



## Therapies Training Manual

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## PURPOSE

This Training manual is a reference tool to assist with the successful completion of all therapy supports and services documentation.

## OBJECTIVES

Upon completion of this training, the users will be able to:

- Access PowerChart to complete all Therapy documentation.
- Complete all sections for all Habilitation Therapy documentation.
- Understand how to identify and complete tasks.

## SECURITY



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.

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

## LOGGING IN

### Training Login (Day of Training)

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**.

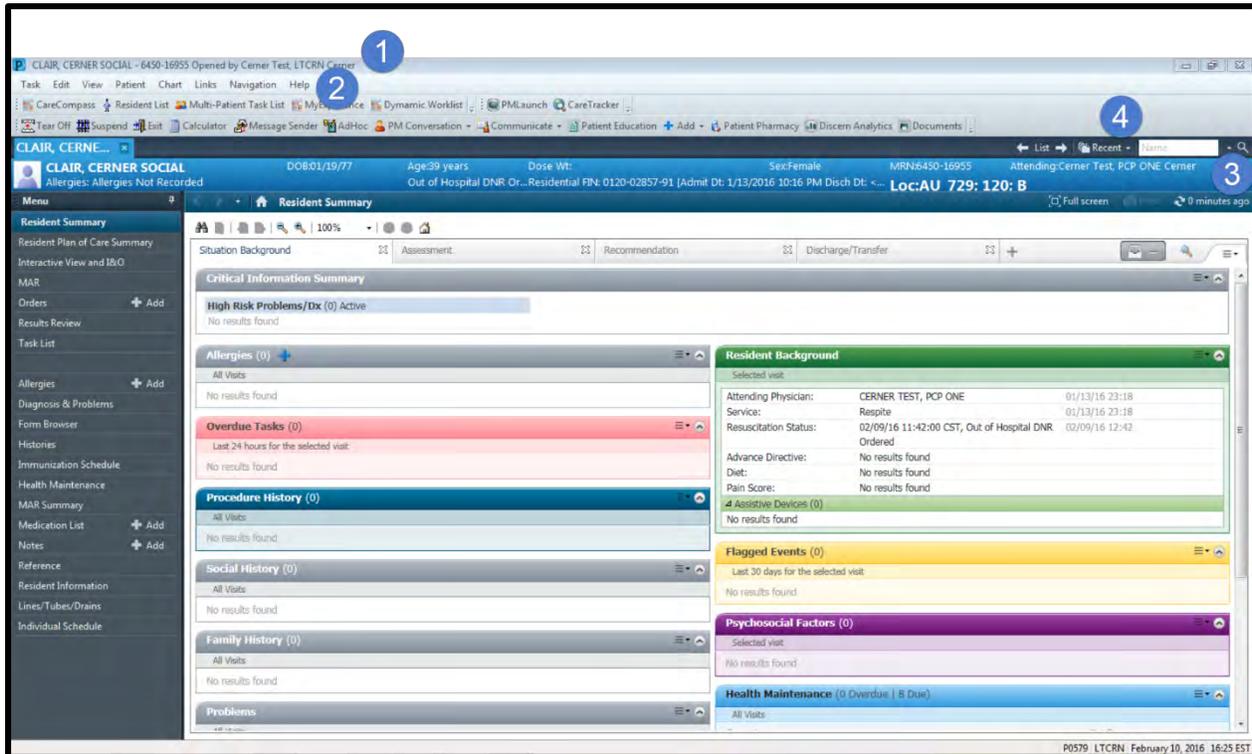
### Daily Login

1. Log into Cerner.
2. Type the training username in the **Username** field.
3. Type the training password in the **Password** field.
4. Click **OK**.
5. 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.

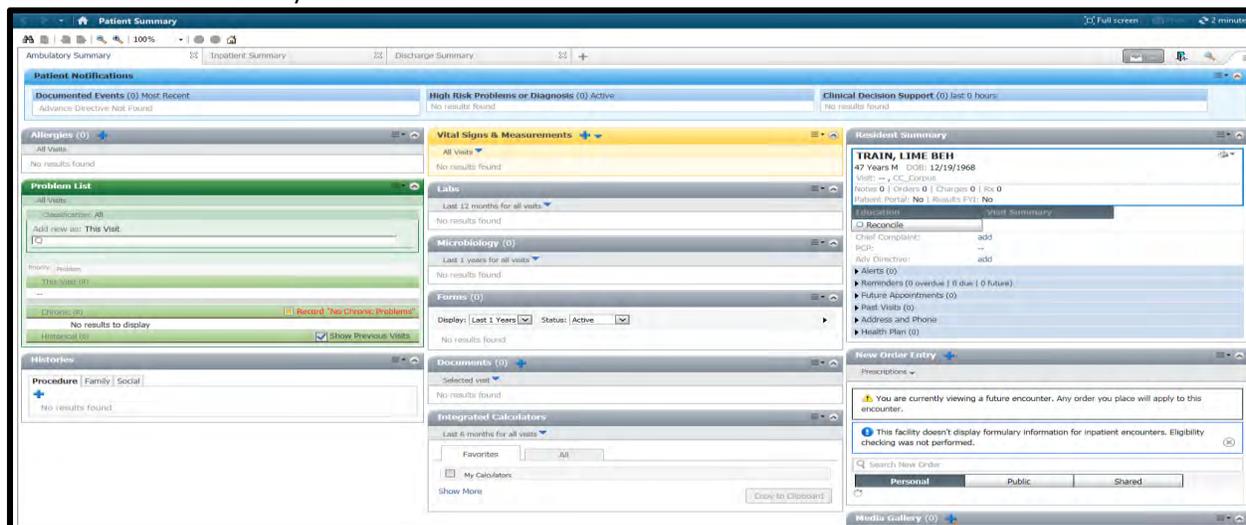
### Resident Summary: Window Overview

Title	Description										
1. Title Bar	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.										
2. Menu Bar	Includes the following menus: <table border="1" data-bbox="422 1344 1412 1869"> <thead> <tr> <th>Menu</th> <th>Description/Functionality</th> </tr> </thead> <tbody> <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: <ol style="list-style-type: none"> <li>From the <b>View</b> menu, click <b>Toolbar</b>.</li> <li>Click <b>Navigation Toolbar</b>, and select which toolbars to view. Any toolbar with a check will be visible; any toolbar without a check will be hidden.</li> <li>Click <b>Resident Toolbar</b> to check (view) or uncheck (hide) the Resident Toolbar.</li> </ol> </td> </tr> <tr> <td>Resident</td> <td>Perform a resident search, view a recent resident, input new orders/allergies/medication list or notes, or complete a Resident Management Conversation.</td> </tr> </tbody> </table>	Menu	Description/Functionality	Task	Change a password, suspend the application, view report, print, refresh the window, or exit the application.	Edit	Cut, copy, paste and delete.	View	View the CareCompass, Resident List, Multi-Resident Task List, MyExperience and Dynamic Worklist. Toolbars can be customized by following these steps: <ol style="list-style-type: none"> <li>From the <b>View</b> menu, click <b>Toolbar</b>.</li> <li>Click <b>Navigation Toolbar</b>, and select which toolbars to view. Any toolbar with a check will be visible; any toolbar without a check will be hidden.</li> <li>Click <b>Resident Toolbar</b> to check (view) or uncheck (hide) the Resident Toolbar.</li> </ol>	Resident	Perform a resident search, view a recent resident, input new orders/allergies/medication list or notes, or complete a Resident Management Conversation.
Menu	Description/Functionality										
Task	Change a password, suspend the application, view report, print, refresh the window, or exit the application.										
Edit	Cut, copy, paste and delete.										
View	View the CareCompass, Resident List, Multi-Resident Task List, MyExperience and Dynamic Worklist. Toolbars can be customized by following these steps: <ol style="list-style-type: none"> <li>From the <b>View</b> menu, click <b>Toolbar</b>.</li> <li>Click <b>Navigation Toolbar</b>, and select which toolbars to view. Any toolbar with a check will be visible; any toolbar without a check will be hidden.</li> <li>Click <b>Resident Toolbar</b> to check (view) or uncheck (hide) the Resident Toolbar.</li> </ol>										
Resident	Perform a resident search, view a recent resident, input new orders/allergies/medication list or notes, or complete a Resident Management Conversation.										

	Chart	This menu contains all of the items that are also located on the chart <b>Menu</b> , which displays on the left side of the window when a chart is open. The following functions are also available: <ul style="list-style-type: none"> <li>Clinical Calculator, Message Sender, AdHoc Charting, Resident Education, Resident Pharmacy, Tear Off This View and Attach to Chart</li> <li>View who has accessed the current chart, and close the current chart</li> </ul>
	Links	Access PMLaunch and CareTracker.  <b>Tip ▶</b> 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.

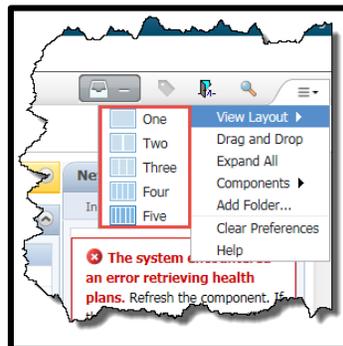


*MPages Tabs*

## 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

Widgets are discrete icons that have programming built into them. 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 **Resident 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 Resident Toolbar is hidden, the Search bar is not available.



*Resident Toolbar*

### Quick Search

1. From the **Resident Toolbar**, click the search icon (  ).
2. From the **Resident 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 *Resident Search* or *Quick Search*, as indicated above.
2. Each new resident opens in a new tab on the Resident 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
- Residential FIN
- 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, Language, MRN, Address, Phone Numbers, and Insurance Number. Information cannot be edited within this window.



*Resident Demographic Banner: Click the resident's name*

## Suspend

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

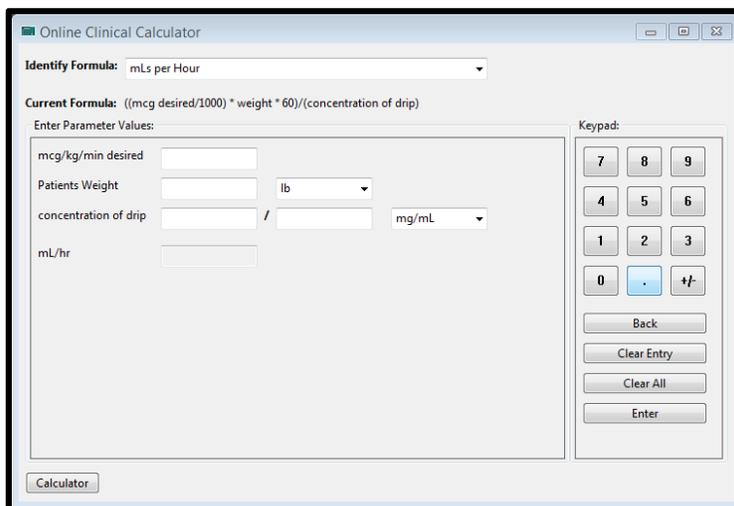


**Suspend the application if it is necessary to step away from the computer, to prevent unauthorized individuals from viewing private resident information.**

## 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.

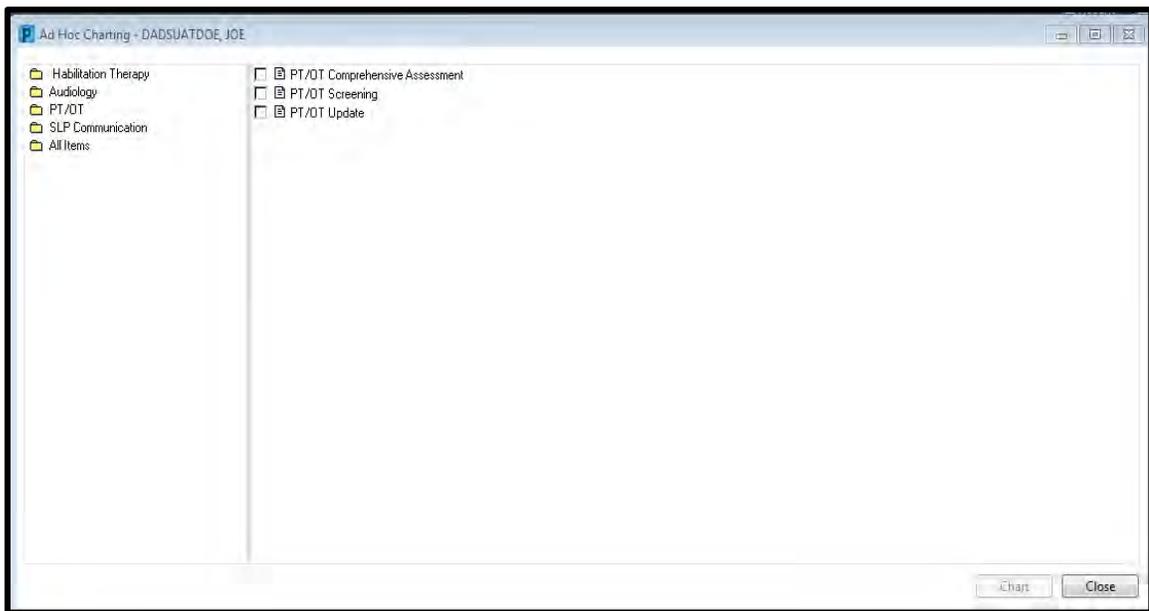


*Calculator*

## AdHoc

AdHoc Forms allow for documentation of 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.
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 (✓).

## Patient Education

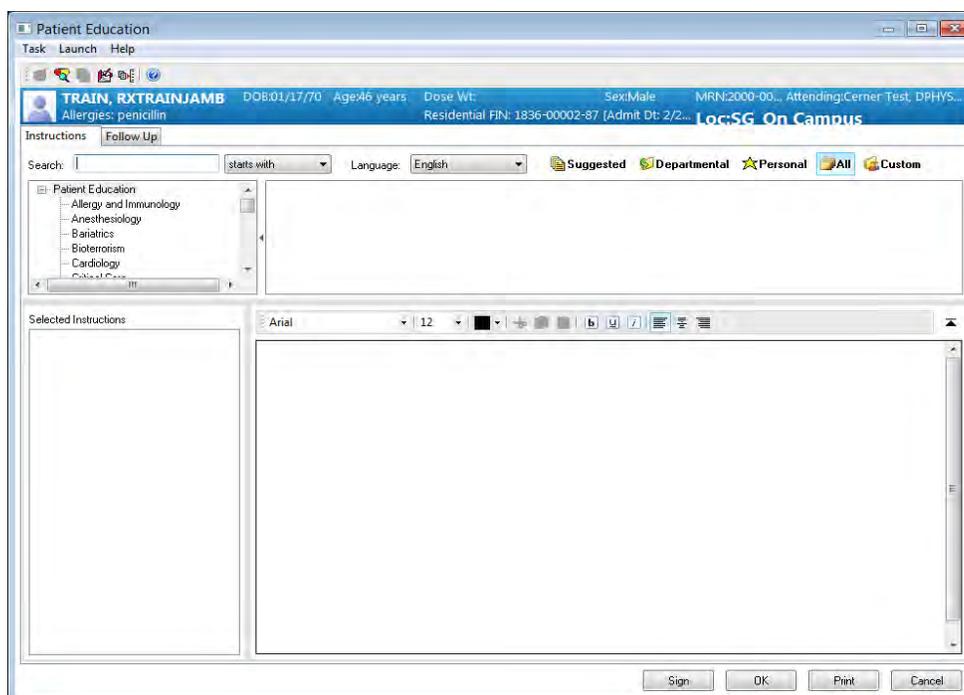
Patient Education provides documentation in areas in that the resident was provided supplemental educational/informational materials to increase knowledge on a specific topic.

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

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

**Tip** ▶ Leave the search field blank and double click the type of Patient Education in the left column under **Patient 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 Patient 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*

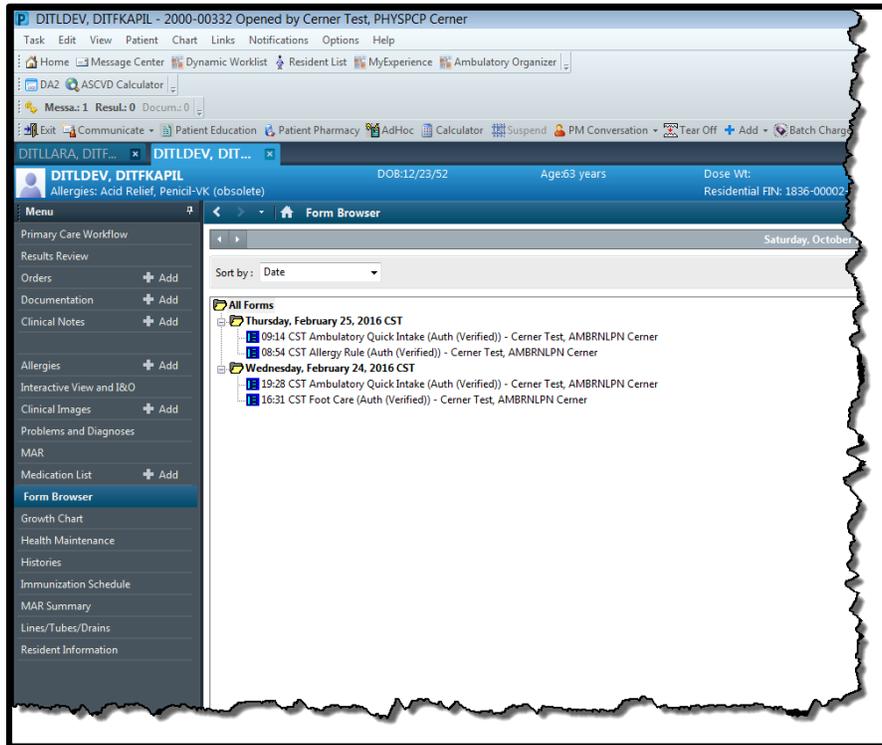
**Note** ▶ Add as many Patient Educational materials as needed to a chart. To delete one, click the Red X (  ) next to the topic to delete.

## CHART MENU

### Form Browser

Form Browser allows for easy access, review and update of 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.

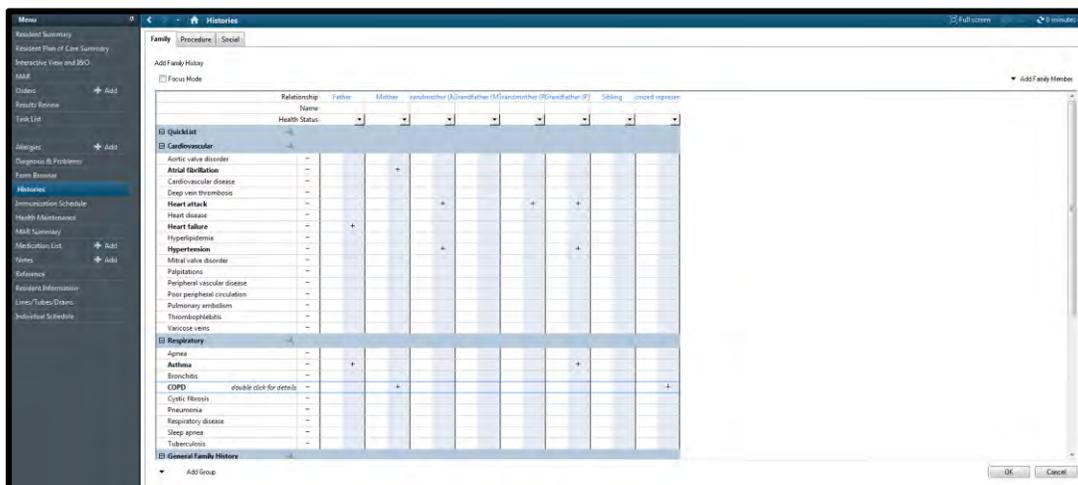


Form Browser Window

## Histories

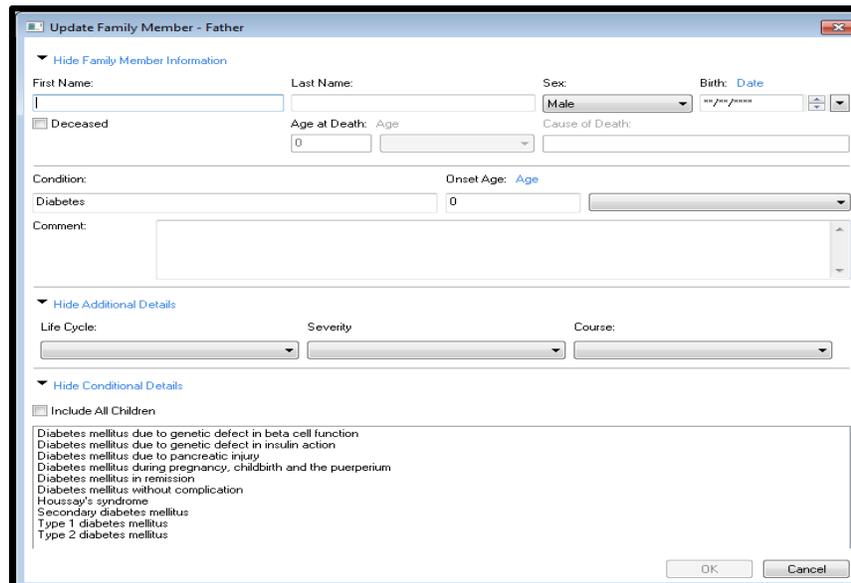
Histories allow for a quick overview of family medical history and health status of family members. From the chart **Menu** click **Histories** to view family, procedure and social historical information for the resident. From any of the tabs at the top of the window, a new history can be added. Click the add icon ( **+** Add ). Add all information, then click **OK** to save the record.

1. Click the **Histories** band to access the Histories window.



Histories Window

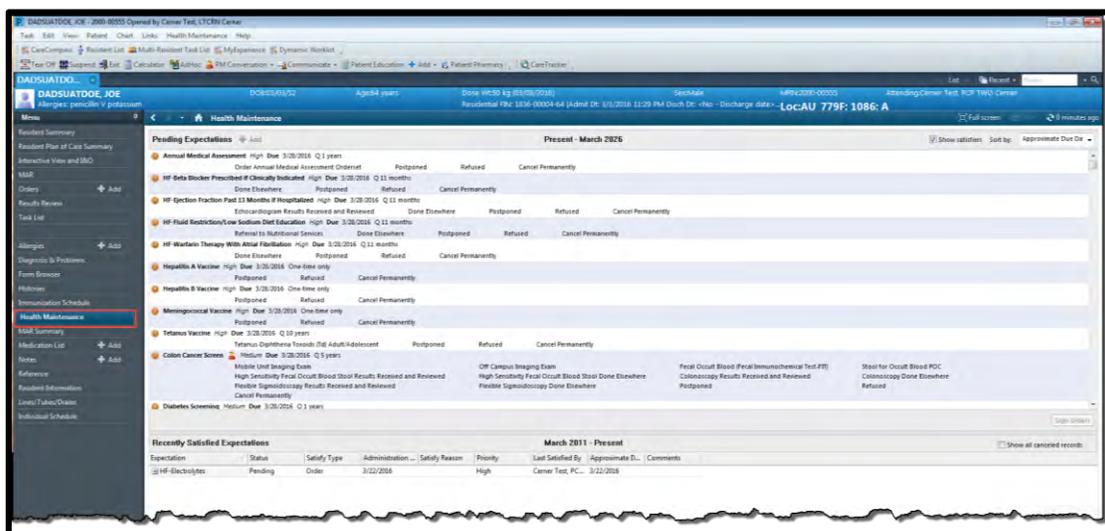
2. Double-click an item to view specific details or to update family history.



Update Family Member Window

## Health Maintenance

Health Maintenance allows for quick reference on the continued health conditions of an individual. From the chart **Menu**, click **Health Maintenance** to view pending Medical consultations, follow up consultations, and Routine Medical consults for the resident. The pending consult and follow-up list displays an action that requires completion to maintain a resident's health. The Recently Satisfied consult and follow-up 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, action or due indicator. Each consult displays the associated priority and due date, and provides the option to select **Postponed**, **Refused** or **Cancel Permanently**.



