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EMR/VISTA

This document contains screen wireframes for OMH EMR based on Vista. Each tab on the lower portion of the Main Navigational Components screen represents a distinct component of the EMR system. Each of these tabbed components are documented separately to give a broader wireframe view. As such there will be a total number of 11 documents that when combined together will represent the entire EMR wireframe effort.

The following indices will be used to reference the tabbed components and each tab's sub-screen will use this index as its base.

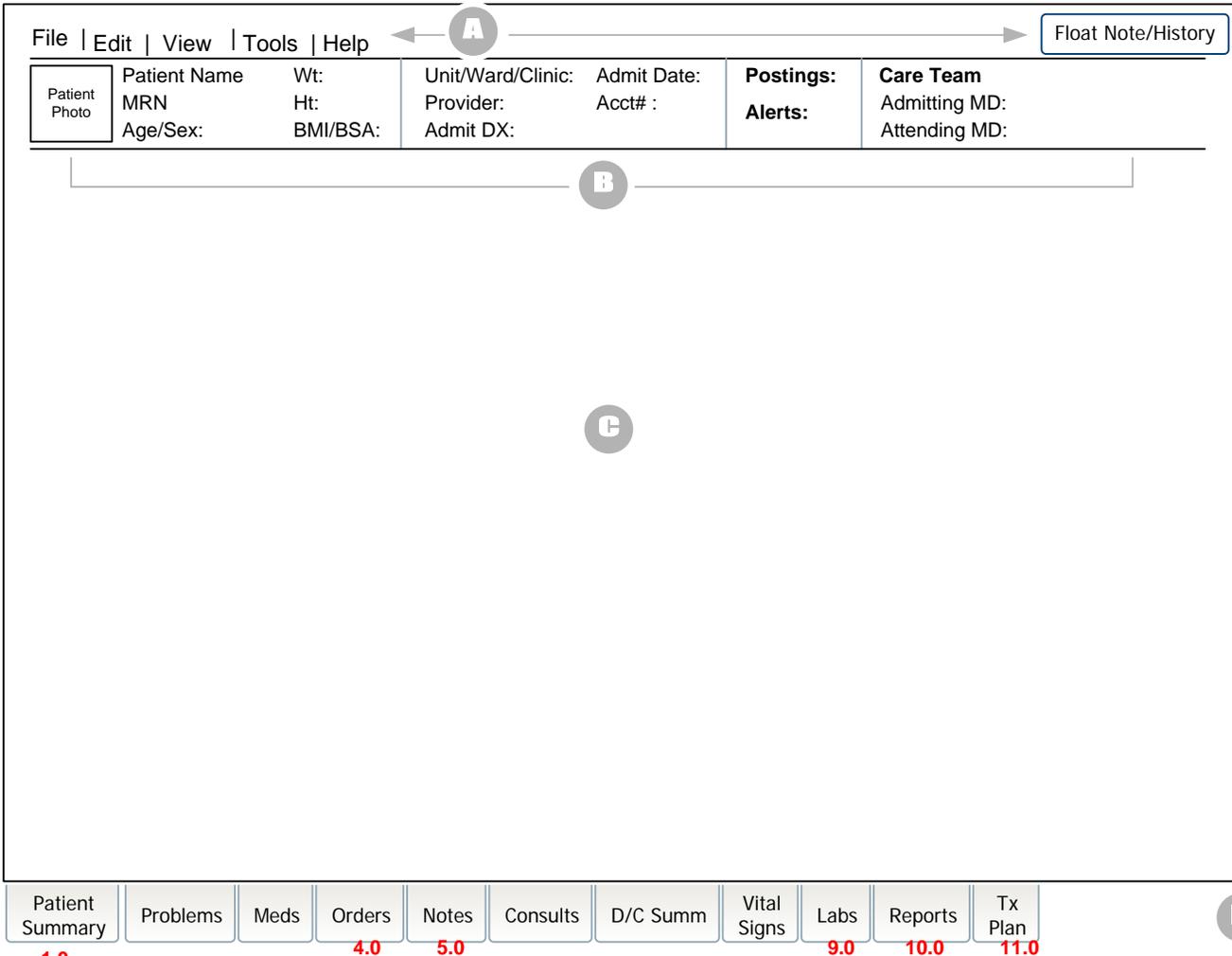
- 1.0 – Patient Summary
- 2.0 – Problems
- 3.0 – Meds
- 4.0 – Orders
- 5.0 – Notes
- 6.0 – Consults
- 7.0 – D/C Summ
- 8.0 – Vital Signs
- 9.0 – Labs
- 10.0 – Reports
- 11.0 – Treatment Plan

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EMR/VISTA

WireFrame – Main Navigational Components



Notes

A Menu bar used to access various functions such as selecting a patient, editing templates, customizing CIS. The Menu bar will also dynamically change based on the tab component selected.

Float History – This button will launch a floating screen that will make available historical information for various notes grouped by discipline for the selected patient. The ability to add notes is available here as well.

B Patient Header Banner – Display basic demographical information about the selected patient and if available the patients' photo.

MRN – Medical Record Number

Postings - messages about a patient which includes, Crises, Warnings, Allergies, (Advanced) Directives, and "Do Not Resuscitate" orders.

Alerts - messages that provide information or prompt you to act on a clinical event.

C This area is used to display the controls and features that are available with the respectively selected tab component.

D Tabs – used to navigate through the main components available in OpenVista CIS.

The Main Navigational Components are present throughout the OpenVista CIS experience and all main screens. It is an intricate part of navigating in this application.



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WireFrame – Main Navigational Components

The wireframe shows a main application window with a menu bar (File | Edit | View | Tools | Help) and a patient information header (Patient Photo, Patient Name, MRN, Age/Sex, Wt, Ht, BMI). A 'Float History' dialog box is open, listing various medical disciplines with 'History' buttons and '+' signs. A callout 'B' points to a list of dates (10/4/2005, 10/2/2004, 9/30/2003) that appears when a 'History' button is clicked. A callout 'A' points to a 'Float Note/History' button in the top right of the dialog. At the bottom, there are buttons for 'Patient Summary', 'Problems', 'Meds', 'Reports', and 'Tx Plan'.

Notes

A **Float History** – This button will launch a floating screen that will make available historical information for various notes grouped by discipline for the selected patient. This component will be available throughout the main navigational components in the application.

B Each drop-down list will display all the historical entries for each respective note. Upon selecting an item in the drop-down list, a separate pop-screen will display the documented note.

This feature is most useful for making available relevant information to the user when completing documentation that requires access to previous notes.

1.0 2.0 3.0 4.0 5.0 6.0 7.0 8.0 9.0 11.0

WireFrame – Cover Sheet Tab 1.0

File | Edit | View | Tools | Help
Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

Active Diagnosis

- Schizophrenia
- Asthma
- Bipolar Disorder NOS

Allergies/Adverse Reactions

- Strawberries
- Lactose
- Aspirin
- Shell Fish
- Penicillin

Patient Record Flag

No Results Found

Active Medication

Active Medication	Status
Home-Med Fish Oil 1200MG Oral Cap	Active
Home-Med Celery Leaf Pwdr	Active
Home-Med Melatonin Cap/Tab	Active
Home-Med Metformin HCL 500mg Tab UD	Active
Home-Med Warfarin NA 2mg Tab	Active

Clinical Reminders

D/C Summ Due Date

Recent Lab Results

No Results Found

Vitals

T	110	3/28/2009
P	98.2F	5/5/2009
R	24	5/5/2009
BP	164/114	5/5/2009
HT		4/30/2009
WT	155 lbs	4/30/2009

Appt/Visit/Admission

3/30/2009	ICU
4/28/2009	Med/Surg
7/6/2009	Inpatient Stay

Patient Summary	Problems	Meds	Orders	Notes	Consults	D/C Summ	Vital Signs	Labs	Reports	Tx Plan
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Notes

- A

The Patient Summary tab is the first screen you see after opening a patient record (unless the site or user defines another tab as the initial screen). The Patient Summary displays an overview of a patient's condition and history. It shows active problems, allergies and postings, active medications, clinical reminders, lab results, vitals, and a list of appointments or visits
- B

Patient Record Flag - advisories that authorized users place on a patient's chart to improve employee safety and the efficient delivery of health care.
- C

Clinical Reminders - furnish clinicians with timely information about the health maintenance schedules of their patients.

WireFrame – Problems Tab 2.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Problem
Edit
Remove
Annotate

	Status	Description	ICD Code	Onset Date	Provider
Active Problem (3 of 3)					
Active		Schizophrenia	295.90	1/13/2010	USER, PHYSICIAN
Active		Asthma		1/15/2010	USER, PHYSICIAN
Active		Bipolar Disorder NOS	493.90 296.7	1/13/2010	USER, PHYSICIAN

Active Problem

Inactive Problem

Both Active & Inactive

Removed Problems

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Notes

A The Problem List tab is used to document and track a patient's problems. It provides clinicians with a current and historical view of a patient's health care problems, and allows each identified problem to be traced in terms of treatment, test results, and outcome.

One problem list is allowed per patient.

B Action menu - These 4 buttons provides options for adding, updating, removing and annotating problems.

New Problem – displays selectable diagnoses that have active ICD9 codes

Edit – modifies that currently selected problem with another active ICD9 code

Remove – removes the selected problem from active or inactive status. These items remain in the system and are viewable as desired but do not impact decision support tools.

Annotate – provides an option to add comments to the selected problem

C Problem Categories – provides the option to view the currently selected patients' problems list base on status criteria.

D Problem List– displays the list of problems for the currently selected patient based on the chosen item in section C. (Ex. The items listed in this sample are Active Problems based on the "Active Problems" selection in section C)

WireFrame – Meds Tab 3.0

File | Edit | View | Actions | Tools | Help Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

New Inpt Medication
New Outpt Medication
New Home Medication
Change
Discontinue/Cancel
Copy

Inpatient Medication	Status	Stop Date	Details
OMEPRAZOLE CAP,SA 20MG [GEQ: PriLOSEC]	ACTIVE	12/16/2008	
SODIUM CL 0.9% /KCL 20MEQ [M] 1000 ML...	EXPIRED	11/18/2008	
CERAZOLIN [I] 1 GM	EXPIRED	11/16/2008	in DEXTROSE 5% [CCL]...
LISINOPRIL TAB 10MG [GEQ: PRINVIL]	PENDING		Give: 10MG PO QD

Home Medication	Status	Stop Date	Details
ABACAVIR SO4 600MG/LAMIVUDINE 300MG...	ACTIVE	2/19/2009	1 TAB MOUTH AT BEDTIME

Outpatient Medication	Status	Stop Date	Details

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Notes

- A
The Medications tab is a straightforward listing of medications for the selected patient. Inpatient Medications, Outpatient Medications, and Home Medications are listed in different areas.
- B
Action menu - to take other actions such as ordering a new medication, changing a medication order, or changing a medication order status (discontinue, hold, or renew), you use this Action menu (section B) or right-click on a medication.
- C
Inpatient Medication – displays Inpatient Medications with respective details
- D
Home Medication – displays Home Medications with respective details
- E
Outpatient Medication – displays Outpatient Medications with respective details

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WireFrame – Orders Tab 4.0

File | Edit | View | Actions | Tools | Help Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

MSE Assess Summary Labs Meds Meds History AMD Note

Smart Buttons

Service	Status	Order
Vitals	Unreleased	>>TPR/BP/SPO2 Q30 *UNSIGNED*
Home Med	Active	HOME MEDICATION ARIPIRAZOLE TAB 10MG...
Home Med	Active	HOME MEDICATION WARFARIN TAB 2MG [GEQ...
Home Med	Active	HOME MEDICATION metFORMIN TAB, ORAL 500MG...
Home Med	Active	HOME MEDICATION MELATONIN CAP/TAB...
Home Med	Active	HOME MEDICATION FISH OIL CAP, ORAL 1200MG...
Home Med	Active	HOME MEDICATION ALBUTEROL SULFATE 2MG/ML...
Home Med	Active	HOME MEDICATION CELERY LEAF PWDR [GEQ: CELER...
Lab - Chemistry	Active	PLATELET COUNT PURPLE-WB BLOOD LC LB #117...

Write Orders

Common orders

Cardiology Menu

Endocrinology

Gastroenterology

Write Delayed Orders

Patient Summary Problems Meds Orders Notes Consults D/C Summ Vital Signs Labs Reports Tx Plan

Notes

- A

From the Orders tab, you can write new orders and view existing orders for the selected patient. You can also create quick orders and order sets that make the ordering process more efficient.
- B

Smart Buttons – Quick access to view (V) relevant information or the ability to update (U) corresponding data elements. *From left to right: Mental Status Exam (U), Psych Assessment (U), Psych Summary (U), Lab Results (V), Current Medications (V), Medication History (V), and AMD note (U).*
- C

View Order Pane - You can control which orders appear on the Orders tab by selecting a specific status.

 - Active Orders** (including pending, recent activity)
 - Current Orders** (active/pending status only)
 - Expiring Orders** (all orders that will expire between now and midnight or now and midnight of the following day if the following day is a holiday)
 - Unsigned Orders**
 - Recently Expired Orders** (This view shows orders that have expired within the number of hours specified by a system parameter)
- D

Write Order Pane - You can place orders for a variety of items and procedures including medications, consults, and lab tests. You can also enter information about a patient's allergies. Order checks are performed on all orders.
- E

Orders Display View – order items listed based on option selected in #2
- F

Write Delayed Orders – An event-delayed order is an order that is executed only after a predefined event (known as a release event) occurs. A release event can be an event such as an admission, discharge, or transfer.

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WireFrame – Notes Tab 5.0

Notes

- A** From the Notes tab you can create new progress notes for a patient and view existing progress notes and documents. You can also create templates to allow you to quickly and efficiently enter progress notes.
- B** Action menu - These 3 buttons provides options for adding, updating, and deleting notes.

Smart Paste Buttons – Provides access to information (as indicated by the button label) that can easily be copied to the working document.
- C** Notes Search Criteria – drop-down list of options indicating the range of notes to display.
- D** This Listbox displays the result of the option selected in section C.
- E** Templates - use document templates to make writing or editing progress notes, completing consults, or writing discharge summaries quicker and easier.
- F** Document View Area - use to display the text results from Templates or from direct text input into this area. Selecting an option in #3 will also display results in this area.
- G** Reminders - used to aid physicians in performing tasks to fulfill Clinical Practice Guidelines and periodic procedures or education as needed for veteran patients. A dialog with a view of due, applicable, and other reminders.
- H** Encounters - To get workload credit and gather information, enter encounter form data whenever you create a progress note, complete a consult, or write a discharge summary.

WireFrame – Consults Tab 6.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

New Consult
New Procedure
Edit Note
Delete Note

A

C
 Search Criteria for Consults

4/23/2009	SKIN CARE NURSE
4/23/2009	CLINICAL DIETICIAN
4/23/2009	SKIN CARE NURSE

B
A

Consult Document View Area

Current Pat. Status: Outpatient
 Order Information
 To Service: SKIN CARE NURSE
 From Service: MED/SURG
 Requesting Provider: SMALL, KAREN
 Service is to be rendered on an INPATIENT basis
 Place: Consultant's choice
 Urgency: Stat
 Orderable Item: SKIN CARE NURSE
 Consult: Consult Request
 Reason For Request:
 Patient has been identified as being at high risk for skin breakdown.

Inter-facility Information
 This is not an inter-facility consult request.

