SESLHD POLICY COVER SHEET

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KEY TERMS	eMR, intraoperative, medical record
SUMMARY	This policy outlines the minimum practice expectation for electronic medical record documentation for all medical and nursing staff working in SESLHD operating suites.

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Electronic Intraoperative Health Care Record – Responsibility and Accountability

SESLHDPD/164

1. POLICY STATEMENT

Documentation into the intraoperative eMR (electronic medical record) will commence and be maintained from the patient's initial presentation into the operating suite; during the intraoperative and the post-operative period until transfer to the post-operative receiving ward.

All medical and nursing staff in the operating suite will be allocated a unique username enabling access into SurgiNet and the eMR system. Users are responsible and accountable for accessing and the documentation entered into each patient's SurgiNet and eMR as per NSW Ministry of Health Policy - PD2012_069 Health Care Records - Documentation and Management and NSW Ministry of Health Policy - PD2013_033 Electronic Information Security Policy - NSW Health

All staff will log out of the eMR system when they have completed documenting an episode of care. This avoids entries being made in SurgiNet and eMR under their username for patient care in which they were not involved and responsible.

2. TARGET AUDIENCE

All medical and nursing staff working in SESLHD operating suites with access and direct documentation responsibilities for patients in SurgiNet and eMR.

3. RESPONSIBILITIES

Nurse Managers / Nurse Unit Managers
Nurse Educators / Clinical Nurse Educators
Medical staff
Nursing staff

Nurse Managers / Nurse Unit Managers

- Ensuring education is arranged with eMR trainers for all operating suite nursing staff on the commencement of employment and as required
- All staff receive a unique username for accessing SurgiNet and eMR
- Ensuring that all staff comply with this policy.

Nurse Educators / Clinical Nurse Educators

- Maintain records for evidence of education and assessment processes
- Work with NUMs to ensure education for new staff occurs.

Nursing and Medical Staff

- Comply with all privacy and confidentiality requirements associated with eMR documentation
- Sign in and confirm the opened SurgiNet eMR corresponds to the relevant patient at the point of care prior to the commencement of data entry

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- Will ensure all care provided is documented in eMR and is accurate and complete
- Complete all SurgiNet eMR mandatory fields for their respective roles during the patient's journey through the operating suite
- Responsible for all mandatory documentation in the paper based patient health care record during the patients journey through the operating suite
- All staff are responsible for complying with this policy.

Nursing staff without eMR access

- In situations where a new employee, student, agency or casual pool nurse has been allocated to provide direct patient care in the operating suite, responsibility will be delegated to the nurse in charge of that theatre for documentation into the patient's eMR.

4. DEFINITIONS

Accountability	The state of being answerable for one's decisions and actions, It cannot be delegated.
Clinician	A health practitioner with current registration and authority to practice with Australian Health Practitioners Regulation Agency (AHPRA). Includes Medical, Nursing, Midwifery and Allied Health.
Responsibility	Directly answerable for actions obliged to complete.
Downtime	Planned or unplanned loss of access to SurgiNet and eMR.
SurgiNet	eMR software platform for operating theatres in NSW Health facilities.
eMR	Electronic Medical Record.

5. eMR DOWNTIME

In the event of a planned or unplanned system and/or power failure when clinicians cannot access SurgiNet, operating suite staff will document health care provided to patients on the Surginet Downtime paper based documentation. The down time paper based record must comply with SESLHDPR/336 Documentation in the Health Care Record

The paper based record **only needs** to capture patient care provided during the eMR downtime. The eMR downtime documentation must remain with the patient in their hardcopy medical record folder. Any documentation occurring during eMR downtime does not have to be replicated into SurgiNet and eMR but is required to be filed in the paper based medical record.

This policy shall be reviewed as changes to the functionality of the eMR system become available.

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6. DOCUMENTATION

eMR – Surginet

SurgiNet Downtime Forms

SurgiNet training records

7. REFERENCES

- NSW Ministry of Health Policy - PD2012_069 Health Care Records - Documentation and Management
- NSW Ministry of Health Policy - PD2013_033 Electronic Information Security Policy - NSW Health
- NSW Ministry of Health Policy - PD2013_05 Management of Instruments, Accountable Items and Other Items used for Surgery or Procedures
- Australian College of Operating Room Nurses. (2016). ACORN Standards for Perioperative Nursing. 14th edition http://www.acorn.org.au/
- SESLHDPR/336 Documentation in the Health Care Record

8. REVISION AND APPROVAL HISTORY

Date	Revision No.	Author and Approval
Sept 2008	0	Fiona Lendon, Perioperative Nurse Educator, The Sutherland Hospital. Approved by Executive Sponsor Kim Olesen, Director Nursing and Midwifery Services and Clinical Council Committee 24 September 2008.
April 2012	1	Reviewed by Fiona Lendon, NM Perioperative Services, The Sutherland Hospital. Approved by Kim Olesen, Director Nursing and Midwifery
March 2018	2	Minor review with changes to wording of responsibilities and EMR downtime and update of references. Approved by Dr Greg Keogh, SESLHD Surgery, Peri-operative Anaesthetic Clinical Stream.
April 2018	2	Processed by Executive Services prior to publishing.

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