

# Health PEI



## **Training Manual**

## **PowerNote ED**

## **Participant Guide**

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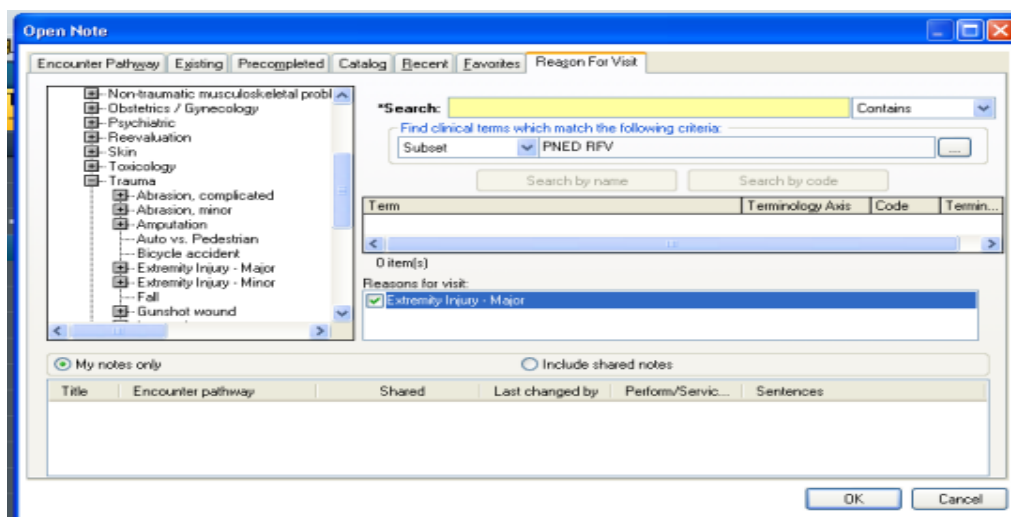
## Introduction

PowerNote is a template-based documentation system based on a patient's presenting problems, age, and gender.

## PowerNote ED: Creating a New Note

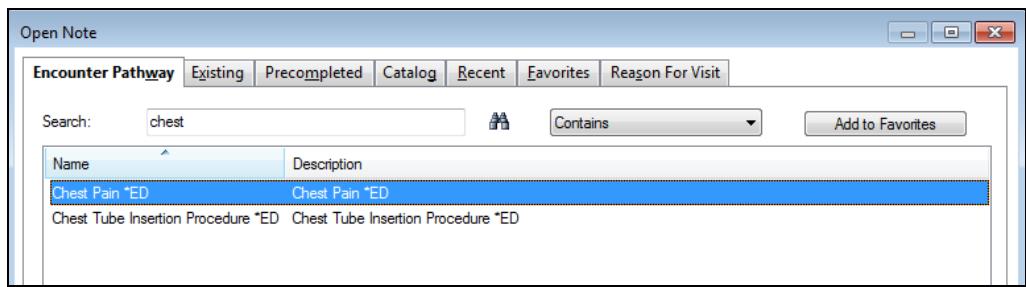
To open a PowerNote ED note for a patient, complete the following steps:

1. From within a patient's chart, click PowerNote ED from the menu (the Open Note dialog box will appear). The default tab is set to the Reason for Visit tab. (If there is a previously selected saved or signed note, the tab will open to that note).
2. The physician can be prompted with a specific encounter pathway, or PowerNote, based on the reason for visit the nurse selects at Triage. If a Reason for Visit already exists and you agree, then skip to step 5.
3. From the Reason for Visit Tab, click the appropriate plus symbol to expand the category. Choose the most appropriate Reason for Visit. Make sure the 'Find Clinical Terms which match the following Criteria' search box reads: SUBSET and PNED/RFV.
4. Double-click on the appropriate term to select the Reason for Visit.
5. Click OK to open the encounter pathway, or PowerNote, in the PowerNote ED tab.



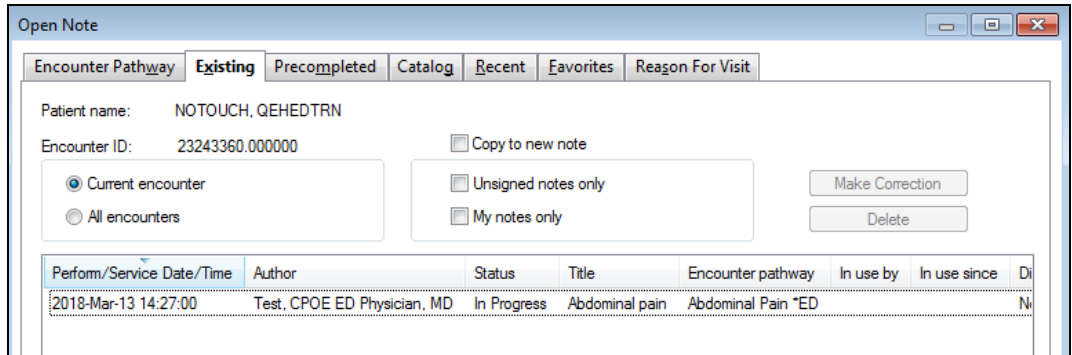
## The Open Note dialog box

1. Encounter Pathway
  - This tab allows the end-user to search for a PowerNote. The information entered in the Name field must be exactly as the encounter pathway is built. It is recommended to use the Reason for Visit tab to conduct all searches.



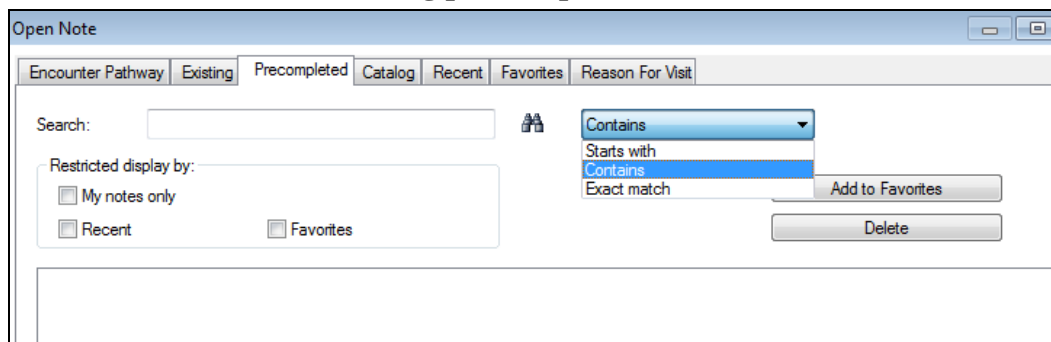
## 2. Existing tab

- Notes found on this tab have been previously created.
- They are in a saved or signed status.
- Options exist for viewing notes from the current encounter or all encounters. There are even options for viewing only your notes.
- You also have the ability to see only unsigned notes.
- From this tab, you can finish notes (sign them) that are in a saved status or delete notes.



## 3. Pre-completed tab

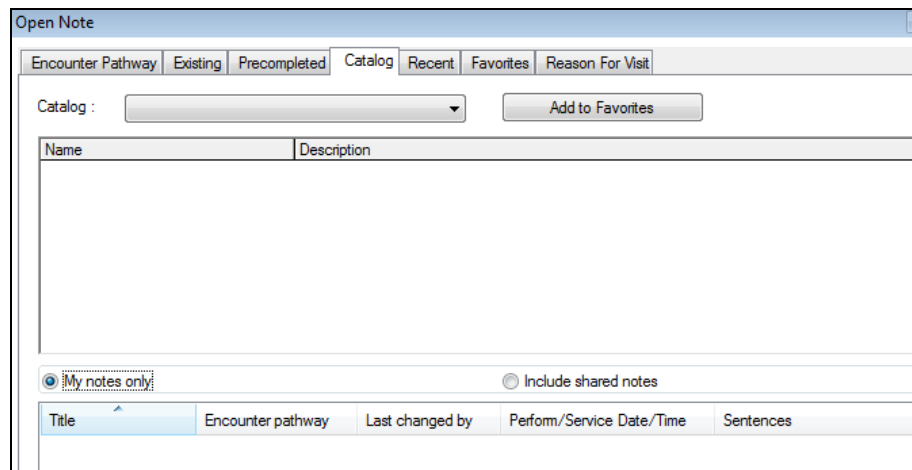
- If you create your patient notes using a consistent style or format, you can save a note as a pre-completed note and use this note format from one patient to the next.
- **Remember to change/edit the date, time, and other patient-specific information when using pre-completed notes.**



#### 4. Catalog tab

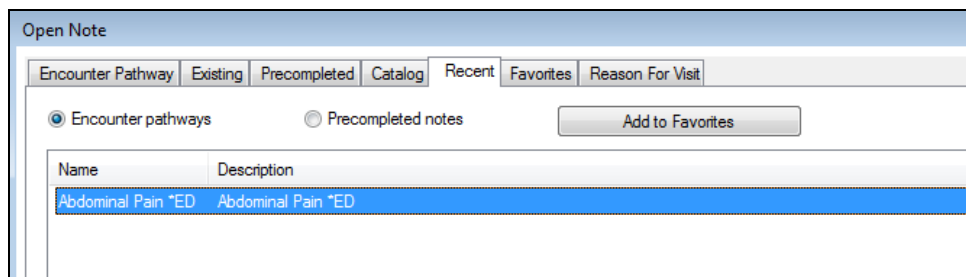
- New notes can be added from the Catalog tab.
- Notes found on the Catalog tab are referred to as care designs or encounter pathways.
- Emergency Medicine encounter pathways are found in the ED Pathways catalog.

**Note: The only time you would need to go to the catalog tab is under RFV to place complaints in your favorites list, to find the Addendums (used when taking patient care over from a previous shift), and to find the Supervisory note –PA/NP (used if ED physician needs to add a supervisory addendum for mid level providers)**



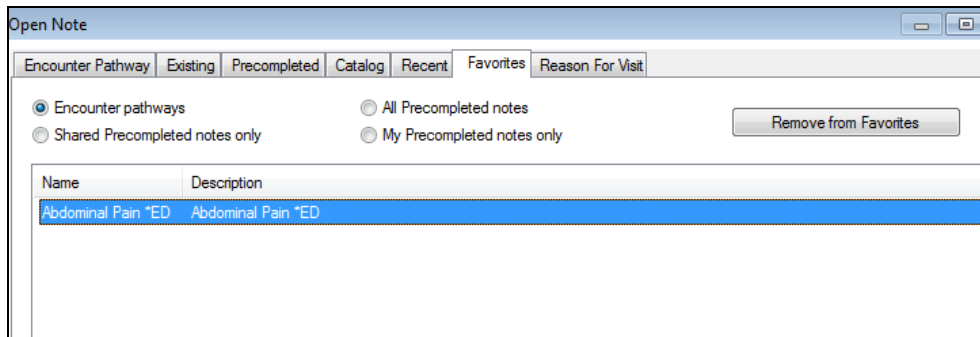
#### 5. Recent tab

- This tab displays the most recent notes that you have accessed, either via the care design or from the pre-completed notes list.
- The most recent note you have used will be listed at the top.



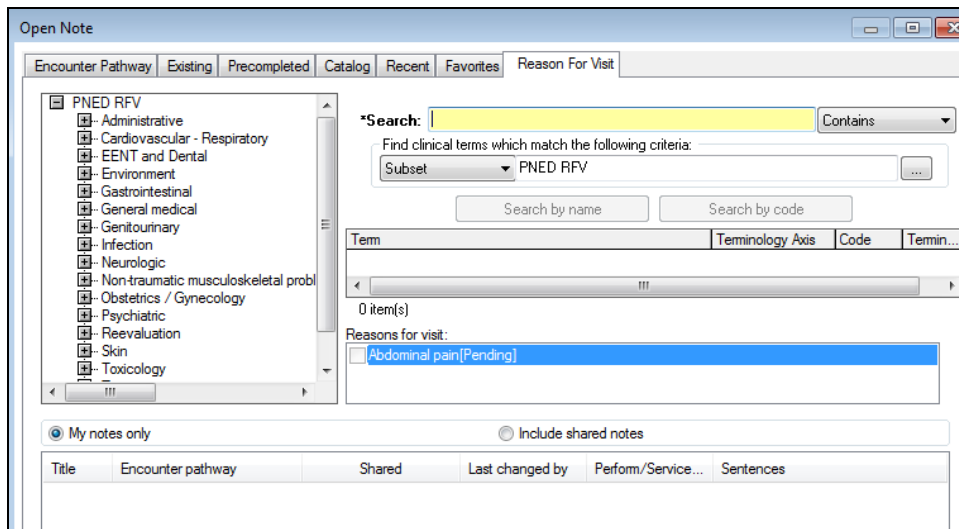
## 6. Favorites tab

- When you add a care design or pre-completed note to 'Favorites', it is saved on this tab.



