Hi, this is Pat Iyer with Legal Nurse Podcast and today we're going to be talking about electronic medical records, which can be a tremendous boost to the legal nurse consultant because of legible medical records. And it also can be what we might refer to as the bane of our existence, producing lots of documentation and sometimes very little information.

I have with me today somebody who is a real expert in the area of electronic medical records, both as an expert witness, and as a behind-the-scenes consultant. Sharon McEwen is a nurse with 30 years of experience in critical care, emergency department, trauma, transplant nursing. She received her Master's Degree in Informatics, which puts her in a very small number of nurses in the United States who have that specialized level of knowledge.

Sharon, welcome to the show.

Tell us what is nursing informatics and why is that background helpful to legal nurse consultants?

Well, Pat nursing informatics is important today with the electronic medical record. It's what we live and breathe. So, nursing informatics defined by the American Nurses Association is a specialty that integrates nursing science with multiple information management and analytical sciences to identify, define, manage, and communicate data, information, knowledge, and wisdom in nursing practice.

What does that mean in layman's terms?

In layman's terms, it means that the major focus of nursing informatics in hospitals is workflow and optimization. That's pretty much the main thing right now. We've been through the meaningful use era. We've put everything into the system that we thought we needed to have, and now we're optimizing the systems more across the country.
just to make sure we only have the information needed for people to document.

We develop policies and organizations, and we also manage outcomes within informatics. It’s an exploding field. It’s very important for what we do as legal nurse consultants, as nurses, and healthcare providers.

**Pat:** I know that many of the people listening grew up in an era in nursing, as I did, when everything was handwritten. There was paper everywhere.

**Sharon:** Yes.

**Pat:** There were flow charts. There were clipboards. There were medical records sitting in the nurses' station and racks and binders, and then we transitioned. Why did we transition to electronic medical records?

**Sharon:** I think a lot of it was driven back in the early 2000s just because of the fact there were so many medical errors. If you recall back in the late 90s, the book came out, *To Err Is Human*, and it showed how many medical errors were happening every single day in hospitals and how many patient deaths were occurring. So, that drove the government to determine we needed to do something.

And that's when back in the early 2000s, we started looking at the HITECH Act and other acts that would make physicians use electronic medical records so we wouldn't have the errors. And that was the whole purpose of it, to decrease the errors that we had and make sure that we could read the physician notes—one of the biggest things, if we all remember. Those handwritten notes, some of them looked like hieroglyphics, and then we had to decipher them as nurses. And I think that's the reason why a lot of the errors were made. Now with the electronic medical record, we're still seeing errors, but we're not seeing it as many errors as we did back in the time when we used to handwrite all our notes.

**Pat:** And I think that background is helpful for our listeners who are in other countries. We have listeners in over 70 countries. They may be focused on handwritten records still because electronic medical records are not universally available throughout the world. And even in the U.S., there are still handwritten records that we must contend with.
Sharon: Right, and I think the meaningful use era put everybody into gear in the United States because the government was giving incentives to the hospitals that met the requirements related to each stage of the meaningful use. Meaningful use now has changed terms. The Office of the National Coordinator decided that we were going to change the term of “meaningful use” to promoting interoperability. Basically, the meaningful use era is over because we have all the incentives have been paid out throughout the country. So, now it's just basically maintaining the systems.

Pat: Tell me what does that term mean, interoperability?

Sharon: Interoperability has to do with being able to make sure that all the EMRs across the system can interface and they can integrate. We want to make sure that we have all that data that's available and for everybody in all the EMRs. As you well know, there are many EMRs and in hospitals we have many disparate systems, and they all must get that data out in one place so that the clinicians can use all that data. So, interoperability is just basically sharing that data across the systems.

Pat: If you go into an emergency department in Chicago and you live in Pittsburgh, and all your medical records are in Pittsburgh, is the hospital in Chicago going to be on the same system as the hospital in Pittsburgh?

