Vermont Psychiatric Care Hospital Policy and Procedure		
Electronic Health Record Downtime		
Effective: December 2024	Revised:	Due to Review: December 2026

POLICY

It is the policy of the Vermont Psychiatric Care Hospital (VPCH) to establish a contingency plan for periods where the Electronic Health Record (EHR) system is unavailable or fails to perform as designed/expected. It is inevitable that the EHR system will experience downtime, and this policy aims to outline a process for continued operations and safe care delivery during any such event. Downtime operations will never be as efficient or as safe as normal operations and VPCH will make every effort to rectify functionality issues and return to expected EHR workflows as quickly as possible. Prolonged downtime events may impact our ability to safely admit and may require VPCH to activate Emergency Operations and/or Continuity of Operations Plans as determined by the VPCH Chief Executive Officer (CEO), or their designee.

DEFINITIONS

Downtime: any event where VPCH's EHR or a technology system that supports the EHR is unavailable or fails to perform as designed requiring use of an alternate documentation procedure.

PROCEDURE

Planned Downtime

When planning a downtime event, efforts shall be made to select times for scheduled maintenance that minimize impact to direct care workflows. Once a date and time have been identified for planned maintenance, one of the VPCH Clinical Informatics Analysts (CIA), or their designee, will inform VPCH staff of the upcoming downtime event through email communication. This communication should include, but may not be limited to the following:

- The scheduled start time;
- The anticipated duration;
- The rationale and any changes end users can expect; and
- Who to contact if unanticipated results occur.

VPCH end users shall again be notified by the CIA, or their designee once connectivity and functionality have been restored.

Unplanned Downtime

Whenever EHR end users experience unexpected functionality issues or concerns, they should immediately notify the on-duty nurse supervisor and/or their respective supervisor to troubleshoot and/or strategize how to best meet care and documentation demands and complete a corresponding event report.

If end users are unable to access the EHR or are experiencing problems with functionality systemwide, they should immediately notify the on-duty nurse supervisor and/or their respective supervisor. The supervisor shall contact the CIA, or their designee, and inform them of the issue.

For Agency of Digital Services (ADS) support for internet outages, the nurse supervisor or designee shall call the ADS support line at 802-828-6620. If after hours or on weekends, the ADS answering service will contact the appropriate individual on call.

The full scope and clinical impact of downtime events may not be readily apparent when the event initially occurs. However, the CIA, or their designee, will generate a communication to VPCH staff. This communication should include, but may not be limited to the following:

- What is known or understood at that time about the outage.
- The anticipated duration.
- Planned follow up action.
- Who to contact with questions and/or with additional information.
- Once a general understanding of the unplanned event is known, more information will follow.

VPCH end users shall again be notified by the CIA, or their designee once connectivity and functionality have been restored.

Downtime Computer

To maintain the integrity of the EHR, the downtime computer will be assessed every shift by the nurse supervisor on duty. If the downtime computer is not maintaining the most up to date documentation, the CIA will be contacted by the nurse supervisor on duty.

In the event of a downtime, certain elements of the backup charts are available for reference and certain elements are printed for anticipated use including:

- 5-day Medication Administration Records (MAR) – these are printed by Pharmacy for anticipated downtimes.
- Current provider orders.

Documentation

Downtime processes are to be utilized whenever a downtime exceeds two hours or will extend beyond a provider's regularly scheduled work hours. Real-time documentation is still required for the following:

- Mediation administration (via the printed MAR)
- New provider orders needed during the downtime.

Elements of documentation required during a downtime shall be completed on paper downtime forms in accordance with the department expectations detailed in Appendix A.
The completion expectation for elements of documentation that are routinely completed outside of the EHR (e.g. Precaution Monitoring, Seclusion/Restraint Records, Treatment Plans, etc.) are unchanged during a downtime.

The Quality Department is accountable for maintaining up to date versions of downtime forms which are available via the VPCH SharePoint site and identified downtime binder(s).

Documentation Reconciliation

MARs and provider order forms shall be left on the Pyxis machines in each medication room for collection by our Pharmacy team. Other chart forms completed during a downtime by all disciplines shall be placed in the corresponding individual's on-unit manila folder and our Medical Records department will collect and scan the paper forms completed during the downtime into the EHR (a folder titled downtime and date range) on the next business day following system restoration. Documents used to reconcile the electronic record should be scanned into a downtime folder.

Medication orders and medications administered will be reconciled in the EHR upon system restoration. The Pharmacy Director, or their designee, will be responsible for reconciling medication orders that were written, with the medications administered during downtime. Pharmacy will enter the medications into the EHR through data back-entry for the time frame that the EHR was unavailable to maintain the continuity of the chart. This will happen at a maximum of 24 hours following system restoration, and ideally as soon as connectivity has been reestablished.

Upon system restoration, providers will reconcile non-medication orders to ensure that all current orders are active in the EHR and conversely that all discontinued orders are no longer active in the EHR.

Reconciliation will NOT occur for discharges occurring during a downtime. Discharge-related documentation completed during a downtime will be placed in the individual's on-unit manila folder and our Medical Records department will collect and scan the paper forms completed during the downtime into the EHR (a folder titled downtime and date range) on the next business day following system restoration.

Post-Downtime Audit

Reviews of downtime events are performed by the Quality Department, or their designee, to monitor for policy compliance. The EHR Steering Committee will review downtime event data on a routine basis to help ensure clinical data needs for hospitalized persons' care are being met, and that the medical record retains integrity during such events.

