1. **Registration**
   * 1. Keep paper log of all registered patients. Date and time must be included with this for back entry when system is active again.
        1. If you can access a computer enter information on sticker form.
        2. Use word to make labels for patients if electricity is available.
        3. If no computer access at all, handwrite on the form with patient’s name, middle initial, date of birth, and event times.
     2. Have patients sign paper Consent to treat form, write or sticker patient’s information. This will be scanned back into EHR by HIM.
     3. Sticker with or write patient’s information on the paper Discharge Safety Checklist (DSC) this will be scanned back into EHR by HIM.
   1. Make Copies of insurance cards, and driver’s license, if not available please hand write information on required form.
   2. All times will be back entered into the computer system manually.
      1. Coordinate with Front Desk Registration and Clinical IT for back entry.
2. **Nursing**
   1. **Documentation**
      1. Once notified of the downtime all forms needed to document will be in the file drawer at the nurse’s station.
      2. Nursing assessment will be documented on the Emergency Department Nursing Assessment forms (adult/pediatric). All forms must be dated and signed before getting to HIM.
         1. All forms must be stickered or handwritten with patient identifiers.
         2. HIM will scan all forms when the system is active again.
         3. Any patients admitted to Med Surg will need to have a copy of their assessment taken to the floor for the receiving nurse.
   2. **Medication Administration**
      1. Keep track of administrations, rate changes, and stop times on MAR part of the assessment forms.
      2. All administrations, rate change, and stop times will need to be entered into the Epic MAR when system is active again.
      3. **Person who didn’t give the medication-** use MAR action: **‘**Downtime Administration,’ Override Reason ‘Clinician Reported given by another. Then type “Per \*\*\* see paper MAR. Using that person’s initials.
      4. **Person who administered the medication**- use MAR action: **‘**Downtime Administration,’ Override Reason System Downtime.
      5. Refer to OMNICELL instructions for adding new patients to pull medications out of the OMNICELL.
   3. **Orders**
      1. New orders from providers need to be added to the order sheet: EKG, Lab, X-ray, and Meds.
         1. All orders need to be timed and dated
         2. The order sheet must have a provider’s signature.
      2. Admission order forms can be found in the filing drawer with other downtime forms. Please mark desired orders, time, date and sign and send to the floor.
         1. All admission orders will be entered by Med Surg nurses as written order mode when system is active again.
      3. Lab
         1. Any new orders after downtime will be back entered by lab when system is active again.
         2. STAT labs will be called as per normal.
      4. Radiology
         1. Any new orders after downtime will be back entered by radiology when system is active again.
         2. All radiology images will have to be viewed in radiology by the provider if we are **without internet/ PACS.**
3. **Provider Documentation**
   1. Directions for dictation is located in the cabinet above the physician’s computer.
      1. These will be in your inbasket to sign once transcribed by HIM.
         1. **Any patients that gets transferred out will have a form on word to fill out (fluency can be used if internet access).**
         2. **Other patients will be dictated**
4. **Admission**
   1. Admission order forms can be found in the filing drawer with other downtime forms. Please mark desired orders, time, date and sign and send to the floor.
      1. All admission orders will be entered by Med Surg nurses as written order mode when system is active again.
   2. Original documentation forms will be kept in ED for scanning or back entry into the EMR when the downtime is completed
   3. All admission/transfer times must be kept in a log by both departments.
5. **Discharges**
   1. ED Discharge Instruction form can be found in the drawer.
      1. A copy of this must be made and given to the patient with their signature and witness signature (Nurse), timed and dated.
      2. A sticker or written patient information must also be put on this form.
      3. All new prescriptions should be written on s script pad, and copied to be scanned and entered in when the system is active.
6. **Transfer Procedure**
   1. Please see section C for provider documentation
      1. Print from word, sticker/write patient information on form. Save a copy to be scanned into E H R during active time.
   2. Nursing documentation will be copied and sent
   3. Transfer forms will be completed per normal procedure.
7. Patients to OR
   1. Orders are to be hand written on paper case request/surgical order form.
   2. All transfers with in the facility should be timed and recorded on the log sheet.
   3. All information will be back logged into the system when active again because it drives charges.
   4. Pre-op
      1. Surgical consents-
         1. Fill out paper Consent to operation, anesthetics, and other medical services found in downtime binder.
         2. Confirm the procedure description with ordering surgeon.
         3. Surgeon will sign and date this form.
         4. Obtain signature from patient prior to the procedure.
         5. Place original copy in packet to go to OR with the patient.
            1. This will later be scanned into the E H R by HIM.

Any questions about documents that need to be scanned can go to the department manager or Clinical IT.

OMICELL INSTRUCTIONS

