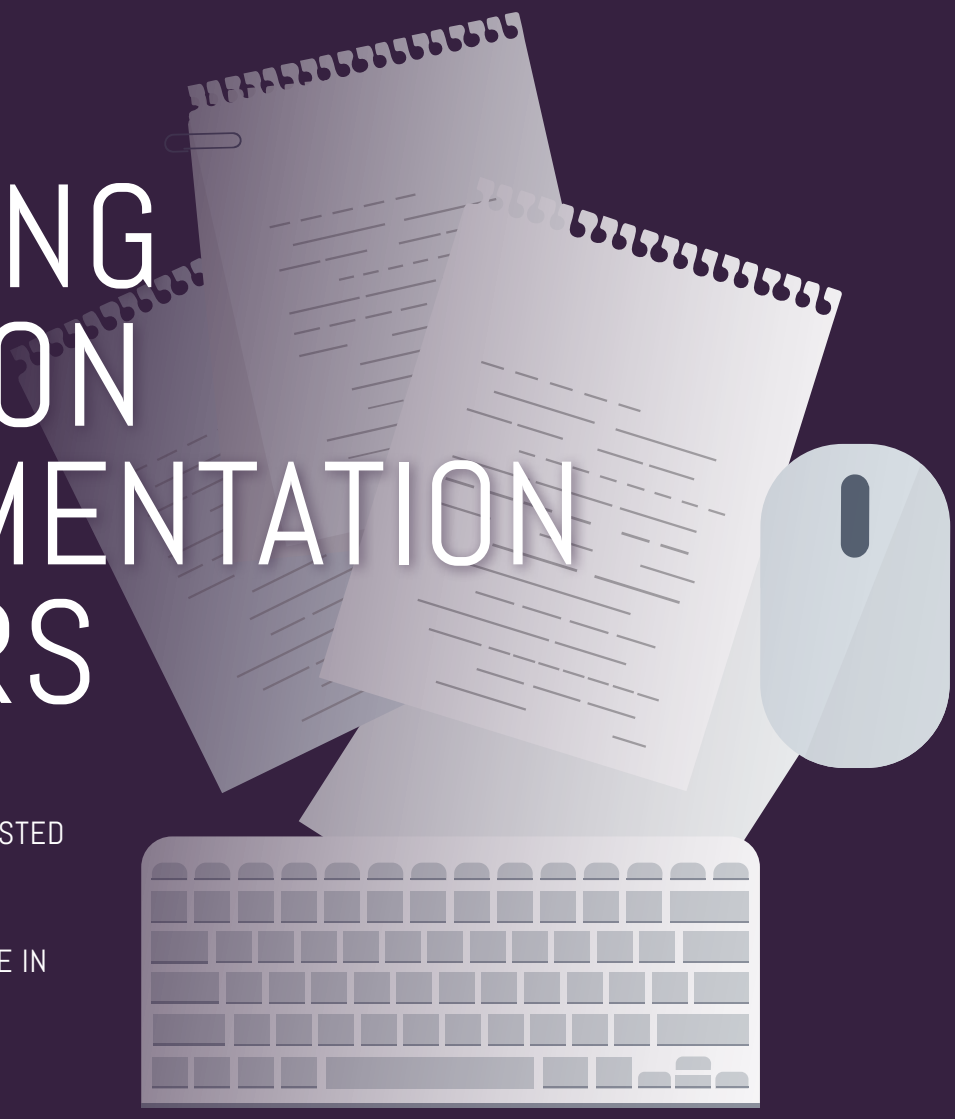
the REPORTER

CME: AVOIDING COMMON DOCUMENTATION ERRORS



AN INTRODUCTION TO AI-ASSISTED DOCUMENTATION TOOLS

CLOSED CLAIM: FAILURE TO DOCUMENT ANESTHESIA CARE IN AN OFFICE SETTING

CLOSED CLAIM: FAILURE TO DIAGNOSE FECAL IMPACTION

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CME: AVOIDING COMMON DOCUMENTATION ERRORS

by Wayne Wenske, Senior Marketing Strategist, with additional material
by Tanya Babitch, Assistant Vice President, Risk Management

OBJECTIVES

Upon completion of this educational activity, the participant will be able to:

1. describe good medical record documentation practices;
2. summarize how to avoid common documentation errors;
3. discuss the unique documentation risks associated with using electronic health records; and
4. define the recommended components of documentation policies and protocol.

COURSE AUTHORS

Wayne Wenske is Senior Marketing Strategist at Texas Medical Liability Trust (TMLT).

Tanya Babitch is Assistant Vice President, Risk Management at Texas Medical Liability Trust (TMLT).

DISCLOSURE

Wayne Wenske and Tanya Babitch have no relevant financial relationship(s) with ineligible companies to disclose. TMLT staff, planners, and reviewers have no relevant financial relationship(s) with ineligible companies to disclose.

TARGET AUDIENCE

This 1-hour activity is intended for physicians of all specialties who are interested in learning more about establishing and maintaining quality patient records and avoiding common documentation errors.

CME CREDIT STATEMENT

The Texas Medical Liability Trust is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education for physicians.

The Texas Medical Liability Trust designates this enduring material for a maximum of 1 *AMA PRA Category 1 Credit(s)™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

ETHICS CREDIT STATEMENT

This course has been designated by TMLT for 1 credit in medical ethics and/or professional responsibility.

TEST

To receive credit, physicians should complete the test questions that follow the activity. A passing score of 70% or better earns the physician 1 CME credit.

PRICING

The following fee will be charged when accessing this CME course online at https://tmlt.inreachce.com.

Policyholders: $10
Non-policyholders: $75

INSTRUCTIONS

CME test and evaluation forms must be completed online. After reading the article, go to http://tmlt.inreachce.com. Log in using your myPortal account information to take the course. Follow the online instructions to complete the forms and download your certificate. To create a myPortal account, go to www.tmlt.org, click the log in button, and follow the on-screen instructions.

RELEASE/REVIEW DATE

This activity is released on March 15, 2024 and will expire on March 15, 2027. Please note that this CME activity does not meet TMLT's discount criteria. Physicians completing this CME activity will not receive a premium discount.

INTRODUCTION

A basic tenet of health care risk management is the importance of producing and maintaining clear, comprehensive, and up-to-date patient records. A patient's medical history; family and social information; relevant clinical findings; treatment plans; procedures; medications; observations; conversations; diagnoses; and follow up are all important components of documentation.

Documentation also improves communication between patients and their caregivers and among caregivers. Maintaining a high standard of documentation—and thus communication—increases the quality and continuity of patient care.

The patient record can also help to demonstrate that the standard of care was upheld from a legal standpoint. Medical boards and regulatory agencies may use medical record documentation to determine

a physician's compliance with state, local, or hospital quality of care standards.

Poor medical documentation can lead to treatment errors, medication errors, and procedural or surgical errors. Adverse consequences of poor documentation can also include:

- unnecessary, expensive diagnostic testing;
- unclear communication among the health care team, which can lead to further errors; and
- inaccurate information provided to the patient during an informed consent conversation.

In a malpractice claim, what's found (or not found) in the medical record will be paramount to the case. Therefore, accurate, legible, and complete documentation is often a physician's best defense when confronted with a claim or medical board action.

This article will review what constitutes a poor vs. quality patient record; how to avoid common documentation errors; and risk management considerations when using electronic health records (EHRs) and scribes.

WHAT DOES GOOD DOCUMENTATION LOOK LIKE?

At minimum, an individual patient's demographics should be included in their record, including:

- full legal name;
- birthdate/age;
- biological sex assigned at birth;
- gender and/or gender identity;
- ethnicity;
- contact information, including address;
- race;
- marital status;
- education level;
- medical insurance information; and
- profession or employer.

