Notes User Guide

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Version : 21

Published : February 2025

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Table of Contents

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.

Chapter 2 Overview

The Notes application is a documentation tool used by clinicians to capture a patient encounter. This can be accomplished through the use of templates, which can automatically insert data elements into a note, by using data elements alone, or through a combination of both. When Notes is opened within a patient chart, it is made up of 3 panels: **Create Note, Note List and Template Library**. The **Create Note** panel allows the user to create new notes using templates, data filters and formatting tools. The **Note List** allows the user to view existing signed notes and drafts. The **Template Library** allows the ability to view, edit or create new templates to be used within the Create Note panel.

NOTE: *Facilities outside of the United States may choose a date format of MM/DD/YYYY or DD/MM/YYYY to be used on all date fields in the Notes Application. 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.*

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.*

Chapter 3 Security for Notes

3.1 Overview

TruBridge has developed security that will create "rules" through what is called the Rule Builder to define security access for Notes to the user's login. A rule states what the "behavior" for a user must be in order to perform a particular function in Notes. How the rule is set up in the rule builder determines what the user's behavior is when accessing the Notes application and screens. Please see the System Administration User Guide for additional setup information.

3.2 Applications

Once Notes has been activated by a TruBridge Representative in the selected facility using notes, the application needs to be turned on per user following the steps below:

1. From System Administration, select the **login** to activate the Notes Application.
2. Select **Applications**.
3. Select **New** to create a rule for the Notes application.
4. From Step 1: Select **Application Code**, select **Facility**.
5. From Step 2: Select **Allow**.
6. From Step 3: Select **Application Code** and select **Add**. Next choose the **Notes** (code NT) application and select **Insert**. Then select the **back arrow** to access the rule builder screen.
7. Select **Facility** and select **Add**. Next choose the **Facility** that the Notes application was activated within and select **Insert**. Then select the **back arrow** to access the rule builder screen.
8. Select **Save** and **enter a rule title** then select **OK** to save the rule. Once the rule is created simple add it to each Login by selecting **Associate rule** and searching for the title created in step 7. Select the rule and choose **Select** to add to the selected login.

3.3 Behavior Controls

To access the Behavior controls for Notes:

Select **Web Client** > **System Administration** > **Login** > **Behavior Controls** > **New** > **Select Condition(s)** > **Select Action(s)** > **Edit The Rule Description** > **Add**

The following Note Behavior Controls are:

- **Add, Edit, and Remove Surgery**: Allows user to add, edit and remove any previously documented surgical history and procedures from the Surgical History filter within Notes.
- **Surgery Read Only:** Allows the user to have view only access to the Surgery History filter within Notes and the Procedure card within Patient Data Console. From the Notes application, the plus icon in the Surgery History filter will not display only allowing the user to insert the filter into the Create Note panel. From Patient Data Console, the user will not be able to enter or edit any data within the Procedure card.
- **Add and Update Chief Complaint**: Allows the filter to display within the Create Note panel and allows the user to be edit the Chief Complaint from within Notes.
- **Chief Complaint Read Only:** Allows the user to have view only access to the Chief Complaint filter within Notes and the card within Patient Data Console. From the Notes application, the plus icon in the Chief Complaint filter will not display only allowing the user to insert the filter into the Create Note panel. From Patient Data Console, the user will not be able to enter or edit any data within the chief complaint card.
- **Copy Forward Notes**: Allows users the ability to copy forward signed notes.
- **Edit other people's draft note**: Allows users to edit unsigned notes that are created by another user.
- **View other people's draft note**: Allows users to only view another user's unsigned notes.
- **Edit other people's signed Notes**: Allows users to edit another user's signed notes.
- **Edit own signed Notes**: Allows the user to edit their own signed notes.
- **Note Viewing Access**: Allows the user to view notes available within the Note List panel.
- **Note Creation Access**: Allows the user to select Create Note to start the process of creating a note on a patient account.
- **Notes CCDA Text Field**: Allows the user to access all options within the Medical Summary Field data set. Medical Summary Fields allow the information documented within the selected filter to pull to the corresponding section on the CCDA. The following filters are available:
  - o Assessment
  - o Hospital Course
  - o Plan

- **Template Administrator Access**: Allows the user to view, create new templates, use and delete existing templates.
- **Template Creator Access**: Allows the user to view, create new templates and use existing templates.
- **Template Library Access**: Allows the user to view and use existing templates.
- **Access to custom and canned filters**: Allows access to the TruBridge EHR Default filters within the Create Note panel and allows the ability to set up custom filters. If a user has this behavior control set to allow, they will not need the Access to canned filters behavior control.
- **Access to Notes Admin Tool**: Allows access to the Notes Admin option within Table Maintenance.
- **Access to canned filters**: Allows the ability to view and access the TruBridge EHR Default filters within the Create Note panel. This will display all filters within the Create Note panel except for the Chief Complaint filter and Notes CCDA Text Field filter.
- **Import CPSI Notes Templates**: TruBridge Use Only.
- **Mark Other people's signed note erroneous**: Allows a user to mark another user's signed note erroneous.
- **Allow no cosignature required option**: Allows the option 'No Cosigner' to display within the Cosigner list in the Create Note Panel. If set to deny, the 'No Cosigner' option will not display within the cosigner drop down listing.
- **Phrases Administrator Access**: Allows access to view, create, edit existing phrases and delete phrases regardless of who created the phrase.
- **Phrases Creator Access**: Allows access to view published phrases, view unpublished phrases created by the logged in user, edit phrases created by the logged in user and delete phrases created by the logged in user.
- **Phrases Library Access**: Allows access to the Phrase Library and view only published phrases.
- **Phrase Search/Insert Access**: Allows the user to insert and search the phrases from the Create Note panel.
- **Add addendum to other people's signed note**: Allows the user to add an addendum to another user's signed note without being able to edit that user's note.

The following controls are for Patient Data Console and do not currently affect the Notes application:

- **Add/Edit/Remove Allergy**
- **Enter Historic/Resolved Problems**
- **Problems Read Only**
- **Add/Edit/Remove Problems**

Once the Notes application is set to active the following defaults will be added to each role:

System Administrator

- o Access to custom and canned filters
- o Access to Notes Admin Tool
- o Add, Edit, and Remove Surgery
- o Copy Forward Notes
- o Edit other people's draft note
- o View other people's draft note
- o Edit other people's signed Notes
- o Edit own signed Notes
- o Note Creation Access
- o Note Viewing Access
- o Notes CCDA Text Field
- o Phrases Administrator Access
- o Phrases Creator Access
- o Phrases Library Access
- o Phrase Search/Insert Access
- o Template Administrator Access
- o Template Creator Access
- o Template Library Access

Provider

- o Access to custom and canned filters
- o Add/Edit/Remove Allergies
- o Add/Edit/Remove Problems
- o Add, Edit, and Remove Surgery
- o Allow no cosignature required option
- o Copy Forward Notes
- o Edit other people's draft note
- o View other people's draft note
- o Edit other people's signed Notes
- o Edit own signed Notes
- o Mark Other people’s signed note erroneous
- o Note Creation Access
- o Note Viewing Access
- o Notes CCDA Text Field
- o Phrases Creator Access
- o Phrases Library Access

- o Phrase Search/Insert Access
- o Template Administrator Access
- o Template Creator Access
- o Template Library Access

Registered Nurse and Licensed Practical Nurse

- o Access to canned Filters
- o Add/Edit/Remove Allergies
- o Add, Edit, and Remove Surgery
- o Copy Forward Notes
- o View other people's draft note
- o Enter Historic/Resolved Problems
- o Edit own signed Notes
- o Note Creation Access
- o Note Viewing Access
- o Notes CCDA Text Field
- o Phrases Creator Access
- o Phrases Library Access
- o Phrase Search/Insert Access
- o Template Creator Access
- o Template Library Access

Nursing Staff and Clinic Staff

- o Problems Read Only
- o Chief Complaint Read Only
  - o Phrases Creator Access
  - o Phrases Library Access
  - o Phrase Search/Insert Access

Chapter 4 Accessing Notes

To Access Notes:

1. From Charts, select a patient.

2. Select **Notes** from the navigation panel.

At the top of the window, the patient name is displayed, along with the date of birth and visit number (account number). The logged in user's name will display in the top right hand corner, along with an activity indicator. The activity indicator is a visual indicator of the current status of the application activity. When there is a lot of activity within the Notes application, a yellow or red indicator will display. This allows the user to know they may experience some delay to real time updates. A green indicator means activity and data is populating quickly without much delay. Notes is organized into 4 panels:

- **Create Note**: Allows the user to create new notes using templates, data filters and formatting tools. Please see Create Note 10 for additional information.

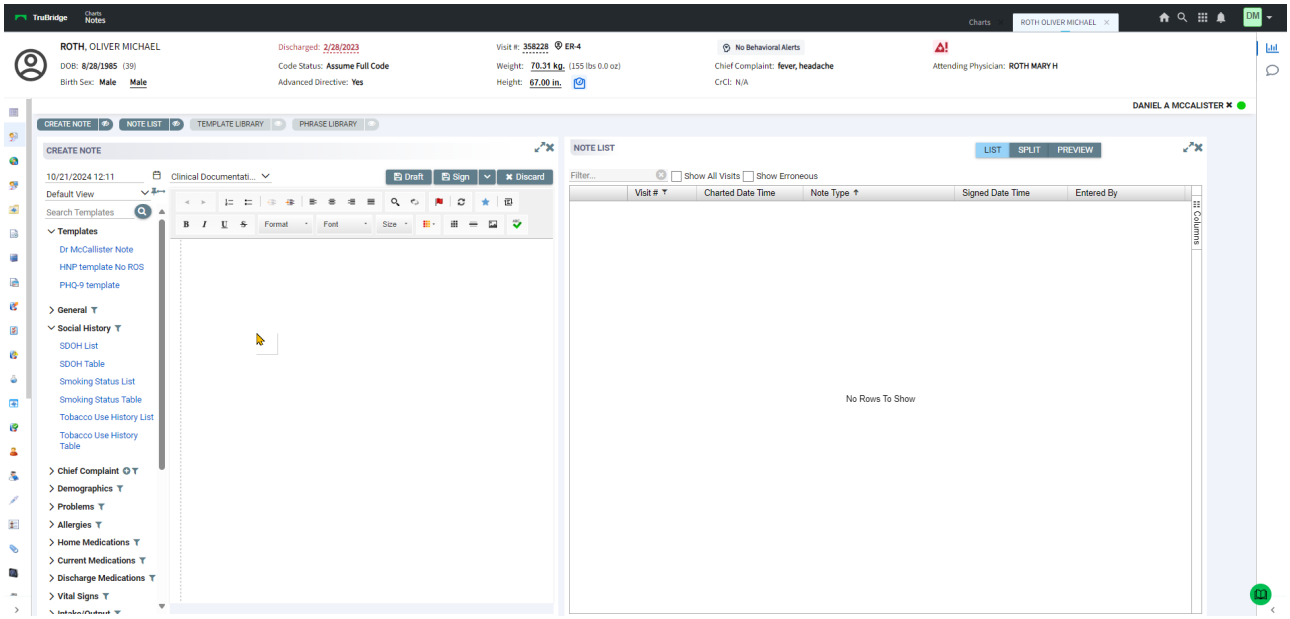
- **Note List**: Allows the user to view existing notes and drafts. From this panel notes may be edited, add an addendum and mark notes as erroneous. Please see Note List 43 for additional information.

- **Template Library**: Allows the ability to view, edit or create new templates to be used within the Create Note panel. Please see Template Library 51 for additional information.

- **Phrase Library**: Allows the ability to view, create and edit phrases that may be used within the Create Note or Create Template panels.

The Create Note and Note List panels display when Notes is accessed on a patient's account. The scroll bar at the bottom of the screen may also be used to move across the panels. Selecting  will close a panel and selecting will display a panel.

Select **Charts > Patient > Notes**



Notes

Chapter 5 Create Note

5.1 Overview

The Create Note panel is used to create notes for the patient visit. Creating notes within the Notes application is based on using templates and importing data through the use of filters.

5.2 Create a Note

1. From a patient visit, select **Notes**.

2. The Create Note panel will display by default, or select the **Create Note** option that displays below the Patient information.

3. **Review and set the Date/Time**. The date and time for the note will default to the current time. To modify, select the **date/time field** and enter the desired date/time.

4. Select the **Note Type** from the drop-down. A favorites list may be created to allow the user easy access to the Note Types they use most often. Select the star icon next to a note type to select it as a favorite. The user's favorite Note Types will display at the top of the list. A default note type may also be designated by selecting the Default icon. Once a default Note Type is selected, it will dispaly as the Note Type when the Create Note panel is opened. If a Note Template is inserted and has a Note Type associated with the template, the associated Note Type will override the Default Note Type. Selecting the blank space at the top of the drop down will clear out the Note Type. The Note Type table is maintained in the Note Type table within the Notes area of Tables. Please see the Table Maintenance - Notes user guide for additional information.

5. Select a **Filter View.** Using the drop-down list, select a filter view. A filter view determines which filters display in the left navigation panel. The TruBridge EHR default is called **Default View** and is available for all facilities.This view may be edited. The **My Favorites View** displays any filters selected as favorites within the Filter Toolbox. See Filter Toolbox within the Table Maintenance User Guide for additional set up information.

6. When the **thumb tack** icon is selected, it will collapse the filter navigation panel. The panel may be accessed by hovering over the words **Insert Into Note.** Select the thumb tack icon again to display the panel. See Filters 23 for additional information on adding filters.

7. The **double sided arrow** allows the navigation panel to move from the right to the left side of the note. Selecting the double sided arrow again will move it back to the left side.

8. From within the **Template** filter, the following options are available for selecting a template:
   - Select a template that displays as a favorite within the Template section. To open the template favorites, select the icon beside the word Templates. This selection will be sticky and the templates will remain displayed until the icon is closed again. Templates that are selected as a favorite will display in alphabetical order. See Template List 51 for favorite template setup options. The selected template will insert where the cursor is placed within the note field and may be edited as needed. If a template contains a filter and it fails to load for any reason, a red text

error will display indicating that an error occurred and indicate the number of filters that failed to load. The filters that fail/error will display in the Create Note panel with a pink background to alert the user to select the filter to refresh, replace the filter using the swap icon or remove the filter that has failed from the note. The failed filters will need to be updated or removed prior to signing a Note. Users may save the note as a Draft if the filter cannot be corrected at that time.

- Search for a template using the Template Search field. Type the desired text within the **...search across name and author** field and select **Enter** or select the **Magnifying Glass** to display the results in a drop down list. The selected template will insert where the cursor is placed within the note field and may be edited as needed.

9. If a template is selected, the template may have  Anchors. The cursor will default to display in front of the first anchor in the template. Select F2 to move to each anchor and add any needed documentation, or delete the anchor if no documentation should be added. If not using templates, or if additional details need to be added to the note, simply begin typing in the note field. Selecting F2 will also toggle to List Phrases that do not have a default answer. See below for additional information on anchors and formatting options.

   NOTE: *If the template inserted does not have any anchors, the cursor will automatically be placed at the bottom of the template.*

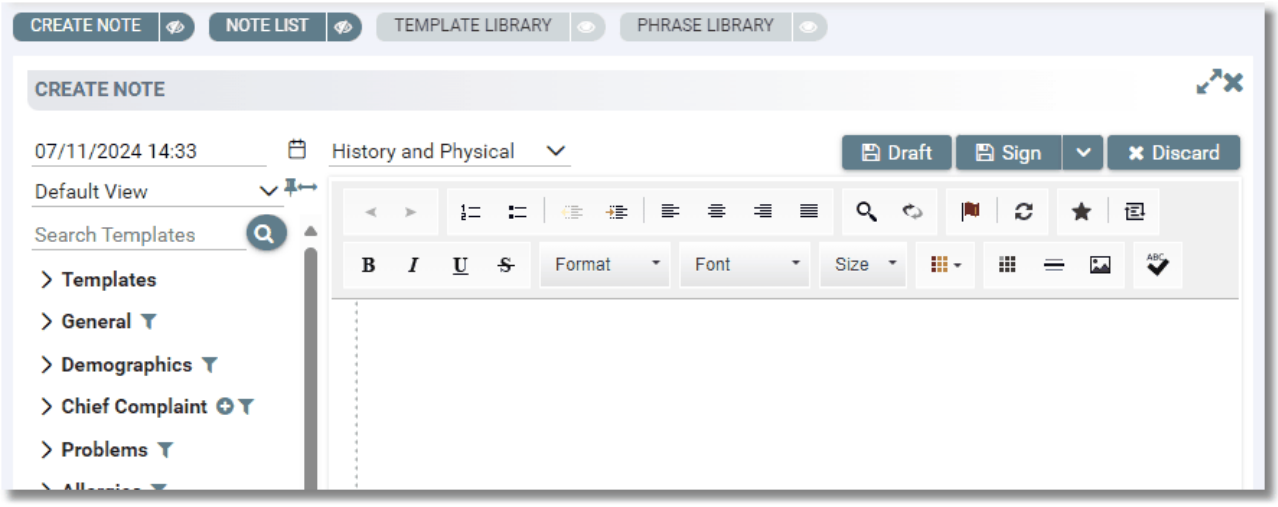
10. The filter view has been updated. Filters can be drag and dropped into the order of the user's desire. They can also be opened or closed. The changes that are made will stick and will remain until the user decides to change them again.
11. Note phrases may entered within a note to allow quick entry of additional information such as filters, template, list or text by entering a backslash (/) followed by the phrase. The  Favorite Phrases icon within the formatting tools will display the user's favorite phrase listing when inserting a Note Phrase into the Note field. When selected, the star will display blue and prior to typing the Note Phrase, the Phrase List will be limited to the user's favorite phrase listing. Deselect the Favorite Phrase option (black star) to view the full phrase search listing. This option will stay selected until the user chooses to deselect the Favorite Phrases icon. For additional information on inserting a phrase see Insert a Phrase 14.

12. After all documentation is completed, select **Sign** to sign the document or **Draft** to save without signing. Selecting **Discard** will delete the note without saving. A note type must be selected and all anchors must be addressed prior to signing. If a user requires a cosigner please see Selecting a Cosigner 19 for more information. Additional options are available within the Sign option when a facility has purchased Communication Center and are using Web client. This will allow a note to be sent to the Communication Center for faxing, or internal mail. The options will also be available when a signed note is edited and resigned, or if an addendum is added to a signed note. The note will attach as a reference link and when the recipient receives the communication selecting the link will display the note. Within the Sign option, selecting the **More** icon  will display the following options:
    a. **Sign and Fax**: When selected, the note will be signed and open the Communication Center to complete the process for the fax to be sent.
    b. **Sign and Mail**: When selected, the note will be signed and open the Communication Center to complete the process for mail to be sent.

