

Thomson, Rogers Lunch 'n Learn | St. John's Rehab

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# THE PITFALLS OF MEDICAL RECORD CHARTING

Presentation created by:

**LEONARD H. KUNKA**

416-868-3185

lkunka@thomsonrogers.com

Presented by:

**SLOAN H. MANDEL**

416-868-3123

smandel@thomsonrogers.com

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## NOTICE OF THE CLAIM

Each hospital develops its own standard of charting practice, usually by taking into account the requirements set by the associations which govern health care professionals in that community. A major tension which develops is the apparent need to “document everything” in order to protect against lawsuits, and the fact that such documentation can be used by a skilled lawyer to attack virtually any health care professional. Equally problematic are hospital policies which have adopted charting protocols, such as the form of charting known as “charting by exception” (CBE) or “variance charting”. These policies are potentially the biggest area of risk for hospitals and their staff, as they provide ample and fertile ground for attack by experienced counsel.

## CHARTING BY EXCEPTION (CBE) OR VARIANCE CHARTING:

- Documents the progression of a disease or illness based on a pre-established nursing care plan, and documents standard patient management and delivery of care guidelines.
- When a patient’s condition deviates from the care plan and significant findings or unanticipated responses are observed, then additional narrative notes or documentation should be added to the chart by the health care professional.

## CHARTING BY EXCEPTION (CBE): ADVANTAGES / DISADVANTAGES

- A major advantage of this type of charting system is an alleged enhancement in the consistency of charting.
- Benefits are also said to include the reduction of confusing or redundant charting, clearer definition of abnormalities requiring attention or intervention, and clearer measurement of patient outcomes.
- Protocol was developed because of health care professionals' concern that in a courtroom, lawyers would take the position that "if it was not charted then it was not done".
- CBE protocol attempts to replace this legal belief with a new premise: namely "unless otherwise noted, all standards have been met within the normal or expected response outlined in the care plan".

## CHARTING BY EXCEPTION (CBE): LITIGATION CONCERNS

- This charting protocol creates a self-perpetuating defence to a claim in negligence by suggesting that all standards have been met.
- In a situation where a patient's condition did deteriorate, or where complications arise, this method of charting can provide an easy avenue of attack for experienced counsel.
- The response to any attack on the absence of documentation will inevitably be, "If I observed or found any abnormality in the patient, I would have charted it".

## CHARTING BY EXCEPTION (CBE):

### LITIGATION CONCERNS cont'd

- Counsel will lead other evidence to show various symptoms exhibited by patient which should have been observed and recorded.
- Lawyer will then argue that those symptoms should have been interpreted as an indication of a patient's deteriorating condition, or an indication of some other serious complication.
- While redundancy of charting may be eliminated using the charting by exception protocol, often the repetition of a particular symptom by different nurses or health care practitioners becomes the triggering mechanism for concerns about the patient's condition.

## OTHER FORMS OF CHARTING

### THE WRITTEN NARRATIVE

- The most widely used form of charting used in conjunction with other styles of charting.
- Offers space for the nurse to document information not captured elsewhere in the health record, (such as in the flow sheets, operative records, emergency record etc.).
- Most effective when the complexity of required care requires a detailed written chronology.
- This style of charting is only as good as the entries made. The entries must be clear, concise and legible.

## OTHER FORMS OF CHARTING

### FLOW SHEETS:

- Flow sheets are standardized forms, usually arranged in a pattern which allows visual comparison of data, treatment or symptoms across a period of time.
- Enhance the continuity of care.
- One major shortfall is where a patient's symptoms are not changing, sometimes the flow sheets are not completed by the nurse or other health care professional.
- Result: critical data can sometimes be missed or alternatively, the data which would help support the nurse's or doctor's decisions or treatment will be absent.

## OTHER FORMS OF CHARTING

### PROBLEM ORIENTED RECORD (POR):

- Gained popularity in the 1980's.
- Focuses on recording patient outcomes in relation to a patient's problems.
- Routine care events and interventions are not recorded in the POR.
- At the present time, this form of charting is not regularly used.

## GOOD CHARTING PRACTICES:

- 1) Include all of your observations, including the date and time of each entry, and your signature.
- 2) Include all your treatment or actions in a clear and concise fashion.
- 3) Record all of the patient's responses to treatment or therapy.
- 4) Do not avoid recording treatment which was missed or omitted, unusual incidents, mistakes or other errors.

## GOOD CHARTING PRACTICES:

- 6) Record all attempts to reach any physician who is treating the patient.
- 7) When there are significant changes in patient's condition, always alert a physician and document in the chart that you have done so.
- 8) Be contemporaneous in your charting. If you have to chart at a later time, indicate that when you are charting and when the actual observations were made.
- 9) Document significant conversations with the patient or their family where appropriate.

## GOOD CHARTING PRACTICES:

- 10) Chart non-compliant or risk taking behaviour of the patient (i.e. patient getting out of bed when not permitted, patient not following dietary restrictions, patient refusing medication etc.).
- 11) Where the patient has had an unanticipated/unexpected/abnormal development or incident, the chart should follow that event until resolution. Some hospitals have a separate procedure for documenting and following such events.

# THANK YOU

**SLOAN H. MANDEL**

Thomson, Rogers  
416-868-3123

[smandel@thomsonrogers.com](mailto:smandel@thomsonrogers.com)