Approved by	**Signature**	**Date**
Emily Hawes, Commissioner, Vermont Department of Mental Health	DocuSigned by: Emily Hawes C50275615A62462...	12/6/2024

Appendix A: Downtime Documentation Requirements by Department

NURSING			
Department	**Form**	**Documentation Expectation**	**Routing**
Nursing	Daily Assessment Flow Chart and Order Chron Acknowledgements	Not completed during a downtime.	n/a
Nursing	Progress Note (titled for admission, daily assessment, discharge, etc.)	Can be completed after 2-hour allotment but at least one note (two for NOC shift) containing relevant clinical updates and assessments must be completed by end of shift.	Place completed forms in the individual's on-unit manila folder.
Nursing	High-Risk Progress Note	Can be completed after 2-hour allotment but must be completed by end of shift.	Place completed forms in the individual's on-unit manila folder.
Nursing	Certificate of Need (CON) and Treatment Plan Addendum for Restraint/Seclusion	Can be completed after 2-hour allotment but must be completed by end of shift.	Place completed forms in the individual's on-unit manila folder.
Nursing	Certificate of Need (CON) and Treatment Plan Addendum for Emergency Involuntary Medication	Can be completed after 2-hour allotment but must be completed by end of shift.	Place completed forms in the individual's on-unit manila folder.
Nursing	Patient Debriefing Following Emergency Involuntary Procedure	Can be completed after 2-hour allotment but must be completed by end of shift.	Place completed forms in the individual's on-unit manila folder.
Nursing	Medication Administration Record (MAR)	Completed in real time.	Place completed forms on top of the unit pyxis machine

			for Pharmacy collection.
MEDICAL STAFF			
Department	**Form**	**Documentation Expectation**	**Routing**
Medical Staff	Comprehensive Physician Progress Note (CPPN)	Weekly Progress Note, completed weekly	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Physician Admission Assessment	Completed within three business days of admission	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Discharge Summary	Completed within five business days of discharge	Place completed forms in the individual's on-unit manila folder.
Medical Staff	7 Day Review of Non-Emergency Medication	When clinically indicated, completed weekly	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Implementation of Court Order Involuntary Medication	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.
Medical Staff	EIP Restraint New	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.
Medical Staff	EIP Seclusion	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Emergency involuntary meds	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.

Medical Staff	Brief Suicide Risk Assessment	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Medical Bed Note	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Medical Consultation Note	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Physician Fall Note	When clinically indicated, completed day of	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Telehealth CPPN	When clinically indicated, completed weekly	Place completed forms in the individual's on-unit manila folder.
Medical Staff	CN Performed	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.
Medical Staff	CN exam refused at admission	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Capacity Evaluation	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Neuro exam	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.

Medical Staff	Normal exam	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.
Medical Staff	Consult Order Request	When clinically indicated, completed before discharge	Place completed forms in the individual's on-unit manila folder.
RECOVERY SERVICES			
Department	**Form**	**Documentation Expectation**	**Routing**
Recovery Services	DAST-10	Completed with the hospitalized individual when possible; attempts documented in each TPR.	Place completed forms in the individual's on-unit manila folder.
Recovery Services	Practical Counseling note	Completed within 24 hours of providing this intervention.	Place completed forms in the individual's on-unit manila folder.
Recovery Services	Brief Intervention note	Completed within 24 hours of providing this intervention.	Place completed forms in the individual's on-unit manila folder.
Recovery Services	Substance Use Assessment note	When clinically indicated, completed before hospitalized individual discharges.	Place completed forms in the individual's on-unit manila folder.
Recovery Services	Recovery Services Note	Completed within 24 hours of a hospitalized individual participating in a therapeutic group or activity; completed within 24 hours of individual session.	Place completed forms in the individual's on-unit manila folder.
PSCYHOLOGY			
Department	**Form**	**Documentation Expectation**	**Routing**
Psychology	Individual psychotherapy note	Completed within 24 hours of an individual	Place completed forms in the

		psychotherapy session.	individual's on-unit manila folder.
Psychology	Multidisciplinary review note	Completed during morning rounds	Place completed forms in the individual's on-unit manila folder.
MULTIDISCIPLINARY			
Department	**Form**	**Documentation Expectation**	**Routing**
Multidisciplinary	Treatment Plan	Completed by the treatment team according to individualized hospitalized person's treatment plan schedule.	Place completed forms in the individual's on-unit manila folder.
Multidisciplinary	Patient Rights Acknowledgement	Completed upon admission.	Place completed forms in the individual's on-unit manila folder.
SOCIAL WORK			
Department	**Form**	**Documentation Expectation**	**Routing**
Social Work	Advanced Directive-Guardianships and Emergency Contacts	Completed within the first 24 business hours after admission	Place completed forms in the individual's on-unit manila folder.
Social Work	Comprehensive Social Assessment Note	Completed within the first 7 business days after admission	Place completed forms in the individual's on-unit manila folder.
Social Work	Discharge/Aftercare Form	Can be started at any time-completed on day of discharge	Place completed forms in the individual's on-unit manila folder.
Social Work	Social Assessment Note	Completed for an admission/stay less than 5 business days	Place completed forms in the individual's on-unit manila folder.

Social Work	Social Work Progress/Discharge Planning Note	Completed weekly for first 2 months and then biweekly after	Place completed forms in the individual's on-unit manila folder.
Social Work	Social Drivers of Health	Completed within the first 7 business days after admission	Place completed forms in the individual's on-unit manila folder.