# Table of Contents

**PowerChart Navigation**

- Accessing the Electronic Medical Record (EMR) .................................................. 8
- Patient Privacy ........................................................................................................... 8
- Citrix Icon and Access ............................................................................................ 9
- Log into the Citrix Application ................................................................................ 9
- Accessing the EMR Remotely .................................................................................. 10
- Opening the Electronic Medical Record (EMR) ....................................................... 10
- Log In Screen for the EMR ...................................................................................... 11
- Toolbars for the PowerChart Organizer .................................................................. 11
- The Home EMR Screen ............................................................................................ 12
- Setting Outpatient Schedule Preferences .................................................................. 13
- Customized Schedule View ...................................................................................... 14
- Searching for Additional Clinic Schedules ............................................................... 14
- Opening an Outpatient Chart .................................................................................. 15
- Creating a Location Inpatient Patient List ............................................................... 15
- Creating a Custom Inpatient Patient List .................................................................. 16
- Granting Proxy to a Patient List .............................................................................. 17
- Opening an Inpatient Chart .................................................................................... 17
  - Additional Option for Opening a Patient Chart .................................................... 18
- The Patient Search Window ..................................................................................... 18
- Validate the Patient’s Information and Encounter ............................................... 19
- The Open Patient Chart ......................................................................................... 19
- The Patient Demographic Banner ......................................................................... 20
- The Menu ................................................................................................................. 21
- The Allergy Band .................................................................................................... 21
- The Clinical Notes Band ......................................................................................... 22
Changing Search Criteria ................................................................. 23
The Results and Vitals Band ............................................................... 24
The Radiology Results Band ............................................................... 24
MAR Summary Band .......................................................................... 25
Details from the MAR Summary .......................................................... 25
The Medication List Band ................................................................. 26
The Medication List ............................................................................ 26
The Medication List Details ............................................................... 27
Display Options for the Medication List ............................................. 27
Reference Information Available from the Medication List ............... 28
A Sample of the Medication Reference Information .......................... 28
The Patient Care Summary ............................................................... 29
The Patient Demographics Tab under the Patient Information Band ... 29
The PowerOrders Band .................................................................... 30
The Intake and Output Band ............................................................... 30

**Message Center** ........................................................................ 31

Signing or Reviewing Documents ..................................................... 32
Message Center Signing or Reviewing Documents ............................ 33
Changing Display Date (for documents over 30 days old) .................. 34
Message Center - Refresh ................................................................ 34
Message Center Reviewing or Refusing Results ............................... 35
Message Center Orders to Approve – Cosign ..................................... 36
Orders to Approve – Renewal ............................................................ 37
Message Center Reminders .............................................................. 38

  LOAD ALL ...................................................................................... 38
  REFUSING .................................................................................. 38

**Health Information Management Services (HIMS)** ...................... 39
Medical Records ........................................................................................................... 39
Assigned Deficiencies in Your Message Center .......................................................... 39
Message Center Setting ................................................................................................. 40
Refusing Assigned Deficiencies .................................................................................... 40
Managing Dictation Deficiencies .................................................................................. 41
Editing and Signing Transcribed Documents ............................................................... 41
Signing Scanned Documents ......................................................................................... 42
Error Handling/Refusals ............................................................................................... 42
Principal Documentation Requirements ........................................................................ 43
  ADMISSION .................................................................................................................. 43
  DAILY ........................................................................................................................... 43
  SURGERY .................................................................................................................... 44
  DISCHARGE ................................................................................................................ 44
  AMBULATORY CARE ................................................................................................. 45
PROTECTION OF MEDICAL RECORDS ..................................................................... 45
MAINTAINING RECORD INTEGRITY .......................................................................... 46
  Copy/Forward,Copy/Paste,Cloning ........................................................................... 46
  Abbreviations .......................................................................................................... 47
  Corrections ................................................................................................................. 48
PowerNotes ................................................................................................................... 49
  Setting a Default Note Type (Reminder) ................................................................. 49
  Accessing PowerNote ............................................................................................. 49
  Icons and Symbols ................................................................................................... 50
Note types .................................................................................................................... 51
  Encounter Pathway Tab ......................................................................................... 51
  Existing Tab ............................................................................................................. 51
  Pre-completed Tab ................................................................................................. 51
Catalog Tab .......................................................... 51
Recent Tab.................................................................. 51
Favorites Tab ............................................................. 52
Selecting terms .......................................................... 53
Removing Select Terms ............................................... 53
Viewing the Note ....................................................... 53
Inserting Free-text ..................................................... 54
Working with Notes .................................................... 54
  Repeating a Term: (Duplicating) ................................ 54
Inserting Drawings ..................................................... 55
Personalizing PowerNotes .......................................... 55
  Inserting a Sentence ............................................... 55
  Creating a Macro ................................................... 55
  Saving a Note ....................................................... 56
  Signing a Note ..................................................... 56
Modifying a Note ...................................................... 56
Correcting a Note ..................................................... 56
Error Notes ............................................................. 57
Copying a Note ......................................................... 58
To view multiple notes: (Notes from different encounters) .... 58
Link to the Copy/Paste Rules in the HIMS ..................... 58
To “In Error” a Note .................................................. 58
To Correct a Note Written on the Wrong Encounter ............ 59
Working with Macros .................................................. 60
  Creating a Macro ................................................... 60
  Inserting a Macro .................................................. 60
  Updating or Deleting a Macro ................................... 60
Working with Pre-Completed Notes ................................................................. 60
Creating a Pre-completed Template ............................................................. 61
Using a Pre-completed Note.......................................................................... 61

Order Entry ...................................................................................................... 62
  Placing Individual Orders ............................................................................. 62
  Modifying Orders ......................................................................................... 63
  Discontinue/Cancel an Order ..................................................................... 63
  Reorder and Cancel an Order ...................................................................... 63
  Cancelling Series or Ongoing Orders ......................................................... 64

PowerPlans .................................................................................................... 65
  Using a PowerPlan ....................................................................................... 65
  Adding Orders to a PowerPlan ................................................................... 66
  Placing Orders in the Planned State ............................................................ 66
  Initiating Planned State Orders .................................................................. 67
  Discontinuing a PowerPlan ........................................................................ 68
  PowerPlan Favorites ................................................................................... 69
    Creating a Plan Favorite ........................................................................... 69
    Using a Plan Favorite .............................................................................. 70

Medication Reconciliation .............................................................................. 71
  Admission Meds Rec .................................................................................. 71

