Provider CPOM Training

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Remote Access SAC

Website: cag.clarkmemorial.org/

Remote access to CMH systems is granted through Citrix.

Remote access, need to install Citrix

1. The Citrix Receiver client can be downloaded from the following URL: http://receiver.citrix.com/

2. This URL either hosts the client or will redirect to the appropriate site.

Windows Desktop download
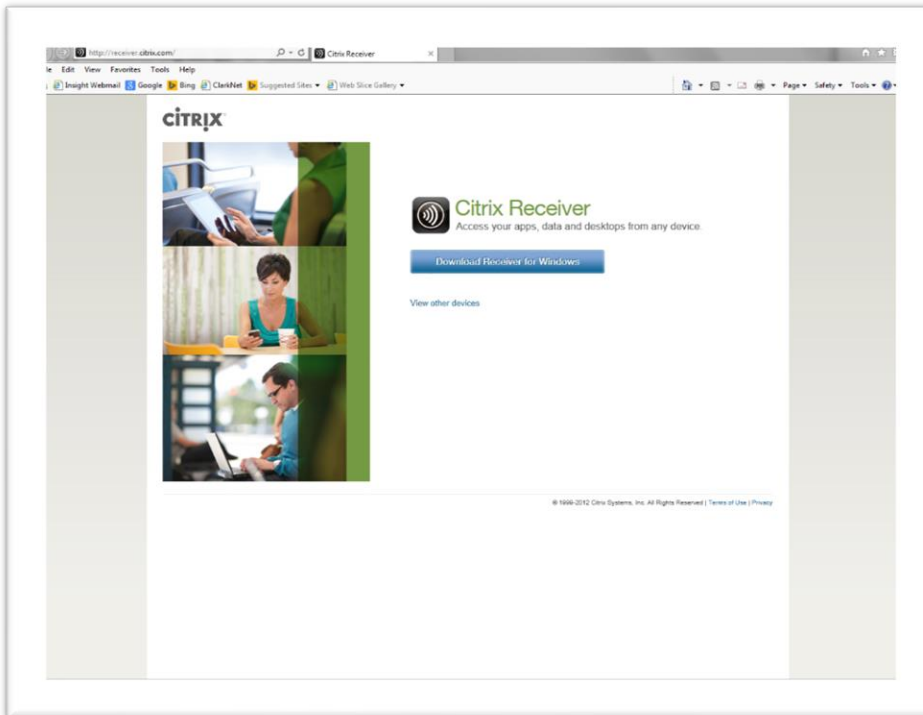
1. For full Windows and Mac operating systems such as laptops and desktops, simply download and install the client.
2. Once installed open a browser and navigate to https://cag.clarkmemorial.org

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Remote access, already installed Citrix

1. If you already have Citrix installed, after opening a browser and navigating to https://cag.clarkmemorial.org, you may click **Already Installed** on the right side.
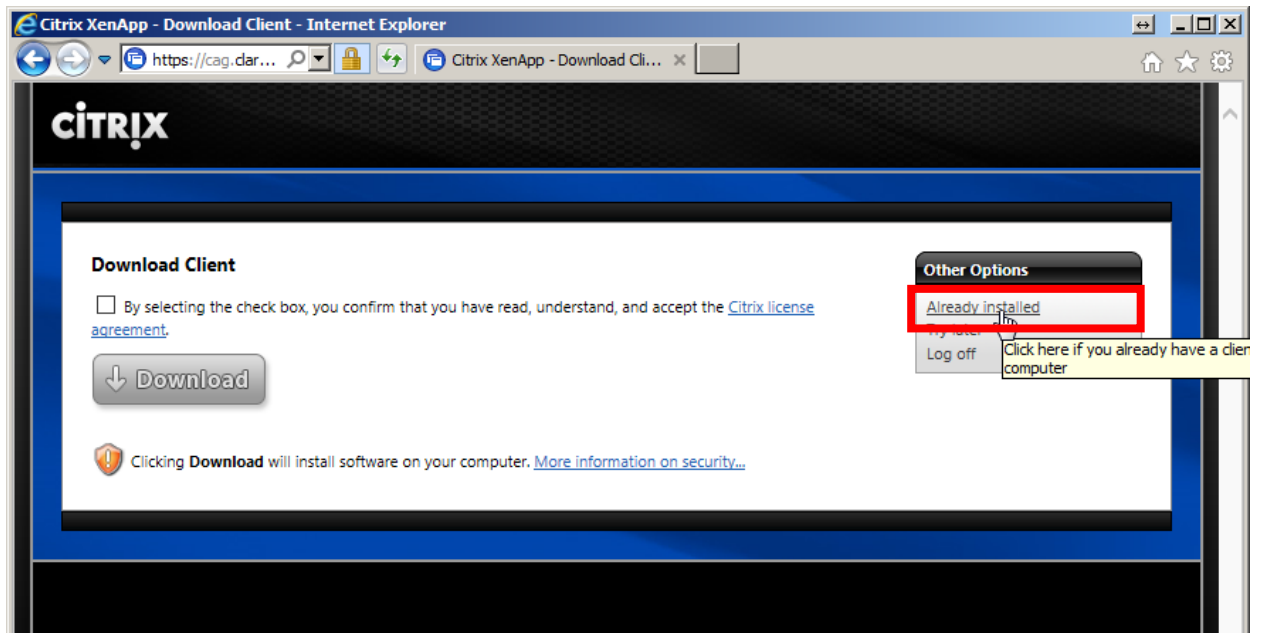
2. You will then proceed to this screen, which is the Citrix Gateway screen.

3. Log In:
   a. Username: you will need to use your CMH assigned username, also known as the AD, Windows, or Network username. It is in one of 3 forms:
      i. First.LastName
      ii. First.LastName@clarkmemorial.org
      iii. The last 5 digits of your Indiana Medical License
      ✎ The correct format should be reviewed during CMH Computer orientation.
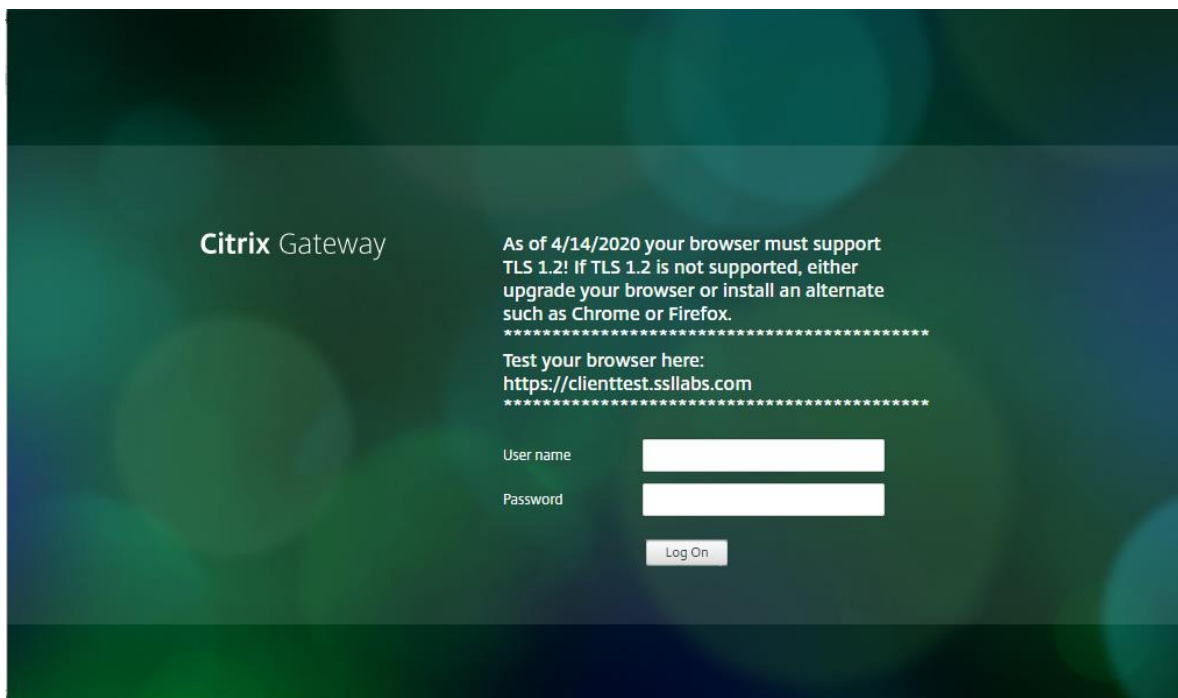   b. Password: the initial password will be given at computer orientation and will be required to be changed upon the first log in.

After logging into Citrix, the icons available to you will be Sovera, Sunrise, and potentially others (some are shown here):
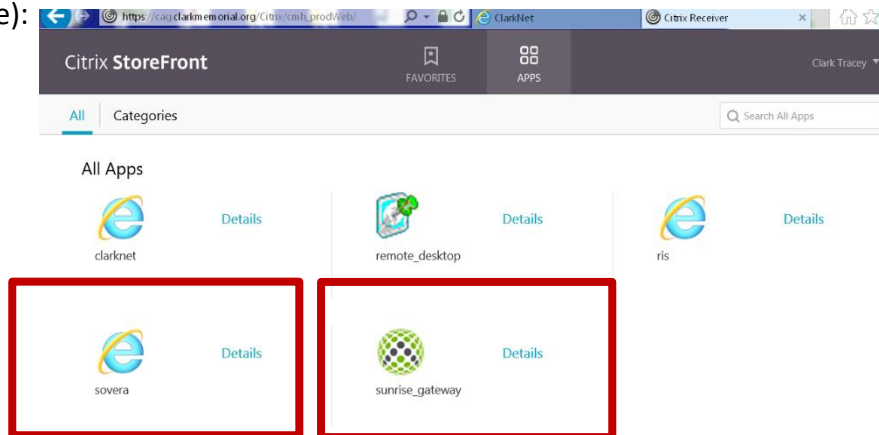
You can then double-click on the icon to start the application.

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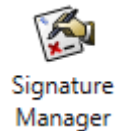## Launching SAC from a Hospital Desktop or Via Citrix

1. Double-click on SAC icon:

2. Enter your Allscripts username & password:

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Signature Manager

Signature Manager

Upon logging in, *the first thing you may see* is Signature Manager if you have orders or documents that need to be signed.
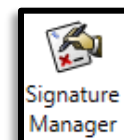

You can access the Signature Manager by clicking the "To Sign" flag from your patient list or by selecting the signature manager icon in the system toolbar.

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Purpose

Signature Manager allows you to:

- Review and sign all verbal/telephone orders for accuracy
- Review and sign PA/NP Orders or Documents
- Review and sign ADMIT TO: or other orders sent via Care Coordination Communication.
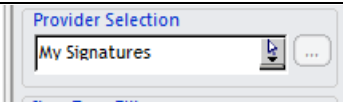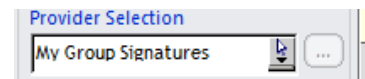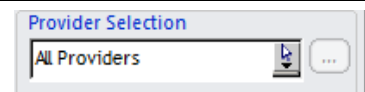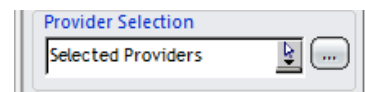- Prevents the need of logging in and signing in Sovera later on.

Signature Manager is no not hard stop, therefore if you need to bypass it, you may. However, ***Signature Manager will continue to appear every time you open SAC until your items are addressed.***

✎ **Important Note:** If a patient is discharged and you have not addressed your items in Signature Manager, you will need to log in to Sovera and address them.

Signature Manager Filters

Filters on are on the left side of the screen. You can filter by date, type, provider, etc.

✎ **IMPORTANT NOTE**: In order to activate one or more of these filters, you MUST select the GET LIST button below the filters.

Provider Selection — My Signatures	Displays items that require YOUR signature ONLY.
Provider Selection — My Group Signatures	Displays ANYONE in your group who has items to be signed.
Provider Selection — All Providers	This option will display items from ALL providers needing signatures.
Provider Selection — Selected Providers	Will display only items that need to be signed by providers you select.
Get List	Activates chosen filter(s).

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If you want to "Refuse" to sign an order, highlight the order and click:
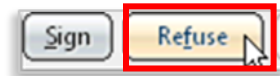
You will be asked to give a reason why you are refusing to sign:

Refusal Reason:	⬛
	Did Not Document
	Did Not Order

If you refuse to sign an order, HIM will follow up with the appropriate person.

Telephone Orders

The physician is expected to enter **ALL** orders for the patient if they have access to the system. The exception to this is no internet access or while driving a vehicle. You will be required to sign these orders the next time you log into SAC. The nurse will require you to stay on the phone with them until the orders are entered to allow you to acknowledge any and all alerts that are presented to the nurse during order entry.

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SAC Navigation

Log IN Screen

This screen displays a default patient list based on your security settings. Here you will see many rows, columns, flags, and information about the patients on the list. Once the SAC option is chosen from the side bar panel, the side bar may be closed to expand your view.

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Toolbar

Located in the upper right corner of your screen.

Displays the icons used to set user preferences, suspend, and close SAC, and Launch Help icon.

1. **Recently Viewed Patient**
   - Allows viewing of recent patients based on application.

2. **User Preference Icon:**
   - Enables clinician specific settings to be set and reset.
   - **Account Settings Tab**: This is where clinicians can change the password for logging into SAC.
   - **General Tab:** Allows clinicians to select which application will display when SAC is launched (if more than one application is assigned to that clinician).

3. **Suspend Session:**
   - Allows the current application to be suspended and resumed later (if un-suspending on the same device).
   - This helps protect patient privacy and freezes your current session when you are away from the computer and re-l aaTemplate, ...

4. **Log Off Session:**
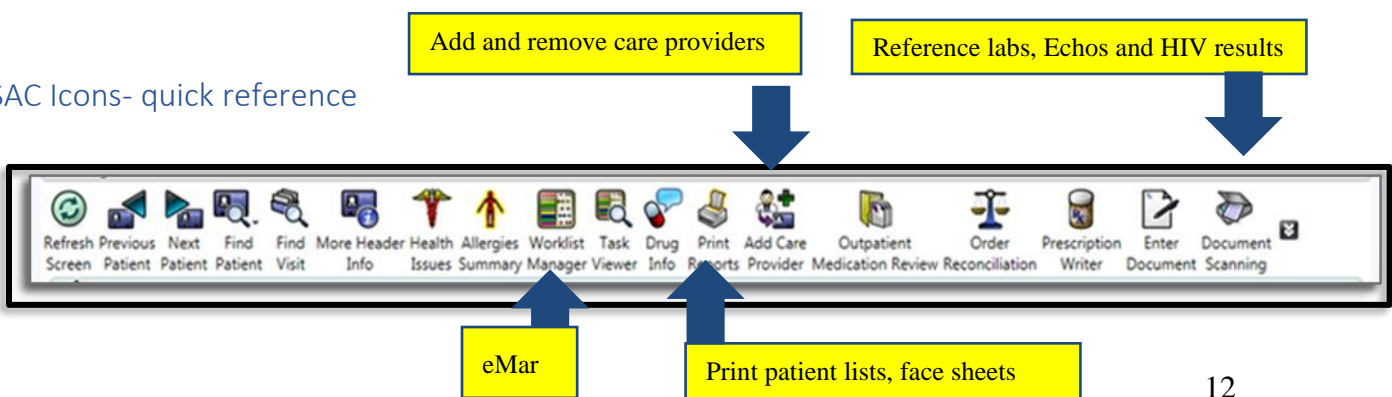   - Closes the open SAC session properly.

5. **Help Icon:**
   - Allows access for clinicians to reference online SAC help. Online help is organized by topic.

Header Information

SAC Icons- quick reference

Add and remove care providers

Reference labs, Echos and HIV results

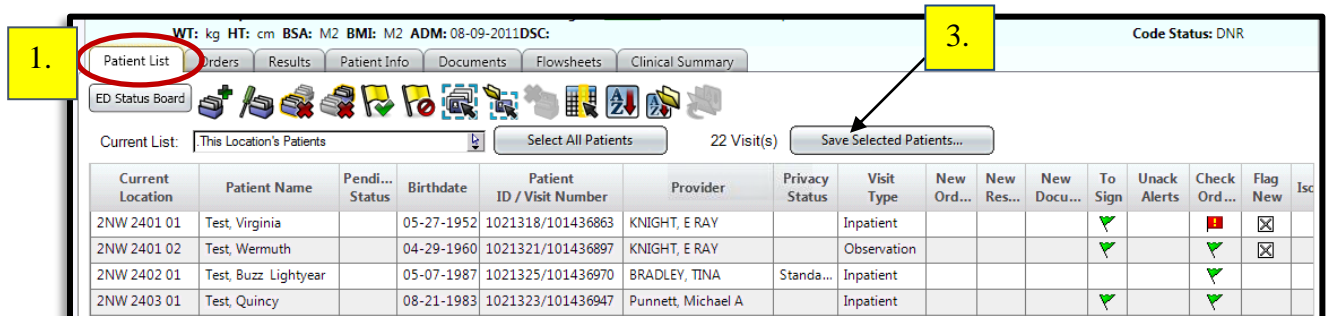eMar

Print patient lists, face sheets

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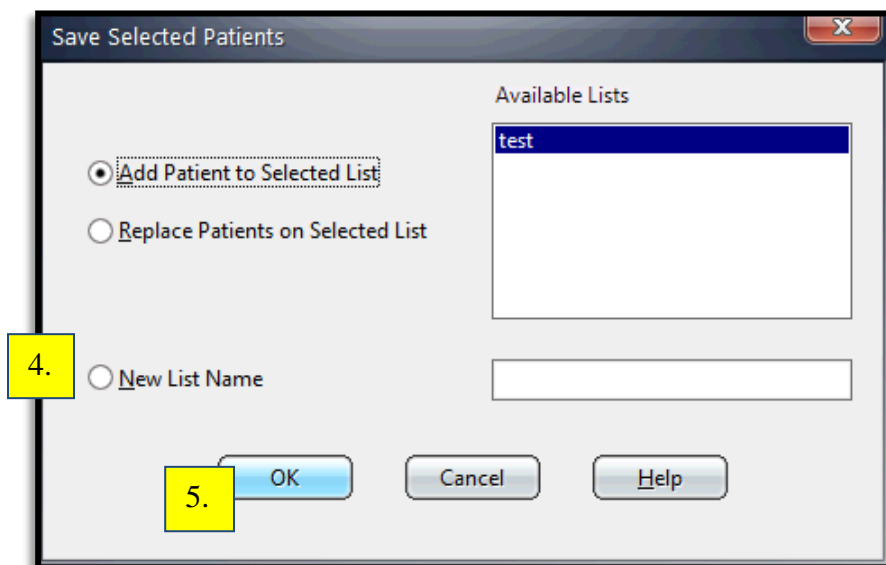
Patient List Tab

The *Patient List* Tab is the starting point for selecting patients and creating Patient Lists. You can create personal lists and criteria-based lists in addition to the preconfigured ones.

Creating a Personal List

1. Select the **Patient List** tab

2. Press and hold the **Ctrl** key to select multiple patient names, then release the **Ctrl** key.

3. Click the **Save Selected Patients** button to display the Save Selected Patients window.

4. Click the **New List Name** radio button and type **Your Name List (ex. Dr. Knight's list)** for the list you are creating.

5. Click **OK** to close the **Save Selected Patients** window, and the system will take you to the Patient List tab, which displays your newly created patient list.

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Maintaining Your Personal List

Personal Lists must be maintained, meaning patients **will not automatically** add or drop from personal lists as they are admitted, transferred, or discharged.

To remove a patient from your list:
1. Highlight the **patient's name.**

2. Click on the **Remove Patient** icon.

➢ A personal list is noted by a * preceding the list name.

➢ Note the similar appearance of these icons:
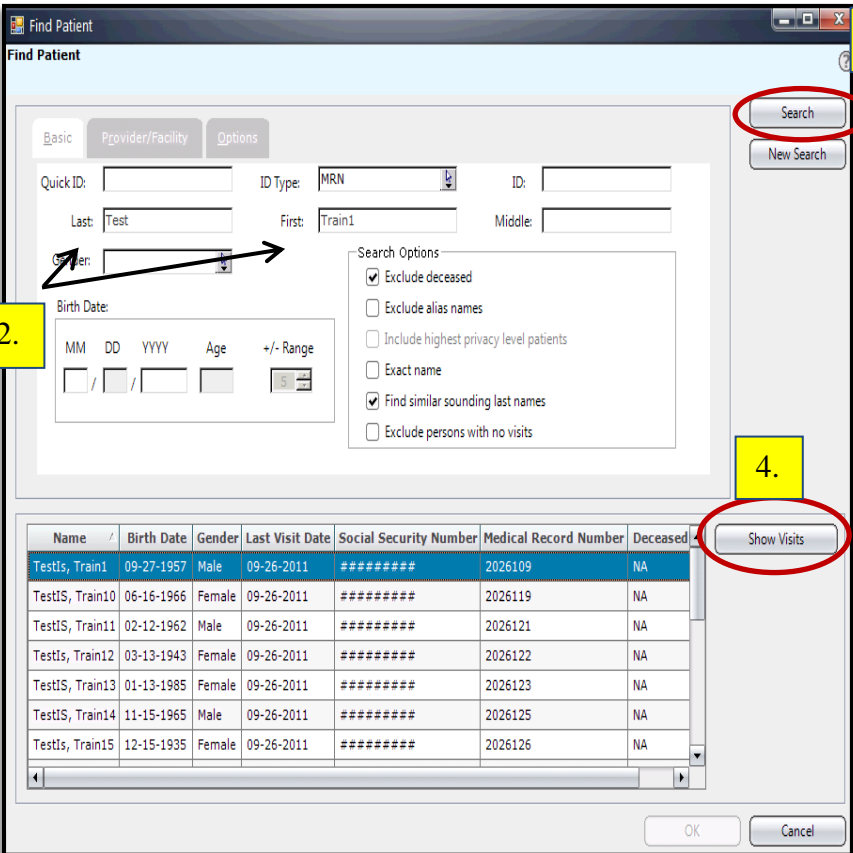
"Delete Current list" and "Remove **Selected Visit**"

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To add a patient that you are not a Care Provider on to your list:

1. Click the **Find Patient** icon.

2. Enter patient's last name in the **Last** field and enter the patient's first name in the **First** field.

3. Click the **Search** button.

4. Select correct patient and click **Show Visits.**

5. Select the visit and click the **Save Selected Patients** button.

6. Select the **Add Patient to Selected List** button.

7. The *Override Chart Access* window will display. In the **Reason** field type *Consult*.

8. Select the list.

9. Click **OK.**

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Creating a Criteria Based List

Another list type you can create is a **Criteria Based** List. Unlike Personal Lists, **Criteria Based** lists update with ADT activity.

