

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.

Copy Forward	Refer to Note 🤹						
PI ROS2	PMH MDRO/POA	MDM PE	Critical Care	EKG Read	Progress Note	Shift Consult	Fa
Complaint	The patient is a (Age	() [Gender] compl	aining of [CCCP trg	chief cmpint].	Time Seen	07-28-2020	12:
					□ Docume	nt Free Text Objectiv	e Staten
Chief Complaint Quote	stomach ache for last	24 hours taking	g Pepto Bismol, but	no relief.	☐ Possible	Admission	
Template			- Histor	y/Exam Limited E	By 🏴 🗖 acuity	□ altered MS □ cond	lition 🗂
	ient C mother C father (Note Open (Read Or Pulse Resp		ficant other C daug SpO2 (%		15 C police	C Document \	/ia Bod
Available Vitals At I Temp (F) Method	Note Open (Read Or	BP sproom	SpO2 (%		IS C police	C Document \	/ia Bod
Available Vitals At 1 Temp (F) Method Severity F C m Pain (Now) F C 1	Note Open (Read Or Pulse Resp · ild ^C moderate ^C sever	BP 8 room 2 7 6 8 6 9 6 1	SpO2 (% sir D	0	IS C police	Document	/ia Bod
Available Vitals At 1 Temp (F) Method Severity F C m Pain (Now) F C 1	Note Open (Read Or Pulse Resp • ild C moderate C sever C 2 C 3 C 4 C 5 C 6 f	BP 8 room 2 7 6 8 6 9 6 1	SpO2 (% sir D	0	IS C police	☐ Document 1	/ia Bod

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.

0-5	igner(s)	

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

⇒ The Co-Signature window appears.

Me OM Ausmus, Jaosn ALL ALL Mut, Jaosn mut, Jaosn ta, Ninfa	Current Providers	Other	Sgarch Specialty
e mus, Jaosn	PA	Org Unit	Specialty
ALL e mus, Jaosn	PA	Org Unit	
e mus, Jaosn	PA	Org Unit	
mus, Jaosn	PA		
mus, Jaosn	PA		
		Emergency Medicine	
ta, Ninfa	MD Attending		Emergency Medic
		Emergency Medicine	Emergency Medic
vider Aware Note			٩
		OK	Gancel
	_	_	dder Aware Note

- 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.

Co -	Signer(s)
•	Mehta, Ninfa



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 🔽 C patient C mother C father C spouse C significant other C daughter C son C EMS
	Presenting Symptoms Location Quality posi_neg_Answer All Generalized Faching posi_neg_anorexia Fepigastric Dand-like posi_neg_constipation Fright upper quadrant Cramping posi_neg_diaphoresis Fight upper quadrant Cramping
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
	$\boxed{ \mathbf{k} \mathbf{N} \mathbf{O} \otimes \mathbf{D} \mathbf{N} \mathbf{P} \mathbf{T} \mathbf{P} \mathbf{P} \mathbf{O} \mathbf{N} \mathbf{F} \mathbf{P} \mathbf{A} }$
	Pain Pain SUB SUB SUB SUB SUB SUB SUB SUB
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 Complaint(s)
	Complaint Location
	Associated Symptoms Radiation
ROS2	Capture Review of Systems assessment.
	The Template selection will pull forward from the HPI section.
	 Based on the Template selected, the associated Systems sections will appear auto-expanded.
	 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:
	 Select your default pos/neg preferences for each respective system.
	 Scroll to the bottom of this section and select Save in the My Default box.