Discharge Overview ....................................................................................... 72
  Using Discharge Overview Method ............................................................. 72
    Patient Information .................................................................................... 72
    Diagnosis .................................................................................................. 73
    Procedures ................................................................................................. 74
    DC Meds Rec ............................................................................................ 75
    Patient Education/Follow-up ...................................................................... 76
Discharge Order .......................................................... 78
Discharge Note ............................................................ 79
Discharge Readiness ..................................................... 80

Sports Medicine PowerNote Modifications ......................... 81
Review of Systems ......................................................... 81
Adding a Sentence to any area .......................................... 81
Histories ....................................................................... 81
Family History ............................................................... 82
Social History ................................................................. 82
Physical Examination ..................................................... 83
Impression & Plan ........................................................ 84
Time Counseling Pt ....................................................... 84
How to modify PN formats ............................................. 85
PowerChart Navigation

Accessing the Electronic Medical Record (EMR)

PowerChart is the Electronic Medical Record (EMR) Application used for patient care; it is also called Synchronicity within the organization. PowerChart is accessed through Citrix, a security and desktop management application. You must access Citrix to view the PowerChart Icon.

Patient Privacy

All Patient Records are to be viewed only “as needed” in your work role. It is important to know you may not view your electronic medical record, your family members’ record, or any patient record for personal reasons. You must request your chart through medical records (HIMS) if you would like to review it.

All patient information is confidential and should not be discussed or disclosed. Be aware patient information should not be discussed in elevators, the cafeteria, in the community, or any public area.
Citrix Icon and Access

The Citrix icon is located on the desktop. Double click on the icon to open the citrix application.

Log into the Citrix Application

- Log into Citrix with your User Name and Password. Your user name and password will be provided in an email. You will be prompted to change your password after you log in.
Accessing the EMR Remotely

To view the EMR and other Citrix applications remotely, download the Citrix Client for Windows or Mac. You may also download the Print Client.

Opening the Electronic Medical Record (EMR)

Once the Citrix application opens select and single click the PowerChart Icon to open the login screen for the EMR. Note: After the initial login Single Sign On (SSO) will remember credentials for future access.
Log In Screen for the EMR

- Enter your User Name and Password. You will be prompted to change your password the first time you log in. This is your Cerner (Synchronicity) password. The first (black screen) password is for Citrix. DO NOT SHARE your password or login information with anyone.

Toolbars for the PowerChart Organizer

- **Title Bar (Black Arrow)** – Displays the application (PowerChart) and name of the Person signed on.
- **Menu Bar (Red Arrow)** – Menu options will change as Organizer Tabs are selected.
- **Organizer Toolbar (Blue Arrow)** – Icons available to use based on the Organizer tab selected.
- **Action Toolbar (Green Arrow)** – Displays support tools.

Note: Many of the toolbar items have dropdown menus. Click on the item to view the dropdown items.
• This is your Home Screen. The left side of the screen contains the Message Center. The right side of the screen is the Outpatient Schedule.
Right click on the screen and click Preferences.

Enter your name in the Default resource field to have your patient schedule available each time PowerChart is opened.

- Click on the Day View tab. Highlight items in the Available Columns list you would like to see and click the arrow in the middle to move to the visible columns.
- Next, place check mark in the Expand to fill screen.

Return to Table of Contents
Customized Schedule View

- Provider name appears in the Resource field. Scheduled patients appear in the time grid. Suggested columns to select in visible columns are: Status, Appt. Type, Name, Duration, Description, Location, Patient Seen, Patient Seen Icon.

Searching for Additional Clinic Schedules

- Type the Provider name in the Resource field and that schedule will appear. To find previously viewed schedules, click the Recent button, the last 10 searches will appear.

Search Tip: Enter the last name of the provider and click the binoculars.
Opening an Outpatient Chart

- Double click on the patient name from a patient list. This will open the chart to the encounter for that day’s visit.

Creating a Location Inpatient Patient List

- Click Patient List Icon
- Click the List Maintenance Icon on the Toolbar
- Click New button at the bottom of the Location Patient List window
- Select Location Patient List Type, then choose the Medical Center, the nursing unit, and then Finish

Return to Table of Contents
Creating a Custom Inpatient Patient List

1. Click Patient List Icon
2. Click the List Maintenance Icon on the Toolbar
3. Click New button at the bottom of the Location Patient List window
4. Select Custom Patient List
5. Type, Enter a name for the List
6. Click Finish.
Granting Proxy to a Patient List

1. Click **Patient List** Icon
2. Click the **List Maintenance** Icon on the Toolbar
3. Click **New** button at the bottom of the Location Patient List window
4. Select **Custom** Patient List Type, then select **Next**.
5. On the Proxy Window Select **New, Provider**. Enter and search for the Provider Name and select type of **Access** (*Full Access, Maintain, Read*), Enter Start/End dates and then **Apply**
6. Then select **Finish**

Opening an Inpatient Chart

- Double click on the patient name from a patient list. It will open the chart to the encounter for that inpatient stay.
Additional Option for Opening a Patient Chart

Search for Patients by clicking on the Magnifying Glass Icon or by entering the Medical Record number to open the Patient Search Window.

The Patient Search Window

Once the search window opens, you can use the Patient’s name, Medical Record Number, Birth Date, Gender, FIN Number or Location to assist with the patient search.
Validate the Patient’s Information and Encounter

- You can confirm that you have selected the correct patient by validating MRN, SSN, Gender, Birth Date, or Age. Select the correct encounter; validate you have the most recent inpatient stay or clinic visit for the correct medical service with no discharge. The “Chart Level Visit” dated 1/1/2005 is an unassigned encounter where you will find non-encounter specific records such as referrals.

The Open Patient Chart

Return to Table of Contents
The Patient Demographic Banner

- The Patient Demographic Bar displays the Patient Name, Medical Record Number, Account number, Sex, Allergies, Spoken Language, Date of Birth, Age, Location Status, Risk Code, Encounter Type and Date, Clinical Study Information, Dosing Weight, and Actual Weight.

- The Patient Demographic Banner has multiple interactive areas. A click on the patient’s name will show the basic patient demographic information. Clicking on the Location will show all encounters (visits), clicking on the Allergies will show the allergy window, clicking on Clinical Study will show Clinical Study Information, Dosing Weight, or Actual Weight will open those results.
The Menu

- The vertical Menu bar lists the bands of the Patient Chart. Each band opens a pane to display chart information.

