



Table Of Contents

- I. Practice Quality Assessment**
- II. Risk Management Guidelines for COPIC Insured Physicians**
 - A. Informational Assessment**
 - B. Systems**
 - C. Practice Coverage**
 - D. Medical Records and Drug Handling/Security**
 - E. Documentation**
 - F. Chart Review**
 - G. Practice Cooperation**
 - H. Special Study/Prenatal Question**
 - I. Specialty Specific Questions**
- III. Charting Do's and Don'ts**
- IV. Practice Enhancement Tools on COPIC's Web Site**
- V. Reference Materials**
- VI. Contact Information**

I. THE PRACTICE QUALITY ASSESSMENT

Practice Quality conducts physician site visits on behalf of the Risk Management Department. The Practice Quality visit is designed to help ensure that adequate office systems are in place to support the provision of reasonable patient care and that patient medical records are maintained in a fashion that accurately reflects the quality of care provided.

Office site assessments are conducted by registered nurses in accordance with risk management guidelines. These guidelines are generally determined by actual malpractice claims and incident reports. Guidelines believed to have significant impact on the frequency, severity and defensibility of malpractice claims are referred to as Level One. Insureds practicing in offices that meet 100% of the Level One Guidelines will receive two ERS (Experience Rating System) points for each two-year cycle in which the guidelines are met.

After the Practice Quality reviewer has completed the assessment, a summary report is printed on site to facilitate discussion with the practice representative. We encourage physicians to participate in this feedback session.

This program is not intended to be an intrusion into your busy professional lives, but rather a way to help improve office systems and documentation in your practice. This will ultimately benefit patients and protect your malpractice premiums. We are dedicated to assisting our insureds in meeting risk management's guidelines.

Offices using Electronic Medical Records should have documentation practices in place equivalent to those required for hard copy systems.

The physician site visit currently consists of the following:

- Informational Assessment and Systems Review with Practice Representative
- Chart Review
- Specialty Specific Questions
- Summary Report Printed On-Site and Discussed with Practice Representative/Physician

II. Risk Management Guidelines for COPIC Insured Physicians

In an effort to help insureds avoid malpractice claims and protect their premiums, COPIC Insurance Company's Risk Management Department will be working closely with Practice Quality to assess certain high-risk areas that have been identified through COPIC's claims and occurrence experience. To address these high-risk issues, risk management guidelines (referred to as **Level One Guidelines**) were developed to help reduce the number and severity of these claims and/or to increase the defensibility if such claims occur. The guidelines are outlined in this handout to help physicians learn about these high-risk areas and develop ways to improve their office systems and medical record documentation.

Insureds practicing in offices that meet 100% of the described risk management guidelines will receive two ERS points for each two-year cycle in which the guidelines are met.

Insureds that do not meet 100% of the described risk management guidelines will either:

- a) be requested to submit a written plan to COPIC's Risk Management Department on how they will address areas needing improvement and will receive one ERS point **or**
- b) for those having significant difficulties meeting the guidelines, a second review in six months will be performed. At completion of this six-month review, insureds will receive either one or two ERS points, dependent upon the review results. If insureds choose not to meet the guidelines following the six-month period of assistance and review, a negative ERS point may be assessed, dependent on the degree of noncompliance.

The following lists the **Level One** guidelines. **Throughout the handout, all risk management Level One guidelines required to earn ERS points will be denoted by a star (*) and highlighted in gray.**

- Patient Follow-Up Tracking System
- Test Tracking System
- Review/Signing of Incoming Reports
- Test Follow-Up Contact System
- Informed Consent Documentation
- Telephone Charting
- Legibility
- Allergies
- Medication list
- Charts Free of Questionable Corrections or Additions

COPIC's Risk Management Department believes that following these risk management guidelines will lead to significant changes in malpractice frequency, severity and defensibility, and we are dedicated to assisting our insureds in meeting these guidelines. This program is not intended to be yet another intrusion into your busy professional lives, but rather a way to help improve office systems and documentation that have been identified as high-risk areas for clinicians. This will ultimately benefit your patients and protect malpractice premiums.

A. INFORMATIONAL ASSESSMENT

ELECTRONIC MEDICAL RECORD UTILIZED
NURSE PRACTITIONERS UTILIZED
PHYSICIAN ASSISTANTS UTILIZED
CERTIFIED NURSE MIDWIVES UTILIZED
COLLABORATIVE AGREEMENT DOCUMENT SIGNED BY MIDDLELEVEL AND SUPERVISING PHYSICIAN
WRITTEN POLICY FOR PATIENT EMERGENCIES
ON-SITE AUTOMATIC EXTERNAL DEFIBRILLATOR
ASSESS AND DOCUMENT USE OF OTC MEDICATIONS
DIABETIC FLOW SHEET UTILIZED
WRITTEN GUIDELINES FOR THE MANAGEMENT OF BREAST PROBLEMS
WRITTEN SCREENING PROTOCOLS FOR BREAST CANCER
WRITTEN SCREENING PROTOCOLS FOR CERVICAL CANCER
WRITTEN SCREENING PROTOCOLS FOR COLORECTAL CANCER
WRITTEN SCREENING PROTOCOLS FOR HEART DISEASE
WRITTEN SCREENING PROTOCOLS FOR PROSTATE CANCER
INFORMED REFUSAL DOCUMENTATION
PHYSICIAN ADMITS PATIENTS TO A HOSPITAL
PERCENTAGE OF PATIENTS YOU ADMIT AS OPPOSED TO USING A HOSPITAL BASED GROUP
ON-SITE RADIOLOGY
RADIOLOGIST OVER READS X-RAYS
IN OFFICE IV SEDATION
IN OFFICE GENERAL/REGIONAL ANESTHESIA
RESUSCITATIVE/MONITORING EQUIPMENT AVAILABLE
(I.E. PULSE OX, REVERSAL AGENTS, O2 & ABILITY TO BREATHE FOR THE PATIENT)
OFFICE PERFORMS:
ACUPUNCTURE
MANIPULATION
BOTOX OR OTHER COSMETIC PROCEDURES
HOMEOPATHIC TREATMENT
TREADMILL TEST
FLEXIBLE SIGMOIDOSCOPY
ADDITIONAL PATIENT IDENTIFICATION USED WHEN CORRESPONDING WITH OTHER PROVIDERS
POLICY FOR HANDLING UNSOLICITED TEST RESULTS (PREFERRABLY WRITTEN)
WRITTEN POLICY FOR AUTHORIZATION OF MEDICATION REFILLS

