Using Your LTC Electronic Health Record for Virtual Care April 3rd, 2020

Disclosure: *I have not received any remuneration from PointClickCare. There is no conflict of interest of bias to mitigate.*

These are helpful hints for attending MD/NPs to maximize remote use of the PointClickCare (PCC) electronic record (EHR) and the additional Point-of-Care (POC) module in order to deliver good medical care. Suggestions from other users are welcome. Practitioners who use other EHR software are invited to compile similar instructions.

Please note that much of the PCC and POC software is configurable by the user, so the system will look different depending on your facility. Your templates, assessments, and POC records may be customized and unique to your location. POC software, used by PSW's to record daily care, is an optional module not implemented in all facilities.

These suggestions are based on my 8 year experience using the EHR to provide medical care to a unit of severely demented residents who could not communicate symptoms, comply with examination, or comprehend a discussion. For those residents, the EHR provided pertinent clinical information from direct care staff. Appropriate physical assessment was still necessary (where possible).

Most pertinent clinical information is part of the EHR, accessible both in-house and remotely. Using all facets of the electronic record allows the attending MD/NP to get a much more complete picture of the condition of the resident, especially when on-call or covering another MD/NP; and does not overburden direct care staff who may not be familiar with a particular resident.

I am assuming you know how to get to the individual resident record. The instructions start there.

A discussion with unit nursing staff after your remote review of the record will help coordinate care. Doctors' orders can be by telephone, by e-MAR, or by writing orders in-person, depending on arrangements made with the facility.

Not Using the EHR yet?

Some attending physicians have continued to use paper documentation of progress notes and assessments; and have relied on nursing staff to identify residents who are ill or to print out clinical information available in the EHR. Now is the time for all attending MD/NPs to connect to the EHR directly and document electronically to:

- minimize time spent in the facility,
- ensure that you access all information necessary to provide good medical care,
- reduce the workload on nursing,
- make your assessments/recommendations available to all members of the health care team, and
- continue to manage chronic diseases

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Use of the EHR when On-Call

If you are not familiar with the resident, background information may be available by clicking on the:

"Medical Diagnosis" tab for diagnoses

"Assessment" tab for Admission/annual physical assessments

"Assessment" tab for Cumulative Resident Profile (CRP/CPP)

"Progress notes" for recent changes

To access other facilities remotely, log in to PCC. On the home screen go to the green ribbon at the top and on the right hand side is the name of your home facility. Click on this drop-down menu, and select the other facility that the patient is in. Then locate the patient in question by entering the name in the Search box on the top right.

It is up to the administrator of facility or group of facilities to grant access to physicians who are on-call but not attending staff at that facility – if there are no other facilities on your dropdown menu, then you do not have access.

The Alert System in PCC

When you first open PCC, in the top green ribbon on the right there is a small bell icon. Click on the bell to see current alerts generated for residents in the facility.

Management of Acute Change in Health Status using PCC +/- POC

In PCC
Click on the Wts/Vitals tab

Click on ""view all"" next to the parameters you wish to review (temperature, blood pressure, respiratory rate, pulse, and oxygen saturation).

Click on Progress Notes and review the last few days for additional clinical information.

In POC

Click on the "Tasks" tab for additional resident information. You will see under "Task Description" a list of tasks that are completed q shift or less frequently by the direct caregiver. To the left of each parameter there is a blue square with a question mark.

Click on the blue square question mark for detailed information.

Once you have selected a task, at the top of the screen the "look back" period has a drop-down menu. It will be configured at a default of (probably) 7 or 14 days. You can click on the dropdown menu to choose a different range of dates from 1 – 30 days.

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At the top of the data table the line "Follow Up Question: "and there can be a number of questions. Click on each question for different parameters.

Prevention of Dehydration

Click on (the blue question mark) next to "fluids" or "oral fluids" to see what the intake of fluids over the past few days. If oral fluid intake is not adequate, then determine next steps based on the clinical condition and goals of care. (hypodermoclysis, labs, etc.)

Prevention of Obstipation or Bowel Obstruction from use of Opioids

Click on Bowel Movements and review. Adjust medication as needed.

Evaluation of BPSD and behavioural symptoms related to delirium

Click on Behaviour monitoring and review, particularly increase/decrease in physical aggression or resistance to care. Consider adjustments to medication and other interventions.

Evaluation of Pain related to acute illness

Click on Pain and review. For increased pain consider conversion of prn to scheduled doses of analgesics or increase in analgesics. Pain may also be recorded in PCC Wts/Vitals tab

Management of Chronic Conditions using PCC only

Diabetes:

Click on the Wts/Vitals tab

Click on ""view all"" next to Blood Sugar

Review the glucose values and decide if oral hypoglycemics or insulin have to be adjusted.

Communicate the new orders (verbally or in person).

Document your assessment in the progress notes. For example:

"Capillary glucose reviewed – values are high/lower than optimal, insulin/meds increased/ decreased. " OR

"Capillary glucose reviewed – control adequate, no change to meds."

Hypertension:

Click on the Wts/Vitals tab

Click on ""view all"" next to Blood pressure

Review the BP values and decide if medications need to be adjusted

Communicate any new orders

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Document in the progress notes. For example:

"Hypertension – BP values reviewed, high/lower than optimal, medications adjusted…" OR

"Hypertension – BP values reviewed, control adequate, no change to meds."

Bradycardia/Treatment with Medications such as digoxin, betablockers or donepezil:

Click on the Wts/Vitals tab

Click on ""view all"" next to "Pulse"

Review the hear rate values and decide if medications have to be adjusted.

Communicate the new orders (verbally or in person)

Document your assessment in the progress notes. See format above.

Weight loss (Resident at risk because of chronic low intake/dysphagia)

Click on the Wts/Vitals tab

Look for any "Warnings" in the right hand column next to "Weight". Your system will be configured to trigger warnings if the percentage of weight loss exceeds a certain threshold.

Click on ""view all"" next to "Weight"

Review the weight values and decide if there are any additional interventions needed or possible.

Communicate orders.

Document in progress notes, e.g.

"Weights reviewed – no significant change, caloric intake adequate" OR

"Weights reviewed – significant decline over ….. months due to severe dysphagia/end-of-life…, all possible interventions in place/dietician to see".

In Summary:

Use the EHR to:

1. Review
2. Communicate – discuss condition and treatment plan with nursing staff. Discuss treatment options with SDM where appropriate.
3. Document

Add appropriate physical assessment where possible and appropriate.

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