This information should be updated when applicable and patients should be regularly asked if their information on file is correct. Collecting patient demographics helps to confirm a patient's identity, facilitates strong communication, ensures correct billing, and helps flag health risks and other factors that may affect a patient's care.[1]

For example, if a patient's address is in an area with limited access to healthy or affordable food (a "food desert"), they may be at greater risk for nutritional deficiencies, obesity, being underweight, cardiovascular disease, certain types of cancer, or birth defects.[2]

Additional non-demographic patient information to collect includes:

- reason(s) for current visit (or chief complaint) and relevant history;
- current prescriptions;
- drug allergies;
- hospitalizations, surgical procedures, and new diagnoses, treatments, or prescriptions from other health care providers if applicable;
- lab work performed during or before the visit;
- exams performed during the visit and their scope;
- positive findings of the lab work and exams;
- relevant negative findings of the lab work and exams;
- key abnormal test findings;
- assessment, clinical impression, or diagnosis;
- reasoning or rationale behind diagnosis;
- clear treatment and management plans;
- informed consent or agreed upon actions with patient;
- future treatment recommendations;
- new administered, prescribed or renewed medications, specifying amount, frequency, number of refills, and dosage;
- education and instructional materials provided to patient and/or family;
- referrals and consultations;
- communications or conversations with patient, patient's family, and friends; and
- recommended return visit date.[2, 3]

A patient's progress, including response to treatment, any change in diagnosis, or non-compliance should also be documented.

Patient information must be added to the record promptly. If there is a delay in documenting any patient or treatment information, the reason for the delay should also be documented. All entries must be dated and accompanied by the name and designation of the person making the entry, and their electronic signature must be included.[2]

The Texas Medical Board also states that "salient records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's

MANAGING MEDICAL RECORDS IN TEXAS

Here are answers to common questions about the management, retention, and release of medical records in Texas. These rules are provided by the Texas Medical Board (TMB).

If you practice outside of Texas, please refer to your state medical board for guidance.

How long do I need to keep medical records?

For adults — all records must be kept for at least seven years from the date of the last treatment. "Keep in mind, 'treatment' might include a phone call, a prescription refill, or other contact with the patient." Hospitals are required to keep records for 10 years, and some physicians may also choose to keep office records for 10 years.[4]

For minors — records for minor patients must be kept for at least seven years from the date of last treatment or until the child turns 21, whichever is longer.

Medical records that relate to any civil, criminal, or administrative proceeding may be destroyed only if the physician knows the proceeding has been finally resolved.

Who "owns" the medical record?

The physical or digital documents are the tangible, personal property of the person or entity that created them. However, by law patients have the right to obtain copies of their medical records. The only clear exception in Texas law is in the Medical Practice Act, which states: "If the physician determines that access to the information would be harmful to the physical, mental or emotional health of the patient." This guideline is outlined in the TMB rules, Chapter 165.2.

The physician might be asked to explain why the records or information may be harmful to the patient. See the next question for details on what is required when denying records to a patient. Never release the original record, except under subpoena and then retain a copy.

Is there a deadline for providing requested medical records?

Texas law gives a deadline of 15 business days to provide medical records upon receipt of a request and any agreed upon fees. Federal guidelines generally require release within 30 calendar days, so practices should check their state laws and release records within the shortest required timeframe.

This same deadline also applies if the physician feels it would be harmful to release copies of medical records to a patient. The physician or health care entity has a deadline of 15 business days to provide a written, signed, and dated statement that details the reason for the denial and provides instructions to the requestor on how to file a complaint with the Department of Health and Human Services (HHS) and the TMB. A copy of the denial statement should be placed in the patient's medical and/or billing records.[3, 4]

medical records." If you practice outside of Texas, please refer to your state medical board to determine what constitutes adequate medical documentation in your state.[3]

COMMON FLAWS IN PATIENT RECORDS — AND HOW TO AVOID THEM

A flawed patient record will most likely be unclear, incomplete, or lacking detail. Other common errors are listed below.

1. Omitting important treatment details, such as:

- the patient's chief concern or reason for scheduling the appointment;
- the patient's vital signs;
- severity of the condition or symptoms;
- test results;
- concerns or questions raised by the patient; and
- education materials provided to the patient.

Medical documentation should be clear, concise, and detailed enough to describe a patient's condition and treatments accurately. It is possible to be too brief or ambiguous in the record, which can lead to incorrect diagnoses or treatment decisions or unnecessary testing.

Make sure your notes are specific, objective, consistent, and clearly present a patient's story. Establish policies and procedures for documentation, including what is required, accepted medical terminology and abbreviations, and medical record review protocol. Any time the policies and procedures are updated, staff members should be required to sign an acknowledgement that they have read and understand the updates.

2. Recent studies have shown that **patient records, particularly in EHRs, can become overloaded with excessive notes and data**, which can hinder a physician's ability to make an appropriate diagnosis and treatment plan. "The overload of information stems from copying and pasting into charts, use of templates, excessive alerts, and adding data that are necessary for billing but effectively useless for clinical care."[5]

Focus on the essential documentation requirements of your organization. Again, these requirements should contain the information that is meaningful and relevant to patient care. Developing these protocols may take time, and involve regular, systematic review to ensure the records are comprehensive and compliant without being overly complicated.

3. Failing to document patient informed consent. Failing to obtain and/or document informed consent can make a physician vulnerable to a claim of negligence. In the context of a lawsuit, a plaintiff attorney will likely reference the old adage, "If it is not documented in the patient record, it did not happen."[6]

Documenting informed consent occurs after explaining the risks and benefits of a procedure or treatment to the patient and assessing the patient's comprehension. Apart from a signed consent form, it is recommended that the consent discussion with the patient be included in the records.

If written consent forms are used, it is important that patients have the opportunity to review the forms and ask questions. Then, obtain the signature of the patient or a patient's guardian, witness signature, and the date that both parties signed the document.

If feasible, and dependent on individual state laws and consent form requirements, the physician obtaining informed consent may also sign the consent form. The physician's signature indicates that he or she fully described the treatment to the patient; that the patient understands the risks and benefits of the treatment; and that the patient consents to the treatment with full knowledge and understanding of the risks involved. Retain all executed informed consent documentation in the patient record.

4. Failing to correctly date and sign a patient note. Every note entered into the record should be signed and dated. Make sure documentation includes a digital signature and date. Notes without a date and signature may also cause confusion for other care team members.

5. Failing to document phone calls. Every clinical encounter with a patient should be documented in the patient's file, including phone conversations.

If a patient calls to ask for clinical advice or help over the phone, the conversation must be documented.

The note should include the reason for the call, any advice provided to the patient, the date and time of the call, and the signature of the provider who fielded the call. In the event of an emergency, the caller should be instructed to call 9-1-1 and this advice should be included in the record.

Your office or organization's policies and procedures should include guidance on whether a patient phone call requires an appointment, either in person or via telemedicine, or if the call may be addressed immediately over the phone. "It is important to keep in mind that a patient's phone call could be the last form of communication with your office before a lawsuit is filed."[7]

6. Failing to document a patient's informed refusal or noncompliance. As with informed consent, it is important to document a patient's refusal of treatment or noncompliance. "Informed refusal" also includes patients who decline medication, routinely miss office visits, defer diagnostic testing, or refuse hospitalization. Again, failing to thoroughly document this refusal or noncompliance can leave a physician vulnerable to claims of negligence or malpractice.[8]

Notes of the discussion with the patient should be included, as well as notes from consultants and specialists, social work providers or organizations, and psychiatry specialty services as needed. These notes should also comment on the patient's mental status and decision-making capacity. Physicians can further protect themselves against claims of negligence or malpractice by having the patient sign the note or a statement that describes the informed refusal.

