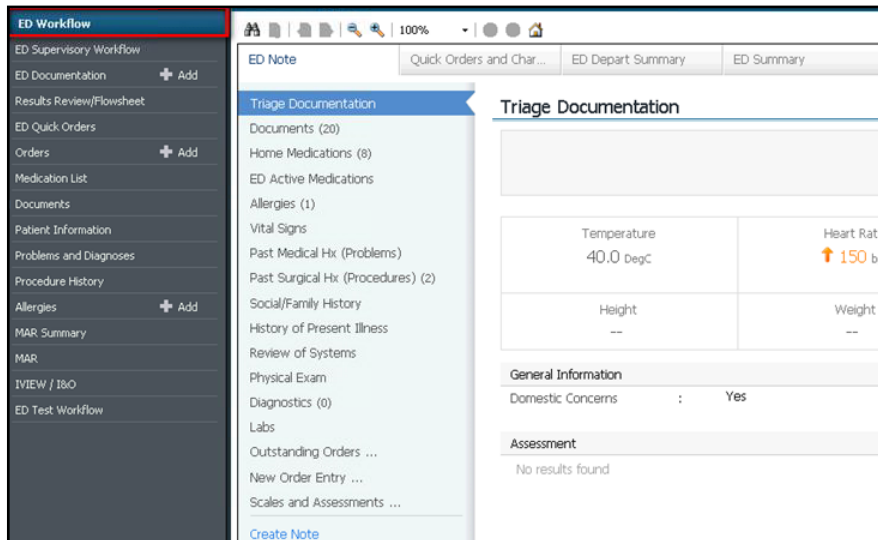


Documentation Workflow

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

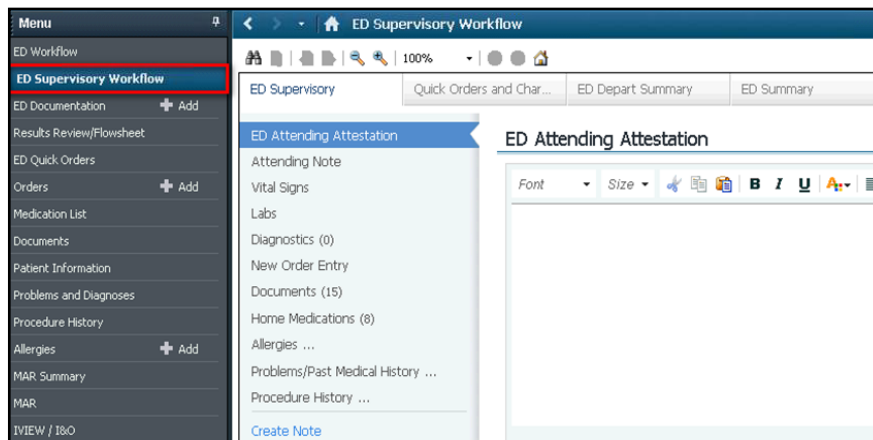
1. From the patient list, open the patient's chart.
2. The **ED Workflows** will open.

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):

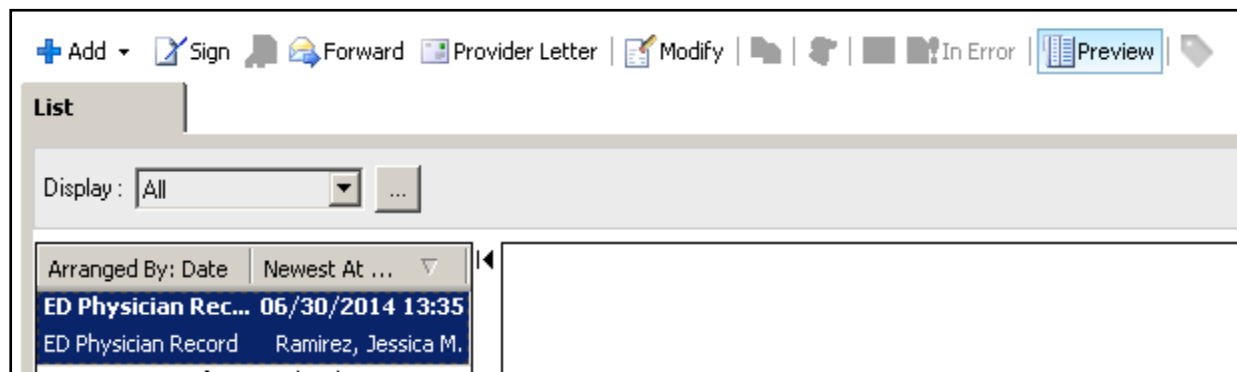
It contains Supervisory Note Documentation Workflow, Quick Orders, Depart, ED Summary



ED Documentation

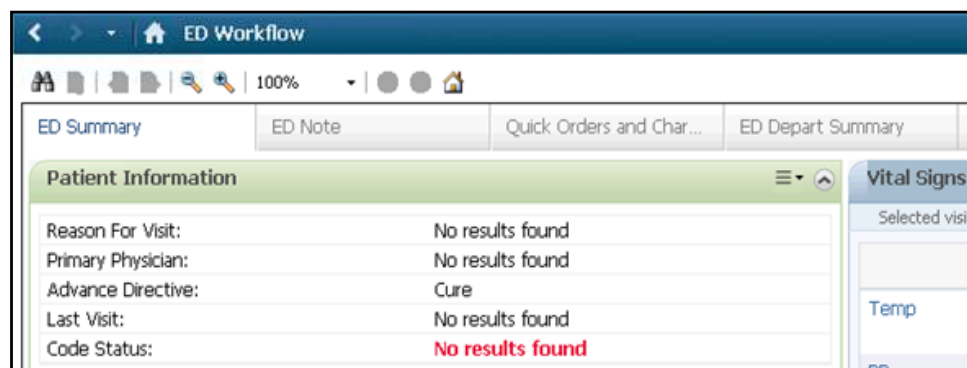
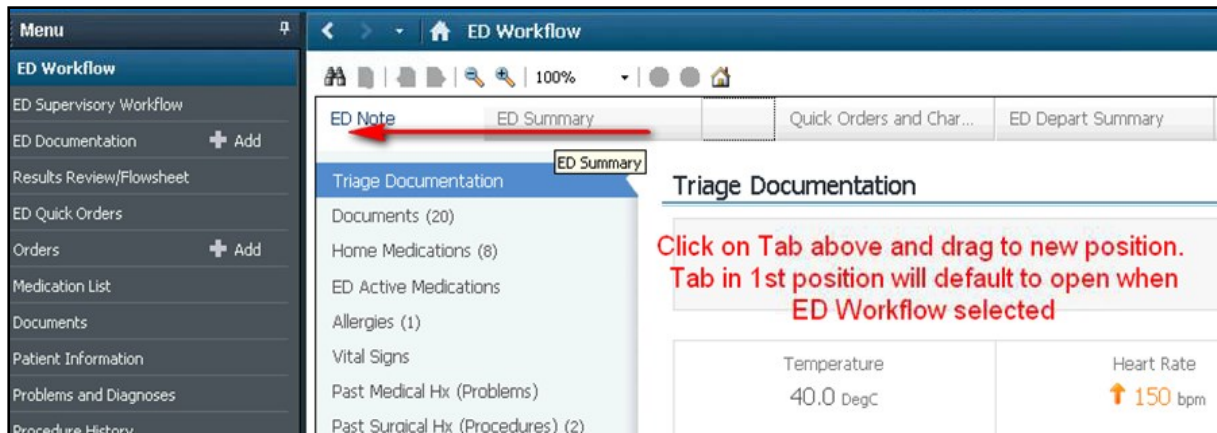
List of ED documents created and frequently viewed documents

This is most efficient location to access a document you created to modify, addend, sign and forward



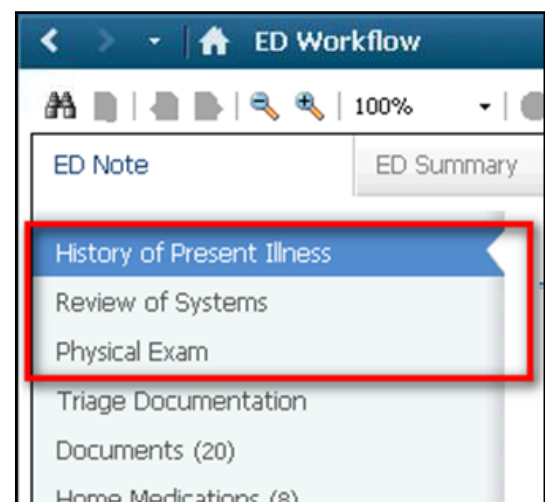
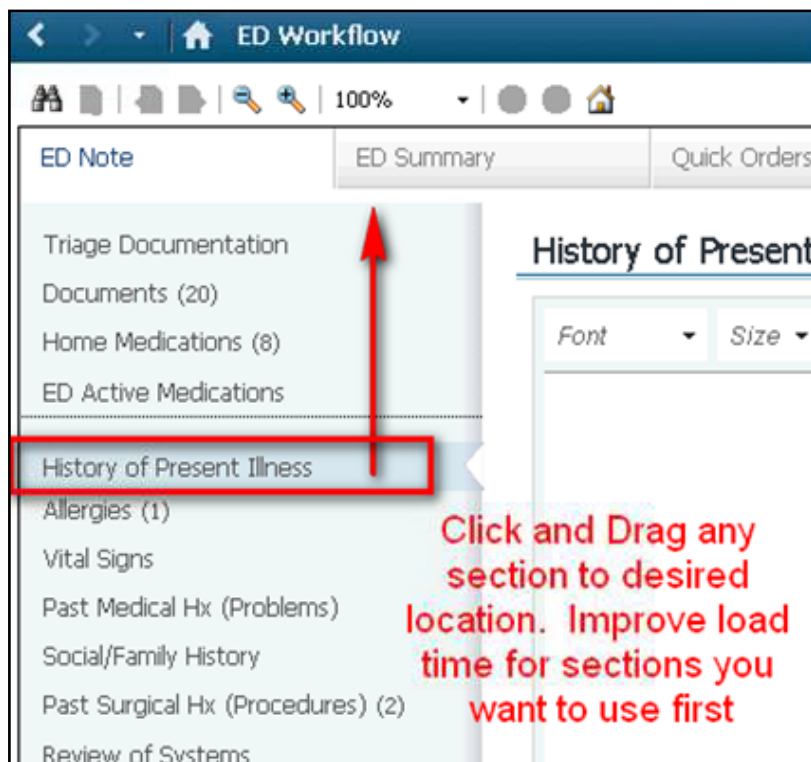
Customize Viewpoint: Click/Drag Tab and place in 1st position to change the default view

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:

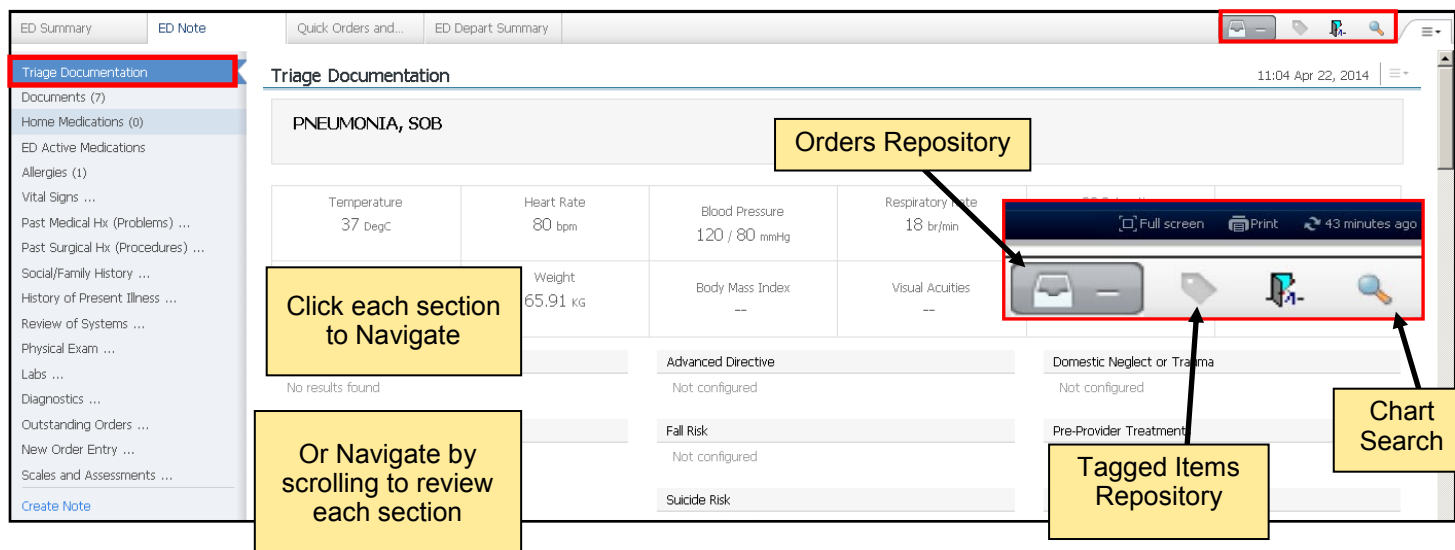
First 4-5 items at top load immediately when page is accessed.



