HERO
Health Electronic Record Online

Excella Health
Provider EMR Training
Session 1 and Session 2
Provider EMR Training Sessions  
(Two – 4 Hour Sessions)

Session 1:

Attendees – Physicians, Physician Assistants, Nurse Practitioners

Agenda

1. Login
2. Patient List and Patient Search
   a. Patient List (Defer To After Accessing Live)
   b. Patient Search
3. PowerChart Overview
   a. Menu Bar
   b. Toolbar
   c. Patient Banner Bar
   d. HERO Menu/Table of Contents
4. Computerized Provider Order Entry (CPOE)
   a. Order Search
   b. Starts with vs. Contains
   c. Selecting/Adding Orders (list of orders)
   d. Order Details, Order Sentences, Required Details
   e. Remove Orders
   f. Modifying Orders
   g. Voiding/Discontinuing Orders
   h. Adding/Deleting Order Favorites
6. PowerPlans
   a. Searching/Selecting PowerPlans
   b. Preselected / Deselecting Items
   c. Notes / Reminders
   d. Order Sentence Drop-Downs
   e. Details Section – Incomplete
   f. Initiate – Orders For Signature – Sign
   g. Planned State PowerPlans
   h. Void/Discontinue PowerPlans & Orders Within A PowerPlan
   i. Adding/Deleting PowerPlan favorites

** BREAK **
7. **Documentation/PowerNote**
   a. PowerNote Tabs/Definitions
   b. Adding a PowerNote (Daily Progress/SOAP Note)
   c. Auto Populate Window
   d. PowerNote Selections, Options, Symbols, etc.
   e. Adding A Diagnosis/PowerOrders
   f. Modify/Correct A Signed Progress Note
   g. In Error Report
   h. Brief Note
   i. System-wide Autotext
   j. Creating Autotext
   k. Precompleted Notes
   l. Entering Supervising Physician For Signature (PAs & NPs ONLY)

8. **Admission Scenario**
   - Patient Needs Admitted From Your Office – Day 1

   From your office enter the following:
   a. Obtain Quick Direct Account
   b. Diagnosis = Pneumonia
   c. Allergies – No Known Allergies, Adding Allergies, Reaction, Severity
   d. Pneumonia PowerPlan In A Planned State
   e. Medication History – Completed by Nursing
   f. Admission Med Rec – Medication History must first be completed by nursing (Note regarding Transfer Meds Rec)

9. **Favorite / Practice Time**
   a. Time permitting - Set up favorites, precompleted notes, etc.
Session 2:

Prerequisites - Session 1 must be completed before Session 2

Agenda

1. Session 1 Review
   a. Patient List
   c. Patient Search
d. Entering Orders
e. PowerPlans
f. PowerNote

2. Review Session 1 Admission Scenario
   a. Where were we at in the process

3. Continue Admission Scenario – Day 2 – Live Access–Setup/View Pt List, Results, etc. For Inpt Rounds
   a. Access HERO Live
   b. Access Patient List (Setup ahead of time)
c. Interdisciplinary Summary Page
d. Results Review
e. Notes, etc.
f. Provider goes to see the patient
g. Need to do Progress Note
   1. Review Progress Note – PowerOrders From Note
   2. Brief Note
   3. System Wide Autotext
   4. Creating Autotext Entries
   5. Pre-completed Notes

4. Patient To Be Discharged – Day 3 – Discharge Summary Page
   a. Discharge Diagnosis
   b. Discharge Patient Order
   c. Discharge Medication Reconciliation
      1. ePrescribe
      2. Printing Scripts
d. Follow Up Instructions
e. Physician Discharge Instructions Via PowerForm

5. Question/Answer Session
6. **Message Center – Review, Sign and Refuse**
   a. Orders For Signature
   b. Documents For Signature
   c. Documents To Dictate
   d. Compliance Documentation Management Program (CDMP)

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**NOTE To Providers:**

Providers will be able to access HERO from their home, office, etc. ANYWHERE you have internet access.

Remote access can be accomplished with MAC devices as well.
To Search For A Patient...

1. Click on “Patient” from the Menu Bar.
2. Highlight and click on “Search”.
3. The Patient Search window appears.

4. Key in the appropriate search information.
5. Click the “Search” button.

6. A listing of patient names will display.
7. Highlight and click on the correct patient.

NOTE To Providers:

VERY IMPORTANT: Providers must make sure to select the correct account number/encounter when searching for a patient.

This is especially important for providers entering direct admit and preop surgical orders in advance of the patient arriving to the hospital.

The “Recent” and “last/first name” option above are not suggested for the direct admit and pre-op surgical order options.
8. A list of encounters/visits will appear. Select the encounter by double-clicking on the encounter. VERY IMPORTANT! You do not want to chart on the wrong encounter!

OR

Searching for a patient by name:

Search by clicking “Recent”

Enter last name, first name
Once the provider has selected the correct patient and account/encounter, the HERO Chart View (PowerChart) will display. The provider is now in the patient’s electronic chart/medical record.

**NOTE To Providers:**

- Only one patient chart can be open at a time.
- However, multiple users can be in the same chart at the same time placing orders, reviewing results, documenting, etc. **with the exception of medications.**
- Only one user can order and document medications at the same time.

**REFRESH...**

The refresh button updates the providers display after orders, documents, etc. have been signed, updated, etc.

Providers will need to click the refresh button quite often.
The Menu Bar contains Task, Edit, View, Patient, Chart, Links, Help (as seen below):

1. **Task** – Here you can change your password, switch users, print, refresh and exit.
2. **Edit** – This enables you to cut, copy, paste, and delete.
3. **View** – Contains shortcuts to Message Center, Patient List, Discharge Readiness Dashboard, PAL, Core Measures and Tracking Shell.
4. **Patient** – Add or delete a patient, search for a patient.
5. **Chart** – Contains all Main Menu/Table of Contents tabs.
6. **Links** – List of web applications. Users can add their own web links if desired by clicking the drop-down arrow next to Links—**Add or Remove Buttons** – Customize options from the toolbar.

The Customize Tool Bars window will display. To add a link – click the “Add” button.

The **Add User Links** window will display.

Key in the name you wish to appear on the toolbar and key in the URL for the website.

Click OK. Close the customize toolbar window. The button should appear on the toolbar.
7. **Help** – Contains quick reference for Help.

**ORGANIZER TOOLBAR:**

The Organizer Toolbar contains icons to that will directly link you to Message Center, Patient List, Discharge Dashboard, PAL, Core Measures, etc.

**PATIENT BANNER BAR:**

The Patient Banner Bar is a quick view of the patient’s name, allergies, DOB, age, MRN and FIN numbers, attending physician's name, height, weight, code status, sex and location in hospital.

**NOTE To Providers:**
Re: Patient’s Height and Weight

- The Patient Banner Bar lists the **most recently measured weight**. Example: If the patient was ordered daily weights – the weight reflected on the banner bar would be the most recently documented weight.
- However, the **dosing weight** that Pharmacy uses for weight-dosed medications is based on the actual measured weight **taken upon admission**.
- If the provider needs the dosing weight to be updated in the system, the provider must enter an “Update Dosing Weight” order.
- The system will also alert providers if there is a 20% difference between the most recent measured weight and the dosing weight charted upon admission.
**MENU BAR/TABLE OF CONTENTS:**

The Menu Bar or Table of Contents is the “organizer” of PowerChart where all of the patient’s documentation, orders, results, etc. is filed and organized.

**Communication To Physician** – Displays certain components of nursing and ancillary documentation for the last 72 hours. Some items included are PT/OT/Speech Progress Note, Communication To Physician, Diet Information, etc.

**Documentation** – Providers will complete their daily progress note from the documentation tab. Surgeons will also complete their immediate post-procedure note from the documentation tab.

**Inpatient Summary** – is a snapshot of the patient’s chart. Providers can review I & O, Vitals, Diagnoses, Results, etc. It is specific to this encounter or visit. How far back it goes depends on what you’re looking at.

**Orders** – All orders will be placed from the orders tab including PowerPlans/order sets.

**Results Review** – Displays vitals, lab, radiology and images.

**Discharge Summary** – Providers will access the discharge summary page that includes all aspects that need to be completed by the physician for discharge.

**Allergies** – Displays a list of the patient’s allergies. Allergies will become part of the patient’s permanent medical record and will carry over from encounter to encounter. Allergies will be assessed and updated by nursing with each admission.

**Patient Information** – Displays the patient’s address, birth date, visit list, patient provider relationships, etc. Providers can view the patient provider relationship to see which nurse is caring for that patient.

**Diagnosis & Problems** – Physicians are responsible for the patient diagnosis on admission, included in daily progress note during the patient stay and at discharge. The diagnosis will automatically default to the status of discharge to save the provider time by not having to change it at the time of discharge. If the diagnosis is not applicable at the time of discharge, the provider can remove it. Nursing is responsible for problems. Physicians can diagnose – nursing cannot. Diagnosis will drop off after each discharge. Problems will remain part of patient’s permanent medical record and will carry over from admission to admission. Nursing will access and update problems at each admission.

**Form Browser** – Probably will not use.

**Growth Chart** – Probably will not use. Based on the Center of Disease Control (CDC) standards.

**NOTE:** Pediatricians may use this but the values that display will only reflect the values collected during the inpatient stay.

**Histories** – Documented by nursing. Displays past medical history, procedures, social and family history.
**Interactive View/I&O** – Displays nursing/ancillary documentation in a flowsheet manner – default for the last 3 days.

**Immunization Schedule** – Immunizations given while in the hospital and documented via the eMAR or entered on admission will display in this section of the chart. (If a patient had a tetanus shot 3 years ago and the nurse documented it, it will appear here.)

**MAR Summary** – *View only access of the Medication Administration Record.* **NOTE:** Anesthesiology does have access to the eMAR to document antibiotics for surgical patients.

**Medication List** – *Listing of medication orders.* Medications can be added from here as well.

**Notes** – *Displays medical record reports* (dictated/transcribed reports, nursing documentation, ancillary documentation, etc.)

