AMPLIFY

Defensive Charting:
Making Your Notes Bulletproof, Part II

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Defensive Charting

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Shameless pitch

SAFEGUARDING CHARTING

Documentation Support That Will Stand Up In Court

An EB Medicine Urgent Care Onboarding Course

EB MEDICINE

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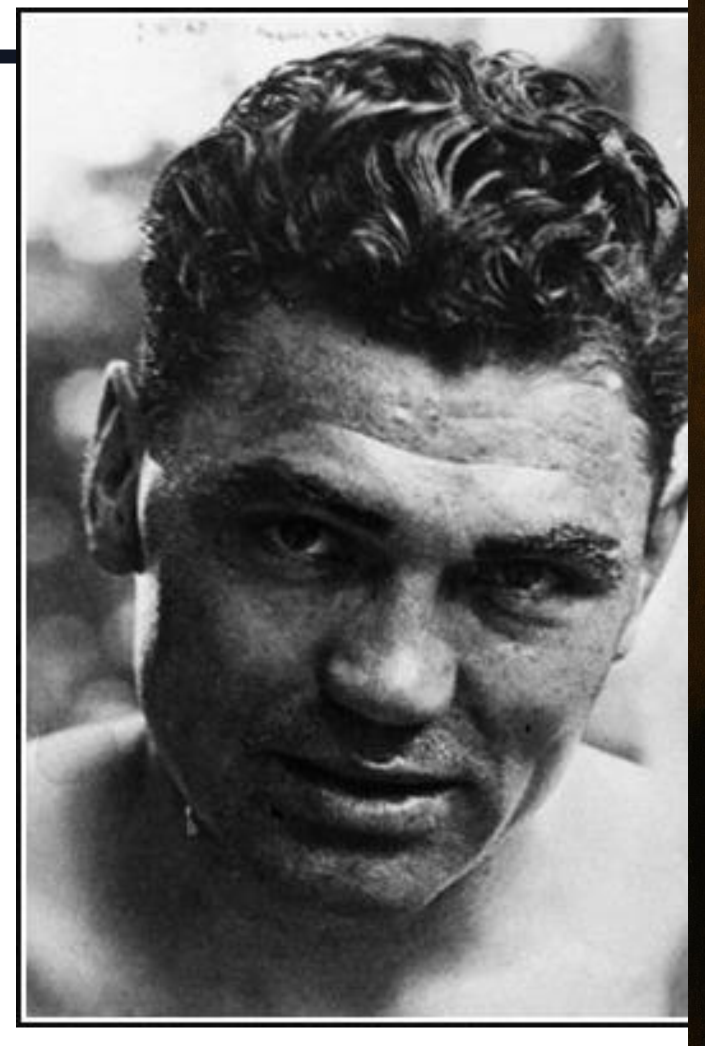
WITH

