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CHAPTER 9

Maintaining Patient Records

REVIEW

Vocabulary Review

True or False

Decide whether each statement is true or false. In the space at the left, write T *for true or* F *for false. On the lines provided, rewrite the false statements to make them true.*

_____ 1. It is not necessary to document in the medical record when a patient in noncompliant.

_____

_____ 2. Patient records may be used to evaluate the quality of treatment a facility or doctor's office provides.

_____

_____ 3. Informed consent forms state that a patient has agreed to treatment.

_____

_____ 4. All written correspondence from the patient, a doctor's office, a laboratory, or an independent heath-care agency should be kept in the patient's chart.

_____

_____ 5. When talking with an older patient, it is important to always speak very loudly as most older patients are hard of hearing.

_____

_____ 6. Transcription is the transforming of written notes into accurate spoken form.

_____

_____ 7. Problem-oriented medical records are a way to overcome the disadvantages of conventional medical charting.

_____

_____ 8. Objective data comes from the physician and from exams and test results.

_____

_____ 9. Computerized records can be used in teleconferences.

_____

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Content Review

Multiple Choice

In the space provided, write the letter of the choice that best completes each statement or answers each question.

_____ **1.** When you are in doubt regarding who is authorized to sign a release of records form for a minor,
- **A.** always ask the oldest person.
- **B.** always ask the minor who is authorized.
- **C.** do not allow anyone to sign.
- **D.** you must ask a lawyer for guidance.
- **E.** you must always ask your superior.

_____ **2.** When children reach this age, most states consider them adults with the right to privacy regarding all of their medical information.
- **A.** 18
- **B.** 19
- **C.** 20
- **D.** 21

_____ **3.** Test results received from sources outside the practice are best organized in sections within what part of the medical chart?
- **A.** Laboratory and other test results
- **B.** A special section in the chart especially for outside source material
- **C.** The very front of the chart
- **D.** The very back of the chart

_____ **4.** Which of the following elements of SOAP charting describes the data that comes directly from the patient?
- **A.** S
- **B.** O
- **C.** A
- **D.** P

_____ **5.** Which of the following elements of SOAP charting describes the course of treatment to be followed?
- **A.** S
- **B.** O
- **C.** A
- **D.** P

_____ **6.** What does the abbreviation PT mean?
- **A.** Partial
- **B.** Physical Therapy
- **C.** Patient
- **D.** Preoperative
- **E.** Professional Tone

_____ **7.** The six Cs of charting include
- **A.** Conformity, Clarity, Cleanliness, Conciseness, Chronological order, and Confidentiality
- **B.** Conformity, Clarity, Completeness, Conciseness, Chronological order, and Creativity
- **C.** Client's words, Clarity, Completeness, Conciseness, Chronological order, and Confidentiality
- **D.** Client's words, Conformity, Cleanliness, Conciseness, Chronological order, and Confidentiality
- **E.** Client's words, Clarity, Conciseness, Conformity, Chronological order, and Confidentiality

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_____ 8. Conventional records are
- **A.** also called source-oriented records.
- **B.** also called POMR records.
- **C.** organized by problems of the patient.
- **D.** especially easy for tracking a specific ailment in a patient.

_____ 9. The P in SOAP documentation stands for
- **A.** purpose.
- **B.** procedures.
- **C.** physical.
- **D.** plan.

_____ 10. As a general rule, if information is not documented,
- **A.** it is not important.
- **B.** it is not useful.
- **C.** no one can prove that an event or procedure took place.
- **D.** it is illegal.

_____ 11. The S in SOAP documentation stands for
- **A.** subjective.
- **B.** serious.
- **C.** sensitive.
- **D.** statistics.

_____ 12. Original documentation
- **A.** is always selected instead of a copy to be given to the patient on request.
- **B.** cannot be faxed.
- **C.** legally belongs to the patient.
- **D.** legally belongs to the physician and belongs in the patient's medical chart.

_____ 13. Completeness in charting means
- **A.** using the patient's exact words.
- **B.** dating all entries into a chart.
- **C.** not leaving out information.
- **D.** using precise descriptions and accepted medical terminology.

