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# Medical Record Documentation:

## Paint the Clinical Picture with Complete and Accurate Documentation

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# Medical Record Documentation:

## Paint the Clinical Picture with Complete and Accurate Documentation

## INTRODUCTION

Medical record documentation errors continue to play a significant role in medical malpractice claims. Incomplete and inaccurate documentation can lead to unintended consequences including delayed diagnosis or misdiagnosis, patient harm, and death, any of which can lead to medical malpractice claims. Documentation errors encompass missing or incorrect information in charts, notes, transcriptions, and other electronic health record (EHR)-related areas. Certain aspects of the medical documentation process may invite behaviors that contribute to errors and inappropriate notations, increasing the likelihood of later liability. In addition to ensuring accurate documentation edits and addressing late entries, physicians must not make biased statements, blame, or negatively characterize another physician or the patient. The medical record is a legal document and often the most critical piece of evidence in medical malpractice defense. Unfortunately, medical students, residents, and physicians get very little education on proper documentation during their training.[1,2]

In this article we will discuss some common documentation errors and resulting claims associated with them. We will also discuss risk mitigation strategies to minimize the likelihood that these errors may lead to medical malpractice claims.

### EHR OPPORTUNITIES FOR DOCUMENTATION PITFALLS

Although electronic health records have the potential to increase efficiency and communication for many healthcare processes, EHRs also pose challenges that can lead to documentation errors. These challenges include copy/forward and drop-down menu functions, documenting on the wrong patient or in the wrong location within a chart, and late entries that may appear concurrent. A single documentation issue can cause patient injuries and impact the defense of a lawsuit.



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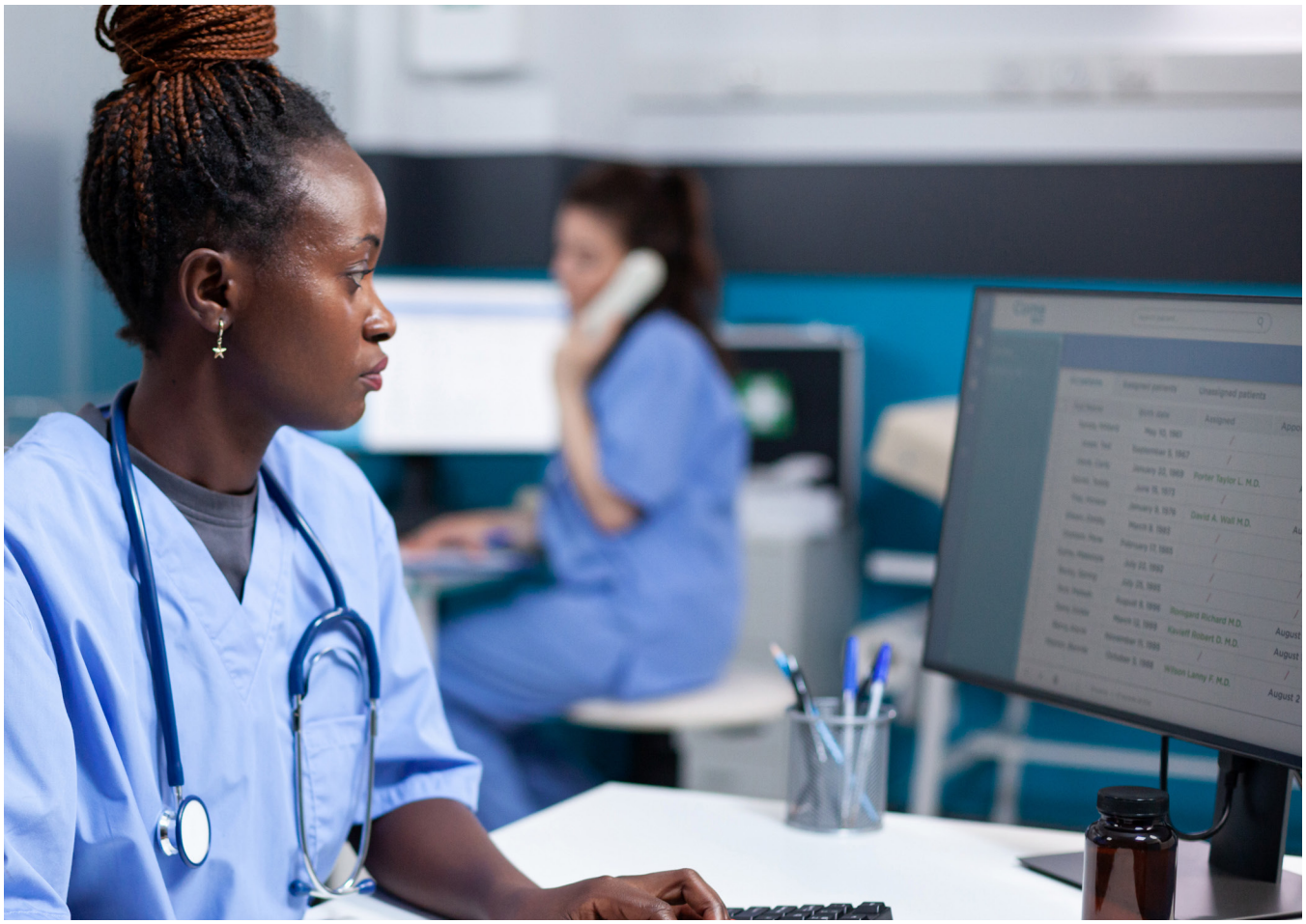

