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AMERICAN PHYSICIANS

Enhancing Documentation Practices for Improved Patient Care

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Disclosure

No planner, faculty, or presenter for this activity has any relevant financial relationships with ineligible companies.

Learning Outcomes:

- Recognize how medical record documentation can have an effect in medico-legal cases.
- Utilize objective findings and avoid vague terminology when documenting a patient's clinical picture.
- Perform comprehensive documentation of patient care and related management decisions.
- Compose notes that avoid the use of comments that could be perceived as disrespectful or stigmatizing.
- Integrate appropriate education materials and strategies in a manner that is culturally sensitive, linguistically accessible, and tailored to meet the diverse needs of patients.
- Create a protocol to effectively manage late entries, addendums, and patient requests for amending their medical record.

The medical record has a variety of purposes:

- To provide a chronology of patient care/management
- To serve as a communication tool with all healthcare members
- To obtain proper reimbursement
- To be utilized as the practitioner's best evidence in a professional liability lawsuit

The Gold Standard:

S.O.A.P. Notes

Subjective - from the patient

Objective - from the physician

Assessment - what needs to be done

Plan - what to do and how to do it

Each patient encounter should include:

- Date, the reason for the encounter, medical history, physical exam, and the plan of care.
- Relevant health risk factors.
- Reasons for and results of lab tests, x-rays, and other ancillary services, including consultations.
- Patient's progress including response to treatment, change in treatment, change in diagnosis and patient non-adherence.
- Patient's consent, and informed consent when required.
- Patient and family education.

What does the data tell us?

- 2020 JAMA survey completed by 26,656 patients
- 22,889 patients reported medical notes requires correction
- 21.1% (4,830) reported a perceived mistake
  - 42.3% (2,043) reported the mistake was serious

- **Common Mistakes**:
  - Diagnosis
  - Inaccurate medical history
  - Medications or allergies
  - Tests/procedures/results

Bell SK, Delbanco T, Elmore JG, et al. Frequency and Types of Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes. *JAMA Netw Open*. 2020;3(6):e205867. doi:10.1001/jamanetworkopen.2020.5867

Individuals who accessed their online medical record used it to view test results, perform health-related tasks and communicate with health care providers.

Table 2: Reported online medical record functionalities used by individuals amongst those who were offered and accessed their record, 2017.

How online medical record was used[1]	% Individuals who accessed online medical record at least once
View test results	**85%**
Performed one or more health-related tasks: Request refill prescriptions, complete paperwork, or make appointments	**62%**
Communicate with health care provider via secure messaging	**48%**
Monitor health or use for informing treatment decisions	**39%**
Update or correct medical record	**23%**
Download online medical record	**17%**
Transmit data to outside party (health care provider, caregiver or service or app)	**14%**
Transmit to another health care provider	**10%**
Transmit to caregiver	**4%**
Transmit to service or app	**3%**

SOURCE: HINTS 5, Cycle 1, 2017

Candello Closed Claims Data

(2017 – 2023)

Closed claims total = **31,963**
Cases with Documentation as contributing factor = **7,244**
Cases with an Electric Health Record (EHR) related issue = **365**

Contributing Documentation Factors	
Delay in documentation.	36%
Inconsistent documentation about clinical details.	31%
Inadequate documentation about review of/participation of care.	30%
Lack of documentation about clinical findings.	28%
Inadequate documentation about clinical rationale.	28%
Insufficient/lack of documentation.	28%
Documentation history was inadequate.	24%
Inaccurate documentation about factual information.	22%
Problematic documentation about an adverse event.	21%
Insufficient documentation around informed consent.	9%

What you **DO** is your first line of defense.

What you DOCUMENT is your second line of defense.

Case #1: Inadequate documentation about review of care (Copy & Paste)

Patient seen for removal of ingrown toenail. During procedure patient told physician that he was experiencing "balancing issues".

Physician copied and pasted a similar procedure note from another patients' record. However, he did not include the patient's concern about his balancing issues.

When patient returned for post-procedure appointment, the physician did not ask about patient's balancing issues.

When the patient left the office, he lost his balance, stumbled and fell sustaining a severe injury to his foot that required surgical intervention.

Case #1 Takeaways

Ensure patient care notes reflect accurate assessments.

- Chart patient statements.
- Validate patient narrative is updated.

Limit the use of copy and paste.

- Validate accuracy of information.
- Develop policy regarding copy/paste practices.

Case #2: Insufficient/Lack of documentation

25 y/o female seen by OB for prenatal care. LMP 8 weeks prior. Orders for BHCG and pelvic ultrasound. Elevated BHCG, ultrasound + IUP.

