

EPIC ASAP “HOW TO DO IT” (draft)

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This is a very short “How to Do It” guide. Please help us improve it by giving suggestions to Rob Garrett.

ATTENDINGS:

A: START OF SHIFT:

1. At start of shift, you must:
 - 1.1. Log-in
 - 1.2. Sign in (there’s a big “SIGN-IN” icon on the Trackboard)
2. Conduct REPORT for the ER, same as you have always done.
 - 2.1. We will still use the Board for report
 - 2.2. You MUST BE SURE THAT EVERY PATIENT IS ASSIGNED TO a Provider**
3. After report, go to the Trackboard and assign yourself to each pt as an Attending
 - 3.1. Right click on each pt’s name and select “assign me”
4. For each patient, you must review the information in sections entitled Med History, Meds and Allergies. This information is input by the Resident or the RN’s. You MUST ENSURE THAT THIS INFORMATION IS CORRECT. YOU MUST ALSO MARK THIS INFORMATION REVIEWED:
 - 4.1. History (This means medical history)
 - 4.2. Meds
 - 4.3. Allergies

B: WHEN THE PATIENT’S DISPOSITION IS DETERMINED:

1. Enter your Attending Attestation
 - 1.1. Open pt’s chart → ED Navigator, → ED Note
 - 1.2. small icon of 3 overlapping pages
 - 1.3. Select “PKED PES ATTENDING ATTESTATION” This inputs the standard form for an Attending. You must go through each of the Suicide Risk Assessment boxes and select either “Yes” or “No.” Click on first box, press “F2” key, mouse click on “Yes” or “No” and then press enter. The cursor should jump to the next box. Repeat this process. You MUST enter an answer for each of these questions or ASAP won’t let you leave this page. (Sorry!) If you want to delete the pre-programmed answer in the box and enter one of your choosing, you can also do that.
 - 1.4. Write the balance of your Attending Attestation. You can use “Smart Phrases” to create and save standard language for your Attestations. There are several standard Attending Attestation forms you can use. Access these from Smart Phrases simply by typing “.PES” or “.rkg” in the body of your note.
 - 1.5. You MUST click on “Accept” or the note will be unsigned, marked as “Pended” and no one will be able to see that it has been done
2. Ensure that the following elements have been properly completed by the RESIDENT. This information is found under Ed Navigator → Disposition.
 - 2.1. Disposition and Follow-up
 - 2.2. Diagnoses

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2.3. Discharge Instructions

2.4. Discharge Condition

2.5. Discharge Evaluation: Look at the Resident’s original Provider Note. There should be a section marked Discharge Eval, with responses to “alert and oriented” etc.

C: NEW PATIENTS:

1. If you need to do intake on any new pt’s, follow the instructions on the Resident’s portion of this memo.

D: AT END OF SHIFT:

1. Make sure you do not have any unsigned or “Pended” notes. There is no easy way to do this, you have to check each pt you have charted on.
2. Assign all of your pts to the next Attending. This is found on the “Sign Out” page.
3. **Sign out**
4. **Log out**

E: MISC:

You can print a copy of the Resident’s HPI to take into your interview if you want: Open pt’s chart → Chart Review (on left tab) → Notes → Highlight the note you want to print (DON’T open it, just highlight it) → Print (print button found at top right of screen).

THERE’S A NOTEBOOK IN THE ER TITLED “THINGS TO FIX ABOUT ASAP.” Please put your suggestions for fixes, improvements, etc. in this notebook. We will have an opportunity to make fixes some time after the system is up and running.

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RESIDENTS

A: START OF SHIFT:

1. At start of shift, you must:
 - 1.1. Log-in
 - 1.2. Sign in
2. Participate in REPORT for the ER, same as you have always done.
 - 2.1. We will still use the Board for report
 - 2.2. **EVERY** pt **must** have a Provider assigned to them
3. After report, go to the Trackboard and assign yourself to YOUR pts as a Provider
 - 3.1. Right click on each pt’s name and select “assign me”

B: For EXISTING Pt’s:

1. **For each patient**, you must review the information in sections entitled Med History, Meds and Allergies. This information is input by **YOU** or the RN’s. **YOU are responsible for making sure that this information is correct. Please make corrections and AND MARK AS REVIEWED:**
 - 1.1. History (this is medical history)
 - 1.2. Meds
 - 1.3. Allergies
 - 1.4. Do NOT click “No” to all
 - 1.5. If these have not been marked as “Reviewed” by an Psych ER physician, click on the button to mark them as “Reviewed”
2. Review balance of chart, make decisions, do your regular job

C: FOR NEW PATIENTS AT THE BACK DOOR:

1. Pt must first be “Arrived” by an RN or by Registration
2. Using a tablet PC or a COW, open up the HPI note for the pt.
 - 2.1. Select pt’s chart → ED navigator → Progress Note → Create Note
3. Conduct the intake interview. You can use the PC to rough draft the HPI and to do the “point and click” portion of the exam. When you are through with the interview, make a decision about medications, seclusion and labs. Give verbal orders to the RN and the Techs about what you think is best for the pt in terms of emergency meds, seclusion, etc.

