Defending your Documentation:
The Electronic Health Record, Documentation and Depositions

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Objectives

At the end of this program the participants should be able to:

- Identify potential problem areas for information omissions and documentation errors.
- Understand the importance of correct and complete medical record documentation to a professional liability case.
- Promote strategies to improve documentation, individually and within their work environment.

Electronic Health Record (EHR) Closed Claims

- We finally have data
- 2019 closed claim study: EHR contributing factor to claim
- 2010 – 2018 = 216 claims
- 1.1% of closed claims since 2010
- Universal adoption and increased risk
- We have been actively talking about this since the spring of 2012
  - ‘Perils and Pearls of the Electronic Health Record’

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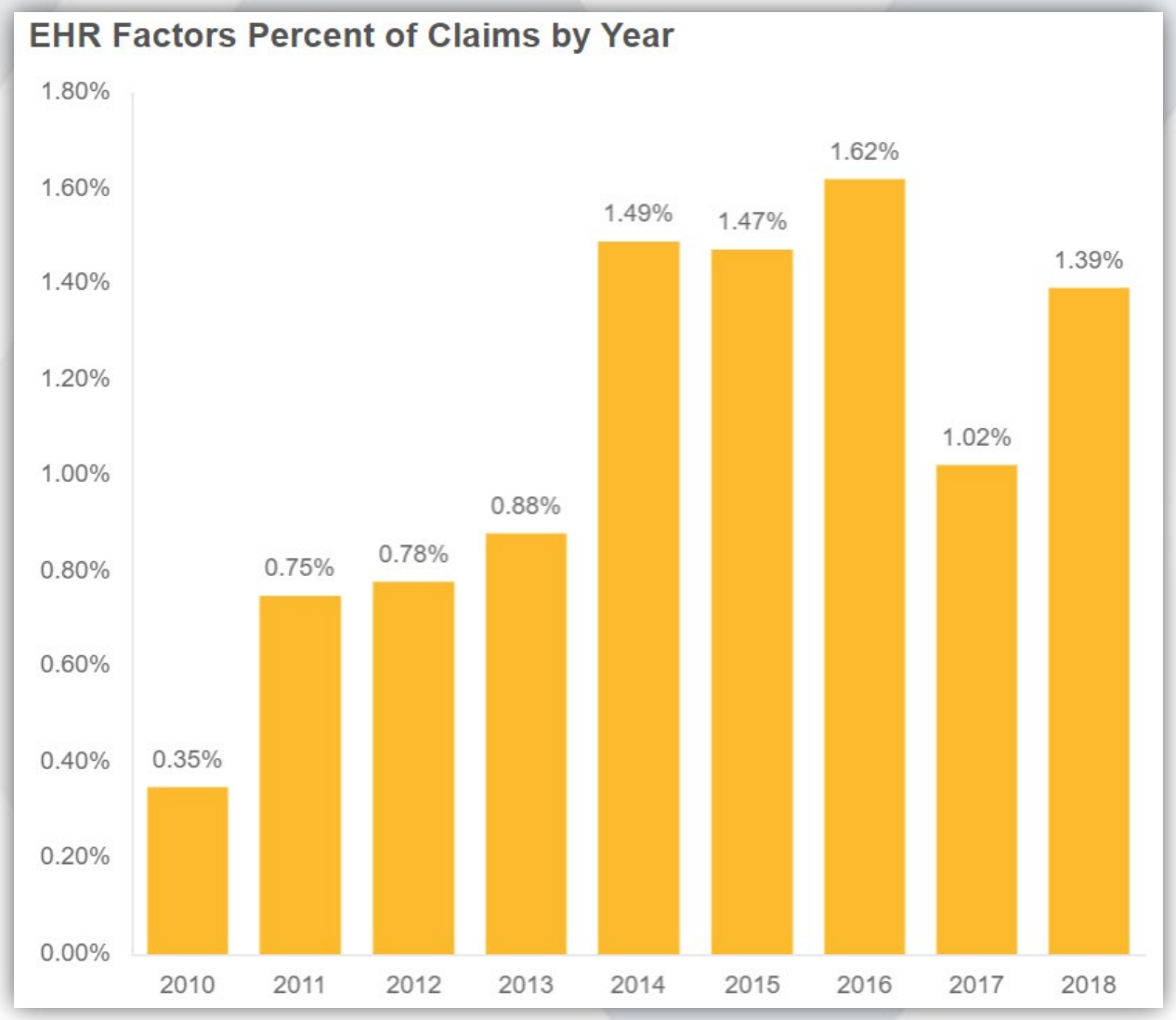
EHR Contribution to Liability Claims



