

# MIEC Recommendations for Defensible Medical Records

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## Organize charts

Secure loose pages to the chart cover with two-pronged clips. In larger charts, use dividers to separate progress notes from lab reports, correspondence, copies of hospital reports, and other materials. **Include the patient's name or other identifier on each page in the medical record.**

## Avoid the use of sticky notes

Avoid the use of sticky notes or unattached slips of paper, which can become separated from the chart. MIEC's office practice surveyors find that most notes written on loose slips of paper or Post-It® notes do not include the patient's name, the full date of the note, other essential details or the writer's initials. Sticky notes are meant to be temporary and lack space for the essentials of meaningful and permanent chart entries.

## Note the reasons for visit

**Begin each progress note with information about the reason for a patient's office visit.** The absence of this data handicaps the defense against allegations that the doctor failed to diagnose a problem the patient reported. As part of the intake or "triage" process, the doctor or an assistant should document the patient's chief complaint using quotes, when applicable, to indicate the patient's own words, and include the onset and duration of symptoms. Office staff should not translate the patient's comments into a medical diagnosis or medical terminology. A sample complaint might read:

"Pt. states: 'Stomach pain, diarrhea, headaches for two days. Has taken aspirin three times.'"

A rubber-stamp-template such as that below facilitates this documentation.

Date _____	Weight _____	BP _____ / _____	LNMP _____
		<i>Sitting</i>	<i>Lying</i>
Complaint(s) _____	<i>(Onset/duration)</i>		
Allergies _____	Meds _____		
Patient's other physicians: _____			
			_____
			Initials

**Anyone who obtains this information should note clearly who the historian is, if it is not the patient. If the patient does not speak English or is hearing impaired, include the name of the interpreter.**

Date <u>1/5/07</u>	Weight <u>125</u>	BP <u>125/85</u> / <u>125/80</u>	LNMP <u>12/15/06</u>
		<i>Sitting</i>	<i>Lying</i>
Complaint(s) <u>Pt. states "stomach pain, diarrhea x2 days."</u>	<i>(Onset/duration)</i>		
Allergies <u>Pencillin</u>	Meds <u>Prozac per Dr. S. Jones</u>		
Patient's other physicians: <u>Dr. S. Jones</u>			
			<u>cad</u>
			Initials

## Chart allergies, current medications, names of other physicians

Ask patients on their first visit about drug or other allergies; periodically update this information. MIEC's claims data reveals that the second most common category of medication-related claims involves the prescription of a contraindicated drug due to an unknown and/or overlooked allergy.

To avoid overlooking patient allergies, physicians should document this significant information on a brightly-colored sticker placed on the cover of each patient's chart or on a triage template (see Figure 2). When patients report "No-known-drug-allergies" (NKDA), document "NKDA" on the sticker or in the chart as evidence that the question was asked and allergies were denied.

Document the names of other treating physicians and note the conditions and/or medications they are managing. Ask patients about medications other doctors have prescribed since the previous visit, over-the-counter drugs, complementary and alternative supplements, and illicit drug use; document the information completely. Ask patients to bring all of their current medication vials to each appointment, so that the doctor can review them.

## Consider a "Problem List" in group practice charts

When more than one physician in an office or clinic treats a patient and makes entries in a unified medical record, communication among the co-treaters can be facilitated by a problem list that identifies serious medical conditions and includes the dates of onset and resolution. The problem list entries alert co-treaters to review their colleagues' progress notes and correlate their own treatment or follow-up advice.

### Caveat:

Problem lists must be current and complete or they could mislead. You may wish to assign an assistant the responsibility to ensure that significant current visit information is added to the problem list.

## Sign or initial all chart entries

Physicians and their staff should initial or sign their chart entries. Author identification gives chart entries credibility and limits the number of people a plaintiff's attorney could question about an unattributed entry.

Phone messages in which important information is received from or given to patients by the staff on the doctor's behalf should be initialed (or signed) and dated.

Medication refill notes should confirm that a physician approved the order (e.g., "per Dr. Jones") and be initialed by the employee who relayed approval to a pharmacy. Staff notes should similarly indicate that medical advice relayed to patients came from the doctor. In multi-specialty group practices, precede progress notes with the treating physician's name and specialty or department. Medical assistants can imprint this data and the visit date with a rubber stamp.

