MEDICAL RECORD DOCUMENTATION:
THE GOOD. THE BAD. THE UGLY.

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Reasons for Litigation

- Fundamental Error
- Anger/Disappointment
- Surprise/Distrust
- “Truth-seeker”
  - What happened and why?

Duty of a Health Care Professional (CACI 501)

A [medical practitioner] is negligent if he/she fails to use the level of skill, knowledge, and care in diagnosis and treatment that other reasonably careful [medical practitioners] would use in same or similar circumstances. This level of skill, knowledge, and care is sometimes referred to as “the standard of care.”

Success Not Required (CACI 505)

- The healthcare professional is not necessarily negligent just because their efforts are unsuccessful, or they make an error that was reasonable under the circumstances.
  - The care need not be perfect
  - Was there appropriate judgment based on the circumstances

Alternative Methods of Care (CACI 506)

- A medical practitioner is not necessarily negligent just because they chose one medically accepted method of treatment or diagnosis, and it turns out that another medically accepted method would have been a better choice.

Why is the Medical Record Important?

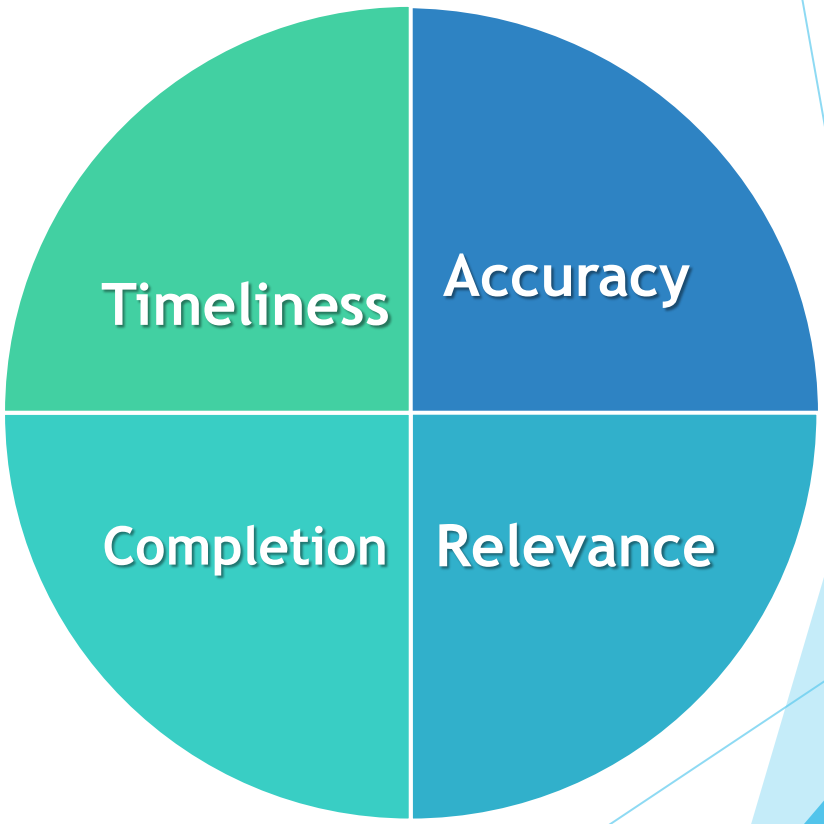
- Reflects Judgment and Plan
- Reflects Diagnostic Tests and Results
- Communicates Plan

Benefits of Documentation

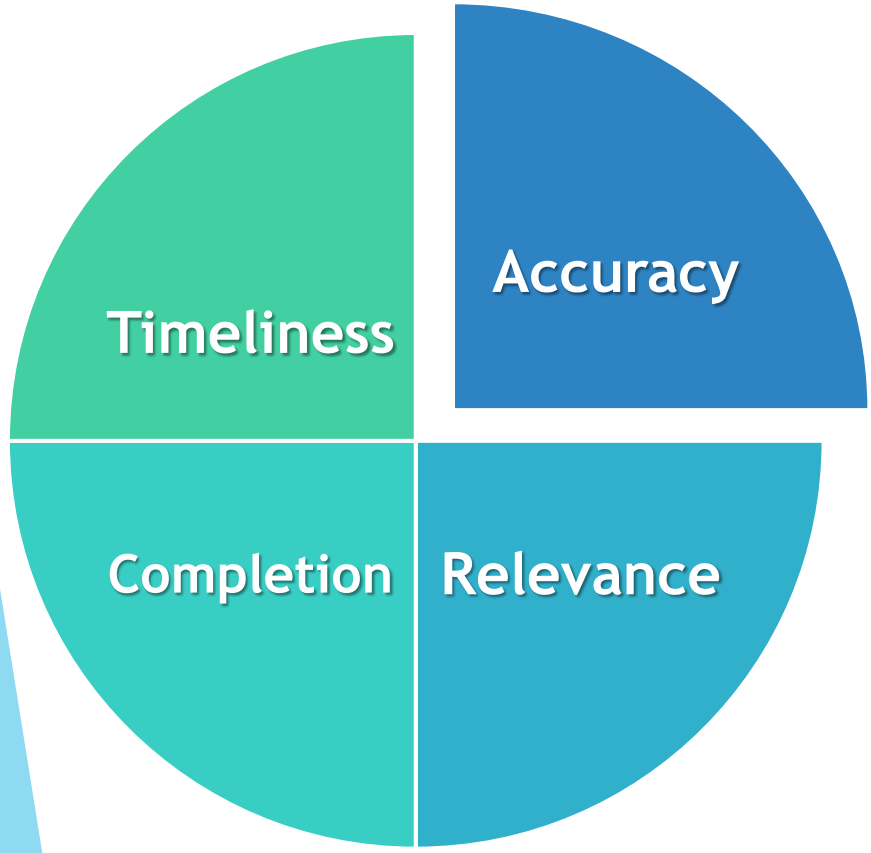
- Juries place great weight on what information is and is not included in the medical records.
- The patient's memory will fade but what is in the record does not.
  - The faintest ink is more powerful than the strongest memory.
- Documentation prevents the opposing expert from making unwarranted assumptions about care.

