EAST TENNESSEE STATE UNIVERSITY

QUILLEN ETSU PHYSICIANS

Module 5: Notes

Clinical Staff and Provider Training Module

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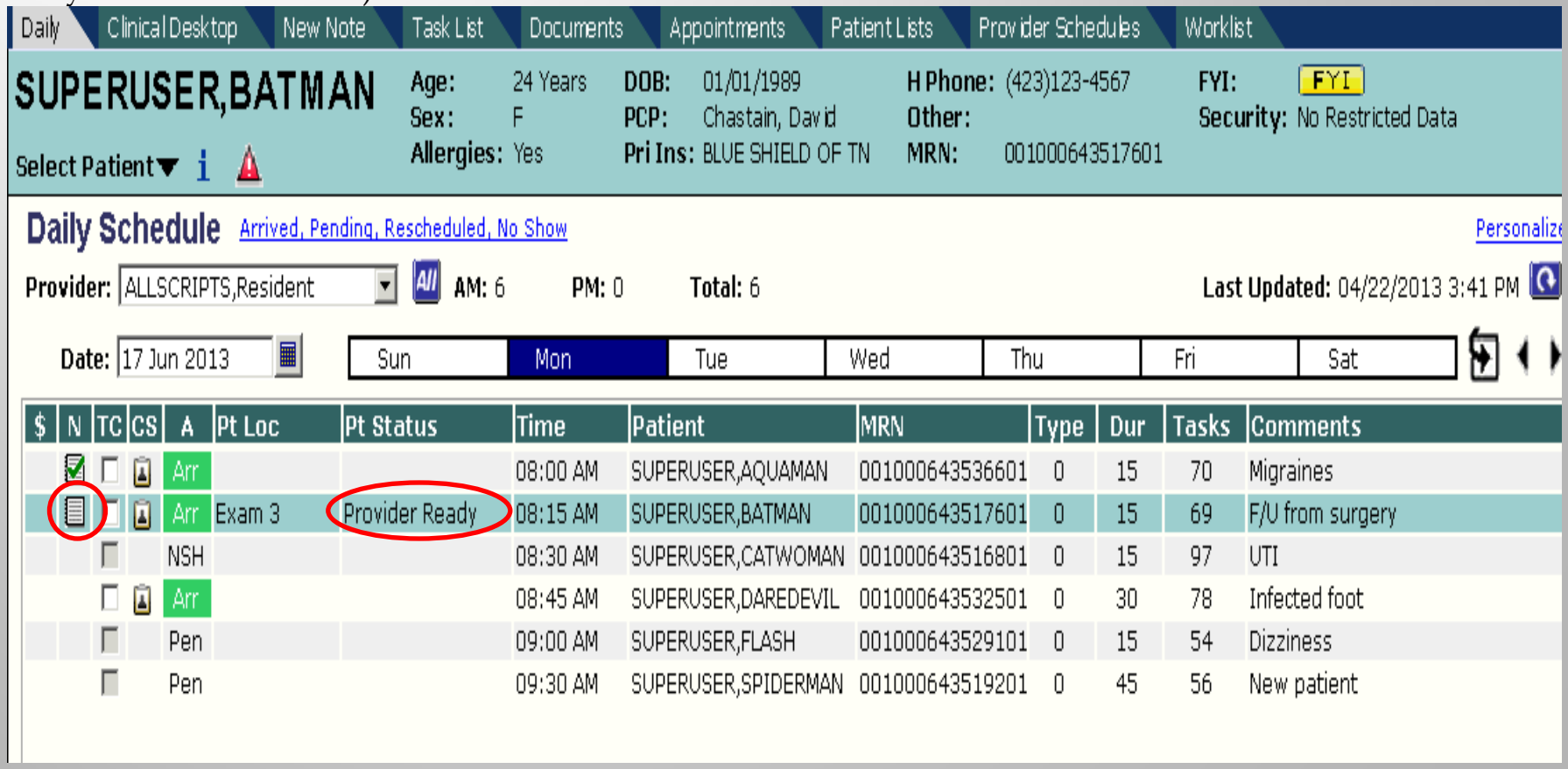
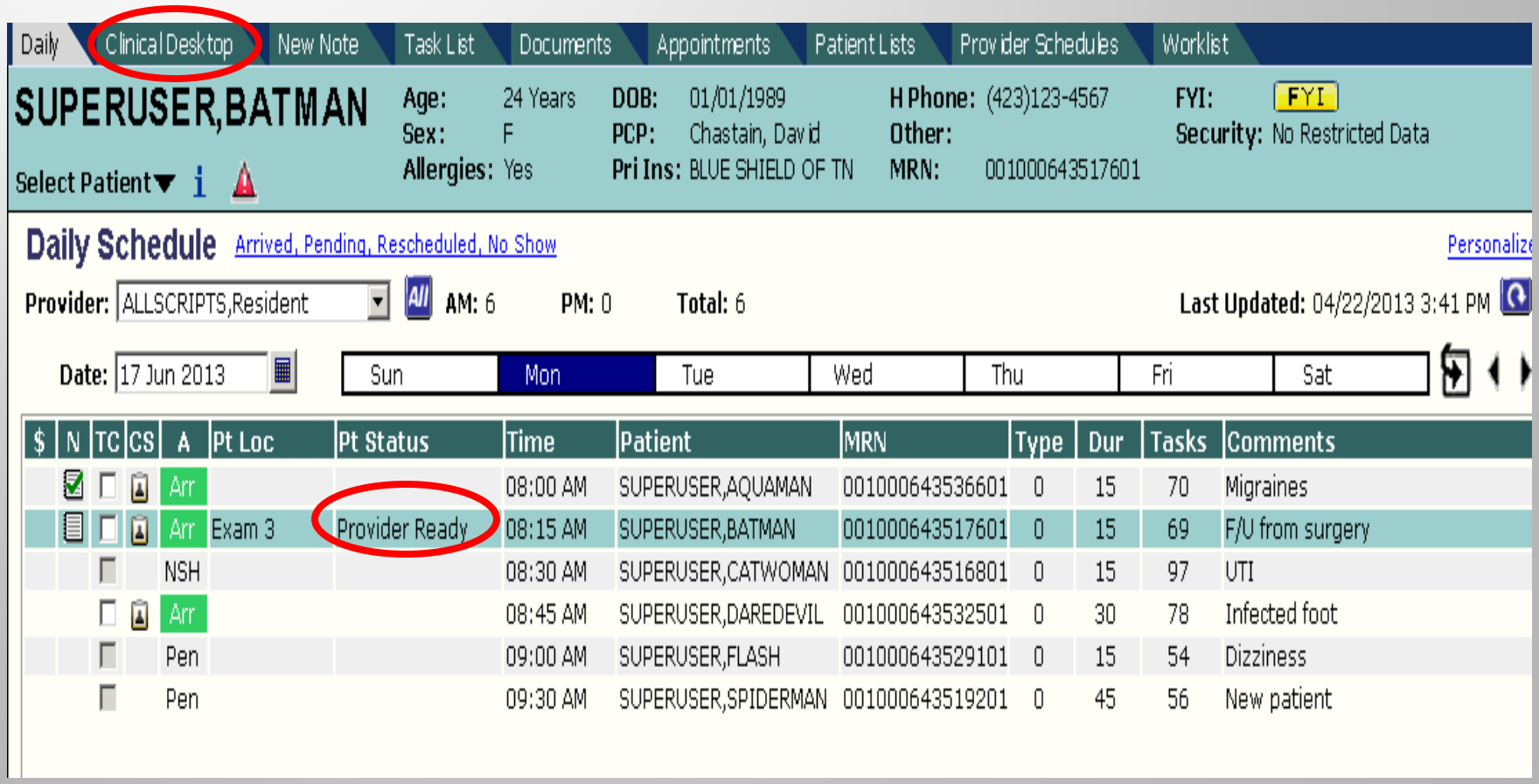
Opening a note started by someone else

In most of the clinics, the nurse will start the note for the provider. She/he will open the note, put in the chief complaint and possibly a reason for visit, and then save and close the note. Once the note has been started, it will appear on your Daily Schedule with a "note" icon in the "N" field. To begin documentation on your patient, **make sure** that the Pt Status is set to **Provider Ready**, and then **double click the note icon** to open your note in "edit" mode. (Slide 7 shows you the "edit" mode)

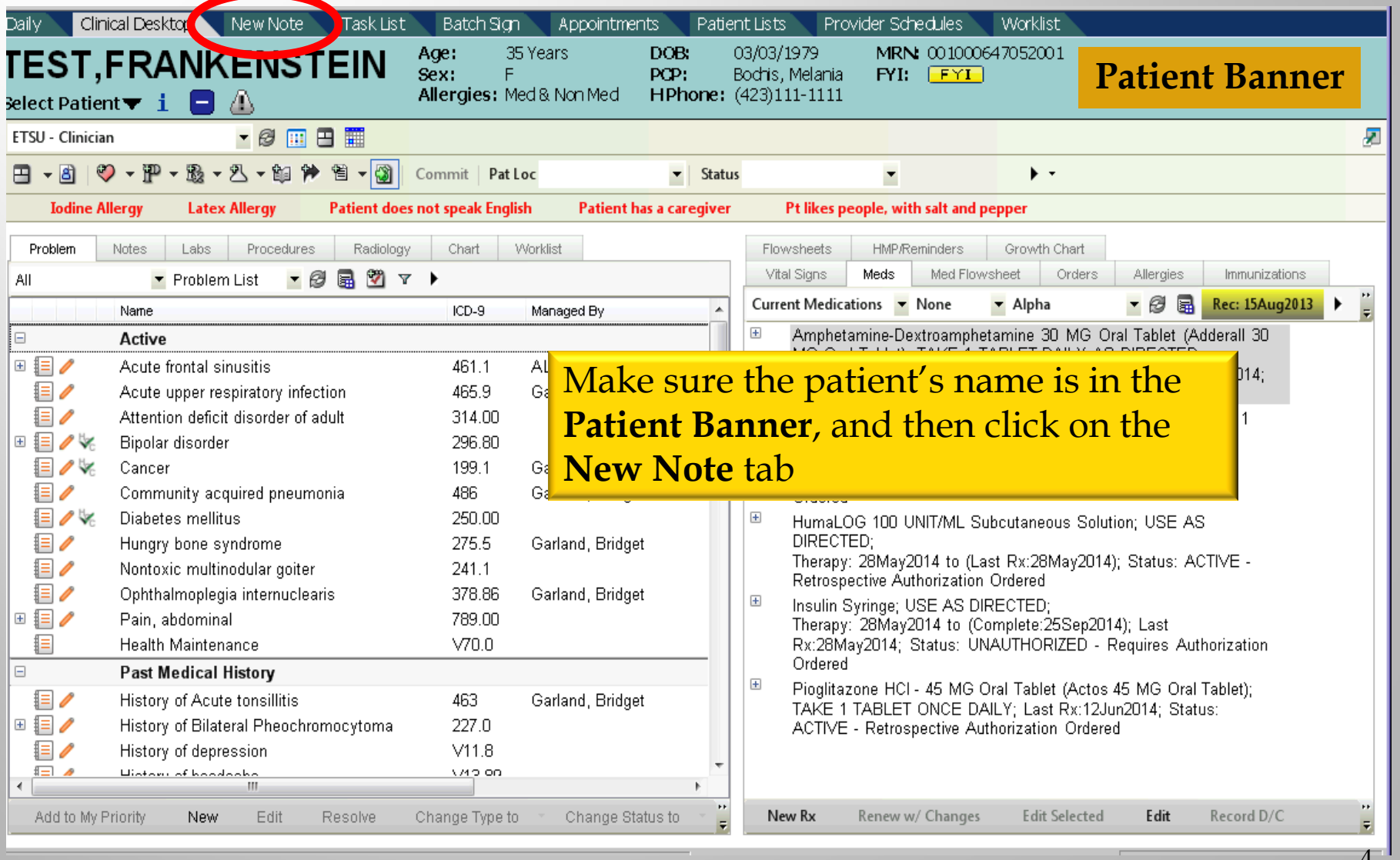


Starting Your Own Note

If the nurse does not start the note for you (or if you are clinical staff), once he/she changes the status to **Provider Ready (or Nurse Ready)**, double click on the patient's name. This takes you to the Clinical Desktop.

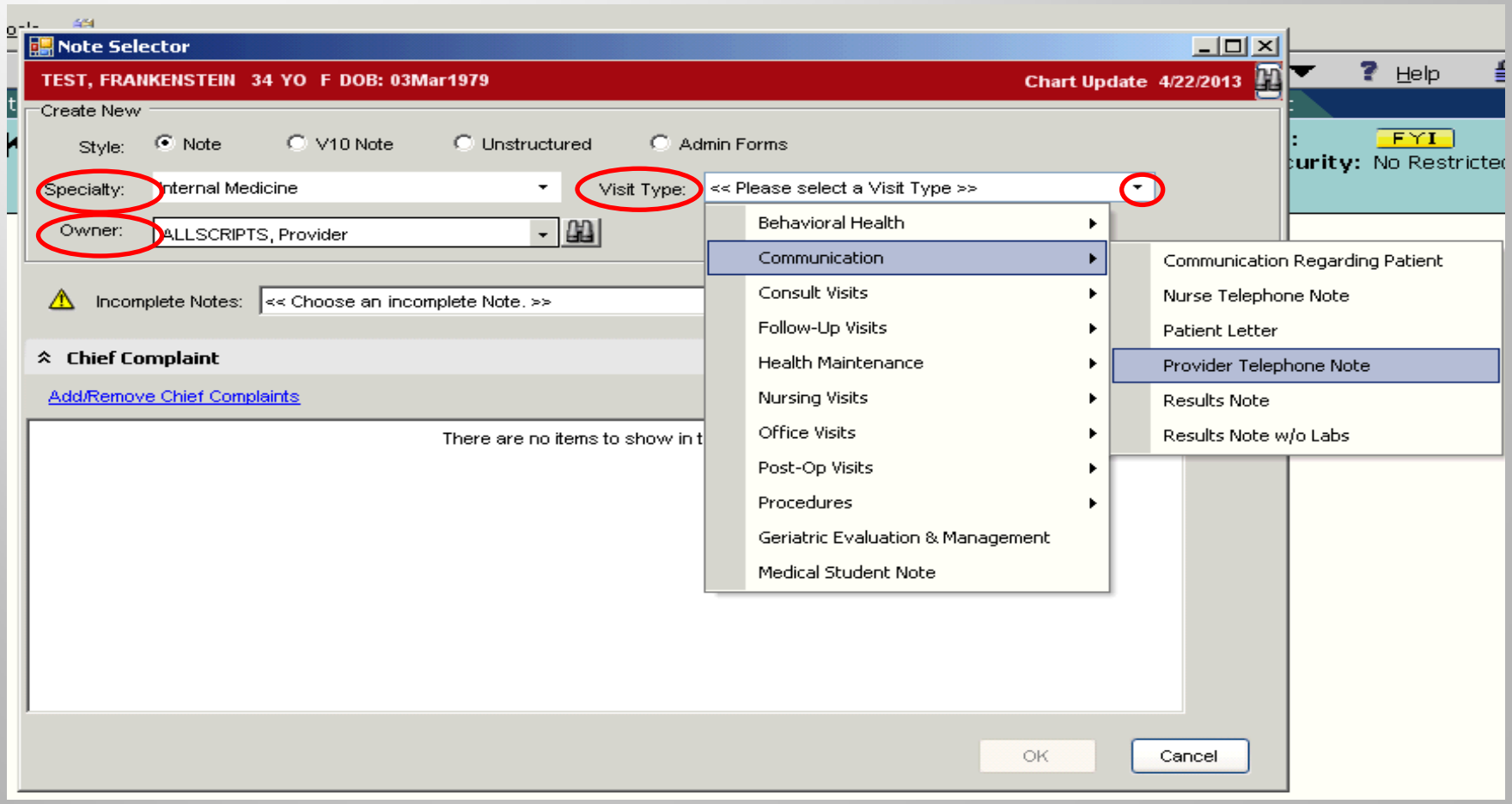


New note tab


Daily
Clinical Desktop
New Note
Task List
Batch Sign
Appointments
Patient Lists
Provider Schedules
Worklist
TEST,FRANKENSTEIN
Select Patient
Age: 35 Years
Sex: F
Allergies: Med & Non Med
DOB: 03/03/1979
PCP: Bochis, Melania
HPhone: (423)111-1111
MRN: 001000647052001
FYI: FYI
Patient Banner
ETSU - Clinician
Commit
Pat Loc
Status
Iodine Allergy
Latex Allergy
Patient does not speak English
Patient has a caregiver
Pt likes people, with salt and pepper
Problem
Notes
Labs
Procedures
Radiology
Chart
Worklist
All
Problem List
Name
ICD-9
Managed By
Active
Acute frontal sinusitis 461.1
Acute upper respiratory infection 465.9
Attention deficit disorder of adult 314.00
Bipolar disorder 296.80
Cancer 199.1
Community acquired pneumonia 486
Diabetes mellitus 250.00
Hungry bone syndrome 275.5 Garland, Bridget
Nontoxic multinodular goiter 241.1
Ophthalmoplegia internuclearis 378.86 Garland, Bridget
Pain, abdominal 789.00
Health Maintenance V70.0
Past Medical History
History of Acute tonsillitis 463 Garland, Bridget
History of Bilateral Pheochromocytoma 227.0
History of depression V11.8
Add to My Priority
New
Edit
Resolve
Change Type to
Change Status to
Flowsheets
HMP/Reminders
Growth Chart
Vital Signs
Meds
Med Flowsheet
Orders
Allergies
Immunizations
Current Medications
None
Alpha
Rec: 15Aug2013
Amphetamine-Dextroamphetamine 30 MG Oral Tablet (Adderall 30
HumaLOG 100 UNIT/ML Subcutaneous Solution; USE AS DIRECTED;
Therapy: 28May2014 to (Last Rx:28May2014); Status: ACTIVE - Retrospective Authorization Ordered
Insulin Syringe; USE AS DIRECTED;
Therapy: 28May2014 to (Complete:25Sep2014); Last Rx:28May2014; Status: UNAUTHORIZED - Requires Authorization Ordered
Pioglitazone HCl - 45 MG Oral Tablet (Actos 45 MG Oral Tablet); TAKE 1 TABLET ONCE DAILY; Last Rx:12Jun2014; Status: ACTIVE - Retrospective Authorization Ordered
New Rx
Renew w/ Changes
Edit Selected
Edit
Record D/C
Make sure the patient's name is in the **Patient Banner**, and then click on the **New Note** tab

Note Selector

The Note Selector screen allows you to choose the type of note you are going to create. Your specialty and name should auto-populate in the **Specialty** and **Owner** fields. Click the drop down next to **Visit Type** and choose the note type. We suggest you talk to your preceptor about what note type to choose.



