Standard Operating Procedure (SOP) Template

Documentation and Electronic Health Record (EHR) Entry Protocol

This SOP establishes the **documentation and electronic health record (EHR) entry protocol** to ensure accurate, timely, and secure recording of patient information. It includes guidelines for data entry, validation, update procedures, confidentiality requirements, and compliance with legal and regulatory standards. The goal is to maintain high-quality health records that support effective patient care, facilitate communication among healthcare providers, and safeguard patient privacy.

1. Purpose

To standardize the process of documenting and entering information into the EHR to promote accuracy, confidentiality, and compliance with applicable regulations.

2. Scope

This protocol applies to all healthcare providers, clinical staff, and administrative personnel involved in the documentation and management of patient health records at [Facility/Organization Name].

3. Responsibilities

Role	Responsibility
Healthcare Providers	Enter accurate and timely patient data, review and verify information, maintain patient confidentiality.
Clinical Staff	Support providers in documentation, ensure data is entered in the correct formats.
Health Information Management (HIM) Team	Oversee record quality, ensure compliance with documentation and data privacy standards.
IT Support	Maintain EHR system functionality and security, assist with troubleshooting.

4. Procedure

1. **Data Entry Guidelines**
    - Document patient encounters in the EHR as soon as possible following service delivery.
    - Use appropriate templates and standardized terminology (e.g., SNOMED, LOINC).
    - Ensure all entries are legible, accurate, and free of personal opinions or unverifiable information.
    - Each entry must include date, time, and user identification (digital signature or login ID).
2. **Data Validation and Review**
    - Verify the accuracy and completeness of information before finalizing entries.
    - Correct errors promptly upon identification and document all amendments according to legal requirements.
    - Double-check demographic and contact details for every patient encounter.
3. **Updates and Amendments**
    - Follow facility policy for adding addenda or correcting records (never delete original entries).
    - Log changes with user details, date, and reason for the amendment.
4. **Confidentiality and Security**
    - Access EHRs only for authorized, work-related purposes.
    - Log out of the EHR system when not in use; do not share login credentials.
    - Report suspected breaches or unauthorized access immediately to the Privacy Officer/IT Department.
5. **Legal and Regulatory Compliance**
    - Adhere to HIPAA, HITECH, and relevant local/state/federal regulations regarding health information privacy.
    - Participate in regular training on EHR use, documentation standards, and data protection.

5. Documentation and Recordkeeping

- All patient encounters and communications must be documented in the EHR.
- Backup and retention of electronic records will follow [Organization]'s data management policy and legal requirements.
- Maintain audit trails for all record access and modifications.

6. Quality Assurance

- Periodic audits of documentation quality and EHR usage will be conducted by the HIM team.
- Feedback and corrective action will be provided as needed to ensure compliance and improve practices.

7. References

- HIPAA Privacy Rule
- HITECH Act
- [State/local health information regulations]
- [Organization's EHR Policies and Procedures Manual]

8. Revision History

Date	Revision	Description
[YYYY-MM-DD]	1.0	Initial SOP development and implementation.
[YYYY-MM-DD]	1.1	Updated data validation procedures.

This SOP is subject to regular review and updates in accordance with legal, regulatory, and operational changes.