NORCAL GROUP®

BEST PRACTICES

RISK MANAGEMENT **RESOURCE**

This exclusive resource was developed and is maintained by NORCAL Group's risk management team and is made available to members of the American Society for Interventional Pain Physicians (ASIPP) by Tom Wierzbowski of Willow Risk Advisors.

MEDICAL RECORDS: DOCUMENTATION DO'S AND DON'TS

NORCAL GROUP

BEST PRACTICES

RISK MANAGEMENT RESOURCE

MEDICAL RECORDS: DOCUMENTATION DO'S AND DON'TS

ABOUT NORCAL GROUP

The NORCAL Group of companies provide medical professional liability insurance, risk management solutions and provider wellness resources to physicians, healthcare extenders, medical groups, hospitals, community clinics, and allied healthcare facilities throughout the country. They share an A.M. Best "A" (Excellent) rating for their financial strength and stability. NORCAL Group includes NORCAL Mutual Insurance Company and its affiliated insurance companies.
Please visit norcal-group.com/companies for more information.

The information contained in this document is intended as risk management advice. It does not constitute a legal opinion, nor is it a substitute for legal advice. Legal inquiries about topics covered in this document should be directed to an attorney.

Recommendations contained in this document are not intended to determine the standard of care, but are provided as risk management advice. Recommendations presented should not be considered inclusive of all appropriate risk management strategies or exclusive of other strategies reasonably directed to obtain the same results. The ultimate judgment regarding the propriety of any specific procedure must be made by the physician/ healthcare provider in light of the individual circumstances presented by the patient.

© 2017 NORCAL Mutual Insurance Company.

Whether electronic or paper, appropriate, consistent and accurate medical record documentation cannot be overemphasized. A complete medical record promotes quality patient care by providing a comprehensive patient history and facilitating continuity of care among all members of the healthcare team. The medical record also supports medical care reimbursement to providers, substantiates quality and incentive reporting program requirements, enables peer review, and defends against allegations of medical negligence.

From a risk management perspective, a complete record can help prevent and minimize the potential adverse consequences of malpractice litigation. Ultimately, the record serves as the basis for the defense of a malpractice claim or lawsuit. In a courtroom setting, the medical record is often referred to as the "witness whose memory is never lost." In addition, in some states it is considered unprofessional conduct to not document all patient encounters in a formal medical record.

Medical Professional Liability Risks

What is, and more often what is not documented in the record can be the pivotal factor in a malpractice lawsuit. The absence of information can lead to allegations of delay in diagnosis or treatment, failure to prevent allergic reactions, medication errors, wrong-site surgery, etc. Incomplete documentation can make it difficult to defend against such allegations. Further, without "facts," physician credibility versus patient credibility becomes the crux of a lawsuit, since juries often believe that "if it wasn't documented, it wasn't done."

Electronic health record (EHR) systems can present challenges as well. For example, if not formatted correctly, some records might be voluminous when they are printed. Reproduction quality is also an issue. The record might be legible on the screen, but not reproduce well in the printed form.

Additional Resources

- NORCAL Risk Management Medical Records Resources:
  - Corrections and Alterations
  - Templates, Forms and Checklists
- *Health IT Safe Practices: Toolkit for the Safe Use of Copy and Paste*. Partnership for Health IT Patient Safety. February 2016. The toolkit is publicly available at: www.ecri.org/resource-center/Pages/HIT-Safe-Practices.aspx (accessed 5/3/2017)
- Safety Assurance Factors for EHR Resilience (SAFER) Guides. Available at www.healthit.gov/safer (accessed 5/3/2017)

