This Quick Reference Guide (QRG) reviews the Acute Medical Specialist workflow.

Review the Medical Specialist Workflow

Here is an overview of the main screens you will use in the patient chart. When you log in you will be in the Provider View.

➢ **Inpatient Surgery 2018 or other speciality page** – Workflow where documentation and chart review should occur. Allows for documentation of Admission H&P, Progress Note, and Consult Notes. This page can be rearranged/customized to reflect your daily workflow.

➢ **Inpatient Quick Orders** – Provides a quick selection of inpatient-focused orders. Here is where you will perform most of your order entry.

➢ **Discharge** – Where you complete the discharge order, and discharge preparation and documentation. All items with a red asterisk must be completed.

➢ **MPages View** – The Calculator tool within the Specialties option can help with using different scales and assessments.

➢ **Patient Info & Story** – Find flagged chart data entered by the clinician with some basic background information.

➢ **Patient Timeline** – Allows for visualization of labs, lines, vents, meds, and vitals in a timeline view.

Complete the Admission Workflow

You will use one financial nmber throughout the visit. This includes visits at Critical Access Hospitals. See your hospital-specific policy for when the same encounter can be used and when a new encounter must be created. Always ensure that you are on the appropriate encounter and the encounter is in an inpatient status before placing orders.

Orders should not be placed while the financial number is registered to the Emergency Department.

STEP 1: Confirm the patient registration is moved to EDIP (ED Inpatient Virtual Unit – Inpatient Status)

STEP 2: Add the patient to your custom patient list or proxy patient list.

NOTE: Ensure you have the correct encounter.

STEP 3: Click the patient's name to access their chart.

STEP 4: Establish your relationship to the patient.

STEP 5: Complete admission med rec from the Home Medications component.

STEP 6: Place the admission PowerPlan and any additional PowerPlans and orders as appropriate. (Please note, not all plans are available at all sites.)

NOTE: For some roles the Quick Orders tab will automatically show ambulatory or inpatient orders depending on the encounter type. For other roles, you may have a separate Inpatient and Ambulatory Quick Orders tabs.

NOTE: You can also use the New Order Entry component to search for commonly used PowerPlans and orders.

STEP 7: Complete the Admission H&P.

STEP 8: Create the note from the Workflow page, making sure you are on the correct inpatient FIN.

Consultation Workflow

STEP 1: Add the patient to your custom patient list or proxy patient list confirming, you are on the correct encounter.

STEP 2: Establish your relationship to the patient.

STEP 3: Place any necessary PowerPlans and orders using the correct FIN from the Inpatient Quick Orders page.

STEP 4: Use Dynamic Documentation to create your Consult Note from the Workflow page.

Complete Daily Rounds

STEP 1: Review and update your patient list for the day's patients.

STEP 2: Review the Provider Handoff.

NOTE: You can print the Provider Handoff, if desired.

STEP 3: Click the arrow next to the patient's name to quickly review IPASS, Clinical Data, and Care Team information from the Physician Handoff workflow.

NOTE: You can also access this information by clicking the severity rating in the patient's chart.

STEP 4: Document IPass information.

STEP 5: Review Patient Info & Story for flagged nursing annotations and results of interest.

STEP 6: Review documentation from the previous day and shift.

STEP 7: Provide direct patient care.

STEP 8: Update the Physician Handoff IPASS tab with any changes when direct patient care is complete.

STEP 9: Use Quick Orders to add, modify, and discontinue orders as needed.

STEP 10: Write your daily progress or consult note within your Inpatient 2018 page using auto-text, M*Modal, or tagging.

NOTE: Only select Create Note once per patient per day to avoid creating duplicate notes.

STEP 11: Sign the note.

Transfer Level of Care

➢ From the Inpatient 2018 tab:

STEP 1: Confirm whether the patient should keep the existing FIN or will be assigned a new one.

NOTE: If a new FIN is required, follow the Discharge and Re-admit workflows. Transfer Level of Care is only used when keeping the same FIN.

STEP 2:   Place the Transfer Level of Care order.

STEP 3:   Perform transfer medication reconciliation.

STEP 4:   Enter new orders as needed.

STEP 5:   Modify the Admission order to update the patient type and placement.

STEP 6:   Document changes in a progress note.

STEP 7:   Place the Transfer Order Complete order to indicate your provider processes are complete.

Discharge Workflow

➢ From the Discharge page in the patient's chart:

STEP 1:   Complete med rec and ePrescribing in the Home Medications component.

STEP 2:   Review the Problem List component to add and prioritize This Visit diagnoses.

NOTE: Use the Diagnosis Assistant for a more specific diagnosis when possible.

STEP 3:   Add the Discharge Order from the Order Profile component.

STEP 4:   Complete the Discharge Quality Measures PowerForm.

STEP 5:   Fill in the Dynamic Documentation components for the following:
- HPI
- Discharge Physical Exam
- Hospital Course
- Patient Instructions
- Follow Up Recommendations

STEP 6:   Create and sign your note.

NOTE: Use Discharge Summary note which will automatically CC to the patient's primary provider.

STEP 7:   Add additional recipients to review or cosign the note, if appropriate.

STEP 8:   Once the patient is discharged, remove the patient from your custom or proxy list for your provider group.