ORCHID TRAINING

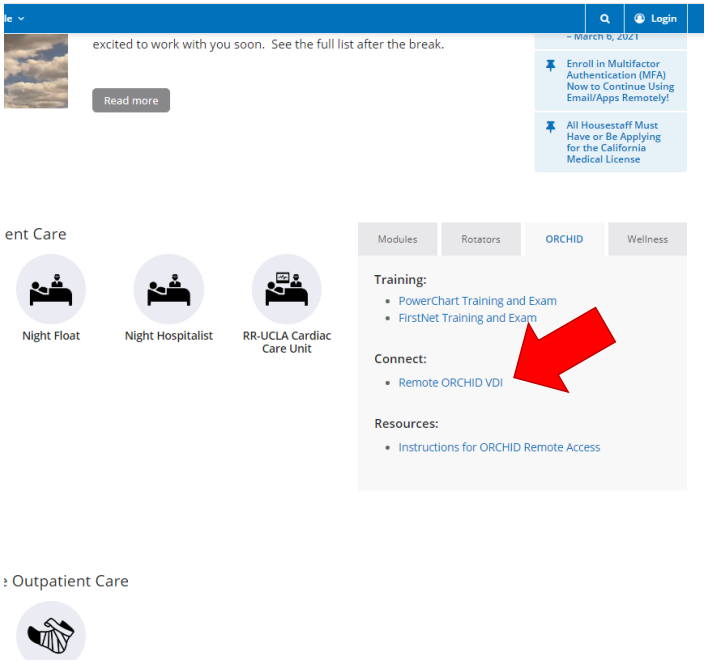
HIPAA

Do not open patient charts unless you are assigned clinical responsibility.

Be mindful of your surroundings when accessing EHR remotely or doing telework.

Basics

- LOG-IN
  - C-NUMBER
  - PASSWORD
- Remote Access
- Message Center
- Quick Links
  - iMedConsent
  - eConsult

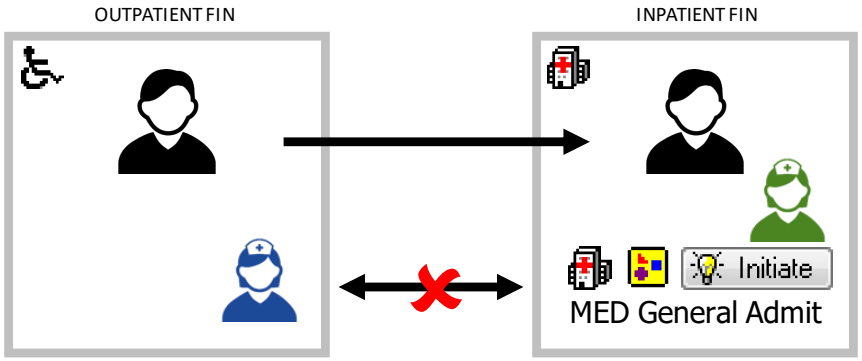


Key Concept: MRN versus FIN

NOTES get attached to FIN
Initiated ORDERS get attached to FIN
➡ = new FIN

ED	Med/Tele/SDU/ICU		
ED	OBS	Med/Tele/SDU/ICU	
Clinic/STC/UCC	➡	Med/Tele/SDU/ICU	
Clinic/STC/UCC	➡	OBS	Inpatient Med/Tele/SDU/ICU
ED	Med/Tele/SDU/ICU	➡	Psych 6A

Key Concept:
Initiate versus Sign Order Sets



For Order sets:

- **Sign = Plan for later** = not active
- **Initiate Now = Activate** = attach to a FIN/encounter = non-transferrable

Basics: Patient Lists & Care Teams

- PATIENT LISTS
  - ED
  - ED/Med/Tele/SDU
  - ICU
  - Set up by Relationships (to get a "recent" patient lists)
    - Provider (Office/Clinic only)
    - Research
    - Resident
    - Reviewing
  - Custom Personal List (to manually add/remove patients, e.g. record of interesting patients)

- Sort these lists by Name, MRN, Room number
- View these lists under Patient List or Physician Handoff

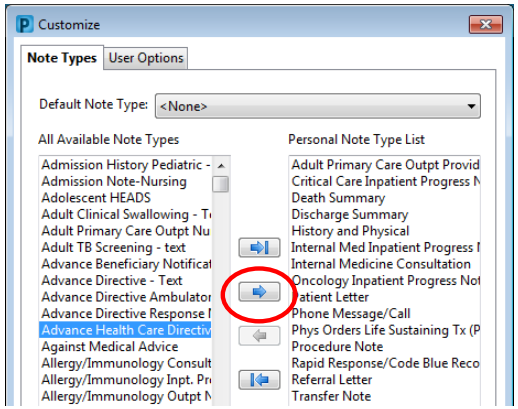
Basics: Patients Lists & Care Teams

- Medicine
  > OVMC Consult General Medicine
  > OVMC Hospitalist Medicine
  > OVMC ICU Medical A
  > OVMC ICU Medical B
  > OVMC ICU Medical C
  > OVMC Medicine A
  > OVMC Medicine B
  > OVMC Medicine C
  > OVMC Medicine D
  > OVMC Medicine E
  > OVMC Medicine F
  > OVMC Medicine G
  > OVMC Medicine H
  > OVMC Medicine Night
  > OVMC Medicine Observation
  > OVMC Medicine X
  > OVMC Procedure Service
  > OVMC TB Unit
- Cardiology
  > OVMC Consult Cardiology
- Gastroenterology
  > OVMC Consult Gastroenterology
- Infectious Disease
  > OVMC Consult Infectious Disease
- Nephrology
  > OVMC Consult Nephrology
- Oncology
  > OVMC Consult Heme/Onc
- Oncology
  > OVMC Heme/Onc Ward
- Pulmonology
  > OVMC Consult Pulmonology
- Rheumatology
  > OVMC Consult Rheumatology

Note Types:
Customize a Personal List

To create your Personal List:

1. Go to Add Documentation
2. From this view, go to View in the menu > Customize…



- Adult Primary Care Outpt Provider Note
- Ambulatory IHA Provider Note
- Critical Care Inpatient Progress Note
- **Death Summary**
- **Discharge Summary**
- **History and Physical**
- **Internal Med Inpatient Progress Note**
- Phone Message/Call
- **Procedure Note**
- **Sensitive Note**
- **Transfer Summary**
- **Urgent Care – Provider Note**
- *[consult service]* + Outpatient Provider Note
- *[consult service]* + Consultation

Note Types:
Customize a Personal List

- Adult Primary Care Outpt Provider Note
- Advance Health Care Directive
- Ambulatory IHA Provider Note
- Critical Care Inpatient Progress Note
- Cardiology Outpatient Provider Note
- Cardiology Consultation
- Death Summary
- Discharge Summary
- Endocrinology Outpatient Provider Note
- Dermatology Outpatient Provider Note
- Gastroenterology Outpt Provider Note
- Gastroenterology Consultation
- Hematology Outpatient Provider Note
- History and Physical
- Infectious Disease Outpt Provider Note
- Infectious Disease Consultation
- Internal Med Inpatient Progress Note
- Nephrology Outpatient Provider Note
- Nephrology Consultation
- Neurology Outpatient Provider Note
- Oncology Inpatient Progress Note
- Oncology Outpatient Provider Note
- Oncology Consultation
- Outside Records
- Phone Message/Call
- Procedure Note
- Pulmo/Chest Outpatient Provider Note
- Pulmonology Consultation
- Rheumatology Outpatient Provider Note
- Rheumatology Consultation
- Sensitive Note
- Transfer Summary
- Urgent Care - Provider Note
- Women's Health Outpatient Provider Note

Note Templates:
Create a Set of Favorite Templates

- **Admission H & P**
- Adult ICU Progress Note
- Ambulatory Office Visit Note
- Consult Note
- **Discharge Note**
- **Free Text Note**
- **Phone Visit Note**
- Procedure Note
- **Progress/SOAP Note**

Add Auto Text Templates / dot Phrases

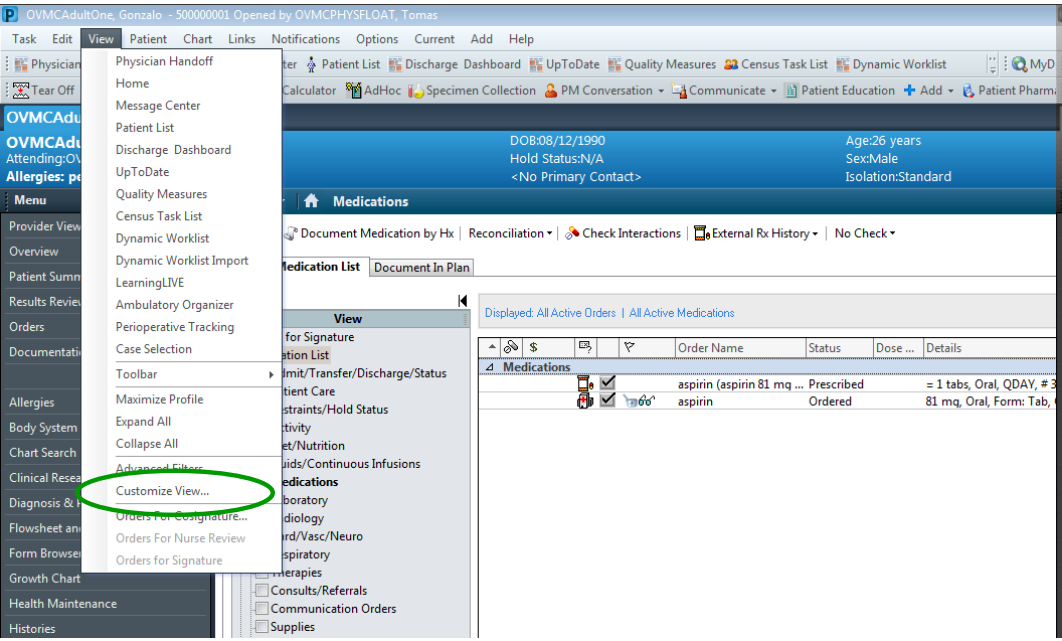
- Copy the text from a source
  - Go to oliveviewim.org > Tools & Resources > ORCHID Templates
  - Log in with "ov im"
  - Go to the General Medicine section
  - Select the template and copy it
- Create the Auto Text
  - Go to a text field (e.g. Subjective/History of Present Illness, create new Note)
  - Click the Manage Auto Text button (last button on the text toolbar)
  - Click the blue Add button
  - Give the text a unique abbreviation, e.g. "..vxtprognotedetails"
  - Paste the copied text
  - Click Save

Important Auto Texts:
- Inpatient Checklist
- Discharge Summary
- Your signature
  - Name MD
  - OV Medicine Resident PGY1
  - Pager XXX-XXX-XXXX