(The Doctor's Company, 2019)

Closed Claim Review 2010 - 2018

Top System Technology and Design Issues	Claim Count	Percent
Other	30	14%
Electronic systems/technology failure (EHR)	26	12%
Lack of or failure of EHR alert or alarm	15	7%
Fragmented record	14	6%
Failure/lack of electronic routing of data	10	5%
Insufficient scope/area for documentation in EHR	8	4%
Lack of integration/incompatible systems	5	2%
Failure to ensure information security	1	0%
Grand total	**104***	**48%**

**Note that the percentages are of the total number of EHR claims (n=216).*

(The Doctor's Company, 2019)

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Medication Error Due to EHR Selection

- *Event:* An elderly female patient presented to her primary care physician for sinus complaints. The physician intended to order Flonase nasal spray. The patient took the medication as directed. Two weeks later, the patient presented to the ED for dizziness.
- *Outcome:* The ED physician discovered the patient was taking Flomax—a medication for enlarged prostate, one side effect of which is hypotension. The original ordering physician had entered “FLO” in the medication order screen, and the EHR automatically selected Flomax. Not noticing the error, the physician selected it. There was no EHR drug alert for gender.

(The Doctor’s Company, 2019)

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Design Failure

- Multiple issues:
  - Other medications starting with “FLO” listed below
  - Alert not entered for this medication or not turned on
- *Result*: The patient made a demand for expenses associated with the cost of the original medication, emergency room visit and two night hospitalization.
- *Defense*: Claim paid

Participant Poll

Depositions – Typical Questions

- Tell me how you document your part of a patient encounter.
- Did you receive training or orientation to the EHR?
- Are their policies and procedures on documentation?
- Did you receive training or orientation on these policies and procedures?
- Do you feel you followed the appropriate procedure when documenting this patient encounter?
- Do you provide the patient with a discharge or care summary at the end of their encounter?

Diagnostic Reports Not Received

- *Event*: 53 year old female patient, new to the practice, examined for general check up. Routine screening mammogram ordered. The mammogram was ordered and completed that same month. Suspicious calcifications were noted in the patient's right breast and a stereotactic biopsy was recommended. The facility performing the mammogram electronically sent the report to the provider's office. However the biopsy was never ordered or performed.
- *Outcome*: The patient returned 6 months later with complaints of a "lump" found in her right breast. After investigation it was noted the report was not received when sent. The results went to a default folder that was not accessible to the practice staff. Staff called for the report and the provider ordered the stereotactic biopsy which resulted in a diagnosis of invasive ductal carcinoma. CT scan showed metastatic disease. The patient began chemotherapy, underwent lumpectomy and at the time the claim closed the patient was in remission.

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Vendor Error - Default Settings

- The staff had no knowledge of this default folder as the vendor set the default and this had been occurring since the EHR system had been implemented.
  - Staff not notified by vendor of this setting.
  - No access - password protected, password unknown.
  - Staff developed a work around to not receiving laboratory and diagnostic radiology reports by calling for the reports to be faxed when prepping for office visits.
- *Result*: The patient brought suit alleging negligence and malpractice resulting in bodily injury, disability, pain, suffering, mental anguish, loss of enjoyment of life, loss of a chance of better recovery or survival, medical expenses and lost wages, future damages.
- *Defense*: Claim paid. Three defendants contributed to settlement.

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Depositions – Typical Questions

- Explain how you normally prepare for a patient's office visit?
- Do you feel comfortable bringing concerns or issues you are having with the EHR to your supervisor, office manager?
- Did you notify your supervisor or office manager that you were not receiving reports?
- How did you come to this conclusion?
- Did you notify the vendor you were not receiving reports as expected?