Criteria Based Lists are built on certain criteria that you set. For the patient to show on the list they must meet all the criteria you set.

Criteria Based List can be based on any or more than one of the following:
- o   Provider Roles
- o   Patient Location
- o   Providers
- o   Service
- o   Visit Status
- o   Orders

Creating a Criteria-Based List: Location and Provider

1. Select "**New Visit List**" Icon


> The Client Selection Criteria dialog opens:

2. Select the "**Location**" tab
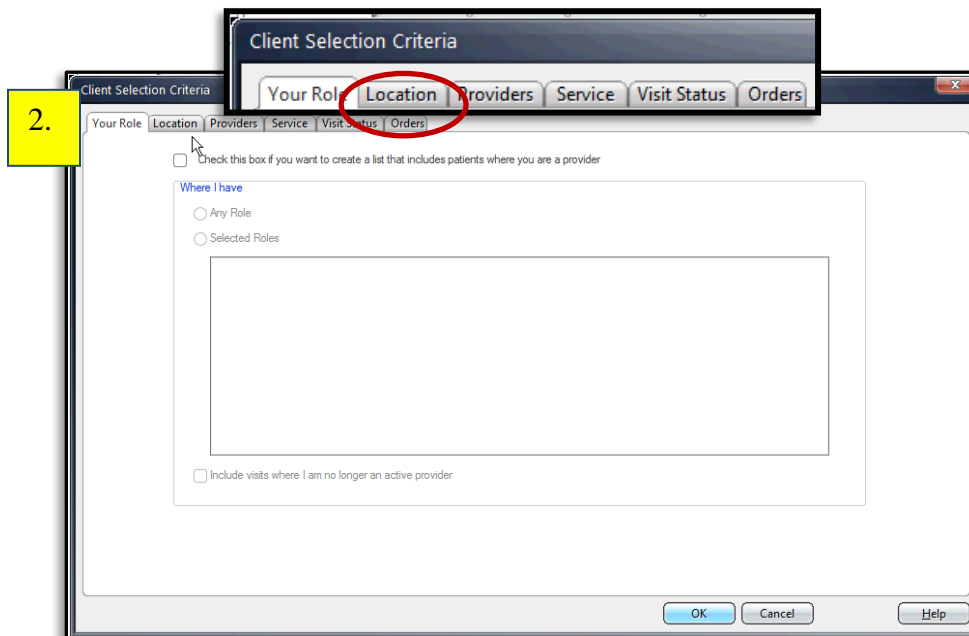
3. Select the **Include patients at selection locations only** option

4. Click the + sign next to Clark Memorial Hospital to expand the list

5. After selection Clark Memorial Hospital, while holding down the Ctrl key, select the + sign next to the units you want in your list.

6. Click Add. (You can select more units if needed)
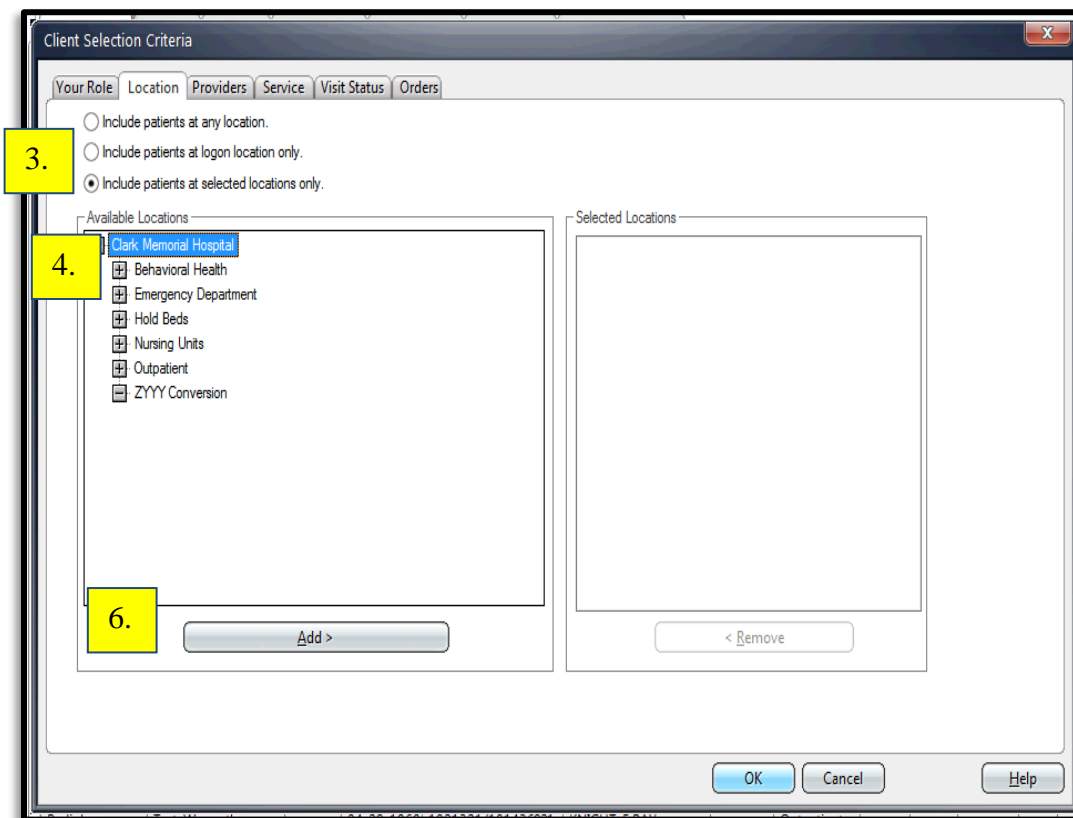
7. Then click on the Providers tab

8. Enter the provider's last name and then highlight their name in the list.
9. Click on the Role drop down box to select their role(s) that you want to add this list.

10. After adding the provider(s), click OK, and name your list – e.g. Location List
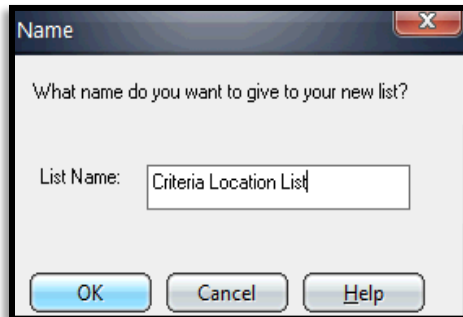
11. Click OK

12. Now your list is available in your drop down of patient lists.

Creating a Criteria-Based List: Location and Orders

Sometimes you may need a list based on more than one criterion. Example of this would be needing a list of all your patients with a PICC line.
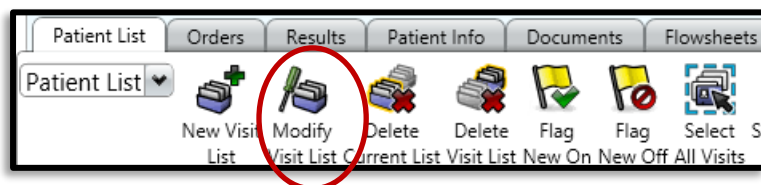
Click the **"Modify Visit List"** Icon

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The Client Selection Criteria dialog opens.
1. Select the **Location** tab:

1.
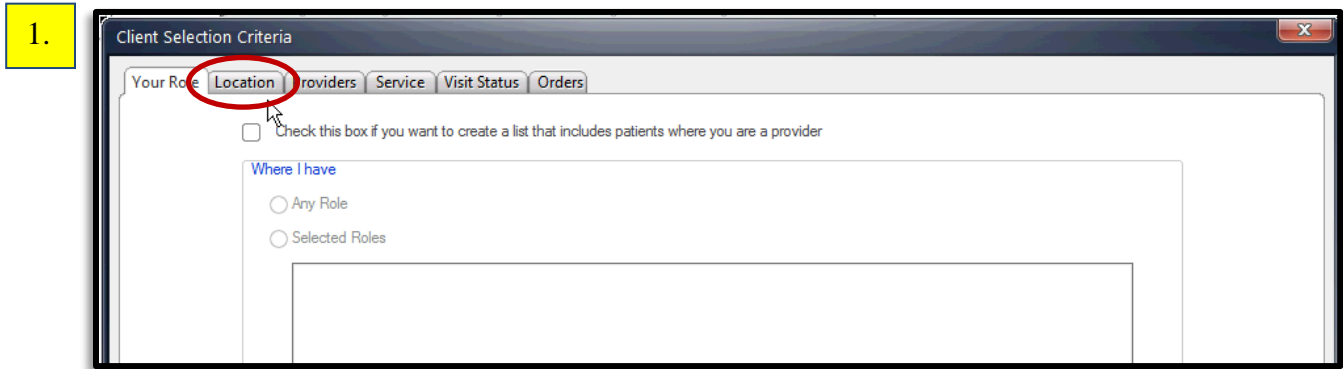
2. Select the **Include patients at selection locations only** option

3. Click the + sign next to Clark Memorial Hospital to expand the list

4. After selecting Clark Memorial Hospital, Select the + sign next to Nursing Units

5. Select the units you want and click Add.
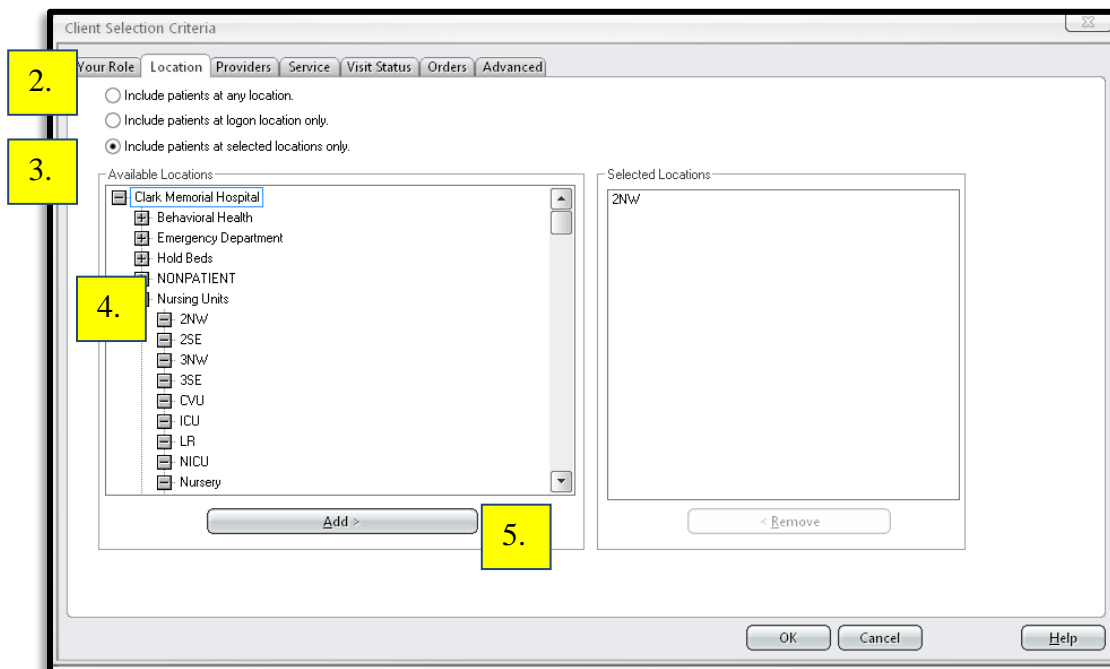
6. Next, select the Orders tab

7. Check the box to create a list of patients that only have orders as specified below

8. Click **Add New** to create an Order Selection Filter

9. Name the Filter.

10. Select the Orders you wish to include, by typing the order names and click ADD to move them from the left to right columns.

11. Next Select Order Status Filter.
12. From here Name the Filter and make the selections needed for your filter.
13. Select OK.

14. Make certain the criteria you have selected are in the boxes

15. Name the List a name of your choosing (e.g. PICC LINE ORDERS) and click OK.

16. The list is now available in your drop down of patient lists:
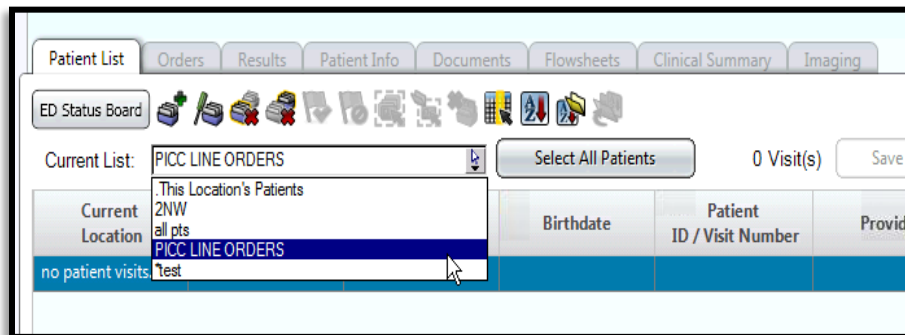
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Flags in SAC
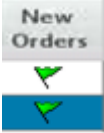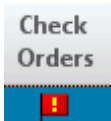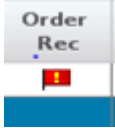
What are Flags?

- Flags alert a caregiver to new things happening within the patient's cart.
- Can alert the user to new orders, new results, new documents, documents that need to be signed, and so on.

Flag Colors/Meanings:

- The ![red flag] indicates that something is of high priority. (Examples: stat orders, abnormal labs, overdue medication reconciliations, etc.)

- The ![green flag] indicates that something is new but of routine/normal priority. (Examples: routine orders, normal labs, new documents, etc.)

- The ![yellow flag] indicates that a new imaging result or a result that cannot be identified as normal/abnormal has been posted in the patient's chart.

Flag Management:

New Orders: **GREEN** - are general orders | **RED** – means STAT orders

Order Rec: **GREEN** – means it needs to be done | **RED** – means it's overdue

To Sign: **GREEN** – means there are orders that need signed | **RED** – you must sign

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Chart Tab Review

Orders Tab

1. Click the **Patient List** tab
2. Select **"Name, Patient**."
3. Click on the **Orders** tab to view their orders.
4. Orders are displayed based on the selections you make in the *Options Panel*, on the left side of the Orders tab.
5. Changing the Display format changes how the orders should be organized (grouped), the Default is *By Department*.

6. This symbol is displayed if you have limited (filtered) what orders are displayed.
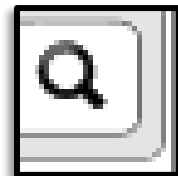
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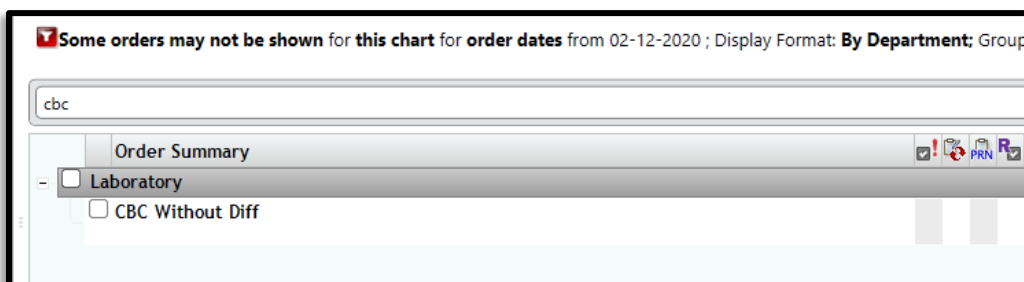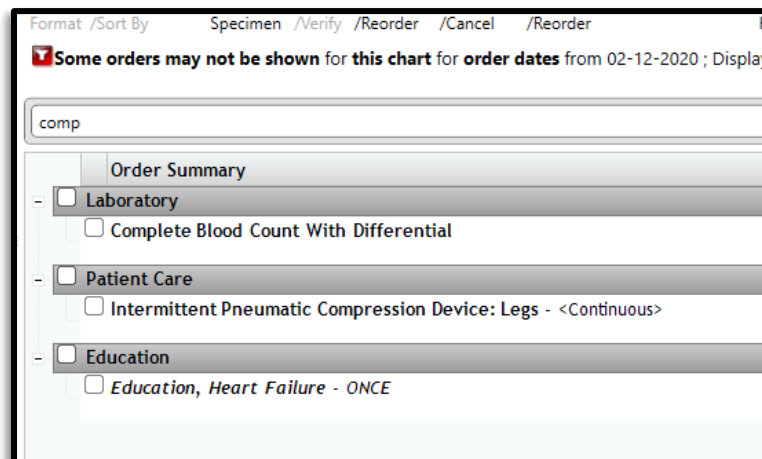
Filters

Orders Search Box

On the orders tab, there is a search box to quickly find orders, rather than using the scroll.
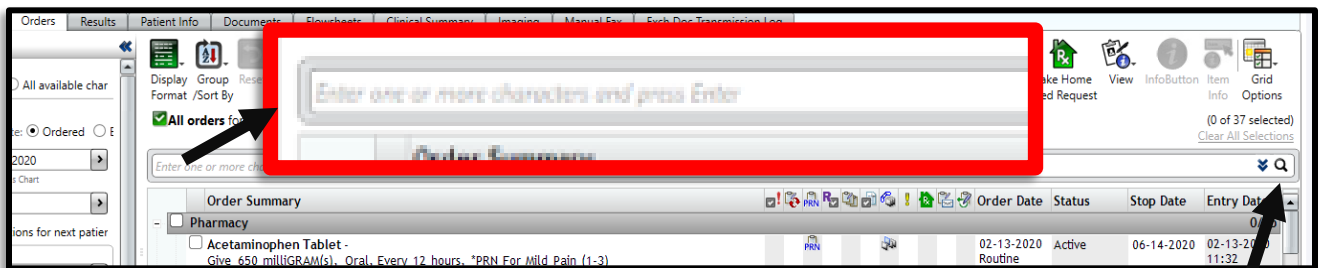
Once you have typed a few letters, selecting the search icon, or pressing enter will begin your search.