NOTE IN "EDIT" MODE

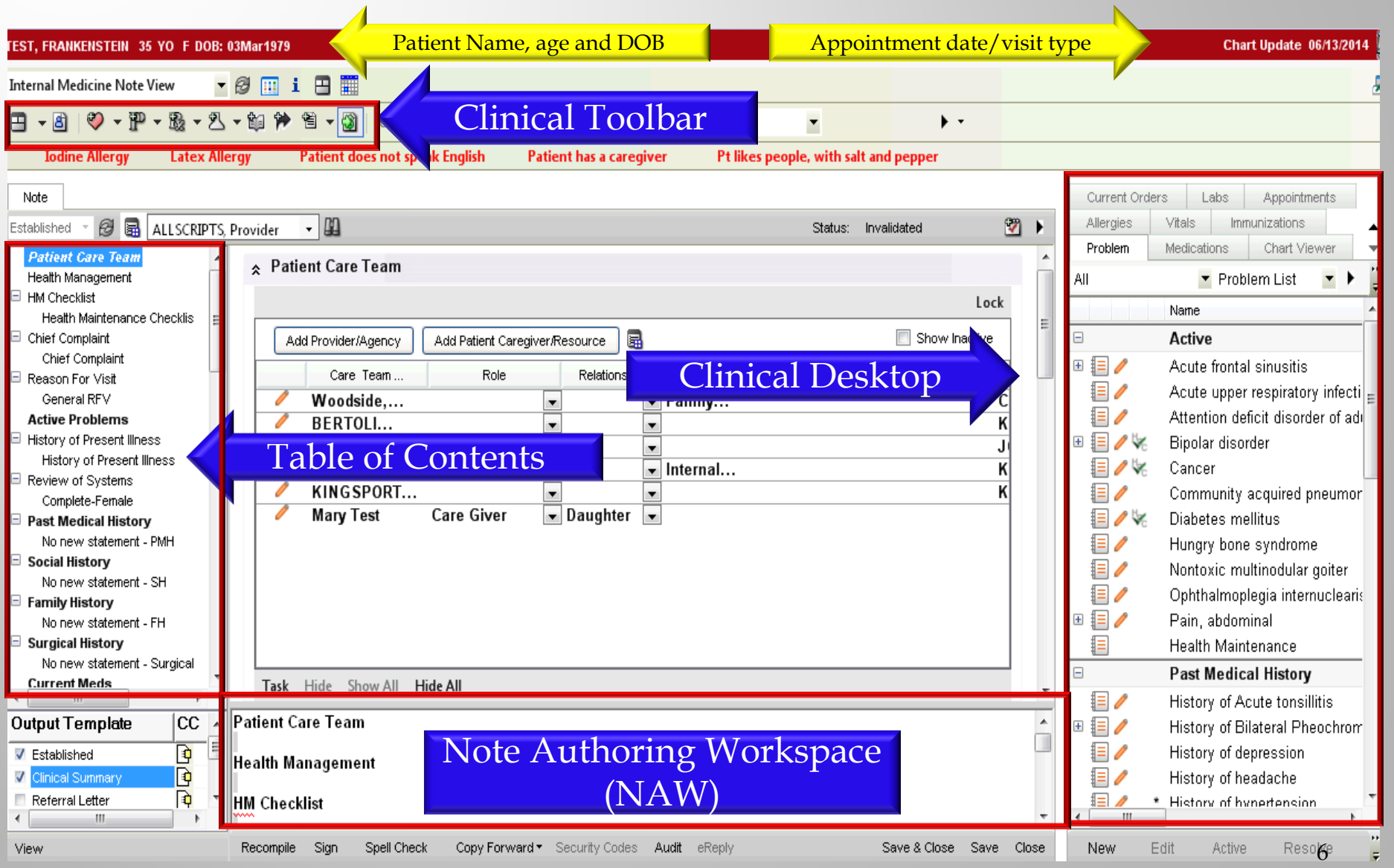
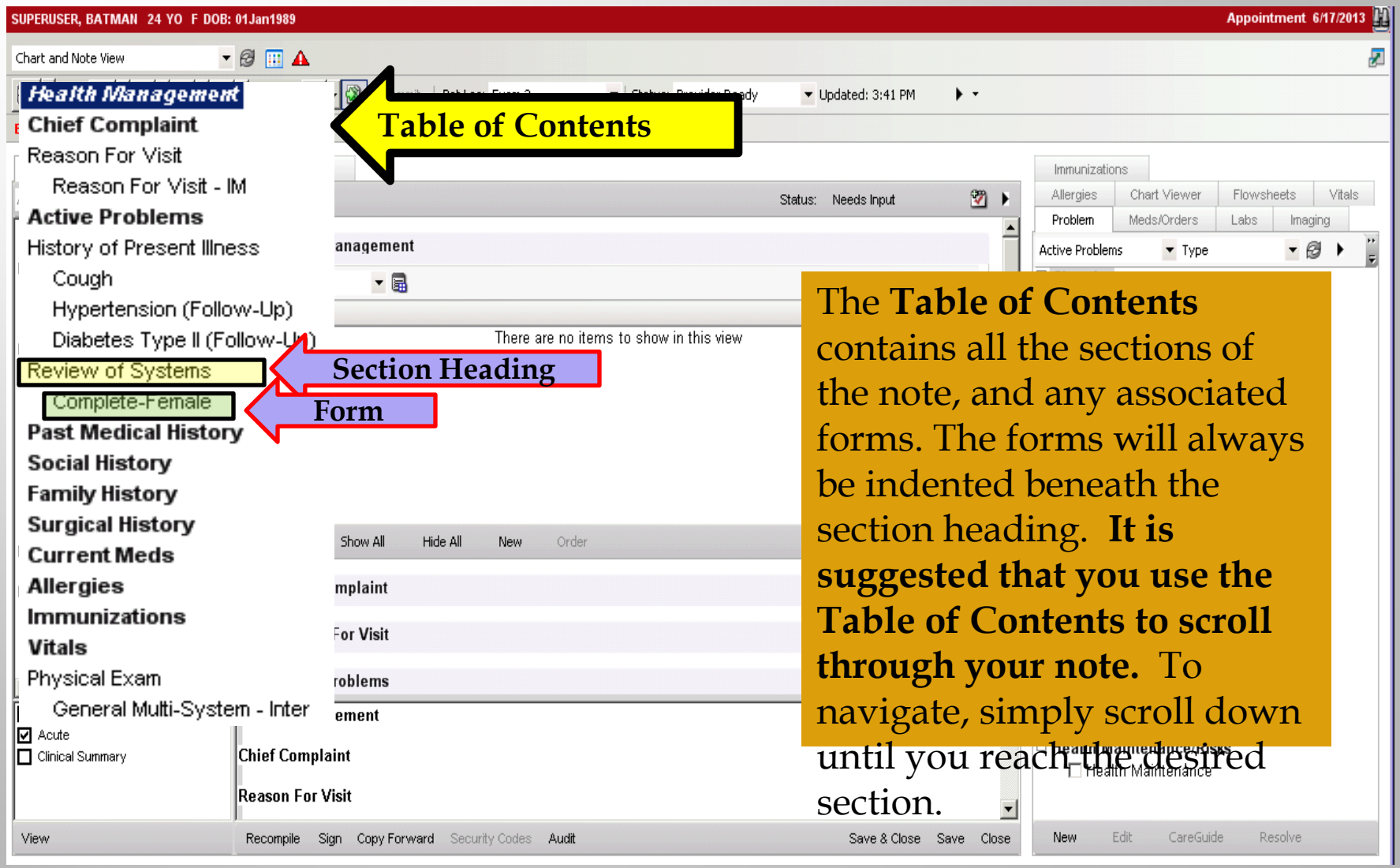


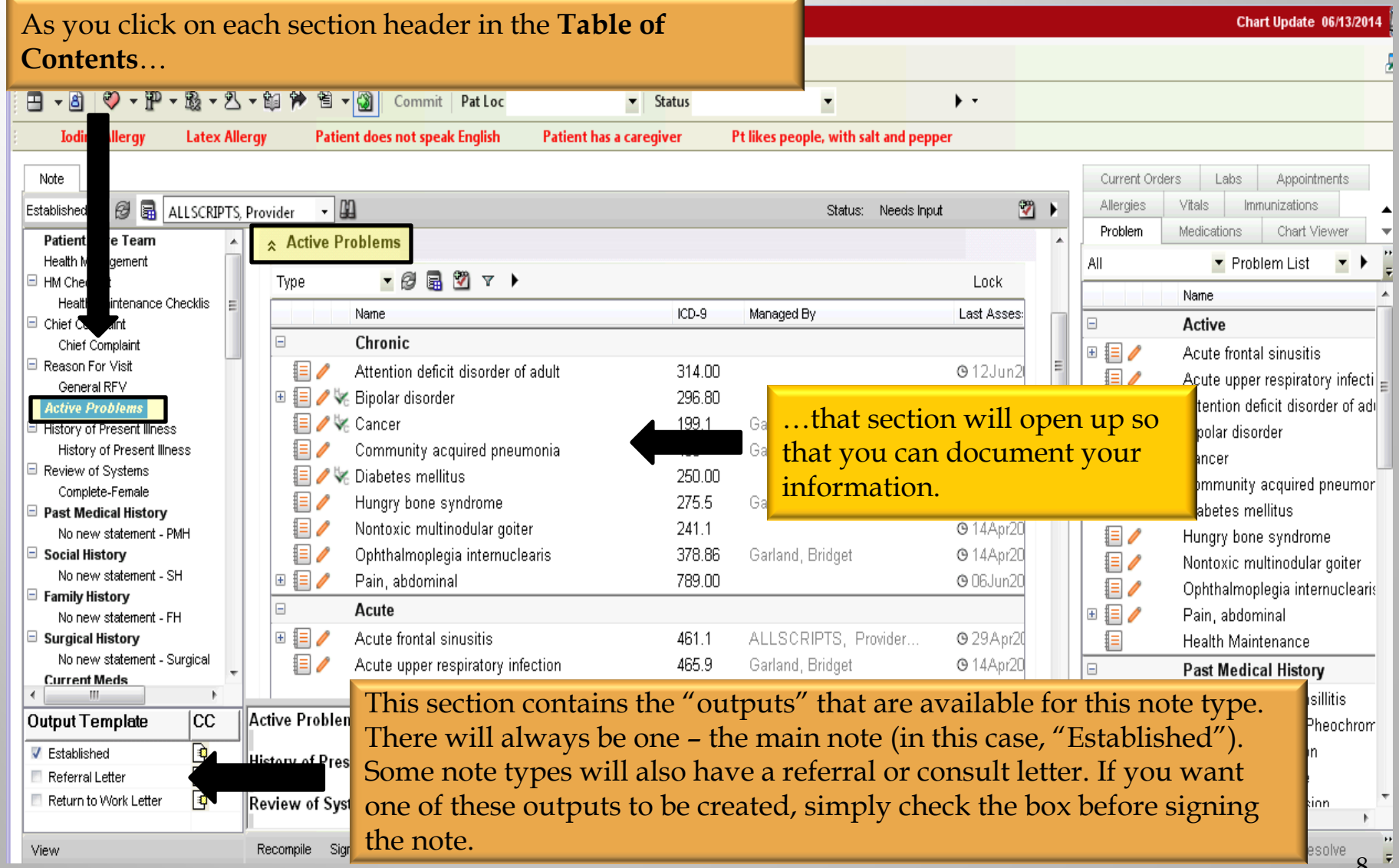
TABLE OF CONTENTS



The **Table of Contents** contains all the sections of the note, and any associated forms. The forms will always be indented beneath the section heading. **It is suggested that you use the Table of Contents to scroll through your note.** To navigate, simply scroll down until you reach the desired section.

TABLE OF CONTENTS

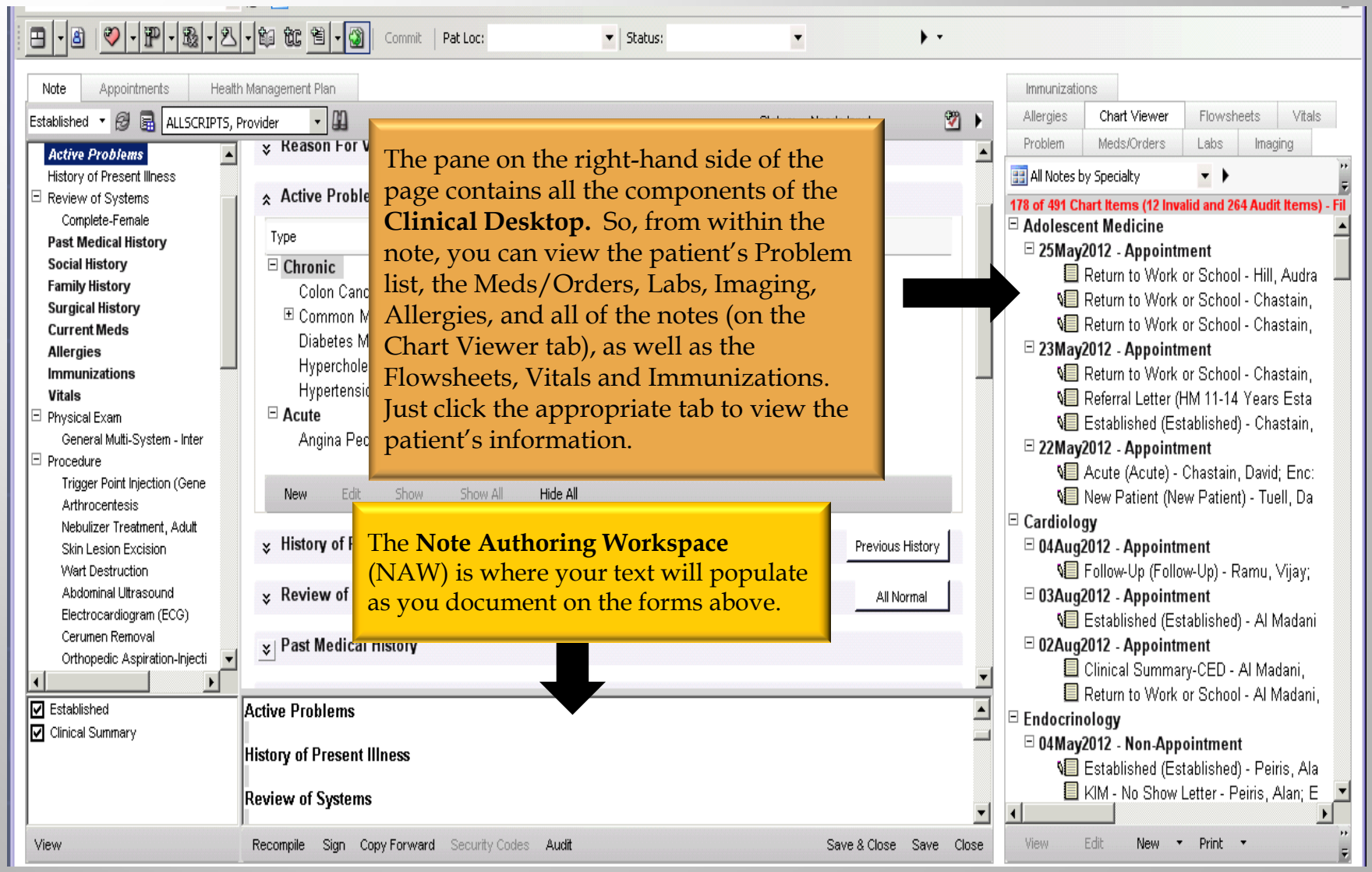
As you click on each section header in the **Table of Contents**…



…that section will open up so that you can document your information.

