

Documentation

Legal Principles of Good Charting

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Overview

- In this presentation we will examine:
 - Why we document
 - What we document
 - When we document, and
 - How to improve the quality of documentation.
- This presentation will also provide tips on how to make notes for your personal use.

Why We Chart

- What are the reasons for charting?
 - To communicate with other caregivers.
 - To provide a basis for billing
 - To ensure we have the basis to defend our actions

Communication

- Caregivers should always chart what they communicate to other caregivers
- One of the most frequent issues in litigation is “what did the doctor know, and when did he know it?”
- It is vital to any provider to be able to show he communicated.

Communications

- We should also note what we are told by:
 - The patient
 - The family
 - Other caregivers
 - Any other third party

Billing

- Providers are not paid for what they cannot prove they did.
- Audit companies inflict severe financial wounds on hospitals that have deficient charting.
- If it isn't charted in the record, the medical records department can't prove the billing is accurate.

False Claims Act

- 31 U.S.C. § 3729 – The Civil False Claims Act
- Provides for:
 - Treble damages against providers
 - Civil penalties between \$5,000 and \$10,000 for each false invoice
 - Large rewards for informers who squeal on their employers.

False Claims

- Government does not have to prove fraudulent intent.
- Only has to prove that the invoice is false (or simply WRONG).
- The FCA is the number one reason why charting should be detailed and accurate to the letter.

Legal Defense

- What did you have for lunch on May 12, 1998?
- We tend to forget normal repetitive functions.
- Routine patient care is a normal repetitive function.
- Therapy charted today may be forgotten two years later.

Legal Defense

- Statutes of Limitation
 - Medical Malpractice (1 to 2 years)
 - Wrongful Death (2 to 3 years)
 - Neonates (8 to 18 years)
 - Incompetents (8 years to 10 years)
- Normal Lawsuit Delays
 - Discovery often takes 3 years to complete.

Legal Defense

- Patient Incident January 1, 1996
- Lawsuit filed on December 31, 1998
- Discovery begins in April 1999
- Your deposition scheduled in August 1999.
- Forty Two Months have elapsed since the incident

Memory Failure

- Most caregivers do not remember care they provided two years ago.
- They almost always have to rely on the medical record for their memory.
- If the record is not complete, the caregiver looks foolish.

Expectations

- The general public believes that when a person dies, it should be a memorable event.
- Television and movies show doctors and nurses caring about the death of every patient.
- This is what patients have come to expect.

Is it Fair?

- Juries expect that you should remember someone who died.
- Juries do not understand the clinical demands of the healthcare professions.
- It may not be fair for them to hold you to this standard, but hold you they will.

Importance Magnified

- The jury's expectation magnifies the importance of good charting.
- Juries expect you to remember what is important, and they expect you to write down everything important.
- Failure to do so looks bad to the jury.

What to Chart

- Now that we know why it is important to chart, let's examine what should be charted.
- It is important to remember that there are no hard and fast rules that govern every situation.
- The suggestions that follow are based on cases I have tried.

What to Chart

- Communication
- Facts Received
- Relevant analysis
- Plan of care
- Follow up on plan of care
- Alterations in the plan
- Adverse Events

Communication

- The Finger Pointing Rule
 - Whenever you point your finger at someone else, there are three pointing back at you!
- Don't point fingers, let their fingers do the walking
 - Charting communication with other caregivers establishes the facts.

Facts

- The most frequent problem encountered in charting is the inability to tell when a caregiver received certain information.
- Always document the time and date that information was obtained and communicated.

Facts

- Pay attention to numbers.
- Juries like numbers!
- Chart relevant data with appropriate times.
- Failure to record times creates the impression, in retrospect, of falsity.
- Usually it is the time that matters most.

Facts

- Chart with specificity
- Which is more competent:
 - All parameters within normal limits
 - BP 120/80, Pulse 100, Resp. 12
- Numbers mean specific things. “Normal” requires interpretation.

Analysis

- Record what you are thinking
- You may not remember two years from now what the data meant to you then.
- “Patients vital signs are nominally normal, but patient is anxious and agitated. I suspect the patient may be hypoxemic.”

Analysis

- Chart Possibilities!
 - Use “rule out” rather than pinpointing a specific problem and focusing on it.
 - “ABG shows PO₂ of 100 on room air, with CO₂ of 22. Rule out hypoxemia. Hypocarbica of unknown etiology. Will continue to monitor respirations.”
 - Remember: you are refreshing your memory two to four years from now.

