Frequently Asked Questions

It's personal.

In this document you will find commonly asked questions and answers on specific topic categories related to the IHealth initiative and the new electronic health record (EHR). This information is all the questions and answers available on the IHealth website's FAQ page.

As new content is available, it will be updated on the website first, so please check often at http://ihealth.islandhealth.ca/

Frequently Asked Questions

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Integration of the new EHR across the care continuum

I've heard this initiative is about having patient information across the continuum of care. Does this mean everywhere on the island?

There is a core data set that will follow a patient no matter where they go within Island Health-owned or operated facilities. The affiliated sites and private sites are not currently part of the integration of the EHR, but there is a longer-term plan to strategize how to integrate this information as well.

Is the eventual plan to make the EHR accessible throughout BC?

Yes. The Ministry of Health in BC has a strategic goal to have one record for each patient across the province.

Does that mean that we will be able to see the records of patients who receive healthcare in other provinces?

No. At this time our EHR will not be able to access the electronic records of patients who receive care in other provinces.

Will a healthcare provider in another province be able to access our EHR?

No. Currently there are no plans to have a direct link to another province's or territory's records. Privacy legislation is one issue that needs to be overcome. There are also technical interoperability issues. Patient records may still be faxed in individual cases, according to current policies.

Will there be integration of the EHR with BC Ambulance Service records?

Currently, the BC Ambulance Service is on a different electronic record system. There is no interoperability at this time. We anticipate that there will be integration with most electronic medical records in the future.

Will patients have access to their EHR information?

Development is underway for a future patient portal that would allow entry of information by the patient and display a "Know Me" view for clinicians within Island Health to view patient goals for health and wellness.

How will the electronic medical records (EMRs) used by community physicians, nurse practitioners and midwives, integrate with the new EHR?

A trial is in place to send notifications to EMRs regarding patient admission, discharge and death. Once regionalized, we will add electronic submission of admission histories, discharge summaries, and procedural notes.

Excelleris is beginning to distribute laboratory and diagnostic imaging reports to EMRs. Soon, we will be receiving pre-operative documentation and summary care plans into the EHR from clinic EMRs.

We are also working towards a Cerner-based EMR that will be available for private primary and specialty physician clinic use. Dr. Steve Holland's office will be the first office to implement this community EMR, at the same time as First Activation at NRGH and Dufferin Place.

Will PharmaNet be integrated with Cerner so that my patients' current Med histories pull into their records?

Yes. Work on this functionality is underway, but is not yet fully built-out and will likely not be ready for the first activation.

When we report patient safety events (e.g., falls and med errors), do these automatically show up in the patient chart under Significant Event?

No. There is no connectivity between the PSLS system (our current incident reporting system) and the EHR.

Customization of the new EHR to meet Island Health's needs

Is this an "off-the-rack" system? How do you know it will work for Island Health?

The integrated Cerner EHR is being successfully used throughout hospitals in Canada and the US. Many existing functionalities of this system are, and will be, applicable for Island Health. Other functionalities, and in particular those outside of Acute Care, are being developed as part of IHealth, driven by front-end clinician and patient input.

Through Island Health's long-term relationship and partnership with Cerner, new functionality is being developed for Island Health. This will allow us to have a system that is modified to meet the needs of Island Health, our staff, and our patients.

Are we modeling IHealth and the EHR after other health authorities or healthcare systems…has it been tried anywhere else?

We are definitely not the first site to do this, and not even the first in Canada. EHRs have been used for decades in other settings. North York, Mt Sinai, PEI and Vancouver Coastal have already moved in this direction, primarily in acute and ambulatory clinic spaces. However, in Island Health we are not just looking at individual sites; we are looking at how to use a single, integrated EHR to provide care across all areas where residents of Island Health access the health care system.

Can the EHR be modified after implementation to accommodate changes in best practice?

The change management processes, once established, will define how we make changes after go live. These processes are designed to support change for many reasons, including change in best practice or evidence.

Are we reviewing "lessons learned" from other hospitals who have implemented EHRs?