Documentation of Medical Records: Overview

Emphasis must be placed on the factors that improve the quality and usefulness of charted information.



Documentation of Medical Records: Accuracy



- Each individual medical record must be correct.
- Information in the medical record is relied upon for accuracy throughout the patient's lifetime
- Inaccuracies (either commission or omission) lead to improper medical advice being provided and may result in adverse healthcare outcomes.

Acute Physical Therapy
Initial Assessment

Recommendations:
Plan of Care Frequency/Duration: 1 time/day;4 times/week;1 week
Therapy Interventions: Bed mobility training;Balance training;Gait training;Home exercise program (HEP)/Caregiver training;Patient/caregiver education;PT mobility protocol;Refer to interdisciplinary plan of care for patient/Caregiver education;Stair Training;Therapeutic exercise;Transfer training

Recommendation for Discharge:
Home with Home Health

DME Recommendation: TBD

Interpretation of Findings/Assessment:
Functional Mobility Limitations: Bed mobility;Gait velocity;Gait with/without AD;Transfer
Impairments: Balance;Limited knowledge of;Muscle Strength;Pain;ROM

Rehab Potential: Good

Additional Comments:
Patient received up in chair, spouse present, drowsy and somnolent with difficulty keeping eyes open likely due to effects of pain medication. Initiated PT evaluation and educated pt on spine precautions and HEP/post-op TherEx (handout issued and reviewed); pt and spouse verbalized understanding. Patient requested to go back to bed due to increasing pain and drowiness and attempted to start moving while PT was setting up room and bed for functional mobility assessment. PT advised patient to remain seated until set up was complete and PT able to assist pt with transfer. During sit<>stand hemo vac drain got caught on chair's armrest and accidentally pulled out. Patient was transferred back to bed, positioned in long sitting and RN was called in room. RN arrived in room and initiated RRT. Patient moved to OR for further evaluation.

See below for full report.

Initial Evaluation Date: 2/3/2015
Date of Admission: 2/2/2015
MD Order: PT spine protocol **Date:** 2/2/15
Reason for Referral:
Activity Order: Ambulate with assistance **Date:** 2/2/15
Room: 8S32/8S32
Precautions/Limitations:
Spine
Fall
Ambulate with brace

History of present Illness/Medical course:

Pertinent Past Medical and Past Surgical History:

Past Medical History

Diagnosis	Date
• Cervical radiculopathy	
• Lumbar radiculopathy, chronic	
• Migraine	
• Allergy, unspecified not elsewhere classified	

Past Surgical History

Procedure	Laterality	Date
• Hx hernia repair inguinal		
• Hx shoulder surgery	Bilateral	
• Hx carpal tunnel release	Bilateral	

Social History
Type of Residence Admitted From: House
Prior Level of Function: Independent with ADL;Independent with mobility;Independent with driving;Independent with homemaking;Independent with transfers

Home Layout: Two level
Stairs into Home: 50
Stairs in the Home: 36
Lives with: Spouse / significant other
Baseline Cognition: Intact

Vitals/Summary
Respiratory Rate: 12
SpO2: 100 %
$Oxygen Start/Off: Continuous
O2 Flow Rate (l/min): >15
BP: 103/71 mmHg
Heart Rate: 78
Patient Position: Supine

Pain Assessment
Pain Assessment Type: Reassessment
Pain (Y or N): Yes
Scale Used: Behavioral scale (0-10)
Pain Rating: 6
Pain Type: Surgery
Pain Location: Neck
Pain Orientation: Posterior
Pain Quality: Aching
Pain Onset: On-going
Pain Duration: Continuous
Pain Intervention(s): Medication

Pain Assessment Behavioral Scale
Face (0-2): Muscles tension, frown, grimace
Restlessness (0-2): Occasional restlessness movement, shifting position
Muscle Tone*(0-2) (if SCI above level): Increased tone, flexion of fingers and toes
Vocalization* (0-2) (Cannot use with patients with airway): No abnormal
Consolability (0-2): Difficult to comfort by touch or talk
Behavioral Pain Score: 5

Multiple Pain Sites
Another Pain Site: No

Pain 2
Pain Rating 2: 4
Pain Type 2: Disease/Condition
Pain Location 2: Back
Pain Orientation 2: Lower
Pain Quality 2: Dull;Aching;Sharp
Pain Onset 2: On-going
Pain Duration 2: Continuous
Patient's Stated Pain Goal 2: no pain

Pain Intervention(s) 2: None
Another Pain Site: No

Functional Assessment
Scooting: Minimum assistance
Bridging: Minimum assistance

Sit to Sidelying : Min assist to left

Sit to Stand: Minimal assist
Stand to Sit: Minimal assist

Chair to Bed: Minimal assist

Neuro Assessment
Alertness: Intact
Orientation Level: Appropriate for developmental age
Vision: Intact
Hearing: Intact
Speech: Intact
Sensory: Intact
Coordination: Intact
Cognition: Intact
Tone: Intact

Balance
Balance
Sitting Static: Good
Sitting Dynamic: Good
Standing Static: Fair+
Standing Dynamic: Fair

Standardized Test:

Boston University AM-PAC™ "6 Clicks"
Basic Mobility Inpatient Short Form

Please check the box that reflects your (the patient's) best answer to each question. **How much difficulty does the patient currently have…**	**Unable = 1**	**A Lot = 2**	**A Little = 3**	**None = 4**
1. Turning over in bed (including adjusting bedclothes, sheets and blankets)?			3	
2. Sitting down on and standing up from a chair with arms (e.g., wheelchair, bedside commode, etc.)			3	
3. Moving from lying on back to sitting on the side of the bed?			3	
How much help from another person does the patient currently need…	**Total = 1**	**A Lot = 2**	**A Little = 3**	**None = 4**

Cesarean Section Procedure Note

Pre-operative Diagnosis: Repeat Cesarean

Procedure: Low Transverse Cesarean Section

Post-operative Diagnosis: Same

Surgeon:

Assistants:

Anesthesia: Spinal

Findings: Normal tubes and ovaries

Procedure Details:
The risks, benefits, complications, treatment options, and expected outcomes were discussed with Luiza Barreto. The patient agreed to surgical plan, giving informed consent. The patient was taken to operating room.

