



Access to EPR



A completed Electronic Patient Record Access Request form needs to be submitted to Data Security. Your EPR ID and password will be provided to you when you call the Helpdesk (x4357) within 24-48 hours after the successful completion of all requirements. You must correctly answer all four ID verification questions to be provided with your EPR ID and password by the Helpdesk. This password will expire 24 hours after issuance.

Patient Search

There are different ways to search for patients in EPR. The preferred search method to use is the patient's Medical Record Number (MRN) or OHIP Number because it is a patient-specific number. i.e:

1. MRN (Medical Record Number: 12345678
2. OHIP Number (always put the letter "o" before the OHIP number): o1234567890
3. Last name *comma* First name: Super, Kathy
4. Last name: Super
5. Wild card search: Sup-, K- (use a hyphen)
6. Visit Number (always put a letter "v" before the visit number): v9800813

Privacy is Important!

By law, you are prohibited from accessing any patient's information that is not within your circle of care. Unauthorized access is considered a privacy violation and may result in termination of employment, prosecution by a court of law and fines of up to \$50,000 for individuals and \$250,000.00 for organizations.

System Navigation

Read the Transaction Line!

- Select:** There are options available above the transaction line for you to select
- Enter:** Type your own text into the transaction line
- Choose:** There are buttons below the transaction line for you to choose from
- OK:** Proceed to the next step
- Back:** Go back to previous field/screen
- Cancel:** Terminates your active task
- Keep:** Quick access the Accept Button
- GoTo:** Enables you to select specific fields to complete

Accept: Saves the information

Select, Enter, or Choose option:	OK
	Back
(A) Accept (E) Continue Editing	Cancel

Scanned Documents

Electronic versions of documents are available 24 hours after being received by the secure facility and can be viewed directly from a link in EPR.

1. Under the Patient Care tab, click View Scanned Documents
2. Click on the dropdown to filter by Document category (For TRI Specific Documents: select _All Documents (TRI))
3. From the Documents tab, select the Document Type or Encounter # (same as Visit #)
4. Click on the Expand/ Compress view

Documents are displayed in the Document Viewer. Use the navigation buttons to zoom in and out of the document or to move forward or backward within the document viewer.

Communication Note

1. From Patient Shortcuts, select Unscheduled Procedures
2. Select Communication Note
3. Enter the date and time
4. Select the type of communication from the list
5. Select who you communicated with from the list
6. Enter Phone Number
7. Enter Reason for the communication
8. Select the information given or if more information needs to be documented, choose the Goto button and select Document More Advice
9. Click OK and Accept

The Communication Note is now write protected. A Telephone Visit (see below) can be created if there isn't an appropriate existing visit to hold the Communication Note.

Telephone Visit

1. From the Reg/ADT tab, select Telephone Visit
2. Enter the Patient's name, MRN or OHIP number
3. Select the Patient from the list
4. Either select an existing visit or click Add a New Visit
5. Enter the date and time of the call
6. Click Expand
7. Select Telephone Visit as the Service Location
8. Click OK until taken back to the Visit Registration Screen
9. Click Accept
10. Click OK
11. Choose Yes to Activate the visit
12. Choose Accept Visit Activation Time

See Communication Note above.

Shortcuts

Date and time:

Full Date = ddmmyy (i.e. 230515 is May 23, 2015)
Time = 24 hour clock (i.e. 1400 is 2:00 p.m)
Date + time = ddmmyy + 24 hour clock (i.e. 230515 *space* 1400 is May 23, 2015 at 2:00 p.m)
n= (Now) current date+time
n-5 = 5 minutes ago **n+5** = 5 minutes from now
n-1h = 1 hour ago
t= (Today) current date
t-1 = yesterday **t+1** = tomorrow
t+1 0800 = tomorrow at 8 a.m

Bed Status

VAC= Bed is vacant **HK=** Bed Being Cleaned
PT= Pending Transfer **PD =** Pending Discharge

Visit Types

IP= Inpatient **OP=** Outpatient
EP= Emergency Patient **SP=** Same Day Patient
CP= Clinic Patient **HH=** Home Health
RP= Referred Visit

We Are Here to Help



The EPR eManual provides step-by-step instructions for EPR users. Regularly check the eManual as the content is constantly being updated. It is conveniently accessible from the first icon on the toolbar in EPR. Call H-E-L-P (4357) internally or (416)340-4800x 4357 to reach the Helpdesk 24 hours a day, 7 days a week.

