ASAP: ED Scribes

TRAINING FOR EMERGENCY DEPARTMENT SCRIBES.

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Trainer Information

Legend

Normal Font = script of how to explain the various topics.

Underlined = scenarios to explain to the learners so they understand the context of the demonstration.

Bold and underlined = Demo Steps.

For screenshots, refer to the slide deck. Slide deck can be used in place of a demo if hyperspace is unavailable.

Training Logins

SCRIBE00 – SCRIBE29; Login dept: GV Emergency

Assessment

https://forms.office.com/r/AHza1UZReD

Start of Shift

Key Points: Overview of Hyperspace and Track Board, Signing In, Assigning Patients, Side by Side Track Board, ED Course.

Patient: Antonio

Scenario: We are starting our shift and have just arrived in the department. Let's go through the following topics to get started.

- Overview of Hyperspace
- Review the Track Board
- Signing in and documenting your supervisor
- Review hand off patients from previous shift
- Assign Yourself to a Patient's Treatment Team

Overview of Hyperspace

Scenario: We are going to start with a quick overview of Hyperspace and review the process of starting your shift.

Let's look at the layout of the screen.

- Across the top, we have common activities you'll need to access. This is called the Hyperspace toolbar. We'll discuss each of these as they are relevant.
- Underneath the Epic button, we have our workspace tabs. Think of these like the tabs on a web browser. When we open a patient's chart, it'll appear here.
    - You will see these items regardless of what screen you're in.
- Since this is your first login for the day, you land on the Emergency Department News Dashboard. This dashboard is used by management to publish updates within the department. After your first login of the day, you will land on the track board by default.

Select the Track Board from the Hyperspace Toolbar

- Below our workspace tabs, we have our track board menu with buttons to complete different tasks.
- At the beginning of your shift, you need to select Sign In. Signing in is your way of indicating you are on shift and ready to start seeing patients.
    - When signing in, you must list your supervisor.
    - **Select Sign In now. Add Brienne <training last name> as your supervisor.**

Below our track board toolbar, we have buttons for our track board views. These views work as filters to display specific lists of patients

Click through each of the Track Board views listed below, direct user to click them when you do

- All Patients displays all the patients in the department
- My Pts + Needs MD – shows patients you are assigned to, your supervisor is assigned to, and patients that need a physician. This is the most focused view to use.
- Waiting Room – shows all patients that are in the waiting room.
- The columns of information change based on the view.

Switch to My Pts+Needs MD

- You can sort by any column by clicking the header. On My Pts + Needs MD, it's common to sort by Scribe column to group your patients at the top and the needs MD at the bottom.
- You can hover for more information (ex. initials to see nurse full name, etc)
- First column is the patient's status. The status updates automatically and reflects where they are at in their visit. Hover over the column for a description. You will quickly learn all the colors by hovering as you seen them.
- LOC shows location of the Pt if other than ED (ex: CT, XR, MRI)
- Cmnt allows you to enter free text comments to display to all users, double click and enter a comment
- New shows whenever there is New Data available
- TT shows the Total Time since arrival

Side by Side Track Board.

The Track Board is split in half. The right half of the screen gives you access to complete quick charting and view reports for any selected patients.

Workup

Workup shows you current lab, imaging, vitals, medications, and RN Documentation.

Scenario: Your Physician is taking over for Antonio while we are waiting for his CT result. Let's review his chart to see if there's anything else we need to know.

- **Single-click on his name with the SxS open**
- **Select the Workup Tab**

New Data:

- Any data you haven't marked as viewed will be highlighted.
- You can select Mark All as Viewed or the New Button in each section.
- Once marked as viewed, the New icon will clear. When there is new information available, the icon will re-appear, working like a notification that there is new data to review.

Let's review each of the sections in more detail.

- In the labs section, you can select abnormal only to see just abnormal values. Select the clock icon to see historical results.
- In Vitals, select Historical Data to see vitals from previous encounters.
- Medication Status – this will list the medications to be given during the visit by status, such as given, in progress, not given.
- The imaging section will show all ordered Images, note the status. New Data icon will be triggered when the image is available (End Exam) and when the radiologist has entered their interpretation (final result).
- RN Documentation will list out all nursing documentation.

ED Course

ED Course is used for making quick updates that are later pulled into the note with time stamps.

