WEISMAN CHILDREN'S REHABILITATION HOSPITAL (WCRH)
ADMINISTRATIVE MANUAL

SUBJECT: ePHI Onsite Backup and EMR Downtime NO: AM 3.30

EFFECTIVE DATE: March 2021 PAGE: 1 of 3
REVIEWED/REVISED: 09/02/2021;1/24

PURPOSE: To establish a process to follow for CPSI outage to ensure continuity of patient care.

POLICY: In the event of a communication loss to CPSI cloud data centers, WCRH has established a process to follow in the event of specific outages. For any scheduled interruption of service, staff shall be notified in advance by the IT Manager or designee. Pertinent ePHI is replicated every 4 hours to an onsite computer. This computer/information is accessible at the nurse's station.

PROCEDURE:

In the event Communication Loss to CPSI Cloud data centers from all Weisman Buildings

- In the event of complete CPSI downtime or communication failure from WCRH to CPSI cloud data centers, this backup will be available locally onsite at the nurse's station. This information can be printed and disseminated as necessary to maintain patient care.

In the event Communication Loss to CPSI Cloud data centers from a single Weisman Building

- In the event of individual downtime, access to CPSI ePHI can be obtained throughout any of the other Weisman Facilities. Each building has an independent connection to the CPSI cloud data centers. Once the requested information is obtained that information can then be transmitted via facsimile, or other offline methods.

In the event Communication Loss to CPSI Cloud data centers:

BEFORE DOWNTIME (if scheduled)

- Patient information should be printed from Medical Records, Clinical History, or the patient chart prior to the system going down.
- Blank Documentation documents can be printed from Table Maintenance if desired (when printed, these documents are lengthy). Pathway: Base Menu> Master Selection> Business Office Tables> Table Maintenance>Clinical>Flowcharts/Pathways/Documents> Select Document> Select Print.

DURING DOWNTIME (scheduled and unscheduled)

- Users should begin documenting all information (including orders and prescriptions) on paper until the system is operational. Documentation Guidelines (Attachment A) should be used at minimum.
- EHR support will communicate downtime status every four hours during normal business hours (9am-5pm). Communication after hours will occur when a change in server status occurs.

AFTER DOWNTIME (scheduled and unscheduled)

- All documentation should be entered into the system utilizing the late entry option which occurred in the previous 4 hours from the time the system is restored.
- Paper documentation that is older than 4 hours from the time the system is restored should be given to the medical records department for scanning into the EHR.
- Documentation that needs to be scanned into the EHR will be immediately placed into the designated scanning bins. Once pickup occurs documentation will be scanned into the EHR within 48 hours.

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Administrator

Weisman Children's Rehabilitation Hospital (WCRH)
Attachment A

EMR DOWNTIME DOCUMENTATION GUIDELINES

1. All pages must be identified with patient's name (last and first) and date of birth.

2. Only black ink should be used.

3. Identification of the specific type of documentation and department name must be noted.

4. Current date and time of documentation should be recorded.

5. Documentation should reflect specific clinical observation(s) as indicated.

6. All entries must be legible, dated, timed, and signed with the full staff person's name and professional credentials/designation (as applicable).

7. All information must be factual and precise.

8. Factual information that was not recorded during the progress note is to be included, dated/timed, and documented as a late entry.

9. An error in charting is to have a single line drawn through it with the word ERROR written above it or besides it. The correction should be authenticated with the documenter's initials. No white out is to be used.

10. Therapist/Nursing countersignature is required for entries by certified/licensed assistants, student(s), and/or department aide(s) as designated.

11. No blank lines will be left between entries in the patient chart. If a space is accidentally skipped, a single black line will be drawn through it.

12. If/when documentation entry extends onto following page, writer must document "cont.'" with full signature/credentials at bottom of first portion of entry, "cont.'" with date/time/department at top of next portion, and full signature/credentials at end of entry.