Medical Records: Documentation

What's the Risk?
Medical Professional Liability (MPL) cases frequently focus on the documentation (or lack of documentation) in the medical record. In an MPL claim or suit, the documentation in the record often defines the claim's defensibility. Some practitioners may scribble only passing notes after each patient's visit or enter scant information in an electronic medical record (EMR). Others may repeatedly neglect to document patient education, informed consent, telephone calls and missed appointments in the patient record, stating that their focus is "patient care, not paperwork." Some resist documenting on standardized forms, flow sheets or lists. All of these issues and a host of others contribute to poor medical record documentation and poor defense of an MPL claim.

When Is This Risk an Issue?
Because MPL cases often rely on the medical record, practitioners must be aware of their obligation to their patients, employer, co-workers and themselves to provide an accurate and complete record of patient care.

Documentation is intended to accomplish the following purposes:
- Provide accurate and complete information about the care and treatment of patients.
- Furnish a basis for planning the course of treatment for each patient.
- Provide an ongoing means of communication among all caregivers involved in the treatment of an individual patient.
- Serve as a legal basis to substantiate care rendered.
- Document treatment and procedures ordered and provided for appropriate billing and coding

Documentation Fundamentals
A complete medical record will contain information necessary to communicate the patient's progress, or lack thereof, in response to the documented plan of treatment and completed medical orders. Issues such as legibility, clarity and timeliness often contribute to poor outcomes. A description of these issues and more follows.

Legibility
Handwriting that is not legible becomes subject to the reader's interpretation, which may be inaccurate. Illegible writing also makes it difficult to refresh the memory of a practitioner who must defend his/her care or try to recollect the rationale for a particular treatment decision. It is difficult to defend care when notations cannot be deciphered. Practitioners with poor penmanship make a very poor presentation in court when personal notes cannot be read or

interpreted, particularly when the offending illegible entry is displayed as a slide or poster for all jury members to see.

Creating legible medical records is probably the single most effective way to improve records.

Document Scanning
Scanned documents are part of a medical record. To prevent misfiling, it is a best practice to appropriately label all documents in the EMR system. According to the American Health Information Management Association e-HIM Work Group on Maintaining the Legal EHR (2005), "Every page in the health record or computerized record screen must identify patients by name and health record number. Patient name and number must be on both sides of every page as well as on every form and computerized printout. Paper and computer-generated forms with multiple pages must have the patient name and number on all pages."

Poor quality scans can cause important protected health information (PHI) to be lost. Poor quality scans may also leave the practice without important documentation in the event of a medical professional liability claim. For more information on scanning, see the chapter titled *Medical Records: Hybrid*.

Clarity
Patient care errors can occur due to miscommunication and misinterpretation of documentation. Additionally, the defense of an MPL claim may be impacted. The clarity and professionalism of each progress note is essential to patient safety.

Omissions
Critical omissions in the record hinder the defense of care and cast a shadow over the accuracy of the entire record. Recall the rule of thumb: if it wasn't documented, it wasn't done.

Timeliness
The medical record is considered open and incomplete until it is locked. The longer the delay in writing or dictating a note, the greater the likelihood that relevant information will not be in the record when the next provider sees the patient. Further, unexplained time delays or time gaps in completing the medical record may be interpreted as delays in patient care. If a medical professional liability case is pursued, such delays may result in allegations that the patient was not provided with timely care.

In terms of transcribing dictated notes, if there are mechanical difficulties with the equipment, questions concerning interpretation of specific words or sections, or unexplained gaps in the tape,

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it is easier to reconstruct the original when there is less, rather than more, time between dictation and transcription.

All clocks in the facility, as well as devices with automatic timers, such as cardiac monitors, portable EKG machines, or video recorders, must be promptly reset when daylight saving time begins and ends each year. Failure to do so may result in the appearance of a time gap or discrepancy. In critical procedures, identify which clock will be used to record the official time; for example, wall clock versus equipment clock.

