Lesson 4: Documenting ED Provider Notes

This lesson introduces the Sunrise Emergency Care functions that are common tasks completed as part of the emergency visit workflow. This lesson highlights the Provider documentation workflows.

Learning Objectives

After completing this lesson, you should be able to:

- Update the Status Board with the assigned Provider.
- Document the ED Provider Note.
- Modify and cancel documents.
- Enter, maintain and complete orders.
- Use the Acronym Expansion feature.
- Use the Add Specimen function to status nurse collect specimen as collected.
- Identify additional documentation that may be used for ED patient care workflow.

Adding the Assigned Provider

At start of provider assessment, the **ED Provider** assigns him/her self to the appropriate Provider column (**ED MD, ED NP/PA, RES**) in the **Status Board** and updates the **STS** (Status) column.

TO ADD THE ASSIGNED PROVIDER:

1. Locate the patient in the **Adult All View**.
2. Double-click in the appropriate **Provider** column cell and select your name from the drop-down.

TO UPDATE THE PATIENT STATUS:

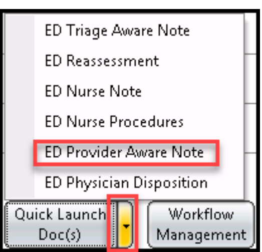
1. Locate the patient in the **Adult All View**.
2. Double-click in the **STS** column cell and select **Treatment in Progress (TIP)**.

Documenting the ED Provider Note

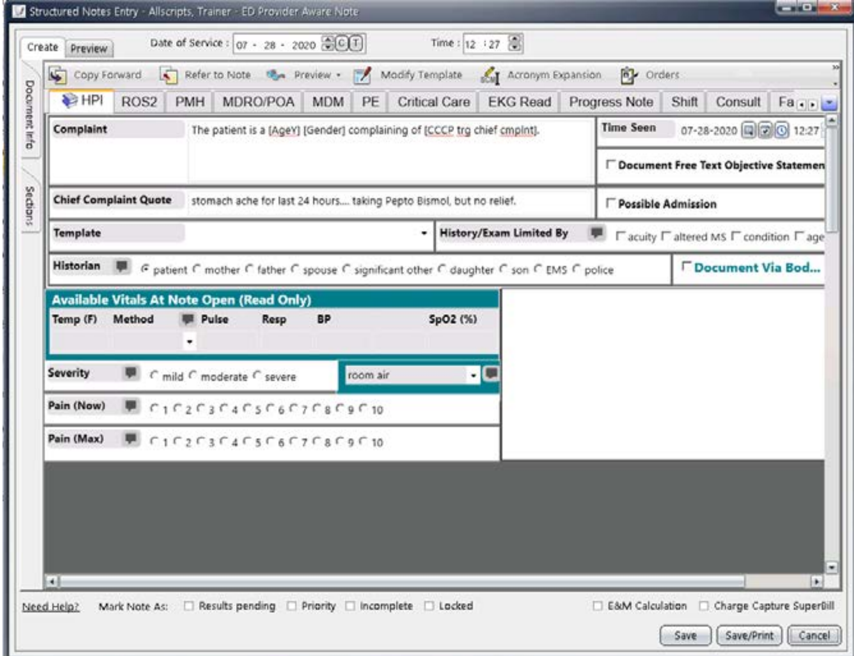
The **ED Provider Note** is used for provider documentation of the patient assessment throughout the emergency visit.

TO DOCUMENT THE ED PROVIDER NOTE:

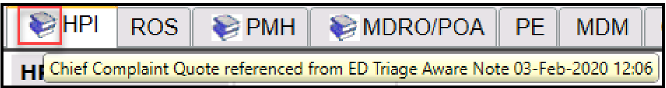
1. At the bottom of the **Status Board**, click the **Quick Launch Doc(s)** drop-down and select **ED Provider Aware Note**.



➪ *The Structured Notes Entry window appears.*



Note: A 'book' icon will display on a Section Tab if documentation has been copied forward (referenced) from Nursing documentation (for example, the **ED Triage Note** or **ED Nurse Note**). Hover your cursor over the icon to display the documentation reference.

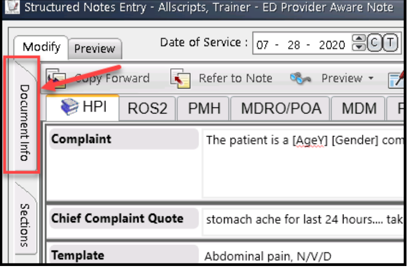


Requesting Documentation Co-Signature

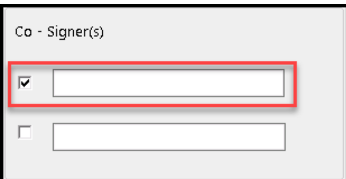
Note: For Providers or Clinicians who must have documentation reviewed and approved under the care of a supervising MD, the user can request the **Co-Signer** within the document window.

2. To add a **co-signature** request for document, do the following:

   a). Within the note, click the **Document Info** tab at the far left margin.

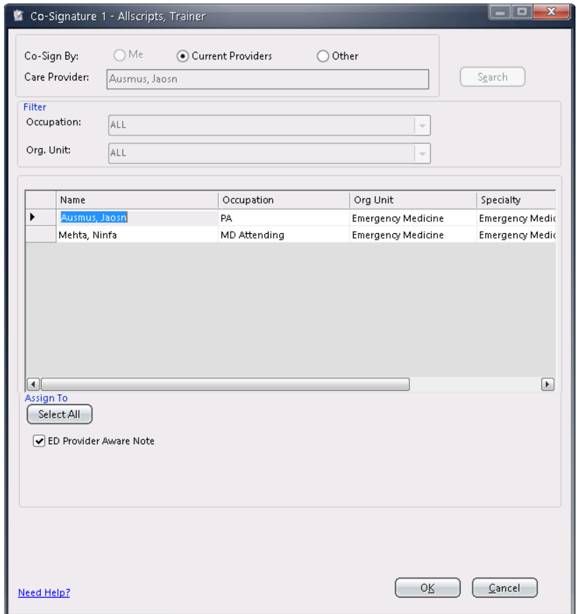


b). Click the **Co – Signer(s)** checkbox.



Note: You can request up to 2 co-signatures.

➪ *The **Co-Signature** window appears.*

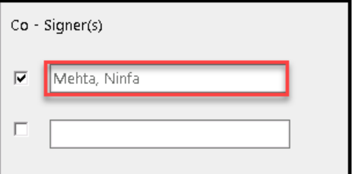


c). In the **Co-Signature** window, do the following:

- **Current Providers:** Selected by default. Select this option, and then select from the list of displayed Providers currently assigned in a care provider role to the patient.
- **Other:** Select this option to search for the **Requesting Provider** by name.

d). Click **OK**.

