Glossary of Terms

IHealth and the Electronic Health Record

Activation: The time that a specific site or region will start to use new information system functionality.
See also: **Go-live**, **Implementation**.

Ad-Hoc Charting – Allows for entry of static, point-in-time clinical documentation into patients' charts. Only those with privileges to perform ad-hoc charting can access the appropriate menu commands to launch a particular documentation tool.

Bar-coded Medication Administration (BCMA) – The complete process of closed loop medication administration.

Items associated with BCMA include: patient wrist bands; scanners; barcodes; and clinical documentation. Drugs in the hospital are labeled with unique bar codes.

When a patient is prescribed medication, the medication is entered into the information system. When it's time for the clinician to administer the medication, he or she uses a hand-held device to scan the bar codes on the patient's wristband and the drug. If the BPOC system cannot match the drug to be given with the order in the system, it alerts the clinician with a visual warning. The system will also alert the clinician to contraindications for delivery. BCMA reduces risk, improving patient care.

BCMA – see: **Bar-coded Medication Administration (BCMA)**.

Best Possible Medication History (BPMH) – A formal process in which health care providers partner with patients, families and care givers to compile accurate and comprehensive client medication information.

BPMH is an admission requirement that nursing and physicians will now complete within the electronic health record; it is also a best-practice for ambulatory and emergency department clinicians.

BMDI – see: **Biomedical Device Integration.**

Biomedical Device Integration (BMDI) – A process that allows for information collected on external biomedical devices, such as vital sign monitors, to be sent to the electronic health record. A clinician will validate, within the electronic health record, that the information is accurate.

BPMH – See: **Best Possible Medication History (BPMH)**.

Care Compass – An innovative, interdisciplinary summary workflow solution that helps the collaborative care team organize, prioritize, and plan patient care by providing the right information at the right time. The solution includes real time order and result notification.

Care Set – A set of commonly requested orders grouped together for ease of order entry.

Cerner Standard – Content and workflows created by Cerner, based on experience and collaboration with experts (including previous and current clients) to form a set of best recommendations for new clients.

Computerized Provider Order Entry (CPOE) – The placement of orders into the computer system using either groups of orders (electronic clinical order sets) or single orders, by the provider or designated clinician.

CPOE tools are implemented in conjunction with electronic clinical decision support to encourage best practice and evidence.

Controls – The data elements about the patient that will cross encounters (medical history, allergies, procedure history, social history, family history).

Once entered into the patient's electronic health record, the controls remain on the patient's chart, and are validated and updated upon each healthcare encounter.

CPOE – See: **Computerized Provider Order Entry (CPOE)**.

Current State – Our healthcare environment as we function now – a hybrid state of paper and some electronic. See also: **Future State**.

Depart Process – A process supported by a component within the Cerner system used to guide and support an informative discharge of the patient.

The depart process includes Educational Material (Healthwise) and follow-up information and referral information, and feeds information into the Clinical and Patient Summary.

Discharge Dashboard – A visual representation of what has been completed from the multi-disciplinary team in respect to a patient's discharge. This information is fluid and updated throughout the patient's episode of care.

Discrete Task Assay (DTA) – A unique date element in the electronic health record.

Domain – An environment of Cerner solutions that has a separate database.

There can be multiple domains used in the development and refinement of a live domain. There is also a BUILD domain that is used to customize content to Island Health's needs.

EHR – See: **Electronic Health Record (EHR)**.

Electronic Health Record (EHR) – The collective electronic medical records of a patient or a population of patients.

Electronic Medication Administration Record (eMAR) – The electronic documentation of the medications administered to a patient at a facility by a health care professional.

Nurses document their administration of medications to the patient online using the electron Medication Administration Record. Typically, this tool displays doses of medication and their scheduled times. See also: **MAR**

Electronic Signature – An electronic means of indicating that an individual verifies the content.

eMAR – see: **Electronic Medication Administration Record (eMAR)**.

Encounter – Describes a particular instance when a patient is registered within the healthcare system (e.g., hospital, clinic, daycare, homecare, or any other department where they receive service). It is a single patient interaction, such as patient registered as inpatient, patient registered as outpatient.

Encounter Number – An encounter-specific identifying number.

End-user – Any person using the electronic health record, including physicians and hospital staff.

FetaLink – Cerner solution displaying data sent from fetal monitoring devices, providing a graphical display of the relationship between uterine contractions and fetal heart rate, and alerting the clinician to out-of-reference-range data trends.

First Activation/Implementation/Go-Live – The first sites (Nanaimo/Dufferin Place/OHC Urgent Care) where the new version of our electronic health record will be as fully implemented as possible.
See also: **Implementation, Go-Live**

FirstNet – Cerner's emergency medicine information system.