Status: PENDING
 Last Action: CPRS RELEASED ORDER

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
 Account: 000000000001
 Admission: FEB 23, 2009@08:27 Admitting Diagnosis: COPD
 Ward: Room Bed:
 Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09)
 ===== END =====

E

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Notes

- A
 Consults/Procedure tab is the primary method that clinicians use to place an order for a procedure, such as an EKG. Then you can use this area to check in a patient and initiate the actual procedure.
- If the procedure is performed on a bi-directional instrument, the patient demographics are automatically transmitted to the instrument. When the procedure is complete, the result is transmitted back to VistA Imaging and attached to a note/document that is associated with the original procedure order.
- B
 Action menu - These 4 buttons provides options for adding, updating, and deleting consults/procedures.
 - New Consult** – add a new consult request
 - New Procedure** – order a new clinical procedure
 - Edit Note** – modify an existing consult/procedure note that has not been signed.
 - Delete Note** – delete a consult/procedure note
- C
 Consult/Procedure Search Criteria – drop-down list of options indicating the range of notes to display.
- D
 This Listbox displays the result of the option selected in letter C
- E
 Consult Document View Area - use to display the text results from Consult/Procedure pop-up screens. Selecting an option in section C will also display results in this area.

WireFrame – D/C Summ Tab 7.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

New Summary
Edit
Delete

Search Criteria for Summaries

8/21/2009 Discharge Summary

8/6/2009 DISCHARGE SUMMARY

TITLE: Discharge Summary
 DICT DATE: AUG 21, 2009@15: 57: 33 ENTRY DATE: AUG 21, 2009@15: 57: 57
 DICTATED BY: KEEP, NOLAN ATTENDING: KETCHERSIDE, JOE
 URGENCY: routine STATUS: UNCOSIGNED

*** NOT YET COSIGNED ***

Admission Date: JUL 6, 2009 09: 37
 Discharge Date: AUG 21, 2009
 Admission Diagnosis: Chest Pain
 Discharge Diagnosis: Unstable Angina
 Hospital Procedures:
 No procedures were done during hospital course

Hospital Course:
 Patient was admitted through the ED and evaluated for chest pain lasting 2 hours. On admission to the unit, patient was pain free without arrhythmias or ectopy. Serial Troponin and CPK were done and patients vital signs were monitored. Repeat EKG and Lab results were negative. Patient was discharged with current medication regimen and follow-up with me in 1 month or sooner if he has any problems.

Discharge Medications:
 Active OUTPATIENT Medications
 =====
 1) Home Med ALBUTEROL SULFATE 2MG/5ML SYRUP
 5ML UD Sig: 1 TEASPOONFUL MOUTH EVERY DAY
 2) Home Med ARIPIRAZOLE 10MG TAB Sig:
 10MG MOUTH TWICE A DAY
 3) Home Med CELERY LEAF PWDR Sig: SMALL
 AMOUNT MOUTH EVERY DAY

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Notes

- A
Discharge Summary - the discharge summary is a formal recapitulation of the patient's course of care, which includes pertinent diagnostic and therapeutic steps and the conclusions reached as a result.

- B
Action menu – These 3 buttons provides options for adding, updating, and deleting discharge summaries.
 - New Summary** – create a new discharge summary
 - Edit** – modify an existing discharge summary note that has not been signed.
 - Delete** – delete a discharge summary note

- C
Discharge Summary Search Criteria – drop-down list of options indicating the range of notes to display.

- D
This Listbox displays the result of the option selected in section C.

- E
Discharge Summary Document View Area - use to display the text results from Consult/Procedure pop-up screens. Selecting an option in section C will also display results in this area.

WireFrame – Vital Signs Tab 8.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Vitals

Entered In Error

Date: All Results
From: 3/30/2010 12:00:00 AM
To: NOW
Graph: TPR

	8/13/2008 0915	8/13/2008 2300	8/28/2008 1030	8/28/2008 1140	8/28/2008 1245	8/28/2008 ...
Temperature	99.6 (37.6 C)		98.5 (36.9 C)	99 (37.2 C)	99 (37.2 C)	99 (37.2 C)
Pulse	78	112	110	80	72	72
Respiration	20	24	24	18	20	20
Pulse Ox.	98	98	96			

■ Temperature ■ Pulse ■ Respiration

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Notes

- A
Vitals Signs - application is designed to store in the patient's electronic medical record all vital signs and various measurements associated with a patient's hospital stay or outpatient clinic visit

- B
Action menu – These 2 buttons provides options for adding, updating, and deleting discharge summaries.
 - New Vitals** – enter new vitals
 - Entered In Error** – Vitals data values cannot be deleted once they have been saved - if incorrect vitals data have been saved, they must be marked "Entered in Error" and replaced with corrected data.

- C
Date – includes a selection of date options to filter and display vital sign results. A custom option is also available to facilitate the selection of user input date range

- Graph – includes a selection of vital sign options to filter and display in the graphical view

- D
This grid displays the result of the option selected in section C (date range).

- E
This chart displays the result of the option selected in section C (Graph) in a graphical view.

WireFrame – Labs Tab 9.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

Reports Showing: All Tests A

TEST BY DATE

WORKSHEET

CUMULATIVE

MICROBIOLOGY

BLOOD BANK

LAB STATUS

Show Abnormal Results Only
 Show Grid Horizontally

Change Filter... H

Test Name	Units	Ref. Range	Results	Flags
GLUCOSE RANDOM	mg/dL	60 - 300	144	
BLOOD UREA NITROGEN	mg/dL	7 - 20	25	H
CREATINE	mg/dL	0.8 - 1.3	1.2	
NA+	mEq/L	137 - 145	144	

Graph F

Best Fit
Show Values
Print Graph...

Date Range

Date Range...

Today

One Week

Two Week

Collection Dates

8/9/2009 0630

8/8/2009 2245

8/8/2009 1200

8/8/2009 0600

Comments

Specimen: BLOOD Accession: HE 0810 5 Provider: CRAFT,ADAM

Performing Lab: General Hospital

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Notes

- A
 The Lab Results tab has the results of lab tests for specific categories that you can view in various formats and by specific periods of time (including all test results for a specific category).
- B
 Reports – A selection of lab reports to view. The results are displayed in section F.
- C
 Date Range – When combined with section B, the date range option provides for filtering results to specific date parameters. The results are displayed in section F.
- D
 Collection Dates – Display results based on the collection Date selected
- E
 Comments – Additional notes regarding the selected Lab Result item.
- F
 Results Display – This area displays lab results based on the items selected in section B, C, and D. Results are displayed in grid format as well as in graphical view
- G
 The Green arrows on either side of the display screen will navigate the previous/next 'Collection Date' of the result set.
- H
 Change Filter – provides for further discretion of data to be displayed in the Grid view

WireFrame – Reports Tab 10.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

Reports

- Clinical Reports
- Health Summary
- HDR Reports
- Imaging
- Graphing
- Lab Status
- Blood Bank Rpt.
- Dietetics Profile
- Vitals Cumulative

Chart Inquiries Display View

APR 6,2010 (13:03) Cumulative Vitals/Measurements Report Page 1

No cumulative vitals data for this patient

Date Range

- Date Range...
- Today
- One Week
- Two Week

Patient Summary

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Notes

- A
CPRS reports include Clinical Reports, Health Summary, Imaging (Radiology and Nuclear Medicine), Lab Status, Blood Bank Report, Anatomic Pathology Report, Dietetics Profile, Nutritional Assessment, Vital Cumulatives, and others that your site wishes to list. You will see these reports in the Available Reports box (section B).
- B
Reports – A selection of reports to view. The results are displayed in section D.
- C
Date Range – When combined with section B, the date range option provides for filtering results to specific date parameters. The results are displayed in section D.
- D
Chart Inquiries Display View - use to display the results from options selected in section B and C.

WireFrame – Treatment Plan Tab 11.0

File | Edit | View | Actions | Tools | Help
Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

History

6/8/2010

3/1/2010

12/5/2009

New Team Note
New Initial Tx Plan
New Tx Plan Review
Edit
Delete

Individual Crisis Prevention reviewed; no changes/updates recommended at this time

Participation in Treatment Plan (List participants, including family members and significant others who provided input; included titles)

*Treatment Team Member

John Overhill, RN – Charge Nurse*

Michael Kavanaugh, LMSW – Social Worker*

Andrea Sopko, Licensed Psychlgst – Psychologist*

Robert Zook – SCTA*

David Thing, MD – Psychiatrist*

Anticipated DC Date:
Tx Review Date:
Next Review Date:

Participants in Tx Plan	Discharge Planning
View Edit	View Edit
Tx Plan Conference Note	Problems
View Edit View All	View Edit
Diagnosis	Strengths
View Edit	View Edit
Additional Evaluations	Goal Plan
View Edit	View Edit
	Patient/Family Statement
	View Edit

Click here to select the Signatories

Patient Summary	Problems	Meds	Orders	Notes	Consults	D/C Summ	Vital Signs	Labs	Reports	Tx Plan
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Notes

- A
Treatment Plan - Provides functionality to record, store and update a treatment plan individualized for each patient and developed with input from the team and based on initial assessments.
- B
Action menu - These 5 buttons provides options for adding, updating, removing Treatment Plans.
- C
History – Displays a listing of Treatment Plans entered for the selected patient.
- D
Display Window – This display field is used to view all or any portion of the Treatment Plan as dictated by the selected item in Section F
- E
Anticipated Discharge Date – Indicates when the patient is expected to be discharge
- E
Treatment Review Date – Date on which the Treatment Plan is being reviewed by the Team
- E
Next Review Date – This is usually a predetermined interval at which the Team will review the Treatment Plan. The review date is in consideration of age, admission date, and LOS.
- F
This area is used to select the various parts of the Treatment Plan. Selecting 'View' will display (in section D) the respective part which would include the most recent changes. Selecting "Edit" would launch a separate display screen used to modify the respective part. Selecting "View All" would display the entire document as you scroll downward.
- G
Use to select the persons that will need to sign this Treatment Plan.

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WireFrame – Patient Summary Tab 1.0

File | Edit | View | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	MRN	Ht:	Provider:	Acct# :		
	Age/Sex:	BMI/BSA:	Admit DX:			

Active Problems

- Schizophrenia
- Asthma
- Bipolar Disorder NOS

Allergies/Adverse Reactions

- Strawberries
- Lactose
- Aspirin
- Shell Fish
- Penicillin

Patient Record Flag

No Results Found

Postings

Allergies

Active Medication	Status	Clinical Reminders	Due Date
Home-Med Fish Oil 1200MG Oral Cap			
Home-Med Celery Leaf Pwdr	Active		
Home-Med Melatonin Cap/Tab			
Home-Med Metformin HCL 500mg Tab UD	Active		
Home-Med Warfarin NA 2mg Tab	Active		

Recent Lab Results	Vitals	Appt/Visit/Admission
No Results Found	T 3/28/2009	3/30/2009 ICU
	P 98.2/110 5/5/2009	4/28/2009 Med/Surg
	R 24 164/114 5/5/2009	7/6/2009 Inpatient Stay
	BP 24 164/114 5/5/2009	
	HT 4/30/2009	
	WT 72 155 lbs 4/30/2009	

Patient Summary |
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 Reports

Notes

A The Cover Sheet tab is the first screen you see after opening a patient record (unless the site or user defines another tab as the initial screen). The Cover Sheet displays an overview of a patient's condition and history. It shows active problems, allergies and postings, active medications, clinical reminders, lab results, vitals, and a list of appointments or visits

Many of these display items will allow the user to add a new entry by right-clicking on the respective listbox.

B Patient Record Flag - advisories that authorized users place on a patient's chart to improve employee safety and the efficient delivery of health care.

C Clinical Reminders - furnish clinicians with timely information about the health maintenance schedules of their patients.

WireFrame – Problem List Tab 2.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	MRN	Ht:	Provider:	Acct# :		
	Age/Sex:	BMI/BSA:	Admit DX:			

A

New Problem
Edit
Remove
Annotate

Active Problems Inactive Problems Both Active & Inactive Removed Problems	Active Problems (3 of 3)				
	Status	Description	ICD Code	Onset Date	Provider
	Active	Schizophrenia	295.90	1/13/2010	USER, PHYSICIAN
	Active	Asthma		1/15/2010	USER, PHYSICIAN
Active	Bipolar Disorder NOS	493.90 296.7	1/13/2010	USER, PHYSICIAN	

Cover Sheet	Problems	Medications	Orders	Clinical Notes	Consults/ Procedures	Discharge Summary	Vital Signs	Lab Results	Chart Inquiries
-------------	----------	-------------	--------	----------------	----------------------	-------------------	-------------	-------------	-----------------

Notes

A The Problem List tab is used to document and track a patient's problems. It provides clinicians with a current and historical view of a patient's health care problems, and allows each identified problem to be traced in terms of treatment, test results, and outcome.

One problem list is allowed per patient.

B Action menu - These 4 buttons provides options for adding, updating, removing and annotating problems.

New Problem – displays selectable diagnoses that have active ICD9 codes

Edit – modifies that currently selected problem with another active ICD9 code

Remove – removes the selected problem from active or inactive status. These items remain in the system and are viewable as desired but do not impact decision support tools.

Annotate – provides an option to add comments to the selected problem

C Problem Categories – provides the option to view the currently selected patients' problems list base on status criteria.

D Problem List– displays the list of problems for the currently selected patient based on the chosen item in #3. (Ex. The items listed in this sample are Active Problems based on the "Active Problems" selection in section C)

WireFrame – Problem Tab –> New Problem Button –> Problem Lookup 2.1

Problem Lookup

Search: heart

Description	Code
Heart Arrest	ICD ICD-9-CM : 427.5
Heart failure	ICD-9-CM : 428.9
Heart Murmurs	ICD-9-CM : 785.2
Heart Aneurysm	ICD-9-CM : 414.19
Heart Diseases	ICD-9-CM : 429.9
Heart Injuries	ICD-9-CM : 861.00
Heart Neoplasms	ICD-9-CM : 164.1
Heart Transplant	ICD-9-CM : V42.1
Heart Hypertrophy	ICD-9-CM : 429.3
Other heart block	ICD-9-CM : 426.6
Left Heart Failure	ICD-9-CM : 428.1
Heart Septal Defect	ICD-9-CM : 745.9
Heart Valve Disease 424.90	ICD-9-CM :
Congenital heart	ICD-9-CM : 414.19

100 of 197 entries displayed

Select Cancel

Notes

- A** When the New Problem button is clicked the Problem Lookup pop-screen is displayed. A search will be conducted for problems that contain the search term. The matching problems will appear in the bottom half of the Problem Lookup dialog (section C).
- B** Enter the search term here and click the Search Button
- C** This area will display the search results
- D** **Select button** – click this button when you have found a suitable item in the list
Cancel button – click this button to discontinue the lookup process

Cover Sheet | **Problems** | Meds | Orders | Notes | Consults | D/C Summ | Vital Signs | Labs | Reports

WireFrame – Problem List Tab → New Problem Button → Add Problem 2.2

Notes

- A** After the appropriate item is selected in the Problem Lookup screen, the Problem Add screen is display
- B** **Problem** – captures the item selected in The Problem Lookup screen
Onset Date – enter the onset date of the problem
Service – indicate the service
Provider – enter the provider name
- C** Status – indicate if problem is active or inactive
- D** Immediacy – indicate if problem is acute, chronic, or unknown
- E** Comments – additional notes regarding the problem
- F** Buttons use to add, edit, and remove comments
- G** Buttons used to save or cancel the 'Add Problem' entry

WireFrame – Problem List Tab -> Edit Problem Button -> Edit Problem 2.3

Notes

- A** Edit Problem – screen used to update or edit a problem
- B** **Problem** – captures the item selected in The Problem Lookup screen
Onset Date – enter the onset date of the problem
Service – indicate the service
Provider – enter the provider name
- C** Status – indicate if problem is active or inactive
- D** Immediacy – indicate if problem is acute, chronic, or unknown
- E** Comments – additional notes regarding the problem
- F** Buttons use to add, edit, and remove comments
- G** Buttons used to save or cancel the 'Add Problem' entry

WireFrame – Problem List Tab → Remove Problem Button → Remove Problem 2.4

Notes

- A** Remove Problem – screen used to remove a problem. Removing a problem does not delete it from the system.
- B** Details – detail information about the problem targeted for removal
- C** Remove Comment – a reason must be entered to indicate why the problem is being removed
- D** Buttons used to remove or cancel the 'Remove Problem' event

WireFrame – Problem List Tab -> Annotate Button -> Add Problem Comment 2.5

The wireframe shows a blue dialog box titled "Add Problem Comment" with a close button (X) in the top right corner. Inside the dialog, there is a text input field labeled "Enter a new comment (up to 60 characters):" and two buttons at the bottom: "OK" and "Cancel".