Section	Description
	MY DEFAULT
	C 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.
PMH	Capture review and updates to patient history.
Allergies/Intolerances	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.
To add/edit allergy histo	ry from within the note:
1. Click the Allergies	Summary button.
Allergies Summary	
The Allergies/Into	blerances Summary View window appears.
Allergies/Intolerances Summary View -	
Gar Hole Contractly Community Alargue Alergue	
Allergies/Intolerances Summary View	Y
Type / Allergen/Pro / 200	Reartion Confidence Le Onset Date Community Confirmed By Last Modified Info Source Status Reason Date Reve
*	
	view History Approve Allerges List Add New Add NEDA Discontrow Details O Delete History Glore
2. Click Add New.	
	ient with no existing allergy history, the Allergy Type window
appears.	×
Allergy Type	0
C No Known Allergies	
C Allergy Status Unknown	
Reason:	2
	Save
	Save Close
	Enter New Allergy/Intolerance



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. F	or this example, select Enter New Allergy/Intolerance.
	he Allergy/Intolerance (Adding New) window appears.
	Allergy/Intolerance(Adding New) - Vaughr, Debbie
^	Illergy/Intolerance Details
	Category: C Allergy C Intolerance Type: Drug Status: Active
	Allergen:
	Reaction:
	Add Reaction
	The second se
	Description:
	~
	Onset Date:
	🗘 Full Date
	Confidence Level:
	Info Source:
	Confirmed By: Me
	Add New Apply
	Reason: Entered:
	Last Modified:
	Attach Document
	OK Cancel Discontinue Delete
5. S	elect the appropriate Category. (Allergy is the default.)
6. S	elect a Type from the drop-down. (Drug is the default).
F	or this example: Select Food.
	elect the Allergen from the drop-down.
	or this example: Select Peanuts.
I	he Reaction Details window appears.



	on Description
	Reaction Details
	C Unknown C Select all reactions that apply
	Reaction Severity
	Anaphylaxis Short of breath
	Unconsciousn
	Chest pain v
	Facial redness v Resp. Symptoms v
	Dizziness
	OK Cancel
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 <i>Allergies/Intolerances Summary View</i> 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.
	🔁 Allergies/Intolerances Summary View - Allscripts, Trainer
	Mail Mail Connexty Connexty Margine Margine
	Tom Hole Connexity Community
	Index Drug Allergy Status Allergies /Intelerances Summary View - Allscripts, Train Drug Allergy Status Image: Allergies /Intelerances Summary View - Allscripts, Train Drug Allergy Status Image: Allergies /Intelerances Summary View - Allscripts, Train Drug Allergy Status Image: Allergies /Intelerances Summary View - Allscripts, Train Drug Allergy Status Image: Allergies /Intelerances Summary View - Allscripts, Train Drug Allergy Status Image: Drug Allergies /Intelerances Summary View - Allscripts, Train Drug Allergy Status
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	Nde- Connergity Margine Nde- Nergies Margine Allergies/Intelerances Summary View - Allscripts, Train
	Nergies/Intolerances Summary View - Allscripts, Train Nergies/Intolerances Summary View - Allscripts, Train Nergy Orug Allergies Unknown Nergy Orug Allergies Unknown Network Cancel Select a required Reason from the drop-down if unknown or click Add NKDA to
	Nde- Connergity Margine Nde- Nergies Margine Allergies/Intelerances Summary View - Allscripts, Train



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 O	utpatient Medication Review button.
Outpatient Me	dication Review
	Add Home Medication button to add home medications using the Quick Entry method does not provide the ability to update existing home medication history.
	Medication
The Outpa	tient Medication Review window appears.
Outpatient Medication R Allscripts_Trainer Triace	cv/cv/ 1000006 / 10000011 55y (07-04-1963) Male
	Drug Aflergies, Feanut
Need Hoto?	Save Complete Save Incomplete Cancel
	atient has existing home medication history, the information will appear in the display
	view and validation.
	nt indicates <u>no history of home medications</u> , do the following: In the upper right corner, click the Med Status : < Not yet specified > hyperlink.
	Med Status: < <u>Not yet specified></u> Preferred Pharmacy: <u><<u>None></u></u>
	The Outpatient Medication Status window appears.



