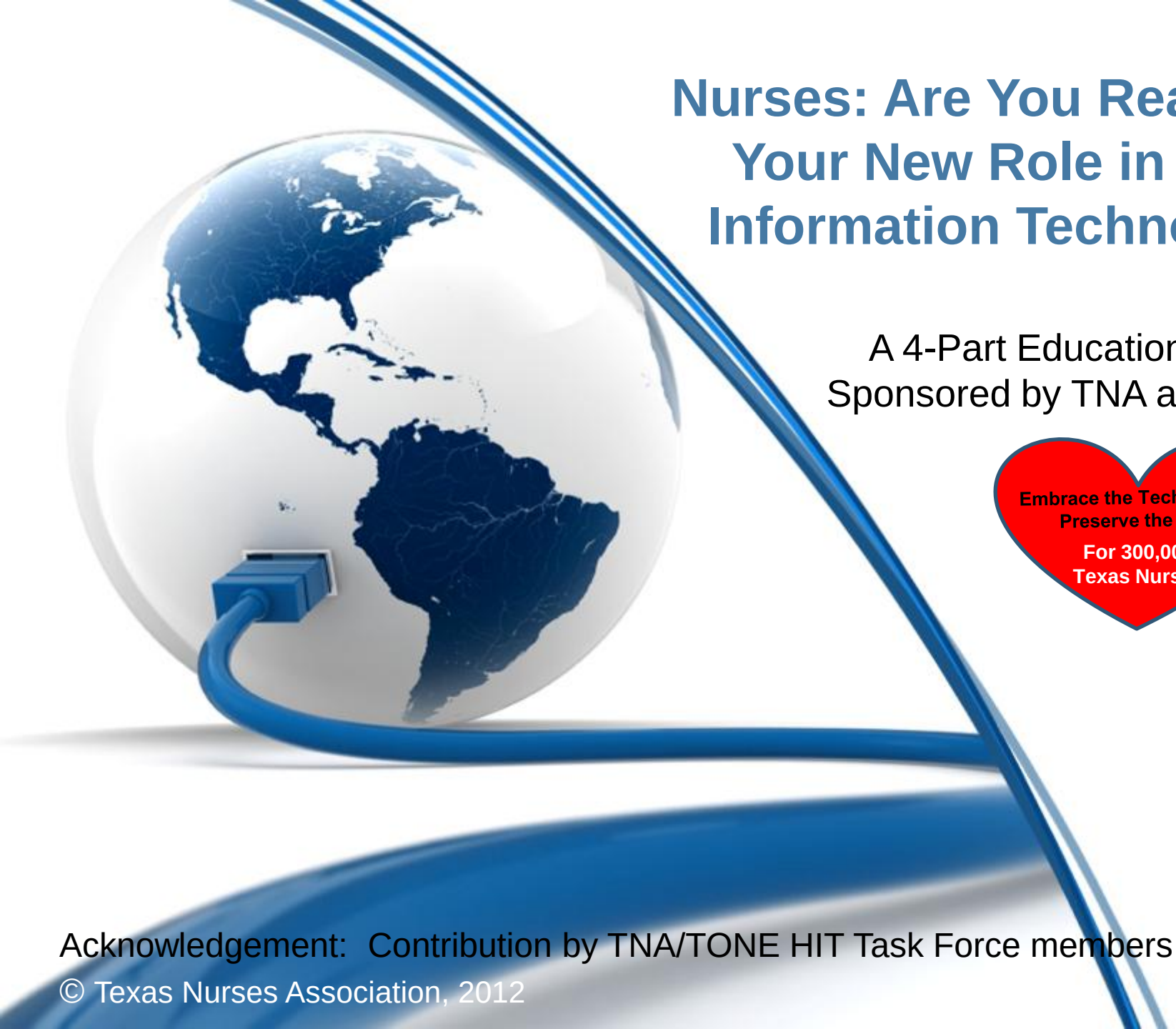


Nurses: Are You Ready for Your New Role in Health Information Technology?

