Documentation of Ophthalmic Care

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ASORN Annual Meeting
October, 2009
San Francisco, California

Disclosures

- I have no financial interest in the topic of this presentation.

Legal Elements of Medical Malpractice

"The Four D's"

- Duty of MD to treat patient
- Deviation from standard of care (requires expert testimony)
  - What would a reasonably prudent ophthalmologist do in the same or similar circumstances?
- Direct causal relationship between deviation and the alleged injury/damages (ie. proximate cause)
- Damages: actual economic and non-economic
  - If paid = "indemnity" payment

Purpose of Documentation

- A complete, legible medical record serves many purposes.
  - Promotes patient safety and continuity of care by providing a comprehensive account of the diagnosis and treatment;
  - Provides evidence that can be used to defend, or possibly assail, the ophthalmologist's care in a claim or lawsuit; and
  - Serves as a basis for coding and billing of the care provided.

This course will provide guidance on documentation of:

- The diagnostic and decision-making process
- Informed consent
- Procedures and complications
- Telephone calls
- Noncompliance

Diagnostic and Decision-Making Process

- How important is your analysis of the patient's condition?
- Do you really need to document your decision- making process?

If it's not documented, it didn't happen, and you didn't consider it.

-Plaintiff Attorney Handbook 101

Diagnostic and Decision-Making Process

Case #1

- 59 year-old patient referred to ophthalmologist by primary care physician with c/o blur and pain OD,↓ VA, and past history of flashes and floaters

Diagnostic and Decision-Making Process

FIRST VISIT EXAM

- 20/30 OD, 20/20 OS, IOP wnl
- VF defect noted both superiorly and inferiorly
- No evidence of RD on dilated exam

Diagnostic and Decision-Making Process

- Diagnosis: ? optic nerve problem
- To medicine for a work-up, begin travaprost, RTC 2 weeks

Diagnostic and Decision-Making Process

SECOND VISIT TWO WEEKS LATER

- C/o decreased visual acuity "since yesterday"
- 20/100, 20/20, IOP 14
- No significant optic nerve swelling
- ↓ red saturation and brightness
- No proptosis, pupils wnl, dilated

Diagnostic and Decision-Making Process

- Diagnosis: rule out GCA (giant cell arteritis)
- ESR and CT of brain
- Consider referral for neuro-ophthalmology evaluation. Patient has no insurance. Requires retinal evaluation.

Diagnostic and Decision-Making Process

STAFF NOTE ONE WEEK LATER

- "Patient walked out and refuses services, because he wanted the __ Hospital to give him free services because he is a monk! Patient came to our office, spoke to doctor on the phone because doctor was not in at the moment. Doctor told patient that he

Diagnostic and Decision-Making Process

STAFF NOTE, cont.

- needed to go to __ County to get medical attention as soon as possible because of not having insurance. Patient made things very hard."

Diagnostic and Decision-Making Process

MD NOTE NEXT DAY

- "Patient called yesterday—walked out of __ Hospital. Expected free services. Patient still complained of decreased vision. Told him to go to County Hospital to seek help. He again was warned about payment."

Diagnostic and Decision-Making Process

UNDATED MD NOTE

- "Patient was called after results of CT obtained which was negative. He was told this. Because of his poor vision, he was told to see retina specialist. Patient stated that this would be a problem since he had no insurance but would see what he could do."

Diagnostic and Decision-Making Process

- Two months from first visit with ophthalmologist, patient seen at the County Regional Medical Center and diagnosed with RD.
- Two years later, he filed a lawsuit for delay in diagnosis.