NOTE: *A user will only have access to the additional options within Sign if they have the appropriate Application permissions for Communication Center - Faxing or Messaging.*

NOTE: *The note will auto save as a draft every 30 seconds. This is the default setting. The last auto save date and time will display in the bottom right hand corner of the Create Note panel. If the note is selected to close prior to an auto save or* ***Draft*** *being selected, the following message will display: THERE ARE UNSAVED CHANGES! Any changes you made will be lost, do you want proceed? Select* ***Close Panel*** *to proceed without saving or* ***Cancel*** *to re-access the Edit Note panel to save changes. The first auto save will push the draft note to the users homescreen.*

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Create Note**



Create Note

The following formatting options are available within the note field:

- **Undo**: (Control Z) Allows the last action performed to be reversed.
- **Redo**: (Control Y) Allows the last Undo action to be reversed. This option becomes enabled once an Undo action has been performed.
- **Number List**: Allows the creation of a numbered list.
- **Bullet List**: Allows the creation of a bulleted list.
- **Decrease Indent:** Allows the indent inserted to be removed. This option becomes enabled once an Increase Indent action has been performed.
- **Increase Indent:** Allows an indent to be inserted into the note.
- **Align Left**: Allows each line of text to begin on the left margin of the note. This is the default alignment option.
- **Center**: Allows each line of text to be centered within the note.
- **Align Right**: Allows each line of text to align on the right margin of the note.
- **Justify**: Allows each line of text to fill the entire space from left to right, except for the paragraph indent and the last line of a paragraph.
- **Find**: Allows a word or phrase to be located within a note
- **Replace**: Allows a word or a phrase to be replaced within a note.
- **Anchor**: Allows a place holder for a user to quickly move through a note by selecting **F2** to add additional information. If no additional documentation needs to be added, select the anchor and

remove it from the note. An anchor count will display in the top right hand corner of the note to alert the user of how many anchors need to be addressed within the note. All anchors must be addressed prior to signing.

- **Refresh Filters**: Allows any data set that has been added to update with the latest information entered within TruBridge EHR.
- **Bold**: Allows the text to display as bold.
- **Italics**: Allows the text to display as italicized.
- **Underline**: Allows the text to be underlined.
- **Strikethrough**: Allows the text to appear as crossed out.
- **Paragraph Format**: Allows changes in the format of text that affects an entire paragraph.
- **Font Name**: Allows the change of the style of text.
- **Font Size**: Allows the size of the font to be changed.
- **Font Color**: Allows the color of the font to be changed.
- **Table**: Allows a custom table to be inserted. See Setting Up a Table for more information.
- **Insert Horizontal Line**: Allows a horizontal line to be inserted.
- **Image**: Allows an image to be inserted into the note. Once an image is opened, select **Choose File** to import a photo from the PC. Once photo is selected, select **OK** to import the photo. The Advanced tab allows the user to manually adjust the size of the photo.
- **Medical Spell Check**: Allows the Create Note field to be checked for medical misspelled words once the Medical Spell Check option is selected. The Spell Check screen will display the first misspelled medical word in red, with the other misspelled words displaying in bold. The following options will be available within the Spell Check screen:
  - To correct the spelling of a word, select the word from the suggested list or type in the correct spelling in the **Change word 'spellchecker' to…** field. Then select **Change All** to correct all misspellings of that word.
  - **Ignore All**: Allows dismissal of the notification for all the medical misspelled word(s) in the note.
  - **Add to Dictionary:** Allows the word to be added to the facility dictionary.
  - **Manage Dictionary:** Allows the words to be added or removed from the facility dictionary. The Manage Dictionary screen will display the following options:
    - Enter the word that should be added in the **Word to add or remove** field. Then select **Add**.
    - To remove a word from the dictionary, select the word and select **Remove**.
    - Select **Close** to return to the Spell Check screen.
  - **Done:** Allows the Spell Check screen to be exited and returns to the Create Note field.

***NOTE**: Selecting F2 will also toggle to EMPTY list phrases and anchors in the note. The Anchor Count that displays at the top of the note will not include the empty list phrases and will only continue to count the number of anchors that display within the note.*

Selecting the **double sided arrow** in the top right hand corner of the Create Note panel will display the Create Note panel full screen. Selecting it again will re-collapse it within the 3 panel view.

Selecting the **X** in the top right hand corner of the Create Note panel will close out the panel. The following prompt will display if sign or draft has not been selected: "THERE ARE UNSAVED CHANGES! Any changes you made will be lost, do you want to proceed?" Selecting **Close Panel** will continue closing the panel without saving and selecting **Cancel** will reopen the Create Notes panel.

Insert a Phrase

Enter a backslash (\) and the phrase. At least three characters must be typed after the backslash.The Phrase Search will return a listing of the first 25 matches of the text from the typed letters from the search in bold. When a phrase is hovered over in the list, the Note Phrase Title will display along with the Note Phrase. If the phrase does not display in the list, select **See More** to display an additional 25 or enter additional characters.
There are 4 types of phrases that may be entered; a text, list, template or data filter.

When inserting a large text phrase, template phrase or data filter phrase into a note, a loading indicator will display next to the phrase alerting the user that the phrase is loading and will insert that data once the load is complete.

When inserting a List Phrase, select **Empty**, the **Default Answer** or **down arrow** to select the answer from the list. The Note Phrase, Title and Description will display at the top of the List Phrase Screen. More the one answer may be selected. Change EMPTY will allow a free text answer to be entered. When data is free text within a List Phrase, this is not permanently added to the list. Then select **Change** to enter the selected items.When a listing has been inserted into a Note more than once, the user may choose to change the previously selected options to the current option by selecting **Change All**. A List Phrase without a default answer will display with the word EMPTY in red font with a red dashed line beneath the word to alert the user that it needs to be addressed. When a user tries to sign a note without addressing a list phrase with the word EMPTY, the list phrase will place a red box around EMPTY with a light red background to alert the user it needs to be addressed. List phrases must be addressed prior to signing a note. List phrases may be inserted into a Create, Draft, Edit and Addendum panels. List Phrases may also be used in Text Phrases and Templates.

NOTE: *If information that is entered via Change EMPTY on a List phrase, that information needs to be edited and should be completed with the note field and not the List Phrase. If the down arrow is selected on the List Phrase, the Change Empty field will display blank.*

Once a phrase has been inserted into the note, if the user attempts to search for the phrase again it will display in a green highlight with a green check mark in front of the title to visually let the user know this phrase is already inserted into the current note. A phrase may be used more than once within a note if needed.

NOTE: *If a template has been deleted after it was attached to a phrase, it will not be inserted into a Note. Users will receive a notification that the template has been deleted.*

When creating a Note, it may be selected and converted into a Text Phrase. To create a Text

Phrase, highlight the needed text and then select  **Create Text Phrase** from the formatting tools. Only items that are text may be converted into a Text Phrase. Filters, tables or images and some pasted text may not be able to be converted. If a highlighted item cannot be converted, a red message will display. Prior to highlighting and selecting the Create Text Phrase option, all Create Phrase Panels should be closed. See Create a New Phrase 64 for completing the Text Phrase.

Setting up a Table

To insert a table, place the cursor in the note field where the table should display. Then select the table icon. Set the number of rows, columns and any other properties as needed following the steps below:

1. Enter the number of rows and columns needed within the **Rows** and **Columns** fields.

2. Select where the table **Headers** should display from the drop down. The following options are available:
   a. First Row
   b. First Column
   c. Both

3. Enter a **Border Size** if the table should have borders around the table cells.

4. Select the **Alignment** of the table from the drop down. The following options are available:
   a. Left
   b. Right
   c. Center

5. Address the table **Width** and/or **Height** within the corresponding fields. The dimensions should be entered in as pixels or a number with a valid CSS unit (px, %, in, cm, mm, em, ex,pt or pc). The default is 500 px.

6. Enter the **Cell spacing** and **Cell padding** in pixels, e.g., 1. This affects the amount of white space surrounding the text entered within the table.

7. Next, enter a **Caption** to label the table**.** The caption will display at the top of the table.

8. The **Summary** option is currently TruBridge Use Only.

9. Select **OK** to create the table, or **Cancel** to exit the table properties without saving.

After selecting OK, the newly created table will display within the note field.

***NOTE**: For advanced setup please see Advanced Settings 17.*

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Create Note** > **Table**

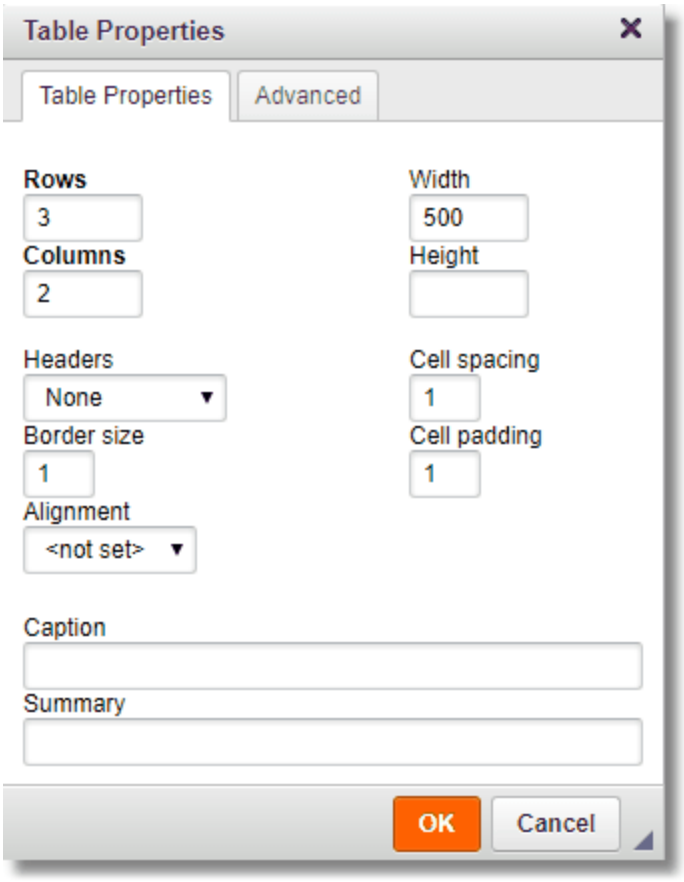


Table Properties

Once the table has been created, the Rows and Columns will not be able to be edited within the Table Properties. To edit the table cells, right-click on the table or individual to open the menu. The following options are available:

- **Paste** allows the items saved to the users clip board to be inserted into the selected cell.

- **Cell** allows the following actions to be made within the selected cells:
  - **Insert Cell Before**: Inserts a new cell before the selected cell.
  - **Insert Cell After**: Inserts a new after the selected cell.
  - **Delete Cells**: Deletes the selected cell.
  - **Merge Cells**: Merges the selected cells into one. This option is only available if two or more cells are selected.
  - **Merge Right**: Merges the selected cell with the cells on its right. The content of both cells become joined. This option is only available if only one cell is selected.
  - **Merge Down**: Merges the selected cell with the cell below it. The content of both cells become joined. This option is only available if only one cell is selected.
  - **Split Cell Horizontally**: Splits the selected cell into two, creating a new cell to the right of the selected cell. The content of the selected cell will display in the original cell. This option is only available if only one cell is selected.

  - o **Split Cell Vertically**: Splits the selected cell into two, creating a new cell below the selected cell. The content of the selected cell will display in the original cell. This option is only available if only one cell is selected.
  - o **Cell Properties:** Displays the Cell properties table which allows the cells to be configured by size, type, color and content alignment. Please see Cell Properties 18 for additional information.

- Selecting **Row** allows the rows to be **Inserted Before** before the selected cell or **Insert Row After. Delete Rows** allows the row(s) containing the selected cell to be deleted. If a cell from each row is selected and then Delete Rows is selected the entire table will delete.

- Selecting **Column** will allow a column to **Insert Column Before** or **Insert Column After** the selected column. **Delete Columns** will delete the columns of the selected cells. If a cell from each column is selected and then Delete Columns is selected, it will delete the entire table.

- Selecting **Delete Table** will delete the entire table.

- Selecting **Table Properties** will reopen the table properties menu listed above.

Advanced Settings

The following options are available within the Advanced tab of the table properties:

- **Id**: Creates a unique identifier for a table element in the note.

- **Style**: Displays the CSS style definitions. Each value must end with a semi-colon and individual properties should be separated with spaces.

- **Language Direction**: Displays the direction of the text in the table. The following options are available:
  - o Left to Right
  - o Right to Left

- **Stylesheet Classes**: Displays the class of the table element. If the table is assigned more than one class, separate each class with a space.

Editing Table Cells

Once the table has been created, the Rows and Columns will not be able to be edited within the Table Properties. To edit the table cells, right-click on the table or individual cell to open the menu. The following options are available:

- **Paste** allows the items saved to the users clip board to be inserted into the selected cell.

- **Cell** allows the following actions to be made within the selected cells:
  - o **Insert Cell Before**: Inserts a new cell before the selected cell.
  - o **Insert Cell After**: Inserts a new cell after the selected cell.
  - o **Delete Cells**: Deletes the selected cell.
  - o **Merge Cells**: Merges the selected cells into one. This option is only available if two or more cells are selected.

  - o **Merge Right**: Merges the selected cell with the cells on its right. The content of both cells become joined. This option is only available if only one cell is selected.
  - o **Merge Down**: Merges the selected cell with the cell below it. The content of both cells become joined. This option is only available if only one cell is selected.

- **Split Cell Horizontally**: Splits the selected cell into two, creating a new cell to the right of the selected cell. The content of the selected cell will display in the original cell. This option is only available if only one cell is selected.
  - o **Split Cell Vertically**: Splits the selected cell into two, creating a new cell below the selected cell. The content of the selected cell will display in the original cell. This option is only available if only one cell is selected.
  - o **Cell Properties**: Displays the Cell properties table which allows the cells to be configured by size, type, color and content alignment. Please see Cell Properties 18 for additional information.

- **Row** allows the following actions to be made within the selected rows:
  - o **Insert Row Before:** Allows a new row to be inserted before the selected row.
  - o **Insert Row After**: Allows a new row to be inserted after the selected row.
  - o **Delete Rows**: Allows the row(s) containing the selected cell to be deleted. If a cell from each row is selected and then **Delete Rows** is selected, the entire table will delete.

- **Column** allows the following actions to made to the selected column:
  - o **Insert Column Before**: Allows a new column to be inserted before the selected column.
  - o **Insert Column After**: Allows a new column to be inserted after the selected column.
  - o **Delete Columns:** Allows the selected column to be deleted. If a cell from each column is selected and then **Delete Columns** is selected the entire table will delete.

- **Delete Table**: Allows the entire table to be deleted.

- **Table Properties** will reopen the table properties menu listed within Setting up a Table 15.

Cell Properties

The following options are available within the Cell Properties table:

- **Width**: Displays the width of the cell in pixels or a percent value.

- **Height**: Displays the height of the cell in pixels.

- **Horizontal Alignment**: Allows the setting of the horizontal alignment of the content in the cells. The following options are available:
  - o Left
  - o Center
  - o Right

- **Vertical Alignment**: Allows the setting of the vertical alignment of the content in the cells. The following options are available:
  - o Top
  - o Middle
  - o Bottom
  - o Baseline

- **Word Wrap**: Allows the setting of word wrapping to be turned on or off with the following options:
  - o Yes
  - o No

- **Cell Type**: Displays whether the cell is a normal data cell or a header cell with special formatting.

- **Rows Span**: Allows the cell to stretch downward over several rows. Entering a numeric value sets the rows span attribute.

- **Columns Span**: Allows the cell to stretch to the right over several columns. Entering a numeric value sets the columns span attribute.

- **Background Color**: Sets the color of the cell background. There are two options for choosing the color:
  - o Enter the RGB value in the text box to select the color.
  - o Select the **Choose** option to open the Select Color window and then select the color from the display.

- **Border Color**: Sets the color for the border of the cell. There are two options for choosing the color:
  - o Enter the RGB value in the text box to select the color.
  - o Select the **Choose** option to open the Select Color window and then select the color from the display.

Selecting a Cosigner

Mid-level providers may require cosignatures on all or some of their notes. Notes which require a cosignature will go to the selected cosigner's Home Screen.

To select a cosigner from within Notes:

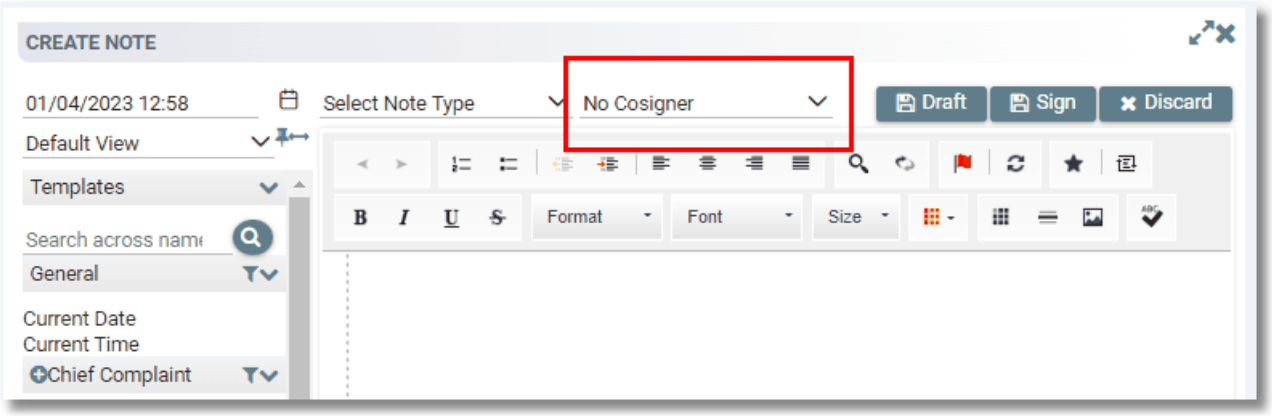
1. When a mid-level is setup to require a cosignature, an additional drop down field will display next to the Note Type where the cosigner my be selected. Select the **Cosigner** drop-down to assign the Provider that should be cosigning the note. Once the note is signed by the mid-level, this will send an alert to the selected provider's homescreen. If a cosigner is not required, the option No Cosigner is available for selection when the user has the behavior control **Allow no cosignature required option**. This will bypass any homescreen notification being sent. If a mid-level has multiple cosigners listed in the events table on their UBL, the cosigner drop-down will display in the order that the cosigners are listed within events. If a note has been returned to the mid-level, the cosign drop down on the returned note will default to the cosigner who returned the note.

2. Select **Sign** to sign the Note, a green success message will display in the upper right hand corner that the selected action was successful.

Multiple Cosigners may sign a single note. The **note PDF** will now display all signatures in chronological order of when the note was signed.

***NOTE**: If a mid-level who requires a cosignature edits or adds an addendum to a note that has already been cosigned, the full note will be resent to the cosigner for a signature. The cosign log will display each cosign action. If an addendum is added to a cosigned note, the cosign log will display within the addendum.*

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Create Note**



Selecting a Cosigner

Cosign Log

Once the note has been signed by the mid-level and a cosigner was selected, the note will display in the Note List panel as signed. A Cosign Log will display with a status at the top of the note when Split or Preview is selected. When the status of the Cosign log is selected the following information will display: Who requested the cosign and the date/time the request was sent. If the cosign was returned the reason for return will also display. If the  Cosign Log is selected a history of actions will display in the following columns:

- **Type**: Displays the following type of cosignature actions:
  - o **Cosign Request**: Displays when a mid-level has requested a cosignature on a note.
  - o **Cosign Completed**: Displays when the provider has cosigned the note.
  - o **Cosign Returned**: Displays when the provider returned the cosignature request to the mid-level whom requested it. The reason for return will display within the Reason column.
- **Author**: Displays the name of the user requesting the action listed within the Type column.
- **Date**: Displays the date of when the action was requested.
- **Reason**: Displays the return reason when a cosignature request has been returned by the provider.