Customizing Information in the Chart: Lab Results

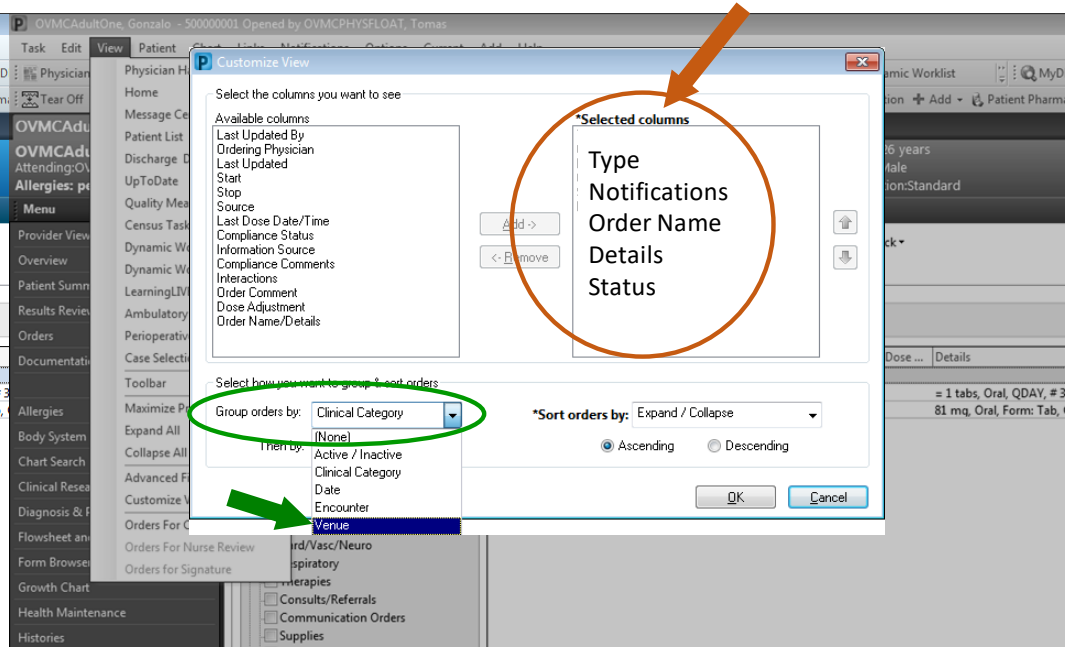
- **Toggle the Units of Measure**
  - View the Result tab
  - Go to Options in the menu > Properties > Display tab
  - Un/check "Units of measure"
  - Repeat for each Result tab as desired
- **Change Default Look-back Period**
  - View the Result tab: Lab - 18 Months
  - Go to Options in the menu > Defaults
  - Change Default Range Offsets: Back to 36 Months
  - Check Re-apply defaults to each new chart
- **Graph the Results**
  - Click the checkbox next to the lab
  - Click the Graph button 

Medication List:
Sort Medications by Venue



Medication List:
Sort Medications by Venue

Add Type, Status, and Details, Then re-order



Add PCA and HD Information

- Go to the **Flowsheet and I&O** section
- Go to View in the menu
  > Layout
  > Navigator bands…
- Move the following from the left to the right column:
  - **"pca"**
  - **"dialysis management"**
  - **"blood product administration"**
- Click OK
- The PCA and Dialysis navigator bands will appear in the list next time

mPage:
Provider View

- Keep these tabs:
  - **Admit | Clinic**
  - **Manage**
  - **Inpt Discharge**
  - **General Medicine**
- Close these tabs:
  - Discharge Review
- Add tabs when needed:
  - Click +

- **Admit | Clinic** (workflow page)
  - Add these components:
    - **Intake and Output**
  - Remove these components:
    - Goals and Interventions
    - Outstanding Orders
    - Quality Measures
    - Check Out
    - New Order Entry
    - Order Profile
  - Rearrange the components as needed to match a good workflow *(click-and-drag)*

Suggested Order:
- Required Provider Note Information
- Intake Info
- Chief Complaint
- Home Medications
- Consolidated Problems
- Histories
- Implant History
- Medications
- Documents
- Vital Signs
- Intake and Output
- Labs
- Microbiology
- Diagnostics
- Pathology
- **Subjective/HPI**
- **ROS**
- **Objective/PE**
- **A&P**
- Patient Education
- Reminders
- Recommendations
- Immunizations

Physician Handoff / Care Team:
Add Yourself to the Care Team

1. Add your team (if you haven't already)
2. Place yourself on the team
    1. Physician Handoff > Manage Care Team Providers
    2. Select your team (All facilities > Medicine > team)
    3. Search your name (do not press <Enter>)
    4. Click Apply
3. When you start, assign yourself as the Primary Contact for your patients

Now for a case

- **DAY 1: You are starting on a ward team and picking up your one patient. The patient needs to be evaluated and admitted from the ED.**
- **The patient presents with foot pain around an ulcer. In the ED, the patient is found to have fever and tachycardia. BP is normal and stable. During the ED course, the patient develops chest pain. Troponin is 1. EKG shows atrial fibrillation with rate 120 without ST deviation. Imaging does not show osteomyelitis. The patient has a known history of diabetes. Home meds are Metformin 1000mg PO BID and Atorvastatin 40mg PO daily.**

- [ ] Get sign-out
- [ ] **Perform brief chart review (including reviewing MAR and previous orders)**
- [ ] Perform history, exam, assessment and plan
- [ ] **Update Consolidated Problem List**

Finding Information in the Chart

- Vitals
- Labs
- Diagnostics
- Microbiology
- Pathology

- **Patient Information**
    - Historical MRN
    - Insurance
    - Preferred Language
    - Contact Phone Numbers
    - Emergency Contact

- **Scheduled Appointments**
    - Patient Schedule
    - Scheduling Appointment Book

Rehash Information in the Chart: Lab Results

- **Graph the Results**
    - Click the checkbox next to the lab
    - Click the Graph button

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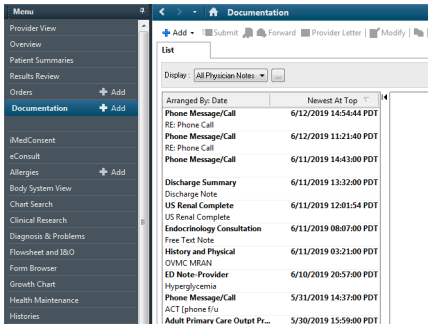
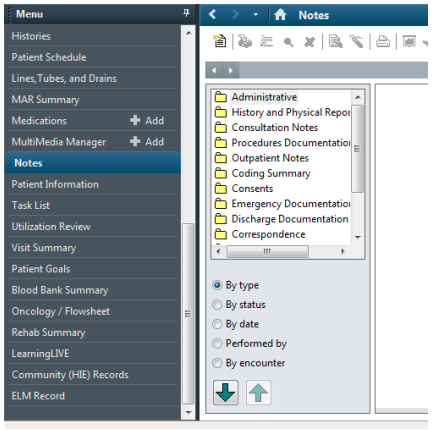
Finding Information in the Chart: Documentation

- **Documentation**
  - Chronological view
  - Use Display filters

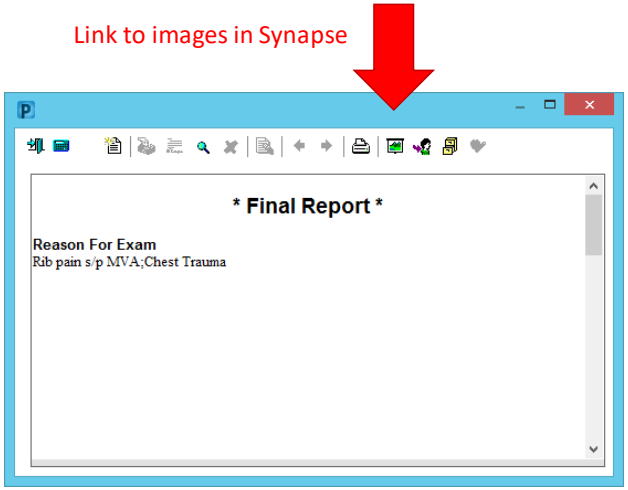


- **Notes**
  - Search/Organize by Date, Note Type, Author!



