

DATE: September 8, 2011
TO: All Members of the LMHS Medical Staff
FROM: Mark A. Greenberg, MD, System Medical Director
of Medical Staff Services
SUBJECT: The Importance of Dating and Timing All Medical Record Entries

The following letter was forwarded to my office by a Medical Staff Member who wishes to remain anonymous. In the letter, the physician shares a personal experience that highlights the importance of documenting the date and time of all medical record entries.

CHART DOCUMENTATION: WHO CARES?

During our busy day to day lives as physicians, we are constantly called/required to perform numerous patient evaluations, order specific laboratory studies, radiologic tests, and perform complete or partial examinations in the office and/or in the hospital. It is not infrequent that these studies, tests and examinations are completed without adequate or perhaps appropriate "chart" documentation.

We should all be reminded that CMS initially published their "documentation" guidelines in November of 2006, indicating that all entries in the chart should complete, timed, and dated. These standards of documentation were accepted by JCAHO in early 2007. Despite these "standards" of documentation being recognized, compliance locally, regionally, and nationally continues to be far, far less than 100%. Additionally, the Florida Statutes and the Florida Board of Medicine can enforce disciplinary action in the absence of specific medical record requirements (F.S.458.331(m)).

This letter is written to reiterate the absolute practical and legal importance of appropriate documentation in each and every aspect of patient care. Having recently completed a 7-day trial (with a defense verdict), I can attest first hand to the importance of this documentation. In fact, a major, and I stress major, component of the plaintiff's case in this trial related to a note that was not timed and dated. Although the time of the charting "event" could be reconstructed using other chart, nursing and laboratory entries, the absence of a timed, dated entry was used to create doubt and propose "sloppiness" in an attempt at character assassination. The importance of this issue cannot be overstated as these 2 pages were culled out of a 4300 page chart relating to a 90-day hospitalization in a patient who had undergone multiple surgical procedures.

While, if necessary, it is usually possible to circle back and find confirmatory information indicating the appropriate timing and dating of a chart or order entry, I can say with 100% certainty that the absence of a time, dated note can and will be used to adversely reflect on your credibility in all other aspects of a patients care.

Having seen this note in front of the jury not once, not twice but at least 15 to 20 times over the 7 day trial period, I cannot overstate how important a time and date would have been to completely eliminate a contentious issue in this specific litigation.

The short answer/take home message is to make every effort to document all care and orders (particularly when important decisions are made) with a timed and dated note. This axiom should also be stressed to our physician assistants, nurse practitioners and any other providers involved in patient care in an effort to ensure their compliance. We all strive to practice exemplary medicine and it is only appropriate that our charting habits reflect these labors in appropriately timed and dated notes and orders. These efforts can only benefit patient care. While it may take seconds of your life today to complete these entries, you can rest assured that today's effort may save your many future hours, days, months of angst, heartache, concern and dollars. It may help prevent you from ever facing a plaintiff's request of \$10,000,000!