
# Documentation Functionality User Guide

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# Chapter 1 Introduction

## 1.1 Attestation Disclaimer

Promoting Interoperability Program attestation confirms the use of a certified Electronic Health Record (EHR) to regulatory standards over a specified period of time. TruBridge Promoting Interoperability Program certified products, recommended processes, and supporting documentation are based on TruBridge's interpretation of the Promoting Interoperability Program regulations, technical specifications, and vendor specifications provided by CMS, ONC, and NIST. Each client is solely responsible for its attestation being a complete and accurate reflection of its EHR use during the attestation period and that any records needed to defend the attestation in an audit are maintained. With the exception of vendor documentation that may be required in support of a client's attestation, TruBridge bears no responsibility for attestation information submitted by the client.

## 1.2 What's New

This section introduces the new features and improvements for the **Documentation application** for release Version 20. A brief summary of each enhancement is given referencing its particular location if applicable. As new branches of Version 20 are made available, the original enhancements will be moved to the Previous Work Requests section. The enhancements related to the most current branch available will be listed under the main What's New section.

Each enhancement includes the Release Note identifier (Jira or Work Request number) and the description. If further information is needed, please contact **Client Services**.

***NOTE:*** *There are no new enhancements for release Version 21.07.*

# Chapter 2 Overview

The TruBridge EHR Documentation application provides a complete ambulatory charting system for management of patient care in the Emergency Department and TruBridge Provider-EHR software. It allows multiple users to access, view, and document on the same patient record while the TruBridge EHR maintains the integrity of the individual entry without interrupting work flow. The Documentation application uses both Provation® and TruBridge documents which, together, provide the most up-to-date clinical content. It also allows for customized Documentation Reports that may be built to bring together all pertinent information into one final note.

***NOTE:*** *HIPAA regulations require that Psychotherapy Notes be kept separate from the rest of the medical record and that only the originator of the document have access to them. The TruBridge EHR is built to be a collaborative tool and therefore does not have the ability to control access specifically to Psychotherapy Notes. For this reason, all Psychotherapy Notes should be stored outside the TruBridge EHR.*

***NOTE:*** *Facilities outside of the United States may choose a date format of MMDDYY, DDMMYY, or YYMMDD to be used on all date fields. Where four-digit dates display, a date format of MMDD, DDMM, or MMDD, respectively, will be used. Whichever date format is selected will be reflected in all date fields and column displays throughout the application. A TruBridge representative should be contacted in order for the date format to be changed.*

# Chapter 3 Security for Documentation

TruBridge has developed new security that will create "rules" through what is called the Rule Builder to define security access to user logins. A rule states what the "behavior" for a user must be in order to perform a particular function in the system. How the rule is set up in the rule builder determines what the user's behavior is when accessing a Patient Care Portal screen. Please see the Identity Management User Guide for additional setup information.

To access the Behavior controls for Documentation:

Select **System Administration** > **Select Login** > **Ctrl** > **Converted Rules** > **New** > **Select Condition(s)** > **Select Action(s)** > **Edit The Rule Description** > **Add**

The Documentation Behavior Controls are listed below.

- **User is allowed to document:** This option allows or denies access to the **Entry Mode** and **Document Search** options on the action bar within Documentation. It also allows access to the Document and Report folders within the document tree. The default is to allow for the following roles: Physicians, Nursing Staff, Registered Nurse, Licensed Practical Nurse, Rehab Services and Cardiopulmonary.

- **User is allowed to complete documents:** This option allows or denies access to the **Complete** option on the action bar within Documentation. The default is to allow for the following roles: Physicians, Nursing Staff, Registered Nurse, and Licensed Practical Nurse.

- **Amend Clinical Documentation For Any Login:** This option allows or denies the user the ability to amend flow chart or documentation data entered via another user. The default is deny. Options include Change date and time for all entries in current section or entire document, Amend all entries for this document, and Remove all entries for this section or document.

  ***NOTE:*** *Currently the Super Amend Functionality does not allow amending Vital Sign documentation by another user.*

- **Copy Forward Documentation:** This options allows or denies the users to copy forward questions that are flagged in setup to copy forward documentation from visit to visit. The default is to allow for the following roles: Registered Nurse and Licensed Practical Nurse.

- **Edit Instructions:** This option allows or denies the ability to Create New Instructions, Edit Instructions and Delete Instructions from the Instruction table. The default is to allow for the Physician Role.

- **Save Default Answers for Clin Doc Documents:** This option allows or denies the user the ability to save and apply default answers. The default is to allow for the following roles: Physicians and System Administrator.

- **Sign Documentation:** This option allows or denies a user the ability to sign documentation and reports and allows access to Key Maintenance to create or change the user's passphrase. The

default is to allow for the Physician Role.

- **Skip required questions in documentation**: This option allows the user the ability to skip questions in documentation which are set up as required or warning in order to continue documenting in additional sections. The user, however, is prompted to address the required or warning questions prior to completing or signing a document.

- **Web Client Documentation**: This option allows the user to have access to the Documentation application from within Web Client instead of launching it from UX.

***NOTE:*** *If only the Documentation application is added to a login without specific behaviors added, Documentation displays in View Only mode.*

# Chapter 4 Accessing Documentation

## 4.1 Overview

Documentation is the process used within Point of Care, Emergency Department Information System (EDIS), and TruBridge Provider EHR to document data relating to the patient visit. This chapter will discuss the available paths that may be used to access Documentation from Point of Care, EDIS, and TruBridge Provider EHR.

## 4.2 From Point of Care

Documentation may be accessed from a Virtual Chart tab. The Documentation link may be added to any Virtual Chart tab, and this set up will be department specific. See the POC Setup User Guide for additional information.

- Select the patient from the White Board to access their Virtual Chart.
- Select the appropriate tab.
- Select **Clinical Documentation**.

## 4.3 From ED and TruBridge Provider EHR

Documentation may also be accessed from within the patient's virtual chart.

- Select **Charts**.
- Select **Tracking Board**.
- Select the patient from the tracking board.
- Select **Documentation** from the Navigation Panel.

# Chapter 5 Documentation

## 5.1 Overview

Documentation has 3 different types of documents available for documentation: Flowcharts, Multi-Clinician, and Forms. This chapter will discuss the different types and how to access the documents.

- **Flowchart**: A document with pre-defined questions and answers. It is intended for multiple entries and provides a Grid View for comparison of the entries.
- **Multi-Clinician**: A document with pre-defined questions and answers. It is intended for one-time documentation by multiple users.
- **Form:** A document with pre-defined questions and answers that has the ability capture a signature via a signature field. It is intended for one-time documentation.

## 5.2 Accessing Documents

Documentation documents may be accessed from the documents setup per department within the Document Tree or searching for documents available in the Document Search.

***Document Tree***

The Document tree displays on the left hand side of Documentation screen and displays the following headers:

- **New Documents**: Displays a list of favorites or commonly used documents that pull from the Department Categories table in Table Maintenance. The documents that display are patient specific, which are based upon the gender, age and diagnosis of the patient. This defaults to open when the patient does not have any documents open on their account. In the event the document Description has been edited in Table Maintenance, the edited Description will display instead of the default title.
- **Diagnosis Specific**: Displays documents that apply specifically to the patient's gender, age, location (Clinic or Emergency Department) and the patient's chief complaint and/or problems within the Physician Problem List. This list will display the same listing of documents that display from the Document Search screen when the check boxes Diagnosis and Demographics are selected.
- **Current Documents**: Displays a list of documents that have been initiated for the patient's current visit. Once a document has been saved, the Current Documents folder defaults to open, and the New Documents folder defaults to collapsed.

- **New Reports**: Displays a list of favorites or commonly used reports that pull from the Report Department Categories table in Table Maintenance. Once a report is selected, it displays on the right hand side window. The reports may display all data from documentation, including documentation that was reflexed as well as clinical data.

- **Current Reports**: Displays a list of reports that have been initiated for the patient's current visit.

- **Completed:** Displays a list of documents and reports which have been completed on the patient. Completing a document will allow a new version of the document to be created.

- **Retracted**: Displays a list of documents which have been retracted. Documents that have been retracted will have all information display with a strike though. See Retracting a Document or Flowchart 68 for more information.

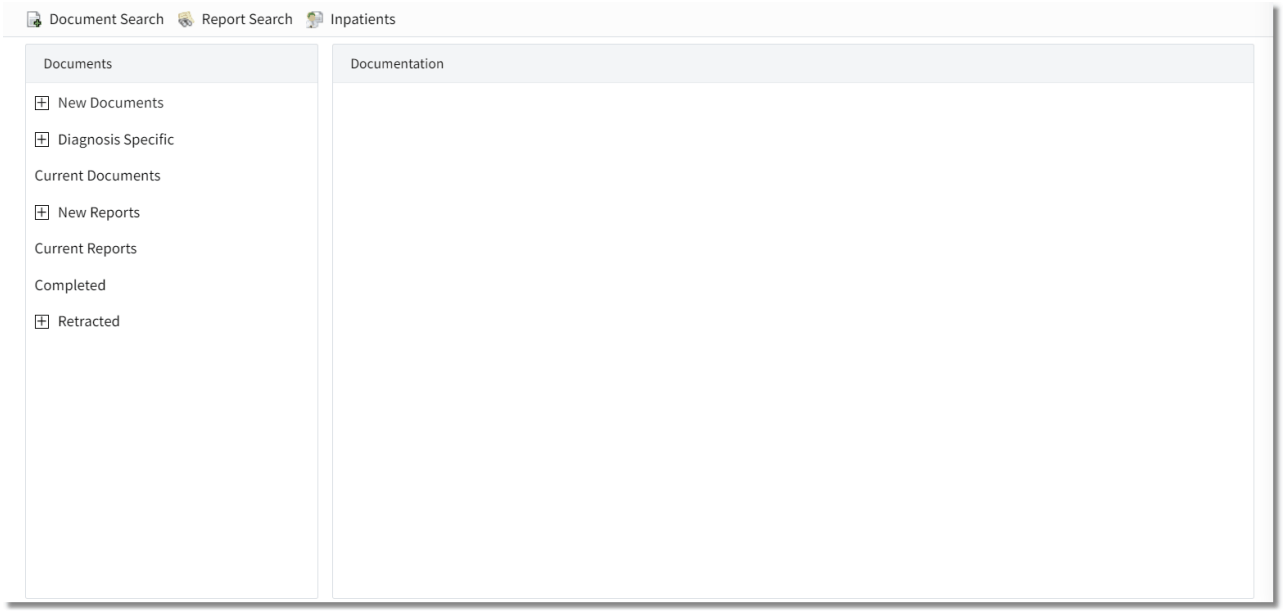
The action bar displays the following options:

- **Document Search**: Allows to search for documents giving the option for patient specific or all documents. See Document Search 9 for more information. In the event the document Description has been edited in Table Maintenance, the edited Description will display instead of the default title.

- **Report Search**: Allows to search for reports.

- **Inpatients**: Allows access to the Phys Doc application. If a physician selects the inpatient option, the Phys Doc document tree will be available. If a Nurse or non-physician Login selects the inpatient option, only the signed current documents will be available. The inpatient option will be enable only if the Phys Doc application is active.

Select **Home Screen** > **Track** > **Patient** > **Documentation**




**Documentation**

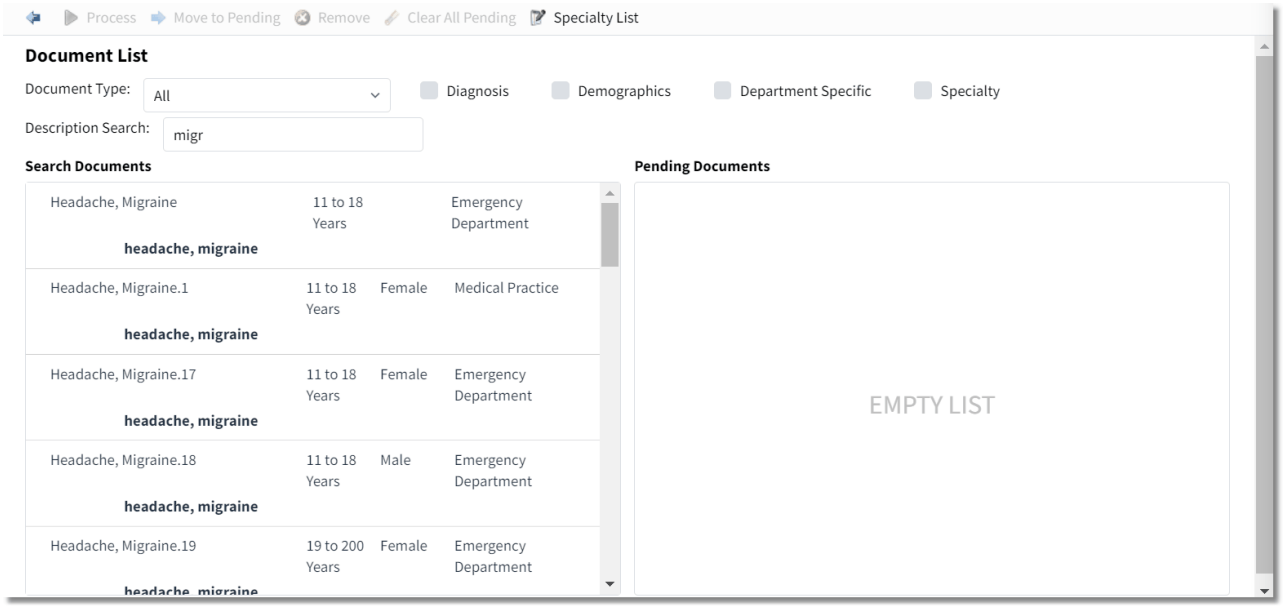
When a document is listed under Current Documents and is selected to be opened from the New Documents folder or from within the Document Search, the following prompt displays, "The selected document already exists. How would like to proceed?" with the following options:

- **Use Current** will open the existing version of the document selected.
- **Open New** will complete the existing document and open a new version of the selected document.
- **Exit** will take the user back to the at its previous state.

### *Document Search*

To access the Document List Screen, select **Document Search** from within Documentation.

Select **Patient Chart** > **Documentation** > **Document Search**




**Document Search**

The Document List screen will display a maximum of 250 documents at one time.

- **Document type:** May be used to narrow down the document search results. Select the Document type from the drop-down menu to establish the document type filters. The available document types are:
  - **All**: Allows all document types to display. This is the default option for the document type.
  - **Flowcharts**: A document with pre-defined questions and answers. It is intended for multiple entries and provides a Grid View for comparison of the entries.
  - **Multi-Clinician**: A template-based document with pre-defined questions and answers. It is intended for one-time documentation by multiple users.
  - **Forms:** A document that will be used to capture signatures for consent forms and doctors' notices.
  - Additional Document Search filters include:
  - **Diagnosis:** Limits the search results to only the documents that apply specifically to the patient's chief complaint and problems within the Physician Problem List. The default is to be checked, but the check box is 'sticky,' and the last document search parameters used for the UBL will display.
  - **Demographics:** Limits the search results to only the documents that apply specifically to the patient's gender, age and location (Clinic or Emergency Department). The default is to be checked, but the check box is 'sticky,' and the last document search parameters used for the UBL will display.
  - **Department Specific:** Limits the search results to only the documents that display in the "New" folder on the Document Tree for that department.

- **Description Search:** This option allows the user to search documents by document title or synonym within the Document List. The Title Search utilizes smart search capabilities so that the result list will automatically populate. The document title and synonym will display the Search Document list. In the event the document Description has been edited in Table Maintenance, the edited Description will display instead of the default title.

Once the document has been located within the Search Document List, double-click the document title to open the document.

- **Search Document** is a multi-select list, and the documents that display are based on the filters selected.

- **Pending Documents** is a multi-select list that displays documents that have been selected or moved to pending from the Search Document list. If no documents are displayed based on filters, 'Empty List' will display.

The action bar displays the following options:

- **Back Arrow:** Allows the user to move back to the Documentation screen

- **Process:** Allows any documents displayed in the Pending Documents list to merge and launch the user to the merged document. This option is disabled if no documents are in the Pending Documents list.

- **Move to Pending:** Allows documents that are highlighted to be moved to Pending Documents list in the Search Document list. This option will be disabled if no documents are highlighted in the Search Documents list.

- **Remove:** Allows any documents highlighted in the Pending Document list to be removed. This option will be disabled if no documents are highlighted in the Pending Documents list.

- **Clear All Pending:** Allows all documents in the Pending Document list to be removed at once. This option will be disabled if no documents are in the Pending Documents list.

## 5.3 Flowchart Documentation

When a Flow Chart is accessed for the first time through the Document Search or the New Document option from the document tree, it will display in a document view as it has been defined in its setup with the cursor in the first documentation field.

- The title of the Flow Chart will display in the upper left corner.

- The date and time will display at the top of the screen and may be changed by selecting the Change Date and Time option from the action bar.

- If a section title is selected, it will open up the document to allow the user to document on any of the questions within the section.

- If a question is selected, the document will open with the cursor populated into that specific question.

- The Section Menu on the left side of the screen may be used to quickly navigate to that area of the Flow Chart.

