**STATEMENT OF COMMITMENT AND POLICY**

The purpose of this policy is to guide staff during scheduled and unscheduled downtime, so to minimize the disruption that it may cause to the patient care processes. South Bruce Grey Health Centre (SBGHC) commits to upholding a high level of operation during downtime procedures, in order to provide the highest quality health care services to our patients. This will include ensuring safe, effective and ethical nursing interventions and care, as well as administration of medication to each patient while ensuring proper documentation during computer downtime that meets professional standards.

**ROLES AND RESPONSIBILITIES**

SBGHC registered staff will:

1. Ensure that any patient information that is collected during a computer downtime will be documented on the appropriate downtime form
2. Participate in downtime requisition procedures for lab, dietary services, and diagnostic imaging departments during downtime
3. Complete an accurate and timely back-entry process in a proficient manner when the system is returned following downtime
4. Commit to maintaining a safe and competent level of care towards patients throughout downtime procedures
5. Maintain effective communication with interdisciplinary team and departments throughout downtime procedures
6. Understand that SBGHC has a responsibility to maintain and update the Cerner platform in order to optimize patient care and documentation which includes regularly scheduled downtimes

**APPLICATION**

This policy applies to all clinical staff at SBGHC, who are providing patient care during planned and unplanned downtime procedures.

**OVERVIEW**

All applicable downtime forms for each department can be found in the Grey Downtime Binders, located in each nursing department. Progress notes should be used to note any assessments or interventions not captured within downtime forms.

When downtime is confirmed, a communication of outage to each site will be completed by the Registration Department by an overhead page. This page will be the trigger for departments to initiate downtime procedures. Downtime procedures will remain in effect until an all-clear page is announced overhead at each site by the Registration Department.

