ANA's

Principles for Nursing Documentation

Guidance for Registered Nurses

Silver Spring, Maryland
2010

Summary

Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Nurses practice across settings at position levels from the bedside to the administrative office; the registered nurse and the advanced practice registered nurse are responsible and accountable for the nursing documentation that is used throughout an organization. *ANA's Principles for Nursing Documentation* identifies six essential principles to guide nurses in this necessary and integral aspect of the work of registered nurses in all roles and settings.

American Nurses Association
8515 Georgia Avenue, Suite 400
Silver Spring, MD 20910-3492
1-800-274-4ANA
www.Nursingworld.org

Published by Nursesbooks.org
The Publishing Program of ANA
www.Nursesbooks.org

ISBN-13: 978-1-55810-284-2 eBook publication, November 2010

Contents

Overview of Nursing Documentation

Overview of Nursing Documentation

Clear, accurate, and accessible documentation is an essential element of safe, quality, evidence-based nursing practice. Nurses practice across settings at position levels from the bedside to the administrative office; the registered nurse (RN) and the advanced practice registered nurse (APRN) are responsible and accountable for the nursing documentation that is used throughout an organization. This may include either documentation on nursing care that is provided by nurses—whether RN, APRN, or nursing assistive personnel—that can be used by other non-nurse members of the health care team or the administrative records that are created by the nurse and used across organization settings.

Documentation of nurses' work is critical as well for effective communication with each other and with other disciplines. It is how nurses create a record of their services for use by payors, the legal system, government agencies, accrediting bodies, researchers, and other groups and individuals directly or indirectly involved with health care. It also provides a basis for demonstrating and understanding nursing's contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care.

Documentation is sometimes viewed as burdensome and even as a distraction from patient care. High quality documentation, however, is a necessary and integral aspect of the work of registered nurses in all roles and settings. This requires providing nurses with sufficient time and resources to support documentation activities. At a time when accessing, generating, and sharing information in health care is rapidly changing, it is particularly important to articulate and reinforce principles that are basic to effective documentation of nursing services.

It is important to bear in mind that this publication's focus on nursing documentation is necessarily more that of a conceptual overview than a technical summary. The pace of innovation and adoption of the digital technologies of such documentation requires this. But the attendant issues of accuracy, confidentiality, and security of patient documentation, in accordance with regulatory guidelines and mandates, are and will remain paramount, whatever the technological platform. These enduring issues inform and underline the principles and recommendations in this publication.

The Uses of Nursing Documentation

Communication within the Health Care Team

Communication with Other Professionals

The Uses of Nursing Documentation

Nurses document their work and outcomes for a number of reasons: the most important is for communicating within the health care team and providing information for other professionals, primarily for individuals and groups involved with accreditation, credentialing, legal, regulatory and legislative, reimbursement, research, and quality activities.

Communication within the Health Care Team

Nurses and other health care providers aim to share information about patients and organizational functions that is accurate, timely, contemporaneous, concise, thorough, organized, and confidential. Information is communicated verbally and in written and electronic formats across all settings. Written and electronic documentation are formats that provide durable and retrievable records.

Foremost of such electronic documentation is the *electronic health record* (EHR), provides an integrated, real-time method of informing the health care team about the patient status. Timely documentation of the following types of information should be made and maintained in a patient's EHR to support the ability of the health care team to ensure informed decisions and high quality care in the continuity of patient care.

- Assessments
- Clinical problems
- Communications with other health care professionals regarding the patient
- Communication with and education of the patient, family, and the patient's designated support person and other third parties
- Medication records (MAR)
- Order acknowledgement, implementation, and management
- 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

Communication with Other Professionals

Patient documentation frequently is used by professionals who are not directly involved with the patient's care. If patient documentation is not timely, accurate, accessible, complete, legible, readable, and standardized, it will interfere with the ability of those who were not involved in and are not familiar with the patient's care to use the documentation. Some of the most common areas of interprofessional use of nursing documentation that are outside the direct care team are summarized below.

