Dear Providers,

Via Christi is replacing multiple existing electronic health records (EHR) with a single, integrated EHR. The single EHR, called OneChart, will improve patient outcomes by reducing errors and unnecessary care. This will help make Via Christi the best place to receive care and the best place to practice.

- OneChart will help us reduce unnecessary care and errors that result from hand-offs between health care providers, poor legibility and delay in the ordering process.
- With OneChart, clinicians will have access to the best practice standards of care.
- OneChart offers clinicians quick, easy access to our patients’ latest medical information.
- OneChart will help meet our patients’ service expectations by allowing them to use our new website portal to manage their health care.
- OneChart is based on the latest technology and builds upon years of EHR experience.

This booklet contains the main functionalities needed to navigate, use and optimize the features of OneChart. More information, tools and educational videos can be found at viachristi.org/onechart
WHY ONECHART?

OneChart is a system that provides integration of clinical information between Via Christi’s outpatient and inpatient settings.

No handwriting to decipher, no orders to transcribe.

OneChart will reduce the number of repeat tests.

CPOE drastically reduces turnaround times for Laboratory, Pharmacy and Radiology.

OneChart allows direct electronic prescribing to pharmacies.

OneChart allows physicians to save favorite content to streamline their workflows.

OneChart provides clinical decision support (CDS), drug and allergy checks and access to evidence-based medicine.

Remote access to records will improve patient care and improve physician satisfaction.
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Accessing/exiting OneChart

There are two methods of accessing OneChart Applications screen. The method used depends on if the user is within the Via Christi network or at a home, office, coffee shop, Europe, etc. and whether the user is on a Via Christi device.

From outside the Via Christi network

1. If on a non-Via Christi device:
   a. User access https://apps.via-christi.org
   b. Choose OneChart icon from the displayed applications list
   c. Then follow the steps under Log in to OneChart

2. If on a Via Christi device:
   a. User connects via VPN
   b. Click the OneChart icon on the laptop
   c. Follow the steps under Log in to OneChart

From within Via Christi network

Click the OneChart icon from the desktop screen of any computer within the network. (Icon may appear differently than illustrated.)
Log in to OneChart

1. After clicking the OneChart application icon, the Cerner Millennium log on screen will open.

2. Enter the user specific log in user name and password (username/password is not case sensitive).

First-time access to OneChart on your PC

1. If this is the first time you have accessed OneChart on a computer, a small software file may need to be installed before OneChart will run.

2. Click the box “I agree with the Citrix License Agreement,” then the Install button.

3. Accept the usage agreement, then follow the steps within Log in to OneChart.

Correctly exiting OneChart

1. To close the patient chart but leave the application open, click the X on the patient name tab

2. Always ensure the application is closed before leaving the computer. To correctly exit, click the Exit door icon seen in the action toolbar.

3. Do not use the red X in the upper right corner.
Message Center

Inbox tab contains multiple sections: **Inbox Items, Orders, Documents, Work Items** and **Notifications**. The Message Center will be the first screen seen every time you log in to the system.

**Inbox Orders/Cosigning Orders**

1. Click on the **Cosign Orders** label to bring the list of orders into view.

2. Double-click the order you want to sign.

3. The order opens and the action pane is displayed at the bottom of the order.

4. Review the details of the order, select the button **Approve**.

5. Click **OK** to approve the order, or click **OK & Next** to approve this order and open the next order for review.

6. Click **Refresh**. The approved order has been removed from the list.

**NOTE:** Orders in the **Cosign Orders** section are currently active orders on the patient chart. However, depending upon the position of the individual who entered the order, a supervising/authorizing provider must provide an authentication signature.

**NOTE:** For proposed orders placed by an individual who does not have the licensure to activate the order, such as a medical student, to authenticate and activate the proposed order, follow the same steps as **Cosigning Orders**.
Refusing orders

An order could be refused, if necessary. The refusal steps are the same as Cosigning Orders, except the button for Refuse would be chosen and a required reason for refusal entered.

**NOTE:** If the order routed to your Inbox belongs to another provider and you know who that provider should be (ex. colleague or partner), please forward the order to them rather than refusing the order.

Documents

Viewing a document

1. From the Inbox tab, select Documents
2. Double-click on a document to open.
3. To close a document, click the X on the document tab. Clicking the X is equivalent to the Cancel button as no action will be taken on the document.

Signing a document

1. Complete Viewing a document steps 1 and 2
2. Review the document
3. Select Sign
4. Enter any comments
5. Click OK or OK & Next

Modifying or correcting a document

1. Open the document in the Message Center
2. Click the Modify or Correct icon from the message box header
3. Make necessary modifications and click Sign
Signing and forwarding documents

1. Complete **Signing a document** steps 1-4
2. Check the **Additional Forward Action** box and select an option from the drop down list
3. Select any recipient(s) from the **To** list using the **Binoculars**
4. Click **OK** or **OK & Next**

**Forwarding a document without signing or refusing**

1. Open or select a document
2. Review the contents and click **Forward Only** in the top of the document pane
3. Check the **Additional Forward Action** box and select **Sign** or **Review** as appropriate from the drop down list
4. Select any recipient(s) from the **To** list using the **Binoculars**
5. Enter any needed comments to communicate with the recipient
6. Click **OK** or **OK & Next**

**NOTE:** The **Refresh** button is important. Whenever the screen does not appear to reflect current data, consider using the **Refresh** button.

**Patient portal**

**Identifying myviachristi patient portal users**

In order to determine if a patient has enrolled in myviachristi, providers should check the patient’s banner bar within OneChart.
1. In the banner bar, a field labeled IQ Health will display **Yes** or **No**.

2. If the patient is not registered yet, the provider can invite them through an option found in the drop down within **Patient Conversation** in the action toolbar.

**Message Center proxy**

**Message Center** proxy allows one user to give access to another user for defined items and actions in the Inbox.

**Granting proxy to another provider**

1. Open the **Message Center** and select the **Proxies** tab in the left pane of the **Inbox Summary**.

2. Click **Manage** to open the **Manage Proxy** screen.

3. Click **Add** button at the bottom left to open the **Setup** window.
   a. In the lower panes, **New Given Proxy** section, search for a user in the user window.
   b. When the correct user name is displayed, click the arrow to move the name into the lower user window.
   c. Continue steps a and b until all desired individuals are listed.
4. Enter the correct begin date and end date

5. Identify what elements of the Inbox to share
   a. From Available Items, if all items are to be proxied, select Grant All button to move items to Granted Items list
   b. Or, if only select items are to be proxied, highlight each item to be granted and click Grant

6. View the chosen items in the Granted Items pane.

7. Click Accept & Next, then OK to complete the process and save chosen settings.

**NOTE:** Provider receiving the proxy will have a message notifying them that access has been granted to them.

**NOTE:** If an Inbox Item is signed as a proxy, the signature will reflect the signature was on behalf of the original Inbox owner.

**NOTE:** If the individual working on a proxied Inbox wants to review an item and leave it in the Inbox for the original recipient, open and review the document/result then close it without signing, refusing or forwarding the item.

**Document medication history**

**Important Note:** This step should be done before admission orders are initiated. Documented meds by Hx must be completed prior
to Admission Reconciliation. Pharmacy techs and/or nurses will complete the history; however, providers still have access to this feature.

If the medication history has been documented as completed, the status bar will display a green checkmark. Additions can be made at any time, even if the history has been documented as complete.

External Rx History

Viewing a patient’s external medication history may be helpful when completing the patient medication history. You have the ability to access their previous prescriptions from participating retail pharmacies, the patient’s insurance plans or pharmacy benefit managers.

1. Click on the External Rx History button found on the Orders or Medication List section

2. Select Consent Granted in the Patient Consent window that opens
3. If the patient information is contained in the database, a list of medications will display (some patients may not have information)

Admission Reconciliation

1. From the Orders tab, verify that the meds history is completed, which is identified by a green checkmark in the status bar at the top right of the screen.

2. Single-click on the Reconciliation button and select Admission to open the Admission Reconciliation window.

3. A line item for each medication in an active state on the Medication List will be listed in the Reconciliation screen. Select the Radio button under the green arrow to continue a medication as an inpatient medication or red square for Do Not Continue.

   a. Formulary medication will convert to an inpatient medication and the physician will only need to complete any missing details
b. If a home medication is not on the hospital formulary, a window will open that gives possible alternative selections

   i. Select the desired alternative by clicking once on the preferred option.

   ii. If a window of order sentence options displays, choose the desired sentence. Click **OK** to return to the **Reconciliation** screen.

   iii. If no order sentences have been predefined, you will be returned to the **Reconciliation** screen. Click on the listed medication in the right pane to open the **Details** window

4. If the provider does not address all medications, the 🔄 icon will display at the left side of the medication. If the reconciliation is signed without addressing all medications, the system will show a partial reconciliation denoted by the circular arrows instead of the green checkmark.

