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| Logo, company name  Description automatically generated |
| Epic ASAP |
| Emergency Department Emergency Practitioner Guided Practice |

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Introduction

Educational opportunities

Classroom training is one piece of your Epic education. Other opportunities to learn more before go-live include:

**E-learning:**

E-Learnings can be rewatched.

There are also recommended after class e-Learnings to reference.

**Independent practice** - Schedule time for practice sessions after class

Access our **Epic Playground** environment and continue your self-exploration through guided exercises found in this workbook.

*At your workstation, you have a Training Tent Card with your login information that will be needed for today’s training.*

If you have questions at any time, please don’t hesitate to ask. We will take a break at the 2-hour mark.

***Any preliminary questions before we get started?***

**Logging into the Epic Hyperspace**

*Let’s begin by logging into Epic by using the* ***Provider User ID (TRN\*\*\*\*)*** *and password* ***(Logins)****; these are located on your Training Tent Card.*

*Once you have selected the* ***Log In*** *button, the Message of the Day will display. Customarily, this screen will display* *upcoming system downtimes. Be aware of what is in the Message of the Day. Click* ***OK****.*

**Accessing The *My Dashboards* Tool**

***My Dashboards*** *is a versatile tool that will allow hospital staff to seek out any data they would like to use for research or other purposes. Before going through a typical patient workflow, let’s explore the important functions of this portion of your Epic System.*

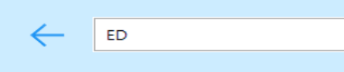
Begin by clicking on the **My Dashboards** button located in the light blue toolbar near the top of your screen.

Click on the link in the center of your screen that says **“Click Here to Open My Dashboards”**

Graphical user interface

Description automatically generatedClick on the dark blue **Show Catalog** button

**Running reports with The *My Dashboards* Tool**

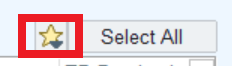
*You will now see the* ***My Dashboards*** *screen for finding any hospital data that has been recorded and categorized within your Epic System. Next, we will look at using this screen to find our desired information.*

Begin by typing **ED** into the **Search Bar** located near the top your screen. Then hit **Enter** on your keyboard.

*Results are now displayed that contain any information relevant to your search.*

To run a desired data report, click on the **Hammer Icon.** The data from this report will now be on your screen

**Saving and Favoriting *My Dashboards* reports**

*Working in the ED time is always of the essence. We will now go over how to quickly save report data so you can easily access it later.*

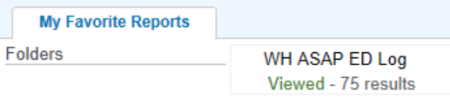
The report you selected earlier should still be open on your screen. To save this report for later review, click on the yellow **Star Button** near the top right corner of your screen

Click **Save View**

Type in a title for your saved report and when prompted click **Accept.** When you are brought to the “Manage Report Views” window, click **Accept** again.

A picture containing company name

Description automatically generatedYour report is now saved. Next, navigate to the left side of your screen and click on the **My Reports** Icon.

Find your list of recently run reports at the bottom of your screen. To make a report one of you *Favorites,* click the **White Star Icon** next to the report name. The **Star** will turn yellow, and your report will be added to your favorites list. You will now be able to quickly find this report the next time you want to use the **My** **Dashboard Tool.**

**Searching for Reports using the Library Function**

A picture containing logo

Description automatically generated*In addition to finding your desired reports by looking through the catalog, you can also for search for them using the* ***Library*** *function of the* ***My Dashboard Tool.*** *The* ***Library*** *function allows you to search not only with a search bar, but also by using a variety of filters that will help you quickly view your desired reports.*

Graphical user interface, text, application

Description automatically generatedTo open the **Library Function,** navigate to the left side of your screen and click the **Library Icon.** This Icon brings you to your report search view.

