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IN THIS ISSUE

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Shortage of on-call specialists for your ED? Help may be on the way

CMS to allow shared or "community" on-call programs

By Robert A. Bitterman, MD, JD, FACEP, *Contributing Editor*

The Centers for Medicare and Medicaid Services (CMS) recently proposed changes to the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations that would allow "community call" programs to be established by groups of hospitals in self-designated referral areas to help address the shortage of ED on-call specialists.[1] A community system could provide a specific medical service, such as neurosurgery or hand surgery, and/or a specific time frame, such as just on the weekends. The involved hospitals would need to establish a formal written plan and comply with set minimum criteria determined by CMS, but no advanced approval from CMS would be required.

Each hospital in the program would still be required to medically screen, stabilize, and arrange an appropriate transfer when sending selected patients to the "community call" facility.[1]

Historical Perspective

CMS is acutely aware of hospitals' difficulty maintaining on-call specialty physician coverage for their emergency departments. It had hoped its "increased flexibility" changes to the EMTALA on-call requirements back in 2003 — allowing simultaneous call, allowing elective surgery while on call (in certain circumstances), and not requiring physicians to be on-call all times — would improve access to specialty physicians for ED patients.[2]

The EMTALA Technical Advisory Group (the "TAG"), established by Congress to review the EMTALA regulations and advise CMS on their application to hospitals and physicians,[3] believed that the 2003 regulations actually decreased, rather than increased, specialty coverage for emergency departments. The EMTALA TAG recommended to CMS that hospitals be allowed to satisfy their on-call coverage obligations by participation in an approved

community/regional call coverage program.[4] The TAG looked to CMS to determine the appropriate approval process.

CMS's Proposed Regulations

CMS responded by proposing community call to be a "formal on-call plan that permits a specific hospital in a region to be designated as the on-call facility for a specific time period, or for a specific service, or both."[1]

Moreover, CMS did not believe it is necessary, nor would it require, a community call plan to be subject to pre-approval by CMS; however, if an EMTALA complaint investigation was initiated, the plan would be subject to review and could potentially be found in violation of the law. It wanted hospitals and their communities to have the flexibility to develop a plan that reflects their local resources and needs.[1]

CMS did, however, expect the hospitals involved to implement a *formal* plan, with formal written agreements recognized in their policies and procedures, as well as backup plans.

The TAG and CMS also expressly emphasized that a community call arrangement would *not* remove a hospital's obligation to perform an appropriate medical screening examination (MSE), or its duty to arrange an appropriate transfer, for any patient who presented to one of the non-designated call hospitals in the plan. CMS anticipates that individuals who arrive at a hospital other than the designated on-call facility, and are determined to have an unstabilized emergency medical condition that requires the services of an on-call specialist, would generally be transferred to the designated on-call facility in accordance with the community call plan.[1,4]

> "Each hospital in the program would still be required to medically screen, stabilize, and arrange an appropriate transfer when sending selected patients to the "community call" facility."[1]

Finally, to devise an acceptable community call system, CMS will require hospitals to incorporate the following minimum criteria:[1]

1. The community call system must be a *formal* plan among the participating hospitals, signed by an appropriate representative of each hospital participating in the plan, and with written policies and procedures in place.
2. Hospitals participating in the community call plan must engage in an analysis of the specialty on-call needs of the community for which the plan is effective.
3. The community call plan must include a clear delineation of on-call coverage responsibilities, that is, when each hospital participating in the plan is responsible for on-call coverage.
4. The community call plan must define the specific geographic area to which the plan applies.
5. The community call plan must ensure that any local and regional Emergency Medical Services (EMS) system protocol formally includes information on community on-call arrangements.
6. The community call plan must include a statement specifying that even if an individual arrives at the hospital that is not designated as the on-call hospital, that hospital still has an EMTALA obligation to provide a medical screening examination and

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stabilizing treatment within its capability, and hospitals participating in community call must abide by the EMTALA regulations governing appropriate transfers.
7. Each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control.
8. There must be at least an annual reassessment of the community call plan by the participating hospitals.