Alterations or the appearance of alterations
Alteration of a medical record is a serious allegation in a civil case and may have criminal repercussions as well. Alterations or the appearance of alterations may well render a defensible case indefensible. Forensic documentation examination techniques are available to determine if a record has been altered and attorneys utilize document experts to help prove their cases.

Authentication
The medical record serves as the legal record of a patient's care. The American Health Information Management Association e-HIM Workgroup (2009) states that a signature, which authenticates the entries in the patient's medical record, serves the following three main purposes:
- Intent: An electronic signature implies that the signer reviewed and approved the information or documented the information and approved the content.
- Identity: The signature identifies the person signing.
- Integrity: The signature protects the integrity of the information against repudiation (i.e., the signer claiming the entry is invalid) or alteration.

The lack of a signature can make it very difficult to link a record entry with its author years after the care was rendered.

Abbreviations
Confusion and possible misinterpretation may occur when several members of a practice use different abbreviations for the same word or phrase. For example, "N/A" can be interpreted as "not applicable" or "not assessed;" "PT" as "physical therapy," "protime," or "patient;" and "BS" can be "breath sounds" or "bowel sounds." Because of the high risk of misinterpretation and involvement in harmful medication errors, the Institute of Safe Medication Practices (ISMP) developed a list of error-prone abbreviations, symbols and dose designations, which is available at https://www.ismp.org/tools/errorproneabbreviations.pdf.

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EMR Shortcuts

When drop-down menus, auto-populated fields or cut-and-paste functions are used, information not reviewed during a patient's visit may appear old and/or be inaccurate or not relevant to that specific visit, calling into question the validity of the documentation and what was done. Inaccurate information may also result in inappropriate billing for the visit.

Scribes

As the use of EMRs grows, so does the use of scribes who document patient care as physicians provide the care. While the scribe documents the care, the physician is responsible for the documentation. Thorough review and authentication of the documentation is imperative as noted by the American Health Information Management Association (2012) below:

> Physician practices need to ensure that providers remain connected to all patient information. When the provider no longer personally dictates or documents the services performed, he or she may miss computer prompts or not review the medical information in the same manner. The provider's review and authentication of the scribed documentation ensures medical procedures have been performed, ordered, and documented; electronic record alerts have been addressed; and patient care has been accurately recorded.

Comprehensive History and Physical Examination

A failure to complete a comprehensive history and physical examination (H&P) or a lapse of three or four years between comprehensive H&Ps may be used to substantiate a claim alleging "failure to diagnose" at a later time.

Forms & Templates

Standardized forms may be used to document review of system findings in a physical examination. Drawing lines through areas or leaving areas blank can raise questions as to what was examined or which system was reviewed. It may also give the impression that important clinical information was overlooked or not considered.

Medical history forms are often utilized to gather information about the patient's past medical history. It is imperative that practitioners review these forms and note relevant information, such as past medical history of cancer. It is difficult to defend a failure to diagnose claim when a practitioner gathers pertinent information and subsequently does not act on the information.

Templates are often used to document an H&P in an EMR. Using templates can facilitate documentation; however, it is critical that the practitioner select and clarify information based on the individual patient. Problems in the use of templates include

- Inability to discern between positive and negative findings
- Conflicting assessments

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- Redundant information auto-populated from previous visits

Family History
In addition to the patient's past medical history, family history can be critical to the early identification and intervention for patients at risk as well as the differential diagnosis process. Attorneys may use failure to document a complete family history, including history of cancer or heart disease, to substantiate a claim alleging failure to diagnose.

Medication List
A complete and comprehensive medication list that is kept current assists practitioners in reconciling the patient's medications at each visit and helps determine the patient's response to medication therapy. Coverys claim data has shown that an incomplete medication list may result in errors that may be difficult to defend in an MPL claim.

Problem List
A comprehensive and current problem list can facilitate continuity of care and serve as an easily accessible and reviewable tool for healthcare professionals. An incomplete list can result in delayed treatment or treatment errors that may be difficult to defend in an MPL claim. For more information on issues related to problem lists in an EMR, see the American Health Information Management Association's (AHIMA) *Problem List Guidance in the EHR* available at http://library.ahima.org/xpedio/groups/public/documents/ahima/bok1_049241.hcsp?dDocName=bok1_049241.

