

## CHARTING RISK MANAGEMENT GUIDELINES

# AON O&P Insurance Program

Chartis specializes in providing risk management services to our insureds. We understand the issues with orthotics and prosthetics (O&P), and can guide you in creating a good patient chart to help minimize the potential for loss to your organization.

A good patient chart contains clear, detailed, consistent notes about what happened during a patient visit, what steps you are taking to provide care for the patient, your recommendations and your observations and concerns. It is **essential** that your chart notes be clear and provide enough detail so that you and others in your office can understand what care was provided in the past, and serve as a guide as to what should be done in the future. This chart also becomes a very important part of a case if a patient brings a lawsuit against your practice.

### **Goal: To Ensure Quality Patient Care**

The following Charting Guidelines are designed to help you meet this goal:

- **Put in enough detail** to distinguish a particular patient, device, topic, appointment and medical reason(s) for use of a particular device from others. Be thorough, including such information as actions taken, adjustments made, and/or recommendations given. It is better to have too much information than not enough. Other details may be required by the American Board for Certification, Medicare or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).
- **Do chart entries promptly**, that way you are less likely to forget details of the patient's appointment. If you are pressed for time, consider using a tape recorder to dictate your notes that can be transcribed for the chart at a later time.
- **Never alter or erase entries**, especially after a lawsuit has been filed against you. Alternatively, draw a line through an entry being revised and above it write the word "error." Anything else will give the appearance that your records have been altered. When corrected, make a note in the margin as to the date and time of the correction.
- **Don't squeeze in words or skip lines**, but rather draw a line through unused space at the end of every entry.
- **Keep supplemental documentation** such as physician prescriptions.
- **Keep all documentation together** in one file. That way, all the relevant information is right at your fingertips, and you do not have to keep track of multiple files.
- **Keep billing information separate** from clinical information, while still in the same folder.

### Contact us

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