B. SYSTEMS

TRACKING AND REMINDER SYSTEMS

There are many different interpretations of the term “tickler system.” In general, a tickler system is one that reminds the physician or office staff that a particular item requires follow-up. There are several important functions that need completion when following patients through their care. In an effort to gain consistency and clarify the various important functions involved, we have renamed “tickler system” to “tracking and reminder systems.” We have divided this section into several parts and named each according to its function.

The essential elements of a tracking and reminder system include:

- A system for recording and tracking events that need to be completed (e.g., a follow-up appointment, referral or physician’s order for labs or imaging studies). It should be located in a **central location (separate from patient charts)** and readily available to everyone involved in patient care. The system may be a computer reminder system, card file system, logbook, file book or any system that can be updated and monitored consistently. The Tracking and Reminder System should be used **in addition** to your regular appointment book or appointment scheduler. **It should include the event being tracked, the date by which the event should be completed and, if applicable, with whom the patient should follow up.**
- Any tracking and reminder system should contain the following components: ability to track completion of an appointment in the office and ability to track completion of a referral.
- A written description (policy) describing how the tracking and reminder system is to work and which members of the practice are responsible for updating and completing the system.
- It is also desirable to have a backup tracking system, in a prominent location of the patient’s chart to alert anyone viewing the chart that expected results or provisions of care are still pending.
- Use various opportunities to address unresolved problems from previous visits and remind patients of needed follow-up, such as when they call or come in for an **unrelated problem** or cancel an appointment. When these opportunities arise, document efforts to remind patients.

*1. PATIENT FOLLOW UP TRACKING SYSTEM

Does a patient complete a follow-up appointment in the office as instructed?

A patient follow-up tracking system alerts a practice to the patient who **must** return to the office and ensures that reasonable attempts are made to help secure the patient’s follow-up. Conditions which may require a return visit include a breast mass, questionable Pap smear, borderline or abnormal test results, special medications or any finding in which the health care provider believes it critical that the patient be seen again. If possible, this should include patients who are discharged from the hospital with instructions to return to the office or to a consultant for essential follow-up care.

2. REFERRAL TRACKING (Revised 12/31/04)

This is especially important when a physician refers a patient for a **high-risk** problem. If the patient fails to follow up with the specialist they were referred to and a bad outcome occurs, it creates increased risk for the referring physician since the referring physician is responsible for following the patient’s care. One way to demonstrate the completion of a referral visit is to have a consultant’s report on the patient’s chart (see Test and Report Tracking and Contact System below).

***3. TEST TRACKING**

A Test and Report Tracking System should be implemented to assure that all screening/diagnostic tests ordered (either done within or outside the office) or reports expected are completed. The system should alert the physician and staff of missing tests or consultant reports or failure of the patient to follow through as requested. For instance, the system should track specimens that leave the office and orders generated from the office.

***4. REVIEW /SIGNING OF INCOMING REPORTS**

It is important for the practice to have a policy to ensure that lab/imaging/test reports, consultations and other pertinent documents are seen by the practitioner prior to being filed in the medical record. **All reports must be reviewed and initialed by the reviewing practitioner (MD, DO, PA, NP)**. If the physician designates someone else to review and sign test reports, protocols should be present for this. The person responsible for filing documents should be trained NOT to file reports unless the above has occurred. If an EMR is utilized, an electronic equivalent of this validation process is required.

***5. TEST FOLLOW UP CONTACT SYTEM FOR LABS/X-RAYS/OTHER TESTS**

A Test Follow-up Contact System ensures that there is a mechanism in place to notify patients of test results (labs, x-rays and other tests) and any further follow-up needed and to document that this took place. Having a test/lab follow-up contact system may help patients better understand the meaning of test results and the need for follow-up care as well as reduce the risk of **abnormal results** not being communicated to the patient in a timely fashion. This task can be appropriately delegated to trained office staff, but important issues may need the physician's personal communication with the patient. **Again, a "no news is good news policy" is strongly discouraged.** Instead, since it is difficult to ensure that every tracking system is perfect, it is recommended that physicians instruct patients to call their office if they have **NOT** received test results by a certain time to protect against a test or result getting "lost in the system." Adequate attention to patient confidentiality is essential.