# CASE ONE:
## Drop-Down Menu Selection Errors

The use of drop-down menus for medication ordering, while convenient and allowing for quick order entry, can also lead to error if the wrong selection is made. Hastily selecting the wrong dosage can lead to catastrophic outcomes. In the following case, a medical error that occurred in the post-anesthesia care unit (PACU) led to permanent injury of a young patient.

Consider what steps could have been taken to prevent patient harm in this case.

A 45-year-old female presented to the hospital for a scheduled laparoscopic hysterectomy. The patient had a large body habitus necessitating conversion to open surgery. The patient tolerated surgery well and was transferred to the PACU. While in the PACU, the patient began to experience increased pain to her surgical site and requested pain medication. The nurse administered the physician's ordered dose of hydromorphone 4 milligrams (mg) intravenously (IV). Shortly after the administration of the hydromorphone, the patient began to have difficulty breathing, and her blood pressure dropped to 82/40. The patient became unresponsive to verbal and tactile stimulation, suffered respiratory arrest, and coded. Chest compressions were performed followed by the administration of naloxone and epinephrine. Intubation was attempted multiple times, unsuccessfully. Eventually the patient's oxygen



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saturation returned to baseline. Unfortunately she suffered an anoxic brain injury during this event that left her with neurocognitive symptoms including episodic memory loss, difficulty with speech, and the inability to perform activities of daily living (ADLs).

Upon investigation it was determined the physician, who routinely ordered a 1 mg IV dose of hydromorphone for postoperative pain control, mistakenly chose a 4 mg IV dose from the drop-down menu. The patient and her husband sued the physician and the hospital. Review of the EHR audit trail clearly indicated who made the order and when the order for the hydromorphone was placed. Ultimately, the case was settled.

## DISCUSSION

Though most EHRs utilize drop-down menus for a variety of orders and entries, it is important to be mindful of what is being entered into the record. Here the physician should have paid closer attention to the dosage selected in the dropdown. There may have also been an opportunity for the PACU nurse to question the order, notify the physician of her concern, and obtain clarification. Both defense and plaintiff experts commented that the usual IV dose of hydromorphone is 0.2 to 1 mg given slowly over two to three minutes. Further complicating matters is the associated boxed warning carried by hydromorphone alerting prescribers of the risk of medication errors and life-threatening respiratory depression.

## RISK REDUCTION STRATEGIES

Consider the following strategies:

### PHYSICIANS

- Review medication entries for completeness and accuracy, paying close attention to selections made from drop-down menus.

### NURSES

- Always clarify orders if there is a question about their accuracy before administering medications.

### ADMINISTRATORS

- Evaluate adding EHR functionalities that alert prescribers to potential medication dosing errors, associated boxed warnings, and drug interactions.
- Establish an environment that prevents interruptions or distractions for physicians during order entry to minimize errors.
- Work collaboratively with clinician users and EHR vendors to optimize functionality and help ensure drop-down menu item choices are accurate and consistent with the expected use. If certain medication dosages are rarely used or unsafe, remove these from drop-down menus.



