Perioperative Patient Information Management



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STUDY GUIDE

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LEARNING OUTCOME

After completing this study guide and viewing the accompanying video, the perioperative registered nurse (RN) and other perioperative team members will have increased their knowledge of managing clinical data and comprehensively documenting the patient's plan of care in the perioperative setting.

OBJECTIVES

The participant will be able to

- discuss the importance of documenting accurate and complete patient information;
- list the advantages of using standardized vocabularies;
- maintain the security of patient information;
- document and authenticate patient care orders; and
- comply with local, state, and federal regulatory requirements.

INTRODUCTION

Perioperative RNs play crucial roles in every patient's preoperative, intraoperative, and postoperative care. Documentation of this care is critical. The patient's medical record should accurately reflect the entire perioperative experience, including nursing diagnoses, every intervention performed, and outcomes.[1]

In addition to documenting the patent's course of care, accurate data collection is necessary to demonstrate the health care organization's progress toward improving patient outcomes.[1] Comprehensive data collection and analysis allow for quality decision making and improvement of care for patient populations.[2] This requires a system for storage and extraction of the vast quantity of data generated by perioperative team members.[2]

Patient medical records are rapidly transitioning from traditional paper charts to electronic formats.[1] Regardless of format, accurate and consistent documentation of reliable patient data is essential for providing quality, goal-directed care and for comparing expected with actual outcomes.[3]

This study guide and the accompanying video provide guidance to assist perioperative RNs and other health care team members in documenting and managing patient care information in the perioperative setting.

THE PERIOPERATIVE HEALTH CARE RECORD

The perioperative health care record is part of the patient's legal health record and should reflect the care of the patient.[1] Important elements include assessment, nursing diagnosis, planned interventions, implemented interventions, expected outcomes, and an evaluation of the patient's responses to care and progress toward desired outcomes.[1] The health care facility must maintain a medical record for every individual evaluated or treated at the facility.[4]

The perioperative RN should record the findings of the patient assessment, including physical, psychosocial, cultural, and spiritual elements, in the patient's record before any operative or invasive procedure is performed. This assessment forms a baseline that can be used to identify the patient's health status, to develop nursing diagnoses, and to establish an individualized care plan.[1]

The RN should document all nursing interventions performed, the time they were performed, the location of care, and the name and role of the person performing the intervention. Documentation of nursing interventions in the patient's medical record promotes continuity of care and improves the exchange of information among members of the health care team.[1]

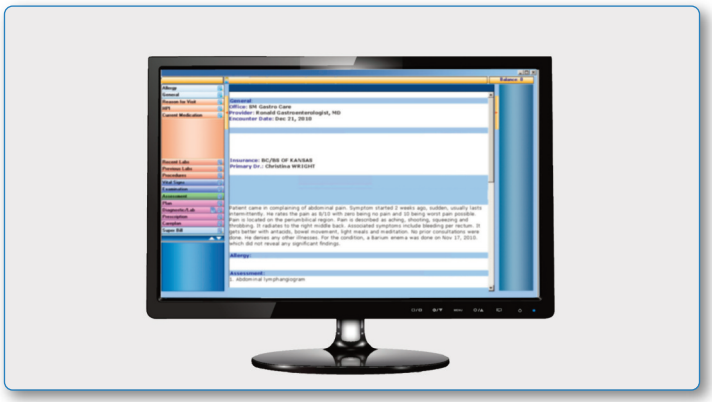
The perioperative RN should evaluate the effectiveness of nursing interventions and progress toward desired patient outcomes and should document these evaluations in the medical record. Recurring assessments throughout the perioperative period contribute to safe patient care. The evaluation process also provides information for performance improvement activities, perioperative nursing research, and risk management.[1]

Team members must collect and record data at the time of each assessment, reassessment, or evaluation. Continuous evaluation and documentation of the patient's condition provides important data that enable the health care team to monitor the patient, coordinate prescribed treatments, and evaluate the effectiveness of care.[1]

FORMAT

Formats for capturing data should be designed to support the perioperative RN's clinical workflow, facilitate data capture, and eliminate redundancies in the entry of information.[1] Nursing documentation should be synchronized with the nursing workflow.[1] Poorly designed documentation systems can lead to interruptions, omission of information, and decreased situational awareness.[3] The perioperative RN should ensure that clinical documentation reflects patient-focused care and includes all information that might be important for ongoing and transitional care.[1]