Please note that some items are not consistent, such as CBC and Complete Blood Count with Differential:

To undo the search filter, select the [icon] at the end of the search box.
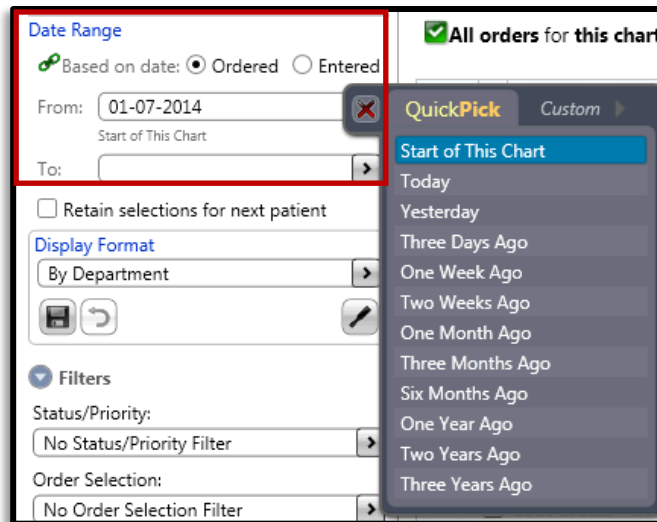
Orders Tab Options Panel

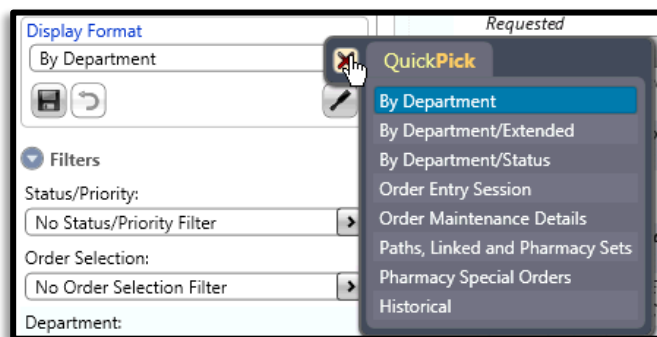1. **Chart Selection** – <u>This chart</u> or <u>All Available Charts</u>

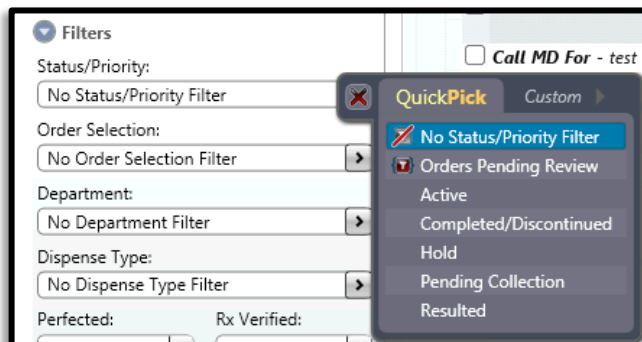2. **Date Range** –

   From: ___ To:___
   or
   Use the QuickPick

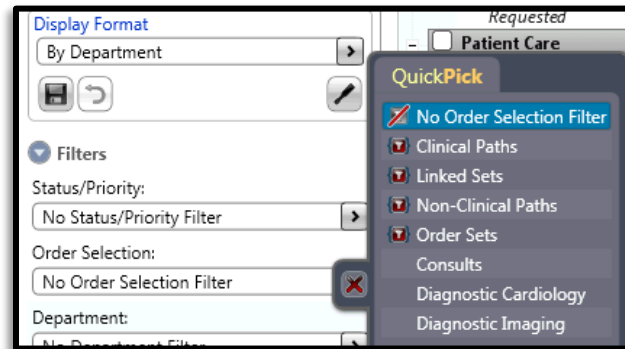
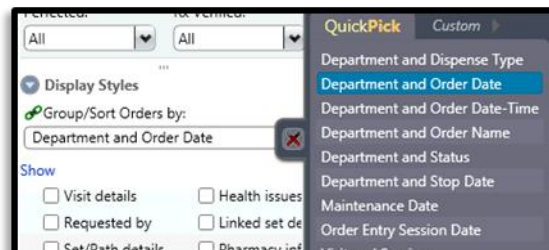3. **Display Format** –

4. **Filters** –
   a) Status / Priority

b) Order Selection

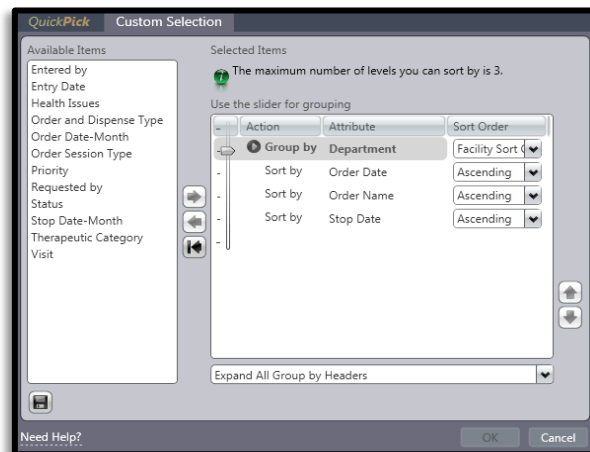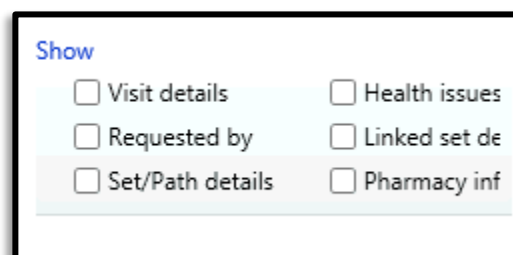c) Department - *(No Department Filter)* is the Default

5. **Display Styles**:

Or Customized:

(THIS IS WHERE YOU CAN SET THE DEFAULT OF EXPANDED OR CONTRACTED HEADERS)
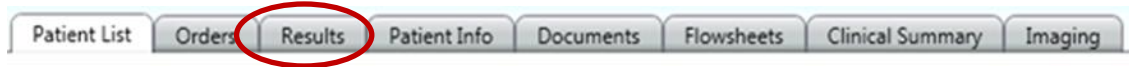

6. You can set your Filters to also display additional Views:

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Results Tab

Clinical Results can be viewed in the Results tab.

The results displayed are based on the selections you make in the **Options Panel** on the left side of the Results tab.

You may also click in the box next to **Abnormal**, if you wish to see **_ONLY_** those test results that have abnormal values.

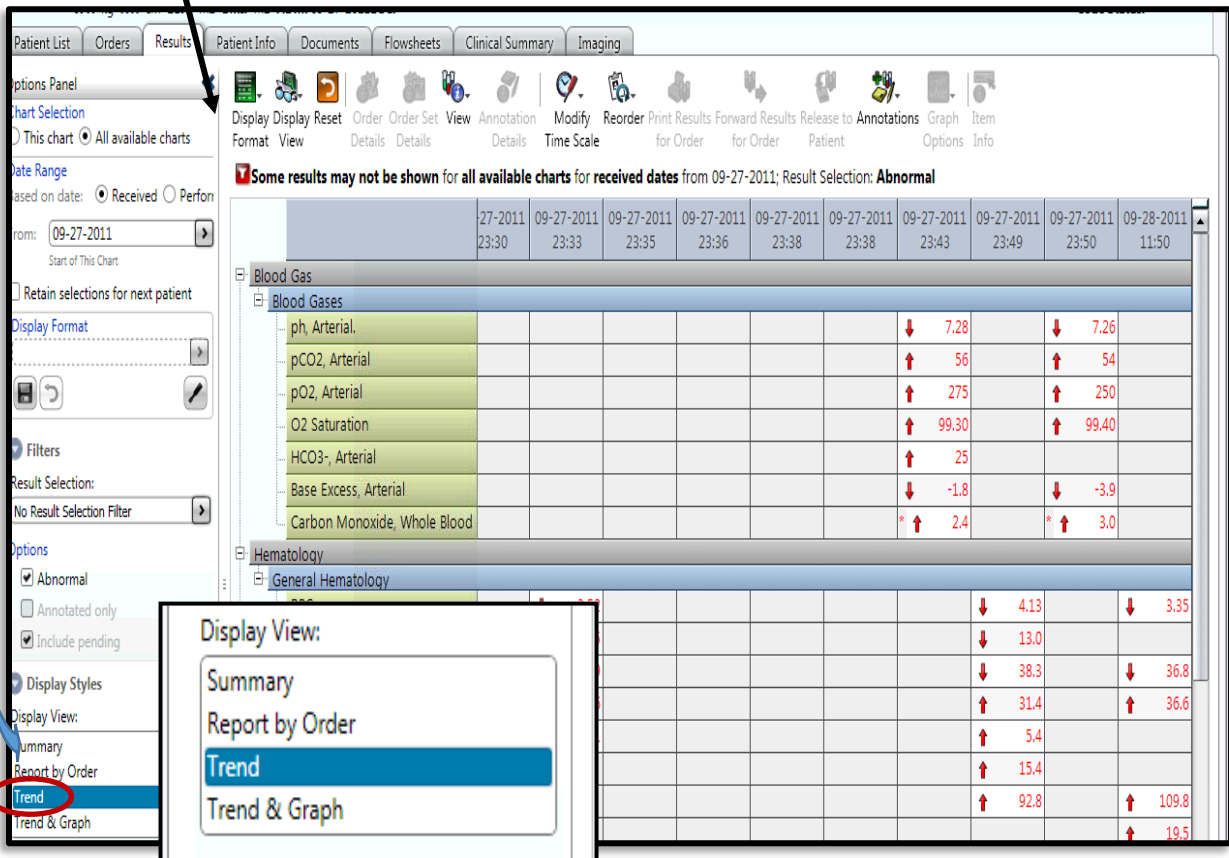# Provider CPOM Training

Results: Summary View

1. Select the **Summary** view to show results grouped in categories (Chemistry, Microbiology, CT and Consults etc.).
2. Select the **Summary** view and click on a Red or Green flag to view individual results

Results: Trend View

Select the **Trend** view to show results at the time they are entered into SAC.

Reminder: This symbol is displayed if you have limited results to be displayed.

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Results: Trend & Graph View
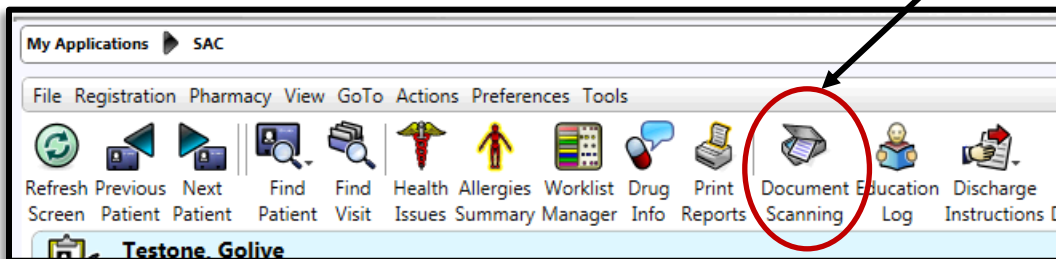
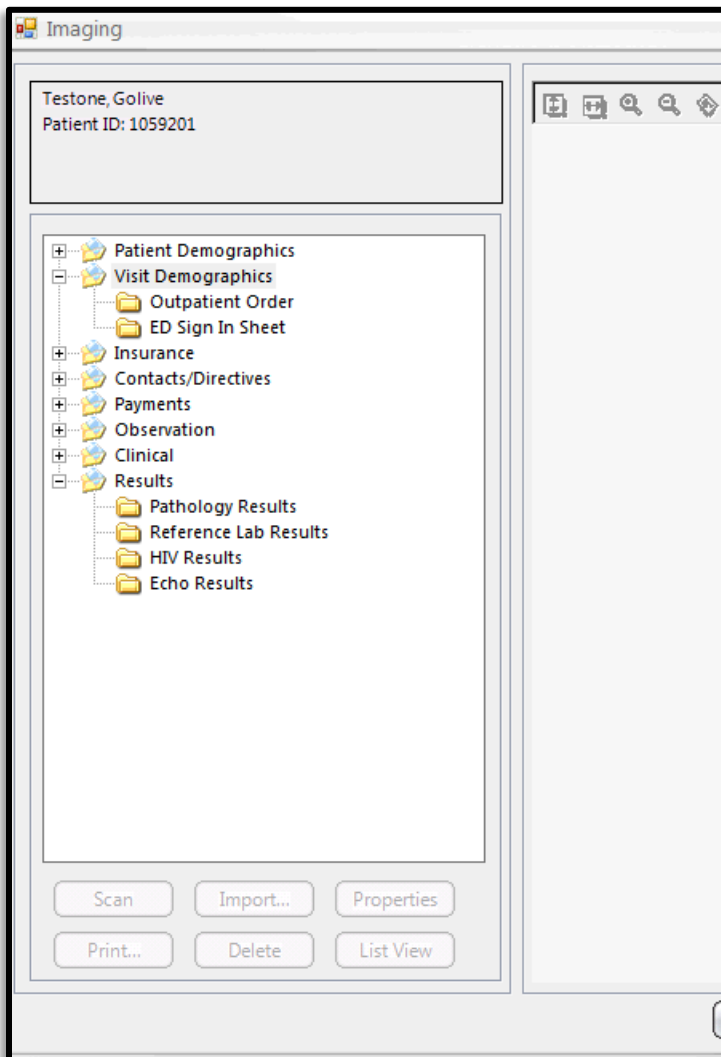Using the Trend & graph option will display the lab values with those values in graph form.
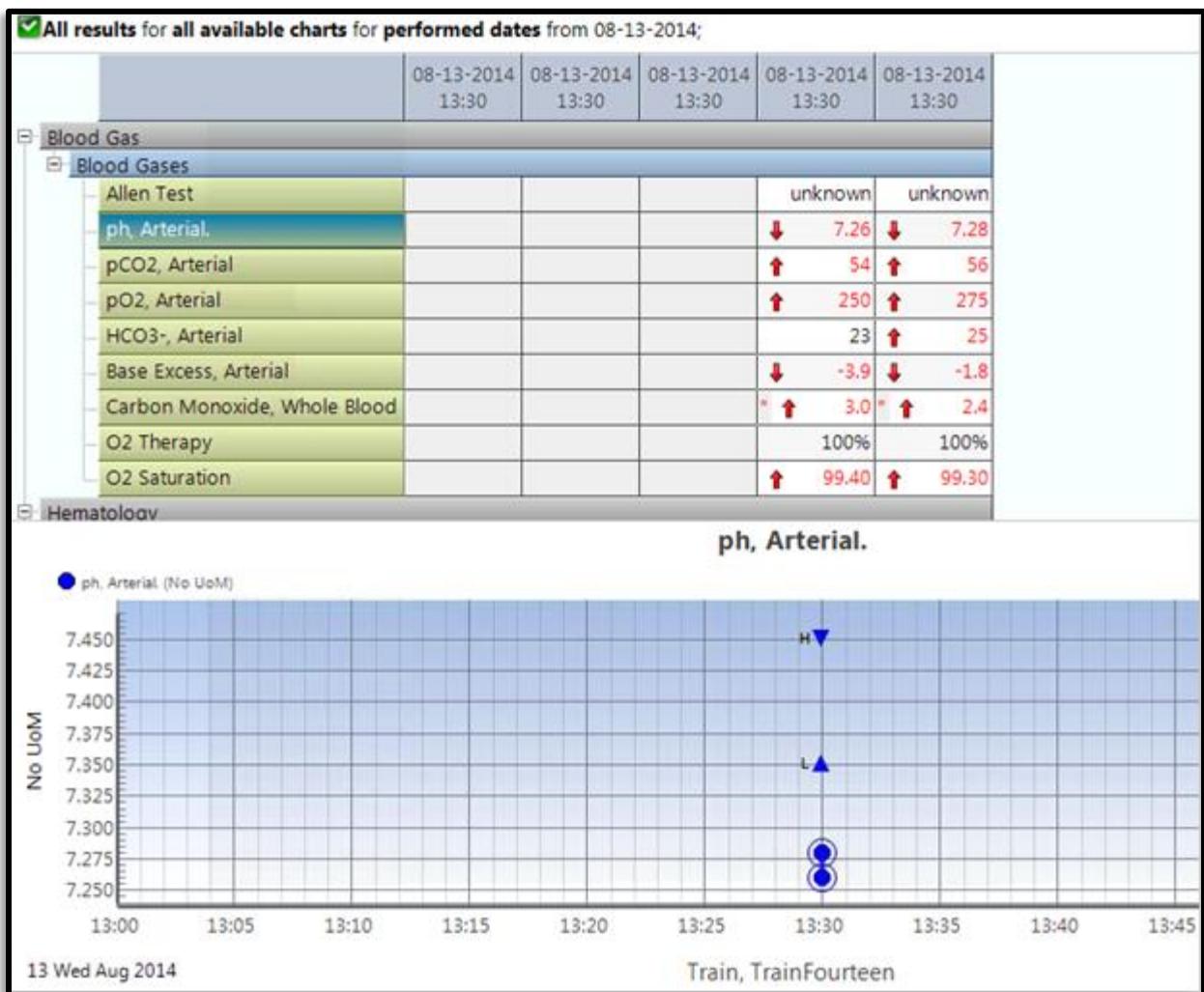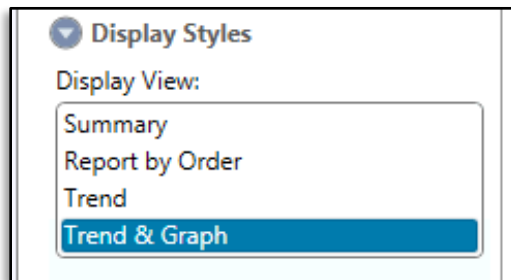
NOTE: Results such as ECHO, HIV, or Reference Labs can be viewed from the Document Scanning icon and only if you have the security right to do so.

1. Selecting this icon will open the menu window for Scanned Imaging.
2. Click on a file folder that has a "+" to view the results in that folder.

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Patient Info Tab

Patient information can be viewed or entered by clicking the **Patient Info** on the main screen.

1. Under the **Summary Views** section, select a category to *display* information
2. Click on the entry for more details.

Role	Provider	Phone	Status	Effective Date	End Date	Entered Date	Org Unit	Specialty
Attending	Trommler, Lloyd...		Active	08-13-2014		08-13-2014 1...	Medicine	Internal Medicine...
Admitting	Trommler, Lloyd...		Active	08-13-2014		08-13-2014 1...	Medicine	Internal Medicine...
Ordered	Lake, Robin (RN)		Active	09-24-2015		09-24-2015 1...	Nursing Services	Nursing
Consulting	Rahman, Zaka Ur...	888-269-9786	Active	12-16-2014		12-16-2014 1...	Cardiology	Cardiology
Consulting	Cardiovascular As...		Active	09-11-2014		09-11-2014 1...	Other	Cardiology
Consulting	aaTemplate, SCE...		Active	08-13-2014		08-13-2014 1...	Medicine	Family Practice
Primary Care	Trommler, Lloyd...		Active	08-13-2014		08-13-2014 1...	Medicine	Internal Medicine...

Summary Views
- Alerts
- Allergies/Intolerances
- Comments
- Care Providers
- Health Issues
- Significant Events

- Addresses/Phones/Contacts
- Demographics/Visit Data
- Financial/Employer
- Visit History

Data Entry
- Address
- Alias
- Allergy/Intolerance
- Care Provider
- Comment
- Contacts/Directive
- Patient Demographics
- Discharge
- Employer
- Health Issue
- Height/Weight
- Insurance
- Phone
- Pregnancy/Lactation
- Significant Event
- Patient Preference

3. The **Data Entry** category allows you to select a form to enter information based on your

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Adding Yourself as a Provider

1. Select your patient from the patient list.

2. Click the **Patient Info** tab.
   - The Patient Info tab appears

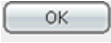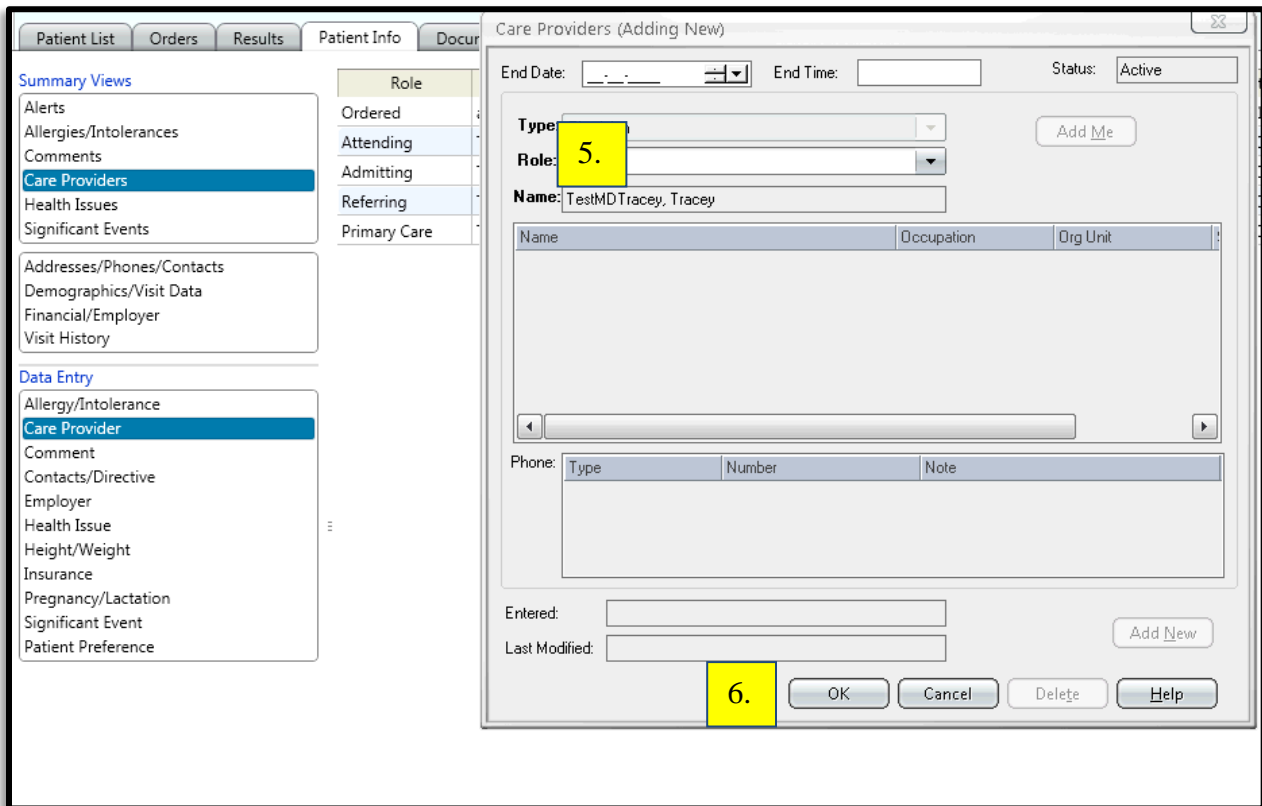3. From the **Data Entry** list, select **Care Provider.**

4. Click the [Add Me] button.

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5. From the Role drop-down list, select your role.

