
Putting the Cart Before the Horse?

By Zynthia T. Howse, JD

In life, and certainly in documentation, there is a right and wrong way to do things. Order is everything.

It is a well-known fact that a complete, accurate medical record will foster quality of care. Most importantly, it is the footprint that guides the course of the patient's medical care and provides needed information to subsequent healthcare providers who facilitate continuity of care. One of the 'Golden Rules' of documentation is that the medical record be prepared as contemporaneously with treatment as possible to avoid confusion and to ensure accuracy. The goal of this rule is to prevent a delay in documentation of what has been done. The defense of malpractice lawsuits has taught us that juries often assume that undocumented events never happened. It is also important that actions or treatment are not documented before they actually occur.

The Case

A female infant was seen by her pediatrician for a routine, initial well-baby visit, which included immunizations. The exam was unremarkable, and the child's chart was marked indicating that all immunizations had been administered. Later, during a follow-up office visit, the child was seen by the same clinic and noted to have received all necessary vaccines. The parents were instructed to return in four weeks.

Subsequently, the baby was seen by the same clinic a third time but treated by a different healthcare provider. It was noted that PCV-13 had not been administered previously. The child had an elevated temperature and an elevated white blood cell (WBC) count. The child was sent to the hospital for lab work and was subsequently diagnosed with pneumococcal meningitis/septic shock. As a result, the child was admitted to ICU. She had seizure activity and required intubation. After a month-long admission, the child was diagnosed with a seizure disorder and significant developmental delay.

The parents filed a medical malpractice lawsuit against the pediatric clinic and its physicians alleging 'negligence for failing to immunize the child' and 'failing to accurately chart the fact that immunizations were not given.' Our insured physicians believed that their care and treatment of the patient was appropriate and within the standard of care. Expert reviewers agreed. However, all involved in the defense of the case agreed that the documentation found in the medical records was sloppy. An investigation of the events led to the realization that a medical assistant had documented the various immunizations that were ordered to be administered. However, the medical assistant later realized that the clinic was out of the PCV-13 immunization at the time. It was not given, but he failed to

update the medical record.

This was a very sympathetic case given the unfortunate and life-altering effects to this baby. This claim was not defensible. As fate would have it, the baby contracted the very disease that the PCV-13 vaccine was designed to prevent. If only the medical record had been documented correctly, one could assume the outcome would have been different and possibly the child would be healthy.

This case reinforces the “Golden Rule” that one should never document a medical record until the medical care has been administered. The lesson is short and simple: documentation should reflect the action(s) taken. Accuracy and order are vital! Premature documentation is just as dangerous as untimely or late documentation, and both can prove detrimental, or in a worst-case scenario, deadly.

“For nothing matters except life and, of course, order.” ? Virginia Woolf, *The Common Reader*

Cybersecurity Coverage: Can You Afford to Be Without It?

By

Cybersecurity continues to rise towards the top of the list of concerns for businesses and medical practices. Consequently, cybersecurity insurance protection is also becoming more and more important. Along with the basic cybersecurity insurance limits (\$50,000) provided by SVMIC at no additional premium, higher limits are readily available through a partnership with NAS Insurance Services. But, with all the financial and regulatory demands on medical practices' resources, many have concluded that they cannot afford more adequate coverage. However, there is growing concern that the potential for loss is probably greater than most realize and the premium for higher limits is more affordable than most may think.

We recently interviewed a couple of practice administrators who have purchased higher limits from NAS to get their feedback. One was a group of six primary care physicians in middle Tennessee. The practice administrator realized that the potential risk of a cyber-attack or information technology (IT) system failure and the ensuing costs to recover data, possible lawsuits and regulatory fines and penalties could add up to more than the basic limits provided by SVMIC.

The group had experienced minor losses prior to their purchase of higher limits – some involving errors by their own staff, and one protected health information (PHI) violation was caused by an outside vendor. The claim generated by their outside vendor took their employees' time away from their regular job duties. These experiences convinced the administrator how vulnerable the group was to potential loss.

When asked how he justified the expense of the premium to his physicians, the administrator credited the physicians with being "smart and logical professionals who understood the cost-benefit trade-off." With the estimated cost of a cybersecurity loss at a minimum of \$30 per record, and possibly more due to the potential for regulatory fines and penalties, it was relatively easy to see that the potential for loss is great, and by contrast, the premium is relatively affordable.

