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Extraordinary Caring. Every Person. Every Time.

Physician Orientation Resources

Prepared by: Medical Affairs August 2016

Welcome to Niagara Health

This Resource Guide provides you with supplementary materials to support your orientation experience.

Within this booklet you will find helpful guides relating to:

- Health Records & Charting
- Dictation
- Entry Point & Order Sets
- Medication Reconciliation
- Incident Reporting System
- Site Specific Information
- Remote Access to NHS Intranet

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Health Records & Charting Guidelines

YOUR HEALTH INFORMATION MANAGEMENT (HIM) TEAM

- Perform qualitative and quantitative analysis of each patient record to ensure assembly order, consistency and completeness.
- Provide medical transcription support, and edit speech recognized dictated patient reports. Reports are electronically authenticated.
- Code inpatient, day surgery, oncology and dialysis patient records, prepare and submit coded, accurate patient data to Canadian Institute for Health Information (CIHI).
- Protect the confidentiality of patient records and provides access/ disclosure in accordance with privacy legislation. (Ontario Personal Health Information and Protection Act (PHIPA)
- Provide record retrieval services for research, education and statistical purposes.

PRIVACY AND RELEASE OF INFORMATION

Privacy and Passwords

- Only use your login/password credentials to access patient database information to provide care and treatment to <u>your</u> assigned patients, in accordance with privacy legislation, PHIPA s20.(2). Unauthorized PHI user access/viewing is a privacy breach.
- **DO NOT share** your user access login/password(s) with anyone. It's your electronic signature. If a privacy breach occurs, the patient is notified and your name is shared.

Protection of Personal Health Information (PHI)

- **Original** patient Health Records are our **legal hospital records** and are not to be removed from hospital premises.
- If you store patient data on your own personal computer/device, not protected by our NHS firewall, you must encrypt it (PHI security measures)
- **DO NOT email Personal Health Information** (PHI) to non-NHS email accounts, unless data is encrypted. Transmission across the internet without encryption is insecure and may be intercepted.
- Hardcopy PHI (paper) must be stored securely or destroyed using a confidential destruction system (i.e. shredding) to prevent unauthorized access.
- **Never leave yourself logged on** to a patient database for another individual to commit a privacy breach using your electronic signature. Press **<u>Ctrl+Alt+Delete</u>** and **<u>sign off</u>** before leaving your station.

Release of Information Specialist

The Release of Information Specialist is responsible for the release of patient health record copies to the patient, and/or authorized requesting parties, in accordance with Privacy Legislation, Health Care Consent Act, Substitute Decision Maker Act and related Canadian Law.

Each hospital site has a Release of Information Specialist located in the HIM Department. Contact them regarding any requests for confidential patient data including requests from the College of Physicians and Surgeons (CPSO).

PATIENT RECORD SYSTEM

Patient Storage Mediums

- **Paper Based -** adults 18 years and older PHI destroyed 15 years after discharge, deaths 10 years after discharge, pediatric patient < 18 years– 15 years after patient's 18th birthday.
- **Electronic** (scanned) - all out-patient records including ED, Day Surgery and Clinics effective November 1, 2013

Patient Unit Number

- NHS hospital's patient records are maintained under a **site-specific** identification unit number. This number is used for any subsequent patient visits to that hospital site. An **alpha-prefix** is added to the unit number to identify each site as follows:

Patient Account Number

D = Douglas Memorial Site (DMS)	**F** = Greater Niagara General (GNG)
K = St. Catharines Site (SCS)	**L** = Port Colborne Site (PCS)
W = Welland Site (WHS)	

- **Every** patient visit to an NHS site is assigned an account number.
- The account number is prefixed with the **hospital site alpha-character & type of visit**. Account numbers are re-set annually based on fiscal year (Apr.—Mar.)

  WE = Emergency WS=Day Surgery WH = Dialysis

  WO = Outpatients WA= Inpatient

Eg. WE000123/08 W = Welland Site E = Emergency

123= Visit Number 15 = Year

Patient Information Access

- **Paper Based -** any record not in Meditech or scanned. Two years hard-copy records are maintained in HIM.
- **Meditech -** PCI (Patient Care Inquiry) to access patient information from any NHS site.
- **Mosaiq** - Out-patient Oncology record system including Branford General, Joseph Brant, Hamilton Juravinski and Niagara Health.
- **Clinical Connect** - Contact ICT at Ext. 44881 to obtain access. User access to patient records from LHIN 1, 2, 3, and 4 partner hospitals.
- **Electronic Scanned Records** - Include all ED, day surgeries, and clinics
- **Key Fob Remote Access to Meditech** - Contact ICT Service Desk at Ext. 42850

PAPERLESS REPORT DELIVERY

Niagara Health has adopted a paperless solution for report delivery. Reports are delivered via autofax. We also provide a "NO PRINT" option whereby reports are not faxed but rather are viewed electronically online in Meditech Patient Care Inquiry (PCI).

Hospitalists, **ED physicians** and **Locum Tenens** profiles are automatically set to the "NO PRINT" option as physicians working in this capacity generally do not have a dedicated office to receive their reports. Electronic viewing options for accessing Laboratory, Pathology, Health Records and Diagnostic Imaging are listed above.

CHARTING DOCUMENTATION GUIDELINES

General Charting Guidelines

- All documentation must be legible.
- Dictated reports are strongly recommended.
- Discharge Summaries MUST be dictated (see *page 19* for details).
- *Every entry* must be authenticated and dated by the author.
- **Black ink** must be used for all written entries to aid in quality scanning.

Charting Abbreviations and Symbols

- **NOTE:** No abbreviations are accepted on the discharge summary and/or face sheet when documenting final diagnoses and operative procedures.

INCOMPLETE CHARTS & SUSPENSION OF PRIVILIEGES

Incomplete Records Process

- Charts will remain on the floor for 24-48 hours post-discharge to support chart completion.
- Physicians with incomplete charts will receive weekly notifications identifying the number of charts for completion and the reason for the deficiencies.
- Charts are to be completed within 18 days of the chart being made available to the physician.
- Incomplete charts are reported to the MAC on a monthly basis.

Suspension of Privileges

- ≥ 5 charts within eighteen (18) days of the chart being made available.
- 1 chart ≥ thirty (30) days.

Suspension Process

- 1st notification letter - day 7 on the Wednesday.
- 2nd notification letter - day 14 on the Thursday.
- 3rd Notification letter & suspension of privileges - day 18 on the Monday.

Reinstatement of privileges will occur once all charts are completed. Notify HIM of any vacation in advance to be temporarily exempted from the suspension process

IMPORTANCE OF DOCUMENTATION

Detailed and accurate chart documentation facilitates positive outcomes for:

- Patient Care and Clinical Outcomes
- Physician to physician communication for continuum of patient care purposes
- Appropriate funding
- Accurate and comprehensive documentation drives what is coded
- HIM Health Records Technicians rely on physician documentation and can only code what is documented. **Be as specific as possible - coding impacts funding**
- The data resulting from coding is used for funding, hospital and program planning, decision making, utilization review, statistics and research.

SITE LOCATIONS, HOURS, AND CONTACT INFORMATION

Douglas Memorial Site

230 Bertie Street
Fort Erie, ON L2A 1Z2

Tel: (905) 378-4647
Fax: (905) 871-9078

Located on the first floor. Enter through the front entrance.
Mon-Fri 0700-1700 hrs.

Manager	52464
Health Information Management Department Transcription	50250 52455

Greater Niagara Site

5546 Portage Road
Niagara Falls, ON, L2E 6X2

Tel: (905) 378-4647
Fax: (905) 358-0829

First floor across from the clinical conference room.
Mon-Fri 0700-1630 hrs.
Sat 0800-1600 hrs.

Manager	52464
Health Information Management Department Transcription	50250 52455

The information in this section was provided by the Health Information Management Team. The department is managed by the Health Information Management and Patient registration manager and staffed by Health Records Technicians, Release of Information Specialists, Medical Transcriptionists and Clerical Staff.

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Port Colborne Site

260 Sugarloaf Street
Port Colborne, ON, L3K 2N7

Tel: (905) 378-4647
Fax: (905) 834-0016

Emergency/Patient Registration Entrance (next to Urgent Care).
Mon-Fri 0800-1800 hrs.

Manager	34589
Health Information Management Department Transcription	32011 33329

St. Catharines Site

1200 Fourth Avenue
St. Catharines, ON L2S 0A9

Tel: (905) 378-4647
Fax: (905) 684-1136

Third Floor.
Mon-Fri 0700-1630 hrs.
Sat 0800-1600 hrs.

Manager	50105
Health Information Management Department Transcription	44477 44471

Wellland Site

Welland, ON, L3B 4W6

Tel: (905)378-4647
Fax: (905) 732-6725

Ground floor, turn left when entering main doors.
Mon-Fri 0700-1630 hrs.

Manager	34589
Health Information Management Department Transcription	33222 33329

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Dictation

WALKTHROUGH OF SYSTEM

The Niagara Health Dictation System can be accessed utilizing:

- In-house dictation stations
- Telephone

Dictation Instructions

1. Call into the dictation system
    - Inside the hospital: ext. 75000
    - Outside the hospital: Call 1-855-666-3246
    - Dictation Issues—Call 1-888-342-8283

2.Key in your five digit **Dictation identification number.**

3. Key in the two digit hospital number.

Hospital #:

DMH	11	GNG	12	NOTL	13
PC	14	SCS	15	WHS	17

4. Key in work type.

History & Physical	01
Consultation	02
Operative Report	03
Progress Note	04
Discharge Summary	05
Labour & Delivery	06
Therapy Report	07
Clinic Report	08
Letter	09
LDAP Clinic	62
Hep C Clinic	65
Late Dictation	67

NOTE: PRIORITY—Only for Transfer Notes & Pre-op reports within 48 hours of surgery.

5. Key in Patient six digit I.D. If entering less than six digits must be followed by the '#' key.

Pre-Op—New Patients—Key in 99# as patient I.D.

6. You will hear "System is ready". **Press 2** to begin dictation. You are then in record mode until you interrupt it with a keypad function i.e. '3' for rewind. Identify yourself by name at the beginning of each dictation. Dictate patients full name, Unit #, DOB and Acct.# if available.

7. **Press 9** to complete report and continue with same work type.

8. **Press 8** to complete report and dictate new work type.

9. **Press 5** to end the last report and disconnect.

10. **Press 77**. To rewind to beginning. Press 2 to begin dictation and state that "This report is to be discarded". Complete report.