_____ 14. The first form used in initiating a patient record is the
- **A.** informed consent form.
- **B.** doctor's diagnosis form.
- **C.** doctor's treatment form.
- **D.** patient registration form.

_____ 15. The term *noncompliant* means that the patient
- **A.** does not understand.
- **B.** does not hear well.
- **C.** is not literate.
- **D.** does not follow medical advice and direction.

_____ 16. When speaking with an older patient,
- **A.** show an interest in the patient as a person.
- **B.** speak clearly.
- **C.** be patient.
- **D.** All of the above

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_____ **17.** If a physician who is dictating speaks with an accent and you find it difficult to understand the dictation, you should

A. state you don't understand and stop.
B. ask others in the office if they understand the physician and ask them to take dictation.
C. record the dictation.
D. do the best you can.
E. ask the physician to speak more slowly than normal.

Sentence Completion

In the space provided, write the word or phrase that best completes each sentence.

18. The patient's past medical history, family medical history, and social and occupational history are included in a part of the chart called the _____.

19. It is important to date and _____ every entry you put in the patient chart so that it is easy to tell which items the medical assistant enters and which items other people enter.

20. When filling out patient charts, it is important to record patients' _____, not your interpretation of them.

21. To make chart data more concise, medical workers use standard medical abbreviations, such as "patient got _____" instead of "patient got out of bed."

22. All information in a patient's chart is _____, to protect the patient's privacy.

23. In a conventional, or source-oriented, record, all the patient's problems and treatments are recorded on the same form in _____ order.

24. In problem-oriented medical record keeping, each _____ is listed separately, making it easier for the physician to track a patient's progress.

25. When documenting problems, you must be careful to distinguish between signs, which are external factors that can be seen and measured, and symptoms, which are _____ that can be felt only by the patient.

26. Because the _____ of information in a patient's chart is important, check all information carefully before entering it.

27. The doctor's transcribed notes for the patient's chart should be initialed by the _____.

28. _____ provide physicians with easy access to patient information no matter where they are.

29. _____ charting describes a patient's condition by the use of four letters. The letters describe what the patient says, what the medical personnel see, an evaluation of the problem, and a directive for care.

30. _____ in medical records are not uncommon but must be changed immediately.

18. _____

19. _____

20. _____

21. _____

22. _____

23. _____

24. _____

25. _____

26. _____

27. _____

28. _____

29. _____

30. _____

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31. _____ means "to leave out."

32. _____ is the age at which most states consider an individual to be an adult.

33. To maintain patient _____, never discuss a patient's records, forward them to another office, fax them, or show them to anyone but the physician unless you have the patient's written permission to do so.

34. A _____ contains a record of the patient's history, information from the initial interview with the patient, all findings and results from physical exams, and any tests, x-rays, and other procedures.

35. In the _____, patient information is arranged according to who supplied the data—the patient, the doctor, a specialist, or someone else.

36. _____ means in the order of the date in which it occurred.

37. _____ means to be brief and to the point.

31. _____

32. _____

33. _____

34. _____

35. _____

36. _____

37. _____

Short Answer

Write the answer to each question on the lines provided.

38. Explain the difference between patient signs and symptoms. List three examples of each.

_____

_____

_____

39. Describe why it is so important to use care when making corrections to medical charts.

_____

_____

_____

40. List four additions that a physician might want to make to a patient's chart.

_____

_____

_____

41. List five tips for fast and accurate transcription of a doctor's recorded dictation.

_____

_____

_____

42. Describe the SOAP approach to medical record documentation.

_____

_____

_____

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43. List six common medical abbreviations that are difficult for you to remember.

_____

_____

_____

44. List six types of data contained in a patient's records.

_____

_____

_____

Critical Thinking

Write the answer to each question on the lines provided.

1. Why is it important to date every entry in the medical record?

_____

_____

_____

2. Do you think the advantages of computerizing medical records outweigh the disadvantages? Explain.

_____

_____

_____

3. What could happen if a medical record was subpoenaed to a court of law and the record was incomplete?

_____

_____

_____

4. Why do medical records include notes of all telephone calls to and from a patient?

_____

_____

_____

5. How do the rules of privacy for the release of a 15-year-old patient's medical records differ from the rules that apply to an 18-year-old's records?

