ASAP Provider Quick Start Guide

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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 in to Epic

*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****.*

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**.

Find patient information on the Track Board

Track Board

The Track Board is the first screen you see when you log in. It contains detailed information about all ED patients. Click  Track Board on the main toolbar to open this activity.

* Click a view button to see a list of patients. For example, click All Patients to see all patients that are checked in and waiting to be seen, or are currently in a room.
* Click a column header to sort the list by that column. A  icon appears to indicate which column the list is being sorted by. Click the header again to reverse the sorting order.

View a patient's status

A patient's status indicates the current stage of the patient's progress through the ED, when events occur the patient's status changes automatically. To see a patient's status on the ED Manager or Track Board, hover over the patient's name in the Status column.

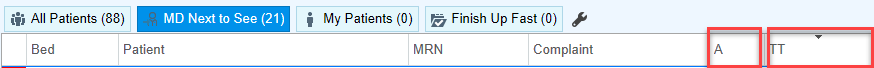
Each patient status is represented by a color, to see what status each color represents, click  Legend. Graphical user interface, application

Description automatically generated

Find patients waiting for a provider

Use Track Board views to identify which patients have been waiting longest or have the highest acuity so you can prioritize them. The MD Next to See view lists patients who haven't yet had contact with a physician. You can further sort patients within the view by acuity or total wait time by clicking the column headers. Once you find a patient, use the Triage and Workup activity tabs in the Track Board to quickly review patient information without having to open the patient's chart.

1. On the Track Board, select the **MD** Next to See view.
2. Click the A or TT column header to find patients with the highest acuity or longest wait time.



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.
* 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**.
* You will find this patient on your My Patients View in the **ED Trackboard.**
* Now take a minute to look at the patient’s treatment team members, **right-click** and select **Treatment Team**.

Side-by-Side Trackboard.

You can learn a lot about your patient without even opening their chart. Use the blue button to expand or hide the side-by-side view. Review information like reports, triage documentation by the nurse, make updates, document impressions and interpretations.

* Select your Val patient to view in the trackboard.



Review the patient's triage information

The Triage activity tab on the Track Board includes triage information documented by the nurse, such as the patient's means of arrival, acuity, vitals, and more.

* Review and update the patient's allergies
* Review the patient's allergies from the Triage tab on the Track Board:
  + Click  to mark the allergies as reviewed with the patient.
* Add or edit allergies:
* Click  to open the Allergies activity, then either select the No Known Allergies check box, search for a new allergy to add in the Add a new agent field, select an existing allergy and update as needed, or click Unable to Assess.
* Click  Mark as Reviewed.
* Val forgot to tell the nurse that she has a Peanut allergy, which causes her throat to swell and make breathing difficult. **Add** this to her chart and click .
* **Exit** out of the chart and go back to the **Side-by-Side Trackboard**.
* Review and update home medications
* Review home medications from the Triage tab on the Track Board:
  + Click  to mark all home medications as reviewed with the patient.
* Add or edit home medications:
  + Click , then either search for a medication to add in the New home med field, click a medication name to edit it, or click  to remove a medication the patient is no longer taking.
  + Indicate when the patient last took the medication.
* In **Med List Status:** select **Provider Complete**, then click  Mark as Reviewed.
* Val tells you she took 2 ibuprophen at home this morning around 8am. **Add** this to her Home Meds, indicate **Provider Complete** and **Mark as Reviewed.**
* **Exit** out of the chart and go back to the **ED Trackboard**.

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|  | * The  icon indicates a patient-reported medication. * The  icon indicates a prescription. |

Review and update the patient's history

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Description automatically generatedReview the patient's history from the Triage tab on the Track Board. Click  to document you reviewed the medical and surgical. For female patients, you can also review their obstetric history.

Click  to open the History activity to review further nursing documentation. In the History section of the Triage navigator, to view more information and family history you will need to click the arrow to open the history activity and go through the History Navigator.

*This is for training purposes, in your normal workflow you will not go in/out of the patient chart, instead you will review all the information on the Trackboard, then enter the chart and begin your work.*

**Tip!** Instead of marking each item as reviewed, if you scroll all the way through the activity the top button to Mark All as Reviewed will appear.

See if lab and imaging results are available

Use the Workup activity from the Side-by-Side Trackboard or the patient’s chart to view the status and final result:

* For a resulted lab, the components and final result appear underneath the lab name. Click the name of a resulted lab to see up to the past three documented results for the lab.
* For an unresulted lab, click  to see the status.
* To be notified when a lab is completed click the .
* For a completed imaging exam, click the final result to read the narrative and impression.
* After you've reviewed new results:
  + Click  New within a single component to mark that result as reviewed.
  + Click  Mark All as Viewed at the top of Workup to mark all new information as reviewed.
* For **Val**, what’s new? When you’ve reviewed the entire Workup thus far, **Mark All as Viewed**.

The button will only be active when there are new results to review. It serves as a *Time Mark* for Results Review, which you can learn more about in the FYI section of this guide.

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| Icon  Description automatically generated | Marking results as reviewed only removes the New Data icon from your view of the Track Board. The results will still appear as unreviewed to other clinicians. |

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| Icon  Description automatically generated | Hover over  Mark All as Viewed to see which sections on Workup contain new data. |

Call out clinical data in ED Course

1. Select your patient on the **Track Board** and go to the Workup tab.
2. **Hover** over things like Vitals, Labs or Images.  When you get a different cursor icon you can click to add that item to your ED Course.
3. Use SmartTools or free text to enter a quick comment or note.
4. Click Accept.
5. Anything you put in your ED Course will later be pulled into your Note automatically.

Try it out:

* For Val, hover over the CBC results and **click** to add to your ED Course.
* In the textbox write **CBC abnormal, recheck 1 hr**.
* Click **Accept**.
* Pick another topic and write your own ED Course note.

Search the chart

Graphical user interface

Description automatically generated with medium confidenceIf you're looking for something specific, or just want to see information that's relevant to a certain condition, save clicks and search the chart. For example, search for "hypertension" to see problems, clinical notes, medications, and other orders related to that condition.

1. Within a patient's chart, enter a keyword in the Search field at the top right of Hyperspace and press Enter.

* Results appear organized by date, so you can get an idea of the history.
* If you prefer to keep your results in view as you chart, click  and select Move to Sidebar.

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|  | Press Ctrl + Spacebar to quickly move your cursor to the Search field. |

1. Hover over a search result to see more info. For example, hover over a medication to see its history, hover over a problem to see relevant meds and labs, and hover over a note to see relevant snippets.

* If necessary, click a search result to open a full report.

1. If you get too many results, narrow them down using the filter buttons at the top. For example, click Meds to see only the patient's medications related to hypertension.

* You can also filter the search results to quickly find relevant notes, labs, imaging, and more.
* Click All to clear your filter.

Try it out:

* In **Val**’s chart search for **asthma**. As they are a training patient, they do not have a robust history.
* You’ll find 1 note mentioning asthma. If there were other results some of the other greyed out tabs would be active.



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|  | Search tips:   * Enter a search term in quotation marks to find results that include only that exact phrase. If you don't enter quotation marks, you also see results for common synonyms and related terms. For example, if you search for arrhythmia, you see results related to arrhythmia, chest pain, and fibrillation. * Refine your search results by using the AND operator. For example, enter arrhythmia AND pain to see only results related to both terms. * Click  at the top right of the Search activity or sidebar and select the Group by Encounter check box to group results by encounter instead of by date. * When organizing your results by encounter, click an encounter heading (indicated by ) to open the encounter report. * Click  to the right of the search field in the Search activity or sidebar to see more tips on searching effectively, including a list of all the items that are included in a search. |

Search for something you see in a report

If you see something in a report or prior note and want to find related information, highlight the term you want to search for, right-click it, and select  Search for <highlighted term>.