Direct any questions or problems regarding transcription by dialing 905-378-4647 with site extension:

GNG	Ext. 52455	SCG	Ext. 44471
WHS	Ext. 33229	NOTL	Ext. 44471
PCG	Ext. 34579	WHS	Ext. 50250

Keypad instructions – Press

1 Pause	Press 1 to place dictation on hold. Press #1 to edit job demographics.
ABC 2 Record Stop	Press 2 to begin dictation Press 2 to pause and/or stop Playback
DEF 3 Skip Back/Play	Press 3 for incremental rewind
GHI 4 Continuous FWD	Press 4 for continuous forward Press 44 to fast forward to last word dictated. Press 3 to release into playback
JKL 5 Complete Report	Press 5 to complete report and disconnect
MNO 6 High Priority	Press 6 to label dictation as HIGH PRIORITY (STAT Transfers/Urgent Cases only)
PRS 7 Forward	Press 7 for continuous rewind Press 77 to rewind to first word dictated Press 3 to release into playback
TUV 8 Complete Report	Press 8 to complete report, and dictate different work type.
WXY 9 Complete Report	Press 9 to complete report and continue with same work type.

Direct questions regarding technical difficulties with Dictation system to:

1-888-DICTATE (342-8283)

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DICTATION TIPS FOR HIGH QUALITY SPEECH RECOGNITION

DO'S

1. **Speak slowly and clearly**
2. **Provide the following information:**

- Correct dates of admission, discharge, procedure and Out-Pt. Visits;
- Complete names of all Physicians involved;
- Patient's full name (first and last; spell all uncommon names);
- Medical Record number and Date of Birth;
- Names and addresses of physicians not on staff to receive copies (copies cannot be sent if not provided);
- Spell the names of new of infrequently used drugs, surgical instruments and procedures.

3. **Keep phone receiver at a reasonable distance**, avoid turning away or having receiver too close.
4. **Press 2 to pause dictation when carrying on conversation**, otherwise your conversation will be recorded
5. **If dictating on multiple patients/reports, press 8 or 9 between each dictation** as this will prompt the next patient/report;
6. **Do not rush**. Dictate at an even pace.

DON'TS

1. ***Do not* dictate where extraneous background noise can be recorded** (i.e. busy nurses' station, TV's, music, pets);
2. ***Do not* eat or chew gum** while dictating;
3. ***Do not* dictate over a speaker phone**. This will result in poor clarity for speech recognition;
4. ***Avoid* overuse of abbreviations**, especially those considered dangerous by ISMP (see policy 555-003-050A).

PLEASE NOTE: *Use of cell-phones may interfere with voice quality in dictations due to unreliable signal strength*

SAMPLE DICTATION CRITERIA

The report criteria, listed below, assist the HIM coder in obtaining accurate information. These templates should be used for medical report dictation purposes.

HISTORY AND PHYSICAL

Work type "01"

The following headings are required when dictating:

Date of History and Physical

Chief Complaint

History of Present Illness

Past History

Physical Examination

Allergies

Current Medication

Admission Diagnosis

OPERATIVE REPORT

Work type "03"

The following headings are required when dictating :

Date of Procedure

Assistant

Anesthetist

Anesthetic

Preoperative Diagnosis

Postoperative Diagnosis

Operative Procedure (title of operation)

Procedure/Treatment (description of procedure/treatment)

NOTE: the patient's **PRE OPERATIVE HISTORY** must be dictated by the Surgeon no later than 48 hours prior to the surgery, and must follow the "History and Physical" criteria as outlined above.

DISCHARGE SUMMARY

All Discharge Summary Reports MUST be dictated

Work type "05"

The following headings are required when dictating:

Most Responsible Diagnosis *(MRDx - the one diagnosis/condition most responsible for patient's hospital stay)*

Pre-Admit Comorbidities *(A condition that coexists at the time of admission)*

Post-Admit Comorbidities *(A condition that develops after admission)*

Secondary Diagnosis *(A condition for which a patient may, or may not have, received treatment but may have an impact on a condition actively being treated. i.e. COPD with Pneumonia)*

Principal Procedure *(Procedure most significant during patient hospital stay)*

Other Procedures/Treatment

Discharge Medications

Follow-up Plan/Care

Please dictate these headings in the same format as outlined above as the system will apply the headings to your report.

If there is nothing to report under one of the chart completion criteria headings please indicate "Nil or N/A" at the time of dictation. If nothing has been dictated it will be left blank.

Report Editing

- Queries on reports will be forwarded to the Physician, from Transcription, for completion/correction. Any necessary editing to original signed reports should be dictated as an addendum.

Report Copies

- No printed report copies are generated. Reports are available via Autofaxing, Clinical Connect or Keyfob remote access to Meditech.

High Priority Dictation

- For High Priority (urgent cases and stat transfers ONLY) press "6" at any time during dictation.

The Information in this section was provided by the Health Information Management Team. The department is managed by the Health Information Management and Patient Registration Manager and staffed by Health Records Technicians, Release of Information Specialists, Medical Transcriptionists and Clerical Staff

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Order Sets

LOGGING IN AND ACCESSING ENTRYPOINT

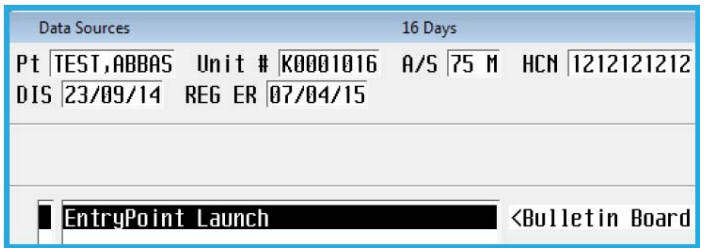
1. LOGIN

Access Electronic Order Sets by launching EntryPoint:

- Login to Meditech and enter PCI (Patient Care Inquiry)

Find and select your patient

- Launch EntryPoint by selecting “EntryPoint Launch” from the PCI Menu
- All of your patient’s information will be automatically carried over in the order set



2. ACCESS

Your Access to Electronic Order Sets:

- Your initial login is your NH email/computer login and password
- ***You will be prompted to create PIN # upon initial login. This will be required to submit/print any Orders from EntryPoint.***
- If you lose/forget your PIN, utilize the self-service password management system through the Service Desk portal on SourceNet.

3. ORDER SET SEARCH OPTIONS

Once you have selected your patient, select an order set by:

- Searching the Title, Keyword, Diagnosis
- Choose from your list of Most Frequently Used or Featured Documents
- Select Browse to view order sets by categories

Most Frequently Used: The Most Frequently Used list auto-populates based on your user history

Featured Documents: Highlights Corporate Priority Order Sets & will be up-dated regularly with new content

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4. COMPLETE

Complete the Order Set:

- Select (or Un-Select) your desired orders
- Choose from drop down menus as appropriate
- Add necessary free text in provided lines

Archive: Submitted order sets are archived automatically

5. SUBMIT & PRINT

- Click Submit & Print
- Enter your authentication PIN when prompted
- Click Submit in Document Submission Window
- Choose your printer and click print
- Retrieve completed Order Set from printer, add to chart and flag

Other Items of Note

DRAFTS: The Draft tab includes Order Sets that have been started and saved to be completed later or Order Sets that are completed by a resident or Clinical Clerk and require a co-signature.

QUALITY BASED PROCEDURE FLAGS: QBP Flags identify performance indicators within Order Sets that are mandated by the MOHLTC. The QBP Flag will appear next to any order or module for which it applies.

QBP

BLANK ORDER FORM: Order Set doesn't exist? Search for Practitioner Order Form for a blank order sheet and free text your orders.

NEED HELP? Visit SourceNet and click on the Order Sets link, Call the Order Sets Hotline @ 4SETS (ext. 47387) or Email: ordersets@niagarahealth.on.ca

FREQUENTLY ASKED QUESTIONS

Ordering Prescribers

Who needs access to login to the EntryPoint program?	Access to EntryPoint will be required by all ordering practitioners (i.e. Physicians, Residents, Midwifes, Nurse Practitioners, Dieticians).
Why are we moving to electronic Order Sets?	Although our current paper order set system provides standardization reflective of best practices, by moving to an electronic system there are many benefits including but not limited to: • Improved Inventory Control • Improved Legibility in the prevention of errors • The ability to collect and analyze precise and real time data through EntryPoint's Spotlight analytics system allowing us to make responsive changes in a timely manner. • Improved efficiency; as this process saves time over completing them on paper and by hand. Moving to Electronic Order Sets is the first step in moving toward computerized provider order entry (CPOE).
What if an order set is not applicable for my patient?	If an order set does not exist, please use the blank "Practitioner Order Sheet". These will accommodate all orders that do not coincide with an order set and can be used for one time orders as well.
Are all order sets to be done electronically?	Yes, where applicable order sets are to be completed electronically using EntryPoint.
What are Featured Documents?	Featured Documents are used for two reasons: 1. To display new or modified order sets 2. To display order sets that are deemed a priority by the organization.

The Information in this section was provided by Brandon Douglas, Corporate Clinical Project manager. The Order Set Project Team and Order Set Approval Committee provided final review of all order sets and the implementation of Electronic Order Sets.

What if I don't agree with an order in an order set?	If you don't wish to implement a specific order contained within an order set you can chose not to select it. If it is a preselected order, you can simply unselect it. Use the blank "Practitioner Order Sheet" if you can't find an appropriate order set. If you are working in an order set and cannot find the order you want, use the free text lines located at the end of the order set. If you would like to see a change within an order set, please contact the development team lead for your program.
Can I change orders after I have printed them?	Once an order has been submitted, it cannot be edited electronically. Printed order sets **should not be edited by hand**. It is recommended that any deletions or additions on an order set be entered using the blank "Practitioner Order Sheet". Orders that are hand written will not appear in the archive history in EntryPoint and therefore other ordering providers will not be able to view your edits.
What happens after the orders are printed? Who is responsible for putting them on the chart?	This process will remain unchanged. It is the prescriber's responsibility to ensure there is communication of new orders following your unit specific processes to ensure the orders get processed and treatment/medications are provided in a timely manner.
What is the process for telephone orders?	This process will remain unchanged and follows policy 555-003-050. Telephone orders will continue to be hand written and the prescriber will be required to sign the order within 24hrs.
What is the process for 'suggest' orders?	For instances where a consultant suggests a course or treatment/action on the physician order sheet, policy 555-003-050 will continue to apply requiring the Most Responsible Physician to co-sign in agreement before they are implemented.
Can I use Electronic Order Sets for my outpatients?	As long as patients are registered in Meditech, they can be found in EntryPoint.

