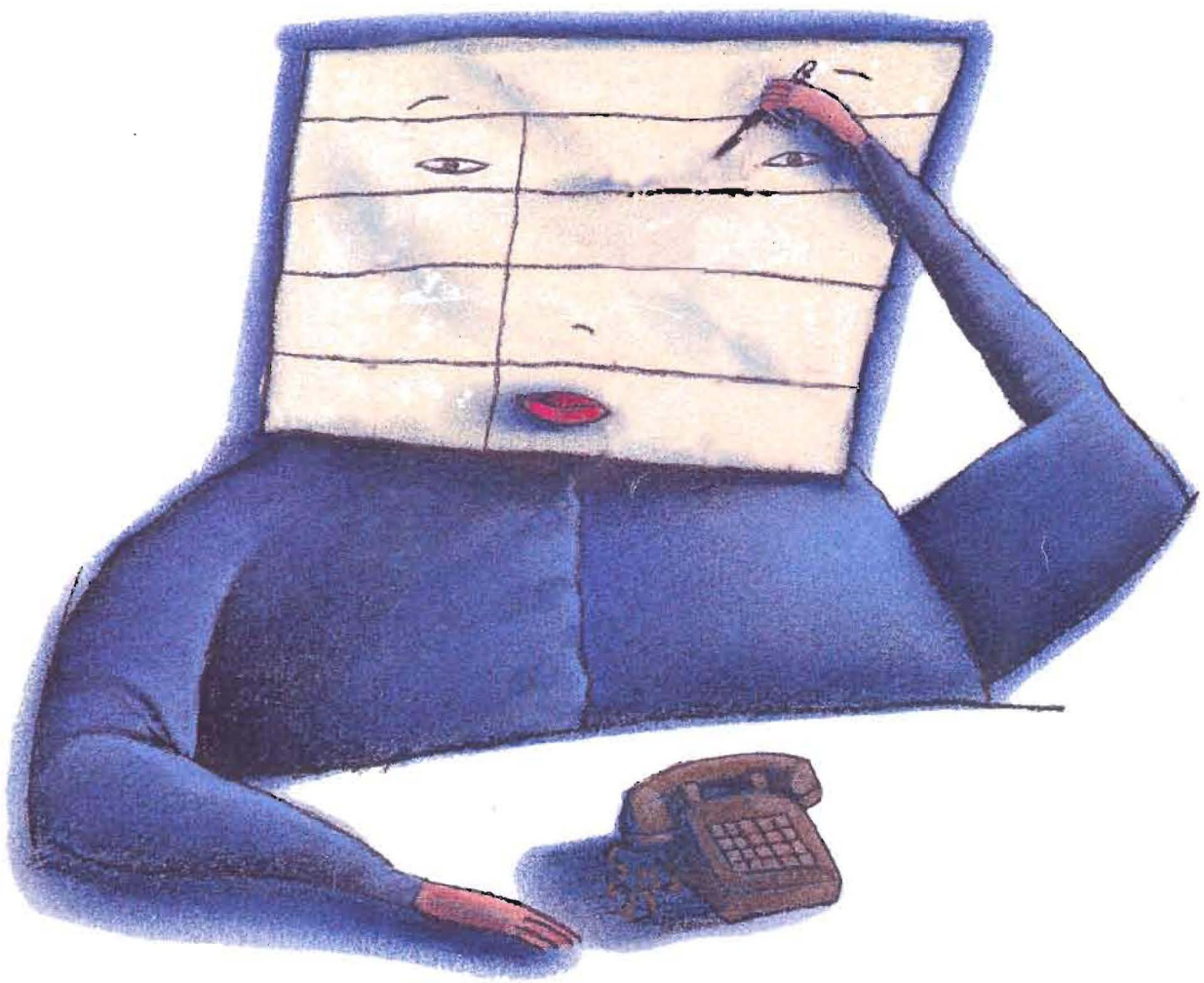
DOCUMENTATION AND TELEPHONE SCREENING



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DOCUMENTATION AND TELEPHONE SCREENING

11 CEUs (1 gen, 4 adm, 6 clin)

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Contents

Introduction

The purpose of this course is twofold: to teach what documentation (charting) is and how to do it. In the first part, the different types of documentation records—such as the medical record, telephone calls, prescription requests and consent forms—are introduced and reviewed. The second part explains how to document and screen patient symptoms and how to assign levels of care based on predetermined guidelines or physicians' authorized protocols.

Upon completion of this course the student should be able to do the following:

1. Document using correct charting format and abbreviations.
2. Document prescription requests using acceptable format.
3. Document appointment requests, cancellations and no-shows.
4. Screen telephone calls to schedule and assign appointments, based on predetermined guidelines.
5. Document telephone screening and scheduling of appointments.

Unit I

Documentation

Upon completion of this unit you should be able to do the following:

1. Define the term "documentation."
2. List at least three types of documentation.
3. List four purposes of documentation.
4. Document a patient's complaint, using the SOAP method.

"Documentation" refers to written proof that the patient has received the medical care ordered by the practitioner. Remember: "If it isn't written down, it did not happen."

Types of Documentation

This study will teach you how to make written documents that record the care you give in the medical office. Some of the written documents that are found in a patient's medical chart are as follows:

- Physician's progress notes
- Physician's orders
- Transcription records
- History and physical examination records
- X-ray and laboratory reports
- Charting notes by medical staff
- Insurance billings
- Encounter forms

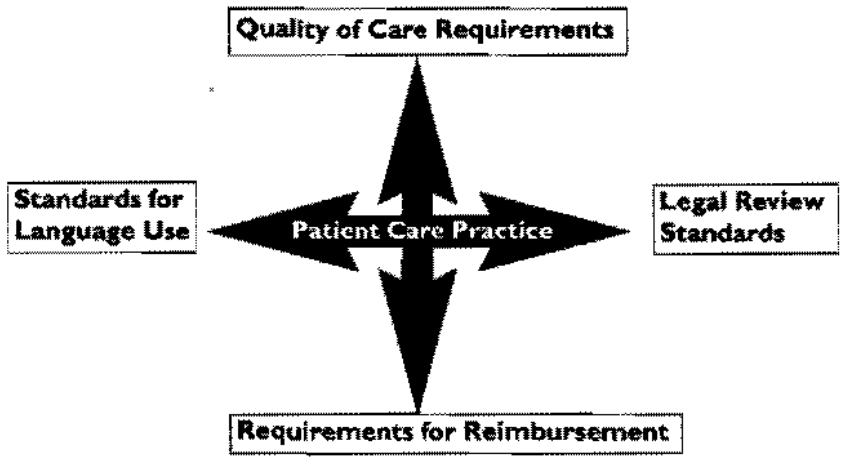
The patient's chart—the medical record—is a legal document. It is the basis for the accountant who bills the patient. It is a record of the course of an illness, the treatment prescribed and the patient's response to the treatment. In the event of controversy in any of those areas, the chart is consulted for evidence of the facts. The medical record must be an accurate, legible narrative of the care given and the charges made. There must be a record of what was done and who performed the service. If it isn't written down, it did not happen!

Documentation Model: Patient Care Practices

There are four purposes (elements) of the documentation model. These four purposes interrelate to support complete and accurate documentation. Only written documentation will confirm that the standard of care was rendered, whatever the patient outcome.[1]

Only one of the four elements of the documentation model relates directly to patient care. This element is "quality of care requirements" and concerns those aspects, both expected and unexpected, of the patient's care that occurred during the patient's visit to the medical setting. The other three elements of the documentation model are standards for language use in charting, requirements for reimbursement, and legal standards for chart review.

Documentation Model



Quality of Care Requirements

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the American Association of Medical Assistants (AAMA) are two entities that define standards of practice for health care facilities and medical assistants, respectively. All medical assistants must abide by those standards, whether they are aware of the standards or not. Quality of care requirements have been defined by these regulating bodies, and a medical assistant is responsible for observing charting practices that support the defined patient care standard.

The medical assistant is responsible for maintaining and documenting the expected standard of care. The documentation model is concerned with the question: How does a medical assistant chart what is necessary and expected in order to demonstrate that safe patient care was administered?

The first element of the documentation model, "quality of care requirements,"[1] is about knowing the standard for care as well as being able to use words that describe the standard of care given to the patient. As patient care progresses or patient events and outcomes occur, entries into the medical record provide the dimensions and details of the quality of care rendered.

The chart notes "tell" the story of the care given or the plans for the care to be given. The key concept with quality of care is, in fact, quality.[1]

Standards for Language in Documentation

The second element of the model involves the standards for language used in documentation. It also involves reviewing the manner in which words are actually put on paper. Your charting must provide an appropriate description of what transpired, what the patient needed and whether any events occurred outside of what is typically routine or expected. It should also indicate whether care was given in a timely and sequential manner. Both common and technical terms must be used to document a sequence of patient events.[1]

The key to these rules for charting is the correct application of language to describe events. Correct spelling, proper use of grammar and punctuation, use of facility-approved abbreviations and familiarity with the policies that the facility uses are all vital to the successful execution of this element.

Legal Standards of Review

The third element of the documentation model, legal standards of review, involves the legal aspects of health care and charting. The focus of this element is on charting practices that are specifically organized to support and record standard of care. How is documentation related to patient events, care and case reviews? Documentation in the medical record is acknowledged to be the primary means with which to review and to evaluate patient occurrences. The patient's chart is a legal record of the patient's care. As such, the aspects of charting become central and relevant in the event that a chart is pulled for legal review. The medical assistant lays the foundation for excellence in practice by using a systematic method for patient assessment and planning care, as well as for documentation. Documentation is the unifying factor between practice and patient care. Language use is the key in documentation. Medical assistants need and use systems to provide care. Documentation models also need a systematic approach. Complete, objective and standardized charting represents a medical assistant's performance and attention to the quality and legal aspects of patient care responsibilities.

The medical record is no place for inadequate or inaccurate documentation. Many lawsuits involve aspects of malpractice or negligence. Negligence can be errors of commission or errors of omission (ie, acts the medical assistant did or failed to do), which fell below the expected standard of care.

Reimbursement

The last element of the documentation model relates to the business and financial matters of patient care. A well-documented patient chart can reduce many problems in the health care system. Charting entries must precisely mirror services provided. Centers for Medicare and Medicaid Services (CMS) regulations

are very specific as to language that must appear in the patient's record related to reimbursement.

A key component is the necessity of documenting the patient's primary complaint and the history of that complaint. In many settings, a medical assistant interviews the patient for chief complaint (CC) and history of the present illness (HPI). A review of systems (ROS) and personal and social history (P/SH) may also be discussed with the patient. The manner and thoroughness with which a medical assistant documents the CC, HPI, ROS and P/SH will affect what services the patient is charged for.

Physician and health care facility reimbursement "tracks" are not one and the same, although regulations for reimbursement generally apply equally to both physician and facility. Documentation is directly connected to monetary reimbursement. More complete documentation can result in higher reimbursements. However, physician and facility charges must be accurate and in accordance with regulations.

There are also branches of the government and Medicare dedicated to protecting payer rights and interests. Their responsibility is to determine medical necessity and to match payment with event. In all such cases, the source for information related to the event is the patient's medical record.

Unit 1 Worksheet

1. Define "documentation."

2. Give four purposes of the documentation model.
   a.
   b.
   c.
   d.

3. Give at least three examples of documentation.
   a.
   b.
   c.

Circle the correct answer to the following:

4. The element of documentation that relates directly to patient care is:
   a. Standards for language use
   b. Legal review standards
   c. Quality of care requirements
   d. Requirements for reimbursements

5. The entity that defines the "standard of care" to be rendered by a medical assistant is:
   a. AAMA
   b. AMA
   c. Hospital administrator
   d. Nurse practice acts

6. _____ is the key in documentation.
   a. Reimbursements
   b. Printing
   c. Language
   d. Spelling

7. The documentation element that relates to the business end of health care is:
   a. Standards for language use
   b. Legal review standards
   c. Quality of care requirements
   d. Requirements for reimbursement

8. The element of the documentation model that involves the legal aspects of health care and charting is:
   a. Standards for language use
   b. Legal standards of review
   c. Quality of care requirements
   d. Reimbursement requirements.

9. Give the abbreviation for the following phrases:

History of present illness: _____

Review of systems: _____

Personal and social history: _____

Chief complaint: _____

Unit 2

Medical Records: Formats

Upon completion of this unit you should be able to do the following:

1. Distinguish between source-oriented and problem-oriented medical record charting.
2. Chart using the "SOAP" method.
3. Name the advantages and disadvantages of traditional methods of charting.
4. List five parts of a problem-oriented medical record.

As a medical assistant, you will be concerned with clinical medical records. Medical records are kept for every patient who steps through the door of a health care facility. Every medical record provides evidence of the quality of patient care given. All records are not alike. Some are organized by a source-oriented narrative method, some by a problem-oriented method and others by variations of these two.

Source-Oriented Narrative Method

The source-oriented narrative method allows caregivers (the source) from each discipline a separate section of the medical record in which to record information. For example, there is a section for "Progress Notes," one for "Laboratory Reports," one for "X rays" and so on.

This traditional method of documentation has the following drawbacks:

1. Charting is done in various parts of the record and information is disjointed.
2. Topics are not always clearly identified.
3. Information is difficult to retrieve. This keeps medical personnel from getting a complete picture of the patient's care and causes breakdowns in communication.

Typically, physicians are the only persons who write the progress notes in this type of charting. Other staff will have a separate section for their documentation of patient care.

An improved version allows for collaborations among medical personnel who use source-oriented narrative charting. All medical professionals involved in the care of a patient write their notes on the same progress notes form. For example, doctors, nurses, medical assistants, and others record their notes here. These patient progress notes serve as the primary source of reference and communication among health care team members.[2]

The charting for a source-oriented chart is called "factual" charting. The charter states in narrative form what has occurred. For example, a mother calls in and tells you that her child has a high fever and runny nose. The chart would read thus:

8/8/xx	9:00 a.m. Mother called. Pt has temperature of 104°F orally-------
	and a runny nose. Nasal discharge is yellow. Baby unable to-------
	nurse. Advised to come in at 10:00 a.m. today----------
	P. Krueger, CMA----------

Factual charting works well if the person charting has training and is experienced in charting in a systematic manner.

Problem-Oriented Method

A problem-oriented medical record (POMR) contains baseline data obtained from all departments involved in a patient's care. The problem-oriented charting method is based on the patient's complaints and illness. The POMR is divided into five parts: (1) the database; (2) a problem list; (3) a care plan for each problem; (4) progress notes; and (5) a discharge summary. In POMR charting, you record your interventions in the progress notes only. To understand the POMR, let us review its parts.

Database

The database is the foundation for the patient's plan of care. It is a collection of subjective and objective information about the patient, the medical history, allergies, medication regimen, physical and psychological findings and the present complaint. The database is usually completed by the physician.

Problem List

The problem list is obtained from baseline data and is used to construct a care plan. Each symptom (complaint) that the patient reports is given a number, and all care for that numbered symptom is recorded and filed at the front of the patient's chart. You will see this problem list primarily in long-term settings. The following chart shows a problem list for a patient.

