Chapter X: Enter and Maintain Documents

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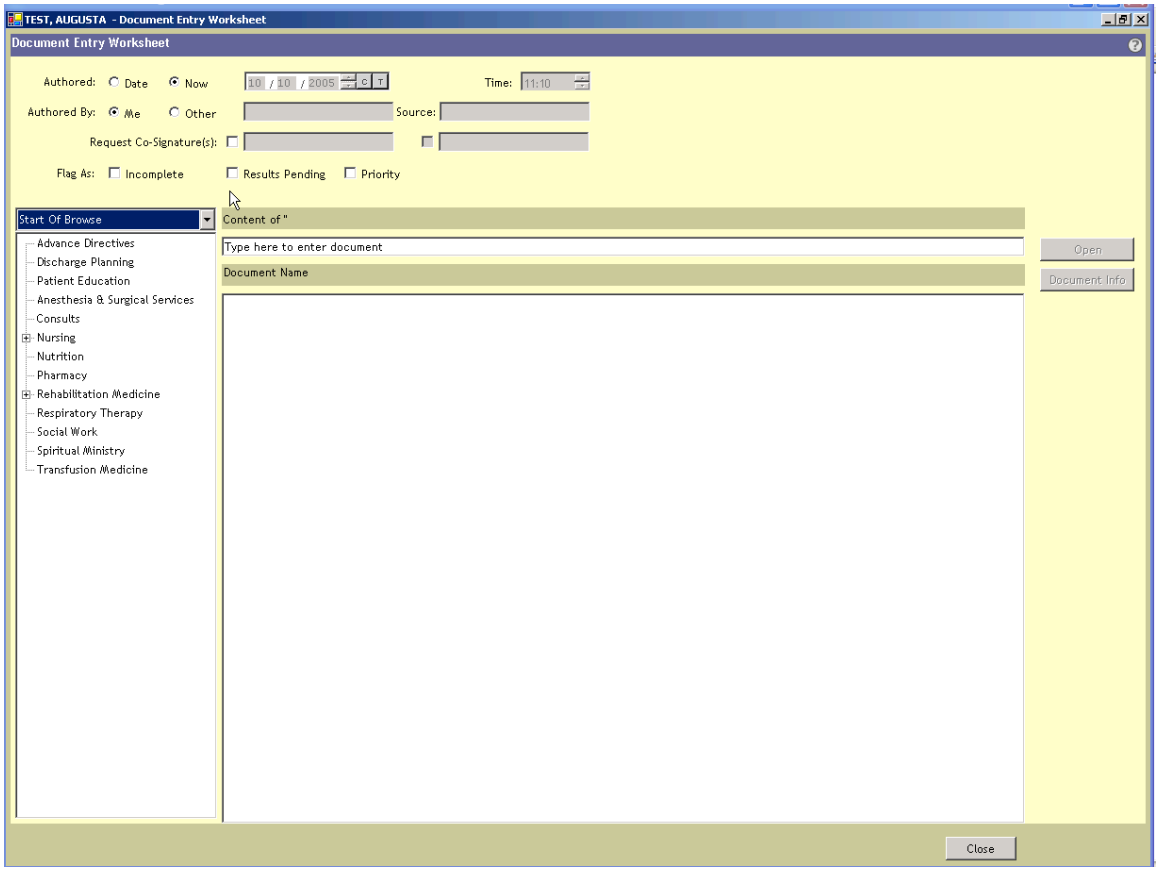
Document Entry Worksheet

You enter documents using the **Document Entry Worksheet**. The types of documents you can enter are:

- Free-text notes that you create by entering text in a text box.
- Structured notes that you use to record pre-defined observations in a question and answer format.

The **Document Entry Worksheet** contains two panes. The **Document Browse** is located in the left section pane and is where you locate the category of the document you want to enter. The **Document Name** is located in the right section pane and is where all notes related to the selected category display.



Screen 10.1: Document Entry Worksheet

Locate Documents

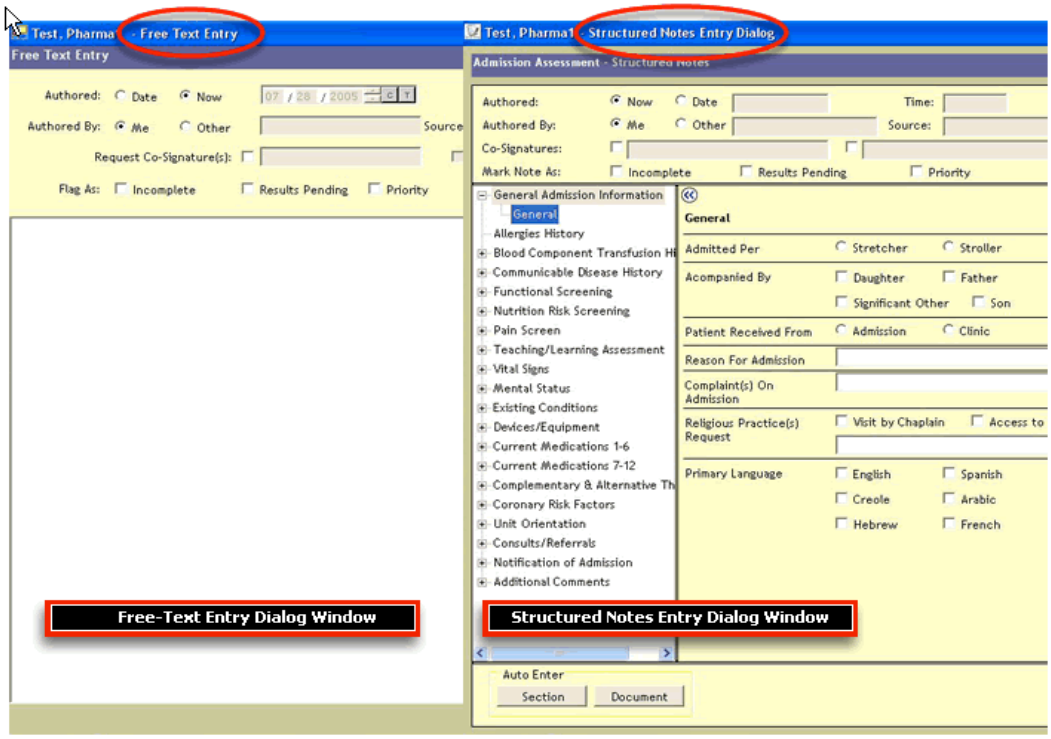
1. Open the **Document Entry Worksheet** using one of the following methods:
    a. On the toolbar, click the **Enter Document** icon.
    b. From the **GoTo** menu, select **Document Entry Worksheet**.

2. Locate a document in one of the following ways:

    a. Select **Start of Browse** and navigate through the tree structure to locate the desired department or document category. Any sub-departments or sub-categories are displayed by clicking on the plus sign **(+)**. When you select a category in the left section pane, the right section pane lists all of the documents in the selected category.

    b. Select **Manual Entry** from the drop down list on the left section pane. The cursor will move to the **Searching For** field. Enter part of the name of the desired document. All of the documents that start with the letters you typed will display in the **Document Name** pane.

3. Double-click the document name or select the document and click **Open**. If the document is defined as a free-text document, the **Free Text Entry** dialog box opens. If the document is defined as a structured note, the **Structured Note Entry** dialog box opens.

