eKiDs PowerChart

Emergency Department Physicians
CLINICAL DOCUMENTATION

Presented by the IS Training Department

eKiDs PowerChart®

POWERCHART® FOR EMERGENCY DEPARTMENT PHYSICIANS

PowerChart is a flexible, graphical tool that provides the clinician immediate access to the information in the clinical database.

PowerChart is designed to operate in two main windows: the **Organizer** and the **Patient Chart**. Both windows can be open concurrently.

The Organizer serves as the desktop for **FirstNet**, linking Emergency Department healthcare professionals to vital patient and department information.

 The Patient Chart displays several customized views of the patient's chart. Access to both the Organizer and Patient Chart makes it easy to navigate between the Tracking List and the patient chart and quickly obtain desired patient information for the best possible outcomes.

OBJECTIVES:

- Review and understand new FirstNet functionality

- Review and co-sign orders entered by clinical staff

- Respond to messages (ex. Co-sign documentation) via Message Center in PowerChart

- Acquire understanding of functionality for new and/or revised chart tabs in PowerChart

- Enter and work with PowerOrders and PowerPlans

- Document and modify information related to a patient's visit via PowerNotes

- Apply new Discharge Process functionality (ex. Med Reconciliation)

SECTION I   POWERCHART STRUCTURE

PowerChart operates in two main windows: the **Organizer** and the **Patient Chart**. Both windows can be open concurrently.

The PowerChart Organizer opens to your home view. The Emergency Department physician home view is the FirstNet Tracking List that provides up-to-date information at a glance to keep the Emergency Department running efficiently.

INTRODUCTION TO FIRSTNET

The implementation of Phase V of PowerChart EMR and CPOE provides enhancements to the FirstNet Tracking List toolbar and icons.

TOOLBAR ICONS
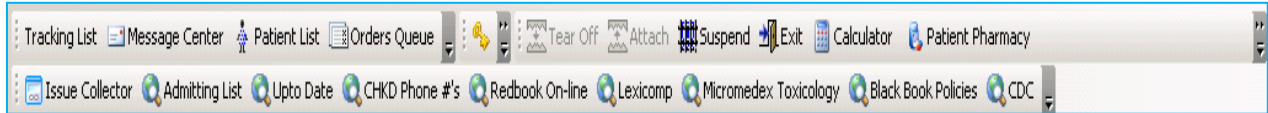
NAME	DESCRIPTION
Message Center	Allows users to manage workflow, review document and prescription requests, sign and route documentation electronically, as well as work with phone and other messages
Orders Queue	Displays a list of orders placed in PowerChart but not yet signed or reviewed
Patient Pharmacy	Displays the patient's preferred pharmacy and also provides a location to search for additional pharmacies
Admitting List	Displays a list of all providers that currently have admitting privileges to CHKDHS.
Up to Date	Launches you into an internet Application that provides you with general medical information
CHKD Phone #s	Launches you to the CHKD internal phone numbers
Redbook Online	Displays the Red Book Online providing current medical literature
Lexicomp	Provides a link to the Lexicomp formulary tool
MicroMedicis	Provides a link to the Micro Medics website
Black Book Policies	Provides a link to the Black Book Policies website
CDC	Provides a link to the Center to Disease Control website

TRACKING LIST ICONS

Tracking List Icons located on the tracking board serves as indicators of patient care status. Icons located on the toolbar provide a launching point to access specific locations/forms within PowerChart.

Icon	Label
	Acuity/Triage
	iView I&O
	Patient Care Task List
	Respiratory Order Entered
	Infusion Billing Form
	ED Transfer- Transport Details
	ED VS- Acuity Level Two
	ED VS- Acuity Level Three
	ED VS- Acuity Level Four
	ED Vital Signs
	Critical Task
	Overdue Task
	ED Specimen Collection Details
	ED Urine Collection Details
	ED CSF Collection Details
	ED Med Response
	Pt on Isolation
	EKG
	Assign Provider
	Provider Check-Out
	Unassign Provider
	RN Exam
	MD Exam Needed
	Mental/Behavioral Precautions
	Minor Care
	Name Alert
	Telephone Triage
	Open Patient Chart
	Set Events
	Base Location
	Admit
	Discharge
	Discharge with Prescriptions
	Co-Pay Due
	72 Hour Return
	Incomplete Consent
	Surgery Consult
	Child Life Requested
	Patient Advocate Requested
	Registration
	Duplicate Patient
	Secondary Assessment

TRACKING LIST TABS

The tab you select will be the active traking list spreadsheet. Depending on your role and security, the chart tabs displayed may differ.
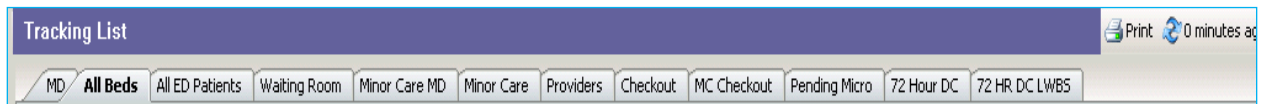
MD Tab -- Displays all patients in the Emergency department and is designed to assist the physician with their provider assignments by organizing the patients according to patient location.

All Beds – Displays all the beds in the Emergency Department and their status. This list allows you to track patients by bed, sort the spreadsheet, and stay informed of the status of beds.

All ED Patients -- Displays Patient Name, Age, Bed Location and Acuity

Waiting Room Tab – Only displays patients who are currently located in the Waiting Room.

Minor Care Tabs – Displays patient assigned to Minor Care (Fast Track). A green circle in the MC column indicates the patient has been assigned to Minor Care. This is triggered by a response in the Primary Triage Assessment.

72 Hour DC and 72HR DC LWBS Tab – Displays a lists of patients that were discharged within the last 72 hours.

Checkout Tabs – The Checkout tab lists patients who have been discharged from the Emergency Department.   When discharge from the registration system is complete, the patient will automatically drop from the Checkout tab.

Pending Micro Tab – The Pending Micro Results tab lists patients discharged within the past seven days who still have outstanding lab results. The number ordered and the number resulted will display. For example, 3/2 indicates three tests were ordered and two have been resulted. A clipboard with a red check icon in the Micro column indicates <u>all</u> tests have been resulted.

 72 Hour DC and 72HR DC LWBS Tab – Displays a lists of patients that were discharged within the last 72 hours.

COLUMNS AND TABS

The implementation of Phase V of PowerChart EMR and CPOE provides additional columns to the FirstNet Tracking List.

COSIGN COLUMN

The Cosign column takes you into the Actions Requiring Co-signature window. Clicking on the order notification icon takes you to the window that displays order actions pending co-signatures.

Example: Orders entered by Nursing or Residents.

Once in this window, you can select all or simply select the order(s) you wish to cosign by placing a check mark in the box beside those order(s).
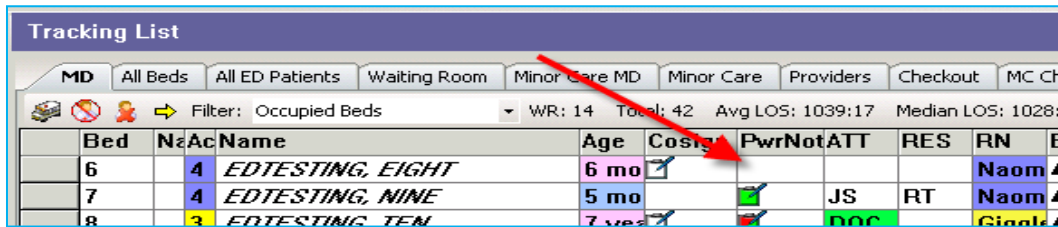
PWRNOTE COLUMN

The PwrNote Column displays an icon indicating the status of the PowerNote for the selected patient. The status of the PowerNote is noted in the columns color-coded icon.
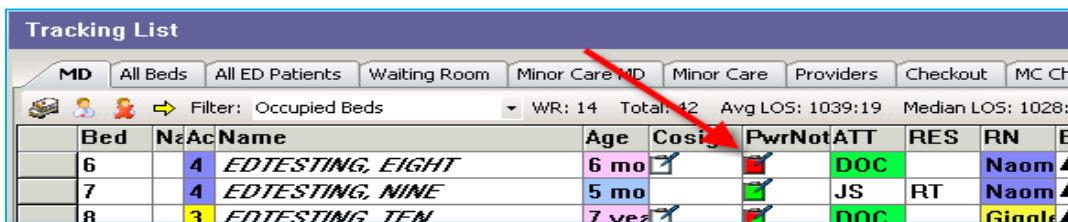
If no Attending Physician is assigned to the patient, no icon will display for the PowerNote status.

Once the Attending Physician is assigned to the patient, a Red indicator will display indicating the PowerForm is assigned for documentation but has not yet been started.

The color will change to a Yellow indicator once the PowerNote has been Saved.

The color will change to a Green indicator once the PowerNote have been Signed.

When another physician is assigned to the patient the PowerNote indicator will be split to show the status of other PowerNote documentation.

Additional Indicators

Provider(s) assigned but all documentation <u>not started</u>

Providers assigned but documentation <u>not started</u> from one provider while documentation has been started and <u>Saved</u> from another

Providers assigned but documentation <u>not started</u> from one provider while documentation has been <u>Signed</u> from another

Provider(s) assigned with all documentation <u>started and Saved</u>

Providers assigned with all documentation <u>started and Saved</u> from one provider while documentation has been <u>Signed</u> from another

Provider(s) assigned with all documentation <u>Signed</u>

Clicking on the icons displays a window where documentation can be displayed and filtered based on your preference. This includes past documentation for the patient. This documentation can be filtered to display all PowerNotes, only specific criteria or a date range for the PowerNotes you wish to display. Advanced filters are available by clicking the ellipsis button allowing you to set your user defined defaults.
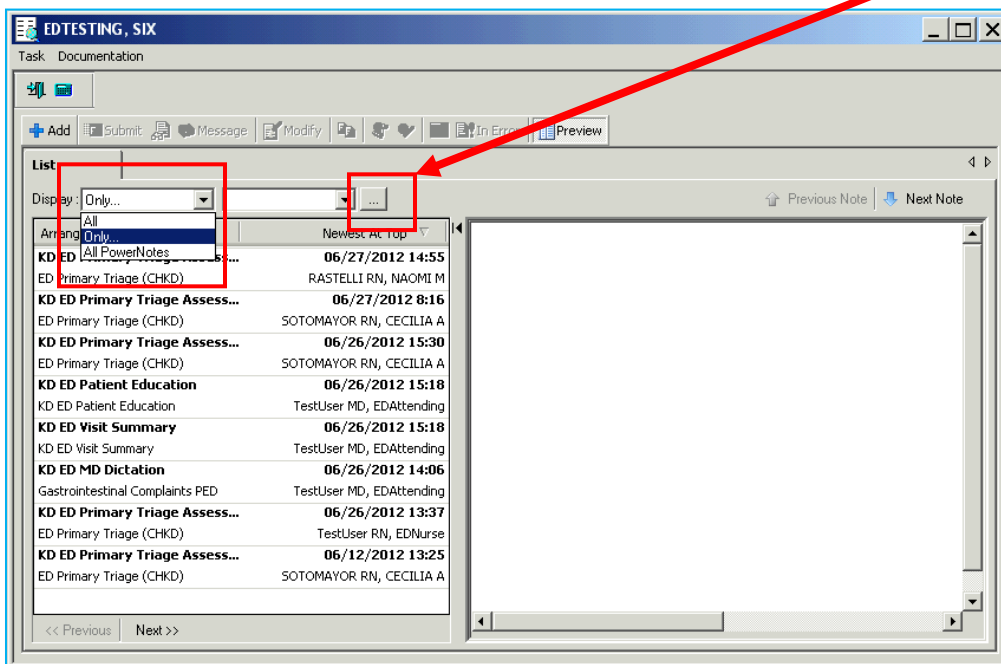
SECTION II   CHART TABS

From within a patient's chart specific information such as orders, results and documentation are available in the Chart Tabs. The Chart Tabs provide actions based on the window that opens. Depending on your role and security, the availability and order of the tabs may differ.

The new and/or revised chart tabs are listed below:

- **ED Summary -** The ED Summary tab displays clinical data as staff contributes documented results to the patient's EMR. Some of the information that will populate this tab include: Patient Information, Diagnosis & Problems, Allergies, Vital Signs, Diagnostic Results, Laboratory and Pathology results, etc. Actions such as entering orders, home meds and adding allergies may be completed directly from the ED Summary. Customization and user preferences can be set to enhance your view and workflow.

- **PowerNote ED –** The PowerNote ED tab offers online documentation at the point of care using a template-based approach to support efficiency and accuracy. Clinical information is saved to the patient's chart so that it can be used for reporting and analysis. You can incorporate previously documented information and test results into your notes and along with seamless ordering, consistently fulfill documentation requirements.

- **Quick Orders --** The Quick Orders chart tab contains the most commonly ordered procedures and tests for the ED such as Lab Orders, Micro Orders, Common Rad Orders, and CT Orders. You can also access additional orders by clicking on the New Order Entry section within the window. Outstanding orders for the selected visit will display as well.

- **PowerOrders -** The Orders section allows you to view and enter orders. The Document Medication by HX sub-tab allows you to enter a patient's medication history.

- **Medication List -** The Medications List tab displays the patient's Inpatient, Outpatient, Prescriptions, Documentation Medication by history and Unspecified Meds. Orders can also be accessed from this tab.

- **Flowsheet** – The Flowsheet Tab provides a view only flowsheet of all documented result information. Combined results of 48 hours in the past and 24 hours in the future may be viewed as a table, group or list. Be aware that other clinicians may have a different view that lists the sub-tabs in Results Review as individual tabs in the menu.

- **Summary Documents** - The Summary Documents tab allows you to view such things as operative reports or H&P's.

- **All Documents** - All Documents tab displays all documents entered into the system.

- **Allergies** - The Allergies tab is used to view and enter allergies for a patient. **If no allergies are noted, "NO KNOWN ALLERGIES" should be documented.**

- **Mar Summary -** The MAR Summary tab displays the patient's medications in a view only mode. This tab will be utilized by providers to view medication administration information. By hovering over a medication, additional information regarding that medication may be viewed.

- **Patient Information** – The Patient Information tab includes information such as the Patient's Demographics, Visit list, and PPR Summary.

- **Form Browser** - The Forms Browser tab allows you to see charted information in its entirety that was done for a selected patient via PowerForms.

- **Problems and Diagnosis** - The Diagnosis and Problems tab provides a view of Diagnosis & Problems that have been entered for a selected patient.   Anything that presents a problem to the patient's overall health may be listed in the Problem List. Only designated roles such as Infection Control Nurses and Physicians can enter problems on the Problem List.

- **Overview –** The Overview Tab displays designated patient information from the last time the chart was reviewed by the user. Selecting DATE/TIME stamp button clears the screen and allows new information to populate from that point forward.

- **Advanced Growth Chart** - The Advanced Growth Chart tab provides a graph of a child's growth compared to the national standard. Gender specific Height, Weight and Head Circumference charts are available for ages 0-36 month and Height and Weight charts are available for ages. 2-18 years. Information can be entered by CHKDHS ambulatory sites that have access to clinical documentation. It can be viewed by all inpatient staff with view access to PowerChart. All staff should follow their unit policies concerning viewing and documenting within growth charts.

- **Immunization Schedule** - The Immunization Schedule tab allows you to view past immunizations administrations documented by CHKD staff at sites that have access to clinical documentation. Immunizations that are administered while the patient is an inpatient will be documented in the eMAR and the information will populate in the Immunization Schedule.

- **Histories** - The Histories tab has two sub-tabs and allows you to view and designated staff to document the patient's procedure history and the patient's family history.
    - Procedures: **CHKD Operating Room Staff** will document procedures that take place at any CHKD operating room facility. This information can be viewed by all staff that have security to view information in PowerChart.
    - Family: Any Family History that has been recorded by a CHKDHS site that has access to clinical documentation can be viewed here by staff that has access to view information in PowerChart. Staff with access can also add Family History as appropriate by clicking the ADD button and entering the appropriate health history for the selected family member.

- **Appointments** – The Appointments tab is a view only tab that displays Future appointments and Past appointments that have been scheduled for your patient by CHKDHS outpatient locations who are currently using PowerChart EMR documentation.

- **Reference Text Browser** – The Reference Text Browser tab displays Drug Reference, Education Leaflet and other Reference Material.

- **iView I&O/2G** - Interactive View, also known as iView/I&O 2G, is a flowsheet of a wide variety of patient data in a single area. Head to toe assessments, Vital signs and I/O are documented on this tab. In iView you can document, view, modify and unchart results

PATIENT CHART

The Patient Chart consists of a combination of tabs that allow the clinician to access information that is pertinent at that moment.
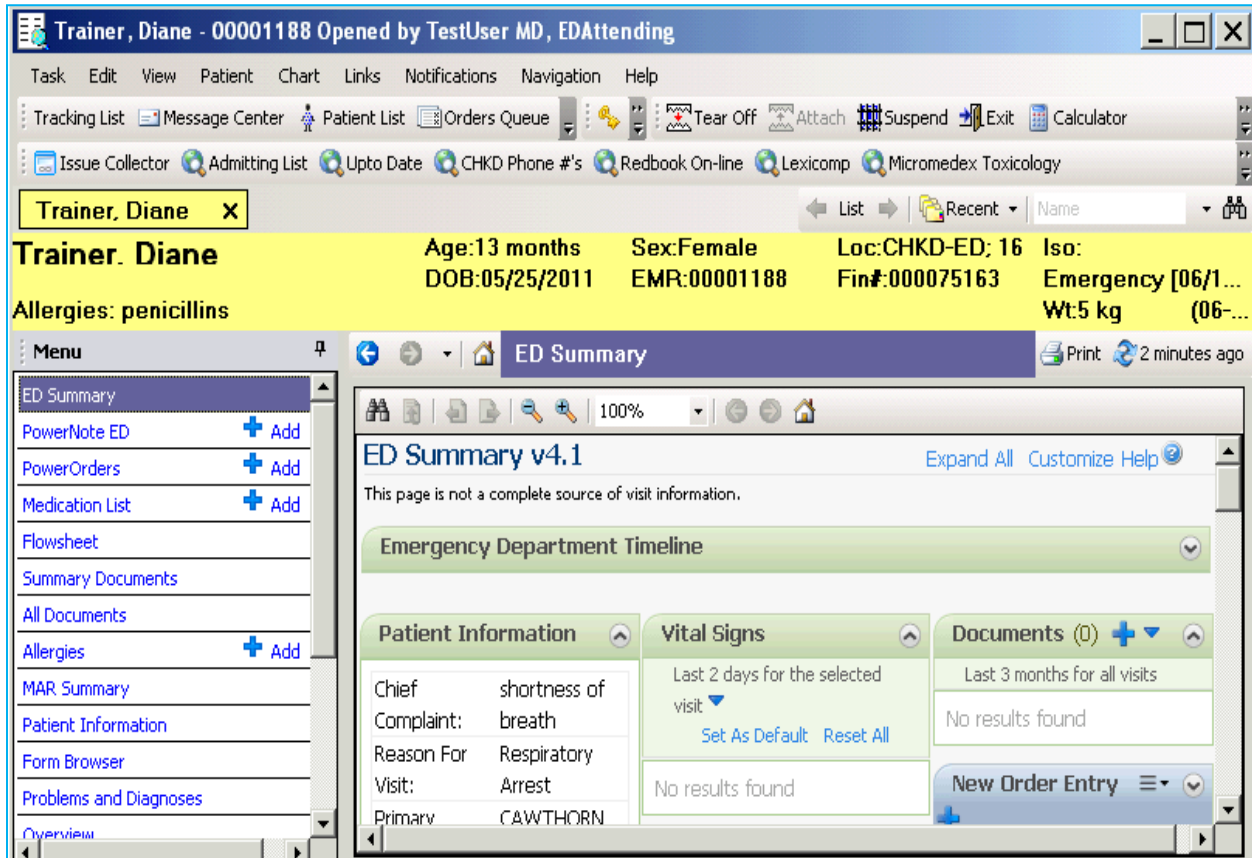
Like most Windows applications, PowerChart utilizes a menu bar and a toolbar.

The menu bar contains textual options of system actions available based on the particular window that is open.

Remember, you must close both the Organizer and the Patient Chart to log completely out of PowerChart.

ED SUMMARY TAB

The ED Summary pulls information entered or viewed in different areas of the chart into a single convenient view. The ED Summary contains a quick view of information such as Diagnoses, Problems documented in the Problem List, Allergies, Vital Signs, and Patient Education.

The ED Summary M-Page supports interactive workflows. For example, physicians can enter orders, and PowerNotes (documents) directly from ED Summary.

You can "jump" to certain areas of the chart from the Patient Summary by clicking on the hyperlink at the top of the specific section.

You can also hover over sections and view additional information about the documented result.
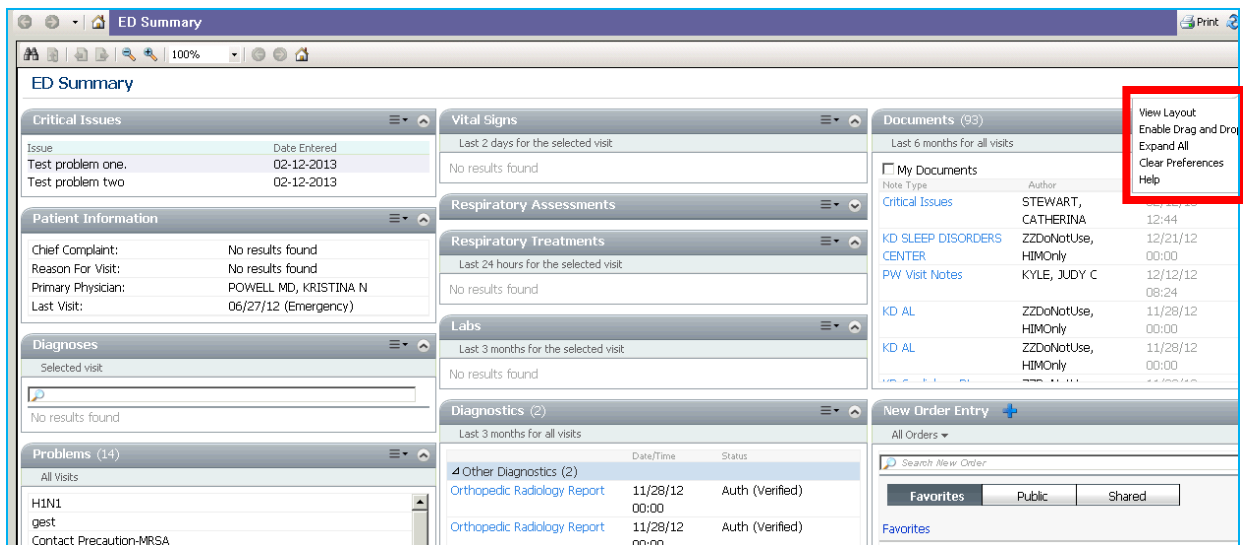
In order to Customize your screen click the link in the upper right-hand corner of the ED Summary MPage.

1. Left-click on the Header that you would like to move and drag and drop it to your desired location.

   Note some Headers such as Patient Information can be moved but will only be displayed in the original column. Before moving headers be sure to consider the screen resolution for your view and how you would like the information displayed.

2. To default the sections to display as opened or closed click *Expand All* (to display all as open) or *Collapse All* (to display all as closed).

You can also choose to display individual sections open or closed.

Clicking the down arrow beside a section will default only that section to Expand.

Procedure History

Clicking the Up Arrow beside a section will default only that section to Collapse.

Family History

3. Once the headers have been moved to your desired location and all defaults are set as desired, click on *Save Preferences* to complete and retain your changes.

DOCUMENTING AND VIEWING CRITICAL ISSUES IN POWERCHART

Critial Issues that are documented in a PowerForm will displays on the ED Summary Tab.
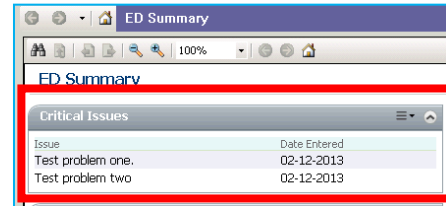
Proposed information on intake form for Critical Issues:

- **Only** enter conditions or allergies that have the potential to cause **serious harm** (e.g., jeopardize life, limb or organ function).
- Also, use Critical Issues to notify providers of special treatment protocols or to communicate essential information (e.g., protocol for inborn error of metabolism).

Effective February 13, 2013, the **Critical Issues** widget will be displayed in the upper left most position on all Summary MPages. The purpose of the **Critical Issues** widget is to provide a consistent location where critical patient information can be rapidly identified by health care providers. This space should **_only_** be used to enter conditions, allergies or adverse drug reactions that have the potential to cause **serious** harm (e.g., may jeopardize life, limb or organ function). Thus, drug or food allergies that cause a rash would **NOT** be listed here. This space **should be** used to note **important** information that may affect patient outcome if not known rapidly.

Examples of conditions that **SHOULD** be listed include:

- Medication or food allergies leading to anaphylaxis or severe drug reaction (e.g., Stevens-Johnson syndrome).

- Critical airway (e.g., patient who is difficult to intubate, or child with tracheotomy who does not have a patent pharyngeal airway).

- Inborn error of metabolism requiring treatment with a specific treatment protocol.

- Conditions requiring unique treatments (e.g., use of C_1-esterase inhibitor in a patient with angioedema).

- Notification that providers should <u>not</u> obtain blood pressure or place an IV in the right upper extremity in a patient with a right Blalock-Taussig shunt.

- History of severe blood incompatibility (e.g., difficult to crossmatch or history of delayed hemolytic reaction).

- Critical communication about management (e.g., a patient with functional abdominal pain who should not receive IV opioids on presentation to the ED, or a patient whose seizures worsens with the administration of fosphenytoin).

- Patient with an implanted medical device, including notation of patient who should <u>not</u> have an MRI.

These conditions may be added by <u>any</u> physician, advanced practice provider or pharmacist. As noted, this is **<u>NOT</u>** the place to list patient problems that are <u>not</u> critical. Thus, it is likely that most patients will **<u>not</u>** have any information entered in this widget. Conversely, it is **very important** that when a problem is identified (e.g., a patient who was found to be very difficult to intubate when undergoing an elective procedure), this information should be entered by the clinician in this widget.

If a patient's critical issue has resolved, the Critical Issues section can be modified by a physician, advanced practice provider or pharmacist. **<u>Note:</u>** all entries or changes to the Critical Issues will record (hidden) the individual who entered the information and will display the date and time the information was entered. Details about who made entries and when are visible using the Form Browser.

Inpatient Summary View – no critical issues entered

Inpatient Summary View – critical issue entered

STEPS TO RECORD A CRITICAL ISSUE:

1. Select the patient and open the chart.

2. Select the AD-hoc icon from the main **AdHoc**   PowerChart toolbar:
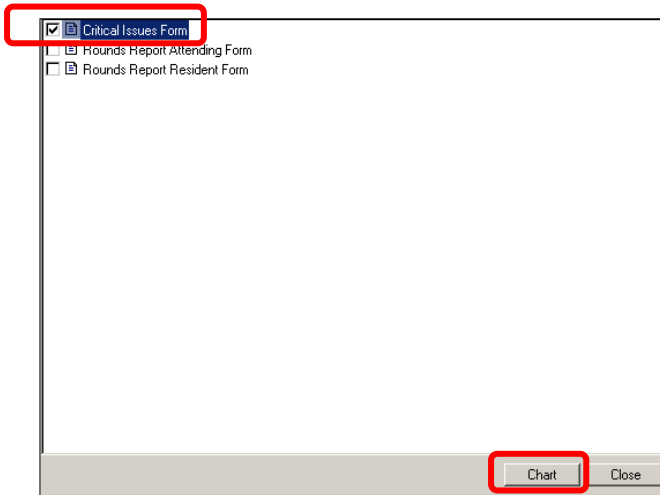
3. Click the check box next to the Critical Issues form and then select the Chart button

4. Enter the patient's critical information in the space provided in the top section of the screen; **never enter critical issue text in the comments section, it will <u>not</u> display.**
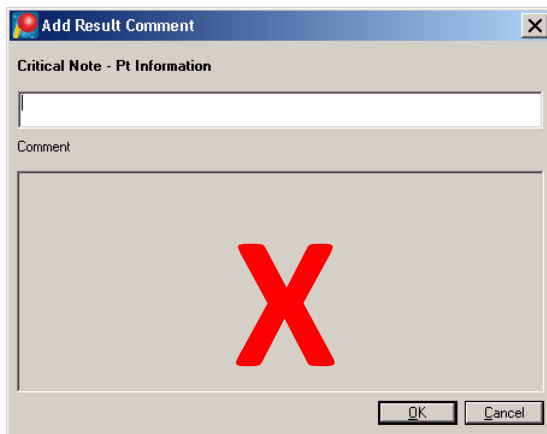
Click in the date field and enter the date, (enter **T** for today or click the down triangle to display and select from a calendar.

5. Click the green check ✓ mark to record the entry

Important Note: If edits are needed, follow the same process steps to access and make changes to the recorded Critical Issue from the Ad-hoc charting folder.

CRITICAL ISSUE TOOLBAR FEATURES

The Critical Issues Toolbar displays on the Ad-Hoc charting window and provides the functionality needed to manage the information.

Critical Issue Toolbar icons	Feature Description
Green Check Mark	Signs the entry and exits the screen
Floppy Disc	Saves the entry and exits the screen; is listed as in progress in Form Browser. **Does not display in the Summary Page widget until signed.**
Blue Circle with diagonal line	Cancels the entry and exits the screen
Pencil Eraser	Clear the entry from the fields
Silhouette of head	Display the logged in user's name; current date and time
Performed on /Time Fields	Defaults in the current date & time; may be edited and is required

STEPS TO RECORD AN ADDITIONAL CRITICAL ISSUE:

1. Select the patient and open the chart.

2. Select the AD-hoc icon from the PowerChart main toolbar:

3. Click the check box next to the Critical Issue form and then select the Chart button.

4. Right click on the grid and select the "Add Row" option to add a new Critical Issue.

5. Enter patient critical information in the space provided in the top section of the screen; **never** enter critical note text in the **comments** section, it will not display.

6. Click in the date field and enter the date, (enter **T** for today or click the down triangle to display and select from a calendar.

7. Click the green check mark to record the entry
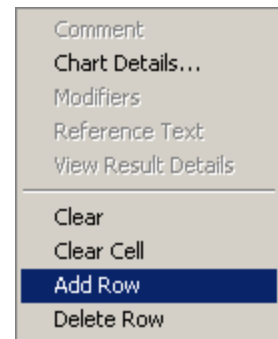
STEPS TO REMOVE A CRITICAL ISSUE:

1. Select the patient and open the chart.

2. Select the AD-hoc icon from the main Power Chart toolbar.

3. Click the check box next to the Critical Issue form and then select the Chart button.

4. Right click on the grid row you wanted to remove and select the "Delete Row" option.

5. If there are no remaining <u>active</u> issues, right click on the grid and select the "Add Row" option, then enter "**None**".

6. Click in the date field and enter the date, (enter **T** for today or click the down triangle to display and select from a calendar.

7. Click the green check ✓ mark to record the entry.
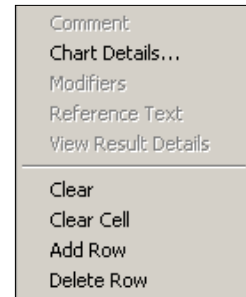
STEPS TO VIEW DETAIL OF THE CRITICAL ISSUE ENTRY:

1. Select the patient and open the chart

2. Select the Form Browser Tab

3. Select the option to sort by **Form**

4. Information on date time and contributor will display
5. Double click on the line item to display the form
6. Select the Close option from the menu seen on the pop-up screen or Click the **X** in the upper right corner to close the display.
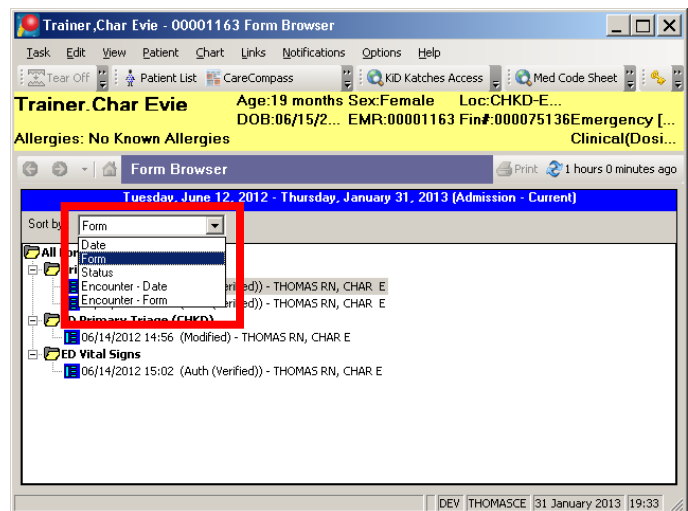
IMPORTANT NOTES:

> Signed critical issues display with a status of Auth-verified and will display on the Summary Page.
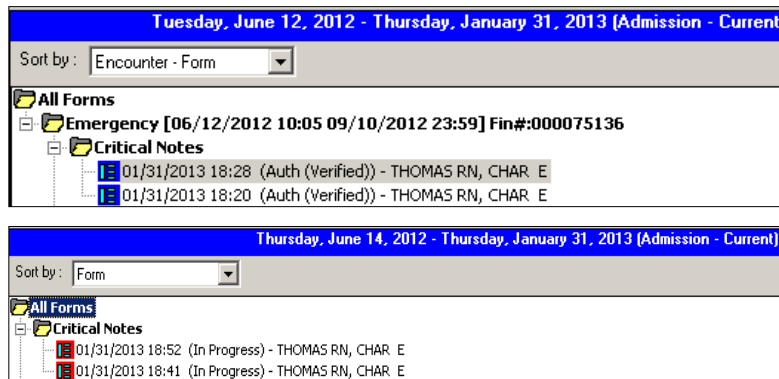
> Saved, unsigned critical Issues will **not** display on the Summary page. These forms are only visible in the Form Browser and will display a status of In Progress as pictured above.

VIEWING INFORMATION FROM FORM BROWSER TAB

Information or results entered during the charting process for the patient are available on the patient's chart. The charted results can be viewed within the related Flowsheet.

Charted PowerForms and PowerForms in process are available within the Form Browser. The Form Browser is a convenient way to view the complete details of any charting that have been completed via PowerForms. The user can see the charted information in its entirety and is better able to view related items.

FORM BROWSER BASICS

The Form Browser window displays a directory tree that lists all the charted, in progress, and uncharted PowerForms for the selected patient. Open a PowerForm to view the information. An icon is displayed to the left of an occurrence. A red icon beside the PowerForm indicates a required field was not completed for that form, and a blue icon indicates that required fields are completed.

You can sort the PowerForms by Date, Form type, Form Status, Encounter Date, or Encounter Form by selecting the Drop-down menu.

If the sort criteria of 'Form' or 'Date' is selected, then the status of the PowerForm (Authenticated, Verified, Modified etc.) also displays.

FORM BROWSER TAB DISPLAYS

The Form Browser tab displays a default time range. A user can change the time range for the **current** session by completing the following steps:

1. Select the Form Browser tab. Completed PowerForms for the selected patient are retrieved for a defaulted time span.

2. Right-click the information bar (where the time range is displayed) and select 'Search Criteria', or select 'Search Criteria' from the Options menu to open the Form Browser dialog box.
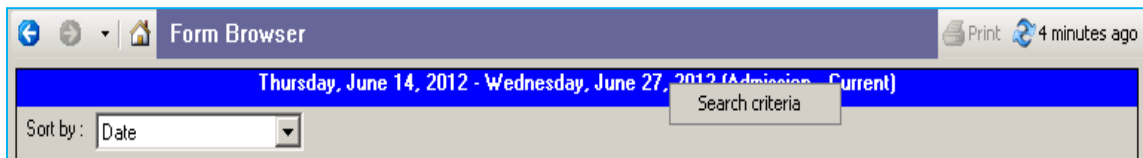
3. To view PowerForms within a specific date range, select Date Range in the View Range group box, and then enter the From and To dates and times. Use the small up and down arrows to increase or decrease the date and time. The large down arrow opens a calendar on which the month and day can be selected.
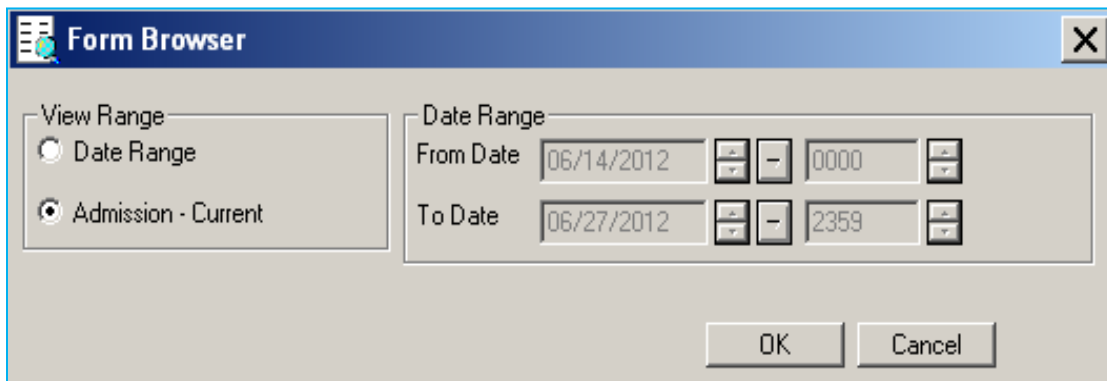
4. To view all PowerForms from admission to the current date, select Admission – Current in the View Range group box.

5. Click OK.

Remember: If the date that the form was charted is not included in the Information Bar, then the PowerForm will not show up in Forms Browser.

CHANGE THE DEFAULT TIME RANGE

To change the **defaulted** time range for retrieving completed PowerForms, complete the following steps. If these preferences are saved, the new time range is used for PowerForm retrieval the next time the Form Browser is opened.

1. Select the Form Browser tab. Completed PowerForms for the selected patient are retrieved for a defaulted time span.

2. From the Options menu, select Properties to open the Form Browser Properties dialog box.

3. In the Sort By box, select the way the PowerForms will sort (by date, form name, status, encounter date, or encounter form).

4. In the Date Range group box, select Date Range to specify how far back or forward the system should search for PowerForms, and the increment value and units of that search (for example, five days).

5. In the Offset group box, change the entries to match you preferences. (Options in this group box are not available if Admission – Current was selected in the Date Range group box.)
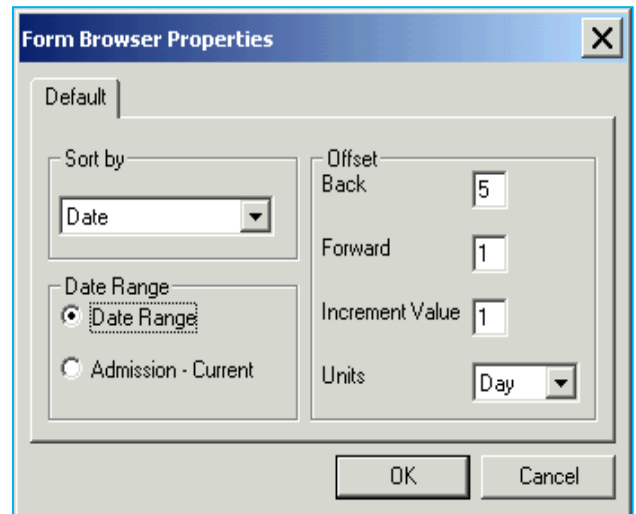
   - **Back box:** Enter a number to indicate how far back from now to search for charted PowerForms. Select a unit such as a day or a week in the Units box.

   - **Forward box:** Enter a number to indicate how far forward from now to search for charted PowerForms. Select a unit such as a day or a week in the Units box.

   - **Increment Value box:** Enter the number of units of time measure that are increased or decreased each time the left or right arrow buttons on the information bar are clicked.

   - **Units box:** Click the down arrow and select the unit of time measure (year, month, week, day, hour, or minute) desired.

6. Click OK to save these settings for the current session of Form Browser, or click Save to save your preferences for all sessions. Click Cancel to return to the previous window without saving any entries.

VIEWING A COMPLETED POWERFORM

To view information that has been entered for a patient as it was charted on a PowerForm, complete the following steps:

1. Select the Form Browser tab. A list of PowerForms completed for this patient during the time range displayed on the information bar is displayed in a tree. The tree may be sorted by date, form, status, encounter date, or encounter form by making a selection from the Sort By box.

2. Double-click a folder under the 'All Forms' folder to open and display the available PowerForms.

3. Right-click the PowerForm occurrence and select View, or select View from the Options menu to open the PowerForm.
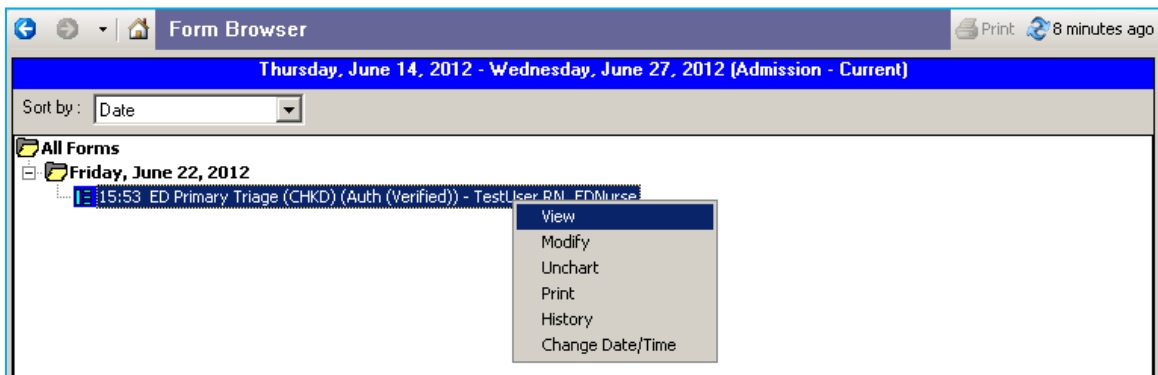
The completed PowerForm is displayed in the form viewer in a **read-only format**. If the PowerForm is subdivided into sections, a list of their names is displayed in the left panel. The first section is displayed. Use the arrows on the toolbar to navigate among the sections.

4. Click [x] in the upper right corner to return to the previous window.

TIP:

 If the date that the form was charted is not included in the Information Bar, then the PowerForm will not show up in Forms Browser.

FLOWSHEET TAB

You can review results and information that has been entered for a patient using the FlowSheet Tab.

You can also customize your view to display Table (default), Group, and List views.

The Table View allows you to view the documented information in a flowsheet format.
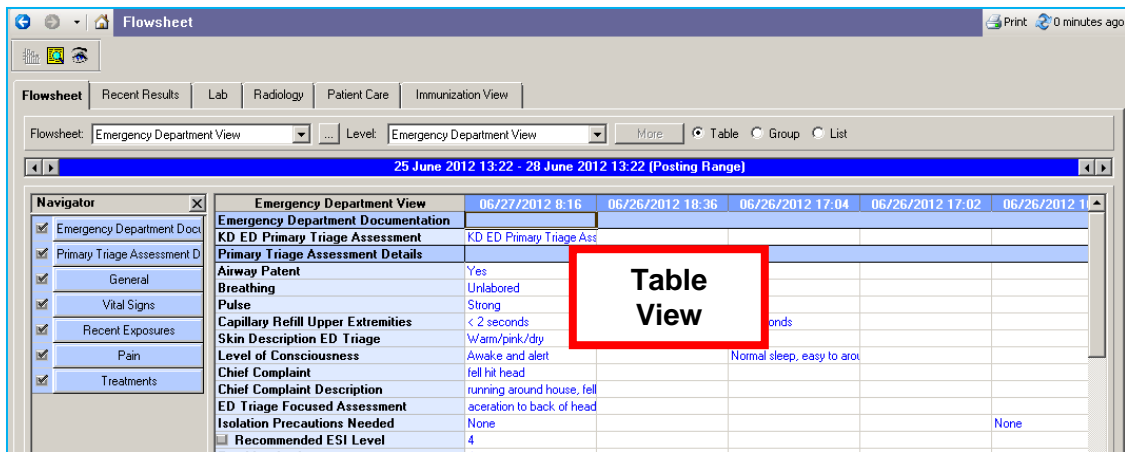
The Group view allows you to view the documented information in groups. In the example below you can view a group of all Emergency Department Documentation, Primary Triage Assessment Details, etc.

The List View allows you to view the information documentation for a select date/time in a list format.
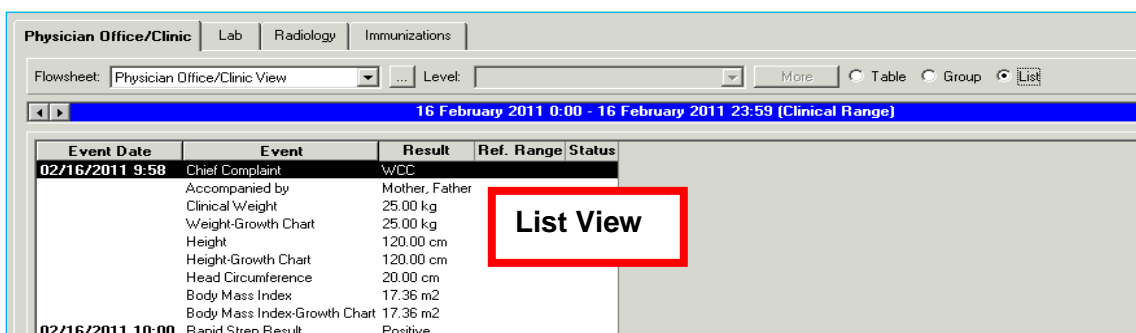
ALLERGIES TAB

Allergies can be accessed and entered from the Allergies Tab or the patient's Banner Bar within the patient's chart. Allergies can also be accessed and entered from the Tracking List within FirstNet.

If the patient has any allergies recorded, you can view these allergies by selecting the Allergies Tab within the patient's chart, the Allergies hyperlink within the patient's demographics bar or the Allergies Icon on the FirstNet Tracking List. If "no known allergies" have been recorded this will reflect on the banner bar, the Tracking List Allergy Icon and the allergy profile window.

Each recorded allergy will be listed, along with the allergy category, reactions, and severity.

- Double clicking on either the (1) Allergies Tab in the patient's chart, (2) Allergies Hyperlink in the Banner Bar or (3) Allergies Icon on the Tracking List

- Access the allergy profile window.

- Allergy documentation can be added, cancelled or modified if needed from this view

- Click Refresh to display the most up-to-date information.

ACCESSING ALLERGY TAB

Double-clicking on the Allergies Tab and access the allergy profile window. The patient's Allergy documentation can be added, cancelled or modified if needed from this view. Click Refresh to display the most up-to-date information.

ACCESSING ALLERGY PROFILE WINDOW FROM THE BANNER BAR

Double click on the Allergies Hyperlink from the patient's banner bar and access the allergy profile window. Allergy documentation can be added, cancelled or modified if needed from this view. Click Refresh to display the most up-to-date information.

ACCESSING ALLERGY PROFILE WINDOW FROM THE TRACKING LIST

Double clicking on the Allergies Icon the Tracking List and access the allergy profile window. Allergy documentation can be added, cancelled or modified (if needed) from this view. Click Refresh to display the most up-to-date information.

Manipulating the Allergy Profile Columns

The Allergy Profile has several pieces of functionality to allow the clinician to more easily see an overview of the allergies and adjust the sort of the allergies based on a particular data point.

To sort the allergies based on a particular data point, click on the column. The system will adjust the sorting of the columns in either alphabetical or reverse-alphabetical order.

Several icons are also available on the view for ease in seeing information:

✔	The green check-mark icon will display when a particular codified allergy is recognized by Multum for Drug/Allergy Interactions.
📎	The paper clip icon will display when additional comments are available on a particular patient.
🔴	See Viewing Allergy Interaction below.

ALLERGY INTERACTIONS

If a patient is on a medication that may cause an interaction with a known allergy, the Allergy Alert will display when the medication allergy or when the reverse allergy search is done.
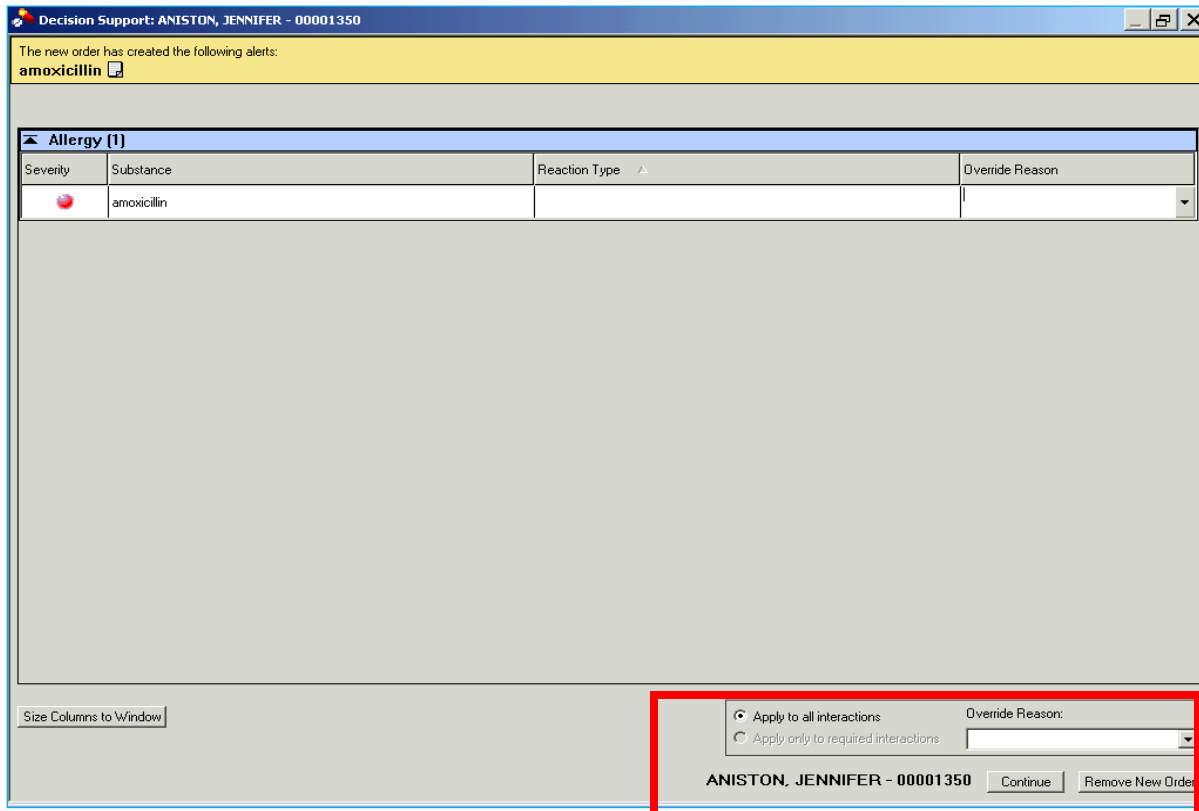
If you wish to continue adding the medication in spite of the reaction, enter an override reason and select continue.

ALLERGIES PROFILE WINDOW COMPONENTS

Column	Description
D/A	A green check in this column indicates that the allergy qualifies for Drug/Allergy interaction checking. No check indicates that no interaction checking is available for the allergy.
Substance	Displays the known allergens for the patient.
Category	Displays the allergen category (i.e. Drug, Food).
Reactions	Displays recorded reactions to the allergen.
Severity	Indicates the severity experienced by the patient to the allergy. • **MILD:** Requires minimal therapeutic intervention, such as discontinuation of drug(s). • **MODERATE:** Requires active treatment of adverse reaction, or further testing or evaluation to assess extent of non-serious outcome. • **SEVERE:** Any serious outcome resulting in life- or organ-threatening situation or death, significant or permanent disability, requiring intervention to prevent permanent impairment or damage, or requiring / prolonging hospitalization.
Type	Displays the type of reaction. • **Allergy –** An adverse reaction of the immune system to the exposure of a substance. • **Intolerance -** An adverse reaction of the digestive system to the exposure of a substance. • **Secondary Effect –** An adverse reaction that is the direct result of another reaction (such as an allergy to peanuts that results in a rash that causes the secondary effect of itching.) • **Sensitivity –** An adverse response to a substance that does not occur in normal situations. • **Other** – Any reaction type that does not fit into any other category as listed.
Comments	Displays comments recorded for this patient's allergy.
Est. Onset	Indicates the estimated onset date of the allergy.
Reaction Status	Lists the status of the allergy. • **Active** – The patient currently experiences reactions to this allergen. • **Proposed –** The allergy has been reported, but not confirmed by a clinician. • **Resolved –** The patient has experienced an allergic reaction to a substance, but the reaction has not re-occurred. • **Canceled** – The allergy was entered in error.

Updated By	Displays who last updated the allergy.
Source	Indicates the source of the information, such as Patient, Family, or Physician.
Reviewed	Displays if and how the listed allergy was reviewed.
Reviewed by	Displays who reviewed the listed allergy information.
Interaction	Indicates the interactions associated with the allergy.

Adding Allergies

There are several methods for entering allergies into the system. The preferred method is shown below.

1. Select Add New / Drug Allergy from the Allergies window.
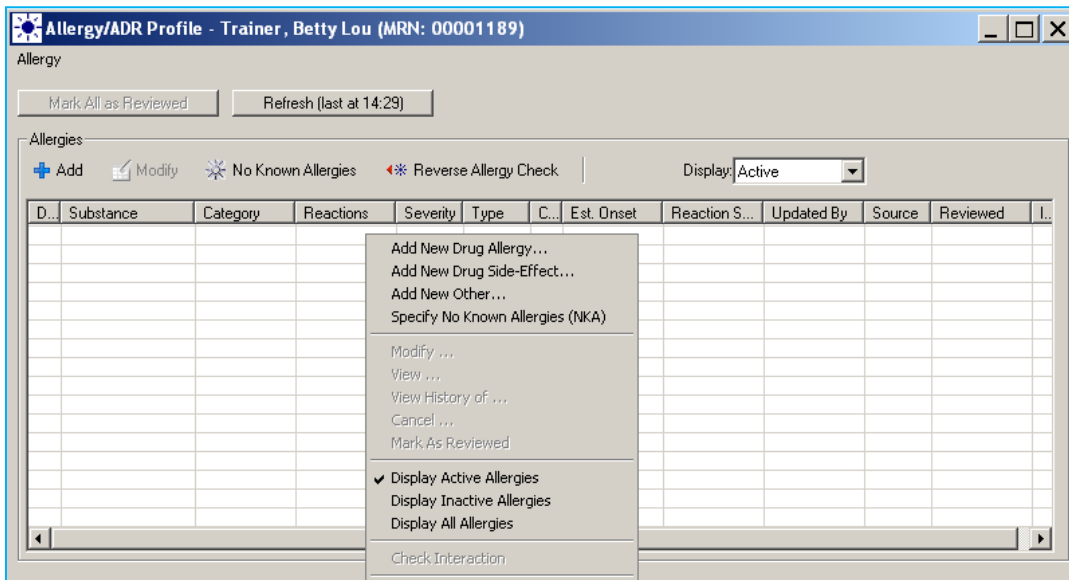
The Add Allergy / Adverse Effect window will open.

