OPERATIONS MANUAL

SUBJECT: CREATION, MAINTENANCE AND MODIFICATION OF THE ELECTRONIC HEALTH RECORD

Purpose

To establish policy, procedures to guide and control the creation, maintenance, modification, correction, and amendment of information in the electronic health record.

Policy

Electronic health record (EHR) information will be created, maintained and corrected in a manner that ensures the information produced from the EHR is accurate, reliable and trustworthy.

The EHR Committee, under the direction of the Clinical Applications Coordinator (CAC) is responsible for coordinating and planning the implementation and continued use of the EHR including recommending and implementing EHR policy and procedure, orientation and training.

The Information Management (IM) Committee will monitor the implementation of the EHR in regard to it's compliance with applicable laws, regulations and standards of practice. The IM Committee will review requests for templates, requests to discontinue printing and filing of patient information, scanning requests, changes in storing, archiving and accessing electronic information and other issues pertaining to legalities of documenting patient care. The Privacy Act, Joint Commission standards, Information Security Regulations, Health Information Portability and Accountability Act (HIPAA) and other applicable State and Federal laws and regulations guide the committee. The Leadership Council is kept informed of decisions/recommendations and is consulted as appropriate.

Procedure

Authorship

Authorship is the origination of recorded information by a specific individual. Authors are responsible for the completeness of their entries in the health record. Authors must be approved to document in the health record as defined by hospital policy and must trained and competent in EHR documentation practices. Typically, those individuals who are approved to document in the paper health record also have documentation privileges for the EHR.

Authentication of Entries

Authentication identifies the author and assigns responsibility for information documented in the EHR. Health Level Seven (HL7) has defined a legally authenticated

document or entry as "a status in which a document or entry has been signed manually or electronically by the individual who is legally responsible for that document or entry."

For the EHR, electronic signatures are the approved method of authenticating entries. Hospital Information Technology (IT) policy provides adequate security measures identifying those users who can document in the EHR and verifying the authenticity of user electronic signatures.

Authentication includes the identity and professional discipline of the author, the date and time signed. Once affixed, authentication of electronic documents cannot be rescinded or repudiated. Therefore, an author is responsible for the sole use of the author's access and verify codes. An author must not create entries under another's access and likewise, must lock the EHR or log-off when walking away from the screen in order to prevent another person from making an entry under the wrong access code.

Service Chiefs and Department Heads are responsible for monitoring compliance of their staff regarding the security and integrity of electronic signatures, access codes and computer-generated health record documents. They shall ensure their staff receive proper orientation about this policy.

Unsigned documents: Viewing unsigned notes is not allowed as there is a risk of clinical decision-making based on incomplete or erroneous data that could be later changed or deleted. Conversely, it is imperative that notes are verified and signed timely so information may be viewed and used by others for patient care.

Countersigner: A co-signer may be the supervising practitioner, service chief, or designee, as defined by the Hospital's By-Laws and/or policies. A co-signer may edit and authenticate or add an addendum to a note. Viewing of un-cosigned notes is determined on a case-by-case basis depending on the nature of the document and how critical the information is to patient care.

Identified signer and additional signer: "Identified signer" and "additional signer" are synonymous and are a communication tool used to alert a clinician about information pertaining to the patient. This functionality is designed to allow clinicians to call attention to specific documents and for the recipient to acknowledge receipt of the information. Being identified as an additional signer <u>does not</u> constitute a co-signature. This nomenclature in no way implies responsibility for the content of, or concurrence with, the note.

Timeliness of Electronic Entries

Timeliness of an entry is critical to continuity of patient care as well as the admissibility of a health record in court as required by the Uniform Rules of Evidence. Entries shall be

reviewed and signed promptly after an event or observation is made. An entry shall never be made in advance. If it is necessary to summarize events that occurred over a period of time (such as a shift), the notations shall use the interdisciplinary note function in order to electronically indicate the actual time each individual entry was made.

EHR users must respond promptly to view notifications which notify them of documents requiring authentication or attention.

