

Documentation of Medical Records



Documentation of Medical Records

Introduction:

- In a continuous care operation, it is critical to document each patient's condition and history of care.
- To ensure the patient receives the best available care, the information must be passed among all members of the interdisciplinary team of caregivers.
- Proper documentation is always important in a healthcare setting.
- Incorrect information, or no information at all, may result in serious injury or death of a patient.
- Negative legal repercussions are often avoided because of proper documentation and appropriate communication of patient information.

Documentation of Medical Records

Objectives:

- Recognize opportunities for documentation
- Apply electronic charting guidelines
- Locate appropriate documentation resources
- Understand staff's responsibility to provide and document patient education resources
- Identify the medical record as protected and confidential information
- Identify legal aspects of proper documentation

Documentation of Medical Records

Topics:

1. Overview
2. Opportunities for Charting
3. CPRS (Computerized Patient Record System)
4. Patient Education
5. Legal Aspects

Documentation of Medical Records - Overview

What is documentation and why is it important?

- Medical record documentation is required to record pertinent facts, findings, and observations about a veteran's health history including past and present illnesses, examinations, tests, treatments, and outcomes.
- The medical record documents the care of the patient and is an important element contributing to high quality care.
- An appropriately documented medical record can reduce many of the hassles associated with claims processing.
- Medical Records may serve as a legal document to verify the care provided.

Documentation of Medical Records - Overview

- The medical record facilitates:
 - The ability of the physician and other healthcare professionals to evaluate and plan the veteran's immediate treatment, and to monitor his/her healthcare over time.
 - Communication and continuity of care among physicians and other healthcare professionals involved in the patient's care.
 - Accurate and timely claims review and payment.
 - Appropriate utilization review and quality of care evaluations
 - Collection of data that may be useful for research and education.

Documentation of Medical Records – Overview

With documentation of medical records, particular emphasis must be placed on the five factors that improve the quality and usefulness of charted information.

- Accuracy
- Relevance
- Completeness
- Timeliness
- Confidentiality

Documentation of Medical Records – Overview

Accuracy

- Each individual medical record **MUST** be correct.
- Information in the medical record is relied upon for accuracy throughout the veteran's lifetime.
- Inaccuracies (either commission or omission) lead to improper medical advice being provided in error and may result in adverse healthcare outcomes or in legal proceedings.

Documentation of Medical Records – Overview

Relevance

- It is important that medical records contain only information relevant to the patient's healthcare.
- Inclusion of inappropriate and irrelevant information could result in damaging legal action.

Documentation of Medical Records – Overview

Completeness

- ALL documentation, including that from the clinics, hospital and TLC, must be included in medical record.
- Every document should be free from omissions.
- Documentation is sent to CPRS which maintains a complete record for each patient.
- The Joint Commission requires continuous review of medical record documentation throughout the year.

Documentation of Medical Records – Overview

Timeliness – There are specific time requirements for completion of the medical record:

- History and Physical – completed and signed within 24 hours of admission
- Post-Operative Note – written immediately following surgery
- Operative Note – dictated and signed within 24 hours of operation/procedure
- Medical Record – must be completed within 7 days of discharge or outpatient visit

Documentation of Medical Records – Overview

Confidentiality

- Medical records are confidential and protected by authority of the Privacy Act of 1974, its amendment and HIPAA.
- Don't leave patient-identifiable information on your computer screen or exposed in your work area.
- Shred papers containing patient information that is not relevant to medical documentation.
- Don't talk about patients or families in hallways, elevators, or in other public places.
- Don't release medical record information without the patient's consent.

Documentation of Medical Records – Overview

Legibility – physicians get a bad rap about notes and prescriptions being unreadable and illegible. CPRS makes medical records easy to read.

Omissions – Seemingly innocent omissions in medical record documentation can have dire consequences.

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Failing to write a note:
 - Some physicians make rounds and pass the nurses' station shouting out verbal orders and not placing a progress note – not even a history or physical – on the chart until days later, often well after the patient has been discharged.

