Document Categories: How the Chart is organized.

1- ALERTS:
Alerts, Cautions, Living will, Court orders
Problem lists, Medication profiles Suspected Allergies

2- BIRTH:
Neonatal Record

3 – CONSENTS:
All consents except for research (Research category) and autopsies (Death category)

4- CONSULTS:
Requests and answers, Consultation 1996- 2004 (from Platypus Adult)

5- CORRESPONDANCE:
Outgoing letters Incoming external documents

6- DEATH:
Autopsy reports (including Coroner's),
Declaration of death, Autopsy consents, Disposal of tissue/organs, NDD Autopsy report 1996-2004 (from Platypus Adult)

7- DIAGNOSTIC EXAMS & RESULTS:

Tests and results/reports, e.g. laboratories, Medical Imaging, skin tests, EEG, External labs, Pathology report 1996-2004 , Cytology report 1996-2004 (from Platypus Adult)

8- EVALUATIONS:
Assessments, Questionnaires, Screenings, Triage, Check lists, Histories

9- IMMUNIZATIONS:
Vaccinations, Immunization record

10- MEDICO-ADMINISTRATIVE:
Admission requests, Chart control, Temporary leaves, Fees, Release of info, Insurance forms, Other legal documents, Judgements

11- OBSTETRICAL CHART (PRENATAL):
Birthing centre documents, Obstetrical chart , MSSS documents

12- OR REPORTS:
OR reports, Lumbar puncture, OR report 1996-2004 (from Platypus Adult), OR done elsewhere

13- ORDERS & PRESCRIPTIONS:
Prescriptions, Protocols, Nurse's orders, Physician's orders

14- PERI- OPERATIVE:
Pre-anesthetic assessment, Intra-op memos, Counts, Implants, Pre-op, Post-op, Recovery room

15- PROGRESS NOTES:
Follow-ups, Observations, Telephone contacts, Flow sheets, Logs, Vitals, Growth
charts, Clinic notes 1996-2004 (from Platypus Adult)

16- RESEARCH:
Research protocols, Research consents

17- SUMMARY SHEETS

18- DISCHARGE / TRANSFER / RESUME:
Discharge summaries, Progress/transfer/discharge, Discharge summaries 1996-2004 (from Platypus Adult)

18- TRANSFER DOCUMENTS:
Documents received when a patient is transferred to MUHC

19- TREATEMENT:
Medication records, Transfusion log/report, Epidurals, Blocks, Resuscitation

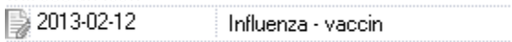
20- UNDETERMINED SOURCE

21- MEDICATION RECONCILIATION

FAQ: Frequently Asked Questions

Q1: Why do I need to add an addendum?
ANSWER: An addendum is used to make changes or add to a document that has been signed and is in circulation.

Q2: How will I recognize that a document has an Addendum added?
ANSWER: When you open the Document Viewer, you will see an icon



Q3: The document Viewer screen / display has been changed, How can I get back the original view?
Answer: You can reset your preferences.

a) Access the Document Viewer
b) From the Document Viewer menu, select: Tools – Reset User Settings

Q4: There are symbols in the document list. How can I know what certain symbols mean?

ANSWER: There is a legend available

a) Access the Document Viewer
b) From the Document Viewer menu, select: Help – Legend

Q5: I have a document open and I would like to view the lab results. Is there a quick way?
ANSWER: Click on "Results" from OACIS menu

Q6: Can I print documents from the Document Viewer?
ANSWER: No the print feature in the Document Viewer is locked, release of information is done by Medical Records Services

Q7: What if I need to print a document that has already been scanned:
ANSWER: Contact Medical Records

IF YOU DON'T HAVE AN OACIS ID, PLEASE CONTACT THE HELP DESK AT 48484.

OACIS TRAINING

www.formationoacis.com/muhc/
Go directly to Scanning: Viewing Patient Charts

SUPPORT

MGH + MCI **45808**
MNH + RVH **88 4735**
MCH **25808**

PRACTICE

To get acquainted with the document viewer without breaking the confidentiality policy, you can access a fictive patient by means of the Search feature by entering the patient's surname and first name "Zebbie, Demo", or by entering the following file number 9999904.

MORE INFORMATION

Consult the Clinical Information System section on the Intranet rapid links.

