Common Documentation Mistakes

**Altered records**

Records should be kept in ink, preferably black, so that clear copies can be made when necessary. How should doctors correct records if a lawsuit is filed? They shouldn't — records should never be altered. Malpractice attorneys often hire expert document examiners to analyze chart notes when it appears a record may have been changed or a post-entry note added (including sophisticated analysis of the ink appearing on the original). There's no faster way to damage your credibility in court than for a plaintiff's attorney to stand in front of a judge and jury and prove you lied. Once notified of a legal action the record should be sealed and no changes made.

**Entries Not Dated or Identified**

Chiropractors see some patients for many years.  Be sure to identify the year along with the patient's name or identifier on each page of the record. When this is not done, errors can be made during photocopying. It's not unheard of for pages — or even different patient records — to be merged together.

**Obliterated Entries**

Mistakes in the record can happen in any office. How they are corrected is important. Always draw a line through the incorrect entry, write the correct information and initial and date the correction. This makes clear what was originally written and what was added. Never use white-out or scribble over the entry because it fuels suspicion about what the original entry might have been.

**Entries Not Signed, or Signed or Countersigned without Having Been Read**

Never send out dictated records without having read them. You have no idea what may have happened during the transcription. Two records may have run together, an entry may have been left out or irrelevant information added by the transcriptionist.

**Entries for Care Performed without Signature**

Always indicate who provided care to the patient and include a signature recording the author of the entry. Even if you are a solo practitioner, it is good practice management to initial the daily note.

**Illegible Records**

Doctors are notorious for poor handwriting and the point of many jokes. The real point is that records must be able to be read by another provider of same license. A situation may occur when you might be unavailable to care for your patients. In that case, a replacement doctor must be able to read and understand your records to provide proper and necessary care.

**Lots of Blank Spaces on the Page**

Busy doctors sometimes need a form that provides memory prompts so nothing is forgotten. And there are valid clinical reasons for leaving a space blank. However, if a form is continually 90 percent blank, move frequently used items to another form and eliminate the unused form.

**Uncommon Abbreviations**

Abbreviations are a wonderful tool and can save time in writing daily records. But if you make up your own, you'll need to send out a legend every time you send out records. Use standard abbreviations.

**Failure to Document Patient Noncompliance**

All doctors have experienced a patient who is noncompliant and felt the need to discharge them from care. Be sure to document the episodes of noncompliance, whether it is missed appointments, frequent cancellations without rescheduling, failure to do recommended exercises or refusal to stop certain activities (work or sport related).  This documentation can be critical if you are later accused of abandonment.

**Not Documenting Phone Calls**

We have all received calls from patients who are in some distress and need advice on what to do. The advice may be a recommendation to lay in a fetal position with ice on the low back or to seek assistance from an emergency department. In any event, it is a clinical encounter with a patient and must be recorded. In an extreme case it could be the last encounter before a lawsuit is initiated.

**Charting Only the Abnormal**

When doing an examination on a particularly busy day, a doctor may be tempted to record only those abnormal (or positive findings) in the record. This can be a dangerous practice. Although abnormal findings are important to determine a diagnosis, negative or normal findings are equally important because they can help rule out serious conditions. For example, the fact that a patient had a negative (normal) SLR, negative Supported Adams Test, negative Bechterew's Test, negative Valsalva Test, normal motor strength, normal peripheral sensation and normal deep tendon reflexes rules out intervertebral disc injury.

**Test Results That Do Not Have a Clinical Rationale, Evidence of Review by the Doctor or Patient Notification**

Clinical records must include: your reason for ordering a test, test results, a description of how the patient's care was affected and an indication the patient was notified of the results.