Allergy Assessment

- For patient safety, an Allergy assessment **MUST** be entered PRIOR to placing any orders for patient
- If food allergies are updated/changed, the diet must be reordered.
- Drug/Latex/Environmental Allergies and Food Allergies are entered differently. (see a below)

- Under the Assessments Tab, select Allergy/Adverse Reaction
- Choose the Source of the information
- Medication Allergy: Choose the Document Allergy/Adverse Reaction or No Known Medication Allergy/Adverse Reaction button

To Document an Allergy Adverse Reaction:

- Select the allergen

If not found on the Common Allergy Option List, please note:

For Drug/Latex/Environmental Allergies: Perform a partial word search to find the allergen listed in EPR. Free-texting should be used as a last resort. EPR will not check for potential interactions /alerts.

For Food Allergies: Partial word search is prohibited. You must select the food allergen from the list of common options or free-text the allergen.

- Select the most severe symptom presented (only one can be selected) and click OK
- In the Addt’nl Symptom field, select all additional symptoms (multiple can be selected) and click OK
- Document another Medication Allergy/Adverse Reaction, if required or click OK to continue

The system will now prompt you to document the following: (follow a - d above)



- Food Allergy - *partial search is prohibited
- Latex / Other Allergy
- Complete all remaining mandatory fields and click Accept to save

Diet Order Entry

- From the Patient Shortcuts, select Order Entry
- Select the Order Type (not in use are verbal/written or telephone/written)
- The current date and time will automatically populate (use the drop down menu to change)
- Select the appropriate Order Author (or search for another Order Author) and click OK
- Click on the Order Selection tab
- Click on the All Nutrition folder
- Select the appropriate Diet Type and click Add Order
- On the Typical Orders screen, select a further option, as desired
- Click on the Order Profile tab
- Follow the system prompts to complete the order, editing as required (consistency, modifier [vegetarian, kosher, halal], and/or supplemental feeding)
- If there are any free-text food allergies, enter in the Comment field (to appear in the Nutrition System)
Tip: Refer to Patient Dashboard for the food allergen with a yellow highlight and asterisk
- Click Order Summary and Accept Order

Modify a Diet By Copying

NOTE: Every time food allergies are updated, the existing diet order must be re-entered. Use the **Copy Orders** and **Edit** options to quickly update the diet order - or start from scratch. Never use the **Change** button to edit diet orders (as the changes will not be transferred to the Nutrition System)

Example of how to copy an existing diet order:



- From the Patient Shortcuts, select Order Entry
- Select the Order Type (not in use are verbal/written or telephone/written)
- The current date and time will automatically populate (use the drop down menu to change)
- Select the appropriate Order Author (or search for another Order Author) and click OK
- From the Order History tab, select the diet order you want to modify
- Choose **Copy Orders** - **Never use the Change button**
- From the Order Preview area at the top of the screen, select the diet and click on Edit
- An advisory screen appears to inform of a duplicate procedure. Click on the **Order Profile** tab to bypass
- Make the edits necessary to complete the order.
- Enter any free-text allergies in the Comment field** (in order to appear in the Nutrition System)
- Once changes are complete, click OK
- Click Order Summary
- Accept Order

Height & Weight Assessment

- Under Assessments, click Height and Weight
- Enter the actual date+time of the assessment
- Enter Height in cm
- Enter the Height again to confirm this value (these two figures must match)
- Select the Height Method used
- Enter Measured Weight in kg
- Enter the Weight again to confirm this value (these two figures must match)
- Select the Weight Method used
- Choose Accept

A patient’s height and weight should be assessed at every visit and changes documented in the EPR.

Chart Review

Chart Review is read-only access to a patient’s orders, results, reports and other health documentation from all of their visits to UHN.

Chart Review Navigation:

Black text:

- Will immediately provide a detailed list of all events for that category

Blue text:

- Contains a sub-menu with additional options

Grayed out area:

- No information is currently available under this category for this patient

Clinical Research

Alerts are displayed in:

- The Caution’s Triangle
- The Patient Dashboard

Detailed Study Information:

- View Clinical Research Study link

Reports

From the Print Functions tab on the Main Desktop click on the report that you want to generate (e.g., Alpha Census) and fill in the report parameters (e.g., Visit Type, Start Date, etc.)

Hard Copy of the Report:

- Click Accept

Email Copy of the Report (Toronto Rehab):

- Click the Continue Editing button
- Select the Print Queue field to Edit
- Click on the Mail button
- Click Ok and then Accept

To View the Emailed Copy:

- Click on the Mail icon at the top-right of your EPR Desktop
- Highlight the report that you generated
- Click the Report button at the bottom of the screen (it may take several minutes or hours to generate and appear in your EPR Mail Account.)