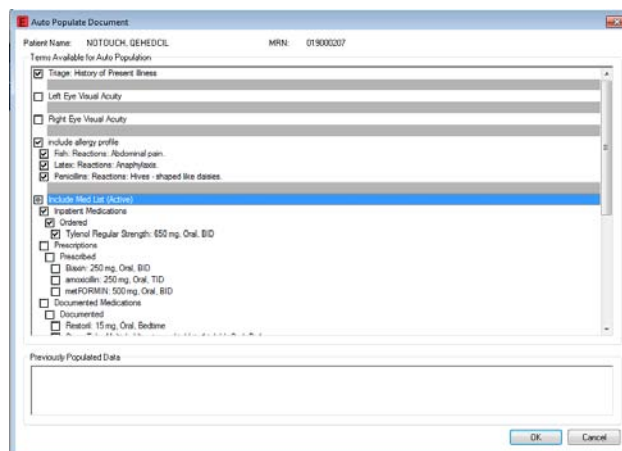
## 7. Reason for Visit tab

- This tab allows you to add a new note. This tab also lets the user search for the pathway by entering the Reason for Visit.
- A selected triage RFV may populate to the open note window under RFV. If the physician agrees with this RFV, they can highlight it and click OK.
- Physician can select provided RFV from the navigation bar.
- If using the search window, they must use clinical terms of subset and PNED RFV.
- They must use terminology related to patient's symptoms and NOT a diagnosis.
- PNED will open to the appropriate note template.



## Auto-Population of the Note

- Once you select a Reason for Visit, the Open Note window will close and the auto-population window will appear.
- Auto-population of the Note allows the physician to pull nursing documentation and results into the PowerNote.
- The following information items are preset to pull forward:
  - a) History of Present Illness from the triage note
  - b) Left and Right Visual Eye Acuity
  - c) Allergy information
  - d) Active Med List
  - e) Documented Medications
  - f) Immunizations
  - g) Problem List
  - h) Vital Signs
  - i) Height and Weight
  - j) Oxygen saturation
  - k) POC Blood Glucose
  - l) Bladder Scan Volume
- The auto-population window is shown below.
- Anything that is checked will automatically pull into the note.
- The physician can exclude a result by un-checking the checkbox adjacent to that result.
- **NOTE: Prescriptions and documented medications should be unchecked unless you are certain the BPMH has been completed for this encounter. This is identified by a Rx on the tracking shell.**

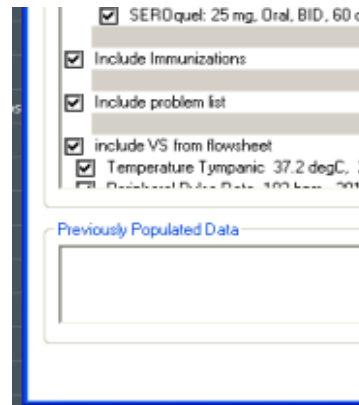
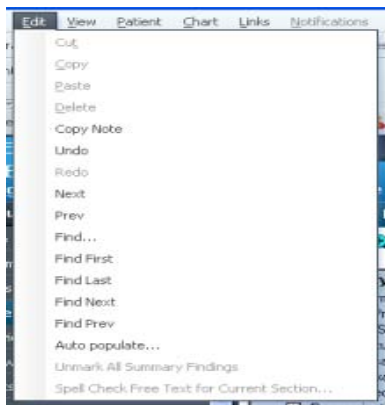


The results will appear within the PowerNote once the OK button is clicked

- Health Status	
<b>Allergies &gt;&gt;</b>	<a href="#">(include allergy profile)</a> <a href="#">Allergic Reactions (Selected)</a> <i>Severity Not Documented</i> Fish- Abdominal pain. Latex- Anaphylaxis. Penicillins- Hives - shaped like daisies. / NKA / Unknown / Other
<b>Medications</b>	<a href="#">(include Med List)</a> <a href="#">Inpatient Medications</a> <i>Ordered</i> Tylenol Regular Strength: 650 mg, Oral, BID / None / Per nurse's notes / Unknown / Other
<b>Immunizations &gt;&gt;</b>	UTD / <a href="#">Include Immunizations</a> / Tetanus UTD / Unknown / Per nurse's notes / Other

Auto-populated content

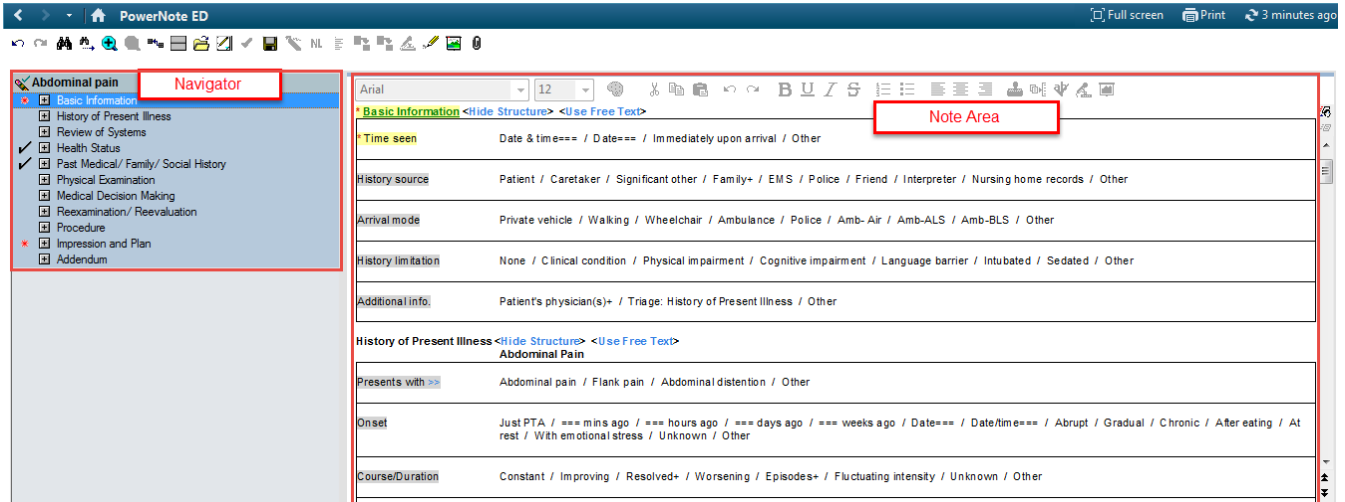
The physician can select the auto-population option that appears under the Edit menu to see if any new data has been documented since the note was last opened or saved. At this time, the physician can select any additional results that they want to auto-populate from the top section of the window.





# PowerNote ED

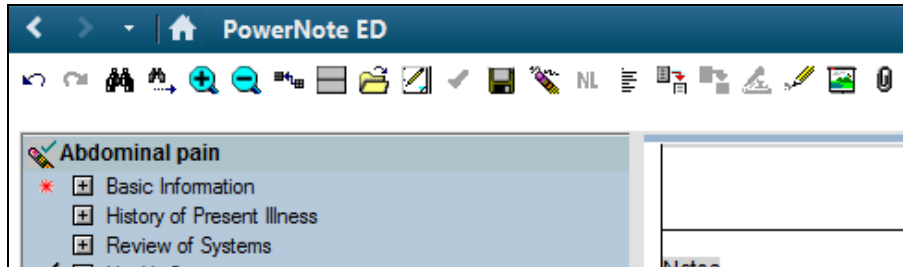
Refer to the following graphics for an overview of PowerNote ED.














The page is divided into two areas: The navigator and the note area.

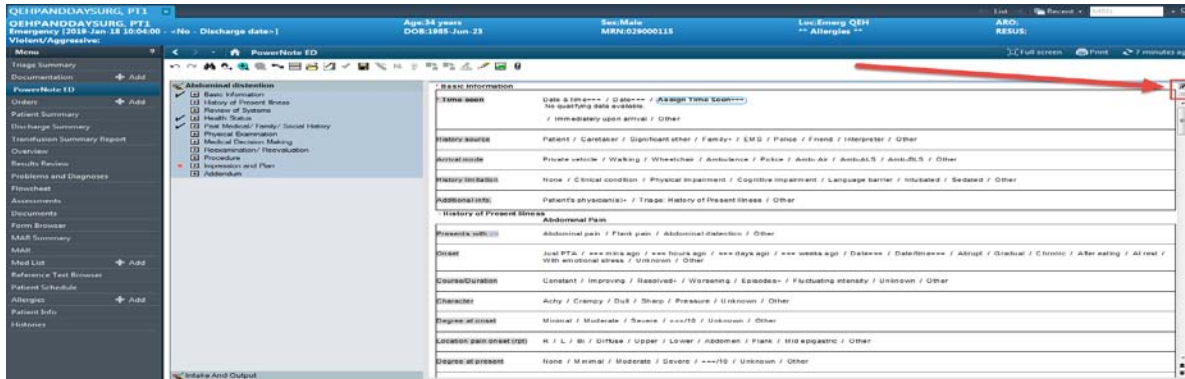
1. The Navigator bar shows all open notes (if multiple PowerNotes are open).
  - It is used to quickly jump to a section of the note.
  - Click on a category from the navigator to display the category at the top of the note field.
  - An asterisk indicates mandatory fields within the category.
  - A check mark indicates documentation within the category.
2. The note area is where the actual documentation is completed.

## PowerNote Icons



Symbol / Icon	Description
	<b>Undo / Redo</b>
	<b>Find</b> – Gives the ability to search for a particular word / header within the document ie. Orders.
	<b>Zoom In or Out</b>
	<b>Collapse Navigator</b>
	<b>Open</b> - This opens the Open Note Window.
	<b>Sign/ Submit</b>
	<b>Save</b>
	<b>Erase last Entry (Clear)</b>
	<b>Use Free Text</b>
	<b>Insert Image</b>
	<b>Contributor View</b> - allows you to see how the PowerNote will look once it is signed. The note appears in a textual format that reads like a story. Any terms that were not circled will not appear within the signed note. (located at the top of the scroll bar to the right of the note area)

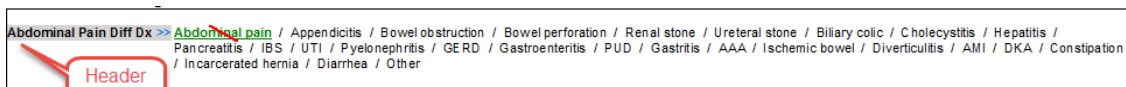
## Contributor View Icon



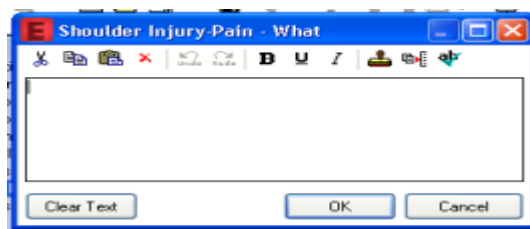
## Document on a Note

1. Single left click to select a term  
Shoulder pain
2. Double Click to chart a pertinent negative  
~~Swelling~~
3. The third click will clear the selection
4. Right-clicking on a term will give you several options, including: adding a comment, clearing the selection and negating a term

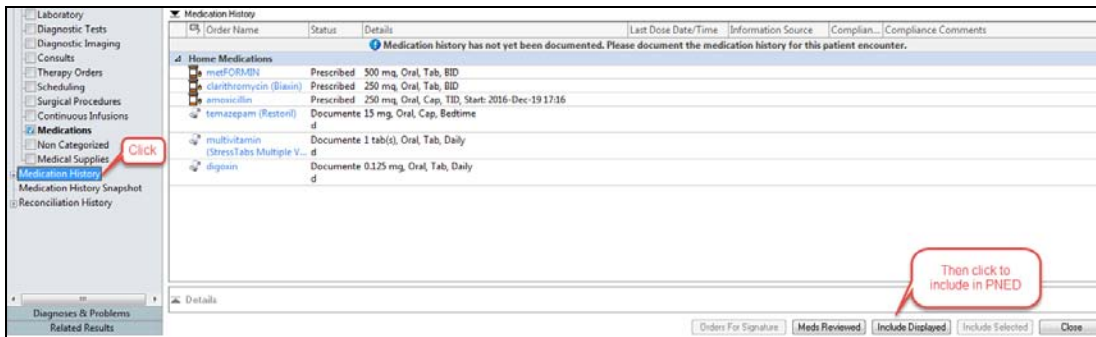
**NOTE: To remove documentation in a sentence, right-click on the header to clear the entire sentence. This way a header will not show up in the text summary.**



5. Click the term "Other" to open a text box.



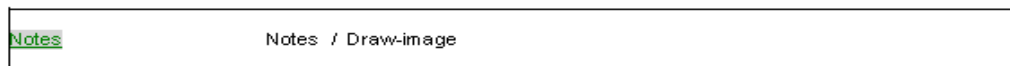
6. Right click on the any term to add comments at any point in the document.  
Direct blow (Collided into another player.)
7. The patient's home meds can be included after the note has been opened by:
  - a. Find the 'Medications' term in the Health Status section
  - b. Click on 'Include Med List'.
  - c. Click on 'Medication History' in the window that opened. This will display the home medications.
  - d. Click 'Include Displayed' button.