**PROCEDURE**

1. **Emergency Room Department**
   1. When a patient presents to a SBGHC ER department to be triaged, manually complete the demographic section of the blank ER Record
   2. Contact the Registration Department (during registration off hours, use central Walkerton registration) by phone to obtain MRN and FIN numbers. ER nurse expected to record both numbers on ER record
   3. ER nurse to photocopy form once the top portion has been completed to be filed in Downtime Binder, and fax to Walkerton Registration Department for filing into night book (519-370-2421)
   4. Document on the Emergency Record and progress notes as per usual process, including orders and medication administration
   5. Apply temporary armband
   6. If labs are ordered by the physician, utilize the Paper Lab Requisition – See Appendix A
   7. If DI is ordered by the physician, utilize the Paper Downtime Form – General Purpose Downtime Requisition – See Appendix B
   8. Clinical Connect may be used via Web-Portal during downtime procedures
   9. Applicable Registration areas will register patient visits when system is back online. If system is operational before a site registration opens, then Walkerton Registration will register the patient visits
   10. Following downtime, when registration has entered the patient visit, ER staff must complete the triage power form online in order to complete Back-Entry (does not need to be the RN that completed the triage) – See Appendix C for Back Entry Procedure
2. **In-Patient Unit**
   1. **Admitting a Patient to the In-Patient Unit**
      1. In-patient nurse will need to ensure that once patient is admitted, that new FIN is applied on all documentation. This FIN will be provided by Registration
      2. Apply temporary in-patient armband. Request additional labels ahead of downtime if known downtime
      3. Refer to paper copy for admission paperwork including: Advance Directive, Adult Admission Assessment, Vital Signs, HOBIC Admission, Medication Reconciliation, Admission History Adult
      4. Document on a paper Nursing Note the patient’s Height/Weight and Belongings
      5. Continue all nursing care intervention/documentation as ordered/as routine
      6. When downtime is over, apply armband that prints with new chart to replace temporary armband created during downtime
   2. **Documentation** 
      1. Complete Downtime Care Plan and place on patient’s chart when appropriate (ex. In advance of known downtimes or admissions during downtime)
      2. Refer to paper Ongoing Assessment Form, Intake and Output Form, Vital Signs Form, and Discharge Care Plan for documentation as applicable
      3. For all other assessments or further documentation, nurse will need to utilize a Nursing Progress Note
      4. For Medication Administration Record documentation, please See Appendix G for Standard Work Process
   3. **Discharge**
      1. Complete Medication Reconciliation
      2. Discharge teaching per usual process
      3. Document on paper Discharge Care Plan
      4. Notify registration of discharge during downtime
   4. **Paper Lab Requisition Process**
      1. Completion of Paper Lab Requisition – See Appendix A
   5. **Paper Downtime Form**
      1. Completion of general purpose downtime requisitions used for DI and Dietary Services – See Appendix B
   6. **Back Entry**
      1. See Appendix D for Standard Work Process for Back Entry procedure
3. **Family Birthing Centre (FBC)**
   1. **Outpatient Visits**
      1. Obtain FIN and MRN from Registration when patient arrives to FBC
      2. Write FIN and MRN on paper copy of appropriate visit type form/Nursing Progress Note, and document as necessary
   2. **Admission and Care of Labour/Postpartum Patient**
      1. If admission is occurring after a triage form process, contact registration for new FIN to attach to inpatient chart
      2. Apply in-patient armband. Request additional labels prior to downtime if known downtime
      3. Continue with patient intervention and documentation throughout labour/recovery as per usual practice
      4. See Appendix A for completing paper lab requisitions
      5. See Appendix B for completing general purpose downtime requisitions (ex. DI and Dietary Services)
      6. Complete Downtime Care Plan and place on patient’s chart when appropriate (ex. In advance of known downtimes or admissions during downtime)
      7. After delivery and recovery is complete, continue all nursing care intervention/documentation as ordered/as routine, using paper forms
   3. **Admission of Newborn**
      1. Contact registration with admission of newborn to obtain FIN, MRN, and Health Card Number
      2. Continue all nursing care intervention/documentation as ordered/as routine, using paper downtime forms
   4. **Back Entry**
      1. See Appendix E for Standard Work Process for Back Entry procedure
4. **Operating Room**
   1. **Admission to OR**
      1. Obtain FIN and MRN from Registration when patient arrives to Pre-op/OR
      2. Write FIN and MRN on paper copy of appropriate visit type form and document as necessary
   2. **Documentation**
      1. Refer to paper forms for all OR encounters. All documentation will be completed on these forms. In the event that there is not a form available, documentation will occur on a nursing progress note
   3. **Paper Lab Requisition Process**
      1. See Appendix A for completing paper lab requisitions
   4. **Paper Downtime Form**
      1. See Appendix B for completing general purpose downtime requisitions if necessary (ex. Diagnostic Imaging)
   5. **Back Entry** 
      1. See Appendix F for Standard Work Process for Back Entry Procedure

**DEFINITIONS**

**MAR** – Medication Administration Record

**Unexpected Downtime** – An unexpected interruption of any or all parts of the electronic chart or Cerner applications

**Routine Downtime** – Scheduled maintenance that facilitates system updates and changes to Cerner applications, resulting in any or all parts of the electronic chart/Cerner applications being unavailable

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**APPENDIX**

**Appendix A:** **Paper Lab Requisition Process**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Complete demographic portion of form manually, or if able attach patient ID label | Physician/Nursing |  | All fields indicated on form are required information |
| 2 | Indicate tests to be done | Physician/Nursing | Separate requisitions are required for each sample (ex. Swabs, blood, urine, etc) | Physician must indicate tests to be done, but nursing staff may enter on the requisition as a verbal order if necessary |
| 3 | Phone order to lab department, specifying urgency level (Time Study, Routine, Urgent, or Critical Event) | Nursing |  | Copy should remain on chart, and copy should also be taken to lab by lab staff |
| 4 | Lab test procedure | Lab/Nursing | To be done by lab staff unless test is specified as nurse collect, or as per site specific after hours procedure |  |
| 5 | Report lab results to appropriate patient unit | Lab |  | Recorded by Physician or RN on patient chart |
| 6 | Have requisition follow patient to different unit if incomplete at time of transfer | Nursing |  | Make a note that the order is unprocessed when moving patient to a different unit if unprocessed at time of admission. Copy requisition from ER to place in the In-Patient Unit Downtime Binder |
| 7 | Back entry of orders once system is back online, and patient visit has been registered | Lab |  | This includes both order and result |