Allergy Status
Adverse drug events can occur when practitioners have insufficient information about a patient before prescribing, dispensing and/or administering medications. An incomplete assessment and/or documentation of allergy status can result in a patient receiving a medication to which he/she has a known allergy. Conspicuously flagging a patient's current allergy status allows for easy viewing by a practitioner and can reduce the risk of patient harm when ordering medications.

Preventive Healthcare
Preventive healthcare is an important and expected component of the primary care practitioner's practice. Organizing preventive health information in one location facilitates the review and tracking of the patient's status with respect to provided examinations, studies, immunizations and educational instructions. It is critical that documentation is up to date and complete. Inconsistent documentation practices can present a significant liability exposure.

Cancer Screening
The public expects cancer screening to be performed in their practitioner's office, and courts of law hold practitioners accountable for cancer screening. Specialists, such as cardiologists who

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act as primary care practitioners for one or more patients, are likely to be held to the same standard of care with respect to cancer screening as their primary care colleagues.

The failure to gather information and provide timely intervention may be viewed as a lost opportunity to diagnose and treat cancer. A cancer screening flow sheet/field organizes this information and facilitates the review and tracking of a patient's status with respect to designated examinations and tests. Whatever method the practice chooses, it is critical that documentation is up to date and complete. Inconsistent documentation practices can present a significant liability exposure.

Breast Cancer
Failure and/or delay in breast cancer diagnosis are significant MPL risk exposures for practitioners who provide primary care or specialty care to women. The documentation of breast examinations (including any abnormal findings), adherence to accepted screening guidelines, and appropriate referrals are often the focus of MPL cases involving breast cancer. For more information, see the chapter titled ***Diagnostic Accuracy: Patient Assessment and History***.

Patient Education
The Institute of Medicine (2001) defines patient-centered care as:

> Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients' wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care.

> Lack of patient-centered care, in particular patient education and corresponding documentation, may become an issue if the patient later alleges that inadequate information and/or preparation contributed to an injury or poor outcome.

Chaperones
Failure to use a chaperone during certain situations—sensitive examinations, when sedation is used, or when a patient is seen after hours, for example—may create misunderstandings about the reason for an examination and/or how the examination is conducted. Such misunderstandings may lead to allegations of inappropriate behavior or sexual misconduct. The Council on Ethical and Judicial Affairs (CEJA) Report 10-A98 of the American Medical Association (AMA) and the American Academy of Pediatrics (AAP) recommend establishing a policy on the use of chaperones during physical exams. Having and implementing such a policy reassures patients of the professional character of the exam and provides a witness to support a physician's actions should a misunderstanding or false accusation occur. Documenting the

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presence and name of a chaperone is important should the patient allege inappropriate behavior or sexual misconduct.

Medical Record Audits

Regular medical record audits can help identify practitioner-specific deficiencies. The following questions lend themselves to formulating standardized medical record audit criteria that can facilitate a user-friendly and comparative report of adherence to risk-focused documentation criteria:

- Are entries by medical staff and other providers legible?
- Is there an adequate medical history, considering the patient's presentation and major complaint? Were there critical omissions?
- Was an adequate physical examination performed? Was special attention given to the body system(s) involved in the chief complaints and presenting symptoms?
- Are the conclusions or impressions that are drawn from the H&P supported by the practitioner's findings?
- Do the clinical findings support the diagnostic and therapeutic orders?
- Is the plan of treatment clearly stated? Is it consistent with clinical findings?
- Are important clinical risk factors (those with a bearing on treatment) clearly identified?
- Were evidence-based protocols used to assist in developing the plan of care?
- Is there evidence that the patient was involved in developing the plan of care?
- Is there physician documentation of informed consent?
- Do progress notes reflect regular attendance to and evaluation of patient progress?
- Are patient responses to treatment described in explicit clinical terms?
- Are clinical observations consistent with those documented by other clinicians?
- Were consultations indicated? Was there thoughtful consideration of the consultant's recommendations?
- Did the practitioner acknowledge and address abnormal findings of diagnostic testing and unexpected results from therapeutic procedures?
- Were other closely related diagnoses considered?
- Is there coordination of the patient's overall care between medical providers?
- Does the record fully support the final diagnosis?

