Documentation in the Era of the Electronic Medical Record

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“IF IT WASN’T DOCUMENTED, IT WASN’T DONE.”

Documentation
In The Electronic Record

Electronic Records:

- Cooperate with training/significant downside to lack of knowledge during a deposition – important to learn updates/improvements.

- Definition of the Medical Record;
  Understand the Hospital/Office Definition;
  Understand what is excluded, such as, reminders, alerts, built in tools to help improve patient care.


STOP
TEXTING

Documentation Accuracy

- During depositions and trial, it is essential to know what was entered by you and what was automatically populated with menu selections.

Documentation Accuracy

Prior to deposition or trial, always consult with Health Informatics professionals at the hospital to make sure you have determined exactly what you documented and when.

Documentation Accuracy

"Patient Portals" make accuracy even more essential.

Documentation Accuracy

Automatic communication back to the Primary Care Physician (PCP) must be utilized.

Printed Electronic Record

Printed Electronic Record:

- Looks very different than what is seen on the computer screen as data is being entered;
- The printed record is lengthy and cumbersome;
- The ability to print the record with differing formats makes the record look different and content may be in another location, but it is always there.
- A summary note is extremely helpful and pieces together a picture of what happened.

Correcting The Electronic Record

Correcting the Electronic Record:

- It is important to correct any errors before signing the electronic record;
- Once the record is signed, it cannot be changed without the assistance of the IT department;
- Correcting the electronic record when an error is found is critical;
- It is critical to follow the correct protocol/policy when correcting the electronic record.

Audit Trail For The Electronic Record

- Each time the electronic record is entered, a stamp/trail is created;
- The audit trail tracks when the record is reviewed, entries are made, revisions or updates are entered by date and time.

Audit Trail *CONT…*

- Reviewing a chart after the patient is discharged is part of the audit;
- Risk management or administration entering a record is part of the audit.

Use of Medical Record By Plaintiff

Use of The Medical Record by Plaintiff's Counsel:

- To establish loose ends which could infer substandard care;
- To find health care providers to sue;
- To develop theories of liability;
- To identify witnesses to treatment and/or to depose;
- To determine if medical practice was or was not in compliance with hospital policy or protocol.

Documenting An Event/Error

- Do not refer to the event as an Error;
- Objectively document what happened per the charting policy;
- Document the patient and family's understanding of the event;
- Document patient statements in direct quotes;
- When in doubt, turn to resources (Risk Management/Supervisor) .

Documentation Can Be Extremely Helpful At Trial

- "The medical record is a witness whose memory never fades";
- It is important to understand the implications of what you wrote and how you wrote it.

Harvard's Top 5 EMR Reasons for Adverse Events

EHR-related adverse events involve both user- and system-related issues.

EHR-related Factors Contributing to Patient Harm

TOP FACTORS	% CASES*
user error	17%
incorrect information in record	16%
pre-populating or copy/paste errors	14%
conversion issues (hybrid paper & electronic records)	13%
system/software design issues	12%

*a case may have more than one error identified

N=420 MPL cases asserted 1/1/11-12/31/15 with an EHR-related factor identified

Have questions? Reach out at any time!

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