Sharon: Not necessarily. And that's where the health information exchange comes into play. That is where we want to have all the EMRs playing in the same sandbox, which has not been easy to do. Cerner is one of the leading EMRs, as well as Epic, and the two of them have not been able to come to terms to be able to share that data across the systems. Many of the other EMRs such as MEDITECH or MEDHOST or NextGen, they have all got into what we call "CommonWell."

CommonWell was formed by Cerner Corporation. And what that is, is we're bringing all the EMRs together so we can have that interface within those systems, and we don't have to have people walking around with medical records from another system going to a different hospital. That's been really the biggest push right now from the government, to have all these health information exchanges to be able to share that data. If I came from Cleveland, for example, and I went
to the Cleveland Clinic to have something done, they're on the Epic system. But if I come to Pittsburgh and go to the University of Pittsburgh Medical Center, we're on the Cerner system, and those will not share data as of right now. There have been talks that I've heard that there has been some progress made so that we will be able to share that data. But that's probably the biggest thing right now, is being able to share that data.

Pat: Yeah. Thank you for that. I'm not sure that everybody listening understood that distinction. Hopefully we will see a decision that will result in sharing of the data so that we can truly as patients know that our medical records are going to be accessible to somebody in a different system.

Sharon: Right, and I think that's where the future of legal nurse consultants is going to play a big role because I have no idea what that medical record would look like with all these different EMRs coming into one single record. So, that'll be something that we will be looking forward to in the future.

Pat: If I asked you to summarize the advantages of having electronic medical records, what would you say?

Sharon: There are several advantages to that. One of the nice things about the electronic medical record is that we have a lot of electronic alerts and reminders. So, for example, if a nurse takes a verbal order from a physician, and they have to co-sign that order, that physician will get an alert in their message center or their email letting them know that they have to go back and sign that order from that nurse.

We also have pop-ups for abnormal labs. There's an abnormal lab, a physician and/or a nurse would get an alert letting them know that there's an abnormal lab in the system. And I think those are very important things that we didn't have in the days of the paper chart of something to be able to tell us right off the computer screen if there's an abnormal lab.

Another good thing about the electronic medical record is it’s faster retrieval of the historical data. I'm sure everybody on the podcast can remember the days whenever the physician wanted to look at the old records, we had to call down to the medical record department, wait
for somebody to answer the phone, somebody to find the records, and somebody bringing them up to the unit. I worked in a larger academic setting, so we didn't store our records in the basement. We kept them down the road, so then we had to call a courier. We must get the courier to go down to the medical record department in the basement, get the information, then go drive down the road to the warehouse, get the medical records and bring them back to the hospital. So, sometimes it was the next day before the physician would get those medical records, where now it's all at our fingertips. We have the historical data all in the computer system and we don't have to wait for those handwritten charts anymore.

Another good thing about it is better compliance. We can mandate fields that have to be required from The Joint Commission and the CMS by having hard stops, hard stops or screens, that you cannot get off unless you hit all the required documentation on a screen. We can force physicians and nurses to make sure we have all that compliance and all that required data because we put these hard stops in place. And that has been shown that we have better compliance with most of the documentation that's required.

And then one last thing (and believe me, I'm just skimming the top, there's a lot more) is keeping track of preventative medicine screening. The computer will generate a letter or reminder to a patient for that colonoscopy, or that mammogram, or that pap smear. It's a generated thing from the computer to the patient. Sometimes it's a letter. Sometimes it's information put into the patient portal. As legal nurse consultants, we must keep those things in mind. If a patient says they didn't get a reminder for that pap smear, we could be able to go back into that chart and see if that generated reminder was put in the computer and was sent to the patient.

**Pat:** Those are important advantages, I agree.

**Sharon:** Yes.

**Pat:** Why do people resist transitioning to an electronic medical record or complain about the current state of electronic medical records?

**Sharon:** I think a lot of it has to do with computer literacy. Computer literacy is a definition that everyone has a different ability within the computer
system. The younger generation, obviously they were born into it so they readily can go through the computer system without any hesitation. Older people have trouble. They might not have a computer at home. They don't know what a mouse is.