8. Drawing / Image. (Current functionality not working as of March 2018 – awaiting fix from Cerner)

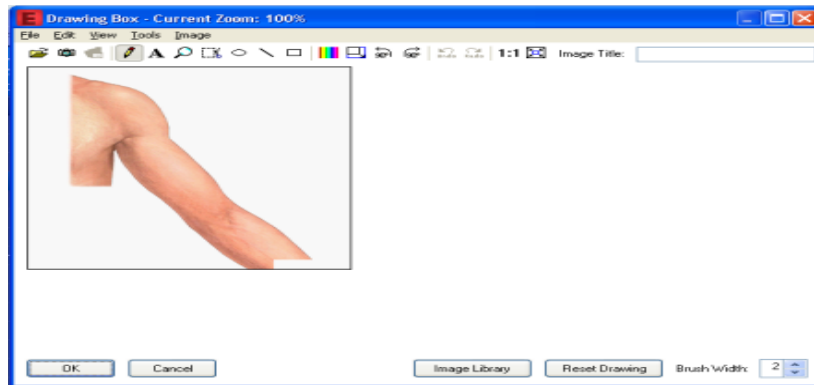
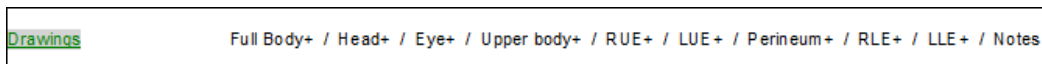
1. Under **Medical Decision Making**, navigate to the term ‘Notes’

a. Double click Draw Image (a separate window will launch)



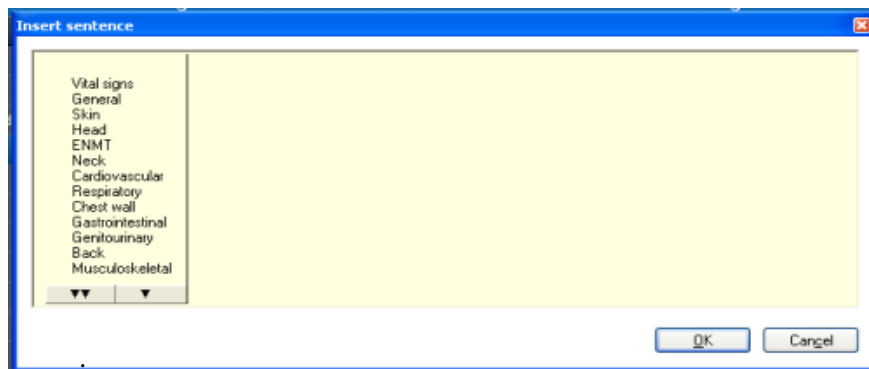
2. Under **Physical Examination**, navigate to the term ‘Drawings’

a. Double click the image you would like to draw on.



9. To Add a Missing Header

a. Right-click on a paragraph category and choose ‘Insert Sentence’. The following Insert Sentence window opens. Different options will be available depending on where you are inserting the sentence:



- b. Use the up and down bars to navigate through the sentences.
- c. To select a sentence, click on it and a check mark will appear to the left of the sentence. More than one selection can be made.
- d. When done, click on the 'OK' button. This will close the window and add the selected sentences to the paragraph.

Example:

The paragraph below is from an abdominal pain note. The ankle, left sentence was added to document details about an ankle deformity.

**Physical Examination M**

General appearance	WNL / Mild distress / Mod distress / Severe distress / Unresponsive / Other...
<b>Ankle, left &lt;&lt;</b>	WNL / Swelling / Deformity / Bruises / Bleeding / Foreign body / Decreased sensation / Achilles tendon injury / Puncture wound / Other... Abrasion ==: length==cm / width==cm / Other... Tenderness: mild / moderate / severe / Other... Ligament laxity: medial / lateral Laceration ==: length==cm / depth==mm / Other...
Skin >>	WNL / Warm / Dry / No pallor / No rash / Other...
ENT >>	WNL / TM's clear / Oral mucosa moist / No pharyngeal erythema or exudate / Other...
CV-heart >>	WNL / Regular rate and rhythm / No extra heart sounds / No murmurs / Other...

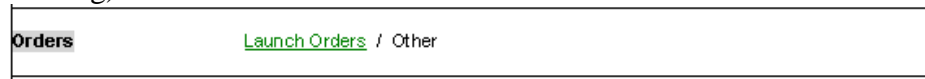
**10. How to Include Lab Results:**

- a. Under 'Medical Decision Making', click on the term 'Lab Results'; a flowsheet will appear.
- b. Highlight the results that you would like to include in the note
- c. Click the 'Include Selected' button. It is not recommended that you pull in all results.

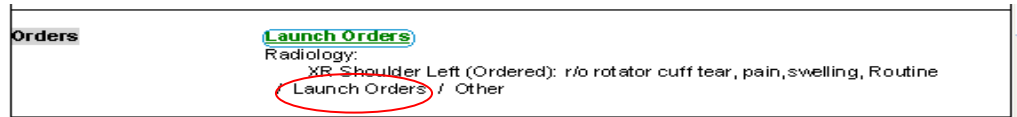
Note: If you click the column header for a specific set of a results the system will automatically select the entire column and will populate the results in that column when the 'Include Selected' button is clicked.

11. Launch Orders:

- a) To launch the Add Order window from within the PowerNote, select the Launch orders term (under the Medical Decision Making)



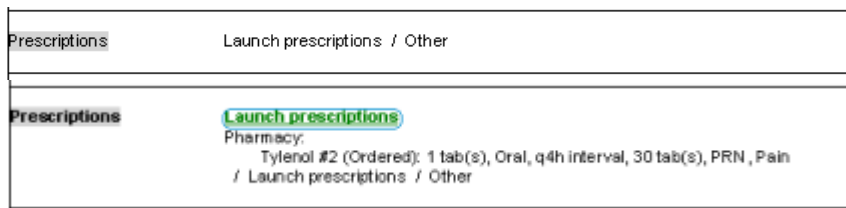
- b) The orders that are placed will appear within the note. If additional orders need to be placed, **be sure to use the second Launch Orders** that appears below the new orders.



- c) Any orders that are placed outside of PowerNote ED will not appear within the PowerNote documentation. Any orders modified and/or canceled outside of the note, must be removed manually.

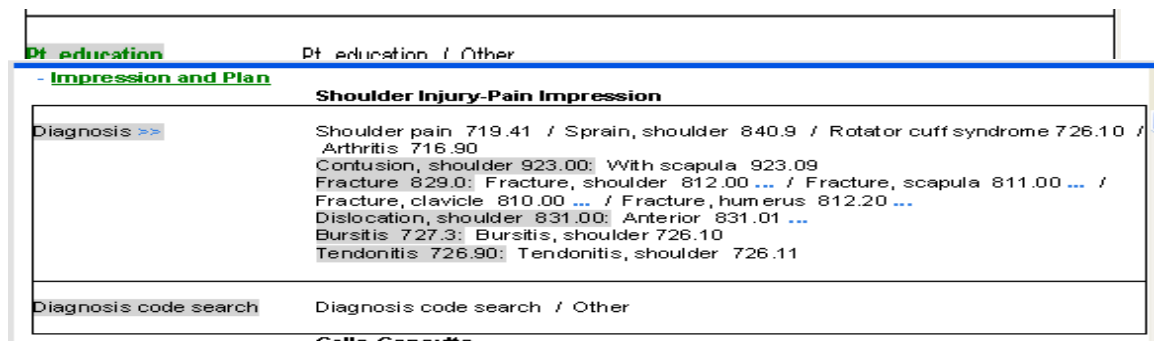
12. Prescriptions:

- a. Electronic prescriptions can be written through the Impressions and Plan section by clicking on the term 'Launch prescriptions'.

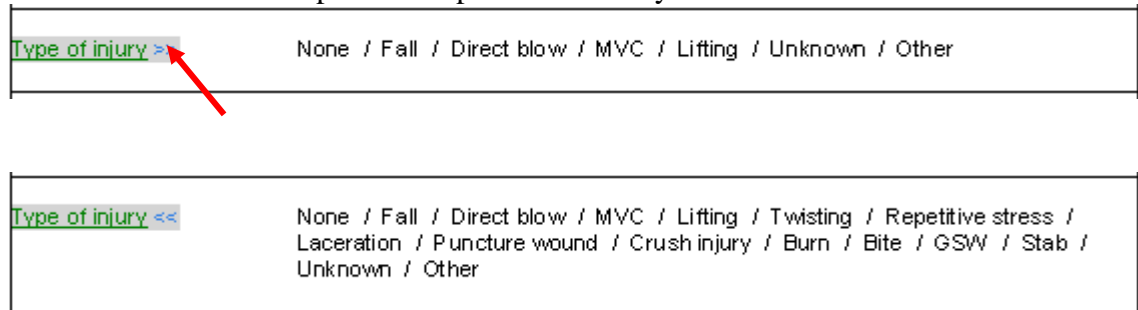


- b. Prescriptions will print upon signature

- 13. The Diagnosis Control can be launched from the 'Impression and Plan' paragraph. The diagnosis can be selected from a list of common diagnoses or you can search for a Diagnosis(s) by clicking the Diagnosis code search term.

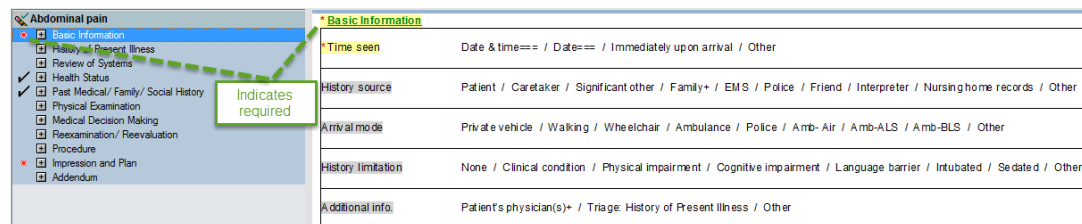


14. You have the option of condensing the length of the PowerNotes by utilizing Expand/Collapse functionality. Each PowerNote has been designed to automatically hide the terms that are least likely to be documented for the selected reason for visit. The Expand/Collapse functionality is shown below:



The blue arrows (chevrons) next to the sentence signify that the sentence is collapsed. Once you expand a sentence within a note it will always appear expanded for that selected reason for visit.

15. Paragraphs can be made to require a hard stop or a soft stop. A soft stop means the physician can sign the note without documenting within the required paragraph. They will have to enter an override reason when they sign the note. A hard stop means the note cannot be signed until the required items are addressed. The required paragraphs have a red asterisk within the navigator and highlighted yellow in the note section as shown below:

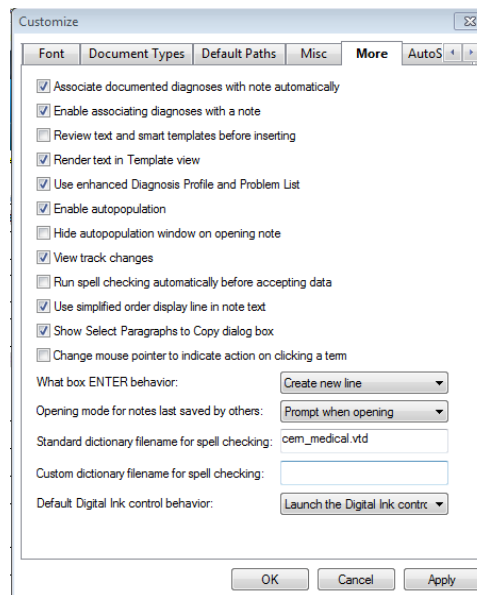


16. There are menu options available within PowerNote ED that allows you to adjust the preferences at a user level. Select the Customize option from the **View** menu. The following options are available.