The administrator said that in addition to purchasing the higher limits through NAS, staff training on PHI and HIPAA security is mandatory. Further, the group has an extensive IT security system in place, both internally and externally, that meets or exceeds all Federal Meaningful Use (MU) standards regarding PHI and IT security. You can find those regulations at the Centers for Medicare and Medicaid Services (CMS) [website](#).

A group of six rheumatologists in east Tennessee also recently purchased excess limits with NAS Insurance through SVMIC. The practice administrator said that seeing the recent news of more frequent cybersecurity attacks, and realizing how vulnerable medical practices are to such attacks, she was prompted to purchase the higher limits.

During a training session for all the practice staff, the doctors were made aware of the potential costs that the practice could incur should there be a cybersecurity breach. They realized that the potential for loss far outweighs the cost of the premium to protect their practice.

This practice also requires ongoing training and sends out reminders to staff to follow up on their training and to stay aware of the potential for a cybersecurity breach. The administrator acknowledges that “cybersecurity expert” is yet another hat that practice administrators are expected to wear. With technology and regulation changing frequently, it is a daunting task, especially if one’s background is not in information technology. However, it is a responsibility that cannot be ignored or taken lightly.

You will also find helpful articles and tips on the SVMIC website on our [cybersecurity resources page](#). In addition, SVMIC’s Medical Practice Services offers consulting and training related to cybersecurity and HIPAA. As mentioned earlier, SVMIC has partnered with NAS to offer discounted premiums on increased limits for cybersecurity insurance. NAS has implemented a resource to offer support and risk management to policyholders. The site offers a 24-hour support hotline, monthly newsworthy updates, webinars and online training and support. This resource can be found [here](#). The cost for additional coverage is based upon the limits chosen, group size and other factors. For more information, please contact SVMIC at ContactSVMIC@svmic.com or call us at 800.342.2239.

Quality Reporting Under MIPS

By Elizabeth Woodcock, MBA, FACMPE, CPC

At first glance, the Merit-based Incentive Payment System (MIPS) may look somewhat like the Physician Quality Reporting System (PQRS), which closed its door on December 31, 2016, but appearances can be deceiving.

MIPS features 271 quality measures, of which physicians and other eligible clinicians must report six, at least one of which must be an outcome measure. Although the MIPS measures are similar to PQRS, it is vital to understand three distinct characteristics of the new program in order to successfully participate:

1. Pay heed to assigned reporting methods. While there are multiple ways to report quality measures under the MIPS program, each measure is “assigned” a reporting method. Therefore, you cannot choose six measures and assume that you can report them all via your electronic health record (EHR). You must review the method attached to each measure, and ensure that you can report it as required.
2. Recognize that select reporting methods apply to *all* patients who, according to the program, “meet a measure’s denominator criteria.” The reporting methods of EHR and registry (including Quality Clinical Data Registry) require you to report all patients, not just those covered by Medicare. It is important to note that registry-based reporting under MIPS involves reporting at least 50 percent of all patients who are eligible for the measure; it is no longer adequate to submit just 20 records, as was the standard for PQRS’ registry reporting.
3. Scoring under the new MIPS program is based on your performance relative to government-defined benchmarks. It is not sufficient merely to *report* a measure; the percentage you submit will be scored based on your *performance*. Furthermore, the benchmarks are dependent on your reporting mechanism; you may receive different points on the basis of your methodology, even for the same score.

To illustrate, consider a quality measure that is often chosen for reporting – Preventive Care and Screening. This measure is defined as: “Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter. Normal Parameters: Age 18 years and older BMI => 18.5 and < 25 kg/m2.”

For MIPS, the measure can be reported by any mechanism: claims, EHR or registry. Your score will be formulated based on your performance according to pre-defined benchmarks. The percentage you report will be sorted by decile, as highlighted in the table presented

below. The decile produces the score, for example, decile 4 equals 4 to 4.9 points; decile 5 equals 5 to 5.9 points; and so on. Decile 3 is the minimum decile for the MIPS program, with 3 points awarded just for submitting your performance.