➪ *The selected Provider displays in the **Co-Signer** field.*



3. Document the appropriate **Sections** of the note per your emergency provider assessment protocol. The following table outlines the sections of the note.

Section	Description
HPI	Capture **History of Present Illness** assessment.
Complaint	Pulls forward a summary statement (including the patient's **age**, **gender** and the **chief complaint**) captured in the **ED Triage Note** or **ED Nurse Note**. **Example:** The patient is a **46**-year-old **female** complaining of **chest pain**.
Chief Complaint Quote	Pulls forward the **Chief Complaint Quote** documentation from the **ED Triage Note** or **EDNurse Note**.
Template	Auto-populates the selected template from the **ED Triage Note** or **ED Nurse Note**. The Provider can adjust the problem-based template by selecting from the drop-down. Based on the template selection, the appropriate assessment parameters will display below the **Historian** section. Historian: patient, mother, father, spouse, significant other, daughter, son, EMS Presenting Symptoms: pos neg Answer All; pos neg anorexia; pos neg constipation; pos neg diaphoresis Location: generalized; epigastric; right upper quadrant; left upper quadrant Quality: aching; band-like; cramping; deep pain
Historian	Auto-populates from documentation in **ED Triage Note** or **ED Nurse Note**.
Time Seen	Auto-populates the current date and time upon opening of the note. Adjust as needed.
Document Free Text Objective Statement	Click the checkbox to expand the **Objective Statement** free text box.
Possible Admission	Click the checkbox to indicate the patient is a candidate for possible admission based on assessment. If selected, the **Possible Admit** icon badge will appear in the **Dsp** (Disposition) column on the **Status Board**.
Document Via Body Image	Click the checkbox to open the **Body Image** view. Use the **toolbar buttons** to annotate or draw on the image.

Section	Description
	Whole Body Front/Back Pain
Available Vitals at Note Open (Read Only)	Pulls forward the most current vital signs assessment at open of the note.
Additional HPI	Click the **document additional HPI complaint(s)** checkbox to expand additional free text sections. Additional HPI ☑ document additional HPI complaint(s) Complaint / Location Associated Symptoms / Radiation
ROS2	Capture **Review of Systems** assessment. The **Template** selection will pull forward from the **HPI** section. o Based on the **Template** selected, the associated **Systems** sections will appear auto-expanded. o **Expand** any additional systems sections as needed. Use one of the preferred methods to document this section: • Within each respective system, manually select **Positive (pos)** and **Negative (neg)** assessment values. • Apply your defined default preferences. In the **My Default** box, select **APPLY (sex ## years)**. **Note:** The **gender** and **age** level are applied based on the selected patient. In order to use this option, you must first define your default criteria: **1.** Select your default **pos/neg** preferences for each respective system. **2.** Scroll to the bottom of this section and select **Save** in the **My Default** box.

<table>
<tr><th>Section</th><th>Description</th></tr>
<tr><td></td><td>

MY DEFAULT
SAVE (male 18+ yrs)

- **Reason Not Obtained:** Capture reason not able to obtain review of systems.
- **All Other Systems:** If selected, indicates ALL the remaining systems not documented are **reviewed and are negative**.

Caution: This indicates that you are documenting review of EVERY system.
</td></tr>
<tr><td>PMH</td><td>Capture review and updates to patient history.</td></tr>
<tr><td>Allergies/Intolerances</td><td>

Existing **Allergy History** will auto-populate into this section of the note.

Allergy history should be reviewed at each new patient visit encounter to ensure the most accurate information is reflected in the patient's chart.
</td></tr>
<tr><td colspan="2">

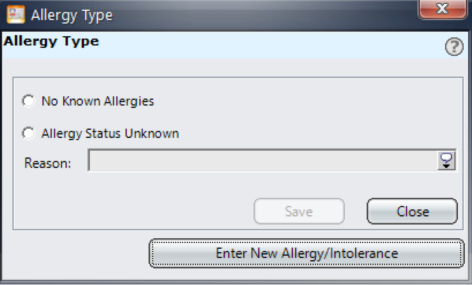
To add/edit allergy history from within the note:

1. Click the **Allergies Summary** button.

*The **Allergies/Intolerances Summary View** window appears.*

2. Click **Add New**.

*If this is a <u>new patient</u> <u>with no existing allergy history</u>, the **Allergy Type** window appears.*



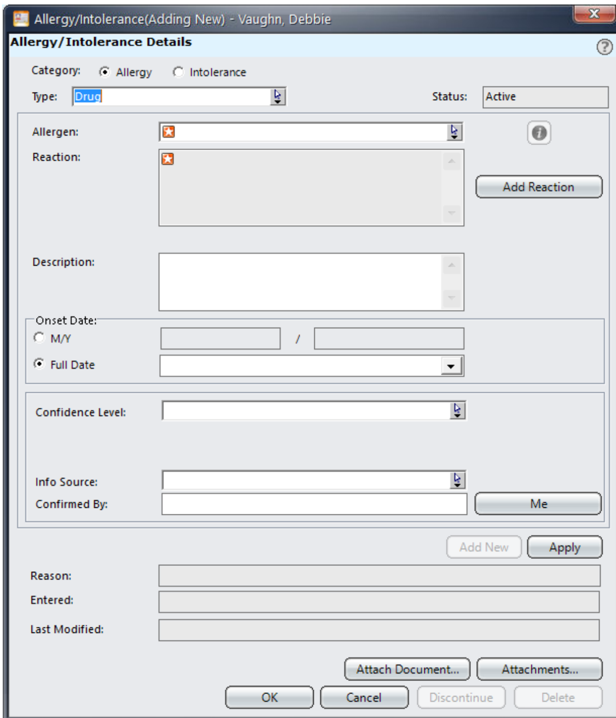
3. Do one of the following:
</td></tr>
</table>

Section	Description

- Select **No Known Allergies** to indicate the patient has no known allergy history.
- Select **Allergy Status Unknown** to indicate inability to capture allergy history. Select a required **Reason** from the drop-down.
- Select **Enter New Allergy/Intolerance** button to add allergy history.

4. For this example, select **Enter New Allergy/Intolerance**.

   *The **Allergy/Intolerance (Adding New)** window appears.*

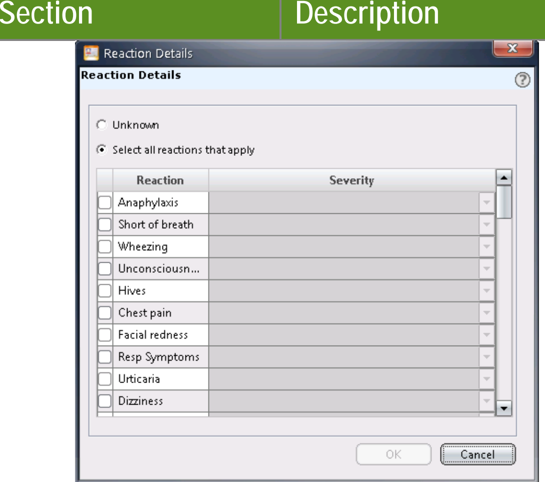


5. Select the appropriate **Category**. (**Allergy** is the default.)
6. Select a **Type** from the drop-down. (**Drug** is the default).

