OMIC
OPHTHALMIC MUTUAL INSURANCE COMPANY
A Risk Retention Group

Risk Management Recommendations

Sponsored by the American Academy of Ophthalmology

Documentation of Ophthalmic Care

PURPOSE OF RISK MANAGEMENT RECOMMENDATIONS

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement these risk management recommendations. Rather, physicians should use their professional judgment in determining the applicability of a given recommendation to their particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology's *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. If legal advice is desired or needed, an attorney should be consulted. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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Inaccurate or incomplete documentation is a threat to patient safety and hampers the defense of a medical malpractice lawsuit. Conversely, careful documentation of the history, exam, and decision-making process may dissuade a plaintiff attorney from accepting a case. It also serves as a basis for coding and billing of the care provided. The following recommendations are based on OMIC's claims experience.

- ## Documentation Rules
  - Include objective account of facts
  - Do not note subjective judgments
  - Do not speculate or blame/judge
  - Date and sign all entries

- ## Changes and addendums to the medical record
  - Corrections
    - Draw a line through the unwanted statement in such a manner that it is still legible, write the appropriate statement, date and initial it.

- Addendums
  - The original information is not removed
  - Serves to add information
  - Date, sign, and place in the chart
  - Do not add after receive claim letter

Diagnostic and decision-making process

- History in the patient's own words
- Impact of cataracts on functional vision OR reason patient wants refractive or elective surgery
- Impact of vision on work history
- Impact of vision on hobbies
- Exam results including all pertinent positive and negative findings
- Assessment including differential diagnosis
- Plan, including treatment
- Decision to propose medical v. surgical treatment
- Instructions given to the patient
- Follow-up appointment or appointment with consultant

Informed consent

- What is "informed consent"?
  - An oral agreement reached after the surgeon advises the patient of:
    - Diagnosis and proposed treatment
    - Risks, benefits, and alternatives
    - Consequence of refusing treatment
    - Informed consent must be documented by
      - Note in medical record (always)
      - Procedure-specific consent form (usually)
- Documentation in the medical record
  - Risks, benefits, alternatives discussed
  - Complications for which the patient is at an increased risk
  - Patient's questions and patient satisfaction with your answers
  - Planned comanagement, if any
  - Off-label use of drugs or devices if integral to the procedure/treatment
- Procedure-specific consent form
  - Provides documentation of content of informed consent discussion
  - Educates patient and helps prepare patient for possible complications.
  - Provides answers to questions the patient may not feel comfortable asking.
    - Give the patient a copy of the consent to take home. Ask him/her to review with family and to call with any questions.

        - Serves as confirmation for ASC or hospital that surgeon obtained informed consent.

- **Procedures and Complications**
    - Procedure (Operative) Report
        - Rationale for surgery
        - Statement that informed consent was obtained
        - Pre-operative assessment
        - Anesthesia: sedation type, amount
        - Technique
        - Assistants, if any
        - Complications
            - How they were handled
            - Disclosure discussion including symptoms that should be reported to the surgeon
        - Discharge condition
        - Follow-up instructions
    - Incident report
        - **DO NOT PHOTOCOPY OR PUT IN MEDICAL RECORD**
        - Alerts facility to need for follow-up
        - Most hospitals and ASCs have protocols that establish when one must be completed, along with specific form
        - Note details more pertinent to physicians and staff behavior and actions than to patient (e.g., profanity used by CRNA)
    - Disclosure discussions
        - Disclose unusual occurrence to patient and family
        - Keep focus on patient's need not on providers
        - Calm, respectful, non-defensive attitude
        - Provide facts known at the time in patient-centered language
        - Do not speculate on what happened
        - Do not assign blame

- **Telephone Calls**
    - Risks
        - Do not have benefit of examination or non-verbal aspects of communication
        - Using phone records, plaintiff can prove that call was made
        - In absence of documentation, experts review deposition testimony given by plaintiff and defendant physician
        - Juries ultimately decide credibility of plaintiff versus defendant
    - Document all care-related calls
        - Calls to staff during office hours
        - Discussion with consultant

        - After-hours from patient
        - After-hours while on call
        - After-hours from the ER
        - Patient sign-offs when going on or off call, or transferring care
    - Content to document
        - Date
        - Time
        - Information obtained and given
        - Assessment
        - Recommendations
        - Follow-up
        - Communication with other providers

- **Text Messaging and Email**
    - Risks
        - If you are communicating outside of an **encrypted or secure messaging portal,** you risk breach of PHI (personal health information) and a HIPAA violation.
        - You should not assume you have consent to respond to unencrypted or unsecured text or email because your patient sent a message to you first.
        - You should stay current on the CMS rules regarding text messaging and your responsibilities under HIPAA.
    - Consent and documentation
        - You can send text or email to your patient if you are using an encrypted mail or secure messaging system/portal.
        - If you are not using encrypted mail or secure messaging AND the patient is requesting to communicate via email or text, we recommend warning the patient beforehand of the risks associated with unencrypted communication. Once you've communicated the risks to the patient, we recommend you obtain verbal consent and document in the medical record.

- **Noncompliance**
  - Risks
    - A patient's failure to comply with appointments and treatment recommendations is a threat to the patient's safety and exposes you to liability.
  - Action needed
    - Educate about disease and how to take medications. Document efforts.
    - Document the follow-up interval in the record
    - Schedule the next appointment before the patient leaves the office
  - Appointments
    - Review daily and notify physician of changes and no-shows
    - Document call to the patient notifying him/her of missed appointment
    - Prepare and send missed appointment letter (retain a copy for your records)
    - Document notification to the referring physician
  - Medication adherence
    - At follow-up visit, ask patient "Tell me how you are taking your medicine."
    - If not instilling drops correctly, reeducate
    - If not taking as prescribed, evaluate reason and target education to it
    - Limit refill to follow-up period
  - Refusal of treatment
    - Patient has the right to accept or refuse all treatment
    - Patient must understand the consequence of refusing care (informed refusal)
    - Determine and document the reason
    - At times, may want to terminate relationship

OMIC RESOURCES (available at www.omic.com)

- "Responding to Unanticipated Outcomes"
  - Difference between maloccurrence and malpractice
  - How, when, why to disclose
- "Telephone Screening of Ophthalmic Conditions"
  - Sample protocol and contact form for staff
  - Sample after-hours contact form for physicians
- "Noncompliance: A Frequent Prelude to Malpractice Lawsuits"
  - Sample tracking system for appointments, referrals, and tests
  - Sample letters for missed appointment, noncompliance
- "Termination of the Physician-Patient Relationship"
  - Process to follow
  - Sample letters
- "Termination of the Physician-Patient Relationship for Financial Reasons"
  - Process to follow
  - Sample letter

Need confidential risk management assistance?
OMIC-insured ophthalmologists, optometrists, and practices are invited to contact OMIC's Risk Management Department at (800) 562-6642, option 4, or at riskmanagement@omic.com.