## Write legibly!

Everyone who writes in the medical record must ensure that entries are legible. Unreadable entries in a medical record usually are not a problem if only one physician relies on the chart - although poor handwriting has subjected many physicians to time-consuming depositions or court appearances just to decipher their writing.

When more than one person has to read and interpret the records, including office staff or other physicians, the potential liabilities of poor handwriting increase dramatically. In both office and hospital charts, a carelessly written

decimal point in a drug order, an unclear number on a laboratory report or vital signs note, or medical orders that even their author cannot decipher, are charting deficiencies that can result in expensive and difficult-to-defend lawsuits. Squeezed-in unreadable entries, initials or signatures that obscure medical notes, improper corrections, write-overs, and cross-outs are not only hazards in patient care, but weaken the credibility of documentation and the defense of a malpractice claim.

### **Dictate your records**

**Dictated and transcribed medical records are an alternative to illegible handwriting.** Dictated progress notes tend to be more complete and thus more helpful in documenting patient care, and more supportive in the defense of a malpractice claim than are many handwritten charts. Their most important feature may be that the ease of dictation enables the physician to include extensive details of history, examination, educational and instructional discussions, and contacts with specialists and referring doctors. Writing fatigue and time constraints make some doctors handwrite less information than they are likely to include in a dictated note. Transcribed records are recommended in complex cases, and in cases in which more than one physician provides care. Dictated records are advisable in cases the doctor reasonably can expect will involve either litigation or liability claims, such as auto accidents, industrial injuries, and reportable abuse. In these cases, the treating physician may be called as a witness. The quality of his or her medical record could become the focus of the litigation or proceeding if medical information has not been accurately, legibly and consistently documented.

### **Consider an electronic medical record**

An increasing number of software programs and complete documentation systems are available for physicians who want to computerize their medical records. When choosing an electronic medical record (EMR) system, physicians should first assess their practice management and documentation needs, and spend some time evaluating the EMR product and the company's stability. Computerized medical records should include the essentials of good documentation as outlined in this text. **Specifically, the EMR should offer (among other features): default fields that cannot be skipped (e.g., allergies, medications); reminders for health maintenance diagnostic testing; pop-up warnings about contraindicated medications due to allergies or prescribed drugs; safeguards against undetected alterations; an automatic backup system; and more.**

### **Avoid untimely dictation**

Operative and procedure reports or discharge summaries dictated too long after an event may handicap physicians who care for hospitalized patients or who are on-call for another physician. **Serious diagnostic and treatment errors have resulted in injury and litigation because these reports were not available. Reports dictated too long after a complication lack credibility, whether or not the complication resulted from negligence.**

### **Do not use a "Dictated but not read" stamp or note on transcription**

Some busy physicians believe this rubber stamped disclaimer excuses them from errors or omissions on reports or correspondence they sign. In fact, such attempts to limit liability actually increase it. If un-reviewed reports contain errors or omissions that result in patient injury, in addition to claiming negligence, plaintiffs could allege in litigation that the doctor was "too busy" or "too unconcerned" to ensure the accuracy of an operative, History and Physical, or consultation report. Juries have not been sympathetic to the excuse that a doctor was too busy to protect patients by reviewing these important documents. It is difficult to correct errors or fill in blanks months or years after a report was dictated. It is even more difficult for doctors to convince jurors they meant to say something other than what appears on the report they dictated and sent without reading.

## Initial or sign questionnaires as evidence of your review

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Many medical practices ask patients to complete a questionnaire that documents information about past medical and surgical history, family medical history, and personal habits. These can be helpful forms as they provide the physician with useful information. As evidence that the physician has reviewed questionnaires and history forms, the doctor should initial the forms and, in the case of significant patient responses to questions, make a note next to these items (or refer to them in the progress notes) to indicate the patient's responses were discussed and considered.

## Fill in or void spaces on forms and transcription

A blank space on a form does not always signify a negative response. Plaintiffs' attorneys and jurors may regard blank spaces on an examination template as evidence that parts of an exam were not done. On a questionnaire, patients may leave spaces blank because they did not understand or overlooked the question, are functionally illiterate, or did not know how to spell a medical or drug term. Fill in or void all spaces for information on forms. Ask office staff to review forms patients fill in to ensure the forms are complete. Physicians should not sign operative reports, discharge summaries, or other transcription before filling in blanks.

