During recent malpractice litigation, it was revealed that the defendant nurse had “forward charted” a number of standard items about the patient’s condition throughout the shift.

“Many of these items would have been expected to be true, such as ‘patient sleeping comfortably,’ but unfortunately turned out not to be true at all,” says Scott Martin, JD, a partner with Husch Blackwell in Kansas City, MO.

Although the patient was charted to have been “sleeping comfortably” at 03:00, the fact was that there was a full code taking place at 03:00. “Based in part on the time-stamping of the early entry as compared with the code documentation, plaintiff’s attorney was easily able to identify the improper charting and then skewer the nurse with it,” says Martin.

Time-stamped EMR entries turn cases from defensible to candidates for settlement

It’s a reason for jury to question physician’s integrity

Time-stamped electronic medical record (EMR) entries complicated the defense of a malpractice case involving a 58-year-old patient with a brain tumor who became quadriplegic secondary to an intraoperative complication. The plaintiff argued that hypotensive episodes during the case led to cord ischemia.

When the plaintiff in this case analyzed the EMR audit trail, it was discovered that the anesthesiologist documented that he had been present at the end of the case, but he did so hours before the case ended.

Everything the anesthesiologist did was then subject to question, says Jonathan M. Fanaroff, MD, JD, associate professor of pediatrics at PRM.
Case Western Reserve University School of Medicine and co-director of the Neonatal Intensive Care Unit at Rainbow Babies & Children’s Hospital, both in Cleveland, Ohio. “He very well may have been there the whole time, but any jury would question his integrity,” Fanaroff says. The case went to trial, but was settled during the trial.

**Critical piece of evidence**

Time stamps complicate the defense if they provide a reason to question the physician’s honesty. “Plaintiff lawyers may try to insinuate wrongdoing based on time stamps, such as asking why a physician looked at the record or printed out certain documents,” says Fanaroff.

Any malpractice case involves the development of a narrative, often competing narratives, regarding what happened and when, says David S. Waxman, JD, an attorney with Arnstein & Lehr in Chicago.

“The time stamp is obviously a critical piece of evidence helping to determine the ‘when,’” says Waxman. In some cases, however, the time stamp doesn’t reflect when certain events occurred. It only reflects when they were charted.

“Depending on how the events and care are memorialized, the time stamp created when the physician’s note is finally inputted can warp the narrative and allow for the creation of a story, which may be plausible but untrue,” says Waxman.

There is a constant tradeoff between efficiency and completeness of charting, he acknowledges. “But when it comes to timing of important events in a patient’s care, whether it be a change in the patient’s condition, receipt of test results, or issuing new orders, making the effort to note when those events occurred is well worth the minimal investment in time required,” says Waxman.

**Defense must explain EMRs**

Time-stamped EMR entries can be confusing to a jury, because the historic expectation is that the time noted represents the time of the event, not the time of the charting.

“Most adults have seen some type
of paper chart based on the time-noted process, but relatively few are familiar with how computer charting may be different,” says Martin.

The specific sequence and timing of events is often critical in malpractice cases. “A handful of minutes may have literal life and death consequences, especially in a code situation,” says Martin. “Even if a few minutes may not matter, a few hours often will.”

End-of-shift notes are generally time-stamped after a shift has ended, but they refer to events that occurred throughout the shift. “If there are not individual times referenced within the note, it will be difficult to place events in the proper sequence,” says Martin. Once a plaintiff’s attorney identifies inconsistent items in a chart, she will often urge the fact finder to mistrust the entire chart. “Then the defense is forced to explain the medical care and the chart,” says Martin.

**Give reason for late entry**

Whenever an EMR entry is made after the fact, the physician should document the reason for the late entry, advises Fanaroff. “Medical and nursing staff need to identify the actual time of events and not rely on the time-stamp,” says Martin. “This sounds basic but is not universally done.”

Clinicians should absolutely not document the outcome of an event or procedure in advance, says Fanaroff. “It is difficult to find a legitimate reason to document something before it occurred,” he says. “It may be that it was done in the paper era just to be sure that the charting was complete.”

Changes or corrections might not be visible on the EMR screen. “But the paper printouts of charts I have reviewed identify original and revised versions of a record,” says Martin. The author and timing of any changes are also identifiable.

“I have not seen an after-the-fact effort to falsify an electronic chart,” says Martin. “But the only time I had heard of that in a paper chart, the whole case became indefensible.”

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The largest and fastest growing group of malpractice claims in the United States involves missed and delayed diagnoses, specifically of lung, prostate, and colorectal cancer, as well as myocardial infarction, says Saul Weingart, MD, MPP, PhD, chief medical officer at Tufts Medical Center in Boston.

Failure to follow up on abnormal test results contribute significantly to these missed diagnoses, especially relevant laboratory tests, imaging, and EKGs, he says. “The abnormal test follow up process is more complicated than one might imagine,” says Weingart. He says that each of these steps is subject to a “low but real” risk of failure: test selection, test completion, result receipt, result interpretation, and result notification.

Weingart says EMRs can help to prevent missed diagnoses if they incorporate “results management” systems. These track outstanding clinician orders for diagnostic tests. They notify the provider if the test is incomplete within a specified time period, if the test has been resulted, and if abnormal findings have been posted. “Strong systems allow for forwarding of results to covering clinicians, and for auditing or oversight of results that have not been acknowledged within a specified timeframe,” says Weingart.

Some systems generate templated results letters to streamline patient notification. “These systems help to backstop the ordering clinician by creating a fail-safe mechanism to ensure and record that test results have been acknowledged and acted upon,” says Weingart.

More colonoscopies obtained

When Mark Aronson, MD, acting chief of the Division of General Medicine and Primary Care at Beth Israel Deaconess Medical Center in Boston, sends patients for a colonoscopy, “often, I see them the next year, and they tell me they couldn’t find the time to do it.”

A referring tracking system was developed for the organization’s EMR, funded by the hospital’s malpractice insurer. The patient is sent a letter and two phone calls, if patients don’t make an appointment in a certain timeframe. “As a result, we have screened hundreds of patients,” says Aronson. “We have picked up several important findings, such as colon cancer, in a number of patients.” (See related story, p. 3, on patients’ failure to obtain recommended testing.) The system sends test results to the ordering provider and allows providers to compare these to previous results. “It gives them the option of calling the patient and discussing the results at that very moment,” says Aronson.

The system is especially helpful when followup is recommended for a future point in time, such as a

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Prevent claims alleging failure to follow up on abnormal test results. `Results management’ systems alert providers