HIDDEN LIABILITIES IN THE EHR

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CAVEAT

PITFALLS OF EHR

Data in multiple locations
Flowsheets = cryptic text
Templates
Copy/Paste
Copy Forward
Patient /Client Dissatisfaction
E-laterogenesis
Metadata
## TEMPLATES

<table>
<thead>
<tr>
<th>Name: TESTPT, PROD G</th>
<th>MRN: 3-640-658-0 (MC1 MRN)</th>
<th>Age: 52 years</th>
<th>DOB: 2/10/1954</th>
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<tbody>
<tr>
<td>Allergies &amp; Adverse Reactions: ** Allergies **</td>
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</table>

<table>
<thead>
<tr>
<th>Health Status</th>
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<tbody>
<tr>
<td>Allergies</td>
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<tr>
<td>Current medications</td>
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<tr>
<td>Prosthetic list</td>
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<tr>
<td>Results Review</td>
<td></td>
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<tr>
<td>Visit Information</td>
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<tr>
<td>Chief complaint</td>
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<tr>
<td>Visit type</td>
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<tr>
<td>History of Present Illness</td>
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<tr>
<td>Associated Symptoms</td>
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<tr>
<td>Review of Systems</td>
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<tr>
<td>Past Medical History</td>
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<tr>
<td>Positive</td>
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<tr>
<td>Constitutional Past Medical History</td>
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<tr>
<td>Exerted Past Medical History</td>
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<tr>
<td>Cardiovascular Past Medical History</td>
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<tr>
<td>Respiratory Past Medical History</td>
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<tr>
<td>Immunologic Past Medical History</td>
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<tr>
<td>Oncologic Past Medical History</td>
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<tr>
<td>Allergic Past Medical History</td>
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<tr>
<td>Exposure Past Medical History</td>
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<tr>
<td>Surgical History</td>
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<tr>
<td>Family History</td>
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<tr>
<td>Social History</td>
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<tr>
<td>Physical Examination</td>
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<td>Health Maintenance</td>
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<td>Immunoprophylaxis</td>
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<tr>
<td>Professional Services</td>
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</tbody>
</table>


## COPY & PASTE/COPY FORWARD

- Appropriate – proceed with caution
- Documents outside of EHR
- Standards
- Liability/Malpractice
- Reimbursement Risk

- Palmetto GBA- Jurisdiction 11 – Entries in the Medical Records, Amendments, Corrections, and Addenda, Jan. 21, 2013
- GCS Medicare, Electronic Medical Record Tips, Sept. 6, 2012
- AAMC Compliance Advisory 2 (July 22, 2011)
<table>
<thead>
<tr>
<th>MRN</th>
<th>Sex</th>
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<th>Age</th>
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</thead>
</table>

### 2013-02-28

I saw the patient with the resident Dr. on 2/28/13. We reviewed the patient's history and performed pertinent aspects of the physical examination together. We are in agreement after discussing the assessment and plan of care.

Family education for caregivers tomorrow.

### 2013-02-25

I saw the patient with the resident Dr. on 2/25/13. We reviewed the patient's history and performed pertinent aspects of the physical examination together. We are in agreement after discussing the assessment and plan of care.

### 2013-02-21

I saw the patient with the resident Dr. on 2/21/13. We reviewed the patient's history and performed pertinent aspects of the physical examination together. We are in agreement after discussing the assessment and plan of care.

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<table>
<thead>
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<th>MRN</th>
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<th>Age</th>
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</thead>
</table>

### 2013-02-28

Occupational Therapist

After 0800-0930 OT session, pt was positioned in her wic with seat belt secured, brakes locked, and in direct supervision of the nurses station.

After 1030-1100 OT session, pt was positioned in her wic and handed off to PT for further therapy.

### 2013-02-25

Occupational Therapist

After 0900-1030 OT session, pt was positioned in her wic with seat belt and harness secured, brakes locked, and in direct supervision of the nurses station.

### 2013-02-21

Occupational Therapist

After 0900-1030 OT session, pt was positioned in her wic with seat belt secured, brakes locked, and in direct supervision of the nurses station.

After 1000-1130 OT session, pt was positioned in her wic with seat belt secured, brakes locked, and in direct supervision of the nurses station.

After 1100-1130 OT session, pt was positioned in her wic with seat belt secured, brakes locked, and in direct supervision of the nurses station.

SLP for further therapy.