Perioperative team members should be involved in the evaluation of electronic documentation systems. Factors to consider include the effect of these systems on clinical workflow, patient safety, the ability of the documentation system to facilitate the organization's objectives, and user requirements for providers. Perioperative RNs should provide their input to the health care facility's information technology team.[1]

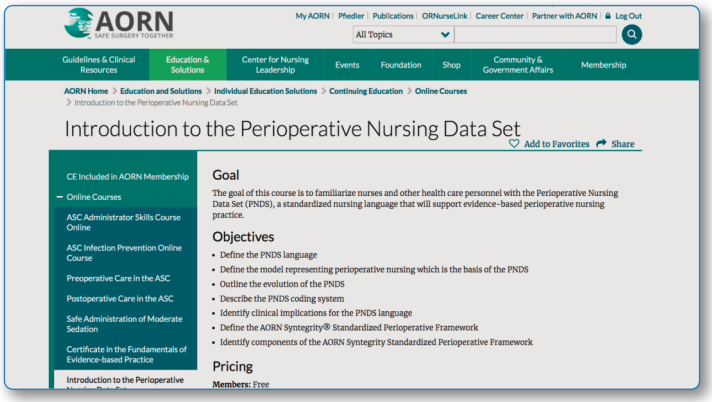


Structured Vocabularies

Electronic formats for perioperative nursing documentation should incorporate structured vocabularies. Structured vocabularies facilitate the use of unambiguous terms with consistent meanings to describe patient care. Each phase of perioperative patient care – preadmission, preoperative, intraoperative, and postoperative – should have discrete representation.[1]

Benefits of structured vocabularies may include

- helping to define data elements that facilitate development of computer databases[5,6];
- providing data to policy makers about outcomes of care provided by perioperative RNs[6];
- allowing comparison of costs and performance across local and national units[6];
- providing quality indicators for outcomes research[5,6]; and
- facilitating comparison of nursing assessments and interventions over time.[5]



The Perioperative Nursing Data Set (PNDS) is a standardized nursing language that focuses specifically on perioperative nursing[5,7] and supports evidence-based perioperative nursing practice.[7] The PNDS is recognized by the American Nurses Association[5,7,8] and is registered in the National Library of Medicine.[8] The PNDS provides clear and consistent terms relating to clinical problems, interventions, and patient outcomes and facilitates consistent documentation of the perioperative RN's contributions to those outcomes.[6,7,8] Recording clinical data using the PNDS also facilitates research and quality improvement projects.[7]

The AORN Syntegrity Solution provides standardized clinical content for electronic perioperative documentation. It was developed to address inconsistent application of the PNDS in paper and electronic records. It is compatible with perioperative information systems that contain nursing documentation.[7]

The PNDS and other structured vocabularies should be incorporated into the health care facility's electronic documentation platform.[1]

The health care organization should implement a documentation system that includes a standardized perioperative electronic framework. Standardized platforms promote the uniform collection of data related to patient care and facilitate sharing of that data. The system must incorporate standardized clinical terminologies identified by the US Government to promote compatibility and access of data across health care organizations and providers. Standardization of electronic health record (EHR) data facilitates sharing of important patient care information, supports continuity of care, and allows for aggregation and extraction of data for research.[1]

PROFESSIONAL AND REGULATORY COMPLIANCE

Perioperative nursing documentation should be structured to meet requirements for professional and regulatory compliance.[1] Perioperative nursing documentation must correspond to the elements of regulatory statutes, health care accreditation measures, national practice standards, and mandatory quality and reimbursement for quality performance criteria.[1]

Clinical documentation should include the following components:

- Assessments
- Clinical problems
- Communications with other health care professionals regarding the patient
- Communication with and education of the patient, the patient's family members, the patient's designated

support person, and other third parties
- Medication records
- Order acknowledgement, implementation, and management
- Patient care interventions
- Patient clinical parameters
- Patient responses and outcomes, including changes in the patient's status
- Plans of care that reflect the social and cultural framework of the patient[1]

Perioperative nursing documentation should correspond with established guidelines and practices for perioperative nursing care. Clinical documentation should incorporate the following elements of perioperative guidelines:

