



Who we are...

Since 1989, Med League Support Services, Inc. has aided attorneys in 37 states. We have nurses and a physician to perform these services:

- Analyze medical records
- Develop case chronologies
- Screen malpractice cases for merit
- Prepare PowerPoint presentations for settlement negotiations or trial
- Provide literature searches
- Prepare pain and suffering reports
- Transcribe handwriting
- Prepare life care plans
- Prepare Life Activity Calendars
- Assist with demonstrative evidence
- Prepare medical illustrations
- Assist with preparation of demand letters and settlement brochures

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**A Legal Nurse
Consulting Firm**

Computerized Medical Records

The computerization of charting has become one of the strongest trends in documentation throughout the United States and Canada. Agencies of all sizes and descriptions are developing or purchasing computerized information systems that support medical practice, although many are reluctant to give up the security of a paper record with manually entered information. Paper charts are familiar to its users, portable, flexible and rapidly browsed. ¹ It may become impossible to replicate a lost paper record. Undetected tampering with paper records may occur, and it is impossible to determine who reviewed a paper chart. It may be difficult to find information within a paper chart. Handwritten charts are often illegible, increasing the risk of medical errors due to misinterpretation of or inaccessible data and the intricacies of litigation.

Benefits to the attorney of computerized documentation

Computerization of documentation provides some benefits for those involved in litigation.

- One of the most obvious benefits is the creation of legible records. Computer-printed



records are completely legible, therefore eliminating the confusion caused by guessing at the meaning of handwritten words.

- The identities of the healthcare providers are easy to determine, as each entry is followed by either initials or a full name and status (MD, RN, LPN and so on). If the entry is followed by initials, somewhere else in the document the person's full name will appear.

- The programs which incorporate the facility's standards of care prompt the healthcare provider to enter the essential information. For example, an admission assessment would include information that would identify the patient's risk for skin breakdown or for a fall. This type of prompting focuses the nurse's attention on key clinical issues and reminds the nurse to collect and enter

the data that would fulfill the standard of care.

- It is possible to determine who has accessed an electronic chart. For example, Registered Nurse Charles Cullen, who confessed to killing many patients, was finally caught in 2003 through the use of computers. His excessive use of digoxin, a medication used to kill his victims, was preceded by accessing medical records of patients to whom he was not assigned. The digoxin was stored in a computerized drug dispensing cart, which recorded his removal of the drug.

- Tampering with the medical record is much more difficult to do with an electronic system. Software programs contain a way to correct mistaken entries, such as an incorrect entry, misspelled word, or typographical error. A clock embedded in the software program indicates the precise time and date of an entry, which makes it impossible to backdate information to make it look as if it was entered earlier. Software programs contain a feature that makes the entry unalterable after a certain time or event. The typical method is to make the entry unchangeable once it is authenticated. There is a regularly scheduled backup time to store data, making it impossible for someone to delete previous entries once they are saved.

Problems for the attorney associated with computerization of documentation

- Data may be inaccurate and widely spread. Misinformation about a patient is difficult to correct as electronic health records are shared around the medical community.²

- Failure to authenticate a medical record may permit alterations of data after the entry should have become permanent. For example, a nurse who fails to authenticate nursing notes until the end of an eight hour shift may make changes after an event has occurred. A software solution that deals with this issue may include making an entry unalterable after a certain period of time, such as within a few minutes. On the other hand, an operative report

may not be considered permanent for one or more days, thereby giving the physician the opportunity to review and correct what was previously dictated.³ The attorney should be alert to the possibility that the original dictation was altered or a substitute operative report was prepared.

- Some electronic medical records have the capability of assembling and printing out all of the data related to specific aspects of the patient's care. For example, all of the nursing entries referring to elimination, skin integrity, or patient education are collected and printed out in chronological form. It becomes difficult for the reviewer to identify a picture of the patient's condition at any one point in time.

- A common complaint about computerized documentation is that some of the individuality of charting is lost. Since the same stock phrases are used over and over, after awhile the charting on the patients ends up sounding alike. While this is also a potential pattern in manual documentation, it is more clearly evident with computerized documentation. Although the software programs usually allow free text entry (narrative notes), many healthcare providers either don't know how to type or don't take the time to create free text entries. This can create frustration for the attorney trying to obtain a clear picture of the patient's status. The assistance of a legal nurse consultant may be invaluable in deciphering data and assembling a chronology of care.

- Free text entries are brief and may not adequately describe an incident or series of events leading up to an emergency. This greatly increases the difficulty in analyzing liability in medical malpractice cases.

