



# Documentation v/s Patient care: which is important

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# Is Documentation important?



**Yes!**





# Case Studies: common adverse events due to poor documentation

## **Failure to document medicines that have been given:**

A diabetic was ordered a stat insulin dose at shift change -The nurse administered it, but did not record it and went off the shift

Resulting in repeat dose at next shift.....insulin overdose... patient went into hypoglycemia

## **Failure to record allergies:**

A doctor did not elicit history of allergies, no documentation

Patient given injection...went into anaphylaxis with brain damage

# Case Studies: common adverse events

## **Failure to record “stop medicine”:**

A doctor did not write to “stop aspirin” in a patient with gastritis...

Leading to severe ulceration and bleeding

## **In the court**

A doctor had not put his notes ...patients allegation that he did not see the patient couldn't be proven wrong, even tho he had taken a round and seen the patient.

# Don't substitute a care process with a mere document

## Example: INFORMED CONSENT

Informed consent is a process in which the physician provides adequate information to the patient or patient's legal representative to make an informed decision on the proposed treatment, including medications or procedure.



# Don't forget the intent....

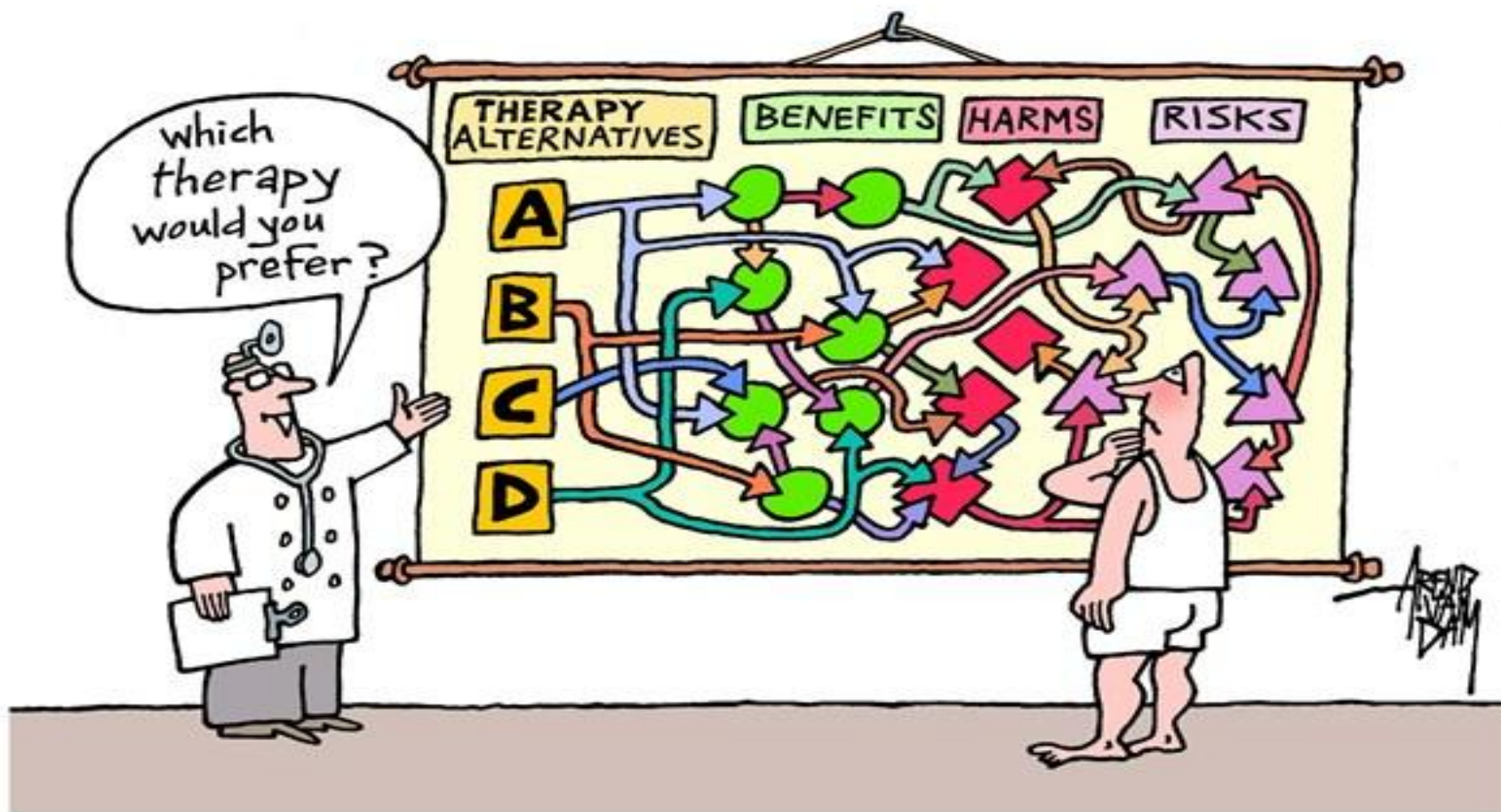
## The patient's rights

- Patients must be given information, in a manner and language that they can understand, to enable them to exercise their right to make informed decisions about their care.
- A patient has the right to give or withhold consent prior to examination or treatment.
- Patients must be allowed to decide whether they agree to the treatment and they may refuse treatment or withdraw consent at any time.



