CANADA

PROVINCE OF NOVA SCOTIA

IN THE MATTER OF THE

FATALITY INVESTIGATIONS ACT

S.N.S. 2001, c. 31

THE DESMOND FATALITY INQUIRY

TRANSCRIPT

HEARD BEFORE: The Honourable Judge Warren K. Zimmer

PLACE HEARD: Port Hawkesbury, Nova Scotia

DATE HEARD: March 12, 2021

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1 **March 12, 2021**

2 **COURT OPENED (09:30 hrs.)**

3

4 **THE COURT:** Thank you, Good morning.

5 **COUNSEL:** Good morning, Your Honour.

6 **THE COURT:** Mr. MacKenzie, I understand you're going to

7 present at least a witness this morning, is that correct?

8 **MR. MACKENZIE:** Yes, Your Honour, thank you.

9 **THE COURT:** Thank you.

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1 **ALYSON LAMB, affirmed, testified:**
2
3 **DIRECT EXAMINATION**
4
5 **MR. MACKENZIE:** Good morning, Ms. Lamb, can you hear me
6 okay?
7 **A.** Good morning. I can, yes.
8 **Q.** Okay. As you know, my name is Daniel MacKenzie. I'm
9 here on behalf of the Nova Scotia Health Authority. I am going
10 to ask you some questions today, in particular about something
11 called a One Person-One Record, or OPOR. Before we begin, I
12 think we've been using that term interchangeably with One
13 Patient-One Record, or One Person-One Record. Can you clarify
14 which one is right so we can get the record straight?
15 **A.** The official name is One Person-One Record.
16 **Q.** One Person-One Record. Thank you. And you're in
17 Halifax this morning?
18 **A.** I am, yes.
19 **Q.** How's the weather in Halifax?
20 **A.** Sunny and beautiful.
21 **Q.** So, Ms. Lamb, I'm going to ask you some questions
22 about your educational background and your professional

ALYSON LAMB, Direct Examination

1 experience. Perhaps it makes sense to bring up exhibit number
2 270 and that's, I think, your *CV*. Can you see that okay?
3 **A.** I can, thank you, yes.
4 **EXHIBIT P-000270 - *CURRICULUM VITAE* OF ALYSON LAMB**
5 **Q.** Okay, great, and you recognize that as your *CV*?
6 **A.** I do recognize that as my *CV*, yes.
7 **Q.** Okay. So we're going to start at the bottom of page
8 two and go through your educational background, okay?
9 **A.** Okay.
10 **Q.** So I don't need to hear about high school but maybe
11 you can take us through your educational background beginning at
12 the University of Guelph.
13 **A.** Yes, thank you. So I did do a Baccalaureate in
14 Biomedical Science at the University of Guelph from 1999 to
15 2003. I then proceeded to the University of Toronto to do a
16 Baccalaureate in Science in Nursing. Then I did practice
17 nursing in Nova Scotia and then returned to Dalhousie University
18 to complete a Masters in Health Administration and a Masters in
19 Nursing, graduating in 2014 from there.
20 **Q.** Okay, I think we all have a pretty good concept of
21 what the Bachelor of Science in Nursing is, but what is the
22 Masters of Health Administration and Master of Nursing program?

ALYSON LAMB, Direct Examination

1 **A.** So it was a combined program that Dalhousie University
2 offered with their School of Health Administration and their
3 School of Nursing. It is a four-year program that the health
4 administration really focuses on leadership and some of the
5 foundational components of leading in the health care system.
6 And then the Masters in Nursing was really focussing on graduate
7 level nursing education and theory of nursing, and I did do a
8 thesis that looked at nursing leadership in the advanced
9 practice role, or what many of you may be familiar with, nurse
10 practitioner and their ability to lead within the health care
11 system.
12 **Q.** Okay. And I understand that you hold various
13 certifications and registrations and those are at page three of
14 your *CV*.
15 **A.** Yes, that is true. Most pertinent would be my active
16 registered nursing license here in Nova Scotia.
17 **Q.** Okay. And what about the certified professional
18 health information management, what's that certification?
19 **A.** So that certification, I have the Canadian CPHIM,
20 which the CA indicates at the end of that, and it is a
21 certification focussed on the management of health information
22 and all the components that go into that. So the technology

1 side of it, the privacy/confidentiality aspects of it, and how
2 we manage information.
3 **Q.** Okay. Under "Achievements", it lists there
4 certificate for completion of certified health information
5 management executive, chief informatics manager bootcamp. That
6 looks to have been completed recently. What can you tell me
7 about that?
8 **A.** I just finished a six-week bootcamp that I had
9 received a scholarship for through the CHIME, which is an
10 American organization of certified health information management
11 executives. The course focussed on really components of
12 leadership as a chief informatics officer and how from an
13 information management and technology to support health care
14 systems. So developing your teams, looking at change
15 management, and some of that further skillset leadership.
16 **Q.** I would like to turn now to your "Professional
17 Experience" and I think that goes in reverse chronological order
18 there. So we will start at page two, just above "Education",
19 and you can take us through that, if you don't mind, your
20 professional background.
21 **A.** Certainly. So post graduation, I did write my
22 registered nurse exam, completed that successfully and started

1 practising in Nova Scotia as a registered nurse for Capital
2 District Health at the time, in several different units, medical
3 and surgical inpatient focus. And then I, at the same time, I
4 worked part-time at The Red Door, which is an adolescent sexual
5 health clinic in Kentville, Nova Scotia.
6 I proceeded to complete my critical care certification from
7 the Registered Nursing Professional Development Centre, which
8 was under Capital Health at the time, and now Nova Scotia Health
9 Authority. When I completed that, I took a job in the critical
10 care unit, or 3A-ICU, Intensive Care Unit, for several years.
11 From there, I moved into quality inpatient safety leader
12 role, in a performance excellence program with a focus in
13 quality and patient safety. And then I took a management or
14 health service management role for a surgical unit and a couple
15 of ambulatory care clinics at the QEII.
16 And then I went to the IWK and took a director of nursing
17 professional practice role for a couple of years and that's what
18 led me into the One Person-One Record position.
19 So I initially started as the lead for One Person-One
20 Record for the IWK as part of my nursing and professional
21 practice role and then took the interim chief nursing
22 informatics officer position when the person who was in that

1 role had to go off. So I've been part-time in the interim chief
2 nursing officer role for two years, approximately, but in full-
3 time position for one year. And then most recently, you'll see
4 I was asked to step into the Senior Director of COVID Planning
5 and Implementation in January. So I've been doing that in
6 addition to the interim clinical nursing informatics officer
7 position.

8 **Q.** So when I'm reviewing your *CV*, the first reference I
9 see to One Person-One Record is in that time you spent at the
10 IWK beginning October 2017. Is it fair to say that that's when
11 it started to become part of your world?

12 **A.** Yes, a few months after that. I would probably say
13 January of 2018 but, yes.

14 **Q.** Okay, so you've been living One Person-One Record in
15 one form or another now for three years or so, a little more
16 than years.

17 **A.** Yes.

18 **Q.** And so your current role, I know that you're wearing a
19 couple of hats right now, but is it chief nursing informatics
20 officer, that's your title right now?

21 **A.** Yes.

22 **Q.** And so you've kind of touched on it, but what is the

1 role of the chief nursing informatics officer, generally
2 speaking?
3 **A.** So, generally speaking, it is to support clinicians in
4 their workflow in the adoption of technology and the ability to
5 have the right information at the right time to provide care.
6 So it really is understanding how information flows through the
7 clinical pathways to support care of patients and/or residents,
8 depending on who ... and clients, depending on what population
9 of patients, and that adoption of technology into the health
10 care system, understanding the parameters in which we have to
11 work from a legal, registration, and so on.
12 **(09:40)**
13 **Q.** So before I get into One Person-One Record and access
14 to records, I think it would be helpful to clarify some of the
15 things that are outside of your area of expertise and maybe
16 outside of your knowledge. So to begin with, to your knowledge,
17 have you ever had any interactions with the late Lionel Desmond?
18 **A.** I have not, no.
19 **Q.** You never interacted with him personally or
20 professionally, to your knowledge.
21 **A.** No, I have not.
22 **Q.** So other than maybe what you've read in the newspaper

1 or on-line, you're not familiar with Lionel Desmond's case or
2 the care he was receiving in advance of January 3rd, 2017?
3 **A.** No.
4 **Q.** So if I were to ask you questions about that, that's
5 not something you can speak to.
6 **A.** That is not something I can speak to, no.
7 **Q.** And while we're on the subject of things that are
8 maybe outside of your knowledge and expertise, I understand that
9 there's a procurement process in place as it relates to One
10 Person-One Record, is that correct?
11 **A.** There is a procurement process in place for One
12 Person-One Record clinical information system, yes.
13 **Q.** But that's not a Health Authority procurement process,
14 correct?
15 **A.** No, that is being led by the Province of Nova Scotia.
16 **Q.** And you're not employed by the Province of Nova
17 Scotia, correct?
18 **A.** No, I'm employed by IWK and Nova Scotia Health.
19 **Q.** So if I were to ask you questions about that
20 procurement process and the pricing of it, could you talk about
21 that?
22 **A.** No, I do not have that knowledge.

ALYSON LAMB, Direct Examination

1 **Q.** And the same question with respect to timing of that
2 process, can you speak to that?
3 **A.** No, I can't speak to that.
4 **Q.** So if anybody has questions about the procurement
5 process and where things stand on that, it's better directed
6 perhaps at the Province of Nova Scotia, is that fair?
7 **A.** Yes, that's fair to say.
8 **Q.** On the issue of timing, though, generally on One
9 Person-One Record, once and if everything is approved and green-
10 lighted and you've got the vendor who is going to provide the
11 product, you can talk about the timing thereafter of the rollout
12 of that program, is that fair?
13 **A.** In general, I can speak to what the proposed timings
14 are after approval, yes, but not to the timing of the approval
15 and procurement process.
16 **Q.** So switching gears now to issues that are within your
17 expertise and knowledge and within your current role, I am going
18 to get to One Person-One Record, I think it's helpful to have a
19 quick overview of current systems before we get there. And I
20 understand that Ms. Linda Plummer is going to be testifying this
21 afternoon and she might be able to give a bit more detail on
22 those issues but I will ask you a few questions about the

1 current state of things before we talk about the future, okay?
2 **A.** Excellent.
3 **Q.** So this is a very question but what is the current
4 state of systems for electronic patient records in the Nova
5 Scotia health care system?
6 **A.** In the Nova Scotia health care system, particularly
7 from a hospital perspective, we have several quite old,
8 nonintegrated clinical systems. So I think it's easier if I
9 describe based on zone and the IWK. So, at the IWK, we have a
10 system called MEDITECH Magic implemented in the early '80s and
11 it provides some electronic functionality and does also store
12 historical health records.
13 In Western, Northern, and Eastern Zones, the Nova Scotia
14 Health Authority, there is a MEDITECH client server systems.
15 They are three separate instances of MEDITECH client server and,
16 again, provides some electronic health record functionality.
17 Those systems are not integrated, do not talk to one another.
18 And then in Central Zone, we have a compilation of "best of
19 breed" system that were formerly known as McKesson products.
20 McKesson is no longer in the market so they now go under
21 different product names. But, again, it's a "best of breed" so
22 we have a system called STAR for registration, PHS for

1 scheduling, and a multitude of other systems for other elements
2 of electronic systems that help support patient care.
3 Many of the systems across the province, like I said, are
4 old. They are in need of significant upgrade and certainly,
5 hence, the vision of One Person-One Record clinical information
6 system. We are still a combination of paper and electronic in
7 our provision of care and not a seamless integration across the
8 province or between facilities, for that matter.
9 **Q.** We've also heard about something called OneContent. I
10 don't know if you mentioned that. Can you speak to OneContent?
11 **A.** So OneContent is one of the many systems I was
12 speaking of in Central Zone, not the IWK, but in Central Zone.
13 So the QEII, Tri-Facilities, Hants. It is a scanning and
14 archiving system. So it's essentially an electronic filing
15 cabinet where paper documents are scanned and fed into that
16 system and then clinicians can log on and see historical
17 documents or try to site them through to find what they need.
18 Everything has a barcode and is filed that way. It's still
19 difficult but there's a lot of information there to find what
20 you need in a timely way.
21 **THE COURT:** Okay, we're just going to stop. So we're
22 getting some background noise and I don't know where it's coming

1 from.

2 **MR. MACKENZIE:** I think it's the heater in that office, if

3 I'm not mistaken.

4 **MS. BENNETT-CLAYTON:** I think it might be some

5 construction noise outside.

6 **THE COURT:** Call the police. They're interfering with

7 the judicial proceedings.

8 **MS. BENNETT-CLAYTON:** I can take a break, if you want me

9 to, because there's a large crane just outside the window and I

10 can see that it may be coming up, so it may get a little noisy

11 here for about five or 10 minutes. I don't know if you want to

12 continue or take a break?

13 **THE COURT:** I think what we'll do is we'll take a break.

14 It will just be easier on everybody's nerves, quite frankly.

15 Maybe you can just stay in touch with Mr. MacKenzie. Mr.

16 MacKenzie, you can be in touch and when it seems that the noise

17 or the crane has cleared the immediate area, we'll come back.

18 Thank you.

19 **COURT RECESSED (09:46 hrs.)**

20 **COURT RESUMED (10:06 hrs.)**

21 **THE COURT:** Thank you. Thank you, Counsel. Thank you,

22 Mr. MacKenzie. Thank you, Ms. Lamb.

ALYSON LAMB, Direct Examination

1 **MR. MACKENZIE:** Hello, again.
2 **MS. LAMB:** Hello.
3 **THE COURT:** No cranes in earshot, I hope.
4 **MS. LAMB:** No, we're hoping not.
5 **THE COURT:** Mr. MacKenzie, when we left off, you had
6 asked the question about OneContent and the answer related to it
7 being a Central Zone system. It was a scan and archive-type
8 system, electronic filing cabinet where clinicians could log in
9 and review whatever scanned documents were in a particular
10 patient's file, I take it.
11 **MR. MACKENZIE:** Yes.
12 **THE COURT:** All right.
13 **MR. MACKENZIE:** Ms. Lamb, were you able to hear Judge
14 Zimmer's summary right there?
15 **A.** I did, yes.
16 **Q.** Okay, and that's all correct from your perspective?
17 **A.** Yes, it is.
18 **Q.** I'm hearing a bit of an echo. I don't know if that's
19 on your end.
20 **A.** We do not hear an echo.
21 **Q.** Okay, I hear an echo of my own voice. So I guess
22 we'll just proceed, unless that's an issue.

1 **THE COURT:** We're good.
2 **MR. MACKENZIE:** We're good, okay. One system that we heard
3 about earlier this week was called Nightingale, and I appreciate
4 that I think that was in relation to a private clinic, but do
5 you know anything about Nightingale?
6 **A.** I do know Nightingale was a former vendor for
7 electronic medical records quite commonly used early on in Nova
8 Scotia's primary care EMR world. So, yes, they are a private
9 clinic or a family physician electronic medical record that was
10 used. They've been bought now by one of the other two companies
11 that exist in the province today for primary care clinic EMRs.
12 **Q.** And what sort of primary care clinic EMRs are in
13 existence at the moment? In Nova Scotia, I should say.
14 **A.** There's two vendors that the province supports. One
15 is a Telus product and the other is an Accuro product, I
16 believe. I don't work in the primary care private physician
17 space but there is two vendors that are supported currently in
18 the province.
19 **Q.** Okay. So we've talked a little bit about MEDITECH,
20 MEDITECH Magic, OneContent. I can't recall if I asked you about
21 SHARE or not, did I ask you about SHARE?
22 **A.** You didn't, no, but I'm certainly happy to speak to

1 it.

2 **Q.** Please do.

3 **A.** So SHARE is the name of a provider portal that
4 laboratory, diagnostic imaging, transcribed reports are sent to
5 electronically to make available in a read-only format to
6 clinicians across the province. So it does give an ability for
7 clinicians to see patient results, not all results but some
8 results from areas outside the facility in which the clinician
9 is practising. So, for example, if a patient were to get
10 bloodwork, let's say, in Kentville and then come in to Halifax,
11 the clinician in Halifax could log on to SHARE portal and mostly
12 likely be able to see the bloodwork that was done, let's say, at
13 Valley Regional in Kentville but it's only lab ...

14 **Q.** And you said most likely would be able to see. Sorry,
15 go ahead.

16 **A.** Depending on the timing and when the patient arrived
17 depends on when the bloodwork was processed and the results
18 uploaded. So there is some timing that plays into this but,
19 yes, most likely as long as the patient has the bloodwork done
20 and the lab results were back in then the results should be in
21 the SHARE portal for the clinician in Halifax to see.

22 **(10:10)**

ALYSON LAMB, Direct Examination

1 **Q.** Okay, so when you say, most likely available, the only
2 reason you wouldn't be able to see that is because of ordinary
3 lag time in getting the record uploaded into the system,
4 correct?
5 **A.** Correct, and ensuring SHARE is working properly. It
6 is an old system, it sometimes has downtime.
7 **Q.** So are there any existing systems that I didn't ask
8 about that you wanted to address or speak to, other than OPOR?
9 **A.** No, I don't think so.
10 **Q.** So you've described some systems and I think you've
11 described them as being old. Let's switch gears now and talk
12 about the future. In broad strokes, what is One Person-One
13 Record?
14 **A.** So One Person-One Record is the province's, and I say
15 province because it's a collaboration of the Department of
16 Health and Wellness, Nova Scotia Health, and the IWK, to have a
17 single, integrated health record for every Nova Scotian. And
18 that's the vision. So, essentially, it's built on the pillars
19 of ensuring that the right information is available for both the
20 right patient and the right provider at the right time. The
21 beginning of that vision and what we are currently working on is
22 the replacement of the antiquated clinical information systems I

1 was talking about before. So the replacement of MEDITECH Client
2 Server in Eastern, Northern and Western Zones. The replacement
3 of MEDITECH Magic at the IWK, and the compilation of hospital
4 systems in Central Zone, in addition to the extension into the
5 Community Mental Health and Addictions because they currently
6 don't have an electronic system. So that is the part of the
7 project that it's working on now. So it is a replacement of
8 those foundation hospital systems that will then allow us to
9 build further into the community and achieve the overall vision.
10 **Q.** So I'm going to ask you a couple of questions where I
11 think the answer might be obvious but what is the benefit of
12 OPOR from a clinical perspective?
13 **A.** So from a clinical perspective, the benefit of One
14 Person-One Record is to have an integrated clinical information
15 system that allows the patient's health information to be in one
16 location accessible to providers at the time that they need it.
17 So that is the benefit and it also allows the patient to have
18 access to their information at the time they need it as well.
19 **Q.** And is it the hope that this is going to be in every
20 hospital in Nova Scotia or would this include the family doctor
21 has access to everything and the private clinic as well, or
22 psychologists in the community?