Potential benefit of community call arrangements

There are a number of scenarios in which community call systems could be highly advantageous. For example, a hospital system with one "main" campus and one (or two) other hospital facilities that are in relative close proximity to each other might find this useful. The hospitals could form their own geographic community call program, designating the main facility as the on-call facility for many services, such as neurosurgery, neurology, orthopedics, urology, or hand surgery, and then not have to require physicians of those specialties practicing at the affiliated facilities to take ED call at those facilities. Such an arrangement would clearly attract physicians to the staffs of the affiliated facilities, and work particularly well if many of the physicians had privileges at both (or all three) of the hospitals.

In communities where specialists, such as neurosurgeons or orthopedic surgeons, were relatively scarce but were privileged and practiced at two or three different hospitals, they could designate one hospital as the on-call hospital for that service and not have to take call at all or simultaneously for the other hospitals in the community. All cases could be directed by EMS to the on-call facility or transferred there if they originally presented to a non-designated call center hospital.

In large cities, competing hospitals or entire mega health care systems could take turns providing call for various specialties; for instance, every other day or one month on then one month off, or alternate weekends might work well. Such a plan would certainly cut down the amount of call days for the specialists, yet still provide continuous 24/7 specialty service to the community.

Over time and with trial and error hospitals/communities should be able to craft many varied and imaginative call programs to improve access to emergency specialty care, while simultaneously lessening the burdens placed on the specialty physicians.

Provider input sought by CMS before it issues a final rule

CMS has welcomed provider and public comments on its proposed elements of a formal community call plan. Additionally, it solicited comments on "whether individuals believe it is important that, in situations where there is a governing State or local agency that would have authority over the development of a formal community call plan, the plan be approved by that agency."[1]

Hospitals and physicians also should submit any other concerns they have regarding the on-call issues under EMTALA, since the TAG made a host of other on-call recommendations that CMS intends to address at a later date.[4,5] In other words, expect still more on-call regulations from CMS in the near future.

Summary

In summary, CMS is proposing that, as part of the obligation to have an on-call list, hospitals may choose to participate in community call, provided that the formal community call plan includes, at a minimum, the elements noted previously.

CMS expects these community call changes will help hospitals attract more physicians to their medical staffs, and anticipates it will afford additional flexibility for hospitals to provide on-call services and further improve access to specialty physicians for emergency care.[1] This time, it looks like CMS is spot on. ■

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Is "the ED was just too crowded" ever a good defense?

Strategy is likely to backfire

Crowding is increasingly becoming a factor in litigation involving emergency department care, putting nurses and physicians at increased risk for being named in a lawsuit.

"I expect that there will be more lawsuits involving adverse outcomes in a crowded situation," says **Robert Shesser,** MD, professor and chair of the department of emergency medicine at George Washington University Medical Center in Washington, DC. "Because the hospital system is so broken, your exposure to medical legal risk goes up."

There is no question that patient outcomes are adversely affected by delays in assessment and treatment caused by ED overcrowding, according to **Jeffrey Freeman,** MD, clinical assistant professor in the department of emergency medicine at University of Michigan Health System in Ann Arbor.

"Overcrowding directly causes errors due to understaffing relative to workload," Freeman says. "It also causes patient dissatisfaction, which leads to increased perception of negligence if damages occur."

Key Points

- Overcrowding puts emergency departments at significantly increased risk of lawsuits, due to poorer outcomes, errors, dissatisfied patients, and patients leaving without treatment. Juries are unlikely to accept overcrowding as a defense for a patient's adverse outcome, according to ED legal experts.
- ED physicians are liable for the care of patients held in the ED, even if the patient has been admitted to another physician.
- Electronic tracking systems or flagged charts can determine whether the ED was crowded on a given day.
- ED physician groups are unlikely to raise issues such as indemnification for patients waiting for inpatient beds, due to fear of losing their contracts.

Also, long wait times increase the number of patients who leave prior to completing their emergency evaluation. This is a group of patients at high risk for bad outcomes, says Freeman.

