Medical documentation

(Medical records, gold standard)

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Introduction

Today we live in a world where people try to get money for almost anything, even in the medical service.

Physicians must try to protect themselves from any possible lawsuits. How does a physician do that? The answer is by taking proper medical documentation.

What is medical documentation?

Definition: Medical documentation is an instrument which helps the health care staff to record all information about patients' health status and the procedures provided by the hospital staff.

It is structured in a way to show that the hospital staff are aware of what they are doing, and observing the care they give to the patient. This is carried out by taking down all important information from the patients' health status and history, but also more detailed information including lab-values, X-rays, etc. (1).

By doing this it will be helpful in the future in case something would go wrong, because the documentation is considered an invaluable factor in the legal system. Hospital staff failing to document important information about the patient, and hence increasing the risk management, can be considered a serious breach and digression from the general healthcare standards (2, 3, 4, 5).

Complete medical records are the most important asset of a good health care system (6).

"Throughout a medical malpractice case, the most important piece of evidence will be the medical record."(6).

If a physician does not have a complete medical documentation of a patient, it will increase their chances of getting sued in the future. This is because they will not have the medical record written down to prove their side of the story.

Medical documentation

Every physician should follow the rule "if it isn't written down, you didn't do it." (6), and every medical document should provide enough information so when a new physician reviews the medical record, they would know exactly what the patient was being seen for, including treatment and future plan of action (6).

"The purpose of collecting and storing patient information is to make it available for decision-making at a point of care or for analysis and action for management and policy" (7).

It is important to understand that most patients may have more than one point of care, and that they might move from one location to another, therefore it is important for their information to be made available at all points of care (7).

There are some required standards in order to represent information for communication (i.e. distributed health data networks) (7).

According to the medical society of the District of Columbia, a patient's medical record should be complete and legible (8).

There are some points the physician must adhere to (8):

Documentation:

- The date the patient was seen or admitted to the hospital.
- The reason for why the patient has come for a consultation.
- Appropriate history and examination for the patients' main presenting complaints.

- Evaluation and treatment plan during a patients stay, and until after the patient has been discharged.

The physician should be able to access the patients past and present diagnoses. The reason and result for diagnoses including X-rays, lab tests and other useful information should be included in the medical report. Health risk factors and everything about patients' progress should be documented (including treatment), and everything added to the data must be dated and authenticated (8).

Throughout the course of a medical lawsuit, the most important evidence the health care physician will have at their disposal is the patient's medical record (6).

In many cases poor maintenance of medical records in addition to inadequate documentation within the patient's medical records contribute to many losses.

By ensuring your records are precise, legible and properly organized, your chances of defending yourself in a law suit will be greatly increased (6).

The loss of many cases can be directly attributed to poorly maintained medical records, or lack of documentation in the patient's medical history. If your records are accurate, legible, and well organized, they will greatly increase your chances of successfully defending a lawsuit (6).

Gold standard:

There are a number of different ways to record patient history. Amongst the most common ones are Electronic Health Recorder (HER) and paper based system (9).

The paper based system used to be the gold standard for keeping medical records, but today many countries are replacing this method to a newer one. It is known as the electronic health

care recorder. These changes are being implemented due to the inefficiency of paper based systems (10).

The challenges of using paper based systems include:

- It is easier to misplace or lose information in paper charts, and the outcome of this can be very dangerous, “one in seven hospitalizations are due to missing clinical information” (10).
- Health care workers are expected to know and remember many guidelines without any help –“A 2003 study in the New England Journal of Medicine reported that the patients receive only 55% of recommended preventive care services.” (10).
- It takes more time and more work to identify patients with individual characteristics (i.e. patients with diabetes or other diseases who need the same treatment or to know how many patient need to be vaccinated by the same vaccine) (10).

The modern Electronic Health Record is a way to view a patient’s medical records through a computerized interface (9), computer systems are used instead of paper charts, all components of a clinical practice are fed into Electronic Health Recorders - everything from assessing a patient’s history and main complaints to creating a new treatment plan for the patient. In addition to this, it is used for managing other areas in a clinical practice as well like billing, surgery, and organization of the hospital (10).

The aim of this new method is to improve and simplify the quality of patient care for the healthcare staff and for the patient (10).

