

Electronic Documentation

Accurate and thorough documentation is the backbone of a sound approach to risk management; it provides essential patient information, historical details about the course of patient care, and a record of services provided.

Electronic health records (EHRs) have not diminished the importance of documentation, but they have fundamentally changed the process of documenting patient care, resulting in unique documentation risks. To address these challenges, healthcare organizations need policies and strategies that reinforce EHR best practices. Organizations can use this checklist to review important risk management strategies for electronic documentation and identify potential areas for improvement.

	Yes	No
Does your organization have written documentation policies that include standards and guidance specific to electronic documentation?		
Do documentation policies support and enforce a consistent approach to electronic documentation among healthcare providers and staff members?		
Do documentation policies include information related to copying/pasting in EHRs and specifically outline when copying/ pasting is prohibited and when it can be used with extreme care?		
Are healthcare providers required to carefully review and sign off on any copied/pasted information in EHRs?		
Are EHR entries periodically audited to check for errors that may have resulted from copying/pasting information?		
Are providers required at each patient encounter to review EHR data fields that default to "normal" to ensure clinical data are not misrepresented?		

	Yes	No
Are providers encouraged to perform a final quality assurance review of all data entered into data fields and check boxes?		
In addition to using data entry fields and check boxes, are providers encouraged to enter patient-specific notes and comments in EHRs as appropriate?		
Do documentation policies include specific guidance related to amending or altering information in EHRs, including how to appropriately amend a record and when alteration is prohibited?		
Has your organization adjusted its documentation policies to account for potential issues that metadata might present, including issues related to the timing of care, response to alerts, and amendments to records?		
Do documentation policies include guidance and requirements for using scribes (if applicable)?		
Are records periodically printed out to ensure that print versions are logical and accurately reflect patient care?		
Are healthcare providers and staff members educated about:		
 The EHR system used at the organization, including its functionality, capabilities, and any nonstandard features or modifications? 		
• The organization's general and electronic documentation policies?		
 The risks and consequences of EHR documentation shortcuts, such as misinformed treatment decisions and fraudulent billing allegations? 		
 The concept of metadata, how the EHR system collects metadata, and what types of data are collected? 		
 State and federal laws or rules related to e-discovery? 		
Does EHR training occur during orientation, as part of in-service training, when policies change, and when new technology is implemented?		
Has your organization identified one or more EHR "super users" who can provide support, answer questions, troubleshoot issues, and help identify areas for improvement?		

Resources

For more information about electronic documentation, see MedPro's *Risk Resources: Electronic Health Records.*

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