TEXAS
Department of Aging and Disability Services

IRIS

Integrated Resident Information System

Provider Manual

TABLE OF CONTENTS

PURPOSE

This document provides an overview of IRIS' basic functionality.

> **Note** ▸ Specific functionality is dependent upon security access. The following information provides common functionality available across multiple system roles.

OBJECTIVES

- Navigate IRIS
- Use IRIS functionality to care for residents

SECURITY

> **Please keep your laptop with you at all times. If it is necessary to step away from the computer, make sure it is password protected and/or secured with a laptop lock. Password protect your laptop by using ⊞+L on the keyboard. A password is required to log back in.**

LOGGING IN

Training Login

1. Double click the training application icon to open the login window.
2. Type the training username in the **Username** field.
3. Type the training password in the **Password** field.
4. Click **OK**.

Daily Login

1. Log into Cerner.
2. Click the icon for PowerChart.

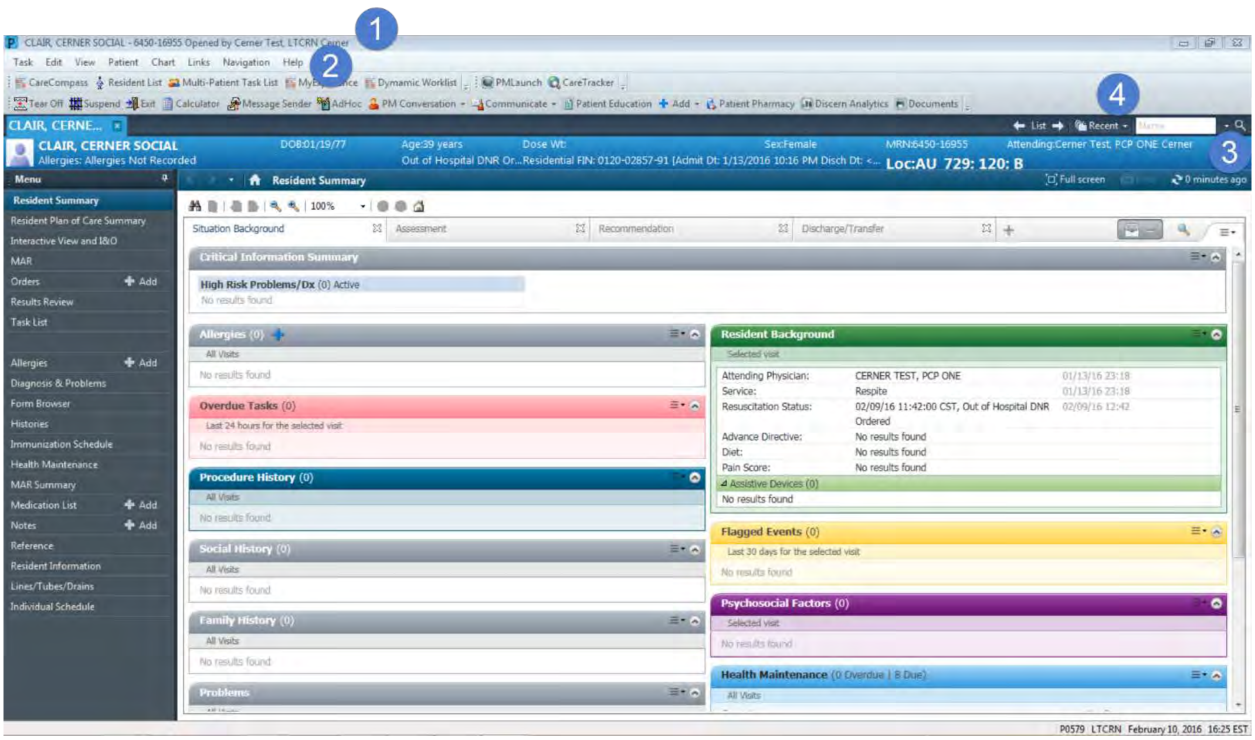
Logging Out (Exit)

1. From any window within the application, click the Red X () at the top right corner of the window to log out.

POWERCHART OVERVIEW

The PowerChart Overview will provide an overview of the main sections of the IRIS windows, how to view a resident's chart, and use common functions.

Note ▶	Identify criteria to group and manage residents by any sequence of factors and/or conditions.



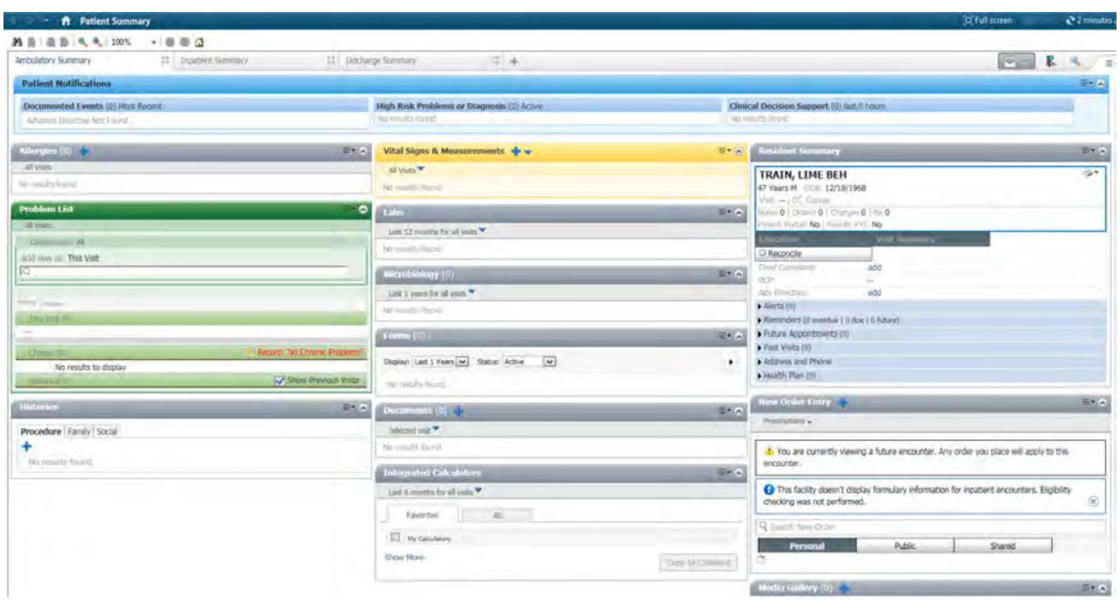
Resident Summary: Window Overview

<table>
<tr><th>Title</th><th colspan="2">Description</th></tr>
<tr><td>1. Title Bar</td><td colspan="2">Displays the application that is currently open, and the name of the individual logged in. On the right, there are buttons to minimize, maximize, or close the application.</td></tr>
<tr><td rowspan="5">2. Menu Bar</td><td colspan="2">Includes the following menus:</td></tr>
<tr><td>Menu</td><td>Description/Functionality</td></tr>
<tr><td>Task</td><td>Change a password, suspend the application, view report, print, refresh the window, or exit the application.</td></tr>
<tr><td>Edit</td><td>Cut, copy, paste and delete.</td></tr>
<tr><td>View</td><td>View the CareCompass, Resident List, Multi-Resident Task List, MyExperience and Dynamic Worklist.
Toolbars can be customized by following these steps:
1. From the View menu, click Toolbar.
2. Click Navigation Toolbar, and select which toolbars to view. Any toolbar with a check will be visible; any toolbar without a check will be hidden.
3. Click PatientToolbar to check (view) or uncheck (hide) the Resident Toolbar.</td></tr>
</table>

	Patient	Perform a resident search, view a recent resident, input new orders/allergies/medication list or notes, or complete a Patient Management Conversation.
	Chart	This menu contains all of the items that are also located on the **Chart** menu, which displays on the left side of the window when a chart is open. The following functions are also available: ▪ Clinical Calculator, Message Sender, AdHoc Charting, Patient Education, Patient Pharmacy, Tear Off This View and Attach to Chart ▪ View who has accessed the current chart, and close the current chart
	Links	Access PMLaunch and CareTracker. Tip ▸ These can also be accessed from the Links Toolbar, located below the Menu Bar.
	Navigation	Navigate through the application with the following functionality: Zoom in or out, change the window orientation to rotate left, right or flip, go to the previous, next or a specific page in a document, perform a search within the window, go back, go forward or go to the Home window.
	Help	Links for CareCompass, Navigation, HNA Help topics, Policies and Procedures, Support Center and About Power Chart.
3. Refresh	Keeps track of how many minutes have lapsed since the window was last refreshed. Click this at any time to refresh the window and return the minute counter to zero.	
4. Recent drop-down menu	Displays the most recent nine residents viewed.	

MPAGES

The MPage, is the first view that displays when a resident's chart is opened in PowerChart, and displays differently based on roles. It consists of multiple widgets (sections), each containing information about the resident. MPage views can be customized by the individual end-user.



MPages Overview: Sample View

Tabs

Based on roles, different tabs display along the top of the window.

1. To view the contents of a tab, click the tab.
2. To close a tab, click the **X** on the right side of the tab.
3. To reopen a tab, click the **+** that displays to the right of the tabs that are currently open, then click the name of the tab to reopen.
4. Rearrange the order of the open tabs by dragging and dropping a tab to the new desired location.

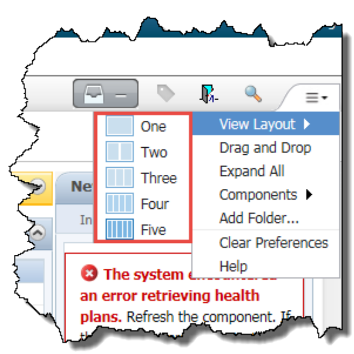
MPages Tabs

Layout

The location of widgets within MPages can be customized using the drop-down menu (≡▾) at the top right of the window.

- Create Columns
    1. From the drop-down menu, select **View Layout**.
    2. Select the amount of columns to display. The window automatically refreshes to incorporate this change.

- Drag and Drop
    1. From the drop-down menu select **Drag and Drop**.
    2. When marked with a check mark, drag and drop widgets to different areas of the window to further customize the view. When unchecked, the drag and drop functionality is not available.



View Layout

Widgets

The look of each individual widget can be customized, to help manage work.

- Color
    1. From the top of the widget, click the drop-down menu (≡▾).
    2. Select **Color Theme**.
    3. Select the desired color for the widget. The widget automatically refreshes to incorporate this change.

- Expand/Collapse
    1. From the drop-down menu at the top of the window, select **Expand All** or **Collapse All** to expand or collapse all widgets at the same time.
    2. From the top of a widget, click the collapse icon ( ) to expand or collapse only the selected widget.

RESIDENT SEARCH

Resident Search

1. From the **Patient Toolbar**, click the down arrow to the right of the Search box.
2. Select to search by MRN, Name or FIN.
3. In the Search box, type the search criteria.
4. Press Enter.
5. From the **Resident Search** pop-up window, double click the resident or encounter to open and view.

> Note ▸ If the Patient Toolbar is hidden, the Search bar is not available.

Resident Toolbar

Quick Search

1. From the **Patient Toolbar**, click the search icon ( ).
2. From the **Patient Search** pop-up window, type in the Phone Number, Encounter Identifier, Person Identifier, Last Name, First Name and/or DOB to conduct the search.
3. Click **Search**, or press Enter to display the search results.
4. Double click the resident or encounter to open and view.

Open Multiple Residents at a Time

1. Perform a *Patient Search* or *Quick Search*, as indicated above.
2. Each new resident opens in a new tab on the Patient Toolbar, and also in a new window.
3. Click the name of the desired resident to move between charts.
4. Click the **X** next to the resident's name to close a chart.

> Note ▸ The maximum number of resident charts open at any time is two. If trying to open a third chart, a pop-up displays with a request to close one chart.

Multiple Resident Tabs

RESIDENT DEMOGRAPHIC BANNER BAR

Resident Demographic Banner

Located at the top of the window above the Resident Summary and **Chart** menu, the Resident Demographic Banner displays when a chart is open. Displayed in blue, it provides pertinent information about the resident's demographics.

> **Note ▸** When two resident charts are opened at one time, the second resident's banner displays in yellow.

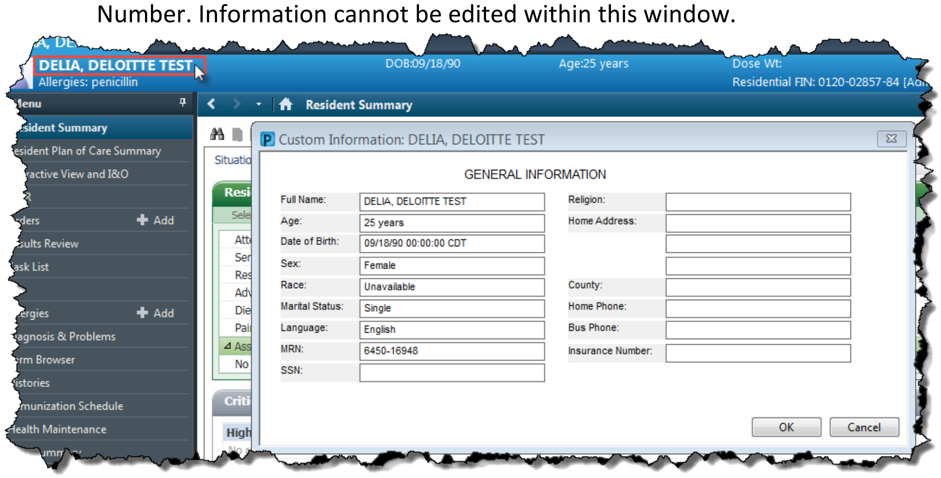
- Resident Name
- Date of Birth
- Age
- Dose Weight
- Sex
- Medical Record Number
- Attending Physician
- Allergies
- DADS Pre-Admit status
- Residential FIN
- Admit/Discharge Dates
- Location

Several items within the Resident Demographic Banner are clickable links, as shown in the screen images below:

Resident Demographic Banner

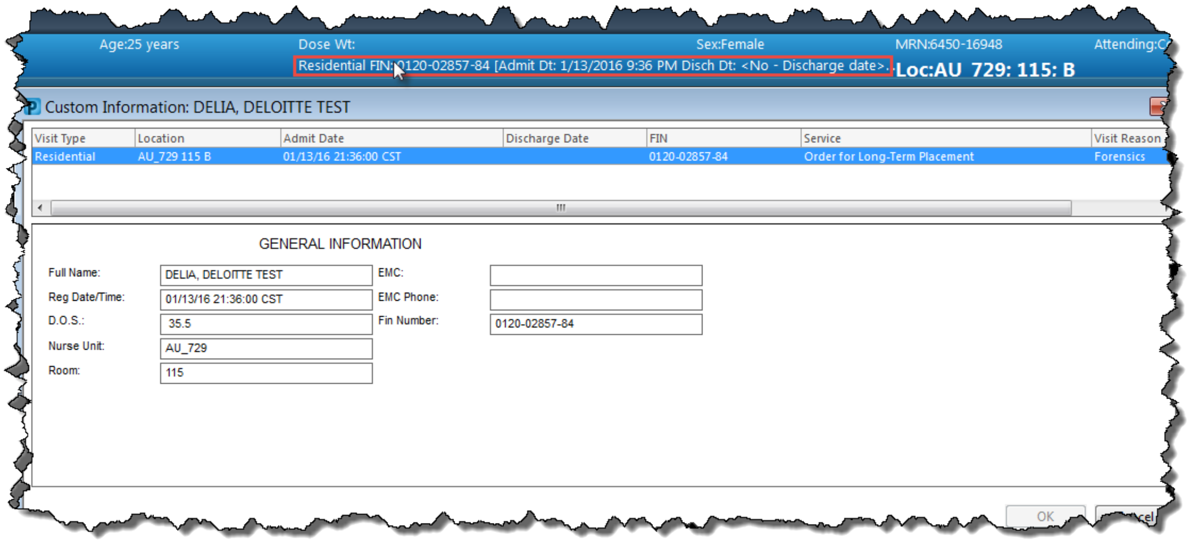
> **Note ▸** These screen images appear with jagged edges in this document, as they are showing small portions of the window, versus a view of the entire application.

- Click the resident's name to display a pop-up window with general resident information including: Age, DOB, Sex, Race, Marital Status, Language, MRN, SSN, Religion, Address, Phone Numbers, and Insurance Number. Information cannot be edited within this window.



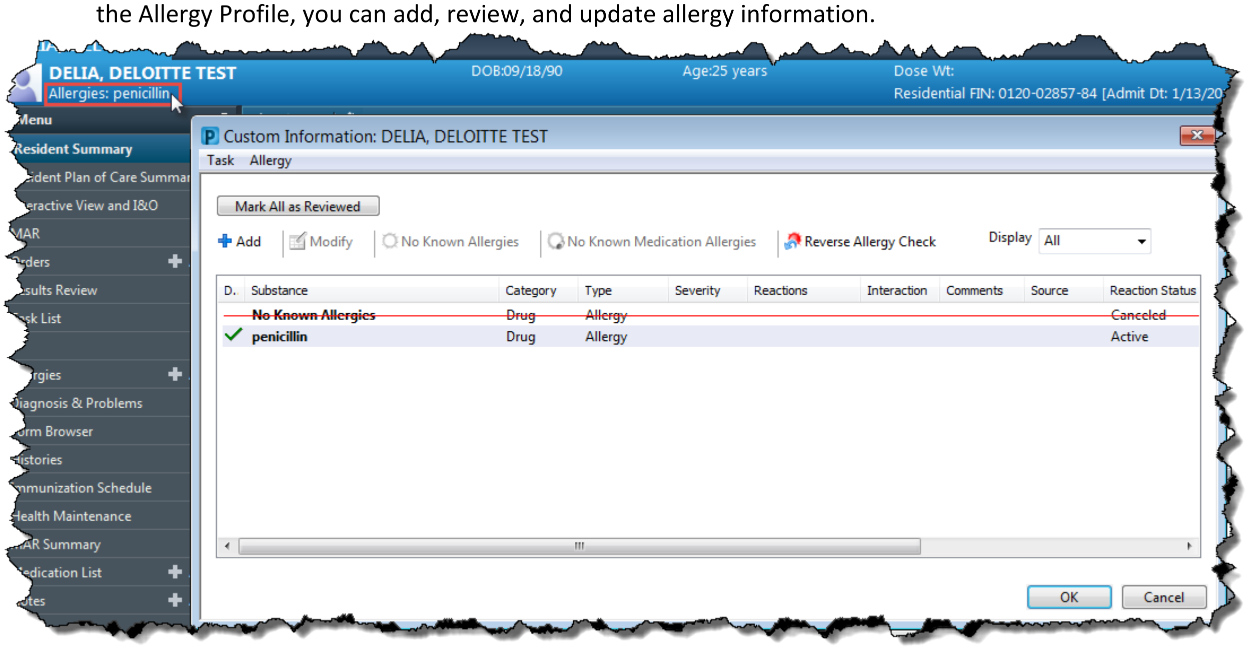
Resident Demographic Banner: Click the resident's name

- Click **Residential FIN** to display a pop-up window with the following information: Name, Registration Date/Time, Discharge Date if applicable, DOS, Nurse Unit, Room, EMC, EMC Phone, FIN Number (FIN=financial), Service type, and Visit Reason. Information cannot be edited within this window.



Resident Demographic Banner: Click Residential FIN

- Click **Allergies** to display a pop-up window, which displays a list of allergy information including: Substance, Category, Type, Severity, Reactions, Interaction, Comments, Source and Reaction Status. From the Allergy Profile, you can add, review, and update allergy information.



Patient Demographic Banner: Click Allergies

TOOLBARS

Patient List

Click **Resident List** under the Menu Bar to display the **Resident List** window. Click the tabs across the top of the window to view all residents within each list. From this window, the functions to add or modify lists are available.

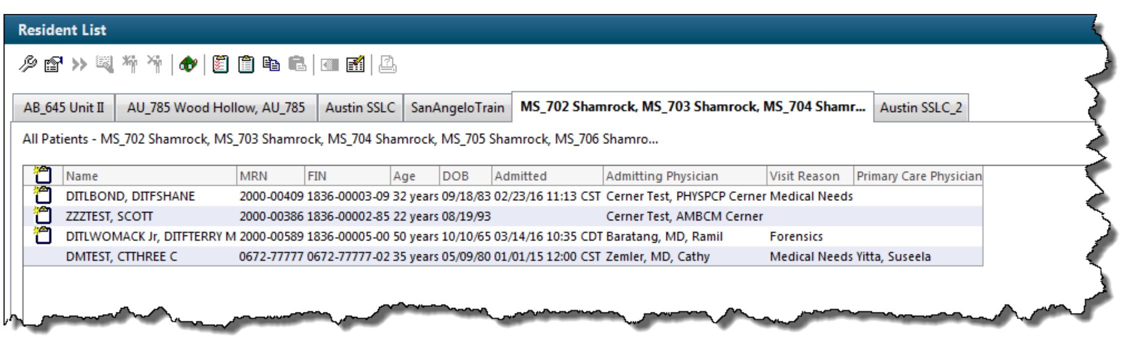
- Add a New List
    1. From the **Patient List** window, click the list maintenance icon ( ).
    2. From the **Modify Resident Lists** pop-up window, click **New**.
    3. From the **Resident List Type** pop-up window, select the type of resident list (CareTeam) to build and click **Next**.
    4. From the **Care Team Patient List** pop-up window, select all list preferences.

       Note ► Click the properties icon ( ) to modify list preferences.

    5. At the bottom of the window, type a name to add to the list, then click **Finish**.
    6. Find the newly created list in the left column of the window under **Available Lists**, and select it.
    7. Click the right arrow to move the new list to the **Active Lists** column.
    8. Click **OK**. The new list displays as a new tab on the **Resident List** window.

- Add a Resident From Another List
    1. From the **Resident List** window, right click on the resident's name.
    2. Click **Add to a Resident List**.
    3. Click the list to add the resident to.
    4. Click the tab for a list to view the updated list.
    5. Click **Refresh**. The resident now displays in the list.

- Add a Resident From the Resident's Chart
    1. From the **resident's chart,** click **Resident** on the Menu Bar.
    2. Click **Add Resident to a Resident List**.
    3. Click the list to add the resident to.

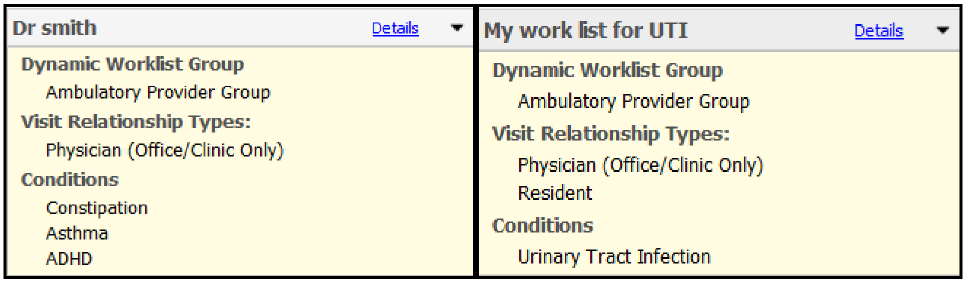


Resident Lists

Dynamic Worklist

The first time **Dynamic Worklist** is clicked, the **Dynamic Worklist** window will be blank. A user can create several worklists, and apply various filters, based on roles they play or special focus areas, such as:

- Provider Group or Provider Name
- Visit Relationship Types
- Conditions

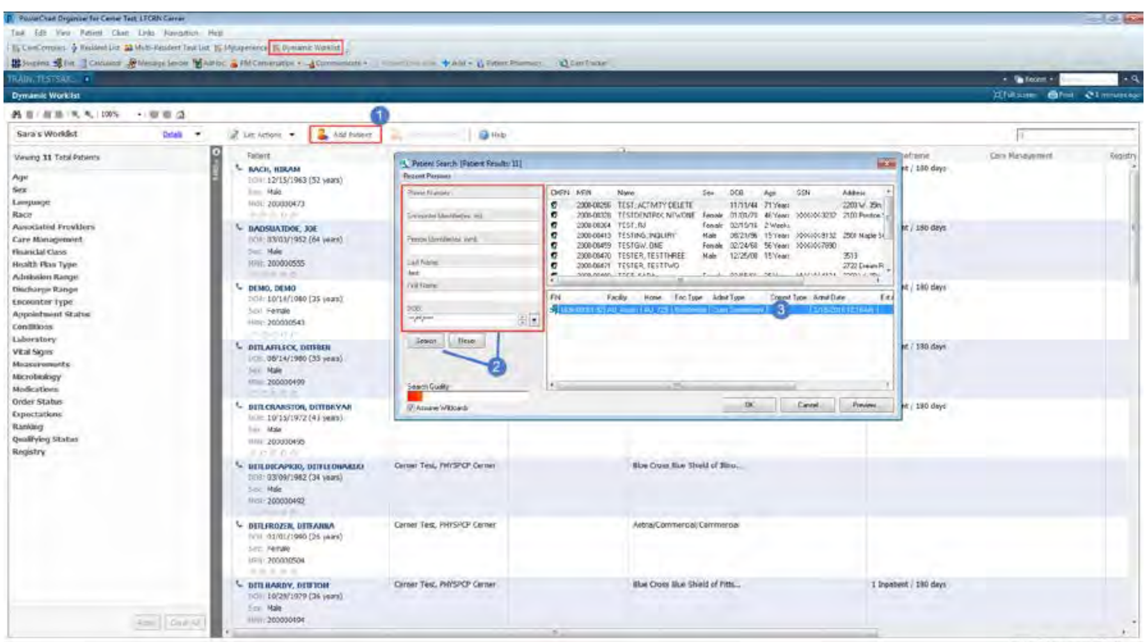


Sample Dynamic Worklists

- Create a new Worklist
    1. From the **Dynamic Worklist** window, click **Create List**.
    2. Type a name for the Worklist being added.
    3. Select providers to add to the list, then click **Next**.
    4. Select all criteria to view in the Worklist, then click **Next**.
    5. Click **Finish**.

Tip ▸ At any time, create, modify, rename, delete, share, export or customize a Worklist by clicking **Actions** and selecting an option from the drop-down menu.

- Add a Resident to a Worklist
    1. From the **Dynamic Worklist** window, click **Add Patient**.
    2. On the **Patient Search** pop-up window, type search criteria then click **Search** or press Enter.
    3. Double click the resident to add to the Worklist.

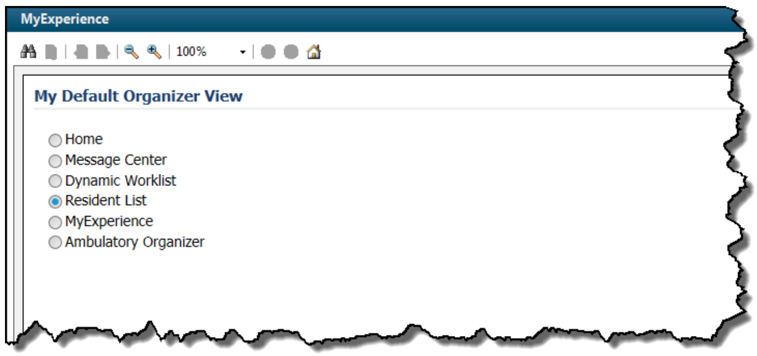


Dynamic Worklist: Add a Resident to a Worklist

MyExperience

MyExperience allows a default view to be set within the application. Possible options to select as a default view are: CareCompass, Patient List, Multi-Resident Task List, MyExperience or Dynamic Worklist. Select the desired default view, then click **Save**. Users may find this feature helpful based on the windows they most often access, the tasks they most often perform, or the order in which they perform them. Selecting default views may limit the information which can be displayed.

Note ▸	Changing the **My Available Positions** or **My Default Organizer View** may limit the windows and information which can be displayed.

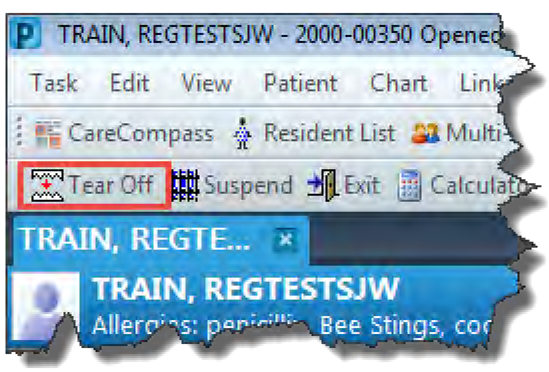


My Experience

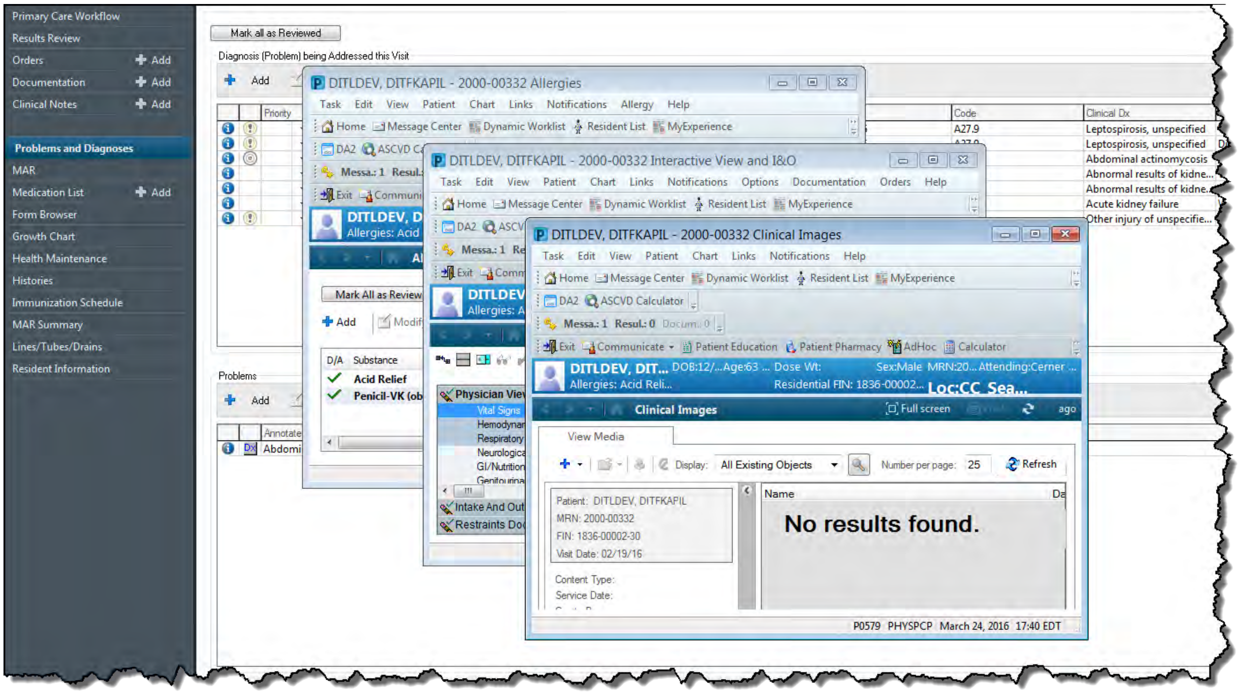
Note ▸	The options provided vary based on positions and roles. Click **Reset** to reset the original settings.

Tear Off

When a resident's chart is open, from the **Action Toolbar** click **Tear Off** to separate the **Resident Summary** from the main window and display it as a pop-up window.



Tear Off



Tear-off View

Note ▸ When the Tear-off function is used the items are removed from the **Chart** menu and can be worked with in a separate pop-up menu.

Tip ▸ This feature may be beneficial when there is a need to update multiple windows in a resident chart simultaneously, or see screens at the same time.

Suspend

From the **Action Toolbar**, click **Suspend** to close and lock the application. A password is required to reopen the application.

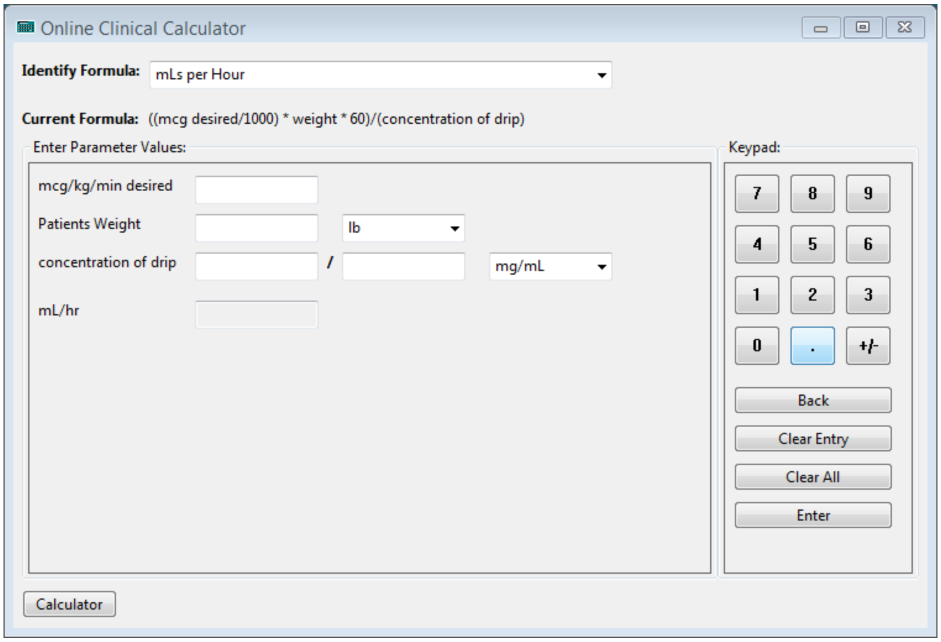
Suspend the application if it is necessary to step away from the computer, to prevent unauthorized individuals from viewing private resident information.

Note ▸ The Suspend feature only works on specific screens.

Calculator

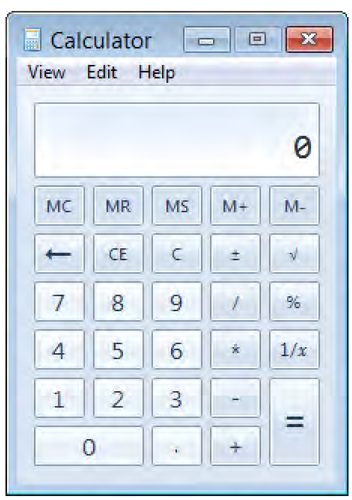
From the **Action Toolbar**, click **Calculator** to display the **Online Clinical Calculator** pop-up window.

1. From the **Identify Formula** drop-down menu, select the desired formula.
2. Use a keyboard or the **Keypad** on the right of the pop-up window to type all required fields.
3. Press **Enter**.



Online Clinical Calculator

Note ▶	Click **Calculator** on the bottom left of the pop-up window, for basic calculator functionality.

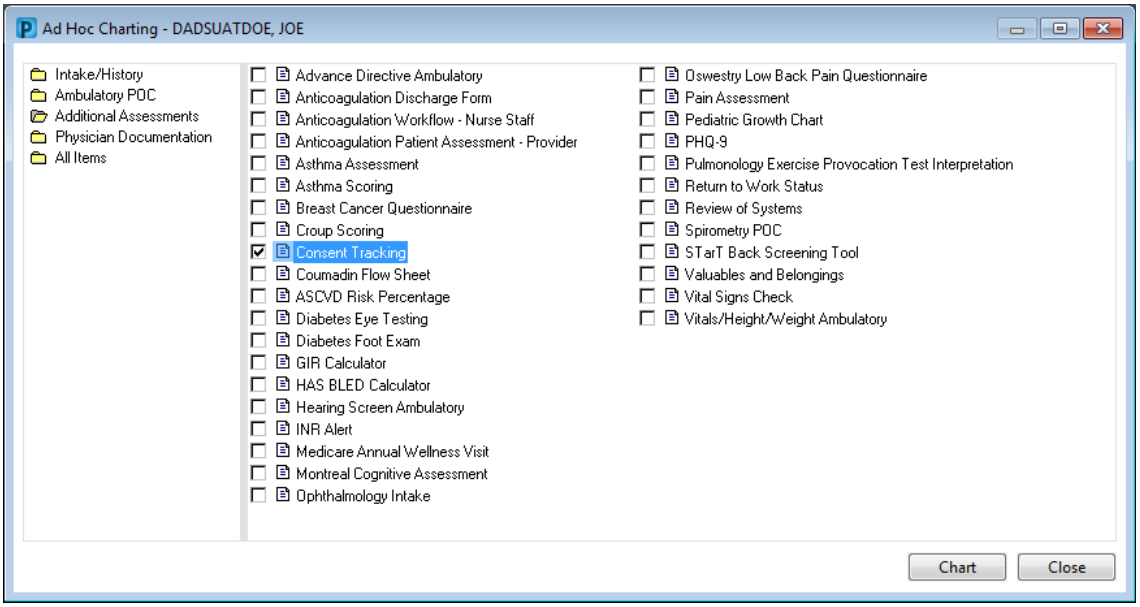


Calculator

AdHoc

AdHoc Forms allow a provider to document required and important information in pre-defined templates and easily add the form to a resident's chart. Open a resident's chart. From the **Action Toolbar**, click **AdHoc** to open the AdHoc Charting pop-up window to chart unordered results and documents.

1. Double click a folder in the left column of the window to select the charting category.
2. In the center of the window, select the task that needs to be charted.



AdHoc Charting

3. Click **Chart**.
4. Another pop-up window displays fields that are specific to the task being charted. Fill out all pertinent information.

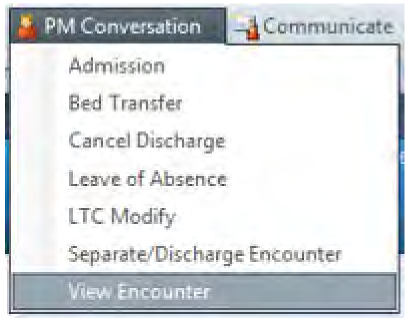
> **Note** ▸ The date that the screening/procedure/etc. is performed is a required field on these windows. The date/time defaults to the current date/time. The time is displayed in military time, CST. To change to the date or time, click in the field and type in the correct numbers, or use the up and down arrows to adjust the date/time as needed.

5. Once the form is complete, click the sign form icon (✓).

PM Conversation

Open a resident's chart. From the **Action Toolbar**, click the drop-down arrow next to **PM Conversation** (Patient Manager Conversation) to View an Encounter.

Note ▸	The options provided in the drop-down menu vary based on positions and roles.

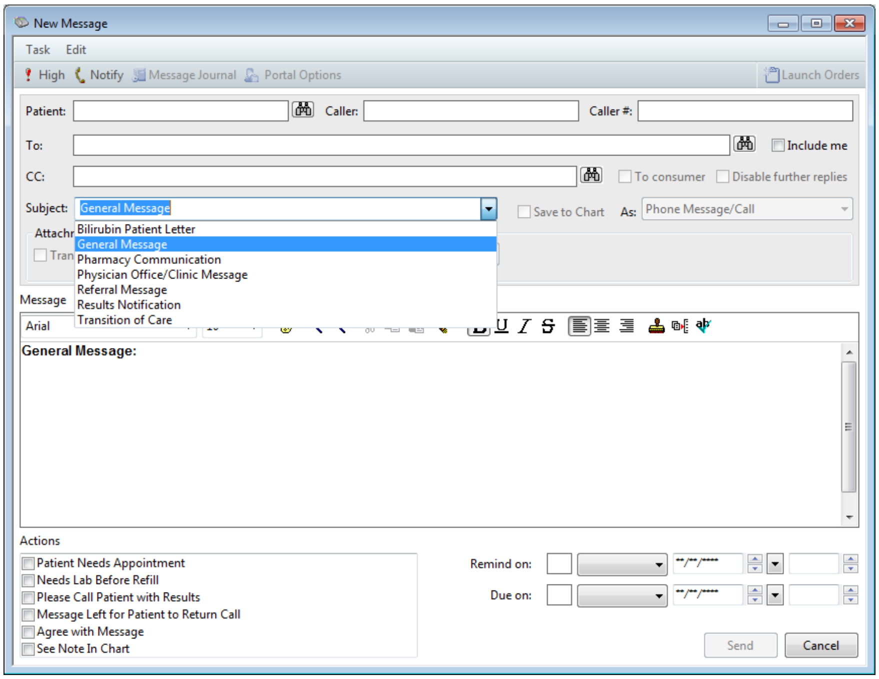


PM Conversation Drop-down Menu

- View Encounter
    1. Click the drop-down arrow next to **PM Conversation**, then select **View Encounter.**
    2. The **View Encounter** pop-up window displays all information that was input during the Admission process.
    3. All information is view-only. To exit, click **Complete**.

Communicate

Open a resident's chart. From the **Action Toolbar**, click **Communicate** to send a new message; or click the drop-down arrow next to **Communicate** to send a message, reminder, resident letter or provider letter.



New Message Pop-Up Menu

- Send a Message or Reminder
  1. From the **Action Toolbar**, click **Communicate** or click the drop-down arrow and select **Message** or **Reminder**.
  2. The **New Message** or **New Reminder/Task** pop-up window displays.
  3. The **Resident** and **Caller** fields default to the resident's name.
  4. In the **Caller #** field, type the resident/caller's phone number.
  5. In the **To** and **CC** fields, use the find icon ( ) to perform a search and select an individual to send the message to.
  6. In the **Subject** field, type the subject of the message.
  7. Click **Browse Documents** or **Other Attachments** to attach a document to the message, if applicable.
  8. In the **Message** field, type the message.
  9. Click **Send**.

Tip ► Use the **Actions** menu at the bottom left of the window to associate an action with the message. Type in a date and time at the bottom right of the window to set a reminder to take action on this message.

- Send a Resident Letter
  1. From the **Action Toolbar**, click the drop-down arrow next to **Communicate**, and select **Resident Letter**.
  2. From the **Create Letter** pop-up window, select the subject from the **Subject** drop-down menu.

3. Type the message. Based on the subject, default text displays in this section of the window, however it can be edited if needed.
4. In the **To:** field at the bottom of the window, use the find icon ( ) to perform a search and select the individual to send the message to.
5. Click **Ok**.

- Send a Provider Letter
  1. From the **Action Toolbar**, click the drop-down arrow next to **Communicate**, and select **Provider Letter**.
  2. In the **Provider Letter Recipients** pop-up window **Search for Provider** field, type in a provider to search for and then click the find icon ( ).
  3. From the search results, use the right arrow to move name(s) into the **Send To** column.
  4. Click **Ok.**
  5. In the **Provider Letter Recipients** pop-up window, click **Ok**.
  6. From the **Create Letter** pop-up window, type the subject and type the message.
  7. Click **Ok.**

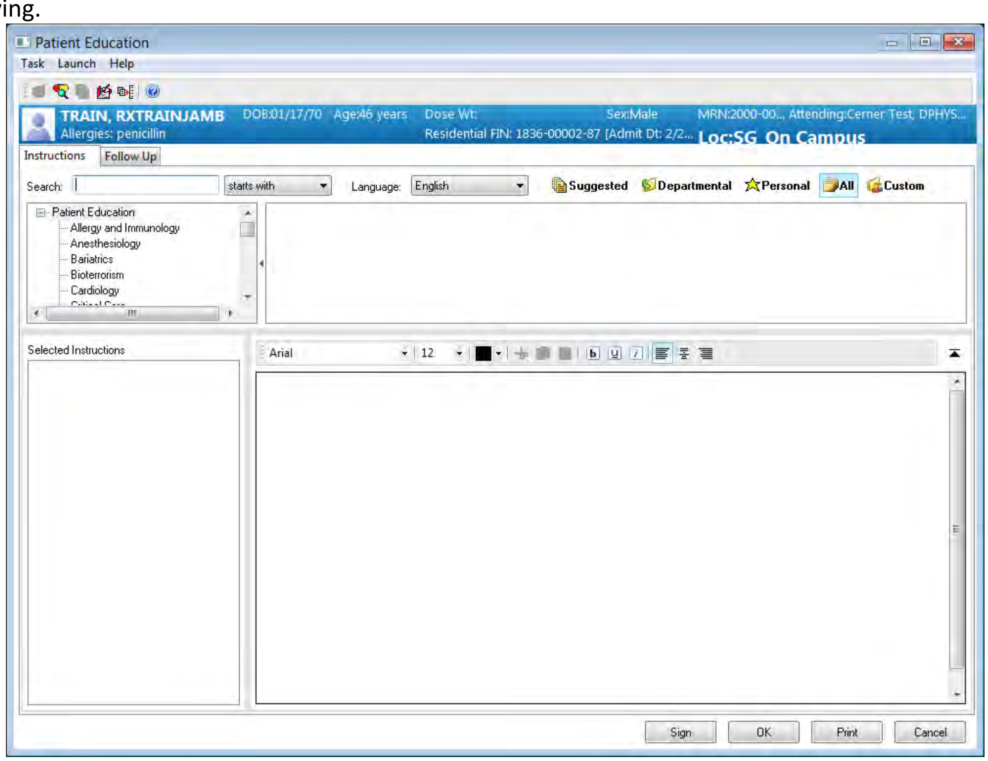
Resident Education

Open a resident's chart. From the **Action Toolbar**, click **Resident Education** to add new education details.

1. From the **Resident Education** pop-up window, use the search field to search for a specific type of Resident Education.

Tip ► Leave the search field blank and double click the type of Resident Education in the left column under **Resident Education**.

2. From the search results window to the right, double click the **Click here for instructions** link.
3. Double click the topic, to display the selected educational information on the bottom of the window.
4. Click **Sign** to sign the Resident Education before saving to the chart; click **OK** to close the pop-up window and save all information to the chart; click **Print** to print; click **Cancel** to close the pop-up window without saving.



Patient Education Pop-up Window

Note ► Add as many Resident Educational materials as needed to a chart. To delete one, click the Red X ( ) next to the topic to delete.

Add

Add an Order, Allergies, Medication List or Note from the **Action Toolbar**, or from the **Chart** menu.

Note ► The ability to add varies based on positions and roles.

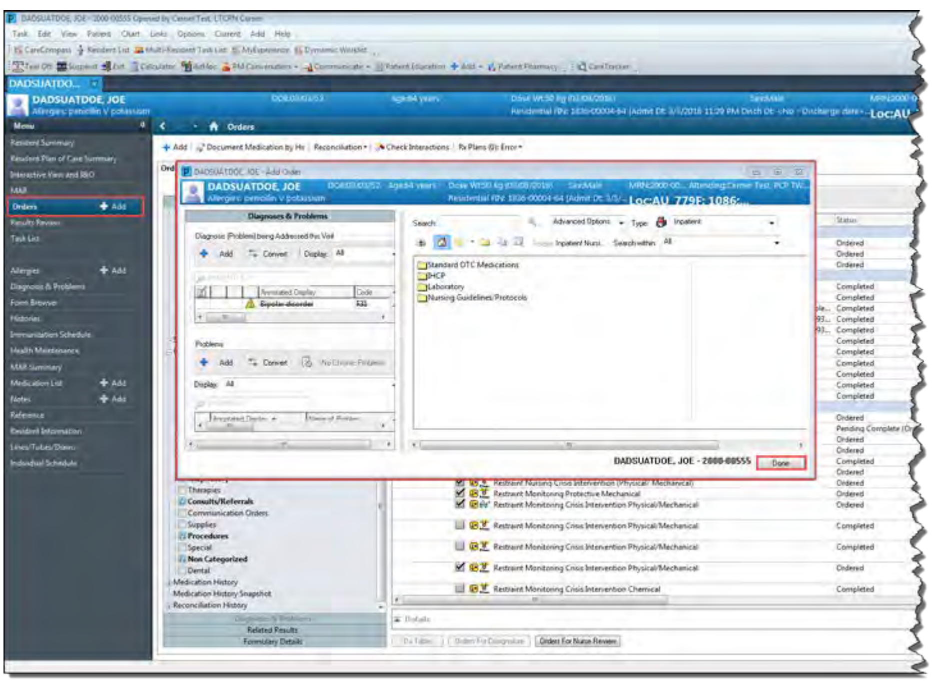
- Add an Order
  1. From the **Chart** menu, select **+Add** next to **Orders**.
  2. From the **Add Order** pop-up window, an order can be added but there must first be a diagnosis to associate with the order.

Note ►	If the chart already contains diagnoses and problems, skip to step 8.

3. From the **Diagnoses & Problems** column on the left of the window, click **Add**.
4. From the **Add Diagnosis** pop-up window, type a diagnosis and click the find icon ( ).
5. From the **Diagnosis Search** pop-up window, type additional search criteria or click on the diagnosis in the search result that needs to be saved.
6. Click **OK**.
7. From the **Add Diagnosis** pop-up window, click **OK**. Repeat steps 3-6 to add additional diagnoses or problems.
8. Select the check box next to each diagnosis or problem that needs to be associated with the order that is being added.
9. On the top right of the window, use the drop-down menu to select the type of order to add: **Document Medication by Hx**, **Inpatient** or **Prescriptions**.
10. In the search field, type the type of Order to search for then press Enter.
11. From the search results, select the appropriate order.
12. For non-physicians who are adding an order, the **Ordering Physician** pop-up window displays. Type the ordering Physician's name. The order date and time default to the current date and time.
13. In the **Communication Type** field, select **Phone, Verbal, Signature Required or Written (Paper)/Fax**, then click **OK**.

Note ►	If a physician is adding the order, steps 12 and 13 are omitted.

14. Click **OK**.
15. Click **Done**.
16. On the **Orders** window, click **Sign** to complete the order.

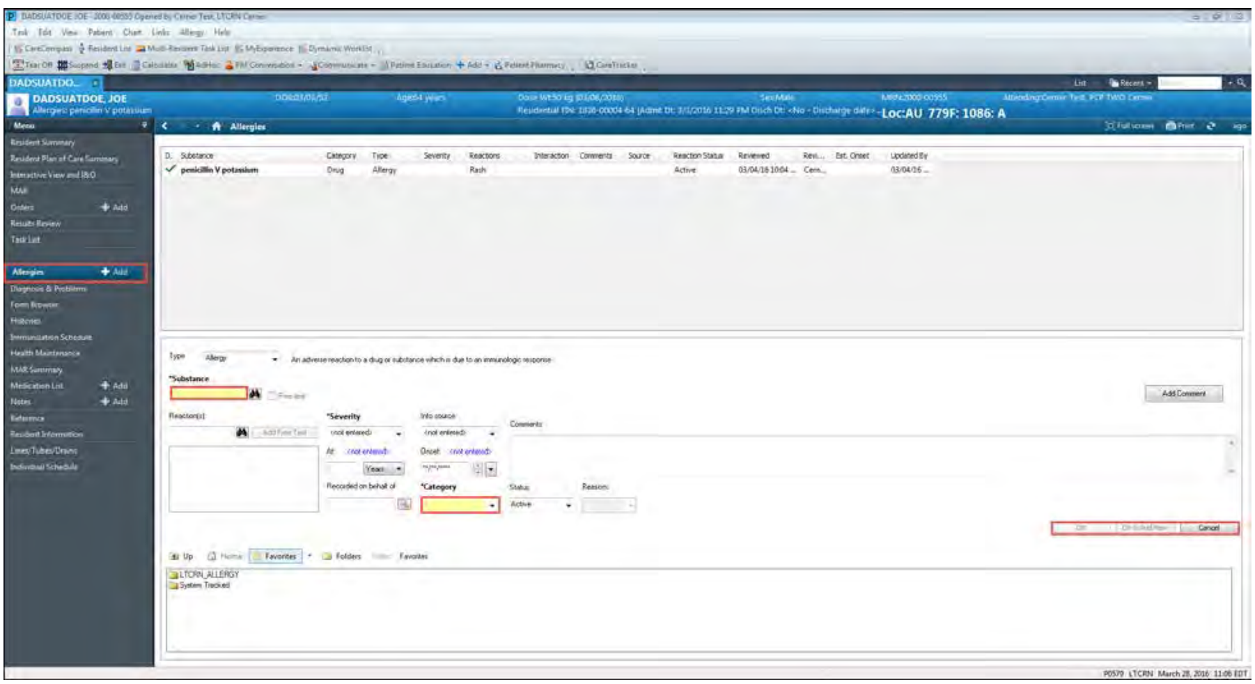


Add Order Pop-up Window

- Add an Allergy
    1. From the **Chart** menu, select **+Add** next to **Allergies**.
    2. On the **Allergy** window, from the **Type** drop-down menu select **Allergy**, **Contraindication**, **Intolerance** or **Side Effect**.
    3. In the **Substance** field, click the find icon ( ).
    4. The **Substance Search** pop-up window displays.
    5. Using the **Search** field, type a substance or allergy code then click **Search by Name** or **Search by Code**.
    6. From the search results click the allergy that needs to be saved, then click **OK**.

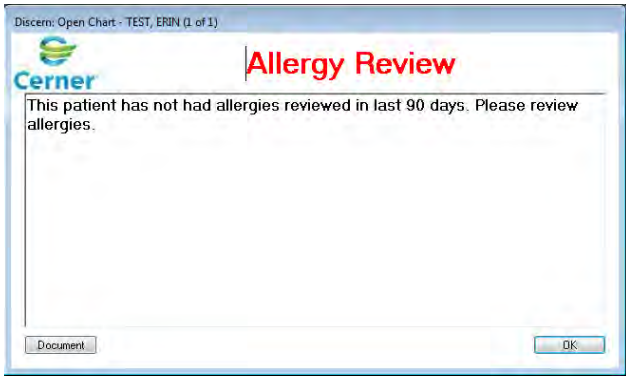
Tip ► To save an allergy to a favorites list, from the **Substance Search** pop-up window, click **Add to Favorites**, before clicking **OK**.

7. On the **Allergies** window, from the **Severity** drop-down menu select **Mild**, **Moderate**, **Severe** or **Unknown**.
8. From the **Category** drop-down menu select **Drug**, **Food**, **Environment** or **Other**.
9. Click **OK**.



Add An Allergy Window

Note ► Allergies can be accessed from a specific workflow when searching for a resident. If the resident's allergies have not been reviewed in the last 90 days, a pop-up window will display, which provides navigation to the allergy window, as shown below. To do this, click **Document**. Click **OK** to bypass the allergy review and open the resident's chart.



Discuss Open Chart Pop-up Window

- Add a Medication

> **Note** ► This functionality is used to place an order for a new medication.

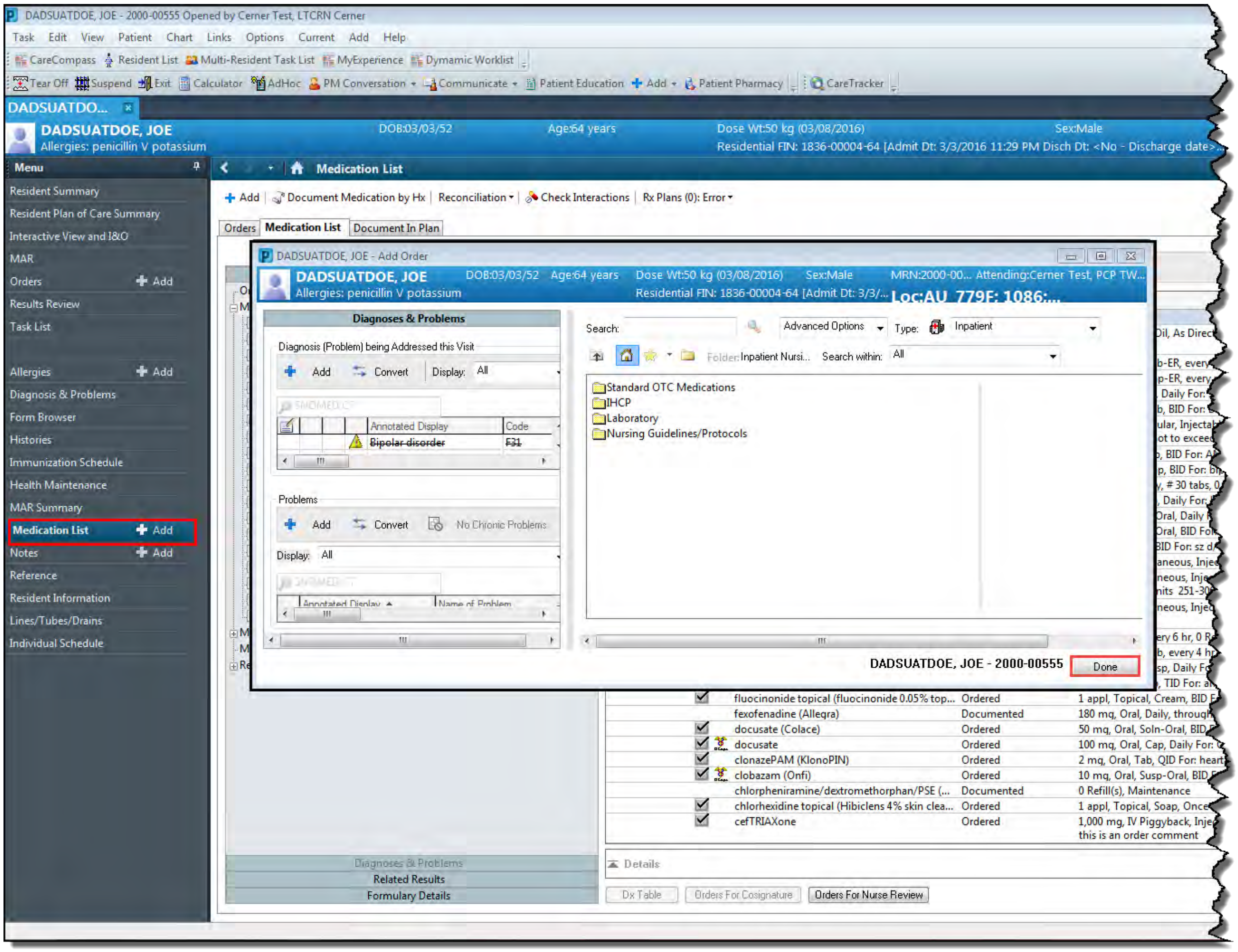
1. From the **Chart** menu select **+Add** next to **Medication List.**
2. From the **Medication List** window, click the add icon (Add).
3. From the **Add Order** pop-up window, a medication can be added but there must first be a diagnosis or problem to associate with the medication.

> **Note** ► If the chart already contains diagnoses and problems, skip to step 9.

