not met by the provider.

- **The provider should have arranged immediate hospitalization and explained to the patient the importance and need of hospitalization to reduce blood pressure**
- **If the provider did not identify the condition as an emergency, the patient should have been instructed reasons/symptoms which would indicated the need to immediately seek emergency medical attention**

Discharge Instructions

For any condition in which follow-up is needed, the patient should be given written discharge instructions, preferably with patient signature, which explain symptoms for which the patient should seek follow-up care at the health center or the local emergency department.

Standard of Care/Documentation Overlap

- Failure to properly document is itself a breach in standard of care
- Ineffective documentation is often a combination of failure to document and failure to provide proper care
- Effective documentation supports care which meets the applicable standard

Final Important Points to Remember

- The attorneys who will represent providers and/or staff can draw only from the documentation those providers/staff have provided
- Charting/documentation techniques can defeat or defend the provider's practice in court
- In order to be truly committed to the excellent practice of medicine and delivery of healthcare to every person, effective documentation must occur
- All healthcare providers have an ethical duty to patients to learn and maintain high standards of documentation

Resources

- Guidelines for Medical Record Documentation. National Committee for Quality Assurance (NCQA) http://www.ncqa.org/portals/0/policyupdates/supplemental/guidelines_medical_record_review.pdf
- Medical Records and Documentation Standards. Group Health Cooperative, Western Washington https://provider.ghc.org/open/render.jhtml?item=/open/workingWithGroupHealth/records-standards.xml
- Medical Records and Documentation. The Doctor's Company http://www.thedoctors.com/KnowledgeCenter/PatientSafety/articles/Medical-Records-and-Documentation
- Documentation of Medical Records. Robert J. Dole VA Medical Center (Wichita, Kansas) http://www.wichita.va.gov/documents/3_Documentation_of_Medical_Records.pdf

Resources

- Complying With Medical Records Documentation Requirements https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/CERTMedRecDoc-FactSheet-ICN909160.pdf
- Fundamentals of Medical Record Documentation. NCBI https://www.ncbi.nlm.nih.gov/pmc/articles/PMC301095/
- Medical Record Documentation for Patient Safety and Physician Defensibility. MIEC Loss Prevention (medical malpractice company) http://www.miec.com/portals/0/pubs/medicalrec.pdf
- Risk Management Tools and Resources: Fundamentals of Documentation. Medpro Group. https://www.medpro.com/documentation-essentials
- Does Your Documentation Defend You? Physician Charting and Medical Malpractice Liability. Michelle M. Samadany, BSN, RN, JD, Area Vice President, Gallagher Healthcare. https://www.ajg.com/media/644145/documentation-physician-charting-malpractice.pdf
- Medical Record Documentation for Patient Safety and Physician Defensibility. MIEC Loss Prevention (medical malpractice company) http://www.miec.com/portals/0/pubs/medicalrec.pdf

Thank You

Additional Questions?

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