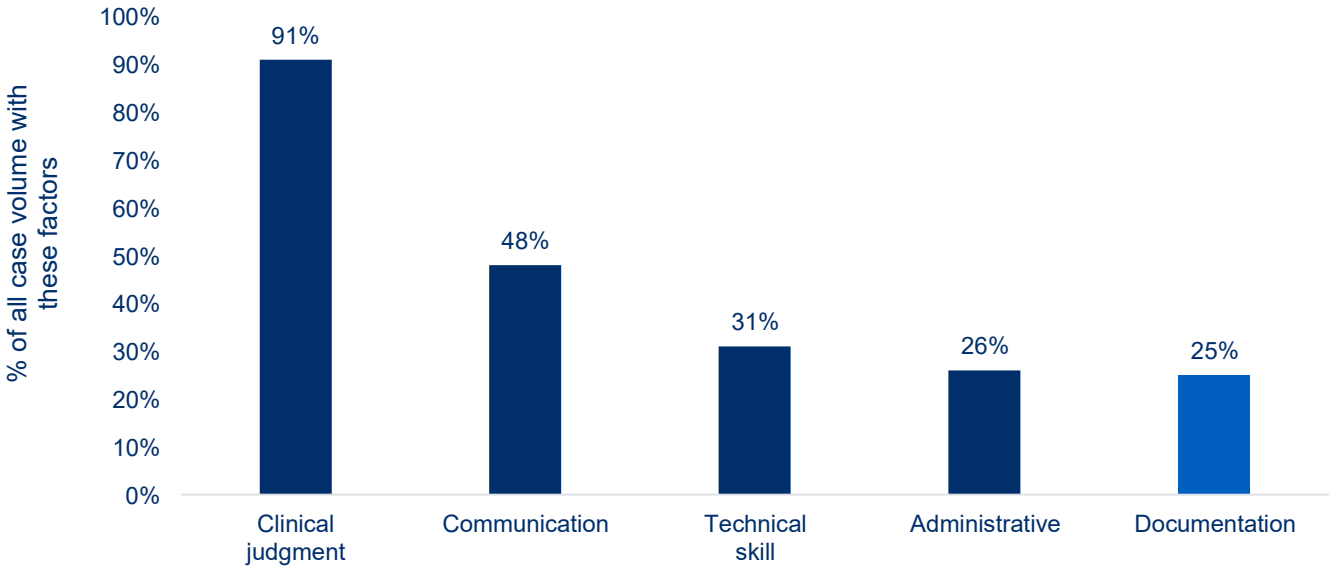
The Role of Documentation in Malpractice Cases with Clinically Severe Patient Outcomes

Accurate, clear, and timely documentation of the clinical progression of patients is a critically important part of the healthcare process. However, documentation continues to represent an area of risk.

An analysis of 11 years of clinically coded cases shows that documentation issues are consistently among the most common risk factors associated with clinically severe patient outcomes (i.e., permanent disability or death). Risk factors are multi-layered issues or failures in the process of care that appear to have contributed to the patient's outcome, and/or to the initiation of the case, or had a significant impact on case resolution. One-quarter of these high severity cases note documentation as a factor (Figure 1), whereas just 12% of low and 18% of medium severity cases do so.

Figure 1. Risk factors in clinically severe cases*



**Clinical severity reflects the National Association of Insurance Commissioners (NAIC) injury severity scale.*
Note: more than one factor is present in most cases, therefore totals are greater than 100%.

Data source: MedPro Group + MLMIC high clinical severity cases involving documentation opened 2012-2022 (N=3767)

Considering that the health record serves as a primary source of information during care transitions from provider to provider, insufficient, inconsistent or incorrect documentation of clinical information, date/time of treatment, and even a provider's clinical rationale for a course of treatment, can have profound effects on the process of care for patients and the risk of liability for healthcare providers and organizations.