I can remember when we started the electronic medical record back in the late 90s, early 2000s, there was people in panic because they did not know how to use a mouse. They couldn't get through the screens. They were very slow at it, and it required a lot of overtime initially, believe it or not, because the nurses weren't getting out of the hospital because there was just so much documentation and they were overwhelmed. And I think that's where the resistance came in. It was very easy to sit down and write whatever they wanted to write when it was time versus going back and remember what they did.

A lot of times what I've been seeing now is that nurses are doing what we call "Batch Documenting," meaning they wait until the end of the shift, and they'd try to remember what they did for eight or 12 hours and then document at one time. Well, we all know that that's impossible. Plus, it's also a timestamp. If I'm sitting down at 5:00 in the afternoon to start my documentation from an 8:00 AM assessment, it's going to show in that electronic medical record. It's not as easy today as it was back in the day of the handwritten charts because I can put any time on there, I wanted to put on there and nobody would ever know.

Pat: And that brings me to a topic that concerns many legal nurse consultants and attorneys is how do we know that that electronic medical record is accurate and hasn't been changed or altered in some way? What are the clues that we should be looking for?

Sharon: It's funny that you would ask that because that was something I wanted to talk about. I guess we can look at it as a pro and a con. Much of the information that we document pools from an encounter to an encounter. An encounter is just an admission. When I gather your information when you come into the hospital on Monday, I ask you your history, I ask you your allergies, and I ask you all the things that we ask as nurses on your assessment. The next time you come in, that information pools to that next encounter.
That's all fine and dandy and that makes the clinicians happy because they don't have to ask the patient again, but how do I know that somebody reviewed that information? That's what we've been running into. That information could be four or five years old, and I don't know that anybody looked at it because it's not telling me anywhere in the electronic medical record. And a lot of nurses, if information is populated, they think that it's okay and it's all right to use.

There is a way, though, that you could tell if that information was reviewed, and that would be an audit trail or an audit log. When you look at an audit trail or audit log, you would be able to tell if that information was reviewed because it's going to have a timestamp next to it. There are some vendors out there that will put a mark as reviewed or indicator out there that if a nurse clicks on that, it would reflect that date and time that that information was reviewed.

If it wasn't reviewed, then it's going to have the old date and time and that's a problem. And that's what we legal nurse consultants need to look at to make sure that information was reviewed, and it is accurate because it could be the wrong information. It's going to be carried on each time that patient comes into the hospital.

Just imagine you are analyzing a medical record. Suddenly, you see a chart entry that does not make sense – or can’t find an entry that should have been there. You look away, bewildered. You begin to form a thought – “Someone tampered with these records.” Your medical knowledge may make you the only person on the legal team to recognize the tampering.

Today’s highly charged atmosphere with its focus on financial survival of healthcare organizations and medical malpractice increases the temptation to alter records when something goes wrong.

There are many reasons why a person would tamper with records, including an intention to commit fraud, such as billing for services not performed, or fear or
guilt when an untoward outcome occurs. How often do you find yourself saying, “I wish I knew how to identify fraudulent records?”

Tampering with medical records skyrockets the implications of a case. You’ll learn why this act so profoundly affects a medical malpractice case. This program contains what every legal nurse consultant should know about altered medical records. You will get the truth about how you can help an attorney with suspicions of altered medical records.

In this 60-minute online training called **Fraudulent Medical Records**, you will learn how to:

- Differentiate between substandard documentation and altered medical records
- Recognize the factors that lead to altered medical records
- Identify the implications of tampering with medical records
- Detect altered medical records

Obtain the details about this online training at the show notes for this program, by going to podcast.legalnursebusiness.com. You qualify for a 25% discount when you use the code listened in the coupon box.

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**Pat:** Tell me about an audit trail and under what circumstances would an attorney or a legal nurse consultant request that?