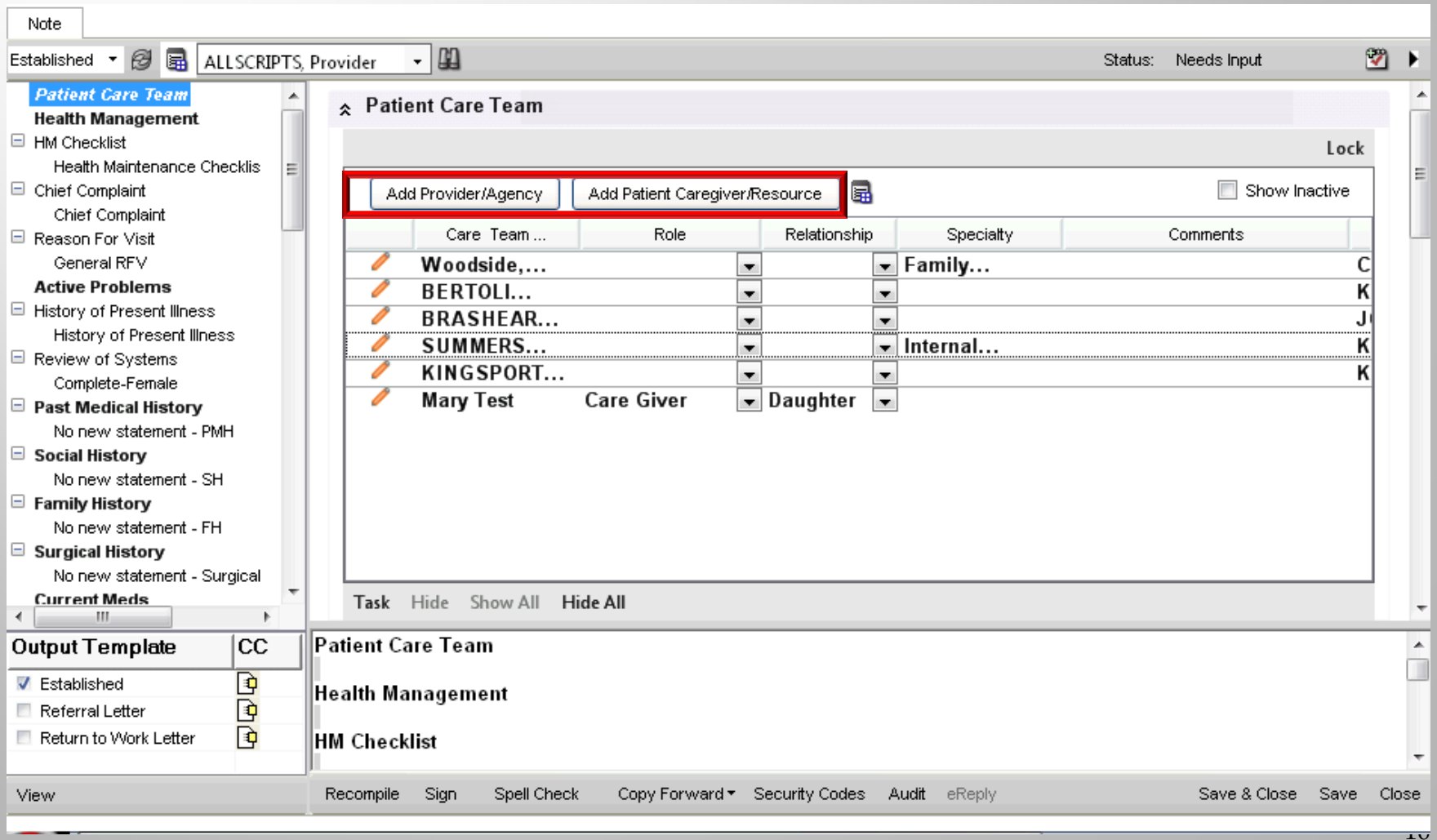
This section contains the "outputs" that are available for this note type. There will always be one – the main note (in this case, "Established"). Some note types will also have a referral or consult letter. If you want one of these outputs to be created, simply check the box before signing the note.

Clinical desktop/naw

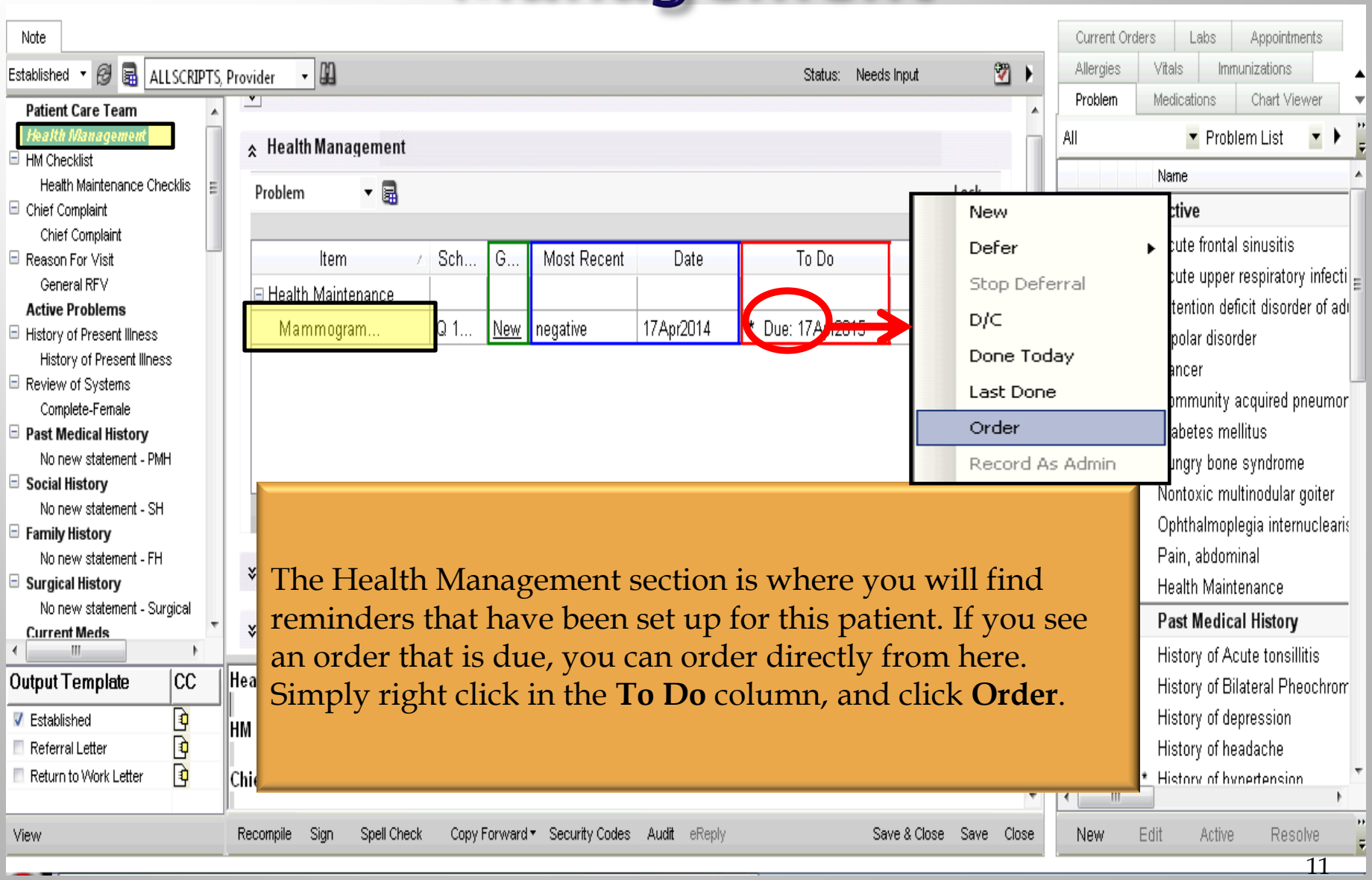


Note Sections – patient care team

The Patient Care Team is a section where clinical staff can enter members of the patient's care team – other physicians, home health companies, and even family members/caregivers.

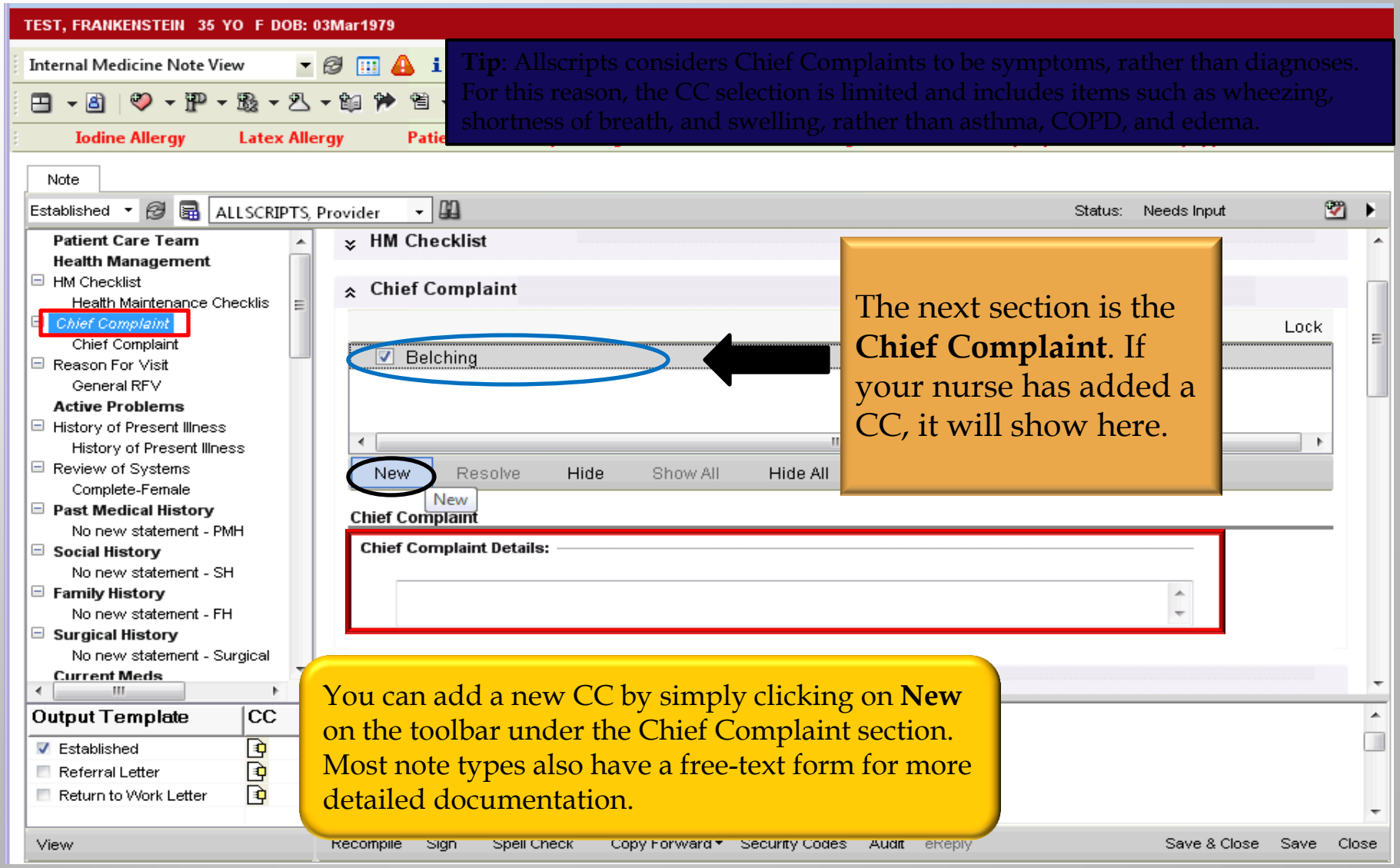


Note Sections – Health Management

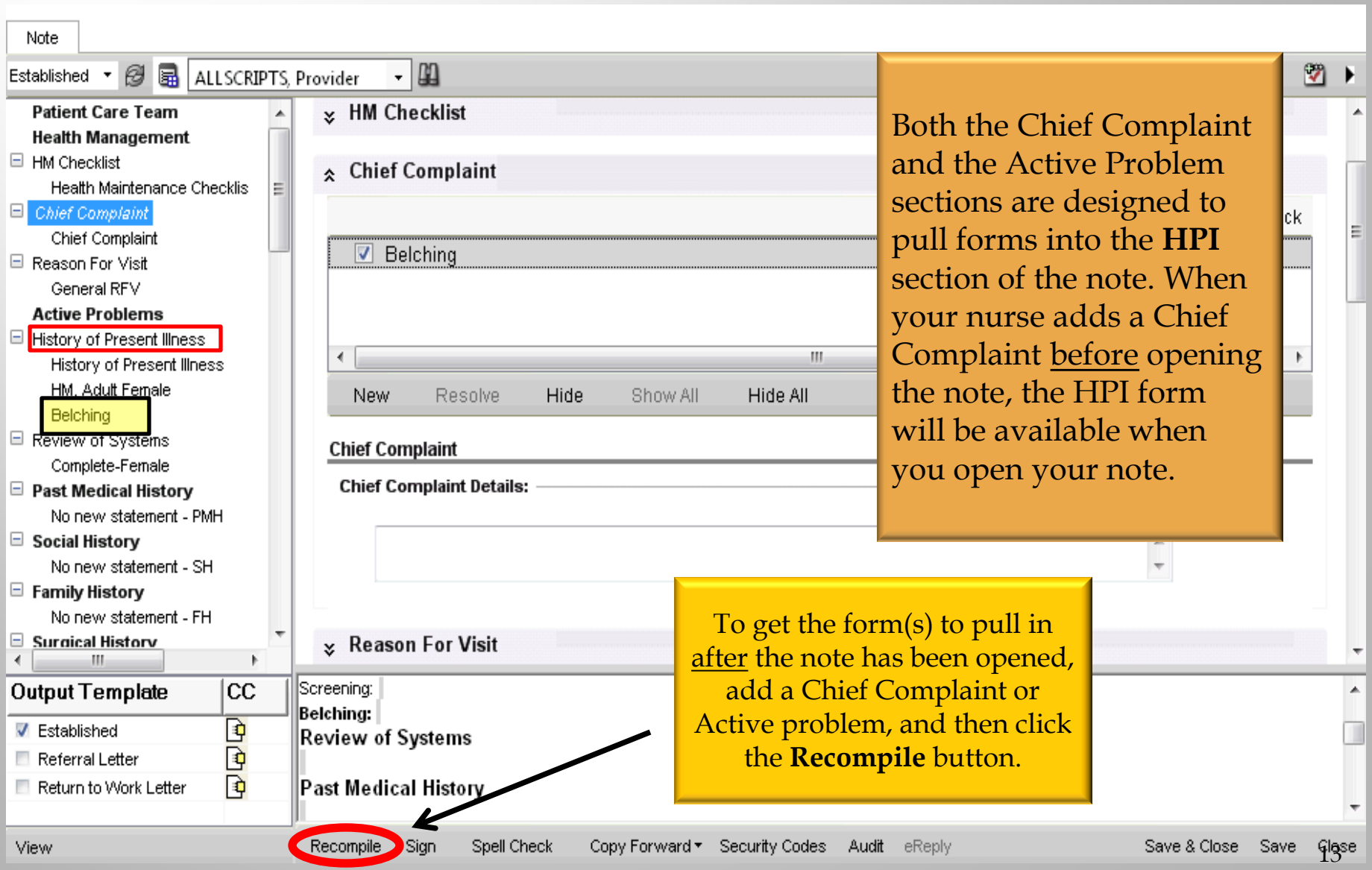


The Health Management section is where you will find reminders that have been set up for this patient. If you see an order that is due, you can order directly from here. Simply right click in the **To Do** column, and click **Order**.