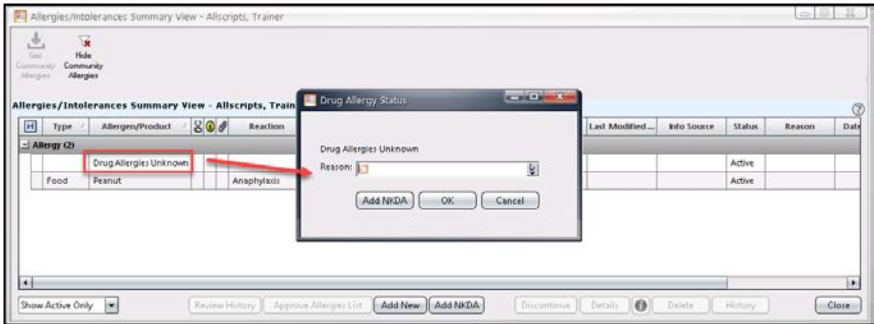
   For this example: Select **Food**.
7. Select the **Allergen** from the drop-down.

   For this example: Select **Peanuts**.

   *The **Reaction Details** window appears.*

<table>
<tr><th>Section</th><th>Description</th></tr>
<tr><td></td><td>


8. Select the appropriate Reaction(s).
9. Optional: Select the Severity from the drop-down.
10. Click OK.
11. Optional: Enter any additional details as required: Description, Onset Date, Confidence Level, etc.
12. If adding multiple allergies, click Apply and repeat the above steps to add the allergy details.
13. When complete, click OK.
The Allergies/Intolerances Summary View window reappears with the added allergy history.
Important: If the patient has No known drug allergies, and you attempt to Close the Allergies/Intolerances Summary View window, the following message appears.

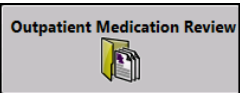


Select a required Reason from the drop-down if unknown or click Add NKDA to indicate the patient has no known drug allergies.
Reminder: You can also add Allergy history outside the note via the Sunrise toolbar button.
</td></tr>
<tr><td>Outpatient Medication Review</td><td>Existing Home Medication History will pull into this section of the note.</td></tr>
</table>

Section	Description
	Home Medication history should be reviewed at each new patient visit encounter to ensure the most accurate information is reflected in the patient's chart.

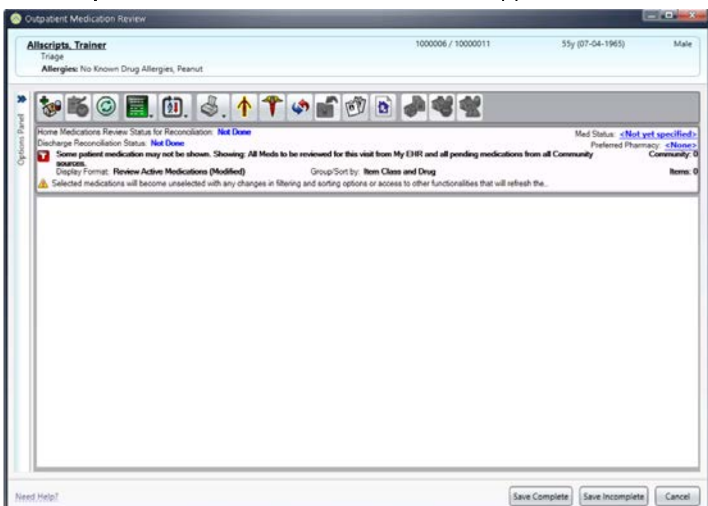
To add/edit home medication history from within the note:

1. Click the **Outpatient Medication Review** button.

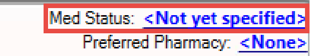
   Note: Use the **Add Home Medication** button to add home medications using the **Quick Entry** method. This method does not provide the ability to update existing home medication history.

   *The **Outpatient Medication Review** window appears.*

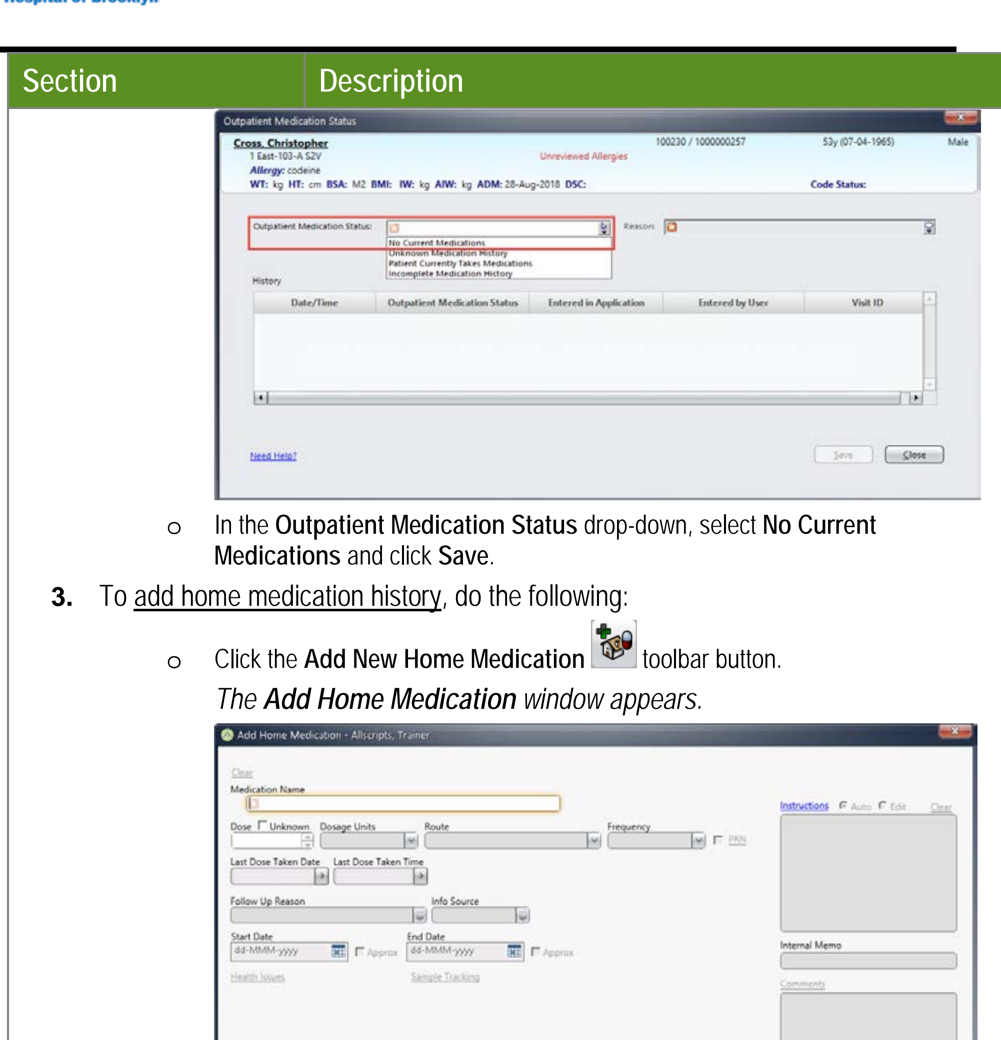
   Note: If the patient has existing home medication history, the information will appear in the display window for review and validation.

