CHARTING

Legal Analysis of the Do's and Don'ts of Creating Medical Documentation

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LEARNING OBJECTIVES

- Learning Objective 1: **Review proper medical charting procedures and techniques**
- Learning Objective 2: **Identify common mistakes in medical charting**
- Learning Objective 3: **Explain the legal impact of medical documentation errors**

LEGAL STANDARDS

- Malpractice
  - Focuses on the “standard of care”
  - Care of which the average, prudent provider in a given community would practice.
  - Another way, it is how similarly qualified practitioners would have managed the patients care under the same or similar circumstances.

LEGAL STANDARDS

- Deliberate Indifference
  - Derived from the Eighth Amendment of the U.S. Constitution
  - 8th Amendment = No “cruel and unusual punishment”
  - U.S. Supreme Court has interpreted this to mean that inmates (and pre-trial detainees) have a constitutional right to adequate medical care.
  - Standard – Defendants cannot be “deliberately indifferent to a serious medical need.”
    - KNEW OF AND DISREGARDED A RISK TO PATIENTS HEALTH/SAFETY

LEGAL STANDARDS

- Deliberate Indifference
  - Beyond negligence or malpractice (although many courts have been closing the gap)

Examples include:

- Absence of a use of “professional medical judgment”
- Persistence in course of treatment known to be ineffective
- Choice of an easier or less effective treatment
- Delay in treatment that prolongs pain or causes increased harm
- Failure to follow recommendations of a specialist
- Failure to follow an existing protocol or policy

BY THE NUMBERS

- 1941 – Less than 5,000 inmates in state confinement. Less than 300 prisoner petitions (including habeas corpus) in total.
- 1966 – First year of Section 1983 statistics – 218 cases
- From 1970 to 2012, inmate population increases from 359,000 to 2.2 million. (state, Federal, jail)
- By 1996, number of pending Section 1983 cases reaches 38k.
- Drop in cases in 1997 after passage of the PLRA.
- But over last few years, numbers of prisoner claims have exploded.
- In 2020, there were over 56,000 new civil filings made by prisoners in federal District Court.
  - That doesn't include state court filings

WHAT DOES THIS ALL MEAN?

- Whether you like it or not, litigation is going to be now, and into the future, an ever present part of your practice.
- This is especially true for those that work in the area of corrections.

WHY IS CHARTING SO IMPORTANT

- Memorializes patient care
- Formulates patient medical history
- Constitute legal documents
- Serve as your best defense

CHARTING

- SOAP – Why did you reach that assessment/plan?
- Include the “Why”
  - Too often, medical records lack any explanation of the particular assessment and plan.
- Don’t need a novel.
- Even just one sentence that explains why you came to your decision

CHART LIKE THE RECORD WILL ONE DAY BE READ BY A JURY

CHARTING

- Errors in Charting
  - Late entries
  - Inaccurate information
  - Illegible handwriting
  - Calling patient names or “liar”
  - Overreliance on boilerplate language in electronic records
  - Lack of detail
  - Obvious omissions
  - Copy and paste

Exam Data/Objective Findings:this is a man with previously witnessed grandmal seizures by this provider and a long history of seizure disorder that perhaps now appear to be improved with maxxed out keppra, addition of low dose depakote, and perhaps neurontin but he seems to on the one hand be having cns side effects, eg. sedation, his c/o of feeling "loopy", and ?/ocular nystagmus, and on the other hand possible signs and symptoms of Psychogenic Non-epileptic Seizures (PNES). he is on 4 AEDS plus addition of zoloft by mental health. BECAUSE OF THESE REASONS THIS MAN NEEDS A FOLLOW-UP WITH NEUROLOGIST (LAST SEEN 7/20/17) - THE PNES CAN ONLY BE DISTINGUISHED IF AT ALL BY VIDEO-EEG IN HANDS OF THE NEUROLOGIST.
PER up tp date
"As noted above, clinical features of events are often not sufficiently sensitive or specific to definitively distinguish seizures from PNES; as a result, confirmatory testing is usually required [116]. While not without limitations, video-electroencephalography (EEG) is the gold standard."

History of Present Illness:

1. SIGNAL 3000

   THE PATIENT WAS ALERT WHEN HE WAS SEEN BY THIS PROVIDER - ALSO THE NURSE THAT NOTIFIED THIS PROVIDER STATED THAT HE WAS ALERT WHEN HE CAME TO THE URGENT CLINIC AND SHE LAID EYES ON THE PATIENT. THE NURSE CLAIMS THAT THE OTHER NURSES TRANSPORTING THE PATIENT FELT HE HAD "SMALL SEIZURE-LIKE EPISODES" THAT WERE NOT DESCRIBED. BY THIS EXPLANATION AND THE CURRENT LACK OF POST-ICTAL, A GRAND MAL SEIZURE TODAY PROBABLY DID NOT OCCUR TODAY.
   CC: I HAVE BEEN REFUSING MY NEURONTIN BECAUSE I HAVE BEEN FEELING NAUSEOUS AND VOMITING WITH DOUBLE VISION AND SO REFUSED THE NEURONTIN
   HPI: THE PATIENT IS THOUGHT TO BE A KNOWN SEIZURE DISORDER OF UNKNOWN ETIOLOGY - EEGS AND MRIS OF NO HELP PER NEUROLOGIST'S OWN WORDS. IN THE LAST MONTH 8/2017, HE ALSO HAS HAD MULTIPLE EPISODES OF NON-GENERALIZED EVENTS PERHAPS "PSEUDO-SEIZURES" OR PSYCHOGENIC NON-EPILEPTIC SEIZURES (OR PNES): 1. WITHOUT REPORTED POST-ICTAL PERIODS, 2. NO CLEARLY REPORTED GENERALIZED LOSS OF CONSCIOUSNESS, 3. NO CLEARLY REPORTED TONIC-CLONIC ACTIVITY, 4. NO TONGUE BITING, AND 5. NO INCONTINENCE WITNESSED. THIS PROVIDER THOUGH HAS WITNESSED LOSS OF CONSCIOUSNESS, TONIC CLONIC ACTIVITY, URINARY INCONTINENCE AND TONGUE BITING PLUS POST-ICTAL STATE IN THIS PATIENT PRIOR TO ADDITION OF NEURONTIN AND DEPAKOTE, AND MAXIMIZING OF KEPPRA (A FEW MONTHS AGO). THIS PATIENT SAW AN OFF-SITE NEUROLOGIST 7/20/2017 WHO ADDED VALPROIC ACID AND DEBATED DISCONTINUATION OF DILANTIN BUT CLEARLY DOCUMENTED ADDRESSING IT IN FOLLOW-UP VISIT (@10/2017. TO ADD TO THE CURRENT CONFUSION, THIS MAN HAD A NEURONTIN LEVEL DRAWN 7/7/2017 THAT SHOWED NO NEURONTIN (<LIMIT OF DETECTION). THE MEDICAL ADMINISTRATION RECORD (MAR) SHOWS: NO MISSED DOSES 7/6/17 AND 7/7/17, AND ONLY ONE MISSED PM DOSE 7/5/17. IF MAR IS CORRECT, THEN THE BLOODWORK @ 12:45 PM ON

ADDENDUM FOR UP-TO-DATE
"Psychogenic nonepileptic seizures
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Contributor Disclosures
All topics are updated as new evidence becomes available and our peer review process is complete.
Literature review current through: Aug 2017. | This topic last updated: Nov 17, 2015.
INTRODUCTION — Clinicians are regularly challenged to identify the nature of episodic neurologic symptoms. Events associated with prominent motor activity or altered consciousness are often presumed to be epileptic seizures. However, the event may actually represent one of a wide array of nonepileptic paroxysmal events, such as syncope, parasomnias, and movement disorders (table 1).

Another notable type of episodic behavior is a psychogenic nonepileptic seizure (PNES). Characterized by sudden and time-limited disturbances of motor, sensory, autonomic, cognitive, and/or emotional functions, PNES can mimic epileptic seizures. However, in contrast to epileptic seizures, PNES are not associated with physiological central nervous system dysfunction but are instead psychogenically determined [1-4].

Other terms, such as pseudoseizures or hysterical seizures, have been used to describe these episodes. The term "hysterical" seizures or "hysteroepilepsy" is now discouraged as both pejorative and oversimplified, failing to capture the broad range of underlying psychopathology. The term "pseudoseizures" is also discouraged, since the root "pseudo," or false, invalidates the genuine, even if psychogenic, disorder that a patient experiences.

PATIENT:
DATE OF BIRTH:
DOC#:
DATE: 07/21/2017 12:17 PM
VISIT TYPE: Chronic Care Visit

Established patient

4.	Assessment	Health examination of defined subpopulations (V70.5).
	Impression	requested low bunk with a history of GSW to right arm. Able to perform ADL's.
	Patient Plan	Low bunk denies.

PATIENT:
ADDENDUM TO VISIT: (07/21/2017 12:17 PM) 12/19/2017 11:08 AM

ADDENDUM DATE: 12/19/2017
PROVIDER: NP

ADDENDUM:Offender seen by Dr. on 07/21/17.

PATIENT:
DOB:
DOC#:
DATE: 10/30/2017 2:08 PM
DOCUMENT GENERATED BY: , MD

Classification Orders

Order	Reason	Status	Start	End
Bottom bunk	severe arm weakness	ordered	10/30/2017	

DOC #:
DATE: 11/16/2017 12:16 PM
VISIT TYPE: Chart Update

Nurse Visit

Reason for visit: BBP DNQ

Orders

Status	Order	Timeframe	Frequency	Duration	Stop Date
ordered	CANCEL BBP EFFECTIVE IMMEDIATELY				11/16/2017

General Comments

per DON and HSA verified pt does not qualify for BBP. His arm weakness is not a severe neurological defect. He does not have any noted atrophy.

