Electronic healthcare records (EHRs) have revolutionized the practice of medicine, creating the potential for significant improvements in patient safety, clinical teamwork and operational efficiency. (See "How EHR Systems Can Improve Quality of Care" on page 4.) However, as always with technology, the effectiveness of EHR depends upon many factors, both technical and human. A poorly designed or utilized system presents a range of potential hazards, including loss or compromise of important information, mechanized and excessively routinized care, data breaches and other security issues, and reduced defensibility when electronic records translate poorly into hard copy.

The risk of error and other unintended consequences is especially acute during the period of transition from a familiar paper-based record to a new, multi-purpose electronic system. By learning more about the underlying causes of liability, leaders are better equipped during this vulnerable period to select software that complements existing work patterns, devise sound operating procedures, train clinicians in safe practices, and establish audit mechanisms to detect and deter risky behavior. This edition of Vantage Point® features seven professional liability scenarios involving common EHR-related problems. It also offers a series of strategies designed to help risk managers train front-line staff in safe, appropriate use of EHR.

Top Contributing Factors to EHR-related Lawsuits
1. Incorrect data entry.
2. Conversion issues stemming from a hybrid paper/electronic record.
3. Failed routing of electronic data.
4. System failures or outages, making data inaccessible.
5. Unethical documentation practices involving copying and pasting of old entries.
6. System design flaws that make routine clinical tasks burdensome.
7. Insufficient user training and education.
8. Incompatible or insufficiently integrated systems.
9. User error (e.g., clicking on the wrong entry in a drop-down bar).

The introduction of EHRs can have a dramatic and possibly disruptive effect on clinical processes. Many organizations utilize “hybrid” records – part paper, part digital – during the transitional period, while meshing the EHR system with existing work practices.

During this hybrid phase, it is essential to consider staff members’ basic computer skills and readiness to navigate between paper and electronic formats. Lack of transitional planning and training can trigger confusion and errors, potentially leading to breakdown even before the system is fully implemented.

Consider the following risk management interventions:

- Determine the components of the healthcare record that will remain in paper form during the transition, and devise policies to protect and preserve data maintained in a hybrid state. To learn more about the impact of hybrid records on the legal requirements of healthcare record management, see AHIMA’s “EHRs as the Business and Legal Records of Healthcare Organizations”.

- Identify areas of possible duplication across paper and electronic systems, and reduce or eliminate potentially confusing redundancies, especially in the high-risk areas of medication prescription and administration, allergy notation, and follow-up on laboratory and diagnostic reports.

- Establish written parameters for use of paper notes in the hybrid record, in order to reduce the risk of missing or inconsistent electronic documentation.

- Ensure that staff members possess necessary IT competencies before proceeding with EHR implementation. Consider evaluating staff skills and documenting the results.

- Acknowledge the increased workload implications of a newly implemented EHR system, providing appropriate support in the form of a call center, additional hands-on training and/or reduced patient loads for clinicians during the transition period. If necessary, assign additional IT staff to clinical settings to assist during the transitional period.

SCENARIO 1: INFORMATION LOST IN A HYBRID RECORD
A hospital-based healthcare system is in the early phase of transitioning hard-copy ambulatory clinic records to an inpatient EHR format. While medication allergies for pediatric clinic patients have been input into the system, retrieving this information requires two additional screen interfaces. Emergency department (ED) nurses are critical of the new ambulatory care module and resistant to the transition plan, often refusing to make full use of the new system, which they perceive as cumbersome. During this period, a 4-year-old with a history of severe allergic reactions to a specific antibiotic presents to the ED for treatment of a bilateral ear infection. The allergic reaction is well-documented in the clinic’s paper record, but is not known to the non-parent guardian who accompanies the child to the ED. The nurse’s inquiry regarding known allergies is, therefore, negative, and the nurse fails to check allergy status in the EHR. A physician subsequently prescribes the antibiotic, triggering an anaphylactic reaction in the child and a week-long hospitalization for respiratory support.

