THIS POWERPOINT WAS CREATED BY ME – SO I HOPE IT IS CLINICALLY PERTINENT & USEFUL. DON’T EVER HESITATE TO CALL OR TEXT ME OR VALERIA IF YOU ARE STUCK OR DON’T KNOW HOW TO DO SOMETHING.

Unfortunately, I can’t cover it all. There is still a lot of stuff that I did not go into great detail here. You will learn this quickly & learn it best by doing. If you would like an additional resource to help you get familiar with CPRS, please look at this training website:

http://www.vehu.va.gov/cprstraining/CPRSTabByTab/000000/index_000000.html

- Thank you for all you do, SB
PATIENT SELECT SCREEN

- Patient name, SSN, Last 4
- Setup Default lists
- Process Notifications

Your default pts would show up here
PATIENT SELECT SCREEN

• You can use the full SSN, Patient’s first initial of last name and last 4, full last name etc.
• To look for Team lists, Select Teams from the Patient Select box and type the name of the team.
• To process Notifications, highlight the notification that you want processed and hit the Process button.
• Notifications can include really important information:
  • Critical lab results
  • Critical imaging results
  • When you are flagged as a co-signer
  • Cancelled orders/expiring orders
  • *Try to clear your notifications frequently so they don’t build up!!*
    
    *You can select which notifications to receive – see later slide!*
NOTIFICATIONS: CHANGING WHAT WILL SHOW UP AS AN ALERT

At the top of the screen, select “TOOLS” then select “OPTIONS” at the bottom of the menu.
NOTIFICATIONS: CHANGING WHAT YOU WILL SHOW UP AS AN ALERT

Click on the Notifications Tab

*There are some “Mandatory” Notifications that you can’t turn off

*The ones that are not mandatory you can unclick the check box and you won’t be alerted on those!
HOW TO MAKE A PERSONAL TEAM LIST

At the top of the screen, select "TOOLS" then select "OPTIONS" at the bottom of the menu.
HOW TO MAKE A PERSONAL TEAM LIST

Click on the “Lists/Teams Tab”

Then select “Personal Lists”
HOW TO MAKE A PERSONAL TEAM LIST

Click on “New List”

The “New Personal List” window will pop up. Pick a name for your list; select “All CPRS users” can see your list if you are creating the “Master Team List”. If the list is only for you, select “Myself Only”
HOW TO MAKE A PERSONAL TEAM LIST

This is our new list.

Highlight the list you want to edit.

Then under the patient section, type in the medical record #, and that patient will show up in the “Patients to add” box.

Click “Add” or “Add All” to move the patient to the “Patients on Personal List” box.

When you are done, “Save Changes” then “Ok”

Patients will stay on your Personal List UNLESS you take them off. When you maintain a master list for your team, you will be responsible for adding patients when they are admitted and taking them off when they are discharged! You may need to make more than 1 list – keep 1 list up-to-date for your current census (“this will be used for the Shift Hand-Off Tool) and then a separate list for follow-ups, discharge summaries, etc.
TEAM LISTS: YOU HAVE MADE YOUR LIST, NOW HOW DO YOU GET IT TO SHOW UP ON THE PATIENT SELECTION SCREEN WHEN YOU FIRST LOG ONTO CPRS?

After selecting Team, type the name of the team. To save the list as your default, Press Save Patient List Settings. This can be done with any of the Patient List types.

The Team List that is saved as your default will automatically pre-populate the "Shift Hand-Off" Tool – More on this later...!
CPRS COVERSHEET OVERVIEW

- Menu options
  - There are Menu Options available for each Tab.
  - Left clicking File will let you pick a new patient or refresh patient information
  - Tools and Vista Apps have a number of links/programs that all areas may use.

- Left click patient’s name to bring up Demographic information. (“Face Sheet”): To find Next of Kin, Last admission, surgery dates, etc.

- Left click Provider box to select the Visit and Provider.
  - Needed when entering orders or consults. This will be the provider that receives notification to sign an order or get results from a test.

- Double left clicking any of the items on the cover sheet area will bring up more detailed information for that item.

- Left clicking a tab will take you to that Page.

- Remote data will be highlighted if there is information available at other VA’s
THE FACE SHEET/PATIENT INQUIRY

If you double click in this box, you will get the face sheet with their contact info, next of kin, address, insurance info, etc.
# THE FACE SHEET

