Putting the Cart Before the Horse?

By Zynthia T. Howse, JD

In life, and certainly in documentation, there is a right and wrong way to do things. Order is everything.

It is a well-known fact that a complete, accurate medical record will foster quality of care. Most importantly, it is the footprint that guides the course of the patient's medical care and provides needed information to subsequent healthcare providers who facilitate continuity of care. One of the 'Golden Rules' of documentation is that the medical record be prepared as contemporaneously with treatment as possible to avoid confusion and to ensure accuracy. The goal of this rule is to prevent a delay in documentation of what has been done. The defense of malpractice lawsuits has taught us that juries often assume that undocumented events never happened. It is also important that actions or treatment are not documented before they actually occur.

The Case

A female infant was seen by her pediatrician for a routine, initial well-baby visit, which included immunizations. The exam was unremarkable, and the child's chart was marked indicating that all immunizations had been administered. Later, during a follow-up office visit, the child was seen by the same clinic and noted to have received all necessary vaccines. The parents were instructed to return in four weeks.

Subsequently, the baby was seen by the same clinic a third time but treated by a different healthcare provider. It was noted that PCV-13 had not been administered previously. The child had an elevated temperature and an elevated white blood cell (WBC) count. The child was sent to the hospital for lab work and was subsequently diagnosed with pneumococcal meningitis/septic shock. As a result, the child was admitted to ICU. She had seizure activity and required intubation. After a month-long admission, the child was diagnosed with a seizure disorder and significant developmental delay.

The parents filed a medical malpractice lawsuit against the pediatric clinic and its physicians alleging 'negligence for failing to immunize the child' and 'failing to accurately chart the fact that immunizations were not given.' Our insured physicians believed that their care and treatment of the patient was appropriate and within the standard of care. Expert reviewers agreed. However, all involved in the defense of the case agreed that the documentation found in the medical records was sloppy. An investigation of the events led to the realization that a medical assistant had documented the various immunizations that were ordered to be administered. However, the medical assistant later realized that the clinic was out of the PCV-13 immunization at the time. It was not given, but he failed to

update the medical record.

This was a very sympathetic case given the unfortunate and life-altering effects to this baby. This claim was not defensible. As fate would have it, the baby contracted the very disease that the PCV-13 vaccine was designed to prevent. If only the medical record had been documented correctly, one could assume the outcome would have been different and possibly the child would be healthy.

This case reinforces the “Golden Rule” that one should never document a medical record until the medical care has been administered. The lesson is short and simple: documentation should reflect the action(s) taken. Accuracy and order are vital! Premature documentation is just as dangerous as untimely or late documentation, and both can prove detrimental, or in a worst-case scenario, deadly.

“For nothing matters except life and, of course, order.” ? Virginia Woolf, The Common Reader

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