When inpatients are boarded in the ED, significant and sometimes fatal delays can occur, warns **Sandra Schneider,** MD, professor of emergency medicine at University of Rochester in NY. Patients are often on complicated inpatient medical protocols that are unfamiliar to the ED nurses, which may lead to errors. "It is actually remarkable how rare those errors are — it is a testament to the nurses who staff the ED," says Schneider.

Freeman points to an ominous sign: Attorneys are beginning to advertise for clients to call them if ED wait times are long, and are publishing articles about long ED wait times on their websites. "It is inevitable that overcrowding will lead directly to bad outcomes and increasing medical malpractice claims," he says.

Juries probably won't sympathize

Jurors are unlikely to look closely at the underlying issues involving ED crowding, and instead, are usually focused on the individual who is suing. "After Hurricane Katrina, we learned a lot about how the public views care in a disaster," says Schneider. "While the medical profession understood the decisions made, such as euthanasia during the disaster, the public clearly did not. If they don't understand that standard of care is compromised in a disaster, how would they understand it in a crowded ED — even if we are in a disaster mode each and every day?"

There is nothing stopping a defense attorney from pointing out that a waiting room was flooded with critically ill patients, to explain why a patient's care was delayed. But would this get the ED physician off the hook, or make things worse?

"In my opinion, most juries would not consider overcrowding sympathetically," says Freeman. "They would likely blame the inefficiencies back on the doctor and the system for not correcting the problem before the event occurred — despite the inability of either to make a significant impact in most cases."

Even if a particular nurse or physician was seen as sympathetic and not liable for a patient's adverse outcome because the ED was simply too crowded, this would likely be offset by the same jury placing an equal blame on the facility for not coping with the problem before the event, says Freeman.

"I wouldn't recommend that a defense attorney try this appeal. It reminds me of asking a judge to forgive

a traffic violation because of icy road conditions," says Freeman. "Their response is inevitably that a driver is responsible for adjusting his operations to meet the conditions, even if they are outside of his control."

It may be true that the number of patients in your ED was a factor in the plaintiff's outcome, but it's not necessarily information you should share with a jury. "I'm not sure it is a good legal strategy to say, 'We saw 50 people that day and I can only see three at a time.' I think that hurts your case rather than helps it," says **Frank Peacock,** MD, vice chief of emergency medicine at The Cleveland (OH) Clinic Foundation. "I don't know anybody who has successfully used that as a defense."

What the jury will hear is that the ED doctor was too busy to do his job and that the patient paid for it. "You can say to the jury, 'I had three people dying at the same time and I had to make some decisions and this guy got a little bit ignored.' But I don't think you really want to admit that on the stand, even if it was a fact," says Peacock.

When you are faced with more patients than resources, one possible defense argument, which would encompass both the hospital and the emergency physician, is that everyone did everything that could be reasonably expected under bad circumstances. "In other words, there was more demand than supply," says Shesser. "But in the event that this defense doesn't prevail, the ED physician and their liability carrier might have to participate in settlements and judgments, for things that are really not their fault."

"When you are faced with more patients than resources, one possible defense argument, which would encompass both the hospital and the emergency physician, is that everyone did everything that could be reasonably expected under bad circumstances."

In fact, plaintiff's attorneys may themselves use the strategy of blaming errors on overcrowding, arguing that the state of the ED is evidence of lack of adequate care resources. When Peacock was sued by an ED patient, the plaintiff's attorney brought up the issue of crowding. "The best part was they didn't know what they were talking about. We pulled up the numbers and said 'It wasn't too busy, your patient was seen in six minutes,'" says Peacock. Still, the incident reflects the fact that crowding is coming up more often in ED lawsuits — something that hospital administrators will ignore at their own peril.

"Hospitals become targets when they don't do their job. The idea that the ED can be ignored is going to get hospitals in trouble," says Peacock. "The ED has become the barometer for the health of the hospital. The longer ED patients wait, the higher the death rate for some kinds of patients — and that means liability for a hospital."