- Administration of local anesthesia
- Administration of moderate sedation/analgesia
- Considerations for patient care (eg, latex allergy, implanted electronic device, dentures)
- Maintenance of aseptic technique
- Management of specimens and tissues
- Measures for traffic control
- Patient information exchanged
- Patient positioning
- Practices for administration of medications (eg, use of abbreviations)
- Practices for sterilization and disinfection
- Safety precautions
  - Electrical safety precautions
  - Equipment use precautions (eg, laser, pneumatic tourniquet, magnetic resonance imaging)
  - Fire prevention
  - Precautions for human tissue procurement, processing, and preservation
  - Prevention of infections
  - Prevention of radiation exposure
  - Prevention of retained surgical items
  - Processes to ensure correct site, side, and person surgery
  - Skin preparation and antisepsis
  - Tissue protection[1]

Perioperative nursing documentation must comply with local, state, and federal regulatory requirements as well as requirements from health care accreditation organizations. Documentation must also incorporate mandatory reporting criteria for reimbursement based on quality performance.[1]

The perioperative RN should record the names, roles, and credentials of individuals participating in the patient's perioperative care, as well as those indirectly involved in the scheduled surgical or procedural intervention, in the patient's health care record. Individuals participating in the patient's perioperative care may include

- approved observers;
- health care professionals contributing to the patient's care (eg, pathologist, x-ray technician, approved health care student);
- identified legal representatives;
- identified patient support person(s);
- industry representatives;
- law enforcement officers (eg, prison guards);
- recipients of patient care information on behalf of the patient; and
- surgical or procedural patient care team members.[1]

Patient Care Orders

The perioperative RN should ensure that all patient care orders given in the perioperative setting are properly documented. Orders should be documented as closely as possible to the time the order is given or the intervention is begun. [1]

All orders must be dated, timed, and authenticated by the health care practitioner giving the order. This includes verbal orders, standing orders, orders on surgeon preference cards, and order sets.[1]

Outdated, incomplete, and erroneous entries can potentially cause harm to patients. To prevent this, the following precautions should be taken with standing orders and preprinted order sets:

- Avoid use of unacceptable abbreviations.
- Avoid use of trailing zeros in medication dosages.
- Use standardized names and terms to describe treatments and interventions (eg, brand names versus generic names for medications, device instructions).[1]

The attending surgeon should review standing and preprinted orders to ensure the information is accurate for the intended procedure.[1]

The perioperative RN should document verbal orders when they are given and verify them using a read-back process that involves the ordering health care practitioner.[1]

Informed Consent

The perioperative RN must ensure that a complete and accurate informed patient consent is included in the patient's medical record for every operative or invasive procedure. The medical staff policies at each facility should identify the procedures and treatments that require informed consent.[1]

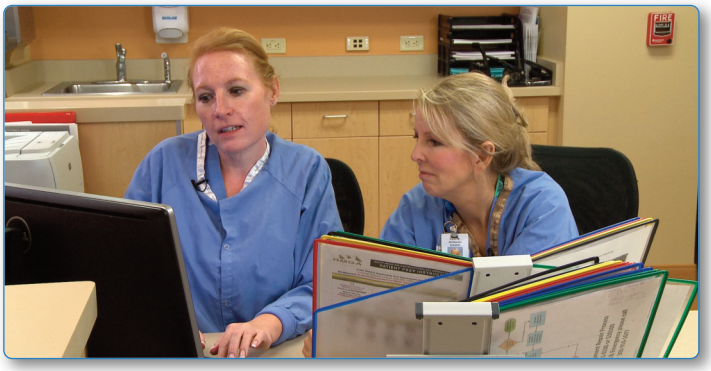
Unless a procedure is a designated emergency according to the health care facility's policies, the informed consent must include the following:

- Name of the health care facility providing the surgery or invasive procedure
- Specific name of the procedure to be performed
- Indications for the proposed procedure
- Name of the responsible health care provider performing the procedure
- Statement identifying the risks and benefits associated with the proposed procedure with indication of discussion with the patient or patient's legal representative
- Signature of the patient or the patient's legal representative
- Date and time the patient or the patient's legal representative signed the informed consent document
- Date, time, and signature of the person who witnessed the patient or the patient's legal representative signing the informed consent document
- Signature of the responsible health care provider who executed the informed consent discussion with the patient or the patient's legal representative[1]