Issues in Liability Claims

Top User-Related Issues	Claim Count	Percent
Incorrect information	29	13%
Pre-populating/copy and paste	29	13%
Hybrid health records/EHR conversion issues	27	13%
User error (other)	25	12%
Training and/or education	16	7%
Alert issues/fatigue, user-related	5	2%
Computer order entry workarounds	4	2%
Grand total	**129***	**60%**

**Note that the percentages are of the total number of EHR claims (n=216).*

(The Doctor's Company, 2019)

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Copy and Paste

- *Event:* A physical medicine physician followed a patient with extreme weakness due to cervical vascular malformation. Nurses and a physical therapist noted neurological changes, but the physician's note indicated no changes. The physical therapist contacted the attending physician to discuss neurological changes including increased weakness. The physical therapist asked the physician to order a neurological consult due to the patient's deteriorating condition.
- *Outcome:* The physician ordered the consult but did not explain why his documentation did not address the patient's changing condition. The patient was taken to surgery and now has incomplete quadriplegia. The physician was criticized for copying and pasting the same note for four days and delaying the intervention.

(The Doctor's Company, 2019)

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Identical Notes

- *Result:* Defense experts concluded the identical progress notes resulted from copying and pasting. The provider did not get the opportunity to defend himself against the allegations.
- *Defense:* Claim Settled

(The Doctor's Company, 2019)

Copy and Paste Second Case

- *Event:* A 38-year-old obese patient presented for medical clearance. His test results were normal. Three months later, the patient presented with shortness of breath and dizziness. His blood pressure was 112/90 and pulse was 106. No tests were ordered.
- *Outcome:* Five days later, the patient expired from pulmonary embolism. Experts questioned whether the physician had conducted a complete assessment. The progress note was identical to the previous note from three months earlier, including old vital signs and spelling errors.

(The Doctor's Company, 2019)

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Identical Notes - Repeat

- *Result:* Defense experts questioned whether the physician had done a complete assessment, because the progress note from the most recent visit appeared identical to the prior visit's progress note—including the same spelling errors—suggesting that the note had been copied and pasted. The provider did not get the opportunity to defend himself against the allegations.
- *Defense*: Claim Settled

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Hybrid EHR–A Tale of Two Sets of Nurses Notes

- Event: This 47 year-old male with a past medical history of uncontrolled diabetes, drug abuse and alcoholism and spleen removal; underwent L4-5 bilateral laminectomy with foraminotomy. After discharge the patient was scheduled to follow up with the surgeon, however was a no-show. The patient saw his primary provider the next day and on several subsequent occasions complaining of back pain and requesting pain medications. One week post op the patient presented to the hospital ER, with complaints of back pain, elevated temperature and BP 92/60. A culture was taken of his laminectomy wound, he was given a Toradol/Phenergan injection and an antibiotic was prescribed. The patient was discharged with instructions to continue his regular medications, start oral antibiotic twice daily, follow-up with his PCP in 4-5 days and follow-up with his surgeon as needed. That afternoon the patient returned to his PCP for complaints of back pain and said he thought that the incision site was infected. BP was 86/60. PCP found no evidence of infection and culture results were not available yet.
- Outcome: The next day the patient presented to the ER and was admitted for possible septicemia, BP 86/70, a blood culture was drawn. The patient's blood glucose was high at 489. WBC was normal but bandemia was high. 5 hours after admission, the patient experienced Code Blue and died. Cause of death was determined to be Group A strep upon receipt of culture results after the patient's death.

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Hybrid EHR–A Tale of Two Sets of Nurses Notes

- *Result:* Unfortunately, there was a situation of two sets of ER nursing notes for the last ER visit. The defense attorneys believe that the ER chart went with the patient to the floor when admitted; the ER notes were scanned into the inpatient chart and the ER nurse could not locate her notes so she recreated them. The content of the two versions is essentially the same. However, the second set is more detailed and reflects additional entries within the chronology of treatment; which gave the appearance that the nurse made a more detailed version after the patient's death.
- Also there was confusion with the multiple versions of records as the hospital provided the defense a copy of its electronic chart but had produced to plaintiff, in response to a records request, a printed copy of the chart. Each version did not contain the exact same pages or same ER nurse's notes.
- *Defense:* The claim was settled. If the claim had not been settled the ER nurse would have been deposed regarding the documentation and processes.

