

DOCUMENTATION MATTERS— EMERGENCY MEDICINE

CMPA.

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better healthcare

Leave your intellectual footprint in the chart

A 5-year review of CMPA regulatory authority (College) complaints and legal actions identified documentation issues as a common theme in cases involving emergency physicians. Deficient documentation of clinical assessments was the most frequent criticism from peer experts.



WHY IS DOCUMENTATION SO IMPORTANT?

- Central to patient care and safety
- Improves communication and increases team situational awareness
- Professional obligation
- Evidence of care provided
- Helps organize your discussions and thought process

TIPS TO OPTIMIZE YOUR DOCUMENTATION

Has your clinical assessment included?

- Relevant positive/negative findings
- Presence/absence of red flags
- Pertinent information from other sources including previous medical records and notes from allied health professionals
- Details of the physical exam including vital signs
- Details and timing of reassessments

Clinical reasoning: Have you documented?

- Your assessment of the vital signs
- Positive/negative findings and red flags you considered
- Interpretation of investigations
- Differential diagnosis and rationale for working diagnosis
- Consultations, patient discussions, shared decision-making plans

If using Electronic Medical Record (EMR) templates:

- Consider using free text and personalizing the note for each patient
- Ensure pre-populated fields accurately reflect the encounter
- Annotate late entries and content changes with time, date and reason for late entry/change
- Beware of copying/pasting incorrect information

Team communication: Have you documented?

- Plans and discussions to maintain team situational awareness
- Consultations: timing, who you spoke with, information provided, and advice received
- Efforts made to reach consultants or follow-up provider, or for transfer arrangements if warranted
- Handover discussions including action items, pending investigations/consults, and contingency plans

Discharge instructions: Have you documented?

- Signs and symptoms that would warrant further assessment
- Where to seek care and urgency of response
- Discussions with patient regarding diagnosis and potential diagnostic uncertainty
- Pending investigations/follow-up appointments
- If the patient refuses investigation or treatment, the patient's informed refusal and associated risk
- Review of handouts if used
- Questions/concerns raised by patients or family