From this view, you can find reports by entering your criteria in the **Search Bar** near the top of the screen. Additionally, you can use the **Filters Toolbox** on the right side of your screen. In the **Filters Toolbox,** check the **ED Box** to automatically bring up any reports related to the emergency department.

Hovering over any of your results will give you the option to *Run* or *Edit* a Report. We will not edit a report in the training environment because no real data exists.

Congratulations on learning the major functions of the **My Dashboard Tool**! Open the **ED Track Board** and let’s begin our workday in the Emergency Department.

**Let Other Clinicians Know You're Working**

**Sign** into the department.

*Sign In/Sign Out - This allows you to sign in and out of the ED. Signing in and out alerts other staff to who is working in the ED (only visible on the ED Manager) and allows you to assign yourself to a patient.*

From the Track Board, click **Sign In.**



You can add a phone or pager number where you can be reached during this shift.

Click **Accept**.

You can also go to the **ED Manager > Current Staff** list to view other available clinicians.



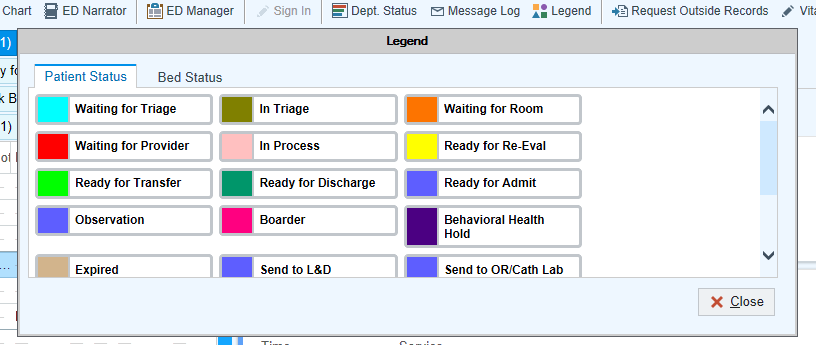
**Find Patients to Be Seen**

*The ED Track Board is an activity used to review patients that are in the ED and where they are in their care process. Not only does the Track Board display where patients are in the ED, but also pertinent information about the patient, such as chief complaint, total time the patient has been in the ED, and if there are any lab results or unacknowledged orders.*

Graphical user interface, application

Description automatically generated You can sort information on the Track Board by clicking any of the column headers. Try that now

*You will notice that patients are all color coded, the color to the left of the patient’s name indicates the patient’s status. To review the color in the far-left column of the Track Board hover over the column in a patient's row to see what status that color indicates. You can also use the Legend located in the toolbar at the top. Do that now.*



***As the patient moves through their ED visit their patient status changes, their Status color will change as well. To manually change the patient’s status, right-click in their row, and select the appropriate status from the status menu.***

**Assign Yourself to A Patient's Treatment Team**

|  |
| --- |
| **Scenario**  Patient Name: Locate your **Val** patient from the Track Board.  Remember to ONLY use the patient listed on your tent card.  Chief Complaint: Complaining of abdominal pain. Presenting with fever, nausea, vomiting, and diarrhea. |

*When we first logged in, we were taken to the ED Track Board, this is defaulted. This screen shows the areas in which a patient might be located within the ED. Patient names become color coded when they are admitted; this color coding indicates where the patient is in the process of receiving care.*

From the **Track Board**. Select your patient's row.

Assign yourself to the patient's treatment team by right clicking the patient and select **Assign Me**, or by selecting **Tx Team** on the Track Board toolbar to see current and past members. For this activity you will use the physician’s name located on your tent card.

You will find this patient on your My Patients View.

Now take a minute to look at the patient’s treatment team members.



* If you are assigning yourself to an Urgent Care patient, they will be classified as “Urgent Care” under patient class. There will be no need to change your context to see this patient demographic.

**Review Patient Information**

You can use the **Triage** tab to review information the nurse entered during triage. Take a few minutes to review the nurse's triage note.