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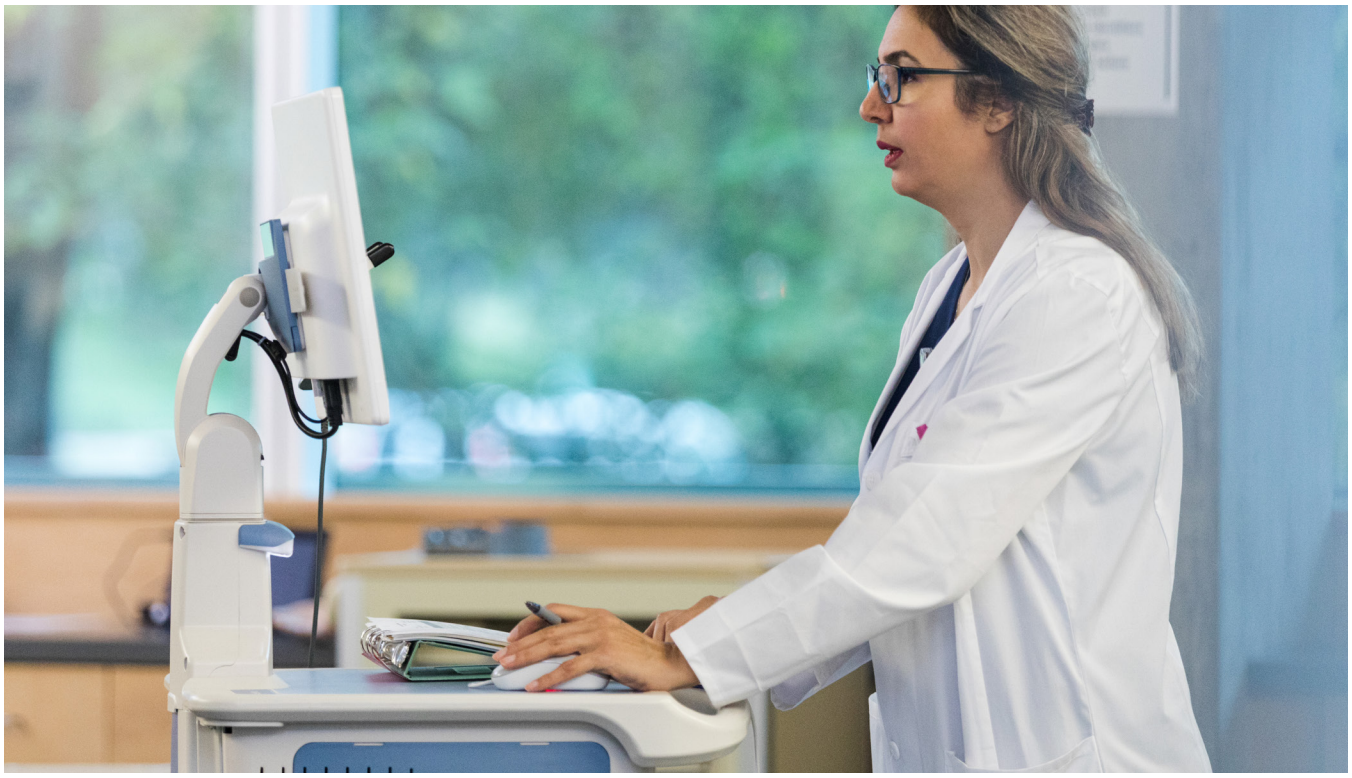

## CASE TWO:
# Medication Order Inconsistencies

Another potential challenge with EHR documentation is the ability to have multiple patient medical records open at the same time, allowing the provider to toggle back and forth between patients with a single click. This feature lends itself to mistakenly documenting in the wrong patient's chart. Examples include placing medication or radiology orders in the wrong chart, improper progress notes for the wrong patient, and treatment given to the wrong patient. In the following case the physician had multiple patient records open in order to place medication orders. The EHR system required that the physician sign off on all orders on one patient before he could write orders for the next. There was also a feature that allowed the physician to sign off on all orders in a chart by clicking one button. Unfortunately, this led to a significant medication error.