SLP for further therapy.
CLONED NOTES

Outpatient Visit Note, 10/16/01

VITALS: BP:136/73 HR:80 Wt:246.4 lb PN 2/10 rt heel S. 57 year old RTC to p/u new FFO. Pt complains of heel pain rt only subsiding slowly with new orthoses; PMH: PTSD, depress, GERD 79 pack years quit smoking three years ago. Currently sober & for THE PAST 3+ years. O Vas: DP/PT palpable b/L, TTT intact b/L, Neuro: Semes weinstein 5.07/10g monofilament wire sensation intact b/L, epidermitis sensation intact b/L. Derm: toenails 1-5 b fl thickened brittle incurvate painful with yellow subungal debris distal 1/3 only. Musc: strength intact, ROM intact. FLEXible PES cavus b/L. Flexible hammertoes b/L. Pinpoint pain with palpable medial heel r only. A. 1. Plantar fasciitis r/L CHRONIC 2. b/L PES cavus 3. onychomycosis 1-5 b fl. P. continue FOOTMAXX FFO rct May 02 renew naprosyn 2 tabs bid # 120

Student Note, 5/30/02

VITALS: 05/30/2002 08:55 BP:127/63 HR:72 Wt:253 lb [115.9] kg S. 57 year old RTC to p/u new FFO. Pt complains of heel pain rt only subsiding with new orthoses; Pt cont to take the naprosyn for pain relief. Pt states clotrimazole 1% is working well for toenail fungus. PMH: PTSD, depress, GERD 79 pack years, quit smoking three years ago. Currently sober & for THE PAST 3+ years. O Vas: DP/PT palpable b/L, TTT intact b/L, Neuro: Semes weinstein 5.07/10g monofilament wire sensation intact b/L, epidermitis sensation intact b/L. Derm: toenails 1-5 b fl thickened brittle incurvate painful with yellow subungal debris distal 1/3 only. Musc: strength intact, ROM intact. FLEXible PES cavus b/L. Flexible hammertoes b/L. Pinpoint pain with palpable medial heel r only. A. 1. Plantar fasciitis r/L CHRONIC 2. b/L PES cavus 3. onychomycosis 1-5 b fl. P. continue FOOTMAXX FFO cont naprosyn, cont clotrimazole 1% soln rct Aug 02 to be rescanned for new footmax flos Pt and tx d/w Dr. XXXX.

POST VISIT EHR

- Defined time for “locking” the EHR
- Formal process for “unlocking”
- Formal process for addenda/corrections

Pub 100-08 Medicare Program Integrity Manual, Transmittal 442, 12/7/2012
**METADATA**

- Electronic signatures
- Amendments
- Overriding alerts
- Audit trail
- CD Create date

**AMENDMENTS**

If the amendment was made to text that was SmartLinked in from the History or Problem List, the following step must be completed to prevent the entry from repopulating. Skip this step if the amendment was made to narrative text or text created from a SmartList.

Click the appropriate activity and highlight the incorrect entry (the same entry that was amended in the note). In this example, the History Activity was chosen, as the amendment was made to the patient’s Past Medical History.
AAMC Compliance Officers’ Forum Advisory

Purpose

The ability of an electronic health record (EHR) to populate selected information into a patient’s note presents new challenges. This Advisory will focus on the issues related to the use of data that can be copied and reused from one place to another within the electronic record, especially in e-prescribing. This Advisory does not address the challenge of sharing patient information electronically, including information that has been copied into an EHR.

This Advisory will:

- Discuss the risks of copy functionality, with an emphasis on revenue protection and quality patient care and
- Provide recommendations about how to use copy functions to generate a medical record with ease and accuracy while maintaining compliance and legal risks.

Secretary Sebelius and Attorney General Holder’s memo regarding EHR

September 24, 2013

American Hospital Association
Richard Umbro, Executive Vice President and Chief Executive Officer
721 North Lake Shore Drive, Chicago, IL 60611

Association of American Medical Colleges
Dr. John O. Nock, President and Chief Executive Officer
199 L St NE, Suite 700
Washington, DC 20002

National Association of Public Hospitals and Health Systems
Ona B. Judge, President and Chief Executive Officer
1111 19th St NW
Suite 800
Washington, DC 20036

Administration

As leaders in the health care sector, our nation’s hospitals have been at the forefront of adopting electronic health records for use in coordinating care, improving quality, reducing costs, and improving patient outcomes. The 35 percent of hospitals have already qualified for Medicare payment incentives under meaningful use of this technology. Used appropriately, electronic health records have the potential to save money and save lives.

