

# Critical Aspects of Emergency Department Documentation and Communication

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## KEYWORDS

- Documentation • Hand-off • Change of shift
- Discharge instructions • Follow-up
- Emergency department

The working environment of an emergency department (ED) is a unique, complex, and dynamic environment. This is reflected in the varying, often overwhelming volume of patients seen in busy emergency departments, as well as the range of acuity of clinical encounters.<sup>1</sup> In addition, an ED is an example of a multifaceted organization composed of complex social environments, where interruptions are frequent and disruptive.<sup>2-5</sup> Such busy environments, where decisions are made under time pressure and with incomplete information, have been considered conducive to error<sup>6</sup> and claims of malpractice.<sup>7</sup> Studies such as the Harvard Medical Practice Study reported that approximately 1.5% to 3.0% of observed adverse events occurred in emergency departments.<sup>8</sup> Most importantly, these studies found that emergency departments had the highest proportion of preventable errors.

Amidst the apparent chaos, documentation often suffers.<sup>9</sup> The ED chart serves as the sole means for the emergency provider to note the details of the care provided to the patient during a visit. Aside from provider and patient memory, it is the only lasting record of the ED visit. Thorough documentation by the physician certainly facilitates accurate billing. More importantly, it can inform primary or future health care providers about the ED evaluation and treatment, as well as protect the ED physician in the event of bad outcomes and litigation.

Every aspect of the ED providers' interactions with their patients and their subsequent documentation and communication is a potential medico-legal risk. The

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management of critically ill patients will often be scrutinized after the fact, especially if there are poor outcomes. Documentation of the initial condition of the patient, timely and thorough examination and evaluation,<sup>10</sup> prompt resuscitation, and timing of specialty consults can be of special importance in cases of major trauma,<sup>11</sup> stroke, myocardial infarction,<sup>12-15</sup> and other emergent conditions. Excellent documentation may protect a physician from liability during a malpractice suit, whereas poor documentation, although not clearly tied to worse outcomes,<sup>16-20</sup> often leads to the commonly argued assertion, "if it wasn't documented, then it wasn't done," which only supports a plaintiff's case against a provider.

Aside from emergent conditions, there are a number of high-risk diagnoses that require careful documentation because of the potential for litigation resulting from missed diagnoses or bad outcomes. Some examples include pediatric fever, asthma, abdominal pain, hand injuries, intoxication, domestic violence, child abuse, and suicidal ideation. One can imagine the scrutiny that occurs after a case of missed appendicitis, a presumed intoxication that is actually an intracranial bleed, or a psychiatric patient who commits suicide after having been discharged from the ED. Proper documentation of a careful history, physical examination, and the physician's thought process regarding worst-case scenario diagnoses may help protect the provider to some degree.

Another aspect of documentation is the important concept of patient reassessment. Many charts now contain a check-box next to the statement "Patient improved." However, this broad statement is not nearly as powerful as having recorded serial sets of vital signs, pain assessments, and focused reexaminations of the patient. Timed reassessment notes are especially important for patients who are discharged from the ED after a prolonged stay, as physicians need to document improvement and appropriateness for discharge. Pediatrics is particularly high stakes because providers often must rely on general appearance and vital signs as opposed to subjective descriptions of improvement in young children.

Documentation that is inconsistent with actions taken in the ED can also put the provider at increased medico-legal risk. For example, a triage complaint of chest pain that is not addressed by the physician owing to later denial of chest pain should be explained in the physician note with at least an acknowledgment of the discrepancy. In teaching institutions, inconsistencies may also occur between a resident and attending diagnosis. A resident documenting an impression of "stroke" while the attending physician's impression is "atypical migraine" requires an explanation of the attending's thought process. Lack of consistency in documentation may invite scrutiny later on.

Other important areas of ED documentation include procedure notes (eg, neurovascular status before and after a closed reduction of a fracture), event notes (eg, a fall while in the ED), adverse reactions to medications, determinations of capacity, refusal of medical care, notes detailing safety for discharge, various discussions with patients, and details pertaining to the physician thought process. Concise notes documenting these key issues are good medical practice, and they may help to limit a physician's potential liability.

