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About the PowerChart Office Course

Using This Reference Guide

This training guide was designed to help new users learn how to use PowerChart Office. The information in this guide was designed to support hands-on learning.

We have included pictures of various system screens to familiarize you with how the PowerChart Office application functions and how the look and patient information is displayed. These are only a small sample of the screens you will use. As you move through the manual you may see information repeated more than once. This is intended to assist you in selecting the proper method for the task you are performing.

IMPORTANT NOTE

There are many data tabs throughout PowerChart Office. Depending on your job role in the department, only the tabs that pertain to your role will be viewable with your sign-on. To get to the selected list, click once on the tab name.

Course Length

This class is designed for 4 hours.

Course Audience

The target audience for this course will consist of MCG, PPG, and MCGHI end users who will be using PowerChart Office in their daily routines.

Prerequisites

All participants are expected to be competent in the following skill areas:

- Computer basics
- Microsoft Windows
Information Security and Confidentiality

When dealing with computerized health care records, specific confidentiality and security issues must be followed to protect the patient. Also, there are a growing number of HIPAA and JCAHO regulations that dictate how these records are handled.

Please Remember:

- When selecting a password, don’t choose anything obvious, such as your birth date, social security number, or spouse and children’s names.
- Do not tell anyone your password.
- Your system may require you to change your password at regular intervals and each password may not be used more than once.
- When you open a chart you will be asked to identify your relationship to the patient. (For example primary RN, attending physician, etc.).
- The system keeps an audit trail, or record, of who enters each chart and at what time. It records who read the chart and who recorded each piece of information in the chart.
- Not everyone will be able to see or perform every activity on the CIS system. For example, a lab technician will be able to see and do more in the lab application than a nurse will.
- Do not leave the computer while still signed on; always log off the system
- Do not access any patient charts that do not apply to your current job and caseload.

MCGHI has its own specific confidentiality and information security policies. These policies describe the repercussions of not following these rules. Please review MCGHI hospital’s policy and procedure manual for information regarding patient confidentiality and information security requirements.
Learning Objectives

At the end of the training session, class participants will be able to perform the following tasks (This training is role based. Users will only learn modules related to their job role):

- Logon to PowerChart Office
- Basic System Navigation
- Create a Patient List
- Locate a Patient
- Patient’s chart
  - View
  - Encounter Summary
  - Workflow Process
  - Allergies
  - Problems
  - Immunizations
  - Medications
- View Results
- Use the Schedule Viewer
- Use the Appointment Book
- Use the Inbox
  - Phone Messages
  - Sent Messages
  - Browser Icon
  - Trash
  - Assign Inbox Proxy
  - Sign & Review
  - Orders to Approve
  - Results to Endorse
- Easy Script
  - View
  - Prescribe
Terms To Know

The following terms will be used frequently in this manual and in the class training sessions.

- **Click** – To tap on a mouse button, pressing it down and then immediately releasing it. The phrase to click on means to select (a screen object) by moving the mouse pointer to the objects position and clicking the left mouse button.

- **COW** – Computer On Wheels

- **Cursor** – The flashing marker that tells you where you are on the screen

- **Default** – Preset information in the system that automatically appears

- **Double click** – Clicking a mouse button twice in rapid succession. The second click must immediately follow the first; otherwise the program will interpret them as two separate clicks rather than one double-click.

- **Dithered** – Icon or menu item that is gray in color, which indicates that it is not available for use or select.

- **Encounter** – A single patient visit or episode of care. The following are examples of encounters:
  
  - Patient registered as an inpatient
  - Patient registered as an outpatient

- **Left click** – To click the left mouse button. When instructions call for a screen object to be “clicked” a left-click is inferred.

- **Maximize** – Located on the menu bar or title bar of the active window. It is used to maximize the window so that it takes up the entire desktop.

- **Menu** – Displays a list of commands. Some of the commands have images next to them so you can quickly associate the command with the image. Menus are located on the menu bar at the top of the PowerChart Office window.

- **Minimize** – Located on the menu bar or title bar of the active window. It is used to minimize the window so that it appears only on the Windows taskbar.

- **Mouse** – A device used to move the cursor around on the screen

- **PC** – A personal computer that is also referred to as a “Desktop”.

- **Right click** – To click the right mouse button. A right-click opens a drop-down menu with a list of options.
• **Scrollbar** – Located on the right and bottom of some screens and is used to adjust the view on screen.

• **Shortcut Menu** – Available when you right-click text, objects, or other items.

• **Title bar** – Located at the top of each window and is used to identify that window.

• **Toolbar** – A toolbar can contain buttons with images (the same images you see next to corresponding menu commands), menus, or a combination of both.
PowerChart Office Overview

PowerChart Office is the application used to access a patient’s Electronic Medical Record (EMR) in a clinical based setting. Your job role will determine your level of access to PowerChart Office. You will use PowerChart Office to view schedules, view results, access the inbox, view, enter profile items (allergies, problems, immunizations, and medications), and etc.

PowerChart Office has two main areas; The Schedule Viewer and The Inbox.

The Schedule Viewer

- The Schedule Viewer is an electronic schedule that displays scheduled patients and appointment times.

The Inbox

- The Inbox is a secure messaging system that allows users to communicate patient related information.

Log on to PowerChart Office

In this scenario you will:

- Log into PowerChart Office

1. Click the Citrix Link on the MCGHI homepage.
2. Click the Power Chart Office Icon.

3. The Cerner logon window displays

![Cerner Millennium Logon Window]

4. In the User Name field, enter your **unique** username.

   **Note:** When you log-on into PowerChart Office for the first time, your password will be the same as your User Name. You must change your password during the first log-on session.

5. In the **Password** field, enter your password (The password is case sensitive).

6. Click on the OK button. PowerChart Office will open to the (General) Schedule/Inbox default screen view.

   **Deleted:** assigned

   **Deleted:** to
Announcement Window Overview

1. The announcement window will appear every time you login unless you check the “Don’t show again until new information has been posted” box.

2. This window will appear every time a new message is posted.

Demographics Banner

The demographics banner contains basic patient information, which includes the MRN, DOB, age, sex, visit encounters, telephone numbers (home and work), aliases, and relationships. The demographics banner can be viewed in a contracted or expanded manner (Expanded manner shown below) by clicking the contract/expand button.
Customizing the Patient Demographics Banner

Note: Cerner provides a standard configuration for the Patient Demographics Banner and recommends that you do not change it.

The standard Demographic Banner setup is what all users will see. The users will not be trained to customize the Demographic Banner. However, if the Demographic Banner has been customized and need to be reset to the standard configuration, complete the following steps:

1. Select Demographics Banner Preferences from the View menu. The Person Banner Properties dialog box opens.

2. In the General group box, select the number of lines of information you want to be displayed from the Number of Phrases spin box.

3. Select the number of lines you want to remain visible when the Demographics Banner has been minimized from the Number of Phrases Always Visible spin box.

4. Select the background color you want by clicking the background color button and selecting a color from the Color dialog box. Click OK when you are finished. The Color dialog box closes.
5. To specify the vertical alignment of each line, highlight the line you want to change and select the alignment you want from the Alignment list in the Phrase Properties group box.

6. Click the Demographics Banner where you want to insert a field.

7. From the Data Fields group box, select the field type you want to insert. If there is more than one field available for the field type you selected, a second list is displayed.

8. Select the field you want and click Add.

9. In the Field Properties group box, select the horizontal alignment you want for the field from the Alignment list.

10. Select the text color you want by clicking the text color button and selecting a color from the Color dialog box. Click OK when you are finished. The Color dialog box closes.

11. Enter the text you want to be displayed for the field in the Caption box.

12. To change the font, click and select the font and size you want from the Font dialog box. Click OK when you are finished. The Font dialog box closes.

13. When you have added all the fields you want, click OK.
Schedule/Inbox Window Overview

- **Title Bar (Black Arrow)** – Displays the application and name of the person signed on.
- **Menu Bar (Red Arrow)** – Menu options will change as Organizer tabs are selected.
- **Toolbar (Blue Arrow)** – Icons available to use based on the Organizer tab selected.
- **Pane Toolbar (Green Arrow)** – The Pane toolbar is located at the top of both panes. This toolbar allows the user to perform functions related to the pane that it is associated with. It is organized specifically for easy access to specific functions.
Creating a Patient List - Practice Scenario

Any time during your shift, if your assignment changes, you can modify your patient list. Or, if your assignment takes you to a different floor, you can create a patient list for that location. The Patient List allows you to view all patients in a certain category, such as location, medical category, attending physician or your own custom patient list.

In this scenario, you will:

- Create a Location List
- Create a Custom List
- Add Patients to a Custom List
- Delete Patient from a Custom List
- Create a Provider Group List

Create a Patient List

1. Click the View Option on the Menu Bar and select Patient List. The Patient List window will display.
2. Click the List Maintenance icon on the tool bar. The Modify Patient Lists window will display.

3. Click New. The Patient List Type window displays

4. Select Location from the available patient list types.

5. Click Next and the Patient List dialog box displays.
6. Click the plus symbol to the left of Children’s Medical Center or MCG Medical Center.

7. Click the plus symbol to the left of MCG Medical Center. The various units and departments will be displayed.

8. Highlight the appropriate unit or department.

9. Click Next and the Filter Status and Type window will be displayed.

10. Select the Filter status and Type, then click next to

11. Select from the Available list window the new location.
12. Click the Right Arrow to move the location to the Active list.

13. Click OK

14. Then, to display the new list, click on the tab displaying the name of the unit or department you just added.
Create a Custom List

A custom list is different than a location list in that a location list is pre-defined in the system. A custom list is unique to and created by the end user.

1. From the Patient List tab, click the List Maintenance toolbar icon.
2. Click New.
3. Click Custom.
4. Click Next.
5. Enter the desired name for your custom list.
6. Click Finish.
7. Select the list in the Available lists window and click the right arrow to move the custom list to the Active list window.
8. Click OK.

Add Patients to Custom List

1. From your custom list tab, click Add Patient on the toolbar.
2. Search for a patient.
3. Select the desired patient.
4. Click OK.
5. Repeat to add the appropriate patients for whom you will be caring.

Delete Patient from Custom List

1. From your custom list tab, select the patient to be removed.
2. Click Remove Patient.
3. The patient is removed from your custom list.
Finding a Patient – Practice Scenario

If you do not find a patient listed on your PAL list or Patient List, use the Person Search feature to locate the patient. You can also use the Patient Search to obtain basic patient demographic information without accessing the chart.

In this scenario, you will:

- Locate a patient

Locate a Patient

1. Click the Find Patient icon on the toolbar to open the Person Search window.

2. Enter the patient’s last name, first name in the Name field.
   
   **Note:** If you don’t know the correct spelling of the last name, enter at least the first three letters.

3. Click Search

4. Ensure the correct patient (upper window pane) and patient encounter (lower window pane) are selected, then click OK.

   Choose encounter based on registration date.
Schedule Viewer Overview – Practice Scenario

The Schedule Viewer is an efficient and easy-to-use tool that provides daily and future access to various resource schedules and patient appointments. Patient’s charts can be opened from the Schedule Viewer by double clicking on the selected patient. In the paper world, such information is accumulated in a schedule book. Since the paper schedule book is a physical entity, only one healthcare professional can have access to the total information at a time. With the Schedule Viewer, multiple users can access schedule information at the same time.

In this scenario, you will:

- View patient appointments
- View the encounter summary
- View the work flow process

Schedule Overview

The schedule consists of the following common elements:

1. **Patient Appointments** – Includes the patient appointment data such as status, type, duration, location, and reason.
2. **Resources** – The resource can be a person, location, or thing that an appointment can be scheduled to.
3. **Schedule Preferences** – The preferences are the custom settings that a user has specified.
Viewing Patient Appointments

Viewing patient appointments from the Schedule Viewer consists of identifying a Resource Schedule and the Schedule Date.

In this scenario, you will:

- **Select a Resource Schedule**
  - Click in the Resource Field
  - Enter the Resource Name
  - Click the Search Button
  - The schedule will be displayed

- **Select the Schedule Date**
  - Click in the Date Field
  - Enter the Date OR
  - Click the arrows next to the Date Field to change the date
  - Note: The Large arrow will display the Calendar

- **Change the Schedule Preferences**
  - Click Schedule on the Menu Bar and then select Preferences or Right Click on the screen and the Click Preferences.
The Schedule – Preferences Window will be displayed
Preferences can be set for the following:
1. Default Resource
2. Visible Fields
3. Day View
4. Schedule Time Interval
5. Check In/Out Tabs (Not Utilized)
Viewing the Encounter Summary

Encounter Summary is a health-oriented overview of a patient's chart or and EMR (Electronic Medical Record), it includes a subset of information that helps clinicians quickly assess the patient's overall health status and evaluate clinical data relevant to the selected encounter. In the paper world, such information is accumulated in the patient chart. Since the paper chart is a physical entity, only one healthcare professional can have access to the total information at a time. The Encounter Summary allows multiple users to access a single chart at the same time.

The Summary Field is the first field in the Encounter Summary and contains information that is NOT specific to an encounter, staying consistent over time. The fields below the Summary Field are specific to the selected encounter. The encounter can be changed, allowing different data to be viewed in these windows. A provider can study the Encounter Summary before walking into an exam room to see the patient.

In this scenario, to begin you will need to: In this scenario, you will:

- Select a Patient Appointment
- Open and review the Encounter Summary
Select a Patient Appointment

To begin, select a Patient in the Schedule Viewer and double-click the patient name.

**Resource Schedule and Date** – The Resource Schedule must be entered into the resource field and selected. The schedule will be displayed and then the date will default to the current date and time. The date can be changed, if needed by using the date arrows.

**Patient Name** – The patient’s name can be selected by double-clicking on the name and then the Encounter Summary will open and display.
Review the Encounter Summary Sections

After double-clicking on the Patient’s Name in the Schedule Viewer, the Encounter Summary will open.

Summary – This section contains a listing of the four major profiles, which are Immunizations, Allergies, Problems, and Medications. This information is recorded and kept at the Chart Level, which means that it is viewable on all encounters. The profiles and the data that they contain are listed as hyperlinks. Clicking on the Profile Hyperlinks will open the selected Profile Window and clicking on the Profile Data Hyperlink will open the associated data window.

- **Immunizations**— A link to the Immunization Profile, which includes the list of immunizations that the patient has received. The Immunization Profile is a different view than the Immunization Schedule. The Immunization Schedule is now the recommended way to document immunizations.

- **Allergies**—A list of the patient’s active allergies. The allergen’s reaction type and reaction signs and symptoms are listed in parentheses if available. A link to the full Allergy Profile is provided, as well as links to the details of each individual allergy.
• **Problems**—A list of the patient’s active problems. The problem’s course is listed in parentheses if available. A link to the full Problem List is provided, as well as links to the details of each individual problem.

• **Medications**—A list of the patient’s active medications. The SIG line is also listed for each medication. A link to the full Medication Profile is provided, as well as links to the details of each individual medication for modification.

**Assessments** – This section contains the Patient’s Vital Signs that were recorded for this visit/encounter. This information is visit/encounter specific.

**My Notes This Visit** – This section contains a list of Clinical Notes for the selected visit that was Performed/Authored by the logged in user. This section is view only. Additional notes can be added on this encounter by creating a note in Clinical Notes, PowerForms, or PowerNote. The date and subject of the note will display next to the document name. The full document can be viewed by double-clicking the note. This information is visit/encounter specific.

**Orders/Test Results This Visit** – This section is a view-only section containing a list of all orders/charges placed and the corresponding results. The order name, order status, date of the order, and any associated results display. If the results are not yet available “Pending” is displayed. By double clicking on the order, the Order Information window is displayed, which provides the full details of the order. This information is visit/encounter specific.

**Other Notes This Visit** – This is a view only section that contains all the Other Notes that were written or entered for the selected visit/encounter. The date, author, and status (or subject if it exists) of the note will display next to the document name. The full document can be viewed by double-clicking. This section will contain any phone messages that were saved to the patient’s chart. This information is visit/encounter specific. This section contains a list of Clinical Notes for the selected visit that was Performed/Authored by someone other than the logged in user. This section is view only. Additional notes can be added on this encounter by creating a note in Clinical Notes or PowerNote.
Viewing the Workflow Process

The Workflow Process is the standard workflow for healthcare providers to follow. This process is setup at the global level and includes the Flowsheet, Allergies, Problems, and Medications. The workflow process will allow healthcare providers to quickly and efficiently review a patient’s chart and update the EMR (Electronic Medical Record) at the same time from one central location. This workflow process will also allow the healthcare provider to prescribe medications, update the medication profile, and print the prescription at the same time.

