Documentation: Essentials and Electronic Medical Records

“The Process and Legal and Administrative Considerations”
Terminology

**Case management documentation:** a documentation method that uses standards of care or clinical pathways to track patient outcomes. Entries in the medical record are written on a flow sheet designed for the particular diagnosis.

**Charting by exception:** a documentation process in which a healthcare provider makes chart entries only when a specific standard of practice is not met.

**EMR:** the acronym for electronic medical record; any electronic, computer-based record keeping system that can create, store, and maintain patient medical records.

**Focus charting:** a systematic form of documentation that is organized in columns.

**Handoff:** a situation in which one professional turns the care of a patient over to another staff member, whether during a change of shift or transfer of a patient to another part of the facility.

**HIPAA:** the acronym for the Health Insurance Portability and Accountability Act, a federal mandate designed to protect the privacy rights of individuals.

**HITECH:** the acronym for Health Information Technology for Economic and Clinical Health, a federal mandate designed to expand health information technology.

**Informatics:** academic field of study encompassing computer science, human-computer interaction, information science, information technology, and algorithms.

**Medication administration record (MAR):** the part of a patient medical record in which all patient medications and administration history are listed.

**PHI:** the acronym for private health information.

**Problem oriented documentation:** an approach to documentation in which healthcare professionals create a list of patient problems and develop a plan for each one.

**Scribes:** unlicensed individuals who can enter information into the electronic medical record.

**Source oriented documentation:** a narrative type of documentation in which healthcare professionals write on a separate form.
Learning Objectives

• Explain the purpose and importance of maintaining accurate and objective documentation.
• Describe how to perform documentation in order to maintain objectivity, accuracy and comprehensiveness.
• List the various types of documentation that are contained within a patient's healthcare record.
• Explain why accurate documentation is so important from a legal standpoint.
• List the most common types of documenting mistakes and sources of inaccuracy.
• Explain the importance of maintaining patient confidentiality.
• Describe strategies to preserve patient confidentiality at all times.
• Explain how new record keeping technologies affect patient confidentiality.
• Explain how to address issues related to noncompliance, unusual occurrence reports and administrative considerations.
Introduction

One of the nurse's biggest responsibilities is documentation in the patient's medical record. Healthcare providers are charged with documenting in the record all encounters they have with a patient, entering subjective and objective data about the patient's baseline health status, problems, interventions, and responses to those treatments.

The patient's medical record also serves as record of a patient's complete medical history in case any legal action is filed against a facility or specific healthcare provider. Therefore, it is vital to understand the documentation process and your role in it.
Functions of a Patient Medical Record

The medical record has several functions. First and foremost, it provides a comprehensive, complete, and accurate account of the health status of the patient as well as the care the patient has received and the response to it.

Through written communication, the entire team caring for the patient can evaluate the patient's condition and determine if changes need to be made to help ensure a better outcome.

In addition, chart review by different disciplines will allow staff to coordinate patient care and schedule therapies, diagnostic procedures, meal times, and rest periods.

The record is also used during "handoffs"—when one professional turns care of the patient over to another staff member. This occurs during change of shift or when the patient is taken to another area of the hospital for care, for example, when the patient is moved from the emergency department to the Intensive Care Unit or from the post anesthesia care unit to an inpatient bed.

Handoffs also take place when an inpatient is transferred from the unit for procedures, such as to radiology, the GI lab, or the pre-operative waiting area.

A third type of handoff occurs when the patient enters a procedure or operating room. Just before the intervention is started, the team must perform a "time out" and ensure it is the correct patient, the correct procedure, the correct body part, and that all pre-procedure actions—such as giving an antibiotic—have taken place.

During handoffs, the receiving staff should ask any questions they might have or request further clarification.
Functions of a Patient Medical Record

A medical record is an important part of the legal documentation of care provided in the facility and can be subpoenaed during a malpractice suit to determine what care was provided and what the patient's response was. If that information is not included, it can be claimed that it was never done, regardless of what witnesses say.

The record also contains data used by insurance companies, as the information is utilized to code specific reimbursements for treatments and procedures. Insurers will also look at the timeliness of those interventions. Finally, healthcare administrators will look at the entire medical record to determine the quality of care in the facility as well as for research studies.

The data can be analyzed for quality improvement initiatives such as reducing urinary catheter-associated infections and surgical site infections.

