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HOSPITAL & CLINICS

Quality & Patient Safety Alert!
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During a recent CDPH unannounced survey, the surveyor noticed that a patient had a condition change during their post-procedure recovery. The procedure report stated that the patient had tolerated the procedure and sedation well and had been discharged to home. The report was a template that was developed by the department to expedite the documentation requirements.

However, the reality was that the patient had severe nausea and pain immediately after the procedure, requiring extensive interventions and had to stay several more hours than anticipated. This episode was clearly documented in the clinical record by staff who was involved in responding to the patient. The surveyor was confused with the difference in the documentation by the physician and the staff. After reconfirming facts with the patient, CDPH determined that the procedural report misrepresented the care provided by the physician. The physician had verified that this was an honest mistake, but the surveyor still wrote this up as a deficiency with regulations.

Moral of the Story: Make sure your documents accurately reflect what is going on with your patient. Edit those templates. Many times the only evidence of quality of care is the quality of your documentation.

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