**AORN Recommended Practices for Perioperative Health Care Information Management**

**Recommendations V-IX Summary and Review**

* **Recommendation V:** *Patient care information must be secure, held confidential, and protected from unauthorized disclosure*
1. HIPAA guarantees the privacy and confidentiality of patients and their identifiable health information through security standards for protecting electronic health information
* Access should be limited to authorized individuals based on health care role
* Perioperative management policies/risk-reduction strategies to mitigate access violation include remote access protocols, time-out exit strategy from the EHR, limited access and identifying procedures with the use of mobile devices
* Access should be achieved through individualized authorization credentials that are both time-sensitive passwords using alpha-numeric-symbol combinations
* Perioperative staff are prompted through the EHR operating system security to change password every 90 days
1. Perioperative staff should be familiar with the health care organization’s information policies before sharing patient information
* Validation occurs for original source authenticity and the accuracy of transmitted information (via fax, email, mobile storage media etc.) as well as evaluation for potential corruption
* Perioperative staff are to assure a signed consent for release of information in the EHR
1. Documentation in the patient’s EHR must include an authentication process at the completion of documentation according to organization’s established policies.
* The EHR must accurately reflect the patient’s care experience and be signed promptly to ensure the integrity of the content
* Perioperative staff verify the intra-operative chart using an electronic/digital signature utilizing their unique alpha-numeric-symbol password as a legal representation or a written signature for the EHR
* Countersignature facilitates accuracy of content entered in the EHR and indicates responsibility for interventions performed and collected *(consider adding this for precepting purposes?)*
1. AHIMA recommends retaining operative indexes for a minimum of 10 years and the register of surgical procedures for permanently.
2. EHR documentation platforms should have an alternate data entry and backup process
* Downtime planning should incorporate strategies to facilitate an uninterrupted patient care schedule and identify changes to existing work flows
* Perioperative staff should be aware and educated on location and flow of paper form documentation, paper order forms and clinical resources available in downtime situations
1. Perioperative staff with EHR access and responsibilities should receive ongoing education on P&P, alternate work flow issues and technology performance assistance
* **Recommendation VI:** *Modification to existing content in the patient health care record must comply with relevant federal and state regulations, health care accreditation requirements, and national practice guidelines. Amendments, corrections, or addendums to the patient care record should only occur to present an accurate description of the care provided or to protect the patient’s interest*
1. The EHR is a legal document which represents the services provided to the patient. Staff are obligated to accurately represent the interventions provided to the patient’s care within the chart
* The organization’s information management policy should outline the process to make legally acceptable modifications through corrections, amendments, and addendums in the EHR
* The EHR should contain versioning or correction function to identify the alterations made to an entry with authentication/signature, symbol or notation to identify when an alteration has been made by creating a new version or retain and link the original document to the newly created version
1. After final signature, corrections will comply with established organizational policies and procedures
* Addendums are to be completed where the original documentation occurred when available and should be reflected in the permanent record
* Addendums within the intra-operative chart should be re-verified by the perioperative nurse to ensure a new version of chart is recorded
* Deletion or retraction of data from a closed/verified EHR must be made according to organizational policies and procedures
* **Recommendation VII:** *Perioperative personnel should receive initial and ongoing education related to accurately documenting patient care and should demonstrate competency in documentation processes and best practices to maintain security and privacy of patient care information*
1. Initial and periodic competency-based education modules should be readily available to maintain proficiency in the application and knowledge of the HER documentation platform
* Competency of perioperative staff utilizing the documentation platform improves the effectiveness of documentation practices and reinforces strategies to avert unintentional disclosure of patient health information
* Perioperative nurses should have a knowledge of the significance overview of the PNDS and contributions of the PNDS to perioperative nursing practice and patient outcomes
* Minimum education should include national and organization documentation standards, guidelines, and requirements as well and procedures for completing amendments, addendums and corrections, accessing and closing the EHR, information system functionality, authentication processes and downtime procedures
* Perioperative personnel should acknowledge how standardized documentation facilitates benchmarks, comparative analysis and efficiency reporting
* **Recommendation VIII:** *Policies and procedure related to perioperative information management should be developed, reviewed annually, revised as need to accommodate changes in practice and documentation standards, and be readily available in the practice setting*
1. P&P establish authority, responsibility and accountability to minimize patient risk factors, direct care, establish guidelines for performance improvement and standardize practice
* The perioperative information management policy should complement and reinforce organization wide policies on documentation but should also include unique considerations for the specialty care setting of the perioperative environment
* **Recommendation IX:** *A quality management program should be established to ensure the integrity of the data within the patient within the patient health care record*
1. Regular monitoring documentation processes is necessary for variance reporting, supporting process and performance capacity of effectiveness and nursing influence on patient outcomes
* Perioperative staff should participate in organizational clinical documentation improvement program (CDI)
* CDI program facilitates data and collection analysis while providing structured framework to achieve consistency in quality process that affect patient satisfaction, accreditation standing and reimbursement status
1. Criteria to be reviewed in CDI programs should include use of unacceptable abbreviations, use of vague or generalized language, blank space/data fields, content omissions, timeliness of documentation/delayed entries, inconsistencies, inappropriate information, absence of signatures or counter-signature or alterations to clinical content.
* Routine audits should be performed as part of a quality-driven information management policy/program.
* Audit trails should be retained and placed on a schedule for needs of the organization.
* Auditing procedure help to establish user and organizational accountability for the legal integrity of the patient EHR