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4. Go back to the Physician work area, sit down and type the balance of the HPI. Be sure and do the HPI, ROS, Physical Exam, Initial Plan and Assessment, etc. Next to most “point and click” section, you can enter free text by tapping on the little box that looks like a page.
5. The Initial Plan and Assessment is found in two places. At the end of the Provider Note, click the boxes and accept the selections. Then go to the very end of the Provider Note and enter some text under “Initial Plan and Assessment.” Something like “25 y/o WF admitted on APOWW after threatening suicide. Precipitant was threatened b/u by BF. You will need to delete the “...” after the system generated title of “Initial Plan and Assessment” The “...” indicates to the ASAP system that some text needs to be entered here. You CANNOT get out of this screen without deleting the “...” You can also press the F2 key (while in the note) and ASAP will take you to the “...”
6. Since the Social Work notes are hard to find in ASAP, you probably should put your notes about Social History, Drug use, etc in your HPI. Simply add paragraphs to the HPI text with the headings of PMH, Social History, etc.
7. Order the labs in ASAP
 - 7.1. Order entry → Order Sets → In the search box, Type “psy”, hit enter → Choose “Psychosis ED PES” → choose “Open Order set” (“Open Order set” is at the top of the order section.)
 - 7.2. Go through the various orders and enter the ones you think are needed. DON’T enter all of them, just the ones you think are needed.
 - 7.2.1. Nursing orders (seclusion, etc.)
 - 7.2.2. POC labs = urine pregnancy, fingerstick glucose
 - 7.2.3. Hematology
 - 7.2.4. Chemistry (Don’t forget to select Random Glucose.)
 - 7.2.5. Urine/Fluid
 - 7.2.6. Radiology
 - 7.2.7. The red Stop Signs next to orders are “hard stops” which means that the system will make you answer some questions before you can enter these orders. Go to the first red Stop Sign and answer the questions, then the next, etc. The system is kind of stupid and will accept any text entry, but you probably want to put in something like “psychosis” or “depression”.
 - 7.2.8. The “Authorized Provider” is the Attending working with you.
8. Enter orders for any meds
9. Have someone complete the OPC, if needed
10. Go to the History, Meds and Allergies sections of the Chart and be sure that the information is correct. If not, enter the correct information.
11. Have your student do an Oacis search and be sure that it gets entered into ASAP. Oacis is the legacy EMR system for the ER.

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D: TRANSFERS TO THE MED ER:

1. Call Doc-to-Doc with the Med ER.
2. Enter order to transfer pt to Med ER.
 - a. ED Navigator → Order Entry → search for “ED to ED Transfer.” Complete the order.

E: FOR NEW PATIENTS AT THE FRONT DOOR:

1. Pt must first be “Arrived” by an RN or by Registration
 - 1.1. Same as for patients at the back door.
 - 1.2. Consider letting a MS3, PA-S or a Psychology Graduate Student do an initial interview for you and report the results back to you. That is good training for them and may enable you to complete your exam more quickly.

F: WHEN A DISPOSITION IS DECIDED ON FOR A PATIENT:

1. Have your student ask Transicare for a follow up appt (if needed)
2. Have your student write paper scripts for pt (if needed)
3. Complete the following sections in ASAP:
 - 3.1. Disposition and Follow-up tab. (Found under “ED Navigator → Disposition”.)
 - 3.2. Disposition: Select “Discharge” “Transfer” or “Admit.” Admit means to 8N. If you are admitting to 8N, **YOU MUST ALSO ENTER AN ADMIT ORDER** under the order entry section.
 - 3.2.1. Enter Follow Up Appt. The NorthStar clinics are found under the “Location” button. Select the date from the little calendar icon.
 - 3.3. Accepting Hospital (if a transfer to another hospital)
 - 3.4. Diagnoses. Pick the Axis I and II from the list.
 - 3.5. Med Reconciliation: **YOU** are responsible for making sure that this reflects ALL of the pt’s meds at the time of discharge.
 - 3.6. Discharge Instructions if discharging home. (Type in your instructions, such as - “Stop using drugs and alcohol, Go to your follow-up appointment, Go to rehab, Take your meds every day, Come back if you are in crisis.” Remember that many of your patients are barely literate and that you need to write to THEIR level. Since our d/c instructions are pretty repetitive, you can use Smart Phrases to make this faster. Check under “.PES” or “.rkg” for some sample discharge instructions. You can also select pre-written text about the common psychiatric diagnoses.
 - 3.7. Discharge Condition (almost always “Stable” – Think medical, not psychiatric.
 - 3.8. Take the chart to the RN’s and tell them the pt is discharged.

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G: AN EASY WAY TO DO “DOC-TO-DOC”

1. Go to “Doc Flow Sheet” or Go to “Patient Summary” on left of main pt page
2. If you go to “Patient Summary,” review all the notes by clicking on “PES Patient Summary”
3. Vitals are found in PES Patient Summary under Physician Handoff
4. Labs are found under “Results Review”
5. When you have finished the Doc-to-Doc, enter a note under “ED Note” Something like “Doc to Doc completed with Dr. Gurguis at Green Oaks.”
6. Finish MOT and have your student give it to Transicare
7. Tell the RN’s you have finished Doc to Doc
8. Finish the Disposition entries in ASAP under Ed Navigator → Disposition

H: AT END OF SHIFT:

1. Cosign all of your student notes. The resident who relieves you should not be signing these notes as they weren’t in the ER when the notes were written.
2. Make sure you do not have any unsigned or “Pended” notes. There is no easy way to do this, you have to check each pt you have charted on. If you leave your initial HPI note as “Pended,” the next Resident will have to create it before the pt can be discharged. This is not a good way to make friends.
3. Assign all of your pts to the next Provider. This is found on the “Sign Out” page.
4. Sign out
5. Log out

I: MISC:

1. Lab Add-on’s
 - a. Have your student call the lab and see if they still have a viable sample that you can use for your desired lab
 - b. Enter order for the desired lab
 - c. At the “Stop Sign” click on the button “Spec in Lab”
 - d. Talk to the HUC to make sure that the proper sticker is taken to the lab.

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