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# Six Tips to Bulletproof Your Chart: Lessons from the Exam Room and the Court Room

**Urgent message:** In the event that you are taken to court over care that is alleged to have been insufficient, negligent, or otherwise poor, your own documentation at the time care is provided can be your saving grace or your undoing.

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## Introduction

Providing proper medical care in urgent care centers is only half of the battle. As the medical record grows in prominence in our practice, the importance of charting has never been greater. This article is an adaptation of a lecture I give on emergency medical documentation, but many of the lessons apply in an urgent care setting as well. These six high-yield tips have been modified to reflect the realities of UC practice.

## Why Do We Create Medical Records, Anyway?

Many urgent care providers would likely tell you that they would do away with (or at least completely hand off responsibility for) medical records *today* if they could. Ensuring proper medical documentation is tedious and eats up time we would prefer to spend with patients.

While that may be true, properly created and maintained medical records are necessary for the practice of urgent care medicine. Medical records document patient flow and facilitate better communication between healthcare providers as patients traverse the medical system. For example, consider the cardiology maxim

that "the best EKG is an old EKG," meaning that the most effective means of determining whether abnormal findings are concerning is by comparison to a prior EKG.

Medical records are also an integral part of receiving proper reimbursement. Treatment for high-acuity patients may justify higher billing codes—but only if that higher acuity is reflected in the medical record.

Documentation may also help illustrate *why* a treatment was rendered (or not rendered) Without a thorough accounting, it would be impossible to differentiate the complexities of a visit from an asthma patient seeking a refill of a metered dose inhaler vs an asthma patient presenting with dyspnea, hypoxia, and retractions.

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By maintaining accurate and detailed medical records, providers can protect themselves against legal liability by clarifying their thought processes and management.

When creating a medical record, it is also important to think about how the documentation will appear to the many different parties that will read those records. For example, consider the different ways that your care would be evaluated if your chart is subsequently read by a colleague who is providing continuing care for the patient, by the health system CEO, by a state medical board representative, or if projected onto a large screen in a courtroom in front of a jury.

Professionalism and competence are often judged by what is contained in a patient's medical records.

Based on my experience as both a physician and as an attorney representing medical providers, here are six tips that I think will help urgent care providers bulletproof their medical documentation.

## Documenting the Vitals Is as Essential as Taking Them

Appropriate documentation of vital signs begins with ensuring they're taken correctly. For example, a 2017 study in the *Chinese Journal of Traumatology* showed that nursing staff did a good job at measuring heart rates, but they measured respiratory rates far less accurately. In the study, 59% of patients had a documented respiratory rate of exactly 20 and another 27% had a respiratory rate of exactly 15.[1] This is physiologically and statistically highly unlikely to be accurate.

Once we obtain vital signs, it is a good practice to document that we have at least considered them. A 2006 study by Hafner, et al showed that about 11% of ED patients had "very abnormal" vital signs and that 15% of patients with "very abnormal" vital signs were discharged without repeat vital signs being documented.[2]

Unsurprisingly, abnormal vital signs have been shown to have predictive value for hospital admission. A 2017 study by Gabayan showed that patients >65 years old who were discharged with at least one abnormal vital were twice as likely to be admitted within the next 7 days.[3] Those discharged with two or more abnormal vital signs were nearly three times as likely to be admitted within the next week.

While abnormal vital signs may be a sign of serious underlying disease, they are usually transient and of little clinical significance. For this reason, documentation of serial vital signs can help to show appreciation for the potential implications of abnormal vital signs. If the vitals normalize when rechecked, this provides reassurance for the provider, and anyone reviewing the chart, that serious conditions were considered but felt to be less likely because the vital signs improved.

If a patient has normal vital signs and is being discharged after evaluation for a minor complaint, one set of vital signs is probably sufficient. If a patient has abnormal vital signs or is receiving treatments in the clinic (eg, nebulizer treatments, pain medications, or antipyretics), consider repeating vital signs to demonstrate normalization or stability prior to sending the patient home. If the vitals remain significantly abnormal, either explain the reason (eg, "The patient remains mildly tachycardic after receiving nebulizer treatment but reports good improvement in symptoms") or consider further testing/referral to the ED to determine a cause for persistently "very abnormal" vital signs.