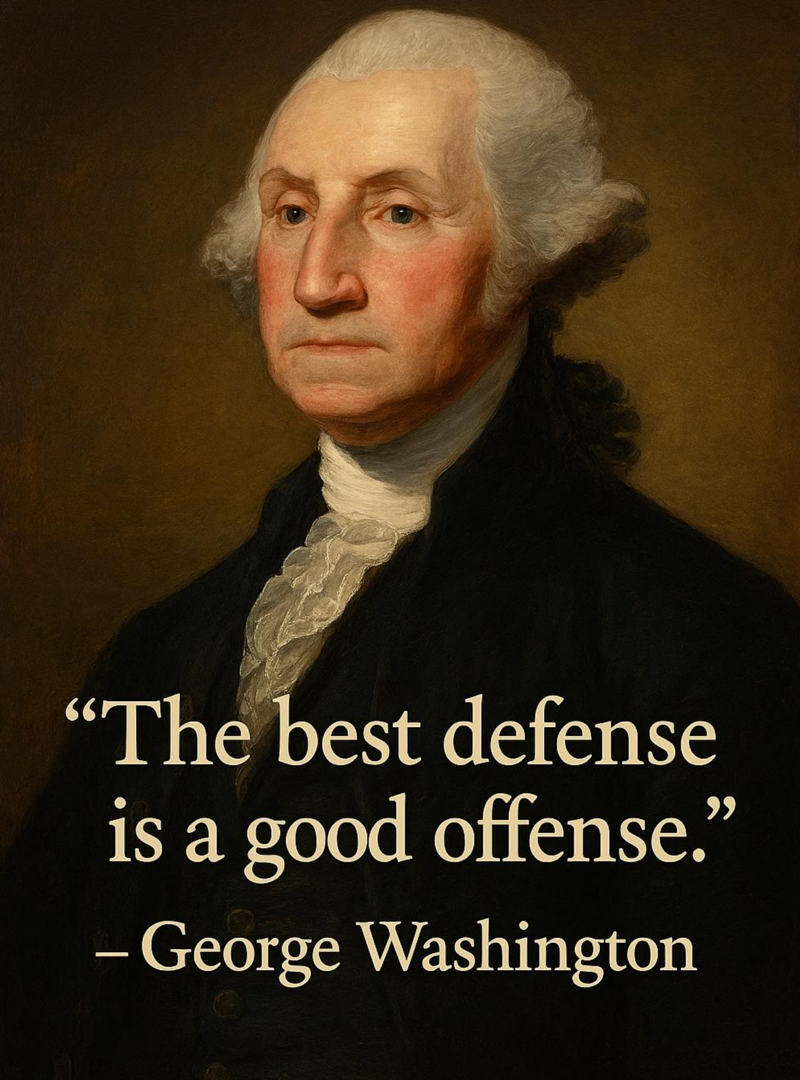
JEFF WILLIS, MD

FACULTY

Why me…

- Expert witness, review cases for merit
- State health department, office professional misconduct
- Reviewed thousands of charts
- Your documentation can make or break you





s a good offense.

mpsey —

OTES

If I send this patient home today, and there's a bad outcome tomorrow, will the documentation in my chart help me, or hurt me?

Can I substantiate my actions in court of law?

Quick Case, Pediatric Patient

- CC: nurse, cold symptoms
- CC: doctor, ST
- Vitals documented by nurse, temp only, no weight, no allergy
- Exam: throat red
- Lab: RSA negative
- Diagnosis: strep throat
- Plan: ~~amoxicillin 400/5~~ Zithromax 200/5

Menti

My first open-ended qu...

What's documentation is missing here?

Responses can be up to 200 characters and will appear here.

You can group responses if you get more than 10.

Turn on voting so people can flag their favorite responses.

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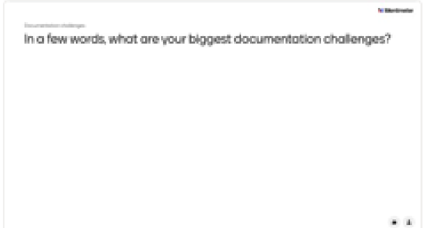
Waiting for participants

Select which slide to add



What are the red flags in physical for otitis externa?

What are the red flags in history for otitis externa?

What is the WCS for otitis externa?

Why care about charting?

- Good documentation is the best protection against anyone questioning your decisions
- You won’t remember the patient 1-3 years from now
- Subsequent clinicians reading your chart will understand your thought process
- Patient complaints, QA, UR, and billing may be more likely to approve your treatment, stand by your decisions, and support your LOS
- Protect yourself from litigation

MANY MALPRACTICE CASES ARE BASED ON DOCUMENTATION FAILURES, NOT CARE FAILURES.

20% of malpractice cases have a charting issue, which increases chance of outcome against the clinician.

Our Purpose Today:

- Identify common pitfalls that make for poor charting and may hurt you later
- Identify worst case scenarios (WCS) based on chief complaint
- Identify history elements that show the reader you looked for "red-flags" that may indicate the WCS
- Identify physical elements that show the reader you looked for "red-flags" that may indicate the WCS
- Teach you how to document your medical decision making to tie it all together

In General

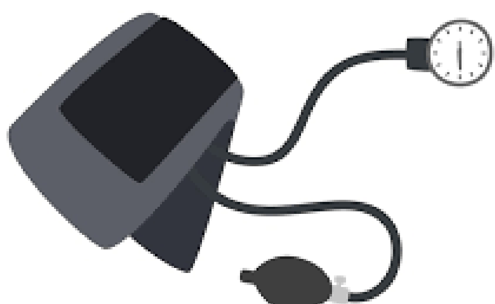
- Paint a picture so you will remember what you were thinking
- Consider adding personal details
- How they look
- How they act