> Consider what the physician could have done to ensure the medication order was entered and approved correctly.

A 42-year-old female, two months post hysterectomy, presented to the hospital with shortness of breath and chest pain. She was tachypneic and tachycardic, and a CT of her chest showed extensive bilateral pulmonary emboli (PE). She was seen by pulmonology, started on a heparin infusion, and admitted to the ICU. On day three of her admission, the patient showed signs of improvement, and the decision was made to transition her to a low molecular weight heparin (enoxaparin) and oral anticoagulation with Coumadin®. The order was entered to start enoxaparin 80 mg twice a day and Coumadin 5 mg daily, and



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to discontinue unfractionated heparin infusion. (The facility had a Coumadin protocol that required the patient to be on heparin or enoxaparin as an adjunctive anticoagulant.)

Shortly after these orders were entered, for reasons that are unknown, the hospital pharmacist canceled the order for the enoxaparin. This action set into motion a process within the EHR requiring the ordering physician to sign off on the cancellation, thereby approving the discontinuation. The ordering physician had multiple medication orders open in the EHR, and instead of reviewing and approving each one separately, he approved them as a batch. This action had the unintended effect of signing off on the pharmacist's discontinuation of enoxaparin.

The next day the patient, who was on bedrest, requested to use the bedside commode. The nurse called the attending physician to inquire if the patient could get up to use the bedside commode and was given an order to allow the patient to ambulate to the restroom. Once on the commode, the patient became pale and short of breath, and her oxygen saturation dropped to 86%. The nurse called for the rapid response team, and the patient was taken back to bed. The patient continued to have shortness of breath, a rapid pulse, and increased pain in her epigastric area. Shortly after, a code blue was called and Advanced Cardiovascular Life Support (ACLS) was initiated. The patient was coded for approximately 45 minutes, became pulseless, and unfortunately expired. An autopsy was performed revealing saddle PE and multiple smaller PEs, which were determined as the patient's cause of death.

## DISCUSSION

There were multiple breakdowns in this case that could have been avoided. Although the reason for it was never established, the pharmacist canceled the orders for enoxaparin. As documented in her notes, the nurse assigned to the patient was aware that the patient was supposed to be on the Coumadin protocol. Yet, the nurse did not recognize the required medication order had been canceled or notify the physician for clarification. And finally, the physician failed to review his own orders for accuracy prior to signing them. This occurred despite his awareness of the EHR hard stop requiring him to review and approve all previous orders before moving to new orders for a new patient. Without reviewing each specific order alerted by the EHR for accuracy, the physician accepted all unsigned orders and, thus, approved the discontinuation of enoxaparin for this patient. The check and balance designed to rectify this documentation issue failed due to user error and negatively impacted the patient. Undoubtedly EHRs create opportunities for unintentionally skipping over or mistyping sections of critical charting.

## RISK REDUCTION STRATEGIES

### PHYSICIANS

- Stay abreast of EHR changes and pitfalls related to hard stops in the EHR and batch approvals or denials.
- Review documentation for accuracy and completeness.

### NURSES

- Clarify orders with the provider if there is a question of accuracy.

### PHARMACISTS

- Remain aware of medication protocols and compliance with such when approving or revising orders.

### ADMINISTRATORS

- Collaborate with the medical staff when implementing hard stops into the EHR to ensure workflow considerations and obstacles are addressed.
- Provide frequent education on EHR updates, including hard stops.
- Allow an environment where providers are free from distractions when entering and approving orders.



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## CASE THREE:
# Hybrid Medical Record Issues

A hybrid medical record poses challenges with documentation and patient care, as it contains a combination of paper records, digitally scanned documents, and the electronic medical record. A hybrid medical record can increase the possibility of delayed diagnoses due to lost or misfiled records such as labs or radiology reports. Inability to find or access records may result in the incapability to review, save, or sign off on results needed to make critical decisions. While hospitals and other facilities have generally converted to electronic records, a physician office practice may still maintain hybrid medical records. A clear process to manage all formats and types of medical chart documentation is imperative to ensure record completeness and safe patient care.

Consider what the provider could have done to prevent overlooking the patient's test results.

