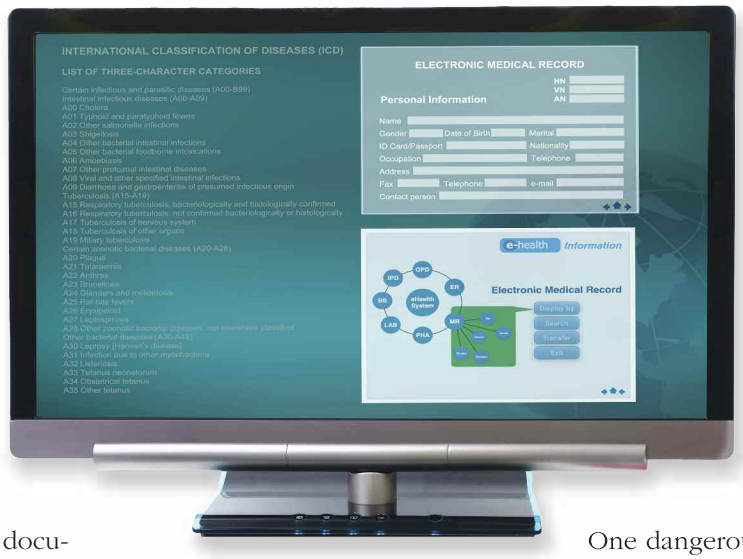
What you need to know about electronic documentation

By Lori A. Catalano, JD, MSN, CCNS, PCCN

ELECTRONIC HEALTH RECORDS (EHRs) are here to stay. Beginning January 1, 2014, all public and private healthcare providers were required to adopt and demonstrate "meaningful use" of EHRs to remain eligible for Medicare and Medicaid reimbursement. The "meaningful use" provision contains criteria that must be met, including adoption of an electronic documentation and billing system and increased engagement by patients in their care.

Healthcare providers must enable patients to be engaged electronically by giving them access to their health records. Termed electronic personal health records (PHRs), these documents enable patients to see their diagnostic test results, send messages to providers, and make appointments. Nurses in hospitals and other healthcare facilities not only must be able to use EHRs effectively but to assist patients in using PHRs.

To use electronic health records appropriately, you'll need to adopt several new practices.



New practices to get used to

Now that you're dealing with EHRs instead of paper documentation, you'll need to adopt new practices. Most importantly, be aware that an electronic record of everything you document now exists, and you can't make it go away. If you accidentally document for the wrong patient, you can't simply start over on a new piece of paper or a new form. With many electronic documentation systems, you'll need to delete every piece of information entered individually; you may not even have the option to delete an entire column or line. If you document incorrectly, a record of it will always exist, so make sure you accurately explain why you had to delete something in a patient's EHR. (See *Tips on electronic documentation*.)

Secondly, remember to document in all applicable windows or tabs. Although many facilities make a tremendous effort to mimic their old paper documentation system, you still need to look for all the forms you used to complete. In the worst-case scenario, if you're called to testify about something that occurred for which you forgot to complete a form, the implication is that you've forgotten other things, too. Legal professionals look for blank or incomplete portions of the EHR to imply that care wasn't given.

Remember the old rule about drawing lines through blank spaces? With EHRs, you still need to put something in a blank space. Input "N/A" if that space isn't applicable. Or if "Denies" or "Not observed" is more accurate, use one of those terms.

Perils of copying and pasting

One dangerous convenience of electronic documentation is the ability to copy and paste previous documentation into the present column or note. *Avoid doing this at all costs.* Many nurses think it saves time because they can simply review and change anything that's different. But copying someone else's documentation is risky because you may fail to change everything that needs to be changed. Also, documentation systems are now being changed so they can track use of the copy and paste function. Remember—legal professionals will look for anything that could imply you didn't give care or you gave it poorly. If you take shortcuts when document-

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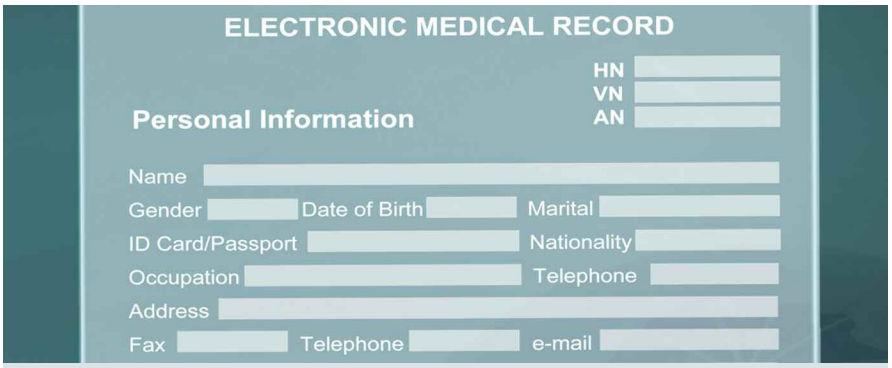

Tips on electronic documentation

- As with paper records, always document everything, remain objective, and avoid unapproved abbreviations.
- Make sure to document in the correct patient's record.
- If possible, document in real time to avoid late entries.
- Don't leave anything blank. Use "N/A" to indicate you looked at the item that was supposed to be documented there. Or write "Denies" or "Not observed" to indicate you asked about or assessed that item.
- Double-check your entries. It's much easier to click on the wrong box accidentally than to manually checkmark the wrong box.
- Never copy and paste someone else's documentation—and never copy and paste your own unless you're absolutely sure nothing has changed.
- Use barcodes on both patients and medications. Don't take shortcuts and override barcodes except in a true emergency.

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ing, they'll argue this implies you also took shortcuts in your care. The only situation in which you can copy and paste is if your documentation system lets you copy and paste diagnostic results into a progress note.

Old truisms that still apply

Don't forget basic rules about documentation, especially "If it wasn't documented, it wasn't done." This applies to electronic charting. Also, avoid using unapproved abbreviations. Although many abbreviations originally were unapproved because of legibility issues, they remain unapproved even though legibility is no longer an issue. Be aware that with EHRs, abbreviation use can be monitored and addressed. Also know that some abbreviations aren't official (such as "SOB" for "side of bed") and can be confusing, so avoid them.

Finally, make sure your documentation is always objective and doesn't impute negative behaviors or traits to your patient. ✭

Selected references

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