Module 1: Daily Schedule & Clinical Desktop

Provider Training Module
Allscripts Touchworks EHR

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June 2018
When you first log in, you’ll land on the Daily schedule page. You’ll notice a “floating” Clinical Toolbar that can be moved to different locations on the screen. You can drag this out of the way, or you can “x” out of it. (You won’t use it on this screen very often). If you need to get it back, click on Tools and choose Show/Hide Clinical Toolbar.
There are two toolbars in Allscripts; the horizontal toolbar (HTB) and the vertical toolbar (VTB). The HTB contains all the tabs that you will need for patient documentation.

The VTB contains additional tabs that will allow you to view the print/fax queue, view our website, and change your clinic location.
When you first log in, you will see your Daily Schedule. To pull in a provider’s schedule, click the drop-down arrow in the Provider field. If their name is not there, click on the search icon. A Search Window will pop up.

Tip: Once you’ve searched for a name, it will appear in the drop-down list the next time you perform a search. This functionality works throughout Allscripts.
IN THE “SEARCH FOR” FIELD, TYPE THE PROVIDER’S LAST NAME AND CLICK GO. HIGHLIGHT THE DESIRED PROVIDER AND CLICK OK.
There are several ways to change the date of the schedule:

1. Click on the day of the week

2. Click on the calendar icon next to the Date field

3. Click on the black arrows to navigate forward or backward a week

4. To get back to today’s date, click on this icon
### Daily Schedule Icons

#### N Column
- **Note icon:** This indicates that a note has been **started** on the patient.
- **Finished Note icon:** Note has been **finalized** by the attending MD.

#### TC Column
- **Transition of Care:** Check if patient is transitioning to your care from another setting.

#### CS Column
- **Clinical Summary:** Indicates whether or not a Clinical Summary has been printed for the patient.

#### A Column
- **Arrival Status:**
  - **NSH** – No Show
  - **ARR** – Arrived
  - **Pen** – Pending
  - **Can** – Cancelled

#### Pt Loc
- **Patient Location:** This tracks the patient's location throughout the visit.

#### Pt Status
- **This indicates the patient's status throughout the visit.**
A single click on the patient’s name from the Daily Schedule will pull them into the Patient Banner. If the patient’s name is in the Banner, that indicates that you are documenting on that patient’s electronic chart, so make a habit of checking the banner when charting to ensure you are working on the correct patient.
You can also manually pull a patient into context. In the Patient Banner, click the magnifying glass to choose the Select Patient. In the Select Patient box, type the patient’s LAST NAME, FIRST NAME. Highlight the correct patient’s name, and then click OK.

Tip: When searching, you don’t have to type the entire name. You can type “Super, Gr,” for Superuser, Grover. You can also search by other parameters, such as DOB, phone number, etc. Click the drop down next to Name and choose the search parameter that you want to use. You can set a different parameter as your default, too. Just click on the blue Personalize button in the upper right-hand corner!
All of the patient’s demographic information can be accessed from the Patient Banner. The age, sex, allergies, phone number, etc., are visible whenever the patient’s name is in context. The FYI box on the patient banner is similar to a “sticky note” on a paper chart. It is used to document information that is not clinically relevant and is typically used by the front desk staff; however, anyone can read the information in the FYI field.

To read an FYI, click on the yellow FYI button on the Patient Banner.

Tip: If the icon on the patient banner is yellow, there is an available FYI. If it is grayed out, the field is empty.
Other patient information can be accessed by clicking on the **i** on the banner.

**Information icon:** Clicking on this opens the Patient Profile Dialog box. Information in this section includes the FYI box, Chart Alerts, demographics, emergency contact info, pharmacy info and patient care team. Hyperlinks at the top of the page will take you directly to each individual section.
Chart Alerts are used to document clinically relevant information. You can add a chart alert by clicking on the patient banner.

Clicking the Add Alert button opens this window, which allows you to add multiple Chart Alerts. There are some available alerts which can just be checked, or you can free text an alert in the Ad Hoc Alert section.

The Chart Alerts will appear on the Clinical Toolbar.
The patient care team, which is also accessed through the Information Icon, allows you to add/delete and view other members of the patient’s care team. You can add providers, healthcare agencies and even family members to the care team.

Click on the Add Provider/Agency button. You can search by last name or specialty. Check the box next to the provider’s name to add it to the patient’s chart.

To add a family member, click on the Add Patient Caregiver/Resource button and free text their name.
Tip: It’s important that you ALWAYS access the patient’s chart by double clicking from the Daily Schedule (if they have an appointment), because this links the appointment date with your chart documentation.
The Clinical Desktop is the patient’s “electronic chart.” There are two main components. Each component contains different tabs, where you will access the patient’s information.
Tip: Each tab on the Clinical Desktop has a couple of different sort options which can be used to help you find information quickly.
The Problem tab is where you will be able to view all of the patient’s active problems (diagnoses), past medical, social, family and surgical histories.

