Meditech Expanse ED - Web

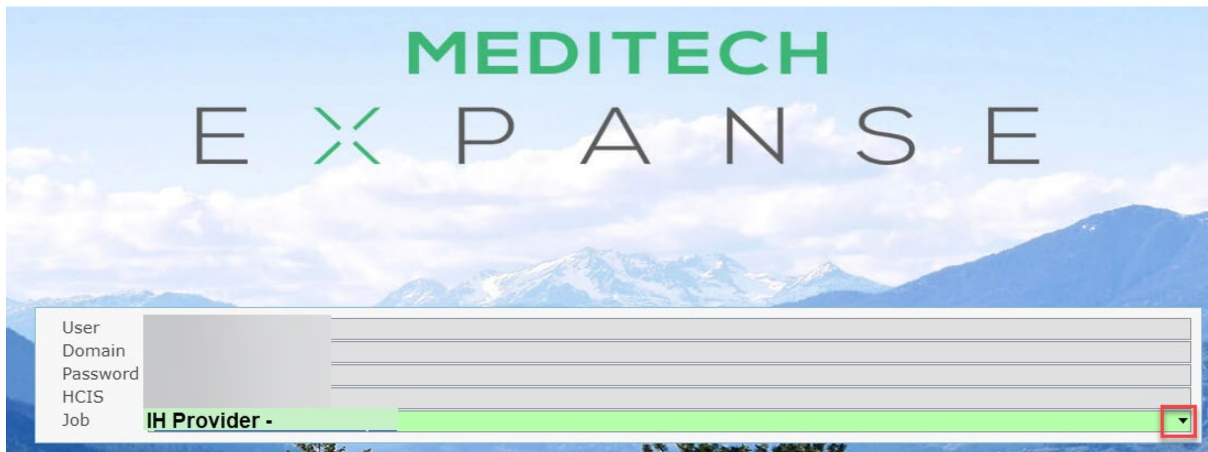
Medical Student ED Documentation Process

Medical students document as SCRIBES in the Emergency Department and must have their documents signed by a preceptor in order for reports to be viewable in the patient EMR and distributed to recipients.

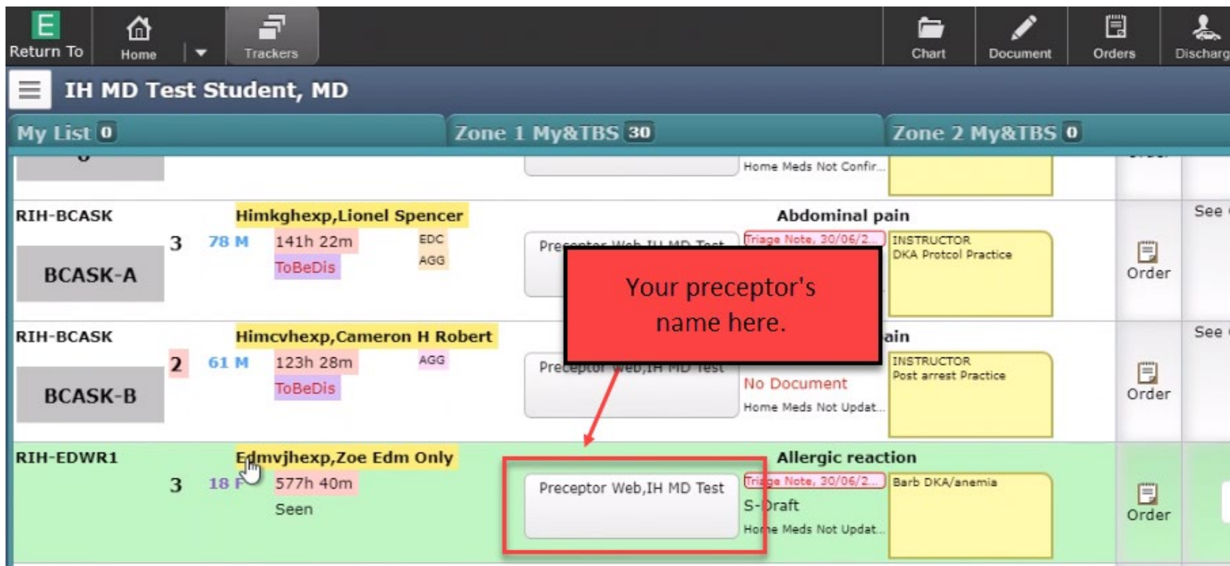
Medical Students:

Step 1: Log In with user role: IH Provider -

When you first login to Meditech, ensure you have the correct role. Click the down arrow to change:

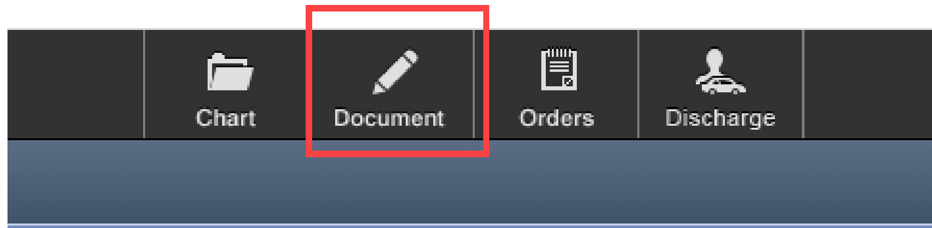


Step 2: Your preceptor should have already signed up for the patient. Do not start your document until your Preceptor has signed up.

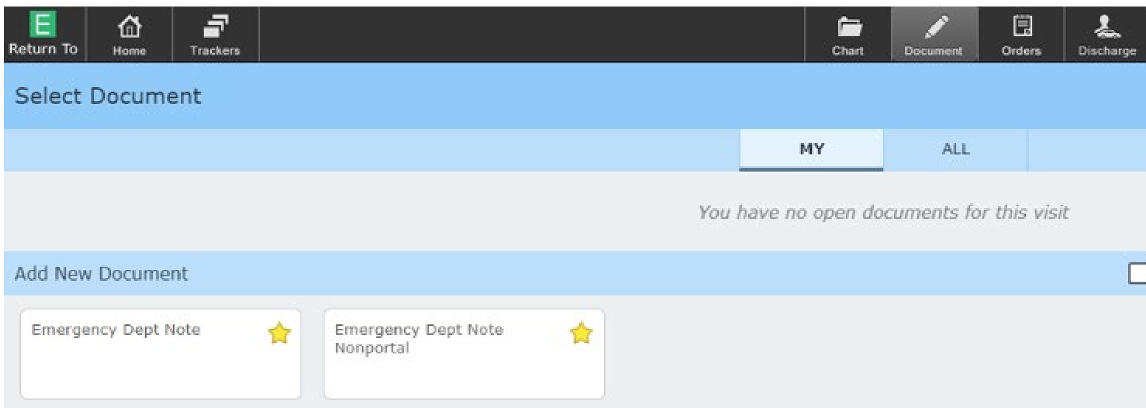


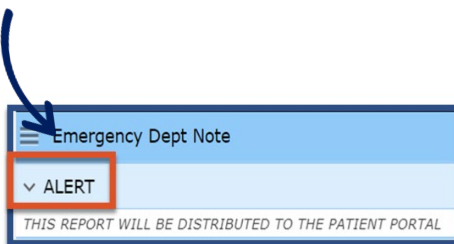
Step 3: Creating a Document

a) Once you've highlighted the correct patient (row turns green on tracker). Click Document.

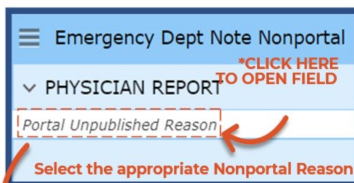


b) On the right-hand side of the screen, confirm you have selected:
   - Correct patient
   - Correct account: click here to ensure you have selected the appropriate visit date, registration type should be ED





An alert advises that the report will be available to the patient in MyHealthPortal.



Nonportal Reasons

Sensitive Information

Concern for patient's safety and well-being. Assess if there is a potential for risk of physical harm to the patient, staff or others. Examples: Sensitive reports may include information regarding sexual, domestic; elder; and/or child abuse, or psychiatric conditions.

