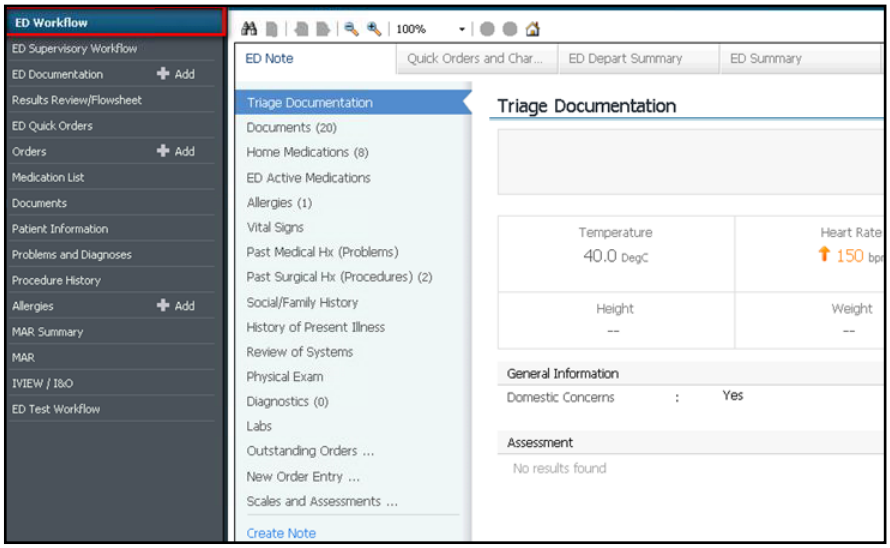
Documentation Workflow

The new ED Workflow page will make the creation of your progress note a by-product of your normal workflow.

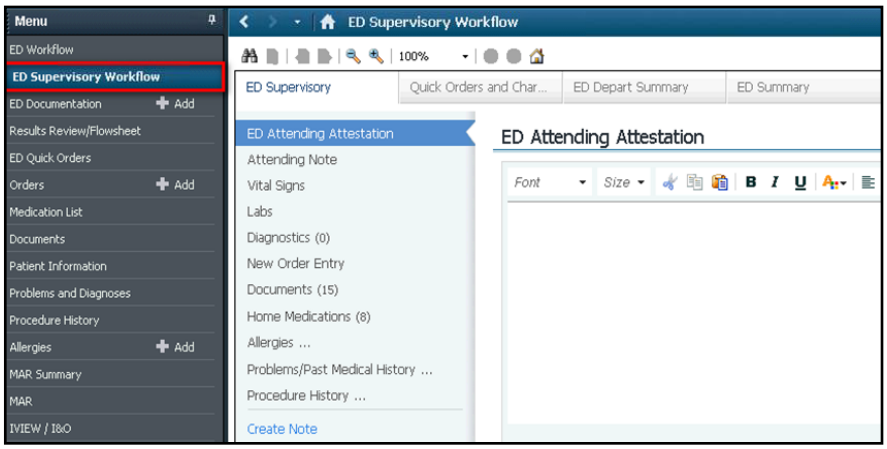
1. From the patient list, open the patient's chart.
2. The **ED Workflows** will open.

ED Workflow (VIEWPOINT): Used for anyone creating a full ED Note. It contains the ED Note Documentation Workflow, Quick Orders, Depart, ED Summary



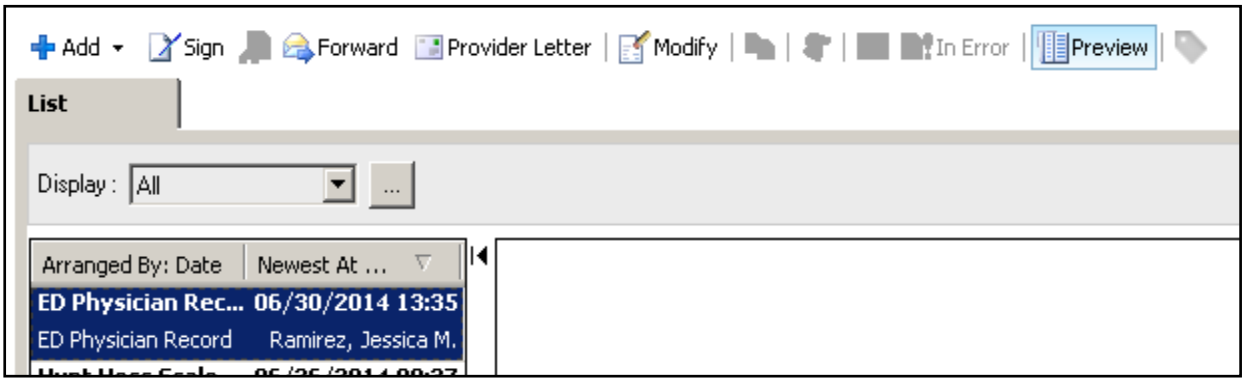
ED Supervisory Workflow (VIEWPOINT):

It contains Supervisory Note Documentation Workflow, Quick Orders, Depart, ED Summary



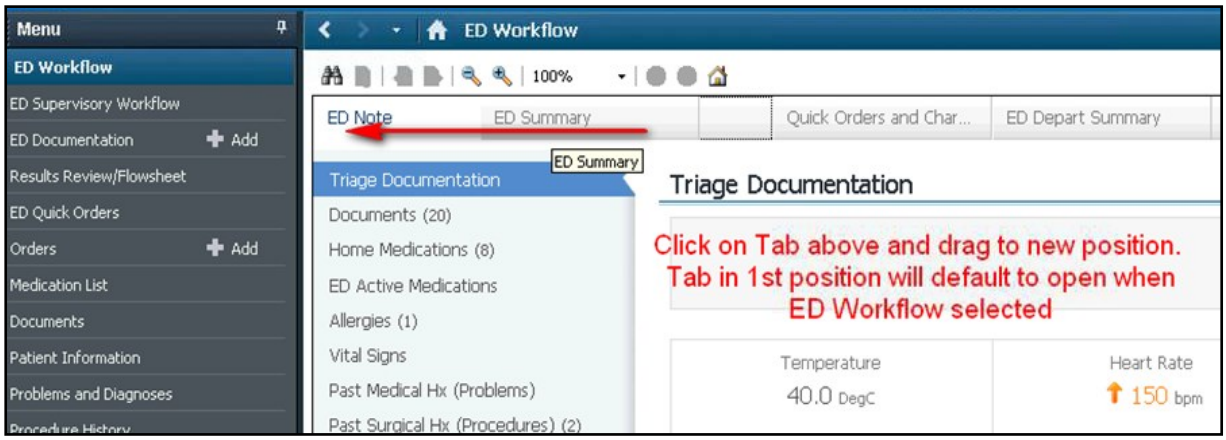
ED Documentation

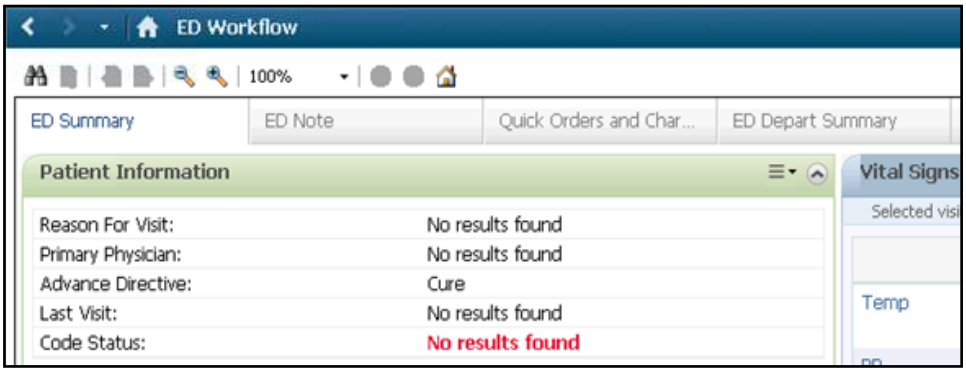
List of ED documents created and frequently viewed documents
This is most efficient location to access a document you created to modify, addend, sign and forward



Customize Viewpoint: Click/Drag Tab and place in 1st position to change the default view

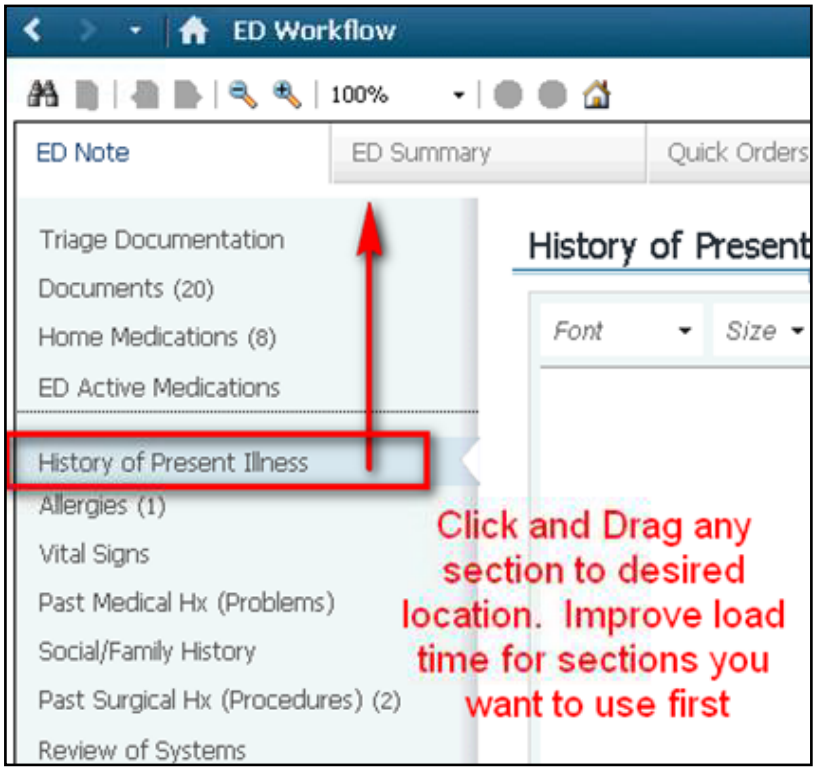
Each tab can be dragged and dropped into different position. Tab in 1st position will default to open when you click on this menu item

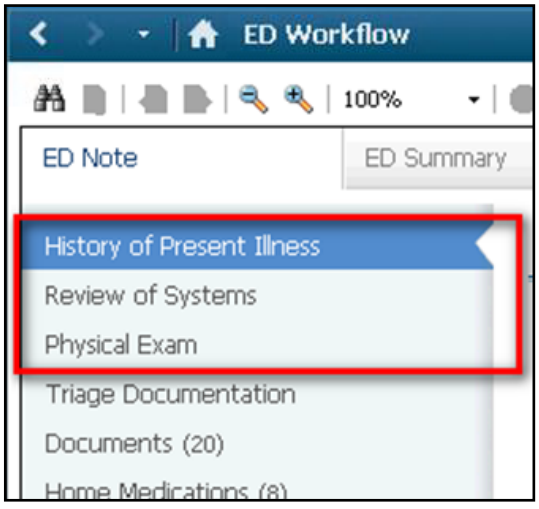




Re-Arrange items with Documentation Workflow:

First 4-5 items at top load immediately when page is accessed.

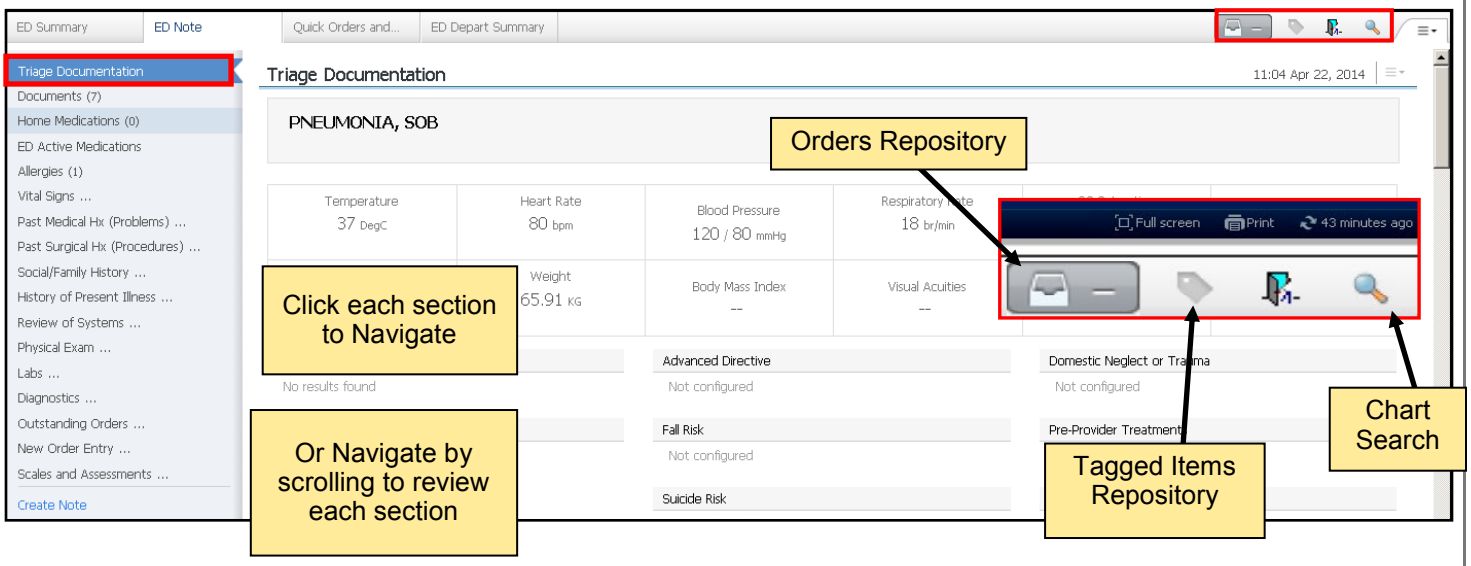




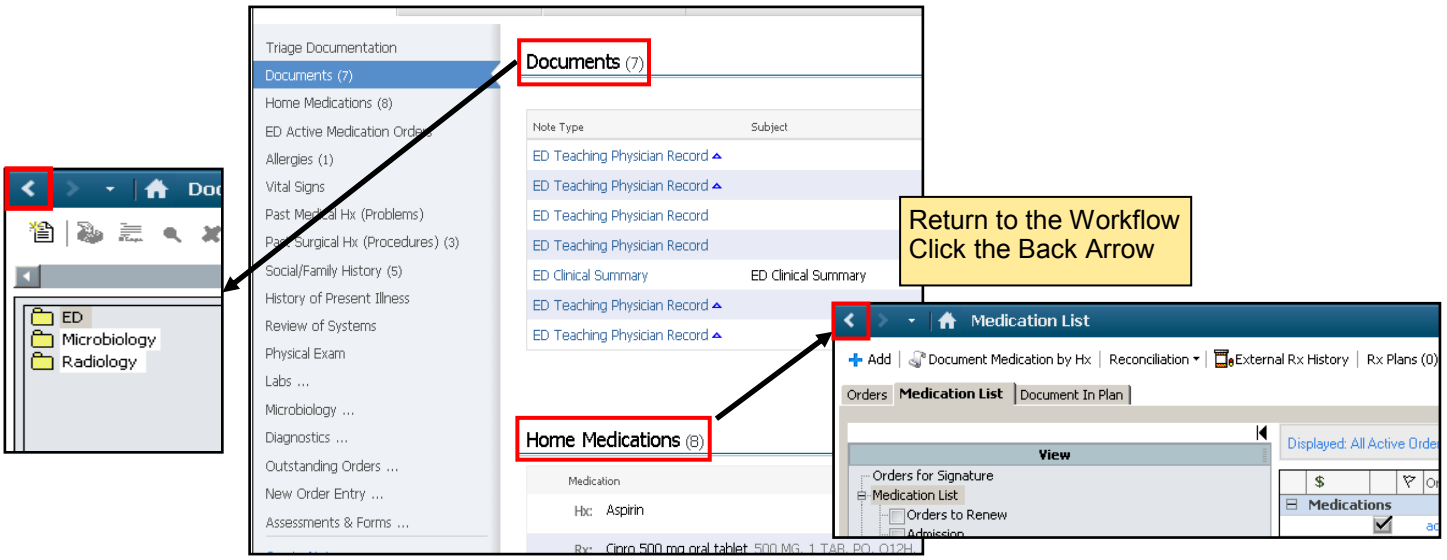
Documentation Workflow

Across the top are different Workflows Options: ED Summary for a quick glance at the MPage, ED Note is the Primary Workflow, Quick Orders, and the ED Depart Summary Workflow for discharging a patient.