Documentation Workflow

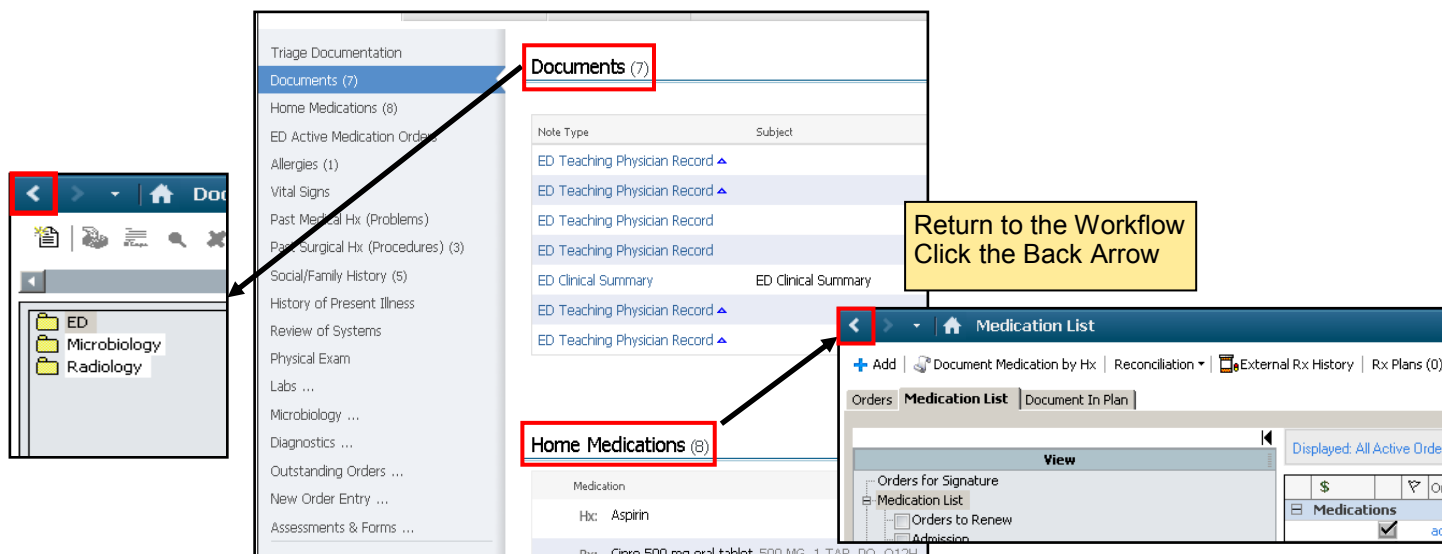
Across the top are different Workflows Options: ED Summary for a quick glance at the MPage, ED Note is the Primary Workflow, Quick Orders, and the ED Depart Summary Workflow for discharging a patient.

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.



The screenshot shows the 'Triage Documentation' workflow for a patient with 'PNEUMONIA, SOB'. The interface includes a top navigation bar with tabs for 'ED Summary', 'ED Note', 'Quick Orders and...', and 'ED Depart Summary'. A left sidebar lists navigation components like 'Documents (7)', 'Home Medications (0)', 'ED Active Medications', 'Allergies (1)', 'Vital Signs ...', 'Past Medical Hx (Problems) ...', 'Past Surgical Hx (Procedures) ...', 'Social/Family History ...', 'History of Present Illness ...', 'Review of Systems ...', 'Physical Exam ...', 'Labs ...', 'Diagnostics ...', 'Outstanding Orders ...', 'New Order Entry ...', and 'Scales and Assessments ...'. The main content area displays patient vitals (Temperature 37 DegC, Heart Rate 80 bpm, Blood Pressure 120 / 80 mmHg, Respiratory Rate 18 br/min, Weight 65.91 kg, Body Mass Index ---, Visual Acuity ---) and a list of orders including 'Advanced Directive', 'Domestic Neglect or Trauma', 'Fall Risk', 'Pre-Provider Treatment', and 'Suicide Risk'. Annotations include: 'Orders Repository' pointing to the top right toolbar; 'Click each section to Navigate' pointing to the left sidebar; 'Or Navigate by scrolling to review each section' pointing to the left sidebar; 'Tagged Items Repository' pointing to the bottom right toolbar; and 'Chart Search' pointing to the bottom right toolbar.

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



The screenshot shows the 'Documents (7)' section selected in the left sidebar. The main content area displays a list of documents including 'ED Teaching Physician Record' and 'ED Clinical Summary'. A 'Home Medications (8)' section is also visible. A 'Medication List' window is open, showing a list of medications including 'Aspirin'. Annotations include: 'Documents (7)' pointing to the selected sidebar item; 'Home Medications (8)' pointing to the sidebar item; 'Return to the Workflow Click the Back Arrow' pointing to the back arrow in the top left corner of the 'Medication List' window; and 'Return to the Workflow Click the Back Arrow' pointing to the back arrow in the top left corner of the main content area.

Sections in Documentation Workflow

Triage

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

Triage Documentation 06:06 Jun 25, 2013

Temperature 36.8 degC	Heart Rate 93 bpm	Blood Pressure 163 / 89 mmHg	Respiratory Rate 20 br/min	O2 Saturation 98 %	Pain 5
Height ---	Weight 50 kg	Body Mass Index ---	Visual Acuity ---	Glasgow Coma Scale 15	

General Information Mode of Arrival : ALS	Advanced Directive Not configured	Domestic Neglect or Trauma Not configured
Assessment Not configured	Fall Risk Morse Fall Risk : Green (Standard Risk)	Pre-Provider Treatments Pre-Arrival/EMS : Pain initial 10/10. Decreased after nitro. Initial SBP 220
	Suicide Risk Not configured	
	Additional History ESI Level : 2	

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

Documents (8)

Timeframe: Last 1 years | Last 6 months | Last 2 years | More

☐ My notes only ☐ Group by encounter Display: Facility defined view

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
ED Teaching Physician Record	ED Physician Record and Teaching Note	Ramirez, Jessica M.	06/25/14 08:57	Ramirez, Jessica M.	06/25/14 08:58
ED Teaching Physician Record		Mink MD, Jennifer T.	09/26/13 08:33	Mink MD, Jennifer T.	09/26/13 08:45

Click on Pane Icon to preview the documents

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

Documents (3)

Selected visit: Last 48 hours | Last 24 hours | Last 1 weeks | More

☐ My notes only ☒ Group by encounter Display: Facility defined view

Progress Note	MDPilot5, Test	04/16/14 13:52
Progress Note	MDPilot5, Test	04/16/14 13:26
Progress Note	MDPilot3, Test	04/16/14 12:14

Progress Note 04/16/14 12:14

Subjective

Objective/Physical Exam

Vitals & Measurements

GENERAL: [awake], [well-developed, well-nourished], [comfortable]
HEENT: [normocephalic, atraumatic], [normal conjunctiva], [pupils equal, round, reactive to light and accommodation], [normal external ear], [normal tympanic membranes], [normal oropharynx]
NECK: [supple], [full range of motion], [no masses], [no thyromegaly]
CARDIOVASCULAR: [normal S1/S2], [regular rate and rhythm], [no murmur/gallops/rub]
LABS: HGB 9.4 G/DL 04/15/2014 13:30 EDT (Low)

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.

Home Medications (8)			
Medication	Last Dose Date/Time	Compliance	Compliance Comments
Hx: Aspirin	--	Not taking	--
Rx: Cipro 500 mg oral tablet 500 MG, 1 TAB, PO, Q12H, 14 TAB	--	--	--
Hx: hydrochlorothiazide-lisinopril.	--	--	--
Rx: Percocet 5/325 oral tablet 1-2 tabs, PO, Q6H, 12 TAB, PRN: Pain	06/18/14 16:19	Still taking, as prescribed	--

ED Active Medication Orders

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

ED Active Medication Orders

Hover to discover Date/Time and Person who completed the Med History

Selected visit ⌵

Scheduled (0)

Continuous (0)

Administered (0) Last 12 hours

Status: Complete
 Last Documented: 06/18/2014 16:21
 Last Documented By: Ramirez, Jessica M.

Status: ✔ Meds History

Adm. Meds Rec ✔ Disch. Meds Rec

✔ = Completed
ⓘ = In Progress
ⓘ = Not Started

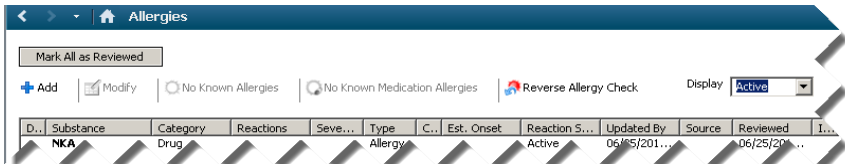
Allergies

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

Allergies (1) +

All Visits ⌵

Name	Severity	Reaction	Reaction Type	Onset	Source	Comments
NKA	--	--	Allergy	--	--	--



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.

Vital Signs +				
	Selected visit: Latest* Selected visit Last 6 months More ⌵			
	Aug 8, 2013 07:06	Jul 24, 2013 13:08	Jul 17, 2013 13:44	Jun 25, 2013 18:55
Temp	36.0	--	--	36.8
BP	--	--	--	163 [2] 89
HR	--	--	--	93
Respiratory Rate	--	--	--	20
Pulse Ox	--	--	--	98
Oxygen Source ED	--	--	--	Nasal Cannula

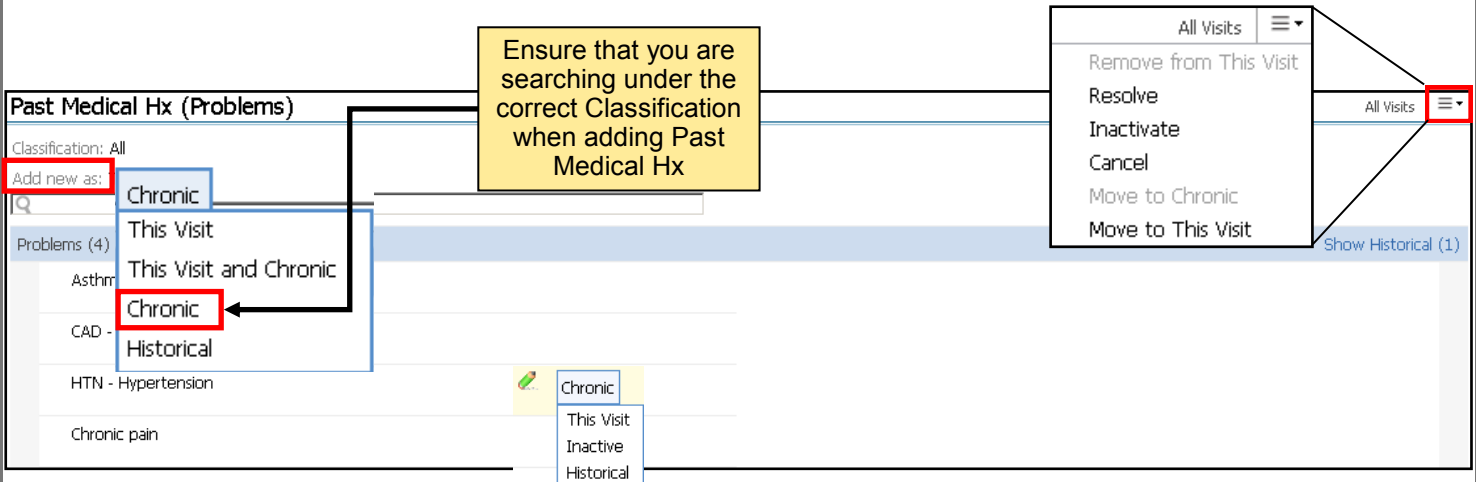
Display defaults to most recent vitals, but the timeframe can be changed.

