Components of a Family Planning Chart Review: Would Your Chart Stand Up To Scrutiny?

Satellite Conference
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Faculty
Victoria L. Green, MD, JD
Associate Professor
Director of Gynecology
Comprehensive Breast Center
Emory University
School of Medicine
Atlanta, Georgia

Program Objectives
1. Emphasize the importance of chart review in quality assurance.
2. Discuss benefits of the chart review process.
3. Identify components of a chart review.
4. Discuss how to develop an auditing system that will identify your documentation strengths and weaknesses.
5. Review a sample chart review form.
6. Demonstrate through written example exercises the chart review process.

“...the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional qualities.”


Quality Assurance
- Championed by JACHO
- Measure of institutional function
  - Designed to detect variations
  - Is variation acceptable or unacceptable?
- Establish clinical indicators
- Identify situations needing peer reviews
  - Deficiencies
  - Remedial action/outcomes

“...demonstrate that the quality of patient care was consistently optimal by continually evaluating care through reliable and valid measures.”

Quality of Professional Services Std
JACHO 1975
Quality Assurance
- There can always be improvement
- Quality cannot be determined by one case
- No further action
- Corrective action

Format
- Identify
  - Variation
  - Specific problem
  - Opportunity to improve care/performance
- Formulate a plan
- Record of actions taken

Format
- Documentation
  - Expectations for change
  - Measurement
  - Follow-up
  - Institutional reporting
- Legal consultation

Applying Risk Prevention Documentation to Everyday Practice

Documentation
- Good medical care
- Minimizes chance for miscommunication
- Legal defense
  - Standard of care
  - Careful, thorough care
  - Poor documentation
    - Careless
    - Force settlement
    - Serious harm

Major Principles
- Accuracy
- Comprehensiveness
- Legibility
- Objectivity
- Timeliness
Accuracy

• Use standard method
• Special circumstances
• Consistent in word usage
• Accepted and agreed upon abbreviations
• Time, date and legible signature

Comprehensiveness

• Identification
• Current condition
• Past medical history
• Past surgical history
• Family history
• Social history
• Medications
• Physical examination

Comprehensiveness

• Initial assessment and reassessment
• Results
• Operative reports
• Procedure notes
• Consultant reports
• Informed consent

Comprehensiveness

• Counseling and education
• Disposition
• Patient correspondence
• Advanced directives

HEALTH ASSESSMENT RECORD

PHAC/CRON LABEL

INVESTIGATION: CD, C1, CL, M, P, FTP, MP, STD, WC

MEASUREMENTS

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Patient Response

- Compliance with recommendations
- Missed appointments
- Patient concerns
- Informed consent
- Informed refusal

Legibility

- Wastes valuable time
- May reflect sloppy/inadequate care
- Misinterpretations

Objectivity

- Relevant facts
- Do not criticize
- Do not resolve differences
- Avoid judgmental words

Timeliness

- Record events when they occur
- Review results in timely fashion
- Develop policy

Quality Assurance

- Information evaluated
- Alternatives considered
- Recommended treatment
- Reasoning
  - Diagnosis
  - Choosing treatment
  - Deviating from the standard of care
  - Deviating from consultant’s recommendations
Exam Documentation: Adopting A Risk-Management Mindset

Effective Communication
- Accept patient’s perspective
- Respond to concerns
- Use verbal/nonverbal communication
- Be nonjudgmental
- Engage patient in discussion
- Convey comfort
- Abandon stereotypes

Patient Satisfaction Problems

SOAP
- Subjective
  - “Quotes”
  - Capacity
- Objective
  - Chaperones
  - Avoid judgments
- Assessment/Opinion
  - Rule out or likely
- Plan
  - Follow-up
  - Referral
  - Access
  - Agreement

Subjective:
41-year-old white female states, "I felt a lump on my right breast yesterday." Lump is nontender without pruritus, bleeding or nipple discharge.
No associated fevers, chills, fatigue, weight change, hot flashes, back or joint pains. No personal or family history of breast cancer.
10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Implementing and maintaining effective patient tracking and follow-up systems.
- Establishing and following clinic policies and procedures.
- Improving patient relationships.