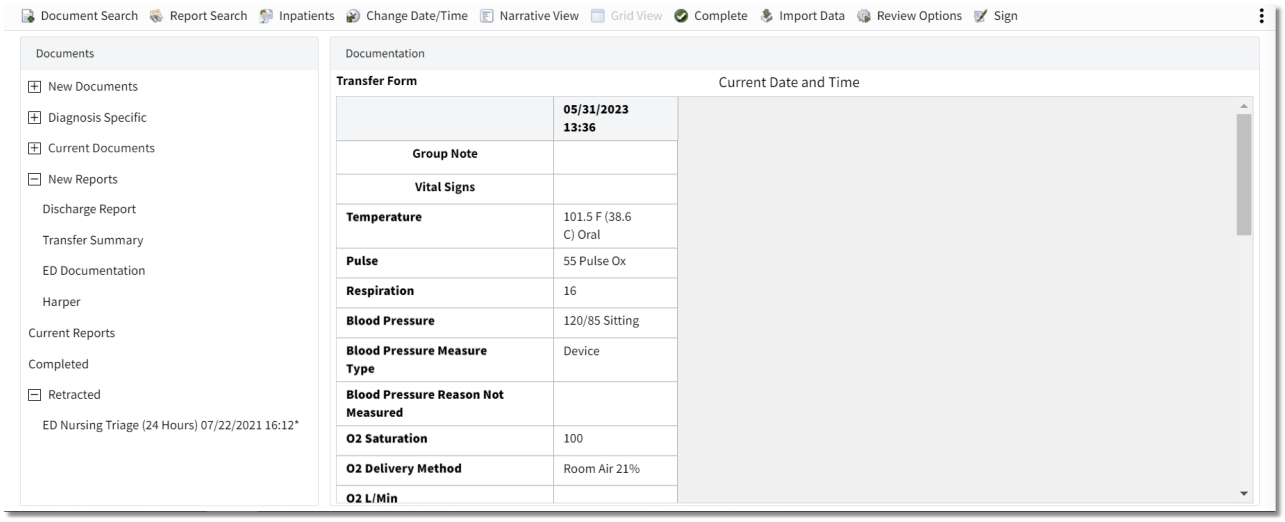
Once documentation for the current section has been completed, several options are available.

- The Action Bar has several options that may be used for charting.
  - **Back Arrow**: This option exits without saving; prompts with the Save and Exit prompt
  - **Update**: This option saves the information that has been documented and takes the user back to the Grid View
  - **Prev**: This option exits back to the previous section and saves the current section
  - **Next**: This option moves forward to the next section and saves the current section
  - **Charting Options**: See Charting Options 21 for further information.
  - **Repeat Questions**: This option allows for multiple entries in the document
  - **Amend**: This option is only available once the data is saved; opens up fields in the section to amend the documentation. See Amending Flowchart Documentation 61 for further information.
  - **Amend Options:** Allows an entire section or for an entire flowchart to be amended at one time. See Amending a Multi Clinician Document 57 or Section 58 for further information.
  - **Pending**: This option displays the number of Pending Reflexes that exist. See the Reflexing chapter for additional information.
  - **All PE**: Physical Exam sections relevant to the patient's account display automatically. Selecting All PE allows the user to document on additional PE sections not initially displayed.
  - **Show More**: This option allows sections, questions and answers, that have been hidden, to display. Once Show More is selected, the option to **Show All** may become available, where additional comprehensive questions and answers will display. See Show More/Show All 15 for additional information.
  - **Quick Add**: This option allows users to quickly add in a free text note to the current section of the document.
    - The note may be entered by scrolling to the bottom of the section and typing in the Note field that was created.
  - **Save Defaults:** This option allows a user to save the selected answers within the current section of a document. See Default Answers 30 for more information.
  - **Apply Defaults:** This option allows a user to apply any previously saved default answers to the selected section. See Default Answers 30 for more information.
  - **Merge**: Allows the ability to merge additional documents with an original document after it has been created. See Merging Documents 18 for more information.

***NOTE:*** *The system will auto-save any documentation completed within a section prior to selecting* ***All PE****,* ***Show More/Show All****, or* ***Merge****.*

Select **Update** once all documentation has been entered for the assessment.

Select **Patient Chart** > **Documentation** > **New Document**




**Documentation Flow Chart Grid View**

- The action bar may be used to change the display format from Grid View to Narrative View. This will allow the user to view any documentation that has been recorded on the selected form.

- To continue documenting under the same date and time column after update has been selected, select the empty cell next to the question. The document will open to document the answer to that question. Select update, and the newly entered documentation will appear under the selected date and time column. If a previous user started the date and time column, only the questions that have not been answered will be available for documentation. The questions that have been previously answered will display in review mode.

- When viewing documentation in the grid view, longer answers containing more than 15 characters are denoted with trailing periods. Hovering over the cell opens a tool tip that will display the full answer.

- The Complete option will then display on the action bar.

- Select **Complete** to indicate that documentation for this flowchart has been completed. Complete will display in the upper right corner of the document. Completing a document allows the user to open a new version of the document.

- **Retract** will allow the user to retract the document. See Retracting a Document or Flowchart 68 for more information.

- Completing documents will cause the document to move from the Current Documents folder in the Document Tree to the Completed Option.

- To return a document to Entry Mode, select Amend from the Action Bar. This will revert the form to its incomplete status, and the document will be accessible from the Current Documents folder.

***NOTE:*** *The Clin Doc Documentation Status Report may be run to display all signed/unsigned and*

*complete/incomplete Documentation documents. See* *Clin Doc Documentation Status Report* 74.

## 5.4 Multi Clinician Documents

When a new Multi-Clinician Document is opened, the first section of the document will display in the documentation area of the screen.

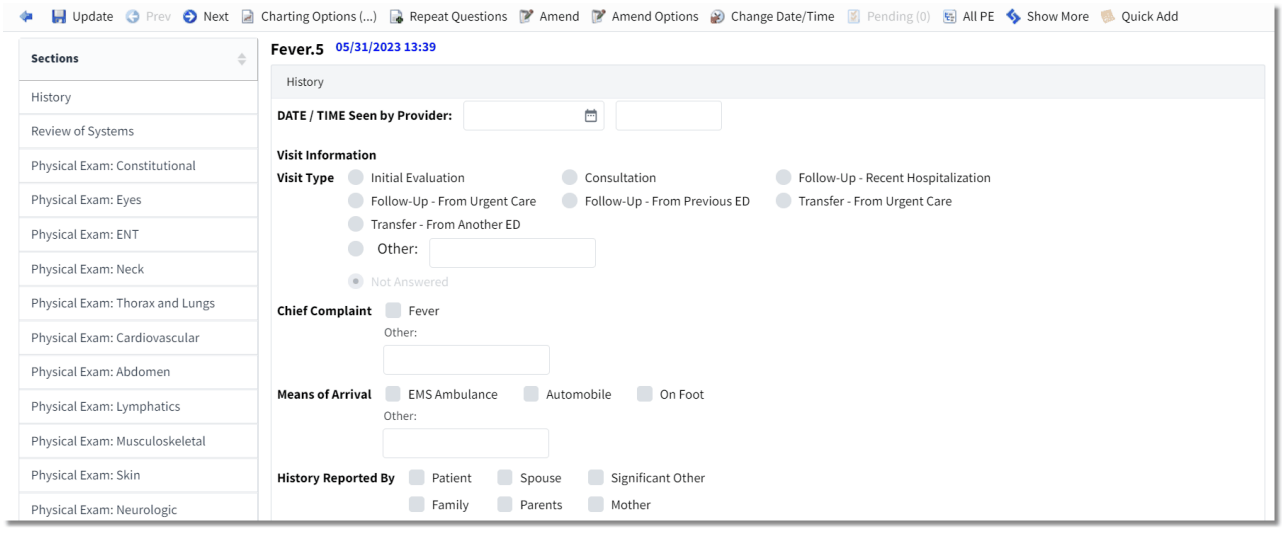
- The title of the Multi-Clinician document will display in the upper left corner. In the event the document Description has been edited in Table Maintenance, the edited Description will display instead of the default title.

- The date and time will display at the top of the screen and may be changed by selecting the Change Date and Time option from the action bar.

- All subsequent sections will be listed in the Navigation area on the left hand side of the page. The sections may be selected from the Navigation area to launch that section of the document.

***NOTE:*** *Section preferences that have been added to a user login or Department from Section Preferences in Table Maintenance will also display in the Navigation Area. Hard coded sections include History of Present Illness, Review of Systems, Physical Exam, Assessment and Plan. If a section does not exist for a document, it will not display in the section list. Selecting a section will automatically pull all documented information in a rich text format. The user then has the option to remove data from the screen by highlighting and deleting the data. This removes the data from the document only, not from within the application.*

Select **Patient Chart** > **Documentation** > **Document Search** > **Document Type: Multi-Clinician** > **Entry Mode**




**Multi-Clinician Document Entry Mode**

If the document is currently being edited by another user, the fields currently being addressed will be grayed out. Once the user saves the documentation, the fields may be accessed.

- The Action Bar has several options that may be used for charting.
  - **Back Arrow**: Exits without saving; prompts with the Save and Exit prompt
  - **Update**: Saves the information that has been documented and takes the user back to the Grid View
  - **Prev**: Exits back to the previous section and saves the current section
  - **Next**: Moves forward to the next section and saves the current section
  - **Charting Options**: See Charting Options 21 for further information.
  - **Repeat Questions**: This option allows for multiple entries in the document
  - **Amend**: This option is only available once the data is saved; opens up fields in the section to amend the documentation. See Amending a Multi Clinician Question 60 for further information.
  - **Amend Options:** Allows an entire section, or an entire document, to be amended at one time. See Amending a Multi Clinician Document 57 or Section 58 for further information.
  - **Change Date/Time**: Allows a user to adjust the date and time of documentation.
  - **Pending**: This option will display the number of Pending Reflexes that exist. See the Reflexing chapter for additional information.
  - **All PE**: Physical Exam sections relevant to the patient's reason for visit display automatically. Selecting All PE allows the user to document on additional PE sections not initially displayed.
  - **Show More**: This option allows sections, questions and answers, that have been hidden, to display. Once Show More is selected, the option to **Show All** may become available, where additional comprehensive questions and answers will display. See Show More/Show All 15 for additional information.
  - **Quick Add**: This option allows users to quickly add in a free text note to the current section of the document
    - The note may be entered by scrolling to the bottom of the section and typing in the Note field that was created.
  - **Save Defaults:** This option allows a user to save the selected answers within the current section of a document. See Default Answers 30 for more information.
  - **Apply Defaults:** This option allows a user to apply any previously save default answers to the selected section. See Default Answers 30 for more information.
  - **Merge**: Allows the ability to merge additional documents with an original document after it has been created. See Merging Documents 18 for more information.

***NOTE:*** *The system will auto-save any documentation completed within a section prior to selecting* ***All PE****,* ***Show More/Show All****, or* ***Merge****.*

- To begin documenting an assessment, address the questions as they apply.

- Once a section has been completed, select **Next** from the action bar to move to the next section of the document. The section may also be selected from the Document Tree. Documentation that has been entered will automatically be saved when a new section is accessed.

- Once each section has been addressed, select **Update** to save all documentation and view the documentation in the narrative format.

- After documentation has been fully addressed, select **Complete**. Complete will display in the upper right corner of the document. Completing a document allows the user to open a new version of the document.

- **Retract** will allow the user to retract the document. See Retracting a Document or Flowchart 68 for more information.

- When a document has been marked as complete, it will be stamped in the upper right corner with the word Complete.

- Completing documents will cause the document to move from the Current Documents folder in the Document Tree to the Completed folder.

- To return a document to Entry Mode, select Amend from the Action Bar. This will revert the form to its incomplete status, and the document will be accessible from the Current Documents folder.

***NOTE:*** *The Clin Doc Documentation Status Report may be run to display all signed/unsigned and complete/incomplete Documentation documents. See* *Clin Doc Documentation Status Report* 74.

### *Show More/Show All*

Provation® Multi Clinician documents are set to display only the sections, questions and answers that are relevant to the patient's reason for visit. Each document contains 3 levels of questions. Priority 1 which display questions/answers that are relevant to the patient's reason for visit and is the level that will display when a document is initially opened. Priority 2 displays additional questions and answers to add additional detail when needed in the document. Show All is the last level, which will display all comprehensive questions and answers in the document. The user may expand upon their documentation by selecting the following options:

- Selecting **Show More** will add additional Priority 2 questions and answers to the document. It will also display any section, questions or answers that were manually hidden using Display Status in setup. See Display Status in the Documentation Setup User Guide for additional setup information.

- Selecting **Show All** will display all comprehensive questions and answers within the document.

***NOTE:*** *Once **Show More** or **Show All** is selected, the information that is displayed will not collapse back to the original questions and answers that were viewable prior to selecting Show More/Show All.*

## 5.5 Forms

When a new form is opened, it will display in the documentation area of the screen.

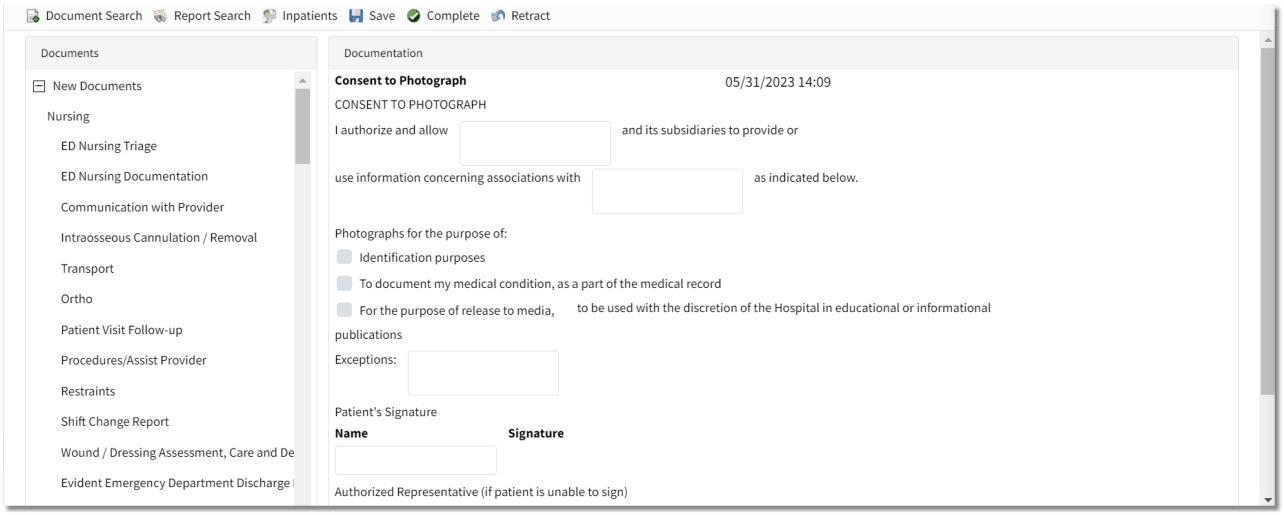
- The title of the form will display in the upper left corner.

The following options are available on the action bar:

- **Save**: This option will save the information documented within the form.
- **Complete**: This option allows the form to be completed and a PDF to be generated. Once completed, forms cannot be amended.

***NOTE:*** *Forms do not have E-Sign capabilities. The signature box is available for signing the form.*

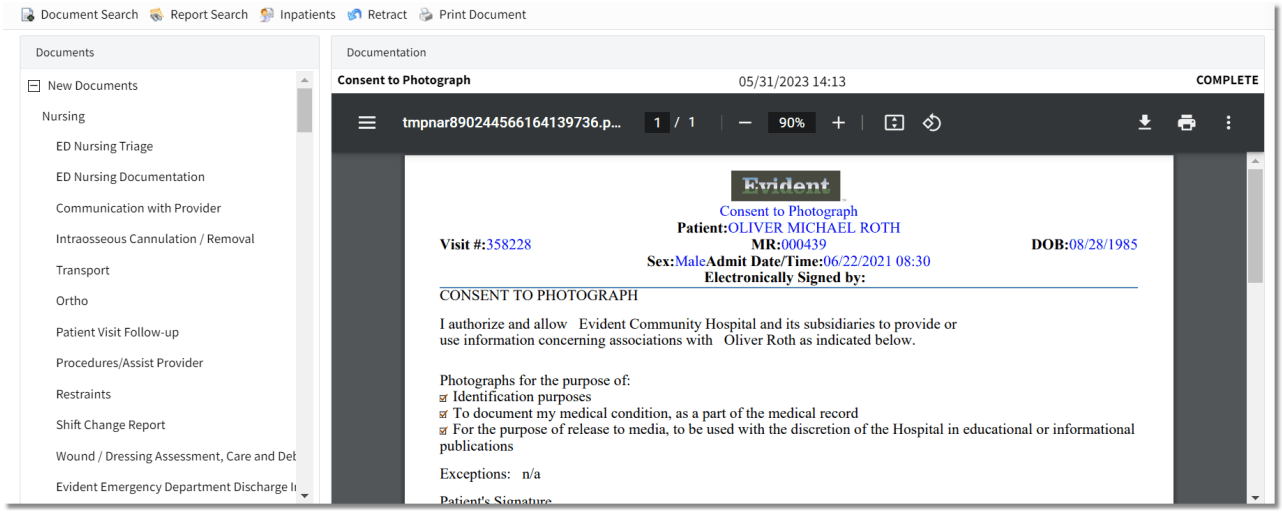
Select **Patient Chart** > **Documentation** > **Document Search** > **Document Type: Form**




**Form Document**

- The user must fill out the appropriate questions on the form.
- A signature box is available on forms to capture an electronic signature of the person who needs to sign the form. The person signing the form will type his/her full name in the signature box. The signature will display next to the signature box with a date and time stamp of when it was signed.
- Once all documentation is complete, the form can be saved or completed. If the form is completed, no changes may be made to it after the Complete option is selected.

Select **Patient Chart** > **Documentation** > **Document Search** > **Document Type: Form** > **Complete**




**Complete Form**

- Once the form is completed, the Print Document option becomes available on the action bar. The Print Document allows the completed form to be printed.

