Navigating FirstNet Tracking Board

What is FirstNet?
A monitoring and tracking system that serves as the hub of all patient activity and is key to improving patient throughput.

1. Organizer Toolbar: Two new buttons:
   - Tracking Shell: Opens the Tracking Board

2. Tracking List Tabs: Based on your current location, you will only see tabs for that location. Click on different tabs to view different groups of patients.

3. Metrics:
   - Patient: Name of patient the user currently has selected.
   - WR: Number of patients in waiting room
   - Total: Total Number of patients checked in
   - Avg LOS: Average length of stay for the total number of patients.
   - Pre-configured filters: Use to view only your assigned patients. Sets back to the default option when you log out.

4. FirstNet Toolbar: Most common functions can be performed by selecting a patient from the Tracking List (left-clicking their name) and clicking the appropriate button from this toolbar.

5. Tracking List Columns: Specific columns on the Tracking List to display tasks, activities and relevant information for providers. Click on the column heading to sort the board by that column.

6. Rows: Each row represents a room and once a patient is assigned to that room, relevant patient information is displayed.
Track patients by location; click on the Tracking List tab for your assigned core.

Vitals are displayed on the Tracking Board for easy reference.

Keep track of what’s happening for the patient with Activities and Events.

<table>
<thead>
<tr>
<th>Tracking Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>Track patients by location; click on the Tracking List tab for your assigned core.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Tracking Columns</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bed Assignment</td>
</tr>
<tr>
<td>Sign</td>
</tr>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>A</td>
</tr>
<tr>
<td>Reason for Visit</td>
</tr>
<tr>
<td>Comments</td>
</tr>
<tr>
<td>DR</td>
</tr>
<tr>
<td>NP</td>
</tr>
<tr>
<td>PA</td>
</tr>
<tr>
<td>RN</td>
</tr>
<tr>
<td>MA</td>
</tr>
<tr>
<td>Tech</td>
</tr>
<tr>
<td>Activities</td>
</tr>
</tbody>
</table>
## FirstNet Toolbar

<table>
<thead>
<tr>
<th>Icon</th>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>🌐</td>
<td>Pre-Arrive Patient</td>
<td>Opens the Pre-arrival window to pre-arrive a patient in the system</td>
</tr>
<tr>
<td>🔄</td>
<td>Pre-Arrival Actions</td>
<td>Used to attach a Pre-Arrival to a patient</td>
</tr>
<tr>
<td>🕐</td>
<td>Downtime Registration</td>
<td>Used to register patients in the event of a downtime</td>
</tr>
<tr>
<td>🗒️</td>
<td>Medication List</td>
<td>Open the Medication List tab of the patient’s chart</td>
</tr>
<tr>
<td>📊</td>
<td>MAR</td>
<td>Opens FirstNet in the MAR Summary view</td>
</tr>
<tr>
<td>📊</td>
<td>Add Order</td>
<td>Opens the Add order window, which you can use to add an order to a patient</td>
</tr>
<tr>
<td>🌐</td>
<td>MAU Workflow</td>
<td>Opens the ED Summary window, which give you a quick overview of documented information</td>
</tr>
<tr>
<td>🖼️</td>
<td>Modify Event</td>
<td>Allows you to modify an order or task that need to be completed in the ED</td>
</tr>
<tr>
<td>🎯</td>
<td>Depart</td>
<td>Discharge Process</td>
</tr>
<tr>
<td>🧑‍⚕️</td>
<td>Assign Provider</td>
<td>Assigns yourself to the selected patient based on your provider role</td>
</tr>
<tr>
<td>🧑‍⚕️</td>
<td>Unassign Provider</td>
<td>Unassign yourself from the selected patient</td>
</tr>
<tr>
<td>🚪</td>
<td>Provider Check in</td>
<td>Checks a provider in to the system if the automatic check in does not work</td>
</tr>
<tr>
<td>🚪</td>
<td>Provider Checkout</td>
<td>Checks a provider out of the system and allows them to reassign patients to a different provider</td>
</tr>
</tbody>
</table>

### Sign

<table>
<thead>
<tr>
<th>Icon</th>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>📜️</td>
<td>No Documentation Started</td>
<td></td>
</tr>
<tr>
<td>📜️</td>
<td>Two Document Tracking (Attending/Resident)</td>
<td></td>
</tr>
<tr>
<td>📜️</td>
<td>Document created and saved, but not signed</td>
<td></td>
</tr>
<tr>
<td>📜️</td>
<td>Document signed (Auth verified)</td>
<td></td>
</tr>
</tbody>
</table>
Activities

Activities are items which require documentation.