On the Left is your Workflow Navigation Components. Click on each component to jump to a different section of your workflow. You can also scroll down the page to review each section in the workflow.



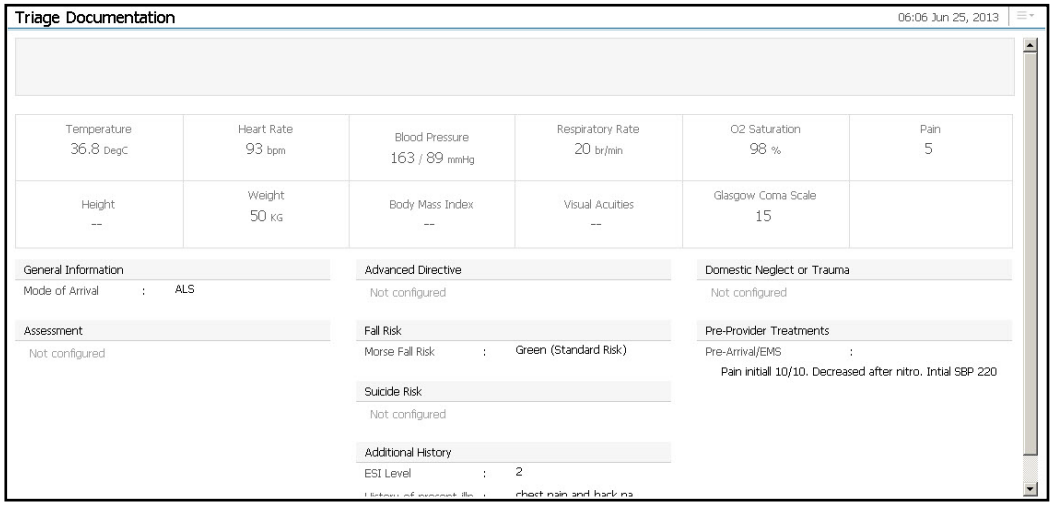
To view additional details, Click the Section Header. This will navigate you away from the Workflow. To return to the workflow select the back arrow at the top left hand corner



Sections in Documentation Workflow

Triage

Triage provides an easy to read view, based on the Triage Nursing Documentation for this visit.

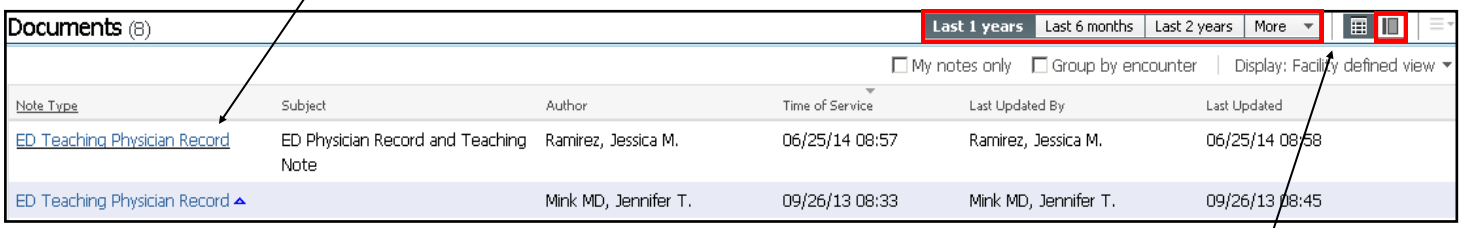


Documents

Documents provides a list of electronic documents based on the timeframe selected. To view more documents, select the header. This will take you to the Documents section of the menu.

Click on the Note Type to open, view and tag the document.

The list defaults to most recent document on top, but the timeframe can be changed



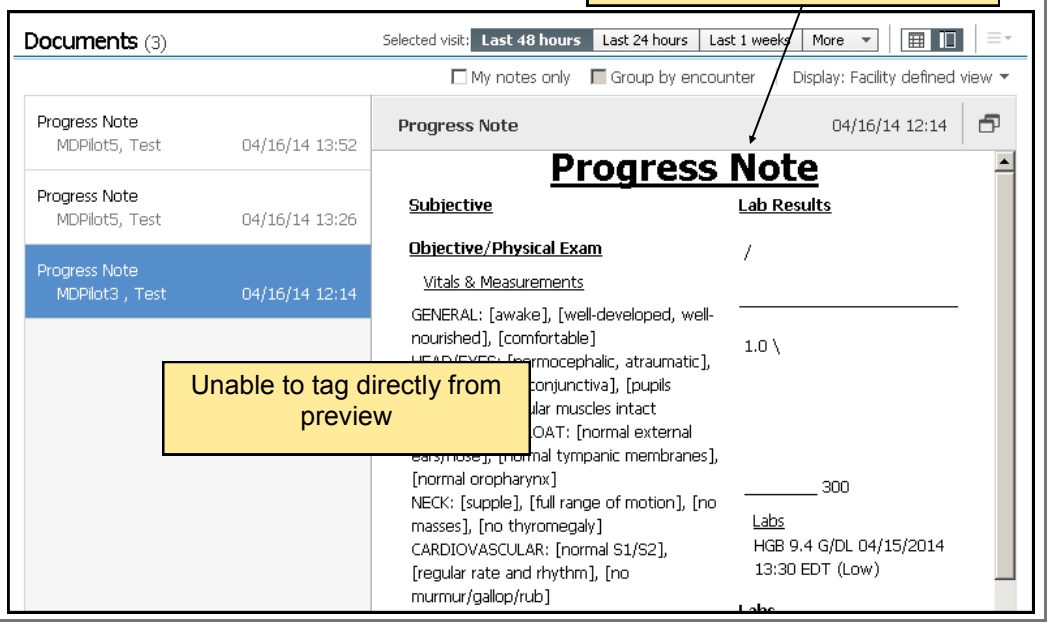
Visible from Documentation Workflow:

ED Notes
H&P
Consults
OP Reports
Stress/ Cath and GI reports
Discharge Summaries

To see Additional Documents Click the Section Header

Pane View

Click on Pane Icon to preview the documents

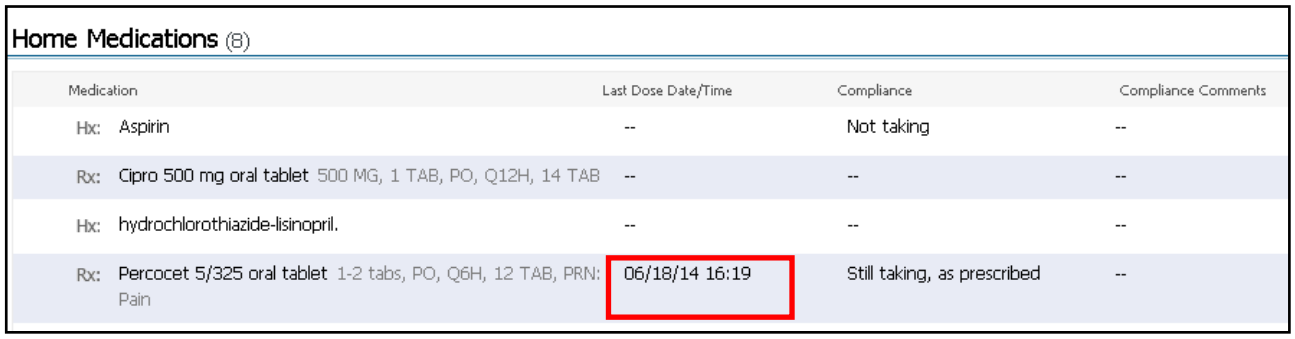


Unable to tag directly from preview

Sections in Documentation Workflow

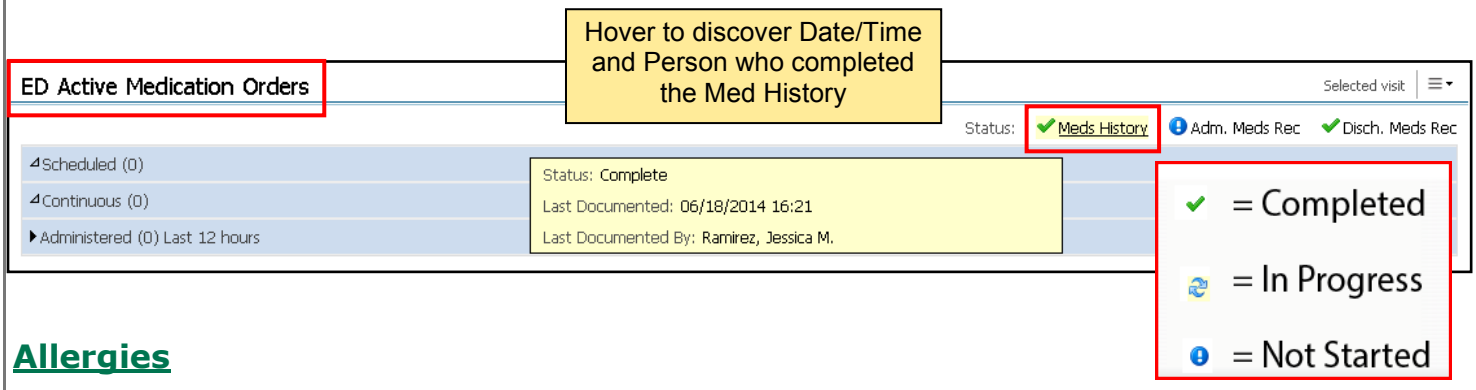
Home Meds

Home Meds Carry over from Encounter to Encounter. Although RN's document the patients Home Meds, it is ultimately the Provider's responsibility to ensure they are accurate and do not contraindicate, as this list will populate in your note. To see if the Med History has been updated for this visit see the Status in the ED Active Medication Orders Section Below.



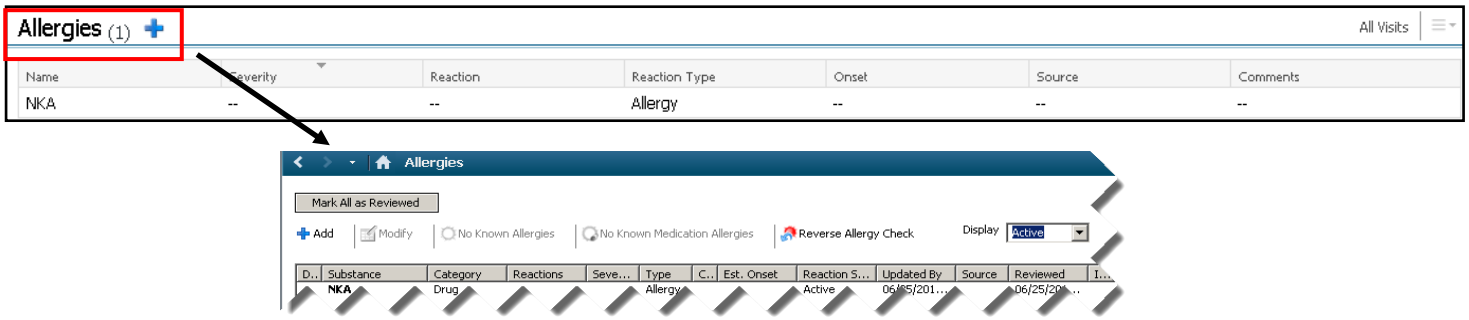
ED Active Medication Orders

For the full list of medications and administrations, select the Heading to view the MAR Summary screen



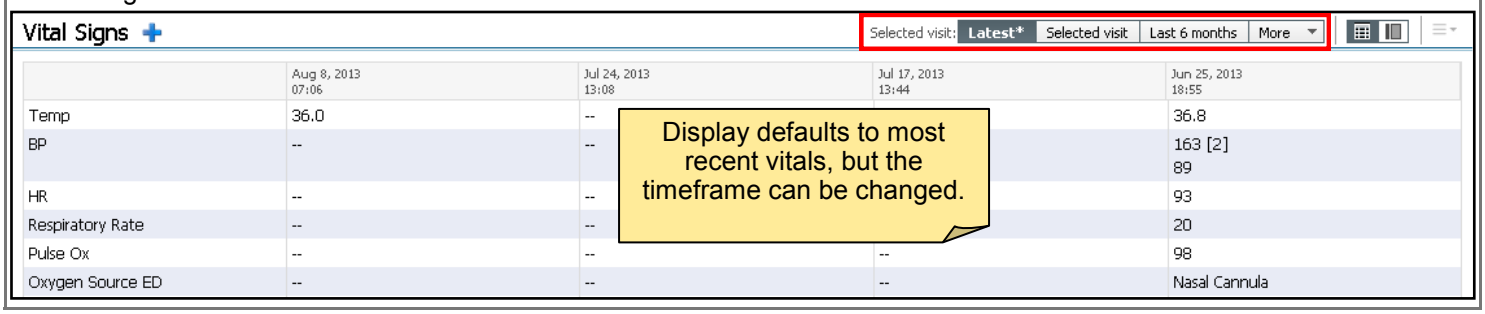
Allergies

Modify Allergies by selecting section header or add an allergy by selecting the plus sign.



Vital Signs

This section only shows vitals from the **current encounter**, To view vital signs from previous encounters, select the header and change the search criteria.

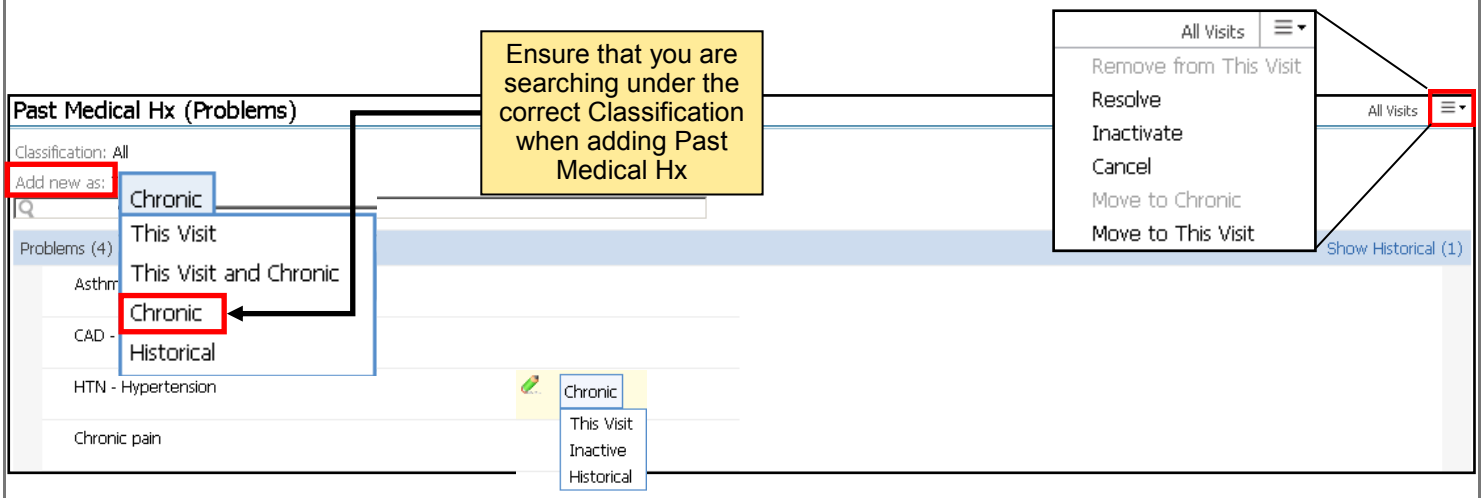


Sections in Documentation Workflow

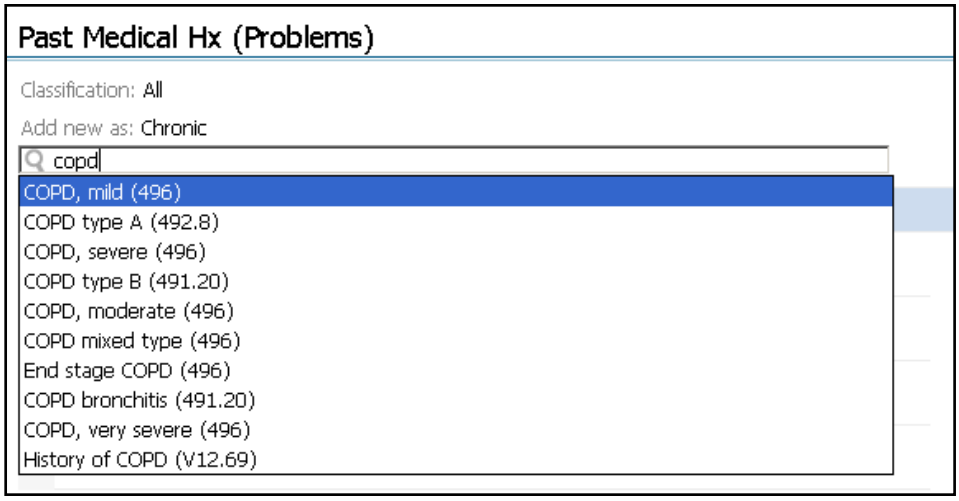
Past Medical Hx (Problems)

Past Med Hx (Problems) is a combined list of Past Medical History and Problems.

