MedMal DIRECT
Insuring a Healthy Practice

CHECKLIST

Electronic Documentation

Documentation is one of the pillars of risk management. A patient's medical record provides essential patient information, historical details about the course of patient care, and a record of services provided. Accurate and thorough documentation is crucial to providing quality patient care and improving the overall patient experience.

The introduction of electronic medical record systems (EMRs) fundamentally altered the way patient care is documented, resulting in new risks and challenges to healthcare organizations and providers.

The following checklist is designed to assist healthcare administrators, providers and staff evaluate their current approach to electronic documentation and identify areas of risk and opportunities for improvement.

	Yes	No
Does your Medical Practice ("Practice") currently have a written policy regarding documenting the electronic medical record?	☐	☐
If so, does the electronic documentation policy address the unique risks associated with electronic documentation?	☐	☐
Does the policy encourage using a consistent approach to electronic documentation among healthcare providers and staff?	☐	☐
Are healthcare providers and staff educated about the electronic documentation policies: (1) during orientation, (2) as part of in-service training, (3) when the policies change, and (4) when new technology is implemented?	☐	☐
Has the Practice established policies related to copying and pasting, or cloning, information?	☐	☐
Do these policies specifically outline when copying and pasting is prohibited and when it can be used with extreme care?	☐	☐
Does the Practice's policy require providers to carefully review and sign off on any copied and pasted information in patient records?	☐	☐
Are EMR entries periodically audited to check for errors that may have resulted from copying and pasting information?	☐	☐

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	Yes	No
If EMR data fields automatically default to "normal," does your Practice's electronic documentation policy require careful review of records at each encounter to ensure they do not misrepresent clinical information?	☐	☐
Are providers and staff encouraged to perform final quality assurance review of all data entered in data fields and checkboxes?	☐	☐
In addition to using data entry fields and checkboxes, are providers encouraged to enter patient-specific notes and comments in the record, as appropriate?	☐	☐
Does your Practice provide staff education regarding the dangers and consequences of documentation shortcuts in the EMR, such as misinformed treatment decisions and fraudulent billing?	☐	☐
Are providers and staff educated about how the EMR system collects metadata and what types of data are collected?	☐	☐
Are documentation policies adjusted to account for potential issues that metadata might present, including issues related to timing of care and amendments to records?	☐	☐
Are providers and staff aware of state and federal laws or rules related to e-discovery?	☐	☐
Are electronic patient records periodically printed out to ensure print versions are logical and accurately reflect patient care?	☐	☐
Does your Practice use its EMR system to track and audit high-risk functions (such as test result tracking) and support quality improvement initiatives?	☐	☐