ALYSON LAMB, Direct Examination

1 **A.** The initial part of the project that is currently
2 approved and being approved in the sense the conduct is approved
3 is the replacement of the clinical information systems for the
4 IWK and Nova Scotia Health. It does not include any private
5 clinicians in the community.
6 **Q.** So that's the preliminary phase, I gather. Is there
7 another phase to this?
8 **A.** There is a hope there will be additional phases that
9 will allow the integration, for example, the community family
10 physician or primary care practices that are private in
11 existence that have the two vendors we were speaking of earlier,
12 the integration of those patient records into the Nova Scotia
13 Health, IWK, One Person-One Record, and then eventually there
14 could be a possibility of other health providers within the
15 community having access but that is a long-term plan, not the
16 immediate plan.
17 **Q.** And so I saw in your *CV* when you were describing some
18 of this, you mentioned that pre-implementation and an
19 implementation. And, again, I'm not asking about the
20 procurement process but are those two distinct phases in the
21 rollout here of OPOR?
22 **A.** Yes, so the pre-implementation, essentially, is the

1 readiness work that we are currently doing, which is identifying
2 opportunities for consistency in clinical practice and clinical
3 standards. So using the same assessment tools across the
4 province for the same type of issue. I guess the simplest
5 description would be, for example, a pain assessment tool.
6 There's many other there but when we want to be able to
7 seamlessly transfer information using the same assessment tool
8 across the province. So, for example, if you go into the
9 emergency department and someone asks you what would you rate
10 your pain and you say five, and then you are then transported
11 into the inpatient unit and they ask you again what your pain is
12 and you say now it's four, we want to make sure everybody is
13 using a scale of zero to 10 because then we can all know that
14 your pain is moderate and, if we gave you medication, it's
15 better with the medications because you then rate it at four but
16 we're all using the scale of zero to 10 versus a scale of one to
17 five, zero to five. So we're working on getting consistency
18 across the province in the assessment tools and documentation
19 we're using in our current systems and that will help us as we
20 move into implementation of a new clinical information system
21 because, in that build, we will build those standard assessment
22 tools, for example, in there and it will make that change

1 management easier for clinicians because they'll just be
2 changing to use a new technology versus new practices in their
3 clinical area of expertise.
4 **Q.** So I think you've explained the concept of OPOR but
5 can you talk about what the technology looks like? Is this
6 every doctor on an iPad, every doctor on a computer? How do
7 they log into this system? Or is that still to be determined?
8 **A.** That's actually still to be determined. It depends on
9 the vendor and when that happens. As I'm sure all of you know,
10 technology is rapidly advancing in this space. So it will
11 require clinicians to log on to a piece of technology to access
12 something. That could be an iPad, that could be a laptop, that
13 could be a handheld device of some form.
14 **Q.** Is it fair to say that OPOR is an intraprovincial
15 system?
16 **A.** Yes, we only have jurisdiction over Nova Scotia Health
17 and IWK records.
18 **Q.** Right. So, in theory, if the OPOR was in place and
19 somebody who lives in New Brunswick shows up in a Nova Scotia
20 ER, they're not going to have access to their records via OPOR,
21 correct?
22 **A.** No, they will not.

ALYSON LAMB, Direct Examination

1 **Q.** And is the thought that with OPOR that the patient
2 would also have access to that record themselves?
3 **A.** Yes, part of the plan is for Nova Scotia to have a
4 patient portal that would allow patients to have access to their
5 hospital records in the care that has been delivered here in
6 Nova Scotia Health or the IWK.
7 **Q.** So, hypothetically, if I lived in Nova Scotia,
8 received treatment in Nova Scotia, and then I moved to Oromocto
9 or Gagetown, New Brunswick and I present at the hospital there
10 and they say, Okay, what's your situation? Could I easily log
11 on and say, Well, I'll just get you my medical records, they're
12 right here on this portal. Is that the thought?
13 **A.** The patient could have access to their records, yes.
14 They wouldn't be able to download them and share them
15 immediately. There would have to be a release of information
16 but they could share them using their view with the clinician in
17 New Brunswick, yes.
18 **Q.** So, in theory, that could be something that they've
19 got on their smartphone. They can show the doctor right then
20 and there what's been happening in Nova Scotia.
21 **A.** In theory, yes, that's the way the technology should
22 work, yeah.

ALYSON LAMB, Direct Examination

1 **Q.** So I'm going to talk about some of the barriers to the
2 rollout of OPOR. Well, I'm not going to talk about them, I'm
3 going to ask them. How does privacy impact OPOR's rollout and
4 moving forward with that system?
5 **A.** Certainly, the **Personal Health Information Act**, when
6 we think about custodianship of all that, custodianship of
7 health records, we have to fall within all of those, that
8 legislation and understand that. So, you know, OPOR will
9 certainly, we often use the term in health care, the circle of
10 care. So clinicians who are within the circle of care, the
11 patient will have access to their records, access to different
12 aspects of the new clinical information system will be role-
13 based. So you will only have access to what you need to do your
14 job. So we will be governed under the legislation that
15 currently exists today. In a clinical information system, it
16 does mean that we will have to set the system up to abide by the
17 legislation.
18 **(10:20)**
19 **Q.** Right. And is there not a certain component to this
20 as well where, if we've got a system of OPOR and I present at an
21 emergency department to have a leg fracture dealt with, is there
22 not still a privacy component that I don't necessarily want the

1 doctors treating my leg fracture to know about my problems as a
2 teenager with mental health? Is there nuance to this or is it
3 all everything goes in one place?
4 **A.** So those are conversations that we certainly need to
5 have as Nova Scotia and the IWK, to determine how we want to set
6 up the system. So there certainly is opportunity in these new
7 clinical information systems to ... the term that's often used
8 is "put it behind a glass wall". So if there is very sensitive
9 information that patients may not want shared, it can go behind
10 a glass wall and that glass wall then needs to be broken and
11 there's an audit trail behind that, as there is an audit trail
12 behind all of the system, to determine and you have to have
13 special permission to break that glass. So if you were coming
14 in for a leg facture and did not want an element of your care
15 seen by the clinicians, it could go behind that glass and have
16 to be broken only with permission.
17 **Q.** I see. Is physician buy-in a big part of OPOR?
18 **A.** So physician buy-in is a significant part of any
19 transformation in health care and certainly One Person-One
20 Record is. And literature would show you and previous
21 implementations do indicate that physician and all clinician
22 buy-in needs to be there. It's a significant change. So

1 certainly the support and willingness, it's needed for the
2 adoption and rollout to go well. So, yes, physician buy-in is a
3 significant part of our readiness for right now and that's what
4 we're focussed on, engaging physicians and determining where
5 their pain points are in today's system so we can ease those
6 with the adoption of new technology.
7 **Q.** And you've described it as a significant change and I
8 appreciate that it's still a somewhat abstract concept because
9 it's not in effect yet. But what does the change look like on a
10 day-to-day basis for physicians, nurses, clinicians, and so on
11 and so forth.
12 **A.** So for the majority of clinicians in Nova Scotia
13 today, when a patient comes in, there's a large amount of paper
14 that is printed that they're documentating on paper, forms are
15 completed, then oftentimes that form is scanned and made into an
16 electronic format to either go in the health record or down to
17 pharmacy to continue on with the medication processes. You're
18 also gathering previous information on that patient, whether by
19 paper or by OneContent, for example, in Central Zone. So old
20 archived information. You're accessing multiple systems to
21 gather the information you need to develop the care plan.
22 In the future state in One Person-One Record, you would be

1 logging into one system, you would be accessing historical
2 information within that same system as well as documenting the
3 new information in that system. Multiple clinicians could be in
4 the same health record documenting at the same time.
5 So you could have a physician documenting their assessment
6 while a registered nurse, who just completed the vitals, for
7 example, blood pressure, heart rate, oxygen saturation on a
8 patient, entering that information and that would immediately be
9 there for the physician to continue on in their plan of care for
10 that patient.
11 **Q.** You've talked about the implementation phase and how
12 this seems to be a bit of a gradual rollout of the program, is
13 that fair?
14 **A.** Once the official approval happens, it is planned on a
15 gradual rollout. Obviously, as you all know in health care, we
16 cannot stop admitting patients to implement new technology. So
17 business needs to continue as-is and we continue to care for
18 patients as we implement new technology.
19 So the old technology needs to be shut down and, at the
20 same time as new technology is stood up and that comes with a
21 significant amount of planning. So a slow, gradual rollout,
22 learning as we go, will be important.

1 We have learned from previous provinces who have
2 implemented new clinical information systems in jurisdictions
3 and best practice certainly does reflect a thoughtful timing on
4 the implementation, particularly when you are talking about an
5 entire province. So we are planning for a several-year rollout
6 across the province but the one thing to remember is that it
7 would be all the functionality of the clinical information
8 system would go live in one jurisdiction so that within that
9 jurisdiction, everybody would be using the new technology and
10 then we move on to another jurisdiction. So it is a thoughtful
11 implementation over a couple of years.
12 **Q.** And so if somebody said to you that, Look, we want
13 this to happen faster, we don't agree with the gradual rollout,
14 here's all the resources to get it done, is that a good idea
15 from your perspective or are you concerned about the issues you
16 were just raising?
17 **A.** I would be concerned about the issues I was just
18 raising. We do need to continue to provide care to patients at
19 the same safe high level quality that we do today while we
20 implement significant change. So that certainly has to be put
21 into consideration even with, quote/unquote, more resources
22 being pushed towards the implementation.

1 **Q.** Is continuity of care an ongoing concern as you
2 address all of these potential changes?
3 **A.** It's certainly part of the planning. You know,
4 patient safety is our utmost responsibility in providing that
5 care. So that is our number one focus as we plan the
6 implementation.
7 **Q.** So let's say we're a few years down the road and, or
8 more than a few years down the road, and somebody shows up, OPOR
9 is in place but patient is coming from another jurisdiction.
10 Clinician decides, Hey, we'd like to see that person's records
11 from Alberta. Does OPOR change that process?
12 **A.** No, it does not change that process. They would still
13 need to call about, in the example you're giving, Alberta Health
14 Services. There would have to be with the consent of the
15 patient release of that patient information to Nova Scotia
16 Health or the IWK and then that, if there was consent given and
17 the records released, the records could then be uploaded into or
18 scanned, if it was paper that came, into the One Person-One
19 Record and then viewed that way. But not, for example, if the
20 patient was in Emerg and they said, I've just moved here from
21 Alberta. You know, the immediate access to those records does
22 not change with One Person-One Record.

1 **Q.** So there's not a thought that this is going to change
2 consent requirements and what other jurisdictions are going to
3 need from us when we're requesting documents from them, correct?
4 **A.** Correct.
5 **Q.** Are there any other barriers to moving OPOR forward
6 that we haven't already discussed?
7 **A.** I don't think so at this time, Daniel. I think we
8 have addressed most of those barriers. I guess the one thing
9 that I could say is that most of the new technology uses good
10 network infrastructure and, certainly, I think we need to make
11 sure that that network infrastructure, for example, wifi, is
12 strong enough and accessible enough in all our facilities within
13 Nova Scotia Health and that is one of the key dependencies to be
14 able to make sure One Person-One Record works well right across
15 the province.
16 **Q.** Well, thank you, Ms. Lamb, those are all of my
17 questions. My friends might have some questions for you.
18 **A.** Thank you.
19 **THE COURT:** Thank you. Mr. Murray?
20
21
22

1 **CROSS-EXAMINATION BY MR. MURRAY**

2 **(10:30)**

3 **MR. MURRAY:** Good morning, Ms. Lamb, how are you?

4 **A.** Good, how are you?

5 **Q.** Good, thank you. I have a couple of questions to help

6 me understand the process now and what change may come and, as I

7 said to you when we spoke before, I may ask some questions that

8 seem a little basic but please bear with me.

9 Ms. Lamb, your job right now is chief nursing informatics

10 officer. What is informatics?

11 **A.** It really is the translation of information from a

12 work flow into delivery of care. So it is the ability to

13 understand from the clinical and patient perspective what is

14 needed so that the technology is able to support the care

15 delivery. So, for example, when we ask a patient, Do you have

16 any allergies, and we document those allergies, that information

17 then should flow through to every other element in the health

18 record where allergies is needed. So instead of, if any of you

19 have had that experience, you're probably asked your allergies

20 10 times on admission. So it is the ability to understand and

21 translate that clinical information into the programmer's

22 ability to create the system to actually allow that smooth work

1 flow for clinicians and patients.

2 **Q.** That helps me, thank you. So there's information that

3 has to get to clinicians and technology has to make it happen

4 and that's what you do.

5 **A.** Right.

6 **Q.** Okay. And your position right now, it says, I

7 understand, is jointly held by the IWK and the Nova Scotia

8 Health Authority. So the IWK is not part of the Nova Scotia

9 Health Authority.

10 **A.** Correct. They're separate organizations.

11 **Q.** So I'd like to ask you a couple of questions about the

12 system as it is now, or the variety of systems. If any of these

13 questions, we will be hearing from Linda Plummer, if any of them

14 are better directed to her, by all means tell me that, but just

15 so I understand. So you said we have four zones and we have

16 different systems in each of those zones and the IWK has its own

17 system. So you said that at IWK the system is MEDITECH Magic

18 and that in the Eastern, Western, and Northern zones, it's

19 MEDITECH Client Services. And then there is a patchwork of

20 services ...

21 **A.** Client Server, yeah.

22 **Q.** What's it called, Client?

1 **A.** Server.
2 **Q.** Client Server.
3 **A.** E-R. Not Service.
4 **Q.** Right, gotcha, okay. And then there are a number of
5 systems in the Central Zone. So just so I understand,
6 presently, you said the MEDITECH Client Servers systems do not,
7 they're not integrated. They don't talk to one another.
8 **A.** Correct.
9 **Q.** So even though they are the same systems, they really
10 aren't. They don't communicate with one another.
11 **A.** They're not the same instance is the term that's used,
12 so, yes, it's not like you log on and could see a patient. If
13 you were in Yarmouth, you wouldn't be able to log on to MEDITECH
14 Client Server in Yarmouth and see a patient in Inverness.
15 **Q.** Okay.
16 **A.** For example.
17 **Q.** Right. And the same goes for MEDITECH Magic that the
18 IWK uses then as well.
19 **A.** Correct.
20 **Q.** So within one region, let's say in the Eastern region,
21 just so I understand, if I log on to MEDITECH in, say,
22 Antigonish, will I see all of the information for that patient

1 that may have been entered into the MEDITECH system in Eastern
2 Zone. So, for example, if the person visited a hospital in
3 Sydney, would I see that in Antigonish?
4 **A.** So I think Linda can give you even more detail around
5 this but, in Sydney at the Cape Breton Regional, they still
6 document mainly on paper, whereas in Antigonish, the non-
7 physician parts of the clinical team document electronically and
8 physicians still document on paper. So when MEDITECH Client
9 Server was implemented in the mid '80s, I think, early '90s
10 maybe, we did things module by module and never fully completed
11 the implementation essentially. So physician documentation
12 wasn't implemented at that time so, hence, why they still
13 document on paper in much of Eastern Zone, all of Eastern Zone,
14 sorry. But at Cape Breton Regional, they didn't actually
15 implement any of the documentation parts of MEDITECH Client
16 Server. So it's just the scheduling, registration, lab, DI, or
17 diagnostic imaging, sorry, that is implemented.
18 **Q.** Okay.
19 **A.** So there's nuances essentially within each zone that
20 do not make a complete health record for any one patient
21 electronically.
22 **Q.** Okay, I see. So there are those limitations in terms

1 of what gets entered into the system but whatever gets entered
2 into MEDITECH, let's say, in Sydney, you said diagnostic imaging
3 may be one thing that gets entered, I would be able to see that
4 in Antigonish, if I logged on to MEDITECH.
5 **A.** Yes.
6 **Q.** Okay, but I would not be able to see if diagnostic
7 imaging was entered into MEDITECH in Kentville, I would not be
8 able to see that in Antigonish.
9 **A.** Unless you were to log on to SHARE and then you could
10 see it through SHARE. But, again, that's a separate log-on,
11 yeah.
12 **Q.** Understood. And we've heard about the SHARE system.
13 So, in different regions, there's different types of information
14 that are entered on to the various MEDITECH systems, depending
15 on what degree of implementation has happened for those systems,
16 is that ...
17 **A.** Right. So entered into the system electronically
18 things are ... anything paper is scanned and entered into the
19 historical part of MEDITECH.
20 **Q.** Okay, but not everywhere.
21 **A.** Sorry, can you clarify what you mean by not
22 everywhere?

