Nursing Documentation 101

Module 6: Electronic Documentation
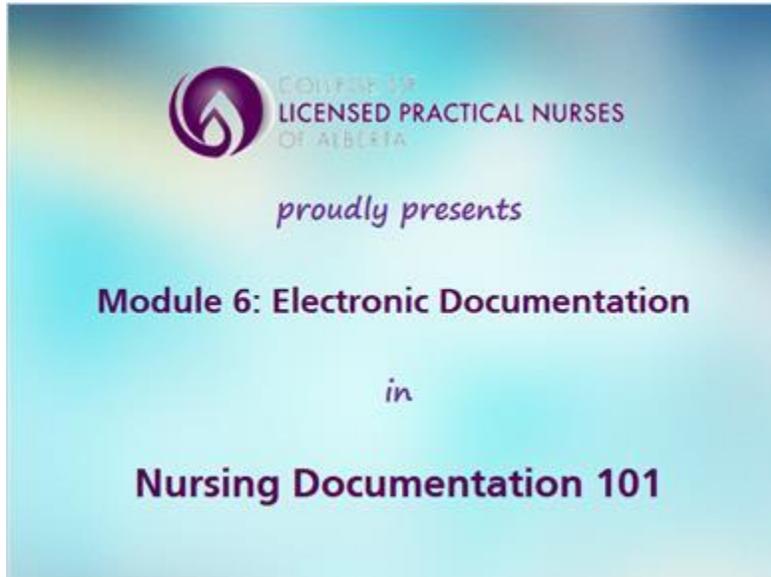
Handout

Module 6 – Electronic Documentation
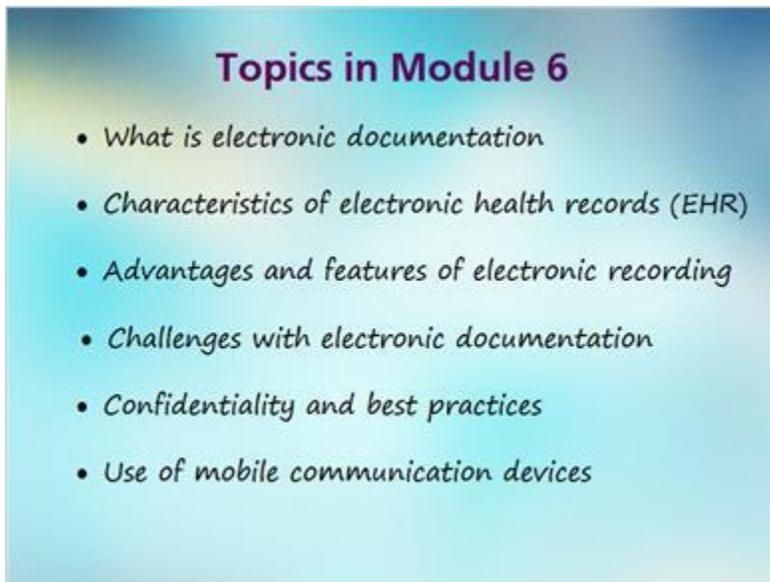
1. Introduction

1.1 Welcome

Narration

No narration, only music.

1.2 Topics

Narration

JILL: Welcome to the final module in this Nursing Documentation course. I'm Jill, here with Mark.

MARK: Hi Jill. I see that this module is about electronic documentation. Does this means we will be talking about using computers to keep track of client health information?

JILL: Yes, that's right. The specific topics include … what is electronic documentation … characteristics of electronic health records … advantages of electronic recording … challenges … and confidentiality issues. We will conclude with an examination of the use of mobile communication devices in a healthcare setting.

Mark, have you used electronic documentation?

MARK: Yes I have … in my practicums and at a couple of hospitals where I worked.

JILL: Great, then you will be able to share some of your experiences with us.

MARK: Sure, I'll be happy to!

1.3 Technology

Narration

JILL: Informatics is the term used to describe the merging of medical and nursing science with computer science to better manage health related data.

MARK: Does everyone now use electronic documentation?

