I. POLICY

Southern Illinois Healthcare (SIH) provides an electronic documentation process through Meditech Patient Care Systems (PCS) and Emergency Department Module (EDM) and a process to provide a seamless transition from electronic to manual documentation in the event of system downtime. The downtime process allows for the patient medical record to maintain a complete and accurate record of all patient care documentation during and after the downtime.

II. DEFINITIONS

Downtime Report – Meditech generated report; containing patient history including information such as last vital signs, last assessment, etc.

Medical Device Interface (MDI) – system that interfaces the patient care monitors with PCS and EDM

Patient Care Provider – any staff person who may use Meditech PCS and/or EDM

Scheduled downtime – previously announced periods of time when Meditech PCS and/or EDM is unavailable; downtime is scheduled for routine maintenance, Meditech upgrades or system hardware/software upgrades

Universal Downtime Requisition – a paper order communication method used when Meditech is unavailable

Unscheduled downtime – sudden, unanticipated, unplanned periods of time when Meditech PCS and/or EDM is unavailable; limited outages or system wide outages can cause unscheduled downtime

III. RESPONSIBILITIES

1.0 Clinical staff who provide patient care and document patient care using the Meditech PCS and/or EDM system and follow downtime procedures when Meditech PCS and/or EDM and related systems are unavailable.

IV. EQUIPMENT/MATERIALS

N/A
V. PROCEDURE

1.0 Scheduled downtime for departments other than the Emergency Department

1.1 The downtime procedure is initiated in:
   A. ICU and SCU/PCU if the scheduled downtime is anticipated to exceed 30 minutes
   B. All other clinical departments using Meditech PCS if the scheduled downtime is anticipated to exceed 60 minutes

1.2 If the scheduled downtime is anticipated to exceed 4 (four) hours the Downtime Report is printed for all patient care areas at least 1 (one) hour before the scheduled downtime.
   A. The report time frame includes the expected length of downtime plus 2 (two) hours.
   B. The Manager/House Supervisor/designee prints and distributes this report.
   C. The Downtime Profile Report is used for communication purposes. Do not document on them. They are not part of the patient’s medical record.

1.3 Any patient care provider enters the orderable PCS interventions onto Universal Downtime Requisitions.
   A. This refers to PCS interventions only. Follow the current order entry downtime process for orders other than PCS.
   B. The nurse assigned to the patient reviews the interventions and gives a copy of the Universal Downtime Requisition to the appropriate care provider.
   C. Respiratory Therapy is contacted for all STAT procedures.
   D. When PCS is back up, the PCS interventions are manually entered into PCS by any patient care provider.

1.4 Copies of screen shots and paper forms are used for documentation during downtime and are accessed from two areas.
   A. Department specific screen shot folders are located on the shared drive in the individual department folders.
      1) Each staff person/designee accesses the department folder located on the hospital H: drive and prints the needed screen shots.
   B. A file containing a master copy of assessment screen shots and forms in printed format is found in Nursing Administration.
      1) Department patient care providers make a copy from the master forms of every assessment required for each of their patients during the anticipated downtime.
         a) Manually document all patient care activity on the printed screen shots and/or forms including date, time and signature in the appropriate place.
         b) Place a patient label if available or write the patient’s name, birth date and account number on every page of documentation.
         c) Any documentation for which there is no screenshot or form is done on the Integrated Progress Notes or Nurses Notes.
      2) Any downtime printed/written documentation becomes part of the permanent medical record.
         a) Only the items listed in section V. 1.7 A. of this policy are retrospectively entered into PCS.
b) Those patients who were both admitted and then discharged during the downtime period are exempt from retrospective data entry.

3) Post-event canned text documentation is entered into Meditec PCS when PCS is available which states “PCS/EMR scheduled to be unavailable beginning at (time). Refer to printed/written medical record for clinical documentation between (time) and this entry.”

a) The time Meditec was scheduled to become unavailable is the time entered into ( ) on the canned text even if the actual time is different.

