General Internal Medicine Review Course

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Documentation

- Mainly referring to the patient health record
  - In general, patients can request a copy of their health records
  - Protected by law – cannot be released without authorization
  - Includes labs, notes, procedures, billing, diagnosis, prescriptions

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  - Includes labs, notes, procedures, billing, diagnosis, prescriptions
  - Anything written or printed
- Functions
  - Keeping the patient's health history organized
  - Describes patient care, patient's response to care, and changing care plan
  - Vital to coordination of care
  - Communication between doctors, nurses, pharmacy, radiology, support staff
  - Records are assessed to ensure the facility meets required standard of care
  - Can be used in a court of law

Question #1

- What is medical documentation?

Documentation

- PROPER and ADEQUATE documentation is essential for quality health care
- Must contain pertinent facts, findings, and observations about the patient
- Must be dated & legible and accurately identify the individual patient
- Sufficient to assure both confidentiality and proper standard of care
- Physicians are obligated to treat illnesses to the best of their abilities with regards to what is documented in the patient's medical records
- Use direct quotes, facts (avoid insulting or denigrating comments)

Documentation

- Minimum is the SOAP note (urgent care, quick visits)
  - Subjective, Objective, Assessment, Plan
- Preferred outpatient note (routine visit, well check)
  - Current history/subjective
  - Past medical history and surgeries
  - Relevant social history
  - Current medications & treatments
  - Physical exam
  - Diagnostic testing
  - Assessment
  - Plan

Documentation

- Inpatient Notes: Problem based versus Organ based
  - Time seen
  - Working diagnoses
  - Interval history and response to treatment
  - Pertinent physical exam and review of data (vital signs, labs, procedures)
  - Plan of care

Documentation

Discharge summary after each hospital stay

- Dates of admission and discharge
- Discharge diagnoses
- Hospital course
- Any new/changed medications at discharge
- Plan for follow-up
- Any special patient instructions

Question #2 - is this adequate documentation?

- Patient presents for dressing change
- Patient presents for dressing change, wound clean based, dressing reapplied, return in 1 week for dressing change again
- Patient presents for refills
- Patient presents for monthly refills. Known diabetes, hypertension. No complaints today. Refills for metformin and amlodipine/losartan given. Return in 1 mo for refills, clinical review every 3 months – next due November.

Question #2 - is this adequate documentation?

Presents with fever, chills; thinks he has malaria

Not in distress, looks well

For Malaria test

Question #2 - is this adequate documentation?

- Known hypertension with headache today, ran out of pills last week, BP 180/116. For amlodipine 5mg STAT and refill meds.

Question #2 - is this adequate documentation?

- 40 year old lady with GBP for many years. BP 170/90. Well appearing. Also complains of weakness and epigastric pain. For H.pylori test.

