February 2023 - Charting

The better your documentation, the less likely any lawyer will take up a case against you.

- Charting doesn't have to be perfect, just display a logical course of thinking.
- This newsletter's aim is to convey some tips to make your charting more defensible. It does not discuss charting for coding.
- Charting Practices to Protect Against Malpractice: Case Reviews and Learning Points
    - 70% of physicians will be named in a lawsuit in their careers. Up to 20% of these suits are due to documentation errors.
        - Missing documentation =70%, Inaccurate content- 22%, Poor mechanics=18%
- **Common Charting Errors involved in Medical Malpractice Claims**
- Missing Documentation
    - Informed Consent- If possible, patients should sign and date consent forms documenting what procedure is to be performed and the risks involved
    - AMA- A signed AMA form is not protection from liability. It's important to document efforts to persuade the patient to stay as well as risks involved that are specific to the case. Additionally, physicians should document decision making capacity in all AMA cases ideally with reference to the four elements of capacity (understanding, appreciation, reasoning, and communication.)
    - Consults- Document name, time and, what was discussed for consultations
    - Document communications with patients at and after discharge. Clearly note any discharge instructions and follow up instructions with the patient including incidental radiology results that should be followed up on.
- Inaccurate Documentation

- Avoid using: Inaccurate templates, copy/pasting from other notes, and conflicting information with other clinicians for the same encounter (Triage nurses, APCs, Nurses..ect.)
    - The content and tenor of your exam/history should align with other documentation in the patient's chart. If there are big differences they should be explained. (ex- Triage nurse notes that the patient is diaphoretic, complaining of crushing chest pain, and is vomiting. When you see the patient they have a completely different complaint and look well.)
    - If what you are told or see on your exam conflicts with other documentation in the note, explain the discrepancy.
    - If this is not addressed, inconsistencies in your note can and will be used against you in the legal process if a suit is filed to try to discredit your entire chart
    - Be careful with templates ensuring that the ROS/Exam is accurate and for the given patient (ex: Amputees moving all four extremities)
    - Avoid using any judgemental language in your charts. This can be used to discredit your chart by demonstrating a bias by lawyers.
- Alterations in charting
    - Real time charting is key. EPIC and other EHRs track each change to the medical record and each time the medical record is accessed. Do not attempt to alter the chart after a bad outcome. If you must add additional information, add an addendum to the chart that is clearly timed for when added.
- Comparative Effectiveness Review No. 258: Diagnostic Errors in the Emergency Department: A Systematic Review (ahrq.gov)

        - This paper seems to be a misrepresentation of the amount of errors in the ED but the public, regulatory agencies, and lawyers are aware of this data. Their conclusion is that EPs misdiagnose 1 in 18 patients each year resulting in 250,000 deaths per year or 8.6% of all deaths in the US.
    - Intra-articular lidocaine versus intravenous sedation for closed reduction of acute anterior shoulder dislocation in the emergency department: a systematic review and meta-analysis - PubMed (nih.gov)
        - Consider Intra-articular lidocaine as an alternative to conscious sedation for shoulder reductions
    - Molnupiravir plus usual care versus usual care alone as early treatment for adults with COVID-19 at increased risk of adverse outcomes (PANORAMIC): an open-label, platform-adaptive randomised controlled trial - PubMed (nih.gov)
        - Molnupiravir is an alternative COVID treatment for patients who cannot take Paxlovid but this study showed that it did not decrease death or hospitalization in COVID vaccinated patients in high risk patients.
    - Appropriateness of Initial Course of Action in the Management of Blunt Trauma Based on a Diagnostic Workup Including an Extended Ultrasonography Scan - PubMed (nih.gov)
        - Do a FAST exam during your initial evaluation in blunt trauma patients
    - Objective assessment of sleep and fatigue risk in emergency medicine physicians - PubMed (nih.gov)
        - Many EPs are chronically fatigued and this fatigue can impair performance.

- Notes from the recent Risk Management Neurology M&M

- Dr. Day recommended not calling code stroke for isolated extremity or facial paresthesia with the exception of trunk paresthesia which is an indication of a true stroke.
- Dr. Nima mentioned that for significant deficits we should call code strokes more than 24 hours from onset as they can do thrombectomies even a few days out