Electronic Clinical Documentation

for Medical Staff

What's in Scope?

Physician Documentation
- Ambulatory ED notes
- Admission H&P
- Consultation notes
- Procedure notes
- Progress notes
- Transfer notes
- Discharge summaries
- Imprivata

The following are out of scope as they require CPOE and electronic orders functionality:
- All orders (including consults, referrals, requisitions, prescriptions, and patient care orders)
- Medication administration
- Medication requests to pharmacy
- Detailed Intake and Output
- Diabetic or anticoagulant flowsheets
- Inter-professional Patient Care Plan (IPCP) or Kardex (linked to Care Planning)
- Care Plans (fall, wound, etc.)
- Surgical Care Pathways
- MRI Screener

Clinical Documentation
- Allied Health discipline-specific documentation
- System Assessments, Post Ops, Transfer, Wounds, Falls
- Vital Signs (BMDI), weights/measurements
- Provider, Clinician, CCOT Notifications
- Sepsis
- Violence (VBACT) and restraints
- Lines, Tubes, Drains Total Intake and Output
- Blood product administration
- Advance Care Planning and eMOST

Scales and Measures
- Braden
- Bristol
- CIWA
- COWS
- CAM/CAM-ICU

Transitions of Care
- IDRAW
- Patient Transfer/Transport
- Inter-facility Transfer
- Informal Team Communication
- eSTR and Discharge documentation

Other Technology
- Imprivata (Tap In, Tap Out)

Allied Health General
- Discipline specific documentation (PowerForms, IView, Dynamic Documentation)
- Use of Multi Patient Task List (MPTL) to support Co-Signing student documentation and saved/not signed PowerForms
- Message Centre (DynDoc Management)
- Therapy Group Documentation

Not in scope at this time:
- Mobility recommendations
- Functional Independent Measures Scores (FIM)/ alpha FIM
- MPTL (receiving consults, managing orders, etc.)
- Patient education handouts (anything not included in health wise)
- Single Document Scanning: paper records/handouts into EHR

Mental Health
- Clinical Profiles (CP) for discharge
- Crisis Nurse (In Reach and Outreach workflows)

Not in scope at this time:
- Electronic Mental Health Act Forms

Critical Care AICU/NICU
- Biomedical Device Integration (Phillips Monitors and Ventilators)
- CareAware Critical Care (Flowsheets)
- NICU
  - Eat, Sleep, Console
    - Neonatal Skin Condition Scale

Perioperative - PACU
- PAC nursing assessment
- Pre-Procedure checklist
- Histories (Allergies, Procedures, Family, Social)
- BPMH

Not in scope until SurgiNet/CPOE implementation:
- Intra-procedural documentation
- Surgical and Blood Product consents
- OR booking packages
- Pre- and post-operative nursing admission/discharge record

Perinatal
- Advanced Registration Functionality for RNs, NUAs
- Perinatal Tracking Shell
- Fetalink (Integrated fetal health surveillance & central monitoring)
- Delivery documentation and summaries

Not in scope at this time:
- Notice of live birth

Pediatric
- Scales and Measures (Braden Q, State Behavioural Scale (SBS), Cornell Assessment of Pediatric Delirium (CAPD), Humpty Dumpty Falls, etc.)

Pediatric DayCare
- Pediatric Ambulatory Intake and History PowerForm
- Pre-Procedure Assessments

What's out of Scope?

The Electronic Clinical Documentation project is limited to acute care areas. Ambulatory/Outpatient areas will be activated at a later date.

Electronic Clinical Documentation not included in scope:
- Patient Consent Documentation
- Requisitions
- Anything requiring a patient signature

One Person, One Record, One Plan for Health and Care