## Initial or sign lab, X-ray, consultants' reports as evidence of your review

A number of patient injuries and malpractice cases are traced to physicians' failure to review and act upon positive laboratory and X-ray reports or treatment recommended in correspondence from consultants before these items are filed in the medical record. It is *not* fail-safe to file these reports in the chart with the expectation the doctor will review them the next time the patient is seen; if the patient does not return, as some patients who became malpractice plaintiffs did not, the doctor may not discover significant findings that require action until the patient suffers an injury. Another unsafe but common practice is to assume that a report was reviewed because it is in the doctor's "out" basket. Every liability insurer has had cases in which un-reviewed reports somehow managed to get into the out basket and were filed, but were never reviewed by a physician. A safer approach is to require physicians to initial all reports as an indication to the staff that each item has been reviewed and can be filed; the staff would file such reports only if evidence of the physician's review was clearly visible.

The template shown below, which can be made into a rubber stamp, has space to note the physician's review, and documentation that the patient was advised of the results.

Report reviewed by: _____
Phone report to patient? <input type="checkbox"/> Yes <input type="checkbox"/> No
Phoned to: _____
Comments: _____ _____
Date/Time: _____
By: _____

## **Avoid unexplained cross-outs, write-overs or squeezed-in entries**

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Cross-outs or other unexplained changes or write-overs obscure both the original entry and correction. These changes often are cited by a plaintiff's attorney to suggest that the medical record was intentionally altered. Correct writing errors by drawing a single line through the incorrect entry so that it can still be read. Write in the correction (legibly) and initial it. Avoid writing over any entry, especially digits (for vital signs, medication doses and amounts, etc.). Start a new page, rather than squeeze in notes at the bottom or the sides of a full page. In litigation, such notes may appear to have been added with the intent to falsify the record after an adverse event occurred or after litigation was threatened.

**Caveat:** When amending progress notes, include the date, time and, if the reasons for the amendment are not obvious, explain the change. **Never amend or correct a medical record after receipt of notice of a potential claim.** Obtain advice from MIEC's Claims Department if charting errors are discovered following a complication or after a claim is threatened or filed.

**Caveat:** Deliberate alteration of a medical record is illegal and unethical, and may subject the writer to criminal and civil penalties, including possible loss of the doctor's medical license. The technology to detect documentation alterations is sophisticated and includes methods that accurately determine if entries on the page were made at the same or different times. **Evidence of questionable late entries or alterations is usually admissible in court and strengthens the plaintiff's case.**

## **Chart medication prescriptions and renewals completely**

As many malpractice claims involve medication problems, physicians should have a good system to ensure that they do not err in prescribing new drugs or granting renewals because they overlooked earlier prescriptions that were noted in the chart, but were not easily visible upon cursory review. Review of MIEC's medication-related malpractice claims found that a large number of errors resulted when the prescribing physician overlooked earlier notations about prescriptions, particularly in offices in which more than one physician prescribed or renewed medications for the same patient. Some cases resulted when a physician prescribed a drug which was contraindicated because of an earlier prescription; the earlier prescription was appropriately documented, but the documentation was "buried" in the depths of the patient's chart and apparently overlooked. In a number of cases involving allegations that too much medication was prescribed, the error was traced to the physician's failure to notice that renewals were being ordered in increasingly shorter time spans. Again, the problem occurred because the medication information was buried in the body of the chart.

## **Use a Medication Control Record**

The risks of harmful errors are reduced by maintaining a Medication Control Record (MCR) that lists all prescriptions and refills and is easily accessible for review. (Contact the Loss Prevention Department for a copy of an MCR or download one from the Loss Prevention section of MIEC's website at [www.miec.com](http://www.miec.com).) Physicians who choose to record medications in progress notes rather than on a medication control form should make certain that all entries are complete. Each entry should include the full name of the medication, dose, number dispensed and instructions. Medication renewal notes should be similarly complete. Notes that read, "Renew meds" are ambiguous — and may be misleading if the patient is taking several medications and not all of them are due to be refilled at the same time the note was written.