2. Click the Catalog tab.
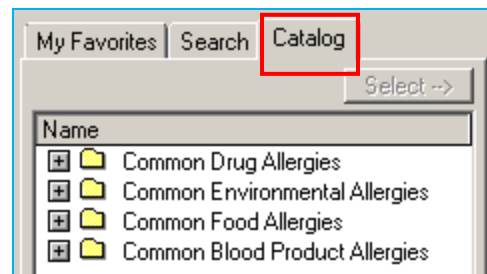
3. Indicate if the allergen is a common drug, food, or environmental allergy by expanding the applicable category (click the + sign beside it).
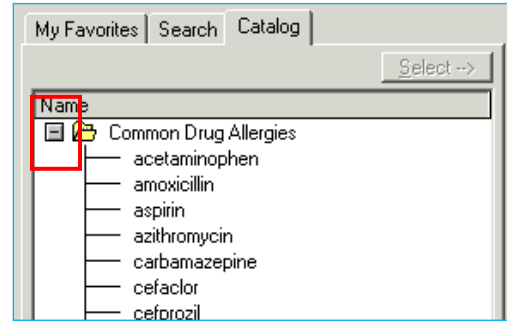
4. Double click the desired allergen. The substance tab will populate with the selected allergen.

5. Indicate the reaction type from the drop down box. Selection options are Allergy, Intolerance, Secondary Effect, Sensitivity, and Other.
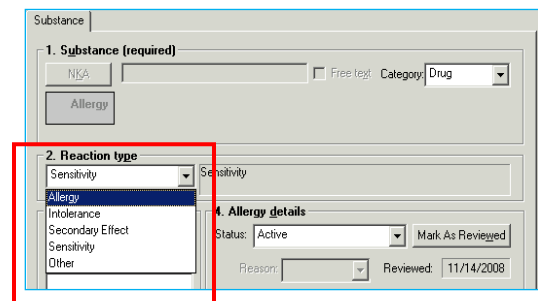
6. Expand the Common Allergy Reaction folder (click the + sign beside it).

7. Indicate the reactions that the patient experiences by double-clicking. More than one can be selected. These reactions will populate in the Reactions symptoms section of the Add Allergy / Adverse Effect window.
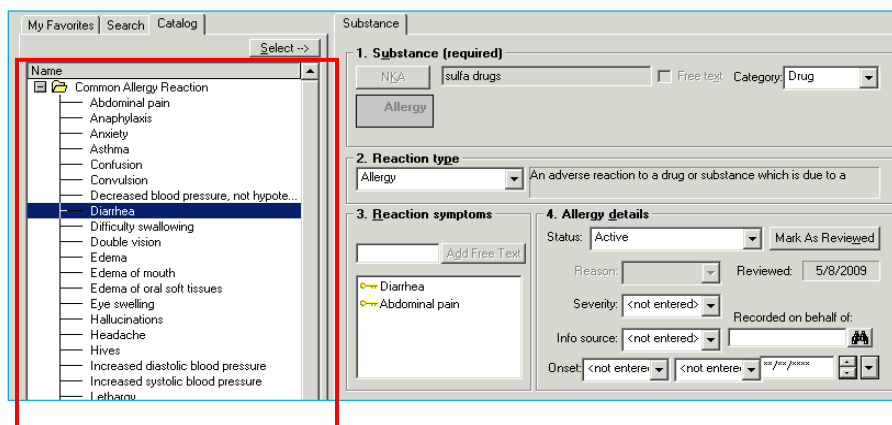
8. Indicate Allergy Details such as Status (Active, Proposed, Resolved, and Canceled), Severity (Mild, Moderate, or Severe), Info Source (who provided the information regarding the allergy), and Onset. **Any allergy that is entered in the EMR should be entered as an "active" allergy** (do not use the "proposed" feature).

9. Add any necessary comments, if applicable.

10. Click Apply and OK to save your changes for the patient. The allergy that you added will appear.

D/A	Substance	Category	Reactions	Severity	Type	Comm...	Est. Onset	Reaction St...	Source	Reviewe
✓	**amoxicillin**	Drug	Rash, vomi...	Mode...	Allergy			Active		3/10/200
	Bee Venom	Environment	Hives, Asth...	Severe	Allergy		Unknown	Active		
	Citrus	Food	rash	Mode...	Allergy		Age 2006	Active	Physician	3/10/200
✓	**penicillin**	Drug	Rash	Mode...	Allergy			Active	Patient	3/10/200

Check for allergies related to: Latex, rubber products, peaches, potatoes, papaya, nectarines, apricots, peanuts, kiwi, chestnuts, cherries, passion fruit, milk, apples, bananas, tomatoes, celery, pineapples, grapes, carrots, avocados, figs, pears, melons, cornstarch, hazelnuts.

CANCELLING NKA (NO KNOWN ALLERGIES) FROM THE ALLERGY Profile

There may be occasions when "NKA" (No Known Allergies) was recorded for a patient and allergy information to be documented was revealed at a later time.

In the example below the initial documentation was "NKA" (No Known Allergies).

- An allergy for Acetaminophen is then added to the Allergy profile
- The system generates a message as seen below
- Answering Yes, will add the new allergy to the patient's allergy profile and cancel the NKA (No Known Allergy) that was previously selected
- Then click OK
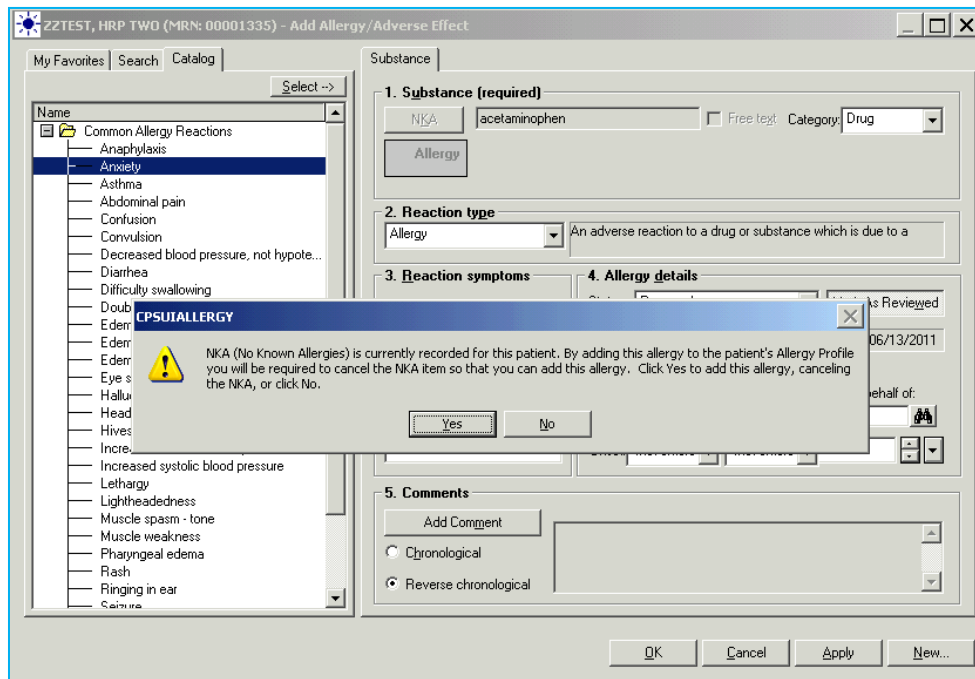
TIPS AND TRICKS

- Both PowerChart and PowerForms share the same data area with regard to patient allergies.

- Reactions can also be entered as free-text (manually typed in) in steps 6 & 7. Simply type in the name of the reaction (i.. 'Vomiting') and click Add as Free Text. The entered reaction will appear in the Reaction Symptoms box, but with a handwriting icon to indicate that the reaction was manually entered.

ENTERING PROBLEMS & DIAGNOSES

Diagnoses (Reasons for Visit) that the clinician may enter during the intake appear on the Results Review form. As a provider, you can enter the clinical (billing) diagnosis for the patient.

To enter a diagnosis from the Diagnoses and Problems tab, complete the following steps:

1. Select the Diagnoses and Problems Tab.
2. Click Add to add a Diagnosis.
3. In the search field (required), enter the clinical diagnosis (or the first 6-7 letters).
4. Click Enter.

All diagnoses that match your search criteria are displayed.
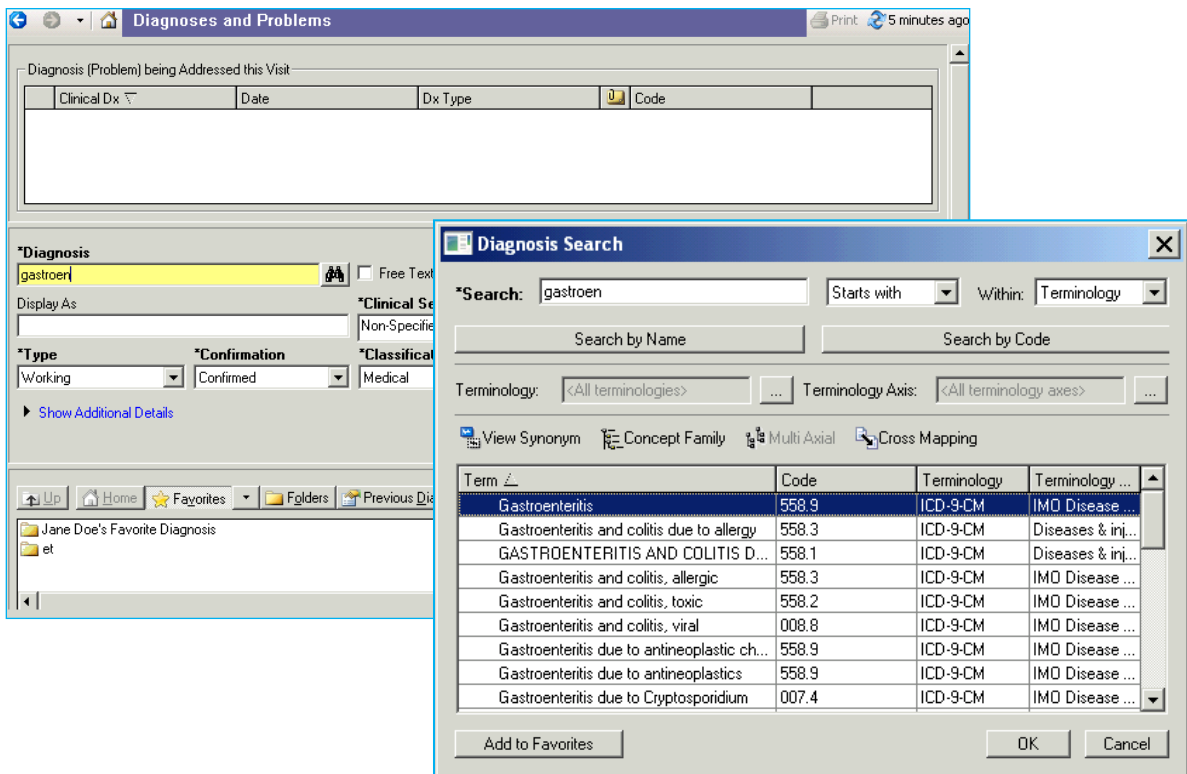
5. Select the correct diagnosis and click OK to close the Diagnosis Search screen.
6. Enter information in other fields, as applicable.
7. Click OK.

TIPS AND TRICKS:

- Multiple diagnoses can be entered.
- If you are unable to locate the diagnosis, change the value of 'starts with' to 'contains' in the Diagnosis Search window.
- You can quickly locate diagnoses by searching in the Emergency Diagnoses folder at the bottom of the screen.

ORDERS TAB

The Orders tab within the patient's chart is used to place, view, modify, cancel and generally work with various types of orders. There are two main sections of the Orders tab: the Clinical Categories Navigator and the Existing Order Profile.

CLINICAL CATEGORIES NAVIGATOR OVERVIEW

The left side of the Orders tab is the Navigator, which lists clinical categories.

The Navigator allows you to select the categories from which you want results displayed.

When the check mark on the left is selected, the category of orders from the profile section is displayed. When it is unchecked, the category and its orders are hidden.

ORDER PROFILE OVERVIEW

The right side of the Orders Tab is the Order Profile. The Order Profile lists patient orders and medications, as well as their statues and detailed information.

TIPS AND TRICKS

The Medication List sub-tab on Orders Profile displays medication orders for the patient. Clicking on the Medication List sub-tab or the Medication List tab takes you to the same list.

DETAIL SCREEN ADJUSTMENTS

The order detail screen can be adjusted up or down. Place your mouse on the Details bar and a double-sided arrow appears. Hold the left mouse button and move the window up or down.

The upside-down triangle on the left corner of the details bar can be clicked to hide this screen.

The order detail can also be expanded left and right. Place your mouse on the side of the clinical categories navigator, and a double-sided arrow appears. Hold the left mouse button and move the window left or right. The upside-down triangle on the right corner of the clinical categories navigator can be clicked to hide this area.
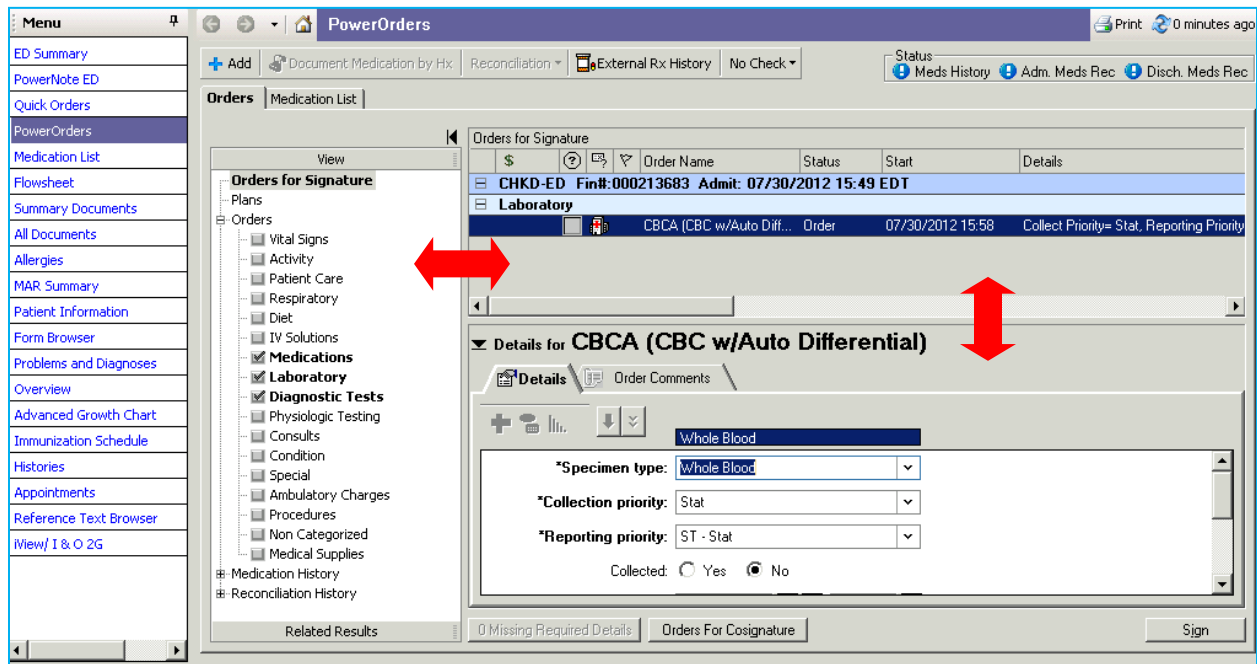
SECTION III - PLACING ORDERS

As a patient's condition warrants, it may be necessary for a health care provider to request orders to facilitate patient care. eKiDs PowerChart is used to process orders.

When placing an order it is important to make sure that you have selected the right patient, test, priority code, date, and time. For most orders, this information will default in, but you may occasionally need to change the order details and also enter required order details prior to signing your order

STEPS FOR PLACING AN ORDER

1. Select the patient from the patient list or from the Schedule.

2. Click the Add button on the PowerOrders tab

3. Locate/Select the order.

4. Order details will populate, based on pre-built order details within the system. However, this information can be changed, as necessary.

5. Review orders and verify accuracy.

6. Sign the order.

7. Select the 'Refresh' button to refresh your screen and see the correct status of the orders.

   Attending – Recieves the orders for signature in Message Center. The process for co-signature will be discussed later in the manual.

ADD ORDER WINDOW

If you are not entering an order from the Quick Orders tab, from the PowerOrders tab within the Patient's chart, select the Add Icon to open the Add Order window.
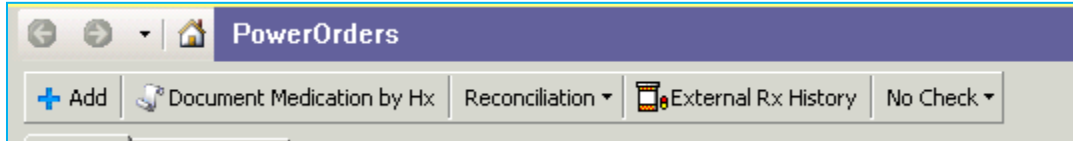
As a shortcut, you can also select ALT+R from your keyboard to open the Add Order window.

When the Add Order window is initially opened, the **Quick Folders** displays by default because they are specified as 'Home'. The Quick Folders offer the ability to drill through and find commonly ordered items by a defined category. (The 'Home' location within the Add Order Window can be changed and is discussed later in this manual).
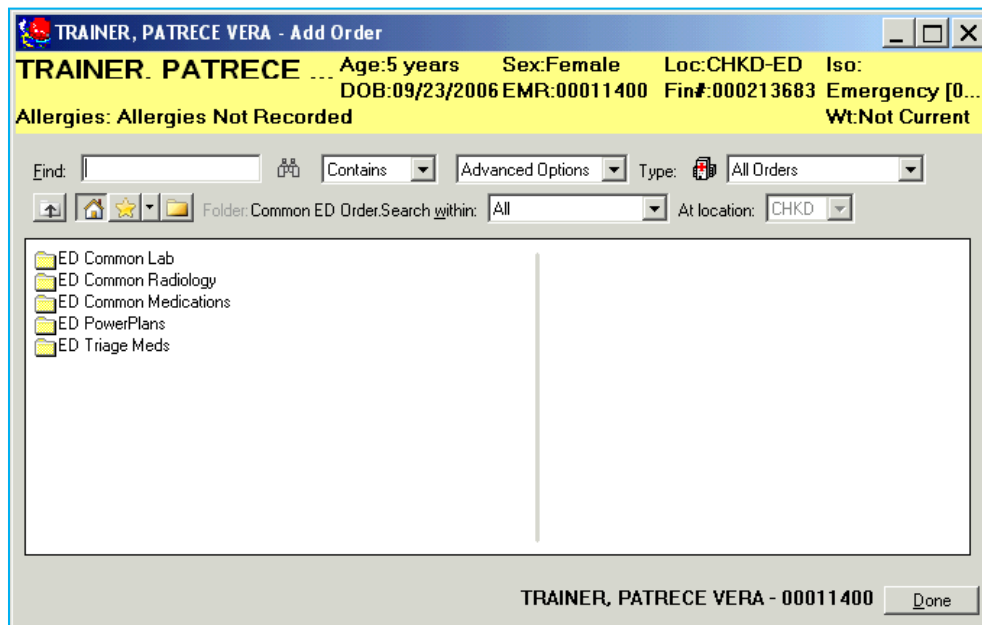
The **Starts With / Contains Drop-down Box** is also located within the Add Order Window. You can direct the system how to locate an orderable using either starts with or contains (i.e. contains the word chest or starts with chest). You only need to type in the first few letters of the order and the system will use completion matching to automatically bring up orders that match what you entered.
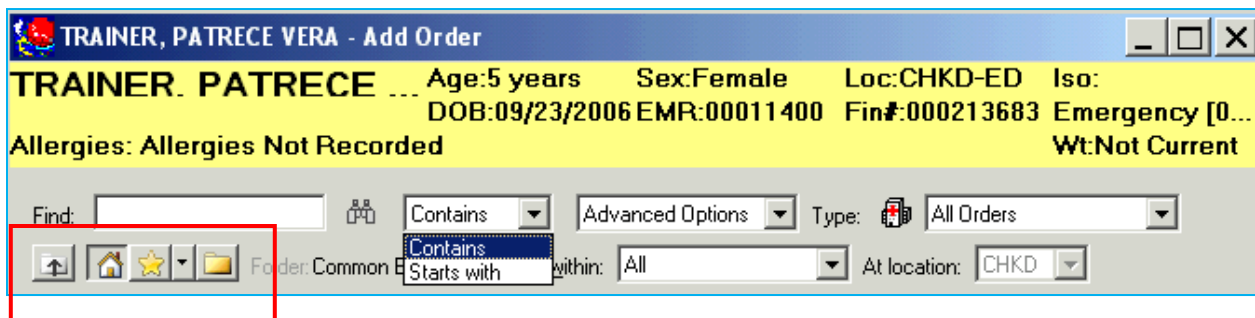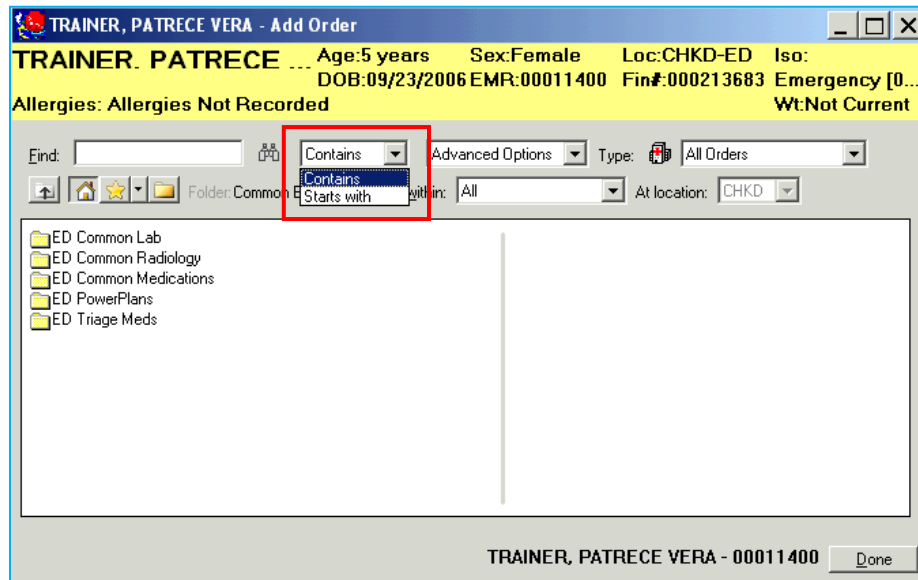
♦ The Up icon ⬆ within the Add Order window will take you up a level when you are in a subfolder.

♦ The **Home icon** 🏠 within the Add Order window will take you back to the folders that are defined as your Home. By default, these are the Quick Folders unless changed.

♦ The **Favorites icon** ⭐ will within the Add Order window will take you to your favorites folder. Set-up and maintenance of the Favorites folder is discussed later in this manual.

♦ The **Folders icon** 📁 within the Add Order window will return you to your Quick Folders.

The Type dropdown displays a selection list of types of orders that you can enter.

♦ **All Orders** is used to search and display all orders available.
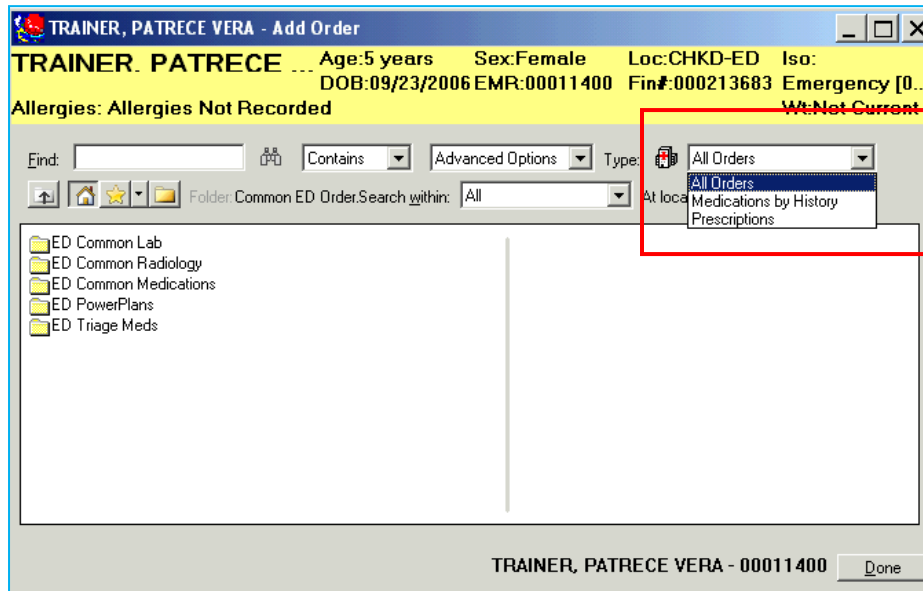
♦ **Medication by HX** is used to document the patient's medication orders that the parent or guardian has administered to the patient at home **or** for meds that were not completed in PowerChart (prescribed by a different provider).

♦ **Prescriptions** is used to search and add prescriptions to be given to the patient upon discharge.

SYSTEM REQUIRED DETAILS

If an **order** has a required detail, the detail must be satisfied before signing the order. System required details are noted in several areas:

Blue Circle with a white 'X' next to the Orderable in the Order Review window.

- Blue circle with a white 'X' in the Details or Diagnosis Tab.

- Order detail is Bolded and Highlighted Yellow within the Details section.

- Notification in bottom of the details window, stating how many required details are missing.

You can navigate to the missing system required details by either selecting the detail within the Order Details column or by selecting the 'Next Missing Required Detail' button.
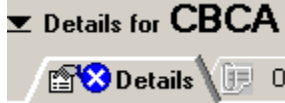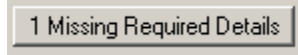
REQUIRED DETAILS

If an order has a required details, the detail must be satisfied before signing the order. System required details are noted in several areas:

Blue Circle with a white 'X' next to the Orderable in the Order Review window.	Laboratory
Blue circle with a white 'X' in the Details Tab.	Details for CBCA
Order detail is Bolded with an asterisk and Highlighted Yellow within the Details section.	*Frequency:
Order detail fields that use radio buttons are Bolded with an asterisk.	*Tube Feed: ○ Yes ○ No
Notification in bottom of the details window, stating how many required details are missing.	1 Missing Required Details

MISSING DETAIL NOTIFICATION

If you attempt to sign the order without satisfying the missing system required details, you will get a warning prompt.

from the warning screen, the First Detail button will take you directly to the first missing required detail.

The Cancel option will close the warning prompt.

REFRESH BUTTON FYI

NOTE:

Do not select the Refresh button prior to signing an Order. If the Refresh button is selected during the Order Entry process (prior to signing orders), a cancellation of the current process is initiated.

If the 'Refresh' button is selected prior to signing the order, a warning message will appear, notifying you that there are pending actions that exist for the selected patient.
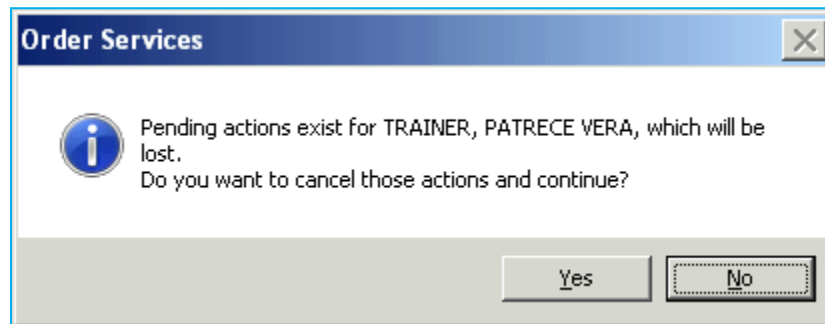
If you do not want to cancel the current ordering process that you were working on before clicking Refresh, click No. The screen will not change, and you will be able to continue modifying the current order.

If you do want to exit or cancel out of the current ordering process (canceling an order, adding an order, etc.) that you are working on, click Yes. You will be returned to the patient's record, and you will have cancelled the current order conversation.

MULTUM ALERTS

Decision Support alerts as displayed below, also known as Multum Alerts display in the system when entering orders or medications that present an interaction for the patient. These alearts should be acknowleged if presented.

Overide reasons can be selected based on the clinical situation.

To address the Multum Alert:

- Select the CONTINUE button to continue with the order (this is based on your Depending on your security)

    Residents are **now required** by the system to enter an override reason for Multum Alerts they receive when placing orders.

- Select the REMOVE NEW ORDER button

- Select and Override Reason by clicking on the drop down arrow in that window.

PRACTICE SCENARIO FOR BASIC ORDER ENTRY

Your patient was admitted to ED for TACHYPNEA, RSV with FEVER.

- ✎ Enter each of the following orders for your patient individually
- ✎ Review and sign them as they are completed.
- ✎ Pay attention to the order status as its status changes from Processed to the new ordered status.
- ✎ Order from Quick Orders when possible

Orders:

- **XR CHEST 2 VIEWS PA/LATERAL.** Stat for evaluation of Bronchiolitis. Transport via stretcher. Patient has contact and droplet precautions.

- **RSV CULTURE.** ROUTINE. Specimen Source: Nasal Wash. Start Date and Time: Today and Now.

- **CBC w/Auto Diff**

- **iStat Collection Blood Gases**

- **Strep Culture**

- **Albumin Serum**

- **Sed Rate West**

- **H&H**

DOCUMENTING MEDICATION BY HISTORY

Documenting medication by history is used to enter medication orders that the parent or guardian has administered to the patient at home **or** for meds that were not completed in PowerChart (prescribed by a different provider).

To document medication by history, complete the following steps:

1. Click Document Medication by HX from the Orders or the Medication List tab.

The Document Medication by Hx window will open.

If the patient has No Known Home Medications or you are unable to obtain the information click in the appropriate box below Medication History.
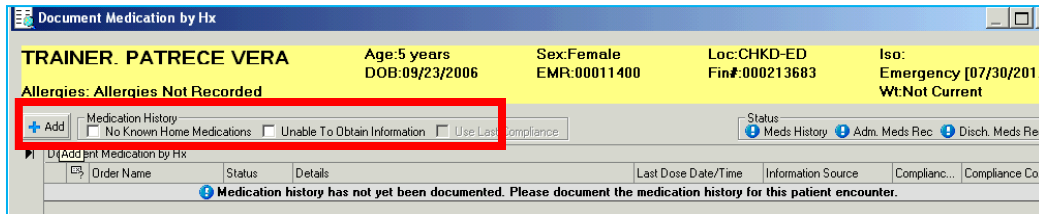
2. Click Add.

The Add Order Window will open.

3. Enter the first few letters of the name of the medication in the Find field.

Note: In the example below, clicking the Search button will allow you to find Albuterol in the list with no dosing information if the drug is known but the dosing information is not.
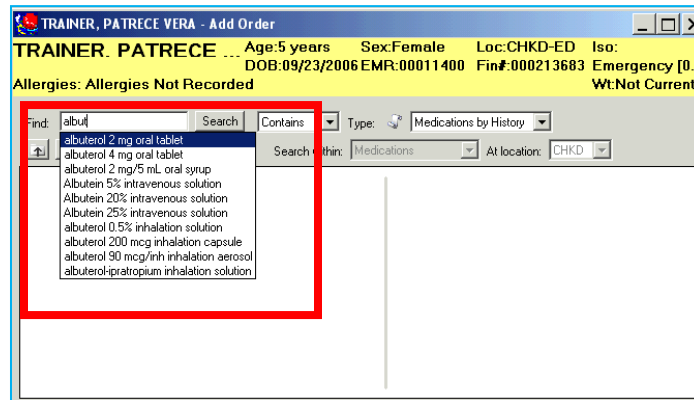
When the medication is found, select it by clicking on it.

4. The Order Sentences will appear, if applicable. Select the appropriate sentence.
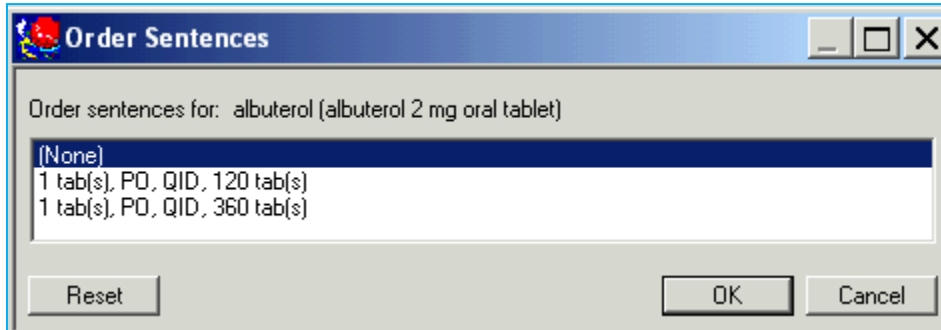
5. Click OK.

6. Continue looking up and adding additional medications, as necessary.

7. When finished click Done.

8. Make modifications to the details window, as necessary.
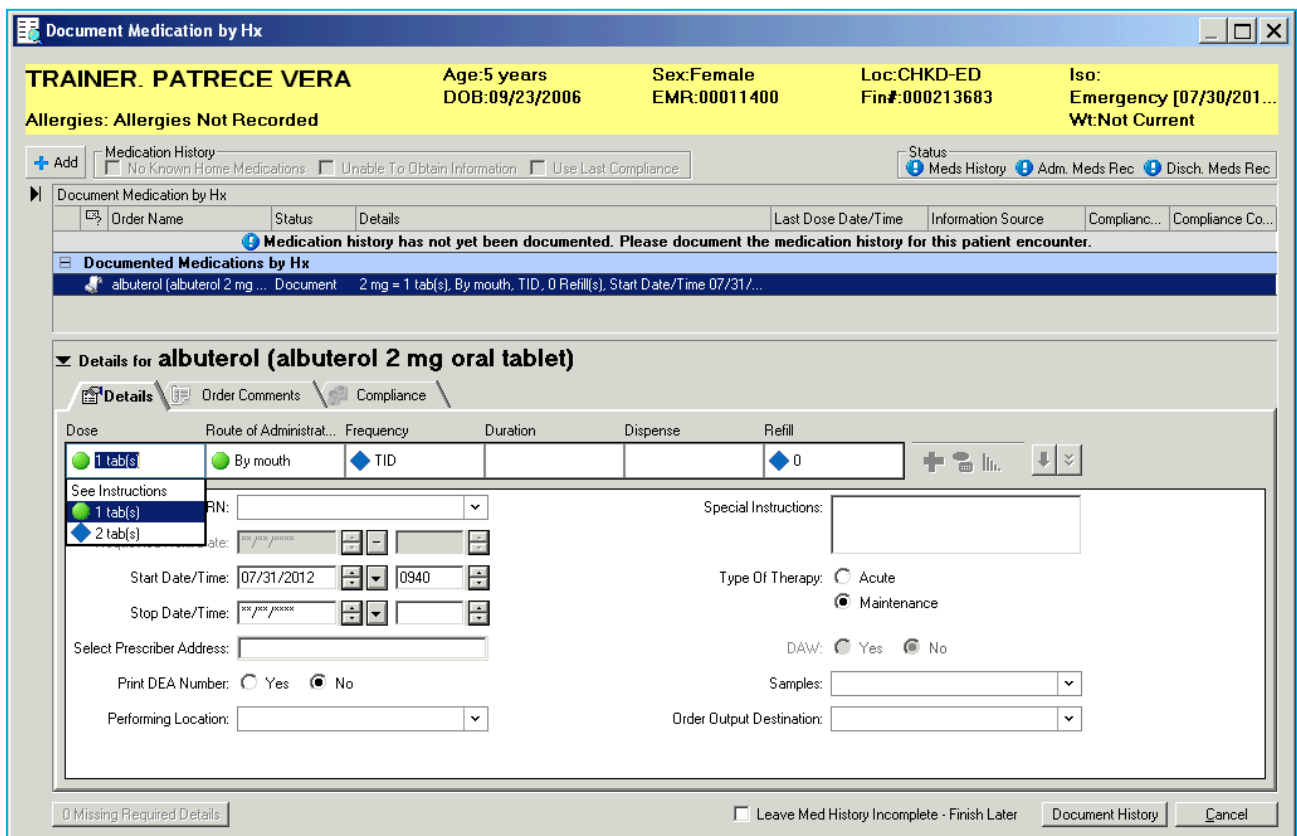
9. When finished (and after you have reviewed the order), click Document History.

10. The Medication that you entered will appear in the Medication List (the tab beside the orders tab) with a status of Documented.

PRESCRIPTION – CREATING A NEW PRESCIPTION

Based on your position and security you can enter prescriptions directly into PowerChart and send to the pharmacy via the system.

1. Select the Orders Tab.

2. Click Add.
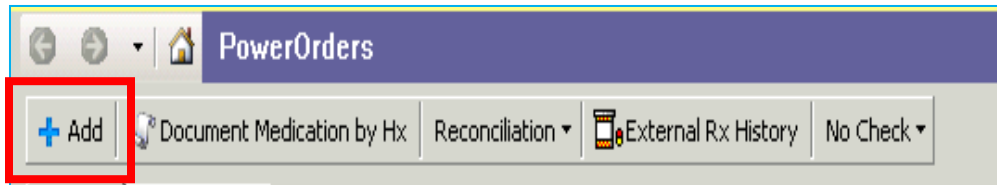
3. The Add Order window will appear.

4. Change the Order Type on the right side of the window to Prescriptions.
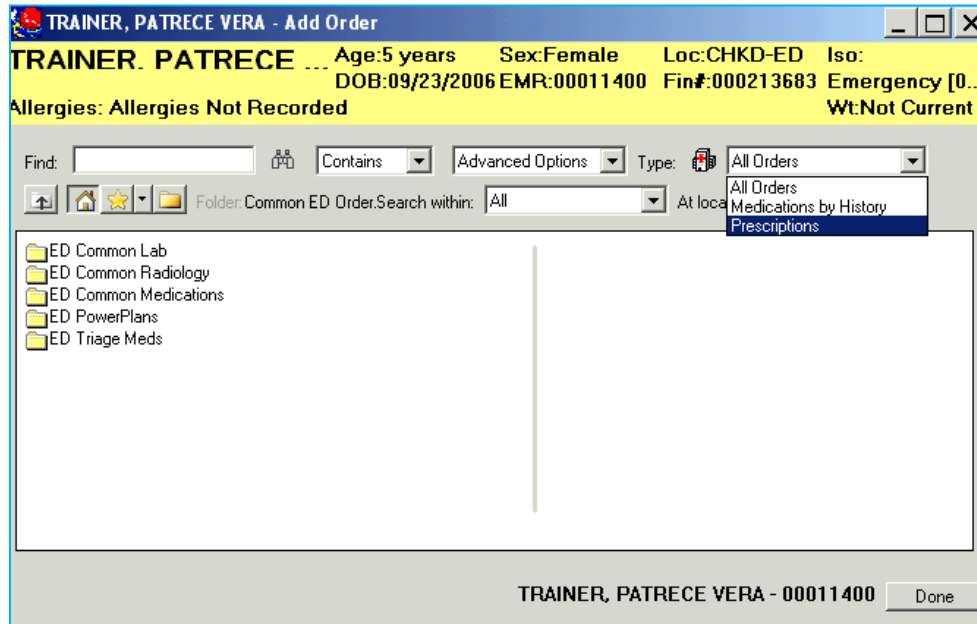
5. Search for the prescription using the first few letters of the name in the search field.

6.   Click on the prescription name.
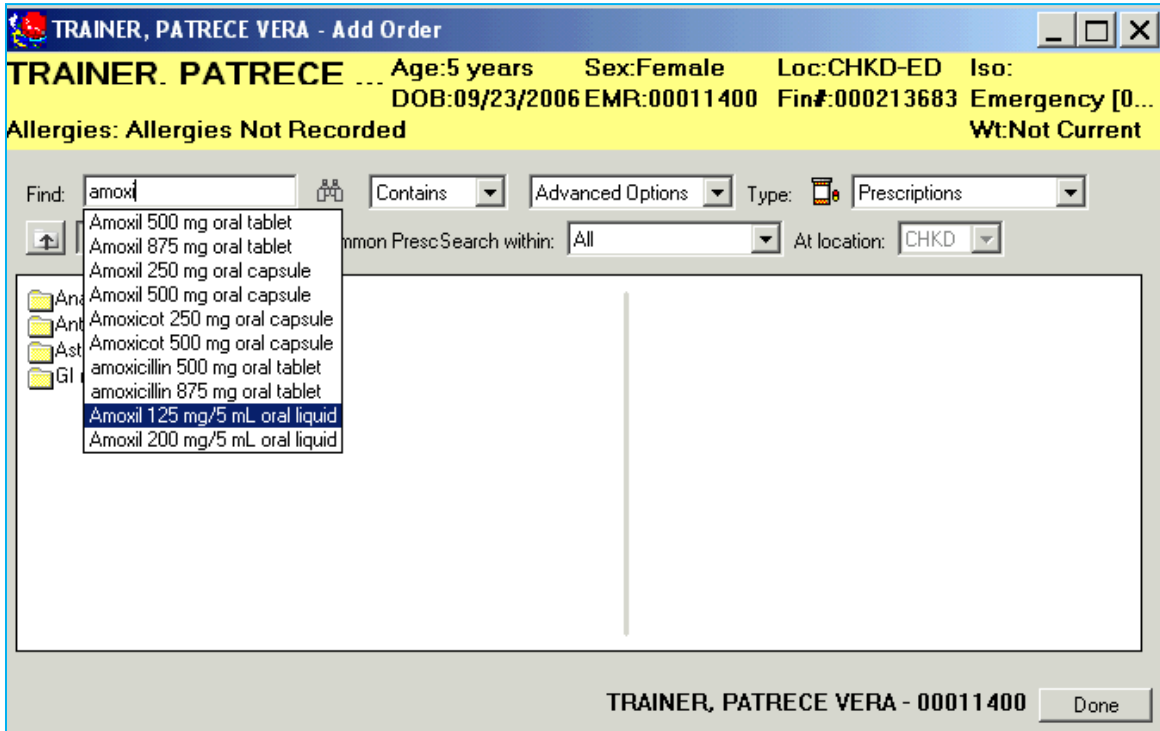
7.   In the order sentence window, select the most appropriate sentence, or click None.
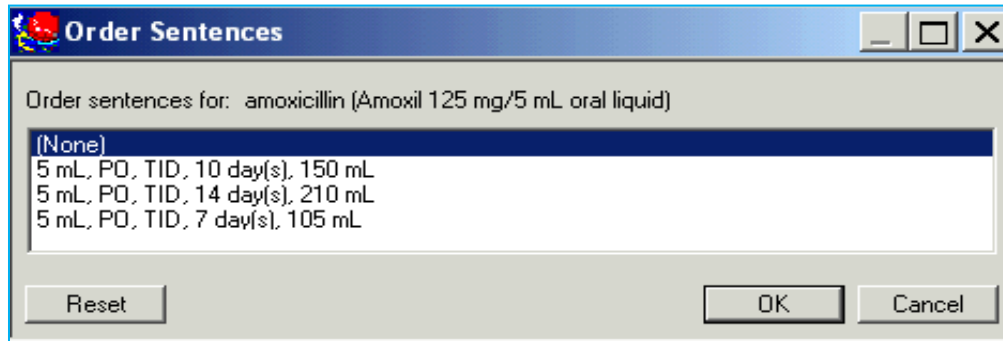
8.   Click OK.

9.   Continue adding prescriptions, as necessary. When finished, click Done.

10. Review the order details for accuracy.

The Dispense window will automatically populate the correct value when you enter the dose in the Dose window and/or the Duration in the Duration window.

In the example below a dose of 5ml with the duration of 7 days was included and the system automatically populated that the dispense amount is 105ml. If the Duration was changed to 10 days the Dispense amount would appropriately adjust.
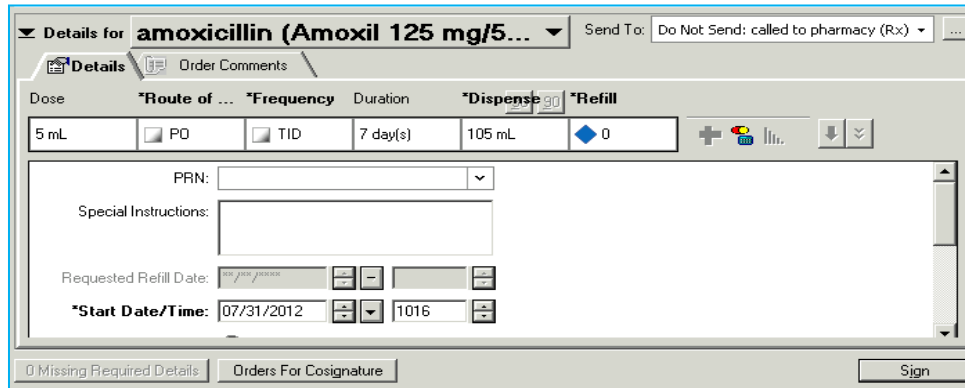
11. In the drop-down above the detail values on the right-side of the screen, indicate how you want the prescription routed.
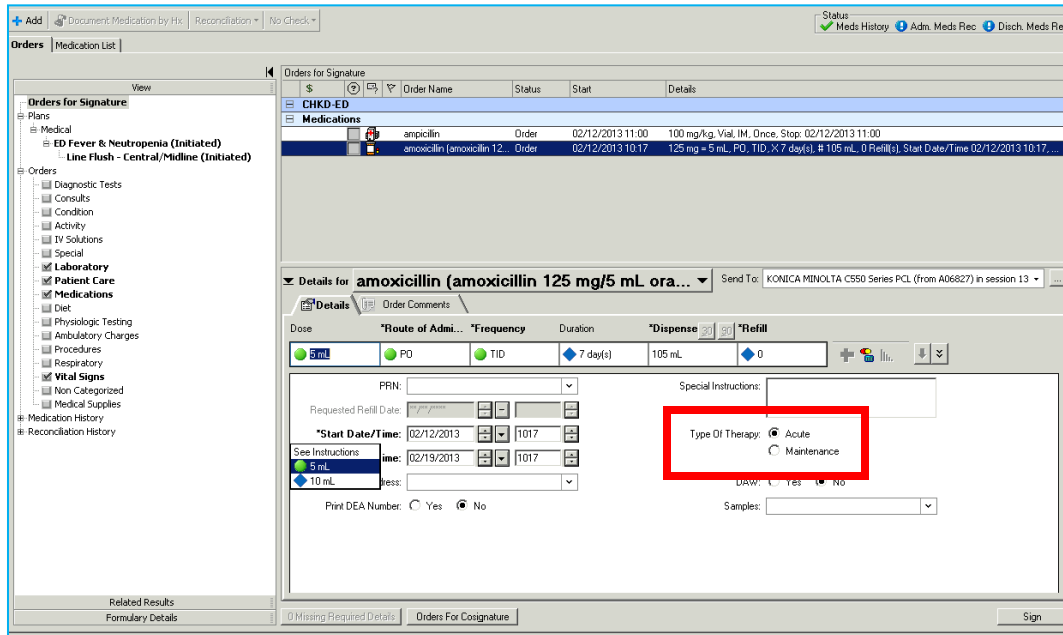
When completing the Order details **ACUTE** should always be selected for **Type of Therapy**.

If Maintenance is selected you will continue to be the ordering physician for this medication.

- If you select print, a requisition will print to a designated printer for the parent or guardian.

- If you select Do Not Send (Called to Pharmacy), the prescription will be called to pharmacy and the prescription will not print but remain part of the patient's record.

- If you select Do Not Send (Samples Given to Patient) Rx, the prescription will not print but remain part of the patient's record. Samples will be given to the patient.

- If you select Do Not Send (Other Reason), the prescription will not be printed but remain part of the patients record. Additional comments about the order can be added to the Order Comments tab in the Details window.

- If you select Pharmacy, the prescription will be electronically routed to the pharmacy that you select.

PRESCRIPTION ROUTING FOR PHARMACY

To find the correct pharmacy, indicate the pharmacy name, city, or zip code and click search.

Click the correct pharmacy and then click OK when done.

You can specify a preferred pharmacy by right-clicking and selecting ADD in the Prescription Routing window.

Once a preferred pharmacy is added, it will be available for future prescriptions by clicking on the preferred tab.

Note: This functionality will not available in the initial phase of implementation.

12. Click Sign to submit the order. If this is an order that is being submitted to the pharmacy electronically, the sign option will generate the request to the pharmacy.

13. Click refresh to update the screen and reflect the correct status of the order.

TIPS AND TRICKS:

Depending on the drug class, the system may not allow electronic functionality.

These drug types have to be entered and printed out of the system via Secure Printing.

COMPLETE/CANCEL A PRESCRIPTION OR MED DOCUMENTED BY HISTORY

1. When you open a patient's chart in PowerChart or FirstNet you will be on the PowerOrders tab and will be viewing the patients Orders Profile.

2. Click on the Medication List tab. This will show you Meds Documented by History and Prescriptions.

   The pill bottle icon depicts a Prescription med; the Scroll icon depicts a med documented by history. (You may need to add this column, labeled "Type")
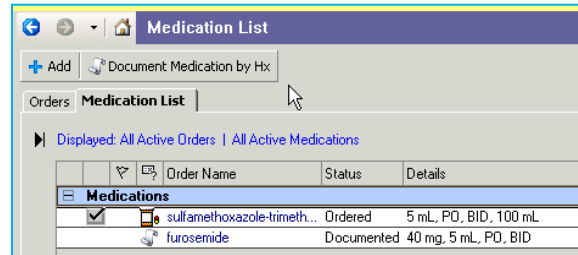
3. Prescriptions will not auto-complete or auto-cancel if they were ordered with a Type of Therapy (stop type) of Maintenance. If the prescription was ordered with Type of Therapy as Acute, the prescription will go to a complete status when it reaches its stop date.

   If a patient presents and has an order (prescription) on their Med List profile and has finished taking that prescription (such as a course of antibiotics), the order should be completed.

- If a patient presents with an active prescription for a med that they were instructed to stop taking, the prescription should be cancelled/DC'd.
- Highlight the order, right click, and choose Complete or Cancel/DC.
- The order will have a line through it; click on Orders for Signature (bottom right) and then Sign.
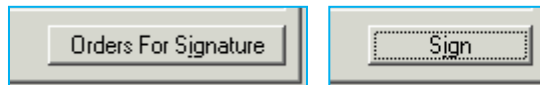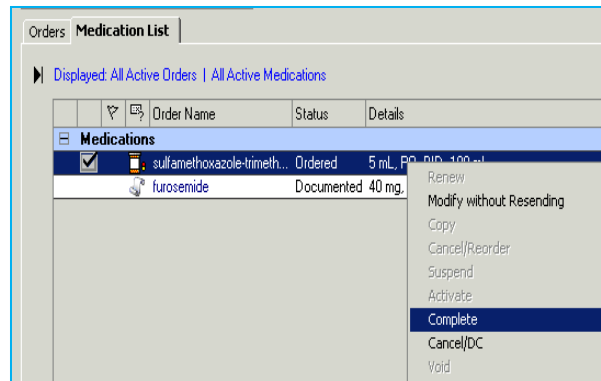
The prescription will now display with a status of Completed or Discontinued. The prescription also may drop off the medication list if the filter is set to All Active Meds.
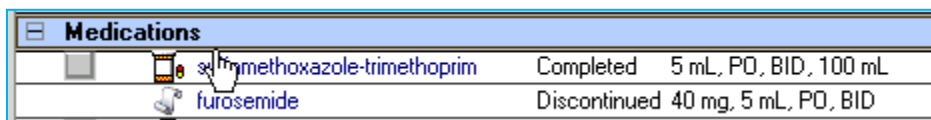
OUTPATIENT PRESCRIPTION REMINDERS AND TIPS:

- Normally, no refills are given so that the patient can follow up with their PCP.

- **Review the prescription** once printed to make sure it is correct and don't forget to sign the prescription under **substitution permitted.**

- Place the script on the patient's chart so the RN can give it to the patient upon discharge. Alternatively, you can give the prescription to the pharmacist for review, and so they can do medication teaching with the family.

- Use an appropriate reference – Lexi-comp is the best reference for pediatric dosing and to look up dosing forms. Epocrates is NOT an appropriate reference for pediatric dosing.

- Verify strength and dosage forms with the ED pharmacist to ensure accessibility for patients. When prescribing liquid medications, please round to the nearest whole number for ease of measurement.

MEDICATION ORDERS

The same steps for entering orders such as Radiology procedures or lab procedures are taken when entering Medication orders. The exceptions found in a medication order include order sentences and the use of the dosage calculator.

