Demystifying the Medical Record

Increasing the ability to find key information in the medical record

May 9th, 2012

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The Purpose of Documentation

- The bodies that govern doctors and nurses identify the purpose of documentation as:
  - Demonstrating Accountability
  - Communicating Health Information
  - Providing Quality Assurance
  - Providing Continuity of Care
  - Facilitating Research

Legal Implication of Documentation

- Documentation is not optional and not considered separate from care. In the context of a lawsuit, documentation is used:
  - As evidence of reasonable care (or not)
  - To reconstruct events, dates, times
  - To remind the healthcare worker of the care
  - To resolve conflicts in testimony

Correlate the Story

- Examine the full continuum of care
- Watch for problems with handover of care
- Correlate story between all parties and providers
- Watch for documentation errors that become self perpetuating ‘facts’

Medicentres

PRIMARY HEALTH CARE CLINICS

REFERRED TO DOCTOR: ER U of M
(NAME) TELEPHONE NO.
(COMPLETE ADDRESS) FAX NO.

APPOINTMENT DATE & TIME:

PATIENT: Brian
(NAME) TELEPHONE NO.
(ADDRESS) TELEPHONE NO.

D.O.B. 1965 11 24 H.C. #: 11529-682c

Symptoms: this is 28 yr old
c sudden onset of nausea
and c some urine difficulty

Findings:
Plz r/o ...

Laboratory Results:

X-rays:

Current medications:

Opinion:

Request:

Yours truly,
DR. E. M.D.
Doctor's Signature

Doctor's Stamp

Date:

In the E.R.

- Was hand-off and triage handled appropriately; CTAS assessment and reassessment
- Learn about GCS, VS, NVS, IV, I&O
- Presenting symptoms vs. working diagnosis vs. lab and diagnostic testing and treatments
- Diagnostic testing vs. clinical signs and symptoms
- Were subtle injuries and pre-existing conditions ignored for the most-obvious injury
- If discharged from the ER, examine discharge diagnosis and teaching and follow up instructions

CTAS Primer

- Level I: Evidence of severe hypo-perfusion requires continuous nursing and/or medical care
- Level II: Hemodynamic compromise requires assessment/reassessment every 15 minutes
- Level III: VS at the upper and lower ends of normal requires assessment/reassessment every 30 minutes
- Level IV: Normal vital signs requires assessment and reassessment every 60 minutes
- Level V: Requires assessment/reassessment every 120 minutes

In the Peri-Operative Period

- Read through the OR and consultation reports
- Compare the pre-op to post-op diagnoses
- Examine surgical start and end times
- Look at the Pre-Anesthetic and Anesthetic records
- Note if additional specialists were brought in
- Examine post-op orders by Anesthesia and Surgery
- Read through the PACU Records
- Check pre-op vs. post-op lab and diagnostic test findings

In the Post Operative Period

- Examine medical orders vs. care provided
- Watch VS, activity, pain levels, labs medication use
- Watch for signs of mental or physical instability
- Read all consultation notes; was care provided by the right Dr. and were recommendations followed
- Examine medication reactions/interactions
- Were pre-existing conditions managed
- If discharged, was it appropriate and were discharge teaching and referrals handled well

In the Rehab Period

All of the above and…

- Look for PT, OT, SW and all rehab involvement
- Were new conditions managed appropriately
- Was there improvement in all areas (if feasible)
- If discharged, was discharge timely and were teaching and referrals appropriately managed
- Were home or community care providers consulted
- Were the family or significant others involved

In all Settings.....

- Watch for trending!
- Watch for misdiagnosis or inadequate treatment
- Compare Flow Sheets/Care Plans to Documentation
- Watch for mental or physical instability
- Know scope of practice of all care providers; nurses, residents, GP's, specialists and mandatory consults
- Watch for wrong diagnosis, delays in assessment, treatment, lab and diagnostic tests, unit to unit transfer, shift change and reporting of information
- Separate new vs. pre-existing symptoms

Make sure that you have everything…

- Request a complete set of medical records from all providers
- Allow 4 to 8 weeks for hospital records
- Combination of paper and electronic records
- Ask about available reporting formats
- Check that advantages of EMR were used
- Get help when you need it