2. If the patient indicates <u>no history of home medications</u>, do the following:
   - In the upper right corner, click the **Med Status**: <**Not yet specified**> hyperlink.

     The Outpatient Medication Status window appears.

Section	Description

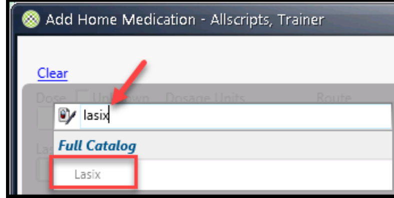


- In the **Outpatient Medication Status** drop-down, select **No Current Medications** and click **Save**.

3. To add home medication history, do the following:

- Click the **Add New Home Medication** toolbar button.
  *The **Add Home Medication** window appears.*

- In the **Medication Name** field, begin typing the name of the medication.
  For this example: Begin typing **Lasix**.
- Select the appropriate item from the search results list.

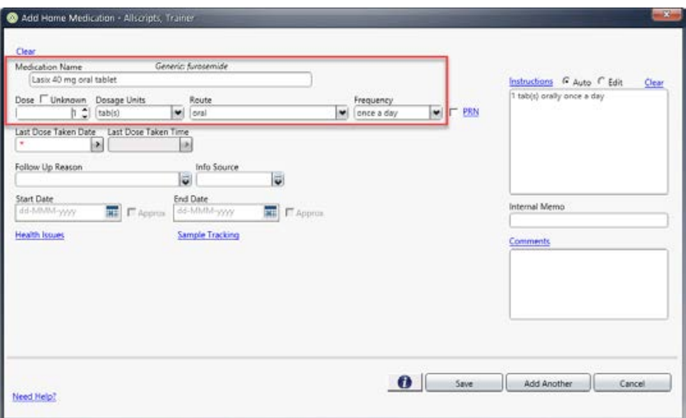


- Continue with selecting across for the appropriate: **Route, Dose** and **Frequency.**

Section	Description

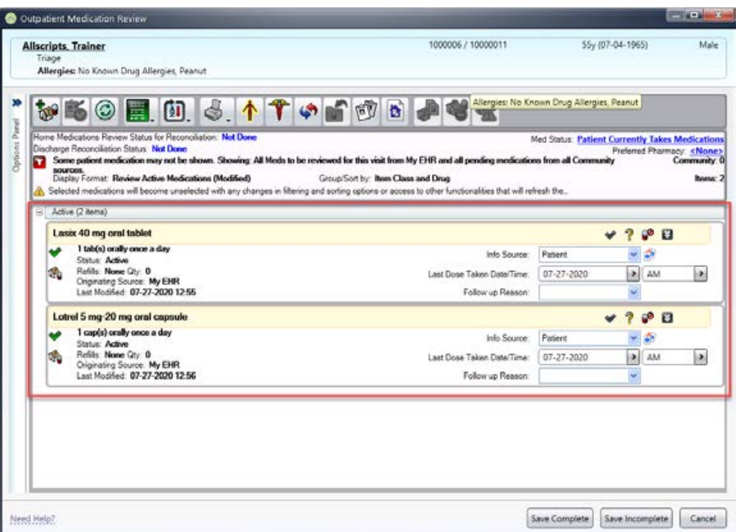
Add Home Medication - Allscripts, Trainer
Clear
lasix
Full Catalog
Lasix
oral
injectable
Lasix 10 mg/mL oral liquid
Lasix 20 mg oral tablet
Lasix 40 mg oral tablet
Lasix 80 mg oral tablet
other...
1 tablet once a day
other...

*The **Add Home Medication** window appears with the selected details.*



4. Complete the required **Last Dose Taken Date** field by selecting one of the following:
5. Complete any additional information as required.
6. Click **Add Another** to add additional home medication(s).
7. When complete, click **Save**.

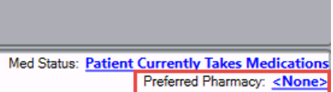
   *The added medications appear in the **Outpatient Medication Review** window with a green checkmark next to each item.*



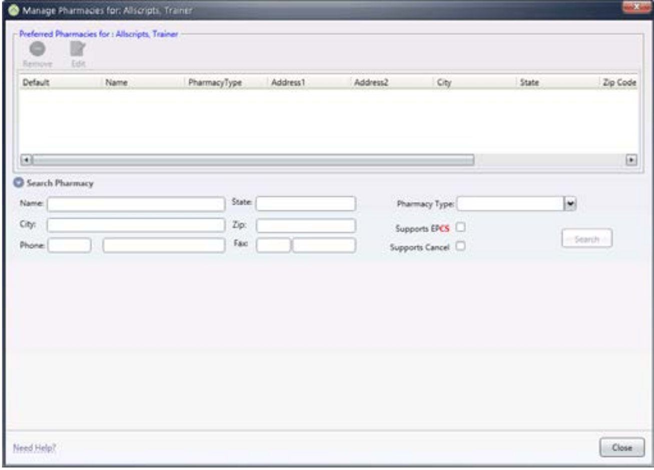
8. To add the **Preferred Pharmacy**:

Section	Description

- Click the **Preferred Pharmacy** link (upper right corner).

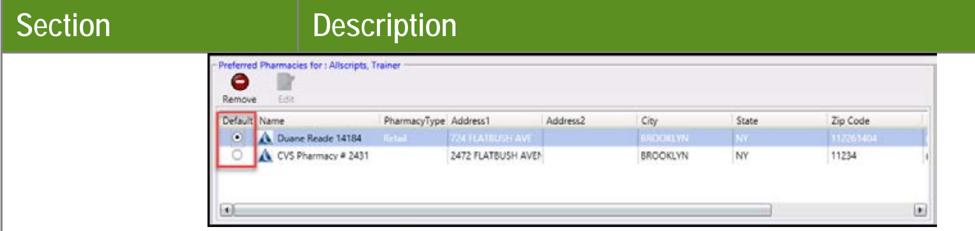
  *The **Manage Pharmacies** window appears.*

- In the **Search Pharmacy Name** field, begin typing the name of the pharmacy.
- Include any additional search modifiers (for example, **Zip**).
- **Optional:** To further filter the search results, select the following:
  - **Pharmacy Type:** Select to filter pharmacies by **Retail** or **Mail Order**.
  - Supports EPCS: Select to filter pharmacies who support Electronic Prescribing of Controlled Substances.
  - **Supports Cancel:** Select to filter pharmacies who support electronic **Cancel** of prescriptions.
- Click **Search**.
- Select the preferred pharmacy from the **Search Results** list, and then click the **Add to Preferred** button.

