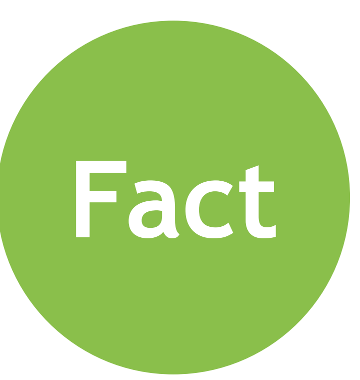
Documentation Essentials for Healthcare Staff

2018



There is a 1 in a million chance of a person being harmed while traveling by plane. In comparison, there is a 1 in 300 chance of a patient being harmed during healthcare.

- World Health Organization, March 2018

“Ultimately, by far the greatest benefit to patient safety will be achieved by increasing the skills and knowledge of the many ………”

- Don Berwick, 2013

Objectives

The objectives of this presentation are to:

- Reinforce documentation function and benefits
- Identify lessons learned from the defense of claims
- Discuss best practices to avoid documentation issues
- Establish goals to strengthen documentation

Function and benefits of documenting well

- Fosters safe patient care
- Serves as a form of communication
- Is the most important piece of evidence

Lessons Learned from Claims Analysis

Think about it!

Medical malpractice claims are just a drop of water in the ocean.

Source: (2012). Disclosure, apology, and offer programs: Stakeholders' views of barriers to and strategies for broad implementation. *The Milbank Quarterly*, *90*(4), pp. 682–705.

Expert witness testimony

Expert witness comments on health record documentation in a malpractice claim:

"The recordkeeping was inconsistent, incomplete, inaccurate and not timely."

"The absence of complete documentation presumes that the care was never provided"

Common documentation examples

- Medication or immunization
- Patient teaching and related questions
- Follow-up with patient who missed an appointment
- Shift-to-shift documentation

Common documentation examples

- Allergy to contrast media
- Provider informed of test result
- Response to pain medication
- Communication with provider or nursing supervisor regarding a patient or resident's declining status

Common documentation examples

Inconsistent documentation of the intended surgical site

Inconsistent provider and nurse documentation

Best Practices

How to Avoid Documentation Issues

Keep in mind

Experts and jurors measure care by what was or was not documented. Make sure your documentation reflects your critical thinking - practicing within the standard for your profession.

Who documents in the health record?

The person who interacts with the patient and/or renders care and treatment

If you are documenting something someone else did, make sure you indicate that in the patient's health record. Use quotes when necessary.

What is documented in the health record?

Nursing process

Tests/Consultations

Important changes

Patient education

Significant conversations

Unexpected events/incidents

Be sure to comply with organizational documentation policies.

When to document

Document as soon as possible!

Record date and time in all entries.

Never pre-date entries.

Keep late entries to a minimum.

Tips

Charting our communications should be done completely and objectively.

When communicating with the team, use your SBAR skills and document the information shared.

Learn more about SBAR to communicate effectively at www.ahrq.gov

Tips

Keep it professional

- The documentation should be factual and free of personal comments, finger-pointing, and derogatory or negative remarks.
- Do not document arguments or conflicts with team members.

Document without negative emotion

Subjective vs. objective documentation

Subjective:

- Patient is upset and the family is angry.
- Patient is a drug seeker.
- Patient is noncompliant.

Objective:

- Patient stated still experiencing pain and family "doesn't understand why the patient can't receive next dose."
- Patient requested pain medication in addition to current prescription.
- Patient stated cannot afford to buy the blood pressure medication.

TIP: Documenting unexpected events

Document:

- A factual account of the incident
- Patient's reaction
- Pertinent names to identify those involved
- Dates and times
- Any follow-up treatment as a result of incident

Do NOT document:

- Speculation as to cause
- Reference to the completion of an incident report
- Reference to legal or risk management consults in the record
- Personal notes

Knowledge check

My documentation can impact safe patient care.

Documentation is a communication tool.

Documentation is better than personal recollection.

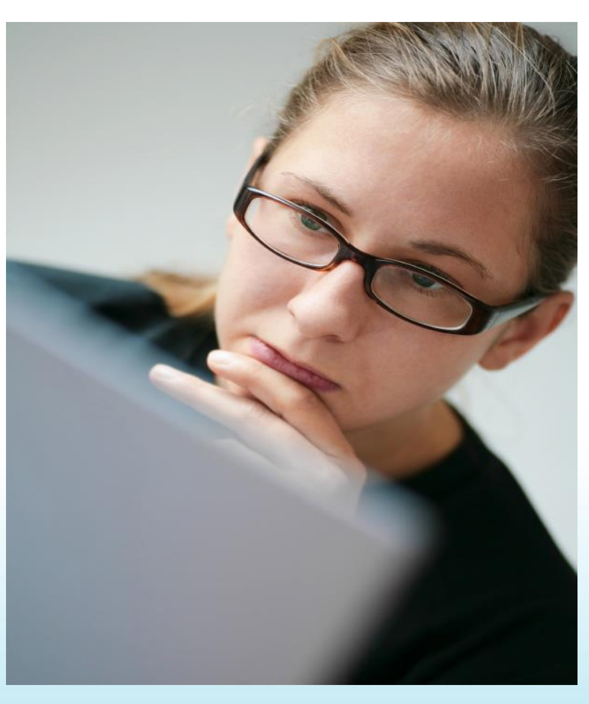
Insufficient and inconsistent documentation is the most problematic.

Improvement Goals

Establish Goals to Strengthen Documentation

Self-check on documentation

How am I doing?



- Does my documentation completely tell the patient story (factual, accurate, timely and complete)?
- Do I communicate the information clearly through documentation so that other members of the healthcare team or patients will understand?

Self-check on documentation

How am I doing?

- Do I review what other members of the healthcare team have charted to identify and reconcile information that is inconsistent with my own?
- Do I *really* know my employer's policies and procedures or professional standards or regulations relating to documentation?

  - Nursing process
  - Test/consult reconciliation
  - Changes in condition
  - Patient/resident teaching
  - Significant conversations
  - Unexpected events/incidents

Resources

Resources

- CRICO Strategies. (2016). 2015 Annual Benchmarking Report: Malpractice Risks of Health Care Communication Failures. Retrieved from www.rmf.harvard.edu/Clinician-Resources/Newsletter-and-Publication/2016/SPS-The-Malpractice-Risks-of-Health-Care-Communication-Failures
- MedPro Group. (2017). Checklist: Documentation essentials. Retrieved from www.medpro.com/documents/10502/2899801/Checklist_Documentation+Essentials.pdf
- MedPro Group. (2017). Checklist: Electronic documentation. Retrieved from https://www.medpro.com/documents/10502/2899801/Checklist_Electronic+Documentation.pdf
- MedPro Group. (2015). Risk Management Review: Deficiencies in documentation make malpractice allegations indefensible. Retrieved from www.medpro.com/documents/10502/2735124/RMR_May+2015.pdf
- MedPro Group. (2016). Risk Management Review: Miscommunication and poor documentation lead to suboptimal outcome for cardiac patient. Retrieved from www.medpro.com/documents/10502/2735124/Risk+Management+Review_11-2016.pdf

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