Below the dialog, the "Active Problems" table is visible. The table has columns for Status, Description, ICD Code, Onset Date, and Provider. The data rows are as follows:

Status	Description	ICD Code	Onset Date	Provider
Active	Schizophrenia	5.90	010	USER, PHYSICIAN
Active	Asthma		/15/2010	PHYSICIAN
Active	Bipolar Disorder NOS	493.90 296.7	1/13/2010	PHYSICIAN
	29			USER, USER,
		1		
		1/		

At the bottom of the screen, there is a navigation bar with buttons for "Cover Sheet", "Problems", "Medications", "Orders", "Clinical Notes", "Consults/Procedures", "Discharge Summary", "Vital Signs", "Lab Results", and "Chart Inquiries". The "Problems" button is highlighted.

Notes

- A** Comment (Annotate) – screen used to add comments about the problems
- B** Text field area used to add comments about a problem
- C** Buttons used to save or cancel the 'Comments' entry

The following indices will be used to reference the Medications tab component and it's sub-screens.

- 3.0 – Medications
- 3.1 – Select Medication
- 3.2 – New Inpatient Medication – Regular
- 3.3 – New Inpatient Medication – Complex
- 3.4 – New Outpatient Medication – Regular
- 3.5 – New Outpatient Medication – Complex
- 3.6 – New Home Medication – Regular
- 3.7 – New Home Medication – Complex
- 3.8 – Discontinue/Cancel Orders
- 3.9 – Copy To New Order

James M. Smith

Information Technology Specialist 4
CIT Patient Application Services

WireFrame – Medications Tab 3.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Inpt Medication
New Outpt Medication
New Home Medication
Change
Discontinue/Cancel
Copy

Inpatient Medication	Status	Stop Date	Details
OMEPRAZOLE CAP,SA 20MG [GEQ: PriLOSEC]	ACTIVE	12/16/2008	
SODIUM CL 0.9% /KCL 20MEQ [M] 1000 ML...	EXPIRED	11/18/2008	
CERAZOLIN [I] 1 GM	PENDING	11/16/2008	in DEXTROSE 5% [CCL]... Give: 10MG PO QD
LISINOPRIL TAB 10MG [GEQ: PRINVIL]	EXPIRED		

Home Medication	Status	Stop Date	Details
ABACAVIR SO4 600MG/LAMIVUDINE 300MG...	ACTIVE	2/19/2009	1 TAB MOUTH AT BEDTIME

Outpatient Medication	Status	Stop Date	Details

Patient Summary
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Medications
Orders
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Consults/Procedures
Discharge Summary
Vital Signs
Lab Results
Chart Inquiries

Notes

- A

The Medications tab is a straightforward listing of medications for the selected patient. Inpatient Medications, Outpatient Medications, and Home Medications are listed in different areas.

To get additional details on a specific medication order you would double-click the entry.
- B

Action menu - to take other actions such as ordering a new medication, changing a medication order, or changing a medication order status (discontinue, hold, or renew), you use this Action menu (#2) or right-click on a medication.

You can also place orders for new medications from the Orders tab.
- C

Inpatient Medication – displays Inpatient Medications with respective details
- D

Home Medication – displays Home Medications with respective details
- E

Outpatient Medication – displays Outpatient Medications with respective details

WireFrame – Medications Tab -> New Inpt Medication Button -> Select Medication 3.1

Notes

- A** Select Medication – provides a list of medications from which the user can choose from. An “Other” option is available for items not available in the list
- B** Search field – here you type enough of the medication name to allow it to populate in the list below
- C** Click “Select” when you have found the desired item. Click “Cancel” to undo the add new medication event.

WireFrame – Medications Tab -> New Inpt Medication Button -> New Medication Order (Regular) 3.2

The screenshot shows a 'New Inpatient Medication Order' window. At the top, the title bar says 'New Inpatient Medication Order' with a close button (A). Below the title bar, there's a patient information section with 'Patient Photo', 'MRN', and 'Age/Se'. The main area contains a text field for the medication name 'ALBUTEROL SOLIN, INHL' (B). Below this is a 'Display Restrictions/Guidelines' field (C). There are two tabs: 'Regular' (selected) and 'Complex'. The 'Regular' tab has three columns: 'Dosage' (MIX 1 PACKAGE 0.5%), 'Route' (INHALATION), and 'Schedule' (PRN checked, BID, MO-WE-FR, NOW). Below these is a 'Priority' dropdown set to 'ROUTINE' (D) and a 'Comments/Indications' text area. At the bottom, there are three buttons: 'Order' (E), 'Save As Quick Order', and 'Cancel'. A 'Copy' button is also visible on the right side of the dialog.

Notes

- (A) New Inpatient Medication Order – used to add a new inpatient medication order
- (B) Used to display additional guidelines, if applicable, regarding the chosen medication
- (C) Regular – provides for ordering medications that consist of regular (basic) instructions
- (D) Priority – ROUTINE, ASAP, STAT
- (E) Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

WireFrame – Medications Tab -> New Inpt Medication Button -> New Medication Order (Complex) 3.3

The screenshot shows a 'New Inpatient Medication Order' dialog box. At the top, the title bar contains 'New Inpatient Medication Order' with a close button (X) and a callout letter 'A'. Below the title bar, there is a text input field containing 'ALOH 225/MGOH 200MG/5ML SUSP,ORAL' and a callout letter 'A'. Below this is a field for 'Display Restrictions/Guidelines' with a callout letter 'B'. There are two radio buttons: 'Regular' and 'Complex', with 'Complex' selected and a callout letter 'C'. Below the radio buttons is a table for medication instructions with columns: 'Dosage/Rate', 'Route', 'Schedule', 'Duration (optional)', and 'then/and'. The first row contains: '200MG', 'ORAL', 'BID', 'PRN', 'Week(s)', and 'then'. Below the table are 'Insert Dose' and 'Delete Dose' buttons. Below the table is a 'Priority' dropdown menu set to 'ROUTINE' with a callout letter 'D'. To the right of the priority is a 'Comments/Indications:' text area. Below the priority is a checked checkbox for 'Additional dose now' and a field for 'Expected First Dose:'. At the bottom of the dialog is a text input field containing 'ALOH 225/MGOH 200MG/5ML SUSP,ORAL PO' and three buttons: 'Order' (with callout letter 'E'), 'Save As Quick Order', and 'Cancel'. The background shows a partial view of the EMR interface with tabs for Patient Photo, MRN, Age/Sex, Home Medication, and Outpatient Medication.

Notes

- A** New Inpatient Medication Order – used to add a new inpatient medication order
- B** Used to display additional guidelines, if applicable, regarding the chosen medication
- C** Complex – provides for ordering medications that consist of complex multi-line instructions
 - Insert Dose – Add a new row for to insert instructions
 - Delete Dose – Removes an existing row of instructions
- D** Priority – ROUTINE, ASAP, STAT
- E** Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

WireFrame – Medications Tab -> New Outpt Medication Button -> New Medication Order (Regular) 3.4

The screenshot shows a 'New Outpatient Medication Order' dialog box. At the top, there is a title bar with a close button (X) and a label 'A'. Below the title bar, there is a text input field containing 'ALBUTEROL SOLIN, INHL' with a search icon (...). Below this is a section labeled 'Display Restrictions/Guidelines' with a label 'B'. The main form area has two tabs: 'Regular' (selected) and 'Complex'. Under the 'Regular' tab, there are three columns: 'Dosage:' with a text field containing 'MIX 1 PACKAGE 0.5%', 'Route:' with a dropdown menu containing 'INHALATION', and 'Schedule:' with a dropdown menu containing 'BID', 'MO-WE-FR', and 'NOW'. There is a checkbox for 'PRN' next to the schedule field. Below these fields is a 'Priority:' dropdown menu set to 'ROUTINE' with a label 'D'. To the right of the priority is a 'Comments/Indications:' text area. Below the priority are three dropdown menus for 'Days Supply' (0), 'Quantity' (0), and 'Refills' (0). Below these are radio buttons for 'Pick Up' location: 'Clinic', 'Mail', and 'Window' (selected). At the bottom of the dialog, there is a text field containing 'ALBUTEROL SOLIN, INHL' and three buttons: 'Order', 'Save As Quick Order', and 'Cancel', with a label 'E' pointing to the 'Order' button.

Notes

- A** New Outpatient Medication Order – used to add a new outpatient medication order
- B** Used to display additional guidelines, if applicable, regarding the chosen medication
- C** Regular – provides for ordering medications that consist of regular (basic) instructions
- D** Priority – ROUTINE, ASAP, STAT
For outpatients this area also includes additional field for Days Supply, Quantity, Refills amounts. A “Pick Up” option is also available to note the delivery method (Clinic, Mail, or Window)
- E** Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

WireFrame – Medications Tab -> New Outpt Medication Button -> New Medication Order (Complex) 3.5

New Outpatient Medication Order

ALOHO 225/MGOH 200MG/5ML SUSP,ORAL

Display Restrictions/Guidelines

Regular **Complex**

Dosage/Rate	Route	Schedule	PRN	Duration (optional)	then/and
200MG	ORAL	BID	<input checked="" type="checkbox"/>	Week(s)	then

Insert Dose Delete Dose Duration: 0 (no selection)

Priority: **ROUTINE**

Comments/Indications:

Days Supply: 0 Quantity: 0 Refills: 0

Pick Up
 Clinic Mail Window

ALOHO 225/MGOH 200MG/5ML SUSP,ORAL
PO

Order
Save As Quick Order
Cancel

Notes

- A** New Outpatient Medication Order – used to add a new Outpatient medication order
- B** Used to display additional guidelines, if applicable, regarding the chosen medication
- C** Complex – provides for ordering medications that consist of complex multi-line instructions
 - Insert Dose – Add a new row for to insert instructions
 - Delete Dose – Removes an existing row of instructions
- D** Priority – ROUTINE, ASAP, STAT
 - For outpatients this area also includes additional field for Days Supply, Quantity, Refills amounts. A “Pick Up” option is also available to note the delivery method (Clinic, Mail, or Window)
- E** Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

WireFrame – Medications Tab -> New Home Medication Button -> New Medication Order (Regular) 3.6

New Home Medication Order
A
✕

Patient Photo

Patient MRN

Age/Sex

Display Restrictions/Guidelines
B

Regular
Complex

Dosage:	Route:	Schedule:	<input type="checkbox"/> PRN
<input style="width: 95%;" type="text" value="325MG"/>	<input style="width: 95%;" type="text" value="ORAL"/>	<input style="width: 95%;" type="text" value="BID"/>	
<input style="width: 95%;" type="text" value="325MG"/>	<input style="width: 95%;" type="text" value="ORAL"/>	<input style="width: 95%;" type="text" value="BID"/>	<input type="checkbox"/> MO-WE-FR <input type="checkbox"/> NOW

Priority: ROUTINE D

Days Supply: Quantity: Refills:

Pick Up

Clinic
 Mail
 Window

Comments/Indications:

ACETAMINOPHEN TAB
TAKE BY MOUTH

E

Notes

- A

New Home Medication Order – used to add a new Home medication order
- B

Used to display additional guidelines, if applicable, regarding the chosen medication
- C

Regular – provides for ordering medications that consist of regular (basic) instructions
- D

Priority – ROUTINE, ASAP, STAT

For outpatients this area also includes additional field for Days Supply, Quantity, Refills amounts. A “Pick Up” option is also available to note the delivery method (Clinic, Mail, or Window)
- E

Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

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NOTE: Diagrams represent information structure only. They do not represent actual screen designs. Page 8 of 11 Last Updated 11/8/2010 2:42:05 PM by James M. Smith

WireFrame – Medications Tab -> New Home Medication Button -> New Medication Order (Complex) 3.7

File | Edit | View
X
A
New Home Medication Order

Patient Photo

Patient MRN

Age/Sex

...

B

Regular
Complex

Dosage/Rate	Route	Schedule	PRN	Duration (optional)	then/and
325MG	ORAL	BID	<input type="checkbox"/>	Week(s)	then

Insert Dose Delete Dose

Duration: 0 (no selection)

Priority: ROUTINE

Comments/Indications:

Days Supply	Quantity	Refills
90	80	0

Pick Up
 Clinic Mail Window

ACETAMINOPHEN TAB
 TAKE BY MOUTH

Order
Save As Quick Order
Cancel

Notes

- A
 New Home Medication Order – used to add a new Home medication order

- B
 Used to display additional guidelines, if applicable, regarding the chosen medication

- C
 Complex – provides for ordering medications that consist of complex multi-line instructions
 - Insert Dose – Add a new row for to insert instructions
 - Delete Dose – Removes an existing row of instructions

- D
 Priority – ROUTINE, ASAP, STAT
 - For home meds this area also includes additional field for Days Supply, Quantity, Refills amounts. A “Pick Up” option is also available to note the delivery method (Clinic, Mail, or Window)

- E
 Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

WireFrame – Medications Tab -> Discontinue/Cancel Orders Button 3.8

Discontinue/Cancel Orders

The following orders will be discontinued:

- ABACAVIR SO4 600MG/LAMIVUDINE 300MG
- 1 TAB MOUTH AT BEDTIME

Buttons: OK, Cancel

Background Medication List:

Medication	Status	Stop Date	Details
ABACAVIR SO4 600MG/LAMIVUDINE 300MG...	ACT	IVE 2/19/2009	1 TAB MOUTH AT BEDTIME

Notes

A Items selected for discontinuance or to be canceled are displayed in this screen.

Clicking 'OK' will process the listed items as such
Clicking "Cancel" will not process this event



WireFrame – Medications Tab -> Copy To Button 3.9

File | Edit | View | Actions

Copy To New Order
ⓘ
✕

Patient Photo
Patient Name
Wt:

MRN
Ht:

Age/Sex:
BMI

New Inpt Medication
New O...

Inpatient Medication

OMEPRAZOLE CAP,SA 20MG [...]
 SODIUM CL 0.9% /KCL 20MEQ
 CERAZOLIN [I] 1 GM
 LISINOPRIL TAB 10MG [GEQ: P

Home Medication

ABACAVIR SO4 600MG/LAMIV...

Outpatient Medication

Status	Stop Date	Details

Copy To New Orders

The current treating specialty is Here.
 PATIENT, CLINICAL is currently at Unit X

Release copied orders immediately

 Delay release of copied orders until:

Effective Date: Today

Select
Cancel

Care Team

Admitting MD:
Attending MD:

Discontinue/Cancel
Copy

Details

in DEXTROSE 5% [CCL]...
 Give: 10MG PO QD

Details

1 TAB MOUTH AT BEDTIME

Notes

- ⓘ Upon selecting the items on the Medication Tab, the respective item can be copied to a new order.
- Release copied orders immediately – indicates that the order should be immediately released
- Delay release of copied orders until – indicates that the order should be delayed until the noted condition or event has occurred

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NOTE: Diagrams represent information structure only. They do not represent actual screen designs.

