Documentation: Minimize Liability and Avoid Common Charting Pitfalls

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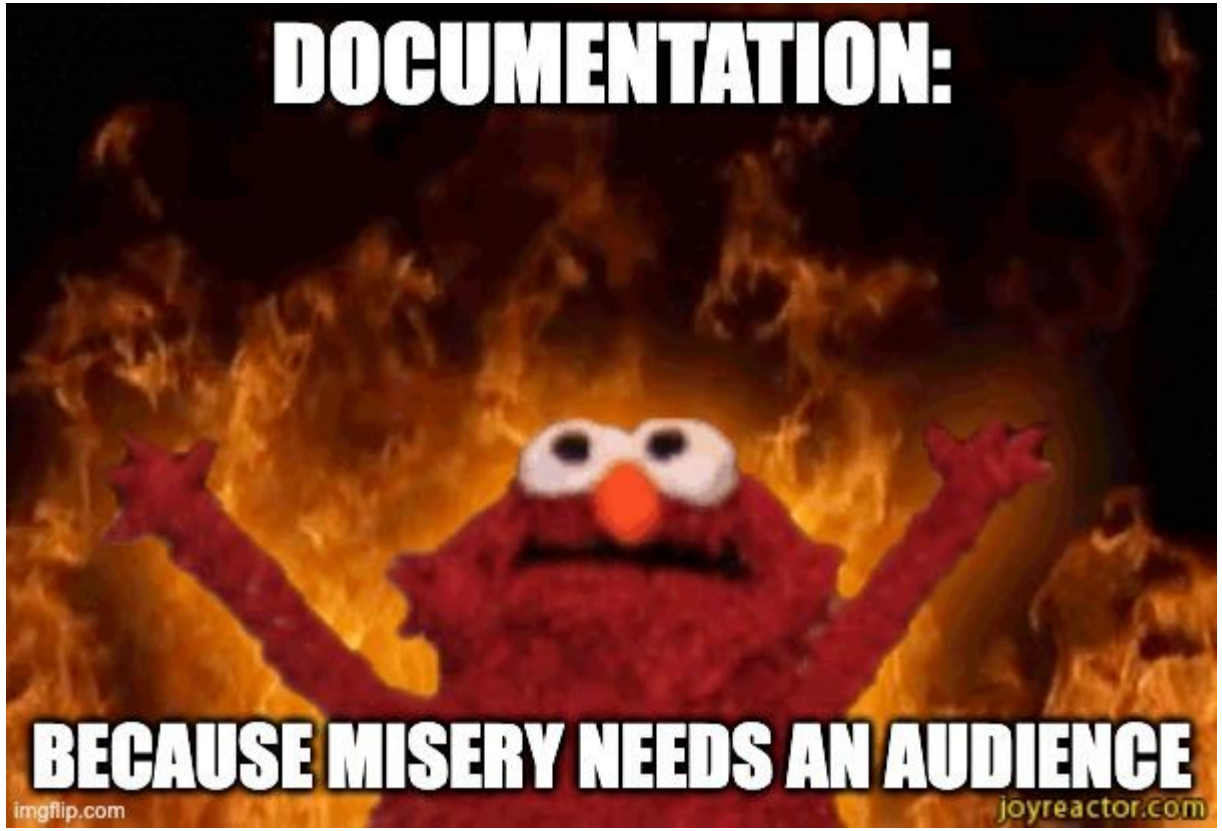
Disclosure Statement:

We do not have any relevant financial relationships with any commercial interest.

Welcome!


DOCUMENTATION:
BECAUSE MISERY NEEDS AN AUDIENCE
imgflip.com
joyreactor.com

Learning Objectives

1.Explain “exercise of judgement” and its implications

2. Review how to concisely document informed consent, risk benefit analysis, and patient ability (or inability) in the clinical record

3. Describe the highest liability risk encounters and the types of questions reviewers often raise regarding the care provided.

Document Accurately:

Important to know your audience when you document, but the catch is sometimes you cannot.
Helpful to know how your records will be used when you document, but the catch is you don't.

1) Help you guide treatment
2) Help others guide treatment in your absence or during subsequent episodes of care
3) Explain the patient's situation to other health providers so they can better provide care
4) Administrative: prior authorizations, billing, coding, institutional requirements
5) Medico-legal
6) Patient may request them

Accurate Documentation

Subjective-
What is the story?
In the healthcare environment, the story the patient tells may be very different from the real story.