Since it's impossible to recall if the ED was particularly crowded on a given day, Schneider suggests using electronic tracking systems, although this won't fully reflect staffing and space considerations, or stamping ED charts with a code signifying that the waiting room was crowded at that particular time. "However, in some institutions, all charts every day would be stamped!" says Schneider.

Sources

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SPECIAL REPORT

Holding Orders: Increased Risk for Emergency Physicians?

By Jonathan D. Lawrence, MD, JD, FACEP, *Contributing Editor, Emergency Physician St. Mary Medical Center, Long Beach, CA, Assistant Professor of Medicine, Department of Emergency Medicine, Harbor/UCLA Medical Center, Torrance*

Controversy continues to swirl around the appropriateness of emergency physicians writing holding orders (or bridge orders, as they are sometimes called) for admitted patients. The two main professional organizations of emergency physicians have differing viewpoints. The American College of Emergency Physicians (ACEP), since 1986, has declared the practice to be inappropriate,[1] while the American Academy of Emergency Medicine (AAEM) believes otherwise.[2] If anything, the pressure on emergency physicians to write some kind of orders for care beyond the ED will increase as attempts mount to relieve ED boarding of admitted patients. How did we get here and what, if any, are the legal ramifications of writing (or refusing to write) holding orders?

Simply for historical reasons, writing orders of any kind for the continued care of a patient once he or she has left the emergency department has never been popular. In the early days of emergency medicine, when emergency physicians lacked respect from more established specialties, such a practice was frowned upon as appearing too much like "scut work," thus having the danger of placing emergency physicians in the position of glorified house officers. Even though such a rationale has, for the most part, been swept aside by time, many emergency physicians view the practice as an anathema, even if writing some orders may be to the patient's benefit.

In addition, most training programs don't prepare residents to write holding orders. Residencies are at big teaching hospitals where each service has abundant house staff. There is simply no need for emergency physicians to write orders once the decision has been made to admit the patient. Although most programs provide experience for their residents at community hospitals, where holding orders might be written, this experience is generally limited. When residents go out into the "real" world, they can find themselves unprepared if their practice situation calls for emergency physicians writing holding orders. In some cases, the viability of a group's contract with the hospital may depend on the good will generated by the courtesy of writing holding orders for the attending medical staff.

The hospital medical staff by-laws play a role in the holding order question. Virtually all such by-laws have provisions that govern how quickly an attending physician must physically be present in the hospital after a patient admission. Typically, such time limits are, on average, 1-2 hours for the ICU and 8-12 hours for a ward admission. Variations on these parameters are common. Thus, an emergency physician (EP) cannot, under the by-laws, demand that an attending come to the hospital. Commonly, in this scenario, the attending and EP will discuss the case and orders will be either dictated by the attending to the ED nurse or the floor nurse, or the EP will write holding orders to cover the time period until the attending comes to the hospital.

In recent years, the proliferation of hospitalists has changed the landscape somewhat. In larger hospitals, full-time hospitalists have eliminated the need for holding orders in many cases. In smaller hospitals, however, the hospitalist is often hired by an HMO or PPO and is responsible only for the plan's patients, may have to split his or her time between several hospitals, and may not be in the hospital 24 hours a day. Thus, the need for holding orders may persist.

Lost in all of this is an analysis of the legal liability involved when an emergency physician elects, or refuses to write, holding orders. ACEP's position is that holding orders appear to extend responsibility for the patient to the ward and beyond the ED, thus exposing the EP to legal liability should the patient deteriorate on the ward. AAEM, while discouraging the practice, finds it permissible. Both organizations long for a "bright line" noting where the responsibility of the EP ends and the responsibility of the admitting physician begins. Unfortunately, such a bright has never existed and nuanced "shades of gray" continue, especially now in the age of boarding admitted patients in the ED. The flip side of the coin is that an admitting physician may actually come to the ED and write orders. If the admitting physician then leaves and the patient is boarding, the EP

can still be on the hook if the patient deteriorates in the ED. The question is; does it matter? Are EP's protecting themselves legally by not writing holding orders or is the reverse true? The author has had extensive discussions with multiple malpractice attorneys and none can recall a case in which liability hinged on the holding orders or lack thereof. This is not to say that such a case doesn't exist somewhere in the country (and the author welcomes feedback if one does), but they must be rare. Here are the reasons why.