#	Date	Problem Statement	Initials	Resolved
1	7/4/xx	Vomiting/fluid loss, dehydration		
2	7/4/xx	Pain		
3	7/4/xx	Anorexia		

Care Plan for Each Problem

The care plan in a POMR addresses each of the patient's problems. Each problem is routinely updated both in the plan and in the progress notes. Once you've resolved a problem, draw a line through it. Or you can show that it is inactive by retiring the problem number and highlighting the problem with a colored felt-tip pen. That number is not used again for the same patient.[2]

Progress Notes: SOAP Format

In today's medical office, the POMR is organized to make medical problems and their history (Hx) readily accessible to the physician. Clinical records include the patient chart, where all examination results are noted in the progress notes. One of the most prominent features of the POMR is the structured way in which the narrative progress notes are written by all caregivers, using the SOAP, SOAPIE or SOAPIER format. The following table is an example of what is called "SOAPing."

Letter	Definition	Example
S	Subjective data	Subjective complaints, or symptoms (Sx), are those obtained directly from the patient. These entries should be made after the chief complaint (CC) or "complains of" (C/O) notation on the progress notes.
O	Objective data	Factual, measurable data you gather during assessment, such as observed signs and symptoms, vital signs (VS), laboratory test values and ECG results.
A	Assessment data or diagnosis (Dx)	Conclusions based on the subjective and objective data from your physician's evaluation. In the absence of a firm Dx, she/he may only be able to form an impression (imp) of the problem. She/he may have to proceed by eliminating or ruling out (R/O) different problems before a firm Dx can be established.
P	Plan of action	Based on the Sx, examination, and test results. Your physician will determine patient treatment (Tx). This may include medication (Rx or meds), further testing, diet, physical therapy (PT), and follow-up (FU) visits.
	Some additional charting may include the following:	
I	Intervention	Measures you take to achieve an expected outcome. As the patient's health status changes, this may need to be changed. Be sure to document the patient's understanding and acceptance of the initial plan in this section.
E	Evaluation	Analysis of the effectiveness of your interventions.
R	Revision	Documentation of any changes from the original plan of care in this section.

It is not necessary to write an entry for each SOAP component every time you document. If you have nothing to record for a component, either omit the letter from the note or leave a blank space after it, depending on your facility's policy.[2] The purpose of SOAP is to help you to systematically organize your documentation to show the care that you gave to the patient.

The following chart is an example of POMR progress notes.

Date	Time	Chart Notes
7/4/xx	0900	S: Pt sts "I am having back pain again."----------
		O: Pt sts pain is 9 on 1-10 scale; skin is warm, pale, and moist. Restless; pacing in room holding right flank area with his hand; c/o nausea----------
		A: Pt in severe pain; needs relief----------
		P: Checked with doctor; check allergies; take VS------
		I: BP: 158/80, P 104, R 24. Gave Tylenol ii Tabs as ordered by MD----------
		E: Relief obtained after 15 min. No nausea. Reviewed Rx directions for pain med. P. Krueger, CMA
7/5/xx	1300	S: Pt sts "I have never had surgery before"----------
		O: Pt is unsure about what to expect----------
		A: Pt needs preop and postop education.----------
		P: Teach Pt about events before and after surgery. Explain why these are important. Evaluate Pt's response to the teaching and document.----------P. Krueger, CMA

Observe the following from the above sample:

1. Use proper abbreviations throughout the charting (documenting).
2. End every line at the margin or draw a line to the end of the row. This protects you as the caregiver. You are responsible for all information recorded before your signature. If you draw a line through the blank area to the margin, no one can enter information that you would be held responsible for.
3. Always sign your documentation with your name. The preferred signature is your first initial and last name. Some facilities use initials in charting; if this is the case, then there must be a page in the chart on which the caregiver signs his/her full name and whatever initials he/she may use.
4. Use your credentials. Credentials lend credibility to your work.

POMR charting has the following advantages:

- Information about each problem is organized into specific categories that all caregivers can understand. This eases data retrieval and communication between disciplines. In today's medical office, POMRs are organized to make medical problems and their history readily accessible to the physician. Clinical records include the patient chart, where all examination results are noted in the progress notes. Test results—such as lab tests, X-rays, electrocardiography, pulmonary function tests, surgical and hospital records—are a few of the clinical records obtained in your office from an outside source. These should be filed as soon as possible after the physician has seen them. Never file this type of record until it has been reviewed and initialed by your physician.
- Continuity of care is shown by combining the plan of care and progress notes into a complete record of the care that is planned and the care that is delivered.
- It encourages documentation that is consistent and essential.

The POMR system has the following disadvantages:

- The emphasis on the chronology of problems, rather than their priority, may cause caregivers to disagree about which problems to list.
- Both assessments and interventions apply to more than one problem, so charting of these findings is repetitious, especially if the SOAP format is used. This makes documentation time consuming to perform and to read.
- The format does not work well in settings with rapid patient turnover.
- Considerable time and cost are needed to train people to use the SOAP method.

Discharge Summary

The discharge summary covers each problem on the list and notes whether it was resolved. This is the place in your SOAP note to discuss any unresolved problems and to outline your plan for dealing with the problem. This section is usually charting done by the practitioner. It is an essential part of charting in an acute care setting.

In some offices entries are made directly into the progress notes; in others, a note is attached to the front of the chart for this information, and the physician will make all entries. As you practice the skills in the following lessons, you will make your own charting entries using appropriate abbreviations.

Abbreviations will be presented throughout your lessons. Abbreviations are standardized clinical shorthand that will save you time and ensure understanding by anyone requiring access to the patient chart.

Abbreviations

C/O	Complaining of
CC	Chief complaint(s)
Dx	Diagnosis
ECG	Electrocardiogram
FU	Follow-up
Imp	Impression
POMR	Problem-oriented medical record
PT	Physical therapy
R/O	Rule out
Rx	Prescription
SOAP	Method of organized charting format done on progress notes
	S = Subjective information
	O = Objective information
	A = Assessment data
	P = Plan of action
Sts	States
Sx	Symptom(s)
Tx	Treatment, therapy
VS, V/S	Vital signs
Hx	History

Unit 2 Worksheet

1. Name two types of medical records used in health care facilities.
   a.
   b.

2. What are three disadvantages of the traditional method of documentation?
   a.
   b.
   c.

3. Give the meaning for the acronym SOAP.
   a. S
   b. O
   c. A
   d. P

4. List five parts of a POMR.
   a.
   b.
   c.
   d.
   e.

Circle the correct answer to the following:

5. Which type of medical record organizes information about specific problems into categories?
   a. Traditional medical record
   b. Source-oriented medical record
   c. Problem-oriented medical record
   d. Progress notes

6. Which area discusses unresolved problems and outlines the plan for dealing with the problems?
   a. Database
   b. Problem list
   c. Discharge summary
   d. Progress notes

7. Which area of charting would contain the CC?
   a. Subjective
   b. Objective
   c. Assessment
   d. Plan

8. Which type of documentation format takes considerable time and cost to train people?
   a. Source-oriented charting
   b. SOAP charting
   c. Traditional charting

9. Give the appropriate abbreviation for the following phrases:
   a. Problem-oriented medical record
   b. Diagnosis
   c. Symptoms
   d. Rule out
   e. Vital Signs
   f. Treatment
   g. Follow-up

Practice Documentation: A patient calls the office at 10:00 a.m. on August 8, 20xx complaining of a severe sore throat. She has taken two Tylenol tablets and has received no relief. Her oral temperature is 101°F. She has had the sore throat and fever for 3 days.

Documentation:

		S:
		O:
		A:
		P:

Unit 3

Medical Records: Documents

Upon completion of this unit you should be able to do the following:

1. List what information must be recorded (documented) on the patient's chart.
2. Tell what is meant by "scope of practice."
3. Name two types of information that can be given without the patient's consent.
4. Name four ways that a medical assistant can prevent a malpractice claim.

Documentation of medical care starts when the client walks into the office. The visit record must contain the patient's correct name and other identifying information. The medical assistant is frequently the first person to meet the patient. After introducing him/herself to the patient, the medical assistant enters on the medical chart the patient's reason for the visit. This is referred to as the chief complaint (CC). Observations by the medical assistant and the patient's vital signs (VS) are also recorded on the medical chart.[3]

Medical records include records of the patient's clinical medical treatment, as well as administrative records (eg, insurance billing and correspondence). Previous records obtained from another physician or facility would be considered clinical records and should be filed in the patient chart. All records are legal documents admissible in a court of law and should be completed with black ink or typed. Blue ink is sometimes used to distinguish the original record from a photocopy. Each facility will determine its policy on the ink color. Records are protected by the patient's right to privacy, referred to as "confidentiality." They should not be revealed to anyone outside the office without the patient's written permission, in the form of an authorization for release of information. Failure to observe patient confidentiality could result in a lawsuit. Your utmost concerns should be to preserve confidentiality, and to protect the patient and your practice.[4] The patient has an absolute right to confidentiality. Information that is given to the physician or to others involved in the patient's care may not be given to anyone else without the patient's permission, with two exceptions: (1) when requested by subpoena or court order; and (2) when there is a reportable injury or illness.

Reportable Injuries

Injuries like knife wounds and gunshot wounds must be reported according to local regulations and statutes. Injuries that appear to be due to child or spousal abuse must also be reported. Failure to report suspected child abuse is a felony in several states. Recently there has been an increase in the abuse of elderly people by their caregivers. This may be because people are living longer and with more physical and mental disabilities. These incidents should be reported to police departments. Most facilities will have a special form to complete to report these injuries. A copy of the form must be kept in the patient's chart. If

there is no form, then write in the chart the date, time, type of injury and to whom it was reported, and sign your name, with credentials.

Reportable Illnesses

Diseases that represent potential threats to the public health must also be reported. The list of reportable diseases includes most contagious diseases, like measles, mumps, and chickenpox. More serious threats on the list include tuberculosis and hepatitis. Sexually transmitted diseases (STDs), like syphilis and gonorrhea, are not only reportable, but public health epidemiologists may consult the patients for lists of their sexual partners to identify untreated individuals. Diseases in this category are reported to local public health departments. Health departments usually have a form that is used for reporting specific diseases. This form should be completed in duplicate or copied and put in the chart. You should enter in the chart notes the date, time and to whom the report was sent, and sign your name, with your credentials.

Except for the above-cited conditions, patients have the right to be confident that their charts will be accessible only to personnel who are involved in their care. If computers are used to track patients, laboratory data, appointments and other information, care should be taken to control access to those computers. Computers and charts should be located so that other patients cannot read confidential information.[3]

Malpractice

A physician may be accused of malpractice if he/she is thought to be negligent. Negligence occurs when someone fails to perform actions that would be performed by any prudent and reasonable person with similar experience and education. A medical assistant is held to that standard. The medical assistant is also held to practice within what the law allows, the "scope of practice."
A malpractice complaint is a type of "tort." A tort is a civil action (other than breach of contract) as opposed to a violation of the criminal code.

The legal request for an individual to testify in a court of law is a subpoena. Medical records can also be subpoenaed, which is a compelling reason to be sure that the medical record accurately documents everything that was done to and for a patient.[3]

Medical assistants can protect themselves from malpractice by observing the following guidelines:

- Always practice within the law.
- Preserve the patient's confidentiality.
- Maintain meticulous records.
- Obtain informed, written consent.

In summary, all records are legal documents admissible in a court of law and should be completed with black or blue ink or typed. Records are protected by the patient's right to privacy. They should not be discussed with or revealed to anyone outside the office without written authorization by the patient. Failure to observe patient confidentiality could result in a lawsuit.

Unit 3 Worksheet

1. What is "scope of practice"?

2. When can information be given without patient consent?

3. What color of ink is used for documentation?

4. What four things can medical assistants do to prevent a malpractice claim against them and the physician's office?

5. Complete this statement:
   If it isn't written down, _____!

Unit 4
Charting

Upon completion of this unit you should be able to do the following:

1. List and define the six Cs of charting.
2. Correct patient records using acceptable legal procedures.
3. Update medical records following acceptable legal procedures.
4. Use selected abbreviations for conciseness of charting.

The Six Cs of Charting

In this unit you will learn how to chart (document). Always keep the following six Cs in mind when filling out and maintaining charts:

- Client's (patient's) words
- Clarity
- Completeness
- Conciseness
- Chronological order
- Confidentiality

Client's Words

A patient's complaint or symptom should be recorded on the chart in the patient's exact words, rather than your interpretation of them. For example, if a client says, "My right knee feels like it's thick or full of fluid," write that down. Do not rephrase the sentence to say, "Client says he's got fluid on the knee." Often the patient's exact words, no matter how odd they may sound, provide important clues for the physician in making a diagnosis.[5]

In SOAP charting, this would be recorded as the "S" (subjective) documentation. Be sure to put whatever the patient says in quotation marks.

Clarity

It is important that you use precise descriptions and accepted medical terminology when describing a patient's condition. For example, "Patient got out of bed and walked 20 feet without shortness of breath" is much clearer than "Patient got out of bed and felt fine."

Completeness

You must completely fill out all forms used in the patient record. Provide complete information that is understandable to others whenever you make any notation in the patient chart. If there is not an answer for the item on the form, indicate "N/A" (not applicable). Do not leave any spaces without some note as to why it is blank. Be sure to sign your name, with credentials, on any form that you have completed.

Conciseness

Abbreviations and specific medical terminology can save time and space when recording information. Your charting should be clear, brief and to the point. Using the above example, you could write, "Pt got OOB and walked 20 ft without SOB." "OOB" and "SOB" are standard abbreviations for "out of bed" and "shortness of breath." Every member of the office staff should use the same list of approved abbreviations to avoid misunderstandings.

Abbreviations are not used willy-nilly. The health care facility should have a list of abbreviations that have been adopted for use in all documentation. JCAHO has set this as one of the standards of care that must be followed by medical organizations. Abbreviations are included in most units, to help you to learn the more common ones used by health care facilities.

Chronological Order

All entries in patient records must be dated to show the order in which they were made. This factor is critical, not only for documenting patient care, but also in case there is a legal question about the type and date of medical services. Sometimes a medical assistant may omit, or forget to include, pertinent facts and information at the time of initial charting and wants to include this information at a later time. When this happens, very clearly indicate that this is a late entry. Do not write in the margins or above existing charting, as this is a red flag to lawyers that proper care may not have been given. You would write the date and time you are entering the late entry, then write "late entry" and proceed with your charting. This will indicate clearly and precisely why you are charting "out of chronological order." An example of a late entry follows.

10/18/xx	1400. Late entry. Pt ambulated at 1000 no c/o SOB, but did feel dizzy and nauseated. Dr. Smith notified. J. Smith, CMA

Confidentiality

All entries in patient records and forms are confidential, to protect the patient's privacy. Only the patient, attending physicians and the medical assistant (who needs the record to tend to the patient and/or to make entries into the record) are allowed to see the charts without the patient's written consent. You should never discuss a patient's record, forward it to another office, fax it or show it to anyone other than the physician unless you have the patient's written permission to do so.

