Physician Documentation (Non ED)

Enter Documentation

1. Launch Meditech. Click the drop down button and select the *IH MD PCMII w Documentation* Job.
2. Click Signon
3. Select Physician Care Manager
4. Find the patient and open the chart.
5. Go to the Document panel. If prompted, select the appropriate account for the patient.

> **Note:** Ensure the correct account is selected by reviewing the Registration Date, Registration Type and Location.

6. Any existing documents for the patient account will display. To create a new document click the New button
7. **Manage Favorites** gives you quick access to your most commonly used notes or reports. Select the checkbox next to the note or report you would like to add to your list.
8. Select the appropriate document template.
9. To begin documenting, click on the <Entered> field.
10. Complete the documentation and click ✓ to spell check.
11. Click OK and then click View/Save
12. Add Additional CC's, if required.
13. Select the Status for the document. * Status ○ sDraft ○ Draft ◉ Signed
    For Signed status, enter PIN.

> **Note:** Report will not be distributed to physician offices and the patient portal (if applicable) until it is Signed.

14. Click Save

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

View Physician Documentation

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

Add Lab Results, Allergies and Medications

1. From the 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.

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.

Edit a Document in Draft Status

1. Go to the Document panel.

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

2. The list of documents will display. Click the document to edit.
3. Click Edit
4. Make the required changes and click View/Save

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

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

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

Selecting your Patient

1. Select the Find Patient panel and search for your patient by **account** number.

Account Num

2. Verify the patient's name and date of birth.

Select the correct patient and correct episode of care by using the up/down arrow keys on the keyboard the press Enter, or use the mouse cursor and **click** on the correct visit.

Always verify that you have highlighted and selected the correct patient visit *PRIOR* to pressing Enter. Look at the registration date to verify

If the incorrect encounter is chosen, your report will not be easily found when other care providers are searching the patient's electronic record which could affect patient care.

Reg Date	Type	Loc	Dis Date	Account Num	Provider	Reason for Visit
23/07/19	**REG CCRO**	SALHCC		HJ0000080/20		
01/02/19	**REG CCRO**	NELHCC		HJ0000037/19		
07/01/19	DIS ACIN	OLISOG1W	12/07/19	SO0000043/19		
07/01/19	**REG CCAD**	PENPHCLL		HJ0000064/19		
04/12/18	**REG PIRC**	KELCTWSHW		DJ0000027/19		
15/11/18	REG REF	KELKGHAORT		KG0000160/19		
12/10/18	DEP ED	KAMRIHED	12/10/18	KA0000015/19		
28/09/18	DEP ED	KAMRIHED	28/09/18	KA0000006/19		

Template Selection/Patient Portal

All signed PDoc reports are published to MyHealthPortal excluding Emergency Room Visit Notes, Progress Notes, Mental Health Reports, and Referral Letters. In addition to these excluded reports, there are two document template options available to be excluded from MyHealthPortal: History & Physical and Consultation Report. If there is third party or sensitive information (information that could compromise patient safety/safety of public), select the Nonportal option.

Document	Type
Consultation Report	Report
Consultation Report Nonportal	Report
History & Physical Nonportal	Report
History and Physical	Report

There is a mandatory field* that requires completion prior to being able to electronically sign the report.

Physician Report
*Patient Portal Nonportal — Third Party Information — Sensitive Information
Reason — Other

For more information about MyHealthPortal, visit: https://www.interiorhealth.ca/YourHealth/MyHealthPortal/Documents/MyHealthPortal%20FAQs.pdf

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.

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.

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

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

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