Although documentation is obviously quite important, the ED provider's primary goal is providing timely, compassionate, and excellent quality care to all patients. Oftentimes this occurs in the setting of severe crowding, boarding of admitted patients, and continuously arriving sick patients. This dualism, providing the safest and highest quality care with the constant potential for medico-legal risk, is a complex dynamic. This is the issue that we address in this article. After starting with a discussion of the various types of ED documentation currently in use, we highlight the important

documentation aspects of two critical transitions in the ED—patient hand-offs and discharges.

## TYPES OF ED CHARTS

Several types of ED charts have been developed over time, including free-text charts, preformatted generic charts, preformatted complaint-specific charts, and dictated and transcribed charts. Each chart type exists in paper and electronic forms, and each is associated with several advantages and disadvantages.

The oldest form of documentation is the free-text paper chart. Traditionally, it is simply a blank space to allow the physician to document the entire note, from chief complaint all the way to final disposition. The main advantage of the free-text paper chart is the ability of the provider to tailor the note to a specific problem area, using the space as needed. For example, the bulk of the space may be used to describe a detailed examination of the hand in evaluating a penetrating hand injury. Disadvantages include a longer time needed to complete a free-text chart, potential illegibility, and potential omission of important parts of the history or physical examination because of the lack of prompts available in other chart types.

With paper versions of the free-text chart, an advantage is the ability to edit or complete a note later on. Generally, time-stamps preclude this with electronic charting. Time-stamps and this editing ability can both be seen as a medico-legal advantage (eg, completing documentation after the fact of an examination actually performed earlier) or disadvantage (eg, retrospectively editing a chart after a bad outcome). Electronic records have the advantage of being accessible from any networked computer, whereas paper charts may be inaccessible (eg, with the patient at CT scan) or missing from time to time. However, access to electronic records is subject to inadequate numbers of computer terminals, network outages, and software glitches whereas paper records are not.

More recently, preformatted generic charts were introduced to improve physician documentation. For example, if a dedicated space was labeled for vital signs, a provider may be more likely to record the vital signs. A 2001 study<sup>21</sup> concluded that overall ED physician documentation was improved with the use of a structured, preformatted chart. Improved documentation is certainly a billing and medico-legal advantage, because of prompting for key elements of the encounter such as vital signs, descriptors of the history of present illness, important components of the examination, pertinent negatives, pain-scale documentation, and reassessment notes, to name a few. Another advantage is that these charts require less time to complete because of the use of labels and check-boxes. The main disadvantage of this chart type is the ambiguity associated with some of the wording; for example, phrases such as “motor WNL” may be listed under the neurologic examination. The exact meaning of this phrase is open to interpretation when the box next to it is checked off.

Disadvantages of paper versions of the preformatted generic chart include potential space constraints. For example, a provider may not have enough space to elaborate on a specific examination element that is critical to the case (eg, a detailed hand examination). In addition, many charts do not leave room to detail serial examinations and reassessments, patient improvement or deterioration, physician thought process, and modification of initial differential and treatment plan based on new information or change in patient condition. These elements of the provider note may be very helpful in the event of bad outcomes. Electronic versions may allow easier customization as to the use of space compared with paper versions. Previously discussed time-stamp and editing issues are still applicable here.

Preformatted complaint-specific charts provide further ability to customize a provider's documentation. For example, very different items need to be documented for a chest pain encounter, as opposed to an ankle injury visit. Complaint-specific charts typically list key elements to check off as positive or negative and often remind the physician to document why the patient is unlikely to have worst-case scenario diagnoses (eg, "no evidence of swelling or redness to the neck" for a toothache/facial pain encounter). A 1992 prospective study by Humphreys and colleagues<sup>22</sup> compared preformatted charts to blank charts in evaluating gynecologic complaints in the ED and concluded that documentation of the history, examination, and laboratory tests was significantly more complete on programmed charts (although outcome and patient satisfaction were not affected). The authors also concluded that patients more accurately recalled their diagnoses and were more satisfied with the physicians' explanations of their diagnoses. Wrenn and colleagues<sup>23</sup> further supported these findings in 1993, concluding that structured complaint-specific ED forms improve documentation and may improve communication, reimbursement, and medico-legal risk. Marill and colleagues<sup>24</sup> confirmed this reimbursement improvement and added the advantage of physician satisfaction when they compared the T-System of paper templates (Emergency Services Consultants, Irving, TX) with undirected written documentation. Other studies have also shown documentation improvements in areas such as asthma,<sup>25</sup> head injury,<sup>26</sup> and poisonings.<sup>27</sup>