**Appendix B: Paper Copy of General Downtime Form**

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| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Input demographic data on general purpose downtime requisitions | Physician/Nursing | Form utilized for DI, Dietary Services, Physiotherapy, and Respiratory Therapy | Complete demographic portion of form manually, or if able attach patient ID label |
| 2 | Indicate tests to be done, add history, reason for exam and sign form | Physician/Nursing | Orders to be obtained by physician and input by nursing | All applicable fields must be complete  Write in test/service required: one order per line; one department per requisition. Fill in the comment section as required |
| 3 | Phone order to department, specifying urgency level (Time Study, Routine, Urgent, or Critical Event) | Nursing |  | Copy should remain on chart, and copy should also be taken to appropriate department (dietary department does not require a copy of their orders) |
| 4 | Note on the Doctor’s Order Sheet “RMO” (requisition made out) | Nursing |  |  |
| 5 | Have requisition follow patient to different unit if incomplete at time of transfer | Nursing |  | Make a note that the order is unprocessed when moving patient to a different unit if unprocessed at time of admission. Copy requisition from ER to place in the In-Patient Unit Downtime Binder |
| 6 | Back entry of orders once system is back online, and patient visit has been registered | Nursing/DI/Respiratory Therapy/Physiotherapy/Dietary Services | DI to enter DI testing, Nursing to enter diet or respiratory orders, Physio to enter physio orders | Order complete online |

**Appendix C: Back-Entry Emergency Department**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Locate the patient on the FirstNet tracking board, after registration has entered the patient visit | ER Nurse | This does not need to be the RN that completed the triage |  |
| 2 | Open the appropriate Triage Assessment Power Form, and change the date and time to the actual time the triage was completed | ER Nurse | \*No quick registration required |  |
| 3 | Complete the Medication review and CTAS Level within the Triage Assessment Power Form All other documentation will stay on the paper copy of the ER Record | ER Nurse | Ensure the proper date and time has been adjusted to reflect when the measurement/care was taken or provided. |  |
| 4 | Document on the electronic form generated after downtime over, “See Downtime ED Record”. Once the Triage Power Form is complete, notify registration to then discharge the patient | ER Nurse |  |  |
| 5 | Write the phrase “entered into computer” on the paper downtime forms before scanning | ER Nurse |  |  |

**Appendix D: Back Entry In-Patient Unit:**

Summary: After conclusion of down-time, the following documentation is required to be back-entered into Cerner: Admission Assessment documentation, IV Infusions, Medications, and any pertinent changes in patient status (i.e. Allergies or Code Status). **All other assessments documented during downtime (i.e. Ongoing Assessment, Activities of Daily Living, Focused Assessment, Clinical Notes, etc.) do not need to be back-entered. These will remain on paper documentation, and will be scanned as part of the health record.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Back enter medications that were administered during downtime | Nursing | Ensure the proper date and time has been adjusted to reflect when the administration occurred, and by whom | Obtain paper MAR to document medications that were administered during downtime for proxy signing  If co-signing is required, enter the nurses’ name who administered the medication in the “Performed By” field. Back entry nurse to use own login for “Witnessed By” field, but must enter a comment stating “Administered during down-time, see paper MAR” |
| 2 | Back-enter admission documentation | Nursing | Only if NEW admission during downtime | 1. Advance Directive 2. Adult Admission Assessment 3. Initial Admission Vital Signs 4. HOBIC Admission 5. Medication Reconciliation 6. Admission History Adult 7. Height/Weight 8. Belongings   *If back-entering is done by a different nurse than the collecting nurse, the back-entering nurse will create a progress note stating “admission documentation collected during downtime by \_\_\_\_\_(the name of the nurse who collected the data and their designation)”* |
| 3 | Back-enter patient care orders | Nursing/ Ward Clerk | Excluding Lab and DI orders | All nursing care plan/physician orders will be back-entered into the system (i.e. dietary changes, wound care, communications, etc.). Lab and DI will back-enter their own orders. |
| 4 | Back-enter any pertinent patient status changes | Nursing |  | Any status changes should be electronically updated so that is reflected in the EHR (ex. Allergy change, code status, etc) |
| 5 | Add note to chart to refer to paper charting | Nursing | Must be added on ALL in-patient charts | Create Progress Note – Clinical Note Nurse: “During the times of \_\_\_\_ to \_\_\_\_ on \_\_\_\_, please refer to paper downtime documentation.” |