Finding Information in the Chart: Diagnostics

Link to images in Synapse



Case, continued....

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You make diagnosis of acute diabetic foot infection and NSTEMI

- [ ] Document Med History
- [ ] Admission orders
- [ ] Admission Medication Reconciliation
- [ ] CTX 2gm IV q24h + Flagyl 500mg IV q8h
- [ ] AM labs
- [ ] heparin gtt
- [ ] SS Insulin
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- [ ] Update consolidated problems (if not already done)
- [ ] Start H&P note
- [ ] Complete and sign note
- [ ] Complete written IPASS sign out

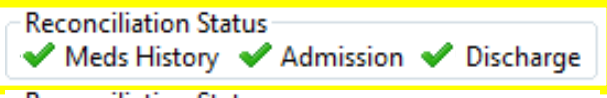
Medications: Document History

- Required!
- Review, modify, re-modify as needed
  - Reconcile with the patient
  - Don't always trust what is in there: meds may be old, completed, or entered by other healthcare team members
- The medications auto-populate into your note, so you are responsible for its accuracy
- The medications populate your admission reconciliation to make ordering in the hospital easy!

Medication Reconciliation

- Reconcile medications with the patient and document
- Why?
  - Patient Safety
  - Communication
  - Clinical Skill
  - Quality measure
  - Reporting

YES!



Not quite:

Not good enough:

Missing a step:

Are you even trying?

Have you seen the patient?

You make diagnosis of acute diabetic foot infection and NSTEMI

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Inpatient Orders: Admissions

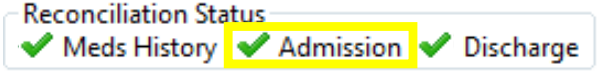
IMPORTANT ORDERS:

- **Place in Observation** (=date/time of obs start)
- **Request for Admit** (=date/time of admission)
- **MED General Admit**

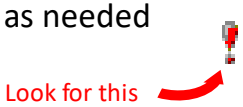
- To change level of care while patient is boarding in ED:
  - DO: Place a new Request for Admit and Admit to Inpatient with the new level of care
  - DON'T: write a Transfer Order while patient is in the ED

- Additional order sets required for:
  - ICU General Admit
  - Sepsis + Blood cultures
  - Insulin
  - Heparin
  - Blood Product Transfusions
  - COVID-19 test
  - TB Bundle

Medications: Admission Reconciliation



- Displays all prior active documented meds, prescriptions, and existing inpatient meds
- Reconcile every medication:
  -  = **Continue** = convert to inpatient order to continue
  -  = **Do not continue** as inpatient = **"Hold" outpt** medication while inpt (will not discontinue the outpt prescription)
- Think about when the first dose of the medication should be, and adjust the date/time of the first dose as needed



Medication and Order Reconciliation

- Reconcile anytime! You are responsible for all the orders.
- Required during:
  - Transition of care (admission, discharge)
  - Transfer of care between providers (switching teams, starting service)
  - Transfer in level of care (in/out of Step Down and ICU)

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- [X] Admission Medication Reconciliation
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Inpatient Lab Orders:

- **Priorities:**
  - **Use: STAT, Timed STAT, Routine, AM Draw**
  - Avoid: Timed Routine
  - **To get AM Labs:** specify Timed STAT or AM Draw with a date/time at 0400
- **Collection:**
  - **Nurse Collect** = Not lab collect = nurse draw or specimen collected by doctor (e.g. from procedures)
  - **Lab Collect** = Phlebotomy service
- **Future Orders:**
  - = orders for a different FIN/encounter
  - must be associated with a diagnosis
  - Specify a window of time
- CPT Orders = 5-digit codes for billing = not an actionable order

- AM Draw = 4AM (collection start time)
- Routine Collection Times: 4a, 8a, 1p, 5p, 9p, 12a
- In-house lab testing:
  - Routine = 4-hour turn around time
  - STAT = 1-hour turn around time

Orders: Tips

- <u>Daily Labs</u>
  - Think about the cost-value…
  - Priority should be routine, not STAT
  - **<u>AM Draw</u>** q24h-INT at 0000 --> 4am
  - **<u>AM Draw</u>** q24h-INT at 0400 --> 4am
  - **Routine** q24h-INT at 2300 --> 12am
  - **Routine** q24h-INT at 1700 --> 5pm
- <u>Diet Orders</u>
  - Select the base diet first, then choose modifiers
  - New diets auto-cancel previous diets!
- <u>Nursing Communication</u>
  - Does not replace other orderables
    e.g. use the Urinary Cath Placement Indwelling order

More Order Tips

- **Urinalysis**
  - "Urinalysis w/ Micro, if ind"
  - "UA w/ Micro, if ind"
  - … does not include culture!!! Order culture separately.

