HOW WILL MY ROLE CHANGE?

A snapshot into the new day-to-day role of a

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WHERE WE ARE NOW...	SAFER. BETTER. SMARTER.
Patients tell their story over and over again.	The creation of a longitudinal chart where information (e.g., allergies, home meds, a patient's medical history, etc.) is accessible visit to visit and across multiple sites.
Physicians currently write orders that are entered by others.	Physicians will enter the orders which are then immediately sent to the appropriate area (e.g., Lab, DI, etc.).
Minimal order sets currently exist. Physicians have to write repetitious orders and at times recall infrequently ordered items.	Physicians will have access to more than 350 peer-reviewed, evidence-based order sets. The access reduces repetition and assists with decision support in situations that are not encountered frequently. Physicians will have the ability to mark their favourite order sets with a yellow star for quick access.
Time is spent hunting down information.	Secure access to patient information on devices from wherever it is needed—the hospital, office, patient's bedside.
Written, hard-to-read orders	Safer care and fewer interruptions to clarify illegible orders.
Poor turnaround on dictation reports causing delays to other providers.	Physicians will document faster through embedded voice recognition recorded from any device. The system is designed to auto-populate fields such as medications, allergies, past medical history or the physician's frequently used phrases.
The physician guides the discharge summary. Information on discharge is scattered throughout the chart.	Universal discharge: everyone on the care team is contributing to the discharge plan, creating a multidisciplinary approach. A patient discharge summary is generated with standard design and predictable information.

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