Credentialing

Nursing documentation, such as patient care documents, assessments of processes, and outcome measures across organizational settings, serve to monitor performance of health care practitioners' and the health care facility's compliance with standards governing the profession and provision of health care. Such documentation is used to determine what credentials will be granted to health care practitioners within the organization.

Legal

Patient clinical reports, providers' documentation, administrators' records, and other documents related to patients and organizations providing and supporting patient care are important evidence in legal matters. Documentation that is incomplete, inaccurate, untimely, illegible or inaccessible, or that is false and misleading can lead to a number of undesirable outcomes, including:

- Impeding legal fact finding
- Jeopardizing the legal rights, claims, and defenses of both patients and health care providers
- Putting health care organizations and providers at risk of liability

Regulation and legislation

Audits of reports and clinical documentation provide a method to evaluate and improve the quality of patient care, maintain current standards of care, or provide evaluative evidence when standards require modification in order to achieve the goals, legislative mandates, or address quality initiatives.

Reimbursement

Documentation is utilized to determine the severity of illness, the intensity of services, and the quality of care provided upon which payment or reimbursement of health care services is based.

Research

Data from documentation provides information about patient characteristics and care outcomes. Evaluation and analysis of documentation data are essential for attaining the goals of evidence-based practice in nursing and quality health care.

Quality process and performance improvement

Documentation is the primary source of evidence used to continuously measure performance outcomes against predetermined standards, of individual nurses, health care team members, groups of health care providers (such as units or code teams), and organizations. This information can be used to analyze variance from established guidelines and measure and improve processes and performance related to patient care. All nurses must have thorough evidence-based knowledge of the impact of the care they provide on the outcomes that patients experience and data on the nursing-sensitive measures such as data available through the National Database of Nursing Quality Indicators (NDNQI®), a repository for nursing-sensitive indicators and a program of the American Nurses Association (ANA) National Center for Nursing Quality (NCNQ®). The data from such analytic activities informs quality improvement activities and evaluations of organizational effectiveness.

Background Publications and Policy Statements

Background Publications and Policy Statements

The following ANA publications are among the practice and policy foundations for the principles and recommendations for nursing documentation as presented on the following pages.

- *Code of Ethics for Nurses with Interpretive Statements* (ANA, 2001) provides individuals throughout society with an understanding of the moral and ethical foundations that support nurses from every setting and in roles at all levels as they provide optimal care and services. Provision 3 of the Code is specific: "The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient" (pg. 12); the Code's Interpretive Statements 3.1 and 3.2 address, respectively, privacy and confidentiality.
- *Nursing's Social Policy Statement: The Essence of the Profession* (ANA, 2010a) describes the pivotal nature and role of professional nursing in health care, nursing's ongoing social concerns and consequent societal responsibility of nurses, and the unique accountability of nurses to patients, clients, and society. The enduring tradition of this distinctive social dimension of nursing informs the whole-person focus of nursing, and is reflected in nursing documentation.
- *Nursing: Scope and Standards of Practice, Second Edition* (ANA, 2010b) builds on content of the code of ethics and the social policy statement, outlines the expectations of the professional role of the registered nurse, and presents the standards of professional nursing practice and accompanying competencies. Documentation is a common thread throughout most of these standards.
- *Adapting Standards of Care under Extreme Conditions: Guidance for Professionals During Disasters, Pandemics, and Other Extreme Emergencies* (ANA, 2008) provides guidance regarding the ethics and standards that apply to decisions about care made during unusual or extreme circumstances such as those resulting from emergencies, disasters, or pandemics. Part of this guidance is the understanding that documentation may need to delayed or abbreviated to meet the challenges of triaging and providing life-saving care in extreme emergencies.

