Diagnosing Documentation Ailments: Errors in Configuration and Use Compromise Electronic Records

By Genna Rollins

While EHRs offer improvements to patient care, they are not documentation panacea for record keeping. Systems must be properly configured and used to generate solid documentation. When they are not they might not represent what actually occurs in patient care, compromising care and complicating matters for physicians faced with professional liability claims.

"There's a misperception by policy makers, healthcare providers, and vendors that EHRs are equivalent to good documentation," explains Barbara Drury, BA, FHIMSS, president of Pricare, a Larkspur, CO-based consulting firm. "But the presence of an EHR doesn't necessarily lead to better quality or a more reliable truth of what happened during an encounter."

"Some physicians are good users of the tool, and some are not," she continues. "Some are not great with capturing details in writing, and we're simply hiding all those [previous] problems in the EHR."

Drury consults with several professional liability insurance carriers and works directly with their physician clients to evaluate how well EHRs capture the patient care process. Good documentation in EHRs, she notes, is a function of good system configurations and good processes.

In her work Drury sees many opportunities for improvement that help cure common documentation ailments.

Documenting after the Encounter

Some professional liability insurance carriers offer discounts to providers that use EHRs on the grounds that the systems lead to better outcomes. However, when it comes to the record, ultimately they look for good documentation no matter the media.

"Medical malpractice carriers are agnostic about the tools physicians use to document care. They just want the records-whether electronic or paper-to represent the truth and be defensible," Drury explains.

One common pitfall in EHR systems involves the practice of documenting part of a patient encounter after the encounter is over. Some systems may record the time of this encounter as the time that documentation was completed in the system.

Drury ran into such a circumstance when a client who used an EHR in the endoscopy suite to document procedures such as colonoscopies asked her if his nurse would be able to close out e-charts. In evaluating the EHR, Drury observed that according to the e-chart, a procedure took place between 1 and 1:20 p.m. However, the record indicated that the physician's review of systems-recording the patient's medical history, allergies, and the like-took place at 5:30 p.m., which was the time the physician actually recorded it in the EHR.

"You and I could ascertain that the physician completed the systems review before the patient underwent the procedure, but that's not what the record indicated," she says.

In this instance, the medical practice planned to go back to the software vendor to see if there was a simple programming solution.

Drury expects that the vendor's response to the request was likely, "If you had put the review in when you did it, the chart would show the right time." However, she notes, "With the clockwork pace of procedures, not everything is documented exactly when it takes place."

If a programming solution was not forthcoming, Drury recommended a workaround in which the physician inputs a note that he was entering the systems review at 5:30 p.m. but had completed it at 1:05 p.m. It is not ideal, she says, but it reflects a reasonable compromise between a vendor's ability to customize software and the operational realities of fast-paced medical practice.

Working outside the System

Other pitfalls come when practices disable, ignore, or do not use systems in a way that can improve care. For example, while observing the care process in one practice, Drury noted that at the end of an examination the physician gave the patient a handwritten paper prescription. Asked when he intended to record the prescription in the EHR, the physician indicated he would do so that evening.

Drury saw a series of potential concerns with this scenario. The electronic record would have been incomplete in the event the patient had a reaction to the medication that afternoon. In addition, the handwritten prescription created the opportunity for the pharmacist who dispensed it to make a dosage or drug error, and if he or she had contacted the practice for verification there would have been nothing in the chart to go by. Finally, the physician did not take advantage of the software's drug safety module, which checks for adverse drug reactions.

Other system configurations may allow information that was in the system to be removed without notation.

Drury cites the experience of one practice in which the nurse spoke with a patient about a health issue, documented her understanding of and recommendations regarding it, and forwarded these electronically to the physician. The physician agreed with her proposed response; however, he deleted his part of the message endorsing the plan, eliminating evidence that he provided appropriate care oversight. This particular glitch was solved by restricting deletion privileges for the physician.

These examples are just the tip of the iceberg, Drury says. "Those things are happening by the gazillions and we don't know about them," she contends.

Education Is the Cure

Drury has found that often staff are not aware of the potential risks or actual problems with how they configure and use their EHR systems. However, she believes there is a great opportunity for HIM professionals to correct misuse and address less-than-ideal functionalities.

Often the person in the practice who deals with EHR issues has little in-depth training on its optimal use, she says. They may lack HIM education. But if trained, they can spearhead better practices and drill into the EHR and recommend changes.

In addition, Drury encourages HIM professionals to look at the EHR analytically, as if they were outsiders assessing it on behalf of a professional liability insurer. The questions to ask include:

- What sequence of events does the record actually show?
- Is the audit trail picking up all actions entered into the system?
- Do free-text fields jibe with corresponding structured data fields?
- What alerts have been activated or deactivated?
- What actions are supposed to be triggered in response to alerts?

HIM professionals also will do well to familiarize themselves with Health Level Seven's EHR System Records Management and Evidentiary Support Functional Profile, Drury says. This industry standard describes the attributes that support the management of health records within the system for business and evidentiary purposes.

These actions may not cure all that ails EHRs, but they will lower the odds that physicians experience unintended consequences from either their use of, or shortcomings with, the software, according to Drury.

"This is a very complicated ball of twine," she says. "We want tools like EHRs to help prevent bad things from happening and we also don't want them to create unnecessary problems."

Genna Rollins (rollinswrites@verizon.net) is a freelance writer specializing in healthcare.

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