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Establishing effective communication with patients and families.
- Improving medical record documentation.
- Avoiding disagreement among health care providers.

10 Most Effective Interventions to Decrease Malpractice Vulnerabilities

- Following applicable practice guidelines.
- Hiring qualified staff and supervising them.
- Maintaining patient confidentiality.
- Avoiding medication errors.

Components of a Family Planning Chart Review

- Accessibility of care: The ease with which patients can obtain the care they need when they need it
- Appropriateness of care: The degree to which the correct care is provided, given the current state of knowledge
- Continuity of care: The degree to which the care needed by the patients is coordinated among practitioners and across organizations and time

Objectives

- Evolution of quality assurance.
- Discuss program development.
- Review screening tools.
• **Effectiveness of care:** The degree to which care is provided in the correct manner - i.e., with error, given the current state of knowledge

• **Efficacy of care:** The degree to which a service has the potential to meet the need for which it is used

• **Efficiency of care:** The degree in which the care received has the desired effect with a minimum of effort, expense, or waste

• **Patient-perspective issues:** The degree to which patients and their families are involved in the decision-making processes in matters pertaining to their health, and the degree to which they judge care to be acceptable

• **Safety of the care environment:** The degree to which the environment is free from hazard or danger

• **Timeliness of care:** The degree to which care is provided to patients when they need it

• **Clinical practice guideline recommendations:** Pain should be assessed and documented routinely at regular intervals postoperatively, as determined by the operation and the severity of pain (e.g., every 2 hours while awake for 24 hours after surgery).

• **Medical review criterion:** For the patient recovering from surgery, the patient’s pain was assessed and documented every 2 hours while awake for the first 24 hours following surgery.

• **Performance measure:** Calculate the following for consecutive surgical patients seen over a 6-month period; the number of patients whose pain was assessed and documented every 2 hours while awake. The performance measure is:

\[
\text{number of cases with criterion met} \times \frac{100}{\text{number of surgery cases}}
\]

• **Standard of quality:** A performance rate of 95% or less triggers a review to determine how to improve assessing and documenting the patient’s pain status every 2 hours while awake for the first 24 hours postoperatively

• **Avedis Donabedian, MD**

  • **Structure**
    – Staffing
    – Equipment
    – Space
  
  • **Process**
    – Direct observation
    – Medical record
  
  • **Outcomes**
    – Results/intervention
- **Plan:**
  - State the objectives of the cycle.
  - Make predictions about what will happen and why.
  - Develop a plan to carry out the change (Who? What? Where? What data need to be collected?)
- **Do:**
  - Carry out the test.
  - Document problems and unexpected observations.
  - Begin analysis of the data.

- **Study:**
  - Complete the analysis of the data.
  - Summarize what was learned.
- **Act:**
  - What modifications should be made?
  - What will happen in the next cycle?

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**Abbreviations**

A progress note read, the AAFP patient in with mother for Depo Provera. This was not a recognized medical abbreviation nor was it approved for use according to the facility policy.

**Best Practices**

Use medical terminology and only abbreviations approved by your facility.
Developing A Program

1) Assign Responsibility
   - Identifies/assigns monitoring responsibilities
   - Formation of committee
   - Appointment of members
   - Consultations
   - Reporting mechanism
   - Written plan

2) Delineate Scope of Care
   - Who are the patients?
     - What is their age range?
     - What are their socioeconomic traits (geo-graphic locale; economic resources; cultural groups, etc.)?
     - Are there other demographics to consider?
2) Delineate Scope of Care

- What diagnoses are made and conditions treated?
  - What are the common diagnosis related groups (DRGs) and what is each group’s average length of stay, Medicare mean length of stay, and payer mix?
  - What conditions occur most frequently?

- What diagnostic and treatment modalities are commonly required?
  - What diagnostic testing is routinely performed?
  - What are the most frequent surgical procedures?
  - What pharmacologic agents are frequently prescribed?