How Can I Reduce Risk?

Use the following strategies to reduce the risks associated with medical records documentation.

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Adhere to Documentation Fundamentals	
Write legibly	• Ensure handwriting is neat, legible and written in black ink. For the practitioner with poor penmanship, consider printing or taking a remedial course in handwriting. Alternatively, consider dictation, use of a scribe or an EMR rather than handwriting.
Be clear, concise and accurate	• Ensure that documentation is clear, concise and accurate, reflecting what was done, by whom, when, for what reason, in what manner, and the patient's response.
	• Review notes that are dictated or entered via a voice recognition system for accuracy. Make corrections before signing or electronically locking the note.
	• Ensure all typed notes, including entries made via text messaging in the EMR, are free of spelling errors, shortcuts, unapproved and/or non-medical abbreviations.
Be objective	• Be specific and objective when describing observed patient behavior and physiological indicators that can lead to a conclusion about patient's potential medical needs. Write in a way to allow the reader to picture the patient's status as the caregiver observed it. Do NOT use personal opinions, negative epithets and derogatory descriptions in the record. Avoid use of "slanted" or judgmental terminology, for example, the words unintentionally, inadvertently, or somehow, or words that reflect doubt, for example, appeared, seems to be or apparently.
Be timely	• Write, enter or dictate notes immediately after an office visit, or in the presence of the patient to allow the patient to have input into or to validate portions of the note.
Develop system to ensure timely transcription	• For those practitioners who dictate notes, develop a system to ensure that transcription takes place within 48 hours of dictation.
Use identifiers on every page	• Include the patient's full name and medical record number on every page including the front and back of double-sided pages.

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Medical Records: Documentation

Adhere to Documentation Fundamentals	
Authenticate entries	• Authenticate all EMR entries made by any practitioner or staff member by either an electronic signature or unique identifier. For any paper records in use, ensure that all entries are dated and signed in ink.
	• Ideally, make, date-stamp and lock EMR records contemporaneously. If not, lock entries within 48 hours of the date of service. If entries are not made and/or locked in real time, include full date of the patient encounter in the documentation. Label entries to an already locked record as an addendum. Reference the specific patient encounter date when creating an addendum.
	• Recognize that the time of each entry, if added, can prove valuable in the event of a future claim.
Individualize progress notes	• In an EMR, use caution with drop-down menus, auto-populated fields, or cut-and-paste functions. Individualize each progress note to reflect the actual events of the patient encounter. Avoid importing incorrect, redundant and irrelevant information.
Update demographic information	• Update and record any changes in patients' demographic information on at least an annual basis. Make changes in any system the practice uses to record patient information; for example, EMR, patient scheduling system, or paper record. Include emergency contact information in case of need to communicate critical test results or patient follow-up.
Document primary care practitioner	• Identify the patient's primary care practitioner in the medical record to assist with coordination of care. If a patient does not have a primary care practitioner, advise the patient of the importance of preventive healthcare and the need for a primary care practitioner. Document this discussion in the medical record.
Scan wisely	• Scan paper documents in their entirety into an EMR. Ensure that the patient's name and second identifier, such as medical record number, are on all scanned pages, including both front and back pages. Implement a quality assurance procedure to ensure

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Adhere to Documentation Fundamentals

	that documents scanned into the EMR are complete and that the visual quality of the scanned images equals the original.
Review and sign scribe notes	• When a scribe is used to document examination findings or treatment, ensure that the treating practitioner reviews the scribe's documentation and co-signs the note within a specified time frame.

