Medical documentation is a topic whose importance can never be emphasized enough. How to properly document is the subject of much debate and, in this paper, I will share insight based on almost 25 years in healthcare and nearly two decades in the field of Intraoperative Neuromonitoring (IONM), spanning roles from technologist and manager to clinical director and, eventually, business owner. Throughout my career, I have frequently – and understandably – been asked to describe and defend our medical documentation protocols.

The first step toward proper documentation of medical records is a firm understanding of both their initial purpose and, from there, the various ways in which they may be utilized in the future. However, in my current area of concentration, Intraoperative Neuromonitoring (IONM) is frequently performed by individuals with little to no formal training or education in medicine or patient care, where documentation is typically learned. As a result, many resort to employer-driven policies – procedures that attempt to encompass every possible scenario that may arise. There’s nothing inherently wrong with policies and procedures, of course; they are essential to create consistency. But policy alone will never tell you exactly what to do in every situation that may come to pass.

Also, consider the environment in which this is occurring. Instances of crisis and extreme stress are commonplace in operating room settings. And of course, it’s exactly at these confusing yet crucial moments when documentation becomes most critical, and when following protocol is likely to be forgotten or abandoned. For these reasons, a solid foundational understanding of the purpose and intent of medical documentation is essential.

Simply put, the primary goal of medical documentation is to capture, as accurately as possible, the patient’s medical issue(s), and the related course of care provided. This documentation needs to be available for many reasons.

First and foremost, documentation benefits the healthcare providers generating the documentation, allowing them to track a patient’s care and progress. Second, documentation should be able to be shared between healthcare providers, so that all medical staff participating in a patient’s care can, whenever necessary, refer to comprehensive information on medical history and care.

A third use of medical documentation is to perform quality assurance reviews, looking for ways to improve care. An example of this in IONM would be examining a procedure, or a series of same or similar procedures, to identify specific points in a surgery where changes typically occur; this information can then be used to alter the surgical approach for safety’s sake.

Then finally – and unfortunately most noteworthy – the role of medical documentation is as a reference point for care regimens in litigation. Medical records are an important tool in counteracting malpractice suits.

We live in a very litigious world, and medical malpractice lawsuits come with the territory, especially considering the high-risk surgeries in which IONM providers typically find themselves.
Considering this, there are a few factors to understand about medical malpractice lawsuits that can help establish the framework for documentation.

First, when a patient is injured during surgery, they will most likely name every person in the operating room as a defendant, including the surgeons, physician’s assistants, nurses, anesthesiologists, medical device representatives and IONM providers. When this happens, these individual providers will inevitably point fingers at each other in an attempt to absolve themselves of liability. No matter how strong a relationship you may have with a colleague in the OR, people forced to defend themselves tend to be markedly less loyal. Conversely, you may have no choice but to implicate one of your friends or clients to avoid undeserved blame yourself.

Second, the plaintiff will search every nook and cranny for signs that you did not do your job properly. In IONM, our responsibilities can be aptly described as three pillars.

1) We monitor neural structures at risk of injury due to the surgery being performed, using the appropriate modalities in the proper manners.

2) We report critical neural changes per the IONM data in a timely manner.

3) We interpret these neural changes to assist surgeons in identifying the cause(s) of the change(s) and determine the appropriate course of action.

Another key facet of medical practice lawsuits is that they are civil rather than criminal. In a criminal lawsuit, the plaintiff has the burden of proving the defendant “guilty beyond a reasonable doubt.” But in a civil lawsuit, the burden of the plaintiff has a much lower threshold, which is to demonstrate that “the preponderance of the credible evidence” is against you. This means that if 51% of the evidence points to guilty and 49% points to not guilty… you are guilty.

This is where documentation can really help, and lack thereof can really hurt. Per a popular medico-legal saying: “If you didn’t document it, it didn’t happen.”

Finally, if you find yourself involved in a malpractice lawsuit, it is likely to be many months or even years after the surgery. Memory will fade by then and, without thorough documentation to review, you’ll likely have great difficulty defending your actions.

Considering all this, allow me to offer some common-sense recommendations for medical documentation in the IONM sector:

1) Document all deviations from normal protocol and the reasons why. You don’t want the surgeon to be able to say that, for example, “TcMEPs were not performed because they weren’t offered to me…” when in fact they were recommended by you and declined by the surgeon.

2) From baseline to close, be sure your documentation demonstrates that the surgeon was fully aware of the status of the data at all times – whether it be good, bad or in-between.

3) When an important communication, such as a change in care course, is delivered to the surgeon or anyone else, document the response of the person to whom the communication was delivered. A common defense that a surgeon might use is to say, “They didn’t tell me anything. I had no idea that there were changes and, had I known, I
would have done X, Y and Z.” For example, “8:07am – Surgeon advised of a loss of the right lower extremity SEP. Surgeon responds, “OK, what do you think is wrong?”

4) Store ALL data. Be careful about resetting an SSEP trail without storing it, as this may appear as a gap in your data at a critical time. I also recommend storing all triggered EMG, including stimulations that produce no CMAP. If you do not do this, you may end up with little to no data to review during pedicle screw stimulation, or when hunting for neural structures during a tumor resection.

5) Exercise caution when documenting surgical steps. This suggestion is probably in stark contrast to most practice’s policies and procedures; however, it is better to document nothing than it is to guess. So, unless you are certain that what you are documenting is accurate, you may be building an argument for the surgeon, allowing him or her to say, “that’s not what I was doing at that time’, to establish your lack of knowledge or level of engagement in the surgery.

6) During times of crisis, it may be impossible or unreasonable to document contemporaneously and, in fact, your focus should be on patient care at those times, not on your keyboard. When this occurs, it is acceptable to thoroughly document the events that transpired at a later time, even if that means waiting until after the surgery is completed. Just be sure that your timelines are as accurate as possible, and you document the actual time your notes were logged. However, it is advisable to complete your documentation as soon after the event as possible, while your memory is still fresh. For example, “2:15pm – At approximately 11:45am, all SSEP and TcMEP responses significantly dropped in amplitude…”

7) It is also acceptable to add to your documentation, but NEVER delete or change a previously entered note – especially after learning that there has been a bad outcome or subsequent law suit.

In summary, the best way to insure good documentation is to continuously ask yourself the following question:

“Two or three years from now, if someone were to ask me details about today’s case, what do I need to be able to show?” The answer, of course, is as much – and as accurately - as possible.

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Gene Boucher, a founding partner of Accurate Neuromonitoring earned his Doctor of Chiropractic degree from Parker College of Chiropractic. Gene also completed a post-graduate fellowship in neurology from the Carrick Institute and was an active member of the Board of Directors of the American Board of Neurophysiologic Monitoring for nearly a decade.