Customizing Your Patient List

- You can customize your list by clicking “Properties”
- Useful columns:
  - Admin Med Rec Complete? – flags if admission med rec not done
  - Cosign Ord – flags if unsigned verbal orders
  - Level of Care – indicates if Pedi or PICU status
  - New Orders (Time Mark) – flags if new orders entered
  - Treatment Team Resident – use to assign pt to interns

Customizing Patient Lists

You can customize the Toolbar in order to display different reports:
- "Cosign Orders:" shows any outstanding verbal orders
- "Handoff:" allows you to see the patient’s handoff
- "Communications Page:" provides hyperlinks to Amion and frequently used phone numbers

Admissions

***This information will then populate your H&P and future notes***
Problem Lists

- All patients need at least 1 “Hospital” problem and 1 “Principal” problem
- Problems should be as specific as possible (Not just “anemia” but “iron deficiency anemia”)
- If you right click on the name of the problem, a list of options appears including: delete, resolve, add to medical history
- The problem list should be updated during the hospital stay, as well as at discharge (resolve problems such as hypoxia, dehydration, etc. at discharge)

Admission Orders

- Enter orders under “Order rec – sign” portion of the Admission Navigator (not the “Orders” tab)
- This ensures review and reconciliation of the home meds

Medication Reconciliation

1. If the meds are known, enter them in the “Review Home Meds” tab
2. Click “Complete” from the box next to Med List Status
3. “Mark as reviewed”
4. Reconcile the meds (“order” or “don’t order”) in the “Reconcile Home Meds” tab

Medication Reconciliation

- If the patient arrives before the parents and home meds are not known:
  1. Select the option “In progress” under “Med List Status”.
  2. Click “Mark as reviewed.”
  3. Reconcile whatever home meds are in the computer – click “Don’t order” if the med/dose has not been verified with the family
- When the family brings the home meds, enter them under the “Orders” tab
Med Rec After Admission

To enter home meds after admission orders are complete:
1. Go to “Orders” tab
2. Click on “Home Meds”
3. Click on “Review prior to admission meds”
4. Add/ edit the home medication list
5. Click “Mark as Reviewed”
6. Go to the next section “Reorder Home Meds” to order them in the system.

Pediatric Order Sets

1. Pediatric General Admission Orders
2. Pediatric Asthma Initial Orders
3. Pediatric Bronchiolitis Admission
4. Pediatric Dehydration Initial Orders
5. Pediatric Hyperbilirubinemia Initial Orders
6. Pediatric Suspected Sepsis/ Meningitis Initial Orders
7. Pediatric Diabetes Mellitus without DKA Inpatient Admission
8. Pediatric In-Patient Insulin Pump Orders
9. Pediatric Subcutaneous Insulin Initial Orders
10. Pediatric Patient Controlled Analgesia (PCA) Orders
11. General Pediatric Blood Administration
12. Pediatric Massive Transfusion Protocol & Emergent Blood Administration
13. Pediatric Parenteral Nutrition
14. Pediatric Central Line Maintenance Orders
15. Pediatric Diabetes Discharge (this should be entered under “Discharge” tab)

PICU-Specific Order Sets

1. Pediatric General ICU Admission Orders
2. Pediatric Diabetes Mellitus with DKA Inpatient Admission
3. Pediatric Rapid Sequence Intubation
4. Pediatric Severe Traumatic Brain Injury (TBI) Admission
5. Pediatric ICU Severe Sepsis Admission
6. Hypertonic Saline Infusion for PICU
7. Pediatric Central Line Maintenance Orders
8. General Pediatric Hyperkalemia

* To make an order set your favorite: right click on it and select “Add to favorites.”

Central Line Order Set

- Created to help us standardize and improve our line care
- Use for any patient with a central line (including PICC, port, Broviac)
Ordering a Diet

- The order for pediatric diets is “Pedi Diet”
- This order incorporates all pediatric diet options: infant feeds (breastmilk, formula, purees) as well as clears, regular diets, and tube feeds.