To add PMH and Problems, change the “Add New As”, located above the search field, to Chronic.

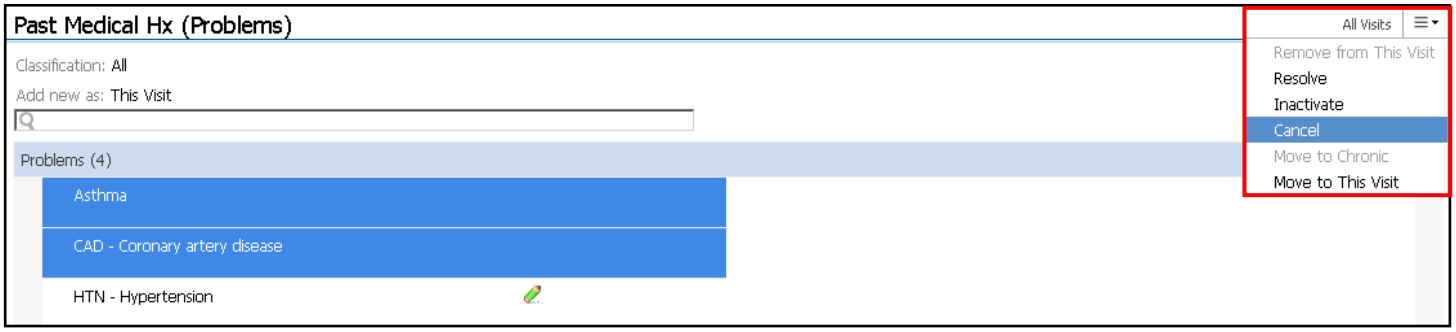


Search, by typing. This will begin yielding results that you can choose from.



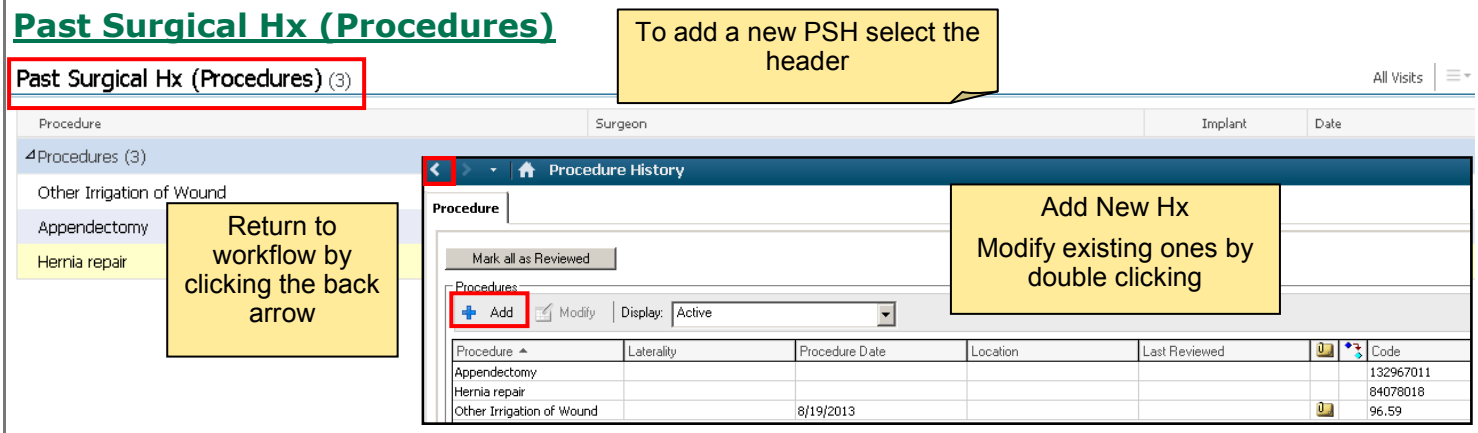
Remove a Problem

Select the problems you wish to remove . The items selected will turn blue. Select the icon on the top right hand corner and select Cancel, or Resolve .



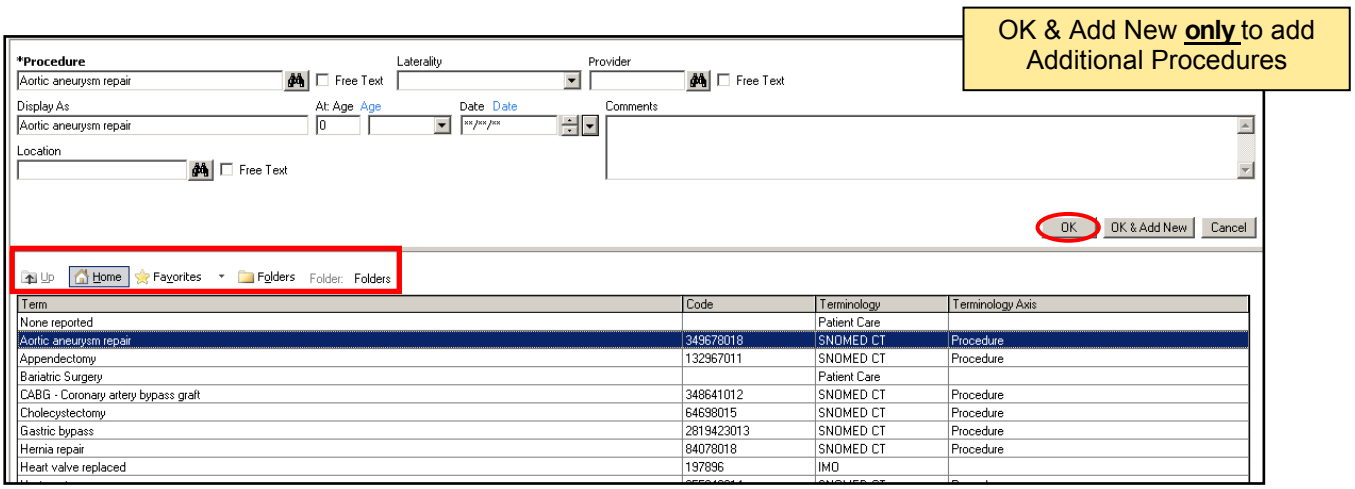
Sections in Documentation Workflow

Past Surgical Hx (Procedures)



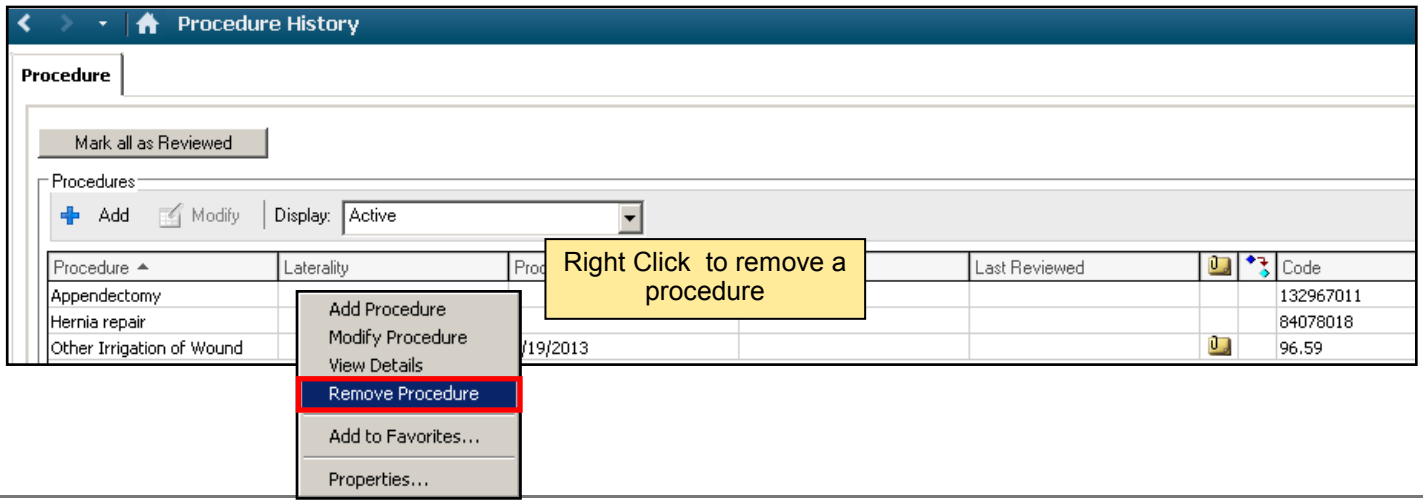
Add Procedures

Use your ED favorites to add common procedures. Double click to select Procedure. Click OK when Done or OK & Add New to add additional PMH/Procedures. Return to workflow by selecting the back arrow on the top left hand corner.



Remove Procedures

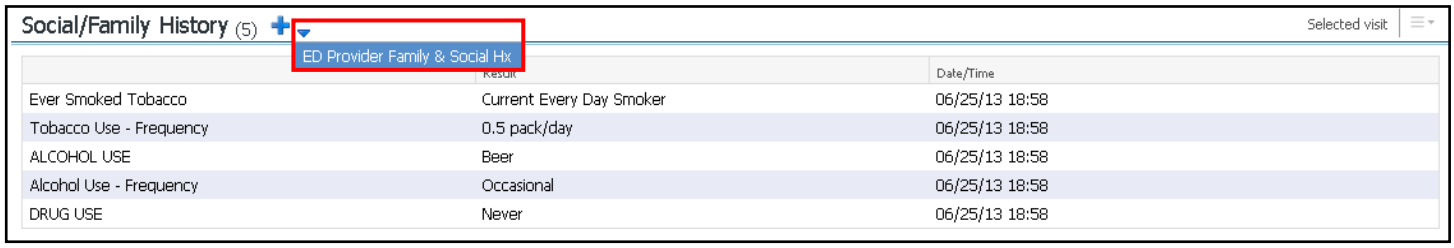
Make sure you are not currently attempting to add a problem. On the main Procedure History Section, right click on the procedure you wish to remove.



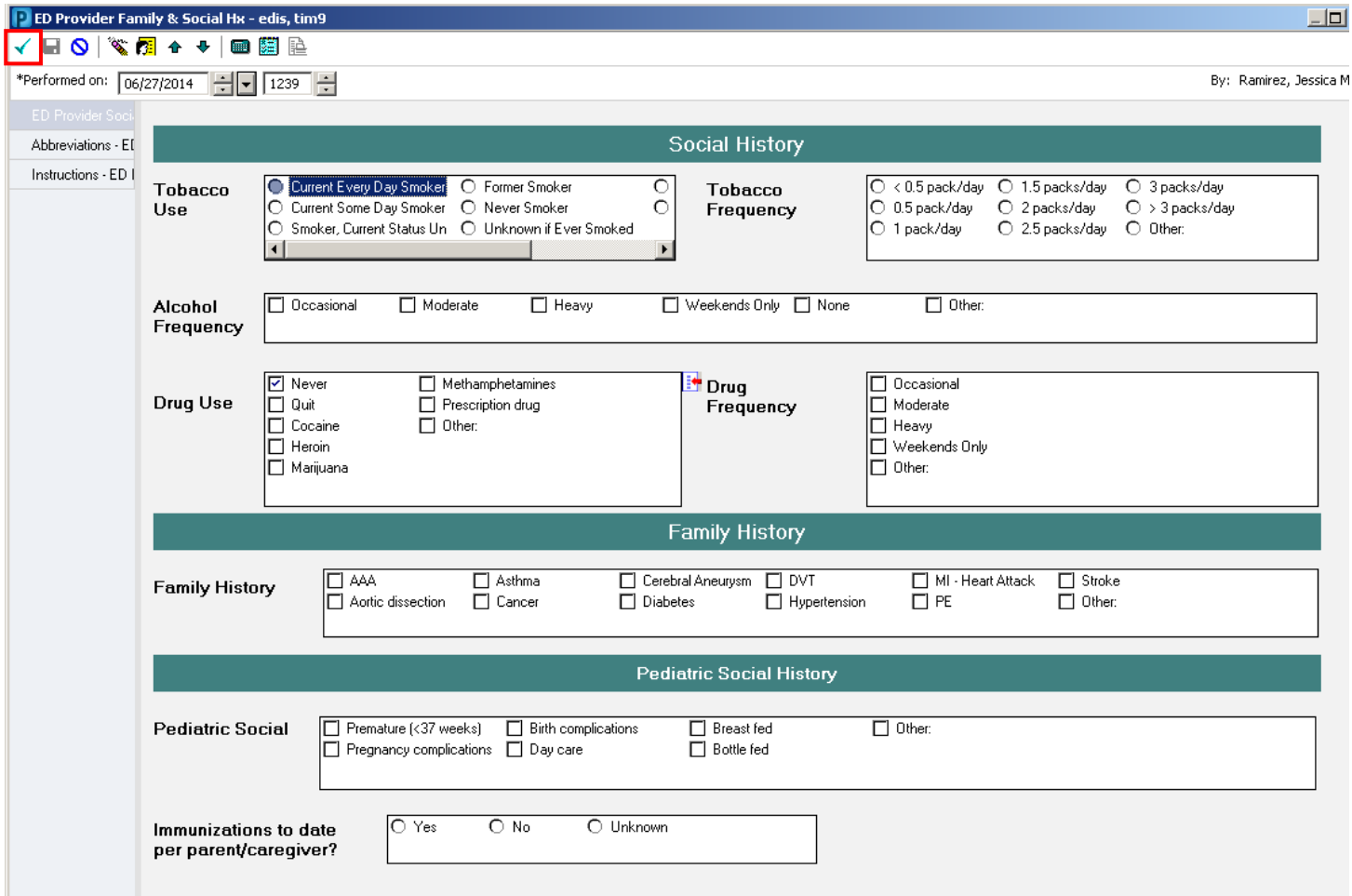
Sections in Documentation Workflow

Social/Family History

Data captured by Nurses. Ensure the date and time are for the current visit. You may want to add additional Social/Family History details. Choose the drop down arrow. This will open a Form for you to fill out.

