Dos and Don’ts of Electronic Medical Record Documentation

Cynthia M.A. Geppert, M.D., Ph.D., M.P.H.
Integrated Ethics Program Officer and Chief Ethics Consultant
NMVACS
Purposes of Documentation

1. To record the contents of a patient-clinician encounter.
2. To communicate health information to other professionals.
3. To meet performance improvement, billing and other third party requirements.
4. As a legal document.
Ethical Values Involved in Documentation

- Professionalism
- Accountability
- Trustworthiness
- Honesty
- Truth-telling
- Integrity
- Fidelity
Do Be Professional

- Do treat other providers with respect in notes even when you do not agree with them.

- “Dr. W is absolutely wrong in thinking this patient is a substance abuser and she must not have reviewed the chart as he is clearly depressed.”
Don’t be Unprofessional

• Even if a patient makes a negative comment about a colleague, be cautious about repeating this in the note unless critical to care.

• Don’t: Mr. F states “Dr. G was abusive to me and never returned my calls.”

• Do: “Mr. F has come to me because he wanted to try a different approach.”
Unprofessionalism with Patients

• Be truthful in communicating diagnoses and clinical facts but not derogatory. Avoid making value judgments about patients.

• Do: “Ms. B has a characterological style that can be somewhat difficult.”

• Don’t: “Ms. B is a raging borderline who is manipulating the system.”
Accountability: View Alerts

- Do: Use view-alerts to communicate to your colleagues information about a shared patient or situation that you have also discussed by other means.
- Don’t: Use view-alerts without discussing with the provider alerted.
- In random or excessive fashion as way of diffusing responsibility.
Accuracy

- Do: Add an addendum to a progress note to record changed or additional clinical information relevant to that particular clinical encounter.
- Don’t: record information days after a clinical encounter without indicating the time difference.
Late Notes

• “This note of 12/8/07 documents a clinic visit with Mr. L that occurred on 12/5/07 in which we discussed his combat experiences in Iraq. Since that time he has called me to report an increase in nightmares and anxiety which I documented in a telephone note of 12/6/07.”
Trustworthiness: copying and pasting from your own notes

- **DO:** Use cutting and pasting from your notes to quickly enter complex data that is consistent over time and requires few changes.

- **Don’t:** Copy information from note to note not relevant to the particular visit.

- **Don’t** copy in a careless, redundant, or misleading manner.
Summary of Medical Notes
Trustworthiness: Copying & Pasting from Other Provider’s Notes

- Do: Indicate in the EMR when you cut and pasted information from other provider’s notes and the name, date and context of the copied information.

- “See below summary of neuropsychological testing done by Dr. S on 10/26/07 and documented in his full consultation of that date.”
Copying and Pasting

- Don’t: Copy and paste information from older notes that may no longer be accurate as you mislead the reader.

- “Mrs. S is has been overtaking her Oxycodone and also using marijuana.”
Honesty

• Copying information you did not actually perform or assessments you did not really make can be considered not only misrepresentation but is dishonest and in some cases can be considered plagiarism or even fraud.
Integrity

- Omit needless text; a short note is far more readable.
- The note should clearly communicate the important information so it can be easily located and reviewed.
- The note should not be a collection of facts but a record of the clinician’s thinking process.
Integrity: Assessment

• One of the biggest factors in forensic cases is spending too much time on the subjective/objective section and not enough on assessment.

• Clearly indicate your not only WHAT you were thinking but HOW you were thinking.
Assessment Do’s and Don’ts

• Don’t: “Mr. M was no longer suicidal once he sobered up so I discharged him from the emergency room.”

• Do: “Mr. M is chronically suicidal especially when he is intoxicated. Hospitalization has been counter-therapeutic. He has an appointment tomorrow with SUD.”
Fidelity in Treatment Planning

• Don’t indicate anything in the treatment plan your not able to actually implement. If the plan changes, make sure to document how and why.

• Do make a clear, specific plan for treatment that corresponds directly to your assessment and how you intend to carry it out.
Example

- Don’t: “Mr. L will stop drinking, find housing, and take his medications regularly and I will see him back when he has made progress.”

- Do: “I contacted SUD and have made an appointment for Mr. L for 12/12/07. I spoke to social worker who is meeting with patient today about per-diem program.

- RN K will work with patient weekly on medication adherence.”
Final Pearls

1. Use the active voice in note writing so it is obvious what happened.
2. Make sure the subject and object of sentences are clear.

• +“Then I told the patient not the - patient was told by me.”
• +“Dr. G told the patient not to take more medication. Not Then he was told by her not to take more of that.”
More Pearls

• Use quotes rather than descriptions.
• This is your educated opinion not a scientific report.

• The patient reported it was not a suicide attempt and he is future oriented. Versus
• “I would never try to kill myself, I am going on vacation next week.”
Checklist for Notes

1. Is the note professional and appropriate?
2. Have I accurately documented the clinical encounter?
3. Does it clearly communicate to other providers?
4. Does the note have potential regulatory or legal problems?
Resources

• Ballas, C. How to Write a Suicide Note: Practical Tips for Documenting the Evaluation of a Suicidal Patient. *Psychiatric Times*

• National Ethics Teleconference on *Copying, Pasting, and Duplicating in the Electronic Medical Record: An Ethical Analysis*. February 24, 2004