Yes. Both Island Health and Cerner have made themselves informed of other implementations and have considered the learning shared by these other organizations.

Upgrading the existing EHR to a new platform with new functionality

I understand that independent of the activation of the new EHR, our current EHR (e.g., PowerChart) will be upgraded to a newer version?

Yes. The upgrade of our current EHR to a new platform is going to happen island-wide before full implementation of the new fully-integrated EHR. This means that the current PowerChart platform will be upgraded to a newer version with more functions than currently available.

NRGH and Dufferin Place will be able to see and use these functions, whereas the rest of Island Health will only have changes to the look and feel of PowerChart.

When we move to this new version, not all patient data is going to be brought forward from the current EHR to the new EHR version. All information will still be accessible via a link, but only crucial "old" data will be inputted into the new EHR.

When PowerChart is upgraded island-wide, will all patient information in our current PowerChart be available, even before we move to the fully-integrated EHR?

When we move to this new version, not all patient data is going to be brought forward to the new version of the EHR. However, this information will still be viewable through a link in the new EHR.

Lots of information is being moved over from the existing EHR to the new EHR, but not all. If all the patient data since Island Health started using PowerChart was going to be moved over for every patient, it would take a minimum of 6-12 months. To shorten this timeframe, not every single item is moving into the new version of PowerChart. Those important items, like lab work and diagnostics, will be transitioned over for each patient for the preceding 3 years.

How come Nanaimo is always first?

Nanaimo was selected for First Activation mainly because we started the IHealth initiative in 2013 when we established a more integrated clinical documentation system in the NRGH ED. The final component of a fully functioning EHR is Computerized Provider Order Entry (CPOE). Before this can be activated, the rest of the NRGH site needs to also have this function. The existing hybrid documentation system continues to be a challenge for many.

Another reason Nanaimo was selected for First Activation is that Oceanside Health Centre was a test site for the first expression of the new EHR, which integrates client records from acute care, urgent care, medical day care and primary care.

Fully-integrating the EHR in Nanaimo and Dufferin Place first will establish a seamless transfer of information as patients navigate through this area .

Transitioning existing patient records

Are all the existing health records being uploaded into the new EHR?

Eventually we plan to have all existing health records uploaded into the EHR, but it is a process that will take time. We know, for example, that all existing health records will not be uploaded for the first activation of the EHR at NRGH and Dufferin Place.

What will happen to the existing paper-based records?

The current plan for existing paper-based records that are not yet uploaded into the EHR is to save them in 3 Health Record Centers (HRCs), referred to as *hubs*. If you need a paper-based record, you will be able to request it from the HRC, where the individual at the HRC will 'batch scan' the paper-based record(s) you request, into the EHR.

Although a huge undertaking, this will be a necessary step to get all paper-based records into the EHR.

What will happen to those paper-based records that we know will still be needed when we transition to the fully-integrated EHR?

We will have targeted locations where single-document scanning will happen. This is when a single piece of paper can be scanned into the EHR in a PDF format. Our goal is to always strive to reduce the number of paper-based records as PDF documents have very limited search-ability within the EHR. This will be available at first activation of the EHR at NRGH and Dufferin Place.

Will we not have charts at all, then?

The goal with the EHR is to move away from paper-based charts. Moving to a totally electronic health record will take time; paper-based records will continue to be used until they are all transitioned to the EHR. As more patient information is entered into the EHR we will use fewer paper-based records.

As all areas are not transitioning at the same time, there will still be the need to share information using the historical data in the paper-based records.

What happens if a patient gets transferred from a site that has gone live to a site that hasn't gone live yet?

All documentation from a facility that has transitioned to the new EHR can be viewed by all other sites. This means the viewing healthcare workers and physicians will have access to the sending sites complete medical chart.

Documentation

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.

Devices and Technology

What kind of devices will be provided to access the electronic health record?

Device assessments are currently underway at all Island Health facilities. This work is taking into consideration facility configuration and workflow design. Mobile and fixed devices will be deployed to support documentation and associated workflows. Updates will be provided as the assessments are completed.

