Charting and Documentation Bootcamp

Kathryn Frelick
kfrelick@millerthomson.com
416.595.2979
Documentation and Charting Bootcamp

- Purposes of documentation and legal and professional requirements
- Documentation best practices and pitfalls
- Use of health records as evidence in legal proceedings and how to protect yourself
Purposes of Documentation

- Clinical purposes
- Legislative and professional requirements
- Accountability – funding, accreditation, professional, audit
- Research and Education
- Resource and health system planning
- Risk, patient safety and quality
Clinical Purposes

• **Primary** purpose of documentation
• Facilitates efficient, quality health care
• Promotes effective communication among providers and continuity of care
• To this end, documentation must be meaningful, clear and concise
• Tells the patient’s story
Purposes of Documentation

• The health record is the legal and business record of the organization (or health professional)

• When recording information, keep in mind the possible uses
  – May be evidence in a legal proceeding
  – May be subject to an access or disclosure request
  – May be used to assess quality of care
Legal Requirements

- Legislation (facility or profession specific, PHIPA, MHA)
  - May be very prescriptive in terms of what must be documented, by whom and how
- Professional guidelines and standards
- Institutional policies and practices / professional staff by-laws
- Common law
Legal Requirements

• Joint responsibility of health facility and health care professionals

• Health facility is responsible for:
  – Developing and maintaining systems, policies, procedures and tools to ensure that documentation obligations are met and monitoring compliance
  – Demonstrating the integrity, reliability and security of health record systems
Legal Requirements

• Health professionals are responsible for their own charting – reliance by others

• Independent contractors / professional staff have independent obligations

• Incomplete or poor documentation may lead to:
  – Sanctions, discipline, removal of privileges
  – Complaints or disciplinary action
  – Liability in a civil lawsuit
Legal/Professional Requirements

• Written from personal knowledge
• Recorded chronologically
• Each entry must include date, time, professional designation and be authenticated
• Recorded contemporaneously or as soon as possible after event
• Must be clear, concise and legible
Correcting a Record

- Common law and/or statutory requirements
- Correct errors openly and honestly
- Original and amendments must be legible and traceable
- Identify the time correction made and by whom
Late Entries

- Judicious use of addendum or late entries may be reasonable, but not as attempt to alter record
- Identify as late entry, along with date and time
- Courts will assess delay / credibility - demonstrate entry made in accordance with established documentation standards
Use of Abbreviations

• Best to minimize the use of abbreviations . . . however, need for efficient record keeping

• If abbreviations are used:
  – Approved by facility and used consistently
  – Avoid use in external documentation and/or documents intended for patients
  – Do not use abbreviations with more than one meaning (e.g. OD)
Charting by Exception

- Documentation systems that allow health care professionals to document, in narrative form, only those findings or observations that fall outside well-defined parameters, standards or norms and that progress towards outcomes
- Must ensure that documentation system reflects complete record of care and that legal and professional standards have been met
Charting by Exception

• Must still document:
  – Significant clinical findings and/or those that fall outside defined parameters
  – Changes in condition i.e. improved, worsened, new problems or lack of expected improvement

• Demonstrate that have completed any relevant assessments
Charting by Exception

• Where charting by exception, the health professional must still be able to demonstrate that they have appropriately exercised their clinical judgment

• Requires knowledge of applicable standards / parameters and how these apply to the particular situation
Documentation Best Practices

• Subjective/objective data – source identified
• Report factually and objectively
• Reflect services provided – amount and detail is proportional to the complexity and any unexpected or unusual circumstances
• Forms should facilitate documentation
Documentation Best Practices

• Record objective facts, i.e. what you see, hear, do, feel, measure, count, etc.

• The 5 “W’s” plus “How”
Documentation Best Practices

Patient Assessment and critical thinking are your business.

These are ACTIVE processes

(write it down!)

Be prepared to support opinions by objective clinical evidence
Documentation Pitfalls

- General statements that do not provide clear information (i.e. “patient had good night”)
- “Interpretation” of statements made patient/others
- Speculation or editorial comments
- Inflammatory or judgmental statements
Documentation Pitfalls

- Statements identifying alleged errors or omissions of individuals or institutional policies
- Information not relevant to patient’s care needs
- Charting someone else’s observations as your own
- Commenting on care provided by others
Use of Health Records as Evidence

The health record may be used as evidence in:

• Civil and criminal proceedings
• Coroner’s Inquests
• Regulatory investigations and discipline
• Labour arbitrations and health tribunals

Even where not directly involved, may be called upon to give evidence in legal proceedings
Use of Health Records as Evidence

- An individual’s or organization’s credibility can be enhanced or diminished by the quality of the health record.
- Quality of documentation itself may come into question in the course of peer review or quality assurance activity, inquests, professional regulatory, disciplinary or civil proceedings.
Admissibility of Health Records

• Health records considered “hearsay” evidence

• *Ares v. Venner* - Hospital records admissible as evidence (and their contents are assumed to be true) if they are:
  – Made by someone with a duty to make the record
  – The individual has personal knowledge of the event, and
  – The entry or record is made contemporaneously with the event
Admissibility of Health Records

- *Evidence Act* - health records are generally admissible as business records as long as created in the usual and ordinary course of business and recorded at the time of the event or reasonably thereafter.
Admissibility of Health Records

- However, where there are questions about the accuracy or timing of documentation, or if there is any evidence of tampering, the documentation will come under scrutiny.

- Court/arbitrator will determine credibility and weight to be given to evidence.
Example - Admissibility of Health Records

• Kolesar v. Jeffries - Patient died after successful surgery, no nurses’ notes for several hours preceding his death
  – Unacceptable to make informal notes then collate later
  – Did not document sufficiently close to actual events
  – Documentation poor and highly suspicious
  – Court refusing to attach credibility to notes made after the fact
“If it was not charted it was not done”

Kolesar v. Jeffries - Justice Haines:

“Where there is a positive duty, on the part of a health care professional, to perform a treatment/procedure or other physical act, the absence of any reference in the medical records to the performance of the act, justifies the inference that the act was not performed.”

In this case, there was a complete absence of documentation during a critical time period and the nurse was not found to be credible.
“If it was not charted it was not done”

- From an evidentiary perspective, not necessarily!
  - Can rely on independent recollection of events
  - Can rely on usual practice
  - Can look to other corroborating evidence
- Requires assessment of credibility
- It may be difficult to defend allegations without proper documentation
“If it was not charted it was not done”

- From a clinical perspective, if it was not charted, the health care team has no way of knowing that it has been done
- Courts have identified that good documentation should demonstrate effective communication from shift to shift and from care provided to care provider
Effective Documentation

• Understand why documentation is important
  – For patient care
  – For patient safety
  – To comply with legislative requirements
  – To protect yourself legally

• Know your obligations and responsibilities
  – Legal, professional, systems, policies, practices
Effective Documentation

• Remember, you are accountable for your documentation
  – to your patient, other care providers, the health facility, your College

• Be reflective about your documentation practices and use your good judgment

• Be diligent, document properly every time!
Kathryn Frelick
Kfrelick@millerthomson.com
T: 416.595.5979

Follow me on Twitter: @Kfrelick