CASE STUDY
DIGITAL VS. WRITTEN DOCUMENTATION – IS THERE A DIFFERENCE?

It has been a busy day in the baby clinic and Helen has been running behind schedule and trying to catch up all day. At 3 p.m., she finishes her last appointment for immunizing a baby and is looking forward to a lunch break. Helen transfers the care of the infant over to her colleague Jodi but forgets to log off of the electronic medical record (EMR). Shortly after Jodi received the baby into her care, the mother of the baby Helen just immunized calls for help. Jodi performs an assessment, realizes the baby is having an allergic reaction and immediately implements the appropriate nursing protocol. After the emergent care has been provided and the baby's condition has stabilized, Jodi shifts her focus to documenting the care she provided. Jodi sees that the EMR is open for access and the baby's record is visible on the screen.

WHAT SHOULD JODI DO?

Jodi must remember that a client record carries the same importance whether the format is paper, electronic or a combination of both. If she does not log off due to the fact that the last provider didn't do it, she will, in fact, be assigning someone else's name to her work.

If Jodi documents under Helen's profile, then Jodi has not demonstrated accountability for her nursing care. Likewise, if Helen kept herself logged on for others to access, questions about her accountability arise. Employer policy usually states that an individual is to log off of the EMR when they have completed their documentation and that each individual is to log on using their own identity to document.

THINKING IN A DIGITAL WAY

Documentation is an inherent part of nursing care and demonstrates the RN's accountability for the care they provide. As with any tool, documentation in the EMR is only as complete as the information that is entered into it. Just as RNs are accountable for what is recorded on paper, they are equally accountable for the information they enter in an electronic record. The technical aspects of the EMR require additional considerations such as appropriate access to client records, log on/off procedures, and signatures. RNs may not always consider the use of technology as a component of nursing care, however in this technologically advanced time period, the opposite is true. As many organizations are moving to electronic health and medical records, the EMR is increasingly the platform that houses the patient's legal documentation record.

The RN's digital signature complies with legal and regulatory requirements, ethical standards and organizational policies and procedures. There are some instances, outlined in legislation or policy, where a handwritten signature may be required, but, otherwise a digital signature is equal to a handwritten signature in terms of accountability under the law.

FOLLOW-UP ACCORDING TO POLICY

RNs should be aware of and follow employer policy with respect to modifying an incorrect entry or signature in an EMR. Depending on policy, it may be necessary to contact the clinical information system support team to correct errors or notify them of incorrect access. As well, RNs need to follow employer policy when it comes to logging on to and off of an EMR.

WHAT HAPPENED?

Just as Helen was sitting down to eat her lunch, she remembered that she did not log off her profile in the patient record. She promptly goes to the computer where she finds Jodi. At the same time, Jodi realizes she is not logged on to the EMR under her profile. Helen and Jodi discuss the situation and they follow employer policy. Helen logs off and Jodi logs on under her own credentials and documents appropriately.

Our case studies are fictional educational resources. While we strive to make the scenarios as realistic as possible, any resemblance to actual people or events is coincidental. Thank you to the College & Association of Registered Nurses of Alberta for granting permission to adapt their case study.

RESOURCES

Standards for Documentation
https://www.nanb.nb.ca/wp-content/uploads/2022/08/NANB-Standards-Documentation-May20-E.pdf

Frequently asked questions about documentation
https://www.nanb.nb.ca/wp-content/uploads/2022/11/NANB-FAQ-Documentation-June20-E.pdf

Standards of Practice for Registered Nurses
https://www.nanb.nb.ca/wp-content/uploads/2022/08/NANB2019-RNPracticeStandards-E-web-1.pdf

Quality Documentation: Your Best Defence (CNPS)
https://www.spiic.ca/index.php?page=85