***6. INFORMED CONSENT DOCUMENTATION**

The informed consent process remains one of the most important risk management tools physicians have in improving defensibility of claims when adverse events occur. Informed consent requires that the physician obtain patient consent for treatment rendered, operations performed, immunizations, steroids, chemotherapy, etc. It is important that the patient understand the risks and benefits of a proposed treatment or procedure, alternatives to a proposed treatment or procedure, the risks and benefits of the alternative treatments or procedures, and the risks and benefits of doing nothing.

Obtaining patient consent is the responsibility of the physician. The physician may obtain assistance from others such as nurses, health educators, physician's assistants, etc. However, the final discussion about the risks and benefits, and the answering of questions must be done by the physician. This minimizes the risk that a patient may claim that they were not completely advised. Informed consent discussions and patient decisions must be documented. Consent forms provide an efficient mechanism to document informed consent and should be filed in the patient's medical record.

Informed consent for elective hospital/outpatient procedures should be obtained and signed by the physician at the time the actual discussion occurs and a copy kept in the patient's medical record.

Consent (this is a process)

Informed: Obtaining consent by a discussion of risks and benefits of a particular procedure or treatment, alternatives, risks of doing nothing, and any special risks for a particular patient.

Consent Form (this is a document)

A consent form is a tool that may be used to efficiently document the informed consent process. The presence of a form does not release the physician from the duty of obtaining consent.

It is a document completed by the physician (or other clinician) and the patient with signatures stating that the patient understands the risks and benefits of a proposed treatment or procedure, alternatives and risks/benefits of refusing. **While a form is often preferred, the process is always required and should at least be noted in the chart.**

The following pages contain a chart detailing procedures and the proper informed consent process.

Office Procedures:

The following, taken from COPIC's Participatory Risk Management Program booklet, lists those procedures which **require a written consent form signed by the patient and physician** and filed in the patient's medical record. (Samples of procedure-specific consent forms are available at www.callcopic.com).

Required:

- All surgical procedures usually requiring general or regional anesthesia
- Any other procedure usually requiring general or regional anesthesia
- Cerebral and coronary angiography
- Endoscopy/flex sigmoidoscopy
- All sterilization procedures
- Any procedure where the usual risk is substantially increased because of some aspect of the patient's medical condition
- All plastic surgery procedures
- All surgical procedures upon the eye
- All surgical procedures upon the middle and inner ear
- Needle biopsy of internal organs
- Allergy treatments
- Treadmills
- Vaginal birth after C-section (VBAC)
- Long term steroid therapy - COPIC has designed a consent form describing risks involved in long-term steroid therapy, either oral or injectable.
- Long term anticoagulation

Immunizations

- The state of Colorado requires documentation that the Vaccine Information Sheet (VIS) was given to the patient.
- If there is a series of immunizations, a VIS must be given with **each** dose.
- A Vaccine Information Sheet (VIS) must be given to the patient/parent/guardian **prior** to administration.

HIV

- The state of Colorado requires consent for an HIV test. A written consent is not needed if there is adequate documentation of confidentiality and release of information noted in the chart.
- It is required that informed consent be obtained and documented in the chart when drawing an HIV test as part of the prenatal panel.
- If blood for HIV testing is drawn off-site, the ordering physician is responsible for obtaining a consent form or documenting informed consent specific to confidentiality issues.

HIV needs documentation of the consent discussion, not necessarily a signed consent form.

Recommended:

For the following procedures, consent forms would be beneficial for any future defense. If a consent form is not used, there should be at least some documentation in the medical record to support that the informed consent process took place. For example, "the risks, including _____, the benefits, including _____, and the potential alternatives of _____ were discussed."

- Minor procedures generally done under local anesthesia (e.g., skin biopsy)
- Injection of contrast material
- Joint aspiration and/or injection
- Prescription/administration of the following drugs or drugs with similar problems: antibiotics which damage the eighth nerve; chemotherapeutic agents; and drugs commonly known to impact bone marrow adversely (Chloromycetin®, Butazolidin®, etc. and weight loss medications).
- Hormone Replacement Therapy (HRT)

***7. TELEPHONE CHARTING**

All telephone communication, either during or after office hours should be documented in the medical record or telephone logbook when one of the following occurs:

- Prescribing or changing medication
- Making a diagnosis
- Directing treatment
- Directing patient to another provider or facility

It is important to include the date and time of the phone conversation. A telephone message slip with the documented advice and decisions reached should be securely attached to the medical record.

One source of potential physician-patient conflict is that of a phone call made by a patient with the claim that the call was not returned by the physician. A simple log of all incoming phone calls kept in a chronological fashion may help to resolve this source of conflict. Should a patient then indicate that a phone call was made on a particular day; the call can be confirmed by referring to the log. Be aware that if a separate logbook is used to record phone calls, it should be retained securely in the same fashion as a medical record (7 years after last date of treatment for adults, 7 years after age of majority for children, and 7 years after any death).