Team members must remember that the patient or the patient's legal representative is entitled to participate in the informed decision-making process for planning care and treatment, including the right to request or refuse treatment.[1,9]

State statutes or administrative rules may require the provision of additional information on the informed consent document. This can include assisting physicians, medical residents, and non-physician health care personnel (eg, RN first assistant, nurse practitioner) who will make significant contributions to the planned procedure.[1]

SECURITY



Patient information must be made secure, held confidential, and protected from unauthorized disclosure.[1]

The Health Insurance Portability and Accountability Act (HIPAA) guarantees the privacy of individuals receiving health care services and the confidentiality of their health information. The Act includes security standards for protecting electronic health information and regulations specifying compliance, investigation, payments, and penalties.[1]

Access to patient health information must be limited to authorized health care personnel based on role, responsibility, and function. Limiting access to patient information helps to

protect patient privacy and reduce the risk of security breaches. The health care organization must establish procedures to prevent unauthorized access to patient data and have a plan for notifying affected individuals if a breach does occur.[1]

Risk-reduction strategies to minimize the risk of unauthorized access include

- implementing policies for information management, including protocols for remote access and practices for information storage on and off site[1];
- identifying procedures for use of mobile devices (eg, phones, tablets) within the perioperative environment[1];
- establishing and reinforcing awareness and sensitivity to data security and privacy[1];
- restricting access to electronic health information to users with individualized, unique authorization credentials associated with time-sensitive passwords that have combinations of alphanumeric characters and symbols[1];
- holding competency-based educational programs about information access and sharing for all employees when they are hired, when changes are made to documentation practices, and when issues are identified[1]; and
- establishing policies related to use and restrictions for social media tools.[10]

Policies should be reviewed and updated as conditions change (eg, new regulations, transition from paper to electronic records).[1]

Ambulatory surgery centers must designate a person to oversee the protection of clinical records. This person is responsible for maintaining the confidentiality, security, and physical safety of records; for tracking who has access to the records; and for identifying designated locations of paper records throughout the facility.[1]

Transmission of Medical Information

Any significant medical advice given to a patient by text, e-mail, or telephone must be permanently entered in the patient's clinical record, signed, and dated.[1]

When sharing electronic patient information, the perioperative nurse should comply with the health care organization's information policies. These policies should include

- ensuring that electronic patient information sent to an outside organization, received from an outside organization, or shared with the patient meets current requirements for information exchange and security (eg, malware protection);
- validating the authenticity of the original source and the accuracy of the transmitted information; and
- evaluating electronically transmitted content (eg, email, text, file transfer protocol [ftp]) for potential corruption.[1]

Electronic transmission of patient health information is held to the same privacy and security standards as facility-based EHRs. A consent for release of information signed by the patient must be obtained and documented in the health care record before patient-specific information can be released. This includes remote access. Sensitive patient information in paper, electronic text, or image formats can be exposed to unintended or unauthorized disclosure if effective sharing safeguards are not in place.[1]

Authentication

Entries into the patient health care record must include a process for authentication after documentation is completed. Authentication identifies the author of the entry and indicates responsibility for interventions performed and information collected. Authentication legally binds the owner of the signature with the responsibility for the accuracy of the content of the entry.[1]

The authentication process might include the following:

- Using electronic or digital signatures or code keys as the legal representation of an individual's written signature for the EHR
- Completing a pen-to-paper signature, using initials with a signature legend on the same document or rubber signature stamp, for paper-based documents
- Using a countersignature demonstrating the accuracy of content entered into the health record; once

countersigned, the content is legally considered the cosigner's entry (eg, a cosigned nursing student's entry)[1]

Verbal orders must be authenticated within the time frame specified by state regulations. If no time frame is specified by state law, then federal regulations require the responsible physician to authenticate verbal orders within 48 hours of entering the order.[1]

Social Media

Social media is a broad category that includes many different types of platforms (eg, social networks, blogs, wikis, photo and video sharing sites). They are useful for personal and professional networking, sharing media, education, and engaging in debate and discussion with colleagues. Some allow real-time collaboration. Benefits of social media from a health care standpoint include promoting healthy behaviors, engaging with the public, and educating patients and caregivers.[11]