- **Echocardiogram**
  - TTE = Transthoracic Echo

Q9955 Echocardio Contrast, Perflexane (Add-On)
Q9956 Echocardio Contrast, Octafluoropropane (Add-On)
Q9957 Echocardio Contrast, Perflutren (Add-On)
CV Echocardiogram Outside study/document Review
CV Echocardiogram Stress Exercise
CV Echocardiogram Stress Pharmacologic
CV Echocardiogram Transesophageal
CV Echocardiogram Transesophageal OR
CV Echocardiogram Transthoracic Complete
CV Echocardiogram Transthoracic Limited
76376 3D Echocardiogram, No Post Processing (Add-On)
76377 3D Echocardiogram, With Post Processing (Add-On)

  - TEE = Transesophageal Echo → talk to Cardiology fellow

- Be sure to select **<u>Future Visit: No</u>**

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- [ ] **Start H&P note**
- **[ ] Complete and sign note**
- [ ] Complete written IPASS sign out

Documentation

- **Note Type** = Type of Service
- **Note Template** = Structure and content of note, Auto-populates certain information
- **Note Title** = Specific

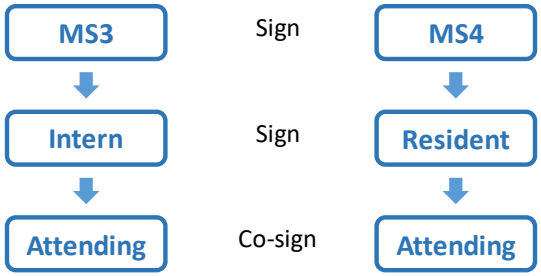
- The note date should reflect the **date of service** (you should not sign future dated notes, but can back-date notes)
- The note type and title can be modified
- Always document under the correct FIN (notes cannot be moved to a different FIN)
- Always forward signed notes to the attending to **co-sign** (not review)

Documentation

Do not copy-and-paste

Documentation

Every note requires MD signature and Attending signature



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Day 2

- [X] Get Sign-out from night float
- **[ ] Review interval results, notes, MAR summary**
- [ ] Round on patients, make assessment and plan

- **[ ] Review interval results, notes, MAR summary**

Day 2

- [X] Get Sign-out from night float
- [X] Review interval results, notes, MAR summary
- [X] Round on patients, make assessment and plan
- > **You notice that the patient is more hypotensive today and blood cultures are positive for gram-positive cocci in chains, so you decide with your resident to upgrade from Tele to Step-down Unit. Patient also became delirious pulling at IVs**
- **[ ] Transfer order**
- **[ ] Transfer order reconciliation (clean up order sets, reconcile orders)**
- **[ ] IVF NS bolus**
- [ ] Assess for and order restraints
- [ ] Required Provider Note Details
- [ ] Start Progress Note

Orders: Tips

- Change in Level of Care
  - If patient is boarding in the ED:
    place new **Request for Admit** and **Admit to Inpatient** orders – they must agree on the level of care (Do not place a Transfer order)
  - If patient is in Ward/ICU:
    place a **Transfer Inpatient Service/Level of Care** order
  - If patient is in Observation, review workflow for change from Observation to Inpatient
- Telemetry indication and duration is required!
  - Place the **Telemetry Monitoring/Level of Care order**; include the indication class and duration of tele

- **[ ] Transfer order**
- **[ ] Transfer order reconciliation (clean up order sets, reconcile orders)**
- **[ ] IVF NS bolus**

Day 2

- [X] Get Sign-out from night float
- [X] Review interval results, notes, MAR summary
- [X] Round on patients, make assessment and plan
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- [X] Transfer order reconciliation (clean up order sets, reconcile orders)
- [X] IVF NS bolus
- **[ ] Assess for and order restraints**
- [ ] Required Provider Note Details
- [ ] Start Progress Note

Restraints

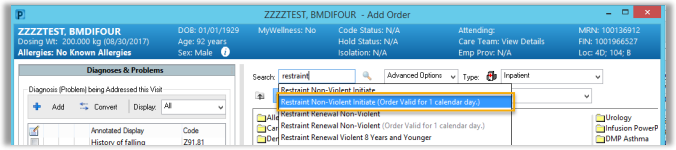
- Provider must perform and record a face-to-face evaluation using ad hoc form for initiation and renewal of restraints
  - One "Initiate" order to start restraints
  - "Renewal" orders to continue restraints

Restraint Type	Violent Restraints	Non-Violent Restraints & Seclusion
"Face to Face" evaluation must be performed	**Within 1 hour** of initiation.	**Within 24 hours** of initiation and at least every 24 hours prior to renewal
Order valid for	**4 hours** for adults (18 yrs. and older)	**1 calendar day**

- Nurse Communication order to discontinue restraints

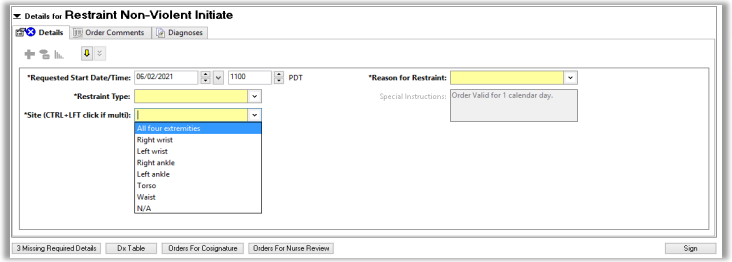
Ordering Non-Violent Restraints

1. Open Orders >> Search for 'Restraint' >> Select "**Restraint Non-Violent Initiate**"



NOTE: Initiate orders are required for all new restraint orders. This order triggers documentation tasks to both the Nurse and Nursing Attendant.