1 **Q.** I understood that when you talked about Sydney, for
2 example, that not all of the doctors' records were entered into
3 MEDITECH.
4 **A.** So they're not entered electronically into MEDITECH.
5 They would write on paper. It is still our responsibility to
6 maintain those records.
7 **Q.** Right.
8 **A.** So they're either maintained in paper or they're
9 scanned and archived into MEDITECH. So, again, there is not
10 consistency, and Linda Plummer can speak more thoroughly to the
11 nuances of what we scan and archive where.
12 **Q.** Fair enough. And the OneContent system that we have
13 in Central Zone, you said that's ... What exactly goes into
14 OneContent, because we've heard about that as well?
15 **A.** So OneContent is the scanning and archiving or the
16 electronic filing cabinet that I spoke of earlier. So in
17 Central Zone, all clinicians, majority, I can't say all, sorry,
18 the majority of clinicians still document on paper. We do have
19 some electronic documentation systems in some select areas
20 within Central Zone. For example, in the operating room, nurses
21 document on a system called Horizon Patient Folder but, for the
22 most part, people, all clinicians document on paper that's

1 scanned and archived into OneContent.

2 **Q.** Okay. And the SHARE system allows clinicians in other

3 regions to log on to that system and see some of this

4 information from the other regions. Say, I could log in to

5 SHARE from Eastern Zone and see some of the material on

6 OneContent from Central Zone. Is that correct?

7 **A.** I don't believe. I think all that goes to SHARE is

8 lab, DI, and transcribed reports. So if a transcribed report

9 from an operating room or a discharge, not all of the

10 information in OneContent but OneContent also has transcribed

11 reports, discharge summaries that also would feed into SHARE.

12 **Q.** And, again, this may be more detailed than you're

13 comfortable telling us and that's, by all means, say that, but

14 there are limits then, if I log into SHARE in Eastern Zone to

15 look at OneContent for a patient in Halifax, there are some

16 things that I will see and some things that I will not be able

17 to see through the SHARE system. Is that correct?

18 **(10:40)**

19 **A.** So when I log on to SHARE, to the best of my

20 knowledge, I do not access OneContent through SHARE. OneContent

21 is a Central Zone information. What is pushed to SHARE is

22 transcribed reports and discharge summaries. So, for example,

1 as a registered nurse, the assessment that I did on a patient
2 in, for example, critical care, would not be seen on SHARE. It
3 doesn't go to SHARE at that stage if I'm in an ICU in Halifax in
4 OneContent.
5 **Q.** Okay, all right. So there's only certain ...
6 **A.** Because they're not ... OneContent, yeah.
7 **Q.** Go ahead, sorry, I interrupted you.
8 **A.** It's only certain ... So it's lab reports, diagnostic
9 imaging, transcribed reports, discharge summaries that go to
10 SHARE, as well as in Central Zone, they go to OneContent.
11 Because SHARE is a read-only. It's an opportunity ... It's a
12 makeshift way for people to have access across the province to
13 some elements that they most likely need to provide care if
14 people are receiving care outside of their usual jurisdiction,
15 for lack of a better description.
16 **Q.** Okay, and is information from other MEDITECH Client
17 Server systems pushed to SHARE? So, in other words, if in
18 Eastern Zone I log on to SHARE, might I see some of that
19 information, say, from Western Zone, would some of that
20 information be pushed to SHARE?
21 **A.** Again, just lab, DI, transcribed reports, and
22 discharge summaries.

1 **Q.** Right, gotcha.
2 **A.** Yeah.
3 **Q.** But the same principle applies.
4 **A.** Same principle, yeah. We send those feeds to that for
5 read-only, view-only situation, yeah.
6 **Q.** Okay. And there are a couple of other systems that
7 you made reference to in Central Zone that relate more to
8 scheduling, I think, or registration. The STAR system, the PH
9 system or, I'm sorry, I don't know if I have the name right.
10 **A.** PHS.
11 **Q.** PHS, is it, for scheduling and STAR for registration,
12 is that correct?
13 **A.** Yes.
14 **Q.** Okay. So there is a patchwork of electronic systems
15 in the province, for sure.
16 **A.** Yes, If you were to draw it out, it often looks like
17 spaghetti on a plate. There are so many different systems with
18 feeds thrown everywhere. If you want a visual, that's probably
19 the best way to describe it.
20 **Q.** Okay, all right. And did I understand you, as well,
21 that there are, for private clinicians, there are a couple of
22 systems that, and I appreciate this is not the environment in

1 which you work, but there are a couple of systems that are
2 approved, I guess, for private clinicians to use?
3 **A.** Yes. There are two systems that are, I would say,
4 supported by Nova Scotia for private clinicians to use.
5 **Q.** Okay.
6 **A.** And that would be private physicians. When you go
7 beyond medical physicians, I'm unsure. There's probably a
8 multitude of other systems available for dentists, other private
9 clinicians.
10 **Q.** Okay, for physiotherapists, psychologists, dentists,
11 chiropractors, whatever, okay.
12 **A.** Right.
13 **Q.** And you said that the SHARE system, because it's an
14 older technology, and this is my word, I'm sorry, can be a bit
15 glitchy or it can have downtimes. Has that been the experience,
16 I think?
17 **A.** Yes, yes. So when SHARE has a downtime, you don't
18 have access to that information. You have to call the hospital
19 in which the patient would have received that care and ask to
20 speak to someone to get, if they needed information immediately,
21 would be the best way to do it. They try to get SHARE up as
22 soon as they can if there's a technical issue but there are

1 sometimes technical issues.
2 **Q.** Are there systems presently that allow physicians, any
3 of the systems that are up and running in the province, to enter
4 records electronically at the first instance or is it pretty
5 much paper everywhere that's subsequently scanned in?
6 **A.** It is paper that is scanned in for the most part.
7 There's a few areas that they are able. For example, in the
8 operating room in some parts of the province, anesthesiologists
9 can enter information in. But, again, for the most part, if
10 they're able to enter the information in electronically, it's
11 been printed and scanned into the chart.
12 **Q.** Oh, really. So they may type it ...
13 **A.** We don't have a (inaudible - audio).
14 **Q.** Type it, print it off, and then scan it back in.
15 Sorry, and I ...
16 **A.** I know that seems nonsensical but that is how these
17 nonintegrated old systems work.
18 **Q.** All right. And the present systems, if I am a private
19 clinician, I'm a private physician, let's say, in my office, I'm
20 not at an NSHA hospital, I'm just in my office on Main Street
21 kind of thing, do I have access to MEDITECH or OneContent?
22 **A.** No, you would have access ... you could have access to

1 SHARE portal to get those pieces of information we've spoken of,
2 but you would not. If you have hospital privileges, then for
3 the care that you're delivering in the hospital, you would have
4 access to the hospital systems, but not in your private clinic.
5 You have access to SHARE to get lab, diagnostic imaging,
6 transcribed reports.
7 **Q.** So just SHARE, not ... Okay, all right. And then,
8 obviously, then a patient doesn't have access to their own
9 record. There's no patient portal presently. That's something
10 that's contemplated with One Person-One Record.
11 **A.** Correct, yes.
12 **Q.** To the extent that you can say presently, and again
13 this may be more a Linda Plummer question, but material that's
14 entered on to an electronic record presently, say, through
15 MEDITECH, there's probably ... Is there a categorization or an
16 organizational system for that information? In other words, if
17 I logged on to MEDITECH in a hospital, say, in Antigonish, and
18 looked at a patient's record, would it have a category for lab
19 results, a category for, you know, discharge summaries, a
20 category for, I don't know what. Is it set up that way?
21 **A.** Yes, you could say it is set up that way. You know,
22 in broad (inaudible) means, typically categorized

1 chronologically, is a pretty standard way that the information
2 is organized within the EMRs, yes.
3 **Q.** So, basically, just in a chronological sense.
4 **A.** It is ... Lab reports are sectioned off as lab reports
5 and then, chronologically, within the lab reports. So if I had
6 bloodwork taken five years ago, that would be at the bottom and
7 my most recent bloodwork would be at the top. That's typically
8 how things are sorted within a clinical information system. So
9 categorized and then chronological order. And then, typically,
10 if something is a high alert or certainly like in laboratory, if
11 something is outside of normal parameters, it's highlighted in
12 some regard to draw the attention to the clinician to look into
13 that.
14 **Q.** Does somebody have to do that to highlight it in that
15 way?
16 **A.** No, typically, the system itself is set up,
17 particularly when it's lab. When there are quantitative number
18 parameters or we can set the rules in, even in MEDITECH, they
19 set the rules of what the limits are and then if it's outside
20 that limit, it's flagged with highlighting or whatever the flag
21 is for that. If it's a numerical parameter that a yes/no rule
22 can be written for, that can be done without a human having to

1 do it. If that makes sense.

2 **Q.** Is there an example of something that might fall into

3 that category that might be highlighted?

4 **A.** So, for example, many of you may know the drug,

5 warfarin, used commonly as a blood thinner, you need typically

6 monthly or weekly bloodwork done to monitor your INR, which is a

7 parameter that will indicate if your blood is too thick or too

8 thin and then there's numerical parameters put around that. So,

9 if your number was too high, your blood is too thin. So you

10 would see it bolded or highlighted on your monthly bloodwork and

11 the clinician would know that they ordered it, to go in and

12 look, and if they saw it was too high, you would often get a

13 call indicating you need to reduce your dose of warfarin, for

14 example.

15 **Q.** Okay.

16 **A.** But it isn't a lab technologist that has to flag that

17 because the system is set up to know where the INR parameters

18 are and then it automatically triggers that highlight for the

19 clinician.

20 **Q.** The way that the various systems are set up across the

21 regions, I guess what I'm referring to is the way that the

22 information is categorized or organized. Is that the same

1 across all the systems across the region or is it a little
2 different in each region?
3 **(10:50)**
4 **A.** It would be a little different.
5 **Q.** Okay.
6 **A.** It's no different that when you walk into Sobeys on
7 one street and Sobeys uptown, the way that they organize the
8 same products is different, depending on the Sobeys. It's the
9 same concept in the clinical information system.
10 **Q.** Okay.
11 **A.** It's organized differently, whether who set it up or
12 the vendor itself.
13 **Q.** Presently, prior to us moving to One Person-One
14 Record, if a clinician at a Nova Scotia Health Authority
15 facility were to obtain information from another province, let's
16 say, could that be or would that be scanned and entered on to my
17 electronic record?
18 **A.** So, yes, within the system that it is. So, for
19 example, in Halifax, if a clinician obtained patient records
20 from outside the province, they would be scanned into
21 OneContent. But that would be in OneContent only. It wouldn't
22 be in the MEDITECH systems so ... Because, again, we do not

1 have a provincially integrated clinical information system. So
2 you have different health records for the same patient in each
3 zone.
4 **Q.** Okay, so ... And that would only be if the clinician
5 that obtained it was at an NSHA facility, correct?
6 **A.** Yes. So if it was a private clinician that obtained
7 it in the community, they likely would scan it into their own
8 local EMR, but then other clinicians would not have access to
9 that.
10 **Q.** Right. So if they scanned it into their own system,
11 it would only be that particular clinic or doctor's office that
12 would be able to see it. And if it's a clinician at an NSHA
13 hospital, they may scan it in, but then it would only be
14 viewable in that region, correct?
15 **A.** Yes.
16 **Q.** Okay. If information comes presently to a clinician
17 and, let's say, it does get scanned in. So let's say a patient
18 just says, you know, I just came from another province, here's a
19 whole lot of records that, you know, I brought with me on a
20 disk, or what have you, if they were printed and scanned into
21 that person's electronic health record, would they be
22 categorized in the same way that the other information is or

1 would they be kind of put in a bundle at the bottom that said
2 miscellaneous or other province or something like that?
3 **A.** Your latter description is accurate.
4 **Q.** Okay, all right.
5 **THE COURT:** Could you say that again?
6 **DR. MURRAY:** Judge Zimmer just asked me to ask that
7 question again. So if a patient had a bundle of documents that,
8 say, they brought from another province and provided them to a
9 clinician at the Nova Scotia Health Authority and that clinician
10 had them printed and scanned into their record, their electronic
11 health record presently, I'm asking how they would be
12 categorized. Would they be broken down into, you know, lab
13 results, discharge summaries, all of that, or would they be put
14 in in an electronic category kind of at the bottom? I think the
15 words I used were like miscellaneous or other province?
16 **A.** They are not filed and sorted separately. It would
17 come as historical record altogether. Miscellaneous,
18 essentially. Historical miscellaneous documents.
19 **Q.** Okay, and that's about as much description presently
20 as there would be?
21 **A.** Right.
22 **Q.** And do I understand that documents that are now being

1 scanned into the various systems, is there a barcoding system or
2 something like that that kind of tells the system where to file
3 them?
4 **A.** Yes, that is correct. Official Nova Scotia Health and
5 the IWK forms do come with a scannable barcode on them. So that
6 when scanned, they are filed in the appropriate folder and then
7 if paper comes that is not barcoded, we then label it with the
8 patient identification and an appropriate barcode so it can be
9 scanned and put in the right folder or in the miscellaneous
10 folder, if there is no appropriate folder that exists for that
11 documentation.
12 **Q.** Okay. So in my example of the patient that arrives
13 with, say, the manila envelope full of papers from, you know,
14 treatment in another province, those are being scanned. Are
15 there going to be different barcodes on things at all? Like,
16 say, there's a lab result in there, a diagnostic imaging,
17 anything like that? They would just all go into the
18 miscellaneous basket.
19 **A.** No. Because it is not Nova Scotia Health information,
20 it is historical patient information from another jurisdiction.
21 So it is all together filed, barcoded as historical in that
22 miscellaneous folder of historical information.

1 **Q.** Okay. So we're moving to One Person-One Record and,
2 again, jumping over whatever approvals or procurement, those
3 types of things, if that happens and if it all comes to
4 fruition, you said the rollout will be gradual and it will be
5 different in the different regions. In other words, you are not
6 going to do it province-wide. Is that the plan?
7 **A.** So the plan is to do it province-wide but, as I've
8 described the different systems in the different zones, we will
9 go zone by zone, essentially, for the rollout. So because, for
10 example, in Central Zone, all within the geographical range,
11 clearly the IWK sits right beside the VG or the QEII, but they
12 are on separate systems. So the IWK rollout will happen and
13 then the QEII would happen, because we have to take down
14 different systems and then stand up a new system. So it is a
15 thoughtful gradual rollout over a couple of years that really is
16 geographically redefined because of the systems that exist today
17 and how we have to take down the old systems but also be able
18 to, quote/unquote, cut over so the information does need the
19 immediate information of those patients that are in hospital
20 beds. On the night we cut over, we still need to make sure we
21 can care for them. So that's a whole thoughtful data migration
22 plan and how we continue to provide good care in the midst of a

1 major change. So it is via geography, essentially, how we would
2 roll out.
3 **Q.** So not necessarily zone by zone but ... I guess I
4 didn't really understand ...
5 **A.** It is essentially (inaudible - audio).
6 **Q.** I may have been mistaken. I thought that the rollout
7 may be planned to occur first in Central Zone and then,
8 subsequently, in some of the other zones. Did I understand that
9 correctly or was I wrong about that?
10 **A.** Yes, that's what I was describing but the nuance of
11 Central Zone is you have two separate organizations because the
12 IWK is not Nova Scotia Health. So we have to be thoughtful of
13 that within Central Zone.
14 **Q.** Okay, all right. And, again, once when and if this
15 project starts, are there anticipated timeframes for the various
16 regions or zones, I guess I should say?
17 **A.** It could be regions by that point. So, yes, there is
18 some general timelines that we're working with. We have done
19 environmental scans. We've read all the reports from other
20 implementations on how things have gone well and how do you
21 learn from others that have gone before you. And, yes, there is
22 some general timelines through that period that we're

1 anticipating over a couple of years to roll out. So we want to
2 roll the new system out, stabilize it, make sure everything is
3 okay, and then move on to the next. It is anticipated overall
4 to take approximately four years from the time we start until
5 the time we finish the project from an implementation, give or
6 take.
7 **Q.** Have other provinces implemented a similar One Person-
8 One Record system?
9 **A.** So the only provincial implementation that is
10 currently happening is in Alberta right now and they are on Wave
11 Four of an Eight-wave rollout, I believe. And they, too, have
12 gone ... Their system is set up slightly different than ours
13 from a zone perspective but they have gone geographical location
14 to geographical location in their rollout as well. But they're
15 the only other provincial rollout that I'm aware of. There's
16 other provinces that have jurisdictions that have come together
17 and rolled out. Ontario, for example, there would be different
18 ... they use a local integrated health network model, or used
19 to. That doesn't exist anymore but they did do several local
20 integrated health networks have, for example, the North East
21 (LIHN), which is relatively the same size as Nova Scotia, they
22 have come together and have one clinical information system

ALYSON LAMB, Cross-Examination by Mr. Murray

1 there that they just ... I don't think they're completely
2 finished their rollout. But, again, it's a phased thoughtful
3 rollout typically based on geography. You start and then you
4 roll out to the rest of the area.
5 **(11:00)**
6 **Q.** And I know you've said this and just so that I'm clear
7 and I understand, the information that will ultimately be in the
8 One Person-One Record is Nova Scotia Health Authority
9 information and IWK information, is that correct?
10 **A.** Correct.
11 **Q.** So, again, private clinicians, private therapists, all
12 of that information will not, at this stage, be in the One
13 Person-One Record.
14 **A.** Correct. The one thing to remember is that consults
15 and referrals, for example, will be in there. So if a primary
16 care clinician consults a Nova Scotia Health or IWK clinician,
17 that consult will be in the One Person-One Record patient's
18 record.
19 **Q.** Okay, so if I go to my family doctor ...
20 **A.** As will the response to that.
21 **Q.** Right. So I go to my family doctor, get referred to a
22 specialist at a hospital, I go see the specialist, the

1 specialist reports back to my family doctor, that correspondence
2 will be in the One Person-One Record file.
3 **A.** Correct.
4 **Q.** Okay.
5 **A.** Yes.
6 **Q.** But whatever system my family doctor is using to
7 record my visits when I go in for my, you know, my sore toe or
8 whatever, that will not be in there unless I go to a NSHA
9 facility.
10 **A.** Right.
11 **Q.** And community Mental Health and Addictions will be
12 part of the One Person-One Record?
13 **A.** Yes, it will be, from a Nova Scotia Health, IWK,
14 community Mental Health and Addictions, that is part of One
15 Person-One Record.
16 **Q.** So if I see a mental health clinician at a hospital,
17 that will be in One Person-One Record.
18 **A.** Yes.
19 **Q.** If I go to a private therapist on Main Street, that
20 will not. Again, subject to the reporting the correspondence
21 type of thing, but if I just go to a private therapist, that
22 will not be there.