- Colour tab – allows the physician to set the font and background colour of the note. A light yellow or off white is recommended.
- Font tab – allows the physician to adjust the style of font for each section of the note. The padding font is used to decrease the space between sentences and sections. It is recommended to set this to Arial, 2.8 in order to decrease scrolling.
- Document Types tab – sets the document type used when you save or sign the note. **This is typically set to ED Note – Physician, but may be different for your facility.**
- Misc – additional settings regarding PowerNote ED functionality. A checkbox exists in this tab that allows you to default the encounter

pathway based on the selected reason for visit. You can also turn on/off the expand/collapse function from this tab.

- e. More – additional settings regarding PowerNote ED functionality. (Ex: ability to turn off/on auto-population of the note).
- f. Default Paths – this is the path to the bitmaps. **Do no change the information in this tab. If you do, you will not be able to see the drawings within the PowerNotes.**
- g. AutoScroll – allows you to configure the note so that it automatically scrolls when you get towards the bottom of the note. If you wish to use the auto-scroll function, then check all of the available check boxes, set the Start/Stop distance to 1, and set the Initial Speed to the highest setting.



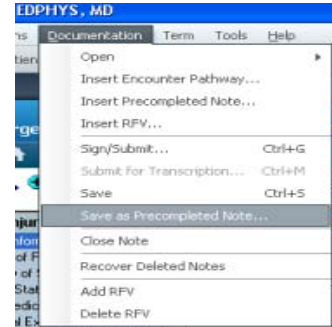


## Pre-completed Notes

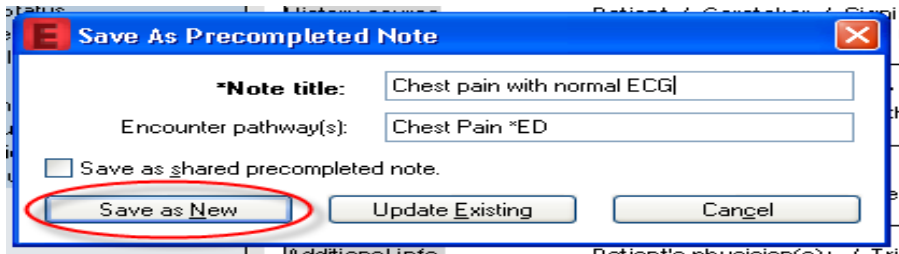
Pre-completed notes can be created at the Note level. These are useful for those common complaints where you often find yourself documenting the same thing each time (ex: ankle sprain, back pain, headache, ear ache, etc).

### *Create and Save a Pre-completed Note*

1. Complete the note, as you would like it to be saved. Remember that patient-specific information, such as free text notes relating to gender, times, dates, weights, and other information will be saved as well.
2. Click on Documentation > Save as Pre-completed Note.



3. Give your note a title. (i.e. Chest Pain w/ normal ECG)



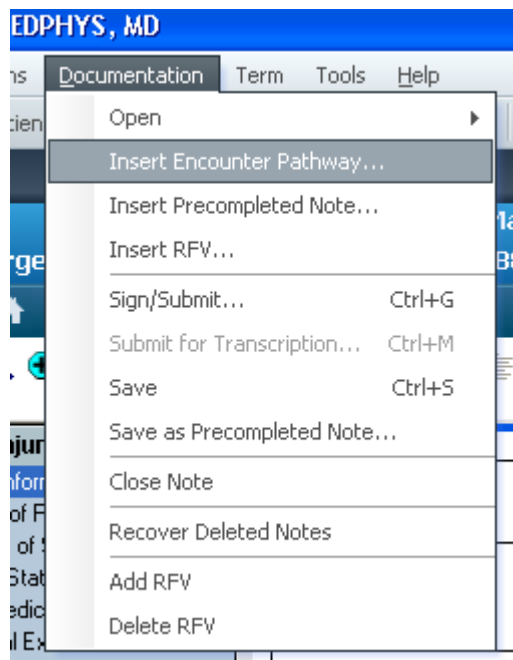
4. Click **Save as New** to save the pre-completed note.

## Inserting a Note within a Note

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Inserting a note within a note is useful for patients that present with multiple complaints.

**Note:** It is recommended that you only insert additional complaints if the nature of the two complaints is completely different. Otherwise, it is advisable to handle the second complaint by making additional comments in either the 'other' or 'Scribble Note' field which exists in HPI and all other sections of the note.




1. With an active note open, from the menu bar, select Documentation >Insert Encounter Pathway
2. Select a note from the catalog.
3. Click OK, the second note will be added within the first notes.
4. Repeat steps 1-4 if you wish to insert additional notes.

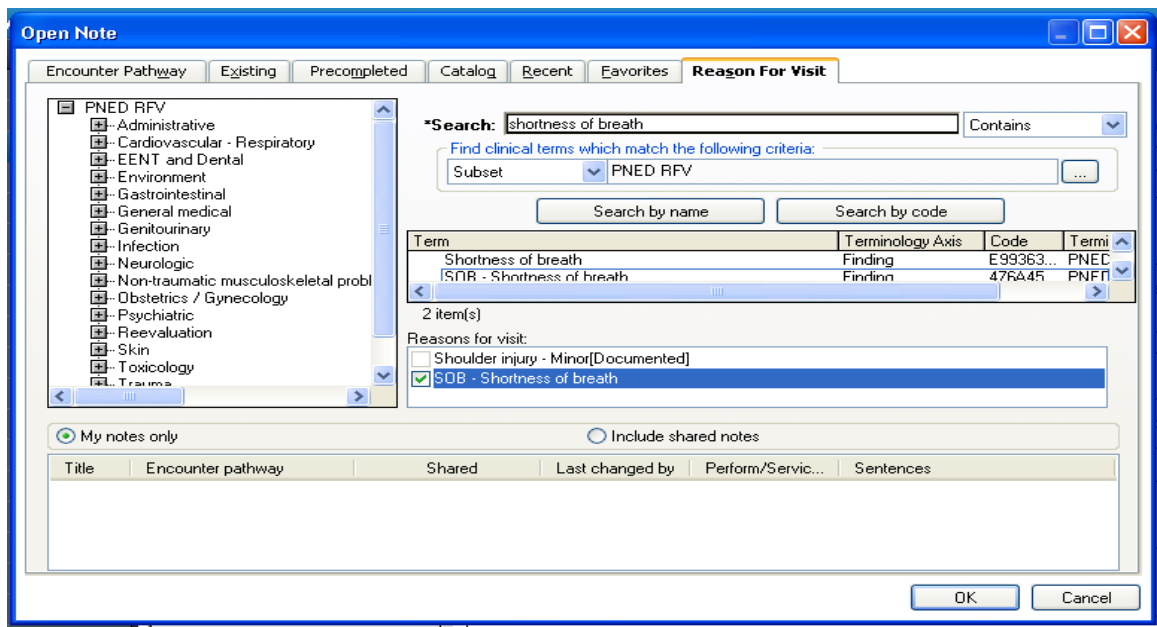
**Note:** You may only insert a note within an existing note if the original note is newly created or in a saved status. You may not insert a note into a signed note. Create a new note on the same patient in this case.

## Adding Multiple Notes

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**Note:** It is recommended that you add multiple complaints if these complaints differ significantly and cannot be handled by adding a few words or a sentence or two to the main complaint.

1. Add the first note (follow the steps on page three, 'Creating a New Note')
2. With the first note open, click the Open Note icon  on the tool bar
3. Select a note from the catalog
4. Click **OK**; the second note will be added with the name of the second note displayed in the navigator bar
5. Repeat steps 1-4 if you wish to add additional notes



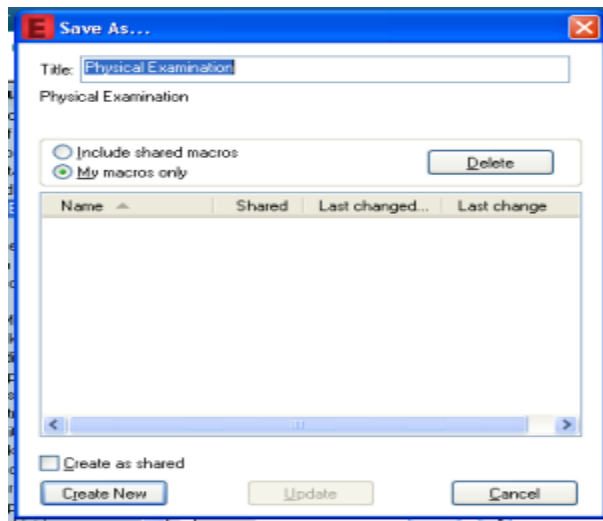
**Note: The process above creates multiple notes. To insert the second note in the original note, see above.**

## Using Macro's [M](#)

### *Creating and Saving a Macro*

When certain terms, sentences and/or paragraphs of a note are completed routinely in the same manner, a macro can be used that will automatically document these terms in the note.

1. Complete the section of a note as you would normally do; **each term that is selected will be saved in the macro.**
2. For example, within the section *Physical Examination*, select the appropriate choices to reflect your pattern of documentation for a typical chest pain patient.
3. Now, right-click on the term *Physical Examination* and select 'Save Macro As...'  
The following window appears:



4. Specify a name for your macro in the title field.
5. Select the 'Create as shared' check box if you want other users to be able to see and utilize this macro. Not recommended without team consultation.
6. Click 'Create New' to save the Macro

**An 'M' will appear next to the Paragraph, or sentence, indicating that a Macro exists. You can click on the 'M' to apply the macro that was created.**

### *Inserting a Macro*

Macros can be created at the **paragraph, sentence, or terms** level; they are not note (problem) specific. If a macro that was completed at the paragraph level is inserted in a different note than the one used to create it, only the sentences that the two notes have in common will be updated by the macro.

To insert a Macro:

1. Click on the **M** next to the paragraph, sentence, or term.
2. Select the macro from the dialog box that appears to the right.
3. Click **More** to see all macros associated with the paragraph or sentence.
4. Click the macro name which will insert the macro (circles term).
  - a. Macros can be saved on 'other' and 'notes' terms which are free-style typing terms.
  - b. Macros can be deleted by going to the 'Save Macro As' option →select the desired Macro →choose delete from upper right corner of Macro window.
  - c. Macros can be updated by altering the term selection as desired: 'Save Macros As' →selecting appropriate macro from the list →click on 'Update at bottom center of macro window'.

**Tip: When you catch yourself saying: 'That is just too many keystrokes for something I document frequently', consider using a macro or a pre-completed note.**

## Modifying a Macro

You can make modifications to a macro that you already created by doing the following:

1. Click on the M and select the macro you are inserting into the note.
2. Make changes to the paragraph, sentence, or term as needed.
3. Right-click on the paragraph, sentence, or terms for which you are creating this macro and select the 'Save Macro As' option.
4. The 'Save As' window will appear. Press the 'Update' button in order to save the changes that you made to the macro.
5. You can also update your macro as shared by selecting the 'Save As Shared' checkbox before pressing the 'Update' button.

## Specific Macros

**It is recommended that each physician create Macros that represent his/her own pattern of providing clinical care and documentation methodology.**

We do not recommend creating shared macros for the following reason:

1. There is concern someone may use a shared macro without knowing what terms are selected and may end up documenting something unwanted.
2. Unless the user takes the time to personalize a shared macro, it will not reflect his/her own pattern.

**Note: Example of macros shown here are from a Chest Pain Note.**

### Basic Information

Date, Time, and Vital Signs will differ for each patient and should not be included in the macro.

You only have to save one macro for basic information as this section is fairly consistent throughout all the templates (except it will add LMP for female and orthostatic vitals where

Basic Information M <Hide Structure> <Use Free Text>	
Time seen	Date & time=== / Date=== / Immediately upon arrival / Other
History source	Patient / Caretaker / Significant other / Family+ / EMS / Police / Friend / Interpreter / Nursing home records / Other
Arrival mode	Private vehicle / Walking / Wheelchair / Ambulance / Police / Amb- Air / Amb-ALS / Amb-BLS / Other
History limitation	None / Clinical condition / Physical impairment / Cognitive impairment / Language barrier / Intubated / Sedated / Other
Additional info.	Patient's physician(s)+ / Triage: History of Present Illness / Other

History of Present Illness <Hide Structure> <Use Free Text>  
Chest pain

appropriate).