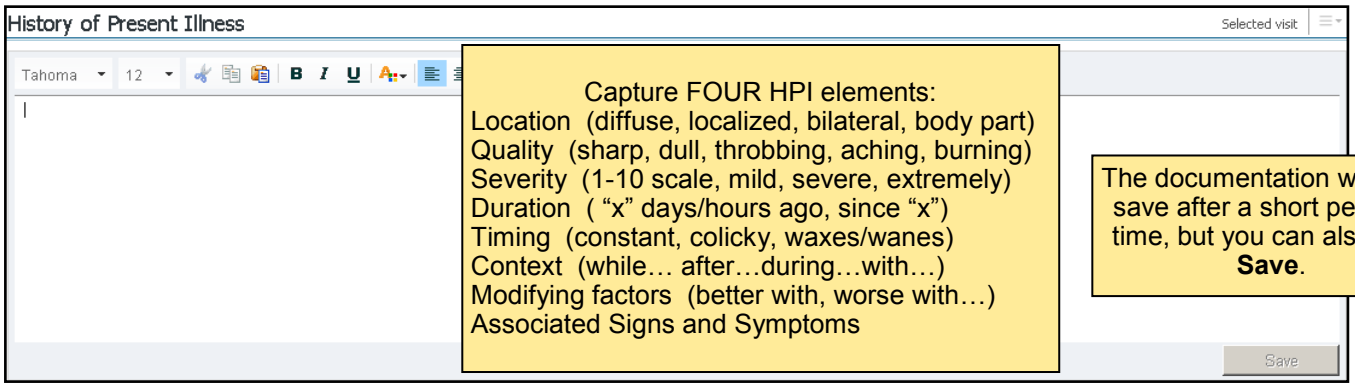


Areas to address are the Family History and Pediatric History. Sign by selecting the Green Check Mark on the top left hand corner of the form.



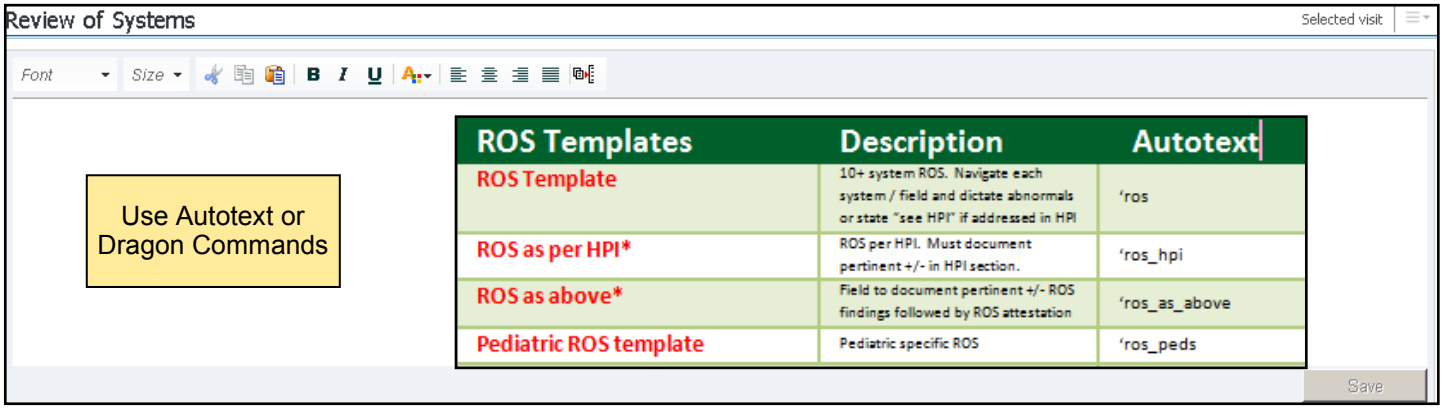
Sections in Documentation Workflow

History of Present Illness



Review of Systems

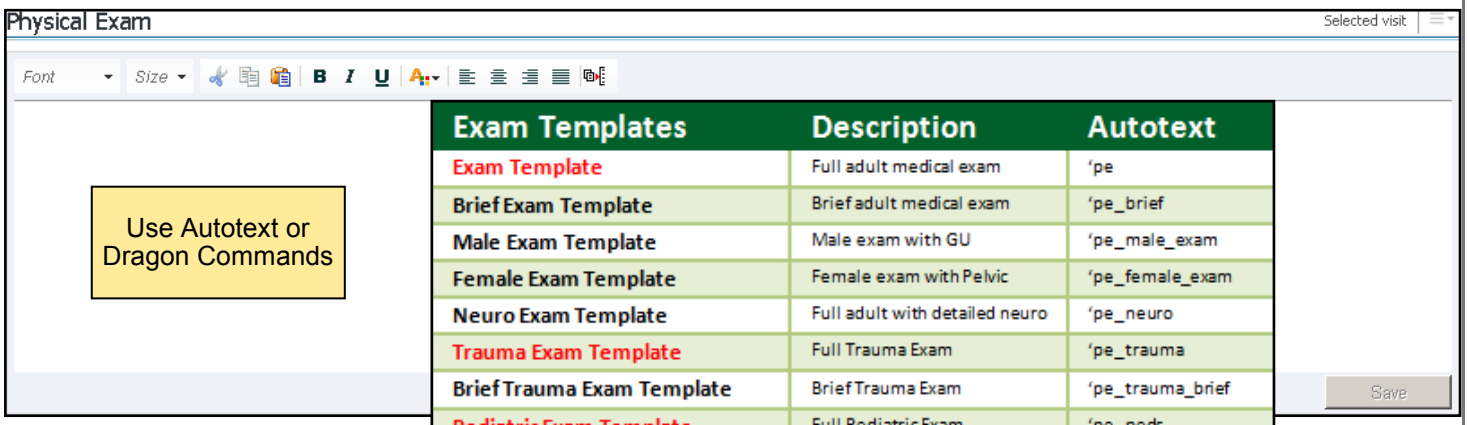
Must Document 10 systems



ROS Templates	Description	Autotext
ROS Template	10+ system ROS. Navigate each system / field and dictate abnormals or state "see HPI" if addressed in HPI	'ros
ROS as per HPI*	ROS per HPI. Must document pertinent +/- in HPI section.	'ros_hpi
ROS as above*	Field to document pertinent +/- ROS findings followed by ROS attestation	'ros_as_above
Pediatric ROS template	Pediatric specific ROS	'ros_peds

Physical Exam

Must Document 8 systems



Exam Templates	Description	Autotext
Exam Template	Full adult medical exam	'pe
Brief Exam Template	Brief adult medical exam	'pe_brief
Male Exam Template	Male exam with GU	'pe_male_exam
Female Exam Template	Female exam with Pelvic	'pe_female_exam
Neuro Exam Template	Full adult with detailed neuro	'pe_neuro
Trauma Exam Template	Full Trauma Exam	'pe_trauma
Brief Trauma Exam Template	Brief Trauma Exam	'pe_trauma_brief
Pediatric Exam Template	Full Pediatric Exam	'pe_peds
Brief Pediatric Exam Template	Brief Pediatric Exam	'pe_peds_brief
Pediatric Trauma Exam Template	Pediatric Trauma Exam	'pe_peds_trauma
Infant Exam Template	Infant Exam	'pe_infant
Psych Exam Template	Med/Psych Exam with clearance	'pe_psych

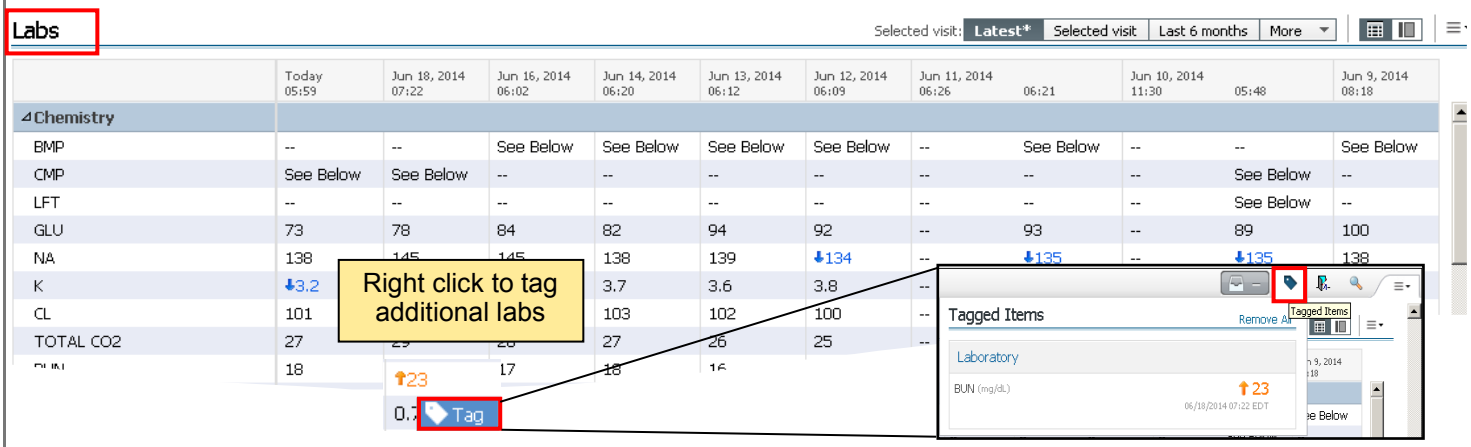
Sections in Documentation Workflow

Labs/ Tagging

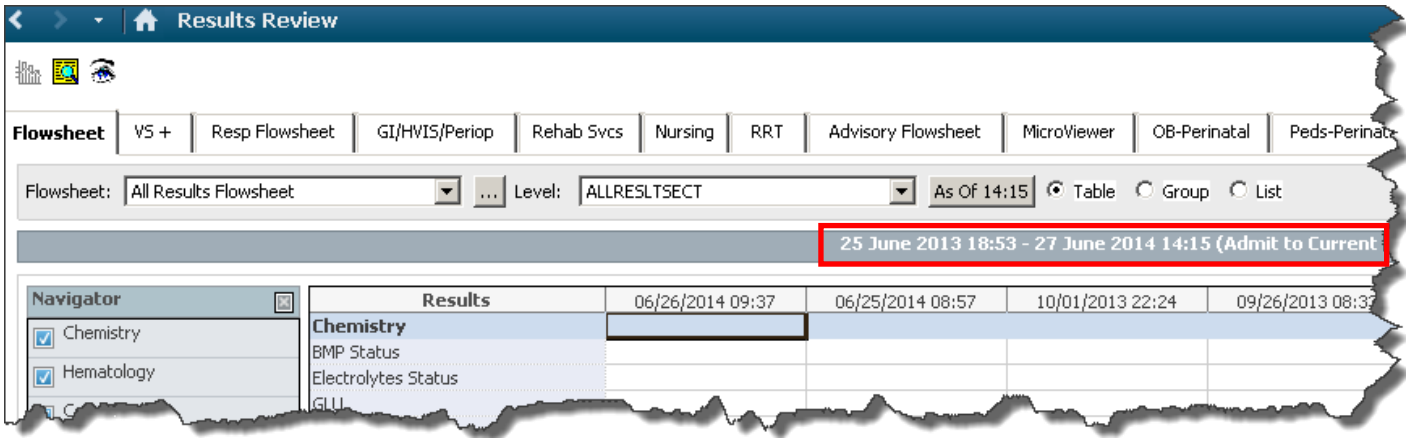
Defaults to Latest labs resulted for this encounter. Change the search criteria by selecting the look back options

Labs that you do not need to tag and will automatically pull into the note include:

Fishbone Labs: CBC/BMP, Troponin, BNP, D-dimer, Mg, Ca, LFT's, Lipase, Ammonia, Lactate, TSH, PT/INR, PTT, Sed Rate/CRP, Type/Rh, HCG Quant, ASA, Tylenol, ETOH, Valproic, Depakote, Phenytoin, Lithium,
Urine Studies: UA, HCG, Urine Tox

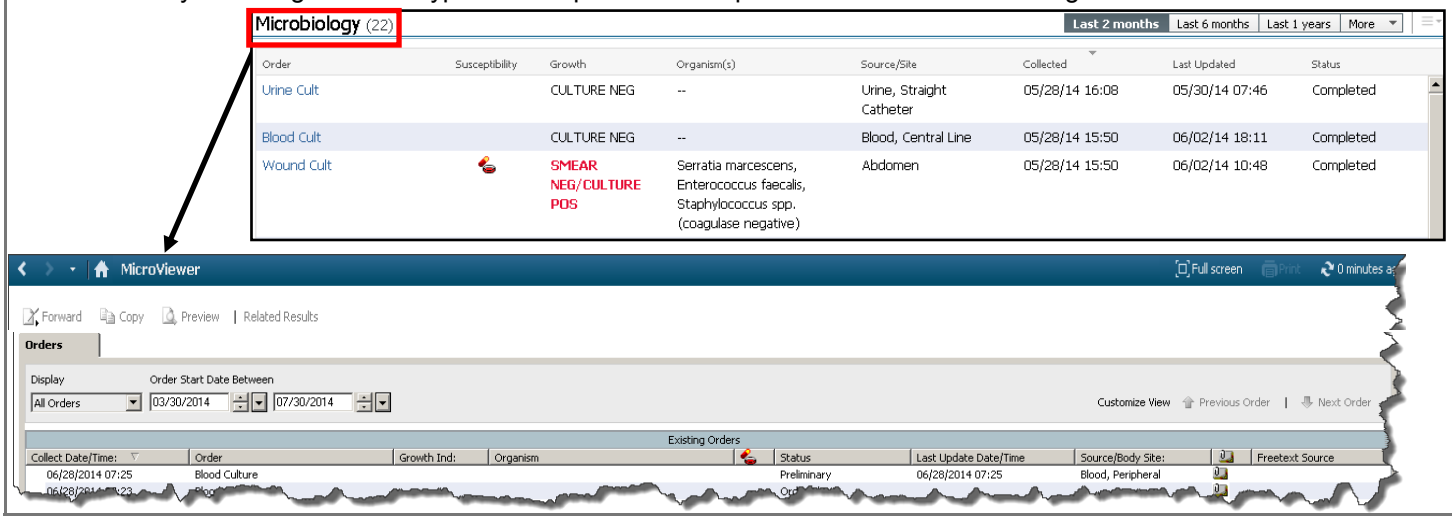


To view labs from past encounters, click the header and it will take you to the flow sheet where you can change the search criteria.