A 4-Part Educational Series
Sponsored by TNA and TONE

Embrace the Technology
Preserve the Art
For 300,000
Texas Nurses

Acknowledgement: Contribution by TNA/TONE HIT Task Force members

Legal Aspects of Documenting in the Electronic Health Record

Mary Beth Mitchell, MSN, RN, BC

CNIO, Texas Health Resources

Webinar 3

April 20, 2012

TNA/TONE Health IT Task Force

- Charge: Determine implications of health care informatics for nursing practice and education in Texas
- Include nationally-based Technology Informatics Guiding Education Reform (TIGER) initiative

Vision: To enable nurses and interprofessional colleagues to use informatics and emerging technologies to make healthcare safer, more effective, efficient, patient-centered, timely and equitable by interweaving evidence and technology seamlessly into practice, education and research fostering a learning healthcare system.

TNA = Texas Nurses Association
TONE = Texas Organization of Nurse Executives

HIT Taskforce Membership

Composed of TNA and TONE Members from practice and academia

Task Force Members

- David Burnett
- Nancy Crider
- Mary Anne Hanley
- Susan McBride
- Molly McNamara
- Mary Beth Mitchell
- Elizabeth Sjoberg
- Mari Tietze

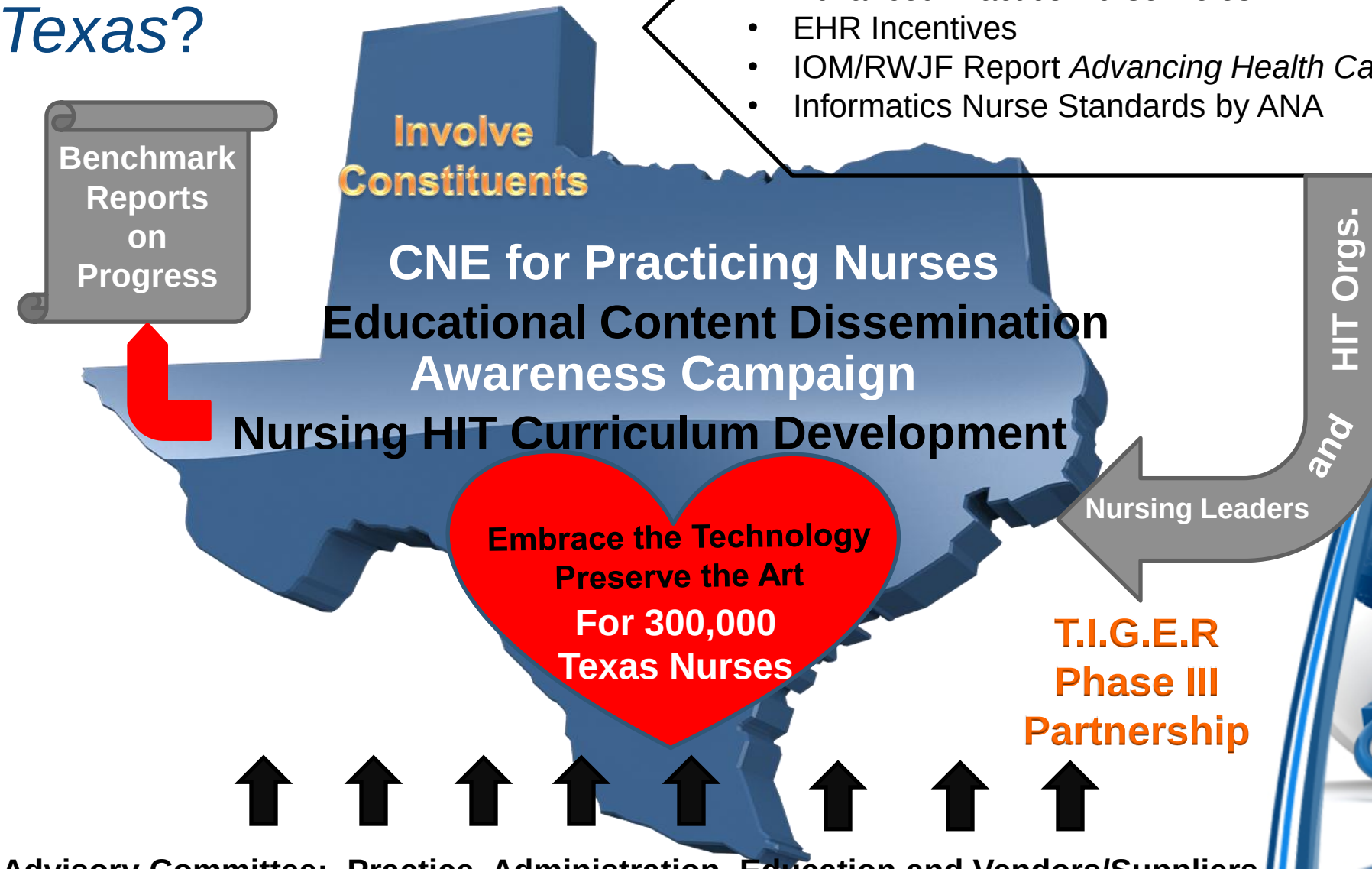
TNA

- Clair Jordan
- Joyce Cunningham
- Laura Lerma

Why Does HIT Matter *Deep in the Heart of Texas?*

Environmental Forces:

- Health Care Reform/ARRA
- Advanced Practice Nurse Roles
- EHR Incentives
- IOM/RWJF Report *Advancing Health Care*
- Informatics Nurse Standards by ANA



Objectives

- Analyze electronic components of the legal medical record
- Discuss how electronic nursing documentation impacts compliance with regulatory requirements
- Identify best practice guidelines for nursing documentation in the electronic health record

To receive contact hours for this continuing education activity you must:

- Have one of the following:
  - Be registered through the Texas Health Resources go-to-webinar system
  - Be signed in at a group site. (Sign-in sheets should be emailed to the webinar coordinator within 24 hours of the completion of the webinar.)
  - Be on the phone only (email confirming your attendance should be sent to the webinar coordinator within 24 hours of the completion of the webinar).
- Be present on the webinar until its completion/actual ending time, including question and answer time.
- Complete and submit the activity evaluation form – link to be provided upon completion of the webinar – within two (2) weeks of the completion of the webinar. NOTE: Once the evaluation has closed, no further access will be allowed.

Disclosures

- **Conflicts of Interest: I have no** relevant professional, personal or financial relationships related to the planning or implementation of this CNE activity.
- **Sponsorship or Commercial Support:** This CNE activity received no sponsorships or commercial support.
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Drivers of the Electronic Medical Record

Dr. David Blumenthal

“The meaningful use of electronic health records will help health care providers and hospitals offer higher quality and safer care.”

What does Meaningful Use try to Accomplish

- Improve quality, safety, efficiency and reduce health disparities