Note Sections – Chief Complaint



HPI Note Forms

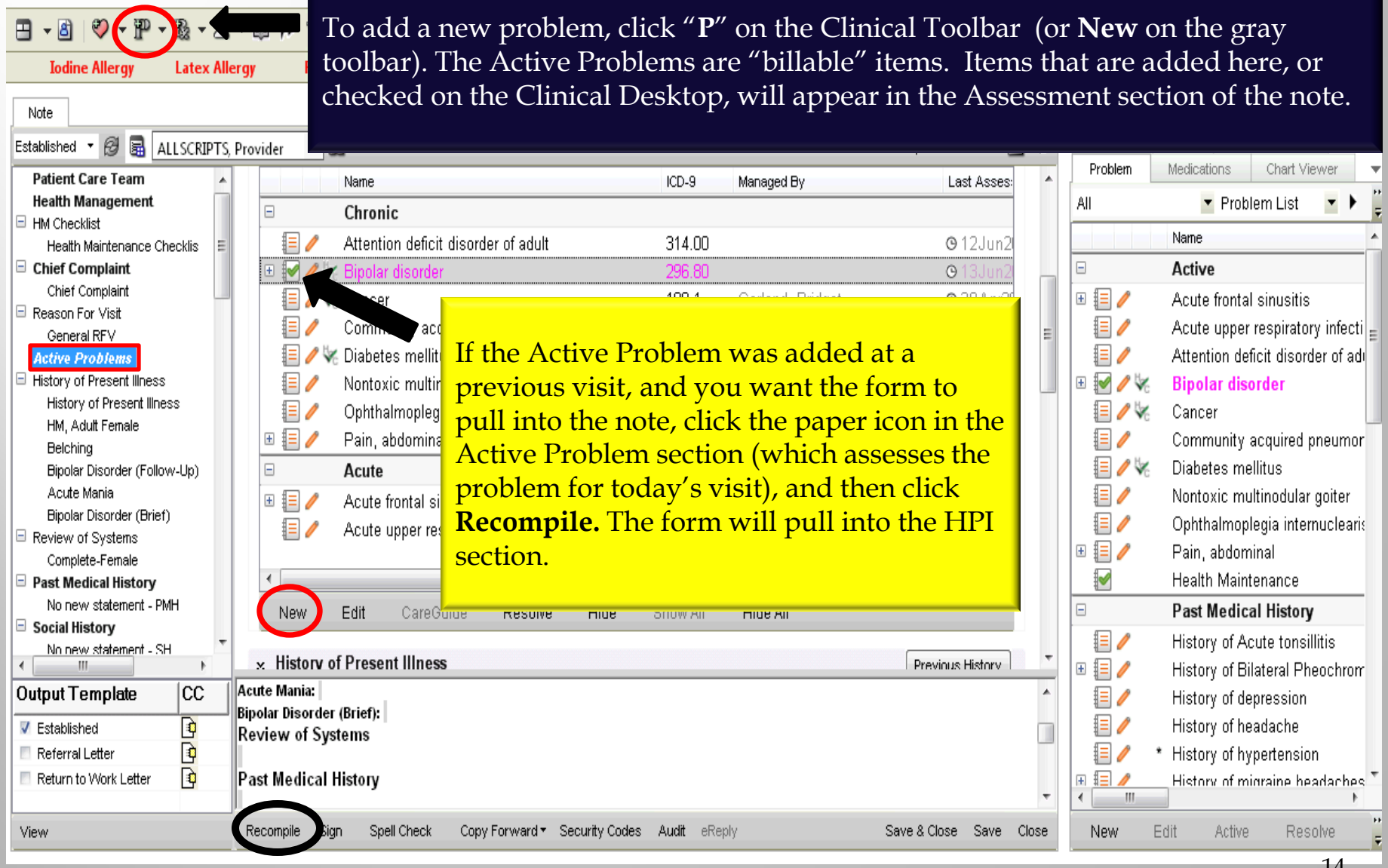


Both the Chief Complaint and the Active Problem sections are designed to pull forms into the **HPI** section of the note. When your nurse adds a Chief Complaint before opening the note, the HPI form will be available when you open your note.

To get the form(s) to pull in after the note has been opened, add a Chief Complaint or Active problem, and then click the **Recompile** button.

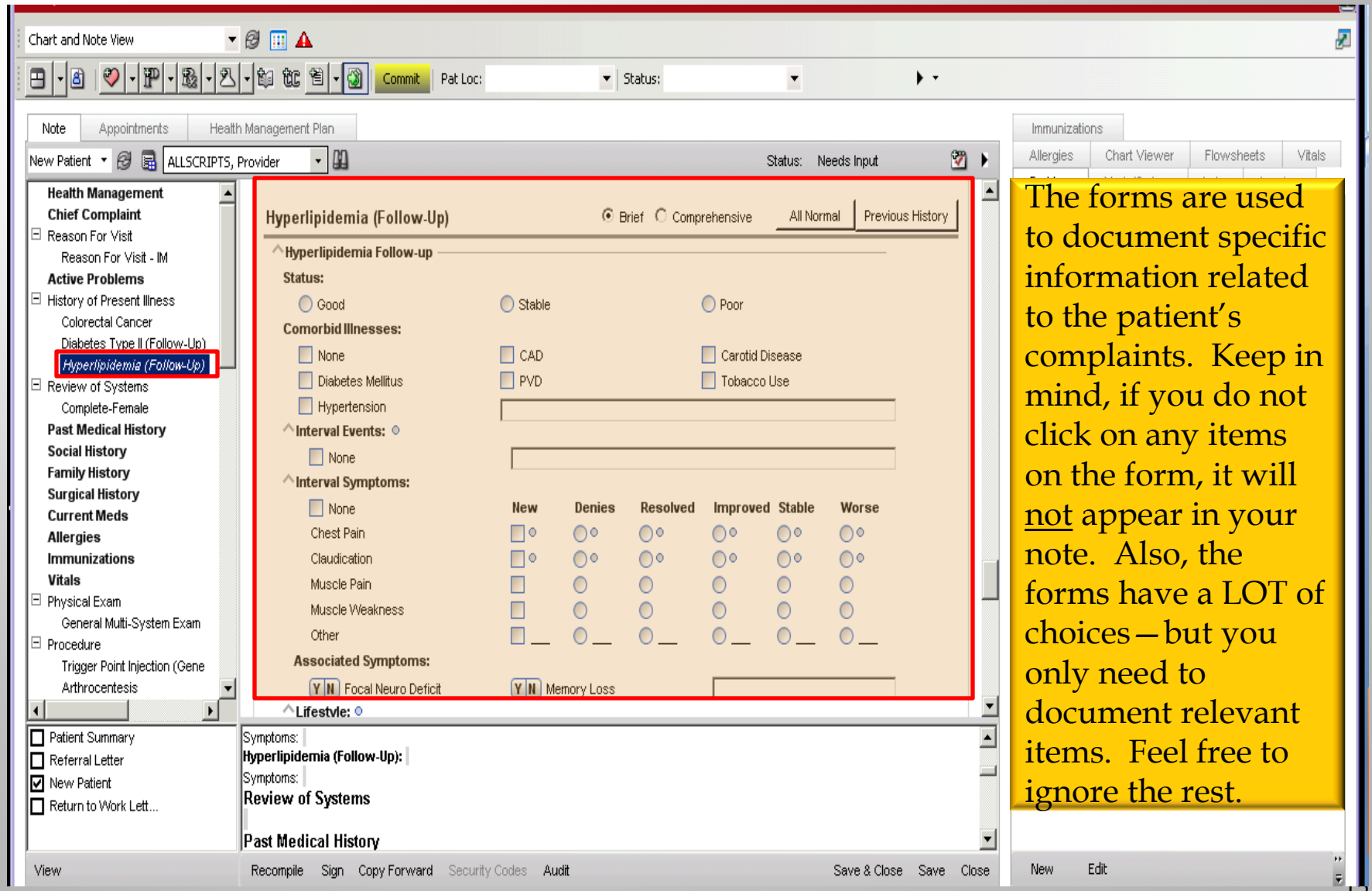
Forms

To add a new problem, click "**P**" on the Clinical Toolbar (or **New** on the gray toolbar). The Active Problems are "billable" items. Items that are added here, or checked on the Clinical Desktop, will appear in the Assessment section of the note.



If the Active Problem was added at a previous visit, and you want the form to pull into the note, click the paper icon in the Active Problem section (which assesses the problem for today's visit), and then click **Recompile.** The form will pull into the HPI section.

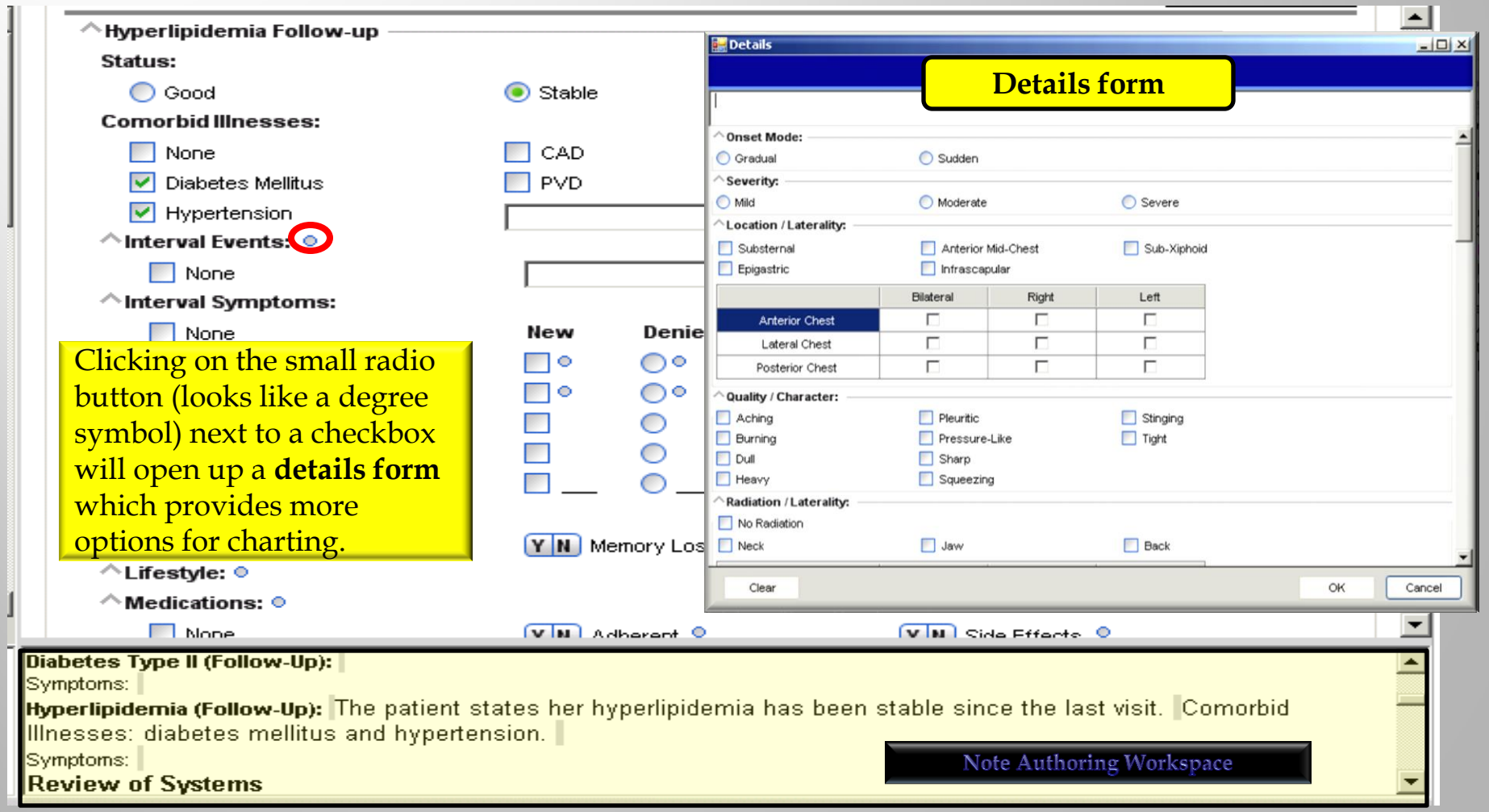
Forms



The forms are used to document specific information related to the patient's complaints. Keep in mind, if you do not click on any items on the form, it will not appear in your note. Also, the forms have a LOT of choices—but you only need to document relevant items. Feel free to ignore the rest.

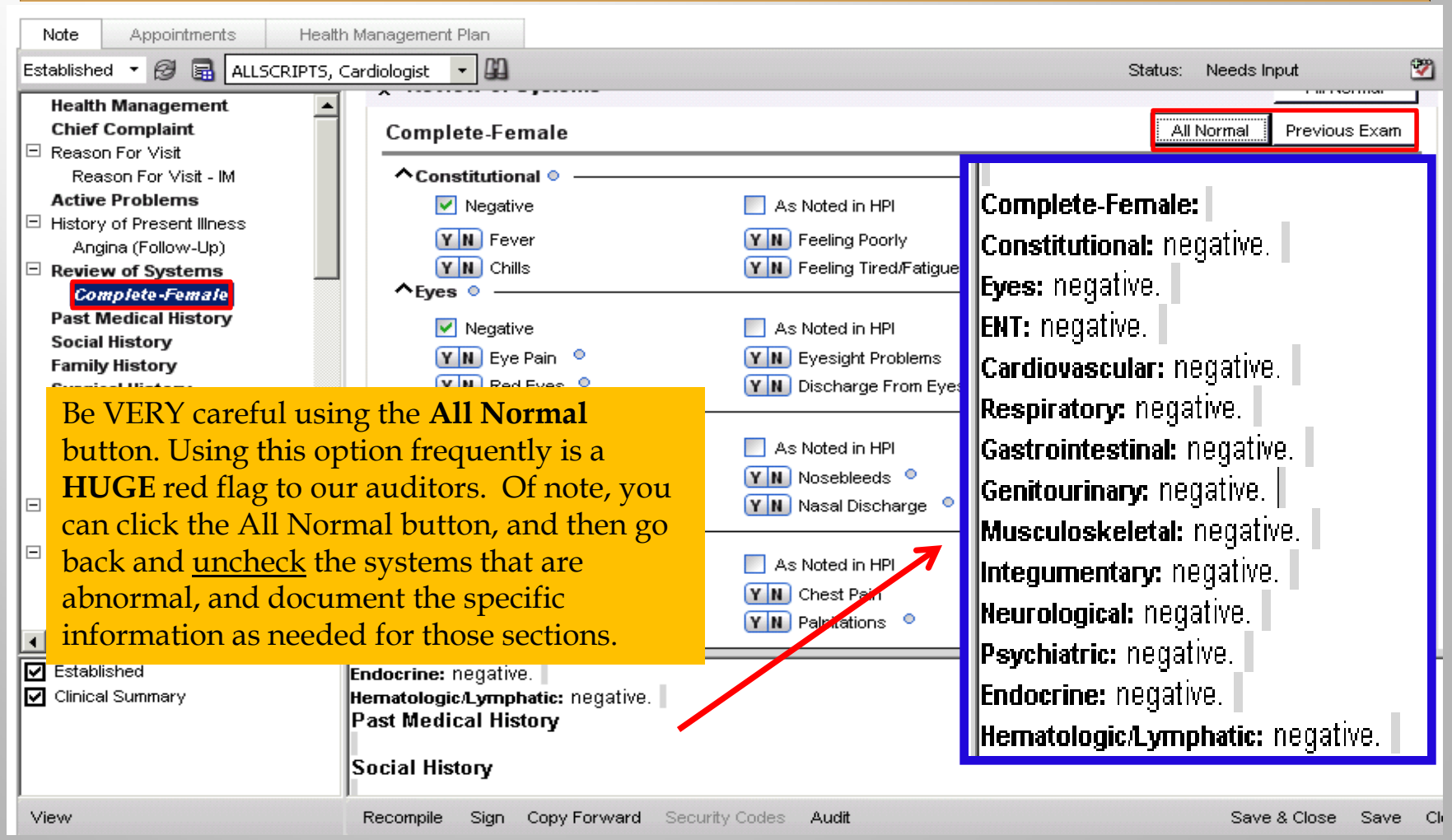
Forms

Clicking the boxes on the forms will populate the text at the bottom of the page (called the Note Authoring Workspace).

