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From the Desk of:

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12 Common Documentation Mistakes (And how you can avoid them)

Naturally, you strive to provide your patients the best of care. It should be enough, but unfortunately, it may not be if your recordkeeping isn't top-notch as well. It's been my experience that making the following common documentation mistakes can put your practice at risk in the event of a malpractice allegation.

1. **Altered records.** Records should be kept in ink, preferably black ink, so that clear copies can be made when necessary. How should doctors correct records if a lawsuit is filed later? They shouldn't — records should never be altered. Malpractice attorneys often hire expert document examiners to analyze chart notes when it appears a record may have been changed or a post-entry note added (including sophisticated analysis of the ink appearing on the original). There's no faster way to damage your credibility in court than for a plaintiff's attorney to stand in front of a judge and jury and prove you lied. Once notified of a legal action, the record should be sealed and no changes made.
2. **Entries not dated or identified.** Be sure to identify the year along with the patient's name or identifier on each page of the record. When this is not done, errors can be made during photocopying. It's not unheard of for pages — or even different patient records — to be merged together. Identifying each page helps ensure your patients receive the care you intended.
3. **Obliterated entries.** Always draw a line through an incorrect entry, write the correct information, and initial and date the correction. Never use whiteout or scribble over the entry because it can fuel suspicion about the original entry.
4. **Entries not signed, or signed or countersigned without having been read.** Never send out dictated records without having read them. Two records may have run together, an entry may have been left out or irrelevant information added by the transcriptionist.
5. **Entries for care performed without signature/initials.** Always indicate who provided care to the patient and include the signature/initials of the author of the entry. Even if you are a solo practitioner, it is good practice management to initial the daily note.
6. **Illegible records.** If you're unavailable to care for patients, a replacement doctor must be able to read and understand your records to provide proper care.
7. **Lots of blank spaces on the page.** Busy doctors sometimes need a form that provides memory prompts so nothing is forgotten. And there are valid clinical reasons for leaving a space blank. However, if a form is continually 90 percent blank, move frequently used items to another form and eliminate the unused form.
8. **Uncommon abbreviations.** Abbreviations are a wonderful tool and can save time in writing daily records. But if you make up your own, you'll need to send out a legend every time you send out records. Use standard abbreviations.
9. **Failure to document patient noncompliance.** Be sure to document episodes of noncompliance, whether it's missed appointments, frequent cancellations without rescheduling, failure to do recommended exercises or refusal to stop certain activities. This documentation can be critical if you are later accused of abandonment.
10. **Not documenting phone calls.** We have all received calls from patients who are in distress and need advice. No matter how simple the conversation may sound, a phone call with a patient is a clinical encounter and must be recorded. It's possible the phone call could be your last encounter with a patient before a lawsuit.

11. Charting only the abnormal. Although positive (abnormal) findings can determine a diagnosis, negative findings are equally important because they can help rule out serious conditions. For example, the fact that a patient had a negative (normal) SLR, negative Supported Adams Test, negative Bechterew's Test, negative Valsalva Test, normal motor strength, normal peripheral sensation and normal deep tendon reflexes rules out intervertebral disc injury.
12. Test results without a clinical rationale. Clinical records must include: your reason for ordering a test, test results, a description of how the patient's care was affected and an indication the patient was notified of the results.

Proper documentation can improve patient care, make your life easier and protect you in the event of a malpractice allegation. If you noticed any areas for improvement in the list above, refer to the tips below for guidance.

Records not up to snuff?

By making a few enhancements, you can significantly reduce the risks to your practice:

1. Do a self assessment of your own records:
 - a. Ask a respected colleague to review a sample of your records.
 - b. Contact the peer review committee of your state association and request an informal record review.
 - c. If you use a consultant, ask the company's records expert to review your records.
2. Develop a plan:
 - a. Does the problem relate to your forms or how you complete—or fail to complete—the paperwork? Then:
 - i. Do a critical review of what works and what doesn't.
 - ii. Keep what works. Don't "throw out the baby with the bathwater."
 - iii. Find forms that fit your practice/ technique style.
 - iv. Don't reinvent the wheel. Review what is available commercially or used by colleagues.
 - v. Borrow what works from others. Don't steal copyrighted works, but ask those who have solved records problems to share what they use.
 - b. Are there significant delays in completing records? If so:
 - i. Is the problem a lack of time or a lack of discipline?
 - ii. Work on revising your schedule — Build in time each morning and afternoon to "get caught up" on your records.
 - iii. Ask your staff to help you develop the discipline to complete your records.
 - iv. Set a goal to complete all records before leaving each day.
 - c. Does every record look identical? Then:
 - i. Study what you write in patient records.
 - ii. Create alternate phrases and terms to describe what you find and see.
 - iii. Write down any alternate terms and phrases you use and keep these close to the area where you complete records.

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The 25 Warning Signs of Poor Documentation, Susan Keane Baker, *American Medical News* republished in Medicare Part B Special Newsletter, July 1996. Contributions from *Risk Management and Record Keeping*, an online continuing education, Stephen M. Savoie, D.C., F.A.C.O., Palmer Institute for Professional Advancement.

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