1 **A.** Right. But, if you go to a Nova Scotia Health
2 therapist in the community, then it will be.
3 **Q.** Okay. Again, I understand the system will be
4 province-wide, it will be integrated, everybody will have the
5 same access. I appreciate there's different levels of access
6 but I mean the general access in Halifax, Yarmouth, Sydney, is
7 all going to be the same, correct?
8 **A.** Yes, based on rollout, you will have the same access
9 and you will have access, if appropriate, to the care that was
10 provided in Sydney, if it is needed for you to provide care to
11 that patient in Halifax or in Kentville.
12 **Q.** Okay. The information that will be inputted into the
13 electronic health record when One Person-One Record is up and
14 running, is there a standardized, sort of similar to the
15 question I asked before, is there a standardized format for the
16 organization of the information in One Person-One Record? In
17 other words, if I get a particular test done in Yarmouth, it
18 gets entered a certain way or in a certain electronic basket.
19 If I get the same one done in Truro, it goes somewhere else. I
20 assume you want to make sure there's consistency, do you, in the
21 way that information is inputted?
22 **A.** Yes. Ideally, if you got that test Tuesday in

1 Kentville and ended up Wednesday in Truro, you wouldn't have to
2 get that test done again because they will have access to what
3 happened in Kentville because information will be entered in
4 real time.
5 **Q.** Okay. So there's ...
6 **A.** And, yes, they would be able to find it in the same
7 location.
8 **Q.** Okay, that's helpful. There's real time entry of the
9 information but also I guess I'm asking about where it gets
10 filed, like what electronic category it gets put into. That
11 will be consistent, will it, with One Person-One Record?
12 **A.** Yes, it will be and I think the thing to remember is
13 we're actually now building a single, single in the sense of
14 Nova Scotia Health/IWK record for that patient. It isn't
15 multiple records like we have today in different zones. So it
16 is one record for that patient. So it will all be, if it's lab
17 work, it's all in this same area within the clinical information
18 system. It looks the same so clinicians will be able to go in
19 and know if I'm looking for INR, it will be in the same place
20 every time, the same parameters will be used. So I will know
21 consistently so that INR doesn't have to be repeated if, for
22 some reason, I'm in an accident somewhere else, the INR that I

1 had taken two days ago in a different part of the province will
2 be there and the clinician will know how to look at it. It will
3 look the same, it will feel the same wherever you are in the
4 province to get that information. There will be that
5 consistency that doesn't exist today.
6 **Q.** Right. So if I were to, again once we're up and
7 running, if I were to go to, say, an emergency department with a
8 mental health crisis to see a mental health clinician there,
9 say, a psychiatrist, and I had had other mental health treatment
10 in the province at an NSHA facility, it would be in a category
11 that would be ... Would it be easily accessible by the mental
12 health clinician at the hospital I'm seeing at that time?
13 **A.** Yes, they would know where to find it and how to find
14 it. It would be at their fingertips because the clinician in,
15 say, the community will have literally typed it into the system
16 as they are treating that patient and then, if that patient then
17 shows up in the Emerg, the Emerg clinicians could pull it up and
18 see that information.
19 **Q.** It's anticipated then with One Person-One Record that
20 the information will be inputted, you said in real time. Is it
21 anticipated that clinicians will be doing a lot of typing as
22 opposed to writing with a pen and paper?

1 **A.** There ideally will be a significant reduction in pen
2 and paper and, yes, they will be documenting electronically.
3 They may be voice dictating in some ways in some cases,
4 depending, but they will be entering information into the
5 system. We will minimize it, and I'll never say we'll eliminate
6 paper, but we will minimize that and it will be the expectation
7 that clinicians do enter information and document in as real
8 time as possible on their patients in the care they're
9 providing. So that other clinicians, who are also caring for
10 that patient whether after or during the same time, have the
11 information that they need to continue to provide that
12 continuity of care that's necessary.
13 **Q.** Will documents, to the extent that there are scanned
14 documents, will there still be a barcoding system or some way to
15 put documents in the right electronic basket?
16 **A.** Yes.
17 **Q.** Okay. So back to my ...
18 **A.** If they are our ...
19 **Q.** Go ahead.
20 **A.** Sorry, let me just clarify that again. If they are
21 Nova Scotia Health documents and our barcoding, yes. If it is
22 external information that needs to go into the patient record,

1 it most likely will still, and I can't completely speak with
2 confidence of future stage, but it will most likely be similar
3 if it is filed under historical patient information and it would
4 be all bundled together, similar that happens today if it's not
5 Nova Scotia Health or IWK information.
6 **Q.** So that part of it may not change. It will still be
7 the patient or the clinician if they obtain information from
8 another province or, say, from Canadian Armed Forces, what have
9 you, if it gets scanned into the file, it would still be in the
10 miscellaneous electronic basket.
11 **A.** Right, but there will be much less in that basket. So
12 it should be much easier to decipher what's in there, as opposed
13 to today where we scan a great deal of stuff. So there will be
14 minimal paper scanned and if it is, but if it is from outside
15 our own jurisdiction, then it would still need to be filed in
16 one group because it can't be sorted and filed in and mixed in
17 with our other information because we didn't provide that care
18 so it is almost a second part of the patient record.
19 **Q.** Right, okay. So if I come from another province and
20 I've been treated at a hospital, let's say, in New Brunswick,
21 I've been treated by a private clinician in New Brunswick, I've
22 been to a hospital in Quebec, and I have records from the

1 Canadian Armed Forces, and if I was able to obtain all of those
2 myself and I walked into my clinician at a hospital in Nova
3 Scotia and I got some stuff on paper and some stuff on a disk
4 and, you know, ultimately, that's still going to be printed,
5 scanned into the record, and filed as other provincial or
6 historical record for the patient.
7 **(11:10)**
8 **A.** Yes. To the best of my knowledge right now, not
9 knowing what the future system exactly looks like, yes, that's
10 how, to the best of my knowledge, that's what will happen.
11 **Q.** Fair enough. And you said that with One Person-One
12 Record, there is going to be a patient portal where I will be
13 able to access some of my own information?
14 **A.** That is correct, yes.
15 **Q.** Will I be able to access the whole record?
16 **A.** That is still to be determined. What we, as Nova
17 Scotia Health and IWK, along with our patients and family
18 advisors, determine what and when information goes to the
19 patient portal but, yes, in theory, you could have access to all
20 your information.
21 **Q.** Okay. And these decisions, I understand, still have
22 to be made but there may be limitations on what I can see as a

1 patient.
2 **A**. There could be. Typically, the limitations are around
3 timing of when you see the information. Certainly, there is
4 evidence emerging that we don't need to set limits, for example,
5 with new diagnoses and sensitive information such as that,
6 sometimes the clinician will want to provide that information to
7 the patient first before they would view it. So you release it
8 after you've actually confirmed you've had a conversation with a
9 patient so they can understand the meaning behind it. For
10 example again, like I said, those parameters still need to be
11 sorted out. The other one to consider is the capacity. So when
12 we talk about minors and age of consent. Those are still some
13 of the things we are working through to determine what the
14 limits are in a patient portal and how much access patients can
15 have.
16 **Q**. Okay. And, similarly, clinicians will have various
17 levels of access depending on, I don't know if I'm using the
18 right term, is there a matrix or a formula, something like that,
19 to determine how various clinicians, how much information they
20 can access.
21 **A**. Typically, it's called role-based access. So, yes, we
22 will be setting up role-based access and, based on your role,

1 you will have access to what you require to do the job you're
2 doing.
3 **Q.** In the system, and this may be a technical question
4 that we can't answer at this point, is it internet based or is
5 it ...
6 **A.** It is internet based. All within Canada all the
7 information stays within Canada but it is internet based on the
8 net. It's on the network. We use the internet and it's network
9 based, yes.
10 **Q.** So if I'm a patient, in theory, depending how the
11 details are worked out, I may be able to access my patient
12 portal on my smartphone, if I'm in another province?
13 **A.** Yes, as long as you have the appropriate
14 authentication to get into it, yes, you should be able to.
15 **Q.** Okay. I think Mr. MacKenzie asked actually a similar
16 question and you had said something about consents. I mean I
17 assume there will be safeguards, obviously, to ensure that I'm
18 the one that's accessing my own record. Was there something
19 about consents for me to look at my own record?
20 **A.** No, I think the consent we were referring to was
21 access to. If a clinician wants access to your record and what
22 he was saying is that I am a patient who've accessed my health

1 record in Nova Scotia and I'm out of province and a clinician
2 wants to see it that clinician would need to receive consent
3 from that patient to make sure everything shows like, clearly,
4 if I'm (inaudible - audio), there may be pursuing consent. It
5 depends on the province you're in and all that other stuff.
6 But, yes.
7 **Q.** Okay. And historical records, those that have been
8 maybe previously scanned into the system, will those be
9 available on One Person-One Record?
10 **A.** So can you clarify what you're asking. Are you saying
11 records that we currently have in Nova Scotia today in the
12 historical content or ...
13 **Q.** I understood that records are ... For a period of
14 time, records have been scanned and, again, this may be better
15 for Linda Plummer, but have been scan ... There's a project
16 scanning records, is that correct?
17 **A.** Yes, that's correct.
18 **Q.** And those records will still be available in the One
19 Person-One Record system?
20 **A.** The technical elements of that are still to be worked
21 out but, yes, clinicians will still need access to all
22 historical information. How that access happens will be moved

1 to One Person-One Record is still to be determined but they will
2 have access to historical information.
3 **Q.** And I understand no project has been stood up but,
4 aspirationally, I guess the philosophy is that down the road, a
5 broader range of health care records will be incorporated into
6 One Person-One Record, is that correct?
7 **A.** The ultimate vision of One Person-One Record is an
8 integrated health record for every Nova Scotian. So, yes, that
9 is a long term vision, that is what has been approved and worked
10 on currently is the replacement of the hospital information
11 systems that I've talked about which would allow that foundation
12 to be there for further integration of other elements of a Nova
13 Scotian's health record to be integrated in. But, again, that
14 is vision and future. We need the foundation to actually do
15 that first.
16 **MR. MURRAY:** No, I understand that. I understand that.
17 Just one moment.
18 Thank you, Ms. Lamb. Those are all the questions I have.
19 **THE COURT:** Ms. Ward? Ms. Grant?
20
21
22

1 **CROSS-EXAMINATION BY MS. GRANT**
2 **(11:17)**
3 **MS. GRANT:** Hello, Ms. Lamb, can you hear me okay?
4 **A.** I can, yes.
5 **MS. GRANT:** Great. My name is Melissa Grant and I'm
6 counsel for the Attorney General of Canada and we represent the
7 various federal entities involved, including Veterans Affairs
8 and the Canadian Armed Forces.
9 I guess starting with just actually a personal note, as
10 someone who has been impacted by the Phoenix debacle, I would
11 commend you on wanting to take a ... taking the time to do it
12 right, rollout of such a huge technological endeavour.
13 And I guess on another personal note, we're all here today
14 able to gather safely, thanks to the great work that our health
15 service providers and frontline workers are doing and I know you
16 have role in COVID. So thank you for that and for allowing us
17 to, you know, continue with this important judicial proceeding.
18 So just a comment there.
19 With respect to, I guess you earlier noted the spaghetti
20 imagery, which I thought was really helpful for us to try to
21 understand what's going on here. What's the image that you want
22 for the future? Is it a circle or what food item perhaps would

1 it be?
2 **A.** That's a good question. Yeah, it would be more
3 circular and holistic. You know, that vision of one and
4 appropriate access. So often we use the patient in the center
5 and rather an umbrella or a holistic circle of the information
6 coming out appropriately is what we would hope to get to. So
7 taking the spaghetti and making a concentric circle with the
8 patient in the center of it would be what we would hope.
9 **Q.** Okay, so maybe more like a doughnut, I guess.
10 Clearly, I'm hungry. Just a point about consent and, Mr. Murray
11 touched on this a little bit, but in the system where you would
12 have so much potentially more information about a person in one
13 centralized location, consent and privacy are still going to be
14 mainstay key issues for you, is that correct?
15 **A.** Correct, yes. It is one of our key pillars, the
16 privacy, confidentiality and patient safety, and security of
17 information.
18 **Q.** Exactly. And so would you envision maybe, and we've
19 talked about sort of down the line in future where perhaps
20 private clinicians would maybe have an opportunity to come on
21 board that system, you would envision the patient still needing
22 to potentially consent for that information to go into that

1 centralized system.

2 **(11:20)**

3 **A.** I would envision that, yes, and we would still, like I

4 spoke of, role based. Security would be in place and the

5 majority, not all but the majority of all professionals have a

6 standard of practice and should only be accessing information

7 that is relevant and pertinent to the care that they are

8 providing to that patient. Yes, consent would need to be

9 involved.

10 **Q.** So there are statutory and policies that ... statutes

11 and policies that you have to follow with respect to those

12 issues you mentioned.

13 **A.** Correct.

14 **Q.** If there's a situation where a clinician, we talked

15 about sort of this historical basket. I think again that

16 imagery is really helpful for us to understand how this

17 information works. If you're presented with a clinician, a

18 hospital ... Sorry, a patient comes into a hospital and has an

19 issue and says, Well, I dealt with this issue in Ontario or

20 Alberta. You would expect a clinician to use their clinical

21 judgement to determine whether or not they needed to seek out

22 those additional records, correct?

ALYSON LAMB, Cross-Examination by Ms. Grant

1 **A.** Yes, correct.
2 **Q.** And I'm not sure how much you're aware of the kind of
3 system that works with the Canadian Armed Members. So if I'm an
4 active Member of the Canadian Armed Forces, all my medical
5 health care is taken care by the CAF. Are you familiar with
6 that?
7 **A.** Vaguely familiar but I know it is a separate system,
8 separate entity, custodian of the records. That stuff.
9 **Q.** So once someone is released from the Forces or leaves
10 the Forces and moves to a province as a veteran, they then
11 access provincial health care, is that your understanding?
12 **A.** That is my understanding. There is also the Veterans
13 Affairs' component but their local care is typically provided
14 within the local context.
15 **Q.** Right. So like there's no veterans hospital, like a
16 Walter Reed-type Hospital that's here in Nova Scotia.
17 **A.** No, except for our Veterans' Long Term Care beds. So
18 we do have veterans' beds in Nova Scotia. But beyond that, to
19 my knowledge, there isn't any veterans' hospital or veterans'
20 specific care beyond long term care.
21 **Q.** So there's the allocation of those beds and then we've
22 talked the last couple of days about the Operational Stress

1 Injury Clinic as well.

2 **A.** Correct.

3 **Q.** That's available for veterans.

4 **A.** I'm not as familiar with that but, yes, yeah.

5 **Q.** So all that is leading up to the question that you're
6 not developing a separate system or a specialist system for
7 different members of the public, different residents of Nov
8 Scotia. If I'm a veteran or I'm me, as a resident of Nova
9 Scotia, or you, and you go to a hospital, this system that
10 you're envisioning, One Patient-One Record, would apply to all
11 Nova Scotians who are resident of the province.

12 **A.** Correct.

13 **MS. GRANT:** Thank you. Those are my questions.

14

15 **EXAMINATION BY THE COURT**

16 **(11:24)**

17 **THE COURT:** Ms. Lamb, when they create this particular
18 heading, it's a basket of information that historical patient
19 information, the historical patient information happens to
20 relate to a veteran, is there any way ... is there any reason
21 why it couldn't have been labelled in such a way as to indicate
22 that it's historical information relating to a veteran, so that

ALYSON LAMB, Examination by the Court

1 if someone is looking for it, they would be able to have it all
2 kind of collected under that heading?
3 An example I'm going to give you is, for instance, as Ms.
4 Grant said, you have a member of the Canadian Armed Forces who
5 is discharged and he or she or they would have an entire file,
6 electronic file that gets sent to someone in the Nova Scotia
7 Health Authority with a request that it be scanned, uploaded,
8 instead of having it just all fall into some historic category.
9 Is there any reason why it can't have an additional label so
10 that it would be identified as relating particularly to a
11 veteran or they'd like the CAF records?
12 **A.** Because we don't have a vendor secured, I can't say
13 with certainty that's possible. I certainly think from a
14 theoretical and a technological perspective, being able to
15 identify within a historical folder, if it was out of province
16 or an additional jurisdiction, there may be an opportunity to
17 file that, like you said, as veterans records or outside
18 jurisdiction records. In theory, that should be able to happen
19 but we don't have a vendor secured for a new system, so I can't
20 speak that, yes, we certainly can do that. But, in theory, that
21 does make sense. That should be able to happen.
22 **THE COURT:** All right. So it's something that somebody

1 could put on a memo pad and it might get addressed down the road
2 when you have a vendor and you're looking at how this is finally
3 going to look when it's implemented.
4 **A.** Yes, quite possibly. If it's technically possible, it
5 should be able to happen, yes, if it's considered a clinical
6 requirement is what we would call that, yes.
7 **THE COURT:** Right, thank you. Mr. Anderson, do you have
8 any questions?
9 **MR. ANDERSON:** No questions, Your Honour.
10 **THE COURT:** No questions, all right. Thank you. Mr.
11 Macdonald?
12 **MR. MACDONALD:** No questions, Your Honour.
13 **THE COURT:** All right, thank you. Ms. Miller?
14 **MS. MILLER:** No questions, Your Honour.
15 **THE CHAIR:** Thank you. Mr. Rodgers?
16 **MR. RODGERS:** Yes, just a few questions, Your Honour.
17 Thank you.
18 **THE COURT:** Certainly.
19
20 **CROSS-EXAMINATION BY MR. RODGERS**
21 **(11:26)**
22 **MR. RODGERS:** Good morning, Ms. Lamb. I'm Adam Rodgers and

ALYSON LAMB, Cross-Examination by Mr. Rodgers

1 I represent the personal representative to Cpl. Lionel Desmond.
2 So I just have a few questions for you here. Thank you for
3 coming in and providing your evidence this morning.
4 I just wanted to pick up a little bit on what His Honour
5 was just asking about the interaction that this system in the
6 military or Veterans Affairs records. So I guess maybe I would
7 ask you to talk about what the expectation is with those
8 records. The expectation is that they would be treated
9 similarly to an out-of-province collection and brought in and
10 scanned into the system so they would be visible to a doctor
11 provider here?
12 **A.** Yes.
13 **Q.** So, in other words, there's no expectation or thought
14 at this stage of some kind of a direct electronic sharing of
15 those records, in other words, that the two systems would be
16 able to interface electronically?
17 **A.** Not at this time, there is no thought. That is larger
18 than our jurisdictional responsibility right now. So we are
19 just considering Nova Scotia Health and the IWK. The
20 interoperability of other jurisdictions inclusive of the
21 military or veterans is beyond my scope and that's not part of
22 our initial project.