Numerous electronic versions of complaint-specific charts have also been developed,<sup>28</sup> and they carry the same advantages and disadvantages discussed previously. The goal of these software packages is to allow quick electronic documentation of a patient encounter while capturing important medico-legal and billing elements of the visit using a variety of templates and prompts. For example, a robust list of pertinent positives and negatives for the history and physical examination would be displayed so the physician could select or cross off these items. The program could also help generate an appropriate differential diagnosis list, reminding the provider of worst-case scenarios that must be considered, given the current findings.

Electronic Medical Records (EMRs) and Computerized Order Entry Systems (CPOE) have a significant advantage as well. With increasing sophisticated use of Clinical Decision Support (CDS), medical errors can be mitigated. For example, with proper use, allergy information entered at triage can detect medication ordering errors made by providers hours later. Oftentimes, clinicians forget to check allergies before either writing orders in the ED or when writing prescriptions upon discharge. Alerts can come close to eradicating these types of errors. The use of CDS can be enormously helpful in avoiding other errors as well. Some examples include warnings when writing orders for low molecular weight heparin—alerting the practitioner that the creatinine clearance is less than 30 mg/dL and offer the option of using unfractionated heparin. Some electronic medical records have risk management modules that help the practitioner consider diagnoses that are rare; for example, certain symptoms combined with height and weight may prompt a message to consider Marfan syndrome and aortic dissection.

The introduction of electronic medical records brings with it its own risks of new potential errors as well. The use of drop-down menus and the need for quickness of data entry into these systems can result in mishaps. For example, when writing prescriptions on discharge, a wrong medication can be chosen from a long list of similarly sounding medications in a drop down list. This has led to the "look twice, click once" admonition when using EMRs. Electronic medical record systems need to be examined closely for attention to these types of details. The use of tall-man lettering (highlighting differences between similar sounding drugs), generic versus brand

name integration, and checking for drug-drug interactions are all important features when evaluating a system for the ED.

The big divide within the emergency medicine EMR discussion is the use of specialized software designed and used only within EDs versus the enterprise-wide solutions that are used throughout hospitals including EDs. The specialized products for the ED have made great strides with ease of use, risk management tools, and acceptance in ED settings; however, hospital administrators often prefer, for good reasons, to have the entire enterprise on one system. The downsides and benefits of both are beyond the scope of this article, but there are valid arguments on both sides of this discussion. Having one integrated system, for example, enables simpler and more effective medication reconciliation among all the outpatient providers, the ED, and the inpatient visit. The lack of sophisticated features specific to the ED, however, typically seen in these systems, is a downside to these enterprise-wide systems, one that will likely be resolved within the next decade.

The final ED documentation type is the dictated and transcribed chart. Instead of writing or typing the details of an encounter, a provider verbally records the details of the visit via telephone, and shortly thereafter, a medical transcriptionist types the documentation for the physician. A retrospective study by Cole and Counselman<sup>29</sup> compared transcribed and handwritten ED charts of chest pain patients and concluded that transcribed charts contained more complete documentation. In addition, a prospective study from San Francisco<sup>30</sup> concluded that a dictation system decreases documentation time, improves legibility, increases provider efficiency, and improves physician satisfaction. Another study<sup>31</sup> later confirmed the improvement in provider efficiency and reduced documentation error rates using a dictation system. Clearly, the benefits must outweigh the additional cost of the transcription service. The obvious disadvantage of dictation and transcription is misinterpretation of the recorded dictation by the transcriptionist, which can result in errors in the typed medical record. Transcription can also be somewhat confusing in academic centers where there are numerous providers (eg, residents and attendings) taking care of a patient.

There is no perfect ED medical record, but there are certainly distinct advantages and disadvantages to each documentation type.