**Patient Inquiry**

**Patient:** Brown, Test  
**ID:** 000-00-7035  
**Date:** Apr 27, 1990

**Address:** 1470 Clairmont Road  
**City:** Decatur, GA 30033  
**State:** United States  
**Zip Code:**

**Phone:** Home: unspecified  
**Office:** unspecified  
**Cell:** unspecified  
**E-mail:** unspecified

**Confidential Address:**  
**Confidential Address Categories:**

**From/To:** Not applicable

**POS:** Persian Gulf War  
**Religion:** Unknown/No Preference  
**Race:** Native Hawaiian or Other Pacific Islander

**Combat Vet Status:** Not Eligible

**Primary Eligibility:** Aid & Attendance (not verified)

**Other Eligibilities:** MEDICARE, VA Pension, Unemployable: No

**Means Test Signed:**

**Means Test Not Required**

**Primary Means Test Last Applied 'Jun 6, 2011' (NO LONGER REQUIRED: Aug 4, 2011)**

**Medication Copayment Exemption Status:** Exempt

**Patient Receives Aid and Attendance**

**Last RN Copy Exemption Date:** Aug 27, 2013

**Status:** Patient has no impatient or longer activity in the computer

**Future Appointments:** None

**Remarks:** ********** THIS IS A TEST PATIENT **********

**Date of Death Information**

**Date of Death:**  
**Source of Notification:**  
**Updated Date/Time:**  
**Last Edited By:**

**Health Insurance Information:**

<table>
<thead>
<tr>
<th>Insurance</th>
<th>Cob Subscriber ID</th>
<th>Group Holder</th>
<th>Effective</th>
<th>Expires</th>
</tr>
</thead>
</table>

No Insurance Information
The area above the provider will tell you the location of the patient:
- Inpatient: room number
- Outpatient: will say the clinic location or "visit not selected"
- *If you are prompted to select a location, pick from the appointments menu*
Primary Care Team
(or “Unassigned” if they don’t have a PCP yet...)

Flags: wandering risk, suicide risk, etc

Clinical Reminders
(*most useful for outpatient, primary care)

Postings: Allergies, DNR status, Advanced Directives

Past & Future Appointments
Postings (CWAD)

Postings are special types of progress notes. They contain critical information about a patient that hospital staff need to be aware of.

If a patient record contains postings, the Postings button (located in the upper right corner of the CPRS window) will display the letters C, W, A, and/or D. These letters correspond to the four types of postings described below.

- **C (Crisis Notes)** – Cautionary information about critical behavior or health of a patient. *Example: Suicidal attempts or threats.*

- **W (Warnings)** – Notifications that inform medical center staff about possible risks associated with a patient. *Example: Patient can be violent.*

- **A (Adverse Reactions/Allergies)** – Posting that includes information about medications, foods, and other conditions to which the patient is allergic or may have an adverse reaction. *Example: Patient allergic to penicillin and latex.*

- **D (Directives)** – Also called advanced directives, directives are recorded agreements that a patient and/or family have made with the clinical staff. *Example: DNR (Do Not Resuscitate) directive on file.*
### Non-VA Medications

Non-VA Medications are meds that the pt gets at a non-VA pharmacy.

### Outpatient Medications

- **DIETHYLSTILBESTROL IMG STUDY DRUG**
  - Qty: 28 for 28 days
  - Sig: TAKE 1 CAPSULE BY MOUTH EVERY DAY
  - Exp: 06/14/06
  - Status: Active

- **DOXUSATE NA 100MG CAP**
  - Qty: 100 for 90 days
  - Sig: TAKE ONE CAPSULE BY MOUTH EVERY DAY
  - Exp: 03/30/06
  - Status: Active

- **METFORMIN HCL 1000MG TAB**
  - Qty: 180 for 90 days
  - Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY
  - Exp: 03/01/06
  - Status: Active

### Inpatient Medications

- **DIETHYLSTILBESTROL IMG STUDY DRUG**
  - Qty: 28 for 28 days
  - Sig: TAKE 1 CAPSULE BY MOUTH EVERY DAY
  - Exp: 04/05/06
  - Status: Discontinue

- **DIETHYLSTILBESTROL IMG STUDY DRUG**
  - Qty: 28 for 28 days
  - Sig: TAKE 1 CAPSULE BY MOUTH EVERY DAY
  - Exp: 04/05/06
  - Status: Discontinue

- **METFORMIN HCL 500MG TAB**
  - Qty: 180 for 90 days
  - Sig: TAKE ONE TABLET BY MOUTH TWICE A DAY
  - Exp: 02/04/06
  - Status: Discontinue
I think it is easiest to look at the medications alphabetically. To do this, be in the “Meds Tab”, go to “View” and check on the last option: “Sort by Drug (alphabetically), status active, status recent expired”
MEDICATIONS SECTION CONTINUED

• First section will be Patient’s current location medications
  • If inpatient, there will also be listed Outpatient meds as well as non VA meds.

• Double click a medication order for more detailed information about the order
  • Who wrote the order?
  • Inpatient: will tell you the timing of each dose, if med was given (or refused, or missing dose…)
  • Outpatient: will tell you when the pt last filled their medications

• You can also increase the size of the columns
  • To Do This: Hover mouse pointer over the line that divides two columns. It will change to two arrows with a horizontal line. Left click and hold the mouse down while changing the size of the column.
You can view expired orders by clicking on “View” and select what you want to see (orders placed during a certain time period, recently expired, etc) see next slide

---

### ORDERS TAB

Start here to initiate new orders

The status column tells you if orders have been “executed” yet:
- “Active” – things are underway
- “Pending” – order has not been initiated
- “Cancelled”, “Expired”, “Scheduled”, “On Hold”

