Open Questions (34)

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1. Do you have a position when there is a discrepancy in the visible time documented vs difference of the digital time stamp when there is a specific requirement to document i.e. q2hr with a digital timestamp that is 2-4 after the expected time?

A. This would occur in the ED during critical care situations such as a code. The provider would document the event, but the times would be off compared to the live documentation occurring by the nurse giving the medication. It has been noticed when putting together the RCA timeline. Assumption then need to be made to determine the root cause if an error occurred.

B. ensuring the time stamp on the defibrillator is the same (or within a minute) of your EHR digital time stamp

DB: I think I have a different interpretation of this question. My interpretation was this was a question re: the difference the note is made in the chart vis the time the medication was ordered or administered.

For example, this may relate to when nurses do medication rounds and may not document in real time. For example, rounds may last 30 min, but the medication is supposed to be given at 7:00 p.m. Clearly it is impossible to give all your patients their 7pm meds at exactly 7pm.

The chart should document the actual time the medication was given. If for some reason you are not able to either document the medication administration in "real time" or the medication is given within a "time window" or is late but the flow sheet forces you to mark off a box for a certain time frame, mark down that the medication was given in the "flow sheet" but then use the narrative notes to explain the discrepancy.

2. When making corrections to an electronic medical record is the correction entered as a separate entry or as an addendum?

***A. Within the new EHR, providers can complete an addendum. Nurses typically complete a Nursing documentation note or in I-view they can "flag" a result to further explain an entry or choose "un-chart" and select "reason" and write in the comment section the reason why if you need to add more detail*.**

How to actually "flag" with a comment, "add comment", or "un-chart": Type in vitals and click out of the box, but before you save, right click and choose flag with comment, add comment or un-chart. I believe if you flag with comment, it shows up in the flag section in the hand off/SBAR page. If you just "add comment" I do not believe it shows up on the flagged section, just noted when you hover over the vitals.

DB: It depends, you should ultimately rely on your clinical judgment. If there is a risk that the error is something like a vital on the wrong patient or is at risk for being carried over, I would recommend editing the original and making an addendum noting that a change has been made. However, if it is not your note, but you note that there is an error that has possibly been carried over or is no longer

accurate for the patient (i.e. post-op day 1, but it's now post-op day 5), make a separate entry noting the error and if there appears to be any perpetuation of the error (i.e. copy forward).

3. How do you document late entry?

DB: Narrative notes. Enter the information into the appropriate fields in the record and the use the narrative note to explain why the entry was late. (i.e. Upon review of records/ at end of shift/ etc., this provider noticed was not previously documented…. Due to emergency, failed to document… Computer failed to save prior entry… whatever situation applies).

4. How do you specifically define "timely"?

A. I believe "timely" is defined as completing a task within the normal standard/best practice if compared to your peers or what evidence based research sets as the standard. So if the case was to be reviewed, would a group of your peers agree and have completed their documentation within that same timeline based on best practice/community of practice standard or evidence based research?

B. Each facility typically has a policy of when notes have to be completed and signed usually with 24-72 hours for ensure accuracy. However, depending on the patient and order type, there are more specific timelines such as restraint placements and documentations of assessments.

DB: Within the time period acceptable based on your professions customs and practice. A few minutes, up to 72 hours.

5. HIM Professionals struggle with getting leadership support when records are not being completed with timeliness. Can we get info on litigation within our MTFs, what have been the documentation issues, how much we are paying out so that we can impress upon leadership why they need to help enforce the documentation requirements?

DB: You can run a report re: delinquent note closures through the EHR, which could help you identify specific providers/ departments with areas of concern. In addition to litigation claims, there are professional guidelines re: how long notes should remain open.

Recommend consulting with your local legal counsel re: issues specific to claims made against your facility. However, I will be happy to bend any ears I need to about these concerns!

6. Would you please comment on any pitfalls or best practice in having medical students document in the medical record? Thanks.

A. In the new EHR, there are challenges with the role of the medical student and who can sign a note. At this point, I believe

DB: Copy forward. Don't do it. Get 'em early.

As a teaching facility, there are no objections to students documenting in the medical record, but emphasizing from above, there needs to be a timely higher level of review noted in the chart. Also, remind students to be "FLAT," and verbosity does not equate to better note writing.