You can also resolve, edit and refine problems from this tab. Cleaning up the patient’s active problem list is easy – just highlight the problem and choose “Resolve” from the toolbar.

You can also right-click on the problem, which will open up an extensive menu.
The 2nd tab is the Notes tab. This is where all of the patient’s notes reside. To read a note, double click on it. To edit a note, highlight and choose “edit” from the toolbar.

Tip: If your patient is seen by other providers within the MEAC organization or at one of the 3 Family Medicine clinics, their notes will be available on the Clinical desktop.
Finalized note icon: This note has been signed by the attending physician

Unfinalized note icon: This note still requires a signature

The small “s” indicates that this is a scanned document

sArchive – document was part of the original paper chart
NOTES – VIEW MODE VS. EDIT MODE

View Mode: This is similar to a “read-only” mode. You can’t make any changes on this page. This is how you should always open a note unless you are charting in it.

To open a note in View Mode, double click the note icon on the Clinical Desktop.

Edit Mode: This is what the screen looks when you are actively charting on a patient.

There are two main ways to open a note in Edit mode:
1. Double click on the note icon on the Daily Schedule.
2. Highlight the note icon on the Notes tab and choose “edit” on the toolbar.
We have an interface with “Orchard” (our own lab), so labs sent to our lab will result back into the system electronically. Labs that are sent to outside vendors will come back on paper and will be scanned in by medical records personnel.

Normal lab that has been verified
Normal lab that has not been verified
Abnormal lab that has been verified
Abnormal lab that has not been verified
Scanned lab
Lab that has been resulted back manually
The next couple of tabs in the first component are pretty self-explanatory: the **Procedures** tab contains procedure reports; **Imaging** has x-rays, CT scans, etc., and the **Chart** tab contains the entire chart—notes, labs, procedures, imaging and administrative documents.

Each tab has a sort option that will allow you to find items easier.
The worklist contains items that need to be verified, such as labs, and medications that need authorization by an attending physician.

Labs will automatically go to the preceptor for signature, but they may be forwarded to the resident for review. It is good practice to check your worklist when you first log in and before you log out for the day.
Typically, your nurse will enter the vitals. Once they have been saved, they will appear here.

The vitals can also be viewed in a graph format. Check the boxes next to the items you want to view and then click the graph icon on the toolbar at the top. To return your screen to normal, click the Refresh button.
The Meds tab allows you to do the following:
1. View the Current Medications. To view the details, double click the med
2. View the Past Medications/All Medications. To view discontinued and completed meds, click the drop down and choose Past Medications
3. Prescribe a new medication (click on the New Rx button on the toolbar)
4. Renew a medication (click on the Renew w/ Changes button)
5. Discontinue/Complete a medication
6. Reprint/Resend a medication
7. View/print the drug education on a prescription (Drug Ed button)
The Orders tab shows all of the Current Orders for the patient. These are items that have been ordered, but not yet resulted/completed. Past orders can be viewed by changing the sort field from Current Orders to Past Orders or All Orders. New items can also be ordered by clicking on the appropriate option on the toolbar.

The faces are tied to the patient’s insurance formulary:

- **Red face** – insurance will not pay for this test
- **Yellow face** – insurance will pay a partial amount
- **Green face** – insurance will pay for test
The Allergies tab shows all of the patient’s allergies. Allergies with serious reactions, such as anaphylaxis, will have a warning icon next to it. Double clicking on an allergy will open the Allergy Viewer screen which will show any additional information documented about the allergy.

Just like with the Medications, the Allergies will need to be reconciled at each visit. If the allergies are up-to-date and accurate, click the yellow button to reconcile the allergies.
As immunizations are ordered, they will automatically flow into this table. The immunization list can be printed by clicking **Print** on the bottom toolbar.
Flowsheets allow you to keep track of various clinical items—usually based upon specific disease processes. Flowsheets are created by the EHR team, depending upon the needs of each clinic.
This table keeps track of all items that have been ordered with a particular diagnosis. Basically, this is the patient’s Plan in table format. At a quick glance, you can view when an item was ordered, if it is due or near due, and what the value was when last ordered.

You can also set goals for various items, such as weight, BMI, lab items, etc.
Growth chart for Pediatric patients

The default is the standard view; however, clicking the drop down allows you to choose either Prematurity or Down syndrome. (The patient must have that dx in their Active Problem list before it will generate the chart).
PLEASE PROCEED TO THE NEXT MODULE – DOCUMENTING HISTORY