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Medication Reconciliation

MEDICATION RECONCILIATION AT NIAGARA HEALTH: HOW-TO-GUIDE FOR PHYSICIANS

1. ADMISSION

Med Rec upon admission to Niagara Health will be achieved using a proactive model where the prescriber uses the Best Possible Medication History (BPMH) form to generate part of the admission medication orders.

If admission orders are written prior to obtaining a BPMH, the BPMH must still be obtained and reconciled against the admission orders retrospectively.

If a blank BPMH form is not in the patient's chart or additional forms are re-quired, forms are available on each unit or from SourceNet under 'Forms" or 'Education & Practice'.

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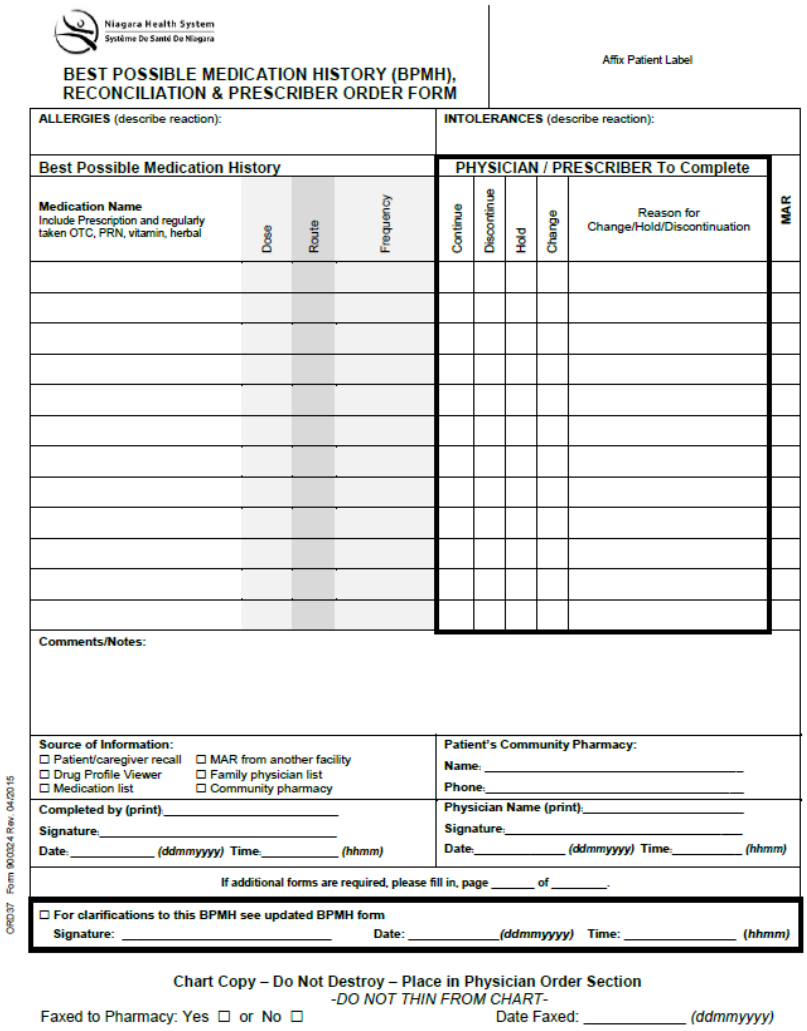


Niagara Health System
Système De Santé De Niagara

Affix Patient Label

BEST POSSIBLE MEDICATION HISTORY (BPMH), RECONCILIATION & PRESCRIBER ORDER FORM

ALLERGIES (describe reaction):

INTOLERANCES (describe reaction):

Best Possible Medication History

PHYSICIAN / PRESCRIBER To Complete

Medication Name Include Prescription and regularly taken OTC, PRN, vitamin, herbal	Dose	Route	Frequency	Continue	Discontinue	Hold	Change	Reason for Change/Hold/Discontinuation	MAR

Comments/Notes:

Source of Information:
☐ Patient/caregiver recall ☐ MAR from another facility
☐ Drug Profile Viewer ☐ Family physician list
☐ Medication list ☐ Community pharmacy

Patient's Community Pharmacy:
Name: _____
Phone: _____

Completed by (print): _____
Signature: _____
Date: _____ *(ddmmyyyy)* **Time:** _____ *(hhmm)*

Physician Name (print): _____
Signature: _____
Date: _____ *(ddmmyyyy)* **Time:** _____ *(hhmm)*

If additional forms are required, please fill in, page _____ of _____.

☐ **For clarifications to this BPMH see updated BPMH form**
Signature: _____ **Date:** _____*(ddmmyyyy)* **Time:** _____ **(hhmm)**

ORD37 Form 900324 Rev. 04/2015

Chart Copy – Do Not Destroy – Place in Physician Order Section
-DO NOT THIN FROM CHART-
Faxed to Pharmacy: Yes ☐ or No ☐ Date Faxed: _____ *(ddmmyyyy)*

Please remember to:

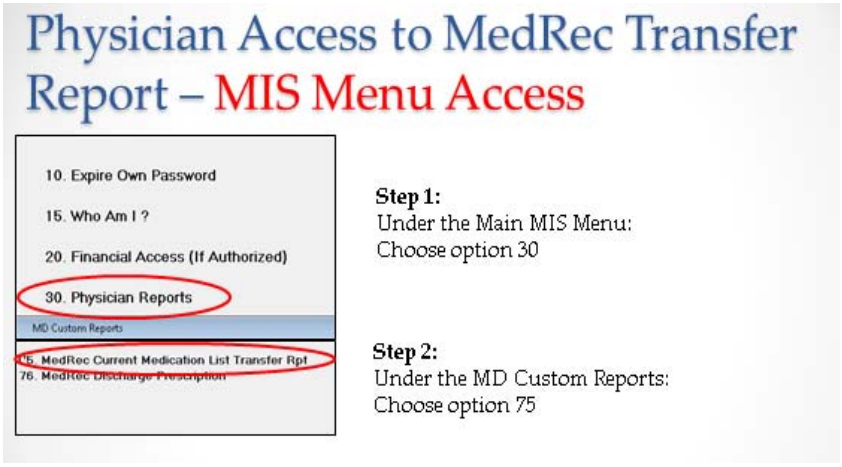
- Confirm the documented medications with the patient/ caregiver, if able
- Document rationale for changed, held or discontinued medications
- Sign the BPMH even if the patient has no home medications

2. TRANSFER

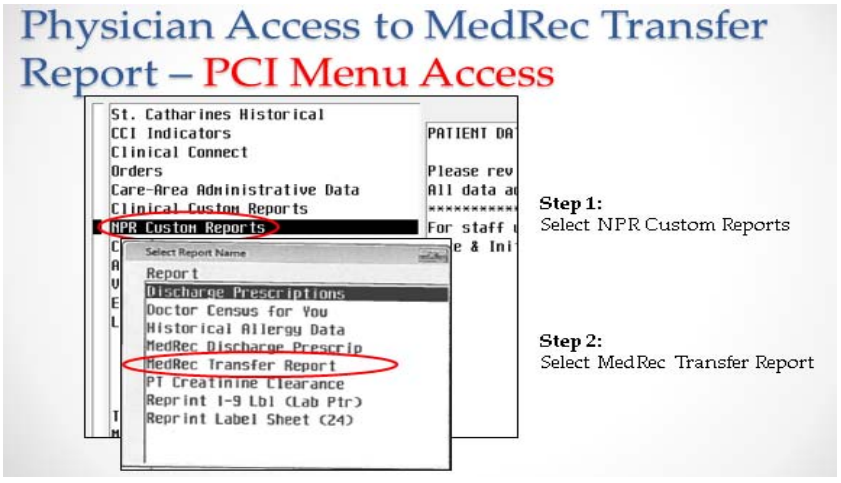
MedRec upon transfer requires:

- Generation of the Current Medication List Transfer Report from Meditech as close to transfer as possible
- The prescriber to compare the admission BPMH with the current medications (transferring units MAR) to create new transfer medication orders – identify if medications are to be reordered or discontinued

The Current Medication List Transfer Report can be accessed through the MIS or PCI menu (see below).

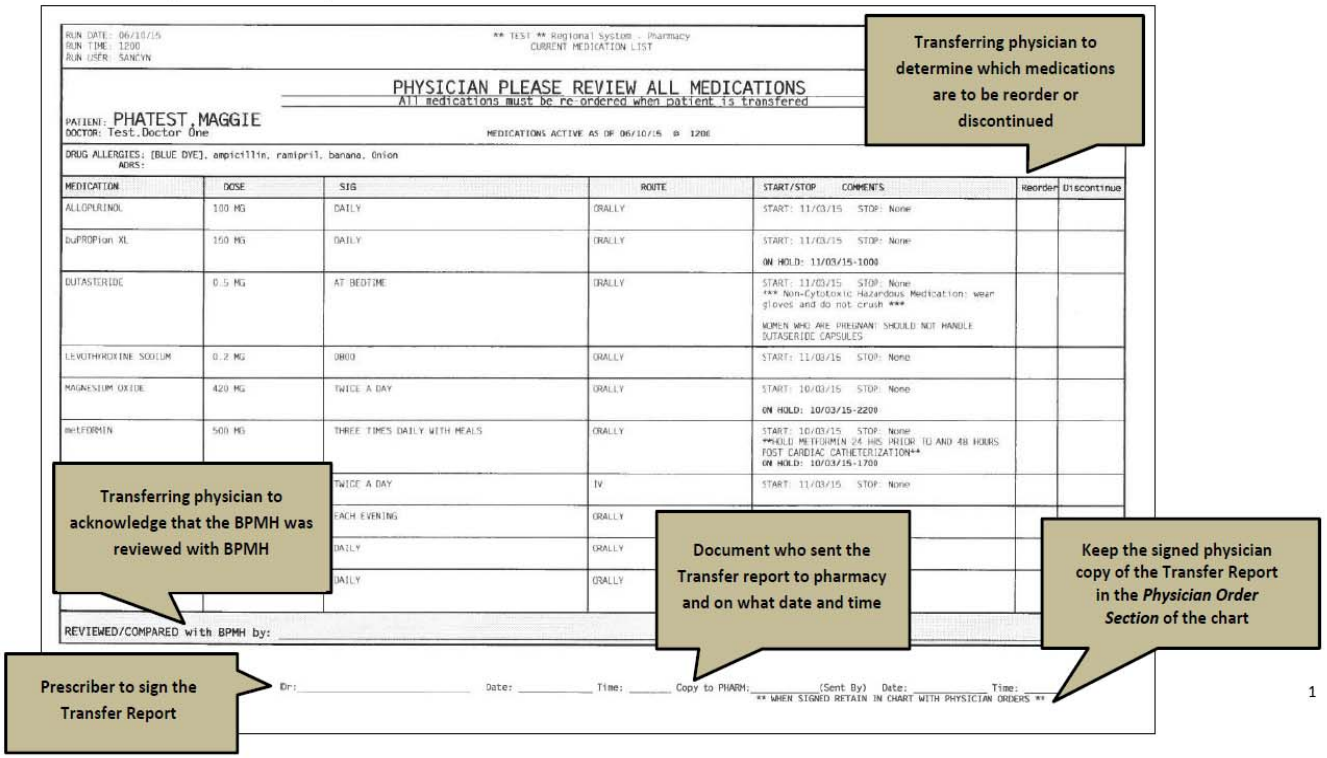


OR



The Current Medication List Transfer Report

Sample Instructions on How to Complete the Transfer Report



RUN DATE: 06/10/15
RUN TIME: 1200
RUN USER: SANCYN

** TEST ** Regional System - Pharmacy
CURRENT MEDICATION LIST

PHYSICIAN PLEASE REVIEW ALL MEDICATIONS
All medications must be re-ordered when patient is transfered