5. To complete the reconciliation, the provider must activate the orders by choosing **Reconcile** and **Sign**. The orders will become active immediately.

6. For orders which should **not** be active until a later time, click **Reconcile** and **Plan** to return to the **Orders** window. These orders can be initiated by a nurse during admission process.
Orders

Adding a single order

1. To place an order, open the patient’s chart and click on the Orders tab.

2. Click the Add button at the top left of the Orders screen.

3. In the Orders Search window, select to search on either Contains or Starts With filters:

   a. Contains looks at any part of the order name as defined by the letters typed in the Orders Search window. You must enter at least 3 letters to search on Contains. As an example, US in the search field would not find ultrasound orders to display.

   b. Starts With can look at as little as one or two letters of the order name to return search results.
4. Click on the desired order once. If an **Order Sentence** window opens select the order sentence closest to what is needed.

**NOTE:** Generally, it is easier to complete an order’s details when starting from a similar sentence option.

5. Repeat steps 4 and 5 for each additional order, then click **Done** to close the **Orders Search** window.

6. Review the orders and fill in any **Missing Required Details** as indicated by this blue dot icon. ✗

**NOTE:** Some orders may need to have details entered to have complete information, even though the field is not required.

7. Click **Sign** to activate the orders.

**Drug and allergy alert notifications**

1. Upon signing the orders, if any major drug/drug or allergy contraindications are identified, the system will notify the ordering provider. This example has drug/drug and allergy contraindications within the medication orders.

2. If any interaction/contraindications are identified by the system, a **Clinical Decision Support** window opens when signing the orders.
3. The user can either choose to **Remove** the order or select an override reason, and then **Continue** the ordering process.
   
   a. If choosing to **Continue** the order, choose the most appropriate override reason from the required field associated with each medication.

   **NOTE:** When a field is yellow, the system requires it to be completed.

   b. The **Continue** button will not be available until a reason is selected.

   c. After selecting the reason(s), choose **Continue** to return to the **Orders** screen.

4. If the order should not be activated, choose the **Remove New Order** button which returns the user to the **Orders** screen.

5. Click the **Refresh** button (Minutes Ago).

   **NOTE:** The **Refresh** button is important. Whenever the screen does not appear to reflect current data, consider using the **Refresh** button.

**Adding an orderset**

Ordersets are orders that have been grouped together to increase CPOE efficiency. Ordersets are identified by the 🔄 icon preceding the name.
1. Click the Add button from the Orders tab.
2. Using the Orders Search window, find the orderset.
3. Select the desired orderset and click Done.
4. To review existing orders while determining which orders are needed from the new orderset, select the Merge View function by clicking the icon at the top of the Orders window.
5. Select and/or deselect orders as appropriate by adding or removing the check in the box at the front of the line item.

Merge View

1. Click on the Merge View icon to view all orders in a list from within the selected orderset.
2. The Merge View button provides a function within ordersets to help locate any duplicate orders that may have already been placed by another provider.

**NOTE:** Merge View is a very important and helpful tool because it allows the user to see what orders are potentially duplicated and avoids a duplicate order alert.

Adding to Phase

Select the Adding to Phase button to add additional order(s) into an orderset.
1. Click the **Add to Phase** button for a drop down menu.
2. Select **Add Order**.
3. In the subsequent **Orders Search** window, fill in the first 3-4 letters of the order that you wish to search for. Using the **Starts With** and **Contains** selectors may help you with this.
4. Click once on the appropriate order.
5. Repeat the search for each order desired. Click **Done**.
6. Complete the details for the order.
7. Click the **Orders for Signature** button to review the orders.
8. Click **Sign** to make the orders active.
9. Click the **Refresh** button (Minutes Ago).

**NOTE:** The **Refresh** button is important. Whenever the screen does not appear to reflect current data, consider using the **Refresh** button.

### Ordering from a subphase

Subphases are subsets of orders found within an orderset — think of it as a “mini” orderset. They are orders grouped for a specific purpose, such as VTE prophylaxis. The icon is used for identification of a subphase within an orderset.

1. From within an orderset, click the checkbox adjacent to the subphase.

2. The subphase opens allowing orders within it to be selected.
3. Address any required details for each selected order within the subphase. When completed, click the **Return to...** button to return to the primary orderset.
Completing the orderset ordering process

Two possible processes exist for orderset completion. The orderset can be **planned** or **initiated**.

1. Planned ordersets are used when the patient is not in the appropriate physical location and/or ready for the new care orders at that time.
   
   i. The orders will not be active until initiated.
   
   ii. Nursing can initiate planned orders when the patient arrives at the desired location, etc.

   a. To plan an orderset, complete all the ordering steps defined under **Adding an orderset**, and **Adding to Phase**.

   b. When desired orders are in the orderset and all needed details completed, select **Sign**.

   **NOTE:** Planning an orderset is helpful when a patient is not in the final location — for example, in the ED or OR before going to the floor. Discharge ordersets can be planned to expedite the anticipated discharge of patients.

2. Initiated ordersets create active orders **immediately**.

   a. To initiate an orderset, complete all the ordering steps defined under **Adding an orderset**, and **Adding to Phase**.

   b. When desired orders are in the orderset and all needed details completed, select **Initiate**.

   c. Then click **Orders for Signature** then **Sign**.

   d. Click the **Refresh** button (Minutes Ago) to see the active orders.
NOTE: Take special care to ensure the orders/ordersets intended to be ordered have been completely processed. When initiating/activating order sets, you must click **Initiate, Orders for Signature** and **Sign**. The order set name and status in the left pane will be in bold font and say *(Initiated)*.

**NOTE:** The **Refresh** button is important. Whenever the screen does not appear to reflect current data, consider using the **Refresh** button.

**Acting on existing orders**

Various order actions are available for working with active orders. These options may not all be available for all orders based on the type of order, current order status and/or order details.

To see the available order actions, right-click on the order to open the dropdown window of options. Unavailable options will display, but in a gray font.

**Modify** Modify an existing signed order. Not available for diets and lab orders.

**Cancel/Reorder** Cancels the existing order and replaces it with the same order allowing the order details to be changed. Do not use this for ordering diet changes.

**Copy** Copy an existing signed order.

**Renew** Renew a prescription order or create a prescription order from a documented history medication.

**Cancel/Discontinue** Cancel a one-time existing signed order or discontinue a continuing order.
**Void** This deletes, or voids, an existing signed order. Typically used for orders that were placed incorrectly and no actions have been taken.

** Cancelling orders and ordersets **

1. Several different cancel options are available in the system: Cancel/Discontinue, Discontinue, Remove and Void.

2. The current status of the order or orderset and the reason for which it is being cancelled will determine which choices are available and which is most appropriate.

3. For a list of available options, right-click on the order or orderset to be cancelled.
   
   a. For planned pending ordersets, not initiated yet and not signed, choose Remove. This action erases any trace of the unsigned orderset from the chart.

   b. For planned ordersets, choose Discontinue or Void.
      
      i. **Void** ensures no orders in the orderset can become active. The orders within the plan display as Voided (Deleted).

      ii. **Discontinue** causes the orders to display as discontinued.

   c. For initiated ordersets, the options are Discontinue or Void.
      
      i. **Void** should only be used if the action is taken immediately after initiation. Void should only be used if there is no chance that the orders have been acted upon by any user or system.

   d. **Discontinue** should be used for most ordersets. This action should be used when the plan is no longer pertinent to the patient’s treatment.
      
      i. **Discontinue** allows the provider the option of keeping specific orders from within the orderset while discontinuing other orders.
(1) After selecting **Discontinue**, a window containing a list of each active order will open.

(2) If any order needs to remain active, click the box in front of the order in the **Keep** column.

(3) Click **OK** to close the window. Click **Orders for Signature**, and then **Sign** to complete the order discontinuation process.

e. For individual orders in an ordered status, click **Cancel/Discontinue**.

   i. If needed, complete the **Discontinue Reason Details Screen**.

   ii. Click **Orders for Signature**, and then click the **Sign** button to complete the order discontinuation process.

