Best Practices in Clinical Record Keeping: Visit Specific Chart/Progress/Encounter Notes

Introduction

Complete and thorough documentation of each clinical encounter using visit specific entries is essential to the process of providing the best quality patient care. The introduction and accelerated adoption of electronic health records (EHR) systems to record information from the patient encounter has created some benefits and challenges. Some of the benefits and challenges are highlighted below but the focus of this Best Practice is to ensure the adoption of this technology is successful in preserving the visit specific entry requirement.

Benefits

Some of the areas where EHR systems can improve the process of healthcare include the following:

- Minimize errors, improve patient safety and support better patient outcomes.
- Improve quality of care and risk management.
- Improve public health outcomes.
- Improve documentation and coding.
- Allow for better coordination of care between providers.
- Improve patient access to health record data.

Challenges

Some of the challenges for providers in implementation and using EHR systems include the following:

- Customization required for work flow.
- Learning curve for use.
- Interference with face-to-face patient care.
- Increased time required to complete charting.
- Copy-paste/ whole note or visit-to-visit cloning/auto-populate/Same As Last Time (SALT), and over-documentation/"note bloat".

Visit Specific Notes

The documentation of visit specific notes for each patient encounter is essential to the process of providing the best quality care. In the world of modern healthcare where time is at a premium, producing a quality clinical record requires attention to detail. Most EHR systems are designed to assist in this process by using templates, macros, and other automated approaches. These methods can be very helpful to a clinician, however the evidence clearly demonstrates it still requires a significant proportion of the patient encounter time to document a quality driven visit specific note. Where the provider uses the EHR to generate a clinical record that is not visit

specific using methods such as copy-pasting, whole note or visit-to-visit cloning, auto-populating, or Same As Last Time (SALT), the outcome does not meet professional standards for clinical record keeping. Some of the unintended consequences of these types of chart note entries are as follows:

- Failure to achieve the medical necessity criteria due to repetition/no documented change in subjective and objective content resulting in denial of services.
- Failure to provide an accurate or meaningful clinical picture of the patient with implications on the quality and safety of patient care.
- Violation of professional licensure standards/rules, state and/or federal law, e.g. Oregon Administrative Rule Chapter 811 Division Consumer Protection Records 811-015-0005 (1): "It will be considered unprofessional conduct not to keep complete and accurate records on all patients, including but not limited to case histories, examinations, diagnostic and therapeutic services, treatment plan, instructions in home treatment and supplements, work status information and referral recommendations."

Another method that results in the same concerns is using software generated notes where there is no visit specificity, i.e. the same thing is repeated from visit to visit but the wording is slightly altered, as depicted in the following chart:

Patient Visit	Subjective Documentation
Day One	"She is afflicted by a moderate degree of intermittent dull pain with stiffness and soreness in both sides of her neck."
Day Two	"In her neck bilaterally, the patient is feeling a moderate degree of dull pain with stiffness and soreness which occurs intermittently."
Day Three	"She is experiencing in her neck on both sides, an intermittent dull pain with stiffness and soreness of a moderate degree."

Practical Application of Visit Specific Clinical Record Keeping

There are a number of conditions seen by healthcare providers where it may take a period of time and/or number of office visits before there are more profound changes in the patient's health status. One analogy to illustrate this point is using a light switch where most conditions respond like a dimmer switch rather than a simple off-on switch. The clinical record is where it is appropriate to record the specific details of the patient's condition that are relevant and representative of their status at each visit. This may include changes that are not necessarily profound in magnitude but are meaningful (e.g. same pain level but decreased frequency) and should be included at each visit. For each condition and individual patient there is a continuum of response to care from no improvement to complete recovery over time. This should be represented in their visit specific clinical record. Following are some examples for each section of the SOAP note that may assist in application of these concepts.