ALYSON LAMB, Cross-Examination by Mr. Rodgers

1 **Q.** So there has not been any discussions held with
2 Veterans Affairs officials or military officials to explore the
3 possibility of those two systems interfacing in a more direct
4 manner?
5 **A.** Not to my knowledge.
6 **Q.** So can I ask was that possibility considered and
7 discarded or was it not considered for the jurisdictional
8 reasons that you've just outlined?
9 **A.** I don't think I can answer that question as I wasn't
10 part of the initial planning and procurement process. So that's
11 beyond my scope.
12 **Q.** Okay. Can you see how it might helpful? I mean if
13 we're thinking of ideal circumstances for or optimal
14 circumstances for a veteran who's move back home or who have
15 been discharged, certainly from their perspective and their
16 health care perspective, having their records integrated into
17 the One Person-One Record system would be optimal from their
18 perspective as a patient, wouldn't you agree?
19 **A.** As a Canadian citizen, I would like to see a national
20 health care system. Unfortunately, we have provincial
21 jurisdiction and, like you said, a military system, and
22 provincial systems, inclusive, as well as First Nations

1 communities as separate systems. So, yes, in theory, to have an
2 integrated interoperable system for all Canadians would be
3 amazing. However, that is beyond my control at this current
4 stage and my responsibility is with the Nova Scotia Health and
5 the IWK.
6 **(11:30)**
7 **Q.** In terms, Ms. Lamb, just a question, I know a number
8 of years ago there were some questions as to whether the Office
9 of Information and Privacy Commissioner was involved with the
10 One Person-One Record development. Has that changed? Is that
11 office now involved in assisting or advising with respect to
12 privacy considerations for the new system?
13 **A.** Privacy is certainly a consideration and there is
14 involvement at the province and within our own health authority
15 from that perspective with the current project, yes.
16 **Q.** So not the office specifically but the topic of
17 privacy, you're saying, is something that's front of mind among
18 other things?
19 **A.** Yes.
20 **MR. RODGERS:** All right. Those are all the questions I
21 had, Ms. Lamb. Thank you.
22 **THE COURT:** Ms. MacGregor?

1 **MS. MACGREGOR:** I have no questions. Thank you, Your
2 Honour.
3 **THE COURT:** Thank you. Mr. MacKenzie, do you have any
4 follow-up?
5 **MR. MACKENZIE:** No follow-up. Thank you, Your Honour.
6 **THE COURT:** All right, I appreciate it. All right,
7 thank you then.
8 Thank you, Ms. Lamb, for your time this morning. We
9 appreciate that I know you've spent some time having discussions
10 with counsel prior to your evidence this morning and I know
11 you've taken some time to prepare. It's been very helpful to
12 us. Again, thank you very much for your time.
13 **A.** Thank you.
14 **WITNESS WITHDREW (11:32 hrs.)**
15 **THE COURT:** Thank you, Counsel. We have the next
16 witness scheduled for?
17 **MR. MACKENZIE:** For 1:30. If we wanted to maybe ask her to
18 be back for 1, I think she might be able to accommodate that.
19 **THE COURT:** If Counsel are content to come back at 1
20 o'clock?
21 **MR. MACKENZIE:** I can't guarantee that she can accommodate
22 that but I will make the request. She's planning to be there

DISCUSSION

1 for 1, so I think we should be okay. Let's assemble here for 1
2 o'clock in the expectation that we might be able to start a bit
3 earlier. If not, we'll just have a casual half hour. Thank
4 you.
5 **COURT RECESSED (11:33 hrs.)**
6 **COURT RESUMED (12:58 hrs.)**
7 **THE COURT**: Mr. MacKenzie?
8 **MR. MACKENZIE:** Ms. Bennett-Clayton is going to be doing the
9 direct of Ms. Plummer.
10 **THE COURT**: From? It's all going to be done remotely?
11 Oh yes, that's right. I'm sorry. Ms. Bennett-Clayton, I forgot
12 that I had received some information that you were going to
13 conduct your examination remotely today.
14 **MS. BENNETT-CLAYTON:** Thank you, Your Honour.
15 **THE COURT**: All right. Thank you. So before we begin
16 we'll have the witness sworn then, please.
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22

1 **LINDA PLUMMER, sworn, testified:**
2
3 **THE COURT:** Go ahead, Ms. Bennett-Clayton.
4
5 **DIRECT EXAMINATION**
6
7 **MS. BENNETT-CLAYTON:** Thank you.
8 Ms. Plummer, I have some questions for you this afternoon
9 about health records from within the Nova Scotia Health
10 Authority and I'll start with asking you what is your current
11 role within the Nova Scotia Health Authority?
12 **A.** My current role is Director of Health Information
13 Services and in that portfolio I have health records, which is
14 circle of care release of information as well. I have
15 transcription. I have coding and abstracting and part of that
16 team has third party release of information.
17 **EXHIBIT P-000271 - *CURRICULUM VITAE* OF LINDA PLUMMER**
18 **Q.** So you can see here on the screen your *CV* which was
19 provided to the Inquiry and it's exhibit number 271. So you're
20 referring to this section you can see on the screen here as your
21 role through 2020 to present, is that right?
22 **A.** That is correct, yes.

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1 **Q.** Okay. And prior to that role that you currently hold,
2 did you have previous roles within the Health Authority?
3 **A.** I did. I started with the Health Authority in 2016
4 and the portfolio grew and in 2020 the org. structure required
5 two Directors of Health Information Services, so that particular
6 portfolio was divided between two of us.
7 So on the screen here from '16 to '20 I had ... in addition
8 to today, I had admitting, registration and switchboard, and
9 those three components now report to the other director as of
10 November of '20.
11 **Q.** So from 2016 until current were you holding a director
12 role within the Health Authority for Health Information
13 Services?
14 **A.** Yes, I was.
15 **Q.** Okay. And in your current role within the Nova Scotia
16 Health Authority as the Director of Health Information Services,
17 what sorts of duties and responsibilities do you have?
18 **A.** I look after the scanning project, the digitization of
19 the records, also the transcription department looking at ...
20 those are dictated reports, and the coding department releases,
21 collects and submits patient data nationally to a national body
22 for indicator reporting, and also third party release of

1 information, those would be to lawyers or to police agencies and
2 things like that. And also circle of care release of
3 information which would be in the circle of care of the patient,
4 so those would be patient information released to care
5 providers.
6 **Q.** And is that care providers within Nova Scotia or
7 outside of the province?
8 **A.** Within Nova Scotia.
9 **Q.** Okay. Prior to starting to work for the Nova Scotia
10 Health Authority I see from your *CV* you worked at the IWK?
11 **A.** That's correct.
12 **Q.** What roles did you hold there?
13 **A.** That was a 31-year career. That career started off in
14 the health record department where I did record management,
15 release of information, as well as doctors' incomplete. I then
16 was sponsored to take a health information management course
17 diploma and then I moved into the coding and abstracting team as
18 a health information professional. And after that, I had moved
19 to the decision support portfolio as a health information
20 specialist, and then the manager position became available and I
21 was successful to move into that position.
22 And then I managed that team and that took me up until I

1 left the IWK after 31 years and moved over to Nova Scotia Health
2 Authority.
3 **Q.** When you moved to the Nova Scotia Health Authority and
4 took that director position for health information, how many
5 staff did you have reporting to you then?
6 **A.** I had 750 people, which equated to 525 full-time
7 equivalents. Because we have part-time people and we have a
8 casual staff so it was 750 people.
9 **Q.** And is that located in a specific zone? We heard that
10 there are zones within the Health Authority currently.
11 **A.** Correct.
12 **Q.** Previous to that there were districts and so forth but
13 currently there's four zones, correct?
14 **A.** Correct, there's four zones.
15 **Q.** And so that the staff that you just mentioned, that
16 750 number, is that located in one zone or is it across all four
17 zones?
18 **A.** It's across all four zones.
19 **Q.** Okay.
20 **A.** Central is in the central Halifax area, and then going
21 across from Western, and then in the middle is the Northern and
22 then to the Cape Breton area is Eastern.

1 **Q.** Okay. And when your position changed in 2020 and
2 another director came onboard so that the portfolio split, how
3 many staff now do you currently have reporting to you?
4 **A.** I have 350 staff now reporting to me.
5 **Q.** Okay. So before I start asking you questions about
6 patient records from within the Nova Scotia Health Authority,
7 perhaps I'll first outline areas that are outside of your
8 knowledge. So did you ever have any interaction with Lionel
9 Desmond in your role within the Health Authority?
10 **A.** I did not.
11 **Q.** And did you know him personally or professionally at
12 all?
13 **A.** I did not.
14 **Q.** So I'm going to ask you some questions about patient
15 records generally and then I'm going to ask you some questions
16 about accessing patient records from within the Health Authority
17 and then I'm going to ask you questions about patient records
18 that exist outside of the Nova Scotia Health Authority.
19 So I'll start with questions about patient records
20 generally. Currently, are patient records within the Nova
21 Scotia Health Authority entirely electronic?
22 **A.** Currently, yes, the patient records are electronic and

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1 they have been electronic during different times across the
2 zones. In Central Zone they've been electronic since 2005 and
3 through Western, Eastern and Northern they have been digitized
4 for about four years now. It was a staggered roll-out so
5 approximately four years they've been digitized.
6 **Q.** So prior to that time, prior to the digitization of
7 patient records were patient records kept in paper form or in
8 any other form?
9 **A.** The majority of the patient record was kept in paper
10 form; however, if there was a system-generated report - and I'll
11 give you an example of the system-generated report - it would be
12 like a lab values, it would be diagnostic imaging, it would be
13 transcribed reports, those would be digitized prior ... back
14 many years ago.
15 So the scanned records that are now digitized, those would
16 have resided in paper and still reside in paper prior to the
17 digitization date.
18 **Q.** So just to be clear, are there patient records
19 currently in Nova Scotia that are in paper for some parts of the
20 record and digital for other parts of the record?
21 **A.** Absolutely. Yes.
22 **Q.** So, the paper portion, would that be patient records

1 that predate when scanning started?

2 **A.** That is correct, yes. The scanning and the creation

3 of the digitized record was date forward.

4 **Q.** And those dates again were ... is it 2005 you said?

5 **A.** 2005 in Central and 2017 at a staggered implementation

6 across those zones, so, 2017. So four years ago.

7 **Q.** Okay. Unless you're in the Central Zone.

8 **A.** Unless you're in Central Zone, yes.

9 **Q.** So the paper portion of a patient record that's still

10 in paper form because it predates those scanning dates you just

11 mentioned, where are those paper records stored now?

12 **A.** The majority of those paper records, outside of

13 Central, are stored within the health record departments onsite

14 in those facilities, and those paper records in linear feet

15 would stretch about 16 miles. And there are some sites outside

16 of Central that are stored at a company, a vendor, in Halifax,

17 the vendor is Iron Mountain. So, for example, of the paper

18 charts that were removed offsite is if the space is required

19 within those health centers those paper records are then

20 moved/transported to Iron Mountain and stored. So, an example

21 of that would be the Glace Bay Hospital, where the health record

22 department was emptied of paper records and created the new

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1 dialysis unit.
2 So the paper records in Central because they have been
3 scanning since 2005, in Central they do not have any paper
4 records onsite; Iron Mountain stores all of their records. So
5 in total Iron Mountain stores more than eight-million of our
6 paper records.
7 **Q.** So from what I heard you say there's the Iron Mountain
8 offsite storage of paper records.
9 **A.** Correct.
10 **Q.** And you estimate about eight-million patient records
11 are being stored at Iron Mountain?
12 **(13:10)**
13 **A.** Yes, over eight-million paper records of ours are
14 stored at Iron Mountain.
15 **Q.** But for some facilities in Nova Scotia, they still
16 store their paper records onsite?
17 **A.** That is correct.
18 **Q.** And you estimated if all those paper records that are
19 stored onsite at various facilities in Nova Scotia were
20 stretched out, it would be 16 miles?
21 **A.** 16 miles of paper records, yes.
22 **Q.** Okay.

1 **A.** It's very significant.
2 **Q.** So that's the paper part of a patient record. I heard
3 you say that since 2005 in Central Zone and 2017 outside of
4 Central Zone records have been digitized.
5 **A.** That is correct.
6 **Q.** So let's talk about electronic records or digital
7 records. Are there different types of electronic records
8 currently?
9 **A.** There are two different storage areas because we have
10 two different clinical information systems. In the province we
11 have three, we're excluding the IWK. So there are electronic
12 records in Central Zone in one system and digitized records in
13 the other three zones because they share a system.
14 **Q.** So are there electronic records currently that are
15 created with an electronic system or are there only electronic
16 records that were created on paper and then scanned to the
17 electronic?
18 **A.** So there are systems that ... such as lab, NDI and
19 transcription and anaesthesia that all collect patient
20 information and some of those systems will actually
21 electronically interface into the patient record but not all
22 systems do. And if the system does not electronically

1 interface/flow technically into the patient record, those
2 records would be then printed and scanned to create the digital
3 version.
4 **Q.** So some of the electronic platforms that are used to
5 create documents interface with the electronic record and others
6 don't?
7 **A.** That is correct. And there's multiple different
8 systems used, so yes.
9 **Q.** And if the system doesn't interface then the record is
10 printed, scanned and added to the electronic record that way?
11 **A.** That is correct.
12 **Q.** So are there then two types of electronic records, the
13 scanned type and then the system-generated type? Is that fair
14 to say?
15 **A.** That is fair to say although the system-generated
16 reports and the scanned reports would all flow into the one
17 patient record.
18 **Q.** So let's talk about that, the patient record. We
19 heard some evidence previously about MEDITECH and OneContent.
20 So can you talk a bit about OneContent? What is it and where is
21 it used?
22 **A.** OneContent is a Central Zone clinical information

1 system and it's only in Central Zone. So if you have a visit in
2 Central Zone, that is where your medical record would be stored.
3 So that is the zone that has been scanning since 2005, so
4 it would hold the digitized records since the beginning of
5 scanning in 2005.
6 **Q.** So is every patient record from 2005 onwards in
7 Central Zone in electronic form?
8 **A.** That is correct.
9 **Q.** And is it held in OneContent?
10 **A.** Yes, that is correct.
11 **Q.** All of the patient record?
12 **A.** Yes.
13 **Q.** Who has access to OneContent?
14 **A.** Access is granted based on the care provider or the
15 staff person that would require that information. So the
16 physicians would have access, any of the care providers, nursing
17 would have access. Any of the care providers that needed to
18 provide care and have the information and use the information
19 contained there would have access.
20 **Q.** So that's the Central Zone platform?
21 **A.** Central Zone clinical information system. Yes.
22 **Q.** System, okay.

1 **A.** Yes.

2 **Q.** Outside of Central Zone, what is used?

3 **A.** MEDITECH Client Server is used in Western, Eastern and
4 Northern and those particular zones have been scanning for much
5 less ... a shorter period of time. So since 2017 we started the
6 roll-out of the scanning project which would make those records
7 digital and it is a similar record storage system. There's
8 different categories where you put different categorization of
9 patient records, so it makes the ease of finding the record much
10 more simple.

11 **Q.** In MEDITECH?

12 **A.** In MEDITECH. There's categories in both OneContent
13 and in MEDITECH.

14 **Q.** But are they the same categories?

15 **A.** They're different.

16 **Q.** And MEDITECH is used in the Western, Northern and
17 Eastern Zone?

18 **A.** That is correct.

19 **Q.** And is it the same product?

20 **A.** No. MEDITECH product is different than the OneContent
21 product. Two different vendors.

22 **Q.** And is the MEDITECH product that's used in the

1 Western, Northern and Eastern Zone the same product?
2 **A.** Yes.
3 **Q.** Do they interact or interface with each other?
4 **A.** OneContent and MEDITECH do not interact or interface
5 with each other.
6 **Q.** And does MEDITECH across the three zones that use it,
7 does that interact with each other across those three zones?
8 **A.** Yes. Yes, it does, and depending on the level of
9 access would be what you would be when you actually go into that
10 system it would allow you to see what you need to see to do your
11 work. It's not a ... not everybody sees everything unless your
12 access actually identifies that.
13 **Q.** So if you are a clinician working in the Northern Zone
14 and you were using MEDITECH, what level of access do you have to
15 see information outside of the Northern Zone in the other
16 MEDITECH zones?
17 **A.** So if I was working in Northern Zone the person
18 providing care would get access to what they required. So if
19 they had access request for the Northern Zone that's what they
20 would see. If they were to request access for Western and
21 Eastern, that access would then be granted and they would be
22 able to see all three zones. So it's access-driven.

