Document, Document, Document! - Overview

The importance of good medical records cannot be overemphasized. Records that are clear, organized, complete, legible, and timely facilitate continuity of care among members of the health care team, minimize the risk of medical errors, offer protection from litigation, support hospital accreditation, and maximize reimbursement. When medical records are handwritten, they must be legible and clear. Only approved abbreviations should be used. Physicians must become adept at using electronic medical record systems appropriately. If something is done but not documented, in many ways it may just as well have never happened. If complications or bad outcomes occur, immediate and thorough documentation decreases the risk of litigation and other adverse consequences. Even mundane details such as recording the date and time of a progress note may prove medicolegally important; therefore, thorough documentation is of great importance.

Document, Document, Document! - Scenario Script

A resident is sitting at a desk surrounded by charts. Her attending physician walks over.

Attending Physician: Okay, let's review Mr. Kahlil's chart. [He reaches into pile, extracts one folder, and leafs through it]

Resident: He is being worked up for a seizure disorder.

Attending Physician: He had a CT and a spinal tap?

Resident: Yeah, I did it right after he came in.

Attending Physician: OK, here's the CT report… nothing there… and the spinal tap results [leafing through the chart] also are of no help. You did write a procedure note for the spinal tap, didn't you?

Resident: Yes, here it is [flips through charts to find it].

Attending Physician: [Takes a few moments to read the chart] You did the tap after you saw the CT results, right?

Resident: Of course…

Attending Physician: But you didn't note it in the chart.

Resident: What's the difference?

Attending Physician: Potentially, if he had elevated intracranial pressure, he could have herniated. That's why you see the CT first…

Resident: I don't see why it's such a big deal. I didn't write it but I did it. I saw the CT report before I did the tap.

Document, Document, Document! - Discussion Questions

1. What deficiency in the resident's patient notes raises the attending's concern?
2. Why is the sequence of the entry of information critical in this case?
3. Should the missing information be entered into the medical record now? If so, how should that be done?
4. If there had been an adverse event with respect to the spinal tap, how might the resident's and the hospital's liability be affected by the timing of the entry?
5. How effective was the attending in educating the resident about the importance of timely and accurate documentation? How might he have been more effective?
6. What does the resident's final response suggest?
7. How should entry errors in medical records be corrected?

Document, Document, Document! - Scenario Analysis

In this scenario, an attending physician is reviewing the charting done by a resident. With her assistance, he locates a procedure note regarding a spinal tap that was done on the patient. The attending is concerned because the note does not indicate that the results of the patient's CT had been reviewed before proceeding with the spinal tap. He points out that it is critical not only to have seen those results before proceeding but to document that they had been reviewed prior to the spinal tap. The resident is somewhat exasperated and doesn't seem to understand why it is "such a big deal."

It is "a big deal" because, unfortunately, if something is not properly documented in the medical record in a timely manner, legally it can be called into question whether it actually occurred. The documented event may be a procedure, a laboratory or x-ray result that might influence patient management decisions, a conversation with the patient or a consultant, or anything else that might allow a reconstruction of the course of a patient's treatment. It may not be true, but for legal purposes the principle is, "if you didn't document it, you didn't do it!"

Beyond meeting the legal requirements for documentation, good medical record keeping serves several other purposes. Good notes allow colleagues and other members of the health care team to understand what is going on with the patient, what the plans are, and the rationale for the current treatment. This facilitates interdisciplinary collaboration and improves patient care. It is important not only to enter accurate, clear, and timely information into the patient's medical record, but also to carefully read all patient note entries made by others, whether they were made by consultants, nursing staff, or others.

Finally, it is just as critical that a doctor never enter false information into a patient record or to try to alter information previously entered. If an entry has been made in error, it should be crossed out in such a way that the original note is not obscured, and the initials of the person making the new entry, as well as the date and time of the correction, should be noted in the margin.