Updates can be free text: **enter "Dr. House - received handoff from Dr. Urgent. Patient stable, pending CT result"**
Updates can be linked to data:

- **click on Resp and enter "patient in distress"**
- **click on glucose and enter "patient eating candy in the waiting room"**

This is the best way to file quick updates to the note and make a timeline of the patient's care. It's very common for the Physician to use the ED Course section to document while you work in the note.

Treatment Team

Patient: Katherine and Martha.

Scenario: Antonio was passed to us from the previous physician, so we are already assigned. For new patients, we need to assign ourselves. Katherine, Martha, and Sawyer are Waiting for Provider and they have been assigned to us.

Assign yourself to a patient's treatment team.

- From the Track Board, right-click the patient and select Assign Me.
- If you assign yourself to a patient by mistake, select Tx Team, select your name and delete yourself and not just unassign.

I want to assign myself to Katherine's treatment team so other providers know we are taking care of her.

Assign yourself to Katherine, Sawyer, and Martha.

When you assign yourself, your supervisor is also assigned to the patient.

You'll immediately see the patient status change to In Process

Prepare for an Exam

Key Points: New Patients, History, Chart Review, Care Everywhere

Patient: Katherine

Format: Demo with follow along.

Scenario: Katherine has been arrived, triaged, and is ready to be seen.

Side by Side Track Board - Triage

We are going to see Katherine first, let's review her triage documentation. On the Side by Side Track Board, **select the Triage Tab**

- On the triage tab, the first section you see is the First Provider Time. This is the time the physician first sees the patient. Click First Provider Time to file the current time, best scenario is to do this right before entering the room.
    - If you need to back enter, type in the time and click first provider time to file.
- Triage Summary summarizes the triage documentation.

- Chief Complaints are entered by the nurse.
- Recent Visits will show you recent encounters – click chart review to find all data for the patient (we'll review this later)
- Allergies and Home Medications will be entered by the nurses. Click the blue check to indicate the physician reviewed these with the patient.
- Problem List will be updated by IP/OP MDs. This section contains ongoing problems being tracked for the patient.
- History will be updated by you and the Physician. If reviewed with patient and accurate, click the blue checkmark. Click the title to update.
- There is also the Mark All as Reviewed to mark Allergies, Home Meds, and History as reviewed at once.

We're now going to edit the patient's history.

Select the History title to edit.

Updating a Patient History

This launches the patient's chart to the history section. The history section is separated into Medical, Surgical, Social and Family.

Medical and Surgical History

- Medical and Surgical sections contain common history items with Positive/Negative buttons. Press + to mark it as positive and – to mark it as negative. Hover and start typing to add a more specific history item. For example, hover over cancer and type the type of cancer to get more specific.
- Only document what applies to the patient. If something doesn't apply, leave it blank.
- Each section also contains a search for less common items.
- **Search for and add Chest Pain.**
- If there is not a broader category for it to be added to, you'll see the other items listed at the bottom of the section.
- Below the quick entry section, you will see the past history and pertinent negatives listed out.

The history form stays with the patient record and only needs to be updated/maintained with each subsequent visit.

Social History

The social history section contains several options for charting that are consistent throughout CottageOne.

- Magnifying glasses are used when you need to choose an option from a predetermined list. Look at the "Smoker Field".
    - **Click the magnifying glass to see all the available choices and pick from the list.**
    - Once you know the available options, you can type in the field instead of clicking the magnifying glass.
    - **For example, if I start to type former, then Former Smoker shows up as a choice.**
    - This concept applies to every field with a magnifying glass.

- Date fields show with a calendar icon, such as start date and quit date for tobacco related fields. You can click the calendar to pick a date from a calendar. There are several keyboard shortcuts that can be used for entering dates.
- **Demo each of the short cuts listed:**
    - "t" will fill in today's date.
    - "t-n" or "t+n" will subtract or add days from the current date. Example, if the date is 7 days ago, you can enter t-7.
    - "w-n" or "w+n" will subtract or add weeks from the current date. Example, if the date was 3 weeks ago, you can enter w-3.
    - "y-n" or "y+n" will subtract or add years from the current date. Example, if the date was 2 years ago, you can enter y-2.
    - These shortcuts are very helpful for estimated date. For example, if the patient said they started smoking about 3 years ago, you can use y-3 to enter an estimated date.

Add a few items to Katherine's history and mark as reviewed.

Marking as reviewed is our way of time stamping the documentation. Since the history documentation follows the patient form visit to visit, marking as reviewed enables us to see when the history was last updated for the patient.