**NOTE:** The individual **Cancel/Discontinue** action is the equivalent of writing D/C of a particular order on paper chart. E.g. D/C dressing changes.

**VTE prophylaxis guidelines and alert**

The system contains rules that look at patient data to determine if a patient requires VTE prophylaxis measures and if any compliant actions have been taken.

1. Any patient over the age of 18 who has been in the hospital over 12 hours may receive an alert if prophylactic steps have not been taken, either mechanical or pharmacologic.
   
   a. Mechanical actions that stop the alert are ambulate,
sequential compression device and graduated compression stockings.

b. Pharmacologic actions that stop the alert are various medications such as Heparin and Enoxaparin.

c. Additionally, completing the risk assessment and any recommended orders via the VTE Prophylaxis Guidelines advisor stops the alert from popping up.

2. The VTE Risk Not Yet Assessed alert opens when attempting to sign any orders on a patient who does not yet meet the exclusion criteria noted above.

3. The alert gives the provider an option to open and utilize the VTE Prophylaxis Guidelines advisor directly from the alert by putting a check in the box inside the alert and clicking OK.

   a. An order for signature called VTE Prophylaxis Guideline is placed on the order scratchpad along with the order which triggered the alert to fire.

   b. When the orders are signed, the VTE Prophylaxis Guidelines advisor opens.

4. The advisor walks the provider through various steps to determine the risk factor level and any proposed orders determined from the responses.
a. Patient type such as medical, burn, specific surgical types, etc.

b. Risk factors vary according to patient type. The risk factor is highlighted. The provider can choose, **Continue** to continue.

c. The advisor presents decision points to be answered related to pharmacologic contraindications, mechanical contraindications, delayed prophylaxis reasons, renal function responses and recent rapid onset HIT potential.

d. Select the **Select Recommendation** button to choose the mechanical and/or pharmacologic options being suggested by the advisor.

e. Finally, review the current VTE prophylaxis regimen and select **Document and Sign**.

5. At each step, the provider has the opportunity to **Reset** the advisor or to select a deferral reason.

6. The **VTE Prophylaxis Guidelines** can be ordered from the order catalog, if desired.
**Reference text**

Reference text is informational material presented to users via OneChart.

1. Reference text may link to documents on the Via Christi intranet containing policies, procedures or other helpful information or textual instruction. They can also link to external resources such as CDC documentation.

2. Reference text can be attached at several points:
   a. Orderset
   b. Order level
   c. Documentation level

3. The link is identified by 📄 or 📖 icons which may display and be opened from the order catalog, or order profile.
   i. If set at the orderset level, the link will be in the order catalog and in the order profile next to the plan name.

   ![MED Respiratory Care Algorithm Therapy (RCAT) VC](image)
   ![MED Respiratory Care Algorithm](image)

   ii. Links set at the primary order level will be able to be seen and opened in the order catalog.

   ![Communication Order](image)

4. Whenever the icon is seen, the user can hover over the icon and select the **Click to See Evidence-based Information** option that opens the reference link in a new window.

   ![MED Respiratory Care Algorithm Therapy (RCAT) VC](image)
   ![Click to see Evidence-based Information.](image)
Lab orders

1. Unless the intention is to place a one-time lab order, duration/duration units should be entered when entering lab orders, e.g., 3 times. These order details keep the orders from occurring indefinitely.

2. Do not enter information into the Order Comments tab of lab orders. The automated lab system may not read and act upon information within that tab. If special requirements need to be communicated regarding the lab order, place the information in a Communication Order. The nurse would then need to call the lab when appropriate.

NOTE: If tests need to be added to blood already collected, use the Add On Lab Order found in the order catalog, ensuring that appropriate specimen and adequate quantity of specimen exist in the Laboratory. Indicate date/time of original collection of specimen.

Lab order collection priority and frequency

1. Routine collection priority — best used for one time orders that do not have a time sensitive collection need or need urgent collection and/or resulting.

2. Stat collection priority — should be used for one time orders that must be collected immediately.

3. AM Draw collection priority — used for specimens that should be collected with the early AM lab collections.

   a. Choosing the AM Draw option automatically placed the next morning’s date and a system defined morning time in the collection date and time field.
b. For a one-time **AM Draw**, no frequency, duration or duration unit is needed.

c. For recurring **AM Draw** orders, enter a frequency of Q24hr and the duration the orders need to be collected—such as five times.

4. **Timed Study** collection priority — used for all labs that need a specific collection time and/or a specific interval between collections.

   a. Enter the desired collection date/time. This information is required for all **Timed Study** orders.

   b. If the order will be recurring at a specific interval, enter a **Frequency** to order the time interval, i.e., Q6hr, Q4hr, etc.

      i. Set the **Duration** quantity with a whole number.

      ii. Set the **Duration unit** to number of times.

**NOTE:** Please use **AM Draw** any time the specimen is needed the **following** morning. If the current time is after midnight and the specimen needs to be collected that morning, use **Timed Study**.

**Miscellaneous lab orders**

In some instances, it may be necessary to order an uncommon/esoteric laboratory for a patient.

1. First, search thoroughly for possible laboratory order names in the OneChart order catalog.

2. If the desired order cannot be found, complete a **Laboratory Downtime Requisition**.
a. Include the appropriate test request information and patient information.
b. Send the requisition to the laboratory.

Pharmacy orders

System medication stops

1. **Hard stop** icon displays to note an order with a hard stop that is a system generated stop that will discontinue the order.
2. **Physician stop** acts similarly to the hard stop, but the stop date is generated by the physician because of his/her defined order details.

Non-formulary medications

In some instances, it may be necessary to order non-formulary medications or to use the patient’s own medication supply.

Patient’s own medication use

1. If the drug to be administered will come from the patient’s own home supply, place the order for the specific drug from the order catalog.
2. Complete all the order details in the same manner as a facility supplied medication. Near the end of the detail line, select **Yes** for **Use Patient Supply**.
**Non-formulary medications**

1. If unable to locate a drug needing to be ordered after searching the catalog, it would be best to call the Pharmacy to determine if the drug is non-formulary or in the catalog under an alternate name.

2. If the Pharmacy identifies the desired drug as non-formulary, enter the non-formulary med orderable found in the order catalog.

3. Complete all the order details for drug name, dose, route and frequency.

4. The orders will display on the MAR with the Non-Formulary Med displaying where the specific drug name is normally seen. The drug name from the order details is a freetext field and displays in parentheses behind the order name within the order profile and MAR.

**Hold Medication Dose**

1. The **Hold Medication Dose** order can be used to hold a single dose. If more doses would need to be held, the order should be discontinued and reordered when drug administrations should resume.

2. The **Hold Medication Dose** order will not remove dosing tasks for the nurse. Communicate with bedside nurses to ensure they are aware of the hold order and do not administer an undesired dose.

**Insulin sliding scale**

Correctional dosing insulin sliding scales are available in **MED Insulin Order Set (ISS) VC**. The orderset includes monitoring, hypoglycemia management and insulin (correctional and long acting) orders.
1. Search for **MED Insulin** in the order catalog.
   a. Select the sliding scale that is needed.
      i. The orders include Low, Med, High and Custom sliding scale options.
      
      ![Image of insulin lispro options]

      ii. Within the order details, select the **Order Comments** tab to view the predefined sliding scale information for the Low, Med and High orders.

      ![Image of insulin lispro order comments]

      iii. The provider defines all the parameters in the custom order.

   b. To define the custom sliding scale, choose the custom orderable and open the order details.
      
      i. Click the **Sliding Calculator** icon.

      ii. In the **Calculator** window, enter the details in the **Starting Levels**, **Increments** and **Conditions** response boxes.

      iii. Click **Calculate** and all the details will populate in the lower pane.
iv. Any of the calculated values can be clicked on and manually modified as needed. Click **OK** when done.

v. After the order is signed, the sliding scale details are viewable to the nurse from the MAR.

**Patient Controlled Analgesia (PCA)**

Ordering a PCA can be accomplished through the **PCA VC** or **PED PCA VC** orderset or a single order from the order catalog. Ordering via the orderset, provides easy access to the supportive care and monitoring orders.

1. To view all the possible PCA ordering options, search for **PCA** using the **Contains** filter.

2. Click on the desired orderable. The complete ordersets for the adult and pediatric patients is identified by the icon.

   a. **Bolus/PCA Dose**, **Lockout Interval**, and **4 hour Limit** fields are required to be completed before signing the orders.
b. Within the ordersets, some of these details have been defined in available medication sentences.