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.



Past Medical Hx (Problems)

Classification: All

Add new as: **Chronic**

Problems (4)

- Asthma
- CAD -
- HTN - Hypertension
- Chronic pain

Ensure that you are searching under the correct Classification when adding Past Medical Hx

Chronic
This Visit
This Visit and Chronic
Chronic
Historical

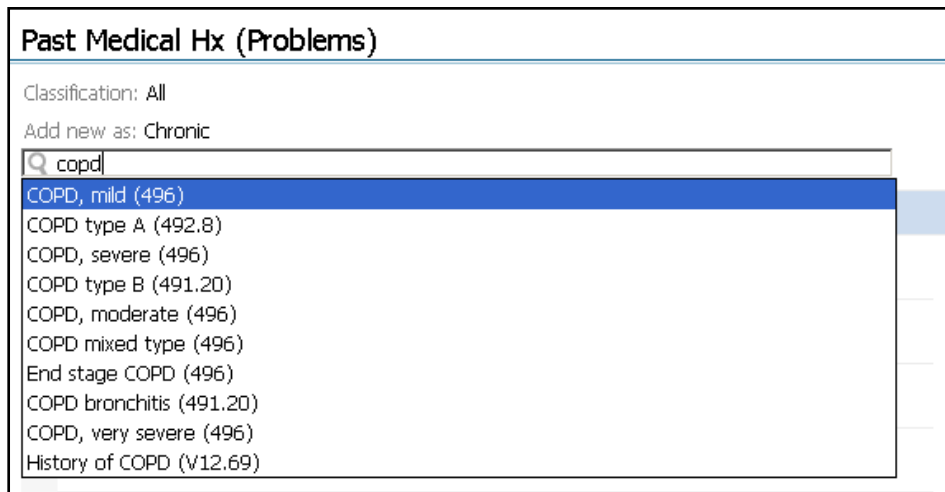
Chronic
This Visit
Inactive
Historical

All Visits
Remove from This Visit
Resolve
Inactivate
Cancel
Move to Chronic
Move to This Visit

All Visits

Show Historical (1)

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



Past Medical Hx (Problems)

Classification: All

Add new as: Chronic

Q copd

- COPD, mild (496)
- COPD type A (492.8)
- COPD, severe (496)
- COPD type B (491.20)
- COPD, moderate (496)
- COPD mixed type (496)
- End stage COPD (496)
- COPD bronchitis (491.20)
- COPD, very severe (496)
- History of COPD (V12.69)

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 .



Past Medical Hx (Problems)

Classification: All

Add new as: This Visit

Q

Problems (4)

- Asthma
- CAD - Coronary artery disease
- HTN - Hypertension

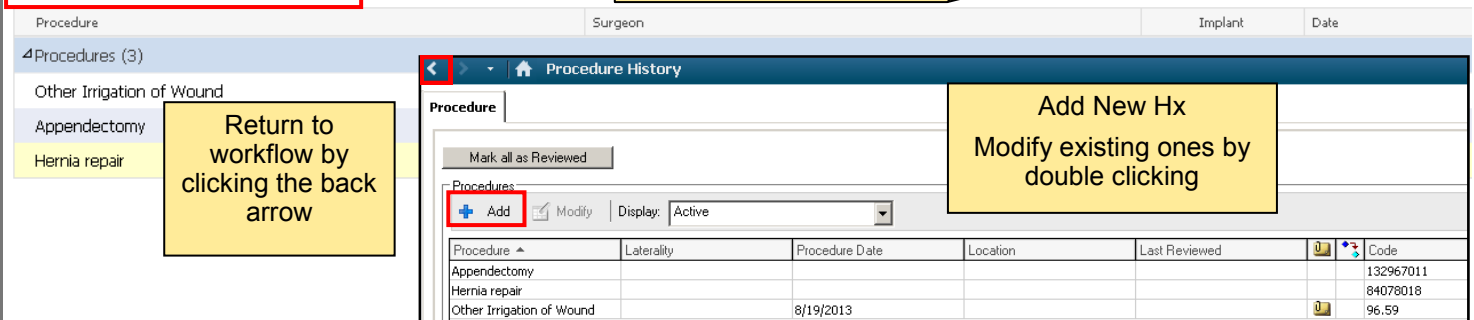
All Visits
Remove from This Visit
Resolve
Inactivate
Cancel
Move to Chronic
Move to This Visit

Sections in Documentation Workflow

Past Surgical Hx (Procedures)

Past Surgical Hx (Procedures) (3)

To add a new PSH select the header



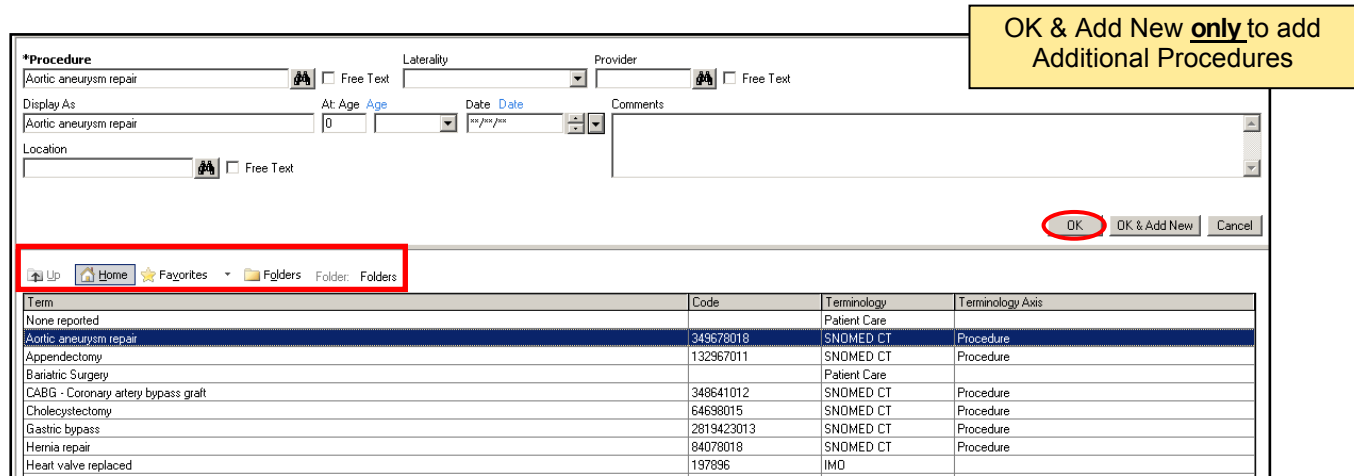
Return to workflow by clicking the back arrow

Add New Hx
Modify existing ones by double clicking

Procedure	Laterality	Procedure Date	Location	Last Reviewed	Code
Appendectomy					132967011
Hernia repair					84078018
Other Irrigation of Wound		8/19/2013			96.59

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.



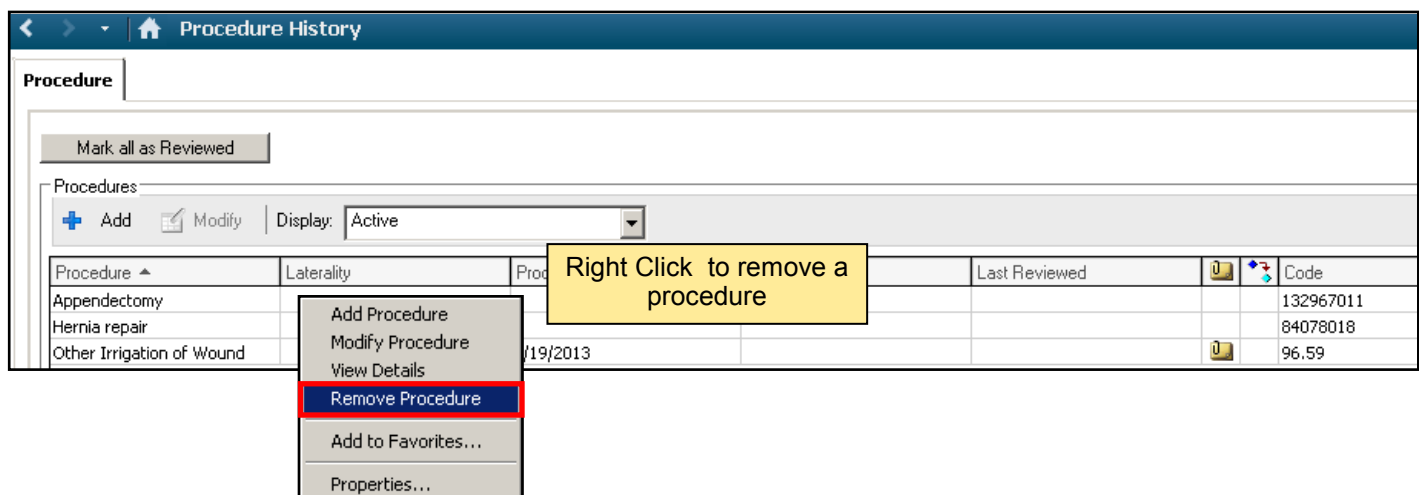
OK & Add New only to add Additional Procedures

Up Home Favorites Folders Folder Folders

Term	Code	Terminology	Terminology Axis
None reported		Patient Care	
Aortic aneurysm repair	349678018	SNOMED CT	Procedure
Appendectomy	132967011	SNOMED CT	Procedure
Bariatric Surgery		Patient Care	
CABG - Coronary artery bypass graft	348641012	SNOMED CT	Procedure
Cholecystectomy	64698015	SNOMED CT	Procedure
Gastric bypass	2819423013	SNOMED CT	Procedure
Hernia repair	84078018	SNOMED CT	Procedure
Heart valve replaced	197896	IMO	

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.





Right Click to remove a procedure

Procedure	Laterality	Procedure Date	Last Reviewed	Code
Appendectomy				132967011
Hernia repair				84078018
Other Irrigation of Wound		8/19/2013		96.59









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.

Social/Family History (5) 			Selected visit 
ED Provider Family & Social Hx			
Ever Smoked Tobacco	Current: Every Day Smoker	Date/Time	06/25/13 18:58
Tobacco Use - Frequency	0.5 pack/day		06/25/13 18:58
ALCOHOL USE	Beer		06/25/13 18:58
Alcohol Use - Frequency	Occasional		06/25/13 18:58
DRUG USE	Never		06/25/13 18:58

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.

