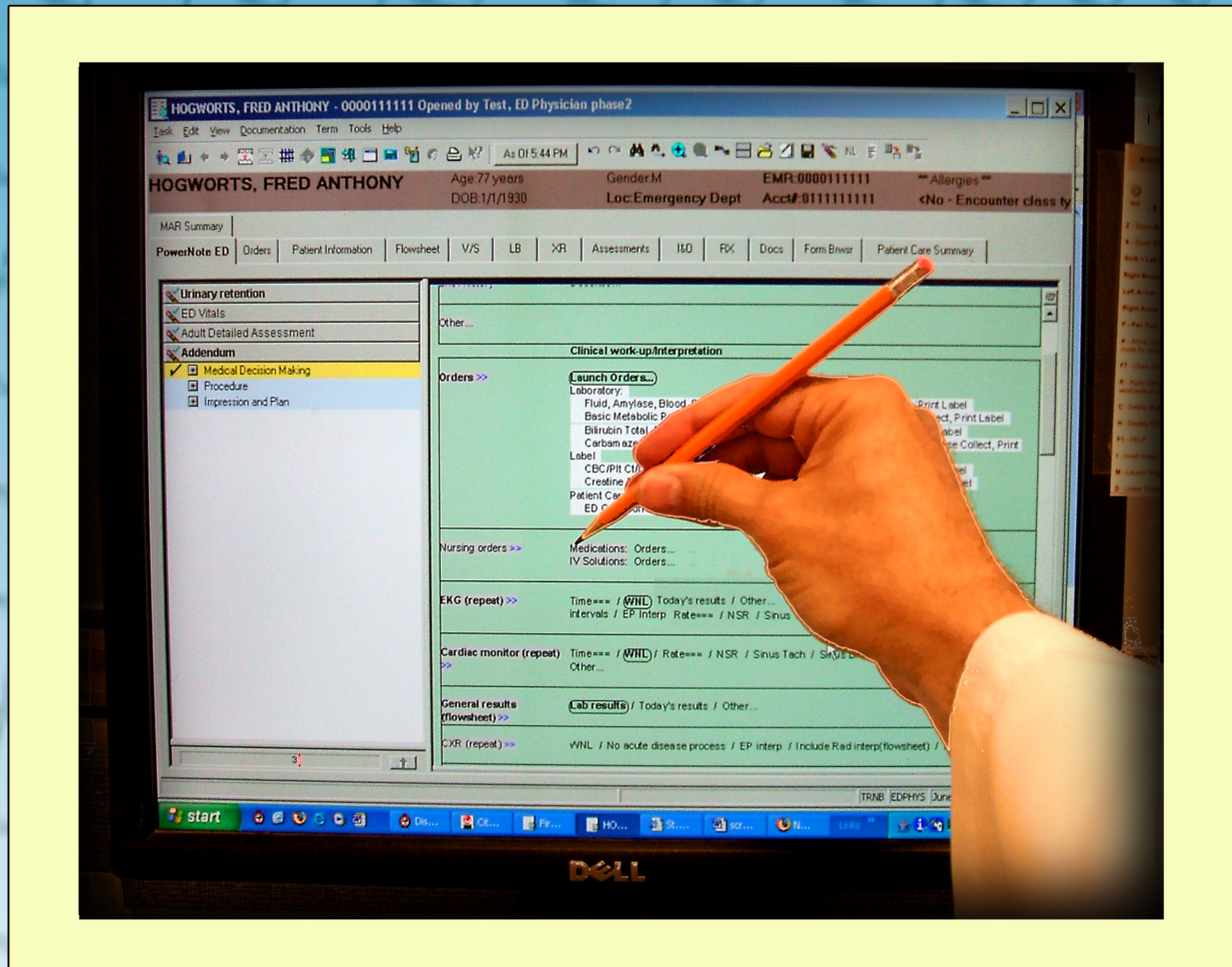# Converting to the Electronic Medical Record

Emergency Physician Training Manual

Cerner FirstNet ED
St. Luke's Hospital Chesterfield

TABLE OF CONTENTS

St. Lukes Hospital and Cerner Millenium
The Physician's Guide to the FirstNet Electronic Medical Record

This is your introduction to using the St. Lukes ED *electronic* medical record. This guide has been prepared to familiarize you with FirstNet, the ED portion of the hospital system. This guide should enable you to navigate the system successfully. If you have any questions, ask a Superuser (Drs. Harris, Lickerman, Saggar, Wachsstock, or Wessely) or any available colleague.

Logging On

1. Double-click the Firstnet icon on the desktop

2. Sign in with the User ID and Password you were assigned (this should be the same as your WebPINS information). Use the <Tab> key to move between the text-entry fields.

3. Click on the Provider Checkin button at the top of the screen. Make sure the following information is correct:
   - Provider (your name)
   - Display Name (your initials)
   - Provider Role (ED Provider)
   - Default Relation (ED Physician)
   - Pick a color for your name on the Tracking List (allows you to find your patients at a glance.)
   - Available Provider and Available Reviewer (bottom boxes must be checked)

Sign Up for a Patient

There are many tabs on the Tracking List screen; each gives a different view of the ER patients.
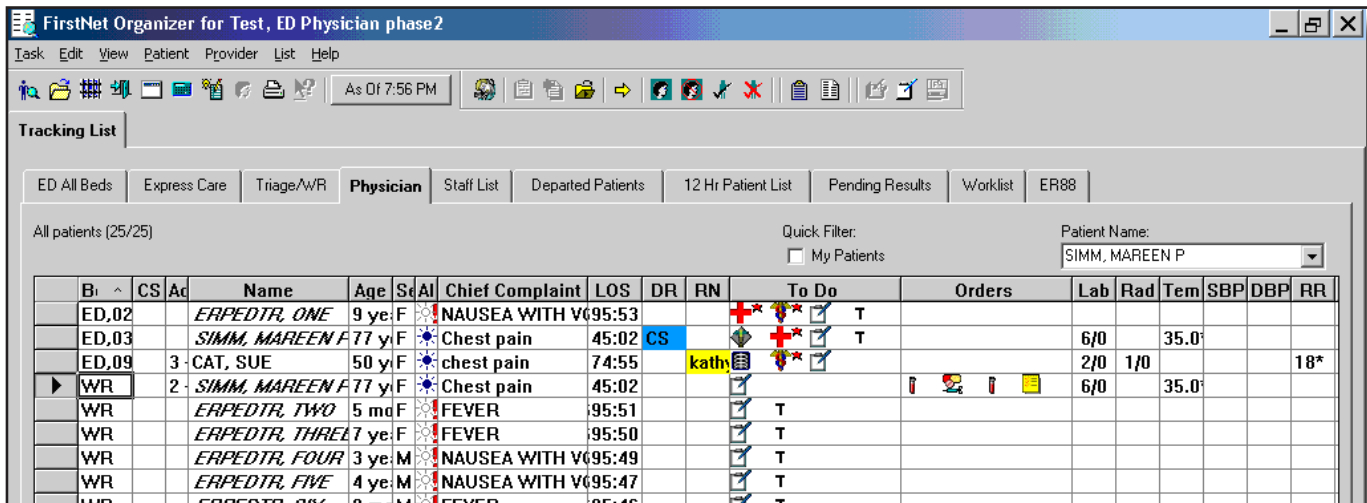
Tabs on the Tracking List:

Physician (4th tab; most useful)
   Includes chief complaint, vital signs

ED All Beds
   All patients registered and not yet discharged

Express Care
   The beds are numbered ED,21-24 and EC,01-04 (for billing reasons)

Triage/WR
   Patients still in the waiting room

Staff List
   Physicians and nurses on duty

Departed Patients
   Patients recently discharged

12 Hr Patient List
   All patients seen in the past 12 hours

Pending Results
   Labs whose results will return after the patient is discharged.

ER88 (Peds)
   ER88 patients

1. **For adult doctors:**
   - Sort by Acuity (column before Name) and LOS, then check the complaint. Columns can be expanded by left-clicking the edge and dragging. The acuity numbers go from 1 (needs CPR) to 5 (needs work excuse).

   For pediatricians:
   - Click on the Age header to sort by age (click twice to sort from youngest to oldest). Note the Chief Complaint so you don't sign up for a minor trauma.
2. DR column: If blank this patient needs a doctor.
3. Select the patient you want; the left-hand grey box will show an arrowhead [▶].
4. Click on the Assign Provider button in the top toolbar [icon]. Your initials will appear in the DR column.

Additional Features of the Tracking List Screen

To display the Quick Flowsheet (vital signs & wt)
>   Double-click any of the columns to the right of RN

To Do column
>   Contains icons for nursing/registration tasks (see next page)

Orders column
>   Contains icons for your orders and allows you to check on their status

Lab and Rad
>   Displays the number of studies ordered and completed (e.g., 6/0)

Temp, SBP, DBP, RR (vital signs) columns
>   Displays farther to the right

Sat (O2 saturation), PCP, and Comments
>   Displays farther to the right. If not shown, use the scroll bar at the bottom of the screen to view the
>   complete comment box.

- If you need to see something that is hidden in a narrow column, left-click the edge of the column
  and drag it to make it wider.

TRACKING LIST ICONS

Icon	Description
	Ready for doctor to sign up
	Needs doctor's note
	Needs to complete registration
T	Needs triage assessment
	Needs nursing assessment
	Item is late
	Item is very late
	Allergies not recoreded
	No known allergies
	Allergy alert
	Place call to PCP or consultant
	Admission order written
	Transfer order written
	Discharge order written
	Lab order written
	Medication order written
	Radiology order written
	Nursing procedure order written
	EKG order written
R	Respiratory order written

There are many icons in the Tracking List To Do and Orders sections; they are shown here and you can find cheat sheets posted throughout the ER.

POWERNOTE ICONS

Icon	Description
	Open Organizer (Tracking List)
	Tear off view
	Launch Application
	Launch Clinical Calculator
	Ad hoc Charting
	Print
	Undo
	Find (in PowerNote)
	Find Next
	Zoom In
	Zoom Out
	Split Screen (data entry/preview)
	Open Chart
	Sign Chart
	Save Chart
	Erase
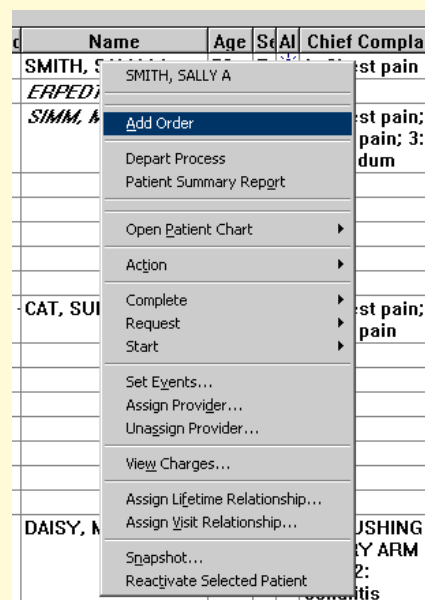
Right-clicking any of the columns in the Tracking List (except To Do, Orders, Lab, and Rad) will give you a menu that is a shortcut to orders, PowerNote ED, and many other sections of FirstNet.