A 62-year-old male patient with a history of a renal cell carcinoma and right partial nephrectomy presented to his urologist for abdominal pain two years post nephrectomy. The urologist ordered a CT scan of the abdomen and pelvis, which was performed the following week. The patient was advised that the results of the CT scan were negative. The urologist ordered another CT scan of the abdomen and pelvis approximately 15 months later. The patient was advised that these results were also negative. He was advised to follow up with his urologist in one year.



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Two and a half years later the patient presented for follow-up. The urologist ordered another CT scan of the abdomen and pelvis. It showed a one centimeter (cm) enhancing lesion and a cystic mass in the pancreatic tail. The CT scan results were auto faxed to the primary care physician (PCP) and the ordering urologist. The standard practice of the urologist was to review incoming faxed diagnostic results when they were received by the office. He would then initial the report signifying and alerting staff that the results were reviewed. It was only after the physician initialed the reports that staff were permitted to scan them into the patient's EHR. Unfortunately, in this case, the CT report was scanned into the patient's EHR prior to being reviewed or initialed by the physician. Nineteen months later the urologist discovered the last CT results had been scanned into the patient's EHR without his review. The physician notified the patient of the findings and ordered another CT scan of the abdomen and pelvis for the following day. This scan showed a lobulated enhancing mass in the right kidney measuring 6.5 cm. The patient was referred to another urologist for a biopsy of the mass, and it was found to be renal cell carcinoma. The patient subsequently underwent a right nephrectomy but later developed metastatic renal caner. The patient brought a lawsuit against the initial treating urologist. The case was settled.

## DISCUSSION

In this case there was a clear breakdown in the established process aimed at reducing errors posed by a hybrid medical record. This office practice had a process for scanning paper faxes into the electronic medical record, but it was not followed. The staff member involved was familiar with the process requiring physician review and signature prior to scanning. She bypassed the process because she was busy. Failure to follow the office documentation process was the root cause of the delay in diagnosis.

Hybrid record maintenance and utilization necessitate additional processes and diligence to help ensure results are not missed. It is the responsibility of the ordering physician to diligently review results of the tests that they order, regardless of where the results are ultimately placed in the medical record. In this case the urologist did not follow up on the results of a test he ordered, and the failed hybrid record process contributed to the missed follow-up. It is important to have clear procedures on how paper records are merged into the electronic system, while also ensuring the provider reviews the reports in a timely manner.

## RISK REDUCTION STRATEGIES

Consider the following strategies:

- Implement a consistent follow-up tracking system to monitor test results and consultant reports. If possible, utilize your electronic health record tracking and follow-up capabilities.
- Reinforce with staff the importance of only scanning results after physician review, emphasizing the possible harm to patients if not done.
- Utilize interface features with laboratories and imaging centers whenever possible.
- Dedicate a fax machine solely to receipt of your ordered tests to streamline the physician review and scanning process.
- Place a fax machine in a secure location within the physician's personal office space, which is dedicated to receipt of ordered test results, to help streamline the review, signature, and scanning steps. Also, develop a backup process if the physician is out of the office.



