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Physician Connection

Back to Basics: Capturing Documentation

Professional SOLUTIONS

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When faced with a stack of charts to complete at the end of a busy day or shift, where does your mind go? To a place of happiness or to a place of frustration? Does it go to a place of necessity or to a place of burden? More importantly, when your charts are complete, do you deem them to be defensible? Or, do you say to yourself, "I will explain it later if I have to."

Even if you believe they are defensible, you need a document that is not only complete and accurate, but also paints a clear picture of the patient encounter. Your note is not just a story about your patient; it also helps with continuity of care, aids in patient safety and can provide a legal safety net.

Accurate documentation may be both the provider's and the patient's only protection against poor or even dangerous care. Documentation reflects the actions you took to protect patients from harm. A well-documented record may help protect you against allegations of malpractice.

After a grueling day, it can be easy to fall behind on charting requirements. It's tempting to do whatever it takes to attend that important meeting or run your children to practice. Adding to the pressure, your employer likely mandates timely chart completion. There are many factors which compound the urgency of completing that stack of charts. Nevertheless, not putting forth a complete and accurate document that is complete can lead to a concerning path of unintended consequences.

Moreover, a chart that omits important details may mean many days—if not weeks or months—of doubting your abilities because you've been named in a lawsuit. Worse yet is the emotional toll it takes on you, your family and your team.

The following are simple strategies that can help you complete documentation in a clear, concise, timely and accurate manner.

THE BASICS

Every chart generated should have four components:

1. History of Present Illness (HPI)
2. Review of Systems (ROS)
3. Physical Exam (PE)
4. Medical Decision Making (MDM)

Having a strong HPI, ROS, PE and

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MDM in every note you generate is paramount to produce a thorough medical record. Each of the four components have separate functions, but tell a good story about your patient encounter when combined. Inconsistencies should be avoided between sections, so the final diagnosis can be supported by the documentation. Moreover, it can beneficial to include a legend IF you are not using standard abbreviations. Additionally, proofreading the document before you sign it is strongly recommended, especially if someone else (student, resident or scribe) is generating the majority of your chart.

FIRST, THE HPI

The HPI should contain as much detail as possible about any relevant factors that brought the patient to you. This can be an exhaustive set of details and figuring out what to include may be tricky.

Tailoring the questions you ask will take some practice, but with time, it will become automatic. Quoting the patient is helpful and helps personalize the note. For example, knowing specific details about their chest pain, abdominal pain or vomiting is important.

Therefore, the HPI should include the important information on why they came in to see you, including:

- What are their symptoms and how long have they had them?
- What alleviates the symptoms, if anything?
- What makes the symptoms worse?
- Have they had these symptoms before, and if so, what was the cause?
- What have family members or paramedics told you about the patient?
- What is the patient's medical, surgical or family history (PMH, PSH, FH)?
- Do they have allergies?
- What medications do they take? Ask specifically about over-the-counter medications, vitamins and supplements as they can affect your care plan.

Perhaps you don't know anything about the patient because they are unresponsive, mentally diminished or intoxicated. If the history is limited, document why it is limited. As you listen to the patient, family, friends, bystanders, EMS crew or police provide you with relevant details, use the available information to complete the HPI. These statements constitute the pertinent positives of your record.

Along with the pertinent positives, it is important to include the symptoms the patient does not have. These are the pertinent negatives, which are exceedingly important to include in your record.

Pertinent negatives show the reader you thoughtfully considered other processes and procedures that could be the root cause of the patient's chief complaint. Both pertinent positives and pertinent negatives help generate a differential diagnosis—a list of possible causes of the patient's illness or injury, without specifically spelling them out.

NEXT, ROS

ROS represents symptoms the patient has and does not have. A strong chart has 8-10 ROS features. This, on the surface, can seem time consuming. However, simply asking the patient about their symptoms and documenting their answer completes this task.

A strong chart note specifically outlines what you asked and how the patient responded in both the HPI and the ROS. As an example, the elusive spinal epidural abscess or cauda equina syndrome diagnosis is "missed" or undiagnosable 50 percent of the time during a patient's initial clinical encounter. Therefore, documentation for every patient who has back pain should include the presence or absence of fever, IV drug use, saddle/perineal anesthesia, stool incontinence and retention of urine.

If you ask and document the lack of risk factors and specific ROS features for this disease, the reader will know that you thought about this potential life-and-limb-threatening diagnosis and did not find it when you treated the patient. Does capturing 8-10 ROS features guarantee you won't be named in a legal matter if the patient ultimately is diagnosed with a condition? Unfortunately no. However, if your document clearly details the lack of symptoms and risk factors, then you may have averted potential risk. If you leave these details out, you may be in a difficult position. Document clearly, concisely, and accurately at the time of the encounter.

PE IS THIRD

The PE should be fairly straightforward. It is what you found when you met, looked at and examined the patient. Be objective, specific and concrete. When possible, quantify your findings by citing specific numbers or ranges.

The PE can be either complete or focused. An example of a focused physical exam would be an ankle sprain. If the patient clearly states they only injured their ankle and did not fall, and you document it as such, examining the neck, back, abdomen, heart, and lungs probably isn't necessary to provide solid patient care and produce a strong chart. However, examining

for a pulse, capillary refill, neurologic status of the foot and toes, as well as for presence of tenderness in the foot and knee would be prudent to examine and document.