Expectation	Status	Safety Type	Administration	Safety Reason	Priority	Last Satisfied By	Approximate D...	Comments
HF-Electrolytes	Pending	Order	3/22/2016		High	Center Test, P.C.	3/22/2016	

Health Maintenance Window

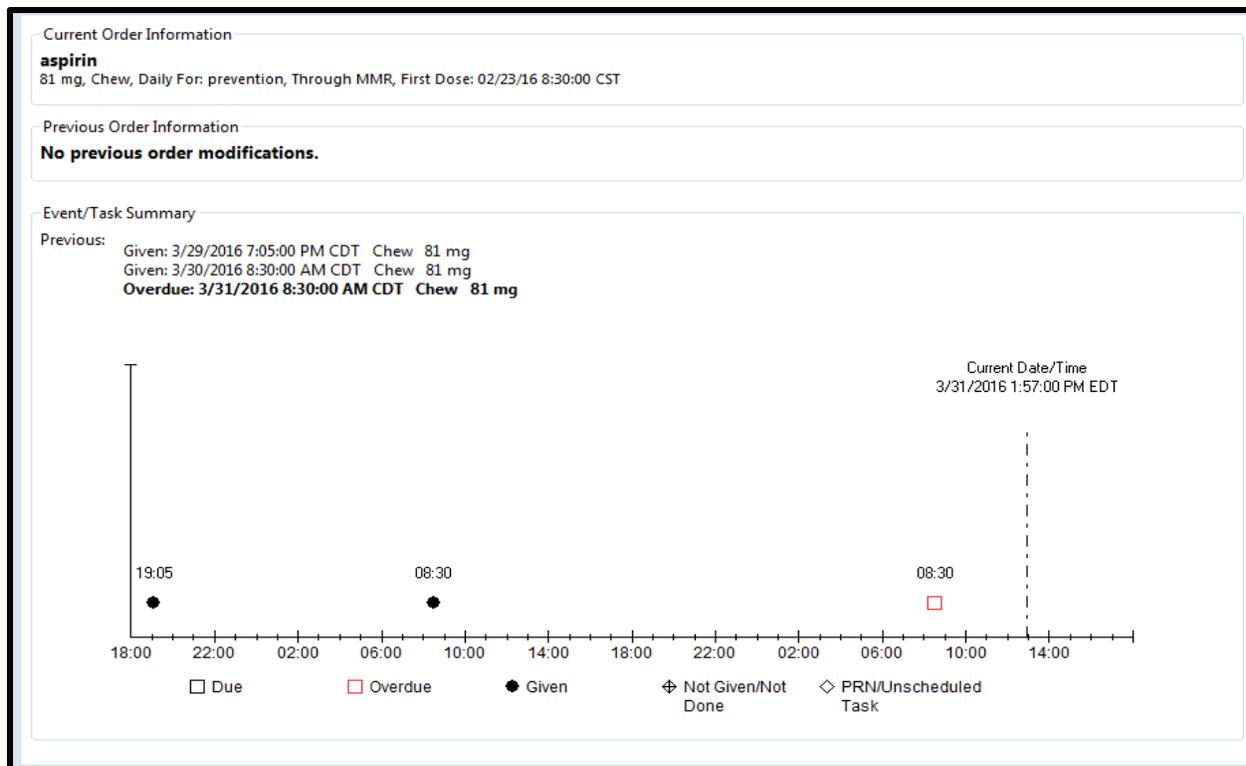
## MAR Summary

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.

Medication List MAR Summary Window

Medication Details

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.

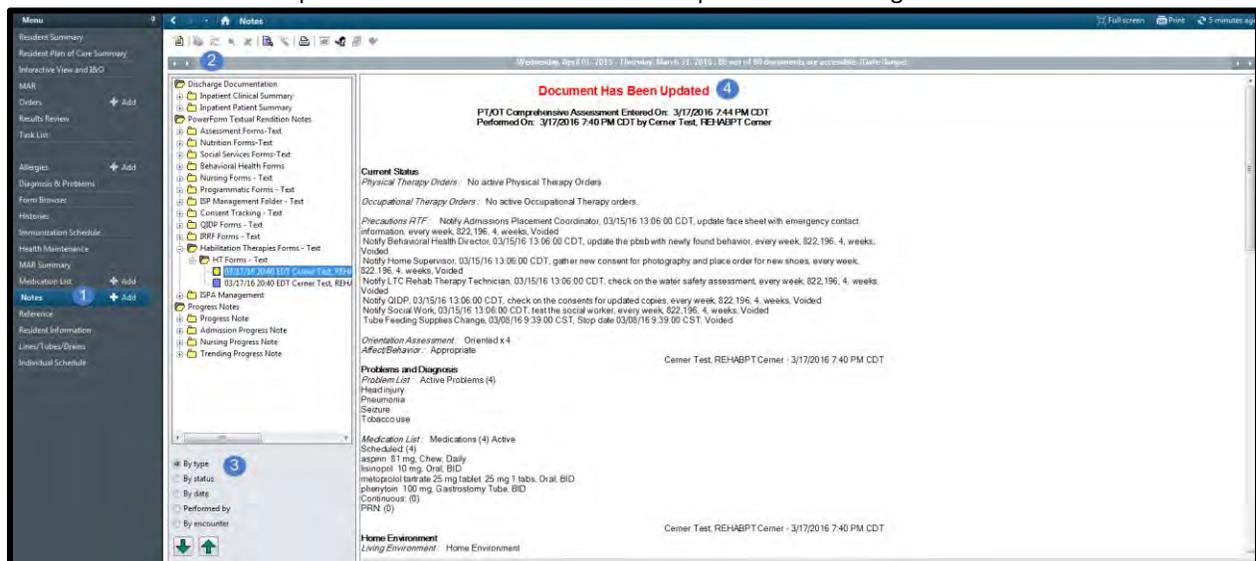


*Event/Task Summary*

## Notes

The Notes band allows access to view Discharge Documentation, PowerForm Textual Rendition Notes, and Progress Notes. From the **Chart** menu click **Notes +Add** to access the Notes functionality. From this window, view, modify or add notes.

- View Notes
  1. From the **Notes** window, view any **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 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 notes.



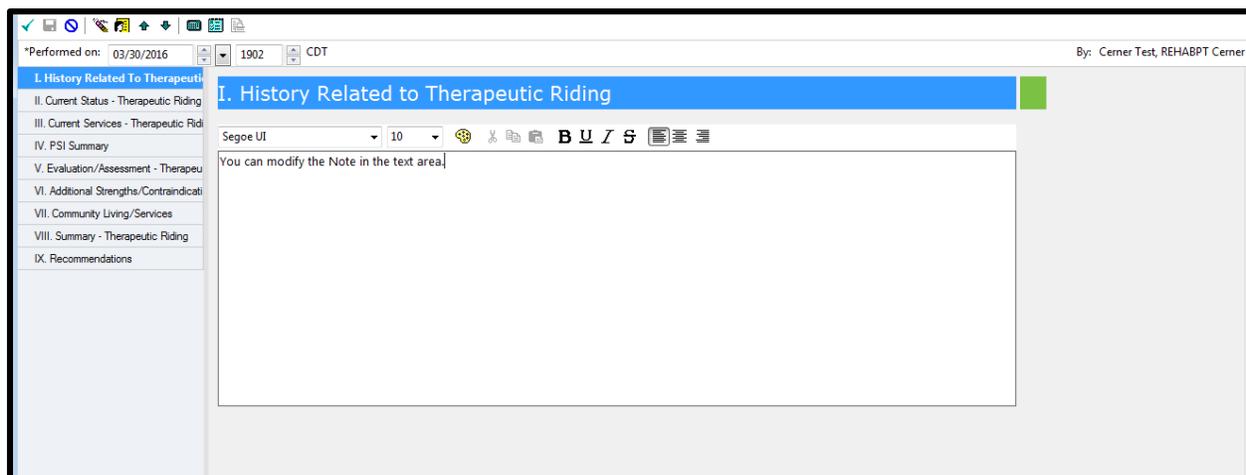
The screenshot shows the IRIS Notes interface. On the left is a navigation menu with categories like MAR, Orders, Results, Allergies, etc. The main window is titled 'Notes' and displays a list of notes on the left and a detailed view of a selected note on the right. The detailed view includes a 'Document Has Been Updated' notification, a 'Current Status' section with 'Physical Therapy Orders' and 'Occupational Therapy Orders', 'Precautions ATF', 'Problems and Diagnosis' (listing Head Injury, Pneumonia, Seizure, Tobacco Use), 'Medication List', and 'Home Environment'.

### Note Documentation

**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 **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 Note
  1. From the **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 (  ).

- After required changes have been made, click **Sign** icon (✓|).



#### Modify Note

- 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?
- Click **Yes**.

**Note** ► After a note is modified, “Document Contains Addenda” will display at the top in red.

- Add a Note**
  - From the **Notes** window, click the add icon (📄) to add a new note.
  - From the **Add Document** pop-up window, select the type of note to add.
  - Complete all fields on the window and type the note.
  - 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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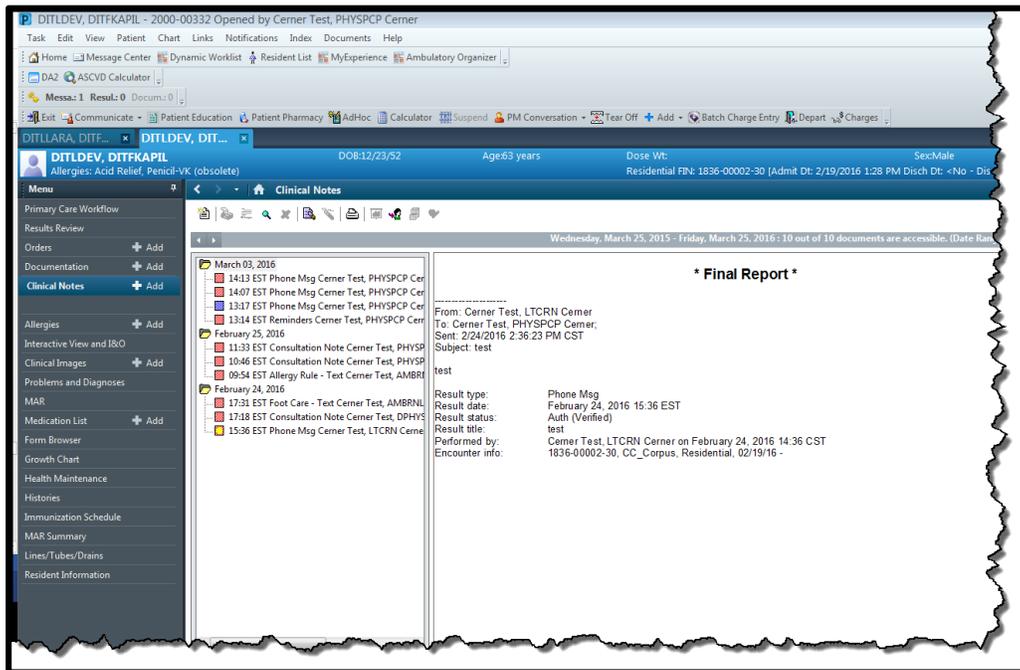
**Tip** ► Even when temporarily walking away from the computer, it is important to always save a note to prevent data loss in the event of a power outage or network failure.

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- 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:

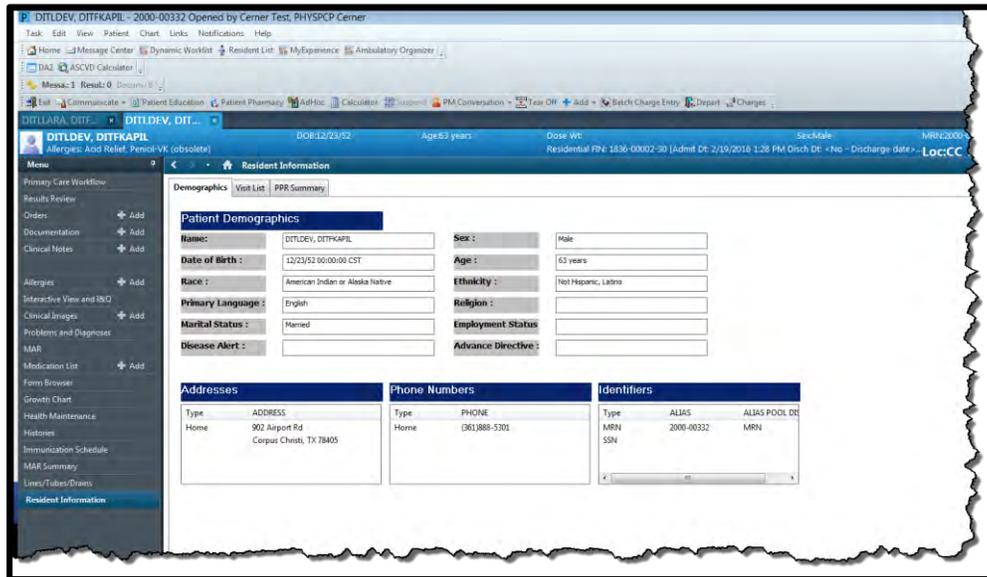
	In Progress – The note is in progress, and has not yet been signed
	Transcribed – The note has been typed, but not yet signed
	Unauthenticated – The note has been signed, but by someone who is not authorized to provide final approval
	Authenticated – The note is finalized and signed
	Modified/Corrected – 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 – The status is unknown



Clinical Notes Window

## RESIDENT INFORMATION

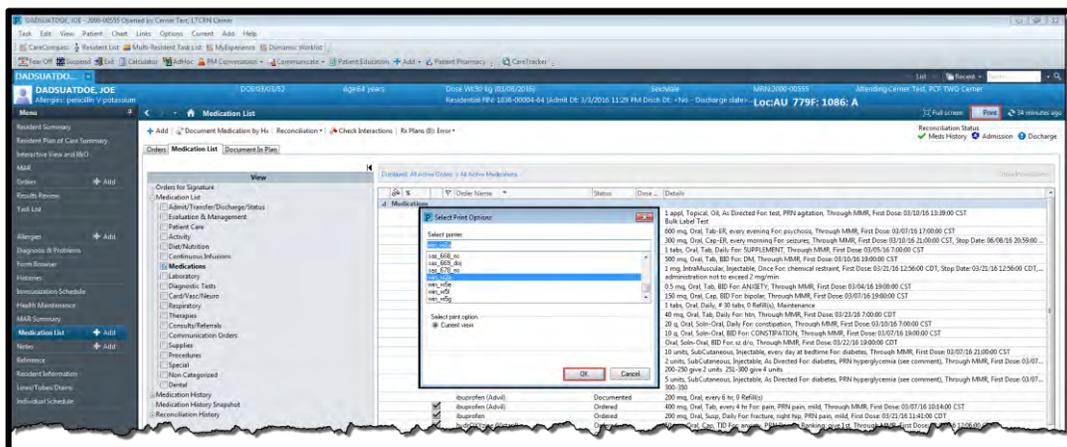
From the chart **Menu**, click **Resident Information** to view resident demographics, the visit list, and the PPR (Primary Physician Report) summary. This report provides a snapshot of physicians that have an established encounter with the resident. This is a view-only window, and information contained herein was typed during scheduling and registration.



*Resident Information Window*

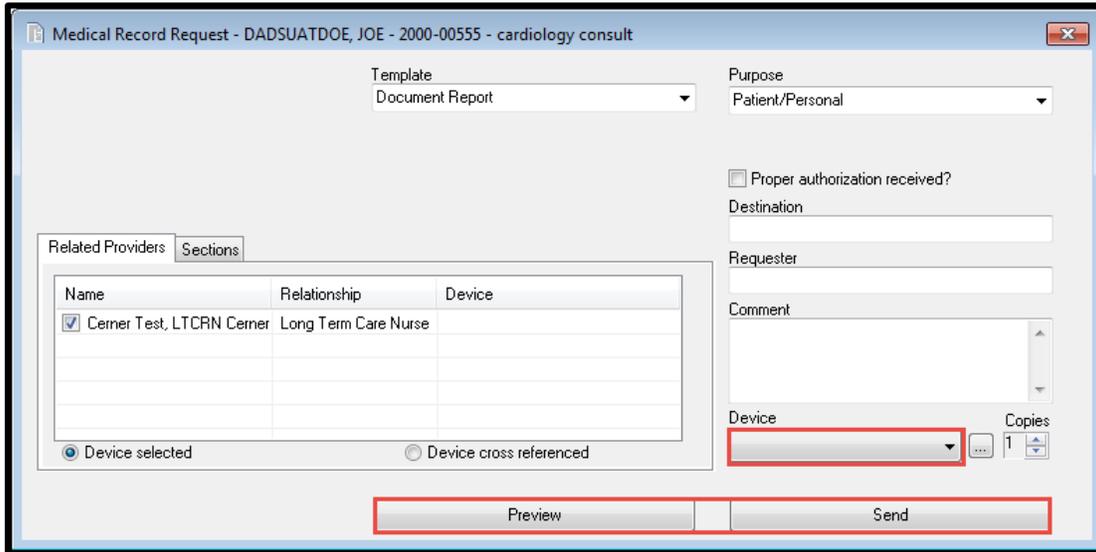
Open a resident's chart, then click the print icon () at the top right of any window to print its contents. The print functionality does not display on every window.

**Note** ► A physician has the ability to print a medication list, or document from the resident chart.



*Select Print Options Pop-up Window*

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



Medical Record Request - DADSUATDOE, JOE - 2000-00555 - cardiology consult

Template: Document Report

Purpose: Patient/Personal

Proper authorization received?

Destination: \_\_\_\_\_

Requester: \_\_\_\_\_

Comment: \_\_\_\_\_

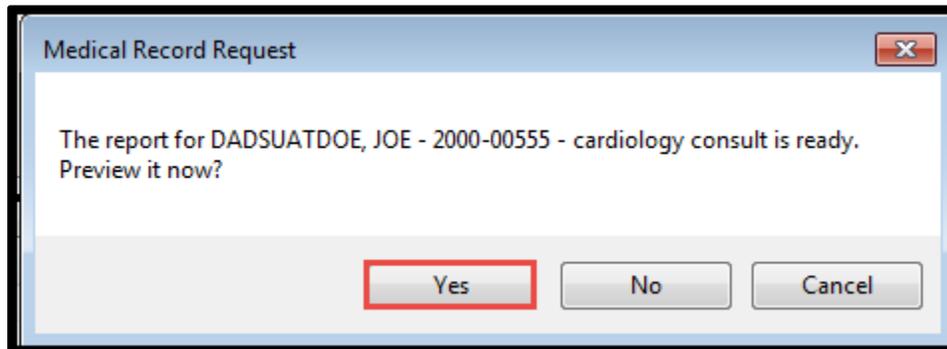
Name	Relationship	Device
<input checked="" type="checkbox"/> Cerner Test, LTCRN Cerner	Long Term Care Nurse	

Device selected       Device cross referenced

Device: \_\_\_\_\_      Copies: 1

Preview      Send

*Medical Record Request Pop-up Window*



Medical Record Request

The report for DADSUATDOE, JOE - 2000-00555 - cardiology consult is ready.  
Preview it now?

Yes      No      Cancel

*Medical Record Request Confirmation Pop-up Window*

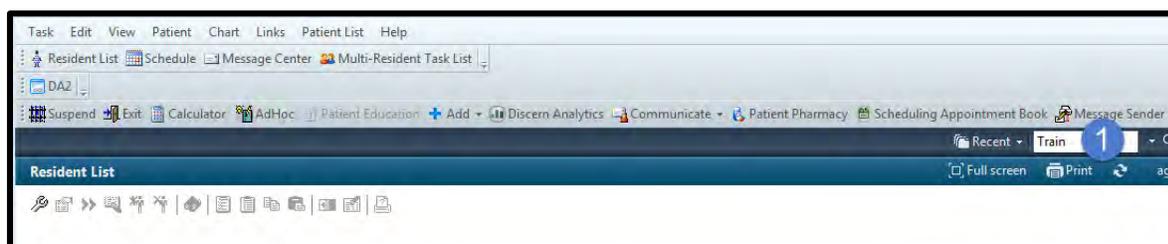
## HABILITATION THERAPY CONSULT DOCUMENTATION

This section will provide an overview of how to:

- Search for a resident
- Add therapy treatment orders
- Review active orders
- Complete a Comprehensive Assessment
- Sign off on assessments and orders

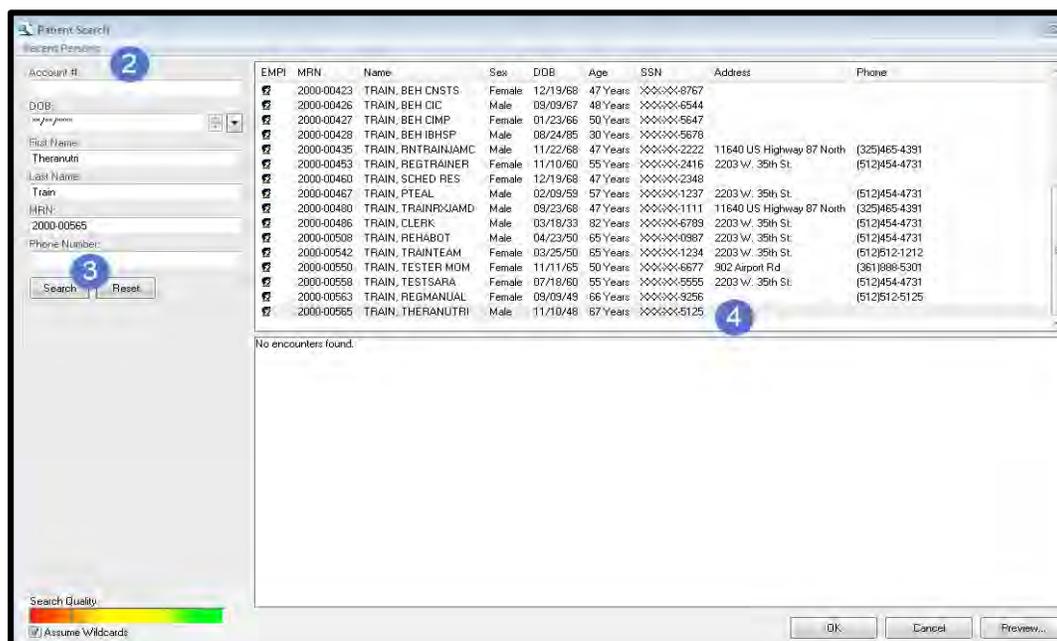
### Resident Search

1. From the **Resident Toolbar**, type resident's last name, then click the magnifying glass icon (  ).



*Resident Toolbar: Search Option*

2. From the **Resident Search** pop-up window, type in the **Account Number, Encounter Identifier (FIN), DOB, First Name, Last Name, MRN (Person Identifier), and/or Phone Number** to conduct the search.
3. Click **Search**, or press **Enter** to display search results.
4. Double click the resident or encounter to open and view or select the **OK** button.