Tracking List Icons in the Top Toolbar

	Find patient
	Open Additional Chart
	Suspend
	Exit FirstNet
	Launch Application (WebPins)
	Launch Clinical Calculator (BSA, pounds to kg, etc)
	Ad Hoc Charting (for charting by other departments)
	Print
As Of 2:07 AM	**Current time/Refresh button**
	Primary Physicians list (updatable list of the patient's specialty physicians)
	Open Patient Chart (access to PowerNote and other useful functions)
	Set Events (a list of what has been ordered/ at what time)
	Assign Provider
	Unassign Provider
	Provider check-in
	Provider check-out
	Reports (a list of your Unsigned Notes)
	Reports (discern) (administrative reports)
	Depart Process (Visit Summary and quick assessment of incomplete tasks)

PowerNote ED

How to Write a Physician's Note
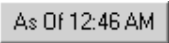
1. Double-click the gray box column to the left of the patient's name.
   An arrowhead will appear ▶ and the patient chart will open in PowerNote ED.

2. A dialog box called Open Note will automatically open at the Reason for Visit.

3. To select the chief complaint, pick a note type from the list on the left
   - a. Click the [+] to open the list for each system, then double-click your selection
     OR search for the complaint you want by typing it in the Search box, then click "Search by Name."

   - b. You have to pick something. You can pick more than one thing. The "general medical" folder has symptom-specific notes that automatically include age-specific details.

4. When you have selected your diagnosis, click OK in the lower right corner of the Open Note dialog box.
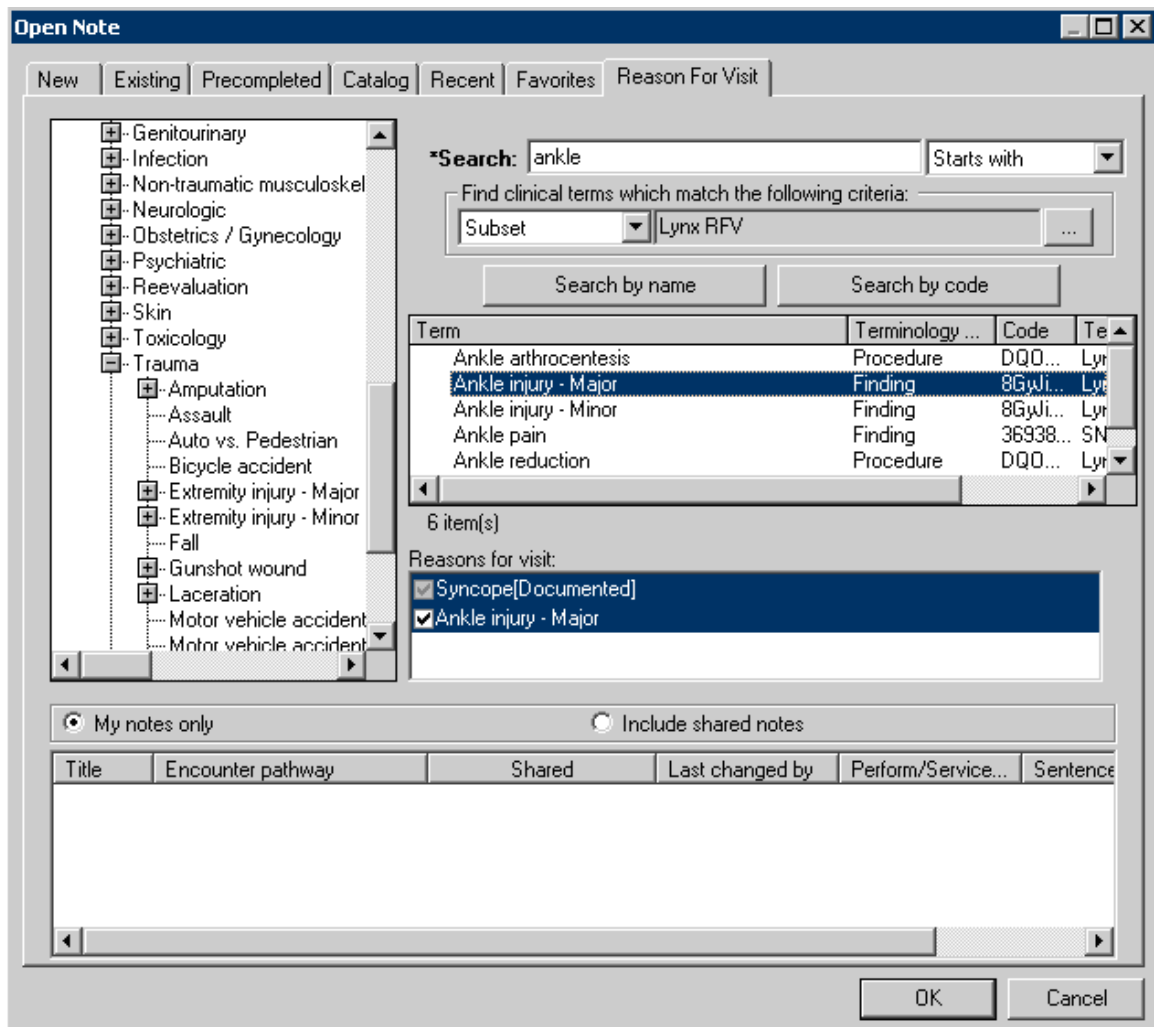
5. The AutoPopulate Document dialog box will open. Select the items you would like to be included auto-matically in your chart. Note: if you select Lab Results, only those results available at the current time will be included (usually none). The system remembers your choices for a given chart template, so you will need to do this only once for chest pain, etc.

6. **Check for the patient name in the upper left hand corner to make sure you are charting on the correct patient.**

7. The time button is in the top center of the screen `As Of 12:46 AM`. FirstNet updates itself every 30 seconds but you can force it to update more often. For example, you can click it to make sure your orders made it to the To Do list.

8. The Save Note button is in the top right of the screen 💾 . Use it often. The system will lock up or go down when you least expect and you will lose your work. Eventually. Guaranteed.

⚠️　Do not click the Sign Note button ✎ which is right next to the Save Note button
This will finish the note prematurely and you will have to write an addendum.

9. Review the nurse's notes and the vital signs. Click the **Flowsheet** tab and select "All Results Flowsheet" on the upper left Flowsheet Selector. You may need to expand the width of the columns to get all the information.

10. There are other tabs but the main location for physician charting is in **PowerNote ED**.

Once you click OK in Open Note, you will jump to the PowerNote ED tab to begin charting.
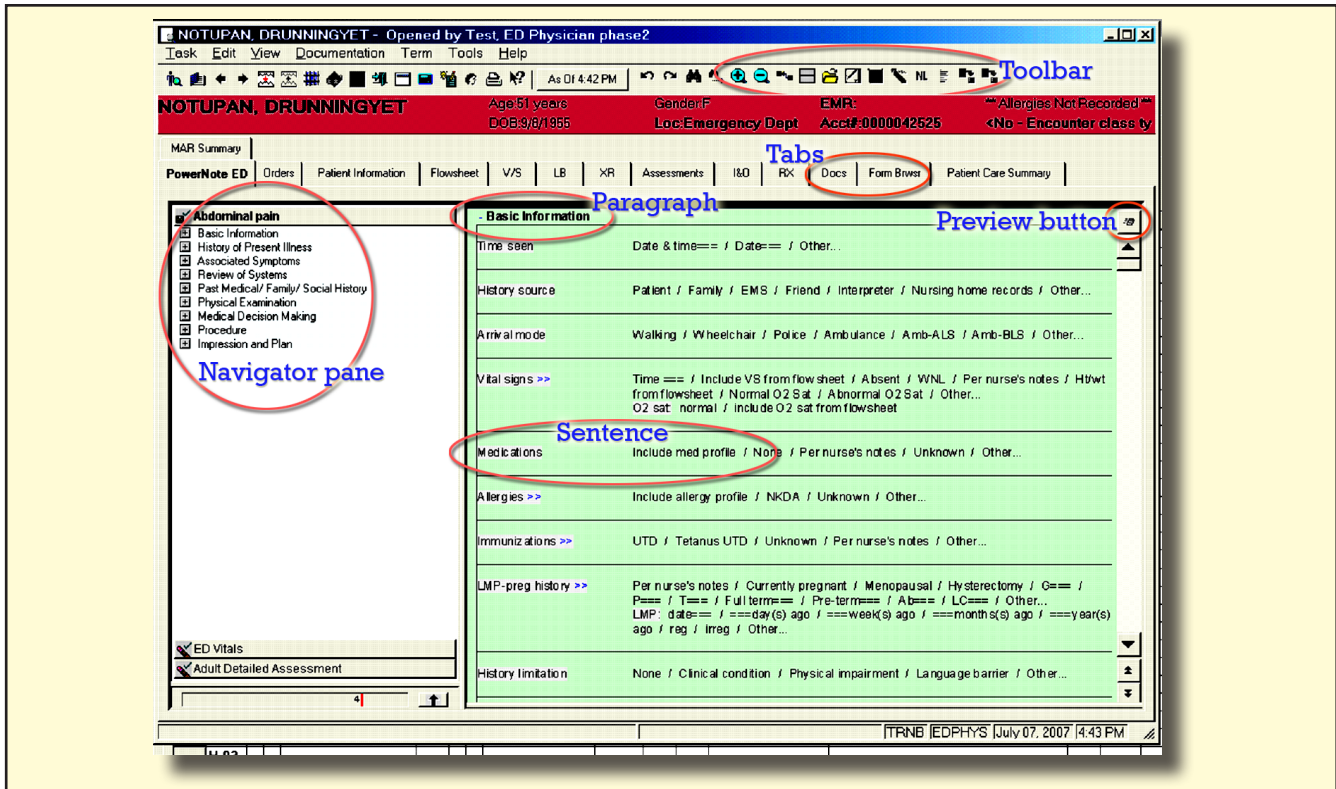
Toolbar
- Icons for opening 🖿, saving 🖫 and signing ☑ charts

Tabs
- Quick access to orders, flowsheets, reports, DOCS, and PowerNote ED

Navigator pane
- Clicking an item in the list allows you to take a short cut to one of the paragraphs (sections) in your note. A checkmark next to the item shows that it has been completed.