6. Click [OK] .

7. You are now listed as a provider for that patient.

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Expiring Yourself as a Provider

If you are no longer a provider for a patient, you may expire yourself from their list of care providers.

1. Fill in the end date
   –OR-
2. You may pull the calendar from the dropdown menu and choose the date.

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Documents Tab

The documents tab is where you can view all the structured notes and transcribed notes for SAC.

The documents displayed are based on the selections you make in the **Options Panel** on the left side of the documents tab.

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Documents Tab Options Panel

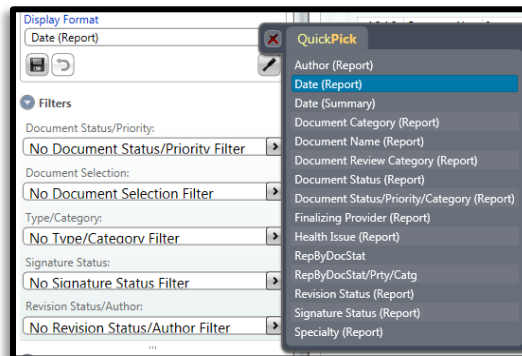Just like the Orders and Results Tabs, the Documents Tab has filter options. These are a few examples:
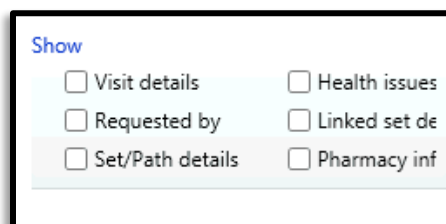
1. **Chart Selection** – <u>This chart</u> or <u>All Available Charts</u>
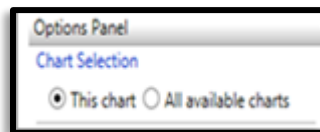
2. **Date Range** – From: ___ To:___ or Use the QuickPick
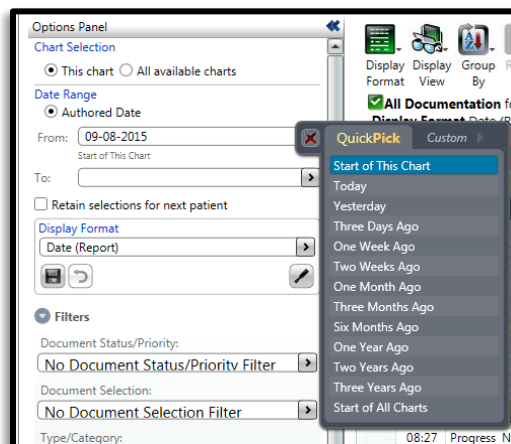
3. **Display Format** –

4. You can set your Filters to also display additional Views:

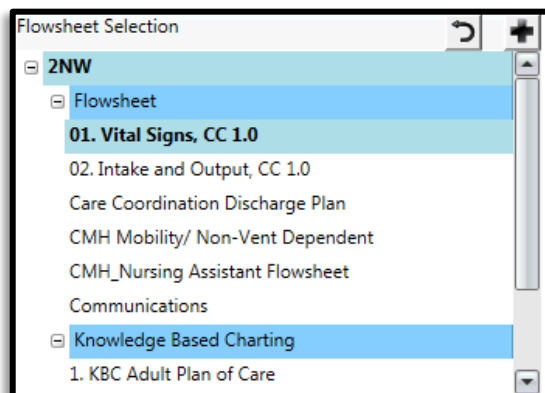# Provider CPOM Training

Flowsheets Tab

Viewing a Flowsheet

Flowsheets can be found and viewed from the flowsheet tab.

A flowsheet is a document that contains information that is entered repeatedly across time, such as Vital Signs and I&O.

1. To get to the flowsheet, first select your patient from the patient list then select Flowsheets from the tabs.
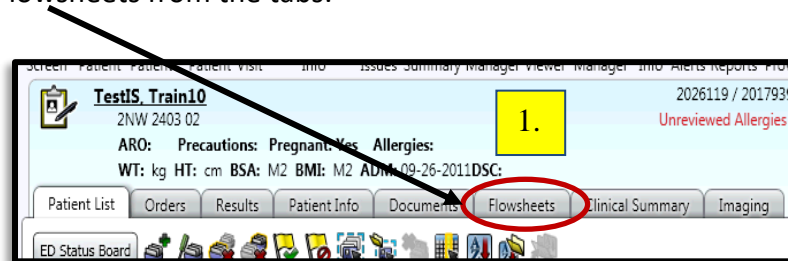
2. Then you can double click on the name of the flowsheet to view.

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Flowsheet Summary View

1. The Summary View of a Flowsheet (located in the Filter section of the options panel) is helpful in finding information without the need to horizontal scroll.

2. Using the Suppress blank rows and columns compacts the information for easy review.

3. The Summary View defaults to "Weekly", however double clicking over the "Weekly" column header will fan out the columns to a daily summary.

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Clinical Summary Tab

The Clinical Summary is a view that pulls together information from throughout the chart in one view. Some tiles are view only; others are interactive for getting more information.

- Select your patient from the patient list then Click the Clinical Summary Tab.
- Each Section is called a "Tile".
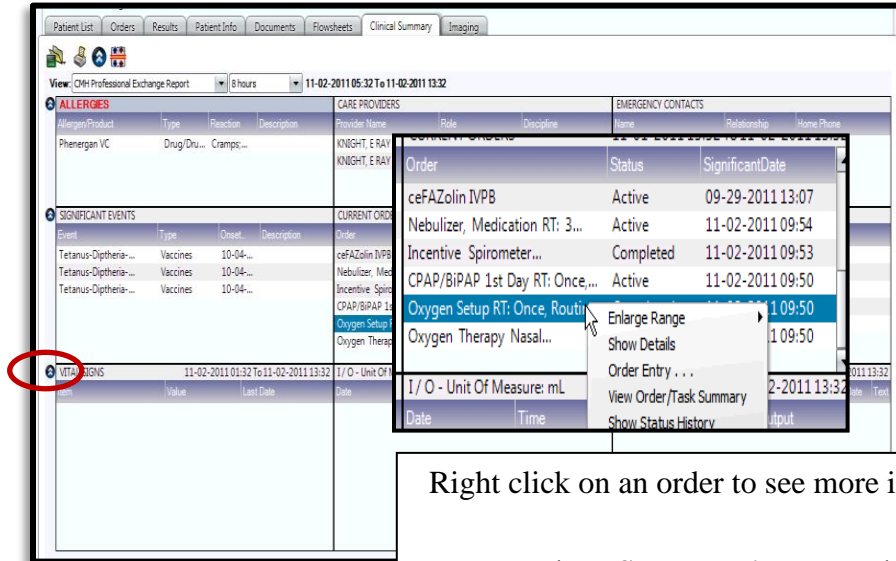- The Clinical Summary defaults to "24 hours". However, you can click the drop down to choose other starting points.

***Notice the arrows to the left of each tile, these arrows allow you to collapse each row.

Collapsed

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The will expand a collapsed set of tiles.

Right click on an order to see more information.

- Select "**Show Details**" to see the original order form.
- Select "**Order Entry**" to put in an order.
- Select "**View Order/Task Summary**" to see task manager view of this order
- Select "**Status History**" to display details about the orders

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Imaging Tab

1. The "**Imaging**" **tab** allows you to see all the patient's radiology/diagnostic imaging statuses and results.

2. This includes both **a.)** Dictated summaries and access to **b.)** Actual radiology images in PACS.

   ** **Please NOTE:** Not all monitors are usable for diagnostic purposes with imaging. Only certain monitors are designated diagnostic appropriate on each unit. Check with a unit staff member as to which monitor is acceptable for diagnostic purposes.

3. You can view "This Chart" or "All Charts" from the drop down menu.

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Order Entry

To Enter an Order

All patient orders are entered in a similar fashion using the Enter Order icon.
All orders are entered into SAC for the inpatient population.

1. Click the **Patient List tab** and select your patient's name.

2. Click the **Enter Order** icon, you are then presented with the order entry worksheet (unless the patient's allergies have not been reviewed).
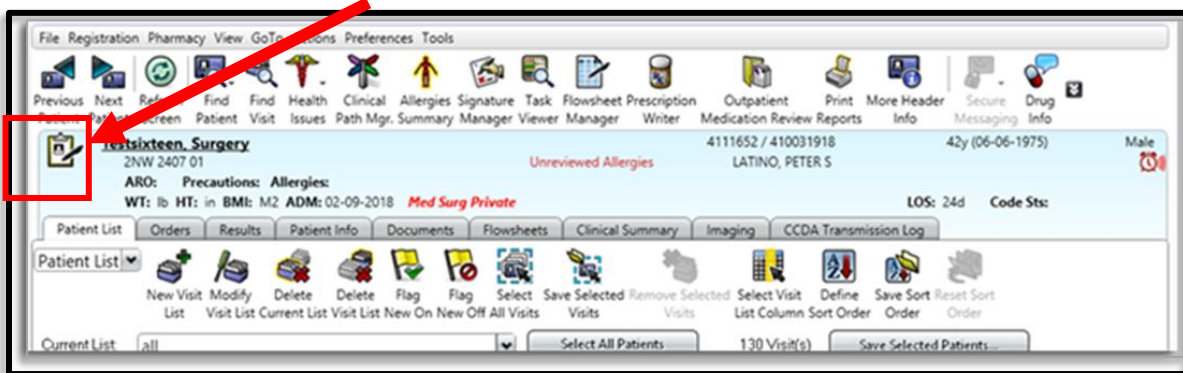
3. If the patient's allergies have not been reviewed, they will present for review.

4. To manage the Allergies, you will a.) Review current allergies or b.) add new to enter the patient allergies
   ➢ *Note: This window will not display if you have previously clicked on the* ***Mark as Reviewed*** *button or if your patient does not have allergies.*
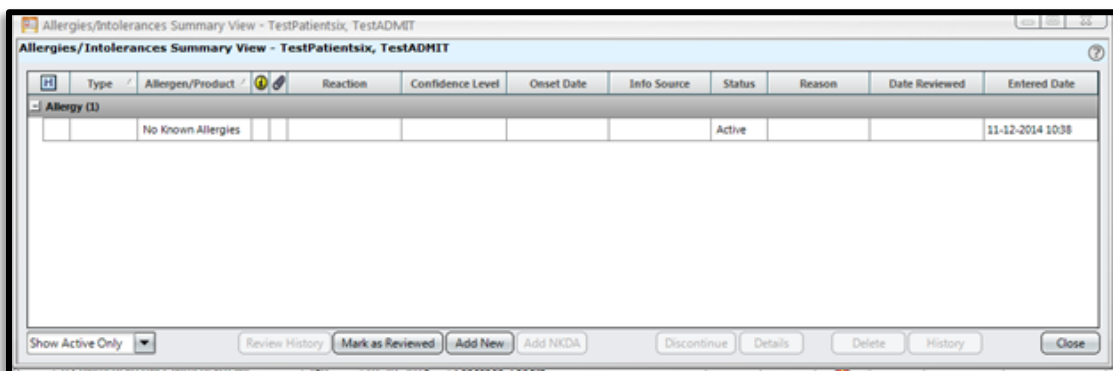
5. Click the **Mark as Reviewed** button to acknowledge you have seen the allergies and the Allergy Summary window will **not** appear the next time you enter orders for this patient. This is only done once a visit.
6. Click the **Close** button to close the window.

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General Order Entry Worksheet Design
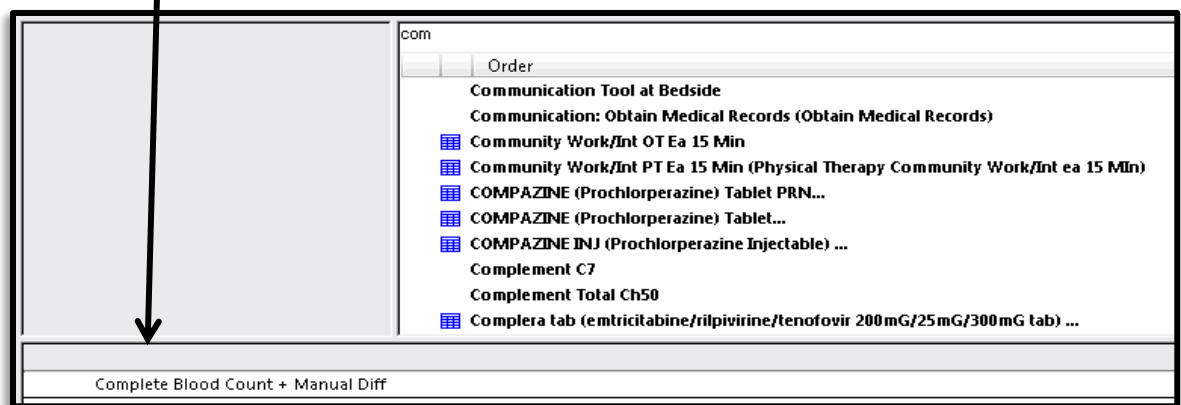

Order Sessions

There are 3 types of Session Types for orders:

   a. **Discharge** – used for discharge orders

   b. **Hold** – used for direct admit orders or post op orders; these orders are to be activated by nursing

   c. **Standard** – *default choice* – used for majority of orders.

Order Entry Icons

- Icons to the left of the options represent information about the item.
- ⊞ The blue grid indicates that the order needs more details to be complete. When you select an order that requires more details (blue grid) the form will open up for you to enter the details. Some fields will already be populated with data but can be changed if it's not what you are wanting.

- The icon with the blue link and the file type icon indicate these are linked order sets. A plain order set does not have the link. An order set is a group of orders that covers multiple department orders.

- Orders that do not have a blue grid are complete orders that when selected will move to the order review pane.

- You can select one or more orders to be entered during an order entry session
- The order review pane will also display when the order is to be active/acted upon.

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Individual Worksheet Fields

a. The field with the red star indicates this is a mandatory field that must be entered before this order can be submitted.

b. The icon at the end of the Signs and Symptoms box indicates that the field can be typed in or select from one of the options that present.

c. A Conditional Order is available to enter a specific "condition" that must be met before the test is to be done. The Nurse activates the order when the condition is met.

Routine Orders

Routine orders that need to be done sometime today: there is no need to indicate a time, date, or priority.

1. Select your *patient's name* from the **Patient List** screen.
2. Click the **Order Entry** *icon* from the tool bar.
3. Select "Me" for the ordering physician, if required.
4. Leave the **Session** type as Standard.
5. Leave the Date and Time fields as is.

6. Type in the order name (example here is CBC)
7. **Select CBC (Complete Blood Count)** and click **Add**
8. If you had additional orders you could go back to the type in field and type another order name and proceed.
9. When you are finished adding orders, review them for correctness in the basket.
10. Click "Submit {patient's name} -----this is a safety feature
11. Type Password and click OK
✎ If a test has more than one common name, the other common name will be in parenthesis.
   i.e.-- CBC (Complete Blood Count)

Priorities Other Than Routine

If you have an order that needs a priority other than Routine, open the order by selecting "View" and the order worksheet will open.   The other Priority choices available are:

- ➢ The "AM" designation will order for the following morning.
- ➢ STAT
- ➢ The "Time Critical" designation will require a date and time

- ➢ Urgent is not used.

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Repeat Orders

1. To place a repeat order, select the [Repeat] button on the bottom **LEFT** of the order entry worksheet.
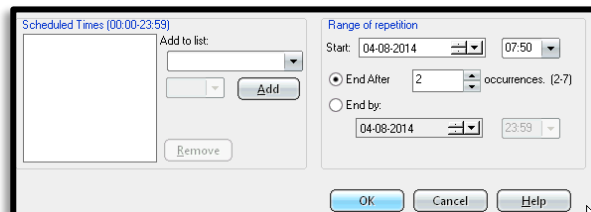
2. Orders can be repeated: Hourly / Daily / Weekly

3. You decide when to start & how often:
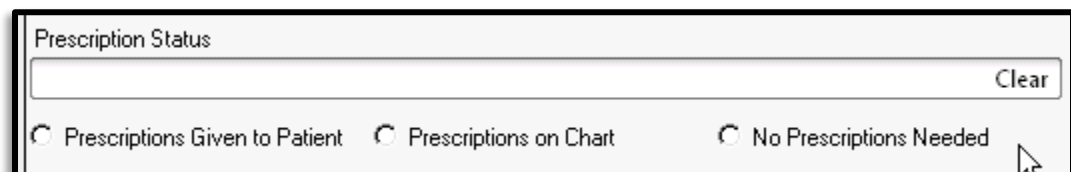
   - The defaults for occurrences are 2 but can be changed to meet your needs.

   - ✎ Sometimes you will see "**checkboxes**" which allow you to select "**more than one option**".
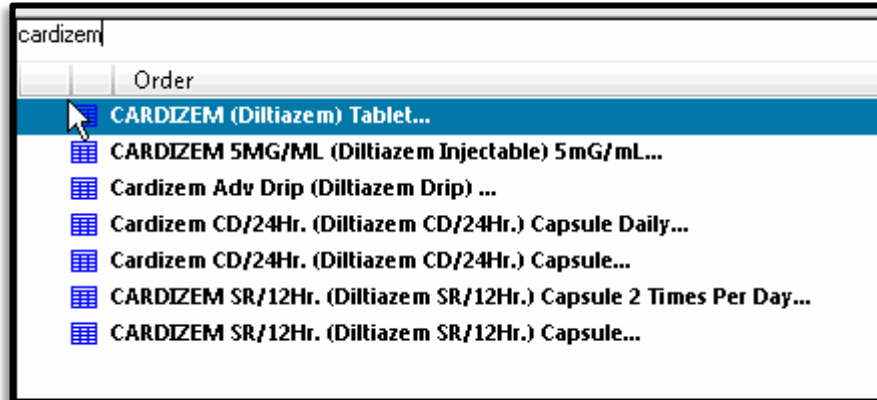
   - ✎ Other times you can see "**circles**" that allow only **one choice**:

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Medication Order Entry
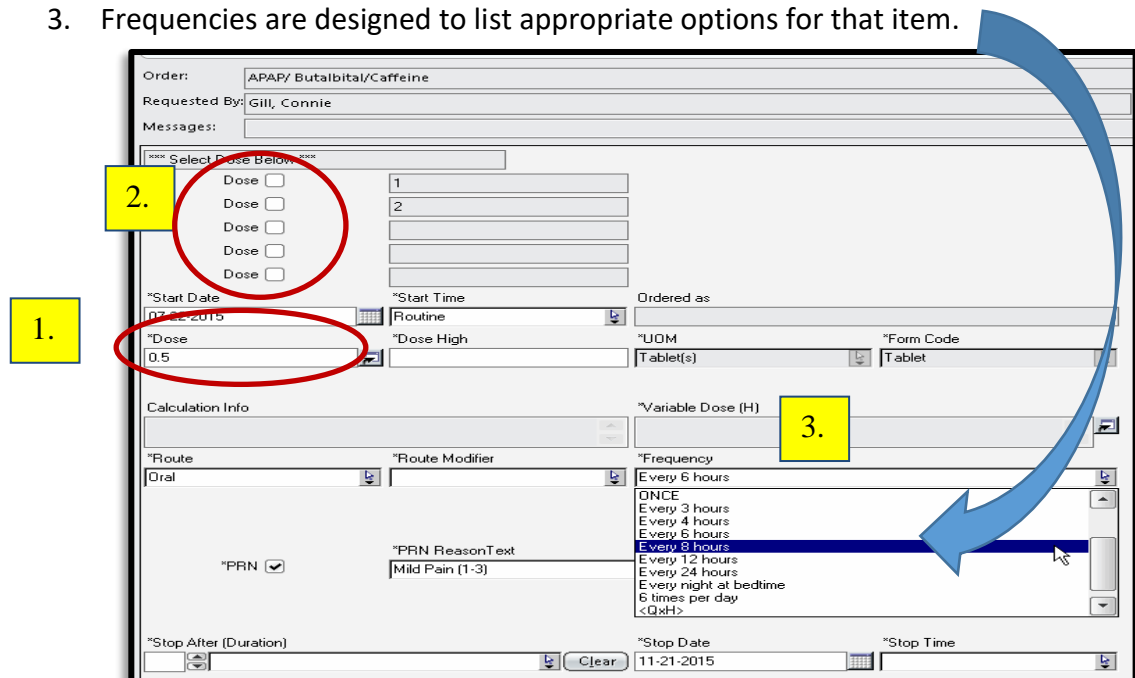
- When ordering medication depending on the order there may be items that are complete, but most require you to enter the dose desired.
- The screen shot shows the different administrations but still require a dose to be selected.

- ➢ Therapeutic substitutions are configured in SAC for items that are non-formulary at CMH.
- ➢ Medication forms default with options that complete the necessary fields to complete an order.
- ➢ Not all substitutions are a 1-1 for dosages.