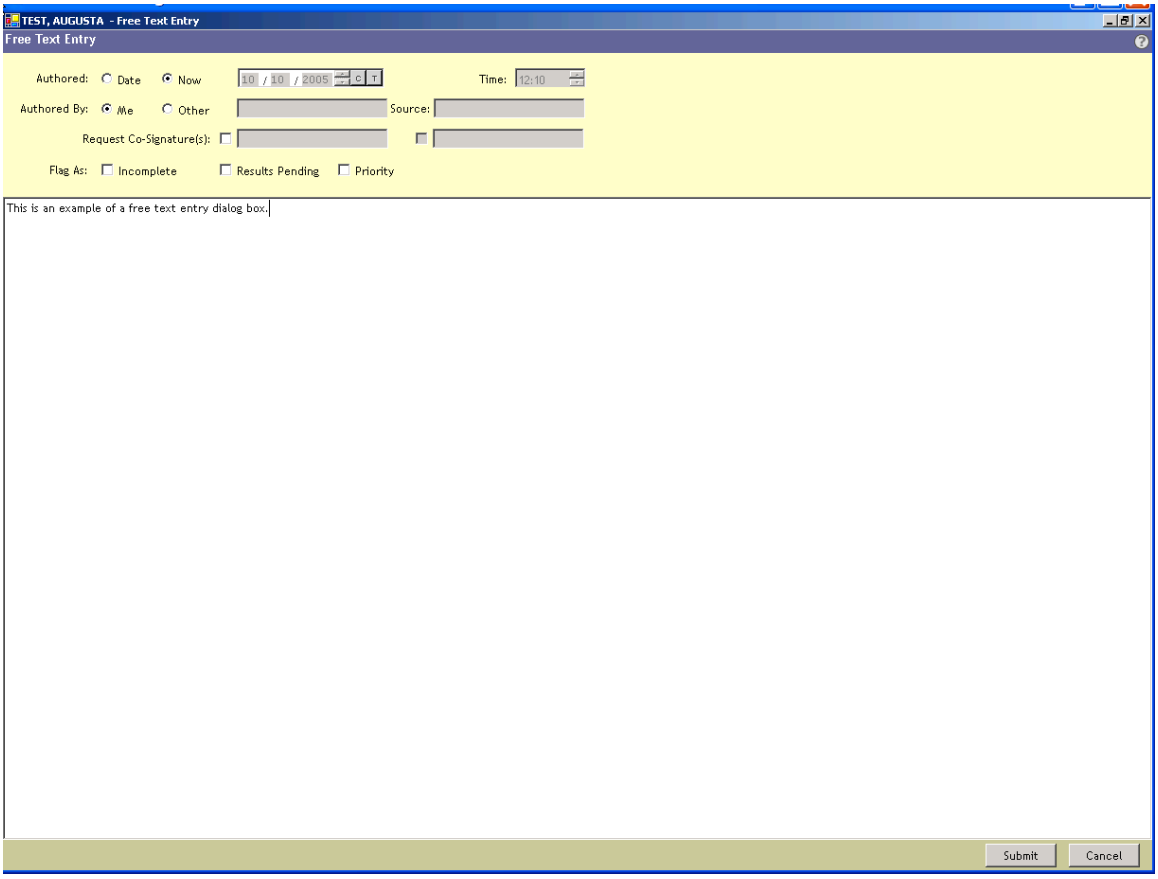


Screen 10.2: Free-Text and Structured Notes Dialog Window

Enter Free Text Notes

Document in a Free Text Note

Free-text documents are those composed of text in a free-form format. In a text window, you type the information you want to convey, creating paragraphs where appropriate. You can enter textual and numeric information, such as a brief progress note.



Screen 10.3: Free Text Entry Dialog box

To Enter a Free Text Note:

1. From the **Document Entry Worksheet**, locate a free-text document and click **Open**.

2. The document provides the current date and time or it can be changed if needed.

3. Enter your notes. You can type data into this window or copy and paste data from another form.

4. Click **Submit** to return to the **Document Entry Worksheet.** At this point, the document has been saved and becomes part of the patient's record.
5. Click **Close** to exit the **Document Entry Worksheet.**

Edit or Cancel Un-Submitted Free Text Notes

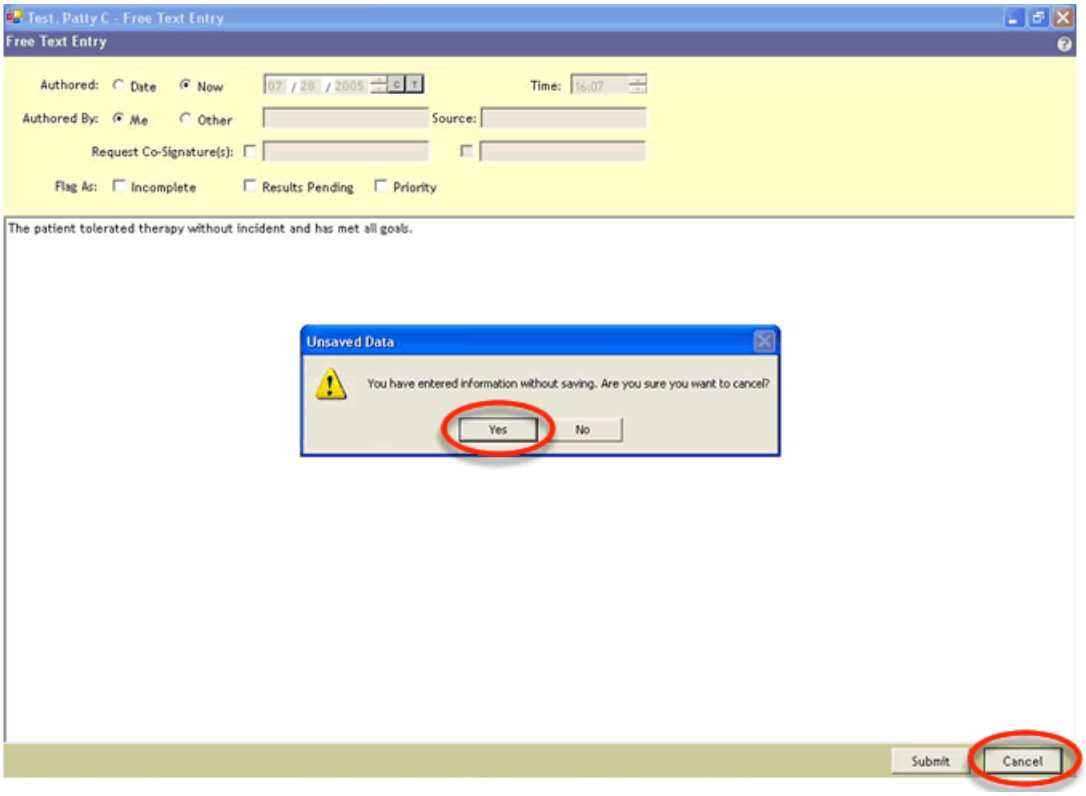
You can edit or cancel a free text **before** you submit it.

To **Edit** a free text note **BEFORE** you submit it:

1. In the **Free-Text Entry** dialog window, select the text you want to edit.
2. Change or add to the existing text and click **Submit**.

To **Cancel** a free text note **BEFORE** you submit it:

1. Click **Cancel** on the bottom right hand corner of the **Free-Text Entry** dialog window.
2. You will receive a warning message asking you if you are sure you want to cancel the document. Click **Yes**.