ENTERING MEDICATION ORDERS

1. Provider will log in to either Powerchart or FirstNet and Choose their patient.
2. In the menu bar on the left Power Orders is highlighted.
3. Click on the +Add to add an order.
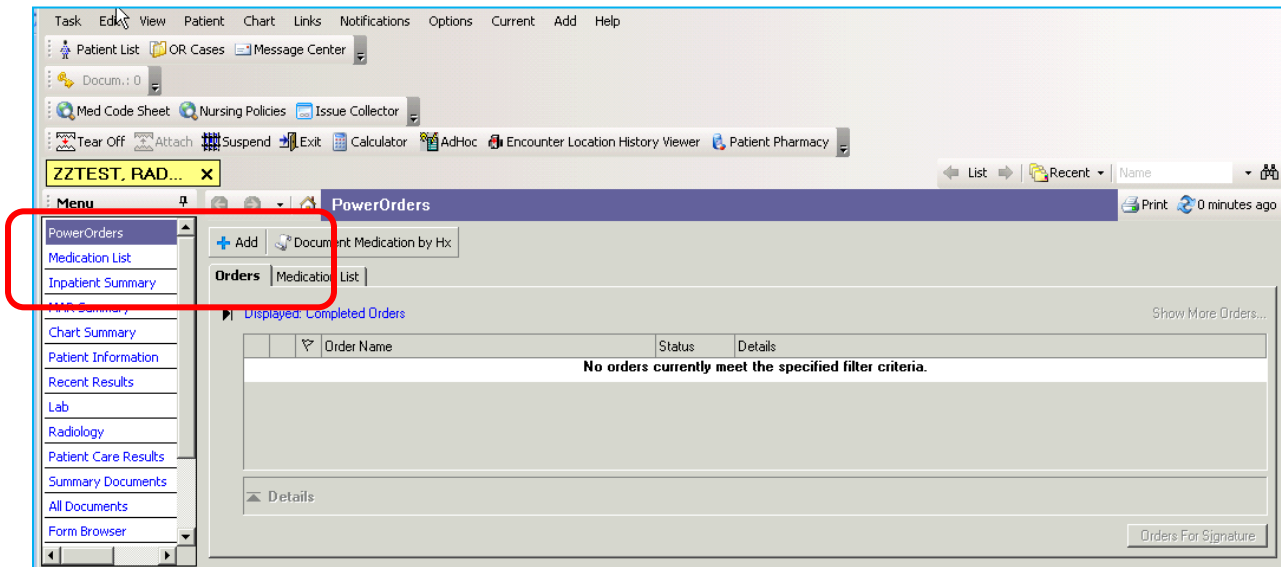
The Add Order dialogue box is shown. You can choose to search "Starts With" or "Contains" as you would when entering any order.
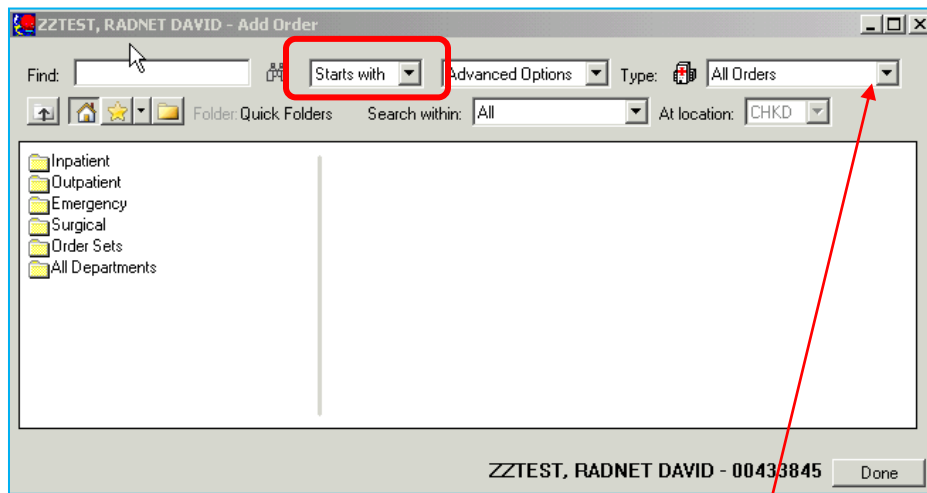
Note: the Type field should be set to All Orders if you are entering a medication order to be added as part of the patient's chart.

4. Enter the name of the medication.
   You may choose an "Order Sentence" from the list or highlight the primary drug name, i.e. ampicillin.
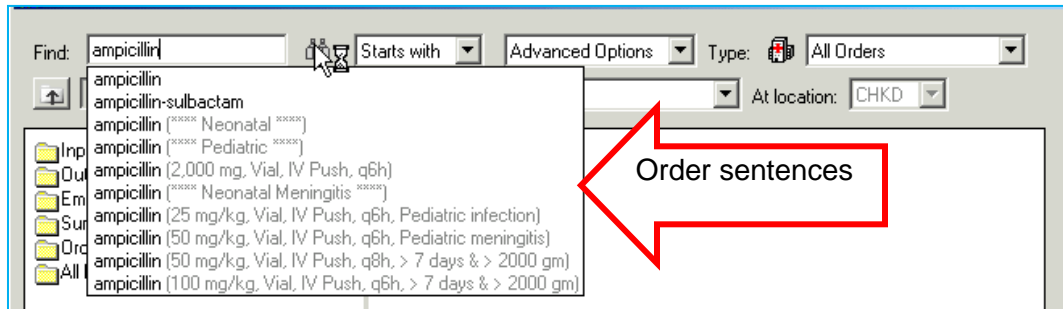
Order details will populate, based on pre-built order details within the system. However, this information can be changed, as necessary.

5. If you are not a prescriber, the dialogue box appears to enter the name of the prescriber. This will route the order to them for co-signature if appropriate.
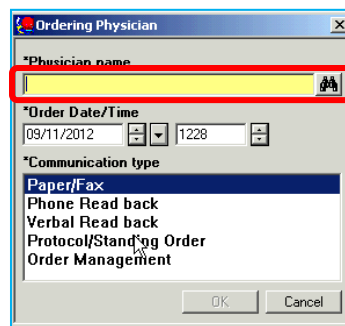
6. Selecting the correct communication type will determine the routing.

Communication Type	Use When…	Routes for MD signature
Paper/Fax	The provider has written an order on paper that must be entered into the system.	No
Phone Read back	You have spoken to the provider over the phone and have accepted an order	Yes
Verbal Read back	You have spoken to the provider face to face and have accepted an order	Yes
Protocol/Standing Order	You are entering an order that you have authority to enter because: · There is an approved protocol authorizing you to enter the order without speaking to the provider. · The provider has entered an order authorizing you to enter this order when a specific criteria is met.	Yes

7. Once the prescriber is entered any order sentences that are pre-built will populate.
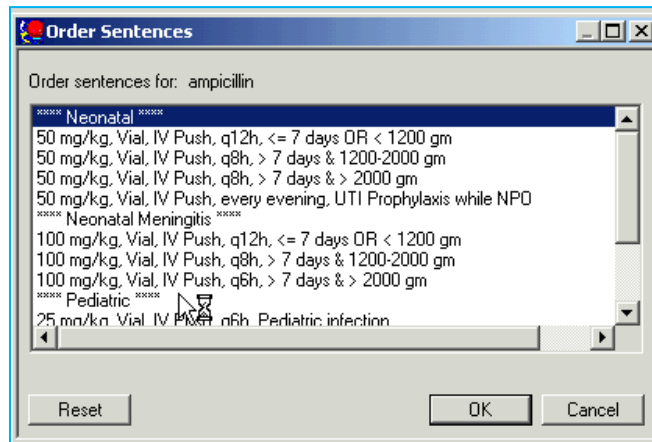
8. Choose the most appropriate order sentence.

9. If a weight based dose is chosen then the dosage calculator window will open.
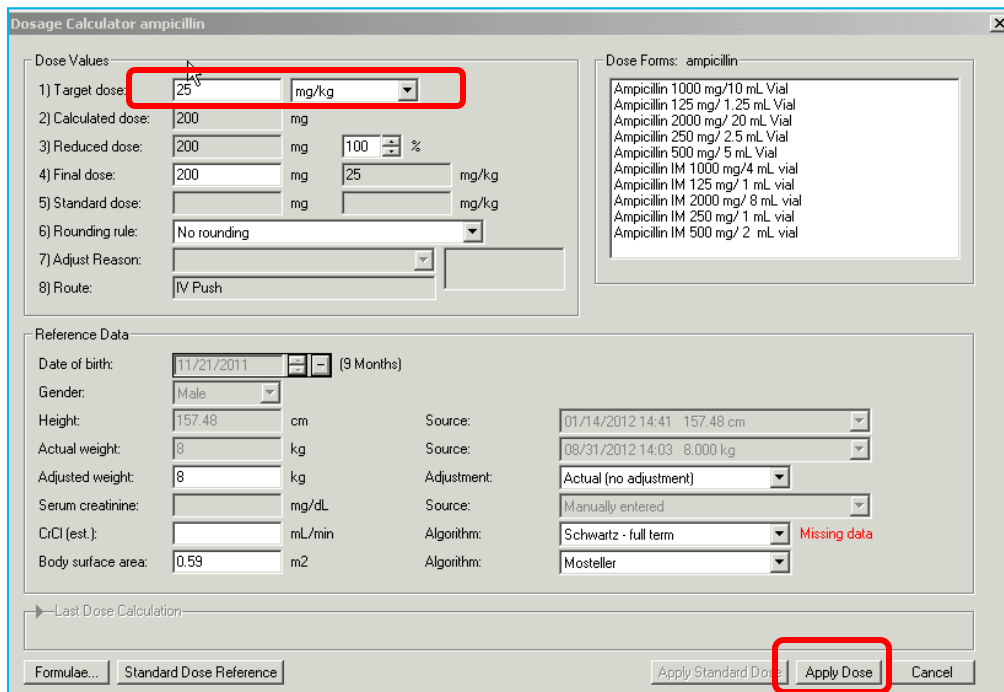
STANDARIZED DOSING

> **IMPORTANT:**
>
> If standardized dosing is available for a medication, the **Apply Standard Dose** button will be available for selection.
>
> When the Dosage Calculator gives the option of "**Apply Standard Dose**" vs. "**Apply Dose**"
>
> ALWAYS select "Apply **Standard Dose.**"
>
> As with pharmacy, prescribers should choose the standardized dose unless clinical conditions warrant. This should be discussed with the Medical Service for authorization.
>
> The Final dose can also be rounded as appropriate in this window.
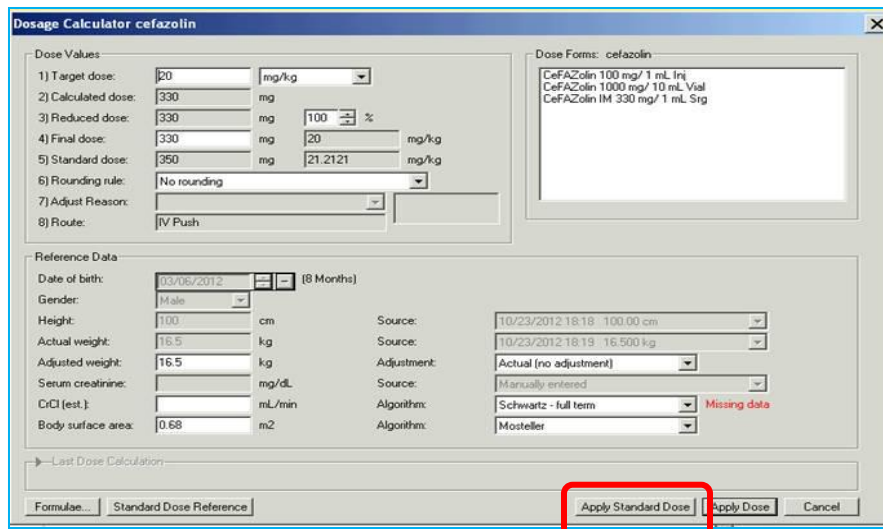
10. Once the "Apply Standard Dose" or "Apply Dose" is chosen, then any allergy warning or interactions will appear.
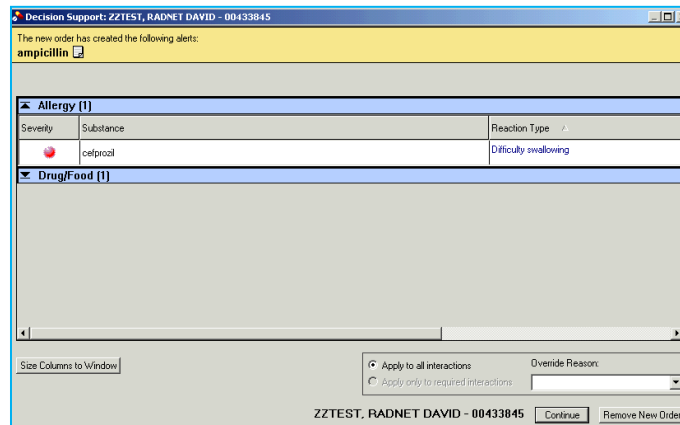
11. Any Override Reason chosen here will be visible to the pharmacist on verification. It is also stored in the Alerts tab in the order in PharmNet.

Note: When the individual order is completed, it will return the user to the Add Order Window. If all necessary orders have been entered, click on "Done".

12. The user is now returned to the Chart window.

DOSE CALCULATOR

When choosing a medication that is a Weight Based medication, the Dosing Calculator will automatically open and display the information on which the dose was based.

If needed, you can access the Dosing Calculator by clicking the "Open Dose Calculator" icon on the order details toolbar.

13. If any required details are missing. Either proceed through each field or click on "Missing required details" and it will bring them up one at a time for clarification.
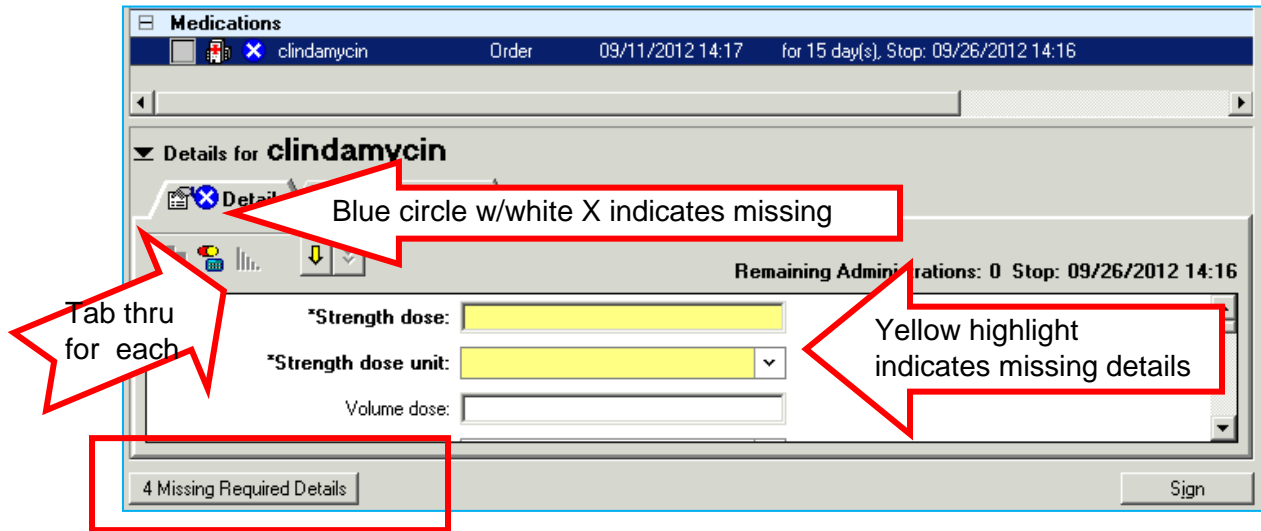
14. Review orders and verify accuracy.

REMINDER:

Using the right-click functionality discussed in prior lessons, any order that is not appropriate can be removed prior to signing the order.

15. Sign the order.

16. Select the Refresh button to refresh your screen and see the correct status of the order and the most up-to-date information.

The orders are sent to the Unverified Orders Monitor in PharmNet for pharmacist verification.

Once orders are signed and screen is refreshed, the order is seen on both the Orders tab (in the Medications section) and Medication List tab.
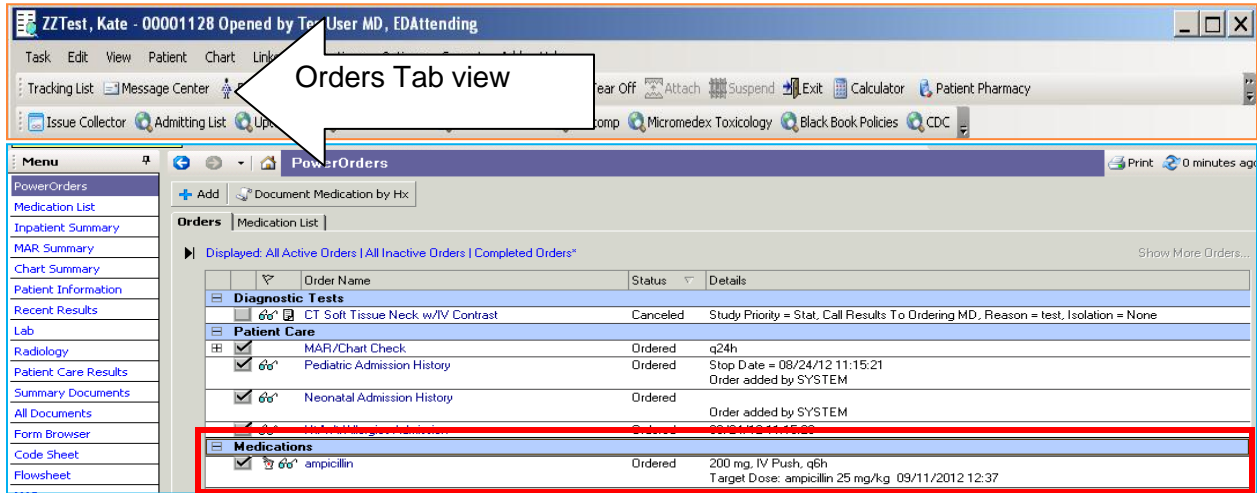
ADDING PREFERRED PHARMACIES

In PowerChart, you can specify a preferred pharmacy for patients.

A Patient Pharmacy button appears on the toolbar.

By selecting this button, you are able to enter the preferred pharmacy for the patient.
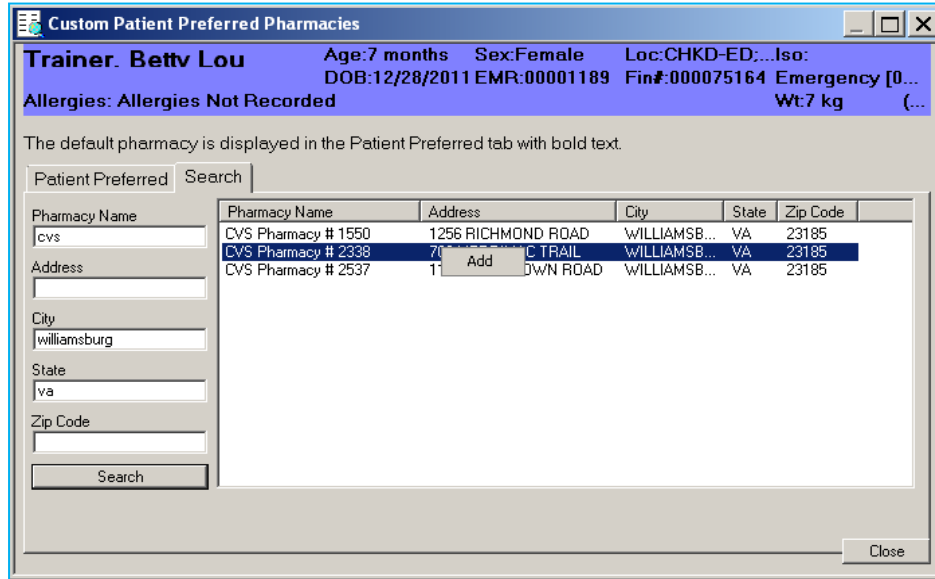
To add a Preferred Pharmacy, complete the following steps:

1. Click the Patient Pharmacy button from within the patient's chart.
    The Custom Patient Preferred Pharmacies window will appear.

2. Search for the pharmacy by entering the name, city , state and or zip code. Remember, the more information that you enter, the more the system will narrow the search and return results quicker.

3. When the desired pharmacy is located, right click and select ADD.

The pharmacy will be added to the Patient Preferred Pharmacy tab.

Note: if multiple Pharmacies are added to the Patient Preferred Pharmacy tab, you can right click on the "set the preferred pharmacy". You can also Remove a Pharmacy but you cannot Remove one entered from a location other than the ED.
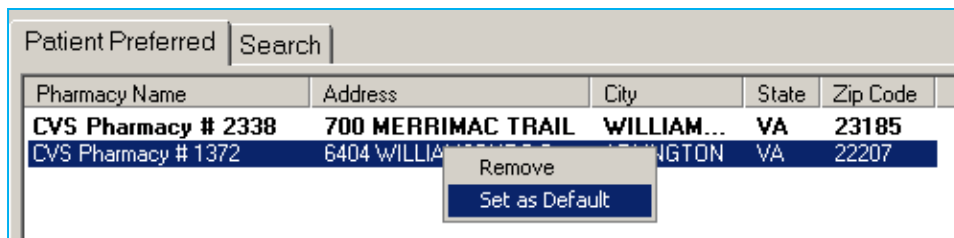
PRACTICE SCENARIOS FOR ENTERING PRESCRIPTIONS

Unless otherwise specified, there is no preferred pharmacy.

Scenario 1:

Your patient presents to the with ED bilateral ear pain

After examining the patient you consult with the patient and parent, and determine a DX of otitis media. The patient's preferred pharmacy is Kroger on Lynnhaven Parkway in Va. Beach

- Enter a RX for Amoxicillin for this patient. 250 mg, 1 Cap, PO, TID, Duration: 10 Days. Dispense: 30 caps. 0 refills.

Scenario 2:

Your patient presents with wheezing and shortness of breath.

After examining the patient, you have consulted with the patient and parent. You determine a diagnosis of asthmatic bronchitis and order a prescription for:

- Albuterol 2.5mg / 3m, INH, Q4H, 2 PUFF for SOB and Wheezing

Scenario 3:

- Your patient presents with a severe headache. After examining the patient. you have consulted with the patient and parent and have determined a diagnosis of Migraine. Order a prescription for: Percocet 5/325, 1 tablet tid , Duration: 3 Days
- The patient's preferred pharmacy is Al's Pharmacy in Eagle, Virginia.

Scenario 4:

- Your patient presents with severe left lower back pain. You have consulted with the patient and parent and have determined a diagnosis of lumbar strain and order a prescription for:

Motrin, 600 mg oral tab, 1 tab po q 8h for 1-2 days then as needed

INTERACTING WITH ORDERS

UN-SIGNED ORDERS

To view available ways to interact with orders <u>prior</u> to signing, select the order and right-click. This action brings up the right-click menu options available for unsigned orders.
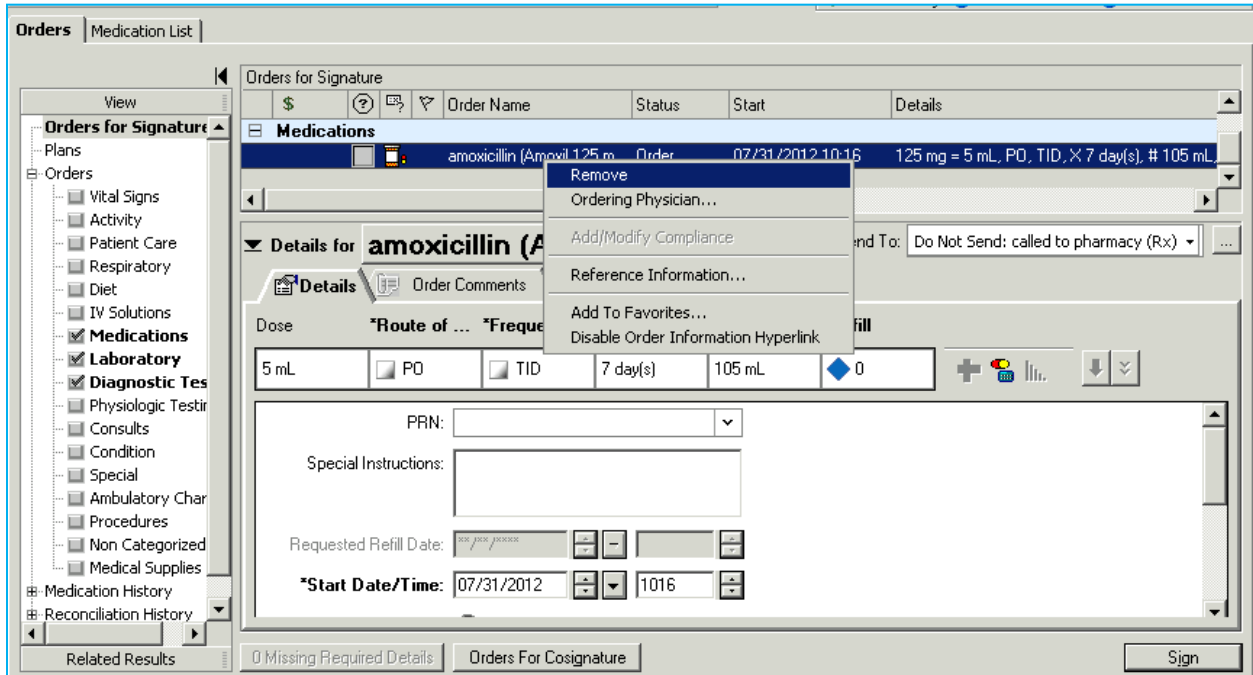
<u>Remove:</u> Allows you to remove an unsigned order. This order will not be kept within order history.

<u>Ordering Physician:</u> Allows you to change the ordering physician for an order.

<u>Reference Information</u>: Allows you to view and print Reference Information (Preps) associated with the order.

<u>Add to Favorites:</u> Adds the current order to your Favorites list for future orders.

<u>Disable Order Information Hyperlink:</u> Disables the hyperlink within the order's name. This option changes the color of the orderable name from blue to black.

REMOVING AN ORDER

To remove an order prior to signing, highlight the order, right click and select remove. When the order is removed, it no longer appears within the patient record because it was never submitted.

NOTE:

After an order has been signed and submitted, it cannot be removed using the Remove option. If the order is no longer needed, cancel or cancel / reorder must be selected.

REFERENCE INFORMATION

Some orders and medications have reference information associated with them. You can view the reference information at any time by right clicking on the order. Some medications have Drug References, Education Leaflets, and Reference (Prep) Information.

To view reference information, right-click on the order and select Reference Information. This reference information can be printed before or after signing the order by right clicking anywhere within the reference information.

You can also access Reference Information by selecting the Reference Text Browser tab. From this tab, type in the substance name and select Search. The system will provide Drug Reference Information and Education Leaflets.

INTERACTING WITH SIGNED ORDERS

To view available methods of interacting with orders after they have been signed, select the order and right-click. This action displays right-click menu options that are available to the selected order. If the option is grayed out, it is not available.
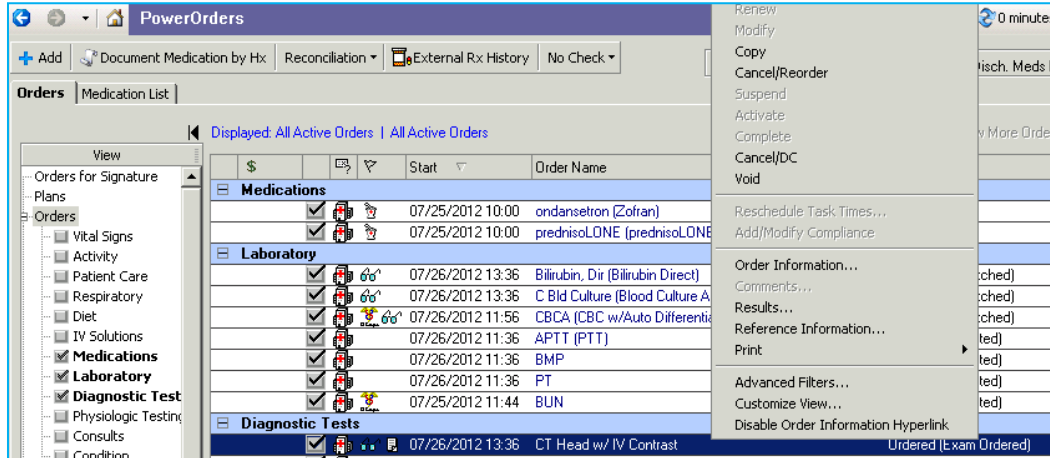
Modify: Use this option when changing parameters to a current order (not available for all orders). Selection will bring you the Order Details screen.

Copy: Allows you to repeat an existing signed order.

Cancel/Reorder: Allows you to cancel an existing order and place another order for the same orderable item. **Note**: This option will create a new order while canceling the first order.

Cancel/DC: - Allows you to cancel a one time existing signed order or discontinue a continuing order. Use this option when the patient is discharged or on leave of absence. This option will **NOT** create another order.

Order Information: Opens the Order Information dialog box and displays various pieces of information about the selected order on specified tabs.

Comments: Displays comments for submitted orders.

Results: Displays results for completed orders in a Flowsheet-like grid.

Print: Reprints an order sheet, a requisition, or consent form to a designated printer.

Reference Information: Displays and prints reference materials if they have been defined by CHKDHS. In this section, Prep information will be displayed and available for you to print.

Advanced Filters: Displays the Order Filters that allows you to indicate which orders statuses that you want displayed or hidden.

Disable Order Information Hyperlink: Disables the hyperlink within an order's name. Selecting this option changes the color of the orderable name from blue to black.

NOTE:

Not all options shown above will be available. Some options are security-driven, while others may be unavailable because of the type of order selected.

MODIFYING ORDERS

Some orders can be changed after they have been placed; however, the original entry will always be part of the electronic record and the changes will be noted as modifications.

To modify an order, complete the following steps:

1. Right-click the order that requires modification.

2. Select Modify from the shortcut menu (only when the Modify selection is **BOLD** can this option be utilized).

3. The Order Details window for that order is displayed in the Order Profile Window.

4. Modify the order details as appropriate.

5. Click the Orders for Signature button .

6. Review the changes, and click the Sign button.

7. Click the Refresh button to refresh the screen.

NOTE:

- If modify is not an available menu item, then the selected order does not allow this option.

- You should consult with the ancillary department before modifying any order.

- The modify option is typically not available with all orders.

VIEWING ORDER INFORMATION

A great deal of information about an order can be viewed in a summary dialog box. This includes who ordered the test, how and when the order was placed into the system, comments, details, and much more.

- Click on the orderable name from the Existing Order Profile. (The Order Information Hyperlink has to be on for this to work.)
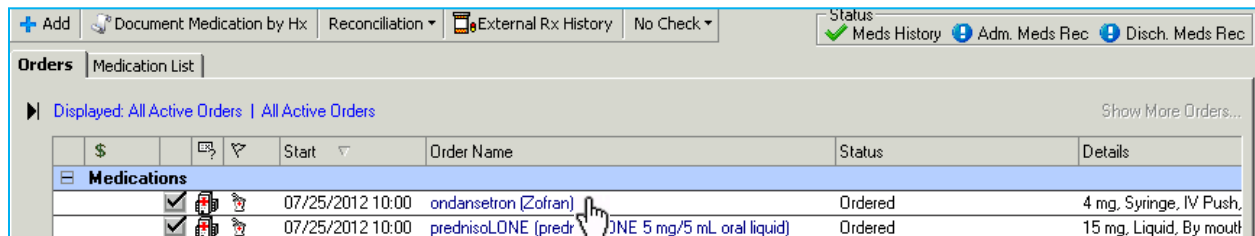
<div align="center">**OR**</div>

- Right-click the order and select Order Information from the menu.

  The Order Information window is displayed.

- Click the desired tab to obtain the needed information. The Order Info window includes the following tabs:

  - **Additional Info** – displays the order name, start time, stop time, order ID number and department status.

  - **Comments** – displays order comments entered for the selected order with the most recent listed on top.

  - **Details** – displays the order format and the current details for the order. If any details have been modified, the newest values are displayed.

  - **History** – displays each action taken on an order in reverse chronological order. The initial order action displays the order details. Subsequent modifications show before and after detail information for comparison.

  - **Results** – displays results for an order.

- Click the Exit button when finished.
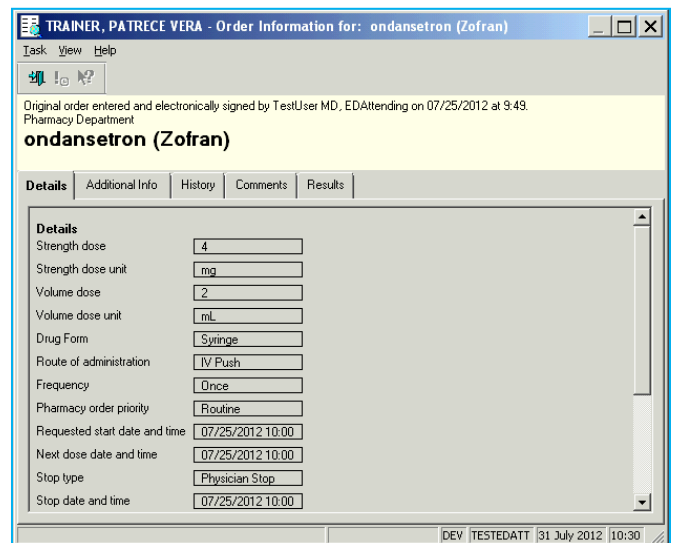
VIEW ORDER MODIFICATION HISTORY

To review the modification history from the orders profile, complete the following steps:

1. Right-click the order and select Order Info.

2. Select the History tab from within the Order Information window. This tab tracks the changes made to the order. Note the Before and After columns showing the changes made to the order. The most recent change will appear on top.

COPYING AN ORDER

To save order entry time, you can select a previously entered order and repeat it. Then you can select it and modify it, if necessary.

To repeat an existing order, complete the following steps:

1. Right-click the order and select copy from the context menu.

2. If necessary, enter additional details.

3. Sign the order to submit it for processing.

TIPS AND TRICKS:

You may select a group of orders and apply a 'Copy' action to all at the same time. At Step 1 above, select all orders to repeat by holding down your 'control' key on your keyboard while clicking on the orders. Then proceed with the remaining steps.

CANCELING ORDERS – CANCEL/REORDER

Orders that have been signed cannot be removed. If an error has occurred, the order can be canceled and reordered in the same sequence by selecting the "Cancel/Reorder" context menu option. The original entry will always be part of the electronic record and the change is then noted as a cancellation.

To cancel an order and reorder the same orderable, complete the following steps:

1. On the Orders tab in the Order Profile Window, right-click the order that requires cancellation.

2. Select Cancel/Reorder from the context menu.

3. The Order Details window is displayed at the bottom of the Orders Profile Window. Enter the correct date/time and cancellation reason.

4. Click the Orders for Signature button.

5. Review and sign the cancellation.

6. Click the Refresh button to refresh the screen.

CANCELING ORDERS – CANCEL/DISCONTINUE

Canceling or discontinuing an order stops any further processing on the order. The order is still displayed on the existing orders list but shows a status of Canceled or Discontinued. If the order was entered in error, you can cancel/discontinue the order.

To cancel/discontinue an order, complete the following steps:

1. Right-click the order that requires cancellation.

2. From the shortcut menu, click Cancel/DC.

3. The Order Details window is displayed at the bottom of the Orders Profile Window. Enter the correct date/time and cancellation reason.

4. Click the Orders for Signature button.

5. Review and sign the cancellation.

6. Click the Refresh button to refresh the screen.
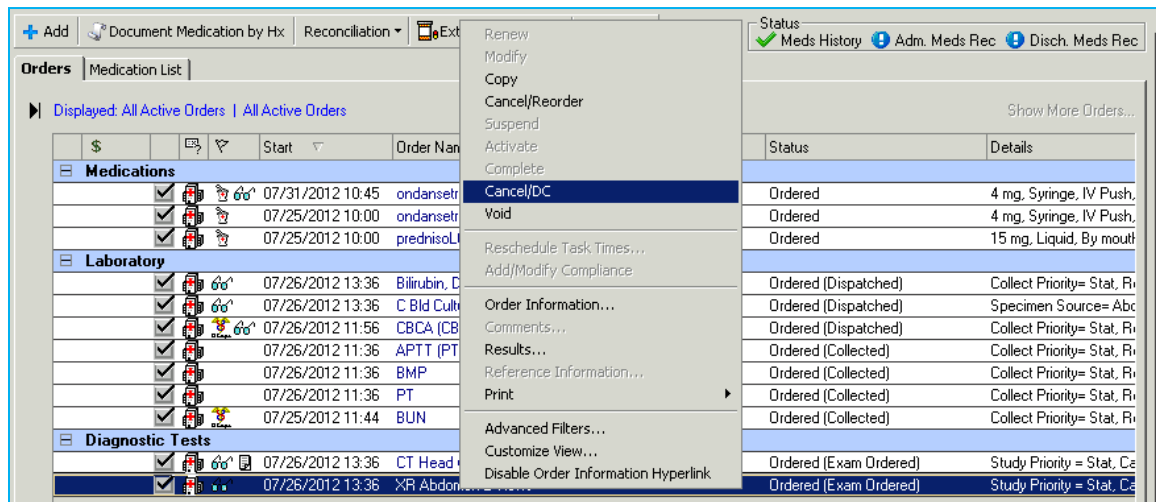
PRINT

Selecting Print from the **Orders Tab** allows you to reprint an Order Sheet or Requisition Form. The option for Consent Form is available, but will not be used at this time. Selecting the Consent Form option will <u>not</u> generate a consent form

To reprint a requisition, consent form, or order sheet, complete the following steps:

1. With a patient chart open, select the order from the Existing Orders profile.

2. Right-click the order and select Print from the context menu.

3. Select the appropriate submenu command (Reprint Requisition).

4. When prompted, enter the ID of your printer, and click OK.

APPROVING A PROPOSED ORDER

Orders that Nursing submit to you are routed to your Message Center inbox for co-signature.

You can also approve these orders from the patient's chart by clicking the Orders for Co-signature button at the bottom of the screen.

PRACTICE SCENARIO FOR INTERACTING WITH ORDERS

1. Add an order for an Echocardiogram but DO NOT SIGN the order. Right click the order on the order profile and select Remove. Note the order is no longer visible and there is no history of the order.

2. Right click on the CBC and select Order Info. Click across the tabs and note the information available

3. Right Click on the Albumin Level and select Discontinue. Enter the reason as Physician Request.

4. Note you can also click the check mark in the Quick Discontinue column to start the DC process.

5. Right click on the RSV Culture and select Reference Information. Review the information and close the window.

ENTERING A POWERPLAN

A PowerPlan is a care-planning tool that allows you to manage orders as they relate to a pre-defined plan of care. POWERPLANS *d*efine decisions, activities and expectations for a specific problem. The plan serves as the primary catalyst for a number of activities such as orders, diagnostics and medication administration executed by the care team. PowerPlans are commonly grouped together for the purpose of completing specific clinical pathways. The PowerPlans in FirstNet are created based on the Existing Clinical Pathways already used at CHKD.

A PowerPlan is accessed from PowerOrders in the same way individual orders or care sets are found.

- Orders placed as a PowerPlan will stay grouped and identified with a PowerPlan Icon.

- Orders can be added to the PowerPlan.

- PowerPlans can be discontinued in two ways:
    - Discontinue the entire Plan
    - Discontinue selected order(s) within the plan

NOTIFICATIONS IN THE ORDERS PROFILE WINDOW

Icons will display in the Notification column within the order profile window of PowerPlans. Hovering over these icons will display the definition of the icon as noted below:

Notifications:

Mortar and Pestle – This order is yet to be verified by a pharmacist

PowerPlan Icon – This order is part of the plan: (PLAN NAME)

Caduceus – This order is yet to be cosigned by the ordering Physician

Eyeglasses – This order is yet to be reviewed by a nurse

Clipboard – This order is yet to be reviewed by a nurse

SEARCHING FOR A POWERPLAN

Steps to Search for a PowerPlan:

1. Click the Add icon [+ Add] from the Orders Window.

2. In the Find box, you can search for a plan by typing the title in the search window. This functionality is the same as searching for any orderable.

   NOTE: You can also select the folder at the bottom of the window specified for PowerOrders.

3. The title of the PowerPlan will appear in the orders window.
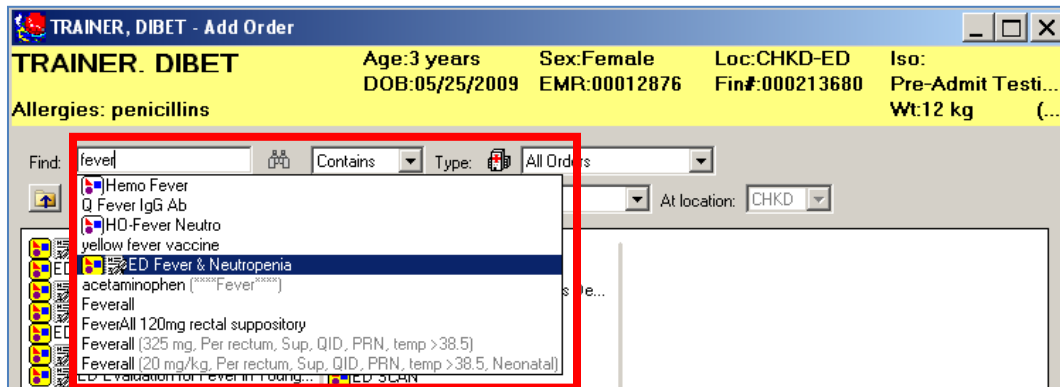
4. The yellow icon displayed in front of the search results indicates these are power plans. This icon is identical to the care set icon except for the yellow color.

5. Clicking the icon beside the CarePlan will display existing Clinical Pathways.
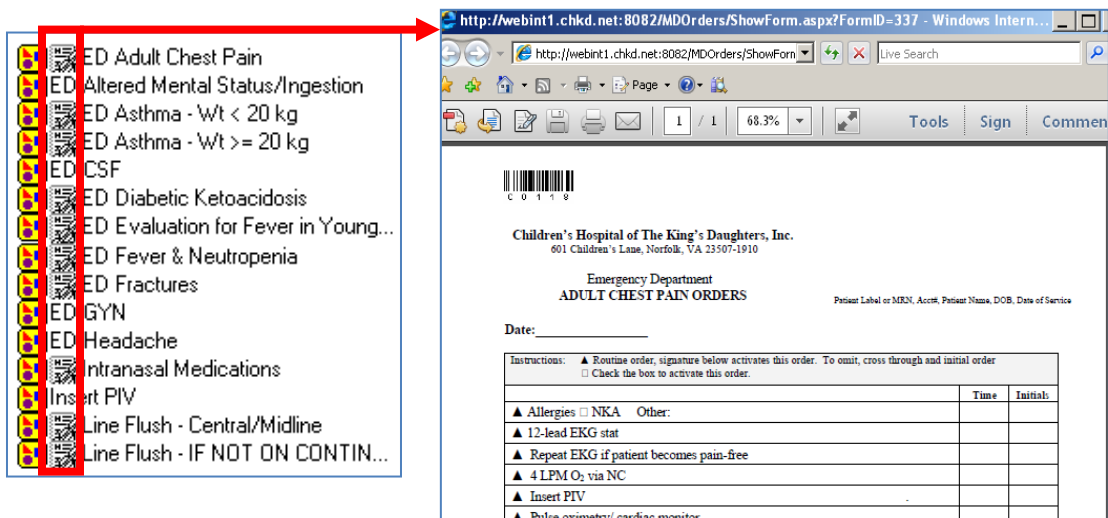
POWERPLAN STATUSES

- **Initiated:** Initiated Pending phases move to a status of Initiated when you sign the Initiate action. As the phase moves to a status of Initiated, the orders within it will have a status of Order. All components (orders, outcomes, and interventions) within a phase get their start date and time from the start date and time of the phase. Exceptions are those orderable items previously assigned a start offset, to indicate that they are to start so many minutes, hours, or days after the start of the phase or orders that have a specific start date and time set in the order details. The Plan History tab is available at this status. It allows you to view a record of activity that occurred on that order while the order was in a Planned status.

- **Completed:** This status denotes a plan, phase, or order whose stop date and time have elapsed, meaning that this plan, or portion of it, has been administered and is finished. A phase will also go to a Completed status when all included components in the phase are in a final status.

- **Discontinued:** Plans can be discontinued automatically at patient discharge. Phases and plans can also be discontinued manually by taking a Discontinue action on them. When the Discontinue action is taken the phase will be displayed in a Discontinue Pending status until the action is signed.

- **Void:** Phases and plans are voided when a Void action is taken against them. When the void action is taken the phase will be displayed in a Void Pending status until the action is signed.

SECTIONS OF A POWERPLAN

The sections to the PowerPlan are laid out in order, similar to a physicians pre-printed paper order sheet. Each section heading is colored blue to help identify the beginning of a new section.
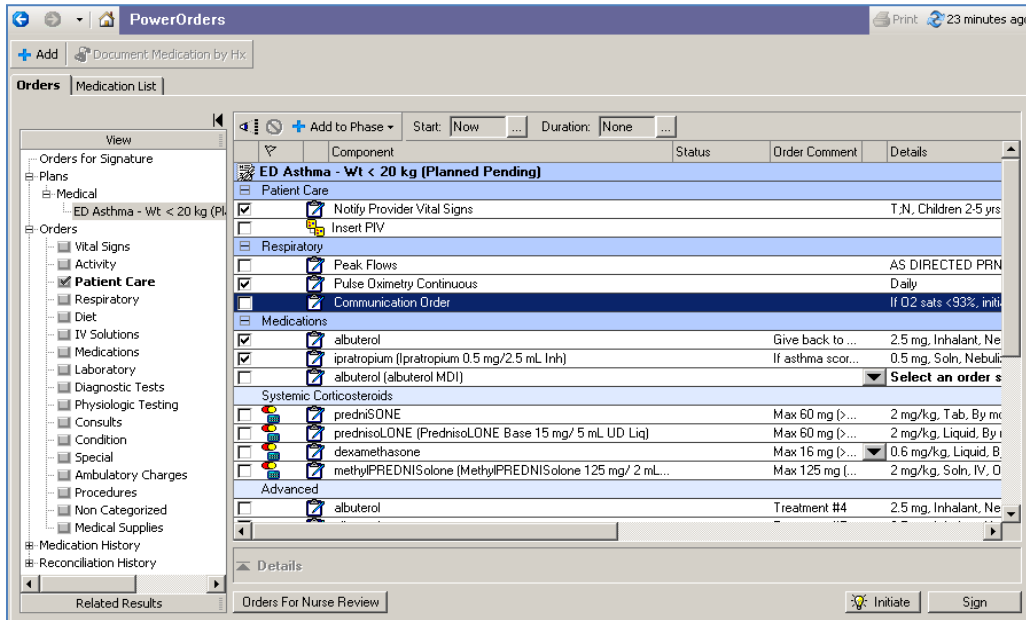
PRESELECTED ORDERS

The checkmarks on the left are preselected orders for your PowerPlan. You can select additional orders or deselect by unchecking the preselected orders.

To allow additional viewing space on the right side of the PowerPlan window, you can collapse the Navigator on the left.
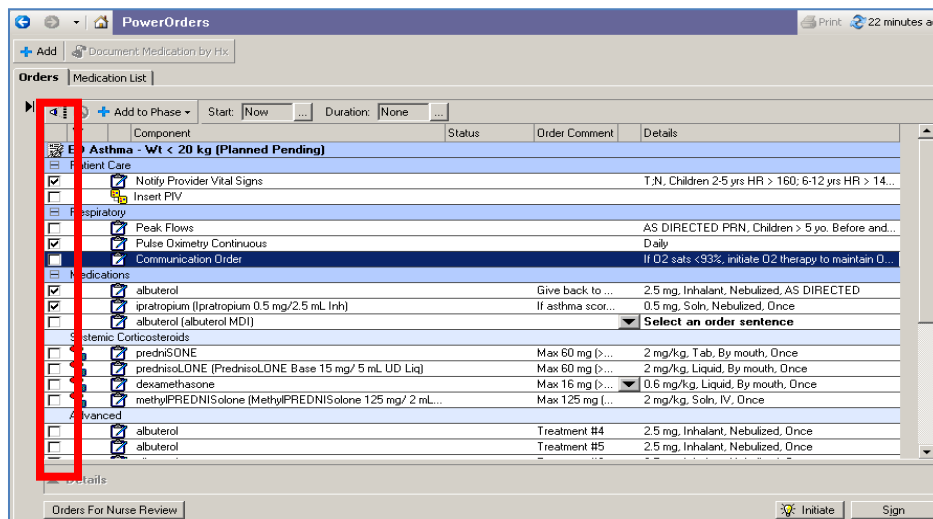
NAVIGATION THROUGH THE POWERPLAN

There are several ways to navigate down the PowerPlan.

1. One way is to collapse each section after completing it.
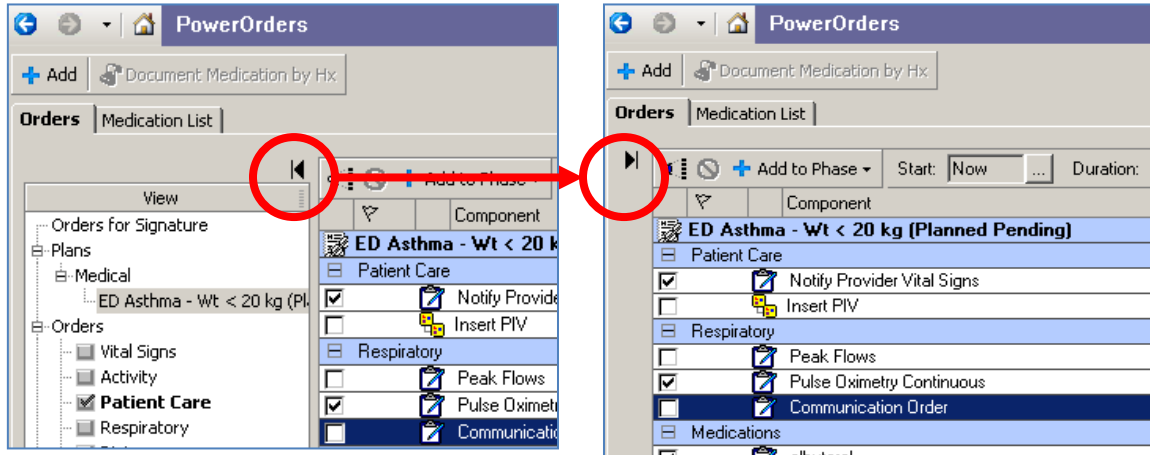
2. Navigate down the PowerPlan by clicking the scroll down bar on the right.
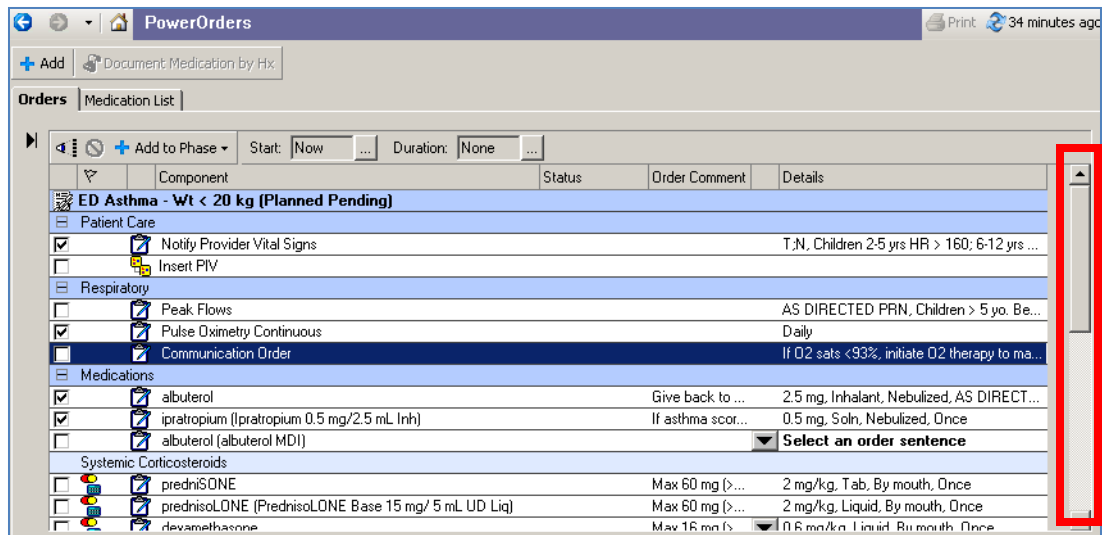
MEDICATION SECTION

The medication section of the PowerPlan will display the most commonly used medications for the selected plan. The Order sentences for each medication are a list on the right.

A drop down arrow is displayed when there are more commonly used order sentences for that medication.
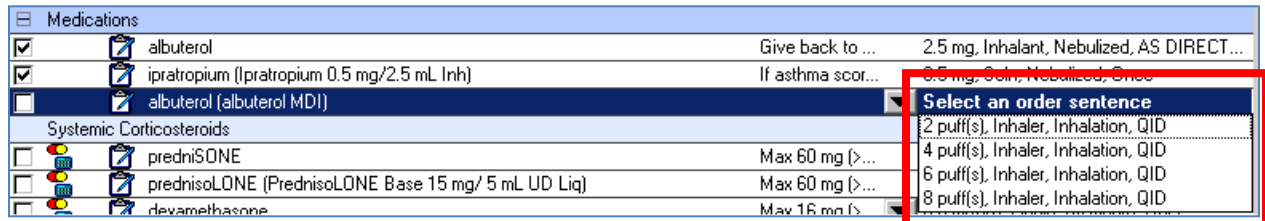
Select the appropriate order sentence details that is defaulted or use the drop down arrows if needed.

When selecting Medication you may be prompted to select the appropriate pharmacy type for the medication selected. You can select Additive or Medication.
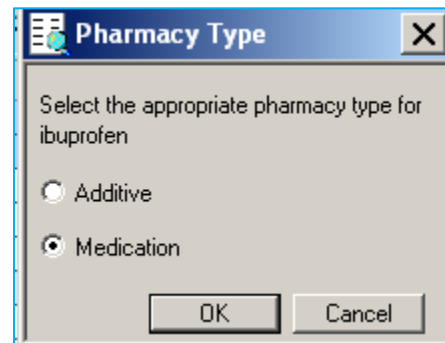
Certain Medications may prompt you to include information in the Ordering Physician Window. If this displays also add the correct communication type for the med order.. Enter the information as you would for any orderable.

DETAILS/FORMATS

Common order entry fields include:

- **Requested Start Date/Time** - determines when the order will start
- **Frequency** - determines how often an order is carried out.
- **Duration/Duration Unit** - determines how long the order will be carried our (e.g. 3 days)
- **Collection Priority** - determines when a lab will be collected.
- **PRN** - determines if the medication or treatment is given on an as needed basis (requires a frequency)
- **Strength dose/Strength dose unit** - determines the dose of a medication
- **Route of administration** - determines the method of delivery

ORDER SENTENCES

Order Sentences are commonly entered values defined for an orderable. When an order is placed, select one set of details without having to enter each value separately. Select the order sentence closest to the values needed and then modify if necessary.

REQUIRED DETAILS

Although some of the order details may be listed, the blue circle with white X indicates there are more Required Details that need to be satisfied.