---

<table>
<thead>
<tr>
<th>Service</th>
<th>Order</th>
<th>Start/Stop</th>
<th>Provider</th>
<th>Nurse</th>
<th>Clerk</th>
<th>Status</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td>Bed Rest Bedrest</td>
<td>06/27/13 08:23</td>
<td>Franco, Denise</td>
<td></td>
<td></td>
<td>active</td>
<td>All Pulmonary-Lab</td>
</tr>
<tr>
<td>Nursing</td>
<td>Nursing Out of bed to chair TID</td>
<td>06/27/13 08:25</td>
<td>Franco, Denise</td>
<td></td>
<td></td>
<td>active</td>
<td>All Pulmonary-Lab</td>
</tr>
<tr>
<td>Intake/Output</td>
<td>TRIMETHOPRIM SULF, OPH Quant: 2.5 Refills: 3</td>
<td>08/27/13 12:06</td>
<td>Lynch, Mary Gerard</td>
<td></td>
<td></td>
<td>cancelled</td>
<td>All Ophthalmic Unit</td>
</tr>
<tr>
<td>Non-VA</td>
<td>Non-VA Bisoprolol Fumarate 50/100 MG, TAB TAKE ONE TABLET BY MOUTH Oct 03, 2011 Non-VA medication recommended by VA provider</td>
<td>10/03/11</td>
<td>Bilton, Michael A</td>
<td></td>
<td></td>
<td>active</td>
<td>Test 1 for Test Panel</td>
</tr>
<tr>
<td>Lab</td>
<td>BASIC METABOLIC PANEL PLASMA SP LB 11391890</td>
<td>06/27/13</td>
<td>Lomina, Orith E</td>
<td></td>
<td></td>
<td>pending</td>
<td>All Pulmonary-Lab</td>
</tr>
<tr>
<td></td>
<td>INTEGRASE GENOTYPE PLASMA SP LB 11585528</td>
<td>03/15/13</td>
<td>Franco, Denise</td>
<td></td>
<td></td>
<td>pending</td>
<td>Test 1 for Test Panel</td>
</tr>
<tr>
<td>Consults</td>
<td>TELEHEALTH – DERMATOLOGY IMAGING (SINARVILLE) Cons Constant’s Choice</td>
<td>10/12/11 11:27</td>
<td>Hall, Donna J</td>
<td></td>
<td></td>
<td>pending</td>
<td>Test 1 for Test Panel</td>
</tr>
<tr>
<td>Procedures</td>
<td>DO NOT USE (CP ECG) CF ECG Proc Cons Constant’s Choice</td>
<td>07/20/10 15:35</td>
<td>Franco, Denise</td>
<td></td>
<td></td>
<td>pending</td>
<td>All Care Areas</td>
</tr>
<tr>
<td></td>
<td>DO NOT USE (CP ECG) CF ECG Proc Bedside</td>
<td></td>
<td>Franco, Denise</td>
<td></td>
<td></td>
<td>pending</td>
<td>4 P SY</td>
</tr>
</tbody>
</table>

---

Start here to initiate new orders

The status column tells you if orders have been “executed” yet:
- “Active” – things are underway
- “Pending” – order has not been initiated
- “Cancelled”, “Expired”, “Scheduled”, “On Hold”

---

You can view expired orders by clicking on “View” and select what you want to see (orders placed during a certain time period, recently expired, etc) see next slide
To change what orders you see, Left Click View and then Custom Order View. Once you’ve customized your view, you can left click on “Save as Default”
• Highlight the Status and Service/Section

• If you want to only display orders for a specific time range, Select Only List Orders Placed...

• To create a more specific list, Left click the + in front of the name and then the detail you want
When orders are “verified” it means they have been “acknowledged” or initiated.
LIFE OF AN ORDER

• Once an order is written, depending on the order type, it will have a Status (sts) of “unreleased”
  • Releasing an order in CPRS is the same as signing an order on paper
  • If you enter an order but forget to sign it – it is “unreleased”
• Once the MD signs the order or the RN releases the order, the status will change
  • Medication orders will have a status of Pending…until pharmacy verifies the order. After verification, the orders will be Active. They may also be Expired, DC’d etc.
  • Medication orders that are not verified by Pharmacy will not have a stop date
  • Text (Nursing) and some other types of orders once signed (released) automatically are Active
DELAYED VS. ACTIVE ORDERS

• All depends on WHERE the patient is located: **Inpatient or Outpatient**

<table>
<thead>
<tr>
<th>Patient location = INPATIENT; you should write active orders</th>
</tr>
</thead>
<tbody>
<tr>
<td>10MED 10C146-2 Provider: BROWN, SHAHED L</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient location = OUTPATIENT; you should write delayed orders if you are writing admission orders – which will become active orders once the patient reaches a new location (i.e. gets assigned a bed &amp; is moved up to the wards or ICU)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATL OPHTH-NEW COMPREHENSIVE Provider: BROWN, SHAHED L</td>
</tr>
</tbody>
</table>
ACTIVE ORDERS

When your patient is already assigned a bed, all orders should be written as “ACTIVE ORDERS”. If your patient is going to change locations & you want orders to take place in a new location, you will write “DELAYED ORDERS” that will not be carried out until the patient is assigned a new bed in a new location.