ED Provider Family & Social Hx - edis, tim9

*Performed on: 06/27/2014 1239
By: Ramirez, Jessica M

ED Provider Social
Abbreviations - ED
Instructions - ED

Social History

Tobacco Use
☒ Current Every Day Smoker
☐ Former Smoker
☐ Current Some Day Smoker
☐ Never Smoker
☐ Smoker, Current Status Unknown
☐ Unknown if Ever Smoked

Tobacco Frequency
☐ < 0.5 pack/day
☐ 0.5 pack/day
☐ 1 pack/day
☐ 1.5 packs/day
☐ 2 packs/day
☐ 2.5 packs/day
☐ 3 packs/day
☐ > 3 packs/day
☐ Other:

Alcohol Frequency
☐ Occasional
☐ Moderate
☐ Heavy
☐ Weekends Only
☐ None
☐ Other:

Drug Use
☒ Never
☐ Quit
☐ Cocaine
☐ Heroin
☐ Marijuana
☐ Methamphetamines
☐ Prescription drug
☐ Other:

Drug Frequency
☐ Occasional
☐ Moderate
☐ Heavy
☐ Weekends Only
☐ Other:

Family History
☐ AAA
☐ Aortic dissection
☐ Asthma
☐ Cancer
☐ Cerebral Aneurysm
☐ Diabetes
☐ DVT
☐ Hypertension
☐ MI - Heart Attack
☐ PE
☐ Stroke
☐ Other:

Pediatric Social History
☐ Premature (<37 weeks)
☐ Birth complications
☐ Day care
☐ Breast fed
☐ Bottle fed
☐ Other:

Immunizations to date per parent/caregiver?
☐ Yes
☐ No
☐ Unknown

Sections in Documentation Workflow

History of Present Illness

History of Present Illness

Tahoma 12

Capture FOUR HPI elements:
 Location (diffuse, localized, bilateral, body part)
 Quality (sharp, dull, throbbing, aching, burning)
 Severity (1-10 scale, mild, severe, extremely)
 Duration ("x" days/hours ago, since "x")
 Timing (constant, colicky, waxes/wanes)
 Context (while... after...during...with...)
 Modifying factors (better with, worse with...)
 Associated Signs and Symptoms

The documentation will auto-save after a short period of time, but you can also click **Save**.

Save

Review of Systems

Must Document 10 systems

Review of Systems

Font Size

Use Autotext or Dragon Commands

ROS Templates	Description	Autotext
ROS Template	10+ system ROS. Navigate each system / field and dictate abnormalities 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

Save

Physical Exam

Must Document 8 systems

Physical Exam

Font Size

Use Autotext or Dragon Commands

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

Save

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

Labs Selected visit: **Latest*** Selected visit Last 6 months More

	Today 05:59	Jun 18, 2014 07:22	Jun 16, 2014 06:02	Jun 14, 2014 06:20	Jun 13, 2014 06:12	Jun 12, 2014 06:09	Jun 11, 2014 06:26	Jun 10, 2014 11:30	Jun 9, 2014 05:48	Jun 9, 2014 08:18
Chemistry										
BMP	--	--	See Below	See Below	See Below	See Below	--	See Below	--	See Below
CMP	See Below	See Below	--	--	--	--	--	--	See Below	--
LFT	--	--	--	--	--	--	--	--	See Below	--
GLU	73	78	84	82	94	92	--	93	--	89
NA	138	145	145	138	139	↓134	--	↓135	--	↓135
K	↓3.2			3.7	3.6	3.8	--			
CL	101			103	102	100	--			
TOTAL CO2	27			27	26	25	--			
CHL	18			18	16		--			

Right click to tag additional labs

Tagged Items

Laboratory

BUN (mg/dL)

↑23

06/18/2014 07:22 EDT

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.

Results Review

Flowsheet VS + Resp Flowsheet GI/HVIS/Periop Rehab Svcs Nursing RRT Advisory Flowsheet MicroViewer OB-Perinatal Peds-Perinatal

Flowsheet: All Results Flowsheet Level: ALLRESLTSECT As Of 14:15 Table Group List

25 June 2013 18:53 - 27 June 2014 14:15 (Admit to Current)

Navigator

- Chemistry
- Hematology

Results

	06/26/2014 09:37	06/25/2014 08:57	10/01/2013 22:24	09/26/2013 08:37
Chemistry				
BMP Status				
Electrolytes Status				
GLU				

Microbiology

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

Microbiology (22) Last 2 months Last 6 months Last 1 years More

Order	Susceptibility	Growth	Organism(s)	Source/Site	Collected	Last Updated	Status
Urine Cult		CULTURE NEG	--	Urine, Straight Catheter	05/28/14 16:08	05/30/14 07:46	Completed
Blood Cult		CULTURE NEG	--	Blood, Central Line	05/28/14 15:50	06/02/14 18:11	Completed
Wound Cult		SMEAR NEG/CULTURE POS	Serratia marcescens, Enterococcus faecalis, Staphylococcus spp. (coagulase negative)	Abdomen	05/28/14 15:50	06/02/14 10:48	Completed

MicroViewer Full screen Print 0 minutes ago

Forward Copy Preview Related Results

Orders

Display Order Start Date Between

All Orders 03/30/2014 07/30/2014 Customize View Previous Order Next Order

Collect Date/Time	Order	Growth Ind	Organism	Status	Last Update Date/Time	Source/Body Site	Freestext Source
06/28/2014 07:25	Blood Culture			Preliminary	06/28/2014 07:25	Blood, Peripheral	
06/28/2014 07:23	Blood Culture			Order			

Sections in Documentation Workflow

Diagnostics

Diagnostics (4) Selected visit Last 24 hours Last 3 days More

Name	Reason For Exam	Resulted	Last Updated	Status
Diagnostic Tests (0)				
No results found				
Imaging (4)				
Chest PA and Lat	--	03/04/14 08:58	--	Ordered
CT Abd,Pelvis w/wo Contrast	--	02/24/14 07:05	02/24/14 07:27	Auth (Verified)
Chest PA and Lat	--	02/24/14 07:05	02/24/14 07:29	Auth (Verified)
Chest PA and Lat	--	01/27/14 10:07	--	Unauth

Tagging is available in:

- Documents
- Diagnostics
- Lab Results

Highlight any specific section of the report and click Tag to insert this information into your Progress note.

Document Viewer - ZZTEST, PHYSDOC6 - 2800100056

* Final Report

5400480
Name: ZZTEST, PHYSDOC6
DOB: 01-24-1986 Gender: F
Med Rec#: 2800100056
Financial#: 3800100074
Location: Christiana Hospital
Ordering Phys: SHIUH, TIMOTHY Y. MD
CC Physician:
Study: CHEST PA AND LATERAL VIEWS
Service Date: 02-24-2014 07:06:00
The heart is normal in size and configuration. Both lungs are expanded and are clear.
IMPRESSION: NORMAL CHEST.
ALAN EVANTASH, MD
(Electronically Signed)
Dict/Trans: Ael Ae
02-24-2014 07:30:00

Result Details - ZZTEST, PHYSDOC6

Valid From	Valid Until
01/28/2014 11:01	Current
01/28/2014 11:01	01/28/2014 11:01

Result Action List

Chest PA and Lateral

Exam Completed

Date/Time 27 January 2014 10:07
Contributor System RIS
Accession Number 22064263
Status Unauth
[Trend](#)

2515475514 Forward... Print... Close

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.

Outstanding Orders (14) Selected visit

	Status	Ordered
Electrolytes (NA, K, CL, CO2)	Ordered	06/23/14 11:49
CBC with diff	Ordered	06/23/14 11:49
PT includes INR	Ordered	05/11/14 22:22

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.

New Order Entry +

Inpatient ▾

Home Favorites **ED Orders** Search New Order

My Favorites

acetaminophen - OXYCODONE (Percocet) 325/5 Dose = 2 TAB, PO, Once	Order	Ibuprofen (Motrin / Advil) Dose of 800 MG, PO, Once	Order
Add On Lab Test	Order	INR includes Prottime	Order
BMP (ELECT/BUN/CRT/CA/GLU)	Order	Ketorolac (Toradol) Dose of 30 MG, IV, Once	Order
BNP, NT Pro	Order	Ondansetron (Zofran) Inj Dose of 4 MG, IV, Once	Order
CBC with diff	Order	POC Glucose-bedside Once	Order
Central Line Insertion	Order	Sodium Chloride 0.9% 1000 mL BOLUS BOLUS, 1,000 ML/HR, IV, Infuse over: 1 HR, Order Start: T;N	Order
Chest PA/Lat Chest Pain	Order	Sodium Chloride 0.9% 500 mL BOLUS BOLUS, 500 ML/HR, IV, Infuse over: 1 HR, Order Start: T;N	Order
Chest PA/Lat Shortness of Breath	Order		

To order, simply click the Order (grey) button next to the order name.

Quick Search Entry for New Orders

Home **Personal** Shared Search **ambien 2.5 po**

Zolpidem (**Ambien**) Dose of 2.5 MG, PO, QHS, PRN for: Insomnia

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.

Orders for Signature (1)

Zolpidem (Ambien)
Dose of 2.5 MG, PO, QHS, PRN for: Insomnia

☐ Show Diagnosis Table

Sign Save **Modify** Cancel

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

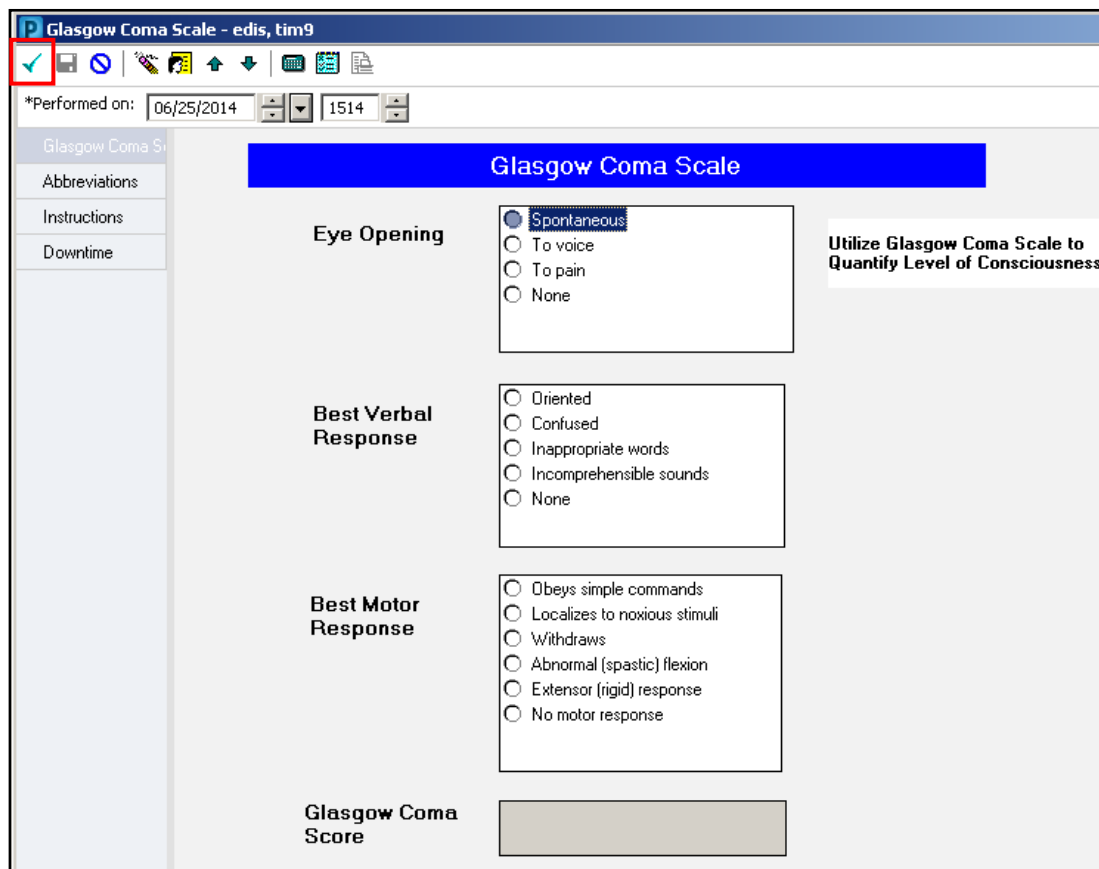
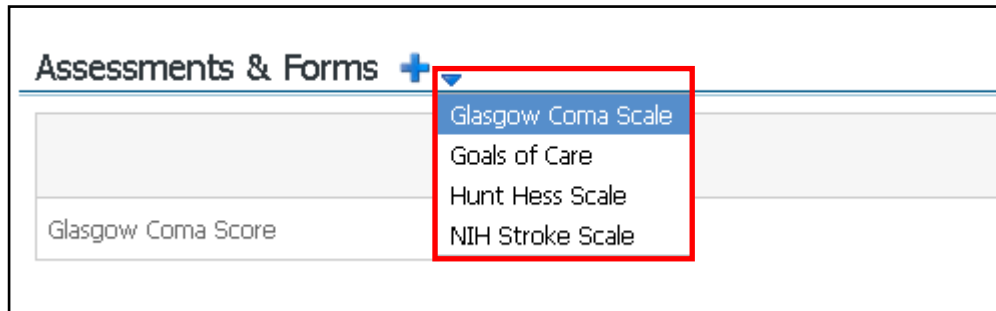
Click **Sign** to complete the order.