Once you have reviewed allergies, home medications, problem list, and history, or select **Mark All as Reviewed** at the top of the activity.

* + - **Best Practice Reminder**: Review all warnings thoroughly and select close when done.

Now let’s review historical visit information.

From the **Triage** tab, scroll to the **Previous Visits** section, click the **Chart Review** link. You are then brought to Cart Review activity in the **Encounters** tab. From here you can review the patient's last visit. Take a few minutes to review the Chart Review activity. Select each tab to review information.

Leave your workspace active as you work through the Review questions.

Review questions

What activity appears first when you log in?

What is the first thing you should do when logging in at the beginning of your shift?

Where can you view historical patient data?

Where can you view current visit data?

What will the patient's status be after you have assigned yourself to their treatment team?

Why is marking first practitioner time important?

Document an Exam

Your workspace should still be open and on your **Val** patient.

**Place Orders**

Let’s place some orders for Val.

The first tab in the Orders activity is **Quick List. Quick Lists** is intended for one off orders, while **Order** **Sets,** are for comprehensive orders for a particular clinical event.

Take a few minutes to explore the Quick List activity.

* + Now let’s place some orders from the **Quick** **List**
    - Order an Influenza A&B, among any other pertinent orders.
    - Complete all the details and click **Accept** for each order.

Graphical user interface, application, Word

Description automatically generatedLet’s move on and review the patients’ **Active** orders.

From the top of the Orders activity click the Active tab.

From here orders can be Modified, Discontinued, or Reordered.

Select an order and modify the dose and/or the frequency

After you have finished modifying your orders you will click **Sign** to indicate you are finished with them. Before you **Sign** these orders**,** take a few minutes to explore the other tabs.



Now let’s review the orders you selected, from the Orders Pane, or "shopping cart," you see a list of all the orders we want to place for Val. To make the orders active click **Sign,** to sign your orders.

Graphical user interface, text, application

Description automatically generatedLet’s look at how to use **Order** **Sets**.

Select **Order Sets** from the top of the sidebar.

Search for an **Order Set** in the Orders sidebar. (Your order sets begin with “ED”.) Feel free to take a minute and fill out an Order Set pertinent to the care of your patient. Don’t for get to **Sign** your order when you’re done.

**Write an ED note**

*After reviewing the patient’s chart and performing your exam, you determined the patient came into the ED today complaining of abdominal pain and is unsure what could be causing the pain. Your patient also has a slight fever, nausea, vomiting, and diarrhea. Let’s document these findings in a note.*

We’re going to start an ED Note, so let’s go to the **My Note activity tab located at the top of your workspace**.

We will open **Note Writer** by selecting the **Create Note** button.

Graphical user interface, text, application, chat or text message

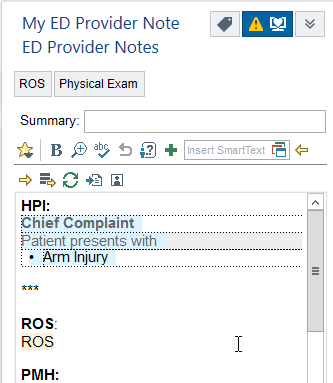
Description automatically generated

A SmartPhrase has been created for your department called (.ednote) Type that into the free text section of your note to pull in the ED template.

When you enter the SmartPhrase it will pull in document assessments from the chart for your patient. You add a SmartPhrase to your note by selecting the period from your keyboard and typing in the type of information you want to add. If you wanted to add the patients age to your note you would type (.age) and the patients age will populate into that section of your note.

Fill in any additional information not provided. Information such as astricts \*\*\* or any SmartLists that required additional information. To easily jump to the next SmartLists and/or \*\*\* you will select F2 from the keyboard.

Continue documenting the **ROS** and **Physical Exam** tabs located at the top of the sidebar:

On each system you can Left-click to document positives, and Right-click to document pertinent negatives. You can add a comment to a specific item by hovering over a button and typing. You can also add a comment to a whole section by clicking the  icon.