Diagnostic and Decision-Making

DEFENSE EXPERT REVIEWS: ↓ SOC

- "Medical record is not defensible"
- Failed to diagnose retinal detachment
- No description of the findings of examination of the optic disc or the retina
- Prescribed travaprost OD even though IOP normal and VF not diagnostic of glaucoma

Diagnostic and Decision-Making Process

- Diagnosed optic nerve problem OD with IOP normal and no description of optic disc
- No differential diagnosis on 2nd visit with ↓ VA
- No attempt to facilitate referral to retina specialist
- Failed to warn patient of symptoms of RD and need for urgent treatment

Diagnostic and Decision-Making Process

CLAIM RESOLUTION

- Settled during mediation for $95,000

Diagnostic and Decision-Making Process

- **Important Elements of Documentation**
  - History in the patient's own words
    - Impact of cataracts on functional vision OR reason patient wants refractive or elective surgery
    - Impact of vision on work history
    - Impact of vision on hobbies
  - Exam results including ***all pertinent positive and negative findings***

Diagnostic and Decision-Making Process

- **Important Elements**, cont.
  - Assessment including ***differential diagnosis***
  - Plan, including treatment
    - Decision to propose medical v. surgical treatment
    - ***Instructions given to the patient***
    - ***Follow-up appointment or appointment with consultant***

Diagnostic and Decision-Making Process

Documentation Rules

– Include objective account of facts

– Do not note subjective judgments

– Do not speculate or blame/judge

– Date and sign or initial all entries

Diagnostic and Decision-Making Process

Other concerns with documentation

- "Patient ...wanted the __ Hospital to give him free services because he is a monk! ...Patient made things very hard."
- "Patient ... expected free services... again was warned about payment."

Diagnostic and Decision-Making Process

- Plaintiff attorney may project a gigantic copy of the record
- Many jury members have, or have had, financial difficulties about which they are embarrassed
- Gives poor impression of practice

Diagnostic and Decision-Making Process

- "Patient ...wanted the __ Hospital to give him free services because he is a monk! ...Patient made things very hard."
- SUGGESTED LANGUAGE:
  "Patient went for CT but left when realized he needed to pay. Was concerned that he has no insurance, hoped hospital would waive fees since he is a monk."

Diagnostic and Decision-Making Process

- "Patient ... again was warned about payment."
- SUGGESTED LANGUAGE:
  "Told patient that even county hospital will ask him to make some payment toward care."

Informed Consent

Case #2

- 67 year-old patient presented with c/o blurriness and distortion OD
  - VA 20/30-, 20/25
  - Macular pucker OD>OS confirmed by FA and fundus photography.
  - "Risks and benefits of vitrectomy OD discussed with the patient"

Informed Consent

- "Informed patient's husband by phone of the results of the FA, surgery only option to remove the pucker"
- Uncomplicated pars plana vitrectomy with membrane peeling and SF-6 injection to OD

Informed Consent

- Two months after surgery, vision not improved and patient complained of horizontal bar obstructing vision OD
  - Persistent mild cellophane maculopathy
  - Optic nerve normal and healthy
  - No macular holes
  - ? cause of visual difficulties

Informed Consent

FOUR MONTHS AFTER SURGERY

- "No improvement"
- VA 20/400 OD
- Mild temporal atrophy to the optic nerve
- "Informed patient atrophy could be caused by small vascular occlusion, not sure of cause"
- Treat slight cystoid macular edema with triamcinolone injection and oral NSAID

Informed Consent

SIX MONTHS AFTER SURGERY

- Patient still c/o bar blocking vision, which had turned from black to gray
- Faint residual cellophane
- ? temporal atrophy
- Referral to neuro-ophthalmologist to determine cause of visual problems

Informed Consent

- Neuro-ophthalmology consult 3 days later
  - 20/400 corrected VA
  - Small amount of temporal atrophy, with cecocentral scotoma
  - Diagnosis: small vascular accident occurred peri-operatively
- Patient never returned to insured

Informed Consent

CLAIM INVESTIGATION

- Strong expert support that diagnosis and treatment met the standard of care and that physician's care did not cause the damage to the optic nerve
- Plaintiff's only criticism was lack of informed consent

Informed Consent

- Defendant's Deposition:
  - Did not have or use procedure-specific consent form
  - Relied on the general consent form used by the hospital
  - Form was missing from hospital chart

Informed Consent

- Plaintiff Expert's Deposition:
  - Assuming defendant's testimony is true, he acted reasonably in providing the patient informed consent
  - Critical of use of hospital's general consent form: standard of care requires that physician prepare a separate, specific consent form

