



## **Tips to Keep You Out of the Courtroom and the Importance of Documentation**

At some point in your career, there is a reasonably high probability that you will be named as a defendant in a medical malpractice lawsuit. You can take steps, however, to reduce the likelihood of being sued and make those that are filed more defensible. The plaintiff has the burden of proving negligence in a courtroom. Good concise documentation is one of the best ways to keep you out of the courtroom. Often, a plaintiff's attorney will obtain a copy of the patient's medical records. The plaintiff's attorney will send an expert a copy of the medical records for review. The expert review of the records may determine if a lawsuit should be filed. The better the documentation, the more defensible the case and the more challenging it is for the plaintiff to prove negligence. The following are tips for avoiding malpractice and wrongful death lawsuits.

### **In the medical record:**

1. Write legibly if still using a paper chart. Illegible writing causes problems in defending any malpractice suit. Ensure that each entry is signed, dated, and timed or an electronic signature is used in electronic health records.
2. The medical record should tell the story. If you use a template record make sure the patient's course of treatment is clear. It should include the chief complaint, medical history, medications, the assessment performed, and care provided. If you were to go back and pull a chart from 6 months ago would it create a picture in your mind of what was going on with the patient.
3. Consider and document differential diagnosis especially in high-risk patients. Document an additional note for complex patients and high-risk conditions, such as abdominal pain, chest pain, pediatric fever, stroke, acute headache, and return visits.
4. Never alter the documentation after the fact. If information must be added it should be clearly labeled as an addendum or a late entry.

Information should never be added to a chart after a lawsuit has been filed. Information can always be given during a deposition.

5. Always be aware of the facility's policy on documentation.
6. If you become aware of an adverse patient outcome do not go back and add additional documentation as this can be viewed as self serving. Adverse outcome information can be discussed with your malpractice carrier or your defense attorney if a lawsuit is subsequently filed.
7. Address any abnormal vital signs and ensure that abnormal ones are repeated. Any abnormal lab or diagnostic test results should be addressed.
8. Just chart the facts and do not speculate. Document patient interactions objectively and avoid the use of personal opinions. Avoid subjective language that could be construed as judgmental, such as "patient is obviously intoxicated, noncompliant," or a "known drug abuser." Use factual information in your charts, such as "patient has slurred speech, gait is unsteady, pupils dilated to 6 mm, and strong smells of alcohol" or "patient counseled about the risk of drug dependency."
9. Document your rationale each time you institute, modify, or discontinue the course of treatment. Be sure your plan of care and the course of treatment are clearly documented.
10. Avoid template creep such as slash marks through an entire section. Address each area of the template, do not leave any blanks and be consistent with use of symbols. For example, a forward slash mark should not indicate "not present" in some cases and "not assessed" in others.
11. Complete medical records as soon as possible and before you leave your shift. Your recall may be diminished over time. If you had to testify that it is sometimes your practice to delay your documentation, this might provide a plaintiff's attorney with an opening to question what you have written. Additionally, it can look self serving to document or dictate at a later time. This is especially true in a case where a patient has a return visit and you have not completed the record from the first visit.
12. Document handoffs and consider using a handoff tool. Make a note when you go off duty and when you come on. Document a reassessment of the patient when you receive a patient from another provider. A handoff checklist to ensure appropriate communication can be helpful especially on complex patients. [Click here](#) for the EPIX Handoff Toolkit.
13. Never criticize another provider in the medical record or in front of a patient. This may be all that is needed to spark a lawsuit. If you disagree

- with another provider's care or plan, factually note the care you are providing and your rationale, and diagnosis based on the assessment.
14. Document conversations with consultants. A note stating "spoke with Dr. Smith" is not enough. Document what specific information was conveyed and what the consultant's response was.
  15. Maintain written reports of preliminary radiology readings in the chart. Be sure the radiology reports are always written and always made a part of the permanent medical record. In some cases, the radiologist has made some changes in the final report.
  16. Record the discharge instructions and provide a copy in writing. The discharge instructions should be specific. Consider giving a specific instruction for follow up and avoid instructions such as "See your primary care physician/primary medical doctor if not better in 2-3 days." Do not use abbreviations. Be specific in your instructions such as, "See your family physician at 10 am tomorrow morning." Document specific signs and symptoms to watch for, for example, patients with splints, elastic wraps and casts should be advised of the signs and symptoms of compartment syndrome. Be sure the discharge instructions match the clinical work up and do not introduce a topic in the discharge instructions that is not addressed elsewhere in the medical record. Document and have a copy on the chart of discharge instruction sheets given like care of sutures, fractures, and other template instruction sheets. Discharge instructions need to include prescriptions and any over the counter drug prescribed. Include any significant risks and side effects of the drugs.
  17. Document details of pertinent discussions with patients and families. This includes conversation regarding the diagnosis and treatment.
  18. Document your differential diagnosis. Make sure the record indicates what diagnosis you considered and ruled out.
  19. Read the nursing documentation and address any inconsistencies between your documentation and nursing documentation without being critical. For example, if the nurse documents that an infant with a fever appears lethargic, and your assessment is different document a detailed description of the child's behavior to clearly show that the child was not lethargic or that there have been changes since the initial triage assessment.