5.3 Create a Note from Another Note

To create a note from another note:

1. Select **Note List**.
2. Select a note.
3. Select the **Copy Forward** option.
4. A Create Note panel will display. The note type will copy forward from the previous note, and this may be edited if needed. Any needed modifications can be added to the note.
5. Select **Draft** to save the note or **Sign** to complete the note, a green success message will display in the upper right hand corner that the selected action was successful.

***NOTE**: Filters will automatically update with current data on the patient's account when copy forward is selected.*

***NOTE**: Copy Forward is not available from a note on the current visit to a note from a past account.*

5.4 Edit a Draft Note

To Edit a Draft Note:

1. Select **Note List**.
2. Sort the **Signed Date Time** column in ascending order. The draft notes will display at the top.
3. Select the note and select **Edit**.
4. An Edit Note panel will display, add any needed modifications to the note. Select the refresh icon to update any filters. If the note is selected to be closed prior to an autosave or **Draft** being selected, the following message will display: 'THERE ARE UNSAVED CHANGES! Any changes you made will be lost, do you want to proceed?' Select **Close Panel** to proceed without saving or **Cancel** to re-access the Edit Note panel to save changes.
5. Select **Draft** or **Sign**, a green success message will display in the upper right hand corner that the selected action was successful.

***NOTE**: Only one edit panel per template ID may be opened at one time. For example, the Progress Note with the ID: 17563 has an edit panel open and the user navigates back to the Note List panel and attempts to select the Edit option from within the Progress Note with ID: 17563 the following message will display: 'Edit panel with id:17563 is already open.' The message will close and the user will be navigated back to the edit panel.*

5.5 Edit a Signed Note

To Edit a Signed Note:

1. Select **Note List**.
2. Select the signed note and select **Edit**.
3. An Edit Note panel will display, add any needed modifications to the note.
4. Select **Resign,** a green success message will display in the upper right hand corner that the selected action was successful.

NOTE: *An OUT OF DATE watermark will display on the background of the original and previously edited versions on a signed note that has been edited.*

NOTE*: Only one edit panel per template ID may be opened at one time. For example, the Progress Note with the ID: 17563 has an edit panel open and the user navigates back to the Note List panel and attempts to select the Edit option from with the Progress Note with ID: 17563 the following message will display: 'Edit panel with id:17563 is already open.' The message will close and the user will be navigated back to the edit panel.*

5.6 Add an Addendum to a Note

To Add an Addendum to a Note:

1. Select **Note List**.
2. Select the signed note and select **Add Addendum**.
3. Enter the additional information for the addendum that will display at the top of the signed note.
4. Select **Sign Addendum,** a green success message will display in the upper right hand corner that the selected action was successful.

NOTE: *If a mid-level selects* ***Add Addendum*** *on a note created by another user that has already been signed, and that user does not require a cosignature, when Sign Addendum is selected by the mid-level, a cosignature request will be sent to the original author of the note for a cosignature. The cosign log will update with Cosign Requested.*

Mark an Addendum Erroneous

To mark an Addendum Erroneous within a Note:

1. Select **Note List**.
2. Select the **signed note** with the Addendum that should be Marked Erroneous.

3. From the preview of the note, select the red **X** next to Mark Erroneous within the addendum field.

4. Select the **Mark Erroneous Reason** by choosing an option within the drop down or choosing Other which allows a free text entry.

5. Then select **Mark Erroneous** to complete the action or choose **Cancel** to exit without marking the addendum erroneous.

6. If Mark Erroneous was selected, the user will be prompted for their passphrase. Once entered, a green success message will display in the upper right hand corner. If the user has the the behavior control Capture Passphrase set as allow for their login, the passphrase will be captured for the designated amount of time and the user will only need to select Mark Erroneous to bypass the passphrase entry.

Once an addendum has been marked as erroneous the check box **Show erroneous addendum** will display. Selecting the check box will then display all addendum that were marked as erroneous in red with the Addendum Sign by date and time, the Marked erroneous date and time, reason for making the addendum erroneous followed by the original addendum text. Deselecting the check box will remove the erroneous addendum from view.

5.7 Filters

Filters are listed in the left navigation pane. They are organized into data sets such as Problems. When creating a note, users select filters from the list to insert the patient data into their note.

Using Filters:

- In the note field, select the location at which the patient data may be added and select the desired filters from the left navigation panel. The cursor must be placed within the note field or template field prior to adding a filter.

- The default setting for filters is closed. The filters for a particular heading may be opened by using the  icon.

- The filters may be repositioned to the user's preference. This can be done through a drag and drop. The filters will remain in the new position.

- Hovering over a filter allows a preview of data for one record of detail within that filter. The Vital Sign filter will only display a preview of data for one vita,l as each vital is a different record.

- The  **filter** icon allows access to the Filter Tool box which allows custom filters to be created. Please see the Table Maintenance - Notes User Guide for additional information.

- When filters are added to a Note, a spinning circle will display next to the filter header to indicate it is retrieving the filter information.

- When there is no data available for the selected filter, a statement indicating that no information is available will display next to the filter title within the note.
- Lists typically display the description of the item and tables typically display metadata for each item listed.
- The  **swap** icon is available within a filter that has been inserted into the note field. This allows the ability to access the filter toolbox and customize the filter for a specific scenario or quickly swap out filters without leaving the note field. See Swapping Filters 24 for additional information.
- To update individual filters, select the  refresh icon or right-click on the table or list of the filter and select **Refresh Filter** to update just the selected filter.
- To remove a filter that has been inserted, select the **Delete**  icon.
- The Surgical History data set allows the patient's surgical history to be edited by adding a new procedure or removing existing procedures by selecting the  **plus** sign icon. See Surgical History 34 for more information.
- Medical Summary Fields filters allow the user to pull the information documented within the filter to the patients CCDA. See Medical Summary Fields 41 for more information.

Swapping Filters

When a filter is inserted into the note field via template or manual selection from the filter list, they may be modified or replaced by selecting the Swap icon. This will allow the ability to quickly adjust the filter to display certain information for a specific scenario without having to modify the original template and/or it will also allow the ability to swap a filter for another when needed.

1. To modify an existing filter or swap a filter for another within the note field select the  **swap** icon within the filter.
2. The Filter Toolbox will display. Make any needed modifications to the existing filter or create new filter. For additional information on editing or creating custom filters please see Filter Toolbox chapter within the Table Maintenance - Notes User Guide.
3. Once the customization of the filter is complete select the  **Insert into Note** icon to display the new filter in place of the filter that previously displayed prior to selecting the Swap icon.

General

- **Current Date**: Will display today's date.

- **Current Time**: Will display the time the current time data was selected.

Demographics

- **Patient Name**: Displays the patient name in a list format.
- **Patient Name, DOB, Age**: Displays the patients name, date of birth and age in a list format.
- **Patient Age**: Displays the patient's age in list format.
- **Date of Service**: Displays the patients admit date in a list format.
- **All Demographics**: Displays the patients demographic information in a table format. The following demographic information will display:
  - o **Name**: Displays the patient's name.
  - o **Date of Birth**: Displays the patient's date of birth
  - o **Age**: Displays the patient's age.
  - o **Sex**: Displays the patient's sex.
  - o **Visit Number**: Displays the patient's current account number.
  - o **Admission Data and Time**: Displays the patient's admit date and time.
  - o **Attending Physician**: Displays the admitting physician listed on the patient's account.
  - o **Date of Service**: Displays the patient's admit date.
  - o **Room and Bed**: Displays the patient's room number.
  - o **Emergency Contact**: Displays the patient's emergency contact name and 10-digit phone number with hyphens (xxx-xxx-xxxx) listed on the patient's profile.
- **Primary Care Physician**: Displays the primary care physician listed on the patient's account.

Chief Complaint

- **Chief Complaint**: Displays the first chief complaint listed within the Reason for Visit screen in a list format.

NOTE: *The behavior control* ***Add and Update Chief Complaint*** *must be set to allow on the user's Login or role in order for the user to have access to the data set and to be able to pull the chief complaint filter into the note.*

To Add a Chief Complaint

The Chief Complaint data set allows a free text chief complaint to be added to a patient's account. Once the chief complaint has been updated from within notes, it will also update the chief complaint within the patient's chart.

1. Select the  **plus** icon next to the Chief Complaint data set or select the **plus** icon within the filter of the note field.
2. Enter the new chief complaint in the text field.

3. Select **Save** to add the chief complaint to the patient's account. Selecting **Cancel** will exit the chief complaint screen without saving.

4. Select the **X** icon to exit the chief complaint screen.

5. If the plus sign icon was selected from within the filter on the note field to edit the chief complaint, select **refresh filter** to display the updated information within the note.

Problems

- **Problem List**: Displays all active problems entered within the Physician Problem List in a list format.

- **All Problems (Active and Inactive)**: Displays both active and inactive problems entered within the Physician Problem List in a table format. The following information will display within the table:
  - **Problem**: Displays the problem description.
  - **ICD Code**: Displays the ICD-10 code. If a problem has more than one ICD-10 code, the codes will be separated by a comma.
  - **Onset Date**: Displays the onset date.
  - **Resolved Date**: Displays the resolved date.
  - **Age**: Displays the patient's age.
  - **Status**: Displays the status of the problem. The status of Active will display for problems with a status of Acute, Chronic, Recurring, Active, and Terminal. The status of Provisional will display for problems with a status of Temporary. The status of Historic will display for problems with a status of Resolved and Inactive.
  - **Comments**: Displays any comments added to the Comment field within the problem.

- **Problem Table**: Displays all active problems entered within the Physician Problem in a table format. The following information will display within the table:
  - **Problem**: Displays the problem description.
  - **ICD Code:** Displays the ICD-10 code. If a problem has more than one ICD-10 code, the codes will be separated by a comma.
  - **Onset Date**: Displays the onset date.
  - **Age**: Displays the patient's age
  - **Status:** Displays the status of the problem. The status of Active will display for problems with a status of Acute, Chronic, Recurring, Active, and Terminal.
  - **Comments:** Displays any comments added to the Comment field within the problem.

- **Treat This Visit**: Displays problems flagged as Treat This Visit within the Problem Management Card of Patient Data Console. The following information will display within the table:
  - **Problem**: Displays the problem description.
  - **Status**: Displays the status of the problem. The status of Active will display for problems with a status of Acute, Chronic, Recurring, Active, and Terminal.
  - **Comment**: Displays any comments added to the Comment field within the problem.

Custom filters may be created to add additional columns to the Problem filter. The following additional columns are available:

- **Addressed Date**: Displays the date entered within the Addressed Date field on the problem from the Problem List.

- **Group Status:** Displays the status of the problem from the Patient Data Console Problem Management Card.The column may be filtered by the following: Treating this Visit (TTV), Historic, and Active Problem.

- **Priority**: Displays the Treat This Visit, History, or Active Problems based on the individual users ranking within the Patient Data Console Problem Management card.

Allergies

- **Allergy List**: Displays the allergy description and allergy type in a list format.

- **Allergy Table**: Displays all active allergies in a table format. The following allergy information will display within the table:
  - **Allergen**: Displays the allergy description.
  - **Type**: Displays the allergy type.
  - **Reaction**: Displays the allergy reaction(s).

- **All Allergies (Active and Inactive)**: Displays all active and inactive allergies in a table format. The following allergy information will display within the table:
  - **Allergen**: Displays the allergy description.
  - **Type**: Displays the allergy type.
  - **Reaction**: Displays the allergy reaction(s).
  - **Severity**: Displays the allergy severity.
  - **Status**: Displays the status of the allergy: active or inactive.

Home Medications

- **Home Meds List:** Displays the patient's confirmed home medications in a list format.

- **Home Meds: Dose and Frequency**: Displays the patient's confirmed home medications in a table format. The following Home Medication information will display within the table:
  - **Medication**: Displays the medication name.
  - **Dosage**: Displays the medication dose.
  - **Frequency**: Displays the medication frequency.

- **Active Home Meds:** Displays the patient's confirmed home medications in a table format. The following Home Medication information will display within the table:
  - **Medication**: Displays the medication name.
  - **Dosage**: Displays the medication dose.
  - **Frequency**: Displays the medication frequency.
  - **Last Dose Date**: Displays the date of the last dose of medication the patient received.
  - **Prescribing MD**: Displays the provider that prescribed the medication.
  - **Special Instructions**: Displays any information entered within the Comments field on the medication within Medication Reconciliation.

NOTE: *Medication listing will display in descending alphabetical order.*

Current Medications

- **Ordered Meds Table**: Displays the current medications that have been ordered on the patient's account in a table format. The following Current Medication information will display within the table:
  - o **Ordered Medication**: Displays the medication description.
  - o **Start Date/time**: Displays the start date and time as entered within order entry.
  - o **Dosage**: Displays the dose amount of the medication.
  - o **Route**: Displays the route of the medication.
  - o **Frequency**: Displays the frequency of the medication.

- **Ordered & Completed Meds**: Displays the ordered and completed medications that have been ordered/given on the patient's account in a table format. The following Current Medication information will display within the table:
  - o **Ordered Medication**: Displays the medication description.
  - o **Start Date/time**: Displays the start date and time as entered within order entry.
  - o **Dosage**: Displays the dose amount of the medication.
  - o **Route**: Displays the route of the medication.
  - o **Frequency**: Displays the frequency of the medication.
  - o **Status**: Displays the status of the medication.

- **Ordered Meds List**: Displays the ordered medication description in a list format.

NOTE*: Medication listing will display in descending alphabetical order. In the inpatient setting, medications must be verified before they will display within the Current Medication filters.*

Discharge Medications

- **Discharge Meds List**: Displays patient's discharged medications in a list format.

- **Discharge Meds Table**: Displays the patient's discharged medications in a table format. The following Discharge Medication information will display within the table:
  - o **Medication**: Displays the name of the medication.
  - o **Dosage**: Displays the dose quantity and dose units of the medication.
  - o **Route**: Displays the route of the medication.
  - o **Frequency**: Displays the frequency of the medication
  - o **Prescribing MD**: Displays the provider that prescribed the medication.
  - o **Special Instructions**: Displays the Sig line from within Prescription entry.

NOTE*: Medication listing will display in descending alphabetical order.*

Vital Signs

- **Vital Signs: Last Hour**: Displays vitals documented within the Vitals application within the last hour in a table format.The following vital sign information will display within the table:

- **Date/Time**: Displays the date and time the vital sign documentation was entered within the Vitals application.
- **Blood Pressure**: Displays the systolic and diastolic blood pressure entered within the Vitals application.
- **BP Position/Site**: Displays the systolic and diastolic blood pressure site/position entered within the Vitals application.
- **Heart Rate**: Displays the pulse entered within the Vitals application.
- **Pulse Site**: Displays the pulse site entered within the Vitals application.
- **Respiration**: Displays the respiration rate entered within the Vitals application.
- **Temp C**: Displays the temperature in Celsius entered within the Vitals application.
- **Temp F**: Displays the temperature in Fahrenheit entered within the Vitals application.
- **SPO2%**: Displays the peripheral capillary oxygen saturation entered within the Vitals application.
- **O2 L/Min:** Displays the oxygen flow rate entered within the Vitals application.
- **FiO2:** Displays the FiO2 entered within the Vitals application.
- **O2 Device**: Displays the O2 Method entered within the Vitals application.
- **Blood Sugar**: Displays the blood sugar value entered within the Vitals application.
- **Pain Score**: Displays the pain scale value entered within the Vitals application.
- **Ht - cm**: Displays the height in Centimeters entered within the Vitals application.
- **Ht - in**: Displays the height in Inches entered within the Vitals application.
- **Wt - kg**: Displays the weight in Kilograms entered within the Vitals application.
- **Wt - lbs/ozs**: Displays the weight in Pounds and Ounces entered within the Vitals application.
- **Scale**: Displays the scale type entered within the Vitals application.
- **BMI**: Displays the calculated BMI from the height and weight entered within the Vitals application.
- **BSA**: Displays the calculated BSA from the height and weight entered within the Vitals application.
- **Head Circumference**: Displays the head circumference in Centimeters entered within the Vitals application.

- **Vital Signs: Last 3 Hours**: Displays vitals documented within the last 3 hours in the Vitals application, in a table format. The following vital sign information will display within the table:
  - **Date/Time**: Displays the date and time the vital sign documentation was entered within the Vitals application.
  - **Blood Pressure**: Displays the systolic and diastolic blood pressure entered within the Vitals application.
  - **BP Position/Site**: Displays the systolic and diastolic blood pressure site/position entered within the Vitals application.
  - **Heart Rate**: Displays the pulse entered within the Vitals application.
  - **Pulse Site**: Displays the pulse site entered within the Vitals application.
  - **Respiration**: Displays the respiration rate entered within the Vitals application.
  - **Temp C**: Displays the temperature in Celsius entered within the Vitals application.
  - **Temp F**: Displays the temperature in Fahrenheit entered within the Vitals application.
  - **SPO2%**: Displays the peripheral capillary oxygen saturation entered within the Vitals application.
  - **O2 L/Min:** Displays the oxygen flow rate entered within the Vitals application.
  - **FiO2:** Displays the FiO2 entered within the Vitals application.
  - **O2 Device**: Displays the O2 Method entered within the Vitals application.
  - **Blood Sugar**: Displays the blood sugar value entered within the Vitals application.
  - **Pain Score**: Displays the pain scale value entered within the Vitals application.
  - **Ht - cm**: Displays the height in Centimeters entered within the Vitals application.
  - **Ht - in**: Displays the height in Inches entered within the Vitals application.

- **Wt - kg**: Displays the weight in Kilograms entered within the Vitals application.
- **Wt - lbs/ozs**: Displays the weight in Pounds and Ounces entered within the Vitals application.
- **Scale**: Displays the scale type entered within the Vitals application.
- **BMI**: Displays the calculated BMI from the height and weight entered within the Vitals application.
- **BSA**: Displays the calculated BSA from the height and weight entered within the Vitals application.
- **Head Circumference**: Displays the head circumference in Centimeters entered within the Vitals application.

- **Vital Signs: Today**: Displays vitals documented within the current day in the Vitals application in a table format. The following vital sign information will display within the table:
  - **Date/Time**: Displays the date and time the vital sign documentation was entered within the Vitals application.
  - **Blood Pressure**: Displays the systolic and diastolic blood pressure entered within the Vitals application.
  - **BP Position/Site**: Displays the systolic and diastolic blood pressure site/position entered within the Vitals application.
  - **Heart Rate**: Displays the pulse entered within the Vitals application.
  - **Pulse Site**: Displays the pulse site entered within the Vitals application.
  - **Respiration**: Displays the respiration rate entered within the Vitals application.
  - **Temp C**: Displays the temperature in Celsius entered within the Vitals application.
  - **Temp F**: Displays the temperature in Fahrenheit entered within the Vitals application.
  - **SPO2%**: Displays the peripheral capillary oxygen saturation entered within the Vitals application.
  - **O2 L/Min:** Displays the oxygen flow rate entered within the Vitals application.
  - **FiO2:** Displays the FiO2 entered within the Vitals application.
  - **O2 Device**: Displays the O2 Method entered within the Vitals application.
  - **Blood Sugar**: Displays the blood sugar value entered within the Vitals application.
  - **Pain Score**: Displays the pain scale value entered within the Vitals application.
  - **Ht - cm**: Displays the height in Centimeters entered within the Vitals application.
  - **Ht - in**: Displays the height in Inches entered within the Vitals application.
  - **Wt - kg**: Displays the weight in Kilograms entered within the Vitals application.
  - **Wt - lbs/ozs**: Displays the weight in Pounds and Ounces entered within the Vitals application.
  - **Scale**: Displays the scale type entered within the Vitals application.
  - **BMI**: Displays the calculated BMI from the height and weight entered within the Vitals application.
  - **BSA**: Displays the calculated BSA from the height and weight entered within the Vitals application.
  - **Head Circumference**: Displays the head circumference in Centimeters entered within the Vitals application.