What not to put in chart: Don’t be judgmental

- The patient states he feels like there is something seriously wrong and he’s going to die
- The patient is rude and obnoxious
- The patient refuses to comply with my recommendations
- No quotations of unsophisticated speech; takes “sugar pills” for diabetes; thinks he has a “confusion” of the right LE, “thinks there might be a fracture but does not believe his ankle is broken”

For all patients

- Comment that you have reviewed nurse’s notes, PMH, Vitals
- ADDRESS ANY DESCREPANCIES
  - If vitals are abnormal, retake or address them
    - Abnormal vitals have a higher odds of return visit to UC, ED or even hospital admission
  - Abnormal BP should be repeated!
  - If nurse notes are different than yours, explain
  - If you do the opposite of what test results tell you, explain why



Use Your EMR to Your Advantage

- Templates
- Epic: Templates, smart phrases and smart lists
- Cerner: Dot phrases
- Experity: Pathways and order sets
- AI (depends on what you are using)

A Word about AI Charting

- Protects you by making your documentation reflect the high-quality care you actually provided
- Can prompt you for elements you missed, improves completeness
- Can improve your medical decision making
- Captures shared decision-making
- Improves clarity by eliminating abbreviations and shorthand
- Can suggest diagnoses, flag missing items, present guideline-based care
- Document non-compliance and refusal of treatment
- Creates a more defensible narrative
- Efficiency benefits are clear; accuracy and consistency remains to be seen.

History

- Chief complaint
  - If someone else puts it in the EMR, review and agree
- HPI
  - Succinct, to the point, but thorough. Address those red flags!
  - Who's giving history, who's in the room (or on the phone)
  - Anything you reviewed, like medical records, previous labs, etc.
  - PMH
  - MEDS
- Does ROS and Social history matter?

O P Q R S T - Mnemonic for Symptom Assessment

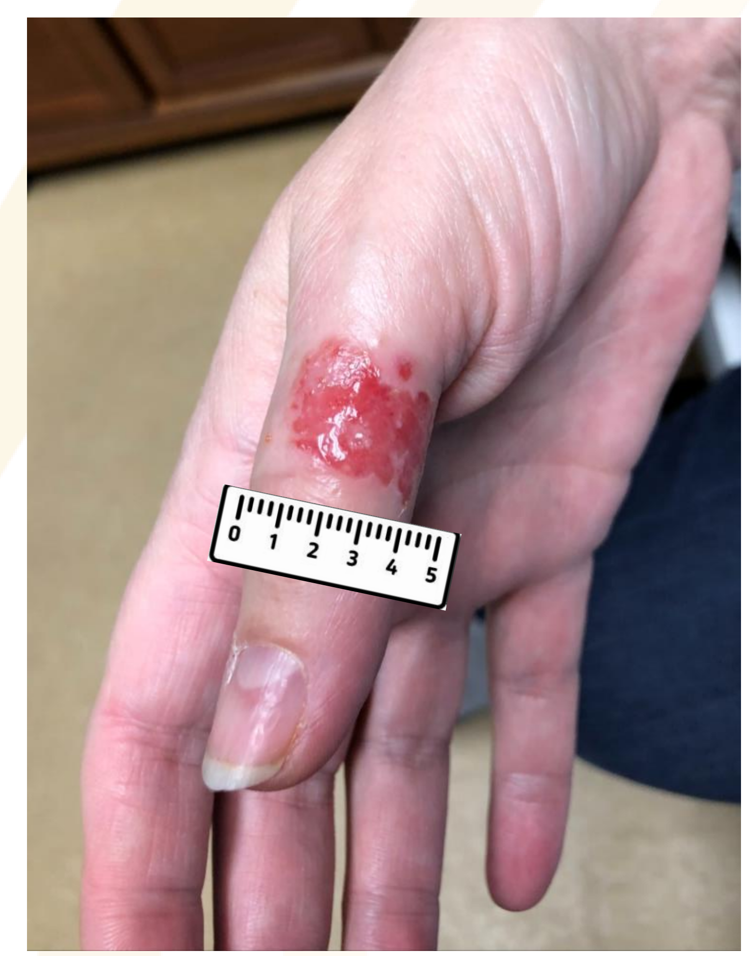
O	Onset of the Event
P	Provocation / Palliation
Q	Quality
R	Radiation / Region
S	Severity
T	Time (history)