IV Fluid Notes

- The easiest way to find IV fluids is to type “.ivf”
- You can also type:
  - “.lr”
  - “.ns”
  - “.d5”
- Specify an IV + PO amount in the “Admin instructions” section of the IV fluid order

Other Orders Notes

- Nebulizer/MDI need to 2 orders: 1 for the medication and 1 for the RT to administer
- These orders are paired - click an order labeled “Order Panel”

Entering Orders Prior to Patient Arrival

- It is important to enter orders through the “Admission Navigator” for patients who are in the ER - when you sign the orders, they will be unlocked and active for the patient’s care from the “Orders” tab. The orders will automatically become active in the patient’s chart.

- If entering from another hospital or clinic, find your patient in the “Associated Patients” list by using the “Patient Station” tab above.
How to Edit Multiple Orders

If you are ordering multiple labs that you want all to be drawn at the same time, you can edit them all simultaneously by clicking on the “Options” button and selecting “Edit Multiple” from the list. You will then be able to designate the priority and start time and date for all labs here.

Cosining Verbal Orders

• To find patients with unsigned verbal orders:
  – Find pending orders in the “Cosign Ord” column of your patient list
  – Click on the “Cosign Orders” tab in the tool bar
  – Sign any unsigned orders

Notes

1. Fill in the Note Type
2. Add the Service
3. Click on “Cosign Required” and specify the attending
4. Click here to access the note templates

Pediatric Note Templates:
1. VMC IP PEDS HISTORY AND PHYSICAL
2. VMC IP PEDS CONSULT – consult note for ED or other services
3. PEDS POST OP NOTES – post-op note for patient who already has H&P/consult note
4. PEDS CONSULT POST OP – consult note for post-op patients
5. VMC IP FED DAILY PROGRESS NOTE
6. VMC IP FED PROGRESS NOTE
7. VMC IP FED PROGRESS NOTE – used to document code status discussions
8. VMC IP FED MEDICAL DISCHARGE SUMMARY
9. VMC IP FED DEATH SUMMARY

Making a Note Type a Favorite

When you make a note type a favorite, you can find it under this tab on your home screen. To make your favorites display first when you search, click on the “Favorites” tab and then click “Make Tab Default.” To make a note type a favorite, highlight it and then click “Add Favorite.”
Note issues

- Do not document exam findings that you did not examine (ie, no gynecological or rectal exams if not done)
- If you copy the previous day’s note and paste into today’s note (not recommended)
  - delete the attending attestation
  - carefully edit the note to update
- Any patients with central lines (including PICC) need daily central line documentation
  - fill out all portions of the smart text, including the reason that the line is needed.

Note Smart Phrases

- Some useful smartphrases:
  - HEADDS exam note: PEDHEADSNB
  - Normal vital signs by age – for admission orders: .VITALSNEWBORN, .VITALSINFANT, .VITALS1YO, etc.
  - Central Line Documentation: .CENTRALLINEDOCUMENT
  - Asthma action plans: .ACTIONPLAN, .ACTIONPLANSPAN
- Feel free to add these to your smart phrases

Note Smart Phrases

To steal someone else’s smart phrases:
1. Click on the “Epic” button
2. Click on “Tools”
3. Click on “SmartTool Editors”
4. Click on “SmartPhrase Manager”
5. Enter the name of the user whose smart phrases you want and click “Go”
6. Click on the smart phrases you want and click the “Share” button with the green plus sign
7. Enter your name under “Users” and click “Accept”

Obtaining Information about Surgery

- If you have a patient who went to the OR and you are trying to find out the details of their case, follow this procedure
Confidential Notes

• To flag the chart so that if a patient’s family requests the medical record, the HEADS note is not released, create an “FYI”:
  – Click on “More activities” at the bottom left hand side of the screen
  – Click “FYI”

Creating a flag, continued:
  – A screen with then come up — click “New Flag”
  – Enter “Release Restrictions” in the “Flag type” box
  – Then in the box below, type the note type and date that you do not want released
  – Click “Accept”

• This will create an “FYI” alert in the patient header
• And will also create an alert for HIM when they go to release the records

Procedure Notes

1. To write a procedure note, click “Procedure” tab

2. This screen will come up — choose the procedure type and fill through boxes to auto-populate your note

Routing a Note

It is helpful to route H&Ps and Discharge summaries to PCPs if they are within the Valley system.
Routing a Note to Outside PCPs

1. Click on your note
2. Click on “Route”
3. Click on “4 Other”
4. Enter PCP Name
5. Enter PCP Fax Number
6. Click “Accept”

Your note will be faxed to the physician at the number entered.

