Securing and Validating the Electronic Medical Record Using PointClickCare’s EHR Platform
EHRs are real-time, patient-centered records that make information readily and securely available to authorized users.¹

Long-Term Post-Acute Care providers are regularly required to produce, deliver and attest to the accuracy of the electronic medical records for the residents maintained in their databases. These requests can be for all or part of the electronic health record and are usually time sensitive, putting pressure on providers to respond quickly.

The PointClickCare EHR includes tools to enable providers to readily produce reliable, consistent and verifiable electronic versions of the clinical chart formerly maintained in paper records.

PointClickCare’s HIPAA-compliant EHR platform provides a variety of security and validation features to permit authorized users of the EHR to confirm the validity, reproducibility, inviolability, confidentiality, integrity, accuracy and completeness of the medical record.

This whitepaper provides an overview of the key security and validation features of PointClickCare’s EHR platform that relate to the production of medical records.

Record Validity via the PointClickCare EHR

Content of the Record

PointClickCare’s EHR provides a secure platform using multi-layered and HIPAA-compliant tools including the encryption of data at rest and in transit along with unique database identifiers and password protected user access. Once data is entered into the PointClickCare EHR, no person, either within the provider organization or outside third parties, has direct access to the database; therefore no changes can be made to the records stored in the provider’s database maintained by the PointClickCare platform. Further, no third-party systems or access points can be used to alter the core content of the record of care maintained in the EHR.

For all transactions involving the clinical/medical record, the PointClickCare EHR ensures that once signed by the appropriate practitioner and saved as part of the record, no system user or outside third party can delete a transaction or item of documentation. This includes, but is not limited to, progress (nursing) notes, assessments and standardized assessments, medication and treatment administration records and weights & vitals. This also prevents deletion or alteration of electronic medical data imported into the PointClickCare EHR from specialty third-party system providers; e.g., skin and wound, therapy and practitioner encounter data.

The system is designed so that the electronic medical record is maintained and protected, ensuring that whether it is delivered to a patient upon discharge or to a physician requiring it for a consultation, the record produced will be accurate, complete and consistent.
Date and Time Stamping

The PointClickCare EHR automatically time-stamps transaction data at the time of creation with the current date and time as well as the identity and credentials of the authorized user. These entries are automatically generated by the PointClickCare EHR and cannot be changed by anyone accessing the medical record. While late entry of data is permitted in certain limited components of the PointClickCare system, such late entries are automatically flagged and identified by the user-entered date of treatment. These late entries are then automatically date and time stamped with the date and time of the entry into the medical record by the system. By doing this, the PointClickCare EHR automatically tracks the “created date” or “documented date” and the “effective date” for transactions where they are not the same, and provides a variety of methods for reporting system-created late entry notices. Late entries are identified with a “LATE ENTRY” stamp in the associated progress notes for visible recognition of interruptions in the resident record of care or within viewable reports that show the time entered and effective time of the transaction. In either event, the information is readily available for viewing.

History of the Record

The history of an entry within the EHR can be viewed via a number of operational reports available to the user. These reports track the history of changes to the medical record including who created the entry, what it contained, when it was made and any subsequent changes made to it. Specific areas of the record such as weights & vitals do not require operational tracking because once saved, those entries cannot be modified; they can only be struck out and tracked as such.

As entries in the PointClickCare EHR are stored over time, the system produces automated reports of the transactions for longitudinal comparisons. Reports of revisions made over defined time periods can also be produced, resulting in a record of modifications and historical changes to the resident’s record over time.

The result is that providers can use PointClickCare tools to produce a complete and accurate representation of the medical record that includes all original and revision entries with effective dates and entry dates clearly identified.
System User-Based Information

The PointClickCare EHR does not currently track end-user-specific activity or activities within the application such as record views. Only new entries or modifications to existing entries that are part of the EHR are identifiable. Specific areas of the application such as immunizations and progress notes offer users the ability to report on entries created and aggregated by a specific system user.

Although the PointClickCare EHR platform permits extensive configuration capabilities in the way information is collected, the data elements, time stamps and tracking do not change. System users cannot make changes directly to the database of resident data or delete saved and completed entries made to a medical record.

Know What You Have and Where It Is

Understanding what is in your EHR is the key to knowing what data can be produced from the system. PointClickCare encourages users and administrators to maintain policies identifying the record set maintained electronically and those records that may be kept on paper. They should have procedures for the production of charts so that the correct content can be produced for each specific request. Requests for documentation should be also be maintained, including the date and time of the printing and the record set contained within.

Conclusions

Producing electronic medical records will be an increasingly important ongoing requirement as residents, families, legal authorities and regulatory bodies place more scrutiny on medical records. Policies and procedures stipulating the record sets and locations of documents will assist in meeting tight deadlines for record production. PointClickCare provides a secure platform for the collection, storage and aggregation of records but it is up to each individual facility to ensure the right people have the right access and know where all records are kept for any resident, whether paper or electronic.

1 https://www.healthit.gov/providers-professionals/faqs/what-electronic-health-record-ehr

2 http://library.ahima.org/PB/DesignatedRecordSet#.V2P6G7srKCg

PointClickCare has helped over 13,000 skilled nursing and senior living facilities meet the challenges of senior care by enabling them to achieve the business results that matter – enriching the lives of their residents, improving financial and operational health, and mitigating risk. PointClickCare’s cloud-based software platform takes a person-centered approach to managing senior care, connecting healthcare providers across the senior care continuum with easy to use, regulatory compliant solutions for improved resident outcomes, enhanced financial performance, and staff optimization. For more information on PointClickCare’s ONC certified software solutions, please visit www.pointclickcare.com.