Nurse Practitioner Spotlight: Healthcare Documentation

Nurses Service Organization (NSO), in collaboration with CNA, has published our 5th Edition of the NSO/CNA *Nurse Practitioner Liability Exposure Claim Report*. It includes statistical data and case scenarios from CNA claim files, as well as risk management recommendations designed to help nurse practitioners (NPs) reduce their malpractice exposures and improve patient safety.

You may access the complete report, and additional Risk Control Spotlights, at: www.nso.com/NPclaimreport.

This Nurse Practitioner Spotlight focuses on the analysis and risk recommendations regarding one of the most significant topics in the report and for nursing professionals: **Healthcare Documentation**

Allegations Related to Healthcare Documentation

While documenting care and treatment represents a critical component of nursing processes and standards, the electronic health record [EHR] has posed a level of complexity for NPs who are often challenged with why, how, what, and where to document in a patient's EHR.

Many factors influence the time and attention that NPs can reasonably dedicate to documentation, but some of the most significant factors lie outside of most NPs' control. These factors include practice setting, provider to patient ratios, severity of patient illnesses, number of other practitioners available (including physicians, nurses, and aides), time of day, policies and procedures, and availability of technology and other resources. Organizations that employ NPs and other healthcare practitioners should consider implementing systemic interventions that can help support provider's documentation efforts, such as scribes, dictation software, pre-populated templates, or video technology. The American Medical Association (AMA) reports that research indicates having a medical scribe transcribe information during clinical visits in real-time frees providers from the documentation burden and improves efficiency, workflow and the patient-provider interaction. NPs should also work with their employers to identify barriers to improving their documentation practices, and potential interventions that can help minimize those barriers, such as redesigning workflows to reduce redundancies and the effects of click burden. When organizations recognize documentation as an essential job function for patient care, rather than an administrative task, they can help NPs avoid the types of documentation deficiencies that contribute to poor patient outcomes, regulatory issues, and professional liability claims.

Documentation deficiencies are contributing factors in many NP professional liability claims, as well as license protection matters. However, in the 5th Edition of the NSO/CNA Nurse Practitioner Liability Exposure Claim Report, lack of a complete patient and family history, incomplete physical assessment, failure to list current medications and/or complaints, failure to document patient nonadherence with appointments, ordered diagnostic tests and/or prescribed medications and absence of notification to the patient of diagnostic test results and recommendations for further treatment or testing reflecting allegations asserted in professional liability closed claims, increased in distribution and severity when compared to the 2011 closed claim report and the 2015 closed claim report.

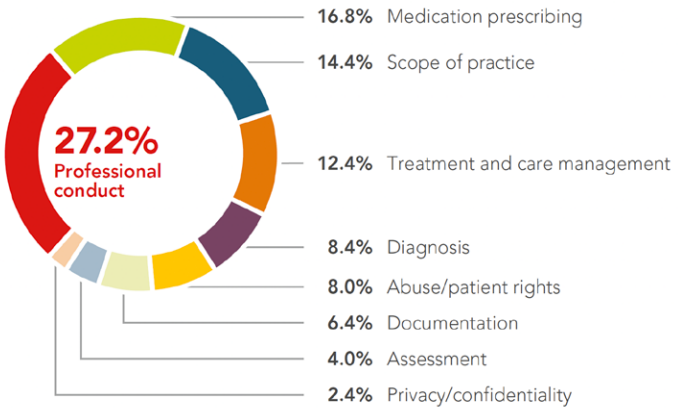
License Protection Allegations Related to Documentation Errors and Omissions

There are several differences between a license protection matter and a professional liability claim. First, a license protection matter only involves the cost of providing legal representation to defend the NP before a regulatory agency or State Board of Nursing (SBON). On the other hand, professional liability claims include an

indemnity or settlement payment. Second, license protection matters asserted against an NP's license to practice may or may not involve allegations related to patient treatment and care. The Nurse Practitioner Spotlight: Defending Your License provides an overview of the role of the SBON in the legal/regulatory system, describes the disciplinary process, and imparts helpful recommendations on defending yourself if you were to receive a complaint summons (NSO and CNA, 2022).

Figure 2 displays license protection matters that closed with defense expense payments. Documentation as a primary allegation comprises 6.4 percent of all license protection matters in the *Nurse Practitioner Professional Liability Exposure Claim Report: 5th Edition.* Over two thirds of the license protection matters related to documentation involve an allegation of **fraudulent or falsified patient care or billing records** (68.8 percent).

Figure 2: License Defense Matters by Primary Allegation Class



An NP's practice and conduct are expected to be safe, competent, ethical and in compliance with applicable laws and rules. However, when a complaint is filed, NPs must be equipped with the resources to adequately defend themselves. Being unprepared may represent the difference between an NP retaining or having limitations placed on your license. Such sanctions may include losing your license to practice, a suspension, as well as a civil monetary penalty. Below is an example of a complaint asserted against an NP with the SBON due to the failure to document.