_____

_____

_____

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APPLICATION

Follow the directions for the application.

1. Initiating a Patient Record

Work with two partners. Each of you should take turns being a medical assistant, a patient, and an observer/evaluator. Assume that this is the patient's first visit to the medical office.

a. Working together, create a model for a patient record. It must contain all the standard chart information, including forms for patient registration, patient medical history, and a physical exam. (You may use the forms shown in Figures 9-2 and 9-3 of the textbook as a guide.)

b. Have one partner play the role of the medical assistant and another partner play the role of a patient complaining of headaches. The third partner should act as the observer and evaluator. Have the medical assistant help the patient complete the patient registration form. Then have the medical assistant interview the patient and record the medical history, using standard abbreviations where appropriate, ending with a description of the patient's reason for the visit. The medical assistant should document any signs, symptoms, or other information the patient wishes to share.

c. Have the evaluator critique the interview and the documentation in the patient chart. The critique should take into account the accuracy of the documentation, the order in which the medical history was taken, and the history's completeness. The evaluator should also note the medical assistant's ability to follow the six Cs of charting, including the correct use of medical abbreviations.

d. The medical assistant, the patient, and the observer should discuss the observer's comments, noting the strengths and weaknesses of the interview and the quality of the documentation.

e. Exchange roles and repeat the exercise with a new patient. Allow the student playing the patient to choose a different medical problem.

f. Exchange roles again so that each member of the team has an opportunity to play the interviewer, the patient, and the observer once.

2. Correcting a Patient Record

a. Using the same patient information as in the model for a patient record created in Application 1, make a correction to three different parts of the record. Pay special attention to Procedure 9.2. Each team member should take turns making three corrections each.

b. Ask your instructor to review each correction and comment on your work. There should be no blacking out or the use of white correction fluid. All corrections should be clear and neat. All corrections should be dated and initialed. Make sure you indicate the reason you made the correction.

CASE STUDIES

Write your response to each case study on the lines provided.

Case 1

You accidentally throw out a sheet of a patient's medical chart. The trash has already been taken away, so there is no chance for you to get it back. You are new in the office, and you are afraid of losing your job if you tell the doctor what you have done. You remember the information that was on the sheet. You think you can easily rewrite it. What should you do?

_____

_____

_____

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Case 2

The doctor you work for reads information about her patients into a tape recorder. You then must transcribe the information and enter it into patient charts. The doctor has a pronounced accent, and many of her words are difficult for you to understand. How should you handle the situation?

_____

_____

_____

Case 3

A former patient of the doctor you work for calls and asks you to send her medical records to her new doctor. She says it is important that the records get to her new doctor by this afternoon and asks you to fax them. Would you have a problem with this request? Why or why not?

_____

_____

_____

Case 4

Dr. Smith receives laboratory results from a test performed on Mr. Jones. He calls Mr. Jones at home on Monday, July 6, at 10:00 A.M. He gets no answer, but he leaves a message on Mr. Jones's answering machine asking him to call the office. By 10:00 A.M. the next morning, Dr. Smith has received no answer from Mr. Jones. He calls again and reaches Mrs. Jones and asks her to have her husband call the office. Mr. Jones calls the doctor's office at 2:30 that afternoon. Dr. Smith discusses the test results with Mr. Jones and asks him to make an appointment for the following week. Mr. Jones is connected with the receptionist. He makes an appointment for 11:00 A.M. on July 12. As a medical assistant, how would you record this series of events in Mr. Jones's chart?

_____

_____

_____

Procedure Competency Checklists

PROCEDURE 9.1 PREPARING A PATIENT MEDICAL RECORD/CHART

Procedure Goal

To assemble new patient record/charts

Scoring System

To score each step, use the following scoring system:
1 = poor, 2 = fair, 3 = good, 4 = excellent

A minimum score of at least a 3 must be achieved on **each** step to achieve successful completion of the technique. Detailed instructions on the scoring system are found on page x of the Preface.

Materials

File folder, labels as appropriate (alphabet, numbers, dates, insurance, allergies, etc.), forms (patient information, advance directives, physician progress notes, referrals, laboratory forms), hole punch