4. From the **Diagnoses & Problems** column on the left of the window, click **Add**.
5. From the **Add Diagnosis** pop-up window, type a diagnosis and click the find icon ( ).
6. From the **Diagnosis Search** pop-up window, type additional search criteria or click on the diagnosis in the search results that needs to be saved.
7. Click **OK**.
8. From the **Add Diagnosis** pop-up window, click **OK**. Repeat steps 4-7 to add additional diagnoses or problems.
9. Select the check box next to each diagnosis or problem that needs to be associated with the order that is being added.
10. From the search bar, type the name of the prescription then press Enter.
11. From the search results, click the correct medication, inclusive of the dose that is being ordered, then click **Done**.
12. For non-physicians who are ordering a medication, the **Ordering Physician** pop-up window displays. Type the ordering Physician's name. The order date and time default to the current date and time.
13. In the **Communication Type** field, select **Phone, Verbal, Signature Required or Written (Paper)/Fax**, then click **OK**.

> **Note** ► If a physician is adding the order, steps 12 and 13 are omitted.

14. Type all details, comments and diagnoses for the order, including the **Medication Indication**.
15. Click **Sign**. The medication now populates in the Medication List and has a Processing status until it is filled by the pharmacy.



Add Order Pop-up Window

Note ▶	For a Physician, when an order needs to be signed **Orders For Signature** at the bottom of the window are enabled.
Note ▶	For anyone other than a Physician, the **Orders for Co-Signature** button is enabled.
Note ▶	For a Nurse, when an order needs to be reviewed, **Orders For Nurse Review** at the bottom of the window are enabled.

- Add a Note
  1. From the **Chart** menu, select **+Add** next to **Notes.**
  2. From the **Notes** window, any notes that have been added to a chart can be viewed.
  3. On the left side of the window, select the folder that contains the note that needs to be viewed. The note displays in the center of the window.
  4. Sort the notes view by selecting a radio button: By type, By status, By date, Performed by or By encounter.
  5. Use the up and down arrow buttons to scroll up and down through the available notes.

6. Click the new icon ( ) to add a new note.
7. From the **Add Document** pop-up window, select the type of note to add.
8. Complete all fields on the window and type the note.
9. Complete the note by:
   - Clicking **Sign** – Completes the documentation, and publishes the note to the resident's chart
   - Clicking **Save** – Saves the note without signing it, but leaves the note window open; this provides the ability to make revisions at a later time. The status of the note will remain as *In Progress* until it's closed

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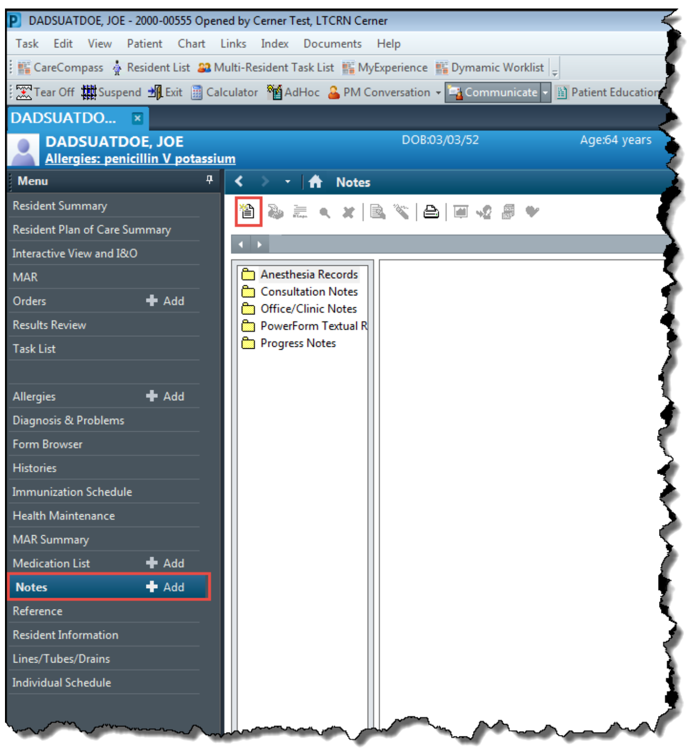
Tip ► Even when temporarily walking away from the computer, it is important to always save a note to prevent data loss in the event of a power outage or network failure.

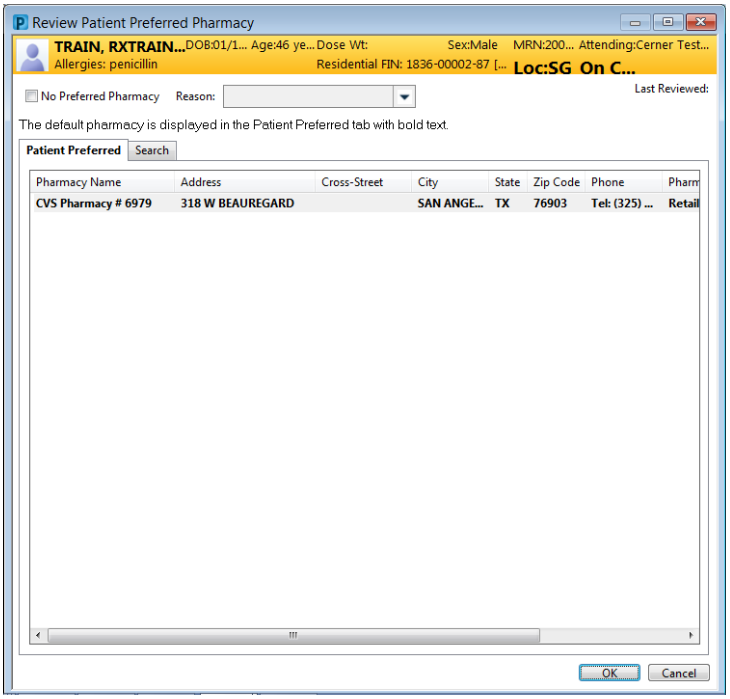
   - Clicking **Save & Close** – Saves and closes the note without signing it
   - Clicking **Cancel** - Closes the pop-up window without saving changes



Add A Note Window

REVIEW RESIDENT PREFERRED PHARMACY

A provider can access a resident's preferred pharmacy information to quickly view where to send or call-in a prescription, or what method of prescription fill (mail-in or in person pick-up) the resident requires. Open a resident's chart. From the **Action Toolbar**, click **Resident Pharmacy** to add/remove a resident's preferred pharmacy.



Review Patient Preferred Pharmacy Pop-up Window

- Add a pharmacy
  1. From the **Search** tab, type the pharmacy name and any other known information (address, phone number, type).
  2. Click **Search**. Results display on the right side of the window.
  3. Right click the correct pharmacy within the search results, and click **Add to Resident Preferred**.

> **Note** ► Multiple pharmacies can be saved as the resident's preferred pharmacy.

  4. Click the **Resident Preferred** tab to view all saved pharmacies.
  5. Click **OK.**

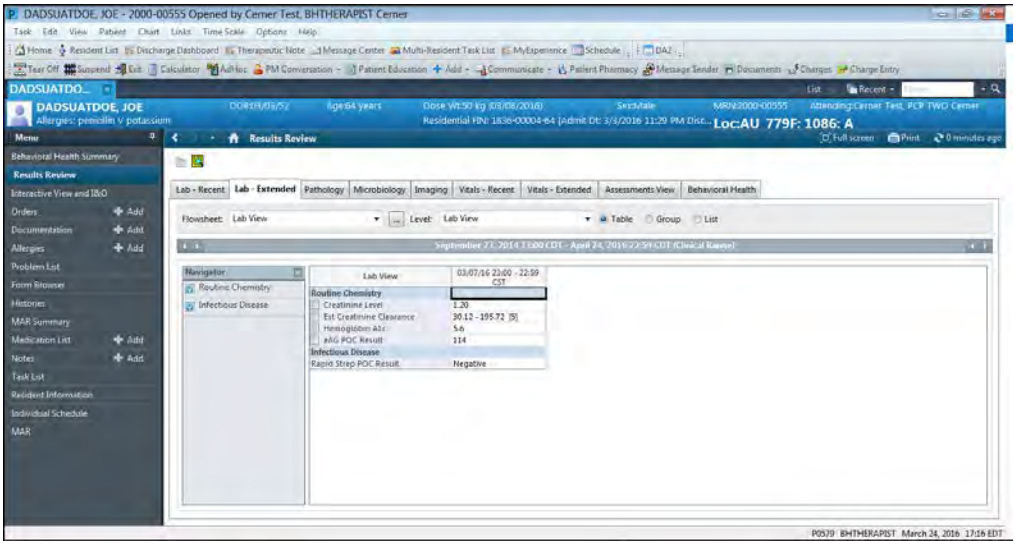
Tip ► If there are multiple pharmacies saved, from the **Resident Preferred** tab, set a default pharmacy by right clicking the pharmacy, then click **Set as Default**. Click **OK.**

- Remove a pharmacy
  1. From the **Resident Preferred** tab, locate and right click the pharmacy that needs to be removed.
  2. Click **Remove**.

> **Note** ► From the **Review Resident Preferred Pharmacy** pop-up window, click the check box for **No Preferred Pharmacy**, if there is not one to add. An associated reason is required.

RESULTS REVIEW

Open a resident's chart. From the **Chart** menu, click **Results Review** to view all recent results including: Ambulatory, Lab, Pathology, Microbiology, Imaging, Vitals, Assessments and Cardiology. Click on each tab to review the results within that category.



Note ▶ This functionality is only available for physicians.

DIAGNOSIS & PROBLEMS

View, add and update a resident's diagnoses and/or problems after a chart is open.

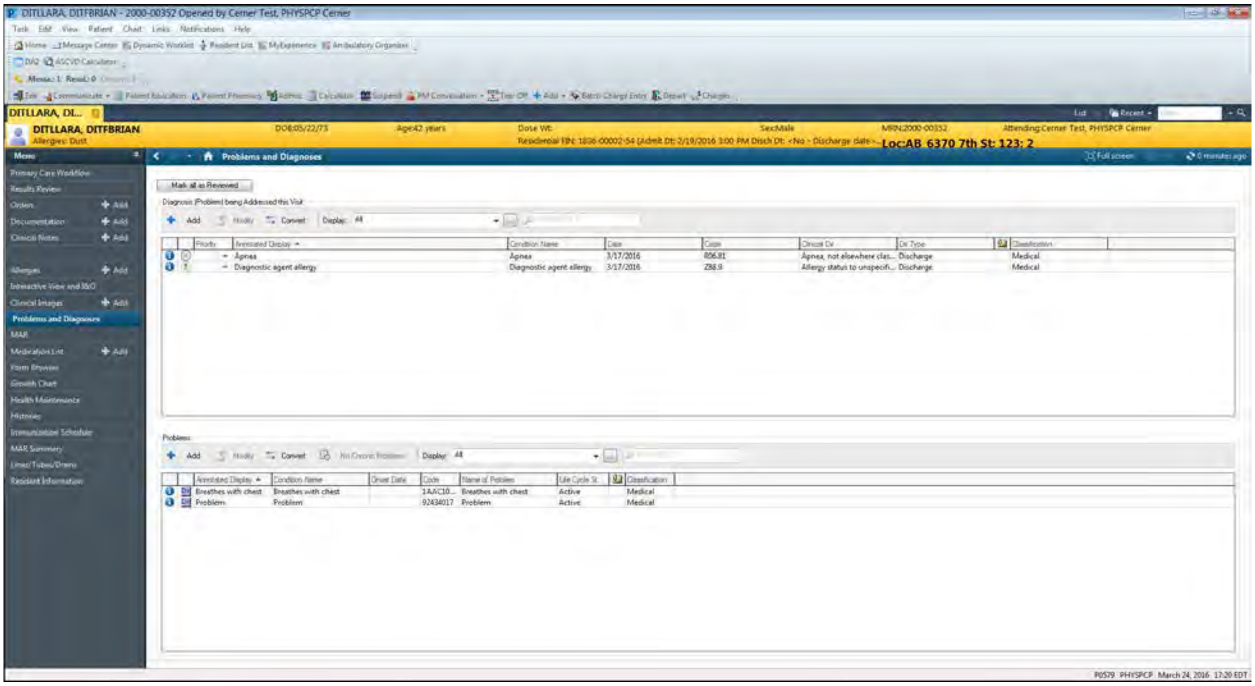
- View a resident's diagnoses and problems
    1. From the **Chart** menu, click **Problems and Diagnoses.**
    2. All charted diagnoses are displayed on the top of the window. All charted problems are displayed on the bottom of the window.
    3. Double click a diagnosis or problem to view additional details.

- Add a diagnosis or problem
    1. From the **Chart** menu, click **Problems and Diagnoses**.
    2. Click the add icon (✚ Add).
    3. From the **Problems** window, type a diagnosis and click the find icon ( ).
    4. From the **Diagnosis Search** pop-up window, type additional search criteria or click on the diagnosis in the search results that need to be saved.
    5. Click **OK**.
    6. From the **Problems** window, click **OK**.

Note ▶ Only providers can add a diagnosis.

- Update a diagnosis or problem
    1. From the **Chart** menu, click **Problems and Diagnoses.**
    2. All charted diagnoses are displayed on the top of the window. All charted problems are displayed on the bottom of the window.

3. Double click a diagnosis or problem to view additional details.
4. Update fields as appropriate.
5. Click **OK**.

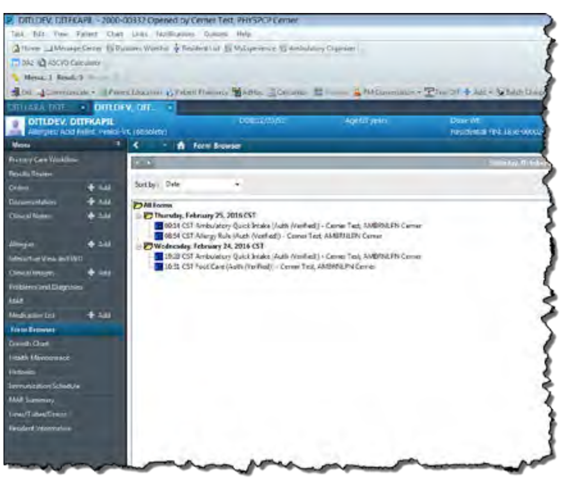


Diagnosis and Problems Window

FORM BROWSER

Form Brower allows a provider to easily access, review and update any forms or completed documentation that has been added to a resident's chart, and placed into the resident chart by **Date**. From the **Chart** menu, click **Form Browser** to view all forms in a chart. All forms are displayed on the **Form Browser** window.

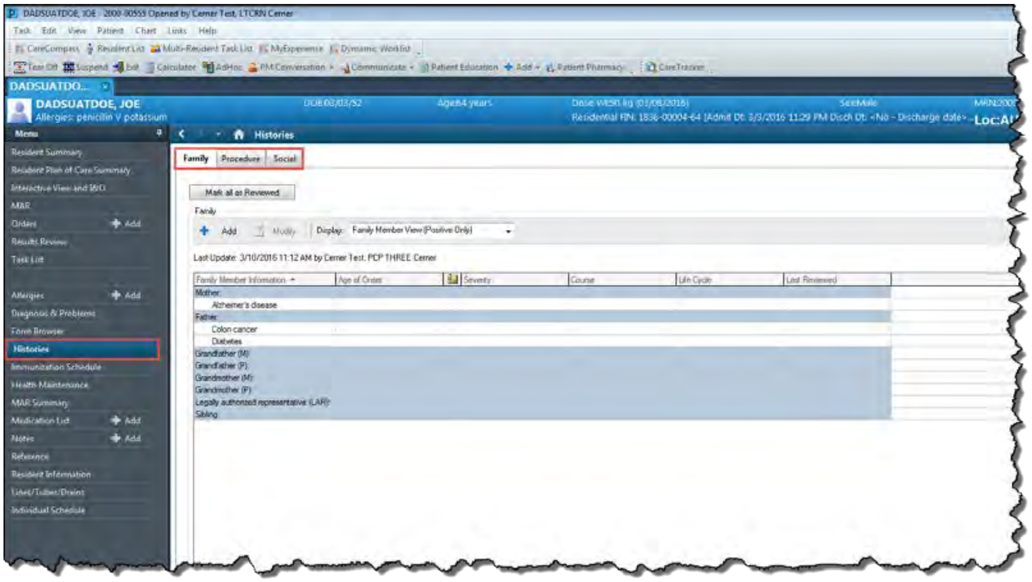
1. Click the **Sort By** drop-down menu to view forms by date, form, status, encounter-date or encounter-form.
2. Double click a form to view its details.



Form Browser Window

HISTORIES

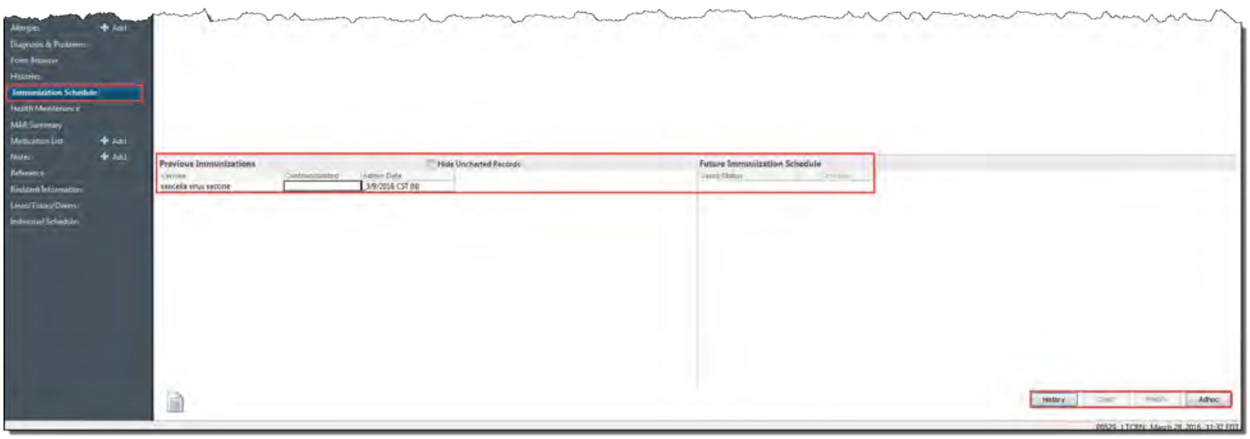
From the **Chart** menu click **Histories** to view family, procedure, pregnancy, and social historical information for the resident. From any of the tabs at the top of the window, a new history can be added. Click the add icon (➕ Add). Add all information, then click **OK** to save the record.



Histories Window

IMMUNIZATION SCHEDULE

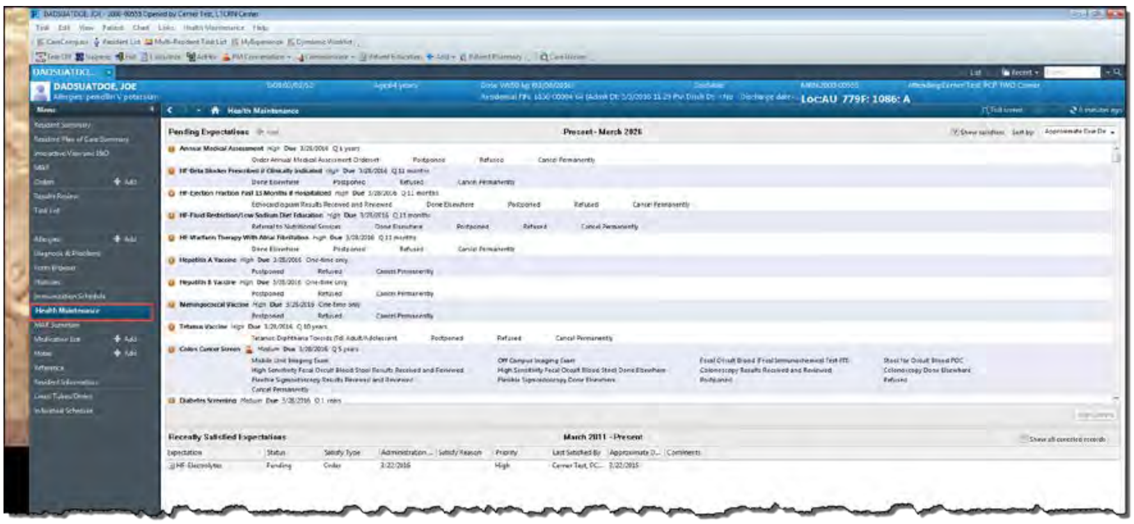
From the **Chart** menu**,** click **Immunization Schedule** to view the resident's Previous Immunizations, and Future Immunization Schedule.



Immunization Schedule Window

HEALTH MAINTENANCE

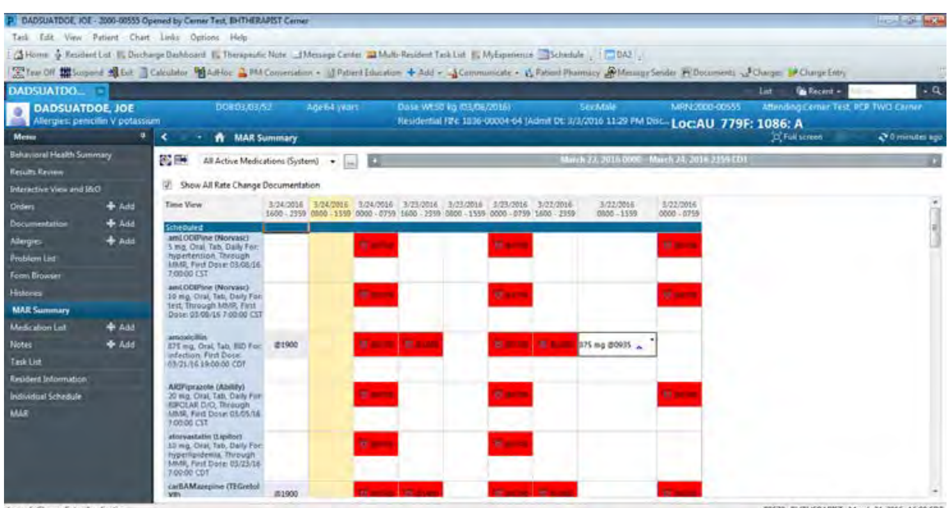
From the **Chart** menu**,** click **Health Maintenance** to view Pending Expectations and Recently Satisfied Expectations for the resident. The Pending Expectations list displays expectations that require completion to maintain a resident's health. The Recently Satisfied Expectations have already been completed and documented in a resident's chart. Use the **Sort By** field to sort the information by status, priority, approximate due date, expectation or due indicator. Each expectation displays the associated priority and due date, and provides the option to select **Postponed**, **Refused** or **Cancel Permanently**.



Health Maintenance Window

MAR SUMMARY

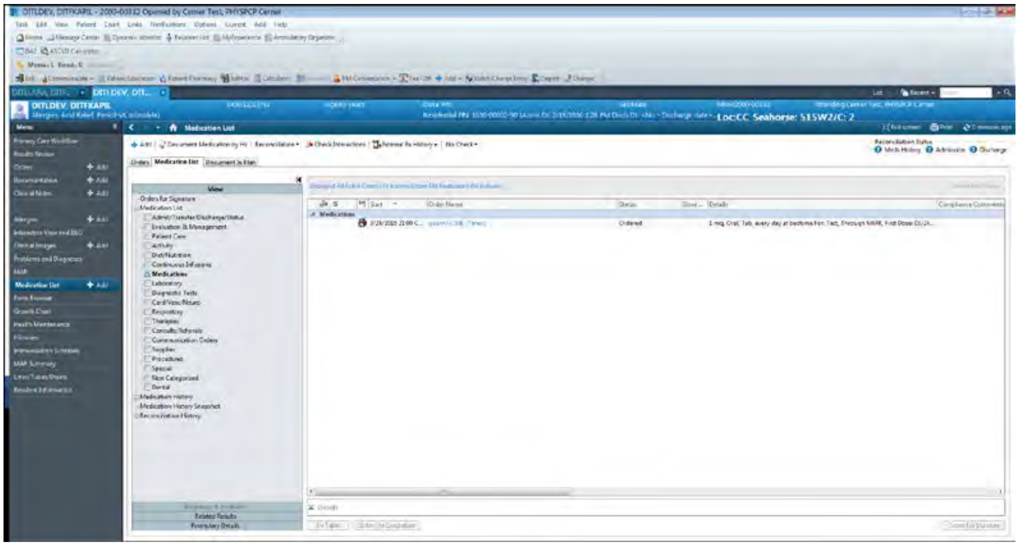
From the **Chart** menu**,** click **MAR Summary** (Medication Administration Record) to view the medication summary. This window displays the dates and times that medications were administered, or are due. Hover the mouse over each medication to view medication details.



MAR Summary Window

MEDICATION LIST

From the **Chart** menu**,** click **Medication List.** Multiple tasks can be performed within the **Medication List** window including: Add, Document Medication, Reconciliation, Check Interactions, and External Rx History. Nurses can review medications, physicians can sign them.



Medication List Window

- Add a Medication

> **Note** ► This functionality is used to place an order for a new medication.

1. From the **Medication List** window, click the add icon (Add).
2. From the **Add Order** pop-up window, a medication can be added but there must first be a diagnosis or problem to associate with the medication.

> **Note** ► If the chart already contains diagnoses and problems, skip to step 8.

3. From the **Diagnoses & Problems** column on the left of the window, click **Add**.
4. From the **Add Diagnosis** pop-up window, type a diagnosis and click the find icon ( ).
5. From the **Diagnosis Search** pop-up window, additional search criteria can be added, or click on the diagnosis in the search results that needs to be saved.
6. Click **OK**.
7. From the **Add Diagnosis** pop-up window, click **OK**. Repeat steps 3-6 to add additional diagnoses or problems.
8. Select the check box next to each diagnosis or problem that needs to be associated with the order that is being added.
9. From the search bar, type the name of the medication then press Enter.
10. From the search results, click the correct medication, inclusive of the dose that is being ordered, then click **Done**.
11. For non-physicians who are ordering a medication, the **Ordering Physician** pop-up window displays. Type the ordering Physician's name. The order date and time default to the current date and time.

12. In the **Communication Type** field, select **Phone, Verbal, Signature Required or Written (Paper)/Fax**, then click **OK**.

> Note ► If a physician is adding the order, steps 11 and 12 are omitted.

13. Type all details, comments and diagnoses for the order, including the **Medication Indication**.
14. Click **Sign**. The medication now populates in the Medication List and has a Processing status until it is filled by the pharmacy.

> Note ► For a Physician, when an order needs to be signed **Orders For Signature** at the bottom of the window are enabled.
>
> Note ► For anyone other than a Physician, the **Orders for Co-Signature** button is enabled.
>
> Note ► For a Nurse, when an order needs to be reviewed, **Orders For Nurse Review** at the bottom of the window are enabled.

CLINICAL NOTES

From the **Chart** menu click **+Add** next to **Clinical Notes** to access the Notes functionality. From this window, view, modify or add notes.

- View Notes
  1. From the **Clinical Notes** window, view any **Clinical Notes** that have been added to a chart within the dates specified on the information bar along the top of the window.
  2. On the left side of the window, select the folder that contains the note that needs to be viewed. The note displays in the center of the window.
  3. Sort the clinical notes view by selecting a radio button: By type, By status, By date, Performed by or By encounter.
  4. Use the up and down arrow buttons to scroll up and down through the available clinical notes.

> Note ► If the note does not display, the date range may need to be changed. Right click the information bar at the top of the **Clinical Notes** window where the date is displayed, and select **Change Search Criteria**. In the pop-up window, change the **From** and **To** dates, then click **OK**.

- Modify a Clinical Note
  1. From the **Clinical Notes** window, double click the note that needs to be modified. The note displays in the center of the window.
  2. Click the modify icon ().
  3. After required changes have been made, click **Sign**.
  4. A pop-up window displays and asks: A change has been made to the note details of the document. Would you like to save this change?
  5. Click **Yes.**

> Note ► After a note is modified, "Document Contains Addenda" will display at the top in red.

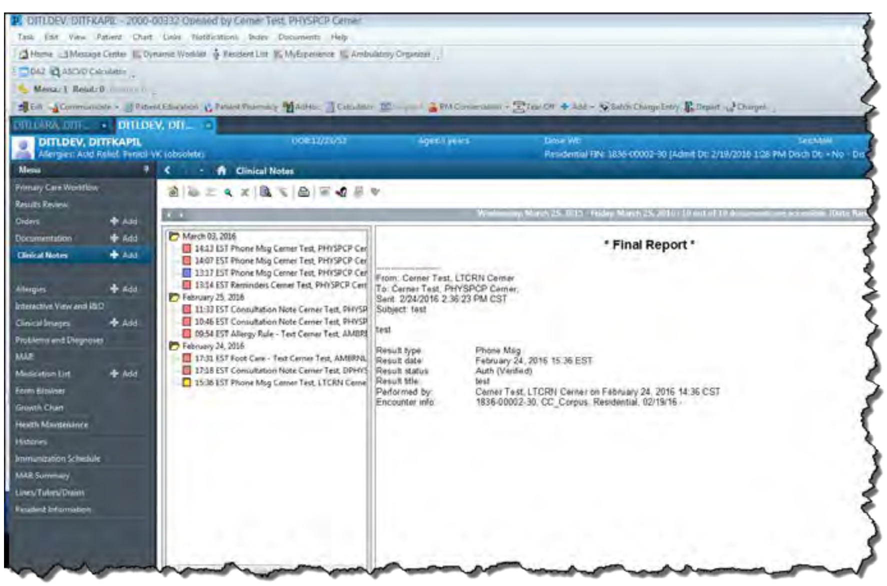
- Add a Clinical Note
    1. From the **Notes** window, click the add icon ( ) to add a new note.
    2. From the **Add Document** pop-up window, select the type of note to add.
    3. Complete all fields on the window and type the note.
    4. Complete the note by:
        - Clicking **Sign** – Completes the documentation, and publishes the note to the resident's chart
        - Clicking **Save** – Saves the note without signing it, but leaves the note window open; this provides the ability to make revisions at a later time. The status of the note will remain as *In Progress* until it's closed

Tip ► Even when temporarily walking away from the computer, it is important to always save a note to prevent data loss in the event of a power outage or network failure.

- Clicking **Save & Close** – Saves and closes the note without signing it
- Clicking **Cancel** - Closes the pop-up window without saving changes

All notes are marked with a colored square to indicate the status. When a note is opened, a yellow dot displays in the center of the colored square. Note statuses are as indicated in the chart below:

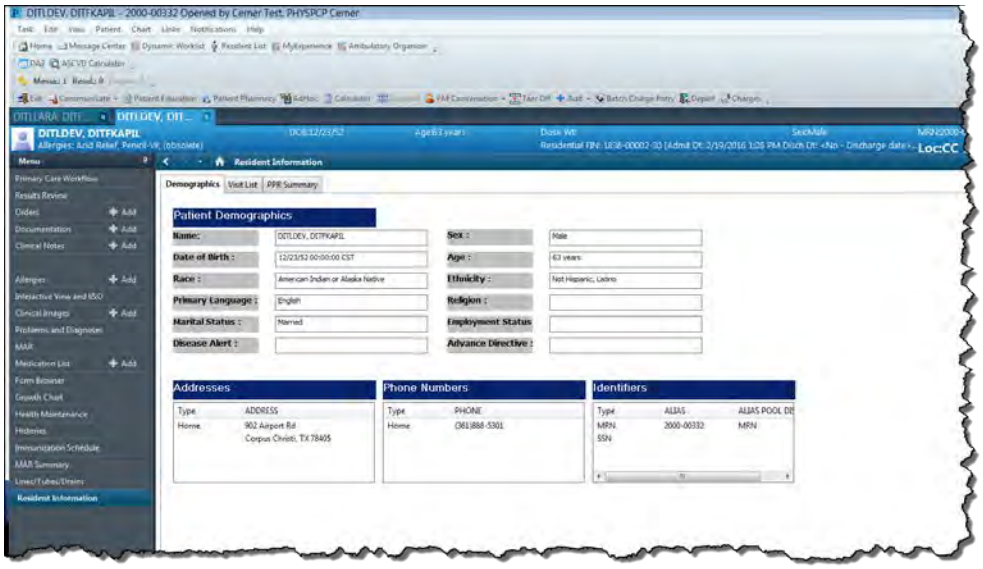
	In Progress – The note is in progress, and has not yet been signed
	Transcribed – The note has been typed, but not yet signed
	Unauthenticated – The note has been signed, but by someone who is not authorized to provide final approval
	Authenticated – The note is finalized and signed
	Modified/Corrected – The note or document has been modified, and there is an addendum
	Anticipated – A record is anticipated, but has not yet been typed
	Error – The note was typed in error
	Unknown Status



Clinical Notes Window

RESIDENT INFORMATION

From the **Chart** menu**,** click **Resident Information** to view resident demographics, the visit list, and the PPR summary. This is a view-only window, and information contained herein was typed during scheduling and registration.

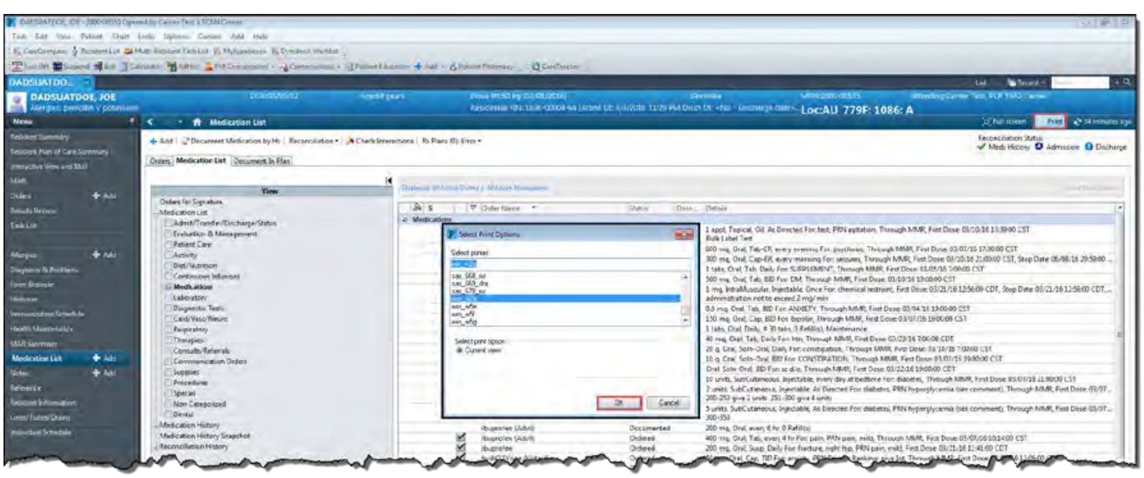


Resident Information Window

PRINTING

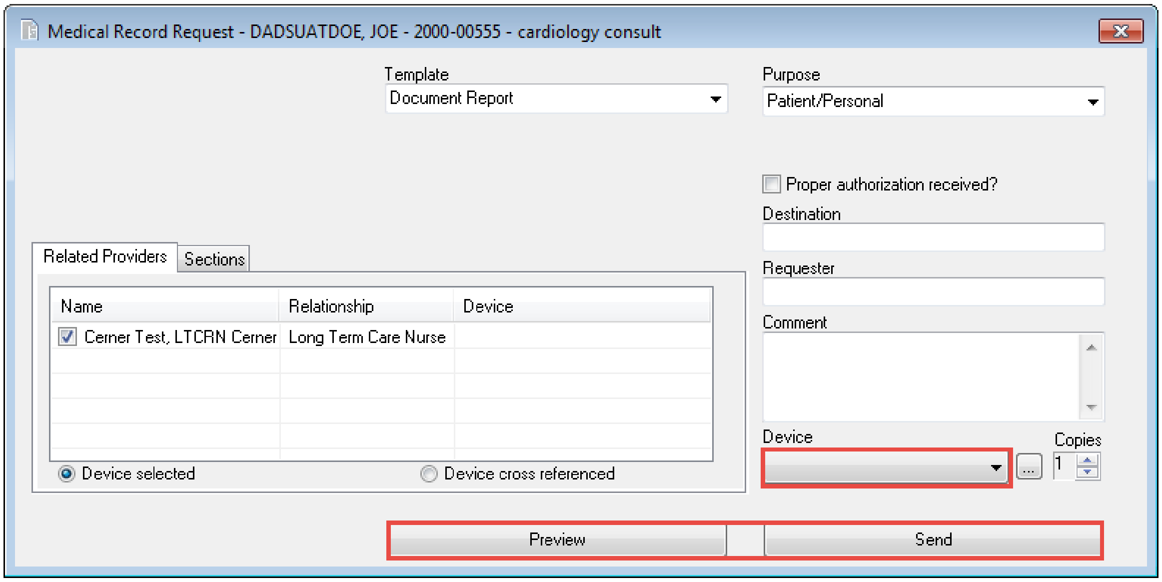
Open a resident's chart, then click the print icon (Print) at the top right of any window to print its contents. The print functionality does not display on every window.

Note ▸	A provider may want to print a medication list, or document from the resident chart.

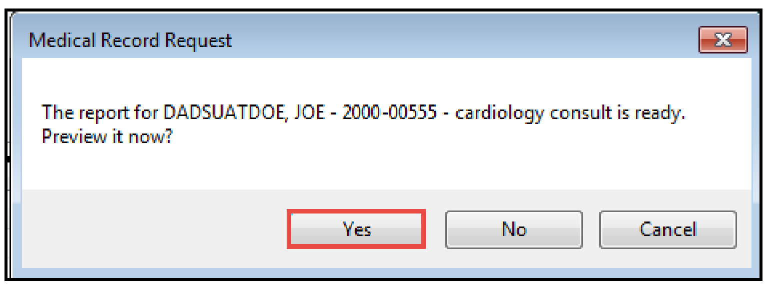


Select Print Options Pop-up Window

Note ▸ The **Print** option also allows a provider to send a portion of the resident chart.



Medical Record Request Pop-up Window



Medical Record Request Confirmation Pop-up Window

VERBAL/TELEPHONE ORDERS

Purpose

This lesson presents the provider workflow for giving, co-signing, and refusing verbal/telephone orders.

Objectives

- Identify the process for giving Verbal/Telephone orders
- Co-sign Verbal/Telephone orders
- Refuse Verbal/Telephone orders

Giving Verbal/Telephone Orders

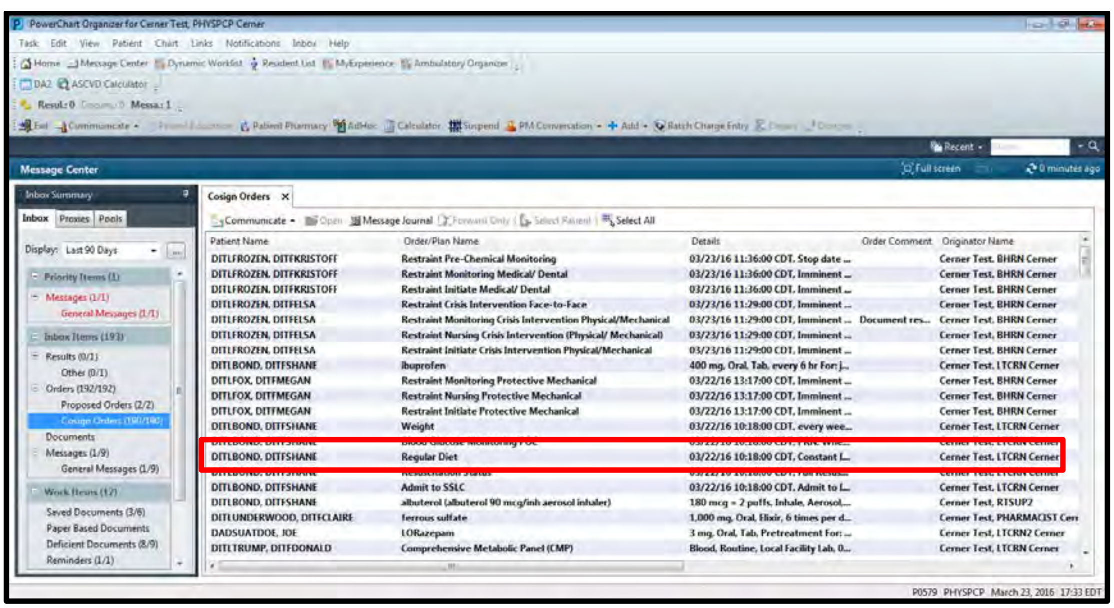
Verbal orders are those spoken aloud by a provider to a (LTC) RN. Telephone orders are those given over the phone by a provider to a (LTC) RN. In both instances, the RN will repeat the verbal order back to the provider for clarification while manually entering the order in the electronic record.

Locating and Co-signing Verbal/Telephone Orders from the Message Center

Verbal and telephone orders require the ordering provider’s signature to authenticate their accuracy and make them legally binding. To approve orders from the **Message Center Cosign Orders** folder, complete the following steps:

1. Log into PowerChart and locate the **Message Center Inbox Summary**.
2. From the **Inbox Summary**, click **Cosign Orders**.

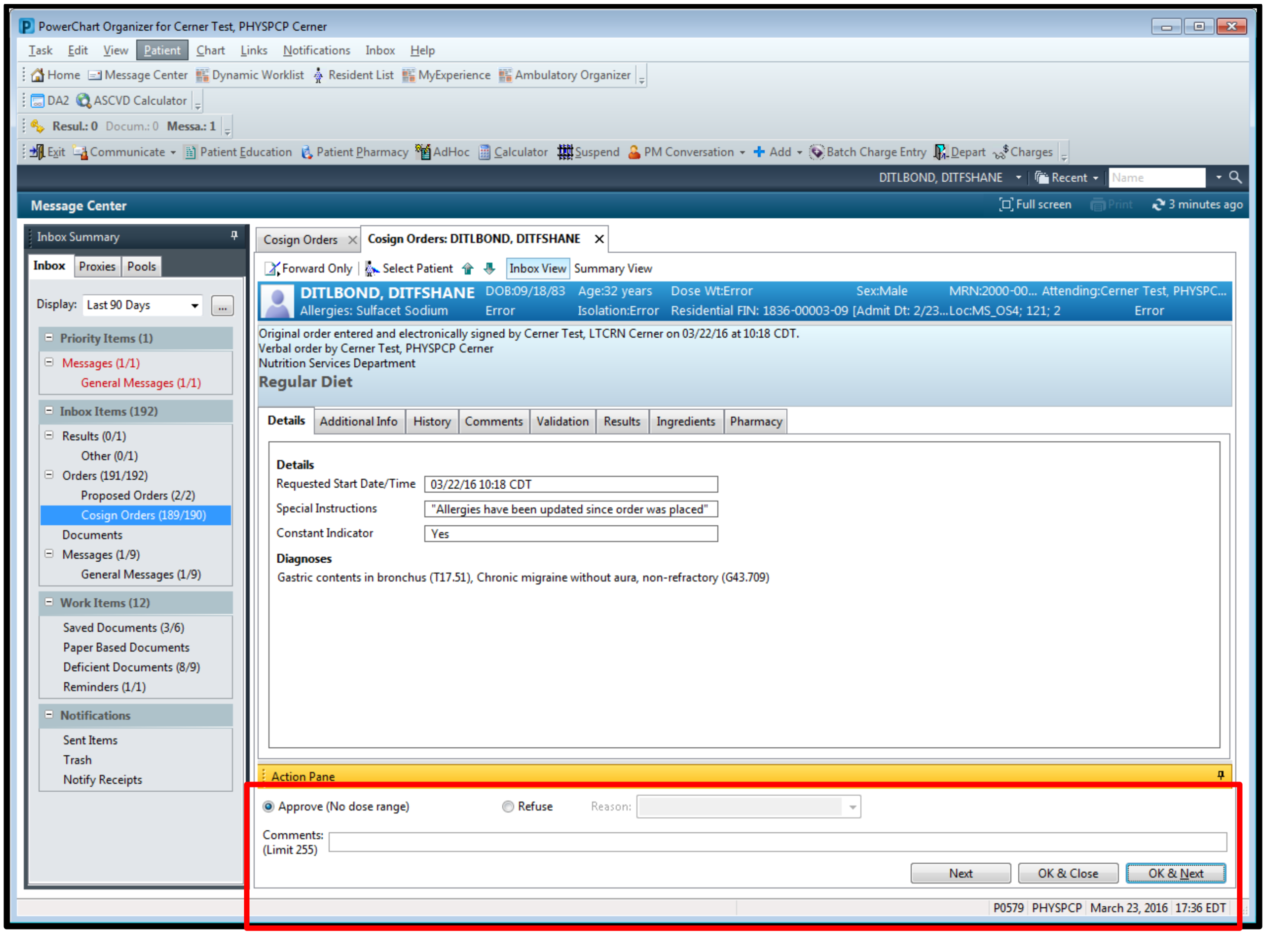
The **Cosign Orders** window displays.



Cosign Orders Window

3. To view an **Order Message** for a particular resident, double-click the resident's name.

   The **Cosign Orders** window for the resident displays.



Cosign Orders Window

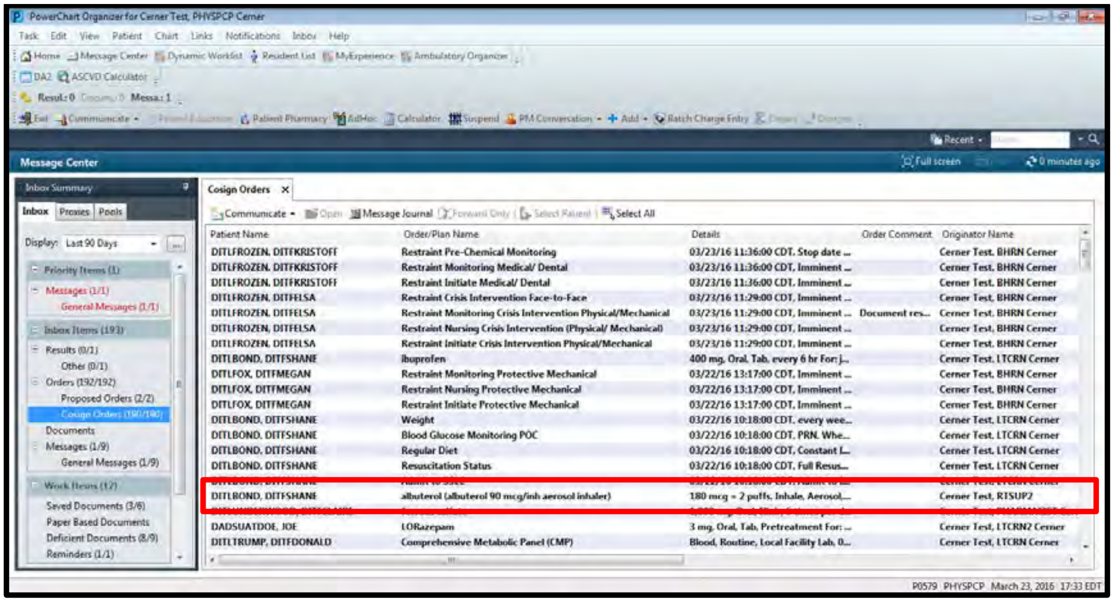
4. From the **Action Pane**, click the **Approve** radio button to sign the order.
5. To accept the order and move to the next order, click **OK & Next**. To accept the order and return to the **Cosign Orders** window, click **OK & Close.**

Refuse Orders

When an order has been submitted for the wrong patient, or the wrong order has been submitted, providers can refuse orders from the **Cosign Orders** window. This action is performed through the following steps.

1. Log into PowerChart and from the **Message Center Inbox Summary** click the **Cosign Orders** band.

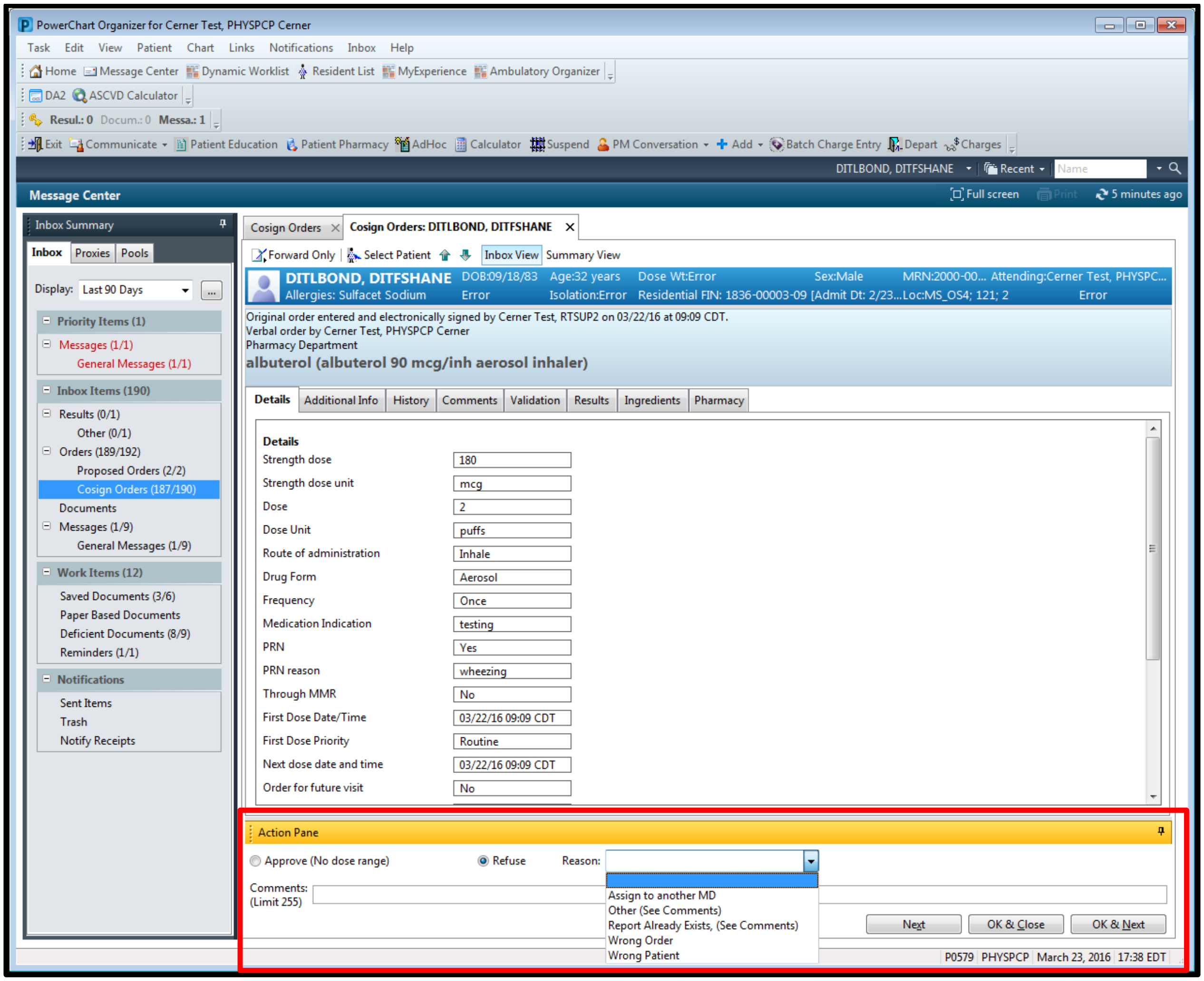
   The **Cosign Orders** window displays.



Cosign Orders Window

2. To view an **Order Message** for a particular resident, double-click the resident's name.

The **Cosign Orders Message Details** window displays.



Cosign Orders Message Details Window

3. From the **Action Pane**, click the **Refuse** radio button to reject an erroneous order.
4. From the **Reason** drop-down menu, select the appropriate reason for refusal.
5. To void the order and move to the next order, click **OK & Next**. To void the order and return to the **Cosign Orders** window, click **OK & Close**.

Exercises

1. Cosign the telephone order for the resident from the Message Center Inbox.
2. Refuse the verbal order for the resident. Indicate "Wrong Resident" as the Reason for Refusal.

RADIOLOGY & DIAGNOSTIC ORDERS

Orders for radiology and diagnostic procedures contain special requirements based on whether the test is performed On Campus by the Radiology Department or Off Campus by a third party mobile imaging resource. The workflows for processing the results differ based on the time of day a test is completed and whether an RN or radiology technician receives the initial results.

Purpose

This section presents the provider workflow for entering a Radiology or Diagnostic order and the processing of those results.

Objectives

- Place Radiology or Diagnostic orders with appropriate order details
- Process Radiology or Diagnostic orders performed On Campus
- Process Radiology or Diagnostic orders performed by third party mobile imaging
- Document results in a Radiology/Lab Results Reviewed note template

Radiology/Diagnostic Orders Performed On Campus

To enter a Radiology/Diagnostic order to be performed On Campus, complete the following steps:

1. From the **Resident List**, click the resident's name to open the chart.

   The resident's **Chart** window displays.

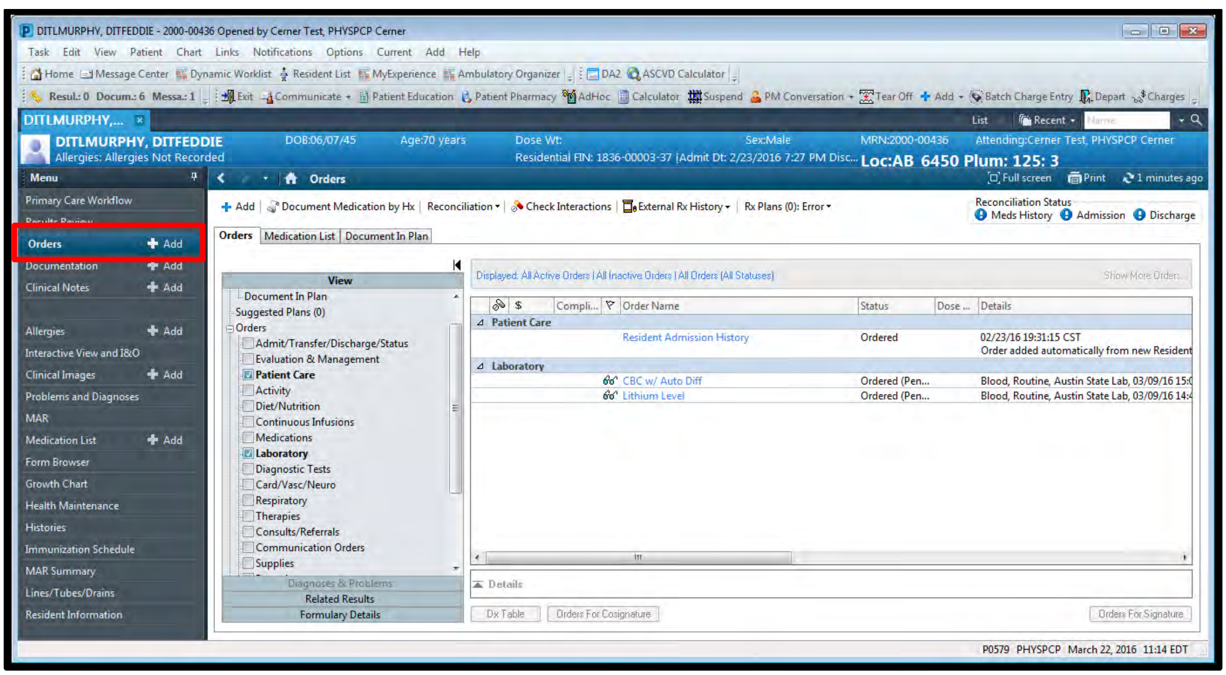
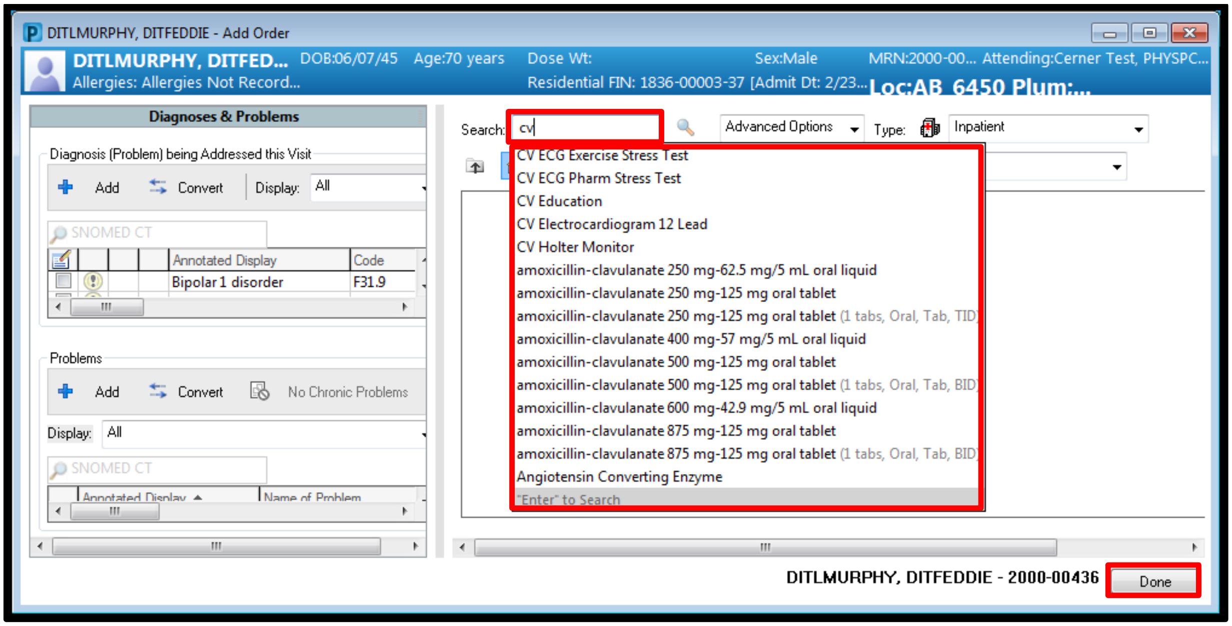


Chart-Orders Window

2. To enter a new order, click **+ Add** from the **Orders** menu.

Tip ▸ From the **View** menu in the **Chart-Orders** window, click the order type check box to add orders by category. Any of the listed categories can be selected and searched.