After induction of anesthesia, the patient was draped and prepped in the usual sterile manner. A foley catheter was in place. SCD stockings were placed. A time out was observed. A Pfannenstiel incision was made. This was carried down through the subcutaneous tissue to the fascia using bovie cautery. The fascial incision was made and extended transversely side to side. The fascia was separated from the underlying rectus tissue superiorly and inferiorly. The peritoneum was identified and entered. The peritoneal incision was extended longitudinally, care being taken to identify and avoid the bladder. The utero-vesical peritoneal reflection was incised transversely and the bladder flap was bluntly dissected away from the lower uterine segment. A low transverse uterine incision was made. The baby was delivered from vertex presentation. There was a nuchal cord. The umbilical cord was clamped and cut. The baby was handed to a member of the pediatric team. Cord blood was obtained. The placenta was removed intact and appeared normal. The uterus was exteriorized. The uterus, tubes and ovaries appeared normal. The uterus was massaged and noted to be firm. The cervix was dilated with ring forceps. The uterine incision was closed with running locked sutures of 0 Vicryl, then an imbricating layer of 0 Vicryl was placed. Figure of eight were used to obtain excellent hemostasis. The uterus was placed back into the abdominal cavity and the gutters were wiped with a lap sponge. The uterine incision was again inspected and noted to be hemostatic. The anterior peritoneum was closed with a running suture of 2-0 Vicryl and the rectus muscles were reapproximated with a running suture of 2-0 Vicryl. The fascia was closed with running sutures of 0 Vicryl. The subcutaneous layer was irrigated and then closed with 3-0 plain suture. The skin was closed with a running 4-0 Monocryl suture. Tincture of benzoine was used followed by steri strips.

All instrument, sponge, and needle counts were correct.
The patient and baby were begun on recovery in excellent condition

Estimated Blood Loss: 700 cc

Drains: Foley

Complications: None; patient tolerated the procedure well.

Attending Signature

I have examined and rounded on this patient with the Nursery Care Team. I have reviewed the physical exam, assessment and plan, and I agree with today's care plan as documented above. Baby's care and plan discussed with the family.

Briefly, this is a DOL#1 FT AGA infant born by repeat c-section. Infant noted to have left elbow swelling and tenderness. Also has limited movement of LUE though does sponataneously raise left arm and flexes elbow 90 degrees (active flexion). Minimal shoulder/upper arm movement against gravity when held prone. Grasp intact. Limited UE movement concerning for brachial plexus palsy. No identifiable risk factors (no shoulder dystocia). Left elbow swelling also not consistent with brachial plexus injury. Obtained clavicle and LUE xrays. Clavicles normal bilaterally. LUE films normal, though could not rule out elbow dislocation. However elbow flexione/extension appears to be intact so dislocation unlikely. Will reassess tomorrow. Will consider neuro consult for the brachial plexus injury and possible ortho involvement if the elbow remains swollen. PT consult today.
I/VI holosystolic murmur heard best at LSB, likely transitional. Will continue to monitor.
Otherwise infant is doing well. Breast feeding. Denies difficulty with latch. Voiding and stooling appropriately. No identifiable risk factors for sepsis. MBT O+ and BBT O+ coombs negative. TcB 5.1 at 12 HOL. HIR; will repeat at 1800. Will continue routine newborn care including newborn screening, congenital heart disease screening, hearing screen and jaundice screening.

Author:

ORTHOPAEDIC CENTER

March 26, 2016

RE: [redacted]
MR#:

NON-DR REFERRED FOLLOW-UP VISIT

DATE OF VISIT: 03/24/2016

HISTORY: [redacted] is now 6 months of age. I had seen him after his birth for a distal humeral physeal injury, which occurred during his delivery. It was most likely a transphyseal fracture. There was some posterior displacement of the distal fragment, but at that time, I made the judgment that simply treating it in a cast was most appropriate, given his newborn status. I thought it would remodel and that ultimately he would have a normal or near normal elbow. His parents come in today for a planned followup. They say he uses the arm fairly symmetrically with the right. He tends to use the right more, but his left seeing stronger than the right. On balance, it seems like he has essentially normal function of the left arm.

PAST MEDICAL HISTORY: Otherwise unremarkable. He is healthy.

MEDICATIONS: He takes no medications chronically.

ALLERGIES: He has no known drug allergies.

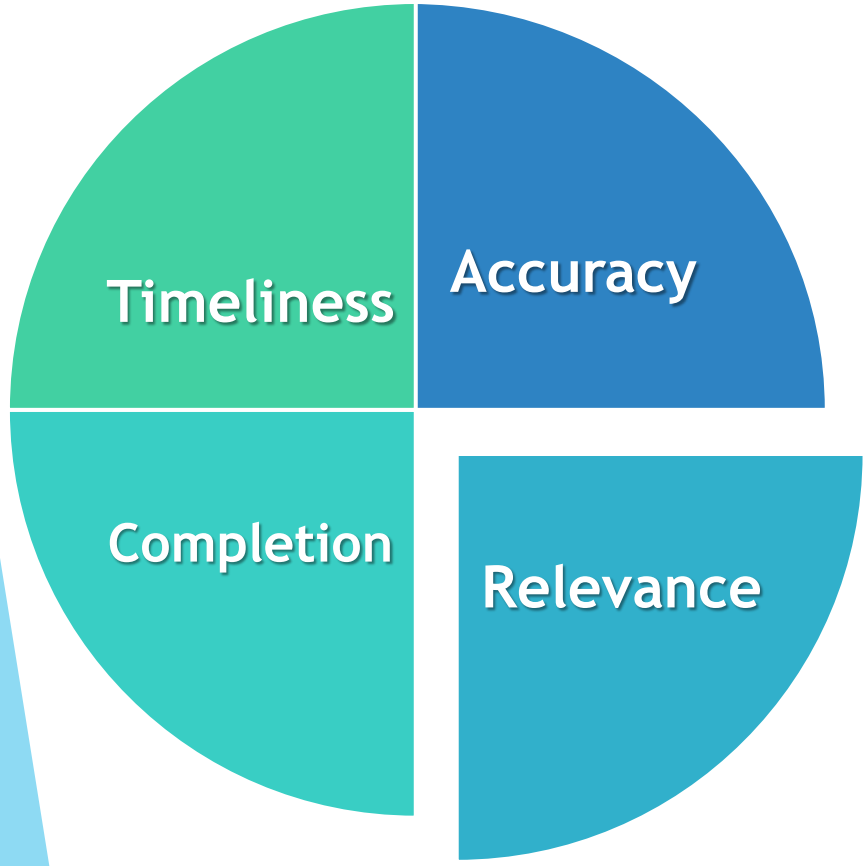
PAST SURGICAL HISTORY: He has had no surgery.