  *The add pharmacy appears in the **Preferred Pharmacies** section (top pane).*

<table>
<tr><th>Section</th><th>Description</th></tr>
<tr><td colspan="2">



- When complete, click **Close**.

9. When complete, click **Save Complete**.

Reminder: You can also add **Home Medication** history outside the note via the Sunrise toolbar button.

</td></tr>
<tr><td>Health History</td><td>

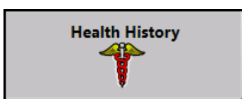
Existing **Past Medical, Surgical** and **Family History** will pull into this section of the note.

Health history should be reviewed at each new patient visit encounter to ensure the most accurate information is reflected in the patient's chart.

</td></tr>
<tr><td colspan="2">

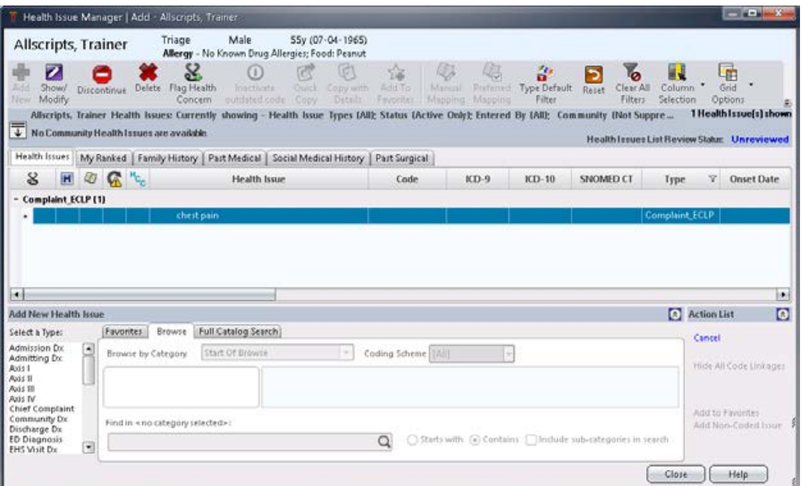
To add/edit health history from within the note:

1. Click the **Health History** (**Entry or Modification**) button.



Note: Use the **Health History (Quick Entry)** button to add problem history using the **Quick Entry** method. This method does not provide the ability to update existing health history.

*The **Health Issue Manager** window appears.*

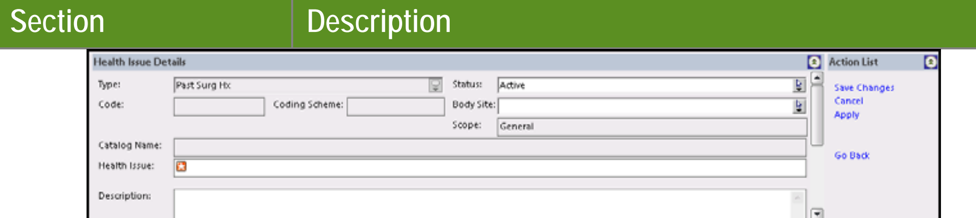


2. In the **Add New Health Issue** section, select the appropriate problem **Type** from the **Select a Type** list.

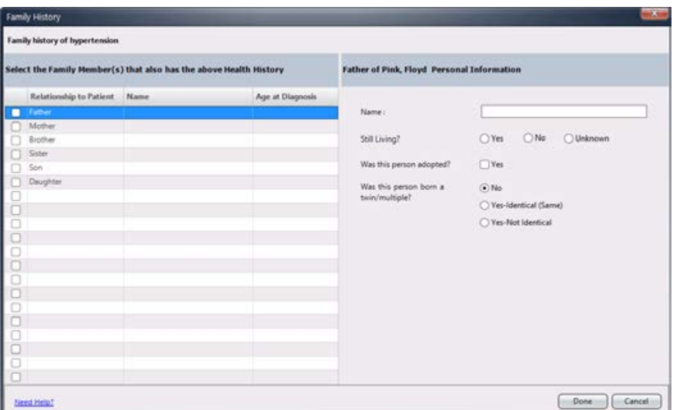
For this example: Select **Past Surg Hx**.

*The **Health Issue Details** area opens.*

</td></tr>
</table>

<table>
<tr><th>Section</th><th>Description</th></tr>
<tr><td colspan="2">


3. In the **Health Issue** field, type the description name of the event.
For this example: Type **appendectomy**.
4. **Recommended:** In the **Onset Date** field, indicate the **M/Y** or **Full Date** of the surgical event.
5. Click **Save Changes**.
6. Now, in the **Select a Type** list, select **Family History**.
7. In the **Full Catalog Search** field, type **htn** and press **Enter**.
8. Click **Add** next to **Family history of hypertension**.
*The **Family History** window appears.*



9. Click the checkbox next to the family member(s) to associate the health issue history.
10. **Optional:** Document additional information as needed, such as: **Name, Age at Diagnosis, Still Living**, etc.
*The added entries appear in the **Health Issues** list in the top pane.*
11. Click **Close**.
Note: You can also add **Health History** outside the note via the Sunrise toolbar button.
</td></tr>
<tr><td>Substance Use & Social Screening</td><td>Will pull forward documentation from the ED Nurse Note. Add or update as needed.
Any selection of Yes will auto-expand additional observation sections to document appropriate details.</td></tr>
</table>

<table>
<tr><th>Section</th><th>Description</th></tr>
<tr><td></td><td>
Substance Use & Social Screening
Current or Former Substance Use
YES never Answer All
never Alcohol
YES never Caffeine Use
YES never Cigarette
YES never Electronic Cigarette
YES never Recreational Drug/Medication
YES never Tobacco
Psycho Social Screening
YES no Answer All
YES no concerns for safety a
YES no feelings of depressio
YES no feels like hurting oth
YES no feels like hurting self
Alcohol Use Detail
Alcohol Use Status | Alcohol Type | Alcohol Amount | Alcohol Frequency
</td></tr>
<tr><td>History Review Attestation</td><td>Indicate review of nurses' notes.</td></tr>
<tr><td>MDRO/POA</td><td>
Capture History of MDRO (Multi-Drug Resistant Organisms) and Device or Pressure Injury Present on Arrival.
Documentation from the ED Triage Note will pull forward to this note.
</td></tr>
<tr><td>MDM</td><td>Capture Medical Decision Making assessment.</td></tr>
<tr><td>PE</td><td>
Capture Physical Exam assessment.
The Template selection will pull forward from the HPI section.
Use one of the preferred methods to document this section:

Within each respective system, manually select normal or comprehensive exam assessment values.