Appearance, Timeliness and Accuracy of Records

The medical assistant must ensure that the medical records are complete. They must be written neatly and legibly, contain up-to-date information and present an accurate, professional record of a patient's case.

Neatness and Legibility

A medical record is useless if the doctor or others have difficulty reading it. You should make sure that every word and number in the record is clear and legible. Here are some guidelines that will assist you in keeping your charts neat and easy to read:

1. Use a good-quality pen that will not smudge or smear. Black ink is preferred, but blue is sometimes used to distinguish the original record from a photocopy. Highlighters are used to call attention to specific items, such as allergies or abnormal lab values. Be aware that unless the office has a color copier, most colored ink will photocopy gray or black. Highlighting pen marks may not be visible on a photocopy.
2. Make sure that all handwriting is legible. Take time to write names, numbers and abbreviations clearly.[5]

Timeliness

Medical records should be kept up-to-date and should be readily available when a doctor or another health care professional needs to see them. The following guidelines will ensure that a doctor can find the most recent information on a patient when it is needed:

1. Record all findings from examinations and tests as soon as they are available.
2. If you forget to enter a finding into the record when it is received, record both the original date of receipt and the date the finding was entered into the record.
3. Document telephone calls. You can either enter the telephone call directly into the record or make a note referring the doctor to a separate telephone log kept in the record. You will learn how to document telephone calls in greater detail in Units 7 and 8 of this study guide.

Establish a procedure for retrieving a file quickly in case of emergency. If the patient should be in a serious accident, the emergency doctor would need the patient's medical history immediately.[5]

Accuracy

The physician must be able to trust the accuracy of the information in the medical record. You must make it a priority to always check the accuracy of all data you enter in a chart. To ensure accuracy, follow these guidelines:

1. Never guess or assume knowledge of names, procedures, medications, findings or any other information about which there might be a question. Always double-check all the information carefully. Ask questions of the physician or other staff to verify information.
2. Double-check the accuracy of all findings and instructions recorded in the chart. Have all numbers been copied correctly? Are instructions for taking medication clear and complete?
3. Make sure the latest information has been entered into the chart so that the physician has an accurate picture of the patient's current condition.

Part of creating timely, accurate records is maintaining a professional tone in your writing when recording information. As stated earlier, record information from the patient in his/her own words. Also record your observations and comments as well as any laboratory or test results. Do not record your personal, subjective comments, judgments, opinions or speculations about a patient's words, problems or test results. You may call attention to a particular problem or observation by attaching a note to the chart. Do not make such comments part of the patient's record.[5] As an example, "Pt called again, wants pain med for backache. This is the third time this month the patient has called. She is probably a drug seeker."

Correcting and Updating Patient Records

In legal terms, medical records are regarded as having been created in "due course." All information in the record should be entered at the time of a patient's visit and not days, weeks or months later. Information corrected or added some time after a patient's visit can be regarded as "convenient" and may damage a doctor's position in a lawsuit.[5]

If changes to the medical record are not done correctly, the record can become a legal problem for the physician. A physician may be able to more easily explain poor or incomplete documentation than a chart that appears to have been altered after something was originally documented. You must be extremely careful to follow the appropriate procedures for correcting medical records.

Mistakes in medical records are not uncommon. The best defense is to correct the mistake immediately or as soon as possible after the entry was made. The following procedure shows you how to correct the patient record.

Procedure for Correcting Medical Records

- Always make a correction in a way that does not suggest any intention to deceive, cover up, alter or add information to conceal a lack of proper medical care.
- When deleting information, never black it out, never use correction fluid to cover it up and never in any way erase or obliterate the original wording. Draw a single line through the original information so that it is still legible. Many charters will cross out just one letter and try to scribble over the top of it the correct letter. This is legally unwise. Watch yourself carefully if you have a tendency to want to correct a misspelled word this way.
- Write or type in the correct information above or to the right of the original line. The location on the chart for the new information should be clear. You may need to attach another sheet of paper or another document with the correction on it. Do not discard the original. Note in the record, "See attached document A" or similar wording to indicate where the corrected information can be found.
- Place a note near the correction stating why it was made. For example, "error," "wrong date" or "mistaken entry." This indication can be a brief note in the margin or an attachment to the record. As a general rule, do not make any changes without noting the reason for them. Some facilities are adopting the policy to write "mistaken entry" rather than "error" when making corrections, as the word "error" may imply medical negligence or may mark the chart with a red flag if an attorney reads it.
- Enter the date and time, and initial the correction.

In summary, the medical assistant must properly prepare and maintain patient records. Patient records, also known as charts, contain important information about a patient's medical history and present condition. Patient records serve as communication tools as well as legal documents. They also play a role in patient and staff education and may be used for quality control and research.

You should be familiar with the most common methods for documenting patient information, which include the conventional, or source-oriented, and POMR approaches. You must ensure not only that the medical records are complete but also that they are neat and legibly written, contain up-to-date information and present an accurate, professional record of a patient's case. In addition, you must know the guidelines for how to correct and update a patient record.[5]

Unit 4 Worksheet

1. List the six Cs of charting:
   a.
   b.
   c.
   d.
   e.
   f.

2. How do you know what abbreviations to use in your charting?

3. What do you do if you charted and later in the day or the next day remember an important fact that should be noted?

4. What are some guidelines that will assist in keeping charts neat and easy to read?

5. What does the term "due course" mean when referring to medical documentation?

6. Correct the following:

8/8/xx	9:45 a.m. Pt called and said that she was nosious and vomitting. P. Smith, CMA

7. Chart the following: You may use SOAP or factual charting.
   a. Patient called at 8:00 a.m. because she had the worst headache of her life.

   b. Patient called at 4:30 in the afternoon because he had pain in his back and blood in his urine. He tells you he cannot stand to sit or lie down and just has to keep walking around.

Circle the correct answer to the following:

8. In SOAP charting, the client's words are recorded in which area?
   a. Subjective
   b. Objective
   c. Assessment/Action
   d. Plan

9. Which abbreviation is incorrect?
   a. SOB for shortness of breath
   b. Pat. for patient
   c. OOB for out of bed
   d. s for without

10. When correcting an error, one should:
   a. White out the mistake.
   b. Black out any letters and rewrite.
   c. Use a single line through the error.
   d. Erase and rewrite.

11. Charting should be done in which of the following ways?
   a. In red ink, so it stands out.
   b. In pencil, so you can correct more easily.
   c. In black ink, for ease of photocopying.
   d. Only on a computer or typewriter.

12. Errors can be denoted by entries such as:
    a. Oops
    b. Sorry
    c. Frowning face
    d. Error, or "wrong entry"

13. If you misspell a word in charting, what should you do?
    a. Leave it alone.
    b. Cross it out and rewrite it above.
    c. Cross it out and insert the correct spelling above all other charting.
    d. Draw a single line through the misspelled word, insert the date and your initials, and rewrite the word.

Unit 5

Medical Records: Forms

Upon completion of this unit you should be able to do the following:

1. Tell how to document consent forms.
2. Document facsimile (FAX) reports.
3. Document medication requests.
4. Document appointments, cancellations and no-shows.

The medical record is probably the most significant documentation that the medical assistant will have to complete. Medical records provide an ongoing account of all patient interactions with the office staff and physicians. Information here should include both subjective and objective findings. Subjective data include information that the patient provides about how an event occurred, how the patient feels and how the patient is responding to treatment. The best way to chart subjective data is to quote the patient directly. Objective data are observable conditions or results of testing. The medical record should include a comprehensive patient history and information that provides the patient with the best care possible. Patient activities, such as smoking habits, exercise and nutrition, should be noted, and changes should be brought to the attention of the physician. The plan for care should be dictated by the physician and should include any expected follow-up needed.[4]

Because of the very extensive and personal nature of the medical chart, preserving the confidentiality of this information becomes one of the medical assistant's top responsibilities. No one, including family members, should be given information from within this chart unless express written consent is given by the patient. (Children are considered minors, and a parent is allowed to access this information as the legal guardian.)

Release of Medical Information

Medical information to be released includes any medical information leaving the office. Common situations in which a release of information is required are: (1) when information goes to insurance companies for billing purposes, (2) when information goes to other physicians for referrals or consultations, and (3) when patients are transferred to another office. The patient's written authorization for releasing this information to persons directly involved with patient care is obtained at the time of the first office visit. It can be on the initial patient history form or on a separate paper.

Informed Consent

Documentation of informed consent becomes an important part of the medical records. Every patient has a right to know and understand any procedure to be performed. In language that is easily understood, the patient should be told the following:

1. The nature of any procedure and how it is to be performed.
2. Any possible risks involved as well as expected outcomes of the procedure.
3. Any any other methods of treatment and those risks.
4. The risks if no treatment is given.

Often, consent forms will be signed if a surgical or invasive procedure is to be performed. The medical assistant may be asked to witness the patient's signature and may be expected to explain the procedure to the patient. The signed consent form is kept in the medical chart and a copy is also given to the patient.[7]

Implied Consent

Implied consent occurs when there is a life-threatening emergency or the patient is unconscious or unable to respond. The physician, by law, is allowed to give treatment without a signed consent. The care given is carefully documented, as well as the patient's condition and why the patient could not sign a consent form. Implied consent occurs in more subtle ways. The patient who rolls up a shirtsleeve for the medical assistant to take a blood pressure reading is implying consent to the procedure by the action taken.

Subpoena Duces Tecum

A subpoena is an order for copies of materials that may be related to litigation. The subpoena is hand delivered, and copies should be made immediately. A subpoena duces tecum requires that the physician physically bring the original chart to be examined. This is the one situation in which the original chart might leave the office, and a copy should remain within the office until the original can be returned. Documentation should indicate when and to whom the chart was delivered. For example: 8/12/xx. 1000. Copy of history and physical done on 7/15/xx sent to Benton County D.A.'s office per subpoena request and on advice of Dr. Jones. P. Krueger, CMA.

Out of courtesy, the physician will notify patients whose records have been subpoenaed. If, for any reason, the patient does not want the record released, the physician must call for legal advice on how to respond to the subpoena.

Certain records, because of their sensitive nature, may require more than a subpoena to be released. These include records related to sexually transmitted diseases, including AIDS and HIV testing, mental health records, substance abuse records and sexual assault records. In some states, for the courts to have access to these records a court order is required.[7]

Documentation of Facsimiles

Fax machines are more and more common in the ambulatory care setting, being used to send reports, referrals, insurance approvals and informal correspondence. Although fax machines are a great time saver for the ambulatory care setting, confidentiality is a critical issue because they are typically located in centralized areas where documents may be seen by unauthorized personnel. Before sending any document, be sure that (1) it will not violate confidentiality, (2) you have permission to transmit it by fax, and (3) you attach a cover sheet that stipulates the information is for the intended recipient only. Transmission lists are provided by most fax machines and can be used as verification that an item was sent and which phone number received it. This serves as documentation of the confidential transmittal of patient information. Document in the patient's chart what, when and to whom the facsimile was sent. For example: 8/12/xx. 1445. Immunization records sent to Dr. Smith's office. P. Krueger, CMA.

Prescriptions and Refills

Prescriptions are legal documents. They are written to the pharmacist giving instructions as to how medications are to be dispensed to the patient. The practitioner usually writes in the progress notes which medications are being ordered for the patient and if the patient is being sent away from the office with the prescription form in hand. Often the practitioner will write an order and ask the medical assistant to call or fax the order in to the pharmacy of the patient's choice. The medical assistant must document that she/he has called the pharmacy and ordered the prescribed medication. Many offices now fax orders to reduce medication errors. If you telephone or fax in an order, the pharmacy will require the patient's full name and date of birth. The medical assistant must document on the chart that the order has been completed as directed by the physician.

If the patient is calling in for a refill of a prescription, the medical assistant documents the name of the medication, the dosage, the administration times and the name of the pharmacy. It is also a good idea to write down the patient's current telephone number, in case the physician has a question or wants you to call the patient for more information. Many offices have forms for prescription refills. These forms must have the patient's name on them and must be attached to the patient's chart as a permanent record.

Telephone Call Documentation

Documenting telephone messages is of vital importance and should be treated as such. Of primary concern is the issue of confidentiality. Data regarding patients may not be given out over the telephone to anyone unless the patient

has given signed, written permission for the release of specific information. It is important to record the date, time, a brief message regarding the call and the initials of the person who responded to the call. All telephone messages regarding patient care should be written down. Include the date, time of call, name and return phone number. For symptom calls, use checklists or protocols. For insurance inquiries, to ensure that the call is handled in a timely manner, checklists should be made with spaces for charges, claim status, payment status and issues in dispute. Most calls will require some kind of documentation, such as entry of appointment or a message. The following are important elements of a telephone message:

- Caller's full name, spelled correctly
- Brief note indicating the nature of the call
- Action required (insurance inquiry, appointment, medical advice, etc.)
- Date, time of call, initials of person receiving call
- Phone number of caller, with area code if long distance[4]

A telephone message pad and pen should be placed by each office telephone. You cannot rely on memory in a busy office where there are constant interruptions. Offices have a variety of methods for recording telephone messages. You may use a preprinted, duplicate telephone message pad; the top sheet is removed and the carbon remains as a permanent record of calls received. The office may use a secretarial notebook that is dated each day; calls are recorded and checked off when returned. You need to develop a follow-up method to be sure calls are returned. The call pad or messages should not be filed until the requests have been given a response. Some offices have a stamp made up that indicates in the patient chart that a telephone communication was made; the caregiver writes a brief note with the date the patient was contacted. It is not advisable to have loose slips of paper in the file, because they are too easily lost. If you wish to keep these in the chart, they should be filed shingle fashion on a sheet of bond paper with the latest call on top. The slips should be fastened with a piece of transparent tape horizontally across the top of the slip. A vertical piece of tape along the side prevents curling of the edges of the slip, which ensures that it is easy to read.