Medication options and how to use them

1. The dose field is required and several of the fields are prefilled in for ease of order entry
2. You can either type in a dose or use the check boxes at top of form to complete the dose.
3. Frequencies are designed to list appropriate options for that item.
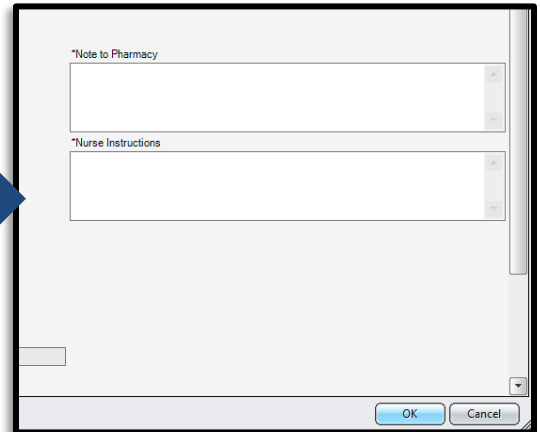
1. The above example shows that you can type in a dose other than the options listed (remember to check the unit of measure whether it is in mg/mcg/tablet/capsule). Some forms are not eligible for fractions. For frequency you may need to slide the bar down to find the frequency you are looking for.
2. If you want the medication to be given only over the next 24 hrs or X2 days, you will want to complete the Stop After (Duration) field.
3. Medications that require different doses at different times of the day **will require separate orders**. Typing in dose changes is not the correct way to enter those orders.
4. For medication that you want the first dose to be given stat you only must change the Start Time from Routine to Stat. This lets nursing know to give first dose now. Then the frequency that you have entered will schedule the future doses.

On the bottom, right side of the form are additional fields that can communicate to pharmacy or nursing any specific instructions you may have for administrations of the medication.
*These areas are not appropriate for dosage changes or titration directions or additional orders.
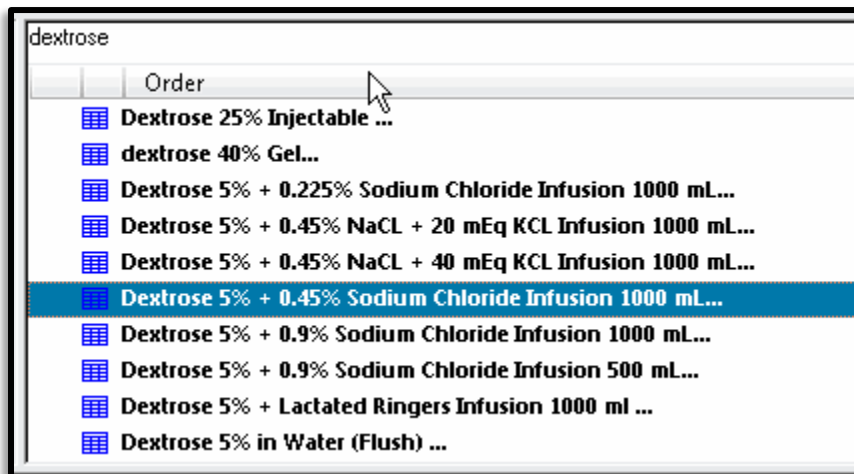
IV Order Entry

- The IV order is displayed with different concentration and amounts of solution.
- Select the intended item to open the form
- Some items are displayed with pre-mixed concentrations of KCL

- The IV Rate (**a**) is the only required field, but you can also use the Total Volume (**b**) to order an item to be given- for example X 3000 ml - and using the stop after field (**c**) to make the order specific to the patient's needs.

- When you select the icon at the end of the IVAdditive Calc field-------

it opens the additive box so you can add additional medications to the IV solution.
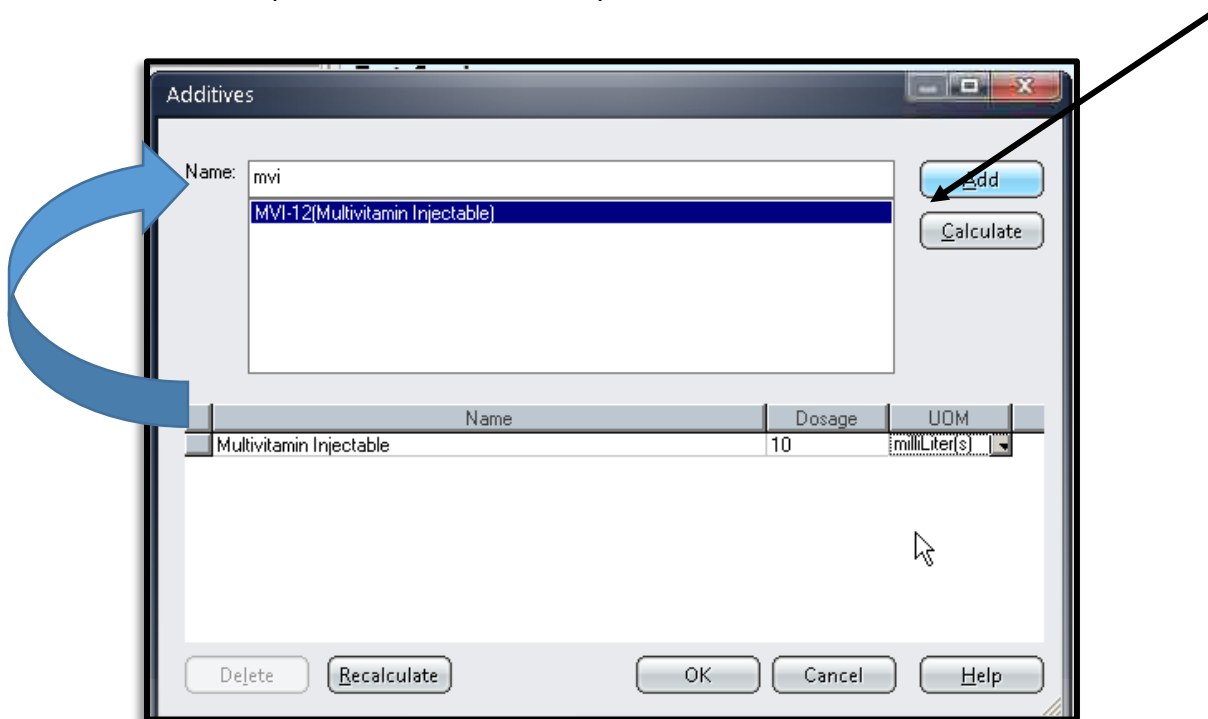
- First type in the additive name, select the additive and then Add, once the additive is in the lower box you will need to enter the dose and UOM.

- When you select OK the additive will display in the IVadditiveCalc box and be a part of the order on the orders tab.
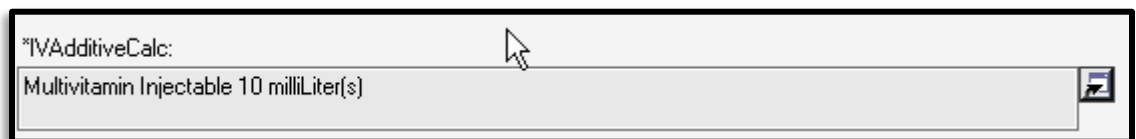
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Radiology Test Order Entry

You can type the name of test you are looking for or use the Start of Browse.

- o Xray
- o MRI
- o CT
- o US

The list is all the tests that can be ordered for that department.

- Radiology test entered on female patients from the age of 12-50 will require you to answer if the patient is pregnant. There is an option of unknown and that requires the technician to determine this before the test can be done.
- Signs and Symptoms are required for radiology tests. R/O is not an acceptable entry.

Lab Order Entry

- Type in the name of test you are looking for or use the Start of Browse.
- You can "double-click" the name of the test, and it will show up in your pending orders and scheduled as "Routine".
- If you "view" the order:

- The current date is already populated. If this is correct, you can then select the appropriate Collection Priority/Time.

- If you want the lab test to be done at a later date, you will need to use the calendar to enter the correct collection date and select the appropriate Collection Priority /Time.

Order Search

All patient orders are entered in a similar fashion using either *Start of Browse* or *Manual Entry* (Type here to enter order name).
Order Entry Options

1. *Start of Browse* allows you to browse various orders from a hierarchical tree structure and then select your order.
   - When you select the "+" to the left of an item it will either open for more specific options or will display all of the options for order entry in that category.

2. M*anual Entry*, the "*Type here to enter* order" name field

   allows you to type in part or all of an order item name (i.e., ABG, urine, cbc, etc).
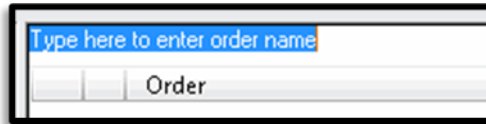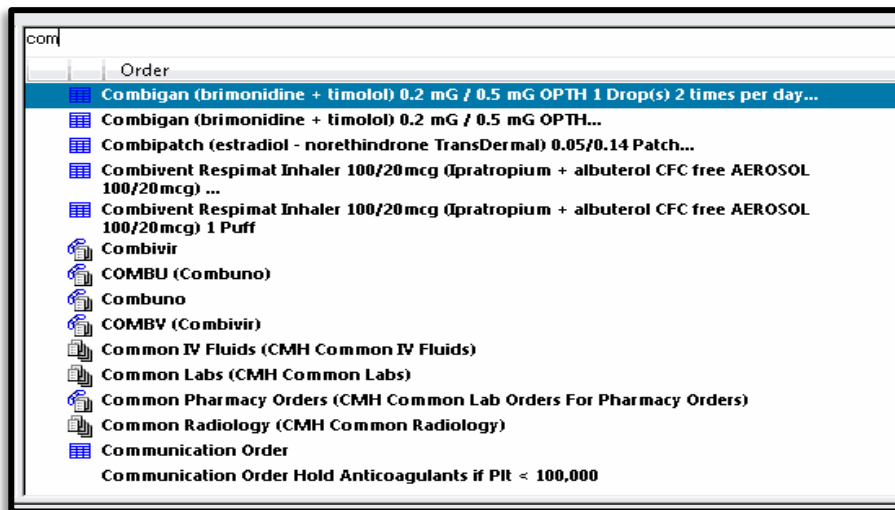
- When the <u>Type here to enter order name</u> is blue you can start typing to find the order you need to enter.

- Note: The more you type the less options you are presented with

3. You also have the option of saving your favorite order sets for easy reference. By choosing "*My Favorite Sets*" from the drop-down menu, you can view your already saved order sets.

- To add order sets to your favorites, highlight the name of the order set and choose "*Add to Favorites*".

Order Sets

Order sets of various types are available for various conditions.

Common Order Sets

There are common orders ets that can expedite order entry. They contain the most commonly ordered items of their type: IV Fluids, Labs, Labs for Pharmacy, Radiology, and ED Medications.
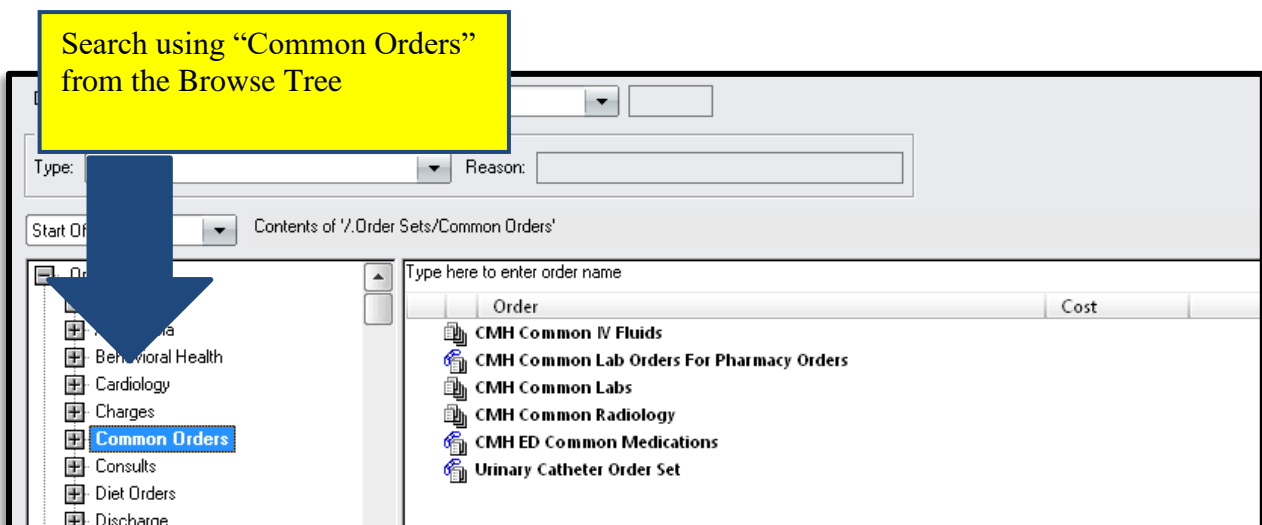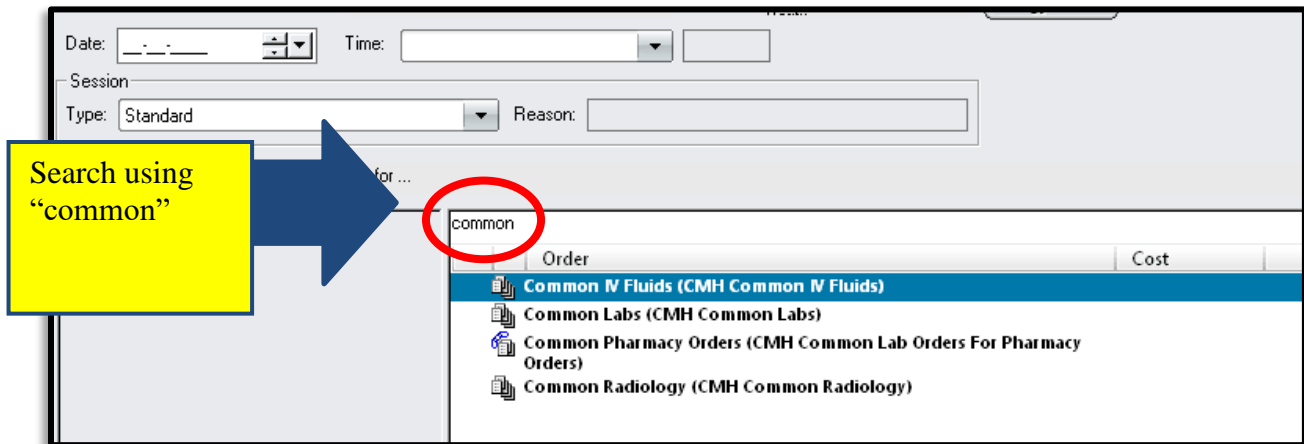
Blood Bank Order Set

1. When ordering Blood Product and Transfusion, the order set allows for entering type & screen as well as ordering product.

2. When ordering blood, first complete the required fields at the top of the order form. (These will then populate the orders you select from the grids.)

3. TRANSFUSION REASON: There is a drop down with suggested reasons, but the field allows for doctor to free text a reason not listed.

4. TRANSFUSION GIVE/HOLD: Select status of blood product—Give/Hold/Conditional.

        Give = give now.

        Hold = Hold, will probably order to transfuse in 24-48 hours.

        Conditional = if specific condition met, want nurse to transfuse; but *only* if condition met.

5. SICKLE CELL Question: This is a mandatory question that blood bank needs answered to do the crossmatch checking on the blood.

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6. Number of Units: Enter number of units needed

Patients must have a **Type + Screen** for blood products. It is valid for 72 hours.

- If the patient has a **_current_** Type + Screen, it will show in the 'Relevant Results' box.

- If the patient does not have a **_current_** Type + Screen, the box will be blank

  *If results are present, please uncheck the box for 'Type + Screen'.**

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✎ With the questions answered on the top of the form, once a blood product is selected it automatically fills in appropriate fields and selects the transfuse now order.

Managing Order Alerts

1. Managing alerts when presented ensure that the most current order is active.
2. The alert presents the current order in process and the duplicate order for review:

3. In some cases, it is appropriate to keep both orders. To do so, click "Proceed".
4. Managing alerts can be done by selecting the "View Actions…" button.
   a. By selecting view actions, you can choose what to do with both orders.
   b. Exiting or cancelling the current screen (possibly losing any other orders already entered) is not necessary.

5. The first order presented is the order trying to be submitted.
   a. There are 3 options to manage this order:
      i. Cancel
      ii. Modify
      iii. Keep

6. The existing order is displayed for review.
   a. There are 3 options to manage this order:
      i. Modify
      ii. Suspend
      iii. Cancel

Practice: Enter the following orders
   These are examples only
   1. Diet – clear liquids,
   1. Diet – NPO after midnight
   2. Activity – Activity – ambulate with assist, up to chair 2 times/ day
   3. Orthostatic Blood Pressure/Pulse 2 times a day. Stop after 5 days.
   4. Notify MD – Temp >101
   5. Troponin q8hrs x3
   6. EKG – unlimited conditional order; when patient complains of chest pain.
   7. CT PE protocol – symptoms SOA/Chest pain (patient takes metformin)
   8. Consult – Internal Medicine for medical management
   9. 500ml LR bolus 999ml/hr, stop after 1 dose
   10. LR @ 100ml/hr (start after LR bolus)
   11. Sucralfate 1 gram PO once a day
   12. Docusate Sodium 100mg 2 times a day
   13. Flagyl 500mg IV every 8 hours
   14. Ativan 0.5mg 2x a day IM prn anxiety/agitation
   15. Maalox Plus 30ml every 8 hours prn indigestion
   (**Submit** orders when finished)

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Admitting a Patient

✎ The workflow for admitting a patient is Reconciling Home Medications then placing the Admission Order Set.

Order Reconciliation Manager
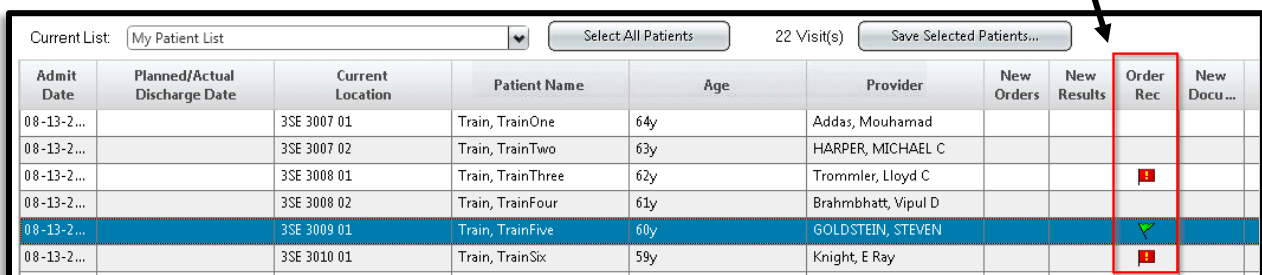
There are three Order Reconciliation types:

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Admission Medication Reconciliation

Upon admission, the patient's home medication list must be reviewed to -
- address continuing/discontinuing home medications for the patient visit
- modify the dose/frequency of home medications during hospitalization
- not continue the medication during this hospitalization

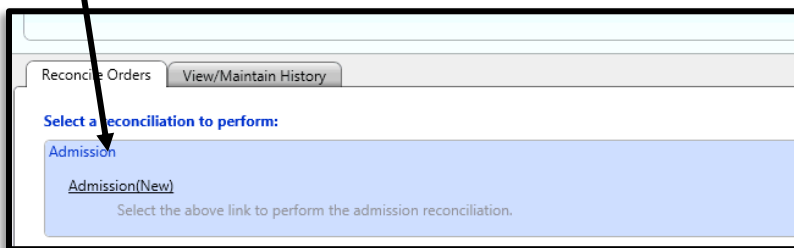**When a patient is admitted, a flag is triggered in the Order Rec column on the patient list.**

Current List: My Patient List				Select All Patients	22 Visit(s)	Save Selected Patients...				
Admit Date	Planned/Actual Discharge Date	Current Location	Patient Name	Age		Provider	New Orders	New Results	Order Rec	New Docu...
08-13-2...		3SE 3007 01	Train, TrainOne	64y		Addas, Mouhamad				
08-13-2...		3SE 3007 02	Train, TrainTwo	63y		HARPER, MICHAEL C				
08-13-2...		3SE 3008 01	Train, TrainThree	62y		Trommler, Lloyd C			!	
08-13-2...		3SE 3008 02	Train, TrainFour	61y		Brahmbhatt, Vipul D				
08-13-2...		3SE 3009 01	Train, TrainFive	60y		GOLDSTEIN, STEVEN			▼	
08-13-2...		3SE 3010 01	Train, TrainSix	59y		Knight, E Ray			!	

