Documentation Risks in Electronic Medical Records

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Many organizations are rushing to get Electronic Medical Records (EMR) programs implemented or enhanced in order to take advantage of the monetary incentives currently being offered for participation in the "Meaningful Use" program. While one of the goals of electronic documentation is to improve the quality of the patient visit, certain practices could actually do more harm than good. EMR has the potential to contribute to medical errors if policies and procedures, as well as monitoring of compliance, are not carefully developed and implemented.

While not comprehensive, here is a short list of some of the more common electronic documentation issues that your organization should examine in the context of your EMR practices:

COPY AND PASTE (also known as Cloning). Copying information from an earlier exam and pasting it into the record for a current visit could carry forward information that is neither accurate nor appropriate for the encounter. Copy and paste also runs the risk of duplicating an error multiple times.

TEMPLATES. Although templates can enhance documentation, they may result in inaccurate information if they are not individualized to the patient. For example, a template for a neurological exam, with a box checked for 'normal value,' would indicate that the patient was alert and oriented to time, place, and person even though the patient was an infant.

COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE). Pre-programmed prescription orders for common drugs and dosages make it easy to select an unintended drug or dose from drop down menus. In addition, many EMR systems include routine pop-ups for drug dosages, interactions, and allergies and—with the hectic schedule of many professionals—there is a tendency for staff to ignore warnings, routinely override, or even turn off such 'patient safety' prompts.

UNTIMELY RECORD MODIFICATION. If modification to records is not transparent, EMR alterations can potentially be subject to allegations of fraud and incomplete records.

EMAIL. While email correspondence has become more acceptable and is often valued by patients, there are a number of issues that must be addressed regarding integration of email into EMR procedures: practices to ensure security, methods of incorporation into the EMR, appropriateness of the subject matter for email correspondence, and timely professional responses.

TEXT MESSAGING. A common practice in many health professionals' personal lives, texting can also offer advantages for clinical care. However, while it may be the fastest and most efficient means of sending information in certain circumstances, there are special concerns, too. Text messages that remain on mobile devices are subject to exposure through third party theft or loss, or simply inadequate authentication (i.e. passwords). Experts are pondering how text messages can be delivered securely and incorporated into the EMR.

Development and implementation of a secure, safe, and helpful EMR system is a work in progress that requires recognition of potential problems and a proactive approach to mitigating them. The bottom line is that your EMR system must be accurate and efficient for the users in your organization. Which leads to one final thought: can the idea of 'one size fits all' apply to the EMR? While it is rarely possible to create complex systems that fit the practice patterns of all health professionals, physician feedback strongly indicates that some customization would be valuable. Variability in how individuals work, and how they document patient records, is a fact of life and EMR programs need to be pliable enough to accommodate some user preferences. Additionally, medical specialties have differing needs for functionality and information retention, e.g. an ophthalmologist may require the ability to sketch the eye. Hopefully, EMR programs will be able to respond to individual and specialty needs by including customized interfaces in the future.

Sources:

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