3. When all the desired orders and details have been selected/completed, click **Initiate** and/or **Sign** as appropriate.

**Titratable drips**

Titratable drips can be ordered from the order catalog or by using an orderset such as **ICU Cardiac Support VC** or **MED Insulin Infusion VC**.

1. Search for the desired orderset name or medication name through the order catalog.

2. Click on the desired medication or orderset.
   
   a. Ordering from the orderset will provide easy access to any supportive orders and instructions.
   
   b. If ordering the medication instead of the orderset, choose the desired order. The following instructions will use the Dopamine D5W 400mg/250mL Premix as the desired order examples.

3. Open the order details for the medication to be titrated.
   
   a. For medications ordered within an orderset, in the **Continuous Details** tab, a default normalized rate may be in place.
   
   b. For single orders from the catalog, the normalized rate may be blank.
   
   c. A normalized rate is an infusion rate for a drip that is administered at a strength of drug over a period of time. The system calculates the mL/min rate based on the concentration of the bag and the weight of the patient (mcg/kg/min).
4. To change/enter the rate, click on the **Normalized Rate** field and enter the desired values such as 5 mcg/kg/min or 0.05 units/kg/hr and press **Enter**. The rate and order display line automatically updates based on the drug concentration and the entered normalized rate.

![Normalized Rate field](image)

5. To complete the titration instruction/parameters:
   a. Click on the **Details** or **Order Comments** tab to enter your titration instructions.
   b. The **Details** tab includes many predefined detail fields to assist in complete titration instructions.
   c. If the needed detail fields are not available, freetext instructions can be placed in the **Order Comments** tab.

6. Click **Initiate** or **Sign** to activate the orders.

**Modifying a medication**

1. Depending what is being changed, a medication order may be modified, cancelled and a new order placed or cancelled and reordered.

2. **Modify** order action may be done for:
   a. Dose changes
   b. Frequency changes

3. **Cancel/Reorder** order action may be done for:
   a. Stop date changes reorder with the new end date
b. Breaks in therapy with a new start date

4. **Cancel/Discontinue** order action with a **new** order placed from the catalog for:
   a. Route changes
   b. Form changes

**Tapered doses**

Allows system to increase or decrease medication doses at a regular interval and rate.

1. Taper dosing in the system has some limitations/requirements:
   a. Functionality is only enabled for certain medications, which were pre-determined to be taper medications.
   b. Dose must decrease by the same amount every interval, i.e., increase by 10mg every x days.
   c. The frequency cannot be changed during the taper.

2. From the order catalog, select the desired medication. Any order sentence can be chosen because the taper instruction will overwrite the sentence details.

3. On the **Order Details** tab, click on the **Taper Tool**. If the tool is gray, tapering is not available for the medication chosen.

4. The taper tool opens and contains 3 sections of details to complete.
   a. **Start** section needs all the elements completed. The start time is defined from the previous **Order Details** screen.
b. **Taper Details** section allows for defining the taper as either an increase or reduce taper. The details of the tapering rate and interval are entered in this section.

![Taper Details](image)

i. Rate of change can be set as a defined amount or a percentage of previous or starting dose.

![Rate of change](image)

ii. Interval of change can be set to days, doses or times.

![Interval of change](image)

c. **Final dose**, a part of the **Taper Details** section, provides a method to identify what the lowest dose in the taper should be and dose period limit, if needed.

![Final dose](image)

5. After completing all the fields in the **Start** and **Taper Details** sections, click the **Calculate Steps** button.

a. If satisfied with the taper calculation result, click **OK**. Click **Sign** to activate the order.

![Planned regimen](image)
b. After signing the order, the MAR will list the medication taper order line. Click the **Plus Sign** in front of the order to display the details of the taper doses including start and stop dates.

![Screenshot of medication order line](image1)

**System-defined therapeutic substitutions**

Based on the physician-selected medication order, some medications are defined by Pharmacy and the available hospital formulary to have therapeutic substitutions.

1. In the order catalog, if the medication has a defined substitution, a ![icon](image2) displays in front of the name.

2. If one of the substitution required medications is selected, a window of available substitute orders is identified.

3. Select the desired option, and click **OK**.

![Screenshot of available substitute orders](image3)
4. On the order profile, drugs ordered through this process are identified with the icon in front of the line item.

Orders View

Customizing the Orders View

Customize View allows the user to add or remove order columns in the Orders View to allow more order information to be seen in the Order Profile screen such as ordering provider or order stop time.

1. Customize View is easily found by right-clicking on the blue Clinical Category bar where the orders are listed.

2. Select the Customize View option.
3. Using the **Add/Remove** buttons and the Up/Down arrows, adjust the columns to match the screenshot below.

![Columns Adjustment](image)

4. When complete click the **OK** button.

**Filtering the Orders View**

When there are a large number of orders on a patient’s electronic chart, it can be difficult to find a specific order. OneChart has the ability to easily filter these orders to help narrow down the displayed orders to exactly what is needed.

1. Select the **Orders** tab from the chart menu.

2. Click on the **Orders** filter text above the orders listing.

![Orders Filter](image)

3. This action opens the **Advanced Filters** window. To filter orders quickly use the drop down menu at the top of the window. A commonly used, helpful filter is the setting for **All Orders (All Statuses) 24 Hours Back** as seen in the screenshot below.
4. Click **Apply** when finished.

**Dynamic Documentation (DD)**

All users have **Dynamic Documentation** as an available documentation option. Selecting the **Add** button opens the PowerNote options. The user can select **Dynamic Documentation** by selecting the small drop down arrow next to the **Add** button.

**NOTE:** Based on the provider specialty, some providers have access to **PowerNotes** (a different form of documentation).

**Adding a DD note**

1. From any **MPage** section for documentation, or the **Documentation** menu, click the **Add** button.

2. Select the desired note type from the **Type** list. The note types vary based upon provider system defined specialty.

3. Select a **Note Template** from the list found in the lower portion of the **New Note** window.
4. The **Title** will automatically be the same as the **Note Template** name. Alter the **Title** as appropriate.

5. Define the service date and time. Click **OK**.

6. The note opens and may be auto-populated with various data elements such as allergies, problems, etc. depending on the template chosen.

7. Click **OK**, and then **Add** and **Edit** text to complete note.

**Altering the DD Note Template**

1. As you hover over the area near the note sections, a group of symbols become visible.

   a. To remove the section, click on \[\]

   or above the note to return the deleted.

   b. To add a new freetext line, click on the \[\].

   c. For a section which auto-populates from documentation in the patient chart, the data can be refreshed to bring in results which were recently updated. To refresh, click the \[\].

**Saving/signing a DD note**

1. When to use **Save** versus **Sign** a note:

   a. Saving a note allows the provider to come back to the note at a later time to add or change information. This documentation is not viewable in the chart for anyone except the documenter.

   b. Signing a note posts the documentation into the patient record for all to view. Any additions to the note will be seen
in an addenda located at the end of the document.

2. With the note open, click **Sign/Submit** or **Save & Close**.

3. Both options cause a window to open in which you review and correct note types, titles, etc.

4. The note type and other details can be corrected and/or updated until the **Sign/Submit** has been chosen.

5. After **Sign/Submit**, the note appears in the **List** tab of the **Document Viewing** window.

**IMPORTANT NOTE:** Pay special attention to the note type selected. Make sure it matches the template type selected. For example, if you select **History and Physical Note** type, do not pick **Discharge Summary** template.

**Forwarding a DD note for review/signature**

1. After signing the document, highlight the document in the **List** tab.

2. Select **Forward** in the toolbar above the **List** pane.

3. The **Additional Forward Action** box will be prechecked. Choose **Sign** or **Review** from the dropdown list.
4. Search using the Binoculars 🕵️‍♂️ to find the name of the individual to receive the note in their Inbox.

5. Enter any needed comments, click OK to complete the forward process.

**NOTE: Dynamic Documentation** notes done by residents, PAs and NPs must be forwarded in this manner to obtain the required supervising physician’s review and signature. Any time a note needs to be forwarded, this method can be used.

**Modifying an existing note**

1. Highlight the desired document by clicking on the name in the document list.

2. Click the **Modify** toolbar button.

3. If the note is a saved note, the document opens and allows any alterations, both additions and deletions, within the body of the note.