2 weeks later (follow-up appt.). OB performed transvaginal US and revealed no IUP. Diagnosis: spontaneous abortion.

2 months later. Patient sees OB for c/o spotting and cramping. LMP 3 weeks prior. Positive home pregnancy. OB performed pelvic ultrasound and ordered BHCG. OB then went on vacation without documenting patient's visit.

3 days later. Patient presents to ED for c/o acute abdominal pain with N/V and lightheadedness. Patient reported OB visit; "Most likely tested positive from prior miscarriage. No fetal HR noted (on US)."

ED ultrasound: No IUP. Free fluid in cul-de-sac. Large heterogeneous mass in anterior uterus. Ectopic pregnancy is not excluded.

Patient became more symptomatic. Underwent exploratory laparotomy and evacuation of hemoperitoneum and right salpingectomy for ruptured ectopic pregnancy.

Case #2 Takeaways

“If it wasn’t documented, it wasn’t done.”

Timely documentation provides you and others a more accurate and informed timeline of patient services and encounters.

Case #3: Inadequate documentation about clinical rationale and informed consent/refusal

80 y/o male with extensive GI history (GERD, hiatal hernia, Barrett's esophagus), DM, CKD Stage IV, HTN and BMI of 47.9, presented to ED with abdominal pain, N/V x 1 week. CT-scan abd: stomach distended with fluid and debris. GI consult: suspected gastric outlet obstruction. Patient to have EGD with MAC anesthesia scheduled for next day.

GI plan: Place NGT prior to EGD to decompress stomach. Patient refused NGT. GI did not document plan or patient's refusal for NGT. EGD went forward with MAC but GI was unable to fully visualize the gastric outlet due to solid and liquid food present. Reschedule procedure in 2 days.

GI again wanted to place NGT to decompress stomach, but patient refused. During second procedure with MAC, patient desaturated and required intubation. Admitted to ICU and treated for suspected aspiration pneumonia. Patient developed multi-organ failure. Made DNR and expired.

Case #3 Takeaways

Specify the clinical rationale behind your decision making.

- Detail risks/benefits.
- Explain if you are not following conventional practice.
- Explain *why* you do not follow conventional practice.

Informed Consent/Refusal

- Nature of treatment and expected benefits.
- Specific risks of the treatment and possible complications.
- Alternatives, including doing nothing.

Case #4: Inaccurate documentation about factual information

69 y/o male seen by PA for c/o 8-day history of urinary burning and dribbling, along with tenderness in his scrotum and perineal region. Exam revealed UTI and prostatitis. Plan to treat patient with Cipro, however, medical record notes Cipro "allergy". PA asked patient about allergy. Patient's only complaint was "abdominal pain" after taking Cipro 12 years ago. PA believed past reaction more likely a common side effect verses a true allergy. Patient agreed to take Cipro. PA removed the "Cipro Allergy" from the medical record to prescribe the medication, with the patient's knowledge.

After 8 days on Cipro, the patient reported numbness and tingling in his feet and stopped taking the Cipro.
Patient referred for neurology consult. Diagnosed with polyneuropathy related to Cipro use.

Case #4 Takeaways

Document Patient education.

- When prescribing a medication, explain the benefits and risks associated.

- Inform the patient of possible side effects and when to contact provider.

- Document the discussion with the patient in the medical record.

- If not English proficient, provide interpreter for discussions and written materials.

Case #5: Missing documentation

Physician receives after-hours call from a patient complaining of a severe headache. The physician instructs the patient to go to the ED for an evaluation. The patient responds, "Okay", but never goes to the ED as instructed and suffers a severe cerebrovascular accident later that night.

The patient subsequently sues the physician, alleging that the physician did not direct her to go to the ED. The patient's allegations were backed up by a friend's witness testimony.

The physician did not document the content of the phone call or the instructions to the patient.

Case #5 Takeaways

Do I need to document that patient phone call?
Yes.

- Document as soon as possible.
  - Include:
    - What the patient told you,
    - What you told the patient,
    - Any prescriptions, or directions to urgent/ emergent care,
    - The follow-up plan, and,
    - The risks of not complying and the patients understanding of discussion.
- Enter call in EMR or write it down and scan note into EMR later.

Other Documentation Related Events and Risk Strategies

Addressing Cultural Linguistic Competency and Implicit Bias

Focus on identifying implicit biases, as well as developing cultural sensitivity and communication skills.

- Are patients provided the same assessment and information regardless of their race, gender identity or other factors?
- Use gender-neutral language whenever possible.
- Develop diverse and inclusive care teams.
- Implement language services, such as interpretation services, and provide language-specific documents.
- Respect religious practices and consider cultural factors in decision-making processes.