Jump to activities

Use the Search field to quickly jump to an activity. As you type, a list of matches appears. Click the name of the activity that you want to open.

Review past visits

Review information about a patient's previous care in Chart Review. It contains information about previous visits, lab and imaging results, procedures, orders, and more.

1. In a patient's chart, select the Chart Review activity tab. The Encounters tab shows the patient's prior admissions, office visits, and ED visits, if any exist. The most recent encounter appears at the top.
2. Select the encounter you want to view. Details appear to the right of the screen.

* If the report is hidden at first, click Preview.

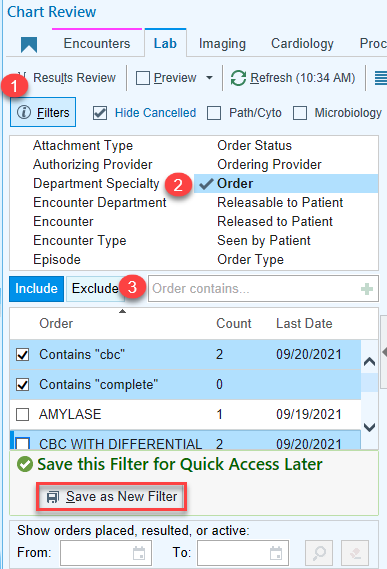
1. Select another tab, such as Labs, to review other information like the patient's test results.

Try it out:

* In **Val’s** Chart Review click on their visit from yesterday.
* Use the links, like **All notes**, **Results**, and **Orders** to see what was done yesterday. Use the  to go back to the encounter summary.

Graphical user interface, text, application, email

Description automatically generated

Filter information in Chart Review

1. While you're reviewing data on a Chart Review tab, such as Labs, click  Filters.
2. Select the type of data on which you want to filter, such as Order.
3. Select the items you want to see from the list or enter keywords in the free-text search field.

* In **Val’s** filter "cbc, complete blood count", and then press Enter to make sure your filter catches labs that use both the acronym and the full name of the lab.

1. Click in the upper right part Chart Review to remove any filters you've applied.

Create Quick Filters

If you frequently filter on certain information, save your settings as a Quick Filters. These filters appear for all of your patients, but only for you. Other clinicians can't see your Quick Filters.

1. In Chart Review, apply one or more filter criteria.
2. To save your current combination of criteria as a Quick Filter, click  Save as New Filter.
3. Enter a name for your Quick Filter and click Accept. The filter appears as a check box at the top of this Chart Review tab.

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|  | To rearrange or delete filters later, click  at the top right of Chart Review and select Manage Quick Filters. |

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|  | If you forget the combination of criteria a Quick Filter uses, hover over it to check its logic. |

Review a patient's ED orders

1. On the Track Board, select your **Val** patient.
2. Click  **Orders**. The patient's chart opens to the Orders activity.
3. Go to the **Active** tab. Review all orders that have been placed and are currently active.

Graphical user interface, text, application

Description automatically generated

Place an order

To place orders to be carried out while the patient is in the ED, use the Orders activity. To open it, select the  **Orders** tab in a patient's chart.

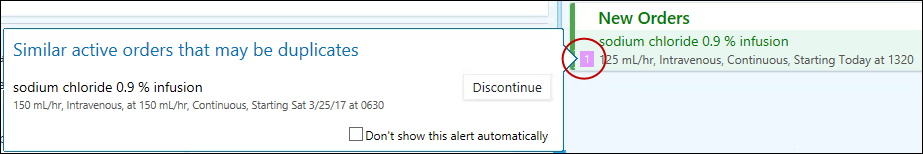
|  |  |
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|  | You can order a prescription for the patient to take home at discharge. See the Admit and Discharge guide for more details. |

#### Place common orders from quick lists

Quick lists are targeted lists of common orders that automatically appear in the Orders activity. You can select medications, labs, and protocols from quick lists without having to search.

1. Go to **Orders > Quick List**.
2. Select the check box for each order you want to place.
3. Review the orders in the Orders sidebar and click  **Sign**.

If you select an order that's already active for the patient, it appears highlighted with a number in the Orders sidebar. Click the number to review possible duplicates before signing the order.



#### Place individual orders that don't appear on a quick list

If the order you want doesn't appear in a quick list, search for it individually.

1. Enter a few letters of the order in the **Place new orders or order sets** field in the sidebar and press **Enter**.
2. Select the order you want in the window that appears and click **Accept**. The order appears in the sidebar.
3. Click the Summary Sentence to open the Order Composer and make changes to your order.
4. When you're finished selecting orders, click  **Sign**.

Try it out:

* Select a CMP, Lipase and a Urine Culture.
* Use the search field to look for **Zofran** and click .
* You will need to enter information for any hard stops.
* Then you will need to sign your orders.

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|  | Click  to remove an order you don't want. |

Write multiple orders with an Order Set

Order Sets help you quickly place multiple related orders. For example, there are Order Sets for stroke, trauma, and STEMI.

#### Choose an Order Set

1. Search for an Order Set in the **Place new orders or order sets** field, the same way you search for individual orders. To preview an Order Set, click .
2. Select the Order Set you want and press **Enter**. The Order Sets activity opens.
3. With an Order Set selected, click  **Open Order Sets**.

#### Select orders

In an Order Set, select the appropriate orders for your patient. Some orders might be preselected for you.

Check boxes () indicate that you can choose one or more orders within a section.

Option buttons () indicate that you can choose only one order within a section.

A stop sign () indicates a required section.

Try it out:

* Search for **abdom** in the Order sets search field.
* Select the **Aspirus ED Physician Abdominal Pain < 18 Years Old**. Click **Accept**.
* In the order set select a **Lactic Acid** lab, a **CT** scan (address the warnings) and **Protonix**.
* **Sign** the order set.

Respond to medication warnings

Medication warnings appear when you sign an order that might interact dangerously with other medications, food, or allergies. A warning might also prompt you to check the dose of the medication, duplicate therapies, or IV compatibility.

When a warning appears, you can either remove the order or override the warning.

1. Click **Remove** next to each order that you want to cancel. If you remove all orders, the  **Override and Accept** button changes to  **Accept** at the bottom of the window.
2. To enter an override reason for individual medications, select an override reason next to each one.
3. To enter one override reason for all of the medications on the list, select an override reason at the bottom of the window.
4. Click  **Override and Accept** when you are finished entering override reasons, or click  **Accept** if you chose to remove all orders.

Try it out:

* Order **Toradol** for Val.
* **Sign** the Order and work through the Medication Warnings. Use the in the search field to see a list of accepted Override reasons or use the quick buttons at the bottom of the pop-up.

Start a note

#### Start a note from the Track Board

Graphical user interface

Description automatically generated with low confidenceWith your patient selected on the Track Board, click  **My Note** at the top of the side-by-side workspace to open the Note activity.

#### Start a note in a notes navigator section

A picture containing graphical user interface

Description automatically generatedIn the **ED Provider Notes** section of the My Note activity, the tools available vary depending on the type of note. Click on **Create Note in NoteWriter** to begin a note.

HPI Note

The first tab in your NoteWriter activity covers the history of present illness. You can utilize a Smart Phrase for this Narrative or you can free text this information. For those who will have access to M\*Modal, you could use the mic in this box as well.

