Northern Light Health

From the Office of Clinical Informatics

Quick Reference Guide (QRG)
Creating Dynamic Documentation

September 11, 2019

This Quick Reference Guide (QRG) outlines the process for Creating Dynamic Documentation.

Common Buttons & Icons

	Notebook icon
Tag	**Tag** icon
	Use Free text icon
	Note Component Refresh icon
	Addendum icon

Document a Note

➢ **From the Provider View in the patient's chart:**

STEP 1: Verify the encounter in the Banner bar for location of care and date of service.

STEP 2: Document and review each component as appropriate for your patient, from top to bottom.

NOTE: **Navigation between components where you want to make a note can be done by scrolling or clicking the component name from the side menu.**

STEP 3: Click the free-text field for a component. Then enter your note.

STEP 4: Click **Save**.

Customize the Provider View layout

➢ **From the Provider View in the patient's chart:**

STEP 1: Click the **Magnification** drop-down arrow. Then select the appropriate magnification rate.

NOTE: **The layout of Provider View may differ based on the size of the screen you are using, such as a laptop. Zooming out allows you to see multiple sections at a time as well as the ability to view the two-column format.**

STEP 2: To move components to a two-column format, click the **Notebook** icon to the right of the component header.

STEP 3: Close the two-column view by clicking the **Notebook** icon again for each component in the new column.

Document for all This Visit diagnoses simultaneously

➢ **From the Provider View in the patient's chart:**

STEP 1: Click **Assessment and Plan** from the Ambulatory workflow menu.

STEP 2: Enter general information for all diagnoses as needed in the blank free-text field at the bottom of the component.

STEP 3: Click **Save**.

Tag Items for Quick Documentation

Tag an individual item:

➢ **From the Provider View in the patient's chart:**

STEP 1: Navigate to the text you want to tag.

STEP 2: Highlight the text by clicking and dragging with your mouse.

- Once text is highlighted the **Tag** icon appears.
- For Lab results, simply click a cell to highlight the entire result.

STEP 3: Click the **Tag** icon.

STEP 4: Click the **Tagged Items** bin to review or to use the tagged information in a patient note as needed.

- Tag as many items as needed and they will be ready for you as needed for quick documentation.

NOTE: Tagging does not work for microbiology reports, scanned documents, and repeat vital signs. Initial vital signs will automatically populate into your note template.

Tag multiple items at one time:

➢ **From the Provider View in the patient's chart:**

STEP 1: Navigate to the first item you want to tag.

STEP 2: Highlight the information by click and drag of the mouse.

STEP 3: Navigate to the next item you want to tag. Then, press the Ctrl key.

STEP 4: While holding down the Ctrl key, click and drag the mouse over the next set of information you want to tag.

STEP 5: Continue to do that until all information is tagged as needed.

Insert tagged information into a note:

➢ **From the Provider View in the patient's chart:**

STEP 1: Click the free-text field for the appropriate component.

STEP 2: Click the Tagged Items bin to open it.

STEP 3: Click and drag the tagged item to the appropriate component free-text note field.

STEP 4: Click Save.

NOTE: **Footnotes appear as an author reference in your final note. If the note is edited in any way it is no longer considered an original and the footnote disappears.**

STEP 5: Click the **Tagged Items** bin to close it.

Using Auto Text

- **From the Provider View in the patient's chart:**

STEP 1: Click the free-text field for the appropriate component.

NOTE: **All system-level auto text starts with a forward slash followed by the topic. For example, auto text for a review of systems template, may be "/roscomplete."**

STEP 2: Type a /, followed bythe name of the auto text.

STEP 3: Double-click the appropriate option to select it.

STEP 4: Mark pertinent positives by of the following:

- Highlight the text and pressing backspace.
- Click the drop-down arrow, then click yes or no.
- Click and type the additional text.

STEP 5: Delete system information by highlighting the information and clicking the backspace button as needed.

STEP 6: Click Save.

Document with Quick Visit

- **From the Provider View in the patient's chart:**

STEP 1: Quick Visits are not appropriate for documenting every patient visit, but for ones that are routine in nature. With common standard care practices.

STEP 2: Click the **Quick Visit** component from the Ambulatory View workflow menu.

NOTE: **For Acute visits where the MA has proposed a quick visit you can accept or dismiss the visit from this component.**

STEP 3: Click Primary Care, Personal, or All filters or type a quick visit option into the Search field and press [Enter]. Then click the appropriate option.

STEP 4: Click the This Visit drop-down arrow.

STEP 5: Click the appropriate This Visit problem radio button.

STEP 6: Scroll down to the other sections of the current visit column. Fill in information as appropriate.

NOTE: You can use auto text to populate notes in various components as needed.

STEP 7: Click Submit to commit the changes to the patient's chart.