Navigating the Chart

Now that we are in the chart, let's go over the layout:

- The Storyboard displays on the left side of the chart, this shows quick glance information for the patient.
    - Hover over a section to see additional information.
    - Click on a section to act on the information.
    - **Hover over treatment team to see all assigned. Click to edit the treatment team.**
- Chart Search allows you to search for specific problems, notes, medications, lab results, imaging results, procedures, and other orders. This can be accessed from any part of the patient's chart. (ex. you could be writing a note and then jump to the search.)
    - **search for headaches.**
    - **search for CBC.**
    - **search for ECG or EKG.**
- The top has your activity tabs. The activities are the different sections of the chart.
    - **Open Triage and Workup,** notice that these are the same things we viewed on the Track Board. The Track Board is more efficient as we don't have to click into each chart. However, if you are focused on one patient, it'll probably be easier to view this full screen.

Open Chart Review.

Chart Review

Chart Review holds all data from Cottage Health

- SnapShot shows you a quick summary of the patient's chart. There are optional reports to view more information.

- **Select Encounters** - Encounters shows you all visits the patient has had at Cottage. Single click on any one to see a summary on the right. There are filters at the top to narrow down what shows.
- **Select Notes** - Notes shows all notes on file for the patient. Use the filters to narrow down what shows. Single click to view the note on the right.
- **Select Labs** - Labs, Imaging, Cardiology, Procedures, will show those items. Single clicking will show you the results. The status will tell you where the order is at in the process. Some common ones are:
    - Ordered – nothing more than the order being placed has occurred.
    - Needs to be Collected – for labs, this means the specimen has not been collected.
    - Collected – for labs, the specimen has been collected but not received by the laboratory.
    - In Process – the lab is processing the specimen.
    - Begin Exam – the imaging department is currently taking the images.
    - End Exam – the imaging department has finished taking images and they should be available to view.
    - Preliminary Result – there is an image interpretation entered by a resident but not a final result from the radiologist.
    - Final Result or Resulted – there is a final result for the lab or image.
- **Select Media** - Media is for all scanned documents for the patient:
    - Advanced Directives and/or other documents provided by the patient.
    - EMS reports will file here as soon as the EMT complete their reports (if done correctly).
    - Wound Images from nursing will file here.
    - ER records from before October 2016.
    - EKGs from Outside Facilities.

I've reviewed Katherine's chart and we are now going to see her in the room.

Document the first provider time and close the chart.

Break for Practice Exercises

Direct everyone to complete the Prepare for an Exam section on page 1.

ED Provider Note

Key Points: Documenting in NoteWriter, One Note Per Visit, Sharing Notes Between Edits

Patient: Katherine

You and the physician just finished your initial review with the patient, and you need to document the details.

Open Katherine's Chart. It will default to the My Note activity.

The My Note activity has several sections available.

- Best Practice advisories will show clinical warnings for the chart.

- ED Provider Notes will show the active note for the encounter.
- Consult Tracking shows all consults orders and the status.

NoteWriter

Select the My Note button.

This will open the note in a side panel. The side panel is beneficial because it allows you to navigate the chart while documenting in the note. For example, if you wanted to reference a lab result, you could select the Workup tab, look at the result, and then document that in the note.

When the note opens, it pulls in the standard template by default. This template has been designed to meet all quality and billing requirements.

Take a moment to scroll the template to view all the information that is defaulted in.

- Anything in blue is being pulled from the patient's chart, clicking refresh will update the information. Most sections should update automatically when you open the note.
- The orange sections correspond to the tabs at the top. Use those tabs to fill in these sections.

History of Present Illness

Select HPI

The HPI is split into two sections.

Narrative is for adding a free-text narrative. **Add something like "patient was at home in the shower and began feeling faint."**

Forms will provide complaint-based forms for documenting common items.

- The most common chief complaints will default in the HPI form. You can select another or add more if necessary. You can also remove default ones if they are not appropriate.
- **Remove one of the defaulted HPI forms.**
- If you can't find an appropriate HPI, use the generic illness or injury HPIs.
- **Select a few options in the form.**
- As I click the buttons in the form, the details I've selected are translated into sentences in my note.
- **Demonstrate each example of using a tri-state button.**
- Some fields contain Tri-state buttons. Select the + for positive, - for negative. You can also right click the middle for negative, left click for positive.
- **Add comment to a tri-state button.**
- Add a comment to a button by hovering the mouse over it and typing a comment.

- When adding associated symptoms, some symptoms are linked to additional forms. Fill these in as appropriate.

Review of Systems

Select the ROS tab.