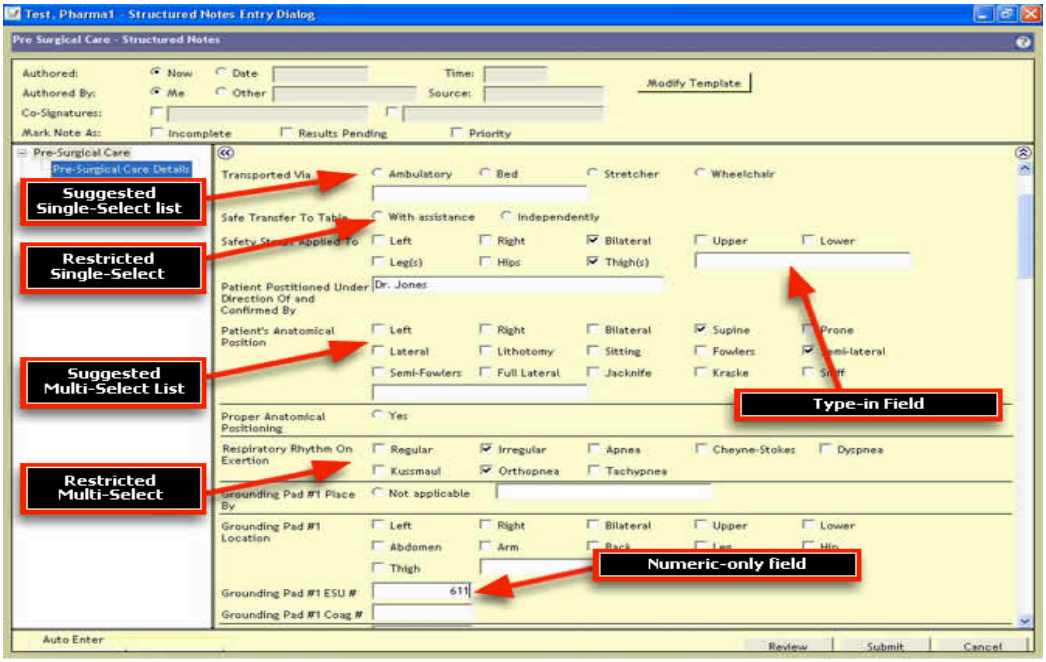
Screen 10.4: Cancel/Edit Feature

Enter Structured Notes

Structured Notes are used to record assessments or observations that are performed on a less frequent basis, such as an admission assessment. There are multiple ways to enter information in a structured note.

Types of entry methods include:

1. Type-in fields are empty boxes. Depending on the question being asked, you may be able to enter up to 2000 characters.
2. Some fields are empty cells where you can **ONLY** type numeric characters (e.g. 100). The unit of measure is added by the system where applicable (e.g. mL). (Numeric Only)
3. Some fields have lists that allow you to either select an option from the list and/or type in additional data. (Suggested Single-Select)
4. Some lists have check boxes that allow you to select one or more options from the list displayed and/or type in additional data. (Suggested Multi-Select)
5. Some fields have lists that require you to select only one option from the list displayed. (Restricted Single-Select)
6. Some lists have check boxes that allow you to select one or more options from the list displayed, but you can **not** type in additional information. (Restricted Multi-Select)



Screen 10.5: Structured Note Entry Dialog Box

Document in a Structured Note

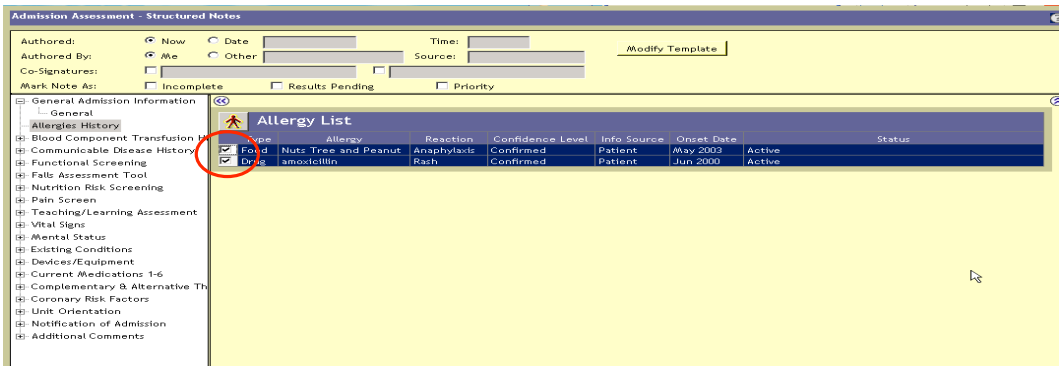
To document in a structured note:

1. From the **Document Entry Worksheet**, locate a structured note-type document from the browse and click **Open**.
2. Click an assessment category from the left pane to display its contents. Once you select the desired category, the contents for that category will display in the right section pane. *Note: Depending on the structured note, you may need to select the plus **(+)** sign to display all of the contents within a category.*
3. Select the desired choice(s) in the right section pane.
4. To continue documentation, select another category or sub-category. The right section pane will change to display the contents of the category you selected.
5. Click **Review** to view your documentation.
6. Click **OK** to return to the structured note.
7. Click **Submit**. At this point, the document has been saved and becomes part of the patient's record.

Depending on the type of structured note, you can also add information such as allergies, significant events, orders, and lab results into a structured note.

Add Allergies

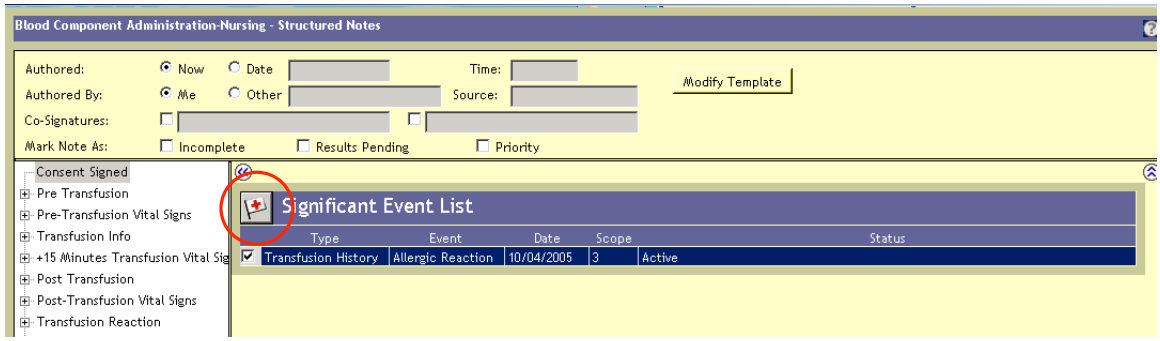
1. Select the allergies that you wish to include in your documentation by clicking the checkbox next to the desired allergy. *Note: By clicking the allergy icon, you can also enter new allergies from a structured note and include them in your documentation.*



Screen 10.6: Adding Allergies to a Structured Note

Add Significant Events

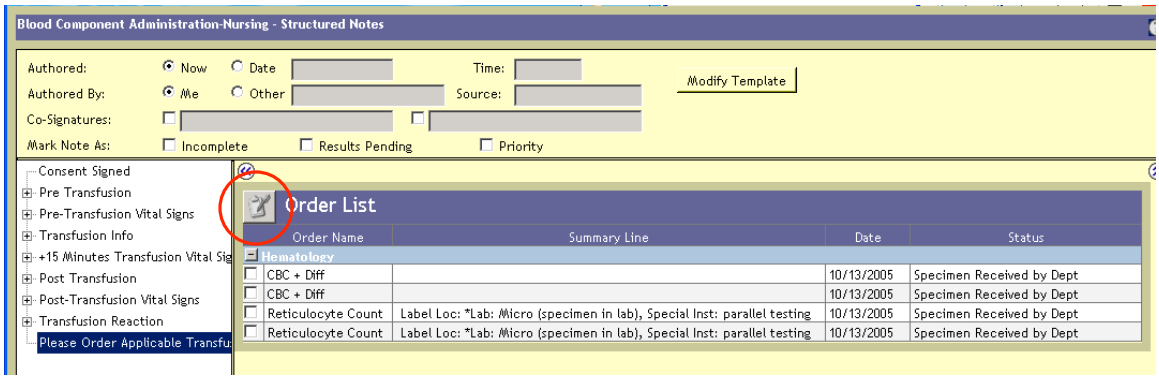
1. Select the significant events that you wish to include in your documentation by clicking the checkbox next to the desired significant event. *Note: By clicking the significant event icon, you can also enter new significant events from a structured note and include them in your documentation.*