Change order information by clicking **Modify**.

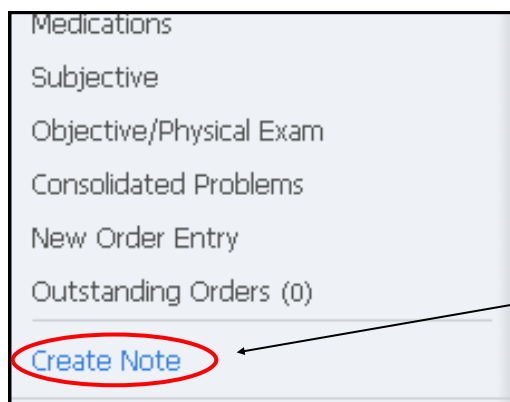
Sections in Documentation Workflow

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

X
List

Hide Note Details

*Type: Position Note Type List

Title: ED Physician Record

*Date: 6/23/2014 2039

*Author: Shih MD, Timothy Y.

***Note Templates**

Name	Description
Brief Consult Note	Consultant Initial Brief Note
Colorectal Surgery Attending Progress Note	Colorectal Surgery Attending Progress Note
Consult Note	Consult Note
ED Physician Record	Emergency Department Physician Record
ED Physician Record and Teaching Note	Department Physician Record with Teaching Note
ED Teaching Physician Record	Emergency Department Teaching/Supervisory Note
NB Newborn History and Physical	Newborn History and Physical
NB Progress Note Newborn	Newborn Progress Note
NB Progress Note Newborn Discharge	Newborn Discharge Progress Note
OB Progress Note GYN	OB GYN Progress Note
OB Progress Note High Risk	OB High Risk Progress Note
OB Progress Note Labor	OB Labor Progress Note
OB Progress Note Postpartum	OB Postpartum Progress Note

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.

*Type: **ED Physician Record** Position Note Type List

Title: **ED Physician Record**

ED Physician Record	Emergency Department Physician Record
ED Physician Record and Teaching Note	Department Physician Record with Teaching Note
ED Teaching Physician Record	Emergency Department Teaching/Supervisory Note

ED Physician Record

Date and Time of Service

07/07/2014
21:38

Basic Information

Triage Chief Complaint:
ABD PAIN RAD TO BACK, CP

History / Exam limited by: ☐

Document any reason
you were unable to
perform a full H&P

History of Present Illness

85 yo female with sudden onset of severe, sharp pain to mid abdomen, which radiates to back and bilateral flank. Symptoms began shortly after eating lunch. Pain associated with nausea, emesis x 2. Pain worse with movement and deep breath. Pain currently 8/10, but was 10/10 at worst. No history of similar in past.

Review of Systems

Constitutional: no fever/chills, + diaphoresis, no weakness, no weight loss/gain
Eyes/Ears/Nose/Throat: no vision problems, no sore throat, no nasal drainage
Cardiovascular: no chest pain, no palpitations
Respiratory: no shortness of breath, no cough
Gastrointestinal/Genitourinary: see HPI
Musculoskeletal/Skin/Lymph: no myalgias, no arthralgias, no rashes, no gland swelling
Neurologic: no headache, no dizziness, no paresthesias, no difficulty walking, no difficulty with speech
Psychiatric: no anxiety, no depression

Physical Exam

Vitals & Measurements
T: 36.9 (Oral) HR: 74 RR: 14 BP: 140/60
Pulse O2: 98 %
GENERAL: moderate distress from pain
HEAD: normocephalic
EYES/EARS/NOSE/THROAT: pupils equal, extraocular muscles intact, no scleral icterus, normal pharynx
NECK: normal inspection
RESPIRATORY: no respiratory distress, clear to auscultation bilaterally
CARDIOVASCULAR: irregular rate and rhythm, no murmurs, rubs or gallops
ABDOMEN/GU: soft, focal epigastric pain, no rebound, no guarding, no organomegaly, no masses, normal bowel sounds
EXTREMITIES: non-tender, normal range of motion, no edema/swelling
NEUROLOGIC: alert and oriented x 3, no gross motor deficits, no gross sensory deficits, cranial nerves intact
SKIN: no rashes

Assessment/Plan

85 yo female with severe epigastric pain radiating to back and nausea/vomiting. Differential includes biliary colic, pancreatitis, GERD, gastritis, PUD, AAA. Will check LFT's, lipase and CT abdomen and pelvis.

ED Progress

As you update ED Progress, make sure you use
the .sign Autotext or Insert Signature Command

Final Impression/Disposition

Critical Care Time

Problem List

Chronic:
DM - Diabetes mellitus
Dysphagia
GERD - Gastro-esophageal reflux disease
Hearing loss
HLD - Hyperlipidemia
HTN - Hypertension
Muscle spasm
Osteoporosis

Procedure/Surgical History

Colonoscopy (10/21/2013), BILATERAL CATARACT SURGERY, Cesarean delivery only.

Home Medications

Home
acetaminophen 325 mg oral tablet, 650 MG, 2 TAB, PO, Q6H, PRN
Amlodipine, 10 MG, PO, QPM
blink tears, 1 DROP, Both Eyes, QAM
Centrum Silver, PO, QPM
cyclopropridine 4 mg oral tablet, 4 MG, 1 TAB, PO, BID
Diovan 80 mg oral tablet, 80 MG, 1 TAB, PO, Daily
Doc-Q-Lax, 1 TAB, PO, BID
Humulin R, 5 UNIT, SubQ, TID AC
Humulin R 100 units/mL injectable solution, 5 UNIT, SubQ, TID AC
Levemir, 10 UNIT, SubQ, QHS
Lovenox 100 units/mL subcutaneous solution, 10 UNIT, SubQ, QHS
lidocaine topical 5% flm, 1 PATCH, Transdermal, Daily
omeprazole 40 mg oral delayed release capsule, 40 MG, 1 CAP, PO, BID
Phazyme Maximum Strength 62.5 mg/5 mL oral liquid, PO, BID
simvastatin 40 mg oral tablet, 40 MG, 1 TAB, PO, QHS
tizanidine 4 mg oral tablet, PO, PRN
Zofran ODT 4 mg oral tablet, disintegrating, 4 MG, 1 TAB, PO, Q6H, PRN

Allergies

NKA

Social/Family History

Drug use: Never

Lab Results

Diagnostic Results

EKG
EKG - 12 Lead

Radiology

CTA ABD/PEL (ordered 07/07/14 17:40)
CTA Chest (ordered 07/07/14 15:27)
Chest PA/Lat (ordered 07/07/14 13:44)

Throughout your
shift Continuously
Save your note

Create Note ED Physician Record – Resident/PA

*Type:

Title:

zzzED Provider Record - Res... X List

Tahoma 12 

ED Provider Record - Resident/PA

Date and Time of Service07/01/2014
18:54**Basic Information****Triage Chief Complaint:**

No Reason For Visit Recorded

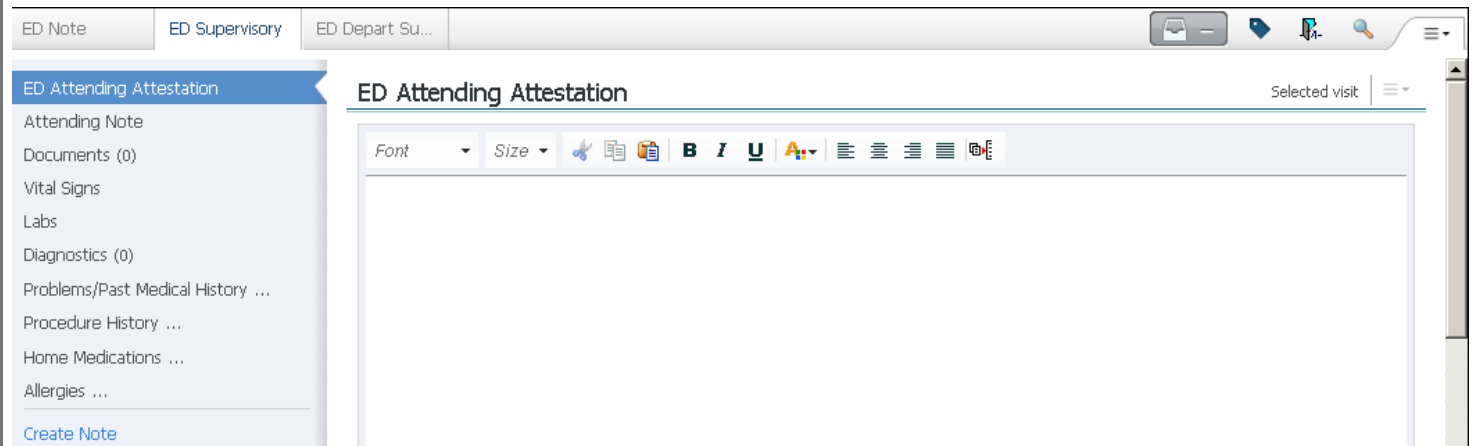
History / Exam limited by: **History of Present Illness****Problem**

Chronic
AF - /
Asthm
CHF -
Chror
Diverl
ESRD
HTN -
Hyper

Procedur

Appendec
repair, Hy:

Supervisory Workflow



The screenshot shows the 'ED Attending Attestation' form. On the left is a sidebar with a menu containing: 'ED Attending Attestation' (selected), 'Attending Note', 'Documents (0)', 'Vital Signs', 'Labs', 'Diagnostics (0)', 'Problems/Past Medical History ...', 'Procedure History ...', 'Home Medications ...', 'Allergies ...', and a 'Create Note' link at the bottom. The main area has a title 'ED Attending Attestation' and a 'Selected visit' dropdown. Below the title is a rich text editor with a toolbar including options for font, size, bold, italic, underline, color, and text alignment. The editor area is currently blank.