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Last Updated 11/8/2010 2:42:05 PM by James M. Smith

The following indices will be used to reference the Orders tab component and it's sub-screens.

- 4.0 – Orders
- 4.1 – Write Orders
- 4.2 – Patient Status
- 4.3 – Patient Movement
- 4.4 – Activity Orders
- 4.5 – Vitals
- 4.6 – Imaging Orders
- 4.7 – Medications
- 4.8 – Lab Orders
- 4.9 – Procedures
- 4.10 – Consults
- 4.11 – Diet Orders
- 4.12 – Nursing Orders
- 4.13 – Enter Allergies
- 4.14 – Text Orders Only
- 4.15 – Write Delayed Orders

James M. Smith

Information Technology Specialist 4
CIT Patient Application Services

EMR/VISTA

WireFrame – Orders Tab 4.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

A
B

MSE Assess Summary Labs Meds Meds History AMD Note

Smart Buttons

Service	Status	Order
Vitals	Unreleased	>>TPR/BP/SPO2 Q30 *UNSIGNED*
Home Med	Active	HOME MEDICATION ARIPIRAZOLE TAB 10MG...
Home Med	Active	HOME MEDICATION WARFARIN TAB 2MG [GEQ...
Home Med	Active	HOME MEDICATION metFORMIN TAB, ORAL 500MG...
Home Med	Active	HOME MEDICATION MELATONIN CAP/TAB...
Home Med	Active	HOME MEDICATION FISH OIL CAP, ORAL 1200MG...
Home Med	Active	HOME MEDICATION ALBUTEROL SULFATE 2MG/ML...
Home Med	Active	HOME MEDICATION CELERY LEAF PWDR [GEQ: CELER...
Lab - Chemistry	Active	PLATELET COUNT PURPLE-WB BLOOD LC LB #117...

E

C
F

Write Delayed Orders

Patient Summary	Problem List	Medications	Orders	Clinical Notes	Consults/Procedures	Discharge Summary	Vital Signs	Lab Results	Chart Inquiries
-----------------	--------------	-------------	--------	----------------	---------------------	-------------------	-------------	-------------	-----------------

Notes

- A From the Orders tab, you can write new orders and view existing orders for the selected patient. You can also create quick orders and order sets that make the ordering process more efficient.
- B Smart Buttons – Quick access to view (V) relevant information or the ability to update (U) corresponding data elements. *From left to right: Mental Status Exam (U), Psych Assessment (U), Psych Summary (U), Lab Results (V), Current Medications (V), Medication History (V), and AMD note (U).*
- C View Order Pane - You can control which orders appear on the Orders tab by selecting a specific status.
 - Active Orders** (including pending, recent activity)
 - Current Orders** (active/pending status only)
 - Expiring Orders** (all orders that will expire between now and midnight or now and midnight of the following day if the following day is a holiday)
 - Unsigned Orders**
 - Recently Expired Orders** (This view shows orders that have expired within the number of hours specified by a system parameter)
- D Write Order Pane - You can place orders for a variety of items and procedures including medications, consults, and lab tests. You can also enter information about a patient's allergies. Order checks are performed on all orders.
- E Orders Display View – order items listed based on option selected in #2
- F Write Delayed Orders – An event-delayed order is an order that is executed only after a predefined event (known as a release event) occurs. A release event can be an event such as an admission, discharge, or transfer.

Common Orders
✕

<p>Patient Status</p> <ul style="list-style-type: none"> Patient Condition Patient Diagnosis DNR Status 	<p>Patient Movement</p> <ul style="list-style-type: none"> Admit Patient Discharge Patient Transfer Patient Change Treating Specialty 	<p>Activity Orders</p> <ul style="list-style-type: none"> Ad Lib Out of Bed May Leave Ward Bathroom Privileges Bed Rest
<p>Vitals</p> <ul style="list-style-type: none"> TPR B/P B/P Temp Pulse ... 	<p>Imaging Orders</p> <ul style="list-style-type: none"> Portable Chest STAT Chest PA & Lateral Hip 2 Views Pelvis ... 	<p>Medications</p> <ul style="list-style-type: none"> Liptor 80mg QD Atorvastatin 20mg QD Omeprazole 20mg QD Celecoxib 200mg QD ...
<p>Lab Orders</p> <ul style="list-style-type: none"> CBC & Diff in AM Platelet Count in AM H/H STAT PT/PTT STAT ... 	<p>Procedures</p> <ul style="list-style-type: none"> EKG Atrial Lead Implant Holter Echo ... 	<p>Consults</p> <ul style="list-style-type: none"> Medicine Cardiology Pulmonary Gastroenterology ...
<p>Diet Orders</p> <ul style="list-style-type: none"> Regular Diet NPO NPO NOW NPO Midnight ... 	<p>Nursing Orders</p> <ul style="list-style-type: none"> Accucheck Neuro Check Incentive Spirometry Tracheal Care ... 	<p>Enter Allergies</p> <ul style="list-style-type: none"> Allergy Enter/Edit <p>Text Orders Only</p> <ul style="list-style-type: none"> Text Orders

Back Forward Close

Notes

A Common Order – a centralized listing of common orders available. Clicking on any one of these list items will bring up the respective pop-up screen for data entry and processing.

Patient Summary

Problem List

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Consults/Procedures

Discharge Summary

Vital Signs

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Chart Inquiries

EMR/VISTA

WireFrame – Orders Tab -> Write Orders -> Common Orders -> Patient Status -> Patient Diagnosis 4.2

Diagnosis [X] [A]

Diagnosis: Heart murmur

Diagnosis Heart murmur [B] [Order] [Close]

Home med	Active	HOME MEDICATION ALBUTEROL SULFATE 2MG/ML...
Home Med	Active	HOME MEDICATION CELERY LEAF PWDR [GEQ: CELER...
Lab - Chemistry	Active	PLATELET COUNT PURPLE-WB BLOOD LC LB #117...

[Close]

Notes

- [A] Diagnosis – provides for manual entry of diagnosis order. Items in the Diagnosis text field are automatically populate to the text field below
- [B] Order button – use to process the order
Close button – use to exit the screen without processing the order or any changes

Notes

- (A) Admit Patient – use to place an order to admit a patient
 - Event** – enter the event for this patient movement
 - Treating Specialty** – enter the treating specialty
 - Attending** – enter the Attending for this patient
 - Primary** – enter primary physician for this patient
 - Instructions** – enter additional instructions regarding this event
- (B) This text field will auto populate with data selected in the above drop-downs and entry fields
- (C) Order button – use to process the order
Close button – use to exit the screen without processing the order or any changes

Notes

- A** May Leave Ward – use to place an order to permit patient to leave ward. Include instructions, and start/ stop date/time of leave
- B** This text field will auto populate with data selected in the above drop-downs and entry fields
- C** Order button – use to process the order
Close button – use to exit the screen without processing the order or any changes

Notes

- (A) Vitals Measurement Order – use to order vital measurements
- (B) Items available to complete the order:
 - Measurement** – use to indicate the vital sign to measure
 - Schedule** – indicates the frequency of the measurement
 - Start/Stop** – indicates the start and stop time of the measurement
 - Additional Instructions** – indicates additional instructions regarding the measurement
- (C) This text field will auto populate with data selected in the above drop-downs and entry fields
- (D) Order button – use to process the order
Close button – use to exit the screen without processing the order or any changes

A
B
X

Order an Imaging Procedure

Imaging Type

GENERAL RADIOLOGY

History & Reason for Exam

Imaging Procedures

CHEST 2 VIEWS PA&LAT

CHEST 2 VIEWS PA&LAT

CHEST 4 VIEWS

CHEST APICAL LORDOTIC

Requested Date

4/3/2010

Urgency

ROUTINE

Transport

Category

INPATIENT

Submit To

GENERAL RADIOLOGY

Available Modifiers

BILATERAL EXAM

PORTABLE EXAM

Selected Modifiers

Exams Over the Last 7 Days

Isolation

Pregnant

Yes, No, Unknown

Pre-Op Scheduled Date

CHEST 2 VIEWS PA&LAT

C

D

Order

Save As Quick Order

Close

Notes

- A
 Order an Imaging Procedure – used to order an imaging procedure

- B
 Items available to complete the order:
 - Imaging Type** – select imaging type (CT Scan, Ultrasound, Mammography, General, Nuclear medicine, etc.)
 - Imaging Procedure** – select procedure from list box.
 - Urgency** – Routine, Stat, ASAP
 - Transport** – select transport type (Wheelchair, Ambulatory, Portable, Stretcher, etc.)
 - Category** – inpatient, outpatient, employee, contract, sharing, research, etc.)
 - Modifiers** – additional info regarding procedure
 - Isolation** – indicate if patient is under isolation procedures

- C
 This text field will auto populate with data selected in the above drop-downs and entry fields

- D
 Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

Medication Order

Patient Photo MRN Age/Sex

LANSOPRAZOLE CAP,SA

Display Restrictions/Guidelines

Regular Complex

Dosage: 30MG
Route: ORAL
Schedule: QD

15MG
30MG
60MG

ORAL

BID
MO-WE-FR
NOW

Priority: ROUTINE

Additional dose now

Expected First Dose:

Comments/Indications:

LANSOPRAZOLE CAP,SA
30MG PO QD

Order
Save As Quick Order
Cancel

Notes

- A** New Medication Order – used to add a new medication order
- B** Used to display additional guidelines, if applicable, regarding the chosen medication
- C** Regular – provides for ordering medications that consist of regular (basic) instructions
- D** Priority – ROUTINE, ASAP, STAT
- E** Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

Order a Lab Test
X

Available Lab Tests

CBC

CBC

CHLORIDE

CHOLESTEROL

CITRIC ACID 24 HR

CITRIC ACID U

Collect Sample

PURPLE-WB (PURPLE)

Specimen

BLOOD

Urgency

ROUTINE

Enter order comment:

▼ Lab Test Info

Collection Type	Collection Date/Time	How often?	How long?
<div style="border: 1px solid gray; padding: 2px;">Lab Collect</div>	<div style="border: 1px solid gray; padding: 2px;">AM Collection: 06:00</div>	<div style="border: 1px solid gray; padding: 2px; background-color: #f0f0f0;">ONCE</div>	<div style="border: 1px solid gray; padding: 2px; background-color: #f0f0f0;"></div>

CBC PURPLE-WB BLOOD LC ONCE
~ In AM

Order

Save As Quick Order

Close

Notes

- A
 Order a Lab Test – used to order a lab test
- B
 Items available to complete the order:
Available Lab Tests – select test from list box
Collect Sample – select procedure from list box.
Urgency – Routine, Stat, ASAP
Specimen – indicate specimen type
Lab Test info – indicate where the test will be conducted, date/time, how often, and how long
- C
 This text field will auto populate with data selected in the above drop-downs and entry fields
- D
 Action buttons that facilitate ordering and canceling the transaction. Save as Quick Order is not available

X
A
B
C
D

Procedure: ELECTROCARDIOGRAM Patient will be seen as
 Inpatient Outpatient

Service to perform this procedure: Attention: Place of Consultation: BEDSIDE

Provisional Dx (REQUIRED) Lexicon Urgency: ROUTINE

Reason for Request:

ELECTROCARDIOGRAM CARDIOLOGY Proc BEDSIDE

C

Order D
Save As Quick Order
Close

Endocrinology

Gastroenterology

< ||| >

Write Delayed Orders

Notes

- A Order a Procedure – used to order a procedure

- B Items available to complete the order:
 - Procedure** – select test from list box
 - Service** – select procedure from list box.
 - Urgency** – Routine, Stat, ASAP
 - Attention** – indicate what physician should receive this consult
 - Place of Consultation** – indicate place of consultation (BED, OFFICE, etc.)
 - Provisional Dx** – Enter ICD9 diagnosis. Lexicon button can be used to access listbox of ICD9 codes.

- C This text field will auto populate with data selected in the above drop-downs and entry fields

- D Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

Order a Consult
✕

Consult to Service/Specialty: CARDIOLOGY ▼

Attention: ▼

Place of Consultation: CONSULTANT'S CHOICE ▼

Urgency: ROUTINE ▼

Provisional Dx (REQUIRED)

Diagnosis

Reason for Request:

Patient will be seen as
 Inpatient Outpatient

CARDIOLOGY Cons Consultant's Choice

C

Order
Save As Quick Order
Close

Endocrinology

Gastroenterology

< >

Write Delayed Orders

Notes

- A
Order a Consult – used to order a consult

- B
Items available to complete the order:
 - Consult to Service/Specialty** – select test from list box
 - Attention** – indicate what physician should receive this consult
 - Place of Consultation** – indicate place of consultation (BED, OFFICE, etc.)
 - Urgency** – Routine, Stat, ASAP
 - Provisional Dx** – Enter ICD9 diagnosis. Lexicon button can be used to access listbox of ICD9 codes.

- C
This text field will auto populate with data selected in the above drop-downs and entry fields

- D
Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

Diet Order
X

Diet

Enteral Formula

Early/Late Tray

Isolation/Precautions

Additional Order

Available Diet Components

NPO at Midnight

1000 ML FLUID RESTRICTION

1200 CALORIE

1200 ML FLUID RESTRICTION

1200 DIABETIC

Selected Diet Component

Effective Date/Time

4/13/2010 11:55:17 AM

Expiration Date/Time

4/13/2010 11:55:17 AM

Delivery

Tray

Cancel Tubefeeding

Special Instructions

Unit Comment

Current Diet:

NPO Diet

Order

Save As Quick Order

Close

Notes

- A
Diet Order – used to order a diet

- B
Items available to complete the order:
Diet – provides a number of items to facilitate the diet component
Enteral Formula – provides a number of items to facilitate the tubefeeding
Early/Late Tray – used to indicate special instructions for delivery times of meals
Isolation/Precautions – indicate if special instructions are warranted for isolation procedures
Additional Order – enter additional diet order information

- C
This text field will auto populate with data selected in the above drop-downs and entry fields

- D
Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

Notes

- (A) Patient Care Order – used to place a nursing patient care order
- (B) Items available to complete the order:
Patient Care – used to select the patient care item in which to order
Instructions – provides for input of additional information for this order
Start/Stop Date/Time – used to indicate start and stop date/times for this order
- (C) This text field will auto populate with data selected in the above drop-downs and entry fields
- (D) Order button – use to process the order
 Close button – use to exit the screen without processing the order or any changes

Notes

- A** Lookup Allergy/ADR – used to enter allergy information
- B** Items available to complete the order:
Patient's Current Allergies –displays previously entered allergies
Find – used to search for Allergies or Adverse Drug Reactions
- C** This text field will auto populate with data based on the characters type in the Find textbox.
- D** No known Allergies – select this option if the patient has no known allergies
- E** Select button – use to process the selected allergy or adverse reaction
 Cancel button – use to exit the screen without processing the order or any changes

EMR/VISTA

WireFrame – Orders Tab -> Write Orders -> Common Orders -> Text Orders Only -> Text Orders 4.14

Notes

- (A) Text Only Order – used to place a text only order
- (B) Items available to complete the order:
Order – used to indicate order information
Start/Stop Date/Time – used to indicate start and stop date/times for this order
- (C) This text field will auto populate with data selected in the above drop-downs and entry fields
- (D) Order button – use to process the order
 Close button – use to exit the screen without processing the order or any changes

Patient Summary
Problem List
Medications
Orders
Clinical Notes
Consults/Procedures
Discharge Summary
Vital Signs
Lab Results
Chart Inquiries

WireFrame – Orders Tab –> Write Delayed Orders Button 4.15

The screenshot displays the 'Event Delay' dialog box overlaid on the 'Write Orders' screen. The dialog box features a blue title bar with a close button (A). Below the title bar is the 'Event Delay List' (B), which is currently empty. At the bottom of the dialog are 'Select' and 'Cancel' buttons (C). The background interface shows a patient's order list with a selected order: 'Lab - Chemistry Active PLATELET COUNT PURPLE-WB BLOOD LC LB #117...'. A 'Close' button is visible in the bottom right of the dialog area.