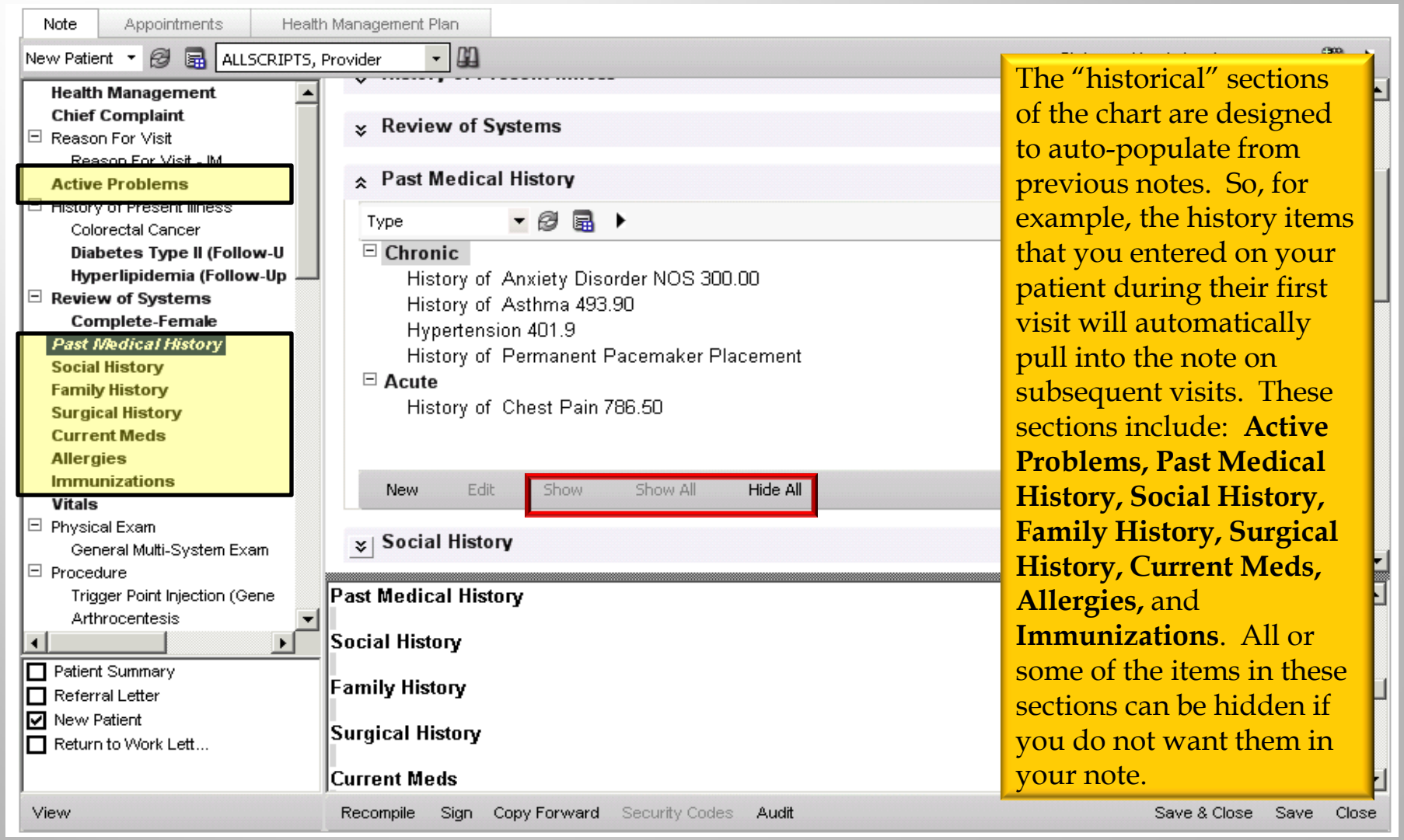


Forms

Some of the forms will have an **All Normal** and/or **Previous Exam** option. Clicking the All Normal button will populate negative/normal text for ALL of the systems. The Previous Exam button will pull in all items from the last exam.



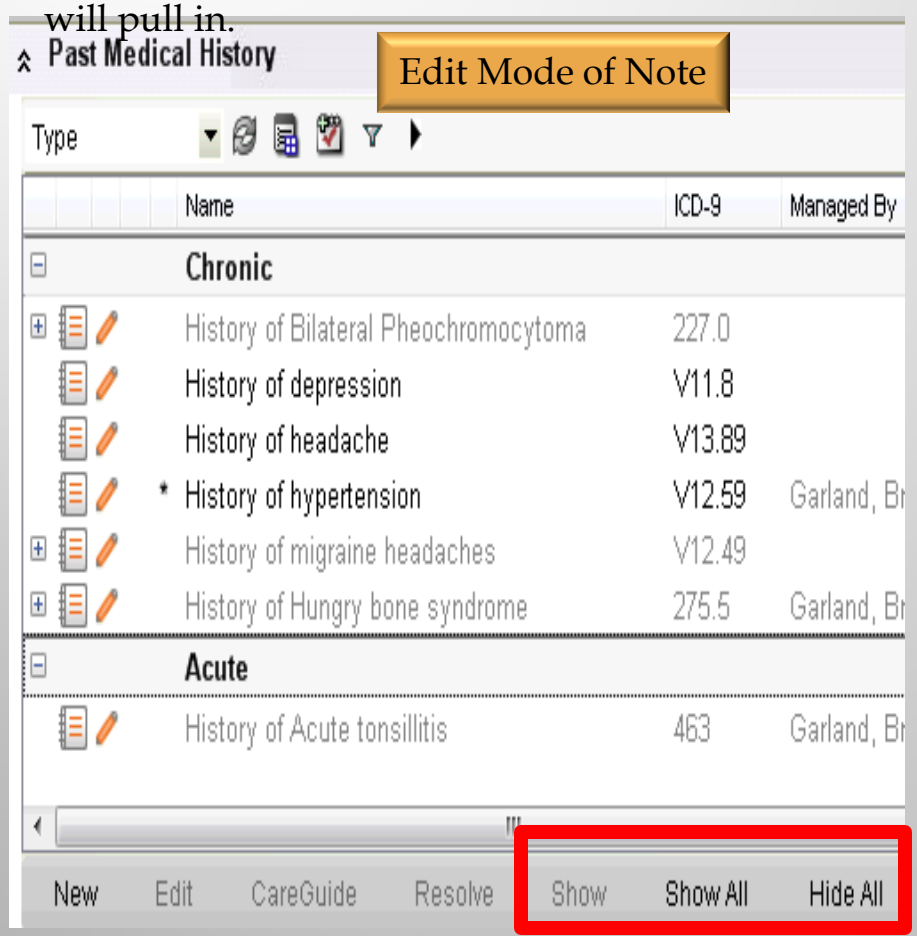
History sections

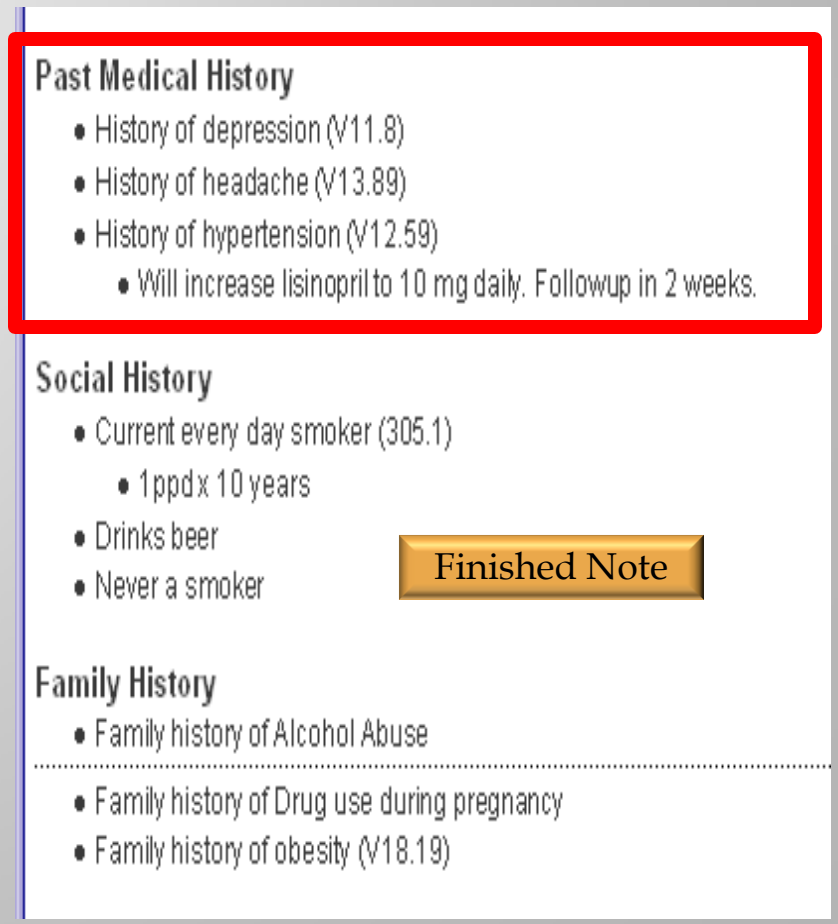


The "historical" sections of the chart are designed to auto-populate from previous notes. So, for example, the history items that you entered on your patient during their first visit will automatically pull into the note on subsequent visits. These sections include: **Active Problems, Past Medical History, Social History, Family History, Surgical History, Current Meds, Allergies,** and **Immunizations**. All or some of the items in these sections can be hidden if you do not want them in your note.

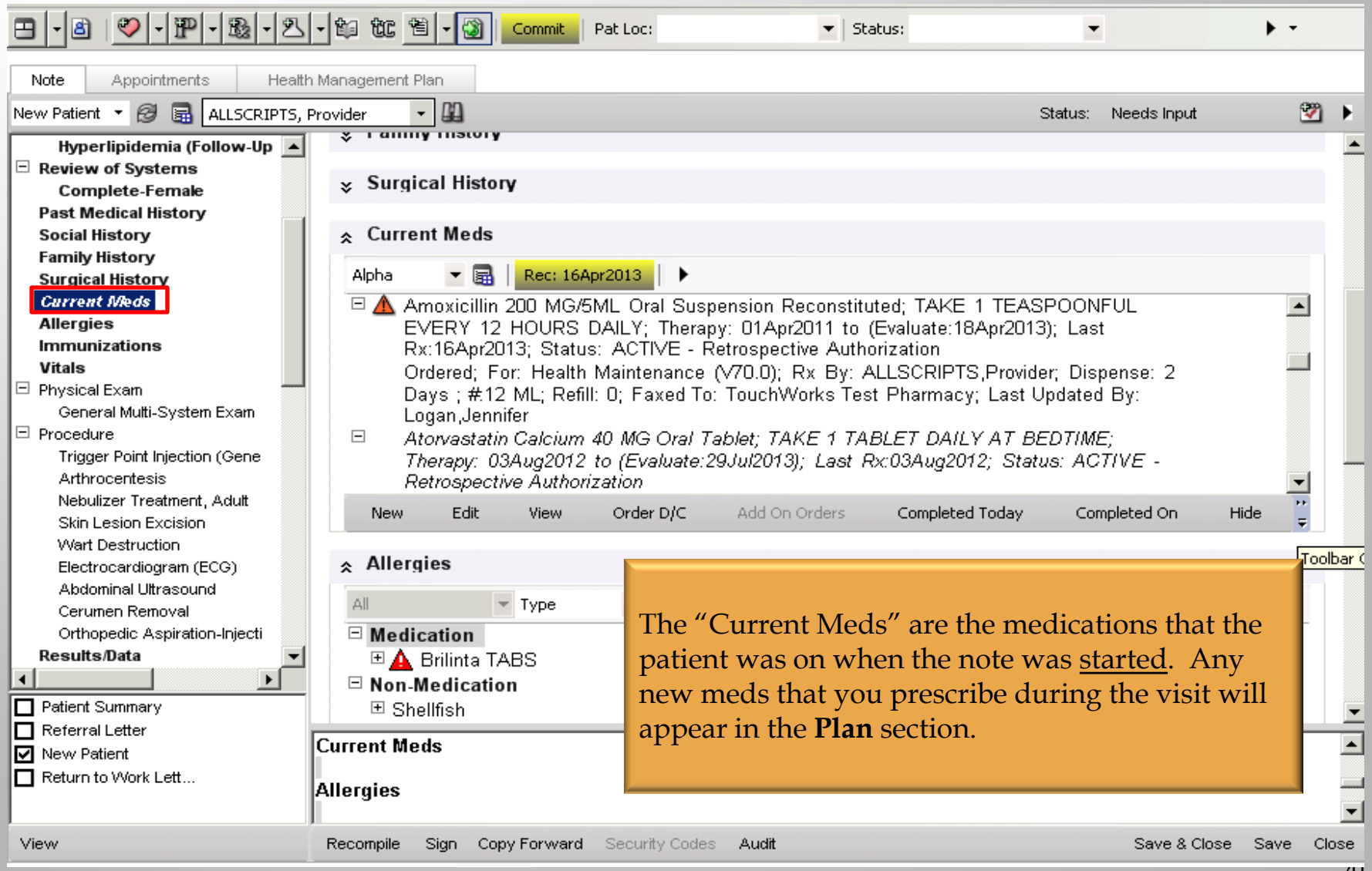
Hiding items

Use the "Show," "Show All," "Hide," and "Hide All" options to pull only relevant items into your note. If the items are **grayed out**, they are hidden. If they are **black**, they will appear in your note. In this example, I've clicked on 3 items, and then clicked "show." Only those items will appear in my finished note. It does not erase them from the patient's chart, however. The next time you open a note, all items will pull in.