Paragraph
- Section titles

Sentence
- The individual lines that make up the real substance of the note. Here's how to construct a sentence:
    - Clicking once on a phrase circles it (pertinent positive);
    - Clicking twice backslashes it (pertinent negative)
    - Clicking a third time clears it (not included in final note).
    - Any phrase with === lets you enter a time, date or number
    - Any phrase with ... lets you type your own comment.
    - Any phrase with Scribble or drawing lets you draw; you can open one of a large number of anatomic line drawings to sketch on.
    - >> gives you more phrases to choose from
    - Right-clicking (**repeat**) and selecting "repeat" from the menu brings up the list of phrases again (so you can document, e.g., left and right or different times).
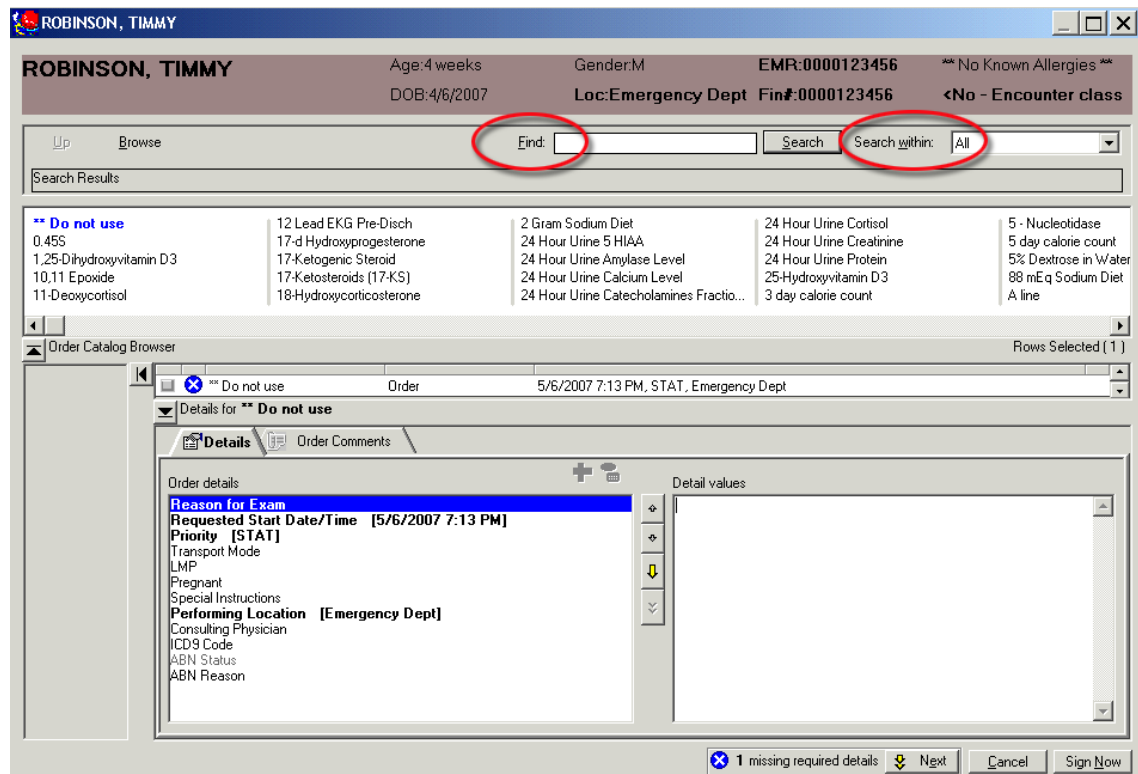
Preview button
- Displays a preview of the finished chart. Click it a second time to return to data entry.

Write Orders

There are three ways to get to the orders section:
1. You can enter orders directly from the Tracking List by right-clicking the patient's name and selecting "Orders"

2. by clicking the Orders tab and then the PowerOrders icon

3. in PowerNote ED in the Medical Decision Making/Clinical Work-up paragraph. Click Launch Orders....

All of these bring up a dialog box to write orders. You can pull the lower edge of the top window down to make it larger.

Finding your orders
- Use the Find window to Search.
  - The list scrolls as you type, so you may not need to type in the entire word. Search uses the first letters of the order's name, and the orders may be named something you don't expect. (e.g., blood cultures are under Culture-Blood.)   *Use Care Sets whenever possible (see box on next page)*

  - Type in "ed". This will bring all the ED Caresets to the front of the list. Note that you can type *any* order in the Find window if the next window ("Search within:") is set to "Any". Resetting the "Search within" box to another order category e.g. "Radiology" limits the search to imaging orders.

- Medication orders:
  - Easiest way to order medications: Use a prebuilt order from one of the Caresets.
  - If you can't find your order within a Careset you will have to build it:
    -Type the name of your desired medication in the "Find" box. Click to select.
    -Enter the details: amount (the number) and unit (mg, ml, etc.) and route separately. To avoid this problem, *use Care Sets whenever possible and save your medication order to your Favorites folder. (See page 30)*

❍ Nebulized meds are under Medications, and under Respiratory. The easiest way to order is by using the ED Respiratory Care Sets (ED Adult Respiratory Distress, ED Pediatric Respiratory Distress.)

❍ When ordering an updraft: order a Nebulizer, then the medications, so that Respiratory Therapy will be called to administer them.

CARESETS

⌘ Caresets are folders containing commonly used orders for tests, treatments, and medications grouped under a category name (e.g., chest pain). Careset orders are prebuilt with details specific to that problem. For example, the chest x-ray detail "Reason for exam" has already been filled in as "chest pain."

⌘ Selecting a Careset: Use the Search window to type "ed". The ED caresets will fill the search return window. Double-click to select the set that is the closest match to your patient's problem (the pediatric ones are called "ED Peds"). Check the boxes for the orders you want.

⌘ Make sure you scroll through the whole list; some items are checked already (e.g., ED Chest Pain has cardiac enzymes, CBC, BMP, etc. already selected). To add orders, click the checkboxes. If details need to be added, a blue circle will precede the order (see next page). Read the details and change them where needed. When you have selected all the orders you need, click "Done."
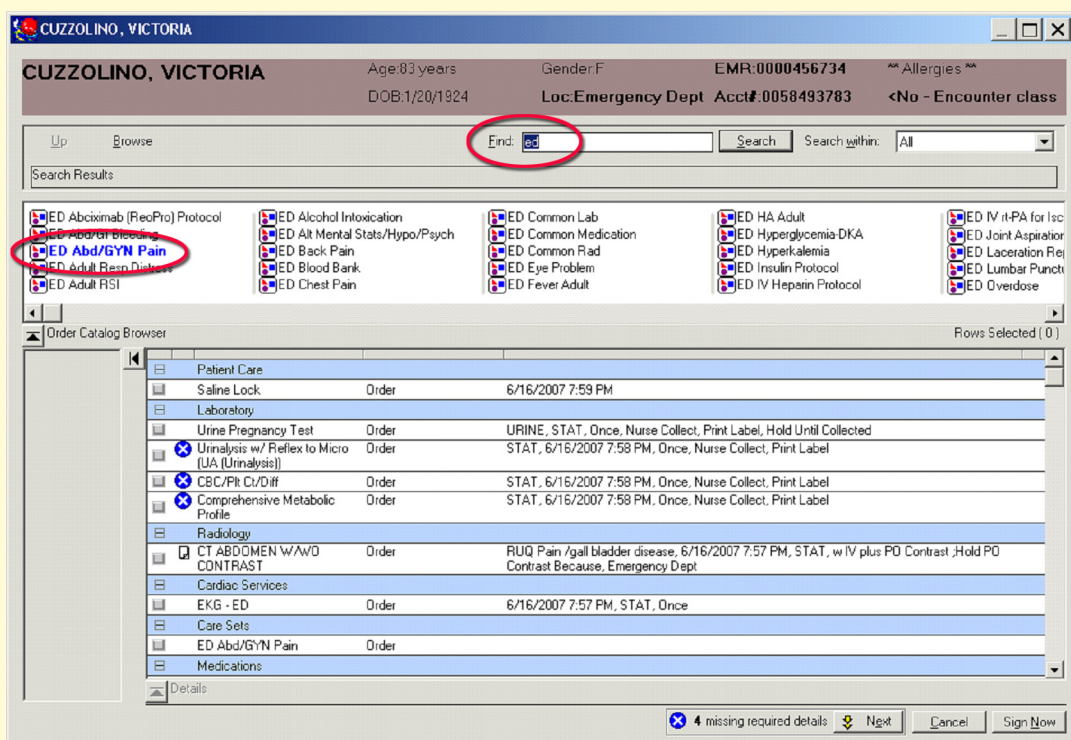
⌘ Expand your view by bringing your cursor to the lower edge of the box. Position it so a double-headed arrow appears. Left clicking and dragging will resize the box.
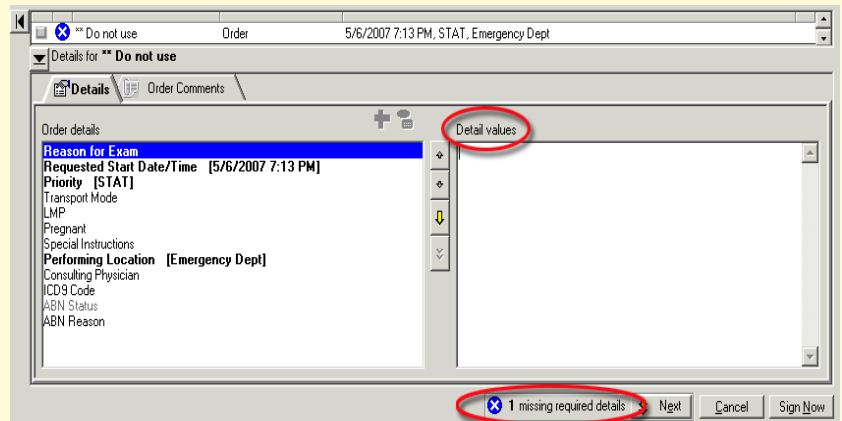
⌘ Type the first letters of the order you want, double-click it and check the details. If required details are not filled in, there will be a blue X next to the order.

⌘ If there are multiple orders that require details, fill in the details of the first order, then click "Next".

⌘ If you click the "Sign Now" button before completing your orders, it will send you back to the chart prematurely.

⌘ When finished, Click the "Sign Now" button in the lower right corner of the screen. You may also have to click the "Orders for Signature" button.

⌘ For radiology orders, the Caresets have pre-selected the "Reason for exam" (e.g, in the ED Chest pain Careset, the reason for a chest x-ray defaults to "chest pain".) When you order a non-Careset x-ray, you will need to fill in the Reason for Exam detail value. Type in "pain" or other indication, then add information helpful to the radiologist (e.g, "fever and acute LLQ pain").

⌘ At times, the Details window may be "below the horizon". In that case, move the mouse over the pane border until you see a double arrow, then left-click and drag to resize the pane. (*See page 40*)
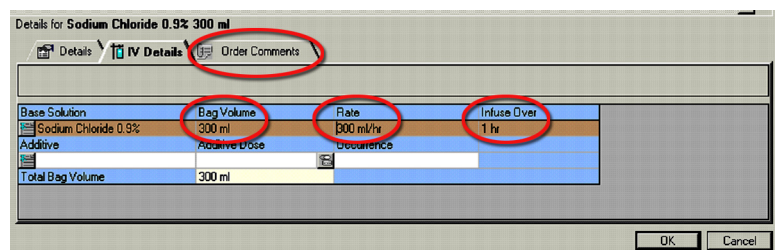
If you are in PowerNote's Medical Decision-Making paragraph and want to return to the orders to add something, click on the second "Launch Orders" which is not circled. DO NOT click the circled "Launch Orders" again (this will erase your initial orders from your note-- but will not cancel the orders in the chart, or in the Lab or Radiology systems). Another option is to use the Orders tab near the top of the page and then click the "Add Orders" icon on the PowerOrders tab. (see graphic at right)
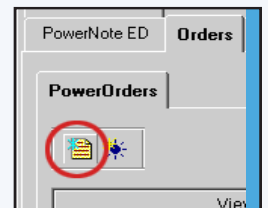
Ordering a Fluid Bolus

1. Select your IV fluid from a Careset
2. In the "Bag Size" field enter the size of your bolus
3. In the "ml/hr" field enter the size of your bolus
4. In the "Infuse Over" field enter 1 hr
5. Select the Order Comments tab and type "Bolus"

Make a Call

There are two parts to this:

1. **Order the Call:**
   - Click the Orders tab
   - Click the PowerOrders icon
   - Type "Call" in the Find window.
   - Select "Call physician"
   - Click the "Order Comments" tab
   - Type in the name of the physician you want to call.
   - Click "Sign Now" to send the order to the Unit Secretary.