The Workflow Process is initiated by clicking the Workflow button until all the workflow screens have been viewed and/or updated.

The Workflow Process setup can be edited at the user level, to complete the following steps to edit the process.

1. Click on Chart in the Menu Bar and select Chart Preferences.
2. Click the Workflow tab to edit the Selected Workflow’s Layout.
3. Click the add button \( \text{add button} \). It will duplicate the item that is highlighted item.

4. Change the item by selecting the workflow process from the selected layout section and click apply.

5. Repeat this process to add multiple WorkFlow process items.

Tips & Tricks

1. Most information can be better viewed by going to the appropriate component in the chart directly than in the Encounter Summary. A document, for example, may require scrolling left and right as well as up and down more often when opened from the Encounter Summary than from Clinical Notes or the Flowsheet.

2. The Encounter Summary cannot be printed.
Customizing the Encounter Summary

Note: The PowerChart Office® system provides a standard set up for the Encounter Summary View and recommends that you do not change this default.

If needed, the Encounter Summary View preferences can be configured to display additional, optional information in the Summary View window, as well as whether certain sections should display if there is no data to display.

On the PowerChart Office® toolbar, select the Encounter Summary icon.

Once the Encounter Summary has loaded, select the Encounter Summary menu and choose Preferences. On the Encounter Summary, the user may choose to hide any of the five main sections when no qualifying data is returned, always hide the section, or always display the section.

The ‘In the Summary Section’ box you can choose whether to make Immunizations, Allergies, Problems, and Medication viewable as a part of the Summary section. This information will either always display or never display according to the checkbox, regardless of whether data exists for the patient. Once the preferences are saved, you receive the same Encounter Summary view for every chart that you open until you set the preferences differently.

Click ‘Apply’ and ‘OK’ to save changes.
Appointment Book

The Appointment Book is the need to leave a short reminder for yourself or other clinicians, Sticky Notes are great for this purpose.

In this scenario, you will:

- Open the Appointment Book and Review a Resource Schedule
- Setting Appointment Book Preferences

To Open the Appointment Book & Review a Resource Schedule

1. Click on the Appointment Book Icon or click Clinic on the Menu Bar and then select Appointment Book.

2. Click the Bookshelf Bar that is located under the Books Tab and then the Select Bookshelf window will open and be displayed.
3. Select the appropriate Index Book by clicking and highlighting the selection and then click OK.

4. The Bookshelf will then display with the Index Book name that was selected in the Bookshelf Title Bar and the departments listed below as books.

5. Open a Department’s Appointment Book by double-clicking the book or single clicking and then clicking the Open button to display the Resource Schedule on the lower portion of the screen.
Setting the Appointment Book Preferences

To Set the Appointment Book Preferences you must Right Click on the screen and select Book Settings. This Option allows the user to Change the Schedule View, to Set the Date and Time, and to Set the Schedule Properties.

1. **Schedule View** – The Schedule View can be changed to one of the following views.

   - Non-proportional, Single-day
   - Proportional, Single-day
   - Proportional, Multiple-day
   - Week
   - Month

2. **Date and Time** – The Date and Time Option allows the user to set the Daily Schedule Begin Time and End Time.
3. **Appointment Book Properties** – The Appointment Book Properties allow the user to set the General Settings, Icons, Fonts, and the View. This option allows the use to establish multiple settings from one place.
All Results – Practice Scenario

In this scenario you will view new results. To view new results, you will access the All Results Flowsheet, which displays new results of all clinical categories for that patient during a defined timeframe. New Results for specialty areas can also be viewed using the individual clinical category tabs.

In this scenario, you will:

- View New Results
- View Result Order Information
- Graph Results
- Bookmark Results

Note: The Encounter displayed in the banner is not necessarily the Encounter that is associated with the Results that are displayed in the Flowsheet. To verify the Encounter that is associated with the results, right-click on one of the results and select View Order Info. The Encounter number will be displayed in the banner.
View All Results

PowerChart allows you to view details for individual results and mark them as reviewed. Results are posted in different colors representing various ranges. Results not yet reviewed are reported in blue text, results that have been Bookmarked are in black text and Critical, High/Low and Abnormal results are posted in red.

**Note:** Results posted in red will remain red even after bookmaking.

1. From the New Results tab view, select Options on the menu bar.
2. Select Result Legend.

![Result Legend](image)

3. Click Close to exit the window.
View Details

1. Right-click on the specific result. A selection menu displays.

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>Temperature</td>
<td>36.5 deg C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Weights and Measures</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Weight kg</td>
<td>22.00 kg (N)</td>
<td>22.00 kg (N)</td>
<td>8.00 kg (N)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Height cm</td>
<td>32.00 cm (N)</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Medications</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>morphine</td>
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</tr>
</tbody>
</table>

2. Select View Details from the selection menu. The Results Detail window displays.

3. Result tab displays more detailed result information.
4. Action List tab displays result activity in chronological order

Graphing Results

You have the ability to create graphical representatives of selected results. This enables you to quickly identify trends or changes in result patterns.

1. Select the gray box(es) to the left of the result(s) to be graphed.

2. Select the toolbar. The Flowsheet Graph window displays a graphical representation of the selected result.
3. Right-click on any circled result point on the chart and View Details to display results.

4. Select Close to close Result Details.

5. Select Close to close graph.

**Note:** If graphing multiple results, select more than one test. DO NOT graph more than three results as the graph becomes distorted and difficult to read.
Bookmark Results

Bookmarking a result creates a visual indicator to the clinician which results have been viewed. When the clinician has bookmarks the new result, the result changes from blue to black. This helps to identify the results that have been reviewed.

1. Select on the toolbar. The results update from blue to black reflecting the results have been reviewed.

Seeker

The seeker is a tool that enables you to quickly scroll to a result location on the flowsheet. Vertical line segments represent results in the sequence they occurred. The seeker is most helpful in locating critical results, indicated in red and spot major clinical occurrence.

1. Click from the patient’s flowsheet. When the Seeker is displayed, it represents the portion of the Flowsheet matching the search criteria you entered. The rectangle outlined represents the current screen display area.

2. Drag the rectangle to any part of the Seeker and release. The view in your Flowsheet window changes to correspond with the focused range.

3. Click to close the seeker.
Patient Chart Views (All Results) - Practice Scenario

The All Results Flowsheet will display your patient’s results regardless of the clinical category. The features of Flowsheet are designed to make finding clinical information as efficient as possible. Information is shown in a spreadsheet with flexible display features that make it possible to create an optimal view.

Flowsheet is divided into two major sections. The left section is the Navigator. By selecting a category, you can zoom immediately to its contents, which are displayed as values in the grid on the right. The right section is the Results display. You can control both sections in the way best suited to get to needed information quickly.

In this scenario, you will:

- Change Result Search Criteria
Changing Result Criteria

The Information Bar displays the date and time range for which results will be viewed.

1. Right-click on the Criteria Bar and the Search Criteria menu will be displayed.

2. Select Change Search Criteria

The Search Criteria window offers you several options to customize the results being displayed.

**Clinical Range** – Displays results with an occurrence time within the specified time range.

**Posting Range** – Displays results that have posting times within the specified time range.

**Result Count** – Allows you to select the specific number of latest entries to the patients’ chart to be displayed from 1–1,000.

**New Results** – View only the results not yet marked as viewed.

**Admission Date to Current Date** – View all results posted for the selected patient from admission date to current date.

For the purpose of this example **Admission Date to Current Date** will be used.

1. Select Admission Date to Current Date
2. Click OK to retrieve results in the chosen range.
Allergies – Practice Scenario

As part of the patient’s complete assessment, use the allergy profile to display recorded allergies, including allergy category, severity, type, onset date, reactions interaction checking, and notification. By default, the allergies are listed alphabetically by substance.

In this scenario, you will:

- View an Allergy
- Add an Allergy
- Indicate No Known Allergies
- Adding Allergies to Your Favorites
- Canceling an Allergy
- Modifying an Allergy
- Viewing an Allergy History
- Marking Allergies as Reviewed
- Removing an Allergy from your Favorites
- Performing a Reverse Allergy Check

Allergy Overview

The Allergy Profile is used to record, modify, and cancel all allergies and adverse drug reactions for a patient. This profile can be viewed by multiple users and provides a quick and efficient method of reviewing allergies prior to a patient’s appointment.

Sorting an Allergy

Allergies are sorted alphabetically by substance in Allergy Profile. To change the sort order, click the column heading by which you want to sort.
Allergy Display

Current Allergies – Displays only current allergies for the patient.

Current Reactions – Displays only current reactions for the patient.

All Reactions – Displays all reactions for the patient.

Check Interaction – Checks the database for interactions between the selected allergy and other substances.

Refresh Profile – Refreshes the Allergy Profile display.

Save Preferences – Saves Allergy Profile settings, as they currently are set.

Preferences – Lets you set Allergy Profile preferences. The Preferences dialog box opens.

Adding an Allergy

Allergies can be added to the Allergy Profile in the following manner.

1. Right Click in the Allergy window and select Add New Drug Allergy, Add New Drug Side Effect, or Add New Other. The Allergy search pane opens.
2. Select the substance you want in the Search, Catalog or My Favorites tab and then click the Search button.

3. Click **Select Button**.

4. Confirm the correct substance is displayed in the **Substance Box** in the **Substance Tab** (Red Arrow).

Note: The remaining steps for entering an allergy are optional.

6. Select a Reaction Type from the list if you wish to record the **Reaction Type** (Blue Arrow).
6. Select the Reaction Symptoms (Green Arrow) in the Search, Catalog or My Favorites tab.

7. Click Select Button.

8. Confirm the correct reaction symptoms are displayed in the Reaction Symptoms Box in the Substance tab.

9. Enter the Allergy Details (Orange Arrow) such as status, reason, severity, information source, user (if you are recording on behalf of another user), or onset date from the lists. The Onset Date lists are designed to enable you to enter a specific or approximate date or indicate if it is unknown.
10. To **Enter Comments** (Pink Arrow) regarding the allergy, click Add comments.

![Image of comments dialog box]

11. Enter your **Comments**.

12. Click **OK**. The comment is added to the allergy.

13. Click **OK**. The new allergy is added to the list.

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**Note:** To add a free-text allergy, click the Free Text option in the Add Allergy/Adverse Effect dialog box. You will receive a warning “Allergy interaction checking is not performed on free text allergy entries.”
Indicating There Are No Known Allergies

If a patient has no known allergies (NKA) you can indicate this in the chart by Right-Clicking anywhere in Allergy Profile and selecting **No Known Allergies (NKA)**, as shown below.

Note: To indicate a patient has no known allergies, any allergies in the profile must be Canceled or Resolved.
Adding an Allergy to Your Favorites

By adding allergies to your list of favorites, you can select them quickly. To add an allergy to your favorites, complete the following steps:

1. In the Add Allergy/Adverse Effect dialog box, locate the allergy you want to add in the Search tab.

2. Right-click the allergy and select Add to Favorites. The allergy is added to the My Favorites tab.

3. Click OK to save your changes and close the dialog box.
Removing an Allergy from Your Favorites

To remove an allergy from your list of favorites, complete the following steps:

1. In the Add Allergy/Adverse Effect dialog box, select the My Favorites tab.

2. Right-click the allergy you want to delete and select Remove From Favorites. The allergy is removed from your list of favorites.

3. Click Cancel to close the Allergy window.
View an Allergy History

1. Right-click on the allergy substance (e.g., Tylenol Cold) to display the pop-up Allergy Profile menu.

2. Select View History of (name of allergy).

3. History data can be sorted chronologically or reverse by clicking on the appropriate radio button.
Canceling an Allergy

To cancel an allergy, complete the following steps:

1. In the profile, right-click the allergy you want and select **Cancel [Allergy]**. The Cancel [Allergy] dialog box opens.

2. Enter the **Reason** under the **Allergy Details Section**. Click OK to **Cancel the Allergy**. The dialog box closes, returning you to the Allergy Profile window. The allergy will be displayed with a Red Line through it.
Modifying an Allergy

Complete the following steps to modify an allergy in Allergy Profile:

1. Right-click the allergy you want and select Modify [Allergy].

2. The Modify Allergy dialog box opens. Confirm the name of the allergy you are modifying is displayed in the Substance box.

3. Modify the Allergy by entering your changes to the displayed information.

4. Click OK.

Note: The changes you made take effect immediately. The modification date and time are displayed in the history.
Marking Allergies as Reviewed

To mark allergies as reviewed, complete the following steps:

1. To Mark Only Specific Allergies as Reviewed, select the Allergy you want to mark.

2. Click **Mark Selected as Reviewed**. The date is displayed in the Reviewed column for the Allergy will be update.

3. To Mark All Allergies as Reviewed, click **Mark All Shown as Reviewed**. The date is displayed in the Reviewed column for all allergies in the patient's profile.
Performing a Reverse Allergy Check

You can check a patient's allergies against current medications at any time. For example, if you enter a new allergy for the patient, you will want to determine whether any medications the patient is taking currently could cause a reaction also. To perform a reverse allergy check, click Perform Reverse Allergy Check in the Allergy Profile window.

Tips & Tricks

1. When searching for allergies, type in the first 3-5 letters of the name.

2. Multum Allergy checking will take place if any related allergy is documented, for example amoxicillin and penicillin.

3. System-Tracked Favorites – The system maintains a list of most commonly used favorites for problems and updates this list daily. The system populates the System-Tracked Favorites folder with the 20 most frequently selected allergies and reactions that have been selected a minimum of 5 times each over the past 90 days.
Super User Information

Selecting Columns for Display

Note: PowerChart Office® defines standard configuration of columns for display and recommends that you do not change them.

If you wish to change which columns are displayed and the sequence, complete the following steps:

1. From the Allergy menu, select Preferences. The Preferences dialog box opens.

2. To add a column to the display, click in the Columns box. A list of the available columns is displayed.

3. Select the column you want to add.

4. To delete a column from the display, select the column in the Columns box.

5. Click . The column is removed from the list of displayed columns.

6. To change the sequence in which the columns are displayed, select a column you want to move and click or until it is located where you want it.

7. Click OK to save your changes and close the dialog box. Click Apply to save your changes and continue setting preferences.
Saving Your Settings

To save any settings you have changed when you close Allergy Profile, complete the following steps:

1. From the Allergy menu, select Preferences. The Preferences dialog box opens.
2. Select the Save Settings on Exit option.
3. Click OK to save your changes and close the dialog box. Click Apply to save your changes and continue setting preferences.

Setting the Menu Display

Allergy Profile menus can be displayed in a cascade format. For example, if you specify cascade menus, the Allergy menu displays the Add New command and a submenu containing the Drug Allergy, Drug Side Effect, and Other commands. If the Cascaded Menus option is deselected, the Allergy menu would display the Add New Drug Allergy, Add New Drug Side Effect, and Add New Other commands.

To set the menu display, complete the following steps:

1. From the Allergy menu, select Preferences. The Preferences dialog box opens.
2. Select the Cascaded Menus option.
3. Click OK to save your changes and close the dialog box. Click Apply to save your changes and continue setting preferences.
Displaying Tool Tips

To display tool tips, complete the following steps:

1. From the Allergy menu, select Preferences. The Preferences dialog box opens.

2. Select the Enable Tooltips option in the Tooltips group box.

3. In the Tooltips Delay Time spin box, select the number of seconds of delay you want before Tooltips are displayed.

4. Click OK to save your changes and close the dialog box. Click Apply to save your changes and continue setting preferences.
Setting the Reverse Allergy Check Preference

Note: For better performance, Cerner recommends that you do not run a reverse allergy check when you open Allergy Profile.

If you want the system to run a reverse allergy check when you open Allergy Profile, complete the following steps:

1. From the Allergy menu, select Preferences. The Preferences dialog box opens.

2. Select the Perform Reverse Allergy Interaction Checking on Load option.

3. Click OK to save your changes and close the dialog box. Click Apply to save your changes and continue setting preferences.
Clinical Notes - Practice Scenario

Clinical documents are used to support and document patient care and are part of patient’s permanent record. Clinical documents are immediately available to all authorized individuals via the PowerChart Clinical Notes tab with the patient’s chart. Documents for the selected patient are listed in an expandable document tree, which can be sorted by date, type, author or status.

In this scenario, you will:

- View a Clinical Document
- View Document History

Viewing a Clinical Document

1. Click the Clinical Notes button in the patient’s chart to display the window.

2. Lists of clinical documents are displayed in a document tree for the time frame or document count displayed on the information bar.

   **Note:** If No Results Found is displayed in the document tree, change the search criteria via the Criteria Bar.
3. Double-click on the Documents folder to display sub folders.