Changed Appointments

One of the most vital functions in the medical office is scheduling appointments. Appointments may be changed by the office, to accommodate a physician's schedule, or they may be changed by the patient. The following three situations result in a changed appointment:

1. Cancellations without making a new appointment
2. Rescheduling an existing appointment
3. Following up on a patient who missed his/her appointment

The acceptable abbreviations that should be made next to the patient's name at the original appointment time and entered into the chart with the date are the following:

1. Canc cancellation, no reschedule
2. RS rescheduled appointment
3. NS no-show

If a patient cancels or does not show up for the scheduled appointment, it should be noted in the patient's chart and the appointment time given to another patient as soon as possible. The record of the canceled appointment or no-show is important in proving that the patient had an appointment but failed to follow the physician's instructions. It is advisable to phone the patient at home and to leave a message about the missed appointment. If patients cannot be reached by phone, mail them a letter noting the missed appointment and requesting that they make another appointment by calling the office. This procedure provides legal protection if a lawsuit is filed against the physician for failure to provide care for this patient.[8] You must document all these calls to protect your office from malpractice for abandonment.[9]

The following is a sample list of abbreviations for medical office use:

1.	NP	new patient
2.	CPE (CPX)	complete physical examination
3.	FU	follow-up examination
4.	NS	no-show
5.	RS	reschedule
6.	C & C	called and cancelled
7.	C, Canc	cancelled
8.	Ref	referral
9.	Cons	consultation
10.	Re	recheck

Unit 5 Worksheet

Circle the correct answer to the following:

1. Information going to insurance companies for billing purposes requires:
   a. informed consent
   b. implied consent
   c. release of information consent
   d. subpoena duces tecum

2. Which of these scenarios requires documentation?
   a. Patient rolls up sleeve for blood pressure to be taken
   b. Patient asks for a prescription refill
   c. Subpoena of chart notes
   d. b and c
   e. All of the above

3. The main issue about using a fax machine is:
   a. Must have a transmission private line
   b. Must use a cover sheet with transmissions
   c. Confidentiality of information
   d. Physician approval is required

4. Telephoned or faxed prescriptions and refills require:
   a. No documentation in the chart
   b. Only written orders
   c. Patient's full name and date of birth
   d. DEA approval

5. The medical assistant must document:
   a. Patient's diet
   b. Patient's occupation
   c. All telephone calls to office
   d. Telephone calls regarding patient care

6. List 5 items that should be documented when taking a telephone message:
   a.
   b.
   c.
   d.
   e.

7. Name three situations that could result in a changed appointment time.
   a.
   b.
   c.

8. Why must all cancellations and no-shows be documented?

9. Give the correct abbreviation for the following phrases:

   Cancellation, no reschedule: _____

   Rescheduled appointment: _____

   No-shows: _____

   New patient: _____

   Called and cancelled: _____

10. Give the appropriate word or phrase for the following abbreviations:

    FU: _____

    Ref: _____

    Cons: _____

    Re: _____

    CPE: _____

Unit 6

Documentation Scenarios

Upon completion of this unit you should be able to do the following:

1. Organize patient data and charts
2. Document what the patient tells you
3. Document what you observe
4. Document what you do
5. Document what you teach

Organizing Your Data

Patient outcomes are more important than ever in evaluating the quality of care provided—a fact that casts documentation in an even brighter spotlight. It is not always easy to make documentation a priority. Time constraints may make other patient care activities seem more important. When you consider the amount of information you must record you may be tempted to push documentation to the bottom of your must-do list. You can make documentation less burdensome by organizing the information into the following logical categories:

- **What the patient tells you**—information you obtain directly from the patient or from others, if the patient is incapacitated.
- **What you observe**—information you collect from physical observation and measurement.
- **What you do**—as directed by the treating physician—interventions you perform in response to assessment findings.
- **What you teach**—as directed by the treating physician—instructions you give to the patient and family.[10]

Document What the Patient Tells You

Gather information about the patient's current symptoms, past health status, previous medical treatments and responses to those treatments during the health history interview.

Information you collect during the interview also serves as the basis of the teaching plan. By determining the patient's knowledge of his/her disorder, drugs and health, the treating physician can identify and prioritize appropriate teaching topics.

Identify the Best Information Sources

Ideally, you should obtain information directly from the patient. In some situations, you'll need to interview family members, refer to the patient's medical records and consult other health care team members to find out what you need

to know. Be sure to document as many details as you can, leaving no gaps or uncertainties.

Quote the Patient Directly

Record the patient's exact words, placing quotes around them. This helps others to clearly differentiate the patient's words from yours.

Document What You Observe

Document your findings from vital sign measurements.

Be Objective and Specific

Use objective language and avoid making judgments when documenting observation data. For instance, if you write, "The patient's heart rate was only 60," this suggests that you think his/her heart rate is low.

Whenever possible, quantify your findings by citing specific numbers. Instead of "Mr. J says he gets up a lot during the night to urinate," write "Mr. J states he gets up 7 or 8 times during the night to urinate." Avoid phrases like "a little" and "a lot." Also avoid using the words "appears" and "seems." You want to state the situation as it is.

Be Concrete

Describe only what you see, hear, feel and smell during your observation. Do not document your interpretation of the patient's behavior. Instead of "Jane Doe was crying because of her depression," write "Jane Doe was crying during the observation."[10]

Document What You Do

Your documentation should show that you took appropriate action based on your assessment of the patient's condition. Record interventions as you perform them or soon afterward. Otherwise, you may forget to record important information. Note the time of each intervention to avoid the appearance that you took too long to intervene after assessing a significant finding.

Document the Patient's Response

Just because you've documented an intervention doesn't mean that your patient benefited from it. To indicate the effectiveness of an intervention, describe the patient's response—whether positive or negative. If it is appropriate, be sure to evaluate the emotional response as well as the physical response.

Record Referrals

Your documentation should indicate whether additional resources are needed and whether referrals should be made to secure those resources.

Document What You Teach

A patient's progress during your care and after discharge home may depend on (1) how well he/she understands the condition, (2) the treatment plan and (3) home care. When you document your teaching, clearly indicate the patient's understanding of the instructions you've provided. Some subjects that you may teach are the following:

- Disease process
- Prescribed drugs, including their names, dosages, administration times and routes, adverse effects and storage
- Ambulation privileges
- Nutritional needs, supplements or restrictions
- Signs and symptoms to report
- Community resources
- Home care

Documentation may be noted as follows: "Patient is able to verbalize symptoms, demonstrate use of crutches, and correctly answer questions."

Documentation Scenarios

Headache

Document on the patient's chart:

Date and time
What the patient tells you (Subjective, S)
What you observe (Objective, O)
What you do (Assess, Action, A)
What you teach, if applicable (Plan, P)

Charting using the narrative method:

09-12-xx	1400 Pt c/o headache x 3 days, worse today. Has Rxd with ASA.
	BP: 180/120, P. 90. Severe pain in right parietal region and behind
	eyes. No nausea or vomiting. (Note: line drawn to margin)--------
	Dr. Smith notified immediately. P. Krueger, CMA----------

Charting using the SOAP method:

9-12-xx 1400	S: "I have had a headache for 3 days and it is worse today. I have been taking ASA."----------
	O: BP: 180/120, P. 90. Severe pain, scale of 9/10, in right -- parietal region and behind eyes. No nausea or vomiting.---
	A: Notified Dr. Smith immediately. P. Krueger, CMA--------
	P: No plan at this time, it would include treatment and --- patient's response to that treatment)----------

Earache (Pediatric)

Document on the patient's chart:

- Date and time
- What the patient tells you
- What you observe
- What you do
- What you teach (if applicable) or implement, or results of action taken

09-25-xx 0835	S: Mother states 8-month-old congested x 3 days. Tugging at Rt ear x 1 day, fussy since last PM.----------
	O: T: 100.6 (Ax), P: 124 (Apical), R: 32----------
	A: Febrile child----------
	P: Dr. Jones to check patient.----------
	----------P. Krueger, CMA

Influenza Symptoms

Document on the patient's chart:

- Date and time
- What the patient tells you
- What you observe
- What you do
- What you teach, implement, or results of what you do

09-24-xx 1610	Pt c/o flu symptoms x 3 days, NVD* and slight temp elevation, aching joints. T: 101.6, P: 94, R: 22, BP: 104/62. Dr. Anderson in to examine Pt. Pt brochure about temperature management given to Pt. Pt expressed understanding of instructions.----------
	P. Krueger,CMA----------

*NVD = nausea, vomiting and diarrhea

Assisting With a Lumbar Puncture

Document on the patient's chart:

- Date and time
- Vital signs before and after procedure. Include the temperature, particularly if the procedure is for a fever of unknown origin (FUO).
- Patient's tolerance of the procedure and complaints or concerns
- Patient education and instructions

09-23-xx	Pt positioned and draped for lumbar puncture. BP: 120/80, T. 99.2, P:86
0830	R: 18. Dr. Smith performed LP----------
0900	LP completed. Pt. tolerated procedure without Sx . CSF sent to lab.
	Post-LP vitals: BP: 114/74, P: 76, R: 16. Pt resting comfortably.-------
0930	Pt denies discomfort. No n/v. No leakage at LP site. Pt and wife---- were given discharge instructions. Verbalized understanding. Pt discharged by Dr. Smith. P. Krueger, CMA----------

Removing Staples

Document on the patient's chart:

- Date and time
- Location of staples
- Number of staples to be removed
- Any difficulty with staple removal
- Any signs or symptoms of infection
- Pt complaints/concerns
- Pt education and instructions

09-19-xx	1245----------
	S: "I get my staples out today."----------
	O: Incision on abdomen in right lower quadrant (RLQ). Four-----
	staples in place. No drainage or redness noted----------
	A: Staple removal needed----------
	P: 1. Four staples removed without difficulty.----------
	2. Antiseptic solution applied. No dressing applied.----------
	3. Discharge instructions given. Pt verbalized understanding
	of same.----------
	P. Krueger, CMA----------

Changing a Sterile Dressing

Document on the patient's chart:

- Date and time
- Location and type of dressing
- Any signs or symptoms of infection
- Presence and type of drainage
- Patient complaints or concerns
- Patient education and instructions

10-02-xx	1330 Pt arrived in office for sterile dressing change on right heel. Dressing was removed with no problems. Ulcerated wound noted on right heel. Yellow drainage noted. Dr. Jones notified. Culture taken as ordered. Wound cleaned with Betadine solution. Sterile dressing applied. Pt instructed to keep limb elevated and keep wound dry. Pt to return in a.m. for dressing change. P. Krueger, CMA

Assisting With Cast Application

Document on the patient's chart:

- Date and time
- Location of cast
- Assessment of circulation to part
- Patient complaints or concerns
- Patient education and instructions

11-14-xx	1045 Short leg cast with walking heel applied by Dr. Cronk. Pedal pulse strong before cast application, toes warm and pink, capillary refill present. Pt voiced no complaints during casting. Toes have full range of motion with good sensory perception after casting. Skin warm and pink. Pt reminded to report signs as outlined in Pt education brochure. Verbalized understanding of all instructions. P. Krueger, CMA

Some key charting rules are as follows:

- Make sure you have the correct chart. Use caution with patients with similar last names.
- Always document in ink. Black is preferred.
- Select the format your facility prefers.
- Enter the date and time that the interaction occurred. Military time is considered standard.

- Document all subjective and objective findings, all procedures performed, to whom you reported any findings, any patient education, any missed appointments and any telephone conversations. Use patient quotes whenever possible.
- Sign your name, with your credentials.

This concludes the first half of this course. The second part, on telephone screening, follows.

Unit 6 Worksheet

1. List four categories that will help you document effectively and efficiently.
   a.
   b.
   c.
   d.

2. The best way to document what the patient tells you is to:
   a. Identify the information source
   b. Make your own assessment
   c. Quote the patient directly
   d. Determine patient's knowledge level

3. Which of these statements is not specific?
   a. BP 120/80
   b. Skin appears dry and warm
   c. Pulse 80, regular
   d. Temperature 98° F

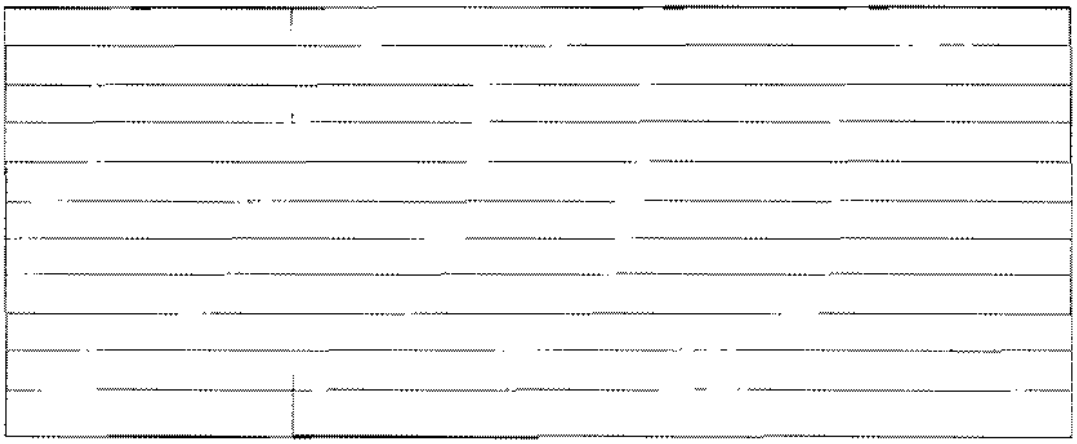
4. Documentation should be done:
   a. At the end of the day, when it is quiet
   b. During the lunch hour
   c. Whenever it is possible
   d. After you perform the action

5. Documentation shows:
   a. Appropriate action was performed, based on assessment of the patient's condition
   b. How long it took to perform a single task
   c. Only patient's positive response

6. A patient's progress after he/she goes home depends on what?

7. Using the SOAP method, chart the following:

October 1, 20xx; 10:00 a.m. Jane comes to the office with complaints of burning pain when she urinates. She says it feels like she has to go to the bathroom about every 5 minutes, but nothing comes out and she has this awful pain. She is crying and holding her hand over her bladder region. Dr. Smith sees the patient and orders a urine sample to be sent for a culture and sensitivity. He sends the patient home with two prescriptions. He wants her to call him if there are any problems or the symptoms get worse.



Unit 7

Telephone Screening

Upon completion of this unit you should be able to do the following:

1. Define "telephone screening."
2. Define "protocol."
3. Define the levels of care for establishing a protocol.

The telephone has become a vital link in health care. Heightened awareness of cost and access to health care services have increased significantly the consumer's use of the phone to determine the urgency of a problem and the need for medical attention. Emergency departments, primary care providers and managed care entities receive numerous questions regarding the need to access medical care, often in an attempt to avoid spending unnecessary health care dollars. The medical assistant can respond to these calls with confidence and consistency while minimizing subjectivity by using organized, systematic telephone screening protocols.[11] Telephone screening is the ability to determine the severity of the symptoms presented and to recognize the needs of the patient, in order to schedule the visit to the physician's office. It is the screening process by which information is obtained that is needed to assess the patient's condition.

Assessment is the collection of patient data that are pertinent for providing optimal health care. As Donald A. Balasa, JD, MBA, Executive Director of the AAMA, stated, "The medical assistant's role is to collect the facts and pass them along based on predetermined guidelines defined by the physician." He adds, "It is essential for medical assistants to limit their activities to set protocols that the supervising physician has established or approved. The medical assistant is not allowed to exercise independent judgment."[12]

Protocols

A "protocol" is (1) an official account of action to take based on symptoms that the patient presents, (2) a detailed plan or (3) a medical treatment. A screening protocol helps health care professionals to ask appropriate questions, to quickly assess the severity of a health problem and to aid the caller in making an informed decision concerning health care.

Note: Protocols are not designed to diagnose the caller's medical condition. Protocols are a comprehensive resource that will benefit medical offices, emergency departments, urgent care clinics, schools, home health agencies, occupational health departments, managed care providers and all who receive calls for medical advice.

Answering the Telephone

The telephone is the center of all activity in the medical office. The professional attitude conveyed is critical to the success of the practice of medicine. The

medical assistant who handles phone calls must be courteous, articulate and a careful and active listener. The rapport established by the medical assistant will contribute to successful communication with patients.