2. **Document the Callback.**
   - In PowerNote, choose Medical Decision Making/Clinical work-up/Calls-Consults.
   - Click on the time, then "Recommends==" to document your discussion with the physician.
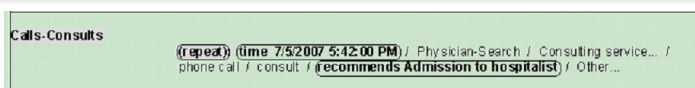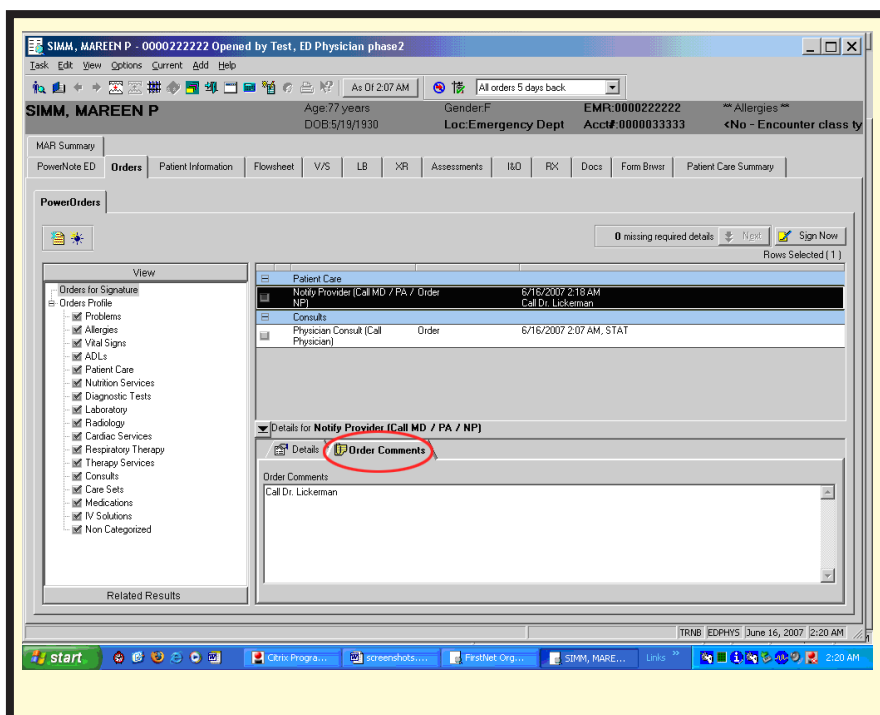
Progress Notes

These can be entered at the end of the Clinical work-up section under the heading of "Notes". Multiple notes can be entered as needed.

Documentation Reviewed

This section should be completed to support the complexity of your medical decision making. There are entries for sources of history such as the ED nurse, EMS, long term care, prior records (Webpins, etc.)

Clinical Work-up/Interpretation Paragraph

You must document your review and interpretation of EKG results, Cardiac Monitor, General (lab) results, X-rays/CT. These can be found in the "Clinical work-up/Interpretation paragraph".

- Quick views of lab and x-rays can be found on the LB and XR tabs at the top of the screen. Selecting one of these will bring up available results. You can also view the same information from the "General results (flowsheet) sentence.

- It is important to review the results of the tests you have ordered and click the "Results Reviewed" button at the bottom of the dialog box.

- If "Results Reviewed" is grayed out so you can't click it, you forgot to designate yourself as an "Available Reviewer" when you checked in for the day. Return to the Tracking List screen and click the Check-in icon ✦ to rectify this omission.

Checking Nursing Documentation

Take a few moments to check the tabs at the top of your screen for the Flowsheet, VS, LB, XR, and nursing Assessments. Access the information on any of the other tabs by simply changing the options in the "Flow-sheet" window. Use the "MAR Summary" tab to view Medication Administration Records.
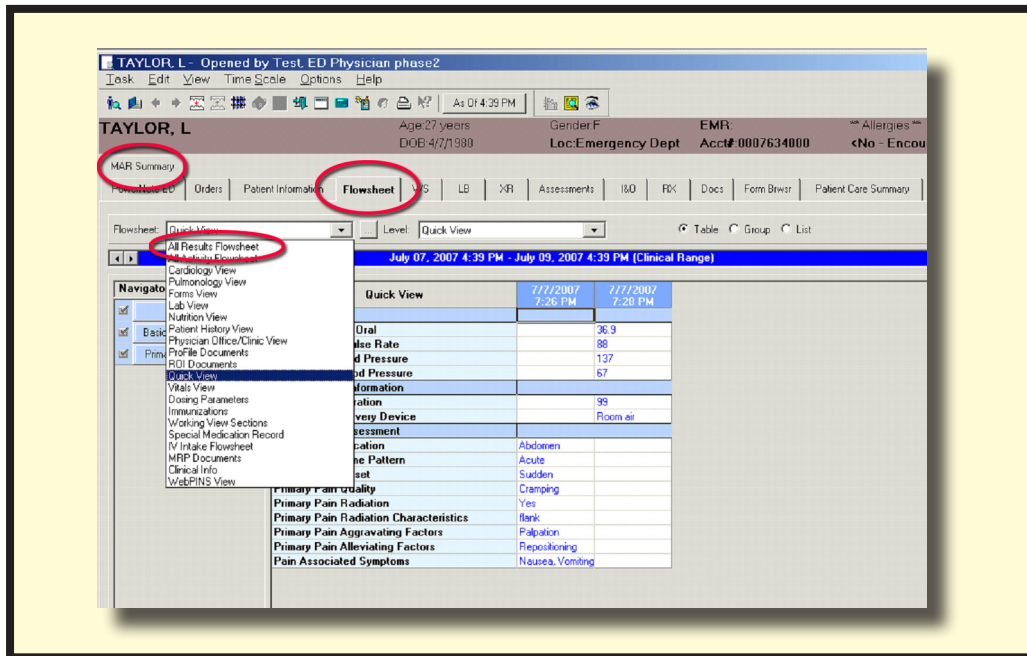
Procedures

Any procedures performed should be documented here. Right-click the word "Procedure" and select "Insert sentence". A variety of procedure types can be chosen from the list. Repeat as needed to cover the procedures you have performed.

Enter the Diagnosis

If you are the physician who completes the chart and the patient's disposition, you should enter the diagnosis.

1. Under Impression and Plan find Diagnosis.
2. Select one of PowerNotes' suggested diagnoses, or use "Diagnosis code search" to find a diagnosis that better fits your clinical impression.

Physician Transfer of Care Process

The physician can document the transfer of care to another ED physician at shift change, or to an attending physician, by using the "Patient transferred to" sentence. This resides in the Disposition sentence under "Impression and Plan". The process is as follows:

1. Physician A documents the care they provided, selects the "Pt care transferred to" term, selects a physician, and signs the note.

2. Physician B opens an Addendum note to document the time they took over the patient's care. The Addendum note can only be opened from the Catalog tab. This is where the receiving physician will document the rest of the patient's visit.

3. This process can be repeated if care is later transferred to a third physician.

4. Return to the Tracking List. Click the Provider Checkout icon in the top toolbar. ✶

   The Checkin Provider screen will appear.

   At the bottom of the screen select the Assigned Patients that you wish to transfer to another physician. (Select multiple patients by holding down the <Ctrl> key while left-clicking to select.)

   Select the receiving physician in the Reassign to Provider window. Click Assign or Assign All as appropriate.

Reassign Providers from the Tracking List

Another way to reassign providers is to do it directly from the Tracking List. This is useful when someone has signed out a patient to you without removing themselves as the doctor.

1. Double-click the initials in the DR column.
2. The Assign/Unassign Providers box will pop out.
3. Make the necessary changes and click "OK".
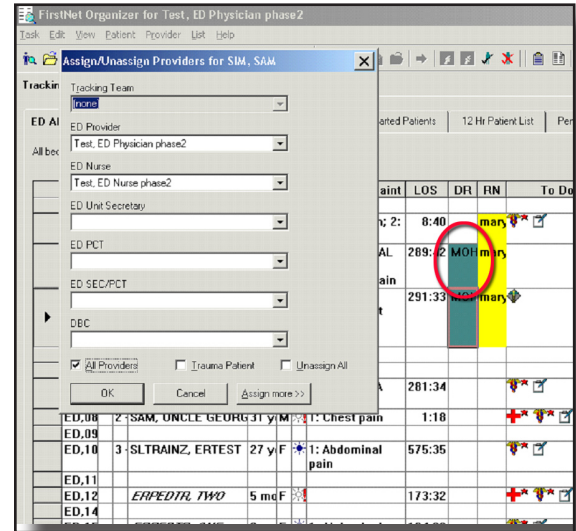
Sign Out in PowerNote

Remember that signing out on the Tracking List does not make an entry in your note. In order to officially transfer care to another physician in the chart, do the following:
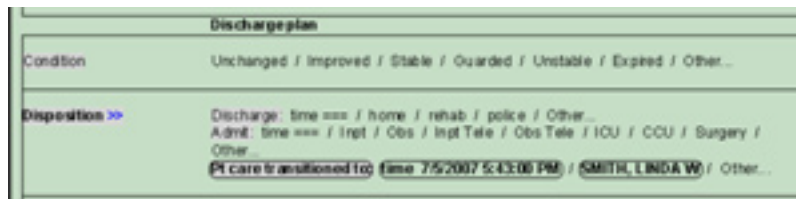
1. Under Impression and Plan find Disposition.
2. Click "Pt care transitioned to:" "time ===" and "Physician-Search" to select the new doctor.
3. Sign the note by clicking the Sign Note button in the top right ✎.
4. Return to the Tracking List and select the patient.
5. Remove yourself by clicking the Unassign provider icon 🔲.

Discharge Events

Discharge, admit or transfer the patient with the options in this section.

Discharge the Patient

A. Create **patient discharge instructions**
1. Under Impression and Plan, find Disposition.
2. Click "Discharge: time ===”
3. Click where the patient was discharged to.
3. Scroll down to "Follow-up"
   -Click Launch Follow-up...
4. Search Window: use binoculars to search for the follow-up physician.
5. Complete the other details on this screen.
6. Click "Sign" which will take you to a second box to "Print.”

B. Write a **discharge order**
1. Click the Orders tab, then the PowerOrder icon.
2. Search for "Discharge Order" and select it.
3. Click "Done" and then "Sign Now" to complete the order.

C. **Sign the note**
Click the Sign Note button on the top toolbar (right side) ◩. A new box will appear.
- Residents: check the box for endorsement (cosignature).
- To print the note (e.g. to FAX to the patient's private physician)
   -Click the Chart Preview button to make it readable
   -Click the Printer icon on the top toolbar
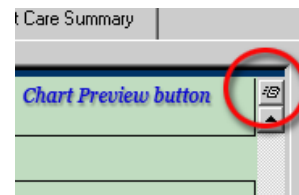
Admit the Patient
1. Click the Orders tab, then click the PowerOrders icon.
2. Search for "Admission order" and select it.
   -Complete the details: admitting doctor and observation vs. admission in the Special Instructions field.
3. (Optional) Under Impression and Plan find Disposition.
   -Click Admit: time === and where the patient was admitted.
4. Click the Sign Note button in the top right ◩.