Do NOT tamper with a medical record	• Recognize that no matter how afraid the practitioner may be of a lawsuit, or how aware the practitioner may be of having omitted a required test or having documented inappropriately, no practitioner should ever change the medical record after the fact. This means:
	
	  ○ Do NOT erase, write over or "white out" errors. Draw a single line through the incorrect entry, date and initial it, and continue with the correct information.
	
	  ○ Do NOT leave blanks. Draw a single line through a line or space skipped in error, as blanks may be filled in by others.
	
	  ○ Do NOT squeeze in extra words. Write any additional thought as a late entry bearing the date it is entered, not the date of its occurrence.
	
	• Do NOT try to "correct" an EMR. When practitioners need or want to make changes to the record, add a note that bears the date and time of the change and that references the note that needs to be changed or enhanced. Add the new note where any new note would be written. Do NOT insert it in or after a paragraph that is already followed by text.

Document a Complete History and Physical

Conduct a complete H&P	• Ensure practitioners conduct and document a complete H&P in the medical record. Ensure that the H&P addresses preventive screening guidelines. Identify significant risk factors including a social history (for example, smoking, alcohol intake, violence, drug use) family history (including family

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Medical Records: Documentation

Document a Complete History and Physical

history of cancer) and environmental exposures. See sample ***Health History*** form.

Update H&P regularly

- Review and update each patient's current medical profile significant risk factors at least annually or more frequently to coincide with practice policy.

- Document the review of the medical history, which may be done in a number of ways, including the following:

  - Note "medical history reviewed" in the progress note. Document the actual medical history and what was reviewed

  - When a patient completes a medical history form, review, initial and date the form

  - In an EMR, update and complete any medical history fields/templates

Use descriptive terminology

- Ensure documentation of the physical examination and review of systems is reflective of the patient's presenting complaint and specific to each body system examined. Use descriptive terminology for positive as well as pertinent negatives rather than terminology such as "wnl" or "non-contributory."

- When using a standardized form or template to document H&P findings, address each area of the form or template. Use the terms "not applicable" or "deferred" as appropriate.

- In an EMR, consider the use of a descriptive template built into the progress note that defines the scope of the examination and what constitutes a normal finding.

- If using an EMR template, select and clarify the information in the template relevant to the patient's examination or intervention.

Define "normal" and "negative"

- Define terms "normal" and "negative" when used in a physical examination, as one practice's definition of those terms may differ from another's. Each needs to have on record its own criteria for determining or defining these frequently used terms.

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Medical Records: Documentation

Document a Complete History and Physical

Document refusal	• If a patient refuses a complete physical, document the offer to conduct a physical examination and the patient's refusal in the medical record. Note the reason the patient refused the physical; for example, lack of insurance coverage.

Utilize Forms, Lists and EMR Screens

Use standard forms	• Use standardized forms, flow sheets and templates as a helpful way to record screening tests and other sequential information. • Ensure all practitioners use the same forms.
Complete forms and templates	• In a paper record, include only complete, current forms in the medical record. Document "not applicable" or "N/A" if certain parts of the form do not apply to the patient, as leaving a blank indicates a forgotten or overlooked question. Do NOT include forms that are completely blank or only partially completed in the record. • When using a template in an EMR, select and clarify the information relevant to each individual patient examination or intervention.

Use a medication list	• Use a medication list to monitor prescription and over-the-counter medications a patient is taking. In an EMR, utilize the dedicated medication list screen. See the sample *Medication List*.
	