1 **Q.** Does it default to provide access to the zone in which
2 you have privileges?
3 **A.** Yes, it would actually default to the facility where
4 you actually had privileges.
5 **Q.** Okay. And if you want or need access beyond that it
6 can be requested and granted?
7 **A.** That is correct.
8 **Q.** We've heard some reference to a system called STAR.
9 Do you know what that is? Can you explain that?
10 **A.** STAR is a Central Zone registration system.
11 **Q.** And what's it used for?
12 **A.** It's used for registering patients when they come in
13 for their visits.
14 **Q.** Is it only in Central Zone?
15 **A.** It is only in Central Zone.
16 **Q.** So who would have access to STAR?
17 **A.** Again, it would be through your access request, what
18 you would have access to. My team would have access to STAR for
19 ... they would be the ones registering the patients for their
20 visits. So it would be access-driven.
21 **Q.** But if you were attending an appointment at a hospital
22 outside of Central Zone, STAR would not be used to register your

1 visit?
2 **A.** That is correct. MEDITECH Client Server would be used
3 to register the patient outside of Central.
4 **Q.** Do clinicians or practitioners outside of the Nova
5 Scotia Health Authority have access to MEDITECH?
6 **A.** No, they do not.
7 **Q.** So a family physician who is working in a private
8 clinic, would they have access to MEDITECH?
9 **A.** If they're not associated with privileges for Nova
10 Scotia Health Authority they would not.
11 **Q.** Okay. And what about a private practitioner like a
12 chiropractor or a psychologist, would they have access to
13 MEDITECH?
14 **A.** They would not.
15 **Q.** And what about OneContent, would they have access to
16 OneContent?
17 **A.** They would not.
18 **Q.** We've heard reference to SHARE. Can you explain what
19 SHARE is?
20 **A.** Sure. SHARE is a portal that receives
21 feeds/information from OneContent as well as MEDITECH Client
22 Server and it's a Department of Health and Wellness product, and

1 they actually own it. And it also has user access, as well, for
2 what levels of access those users would be able to see in the
3 SHARE product.
4 **Q.** So what type of information flows in to SHARE?
5 **(13:20)**
6 **A.** So in Central Zone the information that flows to SHARE
7 would be the visit dates, the area, what type of care they
8 received, was it inpatient or outpatient, and what also flows to
9 SHARE from OneContent is all of the scanned records as well as
10 all of the digitized patient records. Now that's Central Zone.
11 It's different outside of Central Zone.
12 So in Western, Eastern and Northern again, the visits, the
13 registration, the date that the patient was in and the patient
14 registration that happened and the site that the visit took
15 place. And then also flowing would be the system-generated
16 reports going into SHARE. The scanned records do not flow to
17 SHARE in Western, Eastern and Northern.
18 **Q.** So anything that was created on paper and scanned into
19 MEDITECH in the Western, Northern and Eastern Zones, that does
20 not flow through to SHARE?
21 **A.** That is correct.
22 **Q.** But anything that's created in paper and is scanned

1 into OneContent does flow through to SHARE?
2 **A.** That is correct.
3 **Q.** Is there any reason for that that you know of?
4 **A.** It's just a decision from system ... it would be a lot
5 of configuration work and with OPOR on the horizon the decision
6 was not to put the scanned records in MEDITECH flowing to SHARE.
7 **Q.** Okay. Who has access to SHARE?
8 **A.** There's different levels of access depending on the
9 type of provider that you are. So if you were Nova Scotia
10 Health Authority staff or a clinician, you would have access to
11 everything in SHARE. If you're an external, outside of Nova
12 Scotia Health Authority, so if you were a chiropractor or a
13 family doctor, you would have a different level of access in
14 SHARE.
15 **Q.** So SHARE is something that clinicians outside of the
16 Nova Scotia Health Authority can receive access to see?
17 **A.** That is correct. They can, yes. They can request
18 access for SHARE and because they're outside of Nova Scotia
19 Health Authority their access would look different.
20 **Q.** And how would it look different?
21 **A.** This product is actually a DHW product so I can speak
22 high level to it.

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1 **Q.** Okay.
2 **A.** If the questions get more specific, I may need to
3 defer those to DHW, to Department of Health and Wellness.
4 **Q.** Okay.
5 **A.** So in an external care provider, what they can do is
6 create a work list. So their admin assistant would have the
7 ability to add patients to their work list for patients that
8 they are actually providing care to and then they would only be
9 able to access the records on that work list.
10 **Q.** And would it be the same records they would see that
11 we just described?
12 **A.** Yes, in Central Zone they would be able to see more,
13 all the scanned records, but if it was a MEDITECH site visit,
14 they would not be able to see the scanned records. So, yes.
15 **Q.** We talked previously about the fact that there still
16 exists paper patient records for Nova Scotia patients within the
17 Health Authority, some of which are stored offsite, some of
18 which are stored at bigger facilities. And you talked about the
19 scanning project that started in 2005 in Central Zone and in
20 2017 in the other zones.
21 Is there currently any plan to scan the older records,
22 those that are stored either offsite or in facilities in Nova

1 Scotia?
2 **A.** So there is no plan to do, other than just store those
3 paper records, but there is no plan to digitize those records
4 and there's a number of reasons why.
5 In 2017, that's four years ago, those records are now four
6 years old and we know how big they are, there's 16 miles and
7 over 8 million at Iron Mountain. So in order to digitize those
8 records we would actually have to remove the eight-million
9 records from Iron Mountain and it would take over three years to
10 remove those with the amount of records that they can move
11 offsite daily. So that would then add another three years to
12 the already four-year-old records, so they would then be seven
13 years old.
14 And we would also ... the time it would take to digitize
15 the millions of records that we have, those records would
16 probably be nine or ten years old by the time that project was
17 finished and the clinical value of those paper records would
18 diminish over time.
19 So we ran ... we have ... when we have paper records we
20 actually electronically sign them out to people. So we have
21 reports from 2017 of how many times were the paper records
22 requested. And we ran that report again in 2019, two years

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1 after the scanning project - not quite two years after the
2 scanning project. So to give you an example of the ED records
3 requested, in 2017 the ED had - the emergency departments across
4 the province had requested a little over 33,000 paper records,
5 and two years later in 2019 they only requested a little over
6 300 records in a year.
7 So we're now two years away from 2019, so the paper records
8 were just not used clinically and not requested clinically.
9 **Q.** And that's in the emergency department context?
10 **A.** Yes, yes.
11 **Q.** So let's talk about how you access patient records
12 that are held within the Nova Scotia Health Authority and we
13 were just talking about paper records so we'll talk about those
14 first.
15 So for those records, if there was a need or a request to
16 access a paper-based record that's either stored onsite at a
17 facility or stored offsite at Iron Mountain, who generates these
18 requests?
19 **A.** If it's circle of care it's usually the physician, a
20 clinician or their admin assistant who would request the
21 information.
22 **Q.** So is it something that the clinician would initiate

1 or their admin on their behalf?

2 **A.** On their behalf, yes.

3 **Q.** So how is that request initiated?

4 **A.** It can come in a phone call or it can come in a letter

5 request from the physician's letterhead.

6 **Q.** And it goes to where?

7 **A.** It would go to the Health Record Department and they

8 would process the request.

9 **Q.** And which health record department does it go to?

10 **A.** It goes to the health record department where the

11 patient visit took place.

12 **Q.** So before the request can be made, the physician needs

13 to know where the patient received care?

14 **A.** So the patient, when they're ... sorry. When the care

15 provider when they're the talking to the patient would generally

16 ask them have they had any visits and where was that and when

17 was that and that would indicate to the physician where they

18 need to make the request.

19 **Q.** And if that information wasn't forthcoming or

20 available from the patient is there some other way a physician

21 can identify where a patient received care?

22 **A.** They could go into the SHARE portal and look at the

1 visit history there and see the dates. And in that portal you
2 can also see the facility that a patient had actually received
3 care.
4 **Q.** So once the physician knows where their patient
5 received care, what facility and when, they can initiate a
6 request to look at or receive their chart materials you said
7 through a letter?
8 **A.** They can either go to the department and ask for the
9 paper record there. They could do a letter requesting the
10 information as well, or it could come through a phone call.
11 **Q.** And is the letter faxed?
12 **A.** The letter is usually faxed, yes.
13 **Q.** And once their request is received either in person or
14 through the phone or through fax, what happens then?
15 **A.** If the physician is actually onsite they can come down
16 and review it in an office in the health record department or
17 they could sign it out and they could take it with them. We
18 would make copies and fax them out or mail them out depending on
19 which way they would like to receive them. Most of them go back
20 to the care providers by fax.
21 **Q.** And is that for records that are not in the same
22 facility where the physician is located?

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1 **A.** Correct.
2 **Q.** If a request is received for a paper-based patient
3 chart and it's indicated that the materials are required stat.
4 or quickly, is there an average turnaround time for those sorts
5 of requests?
6 **(13:30)**
7 **A.** There is. There's an average time of one hour, and it
8 can be done much faster than that if the size of the record is
9 ... you know, is smaller. It would take more time if the record
10 was a larger record with more pieces of paper that would need to
11 be copied.
12 **Q.** Is patient consent required for these types of
13 requests?
14 **A.** The patient consent is not required because it's
15 considered within the circle of care of the patient. So for a
16 care provider, it would not require patient consent.
17 **Q.** So if a physician is asking for records, for their
18 patient's records for previous visits, they don't require
19 consent from their patient.
20 **A.** That's correct.
21 **Q.** You gave some statistics as to how frequently the Nova
22 Scotia Health Authority various sites are receiving requests for

1 paper-based records in the emergency context.
2 **A.** Mm-hmm.
3 **Q.** Do you have similar type of statistics for the non-
4 emergency requests?
5 **A.** Yes. We had run all of the record requests throughout
6 the province and it is significantly decreased over the two-year
7 period.
8 **Q.** So that's the paper records. That's the older records
9 that predate 2005 in Central Zone and 2017 in the other zones.
10 Correct?
11 **A.** Correct.
12 **Q.** So any records in Central Zone after 2005 and after
13 2017 in the other zones, those are all available in the
14 electronic form. Is that right?
15 **A.** That is correct.
16 **Q.** So let's talk about how a clinician accesses those.
17 If it's a record that is created in the same facility where the
18 physician is located, how are they accessed by a physician?
19 **A.** They would have full access to those patient records.
20 They would go into the system and they could search either by
21 the patient's name or their health card number or their medical
22 record number or their encounter number depending on what

1 information they had available to them, and they would then be
2 able to go into and view all of the entire record.
3 **Q.** And you mentioned that in MEDITECH they have
4 categories for records and those categories are different in
5 OneContent. Do you have any idea how many categories there are
6 for records within MEDITECH?
7 **A.** Yes. There's about ... there's 50, about 50, a little
8 over 50 in MEDITECH and a little over 80 in OneContent.
9 **Q.** Okay.
10 **A.** And just to clarify, the systems are not the same. So
11 the language is a bit different, but the general categorizations
12 would be similar. So an example of that would be an operative
13 report would go into an operative report category. A history
14 and physical would go into a history and physical category in
15 both systems. They might be titled a little different and
16 there's ... as I said, there's, you know, over 50 and over 80.
17 So those are examples of those categories, would be
18 progress note, history and physical, discharge summary,
19 operative report, rehab, lab, DI, those kinds of things.
20 **Q.** So if the physician is in the same facility where the
21 electronic record was created or scanned and loaded they can see
22 the full electronic record by going into either OneContent in

1 Central Zone or MEDITECH in the other zones and can they search
2 by category? Is there a way to do that?
3 **A.** Yes, they can search by category. They can search by
4 full patient. They can go in. There's little boxes to the left
5 that you can highlight the boxes you want to see and they will
6 launch those particular documents. You can actually hit one
7 button and it'll launch every category and then it will launch
8 into the pages within each one of those categories.
9 **Q.** How do documents get sorted into these categories
10 within the electronic system, either OneContent or MEDITECH?
11 **A.** So there are barcodes on the bottom of each one of the
12 paper records and that barcode is actually the code that's read
13 digitally and sends it to that particular category. So it's
14 very similar at the grocery store when your cereal is scanned.
15 It knows the cost of the cereal. It's the same scanner goes
16 through, reads that barcode on the bottom, and if it's a
17 progress note it will electronically put it in the progress note
18 category.
19 **Q.** So that's how you can access electronic records if you
20 are in the same facility where those records were created or
21 scanned and loaded.
22 **A.** Correct.

1 **Q.** What about records that were created n a different
2 facility but within the same zone? So if you were at St.
3 Martha's and you wanted to know about records that were created
4 in Guysborough. Can you see those through MEDITECH?
5 **A.** Yes, you could. If your access permitted you to do
6 that, yes.
7 **Q.** So same question for records that are outside your
8 zone. So this may be where it gets a bit more complicated. So
9 if you're in the Northern Zone are you able to see records in
10 all of the other zones including Central?
11 **A.** You wouldn't be able to if you just had access to the
12 MEDITECH sites. So if you requested access you would have to
13 request ... and wanted for all four zones, you would have to
14 request access for the MEDITECH sites as well as OneContent
15 sites.
16 **Q.** Okay.
17 **A.** So if that's what you would need to do to do your
18 work, you would have access to both.
19 **Q.** Okay.
20 **A.** But you wouldn't ... you would have to access them
21 differently. You would have to access OneContent going in
22 through OneContent and you would access MEDITECH going in

1 through MEDITECH.

2 **Q.** Okay. So what would you use SHARE for in that

3 circumstance or would you have to use it at all?

4 **A.** You would not need to use it at all other than SHARE

5 would give you that overview of where they were and would

6 indicate which system you would need to go into to see the more

7 detail.

8 **Q.** And when you say "where they were" do you mean where a

9 patient was seen?

10 **A.** Oh, which facility. Yes, where the patient was seen

11 ... which facility the patient was seen.

12 **Q.** So if you're in SHARE and you see that a patient that

13 you're treating was seen at different facilities and you can see

14 that in SHARE ...

15 **A.** Yes.

16 **Q.** Can you actually see the records that were created as

17 part of that visit or treatment in those other facilities in

18 SHARE?

19 **A.** In Central Zone if you were ... had a visit in Central

20 Zone identified in SHARE, when you were to click on to that

21 particular visit in Central Zone it would launch you into your

22 record, yes, and all other scanned records in Central Zone would

1 be in SHARE.

2 **Q.** Okay.

3 **A.** So if you are looking at a MEDITECH site and you could
4 see the date of the visit and the facility and you were to
5 launch that particular visit you would see the system-generated
6 reports such as your lab, DI, and your transcription. You would
7 not see the scanned record in the MEDITECH sites, which would be
8 Western, Eastern, and Northern.

9 **Q.** So if you're going in through SHARE and you can see
10 that your patient was seen at the Valley Regional on a
11 particular date you can click on that date but you'll only see
12 the system-generated records from that visit.

13 **A.** Exactly.

14 **Q.** But if your patient was then seen at the VG on a
15 particular date and you clicked on that date you would see the
16 system-generated records and the scanned records.

17 **A.** That is correct.

18 **Q.** Okay. All right, so that's the electronic records.
19 Now I want to ask you about Mental Health and Addiction records
20 because I understand that the system we just described is a
21 little different for Mental Health and Addiction records.

22 **A.** That is correct.

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1 **Q.** So what's the difference for those records?
2 **A.** So Mental Health and Addiction records are managed and
3 stored and retained by the Mental Health and Addiction clinic
4 area for ambulatory records for Mental Health and Addictions.
5 So what I mean by ambulatory, those would be the day patients,
6 the group patients, the clinic visits. Those would be the
7 patients that don't stay overnight on an inpatient stay.
8 So the inpatient Mental Health and Addictions is part of
9 the scanning project already integrated with the medical chart.
10 So the ambulatory records up until August of 2020 - and the
11 project finished in November of '20 - those ambulatory medical
12 records for Mental Health and Addictions prior to those dates
13 resided in paper in the Mental Health and Addiction departments,
14 clinic offices. Some of them were on site. Some of them were
15 off site.
16 **(13:40)**
17 **Q.** Okay, so since August to November 2020 ...
18 **A.** Correct.
19 **Q.** So now all of the Mental Health and Addiction records
20 are electronic just like every other record in every other zone
21 in Nova Scotia.
22 **A.** That is correct, yes.

1 **Q.** So they would be ... now any record that was created
2 from November 2020 onward would be available electronically the
3 same way we just described availability of other patient records
4 electronically.
5 **A.** That is correct.
6 **Q.** But it's prior to that date that we have a difference.
7 **A.** That is correct. Those are paper records and they are
8 stored still in paper. They have no plan either to digitize
9 those. They do reside in those particular clinic areas and
10 Mental Health and Addictions also stores their records at Iron
11 Mountain.
12 **Q.** Okay.
13 **A.** Depending on space.
14 **Q.** And you mentioned ambulatory care records. So Mental
15 Health and Addiction records that are inpatient records, are
16 they treated the same way?
17 **A.** Those were integrated into the medical chart and those
18 would fall into the same previous dates of Central Zone 2005 and
19 outside of Central Zone 2017 onward.
20 **Q.** So they're not treated any differently from other
21 patient records. It's just the ambulatory.
22 **A.** Ambulatory. That's correct.