Notes

- (A) Write Delayed Order – used to add an event to the delay order list
- (B) Items available to complete the order:
Event Delay List – used to enter items to delay list
Effective Date – indicate the effective for the delay list item
- (C) Select button – use to process the selected allergy or adverse reaction
 Cancel button – use to exit the screen without processing the order or any changes

EMR/VISTA

WireFrame – Clinical Notes Tab 5.0

Notes

- A** From the Notes tab you can create new progress notes for a patient and view existing progress notes and documents. You can also create templates to allow you to quickly and efficiently enter progress notes.
- B** Action menu - These 3 buttons provides options for adding, updating, and deleting notes.

Smart Paste Buttons – Provides access to information (as indicated by the button label) that can easily be copied to the working document.
- C** Notes Search Criteria – drop-down list of options indicating the range of notes to display.
- D** This Listbox displays the result of the option selected in section C.
- E** Templates - use document templates to make writing or editing progress notes, completing consults, or writing discharge summaries quicker and easier.
- F** Document View Area - use to display the text results from Templates or from direct text input into this area. Selecting an option in #3 will also display results in this area.
- G** Reminders - used to aid physicians in performing tasks to fulfill Clinical Practice Guidelines and periodic procedures or education as needed for veteran patients. A dialog with a view of due, applicable, and other reminders.
- H** Encounters - To get workload credit and gather information, enter encounter form data whenever you create a progress note, complete a consult, or write a discharge summary.

WireFrame – Clinical Notes Tab – New Note Button – Progress Note Properties 5.1

The screenshot displays the 'Progress Note Properties' dialog box in the EMR/VISTA system. The dialog box is titled 'Progress Note Properties' and has a close button (X) in the top right corner. It contains the following elements:

- Title:** A text input field containing 'GENERAL NOTE'.
- Note Types:** A list box containing the following options: 'SUBSTANCE ABUSE PSYCH ASSESSMENT', 'SUBSTANCE ABUSE SUPPORT GROUP', 'ADVANCE DIRECTIVE', 'ADDICTION', and 'GENERAL NOTE'.
- Date:** A text input field containing '4/14/2010 12:48:51 PM'.
- Author:** A dropdown menu with 'User, Physician - M.D.' selected.
- Buttons:** 'Select' and 'Cancel' buttons at the bottom.

The background interface shows a patient record with a 'New Note' button and a list of templates including 'Discharge Summary', 'Nursing Assessment', 'Social Worker Note', 'Progress Note', and 'Nutrition Care Plan'. The 'Clinical Notes' tab is selected in the bottom navigation bar.

Notes

- A** Progress Note Properties – used to select the class category of which the new note will be associated
- B** Properties available to host the new note:
 - Title** – choose the class document to associate with the new note
 - Date** – indicate the note date
 - Author** – indicate the author of the note
- C** Select button – use to process the selected class document
Cancel button – use to exit the screen without entering a new note

EMR/VISTA

WireFrame – Clinical Notes Tab – New Note Button - Document Entry Area 5.2

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Note
Edit
Delete

4/4/2010 12:48:51 PM GENERAL NOTE, USER, PHYSICIAN

Search Criteria for Notes 3/30/2010 General Note 8/7/2009 Primary Care H&P 2/15/2009 Crisis Note 1/1/2009 Braden Scale < >	Document Entry Area
---	-------------------------

Templates
 Discharge Summary Note
 Nursing Assessment
 Social Worker Note
 Progress Note
 Nutrition Care Plan
 < >

Reminders
 Encounter

Patient Summary
Problem List
Medications
Orders
Clinical Notes
Consults/Procedures
Discharge Summary
Vital Signs
Lab Results
Chart Inquiries

Notes

Document Entry Area - After the Class document has been selected, this area is used to enter the note



EMR/VISTA

WireFrame – Clinical Notes Tab – New Note Button – Templates 5.3

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

4/4/2010 12:48:51 PM GENERAL NOTE, USER, PHYSICIAN

Search Criteria for Notes

- 3/30/2010 General Note
- 8/7/2009 Primary Care H&P
- 2/15/2009 Crisis Note
- 1/1/2009 Braden Scale

Templates

- Discharge Summary Note
- Nursing Assessment
- Social Worker Note
- Progress Note
- Nutrition Care Plan

Reminders Encounter

Document Entry Area

Notes

A Templates – used to assist in the completion of documentation by providing pre-defined outlines of data element that can be transferred to the Document Entry Area.

Templates can be selected from the respective listbox.

.....

WireFrame – Clinical Notes Tab – New Note Button – Template – Progress Note 5.4

Template: Medical – Progress Note
✕

MEDICAL PROGRESS NOTE A

SUBJECTIVE

The patient has no

- complaints
- shortness of breath
- chest pain
- vomiting
- Diet intolerance

The patient has

- complaints
- shortness of breath
- chest pain
- vomiting
- Diet intolerance

Comments

REVIEW OF SYSTEMS:

B

Notes

- A
Template Progress Note – used to assist the user in the inputting core data element based on the documentation needs and provides a uniform means of doing so among all users.

- B
Finish button – use to send the select data elements to the Document Entry Area

Preview button – allows user to preview the format before sending to the Document Entry Area

- C
Cancel button – use to exit the screen without entering a new note

Patient Summary

Problem List

Medications

Orders

Clinical Notes

Consults/ Procedures

Discharge Summary

Vital Signs

Lab Results

Chart Inquiries

EMR/VISTA

WireFrame – Clinical Notes Tab – New Note Button – Templates 5.5

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Note
Edit
Delete

4/4/2010 12:48:51 PM GENERAL NOTE, USER, PHYSICIAN

<p>Search Criteria for Notes</p> <p>3/30/2010 General Note</p> <p>8/7/2009 Primary Care H&P</p> <p>2/15/2009 Crisis Note</p> <p>1/1/2009 Braden Scale</p> <p>▼ Templates</p> <p>Discharge Summary Note</p> <p>Nursing Assessment</p> <p>Social Worker Note</p> <p>Progress Note</p> <p>Nutrition Care Plan</p> <p>▼ Reminders</p> <p>▼ Encounter</p>	<p>MEDICAL PROGRESS NOTE:</p> <p>SUBJECTIVE</p> <hr/> <p>The patient has no complaints, chest pain</p> <p>The patient has chest pain, nausea</p> <p>Comment:</p> <p>This is a test</p> <p>REVIEW OF SYSTEMS:</p> <p>GENERAL:</p> <p>Denies change in appetite or weight. Denies fever, chills, dizziness</p> <p>(+) Appetite change</p> <p>(-) Weight Gain</p> <p>(-) Weight Loss</p> <p>EYE:</p> <p>Denies change in vision.</p>
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Notes

A After clicking "Finish" on the Template screen, information is transferred to the Document Entry Area where it be further edited if necessary.

- Patient Summary
- Problem List
- Medications
- Orders
- Clinical Notes
- Consults/Procedures
- Discharge Summary
- Vital Signs
- Lab Results
- Chart Inquiries

EMR/VISTA

WireFrame – Clinical Notes Tab – Edit Button 5.6

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Note
Edit A
Delete

Search Criteria for Notes

4/4/2010 12:48:51 PM GENERAL NOTE, USER, PHYSICIAN

<div style="border: 1px solid gray; padding: 2px;"> <p>3/30/2010 General Note ▲</p> <p>8/7/2009 Primary Care H&P ☰</p> <p>2/15/2009 Crisis Note ▼</p> <p>1/1/2009 Braden Scale ▼</p> </div> <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;"> <p>▼ Templates</p> <p>Discharge Summary Note ▲</p> <p>Nursing Assessment ☰</p> <p>Social Worker Note ▼</p> <p>Progress Note ▼</p> <p>Nutrition Care Plan ▼</p> </div> <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;"> <p>▼ Reminders</p> </div> <div style="border: 1px solid gray; padding: 2px; margin-top: 5px;"> <p>▼ Encounter</p> </div>	<p>MEDICAL PROGRESS NOTE:</p> <p style="text-align: center;">SUBJECTIVE</p> <hr/> <p>The patient has no complaints, chest pain Ⓒ</p> <p>The patient has chest pain, nausea</p> <p>Comment:</p> <p>This is a test</p> <p>REVIEW OF SYSTEMS:</p> <p>GENERAL:</p> <p>Denies change in appetite or weight. Denies fever, chills, dizziness</p> <p>(+) Appetite change</p> <p>(-) Weight Gain</p> <p>(-) Weight Loss</p> <p>EYE:</p> <p>Denies change in vision.</p>
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Patient Summary	Problem List	Medications	Orders	Clinical Notes	Consults/Procedures	Discharge Summary	Vital Signs	Lab Results	Chart Inquiries
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Notes

- A
Edit Button – Allows user to edit unsigned notes

- B
Listbox containing all notes. Unsigned notes can be selected for editing

- C
Document Entry Area – user can edit the document in this area. Templates can also be used complete or edit the document as well.

Signed notes can not edited. However, an addendum can be added to any signed note.

EMR/VISTA

WireFrame – Clinical Notes Tab – Delete Button 5.7

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Note
Edit
Delete A

Search Criteria for Notes

4/4/2010 12:48:51 PM GENERAL NOTE, USER, PHYSICIAN

<div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> 3/30/2010 General Note ▲ </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> 8/7/2009 Primary Care H&P ☰ </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> 2/15/2009 Crisis Note ▼ </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> 1/1/2009 Braden Scale ▼ </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> < > </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> ▼ Templates </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> Discharge Summary Note ▲ </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> Nursing Assessment </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> Social Worker Note </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> Progress Note </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> Nutrition Care Plan ▼ </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> < > </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> ▼ Reminders </div> <div style="border: 1px solid gray; padding: 2px; margin-bottom: 5px;"> ▼ Encounter </div>	<p>MEDICAL PROGRESS NOTE:</p> <p style="text-align: center;">SUBJECTIVE</p> <hr/> <p>The patient has no complaints, chest pain Ⓒ</p> <p>The patient has chest pain, nausea</p> <p>Comment:</p> <p>This is a test</p> <p>REVIEW OF SYSTEMS:</p> <p>GENERAL:</p> <p>Denies change in appetite or weight. Denies fever, chills, dizziness</p> <p>(+) Appetite change</p> <p>(-) Weight Gain</p> <p>(-) Weight Loss</p> <p>EYE:</p> <p>Denies change in vision.</p>
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Patient Summary

Problem List

Medications

Orders

Clinical Notes

Consults/Procedures

Discharge Summary

Vital Signs

Lab Results

Chart Inquiries

Notes

- A Delete Button – Allows user to delete unsigned notes
- B Listbox containing all notes. Unsigned notes can be selected for deletion
- C Document Entry Area – user can view the document in this area before deleting the unsigned document.

EMR/VISTA

WireFrame – Clinical Notes Tab – Encounter 5.8

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Note
Edit
Delete

4/4/2010 12:48:51 PM GENERAL NOTE, USER, PHYSICIAN

Search Criteria for Notes 3/30/2010 General Note 8/7/2009 Primary Care H&P 2/15/2009 Crisis Note 1/1/2009 Braden Scale < > Templates Discharge Summary Note Nursing Assessment Social Worker Note Progress Note Nutrition Care Plan < > Reminders	MEDICAL PROGRESS NOTE: SUBJECTIVE <hr/> The patient has no complaints, chest pain The patient has chest pain, nausea Comment: This is a test REVIEW OF SYSTEMS: Encounter A ***CONSULTATION*** INTERMEDIATE (30min) Diagnoses: Hypertension (Primary), Hyperlipidemia
--	---

Patient Summary	Problem List	Medications	Orders	Clinical Notes	Consults/Procedures	Discharge Summary	Vital Signs	Lab Results	Chart Inquiries
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Notes



Information entered on Encounter screen is then summarize and transferred to the Encounter text field.



WireFrame – Clinical Notes Tab – Encounter 5.9

The wireframe shows an 'Encounter Form' window with a blue title bar and a close button. Below the title bar are several tabs: 'Visit Type' (selected), 'Diagnosis', 'Procedure', 'Vitals', 'Immunizations', 'Skin Tests', 'Patient Education', 'Health Factors', and 'Exams'. The main content area is divided into several sections:

- Type of Visit**: A large empty text box.
- Section Name**: A large empty text box.
- Modifiers**: A large empty text box.
- Available Providers**: A list box containing 'USER, PHYSICIAN' and another empty space.
- Current Providers**: A list box containing 'USER, PHYSICIAN'.

Two green arrows point from the 'Available Providers' list to the 'Current Providers' list. At the bottom right of the form are 'Save' and 'Cancel' buttons. Below the form is a navigation bar with buttons for 'Patient Summary', 'Problem List', 'Medications', 'Orders', 'Clinical Notes' (highlighted), 'Consults/Procedures', 'Discharge Summary', 'Vital Signs', 'Lab Results', and 'Chart Inquiries'.

Notes

A Encounter – In order to receive workload credit, you must enter encounter form data when you create a new progress notes, complete a consult, or write a discharge summary.

Click the tab where you want to enter information (Type of Visit, where you can also enter the primary and secondary providers, Diagnoses, where you can have diagnoses automatically be added to the Problem List, Procedures, Vitals, Immunizations, Skin Tests, Patient Ed., Health Factors, or Exams).

Information entered on this screen is then summarize and transferred to the Encounter text field on the Clinical Notes tab.



The following indices will be used to reference the Clinical Notes tab component and it's sub-screens.

5.0 – Clinical Notes

5.1 – New Note

5.2 – New Note

5.3 – New Note

5.4 – New Note

5.5 – New Note

5.6 – Edit

5.7 – Delete

5.8 – Encounter

5.9 – Encounter

James M. Smith

Information Technology Specialist 4
CIT Patient Application Services

The following indices will be used to reference the Consults/Procedures tab component and it's sub-screens.

- 6.0 – Consults/Procedures
- 6.1 – New Consult Button
- 6.2 – New Procedure Button
- 6.3 – Edit Note Button
- 6.4 – Delete Note Button
- 6.5 – Consult Tracking Menu
- 6.6 – Consult Results Menu

James M. Smith

Information Technology Specialist 4
CIT Patient Application Services

WireFrame – Consults/Procedures Tab 6.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

B

New Consult New Procedure Edit Note Delete Note

A

Consult Document View Area

C

Search Criteria for Consults

- 4/23/2009 SKIN CARE NURSE
- 4/23/2009 CLINICAL DIETICIAN
- 4/23/2009 SKIN CARE NURSE

E

Current Pat. Status: Outpatient
 Order Information
 To Service: SKIN CARE NURSE
 From Service: MED/SURG
 Requesting Provider: SMALL, KAREN
 Service is to be rendered on an INPATIENT basis
 Place: Consultant's choice
 Urgency: Stat
 Orderable Item: SKIN CARE NURSE
 Consult: Consult Request
 Reason For Request:
 Patient has been identified as being at high risk for skin breakdown.