Submission Method	Decile 3	Decile 4	Decile 5	Decile 6	Decile 7	Decile 8
Claims	41.33 - 45.76	45.77 - 51.46	51.47 - 66.43	66.44 - 90.09	90.10 - 98.60	98.61 - 100.00
EHR	28.73 - 31.80	31.81 - 34.45	34.46 - 37.23	37.24 - 40.19	40.20 - 43.64	43.65 - 50.00
Registry/ QCDR	39.80 - 45.63	45.64 - 50.91	50.92 - 56.68	56.69 - 64.88	64.89 - 75.81	75.82 - 100.00

Source: CMS' 2017 Quality Benchmarks

Assume your percentage was 96.83%. That's good, isn't it? It depends. You would receive approximately 7 points if you submitted that score via claims (requires Medicare patients only), 10 points for EHR-based reporting, or 9 points if the score came in via a registry. (EHR and registry-based reporting require all patients who meet the measure's criteria.)

This example is only one of a handful of quality measures eligible to be reported via all mechanisms. Other popular ones – like “Closing the Referral Loop: Receipt of Specialist Report” – can be reported by only a single methodology; in the case of “Closing the Referral Loop,” this metric is available only through EHR reporting.

Bottom Line: Do not assume that MIPS is just an extension of the Physician Quality Reporting System (PQRS). These three important distinctions — reporting methods, application to all patients and scoring based on relative benchmarks — require careful attention to ensure successful reporting.

As a reminder, you can “pick your pace” in 2017 under MIPS. If you just want to avoid the penalty, the government requires submission of only one measure. This includes one quality measure (regardless of performance), improvement activity, or the base advancing care information (ACI) requirements. For more information about this 2017 exception, please see the [April SVMIC Sentinel Article](#).

Related Links:

[MIPS Quality Measures](#)

[MIPS Quality Benchmarks](#): Download the zip file “2017 Quality Benchmarks”

OSHA in a Medical Practice

By C. Anne Pontius, MBA, FACMPE, CHC, MT (ASCP)

The Occupational Safety and Health Administration (OSHA) is part of the United States Department of Labor. The mission of OSHA is to assure safe and healthful working conditions for working men and women by setting and enforcing regulatory standards. In addition, OSHA is responsible for providing training, outreach, education and assistance to employers and employees.

State Operated OSHA Programs

Tennessee and Kentucky operate their own OSHA programs that have been approved by Federal OSHA. As with most state-run programs, these two states have adopted most of the Federal OSHA rules but in a few cases, relevant to medical practices, they have made amendments and/or additional rules. Rules enacted by states must be at least as stringent as the Federal rules at ensuring the employer provides a safe work environment.

OSHA Regulations Applicable to Medical Practices

The majority of medical practices have compliance risks associated with several of the following OSHA regulations. Please see our list of links and resources [here](#).

The employer has a responsibility to perform a hazard assessment within the medical practice and implement measures to eliminate or minimize the likelihood of an occupational incident. The range of occupational hazards, and the applicability of the OSHA regulations in each medical practice, varies depending on type of services, facility and staff competency. Individuals that perform hazard assessments must have an eye for detail and an understanding of likely sources within the practice that can potentially harm employees.

General Duty Clause

The OSHA General Duty Clause (GDC) is a 'catch-all' safety rule. Whereas there are several specific OSHA regulations that apply to medical practices, in the absence of a specific safety rule, the General Duty Clause prevails. The GDC states:

- Each employer shall furnish to each of his employees employment and a place of employment, which are free from recognized hazards that are causing or are likely to cause death or serious physical harm to his employees.
- Each employer shall comply with occupational safety and health standards promulgated under this act.^[1]

- Each employee shall comply with occupational safety and health standards and all rules, regulations, and orders issued pursuant to this Act, which are applicable to his own actions and conduct.[\[2\]](#)

Even though the GDC is not in the top-ten list of most cited violations for medical practices, it is an important OSHA regulation for employers and managers to understand. The GDC is the basis for the implication of all other OSHA rules and applies to all employers regardless of number of employees or type of industry.

Practices can be cited under the GDC for not meeting guidelines and recommendations from the Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health and Homeland Security. Areas of concern include workplace violence, ergonomics and tuberculosis. If the practice's hazard assessment recognizes these as potential hazards, then it should implement appropriate measures to eliminate or minimize the hazardous risks.

The top-two most cited OSHA regulations in medical practices are from the Bloodborne Pathogens and Hazard Communication Standards. Both of these regulations have training requirements that are often misunderstood or overlooked, making them easy targets for disgruntled employees to claim non-compliance when filing a complaint with OSHA. Once OSHA inspectors are onsite, they can write citations for more than targeted compliant.