Medication Control Record						
Patient Name: _____		DOB: ____ / ____ / ____		Phone: _____		
Allergies: _____						
Meds Rx'd by other MDs: _____						
Pharmacy: _____				Phone: _____		
Complete Date	Medications/Directions (Name, Dose, Amount, Instructions)	Refills				
Start:	_____	Date	____/____/____	____/____/____	____/____/____	____/____/____
Stop:	_____	MD Initials	/	/	/	/
No. of refills: _____ If sample, quantity: _____		Staff Initials	/	/	/	/
Patient handout: _____						

### Dispense drug education materials and document the details

Studies by the National Council on Patient Information and Education say that more than half of the prescriptions doctors order each year for patients of all ages are taken improperly or are not taken at all. According to the National Pharmaceutical Council, patients not taking medications as directed result in 125,000 deaths per year, 10% of all hospital admissions, 25% of all hospital admissions among the elderly, and 23% of all nursing home admissions.

These data underscore the importance of giving patients information about the drugs they are advised to take, and clear instructions for taking them. The studies also emphasize the need to take and periodically update an adequate medication use history, and to document the fact that information about drug side-effects was dispensed to the patient.

To increase patient understanding, promote patient compliance with medication instructions, and to reduce liability exposure, dispense written instructions for prescribed medications. Some commercial materials and some from medical specialty organizations are designed to familiarize patients with the drugs they are taking and to alert them to drug-related problems that they should call to the physician's attention. Doctors who do not like pre-printed forms should consider writing their own drug information sheets.

When written materials are dispensed, a note should be made in the patient's medical record. Medication information sheets may be numbered, so that documentation could consist of a note that says, for example:

"PM I #007," which means patient medication instruction sheet #007 was dispensed, and the patient was told to read it and let the doctor know if he or she had any questions. MIEC's Medication Control Records have a space to indicate that printed information was dispensed.

Physicians who prefer to rely on oral advice should document in the progress notes that they have explained to patients each drug's use, the directions for use, significant side effects and what to do if the patient experiences them, and other significant and/or educational information.

### Document significant phone conversations with dates, names, and content

Document in patient charts phone calls in which a physician receives or imparts important medical information. Documenting the calls in a separate log is risky, because: (1) co-treating physicians in the practice may not seek out and review logged messages about symptoms, medication changes or advice that might affect their own diagnostic or treatment decisions; and (2) as phone logs are not included when a pre-litigation copy of the patient's chart is provided,

the patient's attorney may be unaware of telephoned information essential to understanding the case. Keep phone message pads at home and carry one on hospital rounds to facilitate documenting out-of-office phone calls. Many physicians dictate details of phone conversations into a small pocket recorder and have the notes transcribed when they return to the office or call their dictation service and record the details of a phone call. On-call physicians should document significant after-hours phone calls with their colleagues' patients and remember to inform the colleague. The form shown in *Figure 7* on page 14 can be used to document contacts with a colleague's patients.

Office staff who receive phone calls from patients should document these calls in a consistent manner. An effective telephone message slip, similar to the example in *Figure 8* on page 15, should have space for the physician or staff person to document actions taken (or directed by the doctor) in response to the patient's call.

### **Document referral notes unambiguously**

Document referral recommendations in unambiguous terms. Rather than note, for example, "to see GYN," write, "Pt urged to see her GYN promptly for vaginal bleeding; patient understands urgency." Instead of, "back pain needs ortho," write, "Pt says she will call today for an appt with orthopedist for back pain." In place of "ENT for nasal polyp," write, "Made appt for pt on 10/6/06 with Dr. Nohs for nasal polyp."

### **Include sufficient details of exam findings in progress notes**

In litigation, progress notes can be the strongest or weakest parts of the defendant's medical record. Because of inadequate chart notes, hundreds of defendant-physicians have had only their recollections on which to base testimony about details of physical exams, postoperative bedside visits, advice they gave to patients, and medications they prescribed and renewed. In litigation, patient-plaintiffs often convincingly dispute their doctors' undocumented recollections. Plaintiffs' attorneys cite sparse progress notes to argue to jurors or arbitrators that office visits were too brief, or that examinations were perfunctory, just as the patient "remembers" and alleges. Phrases in progress notes like "OK;" "looks fine;" "normal neuro exam;" "headaches;" "ROS WNL (review of systems within normal limits);" or "some numbness," are too ambiguous for defense experts to evaluate, and provide ammunition for the plaintiffs' experts to question and criticize. These types of notes imply inattention or haste and have influenced the outcome of many "failure-to-diagnose" malpractice suits that physicians were forced to settle or which were lost at trial. More physicians are now dictating hospital progress notes in complex cases to ensure adequate documentation of their bedside evaluations and discussions with patients or their families. Haste is not an affirmative defense for inadequate documentation or resultant errors.