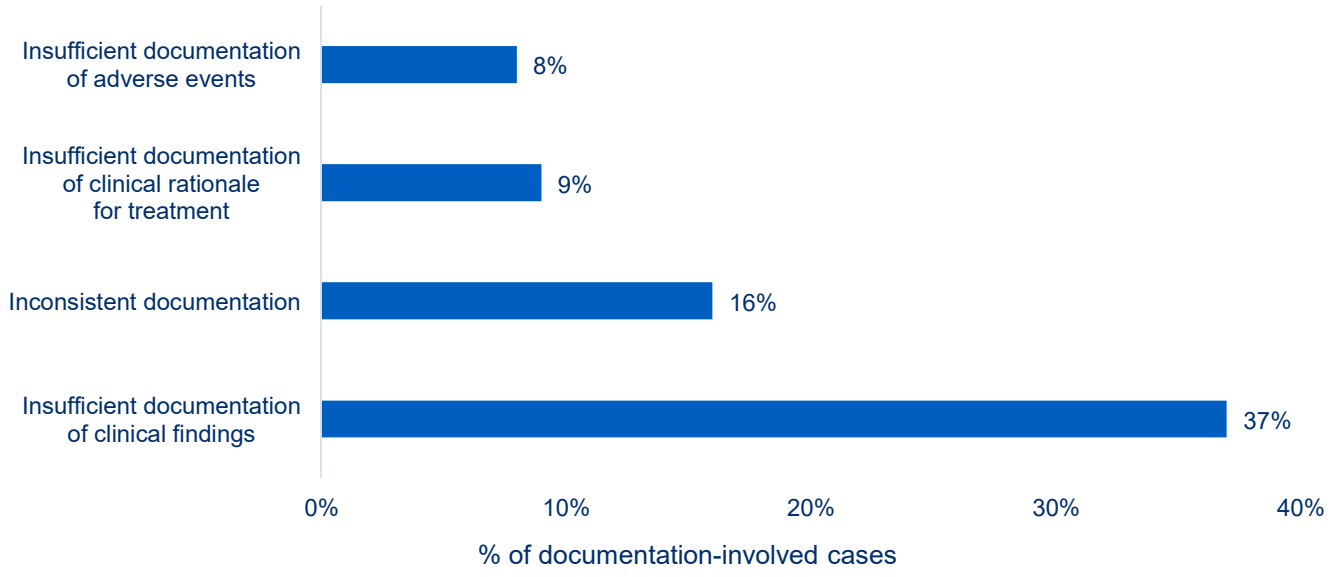
Cases involving suboptimal documentation issues also tend to involve more expensive resolutions in terms of total dollars paid for expense and indemnity costs. Thus, both clinical and financial severity in malpractice cases point to the importance of reviewing documentation protocols as part of risk management efforts.

Breakdown of Types of Documentation Issues

Generally, insufficient/incorrect documentation does not directly cause poor patient outcomes; however, lapses in documenting clinical findings, operative reports, patient vital signs, critical lab results or adverse events can lead to suboptimal patient outcomes and make subsequent malpractice cases more difficult to defend.

Addressing insufficient documentation of clinically important information in medical records is a critical risk management focus.

Figure 2. Most common types of documentation issues in clinically severe cases



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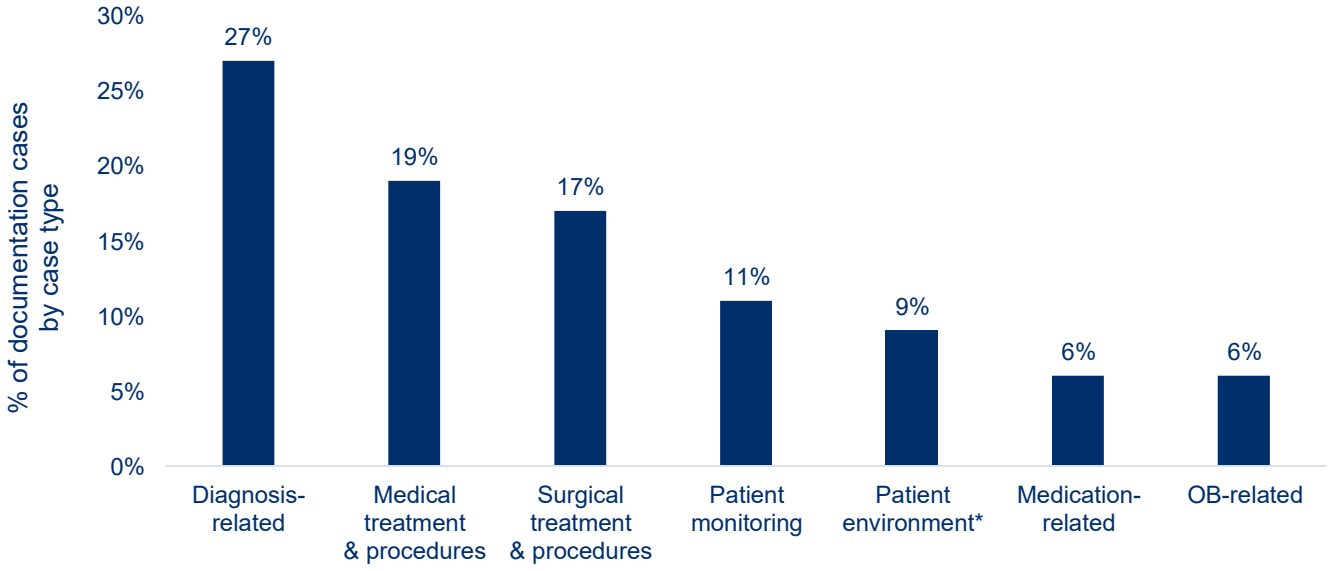
Scenarios showcasing the impact of insufficient documentation of clinical findings include:

- In a case involving failure to diagnose metastatic colon cancer, the radiologist did not document findings of abnormal bowel wall thickening which were present on the initial diagnostic CT scan images.
- A hospital case was settled because the nurse did not document the stage of the patient's progressive sacral pressure ulcer at the time of discharge to a skilled nursing facility.
- In a case involving post-operative compartment syndrome in both legs and a complex recovery, the gynecology surgeon did not document whether the position of the patient's legs were ever changed during an almost 6-hour surgery.

Documentation Factors by Case Type

Across all locations (inpatient, ambulatory and emergency), documentation missteps are most frequently noted in cases reflective of diagnostic, medical, and surgical processes of care, as shown in Figure 3.

Figure 3. Most common case types in clinically severe cases



**Patient environment includes falls, burns, and other general safety events.*

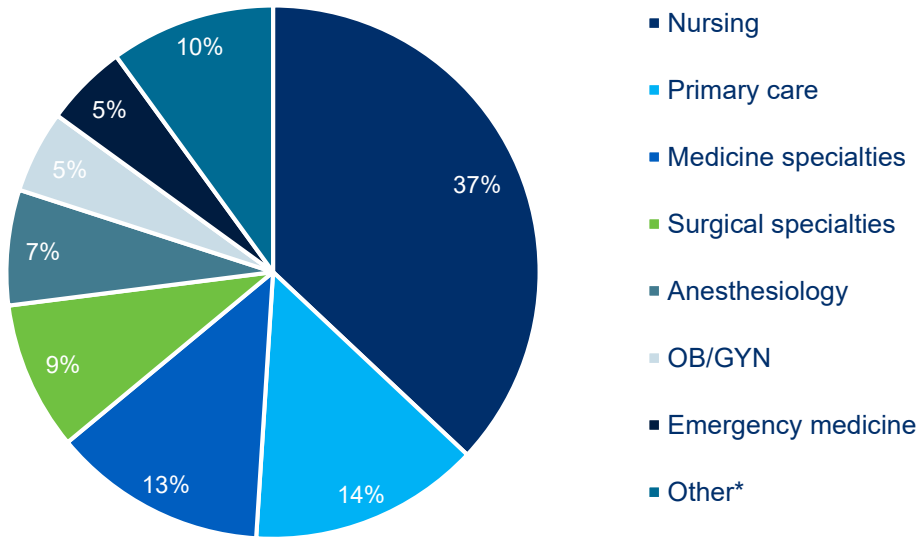
Data source: MedPro Group + MLMIC high clinical severity cases involving documentation opened 2012-2022 (N=3767)

Diagnosis-related cases do stand out. Of note, almost two-thirds arise in ambulatory (offices/clinics, surgery centers) and emergency/urgent care settings. Regardless of the setting, accurate and timely diagnoses are dependent upon comprehensive documentation of patient history and follow-up efforts after diagnostic test results have been received.

Who is Responsible?

