Documentation of the Discussions following an Unanticipated Outcome

Following an unanticipated outcome, a complete, accurate and factual description of the event should be entered into the medical record by the appropriate caregiver. This should include actions taken, ongoing treatment plans and all communication with the patient and family.

This documentation is important as it provides necessary information to assist in treatment of the patients and provides a historical record in the event of litigation.

Recommendations: Applies to unanticipated outcomes occurring in hospitals and office practices.

1. Clinical details recorded by the most knowledgeable member of the healthcare team should include:
    - Objective details of the event, including date, time, and place
    - The patient's condition immediately before time of the event
    - Medical intervention and patient response
    - Notification of physician
2. Documentation of the conversation held with patient/family should include:
    - Time date and place of discussion
    - Names and relationships of those present at discussion
    - The discussion of the unanticipated outcome
    - Patient reaction and level of understanding exhibited by the patient
    - That any additional information has been shared with the patient, family and legal representative if appropriate
    - Any offer to be of assistance and the response to it
    - Questions asked by the patient and family and responses to the questions
    - A notation that as further information becomes available, this information will be shared with patient, family, or legally authorized representative
    - Next steps to be taken by the patient and any providers or the facility staff
    - Any follow-up conversations
3. No derisive comments about other providers or facilities or self-serving entries should be made.