The benefits with Electronic health recorders are (9):

- There is better collection and storage of data, papers don’t get accumulated.
- There are less medical errors, which can easily be done by bad handwriting.
- There is a higher quality of hospital care.

- The patient can access some of their own data.
- It is less time consuming compared to paper based systems.
- There is easier access to patient records, and the patient information can be accessed from outside of the hospital, this method can be very useful in emergencies (10).
- Medical practices can send messages, assign tasks or receive information electronically from other hospitals (10).

The disadvantages of electronic health recorders are (9):

- There may be some data errors which can be time consuming.
- The quality of patient-doctor interaction may be decreased.
- To read text from a computer screen takes 40% more time than to read it in a printed form, and it might be more difficult for some medical staff that are not used to work with computerized devices (11).

Paper-based and electronic patient records are often used together to support different tasks.

Even though the quality of the Electronic Health Recorder is better, most physicians still regard the paper record as the gold standard (12).

Destruction of medical records (13, 14):

Destruction of medical records depend on time and on what type of medical record it is (ex. Paper records, electrical records, X-rays).

GP records are usually kept for 10 years after the patient's death, records of children are kept until the patient is 25, or 8 years after their death

Destruction of records are carried out according to the Health Insurance Portability and Accountability Act regulations. No records can be destroyed before the minimum time required for the medical documentation has been met. The method they are destroyed are

usually by shredding and pulverization, electronic data are destroyed through disposal and servicing.

Medical records are property of patient or the medical institution (15):

Most of the medical records are property of the medical institution, however the patient is allowed to ask for a copy of the treatment records and should be handed the records within 72 hours.

The hospital must keep the medical records confidential and are not allowed to release any information. There are special circumstances in which there may be exceptions to this rule.

Discussion

When reviewing a medical record in court, the lawyer of the prosecutor will try to look for any information that might be weak or missed and stick to it in order to sue the healthcare professional. It can be anything from the time of the documentation to failed communication between hospital staff and patients (16).

So is it important to make medical documentation? In today's society I think that as a medical staff in a hospital it is very important to make a medical documentation. As David Carp says - medical documentation is not only for the patients' safety but also for the physicians' defensibility (17).

The documentation has to be complete, the physician must note everything they do, see, or hear, and they must observe everything. If they feel something is out of the norm or if they say something to the patient they have to put it in to the medical documentation (18).

By taking proper information from a patient and putting it down in writing, or storing it will not only benefit the patient but also the healthcare staff, there will be no mistakes or missing information that may harm the patient later on, and if the patient would complain or blame the staff for missing some information there will be written proof that this is false.

I think this topic should be more stressed in the hospitals, it is very easy for a doctor or nurse to miss out important information and cause a patient harm. If there is a form to follow that helps the staff to collect all information and make a proper medical data this can be avoided, but the medical staff should be aware of this by them self as well and take notes for what they think is important, someone who works in the medical industry should never close their eyes if they see something they have doubts about they should write it down in their data and the should not be afraid of asking another physician for advice, as this might help them later in a legal case.

Making a correct medical data is also important for the medical staff, since these days a lot of patients try to make money by suing hospitals and medical healthcare workers for any little mistake or misunderstanding, even by making up scenarios of things that did not occur. This would be easier to prevent if the physicians would make their documentation properly, and put down every information, by making these proper medical documentations these lawsuits could be avoided and would save the hospitals and the physicians a great amount of money and even their license to practice and in worst case jail.

I also think that the electronic health recorder is a better way to work with than the paper based system, because it is easier to store and keep everything in order and to access the information needed, with paper based system there will not be enough storage and it is much more time consuming and messy to find information, also by using the paper based systems it is easier for information to be lost and misplaced and misunderstandings frequently happen.

By using a computerized method the medical staff will avoid misunderstandings, bad handwriting etc. This will avoid creating dangerous situations for the patients, just because they read something wrong and prescribed the wrong medication.

I think it is important to work with more modern approaches for these type of things not to happen and as it is easier and less time consuming and more precise.

Conclusion

Medical documentation should be made properly, with awareness for the patients' safety, and also for avoiding misunderstandings and lawsuits that should never have taken place or could have easily been avoided in the first place.