3) Important Aspects of Care

- High volume
  - Occur frequently
  - Affect large number of patients

- High risk
  - Involve significant risks
  - Sentinel events
  - Limitation of services

- Problem prone
  - Logistics
  - Implementation
  - Technical support
  - Complex technology

Possible Target Areas

- History/assessment
- STD management
- Medication management
- Plan/treatment
- Progress notes
- Pap smear follow-up
- Method management
- Patient education
4) Identify Indicators

- Sentinel events
- Specific rates
- Positive/desirable
- Negative
- Address process/outcome
- Considerations
  - Approval by staff
  - Realistic

QA/QI In The Office

- Well suited
- Written plan
- Meet periodically
- Suggested items to monitor
  - Concentrate on one system
  - Monitor system
  - Risk management

Suggested Items to Monitor for Quality Improvement in the Office

- Medical Records/Information System
  - Legibility
  - Organization
  - Documentation-general (including problem list)
  - Documentation of drug allergy
  - Lost medical records
  - Misfiled medical records
  - Breach of confidentiality
  - List of current medications

Suggested Items to Monitor for Quality Improvement in the Office

- Appointments and Scheduling
  - Patient Flow
    - Acceptable waiting time for appointments
    - Appropriate waiting time in office to see clinician
    - Follow-up on missed or canceled appointments, tests, and procedures

Suggested Items to Monitor for Quality Improvement in the Office

- Patient Relations
  - Periodic patient survey on perceived quality
  - Patient exit evaluation forms
  - Evaluation of patient complaints
  - Periodic assessment of waiting room reading materials and patient information material for timeliness and appropriateness

Suggested Items to Monitor for Quality Improvement in the Office

- Patient Communications
  - Compliance with established protocol for informing patient of the results of laboratory studies and procedures
  - Method of informing patients of a delayed or rescheduled appointment
  - Monitoring appropriateness of method of terminating practitioner-patient relationship
Suggested Items to Monitor for Quality Improvement in the Office

- Telephone Communications
  - Excessive busy signals (data are available from the telephone company)
  - Excessive holding time
  - Documentation of telephone contact in medical records with disposition documented

- Monitoring of telephone prescription refills for doctor approval
- Monitoring amount of “dropped” or lost calls

Suggested Items to Monitor for Quality Improvement in the Office

- Personnel Management
  - Employee morale
  - Absenteeism
  - Periodic employee performance assessment
  - Maintenance of patient confidentiality

- Equipment and Drugs
  - Periodic equipment check for proper function
  - Maintenance logs of equipment repair
  - Security system to controlled drugs
  - Security system to syringes and needles
  - Method of monitoring drugs for expiration dates (including samples)

Suggested Items to Monitor for Quality Improvement in the Office

- Complications and Adverse Outcomes of Medical Activities and Procedures
  - Drug reactions
  - Wound infections
  - Delayed complications form hospitalized patients (e.g., episiotomy infections, postpartum endometritis)
  - Equipment failure

Developing A Program

[Diagram showing a flowchart for developing a program]
5) Establish Thresholds

- Signals needed for further investigation
- Determine when issue is addressed
- Based on
  - Literature
  - National averages
  - Local statistical control charts

Patient Complaint - Breast

- A medical record revealed this documentation:
  - Patient complained of breast mass before menstruation. Patient counseled to return one week after beginning of next menstrual period for re-examination.
  - No other assessment or intervention was included in the documentation regarding this patient’s status.

Best Practices

Do not document a problem or patient symptom without also documenting your assessment and what you did about it.
Polypharmacy

- A chart audit revealed this information
  - A 30-year-old family planning patient with past medical history of diabetes, hypertension, hypothyroidism, seizures and asthma is seen in the family planning clinic.

Polypharmacy

- Drug count included diabetes (three drugs), epilepsy (two drugs), asthma (two inhalers), hypertension (one drug) and hypothyroidism (one drug).
  - Records indicated last family planning annual visit was 1 year ago to date, when the patient was started on a combined oral contraceptive with physician order.

Polypharmacy

- Patient denied any current concerns and all conditions are under fair control.
  - The medication history was not updated. Patient was issued a year supply of a combined oral contraceptive. No physician order was noted in the chart.

Review

- Patient presents with multiple medical problems.
- Prior documented medication (9).
- Prior physician order for contraceptives.
- Documentation approx. 3 lines, indicates patient provided with one year of COCs.