When would you write “Delayed Orders” for a patient who is already Inpatient & assigned a room? Answer: If a patient is moving/transferring from one inpatient location to another (example: transfer from 10th floor → MICU, 9th floor → 4th floor); When patients move from one inpatient medicine ward to another (7th floor to 9th floor; 10th floor to 8th floor), you DO NOT have to do delayed admit orders!!
DELAYED ORDERS

This patient's location is “Visit Not Selected”; this essentially equals “outpatient”. If this patient is being admitted (from ER, clinic, PACU, etc) they need “DELAYED ADMIT ORDERS”

After you select “Write Delayed Orders”, the “Release Orders” Window pops up. It states the patient's name & that they are currently outpatient. It gives you the option to release new orders immediately or to “Delay release of new orders until” .... Then you have the option to select a “Event Delay” – you should select the “Admit to ___ Treating Specialty” (put your team); don’t use general medicine (*unless you are MICU/CCU), do not use “Hospice for Acute Care”. Just use your Team #.
DELAYED ADMIT ORDERS

Treating Specialty is your Team
Status: Inpatient vs Observation
Can put 7med, 10med, etc
Primary is intern caring for pt
Condition: Stable, Fair, Guarded
Can put specific things here like “Close Obs”, “Needs 1:1”, “Fall precautions”
Notice that there are 2 sections under view orders: “Active Orders” and “Delayed Admit Orders” – you have to be really careful to make sure that orders that you need to be carried out immediately are written in active orders; you may want to continue these orders once the patient is admitted... that’s fine – but need to have a duplicate order in the “Delayed Admit Orders”.

The “Delayed Admit Orders” section is highlighted... that means you are writing Delayed Admit Orders; orders that are unsigned will show up in blue.

When you are admitted a patient, you will have the opportunity to copy active outpatient orders to the “Delayed Admit Orders”. Hold down the “CTRL” button and highlight the orders that you want to be copied into the “Delayed Admit Orders”. You may have to review/verify these orders before they are added to your Delayed Orders List. Some medications may not be able to be copied over. That’s ok you’ll write for them later.
This is reachable through the delayed admit orders process or by going to the “Orders” Tab, and selecting “Clinician Orders (Full Menu)”. There are many protocols, bundles, etc. that can be ordered for active or delayed orders.
TRANSFER MEDS FROM INPATIENT TO OUTPATIENT AND VICE VERSA

Very useful for transition from inpatient to outpatient and vice versa

- Go to the Meds Tab
- Remember, if the patient is assigned an **outpatient** location, outpatient meds will be on top (and vice versa for inpatient)

**LEFT CLICK & PRESS CONTROL ON THE MEDS YOU WANT TO TRANSFER, THEN GO TO "ACTION" ON TOP OF THE SCREEN AND SELECT "TRANSFER TO INPATIENT" – YOU’LL THEN BE ASKED IF YOU WANT TO DELAY THE TRANSFER OF ORDERS UNTIL THE PATIENT IS ADMITTED – CLICK "OK".**

**OUTPATIENT LOCATION, OUTPT MEDS ARE ON TOP, INPATIENT ON BOTTOM**

THINGS I DID NOT GO OVER: MUE, NON-FORMULARY, PRN MEDICATIONS, TIMING OF MEDICATIONS, GIVE DOSE NOW, COMPLEX ORDERS
ORDERING LABS

Some labs are grouped as panels
Microbiology orders are under their own heading
Procedure lab menu
If the lab you are looking for is not listed, select “Other Lab Tests” at the bottom of the page

ORDERS TAB: SELECT “FAST LABS” AND YOU WILL SEE THIS SCREEN

Our BASIC & COMPREHENSIVE METABOLIC PANELS DO NOT INCLUDE MG AND PHOS, THESE LABS MUST BE ORDERED ADDITIONALLY
When you order a test for inpatient, MUST pay attention to “COLLECTION TYPE”, “COLLECTION DATE/TIME”

**LAB COLLECT = PHLEBOTOMY; ROUTINE TIME = “Next scheduled lab collection”, or can select “3 AM”**

WARD COLLECT = NURSE OR YOU ARE COLLECTING (Reasonable & default for stool, urine, sputum); you must discuss with your nurse in person if you need her to draw blood; Ward Collect should be selected for Arterial blood gases – Respiratory Therapy will often help you with this.