Exam

- Your exam should address the complaint in detail
  - If the patient's complaint is SOB, you better do a lung exam
  - If the patient has abdominal pain, do more than "bowel sounds normal", or "tender"
  - Hand/finger injury, be as detailed and specific as possible
  - Extremity injury, examine joint above and below, document neurovascular status distal to injury
  - Laceration, FB, tendon injury, deep tissue injury, viability of margins

Exam

- Be specific
  - Left, right, superior, inferior, lower 1/3, mid-clavicular line, etc.
  - Add photos
  - Drawings
  - Ruler next to area if possible
- Rash on thumb unacceptable



Medical Decision Making

When I review charts, I frequently see this:

MDM:

Don’t be that clinician. It just makes you look dumb.

Medical Decision Making

- Differentials you considered and why (3)
- What you ruled out and why (the WCS)
- The plan and reasoning you used to develop it (no red flags present)
- Tests you did and their results, and how you interpreted them
- Treatment you provided, prescription, OTC, home treatment

Medical Decision Making

- Options presented and shared decision making
- When to seek follow-up if things do or do not go as expected
- Referrals if indicated, including PCP if they do not have one
- The patient understood what you discussed
- If you deviate from the standard of care, document why
- Consider using and documenting clinical decision tools

Medical Decision Making FOR BILLING

1. Complexity and number of problems addressed
   - Chronic vs. acute or new problem
   - Systemic symptoms
2. Data analyzed
   - Results, labs, x-rays, etc, ordered OR interpreted
   - Medical records reviewed
   - Discussion with another clinician or historian
3. Risk
   - Medications, OTC or prescription discussed OR ordered
   - Consent for procedures
   - Decisions to send to ED/higher level of care

Clinical Decision Rules

- Well's criteria
- Canadian C-spine rules
- CT head rules
- CRB-65
- Ankle and knee rules

- If you use them, ***you better use them correctly*** and know the sensitivity/specificity, pitfalls, exclusions. The attorney will.

Response to treatment

- Lungs clear after nebulizer treatment.
- Back pain reduced 60% after ketorolac injection.
- Feels much better after 1 L NS.
- Cerumen cleared from ear after irrigation with no trauma to canal and TM. Tolerated well.
- Extremity neurovascularly intact after splinting.
- Repeat vitals if indicated.

Ending of MDM: Discharge Comments

All nursing documentation including vitals reviewed prior to discharge. Changes made if indicated. Patient advised to contact primary care doctor if worsening or return for problems. Close follow up with PCP recommended. Ibuprofen or acetaminophen for pain or fever if no contraindications. Home care for symptomatic treatment reviewed. Patient education regarding diagnosis and treatment provided for 3-5 minutes both verbally and in writing. Possible complications and when to seek further care reviewed with patient. Patient/guardian seemed reliable, voiced understanding, and was given an opportunity to answer questions. Patient/guardian amenable to plan. Discrepancy may exist between time of charting and when the patient was actually seen. Portions of this chart created with dictation software. Although reviewed, any errors are unintentional and should be omitted.

Disclaimer to Patient

Please understand that you have been evaluated for an episodic event. This visit cannot be a substitute for the continued care and monitoring by your primary care physician and/or specialist for the ongoing care of chronic conditions. It is not unusual that an illness may present itself slowly over time and change from one medical impression to another. This is why follow up care is recommended. Please ensure that you follow up with your primary care physician if your condition changes, worsens, or does not resolve in the time specified. You may go to the closest emergency department if any worsening symptoms develop for further evaluation and treatment. Urgent care has limited resources and is not always able to provide every test or specialty care. If there is any discrepancy in the interpretation of x-rays, or if there is outstanding lab work, we will attempt to contact you. It is your responsibility to call us if you have not heard results in 5 days. Thank you in advance for your understanding.