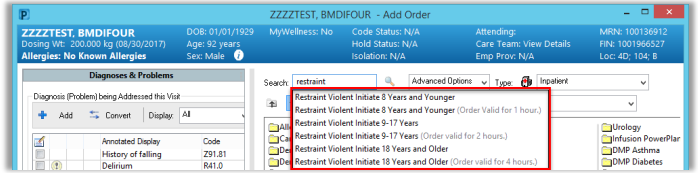
2. Complete the required details, select **Sign** to submit



TIP: You can select multiple restraint "Site" options while ordering Non-Violent restraints simply by holding the "CTRL" keyboard button while selecting multiple options (Left wrist and Right wrist)

Ordering Violent Restraints

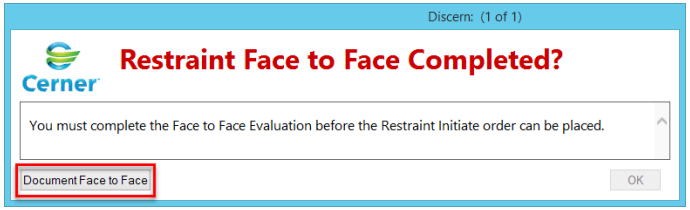
1. Open Orders >> Search for 'Restraint' >> Select the age appropriate "**Restraint Violent Initiate**" orderable



NOTE: Initiate orders are required for all new restraint orders. This order triggers documentation tasks to both the Nurse and Nursing Attendant. There are three orderable available based on age:

- 8 Years and Younger
- 9-17 Years
- 18 Years and Older

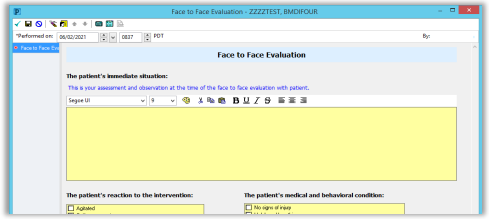
2. The following alert will fire >> select **Document Face to Face** before continuing



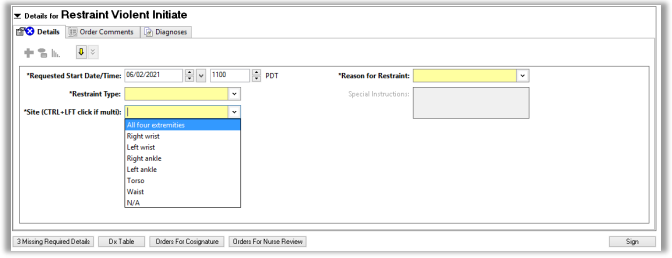
Ordering Violent Restraints *(continued)*

3. Complete the required details on the Powerform

Once complete select the green check mar ✓ to sign the documentation and return to the order entry window.



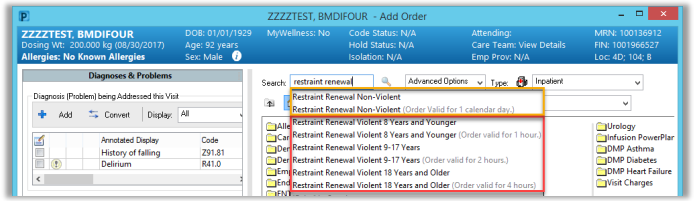
4. Complete the required details, select **Sign** to submit



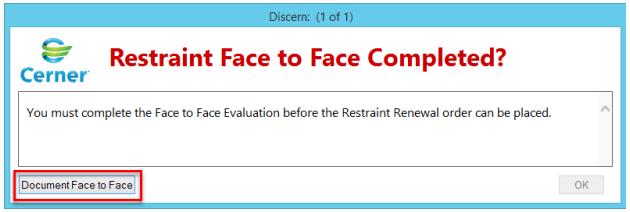
TIP: You can select multiple restraint "Site" options while ordering Non-Violent restraints simply by holding the "CTRL" keyboard button while selecting multiple options (Left wrist and Right wrist)

Renewing Non-Violent & Violent Restraints

1. Open Orders >> Search 'Restraint Renewal' >> Select the appropriate Non-Violent or Violent "**Restraint Renewal**" orderable



2. The following alert will fire >> select **Document Face to Face** before continuing

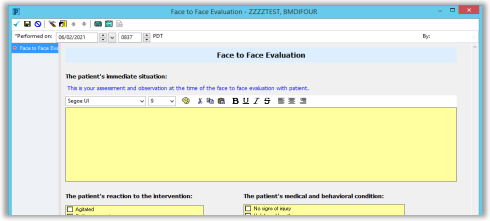


NOTE: A Restraint Alert prompt will begin to alert providers for Non-Violent restraints for the need for a renewal order 20 hours after the initial restraint order is placed, upon opening the chart, and again 20 hours after the renewal order.

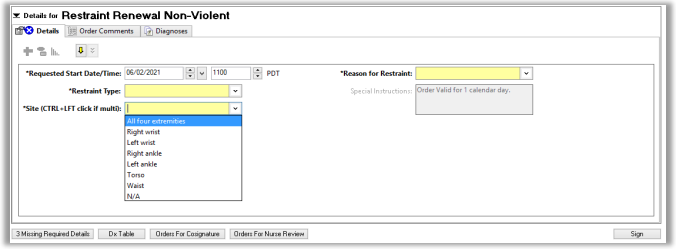
Renewing Non-Violent & Violent Restraints *(continued)*

3. Complete the required details on the Powerform

Once complete select the green check mar ✓ to sign the documentation and return to the order entry window.



4. Complete the required details, select Sign to submit



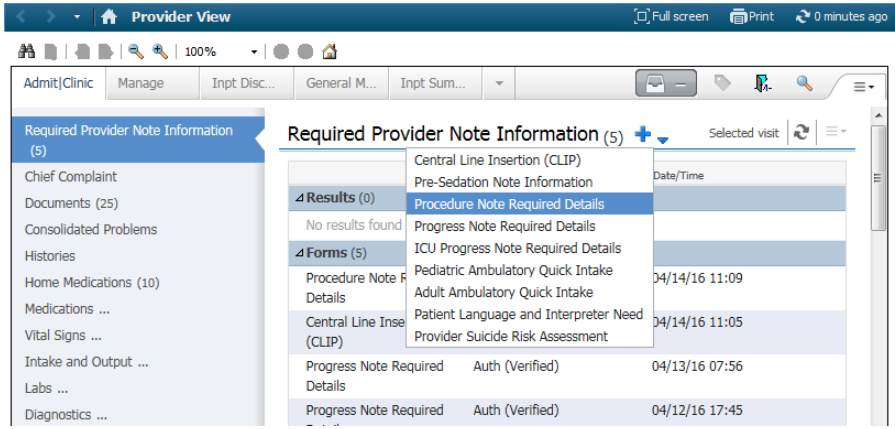
TIP: You can select multiple restraint "Site" options while ordering Non-Violent restraints simply by holding the "CTRL" keyboard button while selecting multiple options (Left wrist and Right wrist)

