

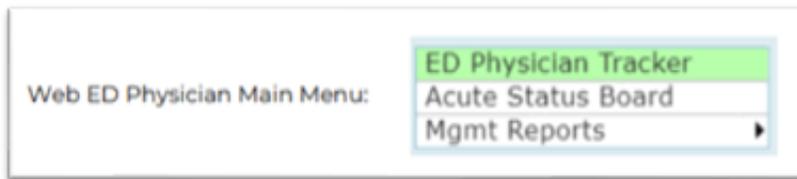
Documentation Instructions – Residents in ED

LOG IN with user role: IH Provider -

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



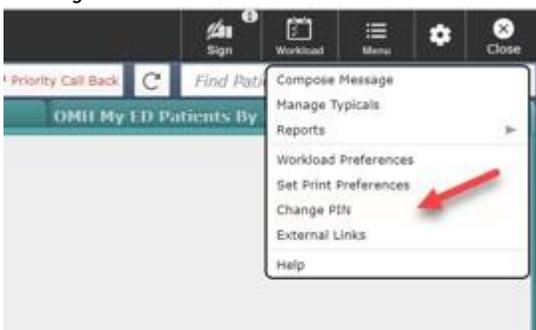
Select ED Physician Tracker from the start menu:



SET UP PIN

Select the Menu option. Change PIN will display. After selecting Change PIN, the following screen will show.

Enter your Network password, and then enter your new PIN in the Enter New PIN and Re-enter to Verify fields. Click OK.



SIGN UP

1. Click on the button with 'Sign Up' written on it and click 'Sign Up' on the drop-down menu that appears to add yourself as the resident assigned to the patient.



That will add your name in blue at the bottom of the button to differentiate from an ED staff provider.

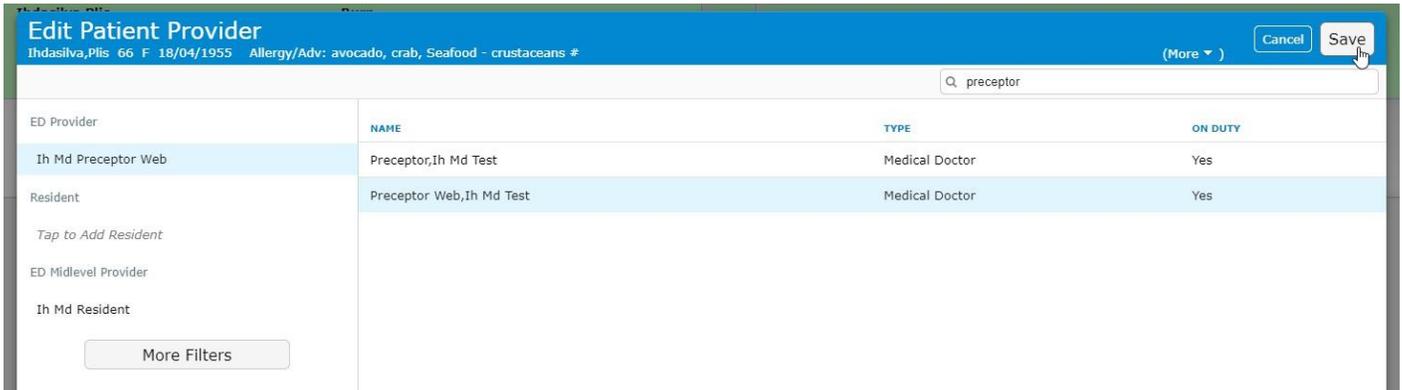
2. Add your preceptor as the ED provider by clicking on the 'Sign Up' button again and click on 'Edit Providers' in the drop-down menu.

⚠ Failure to add preceptor with Sign Up button will mean preceptor needs to be added as Principal on the Document Contributors screen (instructions included later).