IMMEDIATE COLLECT = PHLEBOTOMY; OUTSIDE OF ROUTINE TIME - you will be able to select a time in the future to collect your labs – best for when you want to get afternoon/evening or stat labs

SEND PATIENT TO LAB = OUTPATIENT blood draws; select a date in the future for patient to get blood work done as outpt
LABS: TROUBLESHOOTING

• What if my patient has a picc line or central line?
  • Lab draws for these patient should be “WARD COLLECT”
  • Nursing will draw the blood from their catheter
  • Pick a time in the mid-morning
  • May need to ask nurse in person

• What if I don’t have lab results when I get here in the am?
  • Look in the order tab, under Labs section, in the Status column
    • Requested/Pending: Order is in computer but blood has not been drawn yet & is not on the phlebotomist’s collection list
    • On Collection List: Your lab is scheduled for collection by phlebotomy but not drawn yet
    • Collected: Lab has been drawn, is being processed by lab
    • Completed: You can view the result
    • Cancelled: Usually because patient did not want lab drawn, or they were not in their room (*will need to reorder labs)
ORDERS: IMAGING

Try to be as detailed as possible in the clinical history – it will really help the radiologist make sure that the patient is getting the best study.

Urgency: “ASAP” if I need it done by the end of the day; Use “STAT” if the patient really needs this study with impending deterioration, “ROUTINE” is well, routine.

For extra points: indicate in “Transport” whether or not the pt can be transported by a stretcher or if they can be sent by wheelchair.

Note that I put my PIC number in the clinical history – the radiologists are excellent about calling us with stat results.
ORDERS: IMAGING

ORDERS TAB: SELECT IMAGING
Then select the type of imaging you want from these options:

HELPFUL HINTS:
ANGIO/NEURO/INTERVENTIONAL
• “CHEST PORT”
• “BILIARY DRAIN”
• “TIPS”
• “NEPHROSTOMY”
• “PERMCATH”
• “GASTROSTOMY TUBE”

CT SCAN
• “CT GUIDANCE FOR NEEDLE PLACEMENT” (CT-guided biopsy)
• “DRAINAGE, CT-GUIDED”
• “CT C/A/P”
• “CTA-CHEST”

NUCLEAR MEDICINE
• “BONE DENSITY STUDY” (DEXA)
• “BONE IMAGING” (GALLIUM SCAN, R/OUT OSTEOMYELITIS)
• “GASTRIC EMPTYING STUDY”
• “HEPATOBLIARY SCAN WITH EJECTION FRACTION “HIDA””
• “MYOCARDIAL EF” (MUGA)
• “MYOCARDIAL PERF STRESS/REST” (NUCLEAR STRESS TEST)
• “PET/CT” (WHOLE-BODY PET-CT)
NOTES

• The Notes Tab also located at bottom of page
• Some notes have templates automatically associated with that note title
• To write a New Note:
  • Click on Notes Tab
  • Left Click “New Note”
  • Select a Note Title (if there is a template attached, it will launch, otherwise you have a blank writing pad)
  • If you need to finish your note later, you can “Save without signature” and come back and finish your note
    • When you return to your note, must right click, select “Edit Progress Note”
  • Sign the note using Action, “Sign Note Now”
• If you haven’t signed a note, you can delete it by right clicking, select “Delete Progress Note”
  • Once you have signed a note, you can’t delete it automatically – have to go through medical records (*contact Chief Resident or APD if this happens)
  • If the information in the note is pertinent for that patients – no problem – just make an addendum to that note and document that the note was signed early, and finish documentation
  • If the information in the note is for the wrong pt, need to have note deleted – contact us!
Click "New Note" to start a note – will bring up this box to select a note title.
NEW NOTES

• When completing a note with a template associated with the note, all fields that have an * in front of them must be filled in.
• If you want to copy/paste data for your note, you can put any letter in that field to be able to get to the screens where you can move between tabs and copy & paste information.
• At this point you can either “Sign Note Now” or “Save Without Signature”.
• If you Sign the note, you will not be able to edit it…only add addendums to the note.
• If you Save without signature, it saves the note so you can edit/add to it.
SAVE WITHOUT SIGNATURE

If you need to go to a different patient but you’re in the middle of a note, go to “Action” at the top of the screen, select “Save Without Signature”
SAVE WITHOUT SIGNATURE CONTINUED

• When you’re ready to edit the progress note
  • Highlight the Unsigned note
  • Select Action from the Menu bar
  • Select Edit Progress Note from the list of options
  • Once you are done, select Action, then “Sign Note Now”
  • You can “Save Without Signature” as many times as you need too.
DOES CPRS AUTOMATICALLY SAVE MY NOTES?

• YES – but the interval is a bit long for my preferences
• I suggest changing this (occasionally, a power outage or some other fluke may occur and you don’t want to lose any of your work!)
CHANGING PROGRESS NOTE AUTOSAVE INTERVALS

At the top of the screen, select “TOOLS” then select “OPTIONS” at the bottom of the menu.
CHANGING PROGRESS NOTE AUTOSAVE INTERVALS

Left Click Notes tab

Left Click Notes
Change the “Interval for autosave of notes” to “30 seconds”
SETTING UP NOTE TITLES:
HOW TO GET FREQUENTLY USED NOTE TITLES TO SHOW UP AT THE TOP OF THE PROGRESS NOTE LIST BOX

At the top of the screen, select "TOOLS" then select "OPTIONS" at the bottom of the menu.
SETTING UP NOTE TITLES:
HOW TO GET FREQUENTLY USED NOTE TITLES TO SHOW UP AT THE TOP OF THE PROGRESS NOTE LIST BOX