QUICK LINKS
- “Appendix C: Steps to Prevent Fraud in EHR Documentation,” American Health Information Management Association® (AHIMA).
- “Appropriate Use of the Copy and Paste Functionality in Electronic Health Records,” AHIMA.
- Bowman, S. “Impact of Electronic Health Record Systems on Information Integrity: Quality and Safety Implications,” AHIMA Foundation’s Perspectives in Health Information Management.
- Copy Functionality Toolkit, AHIMA (available for purchase by non-members).
- Helbig, S. “Copying and Pasting in the EHR-S: An HIM Perspective,” AHIMA.
- “Recommendations for Storing Electronic Healthcare Records,” CNA. (Select “Search CNA” in the top right-hand corner of the screen, type the article’s full title in the search box and click on the magnifying glass icon.)
Consider the following risk management interventions:

- Pilot new EHR modules, in order to identify glitches, make corrections, and increase staff members’ proficiency and sense of ownership.
- Encourage EHR users to provide comments, suggestions and other input on an ongoing basis. Document follow-up on all verbal and written suggestions and complaints.
- Consider holding regular staff forums to educate staff about EHR and sound communication practices, as well as to encourage questions and discussion.
- Monitor system interfaces for changes in user behavior. If a common workaround is detected, instruct clinicians to utilize recommended procedures until the risks and benefits of the alternative method are thoroughly understood and either approved or prohibited.
- Seek input from system vendors and peer organizations regarding viable solutions to the problem of potentially hazardous workarounds.
- Retain vendor guidebooks, resources, protocols and programs for reference in the event of a professional liability claim involving system design or utilization.

Electronic record systems often include a variety of diagnostic algorithms, prompts, alerts and other decision-support tools and warnings. Effective intervention depends upon users having the time and ability to process this information, which is not always possible in a busy surgical or medical setting. One risk of automated warning systems is the phenomenon known as “alarm fatigue,” in which the flood of reminders causes practitioners to miss genuinely urgent messages, thus setting the stage for errors of omission.

Consider the following risk management interventions:

- Seek input from providers ahead of time regarding their decision-support needs and preferences, and thoroughly document all alert-related training and orientation.
- Select software that automatically directs alerts and other support interventions to the appropriate clinicians, and that avoids repetition by acknowledging compliance with requested actions.
- Streamline the process of responding to alerts, so that clinicians do not need to click more than once, scroll down or visit additional pages.
- Ensure that alerts are proportional to the identified clinical risk – e.g., alerts regarding preferred dietary changes should not carry the same urgency as a warning about a prescribed drug’s potential for liver toxicity.
- Clearly “label” all alerts, using a tiered system that reflects the type and frequency of the alert – e.g., minor/moderate/severe or routine/urgent/critical.
- Require providers to input a reason for overriding a critical alert, using either a free-text box or a drop-down menu. Avoid “click-to-dismiss” features.
SCENARIO 4: INAPPROPRIATE COPY-AND-PASTE PRACTICES

An elderly patient is admitted on a weekend for treatment of a large pressure ulcer abscess. An admitting resident notes in the EHR that the abscess requires drainage and possible surgical intervention. The surgery proceeds, but the intern fails to note the procedure in subsequent documentation, instead copying and pasting the original entry note for the next two days. The infectious disease team consults on day three and, unaware of the surgical drainage and improvement, makes an unnecessary and deleterious change in the patient’s antibiotic regimen. As a result of the error, the patient remains hospitalized for diarrhea and dehydration, and requires skilled nursing care for several weeks post-discharge.

Clinicians commonly use copy-paste and copy-forward functions to document information within EHR systems. The practice involves selecting some or all of a prior note and replicating it in another entry in the EHR, or repeatedly copying forward a prior notation to create a series of entries. When appropriately utilized in accordance with standardized guidelines, this practice can save time for busy providers without compromising care. However, careless and reflexive use of such shortcuts can result in serious patient mishaps while violating HIPAA privacy rules, federal and payer audit requirements, and fraud and abuse regulations.

Consider the following risk management interventions:

- Incorporate regulatory and industry standards regarding the proper use of copy-paste and related functionalities into IT governing policies, EHR documentation guidelines and training programs. (See page 2 for the link to AHIMA’s “Appropriate Use of the Copy and Paste Functionality in Electronic Health Records.”)
- Avoid repetitive copying and pasting when documenting high-risk items, such as laboratory results, radiology reports and drug formulations.
- Review and update any shared information found elsewhere in the EHR before pasting it into current entries, especially problem lists, diagnoses, allergies, current medications and history relevant to ambulatory care across the continuum.
- Expressly prohibit the following risk-prone functions:
  - Copying-pasting text from another clinician’s note without proper attribution, which may constitute medical plagiarism and lead to allegations of billing fraud.
  - Deleting original source text or data and inserting it elsewhere in the record, thus altering the initial entry and compromising documentation integrity.
  - Carrying forward information – such as prior medical history or diagnostic results – that is readily available elsewhere in the EHR, which creates clutter and may adversely affect the record’s reliability and usefulness.
- Monitor providers’ copy-paste behavior and institute corrective action when the following “red flags” are observed:
  - Copying of outdated and/or redundant information.
  - Inconsistent progress notation.
  - Unnecessarily long progress notes (AKA “note bloat”).
  - Notes that cannot easily be authenticated, dated or attributed to an original author.
  - Propagation of false information.