ACCESSING SCANNED DOCUMENTS

September 2013

Version 2

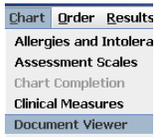
Centre universitaire de santé McGill
McGill University Health Centre

I. Consult the Patient Chart

1. Access Oacis.
2. Select a patent (search for a single patient or access the patient list.)
3. Highlight the desired patient.
4. You can either open the complete patient chart or view the most recently note

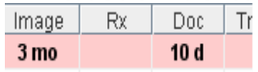
To open the complete patient chart:

5. Click on the Document Viewer icon 
6. From the menu, select *Chart – Document Viewer*



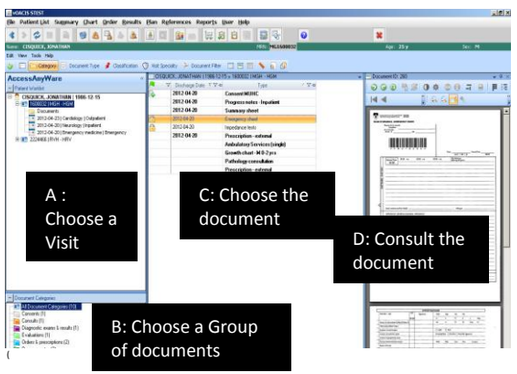
To see the most recent note

7. Double click in the Doc column



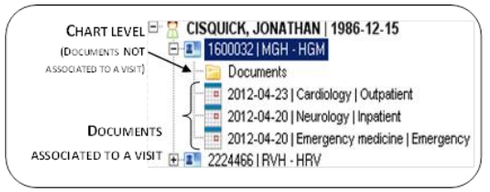
II. Document Viewer: Consult the Complete Patient Chart – The "A,B.C,D" of document consultation

1. Access Oacis.
2. Click on the Document Viewer icon (Section 1).
3. You are brought to the Document Viewer screen.



III. Document Viewer: Consulting the Complete patient chart - Details

(a) Section A - Choose a Visit: Displays the list of all visits against which documents were scanned

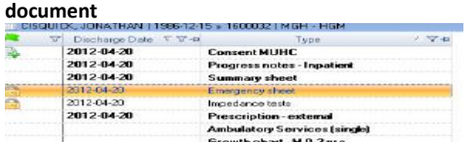


Note *If you only want to see the documents for the particular visit, click on the Visit*

(b) Section B – Choose the category: Displays the categories of documents for the patient. The folders are only those categories for which the patient has documents.

Note *If you only want to see the documents for a specific category (e.g. only Consults), click on the Category*

(c) Section C: Which document do I want to consult? Displays the patient's documents. **Click on the document**

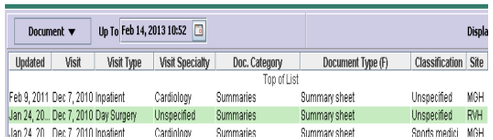


(d) Section D: Consult the Document

The same way you consult a PDF document.

IV. Accessing the most recent note

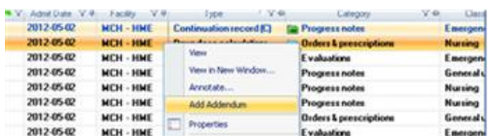
1. Double clicking in the Oacis Doc column displays a listing of all scanned documents
2. You can double click on the document to view the document



Note *Items that are bold indicate a document not yet consulted by you*

V. Adding an Addendum

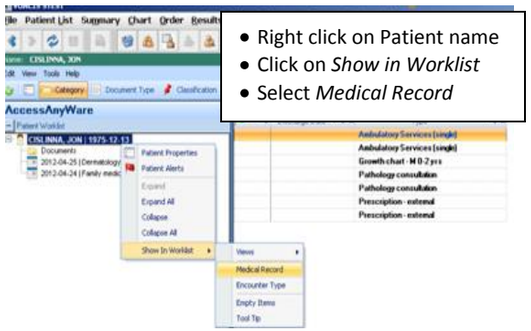
1. Access the patient in Oacis
2. Click on the document viewer icon.
3. Search for the document that requires an addendum
4. From Section C, right click on the document and select **Add Addendum**



5. A blank sheet displays. Enter the necessary information

6. Click on appropriate action
   a. **Save and Sign**: note is complete and "electronically signed by ...". The document cannot be modified once signed Right click on the order
   b. **Save:** To save your note and exit. To retrieve this note, go to your INBOX under Addendum in Progress and double-click
   c. **Cancel:** Equivalent of UNDO (Deletes text you added and EXITS from the document. Go to INBOX to retrieve.
   d. **Remove**: Equivalent of UNDO : Delete text you added since the last save and stay in the document so you can continue your note.
   e. **Delete**: DELETEs the current note (before doing Save and Sign). This will delete the addendum and remove the "legend" indicator next to the document

VI. Viewing Visits by Site



VII. Viewing more details of a Visit (in Section A)

Slowly roll over the visit with the mouse and a tool tip will appear.