More Errors with EHR over Paper Records

A Journal of the American Medical Informatics Association (JAMIA) study has found that doctors make more errors in Electronic Health Record (EHR) note-taking than in paper records. The study, which focused on medical reporting at a Michigan hospital, showed progress notes in the first-stage implementation of EHRs contained more mistakes to paper charts. In fact, JAMIA found that the rate of inaccurate documentation in EHRs was 24.4 percent versus 4.4 percent.

For two years, from August 2011 to July 2013, researchers studied initial progress notes of patients at Beaumont Hospital in Royal Oak. They examined a mix of 500 pre and post-EHR implementation notes and studied five diagnoses with invariable physical findings. They were:

- Permanent atrial fibrillation;
- Aortic stenosis;
- Intubation;
- Lower limb amputation;
- Cerebrovascular accident with hemiparesis.

“Further research is needed to identify training methods and incentives that can reduce inaccuracies in EHRs during initial implementation,” the study concluded.

See Also: EHR Leading to Burnout

The JAMIA research also showed that the new generation of doctors entering healthcare were less likely to make EHR note-taking errors. Additionally, compared to attending doctors, residents had a much lower rate of inaccuracies. The study also indicated that residents made fewer mistakes (5.3 percent v. 17.3 percent) and omissions (16.8 percent v. 33.9 percent) than attending medics.

Meanwhile, the Healthcare Financial Management Association released a study last month indicating that EHR adoption had reached 84 percent of hospitals in the U.S., and nearly as many were able to exchange key information with outside providers, new federal data has shown, according to the Healthcare Financial Management Association.

However the adoption of advanced EHRs—defined as those with comprehensive levels of functionality above basic electronic records with clinician notes—reached only 40 percent of hospitals in 2015. Additionally, 96 percent of acute care hospitals “possessed” a certified EHR in 2015. However, “possessed” means only that the hospital has a legal agreement with an EHR vendor and is not equivalent to adoption.