4. Click the plus sign to open the applicable folder and select the appropriate document. The Colored Icon reflects document status, as shown below.

5. Double-click on the selected document to display.
View Document History

Any action applied to a clinical document adds an event to the document history. This information is maintained in the document history panel, which is hidden from view.

1. Select the appropriate document to view.
2. Place the cursor just beneath the bottom scroll bar until the cursor changes it to an I-beam cursor.
3. Press and hold down the left mouse button while moving the mouse upward to drag the lower border of the document panel upward.
4. Release the left mouse button to display the document history.
Super User Information

Filtering by Encounter

When viewing documents in **Clinical Notes**, you can filter the display of documents to only those associated with a specific encounter. You can turn this filter on and off, and the filter is turned off by default. When the filter is turned off, all documents that meet the search criteria are displayed, regardless of encounter.

Complete the following steps to filter by encounter:

1. Access the Clinical Notes tab.
2. Right-click the green navigator bar, and select to change the search criteria.
3. Select to **filter by encounter**. The system displays in the navigator only those documents associated with the selected encounter and any documents not associated to any specific encounter. On the green navigator bar, a message is displayed to indicate the documents are being filtered by encounter.

Note: You also can filter documents by document date, document count, and admission to current, regardless of whether or not you selected the option to filter by encounter.

4. To change the selected search option, in **Clinical Notes**, select **Documents? Options**, and click the **Index Defaults** tab on the **Clinical Notes** Options window. If you change the selected search options in this manner, the system saves the settings as the default for the specific user.

You also can change the selected search option by right-clicking the Search Information Bar to display the Document Lookup window. If you change the selected search option in this manner, the system does not change the default setting for the specific user.

Note: If you filter the view to only the Selected Encounter, an indicator is displayed on the green navigator bar indicating the view is filtered to the Selected Encounter.
Forwarding or Refusing a Document for Review or Signature

You can forward a request for review or signature of a document of any status to a person who needs to review the document. You can forward a document in a less than Authenticated status to the appropriate person who needs to sign it. Forwarding a document means placing a notification in the responsible person’s Inbox that signature or review has been requested. Forwarding a document does not change the document’s status but does create a line describing the requested action in the document history line.

You can refuse to review or sign a document if either of those actions is requested of you.

To forward or refuse a request for document review or signature, complete the following steps:

1. With a patient’s chart open, select the Clinical Notes icon.

2. Navigate through the index tree to the document level and open the appropriate document.

3. From the Documents menu or right-click menu, select Forward/Refuse to open the Forward/Refuse dialog box.

4. To forward a document, select the Forward option.
   a. Enter the name of the healthcare professional to whom you are sending the request. Click the binoculars to look up the person by name or ID.
   b. Select an action, Review or Sign, from the list in the Requested Action box.
   c. Enter a comment about the request (optional).
   d. Click OK. A row is displayed on the Clinical Notes action history window with an Action of Sign or Review and an Action Status of Requested.

5. To refuse a document that has been sent to you for review or signature, select the Refuse option.
   a. Enter a comment in the Comment box (required).
   b. Click OK. The Action Status of the Sign/Review row is changed from Requested to Refused on the Clinical Notes action history window.
Setting Clinical Notes Options

You can select a default document type, control the way the index tree is initially displayed, and set the preferred data retrieval method by adjusting your user options.

With a patient chart open, complete the following steps to set your options:

1. From the Documents menu, select Options to open the Clinical Note Options dialog box. The Document Types tab is defaulted.

2. To set your index defaults, select the Index Defaults tab.

3. In the Document Lookup group box, specify a method of document retrieval by setting a date range or a document count.

   - **Date range:** Enter a number of days in the Days Forward box to indicate how far in the future to retrieve documents. If your preferences are set to allow future charting, it is possible to create documents and give them a date in the future. In the Days Backward box, enter the number of days back from today that you want included in the search. In the Adjust Offset Days box, enter a number that indicates the number of days to increase or decrease the date range when you click the search adjustment arrows at either end of the search information bar.

   - **Document Count:** If you prefer to retrieve the last n documents, enter a number in the Number of Documents box. The system retrieves the number of documents you specify and it shows you on the range bar in PowerChart the total number of documents retrieved and the number of returned documents that are accessible (published); for example, "Last 50 documents: 32 out of 33 documents are accessible." To increase or decrease the effect of the quick search adjustment arrows that are located on either end of the search information bar, change the number in the Adjust Offset Count box.

4. To set view preferences to show documents arranged in reverse chronological order (most recent at the top of the list), select the Reverse Chronological check box.

5. To have the document history panel in view upon opening a document, select the Expand History check box. Otherwise, you must drag upward a splitter bar from the bottom of the document contents area to display the document’s history.

6. Click OK to save your preferences. The next time you open the Clinical Notes tab, your preferences are in effect.
Modifying Documents

Only a user with the preference to add or modify documents can modify or edit documents in Clinical Notes. Such a user can modify any of the following document types:

- Documents created in Clinical Notes
- Textual rendition documents created in PowerForms or PowerNote
- Documents scanned or imported into the database or received from a document interface

If you select to modify a textual rendition of a PowerForm or PowerNote, the system returns you to PowerForms or PowerNote, as appropriate, to make the modification. If you select to modify any other type of document, the system opens the appropriate Clinical Notes modification window.

If the document is in a status of In Progress, Transcribed, or Unauthenticated, only users who are associated with the document can edit the document, including providers with either a requested or pending action.

If the document is in a status of Authenticated, Modified, Corrected, or Altered, any user in the database with the ability to modify can modify the document. This allows users to add an addendum to the document.

If the document is in a status of In Error, no user can modify the document.
Clinical Notes - Index Menu

**Change Search Criteria** – Opens a dialog box to allow you change the time span for data retrieval. You also can right-click the information bar where the time span is displayed and select Change Search Criteria.

**Refresh** – Refreshes the data display manually.

**Index tree sort options** – The graphic representation of the index tree is adjusted accordingly.

**By Type** – Sorts the documents by category such as Progress Notes or Lab Reports.

**By Status** – Sorts the documents by document status.

**By Date** – Sorts the documents by the dates they were created.

**Performed By** – Sorts the documents by who created them.

**By Encounter** – Sorts documents according to the encounter for which they were created.

**Chronological** – Displays the documents in time order, earliest to latest, within the sorted categories.

**Reverse Chronological** - Displays the documents in reverse time order, latest to earliest, within the sorted categories.

**Color Legend** – Opens the Status dialog box so you can view which colors represent which document statuses.
Clinical Notes - Documents Menu

**Review Document** – Enters an internal indicator that you have reviewed a document. This menu option always is available for persons who have privileges to review documents, regardless of the status of the document. If you review a document that is in an In Progress status, your action does not change its status. If you review a document that has an Authenticated or Modified status, the status is changed to Altered. This status is not displayed except as an internal database indicator that the document has been reviewed, but the review action is displayed as a row in the document history.

**In Error Document** – Changes the status of the selected document to In Error. For example, this action should be applied to documents entered into the wrong patient record.

**Modify Document** – Opens the Clinical Documents dialog box so you can attach an addendum to an existing document that has been signed. You must sign the addendum.

**View Image** – Opens the image viewer for your system so you can view a scanned image such as an X-ray.

**Forward/Refuse** – Opens a dialog box so you can forward a document to a selected individual for signature or review, or for refusal of the requested action (sign or review). You can enter a comment with the request.

**View History** – Opens a spreadsheet with a list of old versions of the same document.

**Print Document(s)** – Prints the selected document.

**Maximize View / Normalize View** – Maximizes the area for displaying the document contents by shrinking the index tree. When the document is maximized, the menu command flexes to Normalize View. Select Normalize View to restore the index tree.

**Options** – Opens the Clinical Notes Options dialog box where you can specify default document types. Also enables you to set a default time range or document count for the index tree display. For example, if you elect to view only History and Physicals from the past week, each time you open the Clinical Notes tab, your list of document displays only the past week’s H&Ps. You also can specify which folders to default as open in the documents tree.
Clinical Notes - Context Menu

**Add Document** – Opens the Clinical Documents dialog box so you can create a new document. You can attach a template, write the text of the document, and sign it.

**PowerNote** – Launches an application that enables you to use predefined blocks of text and formatting to create a document.

**Scan/Import** – Opens the window that allows you to scan a document or import an image.

**Submit Document** – Places a notification in the selected person’s Inbox that a document is ready for review or signature. For example, when a transcriptionist saves a transcribed document, it bears the status of Transcribed. The transcriptionist can submit the document to its author on the Add Document form or can save it. Saving gives the document an In Progress status. The document later can be selected in the Clinical Notes window’s index tree and submitted by selecting the Submit Document command from the Document menu or context menu.

**Sign Document** – Enters your electronic signature. If you are the document’s author and have signature privileges for this type of document, advances the document status to Authenticated. If you are not the author or if you do not have privileges, advances the status to Unauthenticated, and the document requires a co-signature.

**Show/Hide Toolbar** – Displays or hides the text editing toolbar buttons.

**Import** – Opens a dialog box so you can locate a file to import into the current clinical document. The file must be one of these formats: rich text (.RTF), plain text (.TXT), or hypertext markup language (.HTML).

**Export** – Opens the Save As dialog box so you can save the current clinical document in a folder on your hard drive or on a network drive. You must save the document as rich text (.RTF) or plain text (.TXT).
Clinical Notes Toolbar - Buttons & Descriptions

Add Document - Affords the ability to add a new clinical note.

Submit Document - Allows someone who is not otherwise authorized to sign documents to submit an unauthenticated document to the database with and submits a request for signature from another user who does have privileges to sign.

Sign Document - Used to electronically sign or endorse a document.

Review Document - Allows the user to mark a document as reviewed when someone else requested the review.

In Error Document - Allows a user to mark a document as "posted in error"; the document will not be removed.

Modify Document - Affords the ability to be able to modify a clinical note.

Print – Allows you to print document.

View Image - Launches a window which allows the user to view a previously scanned and attached image.

Forward/Refuse - Used to manually forward documents to another user, requesting the other user to either review or sign the forwarded document.

View History - Allows you to view the medical history on the person selected.
Clinical Documents Text Editing Toolbar - Buttons & Descriptions

**Set Color of Selected Text.** Opens a color palette to allow you to select a text color. First select the text you want to be displayed in color. Select the color you want, and click OK.

**Cut.** Cuts the selected text and holds it on the clipboard to be pasted into a new location or discarded. The next time you cut or copy something, the contents of the clipboard are overlaid.

**Copy Selected Text to Clipboard.** Copies the selected text to the clipboard.

**Paste from Clipboard.** Pastes the last item cut or copied into current location of the cursor.

**Clear Uncommitted Text.** Clears all uncommitted text in the word processor.

**Bold Selected Text.** Displays the selected text in bold font.

**Underline Selected Text.** Displays the selected text with a single underline.

**Italicize Selected Text.** Displays the selected text in italic font.

**Strike Through Selected Text.** Allows you to strike (draw a line through) objectionable or incorrect words in an existing signed document, if your system manager has enabled this feature. Displays the selected text with a line through it as illustrated here. Depending upon your user preferences, struck text may be displayed in a different color. Stricken text is still legible.

**Align Left.** Displays selected text as left justified.

**Align Center.** Displays selected text as centered.

**Align Right.** Displays selected text as right justified.

**Insert Template.** Opens a template or form to allow you to enter the variable portions of a type of report or document. Your institution designs templates for major types of documents so that certain required information always is included and always is in the same area of the report. Certain boilerplate text is included to save time in creating the new report, and font size, headings, margins, and special formatting instructions already are built into the template.

**Spell Check Uncommitted Text.** Checks uncommitted text for errors.
Document Imaging Viewer Toolbar - Buttons & Descriptions

**Previous Page.** Displays the previous page of the document image.

**Next Page.** Displays the next page of the document image.

**Zoom In.** Enlarges the size of the document image each time the icon is clicked.

**Zoom Out.** Decreases the size of the document image each time the icon is clicked.

**Best Fit.** Size the document image to best fit the image viewer area.

**Rotate Left.** Rotates the document image to the left.

**Rotate Right.** Rotates the document image to the right.

**Print.** Opens the Print dialog box where you can select printing options and print the document image.
Immunizations Profile – Practice Scenario

As part of the patient’s complete assessment, use the Immunization Profile to display recorded immunizations, including vaccine name, amount, route, provider, manufacturer, lot number, date received, and etc.

In this scenario, you will:

- Add an Immunization
- View an Immunization History
- Modify an Immunization
- Canceling an Immunization
- Adding/Removing an Immunization from your Favorites
Immunization Overview

The Immunization Profile is used to record, modify, and cancel all immunizations for a patient. This profile can be viewed by multiple users and provides a quick and efficient method of reviewing immunizations prior to a patient’s appointment.

Adding an Immunization

Immunizations can be added to the Allergy Profile in the following manner.

1. Right Click in the Immunization window and select Add and the Add Immunization window will be displayed.

2. Enter the Immunization Data such as vaccine name, date and time, amount, route, provider, site, manufacturer, lot number, expiration date and time, and administrative notes.

3. Click OK and the Immunization will be recorded.
Viewing an Immunization History

The Immunization History can be viewed in the following manner.

1. Right Click on the Immunization that you want to view and select View. The Immunization History window will be displayed.
Modifying an Immunization

Complete the following steps to modify an Immunization in Immunization Profile:

1. Right-click the Immunization you want and select Modify.

2. The Modify Allergy dialog box opens. Confirm the name of the allergy you are modifying is displayed in the Substance box.

3. Modify the Allergy by entering your changes to the displayed information.

4. Click OK.

Note: The changes you made take effect immediately. The modification date and time are displayed in the history.
Canceling (Unchart) an Immunization

To cancel an Immunization, complete the following steps:

1. In the profile, Right-Click the Immunization you want and select **Unchart**. The Result Uncharting dialog box opens.

2. Enter a **Comment** in the Results Uncharting window and **Click OK** to **Cancel the Immunization**. The dialog box closes, returning you to the Immunization Profile window. The Immunization will be displayed with a Red Line through it.
Adding an Immunization from Your Favorites

By Adding Immunizations to your list of favorites, you can select them quickly. To add an Immunization to your favorites, complete the following steps:

1. Right-Click the Immunization and select Modify. The Modify Immunizations window will be displayed.

2. Click the Add to Favorites button and the Immunization is added to the My Favorites tab.

3. Click Cancel to close the Modify window.
Removing an Immunization from Your Favorites

To Remove Immunizations from your list of favorites, complete the following steps:

1. Right-Click the Immunization and select Modify. The Modify Immunizations window will be displayed.

2. Click the Remove from Favorites button and the Immunization is removed from the My Favorites tab.

3. Click Cancel to close the Modify window.

Tips & Tricks

1. After entering the Manufacturer, Lot Number, and Expiration Date for each vaccine

2. This information will default each time you document the same vaccine, but can be changed.
Problem List

As part of the patient’s complete assessment, the Problem List is a way you can sort and track patient problems. Use Problem List to view, add to, or update a list of known health problems associated with a person. Anything that presents a problem to the patient’s overall health may be listed in Problem List. You can manually add problems and update the problems as necessary. Duplicate checking is performed on all problems. Problems are recorded and displayed at the chart level so that they are viewable across all encounters.

Problems can be displayed according to an Active or Inactive status. Once a problem is resolved, it is removed from the default view, preventing you from viewing unnecessary information. The view can be switched between All, Active, or Active & Inactive Problems.

In this scenario, you will:

- Add a Problem
- View a Problem History
- Add/View Problem Comments
- Modify a Problem
- Activate a Problem
- Cancel a Problem
- Inactivate a Problem
- Resolve a Problem
- Add/Remove a Problem to/from your Favorites
Problem Overview

The Problem List is used to record, modify, and cancel all problems for a patient. This profile can be viewed by multiple users and provides a quick and efficient method of reviewing problems prior to a patient’s appointment. When you add a new problem, there are many ways to enter the details of the problem, allowing you to record all pertinent information about a person’s problem.

Adding a Problem

Problems can be added to the Problem List in the following manner.

1. Right Click in the Problem List window and select Add New Problem and the Add New Problem window will be displayed.
2. Enter the Problem Data such as problem name, onset date, life cycle, severity, and etc.
3. Click OK and the Problem will be recorded.
Viewing a Problem History

The Problem History can be viewed in the following manner.