A phone-screening manual should be kept near the phone for reference so that each assistant who answers the phone will ask the same standard questions and give the same standard advice that the physician has preauthorized. "Preauthorized" means that the physician has agreed to the type of appointment to be made based on the caller's presentation of symptoms. The assistant must learn how to logically proceed through a set of questions that will reveal the caller's condition and help determine, if necessary, how soon the patient should be seen by a physician. This process is called telephone screening.[8] If the assistant does not know how to handle a patient, or if the questions have not been addressed in the manual, the assistant should refer the problem to one who is more experienced.

Documenting Telephone Screening

Documenting telephone messages is of vital importance and should be treated so. Of primary concern is the issue of confidentiality. Telephone screening is documented in the patient's chart. Follow the documentation procedures presented in earlier units. The format is your choice, unless your facility has specified differently.

Basic information to be recorded for each telephone encounter is as follows:

- Identifying information:
  - Name
  - Age
  - Home telephone
  - Patient ID or health plan number
  - Identity of caller and relationship to patient
- Record what the patient tells you. This should be written in quotes or after the abbreviation "CC," for chief complaint(s).
- Record what the patient can measure, see, hear or feel. This should be written as objective information, preceded by the words "patient states."
- Record what your actions were with regard to this call. Record your action based on what protocol you used. Be sure to include the time of an appointment if one was made.
- If you referred the message to a clinician to call the patient back, this information should be noted in the chart. Tell the clinician the following:
  - The nature of the problem and its urgency
  - How soon the patient expects a call

- Sign your name, with credentials. It is best to sign your first initial and last name.
- Be sure to follow all charting rules.
  - Charting should be done in black ink.
  - Charting must be legible. Print if your writing is difficult to read.
  - Use red ink and highlighter only for attracting attention to specific information.
  - Never enter humorous, sarcastic or casual remarks in the chart.
  - Quote rather than summarize information given by the patient.
  - Use abbreviations that have been approved by your facility.
- Make corrections properly.
  - Draw a single line through the error.
  - After the error, or in the margin, write "error," "wrong entry" or "correction"; the date; and your initials. Insert the correction immediately after these statements.
  - Do not scribble, black out, cross out or use correction fluid to obliterate what has been written.

Unit 7 Worksheet

1. Telephone screening is:
   a. A head-to-toe assessment
   b. Receiving numerous questions regarding health care
   c. Not the responsibility of the medical assistant
   d. The ability to determine the appropriate recommendation to the patient based on following the physician's protocol

2. Protocols are:
   a. Rules to keep the office running smoothly
   b. Directions for performing procedures
   c. Detailed plans
   d. Abbreviated doctor's orders
   e. An official account of action to take based on symptoms presented by the patient

3. A medical diagnosis is made by:
   a. Office managers
   b. Physicians
   c. Medical assistants
   d. Physician assistants
   e. b and d

4. "Preauthorized telephone screening" means:
   a. There are standing orders to be followed
   b. The physician has determined the type of appointment to be given based on the patient's symptoms
   c. Prescriptions and refills can be done by the medical assistant
   d. Medical assistants are not to use the telephone

5. What basic information needs to be recorded for each telephone encounter?

Unit 8

Telephone Decision Guidelines

Upon completion of this unit you should be able to do the following:

1. Identify the levels of care found in telephone decision guidelines.
2. List the steps in making a physician-authorized telephone manual.

The Need for Decision Guidelines

Telephone decision guidelines that have been approved by the clinicians will guide the telephone staff in helping patients and parents decide whether and when to be seen by a clinician. The guidelines delineate: (1) questions to be asked; and (2) whether—and how urgent it is—to see a clinician, based on the response to each question. Questions are prioritized and clustered so that questions revealing emergencies are asked first. Decision guidelines are referred to as protocols, physician-authorized protocols, telephone screening manuals and telephone decision guidelines. As a medical assistant, you must be constantly aware that the telephone actions you take are based only on physician-authorized guidelines. You may not diagnose or give independent judgment on any situation. A physician-authorized telephone-screening manual should be available. If there is not one available, some guidelines that will enable you to make one for your office follow.

Six Steps in Making a Manual

1. Keep a record of the types of symptoms that are called into your office for a 2-week period. This will give you the basis for your manual. There is no need to prepare a protocol page for "labor symptoms," for example, if you work in a urologist's office.
2. List major symptoms. These are the major symptoms that you have identified as the most commonly called in to your office. For example, a patient calls in with "shortness of breath" or "difficulty breathing." This is the heading on the page.
3. Determine the level of care for each set of symptoms possible under the major symptom heading. The level of care will depend solely on your clinician's guidelines. There are usually five levels of care delineated in the manual (see Unit 7).
4. Type up symptoms and care protocols. Use a three-ring notebook and protective page covers.
6. Have the clinician(s) approve and sign each protocol. This can be accomplished by having a signature line on each separate page or a list of the protocols on one page on which the clinician signs a statement to the effect that "I have read the enclosed protocols and authorize their use for care of my patients." A word of caution here: the protocols must be reviewed and signed annually.

There are many websites available on the Internet to assist you with formulating what guidelines to use.

The manual should be updated on a regular basis and new guidelines added as needed. Most importantly, it should be used by all medical assistants who are answering telephones and dealing with patients. Let's review the steps for telephone screening:

Six Steps in Telephone Screening

1. Introduce yourself and establish rapport with the person on the line.
2. Conduct the fact-finding interview.
3. Make a screening decision using an established protocol.
4. Offer predetermined advice based on preauthorized protocols.
5. Conclude the call and follow up as needed. (Give messages to appropriate persons, call in Rxs, call 911, etc.)
6. Document the call.

Unit 8 Worksheet

1. Telephone guidelines suggest that the medical assistant must:
   a. Exercise independent judgment
   b. Base decisions only on training
   c. Base decisions on physician-authorized guidelines

2. Physician-authorized manuals:
   a. Give the physician directions for care
   b. Give the telephone screener guidelines for assigning appointments
   c. Are used only by medical assistants

3. Every appointment given should end with:
   a. Thank you for calling
   b. Call back if the symptoms do not improve or get worse
   c. Call back if you are feeling better
   d. The practitioner will call you to see how you are doing

4. New symptoms and updates on appointment scheduling:
   a. Should be revised and updated as needed
   b. Should be done when an accreditation team visits the health care setting
   c. Are not necessary except at the annual review

Unit 9

Screening Scenarios

Upon completion of this unit you should be able to do the following:

1. Screen illness calls.
2. Document and screen selected medical scenarios.
3. Recognize emergency situations and follow preauthorized physician's directives.
4. List the medicolegal issues involved with telephone screening.

Screening Illness-Related Calls

About one-third of telephone calls will be some type of problem care. Often the person entrusted with the responsibility of answering such calls from patients is incompletely equipped for such an extremely important function. This may lead to errors in clinical management, delays for patients in receiving appropriate medical attention, or unnecessary office visits for problems that actually are more effectively managed at home. Not all patients who are ill need to see a doctor, and it is physically impossible for all phone calls to be managed by the patient's own primary care clinician.[13] All responses to patients with a medical symptom will be given based on the physician-authorized protocol manual. By using a protocol manual, advice is consistent, and patient confidence and satisfaction in the staff and physician are greatly increased.

Some clinicians want telephone attendants to record additional information about such things as medications already tried, associated symptoms and whether the patient has a history of similar episodes. These clinicians believe that having the answers to such questions helps them to prioritize when confronted with multiple patients and makes their own note-taking more efficient when they do see the patient. But often, time does not permit the luxury of a complete history, nor is one always needed. If the situation is a true emergency, time should not be spent on less important questions. The telephone protocol guidelines in the following pages have been formatted to help achieve efficient and informed decision making by properly trained medical office staff.
In cases in which a screening decision cannot be made by the telephone attendant, the decision guidelines also serve the purpose of selectively collecting the most important information to present to the clinician for review and final disposition.[13]

Typing the Guidelines

The first thing you will do to begin making the protocol guidelines is to decide what format to use. Every office seems to have a different style. Regardless of style, it is crucial that anyone should be able to pick up the manual and manage an illness-related call. Thus, your manual should be "user friendly." Another important point is that the guidelines should be kept to a single page. If you must use two pages, then put them in the manual facing each other, so that

when you open the page to a particular complaint (symptom), you will see the entire protocol and not have to flip back and forth to get information.

Once you have decided on the format of your manual, type a template of the style and the level headings. The template will ensure that all pages look the same, and this will facilitate the screening process. Some telephone screeners like symptoms listed as questions, some like simple statements to nudge them through the assessment process. Again, this is purely personal and up to the individual office to decide what format to use. In the following sample, simple formatting has been used.

Telephone Screening for Pediatric Abdominal Pain

Sample 1

Note: The location of the pain is very important to rule out appendicitis.

Level 1: Seek Emergency Care Now

Severe persistent pain

- Rapidly increasing pain
- RLQ pain with poor appetite, nausea and/or vomiting, fever, grasping abdomen, walking bent over, screaming, lying with knees drawn toward the chest
- Unusually heavy vaginal bleeding and possibility of pregnancy
- Ingestion of unknown chemical substances, plant or medication; recent abdominal trauma
- Bloody or jelly-like stools

Level 2: Seek Medical Care Within 1 to 2 Hours or Go to Urgent Care

Severe nausea and vomiting

- Continuous pain >1 hour and unresponsive to home care
- Unexplained progressive abdominal swelling
- Painful or difficult urination
- Blood in urine
- Pain interferes with activity
- Fever>101°F, cough, weakness
- Decreased urine output
- Blood in stools
- Nausea, vomiting, diarrhea >24 hours and unresponsive to home care
- Weight loss

Level 3: Seek Medical Care Within 4 to 6 Hours

Vaginal or urethral discharge

- History of abdominal pain and usual treatment is ineffective
- Significant increase in stress level

Level 4: Seek Medical Care Within 24 to 72 Hours or Call Back for Appointment if no improvement

- Constipation
- History of nervous stomach and increased stress level
- Intermittent mild pain associated with empty stomach
- Eating certain foods, or use of pain antibiotic or anti-inflammatory medications
- Mild, infrequent diarrhea
- Other family members are ill
- Persistent sore throat >24 hours

Level 5: Home Care Instructions[11]

- Clear liquids (fruit juices diluted with water, weak tea, popsicles, gelatin, lemon-lime soda) or bland diet (rice, potatoes, soda crackers, pretzels, dry toast, applesauce, bananas) for 12 to 24 hours. Pedialyte for small children or babies.
- Take food with medications that cause stomach upset (as directed by pharmacist)
- Apply moist hot towel or heating pad to the abdomen for cramping
- **Call back if symptoms worsen or if patient is not improving**

Date: _____ Physician's Signature: _____

(Adapted from Briggs J. *Telephone Triage Protocols for Nurses*. Philadelphia, Pa: Lippincott; 1997.)

Remember: You can only use a guideline (protocol) if the physician has signed it. Once you have submitted your protocol to the clinicians to review, be prepared for many changes. They may want you to ask other questions or they may prefer that you not ask some that you have identified. Do not take this input personally; the physician-authorized manual must reflect the physician's medical advice, not yours or that of some book. The protocol should be put in page protectors after it is signed by the physician. Then you can use it. Notice the difference between the format of Sample 1 (above) and that of Sample 2 (below), for the protocol on abdominal pain.

Sample 2[13]

Question	See Clinician if.....	When To Set Appointment
1. Pt's name, telephone number, age	Under 3 years of age	2
2. How severe is the pain? Is the child crying?	Severe regardless of duration	2
3. Was there any accident in which the stomach area was hurt?	Yes	2
4. Where is the pain located?	On right side of abdomen	2
5. Is the child acting particularly ill? Is the child playing or just lying around?	Child appears ill, is fussy, vomiting, pale, sweating or lethargic	2
6. Are there any associated symptoms?	Over 103°F or fever has been	
■ Fever	present longer than 24 hours. See protocol on FEVER.	2
■ Vomiting	Yes, if vomiting	2
■ Difficulty breathing	Yes	2
■ Severe cough or other chest symptoms	Yes	2
■ Diarrhea	Diarrhea only, see Protocol	8
7. Is the pain constant or intermittent?	Constant	2
8. Is the pain getting better or worse, or is it about the same?	Worse or the same	8
9. Do any other family members have similar abdominal pain, vomiting or diarrhea?	Yes	8
10. How long has pain been present?	More than 48 hours (not severe)	24-72
11. What is the child's usual state of health?	Child has any chronic or serious condition (eg, diabetes, asthma, cystic fibrosis, UTI)	8
12. Has the child ever been seen for this problem before?	Yes, complaint is chronic	24-72

Key:
2 = See ASAP (within 1-2 hours)
8 = See same day
24-72 = Set appointment within 3 days

Date:_____Physician's Signature:_____

Using Physician-Authorized Protocol

Let's look at an example of a telephone complaint about pediatric abdominal pain:

Mr. Smith calls about his 9-year-old son who has a stomach ache. He was called to the school to come and pick Jonny up because the boy was complaining all morning that his stomach hurt and he vomited once in the health room. Mr. Smith is now home with Jonny and wants to know what to do.

Steps to screen

1. Turn to Protocol on Pediatric Abdominal Pain.

2. Gather assessment information:
   a. Name, telephone number, age of patient?
   b. Severity of pain?
   c. Any trauma?
   d. Location of pain?
   e. Child acting ill or lethargic?
   f. Any other symptoms?
      i. Fever?
      ii. Vomiting?
      iii. Diarrhea?
      iv. Severe coughing or difficulty breathing?
      v. Burning or frequency of urination?
      vi. Constipation?
   g. Duration of pain?
   h. Is pain constant or intermittent?
   i. Is pain getting better, worse, or about the same?
   j. Are family members ill with similar symptoms?
   k. Any chronic medical condition?
   l. Has child been seen for this problem in the past?

3. Based on the brief history we have presented, we would be able to screen this symptom as follows.
   a. Pain? Patient denies pain; just aching.
      i. Ask: How long has patient had stomach ache; is it constant or does it come and go; and is it getting better, worse, or about the same?
   b. Trauma? Denies trauma.
   c. Location? Middle of stomach area
   d. Child acting ill or tired? Yes

e. Other symptoms:
   i. Fever? How did you take it? 101°F; mouth
   ii. Vomiting? Yes, once at school. Just sick to stomach now.
   iii. Diarrhea? Yes, two or three times since I brought him home.
   iv. Cough or breathing problems? No.
   v. Burning or frequency in urination? No.
f. Family members with similar symptoms? Yes, mother and sister have same symptoms.
g. Any chronic medical problems? None
h. Has the child been seen for this before? No

4. Determine level of care: Jonny does not fit the criteria for a 2 status, which is ASAP. He does have the criteria for an 8, with his family experiencing the same symptoms. So an appointment should be made for him to come in for an evaluation the same day.