JILL: Not yet Mark. But most facilities today incorporate some type of electronic technology for record keeping. Also, as technology becomes increasingly prevalent in all aspects of our society, it is just a matter of time before electronic systems become the standard for health records.

MARK: What is the general consensus on whether electronic recording is better than paper?

JILL: The technology systems vary greatly among health organizations. However, research has shown mixed results when comparing paper-based systems to electronic systems. As you know Mark, computerized documentation systems consist of complex, interconnected sets of software applications that process and transport data to and from the healthcare team. This data guides the health care team in providing safe, client-centred care while at the same time identifying client needs. Some systems gather not only data while the client is in care, but retrieve past client records from various agencies or facilities.

1.4 Electronic Health Records

Narration

MARK: In my experience, the electronic client records contain similar data to paper documentation.

JILL: Yes they do. The client's electronic health record contains the same components that a traditional paper-based health record would have: medical history … clinical status … laboratory and diagnostic test results, treatments and … documentation of client care interactions.

Regardless of whether paper-based or electronic documentation is used, the same principles of accurate documentation apply. Remember your documentation is not only your memory but also evidence of using the nursing process in caring for your clients.

MARK: Same data, but different ways of recording and retrieving the client's information using technology.

1.5 Electronic Health Record

Narration

JILL: Mark, since you have used electronic health records systems, why don't you give us a brief overview of how they work.

MARK: Sure thing. You must login to the system to either enter or retrieve client information. After entering a password, updated information such as lab tests or new physician's orders may be obtained. Electronic systems automatically record the care provider's name, along with the entry date and time. The care provider may use drop-down menus to enter assessment data or significant client notes. Errors may occur if cutting and pasting client notes when specific information does not relate to a particular client. I found that electronic systems require professional judgment and care in order to record client data accurately and completely.

JILL: Good points Mark! A couple of other issues have been identified with electronic health records. From a legal standpoint, communication between healthcare providers has been inadequately documented in electronic records. Some researchers have even suggested that electronic documentation creates distance between care providers and decreases time spent in caring for clients.

MARK: So no recording system is perfect for all applications! They each have their advantages and downsides. I believe this is what we are going to discuss next?

1.6 Advantages

Narration

JILL: That's right. Mark, why don't you highlight the most commonly touted advantages of electronic documentation systems?

MARK: Okay. Electronic recording usually speeds up the time required to document and improves accuracy and legibility. This advantage is debateable if the care provider does not know how to use the electronic system correctly.

Electronic systems reduce reliance on a care provider's memory as client information can often be completed in real time. Sometimes electronic documentation is done at a specific computer station or at a central location right after the care has been completed.

Electronic documentation systems have the ability to reduce redundant information and prevent recopying of the same client data. Computerized systems permit health care providers who care for a specific client to enter updated data so, other health care team members are immediately informed of changes.

Many computerized systems assist in the standardization of care by providing specific pathways and formats for entering client information.

1.7 Advanced Features

Narration

JILL: Electronic systems may have other advanced features. Most systems incorporate the nursing process. These systems may be interactive and prompt you with questions about assessment data and follow-up of the information that you entered. Some interactive systems require you to enter a brief narrative, while others demand a full narrative on client notes.

There may be mandatory reporting fields for assessment data that ensure that the care provider does not omit these. Some programs contain algorithms that guide a care provider through the nursing process to document client centred care.

Some programs allow a care provider to update prescriptions or these may be done automatically when the physician changes a prescription.

There are software programs that have a discharge plan for health care services. Others have teaching components that assist care providers with clients who are in care or are being discharged from care.

1.8 More Features

Narration

MARK: It is important to remind people that no matter how sophisticated the electronic health records system is, the computer can guide you, but will NOT make the clinical decisions for you!

JILL: That is a very important point that we need to stress Mark. I just want to finish our discussion with a few more advanced features some systems have. Employers track budgets, client outcomes and care needs electronically. Some systems also have management reports, staff scheduling, staffing projections, client classification data, accreditation business and research data. Some systems provide mandatory teaching modules for staff.

