Authoring Patient Records An Interactive Guide

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To my sons, Brian and Anthony, for giving my life a purpose. —Michael

To my mother, Jené, for inspiring me to become a nurse and to my Grandpa Oren, whose tales of being a judge and a lawyer motivated me to follow in his footsteps. —Canera © Jones and Bartlett Publishers, LLC. NOT FOR SALE OR DISTRIBUTION

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Preface

he purpose of *Authoring Patient Records:* An *Interactive Guide* is to help healthcare providers—medical doctors, doctors of osteopathy, physician assistants, advanced practice registered nurses, physical therapists—learn and practice a process for authoring patient records. In addition, this book is intended to be used by health communication researchers, students, and scholars in their evaluations of written or electronic communication about patients' illnesses, injuries, treatments, prognoses, and interactions with healthcare providers.

It should be noted that this text is not intended to replace current texts and pedagogy related to the content required in specific medical records for various healthcare professionals. Therefore, this book assumes that readers will have a fundamental understanding of the medical terms and clinical skills required to interview and care for patients as well as the knowledge of what information about the patient interaction and clinical findings need to be documented in a specific patient record. The focus of this book is on helping providers enhance their communication effectiveness, credibility, and professionalism as well as minimize their malpractice risks.

The goal of this text is to make the writing process—whether on paper, dictated, or computerized—clear, concise, and effective. The author, a physician assistant (PA), has a 30-year history of creating, reading, and researching written, computerized, and dictated patient records. His PA experience includes working in surgery, primary care, women's health, emergency departments, and occupational medicine. In addition, the author has taught writing and health communication courses in universities and professional

programs for more than two decades. He has published three books and numerous journal articles related to healthcare writing and communication.

This book is designed to be a truly interactive text. It can be used by an individual, in a course, or in a small group setting. Throughout the text, you will find boxes to help you assess your understanding of the topics covered in the chapter as well as blank spaces and exercises for you to practice the authoring process being discussed. The answers to these questions can be found in the text that follows them, so try to answer the questions first and then compare your responses to the material in the text. It is important for you to recognize that authoring (whether with pen, pencil, dictation, or computer) is a skill, and, like all skills, it requires assimilation, organization, critical analysis, and practice. It is frequently argued by healthcare providers that modern medical constraints (healthcare maintenance organizations, workload, and institutional policies) limit their time for patient interaction and documentation. This text will offer tips for enhancing your record, keeping with minimal time extensions, but it will also demonstrate and illustrate the importance of effective documentation for quality care, safety, continuity of care, and legal reasons.

In addition, this book includes a unique chapter dedicated to improving your knowledge about malpractice risks related to medical record authorship. Chapter 7 was authored by a registered nurse (RN) with two decades of experience working in community hospitals, emergency medicine, and postanesthesia recovery units. Furthermore, the RN/JD author has more than 5 years of experience as a medical malpractice defense attorney. This chapter includes discussions of how authors can create patient records that provide the information needed by users of the documents without increasing the provider's legal risks.

NOTE: The examples of patient records used in this text are anonymous, real documents obtained from a wide variety of healthcare institutions nationwide.

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