After hour calls often deal with what patients perceive to be acute problems and may lead to litigation if they result in poor outcomes or hospitalization. That is why this is extremely important for risk management. Given that it may be difficult to record all after hour phone calls, a **Patient Phone Call Record** has been developed to help physicians document these calls in the patient's medical record in a systematic fashion. **The physician or office staff may call (720) 858-6275 to obtain a supply of these phone records free of charge.**

C. PRACTICE COVERAGE

1. Scheduling Delays Explained

Having a designated individual in the front office to monitor waiting times is a good idea. Some patients are not assertive enough to indicate their own frustration. In addition, it may be helpful for the physician to acknowledge the delay when he or she sees the patient. Patients are appreciative and more understanding when the office staff takes the time to explain scheduling delays. Patients who wait for an unreasonable time past their scheduled appointment frequently become angry. This is particularly likely to occur if a staff member has not approached them with the reason for the delay.

Scheduling delays are a key factor in patient satisfaction. Offering a specific solution such as rescheduling or the option of continuing to wait with a realistic projection of the amount of time that it will entail, will help reassure and calm the patient. Routine patterns of delay contribute to poor patient satisfaction and may need to be evaluated periodically by physicians and office staff.

2. 24 Hour Practice Coverage

Practices must provide physician coverage. An answering machine message that directs patients to the ED is inadequate. Practice coverage arrangements should be conveyed to covering physicians, facilities and after hour phone answering services. It is acceptable for an urgent care facility to direct patients to the ED if the facility has a recorded message stating patients should proceed to the nearest ED.

D. MEDICAL RECORDS & DRUG HANDLING/SECURITY

1. Minimize Misfiling

It is recommended that the practice have a medical records handling/security system in place to avoid misplacing or misfiling medical records. This could take the form of color-coding or the use of out-guides, alpha stickers, or numeric codes. In cases of family charts, the name of each family member should be included on the outside cover.

2. Medical Records Secure

Original records should not be removed from the office. Whenever possible, records should be returned to the record room at the end of the day. In cases where a chart must leave the office, a tracking system in the form of a sign out/in sheet must be in place for each chart, including who is taking it and where it will be found. It is important for the medical record room and all computers to be secured when physicians and staff leave the office so unauthorized persons do not have access to confidential patient information.

3. Written Employee Confidentiality Policy

A **written** employee confidentiality policy should be signed and understood by all employees, even though confidentiality is verbally implied in all offices.

4. Secure Computer Screens

Computer screens should be protected from patient view.

5. Unable to Hear Conversations of a Confidential Nature

Patients in the waiting room or other areas of the office **should not be able to hear discussions of a confidential nature**, telephone calls or other business matters pertaining to another patient. Referrals and other confidential matters should be conducted away from patient areas.

6. Drug Samples Out of View and Access

Drug samples should be stored out of patient view and access and in a secured area at night.

7. Release of Information

HIPAA Authorizations for Disclosure of Protected Health Information

With a few exceptions, anytime you release copies of a patient's medical record to otherwise unauthorized third parties; you must have a patient's written authorization conforming to the federal privacy standards established by HIPAA. A conforming authorization must meet the following standards:

- (1) The authorization must be in plain English;
- (2) It must clearly identify the patient;
- (3) It must clearly identify the information to be released;
- (4) If information about drug or alcohol abuse, HIV status or psychiatric records will be released, the release must say so explicitly;
- (5) The authorization must specify an expiration date or an expiration event;
- (6) The authorization must identify the recipient;
- (7) There must be a warning to the effect that information released pursuant to an authorization may no longer enjoy federal privacy protections; and
- (8) It must state the patient's rights including the right to revoke the authorization, and the right to treatment even if the authorization is not signed.

You do not need a patient's written HIPAA Authorization to release medical information directly to the patient, but you do need a **signed, dated request from the patient**. You should never release the original medical record. The patient owns the information, but the health care provider owns the record and has a duty to safeguard it.

If a written authorization specifies that "all information" found in the record should be released, you should literally comply with the request, even if other medical providers created portions of the record. If there are portions of the record that you believe in your professional judgment may harm the patient or someone else, you may withhold that portion of the record, subject to a patient's right to appeal your decision.

Notice of Privacy Practices

Every patient should be provided with a copy of the provider's Notice of Privacy Practices. The privacy notice must explain how protected health information is used and disclosed for Treatment, Payment and Health Care Operations, including examples of each. The privacy notice should also explain how protected health information may be disclosed without a patient's knowledge or consent for purposes other than Treatment, Payment or Health Care Operations, including meeting the various public health reporting obligations imposed on providers, or in response to a court order.

Acknowledgment of Receipt of Privacy Practices

Upon receipt of the Notice of Privacy Practices, the patient should sign an "Acknowledgment of Receipt of Privacy Practices" or, if the patient refuses to sign the acknowledgement, your staff should sign and place a form in the patient's medical record noting the patient's "Refusal to Sign Acknowledgment of Privacy Practices."

Use of Protected Health Information for Treatment, Payment and Health Care Operations

After the patient has received a copy of your privacy notice, you do not need a patient's written consent to release medical records to other providers, or for payment purposes, or for purposes in furtherance of health care operations. The patient's consent to sharing protected health information for treatment, payment and health care operations is presumed by giving notice of privacy practices. Sharing protected health information with other health care providers does not require withholding sensitive information about drug or alcohol abuse, HIV status or psychiatric notes.