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EHR Contributions to Claims per Specialty

8%	• Family Medicine • Internal Medicine
6%	• Cardiology • Radiology
5%	• Obstetrics • Orthopedics • Nursing
4%	• Hospital Medicine • Gynecology
3%	• Emergency Medicine • Anesthesia • Plastic Surgery • Urology Surgery • General Surgery

(The Doctor's Company, 2019)

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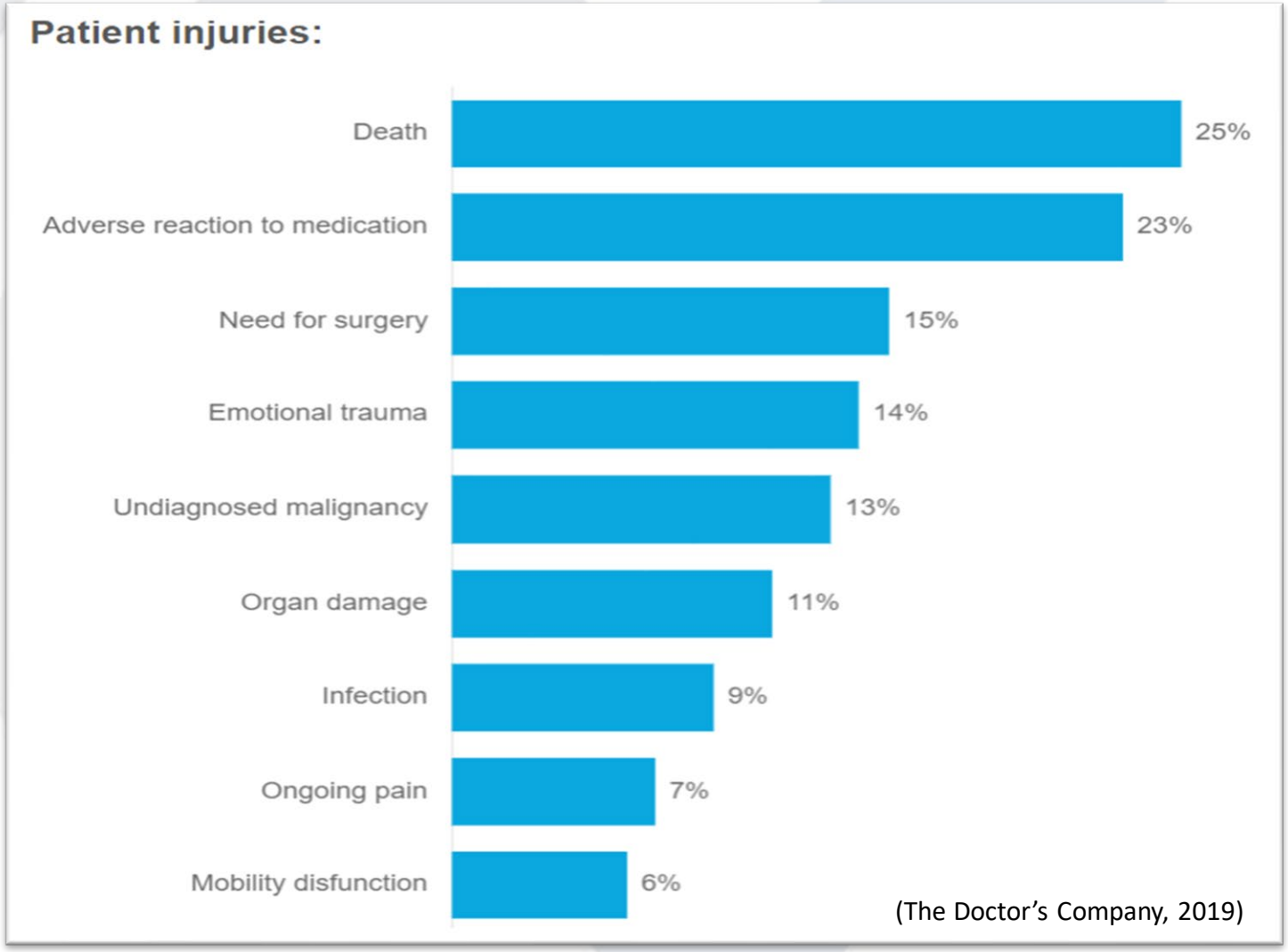
Adverse Outcomes related to EHR in Claims



