



Documentation of Others' Work in the Electronic Health Record

Q When documenting care in the electronic medical record that someone else has provided, what is the responsibility of the person providing the care in documenting that he/she actually provided the care that someone else documented he/she did? Cosign? Progress note?

A Linda Harrington, RN, PhD, CNS, CPHQ, CENP, CPHIMS, Lynn Choromanski, RN-BC, MSN, Nancy Biddle, RN, MSN, and Kimberly Acosta, RN, BSN, reply:

To answer this question, we will provide a few definitions and case

Authors

Linda Harrington is vice president for advancing nursing practice at Baylor Health Care System, Dallas, Texas. Lynn Choromanski is a nursing informatics specialist at Gillette Children's Specialty Healthcare in St Paul, Minnesota. Nancy Biddle is a clinical analyst at Robert Wood Johnson University Hospital in New Brunswick, New Jersey. Kimberly Acosta is an informatics resource nurse at Baylor Regional Medical Center at Grapevine, Texas.

Corresponding author: Linda Harrington, RN, PhD, CNS, CPHQ, CENP, CPHIMS, 407 Andora Court, Dallas, TX 75287 (e-mail: linda.harrington@baylorhealth.edu).

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examples with screen shots, and we will discuss applicable law, standards, and guidelines. The answer is in part dependent upon hospital policy and the design of the electronic health record (EHR) being used.

The following definitions are important to understand when answer-

ing this question.

Authorship: attributing the origination of specific EHR content to a specific individual at a particular date and time.¹

Attestation: the act of applying an electronic signature to content in the EHR, demonstrating authorship and legal responsibility for a particular unit of data or information.¹

Electronic dual signatures, cosignatures, countersignatures: additional authorship signature(s) in situations when regulatory, law, facility policy, or clinical preference require multiple attestations on a particular unit of data or information.¹

Key to each of these definitions is the concept of "authorship." The pertinent question deals with authorship of EHR data by persons other than the actual individual providing the care. More specifically, the question posed addresses whether documentation is the sole responsibility of the person who provided the care or

whether attestation is an acceptable solution to clinical situations where direct authorship is not possible. These situations can arise for several reasons.

Case 1

A nurse has forgotten to document a medication. She goes home and calls back to ask the nurse who followed her to document it for her, as she will not be back to work for a period of time. In this or similar cases, nurses can document medications, tasks, or assessments done by others, if hospital policy permits. The user who is documenting is able to select the person for whom they are documenting by selecting "Mark as Done by Other." This process occurs only if the documenting nurse is certain the event was completed and certain of who completed it. The nurse providing the care will be alerted upon returning to work that a task or a document is ready for an electronic signature in a portion of the application called Signature Manager. It should also be noted that the documenting nurse should not select "Mark as Not Done" unless absolutely certain the medication, task or assessment was not done (Figure 1).

Case 2

Under a different EHR design, nurses are able to use an option

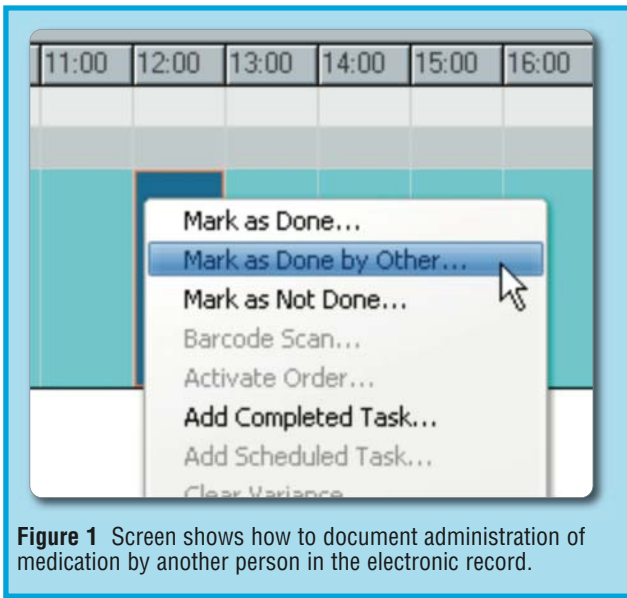


Figure 1 Screen shows how to document administration of medication by another person in the electronic record.

the “File for User” option within the screen and selects the name of the nurse who completed, in this case, the assessment. In the electronic audit trail, the name of the authoring nurse and the nurse who was selected in the “File for User” field will be attached to

then cosigns the documentation of the person who originally documented the care (Figure 3). The nurse may also refuse to cosign if for some reason the information entered into the EHR is not correct, in which case hospital policy and procedure would dictate next steps for correction or retraction.²

It is important to note that if the information is being entered into the EHR by one nurse based on paper documentation by another nurse used during EHR downtime, the paper documentation remains a part of the legal record.

called “File for User.” This option is available in a similar case where a nurse leaves the hospital without charting an assessment or a medication. The other nurse authoring the data for his/her colleague chooses

the data entered (Figure 2).