	• Ensure that the medication list includes:
	    ○ Allergy status – allergies and reactions
	    ○ All medications prescribed and/or dispensed by the practice, such as sample medications
	    ○ Prescription start and end dates, dose, frequency, quantity and number of refills
	    ○ Medications prescribed by other clinicians
	    ○ Over-the-counter medications that the patient regularly takes, including vitamins and supplements

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Medical Records: Documentation

Utilize Forms, Lists and EMR Screens	
	• Reconcile the listed medications with the patient at every visit to ensure completeness and accuracy.
	• When using an EMR, consider contacting the EMR vendor to investigate whether fields in the medication list can be auto populated. When fields in the medication list are auto populated, confirm and update the information in the medication list at each patient visit.
Use a problem list	• Use, review and update a problem list at every patient encounter. Record any identified problems in the progress notes. Record the onset date for problems and, as applicable, document the date the problem was resolved. Examine the problem list at every patient encounter and revise as necessary. As the patient's clinical care evolves, identify problems/symptoms that most accurately reflect the patient's current conditions. Retain problems/symptoms that most accurately reflect the patient's current condition and remove conditions that are no longer pertinent to the patient's current condition.
	• In an EMR, utilize the dedicated problem list screen. Confirm or update problems recorded in auto-populated fields at each visit.
	• Include hospitalizations and surgeries.
	• Include family medical history, as well as family history of cancer, on the patient's problem list or on a family history list. Update this list as new issues are identified. Be sure to include a family social history (for example, drug and/or alcohol abuse). Update this list as new issues are identified. If there is no family history of cancer, document "no family history of cancer."
Consider a health maintenance flow sheet	• In primary care practices, ensure that the medical records of each patient reflect the application of preventive health protocols adopted by the practice, including complete physical examinations. Consider utilizing a preventive health maintenance flow sheet to facilitate review and tracking of a patient's status

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Medical Records: Documentation

Utilize Forms, Lists and EMR Screens	
	related to examinations, studies, adult immunizations and educational instructions. See sample ***Preventive Health Maintenance and Cancer Screening Flow Sheet***.
Use all screens in an EMR	• In an EMR, complete and keep all screens up to date based on the applicability to an individual patient's medical profile and course of treatment.
	• If the practice chooses not to use certain screens, consider contacting the vendor to have the screen(s) removed.

Use Caution With Abbreviations	
Use one system for abbreviations	• Ensure all practitioners in a multi-practitioner practice use the same abbreviations. Keep that list of abbreviations on file in the office to avoid the confusion and possible misinterpretation that can happen when several members of a practice use different abbreviations for the same word or phrase.
Avoid error-prone abbreviations	• Review the ISMP List of Error-Prone Abbreviations, Symbols, and Dose Designations available at https://www.ismp.org/tools/errorproneabbreviations.pdf. Educate all staff members, including physicians, nurses, medical assistants and secretarial staff to avoid using the error-prone abbreviations, symbols and dose designations on this list.
Take steps to approve all new abbreviations	• Take steps to approve all new abbreviations associated with new technology, procedures and equipment.
Watch for abbreviations with dual interpretations	• Watch for abbreviations with dual interpretations. For example, "N/A" can be interpreted as "not applicable" or "not assessed;" "PT" as "physical therapy," "protime," or "patient;" and "BS" can be "breath sounds" or "bowel sounds."

Document Cancer Screening	
Use cancer screening protocols	• Use evidence-based cancer screening protocols as a helpful tool that can serve as a reminder to teach

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Document Cancer Screening

	patients to do a self-exam and/or to make appointments for an appropriate screening exam. • Include (at minimum), the following protocols: o Breast cancer screening o Uterine cancer screening o Colon cancer screening o Lung cancer screening o Prostate cancer screening o Testicular cancer screening
Document adherence to accepted cancer screening protocols	• Ensure that cancer screening documentation follows the practice's accepted protocols for cancer screening and includes exams and tests offered and whether the exam was performed, deferred or declined. Document pertinent information on a cancer screening flow sheet or dedicated cancer-screening field. If certain screening tests, for example mammography or pap smears, are performed or ordered by a practitioner outside of the practice, document results and follow-up in the patient's medical record. See sample ***Preventive Health Maintenance and Cancer Screening Flow Sheet***.
Document breast cancer screening and breast examinations	• Recognize that failure or delay in diagnosis of breast cancer is a frequent MPL claim. • Document the following on a cancer screening flow sheet: o Date of a female patient's most recent breast examination and mammogram. o Deferral of a breast examination: If the patient sees a specialist for gynecologic care, document the name of the gynecologist and date the gynecologist last performed a breast examination. o Breast self-awareness and breast self-examination teaching; include whether the patient performs routine breast self-exams.

