PowerChart Nursing Downtime Procedure

Objective:
The goal of Patient Care Services is that the standard of patient care for nursing documentation and patient care orders be maintained during PowerChart downtime and recovered when the PowerChart system is restored.

Purpose:
The purpose is to define a systematic method of accessing patient information, documenting patient care and recovery of information and patient care orders when the computer system is unavailable due to planned or unplanned downtime.
Provision:

**Downtime Activity**

**Documentation**
A downtime packet for use during downtime will be available to all inpatient nursing units through Forms on Demand. Each nursing unit is responsible to keep at least one paper downtime packet available in the event the network system is unavailable. Each downtime packet will contain the paper substitute for electronic documentation specific to each unit. These packets will only be used during downtime.

**Orders**
All physician orders will be documented in the paper medical record on the Physician’s order sheet and will be sent via OrderComm to the appropriate departments. In the event the network system is unavailable, orders will be faxed or hand delivered to appropriate departments.

During downtime, all pre-existing active orders and active tasks will be available on each nursing unit through a downtime report available on the nursing unit.

**Downtime Recovery**

**Documentation Recovery**
If downtime lasts four hours or less, all patient care documentation will be entered into the electronic forms once the computer application becomes available. If paper documentation forms are used, they will be placed in the paper medical record to be scanned into the electronic medical record upon the patient’s discharge.

If downtime exceeds four hours, all paper documentation will remain on the paper downtime forms and be placed in the patient’s paper medical record to be scanned into the electronic medical record upon the patient’s discharge. When the computer application becomes available, medication administrations, medication history, allergies, intake and output, vital signs, initial or updated height and weight will be entered into the electronic forms so no interruption will exist in graphable data.

During downtime if the clinician completes his/her shift, regardless of the length of time downtime has been in process, the care provided must be documented on the paper forms and placed in the paper medical record to be scanned into the electronic medical record upon the patient’s discharge. When the computer application becomes available, the intake and output, vital signs, initial or updated height and weight will be entered into the electronic forms so no interruption will exist in graphable data. Medication history will be entered into the Medication List. Medications administered will be entered into the MAR by proxy.
If the intake and output, vital signs, allergies, and medication history documentation is electronically entered by a staff member other than the individual making the original paper downtime entry, the individual entering the data will sign the proxy signature on the downtime form to be placed in the patient’s paper medical record.

If downtime forms are to remain part of the patient’s paper medical record, the caregiver will document “Yes” on the Downtime Documentation question on the electronic Vital Signs form, once the system becomes available. This will denote that some patient information may not be part of the electronic chart due to downtime, and can be found as part of the patient’s paper medical record.

**Orders Recovery**

One-time orders that have already been completed will not be entered into the electronic system.

If the physician wrote paper continuing or future orders, or performed Medication Reconciliation, he/she will be responsible for entering those orders and Medication Reconciliation into the electronic medical record.