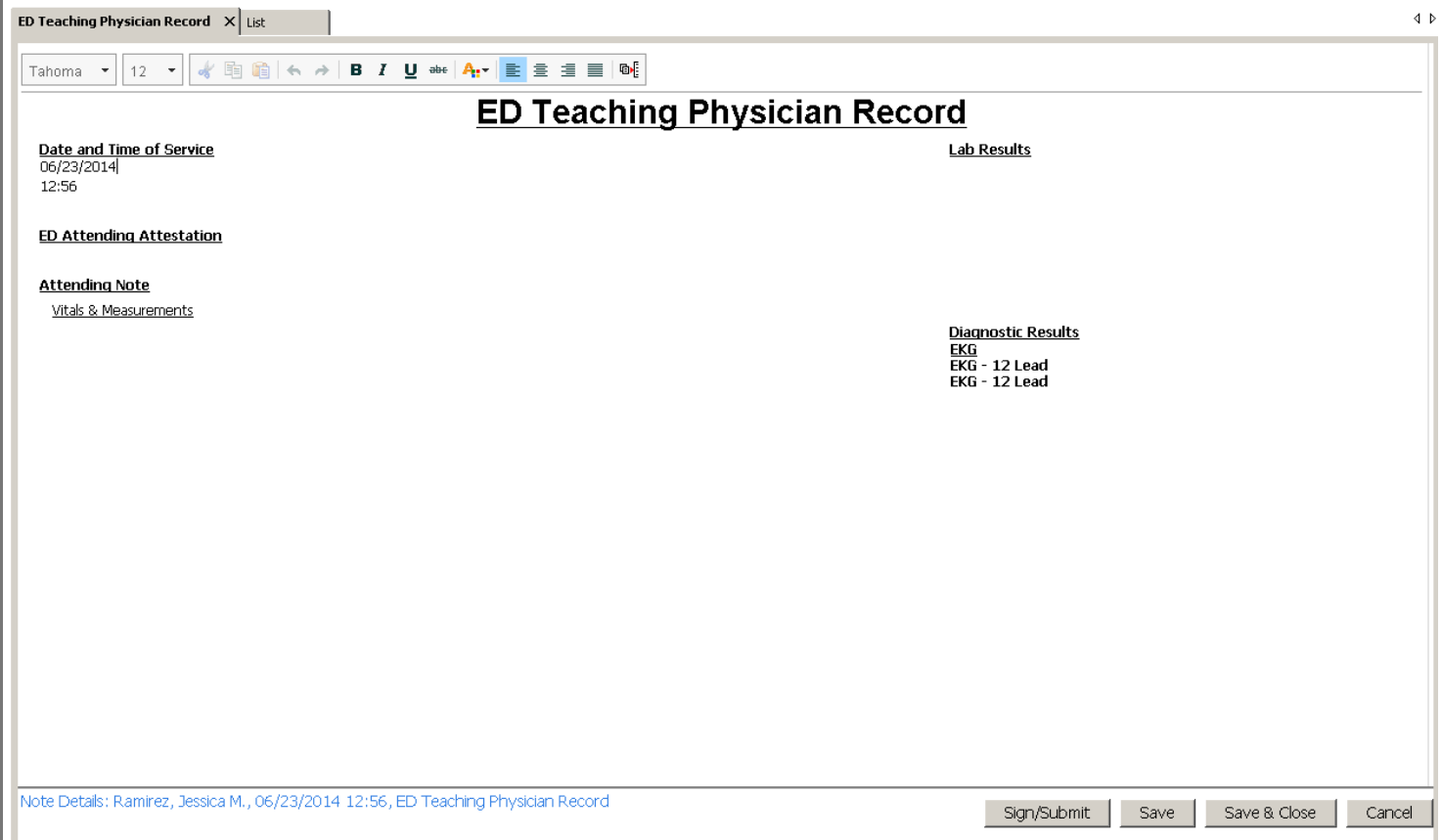
Supervisory: ED Teaching Physician Record Note

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.

*Type:

Title:

ED Physician Record	Emergency Department Physician Record
ED Physician Record and Teaching Note	Department Physician Record with Teaching Note
ED Teaching Physician Record	Emergency Department Teaching/Supervisory Note



The screenshot shows the 'ED Teaching Physician Record' form. At the top, there's a tab 'ED Teaching Physician Record' and a 'List' button. Below the tab is a rich text editor with a toolbar. The form content is organized into sections:

- Date and Time of Service:** 06/23/2014 12:56
- Lab Results:** (Empty section)
- ED Attending Attestation:** (Section header)
- Attending Note:**
 - Vitals & Measurements
 - Diagnostic Results:**
 - EKG
 - EKG - 12 Lead
 - EKG - 12 Lead

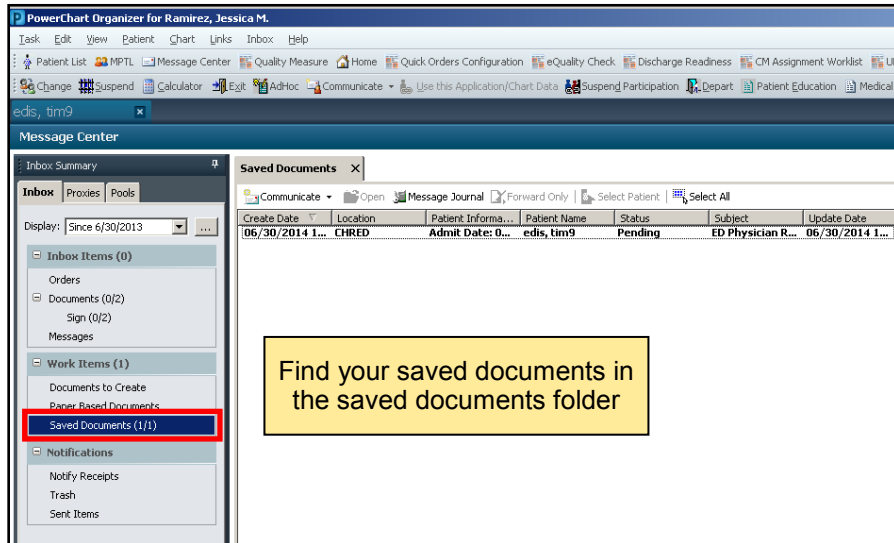
At the bottom, there's a status bar showing 'Note Details: Ramirez, Jessica M., 06/23/2014 12:56, ED Teaching Physician Record' and four buttons: 'Sign/Submit', 'Save', 'Save & Close', and 'Cancel'.

Continuing Documentation

Finding a Saved note


Method #1:

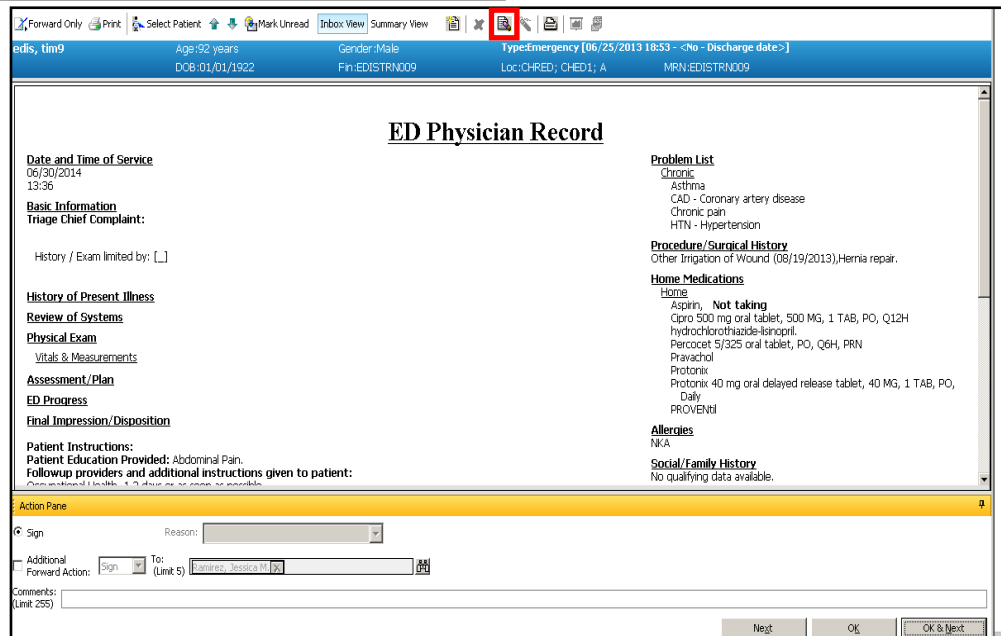
From the Message Center



Double click on the document to open

Find your saved documents in the saved documents folder

Modify the note by selecting the  icon



ED Physician Record

Date and Time of Service
06/30/2014
13:36

Basic Information
Triage Chief Complaint:

History / Exam limited by: []

History of Present Illness
Review of Systems
Physical Exam
Vitals & Measurements
Assessment/Plan
ED Progress
Final Impression/Disposition

Problem List
Chronic
Asthma
CAD - Coronary artery disease
Chronic pain
HTN - Hypertension

Procedure/Surgical History
Other Irrigation of Wound (08/19/2013), Hernia repair.

Home Medications
Home
Aspirin, Not taking
Cipro 500 mg oral tablet, 500 MG, 1 TAB, PO, Q12H
hydrochlorothiazide-lisinopril
Percocet 5/325 oral tablet, PO, Q6H, PRN
Pravachol
Protonix
Protonix 40 mg oral delayed release tablet, 40 MG, 1 TAB, PO, Daily
PROVENTHOL

Allergies
N/A

Social/Family History
No qualifying data available.

Patient Instructions:
Patient Education Provided: Abdominal Pain.
Followup providers and additional instructions given to patient:

Action Pane
Sign Reason: []
Additional Forward Action: Sign To: (Limit 5) Ramirez, Jessica M [X]
Comments (Limit 255)

Next OK OK & Next

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.

Documents (9)

Last 1 yearsLast 6 monthsLast 2 yearsMore

☐ My notes only☐ Group by encounterDisplay: Facility defined view

Note Type	Subject	Author	Time of Service	Last Updated By	Last Updated
ED Physician Record (In Progress)	ED Physician Record	Ramirez, Jessica M.	06/30/14 13:35	Ramirez, Jessica M.	06/30/14 13:36
Completed					
ED Teaching Physician Record	ED Physician Record and Teaching Note	Ramirez, Jessica M.	06/25/14 08:57	Ramirez, Jessica M.	06/25/14 08:58

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.

Assessment/Plan

85 yo female with severe epigastric pain radiating to back and nausea/vomiting. Differential includes biliary colic, pancreatitis, GERD, gastritis, PUD, AAA. Will check LFT's, lipase and CT abdomen and pelvis.

ED Progress

22:04 - 07/07/14 - Timothy Y. Shiu, MD

Pain controlled with zofran and dilauid

Chest XR with no free air.

Labs pending

.s|

.sign *

Final Impression/Disposition

Final Impression: Nausea and vomiting, Epigastric pain

Disposition: Discharge Order. From ED, 07/07/2014 19:45

Followup providers and additional instructions given to patient:

Please return to the ED if you develop fever >102, change in mental status, loss of consciousness, chest pain, shortness of breath, severe nausea/vomiting, blood in your stool/vomit, severe abdominal pain, or any other concerning change to your usual state of health.

Critical Care Time

Social/Family History

Drug use: Never

Refresh Labs for latest values

Lab Results

142 | 100 | 20 /
L 62

4.0 | 30 | 0.85 \

\ 13.7 /
7.7 209

/ 40.6 \

LA 1.0 MMOL/L 07/07/14 13:55

TROP T <0.01 NG/ML

Refresh Final Impression/Disposition:
updates based on the admit/
discharge information placed on the
patient

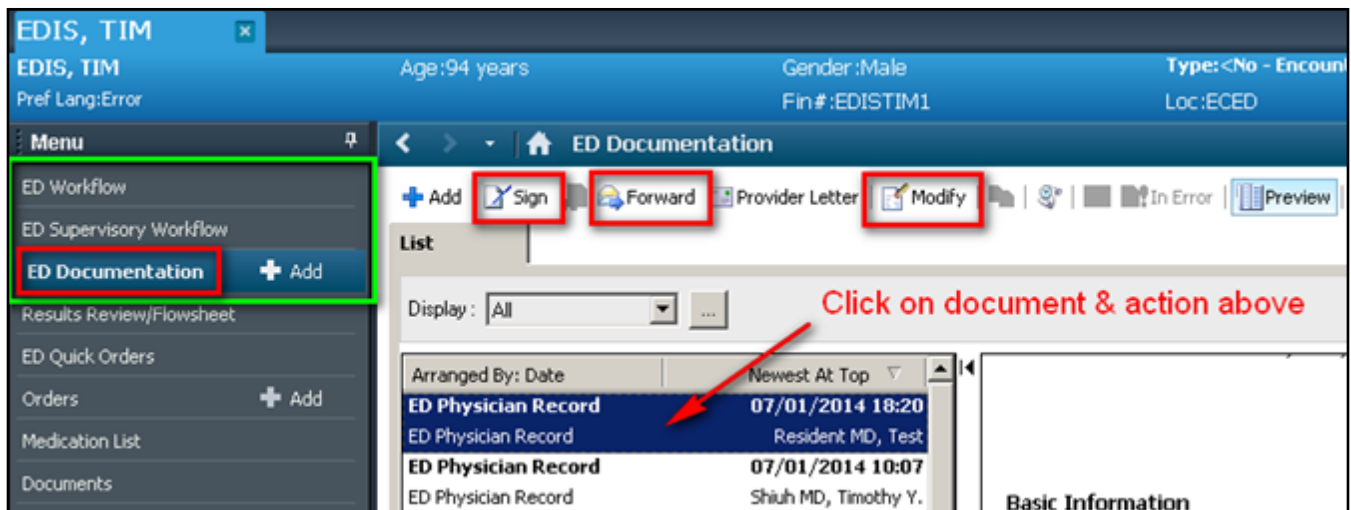
Complete your Note

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



EDIS, TIM

EDIS, TIM Age:94 years Gender:Male Type:<No - Encoun
Pref Lang:Error Fin#:EDISTIM1 Loc:ECED

Menu

- ED Workflow
- ED Supervisory Workflow
- ED Documentation** + Add
- Results Review/Flowsheet
- ED Quick Orders
- Orders + Add
- Medication List
- Documents

ED Documentation

+ Add Sign Forward Provider Letter Modify In Error Preview

List

Display: All

Arranged By: Date Newest At Top

ED Physician Record	07/01/2014 18:20
ED Physician Record	Resident MD, Test
ED Physician Record	07/01/2014 10:07
ED Physician Record	Shiuh MD, Timothy Y.