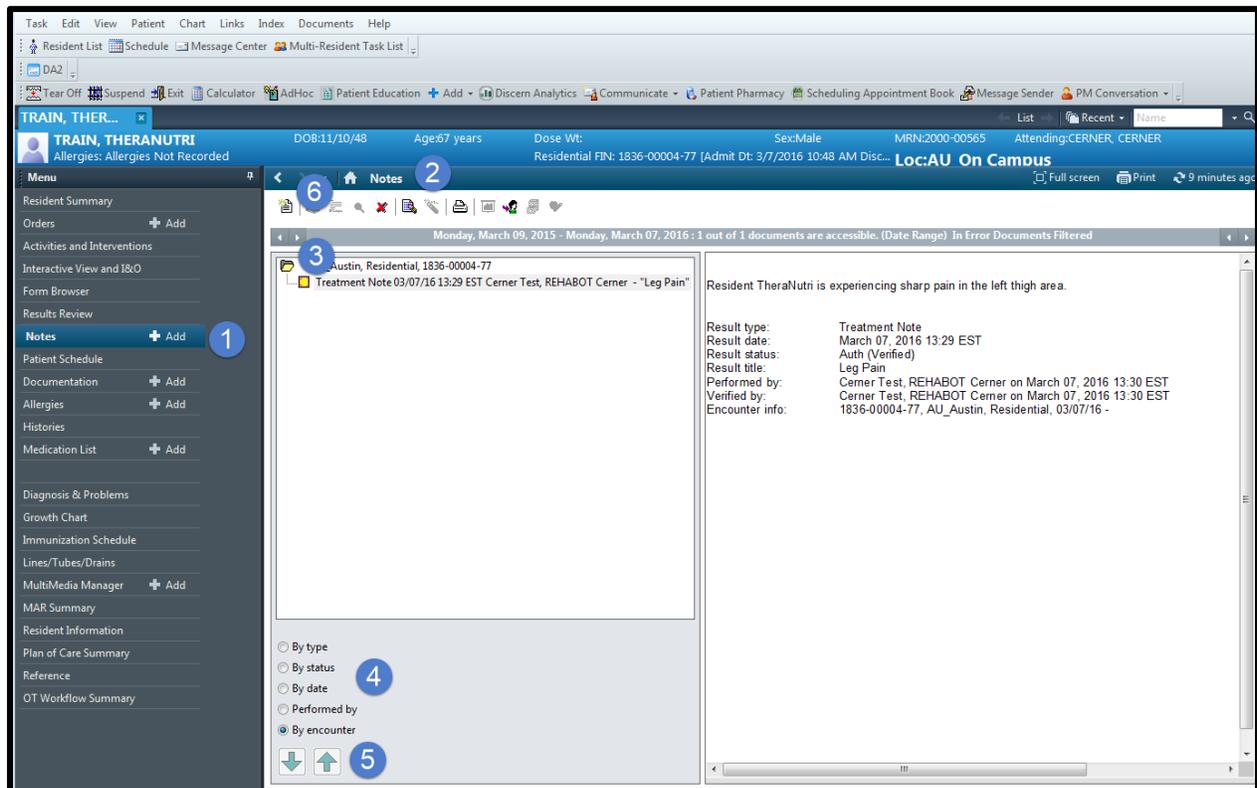


*Resident Search Window*

## Adding Note Documentation

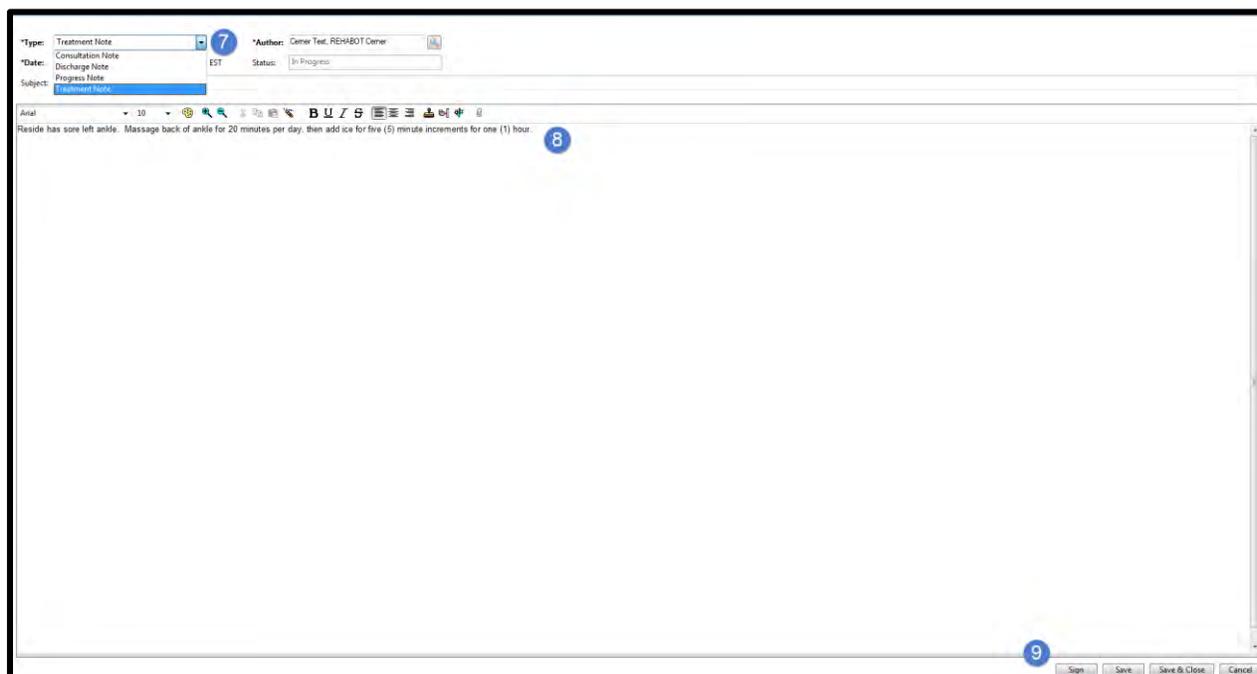
In this section, a variety of Notes can be added to the resident's summary. Note examples: Consult Note, Discharge Note, Progress Note, and Treatment Note. Information regarding a resident can be added to their chart by adding Notes. Notes can be seen, added, or modified at any time.

- Add a Note
  1. From the chart **Menu**, select **+Add** next to **Notes**.



*Chart Menu: Notes Pop-up Window*

2. From the **Notes** window, all notes that have been added to a resident's chart can be viewed.
3. On the left side of the window, select the folder that contains the note 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.



*Notes Pop-up Window*

7. From the **Add Note** pop-up window, select the type of note to add.
8. Complete all fields on the window and type the note.
  - **Consultation Note** – Describes information from resident consultation.
  - **Discharge Note** – Provides information to discharge resident.
  - **Progress Note** – Explains the progress of resident.
  - **Treatment Note** – Provides information for treatment.
9. Complete the note by:
  - Clicking **Sign** – Completes documentation, and publishes Note to the resident’s chart.
  - Clicking **Save** – Saves note without signing it, but leaves 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.
  - Clicking **Save & Close** – Saves and closes Note to be completed at a later time.
  - Clicking **Cancel** - Closes the pop-up window without saving changes.



**Tip** When temporarily walking away from the computer, it is important to always save a Note to prevent loss data in the event of a power outage or network failure.

## Training Exercise

Complete the following exercises.

1. Access **PowerChart** and view Resident Summary. List the proposed treatment orders.
2. Enter Treatment Note to be added onto resident’s chart, “Massage left hand four (4) times per day for 30 minutes.”

## Comprehensive Assessment for PT/OT

The Comprehensive Assessment should provide a current picture of the individual’s status in terms of functional abilities, health risks, personal preferences and potential for community placement. Assessment findings should reflect how conditions and clinical data affect the individual’s function and guide provision of supports. Historical data and information gleaned from chart review should be pertinent to the assessment and provide an analysis of relevance to clinical findings and recommendations. Such material should not merely be transcribed from the record.

- Navigate to AdHoc Forms to access the PT/OT Comprehensive Assessment
  1. Select, **AdHoc** icon button (  ) on the **Chart** menu.

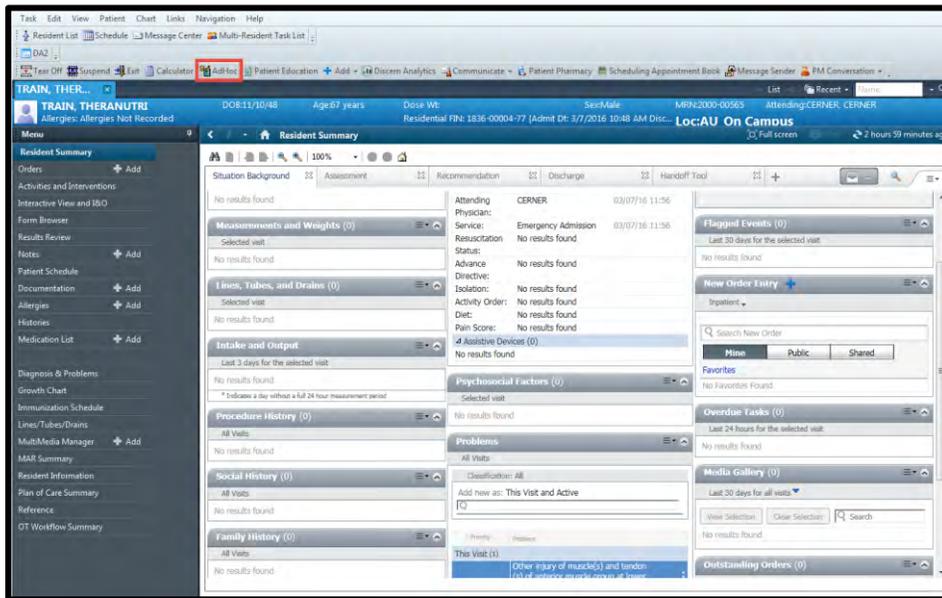


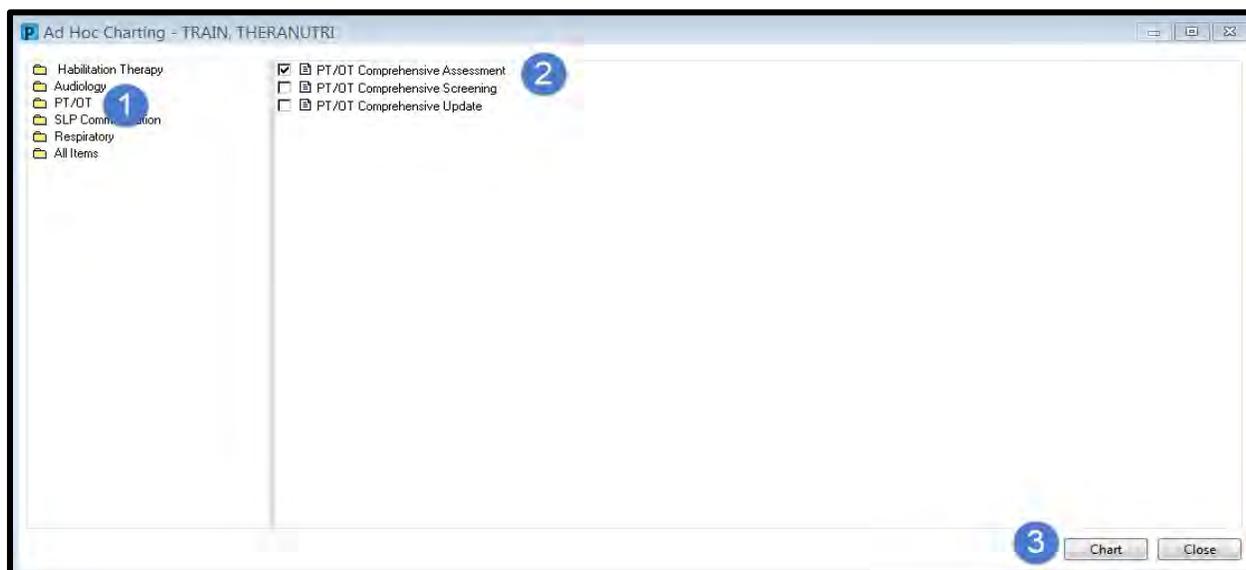
Chart Menu: AdHoc Button

- The **AdHoc Charting** window displays.



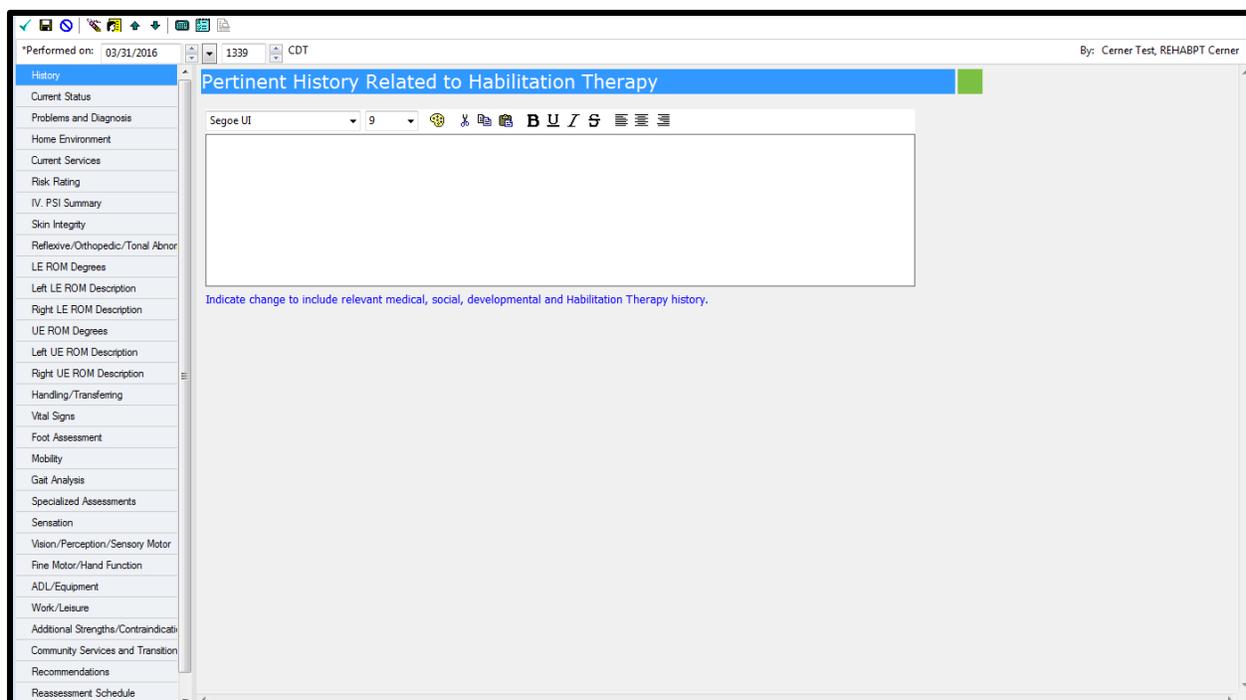
AdHoc Charting Window

1. Select **PT/OT** folder from the left menu.
2. Click checkbox **PT/OT Comprehensive Assessment**.
3. Select the **Chart** button.



*PT/OT AdHoc Charting Window*

4. The **PT/OT Comprehensive Assessment** for resident displays.



*AdHoc Charting Pop-up Window: Chart Menu Bands*

There are a total of 33 section bands within the PT/OT Comprehensive Assessment, however you will only chart as applicable. When the section band has been completed, it turns dark blue in color, indicating the section has been accessed. Then, select the next relevant band until action has been performed on all bands. At the end of the assessment, remember to sign the assessment.

- Complete Comprehensive Assessment

**Note** ► If you must close out and complete the assessment at a later time, select the Save icon (  ) located on the action bar at the top of the window.

**History Band** – Click the History band. Enter pertinent history related to the resident’s Habilitation Therapy.



Chart Menu Bands: History

**Current Status Band** – Complete **PT Orders** sections. Complete **Orientation** by selecting the appropriate checkbox. Complete **Affect/Behavior** section by selecting all applicable checkboxes.

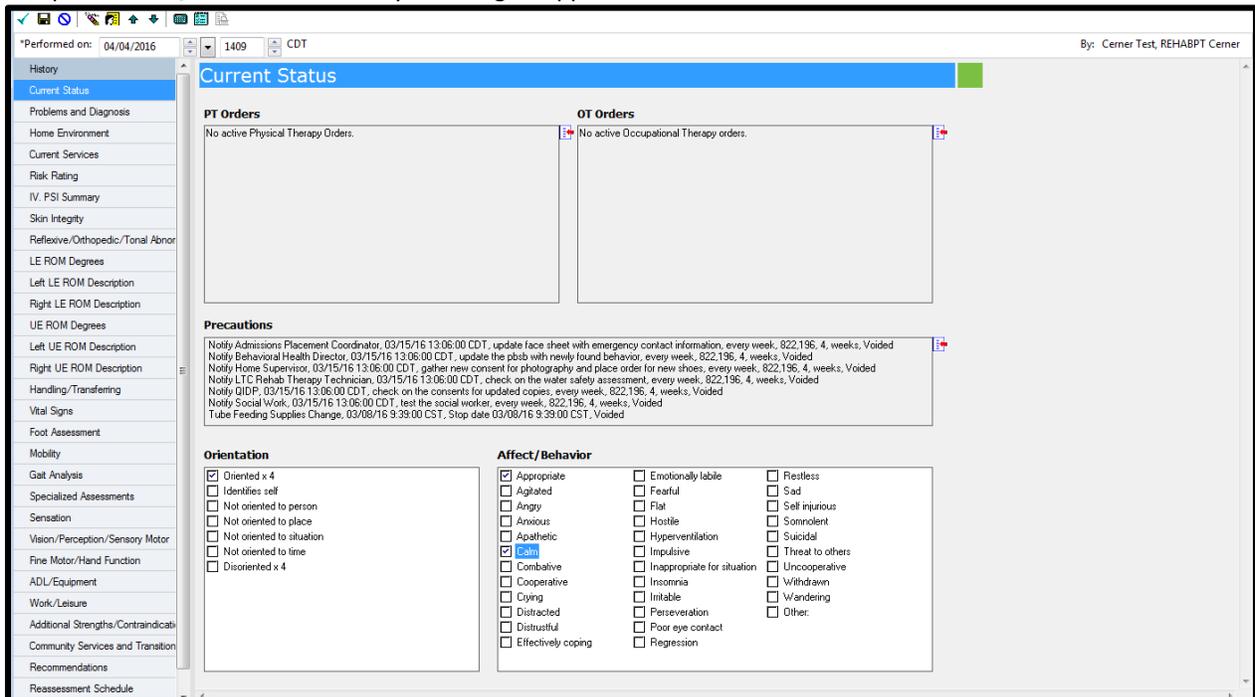
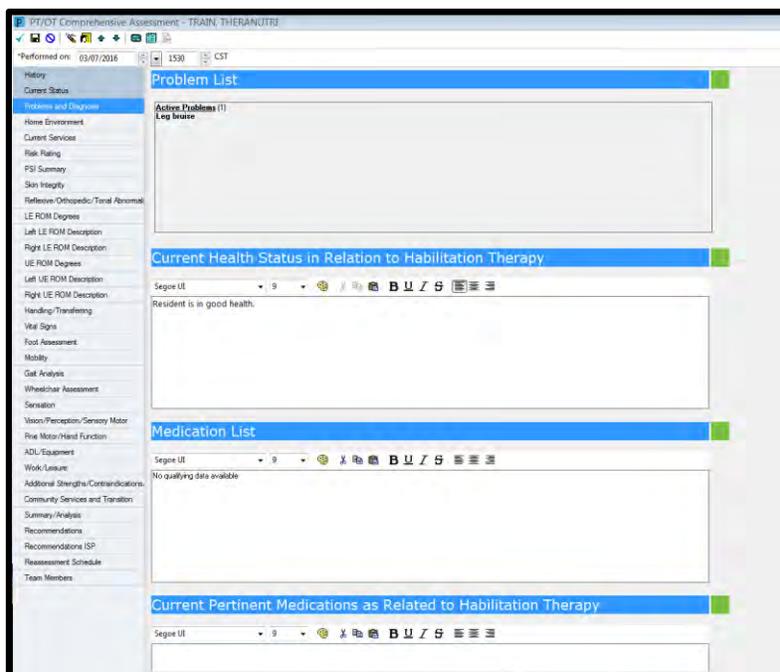


Chart Menu Bands: Current Status – Result Details Window

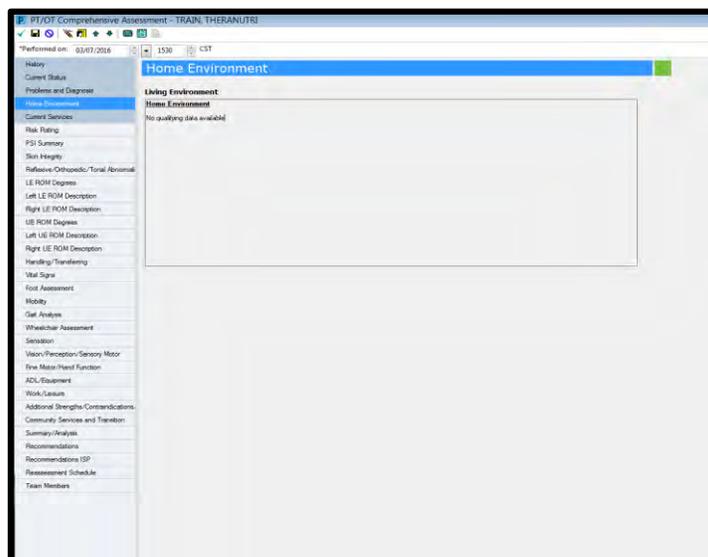
**Problems and Diagnosis Band** – View Problem List banner. This section displays information that was previously entered in the Problem & Diagnosis Chart menu. Complete each section by typing information into the text boxes.

**Tip** ▶ At any time, right click within editable fields to insert comments or clear information.



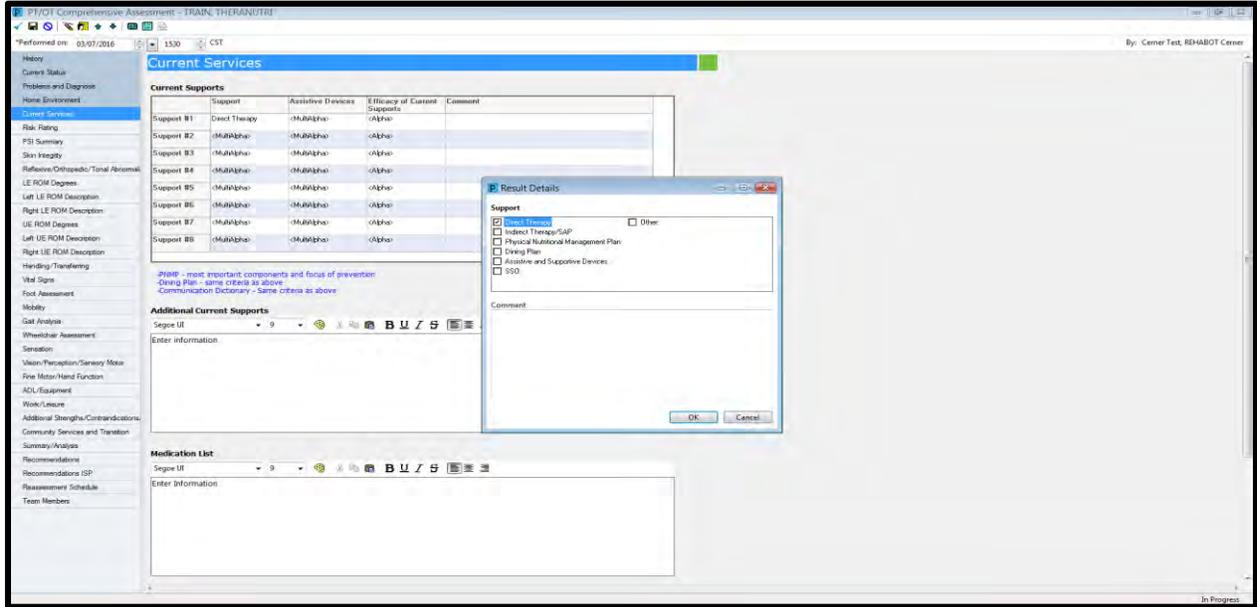
*Chart Menu Bands: Problems and Diagnosis*

**Home Environment Band** – View information regarding resident’s current living arrangements and environment.



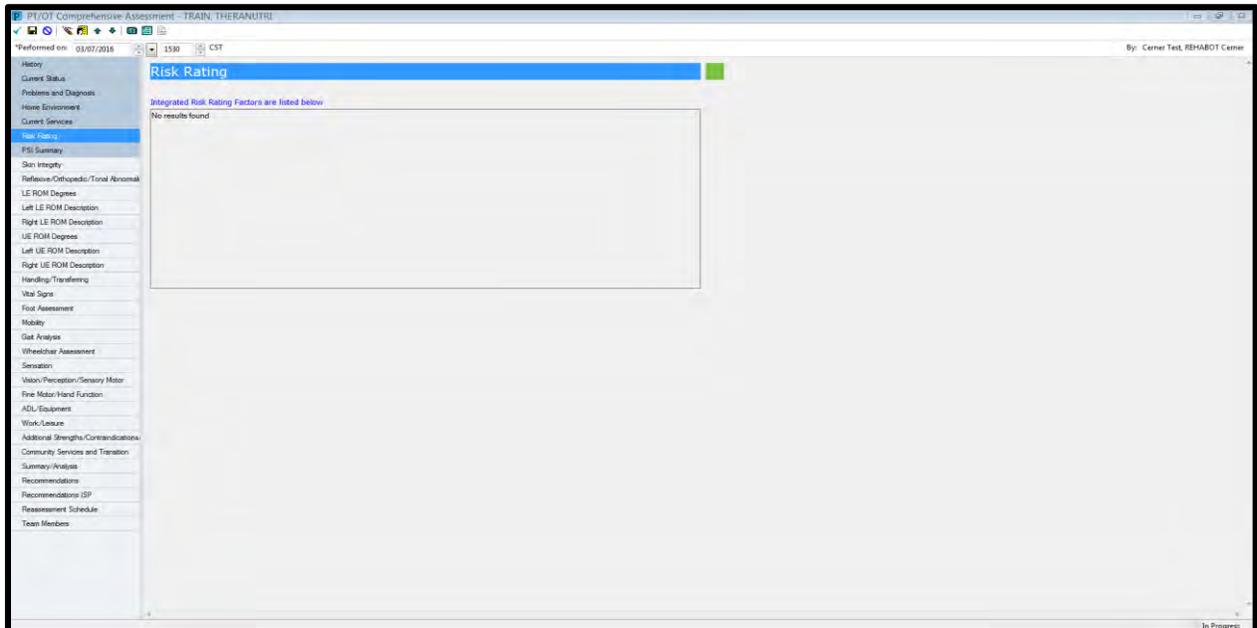
*Chart Menu Bands: Home Environment*

**Current Services Band** – Complete **Current Supports** section. Click in each field to display the **Result Details** pop-up window for each respective header: **Supports**, **Assistive Devices**, and **Efficacy of Current Supports**. Additional comments can be added in the **Comment** field. Click in the following text boxes to add comment(s) to complete each section: Current Supports, Additional **Current Supports**, **Medication List**, and **Pertinent Medication in relation to previous assessment/update**.