**Reference** – *displays reference information* for medications, education leaflets and reference information.

**Pregnancy** – for Westmoreland use.

**Core Measure Data** – includes core measure information that nursing has documented during the patient’s stay. The Core Measure requirements have been built into the PowerPlans and Discharge processes.
ORDERS Display Review:

Order Display Hierarchy

The order display hierarchy displays the different categories of the orders tab. The display has 2 sections:

A. **PowerPlans/Order Sets**
   - Any plans/sets entered will display beneath the plans section.
   - *PowerPlans are groups of orders that will replace order sets.*

B. **Orders**
   - Clinical categories of orders displays beneath the order section. Categories with a check in the box and appearing in bold alert the user that there have been orders placed for these types of orders.

Order Component Overview

The right side of the Orders tab is called the Order Profile. It displays the patient’s existing orders and provides a means for viewing order details, order status and modifying orders.
Providers can search for individual orders, however, many of the orders needed are nested within the Admission PowerPlans with pre-configured defaults. We will discuss these powerplans a little later.

**Searching For Tests/Orders:**

To search/find test/orders, click the **Add button** from the Orders Tab on the Menu or Click the **Add button** above the orders review section.

The Search/Find window will display.

Key in the name of the order/test/procedure you are searching for in the **Find field**.

Next to the **Find field** you can change your search filter by clicking the drop-down arrow and selecting either “Starts With” or “Contains.”
“Starts with” will only display those key items that begin with that description. When searching for a Prothrombin Time (PT), Sodium (Na) or Potassium (K) you will need to use starts with.

“Contains” (the preferred option for most) will display every order that contains the key items being searched for and will populate in the search results. Contains requires the user to key in at least 3 characters.

Select “XR abdomen series.” A box containing predefined order details will appear. The user may select a predefined order detail using this box, or they can manually select their order details. To manually select the order details, click “None.”

At the bottom of your screen, the order details for “XR Abdomen Series” will appear.

**IMPORTANT!** The field(s) that are **REQUIRED to COMPLETE THE ORDER** are **highlighted in yellow and/or BOLDED**.

Use the drop-down arrows in each field to select an option.

In fields that do not contain drop-down arrows for selection, you may type your response.

After you have completed all of the **REQUIRED FIELDS** (those that are highlighted in yellow and bolded), click **Sign** at the bottom right-hand of your screen. Then, refresh your screen by clicking **refresh** in the top right of your screen.
Common Order Folders:

Common Order Folders are available to help providers quickly find the most common orders and PowerPlans they may use on a daily basis. All providers and staff have access to these folders from within CPOE.

To find these folders:

1. From the menu click the **orders tab** and then click the **Add+ button**.
2. Click on the **folder icon** from the toolbar.
3. Click on the **“EH Core Content” folder**.
4. You will see this list of folders.
5. Click on a few folders to view contents.

**Frequency: Every versus Q**

**Q** = Interval – order for every 8 hours starting at 1000. Orders will generate from the start time of 1000. Orders will be generated at 1000, 1800 and 0200.

**Every** = The Frequency is defined as every 8 hours at 0800, 1600 and 2400. An order will generate at Excela Health’s predefined times only.
Folder Contents:

**Specialty Based Content** – Contain orders and PowerPlans for different clinical disciplines – Cardiology, Neurology, Pulmonology, etc. These folders will be added to over time.

**Transitional Orders** – Contains 4 transitional order PowerPlans to assist with quick entry of “tuck-in” orders for evening admissions. Providers can use these directly and/or nursing when discussing orders over the phone.

**Admission** – Contains the most common admission PowerPlans and any stand alone orders related to an admission (Admit to admission/observation status, code status, change provider, etc.).

**Observation** – Contains common observation PowerPlans and related orders.

**Pre-Op** – Contains pre-operative PowerPlans.

**Post-Op** – Contains post-operative PowerPlans and related orders.

**Nursing** – Contains common nursing orders as well as the “hard to find” options such as DC Foley, urinary catheter insertion/removal, continue restraints, etc.

**Diet** – Contains common diets pre-configured with and/or without restrictions, nutritional supplements, NPO orders.

**IV Fluids/Blood/Products/TPN** – Contains IV fluids, bolus orders, blood products Powerplan, TPN Powerplan, fluid and electrolyte imbalance PowerPlans, etc.

**Medications** – Contains common antibiotics, PRN medications, medication protocols and PowerPlans, therapeutic monitoring, pharmacy consults, etc.

**Respiratory** – Contains common respiratory medications, oxygen orders, vent settings, etc.

**Labs** – Contains sub folders for order options (STAT, In the AM).

**Diagnostics** – Contains common radiology studies and other diagnostic testing.

**Consults** – Contains common consult orders.

**Compliance** – Contains orders related to Joint Commission and/or CMS initiatives (continue Foley, continue restraints, VTE risk assessment, etc.)

**Core Measure Documentation** – Contains “orders” to capture the various reasons for not meeting certain core measure elements.

**Discharge** – Contains the discharge order, orders for testing after discharge, and durable medical equipment.
Setting Your HOME Folder:

Providers can default the EH Core Content folder to be their home folder. If the provider does this, the content and folders contained within that folder will be displayed automatically every time you click the Add+ order button.

NOTE: If a provider sets the EH Core Content folder as their home folder, the personal favorites folder will no longer display automatically. The providers will still have access to that content by clicking on the Favorites icon.

Setting the EH Core Content Folder As Your Home Folder:

1. From the menu click the orders tab and then click the Add+ button.
2. Click on the folder icon.
3. Hover over the “EH Core Content” folder
4. Right click and select Set As Home Folder.

To Navigate The Folders and Subfolders:

1. From the folder list, click on the back arrow.
2. To return to your “home” folder, click the home icon.
3. To access your Favorites, click on the favorites icon.

Order Symbols:

Once the order/orders window has been refreshed, symbols display next to the order.

Pharmacy = Mortar and Pestle symbol
Physician = Caduceus symbol
Eyeglasses = Nurse Symbol

If the provider hovers over these symbols a pop-up window will display indicating if the order has yet to be verified by a pharmacist, cosigned by the ordering physician or reviewed by the nurse.

NOTE To Providers

STAT Orders – It is recommended to alert the nurse or unit clerk that STAT orders have been entered.
**Cancel/Discontinue/Modify/Void – Order Options:**

If an order has already been signed and it needs to be changed, right-click to select any of the following order actions:

All functions may not be available for all orders.

**Modify** - Allows modification an existing signed order.

**Orders That CANNOT Be Modified:**

**Lab, Radiology and Medication Orders**

These orders will need to be Cancelled/Discontinued and reordered.

*Note: If modify is not an available menu item, then the selected order does not allow this option.*

**EXCEPTION FOR MEDICATIONS:** IV Fluids and Infusions can be modified.

**NOTE To Providers:**

If the medication needs to be held, the provider should discontinue the med and reorder if and when needed. See explanations below.

**Cancel and Reorder** - Allows user to cancel an existing order and place another order for the same orderable item.

**Medications:**

1) If a daily medication order exists and one dose of medication needs to be held, the provider needs to right-click on the medication from the active orders list, select **Cancel and Reorder**, and change the start date by one day.

2) If a medication order exists with a frequency of q6hr, BID, etc., the provider should right-click on the medication from the active orders lists, select **Cancel and Reorder**, adjust the start date and time accordingly based on the clinical scenario.
3) If the medication order is to be held indefinitely, the provider needs to **Discontinue** the order. All discontinued orders remain available in the list of all orders to be “copied” as new orders if needed in the future.

**Renew** - Allows user to renew a continuing order.

**Cancel/Discontinue** - Allows user to cancel a onetime existing signed order or discontinue a continuing order. *If a medication is to be held indefinitely, the provider should DISCONTINUE the medication.*

**Void** - Allows user to void, or delete, an existing signed order. Void is typically utilized for orders placed on an incorrect patient or ordered incorrectly. I made a MISTAKE!

### NOTE To Providers

- **Suspend** – *(Used ONLY for Medications)* Allows user to suspend, or pause, an existing signed order.

  Orders are effectively suspended when a patient goes to surgery. It is the responsibility of the Surgeon (or whoever assumes post-operative care) to review all active orders after the procedure and update accordingly. Look specifically for fluids, diets and medication duplications.

- **Resume** - *(Only for Medications)* Allows user to resume a suspended order.

### Adding Order Favorites:

Order favorites are:

- Unique to a user
- Maintained by the user
- Not seen by other users
- Convenient to help speed up the ordering process

Users can create, move, delete and organize their own Favorites.
To add an Order Favorite, do the following:

1. From the Add Order window, search for the order you wish to add as your favorite.
2. Click Done.
3. Complete the order details as appropriate.
4. From the Order Review window, right-click the item.
5. Highlight and click on Add to Favorites.

6. The Add Favorite window displays.

7. Choose the existing folder and click OK.

To verify that your favorite order has been saved, go back to the add order window and verify your order displays.

NOTE: There are limitations to setting up favorites. Not all details of the order can be defaulted. For example:
   The Consult to Provider order – the specific consulting provider name cannot be defaulted.
Deleting Order Favorites:

1. From the Add Order window right-click on the order name you wish to delete.
2. Select Remove from Favorites.

**PowerPlans (Order Sets)**

- **PowerPlans/Order Sets**: Primarily entered by the physicians, these order sets replace current pre-printed physicians order sets and includes nursing, medication, diet, and consult orders in a single order.
- **PowerPlans** allow for standardized orders based on specialty.
- **PowerPlans** include provider reminders and appear as yellow post-it notes in the PowerPlan. These reminders are comparable to the directives on our existing paper order sets.
- **PowerPlan** orders can be discontinued individually or as a whole, adding efficiency of order entry.
- Some **PowerPlans** can be placed into a Planned status for later activation when the patient status or location changes.

**PowerPlan Icons:**

The following are the most common icons/symbols you will encounter when working with *PowerPlans*.

