Creating a single point of access for your medical records

The Royal North Shore Hospital

Journey of discovery!

Presentation to HIMAA Conference 30 October 2012

Marriott Hotel Surfers Paradise

Prepared by Margie Luke
Document Imaging Program Manager
Northern Sydney Local Health District
Scope

• Royal North Shore Hospital
• Community Health Centre
• Pathology Sendaways
Overview

- Background
- Benefits
- Actions
- Discoveries
- Top 10 Lessons Learnt
- Results
- Way Forward
Background

Drivers – the case for change

- Minimal storage provision due to $1.25B redevelopment
- NSLHD vision for a digital facility
- Escalating costs for offsite storage & retrieval
- Management of CHC records a major issue
Benefits – Clinical & Administrative

- Increases value of eMR by providing immediate/secure multi-user access
- Logical filing via the ESH
- Minimum training required
- Medical records are never lost or damaged!
- Facilitates coding remotely
The Document Imaging Process

- Sort & Track
- Prep
- Scan
- Quality Control
- Validate (Release to eMR)
- Purge & Archive
- Audit (100% 1st month 10% ongoing)
Establishing the Project
Governance

Sponsor: GM RNS/Ryde Hospitals
Chair: Director Corporate Governance
Co-chair: Clinical Engagement Manager
Secretariat: DI Program Manager

RNS Redevelopment Executive Committee

Document Imaging Implementation Steering Committee

Document Imaging IM&T Technical Reference Group
Actions

- Working Group to design ESH
- Forms stocktake, catalogue & bar coding
- Change management – BPR
- Communications Plan
- Training & Education Plan
Discoveries

Event Set Hierarchy

- Working Group established
- Consultation across the LHD
- Consensus on ESH
- Assign all barcoded forms to the ESH
- ESH built into the eMR
## Our Event Set Hierarchy

### ESH Primary Event Set

<table>
<thead>
<tr>
<th>Event Set</th>
<th>Barcode ID Format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission &amp; Registration</td>
<td>REG999999</td>
</tr>
<tr>
<td>Alerts &amp; Adverse Events</td>
<td>ALT999999</td>
</tr>
<tr>
<td>Assessment Documents</td>
<td>AST999999</td>
</tr>
<tr>
<td>Care Plans</td>
<td>CPL999999</td>
</tr>
<tr>
<td>Certificates/Notifications</td>
<td>CRT999999</td>
</tr>
<tr>
<td>Charts</td>
<td>CHT999999</td>
</tr>
<tr>
<td>Consent</td>
<td>CON999999</td>
</tr>
<tr>
<td>Correspondence</td>
<td>COR999999</td>
</tr>
<tr>
<td>Diagnostic Results</td>
<td>DIA999999</td>
</tr>
<tr>
<td>Discharge Documents</td>
<td>TRA999999</td>
</tr>
<tr>
<td>ED Documents</td>
<td>EMY999999</td>
</tr>
<tr>
<td>Interventions/Procedures</td>
<td>INT999999</td>
</tr>
<tr>
<td>Medication Documents</td>
<td>MED999999</td>
</tr>
<tr>
<td>Medico-legal</td>
<td>MLD999999</td>
</tr>
<tr>
<td>Progress Notes Scanned</td>
<td>PRO999999</td>
</tr>
<tr>
<td>Referral &amp; Requests</td>
<td>REF999999</td>
</tr>
</tbody>
</table>
Discoveries

Forms

- Over 1K forms discovered (>50% unapproved)
- 100% local forms to bar code & template
- Only state forms (18%) bar coded

Patient label

- No encounter bar code
- Unreadable MRN bar code
Discoveries

Change Management

- Decisions – Clinical & Administrative
- Business processes will change
- New policies, procedures & change registers
- Established focus groups, demonstrations, presentations & road shows
Communications

Document Imaging Go-Live

7 weeks to go
This is a Date to Remember
17 MAY 2012

DO NOT use old forms that have no barcode — if it is not available from design you must get it for barcoding.

Document Imaging refers to scanning the paper medical record into the eMR, which commenced in May 2012. This will extend to inpatient commencements in August 2012. To be ready for Document Imaging you must...

DO NOT photocopy documents — this reduces the quality of the document.
DO NOT stick anything to the patient label.
DO NOT use old patient handwrite over patient label.
DO NOT make copies of progress note as removal can cause a tear.
DO NOT remove pages if not used — please leave in the patient record.

Clinical Documents

The Medical Record & Document Imaging

Document Imaging refers to scanning the paper medical record which commences in May 2012. All documents that contribute to the medical record need to have a barcode as well as a patient label. The barcode ensures that the document is in the correct folder once it has been scanned.

A folder (called an Event Set) organises documents into groupings e.g. progress notes, care plans, assessments, correspondence.

The folder structure enables you to conduct a logical search without having to navigate through an entire medical record.