The Allergy Band

- The Allergy band opens to the patient’s allergy information. This screen may note “no known allergies” (NKA) or multiple allergies. Allergies also appear on the Patient Demographic Banner; for accuracy open the tab to see all allergies listed.

Return to Table of Contents
Search Clinical Notes “By Type” or “By Encounter”. Each will give you a view of the patient’s clinical notes. “By Type” sorts the notes through categories and “By Encounter” sorts the notes by patient stays or visits.
Changing Search Criteria

You can search for additional historical results without having to change encounters.

Right click on the gray ribbon at the top of the pane and select **Change Search Criteria**. You can expand the Date Range, Document Count, or select Admission to Current.

This option is available within the Clinical Notes, Form Browser, Iview/Intake & Output, MAR Summary, and Results and Vitals.

To see all possible documents on a patient (including referral records), change to search by Date Range with a start date of 01/01/2005. **This may take a while to load.**

Return to Table of Contents
The Results and Vitals Band

- The Results and Vitals Band is a tabular view of Clinical Flowsheets, Lab Results, Precautions, Respiratory Flowsheet, and Vital Signs. Click on each tab to view information. The Navigator in each tab identifies the information on each tab.

The Radiology Results Band

- The Table view is the default for Flowsheets. The Navigator defines the result headings. A ✓ to the left of the heading indicates there is information available for viewing. Click on the Navigator options to view results as first on the flowsheet. For example, click “Ultrasound” and it will appear at the top of the flowsheet. Results may be viewed in a “Table”, “Group”, or “List” format by clicking the radio button.

Return to Table of Contents
The Medication Administrative Record (MAR) is a view-only section that displays the Inpatient list of medications.

The MAR notes overdue medications in red.

Current time is displayed in yellow in the date/time column.

Details from the MAR Summary

Clicking on a medication will allow a detailed view of the order and show links to see Order Info and the Event/Task Summary.

The Order Info will tell you the Ordering Provider’s name, as well as the time/date of the order.
The Medication List Band

- The Medication List displays the Inpatient Medications, Medications by History, Ambulatory Medications and Prescription Medications.

The Medication List

- Icons demonstrate the Medication location or type. Ambulatory Medications are represented with a Wheelchair Icon.
The Medication List Details

• Details include the status of the medication: canceled; completed; discontinued; documented; ordered; or prescribed.
• The order details are noted on the line with the medication as well.

Display Options for the Medication List

• The drop down box allows you to change the view to show “All Medications (All Statuses) as well as other options. Selecting the “All Medications” option will allow you a historical view of the medications.
The drug reference option provides a current drug information source, such as drug descriptions and interactions, details of possible side effects, and the effects of missed doses and overdosing, as well as instructions for use.
The Patient Care Summary displays an overview of the information including Intervention Orders, Problems/Diagnosis, Critical Labs, and Reason for the Visit.

The Patient Demographics Tab under the Patient Information Band opens to several tabs including Patient Demographics, the Visit List, Patient Provider Summary (PPR), and Immunizations.

The Patient Demographics tab displays patient address, birth date, age, and other information.
The PowerOrders Band

- The PowerOrders Band shows the Providers’ Admission and ongoing orders.

The Intake and Output Band

- The Iview/Intake and Output Band displays a running I & O. Note the Balance is at the end of each time frame. Additional fluid options from the left navigator can be added to the values.
Message Center

**Priority Items:** Includes any due messages or reminders.

**Inbox Items:** Includes items such as Results, Documents, Messages and Orders.

**Work Items:** Includes Saved Documents, Documents to Dictate, and Reminders.

**Notifications:** Includes notification receipts for messaging as well as Trash and Sent Items folders.

A total number is given for each category.

*Note:* The numbers reflect what you have NOT opened, not the total number of items to be completed.

Return to Table of Contents
Documents that require review or signature are displayed in the Inbox Items section under the Documents heading. The notifications that require your review and signature include unsigned orders (discharge, etc.) unsigned notes (progress and staff), transcribed documents, and documents that have been forwarded to you by another provider.
Message Center
Signing or Reviewing Documents

To sign or review a document notification:

- Open and review the notification message.
- Select **Sign** or **Review**, and select the “OK” tab then the “NEXT” tab. The system will recognize the document being signed. The Sign/Review option is selected by default.

**Note:** The Forward Only action is located at the top of the documents window. The documents can be modified prior to signing or reviewing them.

Return to Table of Contents
Changing Display Date (for documents over 30 days old)

Note: DO NOT select the LOAD ALL option in the display – this will remove the “Results” and the “Orders” categories from your message center. With these categories removed, you will not be able to endorse your orders or view your messages.

Message Center - Refresh

Note: If you have completed your “Sign” Inbox Items or “Documents to Dictate” from Work Items and select the refresh (minutes ago), and those items still remain, please call HIM, Workroom for assistance.
To endorse a Result:

Open and review the result notification message.

Select **Review** or **Refuse**, and click **OK** or **OK & Next**. The Sign/Review option is selected by default.

To exclude results from Review or Refusal, uncheck the item(s) prior to Reviewing or Refusing.

**Note:** “Complete all boxes within the Action Pane when refusing (Reason, Additional Forward Action, and To). Also include Comments, if applicable. Send to “Refuse Results, Inbox” if you do not know who is responsible for review.”
Orders that have been sent to you for Cosign will be located in the Orders folder under the Cosign orders subfolder. These are notifications that require your signature to be completed.

**Note:** Cosign orders cannot be Refused. If attempted, the following message will be displayed.

![Message Center - Orders to Approve - Cosign](image)
Orders that have been sent to you for Renewal will be located in the Orders folder under the Renewal Orders subfolder. These are notifications of orders that are approaching their stop date and time.

**Note:** If you approve this renewal it will automatically renew the order and remove the renewal message from the folder. If you do not want to renew the order, close the box; the message will remain in the folder.

Return to Table of Contents
Message Center Reminders

LOAD ALL

Do not use this function; this will remove the “Results” and the “Orders” categories from your message center. With these categories removed, you will not be able to endorse your orders or view your messages.

REFUSING

Make sure you complete all boxes within the Action Pane when refusing (Reason, Additional Forward Action, and To). Also include Comments, if applicable.
PowerNotes or Orders created within Cerner (PowerChart) CAN be refused or forwarded directly to the appropriate physician. DO NOT refuse/forward these notes to the HIM, WORKROOM or HIM, TRANSCRIPTION Inboxes.

