

Medicolegal Documentation and Occurrence Reporting



CLEAN HANDS SAVE LIVES

Protect patients, protect yourself



Alcohol-rub or wash
before and after *EVERY* contact.



www.cdc.gov/handhygiene

Managing Risk:

- Protecting Medical Center assets:
 - Patients
 - Employees
 - Visitors
- Keeping our environment safe

Occurrence Reporting



- An occurrence is any event that is not consistent with the policy or routine operation of the Medical Center (eg., anything “**unusual**” or “**unexpected**”).

Reportable Occurrences:

- Procedural complications/errors
- Patient or visitor falls
- Medication errors (wrong patient/dose/time/med)
- Adverse drug reactions
- Equipment related events
- Exposure or transmission of infectious disease
- New decubitus ulcers or compromise to patient skin
- IV related incidents
- Near misses and hazardous conditions

Special Considerations: Faulty Equipment

- **Safe Medical Device Act** - requires notification to Federal Drug Administration (FDA) of any incident in which a medical device caused or may have contributed to the serious injury/illness or death of a patient.

Special Considerations: Sentinel Events (JCAHO)

- An unexpected occurrence involving death or serious physical or psychological injury
- Medical Center has 45 days to make a report and establish a corrective plan of action
- Non-punitive culture

Sentinel Events:

- Patient abduction
- Infant discharge to wrong family
- Patient rape
- Hemolytic transfusion reaction involving major blood group incompatibilities
- Unanticipated death of full-term infant
- Surgery on the wrong patient or body part
- Patient suicide (within 72h of discharge)
- Unintended retention of a foreign object in a patient
- Severe neonatal hyperbilirubinemia ($>30\text{mg/deciliter}$)
- Prolonged fluoroscopy with cumulative dose >1500 rads to a single field, or any delivery of radiotherapy to the wrong body region or $>25\%$ above the planned radiotherapy dose

Documentation of occurrences:

- PSN = internal system used for recording, evaluating, and trending events for the purpose of quality improvement; occurrence reports are not discoverable
- Medical Record = single most important piece of evidence used in a malpractice lawsuit

Medical Record Documentation of an Occurrence

- Document briefly and objectively.
- Write/sign legibly; date/time the entry.
- Use patient quotes, “I tripped on my shoe”.
- Identify any MD or RN notified.
- Document physical assessment of pt with particular attention to injuries; document clearly if NO injury occurred.
- Never make reference to an occurrence report or discussions with Risk Management or Legal Affairs.
- Call Risk Management if you have questions.

Most lawsuits involving health care employees are civil cases that attempt to prove that negligent care resulted in injury to a patient.

The health care employee has a duty:

- to provide care to the patient
- to follow an acceptable standard of care.

Standard of Care

- Would most other health care providers of same credentials have acted in the same manner under the same circumstance?

To help ensure legal credibility,
make your charting:

Timely – Document care as soon as possible after it is given.

Accurate – Avoid assumptions and document only what you observe.

Complete – Paint a complete picture of the situation.

Areas of Liability for Clinicians:

- Failure to observe and communicate changes in the patient's condition
- Failure to properly assess the patient
- Failure to provide for the patient's safety
- Failure to question orders
- Failure to perform a procedure according to proper standards of care
- Failure to properly administer medication
- Failure to document the patient's condition, treatment, and response to treatment

Timely Documentation

- Never chart care before it is provided as this can lead to charges of falsification Eg., med admin, dressing changes
- Always indicate “Late Entry” with date and time if you are adding information after the fact
- Never add an entry to a chart if greater than 24 hours has elapsed since the care was provided

Accurate Documentation

- Never speculate about what may have occurred; write only what you know
- If you are unsure of details, use quotation marks to document what the patient/family said occurred
- Never assign blame (to yourself or anyone else)

Complete Documentation

- Always describe a situation that is out of the ordinary (eg., patient fall, patient self harm)
- Always document thoroughly if the patient's condition undergoes a rapid change (eg: after surgery or during labor)
- Document each time you contact a physician, even if you do not get through; Note specifically the details you reported, the physician's response, the time you called, the time that new orders or NO orders were received.
- Include enough information to demonstrate that the standard of care was met

Other Charting Guidance:

- Never express a negative view or animosity toward a patient by describing the patient as “uncooperative,” “difficult,” “noncompliant” or “manipulative.” (viewed as not respecting the patient); Describe actions/ behaviors instead.

Other Charting Guidance: Informed Consent

- Consent by the patient/family based on knowledge of the nature of the procedure to be performed and its risks, benefits, and alternatives.
- At MUSC, the Attending MD or Resident performing the procedure or treatment is responsible for engaging the patient in the consent process and for documenting that discussion in the Medical Record.
- Insuring patient signature on the Consent may be delegated to another care practitioner.

Emergent situations:

- Either ask another person to record the events as they occur during the emergency or try to keep some sort of running log of notes. (If possible try to use a central clock.)
- Complete your documentation even if you have to follow the chart to another service area (always within 24 hours – note “late entry”)

Proper documentation includes:

- competent assessment
- frequent observation
- timely and accurate reporting to the MD regarding change in the patient's condition
- use of the chain of command if necessary. (May prevent litigation even when there is a poor outcome.)