**Sharon:** An audit trail can be described as a record that shows who has accessed the computer system, when it was accessed, and what operations were performed. An example of that would be a physician states he needs a chest x-ray, but later may find that there's a tumor in that chest x-ray that had been missed when he was reading it. The physician could state that he read that x-ray very carefully, he took his time. He read it for a long period of time. But if we went in and asked for an audit trail, it would show us exactly how long he spent on that x-ray, looking at it. Because it's going to have the timestamp of when he went into that report and when he left it. So, you're going to be able to track all that in an audit trail and they're very important because there's a lot of benefits for an audit trail.
An audit trail in litigation can help bolster plaintiff or defense claims about whether procedures were performed at the time the clinician says they were performed. Every case does not justify an audit trail though and that's what we must determine, when do we ask for one and when do we need one?

If you suspect a chart has been tampered with at times, and the times and the locations are not adding up, then you should request an audit trail. If a physician states that he was in the hospital assessing a patient at a certain time, and we request that audit trail, it will track the IP address of the computer that he used to document on that patient. If that IP address isn't located in the hospital, then we know that he wasn't in the hospital, and you might be able to hold him liable, or at least question why he was saying that he was somewhere he wasn't. So, it will tell you all that information.

Audit trails are good for that. Not only will they track the documentation, but there are a lot of pop-ups that we get in the electronic medical record as we spoke about before, which are great. However, they become a nuisance after a while. And a lot of hospitals are looking at these pop-ups because sometimes they can cause a lot of alert fatigue for clinicians. If every patient who comes into a hospital has to be on some kind of a prophylaxis, and when a patient comes in and he's not on any SCDs or Lovenox, every time a clinician opens up that chart, they're going to get a pop-up stating, "This patient is not on any prophylaxis."

If a nurse sees it, it's just a reminder for the nurse to call the physician. If the physician gets the pop-up, they have an option right at that point to go ahead and order that prophylaxis or indicate why it was contraindicated. If they choose to just bypass it and just lock themselves out of it, and they continued to do that and that patient has an adverse event happen with a PE or a DVT, we can hold that physician liable. Because we can go back into those audit trails to see how many times he bypassed that alert. It could be very beneficial in the long run for the legal nurse consultants because we can look and see that he bypassed it 25 or 30 times. Because every single time he opens that chart, it's going to pop up until he addresses it.

**Pat:** Yeah, that's a great point. And I could see immediately why that would be useful with if the patient developed a PE.
Sharon: Yes.

Pat: We can go back and look at the behavior of the providers. "Did they do the assessments?"

"Did they consider the prophylaxis?"

The SCDs, for our listeners who may not be familiar with that, is the sequential compression devices on the legs that inflate and deflate. All of this points out some of the power of the electronic medical record, but a lot of legal nurse consultants and attorneys are concerned about whether they have gotten everything when they request a medical record. Are they getting the full electronic medical record?

It's easy when you have a paper chart because somebody in the medical records department flips through the pages and says, "Yes." They copied the front and the back, but they scanned the front and the back, and everything is there. But do we know that we've gotten everything when we get an electronic medical record?

Sharon: No, and I am sure, I could bet my nursing license on it, we are not getting everything. I know that one of the facilities I work at, when I talk to the head of the medical record department, I talk to them about audit trails. And just copying a chart for an attorney or legal nurse consultant, they have no idea what they're copying. They have no idea what's important. They have no idea what we need. They have no idea what we don't need. So, I don't think that we're getting everything. And I think what we really need to do is when we're interviewing a patient, we really need to ask them, did they get a generated reminder for that annual test, the mammogram or the colonoscopy. We really need to get as much information as we can from the patients because here's why.

There are many ways to communicate with patients these days with electronic medical records. It's not just a phone call anymore. There's communication between the physician and the patient through the patient portal. There are emails that go back and forth. There are all kinds of different ways today that these people talk to each other that may not be thought about when we're asking for those medical records.
So, when you're asking for the medical record, you really want to make sure that patient tells you all forms of communication they've had with that physician. If they're emailing him, and the physician emails the patient saying, "Do not take that Coumadin," we need to make sure we have a record of that so we can prove it in court if an untoward event happened to that patient.

