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RESEARCH ARTICLE

TO ERROR IS HUMAN, TO PERSIST IN ERROR IS DIABOLICAL:THE IMPORTANCE OF DOCUMENTATION IN MEDICAL PRACTICE

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Abstract

The need of accurate documentation in safe practice cannot be overstated. The records kept by practicing doctors must be clear, accurate, and legible. The quality of clinical documentation contributes to the best possible care for the patient. Medical notes serve as a key conduit for communication between all individuals involved in the patient's care, as well as with the patient and his or her family members. Medical records are becoming more and more important in medico legal disputes and litigation. Records may provide evidence for any claims that necessitate legal action, and this can happen months or even years after the incident, necessitating the requirement for accuracy. Data from clinical records can also be used for auditing and research. Medical records are also used to monitor hospital targets and performance. Deficient entries are caused by lack of knowledge, disinterest, habits, or a combination of these elements, putting both the patient and the doctor at risk. This may be due to the fact that education upon this issue is sporadic at best, and often non-existent.

What Is The Purpose Of Medical Documents/Records? [1]

1. It is the communication vehicle for the health care team involved in patient management and also with patients and their relatives.

2. It is a most credible document for legal proceedings and other regulatory bodies to decide whether the care given to patient met the standards or not.

3. It determines the appropriate level of care for admission and essential for reimbursement and insurance claims.

4. Medical records provide data for use in audit, research, and education which help to develop and implement new quality improvement initiatives.

Methods Of Documentation: [2]

1. ***Manual method:*** Because it is difficult to tamper written records without being detected, it is more legally acceptable. The necessity for huge storage areas and difficulties retrieving records are the limits.

2. ***Computerized or electronic method*:** They are neat and tidy, and they are easy to save and retrieve. The risk of easy manipulation without notice is a severe problem. Confidentiality is also a key concern.

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Summoning Medical Records By Courts:
Medical records are admissible in a court of law under Section 3 of the Indian Evidence Act, 1872, as revised in 1961. In criminal proceedings, road traffic accidents, labor courts, insurance claims, and medical negligence cases, or under the Consumer Protection Act for insufficiency in hospital or doctor's care, medical records are generally summoned in a court of law. [2]

F A C T Criteria To Be Followed While Documentation: [3]
1. ***FACTUAL*:** Be specific, Use neutral language, Entries should be genuine and unbiased, When you make an error (what you did or fail to do) state, report, and document according to institute policy.

2. ***ACCURATE*:** Precise, quantify, Make clear who gave the care, countersign, double-check calculations. Erasing of entries is not permitted and is questionable in Court.

3. ***COMPLETE*:** It includes Patient response, Communication with family, Transport consent, full discharge notes, transport notes and consent. There should be no blanks, and each page should include the patient's name and ID. Each entry should be completed with the concerned person's signature, printed name, designation, and contact number.

4. ***TIMELY:***
All entries should be dated and timed with 24-hr clock method. It is very important in legal cases. Don't leave documentation until the end of the shift or never document in advance. Computerized entries create a time-stamped record. Entering pertinent information is better done late than never, Enter both incident time and entry time. Medical Records that are written after the discharge or death of a patient do not have any legal value.

S O O O A AP (Subjective, Objective, Opinion, Options, Advice, Agreed Plan) method of documenting medical records: [4]

Subjective:
Use direct patient quotes, thorough Review of Systems and follow up with an inquiry.

Objective:
Provides a list of measurable, reproducible data: Vitals, Labs, Imaging. Perform sensitive exams (breast or genital) in the presence of a certified assistant and document the results. Avoid using descriptions that are judgmental or humiliating.

Opinion:
Explain the limitations of medical diagnosis and record your thought process and differential diagnosis.

Options:
Provides evidence of informed consent or informed refusal, discuss Alternatives, Risks, and Benefits of Evaluations and Treatments.

Advice:
Share your knowledge and support, and keep a record of reinforcement of the idea, that the doctor advised and the patient decided.