- The ANA Position Statement, *Electronic Health Record* (ANA, 2009a) identifies the principles and expectations addressing the design, development, implementation, and evaluation of the EHR in meeting the needs of all persons, communities, and populations. This is the first of a series of position statements related to emerging information technologies and their delivery platforms, and the implications for nursing practice, including some of the operating and regulatory aspects of EHR implementation.

Nursing Documentation Principles

Principle 1. Documentation Characteristics
Principle 2. Education and Training
Principle 3. Policies and Procedures
Principle 4. Protection Systems
Principle 5. Documentation Entries
Principle 6. Standardized Terminologies

Nursing Documentation Principles

The ANA policy documents and publications noted on pages 9 and 10, as well as state nurse practice acts, government regulations, and organizational policies and procedures, include documentation as an essential component of nursing practice. Accordingly, the American Nurses Association presents these principles:

- Principle 1. Documentation Characteristics
- Principle 2. Education and Training
- Principle 3. Policies and Procedures
- Principle 4. Protection Systems
- Principle 5. Documentation Entries
- Principle 6. Standardized Terminologies

Principle 1. Documentation Characteristics

High quality documentation is:

- Accessible
- Accurate, relevant, and consistent
- Auditable
- Clear, concise, and complete
- Legible/readable (particularly in terms of the resolution and related qualities of EHR content as it is displayed on the screens of various devices)
- Thoughtful
- Timely, contemporaneous, and sequential
- Reflective of the nursing process
- Retrievable on a permanent basis in a nursing-specific manner

Principle 2. Education and Training

Nurses, in all settings and at all levels of service, must be provided comprehensive education and training in the technical elements of documentation (as described in this document) and the organization's policies and procedures that are related to documentation. This education and training should include staffing issues that take into account the time needed for documentation work to ensure that each nurse is capable of the following:

- Functional and skillful use of the global documentation system
- Competence in the use of the computer and its supporting hardware
- Proficiency in the use of the software systems in which documentation or other relevant patient, nursing and health care reports, documents, and data are captured

Principle 3. Policies and Procedures

The nurse must be familiar with all organizational policies and procedures related to documentation and apply these as part of nursing practice. Of particular importance are those policies or procedures on maintaining efficiency in the use of the "downtime" system for documentation when the available electronic systems do not function.

Principle 4. Protection Systems

Protection systems must be designed and built into documentation systems, paper-based or electronic, in order to provide the following as prescribed by industry standards, governmental mandates, accrediting agencies, and organizational policies and procedures:

- Security of data
- Protection of patient identification,
- Confidentiality of patient information
- Confidentiality of clinical professionals' information
- Confidentiality of organizational information

Principle 5. Documentation Entries

Entries into organization documents or the health record (including but not limited to provider orders) must be:

- Accurate, valid, and complete;
- Authenticated; that is, the information is truthful, the author is identified, and nothing has been added or inserted;
- Dated and time-stamped by the persons who created the entry;
- Legible/readable; and
- Made using standardized terminology, including acronyms and symbols.

Principle 6. Standardized Terminologies

Because standardized terminologies permit data to be aggregated and analyzed, these terminologies should include the terms that are used to describe the planning, delivery, and evaluation of the nursing care of the patient or client in diverse settings.

Recommendations for Nursing Documentation

Practicing Registered Nurses
Employers and Health Care Agencies
Patients and Consumers
Health Care Systems
Nursing Education
Nursing Research

Recommendations for Nursing Documentation

Nurses should aim to ensure that critical and necessary data and information are documented while avoiding duplicative documentation. To do so, nurses need to understand the forces and other factors that shape the requirements of practice-specific documentation. To that end, ANA makes the following recommendations.