E. DOCUMENTATION

1. Missed Appointment

Missed or cancelled appointments or patient non-adherence with agreed upon plans should be recorded in the patient's medical record. Cancellations or no-shows should NOT be erased from or overwritten in the daily log. Non-adherence includes missed appointments, failure to follow medical advice, failure to have a test or procedure performed or failure to see a consultant when advised. If this occurs, the physician or office staff may contact the patient to determine why follow-up has not occurred and record the results of this in the patient's record. If the problem is more urgent or potentially life threatening, an increased but "reasonable" effort should be made to contact the patient to encourage the follow-up needed. At minimum, this should be done with a phone call that is documented in the medical record. If that is not successful, a letter should be sent to the patient with a copy kept in the patient's record. Particularly in high risk situations, up to three documented attempts made to bring the patient in for required follow-up care, with the final attempt being a certified letter, is preferable to show that an effort was made to promote the necessary follow-up. Clear documentation of these attempts in the medical record will be important in cases where questions arise later. When determining why follow-up has not occurred, (e.g., patient dissatisfied with their care), it may be helpful to address their concerns and then encourage them to complete the needed follow-up.

2. Prescription Refills

There are many reasons why it is important to track medication refills. Some medications have the potential for abuse (e.g., narcotics); others should be used only for a short period of time before further evaluation of the patient's symptoms is warranted (e.g., Prilosec). For these reasons, all prescription refills must be recorded in the medical record. The use of phone logs separate from the medical record is not acceptable.

Prescription refills, either done in the office or by phone, should be authorized only by a physician or someone designated by the physician, with specific written protocols in place for this. It is important for the physician to review compliance with this protocol at regular intervals. The written protocol for renewing prescriptions should include a list of drugs, quantity, and how many refills are permitted without an office visit. It is also wise to have a list made available to staff of drugs that are never refilled over the phone by staff (e.g., tranquilizers, narcotics, etc.). Other urgent medications may need to be renewed by staff for a certain number of days until an office visit can be arranged.

The prescription refill list should be kept current and appear in a prominent or easily found location (preferably in the forefront of the medical record). An efficient way to track medication refills is to use the prescription medication list already present in the chart (see example). It should contain the drug name/strength/frequency/quantity given/date started and date stopped with initials. It is also helpful to include the reason for discontinuation for future reference.

An example of a charting mechanism follows. Individual offices may have developed alternate methods that serve these same functions.

MEDICATION with number given	DATE STARTED	DATE DISCONTINUED with REASON	DATE REFILLED with number given	INITIALS	DATE REFILLED with number given	INITIALS
Lanoxin 0.25 mg qd (#90)	3/7/96		6/12/96 (#90)	K.G.	{future refills}	{future refills}
(Levothyroxin) Synthroid 0.25 mg qd (#1 yr supply)	5/12/96		5/10/97 (#1 yr supply)	K.G.	{future refills}	{future refills}
Prilosec 20 mg qd (#45)	9/1/97	STOPPED 10/15/97 Symptoms persist				
Amoxicillin 500 mg bid (#20)	12/3/98	STOPPED 12/7/98 Rash				

3. Drug Sample Disbursements

Drug sample disbursements should be recorded in a log and include: the patient's name, what was given, how many or how much was given.

4. Educational Materials Available

Educational materials should be available and/or displayed in the waiting room, hallway or exam room or kept on file and distributed to patients as needed.

5. Distribution of Educational Materials Documented

Patient education and/or patient teaching should be documented in the patient's chart. If you are using pre-printed forms, education areas need to be checked off. If you are giving the patient a hand out this should also be documented.

6. Progress Notes Handwritten or Dictated Within 24 Hours of Visit

Progress notes should be dictated or written as soon after the visit as possible, with delays of no longer than 24-hours.

7. Staff Signature/ Initial List

A document that includes a listing of current as well as former staff member names, signatures and initials should be maintained as part of the office's permanent file. This list should also include the physicians and any temporary medical personnel who may have cause to write in the chart.

F. CHART REVIEW

1. Components Secure

All components should be secured to the patient's chart so pages cannot be easily lost or misplaced. Paper clips or the stapling together of sections should be avoided.

2. Clinical Data Separate from Non-clinical Data

The clinical portion of the medical record is expected to contain only data necessary to support the patient's medical care. **Non-medical data such as billing, insurance, and legal correspondence should be kept separate from clinical data in the medical record.** For similar reasons it is best not to include charges for office visits and other services in the progress notes.

3. Organized

Chart components should be compartmentalized in chronological order to facilitate the provider's accessibility to clinical data. For example: progress notes/ labs/imaging studies/consultations/non-medical data.

4. Entries Dated

All chart entries should be dated

5. Patient Name on all Components

Each page of the patient's chart should contain the patient's complete name.

6. Physician Initials Entries

The physician should sign/initial all entries including transcribed dictation and entries into an electronic medical record. Electronic signatures are acceptable providing the practitioner has signed a statement asserting that he/she alone will use the electronic signature

7. Staff Initials Entries

Office staff should initial **all** of their entries in the medical record.

8. Medical History

A complete medical history should be present in the chart of all patients seen three or more times by a PCP or specialist. A medical history may be in the form of a patient questionnaire or documentation by the practitioner. This can be provided by the physician or another clinician who sees the patient and should be updated regularly or as changes occur. History provided by an outside practitioner must be acknowledged by the receiving practitioner as indicated by initials on the report or documentation in the progress notes. An acceptable history may be updated via the problem list or progress notes.

A complete medical history should include the following: past medical history, surgical history, history of accidents, family history, hospitalizations, blood transfusions, and social history. For children and adolescents, past medical history should include the above plus birth history.