Patient-safe (and defensible) progress notes include sufficient information about:

1. Reasons for the current visit;
2. The scope of examination;
3. Positive and pertinent negative exam findings;
4. Diagnosis or impression;
5. Treatment details and future treatment recommendations;
6. Medication administered, prescribed or renewed;
7. Written (or oral) instructions and/or educational information to the patient; and
8. Recommended return visit date.

DATE: \_\_\_\_\_ TIME: \_\_\_\_\_ CALL TAKEN BY: \_\_\_\_\_  
FOR: \_\_\_\_\_ CALLER: \_\_\_\_\_  
PHONE: \_\_\_\_\_ PATIENT NAME (IF NOT CALLER) \_\_\_\_\_  
MEDICATION REQUEST: \_\_\_\_\_ APPROVED BY: \_\_\_\_\_  
OTHER MESSAGE:  
DOCTOR'S RESPONSE:  
ACTION:  
STAFF INITIALS: \_\_\_\_\_

**Date:** \_\_\_\_\_  
**To:** \_\_\_\_\_, M.D.  
**Re: Patient** \_\_\_\_\_

This patient phoned on \_\_\_\_\_ at \_\_\_\_\_ o'clock.  
 I saw this patient in  Office  Emergency Department  
 \_\_\_\_\_ at \_\_\_\_\_ o'clock.

**Complaint/History (and historian)/Allergies/Medication:**

**Examination:**

**Impression:**

**Action/Advice:** Admitted to \_\_\_\_\_

Patient advised to call you in \_\_\_\_\_ days.  
 Patient advised to go to \_\_\_\_\_ Emergency Department  
 Other: \_\_\_\_\_

**Medication prescribed:** (Drug, dose, #, sig.)

Phoned to \_\_\_\_\_  Prescription written  
 Attachment: \_\_\_\_\_

These charting tools expand on narrative descriptions of the location of an injury or lesion, such as lacerations, burns, breast lumps, painful or erythematous areas, foreign body puncture sites, and neurological deficits. They add substance to indefinite phrases such as: "lump in upper outer quadrant left breast;" "laceration on plantar surface;" "facial acne;" "4 mm melanoma on back." A simple line drawing supplements narrative descriptions of size, depth, scope or severity.

### **Document informed consent discussions carefully**

Although a signed consent form technically is evidence of a patient's consent to a surgery or invasive procedure, litigants often claim - and juries believe - they did not read or understand the lengthy form they signed, or that they signed it because they were told the procedure would be canceled if they did not. Even in states in which a signed consent form is *prima facie* evidence that a patient gave an informed consent, a consent form alone may lack credibility unless it is backed up by a physician's handwritten or dictated note in the office or hospital record that verifies informed consent was obtained. Defense attorneys recommend that physicians document their informed consent discussions with a note similar to this: "The patient was advised of the purpose, benefits and significant risks of this procedure, including but not limited to bleeding, infection, (damage to adjacent structures or organs) (other specific, common risks). Alternative treatments and their risks, and the risks of non-treatment also were discussed. The patient's questions were answered. (S)he appears to understand the risks of the procedure and gives his/her informed consent." Defense attorneys further suggest that physicians indicate in the note who else (spouse, relative) was present during the informed consent discussion with the patient.

**Important Note:** Physicians should document informed consent discussions with patients in their office progress note, a History and Physical report, or a consultation report, **but not in an operative or procedure report**, which are dictated **after** the surgery or procedure. If problems occur, notes about **pre-operative** discussions of complications or potentially adverse outcomes in these **after-the-fact** reports appear self-serving and may lack credibility in court.

Physicians are encouraged to ask patients to sign a plain-language consent form for elective and non-emergency office surgery at the time the procedure is discussed. Include statements on the form for the patient to validate, such as: "Dr. (name) has explained to my satisfaction the purpose, benefits and alternatives to this procedure, the significant risks, and the consequences of not having the procedure. The doctor answered my questions and I wish to proceed."

### **Document "informed refusal" discussions**

Several states require physicians to inform patients who refuse medically essential surgery or diagnostic tests if there are potentially deleterious consequences to their decision. Informed refusal, if it is properly documented, protects physicians from liability for decisions the patient has made after being informed of the risks. A brief chart note such as: "Patient refuses test [or procedure ]; explained risks of refusing treatment and degree of urgency, and patient understands," generally suffices.