## Review of Systems

**Note: This paragraph accounts for a total of 14 areas of symptoms and systems.**

The screenshot displays a medical software interface for a 'Review of Systems' form. On the left, a sidebar lists various systems with checkboxes: Basic Information, History of Present Illness, Review of Systems (checked), Constitutional, Skin, Eye, ENMT, Respiratory, Cardiovascular, Gastrointestinal, Genitourinary, Musculoskeletal, Neurologic, Psychiatric, Endocrine, Heme/Lymph, Allergy/Immunologic, and Additional ROS info. The main area shows a structured list of systems with their respective symptoms and findings. The 'Additional ROS info' section is circled in red, containing the text 'All systems otherwise negative / ROS reviewed as documented in chart'.

System	Findings
Constitutional	Neg except HPI / <del>Fever</del> / <del>Chills</del> / Sweats / Weakness / Fatigue / Decreased activity / Other
Skin	<del>Neg except HPI</del> / Jaundice / Rash / Pruritus / Abrasions / Breakdown / Burns / Dryness / Petechiae / Lesion / Other
Eye	<del>Neg except HPI</del> / Recent vision problems / Pain / Discharge / Icterus / Diplopia / Blurred vision / Blindness / Other
ENMT	<del>Neg except HPI</del> / Ear pain / Sore throat / Nasal congestion / Sinus pain / Other
Respiratory	<del>Neg except HPI</del> / SOB / Orthopnea / Cough / Hemoptysis / Sputum production+ / Stridor / Wheezing / Other
Cardiovascular	<del>Neg except HPI</del> / Chest pain / Palpitations / Tachy / Syncope / Diaphoresis / Peripheral edema / Other
Gastrointestinal	Neg except HPI / Abdominal pain / <del>Nausea</del> / <del>Vomiting</del> / Diarrhea / Other
Heme/Lymph	<del>Neg except HPI</del> / Bleeding tendency / Bruising tendency / Petechiae / Gum bleeding / Swollen nodes / Other
Allergy/Immunologic	<del>Neg except HPI</del> / Seasonal allergies / Food allergies / Recurrent infections / Impaired immunity / Other
Additional ROS info	<b>All systems otherwise negative / ROS reviewed as documented in chart</b> Unable to obtain due to+ / Other

- The practice of documentation in this section varies by physicians. Some physicians solely rely on ROS sheets and want to just reflect that they have reviewed this information. This can be accomplished by clicking on the 'ROS reviewed as documented in chart' option toward the end of the section, and leaving everything else blank.
- For those that want to mention a few pertinent positives and negatives, you can do so by clicking on the 'All other systems otherwise negative' option.
- For those who want to document the Associated Symptoms and ROS individually, it makes sense to save macros for your top complaints. The macro can then be inserted and selected terms modified to reflect patient specific findings.
- Associated Symptoms and ROS questions are template specific. These macros should be labeled to reflect the name of the template.
- You can also create your own phrase; for example: 'I have reviewed ROS sheet as documented by.....' This should be done under 'Notes' or 'Other' term and can be saved as a Macro.

## Past Medical/Family/Social/Surgical History (PMFSH)

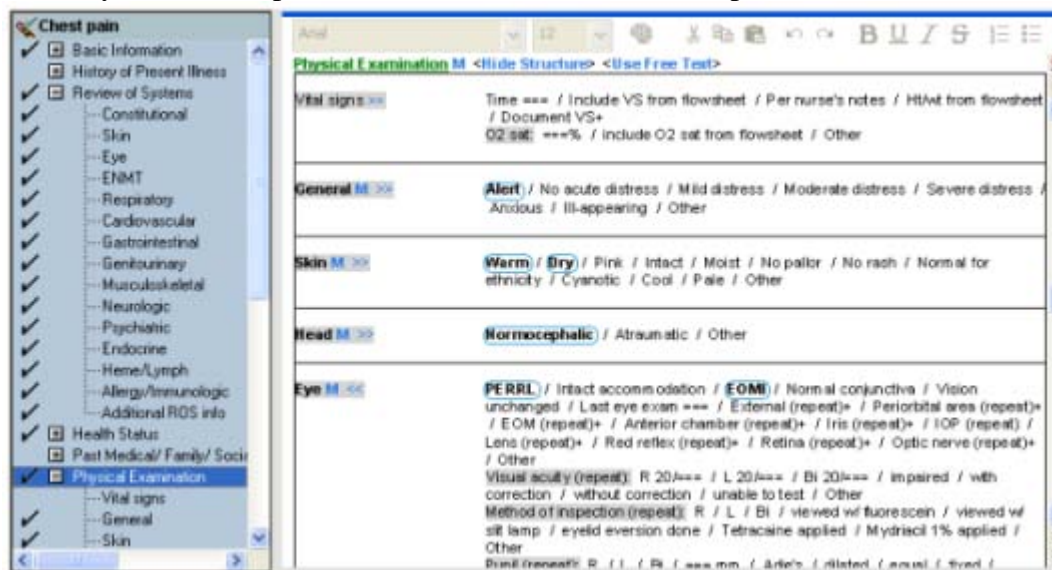
Again, the practice may vary by user. You can either document the individual components or review on the ROS sheet and use 'Reviewed in chart'.

1. A Macro can be created that will circle the following choices at once.



## Physical Examination

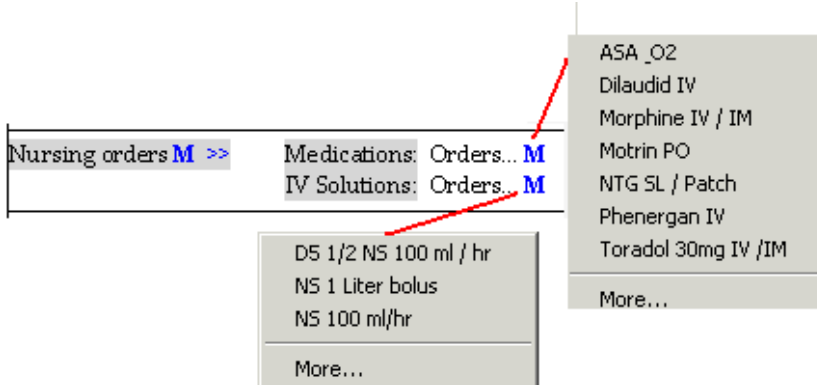
- This is where the greatest time can be saved. It is highly recommended that you create macros for the top 10 complaints. Please be sure to reflect your own pattern of how you examine patients with different kinds of complaints.



## Medical Decision Making

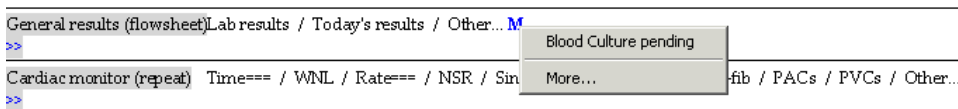
### Orders:

It is important to reflect key orders in physician documentation. This can be done by utilizing macros in Medications and IV Solution orders (if Medications and IVs are in scope).



### Pending Results:

Occasionally, you may want to note that you have pending results which will be followed up by an outpatient physician.



### Procedures:

Procedures Macros: For procedures you are likely to do repeatedly, you should save these as macros. Remember, you can insert any procedure in any template by right-clicking on the 'Procedure' heading and selecting the appropriate procedure.

Here is an example of an ankle sprain procedure note saved as a macro. Details that are likely to change from patient to patient are left out.

**- Procedure M**      **Ankle injury treatment M**

<b>Description &gt;&gt;</b>	Other... Injury type: fracture / dislocation / open fracture / Other... Location: R / L / Bi / Other...
<b>Confirmed correct &gt;&gt;</b>	(Patient) / (Procedure) / (Side) / Other...
<b>Procedure &gt;&gt;</b>	(Informed consent) (obtained) / waived / Other... Anesthesia: Other... Technique: Other... Ankle manipulation: accomplished / not accomplished / Other... Post procedure x-rays show: good alignment / reduction / Other...
<b>Splint/strap &gt;&gt;</b>	(Plaster) / Fiberglass / Long leg cast / Short leg cast / Jones dressing / Other... Location: R / L / Bi / Other... (Immobilization performed by) EP / PA / (nurse) / cast tech / (supervised by EP) (Post procedure assessment) (normal) / normal except / (circulation) / (motor) / (sensation) / pain (Crutches) (provided) / not provided / Other...
<b>Notes &gt;&gt;</b>	Notes...



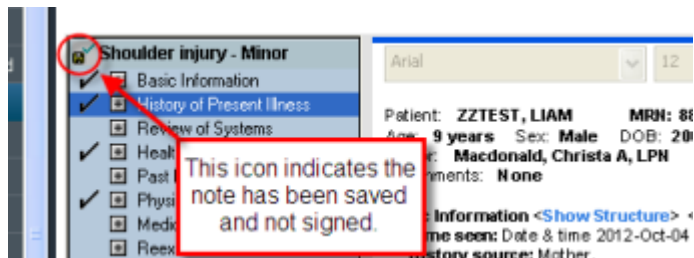
# Save, Sign, and Print a Note

## Save a Note



The Save Note option allows you to save the note **so that you may come back at a later time and complete the note (sign)**. If you do not save your note before exiting PowerNote Ed, you will be prompted to save changes on exit.

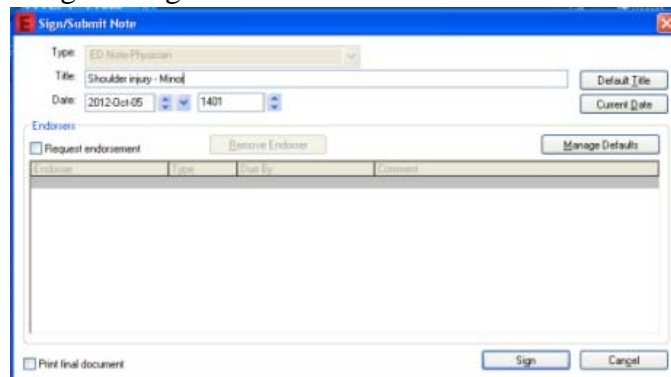
1. Click the Save button on the toolbar or select 'Documentation>Save'.
2. When you return to the patient's chart at a later time, the saved document will automatically display.
3. Saved notes will automatically go to your Inbox.

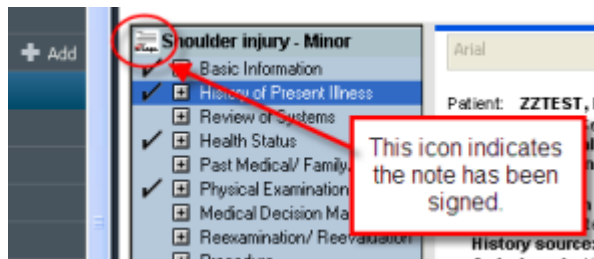


## Sign a Note



1. When you finish creating the note, click on the Sign button on the toolbar or select Documentation >Sign from the menu bar.
2. Select an appropriate document type from the Document Type drop-down box (ED Note – Physician will be set as the default going forward).
3. The default document is the name of the encounter pathway. Change the document title if so desired.
4. Click 'Sign' to sign the note.

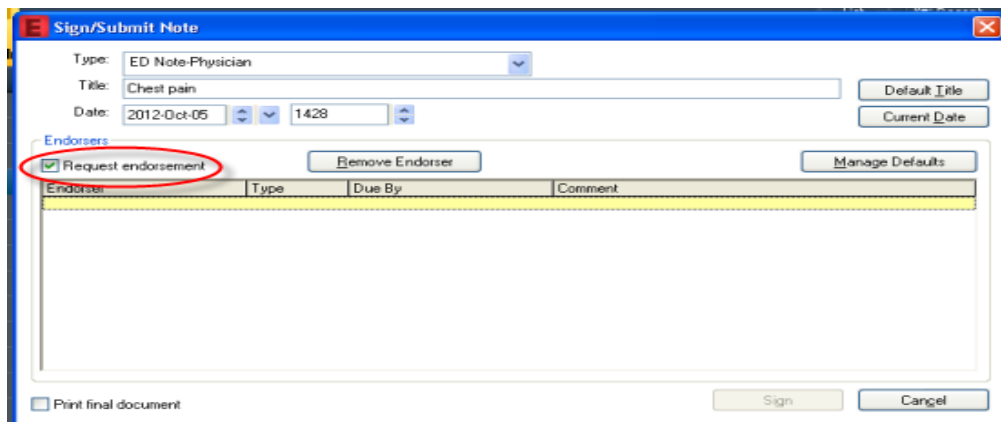




Once a note has been signed, it cannot be modified from the PowerNote ED tab. Your option is either to add a new note within the PowerNote ED tab or add an addendum from the Documents tab.