<table>
<thead>
<tr>
<th>Symbol</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>🔄</td>
<td><strong>Merge View</strong> - Allows proactive duplicate checking. Use for placing postoperative orders to reconcile with existing orders.</td>
</tr>
<tr>
<td>🔆</td>
<td><strong>Initiate</strong> - Activates plan orders, outcomes, and interventions</td>
</tr>
<tr>
<td>🔴</td>
<td><strong>Discontinue</strong> - Discontinuation of Plan or Phase</td>
</tr>
<tr>
<td>✅</td>
<td><strong>Review Excluded Components</strong> - Review those items excluded</td>
</tr>
</tbody>
</table>

The user will search for a PowerPlan in the same manner they search for orders.

1) From the Orders tab, select **+ADD** to open the “Add Order” window.
2) In the “Find” field, type the name of the PowerPlan. For example, to add the *General Admission* PowerPlan type “admission” into the “Find” field.

3) The available *Admission* PowerPlans will populate in the box below. Select “Admission General.”

4) Click **DONE** to close the “Add Order” window.

5) The General Admission Powerplan now displays on your screen.

**PRESELECTED ITEMS AND DeselectING ITEMS:**

The General Admission Powerplan is displayed on your screen.

<table>
<thead>
<tr>
<th>General Admission Inpatient (Planned Pending)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Status</td>
</tr>
<tr>
<td>☑   Initial Inpatient/Observation Order</td>
</tr>
<tr>
<td>☑   Resuscitation Status</td>
</tr>
<tr>
<td>☑   Resuscitation Status</td>
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<tr>
<td>☑   Resuscitation Status</td>
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</tbody>
</table>

**VTE Prophylaxis**

<table>
<thead>
<tr>
<th>VTE Risk/Contraindications</th>
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<tbody>
<tr>
<td>☑</td>
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</table>

**Vital Signs**

<table>
<thead>
<tr>
<th>Routine Vital Signs</th>
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<tr>
<td>☑</td>
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</table>

**Activity**

<table>
<thead>
<tr>
<th>Bedrest</th>
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<td>☑</td>
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<thead>
<tr>
<th>Bedside Commode</th>
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<td>☑</td>
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<table>
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<th>Out of Bed with Assist</th>
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<td>☑</td>
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<table>
<thead>
<tr>
<th>Bedrest with Bathroom Privileges</th>
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<tbody>
<tr>
<td>☑</td>
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</tbody>
</table>
Some PowerPlan orders may already be selected, as seen above with *Initial Inpatient/Obs Order* and *Resuscitation Status*. These orders are already included because they are required as part of the PowerPlan.

The provider will select the orders to include them and modify the order details in the “Order Details” window displayed at the bottom of your screen.

Address each required field.

**ORDER SENTENCE DROP-DOWNS:**

Some orders will appear with drop-down arrows that enable you to select a predefined order sequence. To use, click the drop-down arrow and select an order sequence from the box.

**NOTE TO PROVIDERS:**

Remember, to be included in the PowerPlan, the order must be selected (checked off), even if you have selected an order sequence.

**NOTES/REMINDERS:**

You may find “notes” or “reminders” posted throughout a PowerPlan.

Notes are indicated by the following icon: 🌟. They are meant to be used as reminder for providers and nursing regarding patient care. For example, if a provider selects the Heart Failure PowerPlan, they will encounter the following two notes posted under the “Medications” section of the PowerPlan:

Notice that each note appears directly above the order(s) which are relevant to the reminder.
INCOMPLETE DETAILS:

If a user selects an order within a PowerPlan but fails to complete the order details, a missing details icon will appear next to the order.

If the order does not have a drop-down arrow, right-click the order and select **Modify Planned Order**.

Your order details will appear at the bottom of the screen.

When you are completed the order details, simply take your cursor and click on the down-facing arrow next to **Details for Initial Inpatient/Obs Order**. This will close the Details box at the bottom of your screen and return your screen to the Powerplan orders.

ADDING A “SUB-PHASE”:

A sub-phase is a single-phase plan that is added as a component to a PowerPlan, or a PowerPlan within a PowerPlan.

A Sub-Phase is indicated by an icon within the PowerPlan.

Notice that a sub-phase is located beneath the section of the plan it is associated with and it follows the actions of the plan. An example of a sub-phase is the “Nutrition – Diets” sub-phase located under the “Diet” section in the General Admission PowerPlan. If you select the **NUTR – Diets** sub-phase, the sub-phase will open to reveal your options.

After you select the diet you wish to include, you can return to your PowerPlan by clicking the “**Return to General Admission**” listed above so you can complete the PowerPlan.

IMPORTANT!!!
**ADDING TO PHASE:**

If a provider wishes to add an order to a PowerPlan that is not already included, he/she may do so by clicking the drop-down arrow beside the "Add to Phase."

Then, select **Add Order** from the options box.

The **Add Order** window will appear. Search for the order or orders you wish to add to the Plan, then click **DONE** to close the **Add Order** box.

The order details will appear within your PowerPlan. Complete the missing details.
SIGNING THE POWERPLAN:

When you save a PowerPlan, the plan remains planned until a user selects the **Initiate** button. One example of this workflow is when a surgeon places orders on a patient for outpatient surgery scheduled the following day. Since the patient is not in the hospital, the surgeon does not want the orders initiated until the patient arrives.

1) After placing orders or completing the order details, click **Orders for Signature**, then click **Sign**.

2) Notice the order status displays as “Processing.”

3) Click **Refresh** to refresh the Orders screen.

4) Once the Plan has been signed and refreshed, it is displayed in a “Planned State” in the View panel until it is initiated.

**NOTE TO PROVIDERS:**

Signing the plan without selecting the **Initiate** button saves the plan but does not communicate all of the orders within the Plan to the proper departments.
INITITATING A POWERPLAN:

A Plan can be initiated in several different ways.

1) Right-click the planned PowerPlan in the orders window.
2) Select **Initiate** from the pop-up box.
3) You can also initiate a Plan by clicking.
4) Click **Refresh**. The PowerPlan now displays in an **Initiated** state.
5) PowerPlan orders are displayed in the orders profile once added.

NOTE TO PROVIDERS:

- If a patient is being admitted to the hospital from a provider’s office, the provider will enter the Admission PowerPlan Orders in a **Planned State**.
- Nursing will initiate the PowerPlan orders once the patient arrives on the unit. The nurse should select “protocol not requiring signature” when initiating the powerplan orders. If the nurse forgets or makes a mistake, the provider will receive the orders in message center to sign.
- A few powerplans are set up to auto-initiate automatically... Transitional Orders Medicine, Transitional Orders General Surgery, Transitional Orders Orthopedics, VTE Prophylaxis, Hyponatremia, Common AM Labs, Hyperkalemia, and multiple interventional radiology studies.

MODIFYING A PLANNED ORDER:

1) From the orders section, select the initiated PowerPlan.
2) Then right-click on the order and select **Modify Planned Order**.
3) The “Orders Detail” window is displayed and available for modification. The user will complete the modifications just as with any other order.
4) Click **Orders For Signature**
5) Click **Sign** and **Refresh**.
DISCONTINUING AN INITIATED POWERPLAN:

To discontinue an initiated PowerPlan, complete the following steps:

1) From the view window, right-click on the PowerPlan you wish to discontinue.

   ![PowerPlan Discontinue Window]

   - Click **Discontinue**.
   - Select the orders you wish to discontinue, then click **OK**.

2) Click **Discontinue**.
3) The Plan will go into a **Discontinue Pending** phase.
4) Click **Orders for Signature**.
5) Click **Sign** and Refresh the page. The orders now display in a **Discontinued** phase.

**IMPORTANT!!**

When a PowerPlan is discontinued, every individual order and any sub-phases within that Plan will be discontinued!

If you wish to discontinue an individual order WITHIN the Plan, you should only discontinue that individual order.
IMPORTANT:

Orders that are part of a PowerPlan/Order Set become **active orders** once the PowerPlan/Order Set is **INITIATED**.

PowerPlans/Order Sets can be -

Immediately INITIATED or

placed into a PLANNED STATE, which will INITIATE at a later time.

NOTE To Providers:

*When Do I Initiate PowerPlans??*

*When Do I Enter PowerPlans in a Planned State??*

- **When to INITIATE PowerPlans:**
  - If the **patient** has been assigned and is located in an inpatient room/bed on the nursing floor.
  - If entering an admission powerplan and the **patient is in an inpatient room/bed**.
  - If a medication order is being placed via a PowerPlan and the **patient is in an inpatient room/bed**.
  - If the patient is an inpatient and the orders need to be activated immediately.

- **When to enter a PowerPlan in a PLANNED STATE – Do NOT INITIATE:**
  - If the **patient** has **NOT** been assigned an inpatient room/bed.
  - If the **patient** is still in the Emergency Department and the provider wants to enter admission orders.
  - If the **patient** is a direct admission from a physician’s office and the provider would like to place admission orders prior to the patient’s arrival to the hospital.
  - If the **patient** is being scheduled for surgery ahead of time and preop orders are being entered.
  - If the **patient** is in the PACU following surgery and the surgeon would like to enter their postop floor orders.
Entering PowerPlans in a PLANNED State:

PowerPlans can be placed into a Planned state and later initiated by nursing.

**SCENARIO:**
- The patient is in the office and needs to be admitted as a DIRECT Admit.
- The provider or the provider’s office staff will need to call the admissions department to get a “quick direct” account number.
- Once the account number is received, the provider will access the patient via HERO using the account number and complete the following.

**OR**

**SCENARIO:**
- The patient is in the ED and is going to be admitted.
- The provider will access HERO, bring up the patient and complete the following.

PowerPlan Display:

Once the PowerPlan/Order Set is entered, either planned or initiated, it will display in the Order Hierarchy below the “Plans” section.

NOTE To Providers:

If changes need to be made to a plan that is multi-phase, be sure to select the correct phase of the plan.