Bloodborne Pathogens Standard

The Bloodborne Pathogens Standard (BBP) is applicable to all employers that have employees with job tasks where it is conceivable the employee will be exposed to bloodborne pathogens and other potentially infectious materials (OPIM). Set forth in the regulation, the employer must have a written Exposure Control Plan (ECP), to be updated annually that includes:

- a copy of the BBP regulation;
- identification of employees at risk of exposure (known as an exposure determination) and what puts them at risk;
- the use of universal precautions;
- identification and use of engineering controls;
- work practice controls (procedures that reduce risk of exposure);
- requirements for personal protective equipment (PPE) and how to use PPE;
- hepatitis B vaccination protocols for pre and post-exposure control;
- post-exposure protocol;
- housekeeping and laundry methods;
- signs and labels requirements;
- waste disposal methods;
- employee training requirements;
- recordkeeping requirements, and
- requirement to annually review and update of the ECP.

Each area has specific requirements that are detailed in the regulation. The practice's Safety Coordinator, or person in charge of OSHA compliance, should have a complete understanding of each area and what is required for the practice to be in compliance.

In an effort to reduce the number of occupational incidents due to blood or OPIM contaminated sharps (devices that can penetrate the skin including, but not limited to, needles, scalpels, lancets, broken glass, and broken capillary tubes), the BBP was updated to include requiring employees to use engineered safety devices (i.e., safety needles and scalpels) unless there was evidence that by doing so an employee or patient was put at risk or a safety device was not available. Each practice must perform an annual evaluation to ensure effective safety devices are appropriately being utilized by employees.

Hazard Communication Standard

The Hazard Communication Standard (HCS), the second most cited OSHA regulation in medical practices, is also referred to as the "Right-to-Know" standard or HazCom. In 2012, OSHA updated the HCS to comply with the United Nations Globally Harmonized System (GHS).^[3] Under the GHS, Material Safety Data Sheets (MSDS) were replaced with Safety Data Sheets (SDS) and new chemical labels are now used as the mechanisms to inform individuals about the hazards associated with chemicals.

To ensure chemical safety in the workplace, employers must make available to employees information about the identities and hazards of certain chemicals.^[4] Employers have to train employees to understand chemical labels, how to handle chemicals, and make safety data sheets accessible. Employees that are at risk of exposure to hazardous chemicals should have been trained on the new GHS SDS format and new pictogram labels prior to December 1, 2013. All MSDSs were to be converted to the new SDSs by June 1, 2016.

Not all chemicals in a medical practice are hazardous, but for those chemicals that identified as hazardous, the employer must create a list of such chemicals and update it as new chemicals enter the practice. For each chemical on the list, the employer must maintain a SDS and train employees on the chemicals' hazards before the employee is potentially exposed to the chemical. Chemicals are considered hazardous if they have an identified health or other risk on the label.

Medical Practice OSHA Inspections

The most likely reason an OSHA inspector would visit a medical practice is because of an employee complaint. The most common individuals to file complaints are current and former employees, competitors and patients. OSHA is required to follow up on all complaints. If the complaint is substantiated, then OSHA will conduct an off-site investigation and / or an onsite inspection.

Usually complaint investigations are limited to only the complaint, but the OSHA inspectors have the right to cite other recognized violations. For instance, the inspector may have had a private conversation with an employee and based on that conversation decide it is in the best interest of all employees to expand the inspection. This can lead to costly citations.

OSHA Violations and Penalties

The OSHA violations range from "de minimis" to "willful neglect." As of August 1, 2016, penalty increases almost doubled to a maximum penalty for serious violations to \$12,471, and for willful or repeated violations, it increased to \$124,709.

Each citation received by the practice must be addressed in the required format with a corrective action and date of compliance. If the required format is not used, the response can be rejected and thus eat up valuable response time, as a rejection does not automatically afford the practice additional days to respond. Failure to properly respond and / or meet the deadlines to citations may result in additional fines.

