| TOPIC: | **Immunization Data Entry into Client Records by Non-Providers** | | |
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| APPROVED BY: | **Saskatchewan Ministry of Health** | DATE REVIEWED | **August 25, 2016** |

**BACKGROUND:**

According to the *SRNA Documentation Guidelines 2011,* a Registered Nurse (RN) should record the care/service she provides in a timely and accurate manner based on the documentation tools provided. A Public Health Nurse (PHN) (who is a RN) is considered to have documented appropriately when a school consent form or influenza clinic recording sheet has been correctly completed at the time of vaccine administration.

Reference:
*(http://www.srna.org/images/stories/pdfs/nurse_resources/documentation_guidelines_for_registered_nurses_22_11_2011.pdf ),*

These Guidelines for Data Entry by a Non-Provider allows for the information from the vaccine administration event to be transcribed into the electronic immunization registry system known as Panorama. There is potential risk for transcription errors to occur and actions within this policy are included to mitigate those risks. The mitigation strategy is designating and training staff to enter the data into the electronic system and an auditing system be put in place to ensure the accuracy of the data entered into the electronic system. The extent and frequency of the audit is to be determined by the RHA based on the volume of data entered and experience of the designated staff, who is an authorized Panorama user, entering the data. Data entry of vaccine administration by someone other than a regional PHN or of an immunization record from another jurisdiction may also be entered by the designated staff who is an authorized Panorama user, if the record is considered a non-complicated client record (see policy statement for definition). The RHA may consider the same or other guidelines for auditing of these records.

**POLICY:**

In situations where documentation of vaccines given by a PHN or other vaccine provider is not possible, designated support staff who are authorized Panorama users, can transcribe the vaccines documented by a vaccine provider when the client record is non-complicated as indicated by:

- Documented evidence exists in the form of a client chart, paper copy consent or registration form that is retained as per the employer policy for retention of records.
- An audit system is in place to ensure accuracy of data entry by designated support staff who are authorized Panorama users.
- There is no immunization related information such as warnings, risk factors, special considerations, AEFIs to be entered.
- There is no lab data or TB tests to be entered.

**PURPOSE:**

To ensure timely immunization data entry into client records of those immunized by a PHN or other vaccine provider to inform and support client care and population health management.

**PROCEDURE:**

RHAs:

- Appoint, authorize and train non-PHN designates (e.g., designated support staff who are authorized Panorama users) to enter into Panorama vaccines administered and documented by a PHN.
- Designate a nursing professional (PHN, Nursing Supervisor/Manager/Coordinator or Nurse Clinician), to conduct audits.
- Determine the frequency and process for auditing data entry based on the numbers of data entry required and the experience of the designated support staff who are authorized Panorama users (example; random sample of data entry in client records [1 in 5 ] vs. all client records).
    - Back entry of immunization histories from a hard copy record must be checked by a PHN if entered into Panorama by designated support staff who are authorized Panorama users.
- Retain original documentation of the vaccines provided by the PHN (school consent, influenza form) as per the RHA standard protocols on record retention.
- Ensure vaccines administered by non-PHN providers are documented on the client chart to enable the temporary record of documentation received by Public Health to be shredded upon entry into Panorama.

**REFERENCES & RESOURCES:**

The SRNA has reviewed the above policy and found it to be compliant with the SRNA Documentation Guidelines (December 2011) given original documentation is retained as per RHA Retention policy and the provision of regular audits by a designated nursing professional is completed.