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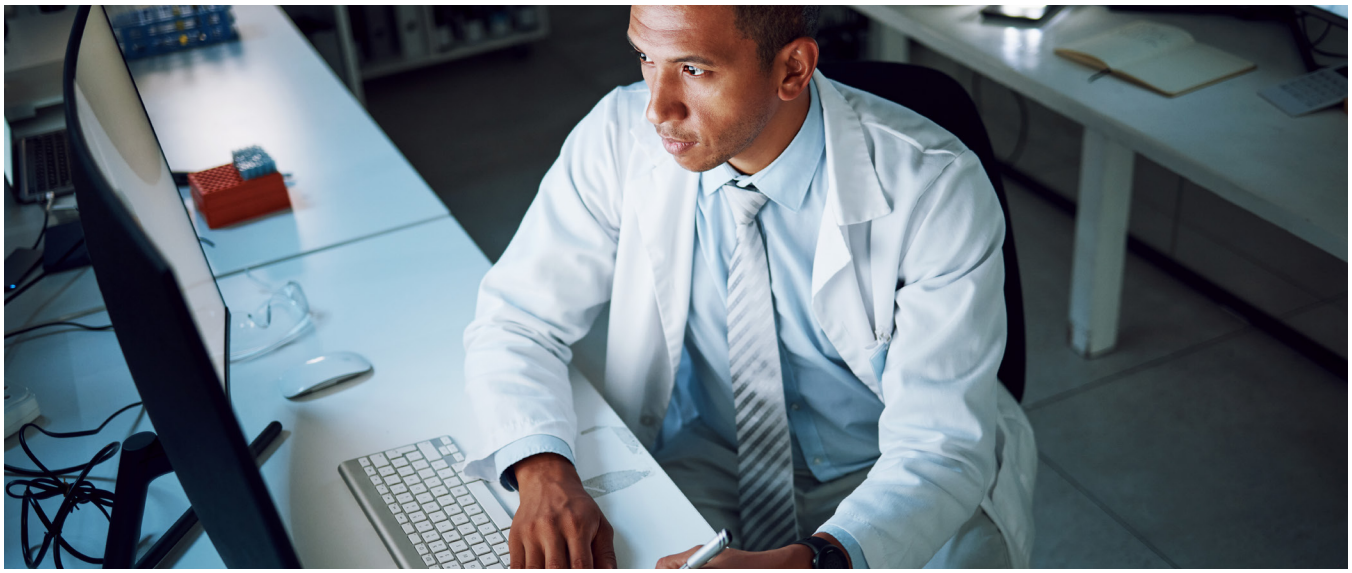

## CASE FOUR:

# Late, Improper, or Self-Serving Entries and Additions to the Medical Record

It is critical to document both routine and out-of-the-ordinary discussions with patients, especially when the content affects clinical decision-making. This includes informed consent, general instructions on medications, worsening symptoms, the importance of following up with specialists or diagnostic testing (and the consequences of not doing so), and any questions or concerns the patient voiced. Documented discussions between the provider or office staff and the patient help to show the complete picture of the relationship, treatment plan, and obstacles to care.

Failure to document key conversations with patients, even when mundane, can lead to difficulty defending a case. For example, a plaintiff's attorney may paint a lack of documentation as inadequate oversight by the provider, who left a patient without direction. Although it may not always be possible to document immediately, such as in an emergency, charting should be completed soon after the conversation. It might be tempting to go back into a patient record to add details about patient or family discussions. Electronic records timestamped long after a conversation occurred, especially after a patient complication or poor outcome, raise suspicions as to the integrity of the late entries. The following case highlights the risks associated with late entries.

Consider how the surgeon's documentation practices diminished the defensibility of this claim.

A 65-year-old female presented to the facility for a scheduled hysteroscopy with dilation and curettage (D&C). The patient had a history of Type 2 diabetes and thyroid disease. The procedure seemed to go well with no apparent complications. Specimens received from the surgery were sent to pathology. The patient was discharged the same day with a postoperative appointment scheduled in two days. The day after surgery the surgeon received a call from the pathologist regarding the patient's endometrial polyps that had been removed during surgery. The pathologist reported to the surgeon that the specimen contained fragments of both adipose tissue and colonic mucosa.



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The surgeon documented that he called the patient on postoperative day one as part of a routine follow-up call. The patient reported she was burping and still felt bloated and full. She also reported some stomach pain. She denied vomiting, vaginal bleeding, fever, or chills, but her blood glucose was elevated. The surgeon reported he informed the patient that she had an appointment for the next day but had advised her to go to the emergency department (ED) should her symptoms worsen. The record further indicated that he discussed the pathology results.

Early the next morning the patient was found by her husband, who could not rouse her. The patient was transported to the local ED via emergency medical services where she was pronounced dead shortly after arrival. An autopsy was performed, and the cause of death was found to be septic shock and septic peritonitis, as a result of uterine and bowel perforation from the surgery. The patient's husband filed a malpractice lawsuit against the surgeon.

## DISCUSSION

Although there was some expert support for the surgeon, during the discovery phase of this case an audit trail of the electronic medical record was produced. The audit showed the surgeon had made multiple modifications to the patient's medical record after the patient's death. The medical record additions included details that appeared self-serving to the surgeon. These late notes included the postoperative phone call and the need for the patient to be seen in the office the next day for an exam and potential CT scan. The notes also included the patient's refusal to come to the office due to lack of a ride, and instructions to go to the ED if her symptoms worsened. The surgeon did not document the possibility of bowel perforation, or the urgency of the situation. Lack of timely documentation of the phone call with the patient, as well as the nature of the late-added details of care were key components for settling this case.