Screen 10.7: Adding Significant Events to a Structured Note

Add Orders

1. Select the orders that you wish to include in your documentation by clicking the checkbox next to the desired order. *Note: By clicking the order icon, you can also enter new orders from a structured note and include them in your documentation.*

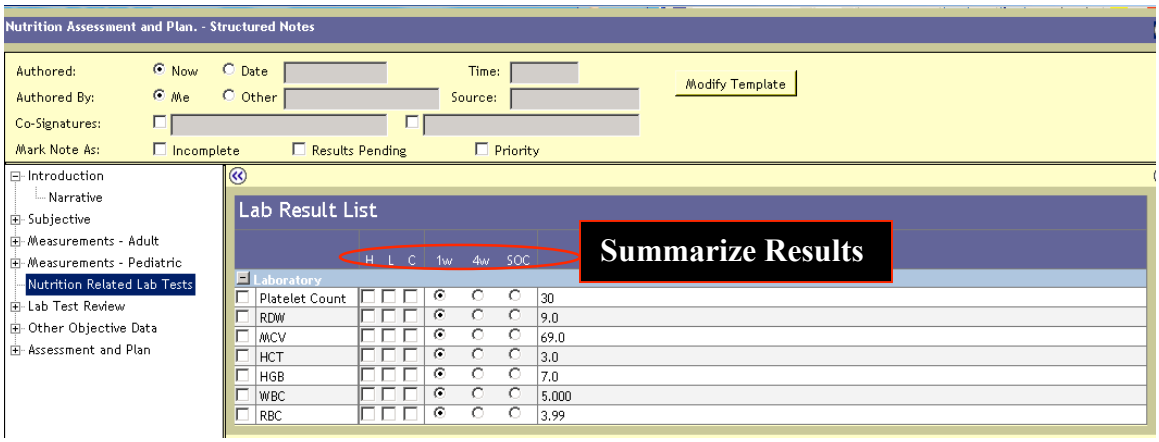


Screen 10.8: Adding Orders to a Structured Note

Add Lab Results

1. Select the lab results that you wish to include in your documentation by clicking the checkbox next to the desired result.

- You can summarize the results by selecting H (High), L (Low), C (Current), or a combination of the three and a time frame. Time frame options may include 1w (1 week), 4w (4 weeks), or SOC (Start of Chart).



Screen 10.9: Adding Lab Results to a Structured Note

Copy Forward

You can also **Copy Forward** information from a previously submitted structured note into a new identical structured note.

To Copy Forward:

1. Go to the **Documents Tab** and click the **Enter Document** icon on the toolbar.

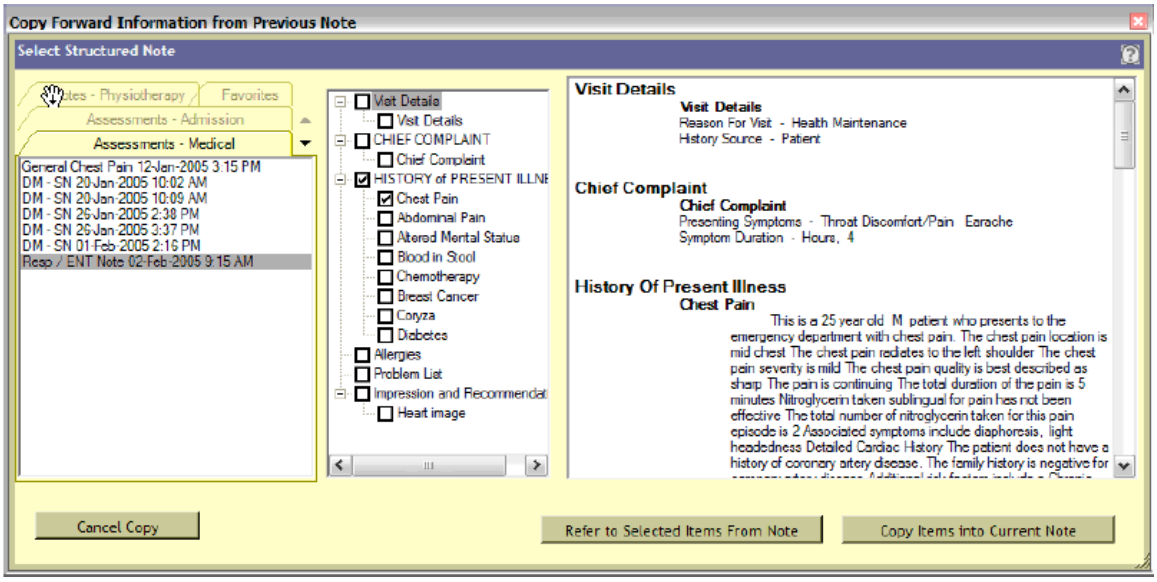
2. Select the desired note to be copied. Click **Open**

3. Click the **Copy Forward** button in the lower right hand corner. The **Copy Forward Information from Previous Note** dialog box opens.

4. Select a tab from the left section pane. The tabs display categories of structured notes previously submitted.

5. Select a structured note from the list in the left section pane. A tree view displays in the middle section pane after a note has been selected. The right section pane displays all contents of the structured note sub-categories.

6. From the tree view in the middle section pane, click items to copy forward.



Screen 10.10 Copy Forward Information from Previous Note Dialog Box

7. Click one of two **Copy Forward** options located at the bottom of the dialog box:

   - **Refer to Selected Items From Note** indicates the information is copied into the current note and referenced from a previous note. (**Charlotte** should we keep this since it has a BUG in it and was recently submitted as a case to Eclipsys??)

   - **Copy Items Into Current Note** indicates the information is copied from a previous note but is not referenced in the current note.

After clicking one of these two options, you are returned to the structured note. The new note displays with information copied from the previous note. Two asterisks (**) in the browse section display next to the categories that were copied.

