MEDICAL RECORDS

The medical record is the primary means of communication among healthcare providers about a patient's medical history and course of care and treatment. It is also a legal document that becomes important as evidence if there is a malpractice claim. Current, complete medical records which assist diagnosis and treatment, and which communicate pertinent information to other caregivers, provide excellent records for risk management purposes.

Documentation Guidelines

Avoid Insufficient Documentation

Most often, missing or inadequately recorded information is related to facts surrounding an adverse outcome. Cases such as these include omitting or under-documenting:

- clinical rationale for what treatment was rendered and what was not
- phone conversations that became pertinent to an adverse outcome
- discharge and follow-up advice
- informed consent discussions
- identification of caregivers
- dates and times care was rendered

To help make your medical records valuable in defending a claim, they should contain detailed and accurate entries that fully describe the patient's diagnosis, the treatment plan, care rendered, advice given, and all other matters that you believe are pertinent to the patient's medical course. Missing, incomplete, or illegible documentation can seriously impede patient care and the defense of a malpractice claim, **even when care was appropriate!**

Routine visit notes may include your diagnostic rationale, informed consent or shared decision-making discussions, and discharge or post-visit instructions. This and all medical record information should be up-to date, clear and readable. The medical record is a resource for you, your staff, and others who care for the patient. Make sure that the information in the chart is the information you would want to have if you were assuming care of this patient, and that it explains both your discussions with the patient and your decision-making process when making diagnoses and treatment decisions.

If there are multiple caregivers responsible for this patient, the medical record should be clear regarding which practitioner has responsibility for which care. For example, a primary care physician's chart on a female patient should clearly indicate who her gynecologist is. The primary can receive copies of the patient's routine mammography and pap tests, which are filed on the chart. In this way his role as primary is fulfilled since he continues to monitor that she is receiving appropriate care whether he gives the care or it is the responsibility of another.

An example of documenting diagnostic rationale would be charting the reason for not following the written recommendation of a consultant. Without being lengthy, your note should indicate alternatives considered, your medical judgment and the clinical basis for your decision.

When dealing with conflicting data, such as disagreements over a clinical conclusion, read the other provider's notes, re-read your prior notes and review any other special study reports even if you have already read the films or seen the test data. Overlooked diagnostic reports, critical

notes, and consultations which point to a different available diagnostic or treatment path, and are not commented upon by the attending physician, may give rise to malpractice claims. Should it be necessary for you to document a different diagnosis or recommended treatment, factually state your opinion and your supporting rationale.

A note in the chart regarding informed consent or shared decision discussions is very important. A signed consent form does not take the place of this note. If your patient refuses a treatment or plan of care, this should be documented too, along with your note describing your conversation with the patient in which you explained the risks, benefits, and alternatives to the course the patient has chosen. More information on informed consent can be found in the Legal/Regulatory section of this toolkit. Information on shared decision-making can be found in the Communication section.

Describe patient behavior, including non-compliant behavior. Be objective: "patient did not return for follow-up appointment," rather than "patient is non-compliant."

Discharge or post-visit instructions should include the time and action-specific directives such as: "If your temperature doesn't return to normal by Wednesday, call me." Follow-up plans should be included, particularly if a more serious or life threatening diagnosis is being ruled out.

Clinically pertinent telephone calls should be documented in the patient's chart and include notations of prescriptions called in or instructions given regarding when to seek further medical care. It can be difficult to collect those stray bits of paper that phone notes have been scribbled on in restaurants or in the middle of the night. All that information needs to be transcribed into the chart. Physicians and practices have been known to give up on what seems to be a time-wasting paperwork task. Yet this documentation can be vital to good patient care.

Princeton has developed phone note pads which are small enough to fit in pocket or purse. Written notes tear off the pad and then peel completely away from their backing to stick firmly into a chart. Using a method of recordkeeping like this may make phone notes a little more likely to show up in the patient's chart on a regular basis. More information on these note pads and how to obtain them can be found in 2 Risk Review Online articles.

All records should have clearly documented medication records which include medication allergies or any prior adverse reactions to medications or contrast media. More information on medication safety can be found in that section of this toolkit.