***NOTE:*** *A* ***Retract*** *option is available to the creator of the Form. This option is also available for users with the Clinical Documentation Behavior Option "Amend Clinical Documentation for any Login." Once selected, the Form will display under Retracted on the Document Tree. Only completed Forms that have been retracted will display in Clinical History and Print EMR.*

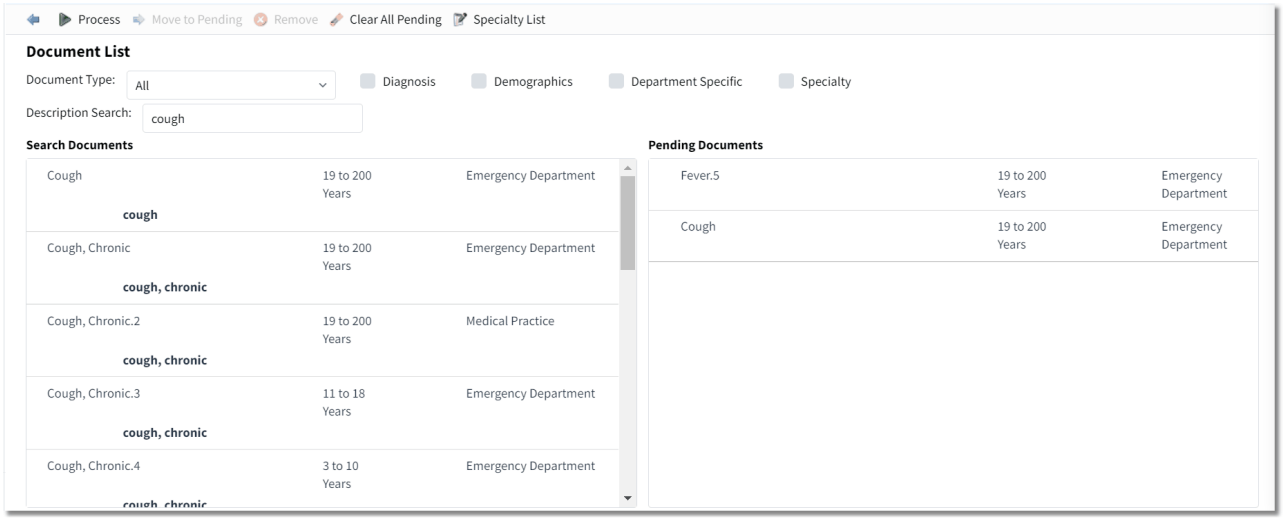
## 5.6 Merging Documents

Multiple documents may now be selected to merge together as one document.

To merge documents:

1. Select the documents from the Search Document list and select **Move to Pending**. Double-clicking the document will also move the document to pending.

Select **Patient Chart** > **Documentation** > **Document Search** > **Document** > **Move to Pending**




**Document Merge**

2. Once all documents have been selected and moved to pending, select **Process** to merge the documents**.**

When Documents are merged, they will display with the following format:

- The title of the merged documents will display as Multi-complaint with the name of document that was selected first in parenthesis followed by a plus sign to show to represent the number of addition documents merged.
- **HPI:** Each document selected will have its own HPI Section. A section will display on the navigation bar with HPI: 'Name of Document' for each document.
- **Review of Systems:** All documents will merge into one Review of Systems section.
- **Physical Exam:** All documents will merge into the individual Physical Exam sections. If a Physical Exam section only exist in one document, then it will not merge and display on navigation bar.
- **Assessment:** All documents will merge into one Assessment section but each document will have its own subsection within the Assessment section.

- **Plan:** All documents will merge into one Plan section but each document will have its own subsection within the Plan section.

- **ED Course:** Each document selected will have its own ED Course Section. A section will display on the navigation bar with ED Course: 'Name of Document' for each document. ED Course section is only available within Emergency Department Documents.

If a merged document is closed by using the back arrow before it is documented, the document will not appear under Current Documents folder on the document tree.

***NOTE:*** *The documents will be listed in the order they were added to the Pending Document list.*

The merge functionality may also be used after a document has been created by selecting **Merge** from the action bar on the Documentation Entry screen. Once selected, if any unsaved data exists in the document, the system will auto-save the information.

The Document List screen will display from within Documentation Entry, the existing document from which Merge was launched will display in the Pending column. No action can be taken on this document at this time. The user will then have the option of searching and selecting an additional document(s), which will then be added to the Pending column. Selecting **Process** will merge all documents. Once processed, merged documents will display as Multi-Complaint documents.

***NOTE:*** *The second document selected will merge into the first document and take the form of the first document's narrative.*

See Merged Documents 64 to see how they will display when reviewed.

## 5.7 Documentation Controls

A variety of controls are used in Documentation documents. Controls include the following:

- **Checkboxes:** Allows for multiple selections for a question.

- **Radio Buttons:** Allows for a single selection for a question.

- **Drop-down Menus:** Allows for a single selection for a question.

- **Text Box:** Allows for continuous type, free-text answers.

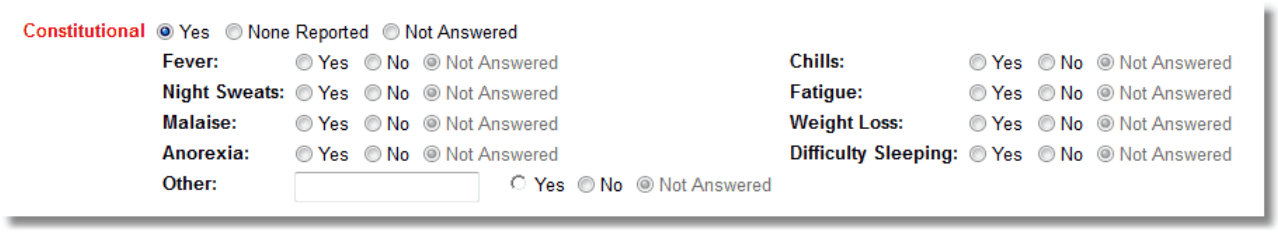
- **Date/Time Question:** The date-picker icon will open a calendar, when selected. The date may be searched for and selected from the calendar or it may be entered manually with the format mmddyyyy. If the date is the current date, entering a period in the field will populate the current date. The time may be entered manually with a four digit military time format. If the time is the current time, entering a period in the field will populate the current time.

Select **Patient Chart** > **Documentation** > **New Document**


**Date/Time Question**

- **Expanding Question:** Allows additional answer options to open when certain Yes radio buttons are selected. The user must select at least one additional answer once it is opened before moving to another section or selecting Update.

Select **Patient Chart** > **Documentation** > **New Document**




**Expanding Question**

**Required Questions:** Prevents a user from moving between sections until the question is addressed. A prompt will display that reads "You must enter a value for..." After the user is prompted to answer the required question, the system will automatically scroll to the area of the document that needs to be addressed.

- These questions will display in red until the question is addressed.
- If the user does not access a section containing a required question, the prompt will not display.
- Required questions may be skipped while documenting if the behavior control for the user is set to "Skip required questions in documentation." This will enable the required question to be treated as a warning question, allowing the user to move between sections to continue documentation. The ability to address skipped, required, or warning questions, however, will be available before a user completes or signs a document or report.
- See Behavior Controls for Documentation 3.

**Warning Questions:** Questions that are set as warning will display the prompt that reads " ...should be addressed. Do you wish to address the question?" The user may then select **Yes** to answer the question or **No** to return to the section without addressing the warning question.

***NOTE:*** *Any required fields will turn red if not addressed, including radio button labels, text box labels and drop-down menu labels. Once* ***Update*** *is selected or the user attempts to move between sections, the system will automatically scroll to the area of the document that needs to be addressed.*

## 5.8 Late Entry

Documentation may be tagged as Late Entry. It will display as "Late Entry: (actual date/time)" and be added to the existing user/date/time stamp. The time frame in which documentation will display as "Late Entry" is set up in the Clinical Documentation Control Table. See Documentation Setup for additional information.

Changing the date and time past the designated number of hours time frame setup in the Clinical Documentation Control table will stamp the entry as a late entry.

To change date and time:

1. Select **Change Date/Time** from the 24 Hour Narrative or from within Entry Mode.

2. Select **Save** to begin documenting in the selected date and time.

- If documentation is made past the designated number of hours as the time frame setup in the Clinical Documentation Control table, the entry will be marked as a late entry. This Late Entry stamp may be viewable on the 24 Hour Narrative, Review Options, and while in Entry Mode.

## 5.9 Charting Options

Charting Options allows the user to insert additional topics into the current Document. A split screen displays for the user. The left side lists out each charting option available to insert in the document. The right side lists all recently entered data that has been charted on the patient's account. The Charting Options button will display the number of newly updated information added to the list on the right side of the screen. This serves as an alert to the user that new information is available.

- Select Charting Options from the action bar to view the available options.

- Upon accessing Charting options, the entry location must be selected. This will determine where the documentation will be displayed within the document.
  - **End of Section**: Designates the added chart option will be added to the end of the current section
  - **Question Title**: Each question title that is within the document will be displayed. Select the appropriate question title to insert the added chart option display after a specific question title.

- Once the location has been selected, the chart option may be selected from the left side of the screen. The following charting options are available:
  - **Add Note**: Allows a free text section to be added to the document
  - **Clinical Data**: Allows the user to add vital signs, lab results or diabetic monitoring to the document
  - **Instructions**: Allows the user to look up instructional documents; the instructional documents will be included within the document
  - **Markups**: Allows the user to select a markup to add to the document
  - **Photos:** Allows the user to select an image / photo to add to the document.
  - **Sections**: Allows an entire section to be pulled into the document

- **Questions**: Allows specific questions to be pulled into the document
- **Medication List**: Allows a patient's medications to be pulled in the document.
- **Problems**: Allows entries from the Physician's Problem List to be pulled into the document
- **Plan of Care:** Allows the Plan of Care to be documented on the patient's account and then inserted into the document
- **Health History**: Allows an entries from the Health History application to be pulled into the document.
- **Patient Education Documents:** Allows Patient Education documents to be pulled into the document.

- When applicable, information will remain on the right side of the screen according to the time set in hours in the Clinic Control Table, ED Control Table and Clinical Documentation Table. Please see the Clinical Documentation Table for more information. Once the time frame has been reached for each updated entry, it will no longer display on the right hand side of screen.

- The following applications will pull recently charted information to the right side of the Charting Options screen:
  - **Vital Signs:** Allows the patient's recently entered vital signs to display.
  - **Health History**: Allows the patient's recently entered Surgical/Procedural History, Family Health, Medical History, Social History, Functional/Cognitive Status and Referral/Transition of Care to display.
  - **Problem List**: Allows the patient's recently entered problems from the Physician Problem List to display.
  - **Plan of Care:** Allows the patient's recently entered problems from Plan of Care to display.
  - **Allergies:** Allows the patient's recently entered allergies to display.
  - **Immunizations:** Allows the patient's recently entered immunizations to display.
  - **Medication Reconciliation:** Allows the patient's recently entered medications from Medication Reconciliation to display.
  - **Patient Education Documents:** Allows the patient's recently added Patient Education Document titles to display.
  - **Order Chronology:** Allows the patient's recently entered Nursing, Ancillary and Medication orders to display.
  - **Order Results:** Allows the patient's recently entered lab results to display.
  - **Administered/Omitted/Discontinued Medications:** Allows the patient's recently administered, omitted or discontinued medications to display.

The **Insert** option  on the action bar is only enabled when an item from the right side of screen has been selected to be inserted into the document.

The right side of the screen has multi-select functionality using the Shift or Control keys.

When Charting Options is used to insert information into the Flow Chart, an icon will display in the answer column for that section that will alert the user that additional information has been charted on the section. To view the additional information, select the icon.

### *Add Note*

To insert a free text textbox, select **Add To Location**, then select **Add Note**. The rich text box will display in the document based on the Location selected.

### *Clinical Data*

To insert clinical data, select **Add To Location**, then select **Clinical Data**.

- Select the type of clinical Data by choosing one of the Clinical Data Options.
  - **Lab Results**: Select to display lab values.
  - **Vital Signs**: Select to display the patient's vital signs.
  - **Diabetic Monitoring**: Select to display Diabetic Monitoring.

***NOTE:*** *Labs resulted in the clinic and labs ordered from Hospital Orders on the clinic visit will be available from the TruBridge Provider EHR documentation in* ***Charting Options****.*

- The Clinical Data screens will default to show clinical data from the past 24 hours but may be filtered to view the most recent values and results or all values and results that have been recorded on the patient's account.

- To insert clinical data, select the data that should be imported into the document. The Clinical Data screens are multi-select screens.

- Once the clinical data has been selected, select **Insert** to pull the information into the document.

### *Instructions*

To insert instructions, select **Add To Location**, then select **Instructions**.

- The instruction List Type will default to the user's My Favorites list. To view all documents, select the **All** List Type.

- Once the instruction has been located within the table, select the check-box next to the document to preview the document in the preview area.

- The following options are available on the action bar if the user has the Control Behavior Edit Instructions set to Allow:
  - **Created New Instruction**: Allows the ability to to enter a new instruction into the table.
  - Delete: Allows the deletion of Instruction from the table.
  - **Edit:** Allows the instruction to be edited by the user.

- Select **Add to My Favorites** to add the document to the user's My Favorites list.

- Select **Insert** to add the instruction into the document. An unlimited number of instructions may be inserted in the patient's documentation.

### *Markups*

To insert a markup, select **Add To Location**, then select **Markup**.

- The Markup List Type will default to the My Favorites list. To view all markups, select the **All** List Type.
- Select the check-box next to a markup to preview the document in the preview area.
- Once the correct markup has been located and selected, select **Insert** to add the markup to the document.
- After the markup has been inserted, notes may be added to the markup image.
- Select the location on the markup to add a note. The note style will default to lettered circles but may be changed by selecting the **tool** icon in the upper left corner.
- Once all notes have been added to the markup, select **Save** to insert the annotated markup into the document.

### *Photos*

To insert a photo, select **Add To Location**, then select **Photos**.

- The Photo List screen will display available photos for documentation. The photo name, date and time the photo was loaded into Image Storage and Retrieval will also display.
- Select the check-box next to a photo to preview the image in the preview area.
- When the correct photo has been located and selected, select **Insert** to add the photo to the document.
- Users are able to insert photos in the following formats:
  - PNG
  - JPG
  - TIFF
  - GIF
- After the photo has been inserted, notes may be added to the photo image using the markup tools.
- Select the location on the photo to add a note.The note style will default to lettered circles but may be changed by selecting the **Tool** icon in the upper left corner.
- Once all notes have been added to the photo, select **Save** to insert the annotated photo into the document.

***NOTE:*** *An image title set up with an alternate name, will display the alternate name in the Photo List*

*screen followed by the date and time.*

### *Sections*

To insert a section, select **Add To Location**, then select **Sections**.

- The Section/Question List page will then display.
- The Type field will default to Section and may not be changed.
- The Status field will default to Active and may not be changed.
- The Title field may be used to search for a section by the Section Title.
- Select a section from the list to display the section in the preview area.
- Select **Add** to insert the section into the document.

### *Questions*

To insert a question, select **Add To Location**, then select **Questions**.

- The Section/Question List page will then display.
- The Type field will default to Question and may not be changed.
- The Status field will default to Active and may not be changed.
- The Title field may be used to search for a question by the Question Title.
- Select a question from the list to display the question in the preview area.
- Select **Add** to insert the question into the document.

## Signatures

Signatures may be added within a document/flowchart through Charting Options. Text typed in the signature text box will display in cursive Homemade Apple Pie font with a date/time stamp next to the signature. Signatures will be viewable on the narrative, PDF formats and entry mode of documents and flowcharts. Amend functionality will function as it does for all questions, in that a user may remove or amend a signature. The original text will be saved and display with a strike through.

To add a signature to a section within a document:

1. Select **Charting Options**

2. Select the location for the signature to display using the **Add to** dropdown menu.

3. Select **Questions.**

4. Use the Title Search field to locate the desired signature.

5. Select the desired signature to move it to the preview pane.

6. Select **Add** and back arrow.

***Medication List***

To insert medications, select **Add To Location**, then select **Medication Lists**.

- The Medication screen will display and will allow home, active, discharge, discontinued orders and removed home medications to pull into the document.

- The Check filter options are:
  - **All** will display all medications types.
  - **Home Medications** will display home medications entered in Medication Reconciliation.
  - **Active Medications** will display home medications entered in Medication Reconciliation.
  - **Discontinued Orders** will display discontinued pharmacy medications.
  - **Discharge Medications** will display discharge medications selected in Medication Reconciliation upon discharge reconciliation and prescription writer.
  - **Removed Home Meds** will display home medications that have been removed in Medication Reconciliation.

- The Pull to documentation filter options are:
  - **Alphabetically** will pull medications to their categories in alphabetical order.
  - **Chronological** will pull medications to their categories in the order the item was entered into the system.

- The **Admission Reconciliation Status** and **Discharge Reconciliation Status** will also display on the far right of the Medication List Screen. The date and time of the admission reconciliation or discharge reconciliation will display when they have been performed. If they have not been performed, 'Not performed' will pull.

- Select the medications needed to pull into the document and select **Insert**. Double-clicking the medication will also insert it into the document.

***NOTE:*** *More then one medication may be selected at time, this is a multi-select screen. Holding down the shift key will all the user to select a block of medications and holding do the control key will allow the user select multiple individual medications.*

- The selected medications will display on the screen as follows:
  - **Description** will display the medication description, dose, units, route and frequency.
  - **Type** will display whether the medication is a home medication, discharge medication, active medication, removed home medication or discontinued medication order.
  - **Status** will display the status of the medication. The following status' will display:

- **Confirmed** will display for confirmed Home Medications.
- **Unconfirmed** will display for unconfirmed Home Medications.
- **Removed** will display for removed Home Medications.
- **Active** will display for active pharmacy orders.
- **Discontinued** will display for discontinued pharmacy orders.
- **Faxed** will display for discharge medications that are faxed within the system. This will only display if Prescription Writer is activated.
- **Electronic** will display if the prescription is sent electronically. This will only display if Prescription Writer is activated.
- **Printed** will display for discharge medications if the prescription was printed. This will only display if Prescription Writer is activated.
- **No Rx Needed** will display for discharge medications no prescription was needed. This will only display if Prescription Writer is activated.

- **Start Date/Time** will display start date and time for active pharmacy orders.
- **Stop Date/Time** will display stop date and time for active pharmacy orders.

### *Problems*

To insert a problem from the Physician's Problem List, select **Add To Location**, then select **Problem List**.

- The Active Problems will display when the screen is first opened. Select the Display radio button to choose **Inactive**, **All** or **Entered in Error.**
- Select the Problem to insert it into the document. This screen allows multi-selecting so that more then one Problem may be inserted at one time.
- New problems may be added or existing problems may be edited. Please see the Physician Problem List User Guide for additional information on the options within the action bar.
- Select the problems to be pulled into the documentation and select **Insert**.
- The selected problem's diagnosis description, diagnosis date and addressed date will pull into the document in a rich text box underneath the Problem List widget.

