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COPIC Tip

DOCUMENTATION CORNER:
The Dos and Don'ts of Charting

Practice Quality Reviews are a great opportunity to gauge how your practice mitigates risk. COPIC stays apprised of trending claim data and looks out for red flags during chart reviews. Take a look at these real-life charting examples, and consider whether these are opportunities for improvement in your own practice environment:

"Lamicatla 25mg/day for 2 weeks."

Lamictal is misspelled; always review notes for correct spelling.

"The patient's identity and current location was confirmed. I discussed the use of video conferencing; including alternative methods for meeting, the limits of confidentiality, emergency procedures and resources. The patient consents to proceed with this virtual visit."

A statement of the telemedicine modality used, and a statement of consent for a telemedicine visit needs to be documented during such an encounter.

"Has continued the metop."

"Metop" is not a standard abbreviation. COPIC recommends using only approved abbreviations.

CLINICAL DOCUMENTATION

Effective clinical documentation entails completeness, accuracy, and readability. Components of the patient record include patient identification, authorship identification, amendments, and corrections. Legibility is important for handwritten information. Providers are ultimately responsible for all of the information/communications documented inthe patient's chart.

General Best Practices

1. Provider-generated content (including alterations) is reviewed prior to finalization. Content created by scribes and assistants is similarly reviewed.
2. Documentation utilities such as templates, drop-down lists, check boxes, auto-completion, "cloning," and copy/ paste are used judiciously. The risk of inaccurate records generated by these functions is appreciated.
3. Providers who use templates or pre-completed forms are familiar with their content and individualize them when used.
4. Procedure time-out is completed and documented prior to the start of the case. Documentation includes patient ID, type of procedure, verification of site/side/level, congruency with the consent, medication and allergy review, and equipment available.
5. The date is evident for all encounters.
6. The identity of the patient is evident for all records.
7. Telehealth visits are identified as such. Documentation includes how the patient was identified, patient location, and patient consent. Techniques used for physical examination and remote monitoring are described. The presence and identity of scribes or other assistants on either side of the encounter is noted.
8. In making changes to paper charts, entries are marked with a line through the information to be changed (without obscuring it), the new information is annotated (e.g., "correction") with the date and identity of the person making the edit. If a substantial revision is needed, an entry near the original information indicates where the amended information can be found. All documentation is legible and readable to others.
9. Records are corrected or amended when necessary; significant alterations are prominently noted and signed; the material that was corrected remains legible.

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