Nurse Practitioner Legal Case Study: Documentation

The insured Psychiatric-Mental Health Nurse Practitioner (PMHNP) was employed with a behavioral health hospital, where he had been working for seven months. The patient had a history of opioid, benzodiazepine, and alcohol abuse, among other medical issues. The patient had reported "good" sleep, about six to eight hours per night, on a regimen that included 50 mg of trazodone and 4 mg of buprenorphine. The PMHNP reduced the patient's buprenorphine dose to 2 mg and raised the trazodone dose from 50 mg to 200 mg to address the patient's increased pain, anxiety, and detox symptoms resulting from the decreased dose of buprenorphine. However, the PMHNP failed to document his rationale for these changes to the patient's medications in the patient's healthcare information record. There were no adverse effects noted as a result of the medication change in the nursing notes over the next few days.

Several days later, another patient gave the patient prohibited food, which caused the patient to begin to choke. The patient was found unresponsive in acute respiratory distress. The patient was stabilized and discharged to another hospital, where she developed a MRSA infection and spent months hospitalized.

The patient filed a lawsuit against the hospital and several providers involved in her care, including the insured PMHNP, asserting that the combination of medications caused the respiratory failure. During the hospital's review of the patient's healthcare information record, their attorneys noted the PMHNP's breach of hospital policy regarding documentation of medication management and filed a complaint against the PMHNP with the State Board of Nursing (SBON).

The SBON determined that there was sufficient cause to take disciplinary action against the PMHNP due to his failure to document patient care/treatment in accordance with state laws, regulations, and hospital policies and procedures. The SBON ordered the PMHNP to complete six hours of continuing education on the state Nursing Practice Act, standards of practice, and documentation of care, in addition to at least six hours of continuing education on nursing documentation. This matter took over two years to resolve, and the defense expenses incurred in this matter totaled more than $20,900.

Healthcare Documentation: Minimizing Risks, Maximizing Benefits

NSO/CNA is often asked about documentation risks and recommendations to minimize those risks. NPs are certainly aware that there are patient healthcare documentation fundamentals. The healthcare information record is a legal document that is an essential tool to:

- Document the services provided regarding the patient's illness or injury, response to treatment, and caregiver decisions;
- Communicate documented information about the patient's plan of care and outcomes to the healthcare team;
- Communicate information to other healthcare providers;
- Support the appropriate information for billing coding; and
- Serve as the organization's business and legal record.

Because complete, accurate and legible healthcare records constitute an essential risk management measure, NPs should maintain proper documentation practices and follow facility policies and procedures governing appropriate and complete records documentation. The facility's healthcare record documentation policies and procedures should address, at a minimum:

- Correcting documentation errors;
- Delineating appropriate use of the copy and paste function in the electronic healthcare record;

- Documenting practices during electronic system failures or outages ("down-time");
- Maintaining patient confidentiality;
- Releasing patient healthcare information records and auditing practices;
- Procedures for late or delayed entries; and
- Any patient communication outside of the patient portal, for example, emails and text messages.

Risk Management Recommendations: Documentation

Maintaining a consistent, professional patient healthcare information record is integral to providing quality patient care, ensuring consistent communication among all professionals caring for the patient, documenting patient care outcomes and response, and establishing the basis for an effective defense in the event of litigation. The following guidelines can help reduce risk:

Documentation – Clinical Content

It may be advisable or useful for NPs to utilize a standard documentation template for each patient visit that would include the following elements. At a minimum, the following facts, events, and interactions also should be documented in the patient's healthcare information record:

- **A current summary of the patient's condition** including, but not limited to, presenting problems, clinical findings, assessment, treatment plan and the outcome of the prescribed treatment
- **Any and all verbal advice and instructions** provided to the patient and/or the friends and family, including patient responses.
- **Patient educational materials provided**, both spoken and written, copy of material should be included in the healthcare information record, as well as the patient's ability to comprehend the information provided. If not a digital resource, note the pamphlet/educational title(s), and as appropriate, the author(s) and year published.
- **Instructions for return visits** to the office for follow-up testing, treatment, or consultation.
- **Referrals** to other providers, tests, or therapies.
- **Missed or canceled appointments**, including efforts to contact the patient. The NP should ensure that there are procedures in their practice to support this function.
- **Receipt of test results and subsequent actions taken**, as well as receipt of results of referral procedures and consultations, which should be signed or initialed by the practitioner before filing.
- **Discussions with patients regarding abnormal test results**, including recommendations for treatment and the patient's response.