9. Tobacco/Alcohol/Illicit Drug Use Assessed

A current assessment of tobacco, alcohol and substance use should be documented in the patient's chart. A current assessment is defined as within the past two years or as documented on the problem list.

10. Immunizations Assessed

The immunization status for both children and adult's, should be assessed by the primary care physician. An immunization record should be kept in pediatric and adolescent charts and an appropriate **history** of the adult's status obtained. (When did the patient receive their last tetanus, flu, etc.?)

11. *Legibility

The office record is a critical part of the physician's response to allegations of poor care. Therefore, the document must be legible to someone other than the writer. Legibility is the key to enhancing the usefulness of the medical record when an allegation of sub-standard care is made. A physician with illegible or poor handwriting may dictate, use a computer, type or print. As an added bonus, dictated notes are usually more complete and better organized. **Legibility deficiencies may be reflected in other areas of the PQ assessment.**

12. *Allergies

Allergies and adverse reactions or no known allergies (NKA) should be clearly documented on the outside of the medical record or on the problem list located at the forefront inside the chart in a designated location. Documentation of allergies at each visit does not substitute for one of these locations. **The practice of flagging allergies only if present is not acceptable, as errors in administering medications occur when individuals assume that blanks or the absence of a sticker means no allergies!** Patients should be questioned periodically about newly developed allergies, especially after long absences from the practice or significant illnesses. Practices should be able to identify one or more people who are responsible for entering and updating the allergy information in charts.

13. Problem List

A problem list serves as a summary device to help avoid overlooking important information about a patient's medical problems. It should correlate with the medication list when possible. **For primary care physicians, or other specialists functioning as a primary care physician, it is highly recommended that a problem list be present and maintained in the chart of all patients. It should identify all of the patient's chronic and recurrent medical problems and significant illnesses, not just those that appear to be relevant to the condition the practitioner is presently treating.** It should appear in a prominent or easily found location (preferably in the forefront of the medical record). To help determine whether the problem list is current, it is suggested that a date be posted on the problem list every time it is updated.

Surgical specialists and dermatologists may *substitute a patient intake form or history* for the problem list. It must appear in a prominent or easily found location in the medical record (preferably in the forefront of the chart). It should be updated on a regular basis or as changes occur, preferably at each patient encounter.

Alternatively, for **any physician, a complete list of the patient's medical problems can be assessed and documented at each patient encounter.** This then becomes a "functional" problem list in that anyone needing updated information can turn to the **most recent** visit to obtain it. If this method is used, it is important to do it at every visit so people do not have to flip through an entire chart to get a current problem list. If the patient is unsure of what medical problems they have, it is important to get that information from previous entries so the entry is current and complete.

14. *Medication List

A medication list serves as a way to readily discern what medications a patient is currently taking. This is important to help avoid drug-drug interactions and to determine dosages and frequencies of medications prescribed. It is highly recommended that a "formal" medication list be present and maintained in the chart of all patients. **It should identify all of the patient's chronic medications and appear in a prominent or easily found location (preferably in the forefront of the medical record).** Alternatively, a complete list of the patient's medications, dosages and frequencies may be assessed and documented **at each patient encounter.** This then becomes a "functional" medication list in that anyone can obtain updated information by referring to the most recent visit. To help determine whether the medication list is current, it is suggested that a date be posted on the medication list every time it is updated. Practices should be able to identify one or more people who are responsible for entering and updating the medication information in charts. *If the patient is not on any medications, it might be helpful for that to be noted on the medication list.*

Surgical specialists and dermatologist may *substitute a patient intake form or history* that includes a complete assessment of the patient's medications for a formal list. It must appear in a prominent or easily found location in the medical record (preferably in the forefront of the chart). It should be updated on a regular basis, preferably at each patient encounter, but at least at any encounter when a new medication is prescribed that potentially could interact with a patient's current medications.

Alternatively, for any physician, a **complete** list of the patient's medications, dosages and frequencies can be assessed and documented at each patient encounter. If this method is used, it is important to do it at every visit so people do not have to flip through an entire chart to get a current medication list. If the patient is unsure of what medications they are taking (e.g., "a pink pill"), it is important to clarify that information by having the patient bring in all their current medications or at least a list of all their current medications.

15. Vital Sign Documentation

When a patient presents to the office with certain medical problems it is important that appropriate vital signs are assessed and documented in the medical record. This would include visits when any patient presents with an **acute illness**.

For patients presenting with an **acute illness** the following vital signs should be documented in the chart:
(T=Temperature; BP=Blood Pressure; P=Pulse; R=Respirations; Wt=Weight)

Adults – T, BP, P, R*

Children 2 to 20 years – T, P, R*

Infants up to 2 years old – Wt, T, P, R**

*For adults and children 2-20 years, respirations need only to be included for an acute respiratory complaint.

**For infants up to 2 years old, a documented respiratory and/or cardiac assessment may be substituted for a respiratory/pulse rate.

The key to documentation is clarity--being complete yet concise, gathering and organizing all meaningful data, and presenting it in a comprehensible manner. The most common format for documentation is a SOAP note, which contains the four components listed below. Although the SOAP format is preferred, other variations of the problem-oriented record are acceptable to clarify what occurred at each patient visit.

