POLICY:

High Peaks Hospice (HPH) uses electronic medical records (EMR) to support its mission and work. HPH staff members are trained in the use of portable computers and clinical notes are recorded electronically to facilitate accurate, timely, and legible documentation. Staff members are expected to electronically sign their clinical notes and safeguards are implemented to prevent unauthorized access to and/or alteration of electronic records. All other policies and procedures pertaining to medical records shall apply to electronic medical records, including, but not limited to accuracy, security and confidentiality of information.

Definition:
Electronic Signature: The combined use of assigned user names and accompanying passwords constitutes an electronic signature for information systems.

PROCEDURES:

1. HPH staff members who document or make entries into the electronic information systems are expected to electronically sign their entries. The electronic signature will be treated as a written signature with all the ethical and legal implications thereof. All staff members will be instructed on the process and security of the electronic signature during orientation and information technology (IT) training.

2. The electronic signature will appear on the EMR documents to authenticate medical record entries that require signature. The format of the electronic signature includes the printed name of the individual and the professional credentials. An example of the electronic signature as it will appear on a document such as a physician order is the statement “E-Signed by John Doe, RN” over the signature line.

3. Staff members are given a Login (user) ID and permission to log on to the system with a generic password.
   A. The first time the individual logs on to the system, it will force the individual to set their own unique password before proceeding past the initial sign-on screen.
   B. Staff member must maintain security of their own password. Sharing the password with any other individual will be grounds for strong disciplinary action and possible dismissal.
4. Supervisors will review electronic documentation for accuracy and completeness. Electronic documentation cannot be modified after it is locked by signature.

5. In the event that incorrect data is entered and saved in the electronic information system, a supervisor must be informed as soon as possible. The Patient Care Coordinator (PCC) shall collaborate with the IT Specialist to determine the nature and extent of the data entry error and the corrective actions needed. All corrections to the EMR will be documented with a reason for correction.

LAST REVIEW DATE Admin Staff 09/19/16, IDT 1/4/17, Clinical Comm 2/7/17

LAST UPDATED: Comp Coord 09/21/16, 1/23/17, 09/01/18

BOARD APPROVAL: March 21, 2017