Documentation of Assessment and Treatment of Suicidal Patients:

Best Practices and Common Pitfalls

Suicide Prevention Summit

Utah Department of Public Health

July 17, 2020

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Purposes of Documentation:

- 1. Communicates key clinical details/ideas to next caregiver
- 2. Verifies clinical activities/decisionmaking for insurers/licensing agencies
- 3. Preserves record for patient/researchers
- 4. Documentation of Decisionmaking In Case of QI Review or Litigation

Psychiatrists sued for malpractice: what they would have done differently

- **The #1 answer:**

- "Maintaining better documentation of their patient's chart"

- Megan Brooks, "Large Number of Psychiatrists Sued for Malpractice," Medscape Medical News, Jan. 28, 2020, p.2 https://www.medscape.com/viewarticle/924388#vp_2

DOCUMENTATION PRINCIPLES

- 1. You are writing for an audience
- 2. Not only “what” but “why”
- 3. Document as close to contemporaneously as possible
- 4. Facts, not conclusions; patient’s own words, not your descriptions
- 5. The signer owns the note.

Whether it’s true or fair

- Good records operate as a proxy for good care
- Shoddy, incomplete, inaccurate records raise inferences of careless practice

Gaddis v. United States, 7 F.Supp.2d 709 (D.S.C. 1997)

- The testimony and evidence in this case, especially the medical records, paint a dismal picture of neglect by the VA Hospital; especially during the last days leading up to Cauthen's death. There are only sparse records about the care, cleaning, and suctioning of Cauthen's trach tube. The sparse medical notes which are present during this time are often illegible. There are several shifts during those days for which no nursing notes are entered…

MOST COMMON PITFALLS

- 1. **PAPER DOCUMENTATION IS ILLEGIBLE OR**
- **EHR DOCUMENTATION IS "CUT AND PASTE"**
- "Dr. Moore testified that 'there are many records made in the medical records that are not fact.' He further described some of the records as "medical record notes that were cut and paste, whether they were done by an intern or medical assistant * * *." Cappuccilli v. Carcieri, 274 A.3d 722(R.I. 2017)

MOST COMMON PITFALLS (cont.)

- 2. **DOCUMENTATION IS FALSIFIED OR ERRONEOUS**
- A. Fifteen minute checks or bed checks

  Doe v. Hospital (Utah confid. Settlement 2011)(pt.dead for hours; nurses admit they just looked through window for bed check)

B. Later documentation recorded as though it was contemporaneous

MOST COMMON PITFALLS (cont.)

- 3. **DISCONNECT BETWEEN FACTS IN RECORDS AND TX PLAN/PROVIDER RESPONSE**
- "In a morning group session run by LT, … he reported that he had suicidal thoughts that morning and considered staying home and overdosing on medication. The medical record does not indicate that Ms. T took any action after Mr. C reported these suicidal thoughts with a plan of taking an overdose of medication that he had contemplated putting into effect that very morning. "
- D.C. v. Cimpeanu, No. 10-00830H (Mass. Super. Offer of Proof, 12/2011)

MOST COMMON PITFALLS:

- 4. **Missing or incomplete documentation, especially of key issues:** instructions to patient and family, inquiries about access to lethal means, informed consent about medication, competence to consent to treatment, med errors
- Lane v. Provo Rehab (nurse's falsification of records related to her medication error imputed to nursing facility)

And especially…

- Do NOT tamper with records
- *McNamara v. Honeyman* (Mass. 1989)(psychiatrist inserted a note in patient's record that she "had no intent for self-harm" *after* she was found hanging);
- *Moskovitz v Mt. Sinai Medical Center* (Ohio 1994)(after doctor destroys incriminating medical records, jury awards punitive damages of his entire net worth; judge reduces award by 2/3)

Best Practices: Facts, Not Conclusions

1. Conclusory characterizations: “Aggressive” “violent” “delusional” “psychotic”
2. INSTEAD: Factual descriptions:

   “Patient threw chair across room”

   “Patient said, ‘I talk to the FBI every day’”

   “Patient said, ‘There will be job openings around here’

Best Practices: Patient's Own Words, Not Your Summary

NOT: "No HI/SI/AH"

INSTEAD: "I could never do that to my parents."

NOT: "Patient floridly psychotic"

INSTEAD: "Pt approached this writer and said 'crickets in a cave doing drugs while listening to vinyl records.' Pt unable to elaborate.

Best Practices: Document Your Thought Process, Not Just Your Conclusion

- The best records reflect awareness of risk and the process of professional judgment that recognized it, took steps to reduce it, and balanced it with patient needs

Best Practices: Document ALL Contacts Related to the Patient As Soon as Possible

- 1.Calls from relatives, including your attempts to contact them, and answering machine messages
- 2. Calls from Other Treaters (see above)
- 3. Calls from Insurance (see above)
- 4. Obviously, *all* contacts with the patient
- Be sure and record the date and time of the contact

Be Sure to Include in Your Documentation:

- 1. Review of past available records
- 2. Consultation with Colleagues
- 3. Discharge coordination
- 4. Rationale for any medication changes, and follow-up after med changes
- 5. Suicide risk assessment
- 6. Access to Lethal Means and Mitigation
- 7. Safety Planning (NOT Contract for Safety)

Best Practices (cont.)

- Genuine affection and concern for the patient can be conveyed in medical records.
- Mahoney v. Allegheny College (one of the best examples of documentation I have ever read)
- By the same token, contempt, exasperation and negativity can also be conveyed in medical records.

Potential Solutions

- 1. CAMS Targeted Therapy for Suicidality: Involves sitting side by side with patient filling out Risk Assessment and Treatment Plan Forms
- 2. Work More Informally to Involve Patient in Contemporaneous Documentation
- 3. BDR-MOR form, prepared for ED documentation of suicidal patients being considered for discharge
- 4. CASE Approach, Shawn Christopher Shea

Be Aware that:

- 1. Attorneys will ask for relevant videotapes to be preserved
- 2. Attorneys will compare different providers' records on the same patient
- 3. Attorneys will seek "audit trails" of EHRs
- 4. Attorneys will seek emails and texts

How to decide and document close calls on involuntary detention

- Suicide: Impossible to predict, can only assess risk, involuntary detention disrupts and damages treatment relationship
- Recognizing, assessing, and documenting risk≠ involuntary detention
- Using research (trauma, epidemiology) to support decisions to avoid involuntary hospitalization
- Assistance in deciding and documenting: BDR-MOR (tool for ER discharge decisions)
- Do not rely on “contracts for safety”

QUESTIONS?