Copy and Paste Functions

Copy and paste functions are allowed, however, this functionality must be used with caution. Any information copied and pasted must be carefully proofread to ensure validity. Copy and paste functions should only be used within a single patient's health record and information should not be copied from one patient to another, to preserve integrity of data and to prevent privacy breeches. If a user copies forward from a previous entry by a different author, an attribution statement referring to the original document, date, and author should be incorporated.

Clinical, ethical, financial, and legal problems may result when text is copied in a manner that implies the author or someone else obtained historical information, performed an exam, and/or documented a plan of care when the author or someone else did not personally collect the information at the time the visit is documented.

Copying information from other portions of the health record is unnecessary duplication of information that makes reading the charts more difficult and time consuming and is overwhelming to the reader and dwarfs the remaining information within the note.

The following rules must be adhered to when copying patient information through cut and paste or importing through objects:

Never copy the signature block into another note.

Never copy data or information that identifies a health care provider as involved in care that the health care provider is not involved in.

Do not copy entire laboratory findings, radiology reports, and other information verbatim into the note when it is not specifically addressed or clearly pertinent to the care provided.

Do not re-enter previously recorded data, unless specifically required for the assessment of a specific patient problem.

Use the functionality of importing data objects into progress notes and other documents carefully. Any imported objects, dialog, etc., if used, must be reviewed for accuracy and corrected at the source as well as in the document if there is any inaccuracy.

Service Chiefs and Department Heads are responsible for monitoring the use of the cut and paste function by their staff for appropriateness. When errors occur, these must be corrected immediately. Where perceived intentional violations occur, findings must be reported to the Privacy Act Officer or Hospital Compliance Officer as appropriate. Failure to comply with these standards may be deemed as Privacy Act violations, HIPAA violations, or falsification of official agency records and could result in disciplinary action or termination

Clinical Postings

Clinical postings consist of crisis notes, clinical warnings, allergies, and advance directives. These are entered with an appropriately titled progress note and can be rescinded by changing the note title (for example, “Rescinded Advance Directive”). This procedure will be in effect until such time as the EHR allows the capability to inactivate a posting without changing the title.

Clinical Reminders

Clinical reminders are a clinical decision support tool to assist healthcare staff; they are not a part of the designated clinical record set or the legal health record. The reminders are recommendations, based on clinical and administrative policy, and are always to be interpreted in the context of the practitioner’s knowledge of the patient. When a clinical reminder is triggered inappropriately due to an improper code selection, hospital policy and procedures regarding correction of errors shall be followed.

Health Record Alterations and Modifications

The Privacy Act Officer and/or Medical Record Department Administrative personnel are responsible for and oversee the amendment or correction of the electronic health record. No editing or alteration of any documentation after manual or electronic signature has been completed can occur without the approval of the Privacy Act Officer or Administrative Medical Record personnel.

There will be times when documentation problems or mistakes occur and these entries should be corrected immediately by contacting the above officials.

There are four types of health record changes:

Administrative Update: An administrative update is current information entered in place of existing data, i.e., an address change or other registration data. Changes to demographic data are the responsibility of the Registration Department and are generally initiated by the patient.

Administrative Correction: An administrative correction is remedial action by administrative personnel with the authority to correct health information previously captured by, or in error. Administrative corrections include factual and transient data entered in error or inadvertently omitted. Examples include incorrect date, association and/or linking data to wrong patient, association and/or linking data to wrong clinician or facility, placing a lab value in the wrong record, transcription typing the wrong word or diagnosis, etc. Request to retract or correct an entry must be initiated by the author. EHR corrections are performed by the Privacy Act Officer and/or Medical Record Administrative staff. Errors from RPMS packages such as Laboratory, radiology and pharmacy are corrected by the package administrator (the Head of that Department).

Addendum: An addendum to a patient note or summary is made when a clinician deems it important to clarify, correct, or add to information recorded in the original document. The addendum option can be utilized by practitioners to continue ongoing treatment discussions, or by supervising practitioners to validate the plan of care.

Addenda are linked to originally created documents and may be entered by someone other than the author. The original author may be alerted to this action by sending a notification to the author. A new note by a practitioner must be initiated for each new patient contact rather than using an addendum.