Example: General Starter Order Set = Phase
VTE Phrphylaxis Sub-phase = Another Phase
**INITIATE PowerPlans:**

When should Powerplans/Order Sets be **INCIITATED** instead of **Planned**?

The difference in placing a PowerPlan that is to be initiated from the time of ordering is one click. The provider will need to click the **INITIATE button**, followed by the **Orders For Signature Button** and then the **Sign Button**.

These orders will become active and be received in the lab, pharmacy, display on the nursing task list, go to the appropriate ancillary department, etc.

**PowerPlan Display:**

To Cancel/Discontinue or Void an ORDER Within an INITIATED PowerPlan:

1. Select the PowerPlan
2. Right click the item you wish to Cancel/Discontinue or Void
3. Select Cancel/Discontinue or Void
4. Click Orders for Signature
5. Click Sign
6. Click Refresh
To Cancel/Discontinue or Void an INITIATED PowerPlan:

1. Select the PowerPlan.
2. Right click on the “Main” PowerPlan name the item you wish to Cancel/Discontinue or Void.
3. Select Cancel/Discontinue or Void.
4. Click Orders for Signature.
5. Click Sign.
6. Click Refresh.

Viewing Excluded Components of 2 PowerPlans:

(Ordering A New PowerPlan and Viewing Items Already Ordered in another PowerPlan)

If a provider wishes to enter a new Powerplan and compare the orders to an already ordered Powerplan, the Excluded Components button can be selected.

The orders of the new PowerPlan will display with the check box next to each orderable item with the already ordered items of the previous PowerPlan displayed below for each clinical category.

Adding PowerPlans As Favorites:

PowerPlan favorites are also:
- Unique to a user
- Maintained by the user
• Not seen by other users
• Convenient to help speed up the ordering process

Users can create, move, delete and organize their own Favorite PowerPlans.

To verify that your favorite PowerPlan has been saved, go back to the add order window and click on the My Favorite Plans folder.

Your favorite PowerPlan will display.
Providers are required to document the following via HERO:

- **Brief Note (Free Text Progress Note) OR the...**
- **Simple SOAP Note (Template Progress Note)**
- **Immediate Post-Procedure Note**

Providers have other document type options via HERO but they are **Not required (Optional)**.

- History & Physical
- Consultation
- Discharge

### NOTE To Providers

- All other documents will continue to be dictated and transcribed as they are now.
- Dictated and transcribed documents will be sent to Message Center for signature.
- Transcribed reports can be modified via Message Center.

### ADDING A POWERNOTE/ CHOOSING A NOTE TEMPLATE:

1. To create a new note, click the **Documentation** tab on the Main Menu.
2. Next, click “+ADD.”
3. An **Open Note** window will display.
4. You will select the type of note you are creating in the “**Type**” field.
5. You can select a note template by using the tabs.

- The tabs listed in the **New Note** window allow you to open PowerNote templates in many ways.

- **New**: A listing of all available templates. Click search to view all templates alphabetically.
- **Existing**: Lists all active (saved) and signed PowerNotes for the selected patient. Here you can finish notes that were saved, or copy a signed note to a new one.
- **Precompleted**: If you create your patient notes using a consistent style or format, you can save a note as a precompleted note and use this note format from one patient to the next. Remember to edit the information in the note as needed before signing.
- **Catalog**: Sets of notes that go together for a specific unit, department, procedure or diagnosis.
- **Recent**: Lists notes that you have accessed, the last note accessed is listed first.
- **Favorites**: Anytime you add an encounter pathway or precompleted note to Favorites, it is saved on this tab.

6. To select a note template, click on the **Catalog** tab. Use the drop-down arrow in the “Catalog” field to select the template you wish to create. For an example, select **Progress Notes**.

7. The available note templates will display in the box.

8. The available progress templates are:
   
   a. **SOAP Note: Simple** – a template providers can use to create their a Progress Note.
   
   b. **Brief Note** – an empty note (does not contain templates) a provider can use if they wish to enter a simple note into a patient’s chart.
   
   c. **Immediate Post Procedure Note** – a template surgeons use to chart patient information immediately following surgery/a procedure.

9. Double-click on the note title to open the note template. For an example, select **SOAP Note: Simple**.
**Auto-Populate Window:**

*PowerNote* is powered with the ability to automatically populate your note with patient information pulled from within the patient’s chart. Based on the content of the particular type of PowerNote you select, automatic population can automatically add the following pieces of information: Chief Complaint From Nursing, Allergies, Medications, Vital Signs, Measurements, Problem List, and Histories.

**NOTE To Providers:**

Before making your selections from the Auto Populate window, think about what you currently document as part of your progress note on paper. Providers have a tendency to include too much information which makes the note look busy & overwhelming.

**REMEMBER – Too much information is not always better.**

**POWERNOTE SELECTION, SYMBOLS & OPTIONS:**

When the PowerNote opens, it is divided into two sections: the *Navigation* area and the *Documentation* area.
**PowerNote Navigator** - The navigator organizes the sections of the selected *PowerNote*, called paragraphs. The paragraphs are listed in a tree in the navigator. Click the plus sign next to a paragraph to reveal the available sections of information, called sentences. To navigate quickly throughout the note documentation, click a paragraph or a sentence within the navigator to link you directly to that item in the documentation area.

**PowerNote Documentation Area** – Complete your notes using the PowerNote Documentation section.

![Tree Diagram of a Sample Note]

**SYMBOLS:**

| General >> | Blue Chevrons are used to indicate that a sentence can be expanded to show additional terms or collapsed to expose only the common terms. |
| Quality << | |
| **Breath sounds**: | Within the body of the template, indicates a term and its associated terms are set to repeat when selected. |
| **Chest**+ | + Indicates there are additional terms that can be selected to further describe a term. |
| **ROM ...** | ... Indicates there are additional terms to further describe a term that is not exposed until >> or + signs expose the parent term. |
| **=== minutes** | = = = Indicates a term where a number will need to be entered. |

![Insert Image Icon] Insert Image icon found in *PowerChart*. Used to insert images into PowerNotes.

![Insert Image Icon] Insert Image icon found in *PowerChart Office*. Used to insert images into PowerNotes.

**<Show Structure>** Displays the structure of a paragraph including the sentences and terms.

**<Hide Structure>** Hides the structure of a paragraph including the sentences and terms. The text rendition of the
SELECTING TERMS:

Your mouse is the main tool for data entry in the PowerNote. By positioning the pointer over a term, you can perform the following actions:
- Click a term once to display that term in your final signed note.
- Click a term a second time to negate the term so the negative is displayed in your final signed note.
- Click a term a third time to clear the selection.

ADDING COMMENTS:

Comments can be added to the PowerNote by performing the following actions:

1. Right-click the term and select Comment from the options box.
2. Enter the comment and hit OK.
3. The comment is displayed in parenthesis beside the term within the note.

NOTE TO PROVIDERS:

In addition, you can enter comments in any sentence that has the term OTHER as an option. For example, when completing Review of Systems in the Objective paragraph, each sentence has the option of OTHER listed within the terms. Selecting OTHER opens a text box allowing you to enter your comments accordingly.
VIEWING PARAGRAPHS IN POWERNOTE:

Hide or reveal whole paragraphs within the note Documentation Area using the Hide Structure or Show Structure link.

This can be useful in organizing the note. If you hide the structure of each paragraph once you are finished, you will see what it will look like in the actual note and be able to tell you are finished.

USING FREE TEXT:

To enter free text into a paragraph structure, select the Use Free Text link to activate a free-text cursor within the paragraph.

NOTE TO PROVIDERS:

Use Free Text should be used to tell the story for History of Present Illness (HPI).

SIGNING A POWERNOTE:

To Save a PowerNote for later completion:

1. Click on the Save button on the toolbar.
2. You may exit from PowerNote.

Your note will not appear in the patient's chart until it has been signed. Saved notes will appear as Active notes on the Existing tab when you return to PowerNote.

To Sign a PowerNote (enter the Note in patient’s chart):

1. Click on the Sign button on the toolbar.
2. Select the appropriate document type. (This should default to the correct document type depending on the template the user chooses.)
3. The document title will display automatically. Do not change.
4. Set the **Document Date** and **Time** to reflect when the note was written or then the patient service was delivered. This will be the date and time that the note will be displayed in the **Flowsheet** and on the **Notes** tab. It will automatically default to the date and time the Note is signed.

5. If you need to forward the note to another provider for review, check **Request Endorsement**, then click under each column heading to complete the information. Remember to select either **Review** or **Sign** under the **Type** column.

6. Click the **Sign** button.

7. **Refresh** your screen.

You can view your document from within Documentation tab or within the **Notes** tab once it has been signed.

**NOTE To Providers – Residents, Nurse Practitioners & Physician Assistants:**

Once the **Sign/Submit** button is clicked the **Sign/Submit Note** window will display. Residents, NPs and PAs will be **required** to enter their Supervising Physician in the Endorser field. The Type will need to be for “Sign”.

---

**Sign/Submit Note**

- **Type:** Progress Note Physician
- **Title:** SOAP Note Simple
- **Date:** 11/19/2012 10:00 EST

<table>
<thead>
<tr>
<th>Endorser</th>
<th>Type</th>
<th>Due By</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMITH, KRESTIN DO</td>
<td>Sign</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Sign** | **Cancel**
Icons and Symbol Definitions:

Chevrons >>  The Blue Chevrons indicate that a sentence can be expanded to show additional terms or collapsed to expose only the common terms. The example below shows the sentences collapsed.

Clicking on the chevrons to expand the sentence will display all terms associated with the sentence. A sentence fully expanded appear as <<. All terms associated with that sentence are exposed.

+ Symbol

The + sign is used to indicate when there are additional terms. These additional terms will display when a term containing the + sign is selected. Below the + sign is used to indicate there are additional terms associated to the term "Finger".

When the + is selected, the additional terms associated to that term will display for selection.