I know what you are thinking…

She's crazy! I don't have time to document like this!

This is where leveraging you EMR with templates comes in!

Dictation!

Leverage things you do every day

- We all have habits when we chart
- Use them to your advantage, make them a template!
  - History for common chief complaints
  - Physical for common chief complaints
  - MDM for common diagnoses
  - Basic instructions for common diagnosis

My templates

- Abdominal pain
- Abscess
- Allergic reaction
- Animal bite
- Ankle
- Back and neck pain
- Basic exam, eye exam, COVID exam
- Cellulitis
- Cerumen impaction
- Conjunctivitis
- COVID
- Chest pain
- Dental
- Dizzy
- Elbow
- Gastroenteritis
- Headache
- Influenza
- Influenza like illness
- Kidney stone
- Laceration
- MVA
- Otitis externa
- Otitis media
- Rash
- Shingles
- STI male
- STI female
- STI asymptomatic
- Sore throat
- Upper respiratory infection, adult and peds
- Urinary tract infection
- Vaginal discharge
- Wrist injury
- Worker's compensation injury new
- Worker's compensation established

Let’s go through a scenario to demonstrate

Then we will work through a few together!

Three things to always keep in the back of your mind:

What is my worst-case scenario?

Red flags for those WCS in history

Red flags for those WCS in physical

Non-traumatic Back pain

- Worst Case Scenario
  - Compression fracture
  - HNP with nerve root compression, motor deficit, cauda equina
  - Spinal epidural abscess or bleed
  - Metastatic disease
  - Consider pyelonephritis, AAA

- Most common
  - Muscle strain
  - HNP with no nerve root compression
  - Poor core strength and body mechanics
  - Pyelonephritis, shingles, kidney stone

Non-traumatic Back pain

- Address red flags in history
  - Trauma, previous back problems, surgeries
  - Gradual or sudden
  - Fever, immunosuppression, diabetes, steroid use
  - Cancer
  - Osteoporosis, steroid use
  - Abdominal pain
  - Urinary symptoms

Non-traumatic Back Pain

- Address red flags in physical
  - Vitals, especially temp
  - Level of discomfort
  - Motor deficits
  - Saddle anesthesia and other sensory deficits
  - Bony tenderness, tenderness to percussion
  - Gait
  - Straight leg raise, crossed straight leg raise
  - Tendon reflexes

Non-traumatic Back pain

- If you did an x-ray, document why
  - X-rays ARE NOT indicated for garden variety back pain
  - Imaging IS indicated if you are concerned about trauma, metastatic disease, compression fracture*
- Cord compression is a medical emergency
- True weakness is a medical emergency
- Back pain and a fever is a medical emergency

*And still doesn't rule it out. Low sensitivity and specificity.

Medical Decision Making

- Differential diagnosis: muscle strain, herniated disc, infection, metastatic disease, cord compression
- "Based on clinical findings, no evidence of sinister causes of back pain, emergent imaging not required."
- Meds provided, home care
- Patient cautioned to return if worsening pain, fever, pain radiating down legs, numbness, weakness, bowel or bladder complaints
- Follow up in 48 hours if not improved, ED if worse

Non-traumatic Back Pain Instructions

BACK AND NECK PAIN NORMALLY TAKES A FEW TO 10 DAYS TO RESOLVE. RARE CASES MAY TAKE SEVERAL WEEKS. THE MEDICATIONS HELP TEMPORARILY, BUT DO NOT NECESSARILY CURE YOUR CONDITION. SEE YOUR DOCTOR IF PAIN DOES NOT IMPROVE, OR IS ASSOCIATED WITH FEVER, RADIATION DOWN THE LEG OR ARM, WEAKNESS, OR NUMBNESS. TAKE ALL MEDICATIONS AS PRESCRIBED. HEAT OR MASSAGE MAY HELP WITH YOUR CONDITION. IT IS BEST TO KEEP ACTIVE WITH GENTLE EXERCISE SUCH AS WALKING. DO NOT LAY IN BED OR SIT IN CHAIR FOR LONG PERIODS AS THIS WILL MAKE YOUR PAIN WORSE.