1. If a patient has an "event" on the ward that leads to litigation, be assured the plaintiff's attorney will name everyone who cared for the patient. If the patient entered the hospital through the ED, that will include the EP. During the discovery process, plaintiff will find out the role of the EP in the care and treatment of the patient. Even assuming the treatment in the ED was up to the standard of care, there is no reason for a plaintiff attorney to dismiss the EP if the patient deteriorates on the ward, with or without orders from the attending physician. This is doubly true if the EP's treatment was not up to the standard of care (or if plaintiff finds an expert to say it wasn't), even if the EP didn't write holding orders. The plaintiff would like to have as many contributors to a settlement or award as possible.
2. The co-defendant attending physician can always question the quality of the work-up or the communication with the EP to explain why the dictated orders were insufficient. This is especially true if the admitting physician doesn't know the patient, such as a physician on-call for the patient's regular physician or a call panel physician for unassigned patients. Staff by-laws protect the admitting physician from demands that he or she come to the hospital immediately. Plaintiff attorneys love it when co-defendants point fingers at each other, but desperate defense attorneys have been known to play this game both to deflect criticism from their client and to have someone else share in the award to the plaintiff. Thus, the admitting physician can aver that he or she was not aware of a certain critical aspect of the patient's condition because the EP failed to mention it. The attending's reliance on the communication with the EP thus would keep the EP "on the hook."
3. The defendant EP's position can be defended as being in the best interests of the patient. Since the EP was the last physician to evaluate the patient, he or she is in the best position to know the patient's current condition and what is necessary in the immediate short term. Provided, again, that the ED evaluation met the standard of care, short-term holding orders provide care for the acute problem for which the patient came to the ED. Holdings orders based on a below-standard evaluation in the ED obviously cannot be defended, but in that case the EP has far more problems than the holding orders.

How to Minimize Liability for Admitted Patients, Whether Or Not Holding Orders Are Written.

1. Understand whether holding orders are written by the ED group you're about to join. If an EP is strongly opposed to the practice, and the group writes holding orders, look for employment elsewhere if you can't live with it.
2. Work with the medical staff to try to make the line as bright as possible between EP and attending responsibility for admitted patients. As part of these discussions, establish responsibility for boarded patients. A written or dictated line in the chart should try to mark the moment the "torch was passed" to the admitting physician.
3. Document, in detail, discussions with admitting physicians, consultants, and others who may influence what is ordered for the patient once he or she is admitted. Document agreement or disagreement on orders and treatments. A dictated chart is useful and much more complete than a "check-off chart" to document these discussions.
4. Do not write orders with which you disagree.
5. Look up unfamiliar drugs before agreeing to write orders for them.
6. Write orders only for the time period between admission and the required appearance of the attending physician. (Thus the name "bridging orders.") This means not ordering tests or treatments beyond the bridging period.
7. Do not obtain informed consent for surgical procedures. This is the responsibility of the surgeon performing the surgery.
8. Do not abandon the boarded patient. Insist that the boarded patients be seen by the admitting physician in the same time frame required as though the patient left the ED. Since emergency charts are generally crowded, it's a good idea to write orders for boarded patients on a separate order sheet, thus minimizing the chance that important orders could be missed.

9. Make sure the patient and the patient's family, guardian, or significant others understand your role versus that of the admitting physician.
10. Make sure any holding orders include a caveat to the ward nurse to call the admitting physician for any clarification of orders or change in the patient's condition.
11. When in doubt, proceed in the patient's best interest.

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ED boarding adds to risk

When intensive care unit (ICU) patients are held in ED hallways, this poses a serious liability risk to ED physicians. "You, as the ED physician, have some liability to care for these tremendously ill patients," says Shesser. "And you are doing so in a unit that is not really designed for ICU patients. But when an adverse outcome occurs, the ED physician is going to get roped into the case."