Try it out:

* Use free text to note that Val is a 30 yr old male presenting with abdominal pain.
* In the form below indicate that the information was provided by the patient, without limitations.
* The next form was automatically pulled in based on the chief complaint. You can add other HPI forms using the search bar to **Add an HPR form**. Search for **Foot**, it will present you with options, select **Foot Injury**.
* If you add a template in error, click the **Remove** button on the ride side of the form and then click **Discard.** Do that with the **Foot Injury**.
* Fill out the Abdominal pain HPI based on the patient's report of pain is located in the right lower quadrant and radiates into his epigastric region of his abdomen. It started suddenly about 4 hours ago, and it’s intermittent. He currently rates his pain as a 7/10 and describes it as sharp and moderate in severity. Patient reports that pain is relieved when he brings his knees to his chest.
  + To comment on something in the HPI Form click on the paper icon type your comment and hit enter. Hover over the  icon to read the comment.
* For associated symptoms you can document them easily by using a **left-click** for a positive response, and **right-click** for a negative response. Fill out the rest of the HPI based on the patient reporting he has had headaches but denies constipation. He reports that his abdominal pain is aggravated by coughing.

Notice the note in the sidebar to the right is populating with the responses you’ve selected above. At this point you would be able to add additional free text and/or SmartPhrases to make note writing faster.

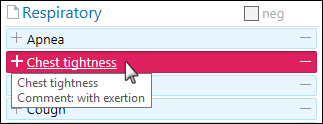
Write a note with point-and-click NoteWriter forms

1. Graphical user interface, text, application

   Description automatically generatedMove across to the **ROS tab to document your systems review**.
2. Document pertinent positives and negatives by clicking buttons.
   1. **Left-click** to mark an item positive.
   2. **Right-click** to mark an item negative.
   3. Click again to undo your selection.
   4. Select the **neg** check box to mark an entire section negative.
3. Review your full note in the sidebar. Add to or edit your note by typing or using SmartTools.

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|  | Click  to remove all documentation on a single tab of the NoteWriter. |

#### Add comments to your note

There are several ways to add comments in NoteWriter:

To enter comments about a section, such as GU, **click** . Hover over  to see the comment.

To add a comment for a positive/negative button, double-click the button or **hover** over a button and **start typing**. Buttons with comments are underlined. Hover over the button to see the comment.

Try it out:

* Document a ROS using your clinical background for your **Val** patient.
* Make sure you practice entering various comments.

#### Phyical Exam

Once you are in the Physical Exam tab, you will notice there are tabs within it as well. The first tab will be related to your patient’s chief complaint. You will document the details of the exam you performed using the symptom buttons that were previously discussed on the previous two tabs.

Graphical user interface, application

Description automatically generatedUse the system-specific tabs, such as Cardio or Skin, at the top of the **Physical Exam** tab to document an area in more detail.

Most system-specific tabs on the **Physical Exam** tab include an image and drawing tools.

1. Select a drawing tool on the left to record your observations. To see what each drawing tool is for, hover your mouse over them.
2. Record your observations.
   1. To add an icon, click once.
   2. To add an icon of a different size or shape, click and hold the left mouse button, and drag the icon.
   3. Click  to remove the last icon you added.
3. Select the comments tab to include notes, if necessary.

Try it out:

* On the **Abdominal Pain** tab, document the details of the exam you would perform using to symptom buttons (similar to the HPI and ROS buttons).
* Go to the **Abd** tab and add additional detail, then circle the area on the abdomen where they are experiencing pain. **Click** on the **pencil**, choose a color and **circle**. Describe or write a comment.
* Look at the note pane on the right and see how your documentation is brought into your note.

#### Document procedures using NoteWriter

Graphical user interface, application

Description automatically generatedTo ensure that you capture all procedure charges, use an ED Procedure Note to document procedures in a NoteWriter note. You can point and click to document discrete data in the NoteWriter.

1. In Notewriter the last tab is for **Procedures**.
2. Verify the performing and authorizing provider fields are correct.
3. There are preformatted templates for various procedures. If you do not see one that is needed, you will need to free text the note unless there is a SmartPhrase for it.
4. Click the relevant buttons to document information about the procedure.
5. You can optionally write a comment in the Comments section using free text or SmartTools.
6. To write additional procedure notes for other procedures you performed, click **Add Another Procedure**.

Try it out:

* Select a procedure to document (use the drop down to see more).
* Complete the pertintent information.
* On the **Edit Note** sidebar tab, review your note text and enter additional text using free text or SmartTools.
  + If you wrote multiple procedure notes, they all appear in the Edit Note tab for review.
* When you've completed the note, click  **Sign** to finish your work.
  + You may still have *wildcards* or *SmartLists* to be filled out. Scroll to the top of your note.
  + Click in the beginning of your note and hit the **f2** key on your keyboard.
  + It will open or highlight the first missing information, in this case, a **wildcard \*\*\***, this is a free text area for you to type in your note (or use M\*Modal). When you start typing the \*\*\* will be deleted.
  + When you are done typing, hit **f2** again to move to the next area that needs to be filled in.
  + When they have all been addressed you can **Sign** your note.

Finishing your Note later

Graphical user interface, website

Description automatically generatedIf you’re not done with the note you can **Pend** your note to save it and come back to edit it. Make sure that when you come back to writing your note that you **do not** start a new note, instead **edit** your existing, incomplete Note. When you click Pend you will see your note has a watermark in the background, marking it as incomplete.

If you **Sign** your note and later need to add more information you do not need to start a new note. Instead you can **addend** your note to open it and continue documentation.

*You should have signed your note for Val already, now you’ll need to addend it so you can practice using SmartTools.*

Write a note with SmartTools

SmartTools are charting shortcuts that you can use to pull different information into your documentation. You’ll learn about them first, then you’ll be able to practice. There are several different types of SmartTools:

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| SmartTools | Use to pull in |
| SmartPhrases | Long words, phrases, or paragraphs |
| SmartLinks | Information from another part of the chart, such as the patient's name or most recent set of vitals |
| SmartTexts | Templates or longer blocks of text |
| SmartLists | A predefined list of choices |

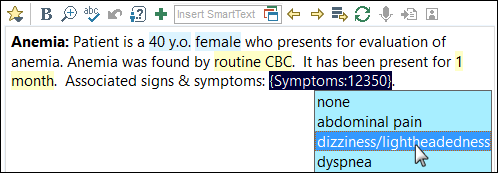
|  |  |
| --- | --- |
|  | You can use SmartTools in many places throughout Epic, such as notes, patient instructions, and letters. If you see these buttons, the field is SmartTool-enabled: |

#### Use a SmartPhrase

SmartPhrases allow you to type a few characters that automatically expand to a longer phrase, paragraph, or template. A commonly used, and HIM approved, SmartPhrase used by ED Providers at Aspirus is **.EDNOTE**

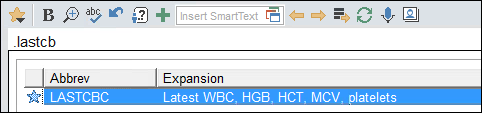
1. In a SmartTool-enabled field, enter a period (.) followed by the SmartPhrase's name. For example, enter ".hpianemia". As you type, a list of matching SmartPhrases and SmartLinks appears.
2. Use the arrow keys to select the SmartPhrase you want to use and press **Spacebar** to insert it.
3. Press F2 to jump to the first SmartLists or wildcard (\*\*\*) in the SmartPhrase.

A wildcard (\*\*\*) is a placeholder. You can type over it with your own text or delete the placeholder.