Understand Documentation Mechanics

Mechanical errors such as inaccurate statements in factual information, errors in transcription or written orders, delayed or post-dated recordings, illegibility, incorrect methods used for corrections or adding an addendum may cast doubts about what was actually done for the patient, as well as when. Delays in documentation can be problematic for the defense of a claim when a note, written after an adverse event, seems to be defensive or self-serving. Also, notes which are incorrect, sloppy and haphazard can give the impression that you are an uncaring or incompetent provider. Therefore, when documenting in the medical record, consider the following:

- Use permanent ink, not soft felt pens or lead pencils.
- Write legibly; print if your handwriting is indecipherable. The use of encounter forms, checklists, flow-sheets, and computer-assisted documentation for high volume activities,

can save time and may also reduce communication problems and errors caused by illegible handwriting.

- Date, time and sign all entries including your professional designation. Use precise time whenever possible. Precision contributes to an impression of thoroughness. Each entry should be in order, e.g. consecutive days.
- Use only abbreviations approved by your facility.
- Do not leave blank spaces between entries.
- Late entries and addendums should be identified as such. Document the date of the note being referenced.
- Do not erase, use whiteout or obliterate a notation. Incorrect entries should be corrected by drawing a single straight line through the mistake, then write "error" or "mistaken entry" above or next to it. Include your initials and the date of the correction.
- Do not alter existing documentation or withhold elements of a medical record once a malpractice claim emerges, since the plaintiff's attorney or other third party usually already has a copy of the records. Changes are immediately obvious and even minor record alterations can greatly harm your credibility. Should you be named in a claim and the medical record is problematic, immediately point this out to your defense attorney.

Prevent Inappropriate Documentation

Only clinically pertinent information should be entered in the patient record. Consider the following:

- Incident reports are not part of the patient record; therefore, remarks about risk management issues, such as "incident report filed" should be avoided.
- Should an "adverse event" occur, only document the facts surrounding the actual event and the subsequent care rendered as a result of the event. Avoid self-serving or accusatory comments.
- Avoid subjective statements regarding prior treatment or poor outcomes presented as facts. When indicating the patient's or family's impression of their condition, use quotation marks, e.g. "cerebral palsy due to a birth injury."
- Avoid oral or written criticisms of health care previously provided by other practitioners. Since all pertinent facts about prior care are rarely available, caution is advised in making judgments and comments until all complete information is considered. Should you disagree with a past or current caregiver, a factual summary of clinical events and honest answering of patient inquiries is advised.
- Derogatory remarks about patients do not belong in the record. Since patients have legal access to their records, such remarks will only increase anger.
- Arguments and conflict with other providers should never be included in the record. Finger pointing or self-serving remarks, especially after an adverse event, will only make the defense of a case much more complicated.

More general information regarding medical records and documentation can be found in a number of articles and documents that Princeton has published:

- information on missing records
- general documentation and medical record information
- documentation tips are found in Princeton's Reducing Risk documents

Record Handling

Along with its system of documentation, a practice should have other systems to manage their records; that includes standard medical records, X-Ray films, practice logs, and other practice documentation. Some of these systems involve the structure of the chart itself, record storage, and systems for record retention. Record release will be discussed in a separate section below.

The practice should assign an administrator or custodian of records to implement and monitor these systems.

Chart Auditing

It is recommended that your practice develop and use a system for periodic auditing of medical record documentation to assure quality patient care. Chart auditing is discussed in a Risk Review Online article. It is further recommended that you maintain a signature log in order to identify individuals who have made entries in the patients' charts should the need arise.

Chart Structure

Whether using paper records or electronic, the contents of a medical record should be organized in a manner that brings key information to the attention of staff and physicians easily. Electronic record software is generally designed to do this, but it is important to make sure that the practice likes the way the electronic charts are organized and flow before investing in that software. When designing the set-up of your paper records, the choice of type of folder and dividers becomes important. Focal documents like medication flow sheets should be located in a prominent area. Many practices choose to put them on the inside of the front cover of the file. Some file folders come with dividers, some dividers are purchased separately. Many dividers have clips on them to hold the documents in place.