PHYSICAL EXAMINATION:
He has a range of motion of both elbows from 0-150 degrees of flexion. He has full pronation and supination of both forearms. His carrying angle is symmetrical on the 2 elbows. He has normal neurologic function distally in the left upper extremity.

IMAGING: We obtained x-rays today, which show marked improvement in the distal humeral anatomy. He has some spiky changes at the metaphysis of the distal humerus, anterior and posterior, but the ossification center of the capitellum appears to be in an appropriate location.

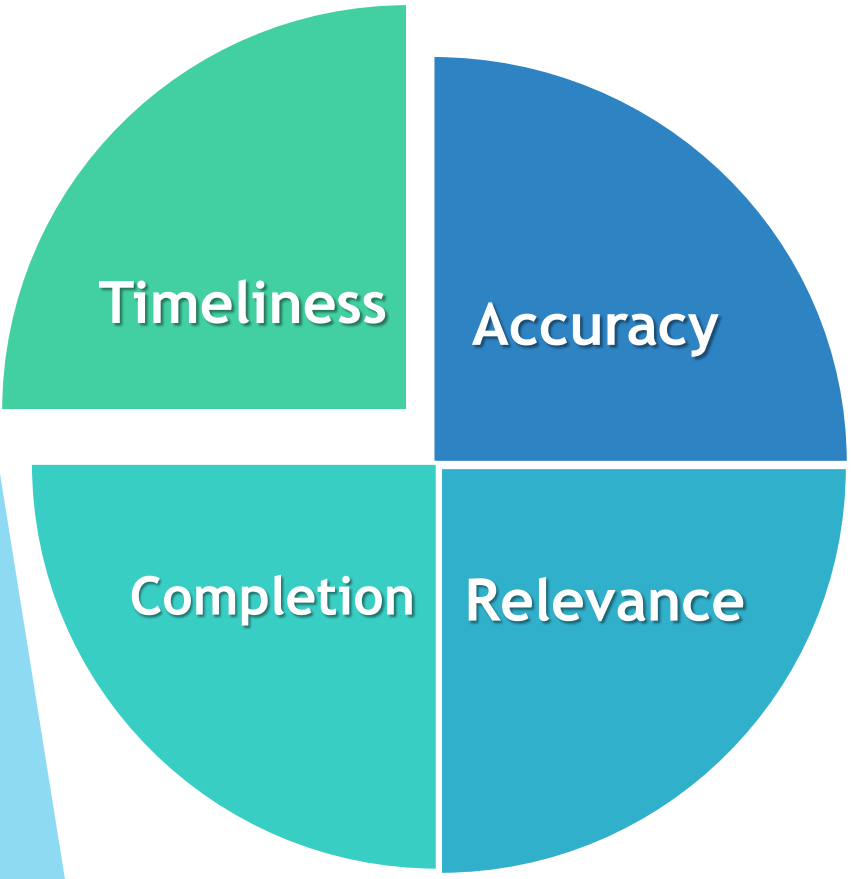
I suggested to his parents that they follow up with us when he is 2 years of age and we will get a new set of elbow x-rays at that time.

Documentation of Medical Records: Relevance



- The initial history should be as complete as possible
- Medical records contain only information relevant to the patient's healthcare
- Inclusion of inappropriate and irrelevant information results in potential action.

Documentation of Medical Records: Timeliness



- Entries should be contemporaneous to event
- Delays in documenting can give impression of delays in treatment
- No early entries
- Role of computers

	disconnect; urine yellow and clear; no vaginal or penile discharge.
Sleep/Rest assessment (nursing)	WDL
Sleep/Rest WDL	WDL = Appeared to sleep most of the night and/or patient states slept most of the night and feels rested.
Psychosocial assessment (nursing)	WDL
Psychosocial WDL	WDL = Affect, appearance, behavior and verbalization appropriate for situation; patient/significant other is involved in the plan of care.
Pain assessment (nursing)	Pain documentation
Has peripheral IV	Yes
Has central line	No
Drains/Tubes trigger	No
Fall risk screen trigger	Fall risk screen

Respiratory

Respiratory distress	None
Breath sounds grid	
Middle left - Fine crackles	
Middle right - Fine crackles	

Integumentary

Mucous membrane color	Pink
Mucous membrane description	Moist
Skin abnormality type 1	Other - scratch
Skin abnormality location 1	None

Pain Assessment Review

Location of pain 1	No pain
Intensity of pain 1	0

Peripheral IV

Peripheral IV care (grid)	
1. Peripheral IV site number	1
Peripheral IV 1 assess/care	WDL
Peripheral IV dressing type 1	Transparent semipermeable
IV dressing condition 1	Dry and intact

Fall Risk Screen

Fall Risk History	No (0)
Fall Risk secondary dxng	No (0)
Fall Risk iv/heparin lock	Yes (20)
Fall Risk mental status	Oriented to own ability (0)
Fall Risk ambulatory aid	None, bedrest, wheelchair, nurse (0)
Fall Risk gait transferring	Normal, bedrest, immobile (0)
Morse Scale calculation	20
Fall Risk morse scale score	No risk

