Common Problems in Medical Record Documentation

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If you work in any aspect of healthcare, you are probably familiar with the adage, *If it wasn’t documented, it wasn’t done.* The medical record, or chart, resides at the top of the healthcare food chain as the ultimate testimony of the care rendered. While initially serving as a communication tool to aide multidisciplinary healthcare team members, the medical record now has the dubious task of serving as a key piece of evidence in the growing number of lawsuits between patients and their healthcare providers.

Litigation due to nonhealing wounds, unintended weight loss, and malnutrition has become all too common. Generally, litigation arises from someone’s dissatisfaction with the level of service or quality of a product. In the healthcare business, that service is often a matter of life and death. In every lawsuit, the medical record is scrutinized to determine the quality and quantity of care rendered. Frequently, the patient’s chart does not support the fact that optimal care was delivered in accordance with accepted standards — illegible, illogical, or incomplete documentation cannot be defended in a court of law and often leads to out-of-court settlements, even though the care was perfectly acceptable. Healthcare providers and their insurers pay out millions of dollars each year because documentation is subpar. This is an awful waste of money, especially at a time when reimbursement rates are stagnant and denied insurance claims abound. In almost every case, the same sections of the chart are problematic. The most common trouble areas are presented.

**Intake and Output Records**

Intake and output records, commonly referred to as I & O’s, are intended to measure a patient’s fluid balance. *Intake* refers to all the liquids consumed, either enterally or intravenously, in a 24-hour period. *Output* refers mainly to urine output, although other losses such as excessive sweating or vomiting also are considerations. Ideally, intake and output are approximately the same or in balance. Excessive gains or losses may indicate edema or dehydration, both of which require intervention and additional documentation.

I & O records are notoriously incomplete and illegible. Plaintiff’s attorneys will ask if it is our (ie, the clinician’s) duty to keep accurate records. The answer is always a resounding yes. The I & O record then is introduced and the clinician is asked if it is complete. If the answer is no, there is a gap in care.

Incontinent patients pose a special challenge unless they have a Foley catheter in place. Simply writing the word *incontinent* across the entire output section makes no sense. In this case, only intake is being recorded; if that is the intention, it should be indicated in the physician’s order. Many of the forms used to record I & Os are not user-friendly — ie, they feature miniscule boxes, “total” lines that do not coincide with shift changes, and lack of instructions. Examining the forms and the facility policy are first steps in correcting this problem.

**Wound Documentation**

Not every wound is a pressure ulcer. In many charts, all skin integrity problems are labeled pressure ulcers. Calling every wound a pressure ulcer sets up expectations for certain interventions, which may not be indicated for other types of wounds. Arterial ulcers, diabetic ulcers, and venous stasis ulcers are not treated the same way as pressure ulcers. Another common problem is describing the anatomical location of the wound. The words *buttocks, sacrum,* and *coccyx* often are used incorrectly and interchangeably. When staff members use different words to describe the location of the wound, it causes confusion in the medical record. Other related problems are inaccurately denoting right and left and being inconsistent in the order of length, width, and depth when documenting wound measurements.

**Silent Charts**

Charts in long-term care often will demonstrate extended time gaps with no entries. For example, notes may be missing in the chart for four consecutive days; on the fifth day, the patient is noted to have a fever and lethargy. Gaps, or silent charts, always raise questions in litigation. Was any care rendered in the four days previous to noticing the patient was ill? Because most lawsuits are brought years after the fact, it is impossible to recall from memory alone. Without any documentation, what actually occurred is unknown.

**Height and Weight**

During the course of an extended illness, a patient may be transferred between acute and long-term care facilities several times. It is not uncommon to see vastly different heights and weights reported between various facilities and even within the same facility. For example, Mr. J was noted to weigh 150 lb on...
Friday at his nursing home. On Saturday, he was transferred to the hospital. After 2 days at the hospital, Mr. J returned to the nursing facility where the staff documented a re-admittance weight of 133 lb. Did the patient lose 17 lb in 2 days? Is that even possible? Weight inconsistencies are so common in charts, some staff members deem it acceptable to chart “weight appears erroneous.” But what does this say about the care we are giving if we cannot properly record the body weight? Imagine the family’s attorney explaining to the judge, “The people working at this facility could not even weigh Mr. J properly, so how were they able to manage his diabetes, hypertension, and advanced dementia?”