*Chart Menu Bands: Current Services – Result Details Pop-up Window*

**Risk Rating Band** – View the Integrated Risk Rating Factors.



*Chart Menu Bands: Risk Rating*

Preferences, Strengths and Goals Band – Section II Summary information prepopulates from PSI in Caretracker.

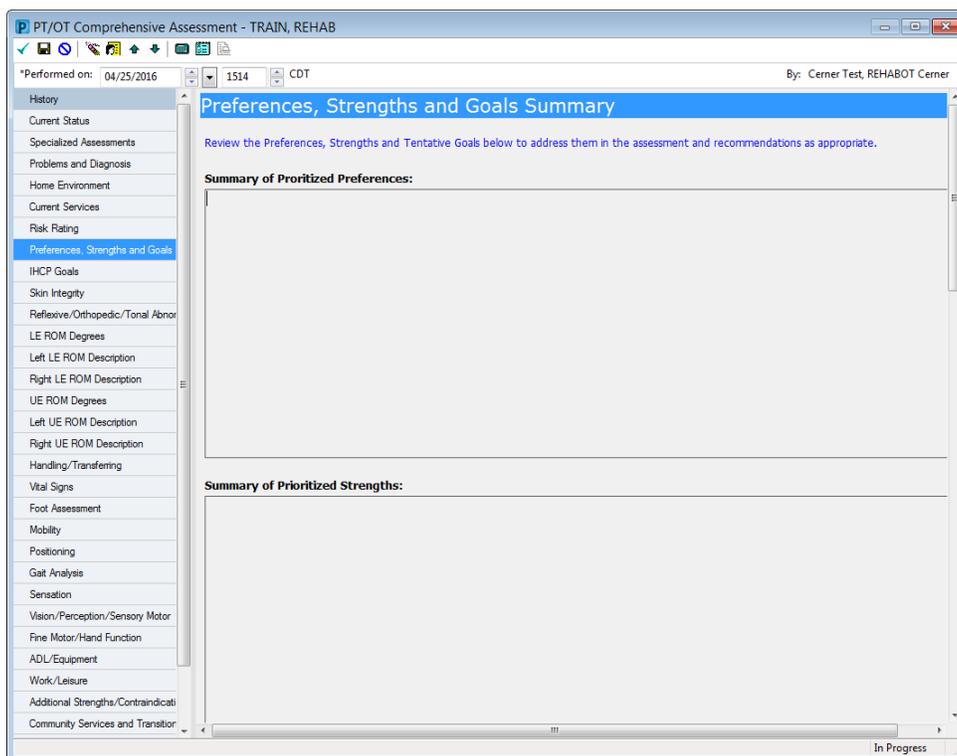


Chart Menu Bands: Preferences, Strengths and Goals Summary

**Skin Integrity Band** – Complete **Skin Integrity** sections. Select all appropriate radio button and checkbox(s): Complete **Skin Abnormality** section. Click in the following fields to display the **Result Details** pop-up window. Select all appropriate checkbox(s).

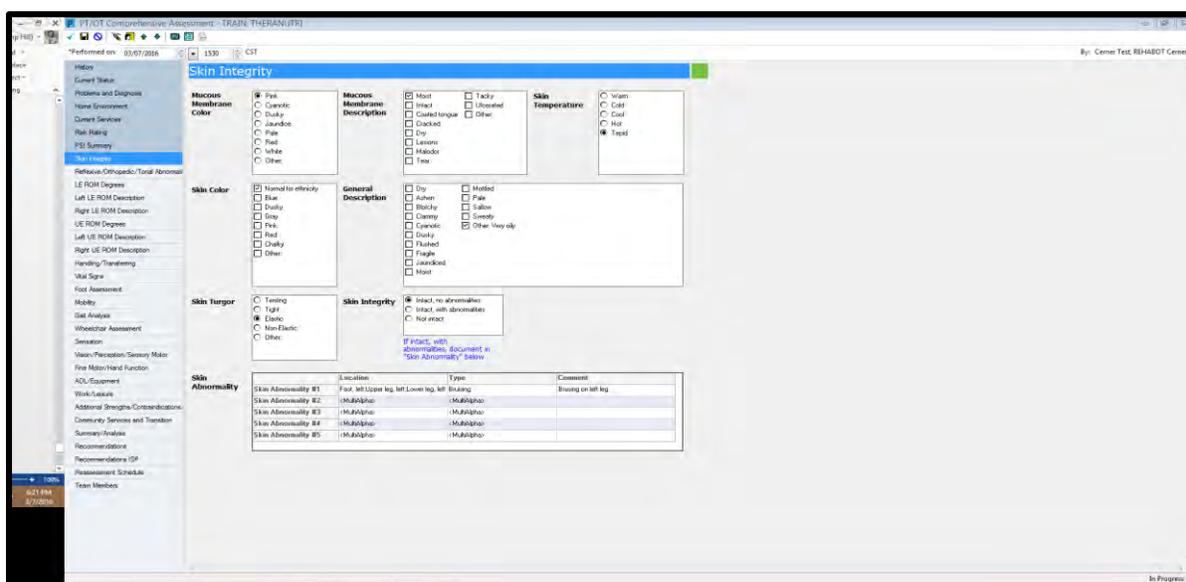


Chart Menu Bands: Skin Integrity

**Reflexive/Orthopedic/Tonal Abnormality Band** – Complete the following sections by selecting the appropriate checkbox(s) or type in the textboxes.

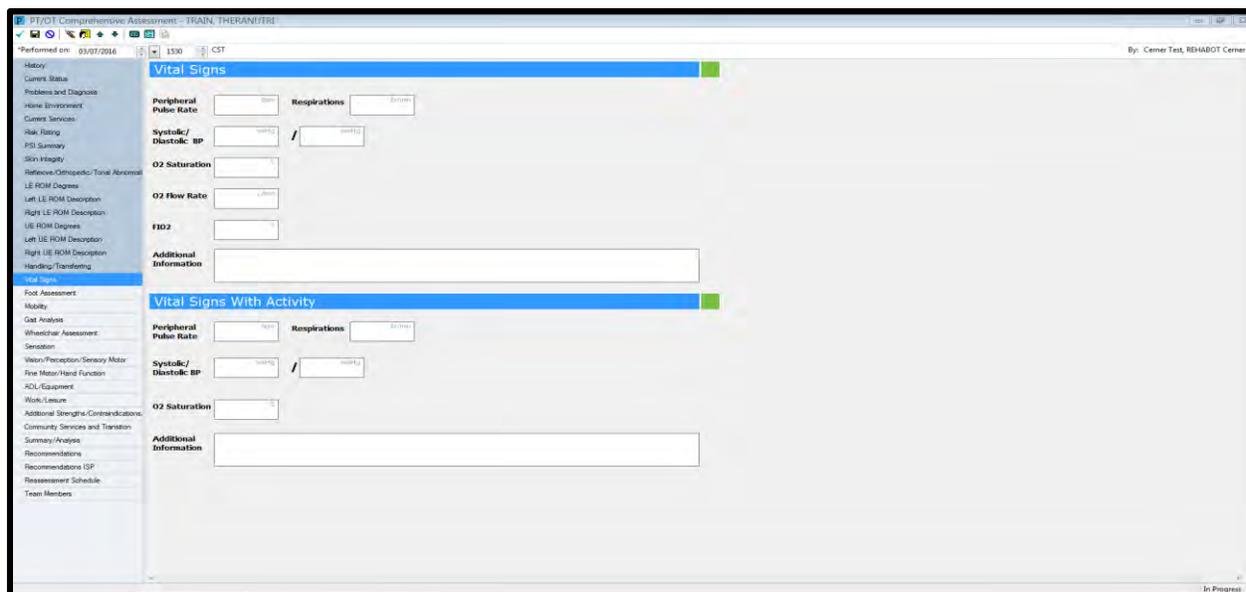
	Supine	Sitting	Standing	Flexible	Fixed	Details
Forward Head						
Capitil Flexion/Extension						
Normal Cervical Lordosis						
Hyperlord Cervical Lordosis						
Accentuated Cervical Lordosis						
Cervical Rotation Right						
Cervical Rotation Left						
Cervical Sidebend Right						
Cervical Sidebend Left						
Rounded Shoulders						
Normal Kyphosis						
Hyperlord Kyphosis						
Accentuated Kyphosis						
Scoliosis C Curve Right						
Scoliosis C Curve Left						
Scoliosis S Curve						
Wrist Scapular						
Trunk Rotation Right						
Trunk Rotation Left						
Trunk Sidebend Right						
Trunk Sidebend Left						
Normal Lumbar Lordosis						
Hyperlord Lumbar Lordosis						

Chart Menu Bands: Reflexive/Orthopedic/Tonal Abnormalities

Complete the following bands and all sections as appropriate. Right click in the fields to: **add Comment, Chart Details, Clear form, or Clear Cell.**

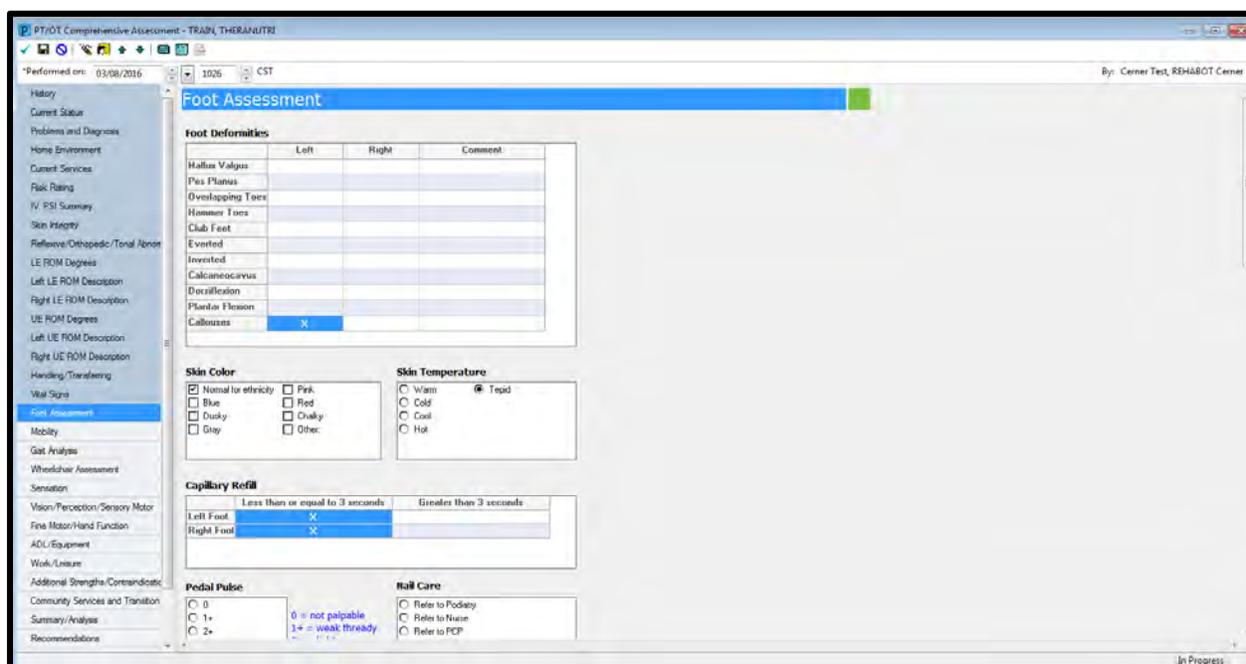
Chart Menu Bands: LE ROM Degrees

**Vital Signs Band** – Complete **Vital Signs** and **Vital Signs with Activity** sections as appropriate. Click in each field, and enter stats by typing information in each field.



*Chart Menu Bands: Vital Signs*

**Foot Assessment** – Complete the following sections by selecting the appropriate checkbox(s), chart results, or type in the textboxes.



Foot Deformities	Left	Right	Comment
Hallux Valgus			
Pes Planus			
Overlapping Toes			
Hammertoes			
Club Foot			
Everted			
Inverted			
Calcaneocavus			
Dorsiflexion			
Plantar Flexion			
Callouses	X		

Capillary Refill	Less than or equal to 3 seconds	Greater than 3 seconds
Left Foot	X	
Right Foot	X	

*Chart Menu Bands: Foot Assessment*

**Mobility** – Complete the following sections by selecting the appropriate checkbox(s), chart results, or type in the textboxes.

**Bed Mobility and Transfers**

	Independent	Requires assistance	Dependent	Comment
Roll Left	<input checked="" type="checkbox"/>			
Roll Right	<input checked="" type="checkbox"/>			
Roll Prone	<input checked="" type="checkbox"/>			
Roll Supine	<input checked="" type="checkbox"/>			
Supine to Sit	<input checked="" type="checkbox"/>			
Sit to Supine	<input checked="" type="checkbox"/>			
Scotching	<input checked="" type="checkbox"/>			
Sit to Stand	<input checked="" type="checkbox"/>			
Stand to Sit	<input checked="" type="checkbox"/>			
Transfer Bed to and From Chair	<input checked="" type="checkbox"/>			
Toilet Transfer	<input checked="" type="checkbox"/>			
Tub/Shower Transfer	<input checked="" type="checkbox"/>			
Car Transfer	<input checked="" type="checkbox"/>			
Floor Recovery	<input checked="" type="checkbox"/>			
Other	<input checked="" type="checkbox"/>			

**Transfer Equipment**  
Segue UI: 9

Enter information in field

**Ambulation Device Utilized**

<input checked="" type="checkbox"/> None	<input type="checkbox"/> Roll on left going up
<input type="checkbox"/> Assistive crutches	<input type="checkbox"/> Roll on right going up
<input type="checkbox"/> Bilateral rails	<input type="checkbox"/> Reverse walker
<input type="checkbox"/> Crutches	<input type="checkbox"/> Rolling walker
<input type="checkbox"/> Forearm crutches	<input type="checkbox"/> Small hand rail cane

Comment: Enter information in field

Chart Menu Bands: Mobility

**Gait Analysis** – Complete all sections of the **Gait Analysis** as appropriate. Select the appropriate checkbox(s) and enter information in textboxes.

**Gait Analysis**

**Overall Gait Analysis**

- Anabolic
- Ataxic
- Crouching
- Decreased cadence
- Decreased pelvic rotation
- Decreased trunk rotation
- Excessive arm swing
- Excessive trunk forward bending
- Feinting
- Lack of arm swing
- Scissoring
- Shuffling
- SMI knees
- Toe walking - Bilateral
- Toe walking - Left
- Toe walking - Right
- Wide base of support
- Other:

**Early Stance Left Lower Extremity**

- Decreased hip flexion
- Excessive dorsiflexion
- Foot slap
- Knee flexion at heel strike
- No heel strike
- Other:

**Mid Stance Left Lower Extremity**

- Compensated Trendelenburg/lateral trunk lean
- Excessive knee flexion
- Excessive pronation
- Excessive supination
- Knee buckling
- Knee hyperextension
- Uncompensated Trendelenburg hip drop on swing leg
- Other:

**Late Stance Left Lower Extremity**

- Anabolic
- Decreased hip extension
- Decreased push off
- Decreased weight bearing
- Decreased weight shift
- Excessive toe in
- Excessive toe out
- Heel whip
- Lateral push off
- Narrow base less than 2 inches
- Pelvic rotation
- Toe walking

**Swing Phase Left Lower Extremity**

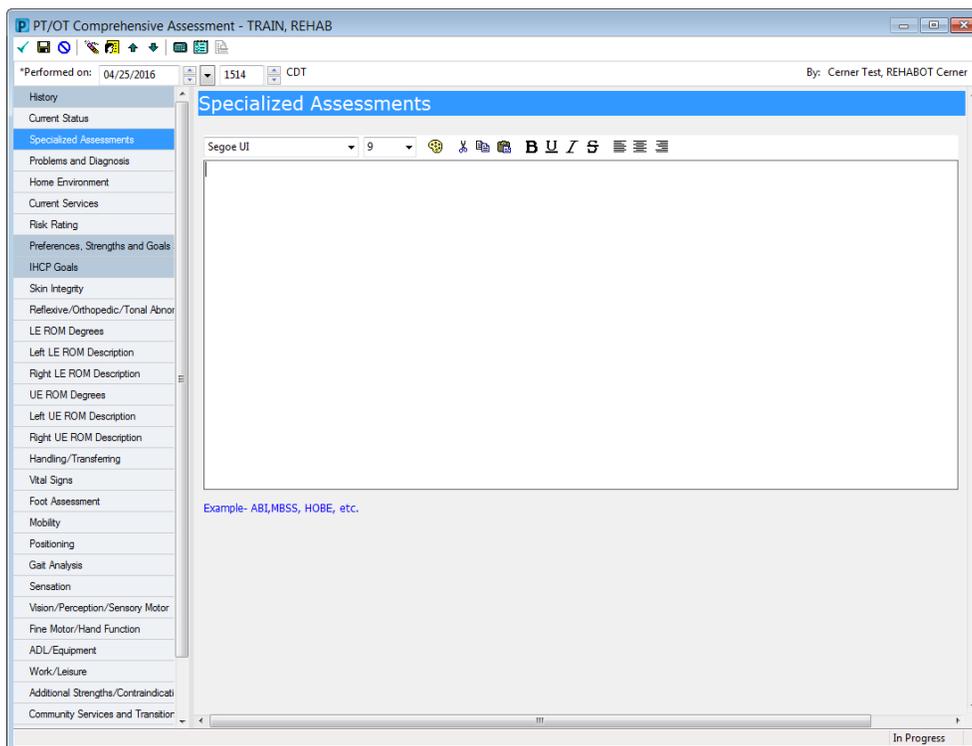
- Circumduction
- Complete foot drop
- Decreased foot clearance
- Decreased knee flexion
- Decreased step length
- Flexor withdrawal
- Hip hiking
- Scissoring
- Steppage gait
- Toe drag
- Walking on contralateral extremity
- Other:

**Early Stance Right Lower Extremity**

- Decreased hip flexion
- Excessive dorsiflexion
- Foot slap
- Knee flexion at heel strike
- No heel strike
- Other:

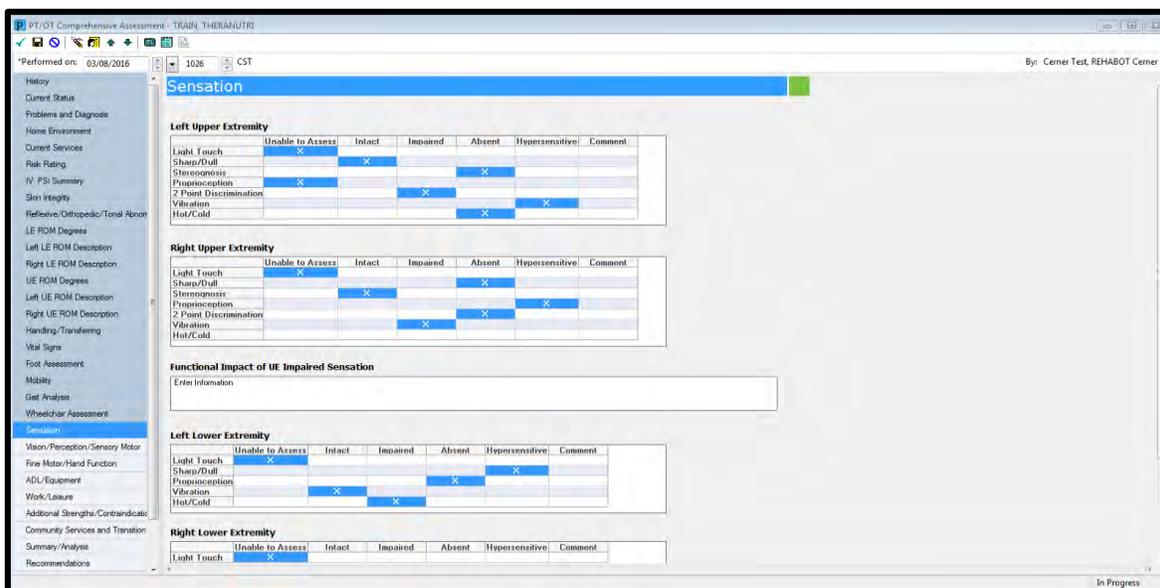
Chart Menu Bands: Gait Analysis

**Specialized Assessments** – Complete all sections as appropriate. Enter information in the textboxes.



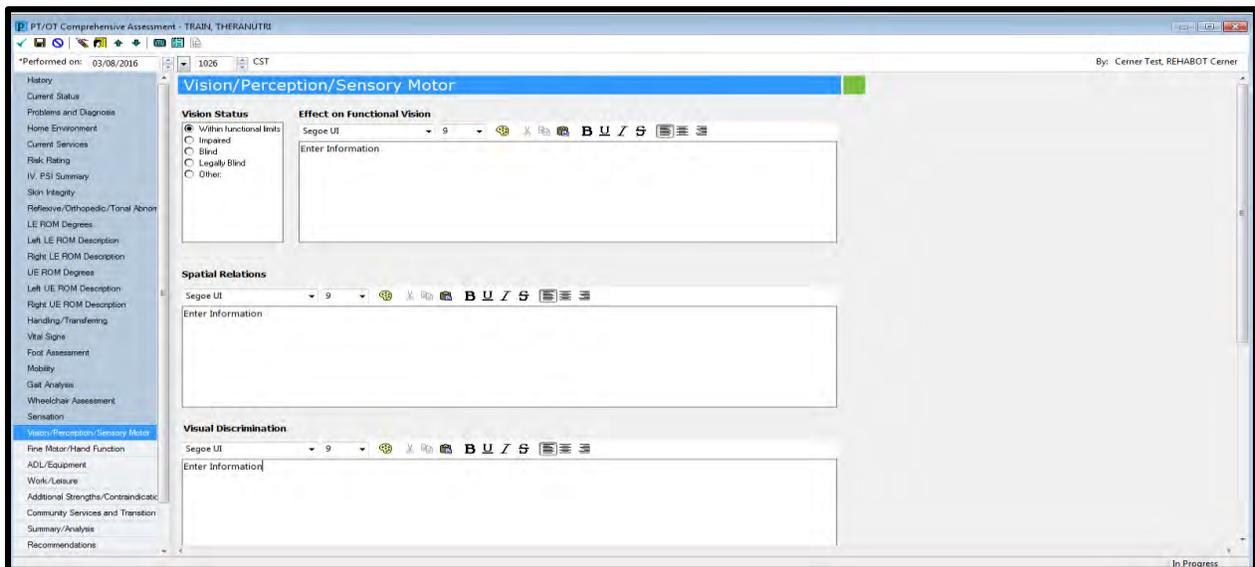
*Chart Menu Bands: Specialized Assessments*

**Sensation Band** – Complete all sections by selecting the appropriate field and entering the information in the textboxes.



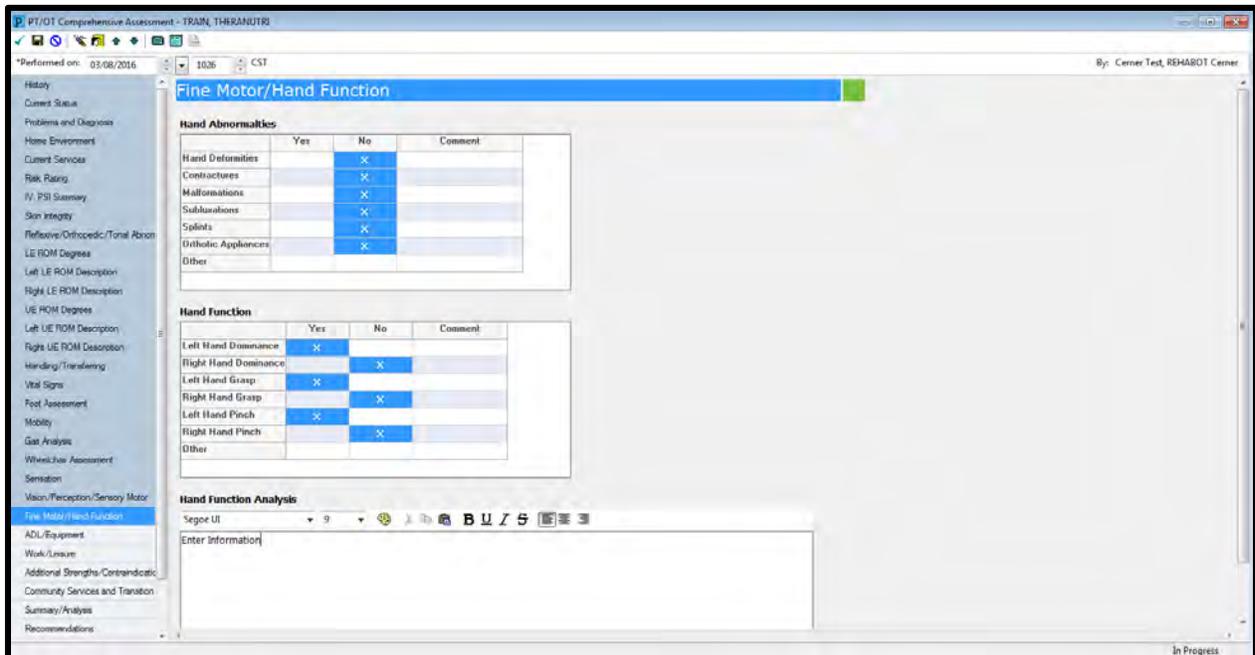
*Chart Menu Bands: Sensation Band*

**Vision/Perception/Sensory Motor** – Complete all sections by selecting the correct radio button, and enter information into the textboxes.



