Insights into Risk Management

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@ Risk: The Brave New Cyber-World of the EMR

By Suzanne Duni, JD, RN, BSN

We've all gotten used to referring to electronic and web-based utilities as "cyber-this" and "cyber-that." The word "cyber" had me intrigued, so I researched where it came from. The prefix "cyber" was first used in "cybernetics," a word coined by Harvard-trained mathematician, Norbert Wiener, to describe communication between man and machine. That made sense, however, the very first word *Google* led me to was "Cydoimus: Greek God of *battle, confusion and uproar."* Although unrelated to math and machines, this seems to be a perfectly relevant representation of the chaos implementation of the EMR has produced in the world of healthcare delivery.

Let's acknowledge the frustration of dealing with EMR's that may have been designed more for billing than clinical care, that don't talk to each other and that are not intuitive to use. And let's further admit that many systems have tried, with limited success, to imitate paper processes rather than developing instinctive methods that are more applicable to an electronic environment. It's clear that beyond any legitimate logistical problems adoption of the EMR creates, there are also significant emotional roadblocks to adapting to electronic documentation in the healthcare setting. However, with patience, time, teamwork and careful use, every provider who uses the EMR to facilitate patient care can be a part of what promises to be an incredibly positive, dynamic shift in healthcare delivery. The first step toward mitigating limitations and fluid use of the EMR is to learn how to use it properly.

Let's start with the basics:

Beware the perils of cutting and pasting

An electronic health record is more than just an electronic representation of a paper chart. It's a legal representation of a patient's medical condition and treatment given at a *particular point in time.* It's quite literally the "black box" in which defense attorneys rely upon to defend you, the provider, in a malpractice lawsuit. For example, in one case we reviewed, Dr. Anonymous cut and pasted from a prior note, "*Patient has no complaints*." He didn't review the pasted portion of his note thoroughly and added at the end of his new note, "*Patient complaining of new onset abdominal pain*." And, this wasn't the only entry where it was shown that Dr. A borrowed information from other notes. At trial, the inference was undeniable that Dr. A was a guy who took shortcuts. When it becomes obvious in a malpractice suit that providers have engaged in cutting and pasting patient information from one note to the next, as in the case of Dr. Anonymous, it suggests desensitized care throughout the entire admission. More importantly, it results in a misrepresentation of the patient's care and may constitute a fraudulent submission for reimbursement when old services rendered are documented (and coded/billed for) day after day.

Check (or uncheck) those boxes

Consistency, completeness and accuracy are key components of good charting, no matter what system of documentation is used. Since EMR's may not always include an area for documenting in narrative form, check boxes often provide the only option to indicate an accurate medical assessment. Juries tend to believe stories backed up with tangible evidence, and when it can be proven that checked boxes do not reflect the patient's actual condition,

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Dept. of Risk Management
167 Point Street
Suite 170
Providence, RI
02903
T: (401) 444-8273
F: (401) 444-8963

Lifespan

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Medical Office Surveys
How Would Yours Measure Up?

The Lifespan Risk Services (LRS) Loss Prevention program offers a self-survey to its indemnified office practices. The survey helps to identify operational strengths and weaknesses in particular areas of the medical office such as credentialing, staff competency, practice management, medication management, information management, documentation, communication with patients, scheduling, consent and test tracking. Respondents are provided with feedback, guidelines and other resources to assist them in improving processes. Some offices receive an in-person site survey from LRS staff.

Similarly, the Agency for Healthcare Research and Quality (AHRQ), offers a medical office survey; however, that survey focuses on the perceptions of staff and providers about the patient safety culture, including teamwork, communication, office processes and patient tracking. While different in focus from the LRS Loss Prevention survey, the results from the Medical Office Survey on Patient Safety Culture 2012 are useful for practices to consider. Perceptions about the culture of safety often differ between providers and staff. Organizations with a strong emphasis on patient safety have been shown to have reliable processes that contribute directly to improved efficiency and productivity and fewer errors, resulting in better outcomes not seen in their counterparts lacking a strong patient safety culture. To improve the safety culture, offices must identify the underlying problem areas and implement solutions to target specific problems. Staff and providers can utilize the survey information to consider strengths and areas with potential for improvement within their own practice's patient safety culture.

AHRQ Medical Office survey results were compiled from data from more than 900 medical offices nationally and nearly 24,000 individual respondents. Sixty-two percent of medical offices had fully implemented electronic medical/health records, and nearly three-fourths were owned by a hospital or health system. Results were expressed in terms of percent positive response (i.e.: the respondent agreed with the statement).

Overall areas of strength for most offices were in questions about Teamwork and Patient Care Tracking/ Follow Up. Areas with the greatest potential for improvement included Communication about Errors, Standardization of Processes and Work Pressure and Pace. Here is a sampling of the individual items queried in the survey and why the issues are important to patient safety.