Cost of OSHA Non-compliance

When it comes to non-compliance with OSHA regulations, there are more than just the costs associated with fines. An occupational incident can cost many thousands of dollars and loss of productivity. The CDC estimates a sharps incident (an event when a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral comes in contact with blood or other potentially infectious materials that results from the performance of a worker's duties^[5]) can cost \$1,500 to \$3,000 per injury.^[6]

In addition to tangible costs, individuals who experienced an exposure incident can sustain intangible costs in the form of psychological trauma. This can occur even when an employee does not develop a disease as a result of the exposure. There is a 'limbo' period between the exposure and the time the employee finds out he/she is infected from

the exposure. It is even more costly for those who know the source blood was infected with HIV or hepatitis. Identified areas of trauma include: post-traumatic stress disorder, depression and nausea. All this comes from the waiting period, follow-up testing and post-exposure prophylaxis treatments.[7]

Implementation of an effective OSHA compliance program can go a long way to avoid costly citations, but more importantly, it can save employees' lives. All practices should train employees to immediately report all injuries, illnesses and near misses due to work related tasks.

To stay current on OSHA, [sign up for the free newsletter](#), *OSHA QuickTakes*. For information relating to SVMIC's OSHA services, email us at ContactSVMIC@svmic.com or call 800.342.2239.

[1] "Sec. 5. Duties." OSHA 29 U.S.C. §654, 5(a).
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=3359&p_table=oshact.
Accessed June 20, 2014.

[2] "Sec. 5. Duties." OSHA 29 U.S.C. §654, 5(b).
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_id=3359&p_table=oshact.
Accessed June 20, 2014.

[3] American Academy of Provider Offices and Laboratories. OSHA injury & illness prevention program for outpatient healthcare. Knoxville, Tennessee: 2014. Chapter 4, page 1.

[4] "Hazard Communication Standard." OSHA. <https://www.osha.gov/dsg/hazcom/>.
Accessed June 27, 2014.

[5] "OSHA Fact Sheet Bloodborne Pathogen Exposure Incidents." OSHA. 2011.
https://www.osha.gov/OshDoc/data_BloodborneFacts/bbfact04.pdf. Accessed June 24, 2014.

[6] Lundstrom, T. "Sharps Injury Prevention: Milestones and Opportunities." Seminar Handout, 2004, page 19.

[7] "Needlestick Injury Claims." JS Miller Solicitors.
<http://www.jsmillersolicitors.co.uk/claims/all-other-claims-accidents/needlestick-injury-claims/>. Accessed June 28, 2014.

QPP Clinician Participation Letter

By Elizabeth Woodcock, MBA, FACMPE, CPC

The federal government granted an exclusion for many physicians to its Quality Payment Program (QPP), which features the Merit-based Incentive Payment System. Physicians – and other QPP-eligible clinicians - are omitted on the basis of billing less than \$30,000 in Medicare Part B allowed charges per year OR providing care for less than 100 Part-B enrolled Medicare patients. According to estimates by the Centers for Medicare and Medicaid Services (CMS), this represents 35% of all eligible clinicians.

Some physicians may see so few Medicare patients, they may know they don't have to be concerned with this new program. However, others may wonder whether they meet the exclusion. CMS recently announced that the agency will be mailing letters regarding the exclusion. Due in "late April through May," the letters will be issued to your practice via your Medicare Administrative Contractor for Part B claims. CMS pledges that these notifications will be "providing the participation status of each MIPS clinician associated with your Taxpayer Identification Number (TIN)."

Risk Pearls: May 2017

By Julie Loomis, RN, JD

Do you have a procedure for handling a missed appointment during which follow-up care or treatment was to be provided? To avoid patient harm and a claim of missed or delayed diagnosis, it is important that practices have a procedure to ensure that no-shows and cancellations are communicated to the treating provider and any actions taken are documented in the medical record. Generally, the efforts required to contact the patient are commensurate with the patient's medical condition and potential consequences of missed treatment. If a patient is at minimal risk (e.g. a well checkup), no action may be required or a single phone call or letter may be sufficient. For patients at moderate risk, such as those who need ongoing monitoring or treatment, a more concerted effort should be taken to contact the patient. Usually two documented phone calls and a certified letter should be adequate. All communications should inform the patient in layman's terms about the consequences of failure to receive needed treatment in a timely manner. As with all patient communication, staff should document the date, time of the call, and place a copy of the missed appointment letter in the patient's medical record. If a patient fails to return to the office repeatedly, after appropriate contact attempts have been made, the treating provider may take steps to discharge the patient from the medical practice. Please visit svmic.com for resources or consult an SVMIC Claims attorney for assistance with individual situations.