As noted, there are many ways to set up a file, but a few key rules generally apply:

- all documents should be held firmly in place in the chart, there should be no loose papers
- in each section of the chart the most recent document (lab result, consult, etc.) is typically filed on top of all other documents in that section
- allergies (including notations of no known allergies) are posted in a prominent location
- all charts in the office should be set up in the same way

New Patients with Old Charts

Continuity of care is served by the medical record in another way. When a physician takes over the care of a patient from another physician, the medical record can be an excellent source of information. Time constraints often lead a physician to a cursory review, if any, of the chart which comes with the patient. This is especially true when a physician is taking over an entire practice from another physician. In these circumstances, it is important to use the chart as a resource along with the patient as historian. The patient alone may forget key information which could lead to medical error. More information on this subject may be found at a Risk Review Online article.

Record Destruction

Medical record destruction needs to be handled carefully to protect patient confidentiality. All destroyed records need to be shredded or burned. If a vendor is used to accomplish this record destruction, then that vendor must abide by HIPAA confidentiality rules. Contracts with the vendor should be reviewed by the practice's attorney.

Though the record itself is destroyed, the practice should maintain a log of basic information on each patient which gives the following information:

- name
- date of birth
- social security number
- dates of first and last visit
- general problems and procedures performed in the office
- documentation of what was destroyed, how it was destroyed, and the date of destruction

Unplanned Record Destruction

Accidents or unexpected disasters can result in extensive water damage to important documents such as medical records and X-ray films. Storm damage, broken water pipes or an overflowing floor drain can result in unexpected destruction of stored medical records in a basement or storage room. Water damage can also be the often-unanticipated side effect of fire fighting efforts.

Damaged records require a quick response on the part of the practice. Insurance claims need to be filed. Other carriers need to be notified, and the records themselves have to be restored, destroyed, and/or reconstructed. You will need to keep a record of your efforts too.

Probably the most important thing a practice can do regarding this type of record damage is to take steps to prevent it. More details on the response to destroyed records and prevention of the same can be found in a Risk Review article on the subject.

Retention of Records

Storing records, especially paper charts, has given rise to another issue for physician practices. Many are running out of storage space and need to define policies for culling out the old records.

The New Jersey Board of Medical Examiners (BME) requires retention of medical records for seven years from the last professional contact or date of record entry, for adult patients. The Board does not specifically address different rules for pediatric charts, but Princeton recommends these charts be maintained the greater of seven years from the last entry or the date of the twenty-fourth birthday.

We also recommend that records of mentally incompetent patients and immunization records be kept indefinitely.

If a practice is involved with federal or state Health and Human Services programs, the concerned charts cannot be culled until approved by HHS or until it reaches the limit stated above, whichever is greater. If the practice is involved in a research program the program or the

FDA may set guidelines for culling of the charts; again, the charts cannot be culled before the recommendation given above.

Furthermore, a practice may need to keep a chart longer if that retention is requested by another physician of that patient, by someone acting legally on the patient's behalf and requesting in writing, or by the practice's legal counsel, risk manager, or insurance company. Finally, when working with managed care organizations it is important to be aware of any rules they may have regarding record retention.

Storage of Old Records

All practices should make arrangements for safe, dry storage of non-active charts and other documents of the practice. Areas of a building which are subject to leaks, overflowing drains, or general dampness can do serious damage to paper records and X-Rays. Fire safety also needs to be considered in the choice of storage locations. Prevention of damage from natural disaster and building leaks is addressed in the section on Unplanned Record Destruction.

When considering storage of electronic records, care should be taken to make sure that the records are securely backed up off site. An onsite back up can also be done, but it should not replace a very secure off site back up. This type of storage may be offered by your EHR vendor.

Release of Records

The New Jersey State Board of Medical Examiners' regulations obligate a physician to provide a copy of a patient's records, including reports and letters from other providers, to the patient or the patient's authorized representative within 30 days from the date that a request is received. This is required even if the physician suspects that he or she will be the target of a lawsuit by the patient.

No subpoena is required for you to produce medical records specified in a HIPAA compliant authorization that is signed by the patient or the patient's authorized representative. The regulations do permit you to charge a fee for the reproduction of the treatment record, not to exceed $1 per page with a $10 minimum charge and a $100 maximum. Also, you may not refuse to provide the record because a patient has an outstanding balance with your office, if the record is needed by another health professional for the purpose of providing care.