So, you just always must think about the methods of communication today. It's not just all in the electronic medical record. A lot of information is being passed through the patient portal today because we really want to engage patients in their care. So, the patient portal has a lot of information in it that we could use as legal nurse consultants and we must keep that in mind when requesting the medical record.

Pat: That's a great point. I just got an email yesterday from a primary doctor who gave me the results of my lab results. I should clarify. It came from the lab itself to tell me what my results were. I remember the days when patients would have to call the physician's office and say, "Hey, how did my blood work turnout?" Now I know probably at the same time the physician does what those results are.

Sharon: It's interesting that you bring that up, Pat, because that was one of the newer things in the electronic medical records that could be a pro, but it also can be con.

So, every organization is required to set a time of when these results will be posted into the electronic medical record for lab results, for example. The organization I work at, we posted within 36 hours of those results of the lab. That was all fine and dandy, but the competitive hospitals around us were posting in 24 hours. On our patient satisfaction results, we were getting a lot of complaints that you know, "This organization gets it in 24 hours, and we don't get it for 36." We discussed it. At that time, we decided, "Okay, we'll go for the 24 hours."

The caveat to that is that the physician may have not looked at those results as of yet and that's one of the biggest problems that we're seeing is that, specifically if it's a pathology report, if it's you know a pap smear might be cancerous, it's going to be posted in that patient portal. That patient is going to be able to see that, but that physician
may not have had that time yet to look at those results. We have seen many times with the patients being very, very upset, calling the physician’s offices. And it's not the physician's fault because they just haven't had a chance to see it yet, so that has been a big problem. We have said our laboratory or bloodwork results will be in 24 hours and the pathology reports will be in 36 to give that physician an extra 12 hours to be able to look at those results.

Pat: Boy, that's a lot of pressure on a busy physician.

Sharon: It is, and you know they have hundreds of patients. And we all know how many abnormal results are in a lab, so it's been very challenging for the healthcare providers for sure.

Pat: Tell us how the clinical decision support term fits into electronic medical records and what does that mean to us as legal nurse consultants?

Sharon: I look at clinical decision support as a safety net. These were placed into the system to give us pop-ups, and alerts, and things like that, that we didn't have to wait for those lab results. If it's an abnormal lab, I'm going to get a pop-up right on my screen letting me know that it's an abnormal. But the definition of clinical decision support is any tool that provides clinicians, administrative staff, patients, caregivers, or other members of the healthcare team with information that is filtered or targeted to a specific person or population.

Clinical decision support is intended to improve quality of care, patient safety, and avoid errors or adverse events, and allow the key team members to be more efficient. Clinical decision support was part of meaningful use or promoting interoperability. It stated hospitals that are participating in meaningful use had to have five clinical decision support interventions.

Some examples of clinical decision support is the drug-drug interaction. Remember the days, and I'm sure we all do, that we had to go look up and find PDR to look up the information. I always had the hard time of trying to find the PDR on a nurses' station. And this drug-drug interaction checking will let you know, again, as another pop-up or a reminder that it shouldn't be given together. An example is if a patient is on aspirin and a physician or nurse comes and orders
Coumadin, you're going to get a pop-up letting you know that, "Hey, you shouldn't be given these two together due to the bleeding potential."

Another clinical decision support example is drug allergy checking. So, if a patient is allergic to sulfa, and the physician comes along and orders Bactrim, once again, we'll get another pop-up letting us know that this patient has an allergy.

Now on the allergy screens, you can do an override. And the reason why you can do an override is because patients think allergies are nausea. We all know as nurses that it's not necessarily nausea; it's an allergic reaction. That's the reason why they can have that override on the allergies. Now if a patient does have an adverse event on an override, on either of the two examples of the drug-drug interaction of the drug allergy checking, again, this could be traced in an audit trail to look to see if the provider overrode screens and didn't pay attention to any of the pop-up alerts. The physician could be held accountable at that point possibly.

