

# **A Quick, Hopefully Useful Overview of Power Notes for the ACC Clinic**

An unofficial addendum to the official CERNER Users Guide

- > Intranet Home Page
- > ENHANCED VIEW INFORMATION
- > QUICK REFERENCE GUIDE link

Fake patients to practice power notes:  
TESTPROD, LISOUTPATIENT  
TESTPROD, LISK

## **Section 1: Default Set-Ups**

### **1. Turning off Spell Check: ONLY NEED TO DO ONCE**

- Click: Add button in the Power Notes tab on the Left Side Menu
- Click: Yellow highlighted area next to Type
- Click: VIEW button on the Top menu
- Select: CUSTOMIZE (last choice)
- Select: MORE from the Top tab menu
- Uncheck Run Spell Checking Automatically
- Click: Apply

### **2. Setting up your favorite notes folder: ONLY ONCE FOR CLINIC, BUT PRIOR TO ALL ROTATIONS**

- Click: Add button in the Power Notes tab on the Left Side Menu
- Click: Yellow highlighted area next to Type
- Click: VIEW button on the Top menu
- Select: CUSTOMIZE (last choice)
- Select: DOCUMENT TYPES from the Top tab menu
- In DEFAULT NOTE TYPE, type in "I"
- Scroll down until you reach IM- Outpt- ESTABLISHED VISIT NOTE
- Click: Apply
- Repeat for all outpatient notes
- Recommend: do the same of inpatient ward folder
- Recommend adding and removing notes when on consults

For example, if you are in the MRICU this month and a MRICU H&P or MRICU progress note will be the note you are writing the majority of the time then it would be beneficially to change your default note. Repeat the above steps but instead of the using the Int Med note select a MRICU note by typing in "M", select a MRICU note, and then click Apply. **After the rotation remove these notes.**

### **3. Setting Up Your Favorite Note Folder: ONLY NEED TO DO ONCE**

- Click: Add new note
- Select the PRECOMPLETED tab
- Highlight a note and open it
- Click on Documentation in the top horizontal menu
- Select SAVE AS PRECOMPLETED NOTE
- Click: Save as new
- When you return to the list of pre-completed notes, highlight your new personal pre-completed notes, then click Add to Favorites
- Repeat these steps for all pre completed shared notes in INTERNAL MEDICINE

### **4. Limiting Your Searches for Attendings: ONLY NEED TO DO ONCE**

- Open a new Note
- Click: SIGN at the bottom
- Click: Endorser and then Click on the Binoculars
- Click: Limit by Group. Choose Department of Internal Medicine
- Click: Limit by Organization. Choose VCU Health System

### **5. Limiting Diagnoses by ICD-9 Codes: ONLY NEED TO DO ONCE**

- Click on Diagnosis & Problems from Left hand menu
- Under PROBLEMS select ADD
- Type in any diagnosis (ex atrial fib) and hit ENTER or click on the binoculars
- Select: SHOW ADVANCED OPTIONS
- Select: search by NAME
- Next to TERMINOLOGY click: ..., then select ICD-9
- Next to TERMINOLOGY AXIS click: ... then select ALL TERMINOLOGY AXES

**\*\* NOTE if you CANNOT find the diagnosis you need you can always click the free text button and type in a diagnosis. DO NOT get in the habit of this because this will not associate an ICD-9 code with the diagnosis! \*\***

## **Section 2: CERNER: Understanding the MENU**

### **Overview >**

- **This visit** - review this at the start of every encounter.
  - **Since last visit\*** - review this at the start of every encounter.
  - **Summary** – a useful reminder if you keep your medications & problems UTD
- \*There often is an 8 second delay when opening this page. Do not kick your computer.

### **Histories >**

- **Past medical** – update this whenever time allows. We highly recommend entering your PMH through the Problems tab as outlined below. If you do it this way it will populate both the Problem and PMH sections. If you only enter it in the PMH section then you will have to re-enter it again in the problem list.
- **Procedures** - useful if you keep this updated
- **Family** – too complex. Do not use this field yet.

### **Diagnoses and Problems >**

\*Focus on updating the Problem data, and from there the Past Medical data and the Diagnoses data can be added.

