Guideline Implementation: Patient Information Management

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Purpose/Goal

To provide the learner with knowledge specific to implementing the AORN "Guideline for patient information management."

Objectives

1. Discuss the importance of documenting accurate and complete patient information.
2. Explain important features for a documentation platform.
3. Identify risks associated with a poorly designed documentation platform.
4. Describe the advantages of using standardized vocabularies.
5. Discuss documentation requirements related to patient care orders.
6. Describe considerations for the security of patient records.

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Jennifer L. Fencl, DNP, RN, CNS, CNOR, has no declared affiliation that could be perceived as posing a potential conflict of interest in the publication of this article.

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ABSTRACT

Clinical documentation captured in a patient's record provides health care personnel with information that can be used to guide patient care. Data collected in electronic health records can be accessed and aggregated across the health care delivery system to enhance the safety, quality, and efficacy of care. The updated AORN "Guideline for patient information management" provides guidance to perioperative personnel on documenting and managing patient information. This article focuses on key points of the guideline, which address data capture that supports the clinical workflow, incorporation of professional guidelines and standards as well as regulatory and mandatory reporting elements, use of standardized clinical terminologies, data aggregation for use in research and analytics, considerations for patient care orders, and safeguards for the patient's security and confidentiality. Perioperative RNs should review the complete guideline for additional information and for guidance when writing and updating policies and procedures. *AORN J* 104 *(December 2016) 566-577. © AORN, Inc, 2016. http://dx.doi.org/10.1016/j.aorn.2016.09.020*

Key words: *patient information, clinical documentation, data management, structured data, perioperative orders.*

The old nursing adage still rings true: If it is not documented, it has not been done. Nursing education programs have historically emphasized the importance of documenting accurate and complete clinical information that reflects the holistic care provided to patients. What has changed is that clinical data can now be captured electronically and used in new and meaningful ways. With the changing landscape of health care focused on population health and health care reform, clinical information documented in the patient's electronic health record (EHR) offers organizations a greater capacity to enhance the safety and quality of care, improve efficacy of care, and access and aggregate information.[1,2] Hallmarks of a comprehensive documentation platform include

- robust systems for patient information management that provide the ability to incorporate the nursing assessment,
- built-in patient safety mechanisms (eg, an alert notifying a provider of a potential drug-drug interaction or a contraindication based on a patient's allergy),
- the ability to create reports and analyze data,
- the capacity to store data and integrate clinical data collected in a larger platform, and
- safeguards for patient confidentiality.[3]

Regardless of the platform in which patient care information is documented, the ability to capture patient data accurately, consistently, and reliably is essential to facilitate goal-directed

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