The ROS pulls in some items from the HPI so that there aren't inconsistencies within the chart and to save you clicks.

- The ROS utilizes the same tri-state button functionality.

Physician Exam

Select the Physical Exam tab.

The physical exam tab has a Basic tab and then tabs for each system. The Basic tab holds the most common items for each system. Fill in the basic tab first and then go into the individual system tabs as necessary.

Select a few of the system specific physical exam tabs.

Select the Procedures Tab.

Here we can select from procedure forms to document in.

- There are buttons for the most common procedures.
- There is also a search for additional procedures.
- Note that Observation is a procedure form

Select Laceration Repair

Note that some fields are highlighted in yellow. These are required but you won't be stopped from signing the chart. When billing reviews the chart it will be returned to the MD to fill in these items if missed

Select Add Another Procedure

- This allows you to document additional procedures. For example, if you need to document two laceration repairs, you can select Lac Repair again to get a new form.

ED Ultrasounds require that the order is placed first before the interpretation can be documented. This is required so the interpretation can be linked to the image and the order as the result.

Current Orders section will show you forms related to current orders.

Select Critical Care

Critical Care holds all the documentation required for billing for critical care.

On the right, scroll through your note. Everything you clicked in the forms generates text. This is a good way to review the documentation to ensure you selected everything you intended to.

Share the note.

Sharing the note will save your changes and enable others, such as providers and other scribes to make edits to the note. Everyone will contribute to the note and share the changes. Once the visit and note are complete, the provider will sign the note.

Break for Practice Exercises

Direct everyone to complete the Note Documentation section on page 2.

Observation

Patient: Katherine

In certain scenarios, such as patients receiving IV fluids, the physician will decide to put a patient into observation status.

When this happens, there are three main steps to the documentation:

1. Placement Documentation
2. Rechecks
3. Disposition Documentation

For patients in observation, it's very common for them to stay in the ED past your shift. Each physician and scribe is responsible for filing updates to the note until the patient leaves. Meaning, that someone may finish the observation note you started, or you may finish someone else's.

STEP 1: Placement –

Go to Procedures tab of the Note and select Observation

- Be sure to enter an accurate Observation Start Time
- Fill out the relevant information (Assignment, Reason, Plan)
- Share the note and return to the track board

STEP 2: Rechecks -

File an update from ED Course on the Track Board - *MD Recheck – Vitals stable, fluids completed, labs redrawn*

- The physicians are required to file regular rechecks on patients in observation.
- File these rechecks using the ED Course section of the Workup.

STEP 3: Disposition -

Open the Procedures Tab of the Note and scroll to the bottom of the Observation Form

- Once the MD has decided the patient no longer needs observation. Fill out the disposition section of the form.
- If the patient is being discharged, fill out the discharge section of the form.

Admissions and Consults

Patient: Martha

Martha fell at home and fractured her hip. The provider thinks she should be admitted.

When patients are going to be admitted, the provider needs to complete a consult with the admitting physician. The Unit Coordinator will start the consult and you will need to complete it.

In the My Note Activity, there is a section for Consults.

Select Consults from the top to jump to that section.

- **Select Hospitalist Consult Update**
- **Select Consult Complete and enter the details of the consult in the Comments**
- This information is pulled into your note automatically.

Open the note and refresh to see the consult information pulled.

-

This information is used to track and report response times of Consulting Physicians.

Break for Practice Exercises

Direct everyone to complete the Additional Documentation section on page 3.

Finding Patient Charts

You worked with a patient earlier in the day who has left the department, but you still need to complete your documentation.

Select ED Chart.

ED Chart is used for searching for patient's that have been in the ED.

- When selecting a patient, if they have been to the ED multiple times, you will need to select which visit you want to open. Be careful and make sure you open the correct one if you are adding documentation.
- Use the Recent Patients tab to access recently viewed patients. This will list the last 25 patient records you had open.

Sign Out and Reassign Patients

Your shift has ended and it's time to Sign Out.

From the Track Board select Sign Out to end your shift.

- You'll be prompted with all the patients you are assigned to with the option to reassign to other scribe.
- You can assign all patients to the same scribe by using the "Reassign all patients to" or select individual scribes per patient using "Reassign selected patients to".

Reassign all patients to Sally Scribe.

Remind trainees that if they are following along, they will need to stay signed in for the assessment.

Assessment

Direct everyone to complete the assessment at this point. Send everyone the link to the assessment and direct them to use the Playground to complete - https://forms.office.com/r/AHza1UZReD.