Late entries into the medical record continue to be an issue in professional negligence cases. Though it is recommended that patient care take priority over immediate documentation, it is important to ensure documentation of treatment is entered into the medical record in a timely manner. It is particularly concerning when documentation is many hours or days late and specifically after a patient suffers a bad outcome. Most entries within the EHR are timestamped and will clearly show when documentation is added or altered. During litigation it is not uncommon for a forensic report of the EHR to be requested by the plaintiff's attorney. This report will show each entry into the record that may include the author, date, time, and contents of the addition or removal of notations.

In this case the documentation was concerning for incompleteness but also potential alteration of key information. The postoperative telephone call should have been documented in a timely manner and contained all elements of the conversation. These would include the possibility of a bowel perforation and the risks associated with not presenting for recommended follow-up. Documentation in the medical record of conversations with patients is extremely important to show the details discussed, the patient's understanding, and any recommendations made to the patient. It is equally important to explain and document the risks to the patient if they choose not to follow these recommendations.

## RISK REDUCTION STRATEGIES

- Document key elements into the patient's medical record. These include discussions with the patient (both in person and via telephone), the patient's understanding of the information relayed, and recommendations given.
- Promptly update the medical record.
- Implement a system to flag or lock down a medical record after being notified of a pending claim or lawsuit, to avoid perceptions of self-serving behavior.



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## CASE FIVE:

# Failure to Document Patient Concerns and Subsequent Late Documentation After a Bad Outcome

There is a difference between correcting existing documentation in the medical record and altering the medical record for the purpose of adding brand new information after an adverse event has occurred. The latter raises ethical alarms, destroys credibility, and calls into question the veracity of the provider's other documentation. It can make the defense of a medical malpractice claim extremely difficult, especially when earlier charting lacks detail. Many states can act against a physician's medical license if it is found they altered a medical record.

Utilization of the copy-forward function of notes from previous encounters can populate misinformation into the current visit, creating potential for later liability. Providers should stay alert to the current details entered into the medical record, ensuring the visit note at hand is accurate and comprehensive. Previous entries likely will not give the current clinical picture of the patient, and providers should understand what notes the EHR may automatically continue to utilize. With the use of copy-forward, outdated patient information such as histories and diagnoses can carry over throughout the chart for long periods of time. In the following case study the physician had multiple entries that were the product of copy-forward. Thus, they did not give an accurate picture of the patient's status or note her concerns with the current pregnancy. In addition to the outward appearance of careless charting, carried forward notes create patient safety and treatment concerns, and raise questions of proper and complete patient assessment.

Consider how the OB could have better documented the patient's prenatal concerns and how this affected his post-fetal-demise notes.



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A 30-year-old pregnant female sought obstetric care at eight weeks of pregnancy. She was new to this obstetrician (OB) and informed him of her history of gestational diabetes. She had two children weighing greater than nine pounds at birth, and conveyed her previous need for early delivery due to complications related to gestational diabetes. This information was documented in her medical record at the time of her first visit.

At her 28-week appointment she inquired about lab testing for gestational diabetes. The physician documented the need for this testing in the patient's medical record but did not order the test. There was no further documentation of gestational diabetes or need for testing during this patient's subsequent office visits, although the patient continued to request it throughout the rest of her pregnancy. The patient's repeated requests to the physician and office staff, both in person and telephonically, for gestational diabetes lab testing were undocumented in the chart.

In her 34th week of pregnancy an ultrasound indicated the baby was approximately 11 pounds with greater than normal amniotic fluid, which is a sign of gestational diabetes. The patient requested induction, but the physician refused. The following day the patient presented to the ED for lack of fetal movement. An ultrasound was performed, and the baby was found to be nonviable. The mother again questioned the nurses and the OB about why testing was not done, and relayed her concerns of a large baby and the request of an early delivery. The parents of the baby filed a lawsuit against the physician and his office for negligence.