Section	Description
0	<image/> <text><text><text><text><text></text></text></text></text></text>
	Merication Name Doe Unknown Dosage Units Route Frequency Image: Control of the control of t
	Need Help?
0	In the Medication Name field, begin typing the name of the medication.
0	For this example: Begin typing Lasix. Select the appropriate item from the search results list.
	Add Home Medication - Allscripts, Trainer Clear Issix Full Catalog Lasix
0	Continue with selecting across for the appropriate: Route , Dose and Frequency .



	Description
	S Add Home Medication - Allscripts, Trainer
	Clear Down Units Route Frequency
	Isix Full Catalog Lasix 10 mg/mL oral liquid 1 tablet once a day
	Lapix injectable Lasix 20 mg oral tablet other
	Follow Up Reason Lalo Source Lasix 40 mg oral tablet Lasix 80 mg oral tablet Lasix 80 mg oral tablet
	other
	The Add Home Medication window appears with the selected det
	Add Home Medication - Alkoripts, Trainer
	Clear Medication Name Generic furstemide
	Lasix 20 mg oral labelet Instructions G Augo F Educe Des F Uninnem Desage Livits Reute Frequency 1 </td
	I h (tabit) V oral V once a day V F 2000 Last Door Taken Time A A A A A A A A A A A A A A A A A A A
	Follow Up Resson Info Source
	Start Date End Date Control Date Start Date
	Health Issues Sample Tracking Comments
	Save Add Another Cancel
	Ned Hep?
4. Complete	1.
following 5. Complete	e any additional information as required.
following 5. Complete 6. Click Ad	e any additional information as required. Id Another to add additional home medication(s).
following 5. Complete 6. Click Ad 7. When co	e any additional information as required. Id Another to add additional home medication(s). Implete, click Save.
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8. To add the Preferred Pharmacy:



Section		Description
	0	Click the Preferred Pharmacy link (upper right corner).
		Med Status: Patient Currently Takes Medications Preferred Pharmacy: <u>None></u>
		The Manage Pharmacies window appears.
		- Notional Pharmacies for : Alberight, Trainer
		Ternove Edit Default Name PharmacyType Address1 Address2 City State Zp.Code
		•
		Sards Pharmacy Name State Pharmacy Type
		City: Zip: Supports (PES) Phone: Fac: Supports Cencel)
		Need Help('
	0	In the Search Pharmacy Name field, begin typing the name of the pharma
	0	Include any additional search modifiers (for example, Zip). Optional: To further filter the search results, select the following:
	0	 Pharmacy Type: Select to filter pharmacies by Retail or Mail Or
		 Supports EPCS: Select to filter pharmacles by Retail of Mail of Supports EPCS: Select to filter pharmacles who support Electron
		Prescribing of Controlled Substances.
		 Supports Cancel: Select to filter pharmacies who support electr
		Cancel of prescriptions.
	0	Click Search.
	0	Select the preferred pharmacy from the Search Results list, and then click
		Add to Preferred button.
		Name: duane State ny Pharmacy Type:
		City: brookym Zip: Supports EPCS Phone: Fas: Supports Cancel Search
		Search Real
		28 Results
		New Perferred Inactive Name PharmacyType_BCS Cancel Address1 Address2 City State Zip Code Name PharmacyType_BCS Cancel Address1 Address2 City State Zip Code Name PharmacyType_BCS Cancel Address1 Address2 City State Zip Code No No No No No No Ti226104 BROKLYN NY Ti226104
		▲ Duane Reade 14201 Retail No No 1417 AVENUE U BROOKLYN NY 112293319
		Duane Reade 14211 Retail No No 4318 13TH AVE BROOKLYN NY 112191338 Duane Reade 14219 Retail No No 3090 OCEAN AVE BROOKLYN NY 112353406