Normal: Selection of this option will apply the system-defined 'normal' statement. Modify Statement as needed.
CONSTITUTIONAL normal comprehensive exam
Modify Statement: Well appearing, well nourished, awake, alert, oriented to person, place, time/situation and in no apparent distress.
Comprehensive Exam: Selection of this option will expand a 'template' of observation parameters for documentation.
GASTROINTESTINAL normal comprehensive exam
Abdominal Exam: soft, firm, rigid, organomegaly (specify), no organomegaly, psoas sign
Masses: no mass on examination, no pulsating masses, masses noted

Apply your defined default preferences. In the My Default box, select APPLY (sex ## years).
Note: The gender and age level are applied based on the selected patient.

In order to use this option, you must first define your default criteria:

Select your default pos/neg preferences for each respective system.

</td></tr>
</table>

Section	Description
	2. Scroll to the bottom of this section and select **Save** in the **My Default** box. MY DEFAULT SAVE (male 18+ yrs) • **mark ALL systems normal:** If selected, indicates documentation of ALL systems 'normal'. **Caution:** This indicates that you are documenting review of EVERY system. Select the **Document Via Avatar** checkbox to open the **Avatar** section to annotate **Problem** and **Context Quality** on the respective body area. **Click and Drag** the appropriate body area. • Click the arrow below the Avatar to turn the body position (front – back).
Critical Care	Capture documentation details for critically ill patient assessments. Selecting the **patient was critically ill** checkbox will expand additional observations. Critical Care Indication patient was critically ill Patient was critically ill with a high probability of imminent or life threatening deterioration Critical Care Provided direct patient care (not related to procedure) interpretation of diagnostic studies consultation with other physicians consult w/ pt's family directly relating to pts condition additional history taking documentation conducted a detailed discussion of DNR status telephone consultation with the patient's family Critical Care Time Spent less than 30 minutes 30-74 min (30 minutes-1 hr 14 min) 75-104 minutes (1 hr 15 min-1 hr 44 min) 105-134 minutes (1 hr 45 min-2 hr 14 min) 135-164 minutes (2 hr 15 min-2 hr 44 min) 165-194 minutes (2 hr 45 min-3 hr 14 min) 194 minutes or longer (3 hr 14 min-longer) Document exact time
EKG Read	Capture **EKG completed / EGK interpreted** details.

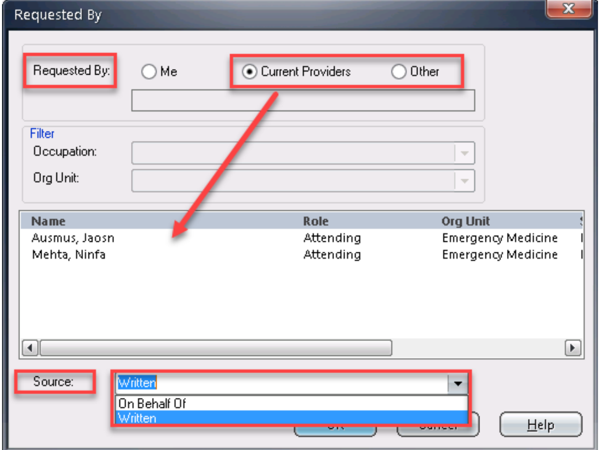
Section	Description
Progress Notes	Use this section to document **re-assessment / patient progress** throughout the ED visit.
Shift	Use this section to document **Change of Shift / Provider Hand-off**.
Consult	Use this section to document request for **Consult**.
Faculty	Use this section for documenting **Attending** review and attestation for **Mid-Level** and **Resident** documentation.
Chart Review	Compiles a summary view of all documented observations within the note.

Placing Orders Within the Note

4. To place orders within the note, click the **Orders** toolbar button.

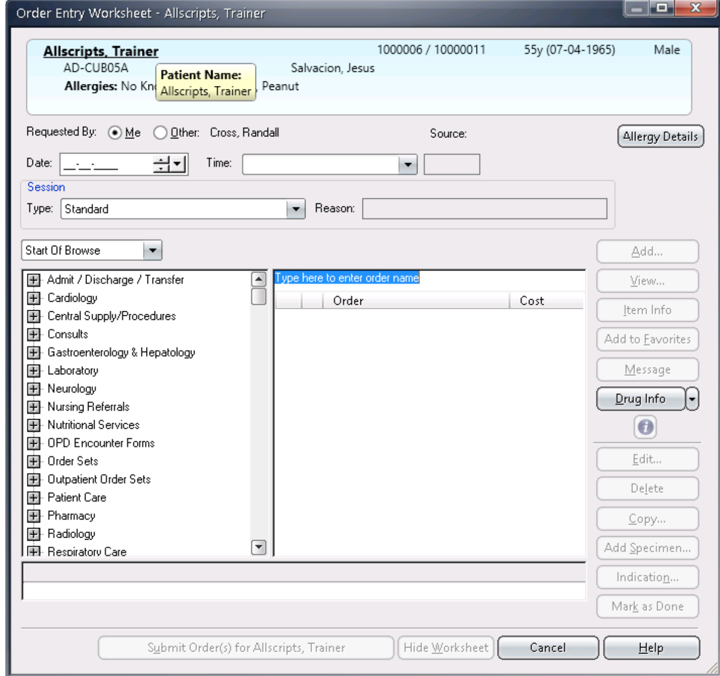
Requesting Order Co-Signature

Note: For Providers or Clinicians that may have the ability to place orders but must place orders under the care of a supervising MD, the **Requested By** window will appear to indicate the **Requesting Provider** and **Source** (such as Written or On Behalf Of).



- **Requested By** – Select the appropriate to indicate the requesting provider:
  - **Me:** Select when orders can be placed on your own behalf and does not require to be placed under the care of a Supervising Provider.
  - **Current Providers:** Selected by default. Select this option, and then select from the list of displayed Providers currently assigned in a care provider role to the patient.
  - **Other:** Select this option to search for the Requesting Provider by name.
- **Source** – Select the ordering source for the authorized order request from the drop-down:
  - **Written:** Indicates the orders are being transcribed from a written document source that is already considered 'signed'. This option will not trigger a provider co-signature to **Signature Manager**.
  - **On Behalf Of:** Indicates the orders are being placed via a non-written source (such as 'Verbal'). This option will trigger a provider co-signature to **Signature Manager**.