Agreed Plan:
Anticipate a significant adverse event and make a plan to deal with it. Document a statement of agreed plan in the medical records that seals the patient's accepted responsibility, and teach your patients to contact you if they arise and document that you have done so.

Common Documentation Mistakes/Red Flag Signs In Court Of Law: [5]
1. Not dating, timing, and signing entries.

2. Writing sloppily or illegibly.

3. Not documenting omitted medications or treatments.

4. Leaving blanks on forms.

5. Adding late entries.

6. Documenting subjective data using terms like “demanding,” grumpy and “irritating” to describe a patient reveals more about care provider attitude than the patient.

7. Using inappropriate abbreviations. Avoid abbreviations that are non-medical, which can result in interpretation errors.

8. Never accept questionable or incomprehensible orders. If you don’t understand the orders, or feel they are not in the best interest of the patient, question them every time. Remember that you are also liable for patient outcomes, even when following someone else’s orders.

9. Failing to document new symptoms or conditions: you should document any new condition where appropriate, including the time of occurrence, the action you took, and the patient’s response. This includes new abrasions, cuts, and pressure marks, falls, bumps, elevated temperatures, seizures, pressure ulcers, unusual behaviors, diarrhea, changes in bowel habits, changes in vital signs, etc.

10. Entering information into the wrong chart: This error can happen easily, especially with electronic records. Ultimately the problem occurs when a care provider isn’t paying attention to the patient’s identity. Always address your patient by name and ensure you have right electronic record or chart in front of you before entering information.

11. Lack of proper discharge notes: The discharge summary should mirror the case notes of the patient records with a summary, relevant investigations, and operative procedures. The doctor can be held negligent if proper instructions are not given regarding the medications and follow up care to be taken after discharge, physical care that is required, and the need for urgent reporting if an untoward complication happens before the advised time of review. [2]

12. Lack of proper referral notes: Referral notes are an important component of patient records. They should include the date and time of issue, the patient’s general condition, cause of reference, and the course of action to be taken. It is wise to keep a duplicate copy of the referral note with the patient’s signature. [2]

13. Confidentiality is an important component of the rights of the patient. The hospital is legally bound to maintain the confidentiality of personal medical records. The patient can claim negligence against the hospital or the doctor for a breach of confidentiality. (Exceptions are during referral, on-demand by the court, insurance claims, and workmen compensation cases)[2]

DO’S And Don’ts Of Medical Documentation: [4]

Don’t Destroy Evidence,

Don’t Ever Change the Record,

Do Label any addition to the chart as a “late entry”

Do Time and Date your entries in the record,

Don’t rely on memory: “The palest ink is better than the strongest memory”,

Do include significant positives and negatives from the patient’s history and physical examination,

Do make your notes legible,

Do indicate that you reviewed the laboratory data etc,

Do describe your Management Plan well,

Don't editorialize about your patient or anyone else - Personal comments are recipe for legal disaster!

Don't Add Administrative Comments: "There were not enough beds available ",

Don't include Peer-Review Comments: "Dr. X failed to arrive in a timely fashion",

Correction Of Documentation Errors:

1. When making a late entry, include both the date of the event and the date you are documenting the information (these will be different dates).
2. Once you circle the error on the front of the medical record, the error should then be explained on the back of the medical record with a signed and dated entry.

Going back and "fixing" records or filling them in after the fact without acknowledging that you are making late entries is considered a falsification of records. Mistakes happen, if you are transparent about a documentation error and correct it clearly; it is not considered falsification of records.

Medical Council Of India Guidelines (2002) On Medical Records: [2, 6]

1. Every physician shall maintain the medical records pertaining to his / her indoor patients for a period of 3 years from the date of commencement of the treatment in a standard proforma laid down by the Medical Council of India.

2. If any request is made for medical records either by the patients / authorized attendant or legal authorities involved, the same may be duly acknowledged and documents shall be issued within the period of 72 hours.

