PROVIDER DOCUMENTATION FOR THE CURRENT HEALTHCARE ENVIRONMENT

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Why do we document?

- Tells a story
- Provides continuity for other providers
- Complete and accurate account of condition and care received

Building Bridges into the Future

Evolution of Nursing: Industrial to Knowledge Base

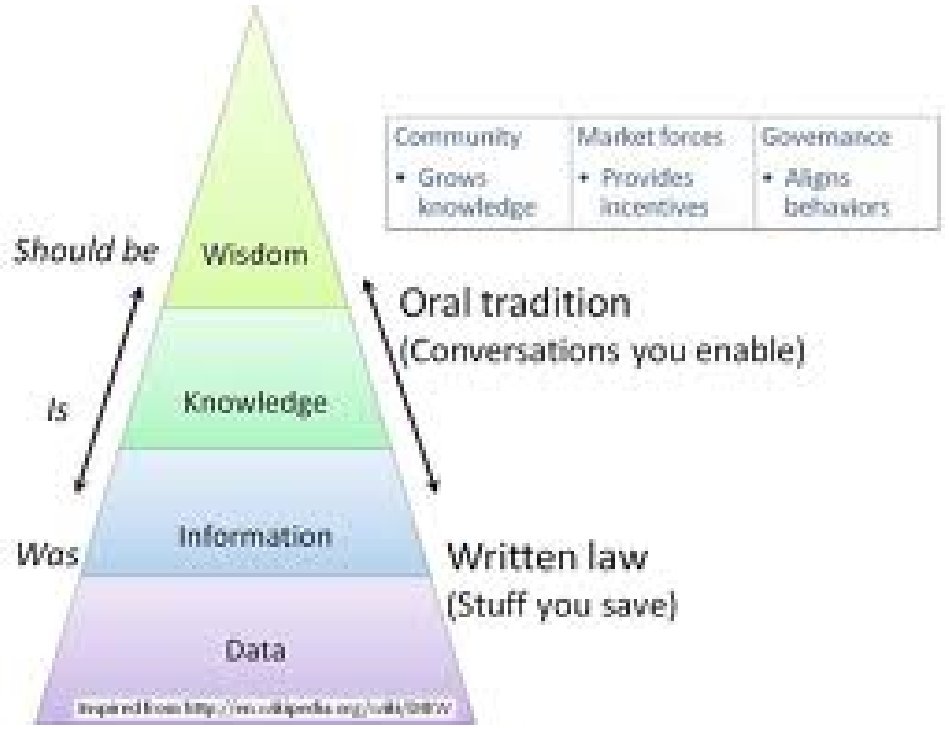
- Prior to WWI most workers in US were farmers and ranchers
- After WWI, many migrated to the urban areas and became industrial workers
- Current workforce requires knowledge workers secondary to expanding technology
- What is a knowledge worker?

The nurse as a "knowledge worker"

- Characteristics of knowledge workers
  - Innovative
  - Specialized
  - Have advanced education
  - High degree of autonomy
  - Control over their own work environments
  - Most efficient when in a multidisciplinary team
  - Team members have complementary knowledge base
  - Team members possess problem solving and decision making skills and interpersonal skills

DIKW

- The model for Informatics
- D: Data
- I: Information
- K: Knowledge
- W: Wisdom

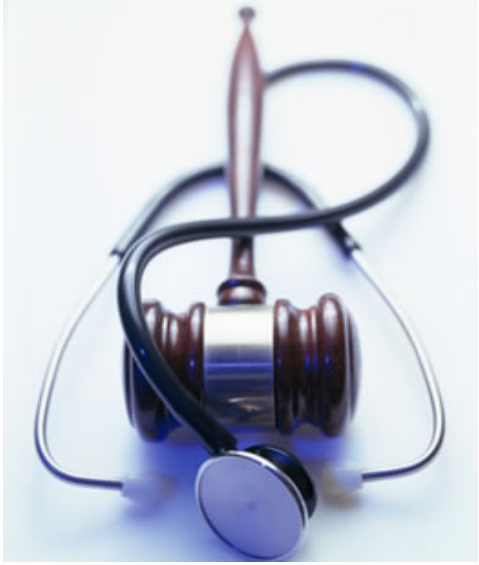


One Record: Many Purposes

- Vehicle for communication among providers
- Reimbursement
- Data for research studies
- Basis for planning and implementing quality improvement measures
- The most credible evidence in legal proceedings