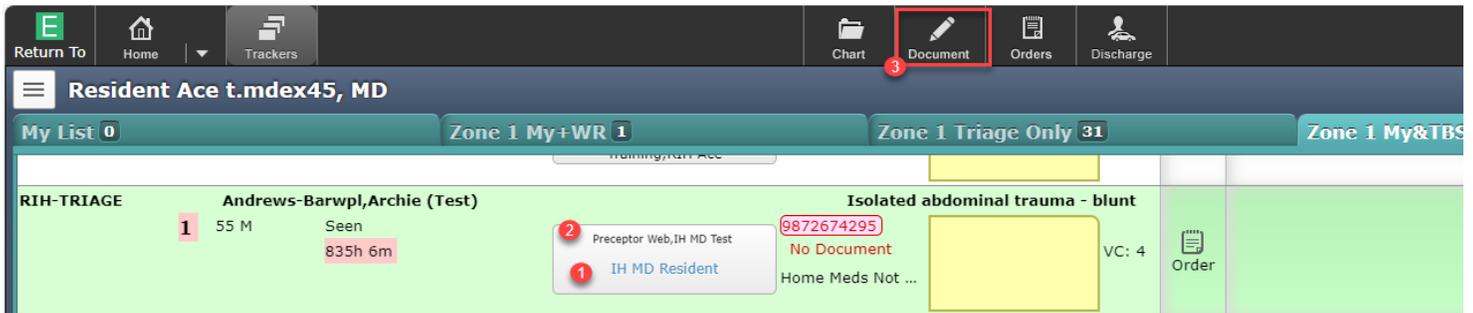
An overlay will appear to allow preceptor to be added.

On this overlay, you will search for your preceptor by name using the search box in the top right corner. The list will filter based on your search field. Click on the correct physician from the list to highlight it in blue. You will also see the physician's name appear on the left under ED Provider. Click Save in the top right corner to confirm your choice.

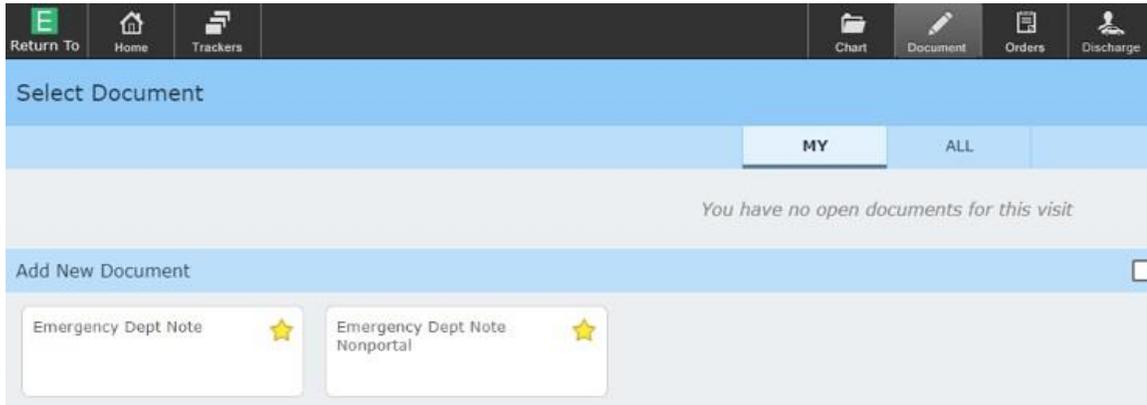


You will return to the tracker where you will see both preceptor and resident appear on the 'Sign Up' button.

- With the patient highlighted, click the Document button at the top of screen to open the document selection screen.



CREATE DOCUMENTATION




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

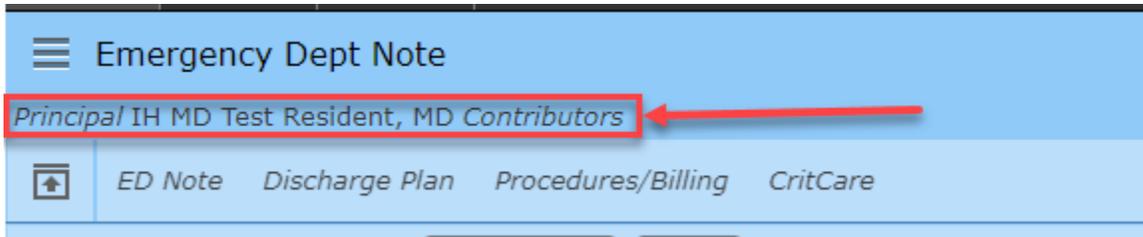
Avoid including information provided by a third party. Example: information disclosed in confidence from a relative of a patient, without the patient's knowledge.