Objective
Physical exam
Outside medical records (very important/staff follow through with release of information (ROIs)

Say What You Mean….

Objective Data:

- Imaging/tests/labs/etc.

- Medical Photos:
- Old saying “a picture says a thousand words” Be sure to obtain informed consent before taking a photo. Helpful to document improvement or regression of a condition.

Assessment and Diagnosis clearly stated

Accurate Documentation

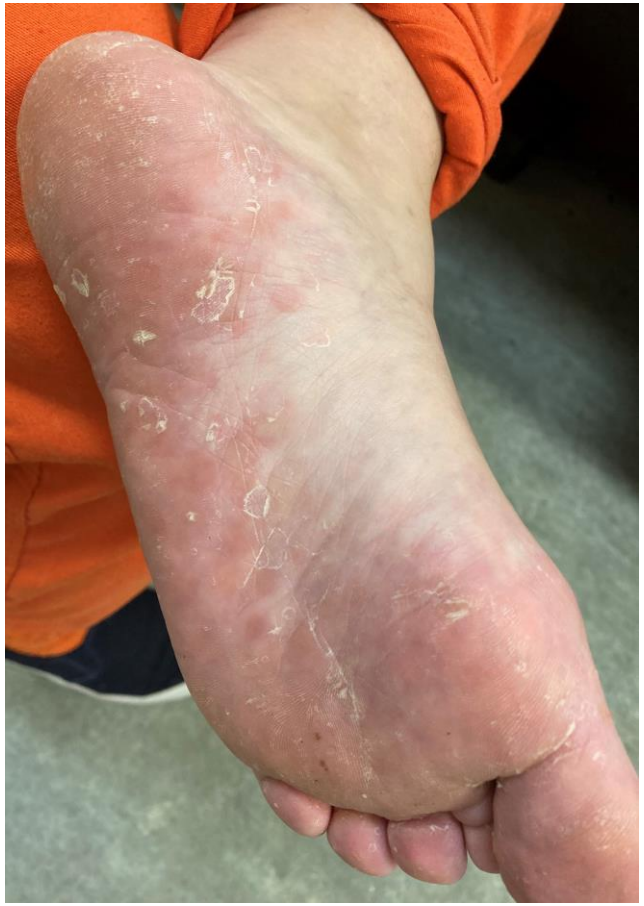
Example:
Subjective: “28-year-old female patient c/o 1 month history of a peeling rash on both feet. She works in fast food and is on her feet all day, and states that she only has one pair of socks and feels that she has athlete’s foot because she is on her feet working all day and unable to obtain clean, dry socks”

Accurate Documentation

Objective: “Patient noted to have worn, heavily soiled socks. Examination of both feet show bilateral peeling rash on soles of both feet, also between toes, with some erythema but no drainage noted.

Sounds good on paper, right?

A Picture Says a Thousand Words, and More Accurately Also



Documenting the Plan

Use Bullet Points/numbering
Example:

1. Acetaminophen 650mg po TID prn x 30 days
2. Etc…

Document as if you were never going to see the patient again, so the next provider can pick up and seamlessly care for the patient where you had left off