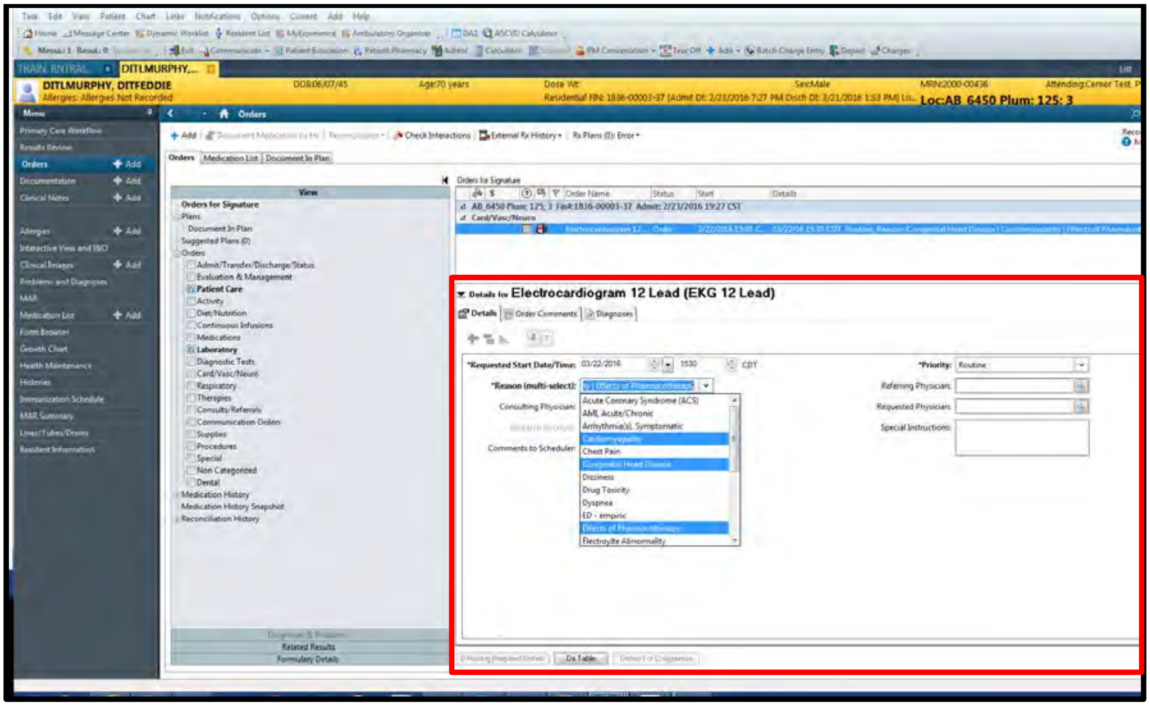
The **Add Order** window displays.



Add Order Window

3. Search for a specific test by typing the test name into the **Search** field.
4. Click to select the desired order.
5. To save the selection and enter order details, click **Done**.

The **Order Details** window displays.



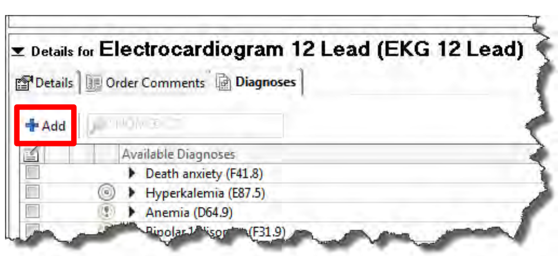
Order Details Window

Three required fields must be completed on the **Add Order** window to successfully submit the order.

1. From the **Priority** drop-down, choose the test priority. The options are **STAT** or **Routine**.
2. From the **Reason (multi-select)** field, identify from the drop-down the reason for the order.

Tip ▸ More than one reason for an exam may be selected. To choose multiple reasons, compress the **ctrl key** in the lower left corner of your keyboard while clicking additional reasons from the list. After the order is signed, each reason for the order will display.

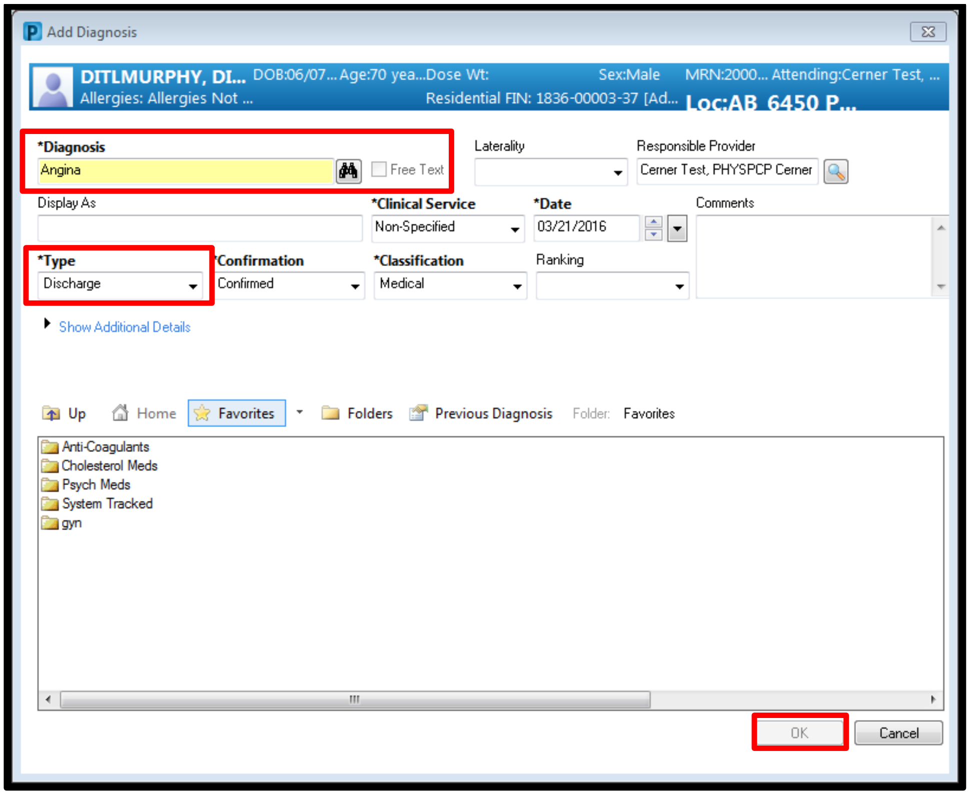
Click the **Diagnosis** tab on the **Add Order** window to add diagnoses.



Add Order Window – Diagnoses Tab

3. From the **Diagnoses** tab, click the **Add** icon (Add) to associate a diagnosis.

- The **Diagnosis Search** window displays.



Diagnosis Search Window

4. In the **Diagnosis** field, type the diagnosis name.
1. Click the search icon ( ) to open the **Diagnosis Search.** A list of matching diagnoses is displayed. To associate a diagnosis, click the corresponding row to choose the entry.
2. From the **Type** field on the **Diagnosis Search** window, select the appropriate diagnosis type (i.e. working, admission, discharge, etc.).
3. Click **OK** to complete the process.

The processing of Radiology and Diagnostic orders differs based on the following:

- If the exam is performed On Campus or Off Campus
- If the results are read by a radiology technician, provider, or third party resource
- Whether the results are received and read before or after 5:00pm

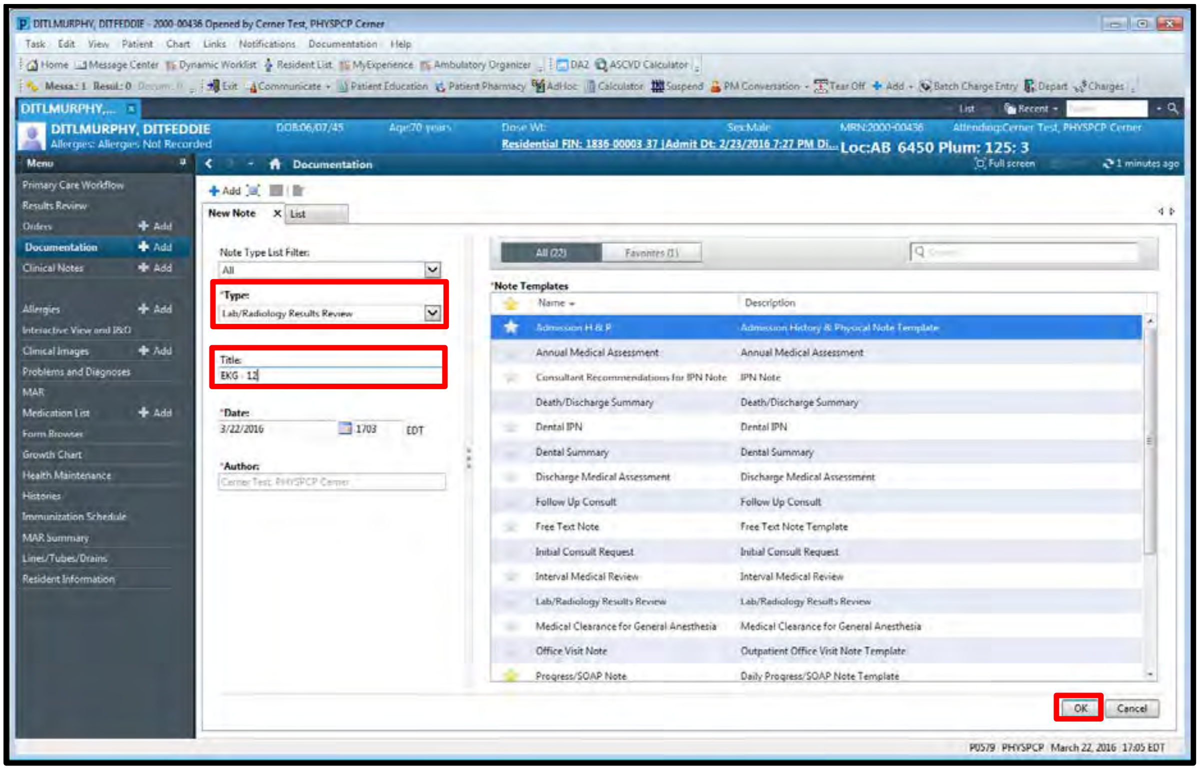
The table below lists the Radiology/Diagnostic order workflows based on the processing criteria.

<table>
<tr><th colspan="2">On Campus Exam</th></tr>
<tr><td colspan="2">Exam is performed by the onsite radiology technician
Results are read by either the radiology technician, provider, or a third party resource</td></tr>
<tr><th colspan="2">Off Campus Exam</th></tr>
<tr><td colspan="2">Exam is completed by a third party mobile imaging
Results are read off site and faxed back to SSLC
Results are received by either the radiology technician or nurse</td></tr>
<tr><th>Results Received/Read Before 5:00pm</th><th>Results Received/Read After 5:00pm</th></tr>
<tr><td>Radiology Tech places results in resident’s paper chart & sends provider an Inbox Message
Provider documents major findings in a Lab/Radiology Results Reviewed note template</td><td>Nurse places results in resident’s paper chart & sends provider an Inbox Message
Provider documents major findings in a Lab/Radiology Results Reviewed note template</td></tr>
</table>

General Message is routed to the **Message Center Inbox** notifying the provider that the paper test results are ready to review. Once a provider views the test results, major findings are documented in a **Lab/Radiology Results Reviewed** note. To access this template, complete the following steps:

1. From the **Documentation** band in the **Chart** menu, click **+ Add**.

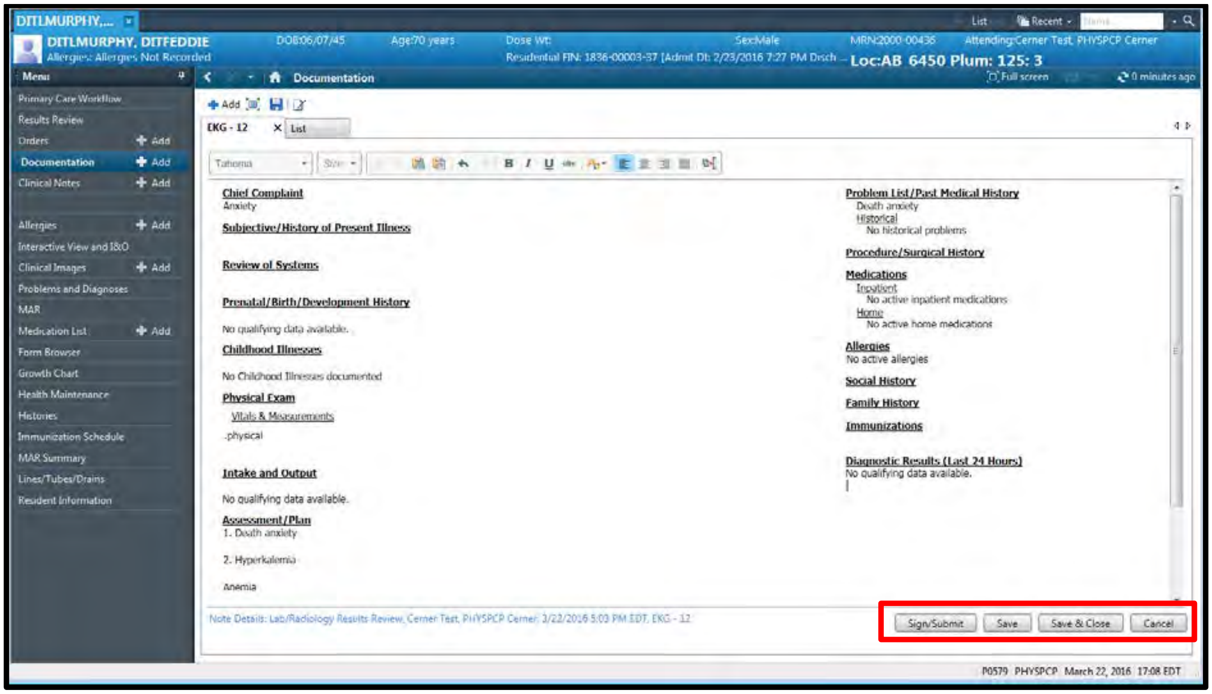
   - The **New Note** window displays.



Documentation - New Note Window

2. From the **Type** drop-down menu, enter **Lab/Radiology Results Review** to choose the type.
3. Select a template from the **Note Templates** section.
4. In the **Title** field, enter the name of the test or procedure being reviewed.
5. To open the **Lab/Radiology Results Review** template, click **OK.**

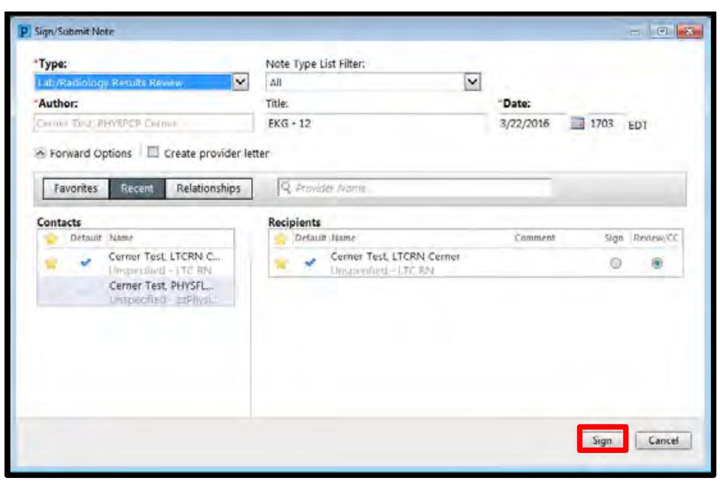
The **Lab/Radiology Results Review** window displays.



Lab/Radiology Results Review Window

6. Enter the results interpretation in the **Lab/Radiology Results Review** note.
7. To sign the note and submit the documentation, click **Sign/Submit.**

The **Sign/Submit Note** pop-up window displays.



Sign/Submit Note Pop-Up Window

8. Click **Sign** to sign the note.

Radiology/Diagnostic Orders Performed Off Campus

The provider process for entering Radiology/Diagnostic orders is identical whether the procedure is performed On Campus or Off Campus; however, results are processed differently depending upon where the order was performed. In both instances, the provider receives a General Message in the Message Center Inbox indicating that the final results are ready for review in the resident's paper chart. The overall Off Campus process is as follows:

1. From order entry, the provider places a **Radiology/Diagnostic** order.
2. The resident's exam is performed Off Campus.

The nurse receives a paper copy of the radiology results from the off-site facility and places it in the resident's chart. The nurse then sends a **General Message** to the ordering provider that the results are ready for review.

3. The provider reviews the results and documents major findings in a **Lab/Radiology Results Reviewed** note template.

Exercise

Complete the following exercise. Reference the workflows from the lesson as a guide.

1. Locate the resident from the Resident List.
2. Enter an order to be performed On Campus.
3. View the message stating that the test is complete.
4. Document the major findings in a Lab/Radiology Results Reviewed note template.

LAB ORDER ENTRY

Purpose

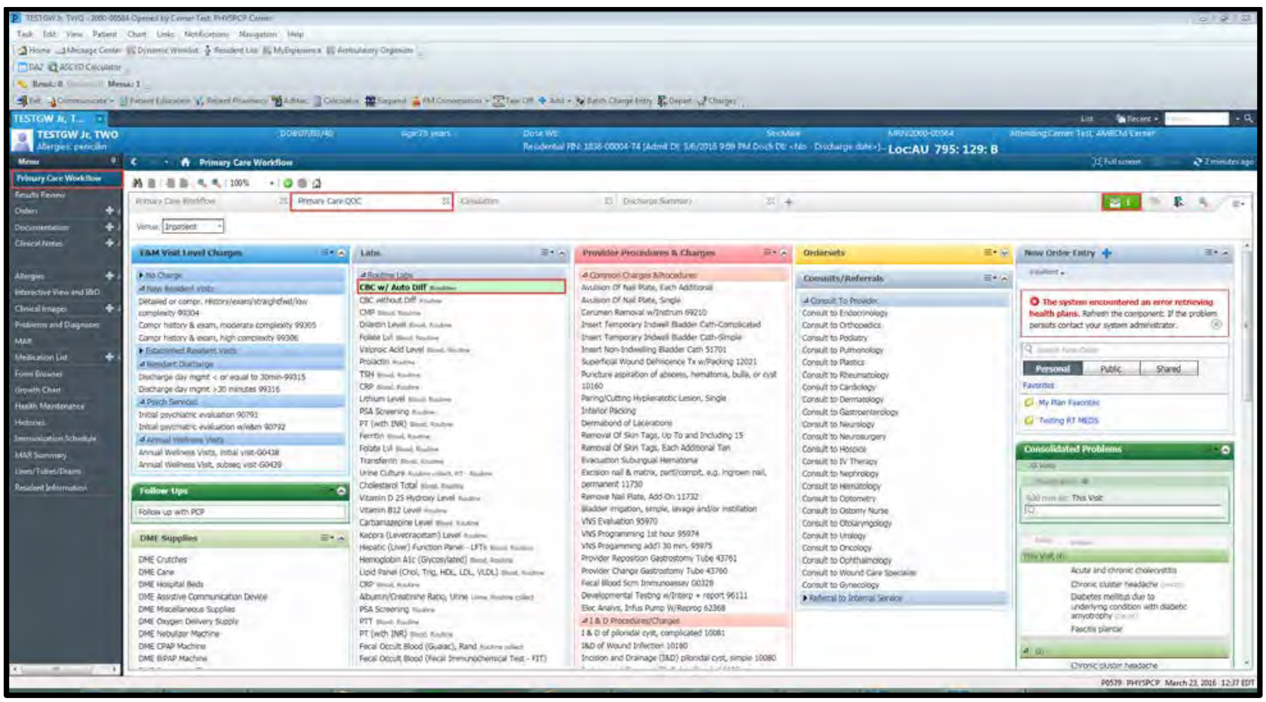
This section presents the provider workflow for lab order entry using a local lab and documenting results in an Integrated Progress Note (IPN).

Objectives

- Enter lab orders using a local or state lab
- Review completed lab results
- Document lab results in an IPN

Enter Lab Orders

1. Navigate to the **Quick Orders** dashboard window.



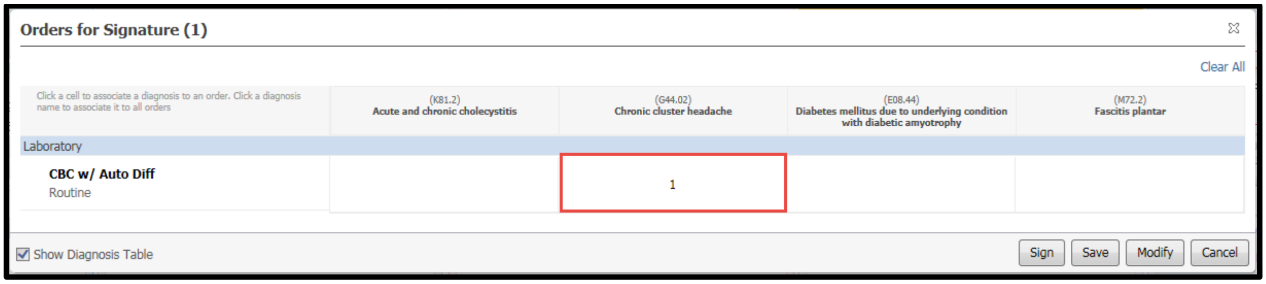
Primary Care Quick Orders & Charges Window

2. From the **Menu**, click **Primary Care Workflow**.
3. Click the **Quick Orders** tab.
4. From the **Labs** tab, click the name of a lab test to order.

Note ▶	To add any order directly from the **Quick Orders** window, click the **New Order Entry** icon.

5. Click the **Orders for Signature** icon ( )

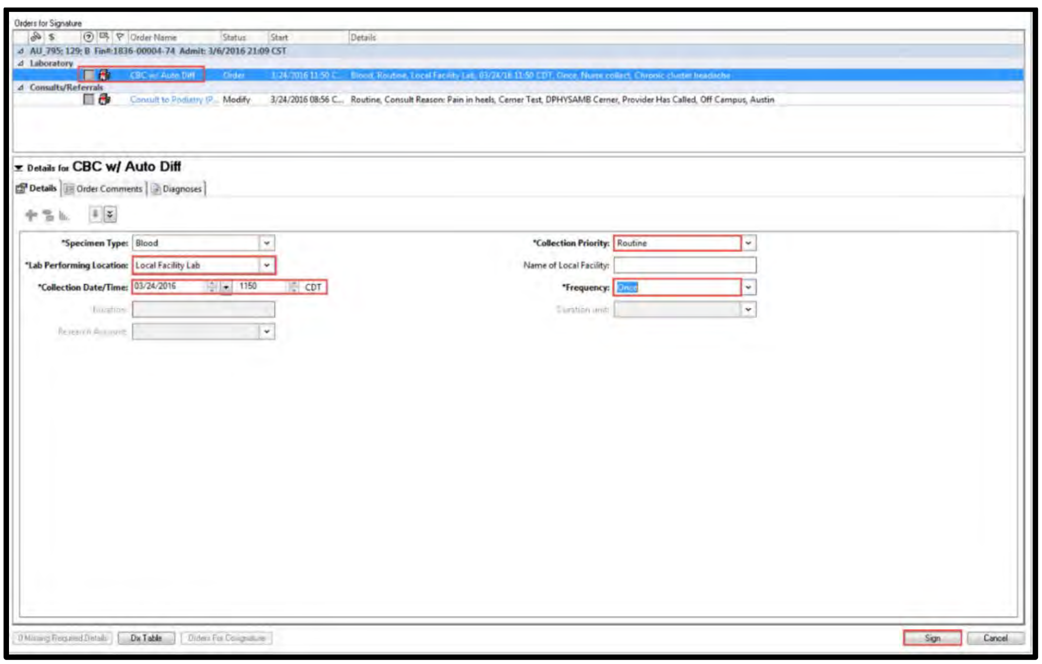
The **Orders for Signature** pop-up window displays.



Orders for Signature Window

6. Click a **cell** to associate a diagnosis to the Laboratory order, or click a diagnosis name to associate it to all orders.
7. To edit order details, click **Modify**.

The **Orders for Signature** window displays.



Orders for Signature: Order Details Window

8. From the **Orders for Signature** window, click **CBC w/ Auto Diff.**
9. From the **Lab Performing Location** drop-down, click **Local Facility Lab.**

Note ►	When using the state lab, click Austin State Lab from the Lab Performing Location drop-down.

10. From the **Collection Date/Time** field, enter the date and time of the collection.
11. Select the **Collection Priority** and **Frequency.**
12. Click **Sign**.

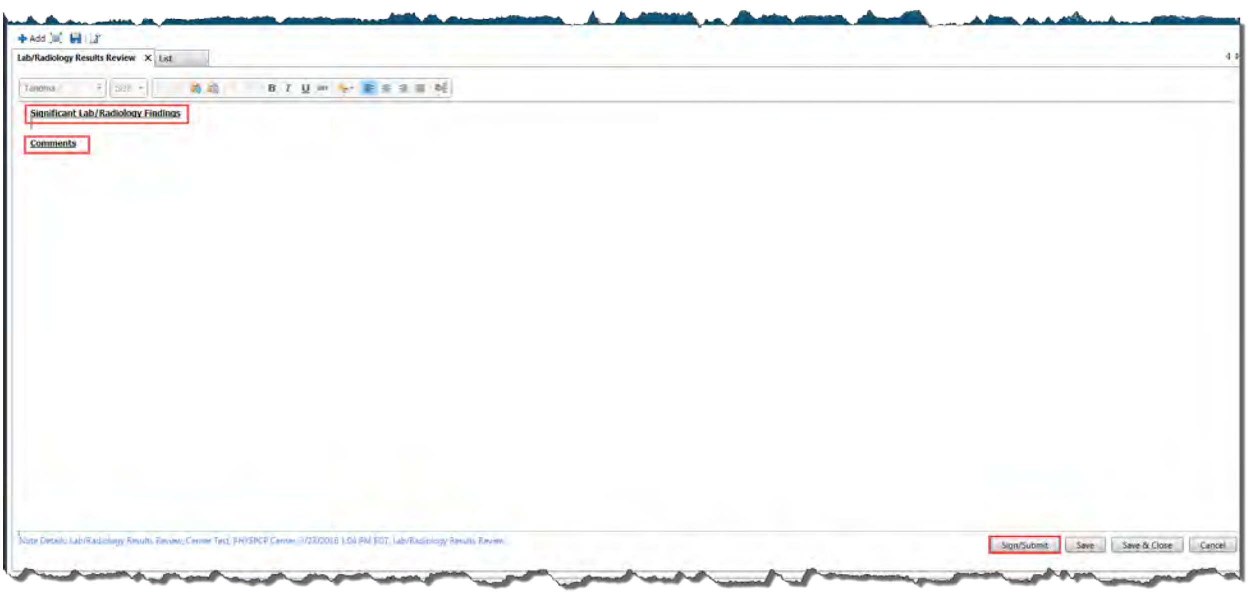
> **Note** ▸ The LTC RN procures the specimen. The specimen is couriered to the local facility and the test is performed. The completed results are faxed to the SSLC. The LTC RN sends the provider a **General Message** via **the Message Center** with notification that the lab results are completed and a hard copy of lab results are in the resident's chart.

Review Completed Lab Results

The Provider views the hard copy of lab results but must document the lab results in the resident's EMR.

1. From the **Menu**, click the **Documentation** band.
2. From the **Note Templates** field, select **Lab/Radiology Results Review**.
3. Click **OK**.

💻 The **Lab/Radiology Results Review** tab displays.



Lab/Radiology Results Note Documentation Window

4. Type the lab results information in the **Note Documentation**.
5. Click **Sign/Submit.**

Exercises

1. Place a One Time Lab Order for a PSA from the Primary Care Quick Orders window.
2. Choose Local Facility Lab for the Lab Performing Location.
3. Document the lab results in an IPN.

CONSULT ORDERS

Purpose

This section presents the provider workflow for entering a consult order with an outside provider (ENT, Podiatry, etc.) and processing the recommendations of the consult.

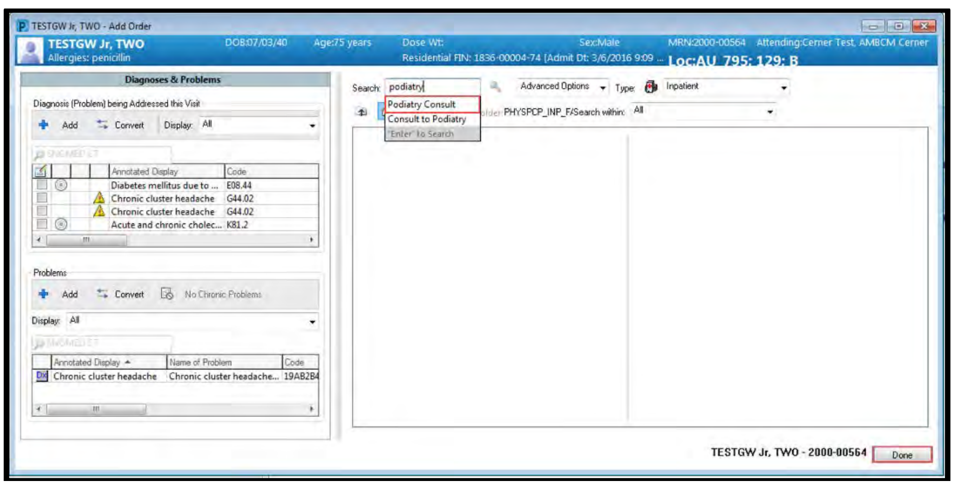
Objectives

- Place a consult order with appropriate order details
- Review the recommendations of a consult
- Transcribe the recommendations of a consult into an Integrated Progress Note (IPN)
- Enter orders and update problems/diagnoses based on the recommendations of a consult

Place a Consult Order

1. From the **Menu**, click **Orders.**
2. From the **Orders** window, click **+Add**.

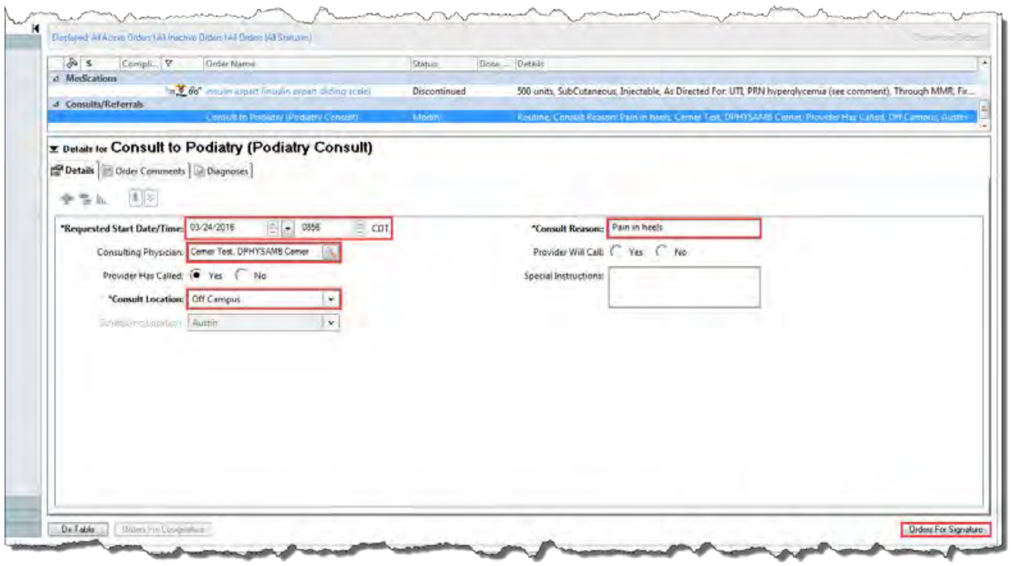
   The **Add Order** pop-up window displays.



Add Order: Consult Window

3. Type the consult name in the **Search** field.
4. Click the name of the consult order.
5. Click **Done**.

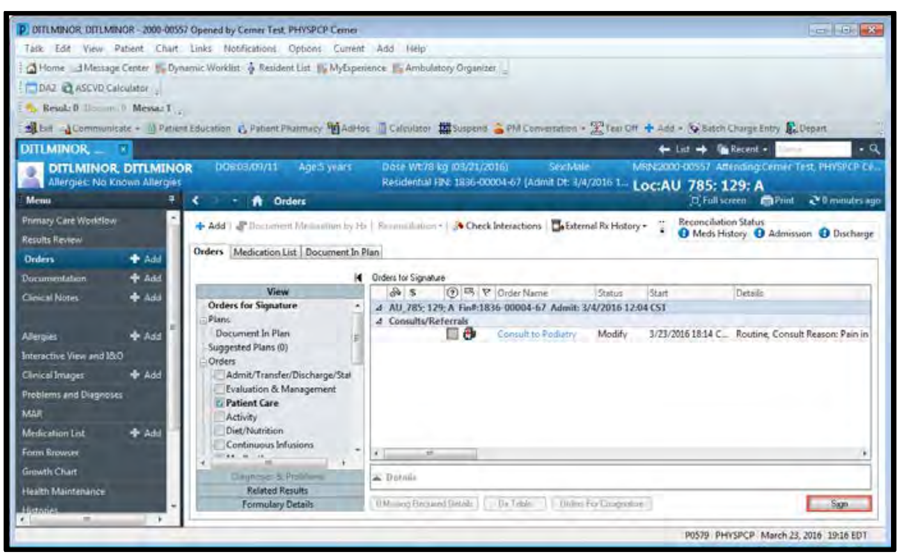
The **Orders** window displays.



Displayed Orders Window

6. Select the ***Requested Start Date/Time**.
7. Select the **Consulting Physician**.
8. In the ***Consult Reason** field, type the reason for the consult.
9. From the ***Consult Location** drop-down menu, select Off Campus.
10. Click **Orders for Signature**.

The **Orders for Signature** window displays.



Orders for Signature Window

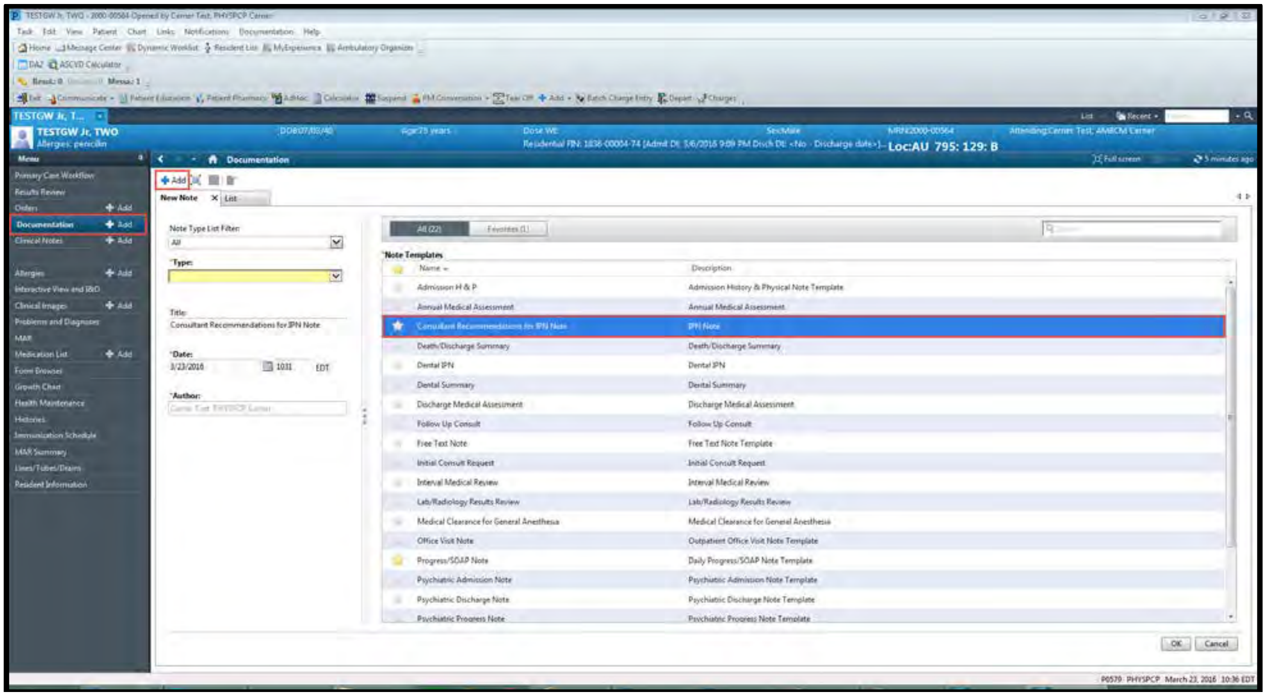
11. Click **Sign**.

Enter a Consult's Recommendations into an Integrated Progress Note (IPN)

After the resident's consult is completed, the provider receives the consult results in the resident's paper chart. The provider reviews the recommendations and transcribes them into a Consultation Recommendations Integrated Progress Note (IPN).

1. From the **Menu**, click the **Documentation** band.

   The **Documentation** window displays.



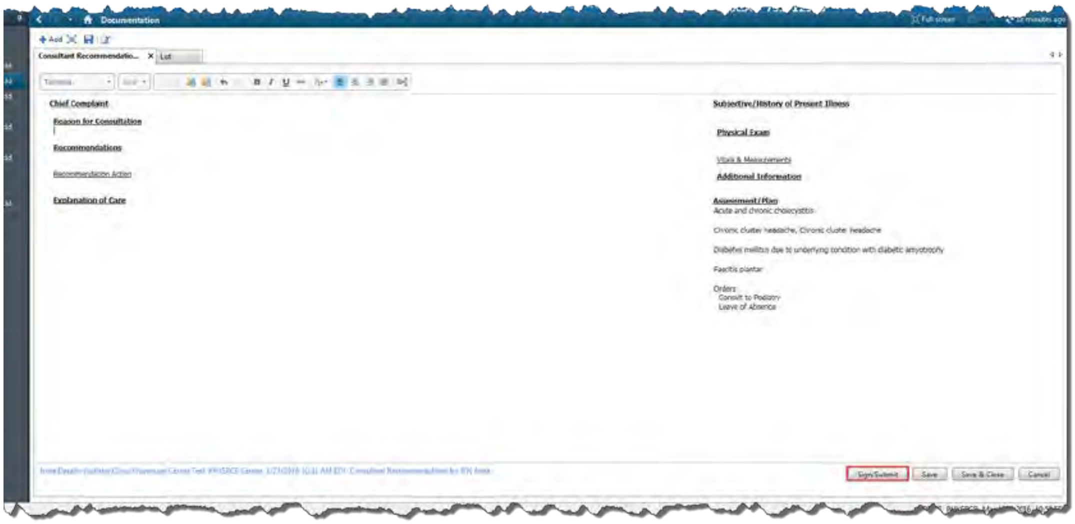
Documentation Window

2. From the **Documentation** window, click **+Add**.
3. From the **Note Template** field, click the **Consultant Recommendation for IPN Note.**

> **Note ▸** The optional **Title** field will automatically populate after selecting the Note Template. The **Date** automatically populates with the current date and time, and the **Author** field automatically populates with the name of the provider writing the IPN.

4. Select the **Type** from the drop-down menu.
5. Click **OK.**

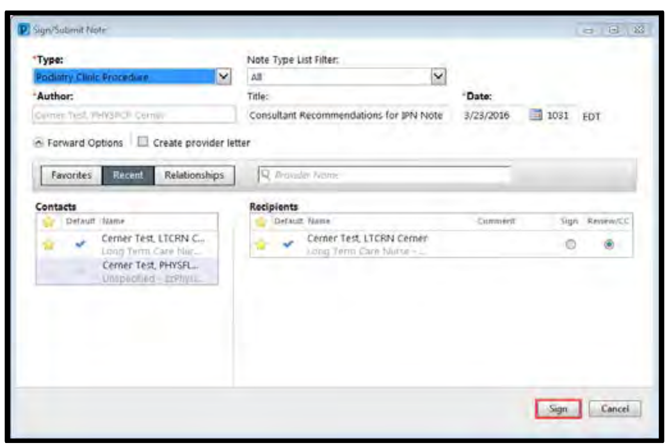
The **Consultant Recommendations for IPN Note** window displays.



Consultant Recommendations for IPN Note

6. From the **Consultant Recommendations** window, document the consult notes.
7. Click **Sign/Submit**.

The **Sign/Submit Note** pop-up window displays.



Sign/Submit pop-up window

8. Review that the Note data is correct.
9. Click **Sign**.

Exercises

1. Place a Vascular Surgery Consult Order, Off Campus, with an Outside Provider on the resident.
2. Document the surgeon's recommendations into a Consultation Recommendation IPN.
3. Update the resident's problem list and order an antibiotic ointment to apply to the foot ulcer.

DYNAMIC DOCUMENTATION

Purpose

This section presents the provider workflow for completing Dynamic Documentation.

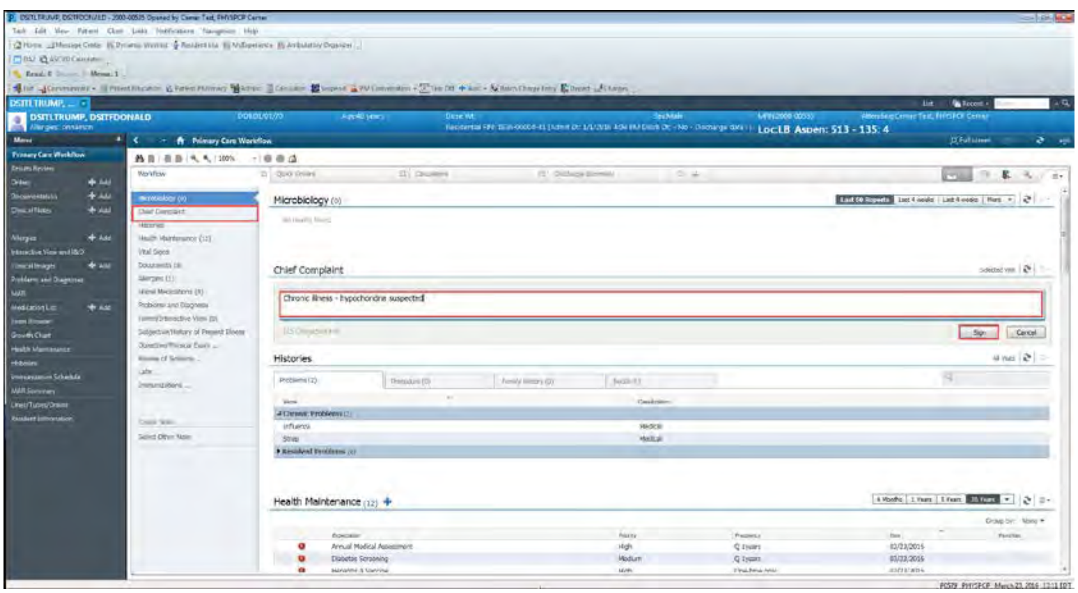
Objectives

- Locate the New Note function in a Resident's chart
- Review all documentation
- Enter the following visit information: Chief Complaint, Vital Signs, Problem List/Diagnoses, History, Medications, and Lab Results
- Select an Objective/Physical Exam auto-text
- Create a comprehensive SOAP note

Enter Visit Information

1. From the **Primary Care Workflow** menu, click **Chief Complaint**.
2. Click in the **Chief Compliant** field.

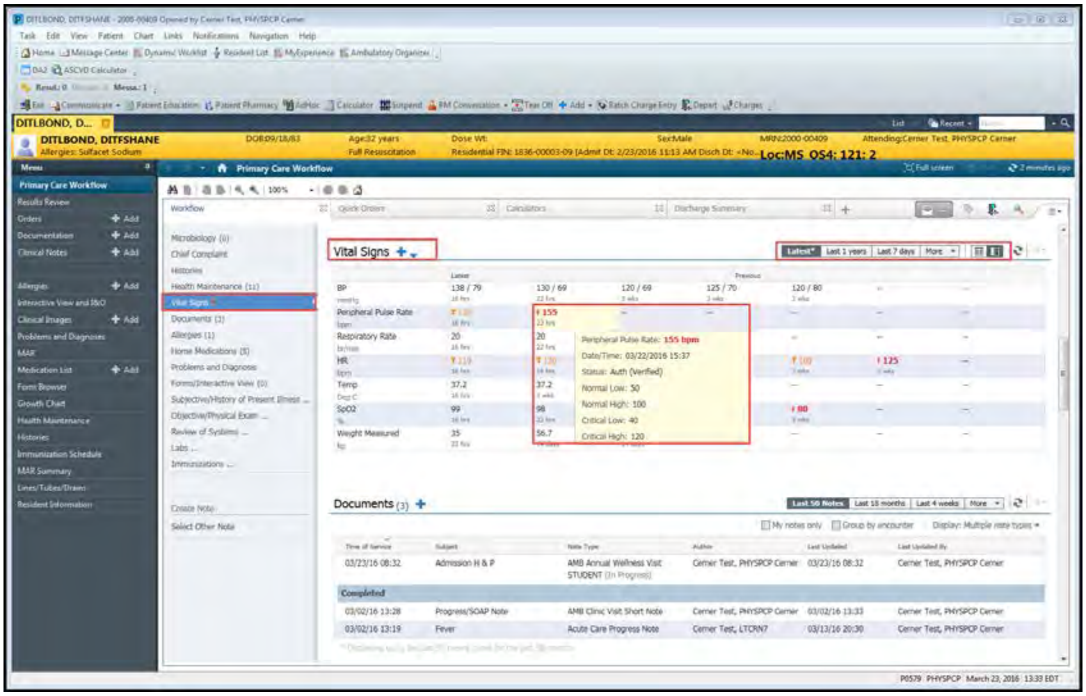
💻 The **Chief Complaint** field becomes editable.



Chief Complaint Window

3. In the **Chief Complaint** field, type the **Chief Complaint** (up to 255 characters).
4. Click **Sign**.
5. From the **Primary Care Workflow** menu, click **Vital Signs**.

- The **Vital Signs** section of the document displays.

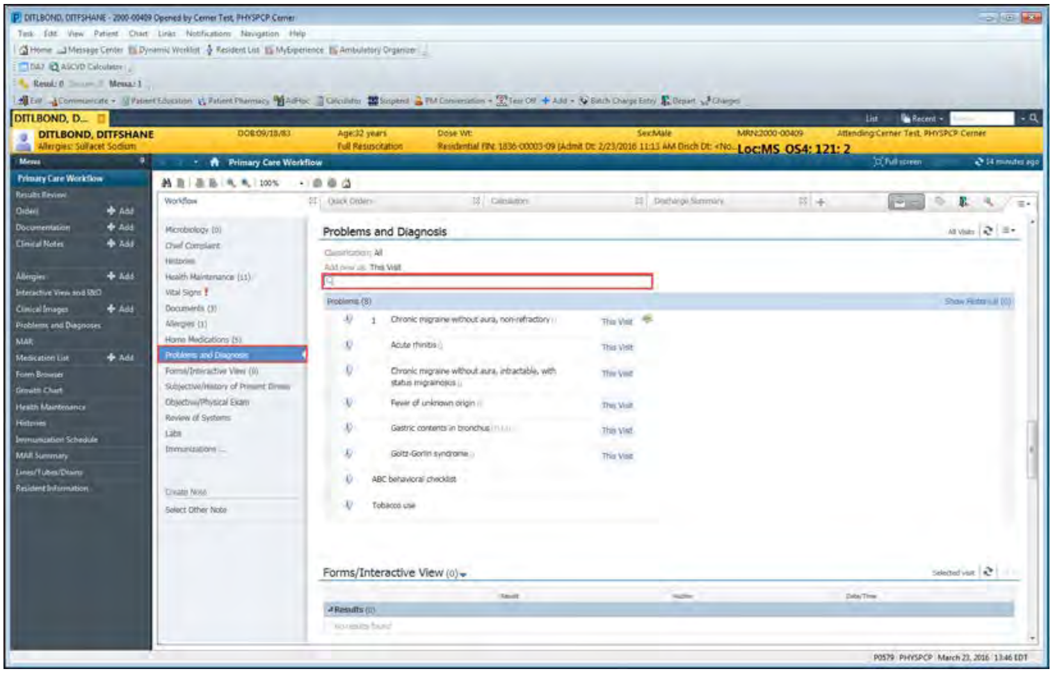


Vital Signs Section

Note	►	Filters are available to view **Vital Signs** from a certain timeframe.
Note	►	A red exclamation mark ( ) indicates results in a critical range.

6. From the **Primary Care Workflow** menu, click **Problem and Diagnosis**.

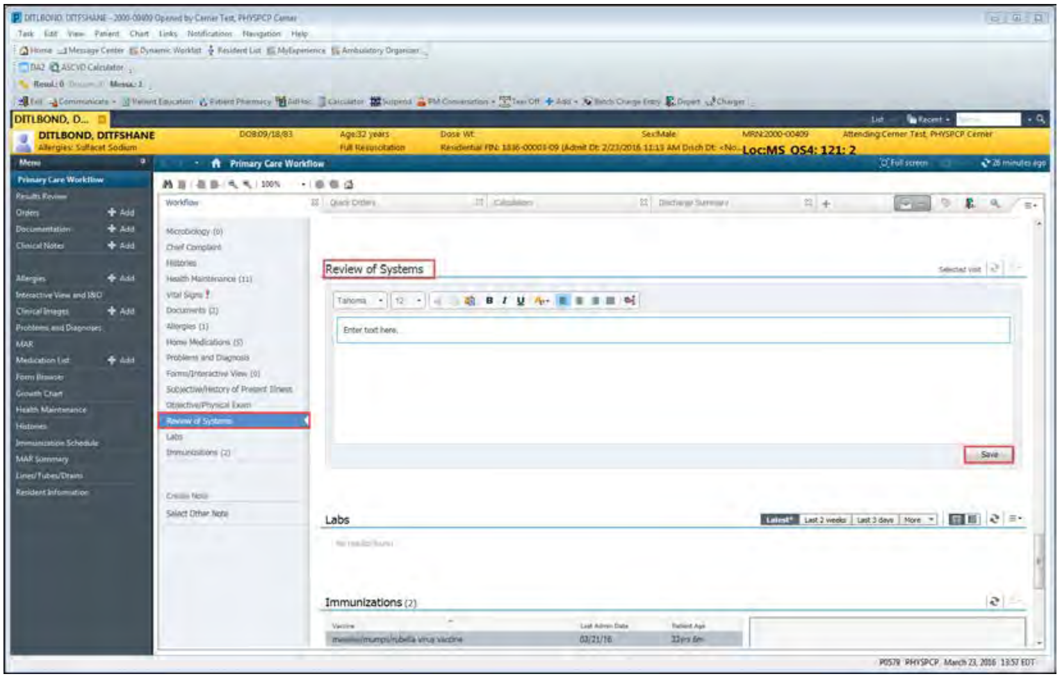
The **Problems and Diagnosis** section of the document displays.



Problems and Diagnosis Section

7. Click **This Visit**.
8. From the **Primary Care Workflow** menu, click **Review of Systems**.

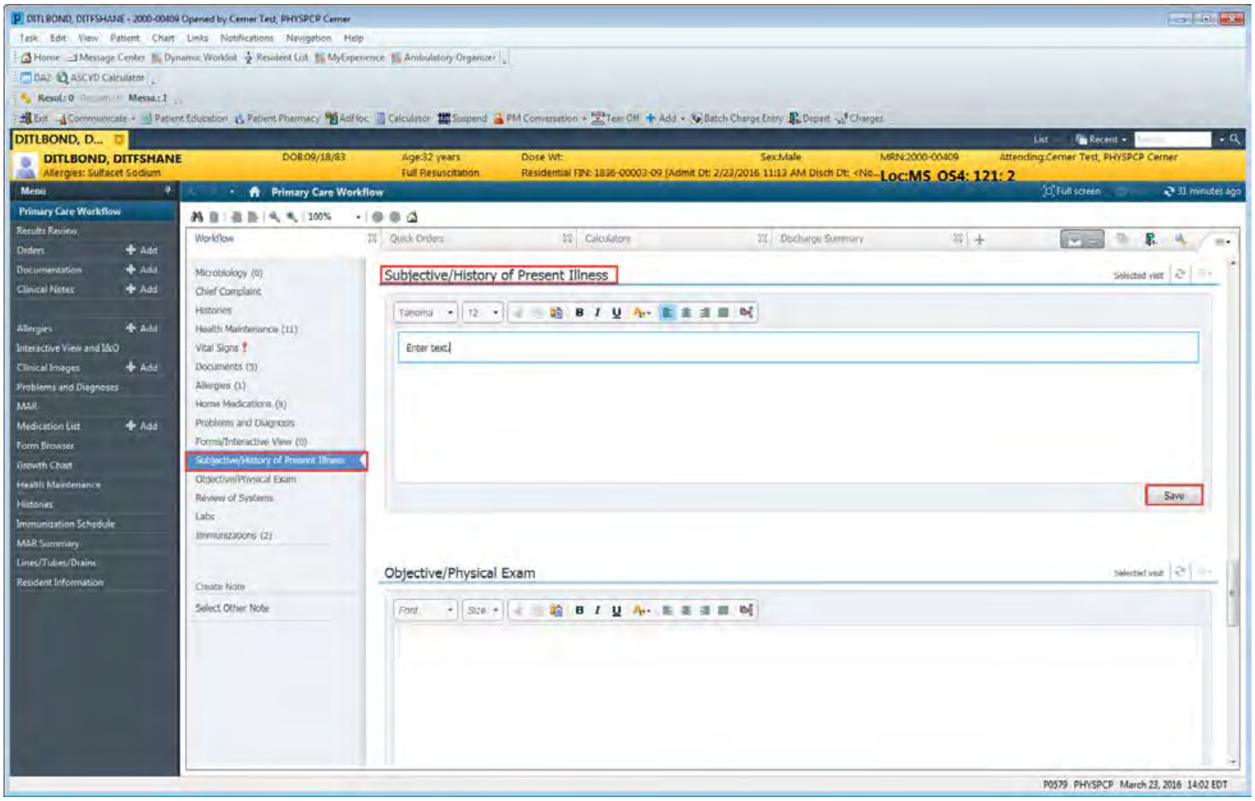
The **Review of Systems** section of the document displays.



Review of Systems Section

9. Click in the **Review of Systems** field.
10. Type text.
11. Click **Save**.
12. From the **Primary Care Workflow** menu, click **Subjective/History of Present Illness**.

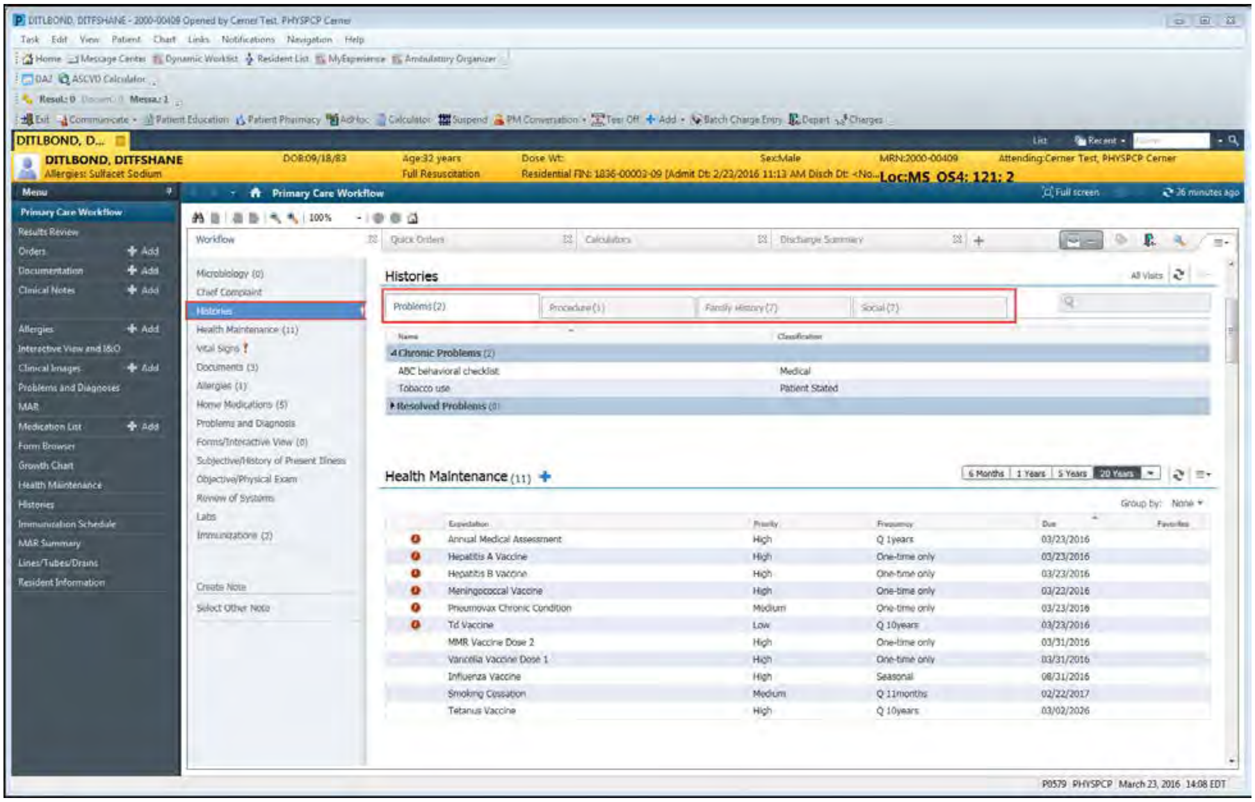
💻 The **Subjective/History of Present Illness** section of the document displays.



Subjective/History of Present Illness Section

13. Click in the **Subjective/History of Present Illness** field.
14. Type text.
15. Click **Save**.
16. From the **Primary Care Workflow** menu, click **Histories**.