7. If requested to be a witness as a provider, do the lawyers have to provide ROI in order for you to answer their questions prior to providing testimony in court?

DB: There should be something in the Court record which permits you to provide medical testimony. It depends on the jurisdiction; it may not be an ROI. You should consult with your facility counsel before providing any testimony in court.

8. Do you know of any mental health cases that you can share?

A. Restraint documentation has to be consistent with the hospital policy, patient assessment and documentation of the patient's safety needs to be strong and continuous

DB: A lot! Mental health care should be documented in the same manner. Be "FLAT!" The primary difference with mental health records is that those records are subject to more restrictions on disclosure.

9. For the scenario or the 0720 vital signs and the 0740 code, what if the nurse was busy with that patient and could not sit down to document before 0800? How is that viewed?

This is reality in many cases, patient care comes first, which leads to either paper documentation or late digital documentation. In the case of late digital documentation, you are able to add in a time in the new EHR, which you are also able to "flag" it with a comment or just "add a comment" of why it is a late entry.

DB: Patient care comes first. Never stop emergent patient care to document. Do the best with what you have.

If you cannot record something in "real time," go back and fill in the record as best you can. Use the narrative notes to explain any discrepancies or why an entry was made late. If you ever need to look back at your record, that explanation will help trigger your memory re: circumstances or the event.

This is also why I emphasize saving primary records. If you are in a code, save the monitoring strips, the code sheet, any paper on which you documented something. These documents can be scanned and saved into the electronic record. During the excitement of the emergent event and with the whirlwind of things that you have to do following these events, it is easy to overlook some details which may have been captured in the primary written record.

10. Are there specific recommendations regarding the documentation of Behavioral Health care that may differ from the material presented?

A. I believe most locations require each patient to be assessed for behavioral health concerns at each visit. The key safety concern, once they are assessed as having a behavioral health concern, is ensuring follow-up treatment/plan of care is discussed with the patient and documented prior to discharge. If the patient needs to be escorted to the ED from a clinic, documenting the patient is escorted with a trained person to ensure patient safety.

DB: See #8.

11. When documenting patient care i.e. nursing assessment /vital signs on electronic health record, is it inappropriate to set the time when the patient care was performed instead of the current time?

A. Refer to answer in question 9.

DB: The medical record should reflect the actual time the care was provided, if there is a significant time discrepancy, explain in the narrative note.

12. My experience has been use of dot phrases for late entries, what about use of dot phrases?

DB: Generally not a fan. Like copy forward or "templates," if you are not mindful or reviewing it each time, it could cause note bloat or perpetuate errors. For example, if you are using it to generate medical history (PMH), it could continue to show resolved issues as active.

13. What standard of care is applied to patient-provider contact via secure messaging?

DB: Not sure what this is asking. Any interaction or attempts to contact the patient should be documented in the record, even if it is a simple, "Called patient, no response." "Left message/ did not leave message because…"

14. I have always been told t document as little as possible as the RN and let the MD be detailed. Is this advised?

A. From a nurse point of view, I would say "no" to minimal documentation. The myth is, "if I don't document, then I won't get called into court." If you assessed the patient you are liable for your documentation or lack thereof. If you are not able to speak to your minimal documentation, your testimony may hurt vs help the patient. This is especially true for sexual assault or abuse cases. Nurses are afraid to document. However, if a patient discloses details to you, you should document those details. (This a good example for when to use quotes.) As long as you stay factual and document that the provider was informed of any abnormal findings, your documentation should cover you legally and the patient.

DB: MDs and RNs have different roles and responsibilities. Recommend anything that would be relevant to the care and treatment of the patient be documented by the provider with the "firsthand" knowledge. If the patient tells you something that in your clinical opinion you believe is relevant to their care, document it.

15. What is the liability on copying and pasting emails; I notice people do that to validate there was communication or something was said that made a recommendation of some sort.

DB: You can copy/paste emails with the patient. I would not recommend copy/paste emails between providers or between staff members.

16. The hospital I work at uses Cerner, so when I need to document vital signs that was done for example 30 mins ago, I set the time on the electronic chart to the time the action was performed, but of course when I save it, it will have the current time. What are your thoughts on this?