- The adage "garbage in, garbage out" applies to the computer medical record just as it does to other aspects of computer programming. Incidents may increasingly occur in which clearly inaccurate information has worked its way into the medical record,

but has not been questioned by healthcare professionals because computerized information is perceived to be infallible. No machine can replace a healthcare professional who can critically evaluate patient data and question information that does not make sense. Attorneys and healthcare personnel must guard against the temptation to deify the computer, keeping in mind that the computer is only a tool to enhance documentation.

This material is excerpted from Iyer, Patricia, *Computerized Medical Records* in a forthcoming book edited by Iyer, P., Levin, B., and Shea, M.A., *Medical Legal Aspects of Medical Records*, to be published by Lawyers and Judges Publishing Company. Contact us at 908-788-8227 or via books@medleague.com to request to be notified when the book is available for purchase.

¹ Bradley, V, Innovative informatics: CPR- computerized patient record, *Journal of Emergency Nursing*, p. 230, June 1994

² id

³ Jergesen, A., Alteration of electronic medical records, www.physicianlawalert.com/publications/articles,PLA_Conf_eHealth_03.htm, accessed 2/15/04



Top Ten Ways to Evaluate Chronologies

Chronologies may be prepared by a legal nurse consultant to achieve many objectives. For example, a chronology may intend to focus on precise timing of events, correlate several factors, define deviations from the standards of care related to events, compare the observations of different providers, or contrast deposition testimony with the events recorded in the medical record. The top ten ways to evaluate the quality of a chronology are as follows:

1. Is the font easy to read? Times New Roman or Arial are two fonts that are commonly used and easy to read.
2. Is there a header at the top of the page?
3. Is there light shading to the title row to set it off?
4. Are the dates consistently formatted? For example, the chronology should either use numbers, such as 1/25/05 or words, such as January 25, 2005 but not both formats within the same document.
5. Is the time consistently formatted? Many people find military time confusing and prefer that military time is translated into AM and PM for ease of understanding.
6. Are entries written in complete sentences?
7. Are medical abbreviations spelled out the first time they are used? For example, the sentence may say, "The physician ordered MTX (Methotrexate) 2.5 mg six per day."
8. When there is an extensive amount of abbreviations used in a chronology or medical summary, is there an appendix of all of the abbreviations in alphabetical order for use by the reader?
9. If a word can not be deciphered, does the chronology indicate this by using ___ or ??? (can not decipher)?
10. Has the document been thoroughly proofread? Look for errors in dates, in referring to the sex of the patient, and for words that the spell checker will gloss over because they are correctly spelled but wrong within the context of the sentence.

Excerpted from our FREE Medication Errors Toolkit (when purchased with the Medication Errors or Nursing Home Liability DVD), produced by Med League Support Services. See our webstore at

From the President's Desk



www.medleague.com for details.

Patricia Iyer was honored by the American Association of Legal Nurse Consultants in April 2005 when she was presented with a Lifetime Achievement Award for Distinguished Service to AALNC. Pat served on the board of directors of the organization for 5 years, including one year as president. She was the chief editor of two AALNC textbooks, including the profession's core curriculum, *Legal Nurse Consulting Principles and Practices*, and a new text, *Business Principles of Legal Nurse Consulting*, published in mid 2005. Pat is currently the chair of the Education Committee. She is pictured here (on the left) with Barbara Levin, President of AALNC.



Visit www.medleague.com for ordering information for the second edition of *Nursing Home Litigation: Investigation and Case Preparation*, edited by Patricia Iyer. This text was expanded from the original 13 chapters to 21 chapters. New material was added on infections, assisted living, pain (mis) management, nursing home liability and its consequences, the claims adjuster's perspective, medical defenses, wandering and elopement, tampering with nursing home records, and skin trauma.

Looking for a medical textbook? Med League has become a reseller of Elsevier textbooks. Elsevier carries over 20,700 books covering a wide range of subjects. A variety of health, life, physical, and social sciences books are available. Visit our website at www.medleague.com for more information.

The staff of Med League mourn the passing of Maureen King, a nurse employed with the company from 1999 to 2001. Maureen was a nursing home expert while on the staff of Med League. After leaving Med League, she was hired as a surveyor for New Jersey Department of Health and Senior Services.

Maureen died at the age of 48 on September 27, 2004, two months after being diagnosed with biliary cancer. She leaves behind two children. Maureen's sunny disposition and love of life are missed.

A handwritten signature in cursive that reads "Pat Iyer".