#### Use a SmartLink

SmartLinks help you write notes quickly by pulling or "linking" information from the patient's chart directly into your documentation. SmartLinks often appear within SmartPhrases, but you can also use them on the fly. Enter a period (.) followed by the SmartLink's name, as you do when using a SmartPhrase.



|  |  |
| --- | --- |
|  | When inserting a SmartLink, press **Enter** to start a new paragraph after pulling in the SmartLink. Press **Spacebar** to continue with the same sentence or paragraph. |

#### Use a SmartPhrase

SmartPhrases allow you to type a few characters that automatically expand to a longer phrase or paragraph. For example, typing ".obhist" and selecting the OBHIST SmartPhrase pulls in a table with the patient's OB history.

1. In a SmartTool-enabled field, enter a period (.) followed by the SmartPhrase's name (".obhist"). As you type, a list of matching SmartPhrases and SmartLinks appears.
2. Use the arrow keys to select the SmartPhrase you want to use in your note and press **Spacebar** to insert it.
3. Complete any SmartLists and wildcards (\*\*\*) in the SmartPhrase.

#### Browse available SmartPhrases and SmartLinks

1. Click  on the SmartTools toolbar to see any SmartPhrases you've created. If none appear, select **System SmartPhrases** to see all available phrases.

The **Abbrev** column shows you what to type after the period (.) to use the phrase or link in a note.

The **Expansion** column shows you the text that the phrase or link pulls in or, for longer phrases, includes a general description of the text.

 indicates a SmartPhrase.

 indicates a SmartLink.

1. To find phrases and links, you can:
   1. Use the **Filter** tab to select the SmartTools you want to see.
   2. Search for specific links or phrases.
   3. Click  to mark links and phrases as favorites.
   4. Use the **Sort** tab to control which items are listed first.
2. Double-click a SmartPhrase or SmartLink to insert it.

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|  | To see all available phrases and links, enter ".?" in a note. |

#### Use a SmartText

SmartTexts are standard templates or blocks of text used to write notes for routine visits or patients with problems you see often.

1. Enter a few letters of the SmartText's name in the **Insert SmartText**  field and press **Enter**.
2. On the SmartText Selection window, double-click a SmartText to insert it.
3. Press **F2** to complete any SmartLists and wildcards (\*\*\*) in the SmartText.

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|  | Preview the contents of a SmartText on the right-hand side of the SmartText Lookup window before adding it to your documentation. |

#### Select from a SmartList

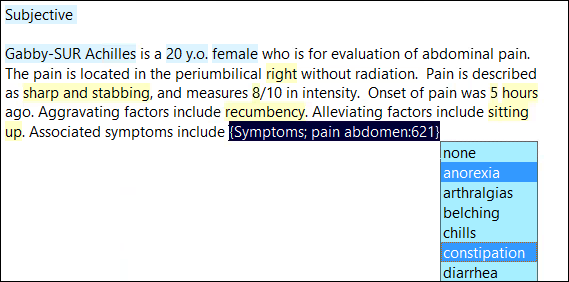
SmartLists are lists of common choices that help you quickly customize your documentation. SmartLists can be included in SmartTexts and SmartPhrases and look something like this: {resp history:19195}.

1. Press **F2** to highlight the next SmartList or wildcard (\*\*\*) in your note. Some values in a SmartList might be selected for you.
2. **Left-click** other values to select them.

A yellow background indicates that you can select only one value.

A blue background indicates that you can select one or more values.

1. If you accidentally select a value, click again to clear it.
2. **Right-click** inside the SmartList to save your selections and move to the next SmartList or wildcard.



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|  | Use the mnemonic "**left-click to pick, right-click to stick**" to remember which mouse button to use when you're making selections. |

#### Undo a SmartList selection

To undo your last selection, click  in the menu on the top or press **Ctrl+Z**.

To undo any SmartList selection, right-click the SmartList and choose **Reselect This SmartList's Selections**.

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|  | You can also use the keyboard to complete SmartLists. With a SmartList selected, press **Up Arrow** and **Down Arrow** to move through the list. Press **Spacebar** to select a choice. Press **Enter** to accept your choices and move to the next SmartList or wildcard (\*\*\*). |

Try it out:

* Click **Addend in NoteWriter** on your note to reopen it for editing.
* In the **Narrative** section of the HPI type in **.cbc** and hit enter.
* In the  field, type in **abdominal** and hit enter.
* Preview the **Abdominal Pain** SmartText and click **Accept.**
* Use **f2** on your keyboard to open the next SmartTool.
* **Left-click** to pick, **right-click** to stick your options.
  + A blue list means you can pick more than one, a yellow list means you can only pick 1.
* Work through the SmartText to enter your note.

*It is probably redundant with what you’ve already done, this is for your practice, not a typical workflow.*

* If there are areas that are unnecessary for documentation you can highlight and delete those lines.
* When you’re done, **Sign** your note.

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|  | You will see and learn about creating NoteWriter Macros and your own SmartTools, but since you’re not logged into your own account, no customizations you do today will follow you into your work environment. Use the FYI section to learn more and create your Macros when you login to Hyperspace using your account. |

Enter a discharge disposition

We use the single screen Disposition activity to document the patient’s disposition for discharge, admit or transfer. You will enter the clinical impression, follow-up, education and instructions for the patient.

1. Open the Dispo activity from the Side-by-Side Trackboard  or from the chart Logo

   Description automatically generated.
2. You are able to add a SmartSet, there may be some suggested based on the Chief Complaint, or you can search to add a SmartSet. The smart-set will auto populate the Disposition and you will only see what is relevant to your selection.
3. If you don’t use a SmartSet, in the Disposition section, select the appropriate option.
4. Add any comments using free text or SmartTools, and complete any SmartLists or wildcards (\*\*\*).

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

Description automatically generatedTry it out:

* Open the Dispo activity for your **Val** patient.
* Select the SmartSet **ASP ASAP Adult Abdominal Pain Discharge**.
* Notice how it fills out the Dispo, Impression, gives a list of suggested medication, letters, follow-up and instructions.

Review and update clinical impressions

Graphical user interface, text, application, Word, Teams

Description automatically generatedThis section is where you will document the patient’s **diagnosis** for the visit. Multiple impressions can be entered, whichever was entered first is listed as the primary diagnosis (indicated by the diamond). If you do not use a SmartSet, or if you need to change the clinical impression that auto-populates, follow these instructions.

Enter a clinical impression

1. Add an impression using one of the following methods:
   1. Select one of the suggested impressions. Impressions are suggested based on the patient's chief complaint.
   2. Click the Add from Problem List link to view and select from the patient's active problems. Click Add from Suggestions to see the suggested impressions again.
   3. Enter a few letters of a diagnosis in the Add a new impression field and press Enter.
2. Optionally, you can also click the impression to enter additional information about it, such as whether it is the primary impression on the list.

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|  | * The  icon indicates the principal problem (the main reason for a hospital stay) in the problem list when a patient is admitted. * The icon indicates a chronic (ongoing) problem. |

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|  | To view resolved problems, select the Past Problems check box. You can also click  and select whether you want to see multidisciplinary, non-hospital, and deleted problems. |

Try it out:

* Add a Clinical Impression of **UTI** in the Add field.
* Choose **UTI (urinary tract infection), bacterial**
* Click **Add to Problem List** to include the diagnosis in the patient’s problem list.

Electronically prescribe discharge medications

1. When you are ready to place new orders during discharge, click **New Order** in the **Prescriptions & Orders** section of the Dispo activity. The Orders sidebar opens.
2. In the search window, double-click the medication you want to order. If you select a non-formulary medication, the Alternative Selection window opens and shows formulary alternatives. Accept the alternative or continue with the original order.
3. Complete the order details and sign the order as usual.

