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If It Wasn't Charted, It Wasn't Done:

Why Thorough Documentation Equals a Measure of Protection in Litigation

There are not many who appreciate the scope of what is required of medical professionals when it comes to the details of medical documentation.[i] Nearly every physician and many a nurse have stayed long after hours to complete charting and/or dictation. Normally, a medical record is merely a chronicle of the interactions between patients and health care professionals. The record not only allows all professionals involved in the patient's care to relay necessary information, but it provides a history upon which patient care may be based. Health care professionals appreciate the need for accurate charting as a function of good patient care, but may not always recognize the significance of a patient's chart in legal proceedings or licensure actions.

In a malpractice action, a health care provider's actions are judged against a "standard of care," which is a legal, not a medical, concept. If a provider's actions do not meet or exceed the standard of care and it results in injury to the patient, a jury may award the injured patient monetary damages. The standard of care is that degree of learning and skill ordinarily possessed and used by similarly situated practitioners under the same circumstances.

Because the "standard of care" will depend upon the specific circumstances surrounding the care given to a particular patient, it will vary from case to case. Many medical providers assume the "standard" is just that, an unchanging set of requirements which, if met, means they took the right course of action. In a legal setting, however, that is not always the case. The standard of care must be established in each particular case, and the circumstances of each case are often determinative. Institutional policies, procedures, guidelines and recognized medical good practices are important, but the standard is often a subjective issue upon which reasonable minds can disagree.

In malpractice or licensure actions, the patient's medical record is, with few exceptions, the most significant source of factual information concerning the timing and order of events that occurred. The facts or evidence set forth in the chart will be reviewed by others as they consider the decisions, course of treatment and/or inaction of a particular medical provider throughout the series of interactions with the patient. As such, a patient's chart often serves as the determinative evidence or the basis for justifying or, conversely, for criticizing the care provided.

Although good charting may not keep you out of a lawsuit, poor charting may well keep you in a lawsuit and cause an attorney to target you as the primary defendant in a malpractice action. Why? It may be due to the old adage, "If it wasn't charted, it wasn't done." Those people with exposure to everyday medical practice know this idea is a myth—every physician knows there are many instances where care is given but not documented. However, because this is such a well-known mantra in healthcare, it is often suggested in litigation.

Certain attorneys make it a point to ask a physician to agree under oath if a particular event or course of treatment is not charted, it did not, in fact, happen. Where the patient's medical chart is poorly maintained and lacking information, the passage of time between treatment and subsequent legal action and the number of patients seen in the interim makes it likely the health care provider will not remember what happened or why certain treatment choices were made at that particular time. A common question asked of physicians in the course of litigation is, if this event was so significant, why isn't it in the record? In the face of a threadbare chart, the medical professional is placed in a terrible position. Even if the health care provider remembers what happened, if he or she tries to relay certain events to the jury where no supporting facts are reflected in the chart, the provider's comments may appear self-serving and incredible.

Minimal charting will also allow adverse counsel to find an expert to fill in the blanks in a way that will allow them to portray the care given as inadequate or inappropriate. Where documentation is lacking, the theory this consultant will devise may be based upon pure speculation. It is never advisable, however, to make improper changes to the medical record if you remember facts after a lawsuit is filed.

In the past, some people working in medical/legal circles encouraged the school of thought that what was not in the chart could not be criticized. However, as discussed, because you will not always be able to remember the facts and circumstances concerning the events that occurred, adopting a practice of minimal charting will not always protect you in a malpractice suit.

In many settings the patient's chart is entered in electronic format. Health care providers are prompted by the electronic medical record-keeping system to make certain information part of the chart. If nothing more than the minimum is added, it results in a Spartan record containing little information to jog your memory or to justify the decisions made and actions taken at the time. In addition, physicians should be aware that attorneys frequently request a copy of the electronic "audit trail" during litigation documenting the time and identity of each person who makes an entry, looks at the record or later changes the patient's electronic medical record.