Practicing Registered Nurses

Nurses in all settings and at all level should participate in decision-making to procure policies, resources, processes, and systems individualized to their organization's needs and populations to support documentation activities and systems that facilitate:

- Creation of an EHR and trialing of custom-made software packages with formats compatible across platforms
- Design of functional, user-friendly processes for documentation that allow and enhance:
  - Access to documentation
  - Comparative analyses
  - Efficiency
  - Evaluation of outcomes
  - Interdisciplinary input and access
  - Revision and improvement of documentation processes and information systems
  - Seamless communications among providers across the continuum of care
  - Transferability and portability
  - Point of care access linkages to evidence-based practice guidelines

Employers and Health Care Agencies

Employers and health care agencies should actively engage nurses in decisions regarding documentation. Nurses, employees, and risk managers from all settings and levels who create documentation, use

documentation systems or are responsible for documentation, data confidentiality or security should be involved in the decision-making, creation, design, and selection and implementation of documentation systems. This process creates opportunities for nurses and all others who have a stake in quality and secure documentation to gain hands-on experience with the policies, processes, and systems.

The employer should provide clear and concise guidelines, policies, and procedures for documentation within the organization. The employer also should:

- Develop innovative documentation education programs
- Evaluate quality and efficiency of documentation requirements regularly
- Make necessary improvements to the documentation of policies, procedures, and systems
- Make available to patients and other third parties information about the availability, use, and dissemination of system-, provider-, and patient-specific information, records, and data
- Provide or require routine and ongoing documentation education, including providing a mechanism for students in professional development activities to have supervised access to actual documentation

Staffing plans should take into account the significant time required to meet nursing accountability and responsibilities for documentation.

Patients and Consumers

Patients are entitled to have access to their own health record. In some cases, patients' families or other representatives may be entitled to have reasonable access to patient records. Documentation requirements, policies, procedures, and systems should consider patients' needs for access to their own records and should enhance patient access. Patients and consumers who are authorized to have access to patient information should be informed about their rights and responsibilities under federal and state law. Access to and information about patient

records and information, including but not limited to care, follow-up and discharge instructions, and consents should be culturally appropriate and well-documented and provided in a manner that allows sufficient opportunity and time to enable patients to understand and appreciate them.

Health Care Systems

Documentation systems should be designed to have interoperability across the health care system such that the documentation can be sent to and received by other systems in a useable format. The documentation interoperability and information transfer includes nursing documentation.

To facilitate interoperability and transferability, standardized terminologies should be utilized to:

- Describe all aspects of nursing care, including assessment, identification of problems nursing diagnoses and interventions, nursing-sensitive outcomes, evaluation, and recommendations
- Provide for a method to accurately document errors (commission, omission, and near misses) that meet a national standard
- Ensure nurses (prepared in nurse informatics or similar specialties), at the level of the health care system, in collaboration with regulatory agencies, contribute to the design and development of data storage and retrieval systems that function in a timely and efficient manner

Nursing Education

Academic learning centers must prepare all nursing students' documentation skills; nurses' accountability, responsibility and potential liability for documentation; risks of poor documentation; and the technologies and digital media of documentation and information access. Documentation curricula should include didactic and clinical components to prepare nurses in the specialties of informatics and related technologies, whether in the context of continuing education, inservice education, or certification. (TIGER 2009)

Nursing Research

Nurse researchers should examine variables related to use of electronic documentation for nurses in administrator, educator, and direct care role including:

- Benefits to patient care variables
- Data use in clinical decision-making that support interventions and the continuity of care
- Ergonomics and other usability factors
- Environmental factors and variable
- Ethical considerations
- Legal considerations
- Nursing-sensitive indicators and patient care outcomes
- Time needed to attain proficiency in documentation
- Time required by nurses in various settings—including the related environmental factors and variables—to create documentation as delineated in this publication
- Time savings to nursing and/or the health care team related to interdisciplinary and interprofessional documentation

Glossary

Glossary

Advanced Practice Registered Nurse (APRN)