20. Ensure the status is clear when the patient needs to stay in the hospital. It should say admit as an inpatient to ICU or place in an outpatient observation bed. It is always important to document medical necessity.
21. There are 90 million Americans with low health literacy so ensure the discharge instructions and any written information can be understood by the patient. Document the use of repeat back or read back to make sure the patient understands.
22. There are 55 million Americans whose primary language is not English. Ensure that an interpreter is used when indicated and document this in the chart.
23. If the patient wants to leave without being seen or against medical advice, have the patient sign a written release form that states the hospital stood willing to take care of the patient along with any risks.
24. Document patient non-compliance.
25. Never document in the chart that an incident report has been filled out. The facts of the occurrence should be documented along with the action taken and the results of the intervention.

#### **At the bedside:**

1. Maintain professional attire and wear appropriate identification that lists name and profession.
2. Introduce yourself to the patient and visitors. Address the patient by proper name such as “Mr., Mrs., or Ms.”
3. Shake hands if appropriate. Establish eye contact at their level.
4. Pull up a chair and listen carefully to what the patient tells you.
5. It is important to maintain a good bedside manner. Studies have shown the importance of things like sitting down when interviewing the patient. Patients who interpret their physician or provider’s behavior as being attentive and caring are less likely to file a malpractice claim. Don’t come in the patient’s room in a rushed and hurried manner.
6. Ask the patient if they have any questions.
7. Don’t let the patient ‘lead you down the garden path.’ While you need to listen to what the patient is telling you, rely on your assessment skills and clinical knowledge. Don’t let a patient convince you that their chest pain is musculoskeletal without a complete cardiac assessment.

8. Don't attempt to justify bad decisions. For example, you want to admit that patient with chest pain for observation but the patient wants to be discharged. If the patient does not want any care then have the patient sign out AMA. This does not have to be and should not be adversarial. Don't change your plan of care based on the patient's desires. If the patient does not want a part of the care that is recommended, the patient should be given written information on the risks and benefits and should sign the document.
9. Strive to see patients within 30 minutes of their arrival in the emergency department. There may be a linkage between claims and door-to-physician times of more than 30 minutes. Apology for any delay and keep the patient informed on any delays.
10. Follow clinical protocols. If you deviate from an established protocol make sure to explain the reason in a narrative note. For example, if you forego a lumbar puncture on a two-month old with fever of unknown origin, you must explain why in the record. Some clinical protocols should not be altered. All chest pain in patients over 35 years old, with non-traumatic chest pain, should be considered cardiac until ruled out.
11. Be approachable. Make sure that nursing and ancillary personnel are comfortable questioning the care provided and pointing out issues. Team training stresses the importance of an environment in which staff feels free to ask questions.
12. Beware of frequent flyers. Patients with chronic pain and chronic conditions and suspected drug seekers need a complete examination and evaluation on each and every visit. Don't make judgments about patients that may influence your care and do not let the judgments of others influence your care. Check the state's prescription monitoring program.
13. Mid-level providers should be adequately supervised and have a clearly communicated scope of practice that is within established hospital protocol and state regulations.
14. Think serial order serial biomarkers, such as a troponin level, and EKGs for patients with chest pain. Document serial examinations for patients with abdominal pain and infants and children with fever.
15. Communicate clearly. Always consider what needs to be communicated to patients, staff, and other physicians and then develop a mental communication plan to assure that what you want to say is what is heard.

16. Remember, that under the federal EMTALA law, any patient who presents to the emergency department should be given a medical screening exam. The purpose of the medical screening exam is to determine if the patient has an emergency medical condition. If this exists, then the patient needs to be stabilized.

**Following the above tips is your first line of defense against a malpractice claim.**

Revised by Sue Dill Calloway March 2016.