## HAND-OFFS AND CHANGES OF SHIFT

“First, do no harm.” Although medical errors have existed since before Hippocrates, the true magnitude of adverse events in health care was brought to the forefront of public debate after the Institute of Medicine (IOM) reported in 1999 that approximately 98,000 deaths per year were attributable to errors in hospitals.<sup>32</sup> Emergency departments were characterized as complex, tightly coupled systems intrinsically prone to accidents. In a subsequent report,<sup>33</sup> great importance was given to the concept of “seamless” health care as the means of improving patient safety. Seamless health care calls for interdependent people and technologies to function as a unified whole. This concept is highly significant at the points of information transfer such as clinician hand-offs, where patient safety is at risk of being compromised.<sup>33</sup>

The Joint Commission has published data on communication errors indicating that approximately 65% of reported sentinel events involve issues with communication.<sup>34</sup> Hand-offs in emergency medicine involve communication between both nurses and physicians at changes of shift, hand-offs with admitting teams, and those between nurses and physicians. These hand-offs, given the nature of emergency medicine, occur innumerable times a day in even moderately busy departments and therefore are usually concise. The potential for loss of significant information is obvious. These

“nodes of interface”<sup>35</sup> provide for a significant opportunity for the degradation of important information and potential for opportunities for negative clinical outcomes. Various additional factors, such as an increasingly complicated patient population and reductions in resident duty hours have added pressure to the hand-off process within the ED. These factors are significant causes of concern in the management of risk within any critical care environment, especially the ED.<sup>35</sup>

Hand-offs and changes of shift are similar nodes of interface, thus they will be dealt with together for the purposes of this manuscript. Hand-off communication is a central tenet of the Joint Commission’s National Patient Safety Goals.<sup>36</sup> Every hospital, by now, should have in place a structured method of communication to decrease the chance of error during the process of hand-off communication.

The second National Patient Safety Goal, 2E, specifically addresses the importance of the hand-off process and in section E specifies the elements of performance. These include (1) ensuring a process for effective hand-off communication that includes interactive communication that allows for the opportunity for questioning between the giver and receiver of patient information; (2) up-to-date information regarding the patient’s condition, care, treatment, medications, services, and any recent or anticipated changes; (3) a method to verify the received information; (4) an opportunity for the receiver of the hand-off information to review relevant patient historical data; and (5) the limitations of interruptions during hand-off communication.

Variations in communication skills, styles, and time constraints between both physicians and nurses can contribute to a breakdown in effective communication, which can lead to adverse outcomes for patients.<sup>37</sup> Many hospitals have chosen to use the SBAR (Situation, Background, Assessment, and Recommendation) form of hand-off communication. This method is particularly useful in the ED setting. SBAR is an easy-to-remember technique that provides for consistent, structured communication between members of the health care team during a critical situation.<sup>38</sup>

A structured tool such as SBAR can standardize the approach and decrease variability in communication between providers. This applies to both ED and inpatient recipients of information. SBAR or another standardized approach can keep the process concise yet ensure that the critical information is transmitted in a reliable fashion. Oftentimes, SBAR forms or small cards are created to be used as prompts for the process. Several EDs have created SBAR nursing FAX report forms, one of which is available on the Institute for Healthcare Improvement (IHI) Web site<sup>39</sup> for download. This tool ensures that the critical information needed is handed off in a consistent manner when patients are transported from the ED to an inpatient unit.

Similarly, a written prompt for use during physician hand-off can improve the consistency of physician-to-physician hand-off at changes of shift. An example of a verbal SBAR hand-off would be as follows:

- **Situation:** This is an 85-year-old male who presented to the ED 5 hours ago with abdominal pain and vomiting for 1 day. He is currently undergoing evaluation and is presently at CT scan. His vitals signs are stable, with a blood pressure of 140/90, pulse of 90, normal respiratory rate, and oxygen saturation of 98% on room air.
- **Background:** He has a history of smoking, hypertension, myocardial infarction, and no previous abdominal conditions. He takes metoprolol for high blood pressure, aspirin, and zolpidem for sleep.
- **Assessment:** His examination revealed mild right upper quadrant as well as mid-abdominal tenderness. Our impression was possible cholecystitis, and

less likely, aortic aneurysm or diverticulitis. Bedside sonogram done in the ED was unrevealing.

- **Recommendation:** Review CT scan results, reexamine, likely admit for observation.