Intrahospital Transfers

If sending to EPS or Rehab, click on the “Discharge Readmit” tab.

Use the Transfer Navigator if sending from PICU to ward (or vice versa).

If making a PICU patient Pedi status without transferring, use the order “update patient status.”

Transferring to Rehab

After clicking on “Discharge Readmit”:
- Scroll to the bottom of the page and click “Go to Order Reconciliation”
- Reconcile the orders
- Under the “New Orders” tab, choose disposition “Rehab Fac w/in this hosp”
- Other new orders needed:
  - Rehab consult
  - PT, OT, Speech therapy
  - Rehab psych (if needed)

Discharges

Discharge orders should be entered through the Discharge Navigator.

To order discharge orders, click here.
Summary of Care

- One of the "Meaningful Use" criteria is to send a "Summary of Care" document to the physician who will be seeing the patient in follow-up.
- This document is transmitted automatically 24 hours after discharge and is NOT a discharge summary (view contents by clicking "Preview").
- If a provider/facility is not listed: Use the "Unlisted" button to free text (including name, phone, location if known). The HealthLink team will add these entries for future use.

Cosigning Orders at Discharge

Check for unsigned verbal orders when discharging your patient by clicking on the "Cosign Orders" tab and signing any orders awaiting cosignature.

Discharge Medication Reconciliation

Pharmacy Options:
1. VMC Discharge Pharmacy: Choose if using Transitions of Care Pharmacists who deliver meds to bedside and provide teaching to family.
2. VSC Pharmacy: Choose if using outpatient pharmacy in Valley Specialty Center (next to visitor parking garage).
3. VHC Pharmacies: Pharmacies associated with satellite clinics (eg, VHC Bascom, Gilroy, East Valley, Sunnyvale).
Discharge Prescriptions

Submit discharge prescription orders at least 24 hours in advance for:
1. Patients with long/complex hospital stays (so family teaching in medication administration can be done)
2. Patients who have compounded medications (show up as “COMPOUNDED ORAL MEDICATION” in the discharge navigator)

Discharge Orders

- To enter discharge orders:
  - Click on the “New Orders” tab
  - Under order sets, type “Discharge” – most discharges will use the “Discharge to Home or Self Care”
- When filling in the “Discharge instructions” or “Diet” orders, any instruction should be entered in the “Comments” section. The “Sched Inst” field does not populate the patient discharge handout.
- It is important for the attending of record to be accurate, because the discharge meds are e-prescribed in his/her name
- Referrals for outpatient follow-up and testing (e.g., MRI) must be entered in the discharge navigator. If testing may require sedation as well, please enter “Pedi Sedation” referral.

Other Discharge Info

- There is a “Pediatric Diabetes Discharge” order set for diabetic meds/supplies
  - These orders should be entered under the “Discharge” tab
  - Should be written in conjunction with endocrinologist as early as possible during the hospital stay so insurance issues can be worked out and supplies obtained
  - Controlled substances need to be hand-written on a triplicate prescription form.
  - All orders for Home Health (home oxygen, pulse ox, feeding pump, supplies, etc.) still need to be written on paper.

Discharge Summary

- Your discharge orders populate the “After Visit Summary (AVS)” which is given to the patient.
- Please review the AVS prior to d/c
  - Click “Preview AVS” in the Discharge Navigator
- If patient has a non-Valley PMDs, fax the d/c summary to PMD and if possible also give to patient’s family
- Every patient needs a d/c summary
- Please double check to make sure the discharge date is correct on discharge summary – it auto-populates when the discharge summary is started
  - Check date of discharge in note as well as date note filed
Patient Summary Reports

- Useful reports include:
  - ICU Data Review (displays VS, pain scores, any drips, vent settings, WAT scores, etc)
  - Current Meds
  - Meds History
  - TPN
  - Blood Transfusion
  - Micro (shows all culture results)
  - Pain (shows pain scores, pain meds, PCA dose, basal rate, #PCA attempts/delinved)
  - Communications Page (links to Amion, frequently used phone #)
  - ED Clinical Summary
  - Glucose Management (for diabetics)
  - Dispensed Meds (displays meds sent to internal and external pharmacies by any provider - shows date prescribed, prescriber, quantity prescribed, and pharmacy name/phone number)
  - Index (this has links to all of the other different report types, like weights if you are monitoring daily weights)

Patient Summary Reports

- To customize the reports you see:
  1. Click here
  2. Click on the magnifying glass, then enter the report type you are looking for in the box that pops up
  3. To add this report to your list, click on the wrench. Then, in the box that pops up, click "Add Current." You can change the order of your reports by using the arrow buttons. When you are done, click "Accept."
  4. When you are done, your report will display here.