= == Symbol

The == is used to indicate a term where a numeric value needs to be entered. In the example below == is used to indicate a value is needed for the "minutes" term.

Once a term with the == symbols is selected, a numeric control will launch that allows for a value to be inserted. Below is an example of the control being launched when the "== minutes" term is selected. After entering the value and selecting "Ok" the numeric value entered will display.
Other Term

The "OTHER" term is one option for inserting freetext into a note. The "OTHER" term is intended for use when the terms available for documentation are not applicable or need to be further expanded upon.

Free-Texting

Free-text allows for text to be entered directly into a note without selecting any terms or sentences from the template provided. The OTHER term, previously described, allows for freetext to be entered at the sentence level through the use of a free-text box.

To Modify or Correct a Signed Note:

1. From the Documentation tab, click/highlight the note you wish to modify.
2. Click the Modify button from the toolbar or right-click in the text area and select Modify.
3. Scroll to the bottom of the document to where it states “Insert Addendum Here.”
4. Key in information and click Sign.
5. The report will reflect that an addendum has been added.
**Note Entered On Wrong Patient or Entered In Error:**

1. From the *Documentation* tab, select the document.
2. Click the “In Error” button from the toolbar.
3. The “In Error Comment” window will display.
4. Key in the reason for the error.
5. Click OK.
6. The Note will display with In Error noted at the top in RED.
7. Any time the report is clicked on the user will receive the following message as well.

DON’T FORGET TO REFRESH YOUR SCREEN!
**System Level Auto-Text:**

System level auto-text is available to all providers and is created by the I.T. staff.

If the provider keys in a “period” – “.” a pop-up box will display with auto-text options.

**.consult** – Displays with the following headings for a free text consult note.

- REASON FOR CONSULT:
- HISTORY OF PRESENT ILLNESS:
- ALLERGIES: - set to prepopulate
- MEDICATIONS: - set to prepopulate with active medications
- PAST MEDICAL HISTORY:
- SOCIAL HISTORY:
- FAMILY HISTORY:
- REVIEW OF SYSTEMS:
- EXAM:
- NEW LABS:
- IMPRESSION:
- RECOMMENDATIONS:

**.hpu** – Indicates that the History and Physical has been unchanged if done prior to a procedure/surgery. The text appears as the following:

_I have examined the patient and reviewed the H&P. No change in the patient’s condition has occurred since the H&P was completed._

**.progress** – Displays the headings for a free text progress note.

- SUBJECTIVE:
- VITAL SIGNS: set to prepopulate the last 24 hours of vital signs
- OBJECTIVE:
- EXAM:
- NEW LABS:
- ASSESSMENT:
- PLAN:

With the Consult and Progress Note auto-text headings, the provider can navigate to the next section/heading by pressing the F3 key on their keyboard. The underscore character “_” serves as a placeholder can be accessed by pressing the F3 key.
**Precompleted Notes (Progress Note):**

A Precompleted note allows the user to save certain aspects of their documentation that are used frequently. These attributes are preselected, noted and then saved as a Precompleted note. The Precompleted note can then be accessed at a later time with all of the attributes already displayed. This will save the user time in completing their documentation.

**Creating a Precompleted Progress Note:**

To accomplish a pre-completed note template, complete the following steps:

**NOTE:** These steps have to be accomplished before the note is signed.

1. Select the Progress Note.
2. Complete the note with all desired information that you wish to apply to your Precompleted note.
3. Click on the Documentation from the Menu bar at top of the PowerChart window and select ‘Save as Precompleted Note’.

4. The ‘Save as Precompleted Note’ dialog box opens. Rename the Note Title to a title of your choice.

5. Click the Save as New button. The progress note has now been saved as a Precompleted Note.
**Using a Precompleted PowerNote:**

1. Open the documentation tab from the Table of Contents.
2. The Documentation window appears.
3. Click the ‘+Add’ button.
4. Select the Precompleted tab.
5. Select the precompleted note.
6. Click OK.

The Precompleted Note will open with the contents already complete with what was saved as part of your note. Edits and additions can be added as desired and sign. Do NOT save any patient specific details in a Precompleted note.

**NOTE To Providers:**

- Providers will be required to enter **Allergies ONLY** if entering Admission Orders outside the hospital.
- Allergies **must** be entered into the system and are **required** prior to placing **medication orders**.
- **Nursing** will enter the **Height and Weight** when the patient arrives.
- **Multiple** Admission PowerPlans will display for different diagnoses.
- Even though the PowerPlans are labeled Admission it doesn’t mean the Powerplans cannot be used if the patient develops the condition while in the hospital.
- A general admission Powerplan is available for when a diagnosis related Powerplan is not available.
To complete Admission Med Rec...

1. Click the drop-down arrow next to Reconciliation.
2. Highlight and click on Admission.
3. The Admission Med Rec window will display.

The left side of your screen is a list of the patient’s active meds entered via:
- Med History
- CPOE – Medications already entered as part of this admission before the completion of Admission Med Rec.

"Continue" means “Convert to Inpatient medication”

"Do Not Continue" means “I don’t want to continue this patient on this medicine in house”—but it will NOT cancel the med as a home regimen.

The right side of your screen is a list of the patient’s medications the provider has chosen to continue as inpatient/observation patient.
Previously Dispensed Medications:

If a provider wishes to see the patient’s previously dispensed medications, the provider can click on the Check Interactions drop down arrow from the order display. Click on the External Rx History selection.

Select the appropriate time frame. The listing will display as shown below.

<table>
<thead>
<tr>
<th>S</th>
<th>Drug Name</th>
<th>Rx Medication</th>
<th>Last Fill</th>
<th>Quantity</th>
<th>SIG</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>albuterol</td>
<td>ALBUTEROL 0.063% INHAL SOLN</td>
<td>01/02/2013</td>
<td>225.000 unknown unit</td>
<td>inhal contents of 1 vial in nebul</td>
</tr>
<tr>
<td></td>
<td>isosorbide mononitrate</td>
<td>ISOSORBIDE MN ER 30 MG TABLET</td>
<td>12/13/2012</td>
<td>30.000 unknown unit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>amloidipine</td>
<td>AMLODIPINE DESYLALE 5 MG TAB</td>
<td>12/13/2012</td>
<td>90.000 unknown unit</td>
<td>take 1 tablet by mouth once daily</td>
</tr>
</tbody>
</table>
EH Common Diagnoses Folders:

Common Diagnoses are available to help providers quickly find the most common diagnoses they may use on a daily basis. All providers have access to these common diagnoses folders.

To Access These Common Diagnoses Folders:

1. Click the Diagnosis/Problems tab from the main menu.
2. Click the +Add button from the Diagnosis section.
3. In yellow field key in CHF
4. Click search button (binoculars)
5. Click (highlight) first choice in list below (it is not required for doctors to select a specific diagnosis according to codes)
6. ONCE DIAGNOSIS IS HIGHLIGHTED, PROVIDERS CAN SELECT “SAVE TO FAVORITES”
7. Click OK & Add New
8. In yellow field key in Pneumonia
9. Click search button (binoculars)
10. Click (highlight) first choice in list
11. Click OK

To Enter Multiple Diagnoses:

1. Click the Diagnoses & Problems tab from the Menu.
2. Click Add Button from the Diagnosis section.
3. In yellow field key in CHF
4. Click search button (binoculars)
5. Click (highlight) first choice in list below (it is not required for doctors to select a specific diagnosis according to codes)
6. ONCE DIAGNOSIS IS HIGHLIGHTED, PROVIDERS CAN SELECT “SAVE TO FAVORITES”
7. Click OK & Add New
8. In yellow field key in Pneumonia
9. Click search button (binoculars)
10. Click (highlight) first choice in list
11. Click OK
**CDMP Folder** – Contains the most common diagnoses defined by the EH CDMP staff.

**Common Acute, Common Chronic, and Signs and Symptoms** – Contains diagnoses as such.

**Setting The Home Diagnoses Folder:**

1. To select any folder as a home folder, right click the folder and select “Set as Home Folder.”

2. That folder will open every time by default.

**NOTE:** If the provider does not “Set a Home Folder” the providers personal favorites will display by default. If the provider has set a different Home Folder, the providers personal favorites can be found by clicking the “Favorites” button.

**NOTE To Providers:**

- The Diagnosis can be added from multiple places with the EMR.
- The first is shown above.
- The diagnosis/diagnoses can be added from the New Order window.
- The diagnosis/diagnoses can also be added from the Impression and Plan section of a documentation template.
Communication To Physician Page:
The Communication to physician page includes specific documentation and information that nursing and ancillary departments would like relayed to the provider for the last 72 hours. Here are some examples:

![Examples of documentation and information relayed to the provider.]

The following is a list of the documentation that will display on the Communication To Physician page:

<table>
<thead>
<tr>
<th>24 Hour Calorie Intake</th>
<th>OT Disposition Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hour Protein Intake</td>
<td>OT Equipment Anticipated, Recommendations</td>
</tr>
<tr>
<td>Communication To Physician</td>
<td>OT Progress Note</td>
</tr>
<tr>
<td>Current Home Treatments</td>
<td>Physical Therapy Progress Note</td>
</tr>
<tr>
<td>Home Equipment</td>
<td>Pressure Ulcer Present On Admission</td>
</tr>
<tr>
<td>Lines or Tubes Present on Admission</td>
<td>Professional Skilled Services</td>
</tr>
<tr>
<td>Lives With</td>
<td>PT Disposition Recommendations</td>
</tr>
<tr>
<td>Living Situation</td>
<td>PT Equipment Anticipated or Recommended</td>
</tr>
<tr>
<td>Nutrition Summary of Recommendations</td>
<td>PT Progress Note</td>
</tr>
<tr>
<td>Occupational Therapy Progress Note</td>
<td>Special Services and Community Resources</td>
</tr>
<tr>
<td>Speech Therapy Progress Note</td>
<td></td>
</tr>
</tbody>
</table>
**Viewing Results:**

There are few different places results can be reviewed. For review the patient’s most recent test results, I&O, Vitals, etc. click the **Inpatient Summary** tab on the Main Menu.