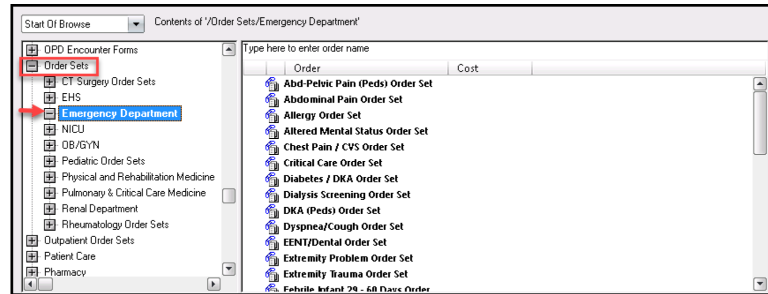
⇨ *The **Order Entry Worksheet** appears.*



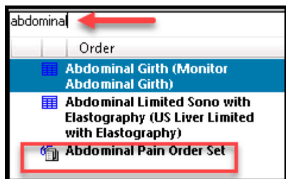
The following table describes the components of the **Order Entry Worksheet.**

Field Name	Description
Patient Header	Displays the Patient Header information.
Allergy Details button	Opens the **Allergies Summary View** window.
Requested By	Displays how the order was requested: **Me** or **Other** (if placing orders on behalf of another care provider).
Date	If you do not enter a requested date, today's date is assumed on the order entry form. **Note:** If entering multiple orders and date may differ, leave blank and specify on the individual order form.
Time	If you do not enter a requested time, the current time is assumed on the order entry form. **Note:** If entering multiple orders and date may differ, leave blank and specify on the individual order form.
Session Type	Provides the ability to change the order submission status (Standard, Hold, Discharge, etc.). The default is **Standard**.

a). In the **Start of Browse**, expand **Order Sets > Emergency Care**.



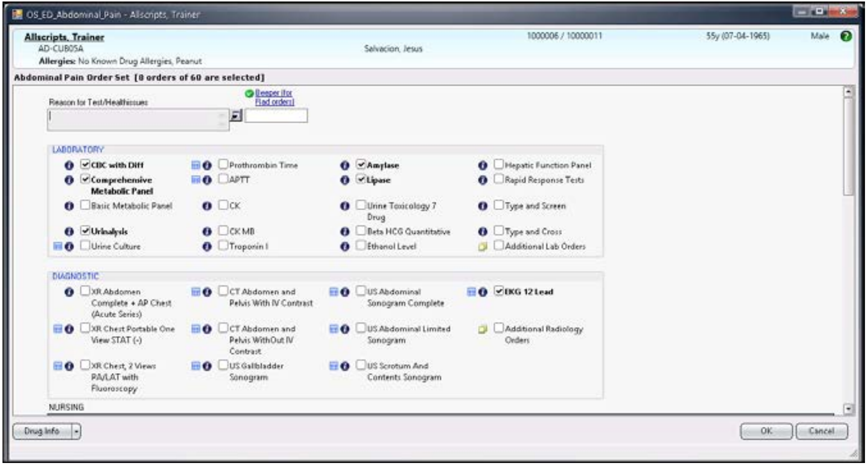
Note: You can also type the name of the order/order set in the search field to initiate a manual search.



b). Select the order/order set from the search results list and click **Add** (or double-click on the order).

For this example: Select the **Abdominal Pain Order Set**.

➪ *The **Order Set Details** window appears.*

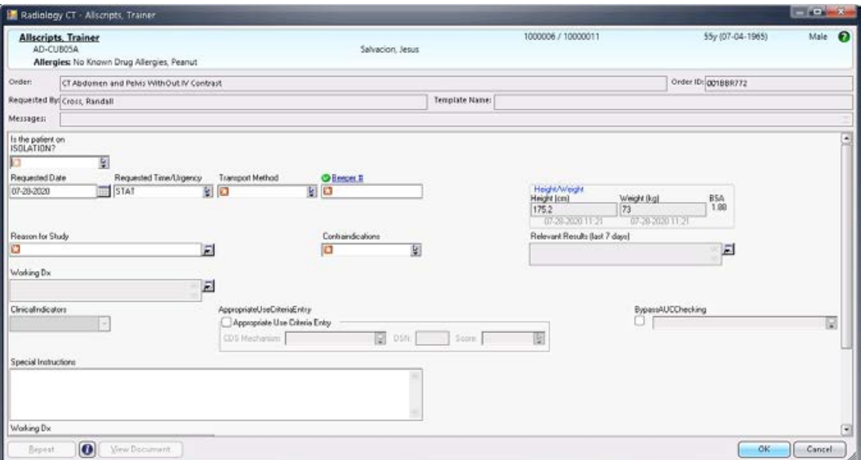


Note: Some order items that are routinely ordered for this problem type have been pre-selected by default. Deselect as needed.

c). Click the checkbox next to the order item(s) to add from the order set.

For this example: Select the **CT Abdomen and Pelvis Without IV Contrast**.

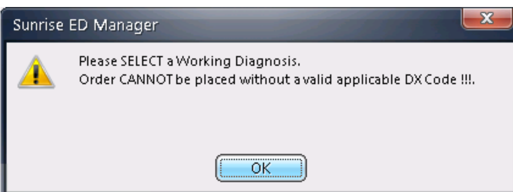
Note: Any order forms that have required entry data fields will auto-open when selected. Any order form field displaying a **red star** indicates required.



d). Complete the required fields as appropriate, and then click **OK**.

e). Click **OK** on the order form when complete.

Note: When placing **Radiology orders** and a diagnosis has not been added prior to placing orders, the following message appears indicating that you must add a **Working Diagnosis** before the order can be placed.



f). To add the **Working Diagnosis** do the following:

- Click **OK** to remove the message window.
- In the **Working Dx** field, click the button at the end of the field.

⇨ *The **Health Issues Manager** window appears.*

- In the **Select a Type** list, select **ED Diagnosis**.

⇨ *The **Health Issue Details** box opens.*

- In the **Health Issue** field, type a free text diagnosis description.
- In the **Action List**, click **Save Changes**.
- Click **Save to Order**.

⇨ *The added health issue appears in the **Working Dx** field on the order form.*

g). Click **OK** on the order form.

h). Select any additional orders on the order form as needed.

i). When complete, click **OK**.

⇨ *The orders are added to the **Order Summary** section.*

j). Click the **Submit Order(s)** button.

⇨ *You are returned to the note.*

5. **Optional:** To save the note in '**Incomplete**' status (and complete charting later), click the **Incomplete** checkbox at the bottom of the window.
6. To save and close your document, click **Save**.

Maintaining Documents

This section introduces Sunrise functions used for maintaining documents, such as modify or cancel a document, and the **Acronym Expansion** feature.

Modifying a Document

You can **Modify** a previously saved document to add additional or change existing documentation.