Even though the ED physician has admitted the patient to another physician, that physician isn't physically present to see the patient. Because the patient doesn't leave the ED, the ED physician has some legal responsibility to keep monitoring the patient and to intervene as appropriate.

"To my mind, that is really the hospital's liability. The hospital should be indemnifying the ED physician group when they can't get patients to the ICU within a certain period of time," says Shesser. "But that is not happening, and it's a hidden cost to the ED physician — not just a monetary cost, but an emotional cost if you are roped into a lawsuit."

More importantly, patients are put at risk because less than appropriate care is given in an ED hallway. "Even if the ICU physician comes down and rounds on the patient, the ED is not a substitute for an ICU," says Shesser. "And the ED nursing staff is having to worry about these critically ill patients, while still receiving patients by ambulance and so forth. I think it's a major problem and ED physicians should be very worried about it."

However, if ED physicians take an aggressive stance on this issue, they'd be at risk for losing their contact, since in most cases the hospital has the ability to fire its emergency group.

"I can see a situation where the insurance carrier for the emergency group would want to take a very aggressive stance toward the hospital. But the ED physician would be caught in the middle of not being able to go after the hospital legally, for fear of losing their contract," Shesser says. "I think it's a nightmare scenario for the emergency physician."

In addition, there are two immediate consequences of overcrowding related to the Emergency Medical Treatment and Labor Act (EMTALA), says Freeman. If a patient is triaged, but suffers delays in care due to overcrowding, then it is possible that the delays could constitute an EMTALA violation for not providing care sufficient to stabilize the patient.

In addition, EMTALA states the hospital must provide care "within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition."

"I don't believe that being overcrowded would fall under not having the staff and facilities available," says Freeman. "But there is increasing likelihood that the threat of EMTALA investigations will coerce hospitals into settling malpractice claims." ■

Could electronic medical records get your ED sued?

Risk of recently added tools may not yet be known

Increasing numbers of EDs are implementing electronic medical records (EMRs), including computerized physician order entry (CPOE), with the goal of improving patient safety. However, not much is known about the liability risks of these new tools.

"We are still on the steep portion of the learning curve with regard to the medical-legal risks of CPOE," says **Tom Scaletta,** MD, FAAEM, chair of the ED at Edward Hospital in Naperville, IL. "It is a relatively new technology, and suits take years to come to fruition."

While electronic systems can potentially prevent errors, automation also can create a false sense of security. "There are no perfect CPOE or electronic charting systems," warns Scaletta.

Key Points

Liability risks of electronic medical records, including computerized physician order entry, include inconsistent use, inadvertent selection error, a high rate of false-positive alerts, and poor physician-nurse communication. To reduce risks:

- Do internal coding audits to prevent embellishing of charts;
- Avoid habitual overriding of alerts caused by high numbers of false positives;
- Carefully design procedures to follow when the system is down; and
- Correct misleading time entries that don't record the actual time of service.

The ideal documentation system is one that adapts to the user, says Scaletta. Your ED's system should offer both a template style for past medical history, review of systems, normal exam findings, and diagnoses; and a free form style for a description of the present problem, abnormal exam findings, medical decision making, and the treatment plan.

Whether electronic or paper template charting is employed, users should not be pressured to check every box just so the charges can be enhanced. To put a stop to this practice, Scaletta suggests doing an internal coding audit to identify and counsel outliers that might be embellishing charts.

"The end result should pass the 'sniff' test," says Scaletta. "It is not realistic that a detailed family history has been obtained in every ankle sprain case."

Transition time is high-risk

The benefits of CPOE are readily apparent: Handwritten and verbal patient care orders are no longer transcribed, so errors due to illegibility or nonstandard abbreviations are prevented. Additionally, alerts flagging medication interactions, allergy warnings, dosing limits, and order duplication can prevent other common errors.

However, during the initial phases of implementation, systems may not be fully functional, and safety mechanisms may not be put into place until later in the process.

For this reason, transition to an electronic system is a high-risk period for your ED. "While robust systems decrease errors on the whole, it can take months or years for systems to be adapted to meet the unique needs of the healthcare environment," says Scaletta.