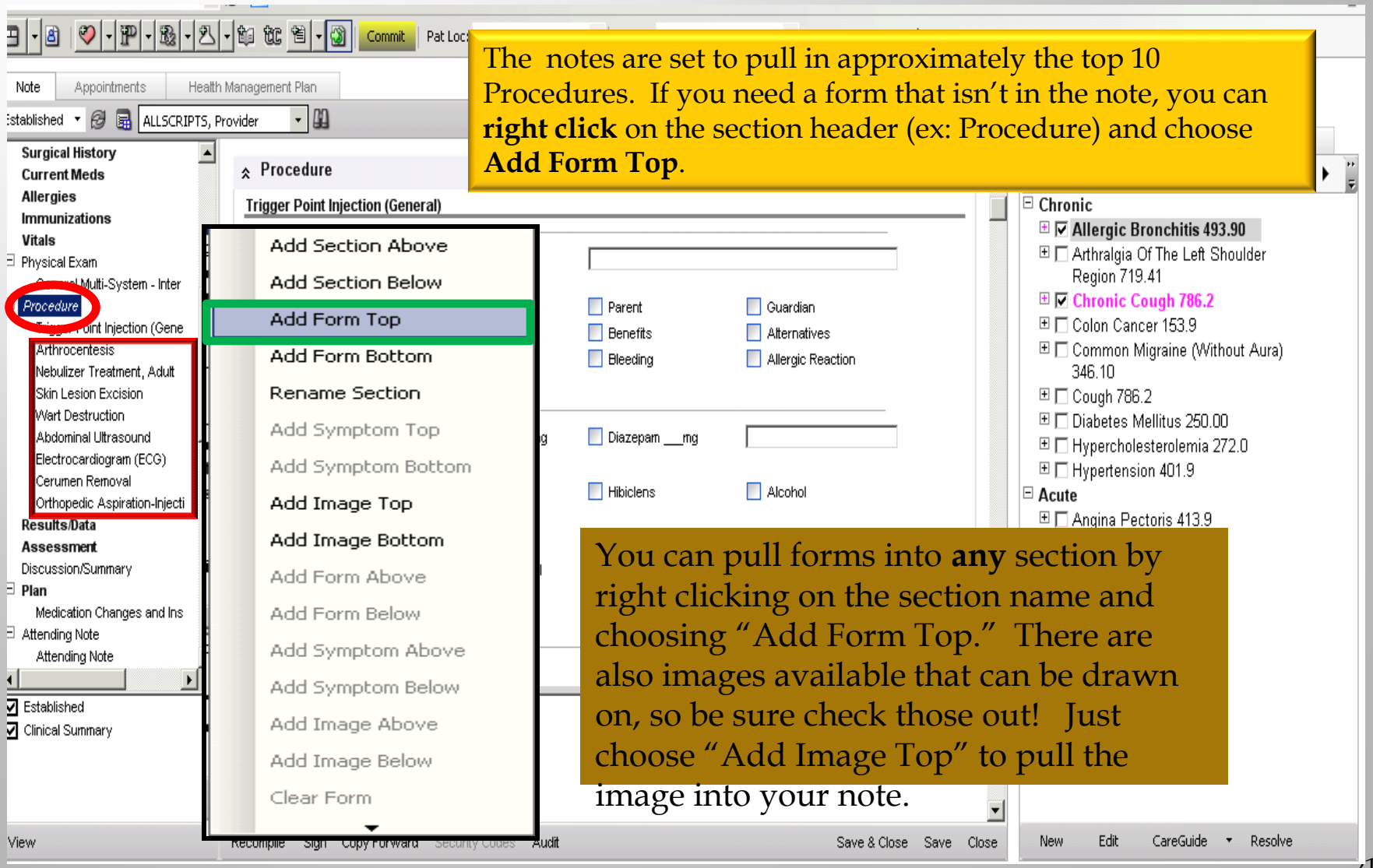


Note Sections – Current Meds

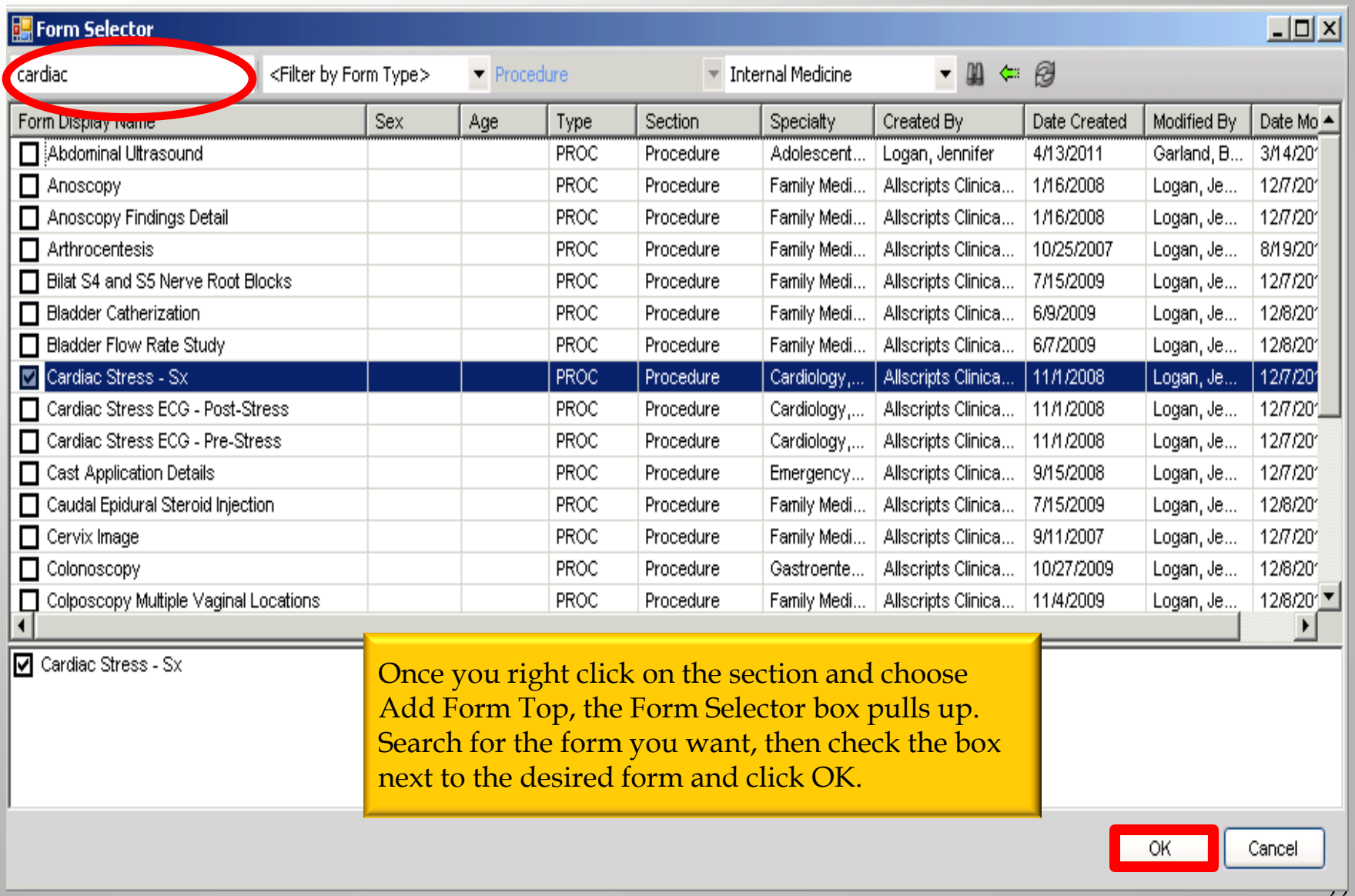


The "Current Meds" are the medications that the patient was on when the note was started. Any new meds that you prescribe during the visit will appear in the **Plan** section.

Note Sections – Procedures



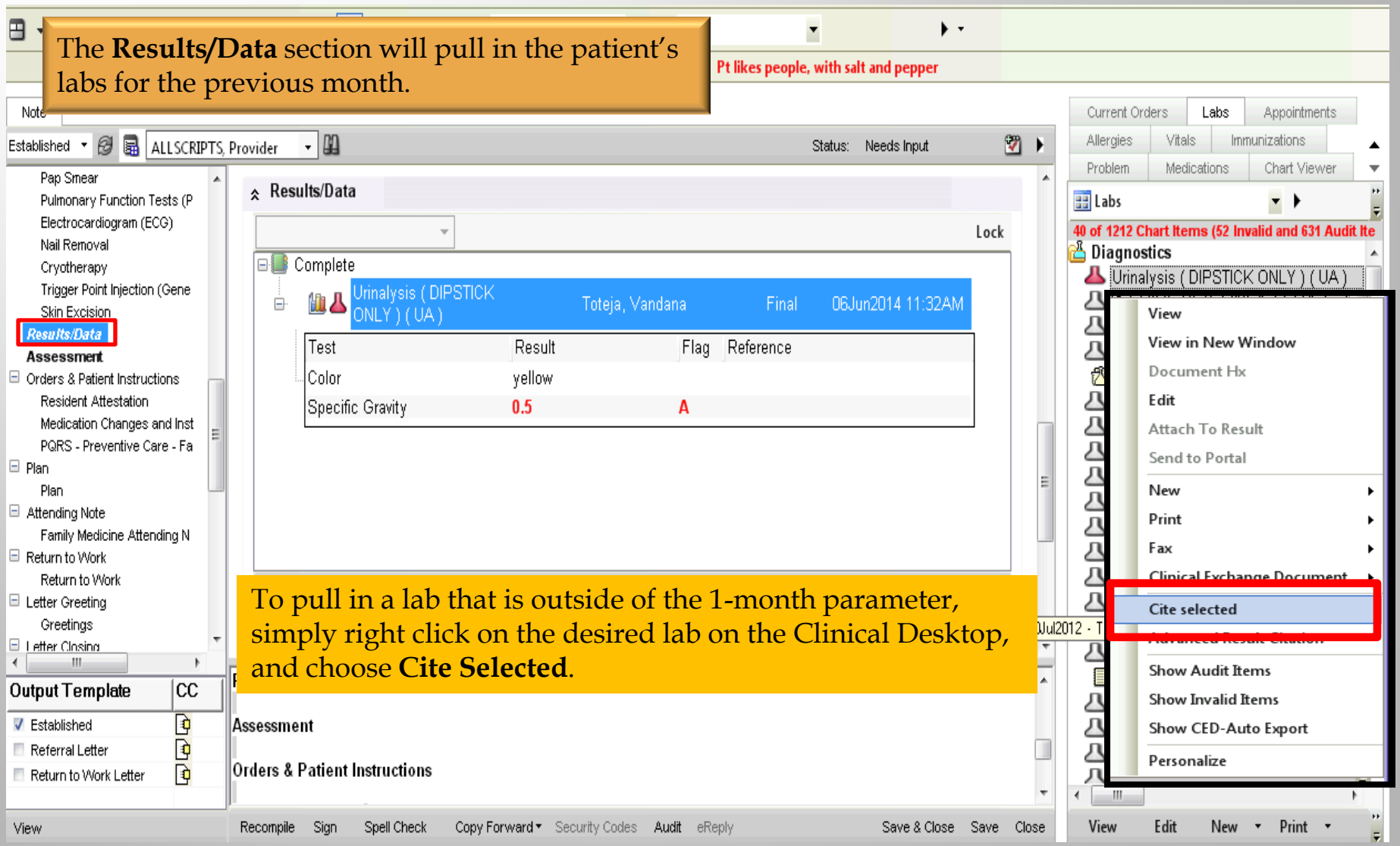
Note Sections – Procedures



Once you right click on the section and choose Add Form Top, the Form Selector box pulls up. Search for the form you want, then check the box next to the desired form and click OK.

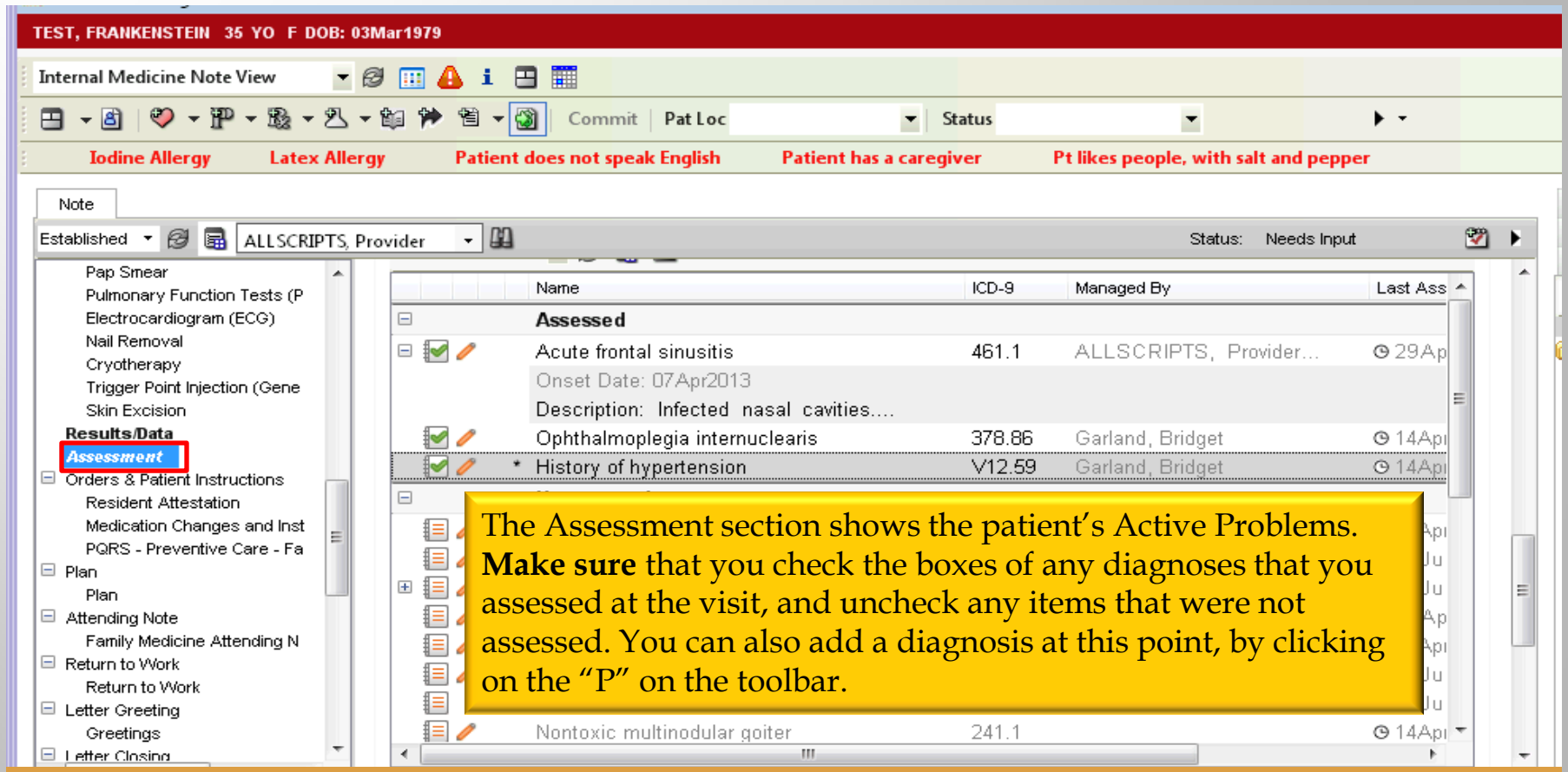
Note Sections – Results/Data

The **Results/Data** section will pull in the patient's labs for the previous month.



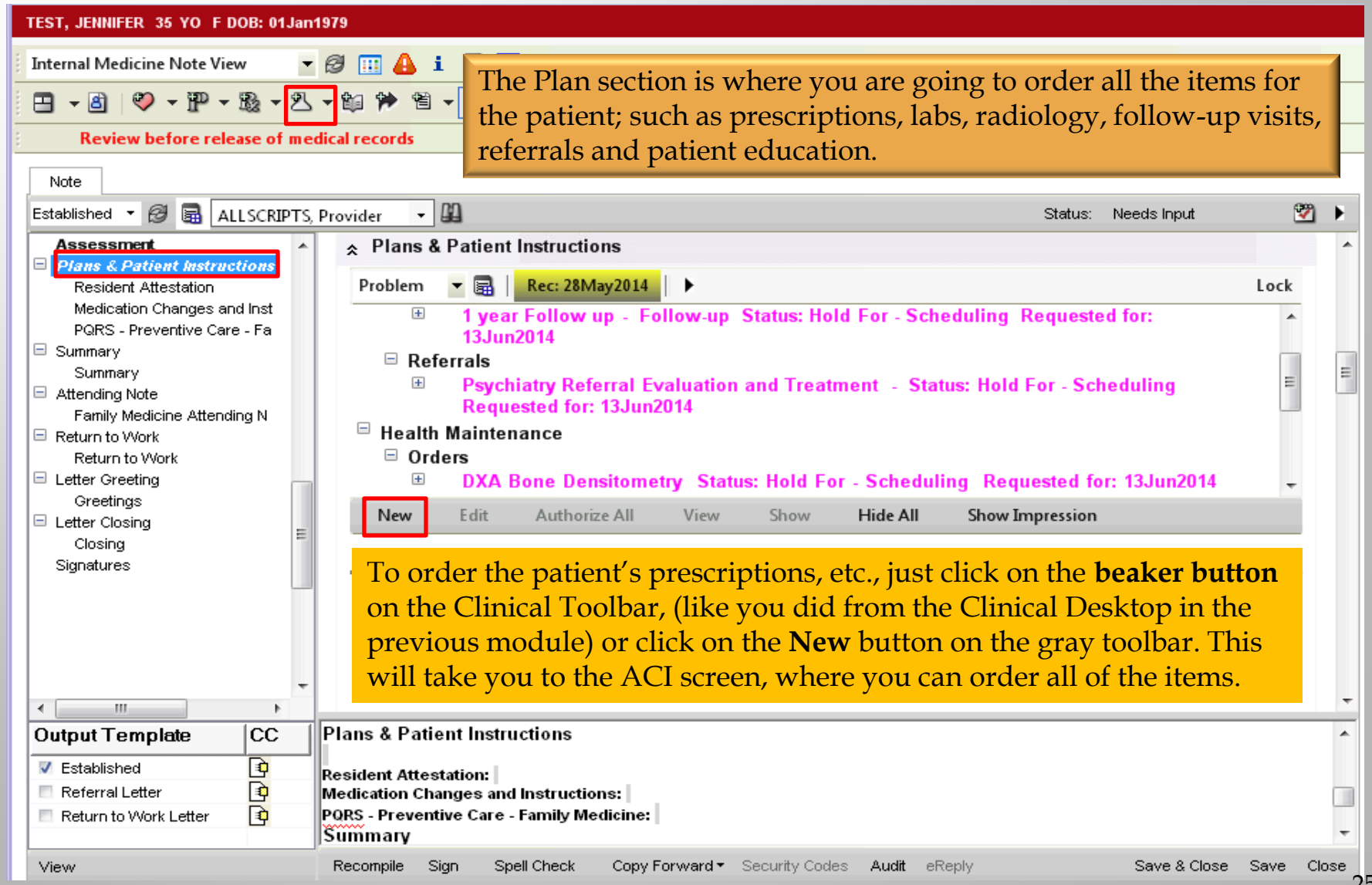
To pull in a lab that is outside of the 1-month parameter, simply right click on the desired lab on the Clinical Desktop, and choose **Cite Selected**.