AHRQ 2012—Sample Survey Results

- This office emphasizes teamwork in taking care of patients. **83%**

  When staff work together well, they can focus on patients and their needs.

- In this office, we discuss ways to prevent errors from happening again. **79%**

  Examining an error to identify why it occurred and what can be done to avoid repeats is essential.

- Staff are encouraged to express alternative viewpoints in this office. **68%**

  Open dialogue and speaking up contribute to stopping/preventing errors.

- We have good procedures for checking that work in this office was done correctly. **66%**

  Checklists, standard routines, audits, and other controls are effective in ensuring tasks are carried out the right way, every time.

- They place a high priority on improving patient care processes. **78%**

  Sound processes contribute to improved productivity, efficiency and better outcomes.

- Our office processes are good at preventing mistakes that could affect patients. **82%**

  Proof that efficient processes work!

How Does Your Office Compare?

We hope this information encourages you to look further at the AHRQ 2012 survey results and consider participating in the 2013 survey or using the other tools on the AHRQ site. Remember, an office practice that focuses on patient safety is one with fewer errors, better outcomes and more satisfied patients. Please feel free to contact us with questions or for assistance.

2012 Risk Management Grant Program : 10 Years and Going Strong!

Now in its tenth cycle, the Risk Management Grant Program will be presenting awards to grant recipients during the week of October 1, 2012. The next grant cycle will begin in March, 2013.

For more information, see our grant website at: http://www.lifespan.org/risk/grant

Meet the Lifespan Department of Risk Management Staff

Who Are We?

In the Spring edition of ***Insights***, we explained that the Department of Risk Management is comprised of two areas, Clinical Risk Management, which is a department of Lifespan Corporate Services, and Lifespan Risk Services, Inc. (LRS), which provides administrative services for Lifespan's self-insured indemnity program, R.I. Sound Enterprises Insurance Co., LTD, or RISE. To recap, LRS includes Loss Prevention, Claims – whose services we previously described in greater detail – and Insurance/Business Operations. Clinical Risk Management provides you with knowledgeable advice and assistance if you have a question, concern, or specific need that arises in your delivery of patient care in the hospital.

The Clinical Risk Management Department

National Healthcare Risk Management Week was commemorated in June, and so we felt it appropriate to highlight Clinical Risk Management in this edition. As celebrated by the theme "Getting to Zero™ through the Power of One" during that week, your Clinical Risk Managers recognize that eliminating preventable serious safety events requires a collective effort , but that *one* person, *one* leader, *one* organization can make a significant difference. They are proactive, responsive professionals who are here to work with *you*, focusing their time on managing risk, eliminating preventable adverse events, promoting patient safety, and protecting our organization's assets and reputation.

Meet The Clinical Risk Management Staff

From top, left to right: **Susan Montminy,** Sr. Risk Management Coordinator, RIH/Hasbro; **Jeanne Buteau,** Risk Manager, TMH; **Elaine Noren,** Director; **Cheryl Chandler,** Risk Manager, NH; **Linda St. Angelo,** Risk Management Coordinator, RIH/Hasbro; **Kerri Floyd,** Secretary, RIH/Hasbro; **Lori Arruda,** Secretary, NH; **Maria Pereira-Silva,** Secretary, TMH; *Not pictured*: **Allison Violante,** Secretary, RIH/Hasbro

What Services Do We Provide?

Following an adverse event, your Clinical Risk Manager responds quickly to gather information and offer necessary advice. This may include:

Talking to all involved parties and gathering information while recall is still fresh

In as little as a week, day or even hours, memories begin to fade and facts blur. It is important to obtain an accurate recall as soon as possible following a significant occurrence in the event the information is needed in the future.

Services

Helping to identify and sequester documents, equipment and devices that may become important pieces of evidence

Your Clinical Risk Manager is skilled in recognizing items that may not seem relevant initially, may become so later on. For example, line tubing that is seemingly immaterial to an event can become import in the defense of a claim. How? For the same reason that it appeared inconsequential, the tubing can support that the event did not occur because of any fault, problem or defect related to the tubing. If the opposing party argues that the tubing caused the problem, the case may be successfully defended by producing the actual tubing used on the patient to discount the claim.

Identifying and contacting others who may need to be notified of the event

This may run the gamut from family members to other healthcare providers, managers and administrators to outside agencies such as liability insurers, law enforcement, Department of Children, Youth and Families, Department of Elderly Affairs, Department of Health and the like, ensuring the organization is compliant with any mandatory reporting.