1. Right Click on the Problem that you want to view and select View. The Problem History window will be displayed.

```
Problem History Window

BLISTERS WITH EPIDERMAL LOSS DUE TO BURN (SECOND DEGREE) OF FACE, HEAD, AND N...  
- Onset date: About 1/2006  
- Confirmation: Confirmed  
- Classification: Medical  
- Life cycle: Resolved  
- 3/23/2006 6:10 PM, PCO, Office RN

Add Comment...  OK  Cancel  Apply
```
Modifying (Updating) a Problem

Complete the following steps to modify a Problem in the Problem List:

1. Right-click the Problem you want and select Update Problem.

2. The Update Problem dialog box opens. Confirm the name of the Problem you are updating is displayed in the

3. Update the Problem by entering your changes to the displayed information.

4. Click OK.

Note: The changes you made take effect immediately. The modification date and time are displayed in the history.
Canceling a Problem

To cancel a Problem, complete the following steps:

1. In the profile, Right-Click the Problem you want and select **Update Problem**. The Update Problem window opens.

   ![Update Problem Window]

   - Change the **Problem Status** to **Canceled** in the status tab and select a Canceled Reason from the drop down menu. Click **OK** to Cancel the Problem. The dialog box closes, returning you to the Problem window. The Problem will be displayed with a Red Line through it.

   ![Problem Window]

2. Change the **Problem Status** to **Canceled** in the status tab and select a Canceled Reason from the drop down menu. Click **OK** to Cancel the Problem. The dialog box closes, returning you to the Problem window. The Problem will be displayed with a Red Line through it.
Activating a Problem

To Activate a Problem in the Problem List, complete the following steps:

1. In the profile, Right-Click the Problem you want and select **Update Problem**. The Update Problem window will be displayed.

2. Change the **Problem Status** to **Active** in the status tab. **Click OK** to **Activate the Problem**. The dialog box closes, returning you to the Problem window. The Problem will be displayed with an Active Status.
Inactivating a Problem

To Inactivate a Problem in the Problem List, complete the following steps:

1. In the profile, Right-Click the Problem you want and select **Update Problem**. The Update Problem window will be displayed.

![Update Problem Window](image)

2. Change the **Problem Status** to **Inactive** in the status tab. Click **OK** to **Inactivate the Problem**. The dialog box closes, returning you to the Problem window. The Problem will be displayed with an Inactive Status.
Resolving a Problem

To Resolve a Problem in the Problem List, complete the following steps:

1. In the profile, Right-Click the Problem you want and select **Update Problem**. The Update Problem window will be displayed.

2. Change the **Problem Status** to **Resolved** in the status tab. **Click OK** to Resolved the Problem. The dialog box closes, returning you to the Problem window. The Problem will be displayed with a Resolved Status.
Adding/Viewing Comments in Problem List

If you have information about the person’s problem that cannot be organized within Problem List’s structured format, you can enter the information as a comment.

1. To add a comment from the Update Problem or Add New Problem dialog box, click Add Comment button. If you are in the Problem Profile window, right-click a problem and select Add Comment from the context menu to open a comment box.

2. Enter the description or comment in the text box, and click OK.

You can view comments from the Status tab on the Update Problem dialog box, or in a popup box when you mouse over the icon on the left-hand side of the problem.

You can change the order in which the comments are displayed on the Status tab. You can sort by clicking the Chronological option to view comments from oldest to newest, or by clicking the Reverse Chronological option to view newest to oldest.
Populating System Tracked Favorites

The system maintains a list of most commonly used favorites for problems and updates this list daily. The system populates the System-Tracked Favorites folder with the 20 most frequently selected problems that have been selected a minimum of 5 times each over the past 90 days.

Tips & Tricks

1. Add the problems you most frequently document to your My Favorite list so they are available without searching.

SuperUser Information

Problem List Context Menu - Commands & Descriptions

The Problem List context menu is displayed when you right-click anywhere in the Problem Profile. It contains the following commands:

Add New Problem – Allows you add a new problem to the list.

Update Problem – Allows you to modify the selected problem.

View Problem History – Displays the selected problem’s history.

View Encounter History – Displays the selected encounter’s history.

Add Comment – Allows you add a comment to the selected problem.

Establish Relationship – Allows you to establish problem-personnel relationships.

Properties – Opens the Properties dialog box, and allows you to set preferences.
Properties in Problem List

PowerChart Office® provides standard configuration for Problems and Diagnoses and recommends that you do not change it.

If you need to adjust the properties, right-click anywhere in the problem profile and select Properties. The Properties dialog box is displayed with two tabs: Columns and Headers.

Columns

Adding or deleting columns determines what details you see when viewing problems. To add columns, complete the following steps:

1. Select a column name under Available Columns.
2. Click Add to move your selection to Show Columns in This Order.
3. To adjust the order of the columns, click Move Up or Move Down to move the column titles to the appropriate positions.
4. Click OK to commit the changes.

You can remove columns by reversing this process.

Headers

Headers are ways to group problems of a similar type. The headers available for you to group problems can vary according to your facility. You can group all problems under All Problems if you want to view all problems at once, or group problems assigned to you under My Problems. By choosing to view problems grouped together under headers, you can narrow the view to those that are most meaningful to you. Other headers you facility could have available are, but not limited to: Nursing, Dietary, Medical, and Lifestyle.

To add headers to the view, complete the following steps:

1. Select a header name under Available Headers
2. Click Add to move your selection to Show Headers in This Order.
3. To adjust the order of the columns, click Move Up or Move Down to move the column titles to the appropriate positions.
4. Click Ok to commit the changes.

You can remove headers by reversing this process.
Medication Profile

The Medication Profile contains a list of your entire patient's current and past medication orders. Using various headings, columns, symbols, and brief descriptions, Medication Profile provides a quick, on-line summary of essential information about each order. This profile features two alternate views that differ in their arrangement of your patient's medication information. Although the views use different headings, they share the same columns, symbols, and descriptive text. You can toggle between the two views by clicking Change View.

The Medication View arranges your patient's medication information into three main categories: pending medications, current medications, and past medications. Within each category, multiple orders for the same medications are grouped together, and then listed according to their original order date, with the oldest orders listed first. Arranged in a tree format, each category and medication subcategory can be expanded or collapsed, allowing you to reveal or conceal in-line order details as needed.

The information contained on Medication Profile View is divided into three main categories, each of which is identified by a heading: pending, medications being given, and prescriptions/home medications. The latter two categories are further divided into current and past subcategories. Medications administered in the office would be included in the medications being given category. Arranged in a tree format, each category and subcategory can be expanded or collapsed, allowing you to reveal or conceal in-line order details as needed.

To ensure your patient's medication history is as accurate and complete as possible, you can document historical medications, which include both current medications prescribed by a different provider, and medications the patient no longer is taking. The Medication Profile is used to support and document patient care and are part of patient’s permanent record. Clinical documents are immediately available to all authorized individuals via the PowerChart Medication Profile with the patient’s chart. Documents for the selected patient are listed in an expandable document tree, which can be sorted by date, type, author or status.
In this scenario, you will:

- Prescribe a Medication
- Add a Medication by History
- View a Medication History
- Add/View Medication Comments
- Modify a Medication
- Cancel/Discontinue a Medication
- Inactivate a Medication
- Resolve a Medication
- Adding/Removing Medications to/from My List ( Favorites)

Terms To Know – Medication Line

**SIG** – Displays the prescriber's directions for administration of the medication (dose, route, frequency, # dispensed, and etc.).

**Form** – Displays the value of the Drug Form.

**DAW** – Dispensed As Written option.

**Comment** – Displays if comments have been associated with the order. It also contains the beginning of the comment text.

**Interaction Checking Not Available** – Indicates whether interaction checking can be performed for the prescription. The system displays if medication interaction checking cannot be performed.

**Provider** – Specifies the name of the provider prescribing the medication.

**Date** – Indicates the starting date of the prescription.

**Status** – Indicates the status of the prescription. Possible values include Incomplete or Active.
Terms To Know - (Right Click Medication)

**Refill/Renew** – Refills and renews the selected order. All fields are available for modification. If the medication name, dose, route or frequency is changed, the system automatically takes a Duplicate/Discontinue action on the prescription. When you perform this action, the system provides automatically one prescription renewal, resulting in one active prescription order. To include additional refills in the renewed prescription order, enter a value for the Refill detail.

**Refill/Sign** – Allows you to refill and sign and order all in one action. When you perform this action, the system will not allow the user to change any of the associated information. If the person refilling the order is different from the person who originally placed the order, the Prescriber Detail automatically changes.

**Modify** – Modifies the selected order.

**Duplicate/DC** – Duplicates the selected order, creating a new order that has the same default information as the original order, and then discontinues the original order.

**Duplicate** – Duplicates the selected order, creating a new order that has the same default information as the original order.

**Cancel/DC** – Cancels or discontinues the selected order, which your patient may be currently taking.

**Void** – This option voids the medication and removes it from the Medication List.

**Complete** – Changes the status of the selected order to Complete.

**Print Rx** – Prints the prescription to the default printer.

**Print English Leaflet** – Prints the English patient information leaflet to the default printer.

**Print Spanish Leaflet** – Prints the Spanish patient information leaflet to the default printer.

**Add Comments** – Adds comments to the order.

**View Comments** – Displays comments associated to the order.

**Reference Text** – Displays the reference text associated to the order.

**Information** – Displays detailed order history and Order Entry Format information.

**Diagnosis Associations** – Associates a diagnosis to the order.
Name – Displays the brand name or the generic name of the medication being prescribed. It also contains an icon indicating whether the medication is a prescription (\textit{Rx}) or a historical order (\textit{Hx}).

Terms To Know – (Right Click Screen)

Prescribe – Writes an active prescription for a patient's current use. This command automatically launches EasyScript.

Add Medication by Hx – Documents a current medication prescribed by a different provider, or document a historical medication the patient no longer is taking. This command automatically launches EasyScript, with the Historical option in the Prescription Pad already selected.

Print List Active Medications – Prints a list of active medication orders to the default printer.

Print List All Medications – Prints a list of all medication orders, both active and historical, to the default printer.

Check Interactions – This command is currently unavailable.

Refresh Profile – Refreshes the contents of the Medication Profile.

See [alternate view] – Switches to the other view of the Medication Profile.

Preferences – Launches the Medication Profile preferences window, in which you can set various parameters related to the appearance of the Medication Profile. For additional information, see Setting Preferences.

Medication Overview

The Medication List is used to record, modify, and cancel all medications for a patient. This profile can be viewed by multiple users and provides a quick and efficient method of reviewing medications prior to a patient’s appointment. To ensure your patient's medication history is as accurate and complete as possible, you can document historical medications, which include both current medications prescribed by a different provider, and medications the patient no longer is taking.

- Historical medications can be documented by using the Medication Profile or EasyScript, and are indicated by \textit{Hx} throughout Cerner Millennium.

- Prescriptions that are prescribed are denoted by \textit{Rx}.
Prescribing a Medication

Medications can be prescribed using the Medication Profile in the following manner. Prescribing Medications is security controlled and only given to designated employees (Physicians and Physician Assistants).

1. Right Click in the Medication Profile window and select Prescribe.

2. The EasyScript window will be displayed. Enter the Medication in the search field and Click Search. The list of possible matches will be displayed below the search field.

Note: The system uses Multum interaction checking when processing prescription actions. Based upon drug interactions or patient allergies, the system may open a Decision Support window.
3. Double click the medication that will be prescribed or click and highlight the medication and then click **Select**.

4. The medication will be displayed on the **Rx Pad**, complete the necessary information. The required fields are indicated in **Red**.

5. Select the **Address** (Physician), **Routing** (Print Rx or Don’t Print Rx), and **Leaflet** (No Leaflet, English Leaflet, or Spanish Leaflet).

6. Click the Sign Orders button.

7. The Medication will appear in the Medication List as a **Rx**.
Refilling a Medication Overview

The medications in the Medication Profile can be refilled quickly and efficiently by utilizing the Right-click menu. To refill medications from the medication profile there are two options to use. The options are Refill/Renew and Refill/Sign.

The Refill/Renew feature will allow the user to refill and renew the selected medication order from the right-click menu. The Easy Script Rx Pad will be displayed and all fields in the Rx Pad are available for modification. If the medication name, dose, route or frequency is changed, the system automatically takes a Duplicate/Discontinue action on the prescription. When you perform this action, the system provides automatically one prescription renewal, resulting in one active prescription order. To include additional refills in the renewed prescription order, enter a value for the Refill detail.

The Refill/Sign feature allows the user to refill and sign and order all in one action. When you perform this action, the system will not allow the user to change any of the associated information and the EasyScript Rx Pad will not be displayed. If the person refilling the order is different from the person who originally placed the order, the Prescriber Detail automatically changes.

Refilling and Renewing a Medication

To complete the Refill/Renew process, complete the following steps.

1. Right-click on the medication that you wish to perform the Refill/Renew action on.
2. Select the Refill/Renew option.
3. The EasyScript window will be displayed. Confirm the name of the Medication you are refilling is displayed in the Rx Pad.
4. Enter the Refill/Renew information in the Rx Pad by entering your changes to the displayed information.
5. Click Sign Orders button.
Refilling and Signing a Medication

To complete the Refill/Sign process, complete the following steps.

1. Right-click on the medication that you wish to perform the Refill/Sign action on.
2. Select the Refill/Sign option and select the Refill quantity (As Dispensed + 1 Refills). The refill quantity can range from 0 – 11.
3. The medication will be refilled and signed.
4. The Medication Profile will be updated with the current information.
Adding a Medication by History

Medications can be added to the Medication Profile in the following manner.

1. Right Click in the Medication Profile window and select **Add Medication by Hx**.

2. The EasyScript window will be displayed. Enter the Medication in the search field and **Click Search**. The list of possible matches will be displayed below the search field.

**Note:** The system uses Multum interaction checking when processing medication by history actions. Based upon drug interactions or patient allergies, the system may open a Decision Support window.
3. Double click the medication that will be prescribed or click and highlight the medication and then click Select. The medication will be displayed on the Rx Pad, complete the necessary information.

4. In the Prescription Pad, the system automatically selects the Document (Don't Print) Rx As: as the value for the Routing detail. Select the additional routing detail for the Hx.

5. The system activates automatically the Historical option in the Rx Pad.

6. Click the Sign Orders button.

7. The Medication will appear in the Medication List as a Hx.

**Viewing a Medication History**

The Medication History can be viewed in the following manner.

1. Double-Click on the Medication that you want to view and the Order Information window will be displayed.
2. Click the **History Tab** to view the *Medication History*.

### Modifying a Medication

Complete the following steps to modify a Medication in the Medication List:

5. Right-click the Medication you want and select *Modify*.
6. The EasyScript window will be displayed. Confirm the name of the Medication you are modifying is displayed in the Rx Pad.

7. Modify the Medication by entering your changes to the displayed information.

8. Click Sign Orders button.

---

**Note:** The changes take effect immediately and the modification date and time are displayed in the history.

---

**Canceling/Discontinuing a Medication**

Using Medication Profile, you can indicate that you want to cancel or discontinue an active medication order. The action the system performs on the order depends upon the value of the order's Start Date and Time detail. If the specified start date and time value is in the past, then the system discontinues the order. If the specified start date and time are in the future, then the system cancels the order.

To cancel a Medication, complete the following steps:

1. In the profile, Right-Click the Medication you want and select **Cancel/DC**. The Cancel/DC Order window opens.
2. Enter a **Discontinue Reason** from the drop down menu (Double-click the reason) and enter a **Comment**.

![Discontinue Reason](image)

3. **Click Sign** to **Cancel/Discontinue the Medication**. The Medication will be displayed in the Past Folder in the Medication Profile.

---

**Adding a Medication to My List (Favorites)**

By **Adding Medications to My List**, you can select them quickly. To add a Medication to My List, this can be completed in two ways. Use the following steps:

1. Click the **Add To My List** button when **Adding a New Problem** in the Easy Script window or Right-Click the Medication and select Modify. Then Click the **Add To My List** button.

---

**Removing a Medication from Your Favorites**

To **Remove Medication from My List** (favorites), complete the following steps:

1. Access the EasyScript screen by clicking the EasyScript button or Right-Click the Medication and select Modify. The Modify Medications window will be displayed.

2. Click the **My List Tab** and right-click the Medication that you want to remove from My List and **Select Remove**.

3. Click the Back Arrow or Close the window when the action is completed and the Medication will be removed from My List.
Tips & Tricks

1. When entering a prescription or medication by history, searching by product returns the most specific medication choices including the various different strengths available for each medication.

2. When entering a prescription or medication by history, there are two exceptions when you should search by Drug Name instead of by product:
   a. The Misc. Prescription is only found by Drug Name search
   b. Herbal medications are only found by Drug Name search

3. When entering a prescription or medication by history, type 3-5 letters of the name of the medication when searching instead of the full name. This saves time and minimizes the chance of not finding a medication because there is a mismatch between the name provided by Multum and the name you typed.