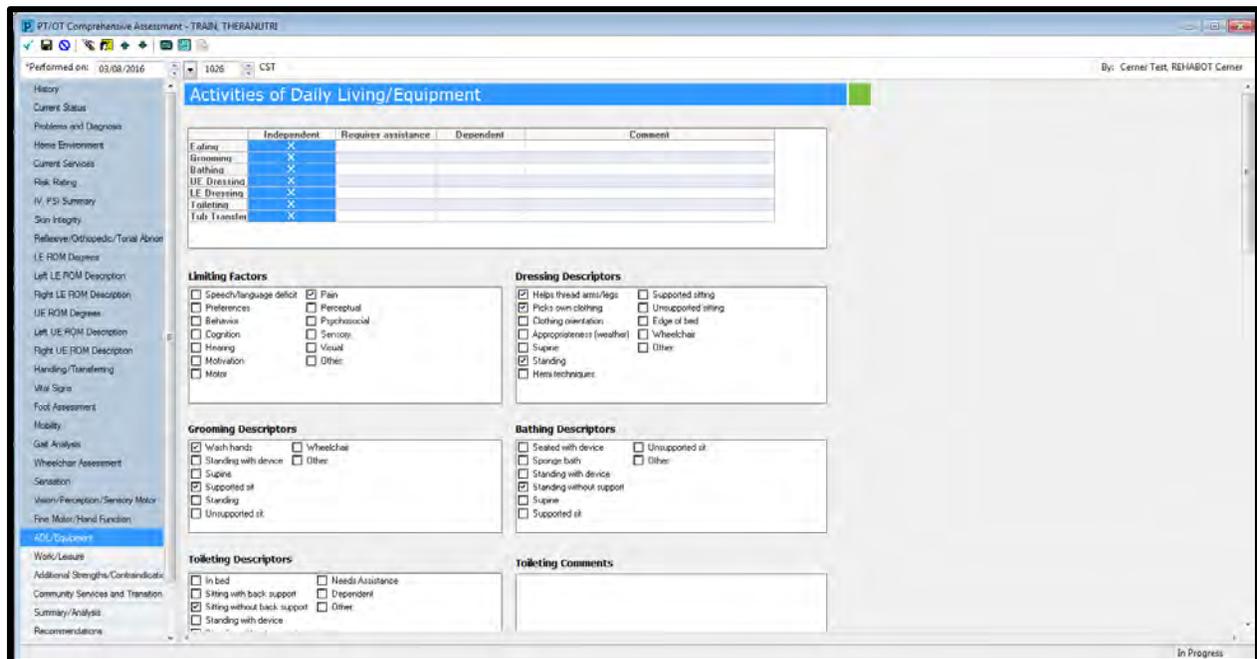
*Chart Menu Bands: Vision/Perception/Sensory Motor*

**Fine Motor/Hand Function** – Complete the following sections by selecting the appropriate fields, and enter information in the textbox.



*Chart Menu Bands: Fine Motor/Hand Function*

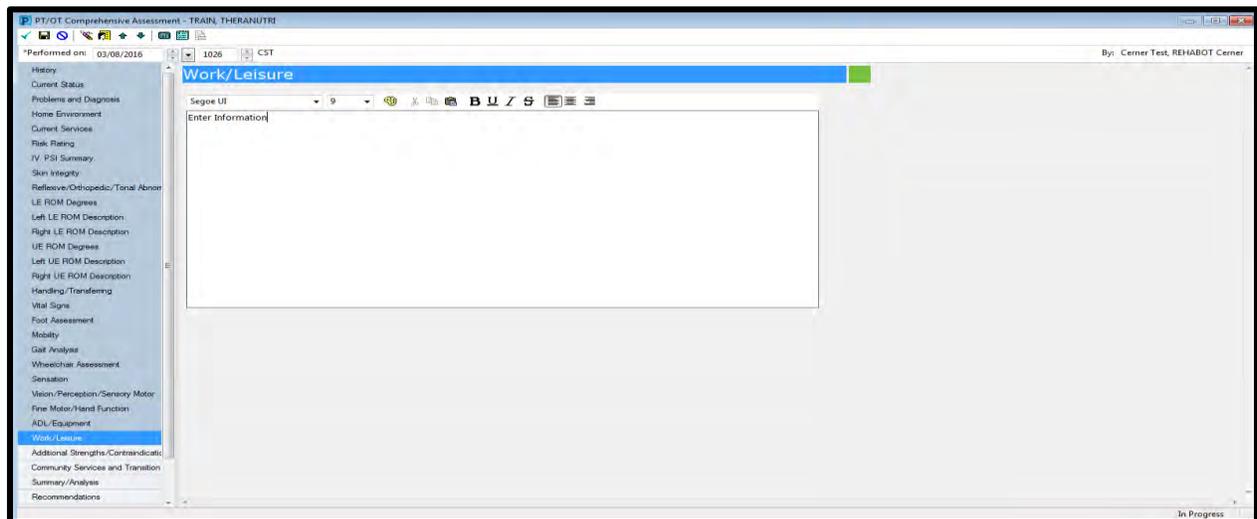
**ADL/Equipment** – Complete the following sections of Activities of Daily Living/Equipment by selecting the appropriate checkbox(s), and fields.



	Independent	Requires assistance	Dependent	Comment
Eating	<input checked="" type="checkbox"/>			
Grooming	<input checked="" type="checkbox"/>			
Bathing	<input checked="" type="checkbox"/>			
UE Dressing	<input checked="" type="checkbox"/>			
LE Dressing	<input checked="" type="checkbox"/>			
Toileting	<input checked="" type="checkbox"/>			
Tub Transfer	<input checked="" type="checkbox"/>			

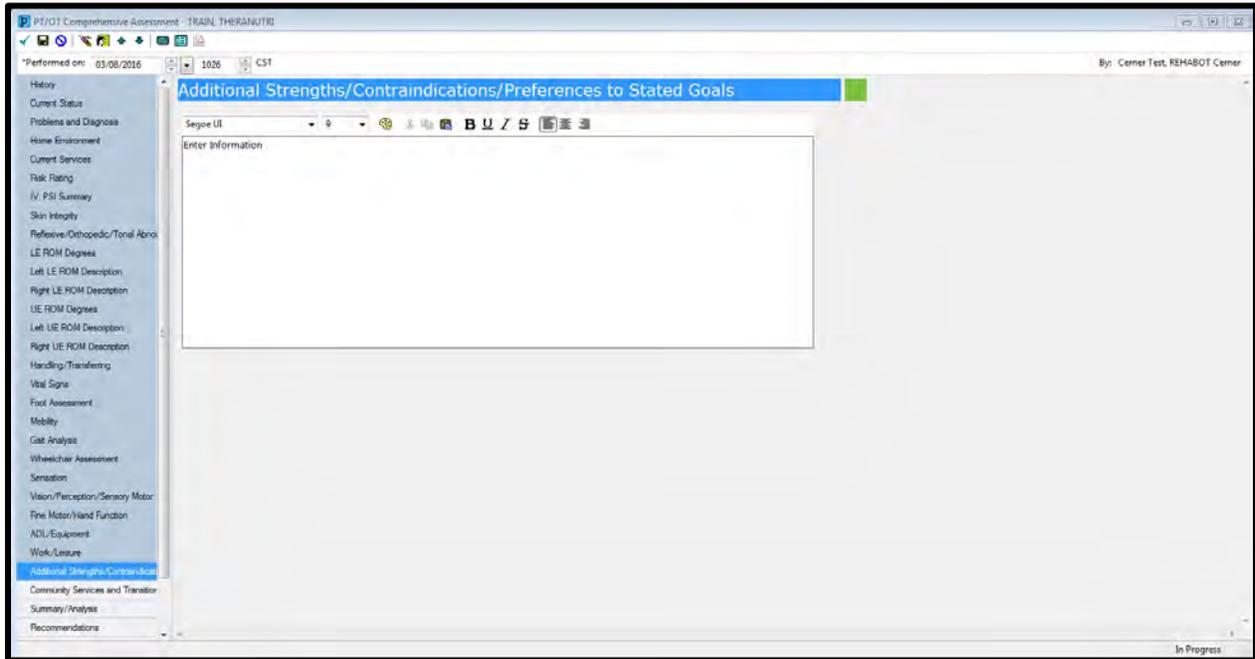
*Chart Menu Bands: Fine Motor/Hand Function*

**Work Leisure** – Complete this section by typing information in textbox.



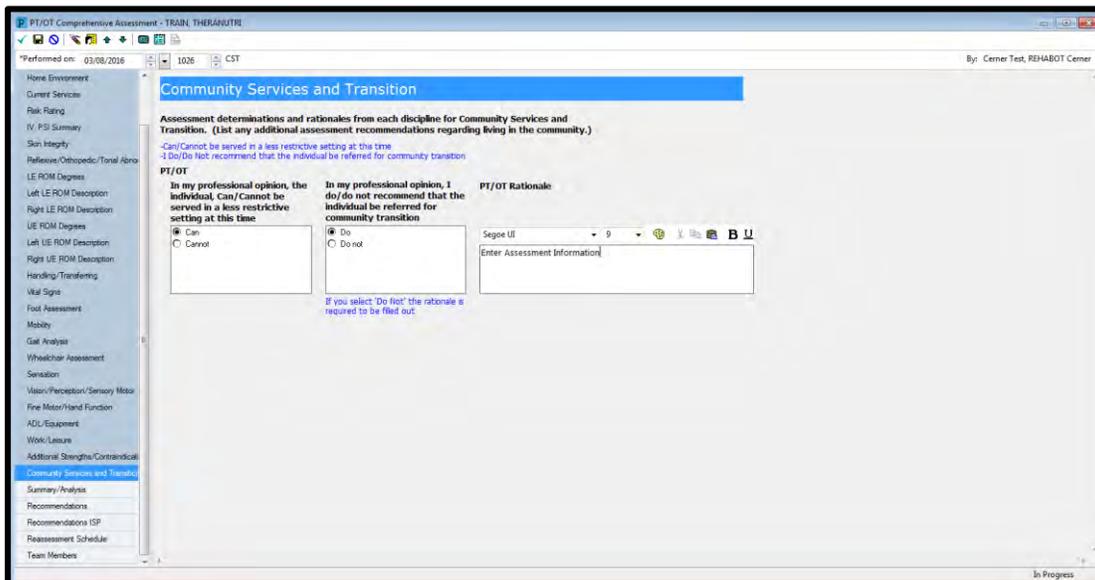
*Chart Menu Bands: Work/Leisure*

**Additional Strengths/Contraindications/Preferences to Stated Goals** – Enter information in the textbox.



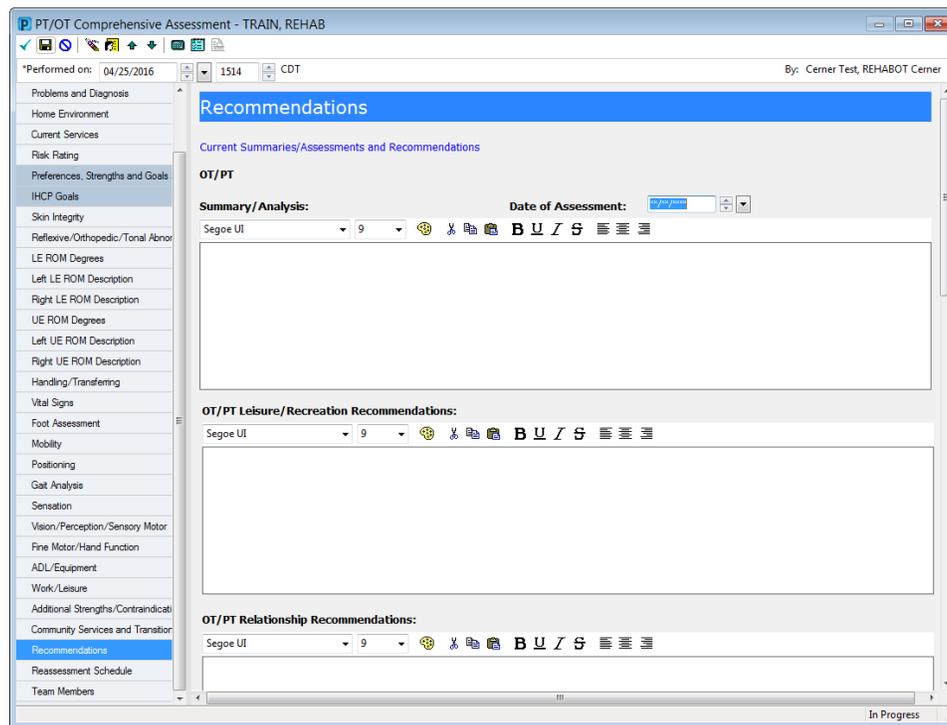
*Chart Menu Bands: Additional Strengths/Contraindications/Preferences to Stated Goals*

**Community Services and Transition** – Complete determinations and rationale for the **Community Services and Transition** section.



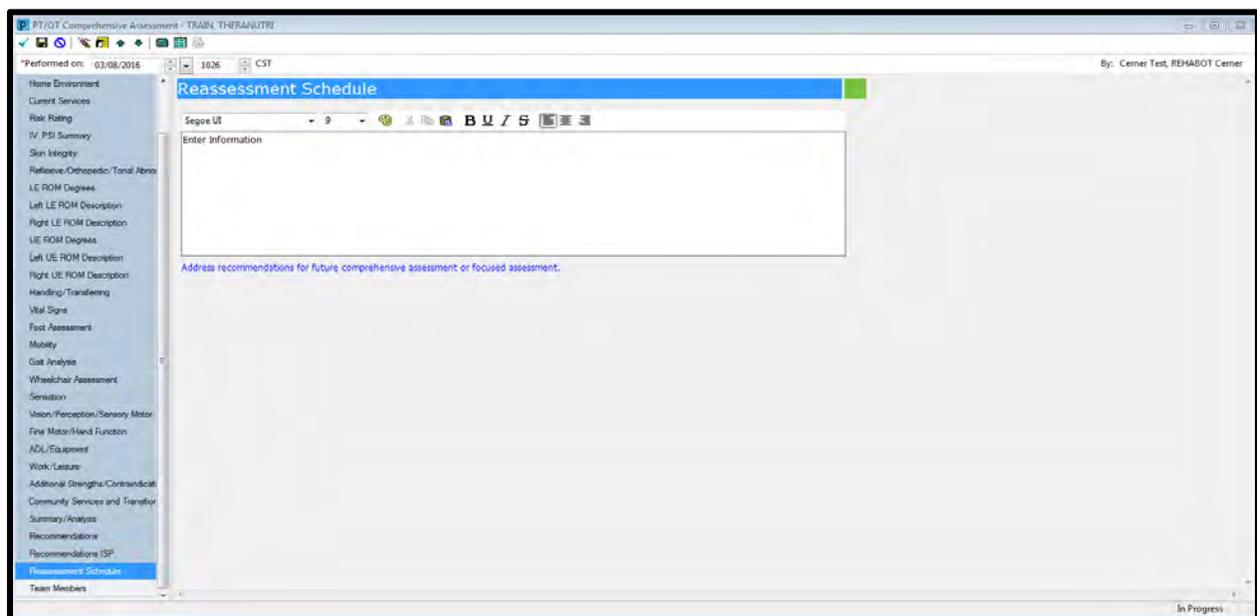
*Chart Menu Bands: Community Services and Transition*

**Recommendations**– Complete the following sections by typing information in textboxes.



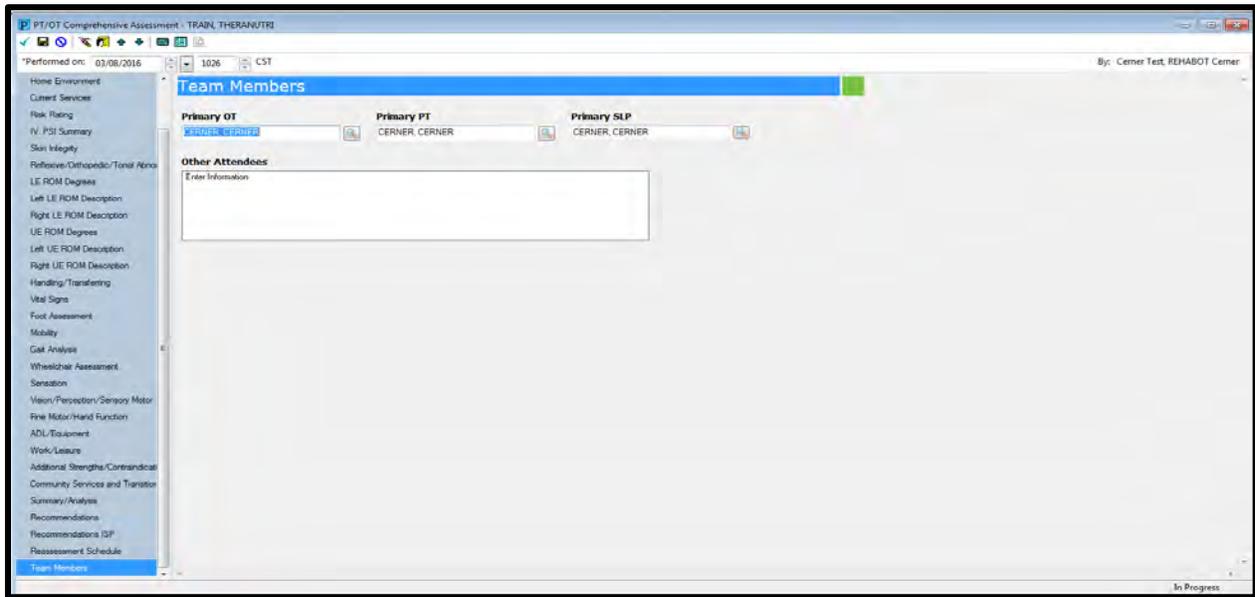
*Chart Menu Bands: Recommendations*

**Reassessment Schedule** – Complete this section by typing in the textbox.



*Chart Menu Bands: Reassessment schedule*

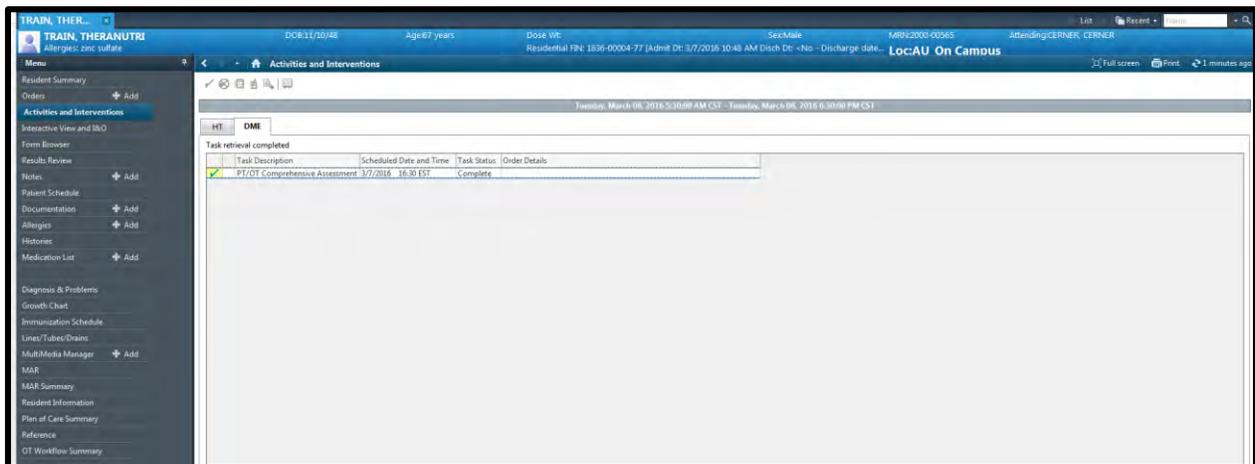
**Team Members** – Complete the following sections by selection the appropriate therapists and typing the names of other contributors as appropriate.



*Chart Menu Bands: Team Members*

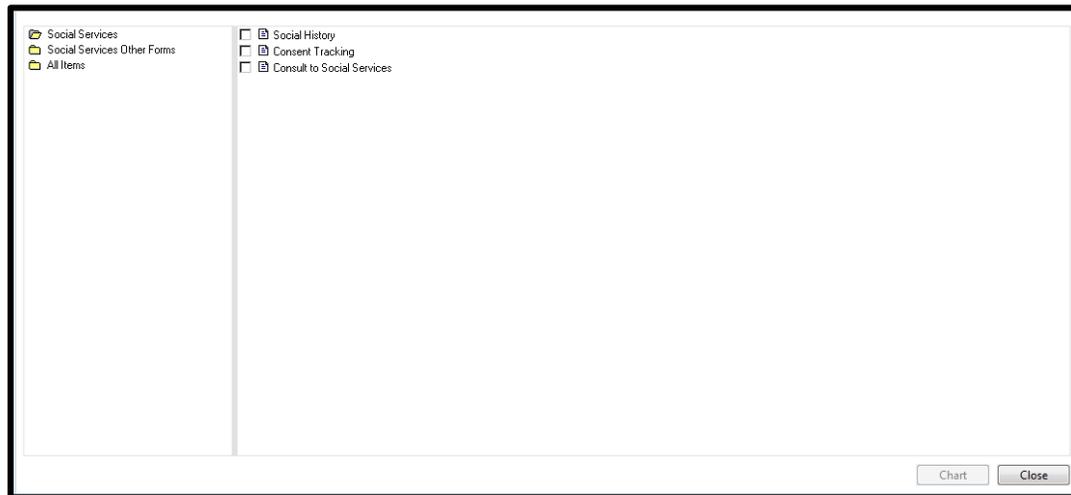
Click the Sign icon (✓) to sign the form. The resident chart displays and the PT/OT Comprehensive Assessment is complete.