Transfer the Patient
1. Click the Orders tab, then click the PowerOrders icon.
2. Search for "transfer" and select it.
   -Type the accepting doctor and hospital in the order details field.
3. Under Impression and Plan, find Disposition.
   -Click Transfer: time === and the transfer information.
4. Fill out the paper EMTALA form and give it to the nurse so she can complete her section.
5. Click the Sign Note button in the top right ◩.
6. Print the note for the transfer.

EZ-Script Prescription Writer

Under Impression and Plan is EZ script. Clicking this brings up the prescription writer.

1. Type the drug name in the Search window on the left. (Click "Product" for the best selection.)

2. Double-click the dosage and form you want from the list.

3. Drug name and dosage will appear on the prescription in the pane on the upper right.
    - If you aren't happy with the available choices:
        A. Customize it:
            Click <Dose> etc. type in those fields
        B. **"Short Lists": right- click any of the blue text and get a list of common choices**
    - The system does not allow "QS" for quantity or "PRN" for refills. However, you can type these into the instructions field.

4. Select the Sig. in the lower left window.

5. Routing/Printing
    A. Click Order Details button on the prescription's right side. This will expand the bottom of the prescription pane.
    B. Select Routing AND
        "Print Rx",
        "Document" (don't print: for OTC meds or things you called in), OR
        "Send Rx by Fax."
    C. A dialog box will appear with a window to type in the name of the desired pharmacy.
    D. Left-click and drag box downward to see more choices (e.g., different Walgreens).
    E. To print on prescription paper:
        -Select one of the two prescription printers (middle of screen) in the ED or Express Care

6. Click "Sign Orders" to print the prescription.

7. "Add To My List": Save common prescriptions to your "My List.".
        -Click the button at the bottom of the page labeled "Add To My List".

Weight-based Dosage Calculator

- All pediatric patients will have their weight routinely entered.

- Nurses will enter adult patient weight on request. The advantage of this is that the weight will be automatically entered for multiple weight-based medication orders.

Ordering a weight-based medication
1. Select a weight-based medication from a Careset and click "OK," the "Dosage Calculator" window will pop up. A physician can also enter a one-time patient weight on this screen.
2. If you are in agreement with the dosage calculated, simply click "Apply Dose."
3. Changes to the dosage can either be made before this click (in the "Final Dose" window) or in the order details after you click "Apply Dose."

Write Discharge Instructions

1. Under Impression and Plan find Pt. education.
2. Click Pt. education to write discharge instruction sheets.
3. Search for your diagnosis, or browse the list on the left. You have to pick something; there is no blank instruction sheet. The text is in the lowest pane; click the arrowhead to make it fill the window.
4. You can edit it (or even erase the whole thing and paste your own information in).
5. Click Print to print it out and OK to commit it to the chart. The title will be recorded in your note under Pt. education.

Work/School Excuses

Work excuses, school excuses and other custom documents can also be generated under Pt. education. In the Find window type "work", "school", AMA, etc. Double-click the item you want from the search returns.

Finish Strong

- Make sure that the prescriptions and discharge instructions are printed and placed in the clipboard. If you give the patient the instructions, note that the last page is the signature page, for the patient to sign and for you to leave in the chart.

- Pediatricians should fill out the paper billing sheet.

Write an Addendum

Addemdums are for documenting on a patient whose care you have assumed, or for occasions when you have signed a note prematurely. They can also be used after the visit for late additions to the chart. The addendum starts after the physical exam section and includes the Medical Decision Making, Procedure, and Impression and Plan sections.

1. Click on the "Open…Chart" manila folder in the top toolbar [Or Documentation/Open/Open]
2. Click the "Catalog" tab
3. Click Administrative, then "Addendum"
4. Before you finish, click "Add to Favorites" for easier access the next time you need an Addendum.
5. Click OK.
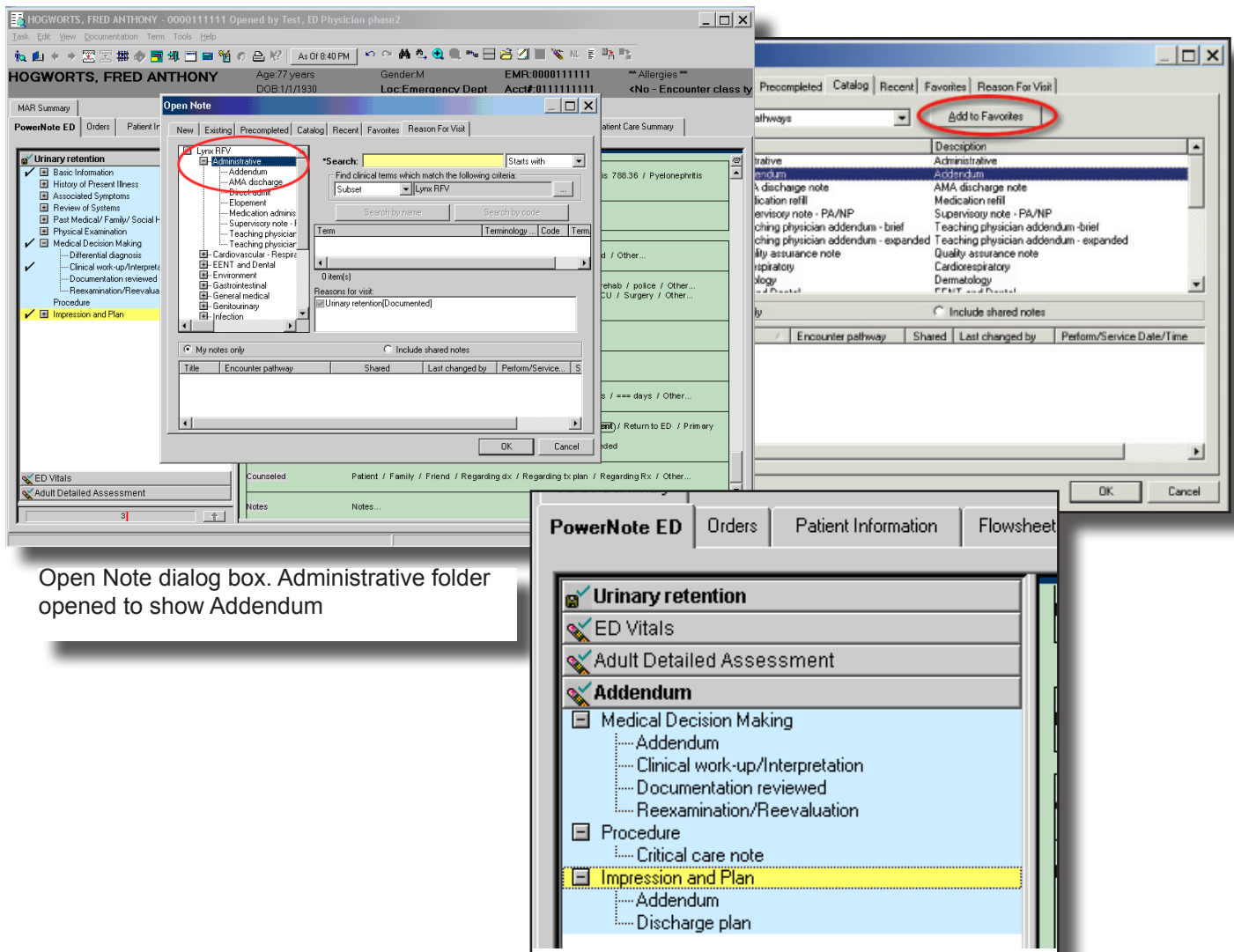
Open Note dialog box. Administrative folder opened to show Addendum

Navigator window showing contents of an Addendum

Customizing PowerNote

Creating and Saving a Macro

When certain terms (phrases), sentences and/or paragraphs of a note are completed routinely in the same manner, a macro can be used that will automatically document these terms in the note.

1. Complete the section of a note as you would normally do; **each term that is selected will be saved in the macro**.

2. For example, within the section Associated Signs and Symptoms select the appropriate choices to reflect your pattern of documentation for a typical chest pain patient.
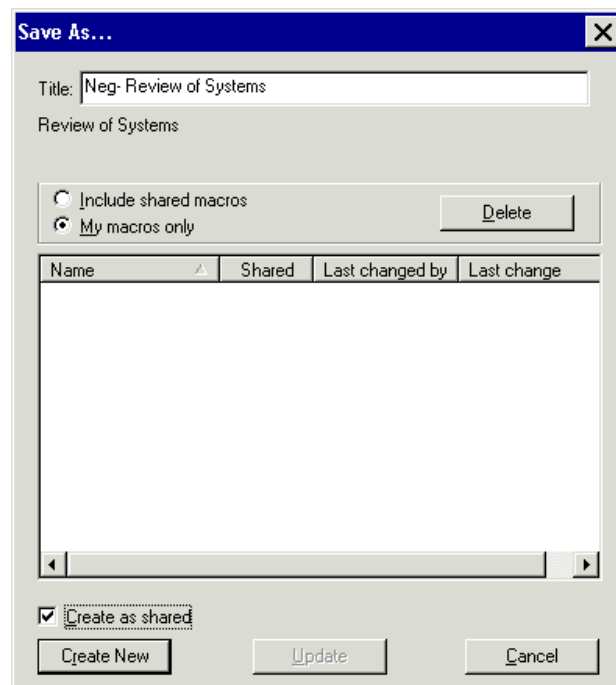
3. Now, right click on the term "Associated Signs and Symptoms" and select "Save Macro As…" The following window appears:

4. Specify a name for your macro in the title field.

5. Select the "Create as shared" check box if you want other users to be able to see and utilize this macro. The routine use of shared macros is not encouraged because of the danger of including items that do not accurately describe your history or examination. However, IF you create and decide to share a macro, add your initials at the end of the name. (E.g., "Normal ROS DL") As the user of a colleague's shared macro it is recommended that you insert the macro, edit it as necessary, then re-save it (unshared) under your own title. This prevents surprises should the originator change the shared macro at a later time.

6. Click "Create New" to save the Macro

Note: An '**M**' will appear next to the Paragraph, or sentence, indicating that a Macro exists. You can click on the 'M' to apply the macro that was created.

Inserting a Macro

Macros can be created at the paragraph, sentence, or terms level; they are not note (problem) specific. If a macro that was completed at the paragraph level is inserted in a different note than the one used to create it, only the sentences that the two notes have in common will be updated by the macro.

To Insert a Macro:

1. Click on the **M** next to the paragraph, sentence or term.

2. Select the macro from the dialog box that appears to the right.

3. Click **More** to see all macros associated with the paragraph or sentence.

4. Click the macro name which will insert the macro (circles terms)

    - Macros can be saved on "other" and 'notes" terms which are free style typing terms.

    - Macros can be deleted by going to Save Macro As / select the desired Macro / choose delete from upper right corner of Macro window.

    - Macros can updated by altering the term selection as desired Save Macros as / select appropriate macro form the list / click on "Update at bottom center of macro window.