STEP 8: Sign the order in the Orders for Signature window.

STEP 9: Review documentation in the right-hand column.

Create and Manage the Office Visit Note

Create the Initial Note

- **From the Provider View in the patient's chart:**

STEP 1: Click **Office Visit Note** in the Ambulatory workflow menu.

- The note template populates with all documentation from the patient's Provider View workflow.

IMPORTANT: Only use the Office Visit from the Ambulatory workflow menu one time per visit. Any edits should be made to the original document.

STEP 2: Click, drag, and drop any tagged item into the appropriate section of the note.

NOTE: Footnotes will appear that credits the original text unless text is edited.

STEP 3: Edit the note as you would any Word document.

- Use free text, speech recognition, or auto-text to edit the note.
- To free text, first you must click the free text icon.

STEP 4: Hover over a component to reveal refresh and free text options.

STEP 5: Click the component Refresh icon in the note to pull in information charted since the note was started, as appropriate.

STEP 6: Note your refresh intent, then click Refresh.

NOTE: Select the Remember my selection checkbox to keep the box from populating each time you refresh.

STEP 7: Document the note using the following options:

- **Sign/Submit** – To sign and submit the note to the patient chart.
- **Save** - To save the information but not close the note.
- **Save & Close** – To save the information to the patient's chart and close the note.
- **Cancel** – Closes the note and any changes since the last save will be lost.

STEP 8: Document information in the Save Note window as appropriate using the drop-down arrows and **Calendar** icons.

NOTE: **You can re-title your Office Visit Note to be more specific by clicking the field and typing in the title you want to use and then pressing [Enter].**

STEP 9: Click **OK**.

STEP 10: Click the **Provider View Refresh** icon.

Review and Modify

- **From the Provider View in the patient's chart:**

STEP 1: Click Documents from the Ambulatory workflow menu. Your note will be listed under the "In Progress" section.

STEP 2: Click the needed note once to open in a preview pane.

STEP 3: Click Modify to make changes.

STEP 4: Complete the note, make any needed changes.

STEP 5: Review for accuracy.

STEP 6: Click Sign/Submit.

NOTE: **Once the note has been signed it cannot be modified. You must create an addendum.**

STEP 7: Click **Sign**.

Finalize with Co-Signature (CC)

- **From the Provider View in the patient's chart:**

STEP 1: Click Documents from the Ambulatory workflow menu. Your note will be listed under the "In Progress" section.

STEP 2: Click the needed note once to open in a preview pane.

STEP 3: Click Modify.

STEP 4: Complete the note, make any needed changes.

STEP 5: Review for accuracy.

STEP 6: Click Sign/Submit.

NOTE: **Once the note has been signed it cannot be modified. You must create an addendum.**

STEP 7: Click the **Provider Search** field in the **Sign/Submit** Note window.

- Use the **Favorites**, **Recent**, and **Relationship** filter to narrow down your search.
- Click the filter you want to use as needed.

STEP 8: Type in the name of the provider you need for co-signature using the last name, first name format.

- Create a favorite contact provider for this search by clicking the star icon next to the provider's name in the Recipients list.

STEP 9: Click the needed provider from the list that populates.

- If a recipient is incorrectly listed hover over the name until an **X** icon appears. Then click the **X** to delete the recipient.
- To add a recipient outside the Northern Light Health System, select **the Create Provider Letter** check box. This allows you to send an accompanying message to the outside provider.

STEP 10: Review the **Sign/Submit** Note information for accuracy.

NOTE: The date listed should always be reflective of the date the patient was seen.

STEP 11: Click **Sign**.

Modify after Signature

➢ **From the Provider View in the patient's chart:**

STEP 1: Click Documents from the Ambulatory workflow menu. Your note will be listed under the "In Progress" section.

STEP 2: Click the needed note once to open in a preview pane.

STEP 3: Click Modify.

NOTE: Once a note is signed the only way to modify it is to use an addendum.

STEP 4: Click the Addendum text box.

STEP 5: Add the needed information.

STEP 6: Click Sign.

STEP 7: Click the Documents Refresh icon.

NOTE: A blue triangle, or Addendum icon next to a document indicates there is an addendum.

Document a Note as In Error

➢ **From the Provider View in the patient's chart:**

STEP 1: Click Documents from the Ambulatory workflow menu. Your note will be listed under the "In Progress" section.

STEP 2: Click the note that is in error.

STEP 3: Click View Document.

STEP 4: Click the Red X icon.

STEP 5: Document the In Error Comments. Then press [Enter].

STEP 6: Click OK.

STEP 7: Click the X Close icon.

STEP 8: Click the Documents Refresh icon.

NOTE: Notes marked In Error are still in the patient's chart under the Documents header.