**Note** ▶ Any action taken is documented automatically by the system with an electronic signature.



*Resident Chart: Complete OT/PT Comprehensive Assessment Display*

## Social Worker AdHoc Forms Display

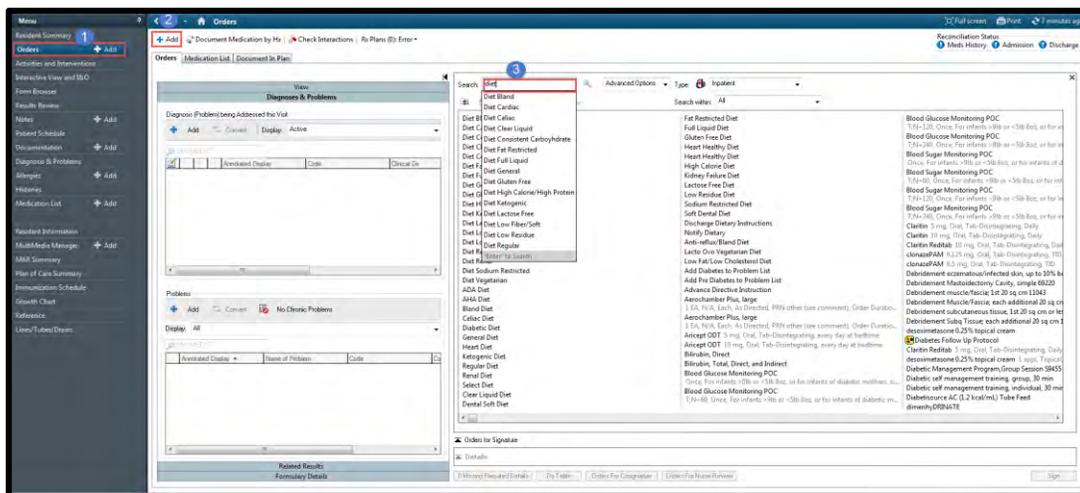


Social Worker AdHoc Forms

## DIET ORDERS

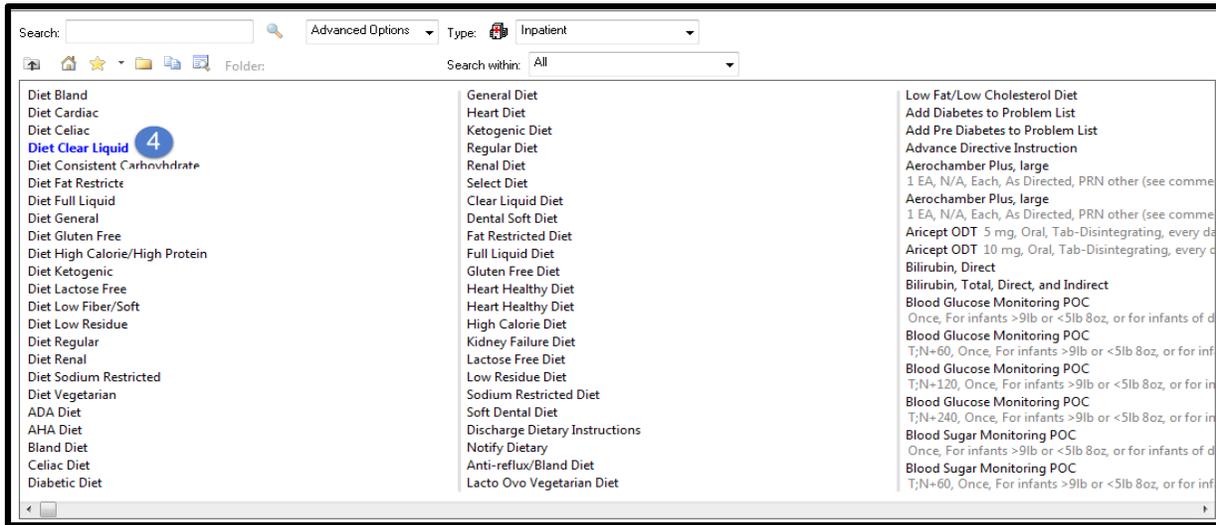
Diet Orders can be added to the resident's chart and is critical for getting external feeding formula reimbursement from Medicare

- Diet Orders
  1. Click the Orders (  Add ) icon in the **Chart** menu.
  2. Select the (  Add ) icon located on the **Orders** window.
  3. Type diet in the **Search** field. Click the (  ) icon.



Add Diet Orders

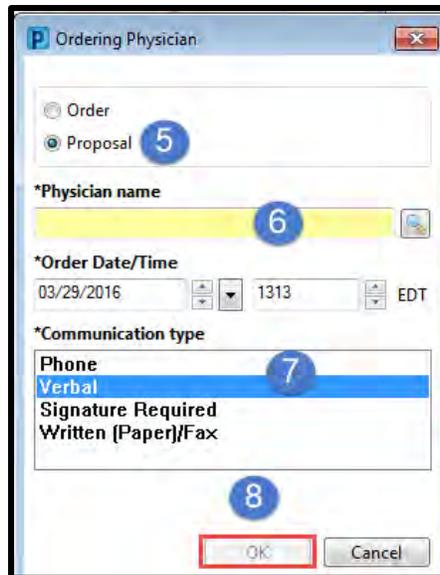
☞ All Diet Orders display.



*Diet Orders Returned Results*

4. Select the Diet Order.

☞ Ordering Physician window displays.

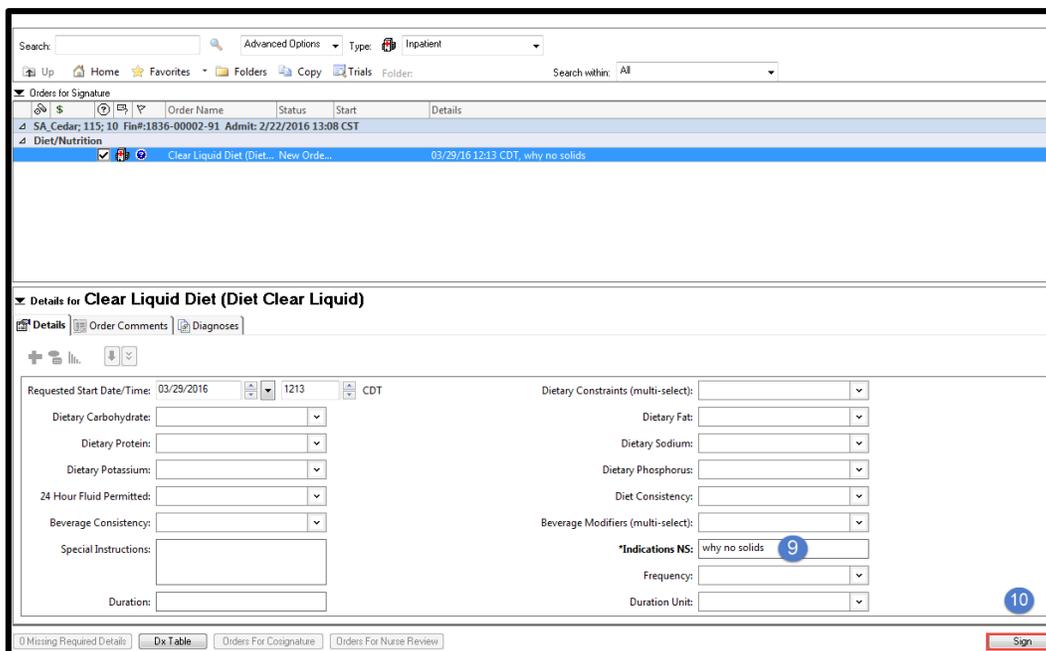


*Ordering Physician*

5. Select Proposal.
6. Type in the Physician name for the proposal to be sent.
7. Select **Communication Type**.
8. Click **OK**.

**Note** ► Proposed orders are restricted by position.

 Details for specific Order displays.



*Details for Specific Order*

9. Complete mandatory field(s).
10. Click **Sign**.
11. Added proposed order is displayed under the Diet/Nutrition header.

Displayed: All Active Orders | All Active Orders Show More Orders...

	Order Name	Status	Dose ...	Details
<b>Diet/Nutrition</b>				
	Clear Liquid Diet (Diet Clear Liquid) <span style="border: 1px solid blue; border-radius: 50%; padding: 2px;">11</span>	Processing		03/29/16 12:13 CDT, why no solids
	Regular Diet (Diet Regular)	Ordered		03/17/16 19:38:00 CDT, Fluid: 1500 mL, Thin Liquid, "Allergies have been updated since order was placed", Constan...
	Tube Feeding Insertion/Care	Ordered		02/24/16 21:11:00 CST, Glucerna 1.2, 10 French, Full strength, Intermittent, 10, TID w/ Meals, Constant Indicator
	Peptamen AF (1.2 kcal/mL) Tube Feed	Ordered		02/22/16 13:24:00 CST, Route: Feeding Tube, Goal Rate: 60 mL/hr, Advance By: 10 mL/hr, every 4 hr, Frequency: BL...
<b>Medications</b>				
	aspirin	Ordered	81 mg, Chew, Daily For: prevention, Through MMR, First Dose: 02/23/16 8:30:00 CST	
	metoprolol	Ordered	25 mg, Oral, Tab, BID For: HTN, Through MMR, First Dose: 02/22/16 20:30:00 CST	
	phenytoin (Dilantin 100 mg oral capsule, extended rel...	Ordered	100 mg, Gastrostomy Tube, BID For: dsf, Through MMR, First Dose: 02/22/16 20:30:00 CST	
	lisinopril	Ordered	10 mg, Oral, BID For: he asked for it, Through MMR, Order Duration: 5 weeks, First Dose: 03/14/16 20:30:00 CDT, St...	
<b>Laboratory</b>				
	Culture (CX), Stool (Stool Culture)	Ordered (...)		Austin State Lab, Feces, Stat collect, ST - Stat, 02/25/16 11:24:00 CST, Once, Nurse collect, Acute bronchitis
<b>Therapies</b>				
	HT Evaluation and Treatment	Ordered		03/24/16 11:21:00 CDT, Daily, Ambulatory
<b>Non Categorized</b>				
	Notify Social Work	Ordered		03/18/16 10:38:00 CDT, Clair please find the updated consent for photography, every week, 822,196, 4, weeks

*All Active Orders Display*

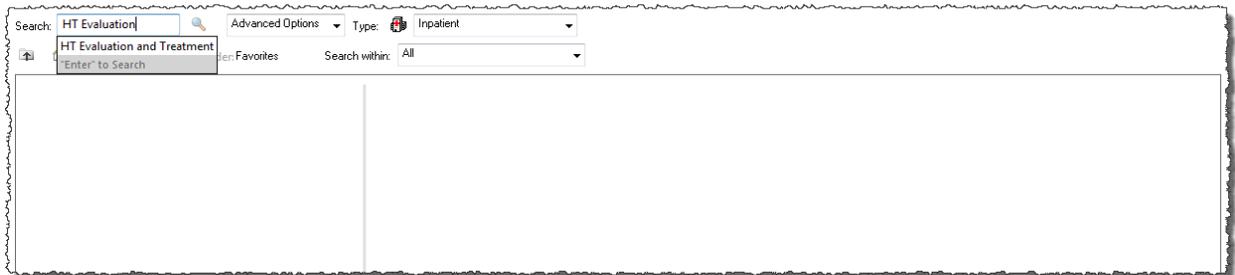
## Training Exercise

Complete the following exercise:

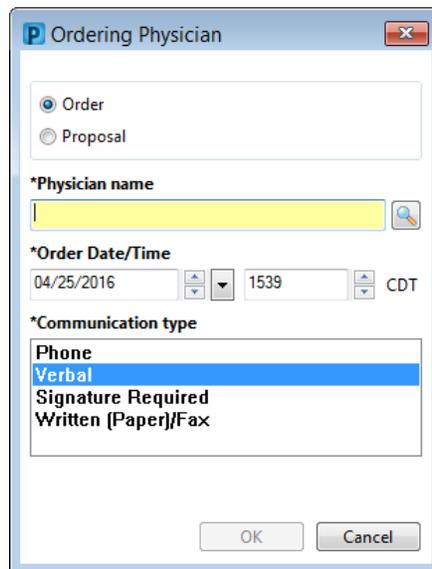
1. Propose a gluten free diet to be sent to physician.

## Evaluation and Treatment Order

- Complete Evaluation and Treatment Order
  1. From the Chart menu, select Orders **+Add**.
  2. Select icon ( **+ Add** ) located at the top left of **Orders** window. The **Add Orders** pop-up window displays.
  3. Type **HT Evaluation and Treatment** in the **Search** field.



*Chart Menu: Diagnosis & Problems Window – Search Field*



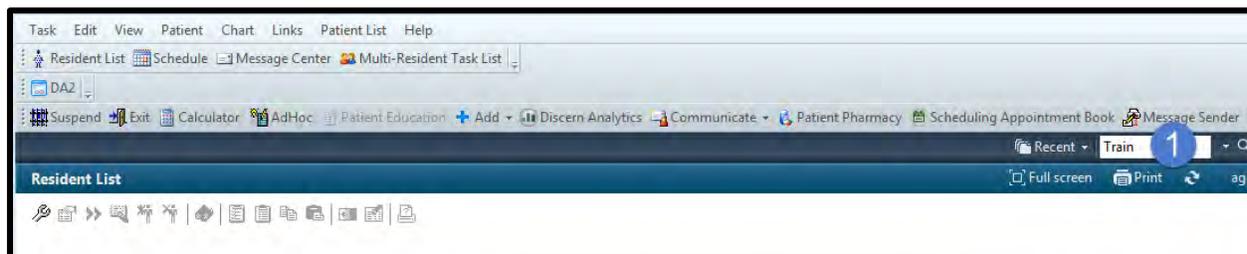
4. Ordering Physician pop-up window displays. Search for Physician name, select the magnifying glass icon (  ).
5. Select the Communication type.
6. Click **OK**.
7. Select **Done**. Task Completed.

## HABILITATION THERAPY ONGOING DOCUMENTATION

### Resident Search

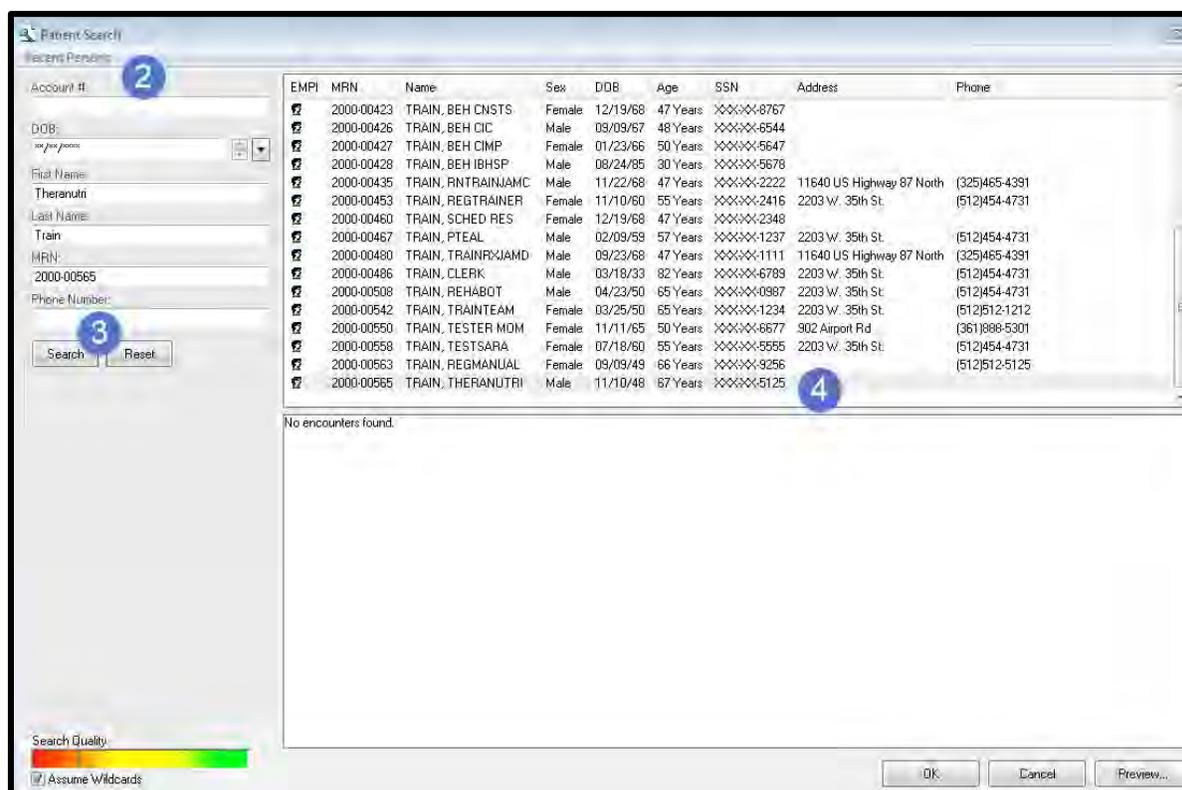
To search for and view information on a specific resident, utilize the search functionality.

1. From the **Resident Toolbar**, type in the resident's last name, then click the magnifying glass icon (  ).



*Resident Toolbar: Search Option*

2. From the **Resident Search** pop-up window, type in the Encounter Identifier (FIN), Person Identifier (MRN), Last Name, First Name and/or DOB to conduct the search.



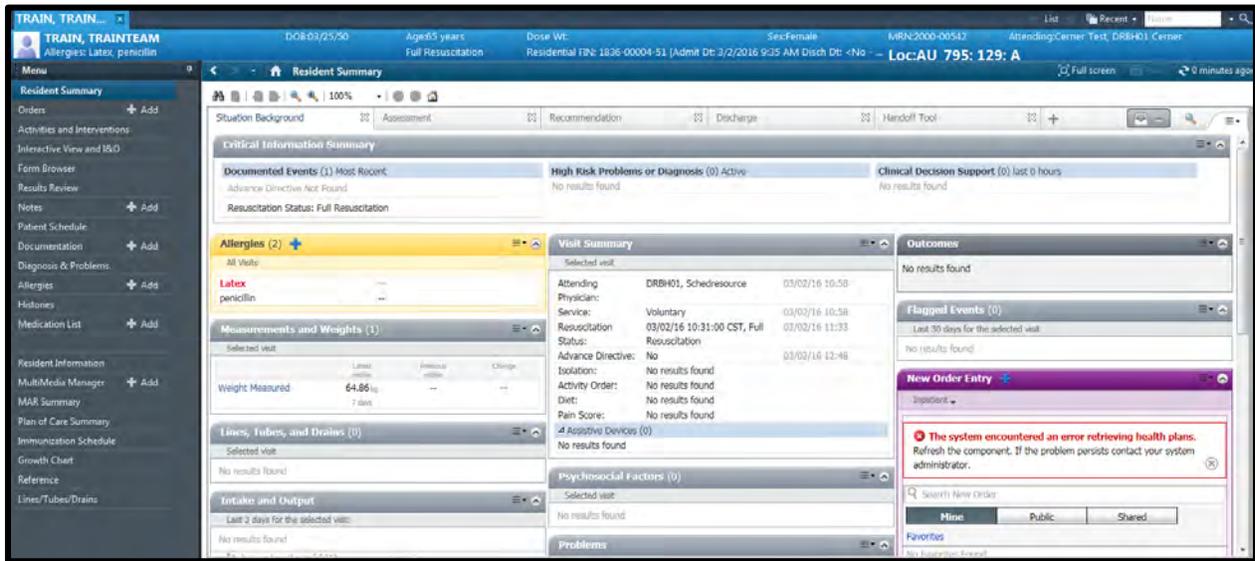
*Resident Search Window*

3. Click **Search**, or press Enter to display the search results.
4. Double click the resident or encounter to open and view or select the **OK** button.

## Review Resident Summary Chart

This window displays critical information regarding the resident including: Allergies, Measurements and Weights, Line, Tubes and Drains, Visit Summary, Intake and Output, Procedure History, Social History, Family History, Psychosocial Factors Problems, Significant Events, New Order Entry, Overdue Tasks, Media Gallery, and Outstanding Orders.

From the chart **Menu**, click **Resident Summary** to view the resident summary.

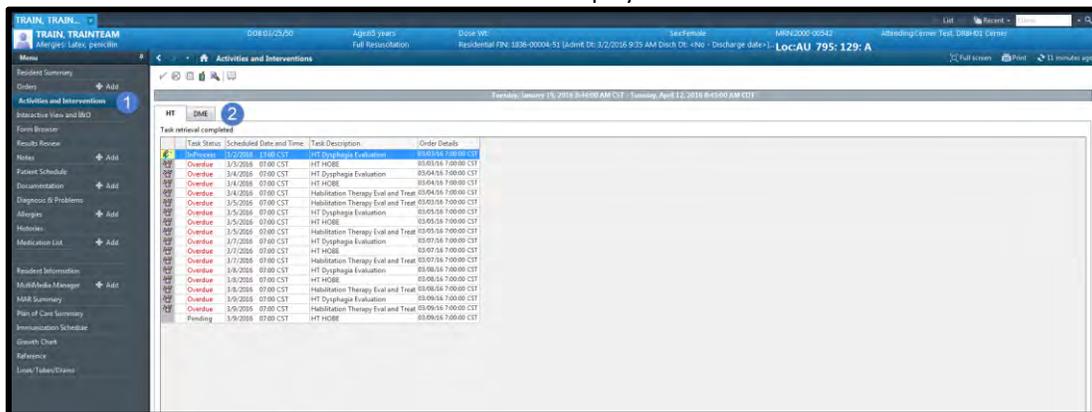


Resident Summary Window

## Activities and Interventions

The Activities and Interventions section provides a snapshot look into tasks that are in a status of Complete, In-Process, Pending, or Overdue on the resident's chart.

- Take Action on Task in Activities and Interventions Window
  1. From the Chart menu, select Activities and Intervention band.
  2. The Activities and Interventions window displays.



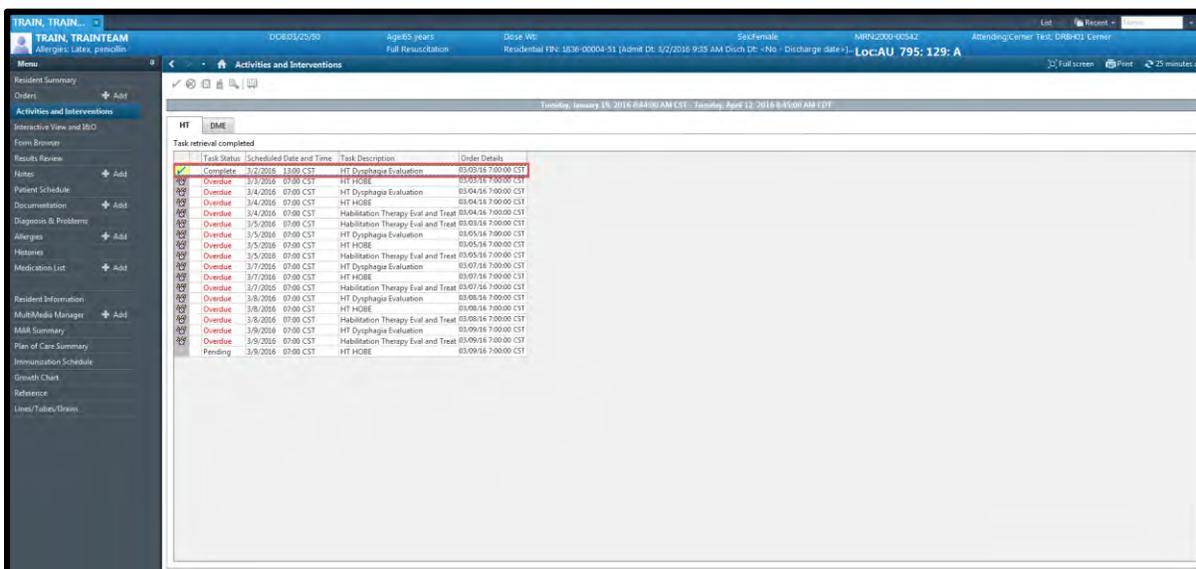
Activities and Interventions Window

- To begin charting, double-click on the task you want to view or complete.
- All sections to be completed, display on the left side of the window. Click through each section to complete the tasks.



*Activities and Interventions Window: Task to be completed*

- To close out and sign completion of tasks, click the **Sign** icon (✓) located on the top left of the Action Tool bar.
- The task of “In-Progress” changed to “Complete.”



*Activities and Interventions Window: Task Completed*

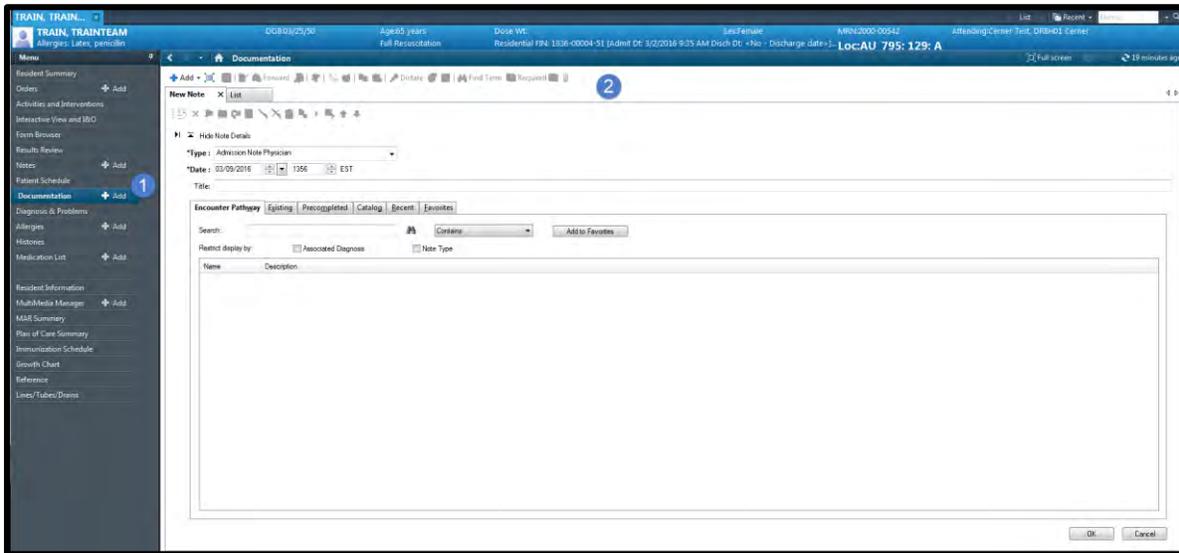
- Select the next task to complete.

