What You Should Know About Physician Documentation

Developed by the Physician Documentation Expert Panel

November 2006

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Introduction

Quality patient care is dependent upon:

- Accurate, complete and timely documentation of a patient's diagnosis, problems, treatment and progress
- Effective communication between physicians along the continuum of care

These essentials are tied to good physician documentation.

Importance of the Health Record

The health record is key to good patient care…

- It is the primary communications tool between acute and primary care physicians.
- A timely transferred discharge summary can help prevent an adverse medication event and gives family physicians the full medical picture to optimize continuity of patient care.
- The health record is a legal document that must be able to withstand court scrutiny.
- There are regulations governing timely chart completion.
- Documentation in the health record forms the basis of data used to make critical health care planning decisions.

Importance of Good Documentation

Studies have shown:

- The risk of re-hospitalization decreased when patients were assessed for follow-up by a physician who received a discharge summary.
- Visits in the emergency department of a teaching hospital were 1.2 hours longer on average for patients with an information gap in their health records than for those without one.
- Only 11% of hospitals in Ontario have discharge summaries completed and signed within 48 hours.

The Current Documentation Environment

- Studies have identified considerable deficiencies in physician documentation.

  Concerns include:

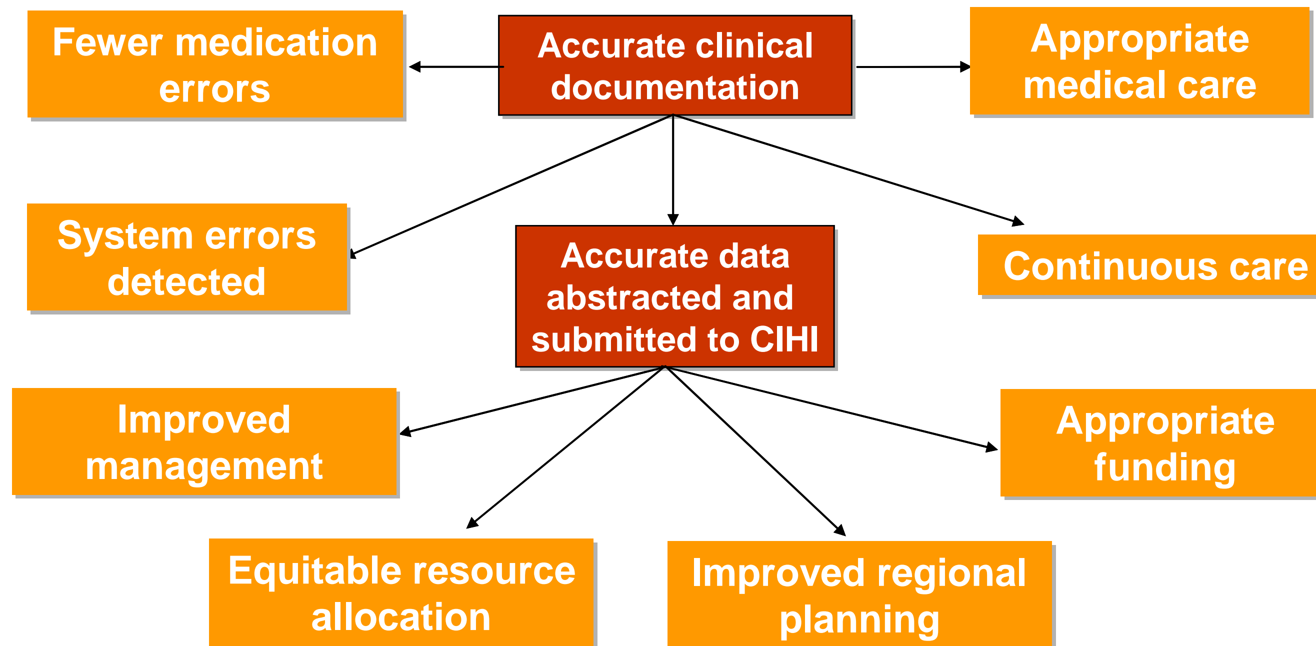
  - Incomplete health records
  - Lack of accuracy
  - Lack of timeliness in discharge summary completion and transfer to primary care physician

- Patients seen by physicians with discharge summaries have better outcomes, a study found.

- A study found longer emergency room wait times for patients with gaps of information in their health record.

The Benefits of Good Documentation

- Quality of documentation linked to quality patient care and health outcomes.
- Good documentation is linked to better health care planning.



Improving Documentation: The Discharge Summary

- Studies have shown that patient care can be improved by sending complete and accurate discharge information to the patient's family physician in a timely manner.

- High quality discharge summaries are short, delivered quickly, and contained pertinent data that concentrated upon discharge information.

- Content that increases quality of the discharge summary most includes:
  - admission diagnosis
  - pertinent physical examination findings and laboratory results
  - procedures and complications while in hospital
  - discharge diagnosis/diagnoses
  - discharge medications
  - active medical problems at discharge
  - arrangements for continuing care [follow up]

Improving Documentation: The Panel's Chart Completion Policy

- The Physician Documentation Expert Panel has developed a chart completion policy to set a standard framework for doctors to consistently and effectively complete patient health records.

- The policy is comprehensive, but streamlined.

- The general guidelines include:
  - Documents must be legible
  - Use of unapproved abbreviations is strongly discouraged
  - Every entry must be authenticated (includes e-signature) and dated by author

- The policy includes guidelines for timely completion of charts and for the transfer of discharge summaries to primary care physicians.

For More Information: A Guide for Physician by Physicians

- The ***Guide to Better Physician Documentation*** reflects the collective input of a panel of your peers.
- The guide includes:
  - Facts about the importance and impact of the patient health record
  - An overview of the current documentation environment
  - A chart completion policy template
  - Information about reporting requirements

Concluding Remarks

We all stand to gain from improved physician documentation…

- Acute care physicians, family physicians, patients and the health care system as a whole benefits from accurate, complete and timely information being maintained in health records.

- As physicians we must work together to ensure the highest quality of information to effectively communicate with each other and our patients.

- Good physician documentation is a powerful tool to optimize patient care and Ontario's health care system.