Modify Template

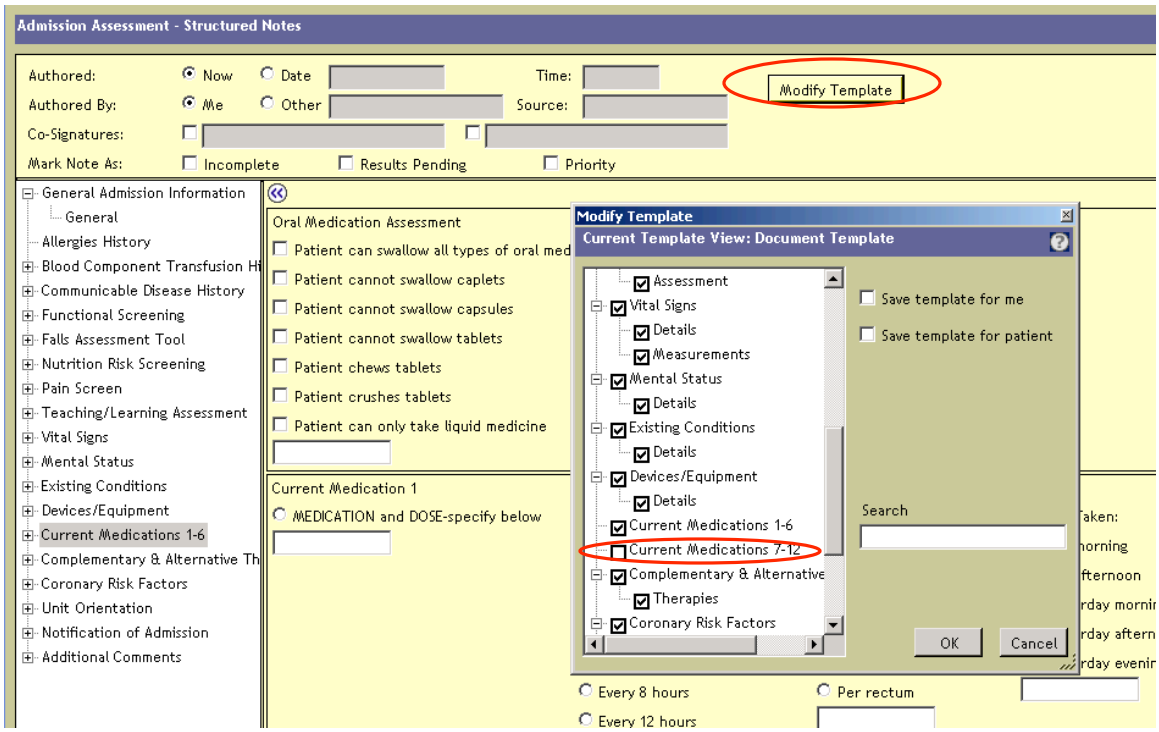
Depending on the structured note, you can add sections if additional information needs to be included in the note and does not automatically display. For example, if a patient is admitted with more than six current medications, you can add a section to the structured note to document additional medications.

To Add Sections to a Structured Note (Modify Template):

1. Click **Modify Template** from the **Structured Notes Entry** dialog window.

2. Click the checkbox next to the section you wish to add to the note.

3. If desired, click either **Save template for me** or **Save template for patient**. *Note: **Save template for me** will save the **Modify Template** selection for the user (yourself) only. **Save template for patient** will save the **Modify Template** selection for all users for this patient.*



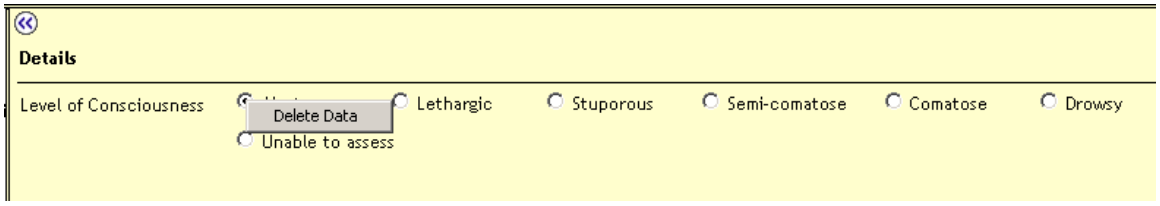
Screen 10.11: Modify Template

Edit or Cancel Un-Submitted Structured Text Notes

You can edit or cancel a structured note **before** you submit it.

To **Edit** a structured note **BEFORE** you submit it:

1. In the **Structured Notes Entry** dialog window, change the observations you wish to edit by changing your selections to the desired choice(s). *Note: To delete a radio button answer, right click on the button and select **Delete Data**.*



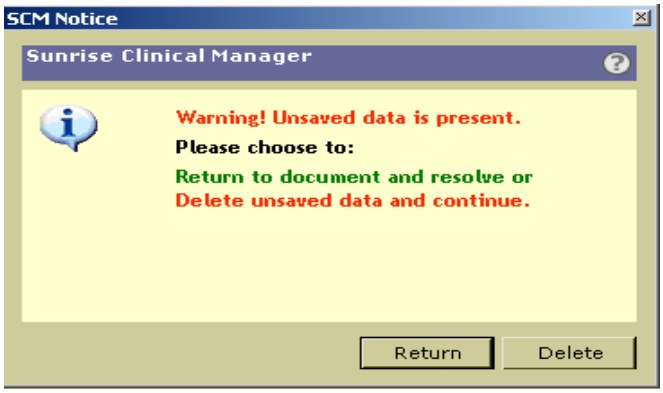
Screen 10.12: Delete Radio Button Information

2. Click **Review** to view your documentation.
3. Click **Submit** to save your note.

To **Cancel** a structured note **BEFORE** you submit it:

1. Click **Cancel** on the bottom right hand corner of the **Structured Notes Entry** dialog window.

You will receive a warning message asking you if you want to delete unsaved data. Click **Delete**.



Screen 10.13: Warning Message Unsaved Data

Enter Flowsheets

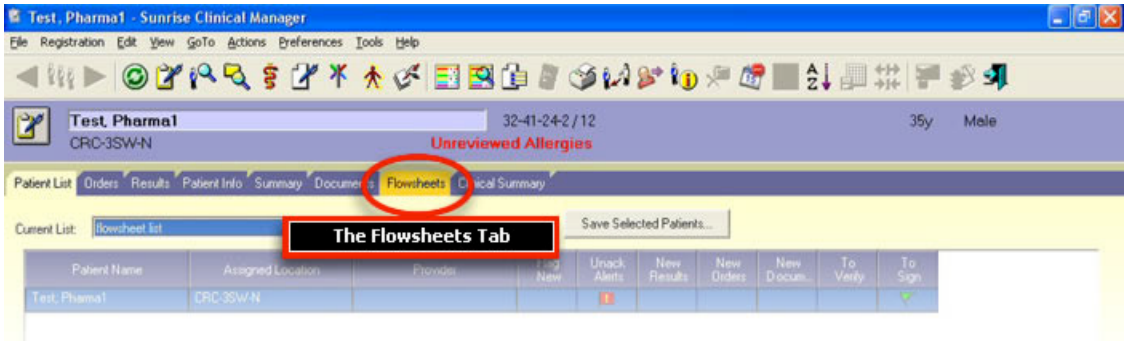
You can use flowsheets to record observations in CRIS. Flowsheets are used to document collections of clinical observations that are repeated on a regular basis and performed repeatedly over time. They represent the most common type of documents used by nurses and other ancillary care providers to record patient care.

Locate Flowsheets

Flowsheets are located by going to the **Flowsheets** tab. Flowsheets are assigned by locations. Depending on the location, some flowsheets will automatically display; others will need to be selected and activated for that location.