Documentation Problems

- Medical history update noted in chart? NO
- Medication history updated in chart? NO
- Annual physician order required to initiate or continue hormonal contraceptive in chart - NO

Best Practices

- Update information - medication history, medical history, allergies and any changes at every patient visit.
7) Evaluate Care

- Quality/appropriateness of care
- Allows review by non-medical personnel
- Generally accepted
  - Below - Substandard
  - Above - Levels of acceptable care
  - Equally acceptable approaches
Preventive Measures

• Education/training
  – Morbidity and mortality conferences
  – Seminars
  – Case studies
  – Equipment demonstrations
• Clinical protocols
  – Complexity of medicine
  – Orient/instruct personnel
  – Control costs
  – Support staff

Preventive Measures

• Acquisition of equipment
  – Proper indications
  – Properly trained
• Policy statements

Abnormal Finding Not Covered In Protocol

• In one medical record, the nurse documented positive urine dipstick for nitrites and leukocyte esterase on a symptomatic patient and 2+ proteinuria. The progress notes stated “no treatment provided, protocol does not allow for management of 2+ proteinuria”.

Best Practices

Do not write excuses such as “treatment not provided due to…” in the medical record.
Corrective Action

• Discussion/counseling
• Observation of practitioner’s skills
• Focused education
• Proctoring
• External peer review
• Remedial education

Corrective Action

• Reassess problem
• Document results
• Discuss with legal counsel
Suggestions

• Develop guidelines
• Training
• Review individual components
• Do not review your own charts
• Allow time for group discussion
• Provide summary report

Common Deficiencies In QA Review

Correcting Medical Records

• Notification
• Place below last entry
• Explain
• Draw a single line
• Do not out
  – Scratch out
  – White out
  – Write out

Correcting Medical Records

• Timely
• Identify late entry
• Spoliation of evidence
  – Document examination
  – Sanctions
• HIPAA
  – Patient may request correction
  – If disagree must notify and offer Statement of Disagreement
  – Civil and criminal penalties may be assessed
    – Pierce v. Penman, 515 A.2d 948

Correcting Medical Records

• No medical record should be altered or back dated

Informed Refusal

• 27 Ca. 3d 285, 1980.
• Repeatedly advised routine pap smear.
• No documentation of explanations/potential risks.
• Died from advanced cervical cancer.
Informed Refusal

- Risks and benefits of examination or treatment or both.
- Reasons for recommendations.
- Documentation of description of exam.
- Clarify any misunderstandings/allay fears.

Informed Refusal

- Assure understanding of consequences.
- Document above discussion/informed consent.
- Include reasons for refusal.
- Must take all reasonable steps to secure patients written informed refusal.

Legal and Ethical Conflicts

Peer Review Privilege

- State statues vary in reach and strength
  - Information protected
  - Collaborations protected
  - Absolute versus partial privilege
  - Statutory revocation

Legal Protections

- General evidentiary rules
  - Remedial measures
  - Attorney-client privilege
    - Typically only includes senior management
    - Protection lost if sent to non-party
  - Work product doctrine
    - Jurisdictions differ
    - Protection not absolute

Legal Protections

- Specific Statutes
  - Promise confidentiality
  - Anonymous reporting
  - De-identification of data
Standards
• Create discussion between leadership/staff
  – Blameless and non-punitive atmosphere
  – Detrimental effect on error reporting/disclosure
  – Provide emotional support

Standards
• Culture of safety
  – Culture of non-tolerance for high error rates
  – Commitment to reducing error
  • Mechanisms to identify and track errors
  • Setting of norms for training and equipment
  • Adoption of practice parameters
  • Mandatory disclosure

Final Thoughts
• It’s not fun
• Time consuming
• Diligence will pay off

"A life is not important except in the impact it has on other lives."

Jackie Robinson

Thanks to
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Department of Ethics in the Health Professions
ACOG QA/QI in OB/GYN
Emory Risk Management Department

For a complete list of upcoming programs, go to the Alabama Public Health Training Network web site at www.adph.org/alphtn