COPIC
Better Medicine • Better Lives

COPIC Tip

# DOCUMENTATION OF PATIENT COMMUNICATION

**Proper documentation continues to be an area of focus in risk management as it is vital for communication between medical providers and staff and serves an important role from a patient communication perspective. Comprehensive and concise documentation in the medical record of telephone and electronic communication (e.g., voicemail, email, telehealth, texting, portal) with patients provides for safe continuity of patient care, reflects clinical decision-making, and supports why certain actions were taken.**

**Failure to properly document patient communications can adversely affect care and lead to potential liability exposure for physicians. In a medical liability trial, poor documentation can cause jurors to question the physician's actions. This can include failure to document key instructions, noncompliance, significant signs/symptoms as well as raise concerns when there is altering of past records.**

**The following are several considerations/guidelines that highlight important areas in documentation:**

## THOROUGHLY DOCUMENT PATIENT COMMUNICATION IN THE MEDICAL RECORD

All communication with patients should be documented when one of the following occurs:

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

Documentation of communication should include the following:

- Patient's name
- Names of people accompanying the patient during a visit or calling regarding a patient's care, and their relationship to the patient
- Date and time
- Date of birth
- Reason for the visit/call, including a description of the complaint or symptoms
- Medical advice or information provided
- An assessment of allergies and other adverse drug reactions if a medication is prescribed

## PATIENT DETAILS THAT SHOULD BE INCLUDED IN THE MEDICAL RECORD

- An up-to-date list of allergies and adverse drug reactions.
- A current, standardized problem list or similar summary device to help avoid overlooking important information about a patient's medical issues.
- A current list of medications the patient is taking.
- Accurate, documented vital signs, particularly in acute illnesses.

## ENSURE DOCUMENTATION IS ACCURATE AND READABLE

Providers should authenticate that what is written in a progress note is accurate, noncontradictory, and meaningful for that patient's visit, prior to sign off. This includes:

- Clear identification of the patient and authorship in all documentation.
- A thoughtful review and analysis of the patient's progress; include differential impressions as well as a narrative of the next steps in the plan of care.
- Clearly mark and date amendments and record corrections.

## BEST PRACTICES FOR DOCUMENTATION

- Confirm that items generated from lists, checkboxes, etc. are what was intended
- Be familiar with the content of any templates you use
- Double check results of drop-downs, templates, auto-complete, etc.
- Be judicious when using "copy" and/or "paste" and carefully edit and remove irrelevant or unintended content
- Have a way to incorporate relevant email and text messages into the EHR
- Record facts in an objective manner; avoid needless commentary
- Minimize use of abbreviations and have an approved list of abbreviations
- Recheck decimal points
- Document discharge instructions