SESLHD PROCEDURE COVER SHEET

Health
South Eastern Sydney
Local Health District

NAME OF DOCUMENT	Student documentation within Cerner eMR
TYPE OF DOCUMENT	Procedure
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EXECUTIVE SPONSOR or EXECUTIVE CLINICAL SPONSOR	Director, Clinical Governance and Medical Services
AUTHOR	SESLHD Health Records and Medico-Legal Committee
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FUNCTIONAL GROUP(S)	Records Management - Health
KEY TERMS	Student notes, co-signing, eMR
SUMMARY	This procedure outlines the requirements for co-signing (verifying) of student notes within the eMR.

Student Documentation within Cerner eMR SESLHDPR/509

1. POLICY STATEMENT

This procedure has been developed to support the NSW Health Policy Directive PD2012_069 - Health Care Records – Documentation and Management requiring the co-signature of a supervising clinician after the review (and/or amendment) of student documentation.

This procedure aligns with SESLHDPR/326 - Student Clinical Placements in SESLHD Facilities and supports the principles of clinical teaching.

2. BACKGROUND

- The purpose of this procedure is to provide a clear process outlining the requirements for reviewing/ co-signing student notes within the electronic medical record (eMR).
- It aims to ensure there is a consistent approach for student documentation within eMR and that unique eMR accounts are provisioned for all students who need to access eMR.
- The procedure covers all student positions that have access to eMR including:
    - Medical students
    - Nursing and midwifery students
    - Allied health students
- Principles of supervision and documentation in the eMR:
    - Students and supervisors must only provide and document care within their scope of practice.
    - Any concerns about a student/ supervisor's clinical or digital capability must be escalated to the team leader and/ or Clinical Facilitator.

3. DEFINITIONS

The following definitions are used in the context of this procedure.

Clinical Facilitator: A person responsible for overseeing/supervising the clinical experience of the student. May be Internal (employed by SESLHD) or External (employed by an Education Provider or Agency). Note- External N&M Clinical Facilitators are NOT endorsed to provide or document clinical care when acting in this role. As a result, Clinical Facilitators are not provided access to the eMR.

Clinical Note: within the Cerner eMR is any clinical information that is entered.

Clinical Placement Coordinator: A person, nominated by the DONM (or Co-Director if applicable) or Discipline Head of Department for Allied Health, who has the responsibility for managing clinical placements (for disciplines other than medicine) at the facility level.

Clinicians: Clinicians include registered health practitioners (nursing, midwifery, medical and allied health).

Education Provider: Registered Training Organisation (RTO) such as a University or TAFE that provides undergraduate, post graduate or pre-registration education.

eMR: electronic Medical Record.

iView: is used to chart ongoing assessments over time, which allows for trending and comparison.

PowerForm: provides templates for purposive data entry to meet the requirements of specific clinical tasks. Completed PowerForms are viewable from the Forms, Documentation and ContinuousDoc sections of eMR.

PowerNote: is a method of entering clinical notes. Free text information and information unable to be captured elsewhere in the eMR can be recorded via PowerNotes e.g. Progress Notes.

Students: Students that are on placement at a Local Health District (LHD) facility including nursing, midwifery, medical and allied health students.

Supervisor: An SESLHD staff member responsible for overseeing the student placement.
Also known as preceptors in N&M workforce.

Team leader: A senior clinician (of any discipline) on duty and responsible for the coordination and support of a group of clinicians (e.g. nurse in charge of a shift, or medical registrar).

Unverified/Unauthorised and Verified/Authorised: Unverified/unauthorised refers to the status of some documents when signed by a student practitioner. The status changes to verified/authorised once the document is signed by a clinician.

More definitions relating to students can be found in SESLHDPR/326 - Student Clinical Placements in SESLHD Facilities.

4. RESPONSIBILITIES

4.1. Clinical Applications Support Manager will:

- Develop and maintain this procedure.
- Liaise with Healthcare Records Committee to ensure that the procedure is relevant and useful.

4.2. Site Medical Record/Health Information Managers will:

- Ensure procedure is followed.
- Conduct quality audits to ensure that the procedure is being adhered to and that data integrity is maintained and corrected if required.

4.3. Healthcare Records Committee will:

- Advise on any policy requirements regarding documentation management that may be relevant to this procedure.

4.4. End users – supervising clinician will:

- Conduct a risk assessment and set clear guidelines with the student regarding scope of practice (and associated documentation) at the beginning of a clinical placement and revisit if/ when circumstances change.
- Supervise patient care and associated documentation done by student.
- Reviews (and/or amends) student documentation within a timely manner.
- Additional actions to take if students enter information incorrectly or outside their scope include:
    - Working with student (where possible) to correct or mark the entry “in error".
    - Supervisors or other authorised staff modifying or marking the student entry "in error" (and including rationale for this as needed).
    - Escalate any concerns about a student's digital health or clinical capability to team leader and/ or Clinical School Manager/ Clinical Facilitator as needed.