Records are reviewed at morbidity and mortality meetings to discuss the care received by specific patients and determine if any changes in that care could have altered their outcome.

Nursing managers can also do a chart review to assist them in evaluating staff performance. The records not only indicate the level of care the patient received, but also the documentation and critical thinking skills of the nurse.
Types of Documentation

• There are several different methods used for documentation. Each facility determines which form will best meet the needs of its staff as well as regulatory and forensic requirements. These methods may be in a handwritten or, more often, an electronic medical record.

• **Source oriented documentation** is a narrative type of record in which physicians, nurses, speech, physical, and occupational therapists, nutritionists, social workers, and other healthcare professionals write about patient encounters and responses on a separate form.

• Entries are made in chronological order. Each should begin with a description of the patient's baseline as well as changes that may have occurred during the course of the shift, therapy session, or meeting. The biggest disadvantages of this form are that it is very time consuming to both write and read, and that the documentation is fragmented as each discipline's entry is on a separate page.
Types of Documentation

**Problem oriented documentation** promotes a problem solving approach to care. Based on the patient's baseline information, a list of problems is created and then a plan is developed for the management of each. Updates are then documented in both the progress notes and care plan as well as discharge summary.

One way to record the changes in patient status is using "**SOAP**" notes, which have the following components:

- **Subjective information**, which is what the patient tells the professional
- **Objective data** that includes what staff can see, touch, feel, or smell as well as measure
- **Assessments** or conclusions made by the providers based on the subjective and objective findings
- **Plan of action** or interventions to solve the problem

A mnemonic you can also use for this type of documentation is "**APIE**":

- **Assessment**
- **Plan of action**
- **Implementation**
- **Evaluation of the interventions**

A third type of mnemonic, "**SOAPIE,**" is a combination of the previous two:

- **Subjective data**
- **Objective data**
- **Assessments**
- **Plans of action**
- **Interventions**
- **Evaluation**
Types of Documentation

Charting

**Focus charting** is a systematic form of documentation that is organized in columns. The first contains the date and time. The second is for the list of problems that may include a symptom such as pain, a specific behavior, or a nursing diagnosis. The third column is where the notes are written. The components are labeled as "DAR", "DAE", or "DARE".

- Data collected
- Action taken
- Response by the patient
- Evaluation of the intervention

**Charting by exception** is a method of documentation in which it is assumed that all standards of practice are carried out and met with expected results. Entries are only put into the medical record when a specific standard is not met. They are usually written in narrative form and describe how the patient's status deviates from the norm.

Facilities using this type of medical record documentation must have detailed protocols and standards in place, following guidelines for practice that have been developed by the healthcare team. Charting by exception will reduce the amount of time you spend in the charting process.

**Case management documentation** is an approach that focuses on providing quality patient care in a cost effective manner. It uses standards of care or clinical pathways to track patient outcomes. Entries in the medical record are written on a flow sheet designed for the particular diagnosis.

The goal of this system of documentation is to achieve positive patient results within an appropriate length of stay and utilization of multidisciplinary resources.
Documentation Process

• Nursing documentation begins upon admission to the healthcare facility. The nurse interviews the patient and collects information about his past medical history, allergies, coping mechanisms, ability to communicate and function, orientation, mental status, and current health problems.

• After a physical assessment of the patient, enter all of this data into the medical record. The process of evaluation and documentation will continue throughout the patient's stay, and any changes in the patient's health status must be noted.

• Nurses should, in chronological order, make entries into the patient's chart at the start of every shift or when care is transferred to them from another department, and at the end of the tour of duty, or when care is transferred to another professional in a different area of the hospital.
Documentation Process

• Document any treatment, such as administration of pain or anti-nausea medications, and document the treatment's effectiveness. All medications given must be recorded on a medication administration record (MAR) or other appropriate systems used in a facility.

• If an invasive procedure is to be done, findings from both a baseline evaluation done before the intervention and a post-procedure assessment should be entered as well. Documentation of these findings must be accurate and complete, and entered into the nursing care record in a clear, concise manner.

Objective and Subjective Data

Objective documentation information includes what you see (skin color, rashes, swollen areas or bruising); what you hear (breath or heart sounds for example); what you observe (like skin that is cold, clammy, or diaphoretic); and what you smell (urine, feces, or foul odor from a wound).
Documentation Process

Record vital signs and other measured parameters such as pulse oximetry in the objective section of the notes. You may also enter a quantified pain score here, and measurements for height, weight, and intake and output.