Despite these benefits, social media is also associated with potential problems. Posting unprofessional content, such as posts involving profanity; sexually suggestive images; public intoxication; or negative comments about patients, employers, or facilities, can damage a team member's professional image. Some employers search applicants' social media when making decisions about hiring. Public posts are available for anyone to see and might be considered an indication of a person's professional judgment. Team members should carefully consider the privacy settings on their personal and professional social media accounts.[11]

Use of social media can raise particular concerns about patient privacy.[11] Team members who breach patient privacy can face penalties and possible legal action under HIPAA and state privacy laws.[11] Simply omitting a patient's name in a post might not be sufficient.[11] A description is often enough to identify a patient if too many details are given.[11] Health care providers have faced disciplinary action from licensing boards for disclosing patient information on social media.[11,12]

Team members should consider the potential legal ramifications of social media posts. Social media can be discoverable evidence in cases of litigation. Posts about specific events or procedures might be used as evidence of failure to uphold the standard of care.[12]

The health care organization should develop and implement policies and guidelines for the use of social media by health care providers. The penalties for violations should be clearly defined.[11]

The National Council of State Boards of Nursing published a white paper on the use of social media, which recommends that nurses should

- recognize ethical and legal obligations to maintain patient privacy and confidentiality;
- avoid transmission of any patient-related image or any information that might reasonably be anticipated to violate patient confidentiality;
- avoid sharing information about a patient with anyone unless there is a need related to patient care or a legal obligation;
- avoid identifying a patient by name or publishing information that might allow the patient to be identified;
- avoid making disparaging comments about patients, coworkers, or employers;
- avoid taking photos or video of patients on personal devices;
- maintain professional boundaries;
- consult the policies of the health care organization about work-related posts;
- avoid posting or speaking on behalf of an employer unless authorized to do so; and
- report breaches of privacy or confidentiality promptly.[13]

Retention of Records

The patient care record must be retained in the original or a legally reproducible form for at least the minimum amount of time dictated by federal and state regulations. The health care facility's policies may require records to be retained for additional time depending on the patient population, facility demographics, or operational requirements.[1]

The American Health Information Management Association recommends retaining operative indexes for a minimum of 10 years and the register of surgical procedures permanently.[14]

Federal minimum retention times for medical records at various types of facilities are presented in the following table:

Minimum Retention Time for Records – US Federal Regulations	
Ambulatory Surgical Services	Not specified[15]
Hospitals	5 years[4]
Hospitals, Critical Access	6 years from date of last entry[16]
Department of Veterans Affairs, Operation Log Files – "operation logs, which indicate type of operation, date, patient's name, surgeon, assistant scrub nurse, sponge count, anesthetist agent, method, preoperation and postoperation diagnoses, complications, and other information"	Destroy after 20 years[17]
Department of Veterans Affairs, Schedule of Operation File – "workload data consisting of the date the surgery was performed, members of the surgical and nursing teams, and other information pertaining to the surgery of a patient"	Destroy after 3 years[17]

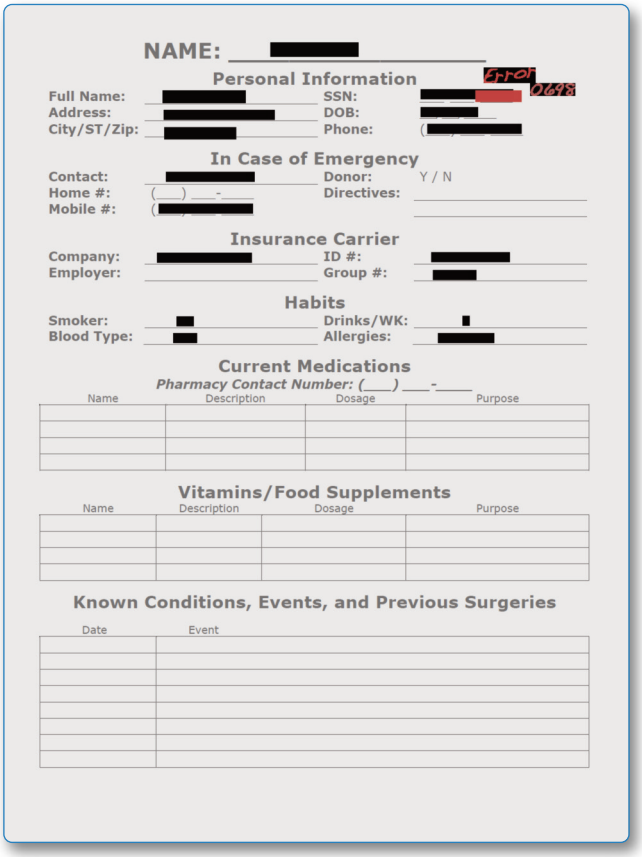
Downtime

Electronic documentation systems should include a process for alternate data entry during system downtime and a protocol for backup. Perioperative services should have a formal process for downtime that addresses hardware, operating systems, and network disruptions so that data can be preserved and patient care can continue uninterrupted.[1]