BAD CHARTING – TOO SHORT

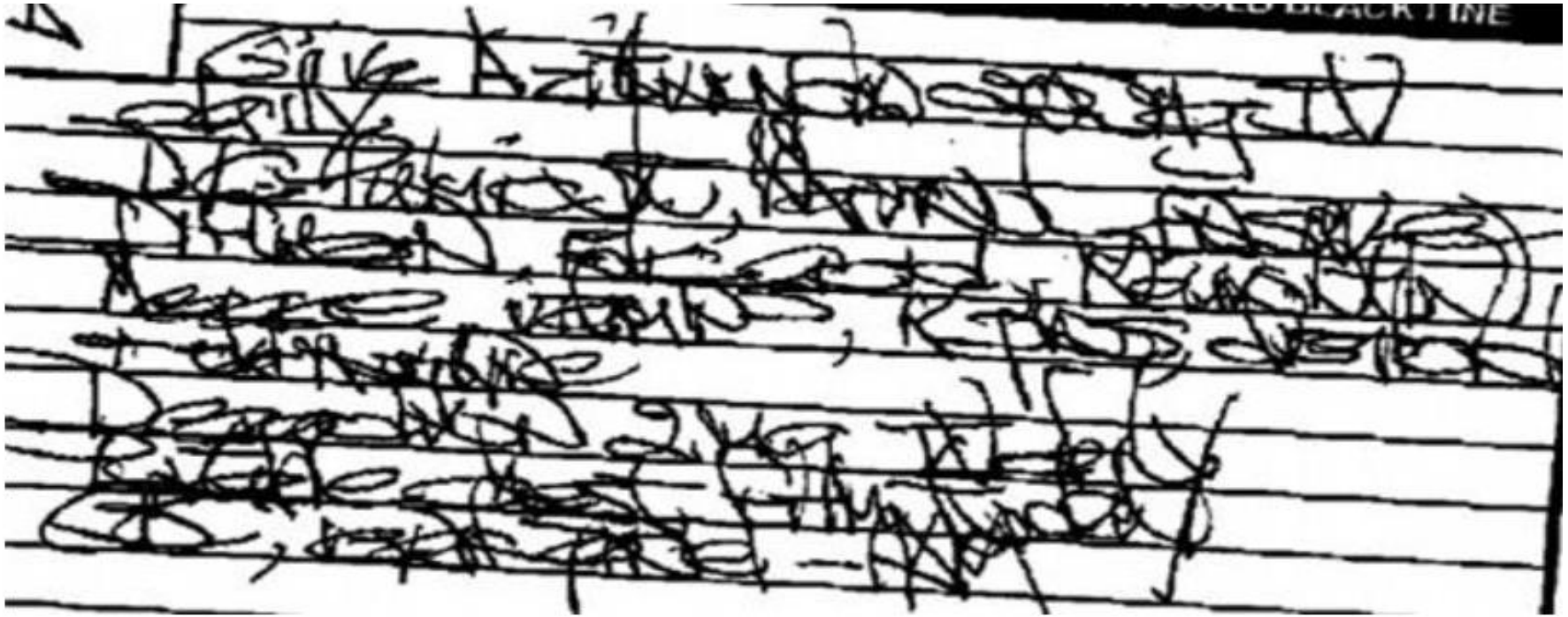
DATE: 08/13/2019 1:07 PM
VISIT TYPE: Nurse Visit

Nurse Visit

Reason for visit: Sick Call Sick Visit.
HCR#: 123057

Statement of complaint (in patient's words): My chest hurts.

BAD HANDWRITING



EXAMPLE OF GOOD CHARTING

DATE: 10/23/2018 03:26 PM
VISIT TYPE: Provider Visit

Established patient

History of Present Illness:

1. Lacerations (FP)
   This is an initial visit. The injury occurred 30 minutes ago. Symptoms related to the lacerations (fp) remain unchanged. The trauma occurred due to a fall while cell approximately 30 minutes ago. The injury was not work related. Date of last tetanus: 06/01/2009. The patient has a laceration on the left periorbital, measuring 1.2500 by 0.5000 cm and is described as linear. The injury is aggravated by Fall. The patient had a fair response to pressure. The injury is associated with headache, joint pain and localized swelling. The patient denies any fever, nausea, somnolence or vomiting. Additional information: He also injured L PIP joint of 3rd digit. He notes pain, swelling, bruising, decreased ROM, and abrasion over palmar aspect of PIP jt.

CONSEQUENCES

- Overall decreased quality of care
- Litigation
- Expense
- Time
- Liability (verdict or settlement)
- License
- National Practitioner Data Bank

GET TO THE POINT

- Litigation is an unfortunate part of the practice of medicine.
- Even the best doctors will be sued.
- Do the best you can to address those areas that are within your control.
- Practice good medicine.
- Keep good records. Protect your patient, and yourself.
- Help us, help you.

REFERENCES

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ANY QUESTIONS?

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