RESIDENT OWLERY

WELCOME TO THE NEXT EDITION OF "RESIDENT OWLERY," a newsletter developed by Professional Risk Management Services® to provide psychiatry residents in training with *owl* you need to help manage your risks as you prepare to start your psychiatric careers. Featuring risk management resources, educational articles, and the latest announcements and events from PRMS, this quarterly newsletter will share relevant news, useful tips, and important updates in the field of psychiatry to help keep you, your patients, and your practice safe, from residency to retirement.

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10 THINGS ABOUT: EHR DOCUMENTATION

1. **No matter how good the system, what you get out of it will only be as good as what you put in. In other** words, garbage in, garbage out. If you have not been thorough with your documentation in the past, your EHR system might make your record look “prettier” but it will not in and of itself create a record that supports good patient care and would be useful in your defense in the event of a claim or a lawsuit.
2. **Concerns about patient safety and the use of electronic health records have been in the news for** years. As the use of this technology has grown so have these concerns. In 2015 ECRI Institute listed errors associated with EHR use among its Top 10 Patient Safety Concerns and the Joint Commission issued a Sentinel Event Alert on the Safe Use of Health Information Technology.
3. **A written record often contains seemingly extraneous information that can become extremely important** to a physician’s defense. For example, who was present when a patient was informed of the risks associated with a certain medication and what questions were asked and answered, or what comments the patient made regarding her adherence to treatment. Unfortunately, some EHR systems don’t provide a mechanism for users to include this information and instead they are limited to checking boxes. The absence of the ability to write a complete narrative is a frustration many physicians report with EHR use.
4. **Template use is an area that is undergoing scrutiny by CMS and other payors. Templates are used** to easily provide additional detail to a note but may not accurately reflect treatment – for example, they may misstate a patient’s age or gender. The result is often a record filled with a large number of identical notes which call into question whether the physician truly did a thorough evaluation of the patient at each encounter. If a template is used for informed consent, it may not capture all of the information you need to establish that the informed consent discussion actually took place, e.g., who was present.
5. **Some systems will automatically populate entries with information from previous visits. On occasion** the system will erroneously enter information from the previous patient. It is often impossible to determine whether data was entered by a clinician or by the system itself. Relying on default data can cause you to make false assumptions about a patient’s condition and making inaccurate default data a part of your record will cause you to lose credibility in any subsequent litigation. Further, some state medical boards have written position statements cautioning licensees against relying upon software that pre-populates fields.
6. **As with template use, the function which allows a provider to copy and paste portions of previous entries** into a new note is undergoing scrutiny by CMS. While intended to improve the thoroughness and ease of documentation, this function may be misused leading to problems both for the physician and the patient. Risks include: the possible perpetuation of erroneous information leading to incorrect diagnosis/treatment; the potential for copying and pasting the note to the wrong treatment date or even the wrong patient’s

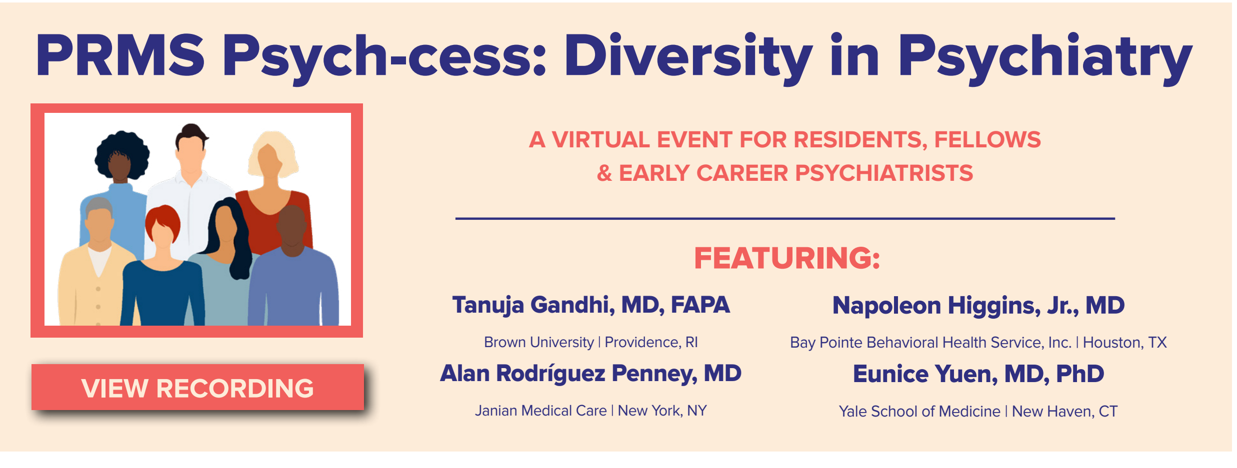
record; the inability to identify the author of the original note and the date of that note; and duplication of information not relevant to the current encounter.