Inter-facility Information
 This is not an inter-facility consult request.

Status: PENDING
 Last Action: CPRS RELEASED ORDER

Facility Activity	Date/Time/Zone	Responsible Person	Entered By
CPRS RELEASED ORDER	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
 Account: 000000000001
 Admission: FEB 23, 2009@08:27 Admitting Diagnosis: COPD
 Ward: Room Bed:
 Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09)
 ===== END =====

Patient Summary

Problem List

Medications

Orders

Clinical Notes

Consults/Procedures

Discharge Summary

Vital Signs

Lab Results

Chart Inquiries

Notes

- A** Consults/Procedure tab is the primary method that clinicians use to place an order for a procedure, such as an EKG. Then you can use this area to check in a patient and initiate the actual procedure.

- If the procedure is performed on a bi-directional instrument, the patient demographics are automatically transmitted to the instrument. When the procedure is complete, the result is transmitted back to VistA Imaging and attached to a note/document that is associated with the original procedure order.

- B** Action menu - These 4 buttons provides options for adding, updating, and deleting consults/procedures.
 - New Consult** – add a new consult request
 - New Procedure** – order a new clinical procedure
 - Edit Note** – modify an existing consult/procedure note that has not been signed.
 - Delete Note** – delete a consult/procedure note

- C** Consult/Procedure Search Criteria – drop-down list of options indicating the range of notes to display.

- D** This Listbox displays the result of the option selected in letter C

- E** Consult Document View Area - use to display the text results from Consult/Procedure pop-up screens. Selecting an option in section C will also display results in this area.

WireFrame – Consults/Procedures Tab - New Consult Button 6.1

File
X
A

Order a Consult

Consult to Service/Specialty: CARDIOLOGY B

Patient will be seen as Inpatient Outpatient

Attention: [v] Place of Consultation: CONSULTANT'S CHOICE B Urgency: ROUTINE A

Provisional Dx (REQUIRED) Diagnosis

Reason for Request:

CARDIOLOGY Cons Consultant's Choice C

Order D
Save As Quick Order
Close

Activity	Date	Time/Zone	Responsible Person	Entered by
CPR S RELEASED ORDER	04/23/09	10:20	SMA LL, KAREN	SMALL, KAREN

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
 Account: 00000000001
 Admission: FEB 23, 2009@08:27 Admitting Diagnosis: COPD
 Ward: Room Bed:
 Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09)
 ===== END =====

- Patient Summary
- Problem List
- Medications
- Orders
- Clinical Notes
- Consults/Procedures
- Discharge Summary
- Vital Signs
- Lab Results
- Chart Inquiries

Notes

- A Order a Consult – used to order a consult

- B Items available to complete the order:
 - Consult to Service/Specialty** – select test from list box
 - Attention** – indicate what physician should receive this consult
 - Place of Consultation** – indicate place of consultation (BED, OFFICE, etc.)
 - Urgency** – Routine, Stat, ASAP
 - Provisional Dx** – Enter ICD9 diagnosis. Lexicon button can be used to access listbox of ICD9 codes.

- C This text field will auto populate with data selected in the above drop-downs and entry fields

- D Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

WireFrame – Consults/Procedures Tab - New Procedure Button 6.2

File
X
Order a Procedure
A

Procedure: ELECTROCARDIOGRAM B

Service to perform this procedure:

Provisional Dx (REQUIRED)

Reason for Request:

Patient will be seen as Inpatient Outpatient

Attention:

Place of Consultation: BEDSIDE

Urgency: ROUTINE

Lexicon

ELECTROCARDIOGRAM CARDIOLOGY Proc BEDSIDE C

Order D
Save As Quick Order
Close

Activity	Date/Time/Zone	Responsible Person	Entered By
CPR S RELEASED ORDER	04/23/09 10:20	SMA LL, KAREN	SMALL, KAREN

Note: TIME ZONE is local if not indicated

No local TIU results or Medicine results available for this consult
 Account: 00000000001
 Admission: FEB 23, 2009@08:27 Admitting Diagnosis: COPD
 Ward: Room Bed:
 Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09)
 ===== END =====

←
⋮
→

Patient Summary
Problem List
Medications
Orders
Clinical Notes
Consults/Procedures
Discharge Summary
Vital Signs
Lab Results
Chart Inquiries

Notes

- A
 Order a Procedure – used to order a procedure

- B
 Items available to complete the order:
 - Procedure** – select test from list box
 - Service** – select procedure from list box.
 - Urgency** – Routine, Stat, ASAP
 - Attention** – indicate what physician should receive this consult
 - Place of Consultation** – indicate place of consultation (BED, OFFICE, etc.)
 - Provisional Dx** – Enter ICD9 diagnosis. Lexicon button can be used to access listbox of ICD9 codes.

- C
 This text field will auto populate with data selected in the above drop-downs and entry fields

- D
 Action buttons that facilitate ordering, saving as a quick order for ease of future retrieval, canceling the transaction.

EMR/VISTA

WireFrame – Consults/Procedures Tab - Edit Note Button 6.3

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	MRN	Ht:	Provider:	Acct# :		
	Age/Sex:	BMI/BSA:	Admit DX:			

Consult Document View Area

<p>Search Criteria for Consults</p> <ul style="list-style-type: none"> 4/23/2009 SKIN CARE NURSE 4/23/2009 CLINICAL DIETICIAN 4/23/2009 SKIN CARE NURSE 	<p>Current Pat. Status: Outpatient</p> <p>Order Information</p> <p>To Service: SKIN CARE NURSE</p> <p>From Service: MED/SURG</p> <p>Requesting Provider: SMALL, KAREN</p> <p>Service is to be rendered on an INPATIENT basis</p> <p>Place: Consultant's choice</p> <p>Urgency: Stat</p> <p>Orderable Item: SKIN CARE NURSE</p> <p>Consult: Consult Request</p> <p>Reason For Request: Patient has been identified as being at high risk for skin breakdown.</p> <p>Inter-facility Information This is not an inter-facility consult request.</p> <p>Status: PENDING</p> <p>Last Action: CPRS RELEASED ORDER</p> <p>Facility</p> <table border="1"> <thead> <tr> <th>Activity</th> <th>Date/Time/Zone</th> <th>Responsible Person</th> <th>Entered By</th> </tr> </thead> <tbody> <tr> <td>CPRS RELEASED ORDER</td> <td>04/23/09 10:20</td> <td>SMALL, KAREN</td> <td>SMALL, KAREN</td> </tr> </tbody> </table> <p>Note: TIME ZONE is local if not indicated</p> <p>No local TIU results or Medicine results available for this consult</p> <p>Account: 000000000001</p> <p>Admission: FEB 23, 2009@08:27 Admitting Diagnosis: COPD</p> <p>Ward: Room Bed:</p> <p>Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09)</p> <p>===== END =====</p>	Activity	Date/Time/Zone	Responsible Person	Entered By	CPRS RELEASED ORDER	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN
Activity	Date/Time/Zone	Responsible Person	Entered By						
CPRS RELEASED ORDER	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN						

Notes

A Edit Note – used to initiate the modification of an existing note.

B Consult Document View Area – area used to display and edit the selected note

EMR/VISTA

WireFrame – Consults/Procedures Tab - Delete Note Button 6.4

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

Consult Document View Area

Search Criteria for Consults 4/23/2009 SKIN CARE NURSE 4/23/2009 CLINICAL DIETICIAN 4/23/2009 SKIN CARE NURSE	Current Pat. Status: Outpatient Order Information To Service: SKIN CARE NURSE From Service: MED/SURG Requesting Provider: SMALL, KAREN Service is to be rendered on an INPATIENT basis Place: Consultant's choice Urgency: Stat Orderable Item: SKIN CARE NURSE Consult: Consult Request Reason For Request: Patient has been identified as being at high risk for skin breakdown. Inter-facility Information This is not an inter-facility consult request. Status: PENDING Last Action: CPRS RELEASED ORDER Facility <table border="1"> <thead> <tr> <th>Activity</th> <th>Date/Time/Zone</th> <th>Responsible Person</th> <th>Entered By</th> </tr> </thead> <tbody> <tr> <td>CPRS RELEASED ORDER</td> <td>04/23/09 10:20</td> <td>SMALL, KAREN</td> <td>SMALL, KAREN</td> </tr> </tbody> </table> Note: TIME ZONE is local if not indicated No local TIU results or Medicine results available for this consult Account: 000000000001 Admission : FEB 23, 2009@08:27 Admitting Diagnosis: COPD Ward: Room Bed: Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09) ===== END =====	Activity	Date/Time/Zone	Responsible Person	Entered By	CPRS RELEASED ORDER	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN
Activity	Date/Time/Zone	Responsible Person	Entered By						
CPRS RELEASED ORDER	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN						

Notes

A Delete Note – used to delete the currently selected unsigned note

B Consult Document View Area – area used to display and delete the selected note

WireFrame – Consults/Procedures Tab - Consult Tracking 6.5

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

Consult Document View Area

Search Criteria for Consults 4/23/2009 SKIN CARE NURSE 4/23/2009 C 4/23/2009 S	Add to Signature List Delete Note Edit Note Make Addendum Upload Image Consult Tracking >> Consult Results	Current Pat. Status: Outpatient Order Information To Service: SKIN CARE NURSE From Service: MED/SURG Requesting Provider: SMALL, KAREN Service is to be rendered on an INPATIENT basis Place: Consultant's choice Urgency: Stat Orderable Item: SKIN CARE NURSE Consult: Consult Request Reason For Request: Patient has been identified as being at high risk for skin breakdown. Inter-facility Information facility consult request. PENDING CPRS RELEASED ORDER <table border="1"> <thead> <tr> <th>Date/Time/Zone</th> <th>Responsible Person</th> <th>Entered By</th> </tr> </thead> <tbody> <tr> <td>04/23/09 10:20</td> <td>SMALL, KAREN</td> <td>SMALL, KAREN</td> </tr> </tbody> </table> al if not indicated r Medicine results available for this consult 9@08:27 Admitting Diagnosis: COPD 09) Weight (lb): 180 (04/30/09) ===== END =====	Date/Time/Zone	Responsible Person	Entered By	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN
Date/Time/Zone	Responsible Person	Entered By						
04/23/09 10:20	SMALL, KAREN	SMALL, KAREN						

Notes

A Consult Tracking – right-clicking on any of the result items will display a menu list of which Consult Tracking is available. Selecting Consult Tracking will then display an additional menu with a number of items that impact the status of the Consult Request.

EMR/VISTA

WireFrame – Consults/Procedures Tab - Consult Results 6.6

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

Consult Document View Area

Search Criteria for Consults 4/23/2009 SKIN CARE NURSE 4/23/2009 C 4/23/2009 S	Add to Signature List Delete Note Edit Note Make Addendum Upload Image Consult Tracking Consult Results >>	Complete/Update Attach Medicine Remove Medicine Print Note Edit Title Reload Boilerplate Text	Current Pat. Status: Outpatient Order Information To Service: SKIN CARE NURSE From Service: MED/SURG Requesting Provider: SMALL, KAREN Service is to be rendered on an INPATIENT basis Place: Consultant's choice Urgency: Stat Orderable Item: SKIN CARE NURSE Consult: Consult Request Reason For Request: Patient has been identified as being at high risk for skin breakdown. Inter-facility Information This is not an inter-facility consult request. PENDING CPRS RELEASED ORDER <table border="1"> <thead> <tr> <th>Date/Time/Zone</th> <th>Responsible Person</th> <th>Entered By</th> </tr> </thead> <tbody> <tr> <td>04/23/09 10:20</td> <td>SMALL, KAREN</td> <td>SMALL, KAREN</td> </tr> </tbody> </table> al if not indicated r Medicine results available for this consult 9@08:27 Admitting Diagnosis: COPD Ward: Room Bed: Height(in): 60 (04/30/09) Weight(lb): 180 (04/30/09) ===== END =====	Date/Time/Zone	Responsible Person	Entered By	04/23/09 10:20	SMALL, KAREN	SMALL, KAREN
Date/Time/Zone	Responsible Person	Entered By							
04/23/09 10:20	SMALL, KAREN	SMALL, KAREN							

Notes

A Consult Results – right-clicking on any of the result items will display a menu list of which Consult Results is available. Selecting Consult Results will then display an additional menu with a number of items that impact the Consult Request.

The following indices will be used to reference the Discharge Summary tab component and it's sub-screens.

- 7.0 – Discharge Summary
- 7.1 – New Summary Button
- 7.2 – Edit Button
- 7.3 – Delete Button

James M. Smith

Information Technology Specialist 4
CIT Patient Application Services

WireFrame – Discharge Summary Tab 7.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

B New Summary
Edit
Delete

Discharge Summary Document View Area

Search Criteria for Summaries **C**

- 8/21/2009 Discharge Summary
- 8/6/2009 DISCHARGE SUMMARY

A

TITLE: Discharge Summary
 DICT DATE: AUG 21, 2009@15: 57: 33 ENTRY DATE: AUG 21, 2009@15: 57: 57
 DICTATED BY: KEEP, NOLAN ATTENDING: KETCHERSIDE, JOE
 URGENCY: routine STATUS: UNCOSIGNED

*** NOT YET COSIGNED ***

Admission Date: JUL 6, 2009 09: 37
 Discharge Date: AUG 21, 2009
 Admission Diagnosis: Chest Pain
 Discharge Diagnosis: Unstable Angina
 Hospital Procedures:
 No procedures were done during hospital course

Hospital Course:
 Patient was admitted through the ED and evaluated for chest pain lasting 2 hours. On admission to the unit, patient was pain free without arrhythmias or ectopy. Serial Troponin and CPK were done and patients vital signs were monitored. Repeat EKG and Lab results were negative. Patient was discharged with current medication regimen and follow-up with me in 1 month or sooner if he has any problems.

Discharge Medications:
 Active OUTPATIENT Medications
 =====
 1) Home Med ALBUTEROL SULFATE 2MG/5ML SYRUP
 5ML UD Sig: 1 TEASPOONFUL MOUTH EVERY DAY
 2) Home Med ARIPIRAZOLE 10MG TAB Sig:
 10MG MOUTH TWICE A DAY
 3) Home Med CELERY LEAF PWDR Sig: SMALL
 AMOUNT MOUTH EVERY DAY

E

Patient Summary
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Notes

- A** Discharge Summary - the discharge summary is a formal recapitulation of the patient's course of care, which includes pertinent diagnostic and therapeutic steps and the conclusions reached as a result.
- B** Action menu – These 3 buttons provides options for adding, updating, and deleting discharge summaries.
 - New Summary** – create a new discharge summary
 - Edit** – modify an existing discharge summary note that has not been signed.
 - Delete** – delete a discharge summary note
- C** Discharge Summary Search Criteria – drop-down list of options indicating the range of notes to display.
- D** This Listbox displays the result of the option selected in section C.
- E** Discharge Summary Document View Area - use to display the text results from Consult/Procedure pop-up screens. Selecting an option in section C will also display results in this area.

