Department: Health Information Management (HIM)	
Policy Number: HHS-4113-HIM	Attachments:
Policy Title: Documentation Guidelines for	r EHR
Date:	
Approved by: (laling thus	Date: 3/18/13
Policy Statement:  Mille Lacs Band Health Services recognize  procedures concerning a complete, accurate a	e the importance of establishing policy and

## POLICY:

The EHR content shall be in compliance with standards established by AAAHC (Accreditation Association of Ambulatory Health Care) and AHIMA (American Health Information Management Association) and shall also comply with requirements in third party payment programs or with licensure requirements of special programs. All patient care documentation will be entered by provider data entry, transcription, voice recognition software and document scanning (when available). Electronically stored patient information is subject to the same medical and legal requirements as the handwritten information in the health record.

## **DEFINITION OF TERMS:**

Health Record: the chronological documentation (paper or electronic format) of health care and medical treatment given to a patient by professional members of the health care team. It is an accurate, prompt recording of their observations including relevant information about the patient, the patient's progress, and the results of treatment.

## PROCEDURE:

- The health record will contain sufficient information to identify the patient; justify diagnoses and treatment; document results of care or treatment; describe the condition of patient upon discharge; and document instructions to the patient regarding followup care, activity levels, and necessary medications.
- Entries must be accurate, relevant, timely and complete.
- Irrelevant text needs to be omitted. Concise notes are more readable than lengthy notes.
- Appropriate note titles must be matched to note content and the credentials of the author. This enhances the ability to find a note more quickly and easily.
- Notes must be reviewed and signed promptly.
- Viewing of unsigned notes is allowed by pharmacy only due to the risk of clinical decision-making based on data that may be changed or deleted. Other limited access to unsigned notes may be determined by local policy.
- EHR users must respond quickly to notifications, which prompt them of documents requiring authentication or additional information.
- The electronic function of copy and paste must be used with caution and according to strict and enforceable policy.

- Never copy the signature block into another note
- Never copy data or information that identifies a healthcare provider as involved in care that he/she is not involved in
- Do not copy entire laboratory findings, radiology reports and other information in the record verbatim into a note. Data copied must be specific and pertinent to the care provided
- Do not re-enter previously recorded data.
- Authentication includes the identity and professional discipline of the author, the
  date, and the time signed. Notes made and authenticated by health care team
  members must be individually identified either by the use of the individual's title, or
  by the appropriate credential designation. On affixed, authentication on electronic
  documents cannot be rescinded or retracted.
- No edit or alteration of any documentation or electronic signature, which has been completed, can occur without approval of the HIM department.
- The author must initiate any retraction or rescission of any entry or originating discipline, i.e., laboratory and radiology are examples of disciplines that may initiate retractions or rescissions within their packages.
- An addendum to a note is made when a healthcare provider deems it necessary to clarify information recorded in the original document or to add to the original document.
  - Addenda are linked to the original created document;
  - Addenda must be authenticated in approved manner; and
  - Addenda must note be backdated.

## ATTACHMENTS:

REFERENCES:

RECISSION:

**DISTRIBUTION:** All Staff