- Engage patient and their families (through electronic communication)
- Improve care coordination- over the health care continuum
- Ensure adequate privacy and security protection for personal health information
- Improve population and public health- through data collection and looking at quality data over time

Pat Wise, RN, MS, MA Vice President for HIMSS

Electronic Health Record

- **Electronic Medical Record-** An electronic record of health-related information on an individual that can be created, gathered, managed, and consulted by authorized clinicians and staff within one health care organization

- **Electronic Health Record-** An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be created, managed, and consulted by authorized clinicians and staff across more than one health care organization.

- **Personal Health Record-** An electronic record of health-related information on an individual that conforms to nationally recognized interoperability standards and that can be drawn from multiple sources while being managed, shared, and controlled by the individual.

The National Alliance for Health Information Technology Report to the Office of the National Coordinator for Health Information Technology on : Defining Key Health Information Technology Terms , April 28, 2008.

Electronic Health Record - A Tool to Transform Nursing

- Allows for congruence with the aims of MU
- Nursing documentation as a tool/means to transform our clinical practice
- Availability of data to support continuity of care
- Better management of care across the continuum
- Access to information tracking, trending, sharing and reporting
- Ability to recognize and manage key patient indicators, regulatory requirements and the drive to outcomes through Clinical Decision Support Tools.

What's In it for Nursing

- Meaningful Use
- Improves patient care, better outcomes, promotes safety culture
- Flexible build, templates
- Uniform capture of data
- EHRs are optimal for dealing with litigation, audits, and patient care.
- Brings together all aspects of the patient experience- Nurses think holistically already
- No lost records, low maintenance

BESIDES……
It Got Rid of All the Paper

So- Let's Take on the Challenge of Electronic Documentation

What is the Legal Medical Record

- Medical Record: The collection of information concerning a patient and his or her health care that is created and maintained in the regular course of the organization's business in accordance with the organization's policies, made by a person who has knowledge of the acts, events, opinions or diagnoses relating to the patient, and made at or around the time indicated in the documentation.
- The medical record may include records maintained in an electronic medical / record system, e.g., an electronic system framework that integrates data from multiple sources, captures data at the point of care, and supports caregiver decision making.
- A longitudinal electronic record of patient health information generated by one or more encounters in any care setting. Included in this information are patient demographics, physician, nursing and ancillary documentation, orders, medications, vital signs, immunizations, and clinical reports