### *Plan of Care*

To insert a plan of care into the document, select **Add To Location**, then select **Plan of Care.**

- If the patient has already had a Plan of Care documented, it may be pulled into the document by selecting the entry, then selecting Insert.
- Add may be selected from the action bar to create a new Plan of Care entry.

### *Health History*

To insert the patient's health history into the document, select **Add To Location**, then select **Health History**

- The Health History screen will default to the List View when accessed via Charting Options.
- To insert the patient's health history select the category or an entry from within a category from the list. For example select the category Family Health. All of the entries within the category will pull into the document when the category is selected. If just an entry under a category is selected the category title will pull into the document along with the selected entry. The categories or entries within a category may be multi-selected.
- Choosing the **Select All** option from that action bar will select all categories within the Health History list.
- Select the **Insert** option from the action bar once all items have been selected to insert the information into the document. The inserted Health History data will display in the List View format once it has been inserted. The insert option is disabled until an item has been selected from the Health History list.
- **New** may be selected from the action bar to create a new Health History entry.
- **Edit** may be selected to edit any of the entries displaying beneath a category. The edit option is disabled until an entry within a category is selected.

***NOTE:*** *Please see the Health History User Guide for additional information on adding new entries and editing existing entries to the Health History application.*

### *Patient Education Documents*

To insert an education document from the Patient Education Documents, select **Add To Location**, then select **Patient Education Documents**.

- The education documents will display when the screen is first opened.
- Select the education documents to insert it into the document. Multiple documents may be selected at one time using the shift key from the keyboard.
- Select **Insert** to insert the title of the selected education documents into the document.

***NOTE:*** *Please see Patient Education Documents for additional information on the Patient Education Documents application.*

### *Add Group Note*

To insert a group note into the document, select **Add To Location**, then select **Add Group Note.**

The Group Note Selection screen will display so the user may insert a group note into the selected documentation document. All group notes for the patient will display with the following columns:

- **Appointment Date/Time**: Displays the date and time of the scheduled task that the group note was entered within the Scheduling application.
- **Appointment Type**: Displays the name of the task that the group note was entered within the Scheduling application.
- **Location/Resource**: Displays the location of the scheduled task that the group note was entered within the Scheduling application.

Select the appropriate **Group Note** and then select **Insert** to pull the group note into the document. This screen is multiselect and will allow more then one selection using the shift or control keys. Notes may also be inserted into a document by a double-click on a single note.

## 5.10 Copy Forward

Documentation Documents may be set to copy forward information from visit to visit.

Once a document is opened, if the first section has data set to copy forward the user will be taken to the Copy Forward screen. If no data in the first section is set to copy forward, the first section will open as usual. As the user moves to another section, the Copy Forward screen will open first if data in that section is set to copy forward.

The Copy Forward screen will display the question description in bold with the answers following a colon. The user name and date/time of the person that originally entered the data will display below the question and answers. The following options are available in the action bar:

- **Back Arrow:** Allows the user to go back to the entry screen for the section and not copy forward any documentation from the previous visit.
- **Accept:** Allows any selected questions to pull in the documentation from the previous visit.
- **Accept All:** Allows all questions to copy the documentation into the section from the previous visit.
- The Copy Forward screen is a multi-select screen that will allow multiple questions to be selected.
- To insert the copy forward documentation select the questions to be inserted and then select **Accept**. The question selected will insert in the selected section.

***NOTE:*** *A user will need the Behavior Control "Copy Forward Documentation" to be allowed to pull information into a document from the Copy Forward screen. See the Documentation Setup User Guide for additional information on Copy forward Setup.*

## 5.11 Default Answers

Documents may be set up to save and apply default answers within each section. Default Answers may be set up on the following types of questions:

- Radio buttons
- Check boxes
- Drop downs

To save default answers within a section of a document:

1. Select the answers that are to be set as default answers for that section of the document. The option is enabled once new answers have been selected within the section.

2. Select Save Defaults

***NOTE:*** *One set of default answers may be saved per section. For Multi-clinician Documents, the Save Defaults option is disabled on sections that already have saved documentation in the selected section. For FlowCharts, the Save Defaults option is disabled on sections that already have saved documentation in the selected section for that date/time column. If a new date/time column is selected from the flowchart, the save defaults option will become enabled.*

To apply default answers within a section of a document:

1. Select **Apply Defaults**. The default answers will be applied and highlighted in yellow to alert the user of the applied default answers. Selecting Next or Previous or using the navigation tree will allow the user to navigate through the document to view all sections with saved default answers that have been applied to the document.

***NOTE:*** *If any of the questions that are part of the user's defaults have been answered, the software will not apply that default answer. It will only apply to questions/answers that have not been addressed within that section.*

- The user may modify, add, or remove any documentation within the current section after applying the default answers.
- The apply defaults option becomes **Deselect Defaults** once it has been selected and default answers are applied.
- Selecting **Deselect Defaults** will deselect any default answers in that section. The option name will change back to **Apply Defaults**.
- If any changes are made to the default answers, the user is able to select the **Save Defaults** answers option to save new default answers again.
- **Update, Next, Previous** or selecting a new section from the navigation menu, must be selected

in order to save the selected answers.

***NOTE:*** *The Save Defaults option does not save the selected answers on a patient's chart. Only users who are set with the behavior control "Save default answers for Clin Doc Documents"' will be able to save and apply default answers.*

### *Resolve Default Conflicts Screen*

If a content update affects any previously saved default answers, the **Resolve Default Answer Conflicts** screen will display when the document section containing the defaulted answers is opened and Apply Defaults is selected.

Conflicts are triggered based on the following criteria:

- Answers have been removed or added to a question containing default answers.
- The content update removed a defaulted answer from the question.
- The description of the defaulted answer or question with the default answer has changed.

This screen enables the user to address new defaults. Selecting an answer and then selecting Acknowledge Conflicts will allow the new answers, along with previously defaulted answers to save to the section addressed. After selecting Acknowledge Conflicts, new defaults may also be applied in the section by selecting Save Defaults prior to moving to a new section or choosing Update.

If the back arrow is selected without addressing questions affected by the content update from the Resolve Default Answer Conflicts screen, a prompt will appear which states “Exiting without acknowledging the conflicts will prevent all default answers from appearing in this section.” The user will then be taken back to the previously addressed section with no new default answers being applied. Only the defaults that were not conflicted will be displayed to that section.

## 5.12 Special Questions

### *Overview*

Special questions are any questions that will upload information to other areas of the TruBridge EHR system.

### *Advance Directives*

The Advance Directive special question is set up as a radio button question with the answer yes, no and not answered.

When this special question is answered within Documentation, it will populate the following areas:

- **Census**: System Menu > Master Selection > Select Patient > Census > Patient Tab > Advance Directives

- **Demographics Drop-down Menu** (review screen only): System Menu > Enter Account > Blue Arrow to Left of Patient Name > Advance Directives

- **POC Demographics Drop-down Menu** (review screen only): System Menu > Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Blue Arrow to Left of Patient Name > Advance Directives

- **POC Flow Chart Demographic Clipboard**: System Menu > Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Flowchart Tab > Flow Chart Menu > Select a Flow Chart > Clipboard (Top right corner) > Advance Directive

- **Clinical Information**: System Menu > Enter Account > Clinical Information > Miscellaneous Tab > Advanced Directives

- **POC Virtual Chart Demographics** (review screen only): System Menu > Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Demographics Area on Virtual Chart > Advance Directive

- **Utilization Review Look Option** (review screen only): System Menu > Master Selection > Medical Records > Utilization Review > Numeric Selection > Enter Account > Look > Demographics > Advance Directives

- **Infection Control Look Option** (Review screen only): System Menu > Master Selection > Medical Records > Infection Control > Account Number Look up > Enter Account > Look > Demographics > Patient Tab > Demographics

- **Profile Demographics**: System Menu > Profile Listing > Select Patient > Clinical Info Tab > Advance Directive

### *ED Arrival Date and Time*

The Emergency Department Arrival Date and Time special question is set up with the calendar date picker and time entry field.

When this special question is answered within Documentation, it will populate the following areas:

- **ER Log**: System Menu > Master Selection > Account Number > Census > ER Log > ED Arrival Date and Time

### *ED Departure Date and Time*

The Emergency Department Departure Date and Time special question is set up with the calendar date picker and time entry field.

When this special question is answered within Documentation, it will populate the following areas:

- **ER Log**: System Menu > Master Selection > Account Number > Census > ER Log > ED Departure Date and Time

### *ED Follow-up Care*

The ED Follow-up Care special question is set up as a check box question to document follow-up care when ordered for a discharge patient after he/she has been admitted to the emergency department.

When this special question is answered within Documentation, it will update any POC Flowchart or Electronic Form that contains the ED Follow-up Care check box with the hard coded database code MUEDFUCARE attached. It will also trigger the software to include the patient in the denominator for the Transitions of Care Create and Transmit measure of Meaningful Use Stage 2.

### *Pain Scale*

The Pain Scale special question is set up as a drop-down.

- The different table options are:
  - 0 - No Pain
  - 1
  - 2
  - 3
  - 4
  - 5 - Moderate Pain
  - 6
  - 7
  - 8
  - 9
  - 10 - Worst Possible Pain

***NOTE:*** *The special question, Pain Scale, is consistent with the Pain Scale question in the Vitals application.*

### *Patient Status*

The Patient Status special question is set up as a drop-down.

- The table options pull from the Patient Status list setup for the department. See Patient Status for specific setup from within the Emergency Department User Guide.

If the Patient Status field has been populated in Patient Location Maintenance, it will pull into the Documentation document when it is opened on the patient's chart. Once the Patient Status field has been updated within a Documentation document, it will also update the Patient Status field within Patient Location Maintenance.

***Pregnant***

The Pregnant special question is set up as a radio button question with the answer yes, no and not answered.

When this special question is answered within Documentation, it will populate the following areas:

- **Clinical Information**: Hospital Base Menu > Enter Account > Clinical Information > Dietary/ Height/Weight Tab > Pregnant

- **POC Flow Charts Demographics Clipboard**: Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Flowchart Tab > Flow Chart Menu > Select a Flow Chart > Clipboard (Top right corner) > Pregnant

- **POC Virtual Chart Demographics** (review screen only): Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Demographics Area on Virtual Chart > Pregnant

***NOTE:*** *This field only appears if the field is answered in of the areas that allow the field to be accessed/changed.*

- **POC Demographics Dropdown Warnings** (review screen only): Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Blue Arrow to the Left of Patient's Name > Warnings

***NOTE****: This shows the word "Pregnant" in red if Pregnant=Y*

### *Fetal Development*

Three Fetal Development special questions can be used in documentation and are also visible in the Vitals application.
They include the following:

- **Fetus** allows for the documentation of the number of fetus and separate fetal heart rates for up to six fetuses using a drop down with the values one through six. The default is one.

- **Fetal Heart Rate and Method** allows for the documentation of heart rate in beats per minute in a text box that is limited to three numeric characters and a dropdown box to document the method for obtaining the fetal heart rate. The following options are available within the dropdown:
  - Handheld Doppler
  - Transabdominal ultrasound
  - Transvaginal ultrasound
  - Other (which allows a free text answer)

- **Fundal Height** allows for the documentation of fundal height in cm in a text box and is limited to three numeric characters.

- Fetal Development vital signs pull to Documentation Reports if documented within the Documentation application or the Vitals application.

- Fetal Development vital signs documented within a document also pull to the Vitals application for review.

***NOTE:*** *Fields for Fetal Development only appear in the Vitals application for female patients that have been marked as pregnant in the TruBridge EHR.*

### *Smoking History*

The Smoking History special question is set up as a drop-down.

- The different table options are:
  - 1 - Current every day smoker
  - 2 - Current some day smoker
  - 3 - Former smoker
  - 4 - Never smoker
  - 5 - Smoker/current status unknown
  - 6 - Heavy tobacco smoker
  - 7 - Light tobacco smoker
  - 8 - Unknown if ever smoked

The special questions, Smoking Start Date and Smoking End Date, are set up with the calendar date picker that allows a free text entry.

***NOTE:*** *The Smoking Start Date question will only open if the answer to the Smoking History question is 1, 2, 3, 5, 6 or 7. The Smoking End Date question will only open up if the answer 3 is selected in the Smoking History question.*

When this special question is answered within Documentation, it will populate the following areas:

- **Census**: Hospital Base Menu > Master Selection > Select Patient > Census > Smoking History, Smoking Start Date and Smoking End Date

- **POC Flow Charts**: Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Flowchart Tab > Flow Chart Menu > Select a Flow Chart > Does Patient Smoke?

- **POC Flow Chart Demographic Clipboard**: Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Flowchart Tab > Flow Chart Menu > Select a Flow Chart > Clipboard (Top right corner) > Smoker Status, Smoker Start Date and Smoker End Date

- **POC Virtual Chart Demographics** (review screen only): Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Demographics > Smoke, Smoke Begin Date and Smoke End Date

- **Electronic Forms:** Any electronic forms set with the following database code
  - PATSMOKES - Does Patient Smoke
  - PATSTART - Smoking Start Date.3
  - PATSTOP - Smoking End Date

- **Clinical Information**: Hospital Base Menu > Enter Account > Clinical Information > Miscellaneous Tab > Smoking Status, Smoking Start Date and Smoking End Date

- **Utilization Review Look Option** (review screen only): Hospital Base Menu > Master Selection > Medical Records > Utilization Review > Numeric Selection > Enter Account > Look > Demographics > Patient Tab > Patient Smoke, Smoker Status, Smoker Start Date and Smoker End Date

- **Infection Control Look Option** (Review screen only): Hospital Base Menu > Master Selection > Medical Records > Infection Control > Account Number Look up > Enter Account > Look > Demographics > Patient Tab > Smoker Status, Smoker Start Date and Smoker End Date

### *Smokeless Tobacco History*

The Smokeless Tobacco History special question is set up as a drop-down.

- The different table options are:
  - 1 - Does not use moist powdered tobacco
  - 2 - Never used moist powdered tobacco
  - 3 - Ex-user of moist powdered tobacco
  - 4 - Never chewed tobacco
  - 5 - Snuff user
  - 6 - User of moist powdered tobacco
  - 7 - Chews tobacco
  - 8 - Tobacco consumption unknown

When this special question is answered within Documentation, it will populate the following areas:

- **Census**: Hospital Base Menu > Master Selection > Select Patient > Census > Smokeless Tobacco

- **Electronic Forms:** Any electronic forms set with the following database code
  - PATUSAGE - Tobacco Usage

- **Clinical Information**: Hospital Base Menu > Enter Account > Clinical Information > Miscellaneous Tab > Smokeless Tobacco User

- **POC Flow Chart Demographic Clipboard**: Hospital Base Menu from a Nursing Department > POC Access > Numeric Look up > Enter Account > Flowchart Tab > Flow Chart Menu > Select a Flow Chart > Clipboard (Top right corner) > Smokeless Tobacco

- **Utilization Review Look Option** (review screen only): Hospital Base Menu > Master Selection > Medical Records > Utilization Review > Numeric Selection > Enter Account > Look > Demographics > Patient Tab > Smokeless Tobacco

- **Infection Control Look Option** (Review screen only): Hospital Base Menu > Master Selection > Medical Records > Infection Control > Account Number Look up > Enter Account > Look > Demographics > Patient Tab > Smokeless Tobacco

***Triage Level***

The Triage Level special question is set up as a drop-down.

- The different table options pull from the Triage Level Table. To set up the triage level table, see the Tracking Board user guide.

When this special question is answered within Documentation, it will populate the following areas:

- **ER Log**: System Menu > Master Selection > Account Number > Census > ER Log > Triage Level

- **Patient Location Maintenance**: Tasks > Charts > Track > Patient Room Number > Triage Level

### *Vital Signs*

Vital signs are available for documentation through Documentation documents. Vital signs that are documented will pull to the Vitals application and the patient's Virtual Chart.

The following Vitals Signs are available:

- Temperature
- Pulse
- Respiration
- Blood Pressure
- O2 Saturation
- Pain Level
- Height
- Weight
- BMI
- BSA
- Head Circumference
- Blood Glucose Level
- Intake/Output

**Temperature** is set up as a text box that will allow up to five characters to be documented in Fahrenheit or Celsius. A drop-down box is used to document site. Site is required when temperature is addressed.

- The drop-down options for site are:
  - Oral
  - Rectal
  - Axillary
  - Tympanic
  - Bladder
  - Saw Ganz
  - Temporal Scanning
  - Temporal
  - Temporal Artery
  - Monitor

- Other: Allows the user to free text an answer not on the drop-down list.

**Pulse** is set up as a text box that will allow up to three numeric characters and a drop-down box to document site. Site is required when the pulse is addressed.

- The drop-down options for site are:
  - Pulse Ox
  - Radial
  - Brachial
  - Femoral
  - Carotid
  - Apical
  - Monitor
  - Other: Allows the user to free text an answer not on the drop-down list.

**Respiration** is set up as a text box that will allow up to three numeric characters.

**Blood Pressure** is set up as a text box that will allow up to three numeric characters for systolic and diastolic. Position and Site are set up as drop-down boxes and are required when blood pressure is addressed.

- The drop-down options for Position are:
  - Lying
  - Sitting
  - Standing
  - Doppler
  - Other: Allows the user to free text an answer not on the dropdown list.

- The drop-down options for Site are:
  - Right Arm
  - Left Arm
  - Right Leg
  - Left Leg
  - Other: Allows the user to free text an answer not on the drop-down list.

***NOTE:*** *Blood Pressure position and site can be set up to have default answers.*

**O2 Saturation** is set up as a text box that will allow up to three numeric characters.

**O2 Method** is set up as a drop-down box.

- The drop-down options for O2 Method are:
  - O2 Cannula
  - Partial Rebreathing Mask
  - Room Air 21%
  - Simple Mask
  - T-Piece
  - Venti Mask
  - Ventilator
  - Other: Allows the user free text an answer not on the dropdown list.

