ELECTRONIC MEDICAL RECORD POLICIES

SECTION:       SECTION NO:
SUBJECT:       Effect Date:  4-1-11
               Interruption of the Electronic Medical Record System

Purpose
This policy ensures access to and documentation of client information for care, treatment and services in the event of an
interruption (e.g. power outage, product malfunction, routine maintenance, etc) to the electronic medical record (EMR).

Scope
MSH’s health record is hybrid in that it consists of information captured in EMR systems along with paper records not yet in the
electronic system. This policy applies to those records that are part of the EMR that will become paper generated in the event of
an interruption to the EMR system.

Policy Statements
Madison State Hospital’s Information Technology Services (ITS) Department shall have a written plan for managing scheduled
and unscheduled interruptions to its EMR systems including a backup for these systems. This plan is tested for effectiveness by
ITS monthly during downtime for monthly generator test. Users are down approximately 1 hour and 15 minutes every month.
Training shall be provided to appropriate hospital staff regarding notification process and to follow when the EMR systems
become unavailable.
In the event that the EMR cannot be accessed due to interruption, clinical documentation shall be completed using paper data
collection documents. The following procedures shall be followed in cases of anticipated or unanticipated system interruptions:

Information Technology Services Department shall
1. notify all departments that “EMR system interruption” procedures should be implemented until further notice;
2. notify all departments when use of the EMR system has been restored and normal system procedures should be reinstated;
3. maintain a “System Interruption Log” to maintain a report of dates and times of impacted medical record documentation.

Health Information Services (HIS) Departments shall
1. ensure that HIS maintains an adequate inventory of paper data collection documents;
2. ensure that RN supervisors have electronic access to paper collection documents (“See Nursing Admin” folder-“EMR
   interruption forms”-ONLY for EMR system interruption during nights, eve, and/or weekends);
3. maintain a log of paper data collection documents completed during system interruption (per clinician notification);
4. audit charts to ensure EMR inquiries/reports of paper data collection documents are present (two [2] business days following
   restoration of system use);
5. purge paper data collection documents and file in client overflow charts (if reports are present);
6. notify responsible clinicians and the HIS Director (if reports are not present);
7. maintain a log of delinquent EMR reports.

Clinical Staff shall
1. continue medical record documentation using a paper data collection document in lieu of the EMR; authenticate the paper data
   collection document (signature, date and time);and file it in the client’s unit chart;
2. notify unit HIS secretaries (or RN supervisor- for use during nights, eve, and/or weekends) that a paper data collection
   document is needed.
3. notify unit HIS secretaries that a paper data collection document has been filed;
4. enter information from the paper data collection document into the EMR within two (2) business days of restoration of system
   use;
5. make an entry in the “Informant Comments” field indicating “This assessment was completed manually on (date) due to a
   system interruption making electronic entry impossible; the paper assessment may be accessed in the client’s overflow chart.”