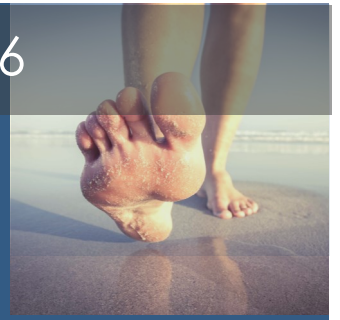




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### EMR Shortcut Charting – Saving Time but Preventing a Defense?

Documentation is time intensive, whether it is in a hardcopy chart or an electronic medical record (EMR). Time intensive tasks, especially when not felt to be directly part of patient care, can be prone to shortcuts, which start out innocent but become more extensive over time. Not surprisingly, shortcuts in charting become much more time intensive later, when otherwise defensible cases become indefensible.

The EMR was developed to increase the tracking of information on patients, and to increase the effectiveness of documentation in regards to billing and reimbursement. Unfortunately, the available EMR programs are challenged when it comes to the narrative patient story, relying more on dropdown fields than narrative statements. While intended to be time efficient, the technology can falter with the result being a chart that does not reflect the individual care rendered to the patient.

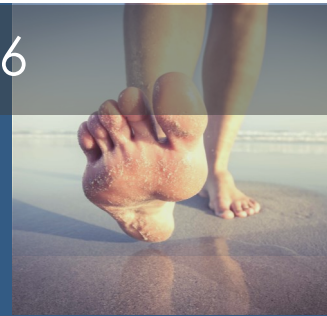
The industry has seen an increase in malpractice cases where incorrect charting entries are preventing appropriate care from being defensible in trial. Incorrect records, even if the mistake is unintentional, reflect poorly on the provider's attention to detail, and fails to communicate that caring, competent care was rendered. Specifically, entries with wrong drop down choices, 'cut and paste' entries that were meant for another patient or the use of pre-filled templates all result in a chart that appears inconsistent with care, careless and even fabricated. Since the chart is the foundation of credibility for the care rendered, and the treating physician, when the chart is less than supportive (or even downright damaging) it directly impacts the ability for the case to be tried on the merits. The jury becomes too focused on the errors and will not see that the standard of care was met, regardless of the quality of the clinical care provided.

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### **Risk Issues to Remember:**

Incorrect entries are difficult to explain in hindsight.

A wrong chart entry, no matter how it arrived in the chart, still becomes part of the legal medical record.

A jury will see what appears in the chart, not what you intended to put into the chart.

Incorrect entries prevent the chart from effectively communicating care to other providers, resulting in handoff misunderstandings.

Patient harm can be caused by incorrect entries.

Failure to check for correctness does not prevent fault from resting on the provider.

Charting is the second most important function in patient care, after clinical decision making.

### **Best practice:**

When using an EMR, click on the field and review all available dropdown options. When you click the option, take a moment to see if the option chosen actually shows in the field.

Double check all entries made before saving the chart.

Review each dropdown field to be sure that what was actually chosen is what reflects the care rendered to this patient.

If needed, add narrative notes to explain treatment plans, changes in the patient's condition, risks and benefits of treatment discussed and any other pieces of information that will allow for communication of the full interaction with the patient on each visit.

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