A. Ensure you "flag" with comment or "add comment" to the vital signs to explain the correct time on the timeline, but the late digital signature.

How to actually "flag" with a comment or "add comment": Type in vitals and click out of the box, but before you save, right click and choose flag with comment or add comment. I believe if you flag with comment, it shows up in the flag section in the hand off/SBAR page. If you just "add comment" I do not believe it shows up on the flagged section, just noted when you hover over the vitals.

17. Regarding, patient education (handout) do we need to document they could read & understand the info?

A. In the new EHR, it is a mandatory field/box which you have to click in order to proceed to remove the patient from the tracking board.

Good question

DB: Yes, and if possible add a copy of the handout to the record.

18. What is your position about closing open encounters for providers no longer affiliated with the military/base?

DB: Administrative note closures should be IAW facility policies and procedures. That provider's (former) supervisor (Service Chief/ Department Head/ Director For) should be aware of the intent to administratively close the notes.

19. PART 1 of 2 From article/made easy: Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, an addendum or a correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change. Late Entry: A late entry supplies additional information that was omitted from the original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry. Example: A late entry following treatment of multiple trauma might add: "The left foot was noted to be abraded laterally. John Doe MD 06/15/09"—What are your thoughts regarding this information?

20. Part 2 of 2: Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should also be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum. Example: An addendum could note: "The chest x-ray report was reviewed and showed an enlarged cardiac silhouette. John Do MD 06/15/09"—What are your thoughts regarding this information?

DB: Not sure what this is asking.

21. Do you recommend full disclosure to a patient to prevent litigation?

A. Most facilities have a Special Assistant for Healthcare Resolutions who can assist you in determining how to proceed. I recommend you speak with JAG, your QSD department or your senior leadership to determine if your facility has a person in that position. If not, usually there is someone for your region who can assist.

DB: Agree. Consult with leadership, HCR, and Legal.

22. You mentioned that each state has different rules. As providers are we subject to the rules of the state we are licensed in or that state we are practicing in as in the federal system we can practice outside of the state we are licensed?

DB: Both.

23. Any experience or pearls for dentistry?

A. Complete and document your time outs for each procedure to ensure you have the correct tooth

24. Is there an effort to ensure that new providers are given proper orientation on the documentation process and expectations?

DB: Would refer you to your local facility's policies & procedures, or call me!

25. Regarding, Refuse vs. Decline: Is there still a preference for which of these words to use when documenting a patient's decision when it differs from the caregivers?

DB: No preference, but refuse has a more negative connotation. Did they refuse or decline?

26. I mostly deal with ROI. I don't do documentation in the records. How would this be more related towards what I do for my facility?

DB: You are the canary in the coal mine. Be aware of things that you are/ are not being asked for. Do you notice things missing from the record? Code sheets, monitoring strips? Are you being asked for metadata from the EHR?

27. Do you find that spelling errors help in the cases that we settle?

DB: What are you misspelling?

These errors are not helpful: Medication names. Mcg v. mg. Acronyms.

28. What are the biggest risks for Non-medical clinicians?

DB: Everyone who documents in the record or is responsible for accurately documenting their care and treatment of the patient.

29. Any advice on documentation that has a lot of errors? Such as misspelling?

DB: If you notice a trend from a provider, the provider may need some re-education on practices.

30. Can you discuss the impact that "throwing other departments or providers under the bus" in the documentation might have on a claim?

DB: Don't do it. Be "FLAT." It reflects poorly on the author. This is why it is important to be objective in documentation practices.

31. Are we able to use the notes that medical students or residents use as long as we edit and attest?

DB: As long as its IAW local facility policy

32. Are there frequent increases in documentation errors when precepting new employees or students and do you have any recommendations for ways to avoid them?

DB: Yes. Be "FLAT." Avoid short cuts. Don't Copy Forward.

33. Federal tort claims vs Feres Doctrine, why would a person want to file against the Feres Doctrine when they can still file in Federal Tort Claims?

DB: Feres Doctrine refers to case law re: the applicability of the FTCA to claims made by active duty service members.

34. Do you have a position on "Charting by Exception?”

DB: Depends on how it’s done. Probably ok if it’s a lengthy admission and relatively little change in patient status.