The Dos and Don’ts of Documentation: A Legal Defense Perspective

Kendra N. Stark, Esq. – Senior Counsel, Raleigh, North Carolina

kstark@grsm.com

August 21, 2024

GRSM50

GORDON REES SCULLY MANSUKHANI

YOUR 50 STATE LAW FIRM™

WHY DO WE DOCUMENT?

- Continuity of care
- Refresh recollection
- Accurate reflection of encounter
- Protect Yourself in a Lawsuit

CONSIDER YOUR AUDIENCE(S)

EXAMPLES OF POOR DOCUMENTATION

Common Examples

- Insufficient attention to questionnaire questions
- Incomplete consents/refusals
- Skipped questions
- Failure to amend / late entries
- Illegible notes
- Insufficient Detail
- Inconsistencies between one part of the chart and another (e.g. form vs. free text)

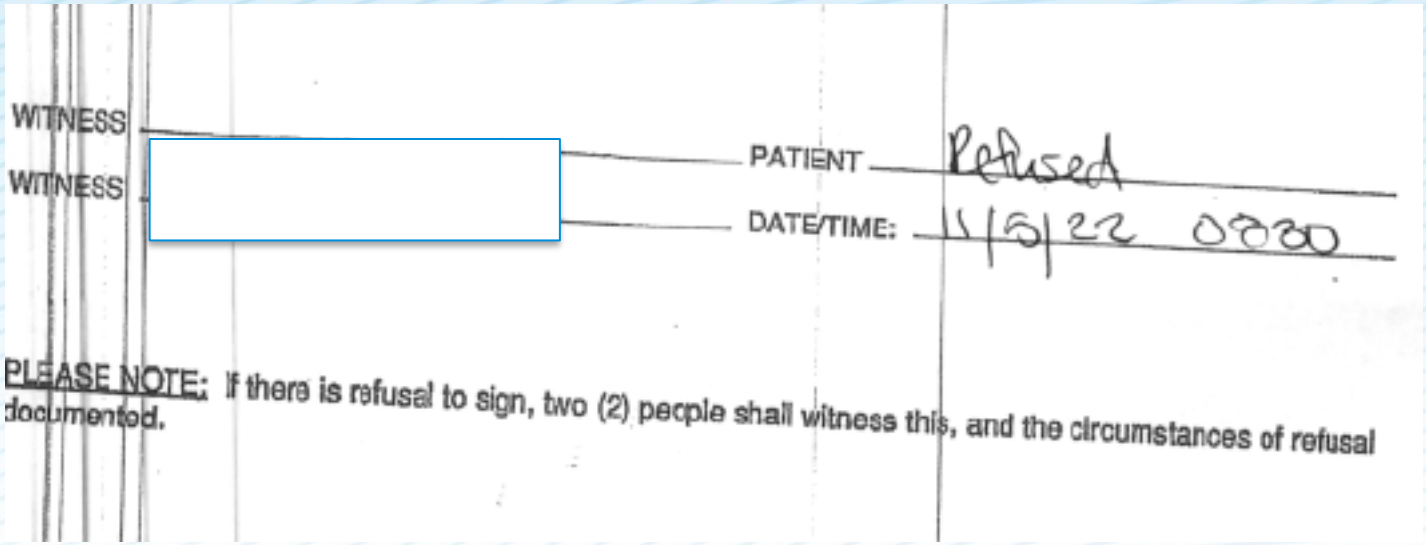
Line Through Questionnaire

- Chart asking specific questions about appearance, mood, affect, speech, HA, delusions, activity
- Staff drew lines through all of the boxes, and wrote “normal” over the chart text

APPEARANCE	MOOD	AFFECT	SPEECH	HA	ACTIVITY
NORMAL	DEPRESSED	NORMAL	NORMAL	VISUAL	APPROP.
DIRTY/DISH	HA	BLUNTED	SLURRED	AUDIO	INAPPROP.
UNUSAL	ANGRY	FLAT	RAPID	TACTILE	OTHER