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Forgetting to place an operative note on the chart the instant after a procedure or operation is performed:
 - The surgeon may dictate the operative note, but will write a postoperative note so there is documentation on the chart when the patient gets care elsewhere, i.e. recovery room, on the med-surg unit, or at home if discharged.
 - When the hospital is called for information about what procedure was done and the surgeon cannot be reached, there is no way to find out unless there is a written post-op note.

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Not entering the time and date that the note was developed, whether written or dictated:
 - Doctors cannot defend the timeliness of their actions if they don't tell anyone what time the action was taken.
 - If the note is not written on the day of the service, the note must start with “Late Note for visit on date of service”.

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Using the phrases, “Doing Well” or “No Change.”
 - This does not tell anyone what happened on that visit.
 - It is unreasonable to bill and expect to be paid for such a vaguely described service.

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Not writing down and getting credit for things done on rounds to non-surgical patients.
- Providers conduct fairly extensive evaluations but only dictate minimal portions of observations made.
 - Fail to mention all organ systems examined
 - Forget to describe how patient answered questions about new medications or new diagnoses
 - Fail to note they spoke to relatives or family about findings

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Neglecting to do a proper History and Physical on every patient.
 - NEVER an excuse for provider not to document a good evaluation of the whole patient.

Documentation of Medical Records – Overview

Physician problem areas and consequences:

- Not naming a diagnosis (or presumed diagnosis) when ordering studies or treatments.
 - Always name the problem that is being evaluated or treated when prescribing medication (even over the phone), sending patient to lab or x-ray, or starting a treatment.

Documentation of Medical Records – Overview

Nursing and Interdisciplinary Team Member Note Problem Areas and Subsequent Consequences:

- Using the phrases, “Doing Well” or “Within Normal Limits.”
 - This does not tell anyone what happened on that visit.
 - It is unreasonable to bill and expect to be paid for such a vaguely described service.

Documentation of Medical Records – Overview

Nursing and Interdisciplinary Team Member Note Problem Areas and Subsequent Consequences:

- Not entering the date on which the note was developed, whether written or dictated.
 - Timeliness of actions cannot be defended if documentation of when the action was taken is not provided.

Documentation of Medical Records – Overview

Nursing and Interdisciplinary Team Member Note Problem Areas and Subsequent Consequences:

- Failure to chart each shift on patient condition.
 - Patient’s condition **MUST** be charted at the end of each shift to provide continuity of care from shift to shift.
 - If the note is not written by the end of the shift, the note must start with “Late Note for visit on date of service”.

Documentation of Medical Records – Overview

Defensive Charting

- Documentation reflects professionalism and competence.
 - Appearance counts – including legibility.
 - Documentation – if it's not documented, it wasn't done.

Documentation of Medical Records – Opportunities for Charting

Admission – This process:

- activates creation of, or access to, veteran's database record.
- initiates a generic Admission Form.
- captures a snapshot of patient upon admission.
- identifies patient's needs, strengths, problems, limitations, support systems, and Advance Directives.
- identifies and screens for further assessment of patient's physical, nutritional, and functional behavior, spiritual, environmental, and psychosocial needs.
- identifies and assesses any incidents of abuse: elder, child, sexual, physical assault, rape, or domestic violence.

Documentation of Medical Records – Opportunities for Charting

Assessments/Reassessments:

- Performed according to each discipline's specific protocol, policy, standards, or guidelines.
- Should be conducted according to intensity and scope of care.
- Should be initiated whenever there is a change in patient's diagnosis or condition.
- Data is used to formulate or update patient's plan of care.
- Patient responses to previous interventions must be charted.