Left Click Notes tab

Left Click Document Titles
**SETTING UP NOTE TITLES:**

**HOW TO GET FREQUENTLY USED NOTE TITLES TO SHOW UP AT THE TOP OF THE PROGRESS NOTE LIST BOX**

*Under “Document Class”, select “Progress Notes”*

*Under “Document Title”, start typing the first few letters of the note you want to add*

*Common note titles to add for inpatient medicine:*
  - Medicine History and Physical
  - Medicine Progress Note
  - Discharge Instructions Medicine
  - Medicine Crosscover Note

*Click “Add” to move that document title to your default list*

*Click “Save Changes” when you are done!
**NOTES: TROUBLESHOOTING AND ADJUSTMENTS**

<table>
<thead>
<tr>
<th>Action</th>
<th>Options</th>
<th>Tools</th>
<th>Help</th>
</tr>
</thead>
<tbody>
<tr>
<td>New Progress Note...</td>
<td>Shift+Ctrl+N</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make Addendum...</td>
<td>Shift+Ctrl+M</td>
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<td></td>
</tr>
<tr>
<td>Add New Entry to Interdisciplinary Note</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Attach to Interdisciplinary Note</td>
<td></td>
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</tr>
<tr>
<td>Detach from Interdisciplinary Note</td>
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<tr>
<td>Encounter</td>
<td>Shift+Ctrl+R</td>
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<tr>
<td>Change Title...</td>
<td>Shift+Ctrl+C</td>
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<tr>
<td>Reload Boilerplate Text</td>
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<td></td>
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<tr>
<td>Add to Signature List</td>
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<td></td>
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<tr>
<td>Delete Progress Note...</td>
<td>Shift+Ctrl+D</td>
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<td></td>
</tr>
<tr>
<td>Edit Progress Note...</td>
<td>Shift+Ctrl+E</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Save without Signature</td>
<td>Shift+Ctrl+A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sign Note Now...</td>
<td>Shift+Ctrl+G</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Identify Additional Signers</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*At the top of the screen, select “Action”*
- You can “Make an Addendum” if you need to add an update to your note
- “Change Title” of your note (*before you sign it*)
- “Delete Progress Note”
- “Edit Progress Note” (*before you sign in*)
- “Save without Signature” (so you can come back and edit it later)
- “Identify Additional Signers” – if you want to “alert” or “notify” another provider, you can identify them as an additional signer to your note, d/c instructions etc. **This does not replace a phone call when critical information needs to be conveyed!**
MORE HELPFUL HINTS FOR NOTES

*Under the “Notes” Tab, at the top of the screen, select “View”
*Select “Custom View”
MORE HELPFUL HINTS FOR NOTES

*For the top box, highlight “Signed Documents (all) and change the Max Number to Return to “200”
- You can always view more notes by going to “View” as you did to get to Custom View and select “Signed Notes (All)” to see all Of the notes for the patient, or You can select by “Date Range” - Can also “Search for Text” if You are looking for something Specific (example “Urology”)

All notes with the word “Medicine” can be highlighted for easy navigation; click “Title” and the type “Medicine” in the “Contains” box
HOW TO MAKE YOUR OWN NOTE TEMPLATES

1. Click on “Notes” Tab
2. Go to “Options” at top of screen
3. Click on “Create New Template”
4. Upper R-hand corner: “Personal Template Properties” – can rename it whatever you want. For template type: keep it template. “Active” should be checked.
5. See where it says “template boilerplate” in the bottom half of screen? Start typing. The text will automatically import each time you use the template. This is where you would type “Medicine Team #4 Resident Progress Note”, and then you can add “Subjective”, “Objective”, etc.
HOW TO MAKE YOUR OWN NOTE TEMPLATES

*I have a History & Physical template, where I type out the different sections, "HPI", "PMH/PSH", MEDICATIONS (**With a tag-line I have reviewed & reconciled inpatient & outpatient medications); and the common systems I review in ROS & physical exam.
How to Make Your Own Note Templates

6. To automatically import up-to-date information into your template:
   Go to "Edit" at the top of the window
   Click on "Insert Patient Data" – this little tool box should come up:

   ![Insert Patient Data Window]

   You can take some time to look at the options – I think medications, allergies, vitals, etc are useful.

   If you choose "Edit" at the top of the window & click on "Insert Template Field" – this is a way to build more complicated templates – ones that have check boxes, fillable boxes etc.

7. When you are done – Go to "Edit" at top of window and select "Preview/Print Template".
   If you are happy with how this looks, can click "Close"
8. It will bring you back to the original template dialog box & if you are happy with everything, click "Apply" at the bottom of the screen and then "OK" at the bottom of the screen.
HOW TO MAKE YOUR OWN NOTE TEMPLATES

To use your template:

Must have an active note open. At the bottom of the screen on the left, click on “Templates”, then click on “My Templates” - just double click on your template & it should load automatically!