Informed Consent

- Defendant's Deposition, cont.
  - Acknowledged error in date in office chart
  - Discussed risks and benefits with patient on day of surgery at hospital
  - Mistakenly wrote note about discussion on entry for preoperative assessment

Informed Consent

- Plaintiff's Expert Deposition, cont.
  - Stated in passing that did not find note about discussion of risks and benefits in the office record
    - ***This statement alerted defense attorney that there were two, different sets of medical records***

Informed Consent

A CHANGE IN THE LIABILITY EQUATION

- Defense attorney needed to explain reason for 2 sets of records, so asked physician
  - The insured recalled making the notation about risks and benefits <u>after</u> he received his initial claim letter with demand from the plaintiff

Informed Consent

- Who will the jury believe?
- The medicine was defensible but how do you prove properly obtained consent if no note and no procedure-specific consent form?
- This new information led to a $25,000 settlement.

Informed Consent

- **What is "informed consent"?**
  - An oral agreement reached after the surgeon advises the patient of:
    - Diagnosis and proposed treatment
    - Risks, benefits, and alternatives
    - Consequence of refusing treatment
  - Informed consent must be documented by
    - Note in medical record (always)
    - Procedure-specific consent form (usually)

Informed Consent

- Documentation in the medical record
  - Risks, benefits, alternatives discussed
  - Complications for which the patient is at an increased risk
  - Patient's questions and patient satisfaction with your answers
  - Planned comanagement, if any
  - Off-label use of drugs or devices if integral to the procedure/treatment

Informed Consent

- Is it okay to use a pre-printed stamp to document the informed consent discussion in the medical chart?

The risks, benefits, and alternatives have been discussed with the patient as outlined in the _______________ consent form(s) and __________ video presentation(s).

[Doctor's signature/date]

Informed Consent

- Yes, provided that all *material* aspects of your conversation with the patient, not accounted for in the stamp, are documented
- Reminder: also use procedure-specific form

Informed Consent

- Procedure-specific consent forms
  - Provides documentation of **content** of informed consent discussion
  - **Educates patient** and helps prepare patient for possible complications.
    - Patient may be illiterate or uncomfortable asking questions. Give the patient a copy of the consent to take home. Ask him/her to review with family and to call with any questions.

Informed Consent

- Procedure-specific consent forms
  - Serves as **confirmation** for ASC or hospital that surgeon obtained informed consent.
  - Ophthalmic-specific consent forms at http://www.omic.com/resources/risk_man/forms.cfm

Informed Consent

CHANGES TO ANY PART OF THE RECORD

- Corrections
  - Draw a line through the unwanted statement in such a manner that it is still legible, write the appropriate statement, date and initial it.
- Addendums
  - The original information is not removed
  - Serves to add information
  - Date, sign, and place in the chart
  - Do not add after receive claim letter

Procedures and Complications

CASE # 3

- 82 year-old patient presented for cataract surgery OS, given topical anesthesia with IV sedation
- Woke up, became disoriented before procedure began and used profanity
- CRNA also used profanity, proceeded to administer additional sedation

Procedures and Complications

- Surgery proceeded without complication
- The Surgeon noted in Operative Report that patient was “restless.”

Procedures and Complications

- 1st postoperative visit patient apologized for the “fuss” but said she did not know what had really happened, only c/o burning from drops.
- Two weeks later, came with neighbor who was very hostile. c/o blurry vision and photophobia, declined refraction for glasses.

Procedures and Complications

CLAIM INVESTIGATION

- Hospital employee overheard cussing and unbeknownst to the physician
  - Went to waiting room and told family that there were complications and that the patient was in pain
  - Filed an incident report stating that patient was mistreated

Procedures and Complications

- Since the surgeon never told the family or the patient of any problems with the surgery or the anesthesia, the family concluded he was hiding something
- The patient lost faith in her physician, and did not allow him to evaluate the cause of her problem and stopped coming

Procedures and Complications

- Long-standing "bad blood" between ophthalmologist and CRNA (employed by ASC)
- Problems with case just before this one

Procedures and Complications

- STANDARD OF CARE EVALUATION
- Lack of documentation of event anywhere in record below SOC and may indeed have lead family to believe there was a cover up
- If restless, may have been poor choice for topical anesthesia