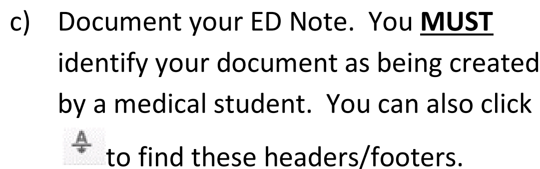
Third Party

Avoid including information provided by a third party. Example: Information disclosed in confidence from a relative of a patient, without the patient's knowledge.

Other

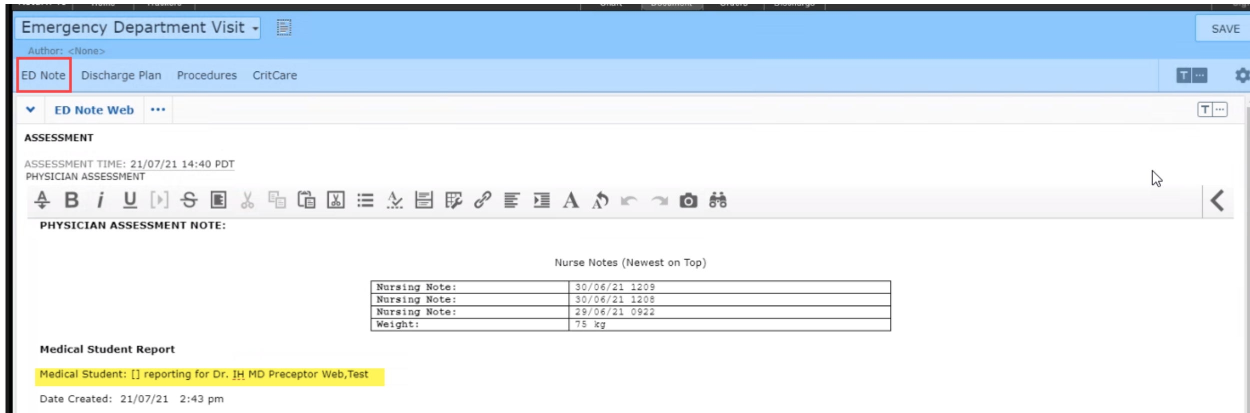
Example: Direct request from the patient to prevent the release of the document to MyHealthPortal.

NOTE: The patient has the right to request copies of their nonportal reports through Health Records Departments as per the Freedom of Information and Protection of Privacy Act.