However, there are3 risk:ing indications that some providers are using this technology to generate revenue, possibly to obtain payments to which they are not entitled. False documentation of care is not just bad patient care; it’s illegal. False documentation by falsely documenting “checking” of computer reminders in order to catalyst what patients are getting. There are also reports that some hospitals may be using electronic health records to facilitate “sweeping” or the deletion of care
LENNON’S ELBOW

“...notes are like music from John Lennon’s elbow. They are created by individuals with great talent, the results are awful, and nobody seems to mind.”


CONTRACTUAL LANDMINES
CONTRACTUAL LANDMINES

- Liability “Shift”
- Data ownership
- Indemnifications
- End User License Agreement
  - Exclusive v. non-exclusive
  - Machine specific v. site specific
- Fees
  - Future upgrades/enhancements
  - Support & maintenance

E-IATROGENESIS
**E-IATROGENESIS**

**Iatrogenesis:**

(Patient harm) introduced inadvertently by a physician or surgeon or diagnostic procedures.

Merriam-Webster

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**E-IATROGENESIS**

**e-Iatrogenesis:**

Patient harm caused at least in part by the application of health information technology.

# E-IATROGENETIC ERRORS

<table>
<thead>
<tr>
<th>Category</th>
<th>Example/Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Errors of Commission (EOC)</td>
<td>Accessing wrong patient’s record; overwriting one patient’s information with another’s</td>
</tr>
<tr>
<td>Errors of Omission or Transmission (EOT)</td>
<td>Loss or corruption of patient data</td>
</tr>
<tr>
<td>Errors in Data Analysis (EDA)</td>
<td>Medication dosing errors</td>
</tr>
<tr>
<td>Incompatibility between Multi-Vendor Software Applications or Systems (IMAS)</td>
<td>Incompatibilities which can lead to any of the above</td>
</tr>
</tbody>
</table>

Source: Jeffrey Shuren, Director, Center for Devices and Radiologic Health, FDA Health Information Technology (HIT) Policy Committee/Adoption/Certification Workgroup (2/25/10)

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**“Conclusions: We have observed an unexpected increase in mortality coincident with CPOE implementation”**.

"...a medical resident had prescribed a NORCURON (vecuronium) infusion for the wrong patient via a computerized prescriber order entry (CPOE) system in a remote location. She meant to order the infusion for a ventilated patient in ICU but accidentally prescribed the drug for a patient on a medical unit.

An independent double-check was required for this medication before administration, so two nurses verified the drug, pump settings, and patient. The infusion was started, after which the patient began walking to the bathroom. We fell to the floor once paralysis began to set in, but fortunately, he was able to call out for help. The resident physician was called, along with the rapid response team. When the team arrived and asked what happened, one of the nurses questioned whether the "new drug" she had just hung could be responsible. Realizing the problem, the physician immediately stopped the infusion. The patient was treated and suffered no long-term effects, although he was frightened by the experience, as were the involved staff.

The prescribing error escaped the attention of at least five staff members—the physician, pharmacist, pharmacy technician, and two nurses. The error was able to get through the system despite safeguards such as warning labels and double-checks. It is also likely that the nurse working on the medical unit, where the drug had never been used, had little knowledge of norcuron, its indication, its paralytic effect, and the need for mechanical ventilation, despite the warning label.

California Health and Human Services Agency, Dept. of Public Health

5/28/08

INTEROPERABILITY

“When the first patient’s information was deleted from the computer in the scan room, it was not deleted from the computer system used by the radiologist.... resulting in unnecessary surgery”.

5/28/08
California Health and Human Services Agency, Dept. of Public Health
“When the dispensed volumes are assigned by the system, the volumes are rounded to 0.01 mls...represents a 20% error in the dose...related to this, we almost had a 10 fold insulin error related to this specific defect”.

MAUDE Adverse Event Report, Event Key 1018749 (6/12/08)
ELEMENTS OF MEDICAL MALPRACTICE

CASE EXAMPLE – ELECTRONIC LOSS OF STANDARD OF CARE DEFENSE

- 7 hour neurosurgery
- Post-operative quadriplegia
- Medical malpractice claim against the hospital (focus limited to the neurosurgeon)

- Anesthesia records produced during e-discovery

- 90 minutes undocumented vital signs

- “Present at emersion”
• Complaint was amended to add the anesthesiologist after plaintiff discovered “questionable” information obtained from the EHR

Result of system failure: lost Standard of Care defense

Confidential settlement, undisclosed amount $
“A computer lets you make more mistakes faster than any invention in human history – with the possible exception of handguns and tequila”.
-Mitch Radcliff