If you want to edit a template you already made:

Click on “Notes” tab
Go to “Options” at the top of screen
Click on “Edit Templates”
When you need a consultant, you need to enter a request in the computer. It is customary to also CALL physician consultants. Asking for a consult takes practice. Be clear, specific, and concise in your request.

For Non-physician consultants (PT, OT, speech) I usually don’t call unless it is an urgent consult or something very specific that needs to be conveyed.
CONSULTS TAB

- Click on “Consults” Tab at bottom of screen or in the “Orders” tab, select “Fast Consult Menu”
- Select “New Consult”
- Select “New Procedure” for:

Cardiology Procedures
- ECHOCARDIOGRAM
- ECG

PM&R Procedures

Pulmonary Procedures
- (PFT) PULMONARY FUNCTION TEST

OTHER PROCEDURES
This window opens up & if you don’t see what you want under this “Fast Consult Menu”, click on “Consult” and the “Order a Consult” Menu comes up.

Type the first few letters of what you are looking for and then double click on the consult title you want.
CONSULTS TAB

- Example: Inpatient Physical Therapy Consult

- Highlight the consult title in the “Order a Consult” Menu & then a new window will open, the “Reason for Request” menu

- Notice that there is a * beside the free-text box, this indicates a mandatory field. You cannot pass go unless you put something here

- You can always put “evaluate & treat” by default for PT and OT consults

- Once you put the reason for request, it will bring you to the “Order a Consult” window. You need to fill in the “Urgency”, Provisional Dx (for example, Weakness, Stroke, etc); and if you need to enter any additional info it will go in the reason for request window.

- Press “Accept Order” when you are done
How do I know if my consult has been acknowledged?

• Again, remember to call your consultant to discuss the case

• In the “Consults” tab, there are abbreviations next to each consult request:
  
  • (p) = pending; the consult request has not been responded to or scheduled
  
  • (c) = completed; consult has been answered & staffed.
    • If you double click on this consult request in the consults tab, it will pull up the initial consult note associated with the consult request
  
  • (pr) = partial results; the consult has been acknowledged & the consult note started but it has not been signed
  
  • (s) = scheduled; consult has been acknowledged & scheduled for a future date
  
  • (x) = cancelled; the consult has been cancelled. The provider will document in the consult request the reasons why
This is a very useful place to find information; click on “D/C Summ” at bottom of page
DISCHARGE SUMMARIES

ALL DISCHARGE SUMMARIES MUST BE COMPLETED USING THE VA-SPECIFIC DISCHARGE SUMMARY

TO COMPLETE A DISCHARGE SUMMARY, GO TO THE D/C SUMM TAB AND CLICK ON NEW SUMMARY

THERE CAN BE ONLY 1 DISCHARGE SUMMARY FOR EACH ADMISSION; SELECT THE ADMISSION DATE FOR YOUR SUMMARY, IDENTIFY THE ATTENDING PHYSICIAN, AND PRESS “OK”, THE TEMPLATE WILL AUTOMATICALLY LOAD, PRESS A LETTER TO GET THROUGH THE MANDATORY FIELDS SO YOU CAN GET TO THE REGULAR VIEW & SO YOU CAN COPY/PASTE THE INFO FOR THE SUMMARY
Many different ways to look at labs. For a quick glance, use “Most Recent”
LAB TAB: CUMULATIVE VIEW

*CAN COPY/PASTE INTO PROGRESS NOTES, H&P, DISCHARGE SUMMARY FROM HERE*

Click on “Cumulative”
Select your “Date Range”

You can highlight what you want to copy & paste into your notes – but clean it up so it doesn’t take up 90% of your note!
LAB TAB: SELECTED TESTS BY DATE
REALLY USEFUL WHEN YOU’RE LOOKING TO SEE IF A CERTAIN TEST HAS BEEN DONE IN THE PAST

• Click on “Selected Tests by Date”
• Select your “Date Range”
Click on “Worksheet”  
Select your “Date Range”

Can’t copy/paste this info into notes but good to look at data in an organized way
Click on “Graph”. Select your “Date Range”, items to graph. Can’t copy/paste this info into notes but good to look at data in an organized way.
Click on “Microbiology”, Select your “Date Range”, all micro reports will populate the top window, click on each item to read results (culture data, sensitivities, etc)

You can copy & paste this info into your notes
Click on “Anatomic Pathology”, Select either Cytology or Surgical Pathology, the final reports will be here

You can copy & paste this info into your notes
LAB TAB - BLOOD BANK

Click on “Blood Bank”; this will give you all historical data in regards to transfusions in the past, blood product requests, etc.

A type & screen expires after 72-hours! You can look and see when the last T&S was done & if you need a new one.
The Reports Tab displays certain data in a more viewable format.

Useful information that can be found here:

- Imaging: dictated radiology reports
- Health Summary: Immunization data, prevention data (last colonoscopy, etc)
- Allergies (remote data)
- Historical Medication Administration (inpatient, BCMA reports)
- Inpatient Vitals (in a copy/paste format)
At the top of the screen, select "TOOLS" then select "OPTIONS" at the bottom of the menu.