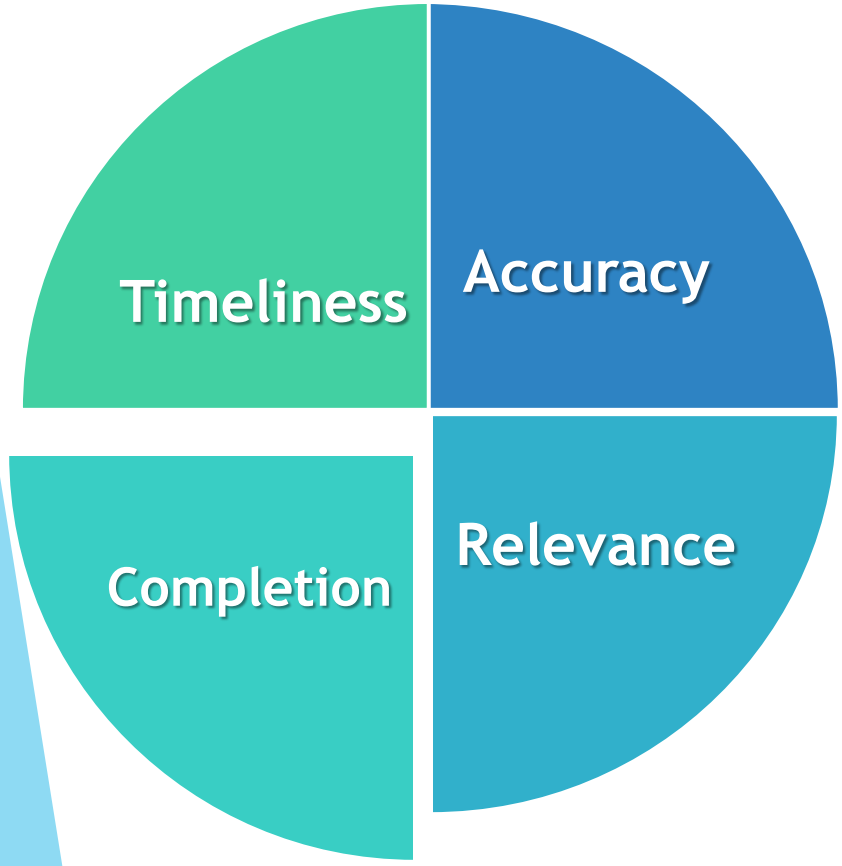
Assessment -
07/26/07 07:00 PDT Performed by
Entered on 07/26/07 15:51 PDT

Updated on
07/28/07 06:33 PDT by

System Review

Skin Color/Description Trigger	Skin color/description
Cardiovascular Assessment Trigger	Cardiovascular
Cardiac monitoring trigger	Cardiac monitoring
Respiratory Assessment Trigger	Respiratory
Oxygen delivery trigger	Oxygen delivery
Neurological Assessment Trigger	Neurological

Documentation of Medical Records: Completion



- Clear, concise, & consistent charting
- Importance of Narratives
  - Needed when there is change
  - Transfer to higher level
  - Physician contact

Use of Narratives in Charting

- Factual Information
- Objective
  - Minimize adverbs/adjectives
- “Take a photo”: What does the patient look like?/What is the response?
- Use cohesive thoughts
- Use proper grammar and spelling

Keys to Charting Narratives

Do…	
Be specific: • Document specific patient symptoms. • Make specific statements related to the patient.	Include justification for treatment
Discuss with patients/parents	Include follow-up activities
Document pertinent negatives	Include non-compliance for refusing treatment/procedure
Use acceptable terminology and abbreviations	Include codes
Read the notes of other professionals, respond to questions	Consults: include initial assessment, plan of care, follow-up results
Note when translators are utilized	Note teaching & instructions (understanding of)

Keys to Charting Narratives

Don't…	
Make generalized statements: "Patient reassured"	
Refer to patient relations	Include incident report made
Reference risk management	Comment on parents' or patient's attitude

The Role of Computers

How computers change the way we chart

What to Know About Computer Charting:

- Stock phrases are repeated
- Drop-down menus are used and narratives are forgotten
- When the chart is reproduced on paper, it does not look like the version on the computer screen
  - Printouts show: Time entry made; by whom; when accessed and identifies when changes were made
- Everything is discoverable
  - No “back screens”
  - No private notes

Key Points Regarding Computer Charting

- Use Narratives!
  - Minimize use of templates or drop-down menu entries
  - Avoid boilerplate charting
- Auto text does not account for grammar and syntax
  - “Hospital Day 1: ‘The patient complains that The patient has been transferred here from Hospital X at her request.’”
- Avoid Cutting and Pasting
  - May create the impression that care is mechanical, routine and impersonal

The Downfall of Copy/Paste

- May create the impression that care is mechanical, routine and impersonal
  - Problem lists never change, despite the availability of new diagnoses or priorities
  - Daily progress notes become progressively longer
  - Notes and errors accumulate, misinformation is carried forward
- Notes become recombinant versions of previous notes
  - Patient who have been hospitalized for weeks can be on Day 4
  - Last month's labs take up permanent residence in the daily results
  - A consultant copies the notes from the requesting physician and requests a consult (from himself)
  - One time seizure turns into a seizure disorder

Copy/Paste in Action

Progress Notes signed by [redacted] MD at 10/25/2012 1:29 PM

Author: [redacted] MD | Service: (none) | Author Type: Physician
Filed: 10/25/2012 1:29 PM | Encounter Date: 10/25/2012 | Status: Signed
Editor: [redacted])

Subjective:

History of Present Illness: [redacted] is a 75 year old female who had a chief complaint of Follow-up. .

HPI

History of Present Illness
Doing better - BP higher now. No SOB. Anemia stable - await labs from Dr
BS at home are still mildly elevated- awaits trip to holy land

Doing well
Awaits travels to Israel and a cruise in Novem ber

[redacted]ecent admission for SOB and severe bradycardia related to a combo of b blocker, amio and
[redacted]his

Progress Notes signed by [redacted], MD at 10/10/2013 11:44 AM

Author: [redacted], MD | Service: Cardiology | Author Type: Physician
Filed: 10/10/2013 11:44 AM | Encounter Date: 10/10/2013 | Status: Signed
Editor: [redacted] (Physician)

Subjective:

History of Present Illness: [redacted] is a 76 year old female who had a chief complaint of Shortness of Breath. .