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Document Cancer Screening	
	• Ensure that breast examination documentation includes a detailed description: for example, "no masses, tenderness, skin changes, or nipple discharge; no lymph node adenopathy."
	• Document the reasoning for a breast examination: for example, in accordance with accepted screening guidelines, in response to a specific patient complaint, including whether or not a corresponding mammogram was ordered.
	• Consider utilizing a diagram to document an abnormal finding or diagnosed breast mass to allow for comparison at subsequent examinations and to enable the practitioner to distinguish a previously observed mass from a new one.
Document patient's refusal	• Document the patient's refusal and/or failure to follow recommended screening protocols. Address the importance of screening and the risk of having cancer that may go undiagnosed. Document the patient's awareness of this risk, acceptance of potential risks, and consequences of refusal.

Document Allergy Status	

Assess allergy status	• Assess and document each patient's allergy status at the time of initial contact.
	• Conspicuously flag each patient's allergy status, including the absence of allergies, in the medical record.
	   ○ In a paper record, flag the front of the chart along with all medication flow sheets. For example, place a colored sticker on the cover of the record. Include notation about the patient's allergy status in the body of the chart.
	   ○ In an EMR, record allergy status in the progress note screen and on any screen with a dedicated allergy field.

Document severity	• Document the severity of the allergy/intolerance and patient response; for example: "Penicillin – anaphylaxis, NSAIDs – nausea."

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Document Allergy Status	
Document if no known allergies	• If the patient has no allergies, note an absence of allergies as "NKDA" (no known drug allergies) or "NKA" (no known allergies) to indicate that an assessment has occurred.
Update periodically	• Recognize that a patient's allergy status may change over time. Reassess allergy status at least annually and when a new medication is prescribed.
	• If allergies are auto-populated into each progress note in an EMR, ensure the treating practitioner confirms and updates allergy status at each visit with a notation such as "reviewed allergies, no changes."
Reconcile periodically	• Periodically reconcile allergy documentation to ensure allergies are consistent across progress notes, medication lists and the allergy sticker (if used).

Document Patient Education	
Include printed and audiovisual material	• Document all education provided to the patient. In addition to verbal instructions, document which printed educational material and/or instructions were given to the patient. Also, document any audiovisual materials provided to or viewed by the patient.
Include anticipatory guidance	• Document age-appropriate anticipatory guidance provided. Pediatric examples include wearing bicycle helmets, avoiding sugary drinks, and limiting screen time. Adult examples include weight management, smoking cessation and stress management. See sample *Preventive Health Maintenance and Cancer Screening Flow Sheet*.
Assess comprehension	• Assess patient comprehension of the education using "teach back" and "show me." Teach back example: "This is important and I want to make sure I have done a good job. In your own words, can you summarize for me what we have discussed?" Show me example: "Please show me how you will use this nicotine patch."

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Document Care Provided in the Office	
Document vital signs	• Develop and implement an office protocol that requires vital signs, including the patient's blood pressure, to be documented in the medical record.
	• Document appropriate vital signs, including the patient's blood pressure, in the medical record.
Document weight	• Measure and document patient weights at every visit using metric units (kilograms or grams).
Document temperature of ill patients	• Take and document temperature for all patients presenting with symptoms of a potential illness. Establish guidelines for how a temperature is to be taken, based on the age and clinical presentation of the patient. Consistently follow these guidelines.
Document in-office procedures	• Document findings and results of procedures performed in the office. For more information, see the chapter titled ***Surgery: Office-Based***.
Document medications	• Document all medications prescribed, refilled, dispensed or administered in the office. Include all injections and immunizations administered in the office as well as samples dispensed. For more information on medication prescription and administration, see the chapter titled ***Medication: Safety***. For more information on dispensing medications, see the chapter titled ***Medication: Dispensing***.
Document referrals and consultations	• Document when a patient is referred for consultation, a second opinion or a diagnostic test.
	• As a consulting physician, provide a written report to the referring clinician.
	• For more information, see the chapter titled ***Communication: Care Transitions***.
Document patient follow-up	• Ensure that documentation in the medical record supports the fact that any proposed, suggested or required follow-up was, in fact, done. For more information, see chapter titled ***Diagnostic Accuracy: Testing, Follow-Up and Tracking***.
Document informed consent and refusal	• Ensure that documentation in the medical record includes informed consent and informed refusal