If an **order** has a **required detail**, the detail must be satisfied before signing the order.

System required details are noted in several areas:

1. Blue Circle with a white 'X' next to the Orderable in the Order Review window.

2. Blue circle with a white 'X' in the Details Tab.

3. Order detail is Bolded with an asterisk and Highlighted Yellow within the Details section.
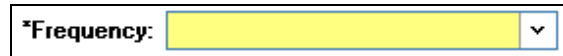
4. Order detail fields that use radio buttons are Bolded with an asterisk.

5. Notification in bottom of the details window, stating how many required details are missing.

The detail window for your order opens. The Reason for Exam has an asterisk and is bold indicating it is a required field. The field itself is yellow, another indication this field is required. Click the drop down arrow to select the reason for the exam.

You can complete or change other details to the order, if needed. Once you have finished collecting all order details you can sign the order.

MISSING DETAIL NOTIFICATION
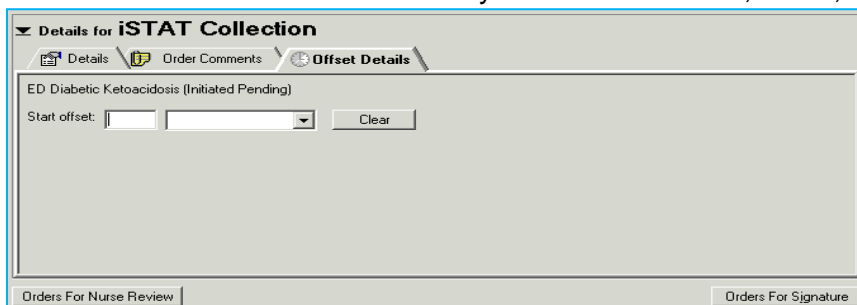
If you attempt to sign the order without satisfying the missing system required details, you will get a warning prompt.
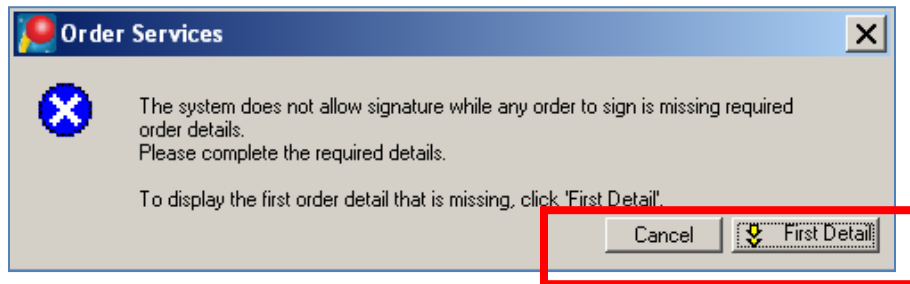
From the warning screen, the First Detail button will take you directly to the first missing required detail. The Cancel option will close the warning prompt.

OFFSET DETAILS

If an order is part of a PowerPlan, the start Offset Details can be utilized if the start date/time of the plan is today and now and you want this particular order to start in 4 hours. You can offset the start date and time of the order by number of minutes, hours, or even days.

DECISION SUPPORT ALERTS

Decision Support Alert Window will display if medications ordered for your patient that are contraindicated. The example below displays a Duplicate alert.
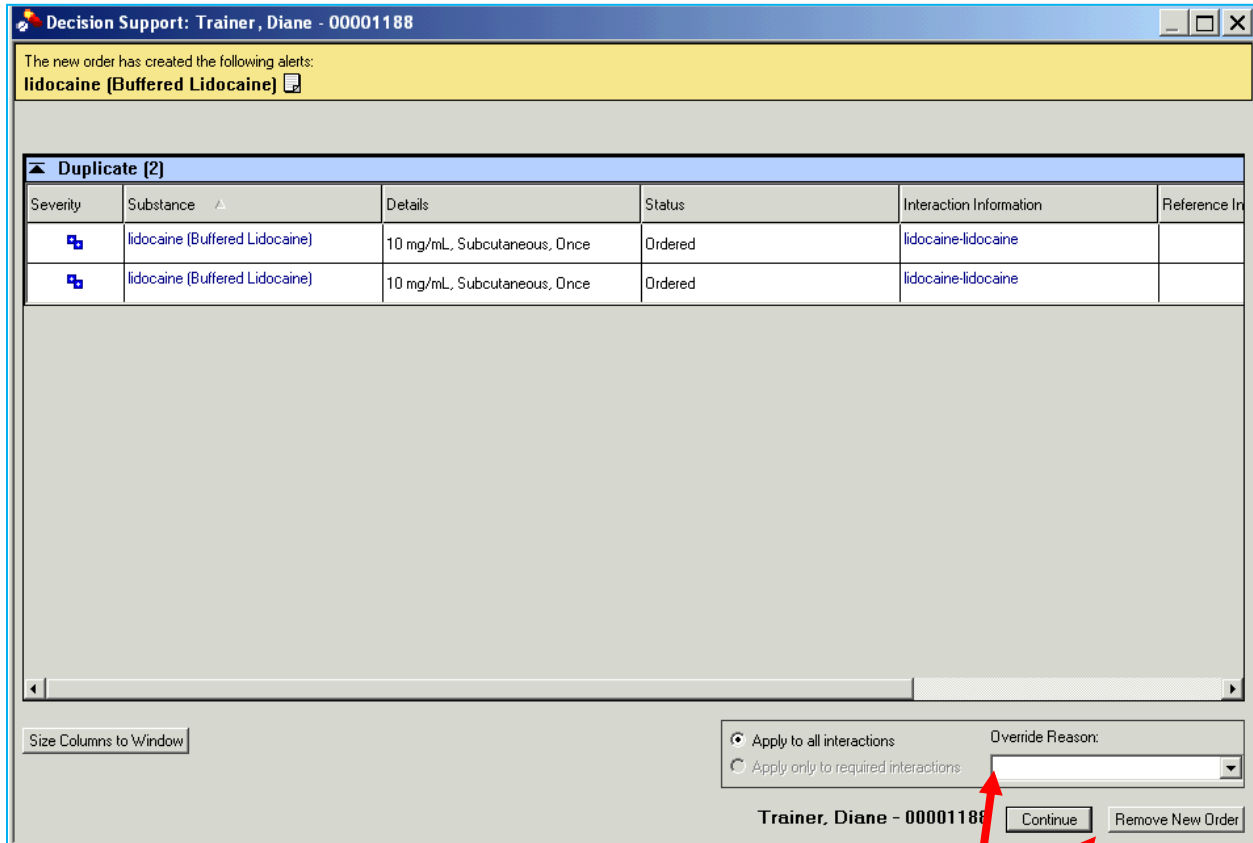
To override the alert select the reason from the Override Reason Drop down menu.

Or

You can select to Continue or remove the new order based on clinical judgment.

DISCERN ALERTS

Discern Alerts are generated for Medication Dose Range Alerts.

In the example below the ordered dose is over the suggested dose range for METOCLOPRAMIDE. You can choose to Cancel the Order, Ignore the alert or Modify the order and click OK.

Choosing Ignore alert will prompt you to enter an override reason. Select the reason for overriding the med alert and select OK to continue and order the med.
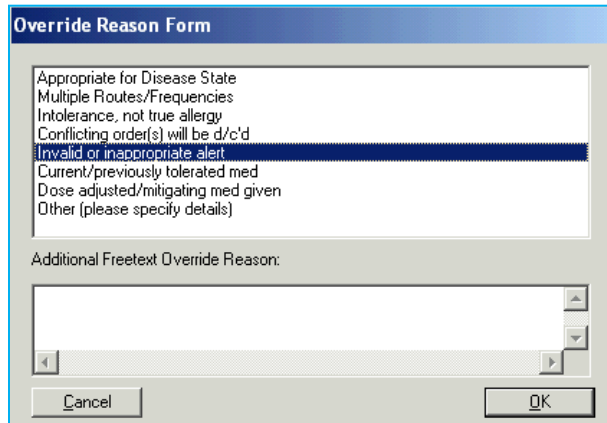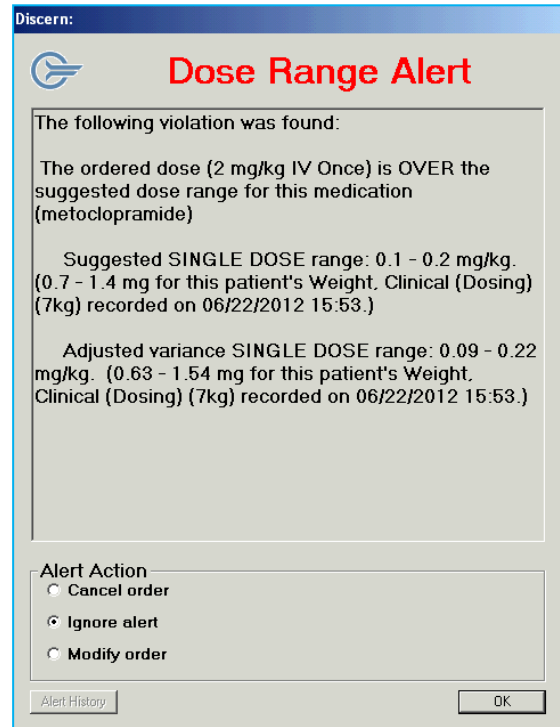
REMOVING AN ORDER

To remove an order prior to signing, highlight the order in the navigator window, right click and select remove. When the order is removed, it no longer appears within the patient record because it was never submitted.
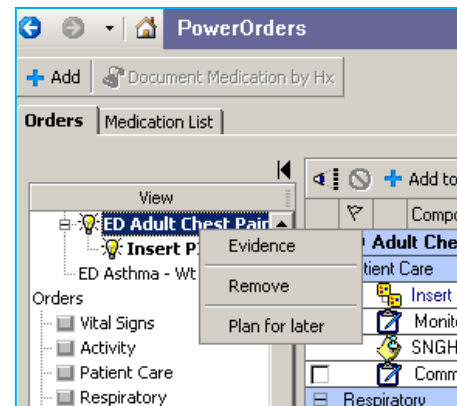
NOTE:

After an order has been signed and submitted, it cannot be removed using the Remove option. If the order is no longer needs, cancel or cancel / reorder must be selected.

RIGHT-CLICK FUNCTIONS

- **Renew** – Currently Not available

- **Modify** - Allows you to modify an existing signed order.

- **Copy** - Allows you to copy the existing order and make modifications before signing the new order.

- **Reorder/Cancel** - is not a recommended function for Pharmacy or Lab orders.

- **Suspend** - Allows you to suspend, or pause an existing signed order.

- **Activate** – Used for orders with a current status of Future

- **Complete** - Allows you to complete orders that do not generate a task (example Nursing communication orders, do not use for medication, lab or radiology orders).

- **Discontinue/Cancel** - Allows you to cancel a one-time existing signed order or discontinue a continuing order. Recommended to use Cancel / DC and place new order when changing a medication's Route or Concentration.

- **Void** – Allows you to void orders when placed on the wrong patient.

- **Order Information** - Displays the order information window.

- **Comments** – Allows you to view any comments on the order if there are any.

- **Results** – Allows you to see any related results associated with the order (e.g. heart rate for a digoxin order).

- **Ingredients** – Allows you to see the specific ingredients in a multi-ingredient order.

- **Reference Information** – Allows you to see reference information in the system related to the order.

- **Print** – Allows you to reprint the orders sheet, a requisition for that order or a consent attached to the order.

- **Advanced Filters** – Allows you to create and save filters to view subsets of orders.

- **Disable Order Information Hyperlink** – Allows you to disable the hyperlink on the Order Name.

Additional Actions Related to Medication Orders

Cosign (No Dose Range Checking) – Allows you to cosign a medication entered by a nurse or attending.

POWERPLAN PROFILE TOOLBAR

The Powerplan profile toolbar allows additional functionality to be performed with an existing PowerPlan.
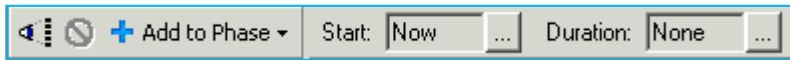
MERGE VIEW

The Merge View icon can be used to review active orders adjacent to pending PowerPlan orders.

1. Click on the appropriate PowerPlan from the Navigator window.
2. Click **Merge View** icon .
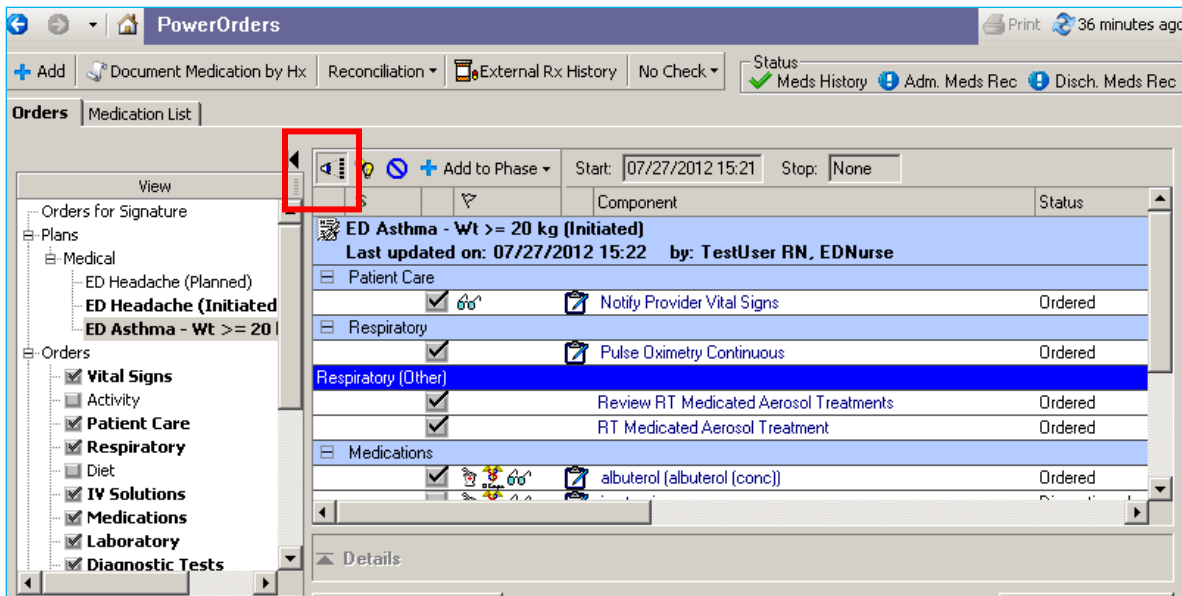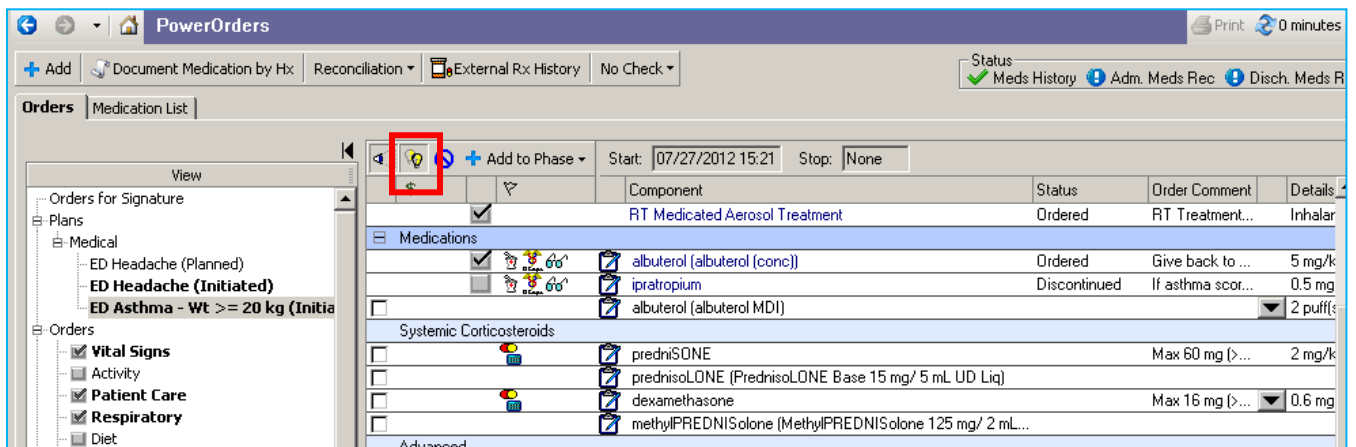
NOTE: When you have finished viewing the plan you may want to click the Merge View icon again to restore your screen to the original view.

VIEW EXCLUDED COMPONENTS

The View Excluded Components Icon (light bulb icon) allows you to view the components of the PowerPlan that were not originally selected. Once in this view you can select additional items within the plan to add them.

To select additional components:

1. Click on the appropriate PowerPlan from the Navigator window.

2. Click the **View Excluded components icon** .

3. Click the check box beside the component/orders to add

4. Complete the Ordering Physican window if applicable

5. Complete any needed details for the order

6. Click Orders for signature

7. Click Sign

8. Click the Refresh Button

9. The additional orders you selected will now be included as part of the selected powerplan.

DISCONTINUE BUTTON

The Discontinue Button opens up the discontinue window where selected components of the PowerPlan can be removed.

In the Keep column you can select the items you wish to keep or remain as part of the plan. Deselected items will be discontinued from the Powerplan.
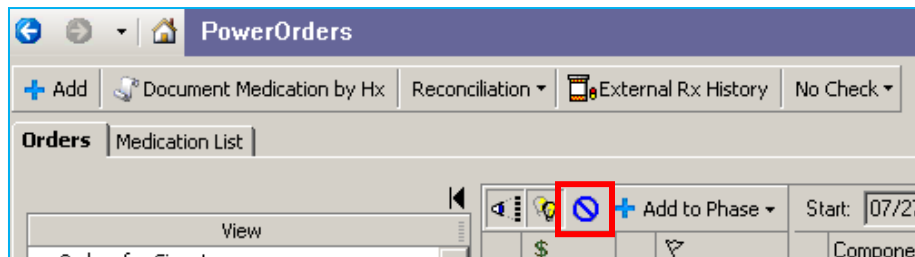
1. Click on the Discontinue Button

2. Click on the items in the **Keep** column you wish to keep

   Note: Any items not selected will be discontinued from the plan.
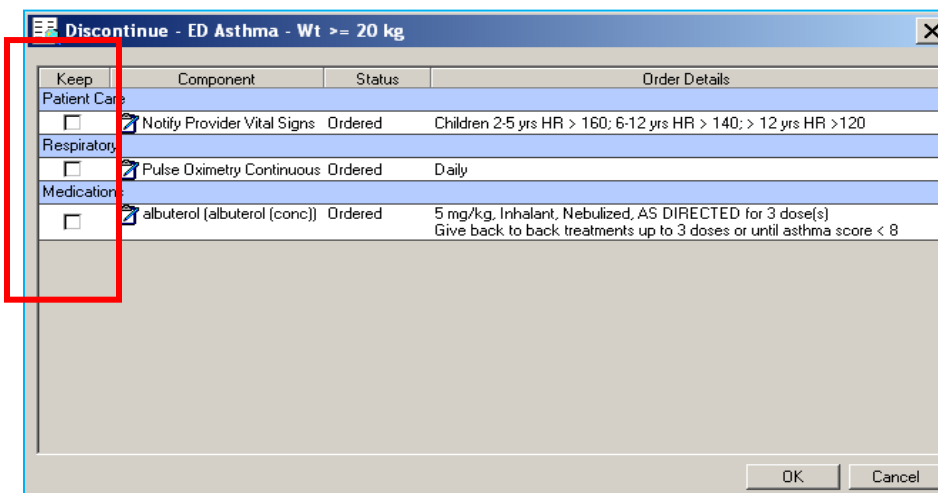
3. Select the OK button

4. Enter the reason for discontinuing the components

5. Complete any needed details for the order

6. Click Orders for Signature

7. Click Sign.

8. Click the Refresh button

DISCONTINUING SELECTED ORDERS

Steps to Discontine a selected order are as follows:

1. Click the PowerOrders tab.

2. Right-click the desired plan found in the Navigator window

3. Select Discontinue

4. Unclick the selected order(s) you wish to discontinue.

5. Click OK

6. Complete the Ordering Physician Window (Enter Physician and Communication Type)

7. Complete required details

8. Click **Orders for Signature for** the discontinued orders to display.

9. Click **Sign.**

10. Click **Refresh** .

+ ADD TO PHASE

The Add to Phase button on the Orders tool bar allow you to add additional orders to a PowerPlan that was previously entered. You may wish to add an order to be included in the plan that was not originally part of that plan.
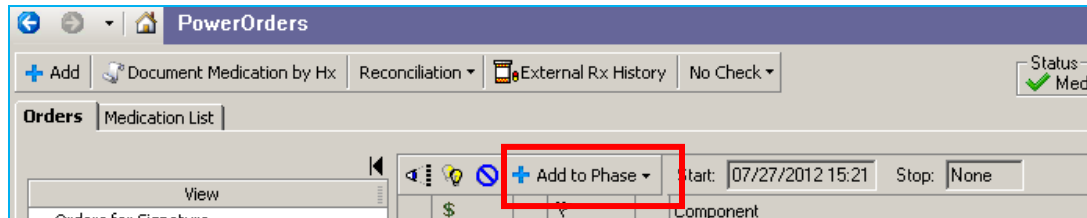
To add an additional order to a PowerPlan that was not included complete the following steps:

1. Click on the appropriate PowerPlan from the Navigator window.
2. Click **Add to Phase** and select **Add Order.**
3. Enter the order name in the **Find** field.
4. Click Search.
5. Click the desired order.
6. Click **Done.**
7. Complete order details.
8. Click **Sign.**
9. Click the Refresh button to refresh.

Note:

If you select the regular ADD button the order **_will not_** become part of the plan. You must use the Add to Phase button to include it as part of the PowerPlan.
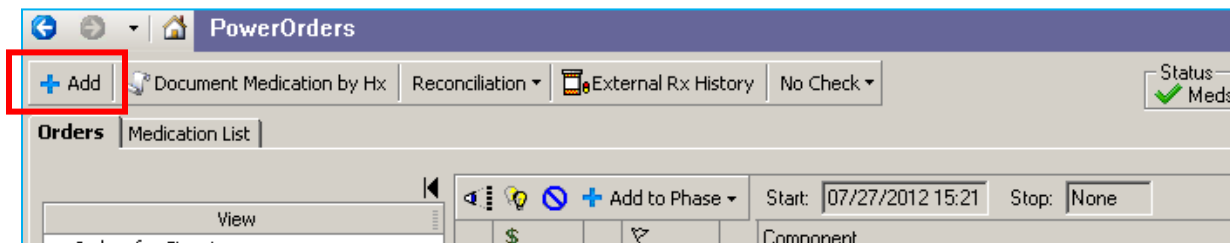
RIGHT CLICK FUNCTIONS FOR POWERPLANS

Additional functionality is available for PowerPlans in the Navigator section of PowerOrders.

By Right-clicking in on a Powerplan you can assess the following functions:
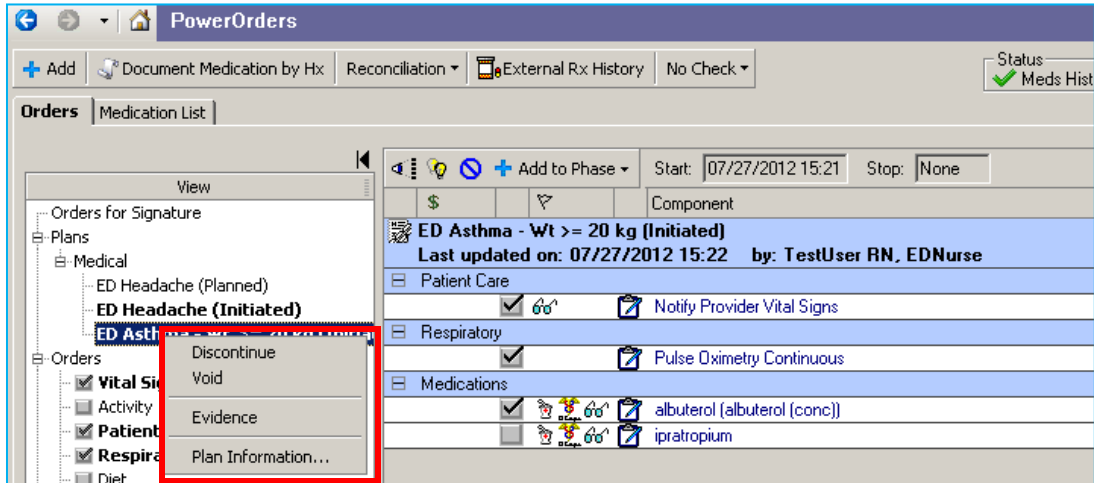
DISCONTINUE

Performs the same function as the Discontinue button on the toolbar. The Discontinue Button opens up the discontinue window where selected components of the PowerPlan can be removed.   In the Keep column you can select the items you wish to remain as part of the plan. Deselected items will be discontinued from the Powerplan.

VOID

Allows you to Void a plan. This option is used if the plan was entered in error and does not relate to the care of the patient.

EVIDENCE

Opens the predetermined CHKD Pathway for selected plan for your review.

PLAN INFORMATION

Opens to a Plan Information window which diplays the progression of the plan.

PRACTICE SCENARIO FOR POWERPLANS

Enter the following PowerPlans on your patient:

Scenario 1:

Enter a PowerPlan for Oxygen Therapy. Include the following orders:

Oxygen Therapy at 2lpm to keep the SpO2 greater than 96.

Pulse Oximetry Continuous

Add to Phase an iSTAT ABG to the Oxygen Therapy PowerPlan

Scenario 2:

Enter a PowerPlan for ED Status Migraine

Include the following orders:

Vital Signs

Pain Assements

Insert PIV Nursing Assessment

Precautions

Positioning

Pulse Oximetery Continuous

Oxygen Therapy 1lpm via mask

Sodium Chloride 0.9% (0.9% Sodium Chloride Bolus)

Sodium Chloride 0.9% (0.9% Sodium Chloride)

Sumatriptan 6mg syringe, subcutaneous, once

Scenario 3:

Enter an order for the ED Asthma PowerPlan for your patient.

Include the following orders:

Notify provider of vital signs

Peak flows

Pulse Ox continous

Albuterol 5mg inhalant

Dexamethosone 8mg

XR chest 1 view portable

The patient is also complaining of chest pain and has a history of irregular heart rhythm. Add an order for a cardiac Doppler ultrasound and an iSTAT ABG to the ED Asthma Powerplan.   (Make sure to use the Add to Phase option when adding this order).

Scenario 4:

You are planning to write prescriptions for the patient upon discharge and you find out that the patient's preferred pharmacy is The CVS Pharmacy at 700 Merrimac Trail in Williamsburg. Add the preferred pharmacy to the patient's record if it is not already there.

Scenario 5:

Enter an order for the ED Adult Chest Pain PowerPlan. Request the following orders in the PowerPlan::

Monitor

Oxygen Therapy 2L nasal cannula

Pulse Ox Check

Aspirin

Morphine (morphine IV) 5mg

iSTAT Chem 8 Components

EKG and repeat as indicated

Scenario 6:

Cancel the Albuterol 5mg inhaled and ordered with the ED Asthma PowerPlan because it was ordered in error. Add to plan an order for Albuterol MDI in it's place.

Scenario 7:

The ED Adult Chest Pain Powerplan was entered in error. Discontinue the entire Powerplan. (Since you signed this PowerPlan you cannot "remove" it.)

Scenario 8:

Add an ED Seizure Powerplan for your patient.

Include the following:

Seizure Precautions

Insert PIV

Pulse Oximetry Continuous

Oxygen Therapy

D5W ½ NS w/KCl 20 mEq in 1000ml

Carbamazepine 100mg

CBCA

Cabam Level, last dose today at 0800

iSTAT Collection Blood Gases

EEG Awake/Drowsy w/stim for seizures, no isolation

QUICK ORDERS

The Quick Orders chart tab contains the most commonly ordered procedures and tests for the ED. It allows quick order entry for orders such as Lab Orders, Micro Orders, Common Rad Orders, and CT Orders, etc. Quick Orders should be used by Physicians whenever possible when entering these types of orders.

You can also access the PowerOrders by clicking on the New Order Entry section within the window. Outstanding orders for the selected visit will display as well.

ENTERING QUICK ORDERS

Steps to enter orders from the Quick Order Chart Tab:

1. Click on the desired order(s) from the listing.

   Orders will display in the Orders for Signature section of the window
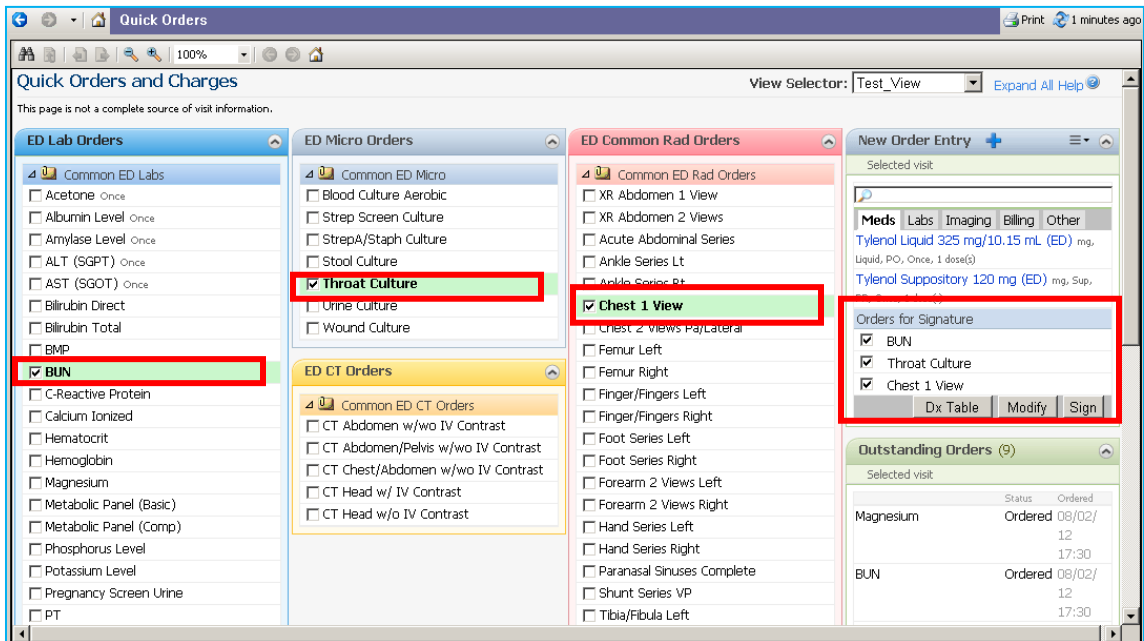
   Note: Any outstanding orders for the patient will display in the Outstanding Orders section of the Quick Orders window

2. Select Modify if you need to make any details adjustments to the selected orders and the PowerOrders Window will launch.

3. Selecting Sign will sign the orders and add them to the Outstading Orders section of the window.
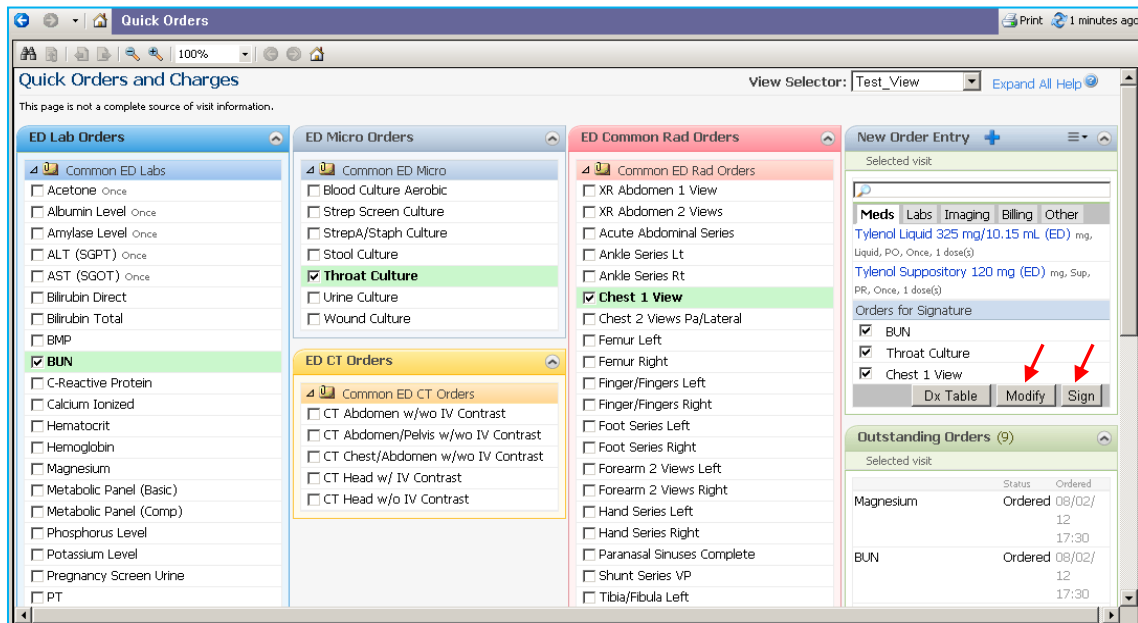
If there are any required order details for the orders you have selected, clicking Sign will launch you to the PowerOrders Window where you can add any required details and complete and Sign your order.

Of Note:

1. Selecting the + in the New Order Entry window will launch you to PowerOrders chart tab where additional orders, prescriptions and PowerPlans can be added that are not aviable on the Quick Orders window.

2. Orders can also be added by searching for them in the search window below theNew Order Entry section

REQUIRED DETAILS

Some orders that you select may require the completion of required order details. If there are any required order details for the orders you have selected, clicking Sign will launch you to the PowerOrders window where you can add any required details and complete and then Sign your order.

PRACTICE SCENARIO

From the Quick Orders Tab, enter the following orders:

1. Iron Serum

2. LDH

3. iSTAT Chem 8

4. Abdomen 1 View

5. Rapid Strep

Sign and finish your orders

From the New Order Entry Section search for the following orders:

1. Amoxicillin

2. Atrovent Inhaler

FAVORITES – ORDER FAVORITES

The Favorites folder is a convenient feature that speeds up the ordering process by having common orders readily available.

Favorite's folders are unique to a user and are maintained by each user. Users create, move, delete, and organize their own Favorites folders.

BUILDING ORDER FAVORITE FOLDERS

1. From the Add Order window, select the item to add to your Favorites folder.
2. Right-click the item.
3. Select Add to Favorites to place the item into your Favorites folder.
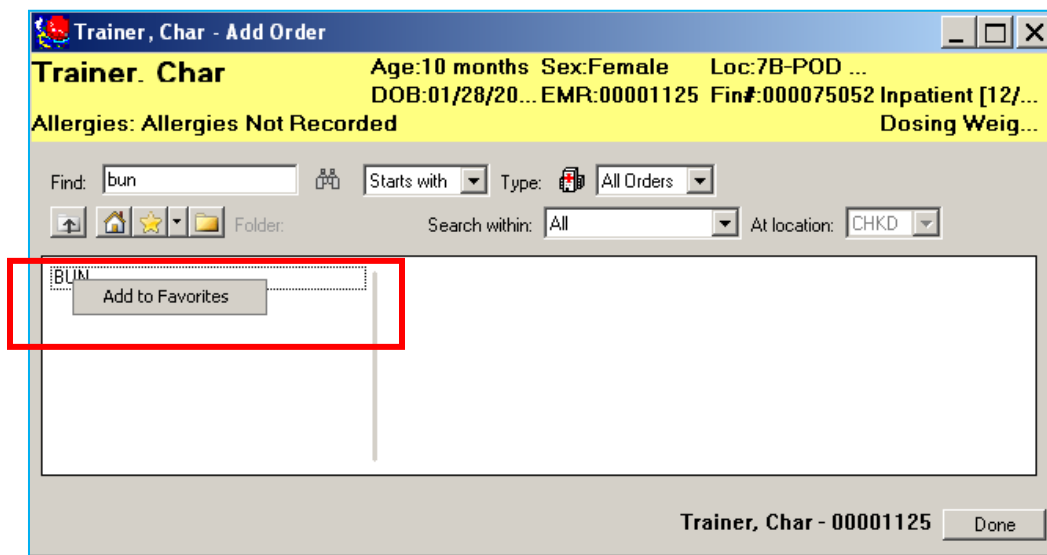
Note:

If you are adding an order to favoirties that you place frequently with the same or similar order details you should

- Add the order
- Complete the order details
- Right click on the order in the interactive view window to Add to Favorites.

This will save the order in your Favorites folder with the details you selected. These details can still be modified and edited if needed when the order is selected from your favorites folder.

4. Choose an existing folder or create a new one. Click OK.
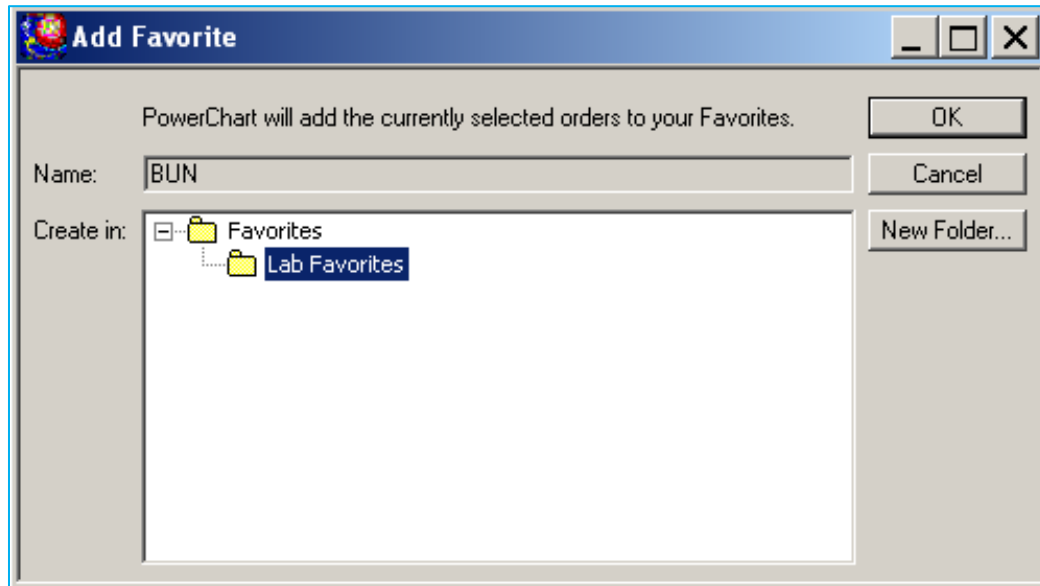
Verify the entry within your Add Order window by selecting 'Favorites' Icon.
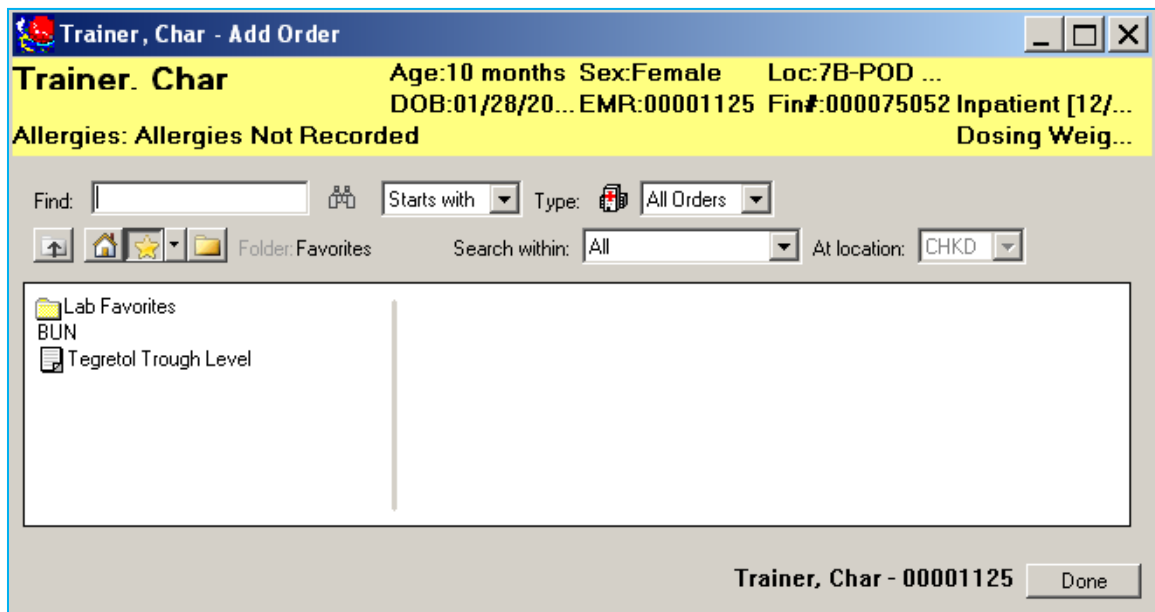
DELETING ORDERS FROM THE FAVORITES FOLDER

You can delete orders that you have previously added as favorites when they are no longer needed.

To remove orders from favorites, complete the following steps:

1. Open the Favorites folder and right-click the order name.
2. Select 'Remove from Favorites' and then 'Done'
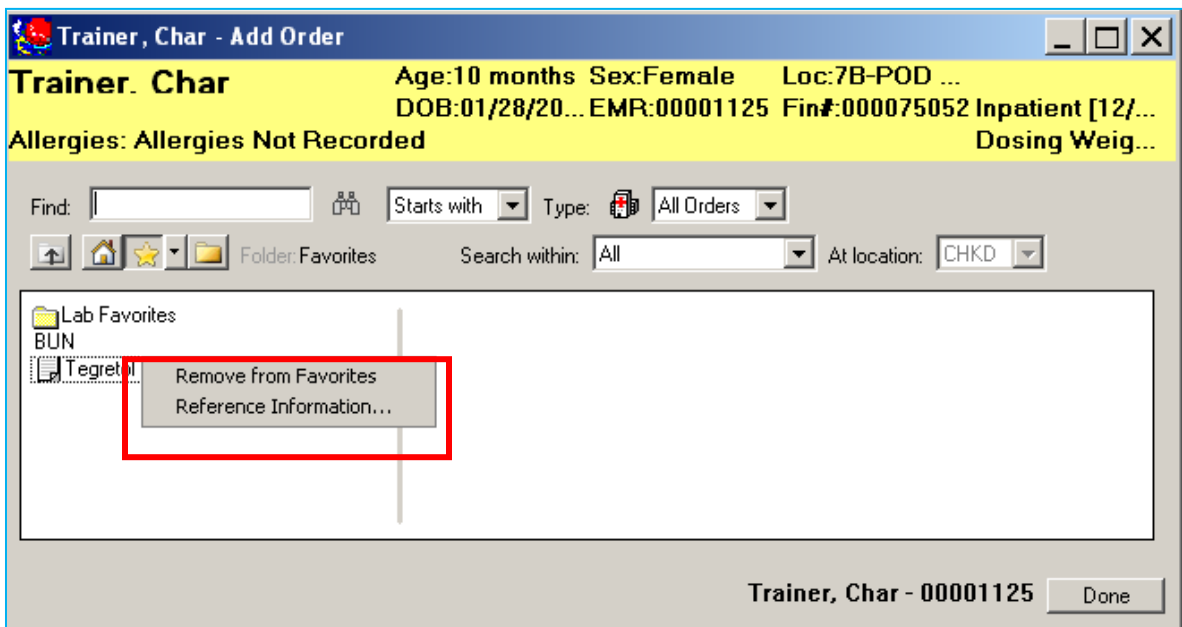
3. Reference Information can also be accessed and printed at this time.

SETTING THE HOME FOLDER

You can select and save a folder as your home folder. When you return to Add Orders, the system automatically displays the contents of the home folder in the Add Order window.

To designate a folder as your home folder, complete the following steps:

1. After you have created your Favorites Folder, right-click on the folder you wish to set as your Home folder.

2. Select the 'Set as Home Folder' option.
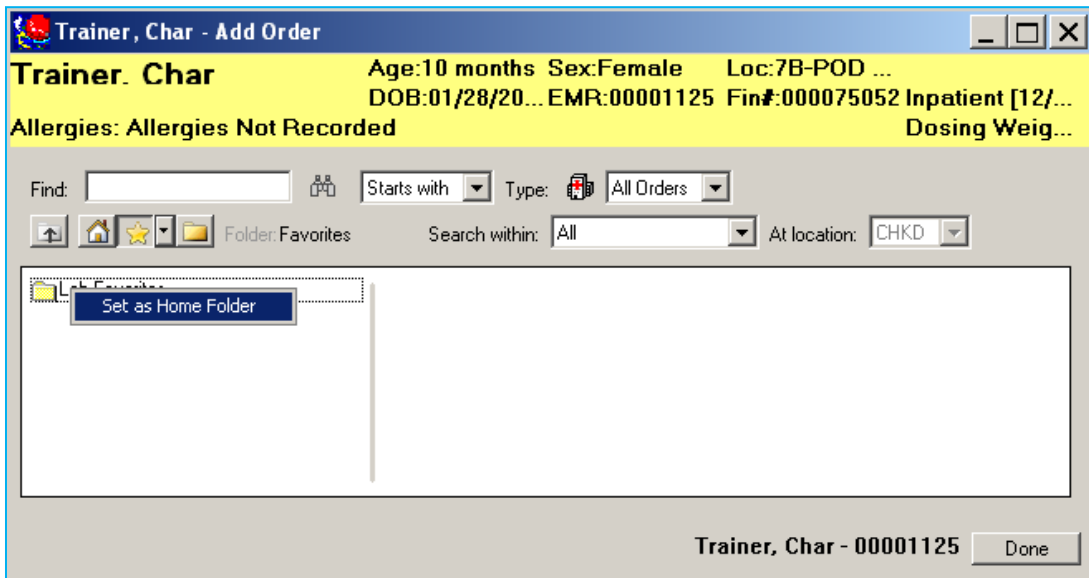
3. Select 'Done' to save this folder as your Home folder.

NOTE:

Only one folder at a time can be designated as your home folder. To select a different folder as a home folder, repeat the above steps.

ORGANIZING A FOLDER

Within the Favorites folder, you can organize favorites. You can list favorite contents alphabetically or chronologically (according to the sequence in which they were added), re-sequence favorite contents, rename a folder, or move a favorite item from one folder to another.

To organize Favorites folders and orders, complete the following steps:

1. From within the Add Order window, select the down arrow (next to the 'Favorites' icon)

2. Select Organize Favorites
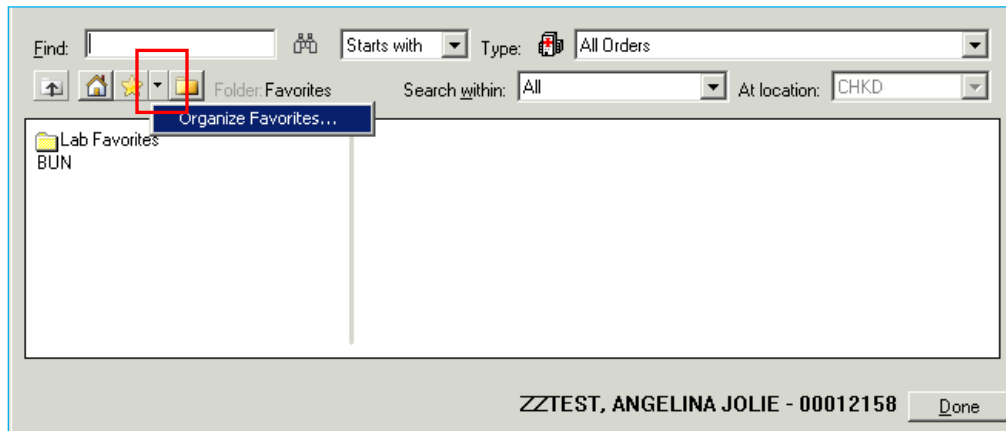
On the Organize Favorites dialog box, select any of the following options:

- To sort folders alphabetically by name, click Sort Favorites Alphabetically. The system sorts folders alphabetically.

- If you deselect this option, the folders resort themselves according to the original sequence in which they were added.

- To re-sequence the items one by one, select the item and click the Up Arrow icon or Down Arrow icon to move it up or down in the listing.
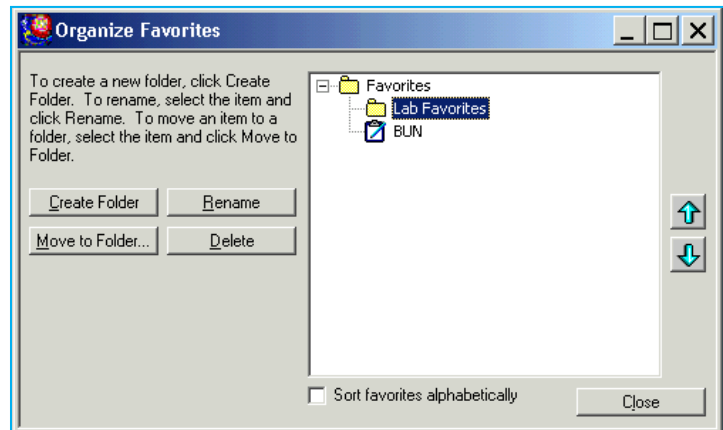
NOTE:

Re-sequencing is not available if the favorites are sorted alphabetically; the Up Arrow and Down Arrow icons are disabled.

ORGANIZING FOLDERS TIPS AND TRICKS
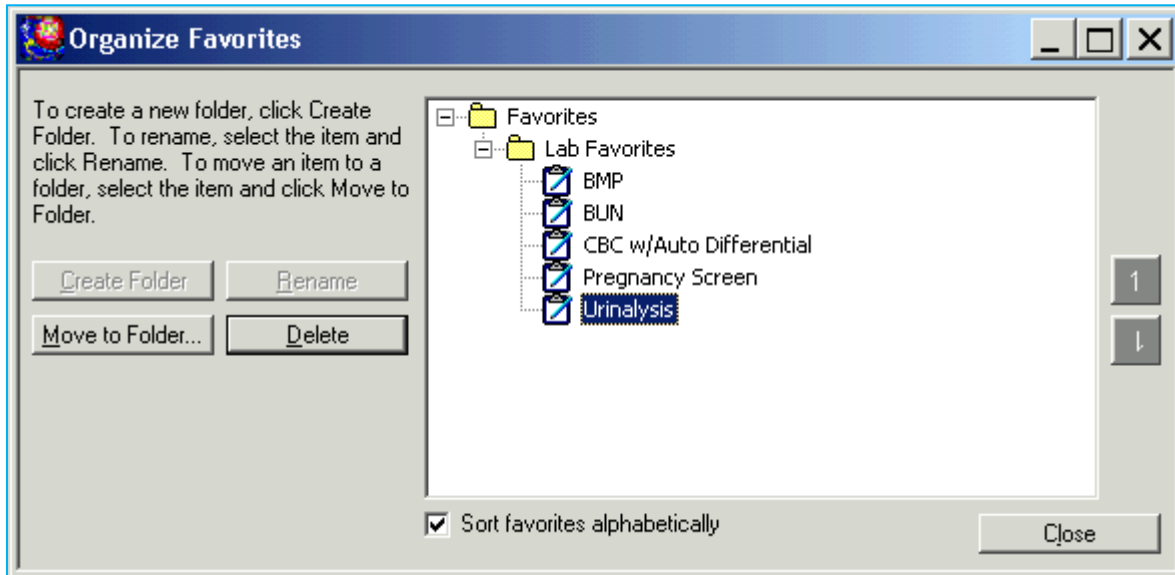
- To rename a folder select the item, click Rename, and enter the new name.

- If the Sort Favorites Alphabetically option is selected, the system automatically resorts the list.

- To move an orderable from one Favorites folder to another, you can select, drag, and drop the orderable into its new location. You can also select it, click the Move to Folder button, and then select the destination. The system moves the orderable from one folder to another.

- If a name is not fully visible in the Organize Favorites dialog box, you can resize. The system saves the size and position last used. In addition, when a name is not fully visible in the Organize Favorites dialog box, the full name is displayed when you hover the cursor over the name you want to view.

SECTION IV – POWERNOTES OVERVIEW

PowerNote is a method of entering clinical documents related to patient care for providers. PowerNote interacts with PowerChart, FirstNet, and SurgiNet. The information that is entered can be viewed across Cerner modules.

BENEFITS

- Reduction in transcription costs

- Standardized documentation

OBJECTIVES

During this course, you will learn how to:

- Create PowerNotes
- Build Macros
- Sign and submit PowerNotes

COMPONENTS OF POWERNOTES

The sections listed below are available from PowerNotes.
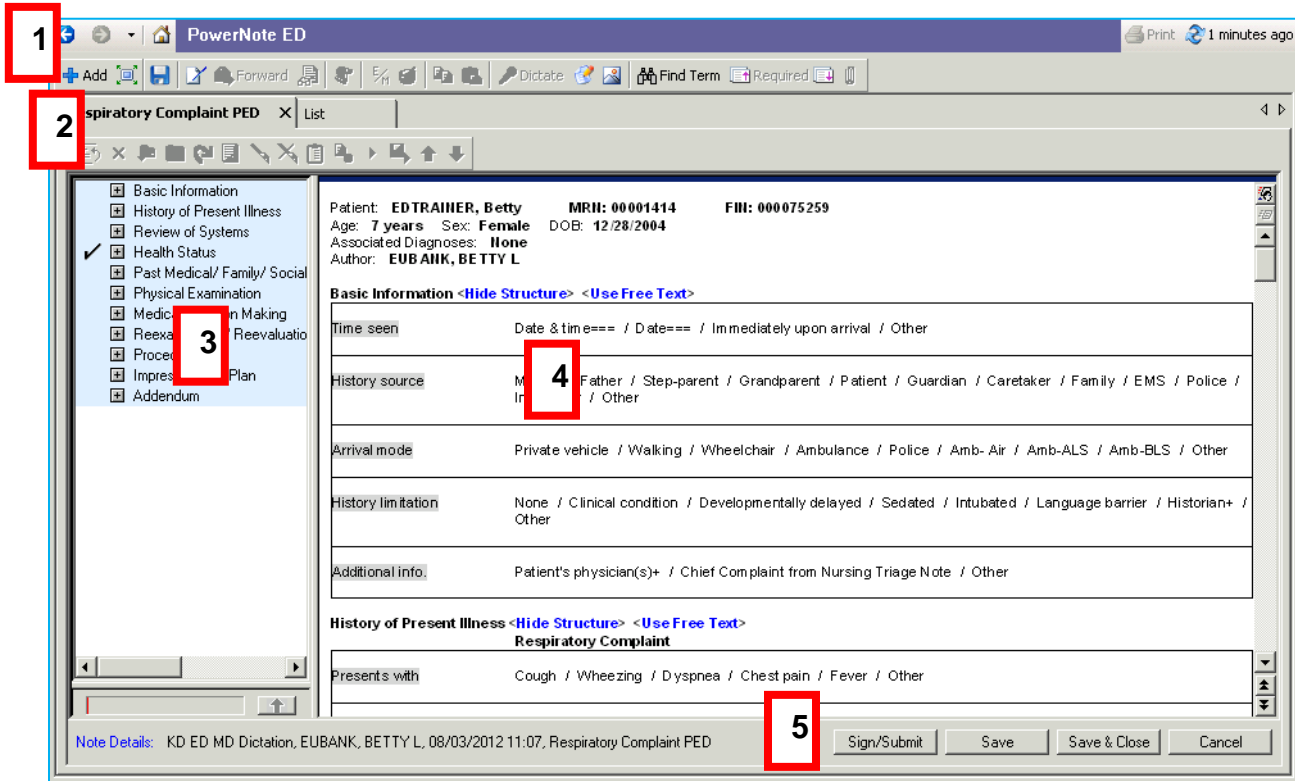
1	**PowerNote Toolbar –** Allows you to initiate and perform functions such as adding and submitting PowerNotes.
2	**Template Toolbar –** Allows you to make changes to the layout and terms included in the PowerNote Display.
3	**Paragraphs –** The different sections available for display and editing within the PowerNote. You can expand the section by clicking the '+' sign.
4	**PowerNote Display –** The display where information is entered and modified.
5	**Submit Options –** Options for submitting the completed PowerNote, including Sign, Save, Save & Close, and Cancel.