### *Request Endorsement*

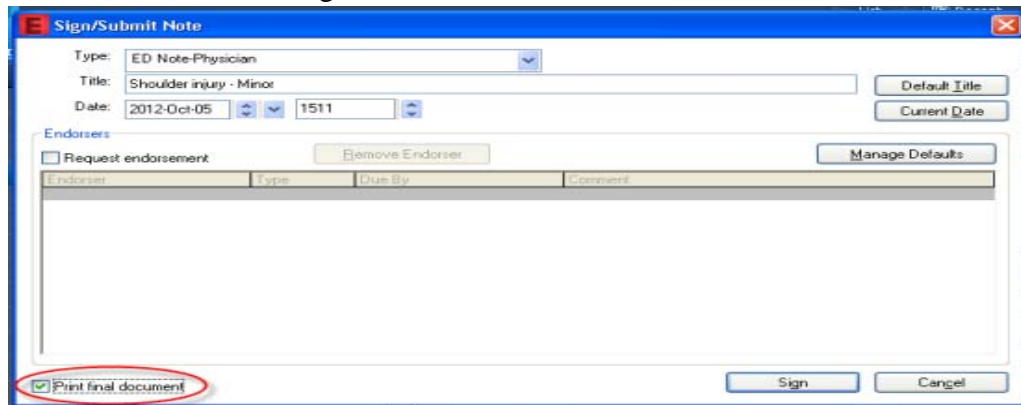
The note can be sent to the Message Centre for endorsement for Pas, NPs, and students by clicking the Request Endorsement field and searching for a provider in the field below. A Provider search box will appear directly beneath the Endorser column which will allow the user to search/select a provider in which to route the Note for endorsement. The Endorser selected will remain as the default endorser for future Notes until this is changed or removed.



## Print a Note

1. Print on signing the note:

- a. To print on signing the note, select the 'Print final document' at the bottom of the Sign Note window and select 'OK'.



2. Print from the Documents tab

- b. Navigate to the Documents tab and select the 'Print Document' icon from the left side of the 'Refresh' button.

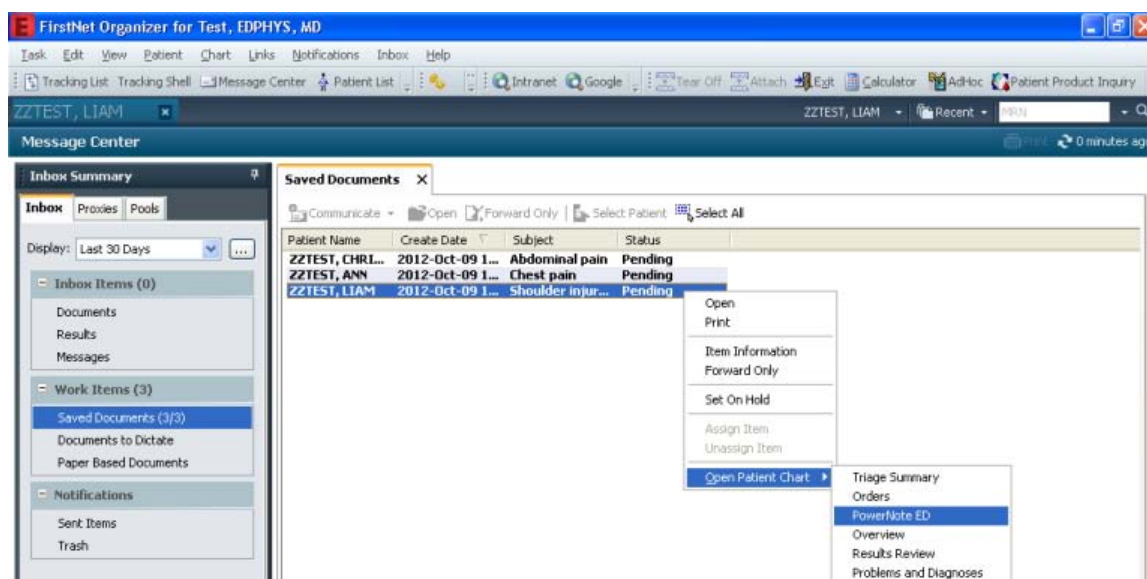
# Incomplete Documentation Tracking

There are 3 ways to determine if you have unsigned notes:

- Through the Inbox
- The PNEC Unsigned Notes report
- The Signature Needed column

## *Using Message Center with PowerNote ED*

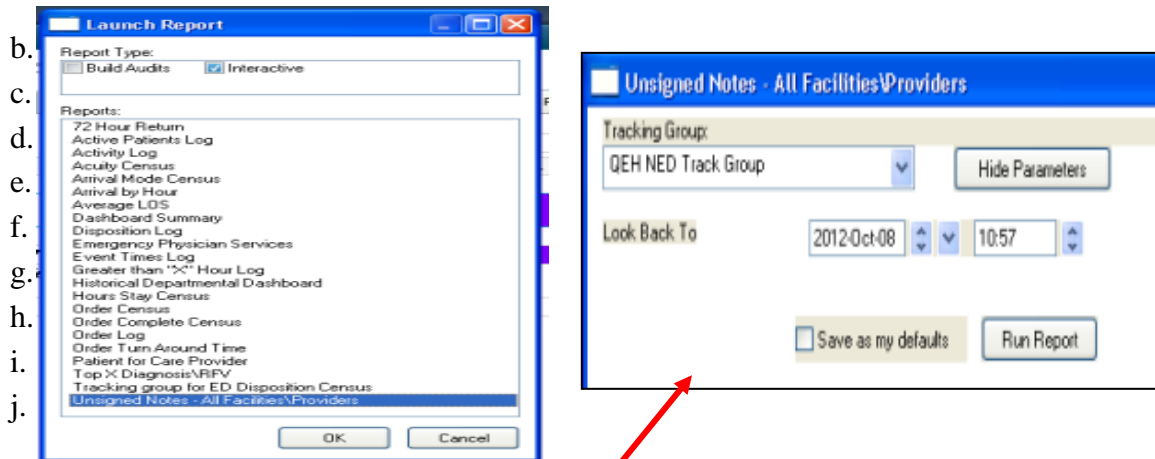
The Message Center displays documents that need review or signature. The document that you have created and are in a saved but not signed status also display here.



1. If a document is a saved (incomplete or unsigned) document that you need to complete, you need to follow the steps below:
  - a. Right-click on the appropriate document→Select 'Open Patient Chart'→Select PowerNote Ed.
  - b. Now you should have the PowerNote ED template open where you can complete the rest of the note.
  - c. The document will be removed from the Inbox upon signing in PowerNote ED (may need to click the 'As Of' Button).
2. If a document is requiring your co-signature (send by midlevel provider), then you need to complete the steps below:
  - a. If you simply want to cosign without commenting/modifying the document, double-click to open it.
  - b. Make sure you have selected the sign option from the bottom left, and click 'OK' (equal electronic authentication of document.)
  - c. If appropriate Inbox options are set up, the completed document will fall off the Inbox automatically.

## PowerNote ED Unsigned Notes Report

- The PNEC note status report can be accessed by clicking on the clipboard icon from the FirstNet tracking organizer screen toward the upper right corner, and clicking on 'Interactive' in the upper window of the Launch Report dialog box, then 'Unsigned Notes –All Facilities/Providers' in the lower window, click 'OK'.



- The following 'Unsigned Notes – All Facilities/Providers' parameters dialog box will appear, giving you the ability to set the needed parameters, then click 'Run Report'.
- It will display a printable report on the screen showing all the patients that have been assigned to a specific provider.

Unsigned Notes			
Report Date/Time	Author	Patient	Title
10/09/12 12:01:00	Macedonald, Chnsta A, LPN	<a href="#">ZZTEST, PATIENT EIGHT</a>	HA - Headache
	Macedonald, Chnsta A, LPN	<a href="#">ZZTEST, CHRISTA ANNE</a>	Abdominal pain
	Macedonald, Chnsta A, LPN	<a href="#">ZZTEST, LIAM</a>	Shoulder injury - Minor
	Macedonald, Chnsta A, LPN	<a href="#">ZZTEST, LIAM</a>	Shoulder injury - Minor
	Macedonald, Chnsta A, LPN	<a href="#">ZZTEST, LIAM</a>	Shoulder injury - Minor
	Test, EDPHYS, MD	<a href="#">ZZTEST, ANN</a>	Chest pain
	Test, EDPHYS, MD	<a href="#">ZZTEST, CHRISTA ANNE</a>	Abdominal pain
	Test, EDPHYS, MD	<a href="#">ZZTEST, LIAM</a>	Shoulder injury - Minor

**End of Report**

## Power Note Column on the Tracking Board:

Bed	Ac Inpt	Retu Name	Age	Sex	Reason for Visit	LOS	RN	DR	PN	Events	Rad	Lab	Cor
Offid..	2	ZZTEST, ANN	56 years	Fe	1: Chest pain	06:31			▲		2/0	4/1	
FT03..	3	ZZTEST, LIAM	9 years	M	1: Shoulder injury - Minor	08:54		RK	▲		4/0	3/0	In >
WR	4	ZZTEST, MICHAEL	46 years	M	1: Abdominal pain	05:01			●				
FT06..	4	ZZTEST, FNDENISE	35 years	Fe	1: Ankle injury - Minor	0:10			■				
FT02..		ZZ TEST, PATIENT EIGHT	35 years	M	1: HA - Headache	96:38	CM	RK	▲				2/0
Offid..		ZZ TEST, PATIENT THREE	55 years	M	1: Extremity Injury - Major	53:08			●				
FT04..		ZZTEST, CHRISTA ANNE	37 years	Fe	1: Abdominal pain	36:58			■				

a. The PN (PowerNote) column on the tracking board can display 3 different symbols which indicate the status of the PowerNote(s) for a specific patient.


- (Red square) indicates PowerNote has not yet been started.
- ▲ (Yellow triangle) indicates the PowerNote is in progress.
- (Green circle) indicates the PowerNote is completed.

## Viewing the Note

Notes can be viewed three ways:

1. From the Documents tab (Signed notes and your saved notes).
2. From the Flowsheet (Signed notes only).
3. From PowerNote ED (Saved, or newly created, also signed notes but not recommended).

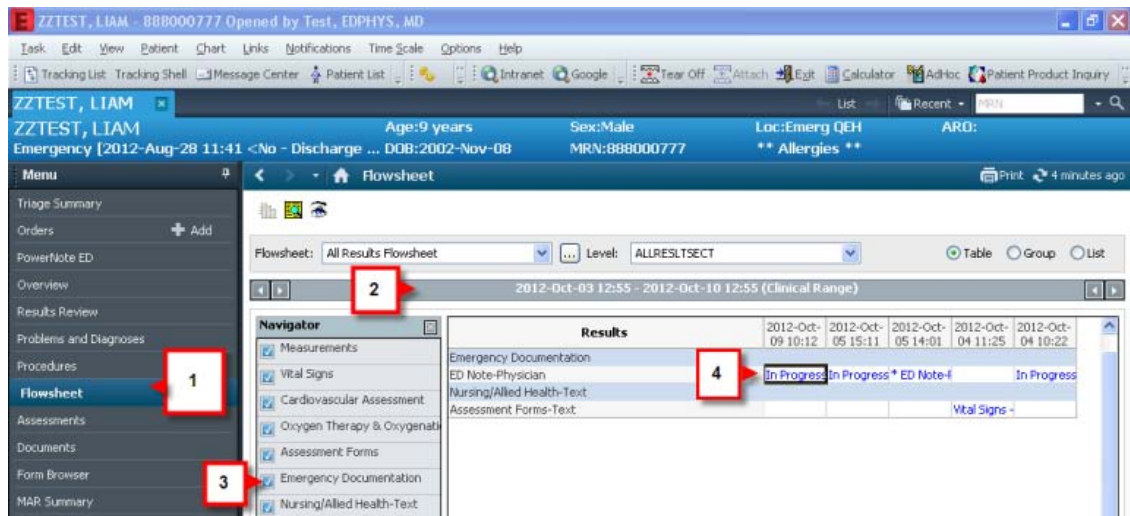
### ***Viewing Notes from the Documents Tab***

1. Click the **Documents** tab if you are not already there
  - a. If necessary, use the buttons at the bottom left to sort the documents by type, status, date, or performed by.
  - b. If necessary, right-click on the long 'grey' search criteria bar to adjust the date range or number of documents to display.
2. Double-click on the appropriate folder in the tree view on the left-hand side.
  - a. Double-click the document to open it.
  - b. The document is open for you to view it.
  - c. Click the **Print** button if you want a hard copy of the note. 

## Viewing Notes from the Flowsheet

Only signed notes can be viewed within the flowsheet.