An Analysis of Pulmonology Closed Claims

By Shelly Weatherly, JD

A review of closed paid pulmonology claims over a seven-year period revealed the primary allegation asserted was failure to diagnose and treat. Most typically, such diagnostic errors were not the result of lack of knowledge or diagnostic ability on the part of the physician, but rather, as the graph below illustrates, were a product of communication breakdowns, poor documentation, and medication errors.



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COMMUNICATION ISSUES: Clear and complete communication between providers and nurses is necessary to provide optimal patient care. Electing to treat a hospitalized patient over the phone was a recurrent criticism faced by physicians when a complication occurred. In nearly every case, the physician came under heavy scrutiny for failing to personally evaluate the patient, or for failing to obtain sufficient information to enable proper treatment over the phone.

A case that illustrates the failure to properly make clear the circumstances upon which communication should take place involved a 33-year-old patient who presented to the emergency room with shortness of breath, dysphagia and facial swelling. A CT revealed superior vena cava syndrome. She was admitted to the hospital by a pulmonologist and then underwent a successful percutaneous transluminal angioplasty, which was performed by an interventional radiologist. However, upon removal of the sheath, the patient's blood pressure dropped from 161/90 to 81/50, she began seizing and then became unresponsive. After being resuscitated, the pulmonologist ordered her transferred to the ICU where she remained hypotensive. He did not personally evaluate the patient, and did not clearly communicate with the nursing staff regarding the patient's situation. Through the night the patient deteriorated, no urine output was noted, and the patient became drowsy and confused. It was not until the patient had pulseless electrical activity, no verbal response and a BP in the 60's, that the nursing staff contacted the physician. The lawsuit alleged that the physician and nurses failed to appreciate the significance of the severely low blood pressure and seizures; and further that they failed to collaborate regarding the patient who was clearly unstable after her procedure.

DOCUMENTATION ISSUES: The importance of maintaining a well-documented medical record, from both a patient care and a risk management standpoint, cannot be overstated.

As the graph above illustrates, documentation issues were a factor in 27% of claims paid in Pulmonology. Most often, there was a failure to document completely the patient and/or family history, details of the physical exam, rationale for the diagnosis and treatment plan, patient education, and conversations with the patient and family regarding treatment recommendations.

MEDICATION ISSUES: Failure to monitor was the primary issue in cases involving allegations of medication error. Coumadin was the drug most commonly involved. One case involved a 51-year-old female who was admitted for treatment of a pulmonary embolus with a Heparin drip and Coumadin. Four days following admission, she was transferred to the ICU after a MRI revealed a retroperitoneal hematoma in the right lower quadrant of the pelvis. The pulmonologist who took over the care did not personally evaluate the patient, but instructed the nurses to continue the anticoagulants due to concerns about the pulmonary embolus. The patient died shortly thereafter from hypovolemic shock. The pulmonologist faced expert criticism for keeping the patient on the Coumadin without making any effort to disprove active bleeding by doing a contrast CT or following with serial hematocrits. His failure to personally assess the patient, or to document his rationale for his treatment plan, further compounded the problem.

LESSONS LEARNED:

- Communicate relevant patient information in a timely and clear manner to all individuals on the health care team.
- When other providers are involved in the care of a patient, make sure there is a clear understanding as to everyone's role and responsibility.
- Clearly communicate with other providers those circumstances upon which you expect contact regarding a patient's situation/status.
- Recognize the limitations of assessing a patient over the phone.
- Engage in a full and clear discussion with patients about the nature of their medical condition, the recommended treatment plan and the risks, benefits, alternatives, and expected outcome. Be careful not to educate above a patient's comprehension level. Be sure to document the details of all discussions with patients and families in the hospital record.
- Document clearly, completely, and accurately, and include the following: a comprehensive medical and family history; the chief problem; all relevant positive and negative clinical findings; your diagnosis or medical impression; the decision-making process for the clearly defined treatment plan; and all relevant information given to the patient and family regarding such treatment plan.
- If your treatment plan deviates from any local community standard or nationally recognized guidelines for your specialty, document your rationale for doing so.
- Clearly document all telephone conversations regarding patient care, including the name, date and time of the call as well as the essence of the exchange.
- To help prevent medication errors: Obtain a medication history; review the history whenever new medications are ordered; discuss risks, side effects, benefits of, and alternatives to, prescribed medications; and closely monitor high risk medications.

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