Physicians', NPs' and Midwives' Practice FAQs

How your practice may change using the new EHR

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 often not 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 signed.

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 when providers 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 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*.

1. PowerNotes are template-based and excellent for documentation in procedure-focused specialities, where the content of a note is often repetitive and detail oriented.
2. 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.

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 Island Health physicians. 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.