When an activity is due for a patient, the system displays a notification icon in the Activities column.

Double-click the icon to open the Document Activities dialog box.

Events

Events are time-stamped activities that occur during a patient’s visit, used to communicate the status of the activities for a patient.

Events are depicted with icons and are visible in the columns on each tracking list.

On the Tracking Board, hover over the event to see what the icon represents.
Provider Check-in

These settings should only have to be configured the first time you check-in.

1. Click the **Provider Check-in** icon.

2. In the Provider Check-in window, your name appears as **Provider**.

3. In the Provider Role box, select from the dropdown: **MAU Doctor**.

4. In the Default Relation box, select from the dropdown: **Doctor**.

5. Select a color. This is identify you on the Tracking Board.

6. Ensure the Available Provider and Available Reviewer boxes are checked.

7. Click **OK** to complete the check in process.

Assigning Patients

1. Highlight a patient on the Tracking Board.

2. From the First Net toolbar, click the Assign Provider button.

3. You are now assigned to the patient based on the provider role you selected when you checked in to FirstNet. You’ll see your name in the RN column.

Unassigning Patients

1. Highlight a patient on the Tracking Board.

2. From the First Net toolbar, click the Unassign Provider button.

3. The patient is now available for another provider.

Room the Patient

Select the exam room to which you are taking the patient.

1. Double click on the WR in the Bed column next to the patient name.

2. In the Select a Location window, double click the exam room in which you want to move the patient.

3. Click **OK**.

4. The patient’s location under the bed column will display the Exam room you selected.
After the patient is registered, Events and Tasks automatically fire in FirstNet under the Activities and Events columns.

1. Double-click the Assessments (clipboard) icon in a patient’s Activities column.

2. MAU Intake and MAU Vitals Assessments are listed. Check the box(es) next to the assessment you want to complete and select Document.

3. The Triage & Arrival Information Power Form will open. When complete, click Sign Form. After the assessment is signed, other tasks/events begin to appear on the Tracking Board.
Sections of the Intake form

There are two pages to the Form: MAU Intake and Home Medications (see the left menu).

If the patient has been seen at other CCHS location, some documented information may pull forward.
Enter any known or required (in yellow) information in each part of the form.
Use the scroll bar on the right to move down the form.

- **Presenting Complaint**: will fill in from Soarian’s reason for visit

- **Presenting History of Present Illness**: Free text the patient’s description of present illness
  *REQUIRED*

- **New vs Established**: Use the answer on the New vs Established patient form provided by the front
desk and make the appropriate selection here. *REQUIRED*

- **Pain**: Indicate the Pain Scale Used, type the Pain Level, identify the Pain Location, Laterality, Quality,
  Radiates and Radiation

- **Allergies**:

  ![Allergies](image)

  - If patient does not have any allergies, click No Known Allergies. Then click OK on the next screen.
  - If patient has No Known Medication allergies, click No Known Medication Allergies The click
    OK on the next screen.
  - If allergies are documented, review with the patient. If there are no changes, Click Mark All as
    Reviewed.
  - If patient does not have allergies documented, click the Add button.
    1. In the Search field, type the name of the allergy (example peanut) and click Search (or
       Press Enter)
    2. Choose from the displayed list by double clicking the name or highlighting it once and
       pressing Select.
    3. The name will appear under Substance.
    4. From the Category dropdown, select the category of allergy.
    5. Under Reaction Type, Allergy will default, but you can choose from anything on the list
       as appropriate (example, intolerance, Side Effect.).
    6. To enter a reaction symptom under Reaction symptoms, click in the field under Add
       Free text and move back to the Search field on the left and type an reaction (example,
       hives). Double click the symptom. It moves under Reaction symptoms
    7. Under Allergy details, you can add a severity by choosing from the dropdown.
    8. Under Comments, you can add additional information about this allergy.
    9. Click OK if you are only adding one allergy.
    10. Click New.. if you are adding additional allergies, then repeat process.
Past Medical History: A quick pick of common problems is listed (in yellow) and one must be selected to complete this form.