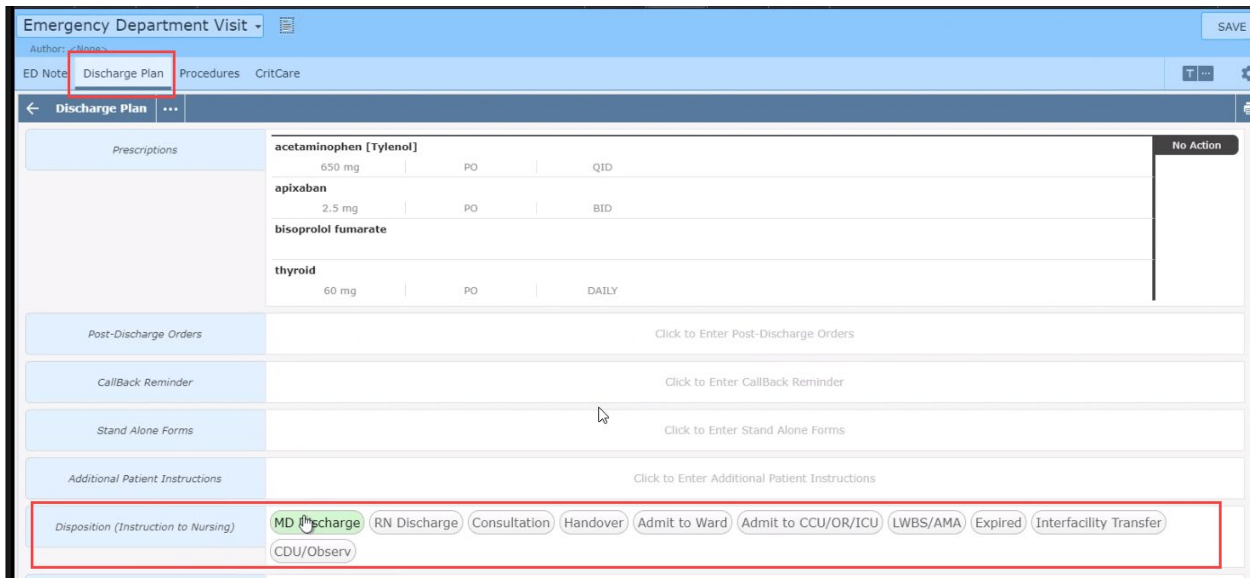


c) Document your ED Note. You **MUST** identify your document as being created by a medical student. You can also click to find these headers/footers.

Type the header **MEDICAL STUDENT DOCUMENTATION** in the first line.
Type the footer **Documented by [medical student name] for [preceptor name].**



d) Next, click Discharge Plan. You must select a Discharge Disposition. This will be verified by your preceptor before they sign the report.



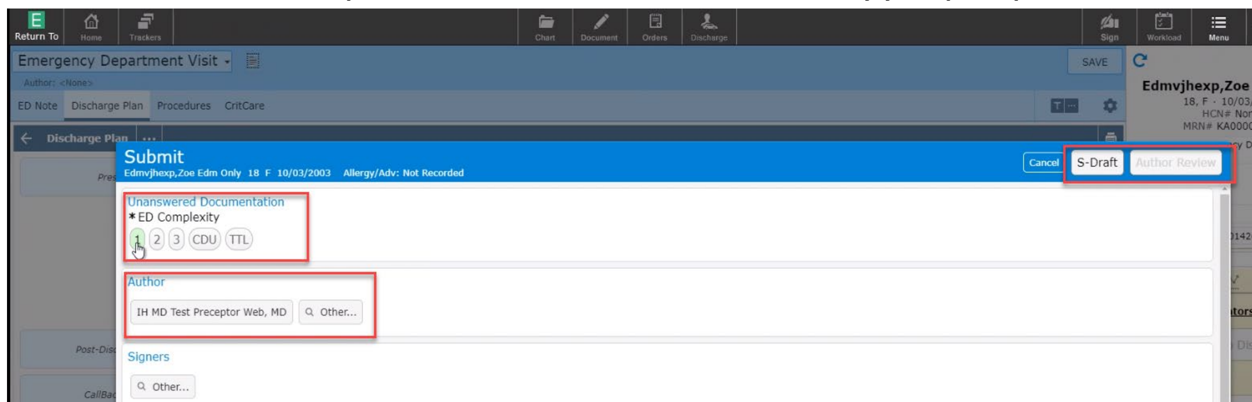
e) Click Procedures or CritCare to add to your document if appropriate.

f) Click Save when complete.

Step 4: Assign Preceptor as Author

Once you click Save, the Sign overlay window will open. There are essential fields to fill out on this screen to ensure your report is viewed by your preceptor.

1. Choose an ED Complexity score based on your assessment. Your preceptor will review and can adjust this if necessary.
2. **You <u>must</u> assign your Preceptor as the Author.** Their name appears, but you have to **<u>click to select/darken name.</u>**
3. Add additional recipients under Copies To. The family doctor will automatically receive a copy, do not add.
4. You can click S-Draft if you would like to continue working on your document OR you can click Author Review if you are ready for your preceptor to view your report.
5. After clicking Author Review, your ED preceptor will now have this document assigned to them to review and sign. You must also verbally communicate your document's completion to your preceptor. **Your document is not viewable in the patient's EMR until it has been reviewed by your preceptor.**



If Medical Student documentation is in sDraft status without an assigned author, anyone who opens the document automatically becomes the author. If this happens, the medical student will have to cancel the report and recreate it – this is why it is imperitive for medical student to assign author and communicate sDRAFT status to preceptors immediately upon document completion.