References

1. **Medical record documentation and understanding legal aspects for certified nursing.** Florida Health Care Association 2008, p 3. http://www.fhca.org/members/workforce/cna/medrecdoc.pdf , June 4,2014
2. Gutheil TG: **Fundamentals of Medical Record Documentation.** Psychiatry (Edgmont) 2004, 1(3): 26-28. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3010959/ , June 3, 2014
3. Gutheil TG: **Paranoia and progress notes: A guide to forensically informed psychiatric record keeping**. Hosp Community Psychiatry. 1980; 31:479–82.
4. Gutheil TG, Appelbaum PS: **Clinical Handbook of Psychiatry and the Law. Third Edition. Baltimore, MD**: Lippincott, Williams, and Wilkins; 2000.
5. Gutheil TG: **The medical record in the acute care setting and issues of confidentiality.** In: Sederer LL, Rothschild AJ, editors. Acute care psychiatry: Diagnosis and treatment. Baltimore: Lippincott, Williams and Wilkins; 1997.
6. Murphy BJ: **Principles of good medical record documentation.** Journal of Medical Practice Management 2001, (March-April): 258-260. http://www.medsch.ucla.edu/AngelUploads/content/0708-UCLA-YEAR4-ACC-1/_assoc/1FBD2F6BAEA940CC8298EBE38EC884A4/Principles.pdf , June 3, 2014
7. WHO: **Management of patient information Trends and challenges in Member States.** Global Observatory for eHealth series - Volume 6, Geneva - Switzerland: WHO. 2012:17-21. http://apps.who.int/iris/bitstream/10665/76794/1/9789241504645_eng.pdf?ua=1 , June 3, 2014.
8. **10 Principles of Documentation for Medical Records.** Medical Society of the District of Columbia, 2005.

http://www.msdc.org/memberCenter/10PrinciplesofDocumentationforMedicalRecords.shtml , June 3, 2014.

9. **Electronic patient record.** NHS Institute for Innovation and Improvement, 2006-2013 http://www.institute.nhs.uk/building_capability/technology_and_product_innovation/electronic_patient_record.html , June 3, 2014.
10. Bloomberg MR, Frieden TR: **Improve quality of care through electronic health records.** New York: The New York Department of Health and Mental Hygiene; 1-9. http://www.nyc.gov/html/doh/downloads/pdf/csi/ehrkit-brochure.pdf , June 4, 2014
11. Walsh SH: **The clinician's perspective on electronic health records and how they can affect patient care.** BMJ 2004, 328(7449): 1184–1187.
12. Stausberg J, Koch D, Ingernerf J, Betzler M: **Comparing paper-based with electronic patient records: lessons learned during a study on diagnosis and procedure codes.** J Am Med Inform Assoc. 2003, 10(5):470-477.
13. **How long should medical records be kept for?** NHS, 05/09/2013 http://www.nhs.uk/chq/Pages/1889.aspx?CategoryID=68 , July 15, 2014.
14. **Medical Record Retention and Destruction; Disposal of Protected Health Information.** THE UNIVERSITY OF TOLEDO, 2/01/2014 https://www.utoledo.edu/policies/utmc/administrative/pdfs/3364-100-90-16.pdf , July 15, 2014.
15. Thomas J: Medical records and issues in negligence. Indian J Urol. 2009 Jul-Sep; 25(3): 384–388.
 http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2779965/ , July 26, 2014.
16. Austin S: **Stay out of court with proper documentation.** Lippincott Williams & Wilkins; 2011:25-29.

http://www.nursingcenter.com/lnc/pdf?AID=1144062&an=00152258-201301000-00010&Journal_ID=&Issue_ID= , 5 June, 2014.

17. Karp D, Huerta JM, Dobbs CA, Dukes DL, Kenady K: **A Handbook for Physicians and Medical Office Staff.** Oakland CA: Medical Insurance Exchange of California: 2008.
    http://www.miec.com/Portals/0/pubs/MedicalRec.pdf , June 4, 2014.
18. **Medical record documentation and legal aspects appropriate to nursing assistant**
    http://studymaterials.healthmanagementventures.com/pdf/MedicalRecordDocumentation , June 5, 2014.