MARK: Yes, the touted capabilities of electronic health systems appear to be very impressive ... when they work, and if everyone knows how to use them. Personally, I will be impressed when these systems can make me a vanilla latte and order me a pizza when I'm hungry! (both laugh).

1.9 Challenges

Narration

JILL: Ah, obviously from your own experiences with electronic health systems, you have identified some problems … or rather challenges as we like to call them.

MARK: Sure have … want me to list a few?

JILL: Go for it!

MARK: Electronic or computer based systems are expensive to design, implement and maintain. Employing facilities or agencies have large departments dedicated to the maintenance of electronic records.

Electronic systems demand increased staff training that can add significantly to costs. In some systems, the care provider must have keyboarding skills and has to enter progress notes using a narrative format.

A healthcare provider who relies solely on electronic documentation may interact less with colleagues. This may reduce collaboration with other health care providers who may have verbal input to ensure quality client care.

Electronic systems may malfunction and routine maintenance may prevent the access of timely client information. If electronic systems malfunction, there must be a back-up system to record significant client information – usually it is the hand-written type.

As with any type of electronic technology, there are hackers who may violate client confidentiality or who can actually disrupt huge systems and steal, erase or alter essential client data.

Electronic health systems are constantly being upgraded. Since there are new and improved technological innovations every year, it is a challenge for health care providers to keep up.

JILL: These are certainly the major disadvantages. However, there still one more concern that we need to mention … confidentiality!

1.10 Confidentiality
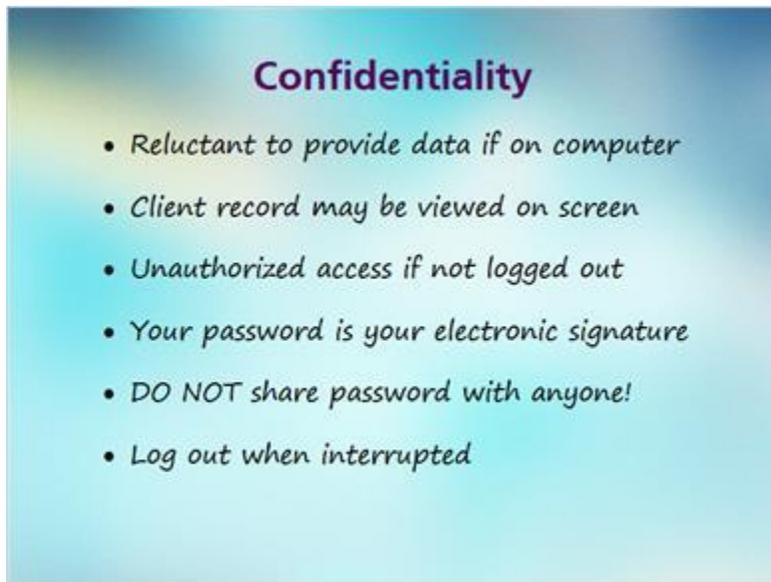
Narration

MARK: Yes, the confidentiality of client data must be protected in electronic systems just as fiercely as with paper systems. The problem is that there are a few new wrinkles with electronic systems.

JILL: Protecting client confidentiality is a major issue for health care providers who document electronically. Some clients may withhold essential information from care providers, if they know that their personal information will be entered into a computer.

If precautions are not taken, a client's record remains open for others to view on the screen until the care provider logs off manually or a time-out feature automatically closes the record.

Unauthorized persons could gain access to client records if a care provider forgets to log off, not just close off the screen.

A care provider's password should not be known or used by anyone else – your password is your electronic signature. NEVER share your password!

The computer screen should not be viewed by anyone who is not directly associated with the client's care. This includes visitors or those who may be passing by. It is important that you log off when you have completed a client entry or have retrieved client information or have been interrupted and must leave the computer.

1.11 Best Practices

Narration

JILL: Let's now look at a few best practices with electronic systems. Mark, why don't you do these?

MARK: Sure thing. As with traditional client records it is important that the right client record is retrieved for recording.

Save your entries when documenting electronically. There is nothing worse than spending 20 minutes documenting, and then forgetting to save and having to do it all over again!