**O2 L/M** is set up as a text box that will allow up to five characters.

**FiO2** is set up as a text box that will allow up to three numeric characters.

**Height** is set up as a text box that will allow up to five characters in the inches field and six characters the centimeters field. Both fields will auto calculate for the other field that is not addressed.

**Weight** is set up as a text box that will allow up to five characters in the Pounds, Ounces, Kilograms and Grams fields. All fields will auto calculate for the other fields not addressed. Scale is set up as drop-down box.

- The dropdown options for Scale are:
  - Stated
  - Bed Scale
  - Sling Scale
  - Floor Scale
  - Chair Scale
  - Newborn Scale
  - Estimated
  - Other: Allows the user free text an answer not on the drop-down list.

**BMI** and **BSA** are display only and calculate once height and weight have been addressed. If height and weight are readdressed, the BMI and BSA will recalculate.

**Blood Glucose** is set up as a series of radio buttons with the following answer options **Level, High, Low, No BG,** and **Not Addressed**. The radio button option for Level is followed by a text box that will allow up to three numeric characters. If any other radio button is selected other than Level, the Level Text box will display disabled and blank. Type and Method are set up as a drop-down.

- The drop-down options for Type are:
  - Average
  - Daily
  - Fasting
  - Random
  - Other: Allows the user free text an answer not on the drop-down list.

- The drop-down options for Method are:
  - Arterial
  - Finger Stick
  - Heel Stick
  - Venipuncture
  - Other: Allows the user free text an answer not on the drop-down list.

**Head Circumference** is set up as a text box that will allow up to five characters in the centimeters and inches field. Both fields will auto calculate for the other field that is not addressed.

**Pain Scale** setup is the same as the Pain Scale 33 special question.

**Intake** options are as follows:

***NOTE:*** *Intake Type options pull according to the chart type selected on the POC Virtual Chart.*

- **Intake Type** is set up as a drop-down box with a hard coded drop-down box with one of the following drop down list:

| Adult Intake Options: | Pediatric Intake Options: | Nursery Intake Options: |
|---|---|---|
| Oral | Oral | Oral |
| NG/Peg Tube Feeding | Oral - Formula | Oral-Formula |
| Hyperalimentation | Oral - Baby Food | Oral - Pedialite |
| Lipids | Oral - Pedialite | Oral - Sterile Water |
| Hespan | NG/Peg Tube Feeding | Oral - 5% Glucose Water |
| Albumin | Irrigation Solution | NG/Peg Tube Feeding |
| Packed Red Blood Cells | Fresh Frozen Plasma | Left/Right Breast |
| Fresh Frozen Plasma | Platelets | Left Breast |
| Platelets | Packed Red Blood Cells | Right Breast |
| Irrigation Solution | Hyperalimentation | OTHER (allows free text entry) |
| OTHER (allows free text entry) | Left/Right Breast | IV FLUIDS |
| IV FLUIDS | Left Breast | |
| | Right Breast | |
| | OTHER (allows free text entry) | |
| | IV FLUIDS | |

***NOTE:*** *IV FLUIDS option will pull the POC Control Table on Page one, the field labeled "Use Pharmacy for IV Intake." See POC Setup for further information.*

- **Volume**: Enter amount consumed displayed in milliliters up to six digits. If NG/Peg Tube Feeding is selected, enter the capacity of the source displayed in milliliters. If the Intake Volume field is left empty, the following alert will display: "Need an Intake Volume Value." Once the user has selected **OK**, a volume should be entered in the volume field or the **None** check box should be selected.

- **None**: Options are unchecked and checked (☑)
  - **Unchecked** (default): Allows an amount to be entered in the Volume field.
  - **Checked** (☑): Sets the Volume field automatically to 0 ml.

- **Left to Count**: Available when NG/Peg Tube Feeding is selected from Intake Type. Enter the remaining volume in milliliters up to 5 numeric characters with one decimal place.

- **Rate Per Hour**: Available when NG/Peg Tube Feeding is selected from Intake Type. Enter the amount of fluid in milliliters consumed within one hour up to five numeric characters with one decimal place.

- **Feeding Quality**: Available when Left/Right Breast, Left Breast or Right Breast is selected from Intake Type. Radio button options are **Poor**, **Fair** and **Well**.

- **Feeding Type**: Available when Left/Right Breast, Left Breast or Right Breast is selected from Intake Type. This is a two digit field with radio button options for **Times** and **Minutes**.

Output options are as follows:

- **Output Measure**: Radio button options are **Volume** and **Frequency.**

- **Output Site** is set up as a drop-down box with a hard coded drop-down box with one of the following drop down list:

| Adult Output Options: | Pediatric Output Options: | Nursery Output Options: |
|---|---|---|
| Voided Urine | Voided Urine | Voided Urine |
| Catheter Urine | Catheter Urine | Catheter Urine |
| Stool | Wet Diapers | Wet Diapers |
| Colostomy | Stool | Stool |
| Emesis | Colostomy | Emesis |
| NG Tube | Emesis | NG Tube Drainage |
| Estimated Blood Loss | NG Tube Drainage | Chest Tube |
| T-Tube | Estimated Blood Loss | Estimated Blood Loss |
| Jackson Pratt #1 | T-Tube | OTHER (allows free text entry) |
| Jackson Pratt #2 | Jackson Pratt #1 | |
| Chest Tube | Jackson Pratt #2 | |
| Hemovac #1 | Chest Tube | |
| Hemovac #2 | Hemovac #1 | |
| OTHER (allows free text entry) | Hemovac #2 | |
| | OTHER (allows free text entry) | |

- **Volume**: Displays instead of Frequency when Volume is selected for Output Measure. Enter the amount produced displayed in milliliters up to six digits. If the Output Volume field is left empty, the following alert will display: "Need an Output Volume Value." Once the user has selected **OK**, a volume should be entered in the Volume field or the **None** check box should be selected.

- **Frequency**: Displays instead of Volume when Frequency is selected for Output Measure. Enter the number of times output is produced.

- **None**: Options are unchecked and checked (☑)
  - **Unchecked** (default): Allows an amount to be entered in the Volume or Frequency fields.

  - **Checked** (☑): Sets the Volume field automatically to 0 ml or the Frequency field automatically to 0 times. If documenting frequency, "NONE" will be displayed on the Review screen.

- **Drain Level**: Available when NG Tube or Chest Tube is selected from Output Site. This is a 6-digit field.

- **Stool Size**: Available when Stool is selected from Output Site and None is unchecked. Radio button options are **Small** (default), **Moderate**, and **Large**

### *Widgets*

Widgets have the ability to access another application from within Documentation documents. A widget will allow the user to launch from Documentation to the selected application. Then, the user will be able to insert any selected information from within the widget into the document.

- All widgets will appear in boldface and highlighted in blue when the mouse moves over the widget within the Documentation documents.

- Widgets that are currently available are: Allergies, Immunizations, Patient Status, Problem List, ED Follow-Up Care, O2 Sat, Social History, Family Health History, Functional/Cognitive Status, Past Medical Procedures and Interventions, Referral/Transition of Care and Quality Measures.

***NOTE:*** *See* *Quality Measures* 51 *for more information on Quality Measures widgets.*

### Allergy

The **Allergy** widget allows access to the patient's allergies from within Documentation documents. The allergy widget will appear bold in documentation and highlight blue when the mouse hovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the allergy widget to launch the patient's allergy screen.

- The following options are available on the action bar:
  - **Add:** Allows the Micromedex allergy listing of available drug, environmental and food allergies to launch and functions as it does within the Allergy application. Please see the Allergy User Guide for additional information.
  - **Remove:** Allows the selected allergy to be removed from the patient's account.This option is only enabled once an allergy is selected.
  - **Insert:** Allows the selected allergies to be inserted into the Documentation document.
  - **NKA:** Allows No Known Allergies to be added to the patient's account.
  - **NKDA:** Allows No Known Drug Allergies to be added to the patient's account.
  - **NKEA:** Allows No Known Environmental Allergies to be added to the patient's account.
  - **NKFA:** Allows No Known Food Allergies to be added to the patient's account.
  - **History:** Allows access to the date, time and initials of the person who entered the allergies and the changes that have been made. It also allows allergies to be reviewed.
  - **Verify All:** Allows the user to verify that all allergies listed on the patient's account are up to date and correct.

Select **Patient Chart** > **Documentation** > **New Document** > **Allergy Widget**

- Select the allergies to be pulled into the documentation and select Insert.

Select **Patient Chart** > **Documentation** > **New Document** > **Allergy Widget** > **Allergy** > **Insert**

- The selected allergy, reaction, severity and type will pull into the document in a rich text box underneath the Allergy widget.

## Immunizations

The **Immunization** widget allows access to the patient's immunizations from within Documentation documents. The Immunization widget will appear bold in documentation and highlight blue when the mouse hovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the Immunization widget to launch the patient's immunization screen.

- The following options are available on the action bar:
  - **Add New:** Allows new immunizations to be added to the patient's profile and functions as it does within the Patient Immunization History application. Please see the Patient Immunization History User Guide for additional information.
  - **Delete:** Allows the selected immunization to be removed from the list of immunizations for the patient. This option is only enabled once an immunization is selected.
  - **Insert:** Allows the selected immunizations to be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Immunization Widget**

- Select the immunizations to be pulled into the documentation and select Insert.

Select **Patient Chart** > **Documentation** > **New Document** > **Immunization Widget** > **Immunization** > **Insert**

- The selected immunizations and the date administered will pull into the document in a rich text box underneath the Immunization widget.

## Family Health History

The **Family Health History** widget allows access to the patient's Family Health History from within Documentation documents. The Family Health History widget will appear bold in documentation and highlight blue when the mouse hoovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the Family Health History widget will launch the patient's Health History Review screen in a List View.
  - Family Health History is defaulted as checked. This screen displays the available Types of

health history, which may be multi-selected and inserted into the document at one time.
- Selecting the header for a Health History type will automatically insert all information included within that header.

- The following options are available on the action bar:
  - **Edit:** Allows the information that displays under a Health History header to be edited. This option is only enabled when information below a Health History header is selected.
  - **New:** Allows the Health History Category screen to launch and functions as it does within the Health History application. Please see the Health History User Guide for additional information.
  - **Insert:** Allows the selected information to be inserted into the Documentation document. This option is only enabled when information is selected.
  - **Select All:** Selects all information displayed, which can then be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Family Health History Widget**

- Select the family health history entries to be pulled into the document and select insert.

- The selected Family Health History descriptions and the associated relatives will pull into the document in a rich text box underneath the Family Health History widget.

## Functional/Cognitive Status

The **Functional/Cognitive Status** widget allows access to the patient's Functional/Cognitive Status from within Documentation documents. The Functional/Cognitive Status widget will appear bold in documentation and highlight blue when the mouse hoovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the Functional/Cognitive Status widget will launch the patient's Health History Review screen in a List View.
  - Functional/Cognitive Status is defaulted as checked. This screen displays the available Types of health history, which may be multi-selected and inserted into the document at one time.
  - Selecting the header for a Health History type will automatically insert all information included within that header.

- The following options are available on the action bar:
  - **Edit:** Allows the information that displays under a Health History header to be edited. This option is only enabled when information below a Health History header is selected.
  - **New:** Allows the Health History Category screen to launch and functions as it does within the Health History application. Please see the Health History User Guide for additional information.
  - **Insert:** Allows the selected information to be inserted into the Documentation document. This option is only enabled when information is selected.
  - **Select All:** Selects all information displayed, which can then be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Functional/Cognitive Status**

- Select the Functional/Cognitive Status to be pulled into the document and select insert.
- The selected Functional/Cognitive Status entry will pull into the document in a rich text box underneath the Functional/Cognitive Status widget.

## Group Note

The **Group Note** widget allows access to the Group Note Selection screen. This allows the user to insert the PhysDoc Template that was documented through Group Note in the Scheduling application. The Group Note widget will appear bold in documentation and highlight blue when the mouse hovers over it. The widget is also available by inserting the special question into the document via Charting Options. Please see Add Group Note 28 for additional information.

## Medical History

The **Medical History** widget allows access to the patient's Medical History from within the Health History application to be inserted into a document. The Medical History widget will appear bold in documentation and highlight blue when the mouse hovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Selecting the Medical History widget will launch the patient's Health History Review screen in a List View.
  - Medical History is defaulted as checked. This screen displays the available Types of health history, which may be multi-selected and inserted into the document at one time.
  - Selecting the header for a Health History type will automatically insert all information included within that header.
- The following options are available on the action bar:
  - **Edit:** Allows the information that displays under a Health History header to be edited. This option is only enabled when information below a Health History header is selected.
  - **New:** Allows the Health History Category screen to launch and functions as it does within the Health History application. Please see the Health History User Guide for additional information.
  - **Insert:** Allows the selected information to be inserted into the Documentation document. This option is only enabled when information is selected.
  - **Select All:** Selects all information displayed, which can then be inserted into the Documentation document.
- Select the Medical History entries to be pulled into the document and select insert.
- The selected Medical History entries will pull into the document in a rich text box underneath the Medical History widget.

## Past Medical Procedures and Interventions

The **Past Medical Procedures and Interventions** widget allows access to the patient's Past Medical Procedures and Interventions from within Documentation documents. The Past Medical Procedures and Interventions widget will appear bold in documentation and highlight blue when the mouse hoovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the Past Medical Procedures and Interventions will launch the patient's Health History Review screen in a List View.
  - Past Medical Procedures and Interventions is defaulted as checked. This screen displays the available Types of health history, which may be multi-selected and inserted into the document at one time.
  - Selecting the header for a Health History type will automatically insert all information included within that header.

- The following options are available on the action bar:
  - **Edit:** Allows the information that displays under a Health History header to be edited. This option is only enabled when information below a Health History header is selected.
  - **New:** Allows the Health History Category screen to launch and functions as it does within the Health History application. Please see the Health History User Guide for additional information.
  - **Insert:** Allows the selected information to be inserted into the Documentation document. This option is only enabled when information is selected.
  - **Select All:** Selects all information displayed, which can then be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Past Medical Procedures and Interventions**

- Select the past medical procedures and interventions entries to be pulled into the document and select insert.

- The selected Past Medical Procedures and Interventions entries will pull into the document in a rich text box underneath the Past Medical Procedures and Interventions widget.

## Patient Education Documents

The **Patient Education Documents** widget allows access to the patient's Education Documents from within Documentation documents. The Patient Education Documents widget will appear bold in documentation and highlight blue when the mouse hovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the Patient Education Documents widget to launch the patient's Education Documents screen.

- The following options are available on the action bar:
  - **New Document:** Allows a new document to be added and functions as it does within the

Patient Education Document application. Please see the Patient Education Documents User Guide for additional information.

- **Edit:** Allows the patient education document to be edited. This option is only enabled once a patient education document is selected.
- **Delete:** Allows the patient education document to be removed from the list. This option is only enabled once a patient education document is selected.
- **Insert:** Allows the selected patient education document titles to be inserted into the Documentation document.
- **View:** Allows the patient education document to display.
- **Print:** Allows the patient education document to be printed.
- **Clinical Knowledge**: Allows access to view education documents based on the patient's lab results, medications and problems. Please see the Patient Education Documents User Guide for additional information.
- **Insert:** Allows the selected patient education document titles to be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Patient Education Document Widget**

- Select the patient education document titles to be pulled into the documentation and select Insert.
- The selected patient education document titles will pull into the document in a rich text box underneath the Patient Education Documents widget.

## Physician Reason for Admit

The **Physician Reason for Admit** allows access to the Physician Problem List from within Documentation documents. The Physician Reason for Admit widget will appear bold in documentation and the answer will highlight blue when the mouse hovers over it. The widget is also available by inserting the special question into the document via Charting Options. If this widget is already addressed on the Reason for Visit screen within Location Maintenance, the Physician Admit Reason will automatically display next to the widget. If the Physician Reason for Admit has not been addressed it will display "No Answer Given" and a reason may be selected.

- Select the **Physician Reason for Admit** widget to launch the Physician Problem List.
- The Active Problems will display when the screen is first opened.
  - Select the Display radio button to choose **Inactive**, **All** or **Entered in Error.**
- New problems may be added or existing problems may be edited. Please see the Physician Problem List User Guide for additional information on the options from the action bar.
- Select the Physician Reason for Admit and select **Insert**.

***NOTE:*** *If more then one diagnosis is selected, the* ***Insert*** *option becomes disabled. Only one diagnosis may be selected as the Physician Reason for Admit.*

Select **Patient Chart** > **Documentation** > **New Document** > **Physician Admit Reason**

- The selected admit reason will pull into the document next to the Physician Reason for Admit widget. Once a physician admit reason is populated in this field, it will copy to all other Physician Admit Reason locations within the TruBridge EHR.

Select **Patient Chart** > **Documentation** > **New Document** > **Physician Admit Reason** > **Select Diagnosis** > **Insert**

## Problem List or Diagnosis

The **Problem List or Diagnosis** widget allows access to the Physician Problem List from within Documentation documents. The Problem List or Diagnosis widget will appear bold in documentation and highlight blue when the mouse hovers over it. The Problem List widget is also available by inserting the special question into the document via Charting Options.

- Select the Problem List widget to launch the Physician Problem List.
- The Active Problems will display when the screen is first opened.
  - Select the Display radio button to choose **Inactive**, **All** or **Entered in Error.**
- Select the Problem to insert it into the document. This screen allows multi-selecting so that more then one Problem may be inserted at one time.
- New problems may be added or existing problems may be edited. Please see the Physician Problem List User Guide for additional information on the options within the action bar.
- Select the problems to be pulled into the documentation and select **Insert**.

Select **Patient Chart** > **Documentation** > **New Document** > **Problem List Widget**

- The selected problem's diagnosis description, diagnosis date and addressed date will pull into the document in a rich text box underneath the Problem List widget.

## Referral/Transition of Care

The **Referral/Transition of Care** widget allows access to the patient's referral/transition of care from within Documentation documents. The Referral/Transition of Care widget will appear bold in documentation and highlight blue when the mouse hoovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Select the Referral/Transition of Care widget will launch the patient's Health History Review screen in a List View.
  - Referral/Transition of Care is defaulted as checked. This screen displays the available Types of health history, which may be multi-selected and inserted into the document at one time.
  - Selecting the header for a Health History type will automatically insert all information included

within that header.