Advanced practice registered nursing by certified nurse practitioners, certified nurse anesthetists, certified nurse midwives or clinical nurse specialists is based on knowledge and skills acquired in basic nursing education; licensure as a registered nurse; graduation from or completion of a graduate-level APRN program accredited by a national accrediting body; and current certification by a national certifying body in the appropriate APRN role and at least one population focus. Practice as an APRN means an expanded scope of nursing in a role and population focus approved by the board, and includes the registered nurse scope of practice. (Those population foci are: family/individual across the life span, adult-gerontology, neonatal, pediatrics, women's health/gender-related health, psychiatric/mental health.) The scope of an APRN includes, but is not limited to, performing acts of advanced assessment, diagnosing, prescribing, and ordering. APRNs may serve as primary care providers of record. (AACN, 2008)

Accreditation

A voluntary, self-regulatory process by which governmental, non-governmental, or voluntary associations or other statutory bodies grant formal recognition to programs or institutions that meet stated quality criteria. (Styles, Schumann, Bickford, & White, 2008, p. 5–6)

Code of ethics

The provisions that make explicit the primary goals, values, and obligations of a profession. In the United States, professional nurses abide by and adhere to the ANA Code of Ethics for Nurses.

Competency

An expected level of performance that integrates knowledge, skills, abilities, and judgment, based on established scientific knowledge and expectations for nursing practice.

Confidential information

Individually identifiable patient information (protected health information) as well as proprietary information. Access to identifiable and confidential information "must be protected and access to it controlled". (Ware, 1993 as cited in Kumekawa, 2001)

Confidentiality

"The respectful handling of information disclosed within relationships of trust, such as healthcare relationships, especially as regards further disclosure." (Lowrance, 1997, p. 18)

Credentialing

Processes designating that an entity has met established standards set by an agent, governmental or non-governmental, that is acknowledged as being qualified to carry out this responsibility. (Styles, Schumann, Bickford, & White, 2008, p. 28)

Cultural competency

"A process in which the nurse continuously strives to achieve the ability and availability to effectively work within the cultural context of a client (individual, family, community)." (Campinha-Bacote, 2005)

Direct care nurse

The nurse providing care directly to patients, excluding the nurse manager and nurse executive. Direct care activities can be reflected as partial full-time equivalents (FTEs). (ANCC, 2008, p.61)

Electronic health record (EHR)

A longitudinal electronic record of patient health information and automated and streamlined to the clinician's workflow. An EHR can help generate a complete record of a clinical patient encounter in any care delivery setting, and thus support other care-related activities, including evidence-based decision support, quality management, and outcomes reporting. Such information is generated by one or more encounters. (HIMMS, 2010)

Evidence-based practice

A process founded on the collection, interpretation, and integration of valid, important, and applicable patient-reported, clinician-observed, and research-derived evidence. The best available evidence, moderated by patient circumstances and preferences, is applied to improve the quality of clinical judgments.

HIPAA (Health Insurance Portability and Accountability Act)

The Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. The Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it permits the disclosure of personal health information needed for patient care and other important purposes. (U.S. HHS/OCR, 2010)

Interdisciplinary

Reliant on the overlapping skills and knowledge of each team member and discipline, resulting in synergistic effects where outcomes are enhanced and more comprehensive than the simple aggregation of the team members' individual efforts. (ANA, 2010b, p. 68)

Interprofessional

Reliant on the overlapping knowledge, skills, and abilities of each professional team member. This can drive synergistic effects by which outcomes are enhanced and become more comprehensive than a simple aggregation of the individual efforts of the team members. (ANA, 2010b, p. 68)

Nurse administrator/executive

A registered nurse who orchestrates and influences the work of others in a defined environment, most often health care focused, to enhance the shared vision of an organization or institution. The goals of their efforts are a quality product focused on safety and the requisite infrastructures that seek to meet the expectations of the nursing profession, the consumer, and society. (ANA, 2009b)

Nursing

Nursing is the protection, promotion, and optimization of health and abilities, prevention of illness and injury, alleviation of suffering through the diagnosis and treatment of human response, and advocacy in the care of individuals, families, communities, and populations.

