Defending your Care through Documentation

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Risk Management’s goal is:

• To protect against external liabilities – litigation & regulatory.

• Identify areas of potential liability and work with appropriate staff to improve those areas.
Documentation is Essential

- Promotes continuity of care
- Necessary to be paid for services
- Satisfy regulations and policies
Good documentation is one of your best defenses when the care you provided is called into question.
Good Documentation

Good ≠ Perfection

- Tells the complete story
- What is the issue
- What is the ordered care
- Care was timely provided
- Outcome of that care
Proactive

• Medical Charting
• Communication

Reactive

• Investigation
• Reporting
Importance of Documentation

- Regulatory: May only look at the charting.
- Litigation: Necessary to bring a lawsuit. Your statements all based on your credibility and difficult to remember accurately years after the event.

Not Documented = It didn’t happen
Most frequently challenged in:

- Lawsuit
- Regulatory Investigation

Each has different goals and methods but both may occur in response to the same event.

The best defense is good quality documentation that reflects the high level of healthcare you provide.
# Lawsuit v. Regulatory Investigation

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<th>Lawsuit</th>
<th>Regulatory Investigation</th>
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<td>4 years</td>
<td>1 year though may be challenged in court</td>
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Depositions are question and answer sessions that take place years after the care was administered. They are not like what you see on television:

- Long, detailed and tedious
- Attorney trying to fluster you

Plaintiff’s attorney will:

- Work to portray you as incompetent
- Look for holes in your care and charting
- Employ medical experts to learn as much as possible
The medical chart is a story.

It has:

Beginning

• Why is this patient here/What is the issue?
• What is your care plan?

Middle

• What care did you provide?

End

• What was the result of your care?
You must include everything you need to tell the story.

What happened – the facts
- Objective: What you see; What was said
- Subjective: Pain levels
- Assessment
- Care Plan: Include how you responded to complaints & follow-up
- Patient Education

When did it happen
- Be specific and consistent: Avoid using blocks of time
- Document as soon as possible
- Assists in establishing your care was timely and appropriate
Medical Charting

Make sure you would want to read it

- Clear & neat handwriting
- Proper spelling
- Grammar
- Work usage
- Avoid abbreviations
Medical Charting

Your story is about the resident.

Your opinions are not part of the resident’s story – tell that to HR

- Judgment
- Blame
- Speculation

Incident and Event reports are not part of the medical chart.
“we busted her knee” - Blame

“improper transfer from w/c to bed” - Judgment

“it was an honest mistake” - Blame & Judgment
Communication

Several types of communication:

• Caregiver & Caregiver
• Caregiver & Provider
• Caregiver & Family

Each unique in both how & what is told.
Communication

All types of communication needs to:

- Organized
- Use Clear & Precise Language
- Expressed in Terms the Listener Will Understand
- Take as Much Time as Necessary
- Confirm the Listener has Understood
Communication: Caregiver & Caregiver

Common Sources of Error

- Inadequate information
- Use standardized report format
- Electronic Medical Record
- Using go-betweens
- Schedule adequate time to provide report
- Failure to follow-up
- Use report sheet
Communication: Caregiver & Provider

Common Sources of Error

• Be prepared to provide full report
  • Complete necessary assessment
• Use appropriate communication method
• Difficulty reaching provider
  • Contact Medical Director
  • Send to hospital
Most important communications to prevent a lawsuit.

Families sue because of perceived indifference.
Communication: Caregiver & Family

- Are you allowed to speak to family member
  - Check release of information – POA
- Not medically trained
  - Use simple but clear language
  - Explain medical terminology
- Emotional
  - Be patient
  - Bring in others if necessary
- Unrealistic expectations
  - Expectation management begins upon admission
  - On-going process
  - Extra communication
Each reported event should be investigated.
Prepare summary of investigation.
Prepare plan of correction as necessary.
Serious events may require a formal root cause analysis.
Investigation Report Writing

An investigation report should focus on the intent of the audience.

- Lawsuit: Purpose is to find fault and award damages. Report will challenge liability and the severity of damages.
- Regulatory: Purpose is to prevent reoccurrence. Report will focus on response to event and corrective actions.
Investigation Report Writing: Structure

Make sure you would want to read it.

- Summarize what happened in the first sentence.
- Chronology is generally the most accessible format.
- Use paragraphs.
- Use headers and sub-headers.
- Use bullet points.
Opinion v. Conclusion

- Opinions are not part of the story.
- Conclusions are part of the story.
- Your conclusions supported by the evidence should be included.
- Your conclusions should be driven by the evidence. Don’t make the evidence fit your conclusion.
Risk Management’s goal is:

- To protect against external liabilities – litigation & regulatory.
- Identify areas of potential liability and work with appropriate staff to improve those areas.
Risk Management: Proactive

Working with Clinical staff to create tools that:

• Identify high risk patients
• Monitor those patients
• Create documentation useful for when care is called into question
Example: Quality Risk Management Tool

A weekly assessment:

• High Risk Fall Patients
• Pressure Ulcers/Wounds
• Medication Errors
• Unplanned Weight Changes
• Infections
• Hospital Transfer/Re-Admissions
• Anti-Psychotic Usage (Monthly)

Initially developed by Administrator & DON.

Monitored by Clinical Quality and Risk staff.

In first 6 months, avoided 2 F-level tags.
You will be judged on your documents; so, make it easy for your reader.
Thank you