

CORRECTIONAL MANAGED HEALTH CARE POLICY MANUAL	Effective Date: 4/7/2017	NUMBER: H-60.4  Page 1 of 4
	Replaces: New	
	Formulated: 1/17 Reviewed: 1/18	
<b>UTILIZATION OF THE ELECTRONIC HEALTH RECORD</b>		

**PURPOSE:** Provide guidelines for the utilization of electronic records including the method, timing, and correction of entries as well as providing guidelines for the security of the electronic health records.

**POLICY:** Electronic Health Records will be utilized and secured in a manner consistent with applicable guidelines.

**I. The Timing of Healthcare Documentation**

- A. The offender’s health record will be made available to the healthcare provider during encounters whenever possible.
- B. All services rendered by either hands-on or indirect care (e.g., radiological interpretations) must be documented in the patient’s health record on or about the time treatment is provided or observations are made by the appropriate health care provider.
- C. Late Note and Addendum
  - 1. Clinical entries will be made by the clinician during the writer’s shift.
  - 2. A late note is defined as documentation added to the offender’s health record after the care giver has completed the shift in which the documentation was required. All late notes must be designated “Late Note” along with the date and time of the original activity.
  - 3. If a completed note requires additional information and it is still within the writer’s shift, an addendum to the entry must be documented on a separate clinic note in the offender’s EHR. (H-60.1 attachment F).

**II. Content of Clinical Entries**

- A. Document Templates (Note Builder or Forms) in EHR may be added at the discretion and approval of the Forms Committee and the Joint EHR Clinical Working Group in order to maintain consistency across the entire enterprise. Document Templates should not be sector-specific and should allow for the expectation that patient care will cross sectors.
- B. Paste Templates used in the EHR should not be pre-populated with results of subjective or objective findings of a patient encounter.
  - 1. Personal Paste Templates should be approved by a user’s supervisor before being added to the EHR.
  - 2. Departmental Paste Templates should be approved by the Department Head(s).

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- C. Per Texas Medical Board rules, the health record should be “legible, contemporaneous and accurate.”<sup>1</sup> For this reason,
  - 1. Previous chart entries that are copied and pasted into a current note should be clearly identified as copied text with the original date and time of the entry at the beginning and at the end of the copied portion of text, however, this practice should be avoided.
  - 2. Forwarding text (“Copy Forward” or “Cloning”) from a previous note on which that text did not originate is not allowed.
  - 3. Pre-population of non-biographic data fields that would typically change from visit to visit should not occur.
- D. “Copy and Paste” of lab or study results into a clinical note should be clearly identified with date and time of the lab or study.
- E. Clinical entries in the patient chart should be created only by authorized clinical users.
- F. Clinical entries should be signed only by the creator(s) and the cosigning authorities and should not be routed through EHR email to unlicensed non-clinical personnel for signature or to any other staff who did not participate in the patient encounter.
- G. Discarding of documents:
  - 1. Must be requested through the Help Desk
  - 2. Must comply with the following criteria:
    - a. Documentation written in the wrong patient’s chart
    - b. Document corrupted and cannot be restored
    - c. Document scanned into the patient’s chart multiple times (e.g., SCR).
- H. Medical records are regarded as legal documents. Any findings suggesting that documentation has been manipulated or misrepresented outside of these guidelines will be investigated and reported to the Office of Health Information Management.

### III. Using Email in the EHR

- A. All EHR users are responsible for signing all email in a timely manner.
- B. The term “Patient-related email” is defined as emailed information for patient care purposes or for medico-legal documentation that is retained in perpetuity as part of a patient’s chart
- C. If patient-related emailed documents are emailed to the wrong person, use “Change Sign User”

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to move the document to the inbox of the correct user.

- D. If a person receives a document via email and deems a clarification is required, he/she should make the clarifications on the Note Builder document titled “ADD-Document Clarification” and attach it to the emailed document being clarified. If new orders are required, the user making the clarification should enter these at this time.
- E. Patient-related emails should not be sent to email groups, or to anyone from whom a response is not expected or required (Exceptions: referrals to mental health special programs, per policy, or for referrals in the Texas Tech sector, Office of Public Health).
- F. Other information should be sent as an “Administrative email” even if it involves a patient. (Documents sent for notification purposes only)
- G. Using email cross-cover
  - 1. Cross-cover should be set up:
    - a. For any employee who routinely receives email and may need to act on clinical information will be out for more than 5 business days and will not predictably look at their Pearl email
    - b. For the duration of the absence.
    - c. By the employee when their absence is known in advance.
    - d. By an administrator or designee through the UTMB Help Desk for any absent employee who has not arranged for Pearl email cross-coverage.
  - 2. The forwarded emails will be handled by the designated receiver to ensure a seamless continuity of care.

#### IV. Electronic Order Entry

- A. Orders for any clinically-related care (unless given as a verbal or telephone order) should be electronically entered by that clinician; orders should not be transcribed by other staff.
- B. Medication orders that are entered as verbal or telephone orders will be routed automatically to the ordering provider for co-signature.
- C. Non-prescription orders (i.e. lab, x-ray, treatments) that are entered as verbal or telephone orders in a nursing note should be routed to the ordering provider for co-signature.

#### V. Security of Health Records

- A. EHR Access will be handled by Access Management Policies at the university level; the minimum access required to perform one’s job will be granted.

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- B. Medical Records (paper or electronic) will be kept confidential per HIPAA guidelines.
- C. Security measures include:
  - 1. computer workstations will be locked when unattended
  - 2. The patient’s paper record will be secured if work area unattended.
  - 3. Password sharing is not permitted.
  - 4. Multiple active sessions of the EHR on different computers are not permitted.

Citations: <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/ehr-compliance-checklist.pdf>

Reference: ACA Standard 4-4380 Mandatory

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<sup>1</sup> Board’s rules on Medical Records, Chapter 165