Words Matter

Open Notes: Respect the patient.

- Avoid words that show bias like “obese”, “failed”, “denied”, “refuses”.
- Eliminate hot button words/abbreviations, e.g.,“F/U”, “SOB”.
- **Use patient’s own words**, put in quotations what the patient said

Templates

Be careful of auto population and dropdown menus

Do not rely on templates that automatically populate a "normal" physical exam or review of symptoms.

- Patient c/o chest pain and documented as "no chest pain".

- Exam that says, "moves all extremities" and the patient has an amputation.

- "Normal prostate" for female patient.

Review and verify each entry prior to signing off on record.

Scribes and AI

Using Scribes: Side-by-Side or Virtually

- Verify transcribed notes prior to signing off.

Artificial Intelligence

- New challenges.

Jousting

Arguing, belittling or criticizing others is **never** appropriate in the medical record.

Examples:

- Nurse's note: "*Patient going into shock. Could not get Dr. Smith to come. We never can!*"
- Physician's note: "*If nurses would read medication orders carefully, we would have fewer emergencies.*"

Discharging Patient from Care

- Patients who fail to keep appointments.
- Patients who refuse to undergo recommended care.
- Patients who behave in an offensive or dangerous manner.

Document the problems encountered and the efforts to resolve them.

Keep objective in tone.

Use patient statements in quotes.

Patient Requests to Amend Their Medical Record

California Health & Safety Code Section 123111 and HIPAA Privacy Rule allow the patient the right to request that their PHI be amended if it is incorrect or incomplete.

- Patient provides request in writing.
- Provider has 60 days to respond to patient's request.
- Patient's request becomes part of the medical record.

- If provider agrees, amendment made to chart.
- If provider disagrees, the denial must be written and provided to the patient.

Adverse Events

Write It Right

- Document only objective observations or known facts.
- Complications that manifested during care should be reflected.
- Document specifically what the patient/family was told.

- **DO NOT** blame others in the medical record.
- **DO NOT** change anything that was previously written.
- **DO NOT** document call to your insurance carrier in the medical record.

Disclosures

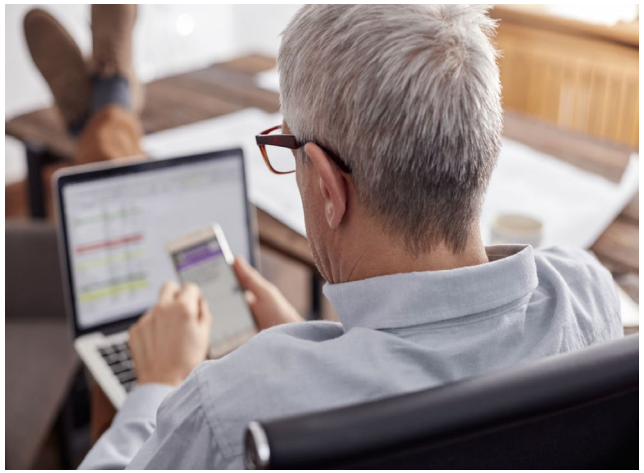
HIPAA Privacy Rule and Patient Rights

Patients have a right to receive an accounting of disclosures of their PHI for six years prior to their request except for disclosures provided to them or pursuant to their written authorization, or with regard to treatment, payment, health care operations, notification and communication with family, and special government functions.

Telephone Calls/Emails/ Text Messages

Any communication that pertains to a patient's treatment, diagnosis, or care plan is considered part of the medical record. That includes:

- Telephone calls
- Emails
- Text messages



Minors

Limited parental access to a minor's medical record (Minors ≥ 12 years old)

Discussions regarding sexual activity, mental health, drug/alcohol abuse.

Custody arrangements with separated and/or divorced parents

Obtain Court Order documents.

Nonadherence

Prioritize patient conditions for risk of injury due to nonadherence

- Ask how the patient understands their medical condition and reason for treatment.
- Provide educational materials to patients (handouts, video) on their condition.
- "Heart-to-heart" discussion with patient on "why" not following medical advice/treatment plan.
- Set boundaries and enforce them.

Document everything.

Special HIPAA Protected Documents

Psychotherapy Notes: a personal record for therapists, includes a therapist's thoughts, observations and hypothesis.

Progress Notes: information about a patient's treatment and response to treatment; official part of the medical record.

- Includes diagnosis, symptoms, treatment plan, medications

Keep them separate!

Psychotherapy Notes

END NOTE

What you *do* is your first line of defense.

What you *document* can save you.

Thank You

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