Document Care Provided in the Office

	discussions. For more information, see the chapter titled *Informed Consent: Process*.
Document patient communication	• Document all pertinent incoming and outgoing communication between the practice and the patient, including telephone calls, emails and letters. For more information, see the chapters titled *Communication: Telephone* and *Communication: Electronic*.

Document Use or Refusal of a Chaperone

Develop policy	• Develop a written policy outlining the circumstances/patient care situations when a chaperone must be present in the patient examination room and how the use of a chaperone is documented in the patient's medical record. See the sample *Chaperone Policy*. Recognize that a chaperone is ideally present during patient encounters that include a sensitive examination, require disrobement, use of sedation or when a patient is seen after hours.
Document use or refusal	• When a chaperone is used, document the chaperone's presence and the name of the individual acting as chaperone in the medical record.
	• When a patient refuses a chaperone, document the patient's refusal to have a chaperone present and, when necessary, defer the examination because of the patient's refusal.
Consider needs of pediatric patients	• Recognize that a chaperone may need to be present during the physical examination of a pediatric patient and consider following Policy Statement – Use of Chaperone during the Physical Examination from the AAP. The AAP Policy Statement is available at http://pediatrics.aappublications.org/content/127/5/991.full.pdf+html.

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Medical Records: Documentation

Maintain Signature List	
Authenticate documentation	• Require all staff entering information into the record to date and sign their entries. • Maintain a signature log as written signatures may be illegible. For future clarification, maintain a log of signatures for employees who document in the record. Include the employees' typed name, written signature, initials (when initials are used) to indicate review, as well as dates of employment. See the sample ***Authorized Signature Log***. • Prohibit the use of signature stamps to reduce the risk of misuse such as fraud and impersonation.
Contact state licensing agency for changed names	• Contact the state licensing agency if a caregiver's name has changed to officially change the name before the practitioner can sign medical documents under the new name.
Take care with similar names	• Recognize that care must be taken when practitioners have the same name or similar names or initials. Define method for differentiating between practitioners for coordination of care, diagnostic results, etc.

Develop policies and procedures	• Address the following in policies and procedures:
	
	  o Require the author's name and title to appear after each narrative record entry. Initials may be used when there are multiple entries on a single page.
	
	  o When flow sheets and/or checklists are used, ensure there is a mechanism for identifying the initials of the individual who performed the observation, assessment, activity, etc. For example, require the use of initials at the bottom of a column or row of check marks and a full signature at the bottom of the document or separate signature page.
	
	  o Establish an internal policy/procedure to address co-signature practice and clearly address the following:

Maintain Signature List

- Requirements for physician and nurse co-signatures;

- Requirement to clearly identify author of an order before carrying out the order;

- Requirement for electronic signatures; and

- Prohibition of signature stamps.

Conduct Medical Record Audits

Perform medical record audits	• Perform medical record audits on a regular schedule, such as quarterly, to identify practitioner-related deficiencies. For more information on confidentiality and protection from discovery, see the chapter titled ***Peer Review: Office-Based***.
Consider multi-disciplinary review	• Review documentation entered by all practitioners in the practice. Consider conducting a multi-disciplinary review and including nurse practitioners, physician assistants and registered nursing staff. See the sample ***Physician Practice Medical Record Audit Tool***.
Consider corrective action	• Consider corrective action for significant practitioner-specific deficiencies addressed as part of the practitioner and nursing staff peer review processes.

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