Guidelines for Consistent Data Entry – Version3

Demographics (Alt-1)

Patient identification details:

- Legal name, address, telephone number
- **Date of birth, sex**
- Chart status (e.g. Active, Transient, Deceased)
- Personal Health Number (PHN)
- Demographic reminder notes

Patient Detail:

- Aboriginal Identifiers (AAI)
- Aliases & Previous names (e.g. maiden name)
- Education, Living situation

ID Alias: Any numeric value that identifies the patient

- NFP (Nurse Family Partnership) client ID
- E.g. RCMP ID, Band Number

Connections: Services patient is connected with

- E.g. Referring Physician, Reserve, School, Dentist, Counsellor, Home & Community Care

Associated Parties:

- Next of kin, Emergency Contacts
- Occupation
- Claims (WCB, ICBC, **MSP Incentive Claims**)
- Settings (for Inphonite Voice)

Encounters (Alt-2)

All patient interactions/appointments booked in the MOIS instance

- Usually only interactions with clinic providers/staff in person or by phone
- Progress notes include appointment status (e.g. arrived, no show), forms, calculators, & measurements from visit
- Link other sections/events to an encounter, attach documents related to visit (e.g. Driver's Medical)
- Minor office procedures (e.g. sutures, paps, liquid nitrogen, cauterization)
- On-site nursing notes
- On-site shared care provider notes
- Phone visits/notes (e.g. INR follow up)
- Nursing home visits
- WCB Report & Encounter Forms

Measures (Alt-3)

All ^lab results and manually entered measurements (including at point of care)

- Manually entered values such as:
- **Height, Weight, BMI, BP**
- **^Pap smears, FIT Test (Fecal Occult Blood)**
- **Tobacco use, Alcohol use, Activity level**
- Scored items and scales such as: PHQ-9, **CSHA Frailty Score**, Mini Mental exam
- **Pulmonary function test, Spirometry,** Overnight oximetry
- **Cardiac Risk Assessment**, Holter monitor, Exercise stress test
- ECG & EEG *("normal" or "abnormal" result with report attached)*
- Polysomnogram (sleep study)

Imaging (Alt-4)

All ^diagnostic imaging reports *(may contain image attachments)*

- **Abdominal Imaging**
- **Bone Densitometry,** Bone Scan
- CT (Computed Tomography)
- **^Mammogram** (Screening & Diagnostic)
- MIBI (Methoxyisobutyl Isonitrile Study)
- MRI, Ultrasound, X-ray

Consults (Alt-5)

All consultation letters received

- ^Ambulatory Care/Outpatient Progress Note
- Audiology Reports
- BC Children's Hospital Info
- Child Development Assessments
- ^NH Consultant Inpatient Progress Note
- Dental Pre-op Assessments
- **Diabetes Education**
- ^NH Emergency Department Consult Note
- HEP C Assessment
- ^NH History & Physical Note
- ^NH Inpatient Consult/Progress Note
- ^NH Long Term Care Progress Note
- Off-site Interprofessional Team Notes
- ^NH Oncology Consult/Progress Note
- **Ophthalmology Reports / Diabetic Eye Exam**
- ^NH Outpatient Consult Note
- Pharmacy Notes
- Prenatal Notes (from other providers)
- ^NH Physician Office Consult Note
- ^NH Radiology Consult Note
- School District Assessments
- ^ NH Specialist Reports (consults and progress notes from NH or visiting specialists)
- WCB Consults

Procedures (Alt-6)

All medical and surgical procedures (in or out of clinic/office); *not minor office procedures*

- Angiogram, Angioplasty
- Biopsy (of breast or other)
- **Colonoscopy, Sigmoidoscopy**
- Day Surgery Report
- ECT (Electroconvulsive Therapy)
- Embolization procedure
- **^NH Endoscopy Note**
- Guided Biopsy
- **Hysterectomy**
- ^NH Interventional Radiology Procedure Note
- ^NH Labour & Delivery Summary
- ^NH Minor Procedure Note
- Nerve Block
- ^NH Operative Note
- Significant in-office procedures (e.g. excision biopsy, vasectomy, wedge resection)
- **Splenectomy**

Interventions (Alt-V-I)

Non-operative interventions

- Allergy Desensitization Summary *(Weekly injections scheduled as Encounters, documented in MAR)*
- Counselling (e.g. Tobacco Cessation, Exercise, Drug & Alcohol)
- Falls Risk Screening Assessment
- ***LOI Assessment*** *may still be found in this folder, new LOI should be added in Preferences.*

Family History (Alt-7)

- Linked family relationships – for those indexed within the MOIS instance
- Family history pertinent to care (with or without linking charts)

Long Term Meds (Alt-C)

Current list of regular medications and natural health products expected to be taken over the middle to long term

