Provider Documentation in the OPOR-CIS:

Key Features and Efficiency Supports

This guide is intended to provide an overview of key features and efficiency supports pertaining to Provider Documentation within the OPOR Clinical Information System (OPOR-CIS).

What does Appropriate and Efficient Documentation achieve?

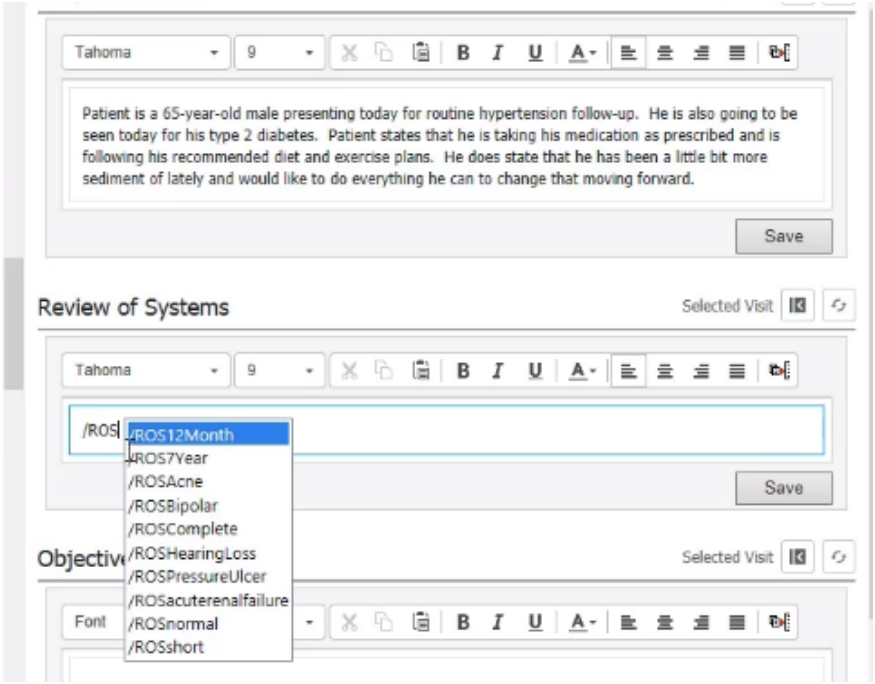
- **Improved communication and coordination** with seamless sharing of patient information across NSH and IWK Health facilities, enhancing care coordination and reducing the likelihood of medical errors.
- **Legible, consistent clinical notes** with standardized terminology and coding, promoting consistency in documentation.
- **Reduced documentation and dictation burden for providers**, with the use of state-of-the-art speech recognition, mobile technology, custom templates, and auto-population of existing clinical data into chart notes.

Documentation Functionality Features within the OPOR-CIS:

Full access to all notes
Providers will be able to see all documents for their patient, regardless of whether who the author was, or which care area it was documented in. For example, a physician treating a patient in Yarmouth Regional Hospital will be able to easily see notes from the patients visit to the IWK Hospital earlier that year.

Efficiency enhancers—pre-made Note Templates, Auto-text, and Smart Tokens

Clinician-led design of **Note Templates** will support providers in easily populating pertinent information, without the burden of repeating the same content ad nauseum. Drop downs within the selected templates allow quick modification of the text to ensure accuracy for your patient. Standardized templates also promote safe and robust documentation across the province. **Auto-text** features allow the provider to type a command key and displays a drop-down menu of templates (for example: “ROS” at various time frames- see image below). **Smart tokens** can be used within Auto-text creation to automatically pull in information from a patient’s medical history, such as name, gender, and age.