## Address the Chief Complaint

While it may sound obvious, documentation can often be improved by simply addressing a patient's complaints prior to formulating a diagnosis. In a review of 1,557 ED medical malpractice claims between 2010 and 2019, the insurance company Coverys found that 57% of malpractice events related to clinical judgment involved issues surrounding patient assessment and diagnosis.[4]

A study by Kachalia, et al showed that of 122 closed malpractice claims alleging missed or delayed diagnosis in the ED, 42% involved failure to perform an adequate medical history or physical exam.[5] Keep in mind that this was a retrospective review, so the issue was not necessarily that the medical providers didn't evaluate the patients thoroughly, but rather that they did not *document* an adequate medical history or physical exam.

My review of malpractice cases has revealed a surprising number of medical records where the clinician fails to even address a patient's chief complaint. One patient who presented for evaluation of abdominal pain and vomiting had no documentation of an abdominal exam having been performed. She was admitted for a diagnosis of pneumonia, vomiting, and "high WBC count." Unfortunately, her perforated duodenal ulcer was diagnosed later that week—at autopsy.

I reviewed the case of a 28-year-old patient complaining of chest pain radiating to his back; he was diagnosed with an "exacerbation of scoliosis" and sent home with anti-inflammatories. There was no mention of his chest pain and no exam of the lungs or heart in the medical records. His symptoms were instead related to an acute myocardial infarction and he developed a severe cardiomyopathy as a result of the event.

Yet another patient who presented with atraumatic leg pain after playing soccer had a cursory exam of the leg documented on the medical record and was discharged

home with a diagnosis of "leg strain." The following day, the patient underwent emergency fasciotomies for compartment syndrome, but developed foot drop and complex regional pain syndrome (CRPS) of the extremity. A jury awarded the patient $7 million in damages.

When evaluating a patient for any given complaint, focus on that complaint. Although no longer required for evaluation and management codes, consider including previous CMS bullet points in the patient's HPI such as location, quality, severity, duration, timing, context, modifying factors, and associated signs/symptoms.

In patients with straightforward complaints and physical examinations, it is probably sufficient to address only a few pertinent elements in the patient's history. In patients with more complicated or potentially serious complaints or those with concerning findings on physical exam, consider addressing more of these elements within the patient's history.

## WCGW?

The website Reddit has a section dedicated to asking WCGW? ("What Could Go Wrong?"). The sub-Reddit includes videos of people texting while driving, climbing wet rocks, and even lighting a firecracker held between the eyelids. The videos demonstrate the unfortunate, but foreseeable, outcomes of those actions.

Approaching documentation in the medical record involves similar foresight. When a patient presents with a complaint, think "WCGW" related to that complaint. Let your medical record reflect that you've considered some of the more potentially serious diagnoses.

For example, the complaint of ear pain doesn't require a binary decision whether or not otitis media is present. Otalgia may be caused by bullous myringitis, otitis externa, dental infections, TMJ syndrome, or mastoiditis. Documentation reflecting that you have considered these issues might read something like "No dental tenderness to percussion. No visible caries. No gum swelling. No TMJ clicking or tenderness to palpation. No parotid or mastoid swelling or tenderness. Tympanic membrane (TM) and external auditory canal (EAC) intact with no bullae or discharge."

Similarly, severe nontraumatic leg pain could represent a deep vein thrombosis, cellulitis, a stress fracture, a pulled muscle, referred lumbar radicular pain, or a $7 million case of compartment syndrome. Noting the location, timing, aggravating and alleviating factors and physical exam findings to detect some of the more serious etiologies (eg, "no palpable cords, compartments soft, no crepitus, no point tenderness") will help narrow the differential diagnosis and justify your treatment plan.

## Despite Its Virtues, Beware the Template

Medical record templates can be quite useful because they populate a large amount of information into a patient's medical record with relatively few keystrokes. Templates can also remind providers of important questions to ask during a history, list pertinent findings to check during a physical exam, and provide detailed situation-specific discharge instructions. Unfortunately, this same convenience also has disadvantages. Overdocumentation of EMRs is common. For example, why document or perform a thorough head, neck, chest, and abdominal exam on a patient with a simple ankle sprain? This additional information is unlikely to have any bearing on the diagnosis or treatment. Overdocumenting a simple complaint wastes time, bloats the medical record, and encourages overbilling. Focused ROS and physical exams for simple medical complaints will improve your efficiency and improve the usefulness of your documentation.