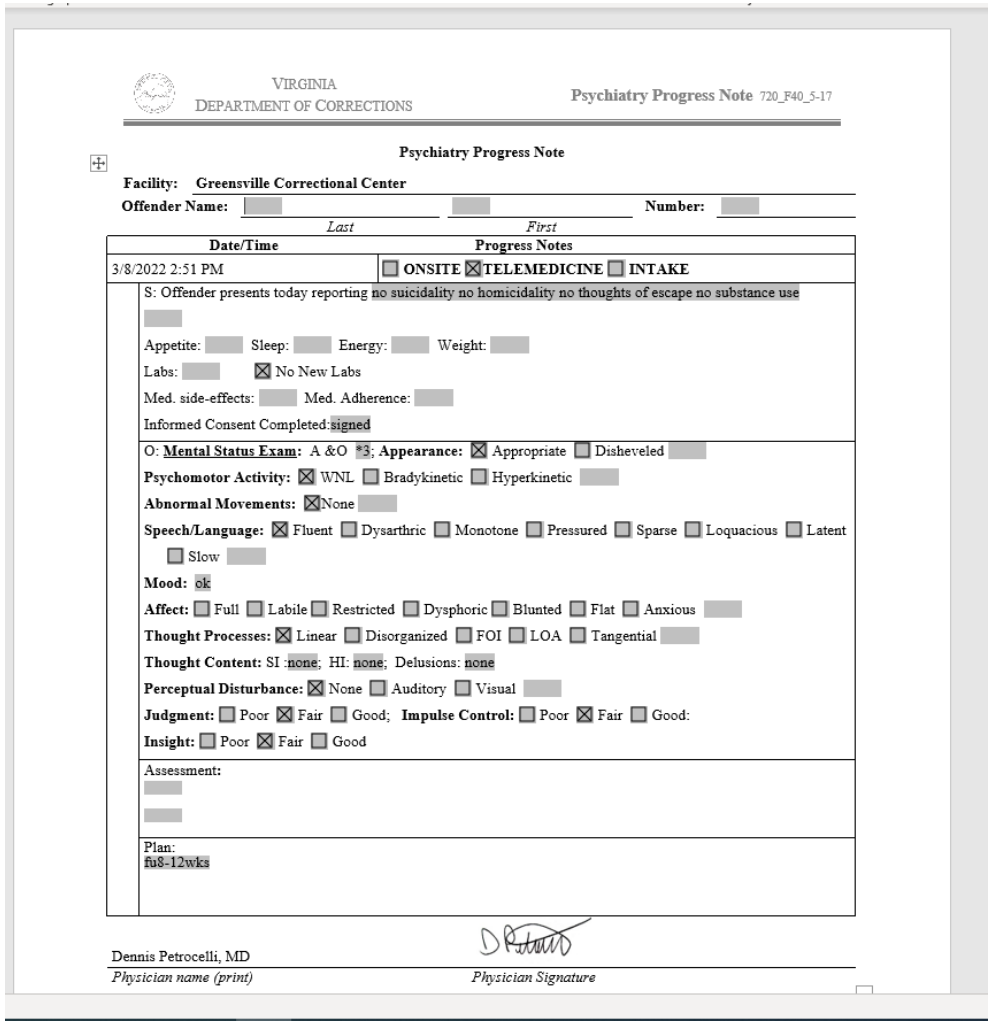
Documenting, Continued

- Templates-may be used in many EMRs, can be intrinsic to the EMR, or cut and pasted from a Word document or electronic sticky note.

- The first Petrocelli/Minter documentation template was made from a manual charting system (or lack of system) and consisted of a Word document that had the basic SOAP note, specific phrases, and info that could be added/circled/filled in, to speed documentation. It was ugly, but it worked.

Petrocelli/Minter Template

(when you don't have an EMR and need one)



VIRGINIA
DEPARTMENT OF CORRECTIONS

Psychiatry Progress Note 720_F40_5-17

Psychiatry Progress Note

Facility: Greensville Correctional Center

Offender Name: _____ _____ **Number:** _____
Last *First*

Date/Time	Progress Notes
3/8/2022 2:51 PM	☐ ONSITE ☒ TELEMEDICINE ☐ INTAKE

S: Offender presents today reporting no suicidality no homicidality no thoughts of escape no substance use

Appetite: ____ Sleep: ____ Energy: ____ Weight: ____

Labs: ____ ☒ No New Labs

Med. side-effects: ____ Med. Adherence: ____

Informed Consent Completed: signed

O: **Mental Status Exam:** A &O *3; **Appearance:** ☒ Appropriate ☐ Disheveled ____

Psychomotor Activity: ☒ WNL ☐ Bradykinetic ☐ Hyperkinetic ____

Abnormal Movements: ☒ None ____

Speech/Language: ☒ Fluent ☐ Dysarthric ☐ Monotone ☐ Pressured ☐ Sparse ☐ Loquacious ☐ Latent ☐ Slow ____

Mood: ok

Affect: ☐ Full ☐ Labile ☐ Restricted ☐ Dysphoric ☐ Blunted ☐ Flat ☐ Anxious ____

Thought Processes: ☒ Linear ☐ Disorganized ☐ FOI ☐ LOA ☐ Tangential ____

Thought Content: SI :none; HI: none; Delusions: none

Perceptual Disturbance: ☒ None ☐ Auditory ☐ Visual ____

Judgment: ☐ Poor ☒ Fair ☐ Good; **Impulse Control:** ☐ Poor ☒ Fair ☐ Good:

Insight: ☐ Poor ☒ Fair ☐ Good

Assessment:

Plan:
fu8-12wks

Dennis Petrocelli, MD
Physician name (print) *Physician Signature*

Additional Tips

-Scribes (if available) can speed documentation time by 50%. Downside, expensive, and may take another staff member away from other duties especially if short staffed

-Dictation programs-can be a lifesaver, but cost $ monthly and can be prone to errors depending on the speaker's pronunciation

Mental Health Documentation

Unfortunately, most mental health records focus on the patient's narrative. Instead, write notes that capture YOUR THINKING ABOUT the patient's narrative.