4. If the note is a signed final report:
   a. The note opens with an **Insert Addendum Here** text box located at the end of the document. Type any new information needed to be added into the **Addendum** section.
   b. To remove previously charted information, the user can strikethrough content in 2 ways:
i. To strikethrough auto-populated line items or an entire freetext field, click the X at the right side of the selection.

ii. To strikethrough selected freetext words, highlight the desired verbiage and click the strikethrough formatting button at the top of the Note screen.

5. Text must be typed into the Addendum section before the note can be resigned. When desired changes are done, click Sign/Submit.

**NOTE:** The strikethroughs will display in red and the note clearly identified with *Document Contains Addenda* at the top.

**PowerNotes**

User may have **PowerNotes** defaulted as the style of notes available. If **Dynamic Documentation** is the default, some specialties may have access to **PowerNotes** by selecting the small drop down arrow next to the **Add** button  

**NOTE:** The majority of providers have **Dynamic Documentation** notes. However, based on the provider specialty (i.e., ED, anesthesia, OB, etc.) some have access to **PowerNotes** documentation type.

**Adding a new PowerNote**

1. Single click on the **Documentation** menu tab.
2. Click the **Add** button.
3. A **New Note** window will open.
4. Select the **Type** of note from the drop down box.
   
a. This field determines into which category your document will be filed in the chart.

   ![Type: History and Physical](image)

   b. **Recommended Note Types** will display at the top of the list based on the template chosen.

   ![Recommended Note Types](image)

   c. If a note type other than the recommended is chosen, the system will display a warning next to the note type field.

   ![Warning: This is not a recommended note type.](image)

**NOTE:** If the note type list contains items which are not pertinent to the user, right click in the space where the note type name displays and select **Position Note Type List**.

5. Locate the desired **Note Template**. Each tab includes different search options.

   ![Search Tabs](image)

   a. **Encounter Pathway** tab allows a search of all templates

   b. **Existing, Recent** and **Favorites** tabs present lists of PowerNotes in the patient chart and/or user defined.
c. **Precompleted** tab presents a list of user-created precompleted notes
d. **Catalog** tab presents lists of notes grouped by catalog and folders within each catalog, i.e., *2G Women’s Health*

6. **Highlight the chosen Note Template** and click **OK**.
   a. Within the auto-population window, click in the box for any element for which system generated data is desired to be pulled to the note
   b. The system will remember the chosen auto-population options the next time the **Note Template** is chosen.
   c. When all desired terms are selected, click **OK** to open the note.

**Forwarding a PowerNote for review/signature**

1. After selecting the **Sign/Submit** button, a window will open which identifies the note type, title and date for the document.

2. For positions requiring an endorser, the **Request endorsement** box should be prechecked. Checking the box causes a yellow line of required information fields to display.

3. Place your cursor in the field below **Endorser** and a search field will be visible. Search for and choose the desired individual’s name.
4. Place your cursor in the yellow space below **Type** to display a drop down option of **Sign** or **Review**. Chose the desired option.

5. When complete, click **Sign** to send the document to the endorser’s inbox.

**NOTE:** PowerNotes done by residents, PAs and NPs must be forwarded to obtain the required supervising physician’s review and signature. If a note needs to be forwarded after the signing process is complete, follow the steps for forwarding a **Dynamic Documentation** note.

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**Pre-Completed Notes**

**Pre-completed notes** allow a provider to prepare templates with details already selected. The predefined details can be altered, if needed, before signing. This option helps streamline documentation for procedures and visits that typically follow a routine and/or have typical results.

**To create a Pre-Completed Note:**

1. Open the desired **PowerNote Template** as defined above.

2. Complete details and elements that are often consistent from patient to patient.

3. Click on **Documentation** from the toolbar.

4. Click on **Save as Pre-Completed Note** from the drop down menu.

5. Enter a descriptive title for your note.

6. Click on **Save as New**.
Modifying or Correcting a Signed PowerNote

After a PowerNote is signed it may be opened for correction or modification.

Modify: Allows the addition of an Addendum at the bottom of the note.
Correct: Opens the note in a template view allowing changes to the body of the note.

1. From the Message Center:
   a. Open the note from the documents section:
   b. Select icon to correct the document contents.
   c. Select icon to modify the document by adding an addenda

2. From the Documentation tab:
   a. Highlight the note in the List
   b. Select the icon to open a window providing an option of Modify Note or Correct Note.

3. Complete the addenda or documentation corrections and click to sign and submit from the Message Center or from the Documentation tab.

   NOTE: Once a note is modified it can not be corrected. It can only modified again.
PowerNote Terminology and Symbols

Hide or Show Structure opens or closes a paragraph in the note.

Use Free Text hides any uncharted structure and adds text at the end of the paragraph.

= = = opens a charting field for freetext, numeric, or time/date entries.

<< or >> means that more terms are hidden. Click on the term to expand or reduce the sentence.

Include opens part of the chart to allow user to identify data to pull into the note

Launch will take you to specific flowsheet or section.

(ST) is a Smart Template that will pull a designated dataset into the note.

Template View This view shows the Note Template for data entry. This icon is located on the right side above the scroll bar.

Contributor View This view shows the note in a preview mode. This icon is located on the right side above the scroll bar.

Documentation “Quick” Tips

Create autotext for PowerNotes and Dynamic Documentation

Autotext is a way to store common documentation phrases to be quickly brought into any freetext field of a PowerNote or Dynamic Document.

1. Some system-defined autotexts exist and can be found in Manage Autotext.
   a. System-created autotext can be:
      i. Formatted Text – defined text
ii. **Smart Templates** — retrieves specific results from within the chart as defined by the specific template, such as all active allergies or labs for the last 7 days.

b. Users can define personal autotext entries for their use

2. To create personal autotext, click on the **autotext** icon at the top of the New Note window while in the process of documentation.

3. Click on **icon** to define a new autotext.

4. Define the autotext labels

   a. Type in an abbreviation which will be the shortcut typed to access the autotext content to bring it into the note.

   b. Start with an infrequently used letter or symbol. Commonly a (.) or (/) is used. i.e. /ROS Neg

   c. Type in a description which will be a longer phrase to identify the text content. i.e., Negative Review of Systems.

5. Click the **icon** to open the texts formatting window.

   a. Text can use different font sizes, colors and styles.

   b. Text can be typed directly into the screens, copied and pasted from emails or word documents, or copied from inside a note.

   c. When desired text is complete, convert so that both the upper and lower windows contain text. This allows the autotext to be able to be utilized in **PowerNotes**, **Messages** and **Dynamic Documentation**.

6. Click **OK**, then **Save**.
Use auto-text for PowerNotes and Dynamic Documentation

1. While in a free text box, type the first few characters of the abbreviation.
2. A drop-down menu will appear and allow you to select the needed auto text.
3. Double-click on the desired abbreviation to bring the text into the note.

Macros for PowerNotes

Allows the user to create some frequently used sets of documentation results at the paragraph or sentence level using the PowerNote discrete data elements instead of freetext.

1. From within a PowerNote, choose the desired elements to include in the macro. Free text content can be included in the macro as well as the discrete elements.
2. After all the responses have been selected, right click on the section title and select Save Macro As.
3. Choose an appropriate descriptive title for the selected responses. More than one macro can be created for the same paragraph or sentence.
4. Click on Create New.

To use a macro for PowerNotes

1. Click on the blue M at the end of the section/sentence title to open the list of associated macros to choose from.
2. Choose the desired macro from the drop-down options by clicking on the name.

**Finding documentation**

Clinical documentation of all types can be found within the patient’s electronic chart under the **Notes** tab. Another place in the chart where documents can also be found is in the **Documentation** tab.

**Notes menu section**

1. Single-click on **Notes** in the menu.

2. A list of folders will appear in the active window.

3. Notes can be sorted by several options. The folder names and contents vary according to the sorting choice.

4. Double-click on a folder to open it. A subfolder list may appear within a folder. Repeat until a list of documents appears.
5. Click on the selected note to open it for viewing.

**NOTE:** The green arrows at the bottom of the folder list can be used to navigate through the documents/folders.

**Documentation menu section**
1. Click on Documentation in the menu.
2. The List tab, containing a list of documents consistent with the filter, is displayed.
3. To narrow or change the filter for displayed documents, select Only in the Display box and select the desired filter options.
4. In the second box, select your filter and the appropriate descriptors for any other boxes displayed.
5. After locating the desired document, double-click the note you want to open. The selected note is opened in the editor.

**Transfer Reconciliation**

Transfer Reconciliation should be used when changing level of care for a patient. Transfer Reconciliation encompasses all active orders for a patient.