For guidelines, see AHIMA’s “Auditing Copy and Paste.”

- Include degree of compliance with copy-paste protocols in the annual performance reviews of clinicians responsible for creating notes in the EHR. For an overview of associated exposures, see Dimick, C., “Documentation Bad Habits: Shortcuts in Electronic Records Pose Risk,” which is available from AHIMA.
- Consider disabling the EHR system’s copy-paste function, as some hospitals have done, if inappropriate copying and pasting of entries becomes a chronic problem.

How EHR Systems Can Improve Quality of Care

By complying with the federal mandate regarding meaningful use of information technology, healthcare providers and facilities also can:

- Improve coordination and continuity of care.
- Reduce communication-related errors.
- Boost staff efficiency and productivity.
- Enhance legibility of documentation, thus strengthening legal defensibility.
- Increase consistency by encouraging use of clinical prompts, decision-making trees and documentation templates, among other electronic aids.
- Spur quality improvement efforts by more effectively gathering health outcomes data.
- Facilitate electronic communication between providers and patients.

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LESSON 5: TEMPLATE DOCUMENTATION AND THE RISK OF DEFAULT NOTATION

A physician assistant completes a history and physical on a newly admitted 65-year-old patient, inputting findings into the EHR via a template designed for a healthy male adult. However, the patient has a significant cardiology history and requires drug prophylaxis to prevent deep vein thrombosis. The template prompts the physician assistant to make only routine inquiries regarding cardiac health, without inquiring further about the patient’s current condition and treatment. The supervising physician subsequently logs into the record and evaluates only proof of positives, while failing to confirm negative findings. He electronically signs the documentation, neglecting to order and carry forward the patient’s existing medication regime. Two weeks later, the patient is hospitalized for an acute pulmonary embolism, at which time the oversight is detected.

EHR vendors offer various tools – including template documentation and population via default – designed to make writing notes easier. Templates feature predefined text options targeted to specific conditions and body parts, while populating via default involves one-click data entry to indicate normal status. When using these forms of notation, providers must enter negative or out-of-the-ordinary findings manually, a practice known as documentation by exception (DBE). Both options carry a high risk for “cloned” documentation, which can render the record of a 70-year-old patient similar in content and appearance to that of a 20-year-old. Such generic records can lead to allegations of deficient care and may be difficult to defend in the event of litigation.

Consider the following risk management interventions:

- Assess whether vendor-developed templates adequately support recommended work practices. If they do not, adjust them to accurately reflect current protocols, standards and regulations.
- Include a variety of input controls to facilitate the capture of all relevant findings, both normal and abnormal. Possibilities include right-left-bilateral confirmation, positive/negative notation, and multiple-choice text and number features.
- Incorporate voice-recognition and text-entry tools to document subjective observations and to enhance future recognition of EHR entries in the event a malpractice action is filed years after the date of care.
- Create a section within templates for relevant past medical history, positive findings on exams and answers to “red flag” questions. For example, on a strep throat template, include prominent prompts for fever, headache, rash, and a history of heart valve or kidney problems.
- Perform quality audits to track incidence of “scribing,” i.e., the overwriting of one practitioner’s authenticating notes by another. Audits also should identify clutter-prone templates and DBE functions (e.g., when routine patient encounters produce more than one to two pages of documentation).
- Prohibit staff from tampering with the EHR’s audit trail capability. Explain that the function is necessary and does not significantly slow down the system.

Assess whether vendor-developed templates adequately support recommended work practices. If they do not, adjust them to accurately reflect current protocols, standards and regulations.
LESSON 6: STAGNANT PROBLEM LISTS
While converting to electronic records, a primary care clinic in a large healthcare delivery system carries over a patient’s existing problem list, which contains more than two dozen entries. The patient’s aneurysm history is located near the end of the long, scrolling list. During a medical procedure a year later, the patient’s aneurysm bursts, with fatal consequences. The surgical specialist later testifies that he glanced at the problem list at a pre-op visit, but failed to read it in its entirety, as he considered much of it to be obsolete and inconsistent with the presenting clinical picture.

