SOP Name:	Administrative Notes in the Provincial Electronic Medical Record (Prov EMR)
Effective Date:	2024-12-16
Next Review Date:	2027-08-20
Revision Dates:	This is to be completed every 3 years as per Health PEI's policy review cycle and standards.
Related SOPs, Directives, Policies, & Forms:	
Owner/Approved:	Provincial EMR Program Standards Committee

Purpose:

Establish a standardized process for using Administrative Notes within the Provincial Electronic Medical Record (Prov EMR) specifically for clinical/administrative and patient safety reasons. Administrative Notes should **only** be marked as **Important** if they are patient safety related or outlined in this SOP. This will ensure accurate, consistent, and efficient documentation that supports patient care and clinic operations.

Important Administrative Notes should be limited to reduced pop-up fatigue and improve workflow efficiency.

Definitions:

- **Administrative Notes:**

A place to document administrative notes that cannot be documented elsewhere in the chart.

- **Important Administrative Notes:**

An administrative note that is flagged as Important to document information that is deemed critical to patient safety and should be viewed by all users of the system. An Important Administrative Note will pop up for all users every time the chart is accessed.

Scope:

- This standard applies to all users of the EMR who perform documentation.
- Health care providers and other users will record administrative notes in accordance with approved guidelines for documentation in the health record.

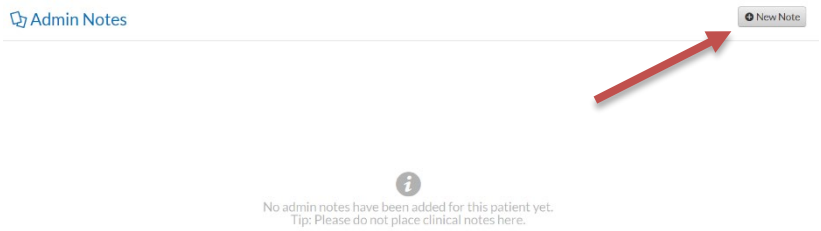
Applications and procedures

• Important Administrative Notes should be used when there are patient safety concerns that should be seen by all users of the system. Important Administrative Notes include:
  ◦ High Risk Behaviour (Please refer to Microsoft Word - Primary Care and Chronic Disease High Risk Behaviour (Flag) Alert Procedure (2-pager))
  ◦ Same or similar name warning
  ◦ Suspected Narcotic Use
• Both Important and Administrative Notes should not be used to document the following:
  ◦ Health Card information
  ◦ Preferred communication methods
  ◦ Next of Kin information
  ◦ Vital Signs
  ◦ Preventive Care Due Dates
  ◦ Medical History
  ◦ Referrals
  ◦ Information directed at a particular user
  ◦ Reminders for tasks (this does not include hyperlinks to the FORM Section)
  ◦ Allergies
• The EMR Program will complete annual quality analysis on Important Admin note end dates.

Documentation process for any EMR user: (Visual steps in Appendix A)	
1	Navigate to the top right corner of the screen and click on the Start/Open tab.
2	Search for Admin Note on the drop-down list.
3	Once opened, click on add new note on the top right corner of the “Admin Note” interface.
4	Assign a title to your note.
5	Clearly and concisely describe the clinical administrative activity, including relevant information to ensure patient’s safety.
6	Select the adequate option for the information provided on the Note: ▪ Mark as important (The note will pop-up when you open this chart) ▪ Mark as private (This note will be visible only to the author)
7	Ensure to fill in start and end dates of the activity (except for perpetual reminder, then do not include end date).
8	Click on Save once the note is completed.

Appendix A:

Procedure Steps: (Visual steps in Appendix A)		
1	Navigate to the top right corner of the screen and	

	click on the Start/Open tab.	
2	Search for admin note on the drop-down list.	
3	Once opened, click on add new note on the top right corner of the "Admin Note" interface.	
	4 Assign a title to your note. **5** Clearly and concisely describe the clinical administrative activity, including relevant information to ensure patient's safety. **6** Select the adequate option for the information provided on the Note: -Mark as important (The note will pop-up when you open this chart) -Mark as private (This note will be visible only to the author) **7** Ensure to fill in start and end dates of the activity (except for perpetual reminder, then do not include end date). **8** Click on Save once the note is completed.	

References

(1) Quality of outpatient clinical notes: a stakeholder definition derived .... https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-12-407.

(2) Guidelines for Effective Use of the Electronic Medical Record (EMR) - AAMC. https://bing.com/search?q=primary+objective+of+clinical+administrative+note+in+an+electronic+medical+record.

(3) Electronic Health Records: Chapter 1 Flashcards | Quizlet. https://quizlet.com/821902756/electronic-health-records-chapter-1-flash-cards/.

(4) Improving clinical documentation: introduction of electronic health .... https://bmjopenquality.bmj.com/content/10/1/e000918.

(5) Guidelines for Effective Use of the Electronic Medical Record (EMR) - AAMC. https://www.aamc.org/media/28271/download?attachment.

(6) Sharing Clinical Notes With Patients Toolkit - American Medical Association. https://www.ama-assn.org/system/files/2021-04/sharing-clinical-notes-with-patients-toolkit.pdf.

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