More complex chief complaints require a more complete PE. Using chest pain as an example, the PE should include documentation of the heart, lungs, neck, chest wall, abdomen, arms and legs. It should include examination of the pulses in the arms and legs, as well as neurologic function of the extremities. Is there a rash on the chest? Is the neck swollen or are the veins in the neck distended?

The PE should include both specific positive and negative findings and not simply be listed as "negative," "normal" or "WNL." Pertinent negative PE features, like in the HPI and ROS, are just as important as pertinent positive findings. This helps augment what you have been doing so far in the chart; developing a differential diagnosis. You are telling the reader, without specifically spelling it out in a differential diagnosis list, what you believe the patient has and what you believe the patient doesn't have.

FINALLY, MDM

The MDM is a summary of the patient encounter: What was done while you interacted with the patient and what you feel is the cause of the chief complaint. It is not uncommon to not know what the patient has despite your best efforts to figure it out. You may have obtained multiple tests on the patient and still don't know. Or, you may have simply interviewed and examined the patient and come to a conclusion.

Either way, your MDM should fully explain your rationale for coming to this conclusion. It must include treatments you provided and response to those treatments.

Describe the patient's response to treatment. It must include your interpretation of any tests you obtained, especially abnormal ones.

MDM is a summary of what you, the clinician, believed to be the cause of the symptoms. It is a summary of what you were told, asked about, found, and didn't find. It is where specific considerations and the differential diagnoses can be outlined. It is the conclusion of the story that the HPI, ROS, PE and tests have been telling. It should be the ending to the patient's story. But, don't forget, the MDM should also include a specific plan for follow up, as well as the reasons for the patient to return.

Prior to leaving your care, every patient should have clear verbal and written discharge instructions. All questions the patient and/or family may have should be addressed and noted in the chart. Clearly indicate the patient's and/or family member's understanding of your instructions. Any education you provide promotes recovery, helps prevent recurrence and aims to manage the condition being treated to maintain optimal health.

Additional documentation should be considered for other types of patient encounters including adverse events, informed consent, informed refusal, non-adherence, telephone calls, disruptive or abusive patients, and telemedicine visits. For adverse events, document the relevant facts and the care rendered. Be factual and objective; avoid self-serving remarks.

To avoid allegations that you misguided or misinformed your patient during the informed consent or informed refusal process, consider documenting:

- The mental status of the patient
- The patient's reasons for providing or refusing consent for the proposed treatment
- All patient questions and your answers (use quotation marks when possible to record the patient's actual statements and questions)
- Your evaluation of the patient's level of understanding, based on their questions
- Your responses and the use of the teach-back method to confirm the patient's understanding

With informed refusal, include the specific treatment refused, names and relationship of people witnessing the refusal, your encouragement to pursue the treatment recommended and the consequences of not following medical advice.

When documenting non-adherence, include details of your discussion with the patient, their stated reason(s) for non-adherence, the teaching you provided about the treatment plan, possible consequences of non-adherence, treatment plan changes made to improve adherence and your communication with other healthcare team members regarding the patient's non-adherence. When appropriate, objectively document the patient's non-adherent behavior.

Clinically relevant telephone calls are part of the practice of medicine. Providing sufficient details in the documentation helps the reader have a clear understanding of the reason for the call and how it was handled. Call documentation should include:

- Date and time of the call
- Name of person calling
- Reason for the call

- Advice instructions provided (and by whom)
- Patient's understanding of the call

In cases of abusive callers or abusive or disruptive patients within the office, objectively document the circumstances surrounding the incident. Use direct quotes when you can. Document what you advised the patient about the exhibited behavior and the ultimate consequences of such behavior.

Treat your document of a telemedicine visit just like you would treat the documentation of an in-person visit. Use the same standards for documenting clinical advice, continuity of treatment and informed consent discussions.

When documenting your telemedicine visit, add the names, relationship and/or titles of other people present during the visit and note the communication method used for the visit (e.g., Zoom). Add comments to your documentation that you can clearly see and hear the patient during the encounter and indicate that an audio/video recording will be stored in their chart, if applicable. Finally, make sure to maintain proper protocols and keep patient privacy paramount to comply with HIPAA and state scope of practice requirements

Finally, as a result of recent COVID-19-related restrictions, some patients may be returning after a gap in care. Consider that the patient's health or medications may have changed during this gap. Therefore, it may be advisable to follow the same protocols you would use when seeing a new patient when seeing patients after a gap in care.

DOCUMENTATION: YOUR BEST DEFENSE

A complete and accurate chart for every patient encounter is of vital importance. Viewing it any other way is dangerous. Charting is painstaking, time consuming and can keep you from going home on time. However, it's the only way to tell your full story of the patient interaction and what you believed was the cause of the patient's symptoms.

Clinicians are not going to get it right every single time. But, if the document produced is less than optimal and specific details are not included, then more times than not, it will be assumed that the ultimate diagnosis wasn't even considered.

Find a strategy to avoid this potential legal pitfall. The next time you are faced with a stack of charts to complete, take the attitude that they are important documents you have complete control over. Seize this opportunity to tell your story and share your accurate and complete thought process. If you are ever faced with a legal matter regarding your care, a strong medical record will be your best defense.

Did you know?

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