Using a structured sign-out/hand-off tool can increase the efficiency and effectiveness of the hand-off process. In an analysis by Arora and colleagues,<sup>40</sup> 25 incidents of communication failures were examined. These cases were resident cases that involved the omission of medications, pending examinations, studies ordered, or active issues. The use of a structured format can help with organization and cognitive thought processes to include items that are active and important for the ongoing care of the patient.

## DISCHARGE INSTRUCTIONS AND FOLLOW-UP

The other critical transition for ED patients occurs at discharge. When a patient is deemed safe for discharge from the ED, the provider must ensure that the patient receives good instructions, both verbally and in printed form. Patients may often have difficulty remembering multipart instructions given only verbally. In addition, Roberts<sup>41</sup> suggests brightly colored paper to help patients not lose their instructions. These printed instructions should explain the diagnosis (or diagnoses) given, what was done in the ED, the name of the ED provider, specific instructions regarding activity and medications, what to expect going forward, with whom and when to follow up, and the symptoms for which to seek medical treatment or return to the ED. If there are test results still pending, the patient should be directed as to how and when to obtain these results.<sup>41</sup> All of these items are important for effective treatment, continuity of care, and patient comprehension. Asking patients to repeat the instructions given may help confirm their understanding.<sup>41</sup> If the patient may not comprehend the instructions, they must be relayed to a responsible party (eg, parents of a child, nursing home staff for a patient with dementia).

The risk of not communicating these key components of the discharge instructions has obvious implications on patient satisfaction and outcomes. ED physicians should beware of cases such as an incidentally found lung nodule where outpatient CT scan and primary care surveillance would be recommended but where the discussion was not properly documented. Malpractice may be claimed years later if the patient developed lung cancer and had forgotten to mention the nodule to their primary doctor. Lack of documentation of such follow-up recommendations probably does not sit well with a sympathetic jury, whereas solid documentation may be protective of the ED provider.

Too often, patients leave the ED thinking “they said I was fine,” which, in many cases, is not the actual discharge diagnosis. Numerous studies have demonstrated that patients (and parents of pediatric patients) frequently do not understand their discharge instructions.<sup>42–46</sup> Patients who do not understand their instructions clearly may have difficulty carrying them out. One pediatric ED study showed that only 63% of patient guardians obtained prescribed medications after discharge.<sup>47</sup> Another concluded that dissatisfaction with discharge instructions independently correlated with nonfilling of prescriptions.<sup>48,49</sup> The effect of insurance status on prescription filling remains controversial.<sup>50,51</sup>

Ideally, the language used in discharge instructions should be written at a level that can be understood by the patient. Sometimes, patients cannot actually read the printed instructions because of illiteracy;<sup>45,52,53</sup> one University of Virginia ED study concluded that hospital and commercially generated patient education materials ranged from 8th to 13th grade level, whereas more than 40% of their ED patients could not read at the 8th grade level.<sup>53</sup> Other studies report similar findings, with Davis and

colleagues<sup>54</sup> noting a gap of more than 5 years between patient reading levels and the comprehension levels required by written patient materials.<sup>55,56</sup> Patients who speak other languages and not English should be able to converse with the help of a translator because comprehension deficits are well demonstrated in non-English-speaking ED patients.<sup>43</sup> Many computer-generated instructions can be printed in Spanish or other languages. At other times, handwritten instructions can be simply illegible to the patient, and clearly this can negatively affect comprehension and compliance with instructions.

Most recently, Engel and colleagues<sup>57</sup> interviewed ED patients immediately after discharge and found that 78% of patients demonstrated deficient comprehension of ED discharge instructions, with 34% of the deficiencies involving understanding of post-ED care. These findings are in line with those reported in earlier studies from Missouri<sup>45</sup> and New York.<sup>58</sup> In the latter study, only 42% of patients were able to name their diagnosis, and only 37% could state the purpose of the medications prescribed to them. To make matters worse, most patients who had deficiencies of comprehension did not realize it, reporting inappropriately high confidence in their recall. These deficiencies are present immediately after discharge and do not account for memory attrition that may occur over longer periods of time (eg, when patients see their primary doctor the following week).

