

Associated Terms

Additional terms factor into the guidance provided within this toolkit. The definitions of these terms are important to understanding the context. For the purpose of this toolkit, the following definitions apply.

Completion: the process of *completing an entry* in the health record by applying the provider's signature, either electronic or manual. Once the signature is applied, the entry is considered complete and the only opportunity to make changes is through an amendment or addendum to that entry. Organizational policy should define documentation points required for completing an entry and how long documents are available in an incomplete status.

Direct documentation: *text entries* made into the health record; e.g., progress notes, nursing notes, physician orders. The process where entries made directly into the health record are automatically authenticated as a result of the author logging into the system.

Electronic Signature: any electronic process signifying an approval to terms, and/or documentation presented in electronic format. Electronic signatures frequently also have the added benefit of ensuring the integrity of the signed document to signify that (1) the document has not been changed since it was signed and (2) the signer cannot 'repudiate' or claim that they did not sign the document. Electronic signatures encompass a broad gamut of technologies and methodologies, ranging from an "I agree" button in a click-thru agreement to an electronic tablet which accepts a handwritten signature to a *digital signature* cryptographically tied to a digital ID or certificate.

Final Signature: The process of applying the responsible provider's electronic signature to documentation. Once applied, the documentation is considered complete. See **Completion**.

Information: changes made to entries within a health record that can be either direct documentation or transcribed reports; e.g., a deletion can be made to either a progress note (direct documentation) or a dictated operative note (report).

Locked: The process by which health record entry is complete and any changes to the entry must be made through an amendment.

Provider: Any staff member providing care to a patient who has privileges to treat and document within a health record.

Reports: Refers to transcribed reports; e.g., history and physical or operative note, not generated within the electronic health record.

Versioning: Refers to the storage and management of previous versions of a piece of information, documentation or documents for security, diagnostics and interest.