American Professional Agency, Inc.

DOCUMENTATION IN PSYCHIATRY

A psychiatrist in private practice treated a 24 year old patient with bipolar for three years. He prescribed a mood stabilizer and she was seen in clinic once a month for medication management. The psychiatrist documented lack of side effects with most visits. The psychiatrist last saw the patient in his office two days before she died, but there is no objective documentation reflecting lack of side effects.

The patient's family files a lawsuit and one of the main issues is that the psychiatrist did not appreciate the patient's presentation of toxicity during the last visit and that had he done so, she would have been referred for immediate medical treatment, and her death would have been prevented. The psychiatrist indicates that he remembers examining the patient and there were no visible side effects. However, the family contends that in the days leading up to her death, the decedent had visible tremors, slurred speech and some incoordination. This case is difficult to defend because there was no documentation to support the psychiatrist's account of his assessment of the decedent during the last visit. Consider how this case would change had the psychiatrist documented his objective observations that the patient denied side effects and that there were no visible side effects seen upon examination. As you can see, documentation can be a critical component in the defense of a lawsuit.

Documentation of a medical record, whether done on paper or electronically, serves to promote patient safety, minimize error, improve the quality of patient care, as well as ensure regulatory and reimbursement compliance.[1] Medical records must be maintained in a way that adheres to applicable regulations, accreditation standards, professional practice standards, and legal standards.[2] Not documenting is unethical, and can lead to license revocation and potentially an inability to defend against a medical malpractice suit.

DOCUMENTATION PRINCIPLES:

It is important to keep in mind who will read the medical record. In the event you are ever involved in a lawsuit, the medical record may likely be used as evidence of care provided (or not provided). The audience can be both the patient and the jury. The medical record is a legal document. It may be:

- The only evidence available years later
- Used to reconstruct the care provided
- Considered to be an accurate reflection of care provided to the patient
- Scrutinized by both plaintiff and defense attorneys
- Should paint a factual picture of past events
- Professional credibility

The medical record should contain the following types of information:

- Thorough medical history
- Relevant information regarding diagnosis and treatment
- Assessment of suicide/violence
- Medications prescribed along with dosages, side effects and monitoring performed
- Informed consent
- Treatment compliance/non-compliance (describe objectively)
- Boundary issues
- Termination
- Relevant information to support billing practices
- Formal consultations

What may not be documented in psychiatry:[3]

- Detailed account of sexuality
- Interpersonal conflicts
- Issues that may be embarrassing to the patient if disclosed
- Third party names

But in some cases:

- Sexual behavior
- Criminal behavior/history

DO'S AND DON'TS FOR WRITTEN DOCUMENTATION

DO

- Write legibly in permanent ink
- Put patient ID # on each page
- Sign, initial and date (month, day, year, time), each entry
- Make entries as soon as possible (do not make entries in advance and identify late entries as such)
- Incorporate prior records into documentation
- Include test results/consultations in record as well as notes that you reviewed
- Document informed consent/refusal
- Use specific, factual, objective language, and not language that speculates, opines, or is subjective in nature
- Document all facts relevant to an event, course of treatment, patient condition, and response to treatment
- Document rationale for deviating from standard treatment, when applicable

DON'T

- Don't leave blank areas on a page
- Don't squeeze in late entries
- Don't use personal/non-standard abbreviations when documenting
- Don't include names of informal consults, nor should informal consults document in the medical record
- Avoid using words like error, mistake, accident, inadvertent, and malpractice
- Don't erase/ block out entered information

When documenting in an EMR system, it is important to remember the following additional principles:

- Use only approved abbreviations, acronyms and symbols
- Exercise caution when moving from one patient record to another
- Do not cut and paste information from one EMR data field to another
- Link each data field in the EMR to the patient by name and health record number
- When referring to another patient, use that patient's health record number, not his/her name
- Each entry and signature must be associated with a date/time stamp
- Don't over rely on templates or diagnosis aids
- Ensure patient data is encrypted and avoid removing portable devices from the office if they contain patient data
- Make sure your system indicates when modifications are made to patient record
- Preserve all electronic data, emails, phone messages and computer records
- Do not delete information
- Do not give out your "login password."

Correcting medical record information:

At times it may be necessary to correct entries whether on paper or in an EMR. When correcting an entry error in a paper chart, remember to:

- Draw a single line through entry errors (make sure original entry is still legible)
- Write "mistaken entry"
- Use first initial and last name
- Write the correct entry as close as possible, but not over it.
- Sign and date the entry (including time)
- Document the correct entry
- DO NOT alter the original entry, or "black it out"

When correcting an error in an EMR, keep in mind the following:

- Every entry should be date, time, author stamped
- A symbol identifying new/additional entries should be viewable
- The original entry should still be viewable, "strike through" methods with author, date, time, commentary, linked to the original entry are often used
- Note the reason for the correction
- If a hard copy is printed, the hard copy must also be corrected

Psychotherapy notes are notes kept by the psychiatrist during therapy session that pertain to the patient's personal life and the psychiatrist's reactions. These records are:

- **Subject to more stringent confidentiality standard**
- **Must be kept separate from the rest of the medical record[4]**

[1] ECRI Institute, "Electronic Health Records, Healthcare Risk Control Risk Analysis," Vol. 2, Medical Records 1.1. (2011). Accessed August 15, 2012.

[2] American Health Information Management Association, e-HIM Work Group on Maintaining the Legal HER, "Update: Maintaining a Legally Sound Health Record—Paper and Electronic," Journal of AHIMA 76, no.10 (2005): 64A-L.

[3] This may be determined on a case-by case basis.

[4] American Psychiatric Association, Office of Healthcare Systems and Financing, Quick Practice Guides for Members, Psychotherapy Notes Under HIPAA, (2005).

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