

What's New in the Patient Safety World

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Patient Requests for EHR Corrections

Your own electronic health record (EHR) says you are allergic to penicillin. You are not, in fact, allergic to penicillin. Yet, you might at some time in the future be denied appropriate use of penicillins or other antibiotics cross-reacting with penicillin.

You once received a trial of amitriptyline for a neuropathic condition. An intern, after review of your medication list, assumed you received it for depression and added depression to the problem list in your EHR. Physicians might avoid prescribing medications to you in the future that are contraindicated in patients with a history of depression.

A pharmacy error incorrectly listed digoxin in your medication list. As a result, a health care provider added congestive heart failure to your problem list. A whole host of medications may be contraindicated in patients with heart failure and physicians might avoid prescribing some of those that might be of benefit to you.

Inclusion of erroneous information in the EHR can have important patient safety implications. The presence of erroneous information in the EHR may be more prevalent than you think. In a 2017 study of the OpenNotes movement ([Bell 2017](#)), patients and care partners reported potential safety concerns in about one-quarter of reports, often resulting in a change to the record or care. Patients and care partners documented potential safety concerns in 23% of reports. 2% of patients did not understand the care plan and 21% reported possible mistakes, including medications, existing health problems, something important missing from the note or current symptoms. Among these, 64% were definite or possible safety concerns on clinician review, and 57% of cases confirmed with patients resulted in a change to the record or care.

In a more recent survey of almost 30,000 respondents ([Bell 2020](#)), 21.1% of patients who read a note reported finding a mistake in their EHR and 42.3% perceived the mistake as serious. The most common mistakes were perceived in current or past diagnoses (27.5%), medical history (23.9%), medications or allergies (14.0%), physical examination, and tests, procedures, or results (8.4%). Notably, 6.5% reflected notes reportedly written on the wrong patient. Of very serious errors, 58.9% included at least 1 perceived error

potentially associated with the diagnostic process (eg, history, physical examination, tests, referrals, and communication).

Older and sicker patients were twice as likely to report a serious error compared with younger and healthier patients, indicating important safety and quality implications. The authors conclude that sharing notes with patients may help engage them to improve record accuracy and health care safety together with practitioners.

So, it's pretty clear that mistakes in the EHR are both alarmingly frequent and potentially dangerous. Encouraging patients to access their medical records could go a long way toward avoiding potentially serious consequences.

HIPAA, of course, mandates that patients have access to their medical records. It also has a provision that patients may request a change, or amendment, to their record. The health care provider or health plan must respond to such requests ([Heath 2019](#)). The health care provider or health plan may, in some cases, deny changes to the medical record but the patient has the right to submit a statement of disagreement with such decisions into the medical record. The Heath article, though, notes that we should address such disagreements as possible communication gaps or signals that patient education may have fallen short. These should be considered as opportunities to improve the physician-patient relationship.

In a 2016 article ([Klein 2016](#)), Klein and colleagues pointed out that having patients read their patient encounters in their medical records provides many opportunities to improve care. Not only might that uncover errors in the medical record, it may also identify gaps in patient understanding of their diagnoses and/or treatment plan. So, in addition to improving patient safety, it may improve doctor-patient rapport. Klein et al. also note the importance of making notes clear and succinct, addressing concerns directly and respectfully, and using supportive language.

And encouraging patients to access their EHR's can have a positive impact on health outcomes. Neves et al. ([Neves 2020](#)) recently performed a systematic review and meta-analysis on this issue. They found a beneficial effect in effectiveness by reducing absolute values of HbA1c. A significant reduction of absolute values of systolic blood pressure was also found but lost in sensitivity analysis for studies with low risk of bias. Regarding efficiency of care, 80% of studies found either a reduction of healthcare usage or no change. A beneficial effect was observed in a range of safety outcomes (ie, general adherence, medication safety), but not in medication adherence.

While 90% of healthcare providers offer patient portals, only about a third of patients actually access the portals ([GAO 2017](#)). While, on average, hospitals gave 95 percent of discharged patients access to view, download, and transmit their information, only about 10% of patients access their medical records ([Lin 2019](#)). A recent Health Affairs Blog ([Bechtel 2020](#)) posits that patient demand is not the reason for low rates of accessing EHR's and describes barriers to access and potential ways to increase such access.

So, we are probably missing good opportunities to make our EHR's more accurate and to improve on communication and our relationships with our patients.

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