Contact MIEC's Loss Prevention Department for a *Claims Alert* with state specific information on informed consent and informed refusal.

## **Document patients' noncompliance in the progress record**



Physicians should document a patient's failure to follow advice, take medication, obtain requested diagnostic studies, keep an appointment with a consultant, or other actions the patient takes or fails to take that could cause or contribute to an injury or delay in resolution of a medical problem. Countless physicians have testified, without benefit of documented proof that a patient's claimed injury did not result from the physician's negligence, but from the patient's own action or inaction. In such cases, denials by patients or by survivors of deceased patients may appear believable when medical records do not support the defendant's assertions of the patient's carelessness. Sometimes documentation does exist, but it is too equivocal to resolve a dispute about what was said or done.

Each of the following notes from actual cases helped somewhat in their writers' defense, but would have been more convincing had the italicized text been included: "patient and husband refuse internal fetal monitor; *limitation on our ability to identify fetal distress emphasized*;" "patient refuses hospitalization and surgery; *patient and wife informed of risks of surgery delay, including sudden death*;" "patient continues to use alcohol and tobacco during pregnancy; *again urged her to stop and stressed risks to fetus*;" "patient has not kept cast dry as instructed; *advised of possible delay in healing and risk of deformity; applied new cast; re-instructed pt in mother's presence*;" "patient says he often forgets to take HTN meds; *gave him written time/dose schedule for all drugs and discussed dangers of not taking all as ordered*;" "patient refuses breast exam, says her GYN will do it next month; *I stressed urgency of prompt evaluation of lump she said she felt*."

## **Chart evidence that patient education information was dispensed**

Patients can sustain an injury when they misunderstand or cannot remember a physician's oral advice. Patients who are not educated about the scope and limits of medical care and/or about their own responsibilities for self care, keeping appointments, or taking medication, often have unrealistic expectations of their physicians, and may sue when the outcome of treatment is not optimal. Increasingly, physicians are becoming convinced that *second only to never making a mistake or never having a bad result, the most effective deterrent to patient injury and litigation is patient education*. Written information on numbered handouts that supplements oral advice and instructions helps to inform patients of their condition, medication, or treatment; transfers responsibilities to patients; and reduces the physician's liability.

Documenting that written (or oral) medical information and advice were dispensed is essential. Some litigants claim they did not receive written material; others do not accurately recall the doctor's oral advice or deny any was given. Documentation strengthens a physician's defense against such claims. A note such as "PI #7" can be used to mean that the patient: (a) received Patient Information sheet #7; (b) was told to follow the written advice; and (c) was encouraged to ask questions about the material. Document oral advice with a note such as: "Discussed hypertension in detail. Pt understands med use and need for BP test every X weeks."

## **Document return visit advice in each progress note**

Conclude office visit progress notes by indicating when the patient was advised to return. Such notes help defend a physician in a malpractice case brought by a patient whose injury resulted from his or her own failure to return for follow-up. The documentation also prevents a patient whose failure to keep appointments resulted in injury from claiming the doctor was negligent for not suggesting a return visit. When no specific follow-up is required, a "return if any problems" or "return if *(cite problems)* occur" note means the doctor gave the patient the responsibility to decide when to return.

## Document failed and canceled appointments in the progress record



Patients who consistently miss or frequently cancel appointments may place themselves at risk; some try to blame the doctor for injuries caused by their own negligence. Failed appointments documented in the patient's chart are likely to be noticed by the attorney who obtains a pre-litigation copy of the medical chart to determine if a patient's claim has merit. Few attorneys relish representing an injured patient who failed to heed a physician's advice to return for further care. Failed or canceled appointments may be recorded in an appointment log or a computer scheduling program, but because the suing attorney does not have access to the log or scheduling system, he or she may not find out how often the patient failed to keep appointments until the lawsuit is filed and the doctor's deposition is taken - unless the information is in the chart. The template below can be made into a rubber stamp.

