Northern Light Health

From the Office of Clinical Informatics

Annotations and Patient Info & Story MPage

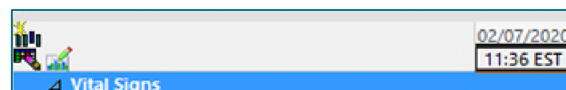
February 10, 2020

The use of Annotations is a current functionality for the ED and Inpatient Nursing areas in iView to allow the nurse to narrate. This helps to pull iView documentation together to tell the patient story and be able to document something that is not available as a discrete field. Annotations are part of the Cerner model content that supports the correct flow of information to the Patient Info & Story MPage. Providers, RT, PT, OT and Speech Therapy, Dietary, and Care Managers have access to the Patient Info & Story MPage to view the flagged annotations.

Documenting an Annotation

- Annotations are not a replacement of the free text nursing note that was in the Adhoc folders.
- Documentation that has occurred in iView should not be repeated in Annotations. Double documentation should not be occurring.
- If there is a place to document in iView, it needs to be completed in that field.
- Be sure to check **Customize View** to ensure that documentation opportunities in iView truly don't exist.
  - Some items are not in view due to low usage and can be brought in view using **Customize View**.
- Appropriate use of iView and Annotations will ensure that Clairvia is providing a more accurate patient acuity level.

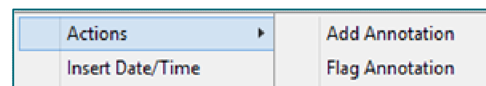
STEP 1: Click in the time field at the top of the iView column. A thick black border will appear around the time.



STEP 2: Right-click and select **Actions**.

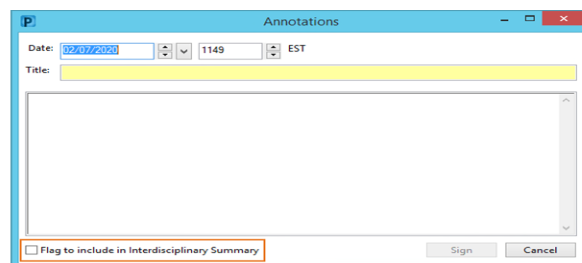
- Options for **Flag Annotation** and **Add Annotation** are available.

STEP 3: Select **Flag Annotation**. This annotation will automatically flow to the **Patient Info & Story MPage**.



NOTE: If Add Annotation is selected, this will not automatically flow to the Patient Info & Story MPage.

- If **Add Annotation** was selected and it was decided that the documentation should flow to the Patient Info & Story MPage, click the box at the bottom next to **Flag to include in Interdisciplinary Summary**.



STEP 4: The date and time can be changed to reflect the real time of the event that is being annotated.

STEP 5: Enter a **Title** for the Annotation. E.g. Cardiac Arrythmias.

STEP 6: In the free text box, document the details of the annotation.

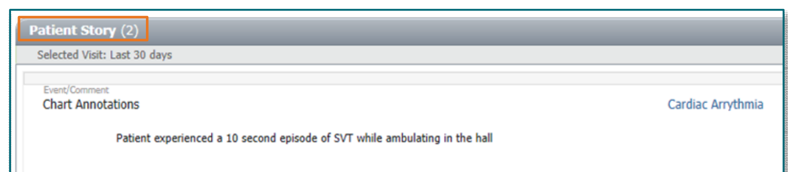
NOTE: **The last character will drop off when the annotation goes to the Patient Info & Story MPage. It is recommended that all annotations are ended with a period. The period would then drop off instead of the final letter of the last word. This is a known issue and currently, Cerner does not have a fix for this.**

STEP 7: Click **Sign**.

Flagged Narratives Examples	
Examples of what to flag	Examples of what NOT to flag
Any events leading up to a code situation	Any documentation that mimics/duplicates other nursing documentation
Behaviors/issues leading up to the use of restraints	Adjusting pillow or other patient comfort items/actions
Safety-related items that cannot be documented discretely within iView (e.g. falls, violent behavior, history of violence, etc.)	Last bowel movement (already documented elsewhere)
"No News" patients – only visitors with a password are permitted.	Medication refusals (should be documented on the MAR)
Involvement of Adult Protective Services and/or DHHS	
Rationale for private room	
Rationale for 1:1 nursing/observation	
If having to do more frequent dressing changes due to drainage or extenuating circumstances	
Any abnormal family dynamics that may impact patient care	
Any abnormal or borderline results; any results that could indicate a trend	

Patient Info and Story MPage

- **Flagged Annotations** will populate in the **Patient Info & Story MPage.**
- The **Patient Story header** will reflect how many annotations are present on the patient's chart.
- **Ten** annotations will display before a scroll bar appears.

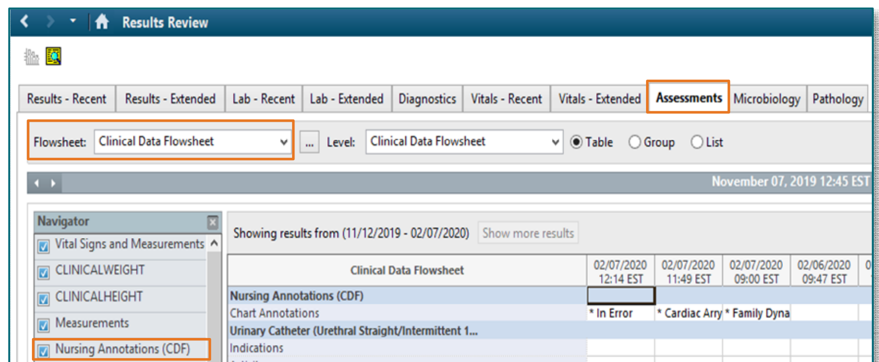


- **Annotations** for the last 30 days can be seen in this MPage.
- **Annotations** are part of the permanent medical record.

- The **Options** menu allows the user to determine whether to abbreviate annotations or to show full annotations.
  - Abbreviated annotations can easily be read by hovering.

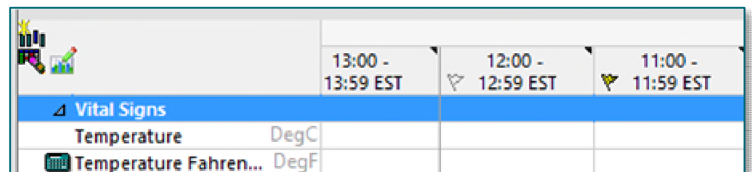
Where else are Annotations located?

- Results Review



  - **All Annotations,** flagged or unflagged, will flow to Results Review in the Clinical Data Flowsheet.
  - Click **Assessments** or **Nursing Data** (seen by some positions) and locate **Nursing Annotations** in the Navigator.
  - To view the annotation, double-click the starred annotation. In the box that pops up, click **Comments** to see the annotation documentation.

- iView



  - A black carat will display in the upper-right corner of the time box when an annotation has been documented that has not been flagged.
  - A flagged annotation will have the black carat in the upper-right corner and a flag located to the left of the time.
  - An "uncharted" flagged annotation would have a colorless flag.
  - To see **Flagged Annotations**, check the **Flag** filter box. Hovering over the highlighted annotation will display the documentation.