Templates also make it easy to unintentionally insert conflicting information into the medical record. One clinic chart I reviewed contained a note stating that the patient had complaints of nonproductive cough, fever, sore throat, nasal congestion, headaches, and body aches. The review of systems stated that the patient "denies fever, chills, earaches, sinus trouble, congestion, throat pain, coughing, shortness of breath, headaches…" among about 20 additional system points including "hot flashes, polydipsia, polyuria, and suspicious moles." Not only did the review of systems contradict the patient's complaints, but it contained a significant amount of irrelevant information—drawing into question whether the physician actually asked about the symptoms that were reportedly "denied."

Remember who will be reviewing your medical documentation. Such discrepancies may cause a smirk and a headshake from a colleague who reads the patient's chart. However, a medical board may take corrective action and a plaintiff's attorney will use the discrepancies to argue that the provider is careless and can't be trusted.

Another common template pitfall occurs when documenting the evaluation of an infant. Infants cannot deny chest pain, shortness of breath, or abdominal pain because they haven't sufficiently developed their language skills. For this same reason, an infant cannot be "oriented x 3" or deny abdominal tenderness on a physical exam. Don't make these documentation errors. Documented complaints should be limited to objective findings noted by the patient's parent or caregiver.

It is appropriate to use medical templates, but use those templates wisely. Double check that the HPI and

ROS in your documentation do not contain conflicting information. Also make sure that you have revised your documentation to remove questions from your template that you did not ask, and to remove findings that you did not perform.

If you are going to use medical templates, consider creating different templates for different patient presentations. For example, you may consider creating different templates for infants, children, and adults. You may also consider creating different templates for simple complaints vs more complex complaints and for medical complaints vs traumatic complaints.

## Algorithms Make Everyone Look Smarter

While clinicians provide medical care based on their experiences and clinical wisdom, in many cases, decision-making can be bolstered by using evidence-based support aids or clinical decision rules. For example, if a patient complains of chest pain, a low-risk Wells' score coupled with a negative pulmonary embolism rule-out criteria score may exclude a PE without additional testing. A HEART Score <3 in the same chest pain patient has a >99% negative predictive value for MACE within the following 30 days.[6]

Seeing a child with a head injury? Calculating the Pediatric Emergency Care Applied Research Network score can guide your decision whether to perform a head CT. Will a patient with syncope benefit from ED referral or hospital admission? Check the Canadian Syncope Risk Score, the OESIL score, or use the Rose rule.

While none of these scores reaches 100% accuracy, calculating the scores and documenting the results on a patient's medical record demonstrates awareness of evidence-based practices and provides objective evidence for your treatment decisions. These and other algorithms can be found at MDCalc.com. You can even download the algorithm results and copy them directly into a patient's medical record.

## The Reexamination

Reexamination of patients is a simple way to demonstrate conscientiousness and vigilance. Consider a tragic case of a child who presents for evaluation of an asthma exacerbation, receives a nebulizer treatment, is discharged home, and who later suffers a cardiac arrest. Now imagine that the patient's medical record shows tachypnea and hypoxia with mild respiratory distress and retractions, but no follow-up exam after the nebulizer treatment was administered.

Even if the child were doing better prior to leaving the clinic, it would be easy to second-guess the provider's decision to discharge the patient based upon the bad outcome. On the other hand, it would be much more difficult to second-guess the provider's decision to discharge the patient if the chart reflects that the patient was given steroids and nebulizer treatments, was reevaluated an hour later, had normal vital signs, had normal oxygen saturation, exhibited no retractions, was breathing normally, was acting normally per the parent, the parent was comfortable taking the child home for continued outpatient treatment, appropriate outpatient medications were prescribed, and follow-up for evaluation the next day was recommended.

Similarly, reevaluating a patient and documenting a response to IV fluids, pain medications, or any procedures performed provides substantial evidence that a patient is getting better and not getting worse prior to being sent home. Conversely, if a reevaluation suggests that a patient is not improving, this gives the clinician cause to reassess a provisional diagnosis and disposition decision.

## Summary

Medical documentation can improve patient care when used properly, but can be damaging to clinical care and detrimental to a provider's defense if used improperly. If using templates, use them wisely. Consider incorporating clinical decision rules into your assessments to provide objective evidence for higher risk patients. Noting appropriate pertinent positive and negative clinical findings will show that you considered alternative serious medical conditions during your physical exam. In patients with higher-risk presentations, documenting reexaminations and repeat vital signs helps support a determination whether a patient is improving and stable or deteriorating and unstable. Add these recommendations to your documentation and you'll be well on your way to a bulletproof medical record. ■

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