4. When entering a prescription or medication by history, use the orders in Typical orders/prescriptions whenever available. If you don’t find an exact match, select the closest order and make modifications as needed instead of completing each order detail individually.
### Super User Information

**Setting Preferences**

PowerChart Office® provides a standard configuration for the Medication Profile and recommends that you do not change it.

If you need to change the configuration, complete the following steps to change your preferences:

1. From the Medication Profile menu, select **Preferences**. The system displays the Preferences dialog box.

2. Perform any of the following tasks to specify values for your preferences:
   
   a. To indicate which order detail values are displayed in the in-line SIG column for prescriptions and historical medications, select the details you want displayed in the SIG, and then click Add or Remove. To reorganize the order in which the details are displayed, select a specific detail in the right list, and then click Up or Down.
   
   b. To save the column widths established in the Medication Profile View or the Medication View during the current user session, click the appropriate button under Column Width Preferences. The saved widths serve as the default values the next time you access Medication Profile.
   
   c. To save the formatting of expanded or collapsed folders established during the current user session, select the Save Expand/Collapse Settings option. The saved formatting serves as the default format the next time you access Medication Profile.
   
   d. The Display Dispenses Column option is not applicable.
   
   e. To indicate whether you want the Medication Profile view or the Medication View to serve as the default view, select the appropriate option under Default View.
   
   f. To indicate how you want the system to display both the generic and the brand names for ordered medications in the Medication Profile, select the appropriate option under Name Display. This preference is only applied when you order brand name medications.
g. To indicate whether you want the system to include the refill history for each order when you print the Medication Profile, select the Print Refill History option. If you deselect this option, the printed Medication Profile includes only a listing of original medication orders.

3. Click Apply to save your preferences.

4. Click OK to close the Preferences dialog box.

Medication Profile Menu - Commands & Descriptions

Use the Medication Profile menu to manage the contents of Medication Profile. The following commands are available from this menu:

**Prescribe** – Writes an active prescription for a patient's current use. This command automatically launches EasyScript.

**Add Medication by Hx** – Documents a current medication prescribed by a different provider, or document a historical medication the patient no longer is taking. This command automatically launches EasyScript, with the Historical option in the Prescription Pad already selected.

**Print List Active Medications** – Prints a list of active medication orders to the default printer.

**Print List All Medications** – Prints a list of all medication orders, both active and historical, to the default printer.

**Check Interactions** – This command is currently unavailable.

**Refresh Profile** – Refreshes the contents of the Medication Profile.

**See [alternate view]** – Switches to the other view of the Medication Profile.

**Preferences** – Launches the Medication Profile preferences window, in which you can set various parameters related to the appearance of the Medication Profile. For additional information, see Setting Preferences.
EasyScript

EasyScript is a prescription-writing tool that facilitates the Prescription Process. This process selects an appropriate generic or brand name medication; checks for potential medication interactions and side effects, and can produce a written or faxed prescription. The process automatically includes Multum drug and allergy interaction checking and patient education leaflets.

Overview
Basic EasyScript Overview

Creating a prescription in EasyScript view involves four basic steps:

1. Selecting the Medication.
2. Completing the order details for the Medication.
3. Printing or faxing the prescription.
4. Signing the prescription.

Selecting & Prescribing a Medication

When prescribing a medication in EasyScript, medications can be selected or order sentences can be selected from the following locations within EasyScript:

- **My List Tab**
- **Search Tab**
- **Typical Orders and Prescriptions** – provided by Multum for most common prescriptions
- **Med Profile Tab**

**Note:** After you select a medication from one of these locations, the system displays the Medication in the Prescription Pad. There you can complete the necessary order details to customize the prescription, and sign the prescription.**
Completing the Medication Details

After you have selected a Medication and the system has displayed the Medication in the Prescription Pad, complete all required and other order details as needed to customize the prescription for your patient.

The Prescription Pad is composed of three main sections: a Primary, a Prescriber, and a Supplementary Order Section. By default, the system displays the primary and the Prescriber sections in the Prescription Pad. You can access the supplementary section by clicking Order Details.

The Primary and Prescriber sections contain the most commonly used or essential order details. Required details are indicated in Red.

While you are completing the order details, the system displays your in-process prescription in the Rx List tab (Prescription List). The prescription remains in this tab until it is signed. The Action column indicates the signing status of the prescription: If the prescription is ready to be signed, then the column is empty; if the prescription is not ready to be signed, then ✗ is displayed in the column. You cannot sign the prescription until you have completed all of the required order details.

After you have completed the order details, you are ready to print or fax the prescription.
Order Details – Terms To know

**Primary Name & Order Detail Description**

**Rx** – Contains the name of the medication being prescribed. It also lists all applicable brand name and generic name products.

**Free-text Product** – Only available if the Miscellaneous Medication is selected, this detail documents medication information. If you cannot locate a Medication using the search options available in the Medication Selection pane.

**SIG** – Contains directions for the administration of the medication, including dose, route, frequency, and duration.

**Dose** – Contains the prescribed dose for the selected medication. This detail also accepts free-text entry.

**Route** – Specifies the route of administration for the medication. This detail does not accept free text entry.

**Frequency** – Displays the prescribed frequency for the ordered medication. This detail does not accept free-text entry.

**Duration** – Outlines the prescribed length of time the medication is to be taken by the patient.

**Dispense/Supply** – Specifies the amount of medication to dispense to the patient in the prescription. For PRN prescriptions, the value of this detail must be entered manually.

1. If the dose value is expressed in units of capsules, tabs, ml, packets, patches, suppositories, or lozenges, and if values are entered in the Frequency and Duration details, then the system automatically calculates a quantity-based value for this detail using the dose, frequency and duration values.

2. If the dose value is expressed in any units other than those specified above, and if values are entered in the Frequency and Duration details, then the system uses the duration value to express a supply-based value for this detail.

3. If the values of the Dose, Frequency, and Duration details are changed, then the system recalculates automatically the value of the Dispense/Supply detail. If free-text values are entered for the dose, frequency, and duration, the system does not calculate a dispense/supply value.

**Refill** – Indicates the number of times this prescription can be refilled.

**Rx Date** – Indicates the starting date of the prescription, with a default value of the current date and time. You can change the value of this detail.
Stop Date – Defines the date on which the prescription is to stop.

1. If the Duration and Refill details are populated, the system automatically calculates the value of the Stop Date detail.

2. If the Duration and Refill details are blank, the system assumes they have a value of zero. You also can enter a stop date or change the calculated stop date using the calendar.

3. If you modify the value of this detail, the system automatically selects the Auto Stop option. If you do not modify the value of this detail and you want the prescription to automatically stop on this date, you can select the Auto Stop option.

Samples – Documents the number of samples given to the patient. This detail accepts a numeric value without a unit of measure.

Total Refills – Indicates the total number of refills available for a prescription. The system updates the value of this detail each time a prescription is refilled. You cannot modify the value of this detail.

PRN – Contains standard PRN instructions for many medications, such as “take as needed for pain.” You can also enter free-text instructions with a maximum of 255 characters in this box.

Instructions – Contains standard instructions for many medications, such as “take with plenty of water” You can also enter free-text, supplemental instructions for the patient.

Indications – Contains free-text documentation of symptoms or reasons why you are prescribing this medication. You can enter a maximum of 100 characters in this box.

Comment – Contains free-text additional documentation for the patient. You can enter a maximum of 32,000 characters in this box.

Prescriber – Specifies the name of the person prescribing the medication. If the user placing a new order is a provider, the system enters the user’s name as the default value of this detail.

Note: You can search for a different prescriber’s name using the Provider Selection dialog box. This dialog box contains options allowing you to filter your search results based on a provider’s group, organization, position, and relationship to the patient. When you select any of these filter options, the system applies the same filters to your subsequent provider searches.

Supervising Physician – Specifies the name of the supervising physician who can cosign an order being placed by a mid-level provider. Privileges set by PowerChart Office® determine whether co signature is required, the name of a default supervising physician, and whether the mid-level provider is allowed to select a different supervising physician.
**Leaflet** – Indicates if a patient information leaflet exists, and enables you to print the leaflet automatically when prescriptions are signed. If available, you can select leaflets in English or Spanish.

**Address** – Indicates the prescriber’s address. The system enters the initial value of this detail automatically after you have entered a value for the Prescriber detail. If a Prescriber has multiple addresses, the system displays a list of the prescriber’s addresses in the Prescription Pad. For the final value of this detail, you can select an address from that list.

**Routing** – Indicates the method by which the prescription is routed to a pharmacy, which can include printing, not printing, or faxing the prescription. Depending upon the method you choose, you also may be required to enter additional routing information.

**Additional Information** – Contains specific routing information, which can include a do not print reason or a fax destination. The system activates this detail when you select the Document (Don’t Print) as or Send Rx by Fax values for the Routing detail.

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**Note:** The supplementary section less frequently used or non-essential order details. The Prescription Pad also contains various options that allow you to further customize the prescription. Activated using check boxes, these options are described below.

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**Quick SIG** - Determines whether the system enables Quick SIG functionality. When you select this option, the system provides a one-step way of choosing the dose, route, and frequency for the prescription. The possible values presented by the system are considered common ways of prescribing a given medication.

**Short List** – Determines whether the system displays abbreviated or complete lists of possible values for specific order details.

1. When you select this option, the system displays a subset of possible values for the Dose, Route, Frequency, Duration, and Dispense details.

2. When you deselect this option, the system displays a full list of possible values for the details listed above.

The system displays four different colors of icons with the possible detail values. The icons are displayed in the following order, as applicable:

1. **Most Common**

2. **Common**

3. **Non-common**

4. **Generic** – This contains all of the possible choices for the given detail. Only the most common choices are visible when you select the Short Lists option.
**Auto Stop** – Determines whether the system enables automatic stop functionality.

1. When you select this option, the system moves a prescription automatically from the Current Prescriptions folder in the Medication Profile to the Past Prescriptions folder when the stop date has been reached and the ORM Continuing Order Update operations jobs runs.

2. When you deselect this option, the prescription remains in the Current Prescriptions folder, even if the stop date has been reached the system automatically selects this option when you modify the value of the Stop Date detail.

3. When you select a value for the Duration detail, although the system automatically calculates the value of the stop date, you must select the Auto Stop option for the system to move the prescription automatically to the Past Prescriptions folder when the stop date is reached.

**DAW** – The Dispense as Written option determines whether substitution is allowed for the prescription.

**Print DEA** – Determines whether the prescriber’s Drug Enforcement Agency (DEA), number, if built in the system, is printed on the prescription form. This is automatically printed on the script based off the system configurations. Typically Schedule 1 and 2 drugs are configured to include the DEA number.

**Historical** – Determines whether a prescription is marked as historical, which means you are recording past medication information about a patient, or documenting a current medication from a different Prescriber. This option is available only when you select Document (Don’t Print) Rx As for the routing option. Selecting the Historical option restricts the possible values for the additional routing information detail.
Printing a Prescription

The system prints your prescriptions to a specific printer based on the printer default option selected in the Output Destination dialog box. The system automatically selects the Always Use the Default Output Destination Associated with the Computer I Am Using option. That option routes all the prescriptions you write using that computer to the computer's default Windows printer.

**Note:** PowerChart Office® recommends that you use this option.

1. The Favorites tab of the Output Destination dialog box automatically displays all of the printers associated with the computer that you are using.
2. The default printer for the computer you are using is automatically selected.
3. To select to print to a different printer than the default printer, locate the printer you want to use.
4. Select the printer to which you want to route your prescriptions.
5. Click OK. The system displays the printer information in the Prescription Pad, and then closes the Output Destination window.

- If you want to print a prescription, select the Print Rx value for the Routing detail while you are completing the order details in the Prescription Pad.
- You will also need to select the printer you want the prescription to print on.
Document (Don’t Print) Rx

If you select the Document (Don’t Print) Rx option, the system displays a group of don’t print reasons. The don’t print reasons determine whether the medication is recorded as a prescription (Rx) or historical medication (Hx) and whether the medication is in the Current or Past folder of the Medication Profile.

- Current Med (Hx) – documents a historical medication (Hx) in the Current folder
- Past Med (Hx) – documents a historical medication (Hx) in the Past folder
- Called to Pharmacy (Rx) – documents a prescription (Rx) in the Current folder
• Samples Given to Patient (Rx) – documents a prescription (Rx) in the Current folder
• Other Reason (Rx) – documents a prescription (Rx) in the Current folder

## Signing a Prescription

After you have completed the necessary order details, you are ready to sign your prescription.

To sign your prescription, complete the following steps:

1. In the Rx List tab (Prescription List), locate the prescription.
2. Check the signing status of the prescription as indicated in the Action column. If the prescription is ready to be signed, then the column is empty; if the prescription is not ready to be signed, then **X** is displayed in the column.

   **Note**: If the prescription is not ready to be signed, return to the Prescription Pad and complete the required order details.

3. Click **Sign Orders**. The system signs all of the orders in the Rx List that are ready to be signed.

   **Note**: If you are a mid-level provider, the system may require a supervising physician to cosign the order. Privileges set by your site administrator determine whether co-signature is required, the name of a default supervising physician, and whether the mid-level provider is allowed to select a different supervising physician.

4. If you want to verify that your prescription has been signed, click the Med Profile tab (Medication Profile). The system has added the new prescription to the Medication Profile.
Adding a Medication to My List

The My List tab in the Orderable Selection pane contains a list of favorite medications, which are unique to each user.

To add a medication to your My List, complete the following steps:

1. Click the Rx List Tab after you have completed the necessary information for the prescription.
2. Select the medication you want to add to your My List.
3. Click **Add to My List**. The system adds the medication to your My List.

Using My List

The My List tab in the Orderable Selection pane contains a list of favorite Medications and their associated order sentences, which are unique to each user.

To select a Medication from your My List, complete the following steps:

1. Click the **My List** tab in the Orderable Selection pane.
2. Review the list of available medications.
3. Select the medication you want.
4. **Click Select**. The system displays the order sentence in the Prescription Pad.

*In the Prescription Pad, you are ready to begin completing order details for this prescription.*
Prescribing a Miscellaneous Medication

If you cannot locate a Medication using the search options available in the Medication Selection pane, you can prescribe a miscellaneous medication instead.

To prescribe a miscellaneous medication, complete the following steps:

1. Click the Search tab in the Orderable Selection pane.
2. Select the Drug Name option.
3. Enter misc in the Search box.
4. Click Search.
5. Select Misc Prescription from the search results.
6. Click Select. The system displays Misc Medication in the first line of the Prescription Pad.
7. Enter the appropriate name for the Medication in the first line of the Prescription Pad, after Misc Medication.

Note: The miscellaneous medication is not subject to interaction checking, since the Medication is not codified.
8. Complete the necessary order details.
9. Print or fax the prescription.
10. Sign the prescription.

Note: The miscellaneous medication is not subject to interaction checking, since the Medication is not codified.
Tips and Tricks

1. Searching by product returns the most specific medication choices including the various different strengths available for each medication.

2. There are two exceptions when you should search by Drug Name instead of by product:
   a. The Misl Prescription is only found by Drug Name search
   b. Herbal medications are only found by Drug Name search

3. Type 3-5 letters of the name of the medication when searching instead of the full name. This saves time and minimizes the chance of not finding a medication because there is a mismatch between the name provided by Multum and the name you typed.

4. Use the orders in Typical orders/prescriptions whenever available. If you don’t find an exact match, select the closest order and make modifications as needed instead of completing each order detail individually.

5. Use My List for the medications you prescribe most frequently. Complete all details in the Prescription pad, select the medication order in the Prescription List, right click, and Add to My List. This adds the medication along with all of the order details to your My List.

6. Use My List for any special or compounded prescriptions you regularly prescribe. Search for the Mis Prescription and enter the information for the prescription, select the medication order in the Prescription List, right click, and Add to My List. This adds the medication along with all of the order details to your My List.
Inbox

Inbox is Cerner Millennium's solution for managing workflow in the clinical office. Rather than having an unwieldy flow of hard-copy documentation being routed through your office and healthcare facility, Inbox is electronic. It enables you to review or sign results, documents, and prescription requests, as well as working with telephone and other messages.

In this scenario, you will:

- Create a Phone Message
- Complete Results to Endorse
- Complete Sign and Review
- Complete Orders to Approve
- Review Sent Items
- Utilize the Browser
- Review Trash Can Items
Inbox Overview

Inbox offers the following benefits:

- All messages and notifications that require your review or attention are routed to Inbox and are organized in folders.
- Recording phone messages and saving the information to the patient's chart are completed electronically.
- Results can be reviewed, signed, or forwarded to other healthcare providers online.
- Your Inbox can be accessed from any computer in your healthcare system.