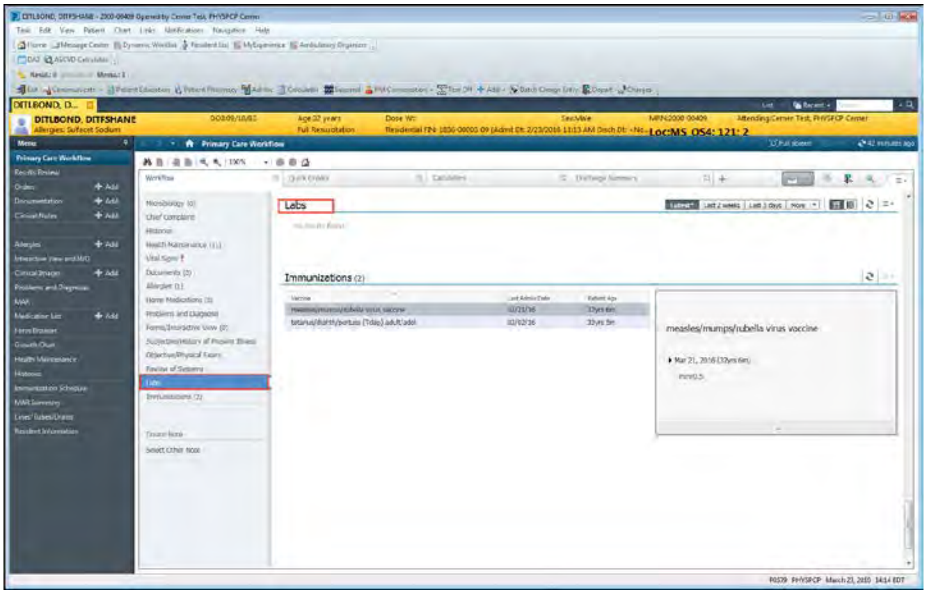
The **Histories** section of the document displays.



Histories Section

17. In the **Histories**, click the individual tabs view information.
18. From the **Primary Care Workflow** menu, click **Labs**.

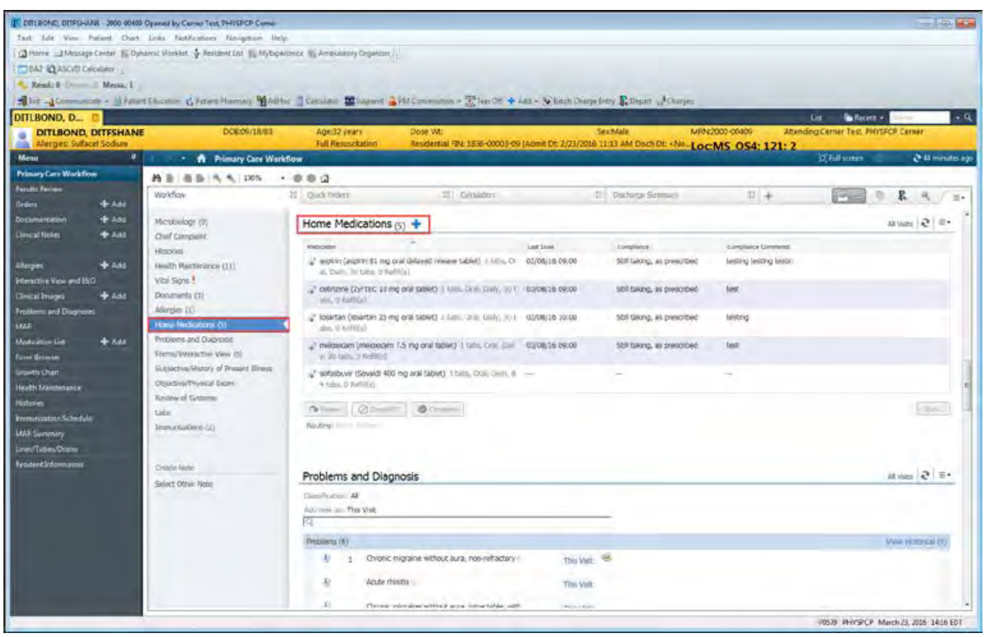
The **Labs** section of the document displays.



Labs Section

Note ► Filters are available to view **Labs** from a certain timeframe.

19. From the **Primary Care Workflow** menu, click **Home Medications**.



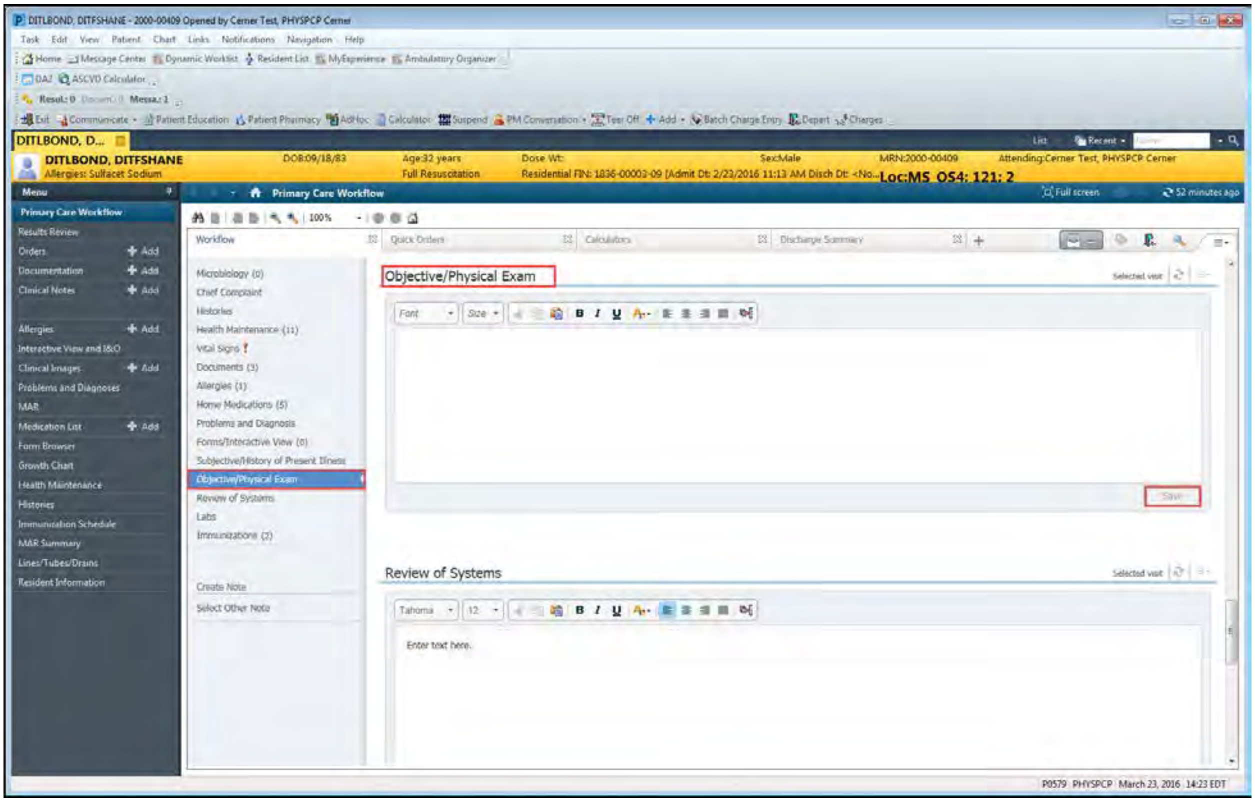
Home Medications Window

20. Click ( ) to **Add** medications.

Select an Objective/Physical Exam

1. From the **Primary Care Workflow** menu**, Workflow tab** click **Objective/Physical Exam**.

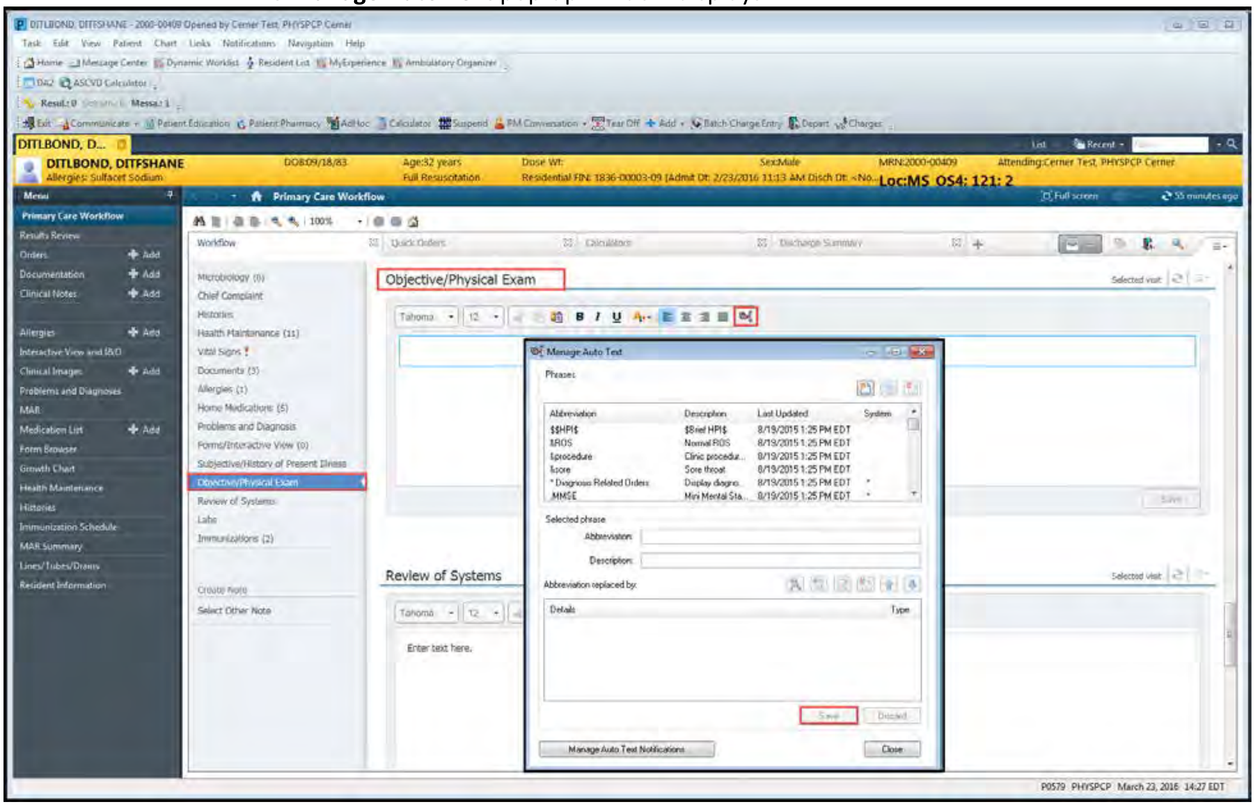
   - The **Objective/Physical Exam** section of the document displays.



Objective/Physical Exam Section

2. From **Objective/Physical Exam** click the **Auto Text** icon**.**

The **Manage Auto Text** pop-up window displays.

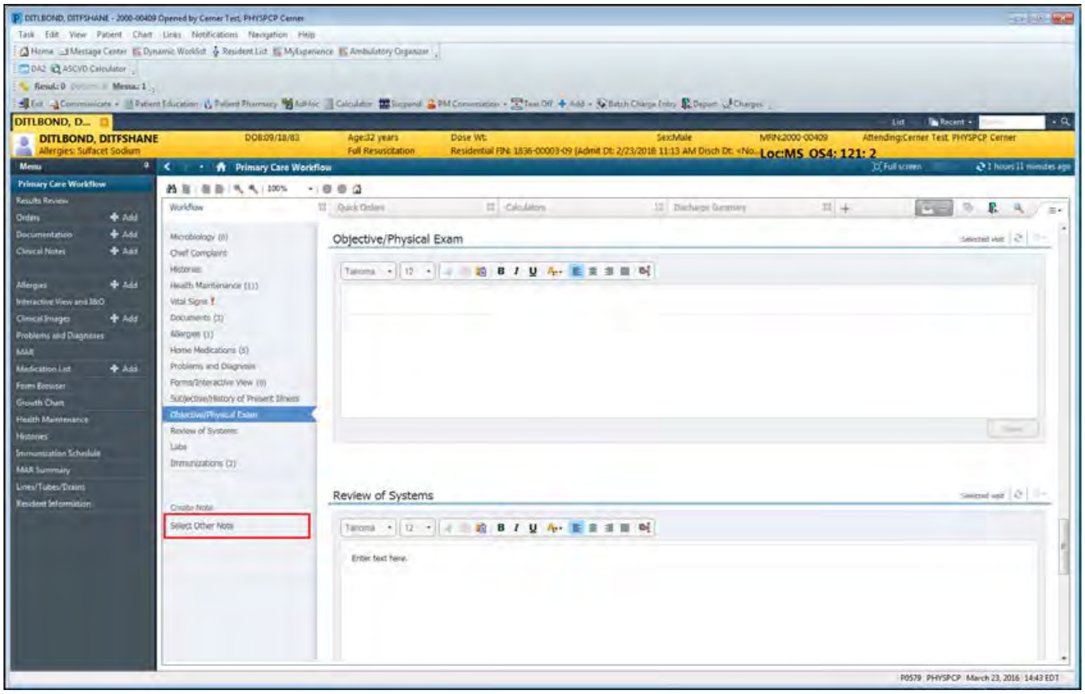


Manage Auto Text Pop-Up Window

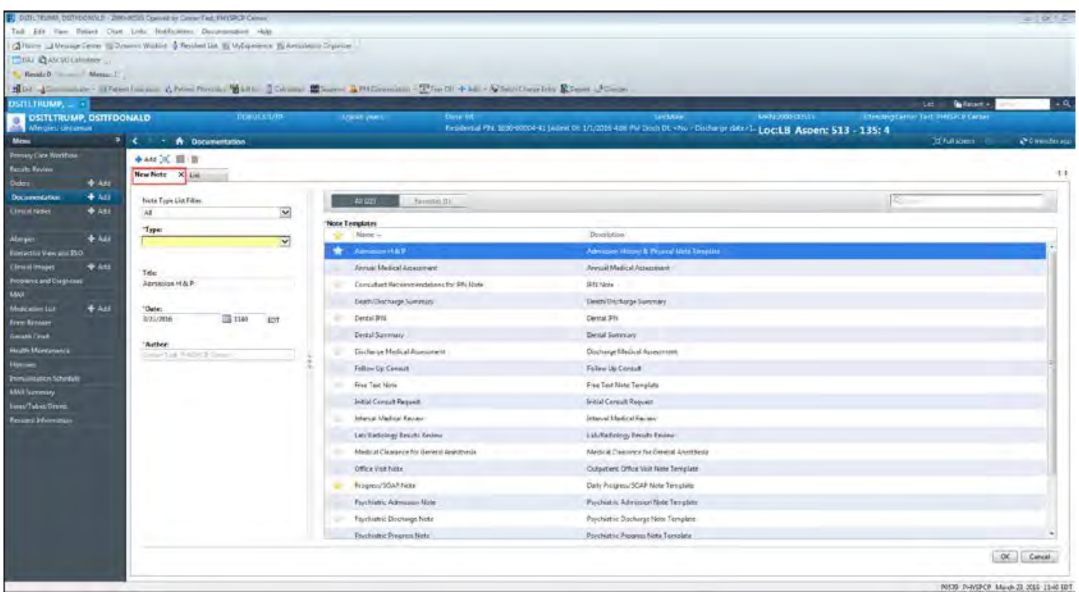
3. From the **Phrases** section of the **Manage Auto Text** pop-up window, click **Normal physical exam,** or a similar example.
4. In the **Abbreviation** field, type an abbreviation for the template.
5. In the **Details** field, click **Normal PE** or a similar example.
6. To save the auto text, click **Save**.

Create Notes

1. From the **Primary Care Workflow** menu click **Select Other Note**.

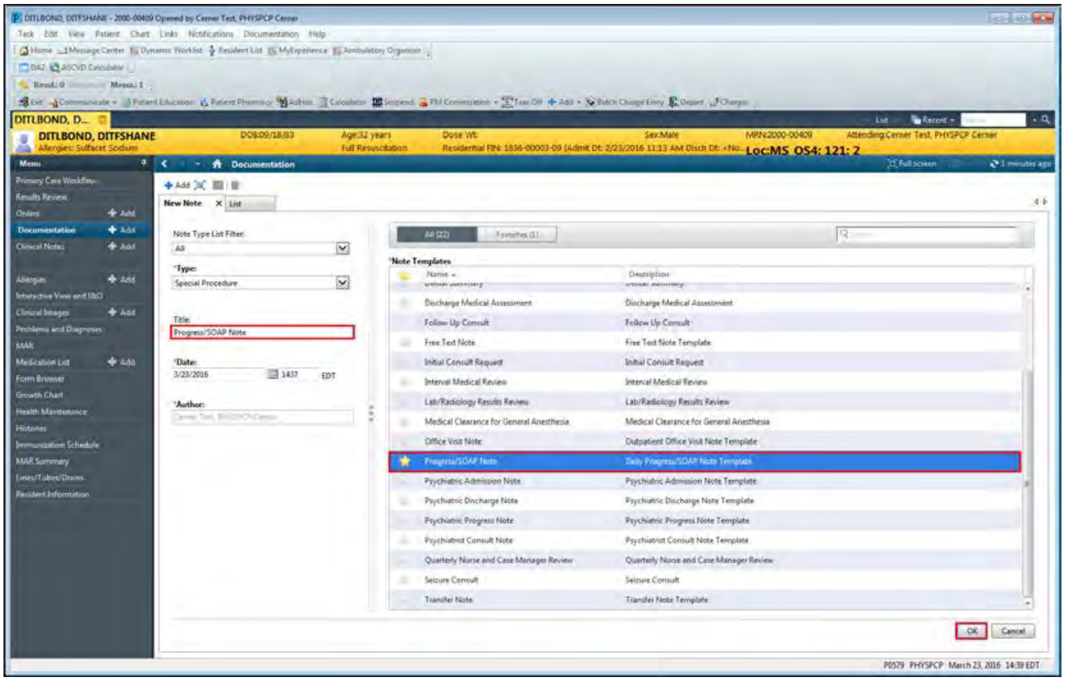


- The **New Note** window displays.



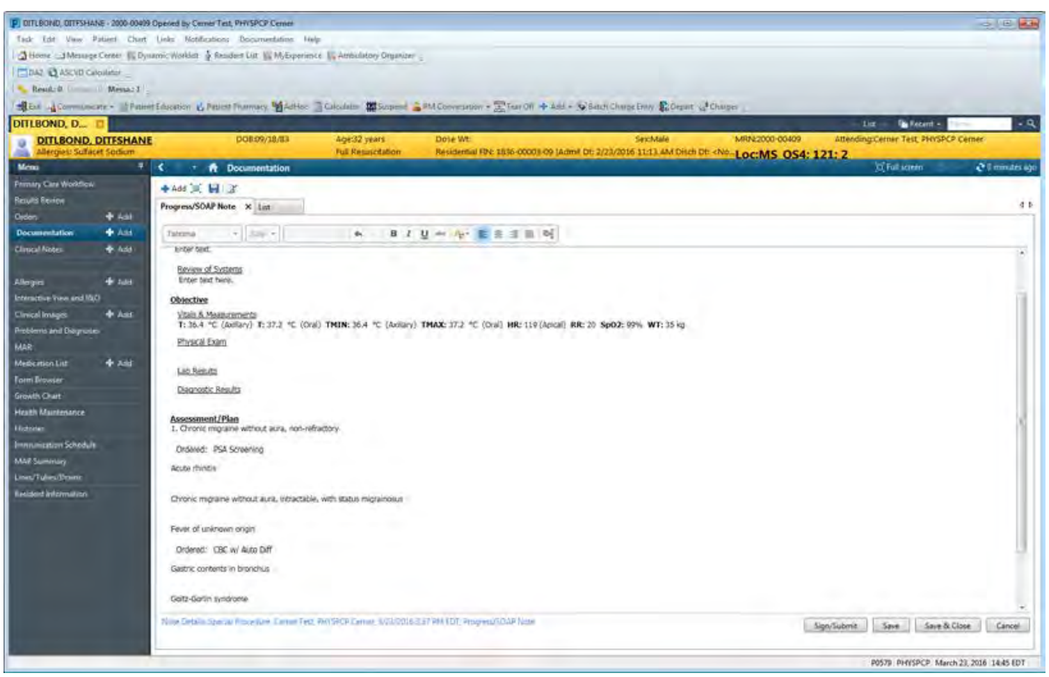
New Note Window

2. From the **Note Template** window, select **Progress/SOAP Note**.
3. Click **OK**.



Progress/SOAP Note Template Selected

- The **Progress/SOAP Note** displays.



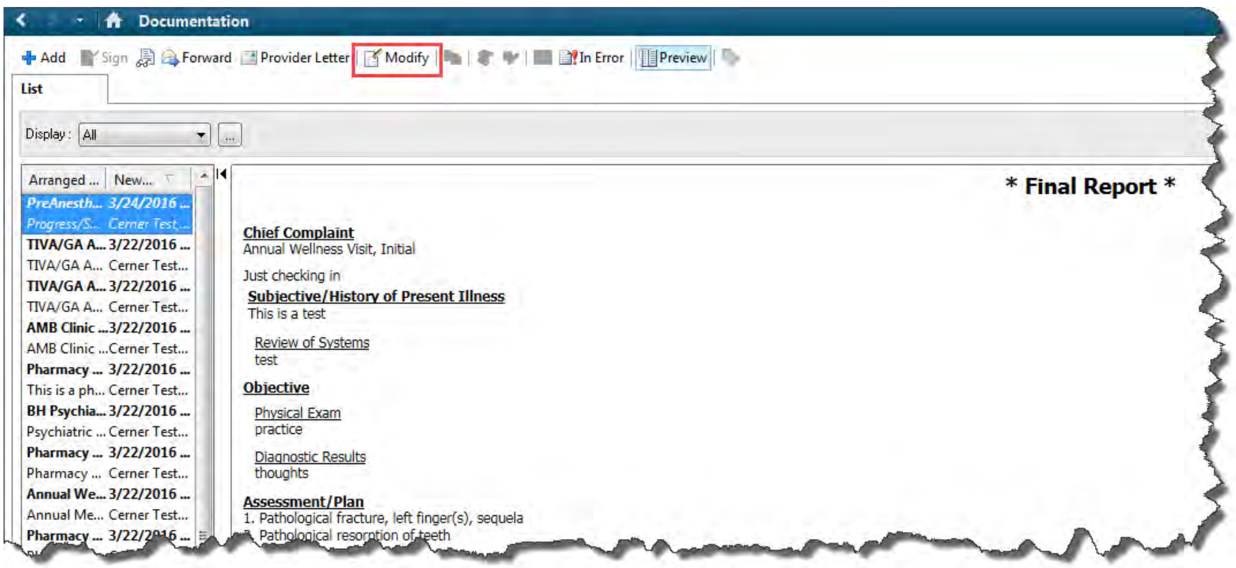
Progress/SOAP Note Template

4. Click **Sign/Submit** to complete the note.

After a Progress/SOAP note has been signed and/or submitted, the provider can make updates or modifications from the **Documentation** window.

1. From the Menu, click the **Documentation** band.

    - The **Documentation** window displays.



Documentation Window

2. Click the **Modify** icon to make any updates or changes.

Exercises

1. Review the resident's clinical information from the Primary Care Workflow window.
2. Chart an Objective/Physical Exam using auto text.

NON-SCHEDULED VISITS

Providers perform non-scheduled visits on residents whenever additional clinical needs arise. This may be an in-person visit or a conversation over the phone. It is important to document any pertinent information regarding the resident using the functionality outlined within this section.

Purpose

This section presents the provider workflow for completing a non-scheduled visit.

Objectives

- Manage the documents, messages and orders for a resident
- Access Resident Lists and select/add residents
- Update the resident's information
- Enter orders from the Quick Orders MPage
- Document a Progress Note from the Primary Care Workflow menu

Manage Documents, Messages, and Orders for a Resident

When conducting a non-scheduled visit, it is important to access and review any pending orders, documents, and messages from the **Message Center**.

> **Note** ▶ To review and process any pending orders associated with a resident, see the **Approve/Refuse Orders – Message Center** section above.

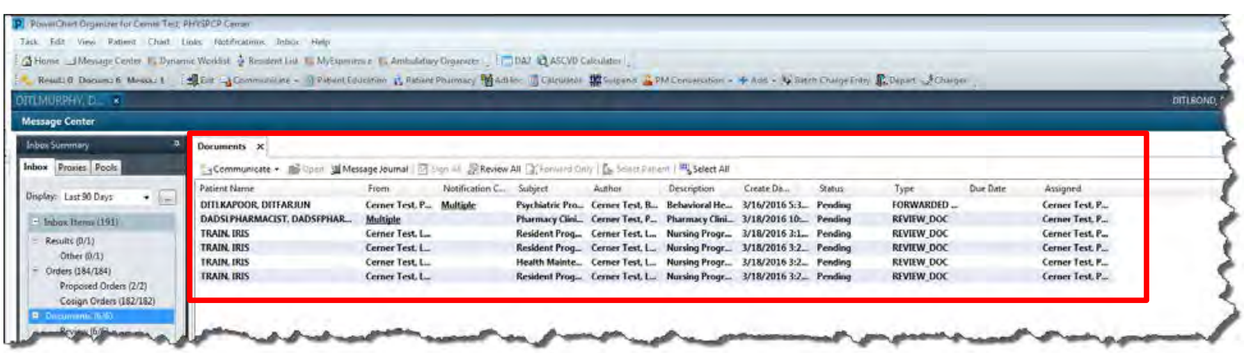
Documents

1. Log into **PowerChart** and access the **Message Center Inbox Summary**.

> **Note** ▶ Whenever a provider logs into **PowerChart**, the **Message Center** displays as the default screen.

2. Click the **Documents** band to access the **Documents** window.

   The **Documents** window displays.

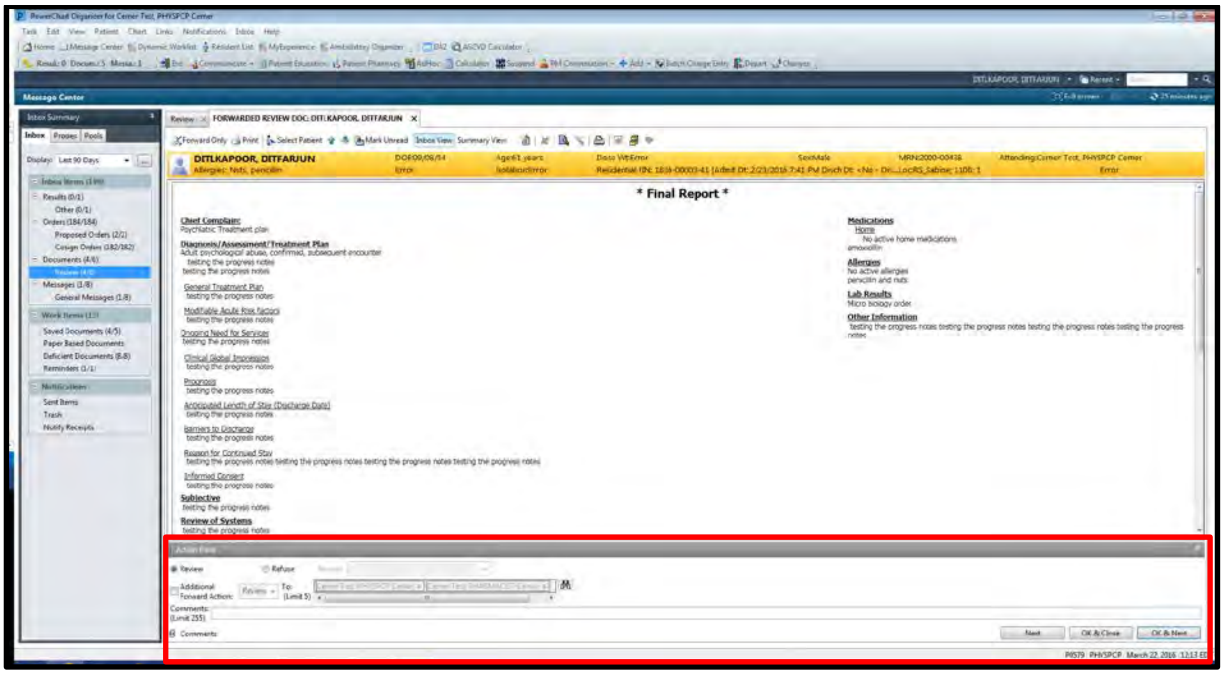


Documents Window

3. All items requiring a signature or review by the provider are displayed in the **Documents** window of **Message Center**.
4. Double-click a document row to open the **Final Report** for any document populated in the **Documents** window.

Tip ► A document can also be opened with a right-click on the appropriate row, and by selecting **Open**.

The **Documents - Final Report** window displays.

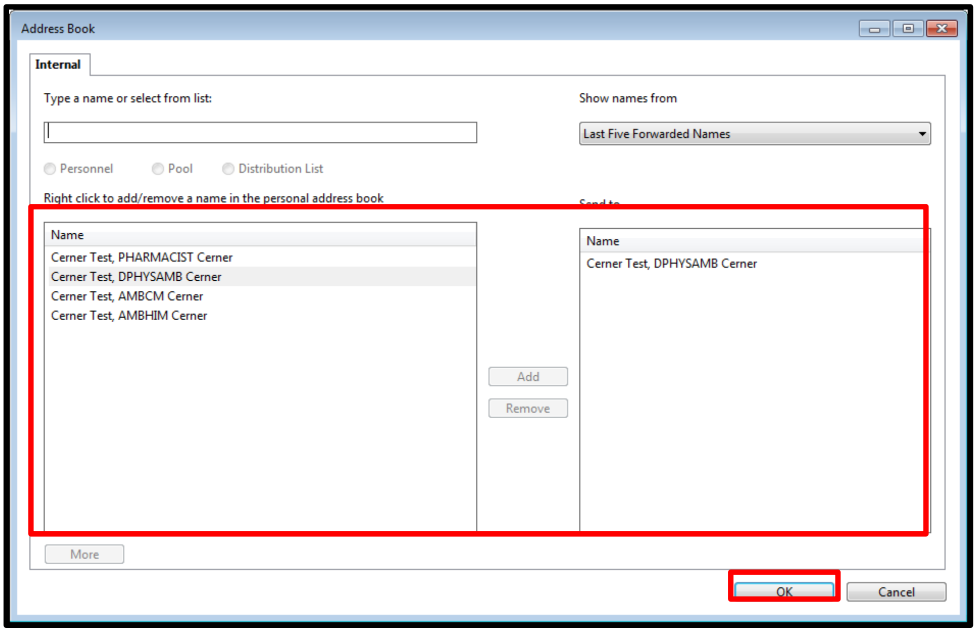


Documents - Final Report Window

5. To complete the review, select the **Review** radio button.
6. To enter a comment, type the information in the **Comments** box (there is a 255 character limit).
7. To complete the review and open the next document click **OK & Next**.
8. To forward a reviewed document to other providers, click **Additional Forward Action**.
9. To select recipient(s), click the find icon ( ) and enter the name(s).

Note ► A limit of five clinicians can be selected.

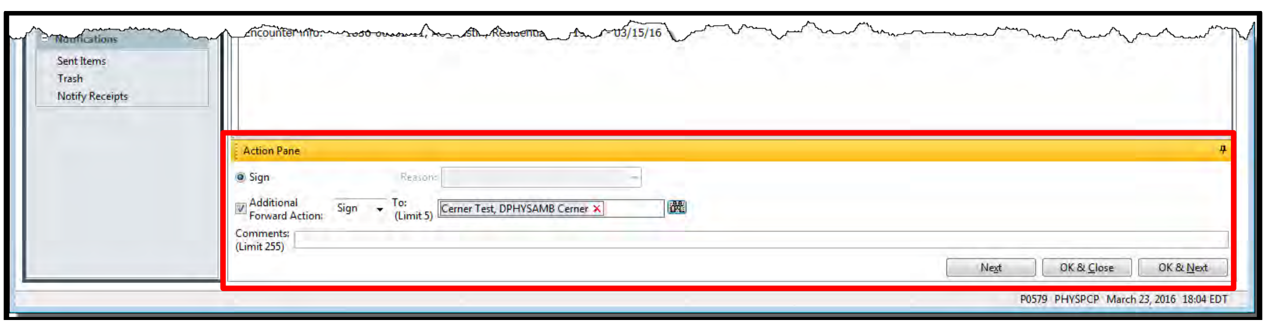
The **Address Book** pop-up window displays.



Address Book Pop-Up Window

10. Highlight the name(s) in the **Name** field to select recipients to receive a copy of the reviewed document in their **Message Center Inbox**.
11. Click the **Add** button.
12. The name moves into the **Send to** field.
13. To save the selected recipients, click **OK**.

The **Action Pane** window displays.



Action Pane Window

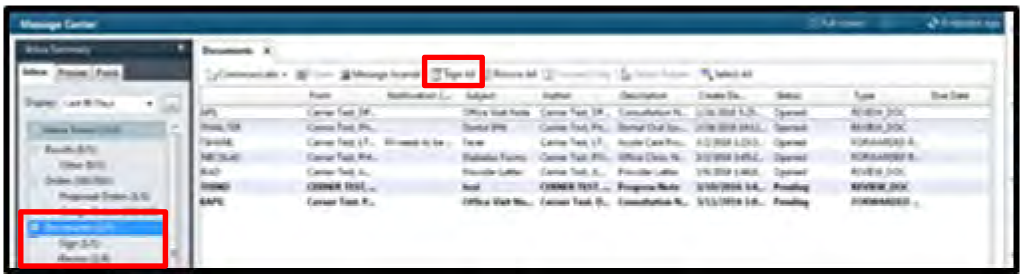
14. To complete the review and forward the document to the new recipient(s), click **OK & Close**.
15. To complete the review and move to the next message, click **OK & Next**.

Note ►	There are two additional folders under Documents. The **Sign** folder and the **Review** folder. These folders contain documents that require the signature of the provider or have been forwarded to the provider for review.

The Documents **Sign** folder gives providers the option to review each document individually. There is also the option to sign all documents at once.

💻 The **Documents to Sign** window displays.

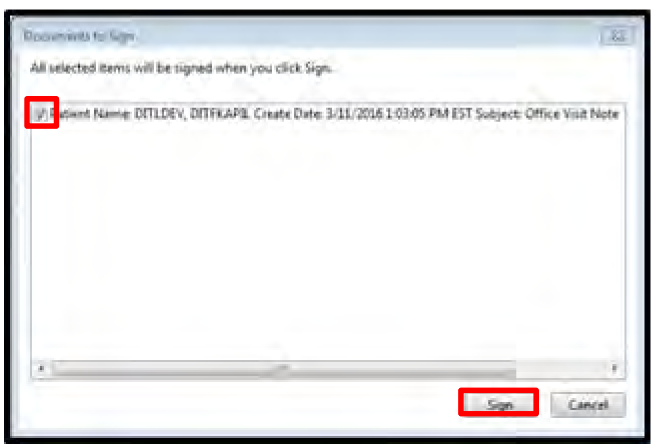
1. Click **Sign** in **Inbox Summary** for the **Sign** folder window to display.



Sign folder messages

2. From the **Sign** folder screen, click **Sign All**. This queues all reviewed documents to be signed.

💻 The **Documents to Sign** pop-up window displays.



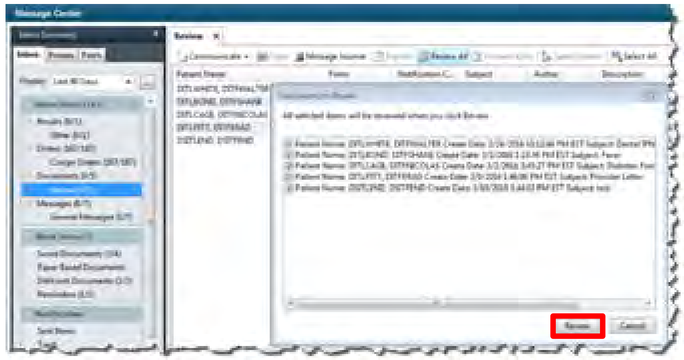
Documents to Sign Pop-Up Window

3. Mark the check box to the right of the document(s) to sign.
4. Click **Sign**. All of the identified documents are signed.

Similar to the **Sign** folder, the **Review** folder has the same option to mark all selected documents as reviewed.

1. To mark all selected items as reviewed, click **Review All**.

> **Note** ▸ This queues all the documents to be marked as reviewed.



Review Documents Window

2. Click **Review** to complete the process.

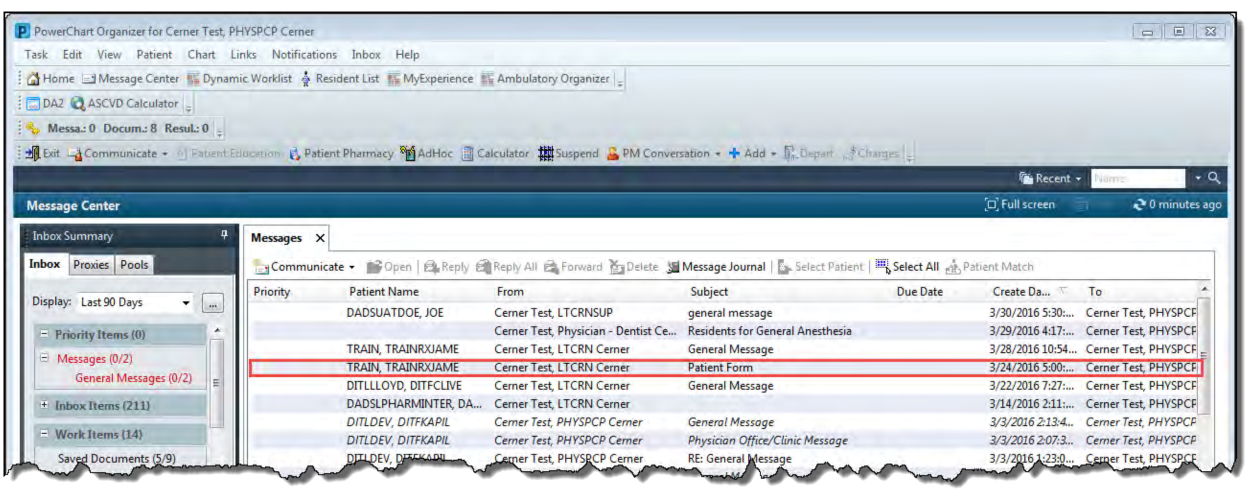
Messages

1. Log into **PowerChart** and access the **Message Center Inbox Summary**.

> **Note** ▸ Whenever a provider logs into **PowerChart**, the **Message Center** displays as the default screen.

2. Click the **Messages** band to access the **Messages** window.
3. From the **Messages** window, all received messages for the residents associated with the provider are displayed.

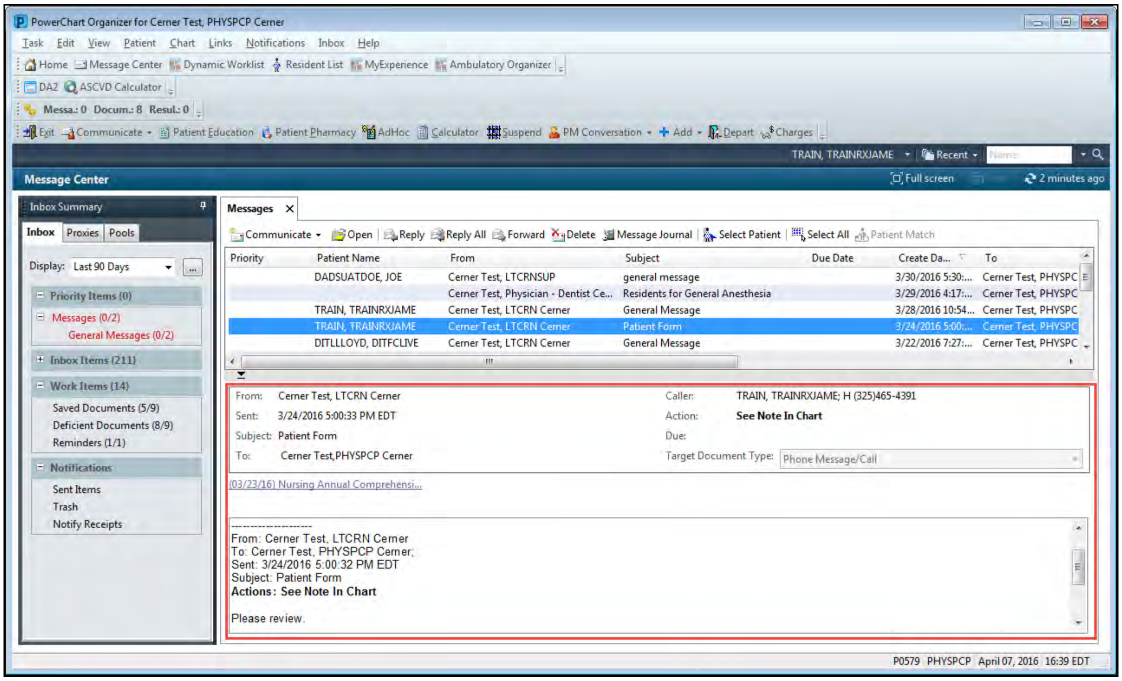
    The **Messages** window displays.



Messages Window

4. Click a message row to view the contents of the message on the lower half of the window.

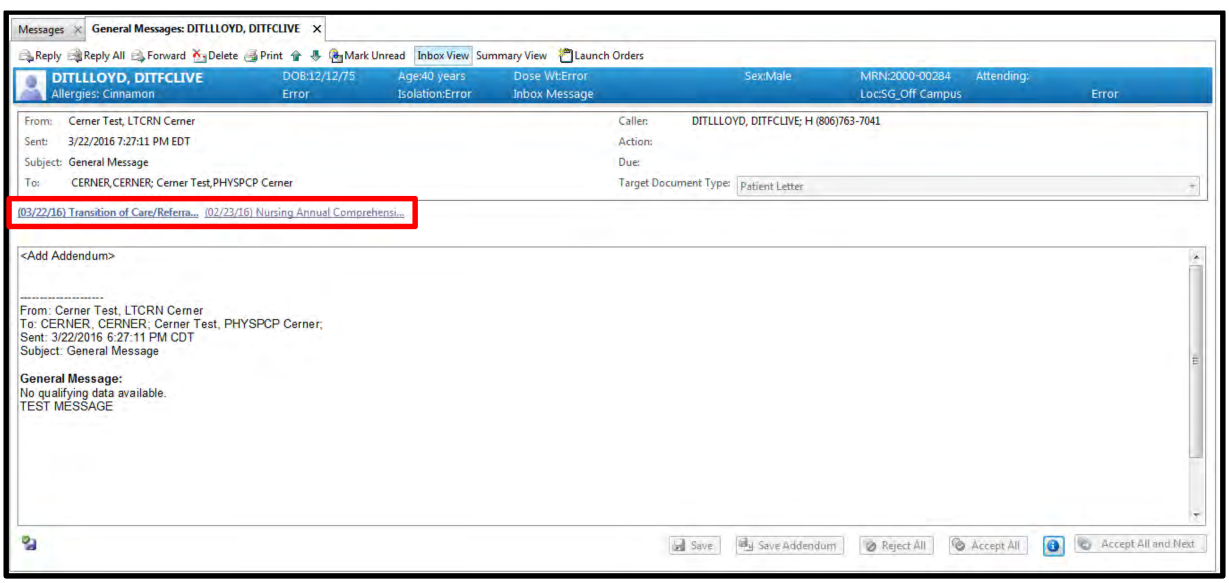
- The **Message Detail** displays.



Messages Detail

Message Attachments

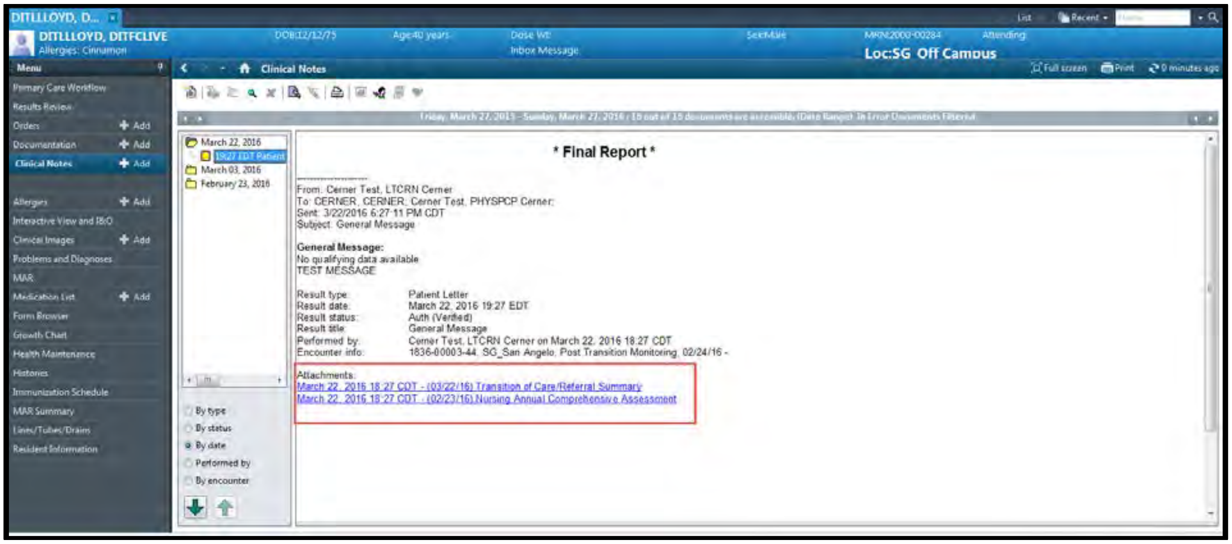
If a message contains any attachments, they are saved directly to the resident's chart.



Message Window – Attachments

1. From the resident's **Menu**, click the **Clinical Notes** band.

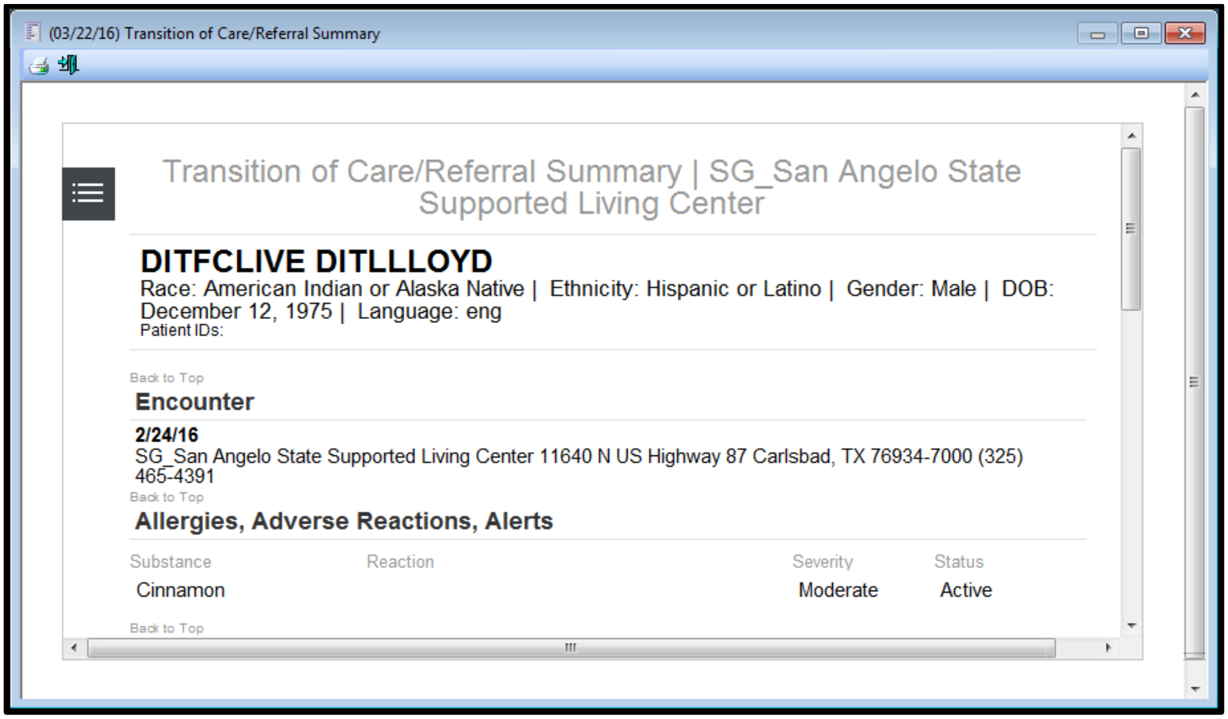
💻 The **Clinical Notes** window displays.



Clinical Notes Window

2. Double click the date folder from the day the message was received.
3. Double click the message to view the item.
4. Double click the link to view the attachment.

The attachment pop-up window displays.

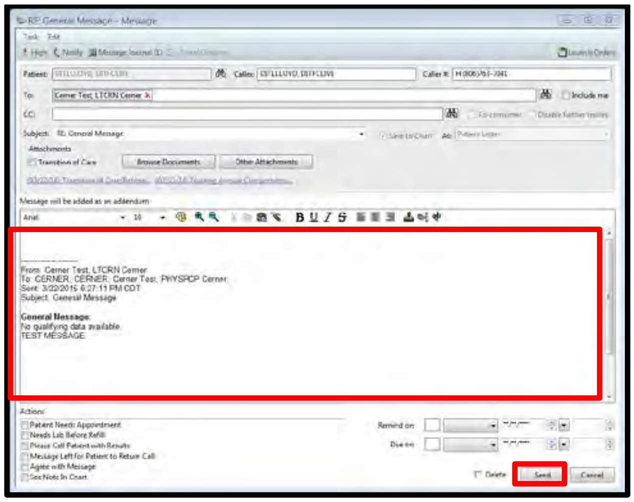


Message Attachment

Reply to a Message

5. From the **Messages** window, select a message and click the **Reply** button to send a reply message.

   The **Reply Message** pop-up window displays.



Reply Message Pop-Up Window

5. From the **Reply Message** pop-up window, type the desired message and click **Send**.
6. Additional actions that may be taken are as follows:
   a. Click **Browse Documents** to attach documents to the message.
   b. Click an **Actions** check box to associate any of the listed actions with the message.

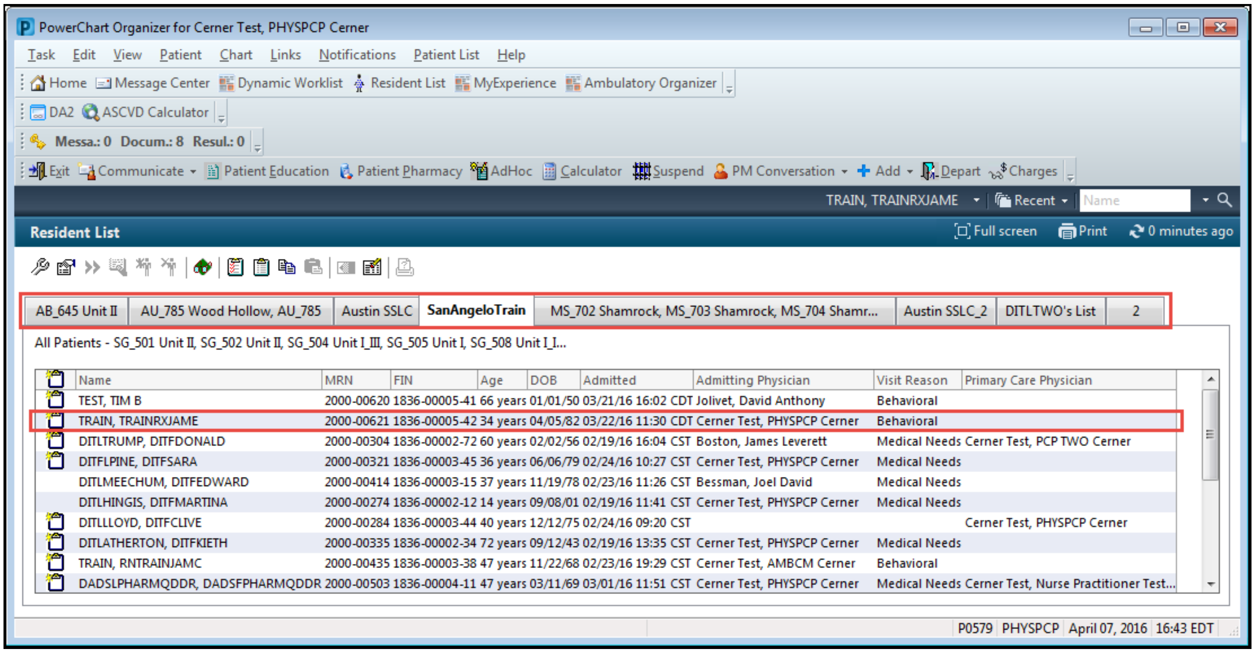
> **Note** ▸ Providers are not able to send messages directly to nurses through the **Message Center**. A nurse can send a message, respond to a resident's chart or add an IPN note. To communicate directly with a nurse, the provider must connect outside of the system.

Access Resident Lists and Select/Add Residents

Resident Lists allow providers to organize and easily access large amounts of clinical data. Most **Resident Lists** are populated automatically by the system while others are built manually. The lists that display are determined by the individual provider. A specific resident's chart can be opened directly from a **Resident List**, but first a relationship must be established with the resident.

1. From the **Action Toolbar**, click **Resident List** to display a list of Long Term Care (LTC) residents.

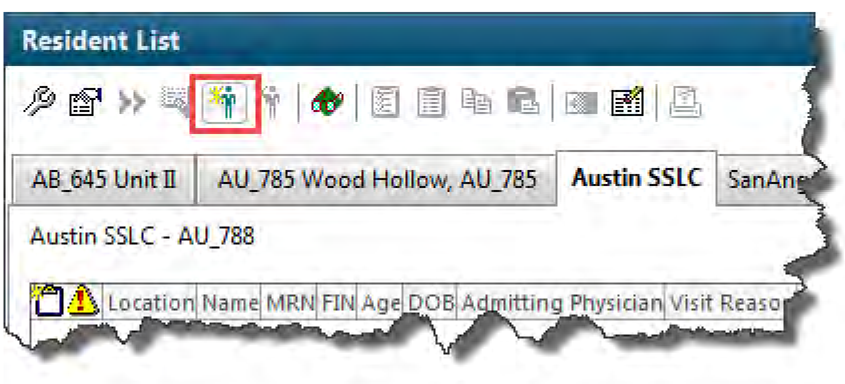
The **Primary Care Workflow** window displays.



Resident List Window

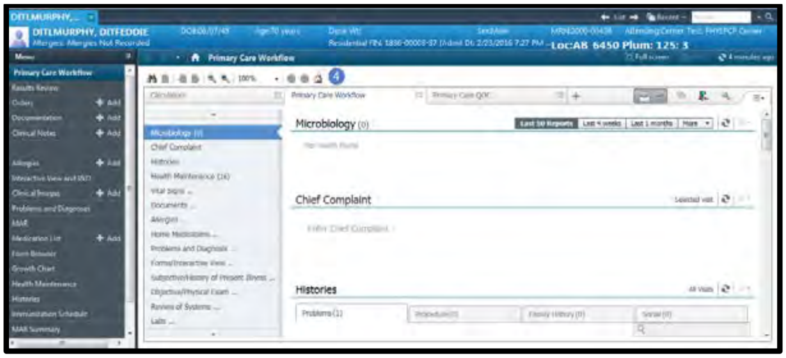
2. To view a specific **LTC Facility** list, click the **Facility** name tab to display the list contents.
3. To view a specific resident's chart, double-click the row identified by the resident's name.

Note ► If an association already exists with a resident manually add a resident to an existing **Resident List**, click the **Add Patient** icon.



Add Patient Icon

The **Primary Care Workflow** window displays.



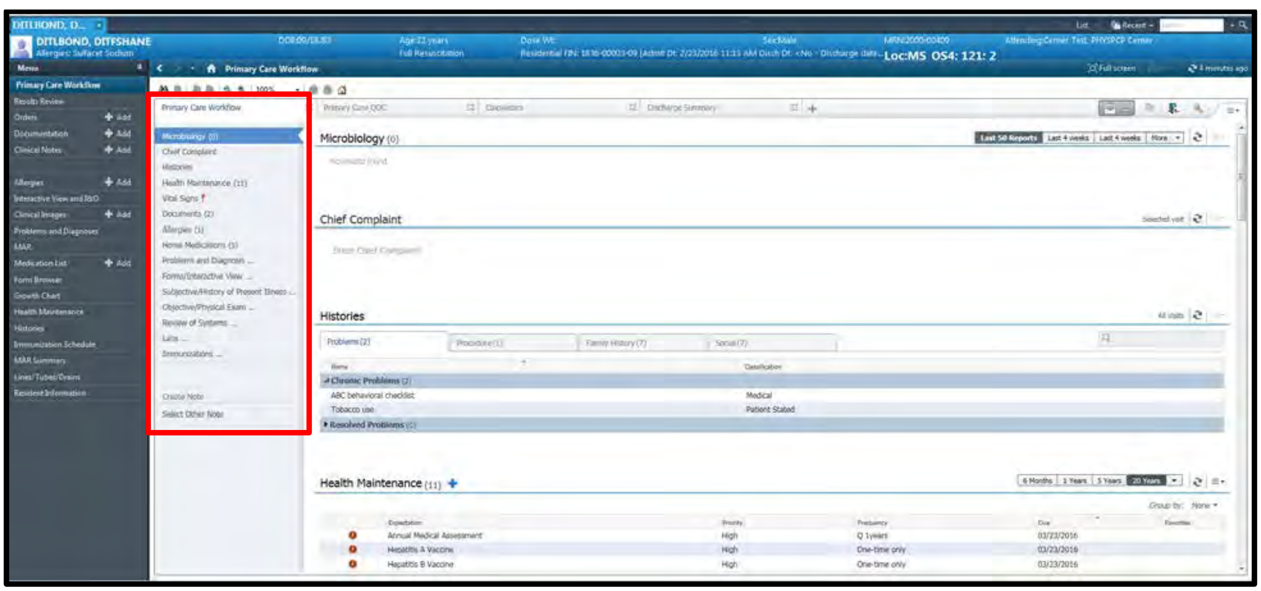
Primary Care Workflow Window

Note ▸ The **Primary Care Workflow** window contains a **Chart** menu to streamline completion of all the necessary visit documentation.