Challenges of Legal Medical Record

- All components have to be defined
- What can be released, what is protected
- What happens to downstream information-
  - audits,
  - documentation that is captured, but not part of the legal EHR,
  - security access information
  - Corrected documentation errors
- What is discoverable
- ROI- Release of Information- every item defined

Data, Data, Everywhere

- Everything that is recorded in any format in the electronic medical record may be discoverable in some way.
- All data can potentially be transmitted electronically
- Deleted, erased, or corrected data is still tracked and viewable in some format

What do I have to Document??

- This is the question
- Many options, many choices
- Staff want better definition around documentation
- Increased risk of incomplete documentation.
- Can document in different parts of the record, in different formats.
- More and more regulatory requirements- how to manage and know everything is covered that is “required”

How to Manage Documentation Requirements

- Ways to make certain items required- ie: Admission- “Red dots”
- Organize information in a way to follow defined steps to get all the documentation requirements
- Flowsheet- manage all assessments and interventions
- MAR- All medications required- show as overdue
- BPA- “Best Practice Advisory”
- Hand-Off- Review of all required elements
- Links to Care Plan or Patient Education Record
- Use notes judiciously- don’t use notes to replace flowsheet documentation

Appropriate Use of Notes

- Describe Changes in Condition
- Pull information together
- Define “Significant Events”
- Communication to physicians
- Status reports

Telling the Patient's Story

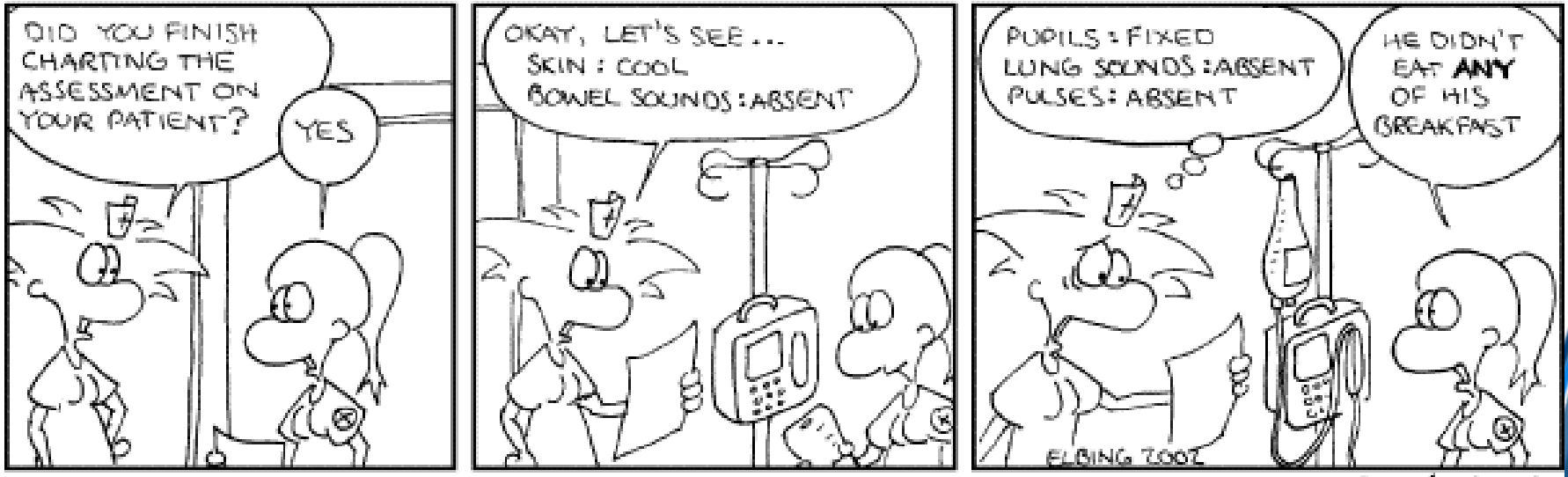
- The biggest issue by far, that we struggle with in nursing is how to "tell the patient story."
- So much information in so many places, that there is tendency to get "lost"
- Difficult to associate documentation to show a complete picture of the patient's condition.
- How do we pull it all together