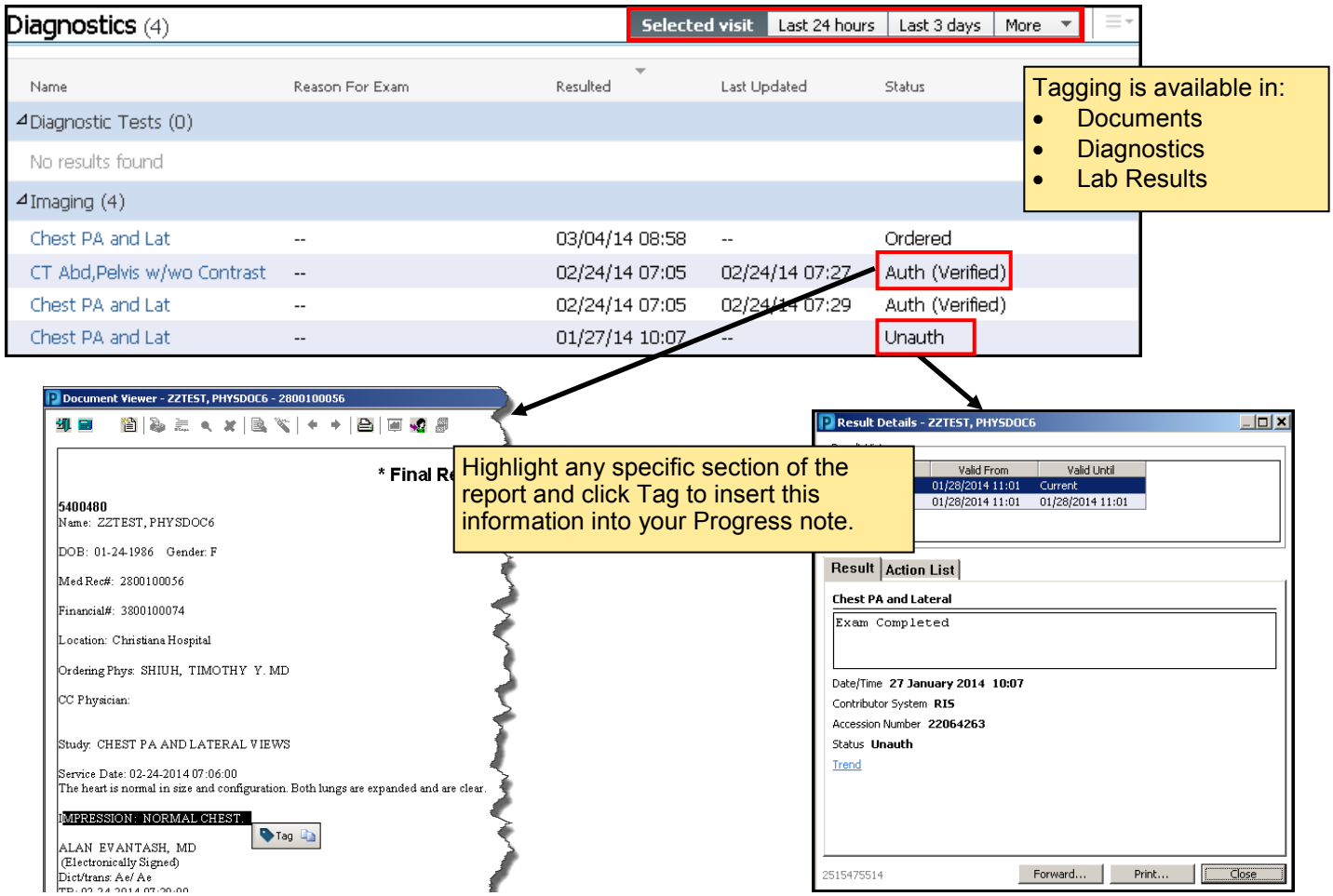
Microbiology

View results by selecting the blue hyperlink to open the full report or Select the header to go to the Micro viewer.



Sections in Documentation Workflow

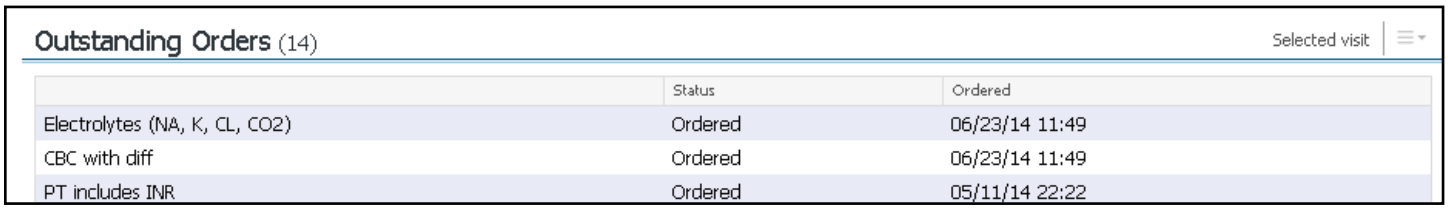
Diagnostics



Clicking an **Unauth** report opens the Result Details window with more information about the order.
Clicking a Report that is Auth (Verified) report opens the Final report.

Outstanding Orders

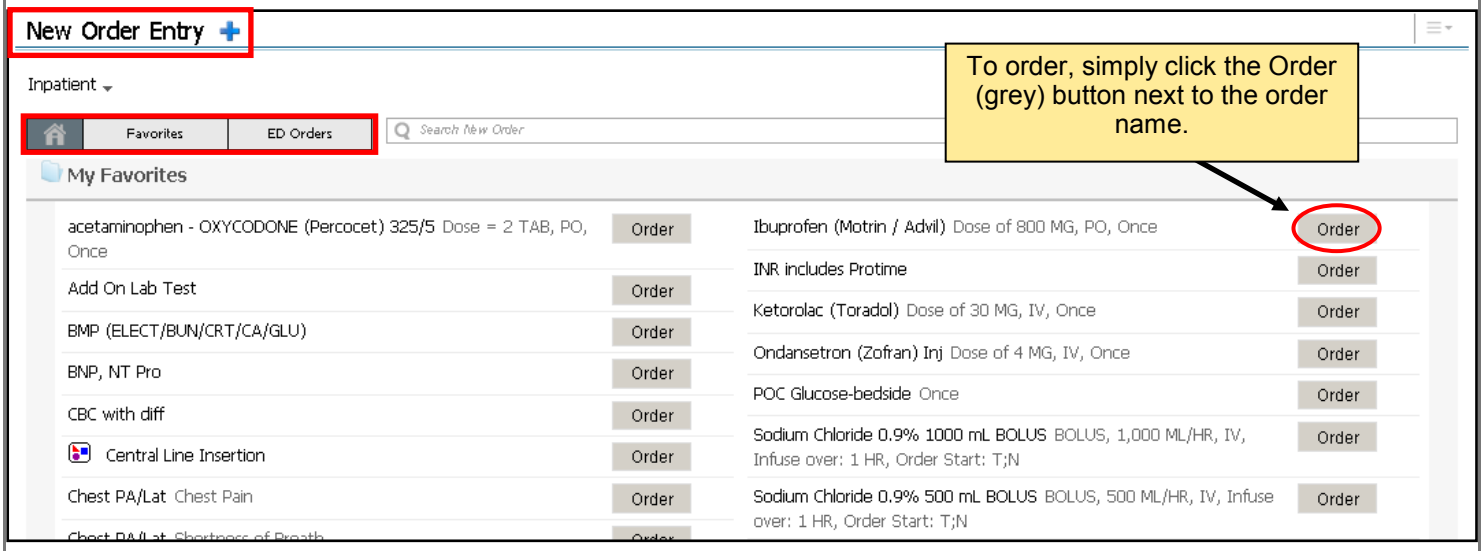
Outstanding orders are orders which have not been completed yet.



Sections in Documentation Workflow

New Order Entry

New Order Entry allows you to quickly add an order from your favorites. The Workflow defaults to your **ED Orders Home Folder**. For your personal Favorites, click the Favorites Section To access the **Quick Orders** screen Click the Header or the Plus sign for the order window you are familiar with. You can also search for an order type the order details into the search field.



Quick Search Entry for New Orders

Be as specific as possible.
1. Type the order, dosage, route and frequency.
2. Select the correct order from the list.

As you make your selections, the Order Inbox in the upper right of the Workflow page turns green and counts the number of orders.
Click the **Order inbox.**

The **Orders for Signature window** appears.

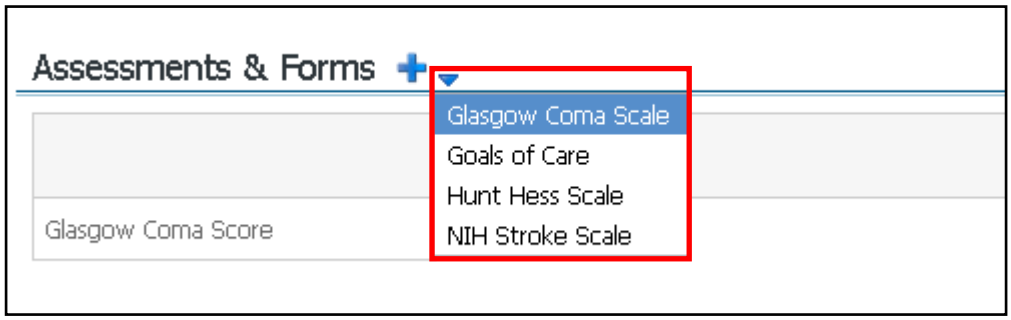
Remove the order by hovering over the order and clicking the **X** that appears.

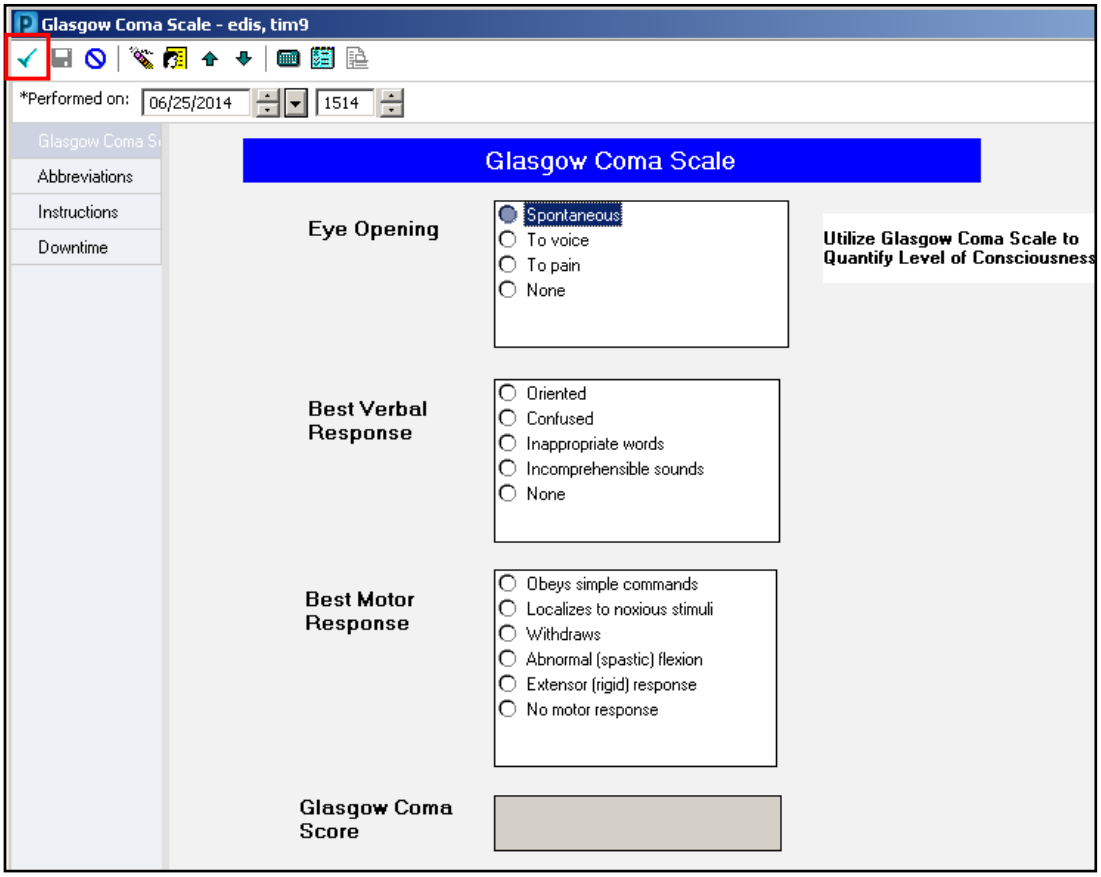
Change order information by clicking **Modify.**

Sections in Documentation Workflow

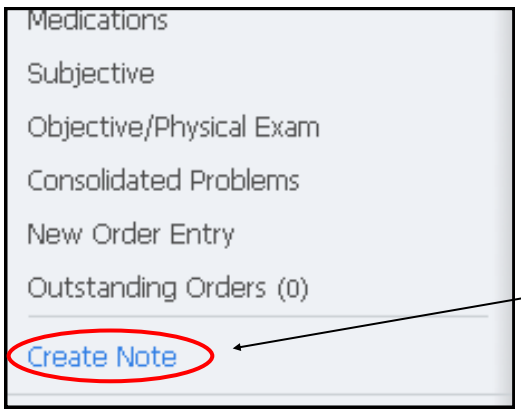
Assessments & Forms

Select the arrow to view the forms you have available. Fill out the details and Sign by clicking the Green Check Mark.





Create Note



Now that your review and documentation are complete, click **Create Note**.

Create Note

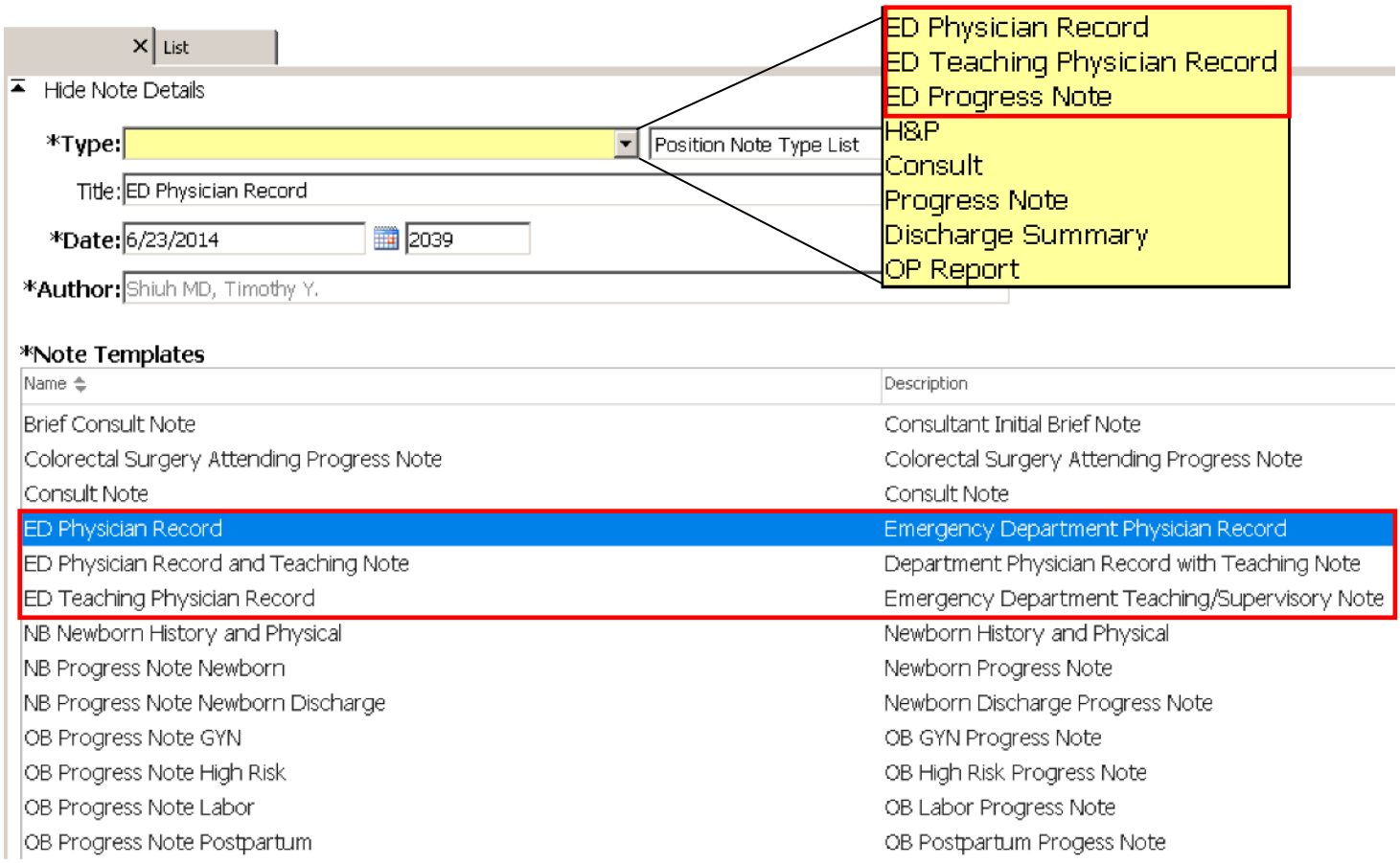
Complete the following steps:

1. Choose your **Note Type**. The Note Type will determine where the document is filed (Location) and will Title your note.
2. Choose the correct **Note Template**. A Note Template determines the structure of your note and items that auto populate (Formal).