To locate and activate a flowsheet:

1. Go to the **Flowsheets** tab.

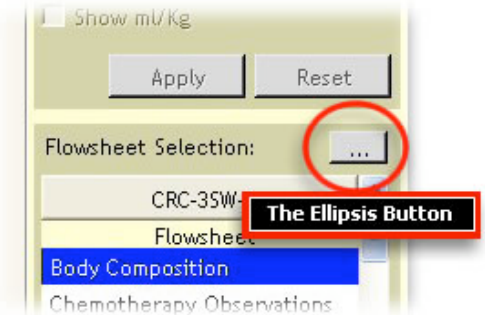


Screen 10.14: Flowsheets tab

2. If a flowsheet is active for a patient's location, it will automatically display in the **Flowsheet Selection** summary box on the bottom left. *Note: You may need to scroll down to see all of the active flowsheets for the patient you are documenting on.*

Screen 10.15: Flowsheet Selection Summary Box

3. If you do not see the desired flowsheet, you must activate it. To activate a flowsheet, select the ellipsis button.



Screen 10.16: Ellipsis Button

4. The **Search Flowsheet** dialog box displays. Type the first few letters of the flowsheet you are looking for and a list will display with all flowsheets that begin with those letters.
5. When you see the desired flowsheet, highlight it and click **OK**. This will activate the flowsheet and add it to the list in the **Flowsheet Selection** summary box on the bottom left.
6. The selected flowsheet is now active for the patient. *Note: If the patient transfers to another location, their flowsheet(s) will transfer with them.*

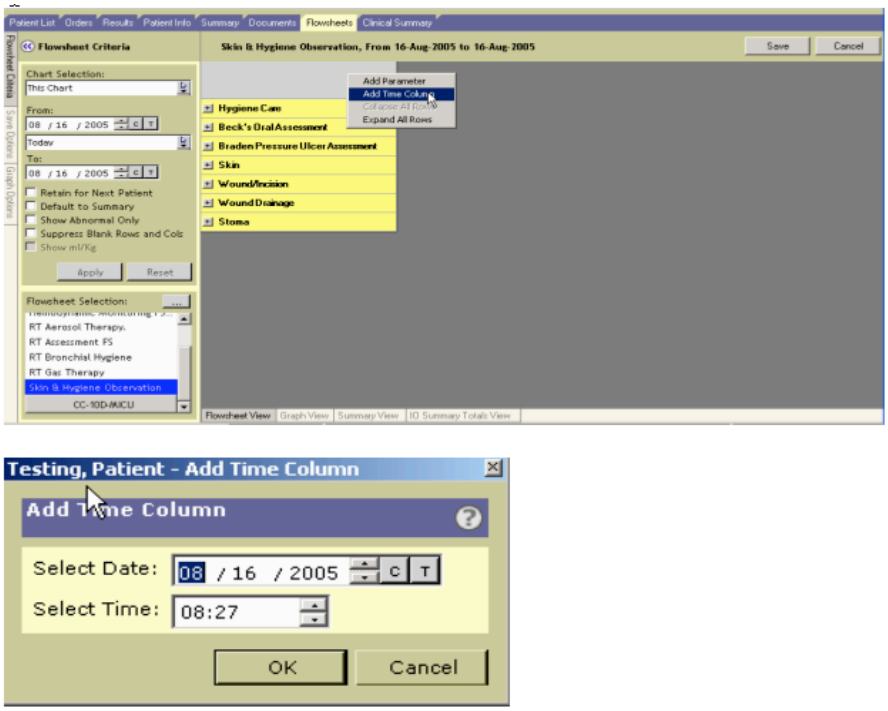
Documenting in a Flowsheet

Flowsheets are made up of columns and rows. Each row contains a series of cells. A cell is where you enter or select your observation. Flowsheet entry methods are identical to structured note entry methods:

- Type-in fields
- Numeric only
- Restricted Single-Select
- Suggested Single-Select
- Restricted Multi-Select
- Suggested Multi-Select

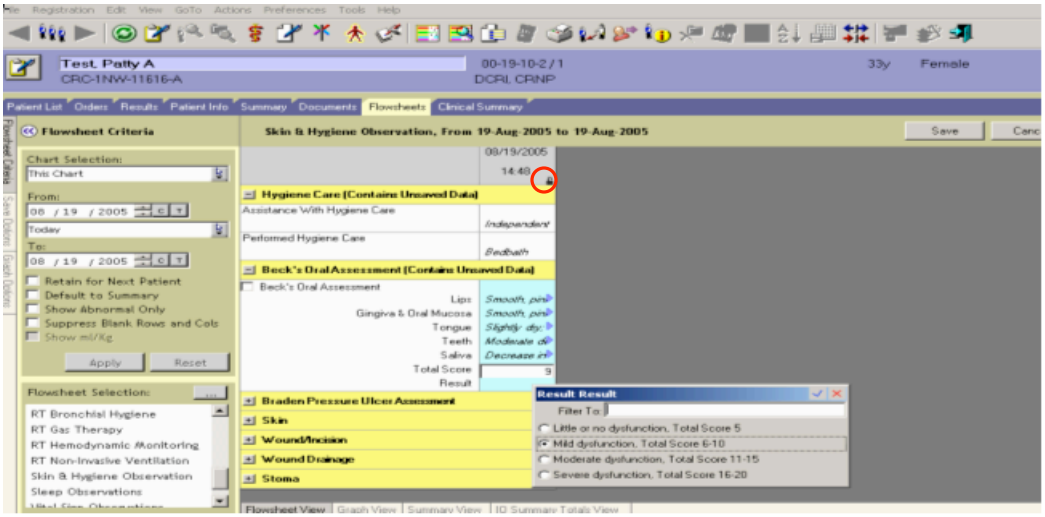
To document in a flowsheet:

1. From the **Flowsheets** tab, locate a flowsheet-type document from the **Flowsheet Selection** summary box and select the flowsheet.
2. Go to the grey area located in the top section of the flowsheet, and right click. A shortcut menu displays.
3. Select **Add Time Column** from the shortcut menu. The **Add Time Column** dialog box displays and defaults to the current date and time. If necessary, change the date and time accordingly and click **OK**. *Note: **C** stands for calendar, and **T** stands for **Today**.* If you select **T,** it allows you to enter a date prior to the current date. For example, if you type in T-1, a date of yesterday will display. You must use the **Enter** key on your keyboard in order for this to function.



Screen 10.17: Add Time Column on Flowsheet

4. A time column appears with a lock at the top of the time column. An open lock indicates that you can document. A closed lock indicates another user is currently documenting and you can not document at this time.



Screen 10.18: Flowsheet Observations with Lock

5. To begin documenting, click the plus **(+)** sign next to the desired section of the flowsheet. This will display all of the observations for that section.
6. To document in a cell, select the desired observation from the pop up list of choices or pop up free-text box.
7. To complete documenting in the cell, click the blue checkmark in the right hand corner. *Note: When you click the checkmark, the next observation pop up box displays. If you wish to exit at this point, click the red X in the right hand corner of the pop up box.*
8. When you are finished documenting in that section, click the plus **(+)** sign in another section to continue documentation. Follow the same procedure to continue your documentation.
9. When you are finished documenting, click **Save**. Once saved, it becomes part of the patient record.