Another example of clinical decision support or reminders for nursing, or we also call them tasks. Task lists are reminders for nurses to do certain things and I absolutely cannot stand them. In our day, I didn't need a reminder for anything, when to do a blood sugar, when to do a vital sign, when to do anything like that. And today the nurses are really attuned to having these tasks and reminders, but unfortunately it perpetuated some clinicians relying more on their task lists and not using their critical thinking skills.

And this has been risky for patients because what we used to consider just doing things and not having a reminder, now it's taking that critical thinking away, and it's risking care that has historically just been a standard of practice. I don't need a task to remind me to go take a vital sign when the patient comes back post-operatively and I think that's really been a problem.

I really think that technology has hindered critical thinking for nurses. I know I just implemented a project. It's called "Infusion Management," and nurses don't even have to do calculations any more for drugs. It's automatically done. Orders are automatically put into an
IV pump. It's calculated there, and it results that back into the computer system, and it documents it for you.

In my day as a critical care nurse, we used to have to do the magic number and I can recite it now like I was doing it yesterday, but that's what we did. We remembered everything without a task. I would write everything I had to do on my scrub pants and that was my reminders like or my hand, one of the two, because I don't wash my hands or don't wash my pants until I made sure everything was put into the chart.

Those are the things that are a part of clinical decision support. And we get a lot of pop-up alerts for a duplicate order. Height, weight, and allergies, no blood products. But you can see how clinical decision support can be traceable on an audit and how this can help legal nurse consultants and attorneys. You always want to keep that in mind as we're going through charts.

Pat: Do you think that electronic medical records are changing the standard of care?

Sharon: Yeah, I really do. I think this is a two-pronged approach. I think that one of them is recognizing the change in the standard of care that's being driven by the use of the electronic health record, and the second one is using the electronic health record in a way that's going to be helpful to meet that standard of care. So, I think it affects both. It does affect the standard of care in both instances and I think I'm beginning to see that shift as the technology continues to evolve.

I think that it will change the standard of care, especially for providers because I think every organization has a different standard of care. It's not one national standard of care, which makes it a little bit more challenging. For instance, a physician who overrides an alert can be accused of deviating from the standard of care. But an overriding alert, really is that of deviation from the standard of care?

From the example I just gave about an allergy, if he overrode the alert because the patient says it's nausea, I'm not sure that's a deviation of the standard of care. But that organization may have a policy around it that would say that it is a deviation of standard of care. So, I think that the other problem with that is the clinical decision support guidelines
(despite implementing EHR by computer programmers, not clinicians) could solidify the standard of care. So, in other words, we're not driving the standard of care.

The vendors know what that standard of care is and what that clinical decision support can do. So, I think a lot of it might not be the clinicians driving it, but the vendor saying, Hey, we can give a pop-up for this and we can give a pop-up for that." They think they're doing us a favor, but I think they're really starting to burn us out with all the different pop-ups. And I mean there's hundreds and hundreds and hundreds of pop-ups. And I think that's why we're seeing everybody just blowing through these pop-ups because every time you open a chart, there's another pop-up or reminder. I'm not so sure that was the intention of it. I think they're starting to scale back, but it's very difficult to figure out which ones you want to remove and which ones you want to keep as far as clinical decision support.

I noticed that one of the standards of care that we had when we had paper charts was at the end of each shift, I can remember taking a red ink pen and red lining the orders, making sure that we reviewed all of the orders and all the orders were captured. And now with electronic medical records, we can't do that.

Nobody knows what's being missed, and there's no way to tell that that order is signed off quickly. I mean, you can see that, but you remember those days whenever we had an order, and I think this is one of my biggest problems with the EHR, was in the days of the handwritten chart, we would look over at the nurses station and we'd see all the charts flags. It was a visual. We as nurses are visual people. We don't have that in electronic health record. We wait for a pop-up again to tell us there's an order. So, I think that, that standard of care alone has been a big difference for nurses.