Guiding you in your discussions with the patient and family

Clinical Risk Managers support disclosure of facts that are known and avoidance of supposition. Immediately following an event, it is often difficult to know exactly what occurred and why. The Risk Manager can help prepare you to tell the patient/family what is known about what happened, how it will affect the patient, and how to answer questions. While it is tempting to jump to conclusions based on what appeared to have happened, it is important to wait until a full investigation is completed and true facts revealed. Always talk with your Risk Manager to understand what to say and how to say it in your conversations with patients and family.

Facilitating a root cause analyses, or "RCA," following an adverse event

An RCA is designed to dig deep to get to the core of an adverse event and identify system and process causative factors. Done methodically, this process requires participants to continually ask 'what, how, and why' until all layers are pulled back to reveal contributory causes for the occurrence. Armed with this information, effective solutions can be developed to prevent a recurrence and the resultant actions can be transferred across the entire organization to benefit others as well.

Given the significance of these steps, timeliness is crucial. Your prompt notification to Clinical Risk Management in the wake of a serious event is of utmost importance.

Clinical Risk Managers are also available to assist with questions about policies, offering help in interpretation and guidance in carrying them out, and are also a resource for situations involving potential or actual liability.

Your Clinical Risk Manager is here for you, available on-site or on-call 24/7 by calling: 444-8265 (RIH/Hasbro), 793-2017 (TMH) or the on-call page operator. For Newport Hospital, call 845-1305 and Bradley Hospital, call 432-1619.

Stay tuned for the next issue of Insights in which we introduce you to the Loss Prevention staff

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it can be impossible for a jury to interpret whether assessments were performed adequately. This action also constitutes fraud, and functionally, the record becomes unreliable and typically loses its utility as a meaningful tool to refresh a defendant provider's memory for testimony.

Understand the consequences of pre-charting

It's tempting to take this popular and dangerous shortcut when you are pressed for time, but saving time now could have devastating effects on your patient's safety and on your credibility if called into question in a malpractice suit. To illustrate this point, consider this case where a surgeon was caught "red-handed."

Dr. Anonymous was heading into his third of six tubal ligation procedures he had scheduled on a busy Friday. To save time, he had pre-charted on four of the cases where he did not anticipate any unforeseen complications to occur. As he entered the O.R., he tripped on an electrical cord, fell and broke his right wrist. His case was cancelled and he was whisked to the E.D. for treatment. A few months later, he performed a difficult and complicated tubal ligation on Patient #3, resulting in a bad outcome and a lawsuit. During the discovery process, Dr. A's operative report did not reflect any of the complications he encountered during the surgery, confounding the experts and attorneys on both sides. It was later determined that the dictation Dr. A had made three months earlier had mistakenly made it into the patient's EMR, and the recent dictation was nowhere to be found. Although defensible, Dr. A's case was settled and payment was made to the patient on his behalf. Dr. A was also sanctioned by the hospital's MEC for violating hospital policy on documentation.

Similar to Dr. A's hospital policy, RIH Med Staff Rules & Regulations specifically call for postoperative notes to be "written or dictated immediately *following* surgery," not before or during the procedure. Furthermore, along with understanding the significant consequences of pre-charting, rejecting the practice of pre-charting provides good modeling for physicians-in-training. The Med Staff Rules remind us that the attending physician is "responsible for medical record deficiencies regardless of whether a designee was assigned to complete them."

Respect the HIPAA privacy rules with proper access

What do Tom Cruise, Farrah Fawcett and Brittany Spears have to do with HIPAA privacy rules? In 2008, UCLA Health System was fined $865,000 for violations of HIPAA when unauthorized (and subsequently terminated) employees looked at PHI in these celebrity's medical records. Employees must have a "valid purpose" for accessing patient records, and HIPAA requires sanctioning against any employee who is found to have violated restriction policies. Georgina Verdugo, Director of the Office for Civil Rights, the federal entity that investigates HIPAA violations, summed things up in a statement, "Employees must clearly understand that casual review for personal interest of patient's protected health information is unacceptable and against the law." Our own Lifespan corporate compliance policy, CCPM-11 calls for employee access to health records, *even their own medical record,* to be limited to a "legitimate, work-related reason," and attaches a mandatory duty to report violations for those who are aware that this type of violation has occurred.

Embrace The Brave New World

It truly is a brave, new electronic world we are living in. We may very well look back longingly at these times as uncomplicated, compared with what the cyber world has in store for us in the future. The implementation of the electronic medical record is simply a natural step in the evolution of health management. Our pivotal mission on this journey is to provide secure passage for our patients as we navigate the medical record information highway. It is up to each one of us to embrace and utilize the EMR in a way that will ensure the safest, most efficient care for our patients. True, the EMR has limitations, but given time to fully evolve, it promises to give us considerable opportunities to improve patient outcomes, save time and reduce costs.