Try it out:

* Select one of the medications suggested for **pain**.
  + *Our provider training logins are not set up to E-prescribe.*
* Then add a **New Order**, search for **ceph**, many of the searches within Epic just need the first few letters to find what you need.
* Select the 250mg capsule of **cephalexin** and click **Accept**.
  + The **InstyMeds** option is for the machines located outside the ED for **after hours** use, or if the patient doesn’t want to go to a pharmacy.
* **Sign** your order, search for the **Aspirus** Pharmacy and click **Accept**.

Attach a Letter

If a patient requests an excuse you can easily add a letter using the suggested SmartSets. Select the type of Letter needed and, if there are any, fill in the hard stops, SmartTools or wildcards \*\*\*. Remember you can use **f2** to get you through, **left-click** to pick and **right-click** to stick.

Try it out:

* Select a **Work** excuse for **Val**.
* Give him a return date of **t+1** (tomorrow)
* Make sure your name is selected for **Signed**.

Specify follow-up providers at discharge

When patients are discharged, their **After Visit Summary (AVS)** includes follow-up names and contact information. You will see suggestions from the SmartSet, which auto populated according to the SmartSet you chose for patient dispo.

Specify the patient's PCP, care team, or the ED

1. In the Follow-Up section of the Dispo activity, select where or with whom you want the patient to follow up:

Click PCP to pull in the patient's PCP from the care team.

Click ED if the patient should return to your ED for follow-up

Click Care Team to select from a list of the patient's care team members.

1. Choose how, when, and why the patient should follow up.
2. Repeat the previous steps for any additional follow-ups.

Specify a new provider

1. In the Follow-Up section of the Dispo activity, click  Other - Lookup.
2. Use the Name, Specialty, or Location fields to look up a clinician.

If there are too many results, enter more information to narrow your search.

If the results don't include what you're looking for, remove some of the information you entered.

1. Select the appropriate clinician from the list of results. The name and contact information appear in the Follow-Up section.

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|  | Select the Search near me and near the patient option to limit the search to ZIP Codes near your login department, the patient's home address, and the patient's workplace. |

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|  | Enter the name of the follow-up clinician, department, or organization in the Other - Free Text field of the Follow-Up section if you can't find what you're looking for in the search window. Note that if you do this, follow-up information won't be automatically sent and the patient's encounter won't meet regulatory requirements. |

Try it out:

* In the **Follow-Up** section Us the **Other – Lookup**.
* On the left side colum of the pop-up under **Provider Specialty**, search for **Family Medicine**.
* Select a provider from the list.
* Then indicate that Val should schedule an appointment with the provider in 2 days if symptoms worsen.

Speed up discharge with customized speed buttons (for ED)

Save time during discharge by making buttons for your most frequently used selections.

1. In the Follow-Up section of the Dispo activity, click  next to the buttons for when and why the patient should follow up.
2. Edit the frequency or reason for follow-up fields as needed.
3. Click Move Up or Move Down to change the order in which the buttons appear in your navigator.
4. Click Accept.Order prescriptions for the patient to take home
5. Go to the Medications section in the Dispo activity.
6. Click New Order.
7. At the bottom of the Orders sidebar, verify you've selected a pharmacy for any medications that will be e-prescribed.
8. Enter new orders for medications or referrals in the Place new orders field in the sidebar.
9. Click  Sign. The prescriptions are now electronically signed and are either printed to give to the patient or are e-prescribed to a pharmacy, depending on whether or not the medication can be e-prescribed.

Write discharge instructions

1. Go to the Instructions section of the Dispo activity. Suggested discharge instructions appear based on the diagnosis or medications you've ordered for the patient.
2. If there aren't any suggested instructions, or to search for additional instructions, click the Clinical References  link. The Clinical References activity opens.
3. If you prefer free text or have SmartTools created you can use the **Patient Instructions** box to include those items.

In the Clinical References activity, documents appear on the **Relevant Documents** tab based on diagnoses or medications you've ordered for the patient. To search for other documents, use the **Additional Search** tab.

1. Click a reference document to preview it.
2. Select the check box next to a document to add the reference material to the patient's chart.
3. Edit the materials or add more instructions, if necessary.

To edit the materials, click the Edit link in the lower left pane, edit the material in the window that appears, and click Accept.

To enter additional instructions, select the Patient Instructions tab on the right-hand side. For example, you might include a comment asking the patient to review the section about reducing the risk of heart disease.

Graphical user interface, text, application

Description automatically generatedAny instructions you attach will be pulled into the **AVS** for the patient to review.

Try it out:

* Select a suggested attachment in each tab (the tabs are based on the entered Clinical Impressions).
* You’ll see them pop up under **Attached Instructions**. Click on them to review, edit/customize the instructions for your patient.
* Explore and preview other patient instructions and education by clicking on the **Clinical References** link.
* Select another attachment for the AVS, then go back to the **Dispo** activity in the patient’s chart.

Complete Charting Reminders

Graphical user interface

Description automatically generated with medium confidenceCheck for incomplete documentation using the **Chart Status** section of the Dispo activity. Click a tab, such as AVS Checks, to expand the group and see what documentation is outstanding.

Red items **need** to be completed before discharge, yellow items are **suggested** to be completed before discharge and green items are **complete**.



Use the Finish Up Fast view on the Track Board to find and complete incomplete charts.

Try it out:

* Click on the **AVS Checks** under **Chart Status**.
* Look over what is incomplete. *(Registration is not done)*
  + Is there anything left undone that is the provider responsibility? If so, take care of those missing items.
* **Preview** the AVS so you know what the patient will receive.
* **Final Step:** Mark the patient **Ready to Go** so that nursing staff know to discharge the patient.

Finish a chart

After you enter a disposition for a patient and finish all of your documentation, including signing the patient's notes, you need to complete any remaining chart deficiencies and reminders. The Finish Up Fast view on the Track Board helps you keep track of patients with outstanding documentation so that you can finish it while the encounter is still fresh in your mind, leaving less room for charting errors.

Graphical user interface, application, Word

Description automatically generated

Find incomplete charts

1. Select the  Finish Up Fast view on the Track Board to see a list of patients you cared for who have unfinished documentation and chart deficiencies.
   1. Note: The Finish Up Fast Track Board view only shows patients who are no longer in the department and whose care team you are no longer on.
2. Select a patient's chart.
3. Review the missing documentation that appears in the Finish Up Fast report. Some documentation, like signing orders, can be done right from the Track Board. For other deficiencies, click the links in the My Incomplete Reminders section to open the appropriate activity in the patient's chart to complete documentation.

After all deficiencies on the To Do sidebar in the chart are complete, the chart is automatically removed from the Finish Up Fast View.

To open a chart you completed in the past 24 hours, click Completed.

If you have other documentation to complete, use the arrows to move to the next chart, or click another chart to open it. Hover over a chart to see patient information before opening the chart.

Knowledge Check!

Using the workflows that you’ve seen and practiced above, work through the following steps:

* Go to the **ED Trackboard**.
* Find your **Richard** patient and assign yourself to his treatment team.
* Use the **Side-by-side** view to review all the nursing documentation and lab results.
* Enter a comment on a lab in the **ED Course**.

**Trainer Check**- if you have questions or need assistance ask now!

* Open the **Note** activity.
* Using **NoteWriter** document the HPI, ROS, and Physical Exam.
  + In the **Insert SmartText** box, search for **uro**, and select the URO Abdominal Pain SmartText to work through.
  + Remember: **f2** to get through, **left click** to pick, **right click** to stick (and open the next list), a **yellow** list is one and done, **blue** it’s up to you (how many you select).
  + **Pend** your note.
* Open the **Orders** activity, and place the orders that you would use for a patient like Richard.
  + Including a **consult**.
* After you **sign** your orders, go back to your **Note**.
  + **Edit** the incomplete note and document **Procedures** you would do on this test patient.
  + **Sign** your note.
* Open the **Dispo** activity.
* You will be **admitting** Richard per the consult that you ordered.