Sample Form

Patient Education Flow Sheet

Revised: July 2017

Patient Care and Documentation

Do…

- Ensure that the EHR provides a record of the day, month, year and time of the patient encounter. In a paper record, note the day, month, year and time of the encounter.
- Ensure that pending work contained in folders or tabs (e.g., in-baskets, task lists, results, telephone contacts, and "cc") is completed. This is important for both continuity of patient care and EHR "housekeeping."
- Document:
  - Reason for the patient encounter or chief complaint.
  - An appropriate history and physical examination, including past and present diagnoses.
  - Negative as well as positive assessment findings.
  - Relevant health risk factors.
  - The patient's progress, including response to treatment, change in treatment, change in diagnosis and patient noncompliance.
  - Monitoring, interventions, treatments and patient responses.
  - Vaccines and/or other medications administered to patients, including the date/time of administration, route of administration, injection site, the name or initials of the person administering the medication and manufacturer and lot numbers of injectables.
  - Missed or canceled appointments, physician notification of missed or canceled appointments and any subsequent contacts with patient (including follow-up).
  - Prescriptions and refills, responses to medications and possible medication side effects.
  - Medication dosages. Be particularly careful of proper placement of decimal points. A leading zero should always precede a decimal expression of less than one (e.g. document 0.5 ml instead of .5 ml).
  - Allergies in a consistent and prominent location in the medical record, including patient's reaction to allergen. Update allergy information at each patient visit.
- Reasons for x-rays, lab tests and other ancillary services.
- Ensure that there is evidence of physician review of all lab, x-ray, and consultation reports, as well as assessments, plans of care, and discharge reports from other ancillary services.
- Include in the written plan for care, when appropriate, treatment and medications (specifying frequency and dosage); referrals and consultations; patient/family education; and specific instructions for follow-up care.
- Ensure that documentation supports the complexity of the patient evaluation and/or the treatment, including thought processes and the complexity of medical decision-making.
- Review notes and other pertinent documents in the medical record, including records obtained from previous providers, and document how unresolved or ongoing health issues are addressed.
- Ensure that the prescription refill process is appropriately managed (e.g., refills are accurate and authorized by licensed providers); implement a quality review process.
- Ensure that all sample medications are recorded and entered in the patient's medication list.
- Review changes/deletions to the patient's medication list and reconcile the list at each patient visit.
- Keep acute and chronic problem lists and medication lists up-to-date.

Do… (continued)

- Review the record for inaccurate entries resulting from use of template defaults or checkboxes.
- Utilize visit summaries, which many EHRs can generate, in order to communicate patient education and discharge instructions.

Don't…

- Document care that was NOT rendered to the patient.
- Use abbreviations, acronyms, symbols or dose designations that are prohibited by The Joint Commission and/or your organization.
- Allow medical assistants (MAs) to reconcile a patient's medication list. MAs should not have authorization to delete a medication from a patient's medication list.
- Use a terminal or trailing zero after a decimal. For example, never document 5.0 mg. This could be misinterpreted as 50 mg.

Interactions with Patients and Others

Do…

- Document:
  - Patient/family instructions (see sample form Patient Education Flow Sheet).
  - Patient behavior **objectively**, including noncompliance or potentially harmful action.
  - Pertinent discussions with the patient and with the patient's other healthcare providers, including those that occur by telephone, letter, fax, email, texting, etc., both during and **after office hours** (and including those with on-call physicians).
  - Informed consent or informed refusal discussions, including risks, benefits, and alternatives as well as potential consequences of noncompliance.
- Include signed and dated informed consent or refusal forms in the medical record, as appropriate. However, the presence of a form alone is **not** a substitute for a meaningful discussion between the physician and the patient along with documentation in the medical record of the informed consent or informed refusal process.
- Link the scanned informed consent form to the discussion note, if possible.
- Verify the accuracy of fax numbers and ensure that information is transmitted correctly.

Don't…

- Make subjective or judgmental comments about the patient, family members, or other healthcare providers in the medical record.
- Write derogatory statements about the patient or others involved in the patient's care.
- Use the medical record to settle disputes or assign blame.
- Include or refer to incident reports in the medical record.
- Make references to legal actions, attorneys or risk management in the medical record.
- Document information that is **not** pertinent to patient care.
- Add explanatory or other notes to a record after learning of a poor outcome or receiving notice of a claim or lawsuit. Contact the Claims Department for guidance on this issue.