## Documentation

The documentation band provides a record of information with insight to the assessment and treatment story of the resident. This information can be viewed dynamically when someone looks into the residents chart.

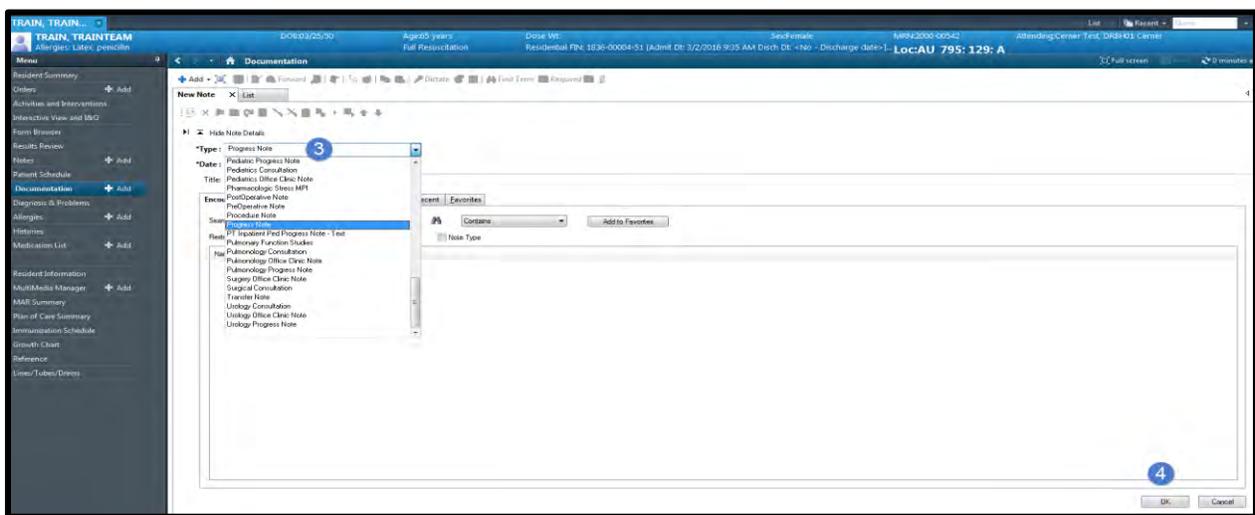
Documentation such as Therapeutic Riding Assessment, Tube Feeding Information, and Progress/SOAP Note, can be located in this section.

- Add Documentation
  1. From the Chart menu, select Documentation band.
  2. Click **+ Add** to add a new note.



*Documentation Window Displays*

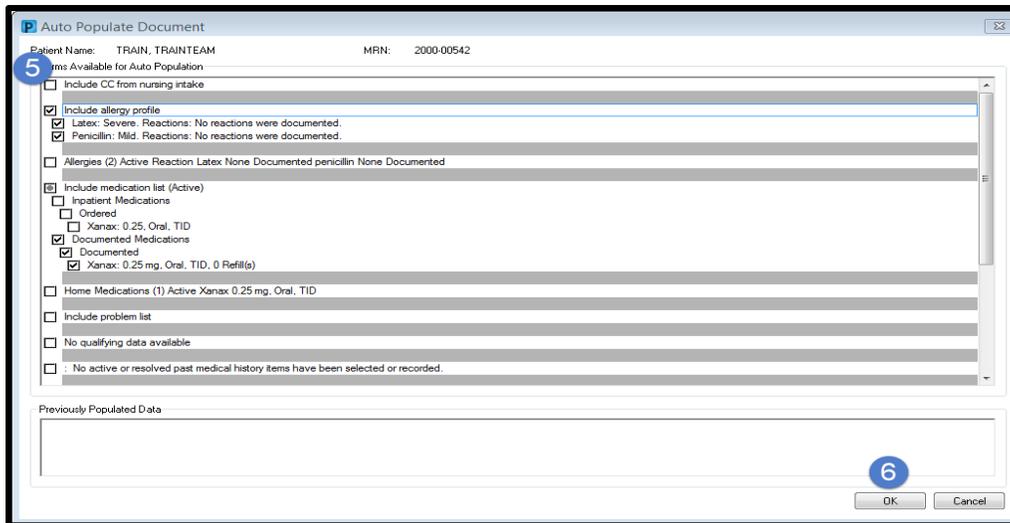
3. Click the drop-down menu to select the Type of documentation to be recorded on the residents chart.



*Documentation Window: Type of Documentation*

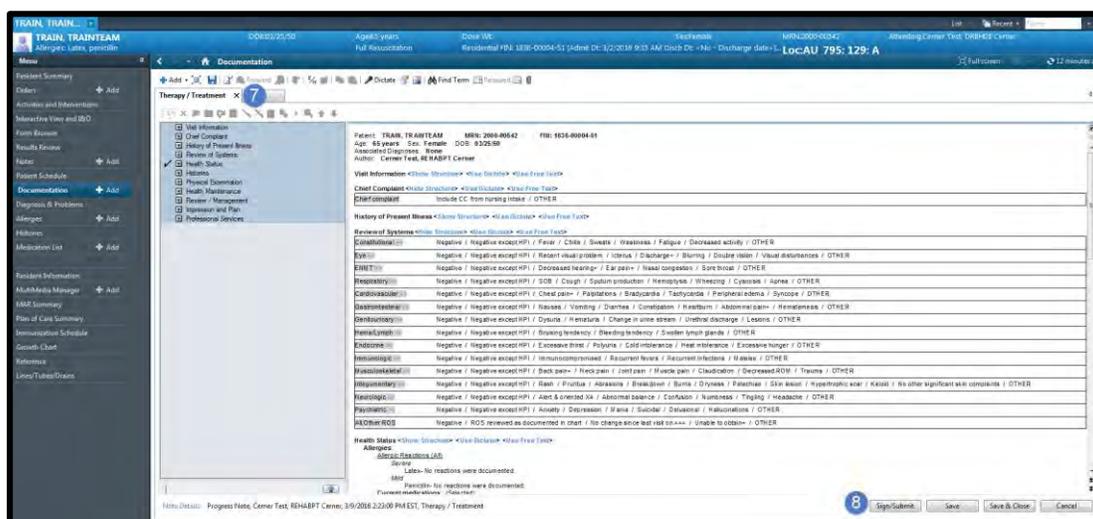
4. Complete all fields, click **OK**.

- Document pop-up window displays. Mark all checkbox(s) to auto populate onto the resident's chart.
- Click **OK**.



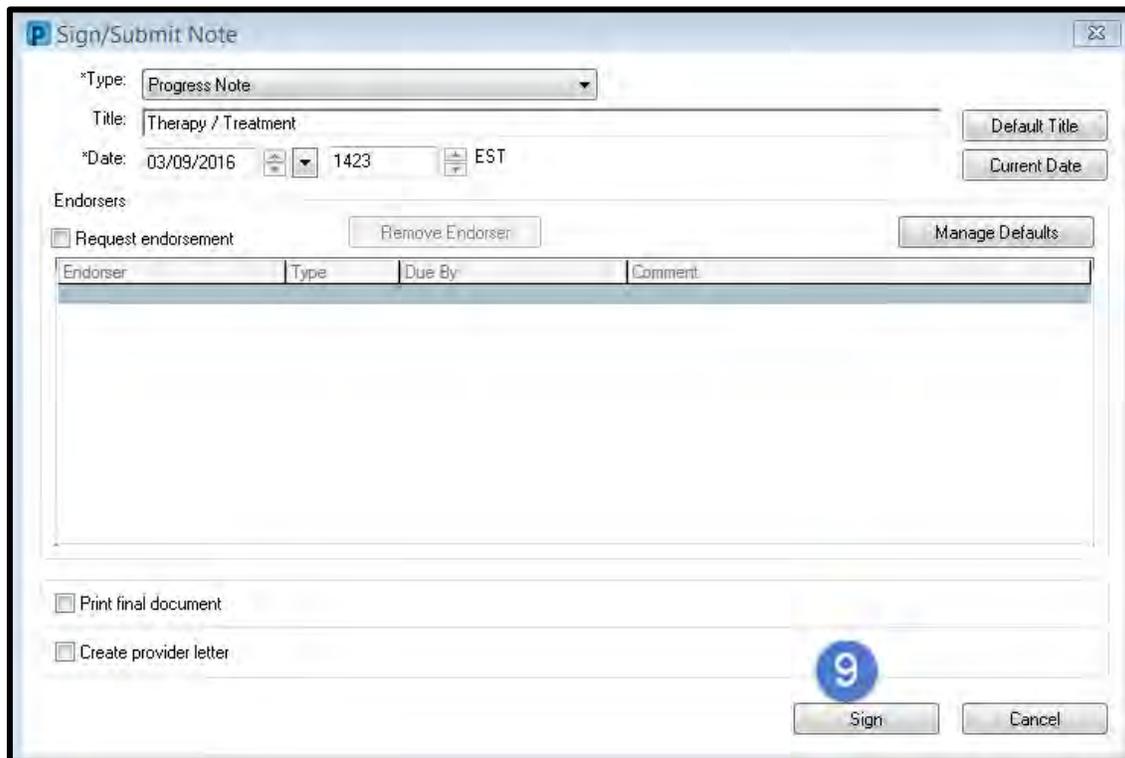
Documentation Pop-up Window: Auto Populate Document

- Information marked is displayed.
- After information is displayed, there are four options:
  - Click **Sign/Submit** – Completes the documentation, and publishes Note to resident's chart.
  - Click **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 closed.
  - Click **Save & Close** – Saves and closes the Note without signing.
  - Click **Cancel** - Closes the pop-up window without saving changes to Note.



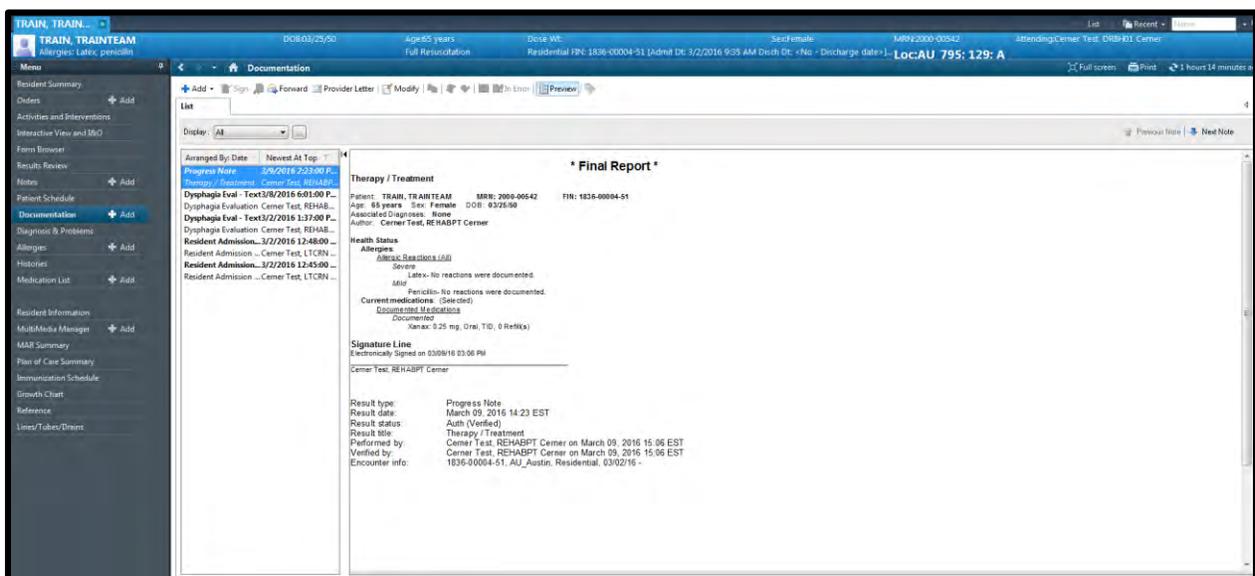
Documentation Window: Documentation Charted

- If **Sign/Submit** is selected, **Sign/Submit** pop-up window displays. Select **Sign** to confirm and close out of window.



Documentation Pop-up Window: Sign/Submit Note

- To view Final Report, right Click on item to view, Final Report displays.

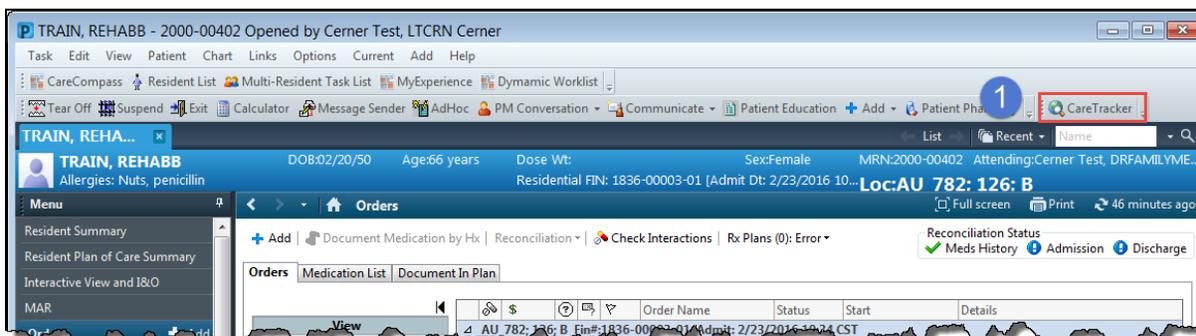


Documentation: Final Report

## Access CareTracker Dashboard in PowerChart

The CareTracker button in the Actions Toolbar provides a direct link to CareTracker from PowerChart.

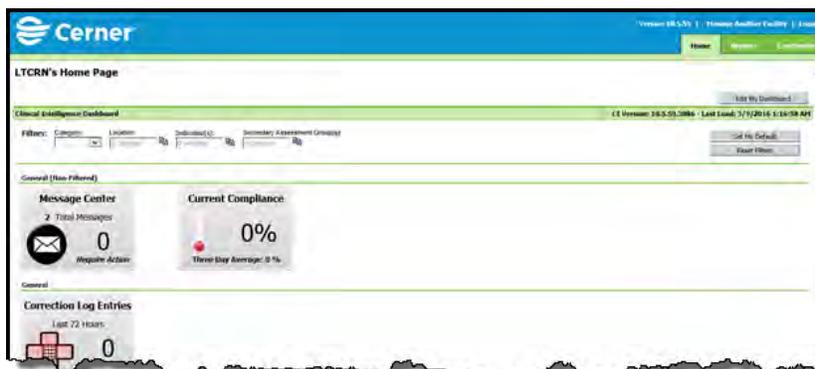
 Navigate to **CareTracker**



*Navigate to CareTracker*

1. From the Action Toolbar, click CareTracker.

 The **CareTracker Home Page** displays.



*CareTracker Home Page*

2. **CareTracker** displays in a new window.
3. Use the **CareTracker** functionality to monitor patients and to send and receive staff messages.

From this screen you will be able to view items such as: condition of equipment, and indirect therapy programs – Walking and Exercising. The reporting functionality allows access and run reports such as, weights, food intake, fluid intake, supplements, alternate foods, seizure records, and Behavioral documentation for a selected timeframe.

**Note** ► From **CareTracker**, individuals with the security access to do so will use widgets to document resident observations.

## Training Exercise

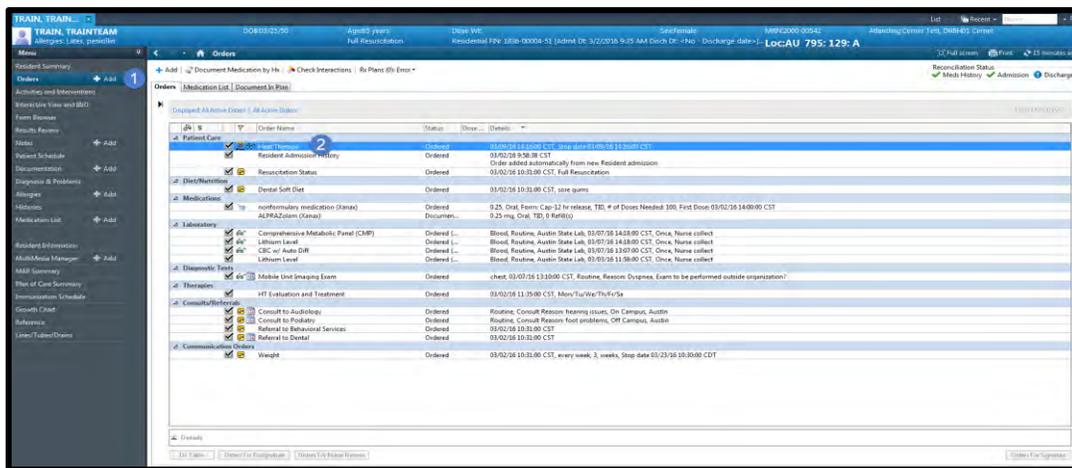
Complete the following exercise:

1. In the Documentation window, add Progress Note.
2. Select information to be charted.
3. Sign/Save information.
4. View Final Report.

## Cancel/Discontinue Order

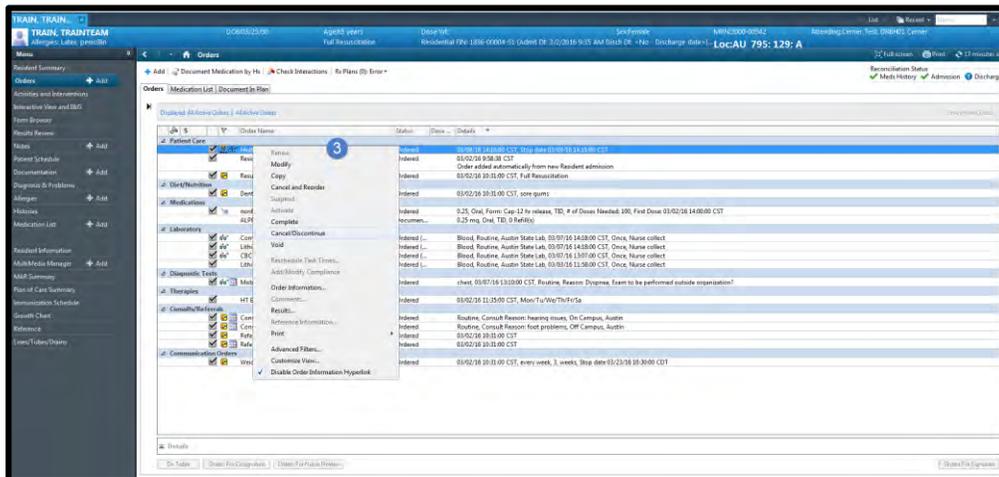
This section provides information on how to cancel or discontinue orders. An order may have been entered incorrectly, change in dosage, or perhaps the order is no longer relevant to the individual.

1. From the chart Menu, select Orders.
2. Right click on the Order to Cancel/Discontinue or Cancel and Reorder.



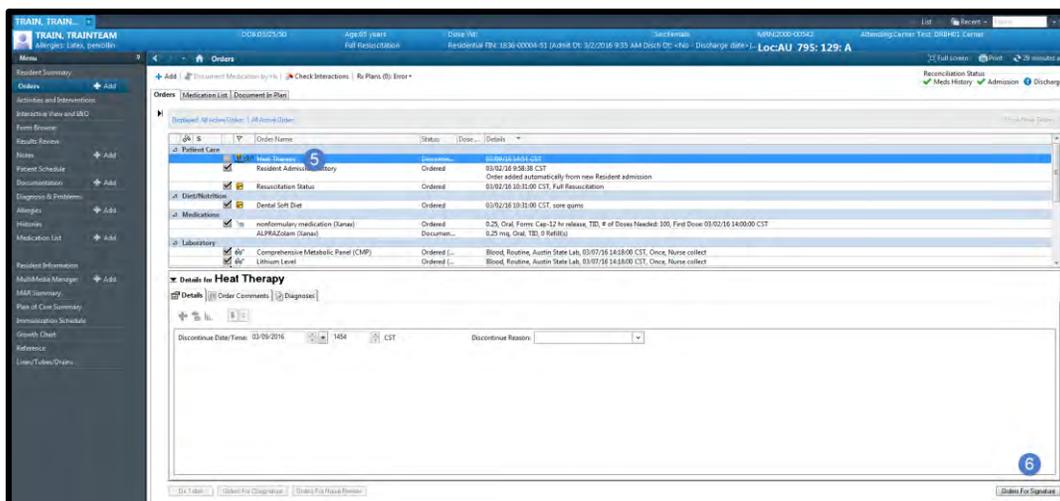
Documentation: Orders Window

3. Drop-down menu displays options. Select appropriate option to cancel order.



Orders Window: Action Display

4. After selection, ordering Physician pop-up window displays. Select the individual name of the person who canceled the order.
5. The Order pop-up window displays a strikeout on the order canceled.
6. Click Orders for Signature button, to send orders to be signed to the Physician.



*Orders Window: Display of Canceled Order – Sign Orders*

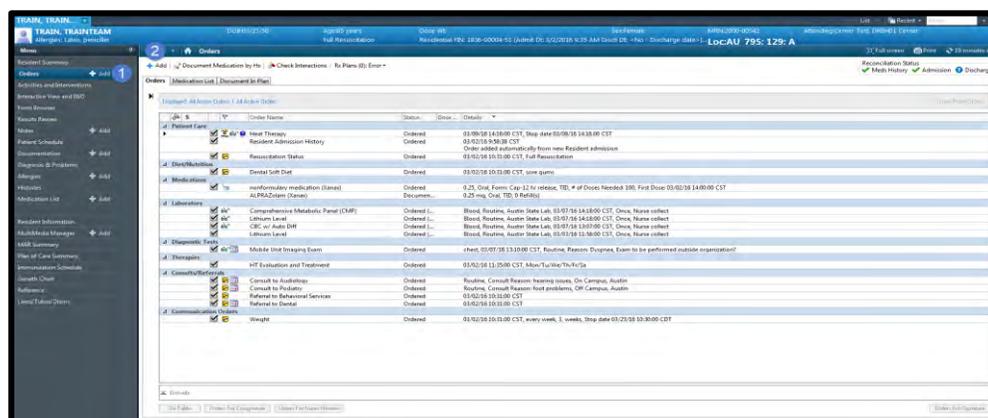
## DME EQUIPMENT MANAGEMENT

Durable Medical Equipment (DME) is medical equipment that is prescribed by a Therapist and signed off by the Physician for use in a resident’s living environment.

**Note** ▶ Not all equipment requires a physician order.

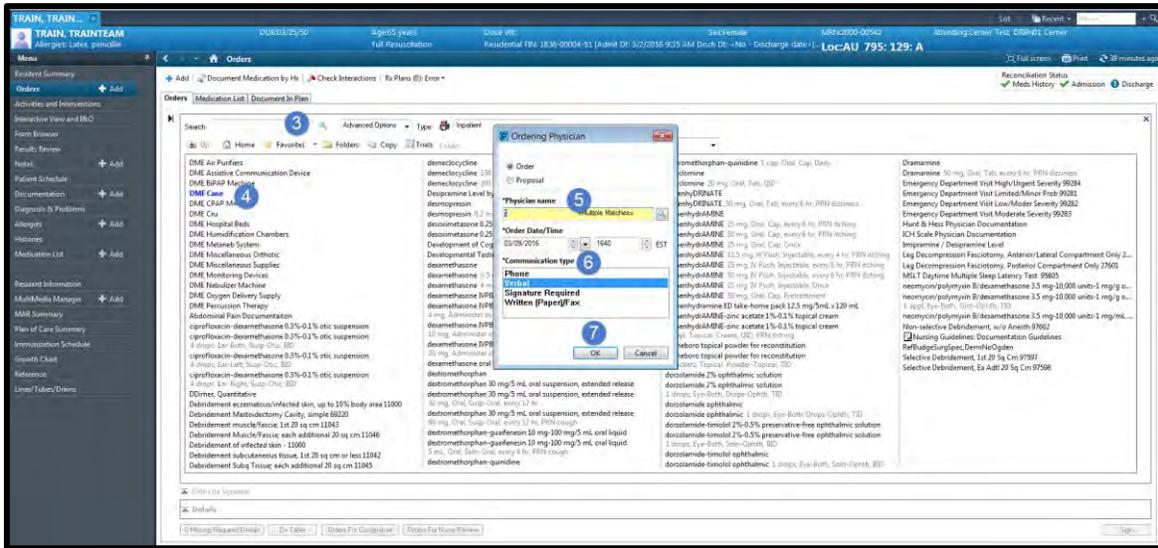
### Initiate DME Order

- Request Authorization from Physician
  1. From the chart **Menu**, select **Orders +Add**
  2. From the **Orders** action toolbar, select add icon ( **+ Add** ).