Click on document & action above

Basic Information

Forward Only: Documents: EDIS, TIM

Additional Forward Action: Sign To: (Limit 5)

Comments: (Limit 255)

Cancel OK

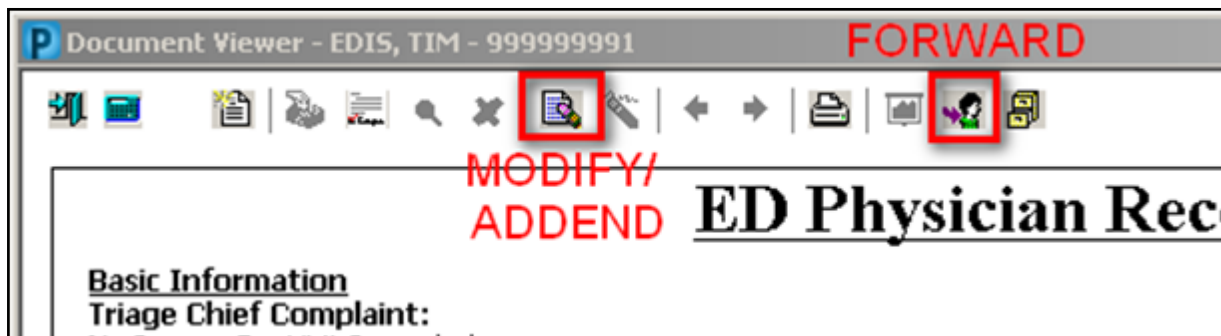
Forward Only: Documents: EDIS, TIM

Additional Forward Action: Sign To: (Limit 5) shiuh

Comments: (Limit 255)

Cancel OK

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



Document Viewer - EDIS, TIM - 999999991

FORWARD

MODIFY/ADDEND

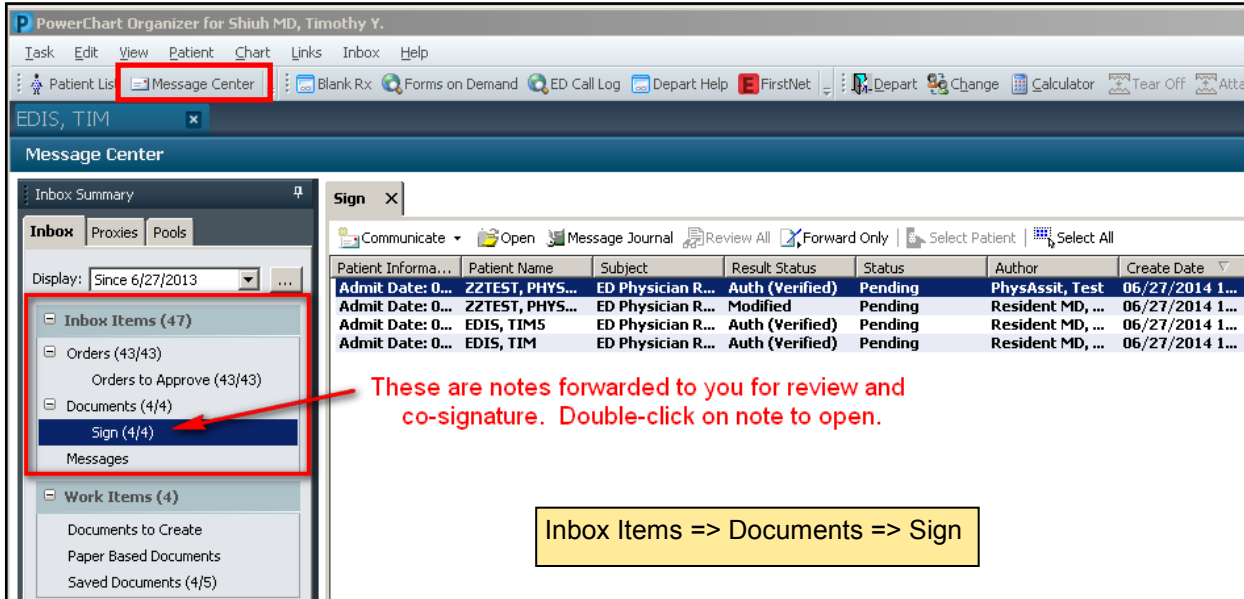
ED Physician Rec

Basic Information

Triage Chief Complaint:

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.



PowerChart Organizer for Shih MD, Timothy Y.

Task Edit View Patient Chart Links Inbox Help

Patient List **Message Center** Blank Rx Forms on Demand ED Call Log Depart Help FirstNet Depart Change Calculator Tear Off Attach

EDIS, TIM

Message Center

Inbox Summary

Inbox Proxies Pools

Display: Since 6/27/2013

Inbox Items (47)

- Orders (43/43)
 - Orders to Approve (43/43)
- Documents (4/4)
 - Sign (4/4)**
- Messages
- Work Items (4)
 - Documents to Create
 - Paper Based Documents
 - Saved Documents (4/5)

Sign X

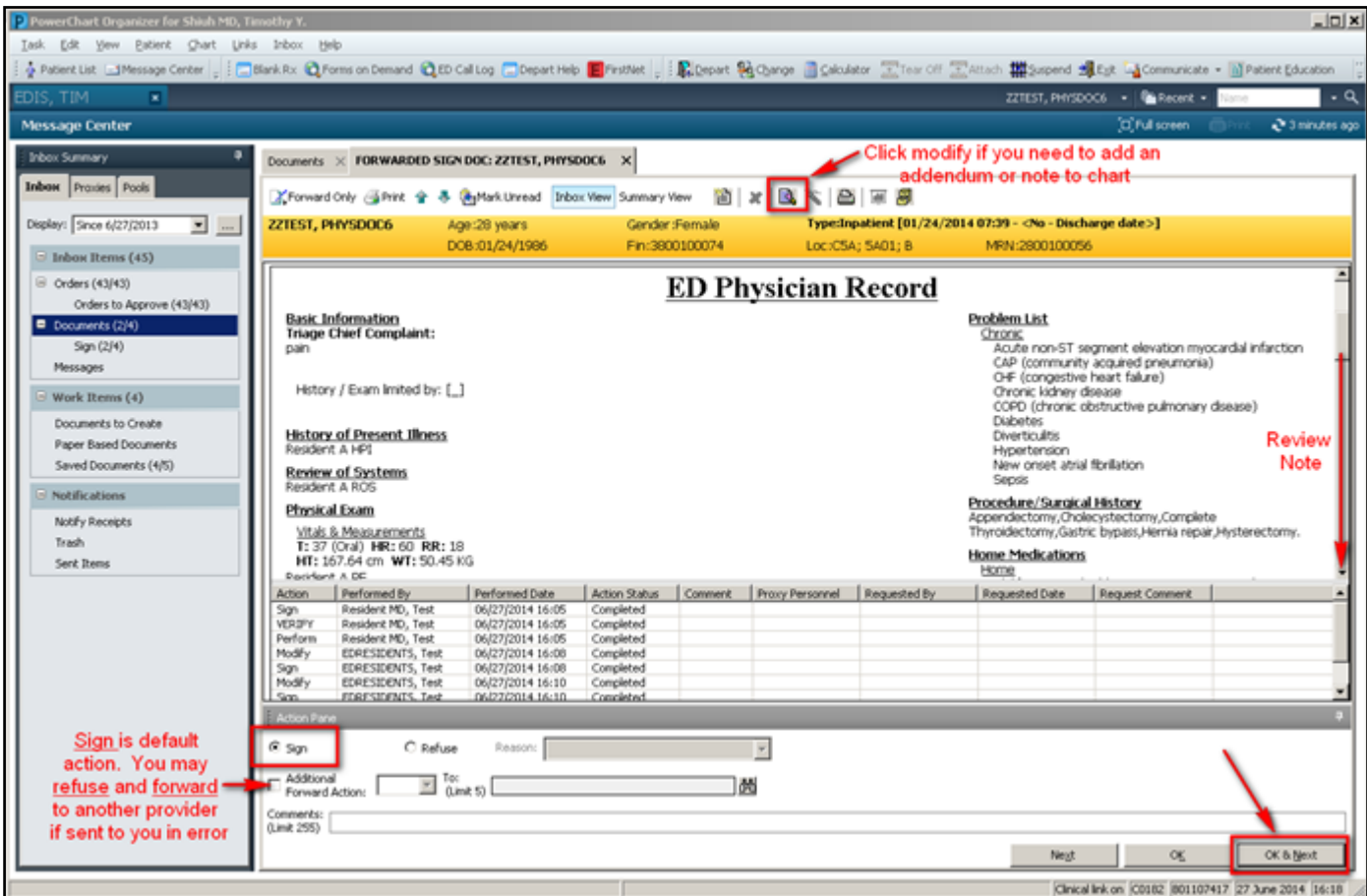
Communicate Open Message Journal Review All Forward Only Select Patient Select All

Patient Info...	Patient Name	Subject	Result Status	Status	Author	Create Date
Admit Date: 0...	ZZTEST, PHYS...	ED Physician R...	Auth (Verified)	Pending	PhysAssit, Test	06/27/2014 1...
Admit Date: 0...	ZZTEST, PHYS...	ED Physician R...	Modified	Pending	Resident MD, ...	06/27/2014 1...
Admit Date: 0...	EDIS, TIM5	ED Physician R...	Auth (Verified)	Pending	Resident MD, ...	06/27/2014 1...
Admit Date: 0...	EDIS, TIM	ED Physician R...	Auth (Verified)	Pending	Resident MD, ...	06/27/2014 1...

These are notes forwarded to you for review and co-signature. Double-click on note to open.

Inbox Items => Documents => Sign

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



PowerChart Organizer for Shih MD, Timothy Y.