Update Resident Information

Access to accurate past and current clinical information helps to provide ongoing quality care for LTC residents. This information, both past and present, is viewed and updated from the **Primary Care Workflow** menu. Click the **Primary Care Workflow** band from the resident's **Chart** Menu, and the clinical contents are viewable and new information is entered as appropriate.

The **Primary Care Workflow** window displays.



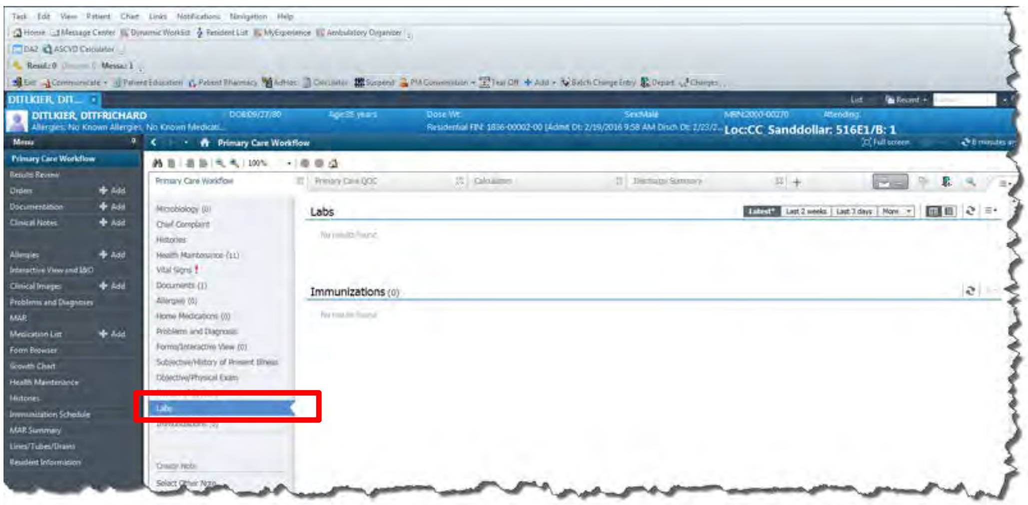
Primary Care Workflow Menu

Note ▶	From any window accessed from the Primary Care Workflow menu, click the **Refresh** icon to verify that the contents of the window are the most up to date.

View Lab Results

1. From **Primary Care Workflow** menu, click the **Labs** band to view the most recent lab results.

   The **Labs** window displays.



Labs Window

2. From the filters on the right side of the window, click a tab to display lab results by the selected timeframe.

Vital Signs

The **Vital Signs** window contains both past and present vital sign records. Current vital signs for a resident can be entered in this section.

1. From the **Primary Care Workflow** menu, click the **Vital Signs** band to display the latest vital sign readings of the resident.

   The **Vital Signs** window displays.

Vital Signs Window

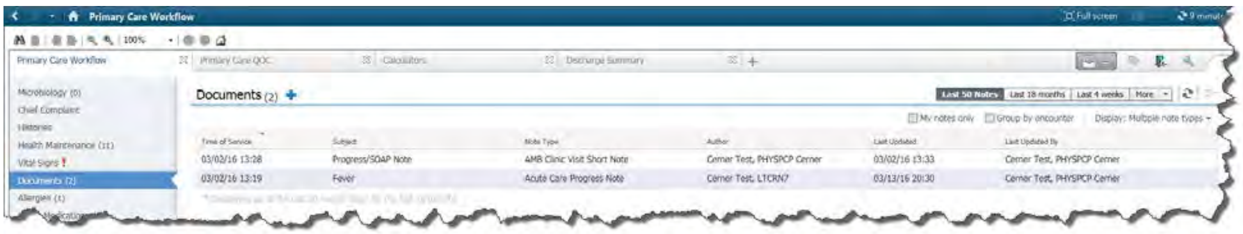
2. From the filters to the right of **Vital Signs +**, click a tab to view all vital signs over the selected timeframe.

Documents

The Documents band in the Primary Care Workflow menu contains past and present documentation entered by all providers.

1. From the **Primary Care Workflow** menu, click the **Documents** band to open the **Documents** window.

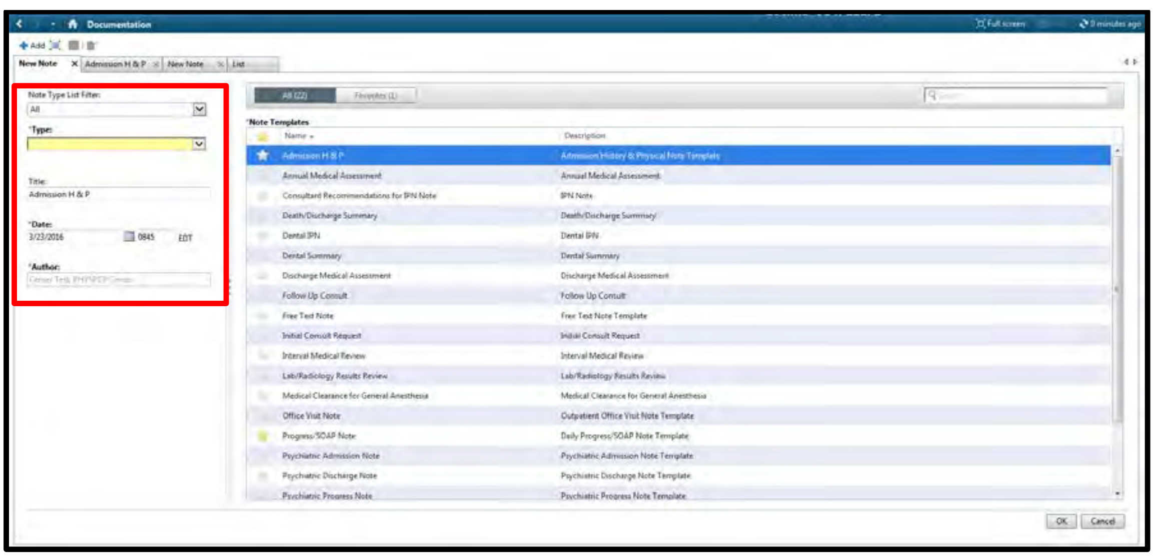
    The **Documents** window displays.



Documents Window

2. Similar to the other windows, documents can be filtered by timeframes selected from the right side.
3. Providers can view only the notes that they are associated with by clicking the **My notes only** check box.
4. To enter a new note, click **Documents +**.

    The **New Note** window displays.

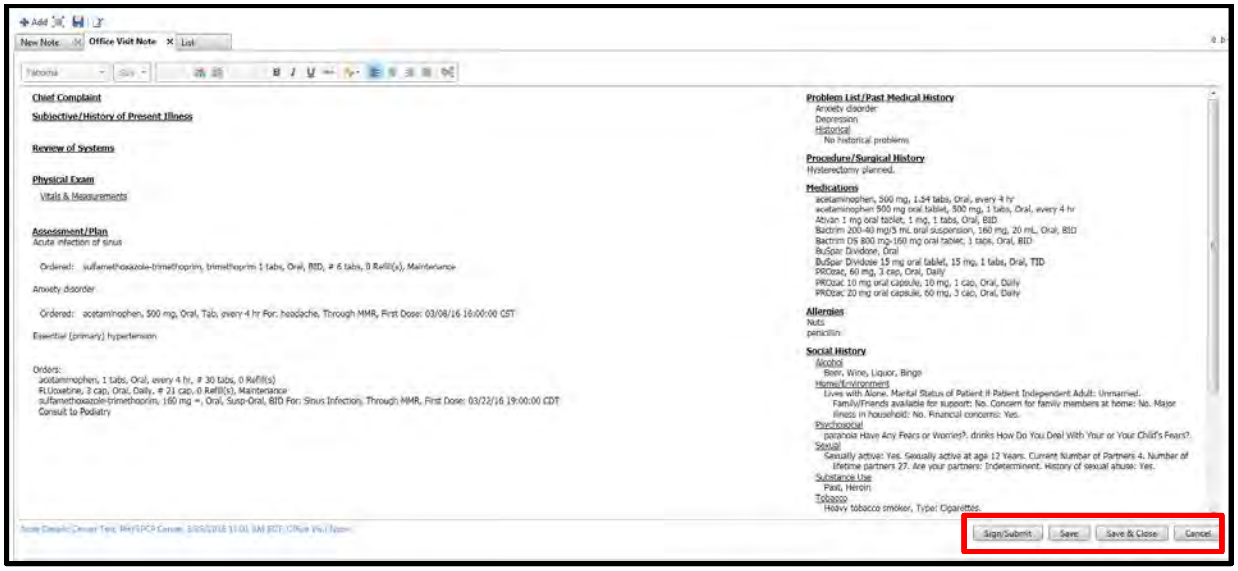


Documentation - New Note Window

5. Select **Office Visit Note** from the Type drop-down.
6. In the **Title** field, enter **Office visit** for the resident.
7. To open the **Office Visit Note** template, click **OK.**

> **Note** ▸ Double click the **Office Visit Note** template from the **Note Templates** window to open the new note directly.

- The **Office Visit Note** screen with prepopulated text displays.



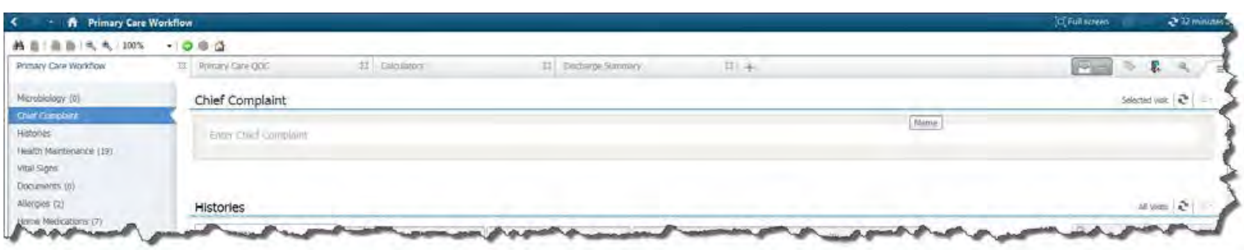
New Office Visit Note Window

8. Enter clinical updates from the visit.
9. To sign the note and submit the documentation, click **Sign/Submit.**

Chief Complaint/Visit Diagnosis

1. From the **Primary Care Workflow** menu, click the **Chief Complaint** band to open the **Chief Complaint** window.

- The **Chief Complaint** window displays.



Chief Complaint Window

2. From the text box, type the applicable chief complaint of the resident (up to 255 characters).

Note ▶	This is the reason for the visit and not necessarily the resident's diagnosis.

The bottom of the **Chief Complaint** window displays.

Chief Complaint Window - Sign

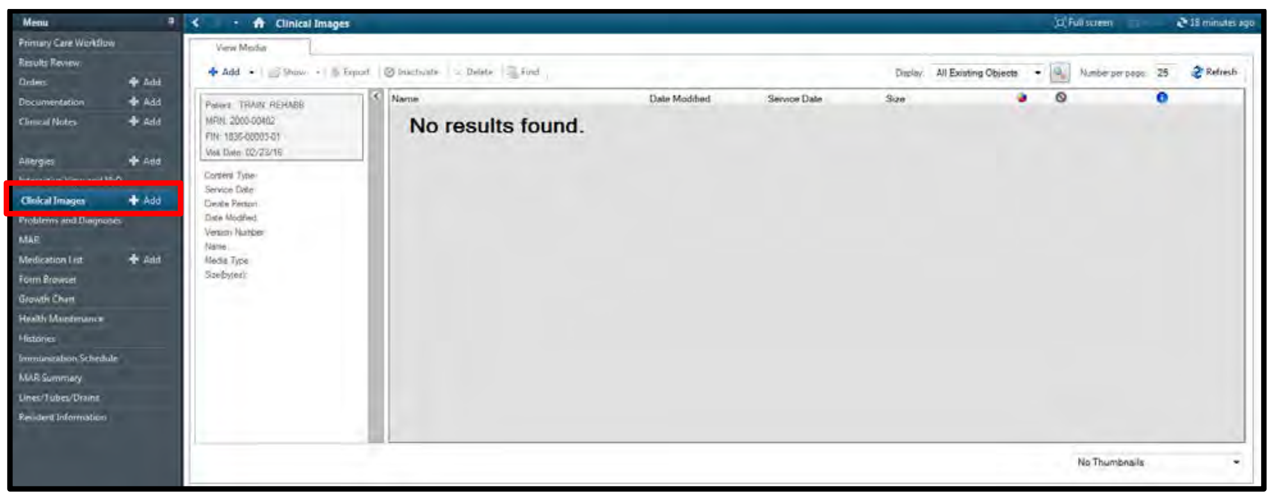
3. From the lower right corner of the screen, click **Sign** to save the entry.

Imaging

From the **Chart** menu, providers are able to view clinical images**.**

1. Click **Clinical Images** to View Media.

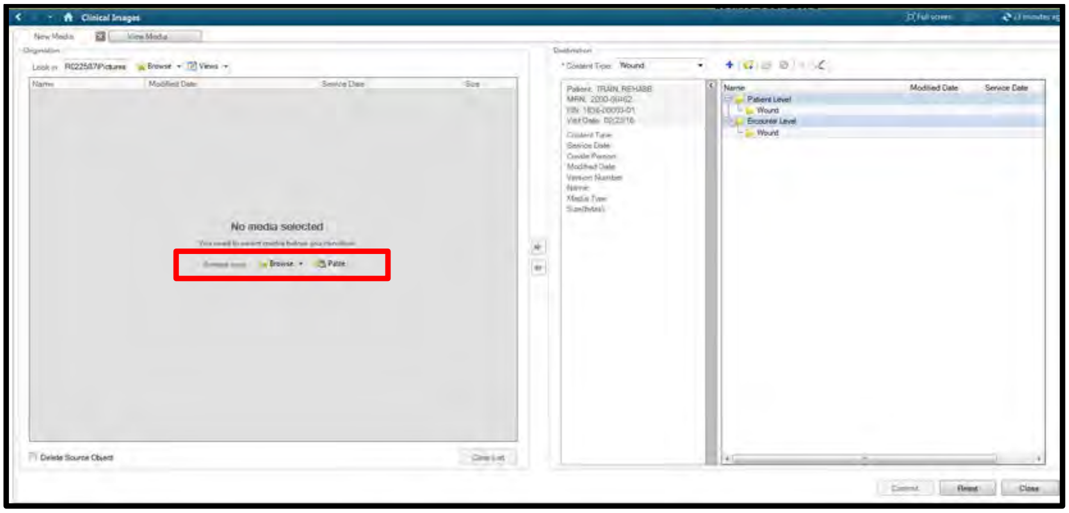
The **View Media** window displays.



Clinical Images Window: View Media

2. To add new clinical images, click the **Add** icon.

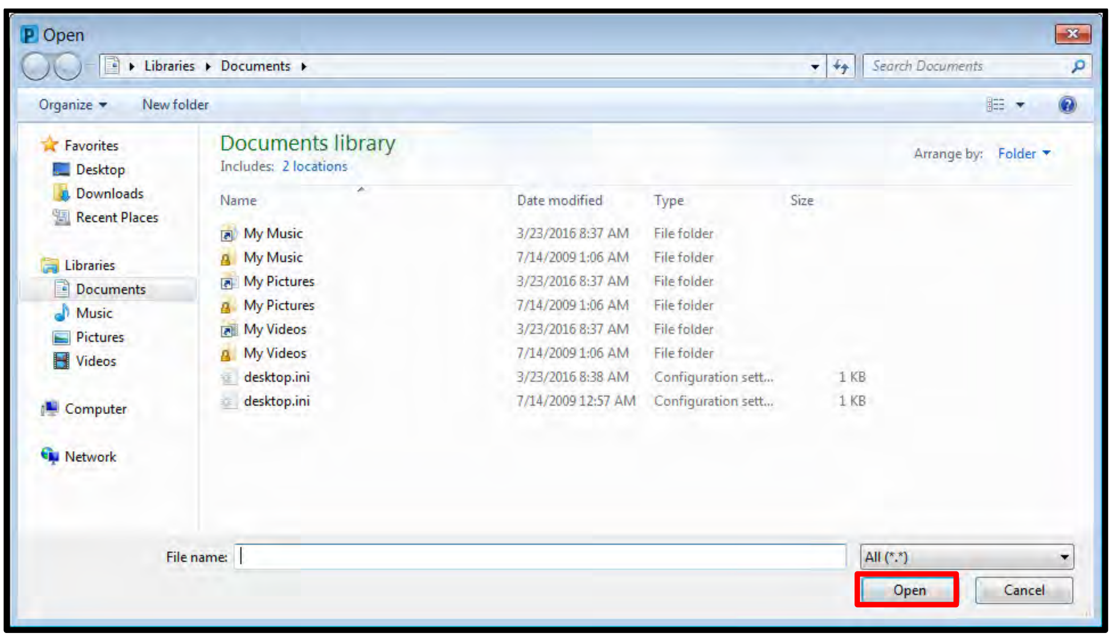
- The **New Media** window displays.



New Media Window

3. From the **New Media** window, browse for media files by clicking the **Browse** icon.

- The **Document Search** pop-up window displays.



Document Search Pop-Up Window

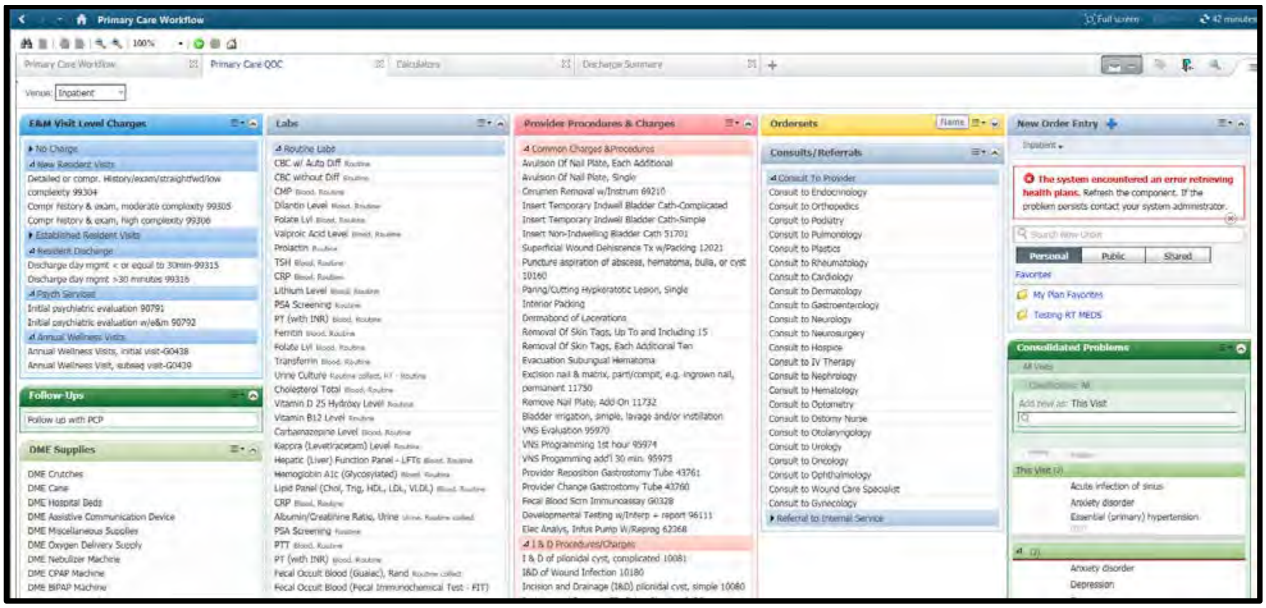
4. Locate the appropriate media file and click **Open**.
5. The file populates in the **New Media** window. Click **Commit** to add the clinical image(s) to the resident's chart.

Enter Orders from the QuickOrders MPage

The Quick Orders MPage is an interactive library of commonly used orders and charges in a centralized location. In the LTC setting, orders are accessible from the Primary Care Quick Orders and Charges (QOC) window. The Primary Care QOC window is located in the Primary Care Workflow workspace.

1. To access the **Quick Orders MPage**, click the **Quick Orders** tab.

    The Primary Care **Quick Orders** window displays.



Primary Care Quick Orders Window

2. From the **Quick Orders** window, click on the names of individual labs, procedures, supplies and professional charges to order for a visit.
3. From the upper right corner of the screen, click the **Orders for Signature** icon ( ).

    The **Orders for Signature** pop-up window displays.

Orders for Signature Pop-Up Window

4. To associate a diagnosis with a single order, click inside a cell. To associate a diagnosis with all orders, click the diagnosis name. Each associated order is populated on the grid with the corresponding diagnosis to the right.

If an order has been entered in error or needs modifications:

1. From the lower right corner of the **Orders for Signature** pop-up window, click **Modify** to edit any of the orders before signing.
2. To the left of the listed order, click to display order details and edit as necessary.
3. From the lower right corner of the screen, click **Sign** to complete the order(s)**.**

If the orders are correct as entered:

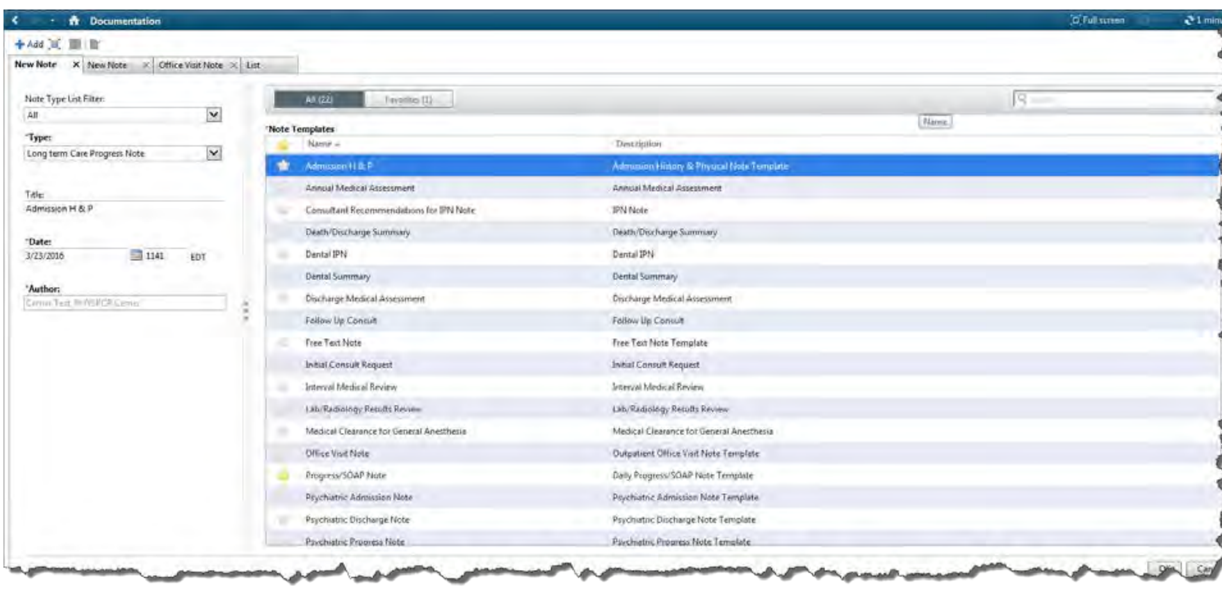
1. Click **Sign** on the **Orders for Signature** window to complete the orders.
2. The screen returns to the **Quick Order** window.

Document a Long Term Care Progress/SOAP Note from the Primary Care Menu

The final step in completing a non-scheduled visit on an LTC resident is to enter a **Progress Note**. The **Progress Note** template is prepopulated with clinical information that has been entered during the LTC visit.

1. Collaborate with resident's nurse.
2. From the **Primary Care Workflow** menu**, Workflow tab**, click **Select Other Note**.

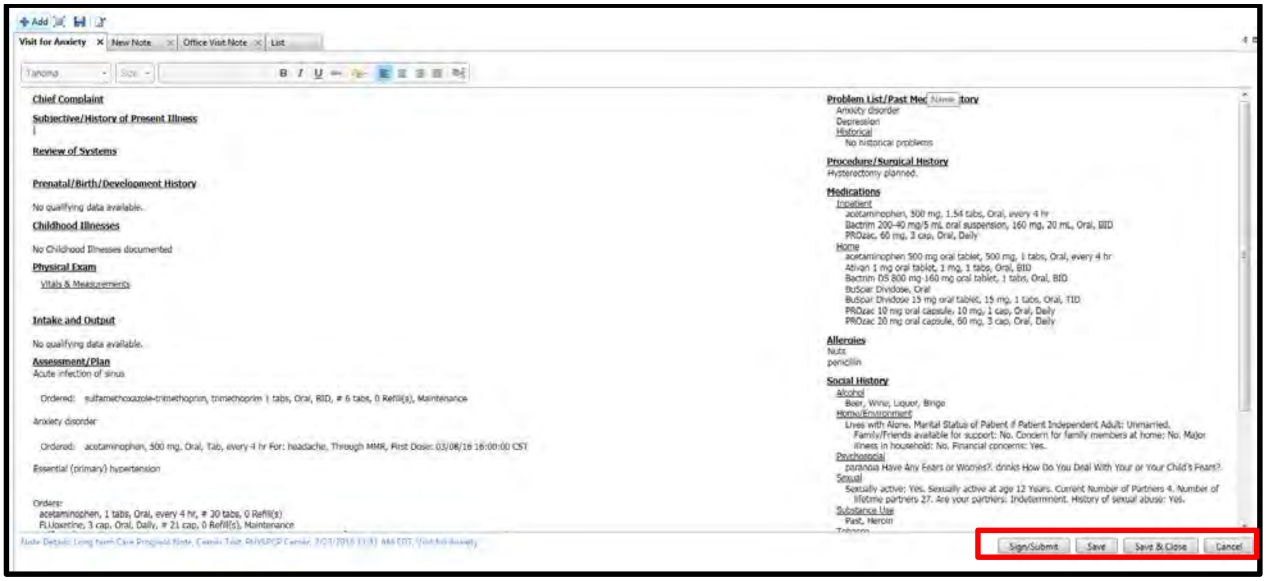
   The **New Note** window displays.



New Note Window

3. From the **Type** drop-down menu, enter **Long Term Care Progress Note** then choose the template from the **Note Templates**.
4. In the **Title** field, enter **Visit for** (diagnosis for today's visit).
5. To open the **Long Term Care Progress Note** select the template from the **Notes Template** and click **OK.**

The **Long Term Care Progress Note** window displays.



Long Term Care Progress Note Window

6. Enter clinical updates from today's visit.
7. In the lower right corner of the **Progress Note** window click:
   a. **Sign/Submit** to endorse the note and complete documentation.
   b. **Save** to save the note and complete documentation later.
   c. **Save & Close** to save the note and exit the documentation field.
   d. **Cancel** to discard the note.

Exercise

Complete the following exercises. Reference the workflows from the lesson as a guide.

1. Enter an order for a chest x-ray to be performed On Campus.
2. View the message stating that the test is complete.
3. View the resident's chest x-ray results in the paper chart.
4. Document the major findings in a Lab/Radiology Results Reviewed note template.
5. Add the resident to your Resident List.
6. Review and Update the following information:
   a. Labs
   b. Vital Signs
   c. Documents
   d. Imaging
   e. Problems/Diagnoses
7. Enter orders from the Quick Orders MPage:
   a. Hgb A1c to be performed at the Austin State Lab
   b. BMP to be performed at a Local Lab
8. Enter an LTC Progress Note.

HEALTH MAINTENANCE

Health Maintenance initiatives are lists of recommended screenings, preventative care monitoring and disease management recommendations for residents based on age, gender, risk factors and documented clinical conditions. A resident's health maintenance status is reviewed and updated during each provider visit.

Purpose

This section presents the provider workflow for updating Health Maintenance expectations.

Objectives

- Locate a health maintenance profile for a resident
- Review pending and overdue health maintenance expectations
- Update health maintenance expectations
- Add a health maintenance expectation

Locate a Health Maintenance Profile for a Resident

1. From the **Menu**, click **Health Maintenance** band.

    The **Health Maintenance** window displays.

Health Maintenance Plan

Review Pending and Overdue Health Maintenance Expectations

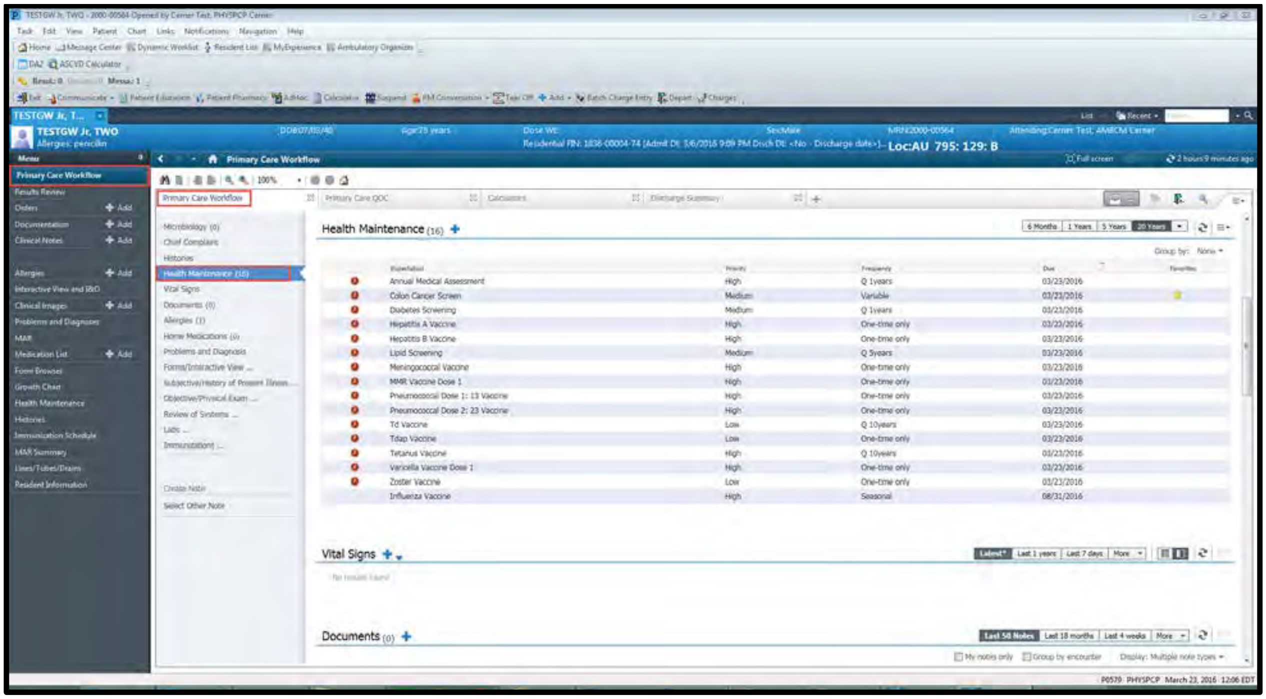
> **Note** ► The **Health Maintenance** window is divided into two sections:
> 1. **Pending Expectations** – Lists of health screenings, vaccines, labs, and procedures that are recommended but have yet to be completed.
> 2. **Recently Satisfied Expectations** – Health maintenance Expectations that have been completed.

Add a Health Maintenance Expectation

Use this workflow to create a Health Maintenance Expectation.

1. From the **Menu**, click the **Health Maintenance** band.

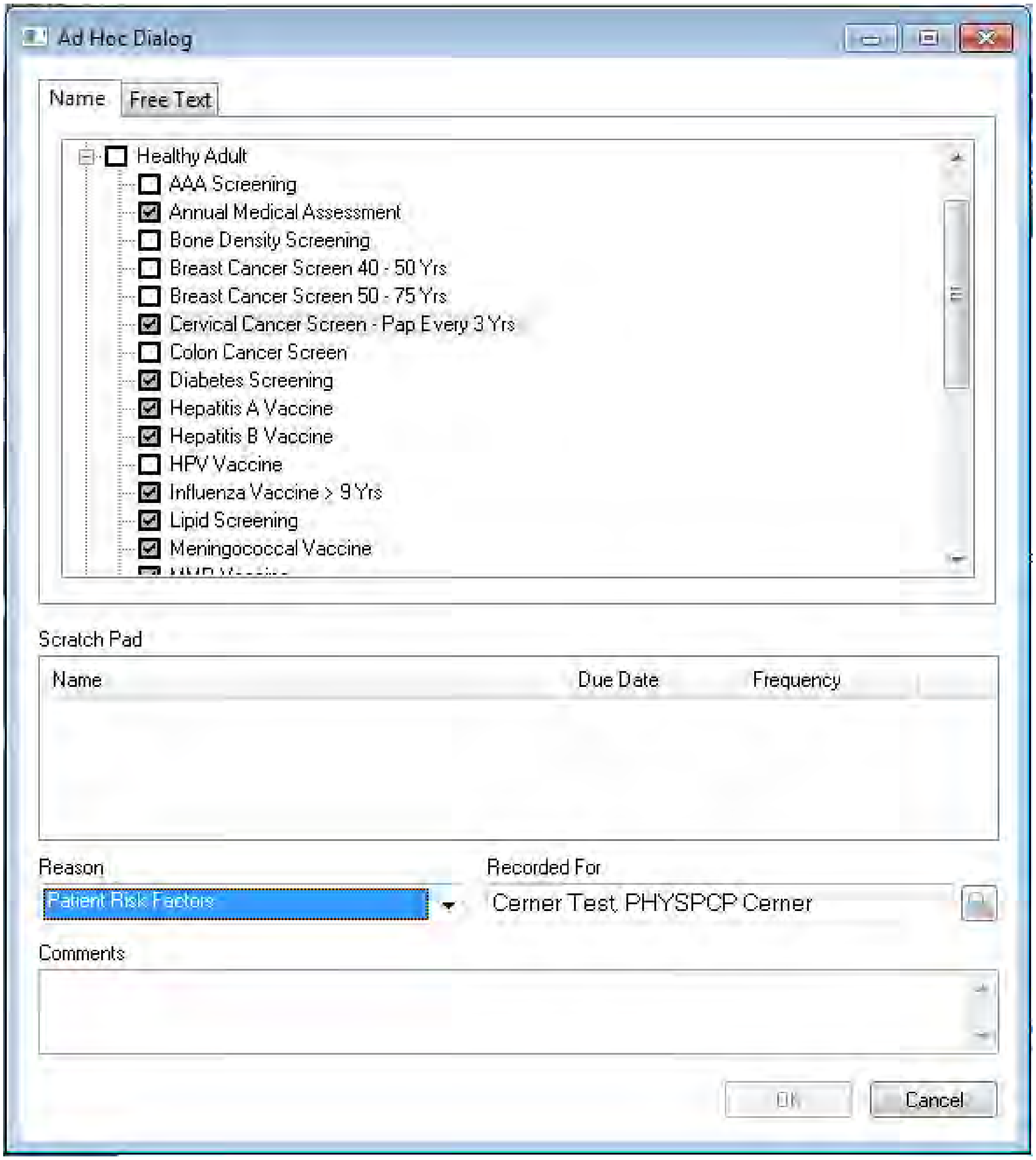
    - The **Health Maintenance** window displays.



Health Maintenance Window

2. From the **Health Maintenance** window, click .

The **Ad Hoc Dialog** pop-up window displays.



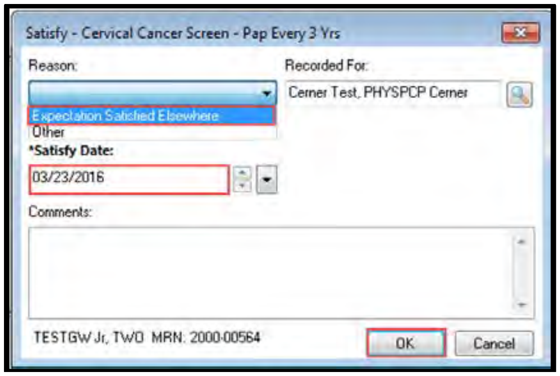
Add Expectations pop-up window

3. Click the black plus sign to expand the **Healthy Adult** category.
4. Mark the **Cervical Cancer Screen – Pap Every 3 Yrs** checkbox.
5. The **Selected Expectations** field populates with the screenings that are due, date and frequency. Update as appropriate.
6. From the **Reason** field, select **Patient Risk Factors** from the drop-down menu.
7. Click **OK.**
8. The **Cervical Cancer Screen** displays in the **Health Maintenance** window.

Update a Health Maintenance Expectations – Done Elsewhere

1. From the **Pending Expectations** window, select the **Cervical Cancer Screen – Pap Every 3 Yrs**.
2. Click **Results Received and Reviewed**.

   The **Satisfy – Cervical Cancer Screen – Pap Every 3 Yrs** pop-up window displays.



Satisfy – Cervical Cancer Screen – Pap Every 3 Yrs Pop-up Window

3. From the **Reason** drop-down menu, click **Expectation Satisfied Elsewhere.**
4. Select the date of the screening.
5. Click **OK**.
6. The **Satisfy – Cervical Cancer Screen – Pap Every 3 Yrs** expectation displays in the **Recently Satisfied Expectations** window.

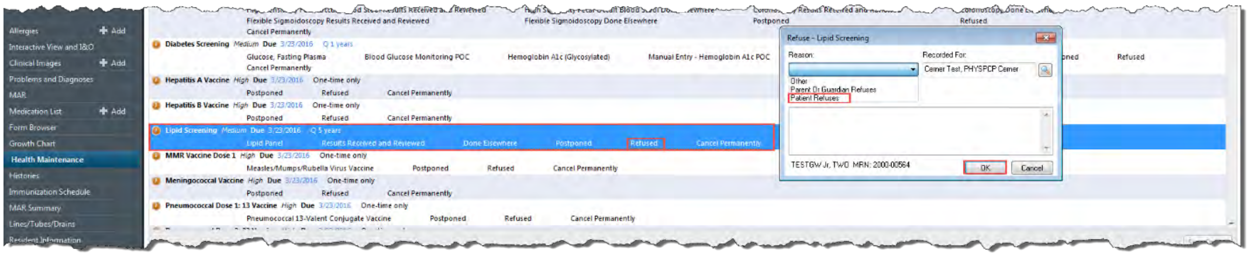
Recently Satisfied Expectations Window

Update Health Maintenance Expectations – Refused

To mark a **Pending Expectation** as **Refused**, complete the following steps:

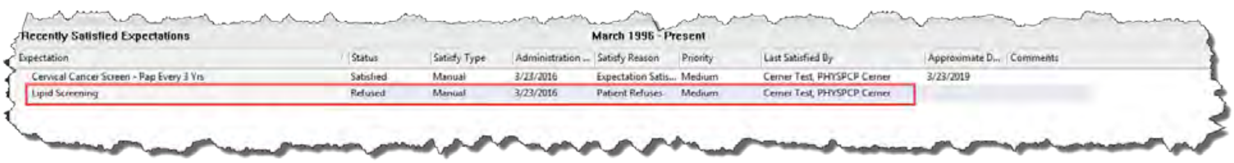
1. From the **Pending Expectations** window, click the Lipid Screening expectation.
2. Click **Refused**.

The **Refuse – Lipid Screening** pop-up window displays.



Refuse Lipid Screening Window

3. From the **Reason** drop-down list, click **Patient Refuses.**
4. Click **OK**.
5. The **Lipid Screening** expectation appears in the **Recently Satisfied Expectations** window as **Refused** with the date of refusal.



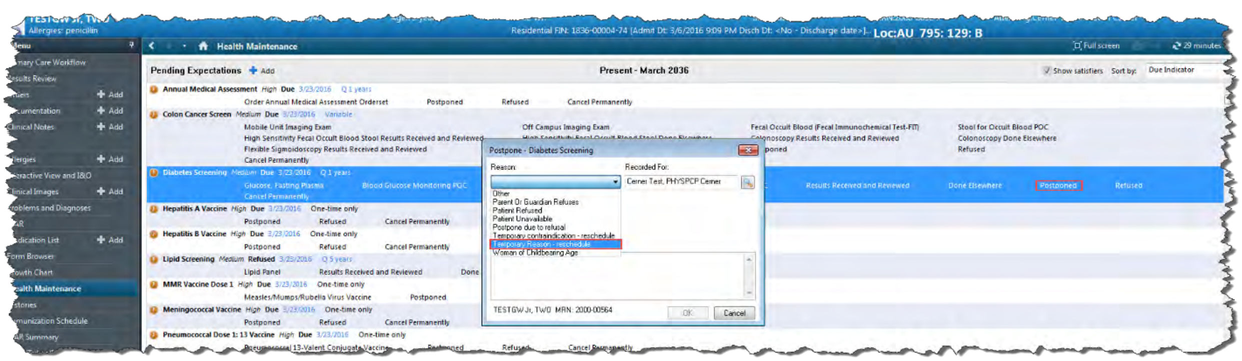
Refused Notice

Update Health Maintenance Expectations – Postponed

To postpone a **Pending Expectation,** complete the following steps:

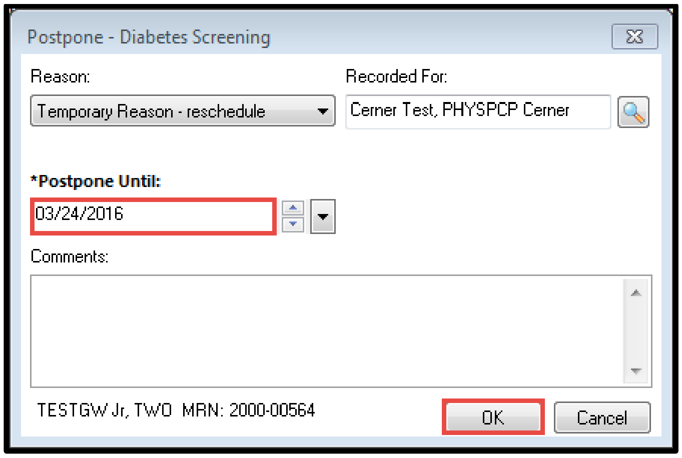
1. From the **Pending Expectations** field, click **Diabetes Screening**.
2. Click **Postponed**.

The **Postpone - Diabetes Screening** pop-up window displays.



Postpone - Diabetes Screening Window

3. From the **Reason** drop-down menu, click **Temporary Reason - reschedule**.
4. From the **Postpone Until** field, enter a future date.



Postpone - Lipid Screening

5. Click **OK**.

Exercises

1. Add a new Diabetes Management Health Maintenance Expectation.
2. For Selected Expectations, choose Diabetes - Fasting Lipid Profile due 1 month from today.
3. Postpone the Diabetes Eye Exam for six weeks. Enter the Reason: Temporary contraindication - reschedule. Enter that the resident has Pink Eye.
4. Permanently cancel the Diabetes-Albumin Creatinine ratio.

GENERAL ANESTHESIA

Purpose

This section presents the provider workflow for residents being considered for General Anesthesia/TIVA based on decisions made at the ISP meeting and input from the Dentist or Hygienist.

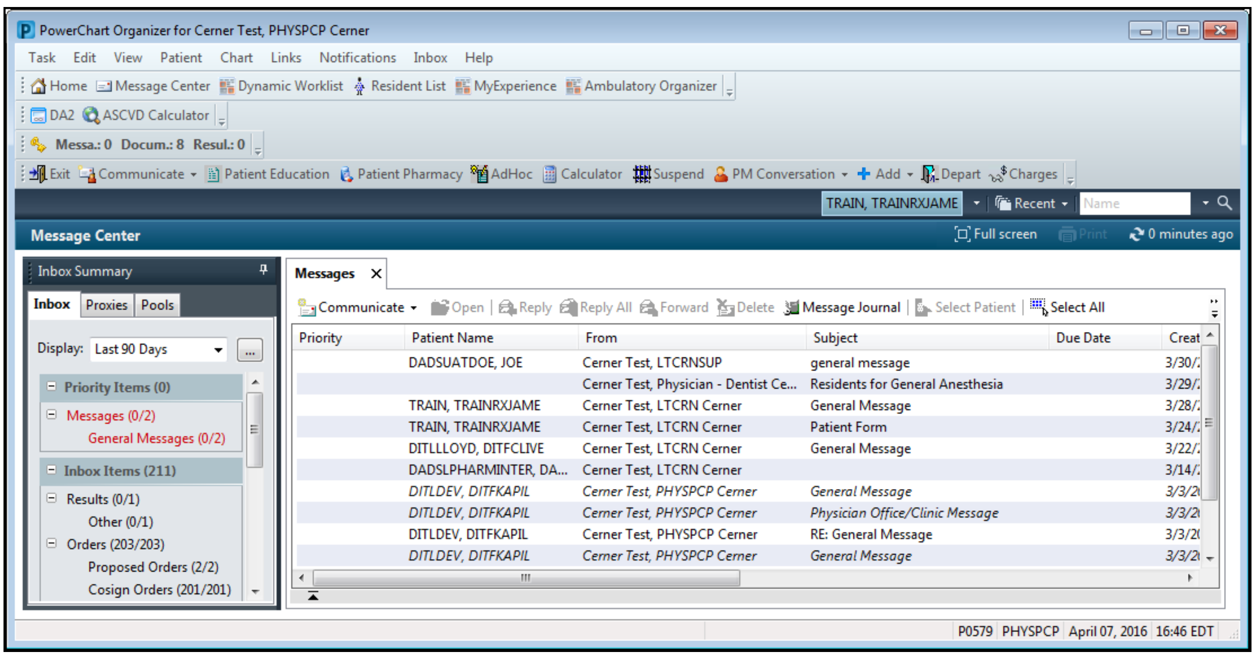
Objectives

- Locate List for residents being considered for General Anesthesia/TIVA by Dentist or Hygienist
- Document recommendations in the Medical Clearance for General Anesthesia/TIVA Dynamic Documentation in each residents respective chart
- Forward the document to Dentists' inbox for Review

Locate List for Residents Being Considered for General Anesthesia/TIVA

1. From the **PowerChart** menu bar, click the **Message Center** icon (Message Center).

    The **Message Center Inbox Summary** window displays.



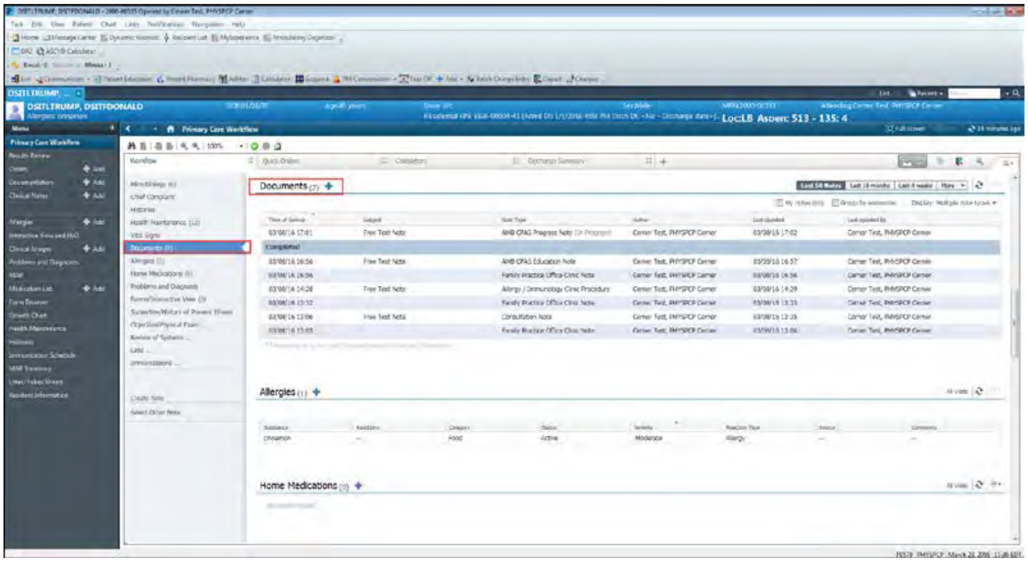
Message Center Inbox Summary

2. From the **Message Center Inbox Summary** window, click the **Messages.**
3. Click to the message row to open the **Document**.

Document Medical Clearance in Dynamic Documentation

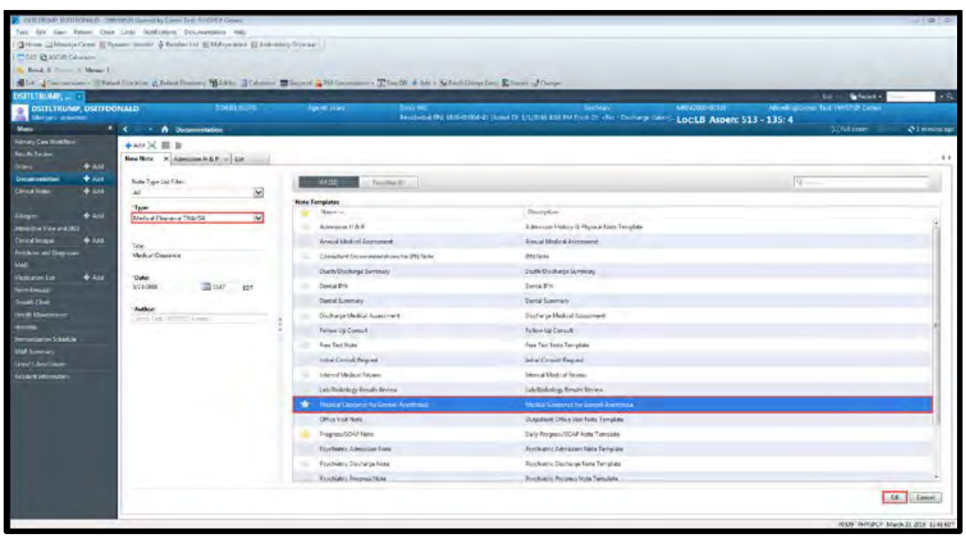
1. From Resident List, click to open the resident's chart.

   The **Primary Care Workflow** window displays.



2. From the **Primary Care Workflow** menu, click **Documents**
3. From the **Documents** window, click **(+).**

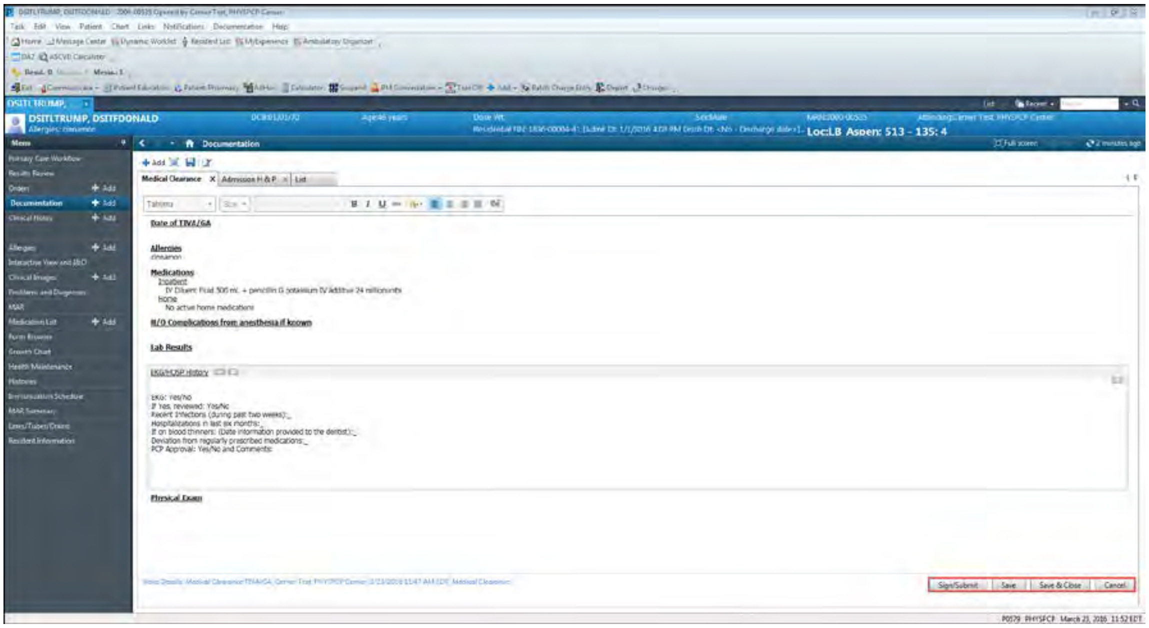
   The **New Note** window displays.



New Note Window

4. From the **Type** drop-down, select the **Medical Clearance**.
5. In the **Title** field, type **Medical Clearance TIVA/GA**.
6. Click **OK**.

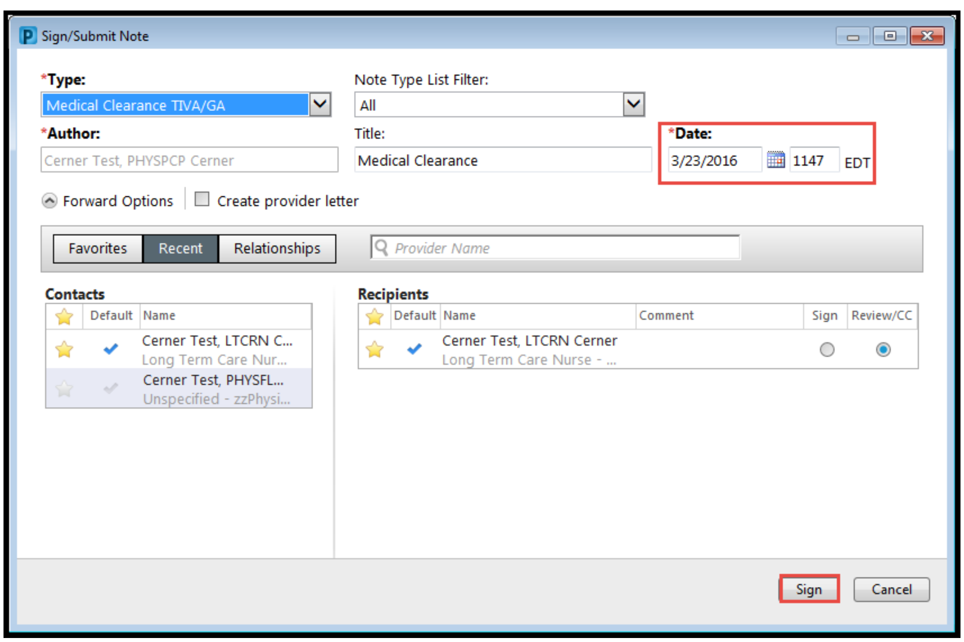
The **Medical Clearance** window opens with the template.



Medical Clearance

7. Type information into the **Note Template**.
8. Click **Sign/Submit**.

The **Sign/Submit Note** pop-up window displays.



Sign/Submit Note Pop-up Window

Note ► The **Date/Time** field auto-populates.

Forward Medical Clearance to Dentists

1. In the **Provider Name** field**,** type the name of the dentist (last name, first name)**.**
2. Click **Sign**.

Note ► The document is forwarded to the **Message Center Inbox** of the identified dentist for review.

Exercises

1. Access the list of residents being considered for General Anesthesia/TIVA.
2. Document a Medical Clearance for General Anesthesia/TIVA note in the resident's chart.
3. Forward the Medical Clearance to the dentist.

MEDICATION RECONCILIATION

Purpose

This lesson presents the provider workflow for the Medication Reconciliation of a resident upon Admission, Transfer, Discharge, and Leaves of Absence from a Long Term Care facility.

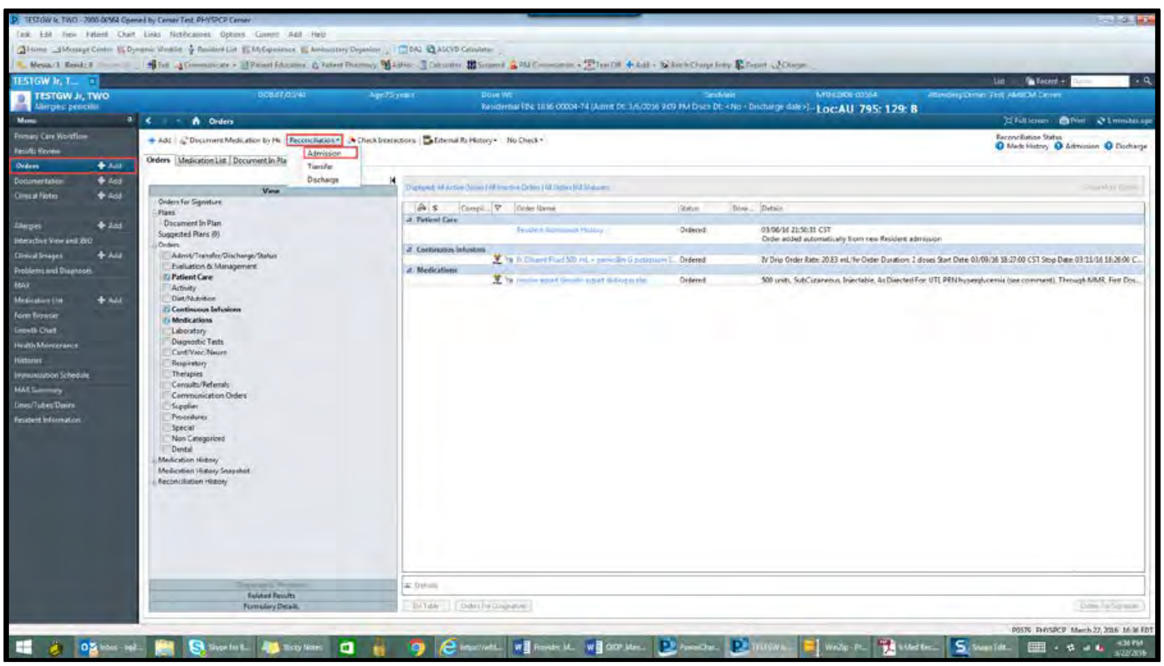
Objectives

- Locate a Resident's Orders from the Primary Care Workflow Menu
- Perform Admission Medication Reconciliation
- Perform Medication Reconciliation when a Resident is being Transferred
- Perform Medication Reconciliation when a Resident is being Discharged
- Perform Medication Reconciliation when a Resident takes a Leave of Absence

Locate a Resident's Orders and Complete Admission Medication Reconciliation

1. From the **Chart** menu, click **Orders**.

   The **Orders** window displays.