Comprehension and retention of discharge instructions can be improved by strategies including the physician spending more time explaining the diagnosis and instructions to the patient,<sup>46</sup> simplifying the language used in discharge instructions,<sup>59</sup> using standardized instructions,<sup>60</sup> using diagnosis-specific information sheets,<sup>61</sup> and even including illustrations.<sup>62</sup> Older pre-printed discharge instructions such as those for head trauma precautions have given way to more complete explanations of the diagnosis, what to watch out for, what to expect, and when to follow up.<sup>41</sup>

Follow-up with a primary care provider or specialist is another essential component of a discharge plan and instructions. Despite being given ED referrals, patients often do not follow up with a doctor, commonly because of appointment availability or insurance issues. According to a major study by Asplin and colleagues<sup>63</sup> in 2005, patients with private insurance failed to obtain a follow-up appointment 36% of the time with appointments being refused by the clinic 40% of the time, most commonly because the clinics were not accepting new patients. Not surprisingly, Medicaid patients fared worse, failing to obtain a follow-up appointment 66% of the time with appointments being refused 80% of the time, most commonly because the clinics did not accept Medicaid. One pediatric study<sup>47</sup> showed that only 60% of patient guardians complied with follow-up instructions to see a physician. Again, privately insured patients fared better than those without private insurance (77% compared with 47% compliance with follow-up). Some studies have reported better compliance with referrals among females, adults older than 40 years, children younger than 18 months, increased severity of complaints, referrals to private physicians, and having private insurance.<sup>64,65</sup>

Several studies have addressed ways to increase successful ED referrals. One study demonstrated that computerized discharge instructions improved patient compliance with follow-up appointments.<sup>66</sup> Perhaps this effect is attributable to the ED provider forgetting to write specific referral instructions on handwritten discharge papers, whereas they are programmed to appear on computerized instructions. Numerous studies have demonstrated that making a follow-up appointment for the patient before discharge significantly improves follow-up compliance.<sup>49,67-70</sup> One Canadian study<sup>69</sup> came to the same conclusion and added that its free clinic appointments also increased compliance with referral. Barlas and colleagues<sup>71</sup> found

increased compliance when free 48-hour ED follow-up was offered. Apparently, the more reminders and increased ease of obtaining an appointment results in improved compliance with referrals.

One other item relating to discharge instructions is the process of medication reconciliation, which is mandated by The Joint Commission as one of its 2009 National Patient Safety Goals.<sup>36</sup> The objective of this effort is to ensure that patients and their primary care providers always have an up-to-date list of their medications and that any provider who is making changes to the medication list should be reviewing the new list for any potentially dangerous situation such as drug interactions, drug allergies, and other issues. Of course, this process is difficult with patients who cannot remember their long list of medications. At other times, difficulties may arise because electronic databases may not include some medications that are foreign or experimental. This update of the patient's current medication list must be completed before discharge from the ED (or any other department), as medications are often stopped or started in the ED. A copy of this medication list should be given to the patient to bring to the primary care physician or next provider.

Sometimes, patients may not be discharged from the ED in the typical fashion. Patients that leave the ED without being seen, fail to complete an ED visit (leave after being evaluated), or sign out against medical advice (AMA) should ideally receive instructions, as well as have the interaction or conversation documented in the medical record. Bad outcomes after a patient leaves in this manner will inevitably result in scrutiny of the ED documentation. A plaintiff's attorney will certainly argue that the patient should have been seen and evaluated more quickly and clearly should have had the risks of leaving the ED better explained. Consequently, important items to document in these cases, when possible, include a thorough history and examination, severity of illness and risks, lack of danger to self or others, patient competency and capacity (including lack of intoxication), and patient understanding of the risks and benefits of and alternatives to leaving the ED.<sup>72</sup> Alfandre<sup>73</sup> estimated that between 1% and 2% of all medical admissions result in AMA discharge, and predictors include younger age, Medicaid or no insurance, male gender, and substance or alcohol abuse. In one UK study,<sup>74</sup> 50% of self-discharge patients were under the influence of drugs or alcohol. In terms of outcomes and risk, Lee and colleagues<sup>75</sup> found that chest pain patients who left the ED against medical advice were at higher risk for myocardial infarction than those who were discharged but at lower risk than those who were admitted.