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Charting on Wrong Chart

- Event: Woman furniture shopping sat on a piece of furniture and it broke causing her to fall to the floor. She presented to the ER for evaluation and complaints of back and hip pain. Patient was evaluated by nursing staff and provider; radiology exams performed and discharged to home with pain medication and to follow up with her primary care provider.
- Outcome: Patient made a demand to the furniture store for costs associated with ER visits, ongoing physical therapy and emotional trauma. The furniture store turned the claim over to their insurance company who requested the patient's medical records. The insurance denied the claim due to the patient having documented drug dependency.

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Charting on Wrong Chart

- Result: The ER nurse had two patients she was evaluating and charting on – when she went to document the other patient's history, it was on the wrong chart, thus documenting the patient's admitted drug addiction history and visit for related issues. The nurse went back and made a note that the documentation was the wrong patient and corrected the documentation. However, the information remained in the audit trail, along with the corrected information. The patient made a request to the facility that the information be completely removed. Unfortunately, it can not be removed from the audit trail or meta data. The patient made a Demand that the information be removed and the facility cover her medical expenses and a sum for emotional trauma.
- Defense: This claim was denied as no medical malpractice occurred.

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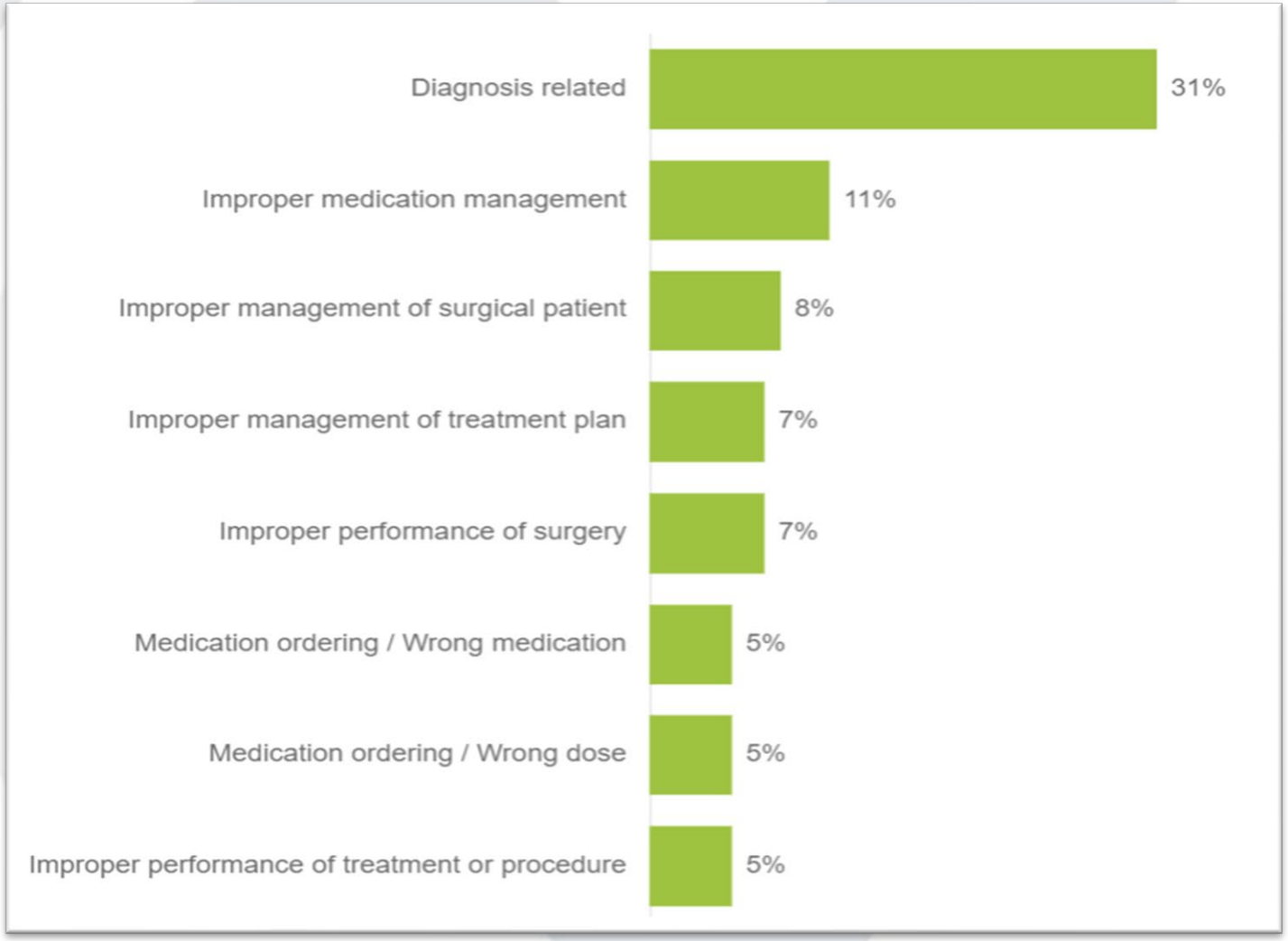
Top Allegations in Liability Claims