Other

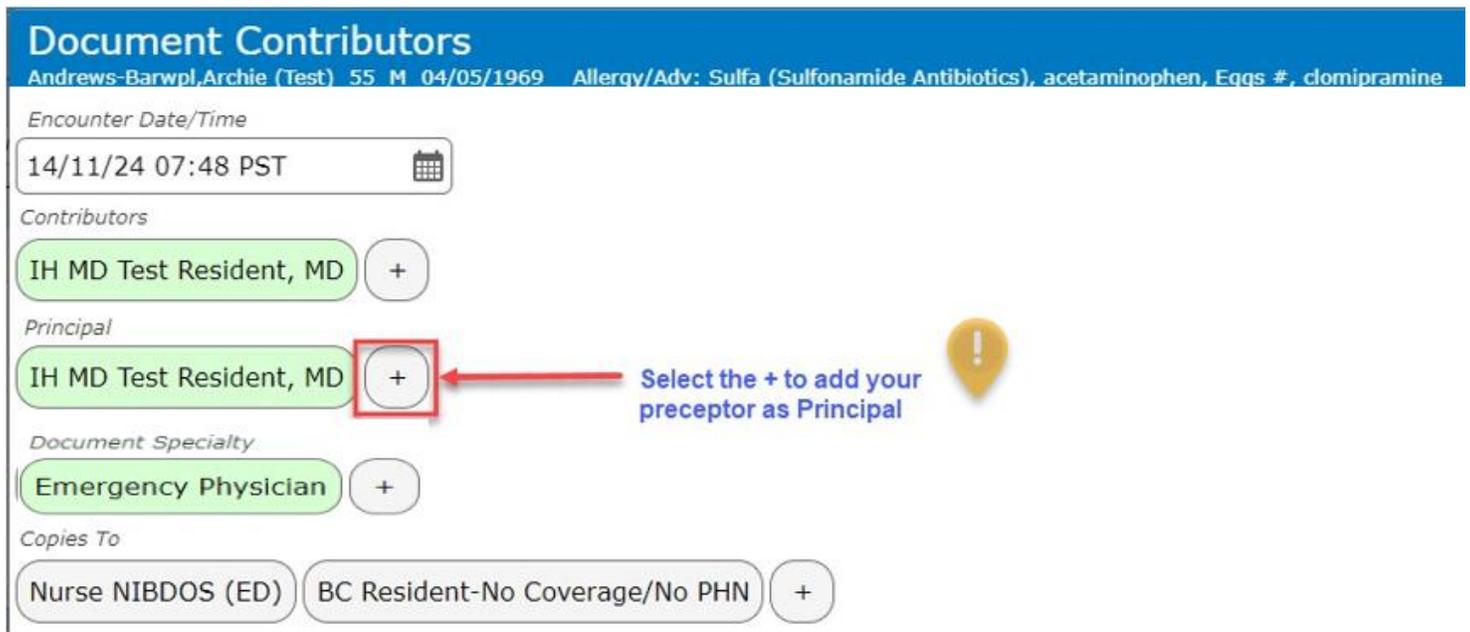
Example: Direct request from the patient to prevent the release of the document to MyHealthPortal.

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.