Note:. When you catch yourself saying "that is just too many keystrokes for something I document frequently," consider using a macro.

Modifying a Macro

You can make modifications to a macro that you already created by doing the following:

1. Click on the **M** and select the macro inserting into the note.

2. Make changes to the paragraph, sentence, or term as needed.

3. Right click on the paragraph, sentence, or term for which you are creating this macro and select the Save As option.

4. The Save As window will appear. Press the Update button in order to save the changes that you made to the macro

5. You can also update your macro as shared by selecting the Save as Shared checkbox before pressing the Update button.

Deleting a Macro

You can delete a macro that you created by doing the following:

1. Right click on the paragraph, sentence, or term that the macro is based on. Select from the menu the item of "Save Macro as".

2. The save as window will open as below, highlight the macro being deleted.
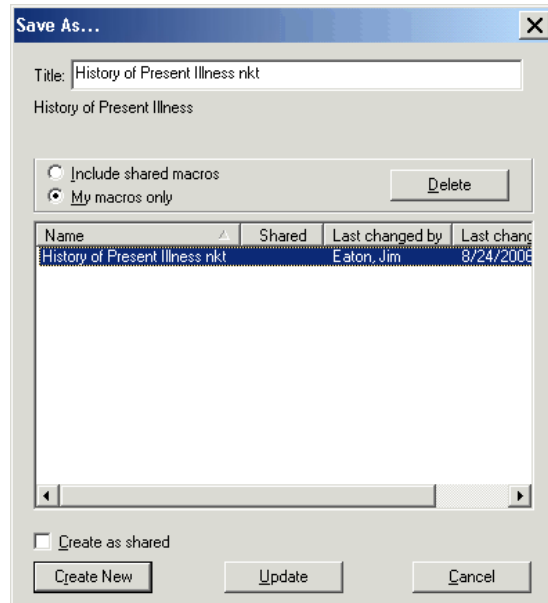
3. Select the Delete button. The following message appears select yes to delete the Macro. The Macro will be deleted from the window. Select cancel to close the window.
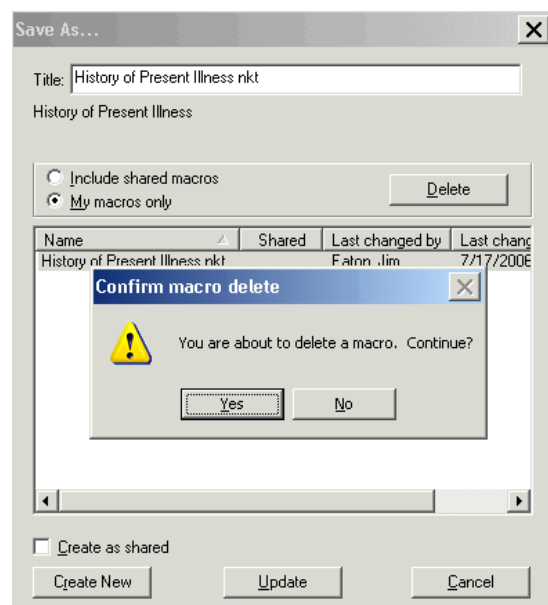
Specific Macros

It is recommended that each physician create Macros that represent his/her own pattern of providing clinical care and documentation methodology.

We do not recommend creating shared macros for the following reasons:

1. There is concern someone may use a shared macro without knowing what terms are selected and may end up documenting something unwanted.

2. Unless the user takes the time to personalize shared macro, it will not reflect his/her own pattern.

Note: Example of macros shown here are from Chest Pain Note.

Basic Information

Date, Time, Vital Signs will differ for each patient and should not be included in the macro.

You only have to save one macro for basic information as this section is fairly consistent throughout all templates (except it will add LMP for female and orthostatic vitals where appropriate)

For all macros: when you name and save them, they will be listed in alphabetical order.

Associated Symptoms & Review of Systems

Note: Together these two paragraphs count for total of 14 areas of symptoms and systems.

The practice of documentation for these two sections varies by physicians. Some physicians solely rely on ROS sheet and want to just reflect that they have reviewed this information. This can be accomplisby clicking on "ROS reviewed as documented in chart" toward the end of section and leaving everything else blank.

For those that want to mention a few pertinent positives and negatives, you can do so by clicking on "All other systems otherwise negative".

For those who want to document the Associated Symptoms and ROS individually, it makes sense to save macros for your top complaints. The macro can then be inserted and selected terms modified to reflect patient specific findings.

Associated Symptoms and ROS questions are template specific. These macros should be labeled to reflect the name of the template.

You can also create your own phrase for example "I have reviewed ROS sheet as documented by ………". This should be done under "Notes" or "Other" term and can be saved as Macro.

Past Medical / Family / Social / Surgical History (PMFSH)

Again, the practice may vary by user. You can either document the individual components or review on the ROS Sheet and use "Reviewed as documented in chart"

A Macro can be created that will circle the following choices at once.

- Past Medical/ Family/ Social History **M**

Medical history >>	Neg / (Reviewed as documented in chart) / Unknown
	Cardiac: murmur / Other
	Respiratory: asthma / Other...
	Cancer: Other...
	Diabetes: DM, type I
	Additional: HIV / Other...
Surgical history >>	Neg / (Reviewed as documented in chart) / Unknown / Valve disease-surgery / Appendectomy / Tonsillectomy / Other...
Family history >>	Not significant / (Reviewed as documented in chart) / Unknown / CAD / DM / CVA / Other...
Social history >>	Not significant / (Reviewed as documented in chart) / Unknown
	Social concerns: none / abuse / living situation / neglect / Other...
	Notes: Notes... / Scribble notes...

You can also take advantage of prior H&Ps in WebPins by copying and pasting past medical history from a recent transcription.

- Go to Webpins, find the material you want to copy. Select it by dragging over it while holding down the left mouse button. type <Ctrl> C to copy the information.
- Return to PowerNote with <Alt> Tab.
- Click Other... in the Medical history section. Press <Ctrl> P to paste the information into your PowerNote.

Physical Examination

This is where the greatest time can be saved. It is highly recommended that you create macros for the top 10 complaints. These should reflect your own pattern of exams for patients with different kinds of complaints.

- Physical Examination **M**

| General appearance >>	(WNL) / Mild distress / Mod distress / Severe distress / Alert / Smiling / Interactive / Lethargic / Unresponsive / Other...
Skin >>	WNL / (Warm) / (Dry) / No pallor / No rash / Other...
Eye >>	WNL / (PERRL) / (EOMI) / (Normal conjuctiva) / Icterus / Other...
ENT >>	WNL / TM's clear / (Oral mucosa moist) / (No pharyngeal erythema or exudate) / Other...
Neck >>	WNL / (Supple) / (No tenderness) / (No carotid bruit) / No JVD / Other...
CV-heart >>	WNL / (Regular rate and rhythm) / (No extra heart sounds) / (No murmurs) / Other...
Respiratory >>	WNL / (Lungs CTA) / (Respirations nonlabored) / Other...
Chest wall >>	WNL / (No tenderness) / (No deformity) / Other...
Drawing >>	Chest drawing
Abdominal >>	WNL / (Soft) / (Nontender) / (Non distended) / Normal BS / No organomegaly / Other...
Rectal >>	WNL / Normal tone / Guaiac negative - QC OK / Other...
Extremity >>	WNL / (Normal ROM) / (No swelling) / (No tenderness) / Other...
Neurological >>	WNL / (Alert) / (No focal neuro deficits) / Other...
CV-perfusion **M** >>	(repeat); (normal) / radial pulse / femoral pulse / popliteal pulse / posterior tibialis / dorsalis pedis / capillary refill / Other...
Notes >>	Notes... / Scribble notes...

Tympanic Membrane, Bowel Sounds, Rectal Exam and other components that are not routinely part of a chest pain evaluation were deliberately left out.

Favorites

Creating Favorites

Creating "favorites" in the Orders section is a time-saving convenience. The best way to do this is to select your orders from the pre-built Care Sets (but the same procedure applies to non-Careset orders.

1. Choose any number of orders in the Careset, then click "OK" to choose them.
2. Hold down the <Ctrl> key and left-click to choose multiple orders. Right-click within one of the marked orders, then click "Add to Favorites" from the list that pops out. This will add all the selected orders to the Favorites area.
3. Click the "Create Folder" button to make a new folder in the Favorites area appropriately named for your orders. For example, you can make a condensed set of abdominal pain orders, common radiology and laboratory tests, or a folder for your preferred pain medications. You can also place them in the Favorites area without putting them in a folder.
4. Click "OK" to return to the Orders screen and sign your orders.
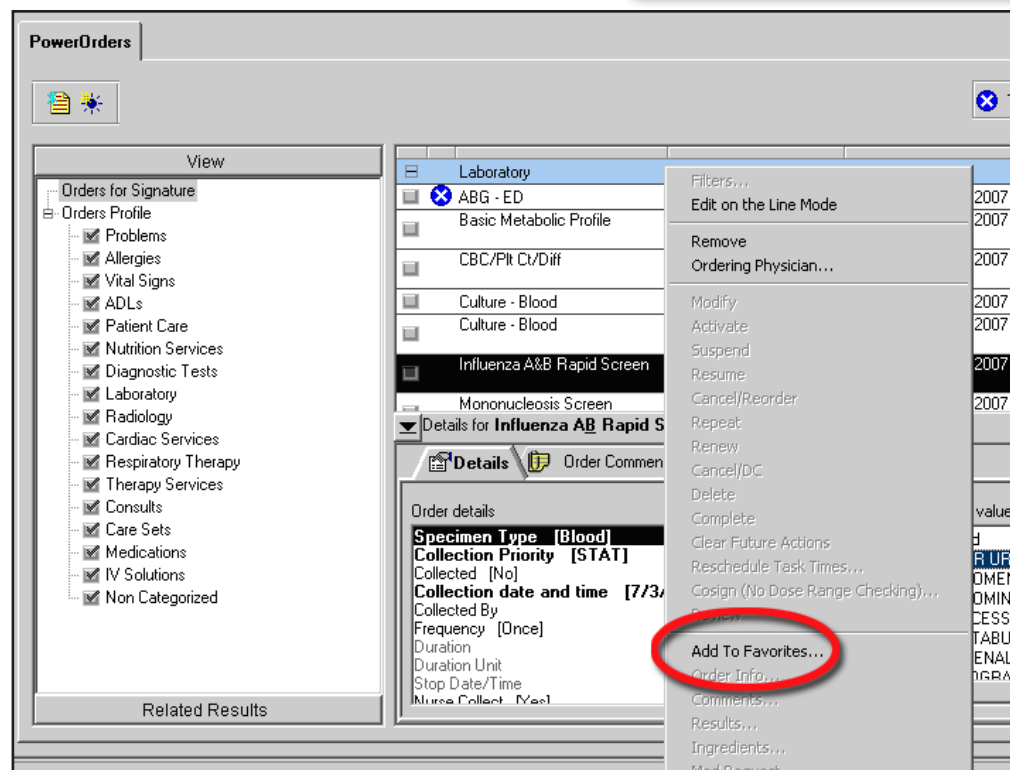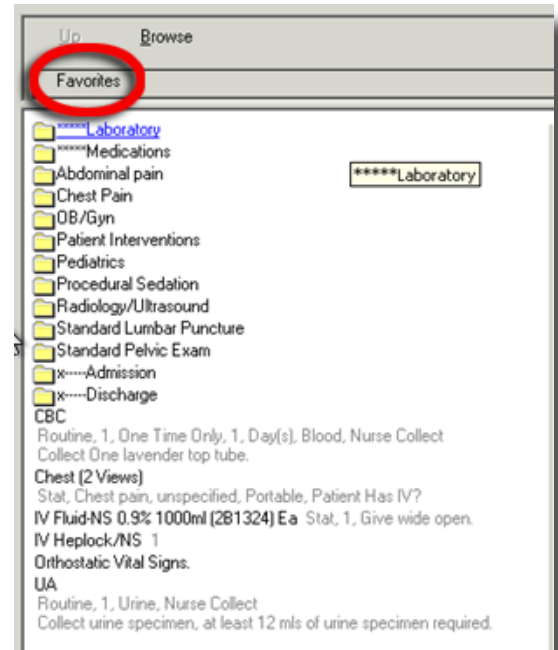
Using Favorites

1. Click the PowerOrders icon

2. Click "Browse", then "Favorites"
3. Click the folder containing your orders to open it
4. Click the orders you want. You can see them being added to the main orders screen as you click each one.
5. Click "Done"
6. Click "Sign Now."