For more information on Nursing and Midwifery student documentation, see **Appendix A.**

4.5. End users – students will:

- Ensure that a personal account is used for accessing eMR and electronic documents have been created correctly.
- Ensure supervisors are aware of the students’ scope of practice and entries made in the eMR.

4.6. Clinical School Managers/ClinConnect or Student Coordinators for relevant discipline (allied health, medical and nursing) will:

- Ensure students have personal eMR accounts by creating online account requests (individual forms), or by requesting bulk creation of student accounts at beginning of student term.
- Organise training for students with the site eMR training and support officers.

4.7 Team leaders will:

- Allocate students to appropriately experienced supervisors based on risk assessments (considering factors such as clinical scope, digital capability, patient acuity, skill mix of the team etc).
- Act on or escalate concerns about patient or staff safety in a timely manner.

4.8 Clinical Facilitator will:

- Be an escalation point for any concerns about a student's clinical or digital capability.

5. PROCEDURE

5.1. Creation of New Student eMR Accounts

5.1.1. Request for eMR account for student(s) is received.
5.1.2. Individual named eMR account is created for the student practitioner.

5.2. eMR Training

5.2.1. Student Supervisors to liaise with site eMR training and support to request training for student(s).
5.2.2. Students have basic working knowledge of eMR and procedures to document.

5.3. Student Documentation

5.3.1. Student documentation requires review and/or co-signing.
5.3.2. Student documents appropriate clinical note within the electronic medical record under supervision of staff member.
5.3.3. Student notifies supervising clinician of documentation awaiting review and/or co-signing. Supervisor ensures to regularly check same with student.
5.3.4. Some student documents require co-signing by supervising clinician before the information entered is reliably visible in all sections of the eMR for all users.
5.3.5. Some Student entries that do not require co-signing will automatically become a verified/authorised document and are viewable within eMR.

For more information on Nursing and Midwifery student documentation, see **Appendix A.**

6. DOCUMENTATION

- Health ICT Account Creation Form
- eMR Quick Reference Guides (QRGs)
  - Student Documentation and Co-signing
  - Co-sign Student Completed Forms
  - Documentation Guidelines
  - Student Nurse/Midwife Documentation in the eMR

7. AUDIT

- Regular audits are performed by site Medical Record/Health Information Managers to ensure relevant student documentation has been co-signed.
- Ad hoc report produced within eMR that will highlight student documentation requiring co-sign.
- Follow up with relevant managers.

8. REFERENCES

- NSW Health Policy PD2012_069 - Health Care Records – Documentation and Management
- SESLHDPR/326 - Student Clinical Placements in SESLHD Facilities
- SESLHDPR/336 - Documentation in the Health Care Record
- SESLHDPD/310 - Information Security Policy

9. VERSION AND APPROVAL HISTORY

Date	Version No.	Author and approval notes
December 2014	1	Author: Lee Speir (initial draft)
October 2015	2	Author: Hayley Ryan (conversion to SESLHD standard format)
November 2015	3	Reviewed and Approved: SESLHD Health Records and Medicolegal Working Party
March 2016	4	Author: Leonie Patterson added in terminology around unauthorised and authorised
	5	Reviewed and Approved: SESLHD Health Records Steering Committee
October 2016	6	Incorporated comments into procedure
December 2016	6	Endorsed by DET
September 2020	7	Executive Sponsor updated from SESLHD Health Records Steering Committee to Director Health ICT. Approved by Executive Sponsor. Published by Executive Services.
February 2022	8	Minor review to update links and minor grammar corrections ahead of detailed review. Approved by Executive Sponsor.
23 November 2023	8.1	Minor review. Revised to align with the technical change to no longer mandate co-signing of PowerForm and iView entries made by nursing and midwifery students. eMR Reference Guides and links updated. Reviewed and Approved by SESLHD Health Records and Medicolegal Committee and Executive Sponsor.

Appendix A

Nursing and Midwifery(N&M) Student Documentation

PowerForm and iView entries

From November 2023, co-signing of PowerForm* and iView* entries made by N&M students will no longer require co-signing by the supervising nurse/ midwife.

* This change has been made on the understanding that:

- The majority of:
  - PowerForm entries made by students are observations/ vital signs.
  - iView entries made by students consist of simple fluid balance information.
- All care and documentation done by the student is within the scope of both student and supervising nurse/midwife.

PowerNote entries

PowerNotes made by N&M students must be co-signed by the supervising nurse/ midwife.

N&M supervisors must document where a student has contributed to a patient's care and/ or health record under their supervision. This may be entered by free text or auto text where this is an option.
For example, "All activity and associated documentation completed by [insert name of student] this shift has been done under my supervision."

Medications

N&M Students are not authorised to document the prescription or administration of medications in the eMR. Student details must be entered in the comments section of the MAR if they have participated in the preparation and/ or administration under direct supervision.

More information

- eMR Training Portal
- eMR Quick Reference Guides (QRGs)
  - Student Documentation and Co-signing
  - Co-sign Student Completed Forms
  - Documentation Guidelines
  - Student Nurse/Midwife Documentation in the eMR
- SESLHDPR/326 - Student Clinical Placements in SESLHD Facilities