As with case types, documentation issues are distributed across cases which are reflective of a variety of responsible service specialties. Nursing and primary care specialties are noted as primarily responsible for the patient's outcome in half of all cases reflective of documentation issues.

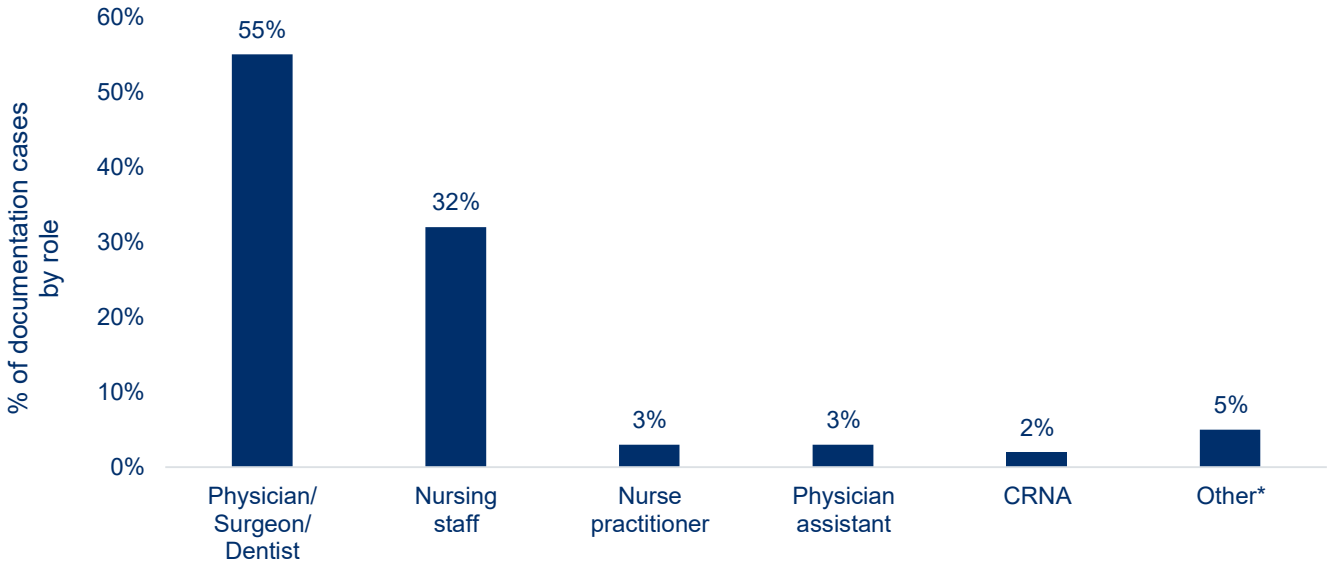
Figure 4. Primarily responsible services in clinically severe cases



**Other includes specialties for which no significant case volume exists.*

Another, more definitive way of examining the "who is responsible" question is to do so by role. In Figure 4a, we see that providers in an attending/consulting role (physician/surgeon/dentist) are most often directly linked to the documentation issue, followed by nursing staff.

Figure 4a. Documentation cases by responsible role



**Other includes roles for which no significant case volume exists, including medical assistants, aides, and techs.*

Case Study: Inconsistent Documentation of Post-Operative Status

A female patient in her early 50's presented to the ambulatory surgery center late in the afternoon for an L4-5 epidural steroid injection. Post-procedure, the patient was monitored by the recovery room nurse, who completed the Aldrete assessment (used to measure recovery after procedures). **The nurse documented** the highest possible score of "2" for activity, indicating **that the patient was able to move all four extremities. However, the nurse also documented that the patient reported repeatedly that her legs were numb and that she could not yet move them.**

The patient later noted that the discharge process "felt rushed", because the facility was closing at 5pm. While she was being transferred to a wheelchair by two techs, **she fell, landing on her hip, which had previously been surgically replaced.** An incident report was completed, but the **fall was not documented in the recovery room record**. The patient was subsequently discharged to home, but presented to the emergency department that same evening complaining of pain in her hip. She was found to have a dislocation of the hip and subsequently required multiple revisions, and sustained permanent significant mobility difficulties.