Day 2

- [X] Get Sign-out from night float
- [X] Review interval results, notes, MAR summary
- [X] Round on patients, make assessment and plan
- > **You notice that the patient is more hypotensive today and blood cultures are positive for gram-positive cocci in chains, so you decide with your resident to upgrade from Tele to Step-down Unit. Patient also became delirious pulling at IVs**
- [X] Transfer order
- [X] Transfer order reconciliation (clean up order sets, reconcile orders)
- [X] IVF NS bolus
- [X] Assess for and order restraints
- **[ ] Required Provider Note Details**
- **[ ] Start Progress Note**
- **[ ] IPASS Signout**

Required Provider Note Information:
Every Day, Every Patient in the Hospital

- Progress Note Required Details
- Adult ICU Progress Note Required Details
- Procedure Note Required Details



- **[ ] Required Provider Note Details**
- **[ ] Start Progress Note**
- **[ ] IPASS Signout**

Day 3

- **Patient is now s/p debridement by podiatry, culture data showing Strep, and signs of infection have improved. Cardiology performed angiogram but found non-obstructive CAD; no stent was placed. Heart rhythm shows persistent Afib but HR now controlled on metoprolol. Cardiology recommends watching patient on monitor for at least one additional night since a new stent was placed. You are planning for discharge. You will need to ensure patient is on aspirin and warfarin.**
- [ ] Check insurance status
- [ ] Check for PCP
- [ ] Verify pt's preferred pharmacy and Rx needs

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- [X] Check for PCP
- [X] Verify pt's preferred pharmacy and Rx needs

Day 3, discharging home!

- **Patient has no PCP and has restricted Medi-Cal. He is okay to follow-up at OV with CCC and Cardiology**

- **[ ] Referrals via message center to Coumadin Clinic for follow-up**
- **[ ] Referral to CCC**
- **[ ] Update Consolidated Problems**
- [ ] Discharge workflow:
  - [ ] Discharge med rec
  - [ ] Discharge instructions + Patient Education
  - [ ] Follow-up
  - [ ] View Discharge Instructions
  - [ ] Discharge Orders
- [ ] Discharge summary

Message Center

- Check your Message Center at least once daily
  - Co-sign: notes, therapy plans, proposed medications
  - Messages
  - Results
  - Saved Documents = unsigned notes
    - Open to continue working on the note
    - Unsigned notes become delinquencies

- All communication through the EHR is part of the patient's chart

- Add these contacts to favorites:
  - **OVM Coumadin ED/UCC Urgent Follow up**
  - **OVM CCC PDC Urgent Request**

Day 3, discharging home!

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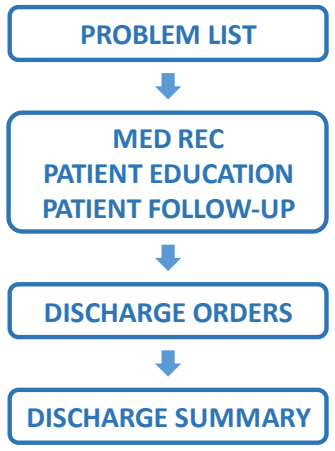
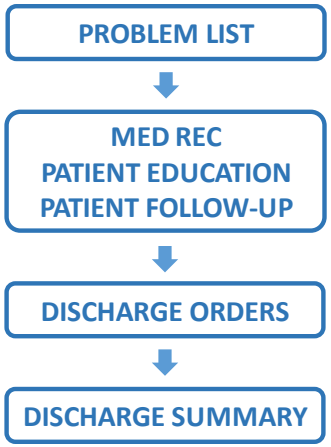
Inpatient Discharge Workflow

- **Preparation**
  - Discharge planning with medical team and interdisciplinary team (e.g. needed labs, studies, appointments, supplies)
  - Determine which pharmacy to send prescriptions
  - Propose medications to licensed resident or attending
- **Required Components (4)**
  - Use the Inpt Discharge tab
  - 1. Problem List
  - 2. Medication Reconciliation
  - 3. Patient Education
  - 4. Follow-up
  - All of this information will be printed out for the patient
- **Discharge Orders (the last step)**
  - If you need to modify any information, inform the nurse directly!



Inpatient Discharge Workflow: Tips

- **Problem List**
  - Do this before placing outpt/future orders
- **Medication Reconciliation**
  - Always perform the Med Rec after proposed meds have been co-signed. Med Rec can be always be repeated
- **Patient Education**
  - Choose at least one "suggested" handouts to meet Meaningful Use
- **Patient Follow-up**
  - Enter "Follow-up as scheduled" as free text and make it a favorite
- **Discharge Orders (the last step)**
  - If you need to modify any information, inform the patient/nurse directly!



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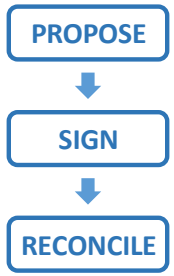
Medications: Discharge: New Prescriptions

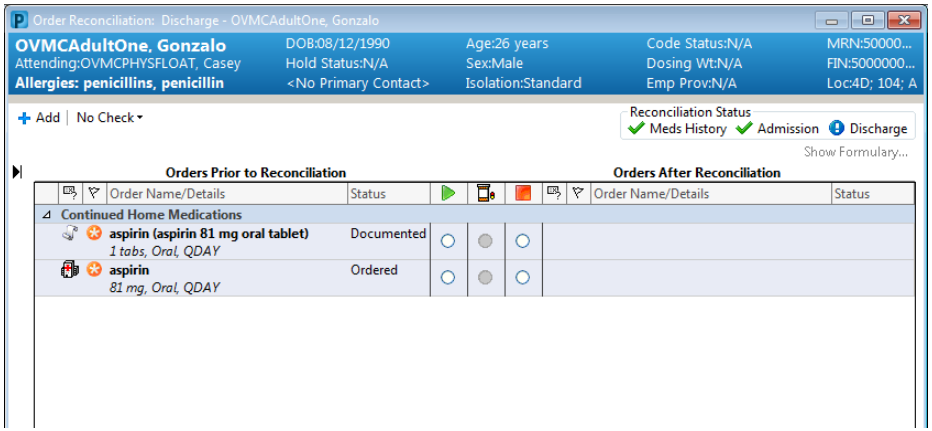
1. Know what prescriptions are needed
2. Determine and select a pharmacy
3. **If unlicensed:**
   1. Propose the prescription and send to licensed provider
   2. Notify and wait for licensed provider to sign prescription
   3. Complete the Discharge Medication Reconciliation
4. **If licensed:**
   - Perform Discharge Medication Reconciliation and use this create new prescriptions