Procedures and Complications

CLAIM RESOLUTION

- Plaintiff attorney demanded $300,000
- Lost interest in claim and never filed suit
- Closed without payment
- Other OMIC cases dealing with inadequate pain relief have led to payments ranging from $50,000 to $450,000

Procedures and Complications

- Procedure (Operative) Report
  - Rationale for surgery
  - Statement that informed consent was obtained
  - Pre-operative assessment
  - Anesthesia: sedation type, amount
  - Technique
  - Assistants, if any
  - Complications
    - How they were handled
    - Disclosure discussion
  - Discharge condition
  - Follow-up instructions

Procedures and Complications

Document in medical record

- "Patient sleeping after administration of IV sedation. Prior to incision, patient awoke, was disoriented. Circulating nurse was able to calm and reorient patient. Additional sedation administered by CRNA; patient slept throughout remainder of procedure. Family informed of disorientation and need for additional sedation."

Procedures and Complications

Document in incident report

- Alerts facility to need for follow-up
- Most hospitals and ASCs have protocols that establish when one must be completed, along with specific form
- Note details more pertinent to physicians and staff behavior and actions than to patient (e.g., profanity used by CRNA)

- DO NOT PHOTOCOPY OR PUT IN MEDICAL RECORD

Procedures and Complications

- **Disclose unusual occurrence to family**
  - "The surgery went well and your mother is resting in the recovery room.
  - To make your mother comfortable, the anesthetist gave your mother sedation.
  - Right before I started the surgery, she woke up and was confused, which can happen with sedation.
  - She was given additional sedation and was comfortable for the rest of the procedure.
  - She will probably not remember any of this. If she does and has questions, please let me know."

Telephone Calls

CASE #4

- 3/18/99: Cataract surgery with IOL OD
- 3/25/99: Cataract surgery with IOL OS
- 4/12/99: Bowen's disease lesions removed from medial canthus OS
- **4/17/99: Telephone call from patient to 2nd ophthalmologist covering for surgeon, who was out of town**

Telephone Calls

- 4/18/99: Patient admitted to ER.
  - LP VA, hypopyon, white pupil due to presumed retropupillary membrane OS
  - Diagnosis endophthalmitis
- 4/19/99: Vitrectomy by 3rd ophthalmologist, complicated by glaucoma.
- Final VA = NLP

Telephone Calls

FOCUS OF CASE: SINGLE **UNDOCUMENTED** TELEPHONE CALL 4/17/99 10:00 am

- Patient informed ophthalmologist covering for his surgeon that OS had become red, scratchy, and painful with blurry vision
- Learned from patient that OS was 2nd cataract procedure, done on 3/25/99
- Did not know that Bowman's lesion removed medial canthus OS on 4/12/99
  - No patient "hand-off"

Telephone Calls

- Using phone records, plaintiff can prove that call was made
- In absence of documentation, experts review deposition testimony given by plaintiff and defendant physician
- Juries ultimately decide credibility of plaintiff versus defendant

Telephone Calls

SINCE NOT DOCUMENTED, MUST RELY UPON MEMORY

- Telephone call 4/17/99
- Suit served 11/20/00
- Deposition 12/27/00

Telephone Calls

- Deposition Testimony
  - Q: So, anything you testify about the phone call [with the patient] would be based strictly upon your memory, as opposed to looking at something to refresh your memory, true?
  - A: True.

Telephone Calls

OPHTHALMOLOGIST'S VERSION

- Asked patient to meet him at office, but patient indicated difficulty in obtaining transportation.
- Patient asked MD to meet him at ER, but then decided couldn't drive
- Through questioning, learned of cataract surgery 2 weeks prior

Telephone Calls

OPHTHALMOLOGIST'S VERSION, cont.

- Told patient symptoms could be caused by dry eyes or something serious
- Continue lubricating eye drops and call back by 2 pm if no improvement

Telephone Calls

PATIENT'S VERSION

- Patient claims he was not told that he might have a serious condition or that he needed to be seen or call back.