7. **If you choose to use documentation shortcuts such as templates and the copy/paste function you must** remember that it is you who will be responsible for insuring that the encounter is billed using the appropriate code. Though the system may create documentation that meets the coding requirements for the highest code, it does not mean that you should bill at that code. Medical necessity is the key to accurate coding – even if a coding tool suggests a higher level of service.

8. **EHR users sometimes find that so much information is being captured and stored that they cannot find** relevant information. This can be problematic in emergency situations as well as routine treatment. One practical solution to this dilemma is to periodically print out a patient record and evaluate it for adequacy. A good medical record is one in which a subsequent provider or an expert witness would be able to understand what happened during the treatment relationship and why.

9. **Metadata is literally data about data and provides an audit trail of everything that occurs within the** electronic record. What this means is that every time you sign onto an electronic health record system, you leave a trail of your activity including what patient records and what portions of those records were viewed, the actual time the record was viewed, how much time was spent looking at the record (including how long it took to view and override a safety alert or other clinical support tool), what entries were made, and any changes that were made to the record. And, as with all other parts of the medical record, metadata may be discoverable in a medical malpractice lawsuit.

10. **Clinical decisions support systems are designed to assist physicians by making recommendations about** possible diagnoses from a set of signs and symptoms, provide alerts on possible drug interactions or critical lab values, or to question a physician's medication dosage or other orders. Unfortunately, these systems often produce a large number of alerts, many of which are not relevant. In other instances, the alerts may be based on out-of-date information. While it is true that many alerts are not clinically relevant it is also true that there are some that are and therein lies the problem. Physicians can become so accustomed to seeing alerts that are not relevant that they tend to not notice when an alert is relevant which is known as alert fatigue.



20 SUREFIRE STEPS TO INCREASE THE RISK OF A MALPRACTICE LAWSUIT OR BOARD COMPLAINT

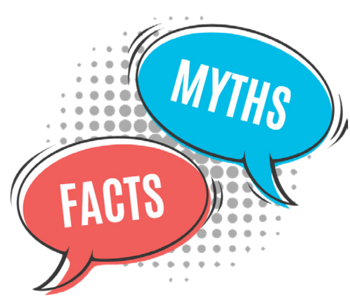
Nobody enters into medical practice planning to be the subject of a malpractice lawsuit or a board complaint. Most psychiatrists are simply trying their best to provide quality patient care, improve revenue streams, and reduce paperwork under difficult even liability exposure. Claims Examiners and Risk Managers who review complaints and lawsuits against clinicians often take note gleaned from actual cases, of surefire steps to **increase** your risk of a malpractice lawsuit or a board complaint.