Strategies for downtime should

- facilitate uninterrupted patient care (eg, paper forms, documentation backup media),
- identify changes to existing workflows (eg, communication of new orders),
- prevent potential loss of patient care data, and
- incorporate patient care data captured using alternative methods for documentation (eg, paper forms) into the EHR.[1]

MODIFICATIONS AND CORRECTIONS


NAME: [redacted]

Personal Information

Full Name: [redacted] SSN: [redacted]
Address: [redacted] DOB: [redacted]
City/ST/Zip: [redacted] Phone: [redacted]

In Case of Emergency

Contact: [redacted] Donor: Y / N
Home #: (___) ___-____ Directives:
Mobile #: [redacted]

Insurance Carrier

Company: [redacted] ID #: [redacted]
Employer: Group #: [redacted]

Habits

Smoker: [redacted] Drinks/WK: [redacted]
Blood Type: [redacted] Allergies: [redacted]

Current Medications

Pharmacy Contact Number: (___) ___-____

Name	Description	Dosage	Purpose

Vitamins/Food Supplements

Name	Description	Dosage	Purpose

Known Conditions, Events, and Previous Surgeries

Date	Event

Modifications and corrections to the patient health care record should comply with federal and state regulations, health care accreditation requirements, and national practice guidelines. Amendments, corrections, or addendums to the patient's record should only be made to present an accurate description of the care provided or to protect the patient's interest. Using inappropriate methods to correct, clarify, or change existing entries in the health care record may expose team members or the health care organization to liability for falsification of patient care information. The process for making legally acceptable modifications to the patient's medical record should be outlined in the health care organization's information management policies.[1]

Corrections, amendments, and addendums in paper records should be performed by

- placing a single line through the incorrect entry, being careful not to obliterate the inaccurate information;

- writing "error," "mistaken entry," or "omit" next to the incorrect text as determined by organizational policy;
- providing the rationale for the correction above the inaccurate entry if room is available or adding it to the margin of the document;
- signing and dating the entry; and
- entering the correct information in the next available space or adjacent to the acknowledged inaccurate information.[1]

Corrections, amendments, and addendums in EHRs should

- have a versioning or "track corrections" function (eg, electronic strike-through with a time stamp) to identify the alterations made to an entry that has been authenticated;
- automatically date-, time-, and author-stamp each entry;
- generate a symbol or other notation to identify when an alteration has been made to existing content that creates a new version of the document;
- retain and link the original version of the document to the newly created version; and
- reflect corrections made to the EHR on the paper copy.[1]

ANALYTICS

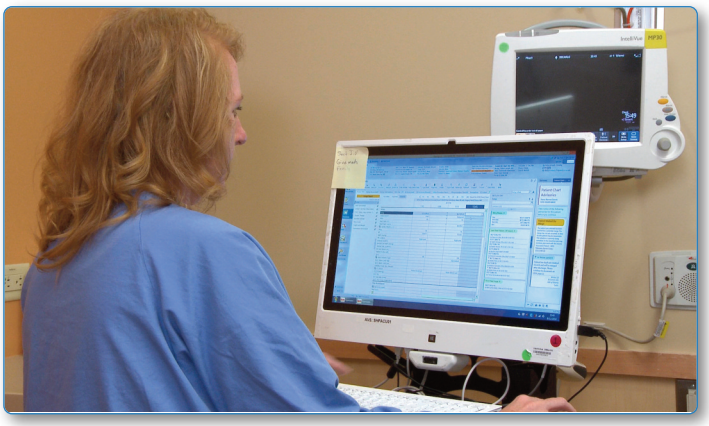
Data analytics are important to health care organizations transitioning from volume-based to value-based systems of reimbursement. Analytics allow organizations to convert raw data into actionable interventions; improve practices; and reduce variations in supplies, labor, and overhead.[18]

It is helpful for perioperative team members to understand some of the terms used for collection and analysis of data.