A valid and signed authorization that satisfies the HIPAA Privacy Rule requirements for disclosure of medical information contains the following elements:

- a description of the information to be used or disclosed, e.g. "entire medical record" or "complete patient file"
- the person authorized to make disclosure, e.g., name of a specific physician or a category such as "any physician or medical facility that has provided services on my behalf"
- the person to whom the disclosure is to be made
- an expiration date or event such as "one year from date the authorization is signed" or "upon the minor reaching the age of majority"
- the purpose for which the information may be used or disclosed
- date
- the right of the patient to revoke the authorization

Use caution when the requested medical records include protected information such as HIV/AIDS, alcohol or drug abuse treatment records or psychotherapy notes. When a signed authorization is not specific regarding such information, check with the patient before providing it; if the patient agrees, be sure that the authorization specifies the information in question.

Retain the original letter and authorization requesting the medical records and document the date that you fulfilled the request and the information that was released.

An attorney's request for records may indeed indicate that you are the subject of a potential lawsuit. Knowing this, it is essential that you do not make any revisions or additions to the record for any reason. It is also advisable to secure the original record in a separate location to preserve its integrity and ensure that no part of it is misplaced.

The Board of Medical Examiners regulations **require** that a transcription of the record be provided at no charge if requested because of illegibility. Also, if a lawsuit follows, you will have the opportunity during the discovery phase to explain what is written in the treatment record. Do not rewrite the record, even if legibility is an issue.

A request for patient records may be a first step in the litigation process and, depending on the specifics of the situation, may be followed by formal notice of a lawsuit. Notify Princeton Insurance promptly whenever you suspect that you will become involved in a malpractice suit so that the company may begin representing your interests properly. A Risk Review Online article discusses general record release issues.

Questions have also been raised when records are requested on deceased patients. Releasing records to family, to the coroner, or to an estate executor all are unique situations. Releasing the records of deceased patients is discussed in a Risk Review Online article.

Subpoenas for Medical Records

Physicians often receive subpoenas directing them to produce medical records and to testify regarding patient care they provided. A subpoena *ad testificandum* requires the subpoenaed person to give testimony. A subpoena *duces tecum* requires the subpoenaed individual to produce specified evidence such as medical records or x-rays at the same time he or she is to testify.

A Note of Caution: Despite the official language and appearance of a subpoena, do not assume that a subpoena is valid and must be honored without question. Some attorneys disregard the court rules and attempt to improperly use a subpoena duces tecum to obtain medical records without paying for them. A "discovery" or "records subpoena" improperly directs a physician to produce a copy of a patient's records and send them to the attorney's office in lieu of attendance at a deposition. This practice is not sanctioned by the courts. If you are served with such a subpoena, contact the attorney who served it and request that he or she either provide a signed authorization from the patient, along with payment of the fee permitted by the BME regulations, or that the records are produced at a deposition.

Releasing a patient's medical records in response to an improper subpoena that is not accompanied by a signed authorization from the patient may place a physician in legal and professional jeopardy for failure to protect the confidentiality of the patient's medical records.

A valid subpoena in a civil action in the Superior Court of New Jersey (state court) must meet the following requirements:

- be served in-person by an individual at least 18-years-old
- name (on its face sheet) the court and title of the action, including the names of the parties and the court docket number and type of action (civil, criminal, or administrative)
- be signed by either the clerk of the court or by an attorney for one of the parties in the action, or by a party to the action, and list the address and telephone number of the person who issued the subpoena
- be accompanied by payment of a witness fee and mileage
- direct properly when and where the witness is to appear:
    - trial – anywhere in New Jersey
    - deposition – the county in which the witness lives, works, or does business – at least ten days notice is required for a deposition
    - state agency – anywhere in New Jersey consistent with the agency's power

To protect both yourself and your patient, if you are served with a subpoena or court order regarding a patient, consider the following:

- designate an individual in your office who is responsible for handling attorney and other legal requests for patient records
- if you have any questions or concerns about a request for patient records, consult Princeton Insurance or an attorney familiar with healthcare law
- keep records of all authorized disclosures of patient-protected health information for a minimum of six years
- be aware of specific kinds of patient information that are subject to federal and state laws restricting or prohibiting disclosure such as HIV/AIDS, drug and alcohol treatment, and mental health records

Court Orders

A court order, unlike a subpoena, is issued by a judge who reviews the request and may conduct a hearing on the matter. A court order directing a healthcare practitioner to produce medical records must be followed. However, it is still advisable that you seek expert advice from an attorney familiar with healthcare law or from Princeton Insurance if you are served with a court order for patient records.

Release of Original X-Rays

X-rays are an integral part of a patient's medical record and often form the basis upon which accurate diagnoses and treatment are rendered.

Measures to secure and maintain x-rays should be given the same priority as the security and retention of medical records, not only from the standpoint of good patient care, but also for the adequate defense of a malpractice claim and possible allegations of records tampering.

Many physicians release original x-rays due to the financial and/or logistical difficulty of providing copies.

From a risk management standpoint, the safest practice is to provide copies of all x-rays and retain original films.

However, it is sometimes necessary and/or mandatory for original x-rays to be released. When that is the case, the following suggestions should be considered in establishing an effective tracking system:

- Both the film itself and the jacket in which it is stored should be labeled with the patient's name or some other identifier. The patient's name should be compared with the name on the film jacket prior to filing the x-rays.
- When original films are released, a patient authorization form releasing the films should be obtained. The form should describe the exact films being released and should include a time frame for return of the films.
- A record of original x-rays released should be maintained. It should include the patient's name, the date the films were released, the destination of the films, and the date the films are to be returned. A periodic review of this record should be performed to identify any x-rays that have not been returned in the specified time. Aggressive follow-up should be undertaken to retrieve all unreturned films.
- In the situation where the films are not returned and cannot be located, documentation should reflect efforts undertaken to retrieve the x-rays.

Electronic Health Records (EHR)

Electronic Health Records (EHR, often referred to as Electronic Medical Records or EMR), are slowly taking the place of paper records in healthcare facilities and physician practices. Electronic recordkeeping is meant to reduce problems inherent in paper record systems, to increase the speed at which medical information flows, and to more effectively link the many sources of medical information on each patient.

Electronic records and systems are not without their own problems and challenges. Princeton has a series of resources available on EHR. Princeton has written a guide to electronic records which is described in more detail in the following section.

Electronic Medical Records: Patient Safety & Risk Management Guide

The Princeton Insurance Electronic Medical Records Patient Safety & Risk Management Guide was created to provide information concerning the proper use of electronic medical records to improve the quality and safety of patient care while decreasing potential liability risk. Once successfully implemented, EMRs create efficiencies in time and productivity which can lead to more quality time with patients, time to see more patients and/or less hectic schedules. However, maximizing efficiencies could result in various shortcuts that may degrade the patient safety benefits. So used, EMRs could actually create and propagate both old and new errors, and the efficiencies could create a roadmap for a plaintiff's attorney to attempt to justify a legal action.

The guide cautions against those uses (including nonuse, modified, or improper use) of EMRs that may increase liability risk. It is not all-inclusive; rather it focuses on those areas most likely to involve liability or make litigation more difficult to defend. Included in the guide are sample screen shots/printouts from a variety of EMR vendors, numerous examples that demonstrate how EMRs can be used properly, and significant discussion of how these features may be improperly used to increase liability risk. Each section includes recommendations on how to avoid or mitigate potential liability risks associated with the use of EMRs, while using their key features to improve the quality, safety, and efficiency of healthcare delivery.

The guide is not intended to endorse any particular EMR system, nor to serve as a comprehensive "how to" implementation manual. Implementation and EMR features are

discussed only to the extent that they affect patient safety and/or risk management. It does not discuss or compare the various pros and cons, including costs (both to implement and to maintain), of any particular EMR systems (or EMRs in general).

This guide should be used to supplement your current use of EMRs or for consideration of the extent to which you will implement certain EMR features. In this context, it should not be regarded as a standalone document for the implementation of EMRs.