ED Physician Record is the FULL ED NOTE — used by all providers

ED Teaching Physician Record is the Supervisory/Teaching Note — used by attending only

ED Progress Note is a miscellaneous note when a completely separate note is needed.— used by all providers



ED Physician Record is the FULL ED NOTE (H&P, MDM, ED Progress, Final Impression/Disposition) Automatically pulls in Date and Time of Service, Triage Chief Complaint, Vitals & Measurements, Final Impression/ Disposition, Problem List/Past Medical History, Procedure/Surgical History, Home Medications, Allergies, Fishbone Lab Results, Diagnostic Orders and has a *ED Attending Note Section*

ED Physician Record – Resident/PA is the same note template as above with additional fields to document name of supervising attending. This is the FULL ED Note template to be used by Residents and PA's

ED Teaching Physician Record is the BRIEF Teaching/Supervisory Note — used by attending when the Resident/ PA completes the ED Physician Record-Resident/PA.

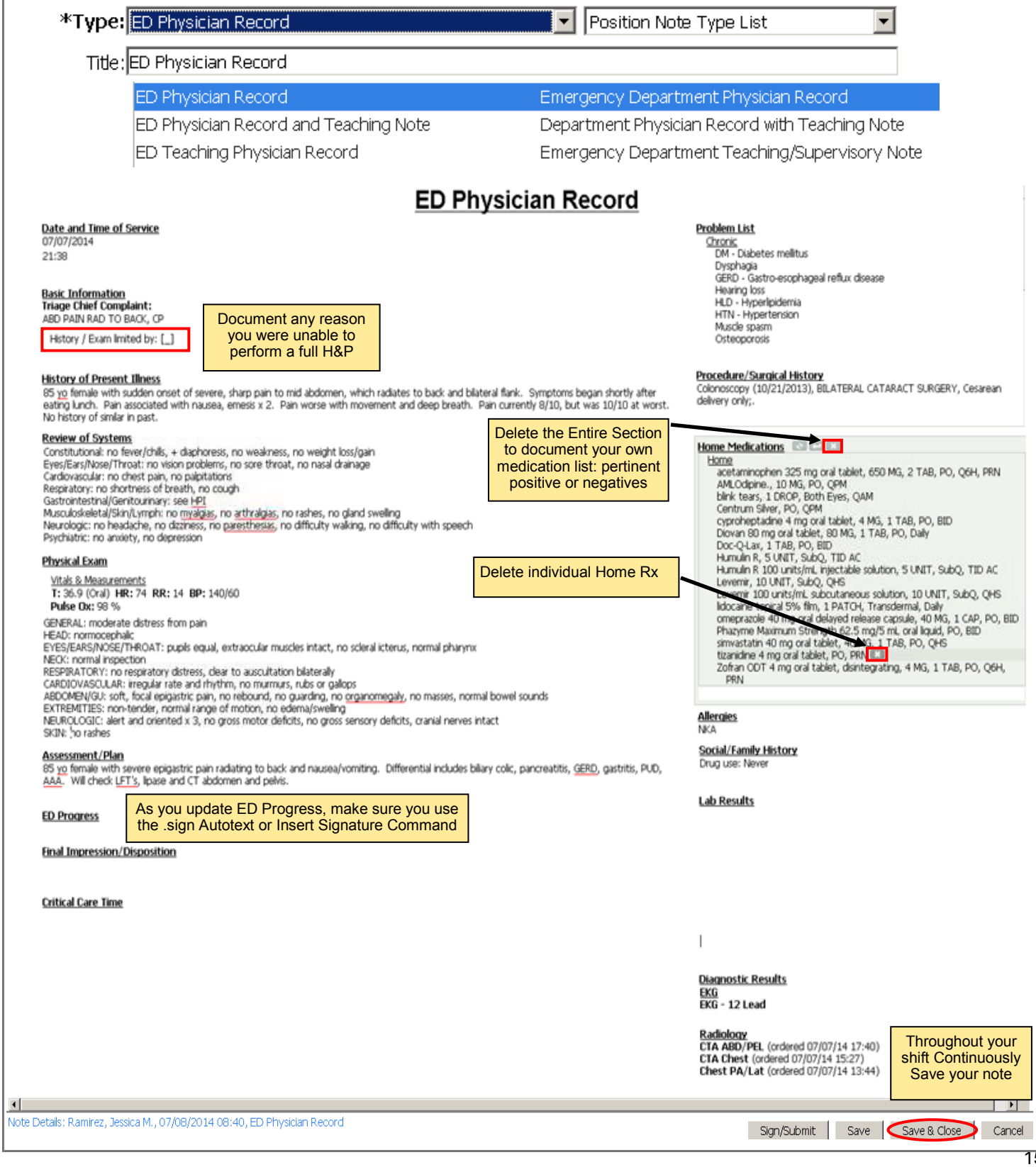
ED Physician Record and Teaching Note is a hybrid FULL ED NOTE with Teaching/Supervisory section for attending. This will be used as the "ED Teaching Physician Record" during the training phase.
Automatically pulls in Date and Time of Service, Vitals and Measurements, Lab results, Diagnostic Result Orders

This note will also be used as a combined Resident and Attending Note in the *future* when **patients are seen synchronously** and be used with the ED Physician Record note type.

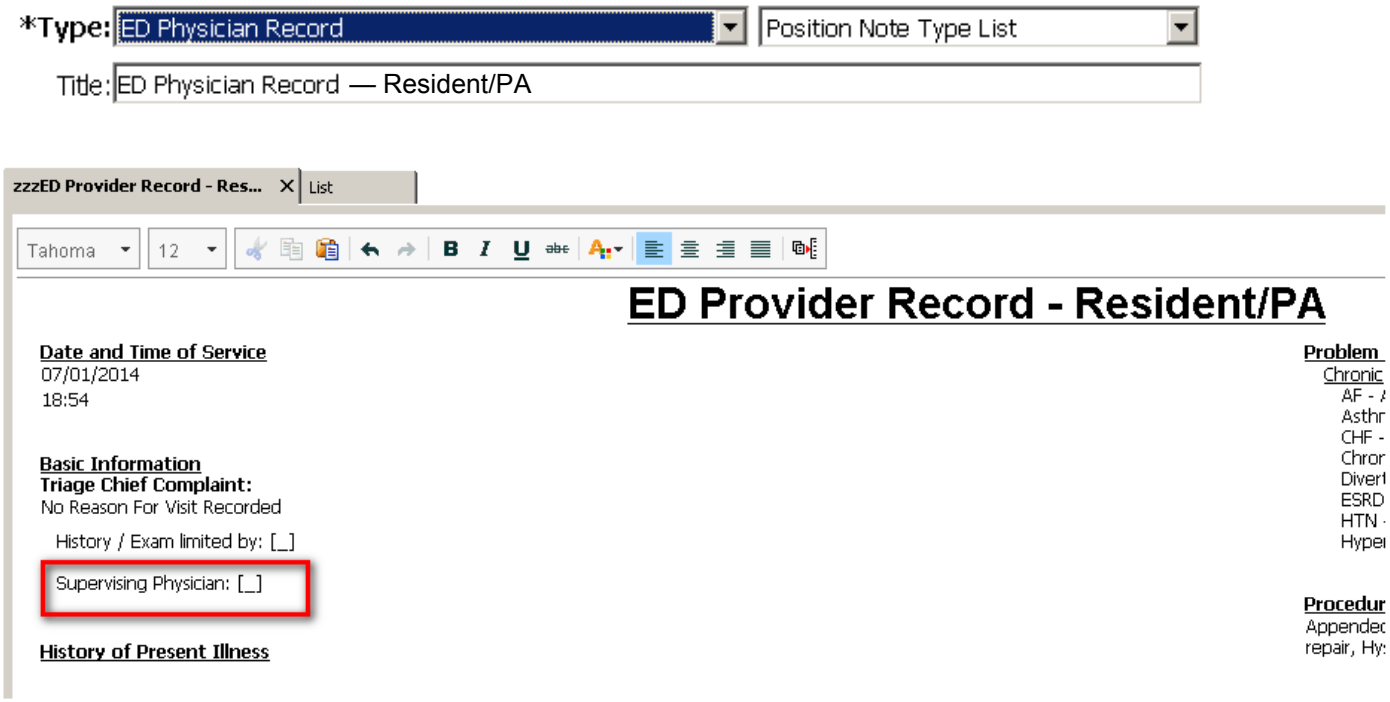
Create Note ED Physician Record Note- Main Note for Attending's

Be aware that Home Meds and Procedures or other information that automatically pulls in may not be up to date. Each section, has the ability to refresh, add a new line or delete the section. Refresh your note throughout the day for the latest information. Refresh and Save your note as many times as needed until the patient disposition is achieved.

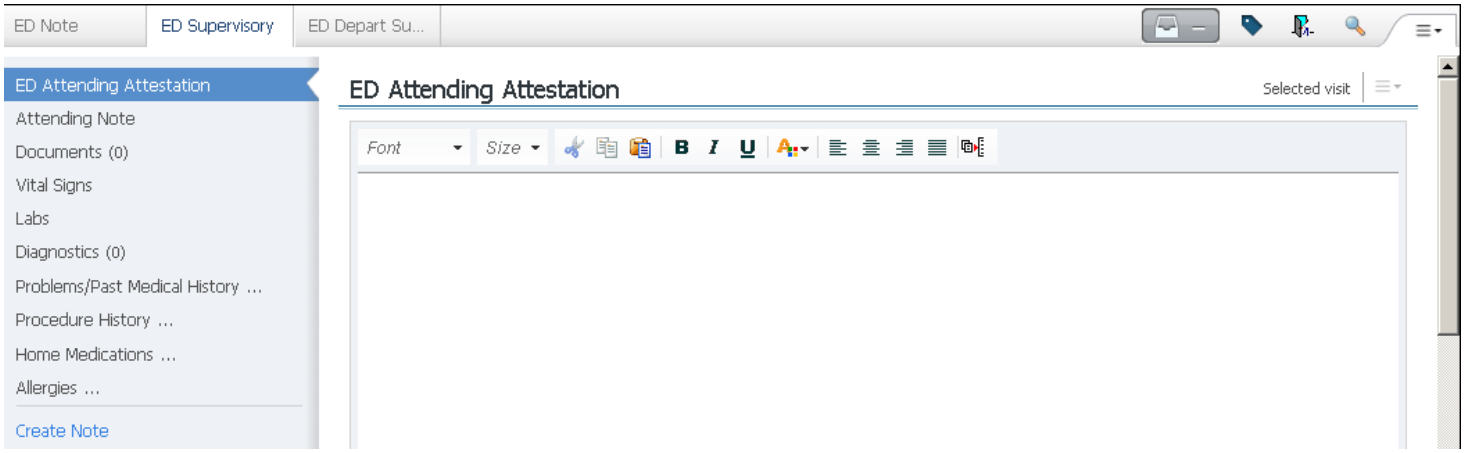
Best Practice: **It is in everyone's best interest** to make sure that the Past Medical Hx, Past Surgical Hx, Home Medication list **is updated in the Cerner controls from the workflow**. This is the *only way* that changes **will carry forward from encounter to encounter**. If you know the medication list is incorrect, please make sure to ask the nurse to update the home medication list and refresh the section afterwards.



Create Note ED Physician Record – Resident/PA

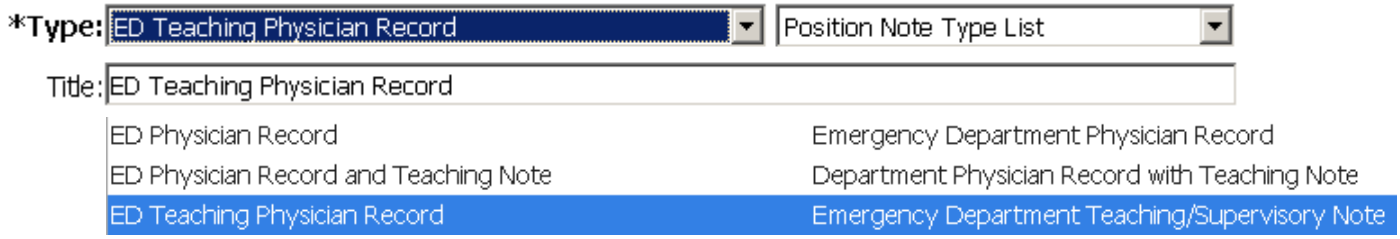


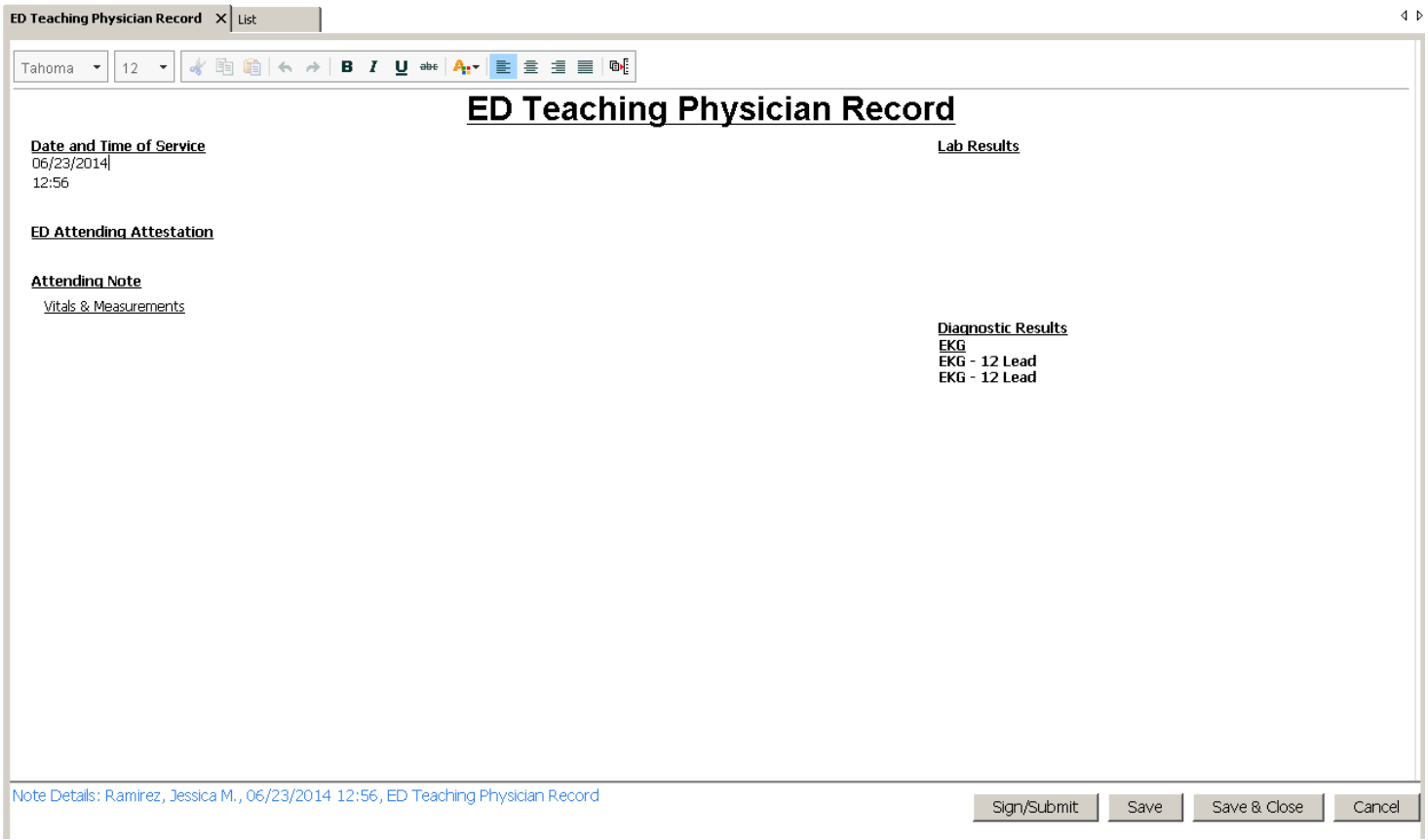
Supervisory Workflow



Supervisory: ED Teaching Physician Record Note

Used by attending only, the ED Teaching Physician Record is the BRIEF Teaching/Supervisory Note — used when the Resident/PA completes the ED Physician Record.