S = Subjective comment (symptoms; complaints)

O = Objective (findings; observations)

A = Assessment (based on S and O)

P = Plan (action to be taken)

16. Problem Statement/Subjective Comment

The key to documentation is knowing when and what to write. Each progress note should contain a statement as to why the patient came to the office, preferably in the patient's own words.

17. Objective Findings

Each progress note should contain documentation of the pertinent findings/observations of the physical examination and/or diagnostic testing.

18. Working Diagnosis (Assessment) Consistent with the Subjective/Objective Findings

A “working diagnosis” is a description of a presumed condition that has not been fully defined. It represents an assumption that directs further evaluation or treatment. The working diagnosis may not be given a name but may be expressed as a care plan, group of possibilities (differential diagnosis), or concern. The physician or other clinician often uses the working diagnosis to establish a direction for further evaluation or management.

The evaluation of patient complaints, management of chronic illness, and provision of preventive health services may defy definitive diagnosis. The working diagnosis offers a plausible destination on the patient care path in an outcome-oriented system.

The Practice Quality reviewer verifies documentation of an expected outcome from testing, treatment or other element of the patient care plan. Alternatively, findings that are unexpected direct another plan of action. Patient refusals, decisions to avoid a workup, or other reasons that alter care plans should be documented.

19. Treatment Plan (Plan of Action)

In addition to the medications, tests, procedures and follow up care, the treatment plan (plan of action) should include instructions given to the patient regarding return visits with specific time intervals documented. **“Return prn” is discouraged** as it does not state the criteria for returning.

20. Treatment Plan (Plan Of Action) is Consistent with Working Diagnosis

This question is similar in design to the previous paragraph on working diagnoses being consistent with findings. The Practice Quality reviewer determines if a (working) diagnosis has been established and whether the treatment plan (plan of action) is consistent with the working diagnosis.

21. Previous Problems Addressed

Continuity of care requires follow-up of problems identified or suggested during previous visits. Unresolved problems from previous office visits should be addressed in subsequent visits. This may be demonstrated by the problem list of serial visits; lab/x-ray results with subsequent patient contact and direction; treatment plans developed and implemented based on consultation or by the resolution of a problem.

22. Referral Correspondence

Managing patient care among multiple providers requires that specific attention be paid to coordination of care, defined as appropriate communication among providers. When health care is provided by a primary care physician and a specialist, the primary care physician assumes the responsibility of coordinating specialist recommendations in the overall care of the patient, unless otherwise stated. For example; a note or letter from one provider acknowledged in the note of the subsequent provider and documentation of a related action or recommendation to the patient. Ideally this would be followed by reported results of this action at the next visit.

23. Care Appears Appropriate

The practice of medicine has often been called the art of medicine. While the measurement of outcomes may be extremely subjective, best practice benchmarks do exist. Physicians are held accountable to benchmarks of care that relate to their scope of practice.

Deficiencies in documentation may result in an “Improvement Needed” in this area. Inadequate documentation fails to support the quality of patient care given.

24. *Charts Free of Questionable Corrections or Additions

Any questionable medical record corrections or additions, e.g., white-out, black marker, notes in the margin, writing between the lines, erasures, etc., can be interpreted as altering the record and should be avoided.

The most effective way to amend an entry is to place a thin line through the incorrect information, noting "error" and initial. If only a single word or phrase needs to be corrected, that can be done at the point of correction if it is dated and initialed as long as the original entry remains readable. If longer, an entry should be included indicating where the corrected information can be found.

It is recommended that handwritten notes not be covered with transcribed dictation, but as long as it's done consistently and only covers reminder words for more accurate documentation, it is acceptable.

Information relative to medications which have been prescribed should not be deleted without clarification. Erroneous entries should be lined through but not obliterated. The date of corrections and reason should be noted and initialed.

G. PRACTICE COOPERATION

- Practice representative available for reviewer discussions.
- Physician strongly encouraged to be present for reviewer discussions.

H. SPECIAL STUDY QUESTIONS

Complete Prenatal System Utilized in Office

COPIC's Risk Management Department has requested that Practice Quality verify the following information on a select portion of their population. A list of practitioners who have indicated that they utilize this form within their office setting has been provided to Practice Quality. The complete prenatal system is composed of the Ambulatory Prenatal Flow Sheet, the Prenatal Data Base Questionnaire, and the Patient Questionnaire. Practice Quality will look for documentation to support the use of the **complete** prenatal system.

I. SPECIALTY SPECIFIC QUESTIONS

COPIC's Risk Management Department has requested answers to certain specialty specific questions based on analysis of COPIC'S claim and incidence experience.

A specific informed consent serves as a means of ensuring that adequate informed consent discussion between the patient and physician has occurred prior to an anticipated procedure. Discussions should include the general risks and potential complications of any procedure and those specific to the procedure. The risks of not undergoing the procedure should also be included. The consent should be completed and signed by the physician at the time that the patient agrees to undergo the procedure.

The operative note should be completed by the physician within 24 hours of completing the procedure and should include specifics about the procedure critical to the operation's safe completion as delineated in previous risk management communication.

If procedures requiring general or regional anesthesia are performed in the office, adequate patient precautions should be in place as indicated by the Colorado Board of Medical Examiners (BME).