Signature requests on *scanned* documents must be refused to HIM, WORKROOM inbox for reassignment to the correct physician. The electronic signature mechanism must be reset to work correctly for scanned documents. Dictation requests or “Anticipated” documents must be refused to HIM, WORKROOM to be cleared or reassigned appropriately.

Signature requests on HIMS transcribed documents must be refused to HIM, Transcription inbox for reassignment to the correct physician. The electronic signature mechanism must be reset to work correctly for these interfaced documents.

Return to Table of Contents
Medical Records

Timely completion of medical records, including dictation, electronic input, signing, dating and timing of all entries, is an integral component of graduate medical education. House staff must complete all medical record assignments in a timely manner, must be familiar with health system record completion policies, rules, and must participate in electronic health record system training. Failure to complete medical records, as prescribed by the Medical Staff Rules and Regulations, may result in serious sanctions against the resident, including documentation of failure to perform duties in the resident’s personnel file and suspension without pay. A Certificate of Completion of residency training will not be issued until all medical record assignments are completed at the end of the training period.

Assigned Deficiencies in Your Message Center

All HIMS assigned deficiencies will be located in your “Documents to Sign” and “Documents to Dictate” folders in the Message Center CPOE orders are located in the “Orders” folder.
Message Center Setting

The DISPLAY date range for the message center has been set for 30 days. If deficiencies are over 30 days, they will not be displayed. Periodically change your display settings for 30 to 90 days to ensure the entire incomplete record listing is viewable within your message center. NOTE: DO NOT select LOAD ALL in the display – this will remove the “Orders” folder from view.

Refusing Assigned Deficiencies

NEVER forward a refused scanned or transcribed document to the “Correct” clinician. HIMS assigned deficiencies should only be refused to the HIM, Workroom or HIM, Transcription Message Centers to reassign the deficiency so the electronic signature will link correctly.

Navigating Message Center “Inbox Items” and “Work Items”

- The “Inbox Items” section will contain all scanned, transcribed, and PowerNote documents needing your signature. This section also includes results to endorse and orders to sign.
- The “Work Items” section contains documents to dictate. These items are located in the “Documents to Dictate” folder.
- It is recommended that you complete all “Documents to Dictate” first, second sign all documents where the admission and discharge dates indicate the patient was hospitalized, then complete the remainder of the items in the message center.

Return to Table of Contents
Managing Dictation Deficiencies

• The system has been configured to automatically remove a dictation deficiency from your message center if the information you supply upon dictation (the medical record number, suffix, work type and dictator ID) matches the information associated with the deficiency. Thus, accurate keying and dictation of this information is vital to maintaining an accurate list of dictation deficiencies in your message center.

• Once a report is dictated, a placeholder will appear in the electronic medical record and be viewable within PowerChart.

Editing and Signing Transcribed Documents

• Once the report is transcribed, it will replace the placeholder as an unsigned document. A signature deficiency will be sent to the responsible attending physician (as indicated by the dictator or listed in the registration system)

• The attending physician will be able to modify and sign the document from within the message center and if desired, can forward the modified document to the resident for review.

• For transcribed reports that require significant changes, the user can REFUSE the unsigned document in HIM, Transcription.
Signing Scanned Documents

• In order for a clinician to be able to sign a scanned document, HIMS staff must affix a signature block annotation to the specific position on the page that requires a signature.
• Never forward a scanned document to another clinician for signature; refuse to HIM, Workroom message center. HIMS must affix the signature block using the ProFile Deficiency Analysis application. Otherwise the Legal Signature will not appear on the scanned report.

Error Handling/Refusals

• If you have been assigned a deficiency in error, do not forward or refuse the document to the “correct” physician; the correction must be performed by HIMS to ensure a thorough cleanup of the error.
• Refuse or forward incorrectly assigned scanned documents to HIM, Workroom.
• Refuse or forward incorrectly assigned transcribed documents to HIM, Transcription.
Principal Documentation Requirements

ADMISSION

The report of **History and Physical Examination** must be recorded within 24 hours of admission and prior to surgery. A history and physical examination recorded during a previous hospitalization or clinic visit within 30 days for the same or related condition will suffice as long as it is updated within 24 hours of admission and prior to surgery. The attending physician must add a teaching statement and countersign the report if it is used as documentation to support professional billing. The H&P shall be proportionate to the complexity and medical condition of the patient and shall meet the standards of care for that area of practice. *Note: H&P’s are only good for 30 days.*

DAILY

**Progress Notes** shall be pertinent and shall be recorded at the time of observation; they shall be sufficient to permit continuality of care and transferability. They shall give a chronological report of the patient’s course and provide sufficient evidence of active participation by the attending practitioner in supervision of the patient’s care. Each of the patient’s chronological problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Patient health education provided by the physician or designee will be included in any progress note following that encounter. The condition of the patient will dictate the frequency with which progress notes shall be written; however, they shall be written at least daily.
Orders shall be electronically entered with few exceptions that are required to be written on paper). They must be signed by a physician or dentist responsible for the patient. Verbal and phone orders must be read back and verified by the receiving nurse or authorized practitioner, then countersigned by the physician giving the order. All requests for laboratory and radiology examinations must include the name of the ordering and attending physicians so that the test results may be routed appropriately.

SURGERY

A complete Operative Report should be entered into the medical record or dictation immediately after surgery and prior to transfer to the next level of care. If the report is dictated, there will be a delay before the documentation is viewable in the medical record, therefore a full Procedure Note should be entered immediately after surgery.

DISCHARGE

A Discharge Summary should be dictated at the time of discharge and is required on all discharges from nursing units (including patients who leave against medical advice) except patients hospitalized less than 48 hours with problems of a minor nature. Discharge summaries should be dictated using the HIM dictation system to ensure they are of acceptable quality. Discharge summaries created via “PowerNotes” or “Add Documents” of unacceptable quality will be rejected. All deaths, trauma and Psych patients require a dictated discharge summary regardless of the length of stay.

Return to Table of Contents
A Discharge Order Form or Discharge Progress Note must be completed on all discharged and transferred patients (including patients who leave against medical advice) and contain diagnosis, procedures, and other information pertinent to continuity of care.

AMBULATORY CARE

Practice Site Notes shall be proportionate to the complexity and medical condition of the patient and shall meet the standards of care for that area of practice.