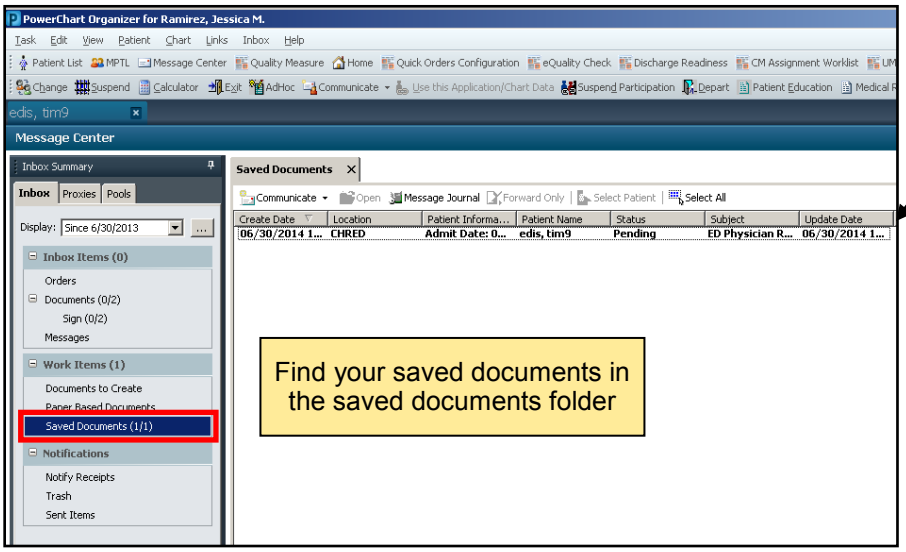


Continuing Documentation

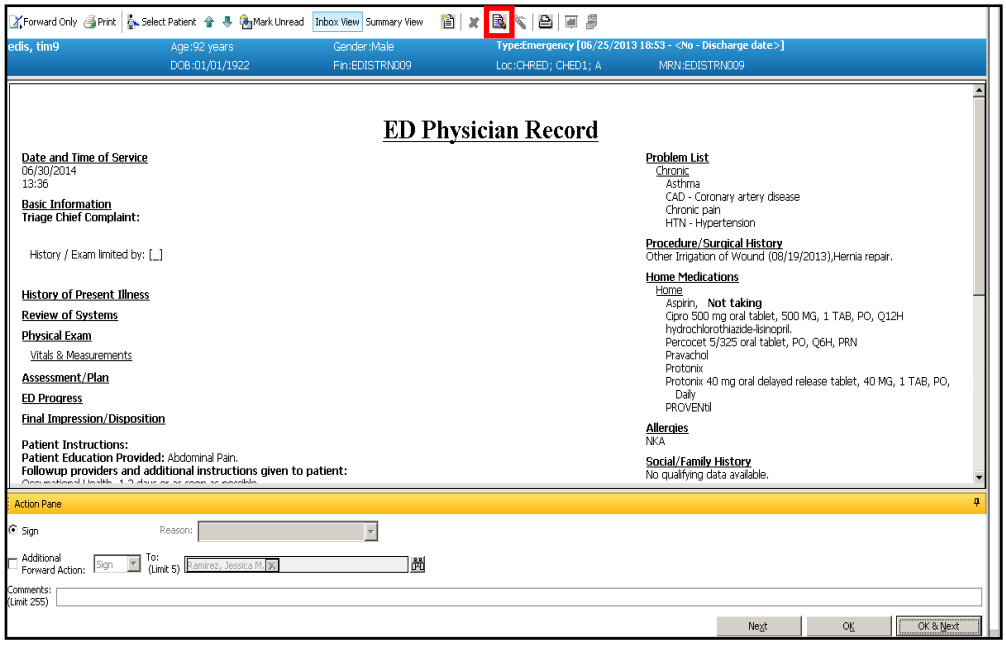
Finding a Saved note

Method #1:

From the Message Center

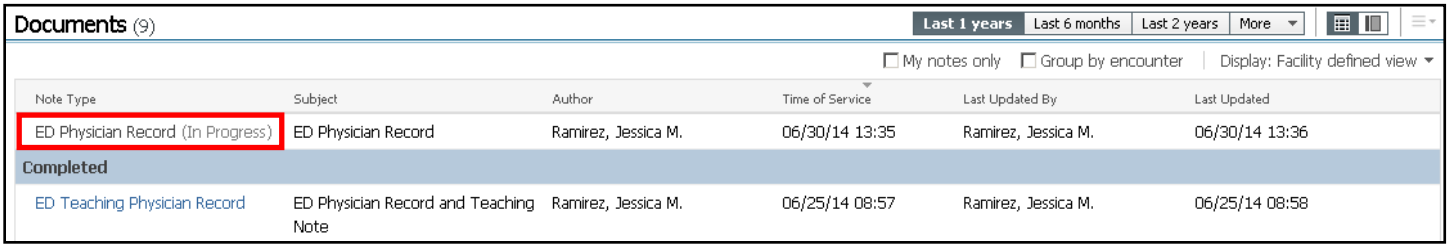


Modify the note by selecting the Icon



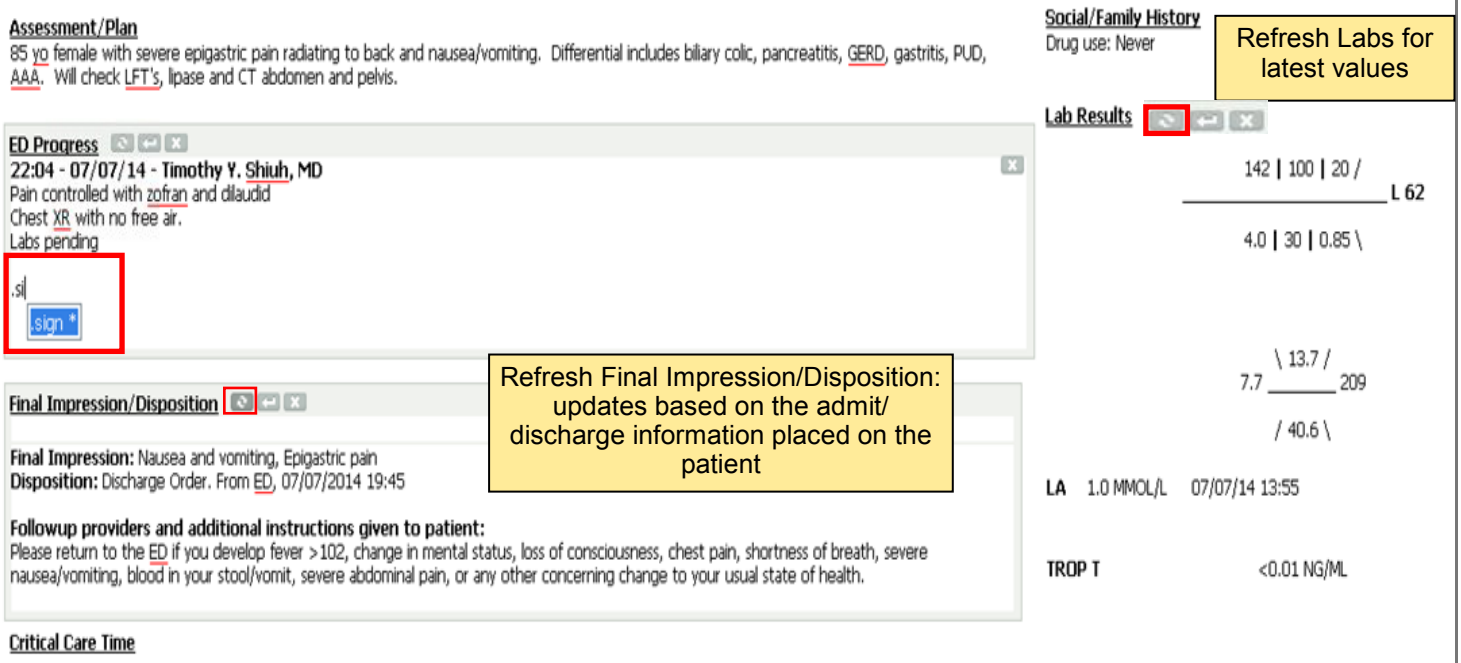
Method #2

From the patients chart, within the documents section you will find your note in progress. Open it by selecting the note type on the left hand side.



Continuing Documentation

1. During the care of the patient, results may come in and new information may be added to the patients chart after you have already started documenting. Refresh each section to pull in new information.
2. As you update the patients progress within the ED Progress Section, use the **.sign** autotext to time stamp your work.
3. Save often.



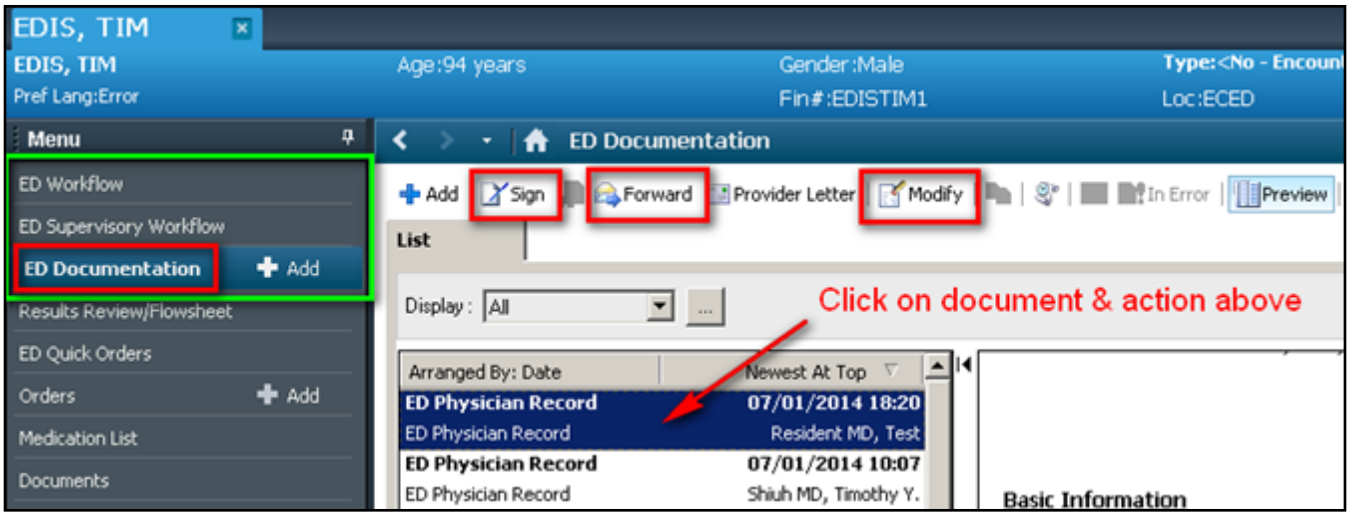
Complete your Note

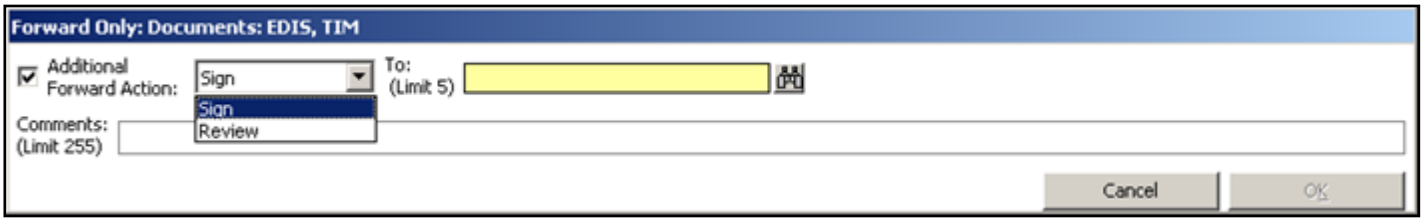
At this point, if the information in your note still is not correct, it is important that it is correct it manually.

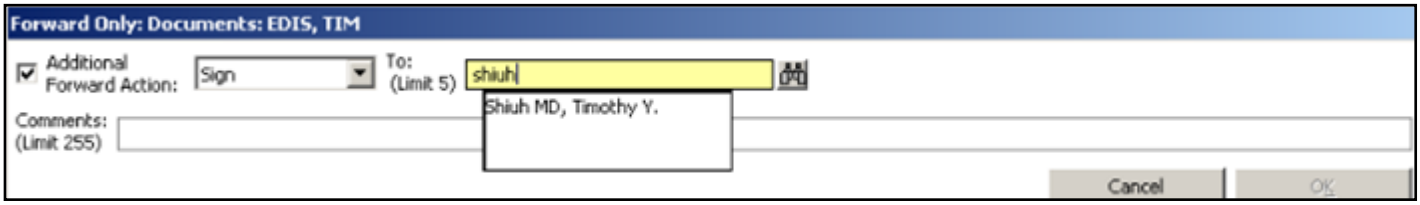
Once you have completed your note, click **Sign & Submit. No more changes can be made in the body of the note, only addendums.**

How to forward a note

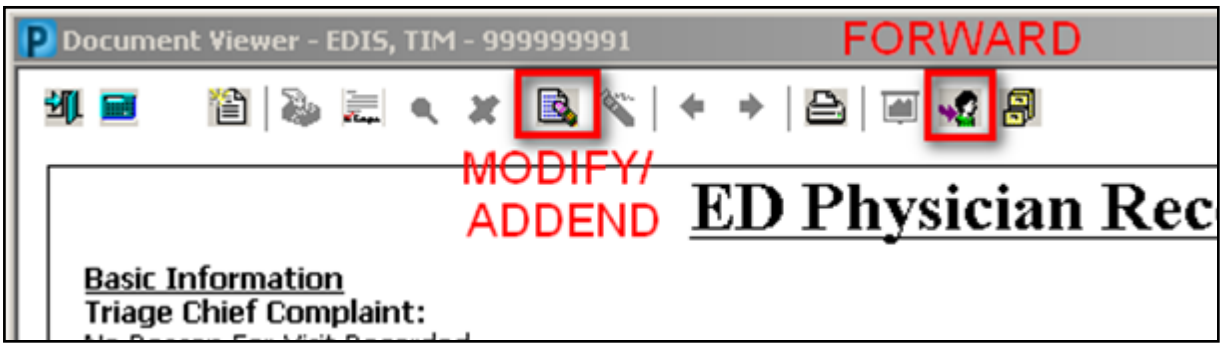
1) Sign Note, back arrow takes you to ED Documentation, click on document to FORWARD
2) Go to ED Documentation menu option, click forward





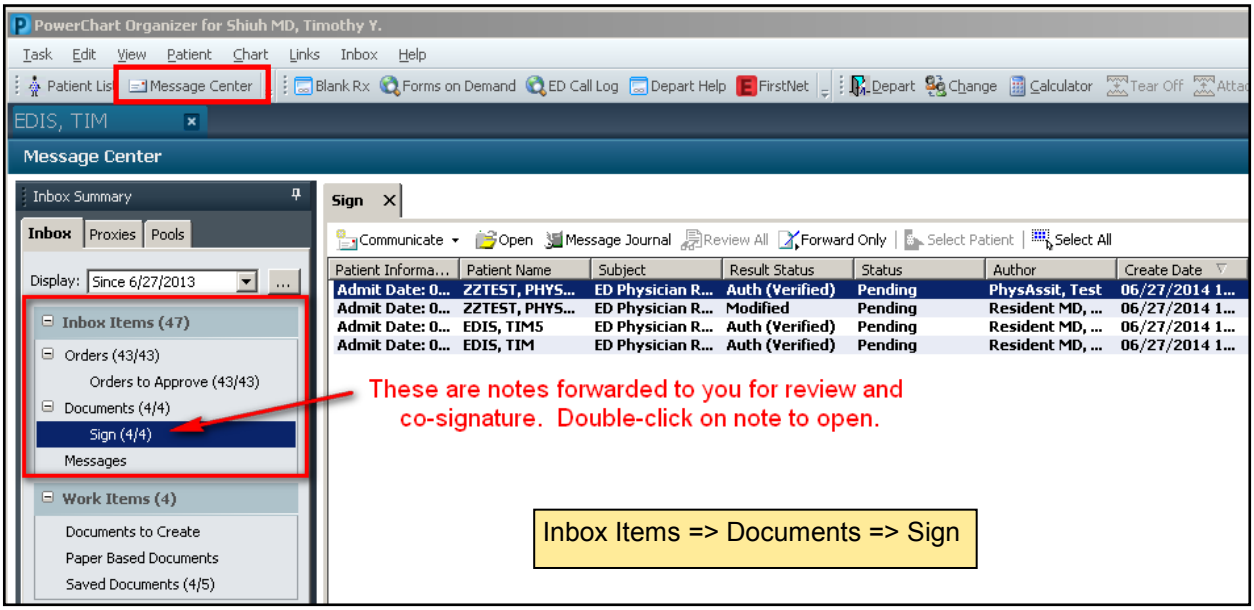


If note opened from workflow or "old" documents menu option, icons are slightly different, but same actions.