Documentation of a patient's informed refusal should include:

- description of the intervention offered;
- reasons the intervention was offered;
- potential benefits and risks of the intervention;
- note that the patient has been told of the risks, including possible jeopardy to life or health by refusing the intervention;
- clearly document that the patient has unequivocally and without condition refused the intervention; and
- reason(s) why the patient refused, particularly if the patient's decision was rational and one that could not be overcome.[9]

You may consider establishing an informed refusal form for your office or practice. If a patient's refusal could lead to severe or permanent injury or death, use this form to help you clearly document the refusal. Also, asking a patient or guardian to complete or sign the form may reinforce the seriousness of the situation to an indecisive patient or guardian and help them to reconsider.[9]

7. Failing to remain objective while documenting patient encounters. It is important to record entries using objective language. For example, if a patient is not performing prescribed physical therapy exercises at home, document that the patient is "noncompliant in following home exercise instructions." Use wording that clearly states the patient's condition and the care provided, not a subjective opinion.

Another example would be to not record a patient as being "a drug addict" or "an alcoholic" without objective substantiation of these assertions. Instead, the physician could conclude that the patient "demonstrated drug-seeking behavior" or "had slurred speech."[10]

Subjective opinions that may be interpreted as stereotyping or expressing disapproval can paint the provider as having implicit biases and stigmatize the patient, negatively affecting the quality of the ongoing health care received.

8. Inadequate or incorrect patient history. Quality patient records often begin with creating a good patient history, including family history, drug allergies; and names of other physicians that the patient is consulting.

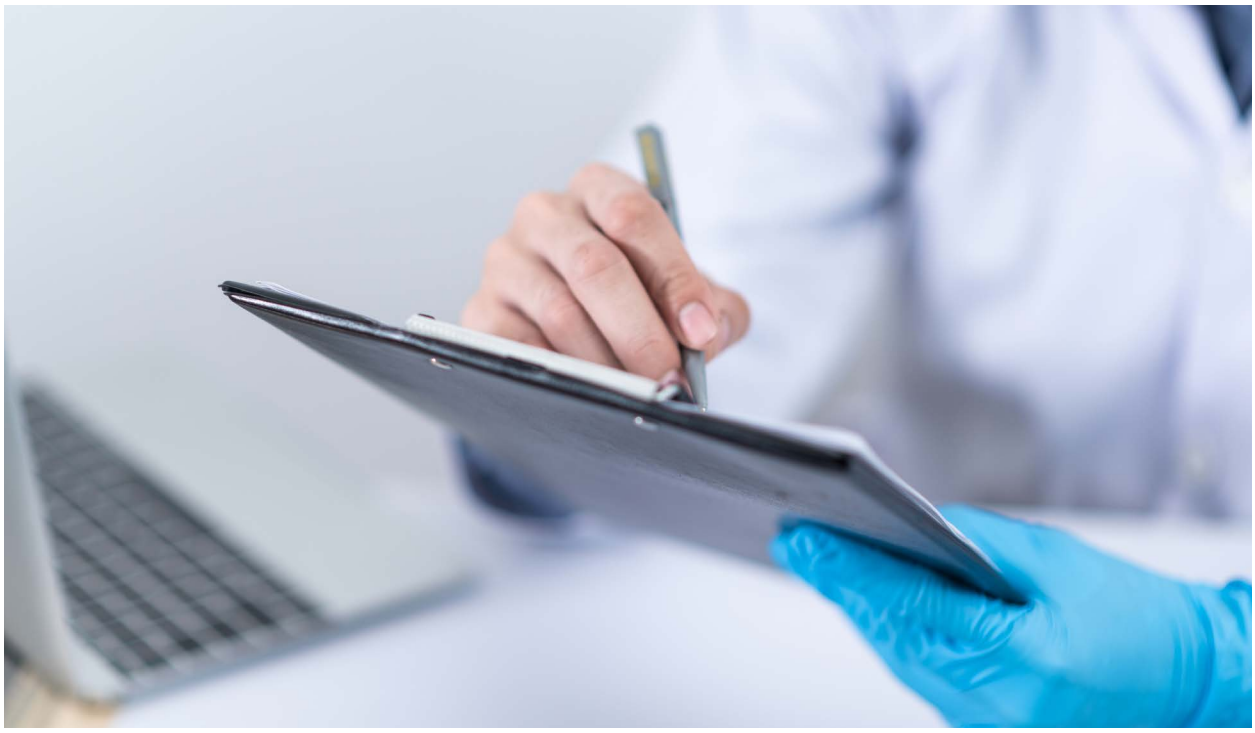
An effective patient history should include:

- **Chief complaint (CC):** A concise description of the patient's major health concern or symptoms that caused the patient to seek care. This includes how long the patient has experienced symptoms and any other pertinent details. The CC is often documented in the patient's words. For example, "Patient complains of shortness of breath ('wheezing' and 'can't catch my breath, like I've been running') for three days, worsens upon walking" or "Patient complains of upset stomach, nausea, fatigue and feeling 'woozy' for two weeks."
- **History of present illness (HPI):** Chronological

description of the patient's illness or condition, described in prose form that conveys the patient's present condition as a linear narrative.

- **Past medical history (PMH):** Patient's history of major illnesses, surgeries, or chronic conditions provided in a chronological listing:
  - major childhood illnesses;
  - adult medical conditions;
  - current medications with dosage, including prescriptions, over-the-counter drugs, vitamins, supplements, oral contraceptives, and complementary medications;
  - surgical procedures;
  - injuries;
  - hospitalizations;
  - immunizations; and
  - allergies.
- **Family history:** When possible, include the following information:
  - ages and general condition of current family members;
  - cause of death and age at time of death for deceased family members, if known;
  - specifically include any family history of diabetes, hypertension, coronary heart disease, cancer, arthritis, substance abuse (alcohol or illicit drugs), obesity, mental illness, unusual or early deaths, or known genetic illnesses, such as sickle cell disease.
- **Social history:** This data helps to provide a context for the patient's life and potential risk factors. Include the following:
  - living arrangements or conditions;
  - lifestyle:
    - marital status;
    - number of children;
    - education level;
    - occupation; and
    - alternative health care practices, such as acupuncture or herbal therapies.
  - health habits or behaviors:
    - good or poor nutrition, exercise, sleep, or caffeine use;
    - use of tobacco, alcohol, or recreational drugs;
    - sexual behavior, especially if there are symptoms or exam findings of sexually transmitted diseases (STDs);
    - allergies to medications, foods, latex, and other environmental factors;
    - sources of stress and stress levels; and
    - domestic violence, if indicated in patient behavior or exam findings.
- **Review of systems (ROS):** This section organizes a more thorough account of a patient's condition, often organized in the patient record as going "head-to-toe." ROS data is often collected from the patient on intake forms and reviewed together by the physician and patient during the patient visit. Negative and positive findings should be documented. Categories to include:
  - General or constitutional – fever, weight gain or loss, fatigue;
  - Eyes – any visual changes;
  - Ears, nose, mouth, throat – hearing loss, sinus pressure, visual changes, soreness;
  - Skin – rash, lesions, breast lump, breast discharge, hives, mole change(s);
  - Respiratory – coughing, shortness of breath, wheezing, etc.;
  - Cardiovascular – chest pain, claudication, palpitations, edema, fatigue, sweating, jaw pain;
  - Gastrointestinal – abdominal pain, constipation, diarrhea, heartburn, nausea, dysphagia, vomiting;
  - Genitourinary – dysuria, polyuria, urinary frequency, discharge, pain during or after sex, pelvic or groin pain;
  - Musculoskeletal – joint pain, back pain, knee pain, neck pain, joint swelling;
  - Neurologic – numbness, weakness, "pins and needles," vertigo, headaches, seizures, weakness, tremors;
  - Mental health – depression, anxiety, self-harm;
  - Endocrine/metabolic – intolerance to cold or heat; polydipsia, polyphagia; and
  - Hematologic – bruising, bleeding, lymphedema, blood clots.

9. Illegible handwriting or transcribing errors, including prescriptions that may be misinterpreted by scribes or other care team members when adding information to the EHR. While electronic prescribing has become the norm, illegible and/or incomplete prescriptions or medication documentation, including missing or wrong dosage, missing or wrong frequency, and missing or wrong route of administration, can threaten patient safety.