Section	Description	
- Pr	rred Pharmacies for : Allscripts, Trainer	
	ove Edit Name PharmacyType Address1 Address2 City	State Zip Code
	A Duane Reade 14184 Inclusion 724 FLATBUSH AVE 1930 A CVS Pharmacy # 2431 2472 FLATBUSH AVE BROW	OKLVN NY 112261404 (OKLVN NY 11234 (
	on complete click Clase	•
	en complete, click Close.	
•	te, click Save Complete. add Home Medication history outside the note v	via the Suprice teelbar button
Health History	Existing Past Medical , Surgical into this section of the note.	and Family History will pull
	Health history should be reviewed encounter to ensure the most acc in the patient's chart.	
	history from within the note:	
1. Click the Hea	Ith History (Entry or Modification) but	ton.
	ealth History (Quick Entry) button to add proble	
method. This m	thod does not provide the ability to update existir	ng nealth history.
Health H	itory	
	sue Manager window appears.	
T Health Issue Manager A Allscripts, Trainer	3 × Aliscripts, frame: Triage Male S5y (07-04-1965) Allerge - No Known Drug Allergies; Food: Peanut	
Add Show/ New Modify Allscripts, Trainer Healt		Filters Selection Options 🚓
No Community Health Iss	is are available mily History Past Medical Social Medical History Past Surgical	Health Issues List Review Slatur, Unreviewed
8 🖻 🖉 🚱 "	Health Issue Code KD-9 KD-10	SNOMED CT Type V Onset Date
• •	christ pain	Complaint, ECLP
Add New Health Issue		Action List
Advision Providence (CB)	Browse Full Catalog Search / Category Start Of Browse * Coding Scheme	Cancel
Axis 1 Axis 11 Axis 10		Hide All-Code Linkages
	o category selected>:	Add to Pavorites Add Non-Coded bour
ED Diagnosis EHS Visit Dx	Q 🔾 Cats with 💿 Contains 🗌 Indude	Close Help
2. In the Add N	ew Health Issue section, select the appl	
Select a Typ		iophale problem i she more n
	2 IISL	
•••	ple: Select Past Surg Hx.	



Secti	on	Description
	Health Issue Details	Action List
	Type: Past Surg Hx Code:	Coding Scheme: Body Site: Structure
	Catalog Name:	Scope: General Apply
	Health Issue:	Go Dack
	Description:	
3.	In the Health Iss	sue field, type the description name of the event.
	For this example	e: Type appendectomy.
4.	Recommended surgical event.	I: In the Onset Date field, indicate the M/Y or Full Date of the
5.	Click Save Char	nges.
6.		ect a Type list, select Family History.
7.		log Search field, type htn and press Enter.
8.		o Family history of hypertension.
о.		5 5 51
	The Family His	tory window appears.
	Family History	
	Family history of hypertension Select the Family Hember(s) that also ha	as the above Health History Father of Pink, Floyd Personal Information
	Relationship to Patient Name	Age at Diagnosis
	Mother	Name:
	Brother Soter	Soll Living? O'Yes O'Ne O'Utstnown Was this person adopted? O'Yes
	Daughter	Was this person born a
	0	txiin/multiple1 (Yes-identical (Same)
	0	
	hered HelloT	Done Cancel
9.	Click the checkb	pox next to the family member(s) to associate the health issue
	history.	
10	. Optional: Docur	ment additional information as needed, such as: Name, Age at
_	Diagnosis, Still	
	•	es appear in the Health Issues list in the top pane.
		es appear in the meanin issues list in the top parte.
	. Click Close.	
lote: \	You can also add Hea	Ith History outside the note via the Sunrise toolbar button.
Suhe	tance Use &	Will pull forward documentation from the ED Nurse Note. Add
	I Screening	or update as needed.
	Juccinny	
		Any selection of Yes will auto-expand additional observation
		sections to document appropriate details.



Section	Description
	Substance Use & Social Screening
	Current or Former Substance Use Psycho Social Screening YES never Allohol YES never Alcohol YES never Caffeine Use YES never Caffeine Use YES no Never Electronic Cig rette YES YES no feels like hurting self YES no feels like hurting self YES never lobacco The Flachd Inset flachel Field States Flachd States flachel Tiger Flache States flachel Tiger Yes States Topet orke F
History Review Attestation	Indicate review of nurses' notes.
MDRO/POA	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.
MDM	Capture Medical Decision Making assessment.
PE	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. • Comprehensive Exam: Selection of this option will expand a 'template' of observation parameters for documentation. • Statement Comprehensive exam: Selection of this option will expand a 'template' of observation parameters for documentation. • 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.