- **Vital Signs: Last 24 Hours:** Displays vitals documented within the last 24 hours in the Vitals application in a table format. The following vital sign information will display within the table:
  - **Date/Time**: Displays the date and time the vital sign documentation was entered within the Vitals application.
  - **Blood Pressure**: Displays the systolic and diastolic blood pressure entered within the Vitals application.
  - **BP Position/Site**: Displays the systolic and diastolic blood pressure site/position entered within the Vitals application.
  - **Heart Rate**: Displays the pulse entered within the Vitals application.
  - **Pulse Site**: Displays the pulse site entered within the Vitals application.

- **Respiration**: Displays the respiration rate entered within the Vitals application.
- **Temp C**: Displays the temperature in Celsius entered within the Vitals application.
- **Temp F**: Displays the temperature in Fahrenheit entered within the Vitals application.
- **SPO2%**: Displays the peripheral capillary oxygen saturation entered within the Vitals application.
- **O2 L/Min:** Displays the oxygen flow rate entered within the Vitals application.
- **FiO2:** Displays the FiO2 entered within the Vitals application.
- **O2 Device**: Displays the O2 Method entered within the Vitals application.
- **Blood Sugar**: Displays the blood sugar value entered within the Vitals application.
- **Pain Score**: Displays the pain scale value entered within the Vitals application.
- **Ht - cm**: Displays the height in Centimeters entered within the Vitals application.
- **Ht - in**: Displays the height in Inches entered within the Vitals application.
- **Wt - kg**: Displays the weight in Kilograms entered within the Vitals application.
- **Wt - lbs/ozs**: Displays the weight in Pounds and Ounces entered within the Vitals application.
- **Scale**: Displays the scale type entered within the Vitals application.
- **BMI**: Displays the calculated BMI from the height and weight entered within the Vitals application.
- **BSA**: Displays the calculated BSA from the height and weight entered within the Vitals application.

- **Vital Signs: This Visit**: Displays vitals documented within the current visit in the Vitals application in a table format. The following vital sign information will display within the table:
  - **Date/Time**: Displays the date and time the vital sign documentation was entered within the Vitals application.
  - **Blood Pressure**: Displays the systolic and diastolic blood pressure entered within the Vitals application.
  - **BP Position/Site**: Displays the systolic and diastolic blood pressure site/position entered within the Vitals application.
  - **Heart Rate**: Displays the pulse entered within the Vitals application.
  - **Pulse Site**: Displays the pulse site entered within the Vitals application.
  - **Respiration**: Displays the respiration rate entered within the Vitals application.
  - **Temp C**: Displays the temperature in Celsius entered within the Vitals application.
  - **Temp F**: Displays the temperature in Fahrenheit entered within the Vitals application.
  - **SPO2%**: Displays the peripheral capillary oxygen saturation entered within the Vitals application.
  - **O2 L/Min:** Displays the oxygen flow rate entered within the Vitals application.
  - **FiO2:** Displays the FiO2 entered within the Vitals application.
  - **O2 Device**: Displays the O2 Method entered within the Vitals application.
  - **Blood Sugar**: Displays the blood sugar value entered within the Vitals application.
  - **Pain Score**: Displays the pain scale value entered within the Vitals application.
  - **Ht - cm**: Displays the height in Centimeters entered within the Vitals application.
  - **Ht - in**: Displays the height in Inches entered within the Vitals application.
  - **Wt - kg**: Displays the weight in Kilograms entered within the Vitals application.
  - **Wt - lbs/ozs**: Displays the weight in Pounds and Ounces entered within the Vitals application.
  - **Scale**: Displays the scale type entered within the Vitals application.
  - **BMI**: Displays the calculated BMI from the height and weight entered within the Vitals application.
  - **BSA**: Displays the calculated BSA from the height and weight entered within the Vitals application.
  - **Head Circumference**: Displays the head circumference in Centimeters entered within the Vitals application.

- **Vital Signs: Last Year**: Displays vitals documented within the last year in the Vitals application in a table format. The following vital sign information will display within the table:
  - **Date/Time**: Displays the date and time the vital sign documentation was entered within the Vitals application.
  - **Blood Pressure**: Displays the systolic and diastolic blood pressure entered within the Vitals application.
  - **BP Position/Site**: Displays the systolic and diastolic blood pressure site/position entered within the Vitals application.
  - **Heart Rate**: Displays the pulse entered within the Vitals application.
  - **Pulse Site**: Displays the pulse site entered within the Vitals application.
  - **Respiration**: Displays the respiration rate entered within the Vitals application.
  - **Temp C**: Displays the temperature in Celsius entered within the Vitals application.
  - **Temp F**: Displays the temperature in Fahrenheit entered within the Vitals application.
  - **SPO2%**: Displays the peripheral capillary oxygen saturation entered within the Vitals application.
  - **O2 L/Min:** Displays the oxygen flow rate entered within the Vitals application.
  - **FiO2:** Displays the FiO2 entered within the Vitals application.
  - **O2 Device**: Displays the O2 Method entered within the Vitals application.
  - **Blood Sugar**: Displays the blood sugar value entered within the Vitals application.
  - **Pain Score**: Displays the pain scale value entered within the Vitals application.
  - **Ht - cm**: Displays the height in Centimeters entered within the Vitals application.
  - **Ht - in**: Displays the height in Inches entered within the Vitals application.
  - **Wt - kg**: Displays the weight in Kilograms entered within the Vitals application.
  - **Wt - lbs/ozs**: Displays the weight in Pounds and Ounces entered within the Vitals application.
  - **Scale**: Displays the scale type entered within the Vitals application.
  - **BMI**: Displays the calculated BMI from the height and weight entered within the Vitals application.
  - **BSA**: Displays the calculated BSA from the height and weight entered within the Vitals application.
  - **Head Circumference**: Displays the head circumference in Centimeters entered within the Vitals application.

- **Blood Sugars: Last 8 Results**: Displays the last 8 blood sugar results, the high/low values, and the unit of measure that were entered within the Vitals application.

- **Blood Sugar: Last 3 Days**: Displays the blood sugar result, the high/low values, and the unit of measure entered within the Vitals application for the last 3 days.

- **Pain Score: Last 2 Days**: Displays the pain scale entered within the Vitals application for the last 2 days in a list format.

When creating a customized Vital Sign filter, users have the ability to create a custom filter that will display the head circumference percentage, along with the measurement, for infants up to one year old.

NOTE: *The Vital Signs filters have the ability to be setup within the Filter Toolbox. It will display the table in an inverted grid with the Vitals description and will display vertically with the date/time displayed horizontally.*

Intake/Output

- **Intake/Output: Last 16 Hours**: Displays Intake/Outputs documented within the last 16 hours in the Vitals application, in an inverted grid. The following Intake/Output information will display within the table:
  - **Description**: Displays the Intake/Output descriptions of the daily totals with the last row displaying the Balance.
  - **Date**: Displays the date for the intake/outputs.
  - **Visit Totals:** Displays the visit total for the intake/output data.

- **Intake/Output: Last 24 Hours**: Displays Intake/Outputs documented within the last 24 hours in the Vitals application, in an inverted grid. The following Intake/Output information will display within the table:
  - **Description**: Displays the Intake/Output descriptions of the daily totals with the last row displaying the Balance.
  - **Date**: Displays the date for the intake/outputs.
  - **Visit Totals:** Displays the visit total for the intake/output data.

- **Intake/Output: Last 8 Hours**: Displays Intake/Outputs documented within the last 8 hours in the Vitals application, in an inverted grid. The following Intake/Output information will display within the table:
  - **Description**: Displays the Intake/Output descriptions of the daily totals with the last row displaying the Balance.
  - **Date**: Displays the date for the intake/outputs.
  - **Visit Totals:** Displays the visit total for the intake/output data.

- **Intake/Output: This Visit:** Will insert a traditional grid for intake and output for the visit. The This Visit filter will not include a Balance row or Visit Total column. The following Intake/Output information will display within the table:
  - **Date/Time**: Displays the date.
  - **Measurement Type**: Displays the type of measurement.
  - **Description**: Displays the description of the intake/output measurement.
  - **Amount/UOM**: Displays the amount for the intake or output measurement along with the unit of measurement.

NOTE: *All I/O filters (Except This Visit) will display the total of the individual entries for the day. For example, today's oral intake is entered at 8 A.M. and noon. The grid will show one Oral row with the total for the filter's time frame, not the individual Oral entries for the day.*

Family History

- **Family History List**: Displays the diagnosis description and relatives diagnosed in a list format.

- **Family History Table**: Displays family health history entered in the Health History application in a table format. The following family health history information will display within the table:
  - **Problem**: Displays the diagnosis description entered within the Health History application.
  - **Entered**: Displays the date and time the diagnosis was entered within the Health History application.
  - **Relative**: Displays the relative diagnosed entered within the Health History application.

- **Age**:Displays the onset age of the relative entered within the Health History application. If an onset age is not entered in the Health History application, then the estimated age displays.
- **Notes**: Displays any comments entered within the Health History application.

Surgical History

- **Surgery List**: Displays the Procedures in list format.

- **Surgical History Table**: Displays the Surgical/Procedural History entered in the Health History application in a table format. The following family health history information will display within the table:
  - **Procedure**: Displays the procedure name of the surgery.
  - **Procedure Date**: Displays the date the procedure was preformed.
  - **Age**: Displays the age of the patient when the procedure was performed.
  - **Notes**: Displays information entered in the Comment field within the Surgical/Procedural History and Interventions section of the Health History application or within the Notes field when adding a new surgery within Notes .

To Add, Edit, or Delete Surgical History

The Surgical History data set allows the patient's surgical history to be edited by adding new procedures or removing exiting. Once surgical history has been updated from within notes, it will also update the Surgical/Procedural History and Interventions section within the Health History application.

1. Select the  **plus** icon next to the Surgical History data set or select the **plus** icon within the filter of the note field.

2. To add a new surgery, begin typing in the ***Surgery** field. The HLI search list will display to allow the selection of the surgery type.

3. Enter surgery date and any additional notes needed. The comments field will allow a max of 80 characters. Select **Save** to add the surgery to surgical history or select **Cancel** to exit without saving.

4. To **edit** an existing surgery, select the  **Edit** icon. Enter any modifications and select **Save**.

5. To remove an existing surgery, select the  **remove** icon. The following prompt will display: “If you click yes ‘SELECTED SURGERY’ will be removed. Continue?” Selecting **Yes** will remove the surgery and selecting **No** will cancel any changes.

6. If the plus sign icon was selected from within the filter on the note field to edit the surgical history, select **refresh filter** to display the updated information within the note.

NOTE: *Any changes made to the Surgical History data set within Notes will also update the Surgical/Procedural History and Interventions section within the Health History application.*

Implantable Devices

- **Device List (Active and Inactive)**: Displays any implantable devices entered within the Health History Device in a Vertical List with Headers, displaying a line break between each device listed so the Description always displays at the beginning of the line.

- **Device List (Active)**: Displays only active implantable devices entered within the Health History Device in a Vertical List with Headers, displaying a line break between each device listed so the Description always displays at the beginning of the line.

- **Device Table (Active and Inactive)**: Displays any active or inactive implantable devices entered in the Health History application in a table format. The following implantable device information will display within the table:
  - **Description**: Displays the description is a Global Medical Device Nomenclature (GMDN) which is a generic name used to identify medical device products.
  - **Device Identifier**: Displays the Device Identifier which is a number specific to the version or model of the device.
  - **Status**: Displays the status of the device.
  - **Procedure**: Displays the procedure added in the Health History application for the device implantation. This may be pulled from the patients Surgical/Procedure History or manually added within the Implantable Devices in the Health History application.
  - **Procedure Date**: Displays the procedure date.
  - **Procedure Comment**: Displays any comments added to the Procedure from the Surgical/Procedure History in the Health History application. It may also be manually added within the Implantable Devices in the Health History application.
  - **Manufacturer**: Displays the manufacturer name of the specific device.
  - **Brand Name**: Displays the proprietary, trade or brand name of the medical device as used in device labeling or in the catalog.
  - **Version/Model**: Displays the version or model found of the device label or accompanying packaging used to identify a category. It may also display the design of a device.
  - **Manufactured Date**: Displays the date the specific device was manufactured.
  - **Expiration Date**: Displays the expiration date of a specific device.
  - **Lot #**: Displays the lot or batch number within which a device was manufactured.
  - **UDI**: Displays the unique device identifier.
  - **MRI Safety Information**: Displays the MRI Safety Information which include MR Safe, MR Unsafe, or MR Conditional.

- **Device Table (Active)**: Displays any active or inactive implantable devices entered in the Health History application in a table format. The following implantable device information will display within the table:
  - **Description**: Displays the description is a Global Medical Device Nomenclature (GMDN) which is a generic name used to identify medical device products.
  - **Device Identifier**: Displays the Device Identifier which is a number specific to the version or model of the device.
  - **Status**: Displays the status of the device.
  - **Procedure**: Displays the procedure added in the Health History application for the device implantation. This may be pulled from the patients Surgical/Procedure History or manually added within the Implantable Devices in the Health History application.
  - **Procedure Date**: Displays the procedure date.

- **Procedure Comment**: Displays any comments added to the Procedure from the Surgical/Procedure History in the Health History application. It may also be manually added within the Implantable Devices in the Health History application.
- **Manufacturer**: Displays the manufacturer name of the specific device.
- **Brand Name**: Displays the proprietary, trade or brand name of the medical device as used in device labeling or in the catalog.
- **Version/Model**: Displays the version or model found of the device label or accompanying packaging used to identify a category. It may also display the design of a device.
- **Manufactured Date**: Displays the date the specific device was manufactured.
- **Expiration Date**: Displays the expiration date of a specific device.
- **Lot #**: Displays the lot or batch number within which a device was manufactured.
- **UDI**: Displays the unique device identifier.
- **MRI Safety Information**: Displays the MRI Safety Information which include MR Safe, MR Unsafe, or MR Conditional.

This filter is customizable via the filter toolbox. If the filter is customized to a Horizontal List with Headers, the information will display in a paragraph format. As applicable to all filters within Notes, if a field is not populated within that filter, the column or field will display as blank to indicate the information is unknown/not entered.

Labs

Lab results will display in an **L** when a low value displays, an **H** when a high value displays, **LL** when a critical low value is displayed and **HH** when a critical high value is displayed. All abnormal lab result values will display in red.

- **Lab Results: Last 4 Hours**: Displays the labs resulted for the last 4 hours for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last 8 Hours**: Displays the labs resulted for the last 8 hours for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last 24 Hours**: Displays the labs resulted for the last 24 hours for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last 72 Hours**: Displays the labs resulted for the last 72 hours for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: This Visit**: Displays the labs resulted for this visit for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last Week:** Displays the labs resulted for the last week for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last Month**: Displays the labs resulted for the last month for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.

  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last 6 Months**: Displays the labs resulted for the last 6 months for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Lab Results: Last 12 Months**: Displays the labs resulted for the last 12 months for the patient's profile. The following lab result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Abnormal Results: Last 4 Hours**: Displays abnormal results for the last 4 hours for the patient's profile. The following abnormal result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Abnormal Results: Last 8 Hours**: Displays abnormal results for the last 8 hours for the patient's profile. The following abnormal result information will display within the table:
  - **Test**: Displays the name of the analyte resulted.
  - **Results**: Displays the results of the analyte resulted.
  - **Units**: Displays the unit(s) associated with the analyte resulted.
  - **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - **Ordered**: Displays the date and time the test was ordered.
  - **Collected**: Displays the date and time the test was collected.
  - **Status**: Displays the status of the test.

- **Abnormal Results: Last 24 Hours**: Displays abnormal results for the last 24 hours for the patient's profile. The following abnormal result information will display within the table:
  - o **Test**: Displays the name of the analyte resulted.
  - o **Results**: Displays the results of the analyte resulted.
  - o **Units**: Displays the unit(s) associated with the analyte resulted.
  - o **Reference Range**: Displays the high and low values of the reference range associated with analyte resulted.
  - o **Ordered**: Displays the date and time the test was ordered.
  - o **Collected**: Displays the date and time the test was collected.
  - o **Status**: Displays the status of the test.

***NOTE**: The Lab filters have the ability to be setup within the Filter Toolbox. It will display the table in an inverted grid with the test displaying vertically and the date/time displaying horizontally.*

Social History

- **SDOH List:** Displays the information that has been input from the Quality Measures Assessment in a list format. ***NOTE**: The Quality Measures Assesssment and Dashboard is a purchased application.*

- **SDOH Table:** Displays the information that has been input from the Quality Measures Assessment in a table format. ***NOTE**: The Quality Measures Assesssment and Dashboard is a purchased application.*

- **Smoking Status List: Displays the smoking status and cessation education entered within the Health History application in a list format**.

- **Smoking Status Table**: Displays the smoking status entered within the Health History application. The following smoking status information will display within the table:
  - o **Smoking Status:** Displays the smoking status for Smoked Tobacco and Smokeless Tobacco use of the Social History section within the Health History application.
  - o **Years Smoking:** Displays the number of years calculated from the entered Smoking Start Date.
  - o **Smoking Start Year:** Displays the year entered within the Smoke Start Date of the Social History section within the Health History application.
  - o **Cessation Education:** Displays the Tobacco Cessation Counseling of the Social History section within the Health History application.

- **Tobacco Use History List**: Displays the information entered within the History of Tobacco Use from Health History in a list format.

- **Tobacco Use History Table**: Displays the information entered within the History of Tobacco Use from Health History. The following tobacco use history will display within the table:
  - o **Tobacco Use**: Displays the type of tobacco selected within the History of Tobacco Use of the Tobacco/Nicotine Use section of Social History in the Health History application.
  - o **Years Use**: Displays the duration of the tobacco use calculated from the Began Use and Ended Use entered within the Tobacco/Nicotine Use section of Social History in the Health History application.

- **Start year**: Displays the Began Use Year entered within the History of Tobacco Use of the Tobacco/Nicotine Use section of Social History in the Health History application.
- **End Year**: Displays the Ended Use Year entered within the History of Tobacco Use of the Tobacco/Nicotine Use section of Social History in the Health History applications
- **Cessation**: Displays the Tobacco Cessation Counseling of the Social History section within the Health History application.

Environment

- **Environmental Health List**: Displays the information documented within the Environmental section of the Health History application.

- **Environmental Health Table**: Displays the information documented within the Environmental section of the Health History application. The following information will display in a table:
  - **Assessment**: Displays the type of assessment performed (Living Condition Assessment Performed or Health Equipment Use Assessment Performed).
  - **Description**: Displays Medical Equipment Used if the Health Equipment Use is addressed or Housing Status if the Living Condition is addressed.
  - **Findings**: Displays the Nursing Home answer when selected within Living Conditions (all other answers will not display).
  - **Date**: Displays the screening date.