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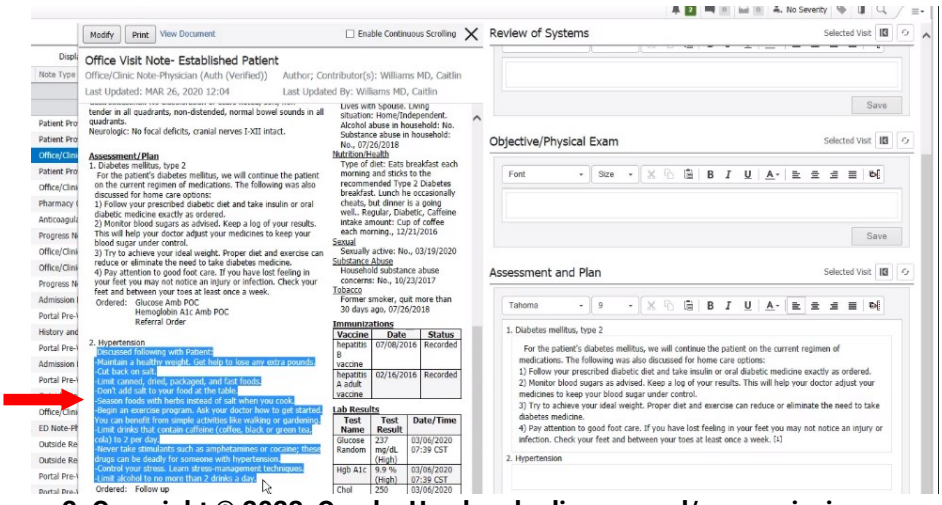
Leveraging previously documented content for continuity of care

Aspects of chart notes (such as a detailed Assessment and Plan from a previous note) can be “dragged and dropped” from an existing note, directly into a new note. A citation is added to maintain documentation integrity.



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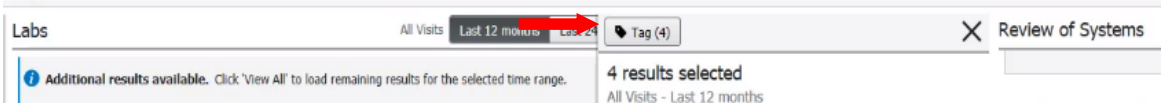
Seamlessly pull in labs and results into notes
Selected Labs can be **Tagged** while you are reviewing them, and then dragged and dropped into your note.



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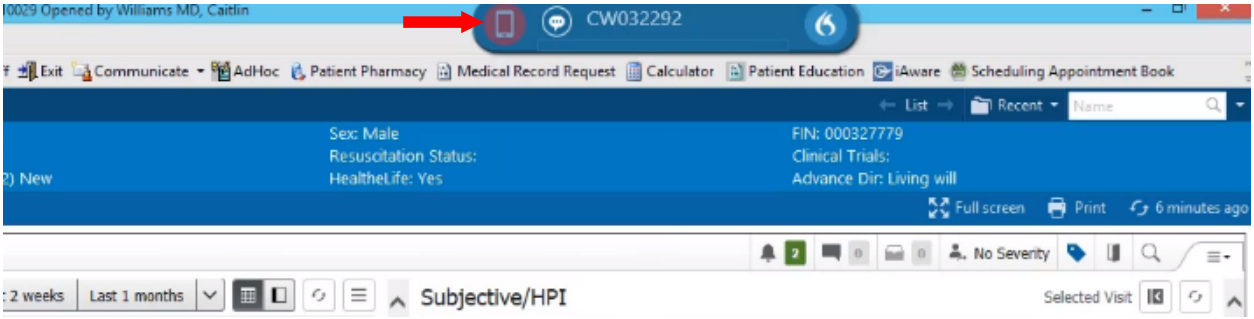
Dictate notes with Dragon Medical One
The OPOR-CIS is fully supported by Dragon Medical One dictation software, which can also be available on your mobile device (Dragon Mic Mobile).



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Quick and integrated sharing with other clinicians
Signed documents can be easily forwarded in-system to other members of the care team. Notes are immediately available within the medical record for all care team members—no more scanning, faxing or messenger pigeons involved. Discharge notes easily populate with pertinent information.

Support patients with easily created and detailed discharge instructions
Includes current medications and what has changed from before their admission in bright red font. Recent test results are populated, and education materials are linked.

Looking to find more information on Provider Documentation?

Demonstration videos are available on the **opor.nshealth.ca** website, as well as here: Cerner Provider Documentation Vignette (5mins)

Please contact **CMIO@nshealth.ca** for any questions about **Provider Documentation** and **how you can be part of this process to ensure it meets your clinical needs.**

While this guide provides a brief overview, the **OPOR Education and Learning team** will prepare you with detailed content and experience leading up to the CIS implementation.

V1 (07 December 2023)