**NOTE:** Transfer Reconciliation is needed for transfers between ICUs and floors, and between ORs and floors.
1. Open the **Orders** menu, click **Reconciliation** and select **Transfer**.

2. Select the radio button under the green arrow for orders to be continued or the radio button under the red square for orders that should not be continued in the next level of care.

3. Medications need to be addressed individually. Other types of orders can be addressed as a group by selecting the **ALL** box associated with each order category.
   a. Select **ALL** under the green arrow to continue all items of that category.
   b. Select **ALL** under the red square to discontinue all items of that category.

4. Click **Reconcile and Plan** or **Reconcile and Sign** as appropriate for the patient situation.

   **NOTE:** As a timesaver, if most of the orders in a category should be either continued or discontinued, select the all button and then manually change the few individual line item exceptions.

   **IMPORTANT:** If you wish to alter a medication in the reconciliation list, select **Do Not Continue**, then add a new order through the **Reconciliation** window with the desired details.

**Diagnoses & Problems**

1. Open the **Diagnoses & Problems** menu tab.

2. The upper pane displays **Diagnoses** and the lower pane displays **Problems**.
   a. **Diagnoses** pertains to this visit
   b. **Problems** can be across encounters. Many problems address chronic issues.
c. Nursing can enter problems, but only providers can enter diagnoses.

3. The display can include **All**, **Active** or **Inactive** items.

![Display Options](image)

4. The display columns can be customized by right-clicking in the white space of the pane and selecting **Properties**.

5. Highlight the column to be added or reordered and move it as desired using the **Add/Remove** and **Move Up/Move Down** buttons. Then click **OK**.

![Column Customization](image)

**Adding a New Diagnosis**

1. Within the **Diagnoses & Problems** section, click **Add**.

2. In the **Diagnosis** box, type the desired diagnosis or keyword to search for. Press **Enter** or click the **Binoculars** icon.

   a. The search results presented are IMO (Intelligent Medical Objects) terminology, which allows searches on common terminology.

   b. The IMO chosen is mapped to the appropriate ICD code.
3. Select the appropriate diagnosis from the search results and click OK.

4. Complete any detail as appropriate and click OK. Diagnoses details initially display with defaulted details which can be changed.
   a. Type=Discharge
   b. Confirmation=Confirmed

Converting Diagnoses and Problems

A problem can be converted to a diagnosis for the visit or a diagnosis can be converted to a problem.

1. Open the Diagnoses & Problems section.

2. Two methods can be used to convert items.
   a. Click on the desired line item to highlight it and then click the Convert button above the specific pane.
   b. Alternatively, right-click on the desired line item. Hold the right mouse button down and drag the item from one pane to the other.

Modifying Diagnoses and Problems

1. From the Diagnoses & Problems section, click on the item to be modified and select above the specific pane.
   a. For a Diagnosis entry, all fields except for the Diagnosis name and Status can be updated/changed.
   b. For a Problem entry, all fields except the Problem name can be updated/changes.

2. To resolve a problem, change the status to Resolved. Problems with a classification of Medical and a status of Resolved will display in the Past Medical History.

3. To inactivate a Diagnosis, right-click and select Remove Diagnosis. It will display as a strikethrough if display All or Inactive is selected.
NOTE: A Medline search can be done by selecting the i in front of the Diagnosis or Problem name.

Discharge Process

The Discharge Process tab of the Workflow section of the patient chart provides access to all the elements needed for a complete patient departure.

As elements of the Discharge Process are addressed, the buttons associated will turn all blue for Meds Rec and D/C Order. Follow Up, Patient Education and Diagnosis will partially fill with blue and must be manually selected to become all blue.

Discharge Diagnosis

1. The Discharge Diagnosis can be entered directly on this tab. Any active diagnosis can be ranked and/or modified to be a discharge diagnosis. A new diagnosis can also be added from here.
   a. To modify an existing diagnosis, click the pencil icon next to it.
   b. Change the Type field to Discharge and click OK.
Discharge Medication Reconciliation

2. **Discharge Reconciliation** opens by clicking the located on the **Medication Reconciliation** section.

   a. The process is similar to **Admission Reconciliation** except the option to create a new prescription is available.

   b. Choose the button under the green arrow for medications to be continued after discharge, but does not need a new prescription. The pill bottle column is used if a new prescription is needed. The red square should be chosen if the medication should not be continued.

   c. If any required details are missing from the continuing medications, the blue circle icon will be visible. All the required details must be entered before reconciliation can be completed.

   d. If any of the medications requires a prescription to be printed or sent directly to a pharmacy, follow the process of selecting printers/pharmacies as defined in the ePrescribe section, if necessary.

   e. After addressing all new prescriptions first (to send to the pharmacy/printer), use the **Continue Remaining Home Meds** button and then **Do Not Continue Remaining Orders** to efficiently make ordering choices after prescriptions are written.

   f. The reconciliation process completes by clicking the **Reconcile and Sign** or **Reconcile and Plan** when done with all medications.
IMPORTANT NOTE: Only providers can do reconciliation. Nurses cannot do reconciliation.

Follow-up instructions

3. Follow-up Care opens by clicking the + on the Follow-up section. The Follow-up window allows the desired details to be identified.

   a. The Who field allows a specific provider, clinic, care facility etc. to be chosen from identified lists or through a free-text option.

   b. The Where field automatically populates unless the free-text Who option is utilized. Double-click on the address box to edit if necessary.

   c. The When field allows for noting a specific appointment date/time or a wide range of other options.

   d. Click OK to save changes or Sign to sign the information.
Exit Instructions

4. **Exit Instructions** open directly by clicking on the ✦ on the *Patient Education* section, but is a tab which can be opened from the *Follow-up* window.

   a. The system suggests some possible instruction based on the patient chart. Other education topics can be found by using the search bar or opening the *Patient Education* categories.

   b. Choose the appropriate language for the patient. The language defaults to English.

   c. Patient instructions can be customized by editing text/formatting in the instructions display (lower right pane).

   d. Click **OK** after all education content is selected.

Medication leaflets

5. Medication leaflets can be printed in Spanish or English.

   a. Click the 🎨 icon on the upper left toolbar.

   b. Select the appropriate language and search for the new discharge medication. The search window only searches by ‘Begins with.’

   c. Click **OK** to save the medication instructions to the discharge summaries.
Discharge Orders

6. From the **Discharge Orders** section, click the + to open the ordering window.
   a. Select the appropriate discharge orderset for your patient.
      
      ![DISC Discharge Orders VC](image1)
      ![PED General Discharge VC](image2)

   b. Ensure the details of the prechecked orders are updated for your patient's needs

   c. **Sign** the orders and **Initiate** when appropriate.

Completing the discharge process

7. The **Discharge Documentation** can be completed at this point. By selecting the + next to **Discharge Documentation**, the **Documentation** window will open to a **New Note** screen.
   a. The note completion process is the same as any other note. Step by step details can be found in the **PowerNotes** or **Dynamic Documentation** chapters of this guide.

   b. Remember to select the appropriate note type and base template for a discharge note.

   **NOTE:** Providers can still dictate a discharge summary. If the note is dictated, the **D/C Note** button will need to be manually completed.

8. The radio button menu at the top of the **Discharge Process** window will capture the elements that have been addressed and/or completed.
   a. **D/C Note**, **D/C Order** and **Meds Rec** buttons will recognize the element has been completed and display a solid blue circle 🔄 if the electronic system is utilized.

   b. **Follow-up**, **Patient Education** and **Diagnosis** will recognize
the element has been addressed and display a partially filled circle 🔄. Because the system cannot know if the element has been completely addressed, the circle must be manually clicked to display the solid blue circle 🔄.

c. Nursing will use the radio button completion status to help identify when a patient is ready for discharge.

9. Review the patient’s **Quality Measures** as a part of the discharge process.
   
a. Review the measures from the **Quality Measures** section.
   
b. Complete any discharge prescriptions and/or contraindication documentation as appropriate.

**EPrescribe**

As a part of the discharge process and medication reconciliation, the provider may need to create a **New Prescription**.

1. In the **Discharge Reconciliation window**, select the button under the 🔄 icon.

2. If any required details are incomplete, the 🔄 icon will display in front of the drug in the right side of the window. Double-click on the prescription order name to open the detail fields. Complete any **Missing Required Details**.
   
a. **Prescription Routing** is a required field.
   
b. The routing will default to the patient-preferred pharmacy if it has been entered into the system.
c. Select the desired routing method in the **Send To** box in the upper right corner. The preferred pharmacy or printer destination can be chosen from the drop-down options under **Select Routing**.

d. Controlled medication prescriptions must be printed.