WireFrame – Discharge Summary Tab - New Summary Button - 7.1

Notes

- A** Discharge Summary Properties – when New Summary Button is selected this form is displayed with an option to choose a document template for summary note
 - B** Title – typing in this area will find close matches for items in the listbox (document class/template)
 - C** Dictation Date - date/time on which dictation of the initiated
 - D** Author/Dictator - person who authored/dictated the note
 - E** Admissions – list admission for the selected patient
 - F** Select button – used to select the chosen item in section B
- Cancel Button – cancel the note and return to the Discharge Summary tab

EMR/VISTA

WireFrame – Discharge Summary Tab - Edit Button - 7.2

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	MRN	Ht:	Provider:	Acct# :		
	Age/Sex:	BMI/BSA:	Admit DX:			

New Summary Edit **A** Delete

Discharge Summary Document View Area

Search Criteria for Summaries

8/21/2009 Discharge Summary

8/6/2009 DISCHARGE SUMMARY

TITLE: Discharge Summary
 DICT DATE: AUG 21, 2009@15: 57: 33 ENTRY DATE: AUG 21, 2009@15: 57: 57
 DICTATED BY: KEEP, NOLAN ATTENDING: KETCHERSIDE, JOE
 URGENCY: routine STATUS: UNCOSIGNED

*** NOT YET COSIGNED ***

Admission Date: JUL 6, 2009 09: 37
 Discharge Date: AUG 21, 2009
 Admission Diagnosis: Chest Pain
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 Hospital Procedures:
 No procedures were done during hospital course

Hospital Course:
 Patient was admitted through the ED and evaluated for chest pain lasting 2 hours. On admission to the unit, patient was pain free without arrhythmias or ectopy. Serial Troponin and CPK were done and patients vital signs were monitored. Repeat EKG and Lab results were negative. Patient was discharged with current medication regimen and follow-up with me in 1 month or sooner if he has any problems.

Discharge Medications:
 Active OUTPATIENT Medications
 =====
 1) Home Med ALBUTEROL SULFATE 2MG/5ML SYRUP
 5ML UD Sig: 1 TEASPOONFUL MOUTH EVERY DAY
 2) Home Med ARIPIRAZOLE 10MG TAB Sig:
 10MG MOUTH TWICE A DAY
 3) Home Med CELERY LEAF PWDR Sig: SMALL
 AMOUNT MOUTH EVERY DAY

Patient Summary Problem List Medications Orders Clinical Notes Consults/Procedures **Discharge Summary** Vital Signs Lab Results Chart Inquiries

Notes

- A** Edit Button – used to initiate the modification of an currently selected summary note.
-
- B** Discharge Summary Document View Area – area used to display and edit the selected note
-

EMR/VISTA

WireFrame – Discharge Summary Tab - Delete Button - 7.3

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings: Alerts:	Care Team	
	MRN	Ht:	Provider:	Acct# :			Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:	Attending MD:			

New Summary Edit Delete A

Discharge Summary Document View Area

Search Criteria for Summaries

8/21/2009 Discharge Summary

8/6/2009 DISCHARGE SUMMARY

TITLE: Discharge Summary
 DICT DATE: AUG 21, 2009@15: 57: 33 ENTRY DATE: AUG 21, 2009@15: 57: 57
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Discharge Medications:
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 =====
 1) Home Med ALBUTEROL SULFATE 2MG/5ML SYRUP
 5ML UD Sig: 1 TEASPOONFUL MOUTH EVERY DAY
 2) Home Med ARIPIRAZOLE 10MG TAB Sig:
 10MG MOUTH TWICE A DAY
 3) Home Med CELERY LEAF PWDR Sig: SMALL
 AMOUNT MOUTH EVERY DAY

Patient Summary Problem List Medications Orders Clinical Notes Consults/Procedures Discharge Summary Vital Signs Lab Results Chart Inquiries

Notes

- A Delete Button – used to delete the currently selected note.
-
- B Discharge Summary Document View Area – area used to display the note selected for deletion
-

The following indices will be used to reference the Vital Signs tab component and it's sub-screens.

8.0 – Vital Signs

8.1 – New Vitals Button

8.2 – Entered in Error Button

James M. Smith

Information Technology Specialist 4
CIT Patient Application Services

EMR/VISTA

WireFrame – Vital Signs Tab 8.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

New Vitals
Entered In Error
A

Date: All Results ▼ From: 3/30/2010 12:00:00 AM To: NOW ← C → Graph: TPR ▼

	8/13/2008 0915	8/13/2008 2300	8/28/2008 1030	8/28/2008 1140	8/28/2008 1245	8/28/2008 ...
Temperature	99.6 (37.6 C)		98.5 (36.9 C)	99 (37.2 C)	99 (37.2 C)	99 (37.2 C)
Pulse	78	112	110	80	72	72
Respiration	20	24	24	18	20	20
Pulse Ox.	98	98	96			

■ Temperature ■ Pulse ■ Respiration

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Notes

- A
 Vitals Signs - application is designed to store in the patient's electronic medical record all vital signs and various measurements associated with a patient's hospital stay or outpatient clinic visit

- B
 Action menu – These 2 buttons provides options for adding, updating, and deleting discharge summaries.
 - New Vitals** – enter new vitals
 - Entered In Error** – Vitals data values cannot be deleted once they have been saved - if incorrect vitals data have been saved, they must be marked "Entered in Error" and replaced with corrected data.

- C
 Date – includes a selection of date options to filter and display vital sign results. A custom option is also available to facilitate the selection of user input date range

- Graph – includes a selection of vital sign options to filter and display in the graphical view

- D
 This grid displays the result of the option selected in section C (date range).

- E
 This chart displays the result of the option selected in section C (Graph) in a graphical view.

WireFrame – Vital Signs Tab - New Vitals Button 8.1

X
A

Vitals Input

Vitals input template: B Patient On Pass

#	Unavailable	Refused	Vital	Value	Units	Qualifiers
1.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Temperature:	98.6	F	APICAL
2.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Pulse:	68	U	SPONTANEOUS
3.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Respiration:	12		CUFF
4.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	B/P:	120/70		ACTUAL
5.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Height:	66	in	STANDING,ACTUAL
6.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Weight:	152	lb	
7.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Pulse Ox:			
8.	<input checked="" type="checkbox"/>	<input checked="" type="checkbox"/>	Pain:	0		

C

▼ Latest Vitals D

Date & Time	Vital	US Value	Metric Value	Qualifiers	Entered By
3/28/2009 12:00 AM	Temperature	98.2 F	36.8 C	ACTUAL	KEEPNO
5/5/2009 10:13 AM	Pulse	110		APICAL	KEEPNO
5/5/2009 10:13 AM	Respiration	24		SPONTANEOUS	KEEPNO

E Save Cancel

Notes

- A
Vitals Input – used to record and view the latest vital signs.

- B
Patient on Pass – used to indicate if patient is unavailable because on pass

- C
Vitals input template – area used to input vital sign or indicate why no vital signs are recorded
 - Unavailable – patient not available for reasons other than being on pass
 - Refused – patient refused this procedure
 - Value – value noted in vital sign procedure
 - Units – unit of measure that corresponds with the value
 - Qualifiers – specific items that indicate how measurement was captured as it relates to the vital sign

- D
This grid displays the latest vital signs recorded for the selected patient

- E
Save Button – used to save the currently recorded vital signs
 - Cancel – used to cancel the recording of the current entries

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WireFrame – Vital Signs Tab - Entered In Error Button 8.2

✕
Entered In Error

Date:

Check the box next to each vital you want to mark entered in error.

Date & Time	US Value	Metric Value	Qualifiers
<input type="checkbox"/> 3/28/2009 12:00 AM Temperature	98. 2F	3 6.8 C	ORAL
<input type="checkbox"/> 5/5/2009 10:13 AM Pulse	110		APICAL
<input type="checkbox"/> 5/5/2009 10:13 AM Respiration	24		SPONTANEOUS

Reason:

Incorrect Date/Time Incorrect Patient
 Incorrect Reading Invalid Record

- Patient Summary
- Problem List
- Medications
- Orders
- Clinical Notes
- Consults/Procedures
- Discharge Summary
- Vital Signs
- Lab Results
- Chart Inquiries

Notes

- A
 Entered In Error - Vitals data values cannot be deleted once they have been saved - if incorrect vitals data have been saved, they must be marked "Entered in Error" and replaced with corrected data.

- B
 Vitals input template – area used to input vital sign or indicate why no vital signs are recorded
 - Unavailable – patient not available for reasons other than being on pass
 - Refused – patient refused this procedure
 - Value – value noted in vital sign procedure
 - Units – unit of measure that corresponds with the value
 - Qualifiers – specific items that indicate how measurement was captured as it relates to the vital sign

- C
 Reason – used to indicate the reason why this entry is being noted as Entered In Error

- D
 Mark Entered in Error – used to save this entry
 - Cancel – used to cancel this transaction

The following indices will be used to reference the Lab Results tab component and it's sub-screens.

9.0 – Lab Results

9.1 – Select Lab Tests

9.2 – Select Lab Tests for Worksheet

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CIT Patient Application Services

WireFrame – Lab Results Tab 9.0

File | Edit | View | Actions | Tools | Help

Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

Reports Showing: All Tests Change Filter...

Show Abnormal Results Only Show Grid Horizontally

Test Name	Units	Ref. Range	Results	Flags
GLUCOSE RANDOM	mg/dL	60 - 300	144	
BLOOD UREA NITROGEN	mg/dL	7 - 20	25	H
CREATINE	mg/dL	0.8 - 1.3	1.2	
NA+	mEq/L	137 - 145	144	

Graph F

Best Fit Show Values Print Graph...

Date Range

Date Range... Today One Week Two Week

Collection Dates

8/9/2009 0630
8/8/2009 2245
8/8/2009 1200
8/8/2009 0600

Comments

Specimen: BLOOD Accession: HE 0810 5 Provider: CRAFT,ADAM
 Performing Lab: General Hospital

Notes

- A The Lab Results tab has the results of lab tests for specific categories that you can view in various formats and by specific periods of time (including all test results for a specific category).
- B Reports – A selection of lab reports to view. The results are displayed in section F.
- C Date Range – When combined with section B, the date range option provides for filtering results to specific date parameters. The results are displayed in section F.
- D Collection Dates – Display results based on the collection Date selected
- E Comments – Additional notes regarding the selected Lab Result item.
- F Results Display – This area displays lab results based on the items selected in section B, C, and D. Results are displayed in grid format as well as in graphical view
- G The Green arrows on either side of the display screen will navigate the previous/next 'Collection Date' of the result set.
- H Change Filter – provides for further discretion of data to be displayed in the Grid view

Patient Summary
Problem List
Medications
Orders
Clinical Notes
Consults/Procedures
Discharge Summary
Vital Signs
Lab Results
Chart Inquiries

WireFrame – Lab Results Tab - Select Lab Tests 9.1

Range	Results	Flags
0	144	
	25	H
.3	1.2	
45	144	

Collection Dates

8/9/2009 0630
8/8/2009 2245
8/8/2009 1200
8/8/2009 0600

Comments

Specimen: BLOOD Accession: HE 0810 5 Provider: CRAFT,ADAM
 Performing Lab: General Hospital

Navigation: Patient Summary | Problem List | Medications | Orders | Clinical Notes | Consults/Procedures | Discharge Summary | Vital Signs | **Lab Results** | Chart Inquiries

Notes

- A** Select Lab Tests – used to select the Lab test items that should be displayed in the Lab Results Tab grid
- B** Available Lab Test – list of lab test items that are available to be displayed in the Lab Results Tab grid
- C** Displayed Test – list of lab test items that have been selected to be displayed in the Lab Results Tab grid
- D** Remove All – remove all items from the Displayed Tests listbox
- E** Select – used to select and display the chosen parameters
- Cancel – used to cancel this transaction

WireFrame – Lab Results Tab - Select Lab Tests for Worksheet 9.2

Notes

- A** The Lab Results tab has the results of lab tests for specific categories that you can view in various formats and by specific periods of time (including all test results for a specific category).
- B** Reports – A selection of lab reports to view. The results are displayed in section F.
- C** Date Range – When combined with section B, the date range option provides for filtering results to specific date parameters. The results are displayed in section F.
- D** Collection Dates – Display results based on the collection Date selected
- E** Comments – Additional notes regarding the selected Lab Result item.
- F** Results Display – This area displays lab results based on the items selected in section B, C, and D. Results are displayed in grid format as well as in graphical view
- G** The Green arrows on either side of the display screen will navigate the previous/next 'Collection Date' of the result set.
- H** Change Filter – provides for further discretion of data to be displayed in the Grid view

The following indices will be used to reference the Chart Inquires tab component and it's sub-screens.

10.0 – Chart Inquires

10.1 – Date Range

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WireFrame – Chart Inquiries Tab 10.0

File Edit View Actions Tools Help						
Patient Photo	Patient Name	Wt:	Unit/Ward/Clinic:	Admit Date:	Postings:	Care Team
	MRN	Ht:	Provider:	Acct# :	Alerts:	Admitting MD:
	Age/Sex:	BMI/BSA:	Admit DX:			Attending MD:

Reports

- Clinical Reports
- Health Summary
- HDR Reports
- Imaging
- Graphing
- Lab Status
- Blood Bank Rpt.
- Dietetics Profile
- Vitals Cumulative

B

Chart Inquiries Display View

APR 6,2010 (13:03) Cumulative Vitals/Measurements Report Page 1

No cumulative vitals data for this patient

D

Date Range

- Date Range...
- Today
- One Week
- Two Week

C

Patient Summary	Problem List	Medications	Orders	Clinical Notes	Consults/Procedures	Discharge Summary	Vital Signs	Lab Results	Chart Inquiries
-----------------	--------------	-------------	--------	----------------	---------------------	-------------------	-------------	-------------	-----------------

Notes

- A CPRS reports include Clinical Reports, Health Summary, Imaging (Radiology and Nuclear Medicine), Lab Status, Blood Bank Report, Anatomic Pathology Report, Dietetics Profile, Nutritional Assessment, Vital Cumulatives, and others that your site wishes to list. You will see these reports in the Available Reports box (section B).

- B Reports – A selection of reports to view. The results are displayed in section D.

- C Date Range – When combined with section B, the date range option provides for filtering results to specific date parameters. The results are displayed in section D.

- D Chart Inquiries Display View - use to display the results from options selected in section B and C.

WireFrame – Chart Inquiries Tab - Date Range 10.1

The screenshot shows the EMR/VISTA interface with a 'Date Range' dialog box open. The dialog box has a blue title bar with a white 'A' icon and a red 'X' close button. The text inside the dialog reads 'Enter a date range -'. Below this are two text input fields: 'Begin Date:' and 'End Date:'. At the bottom of the dialog are two buttons: 'OK' and 'Cancel'. The background interface includes a menu bar with 'File | Edit | View |', a patient information section with 'Patient Photo', 'Patient Name', 'MRN', and 'Age/Sex:', a 'Reports' list with items like 'Clinical Reports', 'Health Summary', 'HDR Reports', 'Imaging', 'Graphing', 'Lab Status', 'Blood Bank Rpt.', 'Dietetics Profile', and 'Vitals Cumulative', a 'Date Range' list with 'Date Range...', 'Today', 'One Week', and 'Two Week', and a bottom navigation bar with buttons for 'Patient Summary', 'Problem List', 'Medications', 'Orders', 'Clinical Notes', 'Consults/Procedures', 'Discharge Summary', 'Vital Signs', 'Lab Results', and 'Chart Inquiries' (which is highlighted).

Notes

A Date Range – When combined with the selected report, the date range option provides for filtering results to specific date parameters. The results are displayed in Document View Area.

The following indices will be used to reference the EMR Treatment Plan tab component and it's sub-screens.