Other objective data include any equipment used, such as a cardio-respiratory monitor, pulse oximeter, I.V. pump, patient controlled analgesia equipment, or oxygen delivery system. Document that the equipment is correctly attached to the patient and working properly.

How the patient feels—reflected in statements such as "I have a headache" or "I am nauseous"—can be recorded as subjective data. You can then supplement this with objective comments by describing, but not interpreting, the patient's facial expression, posture, guarding of a body part, or lack of movement.

Non-routine occurrences must also be documented. These can include:

- Signs of abrasions, cuts, or pressure marks
- Infiltration or extravasation from an I.V. line
- Falls
- Elevated temperature
- Adverse or unusual reaction to medications or foods
- Unexpected episodes of vomiting or diarrhea
- Seizure activity
- Significant weight loss or gain
- The patient's refusal of food, medication, or ordered treatments or interventions
Documentation Process

- It is important for the nurse to document only objective data, not interpretations of what is observed and assessed.

- For example, if a patient is observed on the floor by the bed, do not immediately record that the patient fell. First you need to corroborate what happened by any witnesses or by the patient. The patient may have fallen out of bed, or he may have gotten out of bed and then fallen, or he may have slipped while standing or he may have fainted when he stood up.

- Proper documentation of this event should state exactly what happened. For example, you might write "Found patient on the floor, states he was trying to get out of bed and got caught up in the linens and fell to the floor."

Discharge

When the patient is ready for discharge, you should record:
- Status
- Significant events that took place during his time in the facility
- The outcomes of any procedures, treatments, and interventions
- Any unresolved health problems
- Any patient or family teaching that occurred
- Instructions for continued care such as follow-up appointments, referrals, or medications to be taken at home.
Caveats

To ensure proper documentation, there are some safeguards that should be followed and some pitfalls that must be avoided.

Before putting pen to paper or striking a letter on a keyboard, make sure that the patient's name and identifying information are indeed correct, and that you are documenting the correct patient medical record.

Correct spelling and grammar are essential, although articles such as "a," "an," and "the" may be eliminated. Slang and clichés—like "no apparent distress"—are to be avoided as they do not accurately or objectively describe observations.

Abbreviations and dosage designations should be used judiciously. For example, "units" should be written out rather than using the letter "u." Be sure to use only those abbreviations that are approved by your organization.

"Micrograms" should be abbreviated as "mcg." "IU" should not be abbreviated for "international units" because it may be erroneously interpreted "I.V." or "10." Writing "MS" may cause morphine to be administered instead of magnesium sulfate. Also, never place a trailing zero after a decimal point, and always put a zero in front of a decimal point.

Another caveat to keep in mind is to always protect a patient's HIPAA right to privacy. For example, if a patient witnesses something such as a roommate falling out of bed, you should record the patient's description of the event while being careful not to include any information that can lead to the identification of the witness.
At times you may make a mistake when documenting. Follow your facility's policies and procedures for making corrections. For example, if you are writing on paper, do not erase or use correction fluids. Instead, draw a single line through the incorrect entry. Mark it with the time and date, and then initial the correction. If your institution requires it, state the reason for the change in the documentation. If you make an error in an electronic record, the system's software will determine how to amend it.

All documentation on paper should be done in black, non-erasable ink. Do not skip any lines. Military time should be used so that 2:45 pm is written as 1445, or 8:30 pm as 2030, and so on.

Finally, after each recording, sign the notation with your first initial and complete last name, including credentials such an RN, LVN, etc.
Pitfalls

To ensure accurate documentation, there are a number of activities and situations to avoid.

Never document on behalf of another staff member. Documenting for someone else violates the standards of nursing practice and places the institution and both staff members at risk for legal action.

You should not write in a medical record in advance of any procedure. For example, if you have a medication in hand and are preparing to give it to a patient and sign the MAR before you give it, you may be distracted by an emergency in the unit and not actually administer the medication. While the patient will have missed the dose, the medical record will reflect that it was given, thereby compromising the patient's care.
Special Circumstances: Verbal Orders

Often, physicians give verbal orders over the phone or in person because they do not have the time to write or enter the order in the medical record personally. While this is a common practice, it can lead to disastrous results. In fact, the Joint Commission has stated that, "Medication errors may occur when staff are communicating or transcribing medication orders. Verbal and telephone orders are particularly susceptible to error."