The folders available in the Inbox vary by role and include:

- Inbox Messages
- Results to Endorse
- Sign and Review
- Orders to Approve
- Sent Items
- Browser
- Trash Can
Address Book Overview

Use the Global and Personal Address Books to look up recipients when sending and forwarding Inbox items. To select a recipient, complete the following steps:

1. Open the Address Book dialog box. (In most Inbox windows, click .)

2. In the Show Names From list, select Personal Address Book or Global Address Book.

3. To locate the name you want, you can either scroll through the list or enter a portion of the last name in the Type Name or Select From List box.

4. Select the person you want.

5. Click ->. The name is moved to the Forward Message To list.

6. Repeat Steps 3 and 4 until you have added all the recipients' names.

7. Click OK to add the recipients to the message, or click Cancel to close the dialog box without adding the recipients.

Adding Names to the Personal Address Book

Your Personal Address Book enables you to maintain a list of people in your organization with whom you correspond frequently. Locating a name in your Personal Address Book is much quicker than scrolling through the long list of names in the Global Address Book.
To add names to your Personal Address Book, complete the following steps:

1. From the Inbox menu, select Address Book. The Address Book dialog box opens. Your Personal Address Book is displayed by default.

2. In the Show Names From list, select Global Address Book. All names in the Global Address Book are displayed.

3. To locate the name you want to add to your Personal Address Book, you can either scroll through the list or enter a portion of the last name in the Type Name or Select From List box.

4. Right-click the name you want to add and select Add to Personal Address Book from the context menu.

5. Click OK to close the dialog box and return to the Inbox window.

Note: When you select Add to Personal Address Book from the context menu, that change is saved immediately; clicking Cancel at this time does not cancel the changes you made.

Removing Names from the Personal Address Book

To remove names from your Personal Address Book, complete the following steps:

1. From the Inbox menu, select Address Book. The Address Book dialog box opens. Your Personal Address Book is displayed by default.

2. Right-click the name you want to remove and select Remove From Personal Address Book from the context menu.
3. Click OK to close the dialog box and return to the Inbox window.

Note: When you select Remove From Personal Address Book from the context menu, that change is saved immediately; clicking Cancel at this time does not cancel the changes you made.

Messages Overview

Inbox messages enable you to document a call electronically, add it to the patient's chart, and forward it to other providers. Messages that you receive are placed in the Messages folder where you can take any number of actions, such as reading, adding to the patient's chart, forwarding, and replying.

If a message is sent to a user that does not have the appropriate inbox folder set up to receive that message type, the message will not be delivered to that user’s inbox. If a message is sent to a user that does not have a relationship established with that patient, the user may be required to choose a relationship with which to view the patient’s record.

Creating a Phone Message

To create a phone message, complete the following steps:

1. On the toolbar, click or from the Task menu, select New Phone Message. The Message window opens.
2. Select a patient by entering the patient name and clicking the search button at the end of the Patient box. The Patient Search dialog box opens.

3. You may select an existing encounter, if an appropriate one exists. If you do not select an existing encounter, the most current encounter will be automatically selected.

4. When you select a patient, the patient's name and phone number are displayed in the Caller and Phone boxes by default. If the Phone Message does not pertain to a patient, leave the Patient box empty.

5. If the caller was someone other than the patient, delete the patient's name and phone number from the Caller box and enter the caller's name and phone number.

6. Select a recipient for the message by entering the name in the To field and clicking the search button. The Address Book dialog box opens, click OK to confirm the recipient’s name.

7. If you want to change the default phone message template, make a selection from the Subject list by clicking the Selection List button. The new template is displayed in the Message window.

8. Enter the information you want regarding the conversation in the Message window.
9. To save the phone message to the patient's chart, click the Save to Patient's Chart option. If you do not choose to save the message to the patient’s chart, you will receive the following message:

![Inbox Message]

Message is patient related. Do you want to save it to the patient's chart?

- Yes
- No
- Cancel

10. The message can be saved now or later in the message process.

11. When you are finished documenting the phone conversation, click 

The phone message will be sent to the recipient's Inbox Messages folder.

Repeating to Messages Not Saved in the Chart

You can reply to the sender or you can reply to the sender and all users who received a copy of the message. To reply to an Inbox message that has not been saved to the patient’s chart, complete the following steps:

1. With the message to which you want to reply open, select Reply or Reply to All from the Task menu. The Message window opens with the text and details from the original message displayed.

2. Enter your message.

3. From the Task menu, select Send. Your reply is sent and the Message window closes.

Repeating to Messages Saved to the Chart

For saved messages, the user will modify the message first.

1. With the message to which you want to reply open, select Modify Document from the Documents menu or click the Modify icon.

2. Enter your message.

3. Select Sign.

4. Select Reply or Reply to All from the Task menu.

5. A message window opens.

6. Since you have already modified the message, select Yes.
NOTE: If you select Reply or Reply to All from the Task menu before modifying a saved phone message, you will see the same dialog box as above. In this case, since you have not yet modified the message, select NO. Then begin at Step 1.

Forwarding Messages

To forward a message to another user, complete the following steps:

1. With the message you want to forward open, select Forward from the Task menu. The Message window opens with the text and details from the original message displayed.

2. Select a recipient for the message by clicking next to the To box. The Address Book dialog box opens.

3. If you want to set a follow-up date, select the Due Date option and select a date.

4. Enter your message in the Message box.

5. Click to send the message.

6. The system verifies that the recipients have Inbox set up.

Requesting Medication Renewal While Creating a Phone Message

If you do NOT have the authority to renew a patient's medication, complete the following steps to renew the medication and send a message:

1. With the patient selected in the Phone Message window, select Medication Renewal from the drop down subject menu. The Medication Renewal template populates the Message window.

2. Click the Medication Renewal option in the top left corner of the screen.
3. In the Message tab, enter a message specifying a medication to refill and which pharmacy it should be called to.

Renewing a Medication While Creating a Phone Message

If a pharmacy or patient calls to request a medication renewal, you can document the phone call and refill the prescription from Inbox. If you are a provider, you can document the call, complete the refill, and sign it at once. If you are a non-provider, you can document the phone call, complete the refill, and send the phone message to a physician for signature.

If you have the authority to renew a patient's medication, complete the following steps to renew the medication and send a message:

1. Click on the Reply to Sender icon on the tool bar. The Med Renewal tab is displayed.

2. In the Medication Renewal tab, right-click the row for the medication you want to renew and select Refill/Renew.
3. When the script pad opens, change the Additional Refills box to number of refills desired.

4. For the Routing order detail, select Document (Don’t Print) Rx and select Called to Pharmacy for the Don’t Print reason.

5. Click Sign Orders.

6. In the phone message, click the Message tab.

7. Add a note that the prescription was called to the pharmacy and click Send.
8. Select the Save to the Patient’s Chart option.

Deleting a Phone Message

To delete messages in your Inbox, complete the following steps:

1. Select the message you want to delete.

2. From the Inbox menu, select Delete. The message is moved from the current folder to the Trash Can.
Results to Endorse Overview

The Results to Endorse folder is used to allow providers to have quick and easy access to New Results that they have ordered. The results are only sent to the ordering physician and can then be forwarded to other providers for review.

Opening and Viewing Results to Endorse

To open and view a Results to Endorse item, complete the following steps:

1. Double-click the Results to Endorse item you want to open and view.
2. The Results to Endorse window opens with the results highlighted in yellow.

Endorsing the Results to Endorse

To endorse the Results to Endorse, complete the following steps:

1. Double-click the Results to Endorse item.
2. Review the Results to Endorse that are highlighted in yellow. Please verify the entire Results to Endorse screen.
3. The Endorse radial in the Action section will be selected by default. If not, select the Endorse radial.
4. Enter a data in the comment field, if necessary.

5. Click OK to complete the endorsement process and then click cancel to return to the Results to Endorse folder or click OK & Next to complete the endorsement process and move to the next Results to Endorse item.

Refusing Results to Endorse

The Refuse feature enables you to refuse to endorse a result. The result should be refused if you didn’t order the result or you didn’t follow the patient.

To refuse an item in the Results to Endorse folder, complete the following steps:

1. Double-click the Results to Endorse item. The Results to Endorse window opens, displaying the result information.

2. Review the Results to Endorse that are highlighted in yellow. Please verify the entire Results to Endorse screen.

3. The Endorse radial in the Action section will be selected by default. Select the Refuse radial button.

4. Select the Review radial in the Forward section and enter a provider that the document should be forwarded to for review. Note: You must forward the Results to Endorse item if you refuse it.

5. Select a Refusing Reason it is a required action.
6. Click OK to complete the refusal process and then click cancel to return to the Results to Endorse folder or click OK & Next to complete the refusal process and move to the next Results to Endorse item.

**Forwarding a Results to Endorse**

The Forwarding feature enables you to forward the Results items without endorsing the item.

To forward an item in the Results to Endorse folder, complete the following steps:

1. Double-click the Results to Endorse item. The Results to Endorse window opens, displaying the result information.
2. Review the Results to Endorse that are highlighted in yellow. Please verify the entire Results to Endorse screen.
3. The Endorse radial in the Action section will be selected by default. Select the Forward Only radial button.
4. The Review radial in the Forward section will be defaulted.
5. Enter a provider name in the Forward section (You can forward to a maximum of 5 providers).
6. Enter a comment in the comment field.
7. Click OK to complete the refusal process and then click cancel to return to the Results to Endorse folder or click OK & Next to complete the refusal process and move to the next Results to Endorse item.
Changing a Results to Endorse View

The View feature in the Results to Endorse folder enables you to change how the results to endorse items are displayed in the Flowsheet.

To change the view of the Results to Endorse items, complete the following steps:

1. Click the Results to Endorse item. The Results to Endorse window opens, displaying the result information.

2. Review the Results to Endorse that are highlighted in yellow. Please verify the entire Results to Endorse screen.

![Inbox Options window with various options for changing the view of results to endorse items.](image)
Signing & Review Overview

Documents and results for your review or signature may be displayed in the Sign and Review Folder. Notifications that require your signature include results from orders you placed, transcribed documents, saved documents, scanned documents, and documents and results forwarded to you by another provider.

Signing or Reviewing Documents & Results

To sign or review notification, complete the following steps:

1. Double-click the notification you want. The applicable window opens, displaying that notification's information.

2. In the Action group box at the bottom of the screen, select Sign/Review. You can forward a document at the same time you are signing it.

3. If you want to include comments, enter them in the Comments box.
4. Click OK to sign the notification or click OK & Next to sign it and open the next notification in the folder. The notification is signed.

Note: Refer to the Clinical Notes Training Guide for information about viewing document history.

**Forwarding Documents and Results**

You can forward documents and results to other users for review and signature. Notifications in Sign and Review folders can be forwarded.

To forward a document or result to another provider, complete the following steps:

1. Double-click the notification to open it. The appropriate window for the notification type opens.

2. In the Action group box, select Forward Only.

3. In the Forward group box, click ... The Address Book dialog box opens.
4. Select the user to whom you want to forward the item.

5. Select the Signature option if you want the recipient to sign the item or select the Review option if you want the recipient to review the item.

6. If you have any comments you want to include, enter them in the Comments box.

7. Click OK to forward the item and return to the Inbox window. The item is displayed in the recipient’s Sign and Review folder. Click OK & Next to forward the item and open the next item in the folder. Click Cancel to close the window without forwarding the item.

Note: The system will automatically create a relationship if you forward a document or results to a user who does not have a relationship with the patient.
Receiving Forwarded Documents and Results

A user may choose to forward a document or results to you for review or signature. A comment may be added to relay the reason the document or results are being forwarded. To review a forwarded document or result, complete the following steps:

1. Click the Sign & Review folder and highlight the item in the folder.

2. Scroll to the right to view the comments that were sent with this item.

3. Double click on the item you wish to open. The comments sent along with the forwarded item can also be viewed in the lower right-hand side of the screen.
Refusing Documents and Results

The Refuse feature enables you to refuse to sign a document, result, or forwarded item.

To refuse an item, complete the following steps:

1. Double-click the notification you want. The applicable window opens, displaying that notification's information.

2. In the Action group box, select Refuse.
3. Click OK to refuse to sign the item.

4. You will be required to enter comments and forward the notification to another provider.

5. If the item is added to the patient's chart, a note is included, stating you refused to sign. Click OK & Next to refuse to sign the item and open the next item in the folder. If you do not want to refuse the item, click Cancel.

Orders to Approve Overview

Cosign orders are orders placed by non-providers and require co-signature from a provider. The order types that require co-signature are defined by PowerChart Office® and the provider who is to receive the cosign request is specified in the order.

Note: If a medical student places an order, it becomes a Medical Student Order, which has an on-hold status until signed by a physician.

If another non-provider places an order, it takes effect immediately and is sent for co-signature for the provider specified in the order.

Viewing & Signing Orders to Approve

To approve an item, complete the following steps:

1. Double-click the notification you want. The applicable window opens, displaying that notification's information.

2. In the Action group box, select Sign.

3. Click OK to sign the item. Click OK & Next to sign the item and open the next item in the folder.
Viewing Order Information in Orders to Approve

To sign a Cosign Order, complete the following steps:

1. Double-click the cosign order to open it. Click on the Order Information icon. The Order Information window opens for viewing of order details.

2. Click the Exit icon to return to the Cosign Order window.

3. Click sign to sign the order and click OK. The Order Information window closes.

Refusing Orders to Approve

To refuse a Cosign Order, complete the following steps:

1. Select the cosign order you want to refuse.

2. From the Inbox menu, select Refuse. A statement is added to the patient's chart, stating you refused to cosign the order.

Further information about co-sign:

- Refusing to cosign an order does not stop or cancel it.
- You will be required to enter comments and forward the notification to another provider. System build determines where the refused order routes to. This cannot be determined by the end-user.
**Sent Items Overview**

The Sent Items folder contains a listing of all the items that you have sent to other providers. This folder can be used as an audit trail for the items that you have sent and their current status. The items in the Sent Items folder are organized by the type. These items cannot be deleted or restored but they can be opened and reviewed.

**Browser Overview**

The Browser Icon in the Listbar provides the user with a direct link to the MCGHI homepage. This link can be used to access MCGHI links such as My Health Link or the Internet.
Trash Can Overview

The trash can Messages that you delete are stored in the Trash Can. The items in the trash can will remain there until you restore to inbox messages or empty the trash can. You can review the trash can items from the trash can folder list.

Opening & Reviewing the Trash Can Items

The Messages that you delete are stored in the Trash Can, but you can still open and review trash can items. To open and review a Trash Can item, complete the following steps:

1. Double-click on a Trash Can item or right-click and select Open from the menu.

2. The trash can item will open and display on the screen.

3. Click the (X) in the top right hand corner to close the window.
Restoring a Trash Can Items

The Messages that you delete are stored in the Trash Can, but you can restore the items back to the messages folder. To restore an item back to the messages folder, complete the following steps:

1. Right-click on an item and select Restore from the menu.
2. The trash can item will be restored back to the messages folder.

Deleting a Trash Can Items

The Messages that you delete are stored in the Trash Can until you empty the Trash Can. The trash can allows the provider to delete individual items from the trash can. Once you have deleted an item from the Trash Can, you can no longer restore the deleted message. To delete a Trash Can item, complete the following steps:

1. Right-click on an item and select Delete from the menu.
2. The trash can item will be deleted from the trash can.

Emptying the Trash Can

The Messages that you delete are stored in the Trash Can until you empty the Trash Can (Empty the Recycle Bin). Once you have emptied the Trash Can, you can no longer restore deleted messages. To empty the Trash Can, complete the following steps:

1. Right Click on the trash can screen.
2. From the menu, select Empty Recycle Bin. A message opens, prompting you to confirm the deletion.
3. Click Yes to empty the Trash Can or No to cancel.
Proxy Access Overview

The Inbox Proxy Access feature is a useful tool that enables providers to allow other to selected items within their Inbox. Proxy access enables the proxy to review, sign, refuse, and forward messages in the folders to which you have granted authorization. The only way for someone to have proxy access is for you to grant it.

Granting Proxy Access

**Granting Proxy Access** enables another provider to access your Inbox messages and handle them for you. When granting proxy authorization, the user specifies the provider, the specific Inbox folders, and a date range. Likewise, you can act as a proxy for another provider.