Immunizations

- **Immunization List**: Displays the immunization description and administered date in a list format.

- **Immunization Last Administered List**: Displays the last administered immunization description and administered date in a list format.

- **Immunization Table**: Displays the immunization history from the Patient Immunization History application. The following immunization information will display within the table:
  - **Immunization**: Displays the immunization description from the Patient Immunization History application.
  - **Administered Date**: Displays the administration date from the Patient Immunization History application.
  - **Administration Site**: Displays the site of the immunizations from the Patient Immunization History application.
  - **Route**: Displays the route that the immunization was administered from the Patient Immunization History application.
  - **Dosage**: Displays the administered amount from the Patient Immunization History application.

- **Immunization Last Administered Table**: Displays the last administered immunizations from the Patient Immunization History application. The following immunization information will display within the table:
  - **Immunization**: Displays the immunization description from the Patient Immunization History application.
  - **Administered Date**: Displays the administration date from the Patient Immunization History application.

- **Administration Site**: Displays the site of the immunizations from the Patient Immunization History application.
- **Route**: Displays the route that the immunization was administered from the Patient Immunization History application.
- **Dosage**: Displays the administered amount from the Patient Immunization History application.

Medical Summary Fields

Information entered in the following filters within a signed note will display within the associated section on the patient's CCDA. When a filter of the Medical Summary Field is added to the note, a light green box displays and the cursor will automatically be placed within this field. The field will expand as the user enters information. All information entered in the light green box will move to the corresponding section on the CCDA once the note is signed.

- **Assessment:** Information entered within the Assessment filter will pull to the Assessment section of the CCDA.
- **Hospital Course:** Information entered within the Hospital Course filter will pull to the Hospital Course section of the Discharge Summary CCDA.
- **Plan:** Information entered within the Plan filter will pull to the Plan section of the CCDA.

NOTE: *If a patient has multiple signed notes that contain the Assessment, Hospital Course or Plan filters, then all filters will be pulled to a single corresponding section within the CCDA. For example, if a patient has three signed notes that all include a Plan, all three plans will pull to the Plan section of the CCDA.*

NOTE: *The behavior control,* ***Notes CCDA Text Field****, must be set to allow on the user's login or role in order for the user to have access the data set.*

Radiology

For Customers using Patient Data Console (currently not Generally Available), the Radiology filter may be inserted into a template, or a create note field, to allow the information from the Radiology Card within Patient Data Console to insert into the filter. Notes will display the Radiology text where the Radiology filter was placed in the template. Users will not be able to edit the Radiology filter.

The Radiology filter will not copy forward. If a Signed Note with a Radiology filter is copied forward, the filter will be cleared of any data but the filter container will remain. The user may choose to enter new radiology data from Patient Data Console or remove the filter from the Note.

NOTE: *The new Radiology filter can only be used when the site is using Patient Data Console.*

Plan

- **Referral/Transition List**: Displays the following information entered within the Referral/Transition of Care section of the Health History Application: (Practitioner) Referred To, Address, City/State, Phone (Number), Appointment Date, Referral Reason (Reason Code), and Referral Type (Inbound/Outbound). The information will display in a list format.

- **Referral/Transition Table**: Displays the following information entered within the Referral/Transition of Care section of the Health History Application. The information will display in a table:
  - o **Referred To**: Displays the receiving Practitioner name.
  - o **Address, City/State**: Displays the address of the receiving facility.
  - o **Phone**: Displays the phone number of the receiving facility.
  - o **Appointment Date**: Displays the appointment date for the patient.
  - o **Referral Reason**: Displays the Reason Code for the transfer.
  - o **Referral Type**: Displays the referral/transition type (Inbound/Outbound).

Orders

- **My Non-Medication Orders List: Last 24 Hours:** Displays all orders that the logged-in user has ordered (non-medication) within the last 24 hours in a list format. The list will display the following information: Order, Reason For Order, Start Date/Time, and Status.

- **My Non-Medication Orders Table: Last 24 Hours:** Displays all orders that the logged-in user has ordered (non-medication) within the last 24 hours in a grid format. The following information will display in a table:
  - o **Order**: Displays the order description.
  - o **Reason For Order**:Displays the reason for the order.
  - o **Start Date/Time**: Displays the start date and time for the order.
  - o **Status**: Displays the status of the order.

- **Non-Medication Orders List: Last 24 Hours:** Displays all orders (non-medication) within the last 24 hours in a list format. The list will display the following information: Order, Reason For Order, Start Date/Time, Ordering Provider, and Status.

- **Non-Medication Orders Table: Last 24 hours:** Displays all orders (non-medication) within the last 24 hours in a grid format. The following information will display in a table:
  - o **Order**: Displays the order description.
  - o **Reason For Order**: Displays the reason for the order.
  - o **Start Date/Time**: Displays the start date and time for the order.
  - o **Ordering Provider**: Displays the Provider who entered or signed the order.
  - o **Status**: Displays the status of the order.

Future Orders

- **Future Orders List**: Display the future orders on the patient's account in list format. The following information will display: Description, LOINC, and the Start Date.

- **Future Orders Table**: Display the future orders on the patient's account in a grid format. The following information will display in a table:
  - o **Description**: Displays the name of the order.
  - o **LOINC**: Displays the LOINC code associated with the order.
  - o **Start Date**: Displays the start date of the order.

Chapter 6 Note List

6.1 Overview

The Note List panel displays all notes for the patient's account or medical record. The Note List view defaults to notes from the current visit and lists the note details for each note. From the Note list panel, notes may be edited, add addendum and/or mark the note erroneous.

There are several different views for the Note List panel: List, Split and Preview. To toggle between the views select one of the following:

- **List**: Displays a list format of all the notes available within the patient's chart. This is the default view for the Note List Panel. See Note List View 43 for more information.
- **Split**: Displays a split screen with the listing of notes on the left side and a preview of the selected note on the right side of the screen. See Split and Preview 46 for additional information.
- **Preview**: Displays a full screen preview of the selected note, hiding the note list. See Split and Preview 46 for additional information.

6.2 Note List

The Note List displays all notes for the patient's account or medical record. This view defaults to notes from the current visit.

***NOTE**: If there are no notes available for the patient the Note List will display **Now Rows to Show**.*

To find a note that contains a specific word(s), enter the word(s) in the **Filter** field. To clear the filter, select the **X** icon . The content of the note that matches the text in the filter field will display in yellow.

Selecting the **Show all visits** check box will allow all notes existing within the patients profile to display.

Selecting the **Show erroneous** check box will display all notes marked as erroneous and they will display with a light red highlight. See Erroneous Note 49 for additional information. These check boxes have sticky functionality. If a user logs out or changes patients, the selection of either check box will be saved and display at the next login or patient.

The Note List grid displays several columns to identity a note. The following options are available to display:

-  **:** Displays when a note has been sent via Communication Center. When selected, a send log will display the method the notes sent, where it was sent, who it sent it and the date it was sent. The Send icon will only display within the Note List when a note is from the Notes Application via Communication Center. The send icon will not display within the Note List if a note is from other areas, such as Clinical History.
- **ID**: Displays the Note ID number that is auto-generated when a note is created.
- **Visit #**: Displays the account on which the note was created.
- **Note Type**: Displays the type of note that was selected on the Create Note panel.
- **Charted Date Time**: Displays the date and time of when the note was created.
- **Signed Date Time**: Displays the date and time the note was signed.
- **Entered By**: Displays the name of the user who entered the information within the note.
- **Patient Class**: Currently TruBridge Use Only.

NOTE*: The default view for the List view is: Visit #, Note Type, Charted Date/Time, Signed Date/Time and Entered By.*

The grid may also be personalized to display the view using the options listed below:

- **Change the Column Order**: The columns may be placed in any desired order by selecting a column and dragging it to the desired order number. For example, if the **Created Date Time** field should display in the first column, select Created Date Time and drag it in front of the Visit # column.
- **Show/Hide Columns**: In any column, select the  hamburger icon, then select the  column icon. This area determines what columns display. A check mark means the column is displaying. The default grid and column options display as listed above within Note List grid.
- **Change the Width and Sort Columns**: There are several sorting and column width options. The first sort option is to select a column, this will auto sort with an arrow displayed. When the arrow is pointing up it sorts the data in ascending order. When the arrow is pointing down it sorts the data in descending order. Selecting the column again will remove the arrow. Selecting the hamburger icon is another way to further perform column setup. The following sorting and column width options are available:
  - **Pin Column:** Allows the column to be moved to the far right or left of the grid. The following options are available:
    - **Pin Left**: Pins the column to the far left of the grid, displaying in the first column.
    - **Pin Right**: Pins the column to the far right of the grid, displaying in the last column.

    - **No Pin**: Removes the selected pin and places the column back in its original location.
  - **Autosize This Column**: Allows the selected column to autosize the width of the information displaying.
  - **Autosize All Columns**: Allows all columns to autosize the width of the information displaying.
  - **Group by**: Allows the columns to be sorted by whichever column is selected. For example, if **Visit #** is selected, then Group by will display as Group By Visit #. It will sort the columns by the account number adding a plus sign icon to the first column, that when selected, will expand a listing of notes associated with the selected account number. Selecting the minus sign icon will close the listing.
  - **Reset Columns:** Allows the TruBridge EHR default setting of the columns to be reapplied.
  - **Tool Panel**: Allows the column Tool Panel to display on the right hand side of the Note List screen for easy access to edit the grid display. To re-hide the tool panel, select any column and reselect **Tool Panel**. The following options are available within the Tool Panel:
    - **Show/Hide Columns:** See Show Hide Columns above for more information.
    - **Row Groups:** Allows the rows to be grouped by the column that is dragged to the Row Group area. For example, dragging Entered By to the Row Group area will sort the rows into single rows of each user has entered a note on the patient's profile. See Group by above for more information.
    - **Values:** Currently TruBridge Use Only.

- **Search the Columns**: Select the hamburger icon and then select the  filter icon. This allows the notes to be searched via the following search options:
  - Alphabetical/Numerical Columns:
    - Equals
    - Not Equal
    - Starts With
    - Ends With
    - Contains
    - Not Contains
  - Date/Time Columns
    - Equals
    - Greater Than
    - Less Than
    - Note Equal
    - *In Range*

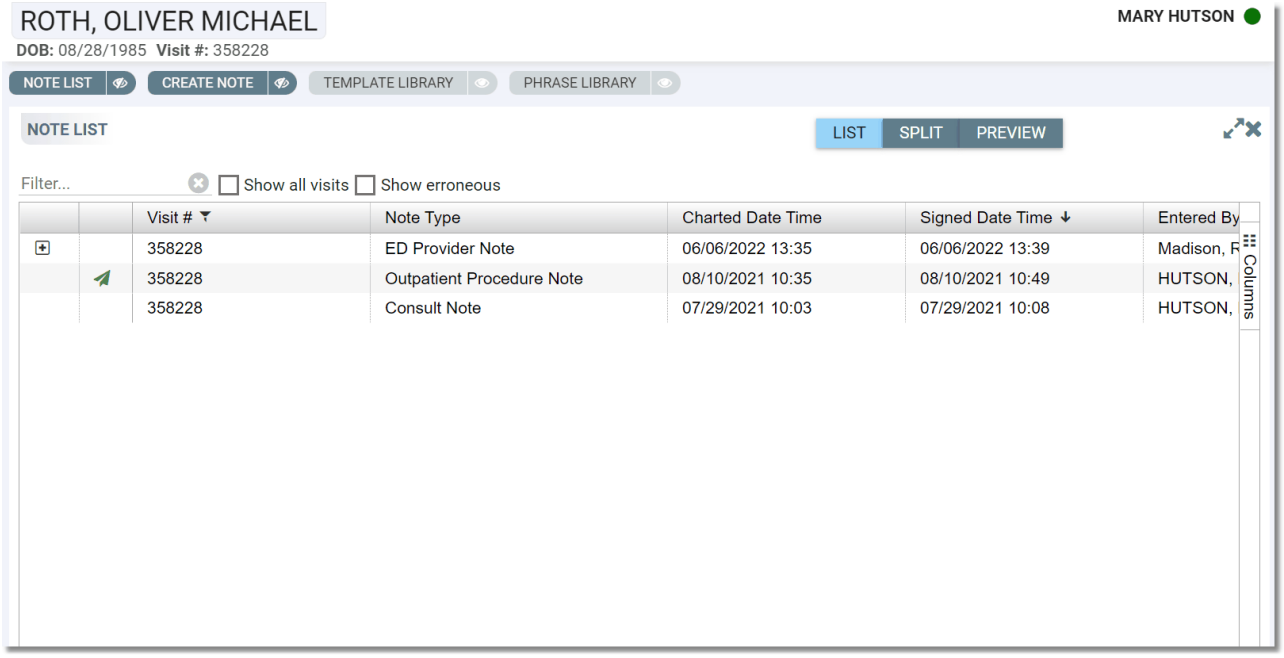
NOTE*: All changes made to the Note List grid will save automatically to the users UBL.*

If a note has a  plus sign icon in the first column, select it to see the Note History. Select the  negative sign icon to close the note history. An **OUT OF DATE** watermark will display in the background of the notes listed within the Note History.

A note that is currently being edited or newly created within the last 24 hours will display with a yellow highlight.

Selecting the **double sided arrow** in the top right hand corner of the the Note List panel will display the Note List panel full screen. Selecting it again will re-collapse it within the 3 panel view.

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Note List**



Note List

6.3 Note Split and Preview

From the Notes List, select the desired note and the **Split** view will automatically display. Or select **Preview** to display the note in the entire panel.

***NOTE**: If a note has not been selected prior to selecting Split or Preview, the following message will display: "Please select a note in order to see a preview."*

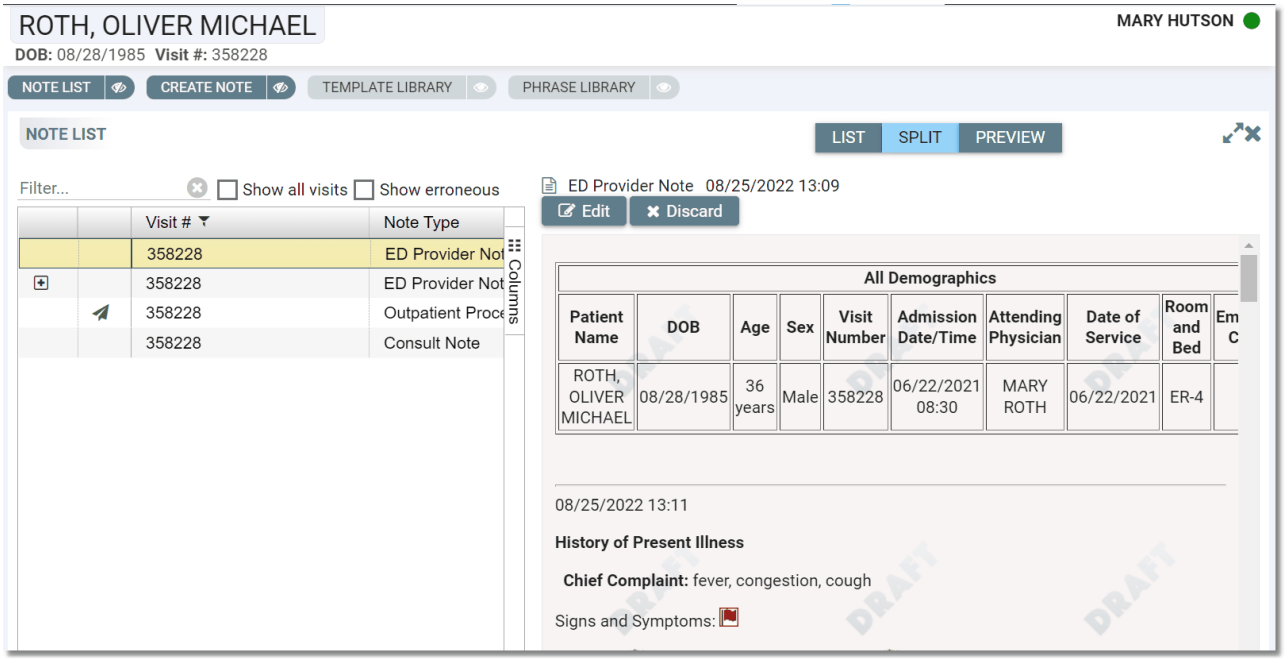
Draft Note

Draft notes will display in the split or preview screen with a DRAFT water mark in the background of the note. This lets the user know they are viewing a draft note.

When a draft note is selected from the note list, the following options are available:

- **Edit**: Allows a draft note to be reopened and modified. See Edit a Draft Note 21 for more information.
- **Discard**: Allows a draft note to be retracted from the chart. Once selected, a message will display verifying " Are you sure you want to discard this draft?" Selecting the **Discard** option will retract the draft and selecting the **Continue Working** option will return the user to the edit draft screen. Once Discard has been selected a green success message will display " Your note has been discarded" and the draft note is removed from the Note List.

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Note List** > **Split** > **Draft Note**



Note List - Draft Note

Signed Note

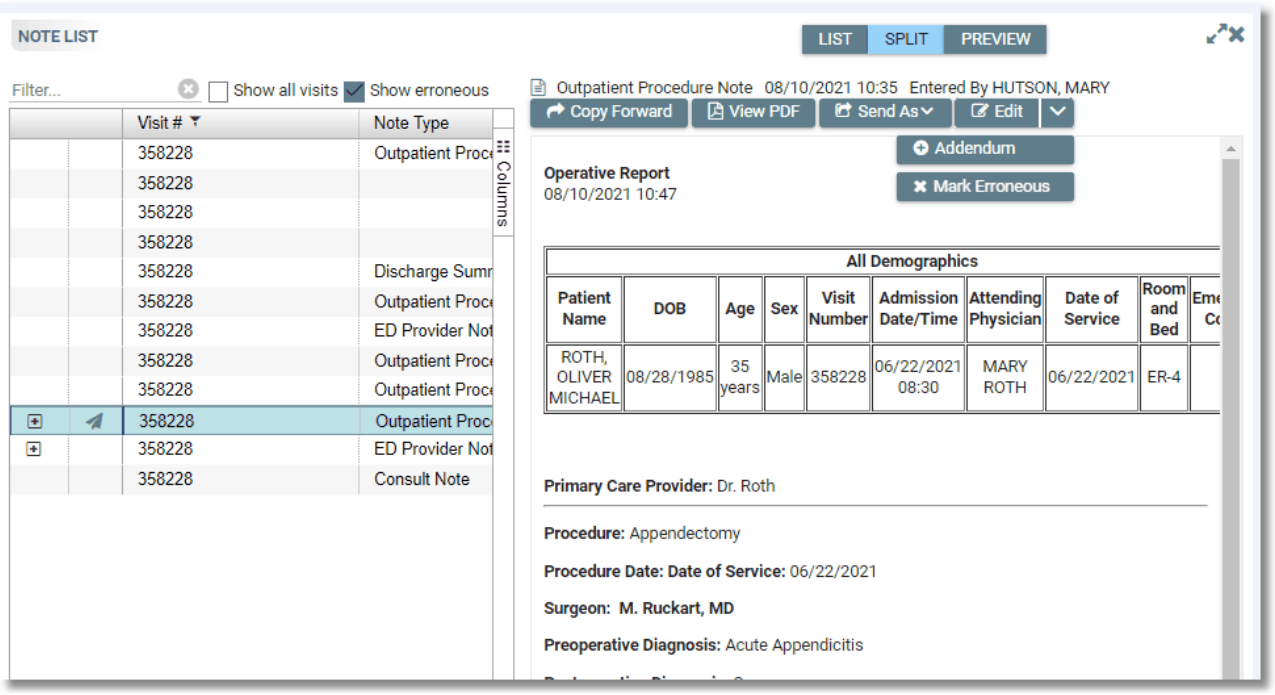
When a signed note is selected from the note list, the following options are available:

- **Copy Forward**: Allows the selected note to be copied to the current visit and edited. See Create a Note from another Note 21 for more information.
- **View PDF**: Allows the PDF of a Note to be viewed and printed. See View PDF for more information.
- **Send As**: For facilities who have purchased Communication Center and are using Web Client, Send As will allow the note to be sent to the Communication Center for faxing, internal mail or for sending a secure text. The note will attach as a reference link and when the recipient receives the communication selecting the link will display the note. Selecting the **More** icon  will display the following options:
  - o **Fax:** When selected, the Communication Center will display to complete the process to send the note via Fax.
  - o **Mail:** When selected, the Communication Center will display to complete the process for sending the note via internal Mail.
  - o **Text:** When selected, the Communication Center will display to complete the process for the note to be sent via Secure Text.
- **Edit**: Allows a signed note to be reopened and modified. See Edit a Signed Note 22 for more information.