An Ambulatory Care Summary List must be initiated for the patients receiving continuing ambulatory care services. The patient’s summary list includes the following information:

- Any significant medical diagnosis and conditions
- Any significant operative and invasive procedures
- Any adverse or allergic drug reactions
- Any current medications, over-the-counter medications, and herbal preparations.

The patient’s summary list is updated whenever there is a change in diagnosis, medications, or allergies to medications and whenever a procedure is performed.

PROTECTION OF MEDICAL RECORDS

Medical records:

1. Medical records are the property of GRMC and shall not be removed for the Medical Center premises except by subpoena, court order, or with the approval of the CEO or his designee.

Return to Table of Contents
2. Paper records must not be removed from the Health Information Management Services unless properly signed out.

3. Printed records are the responsibility of the recipient and should be secured in such a way to prevent unintentional disclosure. When the need for these records has passed, they should be completely destroyed using proper techniques to prevent recreation.

4. Portable devices, such as PDA’s or laptops, containing protected health information must be secured physically, as well as through passwords and encryption.

**MAINTAINING RECORD INTEGRITY**

Medical records that do not satisfy the requirements for a legal medical record can result in claims payment denial and expose a physician’s practice to fraud allegations and increase risk of adverse litigation outcomes.

**Copy/Forward, Copy/Paste, Cloning**

While the use of copy/forward and copy/paste can improve physician documentation efficiency, it can undermine the integrity of the medical record if overused, abused, or used incorrectly. Electronic Health Records should make the patient chart more legible, faster to document and more complete.

To insure “point-and-click” documentation practices don’t end up as “bad documentation habits”, remember these **Do’s and Don’ts:**

- Do use care and vigilance when clicking through templates-the chart you are documenting may be used as evidence in court.

Return to Table of Contents
• Do limit the use of copy/forward to histories and review of systems.
• Do review, review, and review before copying forward a note, making sure all medications, test results and interventions are accurately depicted for the specific encounter you are documenting.
• Do put copied entries from other providers in quotes and credit the author.
• Do electronically sign all PowerNotes that you create (unsigned PowerNotes are NOT VIEWABLE to all users)
• Do error out any PowerNotes created in error.
• Do remember to go back and sign any saved PowerNotes.
• Don’t copy forward documentation without reviewing and confirming it accuracy-don’t make someone else’s mistake YOUR mistake.
• Don’t copy forward documentation and claim it as your own-you must credit the originator.
• Don’t copy forward and entire note that already exists in the record and make it part of a new note-instead summarize the pertinent points and refer to the existing note.
• Don’t copy information from one patient’s record and paste it to another patient’s record.

Abbreviations

Only those symbols and abbreviations approved by the medical staff may be used in the medical record. Symbols and abbreviations should not be used when recording final diagnoses. A list of approved and prohibited abbreviations can be found at https://paws.gru.edu/int/hims/froms-abbreviations/Pages/default.aspx.

Return to Table of Contents
Corrections
Errors made in the Electronic Medical Record require special handling due to the integrated nature of the system. Those errors must be evaluated by Health Information Management Services to ensure the items are properly corrected and re-documentated. Entries written in error in the paper medical record should be corrected by drawing a single line through the incorrect entry. Write “Error”, your signature, date and the time adjacent to the incorrect entry then re-document the note correctly and insert your signature, date, and time of the new entry.
PowerNotes

Setting a Default Note Type (Reminder)

A **Default Note Type** must be set prior to writing your first note. This only needs to be done once.

1. Go to PowerNote and open a note by clicking the yellow folder. Type “gen” then click the search icon (binoculars). Select any note to open.
2. Click on View, then Customize, select the Document Types tab.
3. Place a √ in the box beside Default to Last Document Used.
4. Select **PowerNote Note Type List** as the Default List Type.
5. Do not insert any document types into the Personal Document Type List.
6. The document types to use on clinic PowerNotes are Practice Site Note, Psych Practice Site Note, History and Physical Note. Progress Note is for inpatient notes.

**Accessing PowerNote**

1. Open the patient chart **ensuring the correct visit encounter is selected; this is the encounter you will be documenting on.**
2. In the Ambulatory Summary page Documents section, click on the Add button; or
3. Or, select Documents from the Menu (table of contents), then click the on Add button.

[Return to Table of Contents]
## Icons and Symbols

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Blue Chevrons" /></td>
<td>General: Blue Chevrons are used to indicate that a sentence can be expanded to show additional terms or collapsed to expose only the common terms.</td>
</tr>
<tr>
<td><img src="image" alt="Quality" /></td>
<td>Quality: Indicates that the term is of high quality.</td>
</tr>
<tr>
<td><img src="image" alt="Breath sounds" /></td>
<td>Breath sounds: * Indicates within the body of the template, indicates a term and its associated terms are set to repeat when selected.</td>
</tr>
<tr>
<td><img src="image" alt="Chest+" /></td>
<td>Chest+: Indicates there are additional terms that can be selected to further describe a term.</td>
</tr>
<tr>
<td><img src="image" alt="ROM …" /></td>
<td>ROM …: Indicates there are additional terms to further describe a term that is not exposed until &gt;&gt; or + signs expose the parent term.</td>
</tr>
<tr>
<td><img src="image" alt="== minutes" /></td>
<td>== minutes: Indicates a term where a number will need to be entered.</td>
</tr>
<tr>
<td><img src="image" alt="Insert Image" /></td>
<td>Insert Image: Insert Image icon found in PowerChart. Used to insert images into PowerNotes.</td>
</tr>
<tr>
<td><img src="image" alt="File" /></td>
<td>Insert File: Insert Image icon found in PowerChart Office. Used to insert images into PowerNotes.</td>
</tr>
<tr>
<td><img src="image" alt="Show Structure" /></td>
<td>Show Structure: Displays the structure of a paragraph including the sentences and terms.</td>
</tr>
<tr>
<td><img src="image" alt="Hide Structure" /></td>
<td>Hide Structure: Hides the structure of a paragraph including the sentences and terms. The text rendition of the paragraph will display if terms have been documented.</td>
</tr>
<tr>
<td><img src="image" alt="DATE" /></td>
<td>DATE: Launches a date control that allows for a date and/or date range to be entered into the note.</td>
</tr>
<tr>
<td><img src="image" alt="OTHER" /></td>
<td>OTHER: Launches a box that allows for free text to be entered into the note.</td>
</tr>
</tbody>
</table>
Note types

Encounter Pathway Tab

Type the name or partial name of the note into the Encounter Pathway box and click on the binoculars to Search.