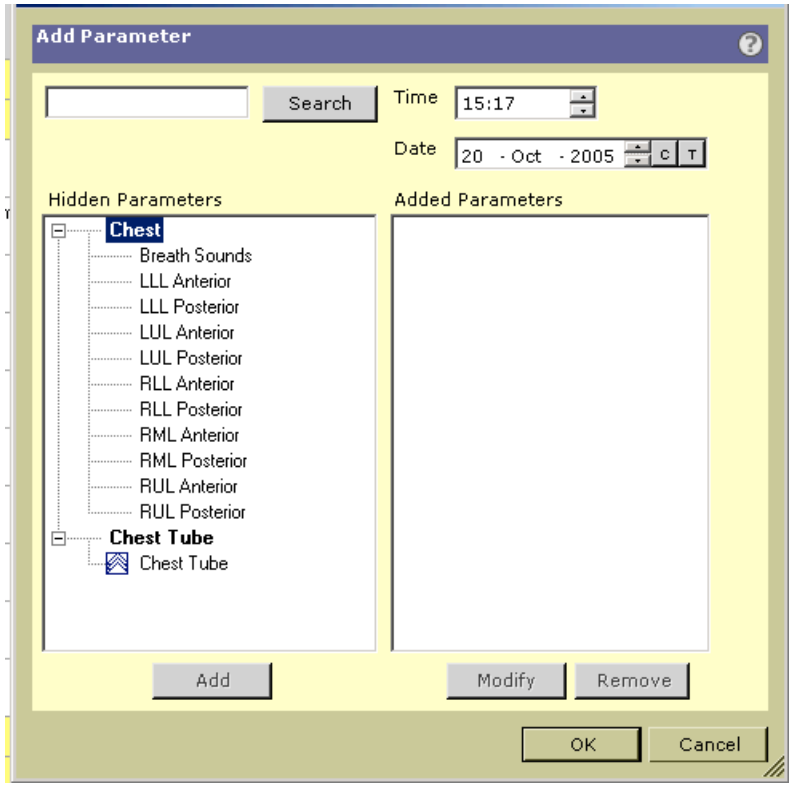
Additional Flowsheet Entry Methods

Information can also be added to a flowsheet using any of the following actions. *Note: Depending on where you right click in a flowsheet, you will receive a list of possible actions which are unique to the selected location.*

Add Parameter

Depending on the flowsheet, you can add observations or sets of observations to a flowsheet. For example, if a patient has more than one type of drain, you may need to add additional drains to document on.

1. Right click in a header or observation.
2. Select **Add Parameter** from the shortcut menu. This opens the **Add Parameter** dialog box allowing you to add an observation or set of observations to the flowsheet.
3. Click the **(+)** next to the desired observation and select a parameter
4. Click **Add** after each parameter selected.
5. Click **OK**.

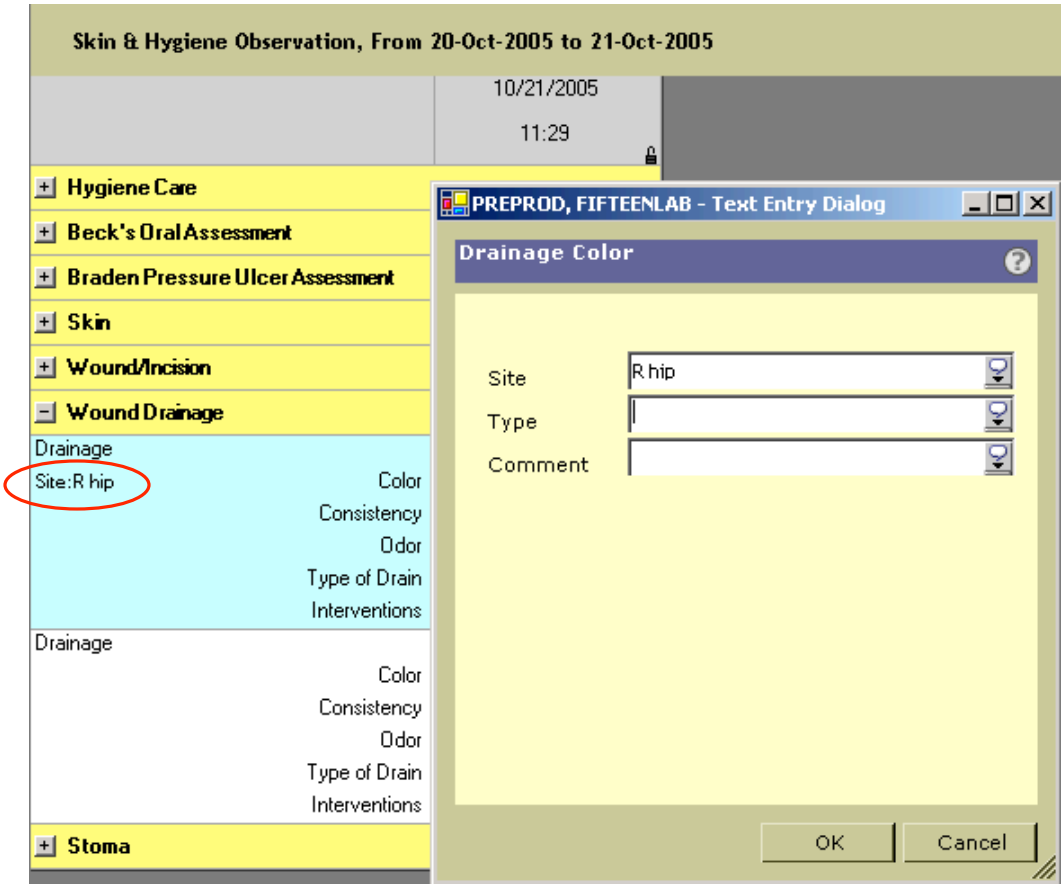


Screen 10.19: Add Parameter Dialog Box

Modify Row Label

You can add a label to an observation row. For example, if you had more than one type of wound or drain, you can specify the location.

1. Right click in a row and select **Modify Row Label** from the shortcut menu. This opens the **Text Entry** dialog box allowing you to add or modify an observation row label.
2. Enter desired information in the text entry boxes.
3. Click **OK**. Information you enter displays in the observation row.



Screen 10.20: Modify Row Label

Enter Comment

Some flowsheets may not contain all the observations you need for your patient. Therefore, it may be necessary to document additional information that is not contained in the observation.

1. Right-click in a cell and select **Enter Comment** from the shortcut menu. The **Text Entry** dialog box opens, allowing you to enter free text comments for the cell.
2. Enter desired information the text entry dialog box.
3. Click **OK**. A blue asterisk displays in the upper right hand corner. of the selected cell.
4. To view a comment, click the asterisk to display the contents of the cell.

Fan Out

Depending on the structured note or flowsheet, some information may automatically display in other flowsheets. For example, if you enter a pain screen in the Nursing Admission Assessment, it will automatically display (fan out) in the Pain assessment/Reassessment Flowsheet. Likewise, if you enter vitals signs in the Post Procedure Observations flowsheet, these vitals signs will automatically display in the Vitals Signs flowsheet.

Actions on Existing Free-Text Notes, Structured Notes, and Flowsheets

Once a document is submitted, you can cancel and/or edit existing documentation. All changes are recorded in the system and are available for review. *Note: An audit trail is maintained and can be viewed.*

Edit Free-Text Notes, Structured Notes, or Flowsheets

To **Edit** a Free-Text or Structured Note:

1. From the **Documents** tab, confirm the **Display Format** filter is set to **Report**.
2. Locate the document you want to edit.
3. Select/Highlight the document.
4. Right-click and select **Edit Document**. The **Free-Text Entry Dialog** or the **Structured Notes Entry Dialog** window opens depending on the type of note selected.
5. Change or add to the existing free-text note or structured note and click **Review**.
6. Click **OK**.
7. Click **Submit**.
8. The document displays with an **Edit** icon.

To **Edit** a Flowsheet:

1. From the **Flowsheets** tab, locate the flowsheet name from the **Flowsheet Selection** summary box.
2. Select/Highlight the flowsheet.
3. Select the cell(s) you wish to edit and enter the new information.
4. Click **Save**.
5. You will now see a red **C** (for correction) in all cells where data has been updated.

Cancel Free-Text Notes or Structured Notes

To **Cancel** Free-Text Notes and Structured Notes:

1. From the **Documents** tab, confirm the **Display Format** filter is set to **Report**.
2. Locate the document you want to cancel.
3. Select/Highlight the document.
4. Right-click and select **Cancel Document**. The **Cancel Document** window for the selected document opens.
5. Select a **Reason** for canceling the document.
6. Click **OK**.
7. The document displays with a strikethrough and a **Cancel** icon.