PATIENT: PHATEST,MAGGIE
DOCTOR: Test,Doctor One

MEDICATIONS ACTIVE AS OF 06/10/15 @ 1200

DRUG ALLERGIES: [BLUE DYE], ampicillin, ramipril, banana, Onion
ADRS:

MEDICATION	DOSE	SIG	ROUTE	START/STOP COMMENTS	Reorder	Discontinue
ALLOPURINOL	100 MG	DAILY	ORALLY	START: 11/03/15 STOP: None		
buPROPion XL	150 MG	DAILY	ORALLY	START: 11/03/15 STOP: None ON HOLD: 11/03/15-1000		
DUTASTERIDE	0.5 MG	AT BEDTIME	ORALLY	START: 11/03/15 STOP: None *** Non-Cytotoxic Hazardous Medication: wear gloves and do not crush *** WOMEN WHO ARE PREGNANT SHOULD NOT HANDLE DUTASERIDE CAPSULES		
LEVOTHYROXINE SODIUM	0.2 MG	0800	ORALLY	START: 11/03/15 STOP: None		
MAGNESIUM OXIDE	420 MG	TWICE A DAY	ORALLY	START: 10/03/15 STOP: None ON HOLD: 10/03/15-2200		
metFORMIN	500 MG	THREE TIMES DAILY WITH MEALS	ORALLY	START: 10/03/15 STOP: None **HOLD METFORMIN 24 HRS PRIOR TO AND 48 HOURS POST CARDIAC CATHETERIZATION**		
				ON HOLD: 10/03/15-1700		
		TWICE A DAY	IV	START: 11/03/15 STOP: None		
		EACH EVENING	ORALLY			
		DAILY	ORALLY			
		DAILY	ORALLY			

REVIEWED/COMPARED with BPMH by: _____

Dr: _____ Date: _____ Time: _____ Copy to PHARM: _____ (Sent By) Date: _____ Time: _____
** WHEN SIGNED RETAIN IN CHART WITH PHYSICIAN ORDERS **

Transferring physician to determine which medications are to be reorder or discontinued

Transferring physician to acknowledge that the BPMH was reviewed with BPMH

Document who sent the Transfer report to pharmacy and on what date and time

Keep the signed physician copy of the Transfer Report in the ***Physician Order Section*** of the chart

Prescriber to sign the Transfer Report

1

3. DISCHARGE

MedRec upon discharge requires:

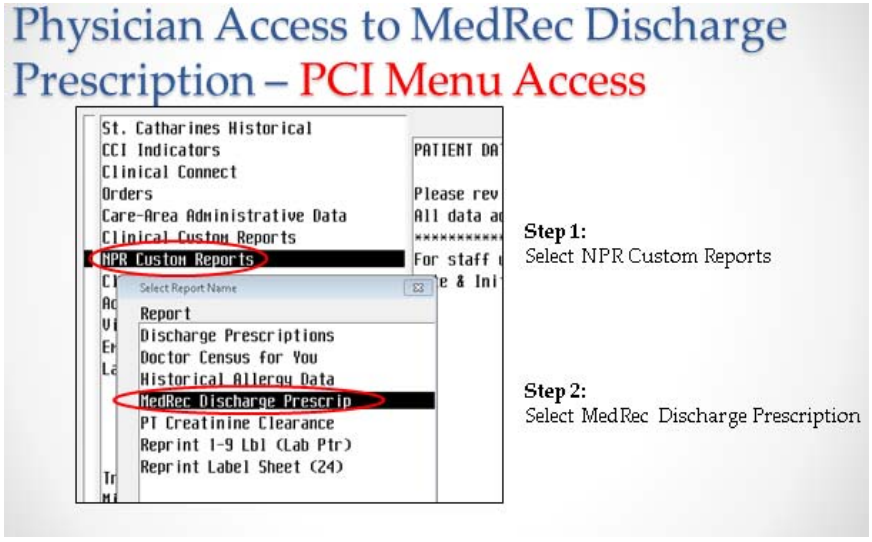
1. Generation of the Best Possible Medication Discharge Plan (BPMDP) report from Meditech as close to discharge as possible

2. The prescriber to review the patients current medications (MAR) with the BPMH

3. The prescriber to identify and document the rationale for any new medications started or home medications changed, held or discontinued while in hospital on the BPMDP form

4. Communication to occur with the patient/family/next provider of care regarding medications that should be taken after discharge relative to the medications they were taking prior to admission. This information should include:
    - The medications taken prior to admission which are to be continued unchanged
    - The medications taken prior to admission which are to be continued at a different dose and/or frequency
    - The medications taken prior to admission which are to be stopped
    - The medications started in hospital which are to be continued (at same or different doses)
    - New medications that are started at discharge
    - The indication of each medication to be taken after discharge

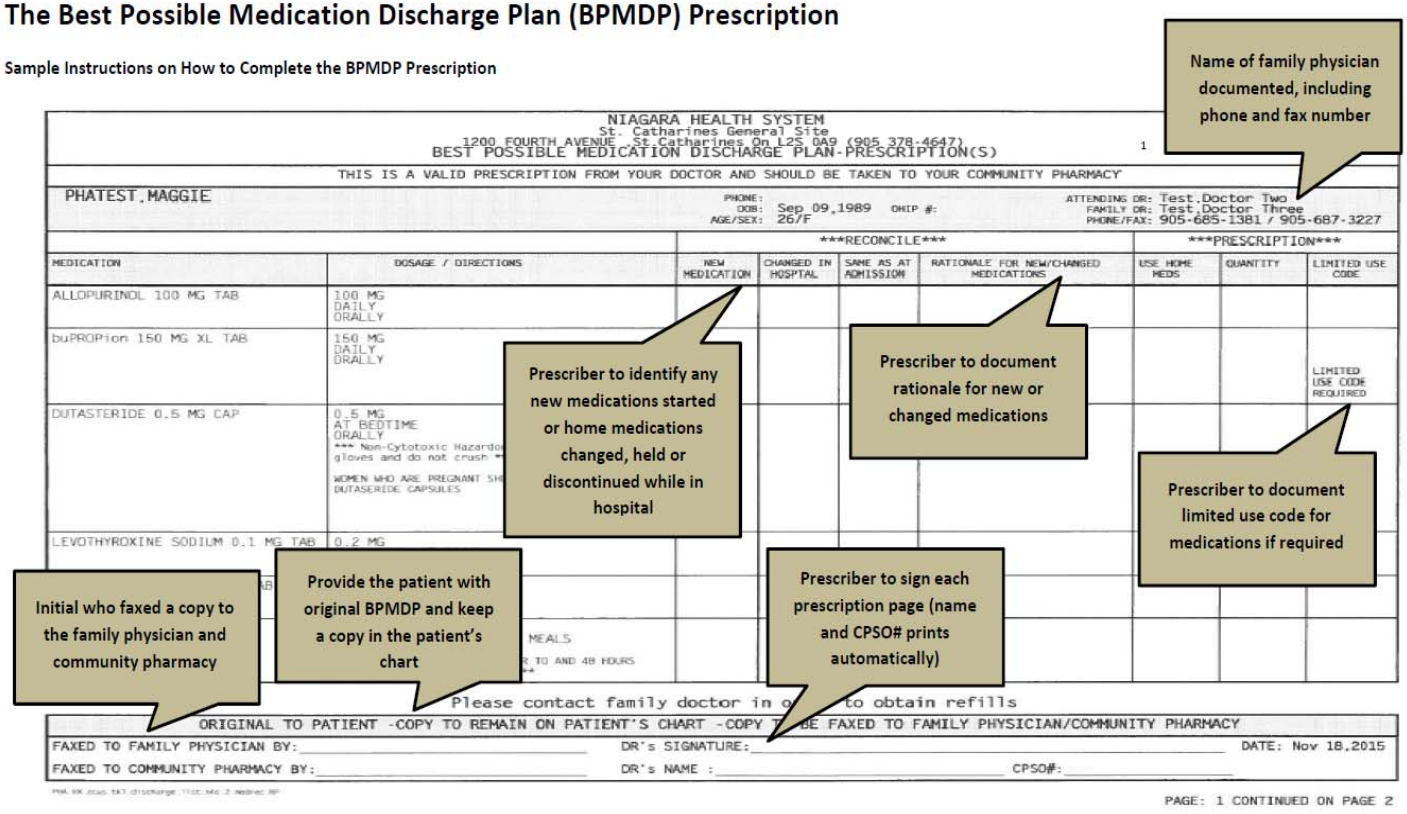
The BPMDP can be accessed through the MIS or PCI menu (see below).