Review the generated note from the sidebar.

When you have completed your documentation sign your note.

Graphical user interface, application

Description automatically generated

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|  | **SmartText/SmartPhrase** | **Forms** |
| **What is it?** | A text template with options to customize the text for each patient. | A point-and-click form that turns your selections into note text. |
| **Where is it commonly used in notes?** | Very brief notes (like short H&Ps or simple progress notes)  HPIs with a unique story  Notes with elements that are not options in NoteWriter | Progress notes (including HPI, ROS, and Physical Exam)  Procedure notes |
| **How can I customize it?** | Save your own version as a new SmartPhrase by clicking the green plus sign. SmartPhrases function like SmartTexts, but: Can be created by anyone.  Are pulled in by typing, ".<phrasename>" | Create a macro to apply your normal documentation in one click. Then, change only what is different for the current patient. |

Leave your workspace active as you work through the Review questions.

**Review questions**

From where can I quickly place the bulk of initial orders on a patient?

What can I use to place a set of orders that are typically found together?

What would you do if there is no HPI form for a patient's complaint?

On what tab of the Orders activity would you modify/discontinue orders?

How do you add a comment to a +/- button in NoteWriter?

Where else can you add a comment?

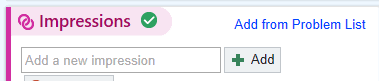
Discharge

Continuing with your **Val** patient.

**Document Discharge Dispo**

Application

Description automatically generated with low confidenceFrom the Track Board select the **Disposition** activity to document a final disposition for the patient.

Document your **Clinical** **Impression**.

Indicate your primary diagnosis in the **Impressions** section.

For certain chief complaints, suggested diagnoses might appear.

Click **Accept**.

* Click **Add to Problem List** next to a diagnosis to add it to the problem list.

Enter **Discharge** as **Disposition** and indicate patient **Condition**. You can also add any additional comments needed in this section.

Go to **Prescriptions & Orders** to perform medication reconciliation. Use the quick buttons to **Modify** or **Discontinue** home medications.

Click **New Order** to write a prescription. Do that now

You will be prompted to select a pickup pharmacy location for your patient. **Enter** any location info.

**Sign** the orders.

Go to **Follow-Up** to indicate whether the patient should follow up with another practitioner.

Complete **Follow-Up** instructions for this patient.

This information appears on the **After-Visit Summary (AVS)**.

A picture containing diagram

Description automatically generatedGo to **Instructions and** select any appropriate attachment and/or free-text instructions that will print with the AVS.

Go to **Work/School and select New.**

* **Complete an Excuse for the patient** to be printed with the **AVS**.

Go to **Chart Status** and click **Preview AVS** to review and print the patient's **AVS**.

Return to the **Disposition** activity.

**Complete Documentation**

* Complete any remaining documentation from **Chart Status** before the patient leaves.

Graphical user interface, text, application

Description automatically generatedMark the patent **ready to discharge**.

Click **Patient Ready to Go** when discharge documentation is complete.

Leave your workspace active as you work through the Review questions.

**Review questions**

Where can you review new results for a patient, and mark them as viewed?

How do you quickly comment on vitals or results to pull them in to your ED Practitioner Note?

When should you click Patient Ready to Go?

Care for Less Complex Patients

|  |
| --- |
| **Scenario**  Patient: your **Richard** patient**.**  Find the patient on the **Track** **Board**  Reason for visit: Urologic Symptoms |

**Place Orders**

Open the patient's chart from the **Track** **Board**.

Place an order from the **Quick List**.

Search for Urinalysis, Macro/Micro with Reflex to Culture under the “Urine” section.

Fill in required order details, such as the **Reason for Exam**.

**Sign** your orders.

**Write a Procedure Note**

In the **My Note** activity go to **Procedure > Create Note** to create a procedure note.