CREATING A POWERNOTE

There are two ways to access PowerNotes:

- ✓ From the Tracking List by clicking on the icon in the "PwrNote" column.
  This is the most common method for the Emergency Department.

- ✓ From within the Patient's Chart by clicking on the PowerNote tab
  This method is only used if additional PowerNotes are needed.

To begin the process of adding a PowerNote for a patient, complete the following steps:

1. Click the new PowerNote Icon from the Tracking List

2. The New Note window will open.
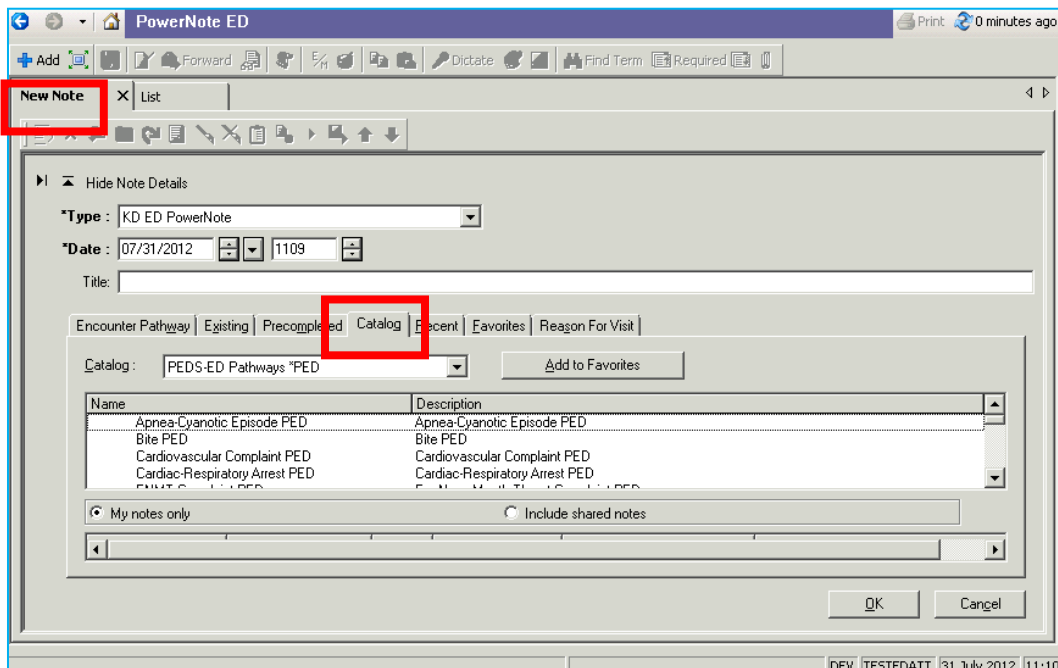
3. Under the Search section of the **Catalog** Tab, you can locate the PowerNote that you want to use.

TIP: As an alternative, you can search for a PowerNote from the Encounter Pathway tab by typing in the first few letters of the PowerNote that you want to enter.

4. Select the correct result from your search and click OK.
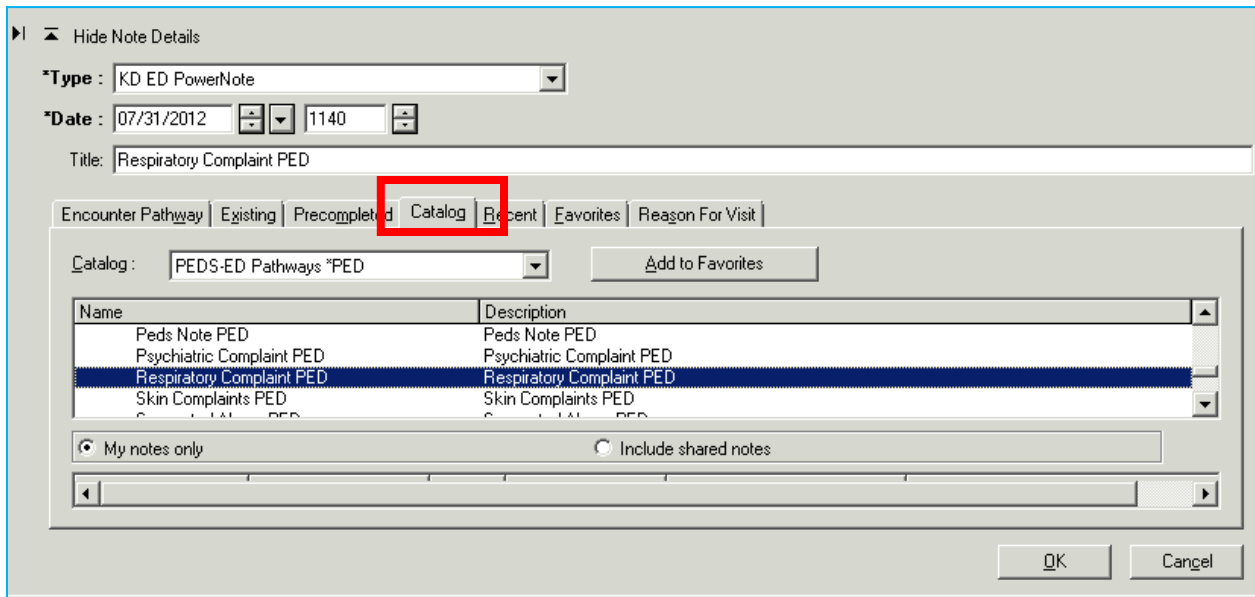
5. The Auto Populate Window appears.
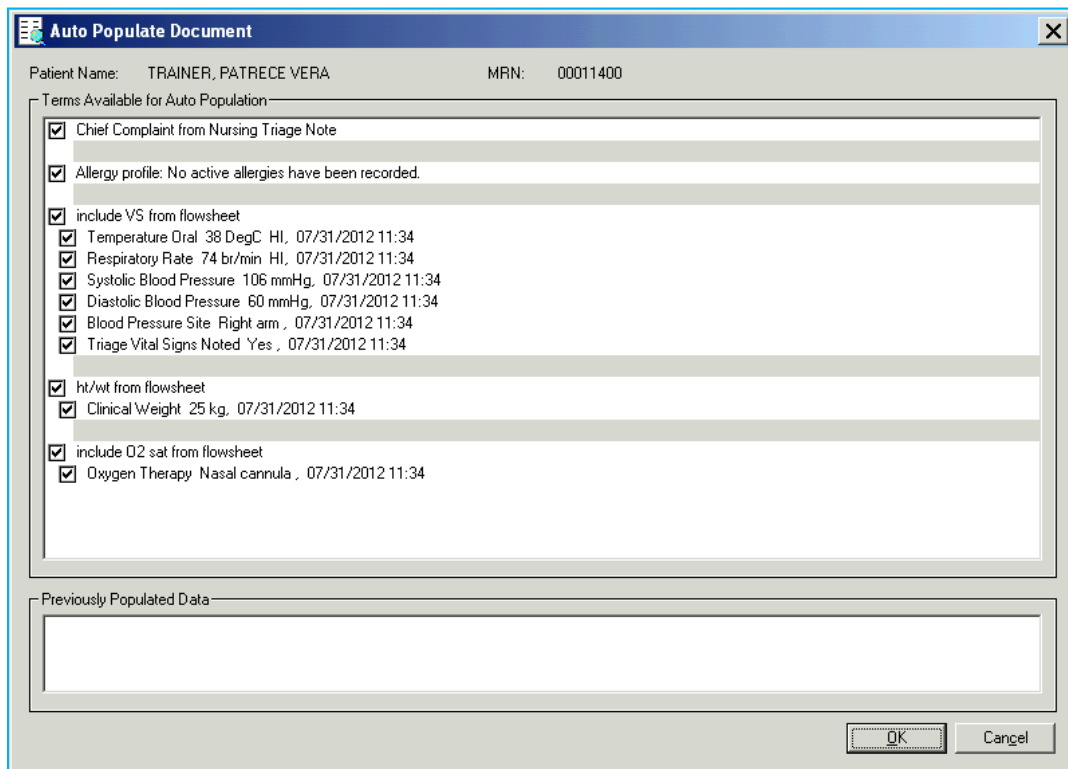
The Auto-Populate window opens every time that you create a PowerNote. By default, all items will be pre-selected in the Auto-Populate window to be included in the PowerNote. You can de-select the items that you do not want to appear on the PowerNote by un-checking the box next to the entry.

6. When you are finished including items for Auto Population, click OK.

The selected PowerNote will appear with Auto Populate terms already entered. The note is defaulted to hide the structure of all paragraphs within the note, with the exception of the Chief Complaint paragraph.

Use the <Show Structure> and <Hide Structure> terms to expose or hide items for documentation.

Completing a PowerNote is as simple as selecting the term on the left (i.e. Review of Systems), and selecting information to be included PowerNote display on the right.

<SHOW STRUCTURE> & <HIDE STRUCTURE> FUNTIONS

You can expand and collapse paragraphs in PowerNotes using <Show Structure and Hide Structure>. These options put a focus on the information that you want displayed.

<Show Structure> displays the structure of a paragraph including the sentences and terms.

Basic Information M <Hide Structure> <Use Free Text>

Time seen	Date & time=== / Date=== / Immediately upon arrival / Other
History source	Mother / Father / Step-parent / Grandparent / Patient / Guardian / Caretaker / Family / EMS / Police / Interpreter / Other
Arrival mode	Private vehicle / Walking / Wheelchair / Ambulance / Police / Amb- Air / Amb-ALS / Amb-BLS / Other
History limitation	None / Clinical condition / Developmentally delayed / Sedated / Intubated / Language barrier / Historian+ / Other
Additional info.	Patient's physician(s)+ / Chief Complaint from Nursing Triage Note / Other

<Show Structure> has been selected for the data above to expand the Visit Information section.

<Hide Structure> collapses the paragraph hiding the sentences and terms.

If terms have been documented within the paragraph, the textual rendition of the paragraph will display. Since the display is collapsed, the *Show Structure* option will be available.

Patient: **TRAINER, PATRECE VERA**   MRN: **00011400**   FIN: **000213683**
Age: **5 years**   Sex: **Female**   DOB: **09/23/2006**
Associated Diagnoses: **None**
Author: **TestUser MD, EDAttending**

Basic Information <Show Structure> <Use Free Text>

History of Present Illness <Hide Structure> <Use Free Text>
Respiratory Complaint

Presents with	Cough / Wheezing / Dyspnea / Chest pain / Fever / Other

<Hide Structure> has been selected for the data above to collapse the Visit Information section.

CHEVRONS >>

Blue Chevrons indicate that a sentence can be collapsed or expanded to show additional terms.

☐ When a sentence is not fully expanded the chevrons appear as **>>.** This indicates that there are more terms associated with that sentence that can be documented.

☐ When you have expanded all areas in a sentence, chevrons appear as **<<.** This indicates that all of the terms associated with that sentence are exposed.

NEGATING A TERM

The **first** time that you click on a term in the PowerNote, it will be selected to be included in the PowerNote.

The **second** time that you click on the term, it will be negated and a strike-through will appear.

The **third** time that you click on the same term, the entry will be cleared.

ADDITIONAL TERMS -- USING THE '…' SYMBOL

The **'…'** symbol indicates that there are additional terms available to further describe a related term. To see the additional terms available, click on the **'…'** symbol. Selecting a term with the …symbol launches a dialog box that displays the other terms that are available to describe the selected term. In the example shown, the term "anterior" is selected to describe the term retracted in more detail.
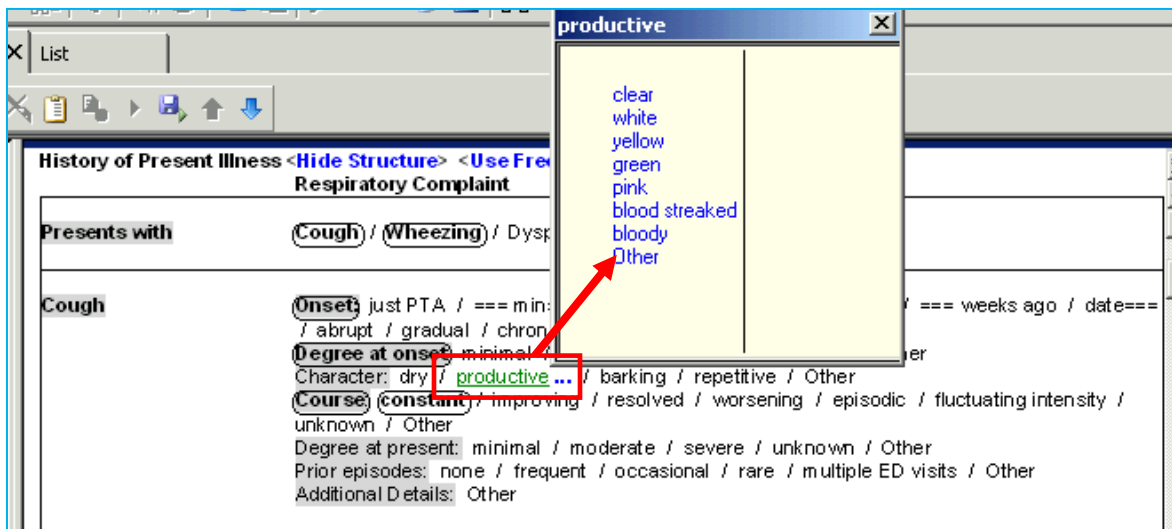
THE 'OTHER' TERM

The **"OTHER"** term is an option available for inserting free text into a note. It is recommended to use the "**OTHER**" term when documenting brief and term specific information within a note.

This term is generally the last term available for every sentence within a paragraph.
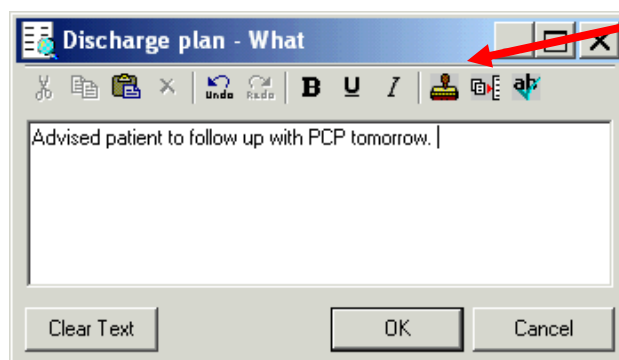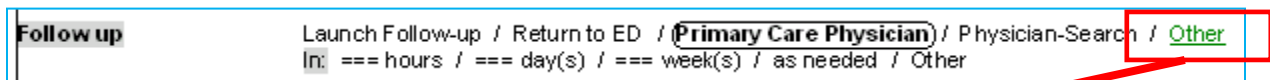
THE '*' SYMBOL AND "REPEAT" OPTION

The * is used to indicate a term that will be repeated if selected. In the example below Calls and Consults placed has one instance.
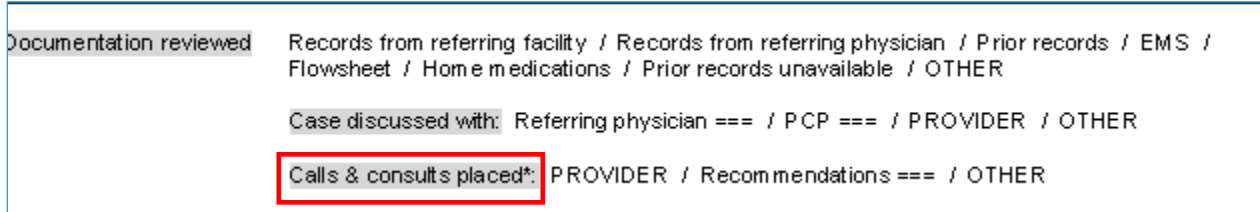
When the term is selected, the system adds a second instance of Calls and Consults placed. This allows you to document additional times within the note for the same term.
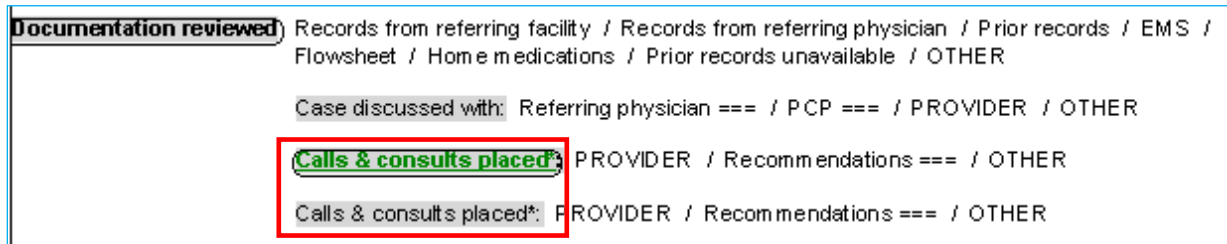
In PowerNotes, some terms can be repeated do not have the * indicator. If this is the case, the **"Repeat"** option will be enabled when you have right-clicked on the term. A new instance of the term will be added.
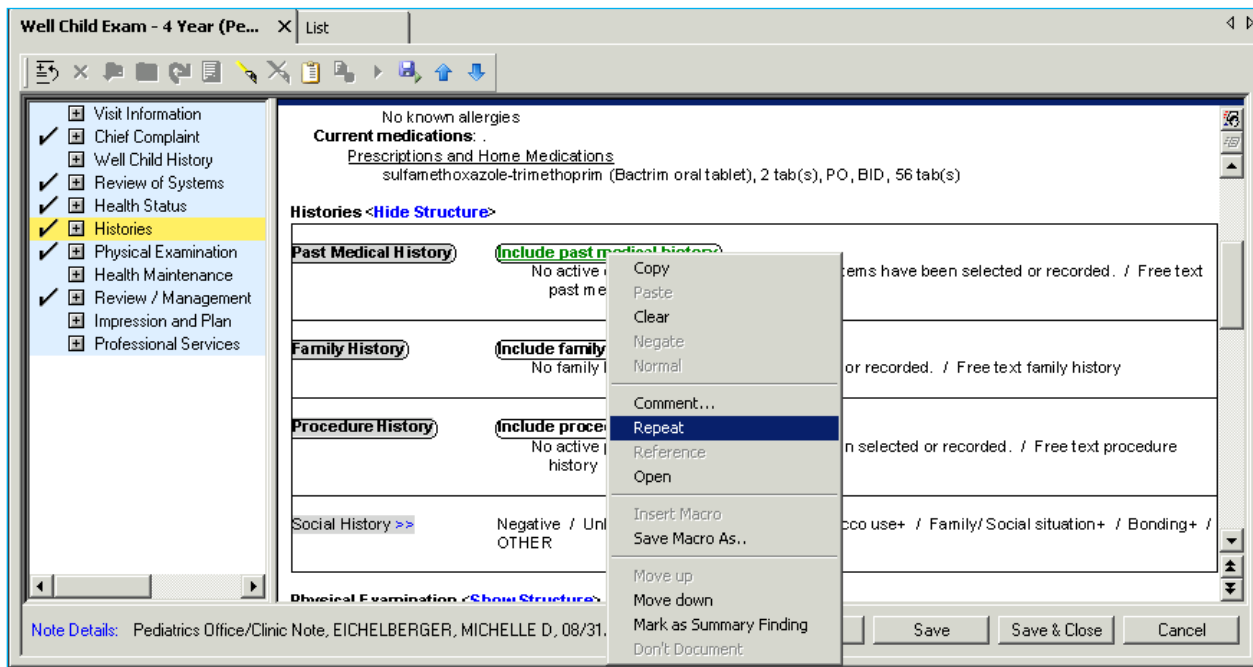
THE '+' SYMBOL

The **+** sign appears when there are additional terms that can be selected to further describe a term. When the **'+'** is selected, the additional terms will appear.

USING THE '===' SYMBOL

When a numeric value needs to be entered, the **'==='** symbol is used. In the example below, **'==='** appears beside baths per week.

Once a term with the **'==='** symbol is selected, a numeric control for you to enter the numeric value.

After entering the value and selecting ok, the **'==='** sign will be replaced with the numeric value entered into the control.

THE SEARCH OPTION

You can search for text within a PowerNote via the Search option. This allows you to find the term that you are looking for within the PowerNote.

To use the search option, complete the following steps:

1. Click the search icon on the toolbar.
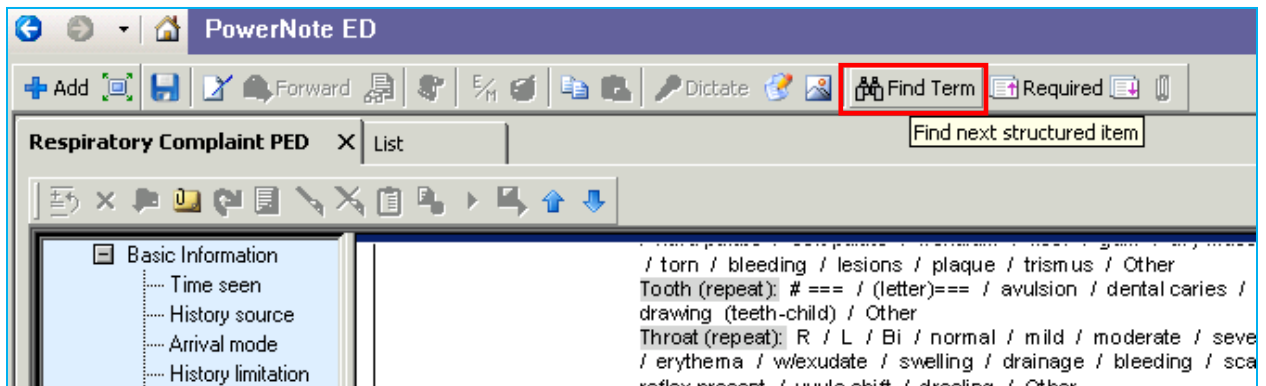
2. Indicate the term that you are looking for and click the appropriate Find option.
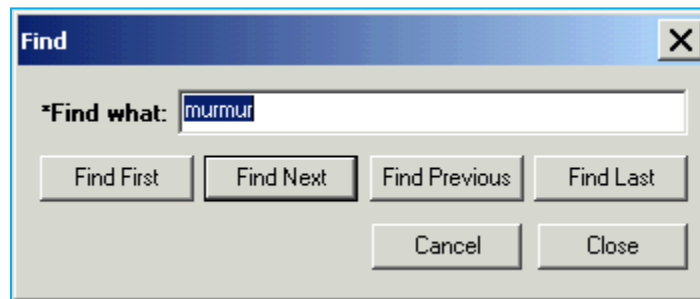
3. The system will search for the term within the PowerNote.
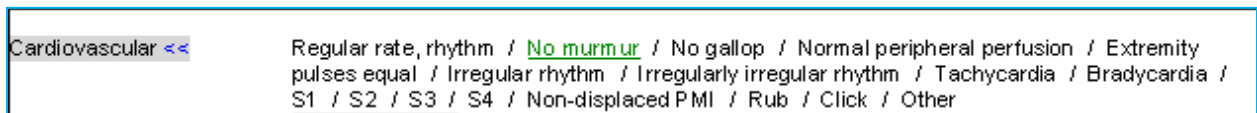
4. When finished click Close.

THE FREETEXT OPTION

Free text allows you to enter text directly into a PowerNote without selecting any terms or sentences from the template provided.

Double clicking within any portion of the note allows text to be inserted directly into the note.

To enable free text at the beginning of a note, double click in a white area between the between the note header and the first paragraph. A cursor will appear to allow free-texting to begin.

Patient: **TRAINER, PATRECE VERA**   MRN: **00011400**   FIN: **000213683**
Age: **5 years**   Sex: **Female**   DOB: **09/23/2006**
Associated Diagnoses: **None**
Author: **TestUser MD, EDAttending**

Basic Information <Show Structure> <Use Free Text>
    NOTES CAN BE ENTERED AS FREETEXT HERE.

History of Present Illness <Hide Structure> <Use Free Text>

Free text can also be entered at the beginning, end or within a paragraph.

TIPS:

☐   To enter free text information if the structure of the note is hidden, double click on the location within the paragraph where the text should be inserted.

☐   To place free text at the beginning of a paragraph, double click within the white space before the sentence name.

ADDING ORDERS FROM WITHIN A POWERNOTE

To add an Order from within a PowerNote, complete the following steps:

1. Select Orders -> Launch Orders under **Medical Decision Making.**

2. The screen will change to the Add window, where you can add orders, medications, etc. (For additional information on entering orders, see the Order Entry section).

3. The order will appear under PowerOrders in the Diagnosis and Plan section.
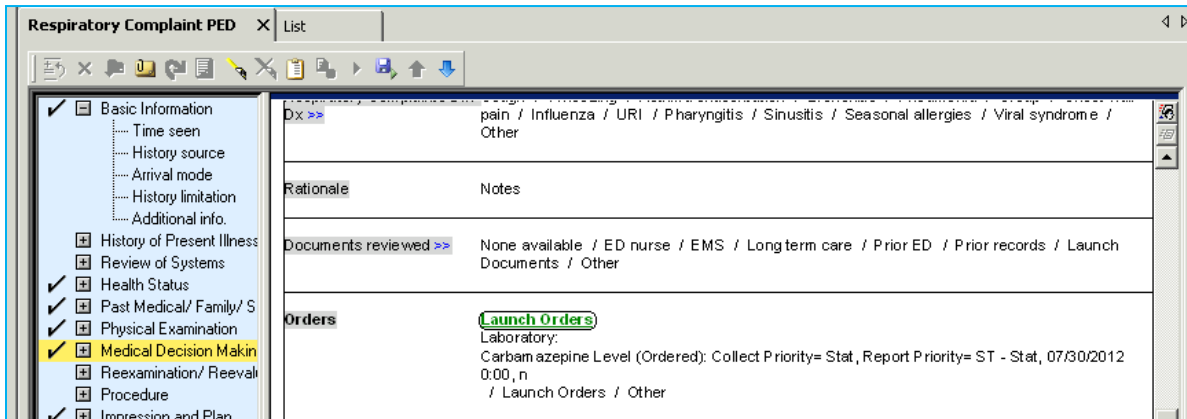
DX / ORDER ASSOCIATION PLAN

You can use the option of DX / Order Association Plan to pull in additional orders that have been entered since the creation of your PowerNote.

- In the DX / Order Association Plan, select Insert DX / Order Association.
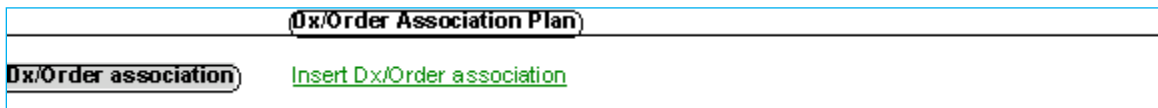
Diagnoses and orders that were entered will populate.
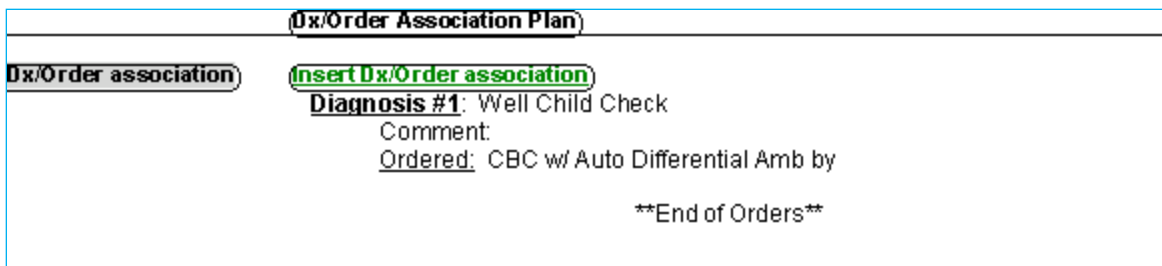
TIP:

If an order is entered after you have clicked DX / Order Association, deselect it and click it again. It will bring the updated orders over.

INSERTING SENTENCES

You can insert sentences to be included in your PowerNote if they are not defaulted. For example, this is helpful if you need to note something on the physical exam that was not included as part of the default note template.

1. To insert a sentence, right click on the paragraph name and select Insert Sentence.
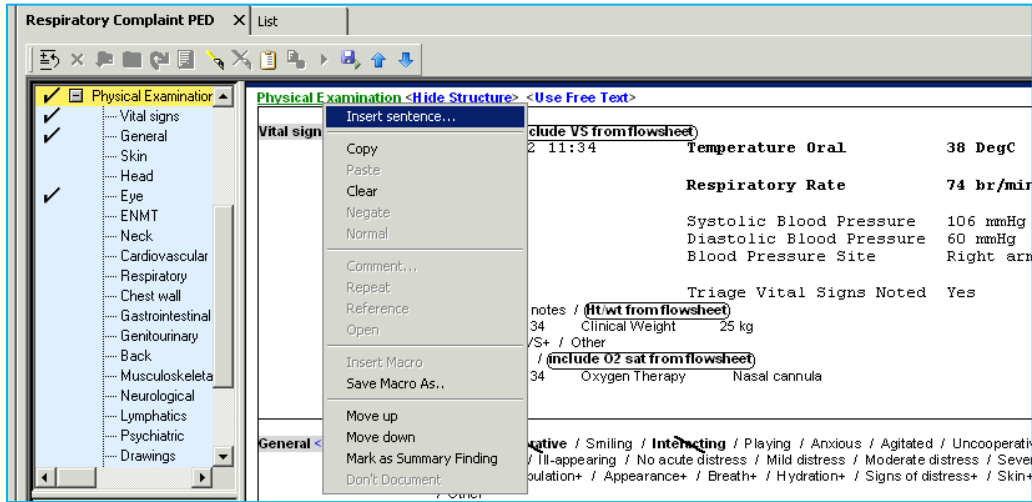
2. In the Insert Sentence window, select the sentence that you would like to be added (i.e. Breast, Feet). Click OK.
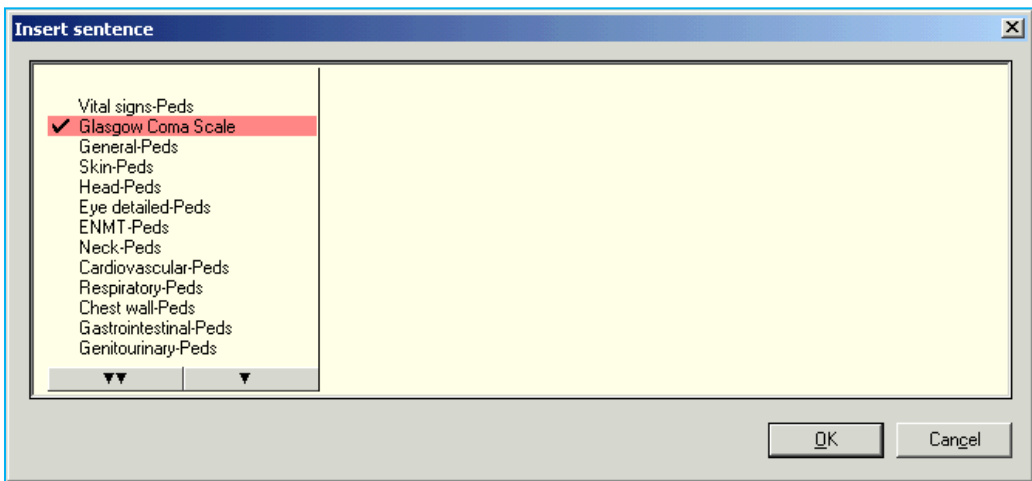
3. The sentence will be added within the PowerNotes so that you can continue documentation.
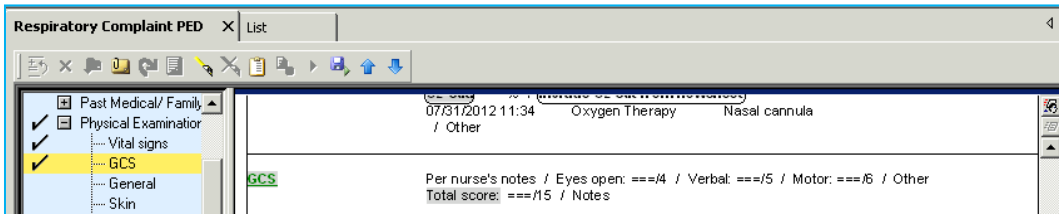
USING THE UNDO OPTION

You are able to use the undo option to clear out the last unsaved change that you made to the system.

You can select undo from the Edit Menu while on the current PowerNote.
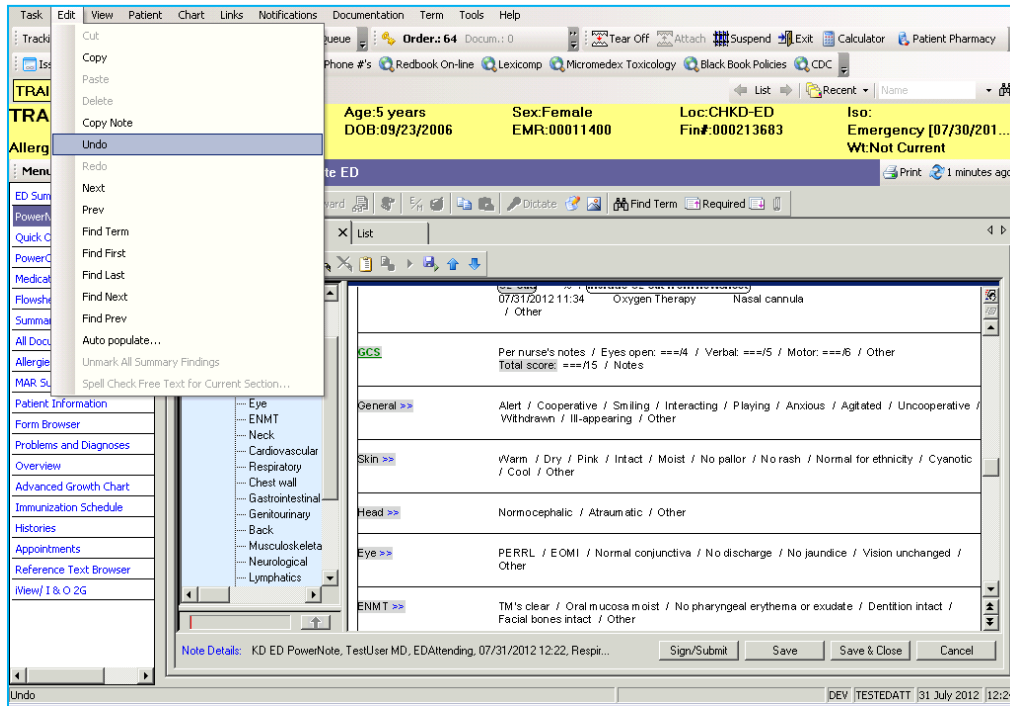
PREVIEWING THE POWERNOTE IN TEXT FORMAT

You can preview the PowerNote that you are entering in the text format by clicking the Display Contributor View on the PowerNote.
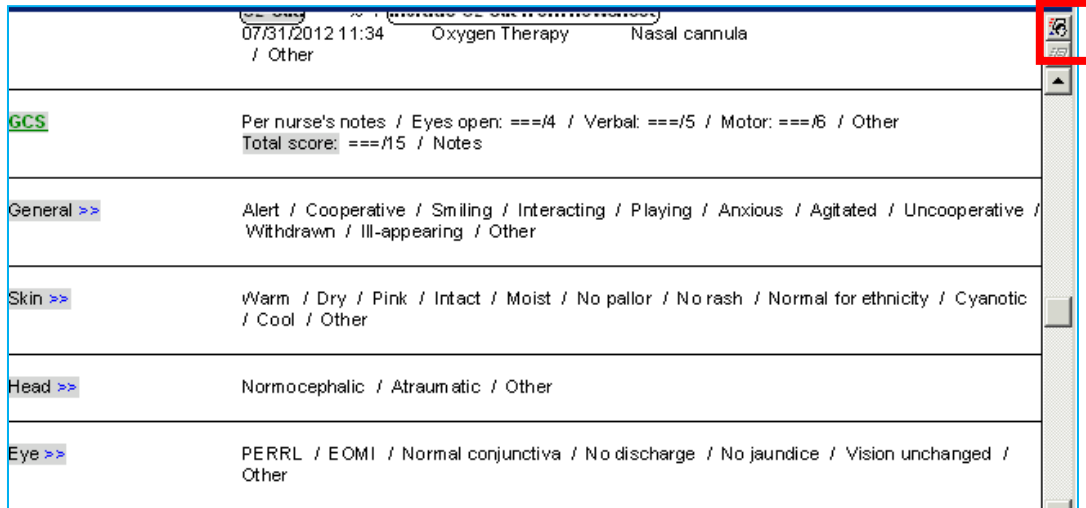
This icon will generate a textual rendition of the PowerNote that you are creating, so that you can see what is included and excluded based on what you have entered.
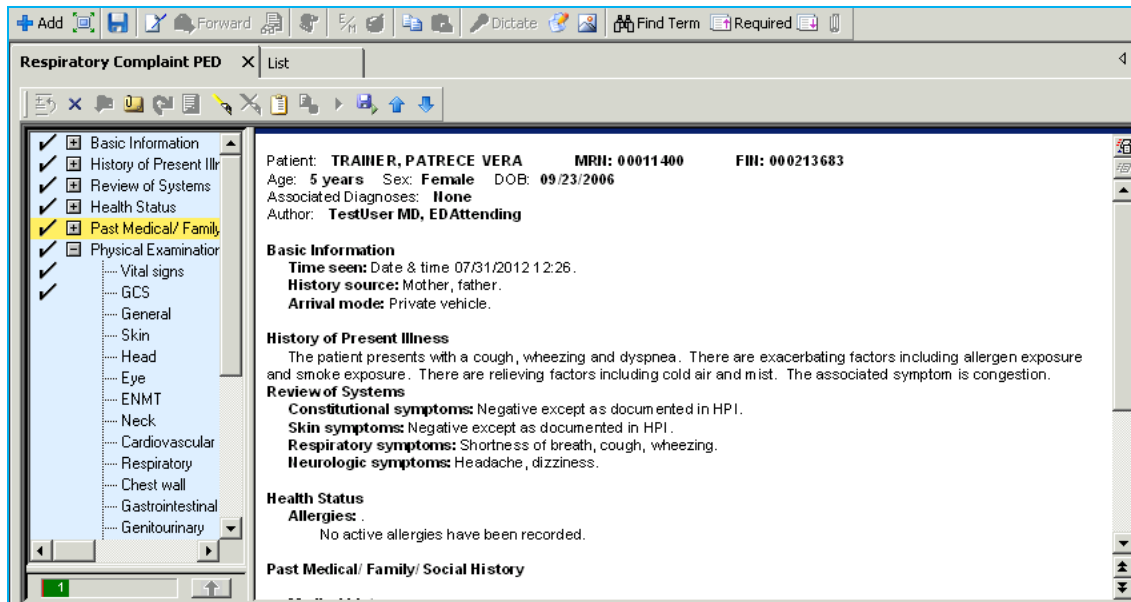
SIGNING AND SUBMITTING POWERNOTES

The process and steps for submitting a PowerNote differs based on your security. A PowerNote can be submitted by both Attendings and Residents to be included in the patient's chart.

SUBMITTING A POWERNOTE AS THE ATTENDING

Attending physician completing a PowerNote you will simply click the SIGN button . Your document will now be a Final Report.

☐ If you would like to save it for future editing (because you have not completed it yet), select **Save**. Then click OK.

Both Save and Save and Close generate the Save Note window.

☐ To Save the Note and close the PowerNote form, click **Save and Close**. Then click OK.

☐ To cancel the note completely, click **Cancel.**

☐ When you have finished entering the information for your PowerNote, click the Sign option.

☐ Then click OK.

The completed PowerNote will appear in the PowerNote list and will display when you double click the note.
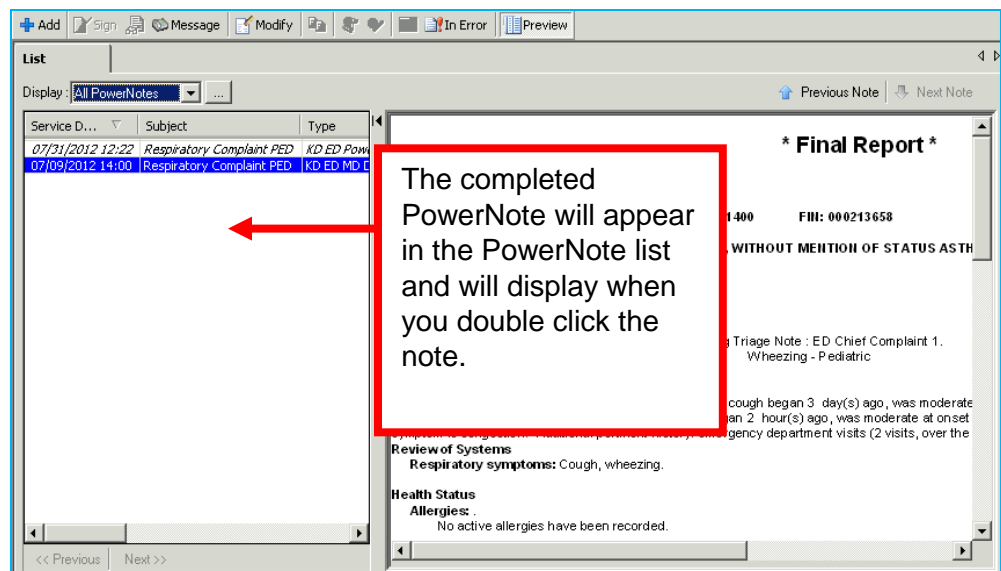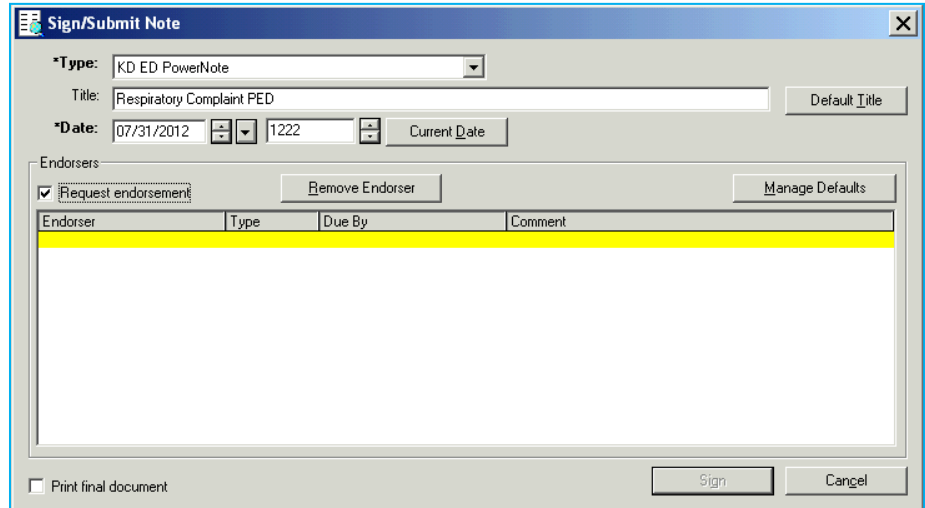
SUBMITTING A POWERNOTE AS THE RESIDENT
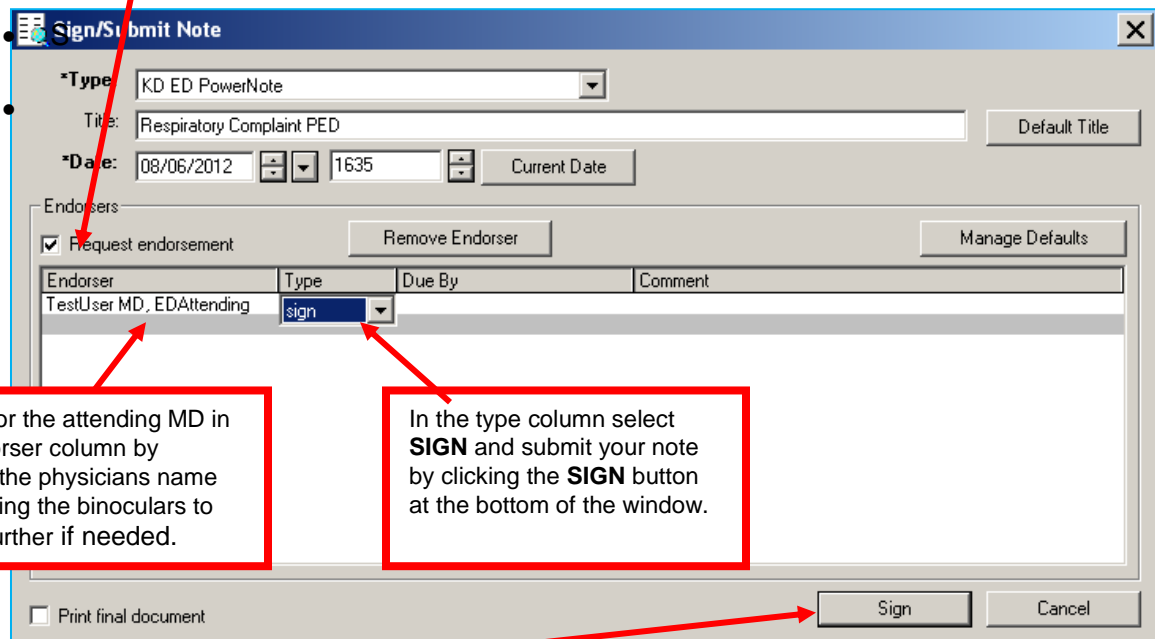
Residents will be required to sign the PowerNote and send it for endorsement by an attending.

If you would like to save it for future editing (because you have not completed it yet), select **Save**. Then click OK.

Both Save and Save and Close generate the Save Note window.

- To Save the Note and close the PowerNote form, click **Save and Close**. Then click OK.

- To cancel the note completely, click **Cancel.**

- When you have finished entering the information for your PowerNote, the Request endorsement box will default checked for you.

Search for the attending MD in the Endorser column by entering the physicians name and clicking the binoculars to search further if needed.

In the type column select **SIGN** and submit your note by clicking the **SIGN** button at the bottom of the window.

- Click Sign

- Your note will now be saved as a Preliminary report until the attending physician has signed off.

- The note it stays in an unauthorized status until it is signed by the Attending

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MANAGING A COMPLETED POWERNOTE

IN-ERRORING POWERNOTES

PowerNotes that have been entered in error can be documented in PowerChart.

To in-error a PowerNote, complete the following steps:

1. From the PowerNote list, select the PowerNote that you want to in-error by clicking on it.

2. Click the In-Error button.
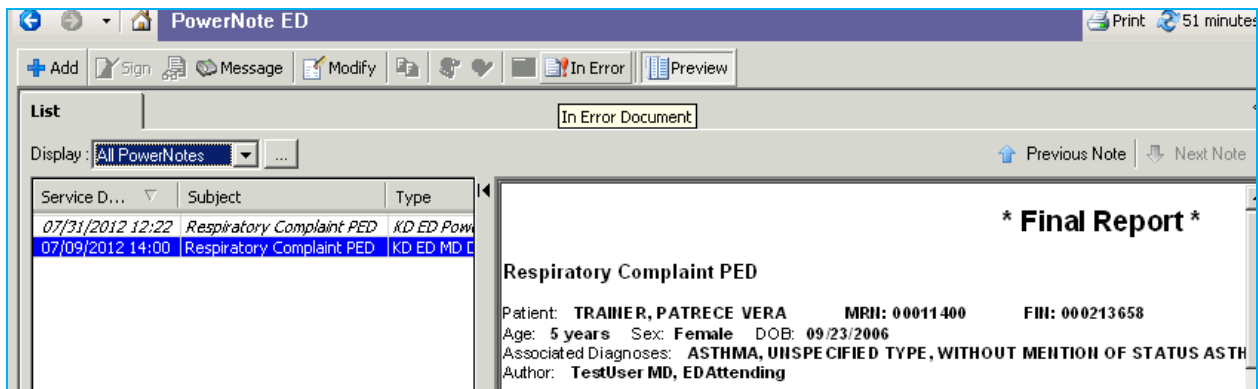
3. Enter any in error comments. Click OK.
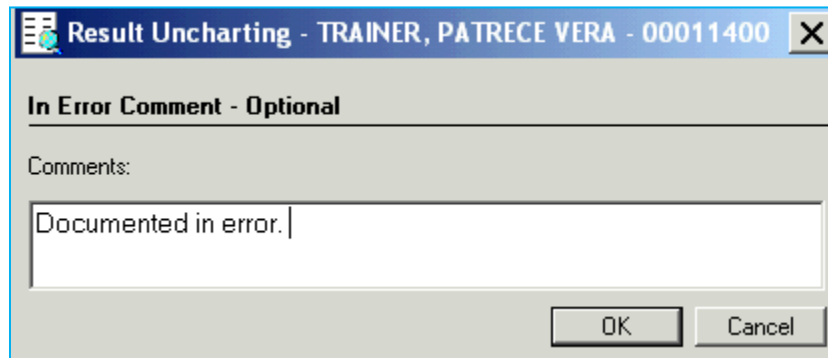
The document will read 'In Error' and remain within the patient's chart.

MODIFYING POWERNOTES

Once a PowerNote has been signed, you will be able to modify it (by adding an addendum).

To modify a PowerNote, complete the following steps:

1. Select the PowerNote that you wish to modify from the List.

2. Click the Modify button.
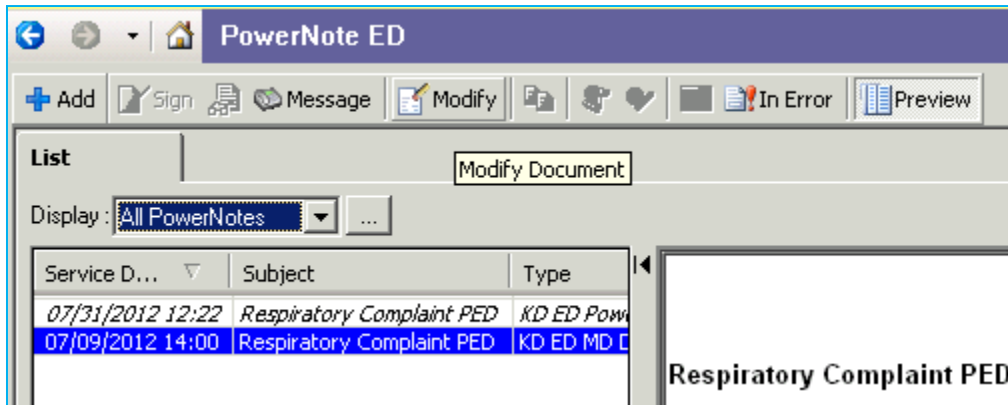
3. The PowerNote will re-open, but you will have to re-enter documentation at the bottom of the PowerNote (under the Insert Addendum section).
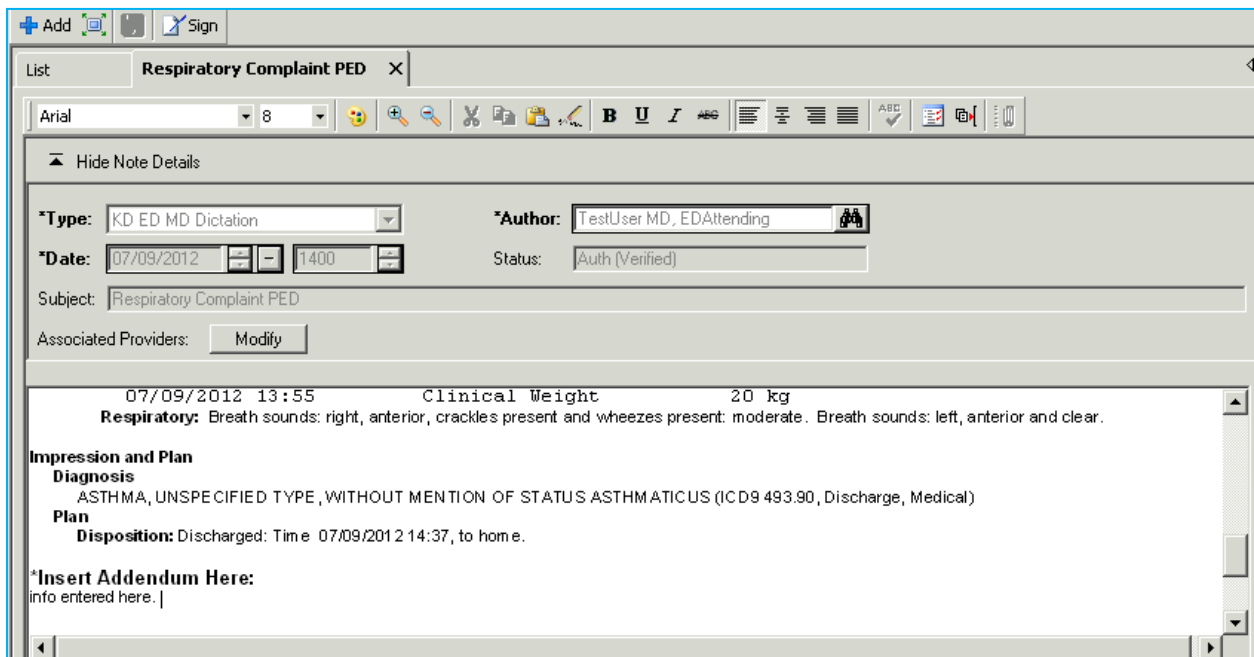
4. Click Sign when finished.