1. Click the **Flowsheet** tab if you are not already there.
2. If necessary, right-click on the long 'grey' search criteria bar at the top of the flowsheet to adjust the date range or the number of documents to display.
3. Locate and select Emergency Documentation in the Navigator then select ED Note-Physician under Results.
4. Double click on the note you would like to view on the flowsheet, Document Viewer window will open showing the note selected.



## Viewing Notes on PowerNote ED Tab

Viewing notes on the PowerNote ED tab is reserved for saved or newly created notes. Signed notes can also be viewed here, but this is not the recommended practice.

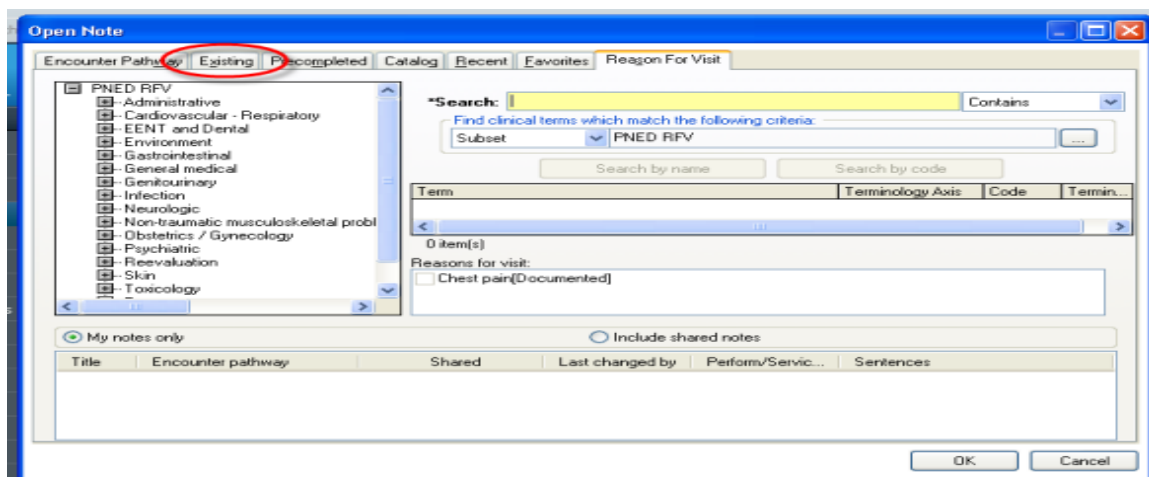
Access the PowerNote ED tab

1. Active notes for the exiting encounter will automatically display (current date only).
2. If the note has been signed and a change must be made, got to Clinical Notes to add an addendum.

## Modifying a Signed Note

A document that was created using PowerNote can be modified from 'Documents' or from the Existing Notes tab of the Open Note dialog box.

**Note: Free Text Addendums added through Modify Function do not display on the PowerNote ED tab.**



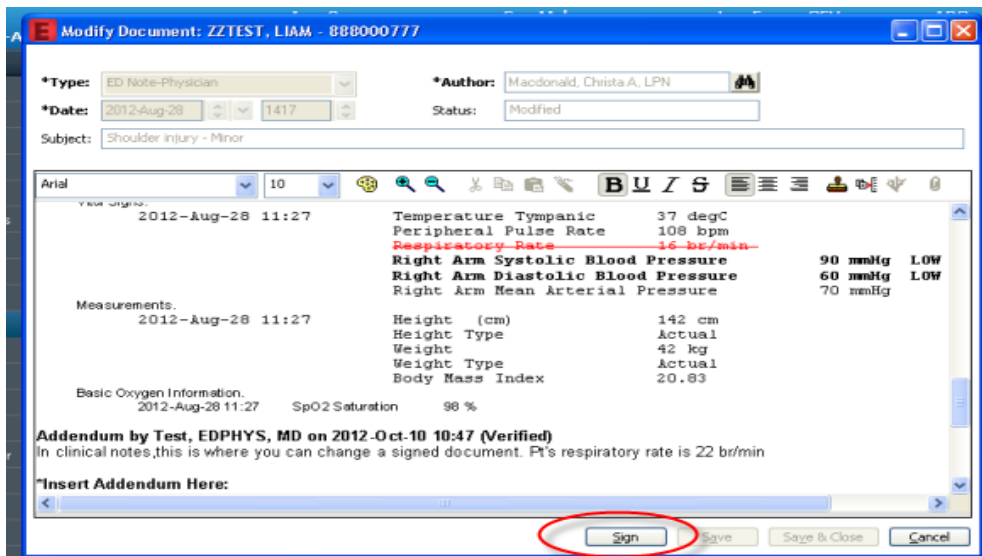
### *Addendums Added Through Documents Tab*

This option should be utilized if the physician needs to add a few sentences to their note after it has been signed. **If the physician needs to add more than just a few sentences to the note, then they should use the Addendum powernote that appears in the catalog tab under the administrative folder. Go to PowerNote ED, then to the Catalog tab, then to Admin Addendum.**

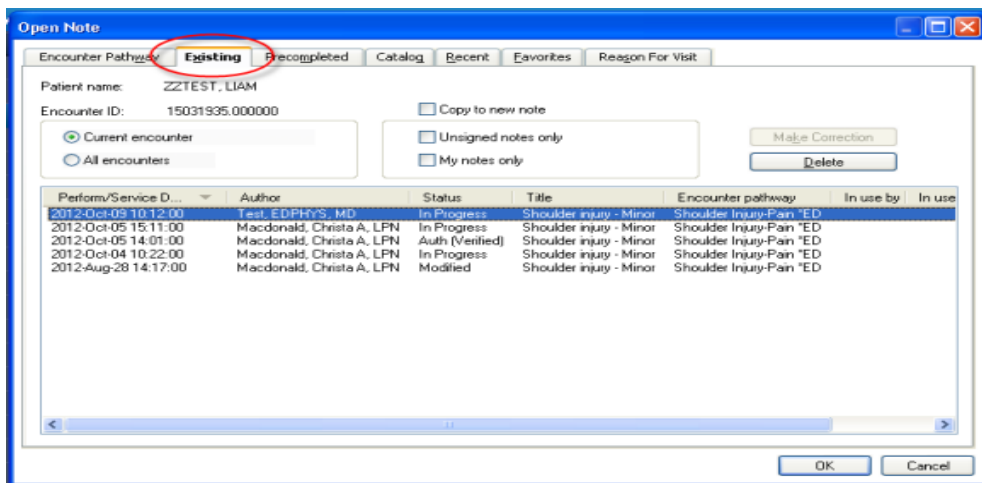
1. Click the **Documents** tab if you are not already there
2. Double-click on the appropriate folder in the tree view on the left-hand side
3. Double-click the document to open it
4. Right mouse click within the document, and select 'Modify Document'
5. Modify the document as needed
6. Strikethrough: Highlight (left-click and drag) a portion of existing test to strikethrough and click on the strikethrough button **S** on the toolbar. The text will appear in red with a red line through it. Strikethrough test will not display in PowerNote ED.
7. Addendum: You may also add an addendum to correct information. Addendums added in Documents are not viewable through PowerNote ED.
8. Once the modifications are made, click the Sign button in the lower right corner.



9. See




below for an example of a PowerNote ED document that was modified through Documents



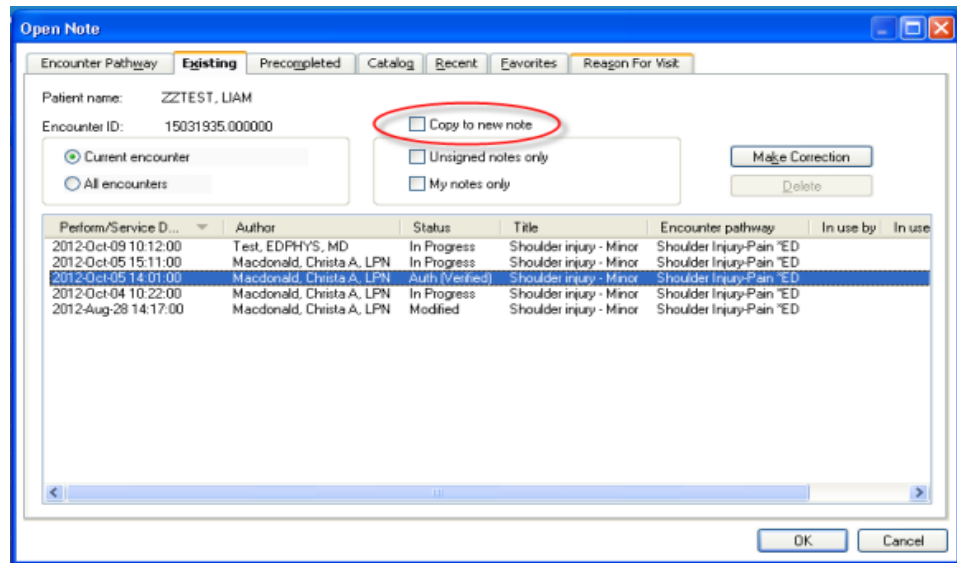
Use the Existing Notes tab to edit a document (creates a new document by copying the existing).

## Copy a Note from the Existing Notes Tab

Editing a note from the Existing Notes tab creates a new note by copying the existing note and making it available for modifying.

- c. Select the patient from the tracking list
- d. Click the 'Open Chart' icon on the tool bar and select PowerNote ED
- e. The signed note is displayed from the PowerNote ED tab
- f. From the PowerNote ED tab, click the Open Note icon 

- g. Click the Existing tab
- h. Select (highlight) the note you want to edit. This note should be in a signed status
- i. Check the *Copy to New Note* box and click **OK**
- j. The system copies the previously signed note to a new note so you may edit the entire document
- k. Update the content accordingly and sign the note
- l. View the changes in Documents



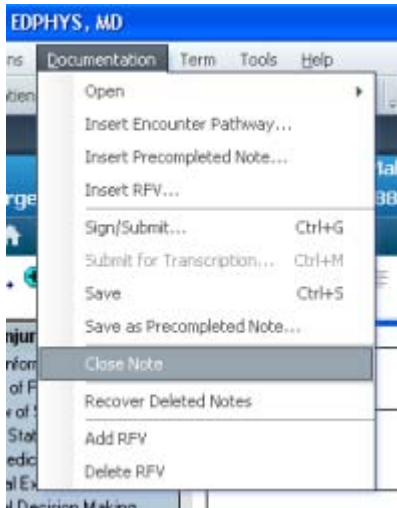
***Attention: When you modify a signed note via Existing Notes as outlined above, you create a new note and you are the author of that entire note. The system keeps a record of previous changes in the background. If the last document is printed from Documents, the physician who signed this note is shown as the physician of record on the hard copy.***

# Delete a Note

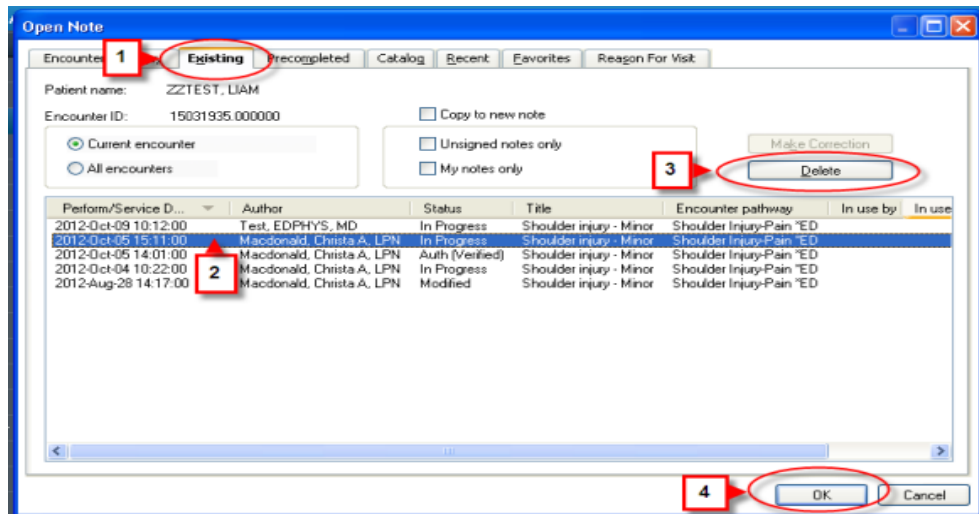
A note can be deleted only if it has not been signed. Once a note has been signed, it is finalized and cannot be deleted. The only option in that scenario is to unchart the powernote through documents.

To delete a note:

1. Ensure the note is in a closed status. With the note open from the PowerNote ED tab, select **Documentation >Close Note** from the menu bar.