When patients leave without the provider being aware of the departure (such as those who leave from the waiting room before being seen), this conversation and assessment may not be possible. However, patients who sign out against medical advice should be counseled regarding severity of illness and risks of leaving the ED, and they should receive discharge instructions as well as optimal medical treatment for their condition. Thorough documentation and discharging a patient against medical advice may partially protect the provider, but it does not prevent liability altogether, as demonstrated by several malpractice cases in the literature.<sup>10,12-15,72</sup>

## PEARLS AND PITFALLS

Following is a brief list of key points to remember in the process of ED documentation and communication with patients.

### 1. High-risk diagnoses

Recognize these conditions. Think about what could go wrong after the patient is discharged. Document clearly the rationale for why the condition is or is not something dangerous. Be conservative. Splinting a patient with minimal

snuffbox tenderness in their dominant hand may be well worth the extra effort.

## 2. Reevaluations

Serial examinations are very important. Detailing patient improvement is especially important for patients who are discharged home after a lengthy ED visit. Otherwise, the chart will reflect only the initial condition of the patient, which often is a patient who is less stable and more uncomfortable than the one who is being discharged home.

## 3. Thought process

It is imperative to detail the physician thought process (differential diagnosis, probabilities, rationale for actions taken). Why was pulmonary embolism unlikely and not something to be ruled out with testing? Without a clear roadmap, a plaintiff's attorney can connect the dots (or data points on the chart) in the way that most benefits the case being made against the provider.

## 4. Patient discussions

Documenting important conversations with the patient may help support a provider's actions and more accurately portray the patient's understanding of the diagnosis (or lack thereof). Rather than concluding "I was fine," a patient who verbalizes understanding that there is a remote possibility that atypical chest pain could represent angina may be more likely to return if worse and/or obtain an outpatient stress test.

## 5. Leaving AMA

A patient who signs out AMA does not leave the ED physician without risk. Extremely careful documentation must accompany this disposition. Most importantly, a provider note must attest to the patient's capacity to make such a decision and to the patient's verbalized understanding of the risks of and alternatives to leaving AMA. Not fully explaining and detailing the specific risks might, in the eyes of a jury, have led to a patient making a decision without the proper information.

## 6. Patient hand-offs

With the high volume of many EDs, the hand-off between providers is often the transition point where information is lost and from which bad outcomes result. The SBAR methodology is just one way to effectively communicate a patient's plan to an oncoming physician. Not properly transmitting an organized plan puts the patient (and the provider) at risk.

## 7. Discharge instructions and follow-up

Patients are more likely to remember their diagnoses and carry out their discharge instructions if they are spelled out in detail and in printed form. Follow-up plans should be clearly specified (where, when), and the patient should be specifically told what to look out for and when to become concerned and return to the ED.

## SUMMARY

The environment of the ED is unique. The arrival pattern of patients is not completely predictable, leading to great variations in provider-to-patient ratios. ED physicians are unfamiliar with new patients presenting to the ED. In contrast, familiarity with patients' known histories, personalities, and prior presentations helps their primary care providers place the patients' complaints in context. There is also no limitation to the spectrum of illness that any single provider in the ED will encounter.

These facts place the emergency physician in a position of increased vulnerability, as compared to some other specialties, with regard to patient adverse outcomes and

potential litigation. The lack of an ongoing, caring relationship with the patient increases the risk of legal actions when things do go awry. This article has focused on the importance of clear documentation of events that occur in the ED. It is the opinion of the authors that documentation is critical and that in most circumstances it will help rather than hinder the defense of the care provided in the ED. This conclusion is not contingent on the type of documentation tool used in your department.

In addition to the imperative to document as completely as possible, the additional vulnerability to the emergency provider is the process of sign-out and hand-off communication. ED providers transfer care to other ED providers, inpatient providers, and, if discharged, to outpatient providers. All of the communication between providers within the ED and those within the continuum of care needs to be standardized to improve care. No longer are haphazard methods of communication acceptable. One example of a standardized hand-off approach was outlined in the article.

Finally, discharge instructions are critical both for patient safety and to protect the ED provider in the event of a liability action. Clear instructions to the patient, especially the importance of follow-up in a reasonable period of time and the indications to return immediately if worrisome symptoms occur, are paramount. Failure to clearly delineate these instructions is a disservice to our patients and puts unnecessary risk on the provider.

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