Mental Health
Risk Retention Group, Inc.

Documenting Behavioral Health Care for Quality Care and Risk Management

Can good documentation prevent lawsuits?

Specific, detailed documentation is critical to prevent lawsuits because it is critical to providing good quality care. The documentation we see in the charts we litigate can provide insufficient information for important decisions about risk, lethality, interventions, and risk prevention activities.

Checking off checkboxes in an electronic health record can often limit information available for treatment decisions. Using general terms also limits information needed. For example, writing that the patient was "aggressive" does not communicate what actually happened, whether someone was injured, or what the behavior indicates about future risk.

How much detail is important in good documentation? We think there is a lot of detail in our charts.

Good documentation provides sufficient detail for the reader to know if a particular client characteristic or a past event are factors affecting current risk levels or which should be addressed in treatment.

For example, simply writing that a client has been diagnosed with schizophrenia does not help the reader know whether the diagnosis is a risk factor for the client to be violent. The vast majority of people living with schizophrenia are not violent to other people. However, people living with schizophrenia who also have feelings that they are being controlled or threatened by others are at increased risk of being violent.

Similarly, simply writing that a client is experiencing family relational problems is not sufficient information to determine whether those problems pose a risk factor for the client attempting suicide. On the other hand, adding the detail that the family relational problems include the client feeling that he or she is a burden to the family indicates that those problems are risk factors.

Further, documenting only that a client attempted suicide six months ago provides quite limited information. Additional detail is important to determining current risk. What were the precipitants, stressors, and circumstances leading up to the attempt and how do they compare to the current situation? How does the client feel now about not succeeding in the attempt? What were the means used in the attempt and how much did the client prepare and plan? Are the same means, such as a firearm or a supply of medication, currently available?

Additionally, documenting that a client was in a bar fight two weeks ago omits information important to determining the level of current risk. Who initiated the fight? What were the motivations for the client's involvement, for example, self-defense, feeling threatened, disinhibition from alcohol or drug use, disorganized thinking? Was anybody injured and what was the level of injury? Was a weapon used? Was the fight spontaneous or planned?

Documenting that a client experiences auditory hallucinations omits information important to understanding whether the hallucinations contribute to risk. Of course, auditory hallucinations, especially command hallucinations, can contribute to risk of both suicide and violence to others. What did the voices say? Where did the voices come from? From inside the client or outside? When did the client last hear the voices? Have there been other voices and what did they say? How often does the client hear the voices? Does anything make the voices more frequent? Does treatment stop the voices? Does medicine stop the voices?

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