TOPICAL PAIN RELIEVERS SUCH AS SALON PAS, BIOFREEZE, BEN GAY OR OTHERS ARE RECOMMENDED HOME TREATMENTS.

YOU MAY TAKE IBUPROFEN AS NEEDED FOR PAIN AND FEVER. YOU MAY TAKE 3 TABS EVERY 6 HOURS OR 4 TABS EVERY EIGHT HOURS. THE MAXIMUM AMOUNT YOU CAN TAKE PER DAY IS 2400MG. DO NOT TAKE IF YOU HAVE KIDNEY DISEASE, PEPTIC ULCER DISEASE, OR HAVE HAD WEIGHT LOSS SURGERY.

YOU HAVE BEEN PRESCRIBED A MEDICATION THAT CAUSES DROWSINESS IN SOME PATIENTS. DO NOT DRIVE OR OPERATE HEAVY MACHINERY OR ENGAGE IN DANGEROUS ACTIVITIES UNTIL YOU KNOW HOW IT EFFECTS YOU. THIS MEDICATION WILL NOT BE PRESCRIBED FROM THIS OFFICE. YOU MUST SEE YOUR PRIMARY CARE PROVIDER.

Sore Throat

- Worst case scenario
  - Streptococcal pharyngitis
  - Peritonsillar abscess/cellulitis
  - Retropharyngeal abscess
  - Epiglottitis
  - Foreign body
  - Cancer

- Most common
  - Viral pharyngitis
  - Streptococcal pharyngitis
  - GERD
  - Allergies/post-nasal drip
  - Dry mouth, snoring, air-conditioning, etc.

Sore Throat

- Address red flags in history
  - Fever, onset, type and location of pain, radiation of pain
  - PAIN OUT OF PROPORTION
  - Ability to swallow solids, liquids, saliva
  - Exposures
  - Previous history, allergies, GERD symptoms

Sore Throat

- Address red flags in physical
  - Vitals
  - Patient appearance; comfortable, drooling, tripoding, will/will not speak, character of voice
  - Ears and nose
  - Throat: redness, swelling and where, exudate, uvula, swelling and deviation, tonsils 1-4+, kissing, stridor, AIRWAY WIDELY PATENT
  - Neck, including nodes, thyroid

Sore Throat

- Medical decision making
  - Differential diagnosis: viral, strep, PND, GERD. Strep result if you did it, or why you did not. No evidence of acute bacterial disease, life-threatening infection, or need for antibiotics at this time
  - No evidence of airway compromise at this time
- Discharge
  - Home care, dietary recommendations, apap, ibuprofen
  - Patient cautioned to return if…
  - Follow up in 48 hours if not improved, ED if worse

Your turn!

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My first open-ended qu...

Select which slide to add

In a few words, what are your biggest documentation challenges?

What are the red flags in physical for otitis externa?

What are the red flags in history for otitis externa?

What is the WCS for otitis externa?

Head injury: differential diagnosis

- Minor head injury
- Mild concussion
- Superficial contusion
- Laceration
- Bleed
- Skull fracture
- Brain damage

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My first open-ended qu...

What are the red flags in history for head injury?

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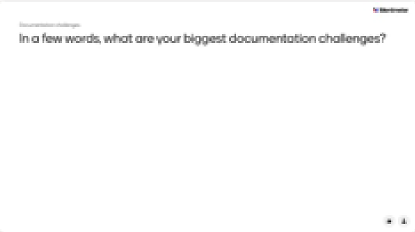

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Head injury: Red flags history

- Mechanism of injury
- Loss of consciousness and time
- Amnesia
- Blood thinners
- Previous concussion or head injury
- Age

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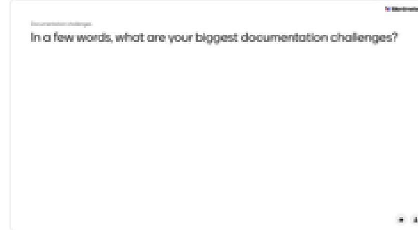

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Head injury: red flags in physical

- Abnormal vital signs
- Appearance
- Abnormal GCS
- Abnormal speech and response to questions
- Battle sign, raccoon eyes, blood from ears/nose, hemotympanum
- Palpation, step offs, crepitus, hematomas
- Neck exam
- FULL NEUROLOGIC EXAM!