Metrics are specific measurement standards (eg, surgical start time). The health care organization should select metrics appropriate for the parameters to be measured (eg, patient satisfaction, percentage of on-time starts).[2]

Key performance indicators (KPIs) are metrics with embedded performance targets. They facilitate monitoring progress toward goals. Tracking over time helps to determine the effect of interventions on progress toward the desired target. The health care organization should select KPIs based on its goals. The primary aim is to identify problems and take proactive preventive action (as opposed to corrective action after events occur).[2]

Benchmarks expand on KPIs and allow the health care organization to determine whether similar parameters are comparable.[2]



Analytics involves the use of data, analysis, and models to drive decisions and actions. The process starts with collection and extraction of data followed by analysis. Analysis leads to determination of insights. Team members and the health care organization can then take actions based on the insights.[2]

Scorecards and dashboards are methods for visually displaying performance information. Dashboards are used for monitoring performance on an operational level. Scorecards are used to track tactical and strategic goals. Scorecards can serve as a bridge between short-term goals and long-term strategies.[2]

"Big data" refers to large amounts of data collected from different sources. The sheer volume makes it challenging to analyze. Big data is important for making administrative decisions and improving quality. The perioperative RN contributes to the health care organization's big data by accurately documenting patient care in the EHR.[5]

Clinical data repositories are centralized databases containing sets of data for secondary uses (eg, quality reporting, research). The quality of the data affects its usefulness for these secondary purposes.[5]

The potential for data to affect health care extends beyond the individual patient. Perioperative nursing data combined with other data in the EHR supports clinical decision-making and provides evidence about nursing assessments, interventions, and outcomes. Perioperative data are also used in developing, implementing, and evaluating the health care organization's policies, procedures, and practice guidelines.[5]

EDUCATION

Perioperative team members should receive initial and ongoing education and complete competency verification

activities related to the principles and performance of documenting patient care and best practices for maintaining the security of patient information. Education improves the effectiveness of documentation practices and reinforces strategies for avoiding unintentional disclosures.[1]

Perioperative RNs should receive education on the significance and use of structured vocabularies for clinical documentation. Education on structured terminologies should include the value of structured terminology in clinical documentation and an overview of the PNDS.[1]

Education and competency verification for perioperative RNs should include a review of the following:

- Compliance requirements for health care data capture
- Legal implications for failure to comply with documentation standards
- National and organizational documentation standards, guidelines, and requirements
- Procedures for completing amendments, addendums, and corrections
- Procedures for initiating notifications about breaches in security
- Procedures for sharing patient information securely while maintaining patient privacy[1]

POLICIES AND PROCEDURES

The health care organization should develop policies and procedures for perioperative information management. These policies and procedures should be reviewed periodically, revised as necessary, and readily available in the perioperative practice setting. Policies and procedures establish authority, responsibility, and accountability and serve as operational guidelines to minimize patient risk factors, standardize practice, direct health care personnel, and establish guidelines for continuous performance improvement activities.[1]

Information management policies and documentation procedures for EHR systems should include guidance on

- amending clinical content in an active or locked patient care record;
- completing corrections in an active or locked patient care record;
- completing delayed entries and updating the long-term record or data repository;
- defining components that are required for record completion;
- selecting or retracting information from a locked patient care record while maintaining the integrity of the record;
- editing content before a final signature or authentication process occurs;
- forwarding addendums to each destination where patient information is retained;
- rectifying a misidentification of patient health information (eg, wrong name association); and
- using cut-copy-paste and "carry forward" functionality to populate the patient care record.[1]

Policies and procedures must include information on data privacy and security and identify risk-reduction strategies to mitigate potential violations of patient health information access. Risk-reduction strategies should include

- establishing remote access protocols, on- and off-site information storage practices, and employee exit strategies to protect patient health information;
- holding annual competency-based education programs on information access and sharing for all employees in the perioperative care environment;
- identifying procedures for using mobile devices within the perioperative care environment;
- reinforcing existing security policies for monitoring and auditing access to patient health information within the perioperative care environment;
- restricting access to electronic health information by user type with individualized unique authorization credentials associated with time-sensitive passwords using combinations of alphanumeric characters and symbols; and
- reviewing and updating policies as the health care information environment changes.[1]

QUALITY MANAGEMENT

The health care organization should develop and implement a quality management program focused on the integrity of data within the patient health care record. Regular monitoring and validation of processes for documentation is necessary for variance reporting.[1]

SUMMARY

Perioperative RNs play a critical role in all stages of a patient's surgical experience, and patient information management is an important component of quality nursing care. By conscientiously managing patient information and maintaining an accurate patient record, the perioperative RN documents his or her contribution to patient health, enhances

the quality of care, and helps to ensure optimal patient outcomes.