Task Edit View Patient Chart Links Inbox Help

Patient List Message Center Blank Rx Forms on Demand ED Call Log Depart Help FirstNet Depart Change Calculator Tear Off Attach Suspend Exit Communicate Patient Education

EDIS, TIM

Message Center

Inbox Summary

Inbox Proxies Pools

Display: Since 6/27/2013

Inbox Items (45)

- Orders (43/43)
 - Orders to Approve (43/43)
- Documents (2/4)
 - Sign (2/4)**
- Messages
- Work Items (4)
 - Documents to Create
 - Paper Based Documents
 - Saved Documents (4/5)
- Notifications
 - Notify Receipts
 - Trash
 - Sent Items

Documents X **FORWARDED SIGN DOC: ZZTEST, PHYSDOC6**

Forward Only Print Mark Unread Inbox View Summary View

ZZTEST, PHYSDOC6 Age: 28 years Gender: Female Type: Inpatient [01/24/2014 07:39 - <No - Discharge date>]

DOB: 01/24/1986 Fin: 3800100074 Loc: CSA; SA01; B MRN: 2800100056

ED Physician Record

Basic Information
Triage Chief Complaint: pain
History / Exam limited by: []

History of Present Illness
Resident A HPI

Review of Systems
Resident A ROS

Physical Exam
Vitals & Measurements
T: 37 (Oral) HR: 60 RR: 18
HT: 167.64 cm WT: 50.45 kg
Resident A PE

Problem List
Chronic
Acute non-ST segment elevation myocardial infarction
CAP (community acquired pneumonia)
CHF (congestive heart failure)
Chronic kidney disease
COPD (chronic obstructive pulmonary disease)
Diabetes
Dyslipidemia
Hypertension
New onset atrial fibrillation
Sepsis

Procedure/Surgical History
Appendectomy, Cholecystectomy, Complete Thyroidectomy, Gastric bypass, Hernia repair, Hysterectomy.

Home Medications
Home

Review Note

Action Page
☒ Sign ☐ Refuse Reason: []
Additional Forward Action: [] To: (Unit 5) []
Comments: (Limit 255) []

Sign is default action. You may refuse and forward to another provider if sent to you in error

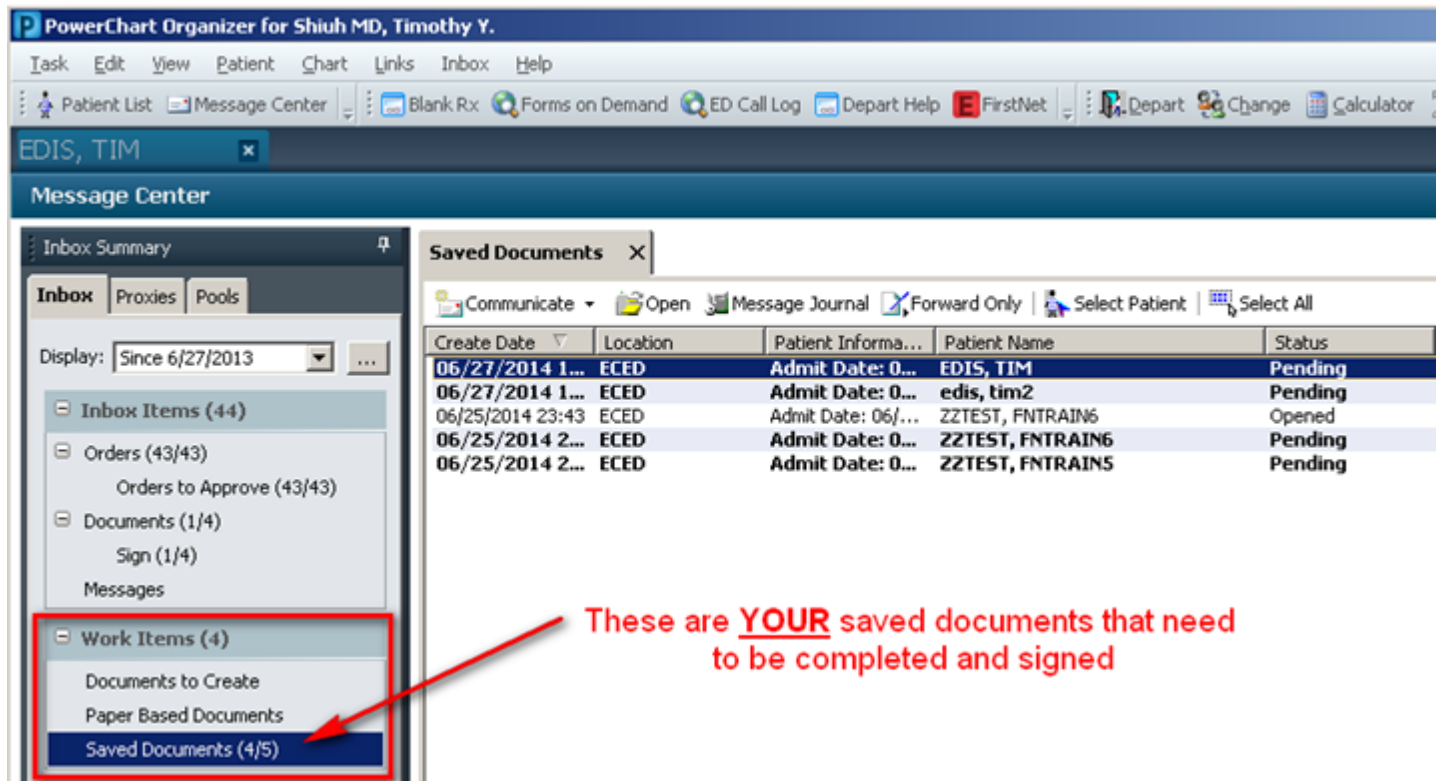
Click modify if you need to add an addendum or note to chart

Next OK **OK & Next**

Clinical link on: C0182 | 801107417 | 27 June 2014 | 14:18

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



PowerChart Organizer for Shih MD, Timothy Y.

Task Edit View Patient Chart Links Inbox Help

Patient List Message Center Blank Rx Forms on Demand ED Call Log Depart Help FirstNet Depart Change Calculator

EDIS, TIM

Message Center

Inbox Summary

Inbox Proxies Pools

Display: Since 6/27/2013

- Inbox Items (44)
 - Orders (43/43)
 - Orders to Approve (43/43)
 - Documents (1/4)
 - Sign (1/4)
 - Messages
 - Work Items (4)**
 - Documents to Create
 - Paper Based Documents
 - Saved Documents (4/5)**

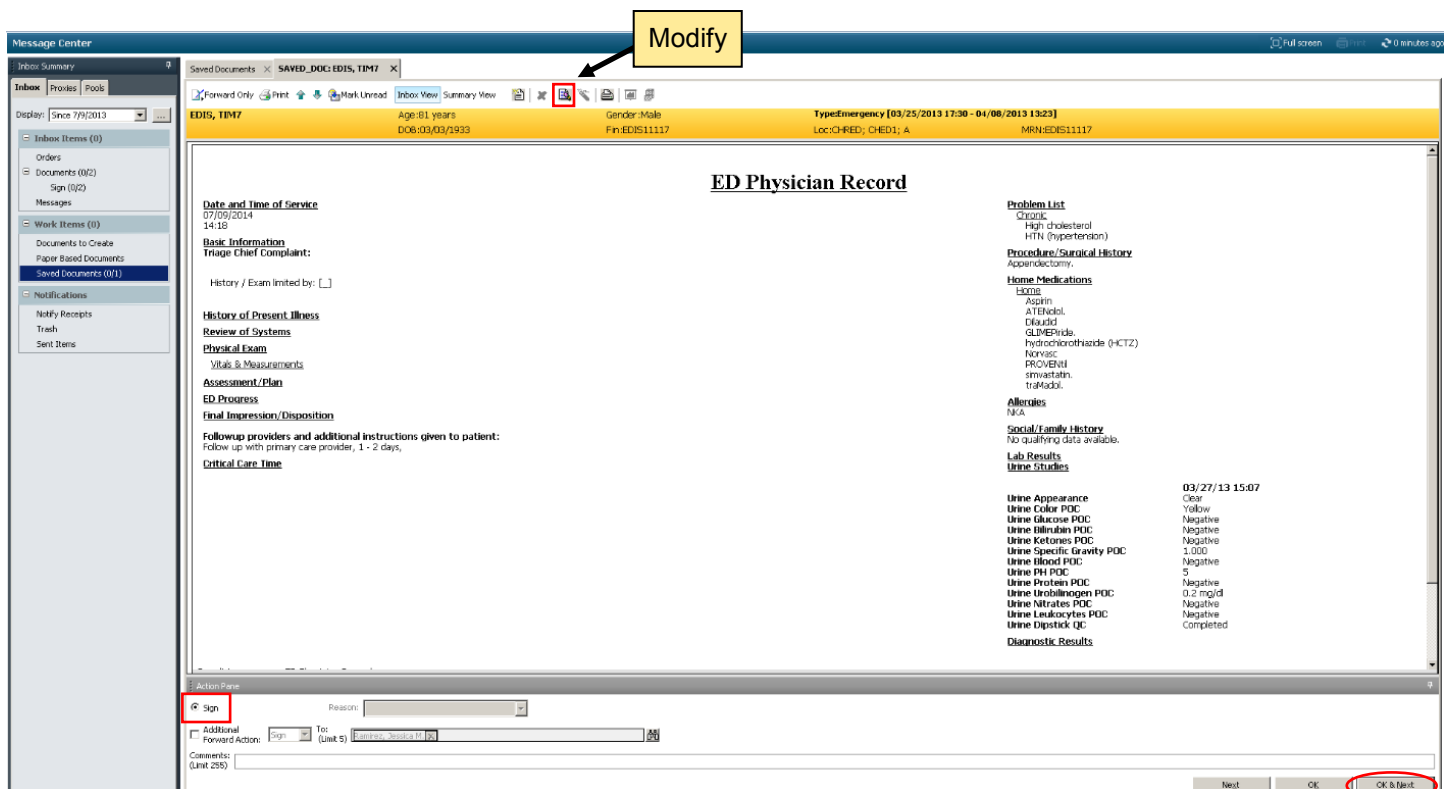
Saved Documents

Communicate Open Message Journal Forward Only Select Patient Select All

Create Date	Location	Patient Informa...	Patient Name	Status
06/27/2014 1...	ECED	Admit Date: 0...	EDIS, TIM	Pending
06/27/2014 1...	ECED	Admit Date: 0...	edis, tim2	Pending
06/25/2014 23:43	ECED	Admit Date: 06/...	ZZTEST, FNTRAIN6	Opened
06/25/2014 2...	ECED	Admit Date: 0...	ZZTEST, FNTRAIN6	Pending
06/25/2014 2...	ECED	Admit Date: 0...	ZZTEST, FNTRAIN5	Pending

These are **YOUR** saved documents that need to be completed and signed

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



Message Center

Saved Documents X SAVED_DOC: EDIS, TIM7 X

Forward Only Print Mark Unread Inbox View Summary View

EDIS, TIM7 Age 61 years Gender: Male Type: Emergency [03/25/2013 17:30 - 04/08/2013 13:23]

DOB: 03/03/1953 Fin: EDIS11117 Loc: CHED, CHED1, A MRN: EDIS11117

ED Physician Record

Date and Time of Service
07/09/2014
14:10

Basic Information
Triage Chief Complaint:

History / Exam limited by: []

History of Present Illness
Review of Systems

Physical Exam
Vitals & Measurements

Assessment/Plan
ED Progress
Final Impression/Disposition

Followup providers and additional instructions given to patient:
Follow up with primary care provider, 1 - 2 days.

Critical Care Time

Problem List
Chronic
High cholesterol
HTN (hypertension)

Procedure/Surgical History
Appendectomy.

Home Medications
ESOL
Aspirin
ATENOLOL
DIAZOLAM
GLIMEPIRIDE
Hydrochlorothiazide (HCTZ)
NORCO
PROVENTIL
smectin
TRAMADOL

Allergies
NKA

Social/Family History
No qualifying data available.

Lab Results
Urine Studies

03/27/13 15:07

Urine Appearance: Clear
Urine Color POC: Yellow
Urine Glucose POC: Negative
Urine Bilirubin POC: Negative
Urine Ketones POC: Negative
Urine Specific Gravity POC: 1.000
Urine Blood POC: Negative
Urine pH POC: 5
Urine Protein POC: Negative
Urine Urobilinogen POC: 0.2 mg/dl
Urine Nitrites POC: Negative
Urine Leukocytes POC: Negative
Urine Dipstick QC: Completed

Diagnostic Results

Action Panel

Sign Person: []

Additional Forward Action: Sign To: (Unit 5) []

Comments: (Unit 255)

Next OK OK & Next

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.