3. A Registered medical practitioner shall maintain a Register of Medical Certificates giving full details of certificates issued. When issuing a medical certificate he / she shall always enter the identification marks of the patient and keep a copy of the certificate. He / She shall not omit to record the signature and/or thumb mark, address and at least one identification mark of the patient on the medical certificates or report.

4. Efforts shall be made to computerize medical records for quick retrieval.

Case Scenarios:
1. In 2015, the Supreme Court imposed Rs 1.80 crore in compensation for a baby who was blinded by medical negligence in 1996. In August 1996, in the government hospital for women and children in Egmore Chennai, the child was born 10 weeks preterm. However, neither the neonatal expert nor the doctor at the hospital told the parents that all premature babies were at risk of retinopathy of prematurity (RoP), which might result in blindness if early preventive steps were not done. The Tamil Nadu government and a state-owned hospital in Egmore, Chennai, have been ordered to pay Rs 1.80 crore to the parents of a child who lost her eyesight within a year of birth 18 years ago owing to doctor carelessness and medical negligence. [7]

Key points:
Discharge summary should include a summary of the case, relevant investigations, and treatment given, treatment advice, and most importantly follow up advice (referral, investigations, or rehabilitation care).

2. Baby X was born with a heart defect and underwent surgery to correct it. Following surgery, he experienced cardiac dysrhythmias. When other efforts to treat the dysrhythmias failed, a physician prescribed digoxin, a drug with a narrow therapeutic window that can raise serum potassium levels. Because digoxin is a high-risk drug, the hospital controlled access to it, permitting it to be acquired only through a special dispensing machine that required a user name and password. Baby X was to receive 450 mcg of digoxin. The initial dose was to be 225 mcg followed by two doses of 112.5 mcg over 2 days. A nurse obtained an ampule of digoxin and administered the initial dose, but incorrectly charted it as 225 mg (not mcg). That this was simply a documentation error wasn't disputed; the ampoule contained only 500 mcg.

Key points:
Medication errors are one of the most common causes of negligence lawsuits involving nurses and treating physicians, particularly in pediatric care. To avoid medication documentation errors, always double-check the dosage and units, especially with high-risk drugs.

3. Dr. P is a registrar in neonatal medicine and is working on-call. A newborn infant Ram of Mrs. K is admitted to the unit with fever and breathing/feeding difficulties. Mrs. K had been induced and the birth was difficult. She was keen to be discharged and has returned home to rest. Ram is started on first-line antibiotics, and blood results in the early hours of the following day are strongly indicative of neonatal sepsis. Lumbar puncture is indicated to investigate the underlying cause. Dr. P, aware that Mrs. K is "exhausted and traumatized" by the birth, decides it would be unreasonable to disturb her in the middle of the night. Dr. P carries out the lumbar puncture and plans to discuss the results and any necessary changes in treatment with Mrs. K in the morning. She is concerned that any delay in determining the cause of his sepsis might result in Ram not receiving the correct treatment early enough to prevent a deterioration in his condition. The next day Mrs. K is informed of the results, which rule out the possibility of meningitis. Although relieved, Mrs. K is angry that she was not contacted by Dr. P to discuss the need for a lumbar puncture – and remains upset following a discussion with the on-call consultant who explained the urgent indication for the procedure.

Key points:
Before undergoing any procedure or therapy, be sure you have the required consent. It would only be justified to carry out an intervention without the patient's consent if the intervention was urgently required to save the patient's life or avoid a serious deterioration in their condition. Any surgery or specific treatment involving a marginal risk to the patient, such as major diagnostic or therapeutic procedures or the prescription of potentially toxic medication requires 'specific consent.' With date, time, and signature, properly document informed consent or informed refusal. [8]

Conclusions:-

Standard treatment guidelines and operating procedures create a strong foundation on which clinical excellence can flourish, which is especially beneficial in high-risk areas and practices. The maintenance of proper medical record keeping necessitates regular auditing due to the continuous rotation of nurses, internees, junior and senior resident doctors. Formal education for nursing staff, medical students, and doctors, as well as reinforcement of correct documentation practices at meetings such as hospital inductions and medical conferences is vital.

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