The use of electronic prescribing has mitigated some prescribing errors. However, if still hand-writing prescriptions, the use of decimals can cause confusion. If written too lightly or illegibly, a handwritten prescription for 1.0 mg of a medication can be misinterpreted as 10 mg. Or .5 mg can be misread as 5 mg.

It is recommended to not use a zero after a decimal (write "1 mg" instead of "1.0 mg") and to use a zero before a decimal point (write "0.5 mg" instead of ".5 mg.")

10. Incorrect use of medical abbreviations. Abbreviations and symbols are often used to save time. However, some abbreviations may be misinterpreted if they have more than one meaning. For instance, "PID" could refer to "prolapsed intervertebral disc" or "pelvic inflammatory disease."

According to the Patient Safety Authority, some commonly misinterpreted or misread abbreviations include:

- "U" for unit;
- "QD" for daily;
- "QID" for four times daily;
- "cc" for cubic centimeter;
- "D/C" for discontinue;
- "AU" for both ears;
- "OU" for both eyes;
- "MSO_4" for morphine sulfate;
- "$MgSO_4$" for magnesium sulfate; and
- "HCTZ" for hydrochlorothiazide.

For example, "a nurse who was taking a patient's medication history recorded his insulin dose using the abbreviation 'U' instead of writing the word 'unit.' The physician then misread the 'U' as a '4' and wrote for 'Humalog 44 U/24 U/64 U.' The patient received a single overdose of insulin but was not harmed. Further overdoses were averted because the nurse said to the patient 'Here's your insulin, 44 units.' The patient responded '44 units? I take 4 units!'" [11]

Many organizations or hospitals maintain approved abbreviation lists to help create consistent and unambiguous records, but it is a good practice to minimize or even eliminate the use of abbreviations when documenting patient encounters.

If using paper records, handwritten symbols can also be problematic. For example, based on an individual's handwriting, a plus sign (+) can be misinterpreted as the number four (4), and an ampersand (&) can

be mistaken for the number two (2). Take care when providing handwritten instructions or prescriptions to ensure your directions are written clearly and that they minimize or avoid the use of abbreviations or symbols.

11. Incomplete prescription or refill information, including failing to document discontinuation of a medication. Medication errors represent the most common patient safety error, with more than 40 percent believed to be caused by inadequate medication reconciliation during patient visits or hospital stays. These errors can lead to adverse drug reactions or overdoses.[12]

Do not leave data fields blank. Blank fields can be misinterpreted by others. For example, leaving a form field blank for "drug allergies" may be translated by other providers as meaning "no drug allergies," when the person left it blank because he or she simply did not know about the patient's drug allergies.[2]

Reviewing and reconciling patient medications at every visit is an important part of every patient encounter and should be a shared duty between a physician and the medical staff. When reviewing a patient's medication record, look for duplicates, blank fields, discontinued medications, or dose changes that need updating.

AVOIDING EHR DOCUMENTATION ERRORS

Fortunately, many of these common documentation errors, such as illegibility or missing time or dates, can be avoided when using the electronic health record (EHR). But EHRs present their own documentation challenges, such as the use of "copy and paste" functions and templates. These challenges can often be mitigated by fully educating staff on EHR use and establishing clear policies and procedures for documentation.

Copying and pasting text in the EHR (also referred to as cloning, copying forward, or carrying forward), either from current or previous patient encounters, may present a significant risk to maintaining quality patient records. Copy and pasting in the EHR can result in:

- inaccurate or outdated data;
- redundancy, disorganization, data overload, and confusion;
- an inability to identify an author, accurate date, or original intent of the note; and
- continued use of false or unreliable information.

Any one of these errors can seriously inhibit a physician's ability to make an accurate diagnosis or make appropriate clinical decisions.

In addition, text that is copied or carried forward from one patient encounter to the next may suggest that the treatment plan is not working or that the physician is not reviewing the record or paying close attention to the patient's progress. While carrying over historical elements of a patient's record may be timesaving, notes should be reviewed and edited for each patient encounter to avoid importing incorrect information.

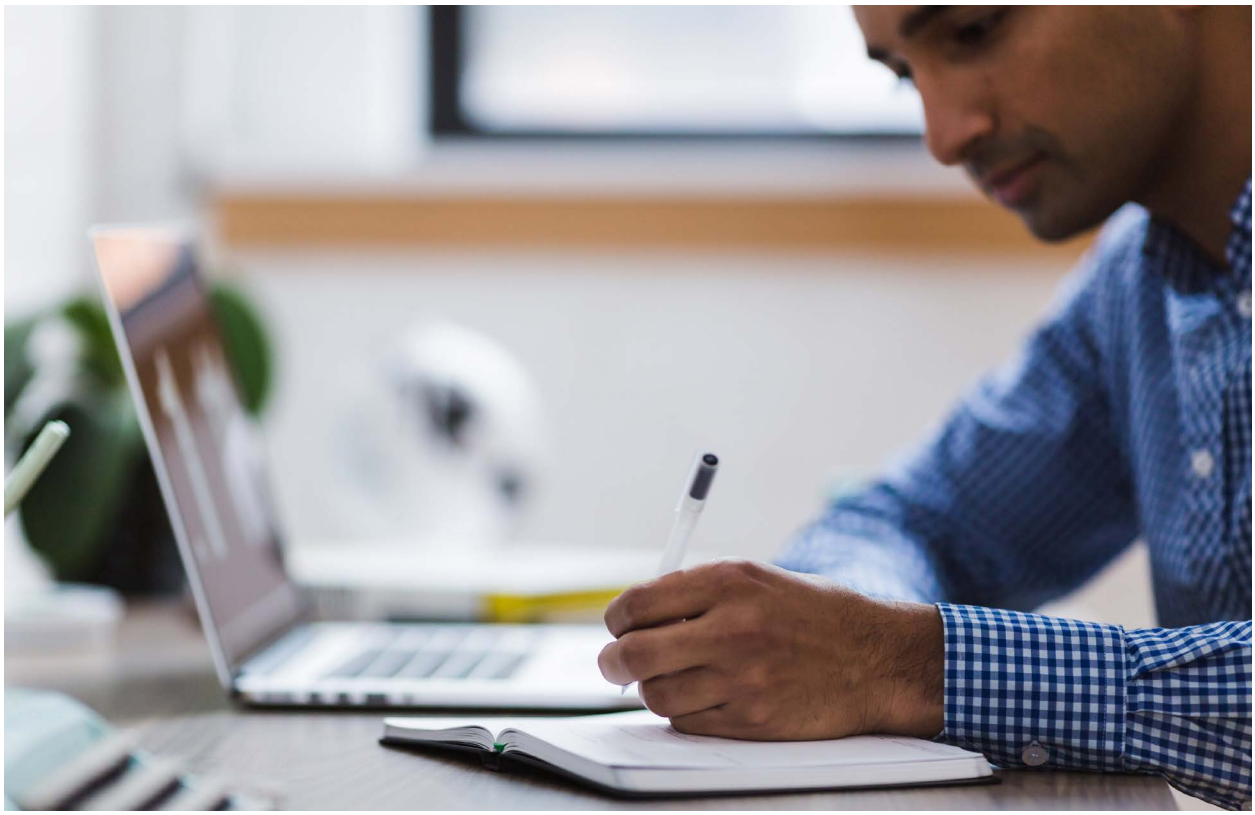
Templates are used to help physicians and staff capture required or essential patient information, such as patient history, informed consent, or other important details pertinent to their practice or specialty. However, some templates automatically fill some data fields based on past data entries or patient encounters, even though this default information does not reflect the current encounter or status of the patient.

If this default text is not updated by the provider, "it will remain in the chart indicating that the physician completed a review of systems. If this review of systems was not done or if the findings were not normal and the [EHR] defaults to 'normal,' the record is inaccurate.

