RISK MANAGEMENT RECOMMENDATIONS:
Documentation for Advanced Practice Nurses

Good documentation can help you avoid litigation and aid in your defense should you be involved in a malpractice lawsuit. Since the medical record is the primary source for communication among all the members in the patient's care team, it must contain documentation that is complete, correct, and timely. The following risk management recommendations are presented as a useful resource for advanced practice nurses. The below information and communications should be documented:

- *Discussions with the patient and/or responsible party regarding diagnostic test results* (both normal and abnormal), as well as recommendations for continued treatment and patient response to results.
- *Informed consent or informed refusal of recommended treatment* and preceding discussions.
- *Patient telephone encounters,* including after-hours calls, with the name of the person contacted, advice provided and actions taken reflected in the written summary.
- *Dated and signed receipt of test results, procedures, referrals and consultations,* along with a description of subsequent actions taken.
- *Referrals for consultation or testing.*
- *Reviews and revisions of patient problem and medication lists* during every visit and with every change in diagnosis.
- *Prescription refills authorized via telephone*, including the name of the pharmacy and pharmacist, and read-back of the prescription.
- *Missed appointments*, including all efforts to follow up with the patient.
- *Educational materials* or references provided to the patient.
- *Use of an interpreter and related contact information*, recognizing that the use of family members, especially children, is discouraged.

Whatever medium is used to store the patient's healthcare information record, the same basic risk management principles apply: The record must be thorough and accurate, and the patient's privacy must be protected. Utilization of EHR technology makes effective security and confidentiality measures even more critical. The following measures can help reduce liability risks associated with EHR use:

- *Establish a policy regarding electronic copying, cutting and pasting.* To this end, consider limiting or deactivating the copy, cut and paste function of the electronic health record software. (For guidelines, see the American Health Information Management Association's statement on "Auditing Copy and Paste." http://library.ahima.org/doc?oid=87789#.WRChkpp1rct.)
- *Avoid copying and pasting when documenting high-risk items,* such as laboratory results, radiology reports and drug formulations.
- *Review and update information found elsewhere in the EHR before pasting it into current entries*, especially problem lists, diagnoses, allergies, current medications and history.
- *Expressly prohibit copying and pasting text from another clinician's note without proper attribution,* which may constitute medical plagiarism and lead to allegations of billing fraud.
- *Do not delete original source text or data* and insert it elsewhere in the record, thus altering the initial entry and compromising documentation integrity.
- *Discourage staff from "carrying forward" information (such as allergies, prior medical history or diagnostic results) that is readily available elsewhere in the EHR*, as this creates clutter and may adversely affect the record's reliability and usefulness.
- *Ensure that key patient identifiers are accurate*, in order to effectively link records within and across systems.
- *Determine what changes can be made in records,* as well as who can make them, when they can be made, and how they are tracked and monitored.
- *Remember that most pharmacies cannot process electronic discontinue/change orders*, although many EHR prescribing systems offer this capability to prescribers. Always check with the pharmacy to see if it has received discontinue/change orders, in order to prevent duplicate or extended therapy.

A complete, well documented health information record is the best legal defense, and below are several recommendations for you to practice thoroughly and consistently:

- *Ensure that patient health information records are in compliance with established standards of documentation.*
- *Retain patient health information records in accordance with relevant state and federal law.* In addition, consult the state-specific recommendations promulgated by nurse practitioner professional associations.
- *Perform periodic audits of patient health i nformation records* to identify departures from documentation standards and to determine opportunities for improvement.
- *Sequester the patient health information record if there is an incident of concern.* Patient health information released for legal reasons also should be sequestered or maintained with limited access to avoid real or alleged tampering or inappropriate late entries.
- *Designate an individual within the practice* who will manage legal demands such as a request for patient health information, a subpoena, or a summons or complaint.

There is no quick and effective protection against malpractice allegations. Prevention, however, is necessary. Thorough and thoughtful documentation provides evidence of proper communication, prevents misunderstanding, and may help guard against a lengthy litigation process. No matter what we say we do, it is virtually impossible to prove unless it is clearly and properly documented.

X-13051-0218