- Selecting the **More** icon  will display the following options:
  - o **Add Addendum**: Allows an addition of information that will display at the top of the signed note. See Add Addendum to a Note 22 for more information.
  - o **Mark Erroneous**: Allows a signed note that has been entered in error to be retracted. See Erroneous Note 49 for more information.

***NOTE**: A user will only have access to **Send As** if they have the appropriate Application permissions for Communication Center - Faxing, Messaging or Secure text.*

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Note List** > **Split** > **Signed Note**



Note List - Signed Note

View PDF

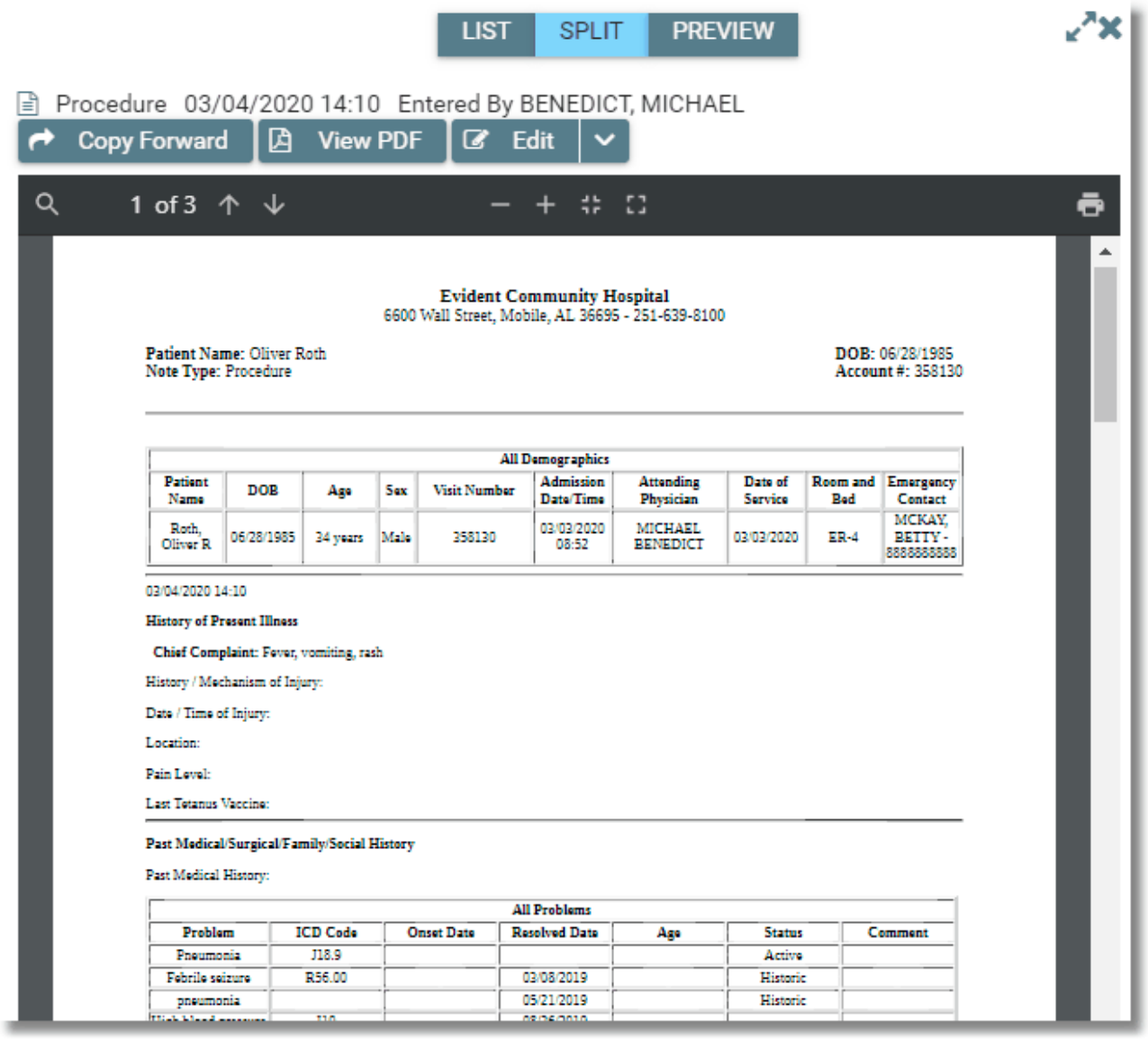
Once View PDF has been selected, the PDF Viewer screen will display within the Note List Preview Panel. The following options are available for selection within the viewer:

- **Search**: Allows the PDF version of the note to be searched for a specific text.
- **Next Page**: Allows the next page of the PDF to display.
- **Zoom Out**: Reduces the size of the PDF of the note.
- **Zoom In**: Enlarges the size of the PDF of the note.
- **Fit Page**: Displays the entire page within the PDF Viewer.

- **Full Width**: Allows the PDF of the note to display the full width of the page within the PDF Viewer.
- **Print**: Allows the PDF of the note to be printed within the Notes application.

To return to the note list split screen, select **View PDF** again.

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Note List** > **Split** > **Signed Note** > **View PDF**



View PDF

Erroneous Note

To mark a note as erroneous:

1. Select a signed note

2. Select **Mark Erroneous**

3. **Select a reason** for why the note is being marked erroneous. If the option Other is selected a free text field will become enabled for the user to enter a reason. The reason table is maintained in the Reason Code table within the Notes area of Tables. Please see the Table Maintenance - Notes user guide for additional information.

4. Select **Mark Erroneous** to continue, or **Cancel** to exit without marking the note as erroneous. Once a note has been marked as erroneous a green box will display alerting the user that "Your note has been marked erroneous."

Erroneous Notes will display in the split or preview screen with an ERRONEOUS water mark in the background of the note. This lets the user know they are viewing a note that is marked as erroneous.

Once a note has been marked erroneous, the following options are available:

- **Copy Forward**: Allows the selected note to be copied to the current visit and edited. See Create a Note from another Note 21 for more information.

- **View PDF**: Allows the Erroneous note to display within the PDF Viewer within the Note List Preview Panel.

Chapter 7 Template Library

7.1 Overview

The Template Library displays a list of available templates for Notes and allows the ability to create new templates and edit existing templates. Notes may also be created from the template library. It will open immediately into the patient's Create Note panel to begin documentation. Note Templates may also be modified in the Template area of the Notes table within Tables

To create a new template, select **Create Template** at the top of the screen. See Create a New Template 57 for additional information.

There are several different views for the Template Library panel: List, Split and Preview. To toggle between the views, select one of the following:

- **List**: Displays a list format of all of the templates available within the library. This is the default view for the Template Library. See Template List 51 for more information.
- **Split**: Displays a split screen with the listing of templates on the left side and a preview of the selected template on the right side of the screen. See Template Split and Preview 54 for additional information.
- **Preview**: Displays a full screen preview of the selected template, hiding the note list. See Template Split and Preview 54 for additional information.

7.2 Template List

From the Template Library, a list of all templates displays. To find a template that contains a specific word(s), enter the word(s) in the filter field. Select the **X** icon to clear the filter.

Selecting **Show deleted** will display all templates that have been deleted with a light red highlight in the template list. This check box has sticky functionality. If a user logs out or changes patients, the selection of the check box will be saved and display at the next login or patient.

Selecting **Show Unpublished** will display all of the templates that are unpublished. This check box has sticky functionality. If a user logs out or changes patients, the selection of the check box will be saved and display at the next login or patient. A user who only has Template Library access will not have access to the Show Unpublished check box.

The Template Library grid displays several columns to identify the template. The following options are available to display:

-  **:** Displays the templates that are selected to as favorites under **Templates** filter within the Create Note panel. A blue star displays when the template is selected as a favorite and a grey star displays when it is not selected as a favorite. Selecting the star when it is grey will mark it as a favorite template which displays the blue star.

- **:** Displays when a template is published/unpublished. A green P displays when the template is selected as published and a grey P displays when it is not. Unpublished templates are only available to the user who created the template. A user with administrative abilities may publish and unpublish any template. Users with only creator abilities may only publish and unpublish templates they have created. Selecting the P will publish/unpublish the template. When the P is selected the following message will display "*Are you sure you want publish/unpublish this template?*" Selecting **Yes** will publish/unpublish the template and selecting **No** will cancel the action.

- **:** Displays when a template is a TruBridge created template and may not be edited. TruBridge templates may only be selected as unpublished if they are not going to be used by the facility.

- **Name**: Displays the title of the template.

- **Creator**: Displays the initial author of the template. CPSI templates will display with SYSTEM as the creator.

- **Created On**: Displays the date and time the template was initially created.

- **Modified On**: Displays the date and time the template was last edited.

NOTE*: The default view for the List view is: Name, Creator, Created On.*

The grid may also be personalized to display the template listing using the options listed below:

- **Change the Column Order**: The columns may be placed in any desired order by selecting a column and dragging it to the desired order number. For example, if the Creator field should display in the first column, select **Creator** and drag it in front of the Name column.

- **Show/Hide Columns**: In any column, select the hamburger icon, then select the column icon. This area determines what columns display. A check mark means the column is displaying. The default grid and column options display as listed above within Note List grid.

- **Change the Width and Sort Columns**: There are several sorting and column width options. The first sort option is to select a column, this will auto sort with an arrow displayed. When the arrow is pointing up, it sorts the data in ascending order. When the arrow is pointing down, it sorts the data in descending order. Selecting the column again will remove the arrow. Selecting the hamburger icon is another way to further perform column setup. The following sorting and column width options are available:
  - **Pin Column:** Allows the column to be moved to the far right or left of the grid. The following options are available:
    - **Pin Left**: Pins the column to the far left of the grid, displaying in the first column.
    - **Pin Right**: Pins the column to the far right of the grid, displaying in the last column.
    - **No Pin**: Removes the selected pin and places the column back in its original location.
  - **Autosize This Column**: Allows the selected column to autosize the width of the information displaying.

- **Autosize All Columns**: Allows all columns to autosize the width of the information displaying.
- **Group by**: Allows the columns to be sorted by whichever column is selected. For example, if **Creator** is selected, then Group by will display as Group By Creator. It will sort the columns by the Creator adding a plus sign icon to the first column, then when selected, will expand a listing of each template that was created by the selected user. Selecting the minus sign icon will close the listing.
- **Reset Columns:** Allows the TruBridge EHR default setting of the columns to be reapplied.
- **Tool Panel**: Allows the column Tool Panel to display on the right hand side of the Template List screen for easy access to edit the grid display. To re-hide the tool panel, select any column and reselect **Tool Panel**. The following options are available within the Tool Panel:
  - **Show/Hide Columns:** See **Show Hide Columns** above for more information.
  - **Row Groups:** Allows the rows to be grouped by the column that is dragged to the Row Group area. For example, dragging Creator to the Row Group area will sort the rows into single rows of each user that created a template. See **Group by** above for more information.
  - **Values:** Currently TruBridge Use Only

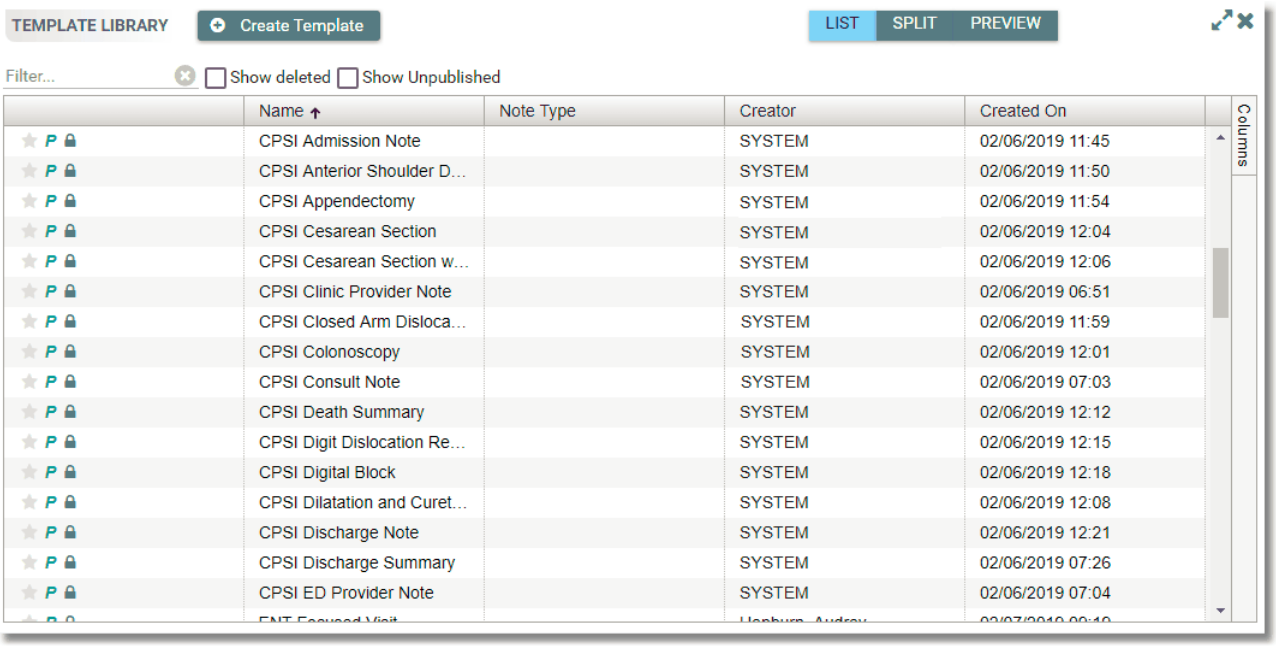
- **Search the Columns**: Select the hamburger icon and then select the  filter icon. This allows the templates to be searched via the following search options:
  - Alphabetical/Numerical Columns:
    - Equals
    - Not Equal
    - Starts With
    - Ends With
    - Contains
    - Not Contains
  - Date/Time Columns
    - Equals
    - Greater Than
    - Less Than
    - Note Equal
    - In Range

NOTE: *All changes made to the Template List grid will save automatically to the users UBL.*

Selecting the **double sided arrow** in the top right hand corner of the the Note List panel will display the Note List panel full screen. Selecting it again will re-collapse it within the 3 panel view. Selecting the **X** icon will close out the template panel.

NOTE: *CPSI (TruBridge) templates may not be edited or deleted. If one of these templates needs to be edited, the template may be copied to a new template and edited with a new name.*

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Template Library**



Template Library

7.3 Template Split and Preview

From the Template List, select the desired template. Choose **Split** or **Preview** to display a preview the template.

***NOTE**: If a template has not been selected prior to selecting Split or Preview, the following message will display, "Please select a template in order to see a preview."*

The following icons will display at the top of the split/preview screen with the Title of the template displaying below the icons:

- **:** Allows the template to be selected as a favorite.
- **:** Allows the template to be published/unpublished.
- **:** Displays when a template is a CPSI created template and may not be edited.

The following options are available to be preformed within the selected template:

- **Delete**: Allows the template to be removed from the Template Library. This option is not available when a CPSI template is selected. See Delete a Template 56 for additional information.

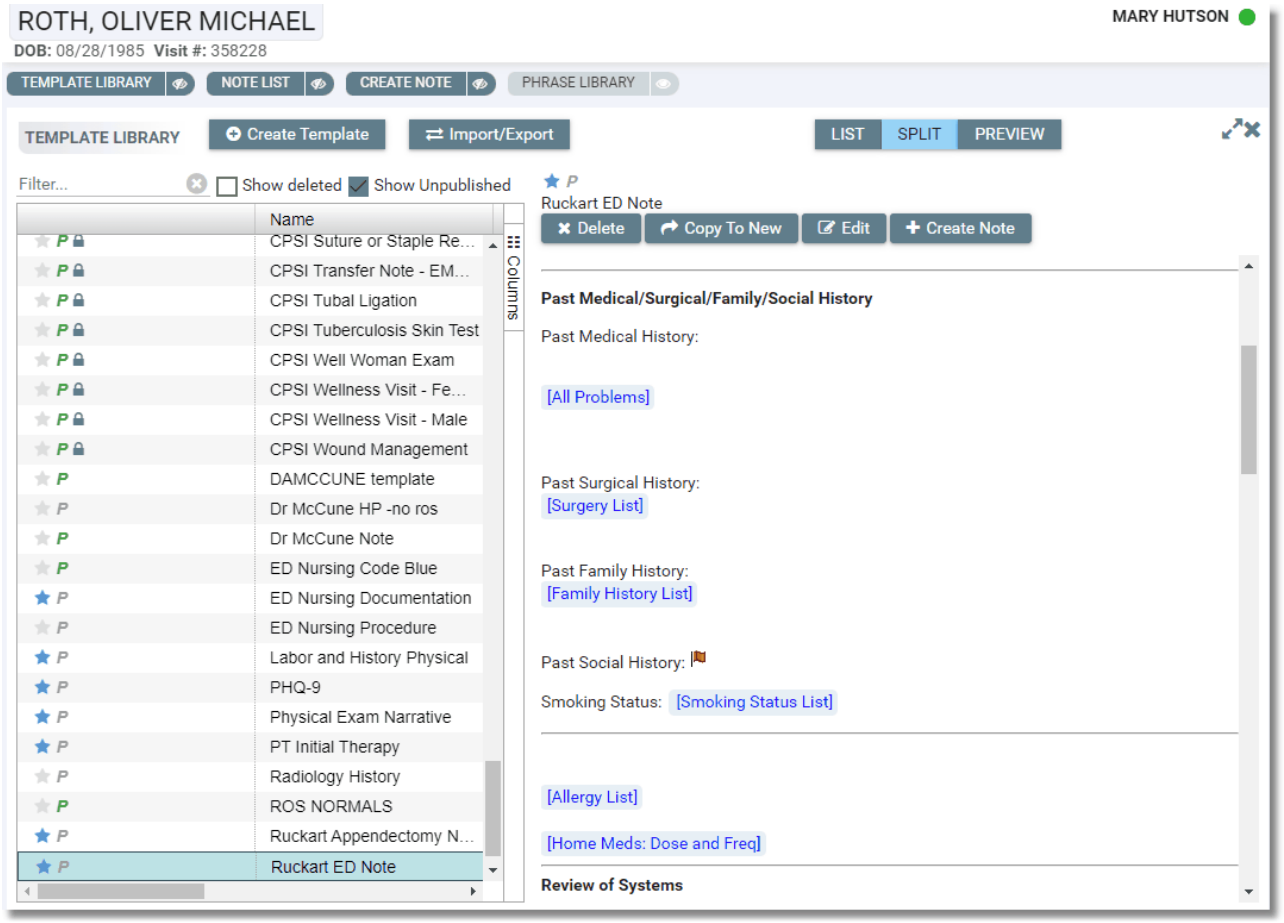
- **Copy to New**: Allows the selected template setup to be copied to a new template. See Create a Template from an Existing Template 56 for additional information.