⌘ The next time you go to PowerOrders, it will open in your Favorites instead of in the Search window.

Using "My List" in EZ-Script

1 Construct a prescription to your satisfaction
2. Click "Add To My List" at the bottom of the screen.
3. To use the list, click the "My List" tab at the top left of the screen.
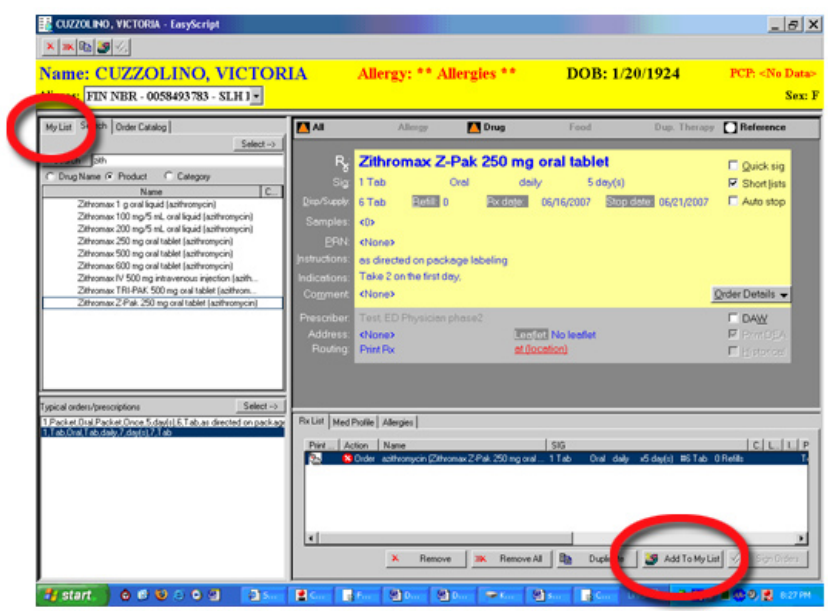
Creating Your Own Discharge Instructions (Patient Education)

1. Start with a patient education template that is close to your topic
2. Edit it as desired
3. Select it in the lower left window
4. Right-click and select "Save custom instruction" and "Individual"
5. Name it appropriately and designate which category to put it in.
6. Click "OK"

Decision Support: Allergy Alert

1. Note the information in the decision support window

2. You can dismiss the window immediately by clicking "OK"

3. Click the drop-down arrow in the "Current Override Reason" and select one of the choices or click the "Free text" option to type in your own reason.

4. If there are multiple drug interactions you may check the "Apply to all" box.

5. If you decide to change your order, you may check the "Remove identified order" box in the lower left corner.

6. Click "OK."

Enter/Update an Allergy

1. Double-click one of the Allergy icons on the Tracking List ☀ ☀! ☀ .. (You can also do this from the Orders tab by clicking the Add Allergy icon or using the keyboard shortcut <Alt> L).

2. The Allergy/ADR Profile will pop up.

3. **If you are modifying a drug on the screen's list**, double-click the drug of interest and the "Add Allergy" screen will pop up.

4. **For a new medication or allergy** right-click the empty area of the window and the "Add Allergy" screen will pop up.

5. Select "Add New.." then choose either "Drug Allergy," "Drug Side-Effect," or "Other'.

Allergy/ADR Profile
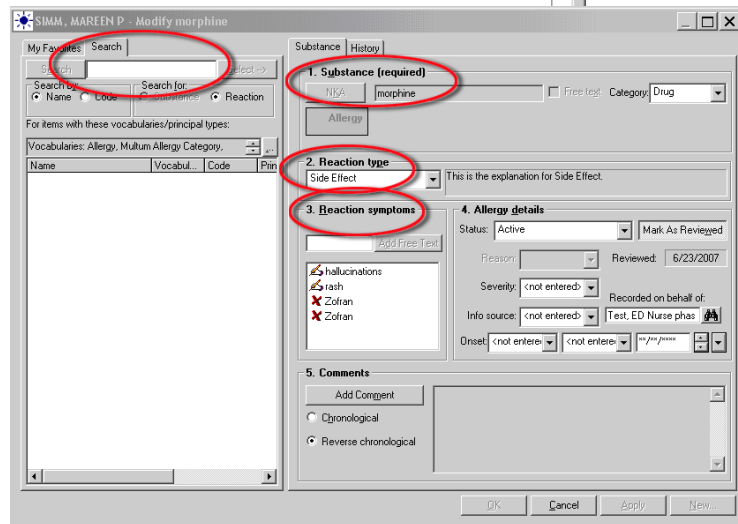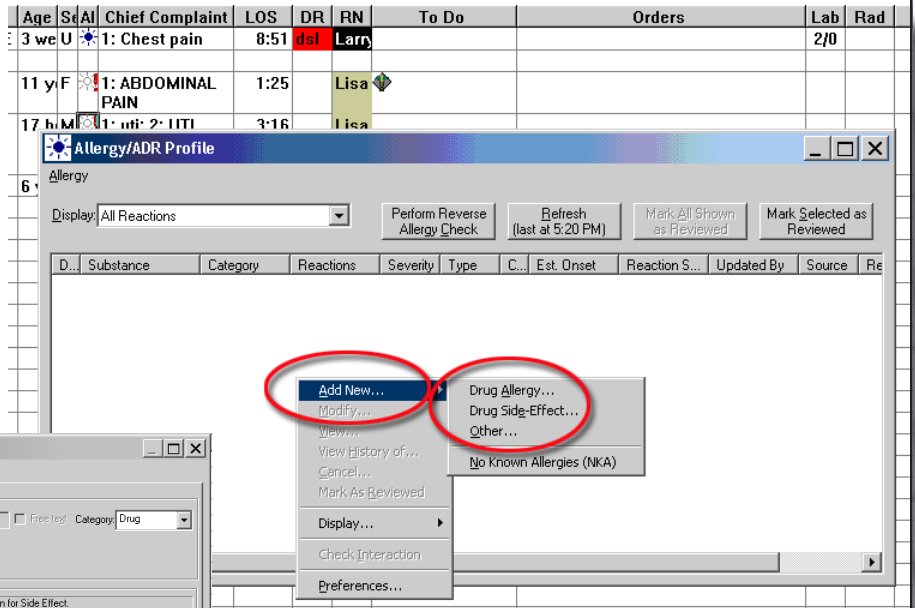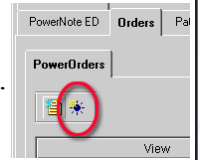
Add Allergy dialog box

It you decide to add or modify an allergy from within PowerNote, you can do so in the Basic Information/Allergies sentence. Click "Include allergy profile." The Allergy/ADR screen that pops up includes an "Add Allergy" button in the bottom right corner.

6. Type the medication in the Search window and click "Search".

7. If your search is successful, you can click "Select" to move the result to the "Substance" window. If you get a list of preparations, you can double-click an item to place it in the "Substance" window.

8. Click the drop-down arrow for "Reaction type" and click the desired selection

9. Type symptoms in the "Reaction symptoms" window and click "Add Free Text"

10. Add other details as appropriate.

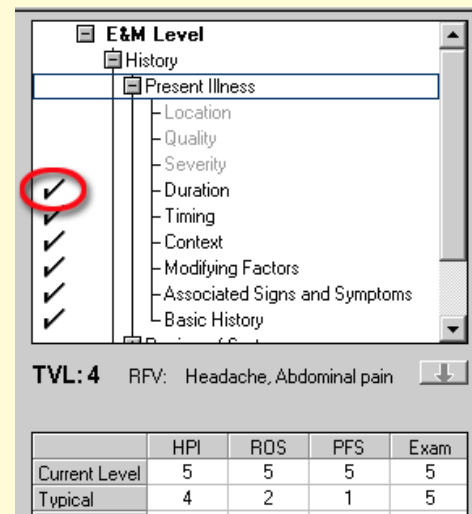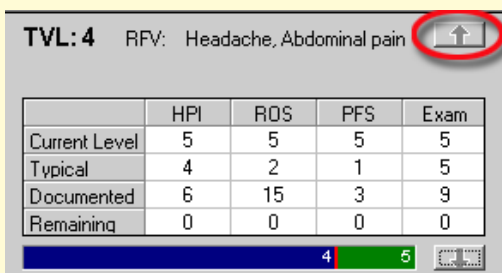11. Click "OK"

Document Quality Indicator

The Document Quality Indicator (DQI) is based on Lynx's algorithm, which was developed using research from over 11 million ED visits. It takes into account the reason for visit, age, and sex of the patient. The DQI guides the physician towards maintaining quality documentation by measuring how complete the documentation is in the areas of HPI (History of Present Illness), ROS (Review of Systems), PFS (Past Medical, Family, and Social History), and Examination. As you select terms throughout the note you can see the DQI increase. The White number indicates the E&M Visit Level based off the Physician's current documentation. The black number indicates the Typical Visit Level associated with the Reason for Visit that is being documented against. As the Note is documented, the bar graph will approach the Target TVL and the E&M Level will increment accordingly to indicate the current E&M Level based off the documentation. It is important to note that the DQI displays current state and will not prompt the user to document more sections in order to increase the E&M Level.

This is the collapsed view of the DQI. It resides in the left lower corner of the PowerNote screen. Clicking the up arrow will expand it to the "moderate view".(below)

- The TVL is the typical visit level for the reason for visit selected. For example, the TVL for a patient complaining of Chest Pain is a 5. This means that some chest pain patients do not meet the level 5 criteria while most do.

- The "Current level" represents the amount of points awarded per area if nothing is documented within the note

- The row titled "Typical" represents the amount of documentation needed to support the TVL of the complaint.

- The row titled "Documented" shows the points earned for each area. The numbers will increase as you document within the note. The row titled "Remaining" shows the amount of points needed to meet the points in the "Typical" row. Note: the "Remaining" section will display in Red until the amount of documentation needed to satisfy each section for the RFV is complete.