Section	Description
	 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. Image: Select the arrow below the Avatar to turn the body position (front – back). Event
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 with a high probability of imminent or life threatening deterioration Critical Care Provide Critical Care Provide Critical Care Treated to procedure) Critical Care Time Spent Critical Car
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.
	HISTORY OF PRESENTING ILLNESS
	The patent is a Mart (Cender) compaining of LCCCP tog dwd motell; Tran was seen by the at Feb-03-0203 (736). The patient's dwd compaint guide was comping pain in abdomait fe This is a possible addressen/thread by Stratoms: wasea and combing. Natient drives and results, companyion, diaphoresis, danhae, distancia, fever and retail blood. Located in this gener symptoms diated yeaterbay. The sinking is gradual omet, Modifying Patent: Effer with lying drive. Perform History is note initiated to reason for vidit.
	REVIEW OF SYSTEMS
	CONSTITUTIONALI: <u>DESCIT</u> ZI fer forer and sensess: <u>Brazilitar</u> fer sensersia, shills disubnetiss; nublica and avegite loss CANDOVARALE: <u>Brazilis</u> for for adordand, centa para o datoboresia, dentini, respirative providente and avegite loss BERRATORY: <u>Blazilis</u> for cough dysores, kensegnya, planetic chest pain and shreeing

Placing Orders Within the Note

4. To place orders within the note, click the **Orders** ^{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		
Requested By: Me	Current Providers	Other
Filter Occupation: Org Unit:	/	· ·
Name	Role	Org Unit !
Ausmus, Jaosn Mehta, Ninfa	Attending Attending	Emergency Medicine I Emergency Medicine I
•		
Source: Writter On Behalf Of Writter		- Help

- **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 <u>will not</u> 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 <u>will</u> trigger a provider co-signature to Signature Manager.
 - ⇒ The Order Entry Worksheet appears.



Allscripts. Trainer 1000006 / 1000011 5 AD-CUB05A Patient Name: Salvacion, Jesus Allergies: No Kn Allscripts, Trainer Peanut	5y (07-04-1965) Male
Requested By: Me Other: Cross, Randall Source: Date: Time: Time: Session Type: Standard Reason:	Allergy Details
Start Of Browse	
Admit / Discharge / Transfer Iype here to enter order name	
Cardiology Order Co	
E Consults	Add to Eavorites
Gastroenterology & Hepatology Laboratory	Message
1 Neurology	
Nursing Referrals Nutritional Services	
OPD Encounter Forms	
Order Sets	Edit
Outpatient Order Sets Patient Care	Delete
n Pharmacy	<u>C</u> opy
Radiology Besniratory Care	Add Specimen
	Indication
	Mark as Done
	Civiark as Done

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.

AD-CUB05 Allergies:		eanut			Salvacion, Jesus	1000	006 / 10000011	55y (07-04-1965)	Male 🕤
minal Pai	in Order Set [8 orders o	of 60 ar	e selected]						
Reason 	for Test/Healthissues		Clesser ifor Had orderit						
LABOR	ATORY								
0	CBC with Diff		Prothrombin Time	0	Amylase	🚯 🗌 Hepatic Fu	inction Panel		
0	Comprehensive Metabolic Panel		DAPTT	0	Clipse	Rapid Resp	ionse Testi		
0	Basic Metabolic Panel	0	□ск	0	Urine Toxicology 7 Drug	O Type and S	icreen		
0	✓ Urinalysis	0	CK MB	0	Bets HCG Quantitative	O Type and O	tross		
	Urine Culture	0	Troponin I	0	Ethenol Level	🗿 🗌 Additional	Lab Orders		
DIAGN	ostic								
0	Complete + AP Chest (Acute Series)	80	CT Abdomen and Pelvis With IV Contrast	80	US Abdominal Sonogram Complete	■O ⊘ BKG 121.e	ad		
80	R Chest Portable One View STAT (-)	80	CT Abdomen and Pelvis WithOut IV Contrast	80	US Abdominal Limited Sonogram	Additional Orders	Radiology		
80	XR Chest, 2 Views PA/LAT with Fluoroscopy	80	US Galibladder Sönogram	80	US Scrotum And Contents Sonogram				
NURSIN	G								. 6
ug Info .								(ок	Cancel

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.