To Complete the Admission Order Reconciliation:

1. Either double click on the flag in the Order Rec column or click on the *Order Reconciliation* icon

   Order Reconciliation

2. Select to perform the Admission Reconciliation

   Reconcile Orders   View/Maintain History

   Select a reconciliation to perform:

   Admission

   Admission(New)
   Select the above link to perform the admission reconciliation.
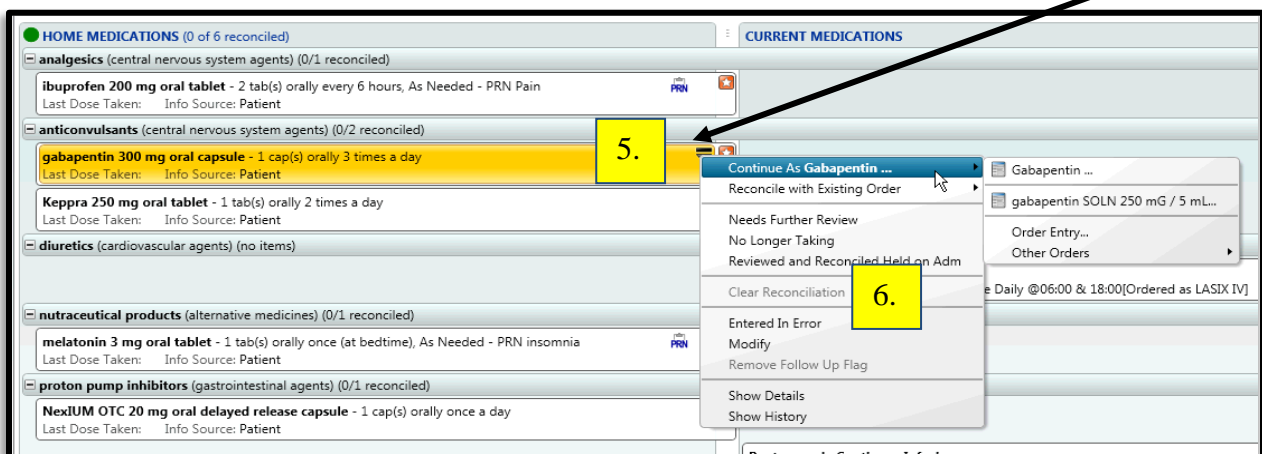
3. When the reconciliation manager opens, home medications entered will appear on the left.
4. Current, active orders will appear on the right.
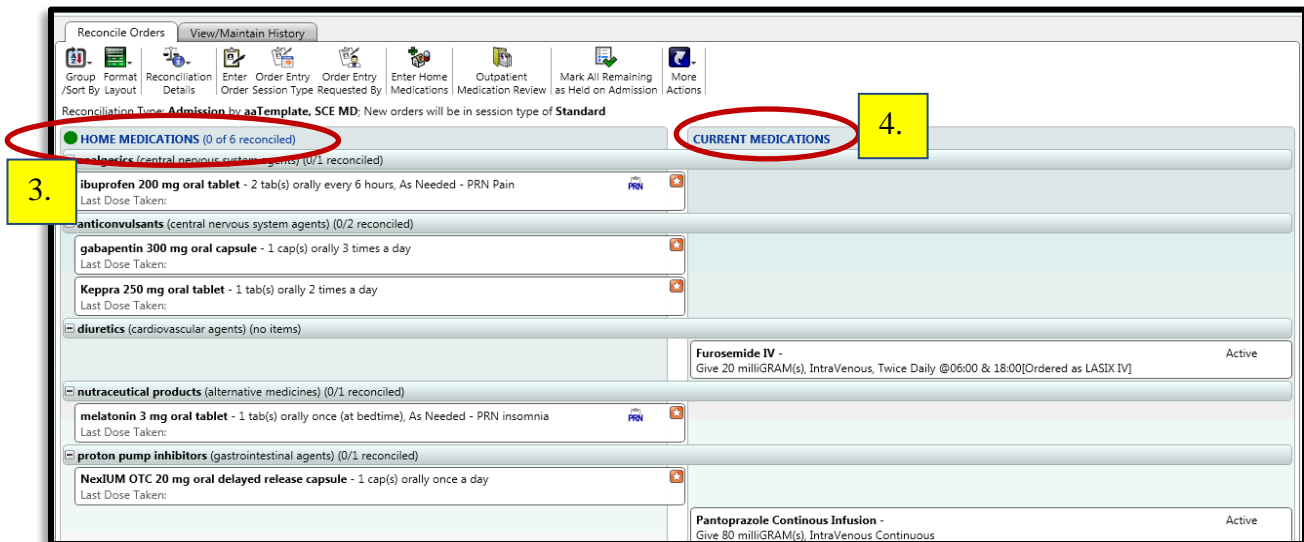
5. To take action with a home medication, hover over the medication name and click on the
6. Choose the appropriate action for that medication.

7. If continuing a home medication, look for **bold print**. This indicates a best match for that medication. Click on the **bold name** to continue.

8. To save time, you can just mark which home medications should be continued using steps 4-6 above. Then for all the medications left (which will be held on admission), simply click the *Mark All Remaining as Held on Admission* icon in the toolbar.
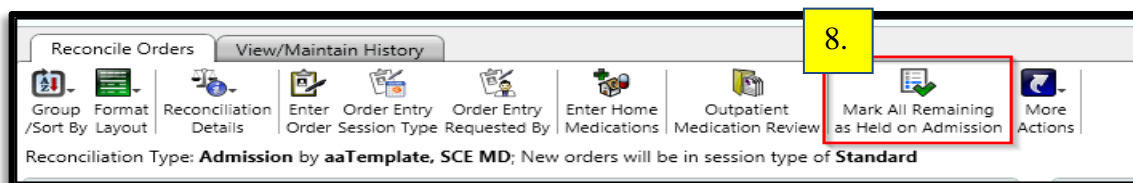
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Admission Order Set

1. The Enter Order Icon [Enter Order icon] allows you to perform order entry, such as the Admission Orders. Selecting the Enter Order Icon will take you to the Order Entry Worksheet.

2. Then you can type "Admission" which will bring up the Admission Order Set

3. When you click on the admission order set, it opens the admission worksheet.

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The Admission Order Set Worksheet

1. Evidence links are provided in the order set to allow you to include them into your orders.
2. Selecting the "E" in the grid will take you to articles related to the topic.

3. The order sets are set up to have the same grid sequence from one order set to another. Columns on the grids are also consistent from one order set to another.

Activity					
	Order	Frequency	.	Stop After	Special Instructions
Activity - 6 item(s)					
☐	Activity (- As Tolerated)				
☐	Activity (- Ambulate with Assistance)				
☐	Activity (- Bedrest with Bathroom...				
☐	Activity (- Bedrest, Strict)				
☐	Activity (- Up in Chair)	with Meals			
☐	Activity				

Nursing

4.

	Order	Frequency	PRN	PRN Reason	Special Instructions	Reason Cath Continued
Assessments: - 6 item(s)						
☐	Weight	Daily	☐			
☐	Cardiac Monitor, Bedside Device		☐			
☐	Seizure Precautions		☐			
☐	Glucoscan		☐			
☑	**Influenza Vaccine Protocol**	ONCE	☐		Seasonal September Through March	
☑	Pneumococcal Vaccine Protocol	ONCE	☐			
Circulatory: - 1 item(s)						
☐	Saline Lock		☐			
Urinary: - 2 item(s)						
☐	Urinary Catheter Order Set					
☐	Straight Catheter, Bladder	PRN	☑	If Unable to Void		

Nursing Communication

	Order	Start Date/Time	Priority	Instructions
Nursing Communication - 1 item(s)				

4. Orders that are pre checked do not require any actions by the user to initiate the order
5. If you do not want this order to be on the patient just select the check and remove it-except for Evidence and quality indicators.

Lab - AM

☐ BNP Triage ☐ CBC Without Diff ☐ Protime INR ☐ Thyroid Stimulating Hormone, Serum TSH
☐ Basic Metabolic Panel ☐ Comprehensive Metabolic Panel ☐ PTT
☐ Complete Blood Count With Differential ☐ Lipid Panel ☐ T4 Serum

Lab - Repeat Daily For 3 Days

☐ Basic Metabolic Panel ☐ Complete Blood Count With Differential ☐ Protime INR
☐ BNP Triage ☐ CBC Without Diff ☐ Troponin I, Serum

LAB - Repeat Every 8 Hours X 3

☐ Creatine Kinase MB, Serum ☐ Troponin I, Serum

Labs - Other

☐ Other Laboratory

6.

⊘ Radiology Signs and Symptoms

Radiology

	Order	Priority	Signs & Symptoms	Special Instructions
X-Ray: - 6 item(s)				
☐	Xray Chest 2 Views			
☐	Xray Chest 1 View			
☐	Xray Chest AP Portable			
☐	Xray Abdomen KUB 2 Views			
☐	Other Diagnostic Imaging			
☐	Other CT Exams			

7.

6. Typing in the Radiology Signs and Symptoms in the box provided on the form will populate ALL of the x-rays you order from this form.
7. If you have a different reason for ordering an exam, make sure to select the column for the signs and symptoms for each individual order and modify.

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8. The headers in each lab section let you know what priority is pre-selected for the items in that grouping.

9. Note the icon beside the repeat orders. This is the indication that the repeat criteria have been set (daily x3 days). You can open the lab item and modify the repeat criteria if needed.

10. Note some of the grids have folders at the bottom that allow for ordering items outside of what is on the order set.
11. Once you select the order(s) and enter them, you will be able to come back to the order set.

12. When possible, the medication grid will have complete orders for you to select. If there are multiple options, you can select the column and pick/type in the desired amount/option.

12.

	Order	Dose Low	Dose High	Units	Route	Frequency	PRN	PRN Reason	Duration	Special Instructions
Pain: - 8 item(s)										
☐	Acetaminophen Tablet (...)	650		milliGRAM(s)	Oral	Every 4 hours	☑	Mild Pain (1-3) or fever		Per P&T policy, if dose is greater than..
☐	Ibuprofen Tablet (...)	200		milliGRAM(s)	Oral	Every 8 hours	☑	Mild Pain (1-3) or Fever		
☐	Ibuprofen Tablet (...)	800		milliGRAM(s)	Oral	Every 8 hours	☑	Mild Pain (1-3)		
☐ ▦	acetaminophen + HYDROcodone 325 mg-5 mg (Tablet..			Tablet(s)	Oral	Every 4 hours	☑	Mild Pain (1-3)		Total daily dose of acetaminophen given..
☐	acetaminophen + HYDROcodone 325 mg-10 mg..			Tablet(s)	Oral	Every 4 hours	☑	Moderate Pain (4-7)		Total daily dose of acetaminophen given..
☐	acetaminophen + oxyCODONE 325 mg/5 mg (TAB...)			Tablet(s)	Oral	Every 4 hours	☑	Moderate Pain (4-7)		Total daily dose of acetaminophen given..
☐	morphine Injectable (...)			milliGRAM(s)	IntraVenous	Every 2 hours	☑	Severe Pain (8-10)		
☐	HYDROmorphone 2 mg/mL Injectable (...)			milliGRAM(s)	IntraVenous	Every 2 hours	☑	Severe Pain (8-10)		
Constipation - 1 item(s)										
☐	Docusate Sodium Capsule (...)	100		milliGRAM(s)	Oral	Daily	☑	constipation		Do Not Crush (taste)
Gastrointestinal Agents: - 4 item(s)										
☐	pantoprazole (ECT...)	40		milliGRAM(s)	Oral	Daily @ 0600	☐			Do Not Crush.; Formulary sub for all PPI's..
☐	Pantoprazole Injectable (...)	40		milliGRAM(s)	IntraVenous	Daily @ 0600	☐			Dilute vial with 10mL Normal Saline. Give..
☐	Metoclopramide Tablet (...)			milliGRAM(s)	Oral	Every 6 hours	☑	nausea/vomiting		Administer on an empty stomach
☐	Metoclopramide Injectable (...)			milliGRAM(s)	IntraVenous	Every 6 hours	☑	nausea/vomiting		For IV use. Give over 1 to 2 minutes.
Antiemetic Agents: - 5 item(s)										
☐	Ondansetron (Tablet...)	4		milliGRAM(s)	Oral		☑	nausea/vomiting		
☐	Ondansetron Injectable (...)	4		milliGRAM(s)	IntraVenous		☑	Nausea/vomiting		per 2014 IV Handbook: Doses upto 4mG..
☐	Promethazine Tablet (...)			milliGRAM(s)	Oral	Every 6 hours	☑	nausea/vomiting		
☐	Promethazine Rectal (Suppository...)	25		milliGRAM(s)	Rectal	Every 6 hours	☑	nausea/vomiting		
☐	Promethazine Injectable (...)			milliGRAM(s)	IntraVenous	Every 6 hours	☑	Nausea/vomiting		IF ADMINISTERED IV DILUTE WITH..
Sedative-Hypnotics: - 3 item(s)										
☐	Zolpidem (Tablet...)	5		milliGRAM(s)	Oral	Every night at..	☑	Insomnia		
☐	Zolpidem (Tablet...)	10		milliGRAM(s)	Oral	Every night at..	☑	Insomnia		
☐	Temazepam (Capsule...)			milliGRAM(s)	Oral	Every night at..	☑	insomnia		
Stress Ulcer Prophylaxis: - 1 item(s)										
☐	Pantoprazole Injectable (...)	40		milliGRAM(s)	IntraVenous	Daily @ 0600	☐			Dilute vial with 10mL Normal Saline. Give..
Miscellaneous: - 2 item(s)										
☐	Nicotine Transdermal (Patch...)	21		mG/24 Hour	TransDermal	Daily	☐			Wash hands after handling patch
☐ ▣	Other Medications									

13. The communication order Call MD For allows you to type in the special instructions.

Communications		
	Order	Special Instructions
Communication - 1 item(s)		
☐ ⓘ	Call MD For	

14. In some order sets this can be pre-filled out.

Communication		
	Order	Priority	Special Instructions
Communications - 3 item(s)		
☐ ⓘ Call MD For		Notify Cardiologist if Change in Rhythm and/or ST Segment, Complains of Chest Pain, or Hypotension (systolic B/P less than 95)
☐ ⓘ Call MD For		Notify Cardiologist if Bleeding or if Extremity Becomes Cold/Hematoma/Bleeding Occurs, or Change in Condition.
☐ ⓘ Call MD For		

15. You can order consult from this worksheet as well. If you check the box, the Consult worksheet will open.

16. Each check box will open the appropriate worksheet. After selecting the information you need, it will revert to this screen, and then you can click "OK" to return to the Admission Order Set Worksheet.

✎ At the bottom of the Admission Order Set worksheet is the CMH VTE order set. This link will take you to another order set to select items and then those items will become a part of this set for this patient.
This must be completed for EVERY ADMISSION or you will not be able to perform a discharge at the end of the stay. (Requirement may not be present for BHS patients).

Provider CPOM Training

- To optimize positive patient outcomes, each patient that is in ICU/TCU should have two forms of VTE prophylaxis, both pharmacologic AND mechanical, OR a documented contraindication reason.
- For example, it will ensure patients that move from a lower level of care (Med-Surg) to a higher level of care (ICU/TCU) consistently have their VTE risk re-evaluated on transfer.

Alert: Patient with No Active ICU VTE Orders

Message: All Critically Ill Patients Should Have **TWO VTE Orders** For ICU/TCU Admission.
PLEASE Select **a Pharmacologic and Mechanical item or a Contraindication Reason**

Go to Order Entry, locate the VTE Prophylaxis Order Set and complete.

This alert will appear on all ICU/TCU patients for VTE Prophylaxis that *do not already* have a pharmacologic and mechanical item active order.

Health Issues

The Health Issues Manager, , holds all the health issues entered on the patient for diagnostic purposes.

Health Issues Toolbar

The toolbar allows you to quickly perform various functions within the Health Issues Manager window.
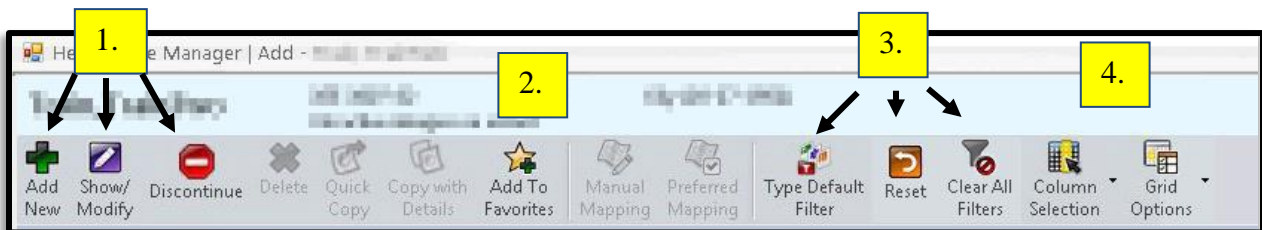
1. Health issues can be added, modified, and discontinued.
2. Add to Favorites – Commonly used health issues can be saved to the physician favorites list
3. Filters can be used to organize the list of health issues
4. Column Selection – allows the physician to customize the columns that present when viewing the added health issues.

Provider CPOM Training

Entering a Health Issue

1. Physicians can enter health issues for the patient by:

   r Health
   Issues

   a) Clicking on the Health Issues icon
   b) Clicking on the drop-down field in the "Admission Diagnosis" heading in the Admission Order Set

1B.

c) Clicking on the mandatory field in the "Discharge Diagnosis" heading in the Discharge Order Set.

1C.

2. Select the type of health issue being added

2.

IMPORTANT: *This step is important to ensure that the health issue is being entered correctly. Diagnoses can easily be entered incorrectly if this step is skipped.*

3. Search for the health issue using the favorites tab, the browse tab, or the full catalog search tab.

3.

4. Once the health issue is located, highlight it, and click ADD

NOTE: Clicking the ✎ will allow the health issue to be edited before it is added.

Quick Copy

To speed up entry of health issues, physicians can use the quick copy feature. This feature allows them to take an existing health issue and copy to another health issue type.

> ✎ Example: admitting diagnosis copied to discharge diagnosis.

1. In the Health Issue Manger, highlight the health issue that needs to be copied.
2. Then in the "Copy To" column, choose what type the health issue is being copied to.
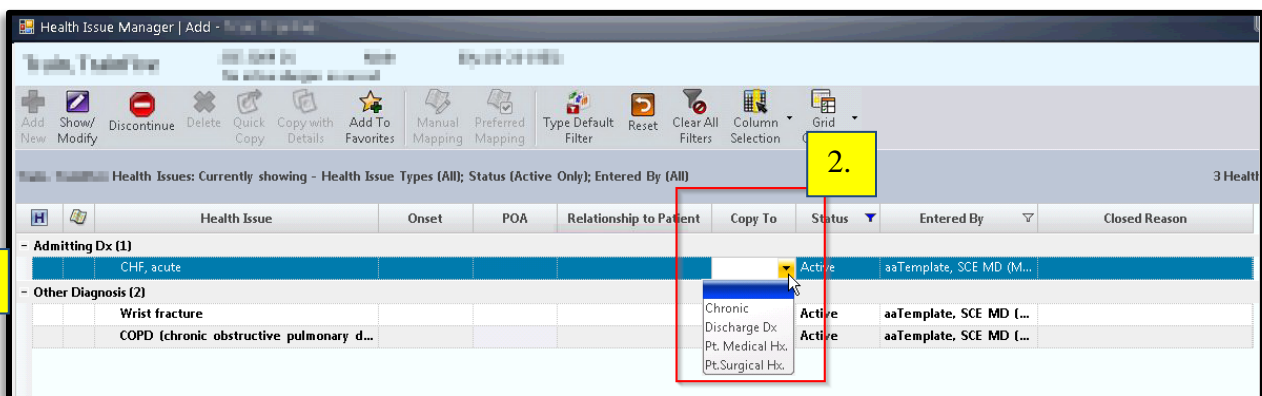
3. Once the type is selected, click the Quick Copy icon in the toolbar.
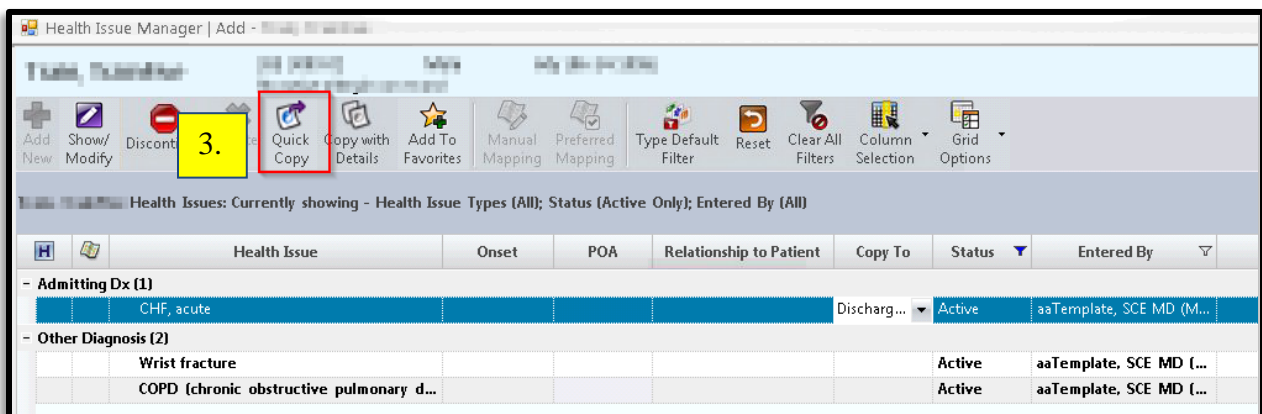
4. The health issue will copy over to the new type.
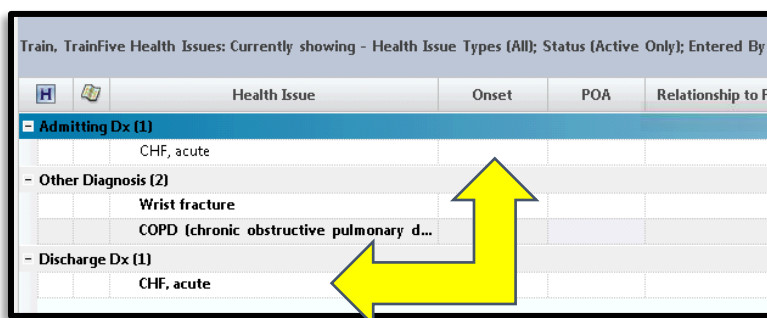
Provider CPOM Training