1 **Q.** So we talked about how a clinician can obtain a part
2 of a patient's chart that's paper-based and we've talked about
3 how a clinician can obtain or access part of a patient's record
4 that's electronic. How can a clinician obtain parts of a Mental
5 Health and Addiction patient chart that predates the scanning?
6 **A.** So because those are in paper those requests come
7 through from the care provider into the Mental Health and
8 Addiction Department where those paper records are stored.
9 **Q.** So if the clinician is in the same location where the
10 ambulatory care Mental Health and Addiction was given to a
11 patient are those paper records stored in the same facility just
12 within the Mental Health and Addiction Department?
13 **A.** That is correct. Yes, that is correct. Some of the
14 mental health offices are outside of hospitals. So there are
15 some out more in the community so ...
16 **Q.** So the request for those records that are paper-based
17 gets directed to the Mental Health and Addictions Department.
18 **A.** Correct.
19 **Q.** And if the Mental Health and Addictions ambulatory
20 care was provided at a different facility how does a clinician
21 get those records?
22 **A.** They would contact that particular clinic as well.

1 **Q.** Okay.

2 **A.** They're all stored within the clinic environment in
3 Mental Health and Addictions.

4 **Q.** And if a request to either view or receive copies of
5 an ambulatory care record kept within a Mental Health and
6 Addiction department is received outside of regular business
7 hours, how are those requests fulfilled?

8 **A.** If the Mental Health and Addiction Department is
9 within a hospital environment they could contact somebody at the
10 facility, the Emergency Department, or the facility lead, and
11 security could let them into the office to access the record.
12 It would be accessible.

13 **Q.** I want to ask you some questions about patient records
14 from outside of the Nova Scotia Health Authority. So those are
15 records that are created outside, either outside the province or
16 outside of the Health Authority itself. Does the Nova Scotia
17 Health Authority have the ability to access patient records that
18 are created outside of the Health Authority?

19 **A.** No, we don't. Those requests would be made by the
20 care provider. Directly hearing from the patient, knowing where
21 to contact where their care had been outside the province, that
22 clinician would make that contact themselves.

1 **Q.** Many of the electronic systems that we've talked about
2 this afternoon interface with any electronic systems used in
3 other provinces or with other agencies.
4 **A.** No. Our systems don't link with anything outside the
5 province.
6 **Q.** So there's no ability to electronically transfer
7 records from outside the province to within the Health
8 Authority.
9 **A.** That's correct, yes. It would come in a paper base.
10 **Q.** So if a patient attends at a Nova Scotia Health
11 Authority site and the clinician decides that they need to see
12 records that were created elsewhere, whether somewhere else in
13 Canada, somewhere else in the world for whatever reason, how
14 does the clinician actually get those records?
15 **A.** The clinician or the clinician's admin assistant would
16 make a phone call to that particular care area outside or
17 outside the ... outside another province or country, and they
18 would request that information and that information would come
19 directly back to them.
20 **Q.** Is there a consent form that the Nova Scotia Health
21 Authority provides to facilitate these sorts of requests?
22 **A.** The way consent works, that would be a Nova Scotia

1 Health Authority consent which would consent for the Nova Scotia
2 Health Authority to release information.
3 **Q.** Okay.
4 **A.** Most agencies have their own consent forms and our
5 team would not be involved in that. It would be the care
6 provider that would be making those requests.
7 **Q.** So if a request was made to a facility in Ontario and
8 they had a consent form that needed to be completed before they
9 could release the patient's record they would have to provide
10 that form that would need to be completed and signed by the
11 patient.
12 **A.** Right. That is correct.
13 **Q.** And then to your knowledge, the records, once they are
14 compiled and sent by the facility outside of the Health
15 Authority, they go directly to the requesting clinician?
16 **A.** Yes. Yes.
17 **Q.** And then what happens to those records then? Do they
18 get added to the patient's electronic record within the Nova
19 Scotia Health Authority?
20 **A.** If the clinician, the care provider, brought the
21 information down to the health record department and requested
22 that it be scanned as part of the patient record we would scan

1 it into a section called "Correspondence" and it would ... just
2 external documents. And that's where those would be kept
3 regardless of what category they were.
4 **Q.** Would they be categorized?
5 **A.** They would not be categorized. They go in ... the
6 category would be "External Documents Correspondence". It
7 wouldn't ... if it was a progress note it's still going to go
8 into that same correspondence.
9 **Q.** Is there a reason why they're not categorized?
10 **A.** It's the ... the way it ... because it's an external
11 document it wouldn't be ... and if they were to look ... if a
12 care provider was to look for all of the information from an
13 external agency, and if we did categorize it, they would have to
14 go to all of those categories to find that complete package.
15 Putting it into one area is much more easily accessible by
16 the care provider. They go to the one spot and it's all in
17 there.
18 **Q.** So that's for records that a clinician specifically
19 requests from an outside agency or outside the province
20 location. Are there circumstances where a patient can bring
21 their records to a facility within the Health Authority and
22 request that their records be added?

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1 **A.** Yes, that is true. They can bring their documents
2 that they've brought from another province in and they would be
3 scanned as well to that external document, yes. A good example
4 of that is if a patient has a "do not resuscitate" request.
5 Those are dropped off quite frequently to the health record
6 department so that it will be a part of the patient record.
7 **Q.** So if somebody is moving to Nova Scotia from another
8 province or another country and they have a particular health
9 issue ...
10 **A.** Mm-hmm.
11 **Q.** ... that they anticipate they're going to need care
12 for in Nova Scotia, they could bring their records with them and
13 request that they be added to their Nova Scotia electronic
14 record.
15 **A.** That is correct and we would scan it.
16 **Q.** Does the Nova Scotia Health Authority's health
17 information systems department play any role in requesting
18 records for a patient from another location, another province,
19 another country, another agency?
20 **A.** No. Those requests come from the clinician
21 themselves.
22 **Q.** And is there a reason for that?

1 **(13:50)**
2 **A.** If we were to handle those for them we would become a
3 middle person and a middle person could create delays. Because
4 the physician, the care provider, knows what they require and
5 the date, they are the ones that have dealt directly with the
6 patient. So if there was to be a middle person, such as my
7 department, it would create delays in that information being
8 received.
9 **Q.** So having a facilitator to assist with the request and
10 receipt of records from outside the province, do you see that
11 there's a value for that within the Nova Scotia Health
12 Authority?
13 **A.** I don't because you're adding another layer of process
14 and so for an example, if the physician had come to my
15 department and said, I need all the records from 2015 and we
16 would make the request saying we need the records from 2015 and
17 if that date was incorrect and it was actually 2016 we would
18 then have to go to that middle person, clarify, Did you want the
19 2015 because there's none for 2015, are you interested in 2016?
20 That's going to create a delay of getting then back to the
21 requester and saying, 2016 is fine, we made a mistake, it's not
22 '15, it's 16.

1 So adding that middle layer in the process, I feel, is
2 going to make a delay.
3 **Q.** Thank you. Those are all the questions I have.
4
5 **EXAMINATION BY THE COURT**
6 **(13:52)**
7 **THE COURT:** Mr. Murray, I'm going to invite you to ask
8 questions as soon as I ask one.
9 Ms. Plummer, I'm just trying to follow some of what you
10 said earlier. If you have an external record ... so, for
11 instance, you have an individual who brings health records from
12 New Brunswick to St. Martha's Hospital. That's going to be his
13 local treatment area. That's where his physician is. He says,
14 I'd like to have all these documents that I have in electronic
15 format, I want to have them available, I'd like them added to my
16 record. And they would then be added to that patient's record
17 through ... in MEDITECH, is that correct?
18 **A.** That is correct, yes.
19 **Q.** All right.
20 **A.** St. Martha's is a MEDITECH site.
21 **Q.** And when that same individual winds up going to
22 emergency department in Dartmouth, he's in the Central Zone and

1 says, Well, all of my records are in the Eastern Zone in St.
2 Martha's Hospital in that area, can they access them?
3 **A.** Technically, electronically, if they do not have
4 access they will not be able to access St. Martha's records from
5 Dartmouth.
6 **Q.** So even though they're in MEDITECH ...
7 **A.** If they do have that ...
8 **Q.** Sorry.
9 **A.** Yeah, that's correct.
10 **Q.** Why would ...
11 **A.** That is correct so ...
12 **Q.** Why would the emergency department in Dartmouth not be
13 able to access those records in St. Martha's Hospital?
14 **A.** So in Central Zone, the system that Central Zone uses
15 is OneContent, and the system that's in St. Martha's is
16 MEDITECH. So they wouldn't ... unless they had previously
17 requested MEDITECH and OneContent access the Dartmouth clinician
18 would not have access to MEDITECH.
19 **Q.** So he's in Dartmouth emergency and unless the
20 particular individual he sees has previously requested that
21 access they'd be trying to treat him without access to all of
22 his full health records. Correct?

1 **A.** That is correct.
2 **Q.** All right.
3 **A.** They could look in SHARE, in the SHARE product that we
4 chatted about a little earlier. If they were to access that
5 patient in SHARE they would see that they had ... the particular
6 patient had a visit in St. Martha's. They could contact St.
7 Martha's and then they would copy whatever it was that they were
8 looking for and send it through to Dartmouth.
9 **Q.** But what that means is that somebody else at St.
10 Martha's has to do the search, know particularly what they're
11 looking for, make certain they get the correct document and then
12 send it to Dartmouth Emergency, right?
13 **A.** That's correct.
14 **Q.** Do you think that would create some delay?
15 **A.** Yes.
16 **Q.** All right.
17 **A.** Oh, absolutely.
18 **Q.** Now if that same individual took their record and when
19 they arrived at St. Martha's Hospital and said, All right, I
20 need this added to my patient record, wouldn't they be better
21 off taking that patient record to Central Zone some place,
22 getting it loaded in to OneContent and now wherever he is in the

1 province going into an emergency department they would be able
2 to access the full content of the record through OneContent?
3 Would that be correct?
4 **A.** Yes, that is correct. And a patient can actually drop
5 off a record, their record, to St. Martha's and ask for it to be
6 added there. They could also bring it to Dartmouth and they
7 would add it to OneContent, as well, if the patient did request
8 that.
9 **Q.** So that capability is already there if a person was
10 aware of the limitations in access depending on where the
11 documents were loaded. The individual could take it to
12 Dartmouth. Where would they go? Where would they physically
13 take their CD and say, I need all this loaded into OneContent so
14 that it's going to be accessible wherever I happen to be in the
15 province? Where do they go to do that?
16 **A.** They could go in to Dartmouth General and they would
17 ask directions to the health record department and they would be
18 directed to the health record department and they would accept
19 those records there.
20 **Q.** So that wouldn't be any kind of a special request or a
21 special event that would require anything more than either an
22 appointment or seeing the right person on the right day.

1 **A.** Yeah. No, they could just go in and ask for ... as
2 long as the office hours are open ...
3 **Q.** Right.
4 **A.** ... they could ... regular business hours. They would
5 be able to go in and drop them off and say, This is who I am and
6 I would like these scanned to my record.
7 **Q.** We were talking about categories, and if that same
8 individual, for instance, had health records that were supplied
9 to them in some electronic format from Canadian Armed Forces and
10 that was their entire medical record from the military, is there
11 any reason why a category couldn't be created so that all of
12 those documents, instead of just being loaded as just documents,
13 external documents, why they couldn't be loaded under a category
14 that said, for instance, CAF medical records? So that when a
15 clinician is looking for a particular record or looking for a
16 discharge summary from a care facility when the person was in
17 the military they would know to go into that category? It would
18 just be a very special category for all of those records? Would
19 that be difficult?
20 **A.** Technically, there could be a category, like, almost
21 like a sub-category, under correspondence and then another
22 category for any veteran files.

1 **Q.** Yes.

2 **A.** It's technically possible to add a category and it's
3 not out of the question to do that. That would be more of an
4 IT/technical question, Is there ... would that be a vendor
5 request? I would have to defer. I would have to defer that to
6 the IT for the build to see because technically is there space?
7 Technically, can we add to it? But those categories are
8 definitely able to be expanded on.

9 **Q.** And that would be whether you expanded that category
10 by name in OneContent or in MEDITECH. You could do it in both,
11 could you not?

12 **A.** You would have to add it to both.

13 **Q.** Yes.

14 **A.** Yeah, you would have to add it to both, yes, for sure,
15 because those two systems don't talk to each other.

16 **Q.** All right. Thank you. Sorry. Mr. Murray?

17 **MR. MURRAY:** No, that's fine, Your Honour.

18 **THE COURT:** Thank you, Ms. Plummer.

19 **MR. MURRAY:** That's a lot of the questions I was going to
20 ask, actually. So that's fine.

21 **THE COURT:** All right.

22

1 **CROSS-EXAMINATION BY MR. MURRAY**
2 **(13:59)**
3 **MR. MURRAY:** Just following up on that, Ms. Plummer.
4 What we were just discussing about a person accessing or
5 bringing their own records from another province and asking them
6 to be added to their electronic health record here in Nova
7 Scotia. Do you have any sense if that actually happens very
8 often? I mean where a person just, themselves, does that and
9 goes to a hospital and says, Please scan this in?
10 **(14:00)**
11 **A.** It does not happen very often. It happens
12 occasionally when a Canadian Armed Forces personnel actually
13 moves from another province into our province. There has been
14 clinical documentation dropped off by those people and they're
15 able to ... they're scanned in but it does not happen very
16 often.
17 **Q.** That's a retired mili- ...
18 **A.** The patient themselves ...
19 **Q.** Sorry. You say that Canadian Armed Forces personnel
20 have done that? You're aware of that?
21 **A.** Yes, and it's usually because they've moved provinces
22 and they're now living in our province. It does not happen very

1 often.

2 **Q.** And that would be retired Canadian Armed Forces
3 personnel, would it, typically? Because I understand that
4 actively serving CAF members have their healthcare taken care of
5 by the CAF.

6 **A.** We don't ask or keep statistics on who it actually is
7 or whether they're actively working or not. We would just
8 fulfill their request. So it's not a statistic or level of work
9 that we actually track. So it's just an observation of how
10 often do we actually receive these and it's not very often.

11 **Q.** I would think more often the person would be seeing a
12 clinician at a hospital and have their records with them and
13 would be giving them to that doctor, that clinician, more
14 commonly. That's how they would get into the system?

15 **A.** Well, that again is true because the patient can maybe
16 maintain these on their own and bring it to whatever care
17 provider they're going to. They may keep it themselves.

18 **Q.** Right. So if a person comes from another province and
19 they have their health records from the other province they go
20 to their family doctor outside of the NSHA environment and give
21 those records to the doctor. That's where they will remain, in
22 that doctor system, correct, or in that doctor's file?

1 **A.** That is correct.
2 **Q.** And if they go to a specialist, let's say, at an NSHA
3 facility and say, Look, here's some discharge summaries or
4 reports I have from when I was in Saskatchewan or New Brunswick
5 or what have you, those may not get scanned into their
6 electronic health record or would they pretty commonly get
7 scanned in?
8 **A.** If the care provider were to attach the external
9 documents with the visit documentation of that day they would be
10 scanned. If they were to maintain that external document in
11 their office, in their private office, they would not be
12 scanned.
13 **Q.** Right.
14 **A.** They would need to reach the health record department
15 in order for them to be scanned into OneContent or MEDITECH.
16 **Q.** And even if those records came on a disk or in some
17 electronic format in all likelihood they would have to be
18 printed and then re-scanned back in.
19 **A.** That's correct.
20 **Q.** Okay. And just on the ... just backing this up a
21 couple of questions. The MEDITECH system that's used in
22 Eastern, Western, and Northern Zones, it's the same product, I

1 guess you said, MEDITECH Client Server, but do those three ...
2 **A.** That is correct.
3 **Q.** Do those three MEDITECH Client Server products, do
4 they interface or not?
5 **A.** They do, yes, they absolutely do. So if you were get
6 access to MEDITECH in all three zones ...
7 **Q.** Right.
8 **A.** ... you would see all three zones.
9 **Q.** All right, so if I'm in ... again, if I'm at St.
10 Martha's, I'm a doctor seeing a patient, I log in to MEDITECH.
11 Anything that's in any of the MEDITECH systems for any of the
12 three zones - that is Eastern, Western, and Northern - for that
13 patient would be visible to me when I logged on. Is that
14 correct?
15 **A.** Yes, if you had access to all three you would see all
16 of the visits at all of the sites within those three zones, yes.
17 **Q.** So maybe the key to the answer is "if you had access".
18 So if I'm a doctor seeing a patient at a hospital, at an NSHA
19 facility, and I log on to MEDITECH, presumably I'm going to have
20 full access, am I?
21 **A.** When a clinician or a physician is working out of a
22 facility the facility access is what they would receive and any

1 access required beyond that facility would then be a request for
2 user access.
3 **Q.** Okay, so I see a patient at St. Martha's and I log in
4 to MEDITECH. I'm going to see their documents on MEDITECH for
5 St. Martha's Hospital only. Correct?
6 **A.** Correct.
7 **Q.** Will I see any documents if they've gone to a
8 hospital, say, in Sydney in the same zone, will I see any of the
9 MEDITECH documents or do I have to make some request to get
10 additional access?
11 **A.** So there's another portion, another part of MEDITECH.
12 When I'm talking about ... so there's MEDITECH the electronic
13 record. There's also in MEDITECH a visit history. They would
14 be able to see the visit history.
15 **Q.** Okay.
16 **A.** Which just tells them that they were at the other
17 MEDITECH site.
18 **Q.** Okay.
19 **A.** They would not be able to launch any (inaudible -
20 audio) the records from there.
21 **Q.** And would SHARE give them any extra access to the
22 other information from the other MEDITECH sites?