Insights is published by Lifespan's Department of Risk Management. Submissions and ideas are welcome and may be sent to **Suzanne Duni @ sduni@lifespan.org** or **Deborah Randall @ drandall1@lifespan.org**, or by fax to **401-444-8963.**

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Special Pull-Out: Focus on Documentation

Transition to the EMR has created confusion about what components of the record constitute the legal medical record. The State of Rhode Island General Laws do not specifically address the existence of an electronic medical record, and broadly suggest that the medical record "shall contain sufficient information to identify the patient and the problem…to describe the treatment…to document the results…and shall conform with the standards set forth by The Joint Commission." [R23-17-HOSP(27.6)(27.7)]. The widely accepted definition of documentation in healthcare is a bit more precise when it comes to electronic records, specifying that healthcare documentation is, "… any written or *electronically generated* information about a patient that describes the care or service provided to that patient."

The implementation of an electronic health record has certainly changed the way patient information is memorialized and communicated, however, the basics of good documentation still apply. Regardless of form, an accurately recorded medical record is necessary to facilitate communication about a patient's condition, and decreases the potential for miscommunication and errors. Good documentation also helps the hospital to meet professional and legal standards by demonstrating appropriate knowledge, skills and judgment were used to select treatments, and to show that reasonable, prudent care was provided, especially where that care is called into question. A well-documented record can prove enormously valuable in defending a malpractice lawsuit.

Objective v. Subjective Opinions

The record should reflect **objective** opinions and observations related to the clinical treatment of the patient.

Objective: observations formed based on what you *observe* with ALL of your senses.

"The patient's vital signs have improved, he is more active and states that he feels better this morning."

Subjective: observations formed based on what you "think" has occurred.

"I feel the patient is on the mend."

In a malpractice action, the patient's medical record is typically the most reliable indicator of what did or did not happen at the time the patient received treatment. Juries tend to place great weight on the medical record, whether recorded electronically or on paper. Without a clear record, the credibility of the defendant doctor or nurse's testimony and character becomes the central issue of the case, rather than the facts surrounding the alleged malpractice.

Try these documentation success strategies:

- Be specific—charting general or vague observations leave the provider open to scrutiny
- Guard your password – per Lifespan policy
- Lock your record/note in a timely manner
- Review past information – even if it's difficult or time consuming
- Pay attention to prompts and red flags
- Include *relevant* information passed in telephone, email or bedside conversations with the patient and/or other providers in the record
- Slow down to avoid charting errors

FOCUS ON NURSING: A Case Study

The purpose of this section is to share summaries of closed cases that have occurred in the New England area and represent real life issues that provide proactive risk management educational opportunities. The cases used may come from Lifespan affiliates, or other institutions or practices, or may be composites of several cases with very similar fact patterns. We present these cases because we believe they have relevance to situations that you may encounter.

***ISSUE*: Was the patient's safety compromised when the RN cut and pasted information rather than entering an updated assessment for each shift worked?**

FACTS:

- An RN complained to her colleagues that once her shift began, she had no time to enter detailed notes in the EMR. To address this problem, she began to routinely copy and paste the prior RN's notes at the beginning of each shift so that at least one note would be entered on each patient by the end of the night.
- Other RN's began to copy and paste as well, sometimes copying notes that were entered three days to one full week prior.
- The patient was an 82 year old woman, admitted from her extended care facility with a 1 cm decubitus ulcer, which was growing larger on a daily basis.
- The treating MD visited the patient each morning, and relied on the RN's notes from the night before, which reflected no growth and led the MD to believe the ulcer had remained unchanged from days prior. Therefore, the MD did not adjust his orders.
- After returning to the nursing home, it was revealed that the patient's ulcer had grown over 5 centimeters since admission to the hospital. This was not reflected in the transfer of care notations, though measurements of up to 4 cm were recorded sporadically in the nurse's notes.
- The patient died of sepsis, thought to have been related to the ulcer. The patient's family successfully brought suit against the hospital for failure to monitor and medical mismanagement.

FINDINGS:

The jury found that:

- The patient's safety was compromised when the RN cut and pasted rather than entering updated measurements.
- The record was rendered ineffective as a source of reliable clinical documentation of ongoing care and accurate response to treatment.
- The RN was found deficient in her documentation of the patient's care, which led to a finding that she violated hospital policy.

Further:

- Billing for the patient's care was potentially fraudulent where procedures performed early in the admission were documented via cut and paste, coded and billed for three days in a row.
- Poor documentation presented a large hurdle for the nurse's attorney to overcome in defending the case.

SUMMARY:

- The RN had a duty to chart on the patient contemporaneously with the time the care was rendered, and violated Joint Commission, local and national documentation standards by cutting and pasting old information into her patient's medical record, without carefully reviewing prior entries and noting current changes before charting.