Recent results from labs, radiology, vital signs, and assessments will display here.

<table>
<thead>
<tr>
<th>Vital Signs</th>
<th>Laboratories</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Selected site</strong></td>
<td><strong>Latest within</strong></td>
</tr>
<tr>
<td>Temp</td>
<td>38.9</td>
</tr>
<tr>
<td>BP</td>
<td>110/74</td>
</tr>
<tr>
<td>Respiration Rate</td>
<td>8.3</td>
</tr>
<tr>
<td><strong>Intake and Output</strong></td>
<td><strong>Latest within</strong></td>
</tr>
<tr>
<td><strong>Last day for the selected site</strong></td>
<td></td>
</tr>
<tr>
<td>Total Fluid Balance</td>
<td>+58.2</td>
</tr>
<tr>
<td>Total Fluid Intake</td>
<td>50.0</td>
</tr>
<tr>
<td>coffee intake + Dextrose 5%</td>
<td>50.0</td>
</tr>
<tr>
<td>Preinf. Dextrose 5%</td>
<td>0.00</td>
</tr>
<tr>
<td>Total Fluid Output</td>
<td>+58.2</td>
</tr>
<tr>
<td>* Indicates a day without a full 24 hour measurement period.</td>
<td></td>
</tr>
</tbody>
</table>

The Hyperlinks from this page will take the user directly into that part of the patient’s chart.

The other option to review results is through the Results Review tab. See next page.

---

**How Far Back of Information Can I Find in HERO?**

**Persons – All persons have been loaded into HERO.**

**3 years 2009, 2010, 2011 and all 2012 to February 13th of the following:**

- Encounters/Visits
- Lab Results
- Radiology Reports (IMAGES from ???? to present)
- Medical Record Reports (H&Ps, Consults, Operative, etc.)

**This information has NOT been loaded into HERO:** EKGs, Allergies, Past Medical History, Problems, Diagnosis or Medications.
Results Continued:
To review the patient’s most recent test results, click the Results Review tab on the Main Menu. Recent results from labs, radiology, vital signs, and assessments will display here.

To view Lab Results specifically, click on the Lab tab...

To view Radiology reports and images, click the Radiology tab...
Results Continued:
To view Radiology report, double-click the Radiology test description...

The radiology report will display...

Result Type: CT Abd/Pelvis w/ Contrast  
Result Date: 05 November 2012 09:20 EST  
Result Status: Modified  
Result Title/Subject: CT ABD/PELVIS WITH CONTRAST  
Encounter info:  

* Final Report *

Report
CT scan abdomen and pelvis: The requisition relates abdominal pain. 
The technologist notes left upper quadrant abdominal pain nausea, 
hernia repair times three. hepatocoele repair.

Scans were obtained from the lung bases through the inferior pubic rami. 
The scans were obtained following the oral ingestion of contrast, and during 
the bolus injection of 128 cc of Omnipaque 300. Comparison is made with a previous PET/ CT of 7/25/08.

The scans show emphysema at the lung bases, with extensive bulla formation. No pleural abnormalities are seen. Attenuation pattern in 
the liver shows a few tiny areas of decreased attenuation persisting 
the delayed sequence, perhaps tiny cysts. The spleen is unremarkable 
with multiple calcifications. The gallbladder demonstrate a small 
stone or stones layering in the dependent aspect. The pancreas is 
unremarkable. No adrenal masses are seen. The right kidney appears
Results Continued:
To view Radiology image, click the View Image button from the Radiology report toolbar...

The image will display:

Once the provider has reviewed the results, the provider will go see the patient and complete their physical exam.
**Discharge Process:**

The Excela Health Wide Discharge Process allows clinicians to manage the activities associated with the process of documenting and discharging a patient.

---

**NOTE To Providers:**

*At discharge, the providers are responsible for completing the following:*

- Enter a Discharge Order
- Review/modify Discharge Diagnosis/Diagnoses
- Complete Follow Up Instructions
- Perform Discharge Medication Reconciliation
- Complete Physician Discharge Instructions via PowerForm

---

**Discharge Summary:**

The *Discharge Summary* page will display.

Each section title will be **bolded** and highlighted in **BLUE**.

Providers must complete each section with an **MD** in parenthesis next to the title.
• **Complete Physician Discharge Instructions via PowerForm** – Discharge instructions appear on the patient’s discharge instructions and include the patient’s diet, wound care, return to work/school, lifting restrictions, significant tests, etc. **Completion of this form is required at discharge.**

• **Complete Follow Up Instructions** – The follow up instructions consist of following up with a provider in so many weeks, months, etc. This information is included in the patient’s discharge instructions.

• **Enter a Discharge Order** – The discharge order is the order that notifies nursing that the patient is ready to be discharged and to begin the discharge process.

  *NOTE: The discharge process can be started ahead of time but it is recommended that this order is not placed until the provider is ready for the patient to leave the facility.*

• **Perform Discharge Medication Reconciliation** – The Discharge Med Rec display will automatically default to continue home medications and discontinue hospital medications. The provider should update, change, add, etc. medication discharge orders appropriately. For short term medications to be prescribed at discharge use the common discharge medication order folder to find these medications. Providers can save their own favorites for other items desired.

• **Review/modify Discharge Diagnosis/Diagnoses** – The diagnoses will automatically display as discharge unless the diagnosis type was changed. If the diagnoses display working, admitting, etc. the provider should change it to discharge. In addition, any additions, modifications, etc. need to be addressed.
1) **Physician Discharge Instructions (via PowerForm):**

The Discharge Powerform includes items that the provider needs to address on Discharge that is similar to our current paper discharge instructions. To access the Discharge Powerform/Instructions complete the following:

1. From the *Discharge Summary* page, click on the drop down arrow next to the *Discharge Powerform* section.
2. Highlight and click *Physician Discharge Instructions*.

![Discharge Powerform Image](image)

3. The *Physician Discharge Instructions* box will appear. Select the diet, activity level, driving, lifting, weight bearing, and return to work/school instructions. If necessary, you may also add instructions for dressing/wound and any other additional instructions in the designated boxes.

![Physician Discharge Instructions Form](image)

4. When you have entered all Discharge Instructions, sign the PowerForm by using the green check top left corner:
2) Follow Up Instructions:

1. From the *Discharge Summary*, select +ADD under the *Follow Up* section.

2. Click the Binoculars icon to search for a Provider.

3. Key in the last name of the provider.

4. Click the **Search** button.

5. Highlight and select the provider’s name.

   **NOTE:** If the provider’s name is not available, use the Free-text Follow Up option.

6. Once you have selected the Provider, his/her address(es) will appear under “Follow up Address” in the *Where* section of the Patient Education box. Select the correct location by checking the box next to the address.

7. In the *When* section, you can select a time range for patient to follow up, or, if patient already has a follow-up appointment scheduled, you can enter the appointment date and time.

8. If the provider chooses to use the **Predefined Comments**, double-click the comment you wish to add. It will display to the right in the “Edit Comments” section.
9. Review the Follow Up Instructions.

10. When you have completed the Follow Up Instructions, click **SIGN**.

**NOTE:**

A summary of all the follow-up instructions will display in the Selected Follow up window. Use the **X** icon to delete any follow-up instructions that are no longer needed and click **OK** to save changes.

3) **Discharge Order:**

This order replaces the order that the provider would write on the chart currently when the patient needs to be discharged.

1. From the Discharge Summary page, click the drop-down arrow next to **Discharge Order**. Highlight and select the **Discharge Order**.

2. The **Discharge Patient Order** will display.

   In addition, if the provider is **NOT** prescribing a required Core Measure medication for the patient at discharge, the appropriate reason must be selected.
Select the Patient Discharge Order and make any other additional orders that are necessary.

Complete the “Order details” section.

When you have entered all of the required information, click OK.
4) **Discharge Medication Reconciliation:**

The Order Reconciliation Discharge screen will appear.

**NOTE:** All Documented (home) medications will automatically default to “Continue After Discharge,” and all hospital medications will default to “Do Not Continue After Discharge.”

To continue a hospital prescribed medication for the patient post-discharge, you will select “Create New Rx” (ePrescribe) for the new medication.

*Prescription(s) for controlled substances must be printed and manually signed by physician.*

---

**Creating New Rx:**

1) Click “Create New Rx.”

2) Click the Details icon and enter the order details:

---

[Image of screenshot showing the medication reconciliation process]
ePrescribe – Send Prescription To A Pharmacy Electronically:

1. To ePrescribe the medication to a pharmacy, click on the ellipsis button.
2. Key in the name of the Pharmacy and location.
3. Click the Search button.
4. Highlight the correct pharmacy and click OK.

Printing A Prescription:

1. From the Add window a list of Discharge Medication Folders will display.
2. Click the Discharge Prescriptions folder you wish to use.
3. Select the medication you wish to prescribe.

**Vicodin 5 mg-500 mg oral tablet**
1 tab(s), Oral, q6hr, PRN Pan, X 7 day(s), # 30 tab(s), 0 Refill(s)
**Vicodin 5 mg-500 mg oral tablet**
2 tab(s), Oral, q6hr, PRN Pan, X 7 day(s), # 30 tab(s), 0 Refill(s)
**Vicodin HP 10 mg-660 mg oral tablet**
1 tab(s), Oral, q6hr, PRN Pan, X 7 day(s), # 30 tab(s), 0 Refill(s)

NOTE: Narcotics must be printed on prescription paper.
4. Click Done.

5. To print the prescription, click on the ellipsis button.

6. In the **Send To** field, select “Printer.”
   a. **Favorites** tab – If you have saved printers to your Favorites, they will be listed on the Favorites tab.
   b. **Other Output Devices** – Use this tab to search for printers.