5. Assign appointment

6. Document on the patient's chart:

   a. What patient or caller tells you
   b. What you evaluate or what the caller sees, hears, feels or measures
   c. What you are going to do
   d. Protocol to support your actions and caller's response to action

09-26-02	1300. Father called. Sts son "Jonny" is complaining of stomach ache. Vomited x1. C/o nausea. Pain located in middle of abdomen. Oral--- temp: 101°F. Denies trauma, diarrhea, breathing problems, burning on urination or constipation. Sts mother and sister are sick with same Sx. No known medical problems. Has not had problem before.---------- Advised to come to office at 1645 per Pediatric Protocol. Agreed to bring son in. P. Krueger, CMA----------

Notice the use of abbreviations to facilitate charting. Also, did you notice the phrase that states which protocol was used and by whom? This protects the screener legally from being accused of diagnosing and offering medical advice. Every question comes from the physician-authorized guideline. No other judgments were made. Be sure to document the patient or patient representative's affirmation of the appointment.

Screening Emergency Calls

The worst possible scenario for a true emergency is for a patient with a life-threatening condition to be brought into the office rather than being referred directly to an emergency room. For the patient, precious time for prompt emergency treatment is lost; for the primary care practice, the office is totally disrupted and the care of the patients waiting is delayed and rushed. A potential life or death emergency situation can be lurking behind any routine telephone call. The telephone screener must be prepared to manage such calls and make important decisions, even if the clinicians are absent from the office. The following symptoms[13] are considered emergencies (a suspected life-threatening illness or event):

1) Airway (compromised or obstructed)
   a) Choking
   b) Neck or spine injury
   c) Croup with cyanosis in any infant or child

2) Breathing problems (severe respiratory compromise)
   a) Difficulty breathing from any cause
   b) Near drowning
   c) Acute allergic (anaphylactic) reaction with respiratory difficulty (food, bee sting, medications)

3) Circulation (suspected or impending shock)
   a) Cardiac arrest
   b) Any chest pains suggesting possibility of heart attack
   c) Uncontrollable bleeding
   d) Acute allergic (anaphylactic) reaction (food, bee sting, medication)
   e) Poisoning or overdose of medication, with change in mental status, signs of shock, or any respiratory difficulty

4) Disability and/or neurologic impairment or paralysis
   a) Convulsion (seizure)
   b) Any neurologic symptoms suggesting possibility of stroke
   c) Coma or unconsciousness
   d) Head trauma with behavioral change or any change in mental status
   e) Diabetic hypoglycemic reaction, with mental confusion and inability to take oral glucose feeding

5) Other
   a) Obvious fracture
   b) Severe pain and unable to walk
   c) Serious suicide attempt or threat
   d) Sexual assault

This list of emergencies should help anyone who is screening telephone calls. In every situation, the caller should be advised to call EMS or 911, or told that you will call for them.

Look for other screening scenarios in the Unit 9 worksheets. There are commercially prepared screening manuals for use in medical offices. Some are for specific specialties. These are a good reference for any office, but the protocols will have to be reviewed and adopted for use. Signature pages must be signed and updated each year.

Medicolegal Issues in Telephone Medicine

Malpractice cases that focus directly on telephone screening decisions and on those who give misinformed medical advice over the phone are increasing. Several preventive measures can be taken to reduce liability and simultaneously to improve the quality of care. As a key step in reducing liability, all medically significant calls should be carefully documented and retained as part of the patient's record. Most medicolegal problems can be traced to three root causes: poor documentation, lack of policies and protocols, and inadequate training of staff members. A telephone encounter form is recommended for most practices. A sample[3] of the basic information that should be recorded for all calls is as follows:

- Identifying information:
  - Name
  - Age
  - Home telephone
  - Patient ID or health plan number
  - Identity of caller and relationship to patient
- Chief complaint or purpose of call
- Outcome of call:
  - Appointment advised and accepted
  - Call referred to (specify)
  - Follow-up instructions
  - Consulted with (specify)
- Home management advice and treatment (specify)
- Message for clinician to call back patient:
  - Nature of problem and urgency
  - How soon patient expects the call

Unit 9 Worksheet

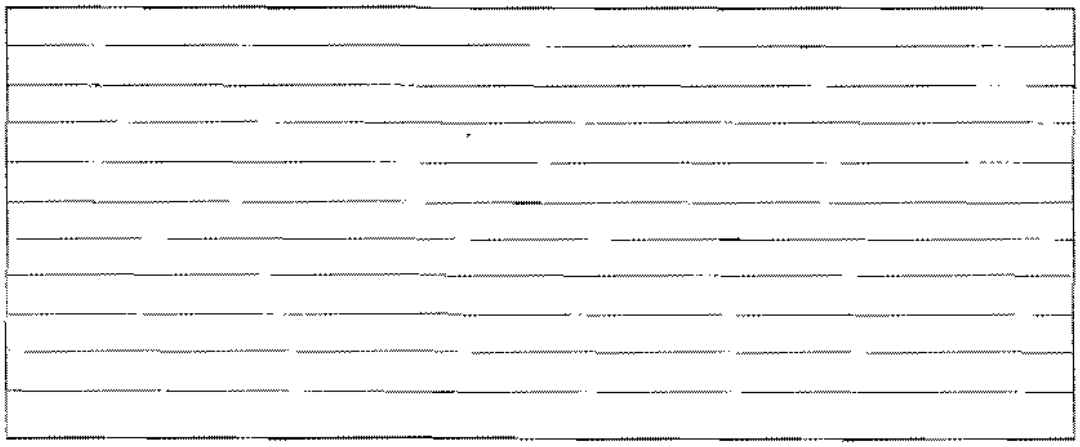
Scenarios

Screen the following patients using the protocols given on the pages that follow. Document in correct charting format this telephone encounter. Be sure to include the protocol that you used.

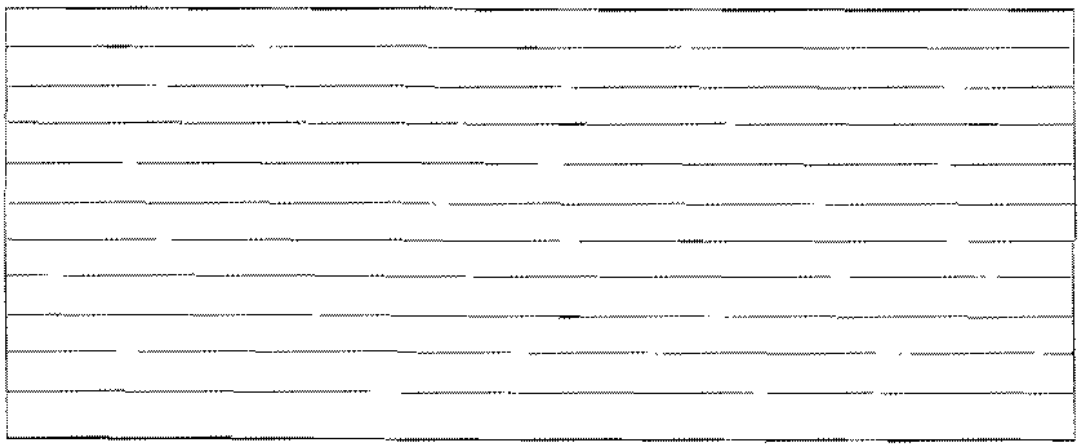
1. Mrs. T calls to report that, on awakening this morning, her 74-year-old mother appears lethargic and glassy-eyed. She took her temperature and it was 102°F orally. No other symptoms are present. Screen this telephone call.

2. A 45-y/o man calls with chief complaint of painful urination for past month. Pt states this is associated with frequent urination and blood in the urine, weakness, back pain and a high fever (102°F). What's your next move?

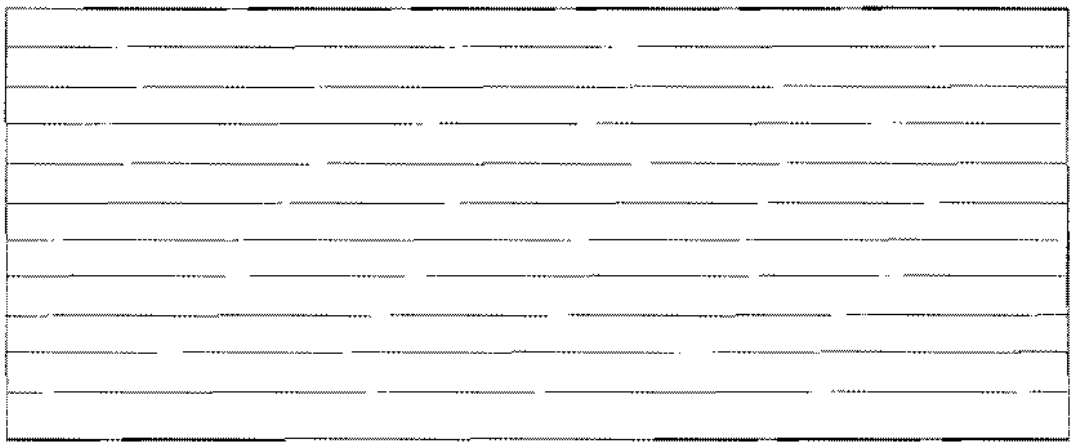
3. The mother of a 10-year-old boy calls in a very frantic state. She tells you that her son was climbing a tree and fell. He is awake, but was unconscious for a short while. His head has a cut and is bleeding. He is complaining that his legs hurt and he cannot move them. She is calling you because her insurance says she must have permission to go to the ER. What do you do?



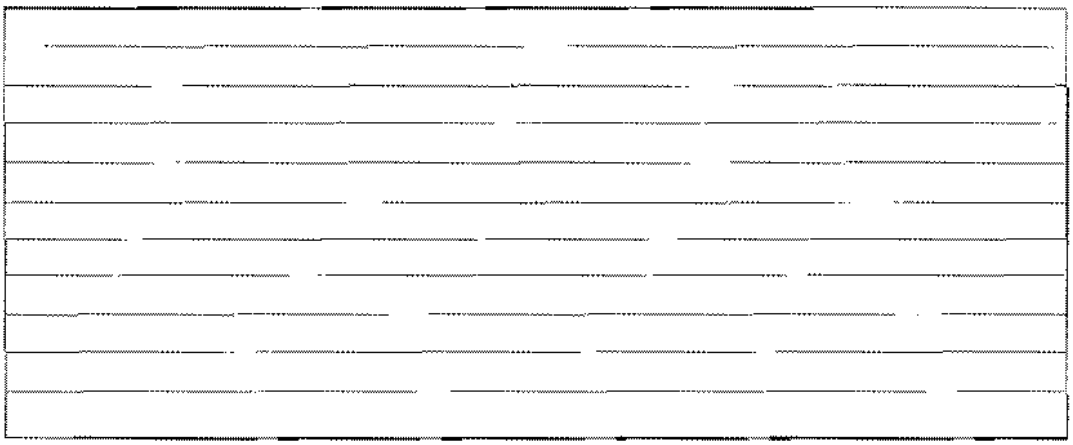
4. Mrs. Knapp's husband calls to tell you that his wife isn't feeling well. She has been up most of the night with pain in her chest. The nitroglycerin has not relieved the pain after 3 doses. She is starting to perspire, be sick to her stomach and the pain is moving down her left arm and up into her jaw. He wants to know if he should bring her to the office.



5. Janey was at a baseball game with a friend when all of a sudden she couldn't get her breath. Her breathing was very labored and painful. Her lips were turning purple. She was gasping for air. Two weeks ago she had been diagnosed with thrombophlebitis. Her friend called the office asking what to do.



6. Mary was playing soccer when she noticed that it was difficult to catch her breath some of the time. She also noted that she was making a "wheezing" sound when she breathed in. She had been experiencing this the past 2 weeks and thought maybe she should call. What's your next move?



Unit 9 Worksheet

Protocols

Directions: Use the following protocols to screen and document the scenarios on the previous pages.

Chest Pain

Key Questions: Name, Age, Onset, History of myocardial infarction (MI), Coronary artery disease, Diabetes, Pulmonary embolism and Deep-vein thrombosis

Level 1

Yes	No	
❑	❑	Pain, tightness, pressure or discomfort accompanied by any of the following:
❑	❑	Shortness of breath
❑	❑	Dizziness/weakness
❑	❑	Cool, moist skin
❑	❑	Nausea or vomiting
❑	❑	Pain in the neck, shoulders, jaw, back or arms
❑	❑	Blue or gray face, lips, earlobes or fingernails
❑	❑	Heart palpitations

Instruct the patient to take nitroglycerin (if available) and/or aspirin while waiting for ambulance.

If YES to the above symptoms, patient should go immediately to the emergency department. If time allows, consult first with MD/NP/PA. Use EMS. If NO to the above symptoms, go to level 2.

Level 2

Yes	No	
❑	❑	Chest pain persists, unrelieved by rest, pain medication, antacids, or nitroglycerin every 5 minutes x3 doses
❑	❑	Chest pain at rest, or awakens person
❑	❑	Change in chest pain pattern in known cardiac patient
❑	❑	Pain/discomfort substernal
❑	❑	Pain develops with exercise and subsides with rest
❑	❑	Leg pain, swelling, warmth or redness
❑	❑	Coughing up blood
❑	❑	Recent trauma, childbirth, surgery, history of blood clotting problem

If YES to the above symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	Pain associated with taking a breath
❑	❑	Pain associated with a cough or fever, but not shortness of breath
❑	❑	Moving the arm reproduces the pain
❑	❑	Recent chest trauma

If YES to the above symptoms, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult. If NO to the above symptoms, go to level 4.

Level 4

Yes	No	
❑	❑	No pain at time of call
❑	❑	Intermittent pain; pain increases when pressure applied to chest
❑	❑	Antacids relieve pain

If YES to the above symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

Yes	No	
❑	❑	Take your usual antacids for indigestion and follow instructions on the label.
❑	❑	Take your usual pain medication (aspirin, acetaminophen or ibuprofen) and follow instructions on the label.
❑	❑	Take nitroglycerin as directed by PCP if pain is typical chest anginal pain; if no relief after 3 to 5 minutes, call back.
❑	❑	If pain is related to an injury that occurred 24 hours ago or more, and pain increases with movement, apply heat to the area for 20 minutes, 4 times a day.

Report the following problem to your PCP/clinic/ED

- No improvement or condition worsens

Seek emergency care immediately if any of the following occurs:

Pain, tightness, pressure or discomfort accompanied by:

- Shortness of breath
- Dizziness
- Cool, moist skin
- Nausea or vomiting
- Blue or gray face, lips, earlobes or fingernails
- Pain in the neck, shoulders, jaw, teeth, back or arm
- Heart palpitations
- No relief from nitroglycerin after taking 1 dose every 5 minutes x3

Date:_____Physician's signature:_____

Cough

Key Questions: Name, Age, Onset, History of present illness (PI)

Level 1

Yes	No	
❑	❑	Sudden shortness of breath, rapid breathing or wheezing?
❑	❑	Coughing due to choking on a foreign body, food or vomit?
❑	❑	Chest pain: Go to Chest Pain protocol
❑	❑	Blue lips or tongue?
❑	❑	Feeling of suffocation?
❑	❑	Frothy pink sputum?

If YES to the above symptoms, patient should immediately visit the emergency department. If time allows, consult first with MD/NP/PA. Use EMS. If NO to the above symptoms, go to level 2.

