Standard of the Month - December 2020

Documentation/Electronic Health Records

As hospitals across the country move towards electronic documentation/electronic health records (EHR), we have received questions from our members on how the ORNAC standards apply to this form of documenting the care provided. Standards relating to documentation in general, and electronic documentation specifically can be found in Section 3, 3.20 *Perioperative Nursing Documentation* (2019 - 14th edition). Additionally, documentation requirements for specific care interventions (e.g., Surgical Counts, Drains, Dressings, and Positioning) can be found in the applicable section. Here are some answers to frequently asked questions to the Standards Committee.

When transitioning to electronic documentation, what are some important considerations?

- There are several options for EHR platforms available. Selection of the platform for your organization should be a team decision, with representation from all stakeholders including, but not limited to; perioperative nurses, site leadership (OR Manager and/or Director), risk management and information technology representatives (3.20.18).
- Features of an EHR that must also be considered include; compliance with legislation (3.20.15); ability to capture the same information as with paper documentation (3.20.17); and the inclusion of auditing capabilities (3.20.22).
- Organizational documentation policy and procedures should be developed that address, among other things; the process for correcting or reconciling charting (3.20.24); downtime procedures (3.20.27); and authentication of electronic signatures (3.20.25).

What is the recommendation around count sheets? Is electronic documentation of the count itself acceptable (provided the EHR has that capability), or should counts continue to be documented on paper?

Count sheets need to be included as part of the patient's health record, whether that is electronic or paper based (Standard 3.15.39). Documentation of counts must be completed at the time of counting, during designated counts (initial or closing), or when countable items are added to/removed from the field. If the EHR platform is capable of performing all required documentation, and there is a device that would physically permit concurrent visualization and documentation (computer on wheels, or tablet vs fixed computer station away from the field), then electronic documentation of the count may be possible. When this is not possible, documenting counts in real time can be completed on a paper form which remains in the patient's chart and, depending on the organization, may be scanned into the EHR upon completion of the surgery or at discharge.

Whether the organization was an early adopter of the EHR or is new to electronic documentation, it is important to remember that electronic documentation is still documentation. It is essential that documentation is factual, accurate, and contemporaneous (3.20.5) as it is the legal record of care provided.