Use of Reports

- Typically in an EHR, where we review information is not the same as where it's entered.
  - Data entered into documentation fields
  - Information reviewed through reporting features.
- Reports can be created to pull different types of information together, from various parts of the record.
- Can have many reports to show different information
- Can be expanded or collapsed
- Can be tracked and graphed over time.
- Can be highlighted or pushed to show significant events
- Often can be user-defined

Nurstoons

by Carl Elbing



www.nurstoon.com

Clinical Decision Support

- **Clinical Decision Support**[1] is a process for enhancing health-related decisions and actions with pertinent, organized clinical knowledge and patient information to improve health and healthcare delivery.
- "Our definition for clinical decision support includes using organized clinical knowledge to enhance decisions and actions.“
- A set of rules and alerts that can help guide decision-making and practice decisions.

Improving outcomes with clinical decision support: an implementer’s guide. Second Edition. HIMSS. 2011 (in press).

Why is CDS so Important

- We hear so much about how many things get missed or overlooked in the EHR, and the risk of that.
- Clinical Decision Support is our “Safety Net”
- Also, so many requirements for care, and documentation of those requirements, CDS rules help us manage all the requirements. (over 85 requirements at present time)
  - TJC
  - Core Measures
  - SCIP Measures
  - Organizational requirements

Types of CDS Tools

- Alerts
  - Allergies
  - Drug interactions
  - SCIP Antibiotic due prior to surgery
- Rules
  - Stop Metformin 24 hours before procedure with contrast
  - Follow-up with pain assessment after given pain med
- Conditions for documentation
  - Criteria for Catheter removal
  - Initiate skin protocol for defined score on Skin Assessment Tool

Risk Factors in Documentation

- Inconsistencies
- Incomplete
- Sloppiness
- Lack of Follow-Up
- Devil in the Detail

Inconsistencies

- When you document something in one place and contradict it somewhere else.
  - Document WDL and then put in a note discussing something abnormal in the same system.
  - Copying forward skin assessment, but providing interventions not associated with the assessment.
  - Document high pain scale values, and pain meds, and then enter that patient had no discomfort in a summary.

Incomplete

- Documentation that leaves gaps in processes:
  - Orders not completed
  - Blood transfusions not completed
  - Giving a pain med with no follow-up pain assessment
  - Document deterioration in patient's condition with no follow-up assessment, or no interventions.
  - Calling physician for specific order, but don't document why you called and what the outcome was.

Sloppiness

- Documentation that raises concerns by virtue of lack of professionalism.
  - Misspelled words
  - Texting format
  - Use of slang or derogatory comments
- Flowsheets decreased some of this potential, but notes still allow for open text.
- Comments need to relate to what they are associated with
- Sticky Notes should always be professional
- “Note Bloat” Writing notes that say the same thing over and over. Risk the chance of it contradicting something else.

Lack of Follow-Up

- Documentation stops short of showing a complete picture:
  - No repeat vital signs after a significant change
  - No documentation of follow-up after a call to the physician
  - Orders not completed
  - Patient request documented, but no response documented.
- Need to close the loop.
- Often the follow-up to documentation are in different parts of the record, so it may be difficult to see and follow.
  - Helps to enter a summary note.

Devil in the Details

- Too much detail can be detrimental, since it's impossible to catch everything, and this sets a higher expectation.
- Increases risks of contradictory documentation.
- Makes a gap in documentation that much more noticeable.
  - If document a full assessment, instead of using flowsheet, maybe missed documentation of decreased breath sounds.
  - Instead use WDL except, and list decreased breath sounds as an exception.
- Need to follow hospital policies for documentation. Don't overdo it.

Security

- Information Security- The protection of information and information systems from unauthorized access, use, disclosure, disruption, modification, or destruction in order to provide confidentiality, integrity, and availability.
- HIPAA Security Rule -sets national standards for the security of electronic protected health information; and the confidentiality provisions of the Patient Safety Rule, which protect identifiable information being used to analyze patient safety events and improve patient safety.

