

Socioeconomic tips of the month

A risk management checklist: Part I

Proper risk management is about meeting and fulfilling reasonable expectations for the various elements of the practice, including adequate documentation of the following: medical records; billing and collection guidelines; employee screening, training, and safety; and environmental safety and comfort.

To help practices meet the demands for risk management, we have developed the checklists presented later in this series of columns. (Part II of the series will be published in the June 2002 issue of the *Bulletin*.) The lists are broken down into key areas including documentation of medical records, medications, consent issues, billing and collections, employee files and training, and the practice environment.

Relevance of risk management

Physicians and office staff who are focused on risk management have safer practice environments, maintain better medical records, respond more quickly to emergencies, can assure better medical care, and are at a lower risk of malpractice and other liability.

Patients, employees, other physicians, hospitals, and regulators have come to expect not only minimal compliance for the records and functions of the practice, but have "raised the bar" with regard to what is termed minimal compliance. Physicians must ask themselves what is a reasonable expectation for the various functions of their practices. As technology improves and changes and as the costs for technology decrease, the anticipation of considerable amounts of data becomes the norm. Practices must meet this demand or face the risk of consequent liability.

Good risk management requires that you change your point of view from that of what is reasonable for your practice to what is expected of your practice by others, including patients, lawyers, insurers, regulators, and other physicians.

The best way to determine whether your practice is meeting these demands is to evaluate the materials and processes from your own practice prospectively. This critical review will prepare

Around the corner

May

- ACS-sponsored basic and advanced coding workshops for surgeons on May 23-24, 2002, in Baltimore, MD.*

June

- ACS-sponsored basic and advanced coding workshops for surgeons on June 20-21, 2002, in Atlanta, GA.*

*Visit the ACS coding workshop Web page at <http://www.facs.org/dept/hpa/workshops/cdwkshop.html> to register.

you for the closest scrutiny, even if the ones evaluating you are in an adversarial position.

Medical records checklist

- Are entries in the medical record legible, dated, and signed?
- Do you have large gaps in the progress note pages? These discrepancies could increase the probability of entries being out of chronological order.
 - Has the physician reviewed and initialed dictated notes that have been transcribed? Are the notes dated?
 - Have follow-up instructions been entered into the record? This sort of information may be on the charge ticket (superbill).
 - Are missed and cancelled appointments noted in the chart?
 - Are test results initialed and dated to indicate they have been reviewed?
 - Is there documentation telling patients the results of diagnostic tests?
 - Are written reports from consultants initialed and dated?
 - Are patient follow-up appointments documented in the record?
 - Are patient cultural and religious preferences noted, so that proper decisions regarding blood

transfusions and organ donation can be made?

- Is there documentation of any brochures given to the patient?
- Are there loose papers in the record?
- Are standardized H&P forms initialed and dated?
- Are stamped signatures used? They should not be used.
- Is there a consent to treat form in the record for minors?
- Are referrals to other physicians for consults documented?
- Are all phone calls with patients concerning patient care documented?
- How long are telephone logs maintained? Most insurers want to see 10 years of such registers.
- How are corrections in the clinical record indicated? A single line through the incorrect information signed and dated is preferred.
- Is the corrected note legible?
- What is the procedure for follow-up on missed appointments? Is it documented?
- Is there an examination and medical indication prior to a prescription or dispensing of medications?
- Is patient compliance documented?
- If the physician-patient relationship is terminated during treatment, is it documented?
- If death occurs outside the hospital, does the record indicate how the doctor was notified and who pronounced the death?
- Is there documentation of health directives, such as a durable power of attorney or other state-specific laws?
- Are there documentation and policies on reviewing all advertising and the use of preprinted brochures?
- Does the documentation support the diagnosis? Is the treatment plan consistent with the diagnosis?
- Is there documentation that a chart has been reviewed by the physician prior to archiving?
- Are all X rays read or confirmed by a board-certified radiologist?

Medications checklist

- Are all sample medications dispensed in the office documented in the patient's record?
- Are sample medications securely stored?

- Are expired medications and samples removed?
- Is there a medication list in the record indicating date, refills, discontinued medications, and ordering physician?
- Are telephone prescription renewals properly documented?
- Are all drug allergies documented and easily identified?
- Are all prescription blanks, medications, syringes, and needles stored in a secure location?
- Is there documentation of all supplies given to patients?
- Are proper and required records maintained for controlled drugs (schedules II through V)?
- Are controlled substances inventoried regularly? The law requires that such inventories occur no less than every two years.

Better safe than sorry

Generally, well-run practices are doing the previously described activities on a regular basis. If there is any problem at all, it tends to be with the documentation of the work being done and the timing. The best way to resolve these issues is to have a regular schedule for double-checking to see that each step is being done. It is also a good opportunity to delegate jobs to different people in the practice. Make sure the assignment is one they are qualified to perform and evaluate, and then make sure they report their findings, corrections, and recommendations.

Practices that make safety, security, and good documentation a part of regular patient care minimize the risks associated with a modern practice and create an excellent environment in which to work and be a patient. □

This information originally appeared in "Tips & Techniques," an Internet newsletter published by Economedix, LLC. Tom Loughrey of Economedix provides individual practice management consultations to ACS fellows during the ACS Clinical Congress. All information is © Economedix, LLC, 2002. All rights reserved.