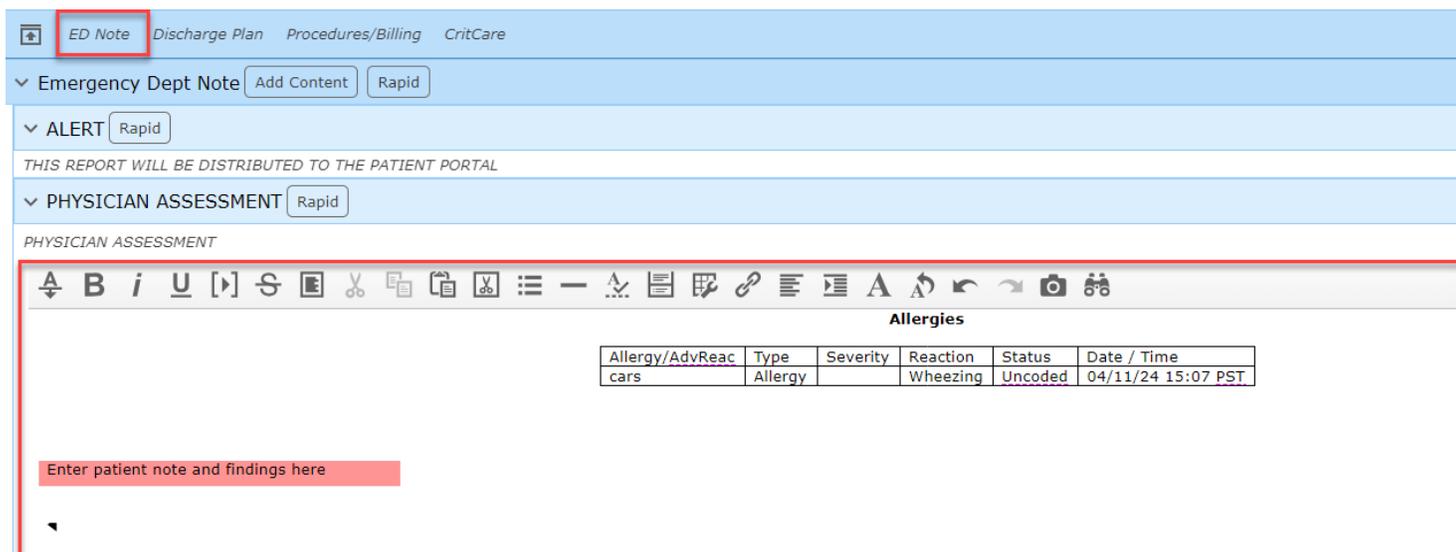
Click on the appropriate Emergency Dept Note document to open it.
Look at the document contributor section underneath Emergency Dept Note:



If your preceptor is not listed as Principal, you will need to click in this area to open the Document Contributors overlay.



Click inside the ED Note text box to start documenting.

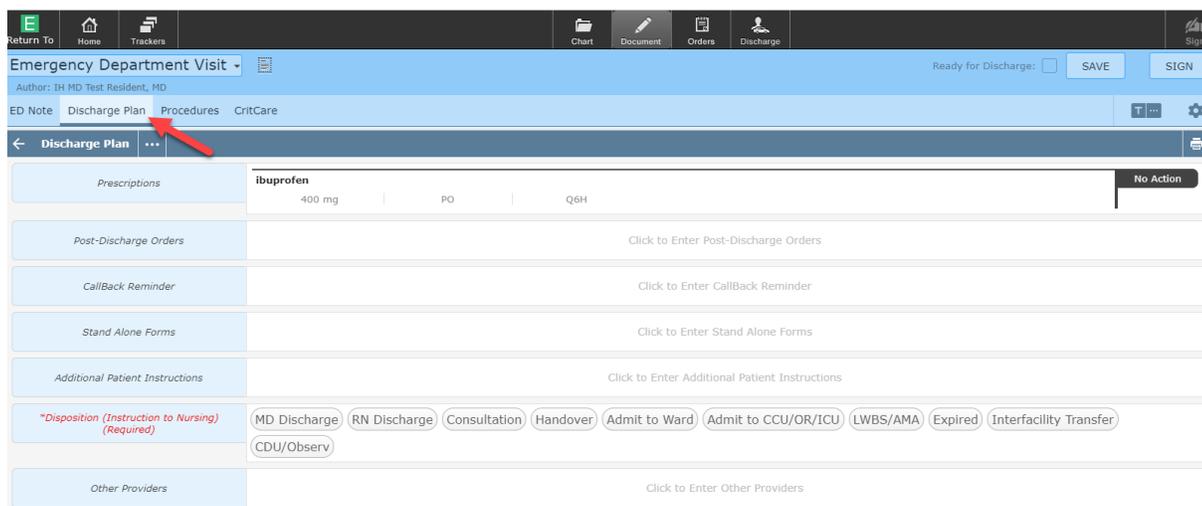


The screenshot shows the top navigation bar with 'ED Note' highlighted in a red box. Below it are tabs for 'Discharge Plan', 'Procedures/Billing', and 'CritCare'. A dropdown menu for 'Emergency Dept Note' is open, showing 'Add Content' and 'Rapid' buttons. Below that is an 'ALERT' section with a 'Rapid' button. A message states 'THIS REPORT WILL BE DISTRIBUTED TO THE PATIENT PORTAL'. Another dropdown for 'PHYSICIAN ASSESSMENT' is open with a 'Rapid' button. The main content area is titled 'PHYSICIAN ASSESSMENT' and contains a rich text editor toolbar. Below the toolbar is a table titled 'Allergies':

Allergy/AdvReac	Type	Severity	Reaction	Status	Date / Time
cars	Allergy		Wheezing	Uncoded	04/11/24 15:07 PST

Below the table is a red text box with the placeholder 'Enter patient note and findings here'.