# Doctor's responsibility is NOT about mere documentation:

- Informed **consent is to be explained** and taken either by the doctor performing the medical or surgical procedure or another doctor from his team who has the requisite qualifications, knowledge of the procedure, its associated risks & benefits. It should be duly signed with name.
- It should always be obtained **before** the procedure is carried out and be placed in the Medical record file.
- Specifically, the **physician must disclose** in a reasonable manner **all significant medical information** that the physician believes is relevant to making an informed decision by the patient in deciding whether or not to undergo the procedure or treatment.



*informed consent*



# Important to stress on the “process” before the document!

**The ‘record’ or the ‘document’ of consent serves as a legal document.**

**In this example...quality is NOT merely documentation.**

# Is Documentation important? ...of course it is...

Why do we document clinical care:

- For communication purposes while caring for the patient
- For continuity of patient care over the course of the treatment
- For evaluating patient care
- For medico-legal purposes
- For use as a source of health statistics
- For research, education and planning purposes

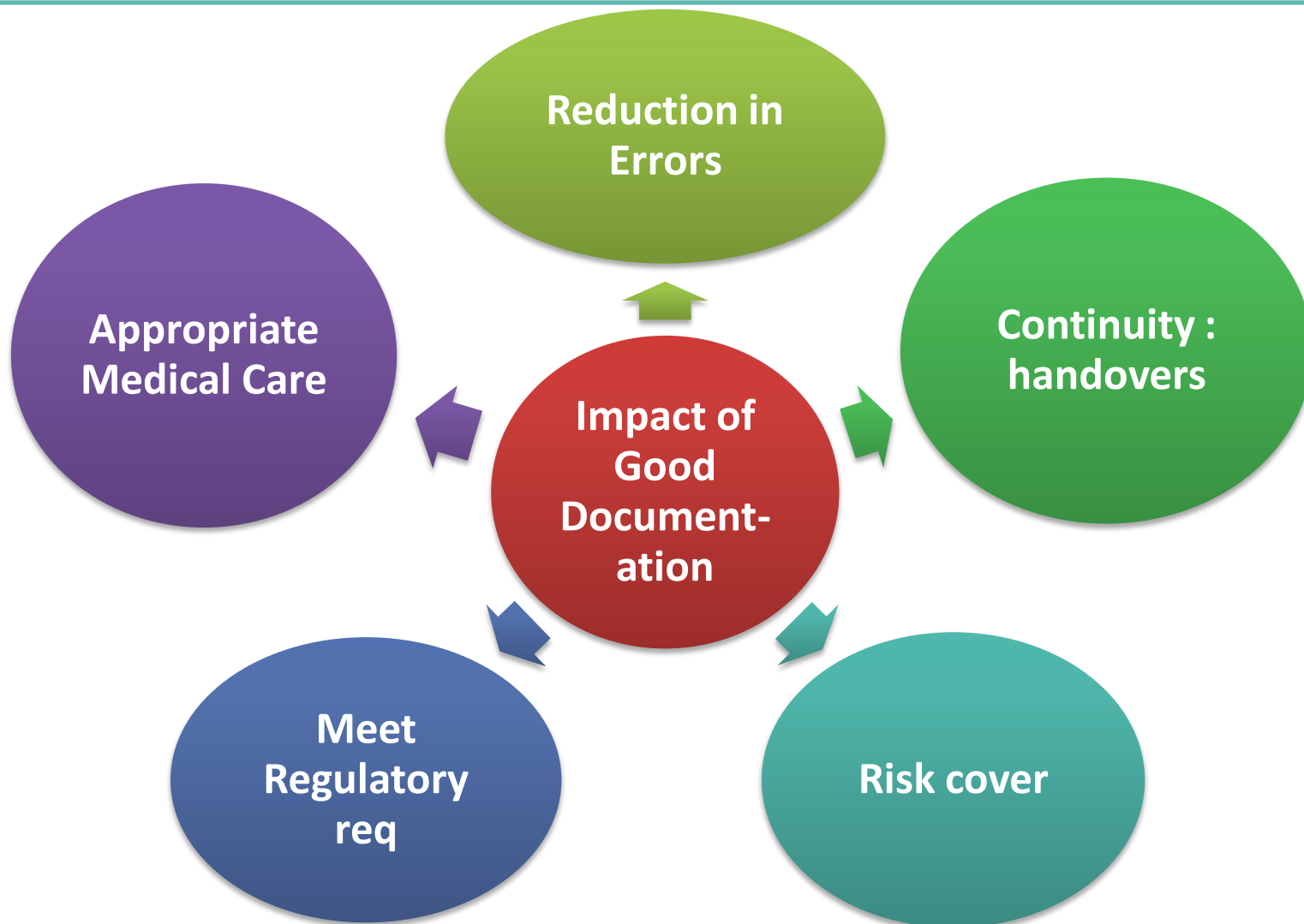
***And....For NABH!!!***



# Quality documentation – the four attributes

As defined by the World Health Organization (2003, 2006), the Royal College of Physicians (2009), Lowe (2009) and Huffman (1994), the quality of the entries documented in a medical record is judged by the following attributes:

- **Availability**
- **Legibility**
- **Adequacy**
- **Accountability**



- **Documentation** is a critical part of patient care and impacts quality of processes and **clinical outcomes**
- The **intent** of required documentation needs to be clear
- The **quality** of documentation should be along lines of “customer centric communication” :
  - Internal customer
  - Patient
  - Law
- Documentation **should not be used to short cut the actual process** (surgical safety, consent)



**Thank you**

**Have a great day!**