Nursing Scope and Standards of Practice

The American Nurses Association (ANA) is the professional organization that has the responsibility to set and maintain the scope of practice statements and standards that apply to all professional nurses, which includes advanced practice registered nurses *(ANA Nursing Scope and Standards of Practice 4th Edition, 2021)*. The ANA incorporates additional standards with competencies for advanced practice registered nurses, which includes the 'ds' of documentation

The *ANA Standards of Practice Competencies* include the following criteria for appropriate documentation:

- Documents relevant patient data accurately and in a manner accessible to the inter-professional team (*ANA Standards of Practice*, Standard 1. Assessment).
- Documents the patient's diagnosis, problems and issues in a manner that formulates a differential diagnosis based on the assessment, history, physical examination, and diagnostic test results (*ANA Standards of Practice*, Standard 2. Diagnosis).
- Documents expected patient outcomes that incorporates costs, clinical effectiveness, and are aligned with the outcomes identified by members of the inter-professional team (*ANA Standards of Practice*, Standard 3. Outcomes Identification).
- Documents the patient's assessment, diagnostic strategies, and therapeutic interventions that reflect current evidence-based knowledge and practice (*ANA Standards of Practice*, Standard 4. Planning).
- Documents implementation and any modifications, including changes to the patient's plan of care (*ANA Standards of Practice*, Standard 5. Implementation).
- Documents the coordination of care (*ANA Standards of Practice*, Standard 5A. Coordination of Care).
- Documents the teaching and health promotion strategies (*ANA Standards of Practice*, Standard 5B. Health Teach and Health Promotion).
- Documents the results gained from data collected from the patient and evaluation the progress with plan of care (*ANA Standards of Practice*, Standard 6. Evaluation).
- Documents communication with interprofessionals in response to situational needs of patients. (*ANA Standards of Practice*, Standard 12. Leadership).
- Documents in a manner that supports quality and performance improvement initiatives (*ANA Standards of Practice*, Standard 14. Quality of Practice).

- **Informed consent discussion(s) or informed refusal(s), including any applicable patient and NP acknowledged documents.**
- **Prescription refills**, including the name of the pharmacy.
- **Documentation of medications prescribed**, the medication reconciliation process, if applicable, and any medications administered, or distributed (e.g., sample medications), as well as the corresponding discussion of potential side effects and other instructions.
- **Notations of patient nonadherence** and/or failure to follow through on recommended return visits or outside referrals, as well as discussions with patient/family regarding nonadherence and its potential consequences.
- **Summarize communications with other practitioners**, including those via telephone, facsimile and e-mail, text messages and patient portal communication and note any subsequent orders and interventions.
- **Notation regarding the use of an interpreter**, including the interpreter's contact information, as well as the patient or family member's willingness to communicate with an interpreter.
- **Termination of the practitioner-patient relationship**, where applicable, including copies of all pertinent correspondence.

Documentation – General Recommendations

- **Establish a policy regarding electronic copying, cutting, and pasting.** 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 "Cloning, Copy/Paste Practice Problems.")
- **Avoid copying and pasting high-risk items without individualizing the entry**, 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** that is readily available elsewhere in the EHR (such as allergies, prior medical history, or diagnostic results), 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.

Documentation – Medications and Prescriptions

- **Review the current medication list with the patient and document** the patient's reported adherence. The review should include both prescribed and over-the-counter medications, including supplements and holistic/alternative remedies.
- **Review and document the patient's medication history as an essential component of the medical history.** This is critical following any hospital admission, changes in care or treatment, transfer from one service to another (e.g., after hospital or rehabilitation), or post-discharge return to care.
- **Clearly describe patient responses to medications**, expected and unexpected.
- **Ensure that adverse drug reactions along with their corresponding symptoms have been documented**
- In the case of any rare verbal orders, ensure that the clinical staff have documented the order appropriately.

For additional information regarding medications and prescriptions, refer to the Nurse Practitioner Spotlight: Prescribing.

Documentation – Diagnostic Tests, Referrals, Consultations

- **If an abnormal test result is received, document the actions taken to notify the patient, as well as the plan for** additional testing or follow-up, and document the interaction.
- **In cases of a non-response/delay or urgent/emergent consultation, ensure that the office staff have contacted the consulting physician(s) or practitioner(s)** to confirm that the consulting provider was notified of the consultation request and to facilitate the timely provision of the consultation and receipt of the results, as needed. Ensure that the staff have documented their follow up actions in the patient's healthcare information record.

For additional information regarding diagnosis, refer to the Nurse Practitioner Spotlight: Diagnosis.