1 **A.** Yes, it would. So the SHARE portal receives all of
2 the visit activity and flows into SHARE. So they'll see the
3 date, the facility, the type of care, inpatient/outpatient, and
4 so they would be able to see that visit history in SHARE.
5 **Q.** And of course with SHARE they would be able to see
6 that visit history for the OneContent system if there was
7 anything in that system.
8 **A.** Absolutely, yes.
9 **Q.** Right. We've heard ...
10 **A.** SHARE ...
11 **Q.** Go ahead.
12 **A.** SHARE has an interface from both MEDITECH and
13 OneContent that would populate all of the patient visits in the
14 province in both systems.
15 **Q.** Is the SHARE interface an easy one to use or is it a
16 bit tricky?
17 **A.** I've actually not gone into it myself. I've seen
18 screenshots of it.
19 **Q.** Okay.
20 **A.** I wouldn't be able to comment on that.
21 **Q.** And is it at times glitchy or does it have down times?
22 **A.** That I wouldn't be able to answer as well. It's not a

1 system that I would support or have any tracking for downtime
2 procedures and that sort of thing so I won't be able to answer
3 that question.
4 **Q.** And the MEDITECH and OneContent systems for doctors, I
5 take it they're older systems, we've heard. They're probably
6 not the most user-friendly or the interface is not the most
7 easily accessed, is that fair?
8 **A.** They are older systems. As far as accessing, that
9 would be more of an end-user question to whether they think it's
10 intuitive and user-friendly.
11 **Q.** Just wanted to ask you a question about accessing
12 paper records. I may not have understood this entirely but if
13 I'm a clinician seeing a patient and I want a paper record, so
14 that would either be a pre-scanning paper record, let's say, or
15 if I'm in a MEDITECH system and I go into SHARE and I see there
16 was ... well, let me put it the other way. I'm a OneContent
17 person. I go in to SHARE. I see there was a visit at a
18 MEDITECH facility but I can't look at the scanned documents so I
19 want those paper documents. I can make a request to the
20 facility where the record is stored?
21 **A.** That's correct. You would make that request to the
22 health record department of the facility where that visit was.

1 So if that care provider had gone in to SHARE, saw that there
2 was a St. Martha's visit, they would then contact the health
3 record department at St. Martha's.
4 **Q.** And you said if it's a stat. request usually that can
5 be done within an hour?
6 **A.** Correct.
7 **Q.** And what if it's Saturday night?
8 **A.** So that request can be made through the switchboard.
9 The switchboard is 24/7 and that switchboard operator would find
10 somebody to process that request. They, themselves, can start
11 that request and pull the paper record and have it available.
12 **Q.** Right.
13 **A.** And it would usually be somebody late at night. It
14 would probably be somebody from the emergency department or a
15 facility lead or a clinical leader on call. It would be
16 completed outside of my team because that department would be
17 closed during those hours but the record would be still
18 accessible.
19 **Q.** Okay.
20 **A.** The paper record.
21 **(14:10)**
22 **Q.** But with a few more steps because someone on a

1 switchboard has to make a request within the hospital. Somebody
2 has to get access through security to the health records
3 department who doesn't normally work in the health records
4 department, find that record, get it copied, scanned, and sent
5 back to the doctor who wants it in the other hospital.
6 **A.** Correct.
7 **Q.** And what if I'm looking for a record that's stored off
8 site at Iron Mountain?
9 **A.** So Iron Mountain has a 24/7 service and if it was
10 needed on a stat. basis they would be able to produce the
11 record.
12 **Q.** And you may have answered this, I'm sorry. But for
13 Mental Health and Addiction records - again, pre scanning that
14 are ambulatory, not the ones that are part of the inpatient
15 record - after hours those are accessible but sort of with some
16 of the same hurdles, like getting access to them and so forth?
17 **A.** Yes, that's true, and those are managed by the Mental
18 Health and Addictions offices. They are not open 24/7 either.
19 So those requests could be made to the facility and they could
20 access those records using the same security to let them in the
21 office to be able to gain access.
22 **Q.** On the issue of the categorization of documents you

1 said there's about 50-ish in MEDITECH and about 80 in OneContent
2 or thereabouts?
3 **A.** That's correct.
4 **Q.** And do those have sub-categories in them or is that 80
5 in total, let's say, for OneContent?
6 **A.** It would be 80 in total for OneContent. So yeah,
7 those ... and yeah, the examples would be history and physical,
8 progress note, discharge summary, lab. Those would be the
9 categories.
10 **Q.** So if there's a category, I don't know if there is,
11 but let's say there's a category for diagnostic imaging. Is it
12 broken down into x-rays, CAT scans, MRIs, that type of thing or
13 is it just ...
14 **A.** It's the one ... there isn't a sub-category. It's the
15 general category and then you can go into that category and see
16 what reports actually fall under that category, which would be
17 named in the title of the report.
18 **Q.** Okay, but some ...
19 **A.** So ...
20 **Q.** Go ahead.
21 **A.** Go ahead.
22 **Q.** No, you. Please, you ...

1 **A.** So those ... so the category of DI. If you were ...
2 you can then open it up and see what the title was. So you
3 would know if it was a CAT scan or an MRI.
4 **Q.** Right. Okay.
5 **A.** From the title of the report.
6 **Q.** Right. But some categories, some broad categories,
7 have sub-categories, do they, or is it just 80 categories?
8 **A.** 83 categories in OneContent.
9 **Q.** Okay. All right. So again, just following up on the
10 question that was asked earlier. I assume those categories have
11 changed over the years? Things have been added or taken away?
12 **A.** Not much has been taken away because we don't take
13 away because we have historical information under those. Yes,
14 there have been new categories added to those.
15 **Q.** Right. Okay. So if there's a need identified you
16 say, Look, you know, maybe we're getting too much information in
17 one of these categories, we need to break it in two, or there's
18 just some new sort of source of information that we didn't have
19 ten years ago and we want to create a category for it, that does
20 happen from time to time?
21 **A.** That is correct, yes.
22 **Q.** Okay, and similarly in MEDITECH, the same thing I

1 assume? Categories can be added?
2 **A.** Yes.
3 **Q.** Okay.
4 **A.** Yes, categories can be added.
5 **Q.** So following up on His Honour's question, if we wanted
6 ... you know, we have this category of external records and
7 correspondence, I think was the way you referred to it. When I
8 bring my records from another province presumably we could
9 create another category for external provincial documents if we
10 wanted to?
11 **A.** Yes, technically, it could be possible.
12 **Q.** Right. And I appreciate you can't speak to the IT
13 part of it but I mean perhaps from a clinical point of view
14 there wouldn't be any problem with having another category.
15 **A.** No.
16 **Q.** No?
17 **A.** I don't see a problem having another category
18 specific.
19 **Q.** Okay. I appreciate your comments about the concern
20 about ... or I guess when you were asked a question about the
21 value in having a facilitator in the Nova Scotia Health
22 Authority in collecting records that does add another layer and

1 can potentially cause confusion. I guess I just ask you this
2 question. The flip side of it. If a person is being asked to
3 access records from another province or from the CAF and they're
4 just not able to do it because they have some limitations or
5 barriers do you see ... if you can answer this. Do you see any
6 value in a facilitator that would assist that person in
7 gathering those records?
8 **A.** I'm wondering if a better way would be ... so I know
9 within veterans - my father was one - that the veterans, I
10 believe, all have a caseworker that handles the case which would
11 help them navigate what was required helping with some of the,
12 you know, pension questions and all of that and some medical
13 care for home-assisted living and all of those types. I'm
14 wondering if the best person to help navigate some of a
15 veteran's ... whatever they may need help with, I'm wondering if
16 that person might be the best person to be able to handle that
17 since that caseworker already knows that veteran and is able to
18 then navigate partners such as Nova Scotia Health Authority and
19 be able to help them in fulfilling the request that they need.
20 **Q.** Sure.
21 **A.** I don't know if Nova Scotia Health Authority would be
22 the best person to do that because I ... you know, thinking

1 about it I would be very concerned about the delay that it would
2 create because if a patient ... and it happens quite often. I
3 actually did the release-of-information job both at the IWK and
4 Nova Scotia Health Authority.
5 I know, you know, when a patient says, I've been to this
6 facility in this year the years can quite often be confused and,
7 therefore, when you make a request for patient information the
8 request for what you're looking for is very specific. And if
9 that is not an exact match to the patient record ... so my
10 example of 2015, all the records from 2015, if there are no
11 records from 2015 that request is ... you'd be sending other
12 information that wasn't a part of the request.
13 So they would have to clarify that year, Well, did you
14 really want '15 or ... because we don't have anything. So I
15 would be very concerned the back-and-forth that that would
16 create.
17 **Q.** I guess I'm thinking more broadly of ...
18 **A.** Where it could come ...
19 **Q.** Of all of a veteran's records. Perhaps a person to
20 liaise with various VAC case managers to ensure that those
21 records are obtained, all of them, and put in one category, for
22 example? One of those ... maybe the 84th category as opposed to

1 the 83rd in OneContent for example. Do you see any value in
2 that?
3 **A.** I definitely see ... you know, see the value of the
4 category and it would be our job to ensure that they resided and
5 ended up in the correct category. It's the process for having
6 those ... requesting those records on behalf of a clinician is
7 the part I have concern about.
8 **Q.** I wanted to ask you one other question about ...
9 there's, I assume, a retention policy for health records, is
10 there?
11 **A.** Yes, yes, there is. Yes,
12 **Q.** Okay, and I don't expect you to have all of those
13 numbers. But ... go ahead.
14 **A.** Yes, there is a policy. That's actually one of the
15 policies that we've just recently completed. So because Nova
16 Scotia Health Authority started in 2015 - that was the beginning
17 of Nova Scotia Health Authority - a lot of the policies are
18 still sitting in the old DHA structure and those policies in the
19 ... if there is not an NSHA policy those DHA policies are still
20 active.
21 So we actually have a Nova Scotia Health Authority policy
22 for record retention and the patient record is to be kept stored

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1 and it has to be kept in a dry, secure area and the patient
2 records need to be kept and maintained for 25 years beyond the
3 patient's last visit or ten years after the patient has expired.
4 **Q.** And that's for all records, is it?
5 **(14:20)**
6 **A.** For the Nova Scotia Health Authority patient record,
7 yes.
8 **Q.** Okay. And does that include everything that's in
9 their health record? Anything that's electronic, paper, et
10 cetera?
11 **A.** Absolutely, yes.
12 **Q.** Would that include the history of their visits to NSHA
13 facilities?
14 **A.** Yes, though the visits would need to be maintained in
15 order to be able to access the paper record or the digital
16 record. So yes, they would be partnered together.
17 **Q.** Including appointments that maybe weren't kept? If
18 that was in a database would that be purged or would that still
19 be kept?
20 **A.** That is the ... our retention policy is for the
21 patient record. It's not the ... like a booking ... what you're
22 referring to now is a booking system. That policy is not a part

1 ... the digital scheduling of patient records would not be
2 included in that retention policy. This is actually the paper
3 medical record or the electronic medical record.
4 **Q.** If there was a contact with a clinician by telephone
5 and a record was kept of that, let's say they made a record of
6 it, that would be caught by the retention policy, would it?
7 **A.** Yes, that is correct. Whether it's a telephone call
8 or a face-to-face visit and any clinical documentation would
9 reside in that retention policy.
10 **Q.** So I'm going to ask if we can bring up an exhibit.
11 It's Exhibit 110. We may have spoken about this briefly in our
12 meeting, but crisis calls to mental health at an NSHA facility,
13 would those be caught by the retention policy as well?
14 **A.** Yes, they would.
15 **Q.** Okay, and ...
16 **A.** Yes, they would.
17 **Q.** All right. And so those ... any record of a crisis
18 call to a facility would be kept for 25 years from the last
19 visit or ten years after the person expired?
20 **A.** That is correct.
21 **Q.** And so we've just brought up the exhibit, which is
22 110, and if we could just focus in on maybe the first three

1 entries there.

2 **A.** Yes, I can see them.

3 **Q.** And I think those are records that indicate that ...

4 in our case we're talking about Lionel Desmond attended at a

5 hospital or made contact at St. Martha's or made a crisis call,

6 and we're wondering about those records. Those are records that

7 would normally have been retained or should have been retained?

8 **A.** That's correct.

9 **Q.** Okay.

10 **A.** That is correct, yes.

11 **Q.** All right.

12 **A.** And these are ... looking at this, these are Mental

13 Health and Addiction records. So they would be maintained

14 within the Mental Health and Addiction. These would be

15 ambulatory that we had chatted about earlier.

16 **Q.** Yes.

17 **A.** And these would be St. Martha's Mental Health and

18 Addiction telephone calls that would reside within the Mental

19 Health and Addiction department chart.

20 **Q.** Okay, so records of those calls should at least still

21 exist if there's something that was taken from those telephone

22 calls?

1 **A.** That is correct, yes, and they would reside in the
2 Mental Health and Addiction department at St. Martha's because
3 those are the ... that would be an ambulatory ... those would be
4 ... they would be stored there.
5 **Q.** Right. Okay. We were of the understanding that those
6 were crisis calls and that the records from those may no longer
7 exist or may have been shredded. Do I understand you that it's
8 your understanding that, in fact, whether that's happened or not
9 those should have been retained?
10 **A.** Yes, absolutely. They would fall within the retention
11 policy.
12 **Q.** Okay. All right. If we were told that those records
13 had been destroyed or purged or shredded after six months, to
14 your knowledge at least, that would not be in accordance with
15 NSHA records policy or retention policy?
16 **A.** That's correct.
17 **Q.** All right. Okay. Thank you for that, Ms. Plummer.
18 Thank you. I think those are all the questions that I have.
19 Thank you.
20 **THE COURT:** Thank you, Mr. Murray.
21 **A.** Thank you.
22 **THE COURT:** Ms. Ward? Ms. Grant?

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1 **MS. WARD:** No questions, Your Honour.
2 **THE COURT:** No questions. Thank you. Mr. Anderson?
3 **MR. ANDERSON:** No questions. Thank you.
4 **THE COURT:** Thank you. Mr. Macdonald?
5 **MR. MACDONALD:** No questions, Your Honour.
6 **THE COURT:** Thank you. Mr. Rodgers?
7 **MR. RODGERS:** Thank you, Your Honour. No questions, Your
8 Honour.
9 **THE COURT:** All right. Thank you. Ms. MacGregor?
10 **MS. MACGREGOR:** No questions, Your Honour.
11 **THE COURT:** Okay. Just while we're here. Mr. Rodgers,
12 I know that Ms. Miller stepped out for a moment.
13 **MR. RODGERS:** Yes.
14 **THE COURT:** Rather than break the connection with the
15 witness here, do you think I could ask you to ask Ms. Miller if
16 she has any questions and ...
17 **MS. RODGERS:** I'll ask her, Your Honour.
18 **THE COURT:** ... if so, what her ETA is to return?
19 **MR. RODGERS:** Absolutely.
20 **THE COURT:** Thank you. Ms. Plummer, one of the counsel
21 had just stepped outside for a moment. Whether she has any
22 questions or not, I'm just going to find out. I know she had a

1 small piece of business to attend to. So we'll check on her
2 status for a moment here if you don't mind waiting for a little
3 bit.
4 **A.** Sure, no problem.
5 **THE COURT:** Thank you.
6 **MR. RODGERS:** Your Honour, Ms. Miller advises that she has
7 no questions for the witness.
8 **THE COURT:** She has no questions? All right. That's
9 fine then.
10 Ms. Plummer, thank you very much for your time today. I
11 know it would have taken some time in preparing. I think you'd
12 met with counsel and had discussions with them just to help us
13 understand some of the information.
14 I'm sorry, did I miss somebody?
15 **MR. MACKENZIE:** No. I can ...
16 **THE COURT:** Did you have any ... oh.
17 **MR. MACKENZIE:** I guess Ms. Bennett-Clayton could have been
18 asked ...
19 **THE COURT:** Well, because Ms. Bennett- ...
20 **MR. MACKENZIE:** ... about re-direct, but I don't think she
21 has any.
22 **THE COURT:** All right, so I ... okay.

1 **MS. BENNETT-CLAYTON:** No, I don't.
2 **THE COURT:** I have lots of lawyers on the file.
3 So Ms. Bennett-Clayton, because you were sitting there and
4 led the direct I assumed that you didn't have any other
5 questions but I should ask you. I take it you have no further
6 questions ...
7 **MS. BENNETT-CLAYTON:** No, I don't.
8 **THE COURT:** ... for your witness? Thank you.
9 **MS. BENNETT-CLAYTON:** No, no.
10 **THE COURT:** That means Mr. MacKenzie does not have any
11 questions I take it.
12 **MR. MACKENZIE:** That's correct, Your Honour. Thank you.
13 **THE COURT:** It's always good that counsel are *ad idem*
14 with their own witness' testimony. Appreciate that. Thank you.
15 But I would like to thank you for your time, Ms. Plummer.
16 It's very important, I guess, for us to have a full
17 understanding of some of the record-keeping, and particularly as
18 it engages some questions with regard to access to records,
19 which was one of the terms of reference in the ... that guides
20 this Inquiry in its deliberations. So thank you very much for
21 your time. We appreciate it. Thank you.
22 **A.** You're welcome.

1 **THE COURT:** Thank you.

2 **A.** Thank you.

3 **WITNESS WITHDREW (14:30 hrs.)**

4 **THE COURT:** All right. Counsel, we're going to adjourn
5 until March the 23rd at 9:30. Just ask you all to remain in
6 attendance for a short period of time. Thank you.

7 **COURT CLOSED (14:30 hrs.)**

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CERTIFICATE OF COURT TRANSCRIBER

I, Margaret Livingstone, Court Transcriber, hereby certify that the foregoing is a true and accurate transcript of the evidence given in this matter, **re Desmond Fatality Inquiry**, taken by way of electronic digital recording.

Margaret Livingstone
(Registration No. 2006-16)
Verbatim Inc.

DARTMOUTH, NOVA SCOTIA
April 7, 2021