Contemporaneous Documentation

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An old Chinese proverb says that *“the faintest ink is more powerful than the strongest memory.”*

Timely documentation is critical in order to ensure an accurate and complete record of the patient encounter. Office notes and dictated procedure notes should be completed, reviewed and signed within 24 to 48 hours of seeing the patient. Late completion of notes puts you and your colleagues at risk. Memory interferes with accuracy and efforts to “catch up” often lead to incomplete documentation. Any intervening adverse event prior to completion of notes makes late documentation appear self-serving.

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 defense of malpractice lawsuits has taught us that juries often assume that undocumented events never happened. It is also important not to document actions or treatment before they actually occur.

Consider the following 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 documented indicating that all immunizations had been administered. Later, during a follow-up office visit, the child was seen by the same clinic and again, documentation noted the infant had received all necessary vaccines. The parents were instructed to return in four weeks.

Subsequently, the infant was seen by the same clinic a third time but treated by a different healthcare provider. The infant had an elevated temperature and an elevated white blood cell (WBC) count. Additional labs were obtained and the infant was subsequently diagnosed with pneumococcal meningitis/septic shock and 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.’ An investigation of the events revealed that documentation in the medical records was sloppy and inaccurate. A medical assistant had documented the various immunizations that were ordered to be administered prior to actual administration. When the medical assistant realized the clinic was out of the PCV-13 immunization, 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 infant contracted the very disease that the PCV-13 vaccine was designed to prevent.

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

After Hours Calls Documentation

Contemporaneously documenting care is particularly crucial when documenting after hours. Calls from a patient outside of normal office hours are often of a serious nature. Without contemporaneous documentation, the physician has to rely on memory to recall the advice or recommendation given. Documenting telephone encounters should be treated with the same level of importance as documenting in-person visits. Telephone conversations, particularly those that occur after-hours, are a major area of liability risk.

Every after-hours telephone exchange should be documented at the time of the call, even if the medical record is not available. This documentation should include the name of the patient or person calling on their behalf, date, time, specific complaint, advice given, medication advised or prescribed, and any referral to other providers or facilities. This note should then be documented in the medical record as soon as possible.

Keep in mind, with many patients using mobile phones, records of a phone call being placed are easy to retrieve. Although they do not confirm the conversation, they will give details about the time and length of the call.

At a minimum, the following types of phone calls need to be documented in the medical record:

1. All phone calls in which test results are reported to patients, noting if the patient was advised to return or seek other medical attention;

2. All phone calls in which the patient is advised to return or seek other medical attention, including instructions to go to the emergency room; and

3. All phone calls in which a patient requests medical advice or prescription refills.

An example of the importance of recording any advice given after hours is seen in a synopsis of a closed case: The scenario involves an undocumented late-night call with instructions given to a mother to take her child with a 104.5 fever and history of kidney transplant to the hospital ER. The child was not taken until the next day when she became nonresponsive. She further deteriorated in the hospital and died from septic shock secondary to a urinary tract infection. The physician’s recollection of the conversation was

that he advised the child be seen in the emergency department. However, he did not phone ahead or make any note about the call. Her mother claimed that she was told the child likely had a virus and that there was no reason to take her to the emergency room. Often, these undocumented conversations become a “he said/she said” dispute and prolong a claim’s resolution. A simple note jotted down and then recorded in the medical record on the front end can save a lot of heartache on the back end. Contemporaneous documentation of the provider’s instructions would have greatly aided in the defense of the case.