Documentation of Medical Records – Opportunities for Charting

Interventions performed or administered:

- MUST be accurately documented in the medical record on appropriate forms, flow sheets, or in the Progress Notes.
- Includes:
 - Treatments or procedures rendered
 - Medications or therapies administered
 - Education or instructions provided to Patient/Family/Significant Other
 - Referrals or Consults Initiated

Documentation of Medical Records – Opportunities for Charting

Other opportunities for charting:

- Regular Discharge
- Interservice Transfer
- Interservice Receiving
- Against Medical Advice (AMA)
- Unauthorized Absence (UA)
- Irregular/Disciplinary Discharge
- Death Notes

Documentation of Medical Records – Opportunities for Charting

Establishing and Documenting a Plan of Care:

- Written Plan of Care is established by the Interdisciplinary Team for each patient.
- Plan of Care:
 - includes establishment of treatment and discharge plan.
 - includes education of Patient, Family, and/or Significant Other.
 - is reviewed and updated throughout the continuum of care .
 - becomes part of the patient record.

Documentation of Medical Records – Opportunities for Charting

Positive Outcomes resulting from timely, appropriate charting:

1. Stable Condition
2. Improving and progressing
3. Moving towards discharge goals
4. Absence of problems or complications (infections, falls, adverse reactions, or sentinel events).

Documentation of Medical Records – Opportunities for Charting

Negative Outcomes resulting from poor charting:

1. Unstable condition
2. Decompensating or worsening
3. Moving away from discharge goals
4. Presence of problems or complications (falls, infections, adverse reactions, or sentinel events)

Documentation of Medical Records – CPRS

What is a Computerized Patient Record System (CPRS)?

- System for entry of orders into VISTA and review of clinical reports and information.
- Embodies VA's commitment to improve quality and efficiency of healthcare by organizing and presenting all relevant patient data in a way that directly supports clinical decision making.
- Data includes:
 - Medical history and conditions
 - Problems and diagnoses
 - Diagnostic and therapeutic procedures
 - Interventions
- Templates and point and click screens can be used to simplify documentation.

Documentation of Medical Records – CPRS

What types of entries can be entered into CPRS?

- Vital Signs
- Intake and Output
- Progress Notes
- Healthcare Providers' (MD, PA, ARNP) order entry
- Consults/Referrals
- Electronic signature in lieu of written signature (established through “Users Toolbox Menu” within CPRS)

Documentation of Medical Records – CPRS

Non-VA Employees can use CPRS/VISTA:

- Entries by non-VA personnel (i.e., students, trainees from affiliate associated health professions) must be co-signed by their instructor, preceptor, mentor, or social work supervisor.
- These personnel will receive VISTA access and training as part of their orientation.
- Instructor, clinical applications coordinator, or preceptor must establish rule to enable another party to co-sign progress notes.

Documentation of Medical Records – CPRS

Correcting mistaken entries:

- Mistaken entries are corrected by using CPRS, Select “*Action*”, then select “*Make Addendum*”.
- Correct your entry using an addendum to the note you need to correct.
- Check your spelling and grammar for accuracy. (spell or grammar check not available).
- Contact IT Help Desk with patient’s name, SSN, Date/Time/Title of note to be removed.

Documentation of Medical Records – CPRS

Charted on Wrong Patient:

- Send e-mail to IT Help Desk (x53070) and provide the following:
 - Patient's name
 - Social Security Number
 - Date/time/title of note to be removed
- If entry is entered out of chronological order, contact the IT Help Desk on how to proceed.

Documentation of Medical Records – CPRS

Electronic Progress Notes:

- Limit documentation to:
 - Objective observations
 - Measurable data
 - Substantiated conclusions (outcomes)
 - Subjective statements made by the patient
- Use only VAMC abbreviations found on the VA Common Drive.
- Documentation should reflect the progress, or lack of progress, of patient's stay.

Documentation of Medical Records – Patient Education

What does it include?

- Final part of Plan of Care
- Teaches patient and his/her family about rehab, community resources, follow-up treatment, and preventative medicine.
- Important with the shift from inpatient to outpatient care.

Documentation of Medical Records – Patient Education

Who is responsible for patient education?