**Appendix E: Back-Entry Family Birthing Center**

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| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Notify registration of any new encounter date/time to ensure visit is registered in Cerner | Nursing | Include triages, preadmissions, follow-ups, induction forms, etc |  |
| 2 | Assign FIN and MRN as appropriate | Registration |  |  |
| 3 | Document FIN and MRN on paper documentation | Nursing | Including outpatient and inpatient forms | FIN and MRN should be copied on all paper documentation forms |
| 4 | Back enter medication that was administered during downtime for admitted patients | Nursing | Ensure the proper date and time has been adjusted to reflect when the administration occurred | Obtain paper MAR to document medications that were administered during downtime for proxy signing on Cerner  If co-signing is required, enter the nurses’ name who administered the medication in the “Performed By” field. Back entry nurse to use own login for “Witnessed By” field, but must enter a comment stating “Administered during down-time, see paper MAR” |
| 5 | Back-enter patient care orders on admitted patients | Nursing/Ward Clerk | Excluding Lab and DI orders | All nursing care plan/physician orders will be back-entered into the system (ie. Dietary changes, order sets, communications, etc) |
| 6 | Back-enter any pertinent patient status on admitted patients | Nursing |  | Any status changes should be changed so that is reflected on the EHR (ex. Allergy change, code status, etc) |
| 7 | Add note to chart to refer to paper charting | Nursing | Must be added on ALL in-patient charts | Create Progress Note – Clinical Note Nurse: “During the times of \_\_\_\_ to \_\_\_\_ on \_\_\_\_, please refer to paper downtime documentation.” |

**Appendix F: Back-Entry Operating Room**

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| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Notify registration of any OR case during downtime | Nursing |  |  |
| 2 | Assign FIN and MRN as appropriate | Registration | Inpatient FIN stays the same but will need to be scheduled in for “check-in” by registration  ER patients will be assigned a new fin |  |
| 3 | Document FIN and MRN on paper documentation | Nursing |  | FIN and MRN should be copied on all paper documentation forms |
| 4 | Back-enter all paper forms for each OR case | Nursing |  |  |

**Appendix G: Medication Administration and Back-Entry Process**

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| --- | --- | --- | --- | --- |
| # | STEPS | RESPONSIBILITY | NOTES | DOCUMENTATION |
| 1 | Print paper MARs | Nursing/Pharmacy | Nursing will print MARS as needed from the 724 Access Viewer. Occasionally, for planned downtimes with greater impact, MARS will be printed in advance by pharmacy.  New patients during downtime will have handwritten MARs. | These are to be put in patient duo-tangs on the inpatient units |
| 2 | If MARs are printed in advance of downtime, verify no additional orders from when MARs were printed vs when they’ll be used | Nursing | Check MARs against doctor’s orders to ensure accuracy. | If additional orders, transcribe on paper MAR printout. This requires a nursing double check/signature |
| 3 | Verify if orders are discontinued during downtime on paper MAR | Nursing |  | Discontinued orders will be highlighted with a highlighter by nurse to signal inactive medication. This requires a nursing double check/signature |