When investigating a medical liability claim or a board complaint, if it becomes apparent that these default statements are not true, the patient's exam may be considered incomplete or the documentation characterized as sloppy.

Notes should be individualized for each patient encounter and relevant sections reviewed to avoid importing incorrect, redundant, and irrelevant information."[13]

It is important when using templates or copying and pasting data to review the record at every patient encounter to make sure the information is accurate and up to date.



One benefit of using templates is that they may be customized to reflect the requirements of your specialty, office, or organization. Customized templates — edited to be clear, concise, and complete — can help reduce redundancy and errors and bring structure and clarity to patient records.

Regularly review the templates with your team, including nurses, billing staff, and coders, to make sure the templates are optimized and accurate. If there are fields or areas that are frequently left blank or unused, consider eliminating them. Before making any permanent changes to templates, review required documentation and coding/billing elements.[14]

Establish documentation policies and procedures for EHR use in your office or practice. Your policies and procedures should define what is appropriate to capture in the EHR that increases the accuracy, breadth, and overall quality of your patient records. To avoid risk of documentation errors, policies should be written to:

- discourage or limit copying and pasting patient data as a way to improve productivity or save time;
- encourage review of patient encounter notes before locking them;
- outline the user's responsibilities when it comes to copied information and notification of errors; and
- detail disciplinary actions for unethical or inappropriate documentation practices.[15]

Additional risk management considerations when using an EHR include:[14]

- **Ensure patient encounter records are "locked" once complete.** Information found in an EHR is likely to be more accurate if entered during or immediately after a patient visit. Once a patient encounter entry is completed, the author should sign it, date it, and lock it in the system. Note that not all EHRs are set to perform this task automatically; make sure you know how to finalize your notes in the EHR system.

- **Clearly identify addendums.** If information needs to be added or comments made after an entry is locked, clearly identify the new

DOCUMENTATION IN YOUR MEDICAL PRACTICE

Upon request, TMLT Risk Managers visit physician practices to help improve patient safety and increase defensibility in the event of a claim, lawsuit, or medical board complaint. Among the most common risk management recommendations given to physicians in 2023 were these five documentation issues — some of which are discussed in this article.

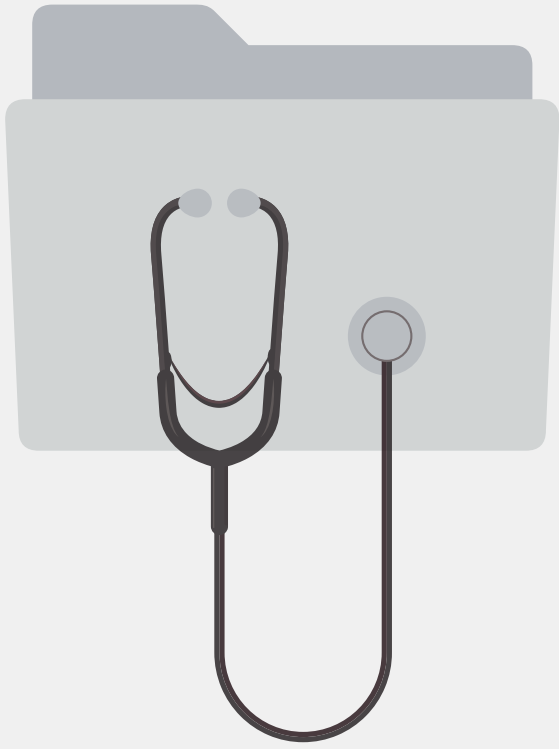
- Visit notes lacked documentation regarding who accompanied the patient to their visit. This may be critical information if the patient is a minor child, an impaired adult, or an elder adult that needs additional assistance.

- Review and update of current medications was not done or was not documented in the record. Risk managers often saw medications that should have been discontinued remaining for months or years on "current medication" lists. In some records, it was unclear that the medication list had been reviewed with the patient and updated appropriately.

- Medical history was not updated. New patient conditions, surgeries, or other pertinent information were not added to the record. Or past acute conditions appeared in the "current problems," when they should have been noted as "resolved." This could make it appear erroneously that a serious concern was either ignored or not improved.

- Allergy information was not updated or documented consistently, or NKDA (no known drug allergies) was not noted in the record. Leaving the allergy section of records blank is never recommended; it should always be noted if a patient reports no allergies. Allergies should be addressed with the patient at each visit and the record updated accordingly.

- Patient education — via handouts, discussion, or other instructions — was not consistently noted in the record. Physicians engage in hours of education of their patients. With the advent of new laws that allow patient access to their own records, documentation of this education is especially important. If documented in the EHR, patients can quickly access and review instructions, precautions, and other information that was given to them during or after their visit.



entry as an addendum with the current date, reference to the original entry date, the reason for the late entry (if significant changes are made), and electronic signature. Unclear, after-the-fact entries may be viewed as alterations to the medical record, which can create legal complications.

- **Make sure physician sign off is clear.** A physician may believe he or she has "signed off" on a note when closing it, but this may not be the case. Review your EHR functionality to confirm that you are appropriately signing, dating, and "locking" all notes. Ensure that all physicians or any staff member making entries know how to properly sign and finalize entries in the EHR system.

- **Review orders or emails before signing off with electronic signatures.** Signing an order confirms that it is correct. "Avoid auto-authentication techniques that do not require the author to review the entry. Do not 'universally' approve or sign off on a series of orders, emails, or internal messages without reading them."[14]

- **Enable tracking mechanisms.** Most EHR systems include an electronic order tracking system to help ensure that patients have completed recommended tests or consultant referrals. These tracking systems can provide ways to:
  - verify that a patient keeps an appointment or completes a test;
  - confirm receipt of a report;
  - prompt a call to the consultant, imaging center, or lab if a report is not received;
  - make sure the physician reviews the report;
  - facilitate documentation of review, sign off, and any actions needed in response to test results;
  - prompt communication of results to the patient;
  - assist in scheduling a follow up appointment if necessary; and
  - document all these steps with dates and electronic signatures.

- **Establish a system to appropriately capture paper and other external clinical documents.** Optimally, all paper documents should be scanned into the electronic record for easy access. These documents could include paper records used before implementing an EHR, paper forms completed by the patient, diagnostic test results, consultant reports, hospital reports, or records from other physician offices. Additionally, a process should be implemented to ensure that, once scanned, the paper documents are properly stored or destroyed.

  While scanning a patient's entire paper record into the system is preferred, it is not always possible. Some patients' previous medical records can be hundreds of pages. In these cases, physicians can review the records, summarize them, and include that information in the patient's history within the EHR. Whatever process you adopt, it is important to develop and maintain a policy for capturing patients' previous medical records.

- **Ensure paper prescriptions are reflected accurately in the record.** If using paper prescriptions, they should be captured by scanning the paper prescription into the EHR or fully documenting the name, dose, quantity, frequency, instructions, and refill amount. Potential side effects or risks should also be documented. The same is true when dispensing sample medications to a patient.[14]

WORKING WITH A SCRIBE

One way hospitals, practices, and organizations have found to ease the administrative and time demands related to documentation is by using medical scribes. A medical scribe is typically an advanced practice provider, nurse, or other staff member who works with a physician to document all pertinent patient encounter information, often in real time.

A 2021 study found that the use of medical scribes has been mostly beneficial to creating patient records and helping physicians to shift their attention away from the EHR and more toward personal interaction with their patients.[16]

The same study offered that many physicians feel that scribes provide an "extra layer" of legal

protection for them. Having a "witness" in the room helps both the physician and the patient verify the information shared during the encounter. Other physicians, particularly those in high stress environments like the emergency department, felt that the mere presence of "a third person in the room makes patients behave better." [16]
Another benefit of employing scribes is that these individuals usually become extremely adept at using the EHR and become "EHR experts," offering help to others in an organization or practice.

This same study recommended the following best practices for working with scribes.