Contributing factors to errors in verbal orders include background noise that affects what is said or heard, distraction from nearby activity, or the prescribed medication may be misunderstood because it has a sound-alike name such as Zantac being mistaken for Xanax. This can be compounded if the nurse or physician has an accent or pronounces the drug name differently than the person taking the order.
To alleviate problems associated with verbal orders, the Joint Commission developed the Medication Management Standard. It states that:

- Hospitals should determine who is authorized to take verbal orders based on state laws and regulations.

- Only authorized individuals take those orders.

- The documentation contain the date and names of the individuals who gave, recorded, and implemented the order.

- The order be authenticated within the timeframe required by state law.

The Commission also recommends that you should write down the order and then read it back to the ordering physician for confirmation.
A medical record is a legal record of patient care. It is the primary method of defense in malpractice cases, and for that reason it must be a complete, accurate, and objective chronological representation of what transpired during the patient's hospitalization. If there are errors or omissions, problems may arise during litigation.

Medical record entries must "stand the test of time" and be adequate to reconstruct the care that was provided. All data should be entered as soon as possible after the care was given, and be written so that it is easy to read and understand. Accounts of patient behaviors and reactions to treatment or interventions must be factual rather than interpretative or based on assumption.

Follow Joint Commission guidelines concerning the use of abbreviations and dosage designations. Avoid omissions, because as the old adage goes, "if it was not recorded then it didn't happen either when it was supposed to, or not at all." This can be apparent when an abnormality is noted during assessment and there is no record of intervention or patient response to treatment or medications.

If a patient refuses a medication or procedure, document the action taken regarding the need for the intervention, as well as the patient's response, positive or negative.
Legal Aspects of Documentation

For example, a patient might say, "I don't want you to start another I.V. I feel like a pincushion. Tell the doctor I want to take the medicine by mouth." You should then contact the physician and document when the physician was called, the time the conversation actually took place, and any recommendations the physician makes.

Because this is considered an unusual occurrence, you should complete a variance report. This form, also called an incident or safety report, is not part of the medical record and is a confidential document between the caregiver and management, hospital counsel, safety officer, and continuous quality improvement team. These individuals review what happened with the goal of preventing it from occurring again.
Legal Aspects of Documentation

• The elements of a variance report include the date and time of the incident as well as objective data, including quotes from the patient, if applicable. In addition, a description of the patient's physical and emotional state should be provided. Include any witness statements that may exist. You should also state who was notified about the event, the nurse manager, the physician, or other staff member, what information was given to them, what instructions were received, and what actions were taken. Also include the patient's response to those actions. Note the time and date, and sign the report with your name and title.

• You can do other simple, common sense things to ensure the medical record is litigation friendly. Avoid spelling errors or typos that can reduce your credibility. Do not use personal descriptions of the patient such as "rude" or "obnoxious" because a patient's attorney can allege improper care because you did not like the patient.

• Finally, it is critical to never write in the record that an error or mistake was made. Avoid using words like "accident," "miscalculation," or "unintentional."

Instead, write an objective account of any incident. For example, you may write:

• "Found patient sitting on floor near bed. Awake and oriented times three. Patient says he fell out of bed on way to bathroom. No complaints of pain or discomfort. No bruises, abrasions, or swelling noted. Full range of motion without discomfort. Dr. Marvin Jones contacted at 1530. No interventions or treatments were ordered. Family notified at 1600."

• During a malpractice trial, the jury only knows what is in the record. If information is not recorded or inaccurate, the result may be a finding of negligence or malpractice against not only the healthcare facility but also the nurse who provided the care.
Electronic Medical Records Overview

"Pen and paper" (print) documentation of patient status is slowly fading away and will soon be as extinct as rotary phones and VCRs. Electronic medical or health records are now the preferred method for storing patient data and communicating it between healthcare providers as well as payers. This process—from pen to keyboard—is a complex one and is regulated by several federal mandates to both encourage its use and at the same time protect patient privacy.