- Unsigned Proposed Medications do not appear on the Med Rec

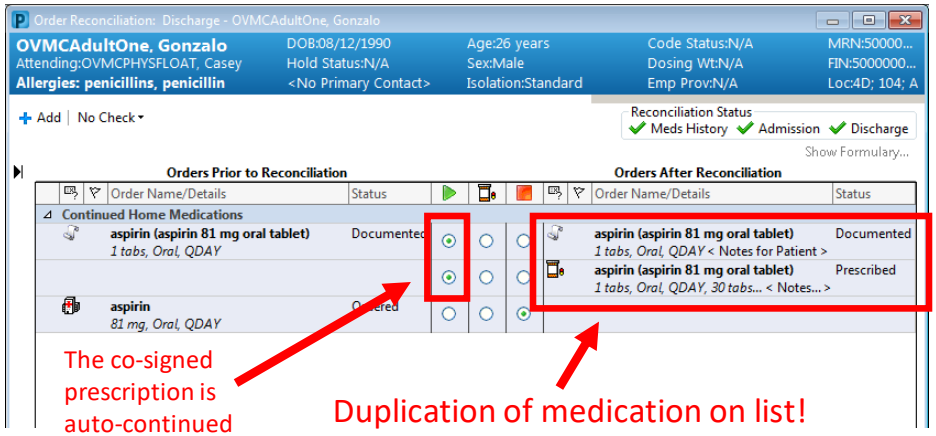
Medications: Discharge

Unsigned Proposed Meds do not appear on Med Rec – Prone to error!



Medications: Discharge

Proposed Meds signed after Med Rec – Prone to error!



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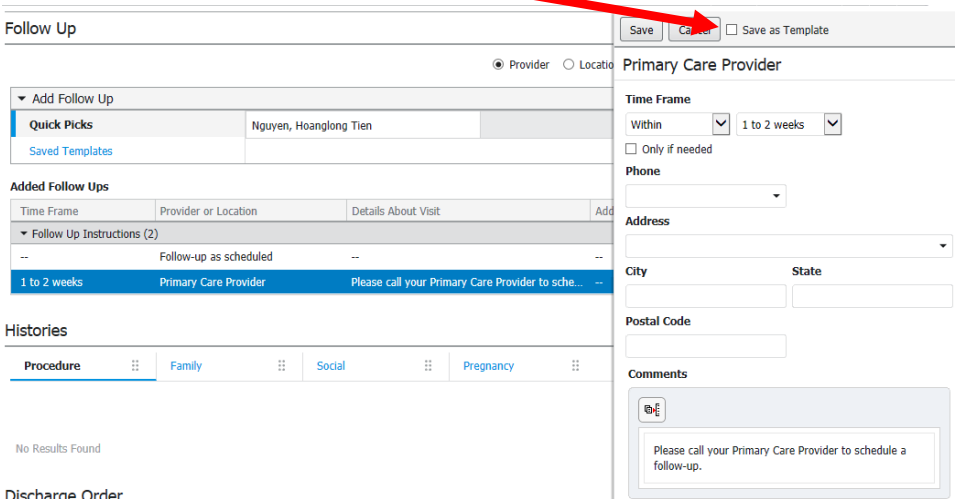
Inpatient Discharge Workflow: Tips

- **Patient Follow-up**
  - Enter "Follow-up as scheduled" as free text and make it a favorite
  - Modify existing -> Save as template



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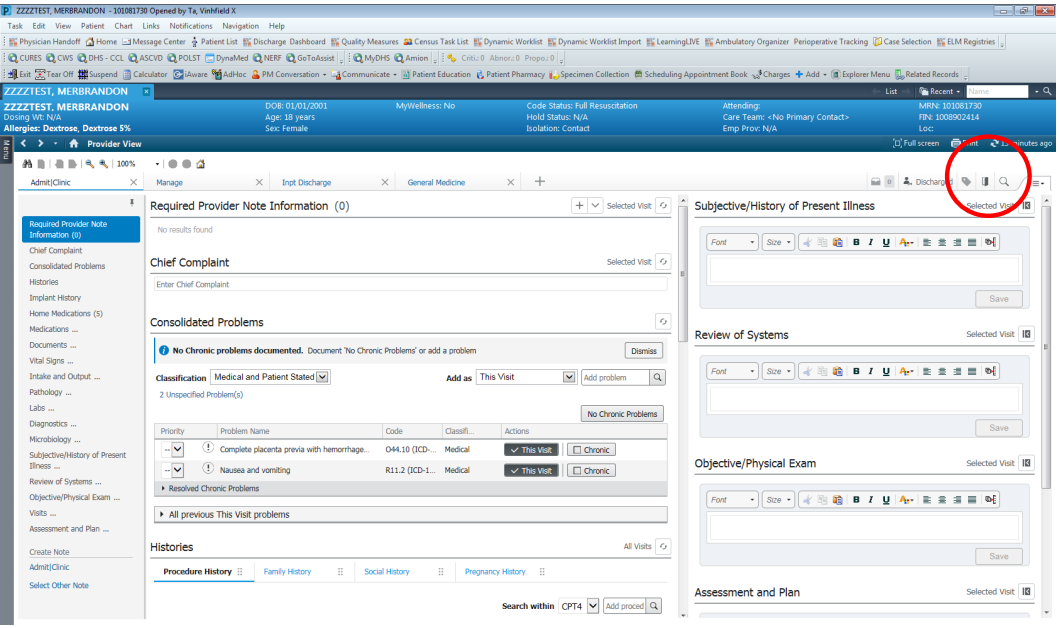
Patient Discharge Instructions:
Review the Instructions



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