- Click: Add under Problems
- Type "Rhinitis" and click the binoculars
- Be sure that the Search operator is "Contains"
- Choose a rhinitis option and click OK to return to the previous screen
- **To the left of the OK box, there is now a small field titled "File to Past Medical History" – choose this if you wish the problem to appear in PMH.**
- A Diagnosis is a Problem that is currently or has been actively addressed during an encounter
- You can create a Diagnosis and a Problem simultaneously by clicking "Add Problem & Diagnosis" OR you can later convert a Problem to a Diagnosis by clicking "Convert"

**Allergies >** updated by you and the nursing staff

**Advanced Growth Charts >** Not applicable unless you are Med-Peds

### **Bedside Data/Vitals >**

- a place to view data but not to input it.
- If you wish to bring your patient back to the room independently, **you can chart vitals etc. in AD HOC CHARTING** Which is located in the 3rd horizontal task bar on the top.

**Results >** Radiology, Lab, Ancillary, Specialty

**Power Notes >** only used to write notes

**Clinical Notes >** Use as a filing cabinet, can list notes by type or date.

**Forms >** Not applicable yet, although info such as outpatient social work notes, patient education, & immunization documentation may ultimately be found in Forms.

**Power Orders >** order entry system. Clerical staff are inputting orders in clinic. DO NOT USE in clinic!

**Orders to Cosign >** Not applicable

**Easy Script >** use this to write all outpatient orders.

- Set up defaults (commonly used Rx: PT, DM supplies) using Non-Formulary Medication

**Medication List >** tab used to view medication profile, KEEP up to date.

- DUPLICATE/DC used to delete selected med and replace it with a different med or dose.
- CANCEL/DC used to delete a selected med from the list

**Medication View >** has 2 views: Medication Profile and Medication View. Change the view by clicking Change View in the upper right hand corner. Both views can be used to modify and prescribe outpatient medications by right-clicking. Medication View is useful to view duplicate medications.

**Meds Charted >** Not applicable

**MAR Summary >** Not applicable

**Ventilator Data >** Not applicable

**Tasks >** Not applicable

**Patient Information >** Demographic Data (telephone #, list of previous encounters, & Immunizations

**Advance Directives >** not applicable yet

**Flags >** look here for epidemiologic flags: contact precautions

**Patient Education Summary >** view nursing documentation of barriers to learning. This is important if you are doing any education.

**Reference Text Browser >** searchable source of patient education materials, prescribing information, and topic references.

## Section 3: POWER NOTES: Creating a Note

### Step 1 – Choose the Correct Note

#### 1) Click: ADD button in the PowerNotes Section of the Menu

You need to make sure that every note you write is filed in the CORRECT folder. If you are seeing a follow up patient then it belongs in the GEN INTERNAL MED ESTABLISHED VISIT folder or if it is a new patient visit that it is in the GEN INTERNAL MED INITIAL VISIT.

#### 2) Select the appropriate note from the Precompleted or Favorite Tab.

There are 4 recommended notes. They appear under the Precompleted Tab currently, and once you save them to your favorites, under the Favorites tab forever. The recommended notes are:

**IM- Gen Internal Med Initial H&P (Female)**

**IM- Gen Internal Med Initial H&P (Male)**

**IM-Gen Internal Med Established visit**

**IM-Gen Internal Med Urgent visit**

The notes differ primarily in the amount of information that you will need. For instance, the initial and established visits have preventative health sections where the urgent visit note does not.

#### 3) Click: OK and an Auto-populate box appears.

This box contains information from other areas of Power Chart that will pull that information into your note. **Auto-populate ALLERGIES and VITAL SIGNS only.** Do not autopopulate anything else unless you really want it in your note. **When you auto-populate Vital Signs only select the values you want included (ie: BP, HR, RR, temp, height (cm or inches), and weight (lbs or kg)).**

#### 4) Copying a note forward.

If you have already written a note on a patient you can copy that note forward, which is an advanced copy & paste. Go to PowerNotes, select ADD, go to \$\$\$\$\$, check off ALL NOTES or MY NOTES ONLY, select the note you want to copy, check copy to new note, and click ACCEPT. A box will come up and click on YES. **VERY IMPORTANT: you must update this note. If you did not address it this visit delete it, if it is different change it.**

### Step 2 – Understand the Components of the Note

**Sections:** The notes have built-in sections (CC, HPI, ROS etc). Some sections you should use and some you should avoid entirely because they do not apply to our current practice. **REMEMBER: your note should drive your plan of care.** In other words, only include the data that matters. For a f/u note you do not have to include every single lab value, only include the ones that impact your decisions. Same for radiology. A section will appear in the note as long as there is something (words or a space) underneath it. If you want a section to disappear all you have to do is delete everything underneath it.