<input type="checkbox"/> No Show	<input type="checkbox"/> Canceled	_____	Initials
<input type="checkbox"/> Rescheduled: _____ by _____			
Date		Initials	
Per Dr. _____:	Patient Contacted:		
<input type="checkbox"/> Reschedule	<input type="checkbox"/> By phone _____		
<input type="checkbox"/> No need to reschedule	<input type="checkbox"/> By mail		
_____	_____	_____	_____
Initials	Date	Initials	Date

## Resolve medical problems from previous visit in the chart

Medical problems reported on prior visits that were not resolved should be "red-flagged" to remind the writer of the need for follow-up on a subsequent visit. For example, a physician may document (i.e., red-flag) a decision to defer a diagnostic test pending results of a short course of medication.

The next progress note should cancel the red-flag alert by indicating that: (a) the problem resolved; (b) further observation is planned; or (c) other actions (referral, tests, etc.) will be taken. If the physician neglects to cancel the red-flag with a closing note and the same or a similar problem surfaces in the future, it may be difficult to distinguish between a new complaint and the older, apparently untreated one. Ignored red-flag notes are serious defense problems in "failure-to-diagnose" claims.

Brightly-colored high lighter markers can be used to flag these important notes.

## Write unambiguous return-to-work or school orders

To avoid injury to a patient, return to work advice should be specific and reflect an understanding of the patient's job requirements. Orders for the patient to return to "light work" or "limited duty" may be misinterpreted by the patient or employer, or disregarded if the job duties cannot be modified as "light" or "limited." The doctor's orders should specify limitations on activities such as lifting, carrying, climbing, standing, or operating equipment. Return-to-school orders similarly should list specific activity restrictions.

## **Avoid unsubstantiated subjective remarks in the progress record**

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Medical record entries should be objective. For example, it is risky to refer to a patient as a "malingeringer" or "alcoholic" or write that he "abuses drugs" without objective substantiation of these potentially harmful assertions. When a physical exam fails to explain a patient's subjective complaints, it is best to say *so*, using professional language; e.g., "I am unable to find an objective explanation for the patient's complaints of pain." When making reference to alcohol, tobacco, or street drug use, include specific amounts reported by the patient. Terms such as "moderate," "heavy," or "occasional" are subject to broad interpretation. The physician should document objectively what the patient did or said that led the doctor to conclude the patient demonstrated "drug-seeking behavior."

## **Avoid criticism of other professionals in chart notes**

Comments critical of treatment by other health professionals are inappropriate in patients' medical records. Too often, criticism is expressed by physicians who have not reviewed prior medical records or discussed the case with the previous physician, but instead relied on the patient's account of what occurred. Uninformed criticism of colleagues triggers a high number of unmeritorious law suits. Physicians should not use a patient's office or hospital medical record to criticize nurses or to comment on the quality of services others provided or failed to provide. This is not to say that physicians or other healthcare professionals should suppress their legitimate concerns about patient care or about the responsiveness of others involved in the patient's care. However, hospital and medical society peer review or quality assurance committees, not the medical record, are the appropriate forums for physicians and others to address issues related to a colleague's competence, judgment or treatment choices.

## **Use prenatal forms with adequate space for data; complete forms legibly**

Many prenatal forms provide minimal space for narrative notes about prenatal visits. OB-GYNs are advised to consider using a supplemental sheet for progress notes if their prenatal forms do not provide enough space to describe the patient's complaints or lack of them, the results of physical examinations, and the substance of the doctor's discussion and advice. A consistent finding in studies done of obstetrical injury malpractice cases was that the reviewers often were unable to piece together a patient's prenatal course because of the scant progress notes, and therefore could not determine if the care was appropriate. The American College of Obstetricians and Gynecologists (ACOG) publishes the *Ante partum Record*, forms that assist physicians in their management of obstetrical patients and offer adequate space to document prenatal care. For information on ordering forms, contact: ACOG, 409 12th Street, SW, Washington, DC 20090-6920; 202/638-5577; website: [www.acog.org](http://www.acog.org).

Physicians should carefully review documentation in labor and delivery records prepared by hospital personnel. In these records, spaces for significant information should be filled in or voided, not left blank.

## **Document prenatal risk evaluation**

The American Academy of Pediatrics (AAP) and ACOG's *Guidelines for Perinatal Care*, as well as comments by expert obstetricians, indicate that physicians should adopt and document a formal risk evaluation system. ACOG's *Ante partum Record* encourages obstetricians and their staffs to document risk factors, vital lab test results, ultrasound results, and more.