Note Sections – Assessment

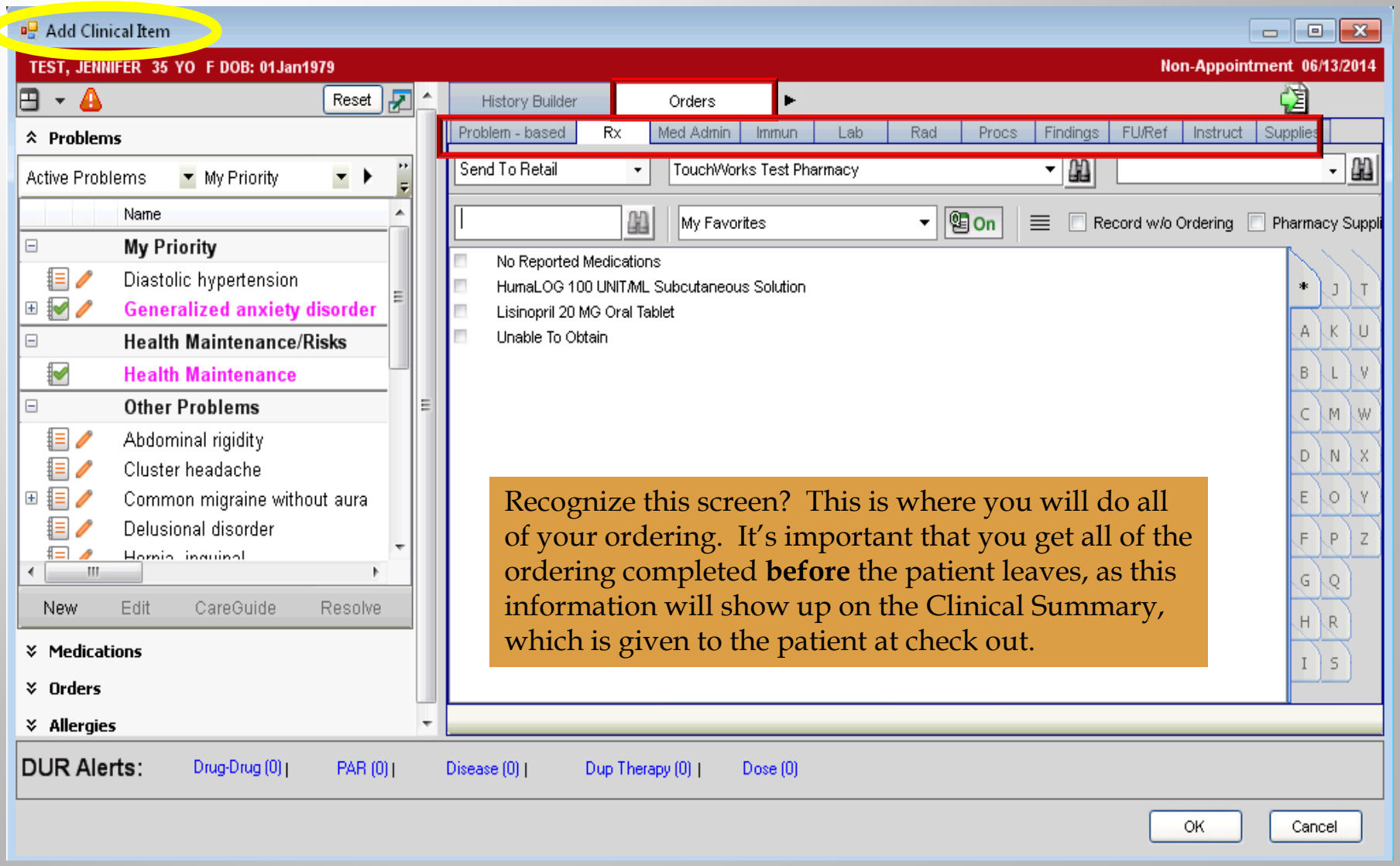


It's **really** important for billing purposes that the items you assessed are placed in order of importance. To do this, simply click on the item you need to move and drag it into place. Currently, we are still utilizing superbills, so the assessed problems in your note need to match the problems you list on the encounter form (superbill). The order also needs to match.

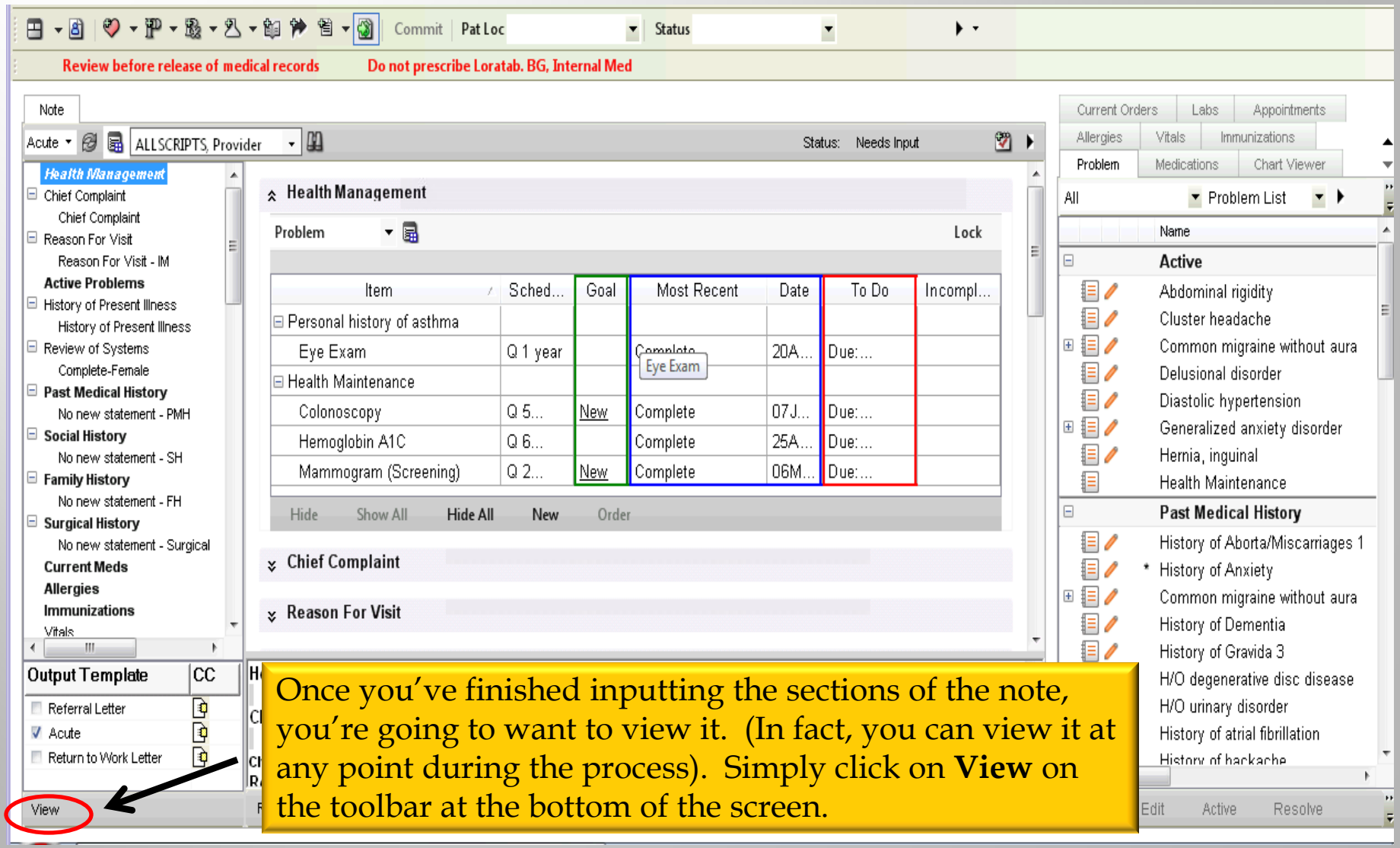
Note Sections – Plan



Note Sections – ordering

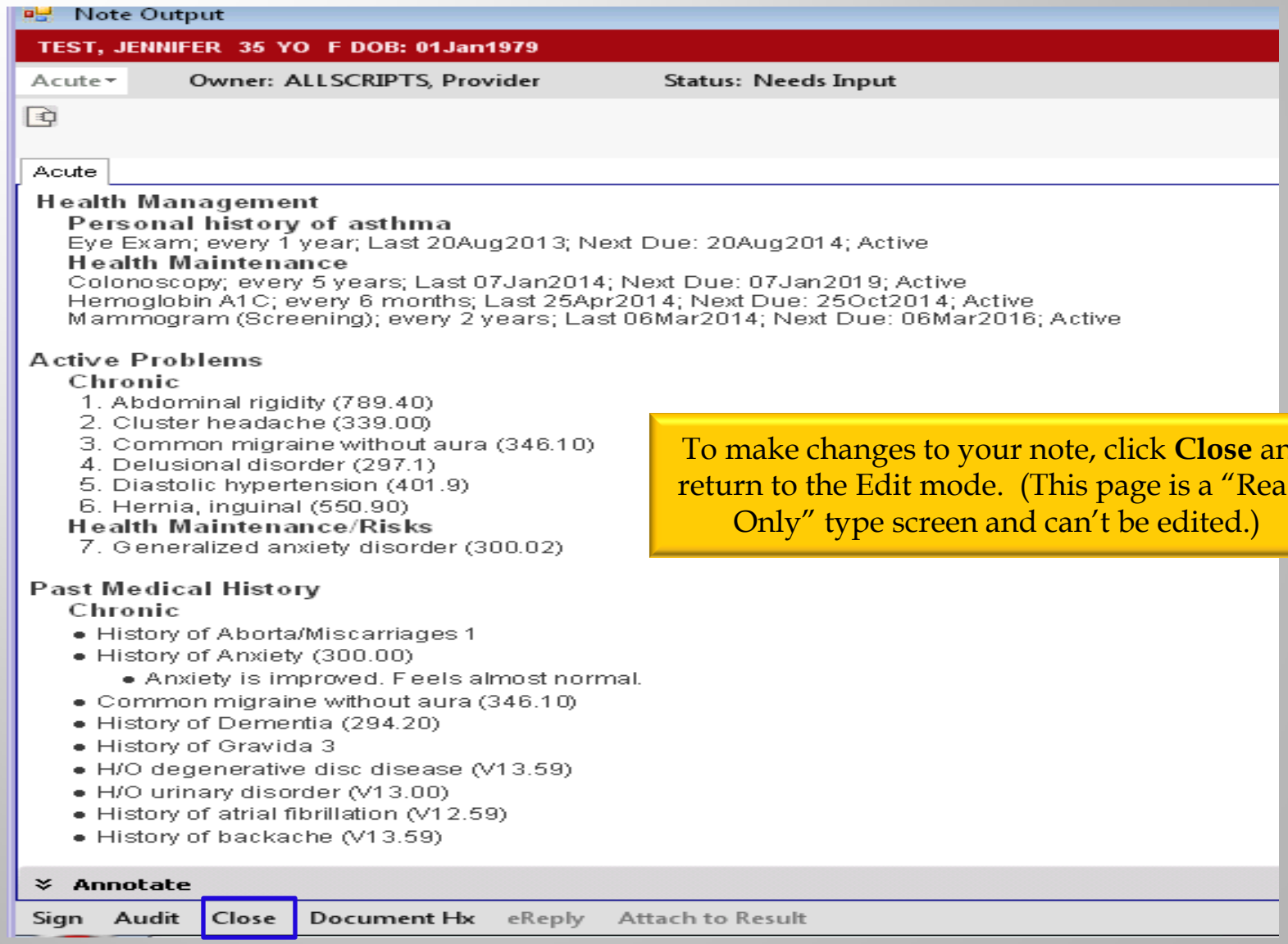


Viewing Your Note



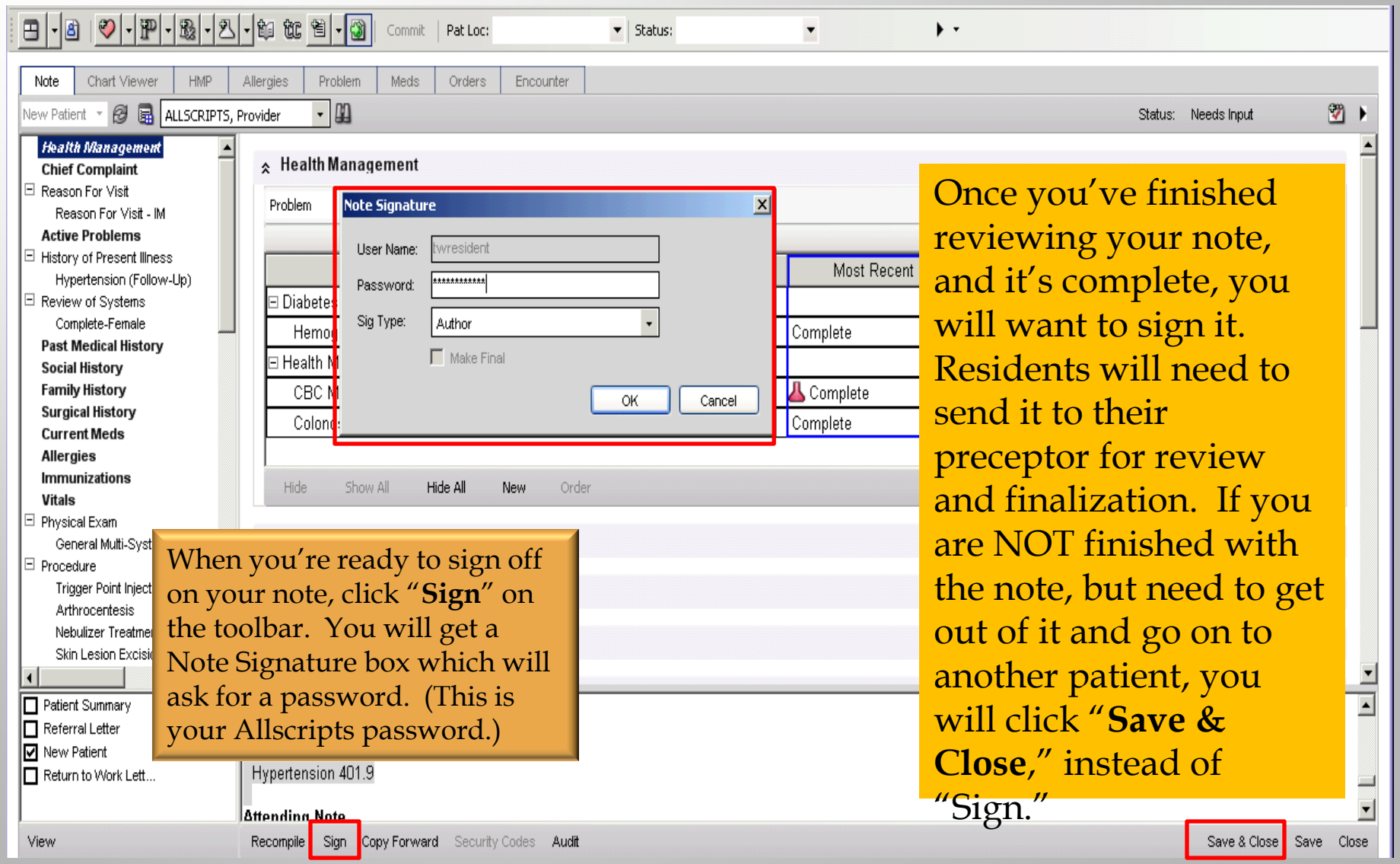
Once you've finished inputting the sections of the note, you're going to want to view it. (In fact, you can view it at any point during the process). Simply click on **View** on the toolbar at the bottom of the screen.