   ![Image of Prescription Routing dialog]

   **NOTE:** When selecting a printer for prescriptions, the printer will display with the facility letter (f, l or w), nursing station (3north, 2south, 1d), with the suffix of Rx. Example: l3northrx, f2southrx, et

   Expanding the “+” (plus signs) next to the hospital name will reveal each unit within that hospital. Select the desired unit on which you wish to print.

7. Highlight the printer to select it and select **OK**.

8. The printer will now display in the **Send To** field.

9. To complete discharge med rec, click the **Reconcile and Sign button**.

   **NOTE:** Do **NOT** click the **Reconcile, Sign and Print Discharge Report button**. Nursing will print the discharge report when the patient is ready to leave the hospital.
To Add A Brand New Medication At Discharge:
(Not listed on Discharge Med Rec display)

1. Click on Add.
2. Search for the medication you wish to add.

**NOTE:** Common Discharge Medication Folders are provided for your ePrescribing convenience...

Examples: Discharge Prescriptions – Pain...

- acetaminophen-codeine 300 mg-30 mg oral tablet
  1 tab(s), Oral, q4hr, PRN Pain, #7 day(s), #30 tab(s), 0 Refill(s)
- acetaminophen-codeine 300 mg-30 mg oral tablet
  2 tab(s), Oral, q4hr, PRN Pain, #7 day(s), #30 tab(s), 0 Refill(s)
- Lotab 10/500 oral tablet
  1 tab(s), Oral, q8hr, PRN Pain, #7 day(s), #30 tab(s), 0 Refill(s)
- Percocet 5/325 oral tablet
  1 tab(s), Oral, q4hr, PRN Pain, #7 day(s), #30 tab(s), 0 Refill(s)
- Percocet 5/325 oral tablet
  2 tab(s), Oral, q8hr, PRN Pain, #7 day(s), #30 tab(s), 0 Refill(s)

Discharge Prescriptions – IVs...

- ceftazid 1 g/50 mL intravenous solution
- ceftazid 2 g/100 mL dopamine solution
- ceftepime 1 g/50 mL injectable solution
- ceftepime 2 g/100 mL injectable solution
- cefotaxim 1 g/50 mL intravenous solution
- cefotaxim 2 g/50 mL intravenous solution
- cefotaxim 2 g/50 mL intravenous solution
- ceftriaxon 200 mg/100 mL dopamine solution
- ceftriaxon 400 mg/200 mL dopamine solution
- Cipro IV 200 mg/100 mL dopamine solution
- Cipro IV 400 mg/200 mL dopamine solution
- Levoxan 250 mg/50 mL intravenous solution
- Levoxan 500 mg/100 mL intravenous solution
- Levoxan 750 mg/150 mL intravenous solution
- levofloxacin 250 mg/50 mL intravenous solution
- levofloxacin 500 mg/100 mL intravenous solution
- levofloxacin 750 mg/150 mL intravenous solution
- vancomycin 1 g/250 mL dopamine solution
- vancomycin 1.5 g/350 mL dopamine solution
- vancomycin 2 g/500 mL dopamine solution
- Zospec 750 mg/50 mL dopamine solution
- Zospec 1 g/50 mL dopamine solution
- Zospec 2 g/50 mL dopamine solution

- Zypax 2 mg/mL intravenous solution
3. Once the details have been complete, click the Done button.

4. The added medication will display on the Discharge Med Rec screen...

To Add A Miscellaneous Medication Order At Discharge

If the provider is unable to find a medication to add at discharge, the provider can search for a miscellaneous medication order.

1. Key in the search field “misc” to find the miscellaneous medication order.

2. Select the Misc. Medication order.

3. Complete the appropriate detail fields

OR

4. Click the dose field and select See Instructions.

5. Key in the drug name, instructions, # to dispense and refill information as shown above.
5.) **Discharge Diagnosis:**

1. From the Discharge Summary, review the Diagnosis section.

2. The Diagnosis/Diagnoses entered previously will automatically default to the Discharge Diagnosis. Review the Diagnosis listed to verify, modify, etc.

   **NOTE:** At discharge, providers should remove any diagnoses that no longer apply by **right clicking** on the diagnosis and **selecting remove**.

**NOTE To Providers:**

*At discharge, there are other orders that can be added:*

- **Outpatient Tests After Discharge** – Use this order to generate an outpatient order sheet to give to the patient to have outpatient tests done at a later time.
- **Non-Medication Items** (lancets, syringes, etc.) – The orders will need to be hand-written.
- **Home Durable Medical Equipment** – Use this order to provide to Case Management with an order for medical equipment after discharge.
- **Home Health Consult** – Use this order to request Home Health services after discharge.
To Review Final Medications For The Patient:

1. From the Discharge Summary, the provider can review the discharge documentation that the patient will receive with a list of the medications by clicking on the Discharge Process link.

![Discharge Summary](image)

2. The Diagnosis/Diagnoses entered previously will automatically default to the Discharge Diagnosis. Review the Diagnosis listed to verify, modify, etc.

   **NOTE:** At discharge, providers should remove any diagnoses that no longer apply by right clicking on the diagnosis and selecting remove.

   ![Diagnosis Removal](image)

   **Medications**

   Take only the medications listed on this sheet! Do not take any over the counter medications, except on the advice of your physician or pharmacist. Discard any medication list and update your medication record with all medication providers. This list will be given to you at all health care visits. If there is confusion about your medications, please contact your doctor as soon as possible for directions.

   - **Acetaminophen hydrochloride (Tylenol 500 mg and tablets) 1 tab(s):** Oral, every 4 hours.
   - **Nebulized saline 3 mL, Nebulized placebo, 4 times a day:** Refill: 0
   - **Albuterol (Proventil 2 mg and tablets) 1 tab(s):** Oral, every 6 hours.
   - **Digoxin (digoxin 0.125 mg oral tablet) 1 tab(s):** Oral, every day.
   - **Prednisone (Prednisolone 5 mg oral tablet) 1 tab(s):** Oral, every day.
Message Center is for provider medical records maintenance. Here, you will review, sign, modify, or refuse Orders and Documents electronically. Message Center is NOT email.

**NOTE To Providers:**

As a general rule, providers should review message center first when accessing HERO. Review orders and document for approval/signature/cosignature.

HERO will automatically open to your Message Center inbox.

You can also click on the Message Center icon to view your inbox.

In Message Center, you will find:
- Orders for Signature
- Documents/Scanned Documents for Signature
- Documents to Dictate
- Results FYI
- Orders To Be Renewed
- Messages - CDMP

**Results FYI** – The ONLY time results will appear in Message Center is results completed after patient has been discharged.

**Restraints & Foley Catheter** daily renewal orders will go to Message Center to be renewed.
ORDERS FOR REVIEW:

What orders will appear in Message Center For Review and Signature/Co-Signature?

- Orders given to and entered by a nurse as a phone order OR
- Orders entered by a Resident, Nurse Practitioner or Physician Assistant will appear in message center for review and co-signature.

NOTE To Providers:
Any images or documents that are scanned after discharge will NOT go to Message Center.

NOTE To Providers:
Message Center is NOT to be used for Critical Results.
Nursing will continue to page/notify providers of Critical Results.
Physicians should continue to page each other for patient clinical issues.

ORDER Options:
Providers will have the option to Approve or Refuse orders.

To navigate through the orders, the provider will click one of the following:

- You will have three orders for review to work with.
- Orders for review can be “skipped” (next), “approved”, or “refused”.

NEXT will skip current order and proceed to next order for review

OK approves the order. Click NEXT to go to the next order.

OK/NEXT will approve the order and proceed to next order for review, through the documents.

ALERT!!!!
The “OK & Next” button is not functioning properly. Use “OK” button followed by the Next button.
NOTE To Providers:

- If the provider knows which provider should have received the order for signature, the provider can forward the order to the correct physician.
- **REFUSED ORDERS** will automatically go to the Nurse Manager/Supervisor Mailbox.
- If the ordering physician is known, the nurse manager/supervisor will forward the order to correct physician.
- If the ordering physician is unknown, the order will be forwarded to the attending physician who must approve the order to get it out of the system (message center) with a comment regarding the situation.

ORDERS To Be RENEWED:

**RENEW Order For FOLEY Catheters and RESTRAINTS:**

- It is required that Foley Catheters and Restraint orders must be ordered daily.
- When an order is placed for these items a renewal order will automatically appear in the providers Message Center Orders Folder.
- The order will generate a **reminder** at 1-hour after the order is entered.
- The second renewal order will generate at 23-hours to reorder/renew (total 24 hrs)
- The provider can Approve the renewal order to continue the Foley Catheter or Restraints.

**NOTE:** The approval of the order is **NOT** an order. If the catheter needs to be continued, a new order must be placed with documentation of the reason for continuation. This order is available in the Common Order Folder – Compliance.

- If the Foley Catheter or Restraint is to be **discontinued**, the provider must approve the renew order in message center and then....
- The provider will need to access the order profile window and place the order **DC Foley**.
- The Restraint PowerPlan will need to be **Cancelled/Discontinued** from the powerplan section of the Order Hierarchy. (See PowerPlan section of this guide.)

(Time frame for renewal is based on calendar day.)
DOCUMENTS FOR REVIEW:

NOTE To Providers:

- All documents/reports (consults, discharge, operative, etc.) will continue to be dictated with the exception of the Daily Progress/SOAP Note and the Immediate Post Procedure Note.
- Dictated/transcribed documents will be sent to Message Center for electronic signature.
- Transcribed documents displaying in message center can be modified by the provider within message center.
- Transcribed documents can be refused. Refused documents should be sent to the appropriate HIM department – Frick HIM, Latrobe HIM or Westmoreland HIM.
- If the provider knows who should have received the report for signature, the provider can forward the report to the correct physician.

Documents for review can be “skipped (next)”, “signed”, or “refused”.

- You will have 4-5 documents to work with.
- Documents can be “skipped” (next), “signed”, or “refused”.
- Show the following examples:
**CDMP Message (Compliant Documentation Management Program):**

Currently known as the **PINK Deficiency SLIPS**.