Flowsheet – A spreadsheet of a selected patient's clinical results for a certain time span.

All types of results are arranged on a grid that is sorted by result categories on one axis, and by time increments or specific times on the other axis. Any result can be opened to view its creation history, status, and, when applicable, its comparison to normal values for its result type. New results can be entered into the flowsheet by electronic capture (handheld devices at the bedside, for example), by direct charting, or by feeds from other systems. The data is refreshed automatically at user-defined intervals, or can be refreshed manually at any time.

Future State – Our health care delivery environment after we have adopted/initiated the electronic health record.
See also: Current State.

Go-Live: The time that a specific site or region will start to use new information system functionality
See also: **Activation**, **Implementation**.

Interactive View (IView) – Clinical documentation in a flow sheet, which allows for trending and comparison.

Interdisciplinary Plan of Care (IPOC) – A plan of care relating to a specific client's needs. Every IPOC is made up of goals, indicators, and interventions.

IPOC – see: **Interdisciplinary Plan of Care (IPOC)**.

IView – See: **Interactive View (IView)**.

LightsOn – Industry-leading advanced electronic health record analytics solution provided by Cerner and designed to support decision making and provide transparency into the Cerner solutions.

LightsOn is used to monitor System Performance and Stability, Provider Adoption and Efficiency, and Solution Build Best Practices.

Lighthouse Programs – Evidence-based tools embedded into clinical ordering and documentation through Cerner applications.

The Lighthouse Programs are designed to drive clinical improvement in these key areas:

- Prevention of venous thromboembolism (VTE).
- Prevention of sepsis and its complications.
- Prevention of pressure ulcers (PU).
- Prevention of hospital-acquired infections and improve infection control.

MAR – See: **Electronic Medication Administration Record (eMAR)**.

MAW – See: **Medication Administration Wizard (MAW)**.

Medication Administration Wizard (MAW) – A tool within the electronic health record facilitating closed loop medication documentation.

The MAW verifies the patient and medications through the scanning process (eMAR).

Medication Summary – The summary page of the eMar that shows the patient's medications, including last doses given, types of medications given, and discontinued medications.

Millenium Page (MPage) – It pulls together information from other documents to create a view that is meant to inform different disciplines and workflows in their work (i.e., "Lines tubes and drains" Mpage).

Model System – The starting system we are using as a starting point that contains Cerner Standard content.

MPage: See **Millenium Page (MPage)**.

Patient Summary (or SBAR) – A Millenium page (MPage) with a specific summary function (Situation/ Background/Assessment/Recommendation), populated from IView and Power forms.

Planned State Orders – Order sets that exist electronically in the Orders section of the electronic health record, waiting for nursing to decide to activate them.

PowerForms – One-time electronic documents that live in an AdHoc folder *before* they are completed, and Form Browser *after* they are completed.

PowerChart – The Cerner Millenium solution that is the clinician's desktop solution for viewing, ordering and documenting the electronic health record for a patient.

PowerPlan – An electronic order set that can be ordered by any provider (e.g., physician, nurse practitioner or midwife). This is the electronic replacement of Clinical Order Sets.

Positive Patient Identification (PPID) – The use of all available sources, data elements, documentation and verbal testament to determine an individual's identity.

A minimum of two data elements is required for positive patient identification, and a minimum of three data elements will be used when they are available (i.e., name, date of birth, MRN and/or PHN and/or Encounter Number).

PPID – See: **Positive Patient Identification (PPID)**.

Problem List – A list of all previous problems and chronic diagnoses, etc. (i.e., all conditions that are inherent to the patient, but not the specific diagnosis for the current visit).

For example: a patient has diabetes, but is here for an appendectomy. The diagnosis is appendicitis, and diabetes goes onto the patient's problem list. A problem can be an active problem, or a history of something resolved.

Quick Glance Functionality – A tool that shows an overview of activities, such as medications due, patient assessments and patient care, for the clinician's group of patients.

Shown in a bar graph format at the bottom of the Care Compass screen.

Sepsis Lighthouse Program – See: **Lighthouse Programs**.

SME – See: **Subject Matter Expert (SME)**.

Subject Matter Expert (SME) – Within the IHealth initiative, these are Island Health direct clinical care staff and clinical support staff who have been participating in the development of the information system, and informing the design of the programming to work/match island health processes.

SurgiNet – Cerner Millenium solution that enables a surgery department to schedule, document on, and run management reports on surgery cases.

Task List (Activities and Interventions) – A list of tasks (requests) generated either from Providers' orders or auto-generated by the system.

This tool helps nursing staff organize their tasks, and move straight to the documentation attached to that task, from the list.

Workflow – The steps you take as you do your job and the order in which you do them (e.g., get my assignment, look through my charts, begin patient assessments, etc.).