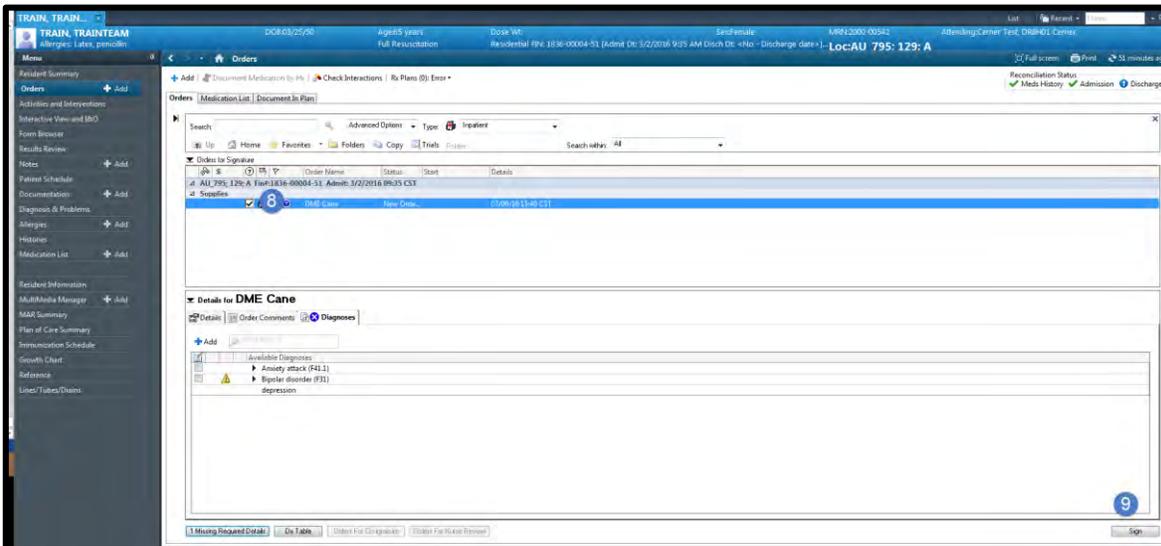
*Orders Window: Add Orders*

- Order search window displays. In the Search field, type DME, then select the magnifying glass icon (🔍). This will return all search results for DME.
- Select specific DME for resident.
- Ordering Physician pop-up window displays. Search for Physician name, select the magnifying glass icon (🔍).
- Select the Communication type.
- Click **OK**.

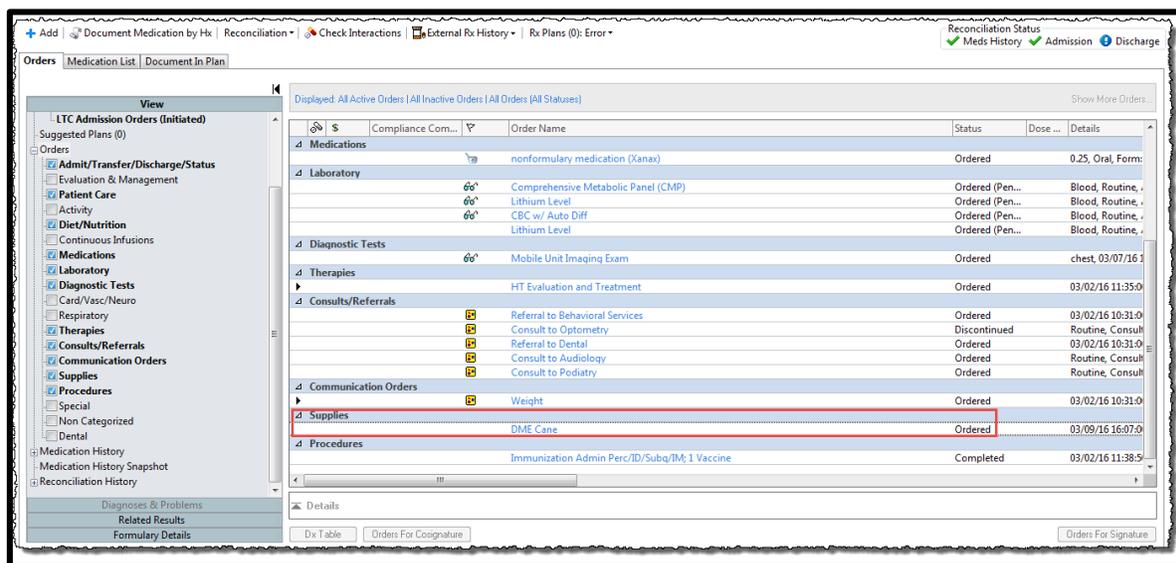


Orders Window: Search for DME

- New order, DME Cane is displays. Click the checkbox to initiate Orders for Signature.
- Click **Sign**.



**Note** ▶ After DME order is initiated, the Physician must take action on the prescribed Order, by accepting or denying the requested order.



Provider Screen: Sign Order for DME Cane

## Training Exercise

Complete the following exercise:

1. Order DME Cane.
2. Add Progress Note: Back Pain, walk with cane at all times when walking.
3. Sign PowerForm.
4. Delete DME order.

## ADHOC THERAPY FORMS

AdHoc Forms provide another level of assessment to chart specific therapies that are non-generalizable in normal charting.

Below is a list of all forms located in the Habilitation Therapy Forms:

- PNMT Review
- PNMP Assessment
- Habilitation Therapy Consultation
- Habilitation Therapy Additional Treatment
- Progress Note Habilitation Therapy
- Wheelchair Assessment
- Head of Bed Elevation Evaluation
- Dysphagia Assessment
- Durable Medical Equipment Rehab

Below is a list of all forms located in Nursing Special Forms:

- Abnormal Involuntary Movement Scale (AIMS)
- Monitoring of Side Effects Scale (MOSES)

- Asthma Assessment
- Infectious Disease Screening
- Influenza Vaccine Screen
- Med Response
- TB Testing and Screening
- PPD Reading
- Self-Medication Evaluation
- Fall Risk Scale
- Post Injury Report
- Annual Integrated Risk Rating Form (IRRF)
- Addendum/Change of Status Integrated Risk Rating Form (COS/IRRF)
- Hospital Liaison Form
- Annual Nursing Comprehensive Review
- Quarterly Nursing Comprehensive Assessment
- Tube Feeding Insertion/Care

- Fall Risk Scale

1. From **Menu bar**, select **AdHoc** icon (  )  
 **AdHoc Charting Window** displays.

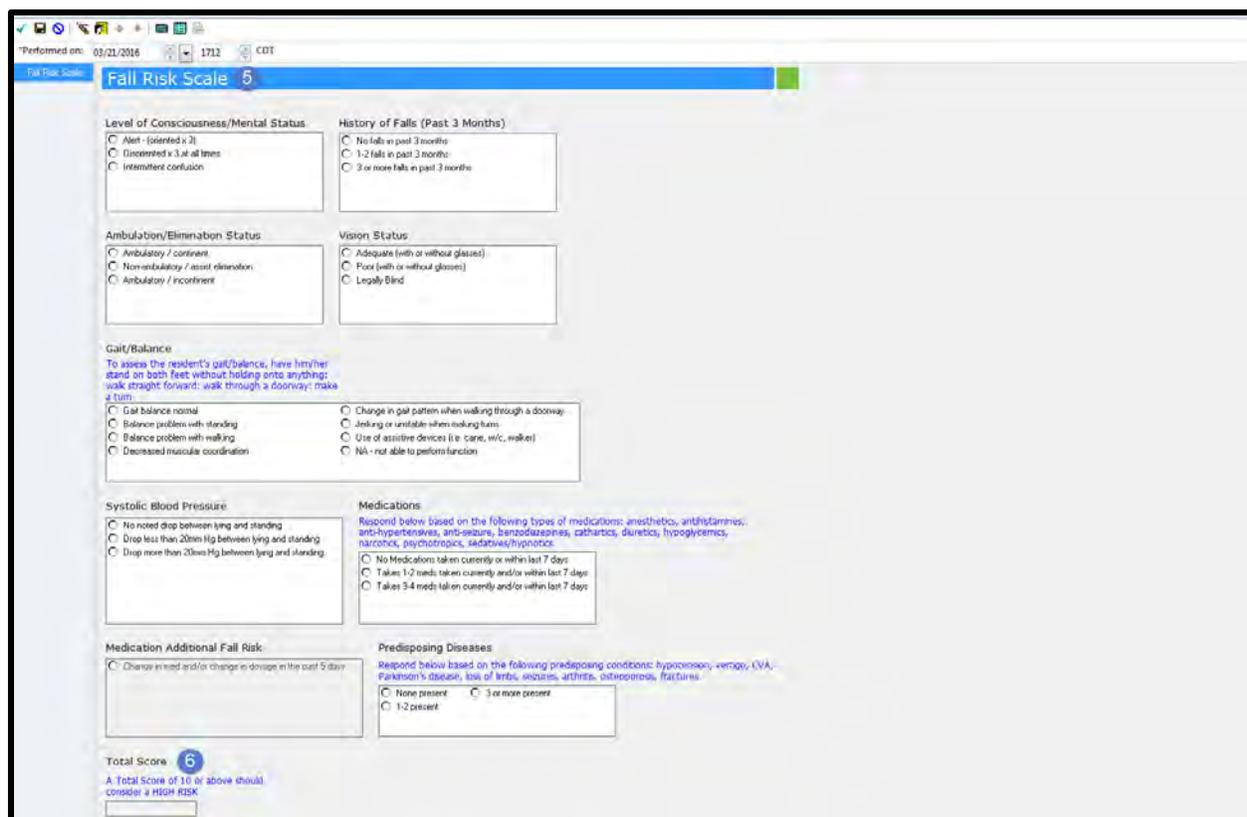


*AdHoc Charting Window*

2. Select **Nursing Special Forms** folder.
3. Select **Fall Risk Scale**.
4. Click **Chart**.



## Fall Risk Scale displays.



Performed on: 03/21/2016 1712 CDT

Fall Risk Scale 5

**Level of Consciousness/Mental Status**

Alert (oriented x 3)

Disoriented x 3 at all times

Intermittent confusion

**History of Falls (Past 3 Months)**

No falls in past 3 months

1-2 falls in past 3 months

3 or more falls in past 3 months

**Ambulation/Elimination Status**

Ambulatory / continence

Non-ambulatory / assist elimination

Ambulatory / incontinent

**Vision Status**

Adequate (with or without glasses)

Poor (with or without glasses)

Legally Blind

**Gait/Balance**

To assess the resident's gait/balance, have him/her stand on both feet without holding onto anything; walk straight forward; walk through a doorway; make a turn.

Gait balance normal

Balance problem with standing

Balance problem with walking

Decreased muscular coordination

Change in gait pattern when walking through a doorway

Jerking or unsteady when making turns

Use of assistive device (i.e. cane, w/c, walker)

NA - not able to perform function

**Systolic Blood Pressure**

No noted drop between lying and standing

Drop less than 20mm Hg between lying and standing

Drop more than 20mm Hg between lying and standing

**Medications**

Respond below based on the following types of medications: anesthetics, antiarrhythmics, anti-hypertensives, anti-seizure, benzodiazepines, cathartics, diuretics, hypoglycemics, narcotics, psychotropics, sedatives/hypnotics.

No Medications taken currently or within last 7 days

Takes 1-2 meds taken currently and/or within last 7 days

Takes 3-4 meds taken currently and/or within last 7 days

**Medication Additional Fall Risk**

Change in med and/or change in dosage in the past 5 days

**Predisposing Diseases**

Respond below based on the following predisposing conditions: hypotension, anemia, DVA, Parkinson's disease, loss of teeth, seizures, arthritis, osteoporosis, fractures.

None present

1-2 present

3 or more present

**Total Score 6**

A Total Score of 10 or above should consider a HIGH RISK

### AdHoc Charting Window

- Complete all sections of the Fall Risk Scale by clicking each radio button to select the appropriate choice.
- View Total Score.
- To sign and save the completed form, click the Sign Form icon (✓).

## MEDICAL RECORD REQUEST

Medical Record Request (MRR) is a tool used to create an ad hoc patient chart through PowerChart. The most common report requested through MRR Document report.

### Requesting a Report

- From the **Task** menu select **Print > Medical Record Request** or the **MRR** tab at the top of the Powerchart.

**Note** ▶ You must be in a resident chart to do this.

- Complete the MRR dialogue box
  - Event Status** – Verified Only
  - Template** – Document(or whatever is applicable)

- **Purpose** –Transfer (or whatever is applicable)
  - **Date Range** – Clinical Range
  - **Section Select**- Narrow down and choose you results to send/print here
  - Check that proper authorization was received
  - Input the proper **Destination, Requester**, and comments (if needed)
  - Select the desired **Device** to send the report – xrchartnull or example printer
3. **Preview the Report to ensure correct information populated. Send the request through MRR.**
  4. “X” out of MRR.

**Note** ► The next time you open the MRR window, the same parameters will populate in the dialogue box for usability.

### Requesting a Single Document

1. From the main menu select Notes (Clinical Notes, Documents, etc. will vary based on client), open the desired document to print.



2. Select the print icon or right click the document you wish to choose.
3. Select the MRR option and complete the MRR window using the Document template
4. Preview the Report to ensure correct information populated. Send the request through MRR
5. “X” out of MRR.
6. The next time you open the MRR window, the same parameters will populate in the dialogue box for usability.

### Additional Information

- Resident Care Report Includes:
  - Patient Care items
  - Such as Iview, allergies, orders, etc.
- Document Report Includes:
  - Clinical and Nursing Notes (Power Forms, things viewable in the Notes tab)
- Tidbits:
  - Printing through MRR is trackable through Report request maintenance. Printing should be limited and generally for outside use.
  - Printing through MRR also allows for easier trouble shooting of any issues in report request maintenance.

## ASSESSMENT

### Question 1

What field would you access to search for a resident?

Fill in the Blank – List the Steps

### Question 2

On the Chart menu, what Conversation band provides access to add a Progress Note to the Resident's chart?

- A. Activities and Interventions
- B. Form Browser
- C. Orders
- D. Notes

### Question 3

How would you navigate to the PT/OT Assessment?

Multiple Choice - Select the Correct Answer

- A. AdHoc Forms
- B. Scheduling Appointment Book
- C. Activities and Interventions
- D. Documentation

### Question 4

What location can a resident's current active therapy orders be viewed?

Fill in the Blank



Question 5

Once an Order has been added to a resident’s chart, is there an option to cancel? If so, how?

Fill in the Blank

Question 6

What letters must be entered to search for medical equipment?

Multiple Choice - Select the Correct Answer  
A. BME  
B. DEM  
C. MEC  
D. DME

Question 7

Can crutches be delivered directly to a resident if not living “On-Campus?”

Select the Correct Answer  
Yes  
No  
Explain...

## APPENDIX A

### Cerner Icon Glossary

Icon	Description
	<b>Medication</b> – Indicates medication activities.
	<b>Patient Care</b> – Indicates resident care activities.
	<b>Assessments</b> – Indicates resident assessment activities.
	<b>Other</b> – Indicates other activities.
	<b>Nurse Review</b> – The order requires a nurse review.
	<b>Immediate Priority</b> – Indicates Stat/Now orders for a resident.
	<b>Critical Results</b> – Indicates critical results for a resident.

	<b>Non-Critical New Information</b> – Indicates new non-critical results or orders for a resident. Click this icon to display additional information.
	<b>Critical New Information</b> – Indicates new critical results for Stat/Now orders. Click this icon to display additional information.
	<b>High Risk Alert</b> – Indicates the patient has high risk indicators. Hover over this icon to display additional information about the high risk indicators.
	<b>Isolation</b> – Indicates the patient is in isolation. Hover over this icon to display additional information about the isolation type(s).
	<b>Help</b> – Click this icon to display the CareCompass Help Pages.
	<b>Order Comment</b> – Indicates an order has a comment attached. Hover over this icon to display the comment.
	<b>Establish Relationship</b> – Click this icon to display the Establish Relationship Dialog box.
	<b>List Maintenance</b> – Click this icon to display the List Maintenance dialog box and to edit the list.
	<b>Add</b> – Click either of these icons to open the Add window and to add: a resident, allergies, orders, medication orders, documentation, etc.
	<b>Abnormal Result</b> – Indicates a result is abnormal.
	<b>High Result</b> – Indicates a result is high.
	<b>Low Result</b> – Indicates a result is low.
	<b>Properties</b> – Click this icon to modify the properties in a Resident List.
	<b>Sign Form</b> – Click this icon to sign a form.
	<b>Find</b> – After typing in a text field, click this icon to perform a search.
	<b>New</b> – Click this icon to add a note.
	<b>Modify</b> – Click this icon to modify an element on the window (list, note, etc.).
	<b>Print</b> – Click this icon to print the information displayed on the screen.
	<b>Order Details Not Complete</b> – Click this icon to view fields that must be completed before an Order can be completed.
	<b>Appointment Inquiry</b> – Click this icon to look up appointment information.
	<b>Check In</b> – Click this icon to check in a resident for an appointment.
	<b>Save</b> – Click this icon to save.
	<b>Expand/Collapse</b> – Click the down arrow icon to expand a section of the window. Click the up arrow icon to collapse a section of the window.
	<b>Quick Chart</b> – Click this icon to chart progress for Outcomes and Interventions.
	<b>Settings</b> – Click this icon to open the settings window.
	<b>Search</b> – Click this icon to open the Resident Search pop-up window and perform a resident search.



## APPENDIX B

### Cerner Terms Glossary

Term	Definition
<b>Account Number</b>	A unique medical record number assigned to each resident or guarantor that remains with the resident regardless of the number of encounters.
<b>Active</b>	An element in the system is active when an action can be performed on it (such as clicking it or pressing ENTER).
<b>Activity Type</b>	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.
<b>AdHoc Charting</b>	Entering unscheduled results into the resident record. Only individuals with privileges to perform ad hoc charting can access the appropriate menu commands.
<b>AdHoc Pharmacy Order</b>	A pharmacy order added one at a time.
<b>Administration Time</b>	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).
<b>Appointment Availability View</b>	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.
<b>Appointment Notification</b>	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.
<b>Authenticated</b>	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.
<b>Authentication</b>	The process that identifies users through the use of log-on names and passwords.
<b>Availability Conflict</b>	A system-detected difficulty in scheduling one or more requested appointments. This could be the result of person or resource availability checking.
<b>Available Physicians</b>	This window displays all available physicians whose last names agree with the starting value entered in the Physician Name field.
<b>Benefit Order</b>	The insurance plans for a resident.
<b>Billing Code</b>	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.
<b>Block Scheduling</b>	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.
<b>Cancel Status</b>	Indicates that the transmission has been canceled.
<b>Canceled State</b>	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.
<b>Care Coordination</b>	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.
<b>Cerner Millennium</b>	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.
<b>Chart Body</b>	The body of a chart that holds the diagnostic information entered for the procedures, administrative information associated with the procedures, or both.
<b>Chart</b>	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.
<b>Charted</b>	Comments that can be posted in a chart or report.
<b>Computer-Based Training (CBT)</b>	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.
<b>Context Menu</b>	A menu that pops up when you right-click some elements.
<b>Comment</b>	A free-form narrative attached to a term in an encounter note using the Comment function.
<b>Continuous Order</b>	One of the three order types used in <i>PharmNet</i> . 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.
<b>Co-Signer</b>	Person who signs off on a document to indicate that the contents of the document are accurate.
<b>Discontinued Order</b>	In <i>PharmNet</i> , 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.
<b>Dosage</b>	In <i>PharmNet</i> , dosage refers to the defined frequency, amount, strength, and quantity of doses of a medication.



<b>Dose</b>	In <i>PharmNet</i> , dose refers to the amount of a drug or drug therapy.
<b>Downtime Sequence</b>	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.
<b>Downtime</b>	Any period of time during which the system is unavailable to users. The cause is not relevant.
<b>Dispense</b>	In <i>PharmNet</i> , to prepare and distribute medications for a single order, as part of a fill list or batch, and to replenish the medication supplies.
<b>Electronic Medical Record (EMR)</b>	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 physicians simultaneously. No longer are the residents' records inaccessible while waiting to be refilled.
<b>Electronic Signature</b>	The act of verifying or accepting a transcribed report online instead of signing the physical piece of paper on which the report is printed.
<b>Encounter</b>	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.
<b>Encounter Number</b>	An internal number assigned by the system for each resident encounter.
<b>Encounter Type</b>	A classification of resident visit types. Examples include inpatient, outpatient, and emergency room.
<b>Encounter Note</b>	The textual documentation of a clinical encounter, such as inpatient, outpatient, or emergency.
<b>Encounter Access Method</b>	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.
<b>Floor Stock</b>	Medications stocked at the care location. Also referred to as ward stock. Floor stock items typically are not included on fill lists.
<b>Free Text</b>	User-entered text, which is saved by the system.
<b>Free Text Field</b>	Free-text field types allow you to specify a free-text response.
<b>Future State</b>	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.
<b>Go-Live</b>	Conversion or go-live is the process by which Cerner makes the system available to the client for the first production use.
<b>Immediate-Print Label</b>	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 <i>stat</i> collection priority.
<b>In-Process Status</b>	This status indicates those requests on which action has been taken but not completed.
<b>Intermittent Order</b>	One of the three order types used in <i>PharmNet</i> . 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.

<b>JCodes</b>	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.
<b>Label Comment</b>	<p>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.</p> <p>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."</p>
<b>Location Group</b>	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.
<b>Lot Information</b>	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.
<b>Medical Record Number (MRN)</b>	A permanent number used to identify the resident. It typically remains unchanged even if the resident has multiple encounters.
<b>Medication Administration Record (MAR)</b>	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.
<b>Medication Order</b>	One of the three order types used in the <i>PharmNet</i> 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.
<b>Multi-Choice Field Type</b>	Multi-choice field types allow you to specify at least one of several responses.
<b>Multiple Select</b>	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.
<b>New Orders Display</b>	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.
<b>Order Category Display</b>	Orders are grouped and displayed in a hierarchy according to clinical interest. The site determines the hierarchy and the orders contained within it.
<b>Order Type</b>	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 <i>PharmNet</i> system are continuous, intermittent, and medication.
<b>Outside Orders</b>	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.
<b>PharmNet</b>	<i>PharmNet</i> fully integrates with other clinical applications, automating medication use across the entire spectrum of medication management.



<b>Physician Name</b>	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.
<b>PowerChart</b>	The Cerner Millennium solution that is the enterprise clinician's desktop solution for viewing, ordering and documenting the electronic medical record.
<b>PowerOrders</b>	A physician order entry solution that gives appropriate access to real-time, relevant clinical information at any point in the care process.
<b>Proxy List</b>	This optional feature allows you to review, accept, and reject reports on behalf of another radiologist.
<b>Proxy</b>	A person designated to perform a task or review results for another health care physician.
<b>Refresh</b>	To replenish new information from the database and redisplay it within the current screen view.
<b>Resident Chart</b>	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.
<b>Resident Demographics</b>	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.
<b>Resident Medication Profile</b>	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.
<b>Review (Orders)</b>	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.
<b>Review (Results)</b>	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).
<b>Reviewer</b>	Additional person who receives a copy of a document for review.
<b>Schedulable</b>	Any item that can be scheduled to a resource or person appointment schedule.
<b>Schedule</b>	The process of creating an appointment request, booking the request to one or more persons or resources, and confirming the booked requests.
<b>Scheduled</b>	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.).
<b>Scratch Pad</b>	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.
<b>Selected Physicians</b>	This window displays the names of physicians who have been chosen from the Available Physicians window.
<b>Selection Criteria</b>	Variables that determine which residents are included in a distribution.
<b>Soft-Stop</b>	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.
<b>Sorts</b>	Sorts are used to put data in a particular order.

<b>Subclass</b>	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.
<b>Summary Sheet</b>	Used to display a summary of the resident's health history to the healthcare physician.
<b>Tab</b>	A window element resembling a folder tab that is used to group similar information.
<b>Task Type</b>	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.
<b>Toolbar</b>	A window element containing buttons or other window elements to facilitate accomplishing a task.
<b>Tooltip</b>	A description displayed when you move the cursor over a button in the toolbar.
<b>Unauthenticated</b>	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.
<b>Uncommitted Data</b>	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.
<b>Untransmitted</b>	The report has not been transmitted.
<b>Unverified Order</b>	In <i>PharmNet</i> , 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.
<b>Verify</b>	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.
<b>Widget</b>	An application, or a component of an interface, that enables a user to perform a function or access a service.
<b>Wildcard</b>	A character that allows a search over a wide range of related data elements.
<b>Worklist</b>	A list of orders that need to be completed.
<b>Worklist ID</b>	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.
<b>Worklist Name</b>	The worklist name is the name assigned to a predefined set of selection criteria for the worklist.