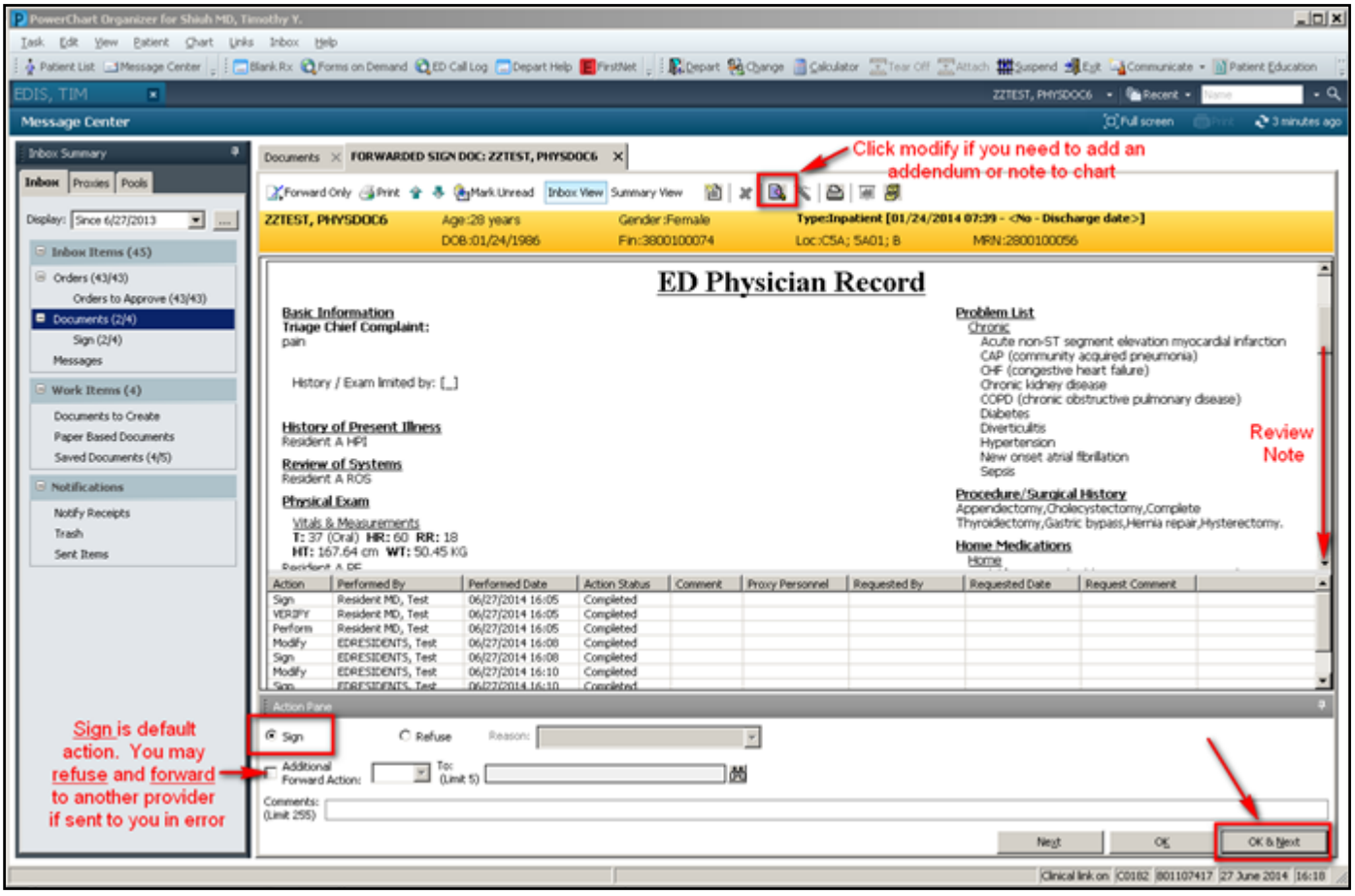


Message Center Workflow (Notes Attending needs to COSIGN)

1. Go to the Message Center at the top left hand side of your screen. Keep in mind that the order of your icons may be differ from someone else.
2. Once you are in the Message Center, in the Inbox Items, go to Documents and then Sign.

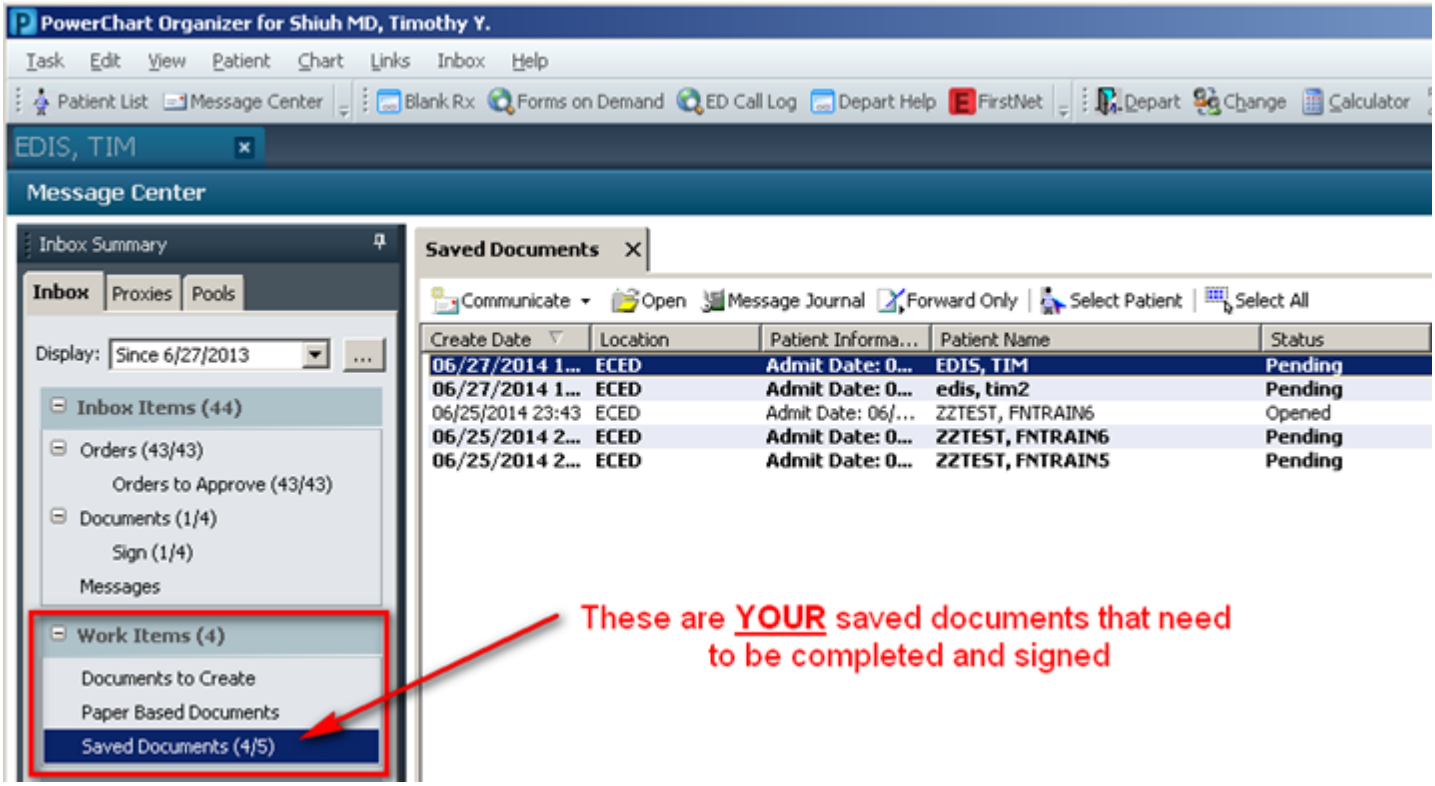


3. Double click to open the document and perform your action— modify, sign or refuse/forward to another provider.

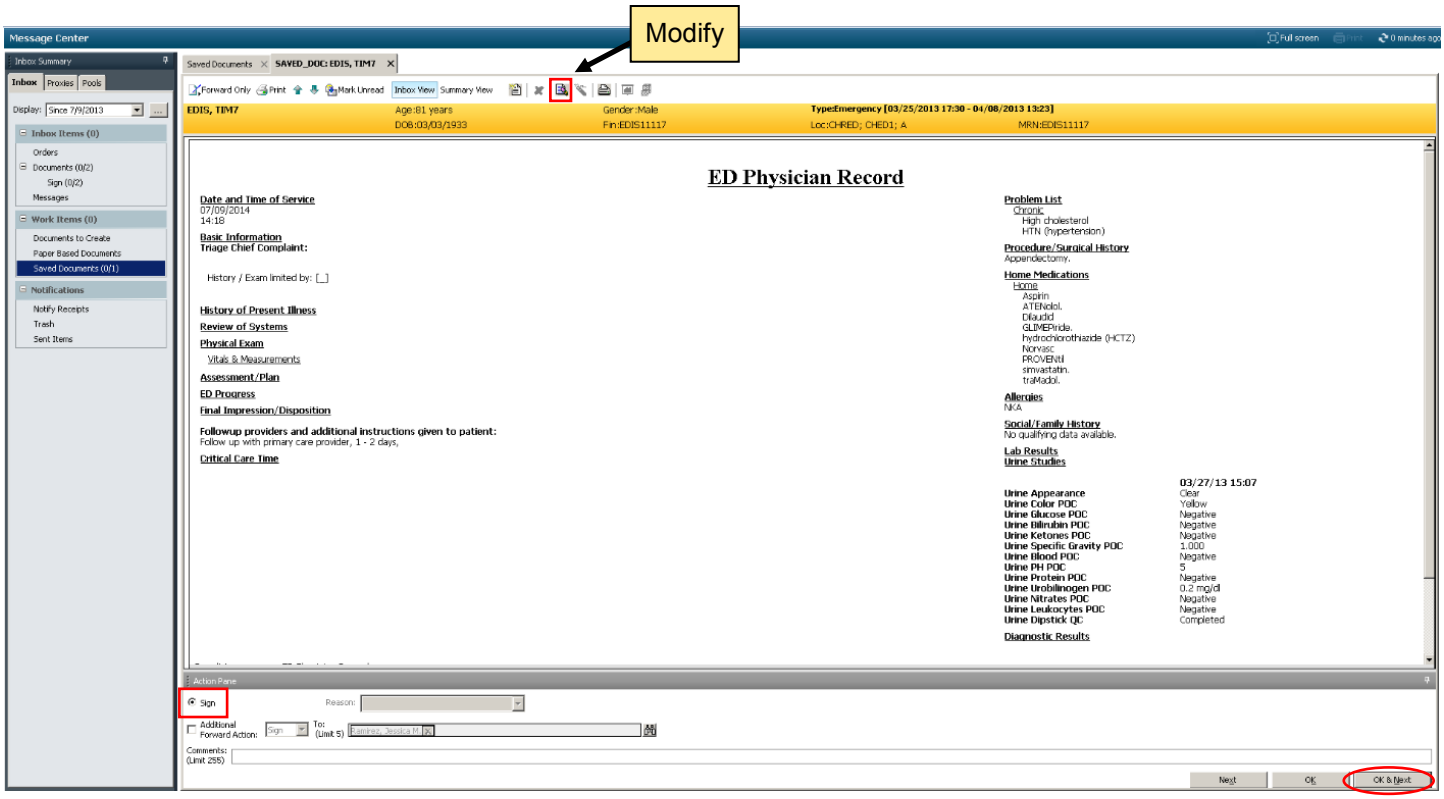


Message Center Workflow (Documents you have CREATED and SAVED and need to finalize and SIGN)

To access your saved documents, go to the Message Center:
Work Items => Saved Documents



Double Click to open a Saved Document and Sign or Modify the document to finalize your note..



Best Practices

1. Providers should document in REAL TIME and keep their note up-to-date during the course of patient care.
2. "Pay It Forward": update Past Medical History, Past Surgical History using the Cerner controls in the workflow. This is the only way to ensure that these updates carry forward from visit to visit. This is a shared responsibility for all providers at CCHS.
3. Similarly, Home Medications should also be updated in the Cerner control. This is vital for accurate documentation and medication reconciliation. Please ask the nurses to update home medications if the electronic list is incorrect and refresh when done.
4. Notes should be created as soon as possible after patient evaluation or case presentation and SAVED to help keep track of notes in message center.
5. Notes should all be SIGNED at the time of patient disposition (admit, discharge). There is a direct link to your documentation in DEPART Mpage. Any additional documentation can be done as addenda.
6. Residents and PAs should forward their note to the attending immediately after presenting the case
   Attending's will receive these notes in their inbox, but should not sign until the note is completed by the Resident/PA

IMPORTANT NOTES:
All notes are published and viewable to others after you CREATE and SAVE
Each time a note is saved, an electronic version is archived and can be audited

Workflow for Shift Change

1. **All notes MUST be updated and SIGNED at time of shift change/transfer of care. This applies to ALL providers—Attending's, Residents, PA's**

2. The provider receiving the patient should continue documenting on the same note. OPEN and MODIFY will create a date/time/signed addendum each time you update the chart and sign the entry. Use Autotext to populate lab results, recent vitals into the addendum, as you will not be able to refresh template sections.

3. At the time of final disposition, use the **'admit_ed or 'discharge_ed** Autotext to populate information from depart or admit process.

4. If the Attending changes while a Resident continues to care for a patient, the Resident should make sure the note was forwarded to the *Attending who received the case presentation and completed the Teaching Note.* The Resident may continue to document on the same chart until their own shift change, at which time the Resident must update, transfer care and SIGN the note.

   The Resident receiving sign out need only forward the note to the new attending if there is significant care or decisions rendered by the new attending.

5. The ED Progress Note may be used if there is a need for extensive continuing documentation

6. Teaching Attending's should continue documentation as addenda to the Teaching Physician Record after shift change/transfer of care.

7. If a provider transfers patient care and leaves without SIGNING/SUBMITTING their note (In Progress status), the receiving provider may continue to modify the original document. Because the note was not signed, the receiving provider will have full edit capabilities and *MUST NOT* change anything that was previously documented. All documentation MUST be done at the end of the note and MUST be qualified with the **.sign** (date/time/sign) Autotext or Dragon Command.

   The receiving provider should then forward the note to all providers *initially involved*, once the note is complete.

8. Notes can be forwarded at ANY time during the course of patient care. Attendings should review notes from message center inbox and SIGN. An Attending may add an addenda to the note should any additional comments or clarifications be required, but ARE NOT REQUIRED to place an attestation or additional documentation as long as the Teaching Note was completed.

   Care should be taken not to SIGN the note until patient care and documentation is complete by the Resident/PA. This will finalize the note and not allow the Resident/PA to continue documentation within the framework of the dynamic template.