- **Edit**: Allows the selected template to be modified. This option is not available when a CPSI template is selected. See Create a New Template 57 step 3 for modification options.

- **Create Note**: Allows the selected template to be used to document against the current patient account. This option is only available when the Template Library is accessed from within the Notes Application in a patient's chart. See Create a Note from the Template Library 56 for additional information.

Selecting the **double sided arrow** in the top right hand corner of the Template panel will display the Template panel full screen. Selecting it again will re-collapse it within the 3 panel view. Selecting the **X** icon will close out the template panel.

Select **Web Client** > **Charts** > **Patient** > **Notes** > **Template Library** > **Split or Preview**



Template Preview

Create a Note from the Template Library

Creating a note within the patient account may be streamlined by using a template from the Template Library. The **Create Note** option is only available when the Template Library is accessed from within the Notes Application in a patient's chart.

To create a note from the template library:

1. Select a template.
2. Select **Create Note** from the top of the screen.
3. A Create Note screen will display. Add any needed modifications to the note and address all anchors. See Create a Note 10 for additional information on editing the note.
4. Select **Draft** to save the note or **Sign** to complete the note.

Create a Template from an Existing Template

A new template may be created from an existing template. This allows the setup from the selected template to copied into a new template.

To create a template from an existing template:

1. Select the desired existing template.
2. From the preview or split view, select **Copy to New**.
3. A Create Template screen will display. The template may be modified as needed. See Create a New Template 57 for modification options.
4. Select **Save** or **Save and Close** to save the template.

Delete a Template

To delete a Template:

1. Select the template from the Template Library.
2. From the Preview or split screen, that displays on the right, select **Delete**. The following prompt will display: “Are you sure you want to complete this action? This template is currently being used (# it has been used) Times. Select **Yes** to delete the template or **No** to cancel the action.

Deleted templates may be viewable again by selecting the **Show Deleted** check box from within the template list screen. They will display with a red highlight in the list. Deleted templates may also be used to create new templates by selecting Copy to New option from the preview or split screen. The template will display in the Create Template panel, where it may be edited and saved to a new template. If a template was deleted accidentally, the user may enter the same template name after selecting Copy to New to restore the deleted template.

NOTE: *TruBridge templates should only be unpublished if they are not going to be used by the facility.*

7.4 Create a New Template

To create a new template:

1. From the template Library, select **Create Template**.

2. A Create Template panel will display to the left of the Template Library. Enter the name of the template in the **...add template name here** field at the top of the Create Template panel. In order to successfully save a template, the following items should be followed when assigning template names:
   a. The name of a Template must be unique.
   b. The name may be alpha or numeric characters but should not include any special characters other than:
      i. -
      ii. \
      iii. /
   c. The max length for a template name cannot exceed 250 characters.
   d. The template must be named prior to saving.

3. Select **Note Type** to be associated with the template. This note type will display as the selected note type when the template is inserted within a Create Note panel unless the user has a default note type selected. To deselect an associated note type, select the blank space at the top of the **Note Type** drop-down to remove the selection. If more than one template is inserted into a note and both have an associated note type, the first template's note type will display. Associated note types will not overwrite a default note type.

4. Begin typing in the template the content of the template. Add any of the formatting features that are available within the toolbar at the top of the template field. See Create a Note 10 for formatting options.

5. From the list on the left, select any filters and/or additional templates to add to the new template. Hovering over a filter shows a preview of the details within that filter. The new template shows the filter name that will pull when a note is created. The filter will display where the cursor is placed on the template prior to selecting the filter. See Filters 23 for additional information on individual filters available.

6. Make an item or area of the template required by adding an  anchor icon. When anchors are placed, all anchors must be addressed or removed prior to signing a note.

7. Phrases may be used when building a template. When a phrase is inserted, the reference ID will display. When the template is inserted into a Create Note Panel, the content of the phrase will then display.

8. When the template is complete, select the **Publish** check box to make it available within the Template Library. Publishing a template allows other users to see it and add it as a favorite. A

user with administrative abilities may publish and unpublish any template. Users with only creator abilities may only publish and unpublish templates they have created. When deselecting the Publish check box, the following message will display: "*Are you sure you want to unpublish this template?*" Selecting **Yes** will unpublish the template and selecting **No** will cancel the action.

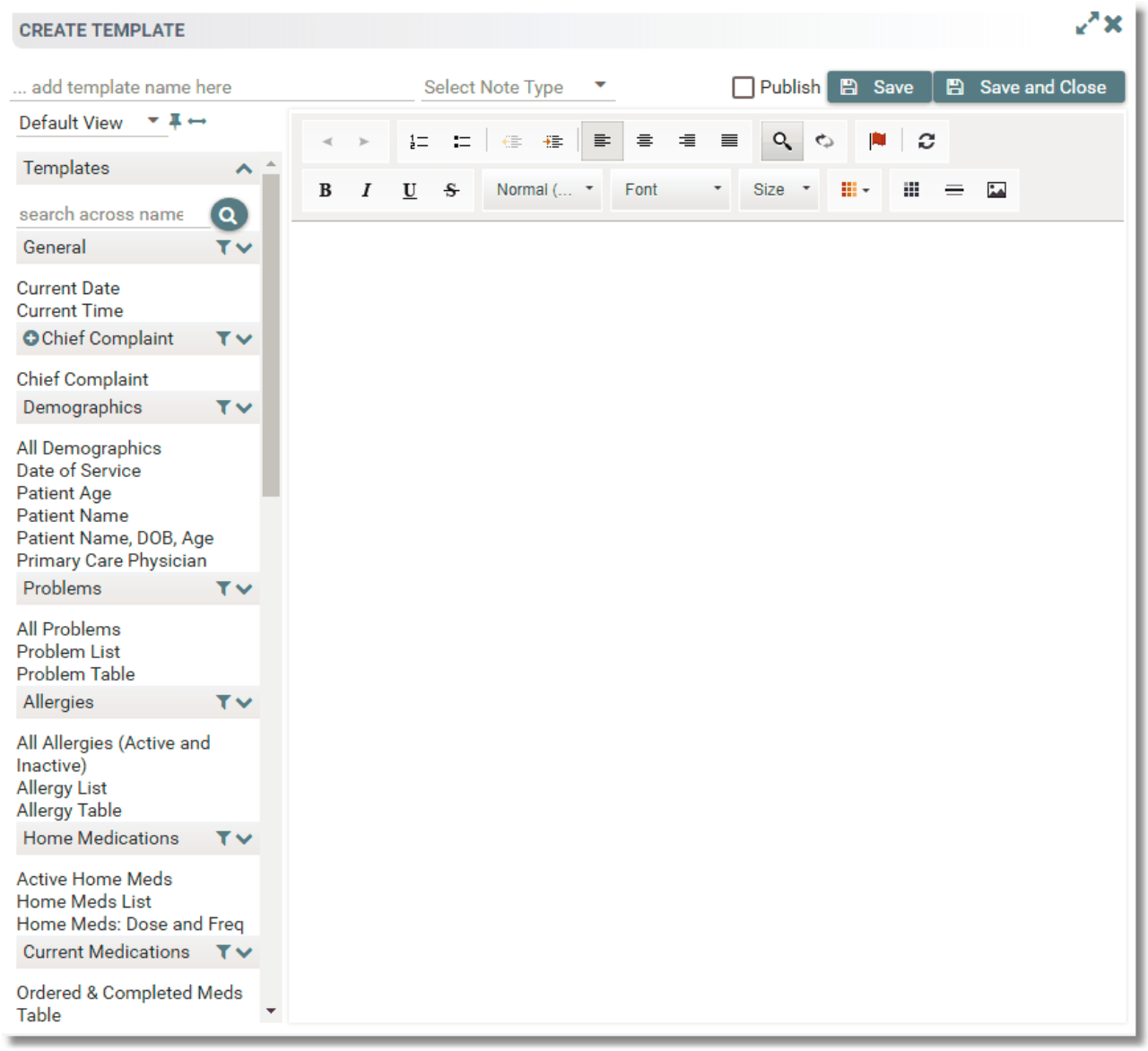
9. Select **Save** to leave the template open, or **Save and Close**. This will allow the template to be added to the Library and it will automatically mark the template as a favorite.

***NOTE**: If the note is selected to be closed prior to an autosave or **Draft** being selected, the following message will display: "THERE ARE UNSAVED CHANGES! Any changes you made will be lost, do you want proceed?" Select **Close Panel** to proceed without saving or **Cancel** to re-access the Edit Note panel to save changes.*

***NOTE**: Filters may not be inserted within other filters. Filters display with a blue background and the user may not edit anything within the blue area of the filter.*

***NOTE:** Templates built prior to Notes 2.9.0 may display List or Text Phrases without the reference ID in a template. If List or Text Phrases are edited within the Phrase Library, they will continue to insert the pre-existing list or phrase prior to the change made within the Phrase Library if the reference ID is not used. Please see Text and List Phrase Changes document for more information.*

Select **Web Client > Charts > Patient > Notes > Template Library > Create Template**



Create Template

Chapter 8 Phrase Library

8.1 Overview

The Phrase Library displays a list of available phrases for Notes and allows the ability to create phrases and edit existing phrases. Phrases allow the user to create blocks of text or sentences that may be inserted into a note by typing a few characters within the note field of the Create Note panel. The Phrase Library will display up to 25 phrases on a single page. At the bottom of the screen, page arrows will display to allow the user move to the next page or back to the previous page.

To create a new phrase, select **Create Phrase** at the top of the screen. See Create a New Phrase 64 for additional information.

There are three different views for the Phrase Library panel: List, Split, and Preview. To toggle between the views, select one of the following:

- **List**: Displays a list format of all of the phrases available within the library. This is the default view for the Phrase Library. See Phrase List 60 for more information.
- **Split**: Displays a split screen with the listing of phrases on the left side and a preview of the selected phrase on the right side of the screen. See Phrase Split and Preview 62 for additional information.
- **Preview**: Displays a full screen preview of the selected phrase, hiding the note list. See Phrase Split and Preview 62 for additional information.

8.2 Phrase List

From the Phrase Library, a list of phrases will display.

Selecting **Create Phrase** will display a Create Phrase panel that will allow a new phrase to be created. See Create a New Phrase 64 for additional information.

To find a phrase that contains a specific word(s), enter the word(s) in the **Filter** field. The Phrase List will display up to 25 phrases with paging arrows at the bottom on the list to see the additional phrases. Select the **X** icon to clear the filter. The filter will search all information listed within the columns of the Phrase List.

Selecting **Show Deleted** will display all templates that have been deleted with a light red highlight in the template list. If selected, when the Filter field is used to search phrases, only Deleted phases that meet the search criteria entered will display.

Selecting **Show Unpublished** will display all of the templates that are unpublished. A user who only has Phrase Library access will not have access to the Show Unpublished check box. If selected, when the Filter field is used to search phrases only Unpublished phases that meet the search criteria entered will display.

Selecting **My Phrases** will display only phrases created by the logged in user. If selected, when the Filter field is used to search phrases, only My Phrases that meet the search criteria entered will display.

Selecting **My Favorites** will display a listing of all phrases that have been selected as a favorite. If selected, when the Filter field is used to search phrases, only Favorite phrases that meet the search criteria entered will display.

NOTE: *The above check boxes have sticky functionality. If a user logs out or changes patients, the selection of the check box will be saved and display at the next login or patient.*

The Phrase Library grid displays several columns to identify a phrase. The following options are available to display:

-  **:** Allows the setup of the selected phrase to be copied to a new phrase. A Create Phrase panel will display to allow any needed edits and a new unique phrase to be entered. See Create Phrase from an Existing Phrase 63 for additional information.

-  **:** Displays the phrases that are selected as favorites. A blue star displays when the phrase is selected as a favorite and a grey star displays when it is not selected as a favorite.

-  **:** Displays when a phrase is published/unpublished. A green 'P' displays when the phrase is selected as published and a grey 'P' displays when it is not. Unpublished phrases are only available to the user who created the phrase. A user with administrative abilities may publish and unpublish any phrase. Users with only creator abilities may only publish and unpublish phrases they have created. When the **P** is selected, the following message will display "*Are you sure you want publish/unpublish this phrase?*" Selecting **Yes** will publish/unpublish the phrase and selecting **No** will cancel the action.

- **ID:** Displays a number automatically assigned by the system to use to numerically identify the note phrase.

- **Note Phrase**: Displays the short word or characters that the user would type into their note.

- **Title**: Displays the title of the phrase.

- **Description**: Displays the additional information entered about the phrase, if available.

- **Type**: Displays the type of phrase created. Phrase types may be text, list, template or data filter.

- **Creator**: Displays the initial author of the phrase.

- **Created On**: Displays the date and time the phrase was initially created.

- **Modified By**: Displays the name of the user who last edited the phrase. The users name will be recorded when a user selects Edit, Save or Save and Close, regardless of any or no changes made. To view a phrase without creating a modify entry, use the library's Split or Preview views.

- **Modified On**: Displays the date and time the phrase was last edited.

***NOTE**: The default view will display in alphabetical order with the following columns: Note Phrase, Title, Description, Type, Creator, Created On and Modified By.*

The grid may also be personalized to display the phrase listing, please see the Template List 51 for additional grid options.

8.3 Phrase Split and Preview

From the Phrase List, select the desired phrase. Choose **Split** or **Preview** to display a preview of the phrase.

***NOTE**: If a phrase has not been selected prior to selecting Split or Preview, the following message will display: "Please select a phrase in order to see a preview."*

The following icons will display at the top of the split/preview screen:

-  : Select this icon to add the phrase as a favorite.
-  : Select this icon to publish/unpublish the phrase.
-  : Select this icon to open the Template Usage List, which displays all templates the list or text phrase is included in.

***NOTE:** If a text phrase was manually altered within the template, the template may not be displayed in the Template Usage List. Example: Create Template > insert text phrase > take words out of the inserted phrase or add words or spacing within it > select Save/Publish Template. The template now contains a manually altered text phrase and depending upon how altered, may or may not appear in the Template Usage List. New templates created with a phrase reference link are not impacted, as they do not insert the actual text into the template build.*

Within a selected phrase, the following options are available:

- **Delete**: Removes the phrase from the Phrase Library. See Delete a Phrase 63 for additional information.
- **Copy to New**: Copies the selected phrase setup to a new phrase. See Create a Phrase from an Existing Phrase 63 for additional information.
- **Edit**: Allows the selected phrase to be modified. See Create a New Phrase 64, Step 3 for modification options.

- **Create Note**: Opens the selected phrase within a Create Note panel against the current patient account. This option is only available when the Phrase Library is accessed from within the Notes application in a patient's chart.

The Phrase Preview will display the Note Phrase, Title and the block of text, list, template name or data filter name that was used within the phrase.

Selecting the **double sided arrow** in the top right-hand corner of the Phrase panel will display the Phrase panel full screen. Selecting it again will re-collapse it within the three panel view. Selecting the **X** icon will close out the phrase panel.

Delete a Phrase

To delete a Phrase:

1. Select the template from the Phrase Library.

2. From the Preview or Split screen that displays on the right, select **Delete**. When a phrase is deleted, it should also be removed from any template it displays within. A prompt will display that lists all templates where the phrase is used, with a confirmation reading, “Are you sure you want to complete this action?" Select **Yes** to delete the phrase or **No** to cancel the action. The phrase should be removed from the templates listed.

Deleted phrases may be viewable again by selecting the **Show Deleted** check box from within the Phrase List screen. They will display with a red highlight in the list. Deleted phrases may also be used to create new phrases by selecting the **Copy to New** option. The phrase will display in the Create Phrase panel, where it may be edited and saved to a new phrase.

Create a Phrase from an Existing Template

A new phrase may be created from an existing phrase. This allows the setup from the selected phrase to be copied into a new phrase. A phrase may be copied from within the Phrase List or a Create Phrase panel.

To create a phrase from an existing phrase via the Phrase List:

1. Select the  **Copy to New** icon within the desired existing phrase.

2. A Create Phrase screen will display. Enter a unique Note Phrase and modify the phrase as needed.

3. Select **Save** or **Save and Close** to save the template.

To create a phrase from an existing phrase via Split or Preview:

1. Select the desired existing phrase.

2. From the Preview or Split View, select **Copy to New**.

3. A Create Phrase screen will display. Enter a unique Note Phrase and modify the phrase as needed.

4. Select **Save** or **Save and Close** to save the template.

To create a phrase from from an existing phrase Create Phrase panel:

1. Select **Copy to New** from Create Phrase panel.

2. A Create Phrase screen will display. Enter a unique Note Phrase and modify the phrase as needed.

3. Select **Save** or **Save and Close** to save the template.

8.4 Create a New Phrase

To create a new phrase:

1. From the Template Library, select **Create Phrase**.

2. Enter the **Note Phrase**, which is a short word or character the user would type into the note. This field is required prior to saving the phrase. This may be edited at any point but must be unique. The following criteria must be met:
   a. A phrase must be Unique. If the note phrase is already in use or has been used, the following pop-up will display: "Phrase must be unique."
   b. A minimum of three characters must be used, but may not exceed 25 characters.
   c. Phrases may only include alpha/numeric characters with the exception of the special characters listed below, no spacing within phrases. The following special characters may be used: _, @, #, %, &, ()

3. Enter a **Title**. Titles do not have to be unique and will allow a maximum of 40 characters. This field is required prior to saving the phrase.

4. Enter a **Description**. This step is optional and may be used if more detail is needed to provide additional information about the phrase, or a longer title is needed.