III. CHARTING “DO’S” AND “DON’TS”

THE MOST IMPORTANT DOCUMENT in the defense of a claim of medical malpractice is the patient’s medical chart. If the documentation is accurate, objective, legible, timely, comprehensive, and free of alterations, it will reflect quality care rendered to the patient. Conversely, if these elements are not present, the plaintiff’s attorney could suggest willingness on the part of the physician to carelessly endanger the patient. It is generally considered that “if it is not documented, it did not happen.” We offer the following “Do’s” and “Don’ts” of charting as a guideline to proper documentation.

“Do’s”

- Write legibly
- Chart day, date and time of each entry
- Record patient ID on each page
- Record facts
- Describe the pathology
- Give overview and summary
- Write pertinent positive information
- Write pertinent negative information
- Record after-hours calls
- Initial office lab and x-ray
- Use standard abbreviations
- Correct by drawing a single line through the error and initial
- Sign corrections, addenda
- Record consent mechanism
- Fill in all blanks
- Read all doctors’ progress notes
- Read all nurses’ notes
- Dictate promptly
- Check all transcription dates
- Mention job of named persons
- Explain your thought processes
- Record non-compliance
- Document incidents and accidents
- Define activities and restrictions
- Current documentation of allergies
- List present medications
- Recheck decimal points
- Duplicate all prescriptions
- Record all communication
- Record family contacts/information
- Read and initial all your dictation
- Document discharge instructions
- Document prescriptions and follow-up visits

“Don’ts”

- Use Liquid Paper™ or erase
- Joke or be sarcastic
- Accept typing errors
- File incomplete charts
- Chart non-medical information
- Criticize other medical personnel
- Write in margins
- Be unnecessarily verbose
- Duplicate orders of others
- Countermand orders unless absolutely necessary
- Cross out errors completely
- Dictate days later
- Change your style of writing
- Be sexist or racist
- Mix medical and legal
- Mix medical and accounting
- “Dictated but not read”
- Argue on paper

IV. PRACTICE ENHANCEMENT TOOLS ON COPIC'S WEB SITE

COPIC Insurance Company maintains its site on the internet as a service to its insured physicians and their practices. Here, you will find current listings for COPIC's Physician Specialty Risk Management Seminars as well as for a variety of other educational seminars. You'll also find a section titled "Risk Management Resources" which contains answers to some of the questions fielded most frequently by COPIC's Risk Management Department. This section also contains a selection of practice-ready procedure-specific consent forms that you can print from your browser for completion and use in patient records. The Web site also contains current and back issues of *Copiscope*, COPIC's bimonthly risk management newsletter.

V. REFERENCE MATERIALS

The following materials are available from COPIC upon request. **Call (720) 858-6071 or obtain many of these forms via our Web site at www.callcopic.com.**

- Tickler File Information
- COPIC's Participatory Risk Management Program
- Frequently Asked Questions (FAQs) about COPIC Insurance
- Patient Phone Call Record Books

Model Consent Forms

(*also available in Spanish)

- Administration of Medication (i.e. Coumadin)*
- Allergy Injections*
- Blood and Blood Products
- Chemotherapy
- Corticosteroid Therapy*
- Flexible Sigmoidoscopy*
- HIV*
- Hormone Replacement Therapy (HRT)*
- Immunizations
- Informed Refusal*
- Laparoscopic Cholecystectomy
- Laparoscopic Fundoplication
- Lumbar Spine Surgery
- Office Operation/Procedure*
- Online Physician/Patient Communication*
- Pre-Authorization to Treat Minors*
- Record Release
- Steroid Therapy
- Surgical Procedure*
- Vaginal Birth After C-section (VBAC)
- Vasectomy

- **Other Forms:**

- HIPAA Compliant Consent for Release of Medical Record/Health Information
- Medical Summary with Problem List
- Combination Problem and Medication List
- Medication List
- Medication Refill Log
- Patient Health Summary

- **Clinical Guidelines**

- *Authored by COPIC*
 - Benchmarks for Electronic Medical Record Systems
 - Breast Lumps and Lesions
 - Laparoscopic Cholecystectomy
 - Laparoscopic Fundoplication
 - Lumbar Spine Surgery
 - Lasik
- *Authored by the Colorado Clinical Guidelines Collaborative*
 - Acute Upper Respiratory Tract Infections in Adults
 - Colorectal Cancer
 - Diabetes Mellitus in Adults
 - Pediatric Immunizations
- *Authored by Rocky Mountain Health Plans*
 - Improving Pregnancy Outcomes

- **Clinical Tools**

- Gail Model Breast Cancer Risk Assessment
- Mammography Quality Standards Act
- Thrombosis Risk Assessment for Medical and Surgical Patients

VI. CONTACT INFORMATION

For general questions regarding the Practice Quality assessment you may contact:

Jeffrey Varnell, M.D.

Physician Risk Manager, COPIC Insurance Company

(720) 858-6134

jvarnell@copic.com

Jennifer Rohy, R.N., B.S.N.

Manager, Risk Management/Practice Quality, COPIC Insurance Company

(720) 858-6123

jrohy@copic.com

You may reach Practice Quality's Registered Nurse Reviewers via telephone or e-mail.

Regina Storms, R.N., B.S.N.

rstorms@copic.com

(720) 858-6255

Rosemarie Wilkinson, R.N.

rwilkinson@copic.com

(720) 858-6256

Stephanie McCullough, R.N.

smccullough@copic.com

(720) 858-6259

Practice Quality Fax:

(720) 858-6201