- **Subjective:** A number of items should be considered at each visit to include in the subjective portion of the clinical record where meaningful change may be represented. This should include elements using the patient's own words when possible indicating their status. Further exploration of the duration, intensity and frequency of a symptom such as pain can be qualified and quantified and documented by using an Outcome Assessment Tool (OAT) such as a pain scale, e.g. Visual Analogue, Numerical Rating Scale or Patient Specific Function Scale. This could also include a frequency component ranging from constant to occasional. Additional items to consider, including in the context of patient status where change in comparison to the initial visit for an episode of care, are as follows: specifics of response to care, effects on Activities of Daily Living (ADL's) such as sleep, walking, etc., palliative and provocative factors, medication dose and frequency, work status/capacity, quality of symptom, radiation if any, and timing.
    - Sample Subjective Documentation:
        - Non-visit specific subjective clinical record: copy-pasted from initial/prior/previous visit; e.g., "The patient returned today reporting that they are still having pain in the neck, 2/10."
        - Visit specific subjective clinical record: "The patient returned today reporting that they are still having pain in the neck, 2/10, however the pain is less constant/more intermittent. It no longer radiates to the upper shoulders and after the last visit there was almost no pain and improved neck mobility for about 24 hours. They are only taking 600mg ibuprofen twice per day whereas they were taking 800mg three times per day initially. They are performing the exercises and not having any trouble with them. Sleeping is still difficult as changing positions still wakes them up but this is less frequent and they are able to return to sleep without significant delay."

- **Objective:** Qualification and quantification of objective findings provide the evidence where meaningful changes may be reflected in documentation of visit specific clinical records. The objective component of the visit may not demonstrate meaningful changes at each visit depending on the condition and the patient, however it's reasonable to expect changes over the course of several visits with most conditions and this should be reflected in the clinical record. This can include some of the following elements in comparison to the initial visit for an episode of care or condition based treatment: degree of antalgia; joint range of motion (ROM) with degrees and associated qualified and quantified symptoms; tenderness (e.g., 1-4/4); muscle hypertonicity (e.g., mild, mild-moderate, moderate, moderate-severe, severe); orthopedic and neurological testing (e.g., muscle testing 0-5); tongue & pulse; other examination/objective findings such as blood pressure, laboratory testing, weight, edema, etc.
    - Sample Objective Documentation:
        - Non-visit specific objective clinical record: copy-pasted from initial/prior/previous visit; may include items that were performed on the

initial visit but weren't performed on a subsequent visit (e.g., vitals, labs, physical exam findings such as lung or heart sounds, ROM, orthopedic tests, etc.) providing erroneous/false information.
    - Visit specific objective clinical record: "examination findings are as follows: mild LLF lumbar antalgia; +2/4 tenderness paracervical areas C4-6; paracervical muscle hypertonicity mild-moderate; cervical ROM full in all planes with mild local right side neck pain in right rotation with all other planes being asymptomatic; segmental joint dysfunction C4-5 on the right."

- **Assessment (may include Action/Treatment):** The assessment should be updated in some detail at each visit. This documents the updated visit specific clinical impression/thought process based on the subjective and objective components of the clinical record to determine the patient's response to care. This should be as specific and descriptive as possible and may include updating components such as the phase (e.g. acute, subacute, chronic), complicating or associated factors, concomitant diseases/co-morbidities. This section also may include action or treatment which is detailed in the Plan section below.
    - Non-visit specific clinical record assessment: copy-pasted from initial/prior/previous visit, e.g. "Diagnosis unchanged from last visit, patient is improving as expected."
    - Visit specific clinical record assessment: "continued slowly improving sub-acute cervical facet syndrome/primary hypertension as evidenced by decreased pain/improved ADL's/improved ROM/decreased daily home and in clinic blood pressure readings".

- **Plan (may include Procedures/Treatment/Prognosis):** Included are updated detailed specifics of treatment (e.g. modalities and procedures, dietary recommendations, medications, patient instructions, etc.), prognosis, compliance, assessment of treatment plan (consistent with diagnosis, deriving expected outcomes and goals of treatment, continue or change based on assessment), consideration and/or documentation of consultations/referrals/imaging.
    - Non-visit specific clinical record plan: copy-pasted from initial/prior/previous visit, e.g. "Adjust T4, continue with current plan, PTR Wednesday."
    - Visit specific clinical record plan: "Treatment included manual manipulation at T4 on the right performed supine with good release and improved segmental mobility; continue with gluten free diet/spinal stabilization exercises with good patient compliance. The patient is making good progress with this being the 4th/6 planned visits. They should return 1x/week X 2 weeks with plans to add levator and trapezius stretching/omega-3 dietary changes at their next visit."

Summary

The clinical record should document a clear picture of the patient's condition and their response to care in a visit specific manner. As outlined in this best practice document, there are challenges as well as benefits associated with the technology that incorporates the EHR into the patient encounter. There is a learning process that accompanies this process and one of the keys to successful implementation is understanding that documentation of clinically meaningful information at each visit is an essential component in providing the highest quality patient care.