Nursing-sensitive indicators

Those that reflect the structure, process and outcomes of nursing care. *Structure* indicators measure aspects of the supply, skill level, and education and certification of nursing staff. *Process* indicators measure aspects of nursing care such as assessment, intervention, and RN job satisfaction. Nursing-sensitive *patient outcome* indicators (such as pressure ulcers, falls, and IV infiltrations) are those that improve with a greater quantity or quality of nursing care. (ANA, 2009c)

Protected Health Information (PHI)

Individually identifiable health information that is (i) held or maintained by a covered entity or its business associates acting for the covered entity, or (ii) transmitted or maintained in any form or medium (including the individually identifiable health information of non-U.S. citizens). This includes identifiable demographic information and any other information relating to the past, present, or future physical or mental health or condition of an individual, or the provision or payment of health care to an individual that is created or received by a health care provider, health plan, employer, or health care clearinghouse. For purposes of the Privacy Rule, genetic information is considered to be health information. (NIH, 2009)

Privacy

"A status of information about aspects of a person's life over which he claims control and may wish to exclude others from knowing about. Such privacy claims may or may not be conceded by others or affirmed by laws." (Lowrance, 1997, p. 18). Examples include past medical history, current and future physical or mental conditions, and payment for the provision of health care. (ANA, 2006)

Plan of care

A comprehensive outline of the components of care that need to be addressed to attain expected outcomes.

Safeguards

Measures taken to protect an "information system … and its contents against unauthorized disclosure, and limit access to authorized users". (ANA, 2006)

Telehealth

The use of electronic information and telecommunications technologies in such activities as long-distance clinical health care, patient and professional health-related education, public health, and health administration. (U.S. DHHS/HSSA, 2010)

References and Bibliography

All URLS were current as accessed on September, 30, 2010.

American Association of Colleges of Nursing (AACN 2008). APRN Consensus Work Group, and APRN Joint Dialogue Group. (2008). *Consensus model for APRN regulation: Licensure, accreditation, certification and education*. July. Aliso Viejo, CA: Author. http://www.nursingworld.org/EspeciallyForYou/AdvancedPracticeNurses/Consensus-Model-Toolkit.aspx

American Nurses Association (ANA). (2010a). *Nursing's social policy statement: The essence of the profession.* Silver Spring, MD: Nursesbooks.org.

American Nurses Association (ANA). (2010b). *Nursing: Scope and standards of practice, second edition.* Silver Spring, MD: Nursesbooks.org.

American Nurses Association (ANA). (2009a). *Electronic health record.* (Position statement, December 8, 2009.) Silver Spring, MD: Author http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/ANAPositionStatements/practice.aspx

American Nurses Association (ANA). (2009b). *Nursing administration: Scope and standards of practice.* Silver Spring, MD: Nursesbooks.org.

American Nurses Association (ANA). (2009c). *Nursing-sensitive indicators.* Silver Spring, MD: Author. http://www.nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/PatientSafetyQuality/Research-Measurement/The-National-Database/Nursing-Sensitive-Indicators_1.aspx

American Nurses Association (ANA). (2008). *Adapting standards of care under extreme conditions: Guidance for professionals during disasters, pandemics, and other extreme emergencies*. Reviewed and approved by the Working Group, December, 2007. Prepared for American Nurses Association, Center for Health Policy , and Columbia University School of Nursing. Silver Spring, MD: Author. http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/DPR/TheLawEthicsofDisasterResponse/AdaptingStandardsofCare.aspx

American Nurses Association (ANA (2006). *Privacy and confidentiality.* (Position statement, December 8, 2006.) http://www.nursingworld.org/EthicsHumanRights

American Nurses Association (ANA). (2001). *Code of ethics for nurses with interpretive statements.* Washington, DC: Nursesbooks.org. Also available online: http://nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/EthicsStandards/CodeofEthics.aspx

American Nurses Credentialing Center (ANCC) (2008) *Magnet Manual.* Silver Spring, MD: Author.