Filter using the starts with or contains option

Existing Tab

Option to view “Current encounter” notes or “All encounters” notes. Saved notes display status of Active. Signed notes display status of as Signed.

Pre-completed Tab

Select “My Notes” only to view your notes saved as Pre-completed notes.

Catalog Tab

This tab displays templates organized into specialty folders such as cardiology and pediatrics.

Recent Tab

Select this tab to view recently accessed notes.

Return to Table of Contents
Select this tab to view any template or saved note added to your Favorites list.
Selecting terms

Single click on a term selects in (circle around term), double click negates it (slash symbol).

Removing Select Terms

To remove data that has been selected, right click on the term and select “Clear”.

Viewing the Note

Use the Toggle button to view the documented note, from the template view, click the toggle button located at the top right corner of the template. When you hover over it, it displays “Click to Display Contributor View”. To return to the template view, click the button again.
Below shows how the terms that were selected display in the Contributor view.

**Review of Systems**

**Cardiovascular:** Calf pain, No palpitations.  
Chest pain: **Right sided.**

**Inserting Free-text**

1. Free-text allows text to be entered directly into a note without selecting any terms or sentences from the template provided.
2. Double click on any open or blank area of the note and start typing.
3. Free text can also be inserted by selecting “Use Free Text”.
4. The “Other” term open a text box in which free-text information can be typed in or dictated in using a voice recognition system.

**Working with Notes**

**Repeating a Term: (Duplicating)**

1. Click the term you want to repeat
2. From the Term Menu, click repeat. (You can also right click the term and click repeat)

**Note:** Not all terms can be repeated.
Inserting Drawings

A Digital Ink term allows you to annotate a drawing with sketches or symbols, and include it in the note. Within the Physical Examination paragraph, select a term which begins with Drawing. The Drawing window opens, select Ok. Use the drawing tools from the dialog box to sketch or include text.

Inserting Drawings

Drawings can also be inserted by selecting the “Insert Image” icon, located within in the toolbar located at the top of the screen. Select a drawing within the PowerNote folder.

Personalizing PowerNotes

Macros, inserting sentences, and creating pre-completed templates allows you to personalize notes.

Inserting a Sentence

Insert a sentence by right clicking on the sentence or paragraph and select Insert Sentence.

Creating a Macro

Macros are partially completed personal templates used as an element of documentation and can be comprised of terms, sentences or paragraphs.
Saving a Note
1. To complete the documentation at a later time, save and close the note by clicking Save from the Documentation menu.
2. The application will close after 45 minutes of inactivity. The note will auto save every 15 minutes; you may wish to save your work more often if entering large amounts of data.

Signing a Note
Sign the note to complete the documentation and place the note in the patient’s chart.

NOTE: The date and time of actual documentation will default.

To have the note endorsed or cosigned by another care provider, click the Request Endorsement check box.

1. Click the “Request Endorsement” check box.
2. Click under the word Endorser. You must choose the provider to endorse and select Sign in the Type field.
3. Click OK to sign the note and send any requests for endorsements. The note will go to the endorser’s Cosign box in Message Center.

Modifying a Note
1. A note may be modified from the Inbox as explained above or by clicking on the Clinical Notes tab. Open the note you wish to add information to. Right click on the note body and then click on Modify Document.
2. Type additional documentation under Insert Addendum Here and Sign the note.

Correcting a Note
1. A note can be corrected by going to Documents from the Menu and then clicking +Add.
2. When the New Note opens, click on the Existing tab.
3. Click on the note you wish to correct and make sure to check the box next to Copy to new note.
4. Your note will open and you can now make any changes and Sign.
5. The final box that opens allows you to change the date/time and edit note Type. This will be your last chance to save this before your note is saved.

Tip: Don’t forget to Error your original note that was created.

**Error Notes**

1. Click on Documents from the menu bar. This will open the List that contains notes written.
2. Click on the note that you wish to Error. The ![In Error] will highlight to allow you to click on it.
3. This will open another window.

4. You have the option to type in a comment and after clicking OK your note will now be In Error.

[Return to Table of Contents]
Copying a Note
1. In the Open Note dialog box, open the Existing tab and click Copy to New Note.
2. In the Encounter group box, select Current Encounter if the note to copy is in the current encounter or All Encounters if the note to copy is not in the current encounter.
3. In the Notes group box, select Unsigned Notes only if the note to copy is unsigned or select My Notes only if the note to copy is one you authored.
4. Highlight the note and click OK. The original note is now copied into a new note; you can proceed with documenting the encounter.

To view multiple notes: (Notes from different encounters)
1. Click Open Note dialog box
2. Click the existing tab
3. Click the note you want to see. (May have to choose the “All Encounters” button)

Link to the Copy/Paste Rules in the HIMS

To “In Error” a Note
1. In Documents, select the note that is “In Error”.
2. Click the “In Error” button on the toolbar
3. An In Error Comment is required. Type in the reason in the test box and click OK.

Return to Table of Contents
To Correct a Note Written on the Wrong Encounter

1. Select the correct encounter by clicking on the Encounter drop down under the patient’s name.
2. Open the “Open Note” dialogue box and select the Existing tab.
3. Select “All Encounters”. You will see a list of all the PowerNotes written on that patient.
4. Select the box beside “Copy to new note” and highlight the note to copy then click OK.
5. The selected note will appear with the new encounter date and information in the Encounter field.
6. Adjust the date and time as needed, then sign the note.
7. In Clinical Notes, go to the original note entered on the wrong encounter and “In Error” the note.

Note: If a note is entered on the wrong patient, the note MUST be retyped in the correct patient chart. Then you MUST In Error the original note entered in the wrong patient chart.
Working with Macros

Creating a Macro
1. Select the desired terms, then right click on the key sentence or key paragraph and select Save Macro As. The Save As dialog box opens. Enter the name for the Macro in the Title box and then click Create New.

Inserting a Macro
1. Click on the blue M beside the associated word and then click the Macro name you wish to insert.
2. Click on “More” to see other Macros that have been created. Click on the Macro name and then click OK.
3.

Updating or Deleting a Macro
1. To update it, open the macro within the note, make changes, then right click on the key macro term, select Save Macro As, then select Update.
2. To delete it, open the macro within the note, then right click on the key macro term, select Save Macro As, highlight the macro to be deleted, then select Delete.

Working with Pre-Completed Notes

PowerNotes allows you to customize by adding additional sentences or other encounter pathways. It is useful when patients present with common problems or conditions that are commonly documented together (hypertension and coronary artery disease).