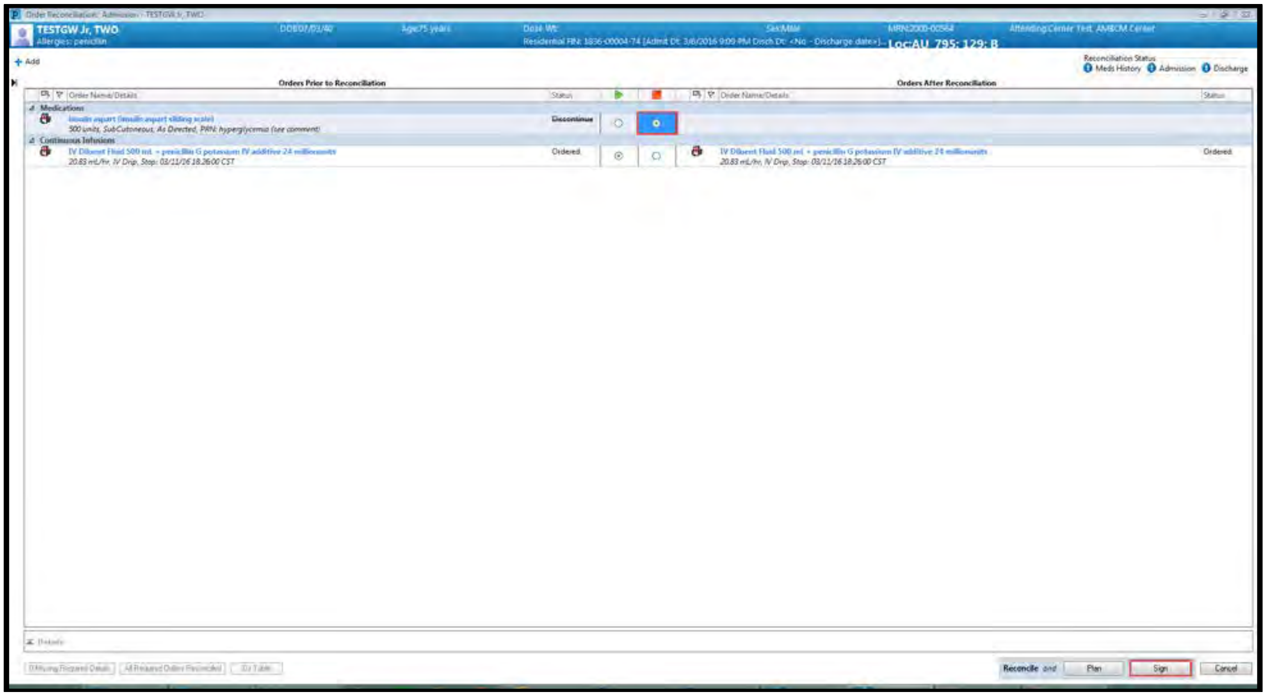


Orders for Reconciliation

2. From the **Orders screen toolbar**, click **Reconciliation** and choose **Admission** from the drop-down menu**.**

> **Note** ► The Orders Prior to Reconciliation are listed by Order Name/Details and Status.

The **Orders Prior to Reconciliation: Admission** pop-up window displays.

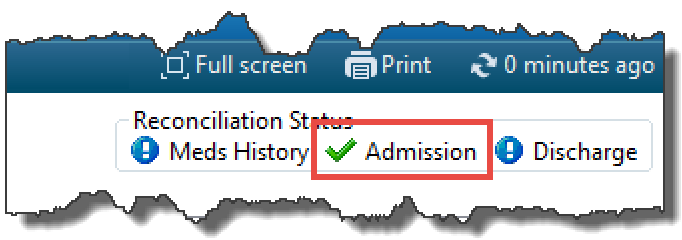


Orders Prior to Reconciliation: Continue or Discontinue

3. From the **Continue** column ( ) , click the radio button to continue desired medications.
4. From the **Do Not Continue** column ( ), click the radio button to discontinue desired medications.

Note ►	Once a medication is discontinued, its status will change to "~~Discontinue~~".

5. Click **Reconcile and Sign** to complete the Admission Medication Reconciliation process**.**
6. The **Reconciliation Status** in the upper right corner of the screen displays a green check mark indicating the process is complete if all other Admission activities are completed.

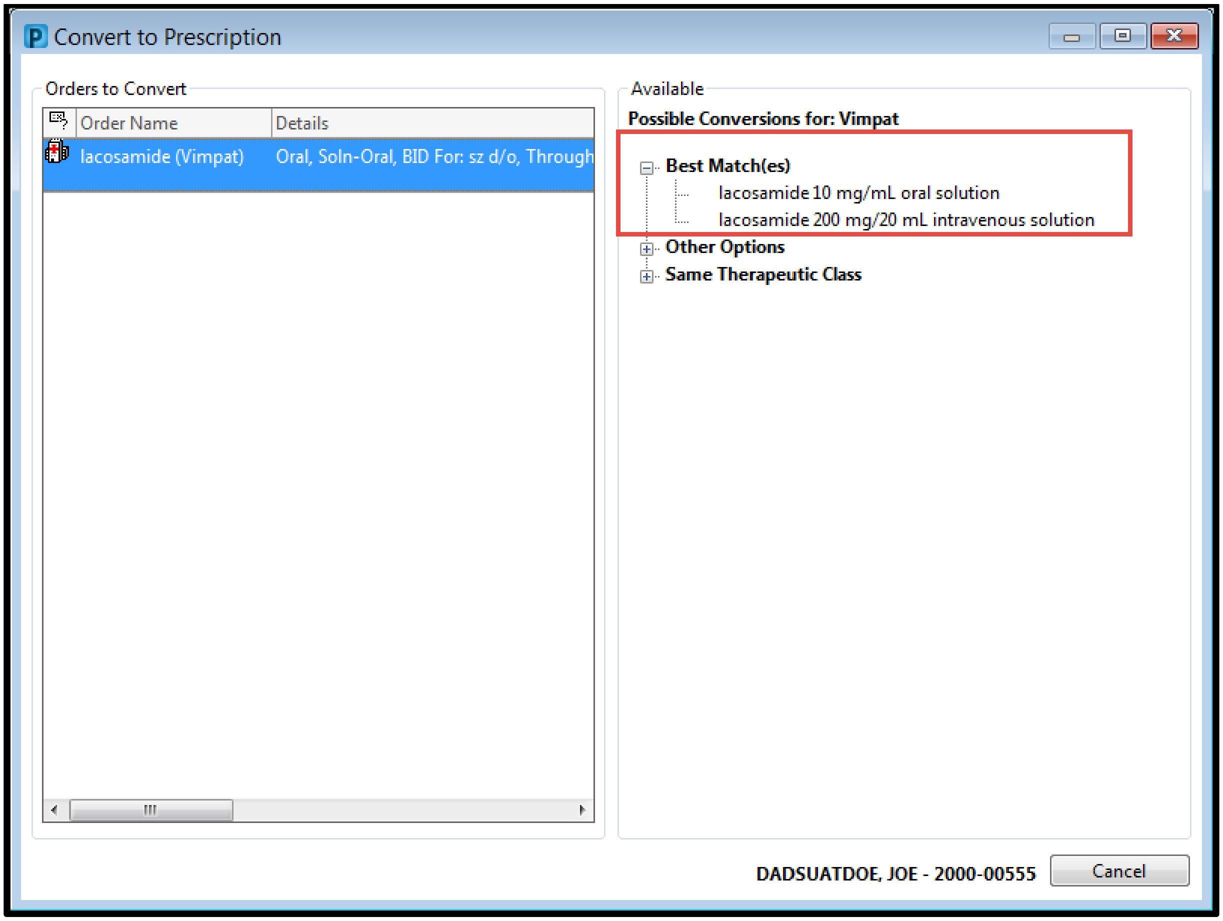


Leave of Absence (LOA) - Medication Reconciliation (Furlough)

When a resident is out on furlough, their medications must be converted to prescription.

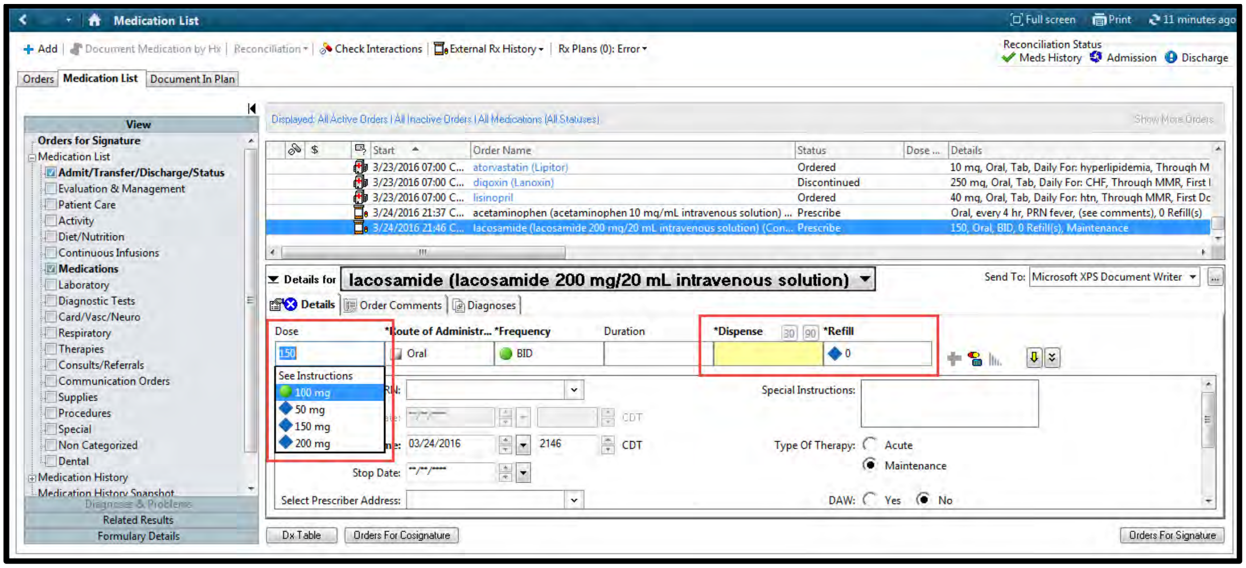
1. From the **Menu,** click **Medication List**.
2. Right-click on the medications to convert during the leave of absence and click **Convert to Prescription**.

   - Depending on the medication, the **Convert to Prescription** pop-up window may display.



Convert to Prescription Pop-Up Window

3. Click the correct medication from the **Available** section.



Medication List - Details Window

4. From the **Medication List – Details for** window, enter the specific prescription information.
5. Click **Orders for Signature**.

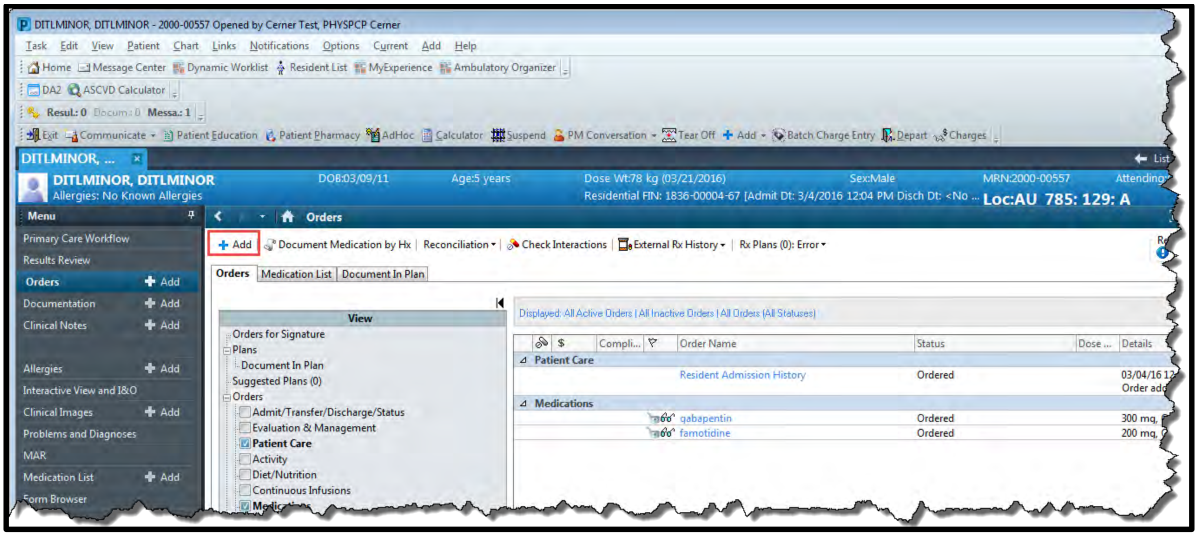
   The **Orders for Signature** window displays.

6. Click **Sign**.
7. Click **Refresh** to see converted order.

When the resident returns from the leave, the Medication Reconciliation process must be completed.

1. From the **Menu**, click **Orders**.

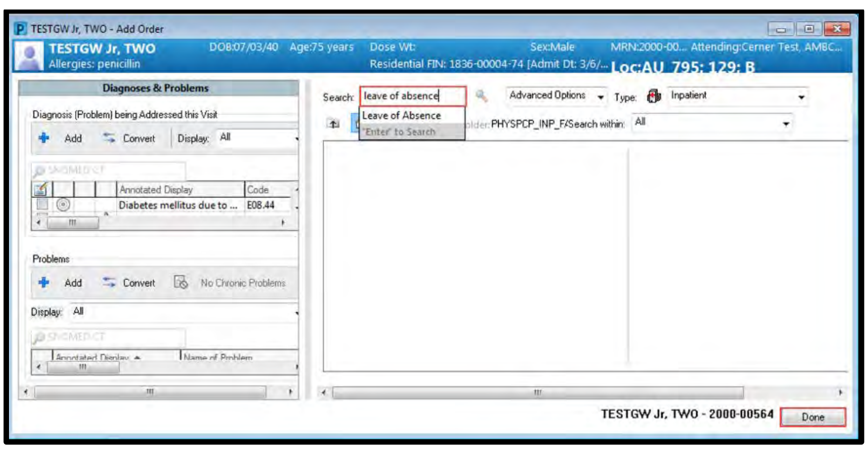
The **Orders** window displays.



Orders Window

2. Click the **+Add** icon.

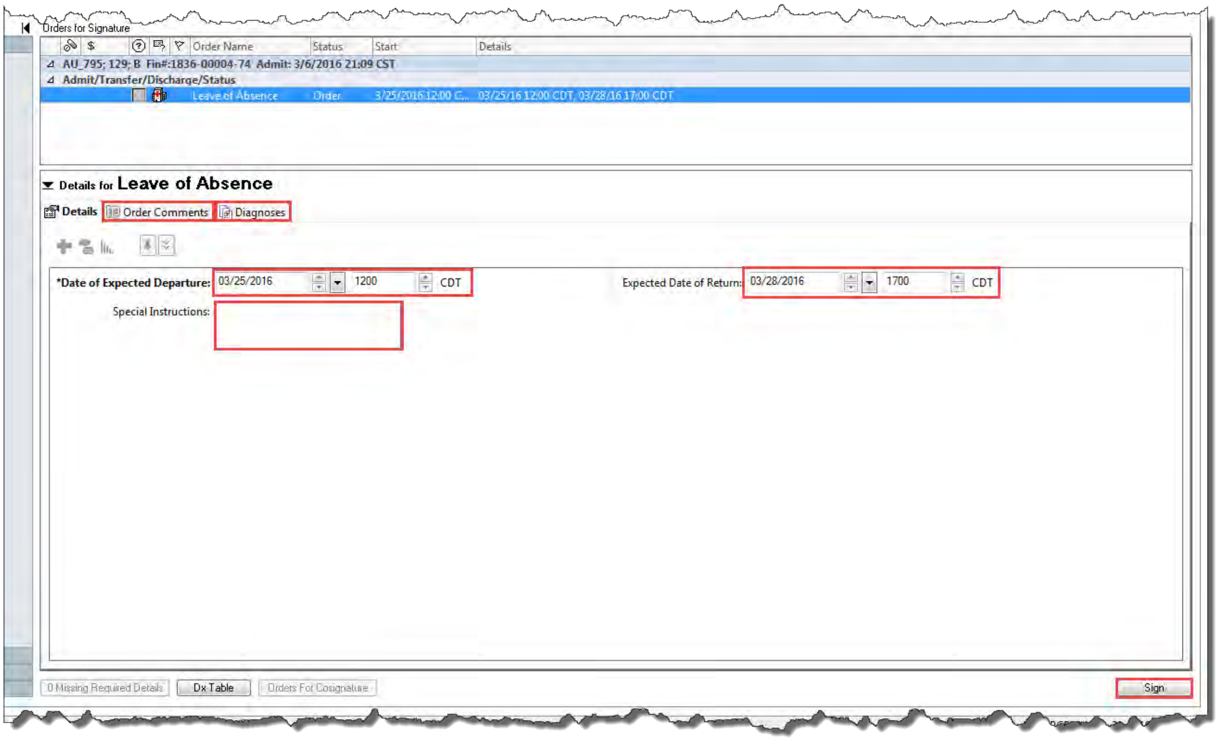
The **Add Order** pop-up window displays.



Add Order Pop-Up Window

3. Enter “leave of absence” in the **Search** field.
4. Click the **Leave of Absence** order.
5. Click **Done**.

💻 The **Orders for Signature** window displays.



Orders for Signature

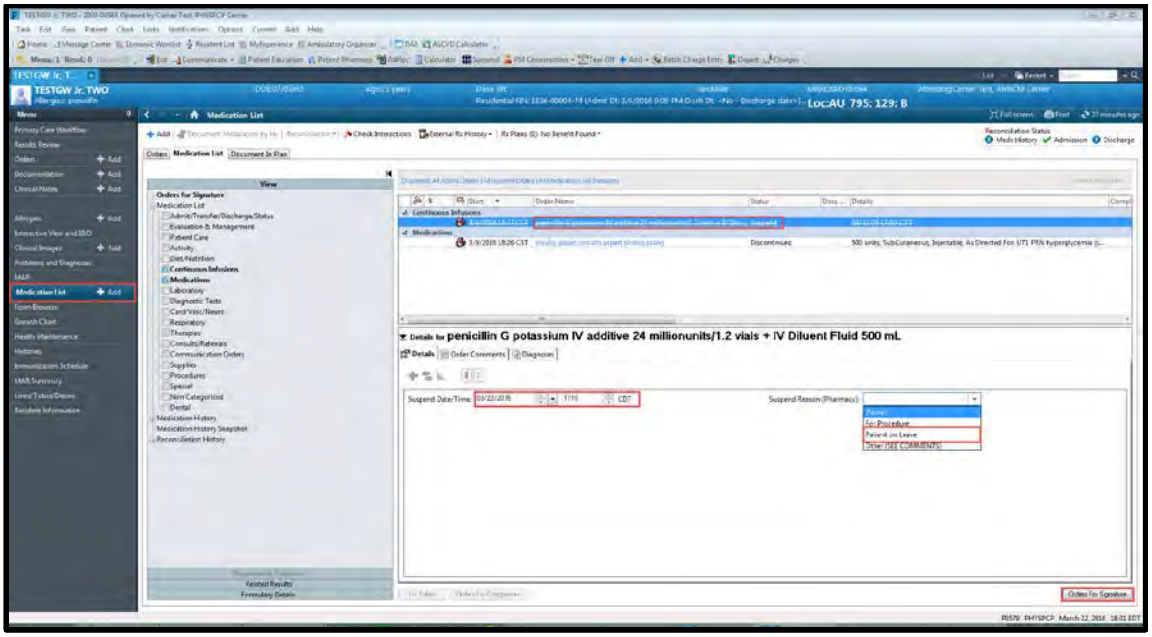
6. Select the **Date of Expected Departure** and **Expected Date of Return**.
7. Type any instructions in the **Special Instructions** text box.
8. Click the **Order Comments** and **Diagnoses** tabs to review relevant comments and diagnoses.
9. Click **Sign.**

Leave of Absence – Medication Reconciliation (Hospital Stay)

Suspension of medication during an LOA occurs when the resident is in a hospital stay. Perform the following steps to suspend a resident's medication due to a hospital stay.

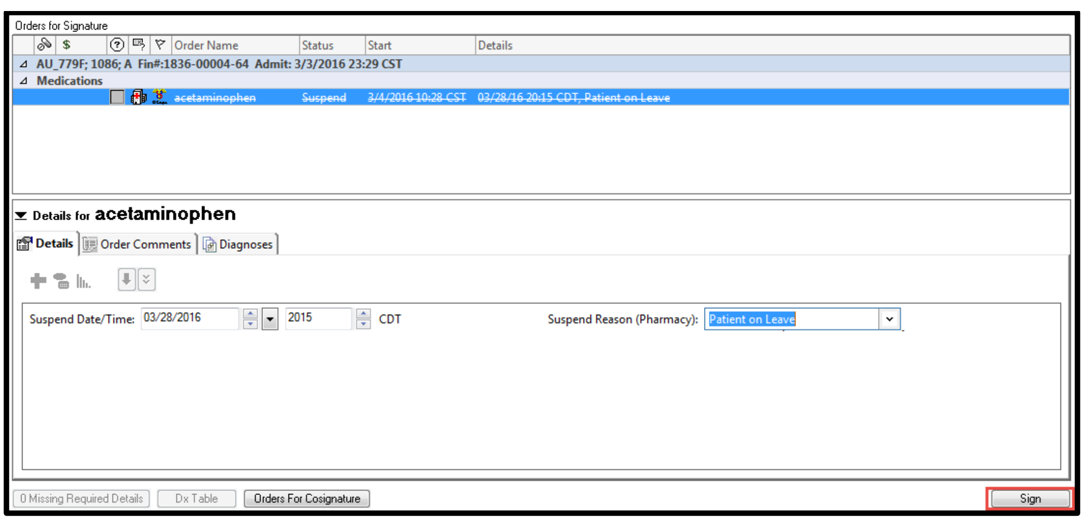
1. From the **Menu,** click **Medication List**.
2. Right-click on the medications to suspend during the leave of absence and click **Suspend**.

The **Details** window displays.



3. Select the **Suspend Date/Time**.
4. From the **Suspend Reason (Pharmacy)** drop-down menu, click **Patient on Leave**.
5. Click **Orders for Signature**.

The **Orders for Signature** window displays.



Orders for Signature

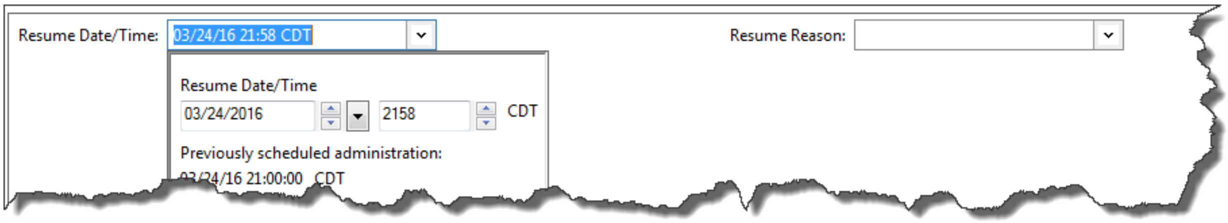
6. Click **Sign**.
7. Click **Refresh** to see the suspended order.

When the resident returns to the facility after the LOA, take the following action to un-suspend the order.

1. From the **Menu,** click **Medication List**.
2. Right-click on the medications to resume by clicking **Resume**.

The **Details** window displays.

3. Identify a **Resume Date**, Resume Reason, and click **Orders for Signature**.



The **Orders for Signature** window displays.

4. Click **Sign**.

Transfer Medication Reconciliation

Complete the **Transfer Medication Reconciliation** process when a resident is transferring from the SSCL to another facility.

1. From the **Menu**, click **Orders**.

The **Orders** window displays.

2. From the **Orders** window toolbar, click **Reconciliation** and choose **Transfer** from the drop-down menu**.**

The **Orders Prior to Reconciliation: Transfer** window displays.

3. From the **Continue** column**,** click the radio button to continue desired medications.
4. From the **Do not Continue** column, click the radio button to discontinue desired medications.
5. Medications that remain active display in the **Orders After Reconciliation** column.
6. Click **Reconcile and Sign.**

Discharge Medication Reconciliation

Complete the **Discharge Medication Reconciliation** process when a resident is discharged from the SSLC to the community.

1. From the **Menu**, click **Orders**.

The **Orders** window displays.

2. From the **Orders** window toolbar, click **Reconciliation** and choose **Discharge** from the drop-down menu**.**

The **Orders Prior to Reconciliation: Discharge** window displays.

3. From the **Continue** column**,** click the radio button to continue desired medications.

4. From the **Create New Rx** column which is the medicine bottle**,** click the radio button to generate a new out-patient prescription for the medication.

    - The **Convert to Prescription** window displays when selecting **Create New Rx**.

5. Click **Do Not Continue Remaining Orders** to discontinue all remaining medications. Click **Continue Remaining Home Meds** to indicate that the resident should continue taking all medications prescribed prior to admission to the SSLC.
6. Click **Reconcile and Sign**.

Exercises

1. Perform an Admission Medication Reconciliation on the resident. Validate all of the Medications associated with the resident.
2. Perform a Discharge Medication Reconciliation on the resident. Convert Xanax to a new prescription.
3. Perform a Leave of Absence Medication Reconciliation on the resident.

180 DAY ORDERS RECONCILIATION

Orders and Medication Reconciliation is the process of identifying an accurate list of clinical orders on a resident and the medications prescribed—including the name, dosage, frequency, and route. This involves comparing current list of orders and medications against the physician's admission, transfer, or discharge orders. Every 180 days, providers must complete a current orders reconciliation. The LTC provider is responsible for completing this process. For residents that are taking psychotropic medications, the psychiatrist must complete the orders reconciliation for all psycho-pharmaceuticals. All other orders/medications are reconciled by the LTC provider.

Purpose

This section presents the provider workflow for completing a 180 day Orders Reconciliation.

Objectives

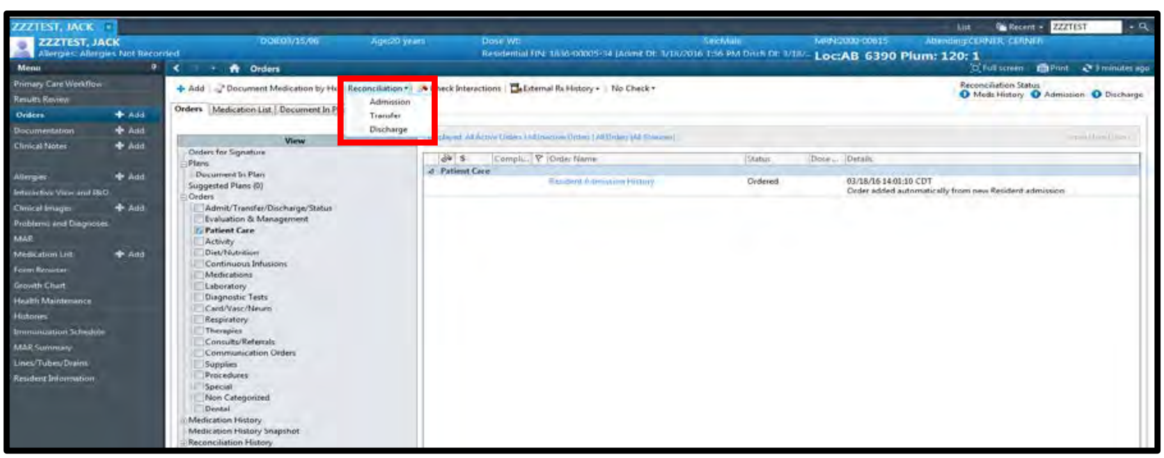
- Complete 180 day Orders Reconciliation for a resident taking non-psychotropic medications
- Complete 180 day Orders Reconciliation for a resident taking psychotropic medications
- Reconcile psychotropic medications
- Inbox messages to PCPs to complete Orders Reconciliation

Continue/Discontinue Non-Psychotropic Medications

Case Manager provides notification that a resident is due for a 180 day Orders Reconciliation.

1. Type the resident's name in the **Search** field, located at the top right corner. Click the search icon ( ).
2. From the **Menu**, click **Orders**.

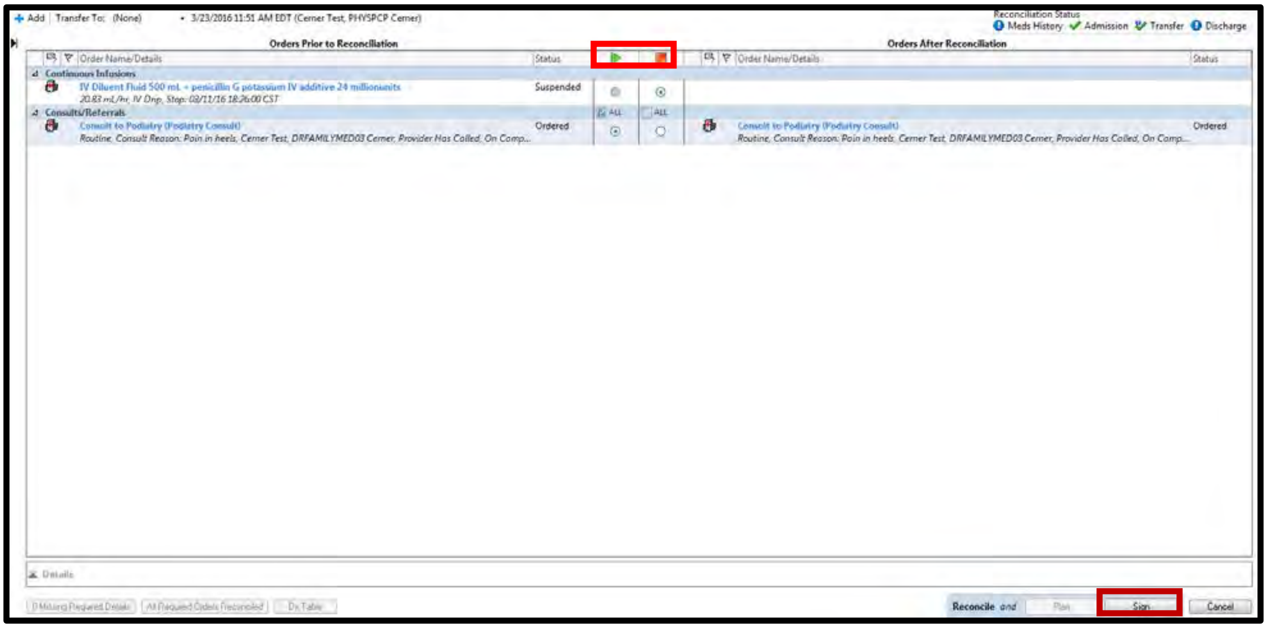
   The **Orders** window displays.



Orders Window

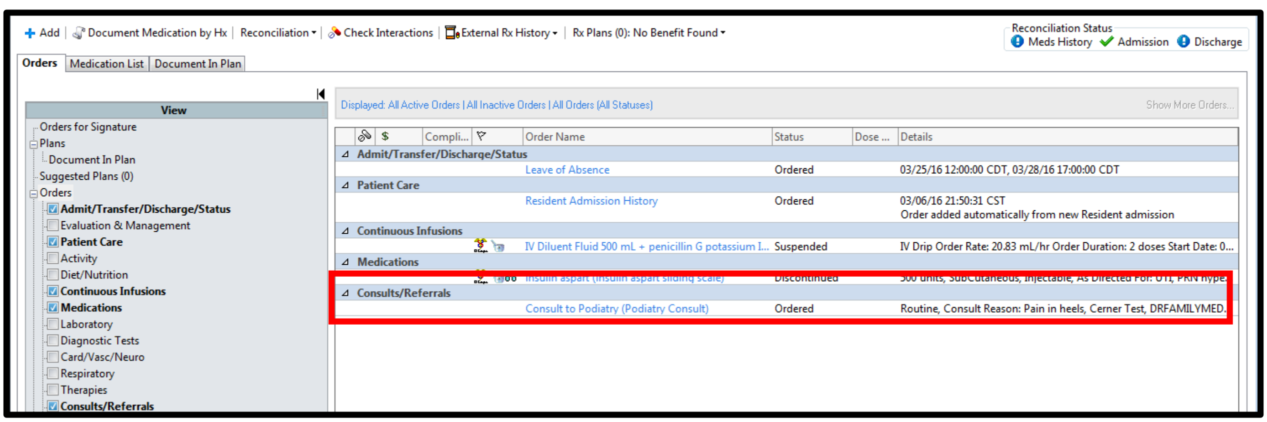
3. From the **Reconciliation** tab drop-down menu, select **Transfer**.

The **Order Reconciliation - Transfer** window displays.



Order Reconciliation - Transfer Window

4. From the **Orders Prior to Reconciliation** field, click the green **Continue** icon ( ) to continue the selected medication(s) or click the **Do Not Continue** icon ( ) discontinue the selected medication(s).
5. New orders are reflected on the **Orders After Reconciliation** section.
6. Click **Reconcile and Sign** to complete the Orders Reconciliation process. Transfer Orders Reconciliations are displayed and can be viewed from the **Orders** menu.



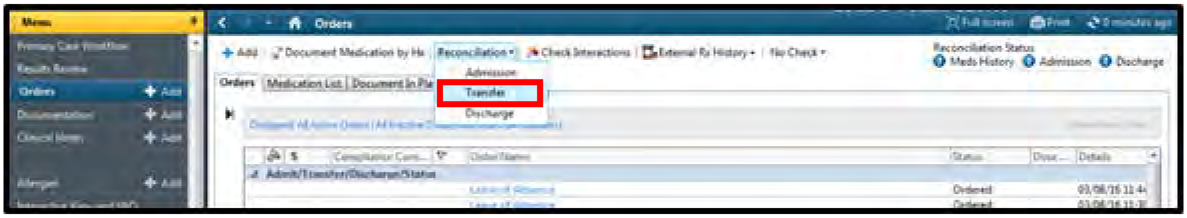
Orders Prior to Reconciliation

Plan Status

Notification is received that a resident is due for a 180 day Orders Reconciliation. A transfer medication reconciliation for only the psychotropic medications of the resident is performed and the reconciliation is put into Plan status.

1. Type the resident's name in the **Search** field, located at the top right corner. Click the search icon ( ).
2. From the **Chart** menu, click **Orders**.

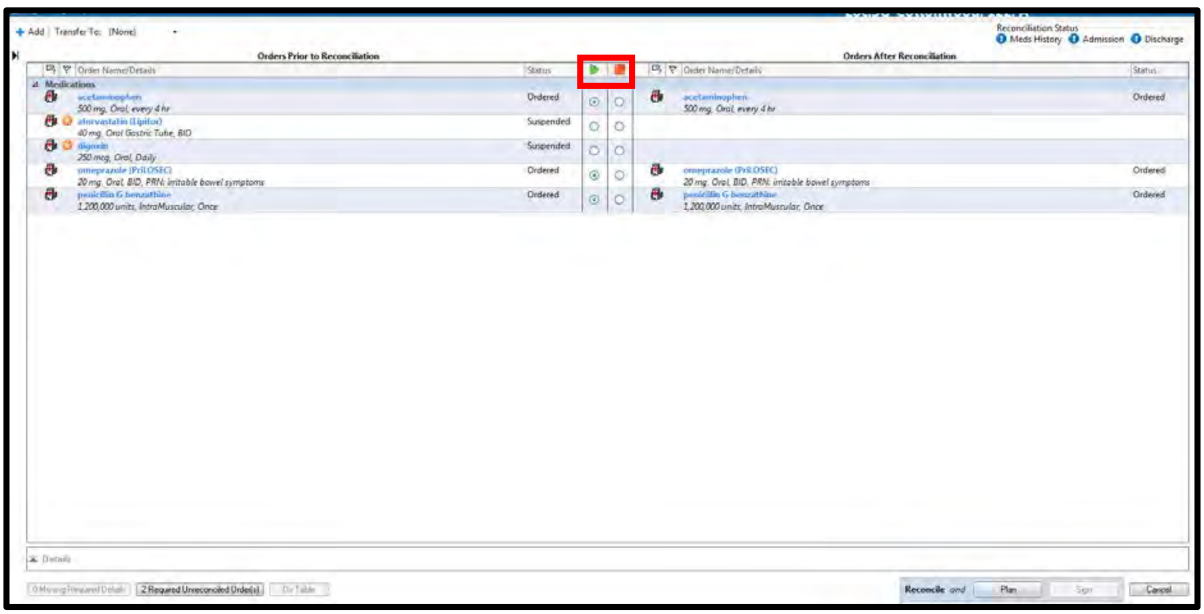
💻 The **Orders** window displays.



Orders Window

3. From the **Reconciliation** tab drop-down menu, select **Transfer**.

💻 The **Order Reconciliation - Transfer** window displays.



Order Reconciliation - Transfer Window

4. From the **Orders Prior to Reconciliation** field, click the green **Continue** icon ( ) to continue the selected medication(s) or click the **Do Not Continue** icon ( ) discontinue the selected medication(s).
5. Click **Plan** (Plan) to place the orders in **Plan** status.
6. From the **Message Center**, the psychiatrist sends the LTC provider an inbox message to complete the Order Reconciliation.
7. The LTC provider completes the 180 day Orders Reconciliation on the remaining non-psychotropic medications. Click **Reconcile and Sign** when complete.

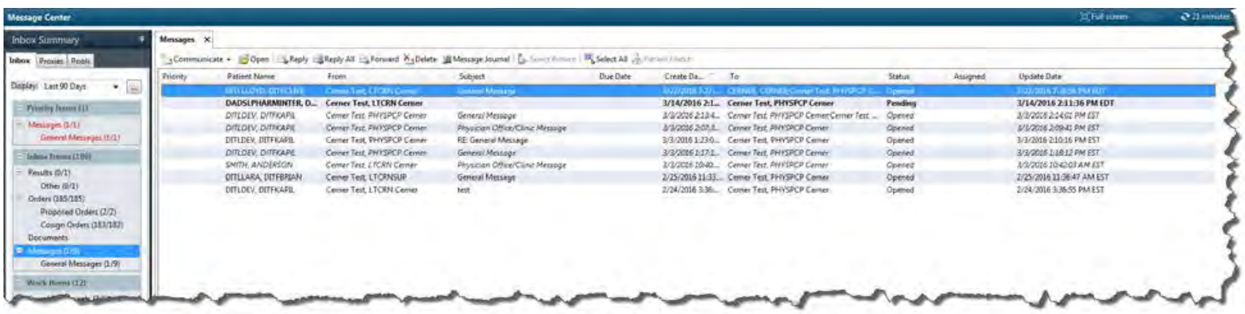
Inbox Messaging

1. Log into **PowerChart** and access the **Message Center Inbox Summary**.

> **Note ▶** Whenever a provider logs into **PowerChart**, the **Message Center** displays as the default screen.

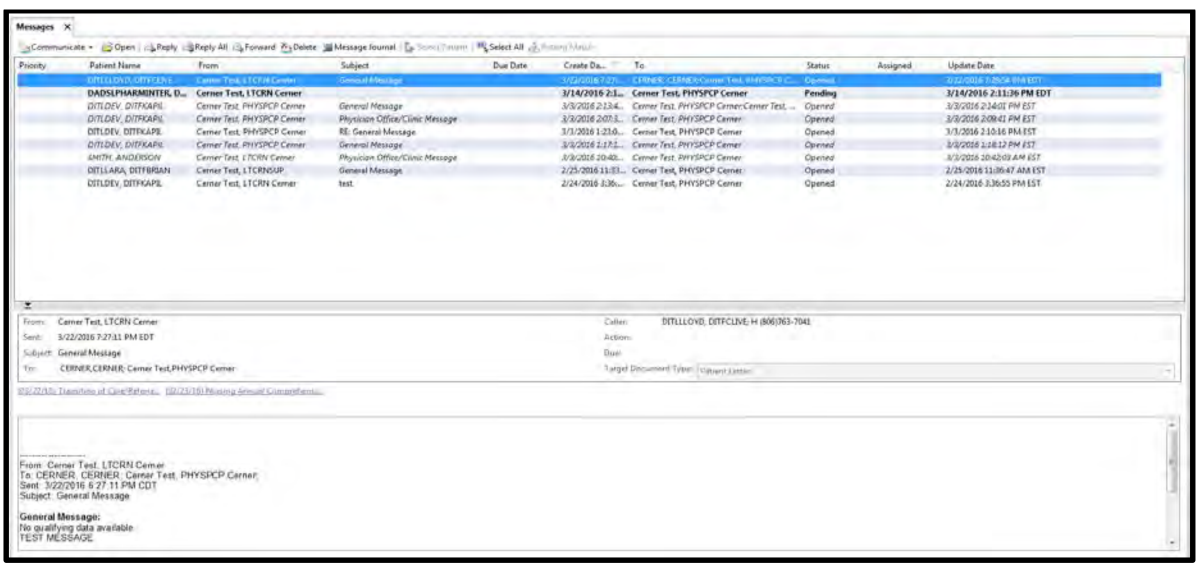
2. Click the **Messages** band to access the **Messages** window.
3. From the **Messages** window, all received messages for the residents associated with the provider are displayed.

   💻 The **Messages** window displays.



Messages Window

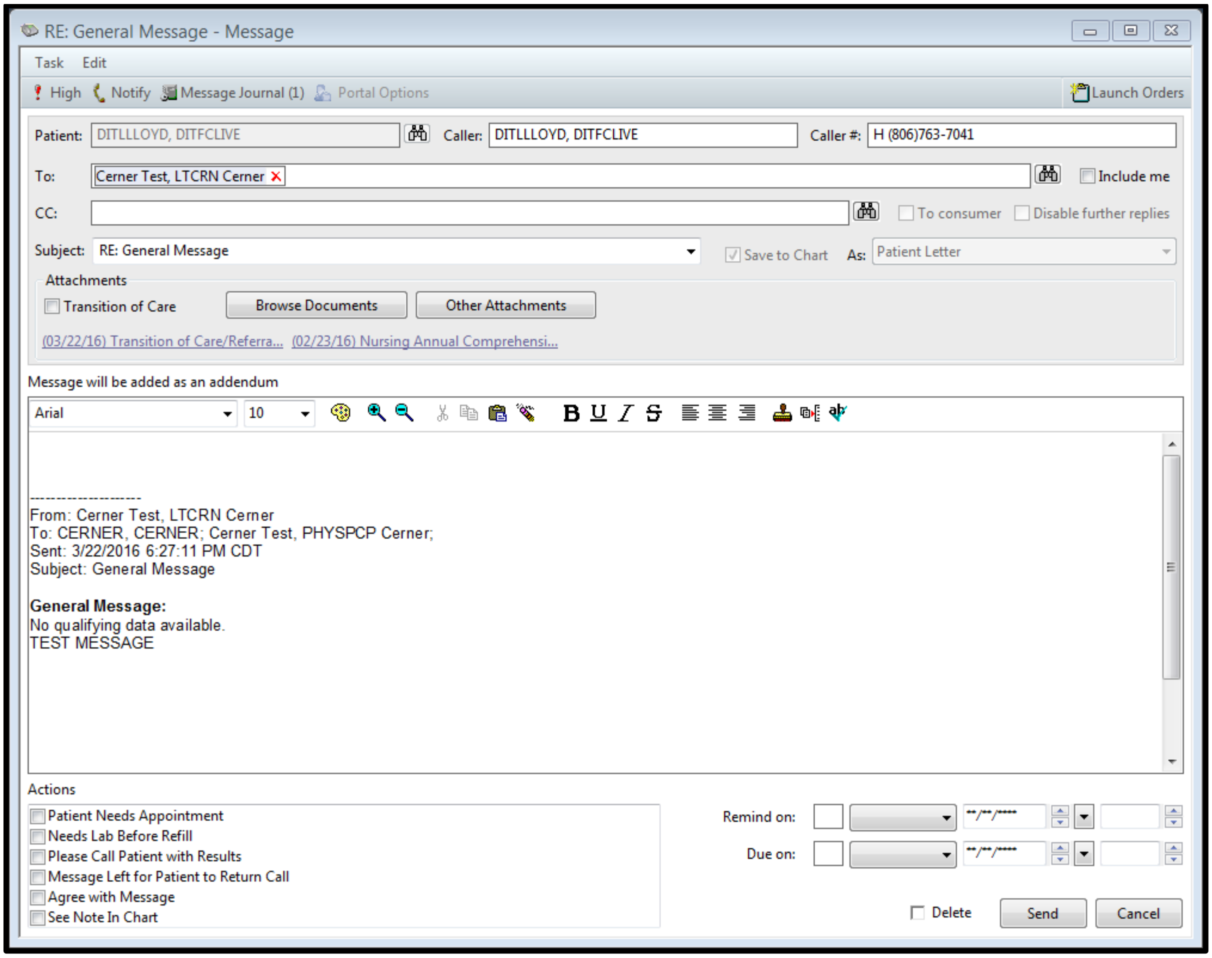
4. Click a message row to view the contents of the message on the lower half of the window.



Messages Window

5. From the Messages window, select the Reply button to send a reply message.

The **Reply Message** pop-up window displays.



Reply Message Pop-up Window

6. From the **Reply Message** pop-up window, type the desired message and click **Send**.
7. Additional actions that may be taken are as follows:
    a. Click **Browse Documents** to attach documents to the message.
    b. Click **Actions** check box to associate any of the listed actions with the message.

Exercises

1. Log into the resident's chart as the PCP.
2. Complete a 180 day Order Reconciliation.
3. As the psychiatrist, begin a 180 day Order Reconciliation.
4. As the PCP, complete the 180 day Order Reconciliation on the same resident.
5. View the Plan.

PSYCHIATRIST SPECIFIC FUNCTIONS

Purpose

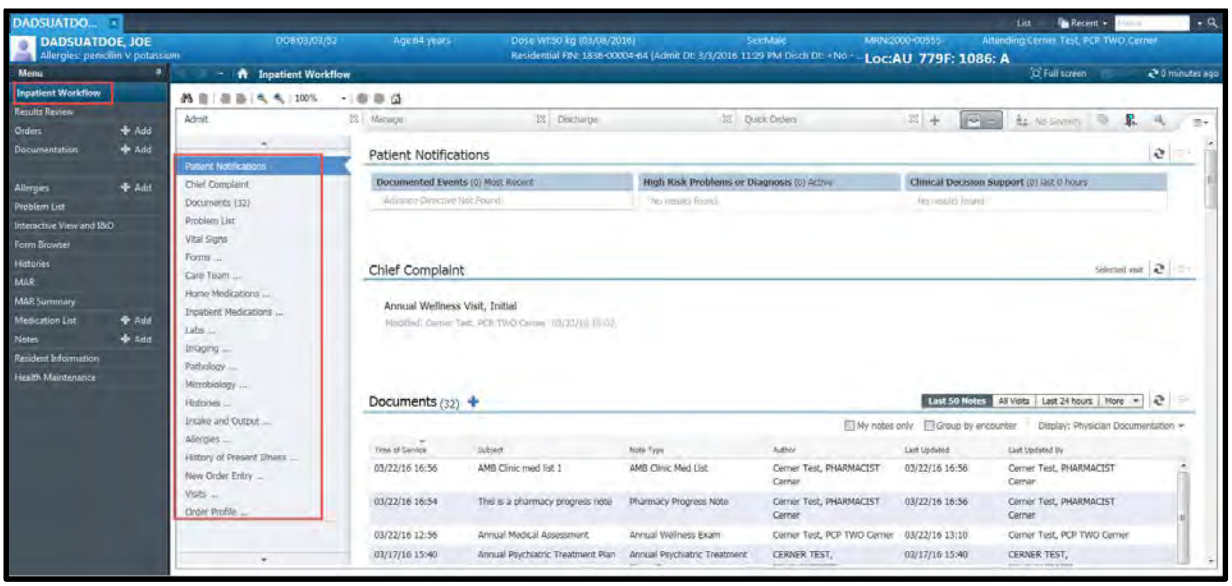
For psychiatrists, the processes associated with resident care encompass several workflows that are unique to the larger provider community. Although functionality within the system is consistent, the lessons identified within this section cover those unique processes and the steps required to complete them.

Objectives

- Understand psychiatric admissions and inpatient workflow specific to psychiatrists
- Perform administration of psychiatric treatment and psychotropic medications
- Administer emergency psychotropic medication
- Complete the forms and processes associated with chemical restraint

Admission and Inpatient Workflow

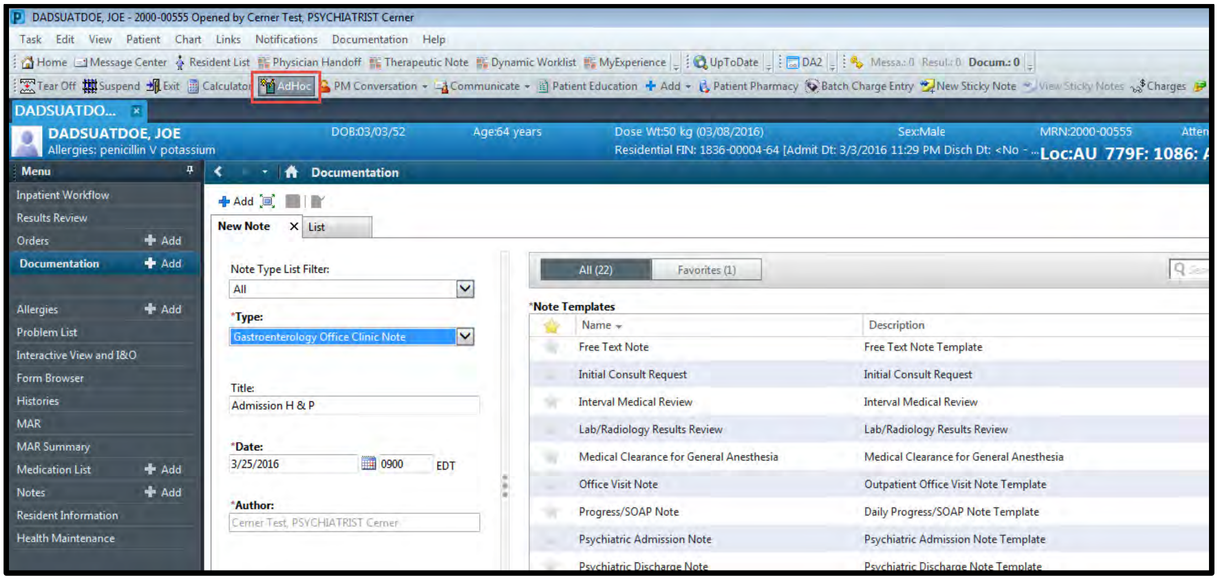
Use the Inpatient Workflow window to manage and update information regarding an individual psychiatric resident. Similar to the functionality and appearance of the general provider Primary Care Workflow window, the Inpatient Workflow window groups pertinent resident information.



Inpatient Workflow Window

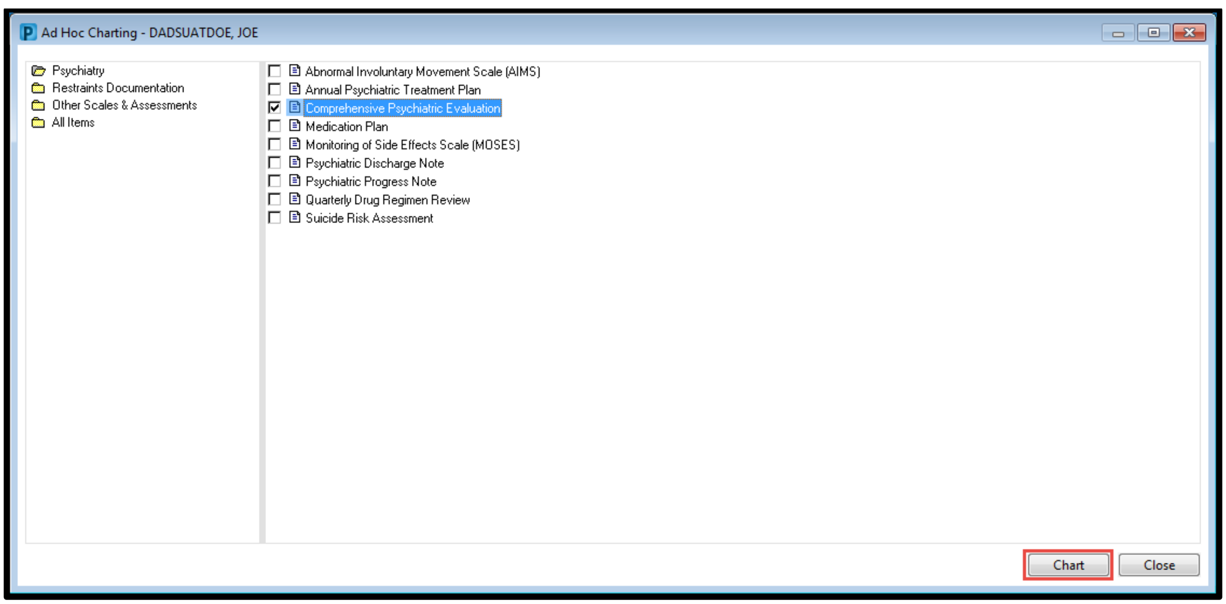
For admission of new residents with a psychiatric diagnosis that are currently taking psychotropic medications, the **Comprehensive Psychiatric Assessment** (CPE) must be completed within 30 days.

1. From the resident's **Chart** menu, click the **Ad Hoc** icon.



Resident's Chart - Ad Hoc

- The **Ad Hoc Charting** pop-up window displays.

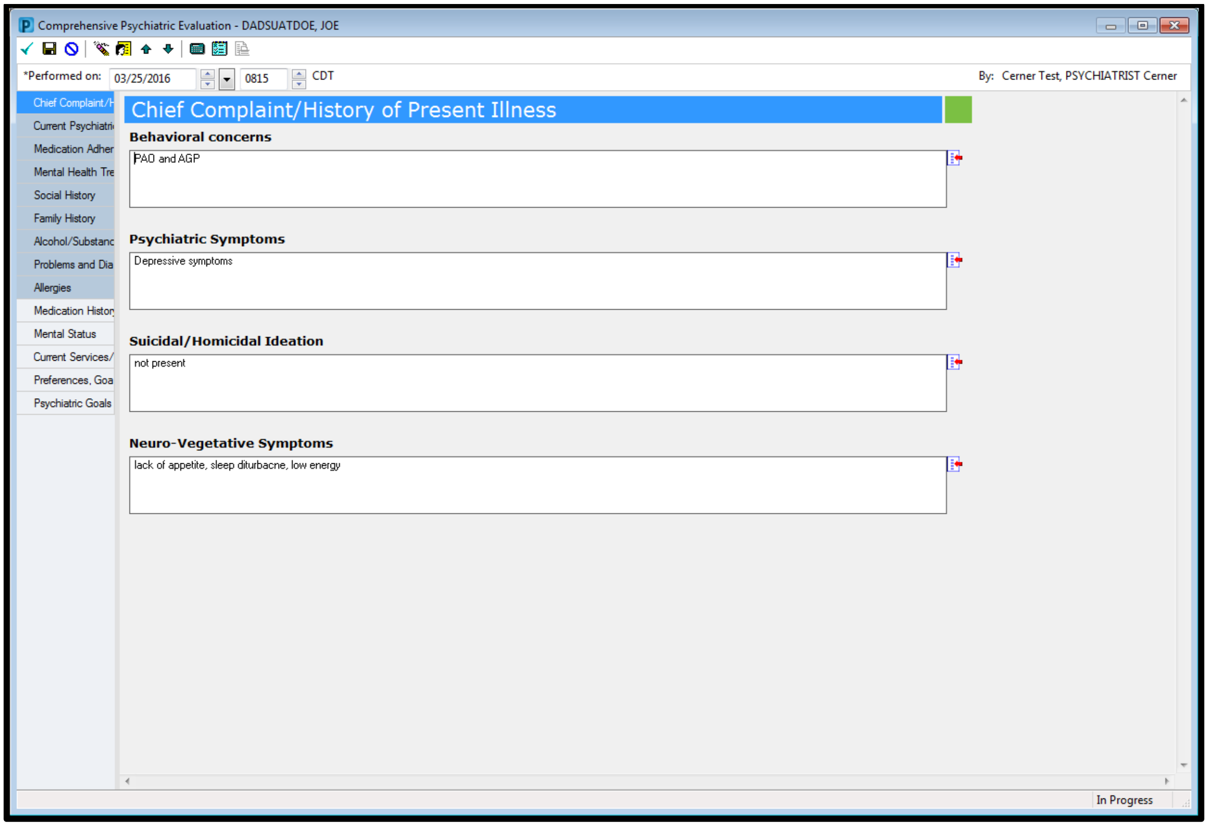


Ad Hoc Charting Pop-Up Window

> **Note ▸** All psychiatric related forms can be accessed from the **Ad Hoc Charting** pop-up window. Use this resource to access any required forms directly from the resident's chart.

2. Click the **Comprehensive Psychiatric Evaluation** check box.
3. Click **Chart**.

The **Comprehensive Psychiatric Evaluation** pop-up window displays.



Comprehensive Psychiatric Evaluation Pop-Up Window

4. Complete the form and click **Sign** ( ).

Note ▶	For admission of new residents that do not have a psychiatric diagnosis, the behavioral health specialist (BHS) must complete a REISS screening.

Note ▶	If the REISS screening indicates that the referral to psychiatry was warranted, a CPE must then be completed within 30 days.