- The following options are available on the action bar:
  - **Edit:** Allows the information that displays under a Health History header to be edited. This option is only enabled when information below a Health History header is selected.
  - **New:** Allows the Health History Category screen to launch and functions as it does within the Health History application. Please see the Health History User Guide for additional information.
  - **Insert:** Allows the selected information to be inserted into the Documentation document. This option is only enabled when information is selected.
  - **Select All:** Selects all information displayed, which can then be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Referral/Transition of Care**

- Select the referral/transition of care entries to be pulled into the document and select insert.

- The selected Referral/Transition of Care entries will pull into the document in a rich text box underneath the Referral/Transition of Care widget.

## Social History

The **Social History** widget allows access to the patient's Social History from within documentation documents. The social history widget will appear bold in documentation and highlight blue when the mouse hoovers over it. The widget is also available by inserting the special question into the document via Charting Options.

- Selecting the Social History widget will launch the patient's Health History Review screen in a List View.
  - Social History is defaulted as checked. This screen displays the available Types of health history, which may be multi-selected and inserted into the document at one time.
  - Selecting the header for a Health History type will automatically insert all information included within that header.

- The following options are available on the action bar:
  - **Edit:** Allows the information that displays under a Health History header to be edited. This option is only enabled when information below a Health History header is selected.
  - **New:** Allows the Health History Category screen to launch and functions as it does within the Health History application. Please see the Health History User Guide for additional information.
  - **Insert:** Allows the selected information to be inserted into the Documentation document. This option is only enabled once information is selected.
  - **Select All:** Selects all information displayed, which can then be inserted into the Documentation document.

Select **Patient Chart** > **Documentation** > **New Document** > **Social History Widget**

- Select the social history entries to be pulled into the document and select insert.

- The selected Social History entries will pull into the document in a rich text box underneath the Social History widget.

### *Quality Measures*

*For MU3, the Clinical Quality Measures Documentation Document should be used for all quality measure documentation. Please see the following document Structured Documentation for Clinical Quality Measures for additional information.*

## 5.13 Reflexing

### *Overview*

Reflexing may be used to generate questions, sections, orders or charges based on the answer choice that is selected during documentation. This chapter will discuss the use of reflexing within documentation.

### *Orders and Charges*

Orders and charges may be generated through a reflex by selecting the answer that is tagged to reflex.

When an answer that has an order or charge reflex attached to it is selected, the Pending option at the top will update to reflect that an item is pending.

- Select **Pending** to view all pending reflexes.
- **Edit** will allow maintenance to be performed for the order or charge.
- **Remove** will change the status of the order or charge from PENDING to REMOVED. Removed reflexes will not be processed.
- **Process** will place the order or process the charge.
- Select **Process** to launch Updated Order Entry to complete the order entry process. Please see the Updated Order Entry user guide for additional information on placing orders.
- Reflexes will display with a QUEUED status until the document has been updated. This is a view only screen.
- Select the **Back Arrow** to return to the document.
- Once documentation has been completed and **Update** has been selected, the reflex queue will automatically display so pending reflexes may be processed.

***NOTE:*** *If documentation that triggered a reflex is later amended, the user will receive a prompt that an order or a charge was triggered based on amended documentation. Reflexed orders and*

*charges are not automatically canceled/discontinued/credited when amending; therefore, those operations will need to be performed manually, if necessary.*

### *Sections*

Subsections may be inserted into the document through reflexes that are attached to questions or answers.

When an answer is set to reflex a section, the section will be pulled into the section once the answer has been selected

- The section will be inserted directly below the question or answer that triggered the reflex.

***NOTE:*** *If documentation that triggered the reflex is later amended, the reflexed section will no longer display within the template.*

### *Questions*

Questions may be inserted into the Documentation document based on the answer choice that is selected.

When an answer is set to reflex a question, the question will be pulled into the section once the answer has been selected.

- The question will be inserted directly below the answer that triggered the reflex.

***NOTE:*** *If the documentation that triggered the reflex is later amended, the reflexed questions will no longer display within the document.*

### *Markups*

Markups may be inserted into a document from a reflex.

- When a markup reflex is triggered, the markup will pull into a rich text documentation area directly below the question or answer that triggered the reflex.

When an answer is set to reflex a markup, the markup will be pulled into the section once the answer has been selected.

- The markup will be inserted directly below the answer that triggered the reflex.

***NOTE:*** *If documentation that triggered the reflex is later amended, the reflexed markup will no longer display within the template.*

### *Instructions*

Instructions may be inserted into a document from a reflex.

- When an instruction reflex is triggered, instructions will pull into a rich text documentation area directly below the question or answer that triggered the reflex. The instructions may be edited or modified as needed.

When an answer is set to reflex an instruction, the instruction will be pulled into the section once the answer has been selected.

The instruction will be inserted directly below the answer that triggered the reflex.

***NOTE:*** *If documentation that triggered the reflex is later amended, the reflexed instruction will no longer display within the template.*

In the Grid View, reflexed data will be indicated in the appropriate question grid cell with an icon.

### *Prescription Writer*

Prescriptions may be set up to generate a reflex when a user selects a particular answer. An action(s) will be added to **Pending** for the prescription associated with the selection. Once the document is Updated, the Pending screen will launch. Pending prescriptions will list the Question/ Answer, medication description and status.

If the prescription reflex is set up as a blank reflex, the Medication Search screen will display with the My Meds radio button selected to display the user's My Meds List. If the user does not have any medications setup as My Meds, then the Medication Search screen will display and allow the user to search the formulary for the needed medication.

To generate a prescription reflex, select the associated answer that was previously setup to trigger the reflex.

Once the document has been updated the Reflex screen will display with the following options:

- **Edit** will allow maintenance to be performed on the prescription.
- **Remove** will change the status of the prescription from PENDING to REMOVED. Removed reflexes will not be processed.
- **Process** will order the prescription.

If the prescription reflex is setup with a preselected prescription, select process to send the prescription to RX Entry as a temporary prescription and "Pending prescriptions only" is defaulted as checked. The user will then have the option of adding a new prescription(s) or processing all pending prescriptions from within the RX Entry screen.

If the prescription reflex was set up as a blank reflex, an edit will be required. Select the prescription and select **Edit** or select **Process** and TruBridge EHR will automatically launch the edit screen**.**

***NOTE:*** *If Medication Reconciliation is set as required within the ED General Control table and a Discharge Reconciliation has not been performed, the user will be notified that "A Discharge Reconciliation is required to process the R/X reflexes." The TruBridge EHR will keep the reflexes as pending until a discharge reconciliation has been completed. Please see the Emergency Department User Guide for more information.*

The Medication Search screen displays with the My Meds radio button selected to allow the user to choose a medication from their medication list. If the user does not have any medications set up as My Meds then the radio button will be defaulted to All Meds.

Once a prescription is selected, if the site is using E-scribe, then the Coverage and Formulary Information screen will display. If they are not, this screen is bypassed. Once the Payer field is addressed select **Continue**.

The Pending Prescription screen will then display. Once all required fields have been addressed select **Process**. If multiple reflexes were processed at once, the next reflex in the sequence will display so it may be addressed.

For more information on the Prescription Entry screens, see the Prescription Entry User Guide.

Once all prescriptions are processed, the back arrow will take the user to the Reflexes screen in Documentation. All processed prescriptions will display with a status of Processed.

### *Messages*

A message can be set up to reflex when a user selects a question or answer. An action(s) will be added to **Pending** for the message associated with the selection. Once the document is Updated, the Pending screen will launch.

Select **Patient Chart** > **Documentation** > **New Document**

Pending messages will be available to Process by selecting **Process**.

If edits are needed, double-click to open the Message Detail screen or select Edit where edits can be addressed. A **Send** option will then be available.

Selecting **Remove** will change the status of the message from PENDING to REMOVED. Removed reflexes will not be processed.

***NOTE:*** *This functionality is exclusive to the TP-EHR setting, as messages and preventatives are viewable in the Communications application.*

### *Preventative*

A preventative can be set up to reflex when a user selects a question or answer. An action(s) will be added to **Pending** for the message associated with the selection. Once the document is Updated, the Pending screen will launch.

Pending messages will be available to Process by selecting **Process**.

"DUE DATE NEEDED!" and *Edit Required* will display.

1. Double-click the preventative to open the Preventative Edit screen where edits can be addressed. A **Save** option will then be available.

2. Select **Process**.

***NOTE:*** *This functionality is exclusive to the Clinic setting, as messages and preventatives are viewable in the Communications application.*

### *Reflex History*

The Reflex History screen displays all processed reflexes for the selected document from the document tree.

Once a current or completed document has been selected from the document tree and processed reflexes are present, the **View Reflex History** option will be available. If the document does not have any processed reflexes, the **View Reflex History** option will be grayed out.

Reflexes listed will display with the reflex type (e.g. Order or Charge), status (Processed), the date/ time the reflex was triggered, the full name of the person who triggered the reflex, the question and answer that triggered the reflex and the item being ordered or charged.

- A smart search is available to delimit the reflexes in the list via the Search field.

- The reflexes may also be sorted via the **Sort** drop-down. The sort options are:
  - **Timestamp**: This is the default.
  - **Answer**
  - **Employee**
  - **Question**

- The **PDF** option will display the listed reflexes in a PDF format for printing.

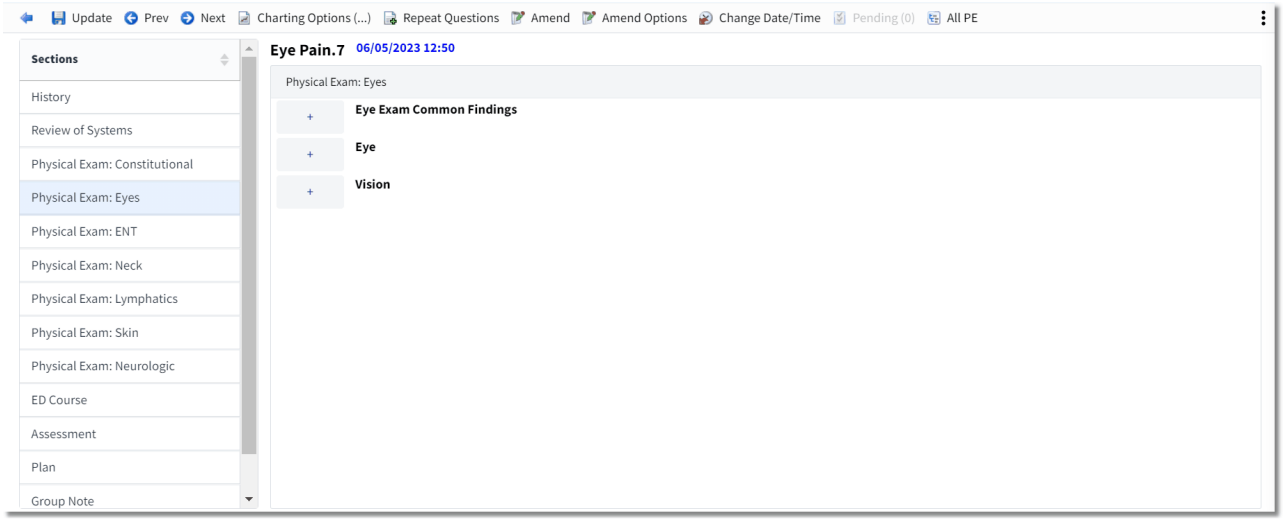
- Select the **Back Arrow** to return to the Documentation screen.

## 5.14 Accordion Style Documentation

Accordion style documentation appears when a section has more then 600 controls; it will appear "collapsed" to only display subsection headers. A white plus (+) sign in a green box will appear next to the subsection header. When selected, the questions and answers associated with that subsection will display. Once a subsection is expanded, it cannot be collapsed again.

- Select the appropriate plus (+) sign to open the subsection.

Select **Patient Chart** > **Documentation** > **New Document** > **Section** > **Plus Sign**




**Accordion Style Documentation**

- Address the section as needed.

***NOTE:*** *Once a subsection is expanded, it cannot be collapsed again.*

## 5.15 ED Provider Documentation after Admit to Inpatient

If an ED patient is admitted to the hospital and becomes an inpatient, the ED Provider may document or amend documentation within the Documentation Application.

- The document must be previously opened on the patient's account prior to the patient being discharged from the ED and admitted to the hospital.
- The document must be selected from the Current Documents folder of the document tree.
- The date and time must be changed back to when the patient was located in the Emergency Department.
- Once the Narrative View of the document displays, the provider will then have access to the Entry Mode option to enter additional documentation.

# Chapter 6 Amending Documentation

## 6.1 Amending Multi-Clinician

***Amending a Document***

To amend an entire Multi Clinician Document:

- Select the document from the Current Documents folder within the Document Tree.
- Select **Amend Options** from the action bar. This will launch the Document Amend Options screen.

Document Amend Options are as follows:

- **Change date and time for my entries in the current section:** Allows the user to change the date and time for his/her entries within the current section. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on your entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel.
- **Change date and time for all entries in the current section:** Allows the user to change the date and time for all entries within the current section. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on your entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel.
- **Change date and time for my entries in the entire document:** Allows the user to change the date and time for his/her entries within the entire document. Once this option is selected, and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on your entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel.
- **Change date and time for all entries in the entire document:** Allows the user to change the date and time for all entries within the entire document. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected, and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on your entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel. This option is accessible only for users with Super Amend security.
- **Amend my entries for this document**: Allows the user to amend his/her entries within the document. Once this option is selected, select **Process** to save. The user may then access all sections to amend.
- **Amend all entries for this document:** Allows the user to amend all entries within the document. Once this option is selected, select **Process** to save. The user may then access all sections to

amend. This option is only available if the user has the Super Amend Functionality 62.

- **Remove my entries for this section:** Allows the user to remove his/her entries within the current section. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through your entries in this section?" will display. Select **Yes** to save or select **No** to cancel.

- **Remove all entries from this section:** Allows the user to remove all entries within the current section. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through your entries in this section?" will display. Select **Yes** to save or select **No** to cancel. This option is only available if the user has the Super Amend Functionality 62.

- **Remove my entries for this document:** Allows the user to remove all of his/her entries documented within the document. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through your entries in this document?" will display. Select **Yes** to save or select **No** to cancel.

- **Remove all entries for this document:** Allows the user to remove all entries within the document. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through all entries in this document?" will display. Select **Yes** to save or select **No** to cancel.

***NOTE:*** *Only fields addressed by the user logged in will be available for amendment. Any documentation by another user will display in review mode and may not be amended unless they have the security to amend documentation for any Login. See Super Amend Functionality 62 below for details.*

- Once a question has been amended and update is selected, the question will display the most recent value on the screen. The prior/original documentation is reviewable on the Review Options screen by selecting Include Stricken. Amended information will display with a strike-through to indicate that it has been changed or amended.

### *Amending a Section*

To amend an entire section within a Multi Clinician Document:

- Select the document from the Current Documents folder within the Document Tree.

- Select **Entry Mode** from the action bar to access the section.

- Once the document opens, select **Amend Options** from the action bar. Selecting **Amend Options** will open the Document Amend Options screen.

Document Amend Options are as follows:

- **Change date and time for my entries in the current section:** Allows the user to change the date and time for his/her entries within the section. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on your entries in this section to YYYY-MM-DD 00:00?" will display. Select **Yes** to save

or select **No** to cancel.

- **Change date and time for all entries in the current section:** Allows the user to change the date and time for all entries within the section. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on all entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel.

- **Change date and time for my entries in the entire document:** Allows the user to change the date and time for his/her entries within the entire document. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on your entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel.

- **Change date and time for all entries in the entire document:** Allows the user to change the date and time for all entries within the entire document. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time on all entries in this document to YYYY-MM-DD 00:00?" will display. Select **Yes** to save or select **No** to cancel.

- **Amend my entries for this document:** Allows the user to amend all of his/her entries for the selected document. Select **Process** to update. The user is now in amend mode, and the document opens to allow any changes that need to be made. When in amend mode, the word "Amend" appears in the top right corner in bold to let the user know they are amending the documentation in the document.To exit amend mode, select **Update** to save the changes or **back arrow** to cancel changes.

- **Amend all entries for this document:** Allows the user to amend all entries for the document. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected, select **Process** to update. The user is now in amend mode, and the document opens to allow any changes that need to be made. When in amend mode, the word "Amend" appears in the top right corner in bold to let the user know they are amending the documentation in the document.To exit amend mode, select **Update** to save the changes or **back arrow** to cancel changes.

- **Remove my entries for this section:** Allows the user to remove all of his/her entries documented within the section. Once this option is selected, select **Process** to update. The prompt "Are you sure you want to strike through your entries in this section?" will display. Select **Yes** to save or select **No** to cancel.

- **Remove all entries for this section:** Allows the user to remove all entries within the section. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through all entries in this section?" will display. Select **Yes** to save or select **No** to cancel.

- **Remove my entries for this document:** Allows the user to remove all of his/her entries documented within the document. Once this option is selected, select **Process** to save. The

prompt "Are you sure you want to strike through your entries in this document?" will display. Select **Yes** to save or select **No** to cancel.

- **Remove all entries for this document:** Allows the user to remove all entries within the document. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through all entries in this document?" will display. Select **Yes** to save or select **No** to cancel.

***NOTE:*** *Only fields addressed by the user logged in will be available for amendment. Any documentation by another user will display in review mode and may not be amended unless they have the security to amend documentation for any Login. See Super Amend Functionality 62 below for details.*

- Select update when all changes are complete.

- Once a question has been amended and update is selected, the question will display the most recent value on the screen.The prior/original documentation is reviewable on the Review Options screen by selecting Include Stricken. Amended information will display with a strike-through to indicate that it has been changed or amended.

### *Amending a Question*

To amend individual questions within a section select **Amend** from the action bar. When a section that has questions previously documented is accessed by the same user, the questions and answers will display in review mode until Amend is selected from the action bar.

- From the selected document, select the question or answer that needs to be amended.

- Once the document opens, select **Amend** from the action bar.