- Records must clearly describe the actions or service of the provider during each individual patient encounter, who documented the service, and the qualifications of each person, such as professional degree or medical title.
- Ensure that the scribe's role and responsibilities are clearly assigned to avoid "scope creep." There have been instances in small clinics and rural areas where a scribe's role has gone beyond documentation to a broader set of duties that the scribe was not licensed to perform. Scribes must keep their roles clearly separate from those offering clinical care.
- All notes should be signed and dated by both the provider and the scribe.
- Documentation completed by scribes must be regularly reviewed to ensure accuracy, completeness, and overall quality. This responsibility is especially necessary while training a new scribe. It can generally take a scribe six months to become well oriented to the health care environment, the behaviors and reasoning of the physician he or she works for, clinical terminology, and how the EHR system works. During this time, the physician will need to spend extra time reviewing the scribe's work and documentation.
- It is important that there is good communication between the physician and the scribe and that both feel comfortable giving and receiving criticism or feedback. To produce positive interactions, efforts should be made to find a scribe that will be a good personality "fit" for the physician. This may not always be apparent during hiring but may be helped by establishing that the relationship will resemble one between a mentor and a mentee. This will help foster a mutually beneficial relationship for both the physician and the scribe.[16]

CONCLUSION

The benefits of creating and maintaining quality patient records are many. A thoroughly documented record provides the physician and care team with a full picture of a patient's condition and greater insight into a patient's risk factors. This ensures that all providers have the necessary information to evaluate the patient and make quality treatment decisions. On the other hand, a poorly documented or maintained patient record can lead to higher incidence of error and potential legal action.

Clear, complete, and logical documentation offers recorded, authenticated proof that the individual physician provides excellent, timely, and meticulous care. It further demonstrates how the physician puts patients first, through considerate, thoughtful, and caring treatment.

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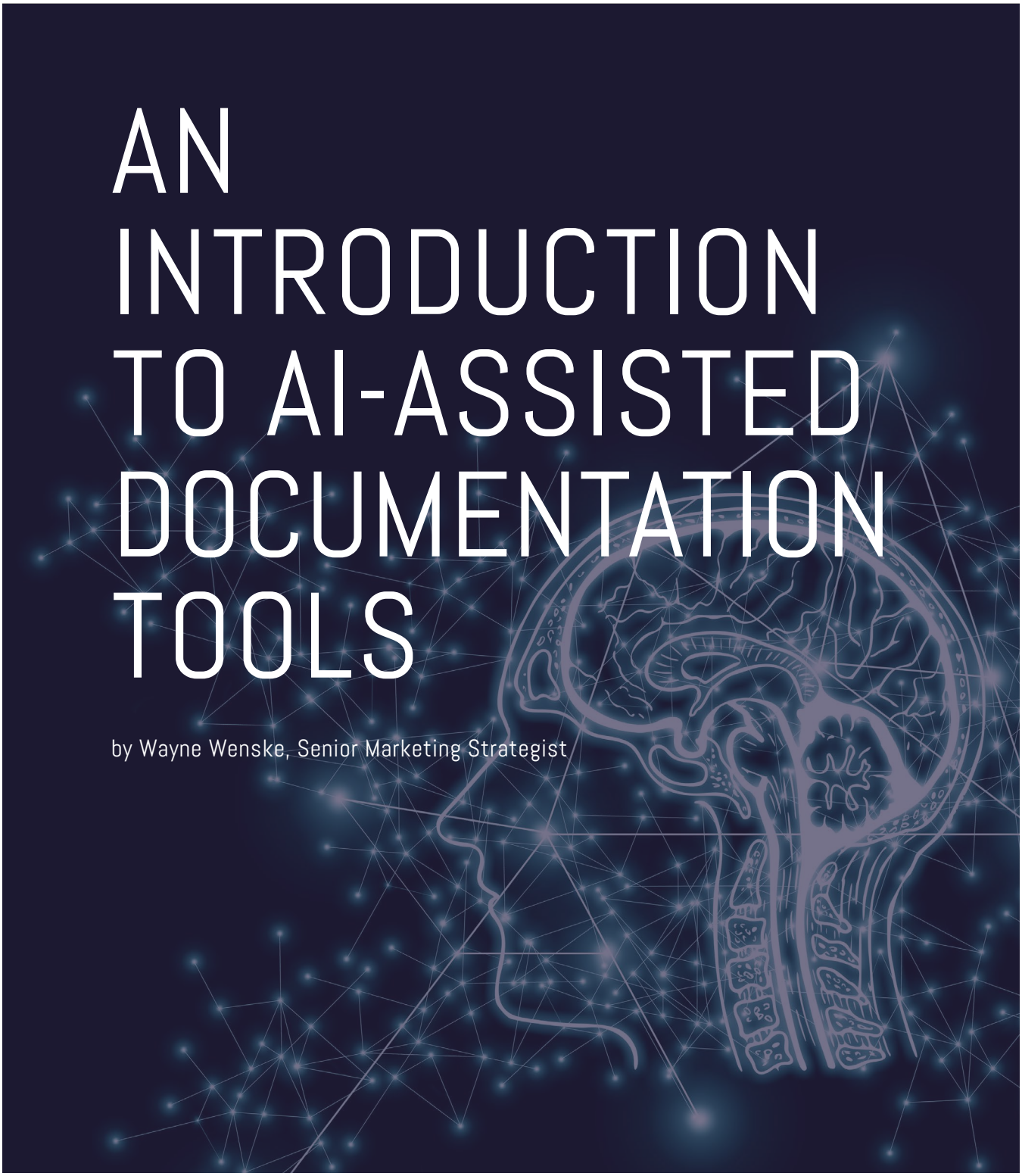
AN INTRODUCTION TO AI-ASSISTED DOCUMENTATION TOOLS

by Wayne Wenske, Senior Marketing Strategist



How artificial intelligence (AI) will affect our lives and work — even our intellectual and cultural development — fuels ongoing (and fascinating) debate. AI has been lauded as the answer to a range of problems – from fighting financial fraud and conducting legal analysis to enhancing education and boosting power systems.

In health care, strides are already being made to employ AI technology in the development of vaccines and medications; to evaluate diagnostic testing; or to assist physicians with making diagnoses, recommending treatments, and tracking patient progress.

But for most physicians, the most immediate use of AI is found in minimizing burdensome administrative tasks associated with the electronic health record (EHR). This includes using AI as a medical scribe or transcription tool during patient encounters. In theory, relieving physicians of these routine duties can help them shift their focus away from the screen and more toward spending quality time with patients.

Voice transcription tools powered by AI can transform dictation or even conversations between the physician, patient, family members, and others into text. Systems are now available that can distinguish different voices and identify medical terminology. Using algorithms that interpret language, these AI tools can even process and understand the context behind what is being said. These tools can be integrated with EHR systems to assist physicians with documentation that immediately and accurately records what is said during a patient encounter.

As with any transcription tool, physicians must review transcribed documentation to ensure accuracy and completion.

However these technologies come to be used (and regulated), they offer incredible benefits. Yet with fast growth comes new risks, including system errors, improper data sharing, or data that reflects human and systemic biases.

AI systems learn by scanning thousands of records and data fields. From these scans, the technology learns how to respond to queries, perform tasks, prioritize information, and make decisions. Therefore, an AI system's performance is dependent on the quality and amount of data it is given. In health care, this data could potentially be pulled from patient records, insurance claims, pharmacy accounts, and other data files created by (fallible) humans across different formats and platforms.

For AI-assisted EHR systems to work well, they must learn from very large sets of patient data. This data includes detailed descriptions of treatments; how patients responded; and specific data about patient populations, such as vital signs, family histories, behaviors, and genetic data. These requirements lead to concerns for patient privacy and whether AI developers are violating federal and state privacy protections.

Privacy concerns also arise when considering that AI developers may use health care data (such as electronic protected health information, or ePHI) to develop AI tools in other industries. For example, patients could see their ePHI being used to determine insurance premiums or influence banking/loan requests.