- Since 1993, The Joint Commission has extended responsibility to ALL healthcare providers.
- VA holds all members of the healthcare team responsible.
- For nursing, this includes RNs, LPNs, and NAs.

Documentation of Medical Records – Patient Education

How is patient education implemented?

- One-on-One Instruction/Coaching
- Use of Videos
- Handouts
- Classroom
- Computer Based Training
- Computer Printouts

Documentation of Medical Records – Patient Education

Resources for Teaching:

- Handouts are a good way to provide reinforcement because they can be taken home.
 - Requests for handouts go through Patient Education Committee (PEC).
 - The PEC reviews content of handouts.
 - Handouts must target a 6th-to-7th grade reading level, similar to newspapers.

Documentation of Medical Records – Patient Education

Resources for Education:

- Classes are offered for diabetes, cardiac, oncology, wellness, smoking cessation, and MOVE.
- Some classes may require a referral or consultation.
- Support groups are another type of education resources and are available for patients and family members.

Documentation of Medical Records – Patient Education

Determining the educational needs of the patient:

- Educational Assessment
 - Staff must first assess patients before providing education.
 - Assessments must be conducted whenever the patient's condition changes and not less than annually.
 - The following information must be documented:
 - Ability to Learn - reading ability, mental status, manual dexterity, vision, hearing, etc.
 - Learning preferences – listening, practicing, observing
 - Readiness to learn – about selected pertinent topics
 - Need for information/skills
 - Cultural (religious and ethnic) preferences which may affect learning.

Documentation of Medical Records – Patient Education

Determining the educational needs of the patient:

- Documentation of Assessment
 - Findings are entered into CPRS electronic record by using a Clinical Dialogue Reminder developed by the Patient Education Committee.

Documentation of Medical Records – Patient Education

Determining the educational needs of the patient:

- Measurable Goal
 - At least one goal should be set for each topic/skill taught.
 - Goal should indicate something the patient will do or say to indicate he/she understands
 - List at least three side effects of Zocor.
 - Test blood sugar according to glucometer manufacturer's directions.

Documentation of Medical Records – Patient Education

Determining the educational needs of the patient:

- Teaching Methods Preferred
 - Teaching methods should be consistent with patient's learning preferences indicated in the education assessment.

Documentation of Medical Records – Patient Education

Determining the educational needs of the patient:

- Evaluate Goal Attainment
 - Ask patient to say or do whatever was stated in the measurable goal agreed upon before education was permitted.
 - Ask about other information or skills taught to verify patient has mastered the information or skill.
 - If goal not fully met, consider whether reinforcement or education for a significant other is necessary.
 - If neither is a viable option, consider placement in a more supervised living situation.

Documentation of Medical Records – Patient Education

Determining the educational needs of the patient:

- Evaluation/Documentation
 - Education provided must be documented in the Medical Record.
 - Documentation of patient education is part of the final step in the patient education process.
 - If it isn't documented, it wasn't done.

Documentation of Medical Records – Legal Aspects

The Privacy Act of 1974:

- If veteran's medical records show inaccuracies, based on either commission or omission, and an adverse determination is made on the basis of this record, the Privacy act of 1974 (and its amendments) provides for the right of that individual to bring the issue as a civil action in the district court of the United States.
- The claimant has two (2) years from the time that he/she knew, or should have known, of the misrepresented or inaccurate information.
- Federal employees are covered under the Federal Tort/Claims Act.

Documentation of Medical Records – Legal Aspects

Remember...

The attorneys who will represent you can draw only from the documentation you have provided.

Your charting techniques can defeat or defend your practice in court.

Documentation of Medical Records

Summary:

- You should now have the knowledge and skills to:
 - Recognize opportunities for documentation
 - Apply electronic charting guidelines
 - Locate appropriate documentation resources
 - Understand staff's responsibility to provide and document patient education resources
 - Identify the medical record as protected and confidential information
 - Identify legal aspects of proper documentation