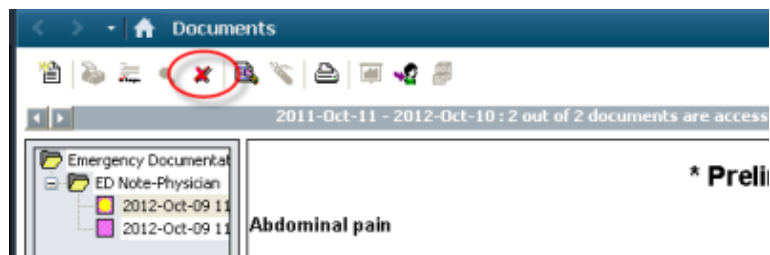
2. Select the Open Note window from the PowerNote ED toolbar.
3. Select the Existing tab.
4. On the Existing tab, select the note to be deleted.
5. Click Delete.
6. Click OK.



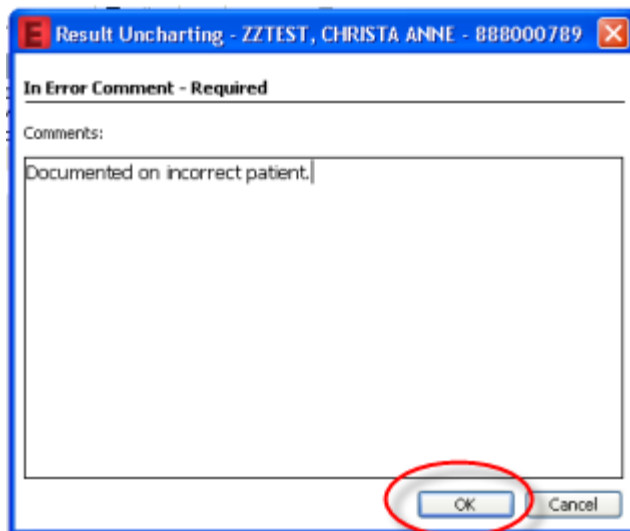
## In Error a PowerNote

The physician has the capability to unchart a pownote if they realize that the data was entered on the incorrect patient.

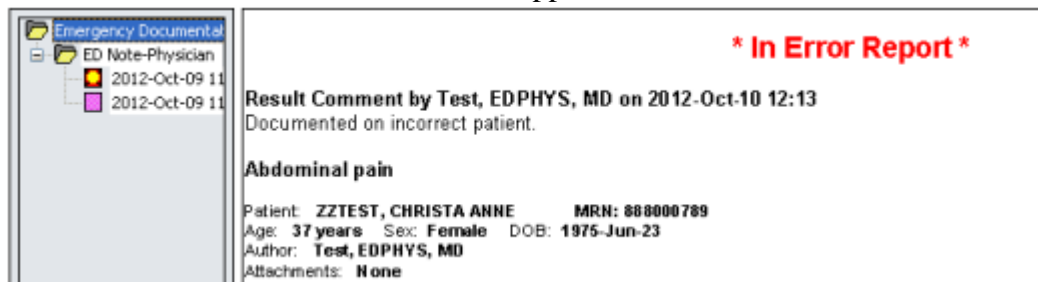
1. Open the note from the Documents tab.
2. Click the red X that appears on the toolbar.



3. You will be prompted to enter a reason for uncharting the note.



4. Click the OK button and 'In Error' will appear as the status of the note.

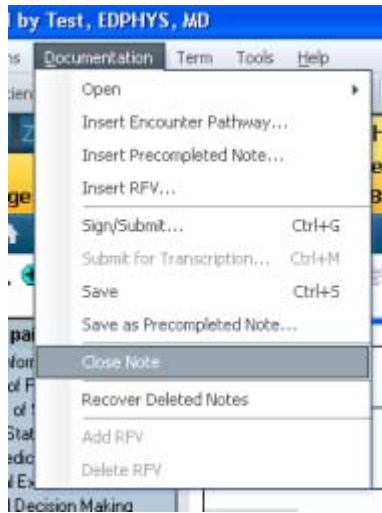


## Note Blank on Entering the Chart

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On occasion, a note does not get closed on the exiting patient's chart. This note will be blank when the chart is opened in the future.

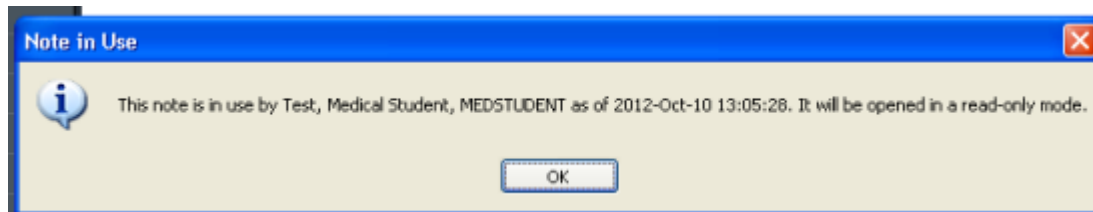
To correct this issue, ensure the note is in a closed status; with the note open from the PowerNote ED tab, Select Documentation>Close Note from the menu bar.



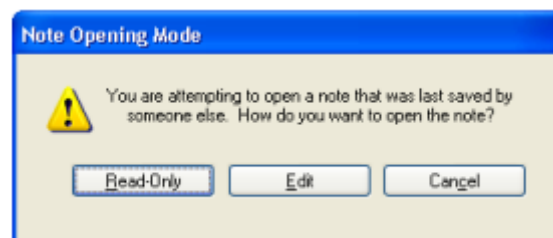
## Locked Notes

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Only one person can be documenting in a single pownote at a time. If someone has a patient's note open, it will be locked to other users. This ensures the note is not being updated by two providers at the same time. The message below will appear if you attempt to open a note that is currently open by another user.



OR



You are prompted with the following options:

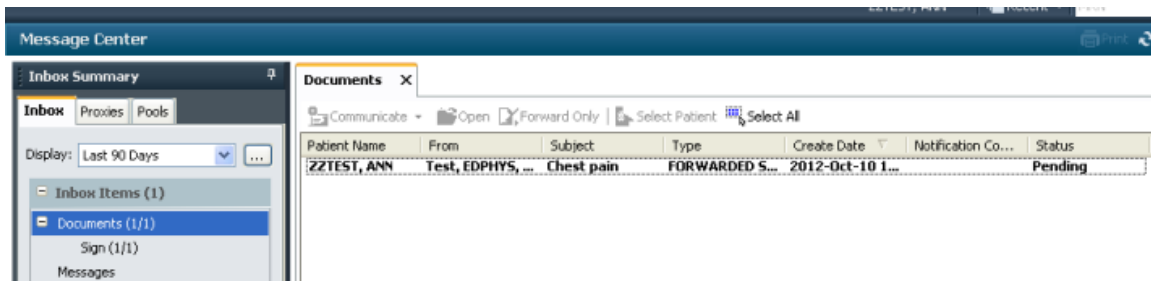
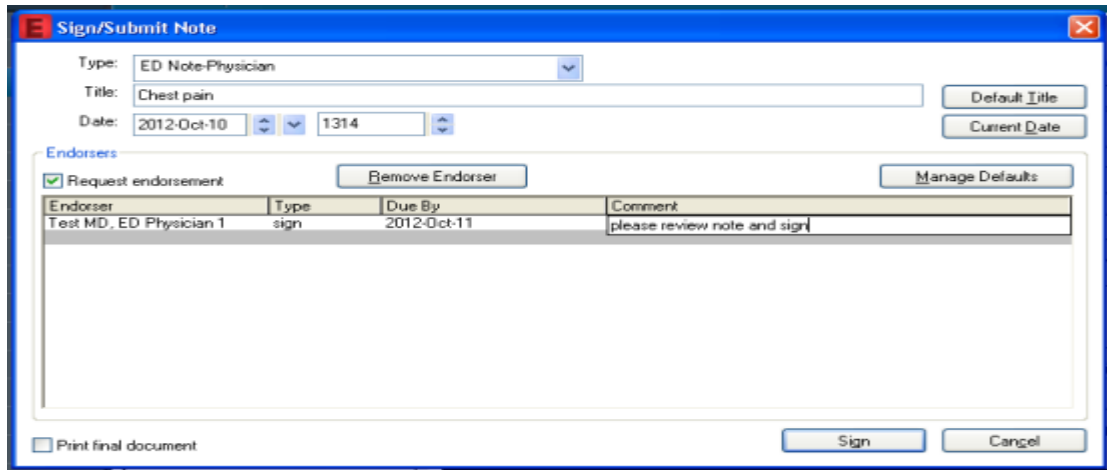
- Open the note in Read-Only mode
- Copy what has been documented and saved within the note so far to a new note

- Open **cancel** the changes that were made by the other user. Select this option if you are the owner of the note and want to continue documenting
- Cancel the request to open the note

Occasionally, the connectivity to the network or the application is lost prior to closing the note. This can also cause the note to be locked.

## Physician Assistant Charts & Cosign Process

The PA's, NP's, and students can send their powernotes to the attending physician for endorsement by selecting the 'Request Endorsement' checkbox within the Sign/Submit Note window and selecting a physician from the provider search.

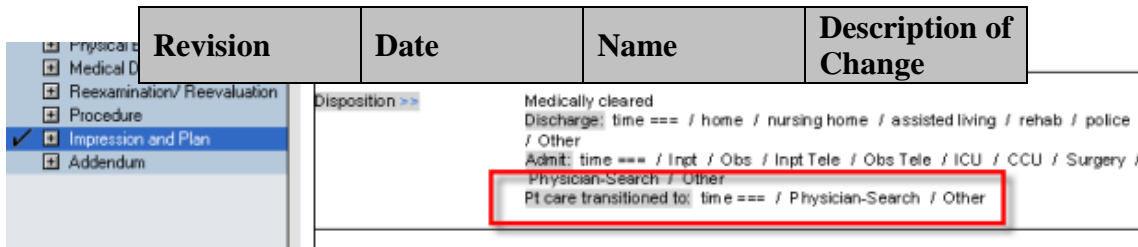


The attending physician can review the powernote from the Message Center. The attending has the ability to strikeout any information that needs to be removed from the note. There are two options available for making additions to the powernote:

1. The attending can add an addendum at the bottom of the signed powernote from PowerChart → Documents tab
  - a. Pro: All of the documentation will remain in one note
  - b. Con: All additions will be free-text
2. The attending can use the Supervisory Note – PA/NP, the Teaching Physician Addendum – Brief, or the Teaching Physician Addendum – Extended, powernote to add any additional comments. The Supervisory Note and Teaching Physician Addendums can only be accessed from the Catalog tab:
  - a. Pro: The additions are not free-text. They are made through a structured note
  - b. Con: Two powernotes will appear in clinical notes for this patient's encounter

# Physician Transition of Care Process

The physician can document the transfer of care to another ED physician at shift change, or to an attending physician, by using the ‘Patient Care transitioned to’ sentence. This resides in the Disposition sentence under ‘Impression and Plan’.

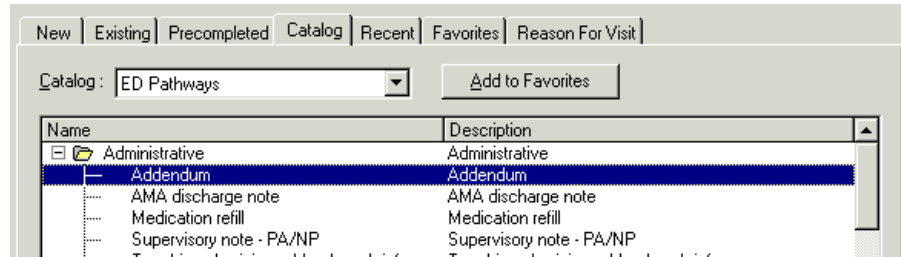


The process is as follows:

1. Physician A documents the care they provided, selects the ‘Pt care transitioned to’ term, selects a physician, and signs the note.

**Pt care transitioned to: time 2012-Oct-10 13:31:00 / Test MD, ED Physician 1**

2. Physician B opens an Addendum note to document the time they took over the patient’s care. The Addendum note can only be opened from the Catalog tab.



- a. The Addendum note contains the same Medical Decision Making paragraphs as the other PowerNotes, except that it is generic.
3. Physician B can even transfer his/her patient over to the next physician if necessary.

001	08-20-2009	Lorraine Dougan	Updated content to PEI Build
002	11-22-2012	Denise Arsenault	Updated with 2012 screen shots
003	04/06/2020	Kerry Rogers	Updated with 2020 screen shots and updated information.