In addition, AI systems could incorporate any biases and inaccuracies found in the data. "For example, African American patients receive, on average, less treatment for pain than white patients; an AI system learning from health-system records might learn to suggest lower doses of painkillers to African American patients even though that decision reflects systemic bias, not biological reality. Resource-allocation AI systems could also exacerbate inequality by assigning fewer resources to patients considered less desirable or less profitable by health systems for a variety of problematic reasons."[1]

The American Medical Association (AMA) recently published "key takeaways" for the health care industry to act upon in the development, use, and regulation of AI. Many of the takeaways address how health care should systemically approach AI for federal or state regulation and create technology frameworks to support consistent data creation.

The AMA takeaways included a few practical actions that physicians can take now. These include:[2]

- **"Promote population-representative data with accessibility, standardization and quality."** "This is the way to ensure accuracy for all populations. While there is a lot of data now, there are issues with data quality, appropriate consent, interoperability and scale of data transfers." [2]

  For physicians or practices, it is important to create records or document encounters consistently. Ensure that notes being captured using AI (such as with voice recognition software) are reviewed by a physician or staff member with medical training to ensure the information collected is accurate, clinically sound, and logical.

  Also, if using voice recognition software, ensure that the AI is capable of interpreting different dialects and accents. There have also been instances where this software had difficulty interpreting male vs. female voices. Background noise – including additional voices that could confuse the record – should also be filtered out.

  The use of EHRs already provides consistency to the format and content of your documentation. However, take care to keep text structured and to not write notes that do not fit in a field. "AI doesn't really understand human language, let alone the kind of shorthand that a doctor might use." [3]

- **"Prioritize ethical, equitable and inclusive medical AI while addressing explicit and implicit bias.** Underlying biases need to be scrutinized to understand their potential to worsen or address existing inequity and whether and how it should be deployed."

  Carefully review patient records to ensure they do not reflect any biases that could add to health care disparities based on gender, race, financial status, religion, age, nationality, sexual orientation, education, or language proficiency. These types of biases can lead AI systems to adopt the same biases and potentially make errors in diagnoses and treatments. It is important to make efforts to build cultural competency in your practice.

  A number of resources are found on the TMLT Resource Hub to help you and your staff build cultural competency at https://hub.tmlt.org/search?ufq=Cultural%20competency.

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CLOSED
CLAIM
STUDY

FAILURE TO DOCUMENT ANESTHESIA CARE IN AN OFFICE SETTING

by Wayne Wenske, Senior Marketing Strategist

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

A 63-year-old woman came to a pain management physician upon referral from her orthopedic surgeon. The patient was experiencing pain, swelling, weakness, tingling, and limited movement in her left shoulder, arm, and hand. Her history included surgical repair of a tendon rupture two months earlier. The patient's orthopedic surgeon referred her for evaluation of complex regional pain syndrome secondary to surgery.

PHYSICIAN ACTION

The pain management physician examined the patient and diagnosed her with type II complex regional pain syndrome of the upper left arm. He noted that the patient's left hand was mottled with dysesthesia and hyperalgesia. The pain management physician recommended a left stellate ganglion block to treat the patient's symptoms.

The pain management physician scheduled the procedure to take place in the office instead of a surgery center to reduce costs for the patient, who was a self-pay patient.

The patient returned to the office two days later for the procedure. The pain management physician obtained informed consent. The patient was given fentanyl 100 mcg (0.1 mg) and 2 mg of midazolam intravenously. The physician anesthetized the skin with 1 percent lidocaine and used a 20-gauge echogenic needle with ultrasound guidance to inject the C6 tubercle.

After negative aspiration of blood and cerebral spinal fluid (CSF), the steroid and bupivacaine solution was injected. After every 2 cc of injection, the needle was aspirated to ensure blood and CSF were not present. The pain management physician injected a total of 8 cc of the steroid and bupivacaine solution and documented that all of the patient's vascular structures were avoided during the procedure. The physician also documented that the patient tolerated the procedure.

Upon completion of the procedure at 8:55 a.m., the patient became apneic and unresponsive; no carotid pulse was detected. The pain management physician started CPR with a bag valve mask. The patient's heart rate was in the 60s with normal sinus rhythm and pulse oximetry in the 60s. The patient's pulse and heart sounds soon became undetectable.

The pain management physician administered 1 mg of epinephrine. Emergency services were called at 9:02 a.m.

EMS arrived at 9:16 am and attempted to resuscitate the patient. The pain management physician suggested to the paramedics that they clear the patient's airway and intubate her, but one paramedic stated that, because pulse oximetry readings were in the 60s and 70s, intubation was considered "elective."

According to EMS records, return of spontaneous circulation occurred at 9:20 a.m. A laryngeal mask airway was placed on the patient as a temporary means to maintain an open airway, but the pain management physician noted that the capnography was poor. The patient was taken to a nearby hospital by ambulance.

The patient was admitted to the emergency department. She was described as unresponsive, "severely acidotic," and unable to maintain oxygen saturations or blood pressure. She was intubated and pressor support was started. A chest X-ray showed "patchy opacity within the mid-left lung" which may have suggested "atelectasis or infiltrate."

Emergency Medicine Physician A noted that the patient may have received a high cervical spine block.

Two days later, a brain MRI revealed global hypoxic anoxic injury. The patient died the next day.

The autopsy report suggested that the patient experienced an obstruction of the airway and that the brain was edematous. The report concluded that the death was an accident caused by respiratory collapse from the stellate ganglion block procedure.

ALLEGATIONS

A lawsuit was filed against the pain management physician. The allegations were:

- failure to have the correct number of qualified anesthesia personnel present during the procedure;
- failure to comply with standards published by the American Society of Anesthesiologists (ASA);

- failure to maintain and provide oxygen supplementation; and
- failure to comply with requirements established by the Texas Medical Board (TMB) for office-based anesthesia.

LEGAL IMPLICATIONS

The plaintiff's anesthesiology consultant stated that the pain management physician failed to follow several ASA guidelines and TMB standards for office-based anesthesia. Specifically, that the physician failed to have the correct number of qualified anesthesia personnel present before, during, and after the procedure to:

- administer intravenous sedatives and anesthesia;
- conduct airway management;
- provide life-saving oxygen supplementation or use appropriate airway maintenance devices;
- monitor vital signs; and
- address any issues that may have occurred during the procedure.

An anesthesiology consultant who reviewed this case for the defense noted that the patient's BMI was within the "obese" range, which may present an increased chance of respiratory complications. This consultant criticized the pain management physician for not providing supplemental oxygen to the patient during the procedure and not monitoring the patient's respirations with a pulse oximeter.

This consultant also pointed out that another anesthesiologist was not required because this procedure involved "moderate sedation." ASA guidelines for "moderate sedation" are less stringent than those for "office-based anesthesia."

For office-based anesthesia, ASA guidelines recommend that qualified anesthesia personnel be continuously present to monitor the patient and provide anesthesia care. While guidelines for "moderate sedation" require continuous presence of an "individual other than the practitioner performing the procedure to monitor the patient's appropriate physiologic parameters and to assist in any supportive or resuscitation measures, if required, throughout the procedure. The individual responsible for monitoring the patient must be trained in the recognition of apnea and airway obstruction and be authorized to seek additional help."[1]

The defense consultant disagreed with the plaintiff's expert, and stated his belief that the patient's respiratory collapse was likely caused by inadvertent injection of long-acting local anesthetic (bupivacaine) into the patient's vertebral artery.

All consultants who reviewed this case were also critical of the documentation. Specifically, pointing to the absence of documented patient vital signs or a log of what was being done and when during and after the code. The operative report was described as insufficient due to a lack of ultrasound images to indicate correct placement of the needle and no record that the injection of local anesthetic and steroid was observed under real-time ultrasound.

DISPOSITION

This case was settled on behalf of the pain management physician.