OR

The Best Possible Medication Discharge Plan (BPMDP) Prescription

Sample Instructions on How to Complete the BPMDP Prescription



NIAGARA HEALTH SYSTEM
St. Catharines General Site
1200 FOURTH AVENUE, St Catharines On L2S 0A9 (905 378-4647)
BEST POSSIBLE MEDICATION DISCHARGE PLAN-PRESCRIPTION(S) 1

THIS IS A VALID PRESCRIPTION FROM YOUR DOCTOR AND SHOULD BE TAKEN TO YOUR COMMUNITY PHARMACY

PHATEST,MAGGIE
PHONE:
DOB: Sep 09,1989 OHIP #:
AGE/SEX: 26/F

ATTENDING DR: Test,Doctor Two
FAMILY DR: Test,Doctor Three
PHONE/FAX: 905-685-1381 / 905-687-3227

MEDICATION	DOSAGE / DIRECTIONS	***RECONCILE*** NEW MEDICATION	CHANGED IN HOSPTAL	SAME AS AT ADMISSION	RATIONALE FOR NEW/CHANGED MEDICATIONS	***PRESCRIPTION*** USE HOME MEDS	QUANTITY	LIMITED USE CODE
ALLOPURINOL 100 MG TAB	100 MG DAILY ORALLY							
buPROPion 150 MG XL TAB	150 MG DAILY ORALLY							LIMITED USE CODE REQUIRED
DUTASTERIDE 0.5 MG CAP	0.5 MG AT BEDTIME ORALLY *** Non-Cytotoxic Hazardo gloves and do not crush * WOMEN WHO ARE PREGNANT SH DUTASERIDE CAPSULES							
LEVOTHYROXINE SODIUM 0.1 MG TAB	0.2 MG							
	MEALS							
	TO AND 48 HOURS							

Please contact family doctor in o to obtain refills

ORIGINAL TO PATIENT -COPY TO REMAIN ON PATIENT'S CHART -COPY T BE FAXED TO FAMILY PHYSICIAN/COMMUNITY PHARMACY

FAXED TO FAMILY PHYSICIAN BY:_____ DR's SIGNATURE:_____ DATE: Nov 18,2015

FAXED TO COMMUNITY PHARMACY BY:_____ DR's NAME :_____ CPSO#:_____

PAGE: 1 CONTINUED ON PAGE 2

Name of family physician documented, including phone and fax number

Prescriber to identify any new medications started or home medications changed, held or discontinued while in hospital

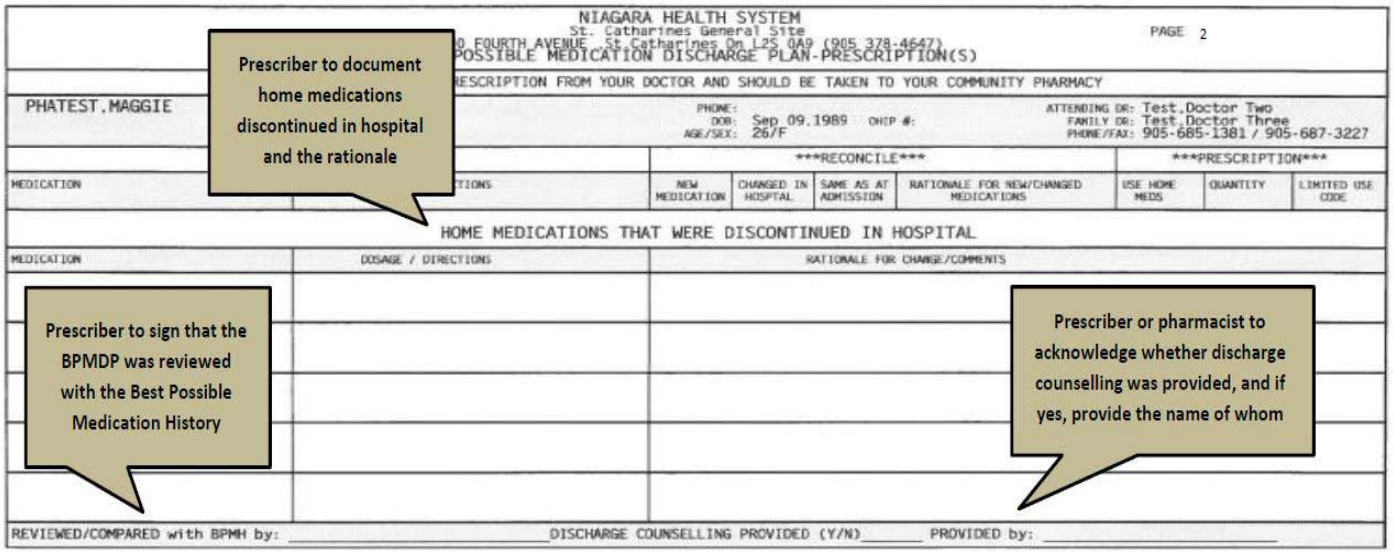
Prescriber to document rationale for new or changed medications

Prescriber to document limited use code for medications if required

Initial who faxed a copy to the family physician and community pharmacy

Provide the patient with original BPMDP and keep a copy in the patient's chart

Prescriber to sign each prescription page (name and CPSO# prints automatically)



NIAGARA HEALTH SYSTEM
St. Catharines General Site
0 FOURTH AVENUE, St Catharines On L2S 0A9 (905 378-4647)
POSSIBLE MEDICATION DISCHARGE PLAN-PRESCRIPTION(S)

PAGE 2

RESCRIPTION FROM YOUR DOCTOR AND SHOULD BE TAKEN TO YOUR COMMUNITY PHARMACY

PHATEST,MAGGIE

PHONE:
DOB: Sep 09,1989 OHIP #:
AGE/SEX: 26/F

ATTENDING DR: Test,Doctor Two
FAMILY DR: Test,Doctor Three
PHONE/FAX: 905-685-1381 / 905-687-3227

MEDICATION	TIONS	***RECONCILE*** NEW MEDICATION	CHANGED IN HOSPITAL	SAME AS AT ADMISSION	RATIONALE FOR NEW/CHANGED MEDICATIONS	***PRESCRIPTION*** USE HOME MEDS	QUANTITY	LIMITED USE CODE

HOME MEDICATIONS THAT WERE DISCONTINUED IN HOSPITAL

MEDICATION	DOSAGE / DIRECTIONS	RATIONALE FOR CHANGE/COMMENTS

REVIEWED/COMPARED with BPMH by: _____ DISCHARGE COUNSELLING PROVIDED (Y/N)_____ PROVIDED by: _____

Please contact family doctor in order to obtain refills

ORIGINAL TO PATIENT -COPY TO REMAIN ON PATIENT'S CHART -COPY TO BE FAXED TO FAMILY PHYSICIAN/COMMUNITY PHARMACY

FAXED TO FAMILY PHYSICIAN BY:_____ DR's SIGNATURE:_____ DATE: Nov 18,2015

FAXED TO COMMUNITY PHARMACY BY:_____ DR's NAME :_____ CPSO#:_____

PAGE: 2 CONTINUED ON PAGE 3

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NIAGARA HEALTH SYSTEM
St. Catharines General Site
1200 FOURTH AVENUE , St.Catharines,On L2S 0A9 (905 378-4647)

PAGE: 3

BEST POSSIBLE MEDICATION DISCHARGE PLAN-PRESCRIPTION(S)

THIS IS A VALID PRESCRIPTION FROM YOUR DOCTOR AND SHOULD BE TAKEN TO YOUR COMMUNITY PHARMACY

PHATEST,MAGGIE
PHONE:
DOB: Sep 09,1989 OHIP #:
AGE/SEX: 26/F

ATTENDING DR: Test,Doctor Two
FAMILY DR: Test,Doctor Three
PHONE/FAX: 905-685-1381 / 905-687-3227

		RECONCILE				***PRESCRIPTION***		
MEDICATION	DOSAGE / DIRECTIONS	NEW MEDICATION	CHANGED IN HOSPITAL	SAME AS AT ADMISSION	RATIONALE FOR NEW/CHANGED MEDICATIONS	USE HOME MEDS	QUANTITY	LIMITED USE CODE

NEW MEDICATIONS THAT ARE TO BE STARTED ON DISCHARGE FROM HOSPITAL

MEDICATION	DOSAGE / DIRECTIONS	RATIONALE FOR NEW MEDICATION/COMMENTS	QUANTITY

Prescriber to document new medications to be started post discharge (NOT STARTED IN HOSPITAL); include dosage, directions, rationale for starting and quantity

Please contact family doctor in order to obtain refills

ORIGINAL TO PATIENT -COPY TO REMAIN ON PATIENT'S CHART -COPY TO BE FAXED TO FAMILY PHYSICIAN/COMMUNITY PHARMACY

FAXED TO FAMILY PHYSICIAN BY:_____ DR's SIGNATURE:_____ DATE: Nov 18,2015

FAXED TO COMMUNITY PHARMACY BY:_____ DR's NAME :_____ CPSO#:_____

PAGE: 3 FINAL PAGE

The Information in this section was provided by the Medication Reconciliation Steering Committee and Andrea Forgione, Regional Medication Reconciliation Pharmacist.

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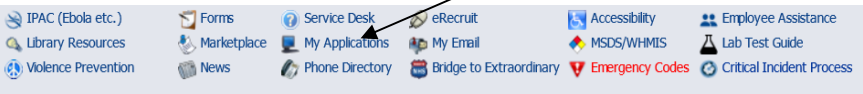
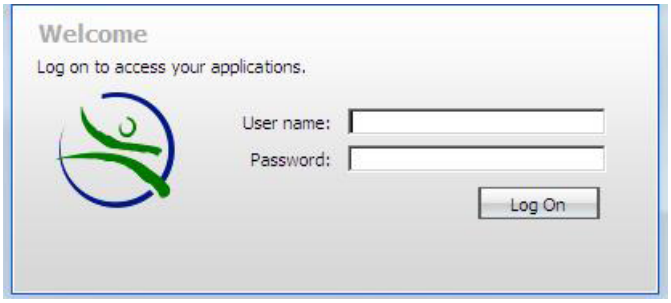
Incident Reporting System

IRS - INCIDENT REPORTING SYSTEM
BASIC USER GUIDE

Step One - Go to source.net and click on My Applications

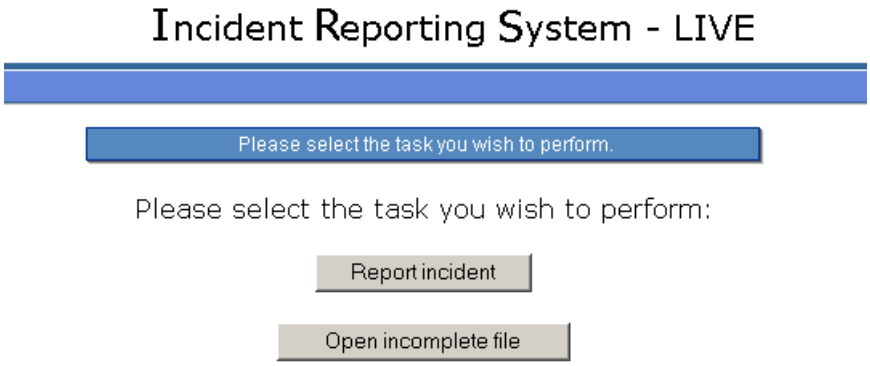


Step Two - Enter your User Name and Password (same as email)



Step Three - Click on IRS - Live

Step Four - Select the task you wish to perform; Report Incident or Open Incomplete (saved) file.