# Documentation Review Self-Assessment

Number of charts reviewed:	Date:	By:
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Criteria	+	-	N/A	Comments
<b>Staff</b>				
Charts are well-organized				
All chart entries are dated and signed or initialed				
All handwriting is legible				
There are no loose slips of paper or Post-it® notes				
No unexplained crossouts, writeovers, squeezed-in notes				
There are no blank spaces on chart forms, questionnaires, consent forms				
Reasons for visit/complaints are noted				
Other physicians the patient sees—and why—are noted				
Current drugs patient is taking, including prescribed, complementary and alternative, OTC and “recreational” are noted				
Allergies or “NKDA” are noted				
Medication orders include the indications for use, drug name, dose, amount, directions, and number of refills authorized; renewals are clearly charted				
Medication renewals include all of the above, plus who authorized the renewal and the initials of the person who “called in” the renewal				
Evidence of dispensed written patient education materials is charted				
Failed, canceled, rescheduled appointments are documented in chart				
Significant phone calls are documented (content, advice, decisions, etc.), dated, signed				
No unsubstantiated, subjective remarks are seen				

Criteria	+	-	N/A	Comments
<b>Providers (including nonphysician clinicians)</b>				
Handwriting is legible throughout				
Dictation is timely, and bears evidence of physician review and correction				
No "Dictated but not read" stamps seen				
Patient questionnaires are initialed by providers as evidence of review				
Significant phone calls (including those taken while on-call) are documented (content, advice, decisions, etc.), dated, signed				
<b>Progress notes adequately detail scope of exam, findings, history, treatment, recommendations, and include:</b>				
Medical history				
SOAP (or similar) format				
Pertinent positive and negative exam results				
Impression or diagnosis; rule-out list				
Treatment rendered in office and/or recommended for future visits				
Why diagnostic tests were ordered or deferred; information reviewed by MD				
Diagrams, when appropriate				
Informed consent discussions				
Informed refusal discussions				
Documentation of noncompliance				
Evidence of oral and written patient education dispensed				
Unresolved medical problems are flagged, addressed and resolved				
Follow-up advice given to patients				
Patient-specific, unambiguous return-to-work/school orders, including limitations				
Return visit date or timeframe for follow-up				
Specific, unambiguous referral notes including indications, urgency, and patient understanding				

## Recommendations for Defensible Medical Records

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Organize charts .....	1
Avoid the use of sticky notes .....	1
Note the reasons for visit .....	1
Triage Template Diagrams .....	1
Chart allergies, current medications, names of other physicians .....	2
Consider a “Problem List” in group practice charts .....	2
Sign or initial all chart entries .....	2
Write legibly! .....	2
Dictate your records.....	3
Consider an electronic medical record.....	3
Avoid untimely dictation.....	3
Do not use a “Dictated but not read” stamp or note on transcription .....	3
Initial or sign questionnaires as evidence of your review .....	4
Fill in or void spaces on forms and transcription .....	4
Initial or sign lab, X-ray, consultants’ reports as evidence of your review.....	4
Lab, X-ray Report Review Template .....	4
Avoid unexplained cross-outs, write-overs or squeezed-in entries .....	5
Chart medication prescriptions and renewals completely.....	5
Use a Medication Control Record .....	5
Medication Control Record sample .....	6
Dispense drug education materials and document the details.....	6
Document significant phone conversations with dates, names, and content .....	6
Document referral notes unambiguously .....	7
Include sufficient details of exam findings in progress notes.....	7
On-call Physician’s Report Form .....	8
Telephone Message Slip .....	8
Supplement narrative text with line drawings, diagrams and templates.....	9
Document informed consent discussions carefully.....	9
Document “informed refusal” discussions.....	9
Document patients’ noncompliance in the progress record .....	10
Chart evidence that patient education information was dispensed.....	10
Document return visit advice in each progress note.....	10
Document failed and canceled appointments in the progress record.....	11
Did-not-keep-appointment (DNKA) Template (Figure 9) .....	11
Resolve medical problems from previous visit in the chart .....	11
Write unambiguous return-to-work or school orders.....	11
Avoid unsubstantiated subjective remarks in the progress record.....	12
Avoid criticism of other professionals in chart notes.....	12
Use prenatal forms with adequate space for data; complete forms legibly...	12
Document prenatal risk evaluation.....	12
Documentation Self Review Assessment Form page 1	13
Documentation Self Review Assessment Form page 2	14