

Open Notes and Results Release for Nurses

The 21st Century Cures Act, a federal law from 2016, mandates that clinical notes should be accessible to patients. Beginning Oct. 29, Sutter Health will go live on Open Notes and Results Release. This means that progress, procedure and telephone notes, as well as care team notes, will be released when signed, and test results will be released immediately to patients in My Health Online. This includes both inpatient and outpatient notes, as well as historical notes dating back to 1996.

Notes can be blocked if they meet certain exceptions. The two most common exceptions are:

- **Preventing physical harm:** A note or result can be blocked if a provider believes that viewing the note could cause substantial risk of harm to the life or physical safety of the patient or another person. Please be aware that causing mental or emotional harm is not allowed as a reason to block a note.
- **Privacy:** A note or result can be blocked if sharing the information would result in a violation of the patient's privacy. Any direct request from patients to block a note or result from their MHO account is allowable under the privacy exception. Information compiled in a note for use in civil, criminal or administrative actions or proceedings also applies.

There are other exceptions, but they are very rare. Read more about the exceptions [here](#).

9 Tips for Writing Patient-Friendly Nurses' Notes

Tip #1: Be clear.

Write so your notes are legible and understandable. Use common words a patient would understand.

Tip #2: Be accurate.

Write facts only and keep it brief. Tense matters (Past or present? Has or had? Is or was?) Chart what you see, hear and do.

Tip #3: Be objective.

Chart without opinion or speculation; use quotes to document patient or family comments or complaints. Chart what the patient says, not how you think the patient feels.

Tip #4: Be complete.

Remember the adage, "*If it isn't documented, it didn't happen.*"

Tip #5: Chart Real Time.

Chart real time; avoid charting at the end of the shift.

Tip #6: Note responses.

Express how the patient responded to treatment. Use examples. Chart whether they followed the advice given by you and the doctor. Add example of documenting pain reassessment.

Tip #7: Describe observations.

Write all important observations with the patient. For example, “color pink, swelling in both legs, pain 4/10.”

Tip #8: Be relevant.

Avoid documenting information that has no value to patient care.

Tip #9: Use your resources.

Know that you have resources around you. Talk to experienced nurses, charge nurses or nurse managers. It’s always better to ask for help than to not chart enough information.

Additional Resources

We recognize this may represent a big change for healthcare providers so a Sutter-wide project team has developed an [OpenNotes and Results Release Resource Page](#) that includes tools to help you prepare for this change, including a Frequently Asked Questions document and a tip sheet on the new note-sharing button now available in Sutter EHR. New resources are added to this page frequently, including an upcoming section on communicating with p10/7/2020atients, so please check back often.