This section of the program will look at the benefits of electronic documentation as well as the recommendations of the Joint Commission concerning it. This course will also discuss the Health Insurance Portability and Accountability Act (HIPAA), a federal mandate which was enacted to protect the privacy rights of individuals. In addition, the Health Information Technology for Economic and Clinical Health (HITECH), established by federal mandate in 2009 to expand health information technology, will be reviewed.
Electronic Medical Records Overview

• Healthcare providers are charged with documenting encounters they have with a patient, entering subjective and objective data about his baseline health status, problems, interventions, and his responses to those treatments. The information in the medical record is to ensure that all staff caring for the patient have access to the data needed to make prudent clinical decisions. In addition, the patient's chart is an archival record of what happened in a healthcare setting in case of legal action.

• One of the biggest problems with a paper record is that it fosters fragmented care. There is little to no sharing of patient information across physicians' offices, clinics, or hospitals. This can lead to redundant diagnostic tests, and the use of medications or therapies that have not been successful in treating the current or recurring problems. This in turn, can cause increased medical costs and delays in care.

• In 1960, a physician named Lawrence Weed introduced the concept of computerized medical records, using a system that would automatically organize data to enhance their utilization and improve patient care. Initially, this system focused on providing chronological data to the physician about the patient as well as provide for collection of data for epidemiological studies and medical and business audits.
This work eventually led to the problem-oriented method of documentation, which is still used today—manually or electronically—in many facilities. By the 1970s, detailed medication information and diagnostic and treatment plans for over 600 common pathologies were incorporated into the core programs for physician reference.

During the next two decades, other systems were developed and refined. Some of the programs were geared toward outpatient care, while others combined both in-patient and out-patient services.
Electronic Medical Records Overview

In 1991, the Institute of Medicine published a report that detailed a vision for the creation of electronic medical records in the United States. The goal of adopting this new technology included:

- Improving the quality of patient care
- Strengthening evidenced-based clinical practice
- Helping to reduce healthcare costs

The hope was that clinicians anywhere could gain access to all of the pertinent medical information of a patient, no matter where the care was provided. This would include lab tests, x-rays, diagnoses, medications, treatments, and responses to any interventions. In addition, drugs and their doses would be vetted to prevent medication errors.

This process, to change to electronic documentation, has been arduous. Initially, systems were in place for billing. Then, they gradually expanded to pharmacy services. And now, computerized systems are used for routine documentation as well as the collection and analysis of data so that patient outcomes can be improved.
Benefits of Electronic Documentation

• One of the benefits of electronic, or computer-based, documentation is that it allows you to utilize a problem-solving approach to patient care. Based on a patient's assessment, you can create a problems list. Based on the problems list, you can establish a plan of care to manage each problem. After providing interventions, the patient can then be re-evaluated and the plan revisited so that it reflects the new needs of the patient. A revision may include stopping treatment if the problem has been resolved or changing therapies to improve the outcome.

• Another benefit is that this method of documentation can be done at the patient's bedside in real time rather than waiting to get the medical record at the nurses' station. The time spent on entering information is also reduced because of this convenience. A third advantage has to do with the entry itself. The date and time of entry are automatically entered. In addition, it is legible, so that no interpretation is needed and there is little chance to misread an entry because of poor penmanship. Thus, the risk of errors, especially those in orders for medications, is reduced.
Benefits of Electronic Documentation

- One of the biggest benefits within hospitals is that all of the data about a patient is available to those within the institution who need it. For example, if a patient enters the emergency department in a compromised state and cannot give the staff a medical history, the physicians and nurses need only to check the database, and if the patient was treated there before, they would have access to all of his records. This can be lifesaving if he has a drug allergy or chronic condition.

- In addition, lab results, radiology images, and reports as well as daily nursing notes can be easily available to physicians so they can gather information at a computer terminal, rather than going to different departments. Billing can also be streamlined because the coders have immediate access to procedures and treatments, allowing them to send payers the incurred charges more quickly.

- Finally, data gathered about the management of specific pathologies or quality improvement initiatives can be gathered quickly so that trends can be analyzed and changes made as needed. This information can also be utilized for accreditation by the Joint Commission, as the data can support the hospital's compliance with the Commission's National Patient Safety Goals or other standards.
Benefits of Electronic Documentation

Electronic records with clinical decision support interventions, computerized order entry, and bar code medication administration can also play a critical role in meeting the Joint Commission's requirements.