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POST-TEST

PERIOPERATIVE PATIENT INFORMATION MANAGEMENT

Multiple choice. Please choose the word or phrase that best completes the following statements.

1. When should the perioperative RN record his or her patient assessment in the health record of a patient undergoing surgery?
   a. Before any operative or invasive procedure is performed
   b. Before discharge from the postanesthesia care unit
   c. Within 24 hours of completion of the procedure
   d. Before discharge from the hospital
   e. Within 48 hours after discharge from the hospital
2. Formats for capturing data should do all of the following EXCEPT
   a. facilitate data capture.
   b. incorporate data important to transitional care.
   c. incorporate redundant entry of information.
   d. reflect patient-focused care.
   e. synchronize with the nursing workflow.
3. Which of the following is a benefit of using structured vocabularies for nursing documentation?
   a. Allows comparison of costs and performance across local and national units
   b. Facilitates comparison of nursing assessments and interventions over time
   c. Facilitates development of computer databases
   d. Provides quality indicators for outcomes research
   e. All of the above
4. Which of the following is a standardized language focusing specifically on perioperative nursing?
   a. North American Nursing Diagnosis
   b. Nursing Intervention Classification
   c. Nursing Outcomes Classification
   d. Perioperative Nursing Data Set
   e. Systematized Nomenclature of Medicine–Clinical Terms
5. Patient care orders must be dated, timed, and authenticated by which of the following individuals?
   a. Charge nurse
   b. Health care practitioner giving the order
   c. Nurse receiving the order
   d. Nurse carrying out the order
   e. All of the above
6. When should a perioperative RN document verbal orders?
   a. At the ordering practitioner's convenience
   b. When the orders are given
   c. Within 24 hours of the orders being given
   d. When the orders are carried out
   e. Within 24 hours of patient discharge
7. Which of the following is an acceptable exception to the requirement for completing an informed consent before an operative procedure?
   a. Emergency procedure
   b. Minor procedure that requires no anesthetic
   c. Patient does not speak English
   d. Procedure that requires no sedation or anesthesia
   e. All of the above
8. The health care facility should implement which of the following strategies to minimize the risk of unauthorized access to a patient's medical record?
   a. Hold competency-based educational programs about information access for all employees
   b. Identify procedures for the use of mobile devices in the perioperative setting
   c. Implement protocols for remote access of information
   d. Restrict access of health information to users with individualized, unique authorization credentials
   e. All of the above

9. Which of the following statements about the use of social media in the perioperative setting is most accurate?
   a. Employers cannot consider an applicant's social media when making decisions about hiring.
   b. Health care professionals can face disciplinary action from licensing boards for disclosing patient information on social media.
   c. Omitting a patient's name is sufficient for preserving privacy in a social media post.
   d. Posts on social media are not discoverable in cases of litigation.
   e. All of the above

10. What is the minimum length of time a hospital must retain patient care records according to federal regulations in the United States?
   a. 2 years
   b. 5 years
   c. 10 years
   d. 20 years
   e. Forever

11. Which of the following statements about making corrections to the patient health care record is most accurate?
   a. Corrected information should be placed in an "addendum" section of the record.
   b. Corrections in an electronic health record do not need to be reflected in the paper copy.
   c. Inaccurate information should be completely obliterated during the correction on a paper record.
   d. The corrected entry must be signed and dated.
   e. The original, uncorrected version of the record should be deleted in an electronic health record.

12. Which of the following terms related to data analytics refers to specific measurement standards?
   a. Benchmarks
   b. Dashboards
   c. Key performance indicators
   d. Metrics
   e. Scorecards

POST-TEST ANSWERS

PERIOPERATIVE PATIENT INFORMATION MANAGEMENT

1. a
2. c
3. e
4. d
5. b
6. b
7. a
8. e
9. b
10. b
11. d
12. d