**PROVIDERS:**

If the provider "agrees" to the question asked, a reply must be sent. In addition, the provider will need to document the answer in their daily progress note and discharge summary.

To open, double-click on the CDMP message from within your inbox. The message will display in the Message section of the Message Center Inbox.
**Reply To Message:**

To reply to the message, click the *Reply* icon. Type your reply, and click *Send*.

---

**Sign Note:**

The final document regarding the deficiency will display in the providers Document section for signature. The provider will sign the document just like any other documents. In addition, the provider needs to update their daily progress note appropriately.
CPOE Future State Workflow: Direct Admit

Provider calls Admitting Office:
LH: 724.537.1855
WH: 724.832.4050
FH: 724.547.1500
Operator will transfer call to Adm.

Provider enters the following:
1. Allergies (Required)
2. Med History (Optional)
3. Dosing Weight/Height (Optional)
4. Admission Powerplan in a PLANNED state.

Log into Powerchart and access the Quick Direct account #

Patient arrives at facility

Admitting will Convert the Quick Direct account to an Observation or Inpatient account.

Nurse accesses Powerchart to complete Admission Care

Nurse will INITIATE Powerplan with communication type of “Protocol Not Requiring Signature”

Provider notified of patient’s arrival to the unit

Provider completes Admitting Diagnosis, Admission Medication Reconciliation and adds orders, documentation, etc. accordingly.

The Initial Inpatient/Observation Order is the physician’s order that indicates if the patient is to be an Inpatient or Observation patient. This order is included in the PowerPlan which fires a task to Clinical Resource Management.

Required for Quick Direct:
1) SSN
2) Birth Date
3) Patient Name
4) Diagnosis
5) Physician
CPOE Future State Workflow: ED to Inpatient

Emergency Room Physician

Disposition of Admit selected/Contacts Admitting Physician

ED Physician or extender reviews patient information/orders with Admitting Physician

ED physician or extender completes physician documentation in EPOWERdoc

MD and RN Documentation available Electronically in Cerner and ePortal

Admitting Physician

ED Nursing completes Intranet Admit Form and patient is Registered as an Observation/Inpatient

Nursing Unit Bed Ready?

Yes

Patient arrives to floor

Admitting Physician evaluates the Patient

Admitting Physician will complete the following:
1. Admitting Diagnosis
2. Admission Orders/PowerPlan
3. Admission Med Rec
4. H&P (dictate or via HERO)

Note: Nursing must complete the Medication Hx prior to Admission Med Rec being completed by the physician

No

Hold Bed Needed

Refer to EH ED Admit to Observation/Inpatient process flow

Yes

Patient arrives to floor

Admitting Physician evaluates the Patient

Admitting Physician will complete the following:
1. Admitting Diagnosis
2. Admission Orders/PowerPlan
3. Admission Med Rec
4. H&P (dictate or via HERO)

Note: Nursing must complete the Medication Hx prior to Admission Med Rec being completed by the physician

Refer to EH ED Admit to Observation/Inpatient process flow
CPOE Future State Workflow: Transfer with Change in Level of Care

**Physician**
- Patient From Lower Level of Care TO
- Patient needs to be transferred to HLOC

**Physician**
- Higher Level of Care
- HLOC provider places order Transfer Patient – Nursing Order.

**Nurse/Registration**
- Patient needs to be transferred to LLOC
- Arranges for transfer and bed

**Physician**
- Patient From Higher Level of Care TO
- Communication between HLOC and LLOC provider about transfer of pt to HLOC

**Physician**
- Lower Level of Care
- Communication between HLOC and LLOC provider about transfer of pt to LLOC

**NOTE:** Physical Therapy requires new orders when patient is going to higher LOC. Physical therapist will discontinue PT orders from lower LOC but physician must enter new PT orders for higher LOC.

**Education:**
- Bed is ready. Patient arrives on unit
- HLOC provider reviews active orders and determines if changes, cancel/discontinues, and new orders are needed (lab, xray, diet, medications, PowerPlans, etc.)

**NOTE:** After the Transfer To order is entered by the physician it will task nursing to make the necessary arrangements with the nursing supervisor. Nursing then enters the Transfer To – Nursing order that prints to Admissions,

**HLOC** = WH – Intensivist
- LH & FH - Attending

**NOTE:** The Provider does not need to complete the actual function of “Transfer Med Rec” via HERO. Medications will be added, discontinued, changed as determined by the HLOC physician.

End
CPOE Future State Workflow: Discharge/Depart Process

**Provider**

1. **Provider decides patient for Discharge**
2. **Access Powerchart & select correct patient**
3. **Select Discharge Summary Tab**
4. **Discharge PowerForm:**
   - Complete Physician Discharge Instructions
5. **Follow Up:**
   - Complete Follow-Up Information
6. **Discharge Order:**
   - Selects Discharge Pt Order
7. **Med Rec & ePrescribe:**
   - Complete Discharge Medication Reconciliation & enter new prescriptions via ePrescribe
8. **Diagnosis:**
   - Confirm patient "Discharge" diagnoses are correct
9. **Review Outstanding Orders/PowerPlans**
10. **Outpt Orders Post Discharge?**
    - **Yes**: Add Order: Outpatient Tests After Discharge
    - **No**: Order Req prints at nursing station – place in clear pocket of Paper Chart
11. **Complete/Dictate Discharge Summary**
12. **End**

**Nurse**

1. **Log into Powerchart, Select Patient and see Discharge Nursing Task**
2. **The discharge order fires a task to nursing letting them know the providers plans for discharge. Review and select Core Measure items if appropriate.**
3. **Performs Nursing Discharge process and documents accordingly**
4. **Patient discharged**

**NOTE:**
- The provider can complete parts of the discharge process ahead of time. However, it is recommended that the Discharge Order not be entered until the provider wants nursing to start the discharge process.

**CAUTION!**
- Once Discharge Med Rec is complete, do NOT add, modify, change, etc. medication orders unless absolutely necessary. This will require that the Discharge Med Rec process be done again!

**REMINDER to Providers:**
- Place printed prescriptions (narcotics) in the clear pocket of Paper Chart

**NOTE:**
- The provider can complete parts of the discharge process ahead of time. However, it is recommended that the Discharge Order not be entered until the provider wants nursing to start the discharge process.

**REMINDER to Providers:**
- Place printed prescriptions (narcotics) in the clear pocket of Paper Chart

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- Place printed prescriptions (narcotics) in the clear pocket of Paper Chart

**CAUTION!**
- Once Discharge Med Rec is complete, do NOT add, modify, change, etc. medication orders unless absolutely necessary. This will require that the Discharge Med Rec process be done again!
### Creating Census/Provider Group Lists:

1. Log into HERO.

2. Click the Patient List button from the Toolbar.

3. Click the List Maintenance button – “wrench” symbol, from the patient list toolbar.

4. The Modify Patient Lists window displays. Click the New button to create a provider group list.

5. The Patient List Type window displays. Click on the patient list type of Provider Group and click the Next button.
6. The Provider Group Patient List window displays.

Search in the right pane for the appropriate group and click the check box next to it.

7. Click the Encounter Types box from the left pane.

8. A list of encounter types will display.
9. Select the following types from the list (you may have to scroll to find these).

<table>
<thead>
<tr>
<th>Latrobe Hospital:</th>
<th>Latrobe Optional:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Rehab</td>
<td>LH MH Inpatient (Adol. MH)</td>
</tr>
<tr>
<td>LH Inpatient</td>
<td>LH Quick Direct</td>
</tr>
<tr>
<td>LH Inpatient Hospice</td>
<td>LH Quick Surgery</td>
</tr>
<tr>
<td>LH Long Term Care</td>
<td>LH Outpatient Surgery</td>
</tr>
<tr>
<td>LH Outpatient Observation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frick Hospital:</th>
<th>Frick Optional:</th>
</tr>
</thead>
<tbody>
<tr>
<td>FH Inpatient</td>
<td>FH Quick Direct</td>
</tr>
<tr>
<td>FH Inpatient Hospice</td>
<td>FH Quick Surgery</td>
</tr>
<tr>
<td>FH Observation Bed</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Westmoreland Hospital:</th>
<th>Westmoreland Optional:</th>
</tr>
</thead>
<tbody>
<tr>
<td>WH Inpatient</td>
<td>WH Inpatient Maternity</td>
</tr>
<tr>
<td>WH Inpatient Hospice</td>
<td>WH MH Inpatient</td>
</tr>
<tr>
<td>WH Observation Bed</td>
<td>WH Newborn</td>
</tr>
<tr>
<td></td>
<td>WH Quick Direct</td>
</tr>
<tr>
<td></td>
<td>WH Quick Surgery</td>
</tr>
</tbody>
</table>

10. Click the Discharged Criteria box from the left pane.

11. Select the 2\textsuperscript{nd} option of “Only display patients that have not been discharged.”

12. Click the Finish button.
<table>
<thead>
<tr>
<th></th>
<th>The Modify Patient Lists window displays. Click on and highlight the Available list. Click the right arrow button.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><img src="image" alt="Diagram" /></td>
</tr>
<tr>
<td></td>
<td>Click on the group name.</td>
</tr>
<tr>
<td></td>
<td><img src="image" alt="Diagram" /></td>
</tr>
<tr>
<td></td>
<td>Click the right arrow.</td>
</tr>
<tr>
<td>13.</td>
<td>The group name will display in the active list pane.</td>
</tr>
<tr>
<td>14.</td>
<td>The group name will display in the active list pane.</td>
</tr>
<tr>
<td>15.</td>
<td>Click the OK button.</td>
</tr>
<tr>
<td>16.</td>
<td>A list of patients will display.</td>
</tr>
</tbody>
</table>

**NOTE:** Initially the docs list will not be complete. Consults are not being entered into HERO so not all patients will display.
PRINTING FACESHEETS FROM POWERCHART:

The physicians will be able to print the face sheet from Power Chart using the print icon from the image control tool bar.

Once it is double-clicked, the Print box appears and the default printer of the device being used is available for printing.