Health Issues Favorites

1. From system toolbar select Preferences,
2. then select Health Issues:
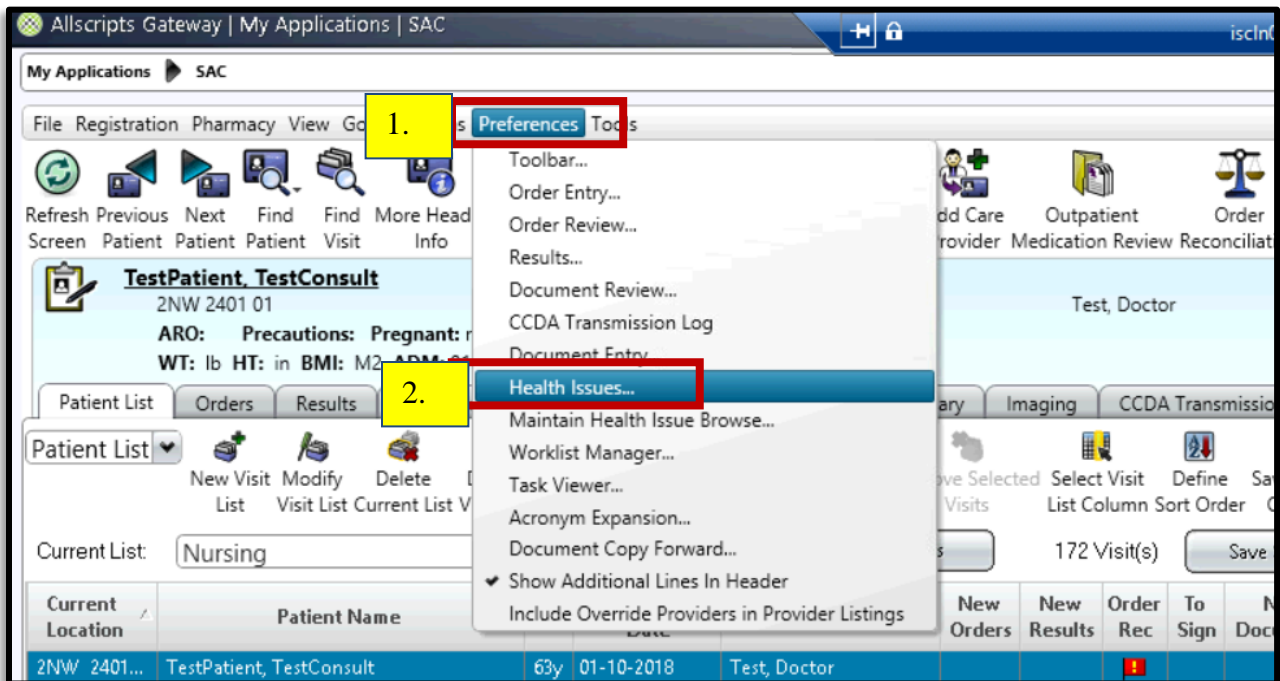
3. From this screen, you can use the menu to perform actions to edit and customize your health issues.
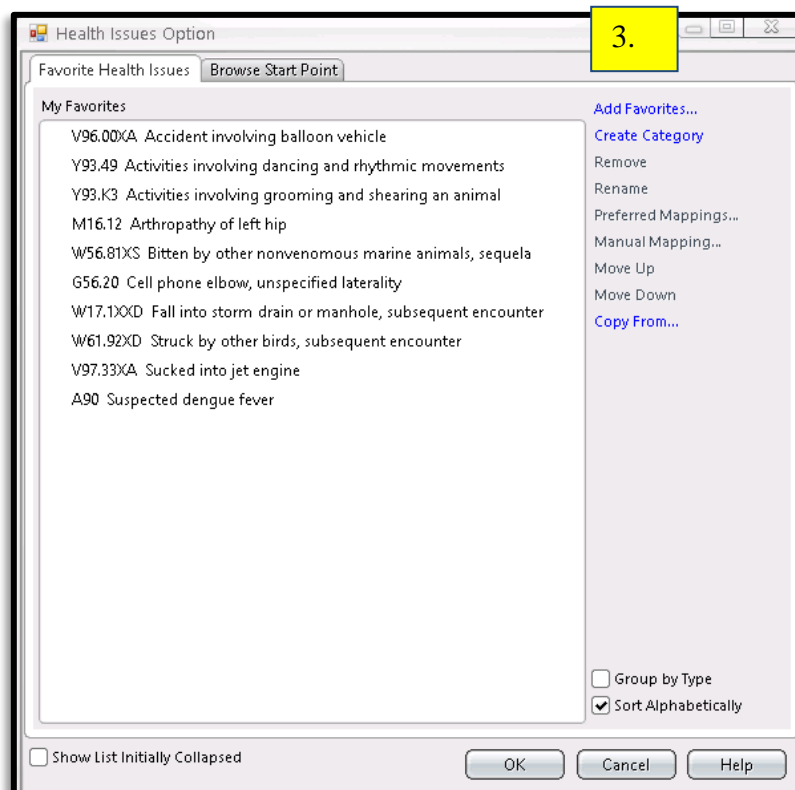
4. The results will then appear in your favorites tab in Health Issues:

Provider CPOM Training

Transfer Orders

To Complete the Transfer Order Reconciliation (in house only):

1. Either double click on the flag in the Order Rec column or click on the *Order Reconciliation*

    icon

2. Select to perform the Transfer Reconciliation

3. In the Icon Toolbar of the Transfer Reconciliation worksheet, select the

    icon to enter the order. This will open the order entry worksheet.

4. Select the Transfer Request order.

5. Select the appropriate unit.

6. The transfer order shows up in the shopping cart.

7. Can review all orders, not just medications before transfer.
8. Home medications can be reviewed again with the transfer since they may now be appropriate for the patient.
9. After review and changing necessary orders, can use the [Mark All Remaining As Continued On Transfer] to expedite the continuation of all remaining orders.

✎ Because patients can be transferred more than once, this type of Reconciliation can be performed several times.

Provider CPOM Training

How to Discharge a Patient

When discharging a patient, the physician should **FIRST** enter their discharge orders. Then they should complete the discharge reconciliation, followed by signing printed prescriptions (if applicable).

Discharge Orders

1. With the patient highlighted, choose the *Enter Order* icon.
2. On the order entry worksheet, change the session type to "Discharge Orders"

3. Search for the Discharge Order Set

4. Choose the appropriate discharge order and then enter discharge orders for the patient.

Provider CPOM Training

5. The medication grids below the discharge orders will be greyed out unless the patient is a Core Measure patient. Then, only the grids for medication type(s) recommended for that core measure will be available for selection.

6. When grids are lit up, the physician must make a selection in each category that is accessible (ACE, ARB, etc.). If not selected, you will be unable to submit the discharge orders.

7. Please note: There are 3 options that will satisfy the requirement regarding omission of the medication, the required medication being ordered by another MD, or the required medication is a HOME medication that is continued on discharge.

Saving Discharge Diagnosis to Discharge Order

1. In the discharge order, select the square icon to the right of the Discharge Diagnosis
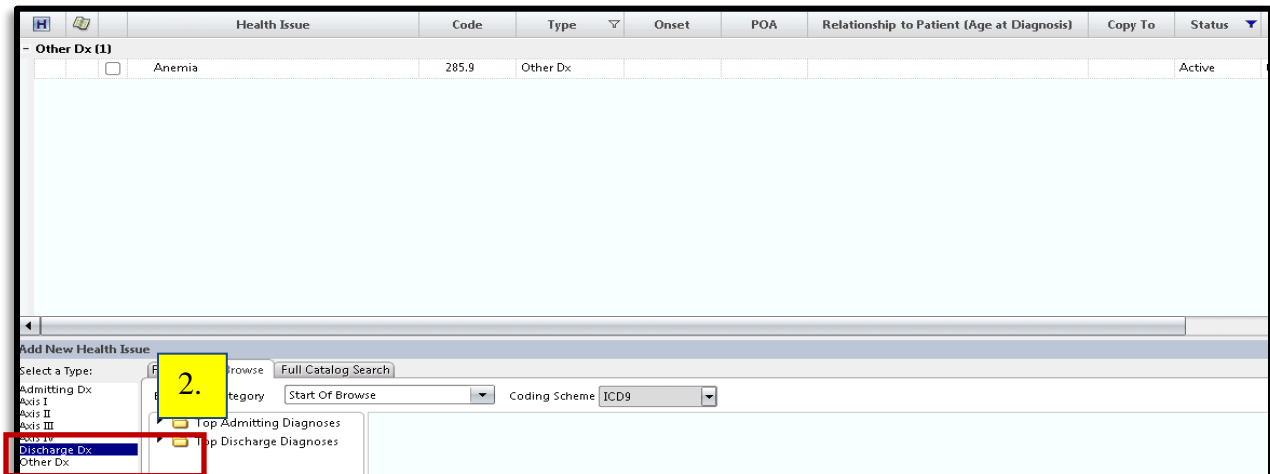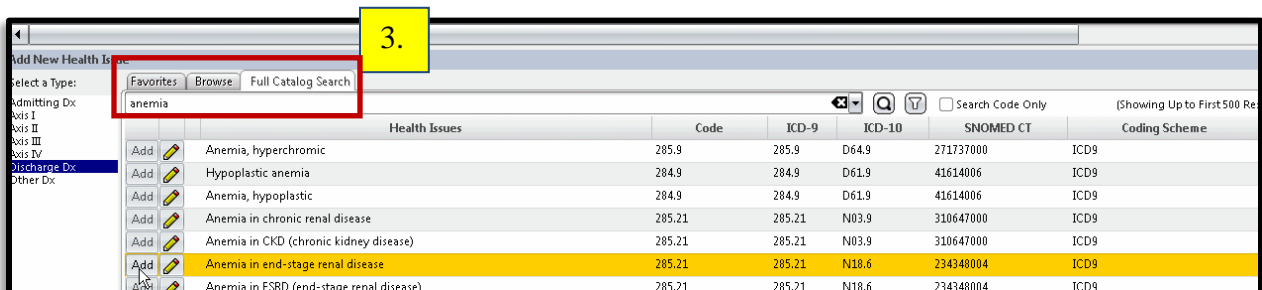
2. This opens up Health Issue Manager:

✎ Note on the left side of screen at the bottom Discharge Dx is highlighted. If not, make sure to select before entering in the appropriate diagnosis.
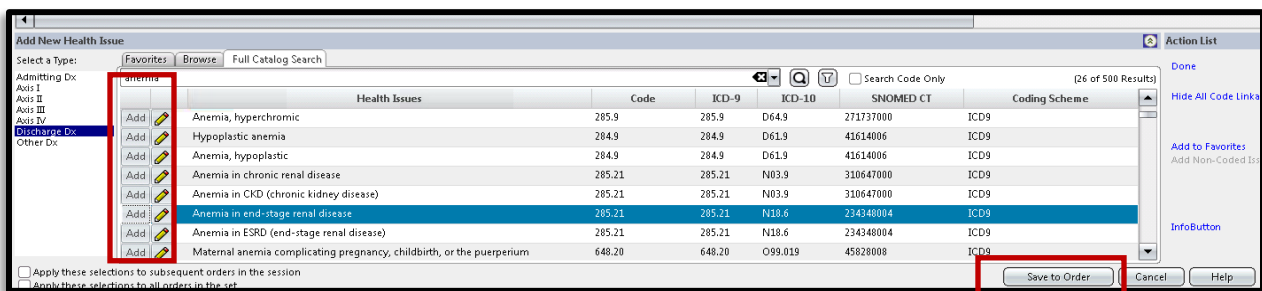
3. You can use any of the browse tabs, Favorites Browse, or Full Catalog Search to find the diagnosis you wish to add to this patient's visit.

4. Select the ADD button for the Health Issue. The Discharge Diagnosis will be added to this visit.

5. Now you will need to select the Save to Order button to add this discharge diagnosis to your Discharge order.

6. You can now continue to add the appropriate instructions to complete the Discharge order.

Conditional Discharge Order

NOTE: If multiple physicians need to approve the discharge or specific requirements must be met prior to discharge:

1. Enter the discharge orders on the Order Entry worksheet per your specialty. (Current workflow)

2. After entering the discharge information and prior to submitting the order, in the bottom right of the screen, select the conditional order box

3. You will then need to select how many times this is applicable (usually once)
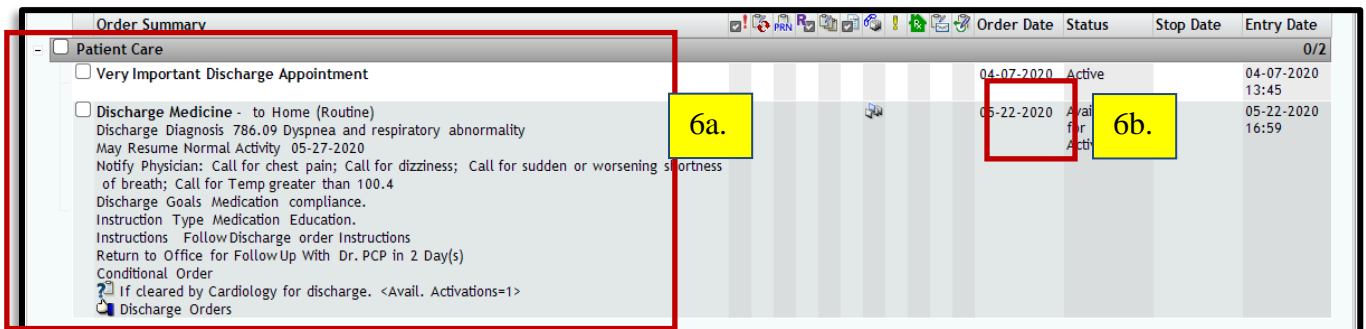
4. Then, type the condition (this is an example only and not meant to be a guideline) in the free text box so the nurse knows what conditions need to be met to activate the order.

✎ Other Condition examples: if okay with (physician / specialty) *, after (medication administration, blood draw, or test), if can void after foley catheter removal, etc.

> * In the event another physician/specialty has not previously signed off on the patient as documented in the progress notes.

5. Once completed, select OK and save the order.

6. If saved correctly, it will appear on the patient's orders tab in the Patient Care heading (6a.) and will have a Question mark in front of it to designate as conditional and (6b.) will have Available for Activation in the status column.

Provider CPOM Training

Discharge Medication Reconciliation

✎ Once the discharge orders are submitted, these orders trigger the discharge reconciliation and a new flag appears in the Order Rec column on the patient list.

✎ **NOTE:** The discharge medication reconciliation should be completed by the admitting physician/service.

To complete the discharge medication reconciliation:

1. Either double click on the flag in the Order Rec column on the patient list, or click on the *Order Reconciliation* icon ⚖ .

2. Select the Discharge Order (Outstanding) to complete the discharge reconciliation.

3. Indicate which medications will be continued on discharge and which will be discontinued on discharge by using the icons in the middle of the screen:

Continue medication   Continue medication as a new prescription   Discontinue medication

6. To save time, after continuing all the medications that are appropriate on discharge, for all the medications left (ones to be discontinued), the physician can use the *Mark All Remaining As Discontinued on Discharge* icon.

More Actions in Order Reconciliation Manger

➢ If an additional medication prescription needs to be entered that are not listed under the items to reconcile, the physician can use the enter prescription icon.

Provider CPOM Training

Document Entry

Search for a Document

1. Select the   **Enter Document** icon.

2. Select "Start of Browse"

3. Select "Physician Documentation" in the browse tree.

4. Select desired document.
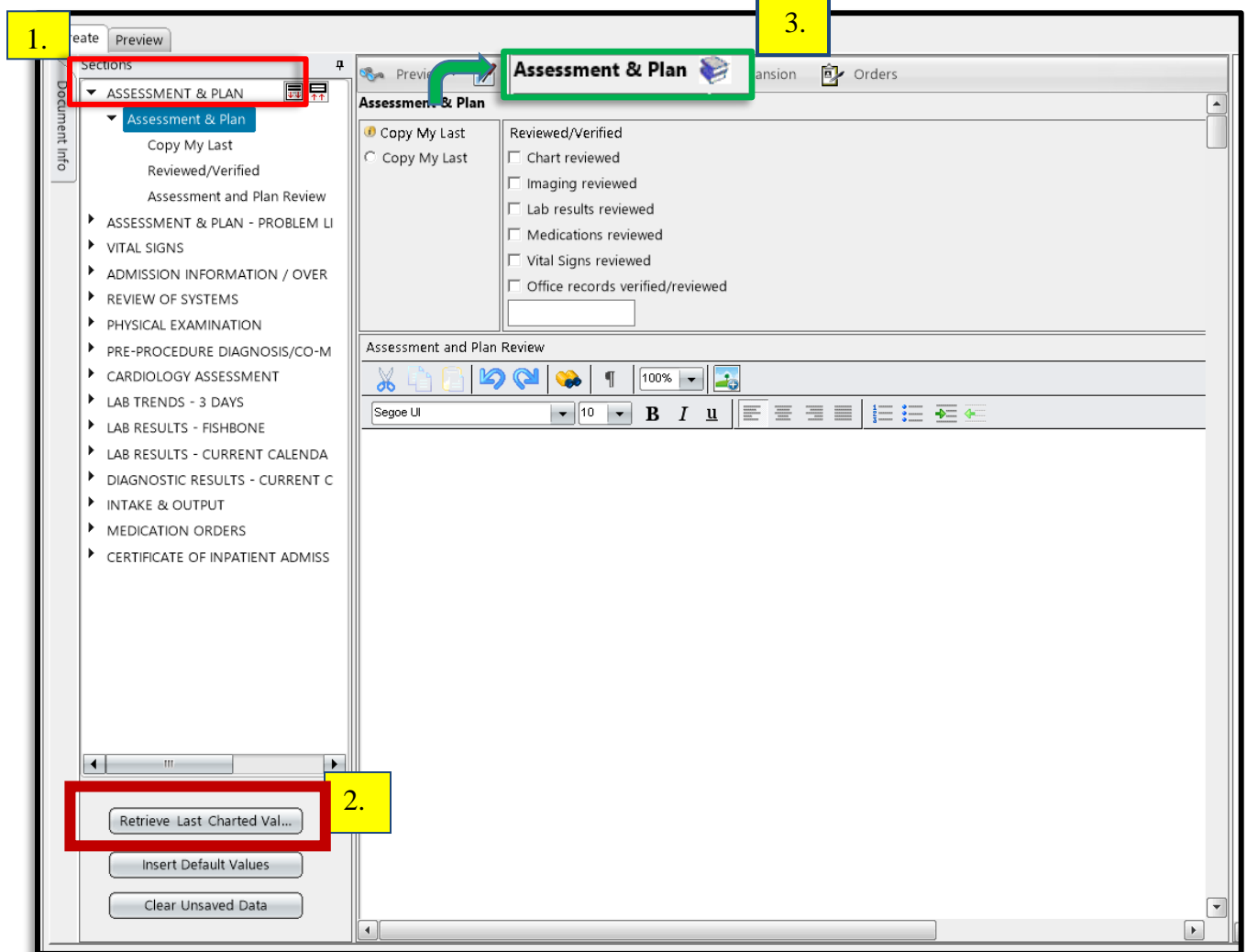
5. Select "Open" and the document will open.

Provider CPOM Training

How to Use "Retrieve Last Charted" and Other Retrieval Options
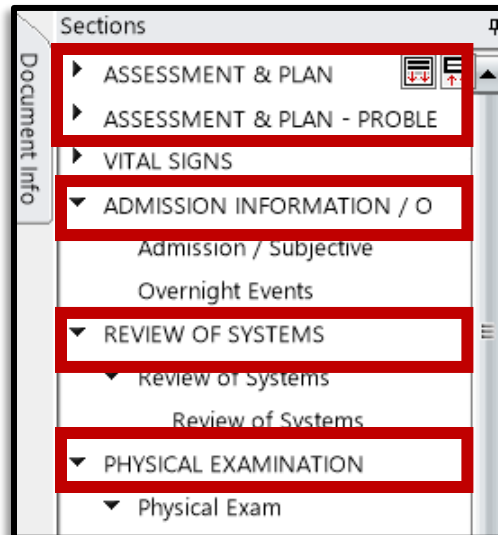
Retrieve Last Charted

1. Highlight the main section header in ALL CAPS.

2. Select this option. This will copy forward information from the last note with this name on this patient for the Assessment and Plan (Free Text) Heading, **IF** there was information placed in the previous note.

3. An icon will appear next to the heading to indicate information has been brought in.

✎ By repeating the above steps, the user can retrieve last charted information on the following sections:

Other Charting Retrieval Options

✎ Each section has a separate option as well to bring in past charting.

Review of Systems Copy Forward (not using Retrieve Last Charted)

1. Will copy in the "users" default (preset) negatives.

2. Will select negatives from a system-supplied dictionary for all items not selected as positive.

3. Will copy in the "users" last charted values from this patient.

Physical Examination Copy Forward (not using Retrieve Last Charted)

Physical Exam 1.		3.		4.
SAVE DEFAULTS	DEFAULT	DEFAULT		DEFAULT
○ save my normal defaults	○ normal	○ my normal		○ my last
General Appearance Comments				General

1. Will save the normal defaults as set by the provider.

2. Will copy in the system supplied (canned) normal.

3. Will copy in the "users" preset normal values.

4. Will copy in the "users" last charted values on this note for this patient.

Problem A&P Copy Forward (not using Retrieve Last Charted)

Problem/Assessment Plan

Problem/Assessment Plan

Copy Problem List
1. ○ Copy Problem List
   ○ Copy from my last saved note   2.