- If conditions are listed under Problems, review the list with the patient. If there are no changes, select the box next to Problem list Reviewed & Up to Date.
- If no conditions are listed, check the box next to any of the appropriate problems on the quick pick list.
- If the problem is not on the quick pick list, click the blue plus sign next to Add under Problems.
  1. Type the problem in the yellow field. Click the binoculars to search.
  2. A list of possible matches appear in the Problem Search window. Select from the list. Click OK to close the search window.
  3. Click OK to save the problem, or click OK & New to save the problem and add another.
  4. Alternatively, you can click the Folders button to see a quick list of problems categorized by system. Double click to add it, then click OK.
Sections of the Intake form (continued)

- **Past Surgical History:** Review the list with the patient and Mark all as Reviewed if correct.
  - If the list needs to be updated or no procedures are listed, click the blue plus sign to add.
    1. Type the procedure in the yellow field. Click the binoculars to search.
    2. A list of possible matches appear in the Procedure Search window. Select from the list. Click OK.
    3. Add additional information such as the date of the procedure, or the age at which it was performed and any comments.
    4. Click OK.
    5. Alternatively, you can click the Folders button to see a quick list of procedures categorized by system. Double click to add it, then click OK.

- **Social History:** Tobacco Use documentation is required. Click the circle next to the appropriate option. Then complete any other information.
**Sections of the Intake form (continued)**

- **Family History:** Check the boxes next to any of the appropriate issues from this Quick Pick list.

<table>
<thead>
<tr>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
</tr>
<tr>
<td>Asthma</td>
</tr>
<tr>
<td>Cerebral Aneurysm</td>
</tr>
<tr>
<td>DVT</td>
</tr>
<tr>
<td>MI - Heart Attack</td>
</tr>
<tr>
<td>Stroke</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

- **Pregnancy:** If the patient is pregnant, indicate that here, as well as the LMP.

  ```
  LMP: [pregnancy start date] | [pregnancy end date] | Pregnant? [Yes/No/Unknown]
  ```

- **Depression screening:** **REQUIRED** The answers you input will calculate a score for Initial Depression Screening Score. If higher than X, a task will fire for the provider to complete the PHQ9 assessment.

  - **How often have you been bothered by the below symptoms over the last two weeks?**
    - **Little Interest, Pleasure in Activities:**
      - Not at all
      - Several days
      - More than half the days
      - Nearly every day
    - **Feeling Down, Depressed, Hopeless:**
      - Not at all
      - Several days
      - More than half the days
      - Nearly every day
    - **Initial Depression Screening Score:**

- **Public Health Screening:** **REQUIRED** Ask the question about travel and document the answer.

  ```
  Has the patient traveled or been in contact with anyone who has traveled in the past 21 days to a country that has an identified emerging infectious disease? [Yes/No/Unable to obtain]
  ```
Sections of the Intake form (continued)

Click the **Home Medications** band on the left navigation menu of the form. The Medication List on the patient’s chart opens. To document the home medication, click **Document Medication by Hx**.

1. On the toolbar, click the **Patient Pharmacy** button.

   1. If the pharmacy has been identified, it will be listed on the Patient Preferred tab.
   2. If it needs to be changed, right click on the Pharmacy name and select remove.
   3. If there is no Pharmacy on file, the window default to the Search tab.
      - Move to the Search tab.
      - In the Search field, type the name of the Pharmacy.
      - Type in a City, State and/or zip code. Then click Search.
      - Right click on the correct Pharmacy and select **Add to Patient Preferred**.
        - The pharmacy will now appear on the Patient Preferred tab.
        - Click Close.