Allscripts, Trainer AD-CUB03A Allergies: No Known Drug Allergies, Peanut	1000006 / 100 Salvacion, Jesus	000011 \$5y (07-04-1965) Male 🚱
Orden CT Abdomen and Pelvis WithOut IV Contrast		Order ID: 001888/772
Requested By Cross, Randall	Template Name:	
Messages:		
Is the patient on ISOLATION?		5
Requested Date Requested Time/Urgency Transport Method OB		
07-28-2020 STAT 📓 🖸	Height/Wei Height (cn)	Weight (kg) BSA
	175.2	
Reason for Study Contra		ultr (last 7 days)
0 2	8	E
Working Dx		
E		
Cirricalindicators AppropriateUseCriteriaEntry		BypassAUCChecking
- Appropriate Use Eriteria Entry		
CD1 Mechanism	DSA. Score.	
Special Instructions		
de la factoria da factoria de	-	
Woking Dx		6
Bepeat O Yew Document		OK Cancel

- 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.

Sunrise	ED Manager
<u> </u>	Please SELECT a Working Diagnosis. Order CANNOT be placed without a valid applicable DX Code !!!.
	OK

- f). To add the Working Diagnosis do the following:
 - Click **OK** to remove the message window.
 - In the **Working Dx** field, click the \mathbf{E} button at the end of the field.
- ⇒ The Health Issues Manager window appears.
 - In the Select a Type list, select ED Diagnosis.
- Arr The Health Issue Details box opens.
 - In the **Health Issue** field, type a free text diagnosis description.
 - o In the Action List, click Save Changes.
 - o Click Save to Order.
- ⇒ The added health issue appears in the Working Dx field on the order form.



Working Dx	
abdominal pain	

- 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.
- \Rightarrow 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**.
 - Arr 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.

📓 Cancel Docu	ment - Cross, Train	
	locument will remove the document from this chart. You will not tate the document.	
Any data entered into other areas of the chart while in this note will remain (Orders, Allergies, Prescriptions, etc). This data will need to be removed from the corresponding areas of the chart.		
Click OK to cance Click Cancel to re	el document. eturn without cancelling document.	
Reason:	•	
Need Help?	OK Cancel	

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

\Rightarrow The 🖄 icon appears next to the document with a strikethrough.				п.		
03-May-2011	23:12			Critical Result / Test Notificati	In Progress	03-May-2011 23:
	22:40	aaTemplate, S	04-May-2011 10:06	Consult Note	Cancelled	03-May-2011-23:

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.



efine Acronym I	Expansion	G	
Acronym	Expanded Text	Туре	

- 2. Click Add.
 - ⇒ The Acronym Expansion Add\Edit\View Dialog window appears.

Cross, Randall - Acronym Expansion - Add\Edit\View	/ Dialog	×
Add Acronym and Expanded Text		(
Acronym:		
Expanded Text:		<u>^</u>
		T
	<u>Apply</u> <u>QK</u>	Cancel

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.
 - \Rightarrow The full text of the acronym expands.

ADMIT REASON Stated Reason for Admission Patient complains of sudden pain that began around the navel area 3 days ago and now the pain is on the right side of the lower abdomen. The pain worsens with cough and walking. Some episodes of

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

Chief Complaint	2 -
Quote	2 acronym(s)
	Search Acronyms
Pain Rating (0-10): Rest	[1] .norm [2] .trn



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.