Remember to follow your agency's policies and procedures when making corrections electronically. Documentation errors can be corrected before storage on the computer; however, once the information goes into storage, the information becomes permanent. In many programs, the incorrect information is corrected similarly to paper-based documentation.

Since computer systems break or are often down for maintenance, know and follow procedures to access client data in these circumstances.

JILL: Thanks Mark. Those are some very important things to remember when working with electronic health records. Let's go on to a somewhat controversial topic … the use of mobile devices in health care.

MARK: Okay, this is going to be fun.

1.12 Mobile Devices

Narration

JILL: Mark, do you have a smart phone or a computer tablet?

MARK: Sure do … I have both and use them a lot. Doesn't everyone?

JILL: Not yet Mark. There is still controversy whether mobile devices should be permitted while care providers are on active duty. If you are using these devices, you must be clear on the personal and professional expectations and consequences.

MARK: Yes, I noticed that the rules for use of these devices were different at the various locations where I have worked.

JILL: Depending on the facility and healthcare environment, mobile devices may assist in timely and safe quality care. Some employers encourage you to use your own personal devices, while others provide mobile devices that you may use while on the job.

Mark, have you used your smart phone on the job?

MARK: Yes, I have. I have used it to look up medications that I have to administer but am unfamiliar with. It also has a calculator that I sometimes use to check on calculation of dosages. Using your phone is a lot easier than looking it up in some book. If these devices are so useful, why doesn't everyone use them?

JILL: There are several concerns about using mobile devices. As with any type of technology, there are major issues surrounding breaches of client confidentiality. If encryption of client information is not used, unauthorized individuals may have access to confidential information.

Mobile devices are targets for thieves and may be stolen. This may result in breaches of client confidentiality.

There are infection control issues when mobile devices are shared in a workplace setting.

These devices have potential for abuse; they can become time wasters and distract you from performing safe and quality client care.

MARK: You mean like texting my girlfriend and mother when I'm at work, or checking the sports scores? I ONLY do that when I am on my breaks.

JILL: Sure Mark, if you say so. (giggles).

1.13 Key Points
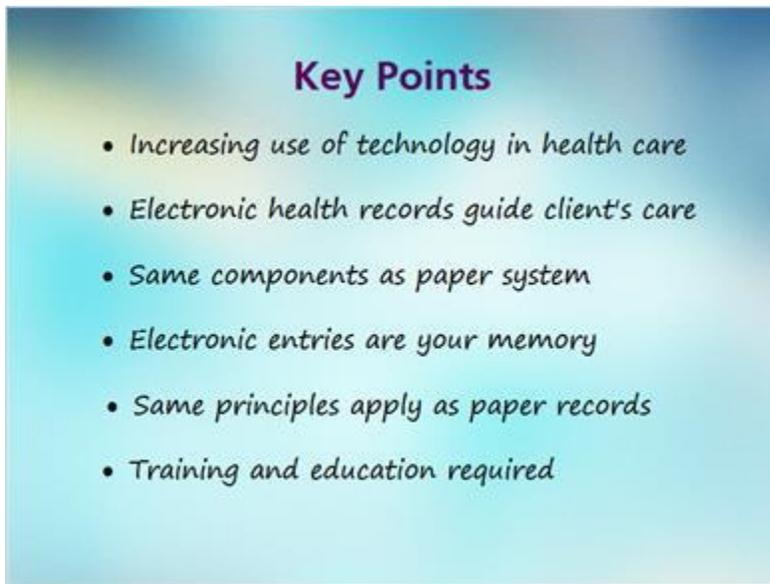
Narration

JILL: This brings us to the end of this module on electronic documentation. Would you summarize the key points?

MARK: Okay. Healthcare organizations using technology for input and retrieval of client information are on the increase.

An electronic record contains the same components as a traditional or paper based health record.

Your electronic entries on client care are your memory.

Principles of paper-based documentation apply to electronic documentation for both input and retrieval of client data.

It is your responsibility to become educated and trained in the electronic system your employing facility or agency uses.