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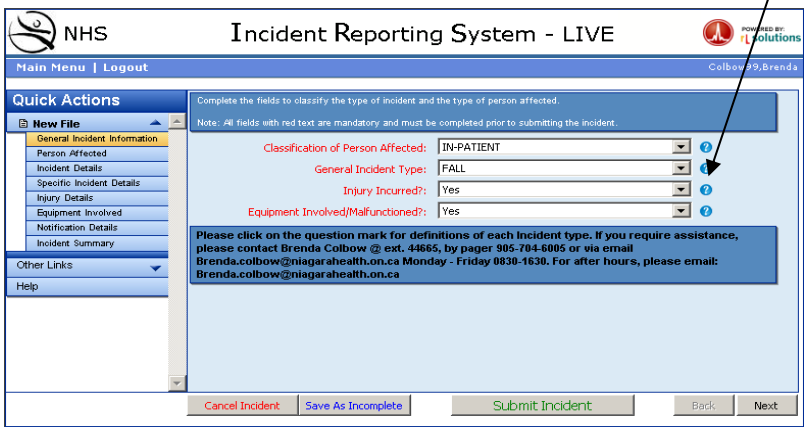
General Incident Information Screen - All **RED** fields are **Mandatory**

Make your selection from the drop down list in each field. Click the button beside each field to see the NHS definition and examples.

To move to the following screen, click Next at the bottom right or under Quick Actions on the top left, click on Person Affected.



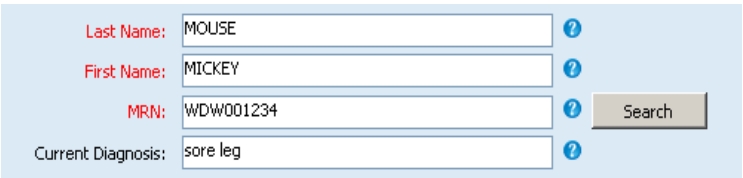
Click **Save As Incomplete** at any time and return later in your shift to finish and submit the IRS.

Submit Incident is final and should only be done when you are satisfied that the report is complete.

Cancel Incident deletes all data.

Person Affected Screen - All **RED** fields are **Mandatory**

The **MRN** (Medical Record Number) is a combination of Upper Case letters and numbers. E.g. P012345, W012345. If you don't have the MRN, you can click **Search** to access the Meditech Patient Database for Patient In-formation. The person lookup dialog box will display - click "**Search in Interface**". Highlight the Patient after verifying the Name, MRN, and DOB are correct, and then click **Ok**.



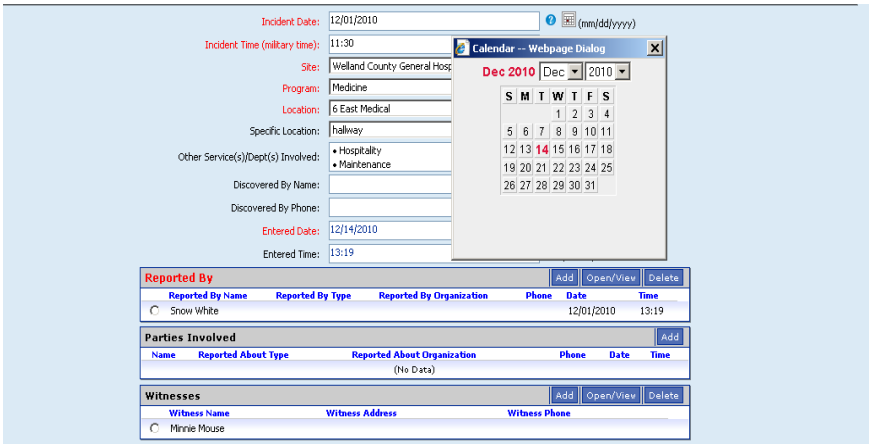
Incident Details Screen - All **RED** fields are **Mandatory**

Click on the Calendar to select the date on the Incident and fill in the time.

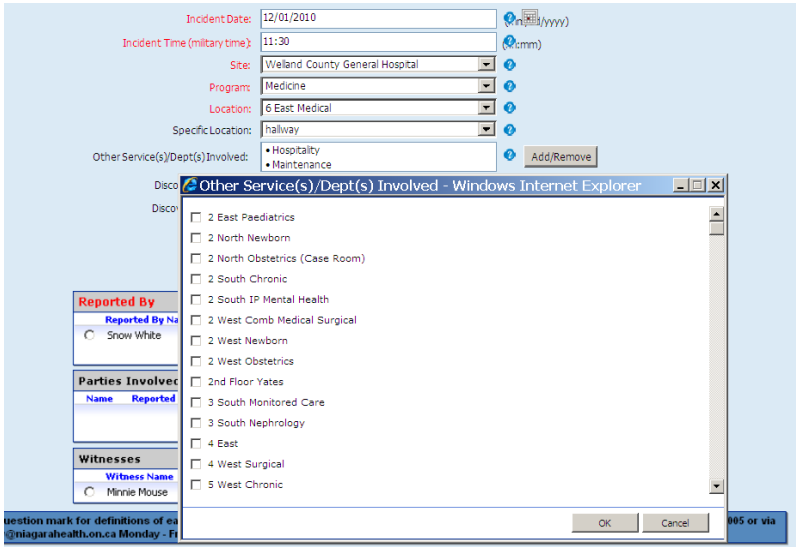
Program - The program in which the Incident occurred.

Location - Where the incident occurred and not where the patient resides.

Specific Location - Make your selection from the drop down list.



Other Services/Departments involved - Indicate other areas or services that are involved in the incident by clicking on **Add/Remove**.



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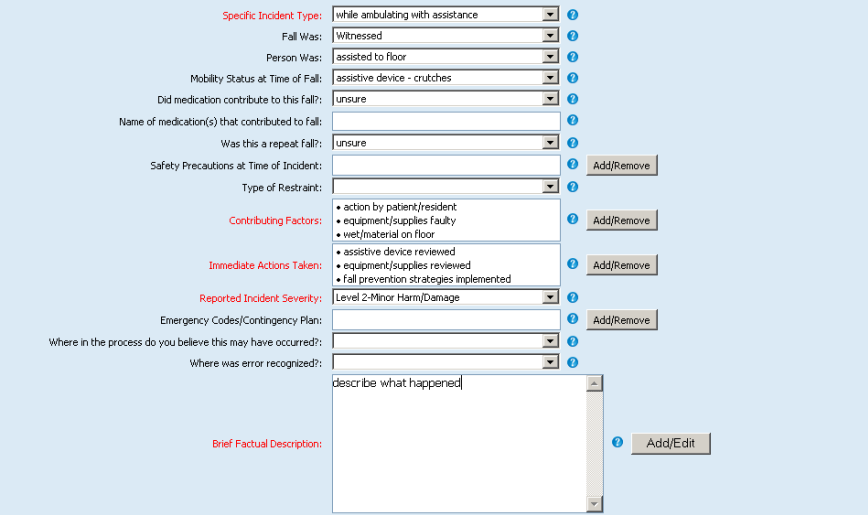
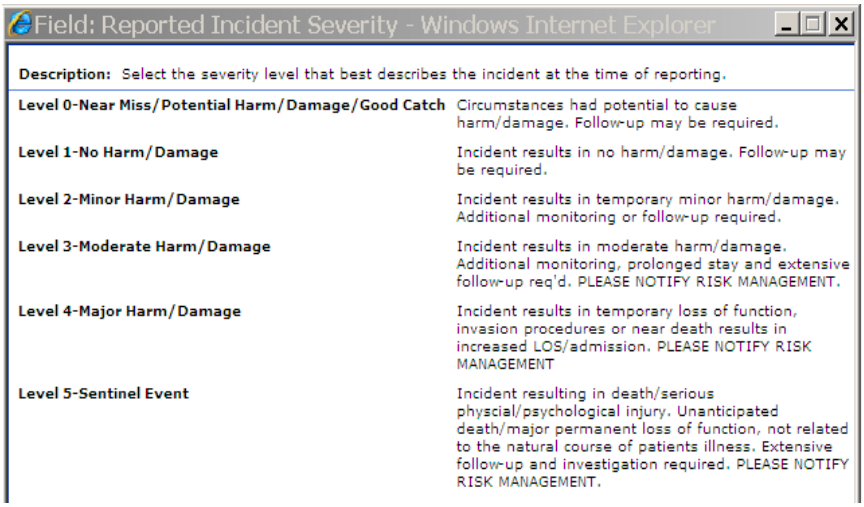
Specific Incident Details Screen - All **RED** fields are **Mandatory**

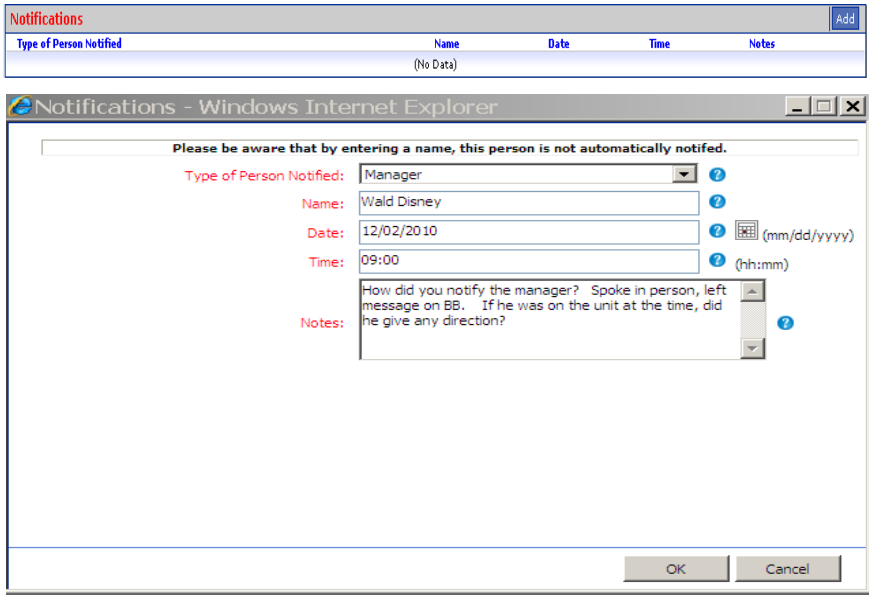
Select the most appropriate option in the fields with drop down lists. Click on Add/Remove to open a dialog box of options; you can select more than one. Be sure you scroll to see the complete list. Review the NHS definition before you select the Reported Incident Severity by clicking on the beside the field.





