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DEALING WITH SYNCOPE
FROM A RISK MANAGEMENT PERSPECTIVE

DOCUMENTATION ISSUES

1. The physician's thought process should be clear in the chart.
   -why weren't activities restricted?
   -why were activities restricted?

2. A clear picture of the patient's symptoms, including frequency, predictability and severity should be presented, as well as a picture of the differential diagnoses.

3. Documentation of discussions, warnings and explanations to the patient should be detailed, including verbalization of understanding.

4. Specific follow up time frames should be written in the chart as well as a detailed plan including reassessment of symptoms.

5. Consider documentation of patient's ability to follow recommendations and plan.

6. Re-evaluate your decisions at each subsequent visit and document. If you ultimately decide you want to voluntarily report a patient who may be a danger to himself or others, you will want your documentation to tell a complete story.

OTHER CONSIDERATIONS

1. Involve family / significant others, if possible, in plan of care.

2. Assess patient's level of understanding not by asking "Do you understand?", but rather "Please tell me what you will tell your family / friends / significant others about what we have discussed".

3. Encourage patient to assist in plan of care to promote compliance with any activity restrictions including driving.

4. Utilize brochures, information sheets and staff to educate patients on hazards associated with their conditions. (ALWAYS document when written materials are provided.)

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