When you have finished documenting, you must fill out the Disposition on the Discharge Plan by clicking on the Discharge Plan button in the blue bar.



The screenshot shows the 'Discharge Plan' section of the interface. A red arrow points to the 'Discharge Plan' button in the top navigation bar. Below the navigation bar, there are sections for 'Prescriptions' (showing ibuprofen 400 mg PO Q6H), 'Post-Discharge Orders', 'CallBack Reminder', 'Stand Alone Forms', 'Additional Patient Instructions', and 'Disposition (Instruction to Nursing) (Required)'. The 'Disposition' section contains several buttons: MD Discharge, RN Discharge, Consultation, Handover, Admit to Ward, Admit to CCU/OR/ICU, LWBS/AMA, Expired, and Interfacility Transfer. There is also a 'CDU/Observ' button.

When your document is complete, select Sign and enter PIN.



The screenshot shows the top right corner of the interface. The 'Sign' button is highlighted in a red box. Below it is a text box labeled 'Enter PIN' with a red border. The 'Save' button is also visible.

The system will return you to the tracker and the document will display in I-Signed status in the patient's EMR.

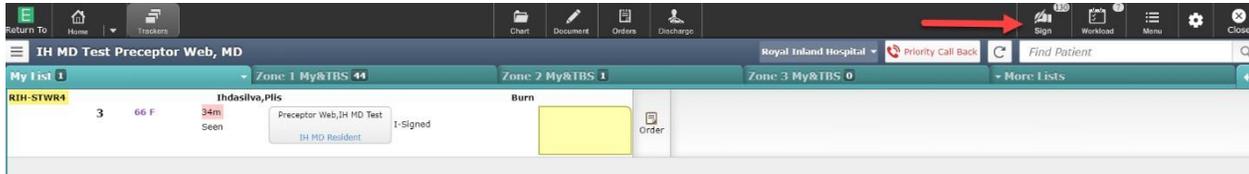
The Preceptor is notified in their Sign queue to complete their portion of the ED document.



Preceptor Instructions – Residents in ED

Preceptor

From your trackeryou will now see the patient that your resident assigned to you. **To review and sign the document, you must click on the Sign List button.** Do not access through the Document panel.



Reports to be signed will appear in your sign queue: your draft reports, as well as student and resident reports.



To add notes of your own and enter the required responses, select the Edit Document button to launch the document. The note the resident originally signed will be captured for audit purposes. The notes the preceptor signs will appear separately and beneath the resident’s documentation.

IHA ** TEST EXPANSE 2.2 **
Emergency Dept Note

Patient Name: Saget-Acuwpl,Bob
Date of Birth: 30/10/1964
Emergency Provider: Preceptor Web,IH MD Test
Date: 22/11/24 13:23

Medical Record Number: KA00000208
Patient Status: Emergency Department
Account Number: KA0010151/25
Initialization Date: 22/11/24 13:23

<Dr IH MD Test Resident, MD - Last Filed: 22/11/24 13:31 PST>

PHYSICIAN ASSESSMENT

Nurse Notes (Newest on Top)

Nursing Note:	30/10/24 1124zzzzzz
Nursing Note:	30/10/24 1123

These are the Resident notes added by resident, per Resident Manual instructions.