1) What elements of the patient's narrative and presentation speak to diagnosis, amenability to treatment, prognosis, or confound treatment?
2) Versus those elements that suggest secondary gain, malingering, obfuscation of symptoms? Do the words match the music?
3) Your thinking and judgment ABOUT the narrative is more important the narrative itself.

The second omission of MH records is WHAT THE WRITER DID during and following the encounter.

1) What specific therapeutic technique did you use with the patient: education, CBT-style Socratic questioning, reframing, Albert Ellis-style disputation of core beliefs, ACT-style mindfulness & perspective-taking exercises?
2) What was the patient's RESPONSE to your actions above? This is tricky to record in a SOAP style note
3) INCORPORATE the above into your thinking about assessment

Example: you evaluate a patient for precautions and decide NOT to implement them.

1) Subjective: include what led to the assessment, select quotes from the patient that relate to precautions, what you did in response, and their response to your intervention
2) Objective: their mental status after the above was finished
3) Assessment: incorporates their positive reaction to your interventions to support your assessment that precautions aren't needed
4) Plan: any instructions given to the patient, security, and colleagues (eg, check in again later today, tomorrow, etc)

Exercise of Professional Judgement:

-We are respected and valued because we have the skill and experience to take in information about our patients and decide what is and is not relevant, what is more likely the diagnosis, and what is the best treatment to offer

-We document the exercise of professional judgment by explaining what supports our diagnoses, what diagnoses we rejected, and why we picked the treatment we did.

Exercise of Professional Judgment Continued…

If we don’t document the exercise of judgment, then when we’re wrong, we have NOTHING to stand on. Remember, it’s understood that we will not always get it right, but it’s unforgiveable to not use judgement.

Use of Key Phrases to Document the Exercise of Professional Judgment

The consistent and concise documentation of informed consent, medication rationale, and differential diagnosis is best done by the use of easily recognized phrases that summarize an otherwise complex encounter.

Diagnosis Related Issues

Diagnosis-related issues:

1) Although diagnosis is never a one-and-done matter, charting/admins believe it is.
2) Where relevant, record a narrative description of your judgment about the diagnosis: “pt’s rational conversation suggests “voices” are [an exaggeration related to secondary gain of a single cell|malingered]”
3) Remember the patient may read the record at some point. We can be honest but respectful and must be especially when the patient is not. Counter-transference looks bad during a deposition or court hearing.

Informed Consent

The informed consent conversation is both the ethical foundation of healthcare and the culmination of the exercise of your professional judgement about the patient.

It’s when you provide the patient and understanding of what is wrong and what you intend to do about it and what the risks, benefits and alternatives are.

Informed Consent, Continued

Medication-related issues:

1) Document informed consent by the following phrase: "patient gave i/c p/ discussion of r/b/a (including DM, SJS, …
2) Write something about why you are using what your using: "targeting hallucinations refractory to Risperdal & Geodon in the absence of DM with Zyprexa"

Informed Consent

Write something that shows you're aware of the risks of what you're doing-lab monitoring, vitals, patient education, AIMS

Sometimes we are in difficult situations and its better off to say so: "although his voices may well be malingered there are enough supportive signs such that I'm treating the most worrisome cause of his presentation to prevent violence, decompensation…"

High Liability Risk Encounters

Describe the highest liability risk encounters and the types of questions reviewers often raise regarding the care provided.

We only have an hour for the presentation

A few of the many:

-Suicide assessment
-Treatment of Pregnancy
-Physical assessment
-Diagnosis of an infectious disease
-Assessment of the need for specialist referral

Types of Questions Reviewers Raise

-Was the standard of care met?
-What would a similarly licensed practitioner have done?
-Did the practitioner follow accepted current guidelines?
-Did what the practitioner did or not do during the encounter contribute to a poor outcome?
-What was the role that ancillary staff took during the encounter?

In Summary

-Use clear, concise language when documenting

-Templates can be helpful, but make sure they are patient specific

-Document thoroughly informed consent and rationale including risks and benefits

In Summary…

-Document the exercise of professional judgement/why you came to the conclusion you did

-Document as if you will never see the patient again, and document as if the patient and/or a reviewer (or attorney) will be reading the encounter.

Questions/Comments?

References

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Thank You!

Safe Travels!