Search for and use the **D/C Urinary Tract Infection-ED** in the SmartText field to document information.

Graphical user interface, text, application

Description automatically generated

* Fill in the template.
* **Sign** your note.

**Document Discharge**

Go to the **Disposition** activity tab and document any pertinent discharge information.

Leave your workspace active as you work through the Review questions.

**Review Questions**

What kind of note do you use to document procedures? Where do you find this?

Where can you review outstanding documentation while a patient is still in the department? When the patient is no longer in the department?

Admission

|  |
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| **Scenario**  Patient: your **Elliot** patient.  Find the patient on the **Track** **Board**  Reason for visit: Abdominal Pain |

*Elliot came to the ED complaining of abdominal pain. His labs and imaging have been completed and reviewed; you diagnose the patient with appendicitis and are going to admit Elliot. The consulting provider or hospitalist on the floor will place the admission orders for the patient. You will be responsible for contacting the hospitalist to arrange for the admit*

**Consult with the Admitting Practitioner**

* From the Track Board go to the **Orders tab** to place a consult order.
* Select the **Internal Medicine Consult Order Set.** Fill in the order.
* Sign the order when complete.
* Consult order will populate the inpatient provider's consult Patient List.

Disposition

* Now we need to complete the Disposition. Select the **Disposition** activity tab from the top of your workspace.
* In the **Disposition** section select **Inpatient**. Document the patient’s condition.
* In the **Clinical Impression** section document the impression of **Appendicitis Acute**.
* Also select to **Add to the Problem List**.

**Reassign patients**

Go to **Track Board > Sign Out** to end your shift.

**Reassign** your patients to other physicians.

**Review questions**

Where do you add the bed request?

How do you assign your patients to other practitioner(s) at the end of your shift?

**Answer key**

Prepare for an Exam

What activity appears first when you log in?

The Track Board

What is the first thing you should do when logging in at the beginning of your shift?

Sign In

Where can you view historical patient data?

Triage tab on the Track Board / Chart Review

Where can you view current visit data?

Triage tab on the Track Board / Track Board reports

What will the patient's status be after you have assigned yourself to their treatment team?

In Process

Why is marking first practitioner time important?

This is a CMS reporting requirement.

It updates the patient's status to In Process.

**Document an Exam**

From where can I quickly place the bulk of initial orders on a patient?

Quick Lists, and then you can search for one-off orders individually.

What can I use to place a set of orders that are typically found together?

Order Set / Order panel

What would you do if there is no HPI form for a patient's complaint?

There are 2 general forms that you could pull in: Illness and Injury.

You can also use free text, Dragon dictation, or SmartPhrases to create your own template.

On what tab of the Orders activity would you modify/discontinue orders?

All Orders tab.

How do you add a comment to a +/- button in NoteWriter?

Hover over the button and begin typing.

Where else can you add a comment?

Any time you see a paper icon, click it to write a comment with the associated section.

**Discharge**

Where can you review new results for a patient, and mark them as viewed?

The Workup tab on the Track Board

How do you quickly comment on vitals or results to pull them in to your ED Practitioner Note?

Click the vitals or results in Workup to comment on them in the ED Course

When should you click Patient Ready to Go?

When all your discharge documentation is complete, and you are ready for the nurse to discharge the patient from the department

**Care for Less Complex Patients**

What kind of note do you use to document procedures? Where do you find this?

A Procedure Note. It is found from either the Procedures activity or the Procedure note type in NoteWriter.

Where can you review outstanding documentation while a patient is still in the department? When the patient is no longer in the department?

Dispo > Chart Status when the patient is in the department

In Basket > Chart Completion after the patient has left

**Admission**

Where do you add the bed request?

From the Orders activity, or from the single-screen Dispo activity.

How do you assign your patients to other practitioner(s) at the end of your shift?

Sign out, then choose one or more practitioners to reassign your patients to.