Shortness of Breath

History of Present Illness
Doing better - BP better .
Feels a little more SOB - changed back to bumex with resolution of edema

Anemia stable - await labs from Dr [redacted]
BS at home are still mildly elevated- awaits trip to holy land

Doing well
Awaits travels to Israel and a cruise in Novem ber

Progress Notes signed by [redacted] MD at 2/13/2014 11:58 AM

Author: [redacted], MD | Service: Cardiology | Author Type: Physician
Filed: 2/13/2014 11:58 AM | Encounter Date: 2/13/2014 | Status: Signed
Editor: [redacted] (Physician)

Subjective:

History of Present Illness: is a 76 year old female who had a chief complaint of Shortness of Breath. .

Shortness of Breath

History of Present Illness
Doing better - BP better
No recurrent SOB
No recent stress test
Also has leg cramps at night and has to walk it off
No obvious distinction between legs . - R leg perfusion much worse than left - patent graft and left pedal pulse

Anemia stable - await labs from Dr
BS at home are still mildly elevated- awaits trip to holy land

Doing well
Awaits travels to Israel and a cruise in Novem ber

recent admission for SOB and severe bradycardia related to a combo of b blocker, amio and cardizem

History of Present Illness: P~ ns is a 77 year old female who had a chief complaint of Chest Pain. .

Chest Pain
Associated symptoms include shortness of breath.
Shortness of Breath
Associated symptoms include chest pain.

History of Present Illness
Doing better - BP better
Recent fall - seen in ER for chest pain - started on Naproxen and now here for further eval
No recurrent SOB
Recent admission with severe pre renal azotemia
Some neck pains
Almost back to normal

No recent stress test
Also has leg cramps at night and has to walk it off
No obvious distinction between legs . - R leg perfusion much worse than left - patent graft and left pedal pulse

Anemia stable - await labs from Dr
BS at home are still mildly elevated- awaits trip to holy land

Doing well
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recent admission for SOB and severe bradycardia related to a combo of b blocker, amio and cardizem

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Doing well
Awaits travels to Israel and a cruise in Novem ber

recent admission for SOB and severe bradycardia related to a com bo of b blocker, amio and cardizem

MD at 4/30/2015 2:28 PM

Author: [redacted] MD | Service: Cardiology Interventional | Author Type: Physician
Filed: 4/30/2015 2:28 PM | Encounter Date: 4/30/2015 | Status: Signed
Editor: [redacted] D (Physician)

Subjective:

History of Present Illness: 78 year old female who had concerns including Wrist Pain. .

Wrist Pain
Associated symptoms include chest pain.
Shortness of Breath
Associated symptoms include chest pain.
Foot Pain
Associated symptoms include chest pain.
Chest Pain
Associated symptoms include shortness of breath.

History of Present Illness
Doing better - BP better - but high a few days ago
BS occasionally high
Significant foot pain last week - now with R wrist pain and shoulder pain

Recent admission with SOB - ? CHF with pneumonia
Doing well
Still SOB with loss of endurance - no Chest pain or leg pains - sleeping well
Appetite is good

Recent fall - seen in ER for chest pain - started on Naproxen and now here for further eval
No recurrent SOB
Recent admission with severe pre renal azotemia
Some neck pains
Almost back to normal

No recent stress test
Also has leg cramps at night and has to walk it off
No obvious distinction between legs . - R leg perfusion much worse than left - patent graft and left pedal pulse

Anemia stable - await labs from
BS at home are still mildly elevated- awaits trip to holy land

Doing well
Awaits travels to Israel and a cruise in Novem ber

Final Thoughts on Computer Charting

- Know the System
  - Audit logs can identify everyone who has looked at a patient's record.
  - Metadata includes information about when a record was created or edited, by whom, and how many versions were created.
- Medical record is all the remains after a healthcare memory fades away.
- Drop down menus and narratives
  - Do the pre-determined selections fit?
- Don't get tied to the computer

Communication

For the Healthcare Provider

Communication

- Begins at the door
  - Knock
  - Introduce yourself/your role
  - Why are you there?
- White Boards
- Active Listening

Active Listening

- **Active Listening** (verb): when one not only hears what someone else is saying, but also attune to others' thoughts and feelings. *Harvard Business Review.*
- Three aspects of active listening
  - **Cognitive:** Paying attention to all the information, both implicit and explicit.
  - **Emotional:** Staying calm and compassionate during the conversation, including managing emotional reactions (annoyance, boredom) that you might experience.
  - **Behavioral:** Conveying interest and comprehension verbally and non-verbally.

How to Actively Listen

- **Be empathetic.**
  - What might the other person need from your conversation? Emotional support, information, or something else?
- **Be vulnerable.**
  - Emotional discomfort or being worried about how we might seem can get in the way of connection. Leave more space to hear what the other person is actually saying.
- **Ask open-ended questions to make others feel heard.**
  - Identify barriers to knowledge.
  - Avoid medical jargon.
- **Be present.**
  - Eye contact, attentive posture, nodding, and other non-verbal cues are important.
  - If you find yourself mentally multitasking, bring your attention back.
  - Don’t mentally rehearse your responses, as it will distract you from being active in the conversation. You can take time to form your thoughts after fully hearing what they have to say.

Building Rapport

- Try to build a partnership
  - You have the same goal: help the patient get better.
  - Treat their concerns as important (empathy)
  - Explain why you prioritize certain concerns over others (vulnerability)
  - Do not imply their opinions are baseless (empathy)
- Cross-cultural differences
- Time expectations
- Negotiate?
  - Try not to show frustration/irritation/intolerance
  - Have patients write down questions/issues

Charting on Difficult Patients

- What is the problem?
- Objective – Material Facts
  - Cause if known
- Plan regarding care of patient
- Action Taken
- If assistance offered

Disclosing Medical Errors

Preparation	• Who will be responsible for the lead in the meeting. • Must include the senior leadership. • Deal with issues of guilt, blame shifting etc.
When	As soon as there is some information available through the investigation.
Where	Set a time with the patient in advance, other family members may want to be present.
How	Admit there was an error and indicate that you will provide what information you can.