Nurse Practitioner Spotlights

For risk control strategies related to:

- Defending Your License
- Diagnosis
- Depositions
- Patient Adherence
- Telemedicine
- Prescribing

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Documentation – Patient Education

- **Describe patient and family healthcare education encounters,** listing the presence of specific family members and their relationship to the patient.
- **Document an assessment of the patient's ability to comprehend and repeat information provided using a "teach-back" approach**, both immediately and after a few minutes have elapsed, in order to test accurate recall. Where the NP does not provide the direct patient education, confirm that the information provided was appropriate and is documented in the patient's healthcare information record.
- **Provide a written assessment of the patient's appropriate demonstration of procedures/taught tasks, such as blood glucose testing or application of dressings.**
- **Maintain a copy of written materials provided** and document references to standard educational tools.
- **Retain patient-signed receipts** for any educational materials provided. If a family member or friend receives the educational materials due to the patient's cognitive abilities, reflect a note in the healthcare information record to that effect. The family member's or friend's name should be documented as the person that received the materials.
- **Note use of an interpreter, including the interpreter's contact information, as well as the patient or family member's willingness to communicate through an interpreter.**

Documentation – Billing

The False Claims Act

While documentation deficiencies may result in a professional liability claim and/or a license protection matter, NPs also may be subject to federal and state sanctions for knowingly falsifying healthcare documentation under the federal False Claims Act (FCA). The FCA imposes liability on any person who submits a claim to the federal government that the person knows (or should have known) is false. An example may include a healthcare provider who submits a bill to Medicare for medical services they know they have not provided. The False Claims Act also imposes liability on an individual who may knowingly submit a false record in order to obtain payment from the government. For additional information on fraud and abuse laws, please see the Office of Inspector General's provider education materials on Fraud & Abuse Laws.

Documentation – General Billing Recommendations

Billing for healthcare services is a complex mix of rules, policies, laws, and exceptions. NPs are responsible for knowing and understanding these guidelines as they relate to Medicare and Incident Billing, no matter the patient, practice setting, and type of visit.

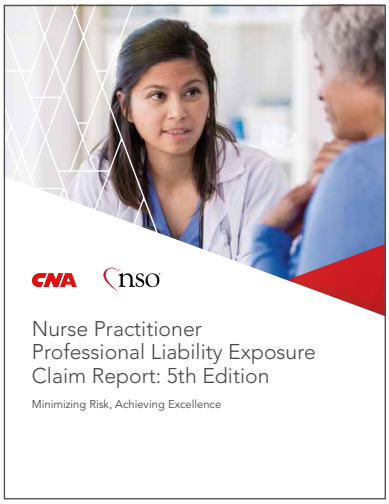
Pursuant to the Centers for Medicare and Medicaid Services (CMS), the following billing guidelines apply to NPs (CMS, 2022, p. 8):

- An NP may:
  - Use their individually assigned NPI to bill services directly.
  - Let an employer or contractor use the NPI to bill the reassigned services.
- Supervising physicians must use their individually assigned NPI to bill for professional services that the NP provides.
- NP must use their individually assigned NPI to bill for the professional services they provided.
- When billing as an assistant-at-surgery services, report only the 'Assistant At Surgery' (AS) modifier on the claim form.
- If providing services on an assignment-related basis, charging a patient more than the amounts is not permitted under 42 CFR 424.55.
  - If a patient paid for a service over these limits, a refund of the over payment must be made back to the patient.

References:

- American Medical Association. (2018, October). The overlooked benefits of medical scribes. Sustainability. Retrieved from https://www.ama-assn.org/practice-management/sustainability/overlooked-benefits-medical-scribes.
- American Nurses Association. (2021). Nursing scope and standards of practice (4th Ed.). Silver Spring, MD: ANA.
- CMS. (2022, March). MLN booklet for advanced practice registered nurses, anesthesiologist assistants, & physician assistants. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Medicare-Information-for-APRNs-AAs-PAs-Booklet-ICN-901623.pdf
- NSO and CNA (2022). Nurse practitioner professional liability exposure claim report (5th Ed.). Retrieved from www.nso.com/npclaimreport.
- U.S. Department of Health and Human Services, Office of Inspector General. A roadmap for new physicians: fraud and abuse laws. Retrieved from https://oig.hhs.gov/compliance/physician-education/01laws.asp.

This information is designed to help nurses evaluate risk control exposures associated with their current practice. It is not intended to represent a comprehensive listing of all actions needed to address the subject matter, but rather is a means of initiating internal discussion and self-examination. Your clinical procedures and risks may be different from those addressed herein, and you may wish to modify the tool to suit your individual practice and patient needs. The information contained herein is not intended to establish any standard of care, serve as professional advice or address the circumstances of any specific entity. These statements do not constitute a risk management directive from CNA. No organization or individual should act upon this information without appropriate professional advice, including advice of legal counsel, given after a thorough examination of the individual situation, encompassing a review of relevant facts, laws and regulations. CNA assumes no responsibility for the consequences of the use or nonuse of this information.



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