DO ensure that you use only barcoded clinical documents from APRIL 2012 prior to medical records scanning into the eMR commencing from MAY 2012.

DO ensure that your department develops a new clinical document, it is submitted to the Forms Committee for approval and barcoding.

DO NOT use old documents that have no barcodes — please destroy them.

DO NOT photocopy documents — this reduces the quality of the barcode.

Questions about document imaging?
Contact: Merle Luke | Project Manager | M: 0409 837 112 | mluke@sscahs.health.nsw.gov.au

Questions about clinical forms and the forms committee?
Contact: Michele Arion | Clinical Forms Manager | Design and Print | P: (02) 4355 3133
Communications

**Electronic Medical Record (eMR) Clinician Consultation Workshop**

**Purpose of the Workshop**
- Doctors, Nurses, Allied Health staff .......we need your input to validate an eMR design decision to ensure it works for you!!
- The design decision is about the Event Set Hierarchy which is the term for the folder structure that enables the medical record documents to be sorted into logical and clinically relevant groupings for display and searching in Powerchart.

**ENUE:** Wallace Freeborn Lecture Theatre, Level 5 Kolling Building  
**ME:** 12md—1pm  
**ATE:** 19 March & 23 March (PLEASE NOMINATE)  
**SVP To:** Margie Luke  
**mail:** mluke@nscachs.health.nsw.gov.au  
**Nome:** 9926 5849 (m) 0459 837 112

**Lunch will be provided**

**The Impact of Document Imaging on Staff**

**What is Document Imaging?**
- Document Imaging is the term used for scanning the paper medical record to create a searchable and electronically accessible record.
- The paper document record is then accessible to staff who are authenticated to view the record.
- The documents in the scanned medical record are organized into folders called events with sub-folders for inpatient notes, discharge summaries, etc.
- This makes it easier and quicker to find the relevant information.
- Information can be accessed via the electronic record through clinical notes.
- The advantage of Document Imaging is the ease and broad access available from any PC location anywhere in the network, as well as secure access from the mobile devices.

**How will it impact me?**
- When a patient receives your service, the electronic record is used for storing patient medication, health checks, etc.
- When the patient returns for their next visit, the medical record will be accessed in the consulting room for the consultation.
- Cost-benefit: improvements in efficiency and higher productivity in clinical work.

**IMPORTANT POINTS TO NOTE**
- All documents that comprised the medical record MUST have a barcode to facilitate fast and accurate scanning into the system.
- NSW documents have been submitted for barcoding and are available to order via Design and Print. Please contact the documents team by May 2012. It is important that you DO NOT use photocopied or old documents.
- A new product listing will be available prior to May 2012. This is a product listing for the eMR and will be DATE/LSN. It is important that you use the NSW Decals since they are available on site. Both documents need to be scanned from the barcode. The barcode will be an element of the patient record and there will be no separate labels—use Decals.

**Correct Patient Label = Correct encounter + Correct Patient**

**Do:** Ensure the correct encounter label is affixed to the patient notes and in the patient's medical record. Ensure that any leftover labels are methodically disposed of after each patient encounter.

**Do NOT:** Remove old paper labels from a previous visit. Wipe or obliterate information on the patient label or the label will not successfully scan.
Discoveries

Training

➢ Minimal training required for eMR users
➢ Quick reference guide provided to all staff
➢ Community Health staff required full eMR training
➢ Training courses established
<table>
<thead>
<tr>
<th></th>
<th>Top 10 Lessons Learnt</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Sponsorship &amp; Governance</td>
</tr>
<tr>
<td>2.</td>
<td>Clinical Forms</td>
</tr>
<tr>
<td>3.</td>
<td>Patient Label</td>
</tr>
<tr>
<td>4.</td>
<td>Change Management</td>
</tr>
<tr>
<td>5.</td>
<td>Manage competing priorities</td>
</tr>
<tr>
<td>6.</td>
<td>Communications Plan</td>
</tr>
<tr>
<td>7.</td>
<td>Training Plan</td>
</tr>
<tr>
<td>8.</td>
<td>Stakeholder Engagement</td>
</tr>
<tr>
<td>9.</td>
<td>Support Model</td>
</tr>
<tr>
<td>10.</td>
<td>Prioritise &amp; keep smiling!</td>
</tr>
</tbody>
</table>
Results

- Throughput
- 100% Audit (first month – one off)
- 10% Audit (monthly & ongoing)
- Error types
Incidence of Form Errors vs All Forms Scanned May - June 2012

98.2%

1.8%

Error Incidences
Total Forms
Way Forward

- Go live of services - timeline & deadlines
- Quality Assurance & Auditing
- Risk Management
- Design & Development of KPIs
- Ongoing Recruitment & FTE Arrangements
- Handover of DI to HIS as ‘business as usual’ early 2013
- Post Implementation Review (PIR)
- Moving on - Ryde Hospital in mid 2013
Thank you!