- Shows on Patient Summary
- "Reviewed" functionality
- Current and discontinued are listed (add an end date as needed)
- Include medications for flare-ups (e.g. COPD antibiotics)

MAR (Alt-V-M)

Medication Administration Record

Documentation of medications that have been given, omitted, withheld, and cancelled

- **Immunizations** (including historical)
  E.g. **Influenza Vaccine, Pneumococcal Vaccine**
- Medications provided at point of care
  E.g. Antipsychotics, Plan B, Rhogam, STI meds
- Consent for immunizations

Health Issues (Alt-P)

Conditions: All past and present health conditions

- Should all be coded entries
- One condition per entry/line
- Start and End dates should be listed
- E.g. **Asthma, Frail, Diabetes, Depression, Tobacco Dependence, HIV, COPD, Unsafe Drug or Alcohol Use, Anticoagulation Therapy, Hypertension, Bipolar Disorder,** Cancer, Pregnancy, Miscarriage, etc.
- Smoking status *(for current smoker or previous smoker only)*

Risks for Conditions: Contains conditions the person is at risk for, but does not currently have
E.g. "Lung Cancer due to Asbestos Exposure"

Needs for Care: Needs that can be addressed by care
E.g. Socioeconomic deprivation

Care Plan

Consolidated view of shared patient data

Preferences: Includes consent preferences for care (including refusals)

- Refusal of all immunizations
- MOST form (Medical Orders for Scope of Treatment) & Other **Advance Directives**
- Pharmanet consent
- Contracts (e.g. Long Term Opiate)

Goals: Qualitative or **Quantitative patient & provider goals**

Planned Actions: Actions to achieve goals

Barriers to Care: Obstacles preventing a patient from getting necessary care. These usually spin off of Needs.
E.g. "English as a Second Language", "Transportation to Appointments"

Patient Resources: Personal resources/ what the patient "brings to the table"

Documents (Alt-K)

All documents including forms and letters attached to other parts of the chart are viewable here. (Option to filter out these documents.)

All documents not attached elsewhere, such as:

- Band Letters
- Birth Records
- ^NH Cardiac Arrest Note
- ^NH General Letter
- Insurance or other forms not linked to visit
- Letters from clients
- Letters of Entitlement (e.g. BC Palliative Care Benefits Application)
- Misc letters/faxes not entered elsewhere
- Previous Charts (scanned from paper or electronic)
- ^NH Physician Initial Assessment Note
- ^NH Sexual Assault Report
- ^NH Trauma Report

Allergy/Intolerance (Alt-A)

Reaction Risks: Allergy status to drug or food *(include No Known Drug Allergy)*

- Drug, food or environmental Reaction Risk

Events: Adverse events linked to related Reaction Risks, all adverse events related to immunizations

- Adverse Events From Immunizations (AEFI)

Contraindications related to adverse events

Prescriptions (Alt-S)

Short term, one-time, trial/sample medications, and natural health products prescribed

- Includes documentation of every product ordered
- Include all dispensed samples *(MOIS only)*
- Items renewed from long term meds will be recorded here
- Not sent with referral letters or on summary

Social History (Alt-O)

Socioeconomic details *(not diagnoses)*, Social Determinants of Health

- Diet information
- Family information
- Sleep information

As needed, mark as sensitive so they do not appear in referrals

Forms

Repository of Paper Forms, Dynamic Forms, and Encounter Forms

Encounter Forms: Read-only versions of Encounter Documentation Forms

- E.g. Insurance Forms – WCB Report
- E.g. Encounter Forms – CHF

Orders (Alt-F)

All service requests for consultations, interventions, labs, procedures, images and other items sent

- E.g. Referral Letters
- ^NH Referral Note

Facility Admissions (Alt-V-Y)

All facility stays, including emergency visits, and other facility admission and discharge summaries

- ^NH Discharge Summary (including psychiatric care)
- Emergency Visits (attach ED reports)
- ^NH Emergency Department Note
- ^NH Transfer Note
- Off-site Walk-In Clinic Reports

Notifications

Patient-specific notifications (show as pop-up when triggered)

Reminders: Free text field

- E.g. Risk of Violence or Restraining Order Against

Recalls: Notices for follow-up, coded

- E.g. CDM, Complex Care, Pap, Immunization, Fluoride Varnish, TB Skin Test Recall

Tasks/Messages: Patient specific tasks for providers/staff or patient-related messages between providers/staff

Responses: Inphonite Voice report

Alerts

Private alerts that never show up as a pop-up; entries have start and end dates

^Downloaded through CIX, Excelleris, CDX (Clinical Document Exchange)

Blue font – Item populates to Health Maintenance Review (Ctrl-H) &/or Scorecard