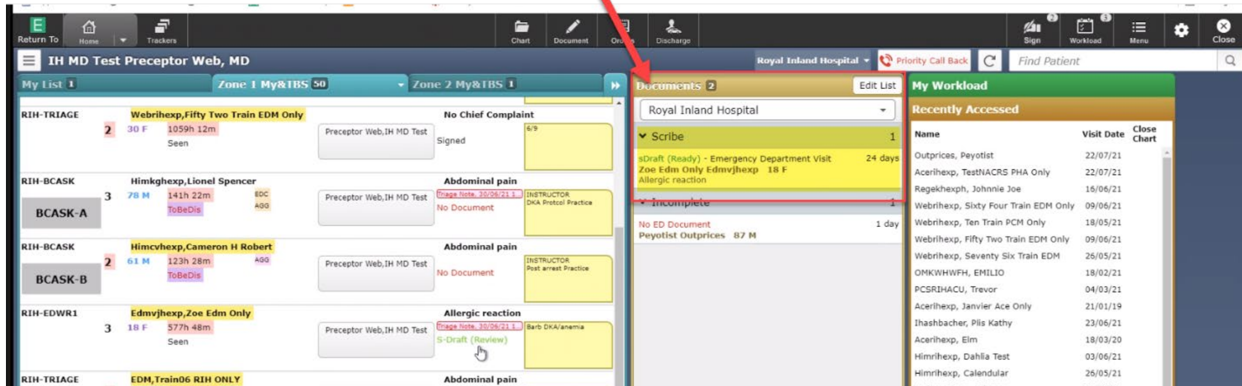
Documentation Best Practice:

- Verify correct patient and account have been selected.
- Only use the Emergency Department Visit document type when working in the ED.
- Proofread your document before completion – verify sound-alike words and context errors.
- Always assign your preceptor in the Author field on the Sign overlay screen.
- Communicate with your preceptor that you have created a document that is awaiting their review.
- If you erroneously save a document, your sDraft will be viewable under the Document panel. You can select your document, click the cogwheel, and Delete to remove it from the patient's record.
- **Health Information Management staff will follow up with all medical students if there are unassigned or incomplete documents.**

ED Preceptor Workflow

Step 1: Medical Student advises Preceptor they have created a document that requires review and signing.

Step 2: Preceptor will also see that an ED Visit Note is assigned to them on the ED tracker under the **Documents** column.