To grant proxy authorization to another provider, complete the following steps:

1. From the Inbox menu, select Update Proxy. The Proxy Display dialog box opens.
2. Select the Proxy List Given by Me option.
3. If you want to give an individual proxy authorization, click Add Person. To give proxy authorization to a proxy group, click Add Group. The Add Proxy dialog box opens.

Note: You cannot **Proxy Access** to Orders to Approve.
4. In the Available Types for Proxy list, select the folder type for which you want to give proxy authorization.

Note: Orders to Approve and Trash Can are not available for proxy.

5. Click Move >. The folder type is added to the Types to Be Shown for Proxy list.

6. Repeat Steps 4 and 5 until you have selected all the folder types you want.

7. Specify a Start Date Time and End Date Time. For example, if you will be out of the office for two weeks, specifying the Start Date Time and End Date Time ensures the proxy will be able to access your Inbox messages during that period only. By setting the End Date Time, you do not have to remember to turn off the proxy authorization when you return.

8. If you are granting proxy authorization to a group, select the group you want in the Select a Proxy Group Name list. If you are granting authorization to an individual, enter the person's name or click [password]

9. Click OK to close the dialog box and grant the proxy authorization. Click Cancel to close the dialog box without granting the authorization. The new proxy authorizations you granted are displayed in the Proxy Display dialog box. They are organized by provider name and document type.
Updating Proxy Access

Once you have granted proxy authorization, you can update the starting and ending dates and times. To update the starting and ending dates and times, complete the following steps:

1. From the Inbox menu, select Update Proxy. The Proxy Display dialog box opens.

2. Select the Proxy List Given by Me option.

3. Open the folder for the proxy whose authorization you want to change.

4. Select the folder type whose authorization you want to change. You can select all the folder types by selecting the first one, pressing SHIFT, and selecting the last one, or you can select various ones by selecting a folder type and pressing CTRL as you select others.

5. Click Update. The Add Proxy dialog box opens, displaying the current settings for the starting and ending dates and times.

6. Make any changes you want.

7. Click OK to close the dialog box and apply your changes. Click Cancel to close the dialog box without saving your changes.
Removing Proxy Access

To remove an existing proxy authorization, complete the following steps:

1. From the Inbox menu, select Update Proxy. The Proxy Display dialog box opens.

2. Select the Proxy List Given by Me option.

3. To remove all authorizations for a proxy, select the proxy’s folder. To remove the authorization for a specific folder type, open the proxy’s folder and select the folder type you want.

4. Click Remove. The proxy name and authorizations are removed.

5. Click OK to close the dialog box and return to the Inbox window.

Viewing Proxy Authorizations Granted

To view a list of all providers and document types for which you have been granted proxy authorization, complete the following steps:

1. From the Inbox menu, select Update Proxy. The Proxy Display dialog box opens.
2. Select the Proxy List Received by Me option. A folder with your User ID is displayed. Opening the folder displays folders for each provider who has granted you proxy privileges. In each folder is a list of the document types to which the provider has given you proxy privileges. The Begin Date Time and End Date Time are displayed for each document type.

3. Click OK to close the dialog box and return to the Inbox window.

Viewing Messages As a Proxy

To view Inbox messages for users who have granted you proxy authorization, complete the following steps:

1. In the Inbox bar, click the button with the name of the user whose messages you want to view. The folders to which you have been given proxy authorization are displayed.

2. Open any folders and review the messages you want. Messages have the same functionality as those sent directly to you. You can sign, refuse, and forward them.

Note: If you sign an item as a proxy, the signature will state you have signed on behalf of the original provider.

3. If you review an item and want to leave it for the original provider to review, close the item. Do not sign, refuse, or forward the item.

4. When you are finished, click the button with your User ID in the Inbox bar. Your Inbox folders are displayed.

Tips and Tricks

1. Add your office staff and members to the Personal Address Book to easily find them when sending messages.

2. Phone messages can be saved at any point in the process and all previously documented information is saved. Once a message is saved to the chart, you are required to modify the message and add an addendum for subsequent documentation.
Super User Information

Restoring Deleted Messages

To restore a deleted Inbox message, complete the following steps:

1. Click the Trash Can icon in the Inbox bar.

2. Select the message you want to restore.

3. From the Inbox menu, select Restore. The message is moved from the Trash Can to its original folder.

Customizing the Inbox Bar

The Inbox bar displays icons for your Inbox folders, as well as folders for any providers who have granted you proxy authorization. It eases working with Inbox by enabling you to open a folder by clicking on its icon, rather than navigating through a tree display.

Note: PowerChart Office® provides standard Inbox folder based on roles and recommends that you do not change them.
If you need to customize your Inbox bar, complete the following steps:

1. From the Inbox menu, select Options. The Inbox Options dialog box opens.

2. Select the General tab. The folders currently displayed in the Inbox bar are listed in the Folders in Inbox Listbar group box.

3. Remove any icons you do not want in the Inbox bar.

4. Re-sequence the icons to best suit your needs.

5. Click Apply if you want to make additional preference changes or click OK to close the dialog box and return to Inbox.

6. After closing the dialog box, click Refresh.

   Note: The New Results FYI folder is not recommended.

The following folders are not available for PowerChart Office®

- Browser
- Consult Order
- E-Mail
Displaying or Hiding the Inbox Bar

To display or hide the Inbox bar, complete the following steps:

1. From the Inbox menu, select View Listbar. If the Inbox bar is displayed, a check mark is displayed next to the Listbar command.

2. Select or deselect the Listbar command to display or hide the Inbox bar, respectively.

Displaying Messages by Status

PowerChart Office® defines standard statuses for display and recommends that you do not change them. The standard statuses are Pending, Opened, On Hold and Deleted. If you need to display or hide messages, complete the following steps:

1. From the Inbox menu, select Options. The Inbox Options dialog box opens.

2. Select the General tab.

3. In the Display Items with Checked Status group box, select or deselect the statuses you want to have displayed.

4. Click Apply if you want to make additional preference changes or click OK to close the dialog box and return to Inbox.

5. After closing the dialog box, click Refresh.
Customizing the Sign and Review Folder

PowerChart Office® provides standard Sign and Review folders and columns based on roles and recommends that you do not change them.

If needed, you can customize the display of the messages in the Sign and Review folder by specifying what columns and types of items are displayed.

Defining the Notification Types to be Displayed

To define what notification types (such as Documents to Sign and Forwarded Results to Review), you want displayed in the Sign and Review folder, complete the following steps:

1. From the Inbox menu, select Options. The Inbox Options dialog box opens.
2. Select the Sign and Review tab.
3. In the Sign and Review group box, select the type you want from the list.
4. Click . The notification type is added to the tree.
5. Click Apply if you want to make additional preference changes, or click OK to close the dialog box and return to Inbox.
6. After closing the dialog box, click Refresh.
Displaying Columns

You can customize Inbox to display only the columns you want for the Sign and Review and Messages folders. To display or hide columns, complete the following steps:

1. From the Inbox menu, select Options. The Inbox Options dialog box opens.
2. Select the tab for the folder you want.
3. To display columns, complete the following steps:
   a. Click . The Data List dialog box opens, displaying any columns that are not currently displayed.
   b. Double-click the columns you want to be displayed.
4. To hide columns, complete the following steps:
   a. In the list of columns, select the column you want to hide.
   b. Click .
5. To re-sequence the columns, complete the following steps:
   a. In the list of columns, select a column you want to move.
   b. Click or until the column is placed where you want it.
6. Click Apply if you want to make additional preference changes, or click OK to close the dialog box and return to Inbox.
7. After closing the dialog box, click Refresh.

Customizing the Messages Folder

PowerChart Office® provides standard Message Folder set up and columns based on roles and recommends that you do not change them.

If needed, you can define properties for saving a new phone message to the patient's chart, the default phone message template, and which columns are displayed in the Message folder.
Saving a new Phone Message to the Patient’s Chart

You can have new phone messages that have a valid patient name saved to the patient's chart automatically. By setting this preference, you do not have to save these messages to the chart manually. To set this preference, complete the following steps:

a. From the Inbox menu, select Options. The Inbox Options dialog box opens.
b. Select the Messages tab.
c. Select the option in the New Phone Message group box.
d. Click Apply if you want to make additional preference changes, or click OK to close the dialog box and return to Inbox.

Setting the Default Phone Template

You can specify which phone message template you want as the default for new phone messages. To specify your default phone message template, complete the following steps:

a. From the Inbox menu, select Options. The Inbox Options dialog box opens.
b. Select the Messages tab.
c. From the Select Default Phone Message Template list, select the template you want.
d. Click Apply if you want to make additional preference changes, or click OK to close the dialog box and return to Inbox.

Customizing the Orders to Approve Folder

PowerChart Office® provides standard Order to Approve Folder set up and columns based on roles and recommends that you do not change them.

If needed, you can customize the display of the Orders to Approve folder by defining how the orders are organized and selecting which columns display for each order.

Displaying Columns

(See previous topic: Customizing the Sign and Review Folder)
Defining Orders to be Displayed

To define what order types, such as Cosign Orders and Incomplete Orders, you want displayed in the Orders to Approve folder, complete the following steps:

1. From the Inbox menu, select Options. The Inbox Options dialog box opens.
2. Select the Orders to Approve tab.
3. In the Orders to Sign group box, select the type you want from the list.
4. Click . The order type is added to the tree.
5. Click Apply if you want to make additional preference changes, or click OK to close the dialog box and return to Inbox.
6. After closing the dialog box, click Refresh.

Displaying Columns

(See previous topic: Customizing the Sign and Review Folder)

Setting the Default Search Date Range

You can define a period of time from which you want results to be displayed in the Results FYI folder. For example, you may want results displayed from the last two years or the last six months. To set the default date range, complete the following steps:

1. From the Inbox menu, select Options. The Inbox Options dialog box opens.
2. Select the Results FYI tab.
3. In the Default Search Date Range group box, select Months, Years, or Weeks from the list.
4. In the Set Back box, enter the number of months, years, or weeks you want.
5. Click Apply if you want to make additional preference changes, or click OK to close the dialog box and return to Inbox. Then after closing (Refresh).
# PowerChart Office Icon Guide

The Office Icon Guide is a comprehensive listing of the Icons that are used within the PowerChart Office. The Icon Guide is separate into General Icons, Inbox Icons, Flowsheet Icons, PowerNote Icons, EasyScript Icons, and Clinical Notes Icons.

## General Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Workflow Home" /></td>
<td><strong>Workflow Home</strong> – This icon will take you to your defined home screen. The small drop down arrow allows you to choose to work with or without PowerNote.</td>
</tr>
<tr>
<td><img src="image" alt="Workflow Next" /></td>
<td><strong>Workflow Next</strong> - This selection will take you to the next selection in your flow. The small drop down arrow provides a list view of the selected screen flow to allow selection from the list as well.</td>
</tr>
<tr>
<td><img src="image" alt="Appointment Book" /></td>
<td><strong>Appointment Book</strong> – This icon will open the appointment book for viewing of schedule for date selected.</td>
</tr>
<tr>
<td><img src="image" alt="E&amp;M Assistant" /></td>
<td><strong>E&amp;M Assistant</strong> - Launches the tool to help manage E&amp;M (Evaluation and Management) coding selections.</td>
</tr>
<tr>
<td><img src="image" alt="Suspend PowerChart Office®" /></td>
<td><strong>Suspend PowerChart Office®</strong> – This icon will put PowerChart Office® “on hold” so that no one can access without entering password.</td>
</tr>
<tr>
<td><img src="image" alt="Change Users" /></td>
<td><strong>Change Users</strong> - Allows you to change users</td>
</tr>
<tr>
<td><img src="image" alt="Print" /></td>
<td><strong>Print</strong> – Allows you to print screen</td>
</tr>
<tr>
<td><img src="image" alt="AS Of" /></td>
<td><strong>AS OF</strong> – This icon will “refresh” your screen and update any information you may have added.</td>
</tr>
<tr>
<td><img src="image" alt="Patient Search" /></td>
<td><strong>Patient Search</strong> – Allows you to search for a patient.</td>
</tr>
<tr>
<td><img src="image" alt="Encounter Summary" /></td>
<td><strong>Encounter Summary</strong> – A collection of patient information specific to an encounter, displayed in interactive sections. You can view, add or modify problems, medications, immunizations, allergies, orders, pediatric growth chart data points, procedure history and patient history.</td>
</tr>
<tr>
<td><img src="image" alt="Flowsheet" /></td>
<td><strong>Flowsheet</strong> - A collection of all of the patient's results, entered by diagnostics, ad hoc charting, interface results and documents. Clinical documents can be viewed in this part of the chart also.</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Clinical Notes</strong> - A collection of all text documents in the database, plus messages entered through the phone message form that has been saved to the database. You can add or modify notes.</td>
<td></td>
</tr>
<tr>
<td><strong>Intellistrip</strong> - A visual representation of the health lifeline for an individual. It displays icons or symbols that represent acute healthcare events, chronic problems and various types of health related documentation.</td>
<td></td>
</tr>
<tr>
<td><strong>PowerNote</strong> - PowerNote is the Cerner Millennium application for documenting the healthcare encounter and creating an electronic record of that encounter.</td>
<td></td>
</tr>
<tr>
<td><strong>Task List</strong> - The tasks that need to be completed for this patient that have evolved from the placement of orders that have tasks associated with them to complete.</td>
<td></td>
</tr>
<tr>
<td><strong>SuperBill Orders</strong> - Launches into the tool for placing orders and charges and selecting diagnoses associated with the order and charges.</td>
<td></td>
</tr>
<tr>
<td><strong>Form Browser</strong> - Opens the interactive listing of ad hoc forms entered online.</td>
<td></td>
</tr>
<tr>
<td><strong>Ad Hoc Charting</strong> - The AdHoc Charting is a working area where you can access all available forms.</td>
<td></td>
</tr>
<tr>
<td><strong>EasyScript</strong> - Launches the medication writing module. The EasyScript provides access to all prescriptions related to your patient.</td>
<td></td>
</tr>
<tr>
<td><strong>Health Maintenance</strong> - Enables PowerChart Office® to document and view pertinent Health Maintenance Data for the patient.</td>
<td></td>
</tr>
<tr>
<td><strong>Profile Menu</strong> - Provides drop down list of patient profile applications: Allergies, Immunizations, Procedures, Problems, Medications, Order Profile, Encounters, Provider Relations, Health Plan, and Patient History</td>
<td></td>
</tr>
<tr>
<td><strong>Previous Screen</strong> - Returns users to the last screen viewed. This icon is previous priority node in the PowerNote application. The small arrow provides a listing of the screens to allow more rapid selection of specific screen if desired.</td>
<td></td>
</tr>
<tr>
<td><strong>New Result</strong> - User configured default for new result, prescription, problem, allergy or immunization. Small arrow provides a drop list for selection if default is not desired</td>
<td></td>
</tr>
<tr>
<td><strong>New Sticky Note</strong> – Ability to attach a message to the patient file. It can be deleted if you want to remove information.</td>
<td></td>
</tr>
</tbody>
</table>
## Inbox Icons