Return to Table of Contents
Creating a Pre-completed Template

1. Open a new note and document, insert sentences, or insert another encounter pathway.
2. Insert another encounter pathway clicking on the Documentation menu, select Insert Encounter Pathway.
3. To save the pre-completed note, from the Documentation menu, select “Save As Pre-completed Note”.
4. The “Save As Pre-completed Note” dialog box opens.
5. In the Note Title box, enter the name of your Pre-completed note and click “Save As New”.

**Note:** This works for notes whether they are saved or signed.

Using a Pre-completed Note

1. From the Pre-completed tab in the Open Note dialog box, highlight the Pre-completed note and then select OK.
2. Document changes/modifications as needed.

Return to Table of Contents
Order Entry

Placing Individual Orders

To place individual orders:

Click the Orders/Plans on the Menu.

Click + Add.

Begin typing the order (i.e., Tylenol) in the Find field. Use the drop down to set Search to Starts With or Contains.

Click on the desired order.

Click the appropriate Order Sentence.

Click OK and DONE.

Modify the order as necessary and complete all required details.

Required order entry fields are highlighted in yellow.

Review order and click SIGN.

Click Refresh Button to display orders.

Return to Table of Contents
Modifying Orders

Right click on the order.
Select Modify Planned order.
Click on the Detail to be changed in the left box and select the Detail Value in the right box.
Close Details and continue with orders.

Discontinue/Cancel an Order

To discontinue/cancel an order:
Right-click the order to cancel.
Select Discontinue/Cancel.
Complete Details as necessary.
Click Sign.

TIP: The orderable is displayed as Canceled if it is cancelled prior to the start date and time. The orderable is displayed as Discontinued if it is cancelled after the start date and time.

Reorder and Cancel an Order

Use Reorder and Cancel to quickly cancel and reorder an orderable. This provides a new order which can be modified.
Right-click the order and select Reorder and Cancel
Complete Details as necessary.
Click Orders for Signature.
Click Sign.

Return to Table of Contents
Cancelling Series or Ongoing Orders

Orders placed with a recurring frequency create series or “children” orders. Cancelling only one of the child orders cancels only that occurrence.

Cancelling the parent order stops the generation of on-going orders.

It is necessary to cancel all of the existing child orders by cancelling the parent order.
PowerPlans

Using a PowerPlan

Click the button.
Type the first few letters of the desired PowerPlan in the Find field (i.e., appen for appendectomy)

Note: Order choices are presented based on the search criteria of Contains or Starts with.

Click the desired plan. indicates a PowerPlan.

Click Done to close the Orders catalog. The PowerPlan is displayed.

Select the desired components within the PowerPlan by checking or unchecking the orderables in the plan.

Modify orders and complete missing details as necessary.

Add orders as necessary using Add to Phase.

Initiate the orders.

a) Click Initiate.

b) Click Orders for Signature.

c) Click Sign. Address any alerts.

d) Click Refresh.
Adding Orders to a PowerPlan

To add orders to a PowerPlan:
   Click Add to Phase.
   Select Add Order.
   Type the order in the Find box.
   Click the desired order to be added to the PowerPlan.
   Repeat Steps 3 and 4 until all desired orders are added.
   Click Done.
   Complete any missing details on the added orders.
   **Tip:** Orders can be added to a PowerPlan at any time.

If the PowerPlan has:
   Not been initiated – continue on with the normal process as described above.
   Been initiated – click Orders for Signature, then click Sign.
   The orders are added to the PowerPlan.

Placing Orders in the Planned State

To place orders in a planned state (to be initiated at some point in the future):
   Complete steps 1 – 5 in **Using a PowerPlan** on the previous page.
   Click Orders for Signature. A blank screen is displayed.
   Click Sign.
   The screen displays Processing. Please refresh.
   Click the Refresh button.
   The PowerPlan is displayed and the PowerPlan in the View Pane shows the plan status as Planned.
Initiating Planned State Orders

To initiate planned state order:
Locate and click on the planned PowerPlan in the view pane. The PowerPlan is displayed.

Complete Step 6 in **Using a PowerPlan**.
Discontinuing a PowerPlan

To Discontinue a PowerPlan:
Right-click on the PowerPlan in the View Pane.

Select Discontinue.
The Discontinue box is displayed.

Select orders to Keep.
These orders remain active when the rest of the plan is discontinued.

Click OK.
Click Orders for Signature.
Click Sign.
Click the Refresh button.
The plan status changes to Discontinued in the View Pane.

Return to Table of Contents
PowerPlan Favorites

Creating a Plan Favorite

To save a PowerPlan with customized selections and modifications:
Complete steps 1 – 5 in Using a PowerPlan.

Click the button on the bottom left of the screen.
The Save as My Favorite box is displayed with the name of the plan.

Important: Use the naming convention described below to enable finding the plan in the future.
Leave cursor at end of plan name and type a space.
Type the first initial and last name of the user.
Click OK.

Find Plan Favorites by clicking the then opening the folder “My Plan Favorites”.

Return to Table of Contents
Using a Plan Favorite

To use a plan favorite:

Click the Add button.

Open “My Plan Favorites” folder or type the user’s first initial and last name in the Find field using Contains.

All plan favorites for the user are displayed in alpha order.

Select desired plan.

The plan is displayed with saved selections and modifications. Proceed as usual.
To complete Admission Medication Reconciliation:

Navigate to PowerOrders.
Click the Reconciliation button and select Admission.

The Medication List is displayed including any current or discontinued hospital medications.
Review and click either Continue or Do Not Continue for every medication on the list. The 🔄 indicates an item to be addressed.

Click Continue to:
Convert a documented home medication to an inpatient order.
Continue a hospital medication order.

Click Do Not Continue to:
Keep as a documented home medication (no order is placed).
Discontinue a hospital medication order.
Modify continued medications as needed.

Complete any missing required details.
Click Reconcile and Sign
Discharge Overview

Depart is completed prior to the patient leaving the hospital. Portions of the process are completed throughout the patient’s stay.