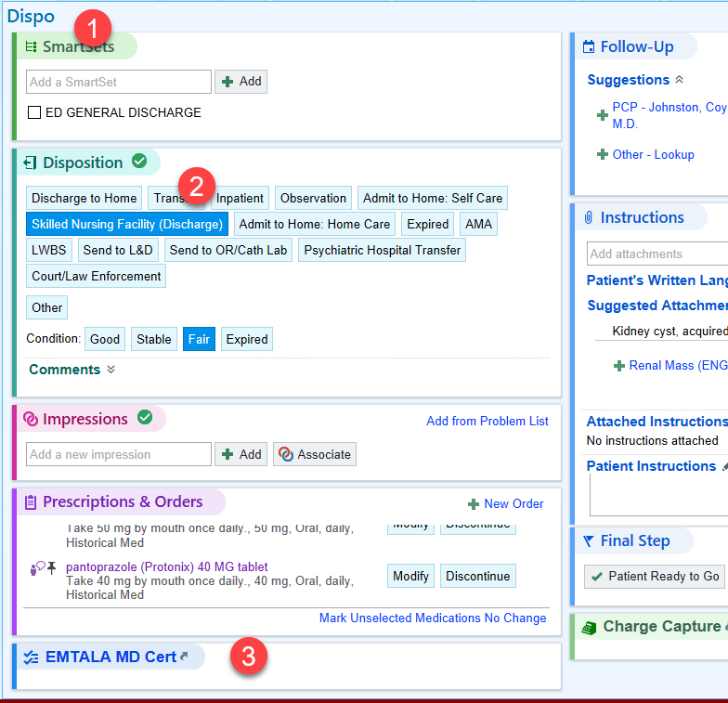
Admitting a Patient

After a consulting provider or hostpitalist on the floor places orders for admission, you will be responsible for contacting them to arrange the admit. Once that is done you can document using the **Single Screen Disposition**.

* Under **Disposition** you will select the fitting destination for the admit or transfer. The Dispo you select updates what documentation you have available.
* Enter the diagnosis in **Clinical Impression**.
* Click **Accept** and **Add to Problem List**.
* Check **Chart Status** for anything you may need to finish up.
* Mark **Patient Ready to Go** to signal that you are done and the patient may be admitted.

Try it out:

* Follow the instructions above to admit **Richard**.
* Use text completion (the first 3-4 letters of a word) to find an **Impression** or two for the diagnosis.

EMTALA Transfer form

The EMTALA Transfer form is part of our EMR environment. The provider portion of EMTALA is to verify the Physician section is correct, sign the form and/or co-sign the form if an APP is the original sending provider.

1. Select the Dispo Activity.
2. The Dispositions, Short Term Hosp, Admit to Home: Home Care, Skilled Nursing Facility, Psychiatric Hospital, Court/LawEnforcement.
3. Click on EMTALA MD Cert.
4. \*\*\*Ensure the Physician Certification section is correct and filled out prior to signing\*\*\*.

Graphical user interface, text, application

Description automatically generated

MD/DO Transferring patient workflow.

1. Fill in Provider Communication Date. (“T” for today)
2. Fill in Provider Communication Time. (“N” for now)
3. Check Patient examined and risks explained.
4. LEAVE APP Section blank if the APP is not transferring the patient out.
5. Click Yes on the Sign / Cosign button.
6. Physician types in their name on the Signing / Cosigning Physician row.
7. Physician then clicks the Verification Statement.
8. Physician adds in Signing / Cosign Date. (“T” for today)
9. Physician adds in Signing / Cosign Time. (“N” for now)

Graphical user interface, text, application, email

Description automatically generated

APP Transferring Patient with MD/DO Cosign

1. Fill in Provider Communication Date. (“T” for today)
2. Fill in Provider Communication Time. (“N” for now)
3. Click Patient examined and risks explained.
4. APP Types in their name.
5. Fill in APP Signing Date. (“T” for today)
6. Fill in APP Signing Time. (“N” for now)

Graphical user interface, text, application

Description automatically generated

\*\*\*If an APP transfers the patient out, please make sure the attending MD/DO is assigned to the patient so the inbasket message can be sent to them for the cosign. \*\*\*

A screenshot of a computer

Description automatically generated

Try it out:

* Change **Richard’s** Dispo to one of the options that requires EMTALA
* Follow the workflow instructions on filling out the form as it fits your role.

**Trainer Check**- if you have questions or need assistance ask now!

FYI: Personalization and more!

Use this section to try out other workflows and learn more about what you can do in Epic, and what Epic can do for you.

In addition to this section you can find much more information on the Aspirus Intranet, including a wealth of Tip Sheets to help guide you through issues or less common workflows.

On the Intranet, hover over Work Tools & Resources to get the dropdown menu, and select **EMR Info Center**. There you will find the Tip Sheets to search through, as well as other information to help you navigate Epic.

Graphical user interface, application

Description automatically generated

Understand locked chart messages

To prevent you and your colleagues from double-documenting on a patient, the system locks parts of a patient's chart when you're documenting certain clinical information. When part of a chart is locked, a message appears telling you that you can't document in that part, but you can still see that part of the chart and document in other parts.

To avoid locking the chart for other users, leave clinical documentation items when you're not actively documenting in them.

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|  | If your computer terminates unexpectedly when you're documenting in a chart, contact the help desk to unlock the chart for other users. |

Review information from several visits at once

If you want to review several of a patient's visits at once, use a report in Chart Review. Within the report, you can search for specific phrases or keywords. For example, if you want to review all visits in which the patient was treated for a cough associated with sore throat, select only visits with a diagnosis of sore throat and then search for the term "cough" in the consolidated report.

1. In Chart Review, go to the Encounters tab and select the visits you want to review.

* If the visits are next to each other in the list, press Shift while selecting the first and last encounter you want to review.
* If the visits aren't next to each other in the list, press Ctrl and select each visit you want to review.

1. Click  Review Selected to view a report that includes information from all of the visits you selected.
2. Press Ctrl+F to search for a specific phrase or keyword across all of the visits you selected.

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| Icon  Description automatically generated | You can also use this method on other Chart Review tabs to review a report that includes multiple labs, procedures, medications, or notes. |

Customize an Order Set

Create your own version of an Order Set to meet the needs of the patients you see most commonly.

1. In the Epic toolbar, click **Personalize** and select **User SmartSets**.
2. In the SmartSets field, search for an Order Set to customize, or select one from the available categories, such as Favorites.
3. With the Order Set selected, click **Create New Version.**
4. Enter a name for your version.

The version name appears only to you, so enter a name that makes sense to you.

1. Click the section header for each group of orders you want to modify. Customize the details as needed, such as the dose, frequency, and rate.
2. Click **Accept** to save and close each order.

Optionally, select or clear the check box next to an order to customize which orders are selected automatically.

1. Click **Accept** to save your version. It's automatically saved to your favorites for future use.

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|  | To edit or delete a User Order Set, look it up in the **User SmartSets** activity and select **Edit This Version**. |

Add another clinician's Order Set as a favorite

If another clinician created a version of an Order Set that you like, add it to your favorites list for easy access.