Data source: MedPro Group + MLMIC high clinical severity cases involving documentation opened 2012-2022 (N=3767)

Expert review indicated concern with the patient being encouraged to stand, despite complaints of numbness in her legs. **Conflicting documentation was a key factor in resolving this case, as was evidence that the epidural injection had been erroneously placed in to the subarachnoid space instead of into the epidural space, which induced a prolonged period of numbness**.

- **Case type:** Patient environment (failure to prevent fall)
- **Responsible service:** Pain medicine
- **Key risk factors:**
    - **Administrative:** Failure to follow post-procedure policy/procedure; failure to correctly perform assessment of patient's ambulatory readiness
    - **Clinical environment:** Patient's discharge was rushed due to facility closing
    - **Clinical judgment:** Inadequate patient assessment resulting in premature discharge from care; failure to appreciate and/or reconcile relevant signs/symptoms
    - **Documentation:** Inconsistent documentation of post-procedure assessment; lack of documentation of adverse event

Case Study: Missing Documentation of Clinical Rationale

A male patient in his early 60's **presented to the emergency department at midnight with complaints of chest pain**. One week earlier, he had undergone stent placement following a myocardial infarction. A cardiac consult and extensive lab work were ordered. (The patient's spouse remained in the parking lot due to COVID-19 visitor restrictions.) **Lab results, including blood cultures, pointed towards sepsis**, as did a chest x-ray which revealed cardiomegaly with peri-bronchial thickening, **likely representing pulmonary edema or a diffuse infectious process.** The patient was taken to the cath lab; results showed excellent flow through the recently stented vessels.

He was then admitted to the ICU under the care of the critical care hospitalist. The **first antibiotic was ordered and then administered at 7am, seven hours after arrival**. At that time, the patient reported no more chest pain, but **confirmed with the hospitalist that he wished to be a "DNR" status. Although the DNR status is documented in the chart, there is no additional documentation as to the context of that discussion**.

Approximately 30 minutes later, the patient sent a text message to his wife indicating that he needed help but that no one was coming. A code was called at 7:45am, but because of the DNR status, no resuscitative efforts were taken and the patient passed away. No autopsy was performed.

Expert review noted that all signs reported to sepsis and that antibiotics should have been started hours earlier. No documentation was found to explain why no one responded to the patient's calls for help; that, combined with suboptimal documentation of the DNR discussion and a delay in administration of antibiotics were noted to be among the reasons the case was settled.

- **Case type:** Medical treatment (improper management of course of treatment)
- **Responsible service:** Hospitalist
- **Key risk factors:**
    - **Clinical judgment:** Failure to appreciate and/or reconcile relevant signs/symptoms/test results; failure to order medication
    - **Documentation:** Failure to document clinical rationale for treatment decision to delay administration of antibiotics; failure to document context of DNR discussion
    - **Environmental:** Impact of COVID-19 pandemic on process of care (patient's spouse unable to accompany him)

Resources

- Article: Electronic Health Records: Patient Safety and Liability Concerns
- Blog post: The Role of Documentation in Diagnosis-Related Malpractice Cases
- Blog post: The Power of Words: Using Language to Support Collaborative Provider-Patient Relationships
- Checklist: Documentation Essentials
- Checklist: Electronic Documentation
- Guideline: Using an EHR as a Quality Improvement Tool
- Risk Tips: Using Scribes to Document Clinical Care

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About MedPro & MLMIC Data

MedPro and MLMIC are partnered with Candello, a national medical malpractice data collaborative and division of CRICO, the medical malpractice insurer for the Harvard-affiliated medical institutions.

Derived from the essence of the word candela, a unit of luminous intensity that emits a clear direction, Candello's best-in-class taxonomy, data, and tools provide unique insights into the clinical and financial risks that lead to harm and loss.

Using Candello's sophisticated coding taxonomy to code claims data, MedPro and MLMIC are better able to highlight the critical intersection between quality and patient safety and provide insights into minimizing losses and improving outcomes.

Leveraging our extensive claims data, we help our insureds stay aware of risk trends by specialty and across a variety of practice settings. Data analyses examine allegations and contributing factors, including human factors and healthcare system flaws that result in patient harm. Insight gained from claims data analyses also allows us to develop targeted programs and tools to help our insureds minimize risk.