An Ideal Medical Documentation

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MEDICAL DOCUMENTATION Part III (Continued from Bulletin 2/2009)

An ideal Medical Documentation is one that subscribes to the following salient features and requirements:-

First and foremost it must contain sufficient information to identify a particular individual. Serious consequences may arise if particulars are incomplete or insufficient. Difficulties will arise in contacting a patient or the next of kin of a patient when the need arises due to inadequacy of particulars. Situations where a next of kin of a patient have to be contacted in cases of emergencies, where a particular patient have to be contacted when it is subsequently realised that wrong medication had been dispensed, where an appointment date has to be changed, where a patient has to come to the hospital for an urgent procedure or any situation where patients or their next of kin have to be contacted for any purpose ,imposes a requirement that all relevant details of a patient be meticulously entered in his document.

Entries in documents must be done by the person carrying out a particular task to ensure the correct details are captured.

All details must be entered in a chronological order and under no circumstances must entries be backtracked, which may indicate adverse intentions, unless it is clearly indicated and expressedly explained.

Under normal circumstances all entries have to be contemporaneous i.e. entered as and when the event happens. However, this may not be possible always. There may be instances where an occasion arises where emergency measures has to be instituted with the primary duty to save lives. In such instances information can only be document after the event. Under such circumstances all relevant information related to treatment and investigations during the course of the emergency intervention has to recorded by any of the team member which can then be subsequently reduced to writing in the document by the treating personnel. Care must be taken to indicate chronological happening of the various measures taken during the whole process of resuscitation. It would be advisable to attach the notes made during the process with the case notes of the patient concerned in case evidence has to produced later on. Special attention must be given to sentinel events as these maybe reliable testimony in litigations later on, if at all one is brought about. .

Notes have to be written legibly and with permanent ink and once made out should not be erased or altered or new words inserted, after a lapse of time , as this may indicate defensive action by the writer in the event of unexpected eventualities in the course of patient management.

Description of patient care must contain all findings, actions or inaction, commission or omission of an act, and any relevant changes in the condition of a patient. Where necessary, grounds and justification for certain acts have to be allocated to counter future challenges. Investigations and treatment should be recorded in detail and in case of invasive procedures, the indication for and the nature of the procedure must be clearly documented. Properly justified procedures can be defended by peers in the event of litigation but when clinical notes are sketchy, poorly made out, illegible, vague and ambiguous and superimposed with deletions and corrections, this may be difficult.

Similarly notes and records relating to operations and invasive procedures should be written meticulously, with attention to indications, findings, relevant details, difficulties encountered and measures taken. The more complex a procedure the more attention must be paid to details. For patients who are at high risk, particularly those who are aged and medically compromised, the possible risk of surgery and anaesthesia need to be clearly explained to the patient or his next of kin and this must be well reflected in the notes.

Unnecessary usage of words and unsavoury language or incriminating remarks must be avoided when making entries in patient's records as patients have a right to have sight of their records and the writer will be viewed in a negative light if a patient comes to know about it. It is always advised to use short sentences in simple language so that everyone reading the notes will be able to comprehend the meaning. As far as possible actual quotations of patients be incorporated in the notes to avoid patients denying what transpired at the examination session. All investigations and findings, both positive and negative must be recorded clearly.

As improper deletions may give raise to suspicion to the authenticity and veracity of the record made, it is advisable to delete appropriately and the person deleting be identified. Erasure and correction fluid must be avoided. If there is a necessity to delete, then the word or sentence can be crossed out and the initial of the person doing so be entered.

The usage of abbreviation must be restricted to universally acceptable ones, if need be.

For every entry the identity of the maker of the document must be clearly indicated and rubber stamped, carrying the name and designation of the person concerned. It is also mandatory to include the date and time of the entry.

If there is an emergency, then this must be clearly indicated in the document concerned.