Focus on Legal Proceedings

- Four elements to medical malpractice suit
- Burden of proof is on the plaintiff
- Plaintiff must prove all 4 elements:'
  - Duty to the plaintiff existed
  - Standard of care was breached
  - Patient was injured
  - Injury was caused by the breach



Flaws in the Record

- Medical record is rich with written facts but riddled with inconsistencies, inaccuracies and voids.
- These can be used by plaintiff's attorney or regulatory bodies for cause of action

Common Flaws

- Pages without any patient identification.
- Notes written with the wrong date or times that don't correlate with the remainder of the chart
- Notes written on the wrong patient
- Long narrations that don't seem to be sequential
- An entry written over a previous entry to correct or change it
- Itemized billings inconsistent with care
- Diagnostic test findings that don't correlate with physical assessment

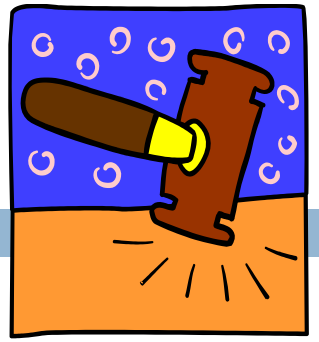
Avoiding pitfalls

- Be objective in assessment
- Document at the same time as the intervention (or as close as possible)
- Avoid gaps in your charting (this allows juries to speculate)
- Don't leave spaces to be filled in later
- Follow policies for making addendums

Pitfalls

- Document adverse events carefully
- Do not leave this up to the plaintiff's attorney to sort out
- You won't like their theory and you won't be able to refute it.
- Notes written as something happens are very credible.

Pitfalls



- Bias:
  - Inappropriate comments regarding patient
  - Labeling patients
  - Labeling a patient's behavior
  - Avoid words like : obnoxious, belligerent, hostile, rude.
  - Document patient's behavior without editorializing.
  - Factually and objectively document patient behavior

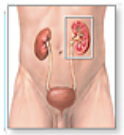
Pitfalls

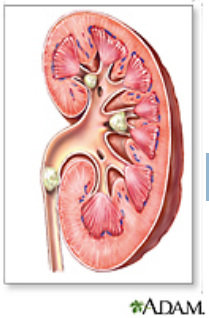
- Deviation from policies and procedures
  - Follow facility policies and procedures carefully
  - Plaintiff's attorneys have a field day with deviations
  - Policy and procedures do not establish Standard of Care
  - Hospital may not indemnify you if you fail to follow policy and procedure.

How and Why do Nurse Practitioners Get Sued

- Failure to accurately assess and monitor the patient's condition
- Atypical presentations
- Failure to document discharge instructions
- Failure to communicate
- Missed diagnosis
- Failure to provide follow up care

Failure to Assess





- 56 year old male with kidney stone
- Admitted to the ED at 1800
- Treated with Demerol and Phenergan
- Admitted for pain control and hydronephrosis
- Hospitalist Admission
- 2330 to Med/Surg Unit –pain controlled
- Vitals 128/86, 98, 28, 91%

Failure to Monitor Response

- Mrs Cousins:
  - Admitted after a fall in SNF
  - Signs of dehydration
  - Head injury
  - IV D5/0.45NS at 125cc per hour
  - Oxygen saturation low at midnight (92%)
  - Coded at 9:30 am
  - Troponin was resulted at 0530 that was simply put in the chart, never reported to the MD or NP

Atypical Presentations

- Justin – 13 years old
- Recently returned from Africa with his church youth group
- Sustained an axillary abscess that was treated with Augmentin 875mg x 10 days
- 2 weeks later sustained blunt trauma to his right thigh in football practice
- Seen for nausea/vomiting by NP

Failure to Communicate!

