

EMR Documentation Issues During the COVID-19 Pandemic

Physicians News Digest

April 20, 2020

By Matthew Keris

As hospitals are overwhelmed with COVID-19 patients and staff are stretched to their limits, electronic medical record (EMR) documentation may suffer as a result of rushed, less detailed and error-prone entries. EMR workarounds are also expected to flourish. In the current medical malpractice climate where greater scrutiny can be placed on the EMR and audit trail over the medicine itself, it is very important to maintain an accurate chart. There are steps that can be taken now to prepare for anticipated documentation issues related to care rendered during the COVID-19 pandemic.

The most important recommendation is to be a good historian. Years from now, you will need to remind and educate counsel, judges and juries of the magnitude of this world pandemic. There are several historical factors that will help explain documentation during the COVID-19 period. Detailed hospital census data will demonstrate how it impacted your institution. You may need to compare COVID-19 period numbers to your typical census to demonstrate the difference. This information will later show that the hospital was much busier than normal, which would impact documentation practices.

EMR technical issues are usually not documented, but they need to be

chronicled. If the EMR system “goes down,” or suffers widespread “glitches,” or is compromised in any way, it contributes to an EMR problem and you will need to explain it later. Best efforts should be made to detail these issues now for use later.

Hospital staffing records will also be important to show an increased reliance of locum tenens, agency nurses, “unretired” health care providers and volunteers who may not be familiar with the EMR. Included within this category are records of staff “call-offs” or sick days. In some instances, medical staff may have never used the particular EMR system prior to rendering care. Those who know how to use the system may not have the time to educate those who do not. A medical staff member’s lack of experience with an EMR system may later explain why there is little or no information in a patient’s record. It may also explain if there is a documentation error. Staffing information will be critical in explaining the EMR for care rendered in this time period.

Medical staff duties and clinical privileges that have been expanded or changed temporarily during this period may be needed later to clarify the record. If nurse practitioners have been given greater independence or a staff member’s responsibilities have shifted from

administrative to clinical, that information may be forgotten. When examining the record at a later date, these new responsibilities may explain why information was documented by a certain person. If not already documented, whenever a person's typical role has changed or enlarged, it should be demonstrated in writing for later use.

It may be difficult to find time to specifically organize these historical materials now, but rest assured, it will be important later. If the above information can be preserved, it will save time and expense in the future. This evidence will certainly aid in responding to any type of documentation discrepancies or criticisms of the health care during the COVID-19 pandemic.

It is also recommended to acknowledge in written form that documentation requirements have been relaxed during the COVID-19 period. At a minimum, it should be specifically acknowledged that documentation of patient care should be performed "as soon as reasonably possible" as opposed to "simultaneous to the care rendered." Most would acknowledge that, under normal circumstances, documentation is done at a quiet time during or after a shift as opposed to coinciding with the care. Officially recognizing the majority practice of documenting patient care as soon as possible will eliminate a later argument that a staff member violated hospital documentation protocols during the COVID-19 period by not documenting simultaneous to the care rendered.

Take efforts to locate "independent" sources of patient information now. For decades, some nurses and other health care

practitioners would keep their own personal notes about patients separate from the chart. In the current crisis climate, they might use their personal smartphone devices while providing care to patients, whether they are documenting their own independent notes, taking pictures of the patient or texting with others. These practices are not typically sanctioned by institutions and rarely does smartphone information find its way to the official record. However, in this period where health care providers are overtaxed, it should be anticipated that smartphone and personal note taking practices are more widespread. Make efforts now to inquire if staff are using their devices for patient care or taking personal notes, and if so, have that information delivered to the official record. Amnesty for use of the independent documentation should be considered during this time period to ensure cooperation by the staff. Otherwise, critical information could be lost that would be useful in defending a claim. Staff should also be reminded against posting work-related and patient-specific information to their social media sites.

There have been reports about the increasing practice of EMR workarounds, where staff, frustrated by a clumsy and time-consuming EMR system, will ignore some of the automated warnings as a way to save time and provide patient care more quickly. Similar to the use of smartphones to document, it should be anticipated that EMR workaround practices have also increased during this time in busy institutions. EMR workaround practices should be investigated for safety purposes and dangerous practices should be ended immediately. However, if institutions discover legitimate workarounds,

administration should have an open mind and eliminate unnecessary EMR redundancies to improve care.

One unsettled area of the law is whether a privilege can attach to an audit trail. Until this issue is settled, health care providers should limit their “footprint” in the EMR after the patient is discharged from the hospital. In states that hold that the audit trail is an “original source” document similar to the hospital chart, attorney or peer review involvement within the EMR may not be protected. An audit trail showing involvement by the attorney or peer review could expose where their concerns about the care are placed. Therefore, before an attorney or peer review of the actual EMR is conducted, consideration should be made as to whether that involvement will be produced later in the form of an audit trail. In the absence of clear guidance on this sensitive issue, review of a hard copy printout of the EMR may be the best option to avoid patients’ lawyers from learning the

potential weaknesses of a case through the audit trail.

One last piece of advice is to strenuously advocate and defend your decisions and practices from the COVID-19 period. Judges and juries will remember and understand the hard decisions made during this unprecedented time period. They will be forgiving for occurrences and practices that broke from the norm. The rightful goodwill endeared upon health care providers will not quickly dissipate. Years from now, when others second-guess or scrutinize decisions made during this period with the benefit of hindsight, return fire and fight back with facts.



Matthew P. Keris is a shareholder and chair of the Electronic Medical Record and Audit Trail Litigation Practice Group in the Scranton office of Marshall Dennehey Warner Coleman & Goggin. He may be reached at mpkeris@mdwvcg.com.