The best means of dispelling the idea that something did not happen because it was not included in the chart is through accurate and complete documentation. For example, there are several possible ways to choose to act after visiting a patient's bedside where there is no change in condition. For medical/legal purposes, an example of the least effective is no documentation at all; noting in the record "at the patient's bedside," would

be a good practice; charting “at the patient’s bedside, no change,” would be the best practice. With that in mind, there are several things to remember when charting.

DOS AND DON’TS OF GOOD CHARTING

DOS:

- Be concise and factual. Chart the facts. If charting any subjective opinions, state so clearly.
- Complete your charting in a timely manner.
- Document the date and time, especially for hand-written orders and notes. Try to be consistent in documenting times.
- Fill in all of the blanks. If they are not applicable, put N/A or a line through it.
- Chart what you see, hear, smell or feel and document observations appropriately.
- Document interactions with nursing staff including what was specifically reported to you by whom.
- Document interactions with other physicians from whom or to whom you refer.
- Take the time to clearly document the details of phone calls regarding patient care. If it was important enough for them to call you, you should chart what was reported and your response.
- Clearly document the bedside interactions or consultations with patients and/or their family including times.
- Include relevant patient and family comments in quotation marks.
- Specific attention to charting on patients that have a crisis in stability (code blue), emergency surgery, change in level of consciousness, change in perfusion, change in urine output or change in oxygen saturation, or other significant change in condition. Be sure that you have a good baseline reported and documented.
- Document any disagreements with plan of care by patient or patient’s family and how the issue was resolved. Clearly document any failure of patient to follow plan of care or to act against medical advice.
- Document all patient interactions.
- Document all patient interventions and plan of care. It is especially important to document instructions given to a patient and the failure of the patient to follow instructions.
- Document all patient responses to interventions and plan of care.
- Document patient consents and understanding for procedures and patient teaching.
- Document patient outcomes, whether good or bad.
- If a correction to a record is made, it should be dated and timed at the time the correction is made and should be signed. Do not date and time a late entry or correction as if made earlier than the correction or late entry is actually made.
- Make sure your written entries and orders are legible and that your signature is legible.

DON'TS:

- Don't chart personal opinions in the chart. Just the facts of care should be in the chart. This may include the history and physical, your assessment, diagnoses (including differential diagnoses), plan of care, patient's response and other important facts about the patient's care and outcomes.
- If hand-written - don't make it illegible.
- Don't leave blanks un-addressed.
- Don't simply record "Call received" or "At patient's bedside" in progress notes. Document the substance of what was reported or what you saw and your response.
- Don't document the making or filing of incident reports, reports to supervisors or risk managers or other similar reports in the chart. These are protected processes that should not be referenced in the patient's record.
- Don't use judgment words, like "error" or "mistake." Document the facts and responses without judgment upon care of yourself or others.
- Don't suggest problems in other's care or assess blame for patient's condition. You can document the facts without assessing blame.
- Don't fail to document obtaining informed consent and instructions given to a patient.
- Don't be defensive in charting after a bad outcome. Continue charting the facts.
- Don't leave gaps in time or unexplained delays in treatment. If you are providing care to the patient, even if by phone or to quickly review the chart on passing the patient's room, it should be documented.
- Don't alter records. If you need to correct a prior entry or a prior dictated report, any correcting entries should be dated, timed and signed with the correct information and what it corrects. Late entries should also be dated and timed at the time they are made rather than made to appear as if part of the original record. Legal counsel should be sought before attempting to make late entries in records in which patient care is in dispute or which are in litigation or have been threatened with litigation.

While good patient care must always be the foremost concern of medical professionals, medical providers should make it their practice to create as complete and accurate a record as is practicable. Beyond establishing a positive relationship with the patient and the patient's family, accurate and complete documentation is often a very effective means of protecting yourself. Good documentation skills may well provide you with a measure of protection in case you are someday drawn into litigation.

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[i] Kansas Administrative Regulation 100-24-1 requires that all licensees of the Board of Healing Arts maintain adequate patient records. The standards for minimal adequacy are set out in the regulation.