1. Open a patient's chart and navigate to the **Orders** activity.
2. In the sidebar, enter the name of your colleague's User Order Set and press **Enter**.
3. Right-click the Order Set you want to add and select **Add to Favorites**.

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|  | You can't create your own version of an Order Set that you are borrowing from another user. |

Save your work for later

If you are interrupted while writing orders, you can save your work and return to it later. Orders that you save are not authorized and do not appear for nurses or other clinicians to carry out. To authorize orders, you must sign them.

1. Open the Orders activity and enter your orders.
2. Click  **Save Work** at the bottom of the sidebar. Your name and the number of changes you need to make appear under the Saved Work heading.
3. To continue managing saved orders, click **change**  near the top of the Orders sidebar.
4. Click  **Manage this unsigned work** to return to the Orders activity and sign the orders.

View all lab results (in Results Review)

To see lab results from current and past visits, go to Results Review.

1. In the Date Range Wizard, choose a date range to view.

To see all results, choose All data.

To see only results you haven't reviewed, select New results since time mark last set.

1. To find a specific result:

Search for the test in the upper left, or

Select a type of test (such as Hematology) or a result (such as WBC) in the tree on the left.

1. When you're finished reviewing, click  Time Mark.

The results you just reviewed won't appear next time you open Results Review with the date range New results since time mark last set.

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| Icon  Description automatically generated | To control how much data you see, click the arrow next to  View and select a view. For example, select Latest Data View to see only the most recent values. |

Graph results over time

1. In Results Review, click the drop-down arrow next to  View and select Extended View.
2. Select the Hide data prior to check box and indicate how far back you want to see historical data.
3. Select a single row to graph individual components, or click and drag to select multiple components.
4. Click  Graph.
5. Review the data trends in the purple line and compare them to the upper and lower ends of the reference range.
6. Click Close to return to your results data view.

Set a default date range to quickly access the most relevant results

Open Results Review and select the date range that you want to see for all your patients. Click Set Default and click Accept. The default you choose doesn't affect other clinicians.

If the Date Range Wizard does not open automatically, click Use Date Range Wizard.

If the Use Date Range Wizard button does not appear, click  Options and select the Show date range wizard before starting Results Review check box. Close Results Review and reopen it.

To change the default date range at any time, repeat these steps.

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| Icon  Description automatically generated | You can prevent the Date Range Wizard from appearing every time you open Results Review. To do so, click Options and clear the Show date range wizard before starting Results Review check box. To turn the Date Range Wizard back on, select the check box. |

Personalize your view of results

1. In Results Review, click  Options.
2. Customize your Results Review activity. The changes you make don't affect other clinicians. Some popular options include:
   1. Increase the number of Columns loaded by default in Extended View to see more data on the screen while respecting the date range settings you've selected.
   2. Select the Show reference range per value check box to see the reference range below each result.
3. Select the Fonts tab to adjust the font and font size to what's comfortable for you.

Open NoteWriter from reviewing ECG orders

When reviewing ECG orders, you can jump to the NoteWriter to create or edit an ECG procedure note directly from the Track Board.

You can review ECG orders from the Workup activity on the Track Board. From there, you can quickly jump to the NoteWriter to document on the procedure.

1. Graphical user interface, text, application

   Description automatically generatedOn the Track Board, select your patient and go to the **Workup** activity tab.
2. Click **Interpret** for the procedure you want to document.
3. Document the procedure in the NoteWriter as usual.

Dictate part of a progress note

With partial dictation, you can use certain tools to write part of your progress note and dictate the rest. For example, if you use NoteWriter to document a patient's physical exam but you want to dictate the HPI, you can do so using partial dictation.

#### Document using voice recognition software

The use of voice recognition within Epic requires the installation of third-party voice recognition software, MModal. If you have the voice recognition software set up, you simply need to move your cursor to the location in Epic where you want to document and speak into a microphone or headset.

Sign a note

When you're finished writing, press **F2** to make sure you completed all SmartLists and wildcards (\*\*\*) in your note. Then click  **Sign**.

Create an addendum to edit a signed note

1. In the Notes activity, select the note you want to modify and click  **Addendum**.
2. Edit your note and click  **Sign**.

Recovering a deleted note

If you mistakenly delete your note you can recover it yourself! The note will not disappear, instead it will appear with all text strickenthrough. If you need to recover your note you have two options:

1. You can click the **Copy** link at the top left of the note. This will open the note in the side panel and you can make any fixes needed and sign again.
2. Click the **View without strikethrough** link. This will open the note in a pop-up, you can highlight, copy (**ctrl+C)**the text of the note and paste (**ctrl+V)** it into a new note. Then you can make any changes you need to in the copy and sign it again.

Graphical user interface, text, application, email

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Create a NoteWriter macro to record your common findings

A NoteWriter macro can help you document a typical exam or procedure more efficiently. A macro is a set of signs, symptoms, and pertinent negatives that you commonly record during an ROS or physical exam, or information that you commonly record in a procedure or progress note. For example, during an ROS, you can document the patient's symptoms and then apply a macro to note all pertinent negatives. Anything you document before applying the macro is preserved, and you can also make changes after applying it.

Note that when you create a macro, it applies only to the SmartBlock you have selected at the time, rather than the entire note. For example, an ROS macro is solely an ROS macro, not an ROS and Physical Exam macro.

#### Create a macro based on a note

Follow these steps to create a macro based on a specific note you've written.

1. After writing a note in NoteWriter, click the arrow next to the  button and select **Create macro from current data**.
2. In the Macro Selection window, enter a name for your macro and click **Accept**.

Note any age and sex restrictions that appear. For example, the macro you create might apply only when you're doing a review of systems for females, age 13 and older. These restrictions allow you to create different macros for female, male, and pediatric patients.

1. In the SmartBlock Macro Editor, edit the macro by selecting any other items that you commonly record.
2. Click  **Accept** to make your macro available for use. Note that any additional changes you make in the editor are not automatically applied to your note from step 1.
3. To apply this macro in the future, go to the NoteWriter tab for the type of macro you created and click the  button for your macro in the toolbar.

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|  | If you have multiple macros for a tab, select the **Set as primary macro** check box in the editor to make your most commonly used macro appear at the top of NoteWriter's macro list. |

#### Create a macro from scratch

1. In NoteWriter, click the arrow next to the  button and select **Create new macro**.
2. In the Macro Selection window, give your new macro a name, enter any age and sex restrictions, and click **Accept**.

For example, you can make the macro available only when you're doing an ROS for females age 13 and older. These restrictions allow you to create different macros for female, male, and pediatric patients.

1. In the SmartBlock Macro Editor, select the signs and symptoms you commonly review during an exam or the prep steps you frequently perform before a procedure, for example.
2. Select the **Active** check box and click **Accept**. Your macro is now available for use.
3. To apply this macro in the future, go to the NoteWriter tab for the type of macro you created and click the  button for your macro in the toolbar.

#### Share a macro with colleagues

1. When creating or editing a macro, go to the Sharing section.
2. Enter the names of your colleagues in the Users list.
3. Select the **Can Edit?** check box if a user should be able to edit the macro.

#### Create a macro for a procedure note

To speed up procedure documentation, you can create macros for procedure notes, such as a laceration repair note.

1. Click  **Personalize**.
2. Select  **Macro Manager (NoteWriter)**.
3. Select **SmartForm**.
4. In the **Select a SmartForm** field, enter the name of the SmartForm you want to create a macro for.

For example, enter **lac rep** for a laceration repair note.

1. Click  **Create a SmartForm Macro**.
2. In the **Macro** field, enter the name for your macro and click **Accept**.
3. Select the buttons and fill in the fields with the desired documentation.
4. Click  **Accept**. The macro will now appear when you click **Apply Macro** in the appropriate type of procedure note.