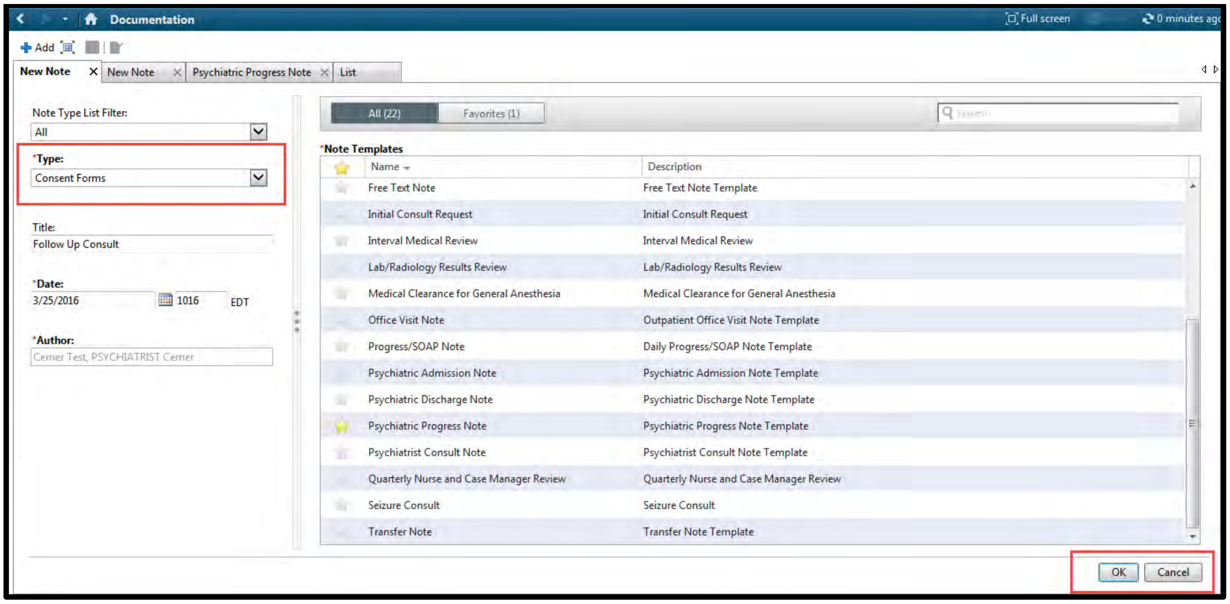
Psychiatric Treatment and Psychotropic Medications

For psychiatric residents that require psychotropic medications, consent is obtained from the LAR or the Facility Director within 30 days of admission, and an additional consent form must be completed and sent for due process by the **Human Rights Committee**.

1. From the resident's **Menu**, click the **Documentation** band.
2. Click **Add+** from the **Documentation** band.

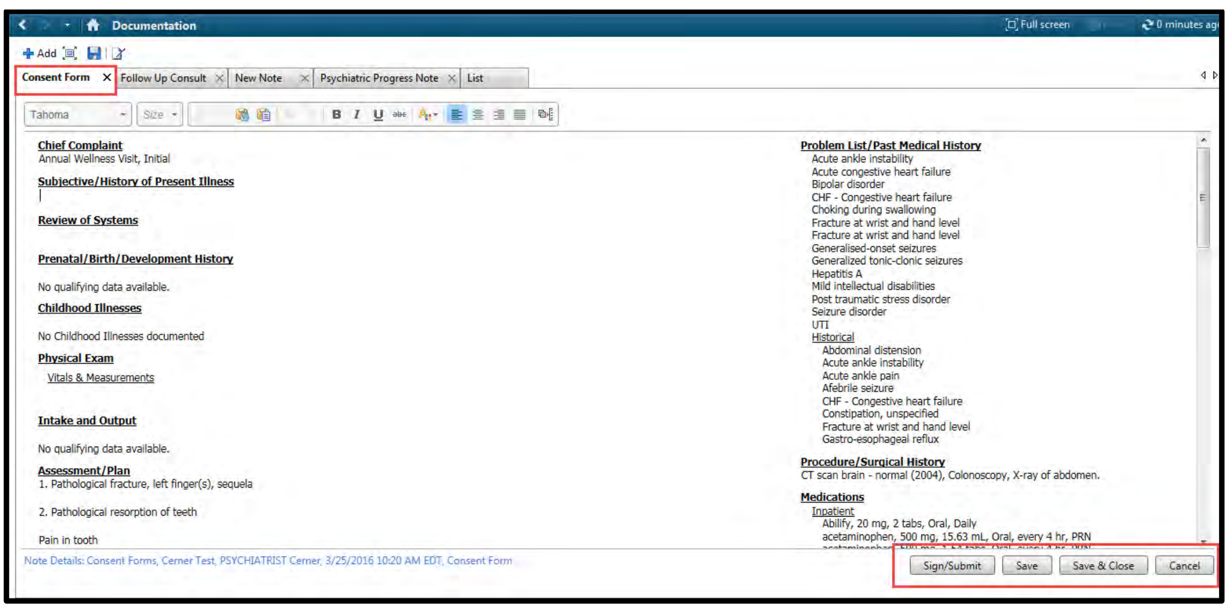
- The **Documentation** window displays.

3. Identify **Consent Forms** as the **Type** and select the template from the **Note Templates** and click **OK**.



Documentation – New Note

- The tab displays the **Title** entered, the **Consent Form** window displays.



Documentation – Consent Form

4. Complete the form with the appropriate information regarding the status of the resident.
5. Click **Sign/Submit**.

Note ▸ Consent forms are renewed on an annual basis. To view consent forms in the future, access the **Notes** band of the resident's **Chart** menu. From this location, consent forms can be viewed and modified.

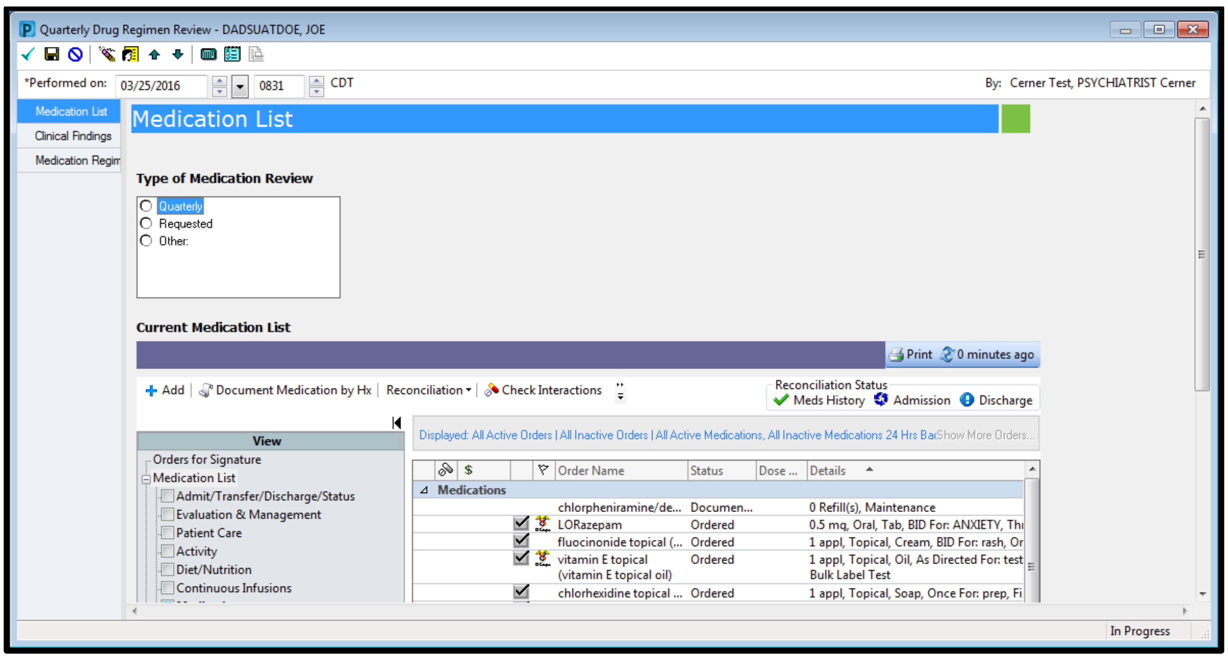
Psychiatric residents also have their psychotropic medications reviewed on a quarterly basis. This action is achieved through the **Quarterly Psychiatry Note**. All of these forms can be accessed from the **Ad Hoc Charting** pop-up window.

1. From the resident's **Chart** menu, click the **Ad Hoc** icon.

   The **Ad Hoc Charting** pop-up window displays.

2. Click the **Quarterly Drug Regimen Review** check box and click **Chart**.

   The **Quarterly Drug Regimen Review** pop-up window displays.



Quarterly Drug Regimen Review Pop-Up Window

3. Complete the form and click **Sign** (✔).

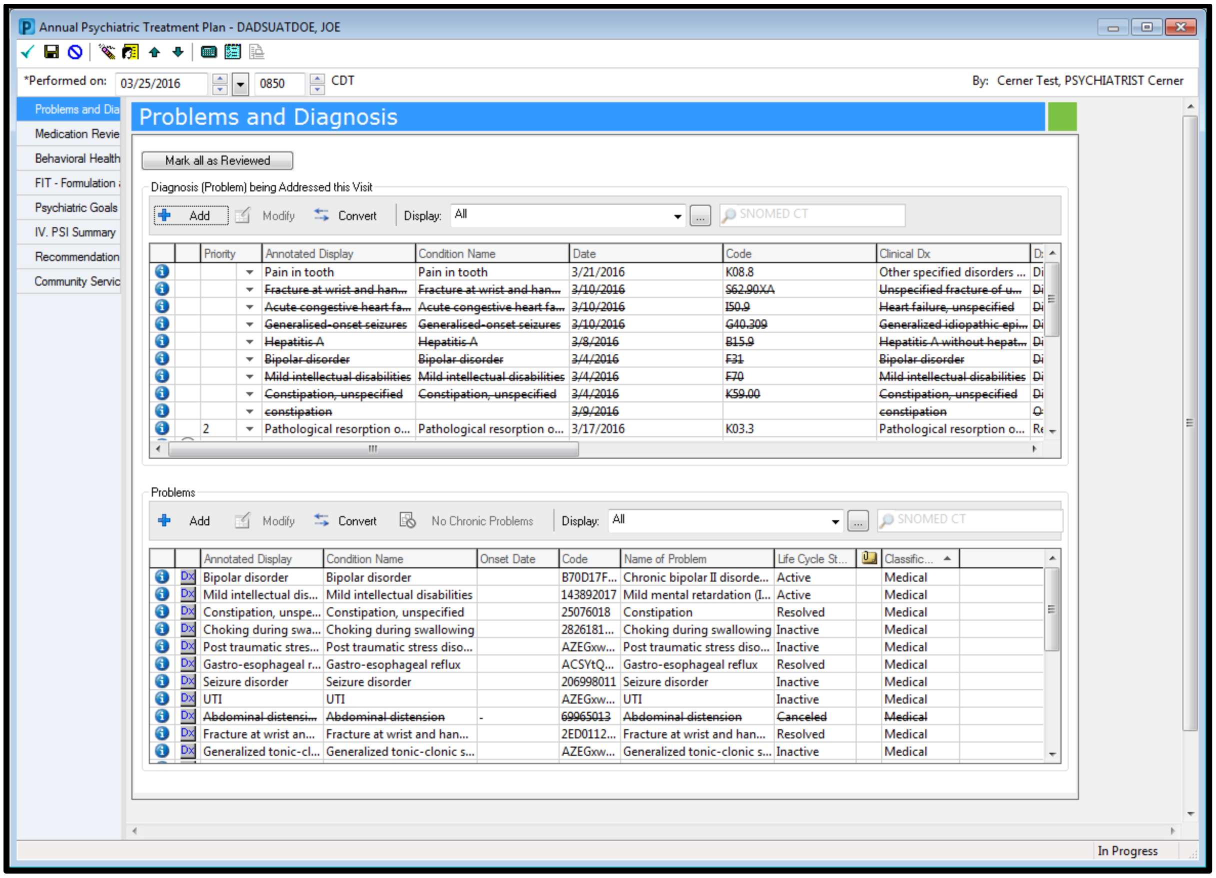
On a yearly basis (10 days prior to the ISP meeting), the **Annual Psychiatric Treatment Plan** and the **Psychiatry Template for IRRF** are completed for psychiatric residents.

1. From the resident's **Chart** menu, click the **Ad Hoc** icon.

   The **Ad Hoc Charting** pop-up window displays.

2. Click the **Annual Psychiatric Treatment Plan** check box and click **Chart**.

- The **Annual Psychiatric Treatment Plan** pop-up window displays.



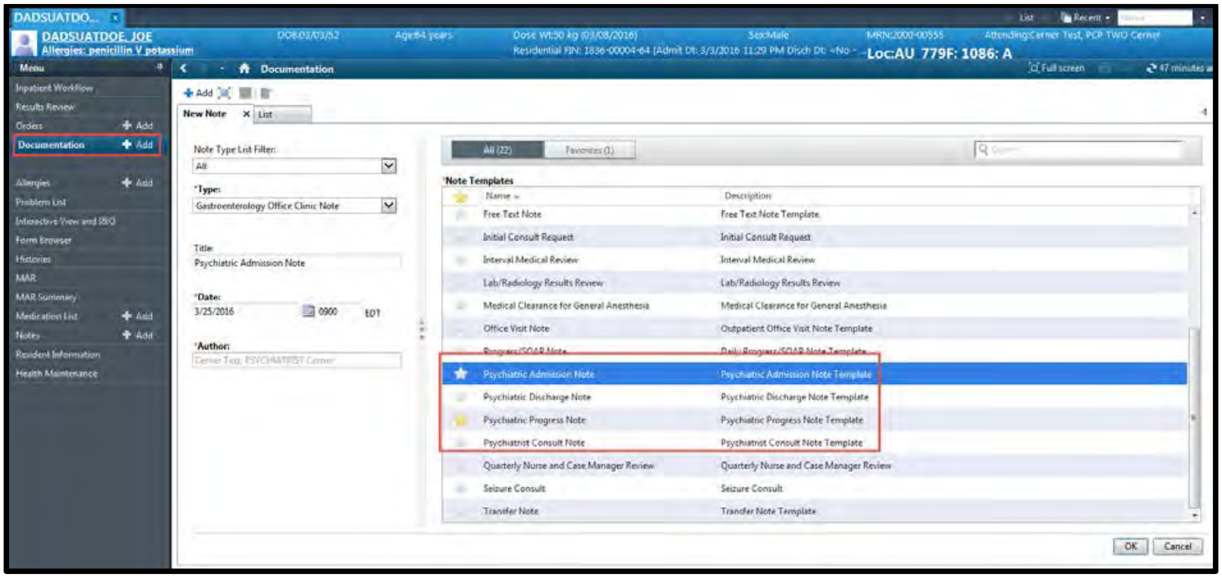
Quarterly Drug Regimen Review Pop-Up Window

3. Complete the form and click **Sign** (✓).

In addition to the regular forms that must be completed on a quarterly and annual basis, residents are seen as needed for acute conditions. When these visits occur, any findings and/or recommendations are documented in a **Psychiatry Progress Note** template.

1. From the resident's, click the **Documentation** band.
2. Click **Add+** from the **Documentation** band.

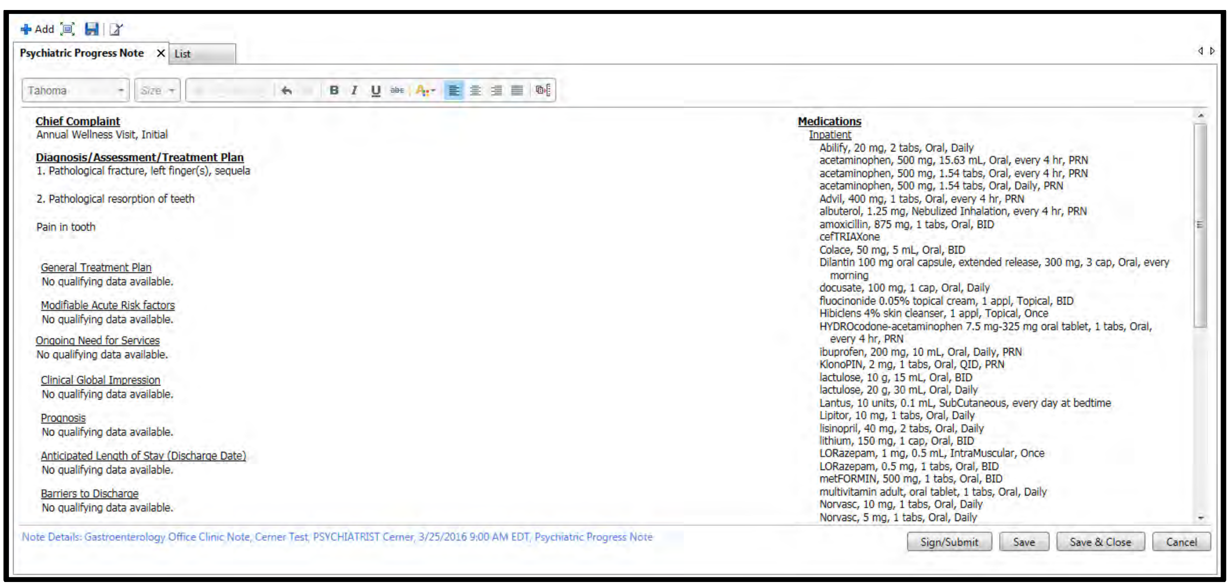
The **Documentation** window displays.



Documentation Window

3. From the **Note Templates** window, click **Psychiatry Progress Note Template**.

The **Psychiatry Progress Note Template** window displays.



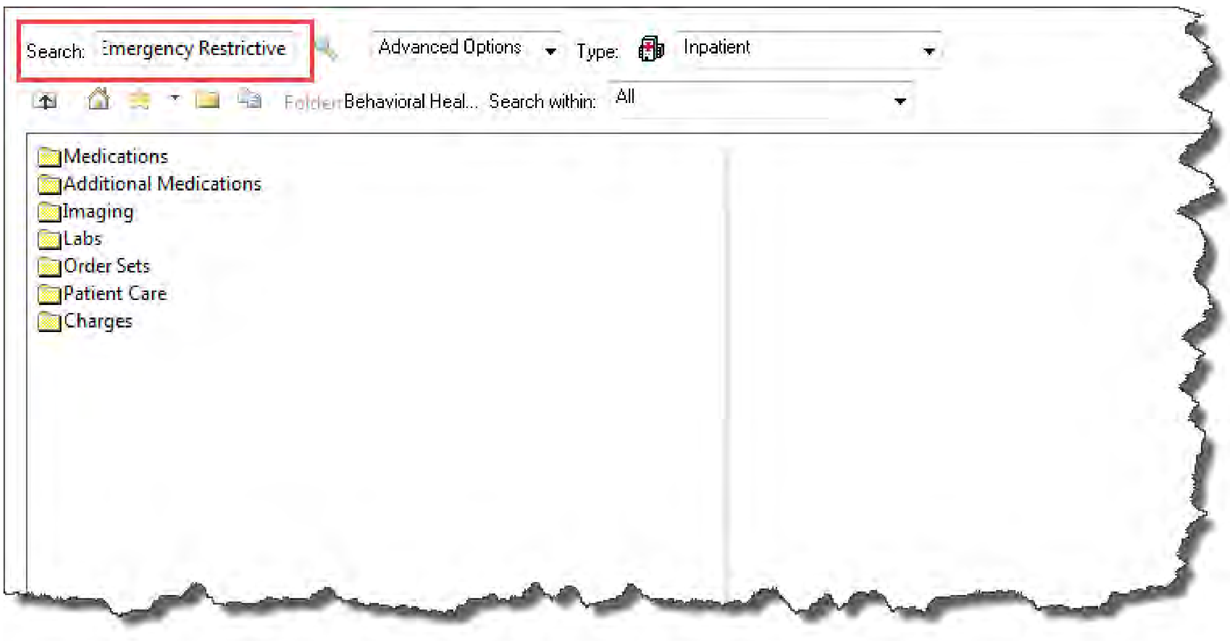
4. Complete the form with the appropriate information regarding the resident.
5. Click **Sign/Submit**.

Emergency Psychotropic Medication

In instances where an individual requires psychotropic medication in an emergency due to a psychiatric condition, the **Emergency Restrictive Practice Use** order must be added.

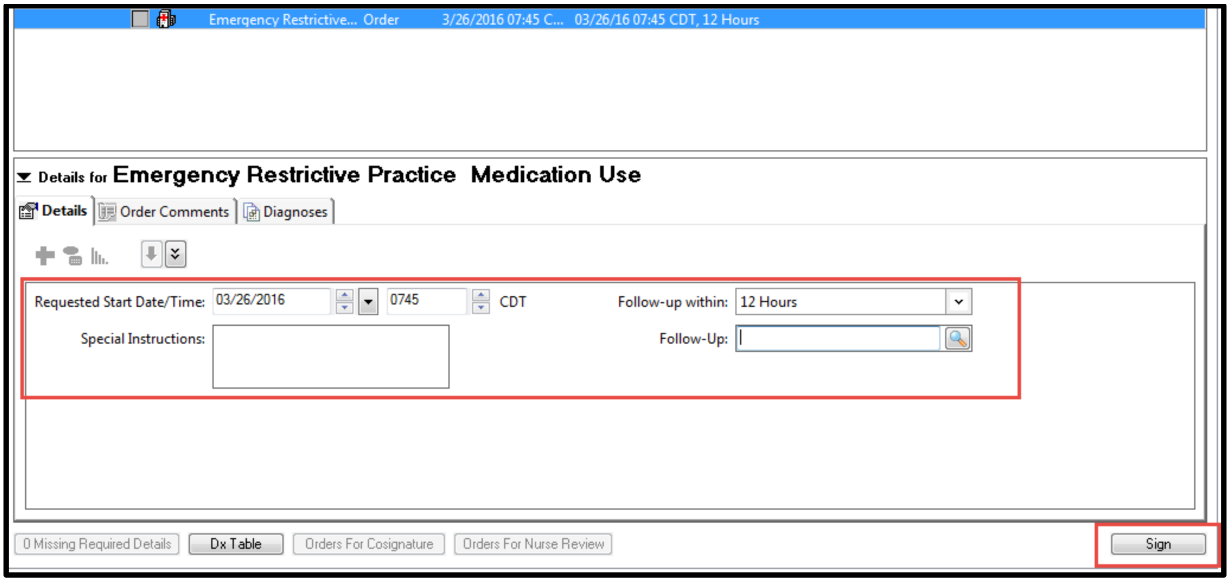
1. From the **Chart** menu, click **Add+** from the **Orders** band.

    The **Add Order** pop-up window displays.



Add Order Pop-Up Window

2. Search for "Emergency Restrictive Practice Medication Use" and click the order and then click **Done**.
3. From the **Orders** window on the resident's chart, complete the **Restrictive Practice** order and click **Sign**.



Order Window – Emergency Restrictive Practice Medication Use

Note ►	A Psychiatry Progress Note should be completed from the resident's chart, documenting all recommendations and relevant information.

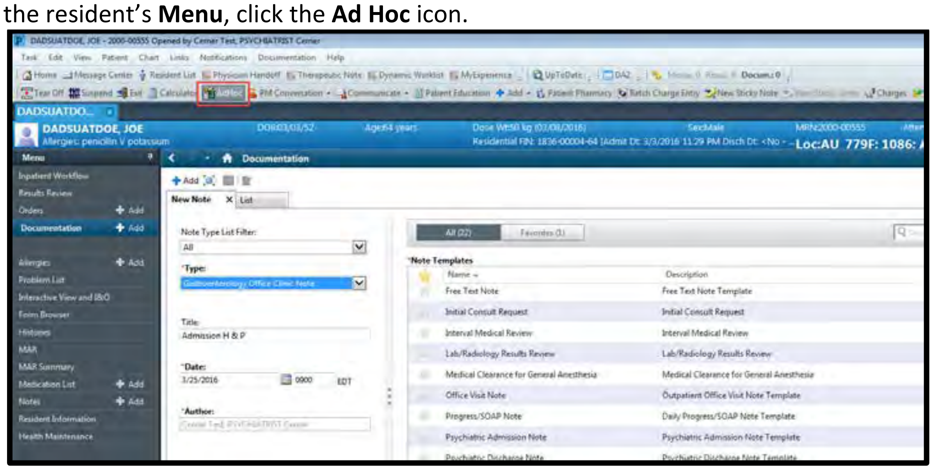
Chemical Restraint

In the case of a resident requiring a chemical restraint due to a behavioral emergency, the chemical restraint should be ordered by contacting the RN through the **Telephone/Verbal Orders** workflow.

The **Post-Chemical Restraint Clinical** review must be completed after a chemical restraint is administered.

Note ►	The **Psychiatry Review** section of the checklist must be completed within 10 days of the chemical restraint.

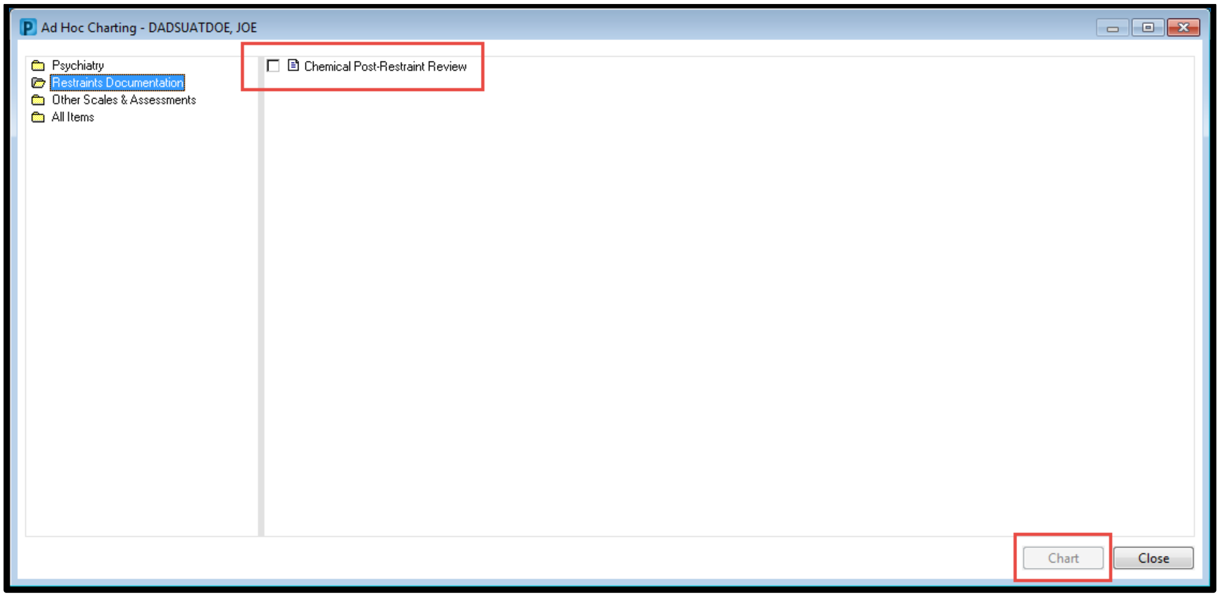
1. From the resident's **Menu**, click the **Ad Hoc** icon.



Resident's Chart - Ad Hoc

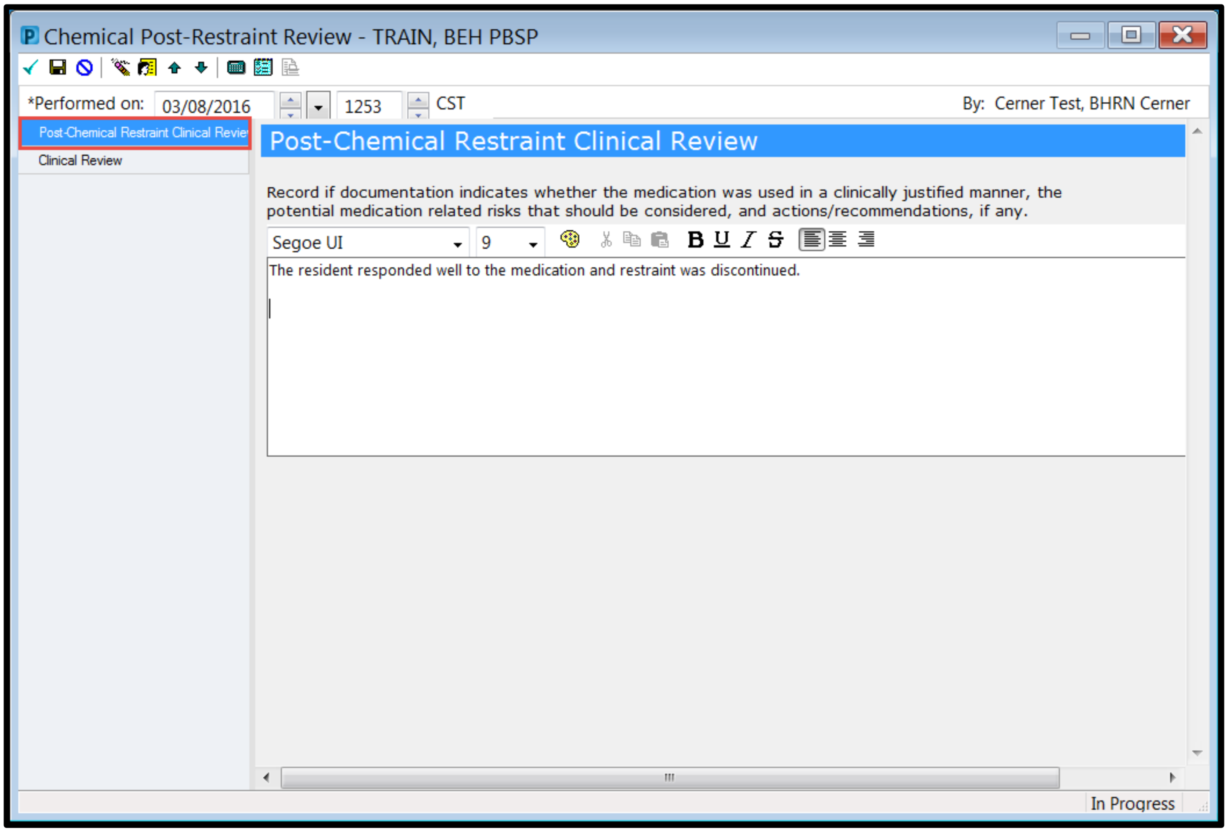
The **Ad Hoc Charting** pop-up window displays.

2. Click the **Restraints Documentation** folder and select the **Chemical Post Restraint Review** check box.
3. Click **Chart**.



Ad Hoc Charting Pop-Up Window

The **Chemical Post-Restraint Review** pop-up window displays.



AdHoc Form – Post-Chemical Restraint Clinical Review

4. Complete the appropriate sections of the form and click **Sign** (✓).

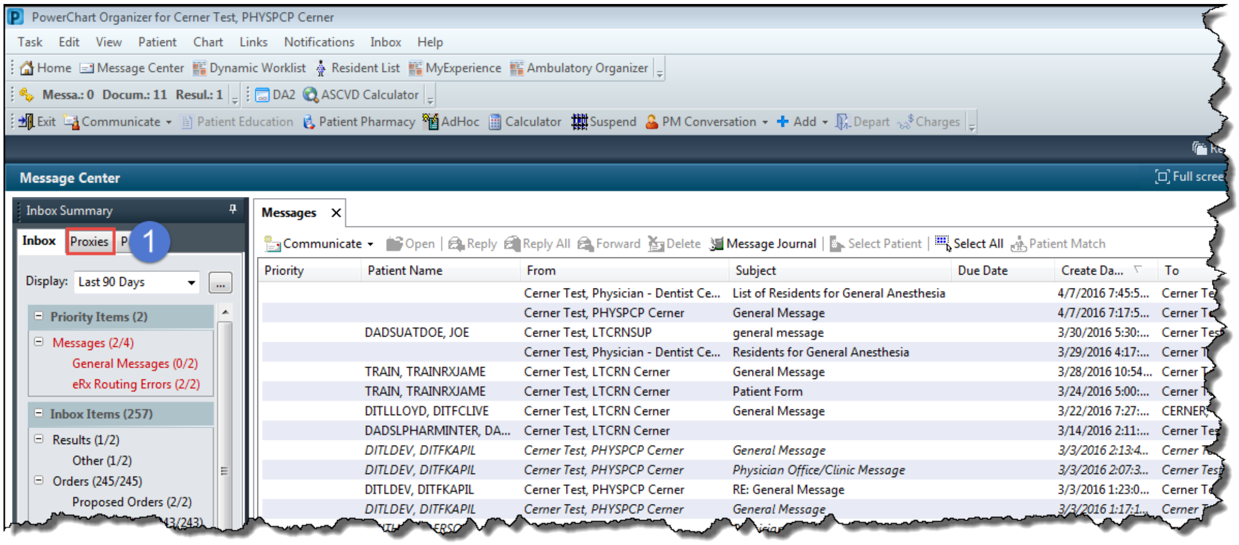
Note ▶	Whenever a chemical restrain is administered, a **Psychiatry Progress Note** should be completed from the resident's chart, documenting all relevant information.

Exercises

- Complete a Consent form.
- Add an Emergency Restrictive Practice order.
- Complete a Quarterly Drug Regimen review.
- Complete a Chemical Post Restraint Review.

ASSIGNING/ADDING A PROXY

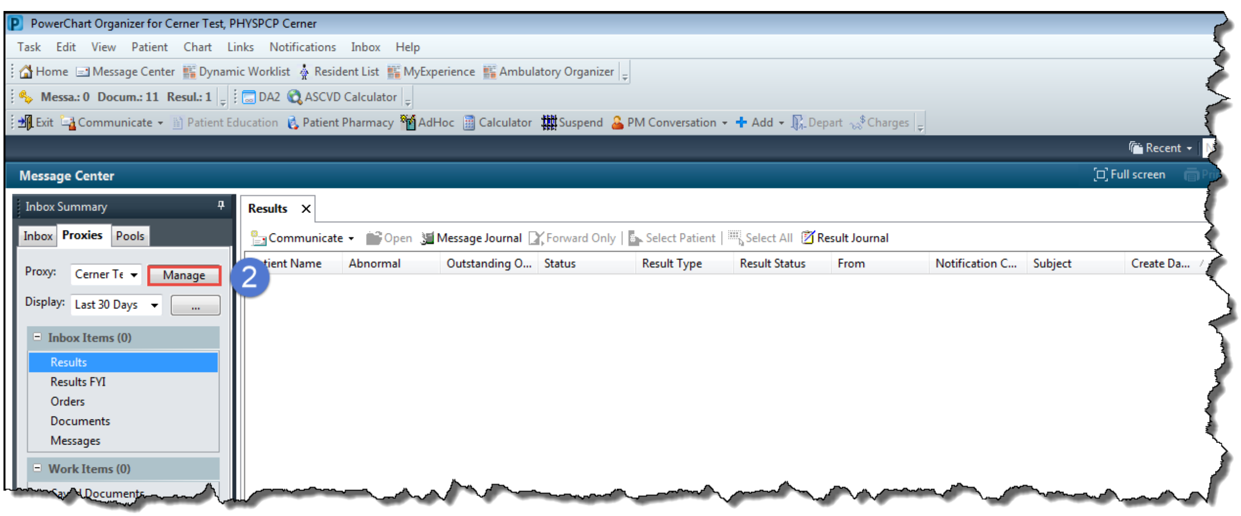
Begin at the **Message Center** window.



Message Center Window

4. Click the **Proxies** tab in the **Inbox Summary** section that is on the left of the **Message Center** window.

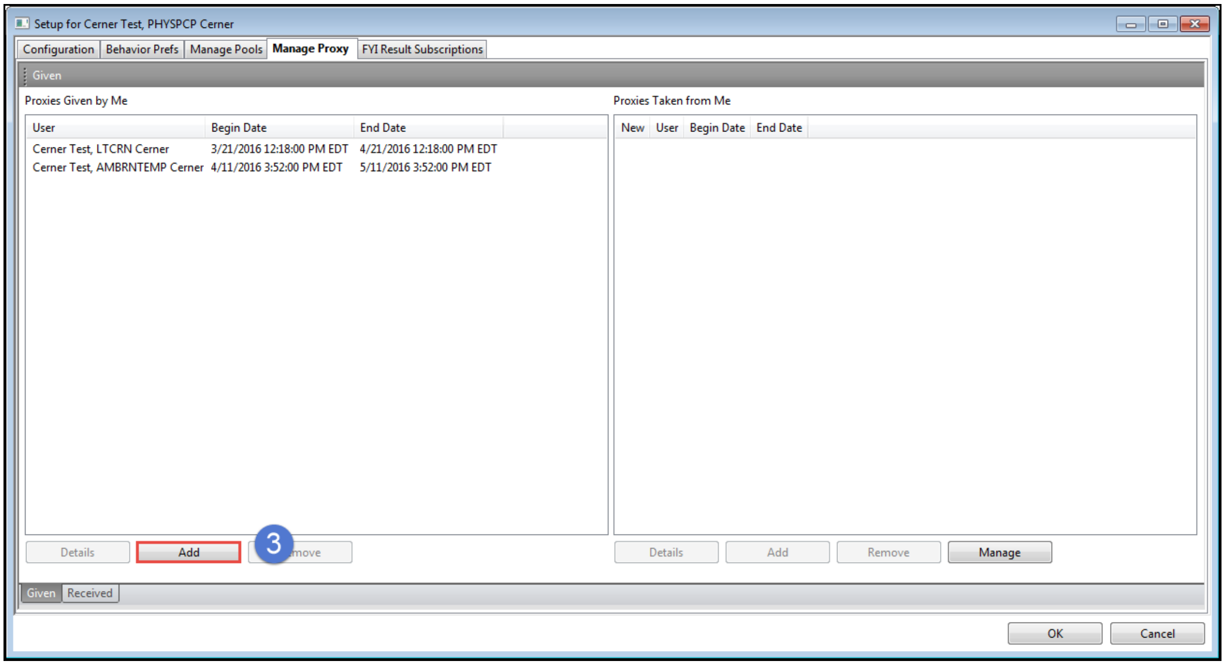
The **Proxies** window displays.



Proxies Window

5. From the Inbox Summary, click **Manage**.

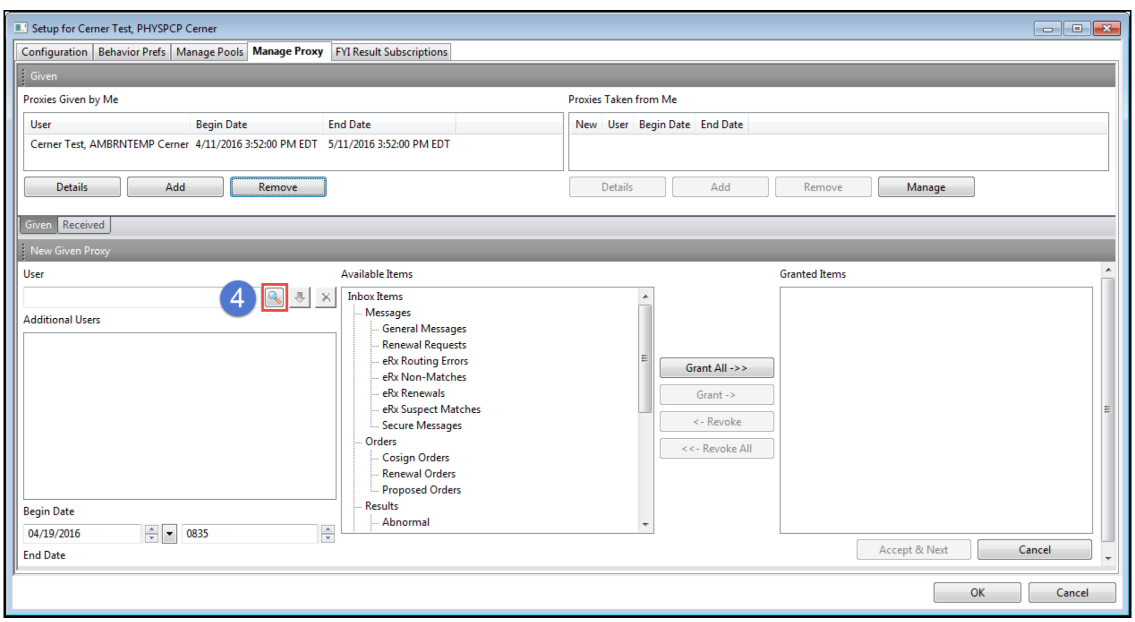
The **Setup** pop-up window displays.



Setup Pop-Up Window

6. Click **Add**.

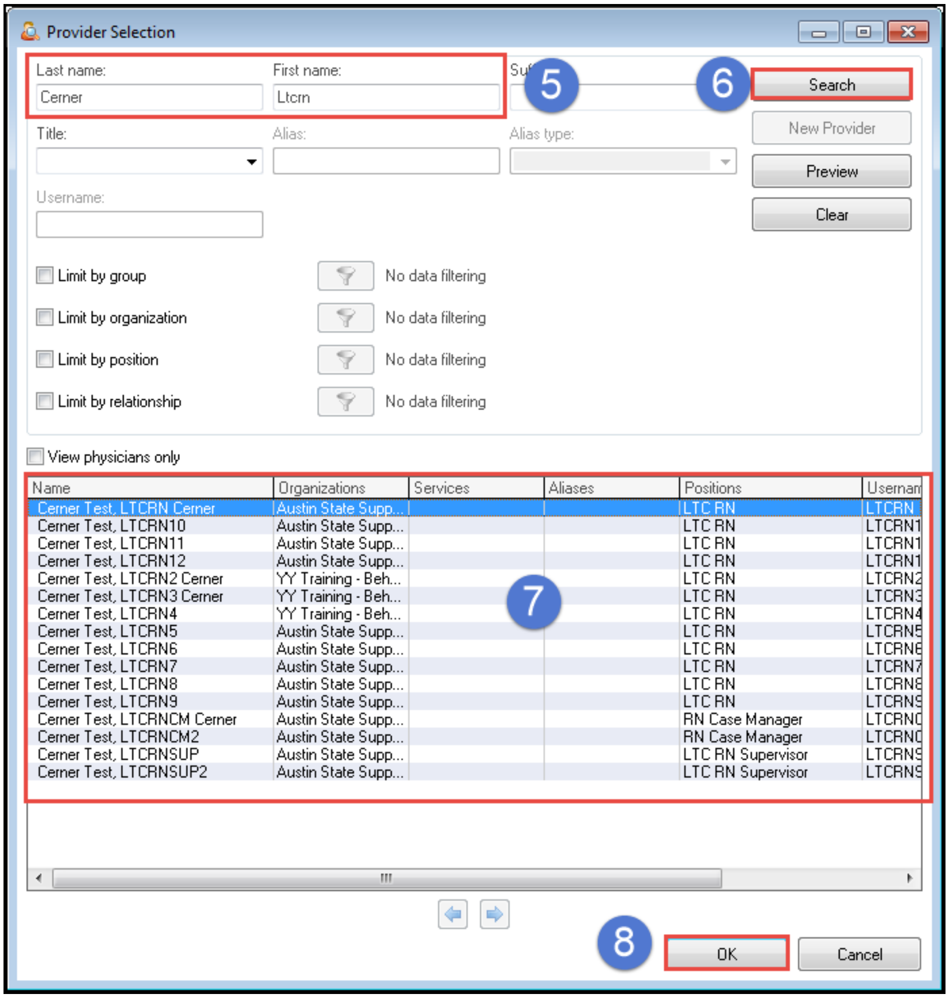
The **New Given Proxy** section of the **Setup** pop-up window displays.



Setup Pop-Up Window: New Given Proxy

7. Click the magnifying glass icon ( ) to search for the proxy to be assigned.

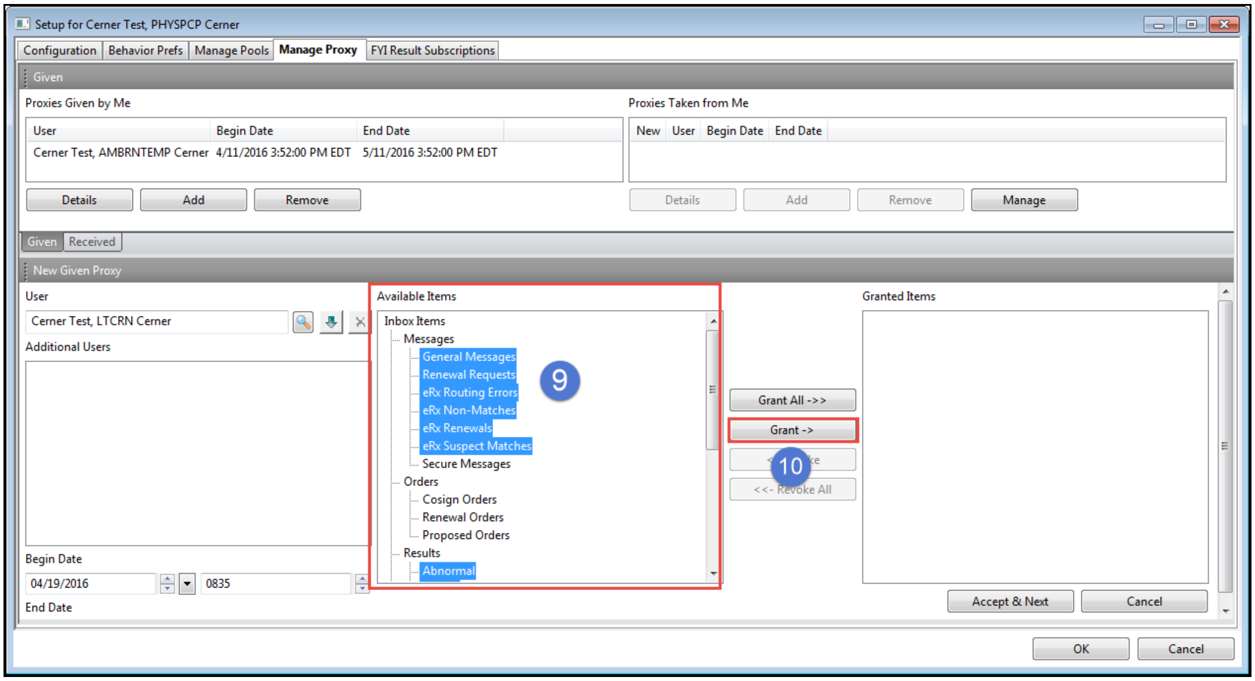
The **Provider Selection** pop-up window displays.



Setup Pop-Up Window: Provider Selection

8. In the **Last Name** and **First Name** fields, enter the proxy's name.
9. Click **Search**.
10. Select the correct proxy from the search results.
11. Click **OK**.

The **New Given Proxy** section displays the selected user in the **User** field.



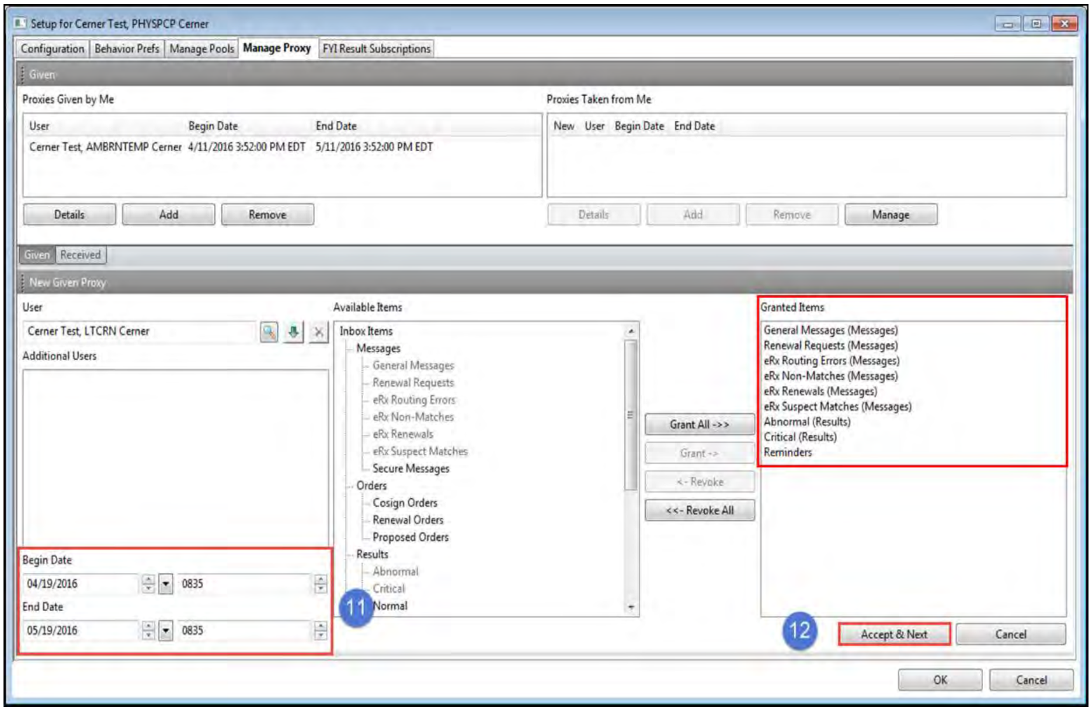
Setup Pop-Up Window: New Given Proxy

12. Using the **Available Items** list, select the first item to which the proxy should have access.
13. Click **Grant** to move that item into the **Granted Items** list.

Note ► To revoke access, select items from the **Granted Items** list and click **Revoke**.

Tip ► To grant access to all items, click **Grant All**. To select more than one item at a time, hold the Ctrl key on the keyboard to select multiple items, then click **Grant**.

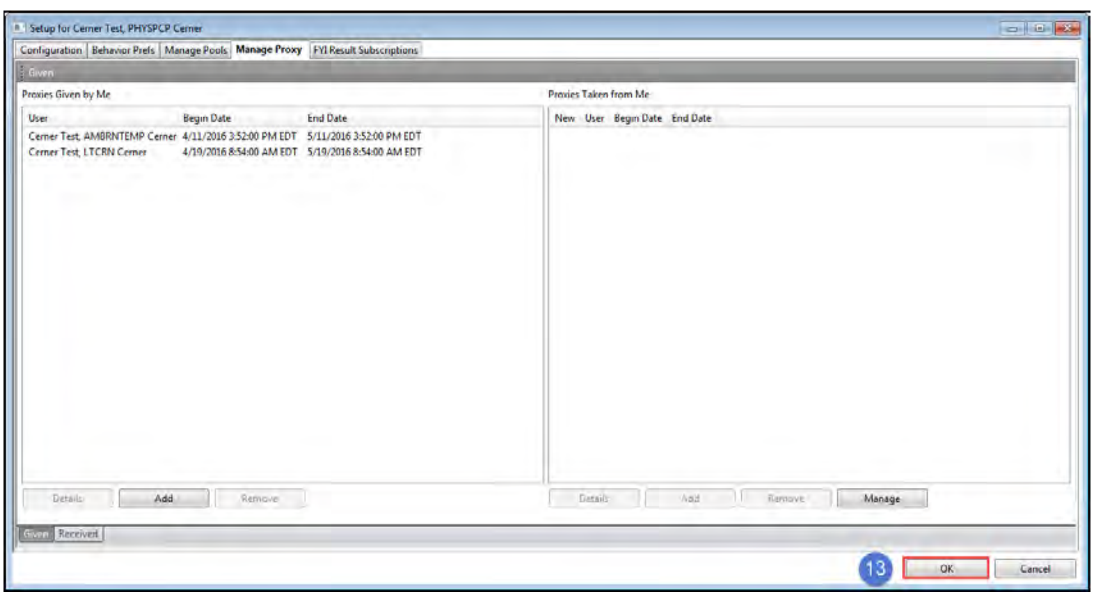
The **New Given Proxy** section displays the granted items in the **Granted Items** list.



New Given Proxy: Granted Items Updated

14. Update the **Begin Date** and **End Date** fields to reflect the time period for the proxy.
15. Click **Accept & Next** to add the proxy.

The **Set-up** pop-up window displays with current proxy name and dates.

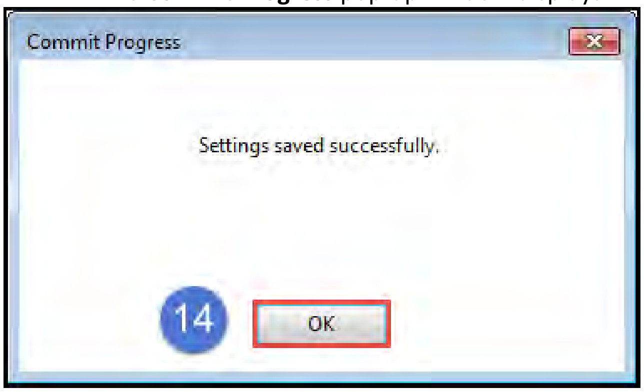


Set-Up Pop-Up Window

16. Click **OK**.

> **Note** ► A proxy which has been granted access for a future date will display as grey in the **User** list under **Proxies Given by Me**.

The **Commit Progress** pop-up window displays.

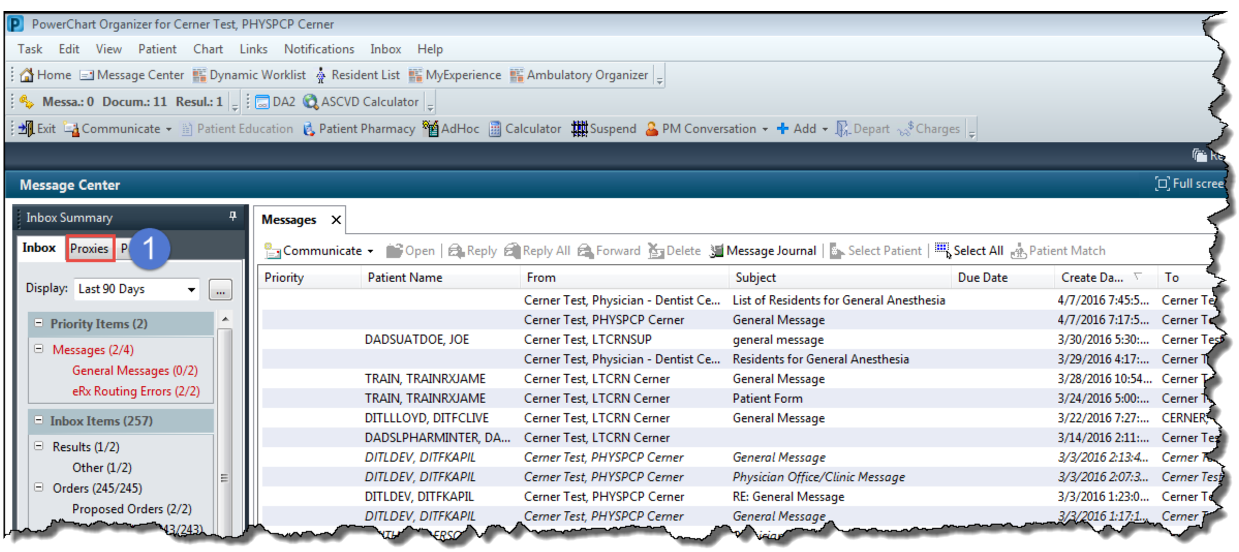


Commit Progress Pop-Up Window

17. Click **OK**.

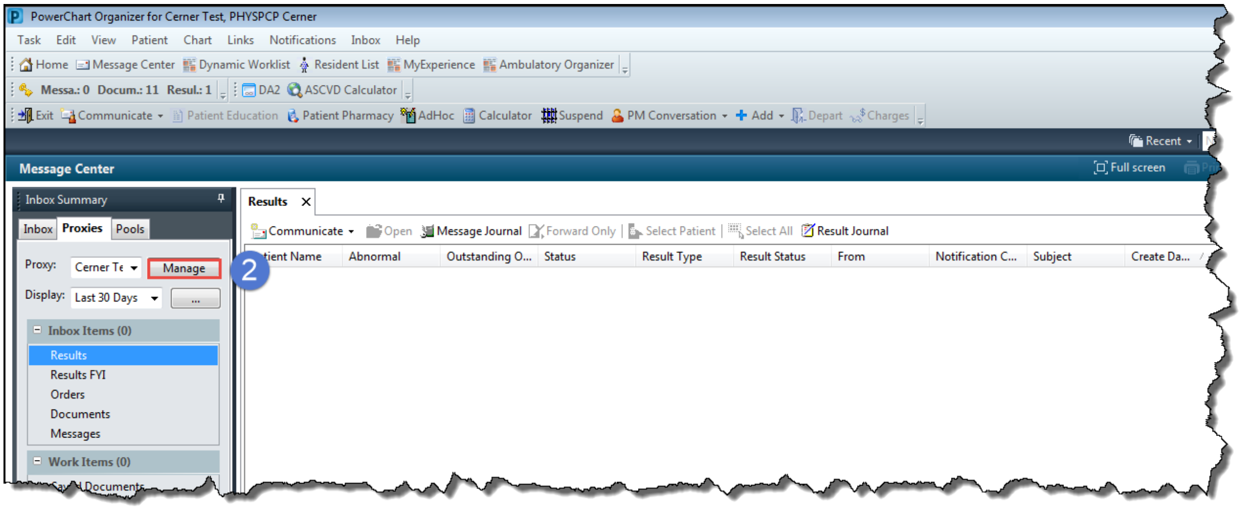
Modifying a Proxy

1. Click the **Proxies** tab in the **Inbox Summary** section that is on the left of the **Message Center** window.



Message Center Window

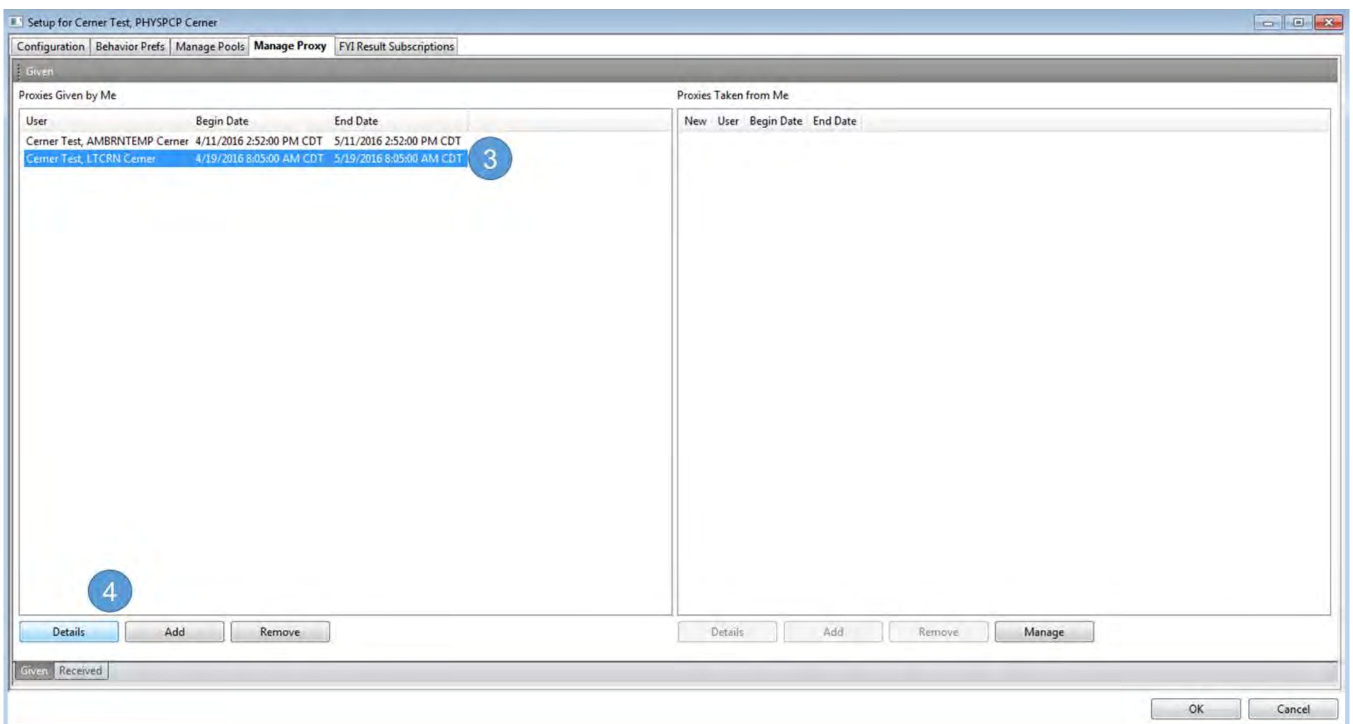
The **Proxies** window displays.