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Risk Management Strategies

- Develop policies and procedures for appropriate documentation methods.
- Educate staff on policies and procedures – document compliance
- Modify or redefine system to meet changing regulatory, technology, or work flow developments.
- Identify specific risks and implement risk mitigation actions.

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Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: Copy/paste may perpetuate incorrect or outdated information.
- *Mitigation*: Avoid copying and pasting except when describing the patient's past medical history.

Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: Many EHRs auto-populate fields in the patient's history and physical exam and in procedure notes, causing the entering of erroneous or outdated clinical information.

- *Mitigation*: Contact your organization's IT department or your vendor if you notice that the auto population feature causes erroneous data to be recorded. If the auto populated information is incorrect, note it and document the correct information.

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Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: Templates with drop-down menus facilitate data entry, but an entry error may be perpetuated elsewhere in the EHR.

- *Mitigation*: Review your entry after you make a choice from a drop-down menu.

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Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: The idea of providers missing a vital piece of information in the EHR can be either a user or a technical error. When a provider doesn't see a test result, it can be a poorly designed interface, it could be the information wasn't routed correctly, whether the physician wasn't notified of the result being there, or the physician clicks it as seen without actually reviewing it.

- *Mitigation*: Develop a follow up system to track results of diagnostic or laboratory studies ordered for patients. If the EHR system has a reminder or tickler module to remind providers to follow up on outstanding results that feature should be utilized. Occasionally a separate module may be purchased as an add on.

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Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: Providers are responsible for the information to which they have reasonable access. EHR metadata documents what was reviewed. A patient injury may result from a failure to access or make use of available patient information.

- *Mitigation*: Review all available data and information prior to treating a patient.

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Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: Alert Fatigue - CPOE systems generate warnings for 3%–6% of all orders that are entered, meaning that a provider could easily receive dozens of warnings each day. Providers become desensitized to safety alerts, and as a result ignore or fail to respond appropriately to such warnings. Occasionally alerts are turned off or never turned on for critical issues.

- *Mitigation*: Review the current alerts within the EHR to ensure that activated alerts are specific and critical to patient safety.

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Risk Management Strategies

Establishing risk mitigation for common EHR pitfalls

- *Risk*: The computer may become a barrier between the doctor and the patient.

- *Mitigation*: Relocate the computer so the physician's back is not to the patient and so the patient can view the screen. Remind the patient that you are listening carefully, even though you may be typing during the appointment and summarize or read the note to demonstrate you have listened.

Questions

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