SOP Name:	Encounter Documentation by MOA in the Provincial EMR
Effective Date:	February 12, 2025
Next Review Date:	February 12, 2028
Owner:	Provincial EMR Program Standards Committee

Purpose:

The Encounter Documentation by Medical Office Assistant (MOA) Standard Operating Procedure (SOP) outlines the standard documentation steps to ensure encounter documentation for independent administrative clinical duties is focused on relevant and significant information and that routine tasks/communications are dealt with via internal messages. Encounter documentation is reserved for a contact between a patient and a provider who exercises independent judgment in the provision of clinical services.

Scope:

The scope of this standard operating procedure applies to all areas within Health PEI using the Provincial EMR and where MOA Encounter Documentation workflow has been approved by their service/clinic leadership. The MOA 1 with Encounter permission will need to be applied as the Provincial EMR user role.

MOA creating encounters is within scope in the scenarios below:

1. To start the workflow for a patient/client visit to be completed and signed off by clinician/provider.
2. For MOA specific patient interactions not involving other clinicians and requiring clinical documentation.

Terms & Definitions:	
Encounter Documentation	Encounter documentation is: • Comprehensive recording of all aspects of patient visits including history, examination, assessment, treatments, follow up plans, prescriptions, and billing. • Documentation that serves as the primary source of a patient's status record. • Documentation that meets program and quality standards • Essential for continuity of care, facilitating communication among providers and ensuring patient safety. Encounter documentation is NOT: • An administrative task (e.g. booking an appointment, sending records, adjusting referrals, uploading patients' files) • Routine or scheduled orders (e.g. a standing order for blood draws where the lab results will still be

	integrated into the patient's record, collecting urine samples)
Internal Messages	Internal Messages: • Serve as a platform for discussing immediate patient concerns, coordination of care, updates and inquiries. • Allows for quick exchange of information regarding patient care, treatment plans, and coordination efforts. • Enhances collaboration and decision-making among the care team. Internal Messages are NOT: • A comprehensive record of patient's status, assessments, and interventions. Intended to replace or serve as a substitute for encounter documentation.
Medical Office Assistant (MOA)	MOA's play an essential role in providing support to providers and clinicians ensuring efficient patient management and smooth office operations. In addition to managing front office functions (greeting and registering patients, scheduling patient appointments, administrative tasks such as handling phone calls, managing patient records, managing medical supplies, etc.) they may under the direction of a provider perform limited clinical duties (take blood pressure, weight, etc.; manage incoming labs and radiology results). MOAs cannot make independent medical assessments or decisions, triage (unless it is an emergency), prescribe, renew prescriptions, or give any type of medical advice.
Routine Administrative Tasks	Request for appointment scheduling, messages from parent/guardian to clinical staff, appointment reminders, scheduling changes, day to day exchanges that are not independent clinical duties.

Application and Procedure

Reasons for MOA encounter documentation:

1. Creating Encounters to start the workflow for a patient/client visit to be completed and signed off by clinician/provider.

    a. To record the independent administrative clinical duties performed by MOA's that impact the overall patient interaction and ensure that continuity of care is maintained by having all relevant information in the same place as provider documentation (e.g., recording vitals; urine dip?)

    b. To gather information to complete forms, documents and case histories to begin the encounter to then be completed and signed off by another member of the clinic team during the patient visits.

    c. To record **No Show** appropriately. If the encounter was started prior to appointment time for preparation work, the MOA may have the responsibility in the clinic to update the Presenting Issue to "**No Show**" and sign to close the encounter. The process ensures appropriate clinics statistics are gathered.

2. Creating Encounters for MOA specific patient interactions not involving other clinicians and requiring formal clinical documentation.
    a. To record any significant communication with the patient/parent/guardian/family member that imposes a risk for the patient, or if a change in patient's status is reported. (e.g. incidents where a patient/family member makes abusive or threatening phone calls, current custody status and who has authority to make care decisions)
    b. To record interactions with patients at the clinic with behaviors or symptoms indicating risk, and who left without being seen by a clinical team member.
    c. Record when a patient calls with medical concerns such as Chest Pain, STROKE symptoms, or others that require urgent care.

#	Description
1	You can start an encounter from: • The appointment on the schedule • The **Visits** dashboard • The patient's chart
2.	Clearly and concisely document the clinical independent activity in the appropriate Encounter section.
3.	The Provincial EMR auto-saves within 10 seconds of every change you make. You also could save at anytime. a) Use Save function only when creating Encounters to start the workflow for a patient/client visit to be completed and signed off by clinician/provider. Use "Sign" function when creating Encounters for MOA specific patient interactions not involving other clinicians and requiring formal clinical documentation as outlined in this SOP.

Approvals:
Provincial EMR Program Standards Committee

References
https://reachhealth.org/wp-content/uploads/2011/10/UDS-Definitions.pdf Clinical Documentation in Electronic Health Record Systems: Analysis of Patient Record Review During Outpatient Ophthalmology Visits - PMC Generating Clinical Notes for Electronic Health Record Systems - PMC
Attachments
For more information on starting or completing encounters please review TELUS CHR provided guides: https://help.inputhealth.com/en/collections/119229-encounters