Meal Intake Records
Most healthcare facilities have adopted a system of recording meal consumption for each meal on a flow sheet using terms such as excellent, good, fair, poor, or refused meal. Consider a typical month in long-term care. The chart should contain 90 entries (30 days with three meals per day). Most charts have several boxes left blank. Does a blank mean the patient did not receive a meal? Usually not. But some testimonies have stated that “based on the meal consumption records, the patient only received 80 out of 90 meals this month.” In other words, it can be made to appear that the patient did not receive a meal because the box is not filled in. In other instances, it is obvious that the entire flow sheet was filled out at one time with the same pen, the same intake amounts every day, and in the same handwriting. In the trade, this process is known as dry-labbing; it is a form of cheating. Keep in mind that time sheets often are subpoenaed and that the initials of the employee on the flow sheet can easily be correlated with the days that employee was scheduled to work. Often, even boxes corresponding to days the patient was not in the facility are filled in. It is quite embarrassing to be asked why Monday and Tuesday are all filled in when the patient was discharged the prior Sunday.

Communication Issues
A recent lawsuit detailed the events leading up to Mr. K’s below-knee amputation. Mr. K. claimed the physician never told him he was going to amputate his leg. In his deposition, Mr. K. stated that the physician only was supposed to “clean up” the wound. The physician said he told Mr. K. an amputation was a possible outcome. The medical record had signed standard consent forms but minimal narrative notes. Clearly, this was a life-altering miscommunication. Listening and hearing are two very different acts; healthcare providers need to ensure their patients hear them and can repeat back what was said.

A related issue is the desire not to be the bearer of bad news. In American culture, we shy away from discussing death and this attitude may even permeate healthcare. Speaking frankly with patients requires finesse. Practice and simulations may help improve communication and avoid subsequent problems.

Incomplete Assessments
Three-page-long nursing admitting assessment forms with entire sections left blank are not unusual. Blank sections on forms always raise questions. Was the nurse supposed to complete that part and just forgot? Was the information unavailable? When a clinician is questioned about missing information during depositions, a typical reply involves explaining that the section in question is never completed. The information is collected somewhere else in the chart and clinicians “just don’t do that part of the form.” Forms that do not match current policies should be redesigned to avoid confusion.

Calorie Counts
A calorie count often is ordered when a patient is losing weight or not eating adequate amounts of food. The typical order requires that 3 days of meals be recorded and the number of calories and grams of protein consumed each day documented in the medical record. Communication is of utmost importance because serving the meal, removing the used tray, recording what was consumed, and performing the nutritional calculations are likely to be done by three or four different staff members. The reality is that unless a system is in place, meal trays often go to the dish room without being recorded; thus, the calorie count is incomplete. This creates a gap in care because the clinician is duty-bound to follow to physician orders. Policies on calorie count procedures should be reviewed with staff to avoid any problems.

Solutions to Common Documentation Problems
• Revise data collection forms. Whether hand-written or electronic, forms should aid in data collection and reflect current policies.
• Review policies to eliminate unnecessary orders such as I & Os for every admittance for the first week. Unless the reason for obtaining such data is clear, the policy may be unnecessary.
• Educate staff on proper ways to deal with noncooperative patients and how to reassure angry and/or frightened patients and families.
• Systematically and consistently conduct chart audits to determine potential problems. Peer reviews and consultants can help with this.
• Understand that we live in a litigious society and the medical record must be complete and accurate. Perhaps the best practice of all is to recognize that people generally do not sue people they like. Provide the type of care you wish for your own loved ones. No one ever envisions having an open wound or a diabetic ulcer and although we might be used to it, the patient is not. Genuine concern coupled with well-documented professional wound care is the order of the day.

Editors’ note: Many forms, policies, and in-service sessions dealing with issues discussed in this article can be accessed at no charge on the author’s websites at www.RD411.com and www.wounds411.com.