The Veterans Administration hospitals have a program in place in which all patient data can be shared by all VA facilities across the country. Important patient information such as blood type, prescribed drugs, medical conditions, medical history, and allergies are included. If a patient comes into any VA institution or clinic, all of this data is immediately available without the patient having the burden of remembering illnesses, surgeries, medical treatments, and prescriptions. With this plan in place, lives can be saved in an emergency. Even in urgent and non-urgent situations, duplication of work—such as getting a past medical history—will be averted, so that evaluation and interventions can begin more quickly, and outcomes can be enhanced.

This process is cost effective as well. Rather than laboring through reams of paper in medical records, entering a few key words into the computer's database will pull up results quickly and effortlessly.
Electronic Records and the Joint Commission

The Joint Commission and Robert Wood Johnson Foundation issued a statement on *The Future of Nursing* in 2010 encouraging the involvement of nursing in the development of electronic records to improve safety and the effectiveness of care.

Their recommendations were:
- For staff to input data in the patient room
- To use prompts to assure the information entered is accurate and complete
- To have the system alert staff about interventions that must be performed
- To list specific needs for patient education

By following these suggestions, it was hoped that time could be saved, errors reduced, care coordination improved, and patient outcomes enhanced. The other recommendation in this statement strongly advised that schools of nursing adopt an electronic medical records course into their curriculum.

A major concern of the Joint Commission has to do with "scribes," unlicensed individuals who can enter information into the electronic medical record. These staff members cannot act independently, but can enter some patient information into the record at the direction of the physician or nurse. For example, scribes may be used in emergency departments to follow practitioners as they provide care. The scribes can then enter the data into the record at the professional's behest, allowing for more patient time.

The Joint Commission states that scribes meet specific standards of care; meaning they must have an orientation to their role, successfully complete competencies associated with that role, sign the medical record in which they entered data, and have that entry cosigned by a physician or nurse. The Commission states that it does not endorse or prohibit the use of scribes for data entry, but it does **not** endorse their use to enter orders into the record due to the risk involved.
The Health Insurance Portability and Accountability Act (HIPAA) is a federal mandate that went into effect in 2001. Its standard assures that an individual's health information is, "...properly protected while allowing for flow of health information needed to provide and promote high quality healthcare and to protect the public health and well being."

In addition, HIPAA deals with protecting information that is held or transferred electronically and protects against hacking and inadvertent sharing of data using electronic communication technologies such as databases, faxes, and the internet. To ensure that confidentiality is maintained and information is secure, hospitals and other healthcare facilities should appoint a HIPAA or privacy officer to oversee the issues concerning this mandate.

One of the primary principles of HIPAA is patient privacy, so that individuals must authorize the release of routine and non-routine use of their protected health information. For example, in order for data to be sent to a payer, patients must sign a form in which there is a detailed description of their right to privacy. It will also state what specific information will be shared with the payer and how it will be transmitted, whether it is oral, written, or electronic.
Health Insurance Portability and Accountability Act (HIPAA)

This mandate also applies to information about a patient even if his name is not given, as long as he can be identified by other demographics or other data. For example, a hospital cannot issue a statement about a 16-year-old male student at JFK high school who crashed his 2013 blue Mustang convertible coming home from prom on Spring Street in Vienna, Virginia, as his identity will be familiar to classmates, neighbors, family, and others in his community even though his name was not mentioned.

Another HIPAA regulation states that health insurance companies cannot give out medical information to a patient's potential employer without his authorization. Patient consent is also needed to release information for purposes of research. Failure to abide by these rules can lead to fines and even prison sentences.

Like any rule, however, there are exceptions, and there will be times when you must break confidentiality. If the welfare or safety of one or more people is jeopardized, HIPAA may be set aside.

Examples of such instances include:

- Child, elder, or domestic abuse when authorities must be contacted
- Communicable diseases where public health agencies must be notified
- Injuries associated with criminal activities, such as gunshots, or stabbings
- Industrial accidents
- Unknown causes of death
- There also may be instances where courts will waive HIPAA protection.
Avoiding Breaches of Privacy

There are some actions you should follow to prevent breaches of patient privacy.

