GUIDELINE FOR PATIENT INFORMATION MANAGEMENT

The Guideline for Patient Information Management has been approved by the AORN Guidelines Advisory Board. It was presented as a proposed guideline for comments by members and others. The guideline is effective July 1, 2016. The recommendations in the guideline are intended to be achievable and represent what is believed to be an optimal level of practice. Policies and procedures will reflect variations in practice settings and/or clinical situations that determine the degree to which the guideline can be implemented. AORN recognizes the many diverse settings in which perioperative nurses practice; therefore, this guideline is adaptable to all areas where operative or other invasive procedures may be performed.

Purpose

This document provides guidance to assist perioperative nurses in documenting and managing patient care information within the perioperative practice setting. Highly reliable data collection is not only necessary to chronicle the patient's response to nursing interventions, but also to demonstrate the health care organization's progress toward improving health care outcomes. Health care data collection and retention is rapidly transitioning from traditional paper formats to standardized electronic applications that incorporate criteria from statutes and regulations, accreditation requirements, and standards-setting bodies. Whether patient data are captured using paper or electronic formats, the nursing process should be completed for each surgical or procedural intervention performed.[1,2]

The nursing process is a formalized systematic approach to providing and documenting patient care that is embedded within perioperative patient care workflow (ie, clinical workflow). Comprehensive perioperative documentation accurately reflects the patient experience and is essential for the continuity of goal-directed nursing care and for effective comparison of realized versus anticipated patient outcomes.[3,4]

This document should be viewed as a conceptual outline that can be used to create a comprehensive documentation platform. It is not inclusive of all documentation elements, nor should it be seen as the only guideline that may be used when developing or revising a clinical documentation system.

The following topics are outside the scope of this document: electronic health record (EHR) adoption, accreditation requirements for health information technology criteria, EHR certification, EHR human factors science, establishing health information exchanges and interoperability requirements, submission of mandatory quality reporting criteria, hand-off communication requirements, perioperative team communications, requirements to complete data analytics, and patient access to personal health information.

Evidence Review

A medical librarian conducted a systematic search of the databases MEDLINE®, CINAHL®, and the Cochrane Database of Systematic Reviews. The librarian also conducted a non-systematic search of the Scopus® database. Results were limited to literature published in English from January 2011 to June 2015. During the development of the guideline, the lead author requested additional articles that either did not fit the original search criteria or were discovered during the evidence appraisal process, and the lead author and the medical librarian identified relevant guidelines from government agencies and standards-setting bodies. At the time of the initial search, the librarian established weekly alerts on the search topics and until October 2015, presented relevant alert results to the lead author.

Search terms included the subject headings and keywords *medical informatics, nursing informatics, documentation, information management, medical records, electronic health records, computerized patient records, information storage and retrieval, forms and records control, computer-assisted decision making, operating room information systems, hospital information systems, health information exchange, clinical decision support systems, interoperability, systems integration, data mining,* and *informed consent.* The concepts of standardized terminologies were included with a broad subject-heading controlled vocabulary as well as individual headings and keywords for relevant standardized terminologies. Subject headings and keywords related to government regulations included *government regulation, meaningful use, Health Insurance Portability and Accountability Act, HIPAA, Health Information Technology for Economic and Clinical Health, American Recovery and Reinvestment Act, Affordable Care Act,* and *Medicare and Medicaid Electronic Health Care Record.* The keywords *big data, electronic signature, charting by exception, variance charting, electronic medical record, EHR, Health Level Seven International, HL7,* and *EMR* also were included in the search, as were terms related to the concepts of data collection, retention, storage, and governance.

Articles identified by the search were provided to the lead author and an evidence appraiser. Excluded were non-peer-reviewed publications and evidence from other disciplines when evidence from the perioperative setting was available (Figure 1). The lead author and the evidence appraiser reviewed and critically appraised each article using the AORN Research or Non-Research Evidence Appraisal Tools