Pat: You brought me back to the days of looking at physician orders and there was a line that we drew down in the margin and then across the bottom under the signature. And that would indicate that we had reviewed those orders and signed them off and it was the night shift’s responsibility to go through every chart and make sure that there were no orders that were missed. So, yes, that's completely different in an EMR.
Sharon: It is different in EMR and I mean, right now our biggest challenge is trying to get the patient engagement. And so, we want to do a report in the rooms with the patients present at the computer. I mean that has been a very challenging thing. When I was a manager, it would take everything I had to get my nurses to go and give report in a patient's room in front of a patient.

I think that's another change that we're seeing as a standard of care. It was a standard to sit in the nurses' station, two nurses sitting there giving a report. Now we want them engaged, and we want them up and talking about the patient in front of the patient. And that's a big shift for nurses. We're not used to talking about the patient in front of the patient, so that's a big change for us.

Pat: One last question, Sharon. Attorneys like to say to nurses, "If it wasn't charted, it wasn't done." Is that true today?

Sharon: It is in a sense, Pat. It's funny because I think we all remember that saying, "If it wasn't documented, it wasn't done." But now I think I'm seeing a shift, believe it or not. I'm beginning to see a shift to “It was documented, but it wasn't done.” And the reason why I say that is I go back to that task list.

A task list is nothing but a list of things that we are supposed to do. The nurse has a choice of done or not done. At the end of the shift, they go down that list and hit done, done, done, done, done, done. Say one of the tasks was to ambulate the patient, and I charted done, but when I go back to look at that documentation, I see nowhere that the patient was ambulated X amount of feet. I think there's a lot of times that we hit done and it really isn't done, and there's really no way to prove it except to go back into that EMR and just search to see if there's any documentation supporting that task that they say was done.

So no, I don't think that it's always done when it's documented, not in the electronic medical record. I think the other piece is that you know many organizations adopted charting by exception. Well, that's very difficult in the electronic medical record. It was much easier on paper, but the electronic medical record, The Joint Commission doesn't frown on charting by exception. But they want to make sure that you must have those policies, guidelines and protocols around the charting by exception. And I really believe it's a slippery slope.
For those of you who may not know what charting by exception is, it's a shorthand method of documenting normal findings based on clearly defined normals, standards of practice and predetermined criteria. So, significant findings or exceptions to the predefined norms are documented in detail. So, in other words, if I come in with abdominal pain, the only system I must document on is my GI system, my neuro, my cardiovascular, my pulmonary, my GU, all are within normal limits. But, again, those within normal limits/guidelines must be in that computer system as a reference for those nurses. So, if they say the capillary refill is less than three seconds, I need to make sure that my patient fits all that criteria within those normals for me not to document against it. So, it's time consuming because I must make sure that everything is normal. But if it's abnormal, I need to document it. So, it's a very slippery slope. I'm not a fan of it, but we did it. But it's challenging.

Pat: Sharon, I feel like we just scratched the surface of what we could talk about with this subject, and we'll have to have you back and probe a little bit deeper. How can our listeners find out more about you and the services that you offer?

Sharon: I do have a website Pat. It's www.mcewenconsultingllc.com and that's M-C-E-W-E-N consulting LLC.com. So, I do have a website out there. That's how anybody could reach me or have any questions. I would be happy to answer them.

Pat: Thank you so much, Sharon, for spending time with me today. And for you listening to this podcast, I hope this has been informative and expanded your mind a little bit about electronic medical records and how they fit into the legal system. Sharon gave some great examples that we need to be aware of as we're evaluating cases and handling the reams of information that come with an electronic medical record.

Sharon: Thank you Pat, I appreciate it.

Pat: Thanks so much and thank you for being part of this podcast and listening to this information. We will be back next week with a new guest and a new topic and enjoy your week.
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