In addition, until the system is fine-tuned, there may be a high rate of false-positive alerts. "Ignoring or overriding such alerts where a poor outcome results could be viewed as a more serious error by a jury," warns Scaletta. "If drug sensitivities are coded the same as life-threatening allergies, those false alerts get doctors accustomed to dismissing alerts."

Using a point-and-click method to rapidly choose an order can be fraught with inadvertent selection errors that may go undetected by the person carrying out the order. "Ideally, you should have a smart system that pairs the order with a complaint or finding," says Scaletta. "A low-tech solution is to alternate color coding of lines, like some spreadsheets do."

Initially, all systems will severely slow an ED's operations. To offset this, users should be well trained and EDs overstaffed until the system becomes familiar, Scaletta recommends.

Another risk with computerized systems is that physician-nurse communication becomes less active and more passive. "With CPOE, we can get out of the habit of a quick powwow," says Scaletta. "CPOE should not replace person-to-person communication in truly emergent situations. Time-sensitive or unusual treatments ought to invoke a direct physician-nurse conversation."

Easy access to voluminous records can improve care, giving the ability to quickly check results of prior tests. "However, this may create unrealistic expectations," says Scaletta. "This wealth of information can suddenly cease during downtime periods."

Downtime procedures must be carefully designed and well-rehearsed, so that quality patient care can occur during such events. "The process of downtime procedures for accomplishing lab and radiology testing and printing discharge packets is very idiosyncratic, and needs to be carefully developed and tested at each institution," says Scaletta. "Many EDs revert back to a paper chart, with lists of the most common tests that can be check marked."

Scaletta recommends setting up electronic systems to create individualized care plans for some patients. Then, when the patient reenters the system, the case can be flagged so the clinician is directed immediately to review the care plan.

"We do this for any case that the care would be better should the team have a "heads up,'" says Scaletta. This includes patients who failed to obtain follow-up care and reappear in the ED, patients with narcotic dependency, and patients with a history of unpredictable violence.

Processes for late charting and signing should be designed such that there can be no inappropriate alteration of medical records. "There should be the ability to record time-stamped addenda when information comes in later, such as a culture result, and requires modification of the patient treatment plan," says Scaletta.

Inconsistent use is a problem

The EMR may be used inconsistently by various providers in your ED, which can increase liability risks. "All attempts to automate the ED have encountered this issue, including use of template forms and dictation," says **Stephen A. Frew,** JD, vice president and risk consultant with Johnson Insurance Services, a Madison, WI-based company specializing in risk management for health care professionals. "With each physician or nurse having their own style and a general resistance to standardization as 'cookbook medicine,' systems have great difficulty in achieving a common documentation structure."

With a lack of consistency, records become unreliable, sometimes unintelligible, and often legally inadequate. "We frequently see records where individuals mark templates and boxes using inconsistent marks that mean one thing for one provider and something else for another," says Frew. "It is similar to making up one's own abbreviation."

To ensure consistent use of the EMR, extensive training, constant monitoring, and administrative enforcement is needed. Quality monitoring should be focused on chart completion techniques, recommends Frew.

"Extra attention should be planned during the start-up phase of any EMR system to assure that all providers are invested in the new system," says Frew. "Retraining, incentives, and ultimately disciplinary consequences are likely to be needed to get full participation in the new system."

Another problem is that EMR printouts do not look anything like the screen versions, and are difficult for physicians and nurses to read and testify from in court.

"Lawyers are having to spend a great deal of time preparing witnesses for testimony in order to avoid issues in identifying the medical record and testifying from it," reports Frew.

While it is possible to get different format capabilities with various systems, the standard format is usually not user or court-friendly, says Frew. Where possible, printouts should be designed to give an appearance similar to paper records.

Setting defaults for when no entry is made can result in inaccurate information being documented, warns Frew.

In one example, a patient came into an ED with respiratory distress and was being managed with intubation. The final disposition was admission for ventilator management. The ED record in between those events, however, showed that the patient was alert and responsive, the throat was normal with no redness, there was no respiratory difficulty, and the patient was talking and relating history.

