MARTIN SNOW, LLP ATTORNEYS AT LAW

DOCUMENTATION IN ELECTRONIC MEDICAL RECORDS: A LEGAL PERSPECTIVE

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What I do

- I defend health care providers in medical negligence lawsuits

- Martin Snow, LLP
  - commercial and banking law, corporate law, family law, litigation, mergers and acquisitions, real estate transactions, securities law, taxation, and trusts and estates

Today's Goal

- Reduce exposure to lawsuits and improve quality of documentation

The best offense is a good defense

Purposes of Documentation

- To comply with regulations of the government and accrediting organizations
- To generate date for research
- To provide evidence in a court of law

Types of Evidence

- Testimonial Evidence
  - Statement made under oath

- Physical evidence
  - Documents and other objects (medical records)

Why is "good" documentation important?

- "Bad" documentation ≠ malpractice
- BUT . . . it can make excellent care look terrible
  - Not documented, not done.
  - Poorly documented, poorly done.
  - Incorrectly documented, fraudulent.

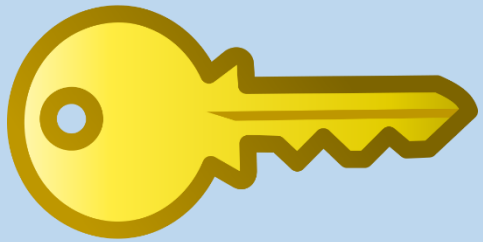
Gray area = uncertainty, questions of fact (jury's role at trial)

Memory fades

- Statute of limitations -- most medical malpractice suits are filed years after the treatment took place
- The legal process takes time
  - Treatment >>> Lawsuit >>> Discovery >>> Trial
- Documentation speaks for itself

Medical records are the key to evaluate the case

- Get the case
- Request a certified copy of records
- Review the records
- Send records to expert
- Discuss records with expert
- Proceed with discovery
- Trial



Medical records frame lawsuits

- Identify the healthcare providers involved in treatment and care
- Set up potential claims and defenses
- Prevent parties/witnesses from later changing their story at trial

Records Custodian

- Problems:
  - Different versions of records
  - Not producing the entire record
  - Surprise records

Electronic Medical Records ("EMR")

- American Recovery and Reinvestment Act required use of EMR by January 1, 2014
- Goals:
  - Improve quality, safety, efficiency, and reduce health disparities
  - Engage patients and family
  - Improve care coordination, and population and public health
  - Maintain privacy and security of patient health information

EMR Software

Electronic Documentation

Strengths:

- Legible
- Prompting
- Changes tracked
- Modifiable System
- Consistent
- Easy to find
- Entries are time and date stamped

MAJOR WEAKNESS: INACCURATE

Wasn't EMR supposed to be "better"?

- Templates
- Filters
- Prepopulated menus
- Copy and paste

Documentation Dos

- Contemporaneously record patient care at the time provided
- Record each phone call including the exact time, message, and response (co-managing a patient)
- Record a patient's refusal to allow a treatment or take a medication, obtain the patient's written refusal
- Record late entries by including the date and time
- Tell the entire story

Documentation Don'ts

- Don't use imprecise descriptions, such as "bed soaked" or "a large amount"
- Don't record care ahead of time
- Don't criticize other health care providers or document your personal opinions
- Don't simply "populate" or "copy and paste" from previous entries

Issues

- Using text messaging to communicate with physicians
- Very late entries demonstrated by audit trail
- Multiple accessing medical records after patient is deceased or discharged demonstrated by audit trail
- Nurses making entries in other patients' charts because computer is logged into the wrong chart, i.e. documenting they are giving medication to a patient who it isn't ordered for it
- Computer-entered physicians orders, when do they expire or terminate, when is a new order needed

Issues

- Lack of documentation
- Copy and pasting from another's documentation
- Hard to find anything when printed out
- Even the providers find it difficult to find things in the chart because the print out of the chart is NOT what it looks like to them when they enter it into the system
- It seems that some things don't always get printed and included
- Who determines the "legal" chart?
- Still having issues with "builds" in the EHR that are not there that we have to add in in order to get payment or for adequate documentation to be done

Questions?

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