Notification Details - All fields are **Mandatory**

Click Add at the top right to open a dialog box. Complete all the fields, and then click "ok". Each person you need to notify is a separate entry. Use the calendar to enter the date. Include in the "notes" any pertinent information related to the notification.



Incident Summary

Review your completed IRS. If you need to make any changes,

- Go to **Quick Actions** on the top left and select the screen name
- Use the "**back**" option at the bottom of the page
- Click the **Blue** screen name on the topic you wish to change.

After you are satisfied that the information is complete, click the **Submit Incident** button at the bottom of the screen. Once submitted the report is final and can't be edited. You will receive a confirmation that the incident has been submitted successfully. The appropriate managers will now be "Alerted" of the incident.

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Niagara Health Hospital Sites

DOUGLAS MEMORIAL HOSPITAL (DMH)

230 Bertie Street
Fort Erie, ON L2A 1Z2

- ***Complex Care***
- ***Diagnostic Imaging***
- ***E.N.T.***
- ***Gastroenterology***
- ***Internal Medicine***
- ***Laboratory***
- ***Nephrology***
- ***Oncology***
- ***Ontario Breast Screening Clinic***
- ***Ophthalmology***
- ***Outpatient Clinics***
- ***Outpatient Mental Health Services***
- ***Oral Surgery***
- ***Orthopaedics***
- ***Paediatrics***
- ***Plastic Surgery***
- ***Psychiatry & Addictions***
- ***Surgery***
- ***Urgent Care Services***
- ***Urology***
- ***Vascular***

Parking at the Douglas Memorial Hospital (DMH) is automated Pay and Display. Tickets are to be purchased from one of the Pay and Display kiosks and the ticket displayed clearly on the vehicle dash.

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GREATER NIAGARA GENERAL (GNG)

5546 Portage Road
Niagara Falls, ON L2E 6X2

- *Anaesthesia*
- *Cardiology*
- *Complex Care*
- *Critical Care Services*
- *Diagnostic Imaging*
- *Emergency Department*
- *E.N.T.*
- *Gastroenterology*
- *Hospitalist*
- *Internal Medicine*
- *Laboratory*
- *Medicine*
- *Nephrology*
- *Off-site Niagara Falls Dialysis Centre*
- *Ontario Breast Screening Clinic*
- *Ophthalmology*
- *Oral Surgery*
- *Orthopaedics*
- *Outpatient Clinics*
- *Paediatrics*
- *Pharmacy*
- *Plastic Surgery*
- *Outpatient Psychiatry & Addictions*
- *Regional Geriatric Assessment*
- *Regional Stroke Services*
- *Surgery*
- *Urology*

P Parking at the Greater Niagara General Hospital (GNG) is gated parking. Gated parking will let you enter the parking lot and access the building. You obtain a ticket at the gate and then must pay for parking on your way out using a kiosk at the main entrance of each site.

PORT COLBORNE HOSPITAL (PCH)

260 Sugarloaf Street
Port Colborne, ON L3K 2N7

- ***Addictions Services***
- ***Complex Care***
- ***Diagnostic Imaging***
- ***E.N.T.***
- ***Gastroenterology***
- ***Internal Medicine***
- ***Laboratory***
- ***Nephrology***
- ***Ontario Breast Screening Clinic***
- ***Ophthalmology***
- ***Outpatient Clinics***
- ***Oral Surgery***
- ***Orthopaedics***
- ***Paediatrics***
- ***Plastic Surgery***
- ***Surgery***
- ***Urgent Care Services***
- ***Urology***
- ***Vascular***

Parking at the Port Colborne General Hospital (PCH) is automated Pay and Display. Tickets are to be purchased from one of the Pay and Display kiosks and the ticket displayed clearly on the vehicle dash.

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ST. CATHARINES SITE (SCS)

1200 Fourth Ave
St. Catharines, ON L2S 0A9

- *Acute Pain Service*
- *Anaesthesia*
- *Cardiology*
- *Children's Health*
- *Critical Care Services*
- *Diagnostic Imaging*
- *Emergency and Urgent Care*
- *E.N.T.*
- *Infectious Disease Consults*
- *Internist (Respirology, GIM< MSSU, Night Hospitalist)*
- *Kidney Care Program*
- *Laboratory*
- *Medicine*
- *Mental Health and Addictions*
- *Nephrology*
- *Neurology*
- *Ontario Breast Screening Clinic*
- *Oral Surgery*
- *Outpatient Clinics*
- *Pharmacy*
- *Surgery*
- *Vascular*
- *Walker Family Cancer Centre*
- *Women's and Babies Health*

P Parking at the St. Catharines Site (SCS) is gated parking. Gated parking will let you enter the parking lot and access the building. You obtain a ticket at the gate and then must pay for parking on your way out using a kiosk at the main entrance of each site.

WELLAND HOSPITAL SITE (WHS)

65 Third Street
Welland, ON L3B 4W6

- *Ambulatory Clinics*
- *Anaesthesia*
- *Complex Care*
- *Critical Care Services*
- *Diabetes Education Centre*
- *Diagnostic Imaging*
- *Emergency Department*
- *E.N.T.*
- *Gastroenterology*
- *Hospitalist*
- *Internal Medicine*
- *Laboratory*
- *Long-Term & Extended Care*
- *Medicine*
- *Nephrology*
- *Ontario Breast Screening Clinic*
- *Ophthalmology*
- *Oral Surgery*
- *Orthopaedics*
- *Outpatient Mental Health Services*
- *Paediatrics*
- *Pharmacy*
- *Plastic Surgery*
- *Satellite Dialysis Centre*
- *Surgery*
- *Urology*
- *Vascular*

Parking at the Welland Hospital Site (WHS) is gated parking. Gated parking will let you enter the parking lot and access the building. You obtain a ticket at the gate and then must pay for parking on your way out using a kiosk at the main entrance of each site.

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Remote Access for Professional Staff

Remote Access - Guide on How to Access Niagara Health Network

This guide is to walk through the process of establishing a connection to the Niagara Health Remote Access. This will allow you to connect to Niagara Health whether you are using your own personal computer.

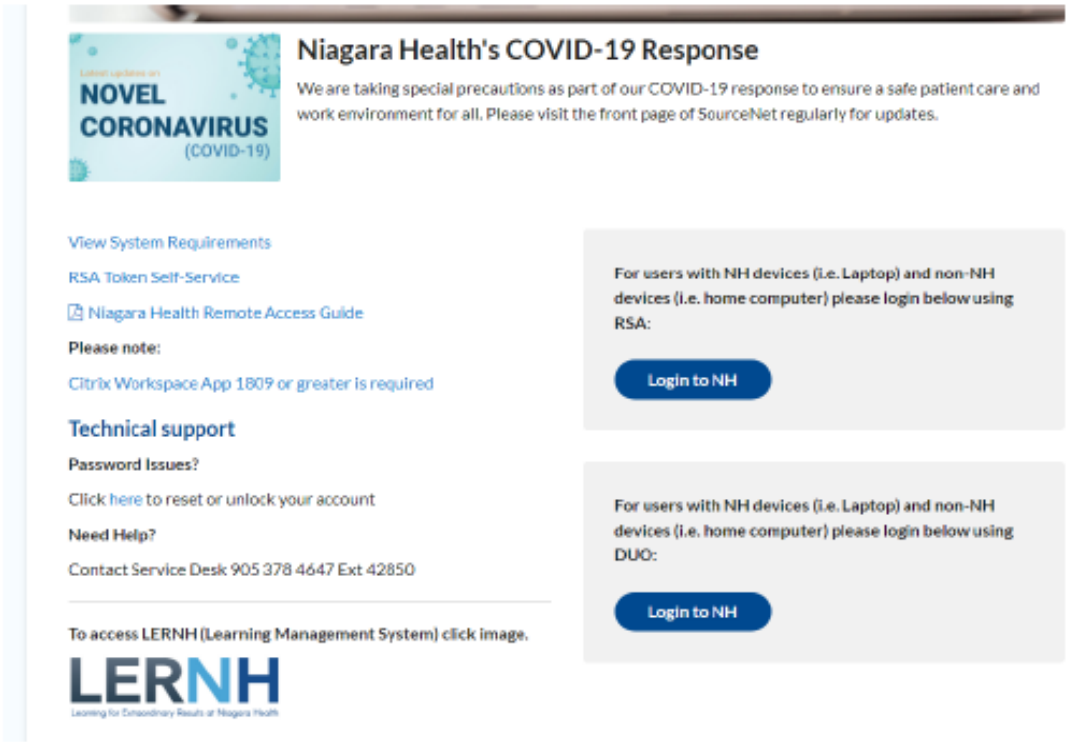
IMPORTANT NOTE for those using a home computer (or non NH-issued device): Before you proceed through these steps, you must ensure that you have DUO set up.

What do we mean by DUO? This is a secure push notification or token provided to you as an additional authentication method so that Niagara Health can remain as secure as possible.

If you have not signed up with DUO you will have an opportunity to do so when you attempt to sign in for first time. If you have any issues please contact Service Desk (at x42850)

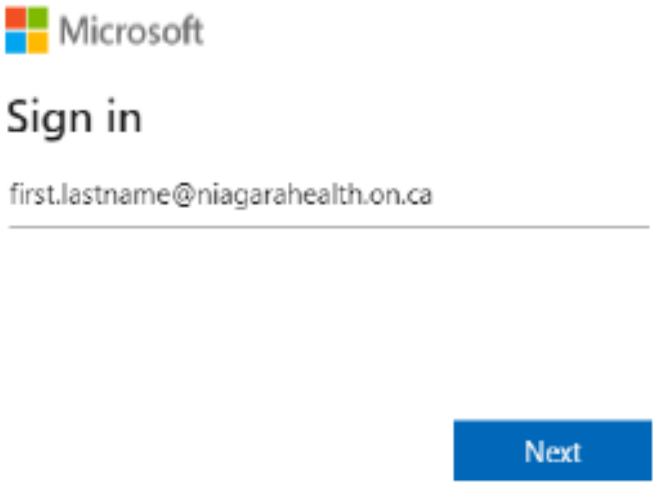
Compatible Web Browsers: Current versions of Chrome (preferred), Edge or Firefox.

