Helpful Tips on Choosing a Perinatal EMR System

BY DOUG BRUNK
San Diego Bureau

LAS VEGAS — Electronic perinatal medical record keeping "has great potential for reducing errors and making our lives easier, whether you're a physician, midwife, or nurse," Lisa A. Miller said at a conference on fetal monitoring sponsored by Symposia Medicus.

In obstetrics, "we're about 10 years behind in the health care field in our use of information technology," added Ms. Miller, a Chicago-based certified nurse-midwife and lawyer who is a perinatal risk management educator and consultant.

Choosing a perinatal computer system can be a daunting task, because you have to assess the various systems, Ms. Miller said.

She listed the following features to look for when selecting a system:

▶ Secure sign-on and access.

▶ Complete record keeping from the prenatal period through hospital course of mother and baby.

▶ Integration of prenatal data into the hospital record without reentry by a clinician. "How much time do you spend reentering data from a paper prenatal record into your system? There's no reason to," she said.

▶ Checklists as forced functions to avoid reliance on memory.

▶ Detailed and complete assessment data tailored to standardized definitions. "If you are going to use the National Institute of Child Health and Human Development [guidelines for fetal heart rate monitoring], you need to make sure that your system can adapt and be edited so that the terminology can be used," she said.

▶ Display big enough for on-screen reading of fetal heart rate data. "You have to be able to see 10 minutes of data at real [paper strip] size or larger," Ms. Miller said. "The small screens are fine for keeping an eye on things, but if you're reading [strips] and you've gone paperless, you need to make sure your display screen size is adequate."

▶ Simple drop-down menus with point-and-click capability that force inclusive charting.

▶ Ability to view data in multiple formats, such as timeline vs. graphic.

▶ Accurate and contemporaneous charting, with safeguards against falsification of records and accurate reflection of entry times. The record should be easy to read both on screen and when the records are printed out, Ms. Miller said.

▶ Automatic calculations to cut the risk of error and save clinician time. "I shouldn't have to do math when I've been up for 24 hours or when I'm working a double" shift, she said.

▶ Visual cues to complete summaries with all pertinent information in the least amount of time and effort.

▶ Accurate and detailed listing of complications for labor and delivery and placenta and cord.

▶ Automatic record of newborn resuscitation for every delivery.

▶ Detailed and complete record of birth attendants and room for narrative comments. "You should always be able to pull up a box and type in a narrative," she said.

▶ Safeguard features against incomplete records. These provide you with a warning sign or error message that informs you what fields you need to fill out before you can complete the record.

▶ Ability to produce statistics on any outcome, such as a report that shows how you've handled patients in the past 6 months who are positive for group B strep.

For additional information, Ms. Miller recommended contacting the Perinatal Information Systems User Group (www. pisug.org). This not-for-profit group provides forums and support for those buying perinatal computer systems. ∎

Common Errors In Documentation

The following common documentation errors can be avoided if you choose the right electronic medical records system for your practice:

▶ Failure to document.
▶ Incomplete charting.
▶ Late entries.
▶ Poor grammar and/or spelling.
▶ Improper error correction.
▶ Lack of standardized abbreviations.
▶ Illegibility.

Source: Lisa A. Miller