Amendment: Amendment is the alteration of health information by modification, correction, addition, or deletion at the request of the patient. A request to amend any data contained in the health record must be submitted in writing to the facility Privacy Act Officer, or designee in accordance with procedures outlined in HIPAA policies and procedures.

If the request is approved, the disputed information must be corrected or deleted using the TIU AMEND action. The TIU Amend action keeps the original, un-amended document with a retracted status. When a request is denied, a statement of disagreement may be filed with the disputed information at the request of the patient. This is accomplished by adding an addendum to the disputed information indicating where the statement or documents are filed or scanned into the EHR.

A request to amend erroneous information of one practitioner by another practitioner is not appropriate and erroneous information by the original author must be notated in an addendum. (Example: Identification of erroneous documentation by a former staff

member, no longer available, is identified by a second practitioner. The original document can only be corrected by the original author; therefore, the only option is to clarify the error by an addendum by the second practitioner.)

The following electronic options for correcting data are currently available:

Deletion/Retraction: An author may delete a patient document prior to electronic signature. Once signed, a document may only be administratively deleted/retracted under the following limited circumstances:

The electronically signed document is totally blank.

A document is written for the correct patient, but is erroneous in content and requires entry of a new document and deletion of the old erroneous document.

A document is written on the wrong patient's record and the note contains imbedded data objects from the wrong patient making reassignment of the note unsuitable. The document must be deleted and re-created on the correct patient's health record.

A patient has been granted a request to amend their patient record by filing an IHS Form 917, "Request for Amendment of Protected Health Information".

The TIU DELETE action is used to delete documents. When used on completed documents, it maintains the original document with a retracted status.

There are two types of deletions/retractions - Privacy Act and Administrative. A Privacy Act deletion/retraction is used when the patient's request for amendment of protected health information has been approved by the Service Unit Director. All other deletions/retractions are administrative.

Reassign: This option is used when the correct data is entered on the wrong patient. This option may only be used if there are no imbedded data objects in the note. These notes need to be retracted immediately upon discovery of an erroneous entry in a patient's health record by notifying the appropriate officials.

Change Title: When a note title is electronically modified, the title is changed from the previous title to the new title; a change of history of the title name is not maintained. The change title option must be used:

If the title of an unsigned note is incorrect, the author may change it to the appropriate note title.

If the title of a signed note is incorrect, the author may request the appropriate officials to change the title.

Amend: Once a request for amendment has been approved, the amend option in TIU is used to make the change or correction. Only the Privacy Officer, Medical Record Administrative staff, or designee is authorized to make amendments.

Late entry: When a pertinent entry was missed or not written in a timely manner, a late entry should be used to record the information in the health record. Late entries are identified as such by:

Creating a new visit, selecting the correct visit date, and identifying the visit as "historical".

Select a note title for "Late Entry".

Identify the new entry as a "late entry" in the note itself.

The EHR automatically assigns the current date and time so an entry cannot be made to appear as if it were written on a previous day and time.

Identify or refer to the date and incident for which the late entry is written.

When documenting a late entry, document as soon as possible. There is no time limit for documenting a late entry; however, the more time that passes, the less reliable the entry becomes.

Retracted documents are not considered part of the designated record set or legal record or visible to anyone. The Privacy Officer and/or Medical Record administrative staff are designated as the only individuals who may view or print retracted documents. An annotation is viewable within the EHR by clinical staff to alert them to retracted or reassigned notes so these documents may be consulted in needed.

Document Scanning

Document scanning is a future development of the EHR. Scanning, or imaging, is a process by which a paper document is converted to an electronic file. See the IHS Disposition and Retention Schedule for record retention and retrieval requirements.

Scanned documents can be linked to TIU documents and displayed with the TIU document. Scanned documents do not require an electronic signature, but are marked administratively complete.

Only those documents that cannot be created in or interfaced with the EHR will be scanned. Development of document scanning policies is coordinated by the IM Committee.

Quality control processes will address integrity of data capture, accurate linking of scanned items or documents to the correct record, accurate indexing of the document, correction process of erroneously scanned documents, and how a scanned image will be annotated to identify that it has been scanned.