Rx: H. PYLO C KIT

Documentation

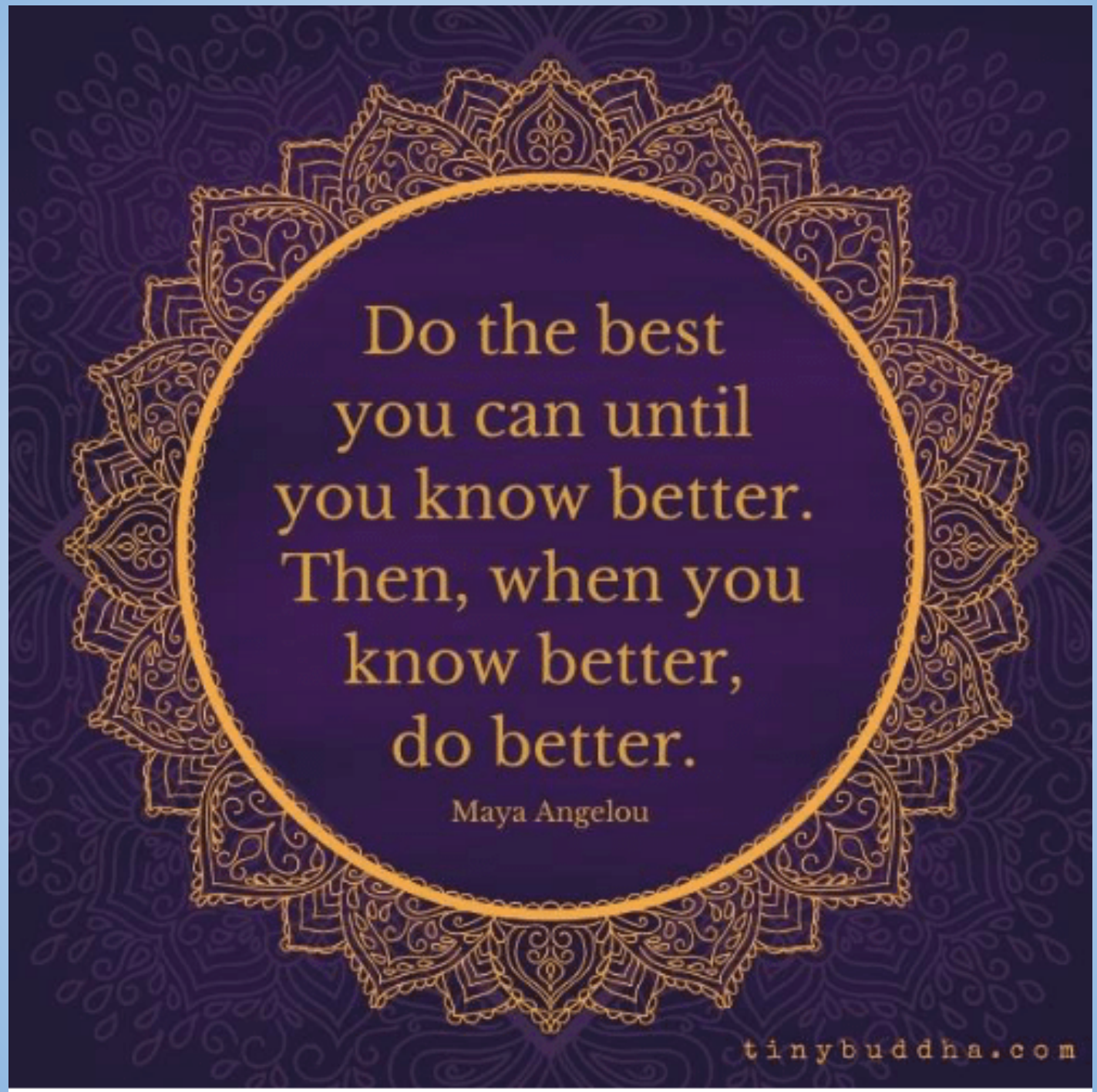
- PROPER and ADEQUATE

- Legal minimum (patient name, date, any word)
- Ethical minimum (SOAP note)
- Quality minimum (did you document providing an acceptable standard of care?)

Documentation

- Standard of care
  - You didn’t do it
  - You did it…but didn’t document it
  - You did it and documented it

- Local, Regional, International Standards
  - Country treatment guidelines or national handbook
  - Equivalent to care provided by peers
  - Institutional policy or order set or standard operating procedure
  - Literature: textbooks, journal articles, online resources
  - Evidence based medicine: agreed upon guidelines and recommendations


Do the best
you can until
you know better.
Then, when you
know better,
do better.
Maya Angelou
tinybuddha.com

Documentation

- How good is your documentation currently?
- How can you improve your efficiency and reimbursement?
  - Use of templates
  - Periodic self review
  - Periodic peer review
  - Periodic supervisor review
- How can you improve clinical practice to ensure you are providing high quality care that meets or exceeds standards?

Templates

- Protocols and guidance for frequent diagnosis or algorithms (examples from Malawi EHR)
  - Hypertension annual review
  - Malaria protocol
  - Early sepsis protocol
  - CCF education and titration
  - Amphotericin B infusion protocol
- Suggested (common diagnoses with established treatment guidelines)
  - Metabolic syndrome annual review
    - Hypertension, dyslipidemia, diabetes, central obesity
  - Asthma / COPD step-wise management
  - Stable coronary disease

- https://www.medscape.com/features/slideshow/med-errors

Medical-Legal issues

- Do not erase or alter prior notes (use an addendum or new note)
- Do not write retaliatory or critical comments
- Do not place blame on your colleagues
- Use proper grammar and spelling
- Document purposeful omissions (medication NOT given and why, treatment NOT done and why)
- Document phone calls and emails with patients
- HANDOVER to another provider should be documented

Medical-Legal issues

- ”If it’s not documented, you didn’t do it”
- You are legally responsible for your treatment recommendations
  - Misdiagnosis / failure to diagnosis (31%)
  - Harm / abnormal injury (31%)
  - Negligence / failure to treat (12%)
  - Poor documentation of patient instruction / education (4%)
  - Errors in medication administration (4%)
  - Failing to follow safety procedures (3%)
  - Improper consent / lack of informed consent (3%)

Medical-Legal issues

- Good documentation usually supports the physician if care is called into question
- Legal action: disciplinary action by hospital/medical board, complaints to media/government, criminal investigation
- 60% of physicians are named in a lawsuit in the USA in their lifetime
- OB-Gyn, Surgery, Orthopedics, Radiology are the most often sued
- More likely to be sued: older, male, poor bedside manner
  - May be an expression of anger due to patient interaction rather than truly about giving substandard care
  - Physicians who respond to patient's emotional needs are sued less

Medical-Legal issues

- Perception of time spent and “being heard”
  - Allow the patient to talk for 60 seconds
  - Spend the first 60 seconds looking at them, not typing
  - Ask up front what issues the patient wants to address
  - At the end, ask if all the issues have been addressed
  - Empathetic language
- The “Difficult Patient”
  - Acknowledge frustration
  - De-escalate
  - Focus on what can be addressed
- Life-threatening illness