These actions include:

• Never leaving papers or written records on a desk or in the nurses' station where they can easily be read by others

• Shredding, not just throwing away, all patient information that is not entered into the medical record

Proper use of computers is a vital part of maintaining patient privacy. Your facility must assure that all computer access is password protected and that security can monitor what staff members are searching for. For example, are users looking at data on just their patients or others not in their charge? This breach of confidentiality frequently involves data about celebrity patients that has been leaked to the media.
Avoiding Breaches of Privacy

Staff should never share passwords with others or log on to the facility database for others. While online, the computer screen must be turned away so it is not visible to visitors or others walking down the hall or at the nurses' station. Privacy screens should be used in common areas so that only the person directly in front of the screen is able to read it.

If you are interrupted, but remain at the terminal, turn the screen off. Also, when you are finished documenting or looking up information, log off. Computers should have an automatic setting for shutting down after a certain time period of inactivity.

Physicians must be given a private place for dictation of their notes, so that their voices cannot be overheard by staff or visitors.

Remember that photographs are restricted by confidentiality laws, and patients should not have pictures taken without their consent. Finally, even though it is common sense not to do this, staff must be reminded never to blog about patients.
The Health Information Technology for Economic and Clinical Health (HITECH) Act is part of the federal government's American Recovery and Reinvestment Act of 2009. Its goals are to promote the adoption and "meaningful use" of healthcare technology and the creation of a national healthcare infrastructure to accelerate the use of electronic medical records to improve care coordination and public health.

The Electronic Medical Records Mandate states that public and private healthcare providers must adopt and demonstrate "meaningful use" of electronic medical records by 2014. To stimulate their introduction and utilization, the federal government has issued reimbursement incentives. Those who do not meet this deadline will be penalized.
Health Information Technology for Economic and Clinical Health (HITECH)

The mandate will be implemented in stages. As of 2012, requirements for electronic filing and billing systems as well as transcription services should have been put into place. By the end of 2014, criteria should expand to areas of disease management, clinical support, medication management, and patient access to their health information. In addition, there should be programs developed for quality measurement and research as well as bi-directional communication with public health agencies.

The 2016 "meaningful use" guidelines have yet to be developed, but it is believed they will stress more improvements in quality of care, patient safety, and staff efficiency and also focus on decision making for national high priority conditions, access to comprehensive patient data, improving public health, and patients' access to self-management information.

In addition to the electronic record-keeping mandate, HITECH has updated some of the HIPAA guidelines. First, it strengthened civil and criminal enforcement of its rules. There are now four categories of violations, each with an increasing level of culpability, and four corresponding tiers of penalties. The original HIPAA maximum fine was $250,000. That remains in place for first time offenders, but repeat offenders can be penalized up to $1.5 million per violation. Criminal penalties may also be applied.
Another change from HIPAA is that cases are not brought to court by individuals, but by Attorneys General, acting on behalf of the person. HITECH also mandates that patients be notified of any breach of their private health information (PHI). If more than 500 are involved in the release of confidential data, the Department of Health and Human Services must be contacted. Patients must also be able to obtain their own PHI. They can also authorize a third party, such as a family member or legal representative, to obtain it.

Finally, there are stricter requirements for disclosure of PHI. Patient consent is needed for any data used for marketing purposes of the facility. Psychotherapy notes remain confidential and cannot be released without authorization. It further states that an individual's genetic profile cannot be made available for insurance purposes, and healthcare providers can withhold to an insurer any information pertaining to treatment paid for by a person out-of-pocket. HITECH also mandates that business associates of healthcare providers comply with the confidential regulations set forth by the federal government.
Avoiding Breaches of Privacy

There are some actions you should follow to prevent breaches of patient privacy.

These actions include:

• Never leaving papers or written records on a desk or in the nurses' station where they can easily be read by others
• Shredding, not just throwing away, all patient information that is not entered into the medical record
• Proper use of computers is a vital part of maintaining patient privacy. Your facility must assure that all computer access is password protected and that security can monitor what staff members are searching for. For example, are users looking at data on just their patients or others not in their charge? This breach of confidentiality frequently involves data about celebrity patients that has been leaked to the media.
Avoiding Breaches of Privacy

• Staff should never share passwords with others or log on to the facility database for others. While online, the computer screen must be turned away so it is not visible to visitors or others walking down the hall or at the nurses' station. Privacy screens should be used in common areas so that only the person directly in front of the screen is able to read it.