**Structures:** Next to every section is a blue link - *Show Structure*. **Structures** are drop-down menus designed to facilitate documentation. Often they contain so much detailed information that they are too cumbersome and we recommend avoiding them. There is a button on the right side of the screen, above the UP ARROW that will turn off these structure.

#### Autotext

The Autotext allows you to save common text phrases that you choose as Autotext, so that you can rapidly pull them into your note in real time. We have created Autotext statements for the most common diagnoses in the ACC Clinic for you to copy and use, but you can make abbreviations for anything.

- Open the "Auto text library" note (located in the shared note folder)
- Highlight the statement of interest
- Right Click and select SAVE AS AUTOTEXT
- Type in zz and then the diagnosis
- Click: CREATE
- Next time you want to add this text, type zz and select the appropriate diagnosis.
- Repeat these steps for all Autotext that you wish to add to your personal collection.
- \*RECOMMEND: zz for outpatient and zzz for inpatient\*

#### Macros

For those that are not fast typists macros were created. These are similar to autotext but involve the drop down menus. They are easy to create.

- Click on ROS or PE
- Fill out what you want to appear (ie for ROS fill out a neg ROS of questions you ask. For PE fill out a nl PE that you do)
- Right click on ROS or PE
- Click save as Macro
- Name the Macro

After you have created Macros an M will appear next to ROS or PE. To pull up a macro click on the M and select from your list.

### Step 3 – Write the note, section by section

**Visit Information** > this Section is already filled out for you, so you can ignore it!! If you do need to modify it, Left click underneath Visit Information and type or click on the Structure and select a choice from the drop down menu.

**Chief Complaint** > this Structure is USELESS! Left click underneath it & type in their chief complaint.

**Interval History** (Follow-Up Notes) or **History of Present Illness** (Initial H&P) > this Structure is USELESS! Left click underneath it & type in your note!

**Review Of Systems** > if you are a good typer then recommend using autotext, if not then recommend using the Structure menu and then setting up Macros.

**Health Status** > this Section includes ALLERGIES, CURRENT MEDS, & PROBLEM LIST.

-ALLERGIES will auto-populated for you

-CURRENT MEDICATIONS (**THIS IS IMPORTANT**).

**Problem List** > consists of your PMH issues plus any acute issues (UTI, cellulitis, URI, etc) you now have 3 options

-Option A. Ignore this section completely and it will not appear in the note

-Option B. Click: Include Problem List. Update the problem list completely then click INCLUDE.

-Option C. Click: Include Problem List. Review the problem list & click MARK AS REVIEWED.

**Histories** > this Section includes PMH, FH, and SH.

PMH – jeither review the PMH and Mark as Reviewed.

**SH** > personal preference. Either a statement that it has been reviewed or discuss EtOH, tob, drugs

**FH** > options include free text or using Structure for initial pt visit. Can continue to post full FH or simple statement that says: “history has been reviewed and unchanged from previous” is sufficient.

**Physical Exam** > highly recommend creating auto-text or macro, will save A LOT of time

**Medical Decision Making** > free text anything that helped influence your decision: labs, xrays.

**Impression and Plan** > free text your reasoning and plan.

**Professional Services** > this is a JHACO mandated requirement

**Attending:** include the name of your preceptor and whether the preceptor individually saw the patient.

**Follow-up:** include a statement of when and why the patient should follow up.

**Pain noted by the patient/nurse was addressed:** yes or n/a.

**Patient and/or caregiver participated in care planning; verbalized understanding of plan and is willing to**

**Learn/Provide/Participate in care:** yes or no.

**Was the education provided appropriate to the patient’s identified learning needs and barriers?** Input yes or no.

### Step 4 - Finish the Note

1. SAVE or SAVE & CLOSE at the bottom of the screen if you are not finished and do not want to sign the note. You can re-open this note either through your MESSAGE CENTER or thru PowerNotes.
2. SIGN at the bottom of the screen when you are finished and want to sign the note.
  - Click on the SIGN button at the bottom.
  - Click REQUEST ENDORSER if it is not already clicked.
  - Click underneath Endorser and type in the name or click the binoculars & search
  - Click Type and then select SIGN
  - Ignore the other 2 options and click OK

### Step 5 - Addendums

1. Select the note from the list of notes either in PowerNotes or Clinical Notes. Right click and select Modify. Addendums appear above the note. Recommend putting a line or a few spaces after your addendum.

### CONGRATULATIONS – YOU ARE DONE!

This will become second nature to you the more you use it. This is here as a reference in the beginning and to help you set up your default settings. Good luck this year.