Patient Privacy

- Privacy - an individual's right in limiting use and disclosure of his/her protected health information.
- The Privacy Rule, (within HIPAA) gives patients rights over their health information and sets rules and limits on who can look at and receive their health information.
- The Privacy Rule applies to all forms of individuals' protected health information, whether electronic, written, or oral.
- The Security Rule protects health information in electronic form, and requires entities to ensure that electronic protected health information is secure.

Security and the EHR

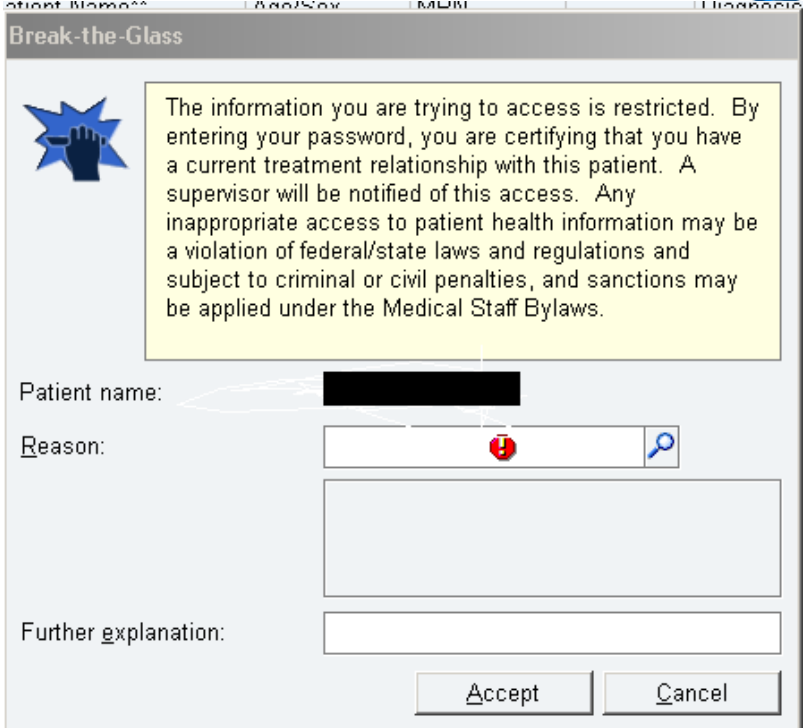
- The EHR is not a confined document, so increased risk for security breaches.
- Better ability to audit and manage access.
- Need to balance the need to know with patient's need for privacy.
- Rules are set-up within the EHR to manage security access to ensure patient privacy.
- Patient's Right to Privacy gives them legal rights if that is broken.
- All access and disclosures of information is tracked.

What you need to know!

- Only access information when have a “Need to Know”
- Everything you document or even look at it tracked and is auditable.
- Systems usually have some type of alert or notification that indicates a possible security breach. Make sure access is needed and why.
- Always be able to justify why a certain part of the record was accessed- need to know for patient care activities.

Break the Glass

- Documentation within the context of “Break the Glass,” may need additional description of purpose in the record.
- Always select the best option why you are accessing the record.
- Only go to the portion of the record you need.
- Realize that you are leaving an “audit trail” that is discoverable.
- Document why you are making changes
- Indicate “Late Entry” or “Follow-Up” if appropriate.



Don’t, Don’t, Don’t

- Don’t edit someone else’s documentation.
- Don’t overuse copy forward
- Don’t make personal judgments in the documentation.
- Don’t criticize other caregivers care or documentation
- Don’t criticize the physicians
- Don’t elaborate or use long flowing, rambling sentences, going on and on about the same thing, which doesn’t add any value, and may include information that creates an inconsistency.
- Change documentation that is in error- make an entry to correct it, listing the discrepancy. (Don’t cover up)
- Don’t ignore alerts
- Don’t text or accept texted orders- against policy

Do, Do, Do

- Document changes in condition, including the data, the action, and the result/outcome.
- Follow-up on interventions and document outcomes associated with an intervention
- Document notes in concise statements with only the relevant information
- Do realize that many other disciplines and possibly even the patient may have access to what you are entering

Post- Discharge Access

- There may be reasons why you need to access a patient record after discharge:
  - Correct an error
  - Document a follow-up call or response
  - Audit a record
- Extended access granted to allow for these conditions.
- Document clearly reason why accessing the record.
- Do not delete any information, only add to.