PRECOMPLETED POWERNOTES

You can also use the Precomplete option to enter PowerNote. This allows the usage of Precompleted Notes, which can reduce the documentation process for conditions that you commonly enter. To use this option, you must first create a precompleted note.

CREATING A PRECOMPLETED NOTE

1. Open a new PowerNote.

2. Document the encounter information, selecting the recurring data elements and excluding patient/encounter specific data. **It is not recommended to document Orders or Diagnosis within a precompleted note.**

 3. Once the note has been documented, from the Documentation menu, select "Save As Precompleted Note."
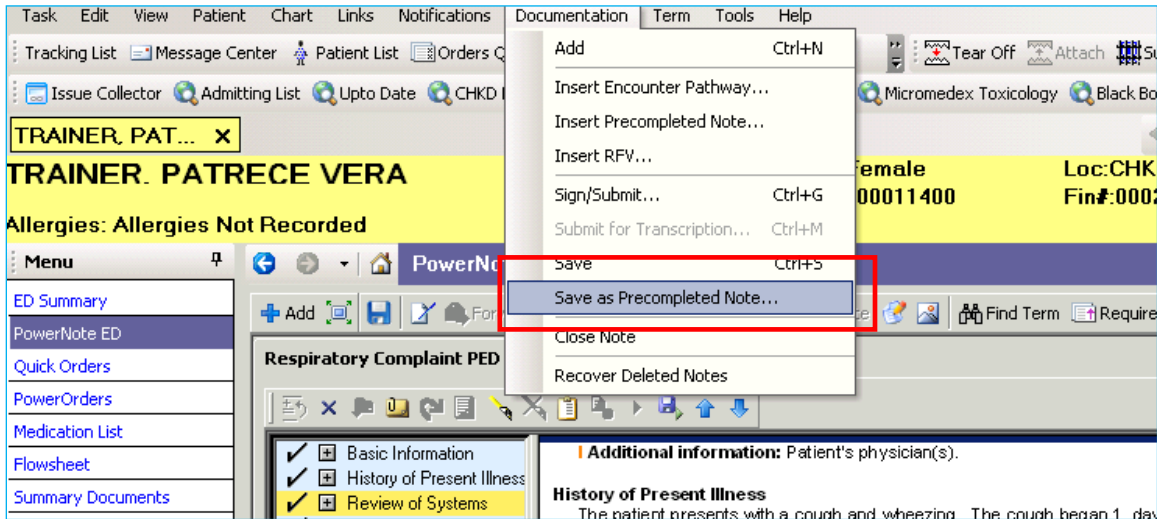
4. This will launch the "Save As Precompleted Note" dialog box. In the Note Title box, enter a title for the Precompleted Note.
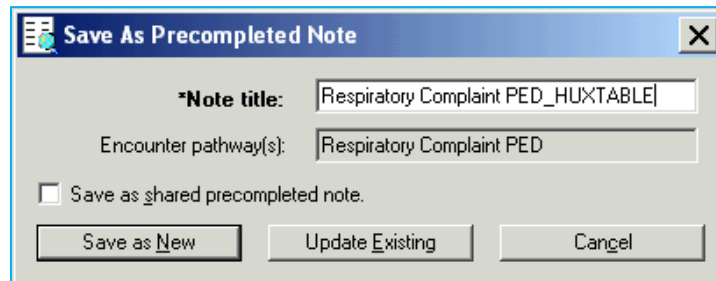
5. Select "Save as New" to save the note.

The Precompleted Note is now a user specific note that can only be used and updated you.

SEARCHING FOR A PRECOMPLETED NOTE

From the Open Note Dialog Box, select the "Precompleted" tab. Enter the name or part of the name of the precompleted note and select the binoculars icon or click enter.
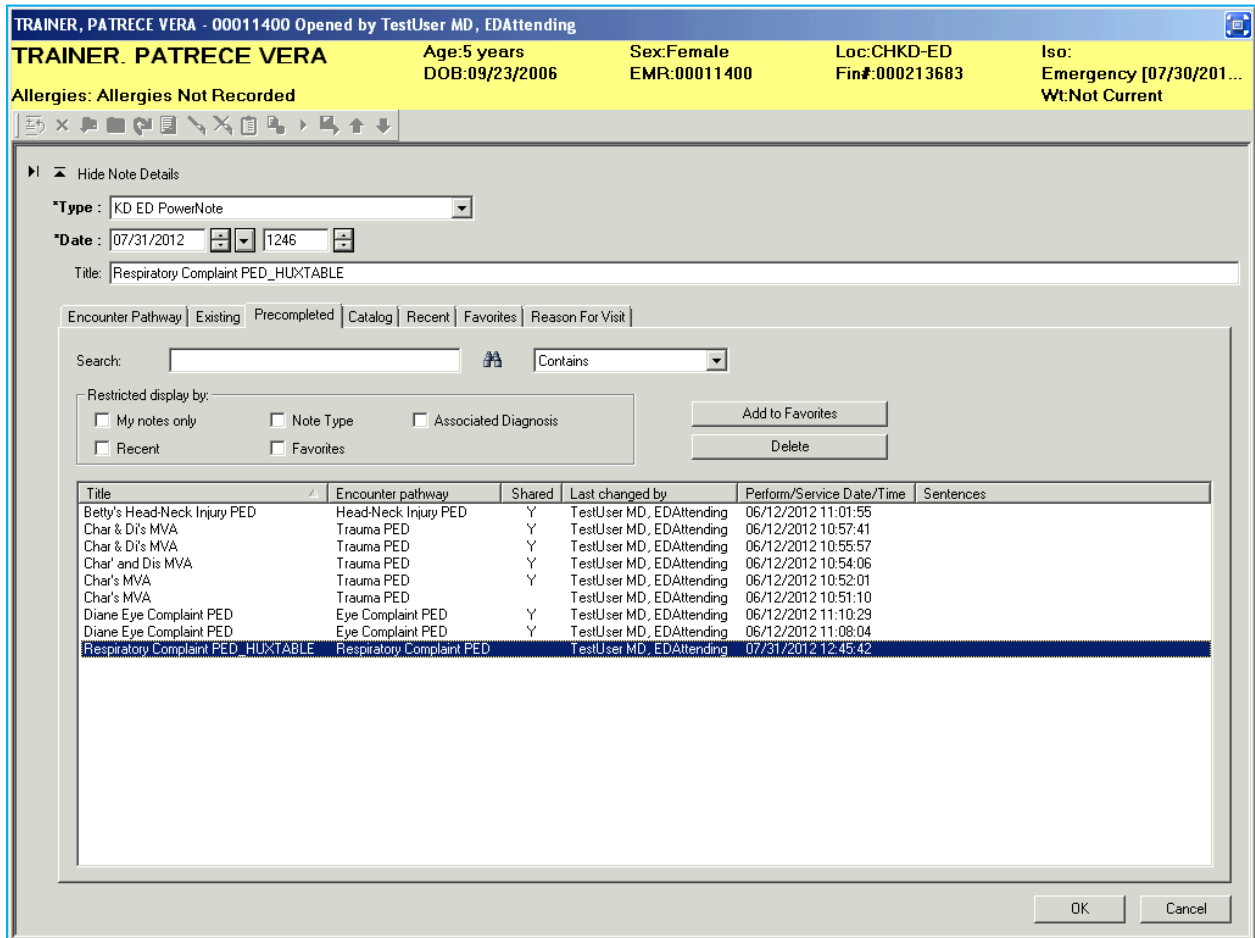
You can also use the filters on the Encounter Pathway tab to search for notes. However, if your notes do not meet the criteria, then they will not display.
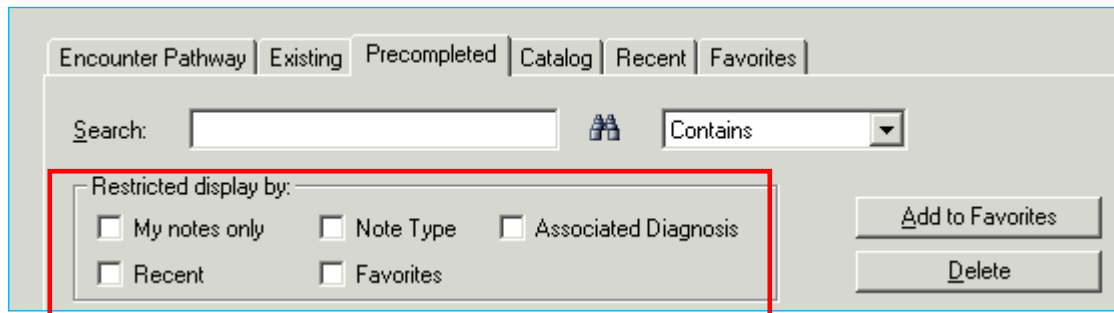
USING A PRECOMPLETED NOTE

Once Precompleted Notes have been created, they can be used as templates for documenting an encounter when a patient presents with the documented problem.

To begin a new note using a Precompleted Note, complete the following steps:

1. Select the "Precompleted" tab on the Open Note dialog box and select the template to document.

2. Once the template is open, document the note with the information for the current encounter. When done, either save or sign the note.

You can also insert a Precompleted note into documentation that you initiate (i.e. from within a Catalog PowerNote). Select Documentation → Insert Precompleted Note.
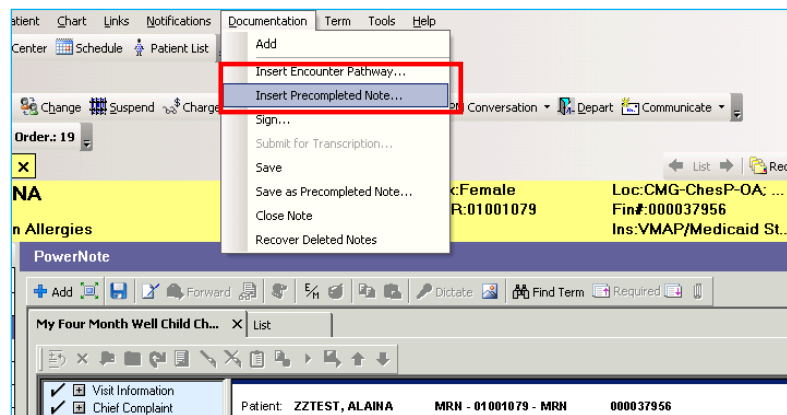
This will launch the Open Note dialog box. Select the "Precompleted" tab and locate the precompleted note to insert into the template. The Precompleted Note will be merged into the already opened template, while redundant terms and sentences will not be merged.

Tip:

Remember, if you are using a Shared Pre-Completed Note, you should save it as your own before making changes.

DELETING A PRECOMPLETED NOTE

If you note that a Precompleted note is not often used, it can be deleted.

To delete a note, complete the following steps:

1. Locate the note on the "Precompleted" note tab of the Open Note dialog box.

2. Select the note to delete.
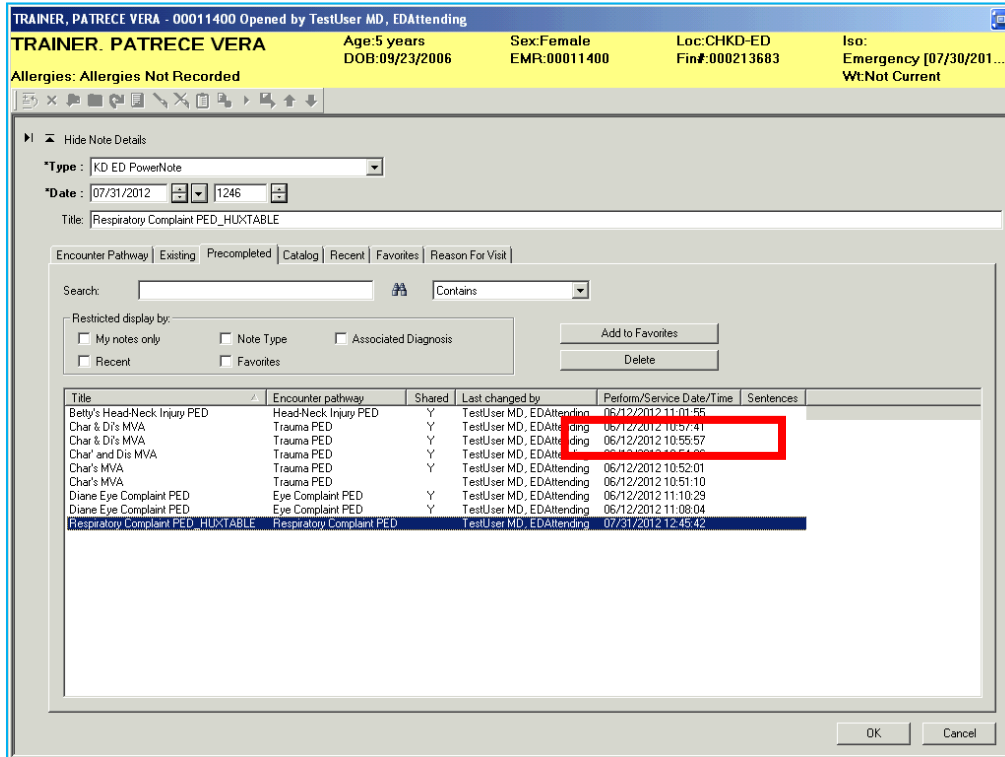
3. Select the Delete button. Click "Yes" to delete the Precompleted Note or "No" to keep the note.
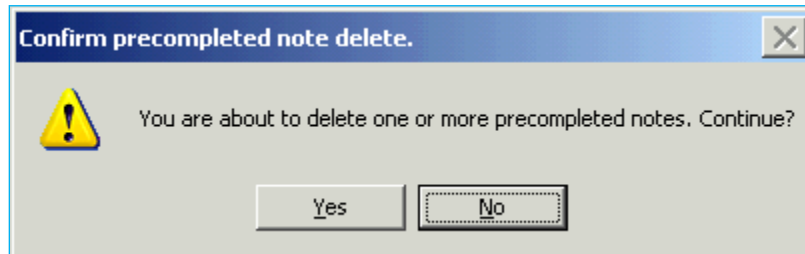
TIP:

- Do not delete Precompleted Notes that do not belong to you.

MACROS

Macros are partially completed personal templates that you use frequently. They can be comprised of terms, sentences or a paragraph. Using Macros will simplify how you enter / create your PowerNotes.

CREATING A MACRO

1. Create a PowerNote and enter the terms within a paragraph or sentence to be included in the macro.

2. Once all of the terms have been selected, right click on the paragraph and select "Save Macro As."

    □   To save the macro at a sentence level, right click on the selected sentence name.
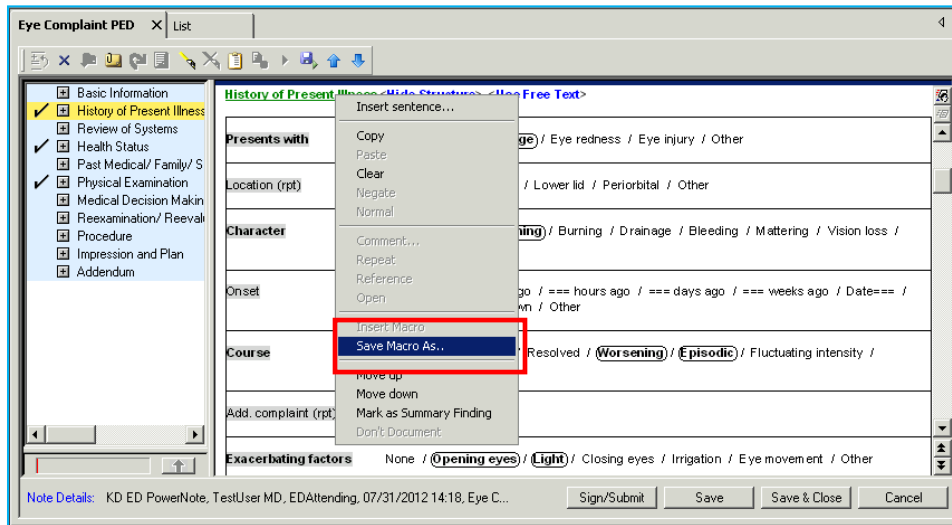
3. Within the Title field, enter the name of the macro. Selecting "Create as shared" will make the macro available to all users (with access to PowerNotes) within the organization. Leaving this checkbox blank, will only you to see it.
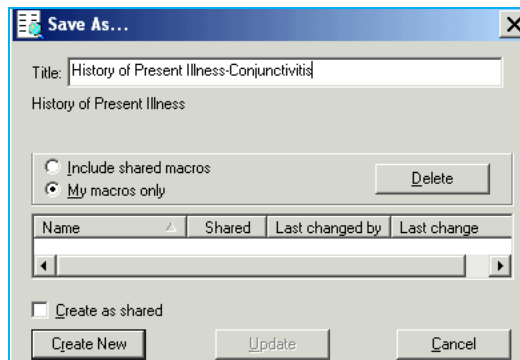
4. Select "Create New" to save the macro.

    An **M** beside the paragraph or sentence indicates that a macro has been built for this paragraph and is ready for use.

INSERTING A MACRO

When you have opened a new PowerNote and want to insert a macro, complete the following steps:

1. To insert the macro, click on the blue "M" indicator. A dialog box will appear that will display the names of all available macros on the top half. The bottom half of the dialog will display the option for "more…"
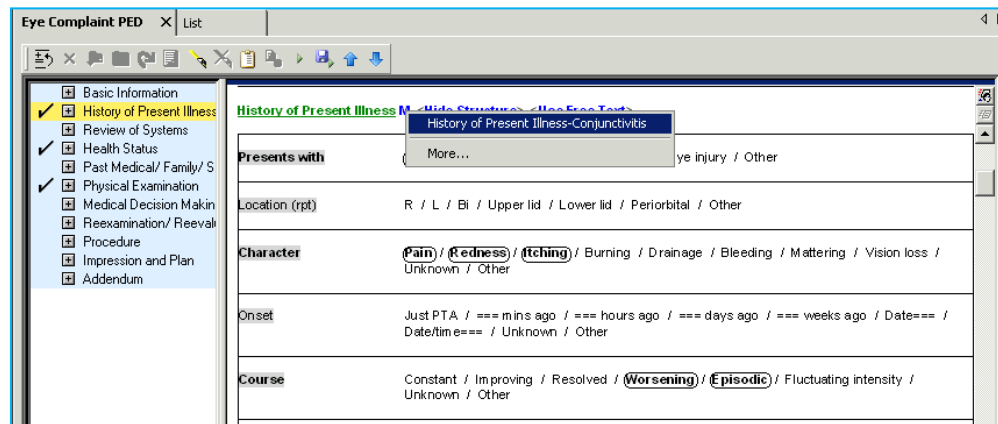
2. Click on the name of the macro to insert it into the note. The options that were selected from the macro that you built will appear in the PowerNote.

TIPS:

Selecting "more…" from the dialog box will display all personal and available shared macros for that indicator. Selecting a macro from this list will insert that macro into the note.

UPDATING A MACRO

To update a macro, complete the following steps:

1. Select the terms to include or exclude from the existing macro.
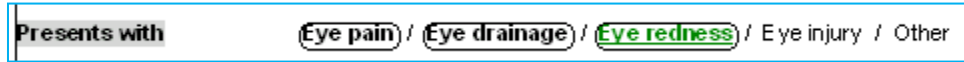
2. Right click on the term next to the blue "M" indicator and select "Save Macro As."

3. Click the name of the macro to update and select the "Update" button.
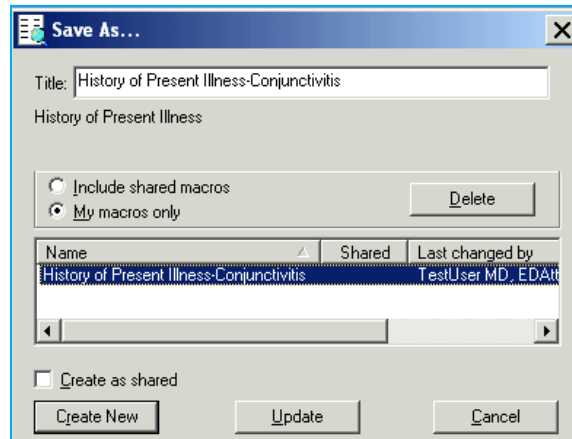
DELETING A MACRO

To delete a Macro, complete the following steps:

1. Select the area that has the blue "M" indicator next to it that you wish to delete.

2. Right click on your selection and select "Save Macro As."

3. Highlight the name of the macro to delete and select the "Delete" button.

4. Select "Yes" to delete the macro or "No" to cancel your actions.
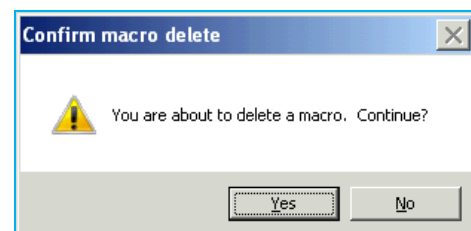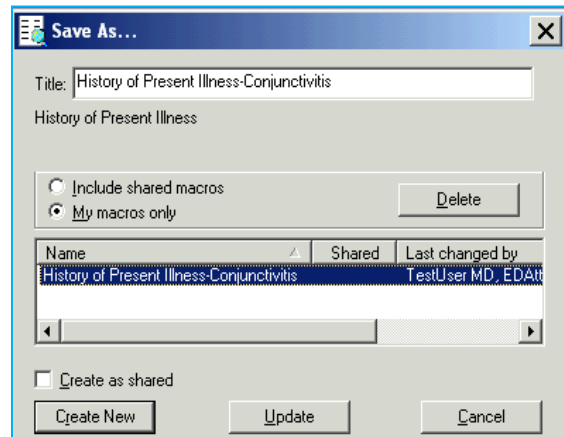
MANAGING AUTO-TEXT

You can create auto-text for entries that you use often. To create Auto-Text, complete the following steps:

1. Select the manage auto-text icon.

   This is available on the toolbar when you have clicked in a <Use Freet Text> section.
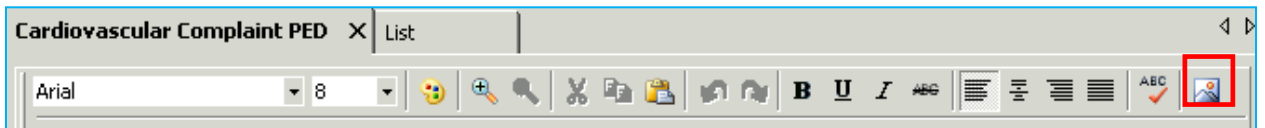
2. The Manage Auto Text window will open. Select the new phrase icon.
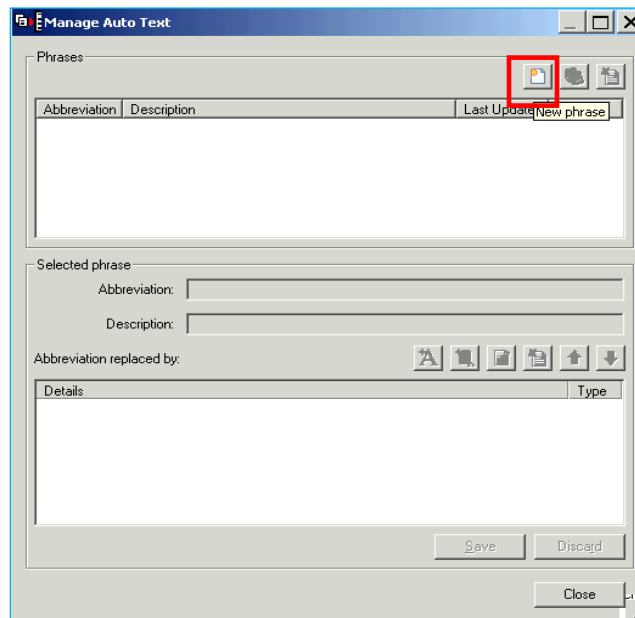
3. The Abbreviation and Description fields will become available. Enter the data as necessary.

4. Click the icon to enter the text.
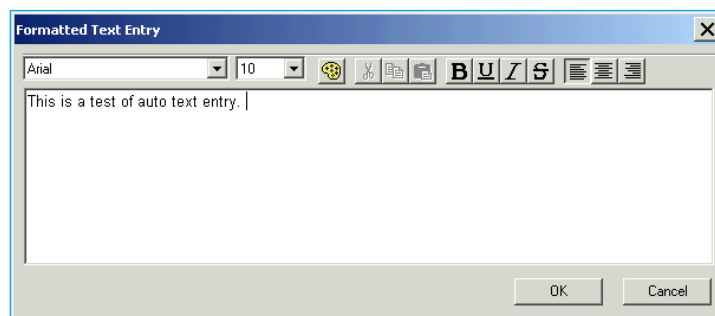
5. Click OK when completed.

6. Click Save.

7. Click Close.

Once you have added Auto-text, you will be able to use it throughout the PowerNote in the Other field.

In the example below, the provider selected Chief Complaint of Other. When the other box expands, right-click and select Insert Auto Text.
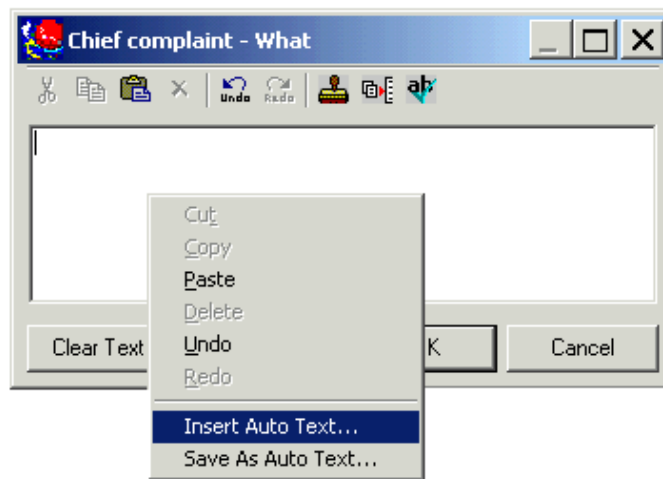
Select the phrase that you previously created. Click OK.
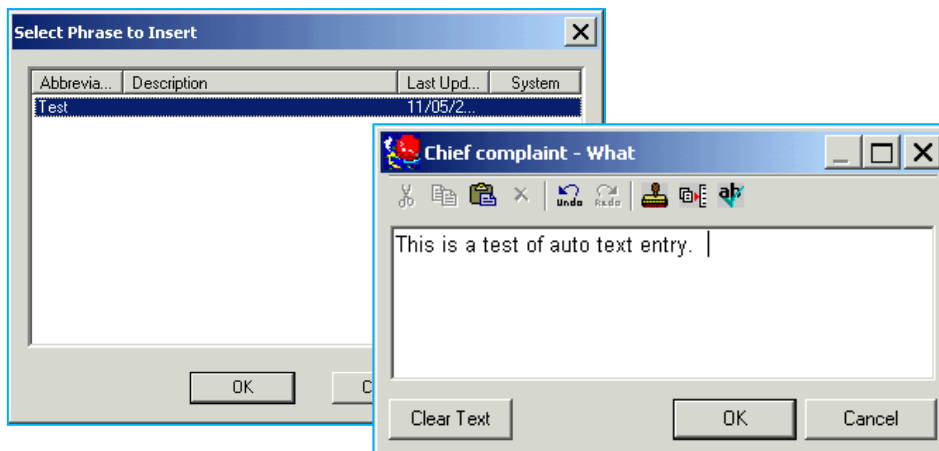
Click OK. The entry will appear on the PowerForm in the selected section.

FAVORITES

Favorites are available for both Encounter Pathways and Precompleted notes. You can use favorites to access PowerNotes that you use often. The favorites that you create will be maintained in your Favorites tab, making it easy to access and update Favorites.

ADDING AN ENCOUNTER PATHWAY TO FAVORITES

1. From the Open Note Dialogue box, search for the name of the Encounter Pathway to add to your favorites list.

2. Select the Encounter Pathway to add and click on the "Add to Favorites" button.

The item will be listed as a Favorite and accessible from your Favorites folder.
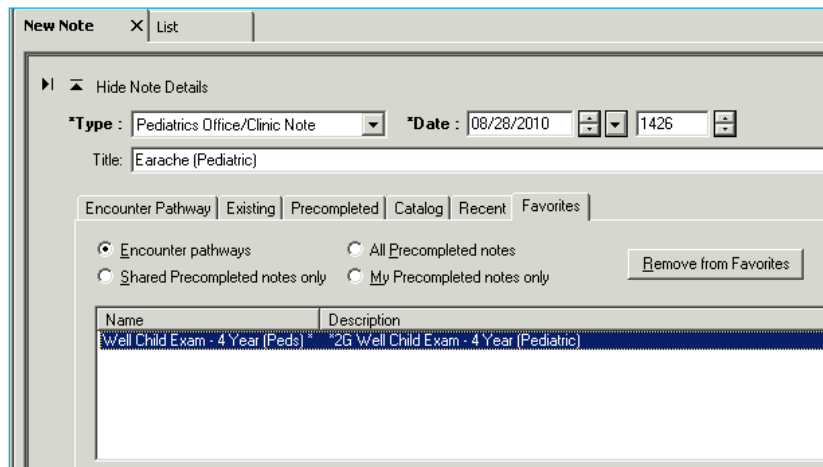
ADDING A PRE-COMPLETED NOTE TO FAVORITES

To add a pre-complete note to your favorites, complete the following steps:

1. From the Open Note Dialog, select the "Precompleted" tab and search for the name of the Precompleted Note to add to your favorites list.

2. Select the Precompleted Note name to add and click on the "Add to Favorites" button.
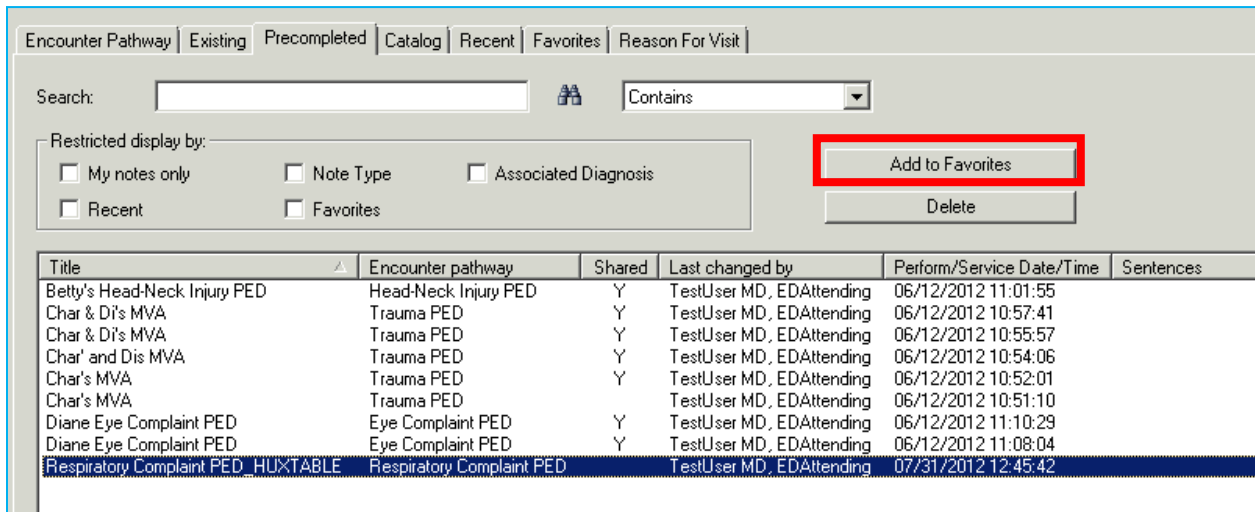
The completed PowerNote will appear on your favorites tab.
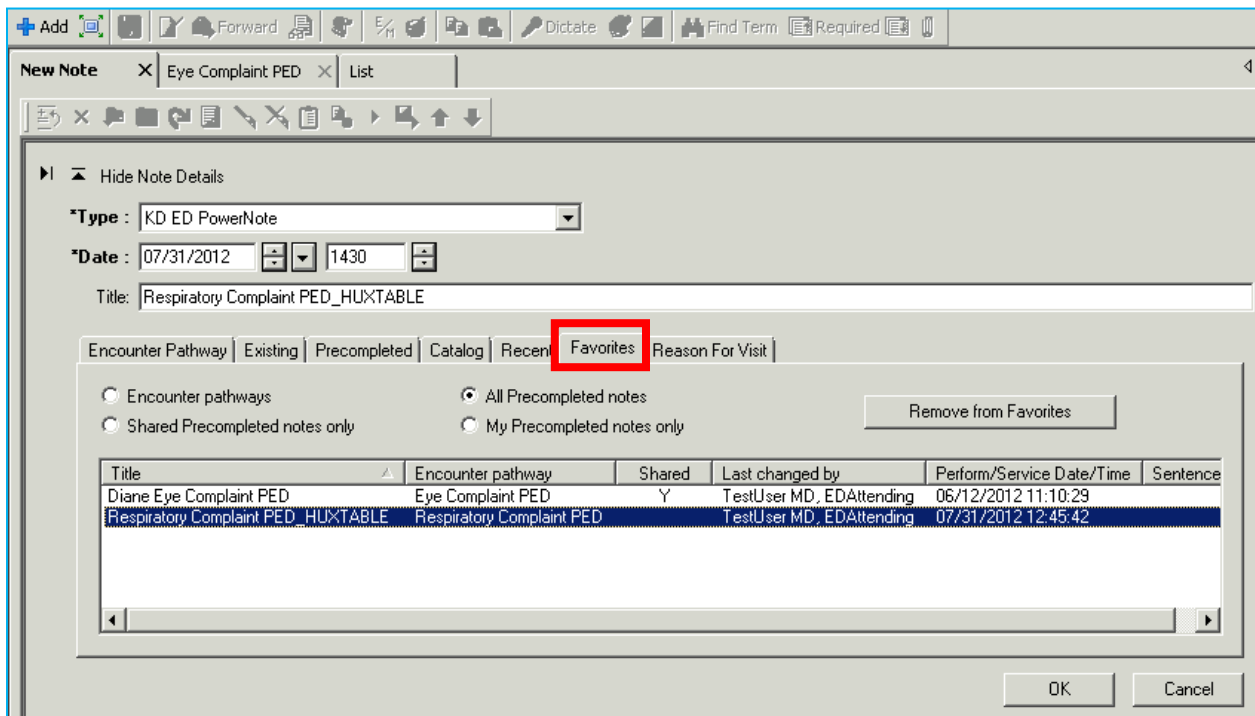
REMOVING A FAVORITE

To remove an Encounter Pathway or Precompleted Note from your favorites, complete the following steps:

1. Select the Favorites tab from the Open Note dialog box.

2. Select either the Encounter Pathways or Pre-completed Notes option button.

3. Highlight the name of the note to remove from your favorites list and select the "Remove from Favorites" button.
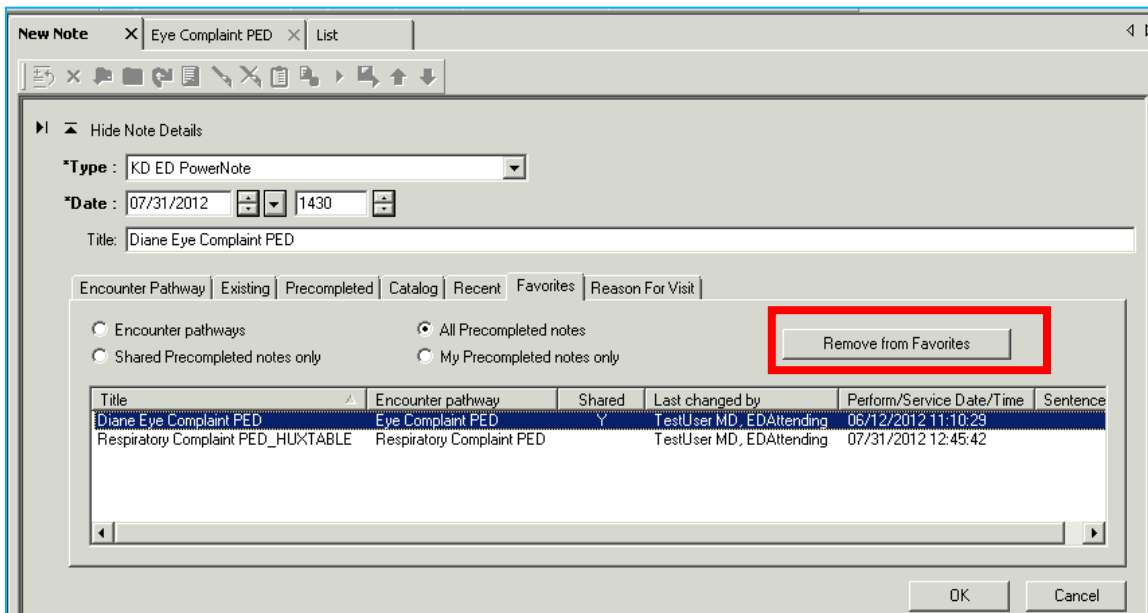
POWERNOTES REMINDERS AND TIPS

- **ONE** note per attending. If the attending changes, start "Addendum/continuation" note type. Resident may document on multiple notes. Continue documenting on new note – you do not need to peat items.

- When auto-populating notes with vitals, take a moment to only select relevant vitals. List may include duplicate vitals or even vitals from a prior visits that should not be included.

- Results / ED course paragraph of PowerNote has sections to document Resident sign-out (time and resident names) supervised and procedure notes.

- Notice Re-examination/Re-evaluation paragraph – This is a good place to document response to therapy or other important events during ED course.

- Please import important lab results into notes. Notice you can select individual results by clicking (hold down CTRL to click and / or drag multiple results).

- Please use items in PowerNote for Discharge Process. Selecting Diagnosis, Patient Education, and Follow-up from PowerNote will allow this information to be documented into PowerNote and well as included in the Discharge Process.

- Codes/Resuscitations will be documented and orders placed on a **paper code sheet**. Once a patient is stabilized, charting and orders may be transitions to the EMR. Residents: Ask MD/nurse if your are unsure of process.

- Co-sign orders on your patient whenever they appear (see tracking board icon).

- When saving a note please change title. If the final diagnosis is not available use the complaint.

  Example: rename "ENMT Complaint – CHKD" to "Ear Pain – CHKD".

SECTION V   USING MESSAGE CENTER

Message Center enables you to perform tasks such as online results review, electronic signature of documents, requesting and signing electronic medication requests, approving and cosigning of orders, management of electronic message and working with proxy authentication. For example, clinical staff enters orders or residents submit PowerForms, it routes to the physician's inbox for electronic signature.

Important Note:

With the exception of Office Notes, Message Center will replace the use of Electronic Signature Authentication (ESA) at CHKDHS.

Other functionality of Message Center includes:

- All messages and notifications that require your attention, review or signature are routed to your Inbox and are organized in folders.

- Your Inbox can be accessed from any computer on your network that has Cerner Millennium installed on it.

- You can customize the items you want displayed in the Message Center by filtering by dates, types of results, etc.

MESSAGE CENTER COMPONENTS

The components of Message Center are shown below.
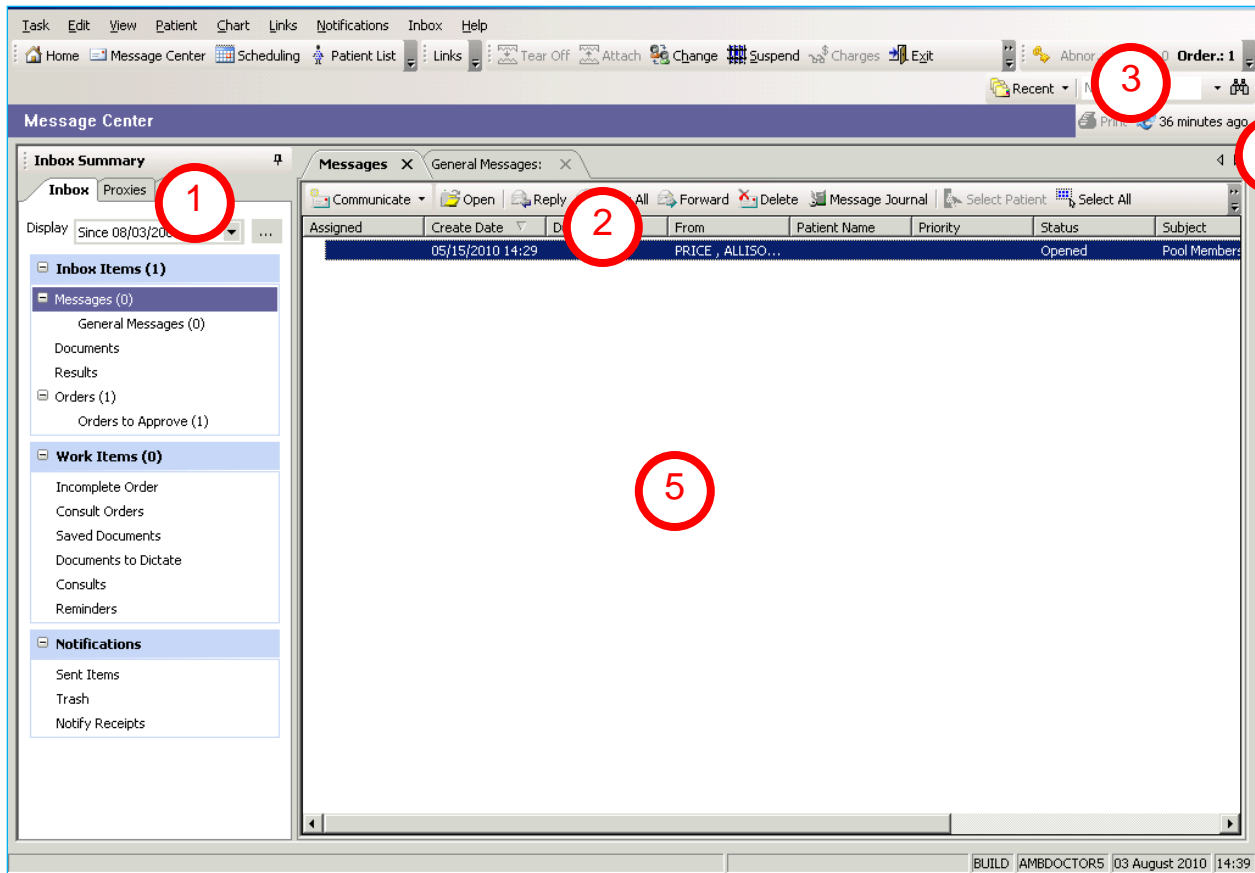
	Component	Description
1	**Inbox Summary**	The Inbox Summary provides you with a quick view of all of the items in your Inbox.
2	**Message Center Toolbar**	The Toolbar provides access to actions that you can perform to a document.
3	**Key Notifications Toolbar**	The Key Notifications Toolbar alerts you when specific notifications are received in your Inbox in Message Center.
4	**Refresh Button**	Refreshes the data that is currently being displayed.
5	**Message Viewing Window**	Contains the Messages and General Messages Tab. Displays information and documents, depending on what is selected from the Inbox Summary.

INBOX SUMMARY

The Inbox Summary provides you with a quick view of all of the items in your Inbox.

The Inbox Summary is displayed on the left side of the window and allows navigation through the Message Center. The Message Center has folders which are expanded/collapsed by clicking the +/- next to the folder. The numbers to the right of the folder name in parentheses indicates the number of unopened/unread items and total number of items in each folder respectively.
You can view messages from the sources below by clicking the appropriate tab at the top of the Inbox Summary:
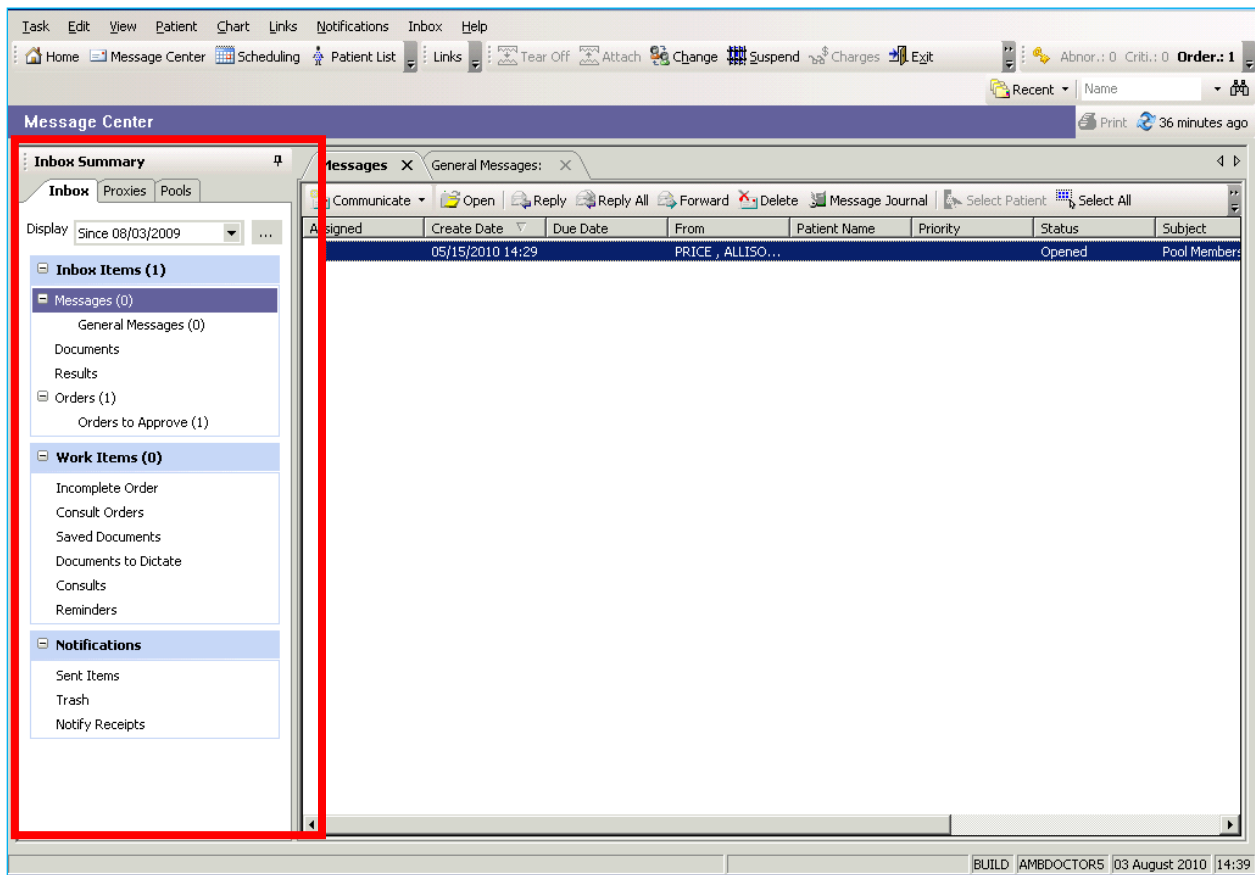
Inbox Summary Tabs

- Inbox: Your own Inbox

Inbox Summary Inbox Items

Messages –
Documents -- Premilinary Reports for signature will be found here
Results FYI
Orders -- Proposed and Orders to Approve (see Appendix F for additional information)

Work Items

Saved Documents
Documents to Dictate

Notifications

Sent Items
Trash

- Proxies: Inboxes for which you have proxy rights

- Pools: Pool Inboxes (i.e. Chesapeake Pediatrics)

The **Inbox Items** section will display the following:

- General Messages that need review

- Laboratory and Radiology Results that have been entered in the system **(Physicians Only)**

- Orders to approve **(Physicians Only)**

- Documents (broken into subsections listed below. **These only appear if the document type exists.**)

    - Sign: Scanned and Soft Med documents requiring signature.

    - Forwarded documents to sign: Documents forwarded from other providers for signature.

    - Review: Documents submitted for review only.

    - Forwarded documents to review: Documents forwarded from other providers for review

The **Work Items** section of our Inbox Summary will contain the following sections **for physicians.**

- Saved documents: Documents added to the Documents tab in PowerChart that have been saved instead of signed or submitted. **PowerNotes that have been saved will appear in Saved Documents.**

- Documents to dictate **for physicians:** These are anticipated documents that are added automatically or assigned by the HIM staff. The only documents that will appear in the Documents to Dictate folder are:

  o **For Residents** RD H&P (resident dictate H&P), RD D/C (resident dictate discharge summary), RD OP (resident dictate operative report), and RD ED (resident dictate ED)

  o **For Attendings** – Anticipated document for the op note (KD OPERATIV RPT)

The **Notifications** section will contain the following sections **for physicians.**

- Sent items: Proxy notifications you have sent to another provider and forwarded documents.

- Trash: Deleted proxy notifications

- Notify receipts: Any notification receipts that you have requested.

MESSAGE CENTER TOOLBARS

The following commands are available on the Message Center Toolbar. Toolbars will vary depending on what selection you have made under the Inbox tab.

 Note: Some buttons are "grayed out" meaning that they may not be available for use at this time.
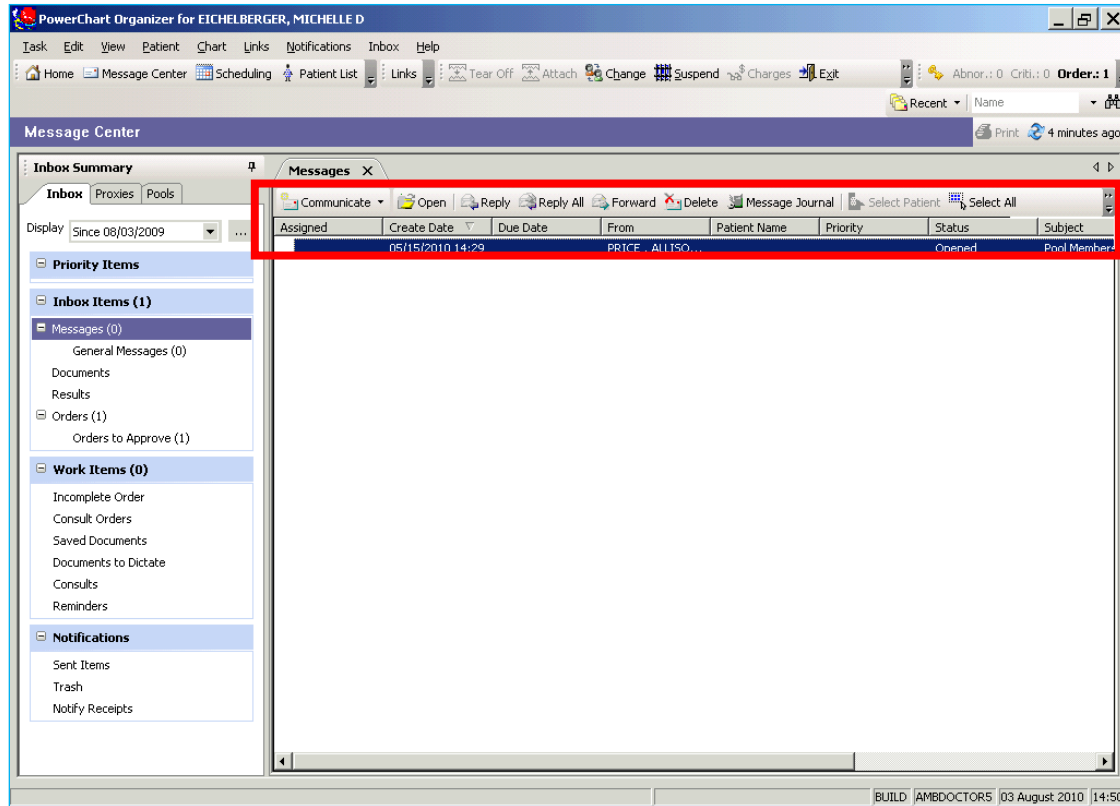
Communicate – Allows you to create new messages, reminders, and consults to be sent to other clinicians / providers using Message Center.

Open – Opens the selected document.

Reply – Enables you to respond to a message sent via Message Center.

Reply All – Enables you to respond to all recipients of a message sent via Message Center.

Forward – Allows you to forward a message to another recipient within Message Center.

Delete – Erases the selected message.

Message Journal – Displays a log of messages, consults, and reminders for a specified patient.

Select Patient – Displays only results, messages and other Inbox items particular to the selected patient. This option allows you to navigate through the items in the patient-specific inbox before returning you to the full-view inbox.

Select All – Allows you to select all messages in the Viewing Window.

MESSAGE VIEWING WINDOW

From the Message Viewing window, you can access consults, messages (responses and messages copied to yourself), and notes by double clicking. The document will open and display in the Message Viewing Window.

The information displayed on the right pane of Message Center will change when an item is selected from the Inbox section.

In the example above, the Documents section was selected and documents for selected patients were sent by a resident for review and signature.