2. If no Home Medications are listed and the patient is not taking any medications, you can click **No Known Home Medications** under Medication History in the toolbar. If the patient is unable to verify information with you, you could click **Unable to obtain**.
Sections of the Intake form (continued)

3. Ask the patient if it is okay to pull information from their pharmacy about any current prescriptions. In the toolbar, click **External Rx History**.

a. From the dropdown, Click Import. Then click Consent Granted.
b. This pulls in the external medications in a side by side view with current medications and allows you to convert an external med to a home med. You must review the lists with the patient or family.
c. Use the side by side to verify the information with the patient or family. Start with what’s documented. Identify anything in External Rx History that is not documented as a home medication, indicated by the orange burst icon. Hover over the medication for more information about it.

d. Click the Add as scroll icon to convert the external med to the home med list. On the Order Sentence window, click None, then OK to bring over the med name. If you have additional details you can fill them in. The med will list as Pending Home Meds until you click the Document History button.

e. On the right side of the screen, one of two icons will appear next to the medication.
   • Prescription icon: electronic prescription from previous encounter whether in ER or inpatient.
     • If patient is still taking, do nothing.
     • If finished the script, right click and select Complete.
   • Scroll icon: indicates a medication from previous history (not a prescription from a previous encounter).
     • If patient still taking but needs to change, choose Modify.
     • If not still taking, chose delete.
Sections of the Intake form (continued)

4. To add new Home Medications, click the Add blue plus sign.
   a. A list of common medications will appear in alphabetical order. You can locate and select the medication from the list.
   b. For faster searching, in the Search field, type the name of the medication.
   c. Results should begin to display as you type.
   d. Click once on the Medication that most closely matches the information the patient gave you. (It is being added to the list behind this window.)
   e. Search for additional medications.
   f. Click Done.
   g. On the Pending Home Medication list, for each medication, review/complete the Dose, Route of Administration, Frequency. Click each field to make selections from pre-defined options.
   h. Click the Compliance tab for each medication to indicate the medication status, who supplied the information and the last dose date/time.
   i. When finished, click Document History button.
   j. On the MAU Intake form, the medications are listed, and the Meds History Reconciliation Status icon changes to a green check mark to indicate complete.

5. When complete, click the green check mark \( \checkmark \) in the upper left corner to sign the form.

6. If only the MAU Intake Assessment was selected, you will return to the Document Activities window and see that the Assessment has been completed. Click Cancel to close the window.

7. The clipboard under Activities will be removed, as well as the MAU intake icon from the Events column.

NOTE: If Home Medications need to be updated after completing the MAU Intake form, click the patient row and then the Medication List icon \( \square \) in the toolbar on the Tracking Board. Then click Document Medication by Hx.
Sections of the Vitals Form

MAU Vitals
After checking the box and clicking Document, the Vital Signs PowerForm will open.

There are three pages on this form (see left menu):
- Vital Signs
- Orthostatics
- Height/Weight

1. On Vital Signs, document the vitals that you take.
2. If you need to document Orthostatics vitals, click the Orthostatics navigation band on the menu on the left of the form.
3. To document Height/Weight, click the Height/Weight navigation band in the menu on the left of the form.
   a. Select the System of measurement: US or Metric.
   b. Type the Height and Weight in the correct units. The measurement will automatically convert to the other unit of measurement and will calculate BMI, BSA and IBW.
   c. Select the Weight Method.
4. When complete, click the green check mark in the upper left corner to sign the form.

- The assessments will be removed from the list on the Document Activities screen. Click Cancel to close the window.
- The clipboard under Activities will have dropped, as well as the Vitals icon from the Events column.
- Documented Vitals will be displayed under the Temp, BP, HR, SAT.
Tasks That Require Documentation

Some tasks are driven by the Activities column and open a PowerForm where documentation can be completed. Once documentation is complete, the icon or item will automatically be removed.