- Address any fields that may need to be amended.

***NOTE:*** *Only fields addressed by the user logged in will be available for amendment. Any documentation by another user will display in review mode and may not be amended unless they have the security to amend documentation for any login. See Super Amend Functionality 62 below for details.*

- Select **Update** when all changes are complete.

- Once a question has been amended and Update is selected, the question will display the most recent value on the screen.The prior/original documentation is reviewable on the review documentation screen with a strike-through to indicate that it has been changed or amended.

## 6.2 Amending Flowcharts Columns

To amend an entire flow chart column or change the date and time, double-click on the date and time at the top of the column. Column Amend Options are as follows:

- **Change column date and time for my entries:** Allows the user to change the date and time for their entries within the column. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time from "MM/DD/YYYY 00:00 to MM/DD/YYYY" will display. Select **Yes** to save or select **No** to cancel.

- **Change column Date and Time for all entries:** Allows the user to change the date and time for all entries within the column. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected and a new date and time is entered, select **Process** to update. The prompt "Are you sure you want to modify the date/time from "MM/DD/YYYY 00:00 to MM/DD/YYYY" will display. Select **Yes** to save or select **No** to cancel.

- **Amend entries for this column**: Allows the user to amend all of their entries documented for the selected column. If the user has the Super Amend Functionality 62, it allows the user to amend all documentation for the column. Once this option is selected, select **Process** to save. The user is now in amend mode, and the document opens to allow any changes that need to be made. When in amend mode, the word **Amend** appears in the top right corner in black to let the user know they are amending the documentation in the template.To exit amend mode, select **update** to save the changes or **back arrow** to cancel changes.

- **Remove my entries for this column:** Allows the user to remove all of their entries documented within the column. If another user documentation exits within the same date/time column, it will still be present under the original date/time column. If all data is removed for the date/time column by removing the user's entries, the column will no longer display. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through entries from MM/DD/YYYY 00:00" will display. Select **Yes** to save or select **No** to cancel.

- **Remove all entries for this column:** Allows the user to amend all documentation within the date/time column. This option is only available if the user has the Super Amend Functionality 62. Once this option is selected, select **Process** to save. The prompt "Are you sure you want to strike through entries from MM/DD/YYYY 00:00" will display. Select **Yes** to save or select **No** to cancel.

***NOTE:*** *When any documentation is amended, the original documentation is reviewable with Review Options, any printed reports and audit area with a strike-through to indicate that is has been changed or amended along with the date, time, name and credentials of the original documentation.*

## 6.3 Super Amend Functionality

**Super Amend Functionality**

- If a login is set to allow for the behavior "Amend Clinical Documentation for any login," the amend option is available on the action bar regardless of the user that documented on the document.
- The Super Amend Process works the same as outlined above.

***NOTE:*** *Super amend currently does not allow the amendment of vital signs.*

# Chapter 7 Reviewing Documentation

## 7.1 Overview

This chapter will discuss how to review both complete and incomplete Flowchart or Multi-Clinician documentation on a patient's account.

## 7.2 Flowchart Documentation

To access an existing flowchart, select the Plus Sign Next to Current Documents to view all available documents, and select the document from list.

- The document will display in the Grid format. Grid View will display the flowchart in date and time columns, and a new column will be created for each new date or time entry.

- Several Options are available from the action bar.
  - **Narrative View** may be selected to leave the grid format. To add additional documentation, select Entry Mode from the action bar.
  - **Import Data** will allow the user to import vital sign information from a Vital Sign Interface.
  - **Review Options may be selected to apply data display parameters. See** Review Options 65 **for more details.**
  - **Retract will allow** the user to retract the document. See Retracting a Document or Flowchart 68 for more information.

- Information within the answer column will display in a truncated view. To review a cell's documentation, select the answer.
  - The document will then display the recorded documentation. If the current user documented the information, the Amend option may be accessed. If not, the Amend option will be grayed out.

- Several Options are available from the action bar.
  - **Grid View** may be selected to leave the Narrative format.
  - **Import Data** will allow the user to import vital sign information from a Vital Sign Interface.
  - **Amend** will allow the user to amend documentation that they recorded.
  - **Review Options** may be selected to apply data display parameters. See Review Options 65 for more details.
  - **Sign** will allow the user to enter his/her passphrase and sign documentation.
  - The **Retract** option is available to the creator of the document. It is also available for users with the Clinical Documentation Behavior Control "Amend Clinical Documentation for any Login." Selecting **Retract** will take the user to the Narrative View screen. The Document will then display under Retracted on the Document Tree. See Retracting a Document or Flowchart 68 for more information.

***NOTE:*** *Review Options also contains the Retract option, where flowchart information may be retracted and will display as strike through. See* *Review Options* 65 *for more details.*

To display the document in Grid View, select **Grid View** from the action bar.

- Grid View will display the flowchart in date and time columns, and a new column will be created for each new date or time entry.

- Documentation that was recording via Charting Options or through a reflexed question or section will not display within the grid view. An icon will display to alert the user that additional information is available for that section.

## 7.3 Multi-Clinician Documentation

To access an existing Multi-Clinician Document that has not been completed, select the **Current Documents** plus sign, and select the document from the list. The document will then display in a narrative format. Several Options are available from the action bar.

- **Entry Mode** may be selected to leave the Narrative format and will allow the user to record additional information. Amend may also be accessed from the Entry Mode.

- **Import Data** will allow the user to import vital sign information from a Vital Sign Interface.

- **Review Options** may be selected to apply data display parameters. Review Options also contains the Retract option, where information may be retracted and will display as strikethrough. See Review Options 65 for more details.

- **Sign** may be selected by the physician only and allows for the physician to enter the passphrase and sign the document.

- **View Signed Documents** may be selected to view the signed document.

***NOTE**: Double-clicking the section title on the narrative will also allow the user to record additional information with in the document.*

- To review documentation that has been recorded via a Multi-Clinician Document, select the plus sign next to the **Completed** option to expand the Completed Document Tree, and select the document from the list.

- **Retract** will allow the user to retract the document. See Retracting a Document or Flowchart 68 for more information.

### *Merged Documents*

To access an existing merged Multi-Clinician Document that has not been completed, select the **Current Documents** plus sign, and select the document from the list.

- The document will then display in a narrative format.

When Documents are merged, they will display with the following narrative format:

- The title of the merged documents will display as 'Multi-complaint with the name of document that

was selected first in parenthesis followed by a plus sign to represent additional documents have been merged.

- **HPI section** will display with a title HPI: 'Name of Document' for each document and the documentation for that section will display underneath.

- **Review of Systems** will display in one section labeled Review of Systems with the documentation for that section displaying underneath.

- **Physical Exam** will display in one section labeled Physical Exam with subsections dividing out the different body systems.

- **Assessment** will display in one section labeled Assessment with each merged documents own subsection.

- **Plan:** will display in one section labeled Plan with each merged documents own subsection.

***NOTE:*** *The documents/documentation will list in the order they were added to the Pending Document list.*

## 7.4 Review Options

Review Options may be selected to apply data display parameters.

- Select **Review Options** from the action bar.

- **Section filters** may be applied by selected a section from the Filter by Selected Sections menu on the left side of the screen.

- **Date and Time filters** may also be applied to the document.
  - **Entire Stay** will show all documentation that has been recorded on the Multi-Clinician Document.
  - **Hours** will allow a specific hour range to be entered, and only data that was documented within this range will display.
    - o Select the radio button next to Hours, then type the number of hours in the Hour text-box to the right.
  - **Days** will allow a specific number of days to be entered, and only data that was documented within this range will display.
    - o Select the radio button next to Days, then type the number of days in the Day text-box to the right.
  - **Date Range** will allow the user to select a beginning date and an ending date. Only data that was documented within the designated date range will display.
    - o Select the radio button next to Date Range, and type the beginning and ending dates or select the dates using the calendar date pickers.

- **User filters** may also be applied to limit the data that is displayed.
  - The document will default to display documentation from **All Users** or **My Documentation** may be selected to view only documentation the current user recorded.

- Select the **Include Stricken** check-box to include any amended data.

- **Exclude Credentials Date/Time** allows for information to display without any user credentials and corresponding date/time stamps. The check box default is unchecked. If the document or report is already set to exclude credentials date/time from within the document settings or report settings, this check box will display as checked. It may be unchecked to display the report or document with the user's credentials date/time stamp.

- Sort By parameters may be used to sort the documentation.
  - **Date/Time** may be selected to list the information in chronological order.
  - **Section then Date/Time** may be selected to list the documentation in section order, then chronological order.

- Select **Reverse Chronological** to display the documentation in Reverse Chronological Order.

***NOTE:*** *In the event the document Description has been edited in Table Maintenance, the edited Description will display instead of the default title.*

- Once all filters have been added, select **Process** from the action bar to apply the filters.

- The filtered documentation will then display in the bottom portion of the screen.

- To clear the filters, select **Clear Section Filters.**

- The **Retract** option is available to the creator of the document. It is also available for users with the Clinical Documentation Behavior Control "Amend Clinical Documentation for any Login." Once retracted, the document or flowchart will be listed under the Retracted option on the Document Tree. See Retracting a Document or Flowchart 68 for more information.

- To view the documentation in PDF, select **View PDF**.

- Select the Back Arrow to return to the entire document.

# Chapter 8 Completing Documentation

## 8.1 Overview

This chapter will discuss how to complete documentation on a patient's account.

## 8.2 Completing Documents and Flowcharts

Completing a document or flowchart will allow a new version of the document or flowchart to be created.

- Select **Complete** from the action bar.
- When the document is completed, it will move to the Completed Folder and may be reaccessed from this folder.

***NOTE:*** *Documentation Documents may be completed and signed together see* *Signing Documentation* 78.

To remove the status of complete from a Multi-clinician Document or Flowchart:

1. Select the document from the Complete folder on the document tree.
2. Select **Amend** to move the document back to the Current Document folder so that additional documentation may be added to the document.

# Chapter 9 Retracting Documentation

## 9.1 Retracting a Document or Flowchart

The ability to retract a document or flowchart that has been opened on an incorrect patient or opened in error can be accomplished using the **Retract** option.

- The Retract option is available to the creator of the document. It is also available for users with the Clinical Documentation Behavior Control "Amend Clinical Documentation for any Login."

- Select **Retract**.

***NOTE:*** *The Retract option is also available for Group Notes where the retracted information will be listed under the Retracted option on the Document Tree and displays as Stricken. It will also display in Clinical History and print EMR.*

- The Retract Reasons table will display to allow the user to select the reason for retracting a document.

- Select the drop down to choose the retract reason and choose select to retract the document.

- To cancel, select the back arrow. Once a retract reason and Select has been chosen, the document has been retracted.

- The retracted document will display under the Retracted folder on the Document Tree. The document will display with a strike through all documentation in the narrative view.

Selecting **Review Options** will display all retracted information as Stricken Data in narrative and PDF format, with the name/credentials of the user that retracted the document, the retract reason and date/time that the document was retracted.

Retracted Documents and retracted completed and/or signed Reports can also be viewed from **Clinical History**.

- Selecting a retracted Document or Report from the Document Tree will display the stricken information in a PDF format.

- Retracted Documents and Reports can also be viewed in Print EMR and will display highlighted in red with the Document or Report title followed by *Retracted* in PDF format. The ability for viewing scanned images/reports must include "Allow Changing Scanned Docs" security.

***NOTE:*** *Retracted documents in Print EMR displays the following prompt when selected: "Electronic File Warning: The electronic file you selected has been deleted. You have permissions to view this file for historical purposes. Do NOT make clinical decisions based on the information in this file and do NOT disseminate this information to others. I have read the statement above and ○ I agree or ○ I disagree."*

# Chapter 10 Reports

## 10.1 Overview

Documentation Reports allow facilities to create custom reports that may be generated based off of Documentation documents. This chapter will cover generating, completing and signing Documentation and Multi Visit Reports.

## 10.2 Generating Reports

To generate Documentation or Multi Visit Report, select New Reports or Current Reports from the Document Tree.

- Reports that have been assigned to the department will be listed under the **New Reports** folder. See the Documentation Setup User Guide for Report Category Setup.

- Select **Report Search** to view a complete list of available reports.

The Report List screen will display a maximum of 250 Documentation Reports at one time.

Select the type of report from the Report Type drop down. The following options are available:

- **All:** Pulls up a list of all active reports

- **Documentation Report:** Displays only active documentation reports. Documentation Reports generate from documentation that was documented during the current visit of a patient's chart. Applications and sections/question may be set up to pull information into a Documentation report. See the Documentation Setup User Guide for additional information.

- **Multi Visit Report:** Displays only active multi visit reports. Multi Visit reports generate from documentation from several visits into one report to follow the care of OB patients, Diabetic patients, Coumadin patients and etc. Sections, questions and report applications may be pulled from Documentation into a Multi Visit report. When viewing documentation in the grid view, longer answers containing more than 15 characters are denoted with trailing periods. Hovering over the cell opens a tool tip that will display the full answer. See the Documentation Setup User Guide for additional information.

**Double-click** the report title to generate the report or select the report, then choose the **Select** option from the action bar. A progress bar will display to show the current status of the report generation as well as the title of the report that is currently being generated.

The Documentation report will be broken down into sections with bold headings, and all documentation that has been recorded for the specific section will display.

- Sections that pull from Documentation documents will display the Section Type as the bold heading and a sub header will display the document description it was pulled from. For example, a Review of Systems section from a Fever document will display Review of Systems in bold with Fever displaying below as a sub header. For documents that are multi-complaint, the Section Type will display in bold as the header with a sub header for each document description included in the multi-complaint. The data pulled from that section will display below its corresponding document title sub header.

- If no documentation has been recorded for a section, the text “No Documentation for This Section” will display. The report will pull documentation based on the date/time filters set within the Report Settings. For additional information please see Report Document Settings within Documentation Setup.

Multi Visit Reports will display in a view only grid view with a column for each date documentation was entered on the different visits that are pulling to the report.

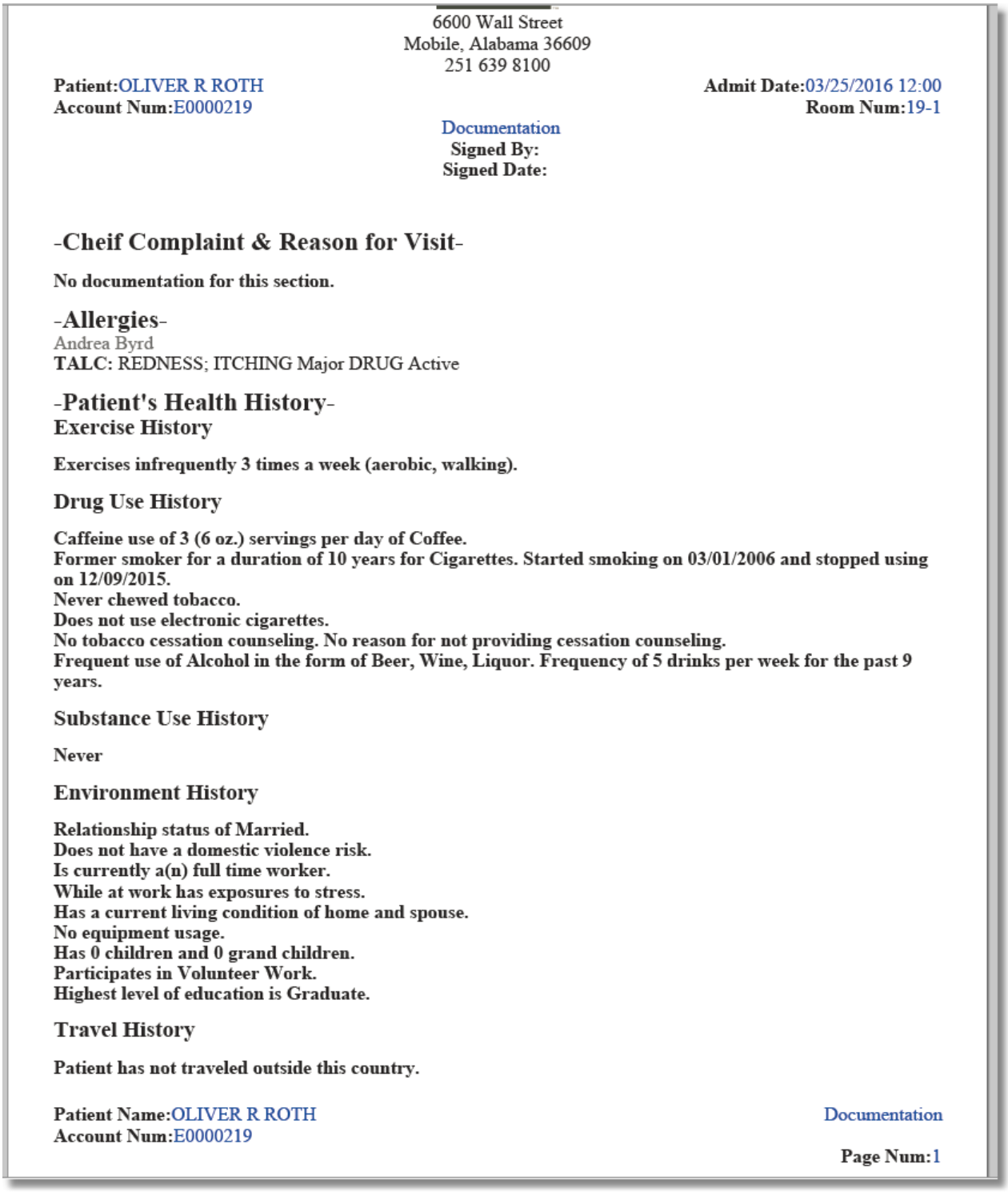
- The information that displays within both the Documentation and Multi Visit Reports may also be filtered through Review Options.

- Select **Review Options** from the action bar to filter the results. See Review Options 65 for more additional information.

- Once all filters have been applied, select Process.

- Select **View PDF** to view the filtered report in PDF format.

