PATIENT SAFETY RESOURCES

SEVERE CONSEQUENCES OF COPY AND PASTE DOCUMENTATION

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DESCRIPTION

A 40-year-old male suffered incontinence and partial quadriplegia attributed to improper management of a cervical hematoma, miscommunication, and substandard documentation among providers.

KEY LESSONS

- Poor communication can lead to adverse outcomes
- Documentation in the medical record is intended to support decision making, reflect care provided during the patient encounter, and guide subsequent care
- If copying and pasting notes, ensure that pasted content accurately reflects the *current* assessment prior to filing

CLINICAL SEQUENCE

A 40-year-old male with quadriparesis resulting from a rare vascular malformation was admitted to a rehabilitation facility with a cervical hematoma. The patient was followed by a physiatrist. The care plan called for conservative, nonsurgical, management (due to high risk of paralysis/death) with a low threshold for admission to the hospital if his condition changed.

During the patient's first week in the rehabilitation facility, there were four consecutive days when the physiatrist entered identical notes in the medical record, while nurses, physical therapists, and occupational therapists all documented subtle declines in the patient's condition. Nine days after admission, a physical therapist spoke to the physiatrist regarding the patient's progressing weakness. The physiatrist ordered tests and spoke to a neurosurgeon. The physiatrist's note, however, was again identical to those previously documented.

Over the next four days, the patient experienced progressive weakness as well as urinary incontinence and a decrease in sensation to all extremities. The patient was transferred to the hospital and underwent decompression surgery for a second hematoma. He required intensive rehabilitation, and now has persistent bowel and bladder incontinence, and partial quadriplegia. The patient requires assistance with all activities of daily living.

ALLEGATION

A case was asserted against the physiatrist for improper management.

DISPOSITION

This case was settled in excess of $1M.

ANALYSIS

Poor communication among providers and failure to appreciate and recognize signs and symptoms

Although the physiatrist's documentation did not reflect any changes, the notes by nursing, physical therapy, and occupational therapy recorded changes in the patient's condition for several days. These inconsistencies went unresolved until a conversation documented by the physical therapist, multiple days into the patient's progressing symptoms. The management was contrary to the original plan to admit the patient to the hospital for any changes in condition.

Best Practice/Recommendations

- Multidisciplinary huddles (at least daily) during which clinical issues are discussed
- Create systems and a culture in which the care team is aware of each patient's plan of care, and everyone is comfortable speaking up regarding any change in patient status

Pre-populate and copy/paste copy/forward EHR

Provider notes were identical for days, including on the day that the physiatrist ordered tests and consulted neurology. Experts criticized the physiatrist for these identical entries in the medical record. According to an analysis in the 2020 CRICO Benchmarking Report, *The Power to Predict*, the odds of a malpractice case closing with an indemnity payment increases 76% when there are indications that documentation of patient encounters and care was inadequate to ensure appropriate care by subsequent caregivers.

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ANALYSIS

Best Practice/Recommendation

- Ensure that patient care notes reflect critical thinking and accurate assessments
- Review notes prior to filing in the record
- Develop an organizational policy regarding copy/paste practices