- Documenting only the first suicidal risk assessment done on a patient; not documenting ongoing monitoring and evaluation of suicidality
- Allowing a patient with suicidal behaviors to be lost to follow-up
- Neglecting to document the clinical basis for ordering a change in the level of patient supervision and/or level of care for a patient with suicidal behaviors information to the family member(s)
- Failing to evaluate the safety of the environment for a patient with suicidal behaviors, e.g., accessibility of firearms and other weapons
- Failing to warn a third party, (or take alternative appropriate steps) when a dangerous patient has identified the party as a potential victim, as allowed or required by law
- Thinking that the other clinician in a collaborative treatment (shared or split treatment) relationship will know what patient information is important to discuss with you and when to call you without ever having had an agreement or discussion about these expectation with the other clinician
- Prescribing lithium **without** conducting regular tests on lithium and electrolyte levels
- Prescribing psychotropic medications without going through the informed consent process (and documenting it), especially when prescribing off-label for children.
- Failing to document what medications have been ordered, the basis for prescribing the medications, and changes to medications
- Assuming that the patient will be grateful and, therefore, not sue you for providing care that falls below the standard of care, because you are helping by providing at least minimal care since the patient cannot sufficiently pay for your services
- Allowing patients to pay for services by mowing your lawn, washing your car, painting your house, babysitting your kids, etc.
- Failing to conduct a thorough neurological evaluation on a patient who presents with decreased level of consciousness, an altered mental state, or who falls during hospitalization
- Ignoring the steps in the clinician-patient termination process
- Summarily terminating treatment with a patient who is in crisis (e.g., a patient assessed to be a danger to self

or others) believing this will decrease potential malpractice risk in the event of an adverse clinical outcome not need to be documented in the patient record

- Ignoring a subpoena for patient records or to testify, since you are not sure of the proper response. Or, conversely,
- Deciding not to establish a patient record for a patient who has very sensitive issues to discuss in treatment
- Altering a patient record after an adverse event
- Becoming involved in a sexual relationship with a patient

MYTHS AND MISCONCEPTIONS: RIGHTS OF DIVORCED PARENTS



Q. I have a nine-year-old patient whose parents are divorced and report that they have joint custody. After several visits, I discussed the option of medication, which I think would be of great benefit to the patient. The mother – the custodial parent – agreed, but the father was adamant that he did not want to "drug" his child. The father has since called me to demand a copy of his child's treatment record, but the mother had previously informed me that the father was not to have any access to the treatment record. How do I determine which parent needs to consent to the medication? Can the mother's assertion that the father cannot access the record be right?

A. Usually the answers to these questions will be found in a legal document such as a custody order, divorce decree, or separation agreement.

Consent to treatment: If the minor patient's parents are separated or divorced, clinicians must take reasonable steps to determine which parent(s) have the legal authority to consent to treatment. The rights of the parents should be set out in a custody order, divorce decree, or separation agreement. Request copies of such documents and all modifications. In the patient record, document your requests for such documents and the steps taken to verify proper authority to consent to treatment. Carefully review and maintain copies of the documents in the patient's record.

Even when a custody or divorce decree exists, parents may still disagree about who may give consent. In most cases, treatment without proper consent should not go forward (except for an emergency) until the parents agree or a court order or other legal action settles the issue.

Carefully review any custody documents that are provided. If the court documentation indicates that the mother has the ultimate decision-making authority about medical decisions, it does not mean that the father cannot be involved in consent discussions. In fact, most clinicians recommend that the risks and

benefits of the recommended treatment, as well as the other informed consent elements, be discussed with both parents (to the extent the parent without authority to consent chooses to participate). In the event both parents share medical decision making authority equally, or in the unlikely event that the court documents do not address medical decision making, the patient's mother should have her attorney assist her in working out an agreement or having the court determine the issue.

Release of information: The release of medical records and/or the disclosure of confidential information are often areas of significant conflict for families involved in child custody and divorce actions. Sometimes one party wants to use information in the medical record that may be viewed as unfavorable to the other party as a "weapon" in the legal action. Generally, both parents have a right to their child's treatment information, unless parental rights have been terminated.

In this case, since the father's parental rights have not been terminated, you should advise the mother of your understanding that the father has a right to a copy of the record, and her attorney would need to provide you with a legal basis for denying such request.

