



North Carolina Department of Health and Human Services
Division of Public Health

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TO: Local Health Directors and Directors of Nursing

FROM: Phyllis Rocco, RN, BSN, MPH
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SUBJECT: Guidance on Electronic Documentation

My office has received multiple questions related to documentation in Electronic Medical Records (EHR). Local Health Departments (LHD) need to assure their EHR is compliant with the following documentation guidelines.

EHR system capability must allow for capturing the necessary documentation to assure that the **information/data entry process** captures the information/data in a manner that supports quality patient care, and meets billing and licensure requirements. The process should be outlined in policy and procedure.

1. Documentation by Ancillary Staff (includes: RNs, LPNs, Interpreters, MOAs, CHAs, Health Educators, Social Workers, Administrative Staff, etc.)

If you use ancillary staff to enter data such as from a self-history form into the EHR, you must assure the following:

- **There is a policy** in place which specifically supports the entry of history information into the EHR by ancillary staff and outlines the information/data entry process as well as the process by which initial and ongoing competency for this skill will be verified. It must be clear that ancillary staff is transcribing the patient generated information/data on a form into the EHR.
2. Documentation by Providers (RNs, ERRNs, Mid-level providers and MDs)
- **There is a policy** in place which mandates that providers not only review the history entered by ancillary staff but expand upon or amend the data when necessary to assure it is accurate and that the provider will sign his/her name and credentials. It must be clear from the documentation that the provider has not only reviewed the data but has utilized that information in providing care to the client.

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3. Documentation Principles and Data Linkages:

- **Documents should be scanned into the EHR as soon as possible.** LHDs should have a policy which states when the documentation of the visit is to be completed, i.e. within 24 hours and should include the timeframe inclusive of scanning of documents in order to have a complete record of the visit.
- **All scanned documents must contain** at least two patient identifiers, the date of service, the signature of the person(s) completing or reviewing the document and discipline credentials if applicable.
- **NCIR information must be linked to the visit.** If using HIS, LHDs should note in HIS that an immunization was given (include type of vaccine) and note, “see NCIR report XX/XX/XXXX (date immunization given).” There is a hyperlink within the HIS **EHR** that will connect the user with NCIR. For LHDs that purchased proprietary EHRs, an internal decision will need to be made to determine a consistent location (e.g., progress notes section, problem list, medication list, etc.) for documenting that a vaccine was administered and assure policies and/or procedures reflect the process. LHDs using proprietary EHRs will need to check with their vendor in order to assure the LHDs documentation process is compatible with how the vendor has configured their system in order to comply with meaningful use.
- **Some screening tools are copyrighted and cannot be embedded into the EHR without specific license.** For example, the Parents Evaluation of Developmental Status (PEDS) screening tool forms are copyrighted and must be purchased for use with each child and cannot be reproduced in house without permission. Parents may complete the paper copy of the PEDS Parent Questionnaire tool and the RN/Provider can complete the PEDS Score/Pathway form. The responses from the parent questionnaire and/or score and pathway can be entered into the EHR template without violating the copyright since the LHD will have purchased the paper copies. If the agency is entering the results of the screening test only (not all components of the screening tool completed by the parent) the notation in the EHR needs to include the name of the screening tool, the score and developmental domains or areas of concern, if identified, not just merely, “developmental screen within normal limits.” If you have questions about the process and how to best document these services, please contact your regional Child Health nursing consultant at:
<http://www.ncpublichealthnursing.org/CHNCMap092214.pdf>.
- **All providers (e.g., Physicians, Mid-levels, RNs, LPN, Interpreters, Ancillary staff, etc.) must document the services they provide using their name.** Within the EHR, there must be a link between medical record information entered and the provider who delivered the service. For example, if a Rostered Enhanced Role RN provides a prevention visit to a child and discovers a problem that requires a higher level provider to examine, such as a MD, you must be able to differentiate between which portions of the visit the Rostered Enhanced Role RN provided and which portion of the visit the MD provided. This is also true when a RN supports a MD by providing the history portion of the visit while the MD provides the exam portion or when a MD is co-signing a fellow or resident’s work.
- **Documentation must be clear that the ERRN is practicing within his/her scope of nursing practice.** When the NP/PA/MD sees a patient following a request by the Enhanced Role RN (ERRN) regarding a problem identified during the patient’s visit, the higher level provider should document their assessment, diagnosis and plan. If the NP/PA/MD is consulted but does not assess the client face to face, the ERRN must document who s/he consulted with and the verbal orders for next steps/plan of care. The NP/PA/MD must sign off on the verbal order within the timeframe established by the agency.
- **Providers MUST have access to previous paper and EHR systems in order to adequately treat the patient.** Frequently on audit, it is noted that a patient visit was documented in the EHR but no supporting documentation is evident as to why the patient was

treated for a particular condition. For example, a patient comes in for a visit and the provider only documents, “patient is doing well on medications” and “medications refilled for three months.” There were no other records from previous provider visits, or reflected in the current visit notes to support the diagnosis or the renewal of medications in the EHR, or the history was not readily available for the provider to review during the visit (i.e., not scanned, but kept in a separate file to be scanned or in a “paper portion” of the chart.) Each diagnosis or clinical impression must have documentation on the day of each service to support the diagnosis and plan of care.

4. Quality Improvement and Medical Record Audits

- **Medical record audits** should be performed on a regular basis to assure correct coding, billing and documentation practices are in place and are being followed by staff. This process should be outlined in policy and should cover all programs. This is particularly important to do within the first three months of implementing the EHR to make sure staff is documenting all requirements. If you have questions about this process or need coding and billing auditing resources, please contact your PHN&PD Unit Nursing Consultant or visit: <http://publichealth.nc.gov/lhd/>

Guidance References:

The Department of Health and Human Services, Centers for Medicare & Medicaid Services, Medicare Learning Network - Evaluation and Management Services Guide (December 2010) references the need for a date and legible identity of the observer as principles of appropriate documentation.

The NC Medical Board has a position statement (Medical Record Documentation Created: May 1, 1994, Modified: May 1996 and 2009, Reviewed: May 2013) which states, “All entries in the medical record contain the author’s identification. Author identification may be a handwritten signature, initials, or a unique electronic identifier.”

The NC Administrative Code governing Nursing Practice, NCAC 21 36 .0224 and .0225 addresses the documentation requirements for Registered Nurses and Licensed Practical Nurses. Interpretation by the Board of Nursing supports requiring nursing staff to document the care nurses provide by using their name.

Resources

- CMA
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>
<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/gdelinesteachgresfctsh.pdf>
- American Academy of Family Practice Physicians
http://blogs.aafp.org/fpm/gettingpaid/entry/here_s_your_sign
- NC Medical Board
http://www.ncmedboard.org/position_statements/detail/medical_record_documentation
- NC DHHS/DPH
<http://ncpublichealth.info/lhd/>
- Public Health Nursing and Professional Development Unit Consultant.
http://www.ncpublichealthnursing.org/phn_dir.htm
- The NC Administrative Code governing Nursing Practice, NCAC 21 36 .0224 and .0225
<http://www.ncbon.com/myfiles/downloads/administrative-code-rules.pdf>