Expanding the DQI field to the FULL view by clicking the up arrow in the upper right corner displays the sentences in each area. This allows you to easily see what has not been documented. Completed items have a checkmark. See the screen shot at right from a partially documented note. If there are unchecked items, you would need to insert the sentence that you want to document within. Note, if the sentence header is dithered, that sentence is not available in the current Note. You must add that section via the insert sentence function located under the "Documentation" Menu item.

The Sign Instead of Save Error

You cannot modify a chart if you "Sign" instead of "Save". You have two options:
1. If you have finished the History, ROS, PMH and Physical Exam, simply create an addendum. (See "Create and Addendum" on page 23)
2. If you have **NOT** completed History, ROS, PMH and Physical Exam, you will want to reactivate the chart by "Copying to a New Note" (probably a rare event),

Reactivating a "Signed" Chart

1. Open the chart in PowerNote ED
2. Click on the "Open…Chart" manila folder in the top toolbar [Or Documentation/Open/Open]
3. Select the "Existing" tab
4. Click on the chart you want to activate
5. Click on the checkbox for "Copy to New Note"
6. Click "OK"
7. Chart on the patient as usual.
8. Then you will have to delete the original note.

It may also be useful to "Copy to a New Note" when a patient returns with the same problem as before (and their Past/Social/Family history is complex). You will have to clear some of the previously completed sections in order to appropriately chart on the new visit. However, you cannot copy notes between patients.
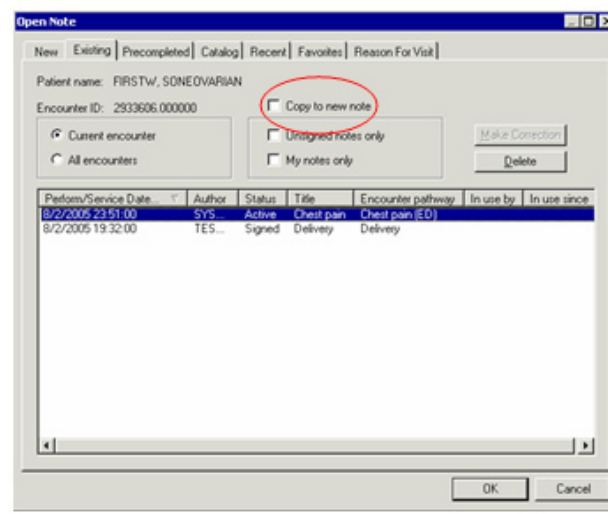
Deleting the *Original* Signed Chart After Reactivation by Copying to a N*ew* Note
1. Close the note by selecting "Documentation" on the top toolbar, then "Close Note".
2. Access the original note by selecting the "Open…" folder on the top toolbar
3. Click on the "Existing" tab
4. Select the note you want to delete by clicking on it. It will turn blue.
5. Click "Delete" [If this is "grayed out", you are not the author of the selected note]
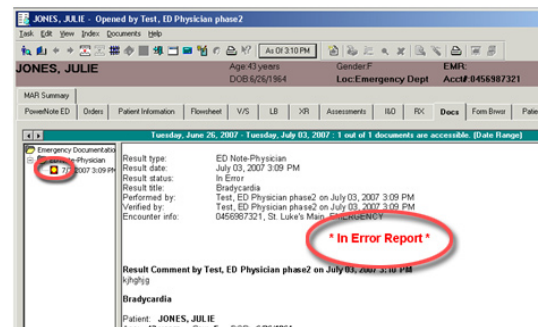6. Click "OK"
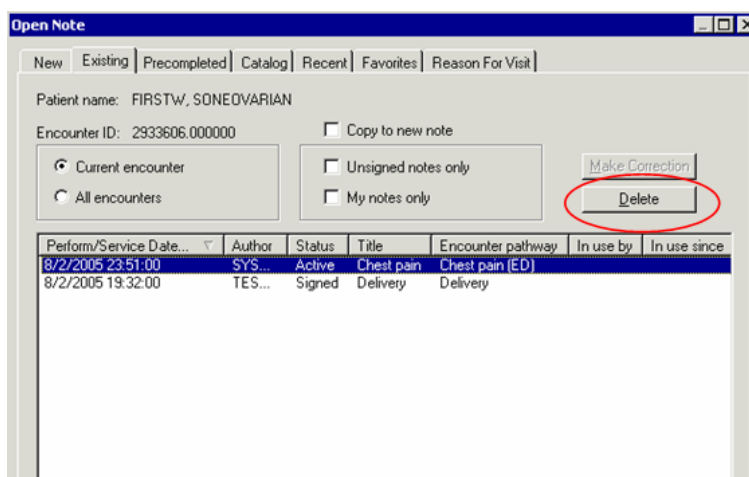
Cancelling an Order

1. Open the patient's chart by double-clicking the arrowhead in the left-side gray box
2. Click the Orders tab
3. Find the order you want to cancel on the list.
4. **For orders that have been signed**: right-click the order and select either (depending on your intention):

   "delete" (for an order that has not been initiated)
   "cancel/DC" (for an order --like a PRN--that has been started) or
   "cancel/reorder" (for an order whose details you want to change)
   - Click the refresh button if the orders are designated as "processing". This will change their status to "ordered" so that you can make changes.
   - **For unsigned orders** a right-click allows you to "remove" them but doesn't give you any of the other choices.
5. Select the reason for cancellation in the lower right box.
6. Sign the order by clicking the check box called "Orders for Signature" which is mid-way up the screen on the right. (Depending on your choice you may have to fill in details and sign twice.)

Charting in the Wrong Chart

1. If you realize you have charted on the wrong patient you can "unchart" the note.
2. Open the DOCS tab and then look for a folder in the left window. Double-click to open it to the note. This may be nested inside a second folder, so double-click until you get to a note with a date.
3. Select the chart you want to delete by clicking on it.
3. Click on the red "x" that will appear on the toolbar.
4. Enter the reason you are "uncharting" or recording this charting as an error.
5. The chart may still be visible on the DOCS navigator pane, but will be marked as deleted by a black box with a red circle inside it. ▣ The chart will be marked as "**In Error**".
6. Additional options are available by right-clicking the selected chart in the left pane.

If you don't see your note on the DOCS tab in the left window, it will need to be signed first.
- Return to the note and click the Sign Note icon in the toolbar.
- Change the title if you wish (in order to be sure you are deleting the correct note later).
- Click "OK".
- Return to step 2 above and follow the procedure from there.

Miscellany

Designating the Patient's Specialist Physicians

1. To add to the list of specialist physicians (for future reference), click the Private Physician icon on the main Tracking List screen
2. Enter up to four physicians that the patient routinely sees.
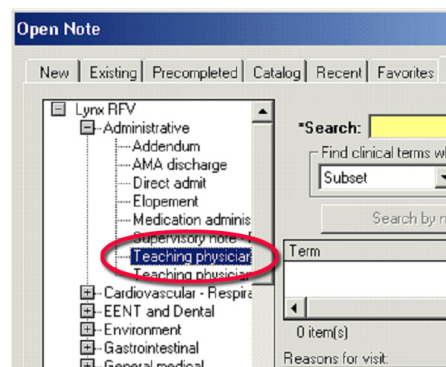3. Refer to this list when you need a specialist for the patient.

Signing and Cosigning During and After the Visit

- If you need to sign an order or a resident's note, a cosign icon will appear in the CS column on the Tracking List.

- Items that require a cosignature may also be found in the 12-hour departed patient list.

- After 12 hours, incomplete charts can be found on the Reports tab. Click on the patient to open the chart for addendums or signatures. These will be on the list indefinitely. The list is not limited to just your patients, so please make an effort to regularly complete your charts so that everyone has a shorter, faster-loading list.

Adding a Teaching Physician Addendum

- Click the Open Note folder from within PowerNote.

- Click the [+] for Administrative notes

- Select either Teaching physician addendum- brief or Teaching physician addendum-expanded. The brief note has sentences for agreement with the resident's note and allows for documentation of exceptions to that agreement. The expanded version includes these sentences plus the same sections as an Addendum note.

Suspend feature [Use in Fishbowl only]

- If you are called away from a computer and are in mid-chart, you can click the suspend button. When you return to the computer and log in, you can pick up your charting right where you left off.
- This feature must be used carefully as it ties up a Citrix server, and there is a limited number of these.
- If too many users suspend charts at the same time, it can significantly slow the system.
- A suspended chart can only be unsuspended from the computer where it was suspended.

Deleting a Paragraph in the PowerNote chart

- Right-click the paragraph heading in your note (i.e., "History of Present Illness") and select "clear" from the choices presented.

Changing the Admitting Physician

Admitted the patient to the wrong physician?

- Verbally inform the Admitting Secretary that the admitting physician should be changed in STAR.

- In the PowerNote "Medical Decision-making" section document that this has occurred.

Use the Depart Process Icon on the Tracking List as a Shortcut

- On the Tracking List toolbar, click the Depart Process icon.

- Click the gray squares preceding Prescriptions and Patient Education to review, edit and print your prescriptions and discharge instructions.

Troubleshooting

PRINTING PROBLEMS: No Output

- Make sure the default printer for your computer is set correctly. Citrix sets the printer when you log on, and to change it you have to log off, reset the default printer, and log on again.

- Set the default printer with "Printers and Faxes" under "Settings" in the Start Menu. Right click the printer you want and select "Set as default".

- If prescriptions will not print:
    A. Click Order Details button on the prescription's right side. This will expand the bottom of the prescription pane.
    B. Find Routing AND (select one:)
        "Print Rx",
        "Document" (don't print: for OTC meds or things you called in), OR
        "Send Rx by Fax."
    C. For Fax, a dialog box will appear with a window to type in the name of the desired pharmacy.
    D. Left-click and drag box downward to see more choices (e.g., different Walgreens).
    E. To print on prescription paper: Select the location of one of the two prescription printers (middle of screen) in the ED or Express Care
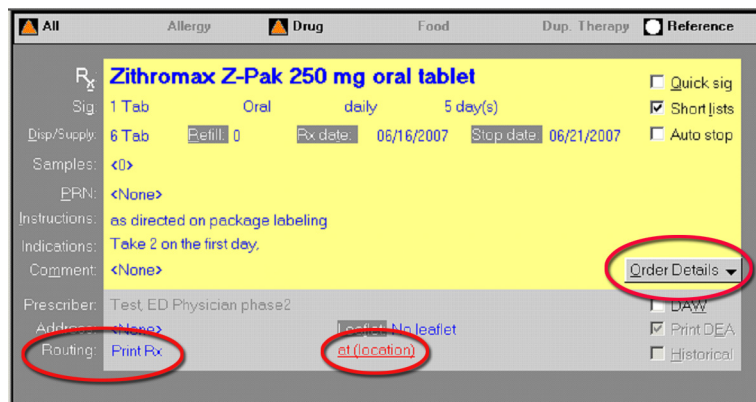
ERROR REPORTING PROCEDURE

- During Go-Live you can communicate problems to Superusers. For the first two weeks we will also have Cerner staff (in red vests) who can address problems.

- After Go-Live call the Help Desk at extension 4357

Order Details Not On-Screen

At times, the Details window may be "below the horizon" and you will be unable to supply missing details.

1. Move the mouse over the pane border until you see a double arrow
2. Left-click and drag upwards to resize the pane.