ARE YOU CROSSING THERAPEUTIC BOUNDARIES? 12 DANGEROUS SIGNALS

1. You are spending a disproportionate amount of time with one patient.
2. You are with the patient when you are "off duty" (such as during your mealtime, after you've clocked out or on the weekend when you are not working).
3. Your patient stays up to see you when you are on the night shift; he or she dresses in a particular fashion prior to seeing you.
4. You believe that you are the only one who understands the patient; other staff are too critical of the patient; other staff are jealous of your relationship with the patient.
5. You tend to keep secrets with the patient; certain information is not charted or reported.
6. You tend to report and communicate only the negative or only the positive aspects of the patient's behavior.
7. You are guarded and defensive when someone questions your interaction or relationship with the patient.
8. Your patient talks freely and spontaneously with you especially in light, superficial conversation and perhaps even with sexual overtones but remains silent and defensive with or avoids other staff.
9. Your style of dressing for work has changed since you started working with this patient.
10. You receive gifts, cards, letter, and/or personal phone calls from the patient.
11. You view the patient as "your" patient in a possessive way.
12. You tend to not accept the fact that the patient is a patient.

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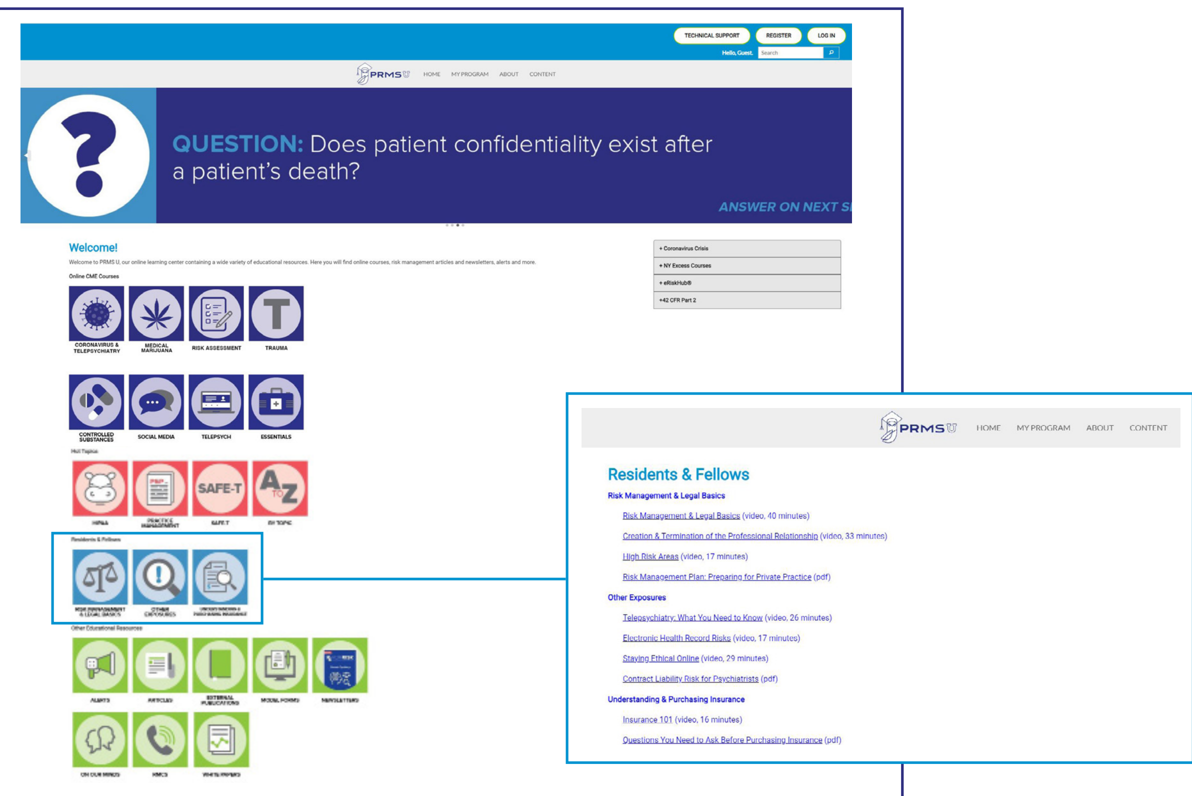

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MORE THAN AN **INSURANCE POLICY**

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