11.0

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WireFrame – Treatment Plan Tab 11.0

File | Edit | View | Actions | Tools | Help Float Note/History

Patient Photo	Patient Name MRN	Wt: Ht:	Unit/Ward/Clinic: Provider:	Admit Date: Acct# :	Postings: Alerts:	Care Team Admitting MD: Attending MD:
	Age/Sex:	BMI/BSA:	Admit DX:			

History

6/8/2010

3/1/2010

12/5/2009

New Team Note
New Initial Tx Plan
New Tx Plan Review
Edit
Delete

Individual Crisis Prevention reviewed; no changes/updates recommended at this time

Participation in Treatment Plan (List participants, including family members and significant others who provided input; included titles)

*Treatment Team Member

John Overhill, RN – Program Director*

Michael Kavanaugh, LMSW – Social Worker*

Andrea Sopko, Licensed Psychlgst – Psychologist*

Robert Zook – SCTA*

David Thing, MD – Psychiatrist*

Anticipated DC Date:
Tx Review Date:
Next Review Date:

Participants in Tx Plan	View Edit
Tx Plan Conference Note	View Edit View All
Diagnosis	View Edit
Additional Evaluations	View Edit

Discharge Planning	View Edit
Problems	View Edit
Strengths	View Edit
Goal Plan	View Edit
Patient/Family Statement	View Edit

Click here to select the Signatories

Cover Sheet	Problems	Medications	Orders	Clinical Notes	Consults/Procedures	Discharge Summary	Vital Signs	Lab Results	Chart Inquiries	Tx Plan
-------------	----------	-------------	--------	----------------	---------------------	-------------------	-------------	-------------	-----------------	---------

Notes

- A

Treatment Plan - Provides functionality to record, store and update a treatment plan individualized for each patient and developed with input from the team and based on initial assessments.
- B

Action menu - These 5 buttons provides options for adding, updating, removing Treatment Plans.
- C

History – Displays a listing of Treatment Plans entered for the selected patient.
- D

Display Window – This display field is used to view all or any portion of the Treatment Plan as dictated by the selected item in Section F
- E

Anticipated Discharge Date – Indicates when the patient is expected to be discharge

Treatment Review Date – Date on which the Treatment Plan is being reviewed by the Team

Next Review Date – This is usually a predetermined interval at which the Team will review the Treatment Plan. The review date is in consideration of age, admission date, and LOS.
- F

This area is used to select the various parts of the Treatment Plan. Selecting 'View' will display (in section D) the respective part which would include the most recent changes. Selecting "Edit" would launch a separate display screen used to modify the respective part. Selecting "View All" would display the entire document as you scroll downward.
- G

Use to select the persons that will need to sign this Treatment Plan.

WireFrame – Treatment Plan Tab 11.0 - Problems

Notes

- A** Problems – This area is used to document signs, symptoms, behaviors which are caused by one or more diagnoses.
- B** Add Button – This button will add to the 'Current Problem List' the information that is listed in section C
- C** This section is used to document the problem, formulation data, and to select the diagnoses that the problems are linked with.
- D** This section will list all of the current problems. Double-click on an item to edit it or to view its details
- E** This button allows the users to remove a problem from the list if authorized to do so

WireFrame – Treatment Plan Tab 11.0 – Goal Plan

File + Net / Lists

Goal Plan

Problem Formulation A

1. Patient does not feel comfortable sharing his thoughts.
2. Anxiety
3. Patient reports command auditory hallucinations

Goal C

Demonstrate appropriate vocational and interpersonal skills necessary for success in the hospital and community.
 Patient will maintain an optimal level of health.
 Patient will tolerate the discharge process without self-harm.
 Trauma: Patient will manage trauma symptoms related to past abuse sufficient to function in the community

Objectives

In 90 days, patient will begin to identify and practice 3 skills needed to be successful in the hospital and in the community.

Methods

Workshop, 8x per week, 45 minutes
 Healthy Lifestyle, 1x per week, 45 minutes
 Working with your Team, 1x per week, 45 minutes

Problems

1. Patient does not feel comfortable sharing his thoughts.
2. Anxiety

Strengths

1. Has resources available to him in the community
2. Once stable, is articulate and follows treatment
3. Responds positively to medication

OK

Current Groups B Edit/View Schedule

Wellness Management and Recovery
 Healthy Lifestyles
 Working with your Team

Notes

- A** Problems List – Displays all of the current problems which must be addressed in the goal plan

- B** Current Groups – displays all the group that the patient is in and must be addressed in the goal plan

Edit/View Schedule – Use to display the component which can be used update the selected patients' treatment schedule

- C** The Goal Plan:

An unlimited number of goals can be added, selected, or removed. Upon selecting a goal, an unlimited number of objectives can be link to that goal. Upon selecting a objective, an unlimited number of methods can be linked to that objective. Each goal must be linked to at least 1 or more problems and strengths

WireFrame – Treatment Plan Tab 11.0 – Goal Plan

Methods

Current Groups A

Wellness Management and Recovery

Healthy Lifestyles

Working with your Team

Group Focus

Develop and sustain hope that recovery is possible

Learn how to reduce relapse frequency and severity

Learn how to establish productive collaboration with treatment team and mental health provider

Individual Focus

Responsible staff	Frequency	Duration
Staff	3x per week	45

Intervention

Education

Clinical Focus

Community Reintegration

Comments

OK
Cancel

Notes



Methods:

User can assign a current group as the method for the selected objective or user can select the complete the remaining section of this form to document a method that will be linked to the selected objective.



WireFrame – Treatment Plan Tab 11.0 – Treatment Schedule

Treatment Schedule

Campus/Building Location ▼

A

Available Groups/Individual Sessions B

Academics
 Adaptive Leisure Skills
 After Hours
 All About Treatment
 Arts and Craft
 Behavioral Self-Management
 COSAD – Relapse Prevention
 Cognitive Skill Building
 Daily Living Skills
 Fit for Life
 Focus Group
 Forensic Group
 Healing Thru Laughter
 Healthy Lifestyles

Add >

< Remove

Selected Activities C

Mon
 10am Wellness and Recovery
 11am Working With Your Team
 Tues
 9am Vocational Shop
 1pm Expressive Therapies
 Wed
 2pm Anger Management
 5pm Medication Education
 Thurs
 10am Community Outing
 1pm Community Reintegration
 Fri

Print Schedule

Group/Individual Session Information D

Mon 1pm
 Leader: Tim Wisdom
 Location: Unit X

 This group is designed to assist the attendees with completing their High School education and acquire a General Education Diploma (GED)

OK

Notes

- A
 Campus/Building Location – use to select the location where a series of group are conducted. The respective groups will be populated in section B

- B
 Available Groups – displays all the groups that are conducted in section A

- C
 Selected Activities: display are the groups and individual sessions that are currently selected for this patient.

 The print button below is used to generate a copy of this schedule

- D
 Displays information regarding the currently selected group.

WireFrame – Diagnoses: Axis I-V

Diagnoses

Axis I
Axis II
Axis III
Axis IV
Axis V

Pending

Diagnosis	Bi-Polar Disorder NOS 296.80	Principal	Severity
Date	10/21/2010	<input checked="" type="checkbox"/> Principal	
Severity			
Comments			

Add
Clear
Remove

History
→ **Details**

Date	DSM Codes /Description	Entry	Status
4/23/2010	296.33 – Major Depressive Disorder	New	

OK

Sheet
Problems
Meas
Orders
Notes
Consults
D/C Summ
Signs
Labs
Reports
Plan

Notes

- A
Campus/Building Location – use to select the location where a series of group are conducted. The respective groups will be populated in section B

- B
Available Groups – displays all the groups that are conducted in section A

- C
Selected Activities: display are the groups and individual sessions that are currently selected for this patient.

The print button below is used to generate a copy of this schedule

- D
Displays information regarding the currently selected group.

Ward Journal

This document contains screen wireframes for Ward Journal. Ward Journal would be accessible from Vista CPRS or from an independent icon on the desktop. Regardless of how it is accessed it will share data resources with Vista database.

The following indices will be used to reference the components and each sub-screen will use this index as its base.

Main Screen

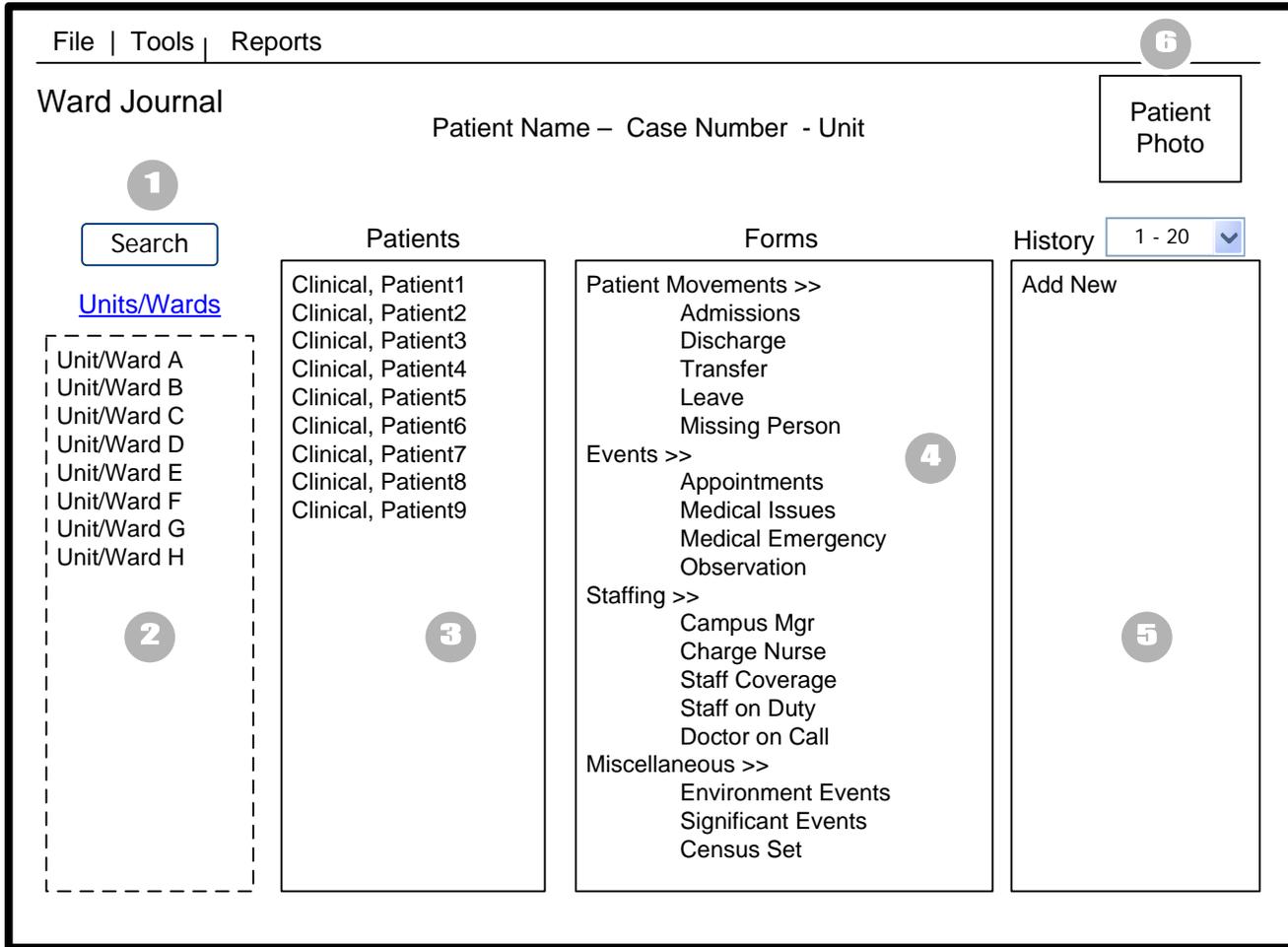
- 1.0 – Patient Movements
- 2.0 – Events
- 3.0 – Staffing
- 4.0 – Miscellaneous

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Ward Journal

WireFrame – Main Navigational Screen



Notes

1 The search button is used to locate patients who are currently active in the system

2 Unit/Ward listbox displays all active clinical units at the facility. Selecting a unit will populate the Patients' listbox with patients currently attached to that unit.

Also, the Unit/Ward label serves as a hyperlink that will display the selected unit/ward shift report.

3 Patients listbox displays the results of the search option or the results of selecting an item in the Units/Wards listbox.

4 Forms listbox displays all active forms for the Ward Communication. These forms are restricted to Unit management type forms that impact effective hand-off communications. Selecting an item in this list will populate the History listbox with a list of completed instances for the respective form and the currently selected patient.

5 History listbox displays in increments of 20 the list of completed instances for the respectively selected form.

6 Patient Photo is displayed when selecting a patient from the Patients' listbox

Ward Journal

WireFrame – Patient Movements 1.0 - Admissions

Repeat Admission 1	New Admission 2
Consec – DOB – Name - Gender	
Patient: <input type="text" value="-Select Patient-"/>	Last Name: <input type="text"/>
Admit Date: <input type="text"/>	First Name: <input type="text"/>
Admit MD: <input type="text" value="-Select Admitting Physician-"/>	Middle Init: <input type="text"/>
Legal Status: <input type="text" value="-Select Legal Status-"/>	DOB: <input type="text"/>
Admit Type: <input checked="" type="radio"/> Transfer <input checked="" type="radio"/> Direct	Admit Date: <input type="text"/>
County: <input type="text" value="-Select County-"/>	Admit MD: <input type="text" value="-Select Admitting Physician-"/>
Referral: <input type="text" value="-Select Referral Agency-"/>	Legal Status: <input type="text" value="-Select Legal Status-"/>
Diagnosis: <input type="text" value="-Select Diagnosis-"/>	Admit Type: <input checked="" type="radio"/> Transfer <input checked="" type="radio"/> Direct
Reason for Admission: <input type="text"/>	County: <input type="text" value="-Select County-"/>
	Referral: <input type="text" value="-Select Referral Agency-"/>
	Diagnosis: <input type="text" value="-Select Diagnosis-"/>
	Reason for Admission: <input type="text"/>
<input type="button" value="Re-Admit Client"/>	<input type="button" value="Admit New Client"/>

Notes

- 1** Repeat Admission – Use to admit a client that has previously be registered in the system. It is important to check the Patient drop-down list before entering a new patient.
- 2** New Admission – Use to admit a new patient in the system. It is important to check the Patient drop-down list before entering a new patient.

Ward Journal

WireFrame – Events 2.0 - Observations

Record an Observation Level 1

To extend an Observation Order, Edit the existing order, and Change the Ending Date/Time to the end date/time of the new order. Do not create another.

To enter a multi-stage Observation, Select the most restrictive as the Observation Type, and put the less restrictive instructions in the Comments section.

Patient	<input type="text" value="-Select Patient-"/>
Observation Type	<input type="text" value="-Select-"/>
Beginning Date/Time	<input type="text"/> <input type="text"/>
Ending Date/Time	<input type="text"/> <input type="text"/>
Comments	<div style="border: 1px solid #ccc; padding: 5px; min-height: 40px;"><div style="text-align: right;"><input type="button" value="↑"/> <input type="button" value="↓"/></div><div style="text-align: left;"><input type="button" value="←"/> <input type="button" value="→"/></div></div>
<input type="button" value="Record Observation"/>	

Notes

1 Record an Observation – use to document a change or renewal of observation status (1:1, 2:1, close, etc.)



Record Coverage or Staffing Exception 1

Staff Providing Coverage

Start Date/Time

End Date/Time

Reason

Staff causing coverage If Applicable

Type of Coverage

Redeployed From If Applicable

Comments

Notes

1 Record Coverage or Staffing Exception – Use to document staff coverage to ensure minimums are being met

Record an Environmental Event 1

Date/Time

Location

Comments

Notes

1 Record an Environmental Event – Use to document an environmental event that has occurred on the unit. This would usually be an abnormal event or a follow-up to an abnormal event.



This Presentation was prepared for a Request for Proposal for New York State Office of Mental Health and is considered proprietary.

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