"How could this occur? Defaults," says Frew. "In this particular system, anything that the physician failed to change was entered as normal, with standard entries automatically generated."

The system did not force each box to be checked. The result was an ED record that would have been indefensible in court and would probably have been cited as an inadequate documentation of a medical screening examination by the Centers for Medicare and Medicaid Services (CMS) during an investigation of the Emergency Medical Treatment and Labor Act (EMTALA).

Another critical default concern is the time logging of entries. System approaches vary, but some systems time the entry when it is validated and not when the service was performed.

Extra effort is required to enter the actual time of service, but even then, the logged time will appear on the index as the time the entry was electronically signed. "This default can cause seriously misleading time entries that can compromise legal defense, quality monitoring, and root cause analysis," says Frew.

Frew suggests using a "Time Line Report" that orders the printout in time sequence. "This is a very important risk management option, as the first thing that is typically done with a file is to spend endless hours creating a time line of what actually happened," he says. "A quick report of the time line will help in quality, risk, root cause analysis, and court defense."

Sources

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Time line reports list each event in the time sequence in which it occurred, combining information from various parts of the record into a sequence that can be readily understood to form an overview of the details.

"The time line often reveals whether care was rendered in the proper sequence and in timely fashion, or conversely, highlights sequence errors, timing issues, or inconsistent entries," says Frew. "It is a valuable tool in analyzing cases quickly and accurately." ■

CNE/CME *Questions*

29. Hospitals involved in a community on-call system would need to establish/provide which of the following?
    A. A formal written plan
    B. Compliance with set minimum criteria determined by CMS
    C. Medical screening, stabilization, and arrangement of appropriate transfer when necessary.
    D. Advanced, prior written approval from CMS
    E. A, B, and C are correct
30. Each hospital participating in the community call plan must have written policies and procedures in place to respond to situations in which the on-call physician is unable to respond due to situations beyond his or her control.
    A. True
    B. False
31. Each hospital participating in the community call plan must have at least an annual reassessment of the plan by the participating hospitals.
    A. True
    B. False
32. Which is true regarding liability risks and ED crowding?
    A. ED physicians are not liable for the care of an inpatient being held in the ED if that patient has been admitted to another physician.
    B. ED physicians can still be held liable for the care of an inpatient being held in the ED, even if that patient has been admitted to another physician.
    C. Juries are typically more sympathetic to the ED if they learn a patient's adverse outcome was due to overcrowding.
    D. There is no link between overcrowded EDs and liability risks.

33. Which is recommended to reduce liability risks of electronic medical records?
    A. Set defaults to automatically enter as "normal" anything that the ED physician fails to change.
    B. Set up systems to create individualized care plans for some patients.
    C. If there are a high rate of false positive alerts, instruct staff to override these.
    D. Offer users either a template or freeform style, but not both.

34. Which is recommended to ensure that electronic medical records record the timing of events accurately?
    A. Time entries when they are validated and not when the service is performed.
    B. Avoid using a time line report because this won't reflect the actual time of service.
    C. The logged time should appear on the index as the time the entry was electronically signed.
    D. Use a time line report that lists each event in the sequence in which it occurred.

Answers: 29. E; 30. A; 31. A; 32. B; 33. B; 34. D

CNE/CME Objectives

After completing this activity, participants will be able to:

1. Identify legal issues relating to emergency medicine practice;
2. Explain how these issues affect nurses, physicians, legal counsel, management, and patients.
3. Integrate practical solutions to reduce risk into the ED practitioner's daily practices. ■

CNE/CME instructions

Physicians and nurses participate in this CE/CME program by reading the issue, using the references for research, and studying the questions. Participants should select what they believe to be the correct answers, then refer to the answer key to test their knowledge. To clarify confusion on any questions answered incorrectly, consult the source material. After completing the semester's activity, you must complete the evaluation form provided and return it in the reply envelope to receive a letter of credit. When your evaluation is received, a letter of credit will be mailed to you. ■