## DISCUSSION

During the discovery phase of the lawsuit, the plaintiff's attorneys requested a full copy of the patient's medical record. It clearly documented the physician was aware of the patient's risk for gestational diabetes at the eight-week visit. Medical record entries for numerous visits failed to mention gestational diabetes, while many entries were a product of copy forward, including weights from previous visits. A key discovery, after medical record review, was a late entry by the OB after the delivery of the baby. The physician documented at the patient's 28-week lab visit that she was offered and refused testing for gestational diabetes. This late entry was seen as self-serving. The case was ultimately settled due to the late entry, which was viewed as an alteration of the medical record and called into question the OB's integrity.

In this case there was concern for breach of the standard of care on behalf of the physician. Equally compelling was the question of the OB's integrity, as it was discovered the physician entered a late note in such a way as to attempt to make it appear contemporaneous with the visit. Since the OB created this note after the fetal demise, claiming lab testing for gestational diabetes was offered and refused, it raised concerns that the tests were not actually offered as the note suggested.

Additionally, the patient in this case voiced questions about her prenatal care. After the fetal demise she felt ignored by the physician, which caused her to feel suspicious and angry. The physician should have taken the opportunity to talk with the patient, address her concerns and questions, and document the conversation in the patient's medical record.



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## RISK REDUCTION STRATEGIES

- Exercise caution with copy forward features to prevent the propagation of outdated or erroneous information across patient encounters.
- If corrections are necessary, ensure they are made promptly, accurately, and in accordance with facility policies.
  - For electronic record correction make sure to add the note as an "addendum" and sign, date, and time the entry.
  - To correct a note in a paper record, draw a line through the incorrect entry and initial it along with the date and time. Enter the correction above or next to the original note.
- Do not destroy documents.
- Without consultation and guidance by assigned counsel, never make an entry or addendum to a medical record after being notified of a pending claim or lawsuit, as this is seen as self-serving.

## DISCLOSURE

Unfortunately, sometimes errors occur or patients are harmed, and full and honest disclosure to the patients or their families is necessary. Disclosure of medical errors has been found to reduce overall malpractice costs. This is perhaps because patients appreciate the honesty that comes with disclosure and the ability to ask questions and understand what happened. It can also allow for early resolution of a potential lawsuit, where warranted.

- When such errors of care occur, work with the leadership and risk management teams on proper disclosure and documentation of this communication within the medical record.
- If appropriate, explain the rationale for clinical decision-making and, if prudent, apologize for the outcome of the care.
- Ensure any disclosure conversation is documented in the patient's medical record, to include those that were present and the date and time.
- Remember that compassion and understanding often go a long way.



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# Medical Record Documentation:

## Paint The Patient Picture with Complete and Accurate Documentation

## CONCLUSION

Medical record documentation is often cited as a key factor in medical malpractice lawsuits because, outside of testimony, the medical record is critical evidence of whether patient care was appropriate or lacking. Potential documentation pitfalls, within EHR functionality and otherwise, can lead to incomplete or inaccurate charting, which may cause harm to a patient or paint only a partial picture of the care provided. For this reason providers must remain diligent in their practices to ensure their documentation is comprehensive, complete, and done in a timely manner. Documentation should not be done hastily and should include relevant communications with patients and families.

The medical record is a legal document. Destroying or altering this record can carry grave consequences, including potential criminal liabilities and ammunition to be used against a defendant in a medical malpractice case. A single suspicion of record alteration during a medical malpractice claim may cause questioning of all other entries by the same provider, as well as any testimony the provider may provide. When changes or additions to the medical record are required, steps must be taken to amend the record correctly so as not to destroy or improperly alter the underlying chart. It is imperative that providers and their staff understand the importance of strong documentation in every patient visit and communication.

## ENDNOTES

The documents referenced in this article, along with many other risk management resource documents and past editions of *Claims Rx*, are available by calling Risk Management at 844-223-9648 or by email at RiskAdvisor@ProAssurance.com.


1. Jason Lai and David Tillman, "Curriculum to Develop Documentation Proficiency Among Medical Students in an Emergency Medicine Clerkship," *MedEdPORTAL* 17 (November 2021):11194. https://doi.org/10.15766/mep_2374-8265.11194.
2. Emily Klatt et al., "Note to Self: Principles for Better Documentation," *NEJM Resident 360*, April 20, 2022, https://resident360.nejm.org/content-items/note-to-self-principles-for-better-documentation-3.




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