Select **Patient Chart** > **Documentation** > **Reports** > **New Report** > **Review Options** > **View PDF**



6600 Wall Street
Mobile, Alabama 36609
251 639 8100

**Patient:**OLIVER R ROTH
**Account Num:**E0000219

**Admit Date:**03/25/2016 12:00
**Room Num:**19-1

Documentation
**Signed By:**
**Signed Date:**

## -Cheif Complaint & Reason for Visit-

**No documentation for this section.**

## -Allergies-

Andrea Byrd
**TALC:** REDNESS; ITCHING Major DRUG Active

## -Patient's Health History-

### Exercise History

**Exercises infrequently 3 times a week (aerobic, walking).**

### Drug Use History

**Caffeine use of 3 (6 oz.) servings per day of Coffee.**
**Former smoker for a duration of 10 years for Cigarettes. Started smoking on 03/01/2006 and stopped using on 12/09/2015.**
**Never chewed tobacco.**
**Does not use electronic cigarettes.**
**No tobacco cessation counseling. No reason for not providing cessation counseling.**
**Frequent use of Alcohol in the form of Beer, Wine, Liquor. Frequency of 5 drinks per week for the past 9 years.**

### Substance Use History

**Never**

### Environment History

**Relationship status of Married.**
**Does not have a domestic violence risk.**
**Is currently a(n) full time worker.**
**While at work has exposures to stress.**
**Has a current living condition of home and spouse.**
**No equipment usage.**
**Has 0 children and 0 grand children.**
**Participates in Volunteer Work.**
**Highest level of education is Graduate.**

### Travel History

**Patient has not traveled outside this country.**

**Patient Name:**OLIVER R ROTH
**Account Num:**E0000219

Documentation

**Page Num:**1

**PDF View of Report Documentation**

Once a Documentation Report or Multi Visit Report has been opened on a patient's account, it will appear under the Current Reports option in the Document Tree. This will allow the user to quickly

regenerate the report if needed. If the user attempts to open a report that has already been generated on a patient's account, the following prompt will display: "The selected report already exists. How would you like to proceed?"

The following options are available for selection:

- **Open New:** Allows an additional report to be generated and lists under the Current Reports folder on the patient's account.
- **Use Current:** Allows the existing report to regenerate and updates the generated date/time. This option will only display one copy of the report in the Documentation Tree.
- **Exit:** Allows the user to move back to the previous screen without generating a new report.

## 10.3 Completing Multi Visit Reports

Completing a Multi Visit Report will not only complete the report but it will stop the report from pulling forward to any of the patient's subsequent account stays. Once a Multi Visit Report is completed on a visit, it will also complete the report on all previous visits from which the report was pulling information. The Multi Visit Report will move from the Current Reports folder to the Complete folder and may be reaccessed from this folder.

- Select **Complete** from the action bar.

***NOTE:*** *Multi Visit reports may be completed and signed together see* *Signing Documentation* 78.

- If the report needs to be regenerated after it has been completed, select amend to move the report back to the Current Reports folder.

## 10.4 Completing Documentation Reports

Completing a documentation report will allow a new version of the report to be created.

- Select **Complete** from the action bar.
- When the documentation report is completed, it will move to the Completed Folder and may be reaccessed from this folder. If the documentation report needs to be regenerated, a new report must be opened from the New Reports Folder.

***NOTE:*** *Documentation reports may be completed and signed together see* *Signing Documentation* 78.

- To print the completed report, select **Print Document**.

## 10.5 Review Options

Review Options may be selected to apply data display parameters.

- Select **Review Options** from the action bar.

- **Section filters** may be applied by a selected section from the Filter by Selected Sections menu on the left side of the screen.

- **Date and Time filters** may also be applied to the documentation report.
  - **Entire Stay** will show all documentation that has been recorded on within the visit.
  - **Hours** will allow a specific hour range to be entered, and only data that was documented within this range will display.
    - Select the radio button next to Hours, then type the number of hours in the Hour text-box to the right.
  - **Days** will allow a specific number of days to be entered, and only data that was documented within this range will display.
    - Select the radio button next to Days, then type the number of days in the Day text-box to the right.
  - **Date Range** will allow the user to select a beginning date and an ending date. Only data that was documented within the designated date range will display.
    - Select the radio button next to Date Range, and type the beginning and ending dates or select the dates using the calendar date pickers.

- **User filters** may also be applied to limit the data that is displayed. The documentation report will default to display documentation from **All Users** but may be filtered to delimit by **My Documentation** or **By Dept** when entering a three-digit department number. When documentation reports are filtered by department, only information documented while the patient was located within the selected department will display. The **By Dept** field uses the Patient Location Summary log to determine the time frame that the patient was within the selected department.

- Select the **Include Stricken** check-box to include any amended data.

- **Exclude Credentials Date/Time** allows for information to display without any user credentials and corresponding date/time stamps. The check box default is unchecked. If the document or report is already set to exclude credentials date/time from within the document settings or report settings, this check box will display as checked. It may be unchecked to display the report or document with the user's credentials date/time stamp.

- Sort By parameters may be used to sort the documentation.
  - **Date/Time** may be selected to list the information in chronological order.
  - **Section then Date/Time** may be selected to list the documentation in section order, then chronological order.

- Select **Reverse Chronological** to display the documentation in Reverse Chronological Order.

## 10.6 Retracting a Report

The ability to retract a report, that has been opened on an incorrect patient or opened in error, may be accomplished using the Retract option. The Retract option is available to all users if the report has not yet been signed or completed. Once the report has been completed and/or signed, the Retract option will be available only to the user who signed/completed the report. It is also available for users with the Clinical Documentation Behavior Control "Amend Clinical Documentation for any Login."

- Select **Retract.** The Retract Reasons table will display to allow the user to select the reason for retracting a report.
- Select the drop-down to choose the retract reason and choose select to retract the document.
- To cancel, select the back arrow. Once a retract reason and select has been chosen, the report has been retracted.

Reports will not display as Stricken once they are retracted. Only reports that have been marked as complete or signed will pull under Retracted folder on the Document Tree. To view a retracted signed or completed report, select the desired signed or completed report under Retracted on the Document Tree.

The **Retract** option is available from the Narrative View and from within Review Options. See Retracting a Document or Flowchart 68 for more information.

## 10.7 Clin Doc Documentation Status Report

The Clin Doc Documentation Status Report may be run to display all signed/unsigned and complete/incomplete Documentation documents. To access the report from the home screen, select **Reports**.

Select **Add Report**.

Select Clin Doc Documentation Status Report and select **Insert**.

Double-click the report to set the appropriate parameters. The options for Parameters are:

- **Facility:** Allows the selection the facility the information for which the report will be pulled
- **Exclude Reports:** Excludes all Documentation Documentation Reports from the report
- **Exclude Documents**: Excludes all Documentation Documentation from the report
- **Signed:** Allows the selection of pulling Signed, Unsigned or both types of documents and reports
- **Completed:** Allows the selection of pulling Complete, Incomplete or both types of documents and reports
- **Admit Date Range:** Allows the report to only include patients admitted within the entered date range
- **Include Cover Sheet:** Allows a cover sheet to be included with the report
- **Safe Mode:** Allows the report to be built when bad data is used in a field. If the report has bad data, a message will appear stating to run report using the Safe Mode. If selected, Safe Mode

will replace all of the bad characters with a **?**. This will allow the intended report to generate. The bad data may then be seen and may be corrected from the account level.

- **Output Format:** Allows the selection of the report format. The format options are HTML, PDF, XML, CSV and TXT.

***NOTE:*** *For more information on the Advanced, Sort, Load, Save, Spool, and Reset options, see Report Writer.*

Once all parameters are set, select **Run Report**. The report will display with the following columns:

- **Patient:** Displays the patient's name
  - **Number:** Displays the patient's account number
  - **Admit Date:** Displays the admit date of the account that the document or report was created
  - **Discharge Date:** Displays the discharge date of the account that the document or report was created
  - **Created:** Displays the date the document or report was created
  - **Signed Status:** Displays whether the document or report is signed or unsigned
  - **Complete Status:** Displays whether the document or report is complete or incomplete
  - **Provider of Care:** Displays the assigned provider of care for that account
  - **Attending Physician:** Displays the assigned attending provider for that account

## 10.8 Cosignature Deficiency List

The Cosignature Deficiency may be run to display any documents with a signed/unsigned Cosignature. The documents will include Documentation Documents, Documentation Reports and PhysDoc Notes.

### Accessing the Cosignature Deficiency Report

To access the report from the home screen:

1. Select **Reports**.
2. Select **Add Report**.
3. Select Cosignature Deficiency List Report and select **Insert**.

### Setting up Report Parameters

Select the report and select **Run** from the action bar or double-click the report.

The Documentation Cosignature Deficiency screen will display where the following parameters may be selected:

- **Facility**: Allows the selection of the facility for where the information of the report will be pulled.
- **Signed Date Range**: Allows the report to only include Documentation Document, Documentation Report or PhysDoc Note that were signed or unsigned within the selected date

range. The following options are available within the drop down table:
- Manual Selection (default): When this option is selected a date range must be manually selected within the two calendar picker boxes following the Signed Date Range drop down.
- Previous Day
- Previous Week
- Previous Month
- Previous Quarter
- Previous Calendar Year
- Previous Fiscal Year
- Last 7 days
- Last 30 days
- Last 90 Days

- **Department**: Allows the report to only include the selected department. Selecting the magnifying glass will display the Department List.

- **Account**: Allows the report to only include a particular patient visit.

- **Signing Provider**: Allows the report to only include the selected mid-level that has signed the Documentation Document, Documentation Report or PhysDoc Note. Selecting the magnifying glass will display a Physician search by name that may include all physicians or staff only.

- **Cosigning Provider**: Allows the report to only include the provider that has or has not signed the Documentation Document, Documentation Report or PhysDoc Note. Selecting the magnifying glass will display a Physician search by name that may include all physicians or staff only.

- **Signing User**: Allows the report to only include the user (employee or mid-level) that has signed the Documentation Document, Documentation Report or PhysDoc Note. Selecting the magnifying glass will display an employee search that may be searched by Name (default), Employee ID, Log Name or Physician ID.

- **Cosigning User**: Allows the report to only include the user (employee, mid-level or provider) that has or has not signed the Documentation Document, Documentation Report or PhysDoc Note. Selecting the magnifying glass will display an employee search that may be searched by Name (default), Employee ID, Log Name or Physician ID.

- **Cosign Status**: Allows the report to include signed and/or unsigned Documentation Document, Documentation Report or PhysDoc Note. The following options are available within the drop down table:
  - Both
  - Signed
  - Unsigned

***NOTE:*** *When using the filters for Signing Provider or Cosigning Provider, the Signing User and Cosigning User fields become disabled. When using the filters for Signing User and Cosigning User the Signing Provider or Cosigning Provider fields become disabled.*

Once all of the parameters are set, select one of the following options from the action bar:

- **Run Report**: Allows the report to be generated.
- **PDF**: Allows the report to be generated and display in a PDF format.
- **CSV**: Allows the report to be generated and display in a CSV format.

The report will display with the following rows of information:

**First Row**
- **Patient Name**: Displays the Patient's full name.
- **Visit Number**: Displays the Patient's account number that the document was cosigned or not cosigned.
- **Document Title**: Displays the Document's Description
- **Cosign Status**: Displays the status of Cosigned if the document has both signatures and Not Cosigned if it is still missing the Cosignature.

**Second Row**
- **Admit Date/Time**: Displays the patient's admit date and time.
- **Discharge Date/Time**: Displays the patient's discharge date and time

**Third Row**
- **Sign Provider/User**: Display the name mid-level that has signed the document.
- **Sign Date/Time**: Displays the most recent date and time the mid-level signed the document.

**Fourth Row**
- **Cosign Provider/User**: Displays the cosigner's Name. If it has not been cosigned this will display the name of the provider that the alert was sent too. If the alert was sent to a group it will display the group name.
- **Cosign Date/Time**: Displays the most recent date and time of when the cosigner signed the document.

A fraction and percentage of the following calculation will display at the bottom right hand corner of the screen:
- **Denominator**: Displaying the number of documents yielded by the selected filters and date range.
- **Numerator**: Displaying the number of documents in the denominator that have been cosigned.

***NOTE**: The Cosign status will depend on the last user to sign the document. For example if the document was signed then cosigned, but then amended and resigned by only the mid-level, it will have a status of Not Cosigned.*

# Chapter 11 Signing Documentation

## 11.1 Signing Documents and Reports

Providers have the ability to sign documentation or documentation reports completed during a provider's shift. Signing a document or documentation report will apply the provider's full name and credentials along with the date/time of the signature to the bottom of document or report.

***NOTE:*** *Non-providers have the ability to sign documentation and reports with the appropriate signature capability behavior control in place through Identity Management.*

Providers will only need to sign their documents or documentation reports once all documentation has been completed. If the report that is being signed is set up as a Progress Note, signing the report will count towards the MU2 Electronic Notes statistic. Please see Documentation Setup for additional information on the report setup.

Any documents or documentation reports that are signed by a provider requiring a cosignature will go to the Home Screen folder for the selected cosigner group or individual.

For any documentation that has been amended, the provider will need to resign the document or report. In the case the provider requires a cosigner, the amended documentation would be sent to the cosigner again.

- To sign a document or documentation report, select **Sign** from the action bar.

- If multiple documents or reports are opened on a patient's chart, the Multiple Document Signing Selection screen will display. The original documented that was selected for signing will display as already selected in the list when the user enters the screen.The Multiple Document Signing Selection is a "multi-select" screen that will allow multiple documents and reports to be selected.

- The following options are available on the action bar:
  - **Back Arrow:** This option will exit the Multiple Document Signing Selection screen without saving.
  - **Process:** This option will take the user to the Passphrase Screen to sign the selected documents or reports. If the user deselects or if no documents are selected, the Process option will be disabled.
  - **Select All:** This option will select all documents and reports displayed in the list.
  - **PDF:** This option will allow the selected document or report to be displayed and viewed in PDF format. Double-clicking a document or report will also display in PDF format. When multiple documents or reports are selected, the View PDF option will be disabled.

- The documents or reports may be filtered by My Documentation or Required. This options use the sticky functionality.
  - **My Documentation:** Selecting this option will display only documents or reports that have been documented by the user. Reports will be included if they have been opened and have documentation from the user.
  - **Required:** Selecting this option will display only documents or reports that are checked to

"Require Signature" in the document settings. Reports will pull if they have been opened and if they are checked "Required" in the report setup.

- Information will display as follows:
  - **Description:** This column will display the document or report title
  - **Status:** This column will display the status of the document or report as signed or unsigned.
  - **Date and Time:** The date and time that the document or report was signed will display in this column.
  - **User:** This column will display who signed the document or report.
  - **Type:** This column will display document or report.

- Select the documents that are to be signed and select Process.

- Enter the appropriate Passphrase, and if the documents or reports need to be completed, select the complete document check box. If a cosigner is required see cosigning steps below.

- Select Accept to sign the document or report.

- Information will display as follows:
  - **Enter Passphrase**: Must contain 10 characters to include a minimum of one upper case, one lower case, one alpha and one numeric character.
  - **Complete document(s) to be signed**: Defaults as selected so the document is completed at the same time as signing. If the provider does not want to complete the document or report at the time of signing, select the check box to deselect it. See Completing Documentation 67 for additional information.
  - **Additional statement with signature**: Allows the user to select a pre-defined statement which will display above the Signature line on documents and reports and will appear in the PDF version. Upon selection, the pre-defined statement will appear in the rich text box below where edits may be made. Users will not have the ability to save edits from this location, as only changes made to the existing statement will be reflected on the document and report open. Any permanent edits will need to be addressed in the Signature Statements table in Table Maintenance.
  - **Cosigner(s)**: Displays cosigner(s) selected by the user.

- Select **Accept** to sign the document or report.

- Once the signature has been accepted in the top right hand corner, **Signed** will display along with the date/time stamp the document or report that was signed.

- After a document or report has been signed, the View Signed Document option will become available for selection. The View Signed Document option will remain unavailable until a document or documentation report has been signed. The user will see a list screen of signed PDFs. Each line will include the date/time the document was signed and the name of the signer.

- Select the View Signed Document

- The list screen will default to reverse chronological order and the columns will be sortable.

- To view a document or documentation report, select the document and choose select. It will open in the PDF Viewer for the document or documentation report.

- To exit, select the back arrow.

### *Cosigning Documents and Reports*

Mid-level providers may require cosignatures on all or some of their documentation. Documentation which requires cosignature will go to the selected cosigner's Home Screen folder.

If the mid-level provider has documentation which does not require a cosignature, the mid-level provider may be set to select **No Cosignature Needed** during the signature process for those documents. When the **No Signature Needed** check box is selected, the **Select Cosigner** option and available cosigners will not be available.

If a mid-level provider requires a cosigning provider on all documents or reports, the security may be set so that the mid-level provider is subscribed to a default cosigning provider(s), or physician group, in the cosigner(s) box. The **Select Cosigner** option on the action bar will open the queue list screen for the selection of a cosigning physician or physician group.

- From the **Select Cosigner** option, the physicians or group selected from the queue's look-up screen will be displayed for the user upon returning to the passphrase prompt. Once signed, the report will be sent to the selected co-signer(s) Home Screen folder.
- If multiple individual physicians are selected, then a signature from one cosigner will not remove this document from the queue of the other selected cosigner(s). If a group is selected, then a signature from one cosigner would remove the need for any other selected cosigner(s) in that group to sign.

Select **Accept** to sign the document or report.

Once the signature has been accepted in the top right hand corner, **Signed** will display along with the date/time stamp the document or report that was signed. The signed document will contain the Electronically Signed by statement and will be available for the cosignature on the Home Screen of the specified provider.

After a document or report has been signed, the View Signed Document option will become available for selection. The View Signed Document option will remain unavailable until a document or documentation report has been signed. The user will see a list screen of signed PDFs. Each line will include the date/time and the name of the signer and cosigner .

- When selecting the **View Signed Document** from the action bar the user, date and time of the signing and cosigning provider will display from Signed Documents.

- Once cosigned, the report will contain both the Electronically Signed and Electronically Cosigned statement on the bottom of the report.

- To exit, select the back arrow.