1.5 The following forms are used for medical record documentation, as applicable, during downtime:

A. Blank Nursing Progress Notes
B. Patient Care Summary Sheet
C. 24 Hour Flow Sheet
D. IV Roadmap
E. Plan of Care
F. Medication Reconciliation
G. Medication Administration Record (MAR)
H. Pain Assessment
I. Core Measure Checklist
J. Admission Database
K. Discharge Assessment

1.6 The following screen shot assessments are used for medical record documentation, as applicable, during downtime:

A. Risk
B. Functional Nutritional
C. Wandering
D. Suicide
E. Vent Bundles

1.7 The current patient care provider retrospectively documents for patients.

A. At least the following assessments and intervention items are retrospectively entered into Meditec PCS regardless of the length of the downtime:

1) Height/Weight
2) Allergies
3) Plan of Care
4) Core Measures
5) Advance Directive
6) Intake and Output
7) Medication Administration

a) Downtime Medication administrations are transcribed into the eMAR.
8) Medication Reconciliation
9) Past Medical History
10) Vaccination Protocol

B. Clinical staff enters the appropriate care provider at the prompt when the situation requires s/he retrospectively document for another clinical staff member.

1.8 Charges that result from PCS documentation which are not entered by retrospectively documenting the associated assessment are handled as follows:

A. Physical Therapy, Occupational Therapy, Speech Therapy and Respiratory Therapy
   1) Document on the hard copy screen shots
   2) Charges are entered manually
   3) A downtime Respiratory Therapy charge log is kept in the Respiratory Therapy department.

B. Each assessment which includes a charge has a notice of that charge on the printed downtime assessment form.

C. The information logged includes:
   1) the date and time the charge is incurred
   2) the patient label or the patient’s name and account number
   3) the care provider’s name
   4) any additional information requested (such as size, etc.)

D. After the system is back on line the appropriate staff person from the involved department reviews the documentation and completes the proper charging.

2.0 Unscheduled downtime

2.1 Any care provider noting a sudden inability to access PCS reports this to the Manager/House Supervisor/designee who:
   A. Verifies that the PCS application is not accessible and places an immediate call to the Help Desk, ext. 67401
   B. Prints the Downtime Profile Report in all patient care areas
   C. Makes copies of the forms needed for each patient

2.2 Follow the remainder of the Scheduled downtime procedure.

A. Post-event canned text documentation is entered into Meditech PCS when PCS is available which states “PCS/EMR unavailable beginning at (time). Refer to printed/written medical record for clinical documentation between (time) and this entry.”
   1) The time Meditech was first discovered to be unavailable is entered into “(time).”
      a) During PCS downtime, the Help Desk determines the exact times.
      b) The Manager/House Supervisor/designee contacts the Help Desk to obtain the time and communicates the time to the affected units.

2.3 MDI Downtime

A. Any care provider noting a sudden inability to load monitor information into PCS:
   1) Calls the HelpDesk to report the issue
   2) Verifies that the bedside monitor is actively collecting patient information
a) Follows established protocols for collecting patient data

3) Records the information into Meditech manually until MDI is available

3.0 Scheduled and Unscheduled downtime for Emergency Department

3.1 Any care provider noting a sudden inability to access EDM reports this to the Manager/House Supervisor/designee who:
   A. Verifies that the EDM application is not accessible and places an immediate call to the Help Desk, ext. 67401
   B. Makes copies of the forms needed for each patient

3.2 Any patient care provider enters the EDM orders onto Universal Downtime Requisitions.
   A. This refers to EDM orders only. Follow the current order entry downtime process for orders other than EDM.
   B. The nurse assigned to the patient reviews the orders and gives a copy of the Universal Downtime Requisition to the appropriate care provider.
   C. Respiratory Therapy is contacted for all STAT procedures.
   D. When EDM is back up, the EDM orders are manually entered into EDM by any patient care provider.

3.3 Paper documentation used prior to the implementation of EDM is used for documentation during downtime and is accessed from Optio.
   A. Paper documentation begins immediately upon notification that a downtime is in effect.
   B. Any downtime printed/written documentation is scanned into ChartMaxx and becomes part of the permanent medical record.

3.4 MDI Downtime
   A. Any care provider noting a sudden inability to load monitor information into PCS:
      1) Calls the HelpDesk to report the issue
      2) Verifies that the bedside monitor is actively collecting patient information
         a) Follows established protocols for collecting patient data
         3) Records the information into Meditech manually until MDI is available

3.5 If the patient is already in Meditech EDM
   A. Downtime documentation is completed on paper as soon as downtime occurs.
   B. A Chief Complaint is added if it was not completed prior to downtime.
   C. The assessment is completed as “Downtime” and documents on it.
   D. Patient is departed in the computer after the system is back up which removes the patient from the tracker board.