There are three ways to open a document:

1. Double click directly on the subject line.

2. Clicking once to highlight and right click to open.

3. Select the subject line highlighted and clicking the open icon.
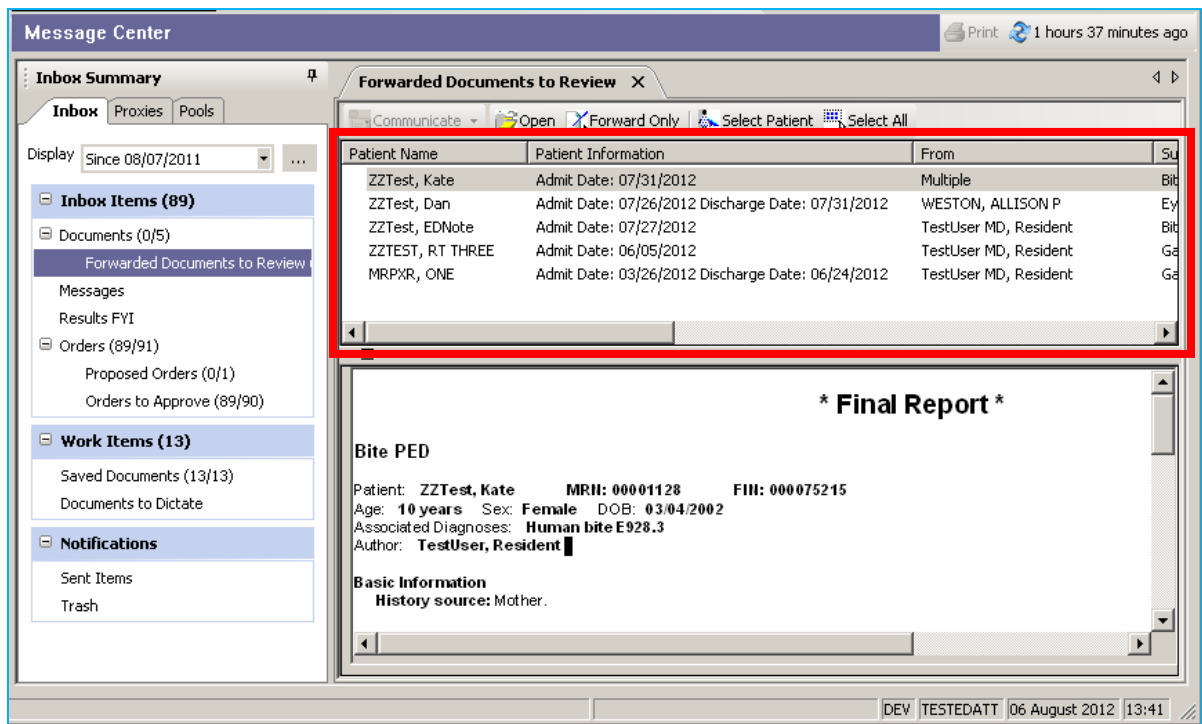
Once one of the above options to open a message has been executed, the document will open in a separate tab titled General Messages.

In this example we have opened a document for co-signature.
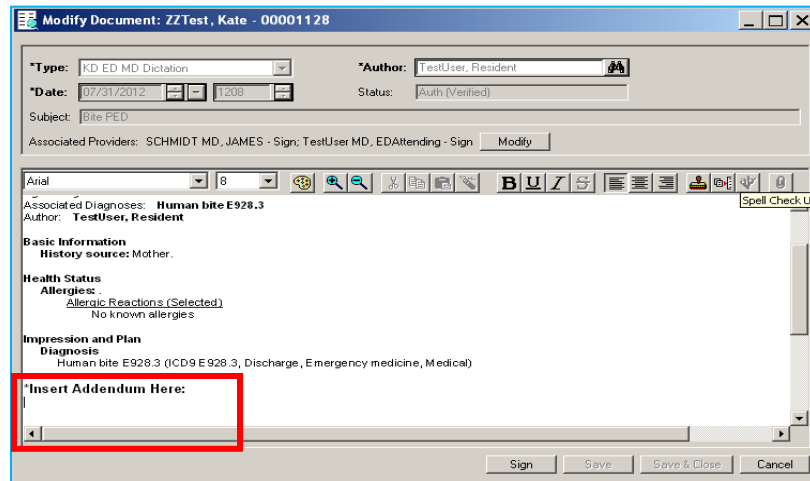
- Once the document is open you can view by scrolling through the window.
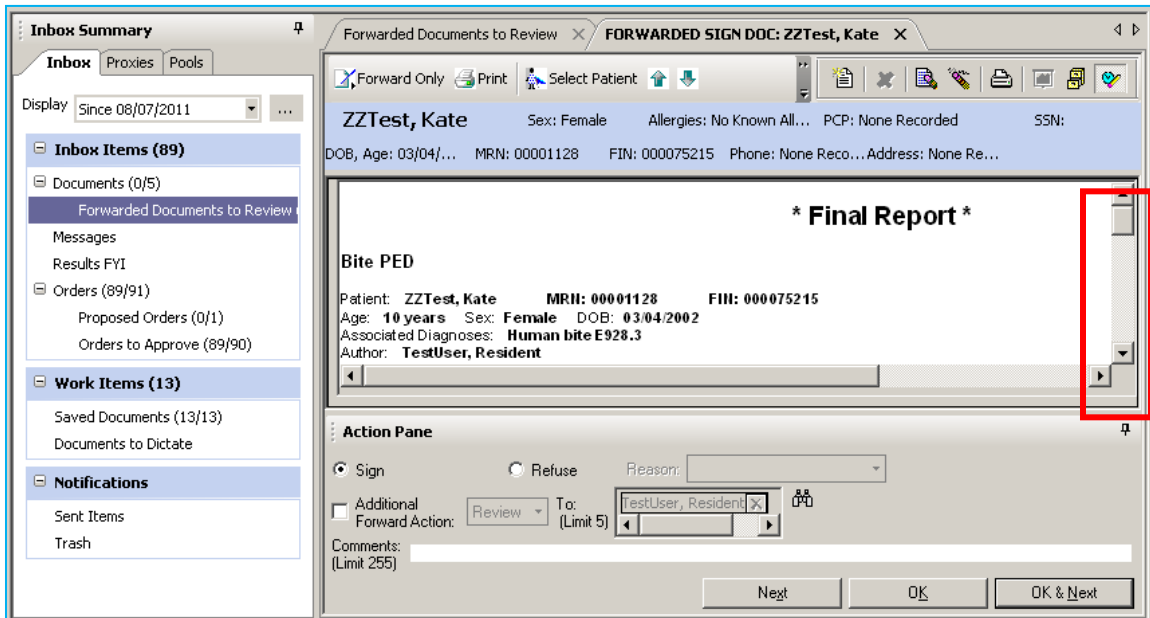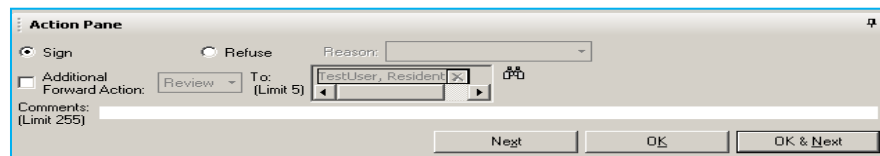
- If changes are needed you can right click on the document to Modify or Correct.
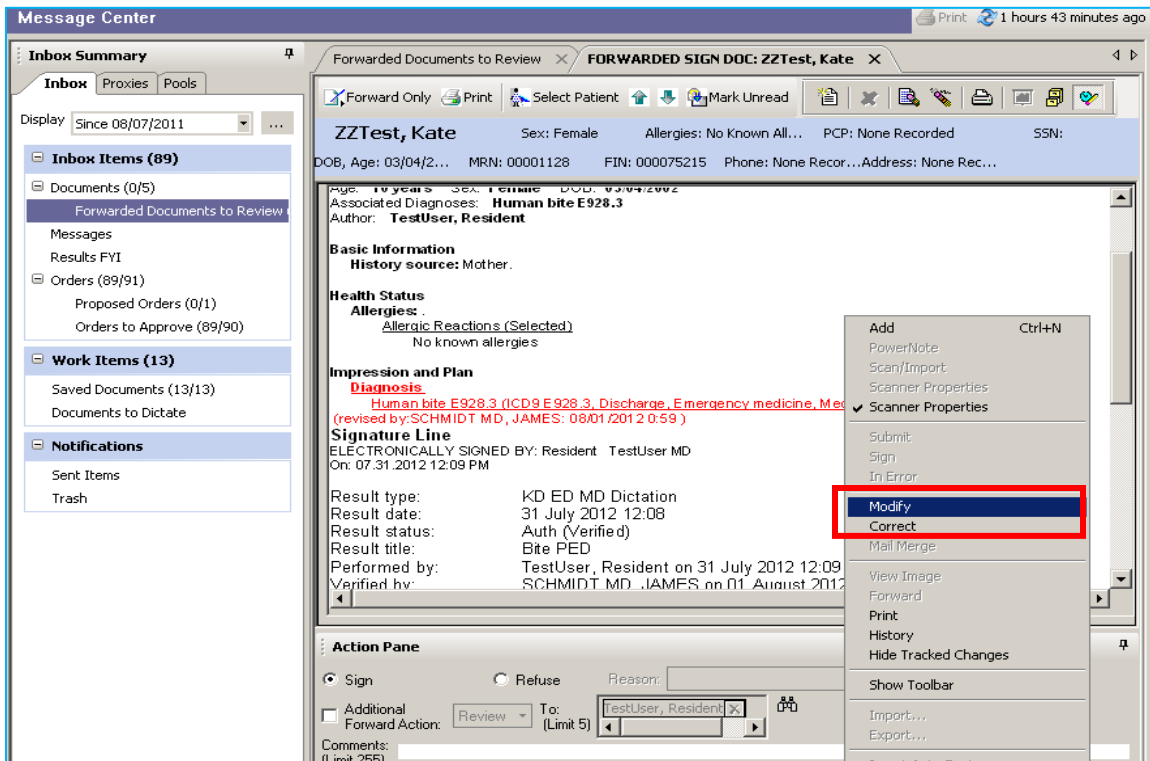
- Final Report
  - o Selecting Modify – Opens the document and allows you to Insert an Addendum

  - o Selecting Correct – Opens the report structure so changes can be made.

- Preliminary Report –
    Residents: You can verify can monitor the status of reports sent in your mailbox.
    Attending: PowerNotes sent to your mailbox from residents will be in a Prelimary Report status until they are signed.

  - o Selecting Correct -- Opens the report structure so changes can be made

- The Action Window allows you perform several functions related to the document
  - o Sign – selecting sign and then OK signs the document in a Final Report Status
  - o Refuse – selecting Refuse and then OK sends the document back to the original sender
    - ▪ When Refuse is selected the drop down window will allow you to select a reason for refusing
  - o Additional Forward Action –Selecting Additional Forward Action gives you the option to send the document back to the sender for review or to sign the document. You can also use the lookup to send the document to up to 5 users. Select OK when finished to send.

- Comments -- Any needed comments can be added here.
    NOTE: In order to sign the document as a FINAL REPORT you must select Sign and then OK.

PRELIMINARY REPORT

If you are working with a Preliminary Report, right-clicking within the body of the PowerNote allows you to select Correct. This action will take you to the PowerForm so that any necessary changes can be completed and signed.
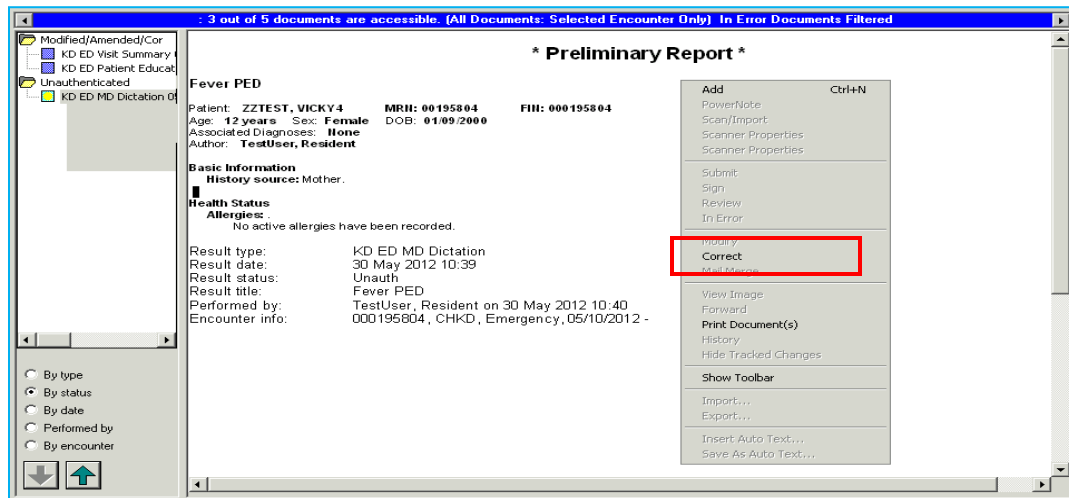
POWERNOTE PROCESS

Resident

- Saves the PowerNote as needed during the patient's stay.
- Modifies the PowerNote when continuing to document.
- Completes and signs the Powernote
- Submits for endorsement (can be sent to any provider)
- PowerNote is sent to Providers Message Center

Attending:

- Receives PowerNote in Message Center
- Note is a Preliminary Report (unauthenticated)
  - o Can Refuse the note – this sends note back to Resident
  - o Can Correct the note – opens window for corrections
  - o Can Modify the note – window opens for changes
  - o Can Sign the note
  PowerNote is signed and goes to a Final Report Status (Authenticated)
- Attending can continue to:
  - o Modify the note –Add an Addendum with username and time stamp
  - o Correct the note – Add changes which opens structure and tracks changes.

KEY NOTIFICATIONS TOOLBAR

The Key Notifications Toolbar alerts you when specific notifications are received in your Inbox in Message Center.
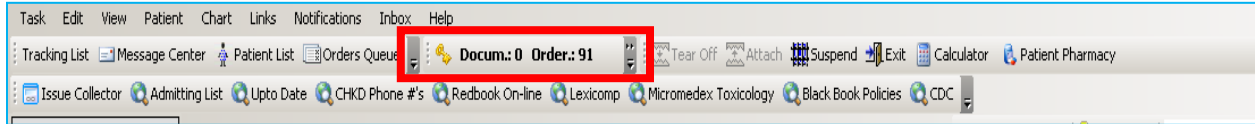
This can display an indicator when Results, Messages, and Orders received in your Inbox. New results are indicated in bold and the number adjacent to the result type indicates the number of new notifications in that category. Clicking the notification name opens the corresponding Inbox folder allowing you to view the details of the notification.

REFRESH BUTTON

The Refresh button is used to refresh any data that is being displayed. It also displays the time that the information was last refreshed. **It is imperative that you Refresh the data after submitting changes.**
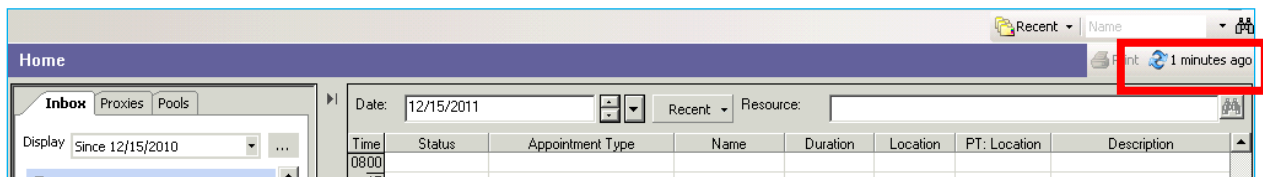
SECTION VI   DEPART PROCESS

The Depart Process dialog box allows you to manage the activities associated with the process of documenting and departing a patient in FirstNet. The window serves as a launch pad for depart-related solutions, PowerForms, registration conversations, and tracking events.

The Patient Demographics Banner is displayed at the top of the window to provide you with pertinent information about the selected patient.

DEPART PROCESS WINDOW COMPONENTS

The **Demographics Banner** displays general information of the patient you are departing.

The **Clinical tab** displays the Visit Summary information for the patient.

The Pt Ed Summary **tab** displays the Education material listed for the patient.

Depart Actions displays the actions that need to be completed before the patient can be departed.

The Depart Process window is where you will complete the Depart Actions before the patient is to be discharged or admitted to the hospital or admitted to the Surgery department.

The following are the Depart Actions for completion:

➢ **Diagnosis** – Click here to enter the discharge diagnosis

➢ **Patient Education** – In this section you can complete the Patient Education Process and print materials to give to the patient before discharge

➢ **Follow-up** – In this section you can give follow up instructions to the patient that can be printed with the DC materials

➢ **Prescriptions** – Prescriptions can be ordered and printed or called to the patient's pharmacy from here

➢ **Med Rec** – Med reconciliation can be done from here. This includes (1) meds to be continued after discharge, (2) creating new prescriptions, and (3) med you do not wish to continue.

➢ **Outstanding Events** – In this section, you can review any outstanding events for the patient's visit. **Note: Completion of this section is done by RNs, techs, and secretaries.

➢ **Discharge** – Indicates the patient is to be discharged and has NO prescriptions.

➢ **Discharge with Rx** - Indicates the patient is to be discharged and has prescriptions

➢ **Admit Patient** – Indicates the patient is to be admitted to the hospital.

➢ **Surgery** – Indicates the patient is to go to Surgery

➢ **&Depart** – Will depart the patient from the Emergency Department.
**Note: Completion of this section is done by RNs, techs, and secretaries.

Selecting your Patient

Prior to departing the patient you will need to select the correct patient from the Tracking List.

- Select the patient you wish to depart by clicking on the patient's name from the tracking list.
- Once the patient's name is highlighted as seen below, select the Depart Process Icon on the tool bar.
- This will launch you to the Depart Process window.
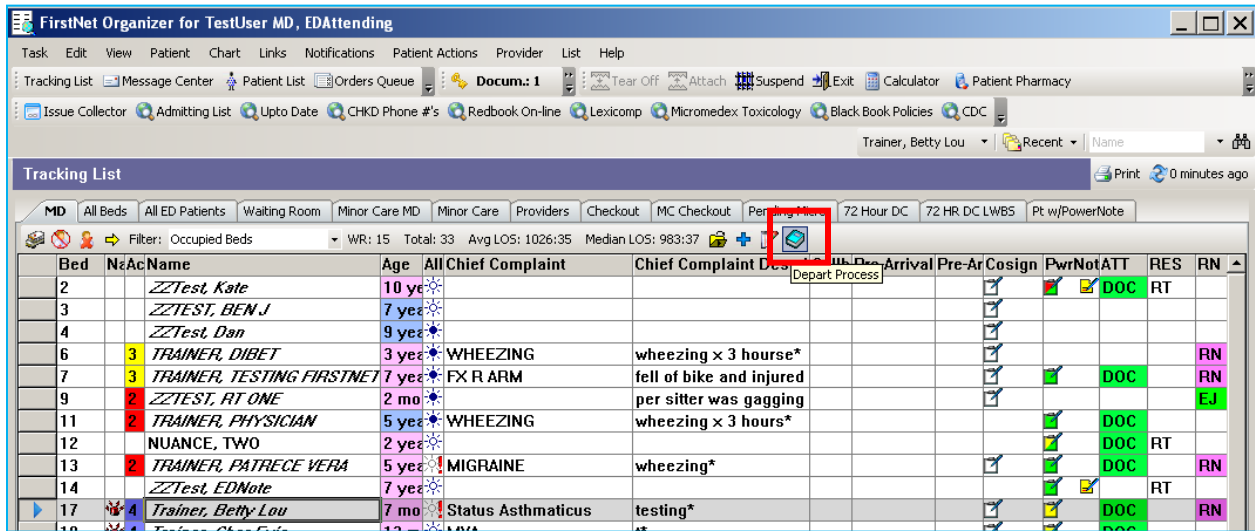
Note: If your patient is deceased, you will receive the following message upon selecting your patient.
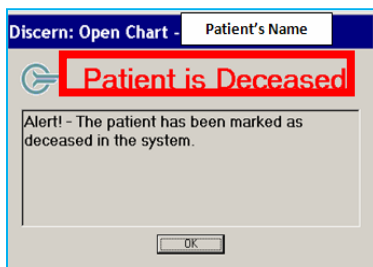
This message will only display once the **Deceased** field has been set to "**Yes**" in a patient's record.

Click **OK** to move on to the patient's record.

You will be able to view this information in the Patient Information tab also.

THE DIAGNOSIS SECTION

Completing the Diagnosis Section

To complete the Diagnosis action, complete the following steps:

- The Diagnosis screen will automatically appear once the Depart Process button is selected
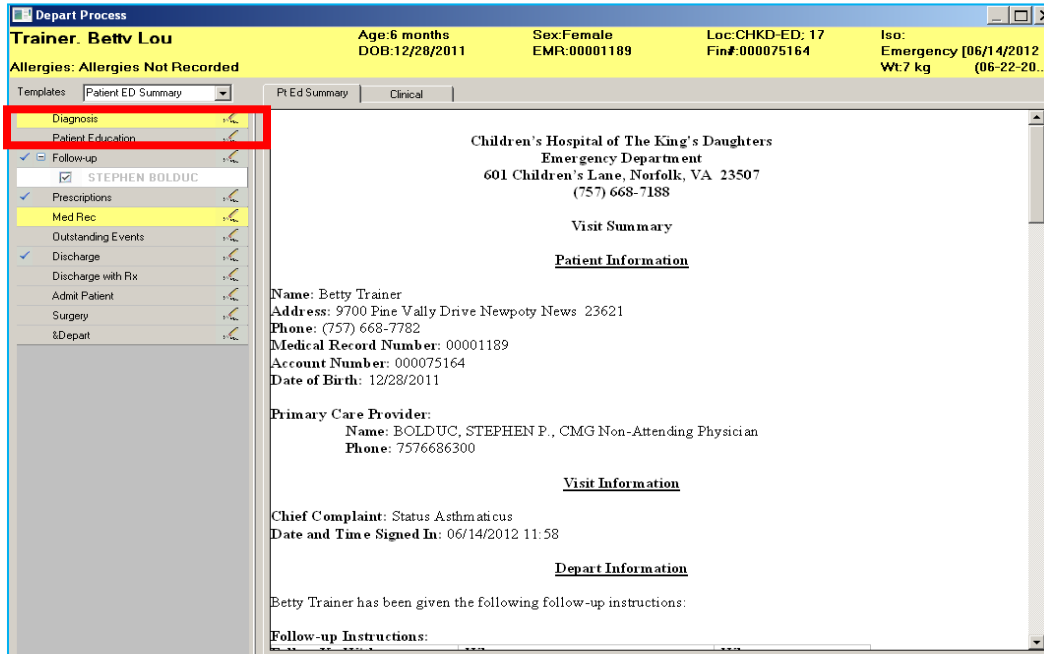
This will open the Discharge window.

➢ At the Discharge window, select Add.
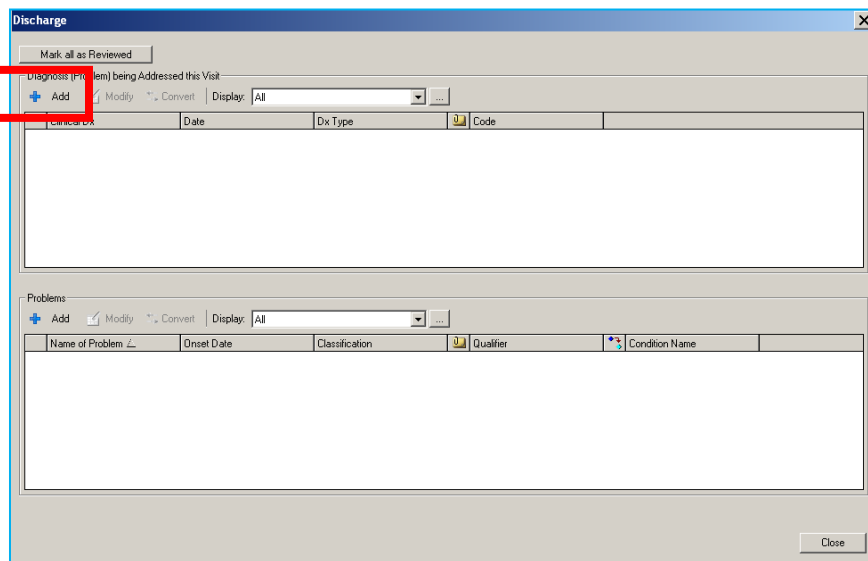
- This Diagnosis screen will appear.

- Diagnosis folders will be available for you to search for the diagnosis. This should be your initial diagnosis search.

- Select the Folders button.

- Select the diagnosis category

- Click on the Emergency Department Folder

- A list of diagnoses will appear.

- Double click on the desired diagnosis.

- Select Ok.

If you do not find your diagnosis in the folders, you must perform a search.

- In the Diagnosis field, type in the diagnosis and select the binoculars or press enter.

The Diagnosis Search box will appear.

- In the Diagnosis Search box you will need to select the correct diagnosis.

- Select the corresponding diagnosis in the search box.

- Select OK.

- Complete the diagnosis information as needed.

- Select Ok.

**Note: If you would like to add an additional diagnosis, select OK & New.

If you still cannot find the proper diagnosis, you will be able to Free Text the diagnosis.

- In the Diagnosis field select the Free Text box.
- Free Text the Diagnosis in the Diagnosis field.
- Select OK.

**Note: If you use the Free Text option, you will have to search for Patient Education materials. Suggested materials will not be available.

FAVORITES IN THE DIAGNOSIS FOLDER

In the Diagnosis section of the Depart Process you can set up a Favorites folder. This will provide you with quick access to frequently used diagnoses.

To build a Favorites folder, complete the following steps:

- In the Diagnosis Search box, select a diagnosis and click *Add to Favorites*.

This will open the Favorites screen.

- Click on the Create Folder Button.

- Create a Folder name.

- Select OK.

    Note: Once the folder has been created you can simply select the diagnosis, then select the appropriate folder. Selecting OK will add to the existing folder.
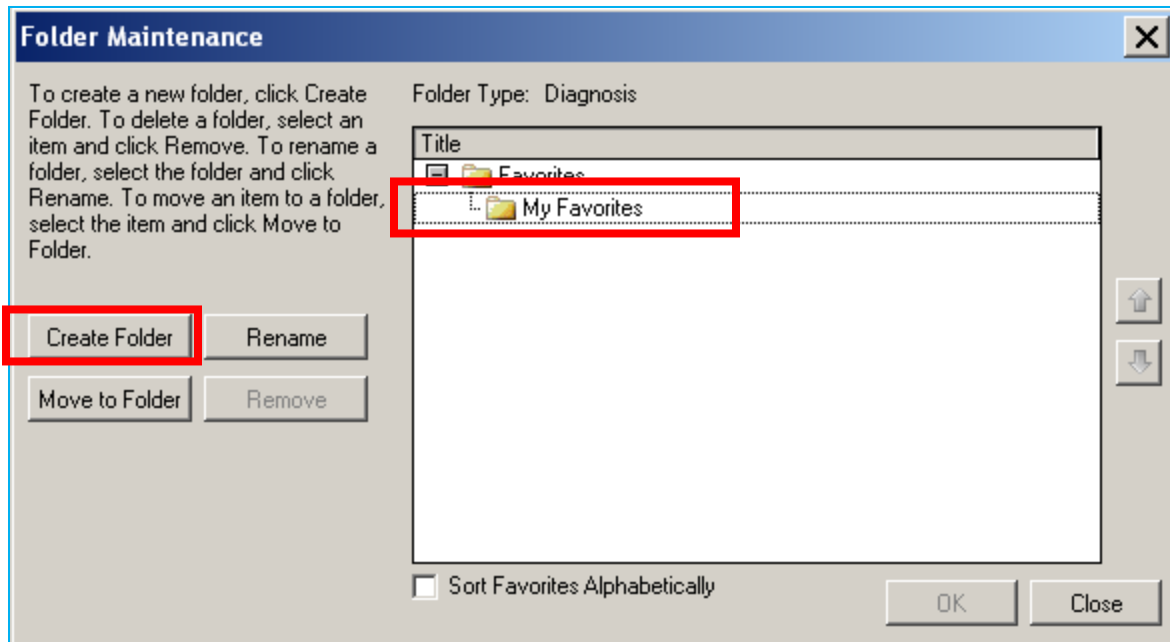
FAVORITES FOLDER

To view the Favorites you added to your folder, complete the following steps:

- At the Discharge window, select the Favorites button.

- Select the folder you created.

- The favorites you added to you folder will now be available for selection.
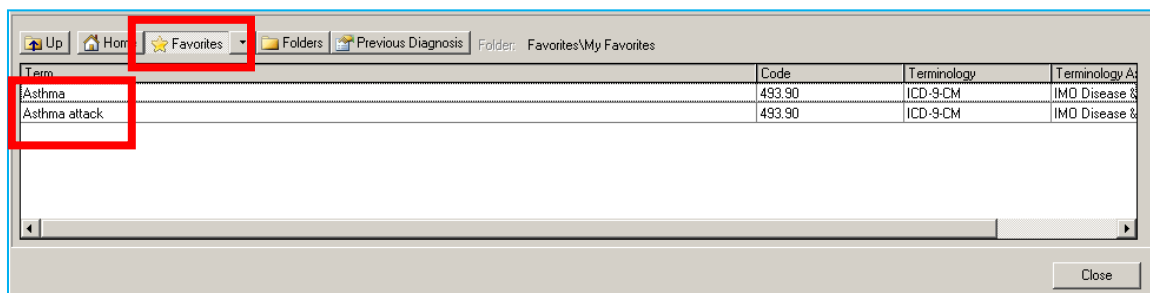
PATIENT EDUCATION SECTION

To complete the Patient Education section, complete the following steps

- Select the icon next to Patient Education.
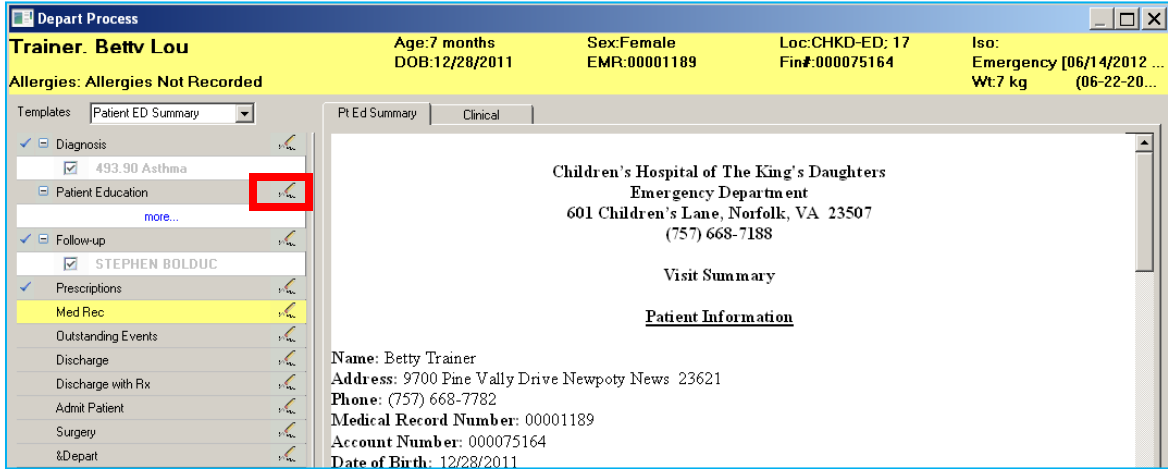
- This will open the Patient Education window.

  The diagnoses that match your diagnosis will appear in the Suggested folder.

- Select from the available options.

  The Patient Education will populate once a diagnosis is selected.
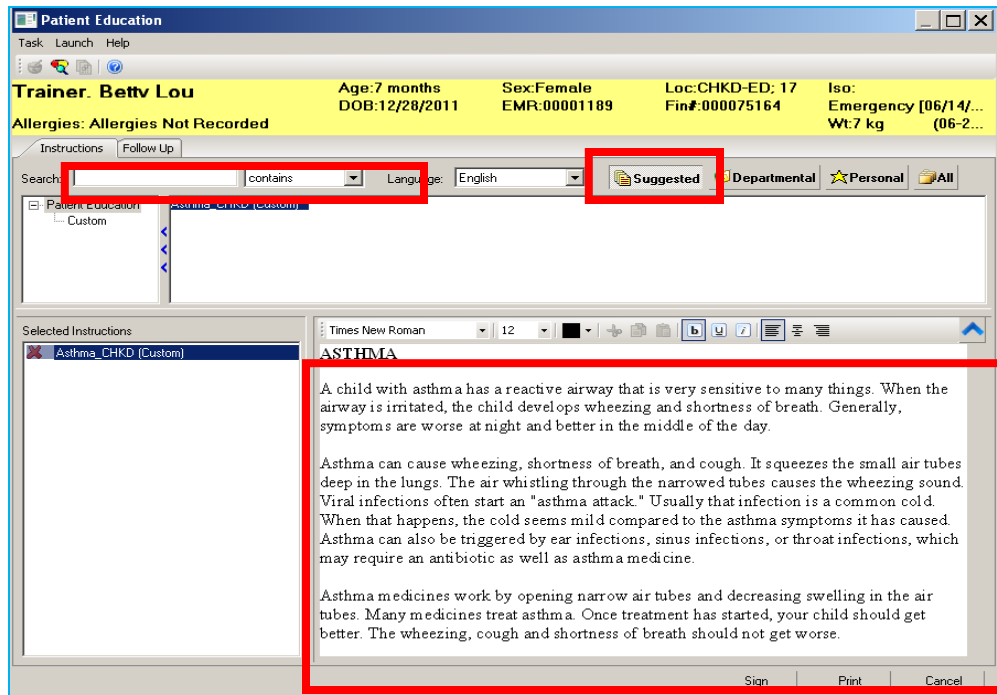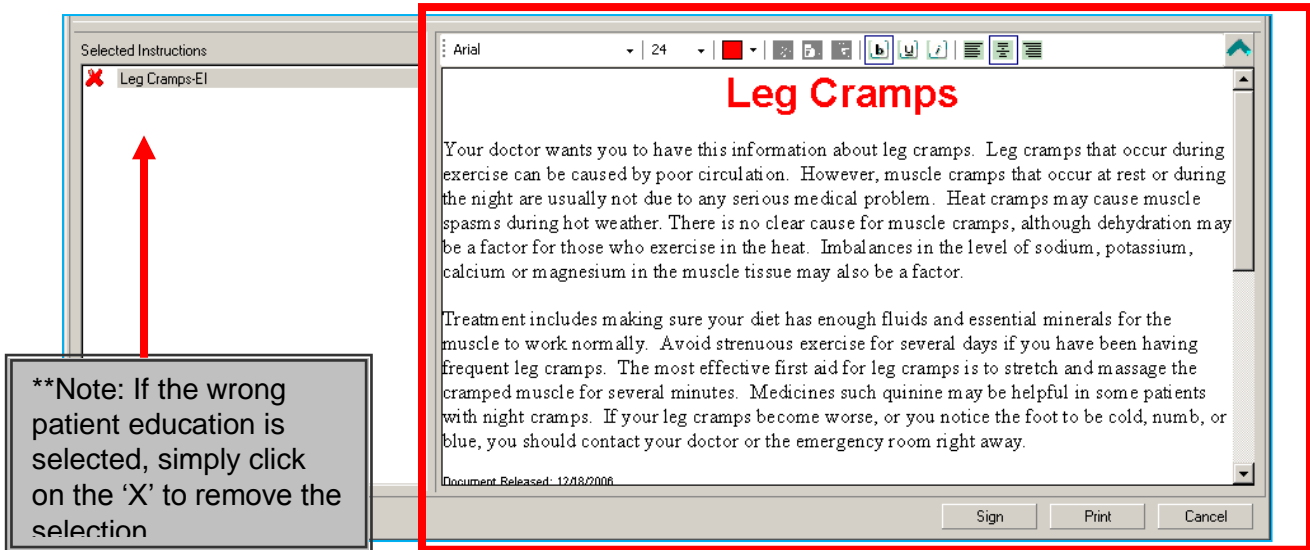
**Note: If no patient education is suggested or if a Free Text diagnosis was entered, you will have to search for it by typing the diagnosis in the Search box provided.

If needed, you can edit information in the Patient Education document before printing out for the patient. This will help to personalize the document to the patient's diagnosis. To edit the information, simply type the information you would like to add in the document.

- Once complete, select Print if you would like to print the information.
- If complete, select Sign.

When the Patient Education is signed, the document is automatically saved to the Documents tab within the patient's chart.   If the document is signed multiple times, it overwrites the existing document instead of making a new one.

**Note: If the wrong patient education is selected, simply click on the 'X' to remove the selection

FAVORITES FOR PATIENT EDUCATION

By right clicking on the selected patient education in the Selected Instructions window, you are able to add frequently used instructions to the following folders:

- **Add to Personal Favorites** – Adds patient education to your Personal folder.

- **Add to Departmental Favorites** – Adds patient education to your Department Folder.

- **Save as Personal Custom Instruction** – Adds your custom diagnosis to the patient education selection list.
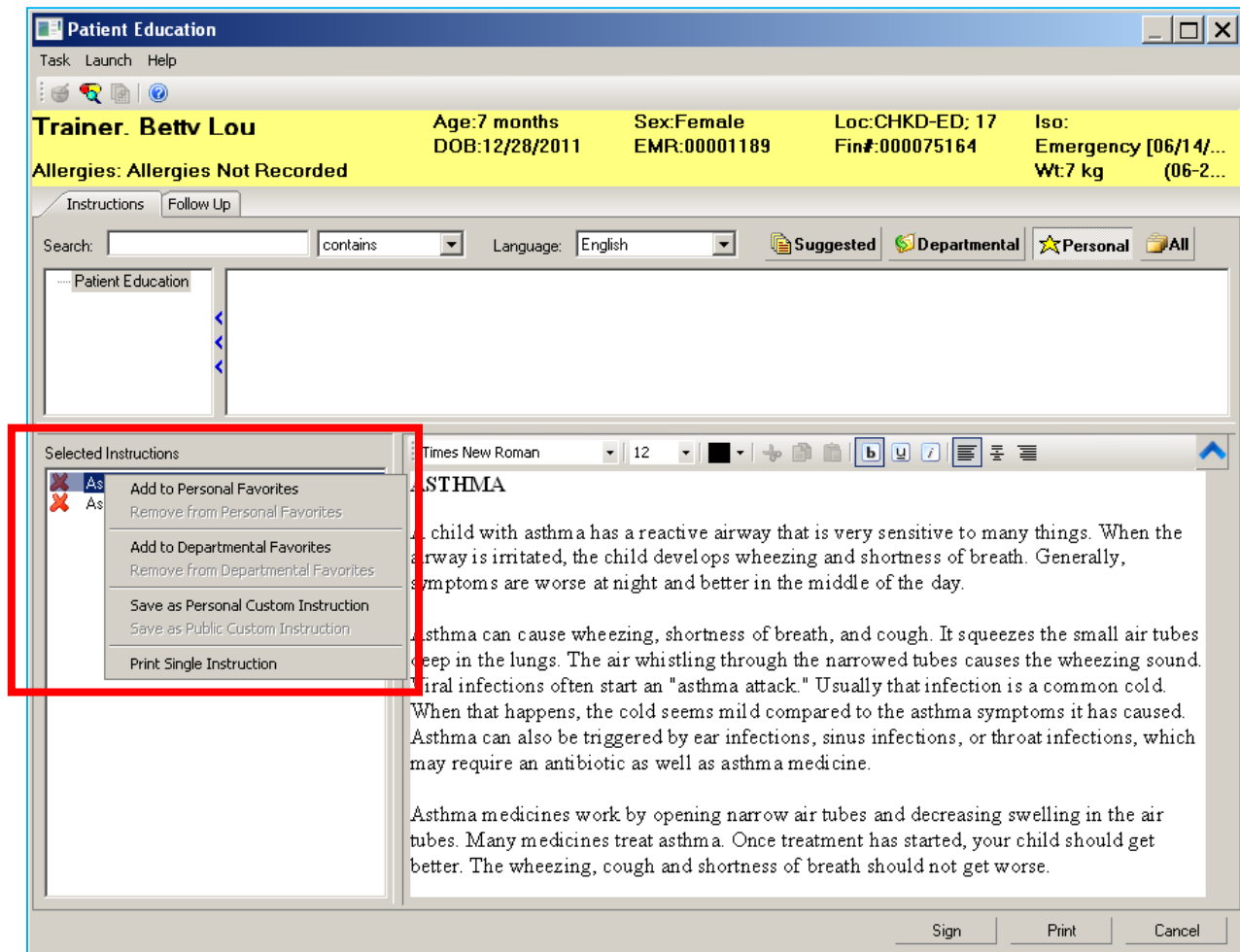
Once you add a patient education to one of the folders, simply click on that folder and the added patient education will be available for selection.

FOLLOW-UP SECTION

This section allow you to indicate if follow care is needed. You can select Who, where and when you would like your patient to follow with their care.

To enter information for a follow up appointment, select the Follow Up tab from the previous window
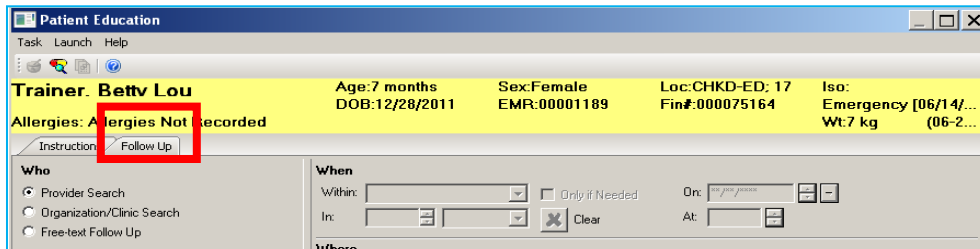
Or

Select the pencil icon next to Follow-up and fill in the appropriate information.
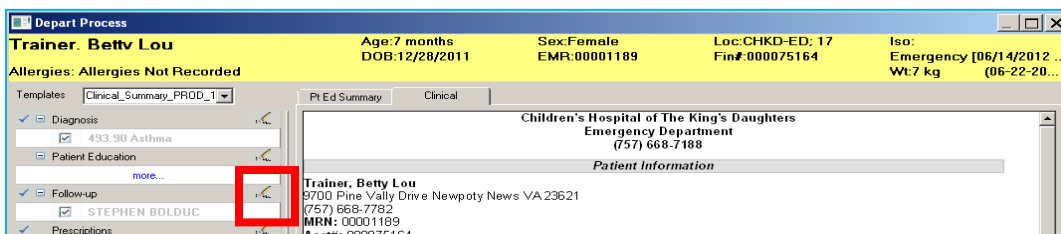
- Complete the Who, When and Where sections
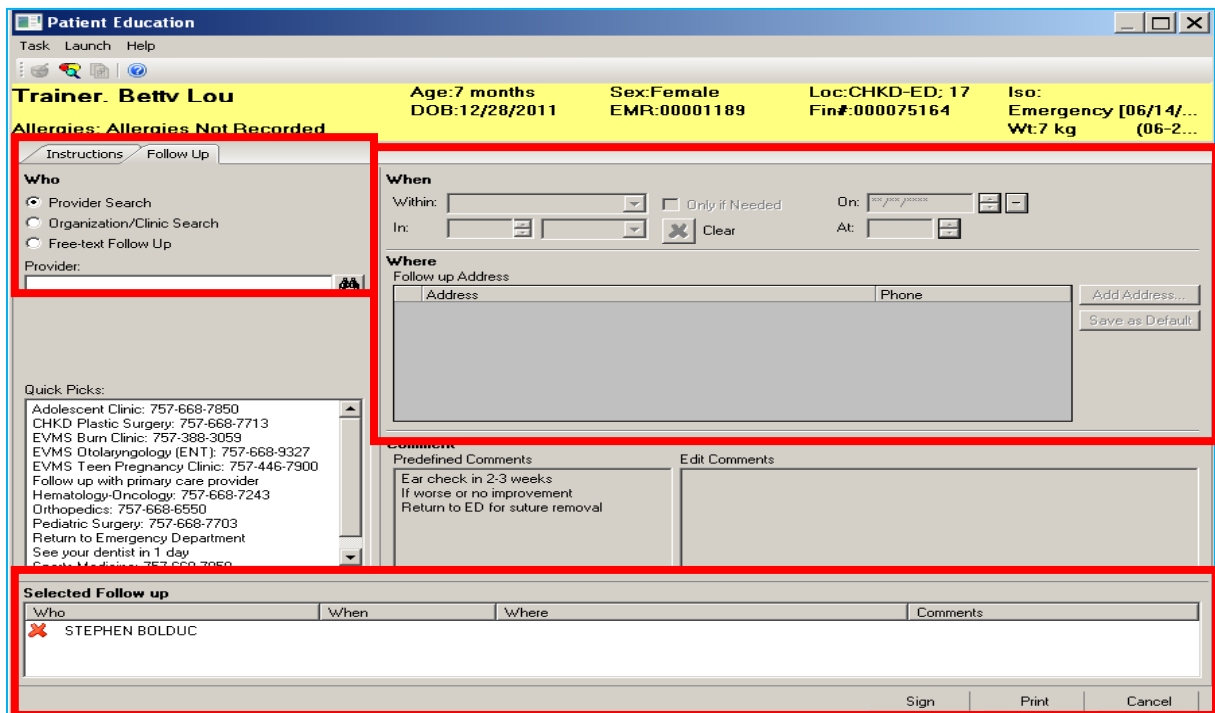
In the Who section, enter who the patient is to follow up.

- You can choose to follow up with:
    - Provider
    - Organization
    - Free Text

- In the When section, you will fill out when the patient should be seen again.

- In the Where section, the address to where the patient should follow up will populate.

    Note: A follow up location can be added if need be by using the Add Address function.

The Quick Picks option is also available which will populate information for you.

- Once the desired information is entered, select Sign.

Once Sign is selected, the Patient Education window will close and bring you back to the Depart Process window.

Notice that a [✓] now appears and the Follow-up status is now complete.

MED REC PROCESS

The Med (Medication) Reconciliation Process should be a single source of up-to-date medications with all necessary order details.

The Med Reconciliation Process allows the physician to:

- efficiently reconcile a patient's documented medication list

- quickly and accurately make the appropriate decision on each medication order

- document compliance on all medications

Before Medication Reconciliation is performed the medication profile needs to be reviewed and corrected. Medications that the patient has not taken for some time, duplicates, and obviously erroneous entries should be corrected or removed.

If a nurse or clinician has documented med compliance and there are meds that a patient is not taking, the provider needs to verify with the patient before removing the medication from the medication profile.

DOCUMENT MEDICATIONS BY HISTORY

Documenting historical medications is the first step in reconciling medications. You can view the status of a patient's medication history in the upper-right corner of the Orders window.
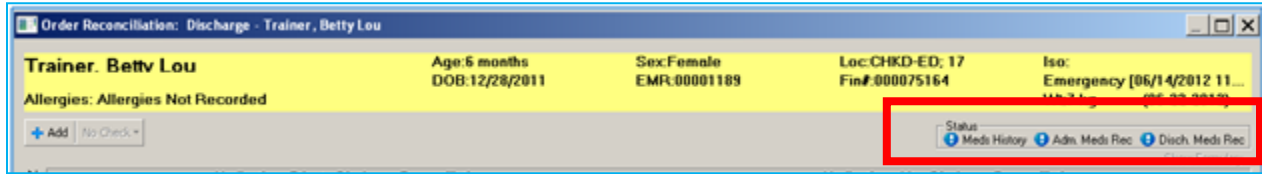
Note: Nursing can reset the Adm. Meds Rec checkmark to signify that more home medications have been added. The medication reconciliation is a continuous process, the Provider should review and complete as needed.

PATIENT WITH HISTORICAL MEDICATIONS

Complete the following steps to document historical medications from the Add Order window:
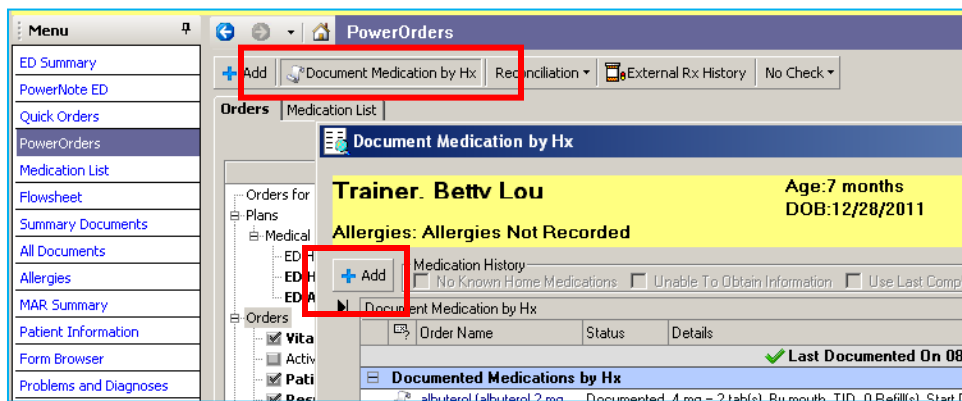
1. From the Orders window, click Document Medications by History
2. Click Add . The Medication Search window opens.
3. Type the name of the medication in the Find box and click Search.
4. Select the medication from the list.
5. Click Done to close the Add Order window.
6. Click the Details tab and enter the order details if known.
7. Click the Compliance tab to select the status and information source. Enter the last dose date and time.
8. Click Document History. The patient's medication history is added to the Medications List in the Order Profile.

Note: You can also document historical medications by clicking Document Historical Medications from the Orders component as described below.

NO KNOWN HOME MEDICATIONS - If there is no known home medication history for the patient, select the No Known Home Medications option. This is displayed in the Medication

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History view as No Known Home Medications, along with the name of the user that documented the information and the date and time it was documented.

UNABLE TO OBTAIN INFORMATION - If you are not able to obtain the patient's medication history, select the Unable to Obtain Information option. This is displayed in the Medication History view as unable to Obtain, along with the name of the user that documented the information and the date and time it was documented.

USE LAST COMPLIANCE - If there are qualifying medication orders, prescriptions, documented medications, or all of the above, and the medication history is not in a completed status, you can document these as Use Last Compliance. When this option is selected, each medication order, prescription, and documented medication use the compliance information that was most recently documented.

LEAVE MEDICATION HISTORY AS INCOMPLETE - This option allows you to sign medication history orders or compliance you have documented while leaving the status as Incomplete.

PRESCRIPTIONS

Prescriptions can be entered directly into PowerChart either prior to or during the Depart Process.

1. Click Add

2. The add order window will appear.

3. Notice that while in the Depart Process the Type will display Prescription

4. Search for the prescription using the first few letters of the name in the search field

5. Click on the prescription name

6. In the order sentence window, select the most appropriate sentence, or click None.

7. Click OK.

8. Continue adding prescriptions, as necessary. .

9. Review the order details for accuracy.

PRESCRIPTION ROUTING FOR PHARMACY

To find the correct pharmacy, indicate the pharmacy name, city, or zip code and click search.

Click the correct pharmacy and then click OK when done.

You can specify a preferred pharmacy by right-clicking and selecting ADD in the Prescription Routing window.

Once a preferred pharmacy is added, it will be available for future prescriptions by clicking on the preferred tab.

1. Click Sign to submit the order. If this is an order that is being submitted to the pharmacy electronically, the sign option will generate the request to the pharmacy.

2. Click refresh to update the screen and reflect the correct status of the order.

TIPS AND TRICKS:

Depending on the drug class, the system will not the electronic functionality. These drug types have to be manually entered and printed out of the system via Secure Printing.

ADMISSION RECONCILIATION

Admission Reconciliation cannot be completed until Document Medications by history has been completed. It can be completed by adding Home Medications or by selecting the No Known Home Medications box, or the Unable to obtain Information box.

Reconciling the medications on admission displays the following orders:

- All active, historical, and prescription orders across the current patient encounter if applicable
- All active inpatient orders across the current patient encounter if applicable.
- All active and previously active medication order from the past 24 hours

Note: All medications selected in yellow are required to be reconciled.

To reconcile these medications:

1. Click Med Rec.

2. Select the appropriate reconciliation action.
   You can select Continue After Discharge, Create New RX or Do Not Continue After. When continuing the use of a home medication ( ), you may be prompted to select an available alternative. Select the appropriate available alternative.

3. Edit details as needed.

4. When all medications have been addressed, click Reconcile and Sign.

MEDICATION COMPLIANCE

Compliance information should be added to all of the home meds listed in your patients chart if the information is available.

To document medication compliance:

1. Click Document Medication by history Review documented compliance for history.

2. Within Document Medication by history window, right-click medication and select.

3. Add/Modify Compliance.
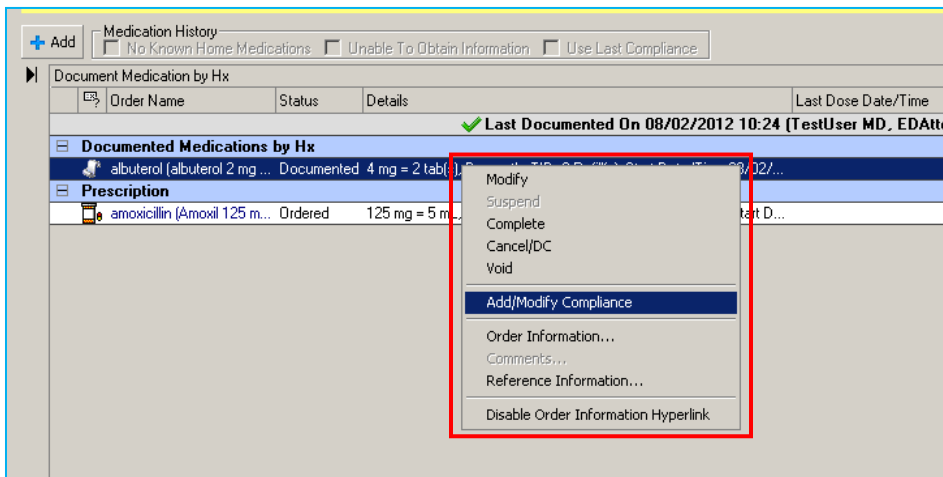
4. Select an option from the list of Status.

5. Select an option from the list of Information Source.
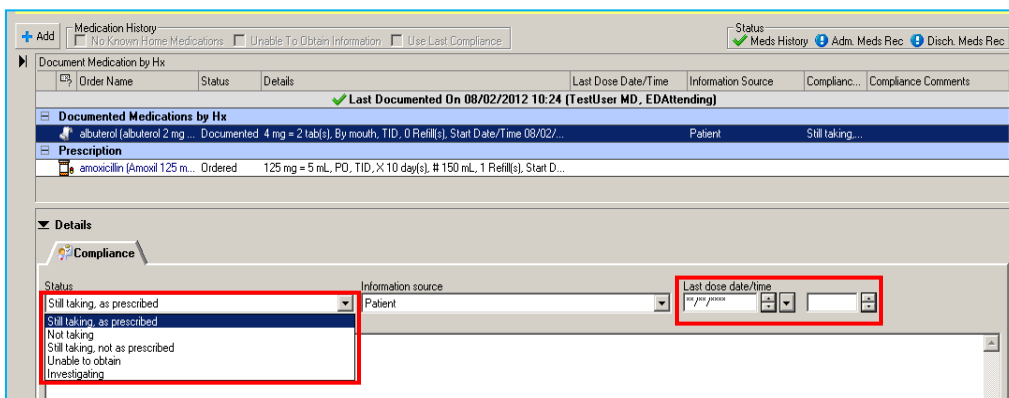
6. Enter the last dose date/time in the Last Dose Date/Time box.
7. If the patient is not taking the medication as prescribed, enter a comment.
8. Describing how they actually taking the drug in the Comment box.
9. Click Sign at the bottom of the window.

OUTSTANDING EVENTS

Completing the Outstanding Events Section

The Outstanding Event section is where you can review any outstanding events for the patient before they are discharged or admitted to the hospital.