Head injury: MDM

- Minor mechanism of injury
- No high-risk features in history
- Normal exam including neurologic exam
- Normal vitals
- Consider clinical decision tools
- Strict return precautions/call 911 if…/ER if…
- Return to activities/restrictions, including sports
- Who you are holding responsible to observe the patient
- PRINTED head injury instructions

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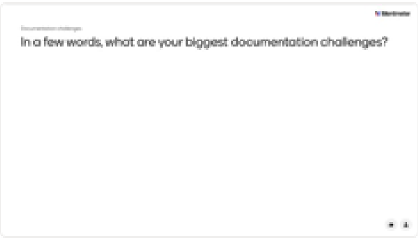
What is the WCS for otitis externa?



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Otitis externa: differential diagnosis

Worst Case Scenario

- Cellulitis of ear
- Malignant otitis externa
- Mastoiditis
- Spreading infection/sepsis

Most common

- Simple otitis externa
- Eczematous otitis externa
- Foreign body in ear canal
- Cerumen impaction

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What are the red flags in history for otitis externa?

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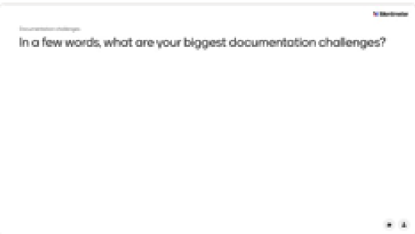

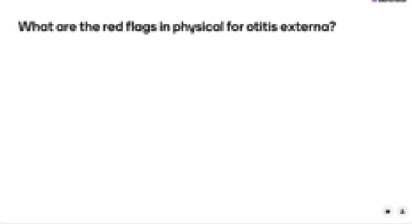

What are the red flags in history for otitis externa?

What is the WCS for otitis externa?

Otitis externa: Red flags history

- Severe pain/pain out of proportion
- History of OE in past
- Fever
- Pain with touching/laying on ear
- Hearing loss
- Drainage from ear
- Diabetes
- Immunosuppression

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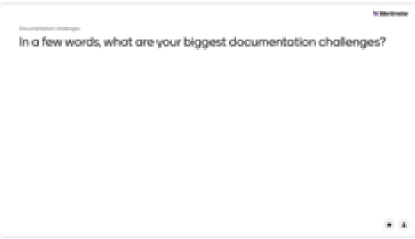

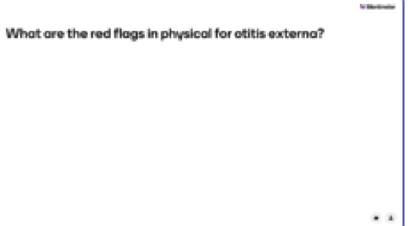

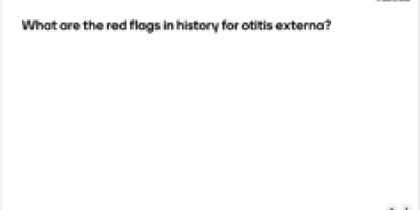

What is the WCS for otitis externa?

Otitis externa: red flags in physical

- Abnormal vitals
- Visible abnormality of external ear, swelling, redness, streaks, granulation tissue, necrosis
- Severe pain with palpation
- Inability to pass speculum/view TM
- Mastoid tenderness
- Lymphadenopathy, streaking on neck
- Neck stiffness

Otitis externa: MDM

- Otitis externa, no evidence of malignant otitis externa, mastoiditis, cellulitis of ear or spread of infection
- Medications provided
- Pain management
- Return in 48 hours if not improved, ED if worse, define worse
- If you placed a wick, when to return.

Take Home Points

1. Good documentation is your best protection against anyone questioning your decisions, including litigation
2. Paint a picture so you will remember what you were thinking, and others will know what your thinking
3. Be sure to add details to your history and physical so the reader will know what you thought about
4. Address the worst-case scenario by teasing out red flags in history and physical and ruling it our in your medical decision making.
5. Provide clear instructions and document in your MDM as well as your instructions to the patient

I Need Your Feedback

Prefer paper?

On the form in front of you, please score me and the content I shared with you today.

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