1.14 Key Points 2
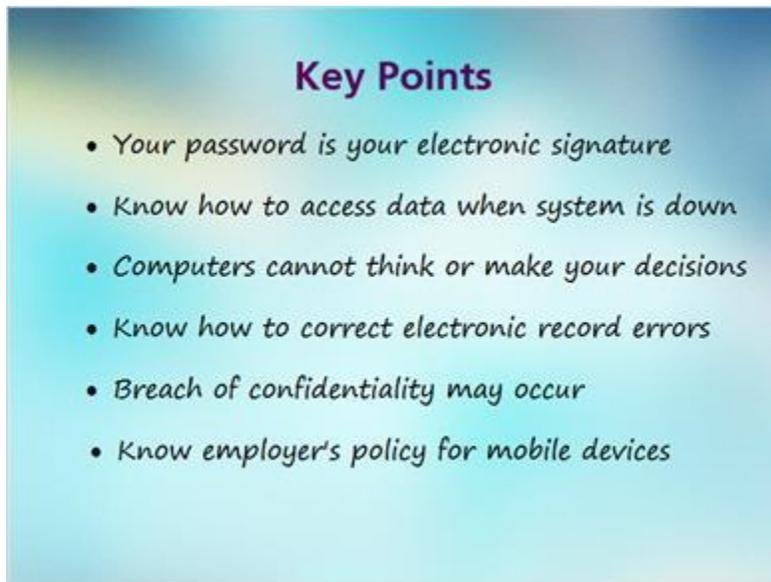
Narration

MARK: Continuing on … Your password is your electronic signature – log off when finished your documentation or if you are interrupted.

Know the back-up system your employer uses in case of systems failure or times for scheduled computer systems maintenance.

Computers cannot think and do not make clinical decisions for you; they can only assist you to make decisions.

Know your employing facility or agency policy for correcting electronic documentation errors.

Breach of confidentiality may occur if a monitor is left exposed or if you are viewing another client's records when you are not assigned to care for the client.

Be sure of your employing facility or agency's policies when using mobile devices in your workplace.

JILL: Well done as usual.

1.15 Reflection
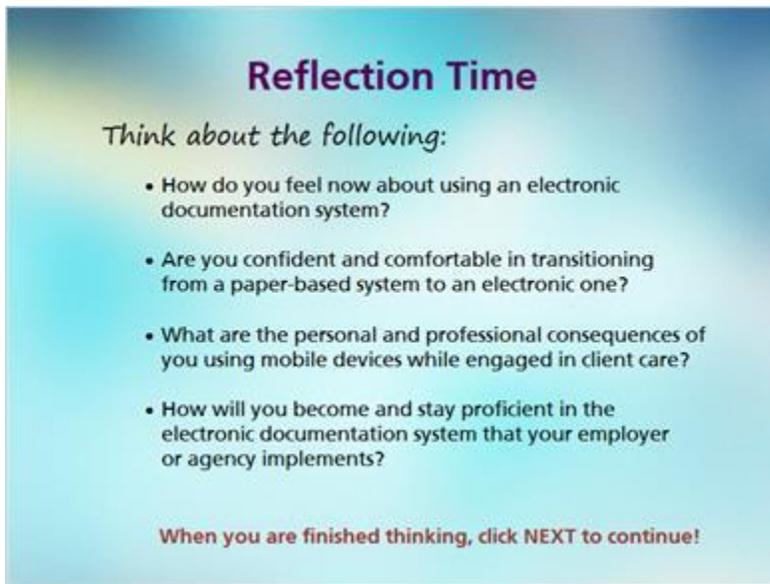
Narration

JILL: Before we go, we would like to remind you to reflect on the questions on this slide. When you are done thinking, click on Next to continue.

Also, since this is the last module in this nursing documentation course, we would like to encourage you to take advantage of the other learning activities, quizzes and exercises. The more you practice, the better you will become at accurate documenting.

MARK: Well Jill, it been great working with you. I have learned so much about how to accurately document health care. Take care and I hope to work with you again soon.

JILL: Thanks Mark. I'm glad you found the course helpful. Bye.

1.1 The End

Narration

No narration … music only.