# ED Physician Documentation

Interior Health

## Enter Documentation

1. From the EDM Tracker, find the patient and sign up.
2. From the EDM Tracker, click the icon to go directly to the document panel.
3. Any existing documents for the patient account will display. To create a new document click the New button.
4. Select the **ED Visit Note** template. The report template will open.
5. To begin documenting, click on <Entered> in the Physician Assessment field.

> **Note:** Current nursing notes, vitals, and allergies will default in.

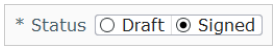
6. Complete the documentation and click to spell check.
7. Click OK
8. The Quick Save button saves the document in draft status and allows for editing later. Documents in draft status are viewable in EMR.
9. To sign the document, ensure the **Required Questions** fields with the asterisk (*) are filled in.

> **Note:** If "sign" is unavailable, this means there are mandatory fields which still need information.

10. Click View/Save to view a preview of your document.
11. Add Additional CC's, if required.

> **Note:** You do not need to send a copy to the patient's family physician if the family physician is attached to the patient's record. The tracker displays the family physician on file.

12. Select the status for the document. For signed status, enter PIN.




> **Note:** Report will not be distributed to physician offices until it is **Signed**.

13. Click Save

> **Note:** It may take a few minutes for the document to display in the EMR panel. Click Refresh EMR to see the most recent data.

## Edit a Document in Draft Status

1. Go to the Document panel.
2. The list of documents will display. Click the document to edit.

> **Note:** If there is only one document it will open automatically.

3. Click Edit
4. Make the required changes and click View/Save to view and save the document.

## Add Additional CC's

The report will be automatically sent to the family physician once it is signed. Use "Additional CC's" to send the report to additional physicians/locations. **Do not use "Assign Providers".**

Use Provider to add additional providers and locations.

- Search by last name to add a provider.
- Search by *x.city* to find a clinic or department, where *city* is the first 3 letters of the city name. For example, use "X.KEL" to find a Kelowna clinic. Use "X.VAN" to find BC Children's Hospital.

> **Note:** Ensure that the recipient is selected from the search results. If no match is found, contact the service desk requesting that the recipient be added.

**Patient Privacy/FOIPPA Regulations**

Copies to outside agencies should not be sent. The ability to send a copy of a report to outside agencies without a written request for information and/or proper authorization (patient consent) is restricted.

Outside agencies include WorkSafe BC, insurance companies, employers, and Ministries.

## View Physician Documentation

1. Click the clipboard icon to go to the report panel and view the report.
2. To print the report click Print Preview and then the icon.
3. Click Back to return to the list of reports.

## Add Lab Results, Allergies and Medications

1. From the free-text documentation screen, click Data Formats
2. Select the data to add. Use Lab - All tests, entire visit to add lab results from the entire visit.

> **Note:** Data that is not required can be removed.

## Sign Documents

Documents that need to be signed can be accessed by clicking the Sign panel from the tracker.

> **Note:** When the Sign button is highlighted in red it indicates that there are items to be signed.

**To Sign** Documents **Documents**

1. Select the tab.
2. Check off the Documents to sign and click View & Sign to sign the documents.

**Service Desk** **1.855.242.1300** **servicedesk@interiorhealth.ca**

## View All Draft Reports

Some patients may have been discharged before documentation was completed and signed, and therefore, this will not be visible on the patient tracker.

1. At the end of the day, under the Lists panel, select "My ED Patients by Date".
2. Ensure no reports show under the "ToSign" column.
3. Complete/sign all draft reports.

## Proofread before Signing

- Check numbers—ensure lab values and medication doses are correct (e.g. 15 vs. 50).
- Look for patient gender errors (e.g. he vs. she).
- Check for nonsensical words. Mumbling/poor pronunciation can lead to added words not intended for the report.
- Include punctuation when dictating, as this will cut down editing time.
- Always use the spellcheck button.

## Add Addendum to a Signed Document

1. Click on the icon to go to the list of documents.
2. Select the document.
3. Click Edit
4. The report will open with an addendum screen. Add the addendum and click OK
5. Enter your PIN and click Save

**Note:** Use an addendum to add additional information to a report. To correct or cancel a Signed report contact HIM at DocumentationSupport@interiorhealth.ca

## Manage Favorites

**Manage Favorites** gives you quick access to your most commonly used notes or reports.

1. To edit Favorites, click Manage Favorites from the New Document screen.
2. Check off the reports and notes to add to your favorite list.
3. Click Save

## Cancel a Document in Draft Status

1. Go to the Document panel.
2. The list of documents will display. Click the document to delete.
3. Click Delete/Cancel Document
4. A confirmation screen will display. Click Yes to delete the document.
5. The document will display on the Reports panel and the Document panel with a status of Cancelled. The cancelled document cannot be viewed.

**Note:** Draft documents may have been viewed in EMR.

## Incomplete Reports

It is important to electronically sign your report upon completion to ensure immediate report distribution.

Delaying electronic signing and leaving it in draft state **impacts the continuity of patient care**, as the report will **NOT** be sent to the family physician or any other provider.

## Copy/Paste Restriction

Copying and pasting text from other providers' reports is **NOT** industry best practice, and poses a significant clinical risk with patient information being outdated or inaccurate.

There is also the risk for copied patient information to be pasted in a wrong patient report/record. In addition, copied text may be in-compatible and not display properly in another provider's office EMR or print properly to Health Records.

## Documentation Quality Improvement

Please note that IH audits clinician-created documentation for quality improvement purposes. Errors that affect patient safety, care or treatment are defined as critical errors, and include:

- Demographic errors (e.g. incorrect patient, MRN, account number, date of service)
- Incorrect drug/lab value or test
- Discrepancies
- Terminology misuse
- Misspelled medication names
- Incorrect courtesy copy/privacy breach