Medical Errors

- What happened and why
  - Provide a description in simple language and factual account
- Apology
  - Health and Safety Code Section 104340
- Next Steps
  - Care Planning
  - Further Disclosure?
- Avoid abandonment
- Documenting the medical record

Other Issues

- What encompasses a medical record?
  - Faxes
  - Texts
  - Emails

The Bad

At around 1830, I was in the patient's room to spike a new IV bag. As I was disconnecting the tubing from her IV, dad walked into the patient's room. When he walked in, I turned around to greet him. As I turned around to greet him, patient saw her father and attempted to sit up. As she was attempting to sit up, lost her balance and fell back onto the padded crib side rail. Father got extremely angry and began to yell at me because she fell back. Dad yelled "you're her f****** nurse my &*(^$, you should've caught her before she fell. Y'all are supposed to be number 1". He proceeded to ask to speak to a higher up. I asked him if he would like to speak to our charge nurse and what issue he had. He agreed and asked to see our charge nurse1

(cont.)

He replied, "Yes my *&^$$%, I'll catch you outside". Dad began to exhibit aggressive behaviors such as approaching the crib while raising his voice and using foul language. I did not feel safe in the room and felt threatened by dad due to him repeating "I'll catch you outside".

I stepped out of the room, notified charge nurse and social work was called. I spoke to social work about what occurred, and she went into the room to speak to family/dad. Social work notified dad that we do not have a tolerance for foul language at the hospital and that he would have to leave the hospital for 24 hours if an event like this occurred once again.

The Good

Patient with nurse communication order for "do not disturb from 10pm to 6am". During my role as Charge RN, made aware of situation that occurred when RCP was at bedside around 2100. Per RCP , mother "kicked him out of room". RT department Supervisor called me to discuss situation and about not being comfortable with not being able to perform vent checks during the night. House Supervisor made aware, who also agreed that this was a safety issue. 5W Manager made aware of situation. Plan made to discuss need to perform checks with mother. Reached out to RT Charge regarding situation. By this time, it was 2300 and mother was asleep, therefore, agreed that RCP would perform quick vent check at 0000 and if mother had any issues, we would address concerns at that time and call if necessary. Updated House Supervisor as well as 5W Manager. As of 0600, no other issues overnight. Leadership team to follow up regarding this matter.

The Ugly

At approximately 1200, I went into patient's room, accompanied by Supervisor , RCP also present in room. Informed mom no changes in assignment to be made. RN will continue to be _____’s nurse. Explained to mom that any transfers out of bed will be done with assistance of staff that have been trained in traction. Mom then said, "If anything happens to _____, you just wait". I asked her to clarify what she meant by her statement. Again, mother stated "If anything happens to _____, if he gets hurt, you just wait." She then repeated several times, "Dad is on his way here right now, and we're gonna take care of it." I told mom that I'm not sure what she means, but that to me it sounds like she is making a threat. Mom said it was not a threat, that when dad arrives, they will talk with Ortho.

I reiterated that RN and all staff members coming in must be able to provide care in a safe, hostile free environment. It is all of our priority to provide safe care.

Inappropriate Chart Entries

- Patient stated if she would lie down, within 2 or 3 minutes something would come across her abdomen and knock her up.
- Patient has chest pain if she lies on her left side for over a year.
- On the 2nd day the knee was better and on the 3rd day it disappeared.
- The patient has been depressed ever since she began seeing me in 1993.
- Healthy-appearing decrepit 69-year-old male, mentally alert but forgetful.
- She stated that she had been constipated for most of her life, until she got a divorce.
- Father died in his 90's of female trouble in his prostate and kidneys.
- She has no rigors or shaking chills, but her husband states she was very hot in bed last night.
- Non-verbal, non-communicative, and offers no complaints.
- Discharge status: alive but without permission.

ALLERGIES: No known allergies.

DATE OF ADMISSION:

HISTORY OF PRESENT ILLNESS:
The patient came to the Emergency Room with fever of 102 times day one. He vomited this day five times. He was having very poor appetite and also he was progressively lethargic on this day.

This is a 13-year-old White male who is known as carnitine deficiency cardiomyopathy actually since he was three months old; right now he is 13 years old.

In the last three months, the patient was coming to the office once in a while, almost like every two to three weeks, because of poor appetite, losing weight, upper respiratory syndrome, but not specifically with any bacterial infection. Patient had CBC and chemistry panel done, urinalysis, and all those labs in the office were normal. The last time he was seen was probably two or three days before Christmas when he was definitely very lethargic and right away he was sent to Dr. office who was his cardiologist since he was born. At that point, x-ray was done and also echocardiogram which showed significantly enlarged heart. Patient was advised for bed rest by Dr. and he will be seen by him every week. We also authorized transfer to Hospital for heart transplant. That was one week ago. It was just before Christmas.

Regarding the history this time, patient claimed on New Year's Eve, on December 31, he was vomiting, he was lethargic, he didn't want to eat, but mother thought that this was only the same situation like all the time before. Then he was just laying down in the bed, but on January 1 he got fever and at this time, mother called the pediatrician, Dr. , who advised patient to go to the nearest Emergency Room and for possible transfer to Intensive Care Unit in other hospital, especially . Mother went to Hospital Emergency Room where x-ray was done and Tylenol was given. CBC and chemistry was done and blood gases, which were almost within normal limits. Also chest X-ray was read as normal, which did not mention big cardiomegaly or anything like that.

was called from the Emergency Room because she was on call for Dr. and patient was admitted to pediatric floor with almost no orders, only with IV to be open and bed rest. After that,

- “I was not advised about (patient) admission until the morning of January 2. I came to see him before I came to the office, and definitely I did not like that the patient was on the pediatric floor and wanted to arrange for the patient to be sent to at least the Intensive Care Unit in our hospital. Also, around 11:00 after I knew that probably the transport team from __ would take a little while, and after talking to the doctor over there, I decided to transport the patient to our Intensive Care Unit, but the patient coded on the pediatric floor at 1:00 while still not transferred there to Intensive Care Unit. CPR was given and adult advanced cardiac life support with measures given for more than one-and-a-half hours. After that the patient was pronounced dead at 14:41.”