To complete Depart:
Navigate to the Discharge Overview page in the Overviews Menu band.
Complete the provider Depart components:
  Patient Information
  Diagnosis
  List of Procedures
  DC Meds Rec
  Patient Education
  Follow-up
  Discharge Order
  Documents

Using Discharge Overview Method

Patient Information

<table>
<thead>
<tr>
<th>Reason For Visit:</th>
<th>CONGESTIVE HEART FAILURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Physician:</td>
<td>Forney MD, Paul D</td>
</tr>
<tr>
<td>Attending Physician:</td>
<td>Fallback MD, David J</td>
</tr>
<tr>
<td>Service:</td>
<td>Inpt Internal Med 1 (Fed)</td>
</tr>
<tr>
<td>Advance Directive:</td>
<td>No results found</td>
</tr>
<tr>
<td>Last Visit:</td>
<td>05/22/2013 (Outpatient)</td>
</tr>
<tr>
<td>Code Status:</td>
<td>No results found</td>
</tr>
<tr>
<td>Emergency Contact (0)</td>
<td></td>
</tr>
</tbody>
</table>
Make sure all the patient information is correct including Attending Physician, as this will populate in the discharge paperwork. If the Attending Physician is not correct:

1. Go to PowerOrders
2. Type “Transfer Patient”
3. Complete the correct fields and Sign your order.

Diagnosis

Verify that the patients Diagnosis are correct. If you need to add a diagnosis, start typing your diagnosis within the box

Return to Table of Contents
1. Click on the blue down arrow and select “List of Procedures Performed”. This will then take you to the form to complete.

2. Once you have checked all the appropriate boxes, click the green ✅ in the top left corner to sign the form.

**TIP:** A student can perform this but the attending must go in to sign the form. To do this:

- Go to Form Browser on the Menu and find the “List of Procedures Performed” and right click and Modify the form.

The Attending Provider must then Click the green ✅ to sign the form.
If you need to add a procedure to a form already completed, follow the steps above. If you open a new form to add a procedure, it will overwrite the prior form.

**DC Meds Rec**

Within DC Meds rec you are able to see:

- New orders
- Continued Orders
- Continued with changes
- No longer taking
- Contact Physician prior to taking

To do Discharge Med Rec: Click the Blue + to do discharge med reconciliation. Choose either to Continue, Create New RX, or Do Not Continue the patients medications.

[Return to Table of Contents]
Make sure to route the medications to the patient’s pharmacy of choice if you are creating a new script.

When you are done make sure to click the **Reconcile And Sign** button.

**Patient Education/Follow-up**

Both patient education and follow-up can be done easily together. Click on the Blue + next to Patient Education:

In the search box you can type in your patient’s diagnosis to find discharge instructions.

**TIP:** Core Measure requirements with Congestive Heart Failure are populating educational items with heart failure instructions. See below and choose the heart failure.

*Return to Table of Contents*
Once you choose your diagnosis then you can make any edits. You can save time by clicking on the follow-up tab before saving in the bottom right corner. This will allow you to enter any follow-up information that the patient needs.
When doing the follow-up, make sure that the correct physician is selected. The system will default to the primary care physician. You are able to change this by typing the providers name and clicking on the binoculars. When selecting time to follow-up, choose from the drop down and don’t put in specific dates. Make sure to save when you have completed all the follow-up information.

**Discharge Order**

Click on the Blue arrow and select Discharge Patient. There will be two required fields that you will have to address. Where is the patient going and what was the patient’s condition upon discharge.

**TIP:** Please make sure to always place your discharge order before completing your note. The reason for this is the two required fields from the discharge order will populate in your discharge note.
Click on the blue Add + and it will take you to the note for documentation.

You want to make sure you select the correct note Type: Discharge Progress Note and the correct Encounter Pathway which is also Discharge Progress Note.

Once your note populates, you will need to place the cursor within the note and type /SSDN. You can see below that once I clicked on the blue /ssdn, it placed what is needed for discharge note documentation.
Discharge Readiness

Some things to know about the Discharge Readiness:

- The discharge order circle will completely fill in once the order has been placed.
- Once you have completed the Diagnosis you will have to finish filling in the blue circle by clicking on it.
- Patient education and follow-up will only half fill in. It is the nurse’s responsibility to finish filling in the circle.
- Currently DC Meds Rec is not functioning so this will stay blank.
- Once you have completed your Documents and Procedures then you must finish filling in the blue circle.
- These are all the steps required by the provider to finish.
Sports Medicine PowerNote Modifications

Review of Systems

Most clinically relevant organ systems are moved to the top of the Review of Systems section.

New Sentence—Amb ROS—will import all the Review of Systems that the Nurse documents on the Adult/Pedi intake PowerForm

Adding a Sentence to any area

1. Right click on Physical Examination heading ->
2. Click on Insert Sentence ->
3. Dermatology -> select sentence needed ->
4. Click OK, Sentence is available to be documented on

**Joint aspiration/ injection procedure**

Date === / Date/ Time === / OTHEI

____________________________________

| Patient / Procedure / Side / Site / S |
**Family History**—You can click on “include family history” and it will import family history, charted on by the nurse.

**Social History** –
New structured text for Denies tobacco, Tobacco use+, Denies alcohol, Social alcohol
If you need to document tobacco usage, click on the + sign to expand the optional charting text.
Addition of local High Schools and Colleges for data collection, will appear on age appropriate patients

**Joint Aspiration/Injection procedure Macro options**
Click on M next to Joint aspiration/injection procedure heading and utilize Macros for Drs. Crosby and Hunter for most frequently used medication for injections
Physical Examination

Sports Medicine specific Physical Exam sentences
VS/Measurement—Auto-populates from charting.
General—as before, use chevrons to expand structure.
Musculoskeletal—all previously used options are available
Respiratory—all previously used options are available
Psychiatric—all previously used options are available
Integumentary—all previously used options are available
Neurologic—all previously used options are available
Impression & Plan

Includes:

• Diagnosis—DX Code Search,
• Plan— options for continued care
• Summary—free text entry
• Orders—Order profile entry
• “OTHER” option available for free text entry

Time Counseling Pt.

Includes:

• Time summary—to document time spent with the patient,
• Counseling summary—included all the possible topics discussed during visit,
• Follow-up—multiple options    Notes— for any free text entry

output sentences will read:

Follow-up: Return to clinic in, 2-3 months or option selected
How to modify PN formats

• View -> Customize -> More -> Change What/OTHER box ENTER behavior to “OK/ Accept text” (to drop down a line type “Ctrl & Enter”)

• To HIDE the Autopopulate window, CHECK the “Hide autopopulation window on opening note” to REDUCE clicks.

• The autopopulation options have been greatly reduced in the Ambulatory clinics.

Return to Table of Contents