Will there be enough devices so staff can access records in a timely way?

All efforts will be made to ensure there are enough devices. Although staff will not be receiving their own dedicated devices, the number of devices deployed for each area will take into consideration documentation frequency and number of staff on shift.

Is there going to be room for these devices in our work areas? What renovations are going to happen?

There is limited capacity and ability to make significant renovations. Devices will be deployed in work areas as appropriate. Given that there is a focus on mobile devices, there is a presumption being made that a high volume of renovations will not be required.

How will staff who are on the road a lot, or do not work in facilities, access records? What device will they be given?

Evaluations are underway to determine off-site options, knowing that wireless connectivity is not dependable across the Island Health geography. An "offline" documentation option, and other connectivity options, is being evaluated.

What is the strategy and approach to address care providers who roam between different computers?

We are examining certain technical improvements to our Citrix environment that will speed the time for smooth roaming. Device selection and placement will be key for this as well.

Will there be iPads?

The quick answer – in the near future no, but in the long term, we're not sure. The iPad is very light and fast, but it is more of a consumer, single-user product – they are not washable and are easily dropped - we are concerned about the robustness of this device. Also we currently have no way to manage IOS devices from an enterprise level (patching, upgrades, security, and privacy concerns).

The tablets we are investigating now are " iPad-like" in terms of speed and usability, but are more aligned with enterprise manageability.

All this being said, the technical team is working on increasing and improving the health connect network, which will increase the scope of device and physician preference to support BYOD (bring your own device). Some Physicians are using iPads now for results viewing, but in a BYOD capacity. Cerner is also working on small form factor device/application options, but these will not be available for a couple of years.

So for now - probably not iPads...but in the future? Perhaps.

Will there be a unit camera available to take pictures of wounds and upload them into the EHR? This would help so much to take a daily picture to assess wound healing process. So much quicker than the long narrative documentation!

Wound cameras and photo upload have been used at Oceanside Health Clinic, and a policy and a procedure have been drafted to support this. The scope of how and who will use this functionality has yet to be determined for First Activation.

I have concerns about the log-on time it takes to get on to a computer, let alone into a client's record in the EHR. Is this being looked at? Will this improve before we transition to the new EHR?

The number of times, and the time it takes to logon, has been identified as a concern across the island. The teams have been trialing new solutions at Nanaimo ED and Oceanside Health Centre. Once the solutions are reviewed from a privacy and security perspective, they will be presented to the Island Health Executive for approval.

What does Infection Prevention and Control have to say about all the new medical devices we will be carrying around with us between patients?

Our device team will ensure the devices meet the requirements set out by Infection Prevention and Control standards.

For mobile devices is it possible to have a 'locator' feature, as equipment will inevitably get left behind at times?

The device team is aware that both theft and loss are a concern and strategies to manage this are being considered.

What is the strategy to support Bring Your Own Device (BYOD)?

The device team will be evaluating and providing BYOD recommendations.

Will I have remote access to the new EHR?

Remote access will be provided for those providers who require it. The EHR platform is available remotely from any computer with internet access, as it uses a Citrix-based voice protocol network (VPN) to host your session logon. This means that although you can operate your own computer as you normally would, no patient information will be stored on your device. This avoids the pitfalls of patient privacy concerns. You will be able to log in to the EHR and view medical imaging content via the PACS Intelliviewer program.

Can we have a summary of the devices that have been targeted for each area?

Yes. A summary will be provided to you in late January 2015; we will be welcoming your feedback. Please note that this summary is a first draft and the devices will be trialed and may need to be changed-out depending on real-time functionality when we activate the EHR in your care setting. This summary will help us ensure that we have not missed any temporary units.

How do we know that the devices we receive will be appropriate for our needs? Was this an issue at NRGH or OHC when they started using an enhanced version of the EHR?

When the EHR went live in the NRGH ED, devices that staff thought they would not like became the devices of preference. Preferences became clear when they came into use. The IHealth team will be involved throughout the activations and beyond, to ensure the devices are functional for the workflow.