3.6 If the patient arrives, is treated, and discharged during downtime
   A. Nurse starts documentation on paper.
   B. When the system is back up the patients are entered into Meditech EDM by the registration clerks and are placed on the tracker.
   C. The nurse
      1) Enters the Chief Complaint
2) Adds the assessment of “Downtime”
3) Documents on it
4) Completes the Depart screen
5) Removes the patient from the tracker (ZFINAL)

3.7 If patient arrives during downtime, but the system is restored prior to discharge, the documentation stays on paper and is completed as in 3.2.

3.8 EDM assessment is completed electronically by indicating “Please refer to paper medical record.”

3.9 Information entered on the Depart screen is reflected on the patient history data for any subsequent visits for both 3.5 and 3.6.

4.0 PCS/EDM Facility Leads/designees check monthly to verify form revisions.

4.1 When revisions are made, the Facility Leads/designees distribute the revised forms and gather old form copies to be destroyed.

4.2 An original copy of each replaced form is marked as “archived” with the archived date and placed in the main binder maintained in the Nursing Administration office.

4.3 Any request to modify or add to the Downtime Reports/process is submitted to the respective facility lead. The facility lead assists in identifying the need/rationale for the request and the proper pathway to enact the change.

5.0 Available patient information resources

5.1 Downtime Patient Profile (DOWNTIME.R)

5.2 Discharge Summary Report

5.3 Patient Notes

6.0 Downtime reports

6.1 Documentation is backed up to the downtime computer automatically on the following schedule:

A. Every 30 (thirty) minutes
   1) SCU/PCU: eMAR, Downtime Profile Report (Kardex)
   2) ICU: eMAR, Downtime Profile Report (Kardex)

B. Every hour
   1) eMAR, Downtime Profile Report (Kardex) for all other nursing units

C. Every 24 (twenty-four) hours
   1) Discharge Summary
   2) Notes

6.2 House Supervisors, Charge Nurses and Nursing Department Managers are granted access to print the Discharge Summary and Notes Reports as needed in a downtime situation. Due to the potential length of these documents, discretion must be used in deciding when these portions of the medical record need to be printed into a hard copy.

A. The Discharge Summary and Notes Reports are used for communication purposes. Do not document on them. They are not part of the patient’s medical record.

B. The Discharge Summary and Notes Reports may be printed from the nursing station PCs if internal network is working.
1) If network is down, Nursing retrieves them from the Downtime PC
   a) Memorial Hospital of Carbondale – Nursing Administrative Conference Room PC
   b) Herrin Hospital – House Supervisor’s office PC
   c) St. Joseph Memorial Hospital – Med-Surg/SCU Managers’ office PC

VI. DOCUMENTATION

1.0 Document using printed/written forms as described in policy.
2.0 Printed/written forms become part of the complete medical record.

VII. CHARGES

N/A

<table>
<thead>
<tr>
<th>Additional Approvals and Review/Revision Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Review Dates:</strong> 9/13</td>
</tr>
<tr>
<td><strong>Revision Dates:</strong> 2/17/11, 9/21/12</td>
</tr>
<tr>
<td><strong>Replaces:</strong> N/A</td>
</tr>
<tr>
<td><strong>Additional Approvals:</strong></td>
</tr>
<tr>
<td>Name (print)</td>
</tr>
<tr>
<td>Marcia Matthias</td>
</tr>
<tr>
<td>Julie Firman, MSN, RN, FACHE</td>
</tr>
<tr>
<td>David Holland</td>
</tr>
<tr>
<td>Shannon Hartke, MBA, CHFP</td>
</tr>
<tr>
<td>Title</td>
</tr>
<tr>
<td>Director Health Information</td>
</tr>
<tr>
<td>VP/CNO</td>
</tr>
<tr>
<td>VP/CIO</td>
</tr>
<tr>
<td>Corporate Director Patient Financial Services</td>
</tr>
<tr>
<td>Signature</td>
</tr>
</tbody>
</table>