RISK MANAGEMENT CONSIDERATIONS

One factor that made this case difficult to defend was the lack of adequate (often absent) documentation. Accurate and thorough documentation is a necessary component of safe, high-quality patient care and helps establish a physician's credibility. Good documentation is important to help successfully defend medical liability cases.

According to the ASA, anesthesia care is made up of three general phases: preanesthesia, intraoperative/intraprocedural anesthesia, and postanesthesia care. The ASA instructs providers to ensure that "accurate and thorough documentation is accomplished for all three phases of anesthesia-related care."[2]

It is important for offices and practices to develop and strictly adhere to documentation policies and procedures that include all required anesthesia or sedation information to fulfill state and national guidelines.

These policies and procedures should include protocols for transferring a patient in the event of an emergency or complication during an office-based procedure to a qualified acute care facility or surgery

center. The ASA's "Statement on Documentation of Anesthesia Care" provides thorough documentation guidelines and is found on their website: https://www.asahq.org/standards-and-practice-parameters/statement-on-documentation-of-anesthesia-care. [2]

Some states have their own laws or regulations regarding office-based sedation or anesthesia care. Office-based anesthesia may be defined differently state-to-state. The Texas Medical Board (TMB) assigns multiple "levels" of anesthesia within their Office-Based Anesthesia rules. Each level of care is defined, and requirements for personnel, training, and emergency equipment and supplies, are outlined in detail. Levels II-IV require physicians to register with the TMB as providers of office-based anesthesia.

"Level III" services include "delivery of analgesics or anxiolytics other than by mouth, including intravenously, intramuscularly, or rectally." [3] Prior to offering office-based services, physicians should familiarize themselves with any regulatory requirements in their state regarding provision of sedation or anesthesia in an office setting.

In this case, the pain management physician elected to perform the procedure in an office setting to reduce costs for the patient. When choosing whether to perform a procedure in a surgery center or in an office setting, it is important that the physician first consider the patient's overall health before opting for an office-based procedure. This includes carefully evaluating the patient's history; making a focused examination of the patient; and considering all consultations with other providers and specialists. All pre-procedure evaluations should be fully documented and include the physician's reasoning for deciding upon an office-based procedure.[3]

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CLOSED
CLAIM
STUDY

FAILURE TO DIAGNOSE FECAL IMPACTION

by Laura Hale Brockway, ELS, Vice President, Marketing

This closed claim study is based on an actual malpractice claim from Texas Medical Liability Trust. This case illustrates how action or inaction on the part of the physicians led to allegations of professional liability, and how risk management techniques may have either prevented the outcome or increased the physician's defensibility. This study has been modified to protect the privacy of the physicians and the patient.

PRESENTATION

On February 26, a 67-year-old man was admitted to the hospital by ambulance for shortness of breath. He had wheezing and respiratory distress with a heart rate of 120 bpm and blood pressure of 217/138 mm Hg.

The patient had a history of COPD, hepatitis C, hypertension, and IV drug abuse with methadone treatment. The patient had been hospitalized several times for advanced COPD, including a prolonged stay with mechanical ventilation and tracheostomy for Pseudomonas pneumonia. Three weeks before his latest admission, he had been hospitalized with acute exacerbation of COPD.

PHYSICIAN ACTION

Hospitalist A treated the patient with bronchodilators and steroids. His condition improved, but he was later transferred to the ICU for BiPAP. The patient was intubated on March 1.

Though a CT scan showed no evidence of pulmonary embolism, Hospitalist A was concerned that the patient had aspirated and developed pneumonia. The patient was treated with antibiotics and kept sedated with fentanyl and propofol while he was ventilated.

On March 7, Hospitalist B noted that an ultrasound of the right arm demonstrated subacute/chronic right subclavian and basilic vein occlusive thrombus. The ultrasound technician noted track marks on the patient's arm due to IV drug use. The results of a d-dimer test were normal.

According to the medical record, the results of abdominal exams conducted during this period were normal, though the patient had not had a bowel movement in six days.

Hospitalist B examined the patient on March 8. He described the patient's abdomen as distended with hypoactive bowel sounds, yet also noted the abdomen was soft and non-tender. An advanced practice provider (APP) working with Hospitalist B ordered docusate.

At 3 p.m. that day, a nurse notified the APP of the patient's positive sepsis screen. The APP ordered blood cultures and prescribed piperacillin/tazobactam and vancomycin. Hospitalist B noted at 6:46 p.m. that the patient's abdomen was soft and nontender, and that the patient most likely had fecal impaction/ileus. Hospitalist B ordered an enema. The patient developed lactic acidosis, worsening hypotension, and an elevated white blood cell count. He was given normal saline and vasopressors throughout the night.

Hospitalist C — who was on call for Hospitalist B — was asked to see the patient at 2:50 a.m. The patient had a severely distended abdomen and Hospitalist C suspected a perforated bowel. The patient's tube feedings were stopped, and a nasogastric tube suctioned one liter of stomach contents. The patient's condition declined, and he went into cardiac arrest. CPR was started, but his family asked for it to be terminated. The patient died.

Hospitalist C noted in the patient's medical record that the cause of death was "septic shock due to bacteremia likely from perforated bowel." There was no autopsy performed. The cause of death was listed as cardiac arrest due to severe sepsis with septic shock.

ALLEGATIONS

A lawsuit was filed against the hospital and Hospitalists A and B, alleging that the patient developed constipation and ileus that went untreated for six days. This led to the bowel perforation that caused the patient's death.

LEGAL IMPLICATIONS

The plaintiff's critical care expert claimed that Hospitalists A and B failed to meet the standard of care because they did not monitor the patient's bowel activity, perform abdominal exams, or timely obtain imaging when it was discovered that the patient had not had bowel movements. According to this expert, the patient's history of opiate use put him at risk for severe constipation, fecal impaction, and bowel perforation, which should have led to greater vigilance from the defendants.

Critical care experts who reviewed this case for the defense questioned whether the patient's death could be attributed to the fecal impaction. One critical care specialist suspected the patient's death was more

likely caused by respiratory failure and septic shock due to end-stage COPD and viral hepatitis-associated cirrhosis.

Another critical care specialist noted that the patient had been treated for constipation as an outpatient secondary to IV drug abuse and methadone treatment. Fecal impactions in that setting and in the ICU are common. Yet colonic perforations from impactions are rare and can only be diagnosed by specific findings during surgery or at autopsy. "From the evidence available in the hospital chart, the idea that this patient had colonic perforation was an ill-considered speculation by [Hospitalist C] with no objective findings to support it."

Despite these causation arguments, the defense was compromised because there was no evidence in the medical record that the patient's absence of bowel movements had been addressed. The nurses documented normal bowel sounds and no issues with bowel movements. Nursing notes on February 27, March 1, 3, 5, and 6 indicated "stool normal." Only one bowel movement was recorded on February 27. On March 7, a nursing entry noted "passing flatus." One expert stated that the physicians may have been misled by these multiple "stool normal" entries.

Additionally, Hospitalist B stated that when she sees a patient, she always asks the nurses if the patient had a bowel movement. However, none of these discussions were documented in the medical record for this patient.

DISPOSITION

This case was settled on behalf of Hospitalists A and B. The hospital also settled their case.

RISK MANAGEMENT CONSIDERATIONS

In this case, communication among those caring for the patient was less than ideal. Important information about the patient's lack of bowel movements was not accurately relayed to Hospitalist A or B. A disconnect also occurred because there were standing orders in the patient's medical record for stool softening and for help with bowel movements, but the nurses did not act upon these orders.

Documentation was also an important factor in this case. Conversations between the nurses and Hospitalist B about the patient's bowel movements were not documented in the record. The defense was concerned that the failure to document these discussions could be interpreted as Hospitalist B failing to check on the patient's bowel movements.

Physicians are encouraged to document their conversations with other caregivers, as this can help maintain clear communication between providers and consistent care for the patient. This is especially true if conversations relate to a review of systems, standing orders, or new symptoms.

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