Note: Any Outstanding Events will be completed by the resident, nurse or any other clinician. NOT the physician.

To review the Outstanding Events complete the following steps:

- Select the icon next to Outstanding Events.

- This will open the Outstanding Events window.

  The Outstanding Events window will display all events that need to be completed for the patient.

- Review the Outstanding Events.
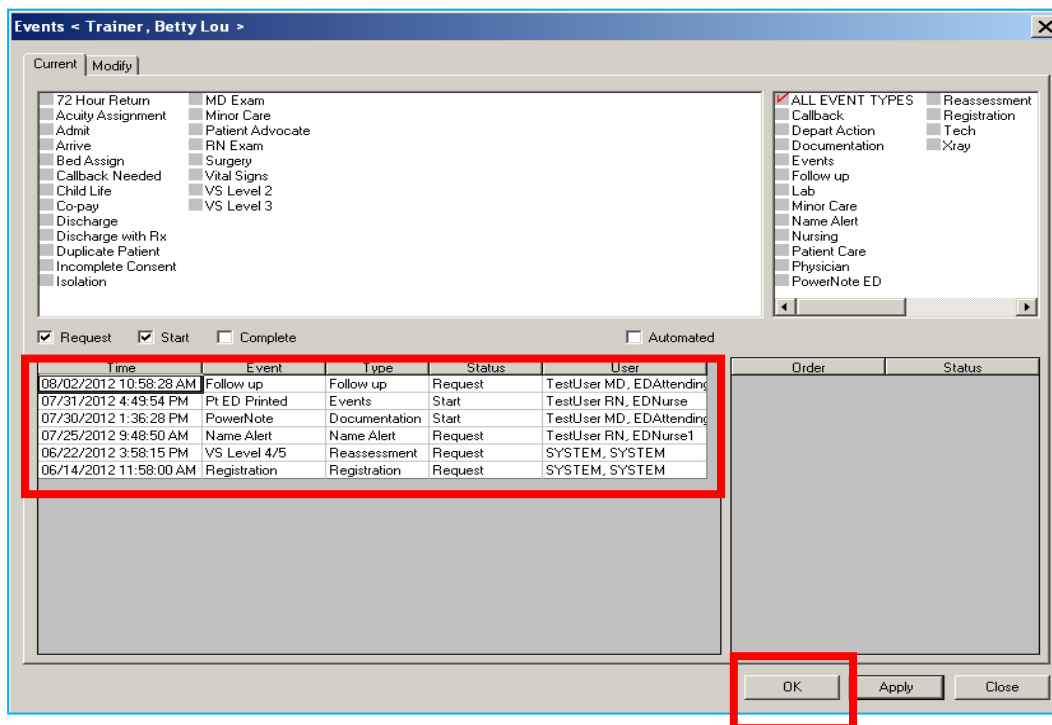
- Once the Outstanding Events are reviewed select OK.

  Note: Any Outstanding Events will be completed by the resident, nurse or any other clinician. NOT the physician.

COMPLETING THE DISCHARGE

Completing this section will notify staff that the depart process has been completed and they can open and print the patient education, deliver it to the patient and begin the process of releasing them from the ED.

DISCHARGE WITH RX SECTION

- If the patient has prescriptions select Discharge with Rx.

- If the patient is ready to be discharged and has not prescription, select Discharge

To complete the Discharge/Discharge Rx, complete the following steps:

Select the icon next to Discharge or Discharge with Rx.

A ☑ will now appear indicating that the patient is ready to be discharged.

**Note: This section should only be completed when the patient is actually ready to be discharged.

A blue book icon will now appear in the Events column on your Tracking List indicating that the patient is ready to be discharged.
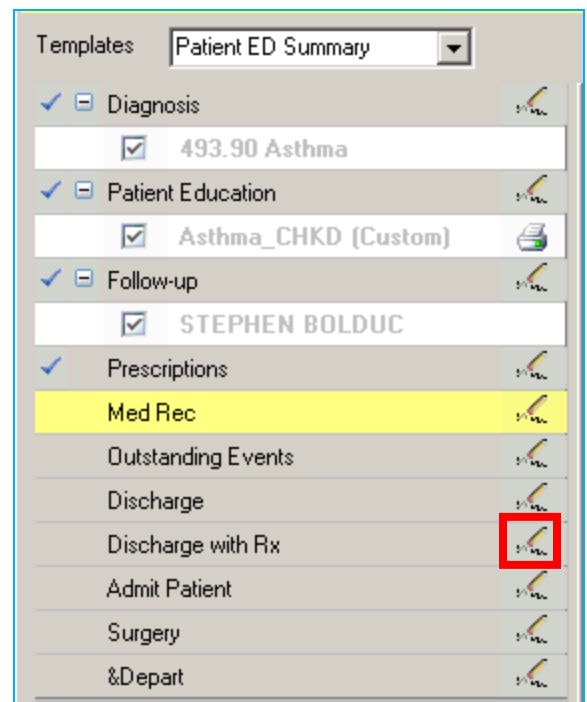
Completing the Admit Patient Section

If the patient needs to be admitted to the hospital, complete the Admit Patient section.

Completing this section will notify staff that the depart process has been completed and then can being the process of getting the patient admitted to the hospital.

To complete the Admit Patient section, complete the following steps:

Select the icon next to Admit Patient.

A ☑ will now appear indicating that the patient is ready to be admitted.

**Note: This section should only be completed when the patient is actually ready to be admitted.

A building icon will now appear in the Events column on your Tracking List indicating that the patient is ready to be admitted.
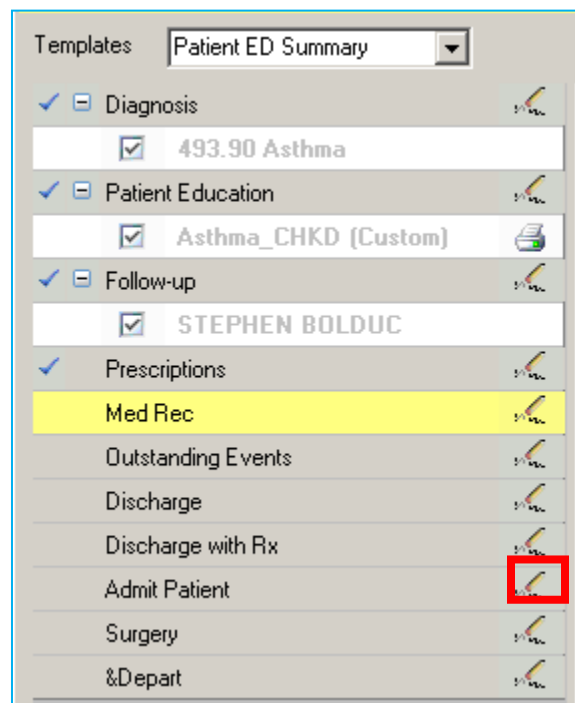
Completing the Surgery Section

If the patient needs to be admitted to the Surgery department, complete the Surgery section.

Completing this section will notify staff that the patient will be going to surgery and they can start the necessary preparations.

To complete the Surgery section, complete the following steps:

Select the icon next to Surgery.

A scissor icon will now appear in the Events column on your Tracking List indicating that the patient is ready to go to surgery.
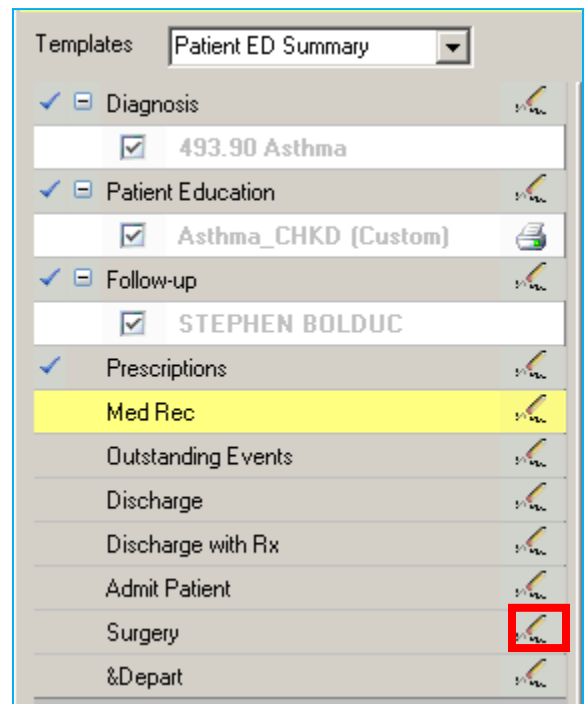
THE &DEPART SECTION

Once all steps in the Depart Process are complete, you are able to depart the patient either to another department in the hospital or home.

To complete the Depart Process, complete the following steps:

- To depart the patient, select the icon next to &Depart.

- The Disposition window will appear.

- Select the Disposition by clicking on the down arrow

- Selecting the corresponding discharge disposition.

- Select Ok.

- Select Save at the bottom of the Depart window.

This will close the depart window and take you back to your tracking lists.

If trying to discharge without completion of required actions the following message will pop up requiring you to select a reasons for the missing actions. Once completed the Set disposition Window will diplay.

Clicking in the Reasons window will display a listing of reasons to select from.
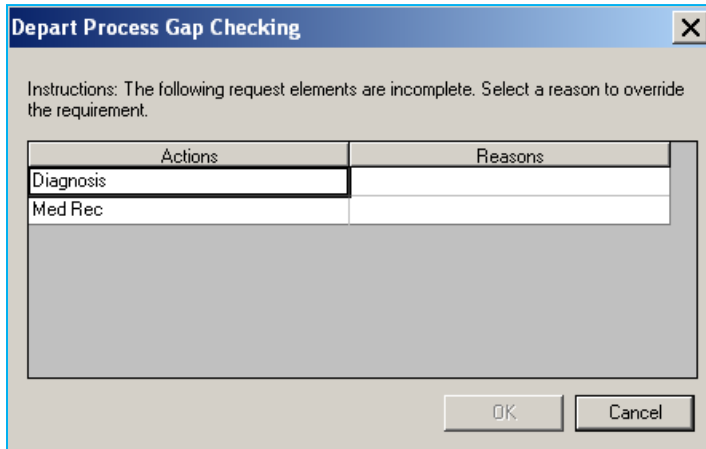
When the patient is ready to leave the ED and the Depart Process is complete, the patient will display

 on the Checkout tab.

A blue notebook will appear in the Events Not Completed column indicating that the patient is ready to be discharged with no prescriptions. If the patient *does* have prescriptions, a Rx icon will appear.

**Note: If the patient was registered in CHKD-Fast Track, the patient will display on the MC Checkout tab.

Note: The patient MUST be discharged in Eclipsys!!

The Depart Process will not be complete until the patient is discharged in Eclipsys.   Once the patient is physically ready to be discharged from the ED, they must be discharged in Eclipsys. The Depart Process will not be complete until this is completed! When they are discharged in Eclipsys, the patient will be removed from the Checkout Tab of the Tracking List.

A member of the registration staff performs patient discharge via Eclipsys.

APPENDIX A: DOWNTIME POLICY

For the most up-to-date copy of the Downtime Procedure for entering Patient Assessment and Medication Administration Data into the Electronic Medical Record (EMR) go to:

Children's Hospital of The King's Daughters Health System

NURSING POLICY/PROCEDURE/COMPETENCY

Individuals Reviewing Policy:

Policy No.: 105-04-ND.04.1

Marti Bevan, RN

Director, Nursing Informatics

Effective Date:07/22/11

H. Brent Loftis, RN MSCIT

Director, IS Applications

Previous Revision: New

Shelly Gilson, RN

Chairperson
Deborah Hardway, BSN, RN

Patient Care Services Director

Jo-Ann Burke, MBA, BSN, RN

Vice President, Patient Care Services

Dates Reviewed:

SUBJECT: **DOWNTIME, PROCEDURE FOR ENTERING PATIENT ASSESSMENT AND MEDICATION ADMINISTRATION DATA INTO THE ELECTRONIC MEDICAL RECORD (EMR)**

POLICY: A structured manual process is used by nursing and respiratory therapy staff for charting assessment data and medication administration during scheduled maintenance downtime or unexpected computer system downtimes. When computer systems return to operational status nursing and respiratory therapy staff are responsible for ensuring that appropriate data is entered into the computer system in a timely manner.

DEFINITIONS: Downtime is defined as any period of time, scheduled or unscheduled, during which the Cerner PowerChart System is unavailable for use by nursing staff.

Downtime Level Definitions:

Level One: Downtime that lasts less than 4 hours

Level Two: Downtime that lasts 4 hours or more

PROCEDURE:

Types of Downtime:

A. Scheduled Downtime

1. In the event of a scheduled downtime of the PowerChart System the Information Systems (I.S.) Department notifies all system users of the planned date, time and estimated level of the downtime (see definitions above). This information is communicated to all users via e-mail communication at least two weeks before the scheduled downtime is to occur.

2. A follow-up communication to remind staff of the scheduled downtime occurs one week prior to and the day of the scheduled downtime. This information is communicated to all users via e-mail communication.

3. I.S. makes every attempt to schedule downtime during off-peak business hours (i.e. weekends, overnight hours).

B. Unscheduled Downtime

1. In the event of an unscheduled downtime of the PowerChart System the I.S. Department communicates the downtime information to Nursing and Respiratory Therapy Staff via an overhead announcement in the Main Hospital which states the estimated level of the downtime if currently known (see definitions above) and e-mail communication if available. Off-site locations are notified of the unscheduled downtime via phone call or text-page to Nursing Management at that location.

2. Updates are provided if the downtime level is increased as soon as that information becomes available. These updates are provided via overhead announcement in the Main Hospital and by calling or paging nursing management at off-site locations.

3. When the system becomes accessible once again an overhead announcement is made in the Main Hospital and e-mail communication is sent to all nursing and respiratory therapy staff members. The operator announces "Level ___ downtime is now resolved. The Cerner PowerChart system is fully operational."

Nursing Responsibilities:

1. Nursing and respiratory therapy staff are notified of downtime (scheduled or unscheduled) by I.S. The unit charge nurse and charge respiratory therapist on duty obtain the "Downtime Documentation Packets" available on the unit. This packet contains up-to-date paper documentation forms that the unit nurse and respiratory therapists need immediately to ensure there is no interruption to the provision of care. On most units this consists of the appropriate unit Flow Sheet and Supplemental Nursing Notes Sheets for nurses and Respiratory Flow Sheets for respiratory therapy staff. Those forms that are unit specific are also available on an as needed basis.

2. The charge nurse and charge respiratory therapist distribute a packet of paper documentation forms to each nurse and respiratory therapist on the unit. These paper documentation sets include the following forms per unit (listed in **bold** for nursing):

TCU	**TCU Nursing Flow Sheet, Supplemental Nursing Notes Sheets**
NICU	**NICU Flow Sheet, Supplemental Nursing Notes Sheets**
NSDU/7D	**NICU Flow Sheet, Supplemental Nursing Notes Sheets**
PICU	**Pediatric Critical Care Flow Sheet, Supplemental Nursing Notes Sheets**
7B	**Inpatient Rehabilitation Nursing Flow Sheet, Supplemental Nursing Notes Sheets** Also available: Inpatient Rehabilitation Unit Guidelines of Care, Nursing Goal Status Sheet (Progress)- Rehabilitation Goals, Weekly Team Rounds Nursing Progress Report
7C	**General Care Flow Sheet, Supplemental Nursing Notes Sheets** Also available: Evening Shift Nursing Burn Care Note

7H	**Outpatient Flow Sheet, Supplemental Nursing Notes Sheets**
8B	**General Care Flow Sheet, Supplemental Nursing Notes Sheets, CVL Flow Sheet**
8C	**General Care Flow Sheet, Supplemental Nursing Notes Sheets**
CCBDC	**CCBDC Flow Sheet, CCBDC Additional Notes/Doctors' Orders Sheets.** Also available: Bleeding Disorders Center Nursing Documentation Sheet
Kidney Center	**Hemodialysis Flowsheet, Hemodialysis Supplemental Flowsheet, Prisma/Prismaflex Flowsheet (pgs. 1 and 2)** Also available: Manual Peritoneal Dialysis Flow Sheet,
ED	**ED Flow Sheet, ED Supplemental Flow Sheet** Also available: P-BRAT Tool, ED Asthma Therapy Flow Sheet, ED Adult Chest Pain Orders, ED Pre-Op/Procedure Nursing Plan of Care
PACU/Day Surgery	<u>Pre-Op</u>: **Surgical Services/Cardiac Cath Lab Checklist, Pre-Anesthesia Evaluation Form** <u>Post-Op</u>: **PACU Flowsheet, Peri-Anesthesia Medication Administration Record, Outpatient Medication Reconciliation Form**
Respiratory Therapy	**Respiratory Flow Sheet**
Supplemental Forms (Available on Units on an as Needed	• Bereavement Checklist • Bronchiolitis Flow Sheet • Calorie Count Flow Sheet • CVL Flow Sheet • Child/Infant Neuro Flow Sheet

Basis)	- Diabetic Flow Sheet - Diabetic Ketoacidosis Flow Sheet - Interdisciplinary Admission Database - IV Infiltration/Extravasations Flow Sheet - Laboratory Downtime Forms - Neonatal Interdisciplinary Admission Database - Neurology Flow Sheet - Neurovascular Assessment Flow Sheet - Nursing Orders for Screening - Nursing/Pharmacy Communication Form - Respiratory Flow Sheet - Respiratory Flow Sheet- Asthma Pathway - Restraint Flow Sheet - Seizure Flow Sheet - Skin Breakdown Flow Sheet - Suicide Precautions/Close Watch Flow Sheet

3. Supplemental documentation forms (see list above) are also available as appropriate for each unit. Staff nurses and respiratory therapists on each unit are responsible for obtaining the additional supplemental documentation forms as needed on a per patient basis.

4. Information Services is responsible for printing active Medication Administration Records (MAR), Last Dose Medication Lists (24 hours) and up-to-date order lists for all patients. These paper MARs, Last Dose Medication Lists (24 hours) and Current Order lists are then delivered to the charge nurse on the appropriate units by the staff in the 6th floor Data Center and I.S. staff. The charge nurse is responsible for distribution of the MARs, Last Dose Medication Lists (24 hours) and order lists to unit staff nurses.

5. Nursing staff are responsible for adding a downtime notation to the orders section of the patient's paper chart. **The notation states that a downtime began at a particular time and date and is signed by the nurse assigned to the patient.** This notation reminds nursing staff to enter orders into the system when the Electronic Medical Record returns to operational status

6. All new medication orders that are written during the downtime are transcribed onto the paper MAR provided to staff nurses by I.S. Staff. These entries are written in the same format as the printed medication orders already on the form.

7. Nursing staff and respiratory therapy staff use paper documentation forms to record all necessary patient care information until the Electronic Medical Record returns to operational status. Paper forms are accurately completed and become a permanent part of the patient's medical record. All new orders received during the downtime are transcribed onto the paper order lists provided by I.S. This ensures that all order lists remain

current and up-to-date and serves as a tool for order entry when the system is restored to operational status. Any orders previously recorded in the patient's chart that were not entered into the PowerChart system prior to the downtime are noted in order to provide an easy reference for order entry when the system again becomes operational. These orders also are transcribed onto the paper order list provided by I.S.

8. When the Electronic Medical Record functionality is restored I.S. communicates this information to nursing staff and respiratory therapy staff as stated above. Upon resolution of the downtime nursing staff are responsible for entering specific patient information into the Cerner PowerChart system according to the Level of downtime experienced. Once this information is entered the staff nurse reviews all of the information entered into the PowerChart system and verifies its accuracy with the paper documentation.

    a. **Level One**: Nursing Staff enters all information collected during the downtime (i.e. assessment data, vital signs recorded, medications given, interdisciplinary admission database, new orders received, etc.) into the PowerChart system for each patient assigned to them. <u>All assigned nursing tasks completed during the downtime are documented with the actual time of completion.</u>

      Respiratory Therapy Staff are responsible for entering all information collected during the downtime (i.e. medications given, treatments performed) into the PowerChart system for each patient assigned to them. <u>All assigned respiratory therapy tasks completed during the downtime are documented with the actual time of completion.</u>

    b. **Level Two**:

      Nursing Staff enters the following information obtained during downtime for each assigned patient:

- last set of vital signs
- any new height or weight measurements
- any new allergy information
- any new ongoing orders
- any new medication orders (orders must be scanned to pharmacy)
- interdisciplinary admission database/neonatal interdisciplinary admission database form (for patients who were admitted during downtime)
- all medications given during the downtime period on the MAR.

Respiratory Therapy Staff enters the following information obtained during downtime for each assigned patient:

● any new ongoing orders

● any new medication orders (orders must be scanned to

pharmacy)

● all medications given during the downtime period on the   MAR.

NOTES:

- **Nurses and respiratory therapists must be mindful to change the current system default time of medication administration and tasks listed in the Power Chart system to document the actual time the medication was given or the task was completed.**

- **One time only non-medication orders are <u>not</u> entered into the PowerChart system if the orders were obtained and completed during the downtime.**

    9. Nursing staff must write a note in each patient's chart in the "Inpatient Care Notes" section noting that a downtime occurred and the length of the downtime (i.e. System downtime occurred from 2400-0400).

    10. All paper documentation used during the downtime is sent to Medical Records for inclusion in the patient's permanent medical record. The paper order list provided by I.S. is the only document that is not sent to Medical Records- it is a reference tool for the staff nurse and respiratory therapist only, and not a permanent part of the patient's medical record.

    11. Nursing staff and respiratory therapy staff resume documentation within the Cerner PowerChart Electronic Medical Record immediately upon resolution of downtime. Paper documentation is discontinued when the PowerChart system is available.

<u>**Special Circumstance:**</u> Downtime occurs during a shift change:

- The nursing staff and respiratory therapy staff who relinquish patient care are responsible for ensuring that all paper documentation is completed the end of their shift.

- The nursing staff and respiratory therapy staff who assume patient care are responsible for documenting certain data collected by the nursing staff and respiratory therapy staff from the previous shift when the Cerner PowerChart system is once again operational. This documentation includes:

    1. Any new height, weight or allergy information obtained during the downtime. (Nursing)

    2. All medications given during the downtime. (Nursing and Respiratory)

3. An Interdisciplinary Admission Database or Neonatal Interdisciplinary Admission Database for any patients admitted during the downtime. (Nursing)

- The nursing staff and respiratory therapy staff who assume care of the patient ensure the EMR reflects the correct time for data collection. Entries on the MAR must be corrected for the time that the medication was actually given and for the staff nurse or respiratory therapy staff who administered the medication (corrected within the "Performed By" section of the administration record).

APPENDIX B: DOWNTIME PROCESS – EMERGENCY DEPARTMENT

For new patient arrivals, the emergency room staff will agree on a set time prior to the planned downtime to start the paper process (i.e. for a planned downtime at midnight, staff will agree to initiate paper documentation for any new patients arriving after 2330). This will allow support staff the opportunity to print the appropriate reports for existing patients.

- Pertinent patient information will be printed and distributed prior to downtime (outstanding orders, tasks, meds)

- During downtime

- RN staff will utilize normal paper process for documentation of care, meds, etc.

- Any new orders prescribed during downtime will be written on paper

- **All patient care documentation related to orders written on paper (or electronic orders not completed prior to the downtime) will be documented on paper (see additional information below for medication documentation)**

- Upon completion of the downtime (for patients still present in the E.D.)
  - o All paper documentation will be scanned in to the medical record (will be available in forms browser)

  - o Nursing will enter an ED Nurse Note to signify when the downtime started and when downtime was complete (this is necessary so caregivers know to look in forms browser for any pertinent documentation occurring during the downtime)

  - o Any <u>new orders</u> will be entered in the EMR

  - o RN staff will resume documentation electronically

  - o **Pharmacy will <u>back enter medication orders</u> written during downtime and nurses will need to document in the EMR to satisfy the med tasks**
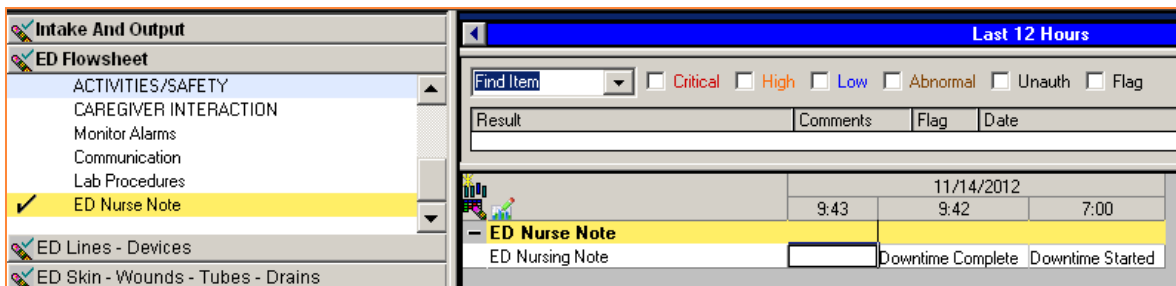
APPENDIX C – TAP & GO

Tap & Go Authentication leverages Proximity Cards for advanced authentication. This technology provides quick access to caregivers to allow you to log on by entering your username and password <u>once</u> at the beginning of your shift. After your initial log in for the day, you can use your proximity card to tap into any Zero Client in your work area to instantly gain access to the clinical patient information needed. Tap & Go Authentication is also referred to as Instant Access or Single Sign On (SSO).

To start using Tap & Go, you must register your Proximity Card (employee identification badge). Once the card is registered, you can use it to tap into a Zero Client in your work area and access patient information without needing to re-enter your password each time.   When you have finished, simply tap the card again on the badge reader to disconnect from the Zero Client.

STEPS TO REGISTER A PROXIMITY IDENTIFICATION BADGE

1. Click on Prox Card at the bottom of the window
2. Tap your ID badge on the Card Reader

3. Select the option to **Enroll this card now**
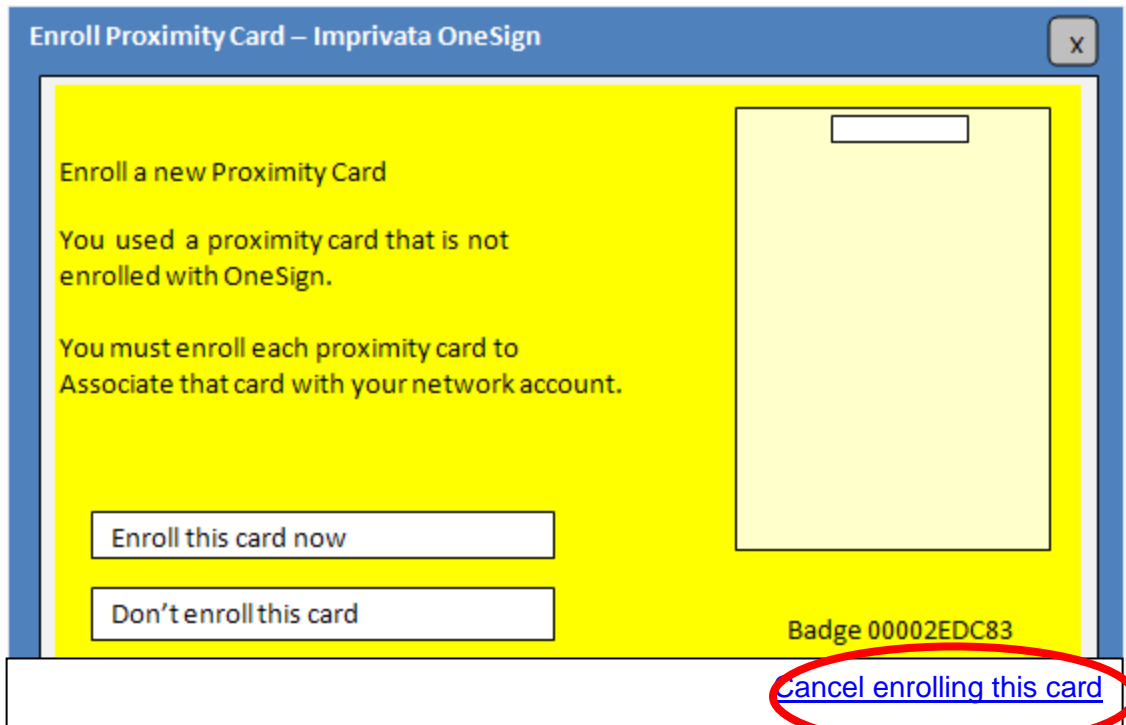
- You can cancel the enrollment of the card by clicking on the hyperlink (circled) in the lower right corner of the screen.

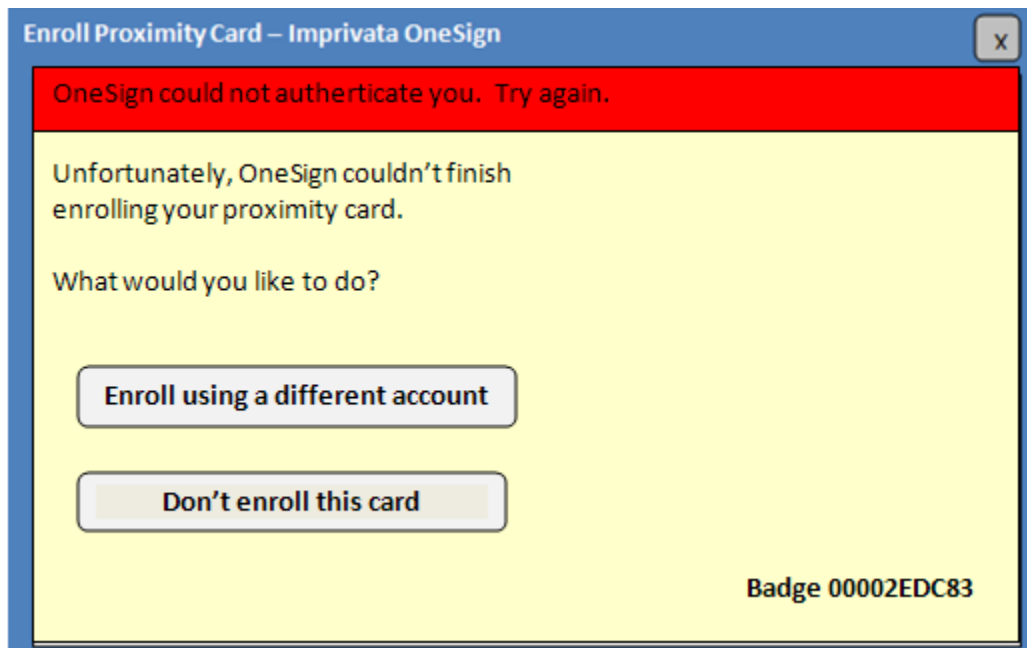4. Enter your network **username** and **password**:

Note: This is the same password you use to log into API or your email.

5. Click **Next**
6. Enter **your password** to proceed with logging in.   The user name field will be dithered (grayed) out with your user name displayed. Once your password is entered, you will be able to access the system as usual.

Enroll Proximity Card – Imprivata OneSign   [X]

Great job! You proximity card has been successfully been enrolled in OneSign. You can use the card to sign in and out of your workstation.

Click **Done** to go to your desktop.

[**Done**]

Badge 00002EDC83
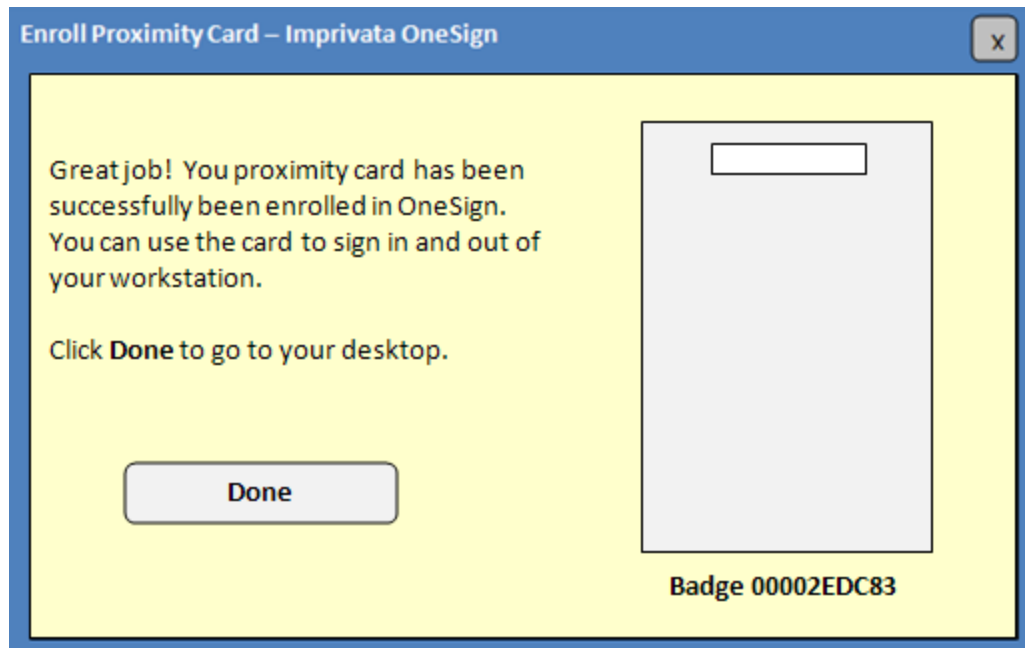
Important Note:

The follow message will display if the enrollment process cannot be completed:
You can select the option to "Enroll using a different account"; this action will restart the process.

Enroll Proximity Card – Imprivata OneSign   [X]

OneSign could not authenticate you. Try again.

Unfortunately, OneSign couldn't finish enrolling your proximity card.

What would you like to do?

[**Enroll using a different account**]

[**Don't enroll this card**]

Badge 00002EDC83

ONESIGN SECURITY QUESTIONS

When you access the Zero Client desktop, you will be prompted to set up personal security questions.

1. To proceed with this step, click the **Set up questions now** button. **If you select the option "ask me again later"; you will be prompted each time you log in until this step is completed**.

2. Select and **answer Personal Security Questions:**

You can choose from a list of questions by clicking on the down arrow; type your response in the space available to the right of each question.
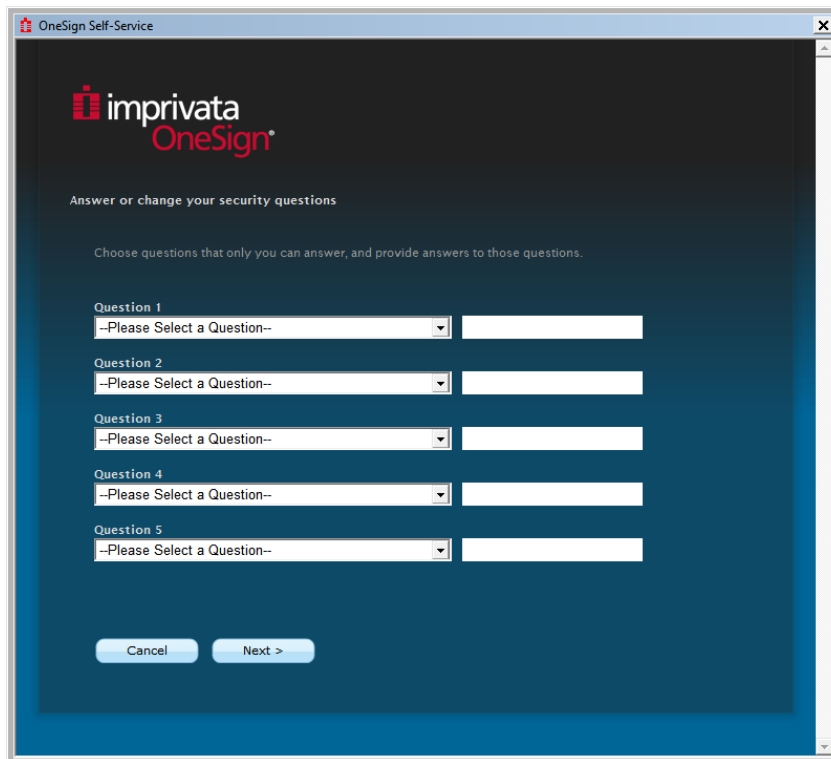
3. Click **Next** to complete registering your personal security questions.
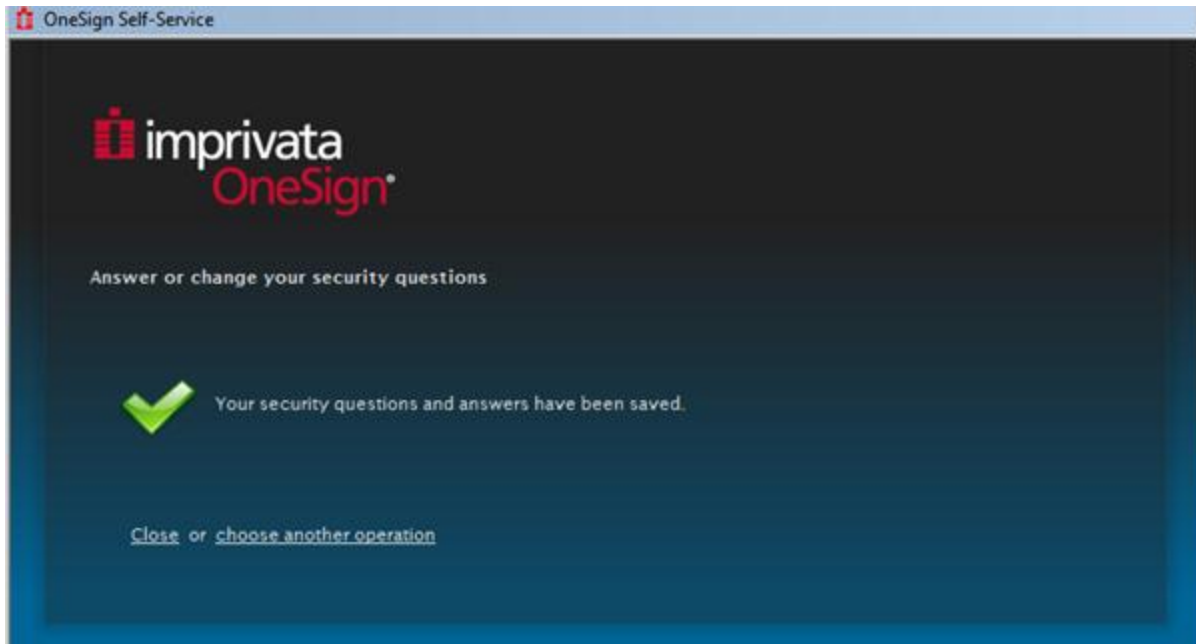
4. Click **Close** to complete the process.

ZERO CLIENT - AUTOMATIC LOCK

Tap & Go is configured so that the Zero Client will automatically lock if it has been sitting idle for **15 minutes** or more without any activity. When this happens; the screen will display the steps to "unlock" the computer as well as the name of the person that was logged on when the computer automatically locked.

To log back into the Zero client, you must first press **CTRL + ALT + DELETE** to unlock the computer; you can then use your proximity card to log back in.   If you are different user; you will be required to restart the computer. **Any unsaved data by the "logged in user" will be lost**.

Sample message:

> ***Press CTRL + ALT + DELETE to unlock this computer***
>
> *Jones, Jessie (CHKD) is logged on*

DAILY LOG IN AND GRACE PERIOD

With Tap & Go, you can use your CHKD ID badge for identification and then enter a password to log in. Once authenticated, a "grace period" is established during which the caregiver can subsequently log on to the Zero Client or any other Zero Client simply by tapping a badge on the card reader.

The first time you "tap in" each day, you will need to enter your password if it has been more than eight hours since you last authenticated by entering your log in credentials. Once your log in credentials (username and password) is entered, the system provides you an 8-hour grace period. The grace period represents the time period where you will be able to use instant access to tap in and out of the Zero Client without re-entering your password.

Once you reach the expiration of the grace period, you simply need to re-enter your password to initiate a new grace period.

Remember, the duration of the grace period set at CHKDHS is 8 hours.

FREQUENTLY ASKED QUESTIONS

1. **Is Tap & Go set up to work on PC's too?**
   No, at this time it is only set up to work on Zero Clients.

2. **With Tap & Go, do I ever need to enter my password after I register my proximity card?**
   Yes, **the first time you log into the system each day,** you will need to enter your password. Once you tap in, the log in screen will appear with your username dithered (grayed) out. Click in the password field to authenticate to the server and begin accessing the system.

3. **What is a "Grace Period" and how does it work?**
   At CHKDHS, the "Grace Period" is the length of time that the user can be logged into the computer and not have to enter their password. Remember, the "Grace" period is **8 hours**.

4. **What should I do if I have lost my proximity badge?**
   It must be reported as soon as possible to the **Information Services Help Desk** to prevent unauthorized access to the system.

5. **Can I still log in without my proximity badge?**
   Yes; you will need to enter your log in credentials in the username and password fields.

6. **What if I come up to a workstation and the username is dithered with another user's name displayed, what should I do?**

   To use the workstation, you must first **click Cancel** to request a new desktop before you are able to access the workstation using Instant Access. Once you click Cancel, you can tap your proximity badge on the card reader to proceed to log in.

7. **What if I don't answer the personal security questions?**

   You will continue to be prompted to answer them each time you log into the Zero Client. Once the questions are answered, you will not be prompted again.

8. **How log does it take before the Zero Client automatically locks from inactivity?**

   Fifteen **(15) minutes**.

TAP & GO / ZERO CLIENT QUICK REFERENCE TIPS

If you…	Then…
Need to register a new proximity badge	**Tap the un-registered badge on the card reader and follow the screen prompts (steps 1-5 in this guide).**
Lost your proximity badge	**Report it immediately to the IS Help Desk**
Need to walk away from the workstation	**Tap your badge on the card reader to disconnect or press the <F4> key; you can also click on the disconnect icon on the desktop.**
Are asked to re-register your proximity badge after completing the process	**Call the IS Help Desk and report the badge number displayed on the screen.**
Need to log into a workstation that does not have a badge reader to use PowerChart	**Enter your login credentials for the application**

Confirm Zero Client Configurations:

- **Click on Options in the upper left corner of the screen**
- **Select Information menu option; ensure firmware version is 3.5.1**
- **Select the Configuration menu option; select the Session tab**

Important Reminder:
If for any reason a user cannot use their Proximity Card to log in/out; **staff can still sign in manually by entering th**eir UserName and Password on the log in screen.

Configure the Session tab – *To Connection to a Peer Device*

 Connection Type: View Connection Server + Imprivata OneSign™
 Bootstrap URL: https://onesignprod1.chkd.net

APPENDEX D: ORDER REFUSAL / REJECTION PROCESS

Below are the steps on what the process / flow is for orders that are refused by physicians.

This ONLY APPLIES TO ORDERS WITH AN ORDER TYPE OF "Verbal Read Back", "Phone Read Back", and "Protocol / Standing Order."

Physician A (TestUserMD, ED Attending) will see an order for signature in their inbox.
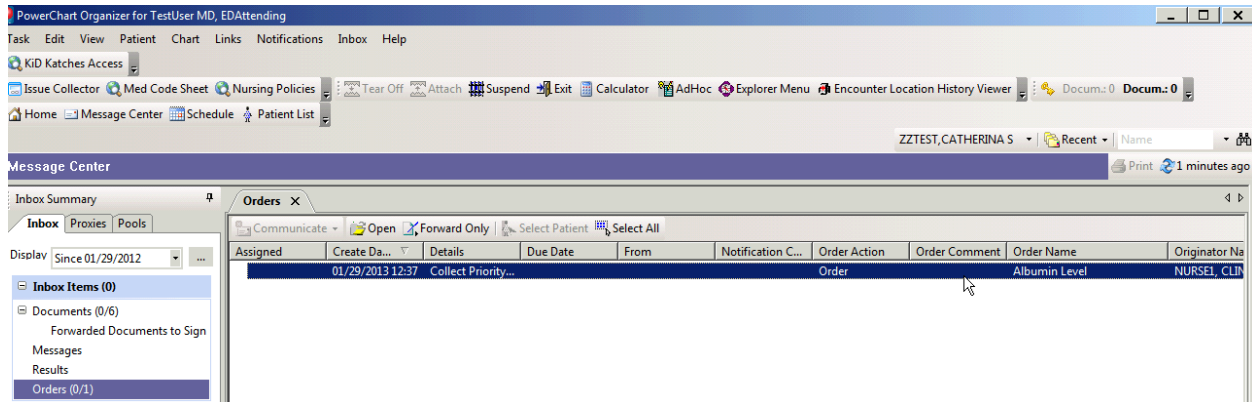
Once they open the order for signature, they will have the ability to either sign (Approve is defaulted) or refuse the order. In this case, we want Physician A to "Refuse" the order. After selecting the Refuse radio button, the physician will be required to select a reason (this is required, can be made optional).
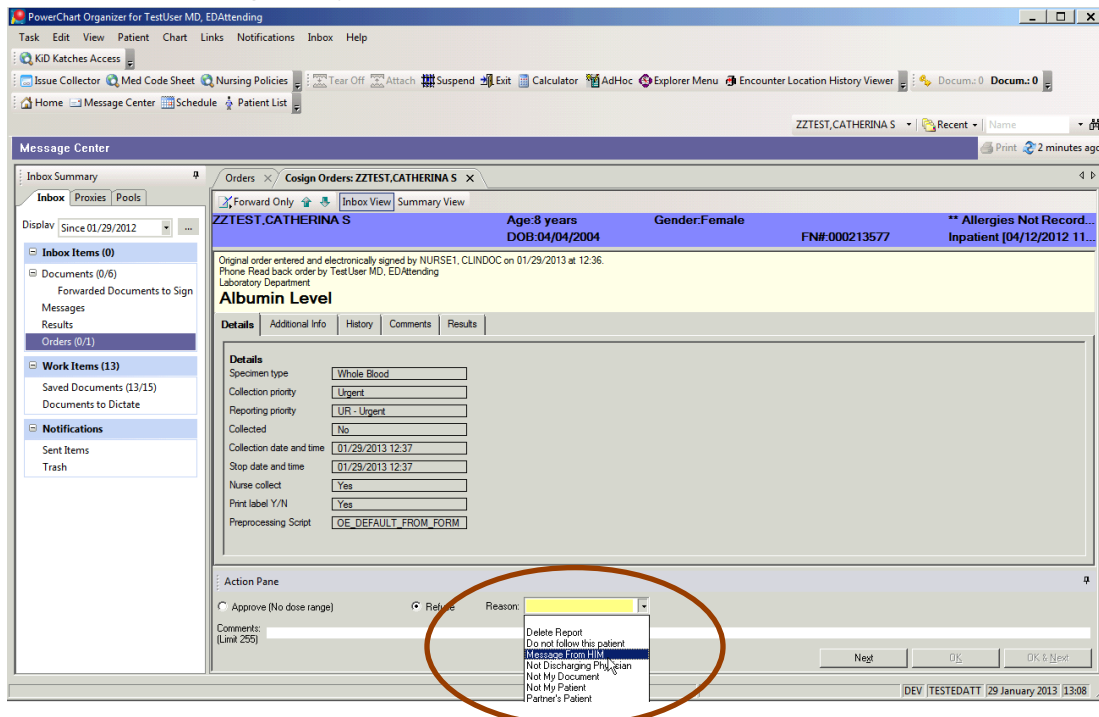
Note that the "Ok" and "Ok & Next" buttons are dithered out until a reason is selected in the dropdown. The Physician can also add comments in the line below. After selecting a reason and adding any comments, the physician will click either "Ok" or "Ok & Next" (clicking "Ok" will just keep you on the current screen after refusing, "Ok & Next" will refuse the order and move to the next item in the inbox).

In the HIM REFUSED, ORDERS inbox, any orders that have been refused will appear. This will be the same for users who are set up as a proxy as well for this inbox. The refusal reason is listed under "Notification Comment."

Refusal Reason

When a proxy opens one of the orders, you can look at the History and see that the order was refused by Physician A. Any comments that the refusing physician enters will be shown under "History."

With the order selected, when "Forward Only" is clicked, a box will pop up allowing you to enter Physician B's inbox (In this instance TestUser, EDAttending3) who should approve the order. HIM will have the ability to also enter comments in the field below. Once you have entered in the physician and any needed comments, clicking "Ok" will send the order to Physician B.

When "Physician B" logs into PowerChart, they will see the forwarded order there from HIM REFUSED, ORDERS. Comments from HIM will display under "Notification Comment."
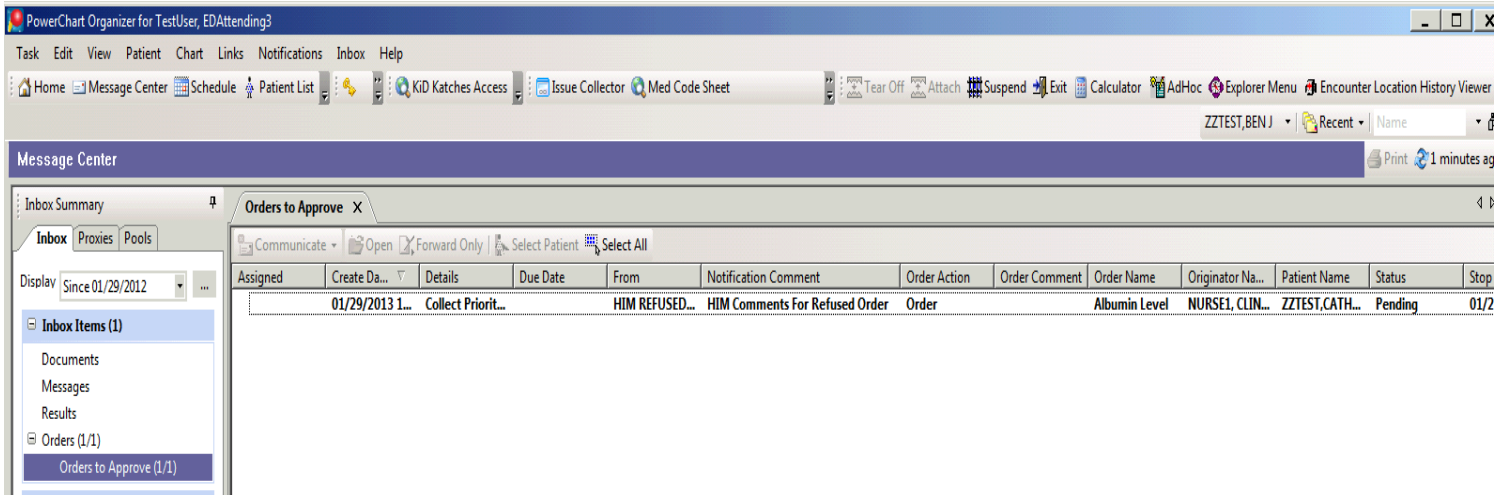
Once the order is opened, by clicking "History" they can see that Physician A refused the order along with any comments from Physician A or HIM
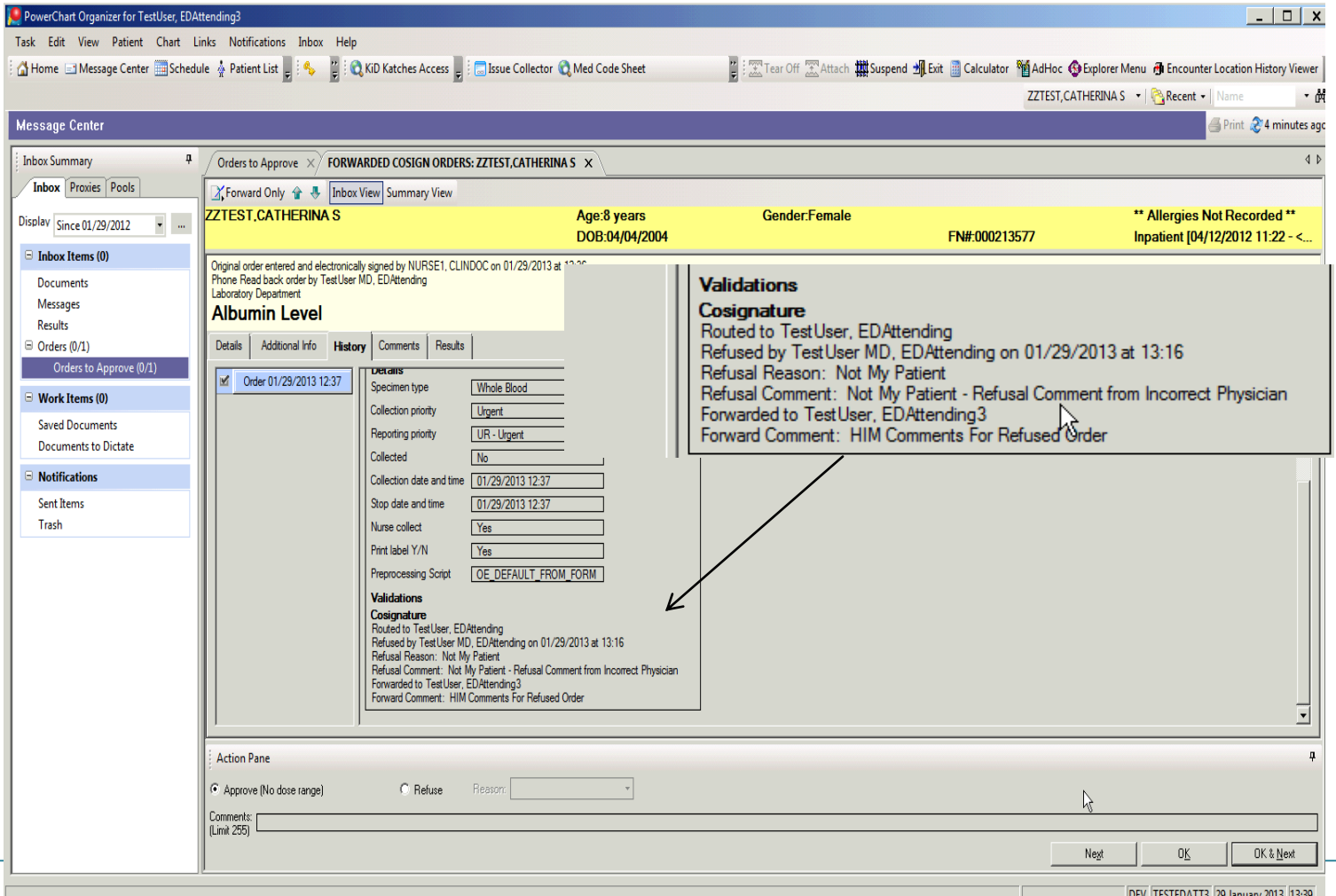
Physician B can now sign the order if it is correct by clicking "Ok" or "Ok & Next.".