<Dr IH MD Test Preceptor Web, MD - Last Filed: 22/11/24 13:44 PST>

PHYSICIAN ASSESSMENT

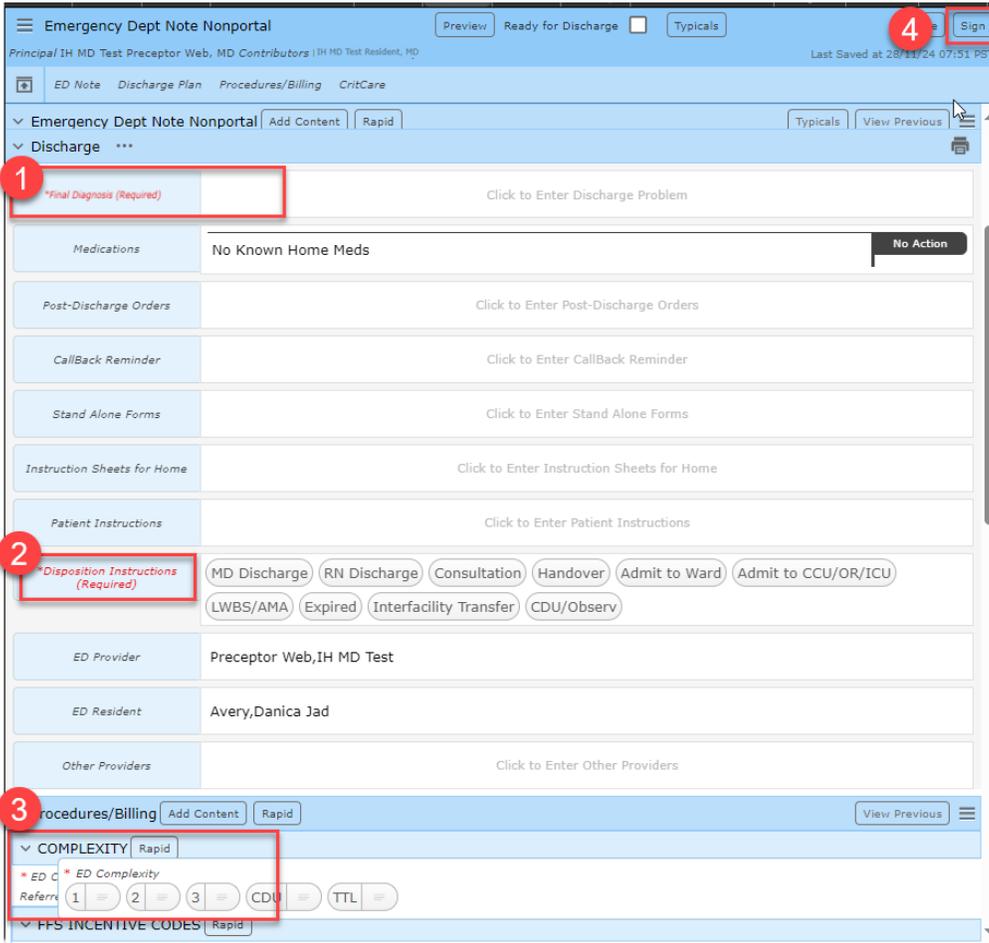
Nurse Notes (Newest on Top)

Nursing Note:	30/10/24 1124zzzzzz
Nursing Note:	30/10/24 1123

This is the Preceptor applying edits to the notes entered by the Resident - I'm modifying this line. I've removed the notes entered by the Resident completely.

Adding a further line.

On the Discharge Plan, complete the required Final Diagnosis, Complexity and Disposition fields.



The screenshot shows the 'Emergency Dept Note Nonportal' interface. At the top right, a 'Sign' button is circled with a red '4'. The 'Discharge' section contains several fields: 'Final Diagnosis (Required)' is circled with a red '1'; 'Disposition Instructions (Required)' is circled with a red '2' and contains buttons for 'MD Discharge', 'RN Discharge', 'Consultation', 'Handover', 'Admit to Ward', 'Admit to CCU/OR/ICU', 'LWBS/AMA', 'Expired', 'Interfacility Transfer', and 'CDU/Observ'; 'ED Provider' is 'Preceptor Web, IH MD Test'; 'ED Resident' is 'Avery, Danica Jad'. The 'Procedures/Billing' section is circled with a red '3' and contains 'COMPLEXITY' and 'ED Complexity' fields with dropdown menus for '1', '2', '3', 'CDU', and 'TTL'.

When all of the mandatory fields have been completed, click Sign and enter PIN to finalize.

IMPORTANT!

If you discover you have created documentation in error (incorrect patient/account/template):

- Immediately create an addendum stating **“This report has been created on the wrong patient/account/template and will be cancelled. Please ensure your records are updated accordingly.”**
- Create the document on the correct patient/account/template
- Email DocumentationSupport@interiorhealth.ca with patient and report demographics so that we can remove the report from the patient’s EMR.

If you discover a typo/text error in your document:

- Create an addendum to correct or clarify the text error.
- If the error cannot be clarified in an addendum, email DocumentationSupport@interiorhealth.ca with report details and we will assist in correction.

Support Information (All)

Our Medical Documentation team regularly audits Resident documentation. We will contact you if your documentation requires attention.

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

