INSTRUCTIONS FOR ADMISSIONS AND PROGRESS NOTES ON HEALTHCONNECT

Computer Log On:
NUID: (i.e. G850934) letter then 6 numbers **Password:** selected during orientation
Domain: CS (usually pre-populated)
Click on WestBay Hyperspace
HealthConnect Log On:
NUID: (i.e. G087343) **Password:** selected during orientation
(no luck- call operator x34780 and ask to be connected to HealthConnect Computer Site Support Specialist

ED PEDS:
-If in ED: Select "EPIC" top left corner, then "Patient Care", then "Emergency Dept", then "Track Board"
-Double Click Patient Name-chart now opens
-Left column with bed # (RC=PIT=physician in triage=urgent care)
-See patients 18 and under (age 2 Y=2 years, 2 M=2 months)-find MD assigned and let them know you're there
-Chart: select patient from track board (above). Select ED consult/H&P in second column
-To write note use dotphrase .sroedpedres
-Press F2 to move through the *** sections then left/right click
-At the end of your note click cosign required box in left upper corner and enter name of attending

PEDIATRIC H&P:
-**If in ED**: Select "EPIC" top left corner, then "Patient Care", then "Emergency Dept", then "Track Board"
-**If transfer from well baby/SCN** (special care nursery) use .babyhp, .babyp, .babydcsum for notes

****Mark as INPATIENT admission (NEVER observation), even if you anticipate a stay <24 hrs****
-Select More Activities at left lower corner
-Select ED Consult/Admission(Peds)
-Click ED consult start and enter
-Review clinic chart-select Chart Review then Encounters
-Review recent inpatient/ED records from past-select IP/ED
-Select Notes for ED doc's note
-To review labs, select Lab
-To review pertinent labs highlight those interested and select Lab Flowsheet along top column
-To review meds, select Meds
-Select Problem List-new medical problems
Now log out of HealthConnect and go see the patient.
-Enter main diagnosis and check box "primary diagnosis"
-Include "Child Healthcare Maintenance" as a diagnosis and use Dr. Steuerle's dotphrase
-Review allergies and select "Mark as Reviewed"
-PTA medications: check appropriate box for current medications
-Select ED Consult/H&P and type in .pedhp to see choices-usually .pedhpgeneric
- **If transfer from well baby/SCN** (special care nursery) use .babyhp, .babyp, .babydcsum for notes
Start your note if waiting for attending. If already discussed with attending, first do orders, then your note
For your note-
*use F2 to highlight *** text boxes, left click your choices, right click to accept
*if any *** remain, you must delete them or note cannot close
*any field highlighted in blue "no info found" must be erased and replaced with correct Hx
***check box "cosign", but** DO NOT end the consult
-You can place orders in the ED if needed-Select "My ED Orders" at the top
-Select Order to Admit along top column

-Enter diagnosis
-Level of care: Peds -Type of Admission: IP/inpatient
-Attending: enter last name, then the big must: SIGN ORDERS

-Select Admission Orders along top column
-Select Admission Order Sets
-Check/type Standard Admission Peds and fill out as indicated
-At bottom select which ED orders to cont, d/c or modify
-Click SIGN AND HOLD ORDERS

-Return to top column, My ED Documentation
-Click on Consult Complete
-Log off the computer via control-alt-delete

INPATIENT PROGRESS NOTES:

-Select Pt Lists along top column
-Along left column select "+" to left of System Lists
-Scroll down to SRO Specialty Departments
-Scroll down again to SRO-Pediatrics
-Find your patient and double click to open chart
-Review chart-defaults to Patient Reports
-Review sign out and vitals
-Select "Orders Modify"-clean up orders-no duplicates, stop meds that are done
-Select Notes on left column
-Review notes if needed (progress notes, H&P)
-Problem List-update daily
-Select New Note top left corner
-In new screen, go to right top corner box, type in Progress
-In text box type .progressnoteped
-Use the F2 function to complete different fields
-Left click to select and right click to accept
-Remember that *** shows you were you either have to use free text or delete the *** (you have to do one of the two before finishing the note)
-when done, **click box "cosign"**, and then click Accept at the bottom
-Select Order Entry along left column for new orders
-No need to cosign orders
-Select Orders Modify along left column to d/c or modify existing order
-Remember to click SIGN ORDERS in blue at bottom

INPATIENT DISCHARGE:

-Discharge at left lower column
-Problem List: update it
-Discharge Orders: at the top select "Reconcile and Write Discharge Orders"
-Discharge Medications: To prescribe d/c medications**, list the pediatric attending as the authorizing provider** so the patient doesn't pay full price for medications
-Outpatient medications are sent to **SRO 1 West** Pharmacy-change to pharmacy to 1 West (SRO 1 W)
-Write Discharge Instructions-for neonates use dot phrase from Dr. Steuerle
-Discharge Summary (this will be in place of your progress note).
-For the body of the note use .peddcsum for older babies and children. For babies from SCN/newborns, use .babydcsum

-Erase the duplicate problem list that appears as free text under Hospital Course-in its place type in a free text paragraph describing the hospital course. At the bottom of the note DO NOT just put "see discharge instructions"-WRITE OUT the plan for discharge. Include follow up appointments, outpatient medications and lab orders. Sign note

-Select D/C Home and select order to discharge icon

NEWBORN ROUNDS: Please note that some babies need H&P and discharge the same day!

