# Legal Implications of Electronic vs. Paper Charts

## Perianesthesia Nurses Conference

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# Paper vs. Electronic Records

Are digital records
better
than paper records?

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# Paper vs. Electronic Records *(cont.)*

## Advantages of electronic records

- Easier to read
- Subspecialty notes are grouped together
- Improved confidentiality
- Electronic prompts help assure that medications and cares are timely
- Can be accessed from more than one location
- Entire record is available all the time

# Paper vs. Electronic Records *(cont.)*

## Disadvantages of electronic records

- Not as much detail recorded
- When there is nothing new, there is nothing recorded
- Entries can look repetitive
- Digital entries do not trigger memory of events as well as personal handwriting
- Not all modules are reviewed by all staff

# **Paper vs. Electronic Records** *(cont.)*

But are the applicable laws different for digital records and paper records?

# Good Documentation Matters

- Good communication
  - Clinically relevant information is effectively transferred between shifts and staff
- Good patient care
  - Good documentation focuses the entire team on clinically relevant changes
  - More likely that a patient's condition will be properly diagnosed and treated

# Good Documentation Matters *(cont.)*

- Good reimbursements
  - Accurate documentation supports proper reimbursement
- Good defense of care
  - Providers can defend themselves that care is properly documented
- Good risk management
  - Accurate and timely records reduce the risk of fraudulent billing

# Good Documentation Matters *(cont.)*

- Poor/false documentation risks civil and criminal liability
  - Can result in fines, loss of employment, loss of license, prison
- Nursing Code of Ethics
  - Accurate and comprehensive documentation honors ethical concepts on which best practice is based and demonstrates the basis for professional and clinical decisions

# Good Documentation Matters *(cont.)*

- A good chart helps to defend your care
  - 35-40% of medical cases become indefensible because of problems with documentation
  - If it is not charted, lawyers will argue that required care did not happen
  - Documentation is scrutinized by the family and the family's lawyer
  - Jury will assume that sloppy documentation means sloppy care

# Good Documentation Matters *(cont.)*

- FACT Formula
  - Factual
  - Accurate
  - Clinically relevant and complete
  - Timely

# FACT Formula

- Factual
  - Objective, not subjective
    - What you see, hear, smell, not what you suppose, assume, guess, believe or feel
    - E.g. write “wound is 4cm x 2.5cm, with red and brown edges and without any odor”
    - Do not write “wound is ugly”

# FACT Formula *(cont.)*

- Accurate
  - Document your observations
  - Don't copy someone else's notes
  - Be careful about accurately describing "left" or "right" sided complaints
  - Only use approved abbreviations
  - Do NOT use texting abbreviations

# FACT Formula *(cont.)*

- Clinically relevant and complete
  - Use terms that have clinical significance
    - E.g. “moderate amount” of bleeding, not “a lot”
  - Use terms that other medical personnel will easily understand
  - Complete all related portions of the record

# FACT Formula *(cont.)*

- Clinically relevant and complete
  - Document all phone calls
  - Document all meetings and notifications
    - E.g., note who you talked to - doctors, families or head nurse manager
    - E.g., note what you talked about
    - E.g., note what you learned from others during the meeting or conversation
    - E.g., note if you left a message or spoke personally
    - E.g., note if orders were written or modified

# FACT Formula *(cont.)*

- Timely
  - Notes should be made contemporaneously (ASAP)
    - The longer we wait, the less detailed, the less complete and the less accurate the notes will be
  - If entering a late note, make sure record is clear about the time and date of the earlier event
    - Electronic charts log time of entry for audit trails

# FACT Formula *(cont.)*

- Timely
  - Try not to wait until the end of the shift to document
  - Some documentation is better than no documentation
    - "The palest ink is stronger than the strongest memory"

# So…

Are these concepts any different when applied to electronic vs. paper charts?

# Criminal and Civil Penalties

- Criminal liability for false records
  - Penal Law Section 175.05
  - Class A misdemeanor
  - Violator can be sentenced to jail
  - Terms of probation can limit practice

# Criminal and Civil Penalties *(cont.)*

- A person is guilty of falsifying a business record in the second degree with the intent to defraud if:
  - Makes or causes a false entry in a business record
  - Fails to make a true entry in a business record in violation of duty to do so
  - Prevents a true entry
  - Causes the omission of a true entry
  - Alters, erases, obliterates, removes or destroys a true entry in a business record

# Criminal and Civil Penalties *(cont.)*

- Violation of Public Health Law
  - Anyone who violates, disobeys or disregards any term or provision of the Public Health Law shall be liable to the State of New York for civil penalty up to $2,000 per violation

# Criminal and Civil Penalties *(cont.)*

- Revocation of license for unprofessional conduct may occur for:
  - Failure to maintain accurate records reflecting evaluation and treatment of the patient
  - Failure to comply with federal, state, or local law, rules or regulations governing your practice
  - Filing of false report
  - Failure to file or impeding or obstructing filing of report required by law

# Criminal and Civil Penalties *(cont.)*

- Revocation of license for unprofessional conduct may also occur for:
  - Disclosure of personal identifying facts, data or information obtained in professional capacity without the patient's consent
  - Delegation of professional responsibilities to a person not licensed or qualified by training, license or experience to perform them

# Paper vs. Electronic Records Again

HIPAA applies to any health care provider “who transmits any health information in electronic form”

HIPAA has enforcement “teeth” that apply to nurses’ employers and can be very costly, hence the impression that legal issues are different

# Paper vs. Electronic Records Again
*(cont.)*

Reality is that changes in business process caused by use of electronic records may result in increased legal risks

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# Business Process Changes

- EHR systems designed to capture data from many encounters over long time periods
  - Designed to track and report outcomes and trends
  - Driven by changes in national health care policy intended to reduce costs and improve quality
  - Checkboxes for “within defined limits”; are limits well documented and known by staff?
  - Has loss of extensive narrative resulted in decrease in quality of care?

# Business Process Changes *(cont.)*

- EHR systems enable real-time charting
  - Anyone in care team can see patient's current status and take appropriate action
  - Trade-off between giving care and documentation
  - Location of charting changed from central station to bedside
  - Potential increased risk of unauthorized disclosure of PHI

# Business Process Changes *(cont.)*

- EHR systems accessible via mobile devices
  - Supportive of real-time charting
  - Screen size may discourage detailed charting and increase risk of error in entry selections
  - Potential loss or misplacement of device carries enormous risk of unauthorized disclosure of PHI

# Questions?

**Thank you!**

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