Medication Management

If a verbal order is not co-signed electronically by a physician (or NP, or Midwife) can the pharmacy fill the order?

Yes. All verbal orders will display and be available to action at the date and time they are entered. They do not require a co-signature for pharmacy to fill.

If a medication is overdue, does the EHR automatically generate an incident report in PSLS?

No. It will not generate a report, nor will it go to PSLS. The EHR can provide operational reports with details and percentages around medications given on time, but these are not reported through the PSLS system.

Will the system prompt Physicians (and NPs and Midwives) to co-sign their verbal orders?

Yes, they are able to review and co-sign all verbal orders as these orders are communicated to the ordering provider via their Inbox in Message Centre.

Does the medication list show what time the medication is due, or just how many medications are due?

The electronic Medication Administration Record (eMAR) view will show all meds ordered, all doses administered, and the date and time the next dose is due for each med.

How will medication orders be transcribed?

Medcation orders will not be transcribed once the new EHR is activated in your region. As soon as medications are ordered they will be in an electronic format, which means there will not be any need for transcription; they will be sent to pharmacy for processing immediately.

Will the medication page show when a medication requires a re-order?

Medications will stay as active orders until discontinued, unless a stop date and time is entered. If the stop date is part of the order, the order will dither out/grey out, and not be available for scanning documentation until re-ordered.

Will the system prompt you if a medication is out of normal dosing range?

At the point of order entry, clinicians will be prompted by alerts when orders are outside of normal parameters set during design and build.

Physicians', NPs' and Midwives' Practice

Why do our current documentation practices need to change?

There are 2 basic functions for documentation in a health care setting:

1. To accurately communicate with the other health care team members involved in the patient's care
2. To accurately record the patient's experience.

In addition, documentation supports quality improvement opportunities and research, and acts as a record of your thought processes and interactions for medicolegal purposes.

The medical record is paramount to the continuity of care. In today's world of shared care it is essential that up-to-date and accurate information regarding a patient's health status is readily available to all involved. With the paper chart system, information is not available at multiple locations and is not often available in real time. Furthermore, it can lead to medical errors due to variations in hand writing legibility. Electronic documentation is available to all involved in a patient's care at the moment a document is completed.

In 2006, a Physician Documentation Expert Panel in Ontario reviewed the current state of physician documentation in that Province. In their report, *the link between poor documentation and increased medical errors, unnecessary readmissions, and other negative outcomes* was outlined. One of the key findings was that very few patients were being discharged with a discharge summary available to their primary care provider. They also emphasized that the patient's chart is a legal document and that physicians *are bound by law to complete it accurately within defined times*.

For Island Health physicians, Health Records must follow Island Health Policy, including internal policies and Medical Staff Bylaws, Rules and Regulations. In addition, increasingly, standards and accrediting bodies are mandating certain documentation standards. Clinicians are required to adhere to BC legislative requirements,

such as, but not limited to, the *Hospital Act*, *Freedom of Information & Protection of Privacy Act* and *B.C. Evidence Act.*

The paper record is not secure. At any time, anyone who has physical access to a patient's record can browse through any component of the chart. With an electronic health record, all access to a patient record is recorded and providers must declare a clinical relationship with a patient before gaining access to their chart. Without this ability to track access, upholding the requirements of privacy legislation is nearly impossible.

What are some other advantages of electronic documentation?

Beyond these regulatory requirements, it is critical that the patient's chart be as an effective communication tool as possible. Thus, an emphasis on succinct, legible and accurate documentation will be promoted; both the time it takes to document and the time required for a reader to find accurate information are being considered. Tools like electronic templates, macros, and autotext will help decrease documentation time and help offset the extra time it could take for Dragon dictation or manual text entry. For example, if the same follow-up instructions are given to a group of your patients, you can build them into a macro which will insert the full instructions with one key stroke.

Elements of the medical history, like social and past procedural histories, are absolutely essential and need to be reviewed for accuracy, but do not need to be copied into every note if there have been no changes. Once these are in the EHR, they will be automatically importable into a physician note. This will save time and improve quality. However, given that it is easy to cut and paste, and therefore duplicate information in an electronic record, care must be made to ensure that only those details that add value to the note are included (i.e., it is important to remember to communicate updates, changes and plans of care).