DATE	HOUR	Progress notes should include date and time of examination, state of positive findings noted previously, new signs or symptoms, complications, changes of impression or diagnosis, record and results of treatment given, and the signature of the physician making observations.

Addendum

during my telephone conversation on with ER physician Dr — I advised her to call Dr — the patient's Cardiologist before admitting the patient to let Dr know the patient condition and to know what is his plan of admission, and I also asked her to please keep me informed with Dr plan. Later on I was called from peds ward to notify me that patient was admitted to ped by — (pediatric Nurse).

DATE: 8/24/98

TIME	PROBLEM #	NOTE	NURSE SIGNATURE
1800	(A)	[illegible] yo [illegible] male received from	
		PR awake but groggy. Irrigated on [illegible]	
		[illegible] 3-way foley CBI c light	
		pink urine [illegible] no [illegible]. Pt denies	
		B/P 112/59 69-18. [illegible]	
1700		[illegible]. CBI cont @ mid [illegible]	
		urine [illegible] light pink c clots [illegible]	
1915	(A)	Urine; Slow continuous CBI c clear	
		and red urine no clots. ⊖ urinary	
		output. Leaking around catheter [illegible]	
2030	(A)	Continues CBI at slow rate c no	
		very little urine output. [illegible]	
2100	(A)	Dr Bakshandeh notified about decrease	
		urinary output, attempted to hand	
		irrigate - ⊖ fluid return. Hooked	
		back to continuous irrigation. [illegible]	
2115	(A)	Dr. Bakshandeh again notified of	
		urinary output [illegible]	
2215	(A)	MD here. Explained that we have	
		a slow urinary output from surgery.	
		MD says "catheter is okay. [illegible]	
		here [illegible]" [illegible]	
		[illegible] since surgery. MD	
		states "it is okay. I had this problem	
		in surgery. I have been doing this for	
		[illegible] and I know what I'm doing!	
		The catheter is draining fine." [illegible]	
		8-25-98	
2400	(A)	CBI turned to very very slow gtt. Appears	
		[illegible] in bed [illegible] awake. [illegible]	
03	(A)	Spasming. Scant amount of urine	
		in [illegible]. Bed linens changed	
		[illegible] CBI continues. Med	
		[illegible] spasms. Side rails [illegible]	
		[illegible] position. [illegible]	

[redacted]

24 HOUR PATIENT CARE RECORD
NURSE'S NOTES

DATE/TIME	
2000	T. Bili [illegible] Baby appears to be feeding a little better [illegible] continues to be [illegible] Parents concerned re: irritability
2000	T. Bili 15.5 Reported to parents. Parents called Dr. [illegible] re: irritability. Dr. also called. No new orders given. Woman's patient on scalp. Skin looks good. Continues to have good output. Parents @ bedside.

5-1-01

CHECK EVERY /15 MIN / TWO HOURS /

CODES

TYPE: B = BEHAVIOR; T = TREATMENT; S = SUPPORTIVE

DESCRIPTION: LWR = LOCKED WAIST RESTRAINT; 2P = 2 POINT; 4P = 4 POINT

LEVEL OF CONSCIOUSNESS: A = ALERT; D = DROWSY; C = CONFUSED

CIRCULATION: N = NORMAL IN ALL EXTREMITIES

MPR OBSERVATIONS

TIME	TYPE	DESCRIPTION	LEVEL OF CONSCIOUSNESS	CIRCULATION	ROM/EXERCISE	[illegible]	BATHROOM	FLUIDS	BP P R	FOOD/CHECK SAFETY	INITIAL
:15	S	W	A	N							[illegible]
:30	S	W	A	N							[illegible]
:45	B	W	A	N							[illegible]
9:00	B	W	A	N							VC
:15	B	W	A	N							VC
:30	B	W	A	N							VC
:45	B	W	A	N							VC
9:00	B	W	A	N							VC
:15	B	W	A	N							VC
:30	B	W	A	N							VC
:45	B	W	A	N							VC
10:00	B	W	A	N							VC
:15	B	W	A	N							VC
:30	B	W	A	N							VC
:45	B	W	A	N							VC
11:00	B	W	A	N							VC
:15	B	W	A	N							VC
:30	B	W	A	N							VC
:45											
12											
:15											
:30											
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:30											
:45											
11:00											
:15											
:30											
:45											
14:00											

TIME	OBSERVATIONS	INITIAL
[illegible]	in chair ē posey, [illegible]	El
1000	[illegible] at [illegible] group. [illegible]	KC
1100	transported to [illegible] Dale ē belongings	El

PATIENT NAME | SIGNATURE/TITLE | INITIAL | DATE

ADDRESSOGRAPH

TIME	NURSES NOTES
24	VS stable, accepted and retained
	voiding, Breastfeeding well with parents.
04	No acute distress noted.
06	No change in assessment.
	[illegible] [illegible] c/o [illegible] watery stool,
	stool looks [illegible] and watery. [illegible]
	given, notified Dr — Dr
	states its normal. OK to give [illegible]
08	VS assessment [illegible] NB care [illegible]
	[illegible] [illegible]
1000	[illegible] Discharge teaching given [illegible]
	[illegible], [illegible] verbalized [illegible] good understanding of
	instructions given and demonstrated good skills in
	self care + NB care.
	Stable — left hospital [illegible] via W/C accompanied
	by [illegible] and father.
date 1030	Called to [illegible] baby crying + checked baby + [illegible]
	[illegible] (Rt) foot toes with blisters, [illegible] applied [illegible]
[redacted]	[illegible] [illegible] ice pack applied to (Rt) foot. Dr
	notified
1100	Dr came and examined NB and ordered silvadene
	cream
1130	Silvadene cream applied to blistered toes [illegible] dsg.
	baby was breastfed, [illegible] [illegible] Dr
13.00	Asleep in open crib [illegible] [illegible] with silvadene on
13.30	Examined by Dr. drsg changed [illegible] silvadene applied
	and shown to parents how to applied dressing
16.45	Discharge home with parents [illegible] med. & drsg supplies
	Cond. stable.

Conclusion

The Good	The Bad	The Ugly

Thank you.

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