Avoid Conclusions

- Never jump to conclusions
- Record data, record analysis, but don't rush to judgment.
- More malpractice cases arise out of snap judgments than anything else.
- Avoid the “snap judgment,” and avoid the problem

The "Katie" Case

- "Katie" is a 46 year old woman with an upper respiratory infection.
- Has respirations of 44, Pulse of 128, Temp of 102.2, and BP of 90/56.
- Doctor orders IPPB with 100% oxygen in ER before he sees patient.

Katie

- Arrives in ER
- Listens anteriorly to chest
- Tells family "she has tracheobronchitis."
- Gives rocephin and goes home.
- No Chest X-ray, ABG, Pulse Oximetry, or lab work.
- Patient Dies

Katie

- Issue: snap judgment based on insufficient evidence.
- Failure to exhaust clinical diagnostic tests made diagnosis unreasonable.
- Failure to record analysis left him without clinical basis for his decision.

Plan of Care

- Record clinical goals
- Record objective findings
- Record subjective findings
- Make it clear to the reader what the plan of care is.
- The plan of care is the one thing most charts lack.

Record Follow Up

- The best information gathering, and the best care planning are worthless if they are not followed up with evaluation.
- Evaluation of the patient requires that you record how the patient responded.
- Response should be specific.

Specificity is Important!

- "Tolerated treatment well."
 - Tells the reader nothing.
 - Simply means there was no adverse reaction.
- "Patient stated they could breathe better at conclusion of treatment. Respiration rate reduced by 2. Less work of breathing noted."

Changes to the Plan

- If the plan changes, explain why.
- If the patient does not cooperate, make a note of it.
- If the patient is not responding, document whom you told.
- Communicate.

Adverse Events

- Chart the CLINICAL information for an adverse event.
- “Patient fell out of bed and dislodged tracheostomy tube. Tube replaced after emergency airway care was rendered.”
- Stick to the facts.
- Don't editorialize.

Adverse Events

- NON CLINICAL information belongs in an incident report
- Report the facts and all supporting data. Do not conclude who was at fault. Do not admit fault. Do not assign fault to someone else.
- “Dagnet Style.” Just the facts ma'am.

Accuracy

- Charting MUST be accurate.
- It must correspond to data recorded by other clinicians.
- Inaccurate charting hurts your case worse than no charting.
- Accurate charting buys credibility with the jury!

Don't Reference

- Do not chart that an incident report was filled out.
- Some courts have held this incorporates the document into the medical record.
- Remember that in some exceptional instances, the incident report CAN be discovered.

Front Page News

- Don't put anything in an incident report that you wouldn't want on the front page of the newspaper.
- Incident reports are sometimes leaked.
- Incident reports are sometimes lost.

No Incident Report?

- If you want to fill out an IR and someone else doesn't want you to, how do you make notes outside the medical record?
- "Notes Prepared In Anticipation of Litigation for my Personal Attorney."
- Creates a "work product" or Attorney-Client privilege.

When to Chart

- Charting must be timely.
- Charting is "hearsay" because it is an out-of-court statement that is offered for the truth of the matter asserted.
- There is an exception for business records created at or near the time of the event and kept in the normal course of business.

Timely

- Make your chart notes near the time they occurred.
- Lawyers frequently ask when notes were written.
- If notes were written one or two days after the fact, they may not be admissible.

Late Entries

- Charting and Fish are a Lot Alike
- They both begin to smell after three days.
- Make a late entry only if you must.
- Never try to hide a late entry.

Removing Records

- Never remove records from the chart.
- Court will presume that record removed hurts your case, and will so instruct the jury.
- Must leave records together.
- Easier to explain the truth than to explain a lie.

How To Chart

- Use a framework
- "SOAP" notes
- "PIE" charting
- Do not chart by exception. It is a ticket to the courtroom.
- Use a framework to organize your thoughts every time so you always capture the important information.

Record Legibly

- Legibility is important
- If you write neat, you appear organized.
- Juries like organized people.
- Lack of organization makes you look incompetent.

Avoid

- Irrelevant Material:
 - Race
 - Religion
 - Marital Status
 - Social Condition
 - References to unverified statements
 - Slanderous remarks "...gangbanger"

More Information

- For More Information order the "Clinicians Charting Handbook" from Penumbra Publications.
- The book is \$12.00 and available from this website.

Conclusion

- Charting is important because it can refresh your memory if you are ever sued.
- Charting is important to ensure proper billing.
- Good Charting requires lots of factual content, good analysis, and accurate information.

Conclusion

- No defendant in a lawsuit ever said "I sure wish I hadn't kept such good notes."
- Lots of defendants say "I sure wish I kept better notes!"
- Charting is excellent malpractice insurance!