What are the physician documentation tools in the new EHR?

There are primarily 2 types of physician documentation tools in FirstNet/PowerChart: *PowerNote* and *Dynamic Doc*.

- PowerNotes are template-based and excellent for documentation in procedure-focused specialities, where the content of a note is often repetitive and detail oriented.
- Dynamic Doc is designed for more text based documentation styles.

Both have functionality that can enhance and add value to the documentation process. For example, one nice feature of the Dynamic Doc tool is that while you are reading through the patient's chart you may select or "tag" certain elements (e.g., prior results, dictated history) and then insert them, with a built in reference to their originating source, into your new document.

Are we turning off transcription?

Transcription services will remain in place while we transition to electronic documentation and voice recognition tools. However, the time delays involved in dictation, along with the laborious process for correcting any typographic errors, will likely cause physicians to gravitate over time to the more immediate and editable EHR documentation solutions.

Who chooses what's on my Order Sets?

The process for determining what goes into the order sets is quite similar to the current process for pre-printed order sheets.

Depending on the originating document, the physician champion for a given set will approve its content. The Computerized Provider Order Entry (CPOE) team ensures that regional feedback is provided through a web-enabled tool called Zynx. The orders will go through a process to add any adaptations required for different work environments. The orders are then vetted through department and division heads as well as ancillary departments and medication safety groups/councils before ultimately being approved by the IHealth Physician Accountability Group (PAG). They are then presented to the Health Authority Medical Advisory Committee (HAMAC) for authorization to implement.

Will I be able to access my most frequently used orders and order sets quickly?

Providers will be able to modify and save their most frequently used orders and order sets into their personal favourites folders to have them more readily available.

How will Computerized Provider Order Entry (CPOE) improve my practice?

Firstly, CPOE will give all providers across Island Health access to the most up to date order sets as created by the physicians at Island Health. No longer will there be some providers using out dated order sets while new ones have already been developed.

One feature of CPOE is the ability to combine medication reconciliation with medication ordering. During the admission process, simply selecting which home medications should be continued will add them to the order at the time of reconciliation.

Also, Clinical Decision Support (CDS) tools use two or more elements of a patient's data to provide relevant clinical advice. With CDS, the system can, for example, alert the ordering provider of a potential medication allergy or interaction. As well, if a provider is ordering a medication that requires renal dosing for a patient with renal failure, an alert could be set up to notify the provider to adjust for renal dosing. Although there are many potential powerful uses of CDS, it will initially be implemented in a limited capacity to minimize the number of alert pop ups.

Clinical Support Staffs' Practice

What does the NUA/Unit Clerk role look like after implementation of the new electronic health record?

With the implementation of the new electronic health record (EHR), there will be new work processes introduced that will change the way work is done and the duties currently performed in the NUA job. It is anticipated there will be opportunities to use Unit Clerks'/NUAs' current and existing knowledge and skills in new ways that better and more effectively support unit operations and patient care.

We do not yet know all of the duties and responsibilities that will be part of the NUA job in future; what we do know is that the current role of transcribing orders will be different, as orders will be directly entered electronically by providers and clinicians.

It is expected that NUA and clerical staff will continue to use solutions such as teletracking and registration. With new functions within the EHR, like computerized provider order entry (CPOE), there will be fewer responsibilities around transcription. However, there will be continued responsibilities around order activities. For example, we expect Unit Clerks/NUAs will still be involved in connecting with the lab for specific lab draws, connecting with other departments to communicate STAT orders, and managing external referral processes (e.g., at discharge, using the Depart process, they can enter the date and time of a follow-up appointment or referral). Other processes to support the care teams, including order entry for supplies or non-clinical orders that would be clerical order entry (e.g., an order for a bedside procedure tray or special piece of equipment), are yet to be determined.

Nursing Practice

This FAQ is in progress. ✱

Allied Health Practice

This FAQ is in progress. ✱