• If you are interrupted, but remain at the terminal, turn the screen off. Also, when you are finished documenting or looking up information, log off. Computers should have an automatic setting for shutting down after a certain time period of inactivity.

• Physicians must be given a private place for dictation of their notes, so that their voices cannot be overheard by staff or visitors.

• Remember that photographs are restricted by confidentiality laws, and patients should not have pictures taken without their consent. Finally, even though it is common sense not to do this, staff must be reminded never to blog about patients.
The Health Information Technology for Economic and Clinical Health (HITECH) Act is part of the federal government's American Recovery and Reinvestment Act of 2009. Its goals are to promote the adoption and "meaningful use" of healthcare technology and the creation of a national healthcare infrastructure to accelerate the use of electronic medical records to improve care coordination and public health.

The Electronic Medical Records Mandate states that public and private healthcare providers must adopt and demonstrate "meaningful use" of electronic medical records by 2014. To stimulate their introduction and utilization, the federal government has issued reimbursement incentives. Those who do not meet this deadline will be penalized.

The mandate will be implemented in stages. As of 2012, requirements for electronic filing and billing systems as well as transcription services should have been put into place. By the end of 2014, criteria should expand to areas of disease management, clinical support, medication management, and patient access to their health information. In addition, there should be programs developed for quality measurement and research as well as bi-directional communication with public health agencies.

The 2016 "meaningful use" guidelines have yet to be developed, but it is believed they will stress more improvements in quality of care, patient safety, and staff efficiency and also focus on decision making for national high priority conditions, access to comprehensive patient data, improving public health, and patients' access to self-management information.
In addition to the electronic record-keeping mandate, HITECH has updated some of the HIPAA guidelines. First, it strengthened civil and criminal enforcement of its rules. There are now four categories of violations, each with an increasing level of culpability, and four corresponding tiers of penalties. The original HIPAA maximum fine was $250,000. That remains in place for first time offenders, but repeat offenders can be penalized up to $1.5 million per violation. Criminal penalties may also be applied.

Another change from HIPAA is that cases are not brought to court by individuals, but by Attorneys General, acting on behalf of the person. HITECH also mandates that patients be notified of any breach of their private health information (PHI). If more than 500 are involved in the release of confidential data, the Department of Health and Human Services must be contacted. Patients must also be able to obtain their own PHI. They can also authorize a third party, such as a family member or legal representative, to obtain it.

Finally, there are stricter requirements for disclosure of PHI. Patient consent is needed for any data used for marketing purposes of the facility. Psychotherapy notes remain confidential and cannot be released without authorization. It further states that an individual's genetic profile cannot be made available for insurance purposes, and healthcare providers can withhold to an insurer any information pertaining to treatment paid for by a person out-of-pocket. HITECH also mandates that business associates of healthcare providers comply with the confidential regulations set forth by the federal government.
Informatics

The conversion from paper to computer-based records has led to a new field of study for computer programmers and healthcare staff—informatics. There are now degrees available in this field of study, which is expanding rapidly.

Since the enactment of HITECH, over 50,000 jobs have been created to implement the project. And, according to the Bureau of Labor Statistics, it should increase by another 20% by 2018, which is at a higher rate than any other occupation.
Conclusion

Healthcare providers are charged with documenting encounters they have with a patient, entering subjective and objective data about his baseline health status, problems, interventions, and his responses to those treatments. In addition, the patient's chart is an archival record of what happened in a healthcare setting in case of legal action. For the protection of the staff, the facility and the patient, it is critical that the medical record is complete, truthful, and adheres to the standards of the Joint Commission. This will assist you in better managing and coordinating patient care.

Furthermore, the use of electronic records can provide for better coordination of care through a nationwide database. Using this technology, data can be collected and analyzed so that treatment regimens and patient safety can be improved. Gathering comprehensive health information on individual patients more easily will enhance their care, especially during disasters such as hurricanes, tornados, mass shootings, or acts of terror. With a few keyboard strokes, the professionals caring for victims in these tragedies can have access to the patients' medical histories, allergies, chronic conditions, and current medical problems.
Suggested Reading


I acknowledge I have read and reviewed *Documentation: Essentials and Electronic Medical Records - “The Process and Legal and Administrative Considerations”* and understand the Learning Objectives as presented.