Seizure Record

- One way to view seizure documentation is to click on the "Synopsis" tab
- The details and frequency of seizure activity as well as medication timing are visible

Viewing Radiology Images

- Click on the hyperlink "Show images" and open up PACS window - may take a few minutes
**Editing the Handoff from within Patient Chart**

- Then click on the wrench
- Then choose the Handoff
- And click "Add Current"

**Signing Out Your Inbasket**

- When you are going to be away from Valley, sign out your inbasket to the resident who is taking over for you:
  1. Click on "Attach"
  2. Click on the tab "Grant Access"
  3. Enter the name of the person you want to cover your inbasket

**Signing Out Your Inbasket**

- After you have granted the person access, they must attach it to their inbasket to see your messages. To do this:
  1. Click on "Attach"
  2. Click on the tab "General"
  3. Enter the name of the person whose inbasket you want to cover

The person's inbasket will then appear in the column on the bottom left hand side of the screen.

**For your reference**

- Log off of Healthlink prior to logging off computer – otherwise Healthlink will be open under your name when next person logs into computer
- "Pediatric Resident Healthlink Tips" binder is in the PICU and conference room – includes all of the information in this presentation
- This presentation is in the "Pediatric Nighttime Curriculum" folder on the S drive
Discharging to Skilled Nursing Facility

- If transferring to another facility, use the “Discharge to Skilled Nursing Facility” order set
- Fill out all the orders, and do the medication reconciliation like any discharge
- You will need to put in an order for a “Non acute hospital transport referral” for the ambulance to transport the patient
- The orders will populate a “SNF Discharge Report” that is printed out and sent to the SNF by the RN

Discharge to Skilled Nursing Facility

- Under Rx Routing, choose “No Print” so the Rx is not sent to a pharmacy and you won’t have to put in # of pills, refills, etc.
- For meds, specify a stop date (if needed) in the Patient Sig section. DO NOT put the stop date in the “Ending:” section – this does not appear the “SNF Discharge Report”

Transfer to Other Acute Care Hospitals

- Either under the “Discharge” or “Orders” tab, type “transfer” to search for the order set “Hospital to Hospital Transfer”
- 3 orders will appear that need to be completed (see below)
- Complete medication reconciliation
- In addition, you will need to enter the formal “Discharge Patient” order

Care Everywhere

- Almost all of the hospitals in Northern California are using EPIC, allowing easy access to outside medical records
- To obtain medical records:
  1. Click on the “More Activities” button in the lower left hand corner of the screen and choose “Outside Records”
2. Check 1+ hospitals from the list, or search for a hospital in the box at the top of the screen
3. Enter your password
4. You will be notified whether records exist at the institution(s) that you have chosen.

5. Confirm that the patient record located is your patient
6. Collect a signed authorization form (this is required):
   a. Click "Print" next to each hospital. Select a printer in the window that pops up and select "Print" again.
   b. After the family reviews and signs the forms, click the button labeled "Signed." Place the signed consent form in the paper chart. Otherwise, click "Declined."
7. Click "View chart" to review the outside records.
8. The records will be located under the "Care Everywhere" tab

Using Haiku and Canto

- Haiku is the EPIC App for iPhone and Androids
- Canto is the EPIC App for iPads
- There are 3 iPads available for use that are stored in the chief residents’ office
- To insert clinical images into the chart, use the following steps:
  1. After logging onto Haiku and selecting a patient, click on the image of a head
     Select "Take Clinical Image" and take the photo. NOTE – "Take Patient Photo" adds a patient photo to Snapshot (displayed in header), not a clinical image.
  2. Choose a Document Type of "Photos" and enter a description
  3. When writing your note, click on the image of the mountains to insert the image.