NORMAL

Incomplete Refusals/Consents


WITNESS

WITNESS

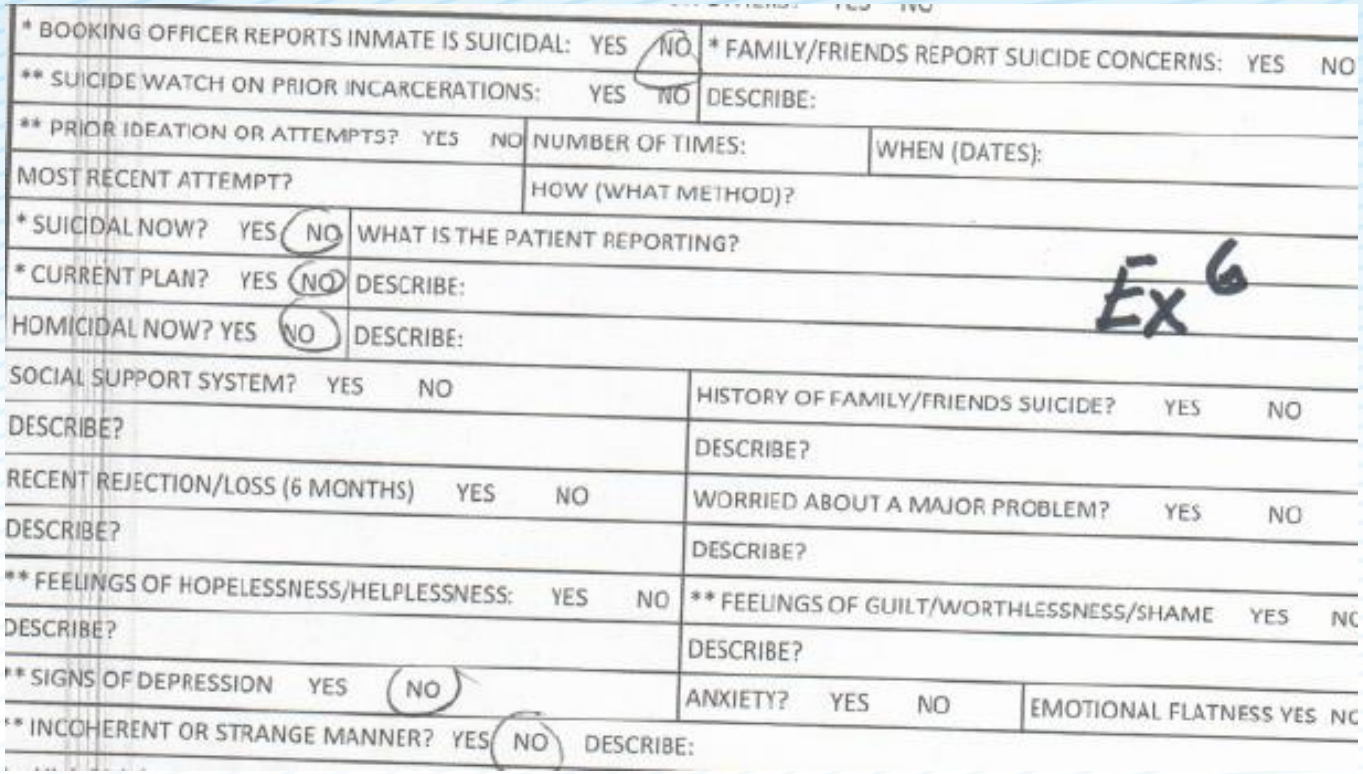
PATIENT Refused

DATE/TIME: 11/5/22 0830

PLEASE NOTE: If there is refusal to sign, two (2) people shall witness this, and the circumstances of refusal documented.

- Patient refused to sign, but there was only one witness, and there were no circumstances of the refusal documented.
- If there are specific instructions on the document you're using, they need to be followed. If not, the failure to follow needs an explanation.

Skipped Questions



* BOOKING OFFICER REPORTS INMATE IS SUICIDAL: YES NO	* FAMILY/FRIENDS REPORT SUICIDE CONCERNS: YES NO	
** SUICIDE WATCH ON PRIOR INCARCERATIONS: YES NO	DESCRIBE:	
** PRIOR IDEATION OR ATTEMPTS? YES NO	NUMBER OF TIMES:	WHEN (DATES):
MOST RECENT ATTEMPT?	HOW (WHAT METHOD)?	
* SUICIDAL NOW? YES NO	WHAT IS THE PATIENT REPORTING?	
* CURRENT PLAN? YES NO	DESCRIBE:	
HOMICIDAL NOW? YES NO	DESCRIBE:	
SOCIAL SUPPORT SYSTEM? YES NO	HISTORY OF FAMILY/FRIENDS SUICIDE? YES NO	
DESCRIBE?	DESCRIBE?	
RECENT REJECTION/LOSS (6 MONTHS) YES NO	WORRIED ABOUT A MAJOR PROBLEM? YES NO	
DESCRIBE?	DESCRIBE?	
** FEELINGS OF HOPELESSNESS/HELPLESSNESS: YES NO	** FEELINGS OF GUILT/WORTHLESSNESS/SHAME YES NO	
DESCRIBE?	DESCRIBE?	
** SIGNS OF DEPRESSION YES NO	ANXIETY? YES NO	EMOTIONAL FLATNESS YES NO
** INCOHERENT OR STRANGE MANNER? YES NO	DESCRIBE:	

Ex 6

- Skipped more than half of the questions on this suicide assessment, likely because the person wasn't reporting they were currently suicidal.

Illegible Notes

- Lawsuits often arise *years* after the care took place.
- It is very likely you will not recall what you did or what the patient told you.
- If you can’t read your own writing, neither can we.
- We also need to be able to identify who wrote each note, so signatures and initials are equally as important.

Why does this matter?