- Glen presents to the family practice clinic with a chief complaint of night sweats
- History indicates he is gay and his partner is HIV positive
- Subsequent testing indicates the patient is HIV positive so he was started on anti-retrovirals

Failure to Document Discharge

- Discharge instructions are proving to be a big area of liability
- Laparoscopic and other procedures
- Fractures – especially splint care
- New medications
- Pediatrics

Failure to convey discharge instructions

- Esther is a 45 year old female
- Patient discharged after a lap chole
  - Readmitted 2 days later
  - Hypotensive, tense abdomen, no bowel sounds
  - Discharge instructions did not allude to possible complications
  - Simply told to follow up with surgeon in 2 weeks
  - Take vicodin for pain

Physician Communication

- Another area of comprehensive documentation needs.
- Make it clear when your responsibility for the patient changes

Missed Diagnosis

- Melissa – 6 year old with left hip pain
- Seen by NP in fast track ED
- No signs of toxicity, pain hip, will not bear weight.
- X ray negative
- CBC, Chem panel negative, except for LFT positives
- NP wants to order a CT of the hip
- Consults with physician

Rodney

- Presented to rural hospital with cyanotic left hand
- PMH: S/P ulnar nerve release x 2 (2 years prior)
- Adm 2033, triage 2035, room 2041, IV 2050
- No pulses detected in the hand with doppler
- Morphine 2055, 2105 and 2135
- Zofran 2058
- Heparin bolus 7000 units 2110, Drip 2119

Providing Follow up Care

- Patients presenting to Family Practice Clinic after ED visit
- Patients with chest pain/ abdominal pain are of most concern.
- Document review of medical records from acute care visit

Chest Pain Follow up

- There are many “do not miss” potentials
- Stephen seen in ED for chest pain, work up negative, discharged with instructions to see primary provider within 2 days.
- Stephen presents at clinic:
  - No chest pain
  - Some GERD Symptoms
  - Medication changed, no further workup

Review of Previous Records

- Double check the records from ED
  - They may be incomplete
- Look at xray and lab reports
- Don't rely on transcriptions of treating provider
  - Report may be incomplete or inaccurate
- Medical Record Clerks do not know what is pertinent in the care of patients presenting for follow up care
- You are the expert

Failure to act in a timely fashion

- We now have standards of care dictated by reimbursement parameters
  - Antibiotics must be given within 4 hours for PNA
  - Antibiotics must be given within 1 hour for sepsis
  - Beta blockers for AMI
  - ASA for Acute MI

Red Flags in Charts

- Lack of treatment (O2 sat low, no intervention)
- Delayed, substandard or inappropriate treatment
- Lack of patient teaching or discharge instructions
- Charting inconsistencies, lapses in time
- References to an incident report
- Patient abandonment
- Battles between health care providers
- Lack of informed consent
- Late entries that appear very “convenient”
- Missing records or gaps in documentation

Societal factors affecting documentation

- The internet: patients can look up anything
- The media: class action suits highly advertised
- Increased acuity of patients
- Larger elderly population
- Increased emphasis on outcomes
- Bedside information systems
  - Epocrates
  - MedScape
  - Micromedex

What will the jury think of you

- Like it or not, juries make value judgments
- Legal actions are usually initiated years after care was provided
- Your documentation will not help your recollection if you just "check the boxes"
- Narrative charting will help with independent recollection
- Misspellings, grammatical errors and sketchy charting gives a poor overall impression and works against you.

No finger pointing

- IV infiltrated because nightshift forgot to check it
- Patient going into shock, could not reach Dr. Jones per usual
- Once again, the lab forgot to draw the patient's PTT this am
- Patient received insufficient care today because nurse patient ratio was 1:7
- Patient fell due to lax nursing supervision

Defensive Charting

- Pertinent negatives
- Thorough explanation of what was discussed with collaborating providers
- Avoid allowing assessments to “carry over” to the next encounter
- Include plenty of narrative notes, but do not contradict yourself
- Keep your documentation objective

QSEN Essentials to Quality Care

- Patient Centered Care
- Safety
- Teamwork and Collaboration
- Quality Improvement
- Informatics
- Evidence Based Practice

THANK YOU!

Questions?????