Select "Patient Lists" from top toolbar
In left column, select + next to "Shared Patient Lists" and select "SRO Newborn"
(consider dragging this icon into your "My Patient Lists")

Newborn Rounding Workflow

From Drs Steuerle & Wright, updated 04/16/2012

Notes - Review the H&P and all recent notes. If no H&P, then open the Newborn Navigator and start the H&P Note (.babyhp)
The generated H&P will contain the maternal history and delivery information. (see link to maternal chart if necessary)
(Orders Modify – Confirm the Newborn Supplemental Order Set is ordered by checking for hearing or bilirubin tests)

Problem List – Confirm "Single Live Birth" is set as principal problem & includes the dotphrase below in the overview

Patient Reports – MAR (check for unexpected treatments)

Chart Review – Labs (check for results and in-process orders)

Document Flowsheet (in "More Activities" at the bottom)
- **Vital Signs Nursery** (check weight & %loss)
- **Point of Care Tests** (Glucose should be >50)
- **I/O Infant** (check breast / bottle / voids / stools)

Dotphrase for Problem List
@GAB@
@FLOW(12039)@
@FLOW(3573,3574)@
Maternal blood type ***, GBS Status ***

Reviewing the Video Whiteboard columns: (located in the center hall, or on many of the computers)
- **Home** – Start with those indicating D/C Days or D/C Nights or D/C
- **Circ** - Lower priority for those wanting Circumcision (circ physician will chart on them)
- **NB Exam** – Put your initials here! Then push the square icon (bottom left of the window) to save the changes.

Charting:
- H&P= **.babyhp**
- Progress Note - **.babypnote**
- D/C Summary & Instructions = **.babydcsum** and **.babydci** or **.babydcispan**

Early Discharge: Newborns may be discharged prior to 24 hours if all criteria are met:

Not 1st baby	38 weeks EGA or later
GBS negative	No Prolonged Rupture of Membranes (>18 hours)
Vitals including glucose stable	2-3 successful feedings
Bilirubin level is low or low intermediate	Passed both stool & urine

GBS Positive/Unknown Discharge Criteria (Risk Factors: prolonged rupture >18h, fever, < 37wks EGA)
- GBS is unknown or positive **with risk factors**, then CBC, blood culture, and the MD will decide based on results
- GBS is unknown without risk factors, then **≥ 24h stay** and ok for 48h f/u
- GBS is positive without risk factors & mother was untreated or incompletely, then **≥ 48h stay** and ok for 48h f/u
  - *Exception, if delivery is a repeat C-Section with intact membranes then **≥ 24h stay** and ok for 48h f/u*
- GBS is positive without risk factors & mother treated at least 4 hours before delivery then **≥ 24h stay** and ok for 48h f/u
- A maternal temp > 101.5 means automatic IMN for baby for ≥ 24h stay for work-up.

Bilirubin Watch List (Located under Shared Patient Lists) bilirubin level is drawn on morning of anticipated d/c

Risk Factors: (EGA< 38, GBS, FHx, birth trauma, hematoma, first breastfed child, poor feeding, Asian, Coombs+)

Newborns go onto the Watch List if bilirubin level is:
- High Risk – All go onto list
- High-Intermediate Risk and ANY risk factors – Go onto the list

High-Intermediate Risk and NO risk factors and eating well – OK to leave off list with prompt f/u
Low-Intermediate or Low Risk – Ok to leave off the list unless unusual circumstances

FYI: Normal bilirubin increases ≤ 0.2 per hour (to see bili graph go to More Activities, Images and search for "bili")

1.) Drag patients chart into the Watch List
2.) Open an outpatient telephone encounter - DO NOT CLOSE THIS TELEPHONE ENCOUNTER
3.) Order an out-patient "Neonatal bilirubin, as standing order with ~10 count, expiring in ~1month, ASAP priority
Inform parents to use the hospital laboratory and use the lobby telephone if the lab is closed (weekends)
4.) In the telephone encounter documentation include the following: (use the **.pedphbili** smartphrase)
Bilirubin level and timing (easy to get from the lab result)
Gestational age, blood type of mom & baby
Breast or bottle fed and success rate and future feeding plans
Note all risk factors (see above)
5.) On Snapshot screen, in "Specialty Comments" enter the due date for the next Bilirubin test.
6.) In the Problem List, add Neonatal Jaundice

CLINIC PROGRESS NOTES:

-Select Schedule along top column
-under the calendar fill in **SRO-PED4** or **SRO-PED5**
-select "+" next to SRO-PED
-locate MD assigned and double click for schedule
-Open chart by selecting patient name
-use Chart Review and then select Encounters to review visits
-The MA will fill in the CC and vitals
-select Progress Notes and complete note using the dot phrase .emnote4
-after note complete, click Analyze, then Approve, then Accept (right lower)
-Diagnosis: Select Order Entry far left
-Enter Diagnosis in that section (i.e. URI) then enter tab
-if more than 1 Diagnosis, pick primary Dx by clicking under "P"
-Orders: select Order Entry on far left column
-at top enter medication name (or part i.e. amox) and select
-pick pharmacy (SRO Stein) and Accept
-Select Association and select appropriately
-PEND orders (top column)-then ask attending to sign
-DO NOT CLOSE THE ENCOUNTER-please "EXIT" the workspace or click the "X" next to pt