Documentation FAQs

Documentation and downtime in the new EHR

Not everything can be documented in check boxes. Where does my narrative about the patient go?

Patient data will be entered in a structured field format for most information collected during care. The replication, or duplication, of information into narrative notes is not part of the recommended workflow for most clinicians. Summary views will collect, sort and display key patient information for clinicians, replacing the narrative summary notes we historically created. These views also contain links to areas within the record that may need further investigation.

Which unit-specific assessments will be included in the new EHR (i.e., NIHSS)?

Current assessments completed on paper will be recreated in the EHR in a single, regional format for all impacted end users to access. Customization of assessments at the unit level is contradictory to the regional vision of a single standard of care within Island Health.

Will HCAs be documenting their care?

Yes. HCAs will be documenting the care they provide, wherever they provide it.

Can you change the time when you document (as you don't always have the time to document right after doing something)?

Yes, you can change the documentation date and time. It will display for that date and time, but the date and time you actually documented it will be attached to the information as well.

When generating information for the Patient Summary, can Social Workers or Liaison Nurses input data as well (i.e., social history)?

Yes. All clinicians, if appropriate for their scope of practice, will have access to the Histories controls, and can enter information.

If a provider consults on a patient, does the nurse have to document that consult has been done, or does the provider do this?

When a nurse consults another provider, he or she enters the order; all other actions for this order would be completed by the provider.

Will the EHR show why a patient is on isolation?

Yes.

Will nurses and other care staff (within their scope) still be able to take and enter verbal orders from providers?

Current policy regarding verbal orders will remain unchanged. The only difference in the new system will be that the new order will be placed electronically and co-signed electronically, rather than in a paper chart.

Tip! Review Island Health's policy on taking verbal orders, and make sure you are applying it to your current practice.

How does one access particular chart entries, such as a shoulder assessment done by a PT on a previous encounter, or a previous Home and Community Care entry?

In many areas of the EHR, adjusting the *look back* date and time to the period of time the documentation occurred will display previous values and documents. To access order information from particular chart entries, you will need to access that specific encounter.

Do we still use IView to enter information, or do we directly enter it into the Patient Summary?

We will continue to use IView for ongoing assessment documentation.We will not enter assessment information into the Patient Summary page, as this page only displays information and links to information in records.

Can 2 different clinicians chart on the same chart at the same time?

Yes. The only action that two clinicians cannot do in parallel is placing orders. This is a safety feature that allows for constant cross checking on orders within the patient record

Are there still going to be paper Medication Administration Records (MARs)?

Paper MARs will be replaced by an electronic MAR (eMAR) when the new EHR is activated at your site. The *eMAR* will be updated and accurate for all medication orders as they are placed or discontinued.

If a Physician, Nurse Practitioner or Midwife faxes, can a unit clerk transcribe the orders into the computer, or does the nurse have to?

We're not sure. The role of the Nursing Unit Assistant in order transcription is under review with the Human Resource department and resources within the IHealth initiative.

What happens if you accidentally click on a wrong relationship? For example, I am an RN and I accidentally click "Student RN". What happens?

All visit and life-time relationships that are associated to the patient are visible in the record and can be corrected within.

Downtime

For downtime (both planned and unplanned) what is going to happen with the EHR?

Downtime describes when an electronic system is unavailable for use. Island Health's downtime policy was put into place for the 2012 Cerner upgrade. We will continue to follow current downtime procedures in the event of planned and unplanned downtimes (document on paper and back-enter after the downtime is over).

Computerized Provider Order Entry (CPOE)

What is CPOE?

Computerized Provider Order Entry (CPOE) is the placement of orders into the computer system using either groups of orders (electronic clinical order sets) or single orders. CPOE tools are implemented in conjunction with electronic clinical decision support to encourage best practice and evidence.