Case 3

In this case, a nurse has authored a task performed by another in the EHR. The nurse providing the care

Discussion

Federal regulations require each author take a specific action to verify and attest an entry into the medical record.¹ The Medicare Conditions of Participation for Hospitals Section

482.24 of the Code of Federal Regulation states, “All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.” The hospital is

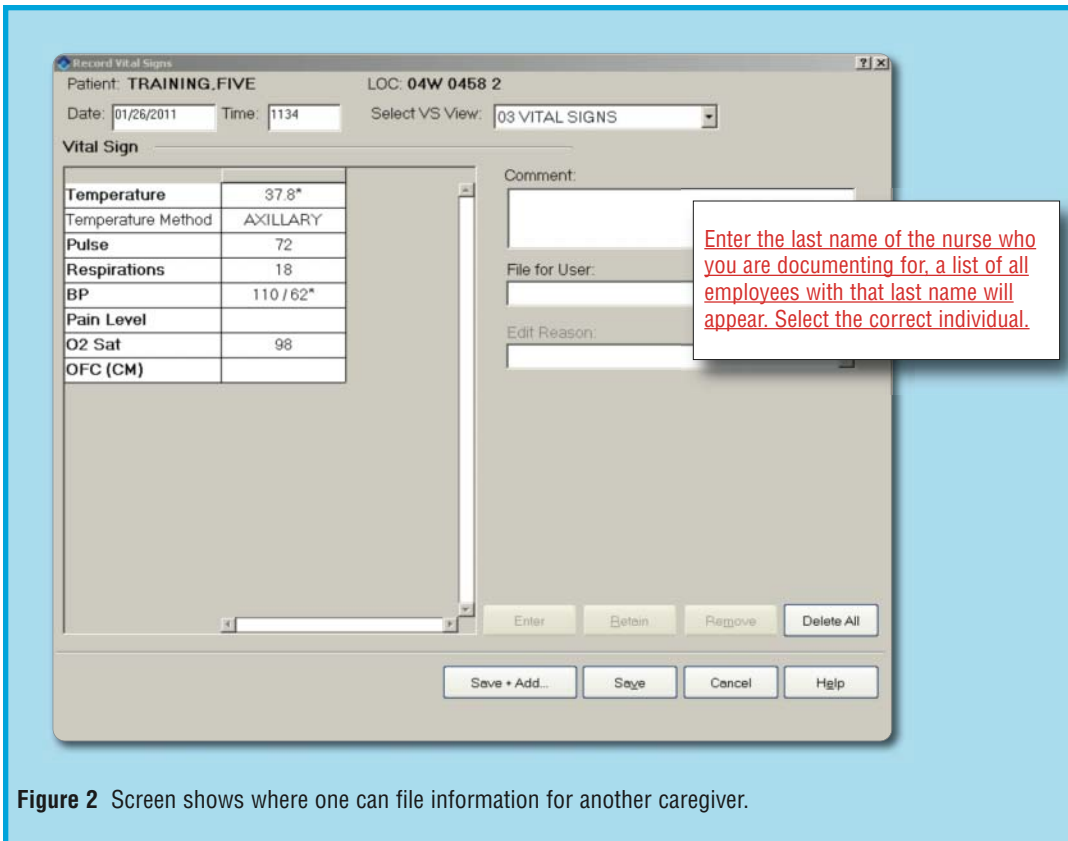


Figure 2 Screen shows where one can file information for another caregiver.

Route	by mouth
Form	powder for reconstitution
Early/Late Reason	
Comments	Administered by Nurse Ann prior to patient transfer.
CoSignature	SMITH, ANN
Performed By:	SMITH, ANN (RN)
Entered By:	Acosta, Kimberley A. (RN)

Should include the date performed and the date authenticated by the person who performed it.³

Figure 3 Screen shows authorship and cosignature.

required to have a policy that requires each author take a specific action to verify that the entry authenticated in the EHR is his or her entry or that he or she is responsible for the entry and that the entry is accurate. There may be additional state laws that should be considered.

In addition to applicable law, regulatory standards should also be considered when developing policy and procedures related to documentation in the EHR. No current Joint Commission standards address the issue of nurses documenting or authoring data in the EHR for another individual providing the care. This situation was verified in a response from the Joint Commission to a question posed on their online standards question form (<http://www.jointcommission.org/about/contactus.aspx>).

The American Health Information Management Association (AHIMA) provides helpful guidelines for developing a legal health record policy that take into consideration electronic health records.⁴ AHIMA acknowledges that at times the original documentation of care may be performed by a person

other than the person providing the care. Their advice is that hospital policy should indicate when this is appropriate and how it will be handled considering the functionality of the hospital's unique EHR. Similar to the Centers for Medicare and Medicaid Services, AHIMA also advises adherence to applicable state laws.

Conclusion

Facilities with an EHR should have a clearly written policy and procedure that describes the process for authoring information on care provided by another clinician and the follow-up documentation required of the person providing the care. AHIMA provides excellent resources to assist in the development of such policies and procedures.⁴ Persons providing care should take responsibility to ensure that the care is appropriately documented. How this is accomplished will depend on hospital policy and the features of the EHR being used. **CCN**

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Financial Disclosures
None reported.

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