Campinha-Bacote, J. (2005). Cultural competence: An integral part of holistic nursing practice. *Medscape Nurses,* Sept 30, 2005. http://www.medscape.com/viewarticle/513607

Healthcare Information and Management Systems Society (HIMMS) 2010. Electronic health record (EHR). Chicago, IL: Author. http://www.himss.org/ASP/topics_ehr.asp

Kumekawa, J. K. (2001) Health information privacy protection: Crisis or common sense? *Online Journal of Issues in Nursing 6*(3): September. American Nurses Association. http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume62001/No3Sept01/PrivacyProtectionCrisis.aspx

Lowrance, W.W. (1997) *Privacy and health research*: *A report to the Secretary of Health and Human Services.* May. Washinton DC: Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation Office of Program Systems, Division of Data Policy. http://aspe.hhs.gov/DATACNCL/PHR.htm

National Institutes of Health (NIH) (2009). What health information is protected by the Privacy Rule? From *HIPAA Privacy Rule: Information for Researchers.* Bethesda, MD: Author. http://privacyruleandresearch.nih.gov/pr_07.asp

Styles, M. M., Schumann, M. J., Bickford, C. J., & White, K. M. (2008). *Specialization and credentialing in nursing revisited: Understanding the issues, advancing the profession*. Silver Spring, MD: Nursesbooks.org.

Technology Informatics Guiding Educational Reform (TIGER). (2009) *TIGER Informatics Competencies Collaborative (TICC) final report*. August. http://tigercompetencies.pbworks.com/f/TICC_Final.pdf

U.S. Department of Health and Human Services, Health Resources and Services Administration. (2010). What is telehealth (para.1). Washington, DC: Author. http://www.hrsa.gov/telehealth/default.htm

U.S. Department of Health and Human Services. Office of Civil Rights. (2010). Health information privacy. Washington, DC: Author. http://www.hhs.gov/ocr/privacy/index.html

Ware, W. (1993). *Lessons for the future: Dimensions of medical record keeping in health Records: Social needs and personal privacy*, 43, Task Force on Privacy. Washington, DC: U.S. Department of Health and Human Services.

Contributors

Contributors

Co-Chairs

Jennifer H. Matthews, PhD, ACNS-BC
Carola M. Bruflat, MSN, RNC, WHNP-BC/FNP-BC
Association of Women's Health, Obstetrics and Neonatal Nurses (AWHONN)

Workgroup Members

Robin Chard, PhD, RN, CNOR
Association of perioOperative Registered Nurses (AORN)
William R. Donovan, MA, RN
Lisa A. Gorski, MS, HHCNS-BC, CRNI, FAAN
Infusion Nurses Society (INS)
Debra Hobbins, MSN, APRN
Patricia Leo Holloman, BSN, RN, CNOR
David M. Keepnews, PhD, JD, RN, FAAN
Theresa Ann Posani, MS, RN, CNS, APRN-BC, CCRN, CNE
Thomas E. Stenvig, PhD, RN, MPH, CNAA

ANA Staff

Lisa Summers, DrPH, CNM – Content Editor
Yvonne Humes, MSA – Project Coordinator
Maureen E. Cones, Esq. – Legal Counsel
Eric Wurzbacher – Project Editor

About ANA

The American Nurses Association (ANA) is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent member nurses associations, its organizational affiliates, and the Center for American Nurses. The ANA advances the nursing profession by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and by lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

This ANA publication—*ANA's Principles for Nursing Documentation*—reflects the thinking of the nursing profession on various issues and should be reviewed in conjunction with state board of nursing policies and practices. State law, rules, and regulations govern the practice of nursing, while this publication guides nurses in the application of their professional skills and responsibilities.