Format

Do…

- Ensure that the system dates, times, and authenticates all entries. In a paper record, make entries chronologically and date and time all entries.
- Use only known, approved abbreviations.
- Ensure that documentation is entered into the **correct** record. In a paper record, include the patient's name and identification number on each page including both sides of a two-sided page.
- Have a written and consistently used policy and procedure for correcting errors and making amendments in the EHR.
- Have a written and consistently used policy and procedure for copying and pasting information into a patient's record.
- Use a consistent, clear format or documentation template. When using patient information pulled forward from prior notes and/or template phrases and default entries, be careful to check that each visit note contains accurate information and reflects the details of what actually occurred during the visit.
- Consider using voice recognition software to facilitate documentation.
- Ensure that information is current and accurate.
- Follow standardized scanning procedures. Include copies of records from other facilities or providers.
- Ensure checklists, forms and templates are completely filled out in the medical record. In a paper record, if some parts of a form are not applicable to a particular patient situation, note "not applicable" or "not examined" on that individual form on the area(s) not used.

Don't…

- Write notes that appear canned, copied from other entries or disorganized.
- Sign-off from the system before ensuring that the data entered are accurate.
- In a paper record, don't skip lines, leave blank spaces or write in the margins except to direct the reader to an addendum for that time.

Accuracy

Do…

- Use medical terms correctly.
- Use specific, objective words; facts only.
- Avoid typographical errors that make the record appear unprofessional.
- In a paper record, correct documentation errors by drawing a single line only through the error; initial and date the entry.
- Ensure that scanned documents are legible in the EHR.
- Ensure that the printed format of an electronic record is easy to understand and accurately reflects what was done.
- Adhere to organization policy on timely documentation and closing of electronic medical record encounters.

Do… (continued)

- Review and sign off your record when documentation is complete to ensure that records are accurate and cannot be altered.
- Proofread all notes documented by transcription or a scribe.
- Identify addenda or late entries as such.
- Ensure that procedure and diagnosis codes reported on the health insurance claim form or billing statement are reflected in the medical record documentation.

Don't…

- **Alter a medical record ever.** Even the intent to make a simple clarification could destroy the credibility of a medical record, if not done correctly.
- Try to fix documentation errors in an EHR by attempting to delete. (Metadata will reflect changes or deletions made to the record.) In a paper record, don't obliterate documentation errors by erasing, scribbling through them or using white out.
- Use subjective or non-specific terms such as "appears confused" or "medication for pain."
- Document incorrect information.
- Document in advance. An interruption or other intervening action may result in charted care not actually being performed.
- In a paper record, don't backdate, tamper with or add to previous notes.
- Rely on recall (entries should be contemporaneous with the patient visit).
- Document for someone else or have someone else document for you.
- Countersign inappropriately.
- Use jargon or slang.
- **Share your password.**

Legibility (paper record)

Do…

- Make sure the author of every entry can be identified.
- Make sure all entries can be read.
- Consider one or more of the following alternatives if your handwriting is difficult to read:
    - Implementing an EHR system
    - Using template forms that allow checking or circling items
    - Printing instead of cursive writing
    - Using a scribe
    - Using dictation/transcription
- Use permanent ink.

Patient Education Flow Sheet

Patient Name:

Date	ED Need	Information Taught	Who	How	Response	Initials

SAMPLE

KEY			
Educational (ED) Need	**Who**	**How**	**Response**
CR = Community resources Diet = Modified diet F/D = Potential food/drug interaction MED = Safe and effective use of medication RES = Responsibilities of patient in his/her care EQ = Safe and effective use of equipment RX = How and when to obtain further treatment Other – Please specify	F = Family PT = Patient Other – Please specify	V = Verbal instruction P = Pamphlet W = Written instruction D = Demonstration MED = Medication instruction sheet Other – Please specify	VR = Verbalized recall & understanding DA = Demonstrated ability Q = Asked questions A = Attentive R = Requires reinforcement DI = Seems disinterested UL = Unable to learn REF = Refused teaching/ material

Revised: June2017

This sample is a template only and is not intended to be used "as is." It is an example to assist the policyholder in the development of a document that is tailored to the individual practice. This sample is intended solely for the use of NORCAL policyholders as reference material only. It does not constitute legal advice, but is intended to supplement risk management advice. You may want to have this information reviewed by an attorney to determine if it is appropriate for use in your practice or institution.

© 2017 NORCAL Mutual Insurance Company.