3. When the reconciliation is complete and signed by the provider, the prescriptions will print or be electronically sent to the pharmacy.

**Favorites**

Users can save various frequently used items to their favorites folders to speed the ordering and/or documentation processes. Favorites can be created for: **(Orders, Ordersets, Problems, Diagnoses, Procedure History, Past Medical History, Allergies, Medication History, and PowerNotes.)**

**Save an orderset as a Favorite**

Orderset favorites allow the user to customize with specific details and/or additional orders to be used without replicating the work efforts for every patient.
1. Open the orders catalog, search for and select the desired orderset.

2. Select, deselect and modify order details as appropriate. Also add any additional orders using the Add to Phase button.

3. At the bottom of the screen, click the Save as My Favorite button. Enter a descriptive title for your orderset. Keep in mind that this new title displays in the patient chart for all users to see. Via Christi naming convention is to add the provider’s first initial, middle initial and last name within the plan name.

4. Single-click OK.

NOTE: An orderset that was previously completed and planned or initiated can also be saved as a favorite.

5. The saved orderset can be found by clicking the Star icon in the Order Search window.
Save a medication/order as a Favorite

1. Search for a medication or order as normal.
2. Make any appropriate changes to the order details in regard to dosing, frequency, etc.
3. Prior to signing the order, right-click on the medication and click on Add to Favorites.
4. Choose a favorites folder or create a new folder and click OK.
5. The order will be found by clicking the Star icon in the order search window.

Save a PowerNote Template as a Favorite

1. Search for a PowerNote Template from the New Note screen for PowerNotes.
2. Click to highlight the note to be added as a favorite. Click Add to Favorites.
3. The selected note will appear under the **Favorites** tab in the **New Note** window.

**Procedure, Problem, Diagnoses, Past Medical & Allergy Favorites**

A list of favorites for frequently used terms will streamline the documentation process for subsequent patients.

1. Favorites for **Procedure History, Problems, Diagnoses** and **Past Medical History** can be added to the provider’s favorites folder from existing items in a patient chart.
   
   a. If the term already exists on the patient chart, right-click on the specific term desired to be in favorites.
   
   b. Select **Add to Favorites** from the drop down menu.
   
   c. In the folder maintenance window that opens, select the folder the term should be placed in or create a new folder as described in the Organizing Favorites steps below.

2. Favorites can also be added during the **Add New** process for **Allergies, Procedure History, Problems, Diagnoses** and **Past Medical History**.
   
   a. To add a term to favorites during the creation of an item.
   
   i. In the **Add** screen, enter the term in the search screen and click the **Binoculars**.
ii. In the window displaying the search results, click on the desired term to highlight it.

iii. Click on the **Add to Favorites** button.

iv. In the folder maintenance window that opens, select the folder the term should be placed in or create a new folder as described in the Organizing Favorites steps below.

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**Organizing Favorites**

1. In **Orders, Histories, Diagnoses, Problems** or **Allergies** chart section which allows favorites, click the **Add** button.

2. Click the small black arrow icon next to the **Star** icon or **Favorites** icon and select **Organize Favorites**.

3. The **Organize Favorites** window will open to allow editing of folder names, addition of new folders, and deletion of favorites.

4. Click **OK** when done.
Patient lists

Patient lists allow the user to display a list of patients including location and various demographics. The various lists contain specific patients based on defined filters. Patient lists are located by selecting the Patient List icon in the organizer toolbar.

Creating a Patient List

1. Within the Patient List section of the chart, click List Maintenance icon above the Patient List pane.

2. In the Modify Patient List window, choose .

3. Select the type of patient list you want to build and click

4. Types of lists a provider would use include:
   a. Custom lists contain no system-defined filters. They allow user to define no filters or any combination of other available criteria.
   b. Location automatically populates based on the location registration of patients.
   c. Medical Service automatically populates based on the service entered at registration.
   d. Provider Group automatically populates based on the provider group identified in the system for the attending physician assigned by registration.
   e. Relationship automatically populates based on user-defined relationships chosen when entering patient charts and registration-defined Attending/Admitting physician.
5. Choose the defining elements for the list by selecting items in the right pane. If the right pane includes line items with a plus in front of the line, click the Plus Sign to view the individually available options.

6. Select each filter option by clicking in the box in front of the title.

7. Choose any other Patient List preferences desired by selecting the filter type in the left pane and the details in the right pane in the same fashion as noted in steps 3-6.
   
   a. In addition to the primary Patient List type chosen, other criteria to filter can be chosen
   
   b. Additional filter criteria include: Encounter Types, Medical Services, Locations, Time Criteria, Admission Criteria, Discharged Criteria and Use Best Encounter options.
   
   c. To limit the lists to patients currently registered, choose Discharged Criteria and select Only display patients that have not been discharged.

8. After completing all desired filter definitions, enter the desired name for the list and click Finish.

9. The newly created list will display in the left pane under Available lists. To highlight the list name, Select the list you just made from the available list then click Move to move the list to the Active list. Click OK.
a. Available lists have been defined, but are not viewable on the Patient List tab.

b. Active lists are viewable on the tab. The system allows up to 10 active lists at any one time.

Adding a patient to a Patient List

Patients can only be added to custom lists. All other lists have system-defined parameters which cause autopopulation of the lists.

1. Patients can be added to a list by copying the patient from an existing list and placed on another list or by searching for a patient.

2. Copying a patient from one list to a custom list:
   a. Locate the desired patient(s) on a patient list. Click on the patient name to highlight it. Hold down the control key if multiple patients will be copied.
   b. Right-click to display and select Add to a Patient List.
   c. Any lists which can accept the patients will display to the right. Click the desired list name. Change to the selected Patient List tab to view the added patients. If the patients are not displaying, select the to refresh.
3. To add a patient from a search, select the tab for the list the patient is being added to.

4. If the list can accept patients from a search, the 🧾 icon will display in the toolbar. If the icon is gray, the list cannot accept a search patient.

5. Click the 🧾 icon. The Patient Search window will open to accept patient name, MRN, etc. elements to search from.

![Patient Search window](image)

6. In the search results, select the correct patient and desired encounter. Click OK to have the patient display on the list.

**NOTE:** The Refresh button is important. Whenever the screen does not appear to reflect current data, consider using the Refresh button.

7. Add the patient to the list by selecting an appropriate lifetime or visit-specific relationship and clicking OK.

**Granting proxy access to another provider**

1. Click Properties 🏡 from the Patient List toolbar. Select the Proxy tab. Click New.

![Customize Patient List Properties](image)
2. Select the button for either Group or Provider.

3. Either select the desired group from the drop down list or click on the Search icon for the provider name in the search window.

4. Identify the level of access to be granted to the provider/group.
   a. **Full Access** allows provider to use, amend and provide other end users proxy access.
   b. **Maintain** allows the provider to use and amend the patient list.
   c. **Read** allows the provider to use the patient list.

5. If applicable, enter the end date and time to determine the proxy’s expiration. Click OK.

**NOTE:** If someone grants patient list proxy, the accepting individual must open the Patient List Maintenance window and move the proxied list from the available to active window. Proxied lists will not automatically display in the Patient List tab.

**Patient Handoff**

The Physician Handoff view is used while the patient is in the hospital. It provides a concise summary of patients to be used during care handoff between providers. This multi-patient view provides valuable patient information that improves communication between physicians during the handoff of care.
1. To open the handoff screen, click on the **Handoff** button found in the organizer level toolbar.

2. The first time the user enters the handoff screen, it will be blank except for a drop down window used to select a patient list and the message telling them to select a list.

3. The list of available will be the lists in the drop down will be the active patient lists as seen in the **Patient List** section.

![Handoff Screen](image)

4. At a glance, the user can view and/or edit:
   a. Patient locations
   b. Patient name, age and sex
   c. Illness severity—Unstable, Watch, Stable, Discharging
      i. Each severity is associated to a specific color.
      ii. Severity is entered through the **I-PASS** tab which opens by clicking the gray arrow in the center of each line.

   ![Severity Colors](image)

   d. Physician contact name
   e. Diagnosis

5. Additional patient data and handoff information can be found in the window that opens by clicking the gray arrow. The window which opens contains two tabs — **I-PASS** and **Clinical Data**.
a. **I-PASS** tab contains elements which pull in results from the chart and freetext fields to be completed and updated by the providers

i. Data pulling in from the chart include: Procedures, Active Diagnoses, Length of Stay/Expected Length of Stay, and Code Status.

ii. Elements documented by the provider include: Illness Severity, Patient Summary, Actions, and Situational Awareness & Planning,

b. **Clinical Data** tab contains lab results and active medication orders for the last 24 or 48 hrs.