TO MODIFY A DOCUMENT:

1. In the **Documents** tab, select the document to modify.
2. Do one of the following:
   - Click the **Modify** tab-level toolbar button.
   - Right-click on the document and select **Modify Document**.

   ⇨ *The **Structured Notes Entry** window opens in **Modify** mode.*
3. Add or update documentation as needed, and then click **Save**.

Cancelling a Document

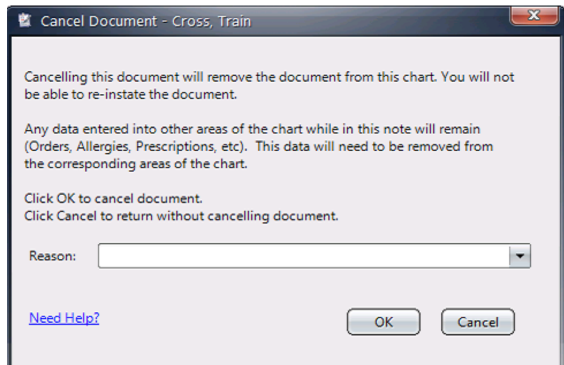
The **Cancel Document** function allows you to cancel a previously saved document.

TO CANCEL A DOCUMENT:

1. In the **Documents** tab, select the note to cancel.
2. Do one of the following:
   - Click the **Cancel / Delete Time Column** tab-level toolbar button.
   - Right-click on the document and select **Cancel Document**.

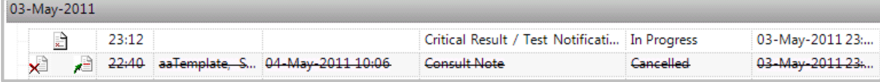
➪ *The **Cancel Document** window appears displaying a warning message concerning the removal of the document from the patient's chart.*

Note: When you cancel a document, any patient data such as, Orders, Allergies, Problems, etc., will not be removed from the chart. This is very important to remember if you cancel a document entered on the wrong patient.



3. Select a **Reason** from the drop-down and click **OK**.

➪ *The icon appears next to the document with a strikethrough.*



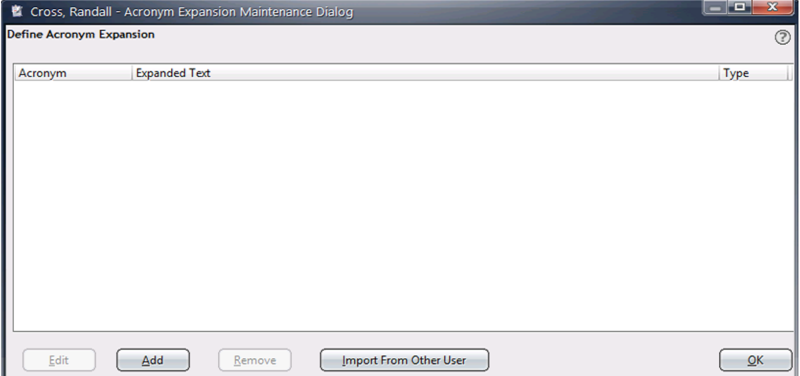
Creating Acronym Expansion Text

The **Acronym Expansion Maintenance** window allows you to add, edit or remove a list of acronyms and expanded text for the acronyms you define. This feature may prove beneficial when documenting structured note fields where you type free-text narrative statements.

To Create an Acronym Expansion Text:

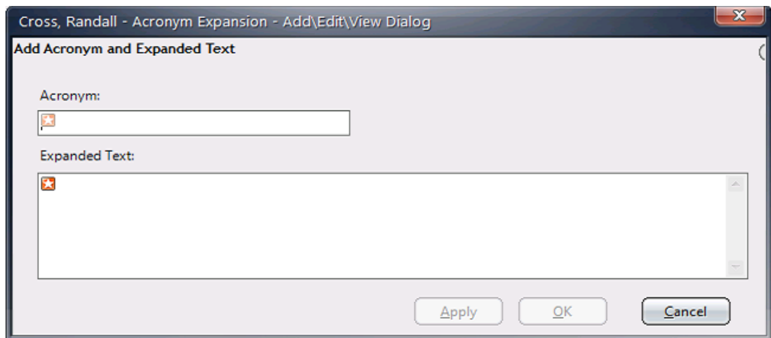
1. Access **Acronym Expansion** using one of the following:
   - From the Sunrise menu bar, select **Preferences > Acronym Expansion**.
   - From within a **Structured Note Entry** window, click the **Acronym Expansion** toolbar button.

➪ *The **Acronym Expansion Maintenance Dialog** window appears.*



2. Click **Add**.

   ➪ *The **Acronym Expansion – Add\Edit\View Dialog** window appears.*



3. Type the acronym in the **Acronym** field.

   Important: Do not use the following characters, except as the first character:

   - . (period)
   - ? (question mark)
   - : (colon)
   - ; (semicolon)
   - , (comma)
   - ! (exclamation mark)

   These characters are acronym terminators, which are reserved characters that you enter to open the acronym search window. (For example, **.wbc** is an example of a valid acronym; **w.b.c.** is not a valid acronym).

4. In the **Expanded Text** field, enter the full text of the acronym.

   Note: The max number of characters is 20,000.

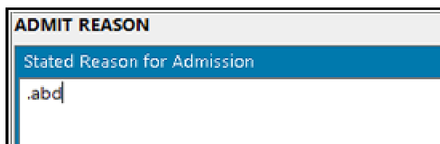
5. Do one of the following:

   - Click **OK** to save your changes.

- Click **Apply** to save your changes and add another acronym.

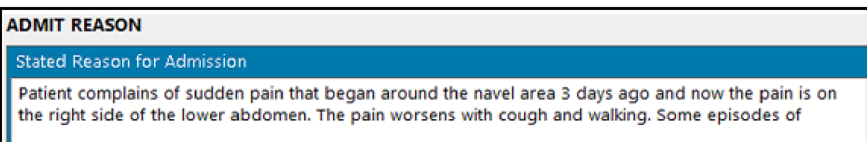
TO USE ACRONYM EXPANSION IN A STRUCTURED NOTE:

1. In a structured note free text field, type the **acronym.**

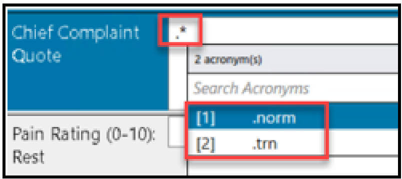


2. Tap the space bar on the keyboard.

➪ *The full text of the acronym expands.*



Note: To initiate a 'wild card search' on your list of acronyms, type the **terminator** followed by an **asterisk** (for example, .*).



Lesson Review

Having completed this lesson, you should be able to:

Update the Status Board with the assigned Provider.

Document the ED Provider Note.

Modify and cancel documents.

Use the Acronym Expansion feature.