Level 2

Yes	No	
❑	❑	Cough unrelated to cold symptoms and a history of:
❑	❑	Chest trauma <48 hours
❑	❑	Blood clots or recent long sedentary period
❑	❑	Recent surgery
❑	❑	Recent childbirth
❑	❑	Recent heart attack
❑	❑	Asthma
❑	❑	Coughing up blood
❑	❑	Child <6 months old with rapid breathing and persistent cough
❑	❑	Child appears very ill
❑	❑	Change in child's breathing pattern; labored, noisy, wheezing, chest retractions >30 minutes

If YES to the above symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	Cough present <8 hours, present once or more per hour
❑	❑	Coughing every night and keeping awake
❑	❑	Phlegm or sputum bloody, yellow, green or brown

- ❑ ❑ Other medical conditions, HIV, AIDS, asthma, CHF, CAD; sinusitis, rhinitis
- ❑ ❑ Fever of 101.6°F to 102°F
- ❑ ❑ Child has a "barking cough," unrelieved by exposure to cool air, humidifier or steam

If YES to the above symptoms, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult.
If NO to the above symptoms, go to level 4.

Level 4

Yes No

- ❑ ❑ Low grade fever of 100.0°F–101.6°F
- ❑ ❑ Cough present 2–14 days
- ❑ ❑ Coughing moderately often (a few nights)
- ❑ ❑ Green or brown sputum >72 hours
- ❑ ❑ Child with fever >101°F >24 hours
- ❑ ❑ Cough with weight loss

If YES to any of the following symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Yes No

- ❑ ❑ Breathe steam from a shower or tea kettle with towel held over the head for 10 to 15 minutes to loosen phlegm
- ❑ ❑ Elevate head of bed at night
- ❑ ❑ For children <1 year old: give 1/2 teaspoon lemon juice mixed with 1/2 teaspoon corn syrup to soothe cough. (Do not give honey.)
- ❑ ❑ Give older children and adults 1/2 teaspoon lemon juice mixed with 1/2 teaspoon honey
- ❑ ❑ Drink warm lemonade, apple cider or tea
- ❑ ❑ Take OTC medications as needed, being sure to follow instructions on the label:
- ❑ ❑ Wet cough: use decongestants
- ❑ ❑ Dry cough: use expectorant during day and suppressant at night
- ❑ ❑ Allergy: use antihistamine or decongestant

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

Report the following problems:

- No improvement or condition worsens
- Fever >72 hours
- Green, brown or gray sputum develops and lasts >72 hours
- Coughing up blood (more than flecks)

Go to emergency room immediately:

- Blue lips or tongue
- Feelings of suffocation
- Frothy, pink secretions

Date:_____ Physician's signature:_____

Fever (Adult)

Key Questions: Name, Age, Onset, History of PI

Level 1

Yes	No	
❑	❑	Difficult or rapid breathing, difficulty swallowing, wheezing
❑	❑	Confusion, delirium, difficult to arouse
❑	❑	Headache with stiff neck
❑	❑	Purple blotchy rash with headache and fever
❑	❑	Dehydration signs
❑	❑	Decreased urine
❑	❑	Sunken eyes
❑	❑	Pinched skin does not spring back
❑	❑	Excessive thirst, dry mouth
❑	❑	Fever >101°F in elderly or immunosuppressed (AIDS, cancer, etc.)
❑	❑	Fever >104°F and unresponsive to fever-reducing measures

If YES to the above symptoms, patient should immediately visit the emergency department. If time allows, consult first with MD/NP/PA. Use EMS. If NO to the above symptoms, go to level 2.

Level 2

Yes	No	
❑	❑	Chest pains not affected by breathing
❑	❑	Abdominal pain, severe
❑	❑	Diarrhea, nausea and vomiting, and able to drink

If YES to the above symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	Temperature >103° F
❑	❑	Had fever >72 hours
❑	❑	Pain or difficulty urinating, urinary frequency, back pain
❑	❑	Swollen or tender red skin, rash
❑	❑	Productive cough
❑	❑	Asthma, renal failure, congestive heart failure, COPD, diabetes, cancer, AIDS, sickle cell anemia, coronary artery disease

If YES to the above symptoms, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult. If NO to the above symptoms, go to level 4.

Level 4

Yes	No	
❑	❑	Nasal congestion, sneezing, sore throat, painful glands, ear pain
❑	❑	Patient has been in contact with someone recently who has been sick
❑	❑	Joint or muscle ache, swollen joints

If YES to the above symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

- Increase fluid intake
- Take usual medication (acetaminophen or ibuprofen) for fever and achiness. Follow instructions on label.
- Lukewarm sponge bath or bath soaks.
- Wear light clothing.
- Check the temperature every 2 to 4 hours. If no improvement, notify PCP.

Report the following problems:

- **Fever increases >104°F**
- **Fever persists >24 hours and no known cause**
- **Rash**
- **Frequency, blood or pain with urination**
- **Condition worsens**
- **Signs of dehydration**

Go to emergency room immediately:

- **Seizure**
- **Unresponsive**
- **Difficulty breathing**

Date:_____ Physician's signature:_____

Head Injuries

Key Questions: Name, Age, Onset, History of Pl

Level 1

Yes	No	After a blow or injury to the head:
❑	❑	Difficult or abnormal breathing
❑	❑	Decreased level of consciousness, difficult to arouse, confusion, agitation
❑	❑	Uncontrolled bleeding
❑	❑	Difficulty moving arms or legs, weakness, incoordination or slurred speech
❑	❑	Seizure activity
❑	❑	Vomiting
❑	❑	Loss of vision
❑	❑	Clear or blood discharge from nose or ears, bruising behind the ears

If YES to the above symptoms, patient should immediately visit the emergency department. If time allows, consult first with MD/NP/PA. Use EMS. If NO to the above symptoms, go to level 2.

Level 2

Yes	No	
❑	❑	Persistent headache
❑	❑	Stiff neck or fever since the injury
❑	❑	Persistent bleeding >10 minutes; patient on blood thinners
❑	❑	Gaping, split, jagged or deep wound
❑	❑	Laceration <8 hours old
❑	❑	Persistent vomiting
❑	❑	Blood or fluid draining from nose or ears and no known injury to nose

If YES to any of the following symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	Child >1 year old with a soft, spongy, swollen area over the skull for 12 hours

If YES to the above symptom, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult. If NO to the above symptom, go to level 4.

Level 4

Yes	No	
❑	❑	Goose egg (swollen area on the forehead or scalp)
❑	❑	Intermittent headache responsive to pain medication

If YES to the above symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

- Apply ice packs or cold compresses to area for 20 minutes every 2 hours to reduce swelling and discomfort.
- Allow a child to sleep after an injury. Awaken every 2 hours for 24 hours to determine level of consciousness and responsiveness.
- Take usual pain medication (acetaminophen, ibuprofen, no aspirin for children under 18).
- Avoid alcohol, sleeping pills, sedatives first 24 hours after injury.
- Avoid heavy activity first 24 hours. Rest with head elevated.

Report the following problems:

- **No improvement or condition worsens**
- **Persistent headache**
- **Persistent swelling >24 hours after ice pack application**
- **Blood or clear drainage from nose or ears**

Go to emergency room immediately:

- **Confusion, disorientation, agitation, change in vision**
- **Decreased level of consciousness**
- **Numbness, tingling or weakness in an arm/leg**
- **Persistent vomiting, severe headache, speech problems, seizures, lethargy**

Date:_____Physician's signature:_____

Shortness of Breath (SOB)

Key Questions: Name, Age, Onset, History of PI

Level 1

Yes	No	
❑	❑	Chest pain present? Go to Chest Pain Protocol
		Any of the following:
❑	❑	Blue lips or tongue
❑	❑	Pale or gray face
❑	❑	Clammy skin
❑	❑	Frothy pink or copious white sputum
❑	❑	Decreased level of consciousness
❑	❑	Severe SOB with sudden onset

If YES to the above symptoms, patient should immediately visit the emergency department. If time allows, consult first with MD/NP/PA. Use EMS. If NO to the above symptoms, go to level 2.

Level 2

Yes	No	
❑	❑	History of pulmonary embolus, blood clots or lung collapse
❑	❑	History of asthma not relieved with inhaler
❑	❑	Difficulty taking a deep breath due to severe pain
❑	❑	Severe SOB, wheezing/noisy breathing started within past 2 hours
❑	❑	Recent trauma, surgery or childbirth
❑	❑	Inhalation of a foreign body
❑	❑	Exposure to something that caused significant reaction in past: sting, medication, plant, chemical, food, animal and patient used prescribed allergic reaction kit as directed

If YES to the above symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	Fever >101.6°F
❑	❑	SOB only when on back
❑	❑	Breathing pattern causes considerable discomfort with usual activities
❑	❑	Productive cough with gray, green or yellow sputum
❑	❑	SOB for 3 to 14 days

If YES to any of the following symptoms, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult. If NO to the above symptoms, go to level 4.

Level 4

Yes	No	
❑	❑	SOB 1 to 2 times per month
❑	❑	Able to do a majority of activities
❑	❑	SOB for 2 weeks or more
❑	❑	Recent exposure to a stressful event
❑	❑	Nasal congestion

If YES to the above symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

- Rest and relax as much as possible
- Rest or sleep with head elevated on a couple of pillows

Report the following problems:

- Condition worsens or no improvement in 2 days
- Fever >101°F

Go to emergency room immediately or call ambulance:

- Chest pain
- Blue lips or tongue, pale or gray face
- Clammy skin
- Feeling of suffocation
- Frothy pink or copious white sputum
- Decreased level of consciousness

Date:_____Physician's signature:_____

Urination (Painful)

Key Questions: Name, Age, Onset, History of PI

Level 1
If YES to any of the following symptoms, patient should immediately visit the emergency department. If time allows, consult first with MD/NP/PA. Use EMS.

There are no symptoms warranting EMS.

Go to level 2.

Level 2

Yes	No	
❑	❑	Recent urinary tract surgery and unexpected pain with urination
❑	❑	Taking blood thinners and urine is pink or red

If YES to the above symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	Burning or pain on urination
❑	❑	Frequency or urgency of urination
❑	❑	Large amount of blood in urine
❑	❑	Back or flank pain
❑	❑	Fever
❑	❑	Severe scrotal pain or swelling
❑	❑	Penile discharge
❑	❑	Pregnancy
❑	❑	History of lupus, glomerulonephritis or single kidney
❑	❑	Nausea and/or vomiting

If YES to the above symptoms, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult. If NO to the above symptoms, go to level 4.

Remember: You can only use a guideline (protocol) if the physician has signed it.

Once you have submitted your protocol to the clinicians to review, be prepared for many changes. They may want you to ask other questions or they may prefer that you not ask some that you have identified. Do not take this input

personally; the physician-authorized manual must reflect the physician's medical advice, not yours or that of some book. The protocol should be put in page protectors after it is signed by the physician. Then you can use it.

Level 4

Yes	No	
❑	❑	Urgency or frequency >3 days
❑	❑	Pain over bladder
❑	❑	Increased pain at end of urination
❑	❑	Cloudy or foul-smelling urine
❑	❑	Recurrent urinary tract infection
❑	❑	Painful urination after sexual contact
❑	❑	Frequent bubble baths or soap remains on genital areas, particularly in young girls

If YES to the above symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

- Drink lots of fluids, especially cranberry juice
- Urinate before and after intercourse
- Wear cotton underwear
- Avoid frequent bubble baths and wash perineum with clear water only
- Add 1/2 cup white vinegar to bath and soak for 20 minutes. Repeat in 2 and 12 hours.
- Take your usual pain medication for discomfort and follow instructions on label

Report the following problems:

- **Persistent discomfort or condition worsens after 48 hours of home care or antibiotic therapy**
- **Fever, back or flank pain**
- **Increased blood in urine**

Date:_____Physician's signature:_____

Wheezing (Asthma)

Key Questions: Name, Age, Onset, History of PI

Level 1

Yes	No	
❑	❑	Severe respiratory distress
❑	❑	Unable to speak
❑	❑	Chest retractions
❑	❑	Aspiration of foreign body
❑	❑	Blue lips or face
❑	❑	Severe chest pain

If YES to the above symptoms, patient should immediately visit the emergency department. If time allows, consult first with MD/NP/PA. Use EMS. If NO to the above symptoms, go to level 2.

Level 2

Yes	No	
❑	❑	Unresponsive to medication treatment
❑	❑	Unresponsive to home care measures
❑	❑	Must sit up to breathe
❑	❑	Wheezing similar to prior episodes that required hospitalization or injections
❑	❑	History of CHF, cardiac disease, pulmonary embolus or blood clot in leg
❑	❑	Green, yellow or rust-colored sputum
❑	❑	Infant or Elderly

If YES to any of the following symptoms, patient should be evaluated within the hour, at either urgent care, emergency department or MD office. If NO to the above symptoms, go to level 3.

Level 3

Yes	No	
❑	❑	First wheezing episode and resolves in short period of time
❑	❑	Fever

If YES to the above symptoms, patient should be seen within 4 to 6 hours, or up to 12 hours if patient is stable and with MD/NP/PA consult. If NO to the above symptoms, go to level 4.

Level 4

Yes	No	
❑	❑	Frequent episodes (1 to 2 per week)
❑	❑	Has had moderate trouble with lungs in past
❑	❑	Wheezing is getting worse over last several days
❑	❑	Wheezing interferes intermittently with some daily activities

If YES to the above symptoms, time of visit is not critical but routine office visit appointment may be warranted within 24 to 72 hours. Have patient call if symptoms change for the worse or are not improving. If NO to the above symptoms, go to level 5.

Level 5

Office visit is not necessary at this time. Practitioner offers self-care advice based on patient's symptoms. Have patient call if symptoms change for the worse or are not improving.

- Take medication as directed
- Use vaporizer with cool mist

Report the following problems:

- Condition worsens
- No improvement with medication

Go to emergency room:

- Lips or face become blue
- Fighting for air
- Decreased level of consciousness

Date:_____Physician's signature:_____

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Answers to Unit Worksheets

Unit 1

1. Documentation is written proof that the patient has received the medical care ordered by the practitioner.
2. Quality of Care Requirements, Standards for Language Use, Legal Review Standards, Requirements for Reimbursement
3. Doctor's progress notes, doctor's orders, transcription records, history and physical examination records, x-ray and laboratory reports, charting notes by medical staff, insurance billings, encounter forms
4. c
5. a
6. c
7. d
8. b
9. a. HPI
   b. ROS
   c. P/SH
   d. CC

Unit 2

1. Source-oriented narrative method; problem-oriented method
2. a. Charting is done in various parts of the record and information is disjointed.
   b. Topics are not always clearly identified.
   c. Information is difficult to retrieve.
3. S: Subjective data; O: Objective data; A: Assessment data; P: Plan of action.
4. a. database
   b. a problem list
   c. a care plan for each problem
   d. progress notes
   e. discharge summary

5. c
6. c
7. a
8. b
9. a. POMR
   b. Dx
   c. Sx
   d. r/o; R/O
   e. V/S, VS
   f. Tx
   g. Fu; FU

Unit 3

1. Range of duties that are permitted by law and that are within the level of training and instructions of persons in that occupational field.
2. Injuries from knife wounds and gunshot wounds, injuries that may be due to child abuse or elderly abuse; diseases that represent potential threats to the public health, such as sexually transmitted diseases.
3. Black is preferred.
4. Always practice within the law; preserve the patient's confidentiality; maintain meticulous records; obtain informed, written consent.