<table>
<thead>
<tr>
<th>Image</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1.png" alt="Image" /></td>
<td>Open Component in current pane - Opens the selected inbox item.</td>
</tr>
<tr>
<td><img src="image2.png" alt="Image" /></td>
<td>Expand Pane – This expands the pane in order to fill the layout.</td>
</tr>
<tr>
<td><img src="image3.png" alt="Image" /></td>
<td>Open Message – Allows you to open the selected message.</td>
</tr>
<tr>
<td><img src="image4.png" alt="Image" /></td>
<td>Print – Will print selected inbox message.</td>
</tr>
<tr>
<td><img src="image5.png" alt="Image" /></td>
<td>Delete – Allows you to delete selected item.</td>
</tr>
<tr>
<td><img src="image6.png" alt="Image" /></td>
<td>Create New E-Mail – Allows you to create a new e-mail message.</td>
</tr>
<tr>
<td><img src="image7.png" alt="Image" /></td>
<td>Inbox Message – Allows you to create a new Inbox Message.</td>
</tr>
<tr>
<td><img src="image8.png" alt="Image" /></td>
<td>Address Book – A list of all save contacts.</td>
</tr>
<tr>
<td><img src="image9.png" alt="Image" /></td>
<td>Reply – Send a reply to the person who sent the message.</td>
</tr>
<tr>
<td><img src="image10.png" alt="Image" /></td>
<td>Reply to All – Reply to all persons referenced in message.</td>
</tr>
<tr>
<td><img src="image11.png" alt="Image" /></td>
<td>Forward – Forward message to selected person.</td>
</tr>
<tr>
<td><img src="image12.png" alt="Image" /></td>
<td>Inbox List Bar - Hides or displays the Inbox List Bar, which displays the Deleted Items trash can as well as proxy inboxes.</td>
</tr>
<tr>
<td><img src="image13.png" alt="Image" /></td>
<td>Selected Patient - Allows the user to select an individual patient and just view that patient’s inbox items, or to view inbox items for all patients.</td>
</tr>
<tr>
<td><img src="image14.png" alt="Image" /></td>
<td>Message Journal – Takes you to all message you have saved for reference later.</td>
</tr>
</tbody>
</table>
Flowsheet Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="select_component.png" alt="Select Component" /></td>
<td><strong>Select Component</strong> - Select component provides a drop list of available selections to view in the pane in focus. Allows user to change component selection without changing framework--IE split screen vertical, full screen, etc.</td>
</tr>
<tr>
<td><img src="split_screen_vertical.png" alt="Split Screen Vertical" /></td>
<td><strong>Split Screen Vertical</strong> - Provides a 2 pane view splitting the screen in a vertical line.</td>
</tr>
<tr>
<td><img src="split_screen_horizontal.png" alt="Split Screen Horizontal" /></td>
<td><strong>Split Screen Horizontal</strong> - Provides a 2 pane view splitting the screen along a horizontal line.</td>
</tr>
<tr>
<td><img src="graph.png" alt="Graph" /></td>
<td><strong>Graph</strong> - Plots a line graph for selected results in the flowsheet.</td>
</tr>
<tr>
<td><img src="seeker.png" alt="Seeker" /></td>
<td><strong>Seeker</strong> - A navigation device for the flowsheet which gives a map view of the flowsheet and the by placing a viewfinder over a section helps to hone in on an area of the flowsheet.</td>
</tr>
<tr>
<td><img src="sign.png" alt="Sign" /></td>
<td><strong>Sign</strong> - Used to electronically sign or endorse a document.</td>
</tr>
<tr>
<td><img src="bookmark.png" alt="Bookmark" /></td>
<td><strong>Bookmark</strong> - Marks results as seen.</td>
</tr>
</tbody>
</table>

PowerNote Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="open_document.png" alt="Open an Existing Document" /></td>
<td><strong>Open an Existing Document</strong> - Opens an existing document.</td>
</tr>
<tr>
<td><img src="save_note.png" alt="Save Current Note" /></td>
<td><strong>Save Current Note</strong> - Clicking this icon will save note you are currently creating.</td>
</tr>
<tr>
<td><img src="sign_note.png" alt="Sign Note" /></td>
<td><strong>Sign Note</strong> - Allows you to electronically sign note you have created.</td>
</tr>
<tr>
<td><img src="paste.png" alt="Paste" /></td>
<td><strong>Paste</strong> - This will paste note you have created to a different area.</td>
</tr>
<tr>
<td><img src="copy.png" alt="Copy" /></td>
<td><strong>Copy</strong> - Allows you to copy note you have created.</td>
</tr>
</tbody>
</table>
### Find a Specified Node
- Search icon to find a note previously created.

### Print
- Prints note selected.

### Priority Node Back
- Return to the previous priority node. This represents return to last screen outside of the PowerNote application.

### Priority Node Forward
- Go forward to the next priority node. This represents move forward in workflow outside of the PowerNote application.

### Help Icon

### EasyScript Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Remove</td>
<td>Allows you to remove prescription selected.</td>
</tr>
<tr>
<td>Remove All</td>
<td>Allows you to remove ALL prescriptions.</td>
</tr>
<tr>
<td>Duplicate</td>
<td>Will duplicate prescription ordered.</td>
</tr>
<tr>
<td>Add To My List</td>
<td>Will add to your prescription list.</td>
</tr>
<tr>
<td>Sign Orders</td>
<td>Allows you to electronically sign prescription ordered.</td>
</tr>
</tbody>
</table>
## Clinical Notes Icons

<table>
<thead>
<tr>
<th>Icon</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image1" alt="Icon" /></td>
<td><strong>Add Document</strong> - Affords the ability to add a new clinical note.</td>
</tr>
<tr>
<td><img src="image2" alt="Icon" /></td>
<td><strong>Submit Document</strong> - Allows someone who is not otherwise authorized to sign documents to submit an unauthenticated document to the database with and submits a request for signature from another user who does have privileges to sign.</td>
</tr>
<tr>
<td><img src="image3" alt="Icon" /></td>
<td><strong>Sign Document</strong> - Used to electronically sign or endorse a document.</td>
</tr>
<tr>
<td><img src="image4" alt="Icon" /></td>
<td><strong>Review Document</strong> - Allows the user to mark a document as reviewed when someone else requested the review.</td>
</tr>
<tr>
<td><img src="image5" alt="Icon" /></td>
<td><strong>In Error Document</strong> - Allows a user to mark a document as &quot;posted in error&quot;; the document will not be removed.</td>
</tr>
<tr>
<td><img src="image6" alt="Icon" /></td>
<td><strong>Modify Document</strong> - Affords the ability to be able to modify a clinical note.</td>
</tr>
<tr>
<td><img src="image7" alt="Icon" /></td>
<td><strong>Print</strong> – Allows you to print document.</td>
</tr>
<tr>
<td><img src="image8" alt="Icon" /></td>
<td><strong>View Image</strong> - Launches a window which allows the user to view a previously scanned and attached image</td>
</tr>
<tr>
<td><img src="image9" alt="Icon" /></td>
<td><strong>Forward/Refuse</strong> - Used to manually forward documents to another user, requesting the other user to either review or sign the forwarded document.</td>
</tr>
<tr>
<td><img src="image10" alt="Icon" /></td>
<td><strong>View History</strong> - Allows you to view the medical history on the person selected.</td>
</tr>
</tbody>
</table>
## General Icons & Buttons

<table>
<thead>
<tr>
<th>Button</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Find Patient" /></td>
<td>Find Patient</td>
</tr>
<tr>
<td><img src="image" alt="Change User" /></td>
<td>Change User</td>
</tr>
<tr>
<td><img src="image" alt="Exit" /></td>
<td>Exit</td>
</tr>
<tr>
<td><img src="image" alt="Launch Application" /></td>
<td>Launch Application</td>
</tr>
<tr>
<td><img src="image" alt="Launch Clinical Calculator" /></td>
<td>Launch Clinical Calculator</td>
</tr>
<tr>
<td><img src="image" alt="Ad Hoc Charting" /></td>
<td>Ad Hoc Charting</td>
</tr>
<tr>
<td><img src="image" alt="Print" /></td>
<td>Print</td>
</tr>
<tr>
<td><img src="image" alt="Delete" /></td>
<td>Delete</td>
</tr>
<tr>
<td><img src="image" alt="Copy" /></td>
<td>Copy</td>
</tr>
<tr>
<td><img src="image" alt="Paste" /></td>
<td>Paste</td>
</tr>
<tr>
<td><img src="image" alt="What’s This? Help" /></td>
<td>What’s This? Help</td>
</tr>
<tr>
<td><img src="image" alt="List Maintenance" /></td>
<td>List Maintenance</td>
</tr>
<tr>
<td><img src="image" alt="Add Patient" /></td>
<td>Add Patient</td>
</tr>
<tr>
<td><img src="image" alt="Remove Patient" /></td>
<td>Remove Patient</td>
</tr>
<tr>
<td><img src="image" alt="View Charges" /></td>
<td>View Charges</td>
</tr>
<tr>
<td><img src="image" alt="Select All Patients" /></td>
<td>Select All Patients</td>
</tr>
<tr>
<td><img src="image" alt="Clear All Selections" /></td>
<td>Clear All Selections</td>
</tr>
<tr>
<td><img src="image" alt="Suspend" /></td>
<td>Suspend</td>
</tr>
<tr>
<td><img src="image" alt="Launch Charge Entry" /></td>
<td>Launch Charge Entry</td>
</tr>
<tr>
<td><img src="image" alt="Graph" /></td>
<td>Graph</td>
</tr>
<tr>
<td><img src="image" alt="Open Organizer" /></td>
<td>Open Organizer</td>
</tr>
<tr>
<td><img src="image" alt="Seeker" /></td>
<td>Seeker</td>
</tr>
<tr>
<td><img src="image" alt="Bookmark" /></td>
<td>Bookmark</td>
</tr>
<tr>
<td><img src="image" alt="As Of 4:29 PM" /></td>
<td>As Of - Refreshes information on the screen to reflect any changes that have occurred.</td>
</tr>
<tr>
<td><img src="image" alt="Temporary Location Change" /></td>
<td>Temporary Location Change</td>
</tr>
<tr>
<td><img src="image" alt="Selected Patient" /></td>
<td>Selected Patient</td>
</tr>
<tr>
<td><img src="image" alt="Inbox List Bar" /></td>
<td>Inbox List Bar</td>
</tr>
<tr>
<td><img src="image" alt="Chart not done" /></td>
<td>Chart not done</td>
</tr>
<tr>
<td>Icon</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td></td>
<td>Unchart</td>
</tr>
<tr>
<td></td>
<td>Patient Management Conversations</td>
</tr>
<tr>
<td></td>
<td>Cancel</td>
</tr>
<tr>
<td></td>
<td>Orders to Sign</td>
</tr>
<tr>
<td></td>
<td>Order Details</td>
</tr>
<tr>
<td></td>
<td>Sign Form</td>
</tr>
<tr>
<td></td>
<td>Save Form</td>
</tr>
<tr>
<td></td>
<td>Physician Cosign (entered by someone who is not a physician)</td>
</tr>
<tr>
<td></td>
<td>Nurse Review</td>
</tr>
<tr>
<td></td>
<td>Physician Cosign for Medical Students</td>
</tr>
<tr>
<td></td>
<td>Results Info</td>
</tr>
<tr>
<td></td>
<td>Clear</td>
</tr>
<tr>
<td></td>
<td>Transfer Cancel Orders</td>
</tr>
<tr>
<td></td>
<td>Search</td>
</tr>
<tr>
<td></td>
<td>New Order</td>
</tr>
<tr>
<td></td>
<td>New Result</td>
</tr>
<tr>
<td></td>
<td>Exit current window</td>
</tr>
<tr>
<td></td>
<td>Ellipsis</td>
</tr>
<tr>
<td></td>
<td>Expand Pane</td>
</tr>
<tr>
<td></td>
<td>New Phone Message</td>
</tr>
<tr>
<td></td>
<td>Day View</td>
</tr>
<tr>
<td></td>
<td>Week View</td>
</tr>
<tr>
<td></td>
<td>Month View</td>
</tr>
<tr>
<td></td>
<td>Preferences</td>
</tr>
<tr>
<td>Workflow Home</td>
<td>This icon will take you to your defined home screen. The small drop down arrow allows you to choose to work with or without PowerNote.</td>
</tr>
<tr>
<td>Workflow Next</td>
<td>This selection will take you to the next selection in your flow. The small drop down arrow provides a list view of the</td>
</tr>
<tr>
<td>Icon</td>
<td>Description</td>
</tr>
<tr>
<td>------</td>
<td>-------------</td>
</tr>
<tr>
<td><img src="image" alt="Appointment Book" /></td>
<td><strong>Appointment Book</strong> – This icon will open the appointment book for viewing of schedule for date selected.</td>
</tr>
<tr>
<td><img src="image" alt="E&amp;M Assistant" /></td>
<td><strong>E&amp;M Assistant</strong> - Launches the tool to help manage E&amp;M (Evaluation and Management) coding selections.</td>
</tr>
<tr>
<td><img src="image" alt="Suspend PowerChart Office" /></td>
<td><strong>Suspend PowerChart Office®</strong> – This icon will put PowerChart Office® “on hold” so that no one can access without entering password.</td>
</tr>
<tr>
<td><img src="image" alt="Change Users" /></td>
<td><strong>Change Users</strong> - Allows you to change users</td>
</tr>
<tr>
<td><img src="image" alt="Print" /></td>
<td><strong>Print</strong> – Allows you to print screen</td>
</tr>
<tr>
<td><img src="image" alt="As Of" /></td>
<td><strong>AS OF</strong> – This icon will “refresh” your screen and update any information you may have added.</td>
</tr>
<tr>
<td><img src="image" alt="Patient Search" /></td>
<td><strong>Patient Search</strong> – Allows you to search for a patient.</td>
</tr>
<tr>
<td><img src="image" alt="Encounter Summary" /></td>
<td><strong>Encounter Summary</strong> – A collection of patient information specific to an encounter, displayed in interactive sections. You can view, add or modify problems, medications, immunizations, allergies, orders, pediatric growth chart data points, procedure history and patient history.</td>
</tr>
<tr>
<td><img src="image" alt="Flowsheet" /></td>
<td><strong>Flowsheet</strong> - A collection of all of the patient's results, entered by diagnostics, ad hoc charting, interface results and documents. Clinical documents can be viewed in this part of the chart also.</td>
</tr>
<tr>
<td><img src="image" alt="Clinical Notes" /></td>
<td><strong>Clinical Notes</strong> - A collection of all text documents in the database, plus messages entered through the phone message form that has been saved to the database. You can add or modify notes.</td>
</tr>
<tr>
<td><img src="image" alt="Intellistrip" /></td>
<td><strong>Intellistrip</strong> - A visual representation of the health lifeline for an individual. It displays icons or symbols that represent acute healthcare events, chronic problems and various types of health related documentation.</td>
</tr>
<tr>
<td><img src="image" alt="PowerNote" /></td>
<td><strong>PowerNote</strong> - PowerNote is the Cerner Millennium application for documenting the healthcare encounter and creating an electronic record of that encounter.</td>
</tr>
<tr>
<td><img src="image" alt="Task List" /></td>
<td><strong>Task List</strong> - The tasks that need to be completed for this patient that have evolved from the placement of orders that have tasks associated with them to complete.</td>
</tr>
<tr>
<td><img src="image" alt="SuperBill Orders" /></td>
<td><strong>SuperBill Orders</strong> - Launches into the tool for placing orders and charges and selecting diagnoses associated with the order and charges.</td>
</tr>
<tr>
<td><img src="image" alt="Form Browser" /></td>
<td><strong>Form Browser</strong> - Opens the interactive listing of ad hoc forms entered online.</td>
</tr>
<tr>
<td><strong>Ad Hoc Charting</strong></td>
<td>The AdHoc Charting is a working area where you can access all available forms.</td>
</tr>
<tr>
<td>--------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>EasyScript</strong></td>
<td>Launches the medication-writing module. The EasyScript provides access to all prescriptions related to your patient.</td>
</tr>
<tr>
<td><strong>Health Maintenance</strong></td>
<td>Enables PowerChart Office® to document and view pertinent Health Maintenance Data for the patient.</td>
</tr>
<tr>
<td><strong>Profile Menu</strong></td>
<td>Provides drop down list of patient profile applications: Allergies, Immunizations, Procedures, Problems, Medications, Order Profile, Encounters, Provider Relations, Health Plan, and Patient History</td>
</tr>
<tr>
<td><strong>Previous Screen</strong></td>
<td>Returns users to the last screen viewed. This icon is previous priority node in the PowerNote application. The small arrow provides a listing of the screens to allow more rapid selection of specific screen if desired.</td>
</tr>
<tr>
<td><strong>New Result</strong></td>
<td>User configured default for new result, prescription, problem, allergy or immunization. Small arrow provides a drop list for selection if default is not desired</td>
</tr>
</tbody>
</table>
| **New Sticky Note** | Ability to attach a message to the patient file. It can be deleted if you want to remove information.
15. Glossary

**Double click** – Clicking a mouse button twice in rapid succession. The second click must immediately follow the first; otherwise the program will interpret them as two separate clicks rather than one double click.

**Dithered** – Icon or menu item that is gray in color which is not available to use or select.

**Left click** – To click the left mouse button. When instructions call for a screen object to be “clicked” a left-click is inferred.

**Maximize** – Located on the menu bar or title bar of the active window. It is used to maximize the window so that it takes up the entire desktop.

**Menu** – Displays a list of commands. Some of the commands have images next to them so you can quickly associate the command with the image.

**Minimize** – Located on the menu bar or title bar of the active window. It is used to minimize the window so that it appears only on the Windows taskbar.

**Mouse** – A device used to move the cursor around on the screen (replacing a light pen).

**PC** – Personal computers (replacing the present terminals).

**Right click** – To click the right mouse button. A right-click opens a drop-down menu with a list of options.

**Scrollbar** – Located on the right and bottom of some screens and is used to adjust the view on screen.

**Shortcut Menu** – Available when you right-click text, objects, and/or other items.

**Title bar** – Located at the top of the each window and is used to identify that window.

**Toolbar** – A toolbar can contain buttons with images (the same images you see next to corresponding menu commands), menus, or a combination of both.