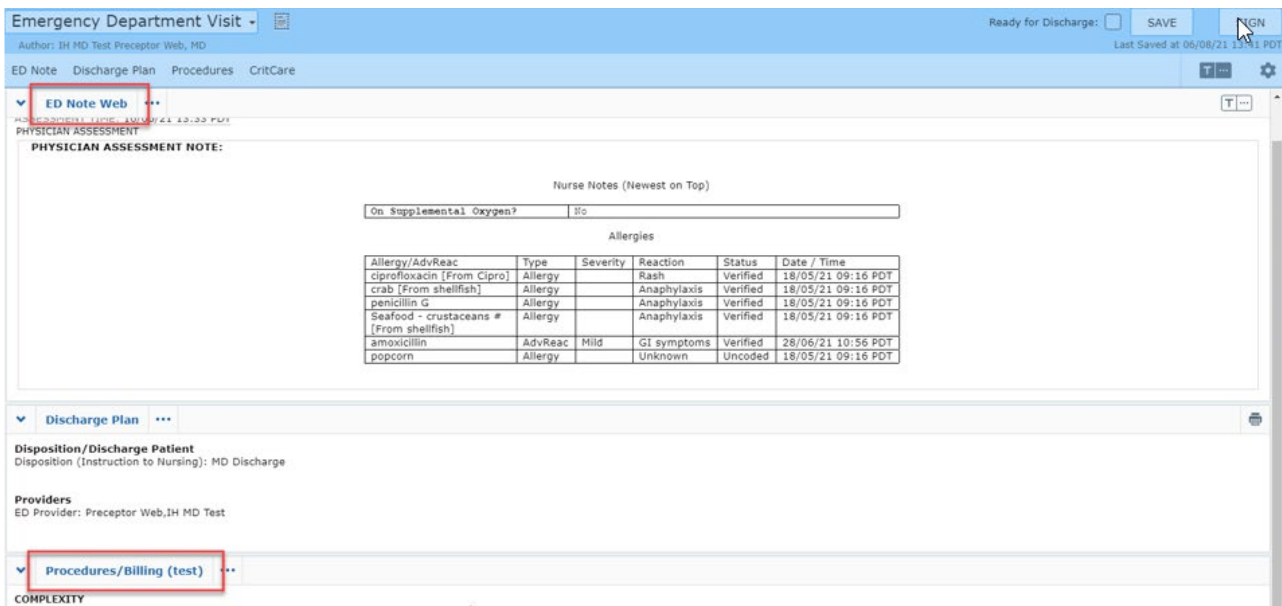


If the patient has been discharged from the ED, the preceptor will need to look the patient up by clicking on Find Patient and searching for patient based on information provided by medical student OR view the Discharged Patients list and sort by date.

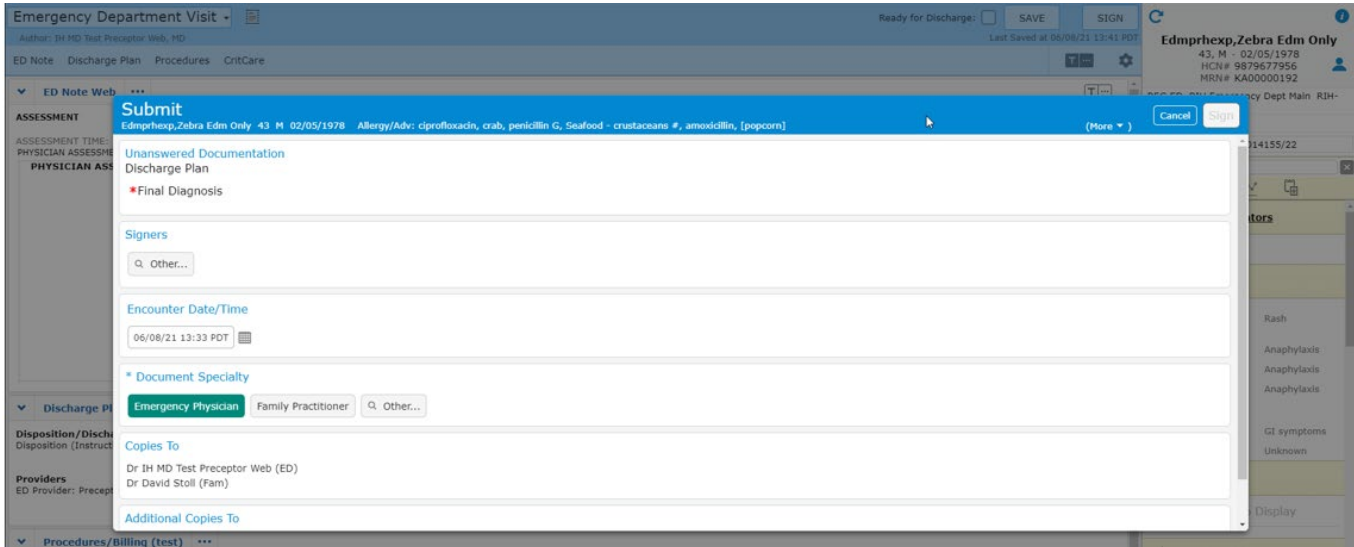
Preceptors will <u>not</u> access Medical Student documentation through their Sign Queue as they do for residents.

Step 3: Preceptor opens Medical Student document and makes any revisions/corrections.

To edit the documentation and/or ED Complexity, click on the header for each section to make changes.



Step 4: Preceptor must complete the mandatory field “Final Diagnosis” and verify medical student’s ED Complexity and Discharge Disposition. These fields must be filled in prior to electronically signing the document.



Step 5: Preceptor ensures that:

- Medical student has left the Signers field blank with no names entered.
- Ensure any CC’s added are for the correct recipients.

Step 6: Preceptor electronically signs the document with PIN and report is distributed and viewable in patient’s EMR.

Support Information (All)

For Documentation questions, quality issues or corrections, email DocumentationSupport@interiorhealth.ca
For technical support please contact IMIT SERVICE DESK: 1-855-242-1300 or servicedesk@interiorhealth.ca