Problem 1	1 - Actions
	○ Move Down
Assessment/Plan 1	○ Clear Data

1. Copy Problem List - Will copy in all of the problems listed in Health Issues.

2. Copy from my last saved note - Will copy in the "users" last charted values on this note for this patient.

Provider CPOM Training

Completing a Document

✏ Amount of content charted is determined by the provider. There is no "required" amount of charting or "required" charting fields in a note. The ONLY exception to this is if the provider is completing the "Certificate of Inpatient Admission" section, which has required fields.

 ✎ The provider can use the predefined check boxes and/or radio buttons in each section or use the free text boxes.

✎ Content highlighted in blue color is automatically added to the note. If content is not desired in note, select the check box or the blue content box itself to remove from note.

✎ The provider can use the predefined check boxes and/or radio buttons in each section or use the free text boxes.

✎ If the provider does not want to use the supplied content or retrieve previous documentation, they can free text.

✎ Content highlighted in blue color is automatically added to the note. If content is not desired in note, select the check box or the blue content box itself to remove from note.

✎ A fishbone lab section is available if desired.

✎ Results will only appear if they fall in the designated time frame. For lab and diagnostic results, the default is 1 calendar day.

✎ An option for 2 calendar days is available in "modify template".

Provider CPOM Training

- Most recent I/Os are available for review.

- If content is desired in note, select the check box or the content box itself to add to the note.

- Medication orders appear in blue highlight. To remove, de-select the check box to the left.

Provider CPOM Training

Items for NP or PA: Assigning a Co-Signer during selection of document:

NPs or PAs are required to assign a co-signer and indicate document is incomplete. This will allow the designated co-signer to perform necessary actions on the document as well as be properly identified to HIM.

1. Select Co-signer box.

2. Choose a physician from the list or search for the appropriate one:

3. Mark as incomplete prior (a.) to selecting the note or while already in the note (b.):

4. Submit as Incomplete selection results in appearance on documents tab with Document Status of Incomplete:

5. If needed, it is possible to still edit this Incomplete Status not by selecting the Modify Document icon, Modify tab, or Modify Document bolded option.

Provider CPOM Training

Sovera

- Sovera is CMH's comprehensive medical health record.

- Accessing Sovera

    o Separate icon on hospital desktop

    o Through SAC Thin client – toolbar icon in SAC

    o Through CAG

After logging into the Citrix Portal you will see a listing of those applications you have requested and been granted access to.

Select **Sovera**
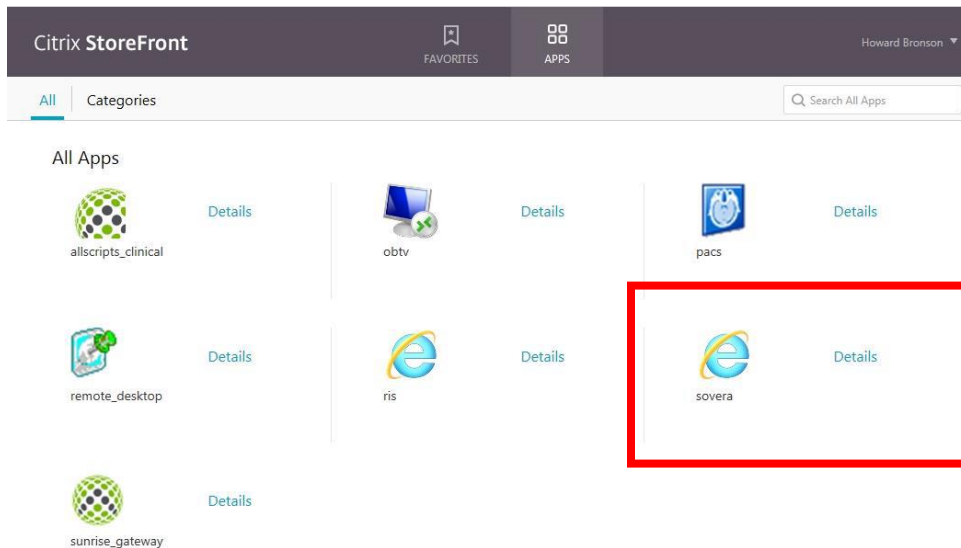
May take a while for it to launch for the first time.
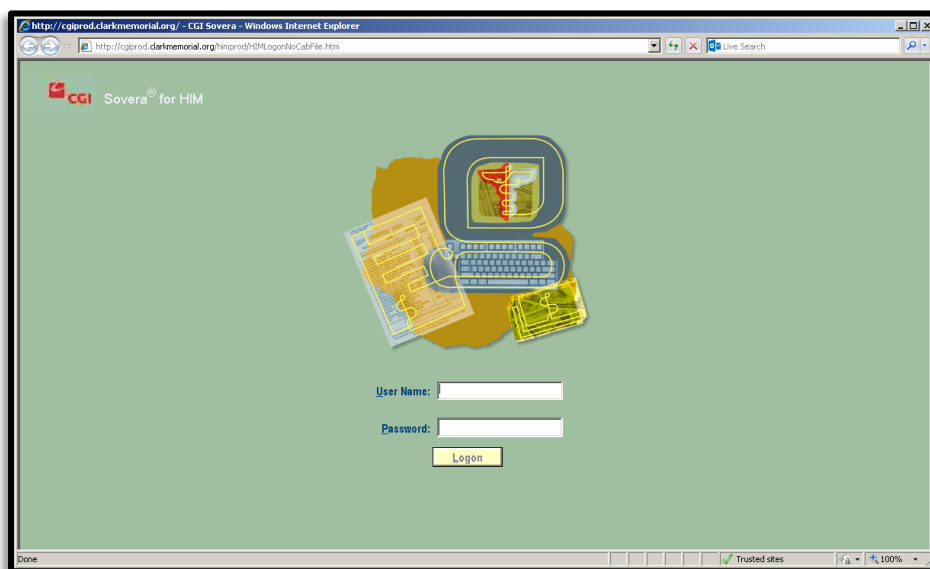
1. When you log in you will need be presented with a search pop up (see next section) or you can find the icon "Retrieval" to search for medical records or deficiencies.
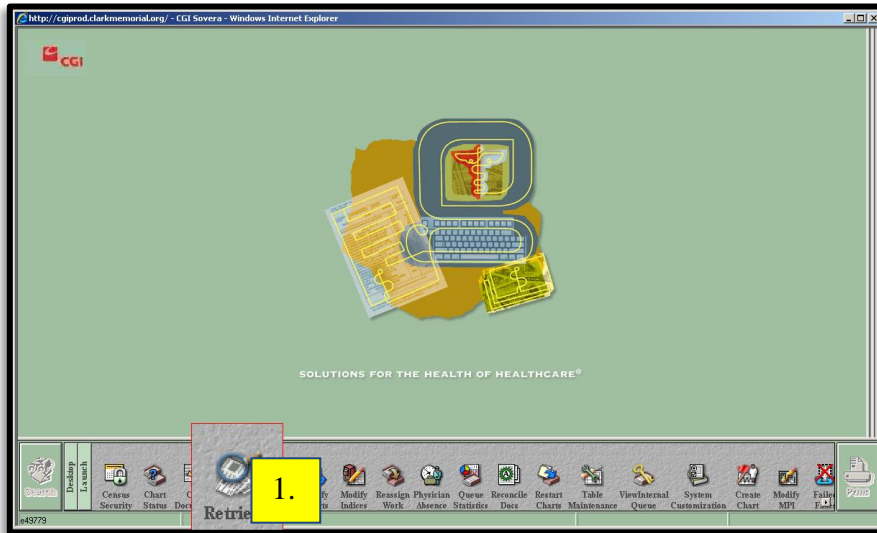
Searching for Medical Records

1. In the new (pop up) window,

   change the sort to Name/MRN
   and enter the appropriate information.
2. Select Retrieve to view that patient's data.

3. You can then view documents located in the tabs of the chart. Click on the title of the document and it will appear in the PDF viewer.

Provider CPOM Training

Addressing Deficiencies

1. Click on the drop-down box and select "Deficiencies".

2. The information you need to complete your deficiencies is contained on this desktop.

Provider CPOM Training

This is a list showing all of your Deficiencies. To sort these, you can Click on the headers that you want it to sort by -- Doc type, message, delinquent Date, Account or Type (scroll to the right to see all columns.)
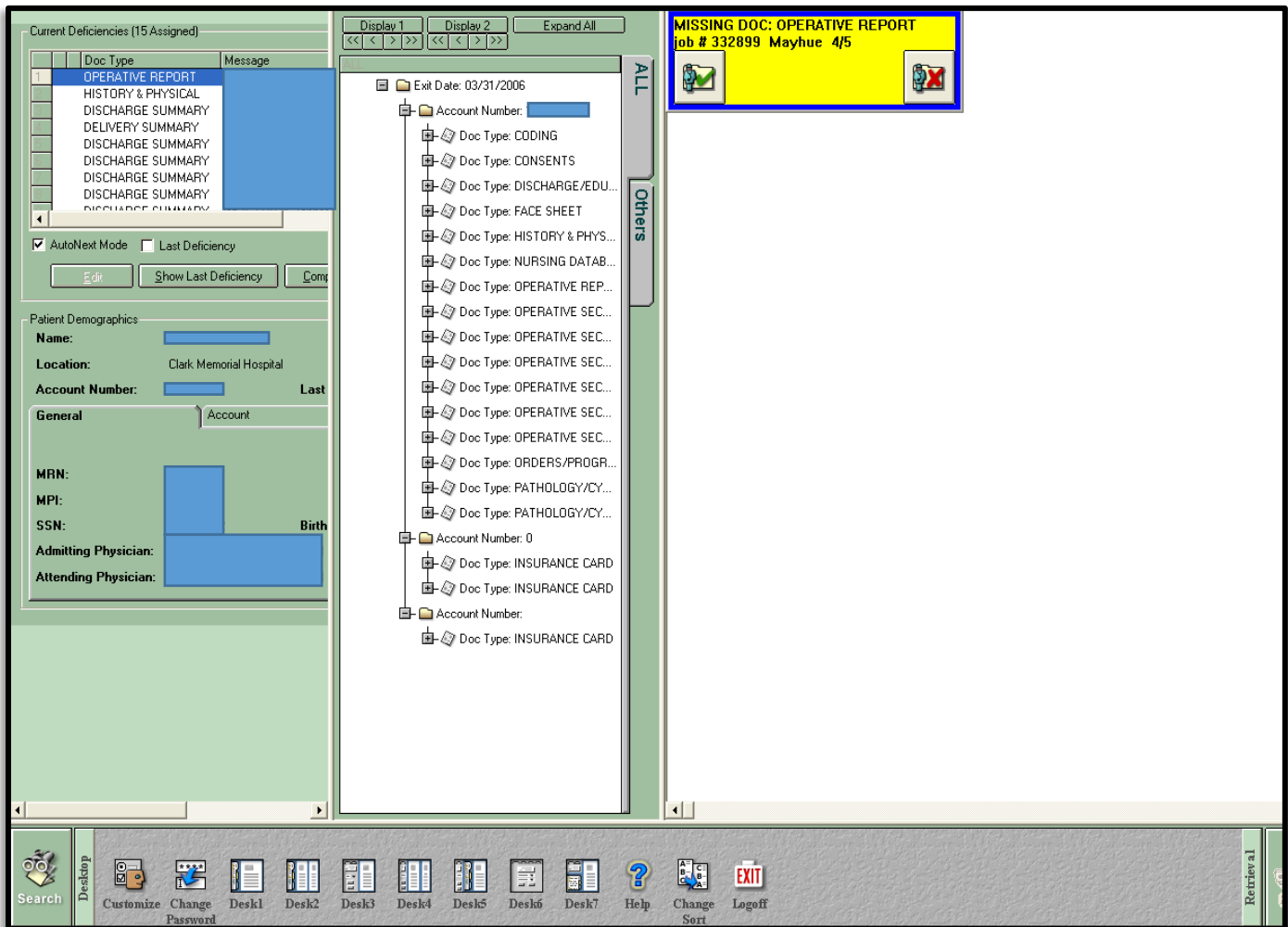
Current Deficiencies (21 Assigned)

	Doc Type	Message
	CONSULTATION	
	RADIOLOGY	
	CONSULTATION	
	RADIOLOGY	please attach "sticky note" with missing
	DISCHARGE SUMMARY	job # 323477 Bacala 3/14
	SHORT STAY	job #322701 Godlstein, Steven 3/13
	DISCHARGE SUMMARY	job #50013694 Mayhue 3/15
	SHORT STAY	job #323906 Howerton, D. 3/15
	DELIVERY SUMMARY	

☑ AutoNext Mode   ☐ Last Deficiency

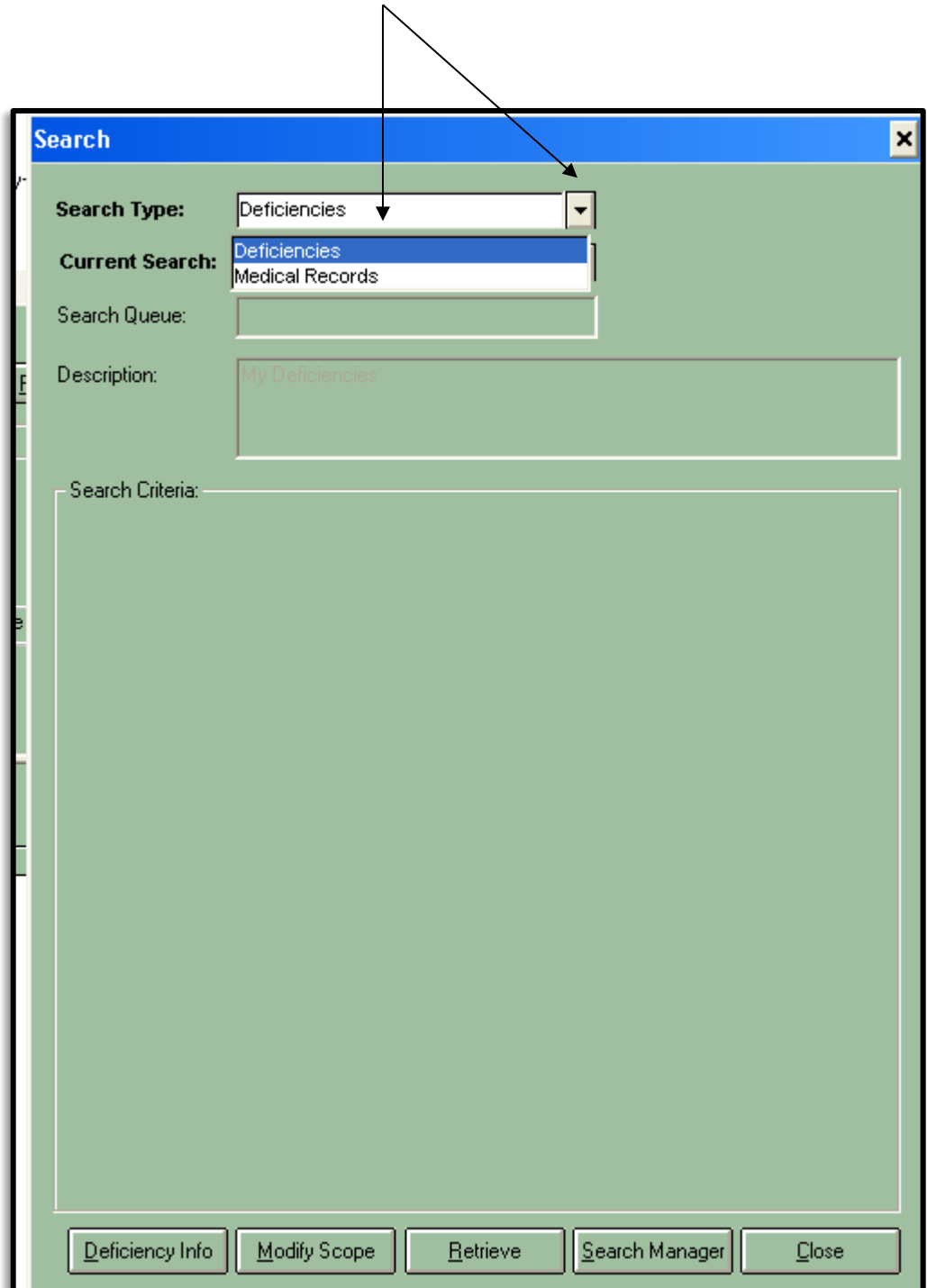[Edit] [Show Last Deficiency] [Complete] [Reject] [Undo]

Be sure to have a check mark in the "AutoNext Mode." (click on box to check)

Patient Demographics

Name:	TEST, SOVERA
Location:	Clark Memorial Hospital
Account Number:	14109938	**Last Updated:** 06/08/2006 09:14

General | **Account** | Site Definable

Admit Date: 11/26/2001   **Discharge Date:**
Patient Type: O

This is where you will find the Name and account number. Click on the account tab to see the admit and discharge date. The general tab will give you the MR# Birth date and attending physician.

[Display 1] [Display 2] [Expand All]
[<<][<][>][>>] [<<][<][>][>>]

ALL

- 📁 Exit Date: 11/26/2001
  - 📁 Account Number: 14109938
    - Doc Type: CONSENTS
    - Doc Type: CONSULTATION
    - Doc Type: EMERGENCY ROOM DOCUMENTATION
    - Doc Type: FACE SHEET
    - Doc Type: FACE SHEET
    - Doc Type: H&P OFFICE
    - Doc Type: LABS
    - Doc Type: MEDICATION

**This is where you will see the list of documents for the selected account. On the right is where you can view the document**

Search | Desktop | Retrieval | Viewer1 | PrevPage | NextPage | GotoPage | Add Sticky ... | Edit Sticky ... | Magnifier | Z

# Provider CPOM Training

Placing a "Sticky Note" on the Chart

✎ Please note: If you reject a missing document; for example, an H&P because you want to use the H&P you entered in a Progress Note, you need to put a "sticky note" stating this in the Progress Notes where you wrote the H&P. This will be permanently placed and viewable in the chart. Any notes you type in the box you receive when you reject the deficiency are only seen by the analyst and is not permanently placed in the chart.

1. Select the page from the medical records you want to place the sticky note on. (it is selected when you can see it in the right-hand pane.
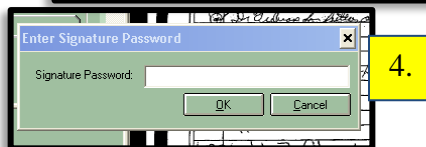
2. Then click on "add sticky"
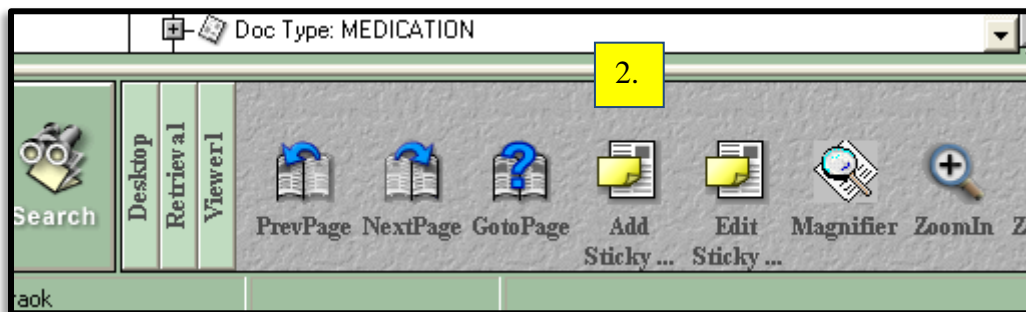
3. You will then see this window open.

   Type your note in this box.
   (remember, this will be viewable on the
   chart). Then click "ok".
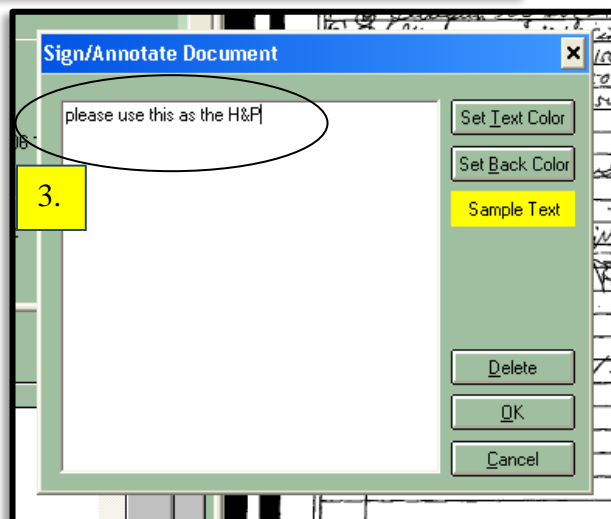
4. You will then get a signature box.
   Type in your 5 digit logon (you will
   only need to do this the first time
   you sign) and select "ok".

5. You will now see your sticky note on the page to your right. If you left click and hold on that box, you can drag it to where you want to place it on the page.