5. Select the phrase type. The following types are available:
   a. Text: If selected, the **Phrase Content** will display to enter the text that will display when the phrase is inserted. There is not a character limit, however, if the content consists of multiple paragraphs, it is highly recommended to use a Notes template instead of a text phrase. Text may be pasted into the Phrase Content field, but formatting will not conform to the text that was pasted. If Text is selected, this field is required prior to saving the phrase. Both the text formatting tools and medical spell check are available within the Create Phrase screen. When the phrase type is Text, the formatting tools and medical spell check will display above the Phrase Content field. These tools will work the same as when a user is creating a Note within a patient's chart. The formatting tools will be limited and the following tools will not be available: Tables, Images, Horizontal Line and Anchor. If a phrase requires one of these tools, for

example an Anchor, then the user should create that phrase as a template and attach the template to a Note Phrase.

b. **Template**: If selected, the **Template Name** field will display to allow a search for the needed template. Enter the first character of the template name and a search list will display.Templates that have been deleted will not display in the template search. If a template has been deleted after it has been attached to a phrase, the template will not insert into a Note. Users will receive a notification that the template has been deleted. Select the template that will be inserted when the phrase is entered.
c. **Data Filter**: If selected, the Data Filter Name field will display to allow a search for the needed filter. Enter the first character of the filter name and the search list will display. Up to three filters may be selected to display when the phrase is entered. A filter may be removed by individually selecting the **X** icon or all filters may be cleared by selecting the  **Clear All Filters** icon. The following filters along with deleted filters will not be available within the search list: Radiology, Assessment, and Hospital Course.
d. **List**: If selected, the Options field will display to allow list items/choices to be added or edited. See List Phrase 65 for additional set up information.

6. Once the phrase is complete, determine if the phrase should remain as a published phrase allowing all users to have access to it, or deselect the Publish option to only allow the phrase to be used or viewed by only the creator and the administrator.

7. To save the phrase the following options are available:
   a. Selecting **Copy to New** allows the phrase setup to be copied to a new phrase. See Create a Phrase from an Existing Phrase 63 for additional information.
   b. Selecting **Save** will save the phrase, but leave the Create Phrase panel open to allow the user to continue creating additional phrases.
   c. Selecting **Save and Close** will save the phrase and close the Create Phrase panel.
   d. Selecting **Cancel** will exit the Create Phrase panel without saving the phrase.

***NOTE**: Copy to New, Save and Save and Close will become enabled when all required fields have been addressed in the Create Phrase panel. The required fields are Note Phrase, Note Title and Phrase Content.*

Once a phrase is created and saved, the phrase will automatically save a favorite for the logged in user.

List Phrase

Within the Create Phrase panel a note phrase option, List, will display that allows the user to create a drop-down list of options. List phrases may be inserted into the Create, Draft, Edit and Addendum Panels. List Phrases may also be used in Text Phrases and Templates.

To create a List Phrase:

1. Select **Create Phrase**.

2. Enter the Note Phrase and Title.

3. Select the **List** radio button.

4. Enter the first item in the Options field. Select the  **Add** icon or select Enter on the key board to save then entered information. To clear the Options field, select the  **Cancel** icon. The option field will allow a maximum of 100 characters. Continue adding all the needed list options.

5. The first item created will default as the selected option for the list. This may be modified by selecting the  **Check Mark** to remove the option as the default. A green check mark with  represents the default answer option. A List Phrase may have more then one answer selected as a default or may be saved without a default answer selected.

6. Items within the listing may be edited by selecting the the  **Edit** icon or removed by selecting the  **Delete** icon.

7. To change the order of the listing select the  **Drag** icon.

8. Once all list options have been added, select **Save** or **Save and Close** to save the phrase list.

NOTE: *When a List Phrase is edited and included in a Note that is edited or a draft, the list will notate the change when the Note is opened unless the user removes and re-enters the list phrase keyword.*

Create a List Phrases within a Text Phrase:

A List Phrase may be used within a Text Phrase. To build a List Phrase within a Text Phrase:

1. Create the List Phrase by selecting **Create Phrase**.
2. Enter the Note Phrase and Title.
3. Choose the option **List** and add the items from the list.
4. Select **Save**.
5. Create a new phrase by entering a new Note Phrase and Title.
6. Change the type to **Text**.
7. Enter the needed text within the Phrase Content. After the word the list phrase should display in; enter a backslash with no space between the word and backslash. For example, if the phrase list

should follow the word ‘and’ in your Phrase Content the backslash should be entered behind the letter d; and\. The search list will display and return a listing of List Phrases. Select the Phrase List. The list will display the default answer and down arrow. If the list has no default answer, then a blank line with the down arrow will display.

8. Finish entering the phrase content and select **Save** or **Save and Close**.

Chapter 9 Signing Notes from Tasks

9.1 Overview

Once a notes has **autosaved** or **Draft** has been selected within a note in the Create Note panel or a note that requires a cosignature has been documented within a patients account it will display in the user's Personal Inbox or a designated folder on the Task Screen to be signed. The following task types should be added to the user designates folder: **UnsignedDraftNote** will display draft notes that should be signed**, NotesCosign** displays notes that should be cosigned and **NotesCosignReturn** displays the notes that have been returned to the mid-level from a provider whom a cosignature was requested.

The following information will display within the Task alert:

- **Alert Type**: This will display the type of Note alert. The following options are the different type of note alerts:
  o Unsigned Draft Note
  o Cosignature Required

- **Note Type:** This will display for the description of the document. If the note type was not addressed, the note will display as Draft.

- **Patient Name:** Displays the patient's name.

- **Account Number:** Displays the patient's account number.

- **Date/Time:** Displays the date and time the note was created.

9.2 Signing Notes

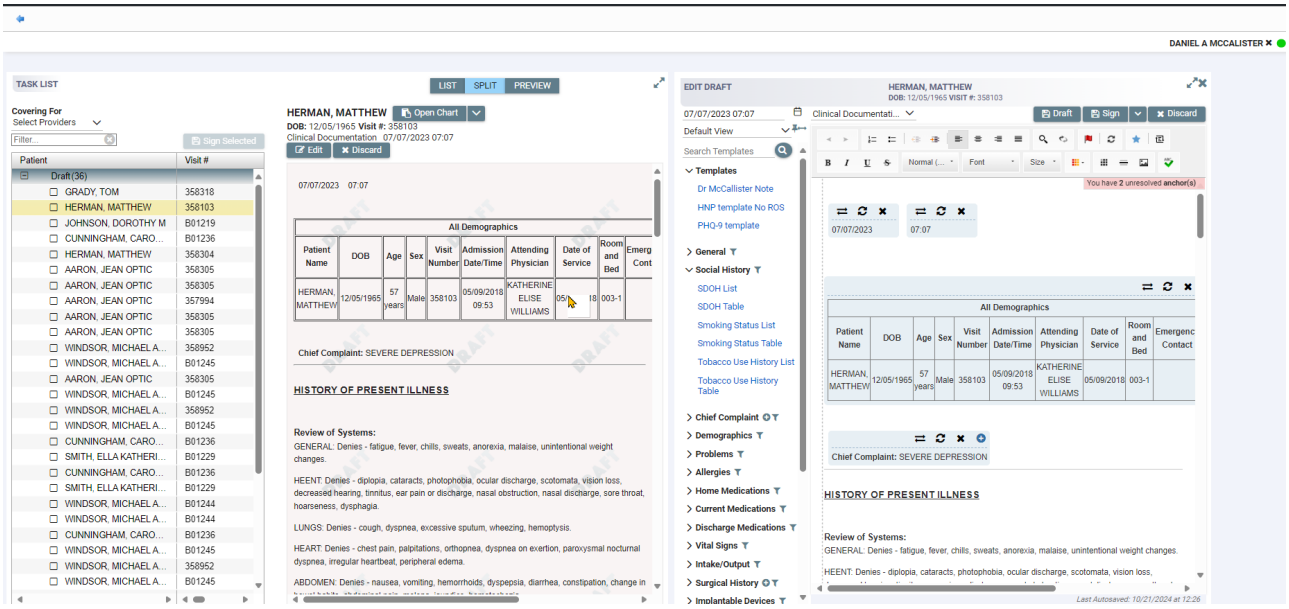
To Sign a Draft Note from the Task Screen:

1. **Double-click** the Unsigned Draft Note that needs to be signed.

2. The Edit Draft panel displays which will allow the user to make any needed edits or refresh any filters.

3. Select the Note Type if needed and then select **Sign,** a green success message will display in the upper right hand corner that the selected action was successful.

4. Select the **Back Arrow** to return to the Task Screen. Once the note has been signed it will automatically be removed from the Notes Task List.



Signing a Draft Note from the Task Screen

9.3 Cosigning Notes

To Cosign a Note, Return or Add an Addendum requiring a Cosignature from the Task Screen:

1. **Double-click** the Cosignature Required Note that needs to be cosigned.

2. The Cosignature panel displays and will allow the user to cosign, return or add an addendum to the note. Only the cosign panel will be accessible from the alert. The patient's name, account number, Note Type, the date and time of the entry and the user that signed the note will display within the panel.
   a. If **Cosign** is selected the cosign log 20 will update with a status of Cosigned.

b. If **Return** is selected, a prompt will display for the user to select a return reason. Once a reason has been selected and saved, the returned note will display an alert of Cosign Returned on the mid-level's Task Screen and update the cosign log 20 with a status of Cosign Returned. If the note has more then one cosignature and the **Return** option is selected, a new drop-down will display, **Select return to…**, which displays the author and any cosigner of the note allowing the user to choose who they are returning the cosignature request to. The author of the note will display in the listing first, followed by the additional cosigners. When the note is resigned during the return process, the PDF of the note will display the date and time stamp of the final signature.The return reason table is maintained in the Reason Code table within the Notes area of Tables. Please see the Table Maintenance - Notes user guide for additional information.
c. If **Add Addendum** is selected, enter the additional information for the addendum that will display at the top of the signed note. Then select **Sign Addendum and Cosign** to sign the addendum and cosign the note at the same time. If **Sign Addendum** is selected, only the addendum will be signed and the provider will still need to select **Cosign** to complete the cosignature of the note or select **Return** to send the note back to the mid-level. For additional information on adding an addendum, please see Add an Addendum to a Note 22.
d. The **note PDF** will now display all signatures in chronological order of when the note was signed.

3. Once the note has been cosigned or returned, the note will close. Select the **back arrow** to return to the Task Screen.

NOTE: *If the cosign fails, a red message will display in the top right corner alerting the user that "There is a problem signing the note. Cosignature has not been applied. Please try again. If further assistance is needed contact TruBridge*."

NOTE: *The Cosigner will need to have the behavior control to edit and view other people's notes.*

Chapter 10 Viewing Notes in Clinical History

Signed Notes will display within Clinical History in a PDF Format. The PDF Format will include a header and footer for each page of the note. The header will include the Facility Name, address and phone number(s), the Patient's Name (first and last), Date of Birth, Medical Record Number, Account Number and Note Type. The footer will include the signature of the provider and the provider's credentials, if available, along with date and time of signature. If the note was cosigned, both signatures will display. A page number will also display within the footer.

NOTE: *The physician's credentials field is limited to display a max of 20 characters, including any commas.*

NOTE*: The addition of the Medical Record Number displaying in the PDF header only impacts any note created, edited, addendum added or signed after the Notes 2.4.3 update is installed. Notes signed prior to the update will continue to only display the account number within the PDF header.*

To View Signed Notes within Clinical History:

1. Select **Clinical History** from within the Patients Chart.
2. Select the **Documentation** check box or select the **All** check box.
3. All Signed notes will display with the Type NT. Select the appropriate note and select view to display the PDF.
4. Once the PDF displays, the note may be attached to a message by selecting **Note** or it may displayed in Adobe PDF by selecting **Export**.

NOTE: *Only the most recent signed version of the note will display within Clinical History. Signed Notes marked erroneous will display in Clinical History as *Retracted* with Marked Erroneous in the header of the note along with the reason for why it was marked erroneous.*

Chapter 11 Viewing Notes in Print EMR

Signed Notes will display within Print EMR in a PDF Format. The PDF Format will include a header and footer for each note. The header will include the Facility Name, address and phone number(s), the Patient's Name (first and last), Date of Birth, Medical Record Number, Account Number and Note Type. The footer will include the signature of the provider and the provider's credentials, if available, along with the date and time of signature. If the note was cosigned, both signatures will display. A page number will also display within the footer.

***NOTE**: The addition of the Medical Record Number displaying in the PDF header only impacts any note created, edited, addendum added or signed after the Notes 2.4.3 update is installed. Notes signed prior to the update will continue to only display the account number within the PDF header.*

To View Signed Notes within Print EMR:

1. From the Hospital Base Menu, select **Master Selection**.
2. Select **Medical Records**
3. Select **Print Electronic Record**
4. Select **Account Number**
5. All Signed Notes will display with the date column displaying the signed date and File Source column displaying NotesDoc. Select the appropriate note and select **Print** and then select **Windows** to display the PDF.

***NOTE**: Signed Notes marked erroneous will display in Print EMR as *Retracted* with Marked Erroneous in the header of the note along with the reason for why it was marked erroneous.*

Chapter 12 Report Distribution

12.1 Overview

The ultimate goal for Report Distribution for TruBridge EHR will be to leverage the Communication Center. In order to assist facilities with Notes Report Distribution until the Communication Center is available and implemented, traditional Phys Doc/Documentation Report Distribution has been leveraged to allow facilities to distribute signed Notes. This functionality uses the traditional Medical Records Report Distribution logic.

The Notes Report Distribution functionality is that signed Notes will transmit (print/fax) if the physician of record is setup appropriately and the Note Type is setup for “distribute when signed.” A new switch (Distribute when signed) will be added to the Note Type table to allow sites to define which Note Types are distributed when signed to match the current functionality of Phys Doc/Documentation Report Distribution setup.

12.2 Setup

Physician of Record Setup

Physician:

- **Transcriptions-M/R Trans Send Mode Path**: Tables > Clinical > Physician > Select Physician > Pg3 > M/R Trans Send Mode (Print or Fax)
- If set to PRINT, **M/R Trans Printer must be setup Path**: Tables > Clinical > Physician Security > Select Physician > Pg3 > M/R Trans Printer
- If set to FAX, **Fax Phone # must be setup Path**: Tables > Clinical > Physician Security > Select Physician> Pg3 > Fax Phone #

NOTE*: If the area code is not needed for certain distribution tasks, it is recommended that non-area code fax # be entered in the Custom Fax Command field. Escribe and other tasks require the Fax Phone # field to include the area code.*

Physician Security:

- **Send Physician a copy of transcription Path**: Tables > Clinical > Physician Security > Select Physician > Pg1 > Send Physician a copy of transcriptions: (Any option P= Preliminary, F= Final, or B= Both).
- **Send copy of transcription Path**: Tables > Clinical > Physician Security > Select Physician > pg2 > Autoprint Medical Records Reports: (All 5 Patient Types checked)

Note Type Setup

Path: Tables > Notes Admin> Note Type > Select the Edit option for the Note Type > Select Distribute when signed.

Chapter 13 Reports

13.1 Notes Signature Deficiency List

The Notes Signature Deficiency List report may be run to display any draft notes, signed notes or notes with a signed/unsigned Cosignature.

Accessing the Notes Draft Report

To access the report from the home screen:

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

Setting up Report Parameters

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

The Notes Draft 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.
- **Note Type**: Allows the report to include a specific note type. Selecting the magnifying glass displays a list of the available note types.
- **Signing User**: Allows the report to only include the user (employee or mid-level) that has signed the note. Selecting the magnifying glass will display an employee search that may be searched by Name (default), Employee ID, Log Name or Physician ID.
- **Sign Status**: Allows the user to filter the report by the following Sign Status:
  - **All**: When selected, this will display all notes regardless of the Sign Status.
  - **Unsigned Drafts**: When selected, this will display only notes that have not been signed by the owner of the note.
  - **Signed Drafts**: When selected, this will display notes that have been signed by the owner of the note.
  - **Awaiting Cosignature**: When selected, this will display notes that have been signed by the owner but have not been signed by the assigned cosigner(s).
  - **Cosigned**: When selected, this will display the notes that have been signed by the owner of the note and the assigned cosigner(s).

***NOTE**: The Sign Status will filter the note independently of one another. Selecting any combination will pull all notes that meet at least one of the filters selected.*

- **Signed Date Range**: Allows the user to search for all notes that have been signed within a specific date range. Selecting a date range from the drop-down, or manually entering a date range, will disable the search for the Sign Status filters All and Unsigned Drafts. 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 Created 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

- **Notes Created Date Range**: Allows the user to search for notes that were created within a specific date range. Selecting a date range from the drop-down, or manually entering a date range, will disable the Signed Date Range option. 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 Created 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

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

- **Account Admit Date Range**: Allows the report to only include patients within the selected admit 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 Created 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

- **Account Discharge Date Range**: Allows the report to only include patients within the selected discharge 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 Created 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

***NOTES**: If both an Admit and Discharge date range are defined, only accounts that meet both parameters will display within the report.*

- **Department**: Allows the user to select a department to view notes that were signed by the owner while the patient was in a specific department. If a patient is admitted to the ED and then admitted to Inpatient, when the ED department is selected, only notes created/signed within that department will display. Any notes created/signed in the Inpatient department will not pull to the report.

***NOTE**: The Department look-up should not be used to generate a report for a patient visit if the patient has been admitted to different departments during the stay. This could result in an incomplete list of notes.*

Generating the Report:

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.
- **Schedule**: Allows the report to be setup to generate on a regular recurrence.
- **Clear Note Type Filter**: Allows the removal of the selected Note Type.

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 the note was signed or not signed on.
- **Note Title**: Displays the selected Note Type of the note.
- **Sign Status**: Displays the status of Signed when the note has been signed .

- **Cosign Status**: Displays the status of Cosigned if the note has both signatures and a status of 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
- **Note ID**: Displays the ID assigned to the note when it was created and displays within the Note List.
- **Room**: Displays the Room of the patient.

Third Row

- **Scribe:** This feature will be available in a future release and will display the name of the person that transcribed the note for the provider.

Fourth Row

- **Sign Provider:** Displays the name of the user that signed or saved the draft.
- **Sign Date/Time:** Displays the date and time the draft was signed by the note owner.

Fifth Row

- **Cosign Provider(s):** Displays the cosigner's Name. If it has not been cosigned, this will display the name of the provider the alert was sent to. When signed, the date and time of when the cosigner signed the note will display.

13.2 Notes Cosignature Deficiency Report

NOTE: *The Notes Cosignature Deficiency List report template will be removed from Report Dashboard on a future release. All the functionality (and more) of this report is now contained in the new Notes Signature Deficiency List report. Users who previously added these older reports to their personal Report Dictionary List and/or had added them as a Scheduled Job in Report Dashboard, will still see those options until manually removed. The Cosignature Deficiency report may be run to display any notes with a signed/unsigned Cosignature.*

13.3 Notes Draft Report

NOTE: *The Notes Draft Report template will be removed from Report Dashboard on a future release. All the functionality (and more) of this report is now contained in the new Notes Signature Deficiency List report. Users who previously added these older reports to their personal Report Dictionary List and/or had added them as a Scheduled Job in Report Dashboard, will still see those options until manually removed. The Cosignature Deficiency report may be run to display any notes with a signed/unsigned Cosignature.*

Chapter 14 Notes Downtime Procedures

In the event that Notes is down for extended period of time at your facility, the below are scenarios that users can take to document and/or review previous documentation.

Documentation Options:
• The user may document directly in Microsoft Word by typing out the documentation or using voice recognition software to complete. Once documentation is completed, Medical Records will need to scan the document into the system. The Image Title can be setup to send the document to the provider Esign queue for electronic signature if needed.

• The user may document in Word and once Notes is back up, they can copy and paste their note, change the date/time to when they documented their note and sign their note in the patient's chart.

• The user may complete documentation by hand and then have Medical Records scan the signed paper copy into the system for that account.

Review Previous Documentation:
• Any previously signed Note document may be viewed via Clinical History or Print EMR.