

Properly inputting data into an Electronic Medical Record

Properly inputting data into an Electronic Medical Record (EMR) system is crucial for maintaining accurate patient records, facilitating effective patient care, and mining the data to better understand your panel. Here are some tips for ensuring data input is done correctly:

Training: Ensure all staff members who will be inputting data into the EMR system are properly trained on how to use the system. This includes understanding the various fields, dropdown menus, and data entry conventions.

Patient Identification: Double-check patient identification details such as name, date of birth, address, contact information and Medicare number at each visit to ensure accuracy. Mistakes in patient identification can lead to serious errors in treatment.

Accuracy: Enter data accurately and avoid shortcuts, such as copy-pasting information without verifying its correctness. Double-check numerical values, medication names, and other critical data points.

Standardized Terminology: Use standardized medical terminology and coding when inputting data. Using ICD codes is important for patient management, billing help and panel research. This ensures consistency and improves interoperability between different health-care systems.

Completeness: Ensure that all relevant information is documented. This includes medical history, current medications, allergies, vital signs, and any other pertinent details for each patient encounter.

Timeliness: Input data in a timely manner to ensure that patient records are up-to-date and reflect the most recent information. Delayed data entry can lead to discrepancies and potential patient safety issues. Dictation and ambient scribe tools can be useful.

Security and Privacy: Adhere to security and privacy protocols when inputting sensitive patient information into the EMR system. This includes following HIPAA guidelines and ensuring that only authorized personnel have access to patient records.

Documentation Standards: Follow established documentation standards and guidelines set forth by your health-care organization or regulatory bodies. Consistent documentation practices ensure clarity and accuracy in patient records.

The College of Physicians and Surgeons of New Brunswick maintains the professional standards required applicable to medical record data entry. Follow this link for more information:

www.cpsnb.org/en/physicians/professional-standards2/438-the-patient-medical-record

Communication: Communicate effectively with other health-care team members to ensure that relevant information is shared and documented in the EMR system. This promotes continuity of care and prevents information gaps.

The content of this guidance document is intended to provide general information and guidance to the reader on the subject matter. The NBMS does not provide legal/accounting or professional advice. Specialist advice should be sought about your specific circumstances where necessary.

Review and Audit: Regularly review and audit data entered into the EMR system to identify any errors or discrepancies. This helps maintain data integrity and ensures the quality of patient records.

By following these guidelines, health-care providers can ensure that data input into an EMR system is accurate, complete, and secure, ultimately leading to improved patient care outcomes.