REPORTS TAB: PREFERENCES
YOU NEED TO CHANGE YOUR DEFAULT PREFERENCES FOR THE "REPORTS TAB" TO MAKE SURE YOU ARE GETTING ENOUGH USEFUL DATA.
Click on the “REPORTS” tab, then select “SET ALL REPORTS”, then change the start date to some time in the early 1990s, end date should be today’s date, and the max # of reports to return should be 1000. Press “OK” when done.
Under the “REPORTS” tab, click “IMAGING”

Click on the studies listed above for the dictated report

This can be copied/pasted; but clean it up!
Click on the “REPORTS” tab, then select “VITALS CUMULATIVE”, select the “DATE RANGE” at the bottom of the screen.

*You can copy/paste this*
Click on the “REPORTS” tab, then select “HEALTH SUMMARY”, where you will find the following:

- BCMA (Bar Code Medication Administration) – basically Nursing Flow Sheets for medication administration
- Colorectal cancer screening information
- Future Appointments
- Immunization Status

*You can copy/paste this information*
VIEWING RADIOLOGY IMAGES:
CAN VIEW MOST IMAGES IN "VISTA IMAGING"

- Click on "TOOLS" at top of screen
- Select "WINDOWS 7: Vista Imaging, Consents/Directives/Agreements, Medflow EMR"
- Select "Win7 – Vista Imaging"

*this will launch the image viewer & image list on the next slide*
VISTA IMAGING

- Vista Imaging contains radiology images, scanned notes & documents (outside records, consents, eye clinic notes, etc)
- Highlight & double-click on the image or document that you want to look at & it will open in a new window
VISTA IMAGING

• Let’s say you want to look at a head CT
• You double clicked on the image list and this is what would come up
• You could double click on any of these images to “start”
• You could scroll up and down through all 84 images
- From here you could move through the scan quickly, change the CT presets (bone vs mediastinum vs lung)
- Zoom in/Zoom out
- Set up a 2-window view to compare this one with an older study
EKGS

CLICK ON “TOOLS” AT TOP OF SCREEN & CLICK ON “ECG”

This will launch a website in a new window with the patient’s EKGs. Double click on one of the thumbnails & a pdf of the EKG will open in a new window.
You will get a pretty good copy of the EKG. You can print any of these EKGs (remember to change the printer orientation to “landscape”!)

There is a paper copy of the EKG when it is actually done. This is located in the patient’s chart which is located in a folder/binder in the nurses’ station.
CARDIOLOGY PROCEDURES

• Transthoracic & Transesophageal Echocardiograms are located in “Vista Imaging” as PDF files

• Cardiac catheterization reports are found in the “Notes” tabs & also found in the “Reports” tab under “Health Summary” then “Cardiac Catheterization Report”

• Nuclear stress test reports are found in the “Reports” tab under imaging
HELPFUL TOOLS:
ATLANTA CLINICAL RESOURCES
CLICK ON “TOOLS” AT TOP OF SCREEN & CLICK ON ATLANTA CLINICAL RESOURCES

Atlanta Clinical Resources (opens as a new website window)
- **UP TO DATE**
- **NEW ENGLAND JOURNAL OF MEDICINE**
- **MICROMEDEX**
- **THERADOC** (Log-in: antibiotic, Password: resident)
REMOTE DATA

• If the Remote Data box is blue, there is remote data available
• Remote data is patient information, records from other VA sites
• To access remote data:
  • Left click the Remote Data box (if its not blue, there is no data available)
  • Select the sites you want data from. Usually you’d select all locations. A Check indicates that it is selected, unchecked box means its not selected
• The Remote Data “Chart” will open in a new internet explorer window
SHIFT HAND-OFF TOOL

1. Start the Shift Handoff Tool from the CPRS Tools drop-down menu.

2. Select List to print. Double click list or hit Submit button. Right click patient name in ‘Patient Box’ to delete patient from list. Personal List only – Right click on selected Personal list to delete a Personal List. HOT List – if you hold the manager key you are allowed to delete a HOT list.

The shift hand-off tool will automatically import patient information based on what is your “DEFAULT LIST” in CPRS. This is the list that comes up automatically when you first log onto CPRS. You can set this by going to TOOLS → OPTIONS → LISTS and creating a personal list. Then go back to the select a patient screen, find your list and then make it default.
SHIFT HAND-OFF TOOL

3. Enter/Edit data.
Yellow boxes: Editable fields. (data in these fields have an expiration date)
White boxes: Uneditable fields, data comes from Vista.
SAVE DATA, by moving from one field to another initiates the save field or hit the SAVE button at top of screen.

MAKE SURE YOU UPDATE THIS DAILY.
MUST INCLUDE:

- YOUR NAME, YOUR RESIDENTS' NAME, YOUR ATTENDING'S NAME AND CELL PHONE NUMBERS
- FOR EACH PATIENT, MAKE SURE THEIR CODE STATUS IS ACCURATE & YOU HAVE A CONTACT NUMBER FOR NEXT-OF-KIN