Accurate patient problem lists are essential to effectively manage patient populations and provide care across multiple sites. However, keeping problem list data relevant and up-to-date can be a challenge, due to the large number of disciplines and services – ranging from health IT, medical staff and nursing services to billing, quality management and clinical departments – involved in the compilation process. For this reason, problem lists tend to accumulate a wide variety of symptoms, health factors, diagnoses and ICD code descriptors. If not regularly reviewed and updated, lists may become riddled with obsolete and irrelevant information, potentially compromising quality and continuity of care.

Consider the following risk management interventions:
- Clearly define the purpose and scope of the problem list in all healthcare settings, focusing on these critical functions, among others:
  - Facilitating continuity of care between patient visits.
  - Recording medical conditions for treatment and reporting purposes.
  - Coordinating communication during patient transitions between settings and care providers.
- Create a written procedure for developing problem lists, and also for updating and reconciling them in the following medical situations, among others:
  - Primary care: at the end of each episode of care and annually, at a minimum.
  - Internists and specialists: at the end of each episode of care.
  - Attending physicians: upon discharge from an inpatient or outpatient setting.

For additional information, see AHIMA’s sample policy and procedure template.
- Authorize only selected individuals to make or change entries in patient problem lists, and instruct them to use an approved standard vocabulary for problem list notation. See ASTM International’s “Standard Practice for Content and Structure of the Electronic Health Record (EHR),” which is available for purchase.
- Strictly prohibit the use of problem lists as a source of billing data, a tool for revenue management purposes or a substitute for a final diagnosis list in discharge summaries.
- Establish timeliness requirements for problem list entries and audit activities. See AHIMA’s “Problem List Guidance in the EHR” and also “Standardizing the Problem List in the Ambulatory Electronic Health Record to Improve Patient Care,” from Qualis Health.

Keeping problem list data relevant and up-to-date can be a challenge, due to the large number of disciplines and services involved in the compilation process.
LESSON 7: MISMANAGEMENT OF ANCILLARY DATA

A small hospital implements an EHR module that allows outside laboratories to input test results directly into the system, but does not require end-users to note receipt and review of the results. When the system first goes into effect, physicians assume that lab results are printed out and added to the respective patient’s paper medical record, while nurses assume that physicians are reviewing the results in electronic form. During this transitional period, a patient dies of overwhelming sepsis. In the discovery phase of subsequent litigation, a request is made for the hospital’s written policy and procedure regarding staff review of daily incoming lab reports. However, no such policy exists. The jury is later instructed to infer that the hospital failed in its basic duty to oversee and direct safe, coordinated care.

A healthcare setting’s initial use of computerized records often involves diagnostic data – including imaging studies, laboratory values and radiographic exams – while other documentation functions remain paper-based, creating the potential for miscommunication. This transitional “hybrid” phase may last several years. During this period, providers and staff from all departments and disciplines should discuss documentation processes and issues, in order to better coordinate the flow of laboratory, pharmacy, financial and other ancillary data into the EHR system. Missing data may indicate poor system integration, which, if left unchecked, can result in patient care lapses and associated liability.

Consider the following risk management interventions:

- **Budget sufficient time, administrative effort and resources to integrate EHR with ancillary and financial data systems.** Be aware that the process can be expensive, challenging and time-consuming, often taking six months or more.
- **Select an EHR system with a proven track record in comparable practice or facility settings, and ask administrators of these facilities about their experience integrating diverse data sources.**
- **Rigorously test system interfaces and run mock reporting trials of sample data to foresee and resolve potential integration problems.**
- **Design EHR systems to capture and display thorough patient histories**, including recent lab results and office visits, as well as the results of mammograms, colonoscopies, and other preventive and diagnostic tests and procedures.
- **Engage an experienced data analyst to oversee the conversion from paper-based to electronic reporting**, in order to ensure that all user needs are understood and addressed.

While EHRs can be a powerful tool for capturing healthcare information, they also may pose their own set of risks to both patients and providers. The safeguards and strategies described in this publication can help organizations avoid potentially costly missteps and ensure that their EHR investment pays a dividend in terms of enhanced patient safety, productivity, regulatory compliance and reduced liability exposure.
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