Telephone Calls

- Defense expert
  - ↑ SOC if ophthalmologist's version accurate
- Plaintiff expert

  Even if deposition testimony truthful:
  - Should have insisted on seeing the patient
  - Should have clearly warned the patient of the potential for endophthalmitis

Telephone Calls

CLAIM RESOLUTION
- Case settled for $100,000
- Cost of defense: $64,867

Telephone Calls

- DOCUMENT ALL CALLS
  - Calls to staff during office hours
  - Discussion with consultant
  - After-hours from patient
  - After-hours while on call
  - After-hours from the ER
  - Patient sign-offs when going on or off call, or transferring care

Telephone Calls

- Content of Documentation
  - Date
  - Time
  - Information obtained and given
  - Assessment
  - Recommendations
  - Follow-up
  - Communication with other providers
- Suggestion: Consider carrying a Dictaphone while on call and dictating a note right at the time for later filing

Telephone Calls

- Get "Telephone Screening of Ophthalmic Problems" for:
  - Sample screening guidelines
  - Contact form for calls to staff
  - Contact form for after-hours calls
  - http://www.omic.com/resources/risk_man/recommend.cfm#telephone

Noncompliance

CASE # 5

- 1/20/93: Referred by OD for glaucoma work-up
  - VA 20/20 OU; IOP 35 OD, 28 OS.
  - Levobunolol prescribed for primary open angle glaucoma
  - Explained seriousness of disease
  - Told patient to take all drops, keep all appointments
  - RTC 1 week

Noncompliance

- ONE WEEK F/U VISIT (1/29/93)
  - IOP ↓
  - No side effects
  - Levobunolol refilled
  - RTC 4 months

Noncompliance

- FOLLOW UP VISIT 12/29/93 (7 months late)
  - C/o ↓ VA OD > OS x 3 weeks
  - Only using drops "once a day mostly"
  - IOP 38 OD, 36 OS with ↓↓ VA
  - Reiterated importance of using Levobunolol exactly as prescribed, and to add pilocarpine
  - Referred patient to glaucoma specialist and stressed importance of keeping appointment

Noncompliance

- GLAUCOMA SPECIALIST
- Trabeculectomy OS 1/11/94
- Trabeculectomy OD 2/1/94
- Final BCVA 20/80 OD, 20/25 OS

Noncompliance

DEFENSE EXPERT ANALYSIS: ↑ SOC

- Advised patient of:
  - glaucoma diagnosis and its seriousness
  - the need to take his drops as prescribed
  - importance of returning for follow-up visits
- AND documented advice in the medical record

Noncompliance

INVESTIGATION

- Bill contained a notation to return in four months for follow-up
- Ophthalmologist testified that "missed appointment" letter sent to the patient. However, the defense was unable to produce this letter.

Noncompliance

- Medical records staff member testified that she was responsible for printing all letters and that she sent out about 500-700 letters each month.
- Pharmacy records: patient did not get his drops filled as prescribed (only 4 of 7 refills)

Noncompliance

- DEFENSE VERDICT AT TRIAL

Noncompliance

- A patient's failure to comply with appointments and treatment recommendations is a threat to the patient's safety and exposes you to liability.

Noncompliance

- Educate about disease and how to take medications. Document efforts.
- Document the follow-up interval in the record
- Schedule the next appointment <u>before</u> the patient leaves the office

Noncompliance

- Have staff alert you to missed appointments, and follow-up
  - Document call to the patient notifying him/her of missed appointment
  - Prepare and send missed appointment letter (retain a copy for your records)
  - Document notification to the referring physician

Noncompliance

MEDICATION ADHERENCE

- At follow-up visit, ask patient "Tell me how you are taking your medicine."
- If not instilling drops correctly, reeducate
- If not taking as prescribed, evaluate reason and target education to it
- Limit refill to follow-up period

Noncompliance

REFUSAL OF TREATMENT

- Patient has the right to accept or refuse all treatment
- Patient must understand the consequence of refusing care (informed refusal)
- Determine and document the reason
- At times, may want to terminate relationship

Noncompliance

- See “Noncompliance” for detailed follow-up instructions and sample letters
- http://www.omic.com/resources/risk_man/recommend.cfm#noncompliance

Questions & Answers