Unit 4

1. a. Client's words
   b. Clarity
   c. Completeness
   d. Conciseness
   e. Chronological order
   f. Confidentiality
2. Your health care facility should have a list of abbreviations that have been adopted for use for all documentation.
3. Very clearly indicate that this is a late entry. Write the date and time you are entering the late entry, then write "late entry."
4. Use black pen that will not smudge or smear; have legible handwriting; print if you have to. Write name, numbers and abbreviations clearly.
5. Information in the record has been entered at the time of a patient's visit.

6.

8/8/xx	9:45 a.m. Pt called and said she was nauseous error 8/8/xx pk ---- -nauseated and vomiting wrong entry 8/8/xx pk vomiting. P. ---- Krueger, CMA----------

7a.

11/1/xx	8:00 a.m. TC. CC: "have the worst headache of my life." P. Krueger, CMA----------

Or

11/1/xx 0800	T.C. S: "I have the worst headache of my life."----------
	O: Pain 10 on scale of 1-10. No numbness/tingling in ---------- extremities; no Hx of migraine----------
	A: Dr. See notified. Come to office immediately, or go to urgent care----------
	P: Dr. See notified that patient is coming in.----------
	P. Krueger, CMA----------

7b.

11/1/xx	4:30 p.m. Phone call (PC). c/o "pain in back and blood------ in urine." Sts cannot sit or lie down; just keeps walking------ around. P. Krueger, CMA----------

Or

7c.

11/1/xx	PC. S: "I have pain in my back and blood in my urine. I ---- cannot stand to sit down or lay down. I have to keep------- walking around."----------
4:30 pm	O: Pain 8/10----------
	A: Notify Dr. Jones.----------
	P: To go to ER STAT----------
	P. Krueger, CMA----------

8. a
9. b
10. c
11. c
12. d
13. d

Unit 5

1. c
2. d
3. c
4. c
5. d

6. Caller's full name (spelled correctly)
   Action required
   Date, time of call
   Initials of person receiving the call
   Phone number of the caller
7. Cancellation without making a new appointment
   Rescheduling an existing appointment
   Following up on a no-show patient who missed their appointment
8. To protect office from malpractice for abandonment
9. CANC
10. RS
11. NS
12. NP
13. C & C
14. Follow-up examination
15. Referral
16. Consultation
17. Recheck
18. Complete physical exam

Unit 6

1. Document what the patient tells you
   Document what you observe
   Document what you do
   Document what you teach
2. c
3. b
4. d

5. a
6. How well he/she understands the condition, treatment plan, and home care
7.

10/01/xx	10:00 a.m.. OV.
	S: c/o "burning pain when I urinate. It feels like I have to go to the bathroom q5min but nothing comes out".
	O: holding hand over bladder region and crying
	A: BP: 134/86; P. 88; T 99.6°F
	P: UA to lab for C & S per Dr. Smith. Rx sent home. To call if Sx worsen. P. Krueger, CMA

Unit 7

1. d
2. e
3. e
4. b
5. Name, age, home telephone, patient ID or health plan number, identity of caller and relationship to patient

Unit 8

1. c
2. b
3. b
4. a

Unit 9

1.

12/19/xx	TC. From daughter. Sts mother "appears lethargic and glassy-eyed." Temp 102°F. Denies ----------
0830	breathing difficulties, headache, stiff neck, excessive------ thirst. Advised to bring mother to office.----------
	Within the hour per FEVER protocol. P. Krueger, CMA

2.

12/20/xx	TC: CC: frequent urination and hematuria. Sts has------- weakness, back pain and a temp of 103°F----------
1000	Appointment made for 1420 today per URINATION , Painful protocol. P. Krueger, CMA----------

3.

12/110/xx	1200. TC. Mother sts son fell from tree. Cut on head---bleeding. Son unable to move legs.----------Loss of consciousness at time of fall, now alert. Advised to call 911, do not move son.----------P. Krueger, CMA----------

4.

12/20/xx	1125. TC from husband. Sts wife c/o chest pains radiating down left arm and up into the jaw. Has taken 3 nitroglycerin. Is perspiring and nauseated. Advised to have wife chew an aspirin and call 911 per CHEST PAIN protocol. P. Krueger, CMA----------

5.

12/17/xx	TC. Friend reports that Pt c/o SOB. Lips turning purple, gasping for air. Hx of thrombophlebitis. Advised to call 911 per SHORTNESS OF BREATH protocol. P. Krueger, CMA

6.

11/10/xx 1500	TC. c/o "wheezing for past 2 wks especially following playing soccer. Advised to come to office at 1000 11/12/xx per Wheezing Protocol. Pt agreed to appt. P. Krueger, CMA

Biography

Peggy M. Krueger, MEd, BSN, RN, CMA

Peggy M. Krueger, MEd, BSN, RN, CMA, is the program coordinator of the medical assistant program at Linn-Benton Community College, in Albany, Oregon. Krueger graduated with a BSN in nursing from Humboldt State University, in Arcata, California, and a master's degree in education from Oregon State University, Corvallis, Oregon. She has worked in a variety of health care settings—in the local hospital as a float RN; in public health, running the well-baby clinics; and in an OB/GYN office—and, since 1977, has simultaneously taught at Linn-Benton Community College. She has reviewed many textbooks and is the author of a medical terminology videotape series.

Documentation and Telephone Screening
CEU Test

Directions: Select the correct answer and circle the corresponding letter on the following answer key.

1. Written proof that the patient has received the medical care ordered by the practitioner is:
   a. A prescription
   b. Consultation letter
   c. Documentation
   d. Insurance billing

2. The patient's chart is:
   a. None of the patient's business
   b. Kept under lock and key at all times
   c. Written in only by practitioners
   d. A legal document

3. The standards for language used in documentation include:
   a. Correct spelling
   b. Proper use of grammar and punctuation
   c. Use of facility-approved abbreviations
   d. All of the above
   e. A and C

4. The medical assistant's scope of practice is established by:
   a. State law
   b. AMA
   c. Medical assisting programs accredited by the Commission on Accreditation of Allied Health Education Programs

5. _____is the key in documentation.
   a. Reimbursements
   b. Printing
   c. Language
   d. Spelling

6. ROS is the abbreviation for:
   a. Range of stretching exercise
   b. Root of spelling
   c. Review of systems
   d. Right and left eye

7. The _____medical record allows caregivers to use a separate section in the chart to record information.
   a. POMR
   b. SOAP
   c. Source-oriented narrative
   d. Problem-oriented narrative

8. Sx is the abbreviation for:
   a. Subjective
   b. Sick
   c. Source-oriented record
   d. Symptom(s)

9. The plan of action in the SOAP method:
   a. Is factual, measurable data
   b. Is subjective complaints
   c. Is based on the Sx, exam and test results

10. Abbreviations are:
    a. Standardized clinical shorthand
    b. Difficult to learn and time-consuming to use
    c. Not used very often in the patient charting

11. In a health care setting, C/O means:
    a. Care of
    b. Cardiac obstruction
    c. Complaining of
    d. Carbon dioxide

12. Which area of charting would contain the CC?
    a. Subjective
    b. Objective
    c. Assessment
    d. Plan

13. Which type of documentation format takes considerable time and cost to train people?
    a. Source-oriented charting
    b. SOAP charting
    c. Traditional charting

14. All medical records are:
    a. Legal documents
    b. Not admissible in a court of law
    c. Completed with pencil
    d. Only legal if notarized

15. Failure to observe patient's right to privacy could result in:
    a. Abandonment
    b. Cancellation of appointment
    c. A lawsuit
    d. Charting that is discriminatory

16. An exception to the patient's right to privacy and confidentiality is:
    a. Emergency situations
    b. Good Samaritan laws
    c. Information requested by subpoena
    d. Spousal request for information

17. When correcting a charting error, one should:
    a. White out the mistake
    b. Black out any letters or words and rewrite
    c. Use a single line through the error
    d. Erase and rewrite the entry

18. Charting should be done:
    a. In red ink, so it stands out
    b. In pencil, so you can correct it more easily
    c. In black ink
    d. Only on a computer or typewriter

19. Charting errors can be denoted by entries such as:
    a. Oops
    b. Sorry
    c. Frowning face
    d. "Error" or "wrong entry"

20. In SOAP charting, the patient's words are recorded in which area?
    a. Subjective
    b. Objective
    c. Assessment/action
    d. Plan

21. Which abbreviation is incorrect?
    a. SOB for sitting out of bed
    b. Pt for patient
    c. Hx for history
    d. Px for prognosis

22. If you misspell a word in charting:
    a. Leave it alone
    b. Cross it out and rewrite it above
    c. Cross it out and insert the correct spelling above all other charting
    d. Use a single line through the misspelled word, insert the date, your initials and rewrite the word

23. Information going to insurance companies for billing purposes requires:
    a. Informed consent
    b. Implied consent
    c. Release of information consent
    d. Subpoena duces tecum

24. Which of these scenarios requires documentation?
    a. Patient rolls up sleeve for blood pressure to be taken
    b. Patient asks for a prescription refill
    c. Subpoena of chart notes
    d. B and C
    e. All of the above

25. The main issue about using a fax machine is:
    a. Must have a transmission private line
    b. Must use a cover sheet with transmission
    c. Confidentiality of information

26. Telephoned or faxed prescriptions and refills require:
    a. No documentation in the chart
    b. Only written orders
    c. Patient's full name and date of birth
    d. DEA approval

27. The medical assistant must document:
    a. Patient's diet
    b. Patient's occupation
    c. All telephone calls to the office
    d. Telephone calls regarding patient care

28. All cancellations and no-show appointments must be documented to:
    a. Keep a record of who needs the next available appointment
    b. Let the doctor know who is not keeping appointments
    c. Prevent a lawsuit for abandonment by the physician
    d. Inform insurance companies, who require it

29. The correct abbreviation for cancellation is:
    a. Clld.
    b. Ca.
    c. Cons.
    d. Canc.

30. The best way to document what the patient tells you is:
    a. To identify where the information is coming from
    b. By what you assess
    c. By quoting the patient directly
    d. By determining the patient's knowledge level

31. Which of these statements is specific?
    a. BP. About 122/50
    b. Skin is dry and warm
    c. Lips look purple or blue
    d. Seems lethargic and glassy-eyed

32. Documentation should be done:
    a. At the end of the day, when it is quiet
    b. During the lunch hour
    c. Whenever it is possible
    d. As soon as the task is completed

33. Documentation shows:
    a. That appropriate action based on assessment of the patient's condition was performed
    b. How long it took to perform a single task
    c. Only patient's positive response

34. Telephone screening is:
    a. A head-to-toe assessment
    b. Receiving numerous questions regarding health care
    c. Not the responsibility of the medical assistant
    d. The ability to determine the severity of the symptoms in order to schedule an appointment

35. Protocols are:
    a. Rules to keep the office in compliance with federal laws
    b. Directions for performing procedures
    c. Accounts of actions to take based on symptoms
    d. Abbreviated doctor's orders

36. A working diagnosis:
    a. Is designed to diagnose the caller's medical condition
    b. Is based on an assessment of unconfirmed symptoms
    c. Is made by a medical assistant
    d. Is forbidden by federal law

37. A medical diagnosis is done by:
    a. Nurses
    b. Physicians
    c. Medical assistants
    d. Physician assistants
    e. b and d

38. "Preauthorized telephone screening" means:
    a. There are standing orders to be followed
    b. The physician has agreed to the type of appointment to be given based on the patient's symptoms
    c. Prescription and refills can be done by the medical assistant
    d. Medical assistants are not to use the telephone

39. Telephone guidelines suggest that the medical assistant must:
    a. Exercise independent judgment
    b. Base decisions only on schooling
    c. Base decisions only on physician-authorized guidelines

40. Physician-authorized manuals:
    a. Give the physician directions for care
    b. Give the telephone screener guidelines for assigning appointments
    c. Summerize federal and state law

41. The first level of care on the protocol page is:
    a. Same-day appointment
    b. Urgent appointments; see within 1 hour
    c. Emergency services needed; go to ER or call 911
    d. Routine office visit within 24-72 hours

42. Advice for home care is usually which level on the protocol page?
    a. Level 4
    b. Level 3
    c. Level 2
    d. Level 5

43. Every appointment given should end with:
    a. Thank you for calling
    b. Call back if the symptoms do not improve or get worse
    c. Call back when you are feeling better
    d. The practitioner will call you to see how you are doing

44. New symptoms and updates on appointment scheduling:
    a. Depend on the physician's desires
    b. Should be revised and updated as needed
    c. Are not necessary except at the annual review

45. Screening decisions are made on the basis of:
    a. Anxiety of the patient
    b. Established preauthorized protocols
    c. Whether or not the patient is a member of the physician's family

46. After a screening decision is made, the medical assistant:
    a. Notifies the physician
    b. Notifies the office manager
    c. Conducts the assessment interview
    d. Documents the call

47. "If it isn't written down, _____."
    a. The physician could go to jail
    b. The medical assistant can't be held responsible because he/she is under the practitioner's license
    c. It didn't happen
    d. It wasn't worth noting

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Answers (circle the correct letter)

1.	A	B	C	D	E	25.	A	B	C	D	E
2.	A	B	C	D	E	26.	A	B	C	D	E
3.	A	B	C	D	E	27.	A	B	C	D	E
4.	A	B	C	D	E	28.	A	B	C	D	E
5.	A	B	C	D	E	29.	A	B	C	D	E
6.	A	B	C	D	E	30.	A	B	C	D	E
7.	A	B	C	D	E	31.	A	B	C	D	E
8.	A	B	C	D	E	32.	A	B	C	D	E
9.	A	B	C	D	E	33.	A	B	C	D	E
10.	A	B	C	D	E	34.	A	B	C	D	E
11.	A	B	C	D	E	35.	A	B	C	D	E
12.	A	B	C	D	E	36.	A	B	C	D	E
13.	A	B	C	D	E	37.	A	B	C	D	E
14.	A	B	C	D	E	38.	A	B	C	D	E
15.	A	B	C	D	E	39.	A	B	C	D	E
16.	A	B	C	D	E	40.	A	B	C	D	E
17.	A	B	C	D	E	41.	A	B	C	D	E
18.	A	B	C	D	E	42.	A	B	C	D	E
19.	A	B	C	D	E	43.	A	B	C	D	E
20.	A	B	C	D	E	44.	A	B	C	D	E
21.	A	B	C	D	E	45.	A	B	C	D	E
22.	A	B	C	D	E	46.	A	B	C	D	E
23.	A	B	C	D	E	47.	A	B	C	D	E
24.	A	B	C	D	E						

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