Viewing Your Note



To make changes to your note, click **Close** and return to the Edit mode. (This page is a "Read-Only" type screen and can't be edited.)

Signing a Note

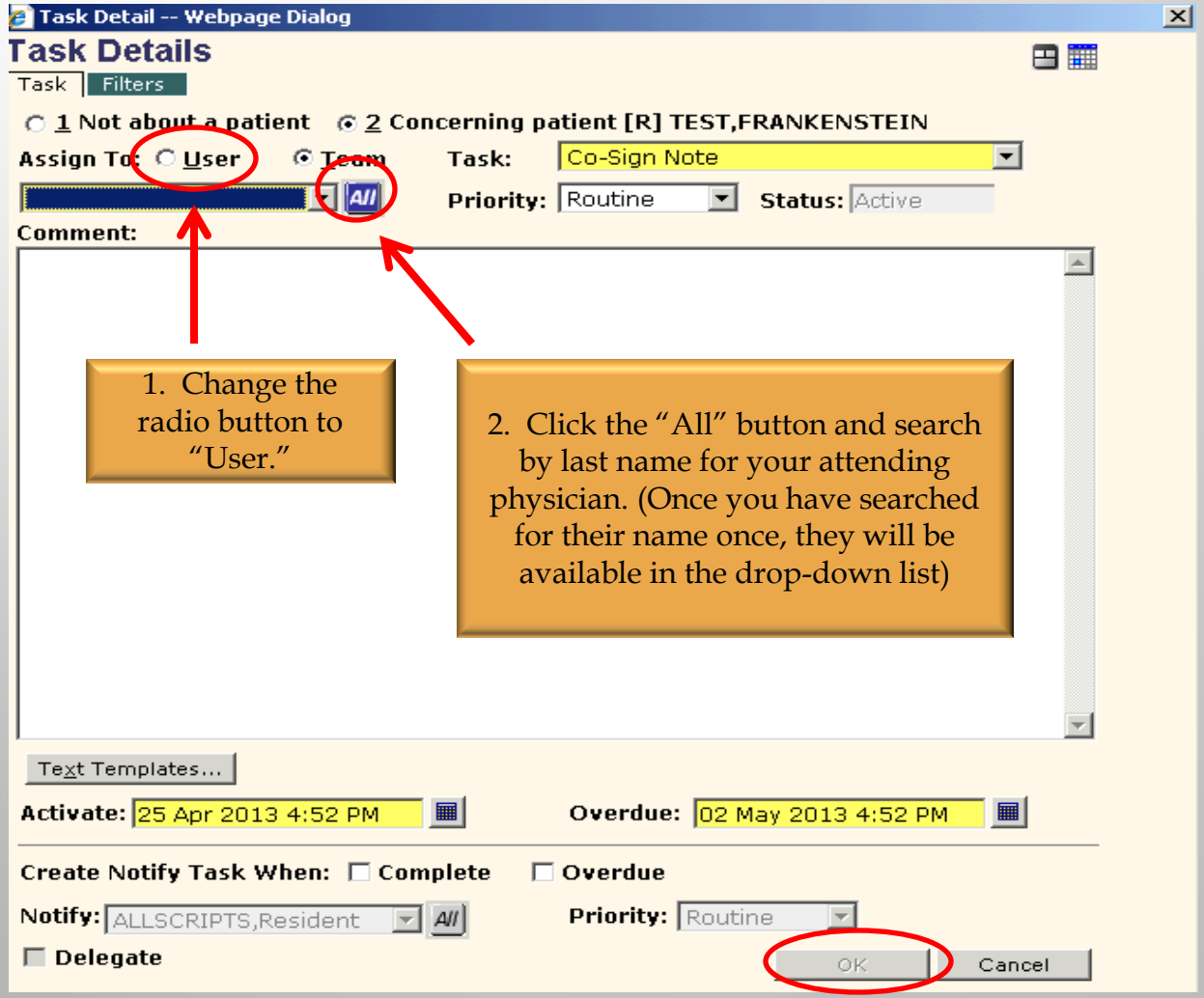


When you're ready to sign off on your note, click "**Sign**" on the toolbar. You will get a Note Signature box which will ask for a password. (This is your Allscripts password.)

Once you've finished reviewing your note, and it's complete, you will want to sign it. Residents will need to send it to their preceptor for review and finalization. If you are NOT finished with the note, but need to get out of it and go on to another patient, you will click "**Save & Close**," instead of "Sign."

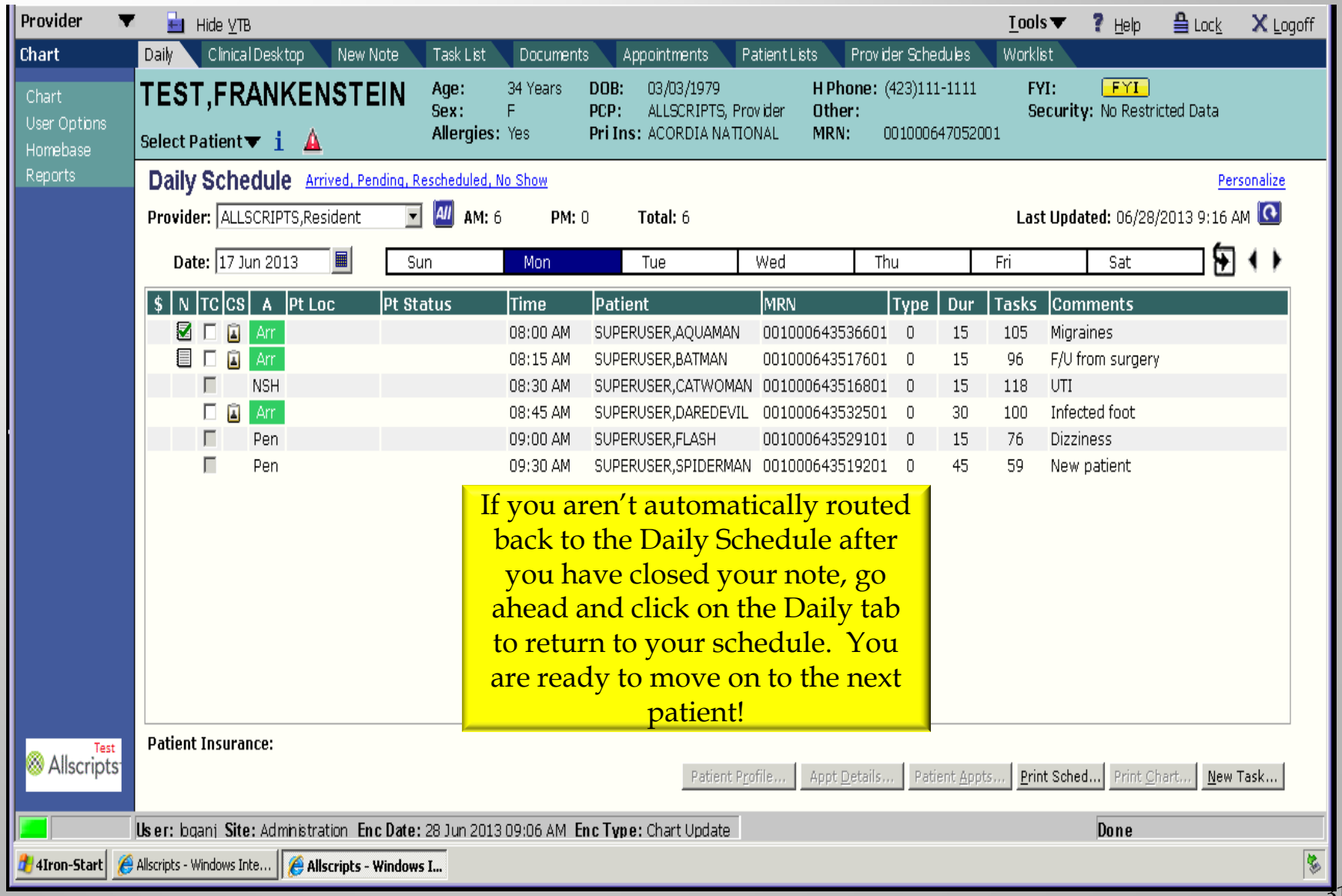
Co-sign note task

Once you click OK on the Signature Box, residents (and nurses, if they are creating a note that needs to be finalized by an attending MD) will get a **Co-Sign Note** task.



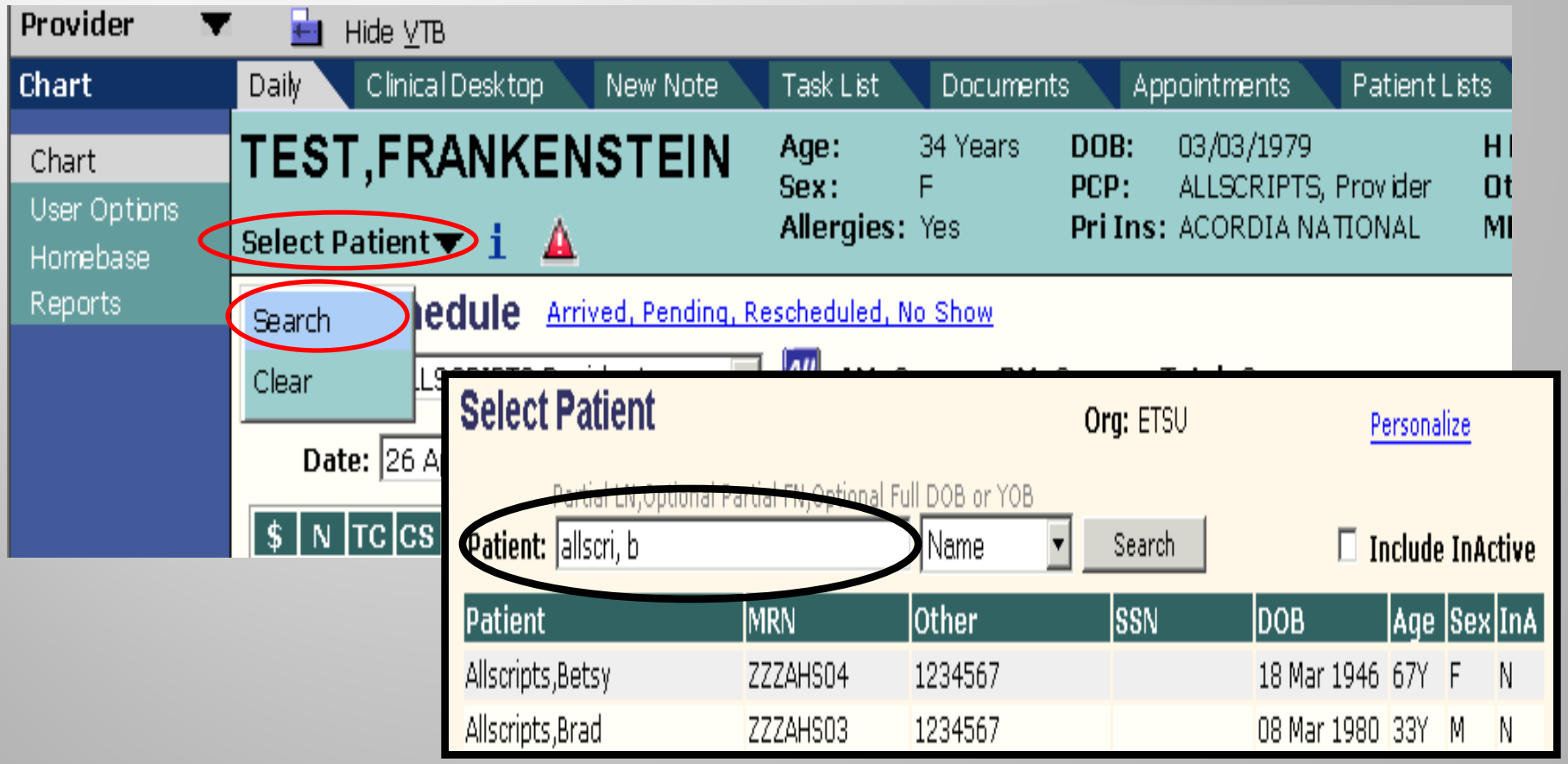
After you have put your **attending physician's** name in the Assign To: field, click OK. There is no need to type anything in the Comment section. (When your attending double clicks on this task, it will take him/her directly into the note to be signed and finalized.)

Return to daily schedule



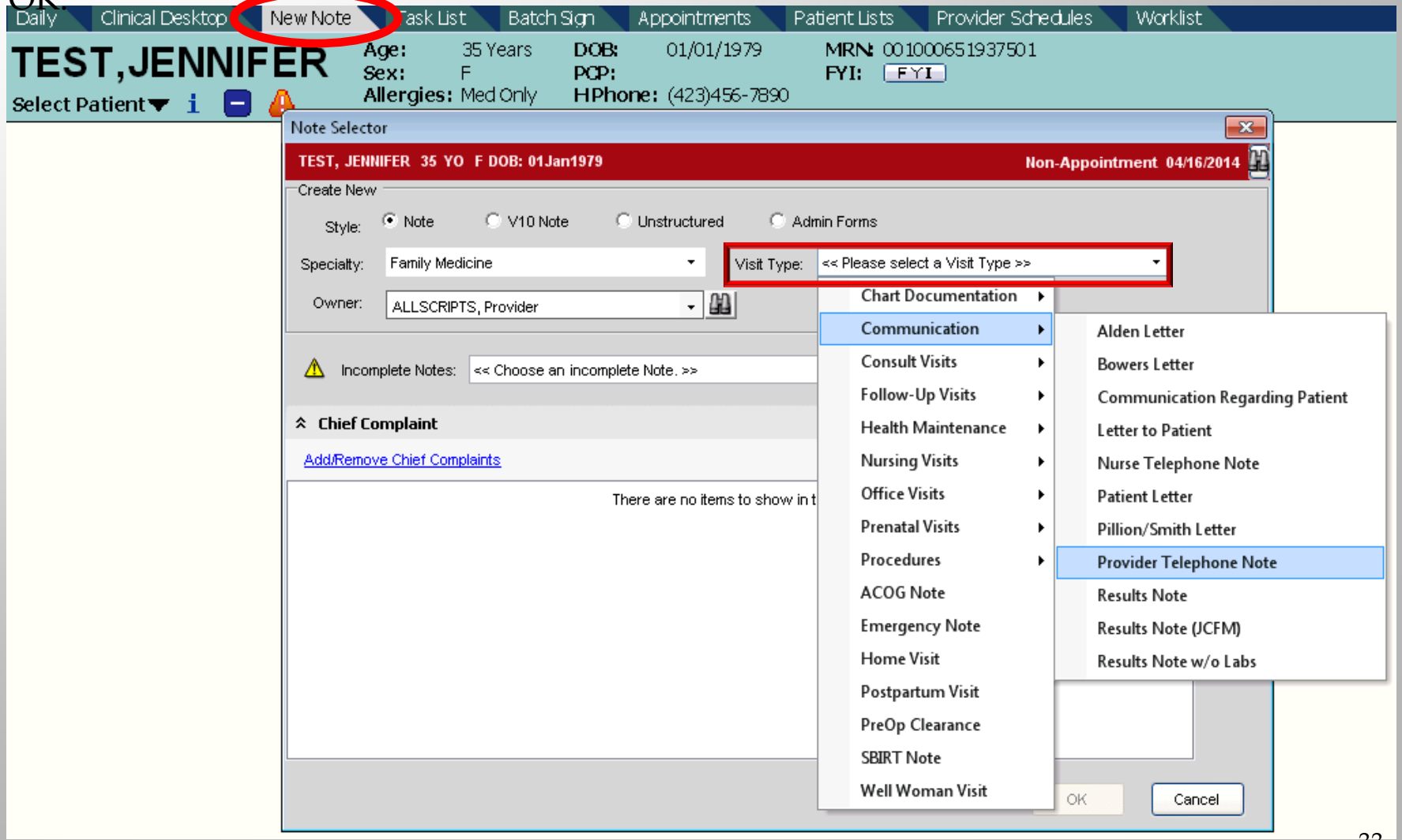
Starting a note

Most of the time, you will be doing notes on patients who are on your schedule. But, from time to time, you'll want to create a telephone note on a patient who isn't on your schedule. To document a note in this situation, click "Select Patient" on the banner, and choose "Search." A "Select Patient" box will appear. Search for your patient by **Last Name, First Name**. Click Search. Highlight the patient's name and click Enter.



New Note tab

Once the patient is in the Banner, click on the New Note tab. Choose your Visit Type. Click OK.



You have now completed all of the required modules for Allscripts EHR training.