Proxies Window

2. From the **Inbox Summary**, click **Manage**.

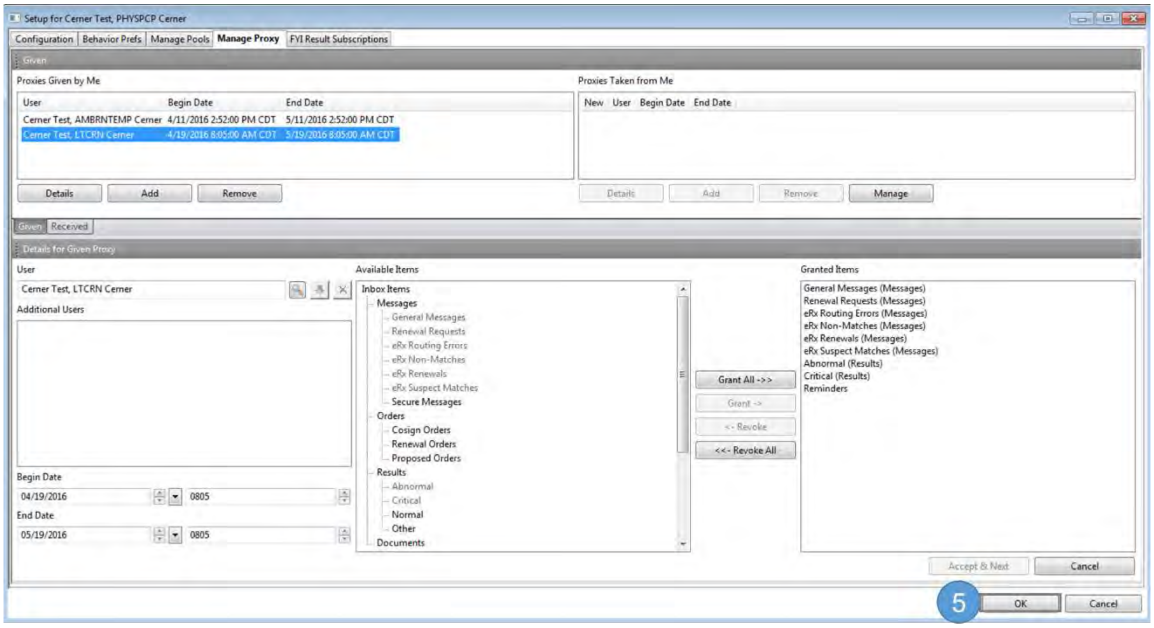
The **Setup** pop-up window displays.



Setup Pop-Up Window

3. Select a proxy from the **User** list.
4. Click **Details** to display the items granted and the associated dates for the user/proxy.

The **Details for Given Proxy** section displays.



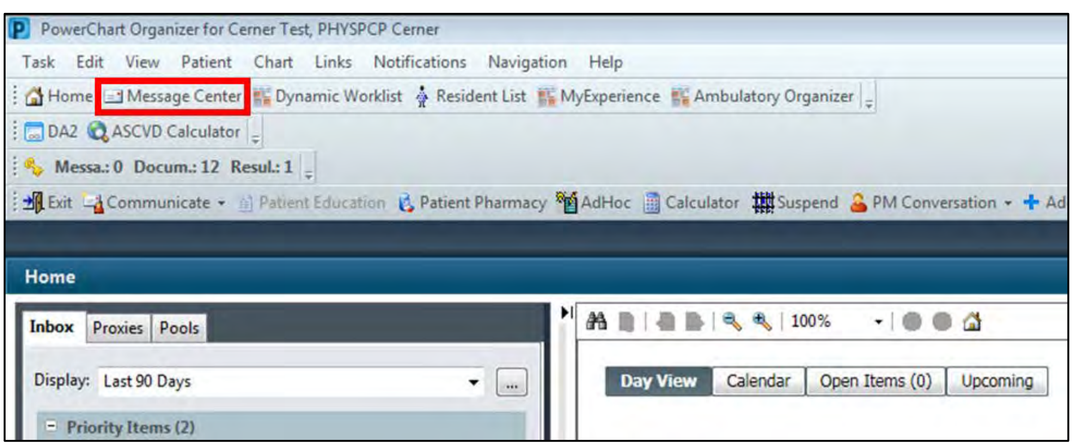
Details for Given Proxy

5. Make any desired updates and click **OK** to save.

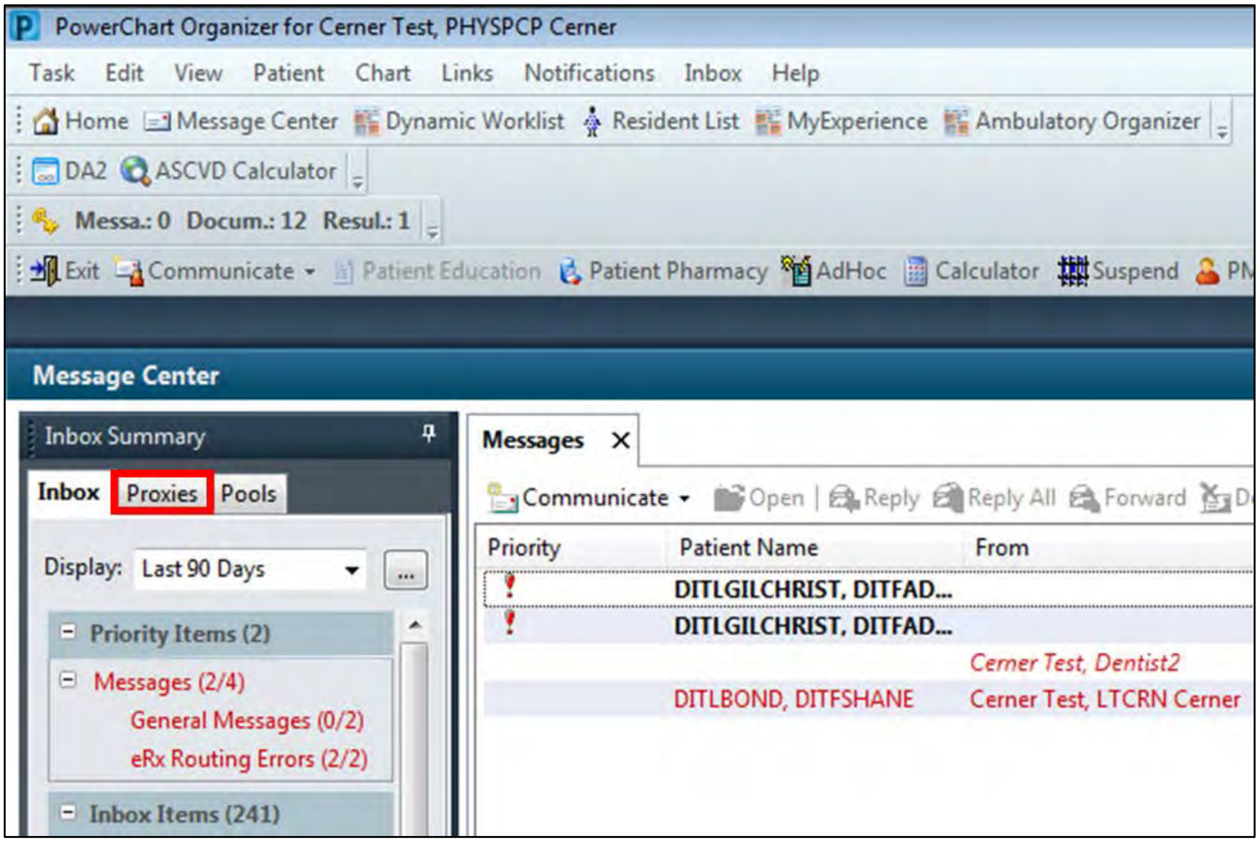
Note ▶ Available Items may be granted or removed from this window.

View Details of a Proxy

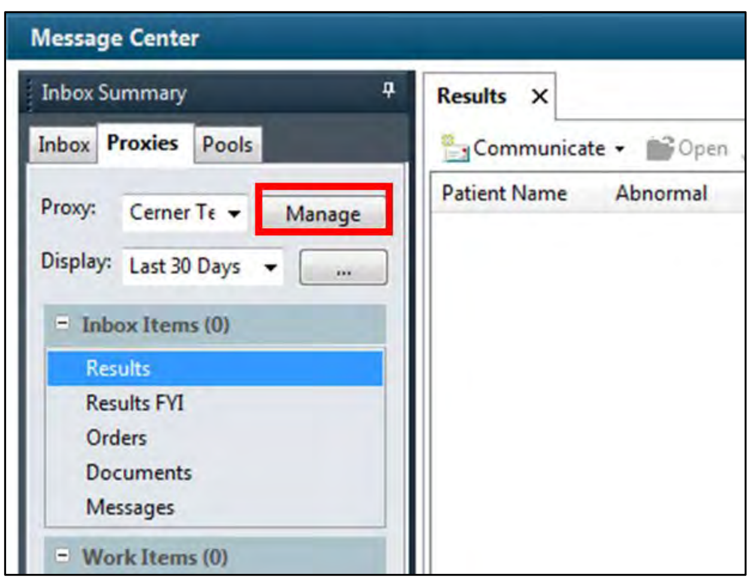
1. Navigate to the **Message Center**.



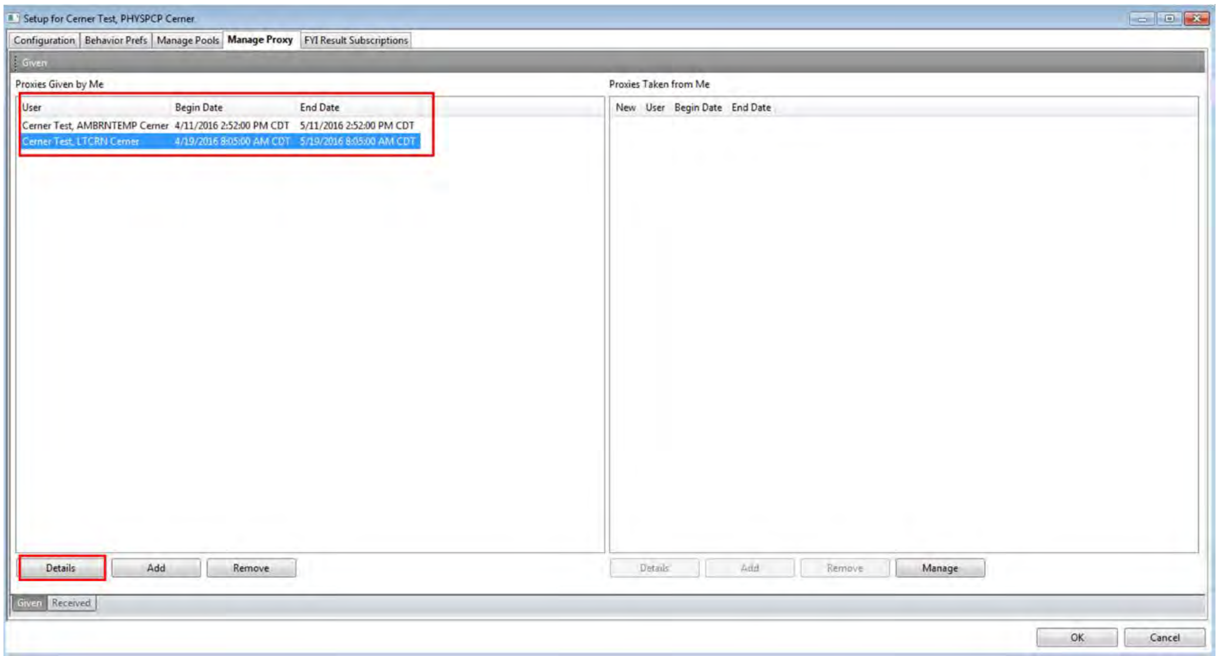
2. From the Inbox Summary click **Proxies**.



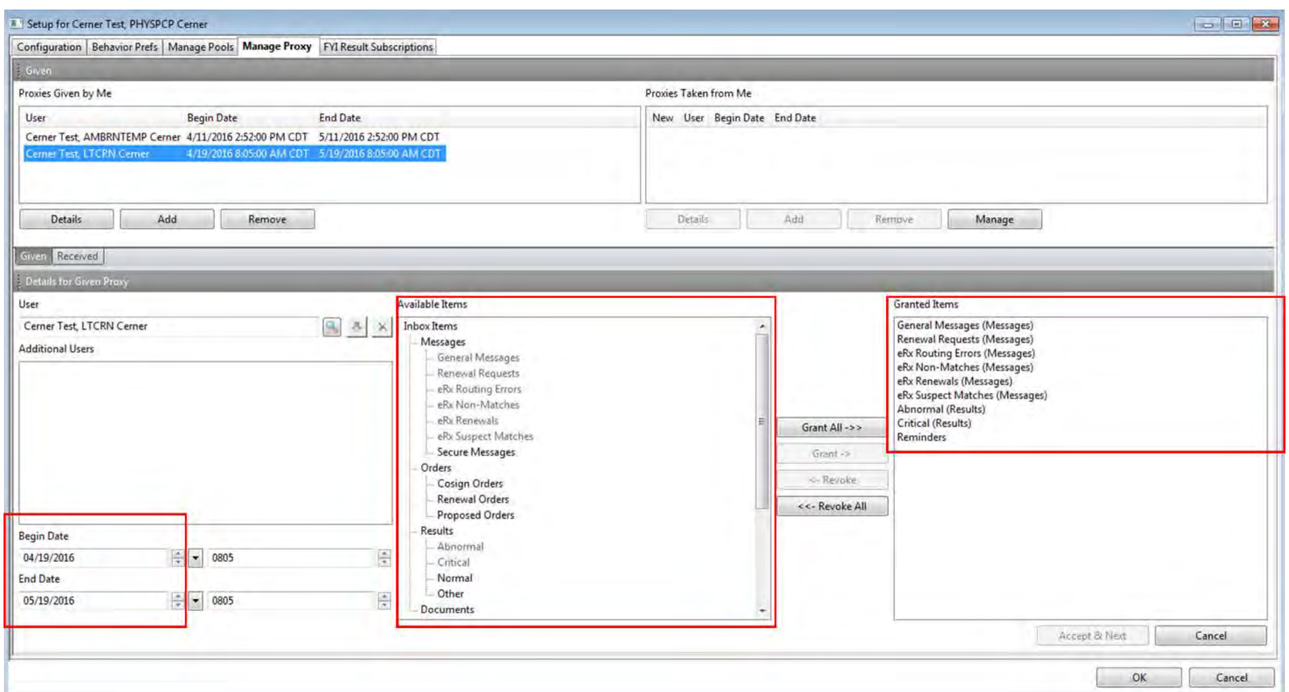
3. From the **Proxies** window click **Manage** to add, remove, manage, and view the details of assigned proxies.



4. To view details of a proxy, select a **User** and click **Details.**



5. From the **Manage Proxy** tab, the items granted and associated dates for the proxy display. Available items may be granted from this window.

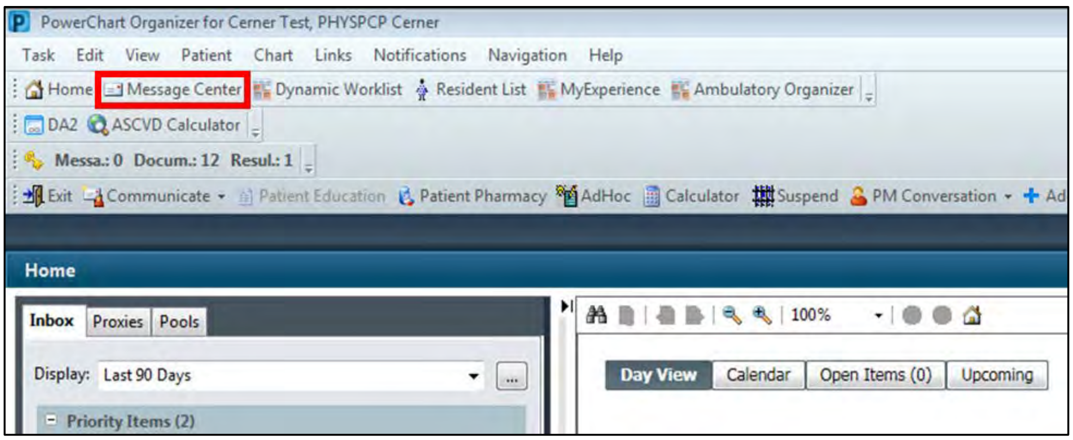


Remove Proxy

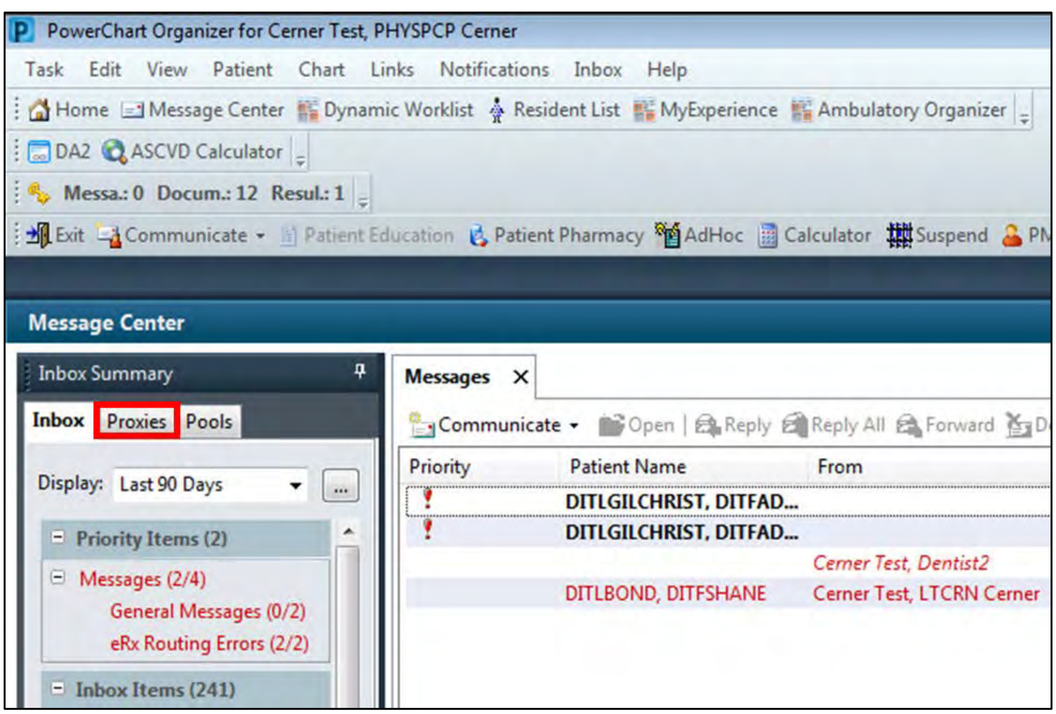
1. From the **Manage Proxy** tab, select a user and click **Remove** to remove a user as a proxy.
2. After a proxy is removed, the user is not saved for future use and must be re-added using the above described steps.

Manage Additional Users

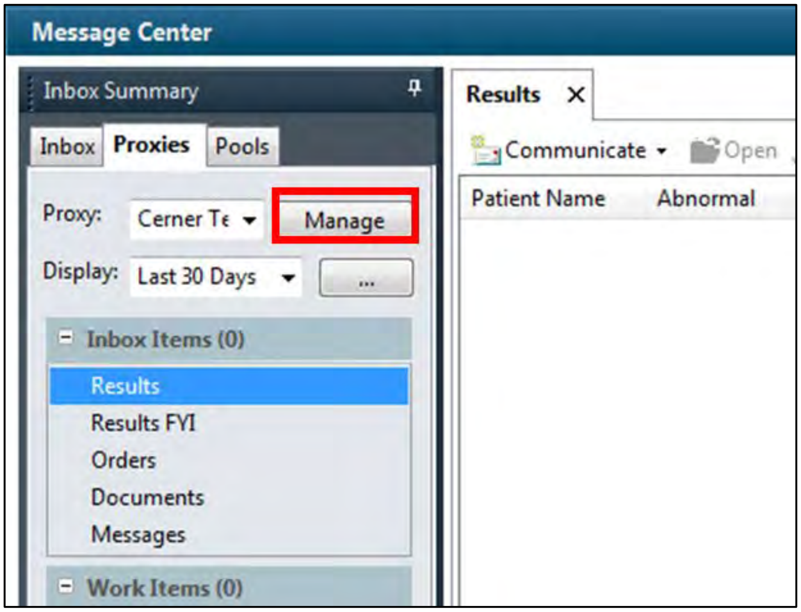
1. Navigate to the **Message Center**.



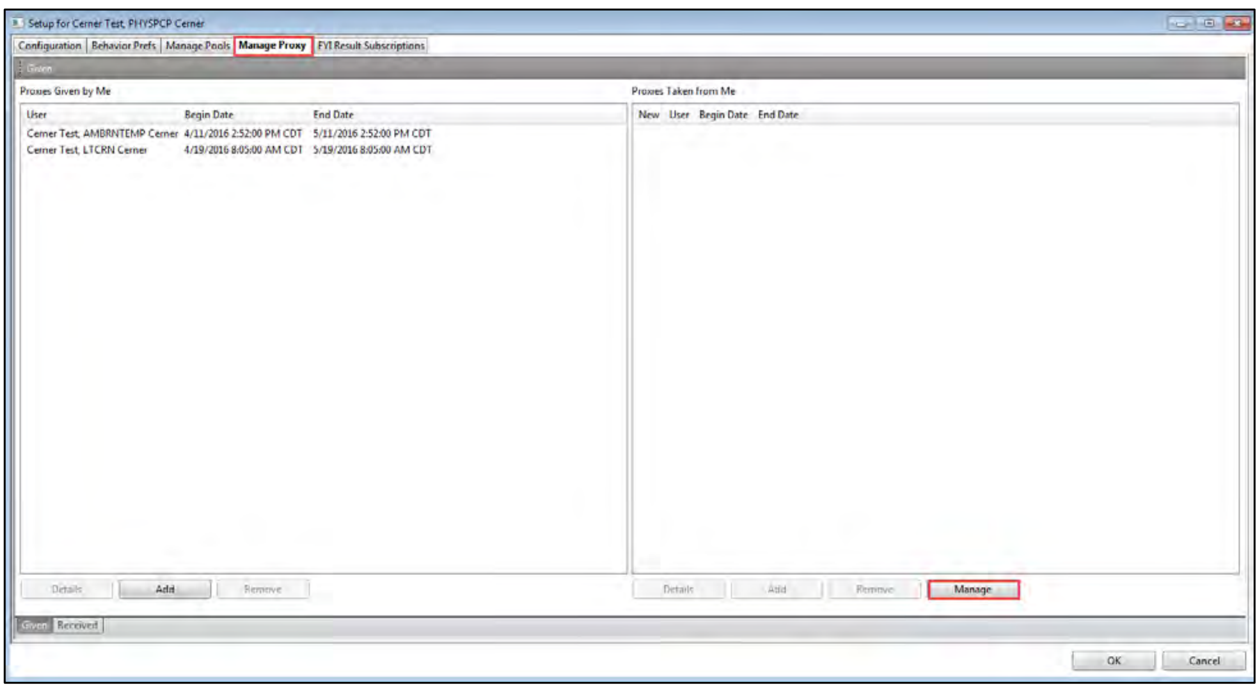
2. From the Inbox Summary click Proxies.



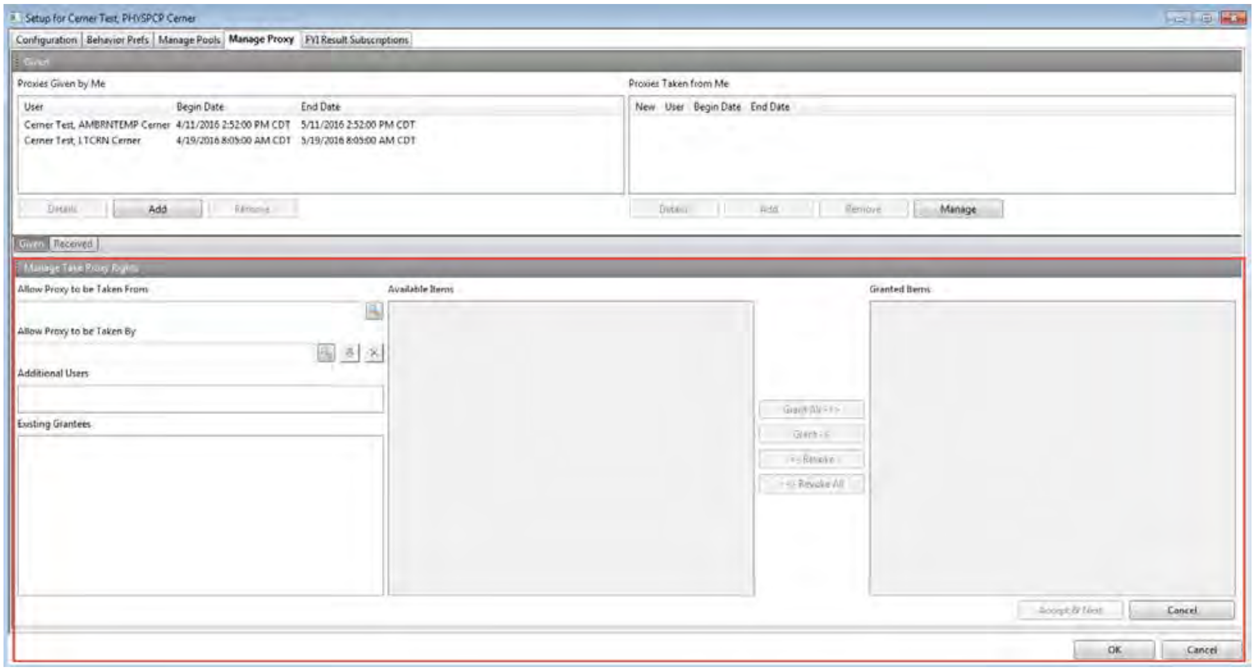
3. From the **Proxies** window click **Manage** to add, remove, manage, and view the details of assigned proxies.



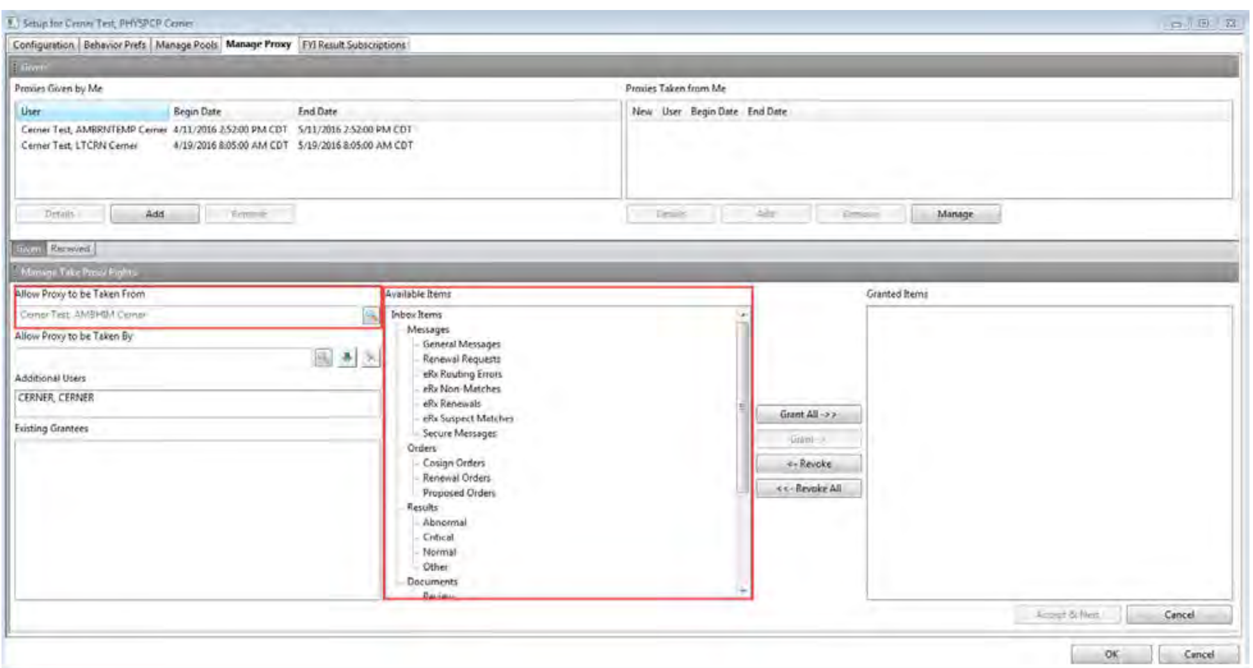
4. From the **Manage Proxy** tab, click **Manage** to add additional users.



- The **Manage Take Proxy Rights** section appears in the window.

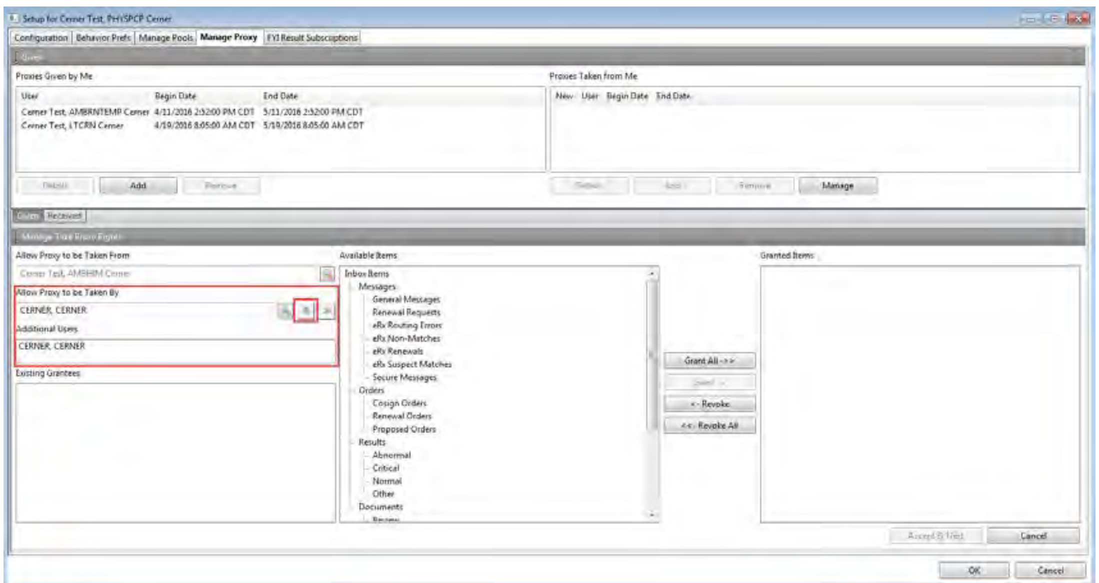


5. From the **Allow Proxy to be Taken From** field, search for a user that the proxy will be taken from.
6. Select the desired user from the pop-up window. This will populate the **Available** Items field.



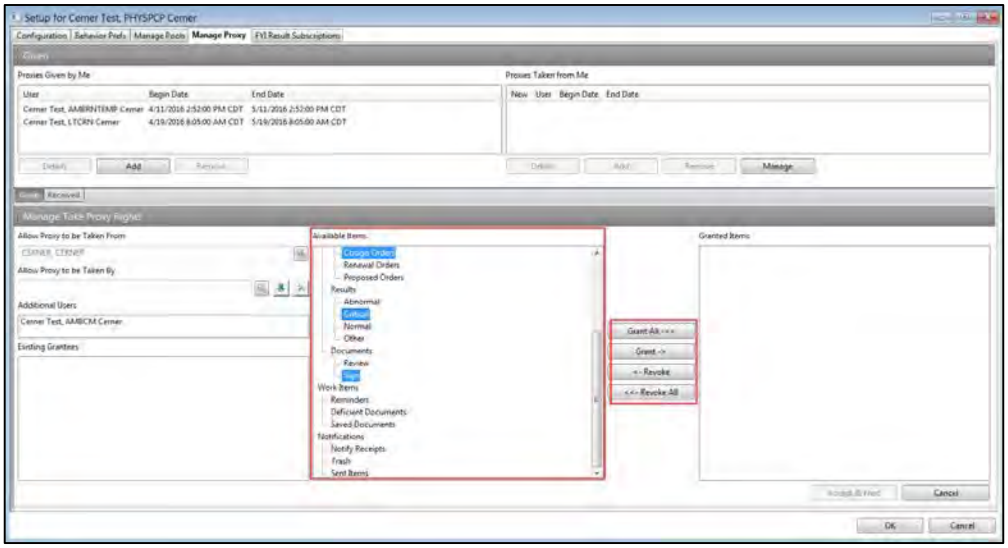
> **Note** ▸ A user must be entered in the **Allow Proxy to be Taken From** field for the **Available Items** to display.

7. From the **Allow Proxy to be Taken By** field, search for a user that will take proxy.
8. Select the user from the pop-up window.
9. Click the downward facing arrow beside the **Allow Proxy to be Taken By** field to add the user to the **Additional Users**.

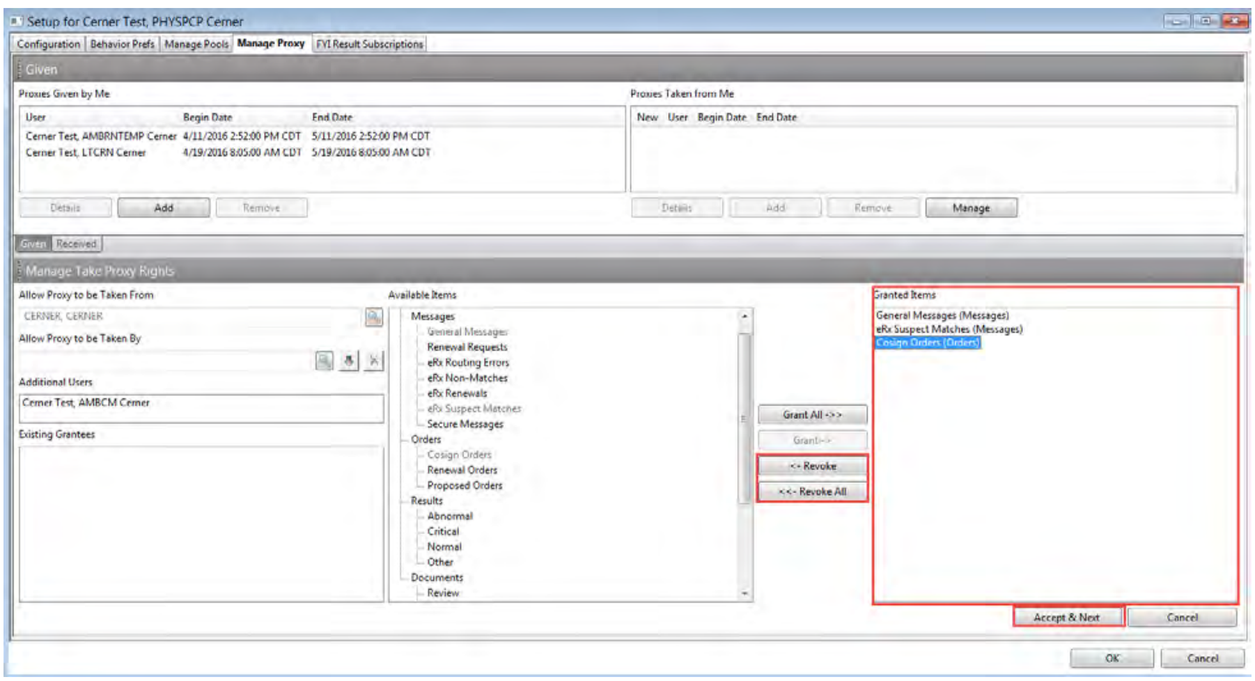


> **Note** ▸ Multiple users may be added to the **Additional Users** field

10. Click the **Available Items** while holding down the **CTRL** key on the keyboard to select individual items to grant to the proxy.
11. Click **Grant** for the selected items or **Grant All** for all items.



12. Click individual items within the **Granted Items** field to revoke items using either **Revoke** for selected items or **Revoke All** for all items.
13. Click **Accept** and **Next** to add the proxies.



ASSESSMENT

Question 1 – *Select the correct response*
When refusing an order from the Cosign Orders folder, the provider must identify a reason?

a) True
b) False

Question 2 – *Identify the correct order of steps to complete this process*
A resident needs a chest x-ray. The procedure is to be performed by an onsite radiology technician On Campus before 5:00pm.

________Exam is performed and the results are read by the radiology technician.

________Provider receives a message/access to the results in the resident's paper chart.

________Order is placed for a chest x-ray.

________Radiology technician sends a notification to the provider and adds the results in the resident's chart.

________Provider reviews the results and documents any findings in a Radiology/Lab Results Reviewed note.

Question 3 – *Select all that apply*
To add a non-scheduled resident to a Resident List, which of the following steps must be completed?

a) Perform a resident search from the Resident List toolbar.
b) Enter the resident's most recent phone number.
c) Double-click the resident's name to open the chart.
d) Assign a proxy from the Customize Patient List Properties pop-up window.

Question 4 – *Fill in the blank with the appropriate location*
A resident's lab results performed at the state lab are posted in the ______________________________folder in the Message Center Inbox when ready.

Question 5 – *Select the correct series of steps to complete the process*
A resident is being transferred to another SSLC. To perform a Transfer Medication Reconciliation, the provider must complete the following steps:

a) Select Transfer from the Reconciliation tab and make a decision to continue, discontinue, and/or convert to prescription for each medication. Select Reconcile and Sign.
b) Select Transfer from the Reconciliation tab and make a decision to continue, discontinue, and/or convert to prescription for each medication. Select Reconcile and Plan.
c) Convert all medications to written prescriptions. They will be transferred with the resident to the new facility.

Question 6 – *Select the correct response*
When giving a telephone order to an RN, an alert can be ignored and addressed at a later date.

a) True
b) False

Question 7 – *Select all that apply*
When placing an order for a consult with an outside provider, which of the following steps must be completed?

a) Choose Off Campus for the location of the consult.
b) Review the consulting physician's recommendations from the results folder in the Message Center Inbox.
c) Review the consulting physician's recommendations from paper documentation.
d) Transcribe all recommendations into a Consultation Recommendation Integrated Progress Note (IPN).

Question 8 – *Select all that apply*
When adding a pending expectation for Diabetes Management in the Health Maintenance window, a Consult to Optometry is one of the selections for the diabetes eye exam.

a) True
b) False

Question 9 – *Identify the correct order of steps to complete this process*
A medical clearance for general anesthesia/TIVA must be documented for a resident.

________Place an additional order for Ativan PO one hour prior to the procedure to control anxiety.

________Document medical clearance for general anesthesia/TIVA in the resident's chart.

________Forward the documented medical clearance to the dentist's Message Center Inbox for review.

________Access the list of residents being considered for general anesthesia from the Message Center Inbox.

Question 10 – *Select the correct response*
After reviewing a resident's information, an Objective/Physical Exam can be completed from the following location:

a) Message Center
b) Ambulatory Organizer
c) Workflow MPage

Question 11 – *Select the correct series of steps to complete the process*
In order to perform a 180 day Orders Reconciliation on a resident with psychotropic medications, a provider must complete the following steps:

a) Log into the resident's chart as a PCP, access the orders profile, and select Transfer from the Reconciliation tab. An RN case manager will notify the psychiatrist to reconcile the psychotropic medications.
b) Log into the resident's chart as a PCP and reconcile only the non-psychotropic medications. An RN case manager will notify the psychiatrist to reconcile the psychotropic medications.
c) Log into the resident's chart as a PCP, access the orders profile, and select Transfer from the Reconciliation tab. Reconcile only the non-psychotropic medication and place the reconciliation in Plan status. An RN case manager will notify the psychiatrist to reconcile the psychotropic medications.
d) Log into the resident's chart as a PCP, reconcile only the non-psychotropic medications, and place the reconciliation in Sign status. An RN case manager will notify the psychiatrist to reconcile psychotropic medications.

APPENDIX A

Cerner Icon Glossary

Icon	Description
	Medication – Indicates medication activities.
	Patient Care – Indicates resident care activities.
	Assessments – Indicates resident assessment activities.
	Other – Indicates other activities.
	Nurse Review – The order requires a nurse review.
	Immediate Priority – Indicates Stat/Now orders for a resident.
	Critical Results – Indicates critical results for a resident.
	Non-Critical New Information – Indicates new non-critical results or orders for a resident. Click this icon to display additional information.
	Critical New Information – Indicates new critical results for Stat/Now orders. Click this icon to display additional information.
	High Risk Alert – Indicates the patient has high risk indicators. Hover over this icon to display additional information about the high risk indicators.
	Isolation – Indicates the patient is in isolation. Hover over this icon to display additional information about the isolation type(s).
	Help – Click this icon to display the CareCompass Help Pages.
	Order Comment – Indicates an order has a comment attached. Hover over this icon to display the comment.
	Establish Relationship – Click this icon to display the Establish Relationship Dialog box.
	List Maintenance – Click this icon to display the List Maintenance dialog box and to edit the list.
Add Add	**Add –** Click either of these icons to open the Add window and to add: a resident, allergies, orders, medication orders, documentation, etc.
	Abnormal Result – Indicates a result is abnormal.
	High Result – Indicates a result is high.
	Low Result – Indicates a result is low.
	Properties – Click this icon to modify the properties in a Resident List.
	Sign Form – Click this icon to sign a form.
	Find – After typing in a text field, click this icon to perform a search.
	New – Click this icon to add a note.
	Modify – Click this icon to modify an element on the window (list, note, etc.).
Print	**Print –** Click this icon to print the information displayed on the screen.
	Order Details Not Complete – Click this icon to view fields that must be completed before an Order can be completed.
	Appointment Inquiry – Click this icon to look up appointment information.
	Check In – Click this icon to check in a resident for an appointment.
	Save – Click this icon to save.

	Expand/Collapse – Click the down arrow icon to expand a section of the window. Click the up arrow icon to collapse a section of the window.
	Quick Chart – Click this icon to chart progress for Outcomes and Interventions.
	Settings – Click this icon to open the settings window.
	Search – Click this icon to open the Resident Search pop-up window and perform a resident search.

APPENDIX B

Cerner Terms Glossary

Term	Definition
Account Number	A unique medical record number assigned to each resident or guarantor that remains with the resident regardless of the number of encounters.
Active	An element in the system is active when an action can be performed on it (such as clicking it or pressing ENTER).
Activity Type	A division of a catalog type in the Order Catalog. For example, a catalog type of Laboratory can have activity types of General Laboratory, Blood Bank, Microbiology, and Anatomic Pathology. Activity types also can be subdivided into activity subtypes. For example, Anatomic Pathology may have the activity subtypes of AP Processing and AP Reports. Note - Each activity type is associated with a specific catalog type. Every item in the Order Catalog must have a catalog type and an activity type.
AdHoc Charting	Entering unscheduled results into the resident record. Only individuals with privileges to perform ad hoc charting can access the appropriate menu commands.
AdHoc Pharmacy Order	A pharmacy order added one at a time.
Administration Time	The time at which a medication, or continuous or intermittent order is administered to a resident. A nurse or other health care professional records the administration time on the medication administration record (MAR).
Appointment Availability View	Scheduling Appointment Book offers the option of displaying an availability bar that graphically depicts conflicts or available times during appointment scheduling. Duplicate appointment checking, interaction and sequencing rules, as well as advanced scheduling notification rules are used.
Appointment Notification	Notifications sent to specific routings or printers whenever an action such as confirm, modify, or cancel is performed on an appointment. Advanced appointment notifications can be defined where warnings are sent if an appointment is scheduled with inadequate advance notice according to predefined time limits.
Authenticated	The status of a document or result that has been approved or signed by the person ultimately responsible for it. The result or document is not considered final until it has been authenticated.
Authentication	The process that identifies users through the use of log-on names and passwords.
Availability Conflict	A system-detected difficulty in scheduling one or more requested appointments. This could be the result of person or resource availability checking.
Available Physicians	This window displays all available physicians whose last names agree with the starting value entered in the Physician Name field.
Benefit Order	The insurance plans for a resident.
Billing Code	An alphanumeric identifier assigned to an item to identify it to another system. Some examples are a CDM (Charge Description Master), which identifies items to a hospital billing system, and a CPT (Current Procedure Terminology), which identifies an item to most insurances and Medicare.
Block Scheduling	An enhancement to scheduling slots and is useful for utilization of resources such as operating rooms. With scheduling blocks, you can determine a release time for that slot or block of time to expire into a different slot. Reports can be run that analyze the data to determine the efficiency and utilization of the resources reserved in these blocks.

	The process of booking appointments to resource calendars composed of slots of a predefined time. Appointment slots have a single usage definition that does not change over time. Attempting to book a slot with an appointment request that does not match the definition of the slot will result in a warning message. Users with proper security may override this warning.
Cancel Status	Indicates that the transmission has been canceled.
Canceled State	A previously scheduled appointment type that has been removed from all resource schedules as well as the person schedule. Canceled appointments no longer occupy time for the originally booked person and resources.
Care Coordination	The Cerner Millennium solution that supports the care planning process and the delivery of the direct resident care that is defined in the plan of care. The solution can use clinical pathways, nursing care plans, and multiple-disciplinary plans of care.
Cerner Millennium	Cerner Millennium is Cerner's comprehensive suite of solutions that promote personal and community health management by connecting consumers, clinicians and healthcare organizations into a streamlined, unified single care process. Cerner Millennium applications work on a cohesive platform that is open, intelligent and scalable, allowing vital health information to be accessed and shared throughout the healthcare system.
Chart Body	The body of a chart that holds the diagnostic information entered for the procedures, administrative information associated with the procedures, or both.
Chart	In PowerChart, a chart is the aggregation of all information recorded about a person's health status. All inpatient and outpatient visits, lab results, procedures, evaluations, orders, reports, X rays, photographs, films, audio recordings, and other multimedia information pertaining to a person's health are considered part of the total chart. Historically, the chart has been paper-based. Recently, many institutions have begun storing resident information in databases accessible by computers, and the chart has become increasingly electronic.
Charted	Comments that can be posted in a chart or report.
Computer-Based Training (CBT)	Standard computer-based training may be purchased for those Cerner Millennium applications for which CBT is available; or a CBT can be custom-designed for a client as an optional service.
Context Menu	A menu that pops up when you right-click some elements.
Comment	A free-form narrative attached to a term in an encounter note using the Comment function.
Continuous Order	One of the three order types used in *PharmNet*. Continuous orders are intravenous orders marked by uninterrupted infusion over a period of time sufficient to require additional supplies of the product or products at regular intervals. For example, a large volume parenteral is a continuous order. The set of attributes required to correctly distinguish continuous orders from other order types includes interval, rate, and total volume.
Co-Signer	Person who signs off on a document to indicate that the contents of the document are accurate.
Discontinued Order	In *PharmNet*, a pharmacy order that was stopped by a physician, pharmacist, or clinician, or because its course of therapy has been completed. For example, an order can be discontinued for an antibiotic when the resident has completed the course of therapy. An order can also be discontinued by a clinician when a resident has an adverse drug reaction or does not tolerate the side effects of the medication.
Dosage	In *PharmNet*, dosage refers to the defined frequency, amount, strength, and quantity of doses of a medication.

Dose	In *PharmNet*, dose refers to the amount of a drug or drug therapy.
Downtime Sequence	The sequence used by the system when it is assigning numbers during a system downtime. The pool of available numbers for this sequence should be separate from those used for the default sequence.
Downtime	Any period of time during which the system is unavailable to users. The cause is not relevant.
Dispense	In *PharmNet*, to prepare and distribute medications for a single order, as part of a fill list or batch, and to replenish the medication supplies.
Electronic Medical Record (EMR)	The electronic medical record replaces the resident's paper medical record. The EMR is at the heart of the automated health system. It allows resident records to be viewed and updated by numerous healthcare providers simultaneously. No longer are the residents' records inaccessible while waiting to be refiled.
Electronic Signature	The act of verifying or accepting a transcribed report online instead of signing the physical piece of paper on which the report is printed.
Encounter	A single resident interaction. The following interactions are examples of encounters: resident registered as an inpatient, resident registered as an outpatient. In the homecare setting, the following interactions are examples of encounters: resident admitted to home health, resident admitted to home infusion services.
Encounter Number	An internal number assigned by the system for each resident encounter.
Encounter Type	A classification of resident visit types. Examples include inpatient, outpatient, and emergency room.
Encounter Note	The textual documentation of a clinical encounter, such as inpatient, outpatient, or emergency.
Encounter Access Method	Person name, Person ID, Medical Record Number, and Social Security Number can be used to access encounter information. Person name and Person ID require the selection of an encounter if more than one exists on the person. Medical Record Number and Social Security Number are encounter identifiers, and directly access the appropriate encounter.
Floor Stock	Medications stocked at the care location. Also referred to as ward stock. Floor stock items typically are not included on fill lists.
Free Text	User-entered text, which is saved by the system.
Free Text Field	Free-text field types allow you to specify a free-text response.
Future State	A narrative or graphical description of how each type of process in the analyzed work area will work after improvements are completed. This future state may include targeted benefits and proposed processes to collect measurement data to monitor improvement.
Go-Live	Conversion or go-live is the process by which Cerner makes the system available to the client for the first production use.
Immediate-Print Label	A specimen label produced by the system as soon as an order is requested. This type of label is typically printed when specimens have already been collected for the orders, or when orders are requested with a *stat* collection priority.
In-Process Status	This status indicates those requests on which action has been taken but not completed.
Intermittent Order	One of the three order types used in *PharmNet*. Intermittent orders are intravenous orders defined by short periods of infusion that are interrupted before the next scheduled administration time. An intravenous piggyback is an example of an intermittent order. The set of attributes required to correctly distinguish intermittent orders from other order types includes interval frequency, rate, infuse over value, and total volume.

JCodes	Billing codes associated with pharmacy charges used to identify specific ingredients and dosage in a given injection. It is defined in Charge Services as a bill code.
Label Comment	Label comments are predefined messages created as a database to be shared with other applications. When you enter the corresponding code during order entry, the system displays the appropriate label comment. A textual comment that is to print on container labels or collection lists, depending on the customized label format. Label comments typically are entered when the order is requested, and serve as instructions to persons collecting or handling the specimen. Examples of label comments might be "Draw from right arm" or "Nurse will call when ready."
Location Group	A group of locations by which you can filter a list of tasks to be performed. For example, if you work in the locations 2N and 3N and these are defined together as a group, you could select this group when requesting your list of tasks.
Lot Information	Drug manufacturers and wholesalers routinely supply lot numbers and expiration dates for products. The ability to track lot numbers and expiration dates can be used in a variety of situations, including drug recalls.
Medical Record Number (MRN)	A permanent number used to identify the resident. It typically remains unchanged even if the resident has multiple encounters.
Medication Administration Record (MAR)	A report that serves as a legal record of the drugs and drug-related devices administered to a resident at a facility by a nurse or other healthcare professional. The nurse or healthcare professional signs off on the record at the time that the drug or device is administered. This report also documents that the appropriate therapy is provided to the resident.
Medication Order	One of the three order types used in the *PharmNet* system. Medication orders are distinguished by administration at a discrete moment in time, whether once or at regular intervals. Examples of medication orders include tablets, capsules, suppositories, and syringes. The presence of frequency, without rate, infuse over value, or total volume distinguishes medication orders from other order types.
Multi-Choice Field Type	Multi-choice field types allow you to specify at least one of several responses.
Multiple Select	To select more than one item, click the first and last items while pressing Shift, if they are listed sequentially. If they are not sequential, press CTRL and click each one individually.
New Orders Display	The area of the Orders view of the resident chart that displays all unsigned orders placed during a particular conversation. Also called the scratch pad.
Order Category Display	Orders are grouped and displayed in a hierarchy according to clinical interest. The site determines the hierarchy and the orders contained within it.
Order Type	Order Types are categories used to classify pharmacy products on the basis of how they are ordered, in particular, on the basis of a set of attributes that varies from one Order Type to the next. The three Order Types available for selection in the *PharmNet* system are continuous, intermittent, and medication.
Outside Orders	Outside order are those orders place in another order entry application, such as PowerChart, Departmental Order Entry, OSM Requisition Order Entry, or even from an interface with an external system. When the specimens are received in the laboratory, these orders are logged in using Maintain Case.
PharmNet	*PharmNet* fully integrates with other clinical applications, automating medication use across the entire spectrum of medication management.

Physician Name	The first few letters of the last name of the consulting physician should be entered in this field. Upon doing so, the user can then click Search to reveal a list of physicians from which to choose.
PowerChart	The Cerner Millennium solution that is the enterprise clinician's desktop solution for viewing, ordering and documenting the electronic medical record.
PowerOrders	A physician order entry solution that gives appropriate access to real-time, relevant clinical information at any point in the care process.
Proxy List	This optional feature allows you to review, accept, and reject reports on behalf of another radiologist.
Proxy	A person designated to perform a task or review results for another health care provider.
Refresh	To replenish new information from the database and redisplay it within the current screen view.
Resident Chart	In Cerner Health Information Management, a resident chart is an encounter-level collection of resident information. The resident chart includes all documents, notes, and images pertaining to a single visit.
Resident Demographics	Information defined for the person or encounter. Demographic information includes elements such as the current location (nursing station, room, and bed, for example), alias identification values, age, birth date, gender, and maiden name.
Resident Medication Profile	A printed report that lists all of the drugs prescribed for a resident, which may contain active, suspended, or discontinued orders. The resident medication profile can be used to support the health care facility in case of a system failure or power outage to ensure that residents receive the appropriate drug therapy.
Review (Orders)	The process of checking an order for accuracy and appropriateness. Orders subject to nurse review are designated with an icon that resembles a pair of spectacles. The site defines which orders require nurse review.
Review (Results)	To verify a result. Results entered in the flowsheet become part of the resident record. Whether the result records a discrete task assay, document, or laboratory value, the person ultimately responsible for its accuracy must verify or review the result and sign it. When signed by the appropriate person, the result has the status of Authenticated (final).
Reviewer	Additional person who receives a copy of a document for review.
Schedulable	Any item that can be scheduled to a resource or person appointment schedule.
Schedule	The process of creating an appointment request, booking the request to one or more persons or resources, and confirming the booked requests.
Scheduled	A medication order that has fixed dose times. The times can be fixed to always occur at the same time of day or be determined by the system based on an interval. These are usually identified by standard frequency codes, such as bid (twice daily at 0800 and 1600) or q8h (every eight hours starting from 10 a.m.).
Scratch Pad	The new order area of the Orders view of the resident chart. All unsigned orders placed during an order conversation are displayed on the scratch pad until they are signed and submitted.
Selected Physicians	This window displays the names of physicians who have been chosen from the Available Physicians window.
Selection Criteria	Variables that determine which residents are included in a distribution.
Soft-Stop	Soft-stop review policies are implemented to notify the prescriber that a medication order requires review, but the medication actually will not be discontinued if the situation is not addressed by the prescriber.
Sorts	Sorts are used to put data in a particular order.

Subclass	A subclass is a method to categorize or group interesting case files. Subclasses allow radiologists or residents to group certain interesting case files together and assign a name to that group. Subclasses are personal or shared.
Summary Sheet	Used to display a summary of the resident's health history to the healthcare provider.
Tab	A window element resembling a folder tab that is used to group similar information.
Task Type	Task types are used to group similar, individual tasks together. For example, a task type of dietary might contain all dietary tasks such as clear liquid diet, soft diet, and so on.
Toolbar	A window element containing buttons or other window elements to facilitate accomplishing a task.
Tooltip	A description displayed when you move the cursor over a button in the toolbar.
Unauthenticated	The status of a document or result that has not been approved or signed by the person ultimately responsible for it. The result or document is not considered final until it has been authenticated.
Uncommitted Data	Data that has been entered but not saved or signed. Sometimes, uncommitted data is displayed in a special color until it is saved. If the user attempts to close a window or exit an application with uncommitted data, a system prompt warns that this data will be lost.
Untransmitted	The report has not been transmitted.
Unverified Order	In *PharmNet*, an order entered in the system by a pharmacy technician or other healthcare professional that must be verified by a pharmacist. Unverified orders include all pharmacy order types---continuous, intermittent, and medication.
Verify	To confirm that the result entered for a procedure is correct. The process of verifying updates the status of the result to Complete. Results of procedures are not available for general inquiry, transmission, or charting purposes until verification occurs.
Wildcard	A character that allows a search over a wide range of related data elements.
Worklist	A list of orders that need to be completed.
Worklist ID	The worklist ID is an identifier that is assigned to a specific worklist. The date and time is also stamped with the worklist ID so that if the same worklist ID is used multiple times, the date and time will differentiate each worklist ID.
Worklist Name	The worklist name is the name assigned to a predefined set of selection criteria for the worklist.