1. Open your browser and navigate to https://remote.niagarahealth.on.ca

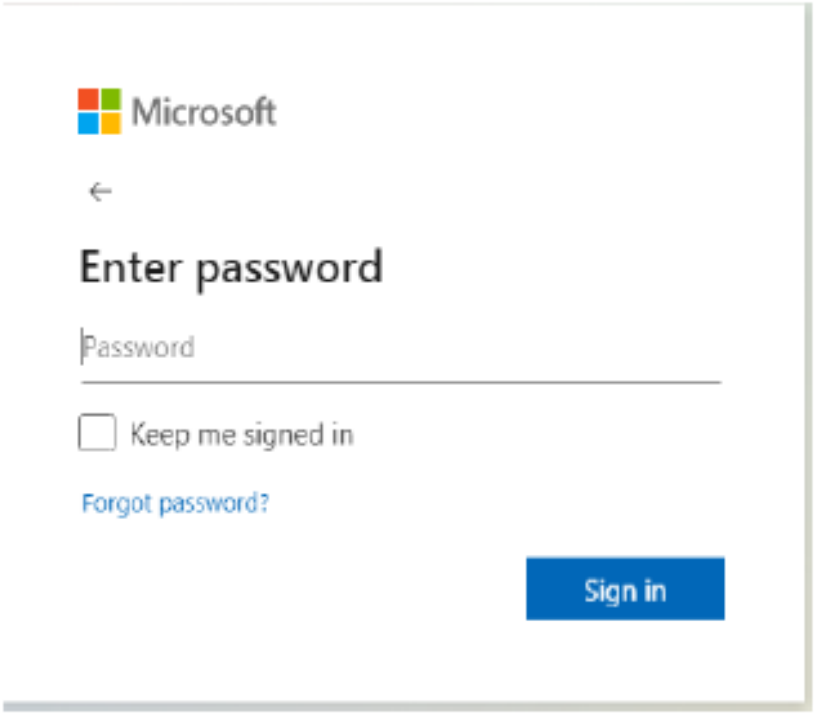


2. Click on Login to NH using DUO

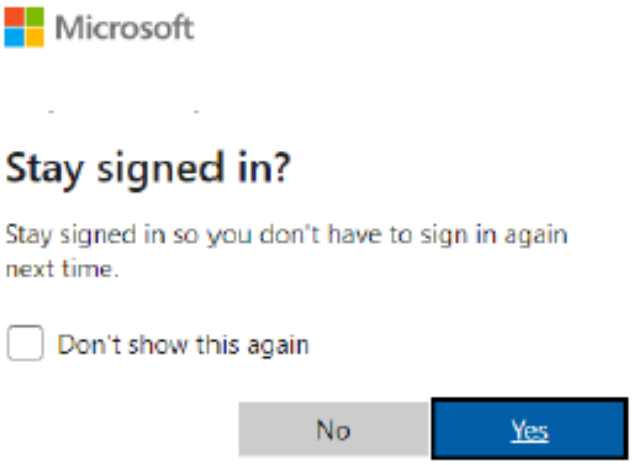
3. A Microsoft Login page will open. Please enter your username this will be first.last@niagarahealth.on.ca or first.last@hoteldieushaver.org and click next.



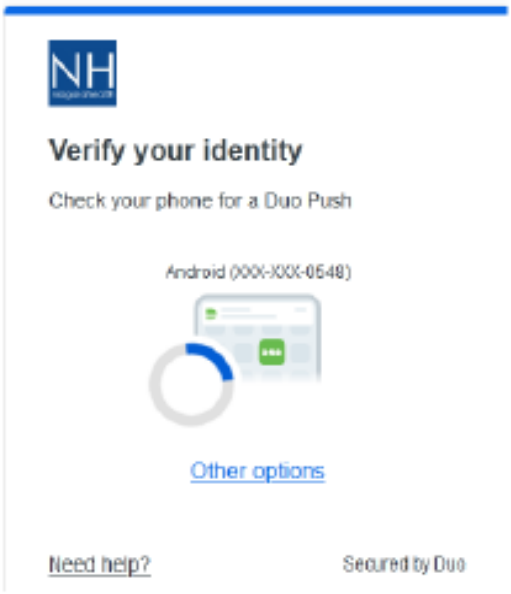
4. Proceed to enter your password and click sign in.



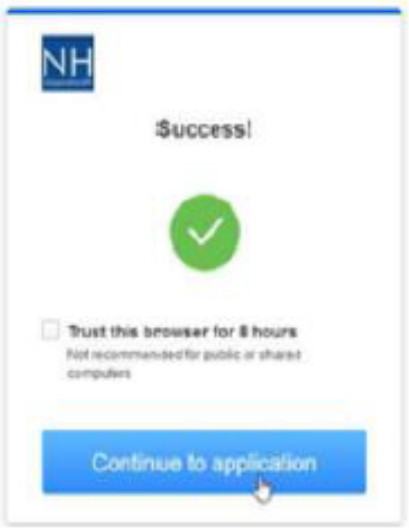
5. You will now be prompted to stay logged in, say yes if it's a personal computer and no if it's a public computer



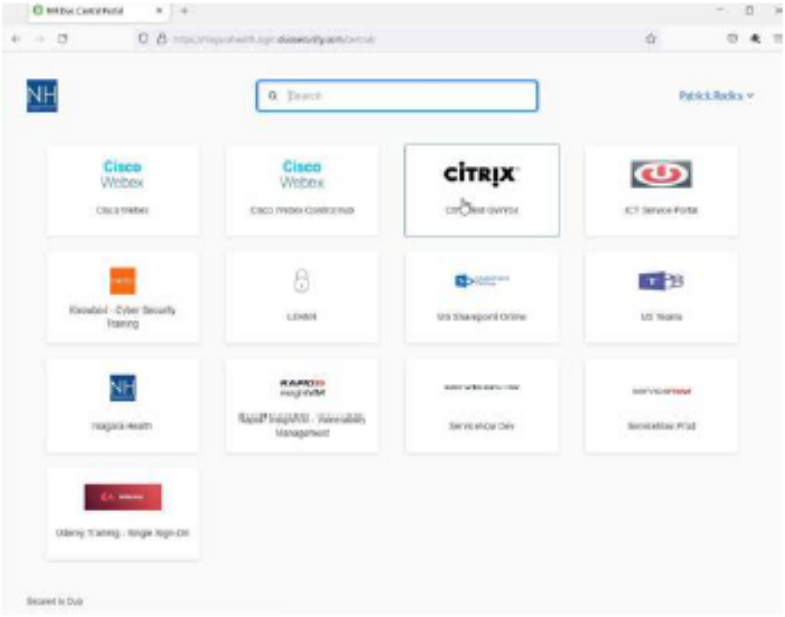
6. You will then receive a Push Notification from the DUO Mobile App. Click on the Push Notification and then select the approve button. If you did not set up the Push Notification and you enrolled in SMS/Call. You will need to input the SMS/Call token code.



7. Once you clicked approve on your mobile phone you will see a pop up for Trust this Browser (Ensure you are trusting the browser for 8 hours) and select "Continue to application".



10. Once the Log On process is complete, the following screen will appear, providing an icon for each application you have access to. Click on any of the available options to launch the associated application (see example below).



If you are presented with any errors during the software installation, please contact the Service Desk at (905) 378-4647 x42850.

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Privacy and Confidentiality

Privacy and Confidentiality

Maintaining confidentiality of patient personal information while also ensuring the delivery of effective healthcare is very important to Niagara Health. Please read the information below to understand your privacy rights and the rights of your patients.

PHIPA: The Personal Health Information Protection Act is a consent driven privacy act which establishes rules for the collection, use, and disclosure of Personal Health Information

FIPPA: The Freedom of Information and Privacy Protection Act applies to the custody and control of hospital business records (statistics, surveys, minutes, etc.)

HIPA: The Health Information Protection Act, of Bill 119, was passed on May 5, 2016. It increases fines for snooping on patient records and also enabled province wide electronic health record sharing.

PHIPA & FIPPA apply when we collect, use, or disclose PHI either verbally, in writing or electronically, that specifically identifies an individual. This information could include:

- Patient's name, date of birth, and/or address;
- Information relating to the physical or mental health of an individual;
- Patient's health card number;
- Information relating to the provision of health care to an individual, including the identification of their health care provider

Patients do *not* have to be named for information to be considered PHI. If the information collected can be used with other information to re-identify the patient then it is identifiable PI

Consent

HIC (Health Information Custodian/hospital) needs to obtain a patient's knowledgeable consent to collect, use and disclose PHI. The patient must know why the information is being collected, used, disclosed, and informed they have the right to withhold consent.

Consent must satisfy the requirements of PHIPA and be *implied* or *expressly* collected.

Implied consent: Consent is implied when information is exchanged between HICs in patient's '*circle of care*' (Nurses, social workers, volunteers, lab & xray technicians)

Express Consent: Express Consent is explicit and direct. It may be given verbally, in writing or recorded by electronic means. This is required for disclosure of PHI to a non-custodian outside the circle of care (ie. third party insurance company, law firm, employer, etc.) or for the disclosure of information by one custodian to another custodian for a purpose outside of providing health care.

Remember:

P	**Protect your Password** Your database user login/password is your electronic signature. It leaves an auditable trail in the electronic patient information system and identifies PHI you accessed
R	**Realize Your Surroundings** Don't discuss confidential information in areas where someone else may overhear
I	**Incidents** Store hard copy PHI in locked desk or cabinet Don't share your password Report privacy violations to Privacy/FOI office and your Supervisor right away
V	**Valuable PI/PHI** Encrypt your mobile device Log off before leaving your computer Never leave an active computer screen unattended Dispose of health information in confidential 'shred it' bins
A	**Access only PHI Required for your Job** Do not access information NTO required to perform your job duties Do not access your own health information or your family friends, co-workers, neighbours
C	**Confidential** Email communication is NOT encrypted or completely secure. Emailing sensitive patient data is prohibited Never store PI/PHI on your mobile device unless it's encrypted Contact ICT (x42850) to ensure secure drive access before storing patient information
Y	**You!** Please ensure you understand and accept your PHIPA privacy obligations when accessing and handling Niagara Health patient PI/PHI If you have any questions feel free to contact: Privacy / FOI Office Hot Line, Ext. 46203 PrivacyFOI@niagarahealth.on.ca

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Extraordinary Caring. Every Person. Every Time.