Cancel (delete) a Time Column in a Flowsheet

To **Delete** a time column:

From the **Flowsheets** tab, locate the flowsheet name from the **Flowsheet Selection** summary box.

1. Select/Highlight the flowsheet.
2. Right click in the grey area at the top of the date/time column. *Note: You must click the plus **(+)** sign(s) to open up the flowsheet section(s) to view your documentation.*
3. Select **Delete Time Column** from the shortcut menu.
4. Right click in the grey area at the top of the date/time column and select **Edit Text** from the shortcut menu.
5. Type in a reason for the deletion in the **Text Entry Dialog** window.
6. Click **OK**.
7. Click **Save**. You will now see the reason for the time column deletion at the top of the time column. A red **C** (for correction) displays in all cells where data has been deleted.

Discontinue or Reinstate an Observation in a Flowsheet

You can also discontinue an observation or reinstate (bring back) one when necessary. For example, if an IV or drain is discontinued and then restarted at a later date/time, you can reinstate that observation.

To **Discontinue** or **Reinstate** an observation in a flowsheet:

1. From the **Flowsheets** tab, locate the flowsheet name from the **Flowsheet Selection** summary box.
2. Select/Highlight the flowsheet.
3. Right click the observation.
4. Select **Discontinue** from the shortcut menu to discontinue an observation, or **Reinstate** to bring back a discontinued observation.

Documents Available in CRIS by Department

The following list contains all documents in CRIS by department. Free text notes are indicated by the initials FT. Flowsheets are listed at the end of each department's section.

Nursing Documents and Flowsheets

Nursing Documents

Admission/Initial Assessment
- Admission Assessment
- Growth & Development Assessment Note
- Initial Physical Assessment
- Mental Status Assessment Note
- Psychosocial History Note
- Restraint Risk Assessment
- Self Harm/Suicide Assessment
- Substance Abuse Assessment Note

Blood Component Administration
- Blood Component Administration – Nursing
- Surgery Branch Cell Prod Administration

Chemo & Biotherapy
- Chemo/Biotherapy Administration

Circulation
- Holter Monitoring Note
- VAD Central Assessment Note
- VAD Peripheral Assessment Note

Conferences
- Care Conference Note
- Telephone Contact Note

Physical Safety
- Missing Person Note
- Physical Injury Assessment Note
- Physical Safety Room Search Note
- Post Seclusion and Restraint Note
- Pre-Restraint/Seclusion Assessment Note

Procedures and Tests
- Bronchoscopy Procedure Note
- Endoscopy Gastric Analysis Note
- Endoscopy Procedure
- Endoscopy Visit Note
- Expiration Note
- Insulin Pump Note
- Liver Biopsy Procedure Note
- OR Transfer Note
- Pass Note
- Serial Testing

Nursing Documents (cont.)

Skin & Hygiene
- Extravasation Note

Transfer/Pass & Expiration
- OR Transfer Note
- Pass Note
- Expiration Note

Vital Signs
- 3/10 Body Measurements

Nursing Flowsheets
- Circulation Observations
- Elimination Observations
- Food & Fluid Needs Observations
- Hemodialysis Observations
- Insulin Pump Observations
- Intake and Output
- Mobility Observations
- Neurological Assessment
- Neuro Vital Sign Observations
- Pain Assessment/Reassessment
- Point of Care Testing
- Post Procedure Observations
- Psychosocial Observations
- Respiratory Observations
- Restraint Log – Medical Surgical
- Restraint/Seclusion Log – Behavior Health
- Seizure Observation
- Skin & Hygiene Observation
- Sleep Observations
- VAD Observations
- Vital Sign Observations

Ancillary and Other Clinical Documents

Advance Directives
- Advance Directives

Anesthesia & Surgical Services
- Post Operative Nursing Evaluation
- Post-Surgical Care Minor Surgery
- Post-Surgical Care Neurosurgical
- Post-Surgical Care -Oncology/Eye
- Pre Surgical Care
- Pre-Operative Nursing Assessment
- Receiving Area Assessment

Consults
- Dental Service Consult (FT)
- Wound/Ostomy/Continence Consult Service

Discharge Planning
- Art Therapy Discharge Note
- Massage Therapy Discharge Note
- Music Therapy Discharge Note
- Nursing Discharge Note
- Patient Discharge Instructions
- Recreation Therapy Discharge Note
- Social Work Resource/Discharge Summary
- Spiritual Ministry Discharge

Nutrition
- Nutrition Research Note
- Nutrition Assessment and Plan
- Nutrition Note (FT)
- Nutrition Screening Note
- TPN & TF Recommendations (FT)

Flowsheets:
- Body Composition
- Nutrient Intake

Patient Education
- Patient Education Note

Pharmacy
- Pharmacy - Pain Management Note (FT)
- Pharmacy - Parenteral Nutrition Note (FT)
- Pharmacy - Pharmacokinetics Note (FT)
- Pharmacy - Pharmacotherapeutics Note (FT)
- Pharmacy Chemotherapy Verification
- Pharmacy Medication History

Rehabilitation Medicine

General
- Rehabilitation Medicine Encounter

Art Therapy
- Art Therapy Discharge Note

Rehabilitation Medicine (cont.)

Physical Disabilities Branch
- Human Movement Disorders (HMD) Note
- Oral Motor Function (OMF) Note

Physical Therapy
- Physical Therapy Note

Occupational Therapy
- Occupational Therapy Note

Recreation Therapy
- Rec Therapy Functional Assess Rating
- Rec Therapy Short-Term Treatment Note
- Recreation Therapy Discharge Note
- Recreation Therapy Note
- Recreation Therapy Service Note
- Recreation Therapy Assessment
- Recreation Therapy Treatment Note
- Recreation Therapy Treatment Plan

Speech Language Pathology
- Speech Language Path Discharge Report
- Speech Language Path Pt Contact Note
- Speech Language Pathology Interim Note
- Speech Language Pathology Note

Respiratory Therapy
- Respiratory Therapy Note (FT)
- RT ABG Note
- RT EEG Note
- RT Procedure Note
- Six Minute Walk Test

Flowsheets:
- RT Aerosol Therapy
- RT Assessment FS
- RT Bronchial Hygiene
- RT Gas Therapy
- Hemodynamic Monitoring FS (RT)
- RT Invasive Ventilation
- RT Non-Invasive Ventilation

Social Work
- Interdisciplinary Consult
- Preadmission Assessment
- Psychosocial Assessment
- Reassessment
- Screening
- Social Work Resource/Discharge Summary

Flowsheets:
- Social Work Treatment Plan & Outcome

Art Therapy Service Note
Art Therapy Short-Term Therapy Note
Art Therapy Treatment Note

Massage Therapy

Massage Therapy Discharge Note
Massage Therapy Service Note
Massage Therapy Short-Term Therapy Note
Massage Therapy Treatment Note

Medical Section

Rehabilitation Medicine Consultation

Music Therapy

Music Therapy Discharge Note
Music Therapy Service Note
Music Therapy Short-Term Therapy Note
Music Therapy Treatment Note

Spiritual Ministry

Spiritual Ministry Assessment
Spiritual Ministry Discharge

Transfusion Medicine

Apheresis (Automated)
Apheresis Exchange Therapy
Blood Component Admin-Apheresis
Blood Component Administration-Surgery
DTM Transfusion Reaction
Manual Apheresis/Phlebotomy