- Statute of limitations is 1-3 years on these claims
- Goal is to be able to understand (or even remember) what you discussed with the patient or what you did YEARS later
- You need to be able to explain your own charting- what you did and WHY
- Plaintiffs' attorneys will criticize any small gap or inconsistency in documentation

BEST PRACTICES FOR IMPROVING DOCUMENTATION

Examples of Good Documentation

- Subjective sick call notes:
  - “During med pass pt was c/o bunk being too low for her to lay on and she needed to be moved. Stated getting up and down out of bed is making her almost pass out and she is going to have a seizure. Stated her pain is severe and that **this is cruel and inhumane treatment**. Pt states she has her medical records from emergency room stating she has physical restrictions. Per Officer there is no difference in bunks and she would not be moved. Pt was offered [medication]. Pt agreed to take them. After meds were taken pt began yelling at Officers again. As this writer began to leave the pod, pt was heard yelling "I'm going to kill myself". Decision made to place pt on suicide watch.”

- Very thorough, contains specific language and quotes from patient, and picks up on key words indicating patient may be litigious.

Examples of Good Documentation

- “6/30/16, 12:10pm: Pt here discuss meds, since as of yet have no records of [medication] ever filled. Pt also reports he is on an antidepressant which he had filled at Walmart in [town]. Plan: Send for records @ Walmart in [town]. Contact Walmart pharmacy, verify meds. Signed full name.”
  - This was handwritten and legible. Full sentences were used. She discussed medications with patient after attempts to verify his meds were unsuccessful.
  - Includes plan to verify additional meds.

Examples of Good Documentation, cont’d

- Refusal documentation:
  - “ATTEMPTED sick call for pt with hx of serial refusals of practitioner assessments on 1/6/22 (MD), 1/30/22 (MD), 2/1/22 (PA), 2/2/22 (MD), 2/25/22 (MD) and 4/6/22 (MD). IP refused to be seen when tasked for MD visit, thus was approached cell side on 4/6/22 by writer in an attempt to convince IP to be seen for chronic care f/u for his report of headaches and to coordinate f/u MRI and f/u labs. IP refused x 3 stating, "I don't want to see you." "Go away." When AMA explained, IP states "just get the hell out of here, I told you I don't want to see you." Will continue to approach IP for attempts at chronic care f/u at 4-6 week intervals.

- Documents multiple prior refusals with dates, number of times the writer tried to convince the patient to accept services, specific quotes from patient, and plans to try again.

Best Practices

- Contemporaneous documentation is **key!**
- Clear writing
  - Writing that is legible and grammatically correct
- Detailed and thorough notes on interactions with patient
  - Including specific quotes when possible
  - Include the format through which you communicated if not in-person (phone, app, messaging system, etc.)
- Every question in assessment or form addressed, and addressed separately
- Inclusion of “why” for every decision made
  - Starting any new treatment
  - Changes in any treatment/med

Best Practices

- Document all communications with other team members
  - MA, Nursing Staff, Mid-levels, even the front desk
  - Be clear about who specifically had the patient interaction (ex. phone calls)
- Medications
  - Types, amounts, and specific administration times should be documented
  - Document any medication substitutions and the reason for the substitution
  - Document discussion of any specific side effects that this patient may need to worry about
- Vital Signs: Always document vital signs, and if they seem abnormal, explain why
  - Ex: Elevated HR due to fever or withdrawal
  - If unable to obtain typical vitals, document clinical vital signs (e.g. skin turgor, pupils, respiratory rate, whether patient is eating/drinking/voiding)

Best Practices

- Documentation of actions should match policies
  - If they don’t for some reason, you need to document a reason why this case was an exception.
  - Advise your clients to regularly review policies as well.
- Documentation should match any audio/video present in the facility
  - Make sure your providers and staff are aware of what type of recording is present
  - If something may be misconstrued when reviewing a recording, explain why in your charting.
- Document refusals / actions against medical advice
  - Not just the first refusal- document each time the patient refuses treatment
  - Clearly document the discussion had with the patient about the risks involved with refusals or AMAs
- Document bad behavior or remarks from patient
  - Use actual quotes whenever possible

Best Practices – Over-Documentation

- How much detail should you go into?
  - As much as possible

- **Beware of EMR auto-population**
  - Documenting certain things may auto-populate in another area
    - e.g. stroke scale that was never performed
  - See if that's something that can be addressed on an administrative level

- Use copy and paste sparingly
  - Gives the impression that you did not spend much time actually thinking about the patient
  - It becomes unclear what is still present at multiple visits vs. what has changed

Best Practices – Addressing Charting Mistakes

- They are a problem and should be corrected.
- Never go back and alter the existing chart!
- Leave original notes intact, and add an addendum with a new time stamp and new date, explaining what you did.
  - There will be an audit trail, which will show that you made changes, but won't show WHY.
  - This way, the audit trail matches the documentation.

BIG PICTURE:

- Your patients are important to you.
- You are listening and spending appropriate time and energy addressing their medical concerns.
- You are well-trained and well-versed in the standard of care, and you meet it in every interaction.

QUESTIONS