Red Hot Review

- Some areas are under a lot of scrutiny due to increase use of EHR's
- What are the areas to pay special attention to, to minimize your risk:
  - Document as close to real time as possible.
  - Critical Value notification
  - Hand-Off and communication between caregivers
  - Action on alerts
  - Use of templates, flowsheets, and tools within the system. Are you using the functionality as intended

Over-Reliance on Technology

- Pay attention to the technology, but don’t trust it to prevent errors.
- Don’t assume bar-coding is fool-proof
- Don’t assume you will be alerted and prevented from making an error.
- Be attentive to how things work in the EHR- there could be a technology related error.
- Follow proper procedures for logging in, saving, logging out and managing the EHR.

Additional Information

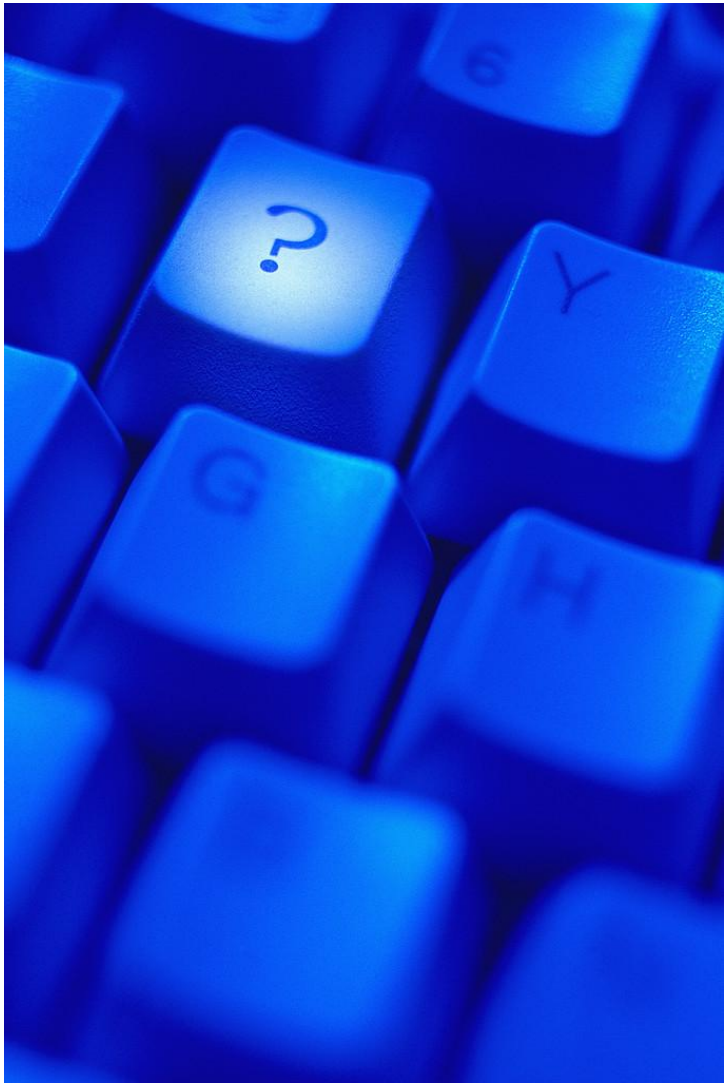
- Corrections and edits are always visible. You cannot delete information, only explain or manage it.
- Be careful around verbal orders. Computerized Physician Order Entry (CPOE) can be error prone, especially with Nurses entering orders rather than physicians.
- Never leave the computer unattended without logging off. Documentation should never be visible on a computer screen.
- Never share log-on and password- that is your signature.
- Always follow policies and procedures for documentation.
- Remember what you enter is there for others to see, it is not confined to the HIM department.

Common Charting Mistakes

1. **Failing to record pertinent health or drug information**
2. **Failing to record nursing actions**
3. **Failing to record that medications have been given**
4. **Recording on the wrong chart**
5. **Failing to document a discontinued medication**
6. **Failing to record drug reactions or changes in the patient's condition**
7. **Transcribing orders improperly or transcribing improper orders**
8. **Incomplete records**

8 Common Charting Mistakes to Avoid, Nurses Service Organization 2011

Questions



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Contact

TNA/TONE HIT Task Force

Mary Beth Mitchell, MSN, RN, BC

Texas Health Resources

marybethmitchell@texashealth.org