6. **Physician Contact** name displays a single assigned provider on the screen.

a. Clicking the **Assign** link on the screen opens a window to select yourself as the contact.

b. If a different provider needs to be selected or multiple patients want to be assigned, click the button at the upper right of the screen and select **Physician Contact**.

i. Place a check in the box for every patient being assigned to the same physician contact.
ii. Either select the **Assign** button under **Assign Myself** or search for the physician in the provider search window and select **Assign** under the name after locating the provider.
## Icon List

### Organizer ribbon icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Home" /></td>
<td><strong>Home</strong> returns the user to organizer default which is usually Message Center.</td>
</tr>
<tr>
<td><img src="image" alt="Message Center" /></td>
<td><strong>Message Center</strong> opens</td>
</tr>
<tr>
<td><img src="image" alt="Patient List" /></td>
<td><strong>Patient List</strong> opens</td>
</tr>
<tr>
<td><img src="image" alt="Ambulatory Schedule" /></td>
<td><strong>Ambulatory Schedule</strong> opens if appropriate for the provider</td>
</tr>
<tr>
<td><img src="image" alt="Opens" /></td>
<td><strong>Opens</strong> a defined web-based link</td>
</tr>
<tr>
<td><img src="image" alt="Key Notifications" /></td>
<td><strong>Key Notifications</strong> identifies when specific notifications are received in your Inbox</td>
</tr>
</tbody>
</table>

### Action ribbon icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Tear-off View" /></td>
<td><strong>Tear-off View</strong> opens the current screen in a new window</td>
</tr>
<tr>
<td><img src="image" alt="Attach View" /></td>
<td><strong>Attach View</strong> closes the separate window</td>
</tr>
<tr>
<td><img src="image" alt="Suspend" /></td>
<td><strong>Suspend</strong> minimizes and locks the application but leaves it running to allow a quick resume</td>
</tr>
<tr>
<td><img src="image" alt="Exit Door" /></td>
<td><strong>Exit Door</strong> closes the application</td>
</tr>
</tbody>
</table>
Launches Clinical Calculator with predefined formulas and a standard calculator

Ad Hoc opens the list of available documentation forms

Quick access to a list of available message templates

Patient Education/Instruction window opens

Quick access to Create New orders, notes, documentation, allergies or Medication List

Patient-preferred Pharmacy documentation window

Medical Record Request window opens

Change User closes the current user application and opens a new sign-on window

Opens the Charge Viewer tool

Message center icons

Communicate allows quick access to various messages

Opens the highlighted Inbox item

Message journal displays a list of all phone messages, reminders and consults that have been documented for the selected patient

Forward Only forwards the selected item without signing
Select Patient displays only results, messages and other Inbox Items particular to the selected patient.

Select All displays all results, messages and other notifications.

Result Journal opens an endorsed or reviewed results query.

Patient list icons

- Opens List Maintenance to make a new list or alter existing lists.
- Properties allows currently viewed patient list to be modified.
- Add Patient opens a search to add a patient to a custom list.
- Select All selects all patients on the displayed patient list.
- Clear All Selections deselects all the patients on the list.
- Copy copies selected patients so they can be pasted on a different list or report.
- Paste places copied names from the clipboard into a different list or report.
- Customize Columns tool opens so sequence and fields in list can be altered.
- View Charges displays the current financial charges associated with the visit.
- Remove Patient removes the selected patient from a custom patient list.
General chart icons

Home returns the user to the first menu section from their complete list

Move user through the recently viewed chart sections

Increase or decrease size of the section for ease of viewing by temporarily hiding menu ribbons

As Of button identifies time since last refresh and allows a manual refresh

Recent Patient List displays a drop down list of last five charts viewed

Patient Search opens to find patients by MRN or name

Medication reconciliation icons

Prescription Medication documented from a prior inpatient or discharge prescription

Documented Medication by History for patient

Inpatient medication — This was prescribed during the current admission

This medication has yet to be reconciled

Missing Required Details
Eprescribe icons

- Opens a **Dosing calculator**
- **Most Common Choice**
- **Common Choice**
- **Uncommon Choice**
- **Not Mapped**

Order catalog icons

- Precedes the title of either an **Order Set** or **Subphase**
- Reference text information or an associated form is available to open when clicking on the icon
- **Hyperlink** for reference information attached to an **order or orderset**
- Opens the user’s **Favorites folder**
- **Returns** the user back one level in the folder structure
- **Returns** the user to the defaulted order catalog view
- **Moves** the user to the system-defined folder list—may be the same as the home view
- **Initiates the order search** for the text typed in the find window
Orders/medication list upper row icons

+ Opens the Order Catalog Search window

Opens the Document Medication by Hx window

Checks interactions of medication in the patient orders

External Rx History allows viewing of some prescription history from outside sources

Reconciliation not started

Partial reconciliation started

Reconciliation or history complete

Order profile icons

Drug interaction identified as major exists for this medication

This order is part of an orderset

Sub-phase icon seen

This order is pending physician co-signature

This order is pending nurse review

This order is pending pharmacist review

Order has incomplete details which must be completed
Open a **Dosing Calculator**

Reference text or an associated form is available through this linked icon

Order will be discontinued unless renewed

Expand/Collapse the **Order Details** window

**Inactive Order**

**Active Order**

**Prescription Order**

**Inpatient Medication Order**

**Order set icons**

- Merge View
- Initiate Plan or Phase
- View excluded components
- Discontinue
- Plan Comments
- Add to Phase
- Filter phase components
### Mar summary icons

- **Navigator** opens list of customizing or navigating options
- **Show View** opens a menu of possible med filtering options
- **Order pending nurse review**
- **Order pending pharmacy verification**
- **Order is from an orderset**
- **Immediate priority**

### Flowsheet/result icons

- **Graph** plots a line for selected numeric results
- **Seeker** opens a navigation tool to make it easier to locate color-coded result
- **Collapse** the flowsheet navigator
- **Split** the screen horizontally
- **Display** empty columns
- Opens an **Overdue Task** window — nursing
- Opens a **Customize View** window
- Opens a window to change the I/O display start time — nursing
Opens **PRN/Continuous Tasks** — nursing

Opens the **Advanced Graphing Tool** to create a new graph

Opens the tool to **Modify Existing Graph**

**Close the Last Graph** in the viewing pane

**Toggle** up and down through the open graphs

**Workflow/summary/viewpoint icons**

**Find** opens a search to look for a word or phrase on the page—cannot be within a collapsed component

**Expand**

**Collapse** specific page component

Opens a menu for the page or component

Opens the **Depart Process** screen containing the patient and clinical summaries.

Opens the area of the chart identified in the component

**History and dx/problem icons**

Documents **no chronic problems** in a patient chart
Opens the screen to document a new item, which varies according to which tab or section you selected the icon from.

Opens the tool to **Modify Highlighted Line**

Converts the **Dx to a problem** or a **problem to a Dx**

Denotes the entry has a comment in the details

Opens a **Medline Search** screen

Converts the problem to a **Dx**

If the column is visible in the view, the icon identifies content entered as freetext instead of a codified response

**Allergy icons**

- **Interaction Identified against active patient medications**
- **Check active allergies** against the active medications
- **Drug/allergy interaction checking is available** for the line item
- Opens the fields to **Enter a New Allergy**
- Opens the tool to **Modify the Highlighted Line**
Documentation

- **Manage Autotext** to create or modify autotext for *PowerNotes* or *Dynamic Docs*

- Contributor view allows the *PowerNote* to display in the printable format

- **Opens PowerNote** section to accept dictated content if authorized

- **Collapse PowerNote** section and be ready to accept freetext

- Opens a search window to look for specific words in the PowerNote

- Opens **Insert Image** tool to bring a drawing or media manager file into a PowerNote

- **Will In Error** the selected document

- Opens note to **Allow Corrections** to text body

- **Modify** opens note to allow addendum
Data archiving and migration

Meditech
- Pittsburg
- Mercy
- McPherson
- Wamego
- Via Christi Rehab Hospital

NextGen

Soarian

Mirror Image

Via Christi Clinical Archive

Cerner Server Kansas City

Data migration

Migrated data
viewable through native Cerner tabs

Archived data
viewable in Cerner through a link