APPENDIX C Documentation Best Practices in the Electronic Medical Record

General:	All activity relevant to patient care must be documented accurately in the EMR at the time the care is provided, or as soon as possible thereafter. All documentation must be completed within the same working day as the care was provided. Coded fields should be used as much as possible. Use free text for all other information.
1. Medical History (Bands)	All active problems to be documented in the "history of problems". Recommend Medical/Surgical history be used for surgical history and past problems. All active medications to be documented, regardless of prescriber (including meds prescribed elsewhere, "external meds" (see medication review below). Lifestyle, family and social history to be documented in the "patient medical history" section of the EMR (ie. left sided band). **Medical history should be updated at each Periodic Health Exam (PHE), Prenatal (PN) or Pre-Op visit at a minimum and** ideally updated with each encounter. For patients on anti-coagulant therapy, the INR target should be documented in the free-text area under the relevant diagnosis. Residents/other learners: When updating the medical bands, it is advisable to document that this has occurred. You can use the macro "**mband**" then press control and enter keys together within your encounter note to populate the note with a list of the updates to the medical bands entered today. This facilitates preceptor review.
2. Encounter Notes (Progress Notes)	To be documented on each visit/patient encounter (clinic visit, phone call), by all providers. **To be completed within the same day as the encounter**. • Exceptions: Nursing management of INRs is done in the INR table, unless additional documentation is warranted. All Prenatal (PN) care must be documented on the Manitoba PN Record. Well child visits should be documented using the Rourke record. Cross-referencing to the encounter notes must be done where encounter notes are used for additional documentation, in all cases (e.g., INR, PN). • Residents/other learners: For those patient encounters precepted by someone other than your assigned preceptor (of the day), task the person who precepted the encounter to review your documentation. • Preceptors: All resident generated encounter notes **should be reviewed within 3 days of the patient encounter**. Right click on the encounter note and select "reviewed". Clinics with residents should have a process to ensure this timely review occurs, e.g., preceptors may be provided a list of unreviewed charts on a weekly basis. *Applicability of the encounter note review process to other health professional learners requires further discussion*.
3. Physical History	Vital signs, height and weight should be documented within the physical history section of "labs. Documenting in the physical history section allows this information to be dragged into an encounter note, auto-populated onto forms and in the primary care quality indicators worksheets (PCQI).
4. Prenatal care	Document all PN care on the Manitoba PN record. If more detailed documentation is required, cross-reference to the encounter notes. Add pregnancy to the history of problems, to facilitate quality monitoring of PN patient care. Document the EDD in the "description field" and at the postpartum visit, document a brief history if available, e.g., SVD, C/S, right click and mark the diagnosis as "recovered" with the birth. Complete the Family Medicine Obstetrical Network (FMON) referral form at 1st prenatal visit for PN patients followed by a physician in the FMON. Use "internal referral" if patient's care is to remain at the same site, otherwise send referral according to patient/provider decisions. Update the FM PN Checklist in the EMR at all relevant visits. Ensure all patient education and care related items are completed in a timely manner according to established practice guidelines. For the PN checklist and PN record, only one of each document should be generated for each patient. At each visit use the "DOS (Date of Service)" field to link note to a new visit then document the encounter information accordingly. If updating the record outside of visit (ie blood work or imaging results) make sure that all information is accurate and up to date. Task and administrative staff member to fax the entire prenatal records and supporting documentations at 36 weeks gestation and if/when any new information becomes available.

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5. Collaborative care and Consultation	Collaboration and consultation that occurs within and beyond the team must be reflected in the chart, in the encounter notes (or INR table, PN record as appropriate). **Letters** for referral and consultation require preceptor review and sign-off prior to being faxed from the EMR. • Residents/Learners: Edit and format generated letters to and load into the letter queue on the **same day as the encounter**. The name of the sending provider should be changed to that of the preceptor. Task your preceptor to review. • Preceptors: Review letters **by the end of each clinic day**. Indicate "ready to send" in the letter queue, at which point support staff monitoring the queue will fax out. Support staff will track letters as outstanding orders to facilitate follow-up. • Support staff: **Send all letters out by the end of each clinic day** and follow up by communicating with faculty regarding any unreviewed letters. See PGOG #30 Results Management: Outstanding Orders for additional details.
6. Plans of care	Treatment and investigation plans as well as self-care and lifestyle behavior management plans must be documented in the encounter notes section of the EMR and should reflect collaboration within and beyond the team.
7. PC Quality of Care Indicators (PCQI)	PCQI worksheets prompt appropriate follow-up as defined by the PC quality of care indicators (developed by Manitoba Health in collaboration with Manitoba Centre for Health Policy) and are included in the EMR data extract and comparative analytic report received by your clinic. These worksheets have been mapped to other fields in the EMR, to minimize the amount of data entry required. Relevant worksheets should be reviewed and updated at PHEs and the chronic disease specific worksheets reviewed and updated at relevant visits.
8. Patient care follow-up (tasks and return visits)	Any patient care tasks that require follow-up should be entered into the record as tasks (not messages). Tasks can be directed to specific individuals, the entire team or groups, e.g., PCA/UA/NA (clinical support staff) within the clinic (intraoffice tasking). Inter Office tasking (outside of the clinic) is not deemed as acceptable practice due to safety risks. Tasks can be future dated (e.g., repeat BMD in 2 years). **Prior to any patient encounter, review the chart for any outstanding patient care tasks, press "F7**". Complete patient care tasks at visits if possible and mark these completed. When directing patients to book return appointments a range of time should be suggested as appropriate to care needs, e.g., within 1-2 weeks or within 3-4 months to facilitate booking.
9. Requisitions and Prescriptions	Residents and other learners must change the provider name at the top of all requisitions and prescriptions to the name of their preceptor. Clinic workflow may still include tasking support staff (PCA, UA/NA) to fax requisitions which need to be faxed. Any requisitions generated in error by any provider must be promptly transferred to the appropriate "duplicate document" folder. This is the only mechanism to delete unwanted items. This is important for results management (see PCOG#30).
10. Medication and Allergy review	Verify the patient's allergies and document in the Allergy section, including no known allergies. The medications noted in the patient's record should reflect all medications they are currently taking (best possible medication history) Medication and allergy history should be reviewed / verified with the patient each time a new prescription is issued. At a minimum at PHEs, Pre-Op, PN visits and at transitions in care, e.g., referral or consult to specialty care, follow up on hospital admission, sending to hospital/ER/birthing centre, etc. *[guideline under development].* Medication and allergy review should be documented in an encounter note. Change the title of the note to "medication review". Note any differences between what the patient is taking and what was prescribed. Using the task function, flag the note for the prescribing provider to follow-up. Any new external medications (prescribed by providers outside of your clinic) should be documented in the medication tab.
10. Traffic Manager and Billing	At the end of each patient encounter, mark the visit "complete". This signals to support staff they can prep the room and bring in the next patient and informs efforts to improve office efficiency. At the end of each visit, enter the relevant tariff and ICD-9 code in "claim" linked to the appointment. Preceptors review claims prepared by residents and sign off according to clinic workflow.

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11. Diabetes	Use the Diabetes Lab panel for easier manual entry of diabetes related test (i.e, BP Weight, A1C, Cholestrol). A diabetes lab summary view was also created for easier trend analysis of a patients diabetes results.
12.COPD	Document on the COPD Action Plan.
13.Asthma	Document on the Asthma Action Plan.
14. Tobacco	Document all Tobacco (Assessment, Management and Supportive Counselling) and complete Spirometry Screening tool (if criteria is met). Update Tobacco Lifestyle band and PCQI Prevention Tab.