Organize, edit, or delete your note macros

In the Macro Manager, you can  search for a particular macro you have access to, browse other user’s macros, and add yourself as a user without having to ask the creator to add you.

To open the Macro Manager, click  in the NoteWriter, or  **Open a List of Macros** in the Macro Editor.

Use the search bar to find macros that you own or that are shared with you.

Double Click a macro or click **Open** to open the Macro Editor.

Click  **Browse Macros by User** to search for a macro made by a different user.

Double click a macro or click **Open**  to open the Macro Editor. From here, you can add yourself to the list of users for that macro.

Jump start routine notes with speed buttons

Add buttons to the My Notes activity so your most commonly used note templates are available in one click. You can create a button that starts a new note with the SmartPhrase or SmartText of your choice.

1. Click  in the **ED Provider Notes**, **ED Procedure Note**, or **ED Attestation Note** section of the My Notes activity.
2. In the Notes Personalization window, click  to add a new button.
   1. In the **Caption** field, enter the name that you want to appear on the button.
   2. Add either a SmartPhrase or SmartText.
3. Click  **Accept.** The button appears at the top of your Notes section.

Create a SmartPhrase to reuse text you commonly type

#### Create a SmartPhrase from text you type

1. While charting, type the text you want to save as a SmartPhrase. Make sure the text doesn't include any patient-specific information, so you can reuse it for other patients.

You can create a SmartPhrase anywhere you see this toolbar: 

1. Select the text and click .
2. In the SmartPhrase Editor, enter a short, intuitive name for your SmartPhrase in the **Name** field. This is the name you'll type to insert the SmartPhrase in a note.

You can't include spaces or symbols in the name.

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|  | Preface the name with your initials so you can find it easily. |

1. Enter a summary of your SmartPhrase in the **Description** field.

When you search for your SmartPhrase, this description appears in the results after the SmartPhrase name. If you leave the description blank, the beginning of the SmartPhrase text appears.

1. Click **Accept** to save and close your new SmartPhrase.
2. To use your SmartPhrase in a note or letter, type a period immediately followed by the SmartPhrase name. Press the **Spacebar** to insert your SmartPhrase in the note.

#### Create a SmartPhrase from a SmartText

If you frequently make the same changes to a certain SmartText, save your edited version of the text as a SmartPhrase.

1. In a note, click  to open the SmartPhrase Editor.
2. In the **Insert SmartText**  field, search for the SmartText you want to edit.
3. Edit the text to reflect your preferences.
4. Name your new SmartPhrase and click **Accept**.

Customize your SmartPhrases

To edit a SmartPhrase you created, open **My SmartPhrases** from Chart Search. Double-click the SmartPhrase you want to edit.

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|  | To delete any duplicate or unused personal SmartPhrases, select it and click  **Remove**. |

#### Add a SmartLink to your SmartPhrase to pull in patient-specific information

1. In the location where you want the SmartLink to appear, enter a period followed by the first few letters of the SmartLink's name. A list of matching SmartLinks appears.
2. Double-click a SmartLink to insert it. The SmartLink appears in your SmartPhrase between @ symbols, such as @NAME@.
3. Graphical user interface, text, application

   Description automatically generatedClick **Accept**. The next time you use this SmartPhrase, patient-specific information appears where you added the SmartLink.

#### Add synonyms to quickly find your SmartPhrases

When writing a note, you can pull in your SmartPhrase with its name or a synonym.

1. Open one of your SmartPhrases.
2. In the **Synonym** field on the right, enter any other names you might use to search for this SmartPhrase. For example, you might name a SmartPhrase ABDOMINALPAIN and include a synonym of STOMACHPAIN.
3. Click **Accept**.

#### Add a SmartList to your SmartPhrase

Use SmartLists to select from a list of common choices when writing your note.

1. Open one of your SmartPhrases. In the **Insert SmartList** field, enter the first few letters of the SmartList and press **Enter**.
2. Select the SmartList you want.
3. Click **Accept**. The next time you use this SmartPhrase, you must make selections from all included SmartLists before you can sign the note.

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Pull lab results into your note with SmartLinks

By setting different parameters, you can specify which result components to include, as well as whether to pull in a certain number of results or to include all the results within a given period of time.

#### Look up component base names

To pull in results for a specific component, you need to know the component's abbreviation, or base name. You can find components' base names in lab reports in Chart Review.

1. In Chart Review, select the **Labs** tab and select a result that includes the component you're interested in.
2. In the lab report, scroll to **View SmartLink Info** and click the link for this test.
3. Note the entry in the Base Name column of the table. This is the base name that you can use with any of the following SmartLinks to pull results for this component into your note:

RESUFAST

LABRSLT

LABRCNTIP

The RESUFAST and LABRSLT SmartLinks are typically used for outpatient contexts, while the LABRCNTIP SmartLink is typically used for inpatient contexts.

#### Pull in recent results for specific components with a SmartLink

To keep your note brief, use one of the following SmartLinks to pull in the results of a recent lab of your choice in a table listing the date, result value, reference range, and status of the result, as well as any comments entered with the result:

RESUFAST

LABRSLT

LABRCNTIP

The RESUFAST and LABRSLT SmartLinks are typically used for outpatient contexts, while the LABRCNTIP SmartLink is typically used for inpatient contexts.

Let's say you wanted to use the RESUFAST SmartLink. In your note, place your cursor where you want to insert the results, enter ".resufast[BASENAME:#", and press **Enter**.

In place of "BASENAME", enter the base name of the component for which you want to insert results.

In place of "#", enter the number of results you want to insert. For example, enter ".resufast[pocglu:3" to insert the patient's last three POC glucose results.

To insert all of a patient's results for the component, enter "\*" instead of a number.

To insert only the most recent result, omit ":#" and just enter ".resufast[BASENAME".

To insert results for multiple components, separate them with commas. For example, enter ".resufast[pocglu:3,poccreat" to insert the patient's last 3 POC glucose results and her most recent POC creatinine result.

These bullet points apply to all three of the SmartLinks mentioned above.

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|  | For additional instructions on using any of the aforementioned SmartLinks or other lab-related SmartLinks that require you to set parameters, enter a period (.) followed by the name of the SmartLink and press **Enter**. For example, enter ".labrcnt" and press **Enter**. Instead of pulling in lab results, the SmartLink pulls in help text. When you've read the text and successfully inserted the lab results you want, just delete the help text. |

#### Pull in all of a patient's recent lab results with the GETLABS SmartLink

If you need to insert all of a patient's recent lab results, use the GETLABS SmartLink. You can specify the time period in which to search for results and the display format.

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|  | If a patient has many recent lab results, using the GETLABS SmartLink can cause your note to become quite long, making it more difficult to read. We recommend using the any of the following SmartLinks instead to pull in results for specific components:  RESUFAST  LABRSLT  LABRCNTIP |

In your note, place your cursor where you want to insert your patient's results. To pull in all of a patient's lab results from the past 6 months, enter ".getlabs[6M,1".

Entering "6M" pulls in results within six months of the current visit or admission. Replace "M" with "D", "W", or "Y" to specify days, weeks, or years, respectively.

The second parameter controls what information appears. Enter "1 "to pull in the component name, value, reference range, and status of each result. Enter "2" to pull in only the component name and value of each result.

Discharge a deceased patient

If a patient expires, document the disposition and preliminary cause of death in the Dispo activity.

1. Open the Dispo activity.
2. In the Disposition section, search for Expired.
3. Document the preliminary cause of death and any additional comments using free text or SmartTools.