1. An icon will display in the **Events** column indicating the type of task to be performed.
2. After the test has been completed, double-click the Clipboard icon under the Activities column to open the Document Activities dialog box.
3. Under the Patient Care section, check the box next to the test.
4. Click **Document**.
5. The **PowerForm for the test** displays. Document the results. Click Sign.
6. In the Document Activities box, the task under Assessments is removed from the list.
7. The icon will automatically be removed from the Events column.

<table>
<thead>
<tr>
<th>Task</th>
<th>Icon</th>
<th>Trigger</th>
<th>How to Complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>MAU Intake</td>
<td>![Icon]</td>
<td>Fires on Arrive</td>
<td>PowerForm</td>
</tr>
<tr>
<td>MAU Vitals</td>
<td>![Icon]</td>
<td>Fires on Arrive</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Blood Glucose</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC HCG</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Urine</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Strep</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Rapid Flu</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Hgb</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Occult Blood Stool</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>POC Mono</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>Oxygen Admin</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>Pulse Ox</td>
<td>![Icon]</td>
<td>Order</td>
<td>PowerForm</td>
</tr>
<tr>
<td>MD Exam</td>
<td>![Icon]</td>
<td>Fires on Rm</td>
<td>Assign Provider</td>
</tr>
<tr>
<td>Crutches/ Crutch Walking</td>
<td>No icon</td>
<td>Order</td>
<td>Task/Document (Chart Done)</td>
</tr>
</tbody>
</table>
Accessing Patient’s Chart

Tip: If you see a patient name in italics, it means someone else on the tracking board has the same last name. Use caution in selecting the correct patient.

You can review/access other parts of the patient’s chart any of the following ways:

1. Right click on the patient name.
2. Select the task or chart option from the dropdown list.

1. Double click on the first cell of the patient row to open the chart.

2. The chart defaults to MAU Workflow

3. Click on the desired tab in the Menu on the left.

1. Click Chart in the top toolbar.

2. A drop down list appears to choose where in the chart you’d like to go.
The MAU Workflow is a streamlined collection of all pertinent information for this patient’s visit.
**MAU Workflow**

**Documents**

Not all Documents types will display here.

You’ll see the last 50 documents for the past 3 years (across encounter) of these types:
- H&P
- Consults
- Discharge Summary and Planning
- ED Documents
- OP reports

Check Group by Encounter (A) to sort the documents by encounter and make it easier to distinguish which notes belong with which encounter.

Use the Display filter to selectively limit the document that display. Click the Display dropdown (B).

Uncheck Facility defined view. Check the boxes next to the type of documents you want to display. Then click Apply.

Only those documents types will display. To see all available documents again, click the display dropdown and click Reset All and Apply.

Click on a document once to open a preview directly in the workflow.

When previewing a document on the workflow, you can also tag from the document. Highlight the information you wish to include in your note and then select the Tag button.

The items will be available to move into your note when you create it.
MAU Workflow

**Home Medications**
A list of all documented home medications taken by a patient, including medication from previous hospital visits.
Verify the list has been updated this encounter.

Medication reconciliation status bar

- Green check mark next to Meds History (A) indicates the list was verified this visit.
- Can launch Discharge Meds Rec by clicking the link (B). Refer to the Discharge Med Rec section later in this document.

**Histories**
**Problems Tab:** Manages Chronic Problems (Past Medical History)
A list of Chronic (ongoing) and Resolved (resolved chronic) Problems. Items entered in Intake form will display here.
Click on a problem to open the preview pane.
- Use Modify to change problem details.
- Use Resolve to make the problem historical, not ongoing; it will move the problem to the Resolved section.
- Use Cancel to remove it as a chronic problem.
- Use the X to close the preview.

You can add new chronic problems by using **Add problem** search field.
MAU Workflow

Histories
Procedures Tab: Manages Past Procedures (Past Surgical History)
A list of any documented past procedures (Past Surgical History).
Add a procedure by using the search field.
- Type the name of the procedure.
- If you don’t know the specifics of the procedure, there’s an option to add it as free text.

You MUST click Save to add a procedure on the workflow.

Social/Family History
Review and validate existing information added from Social/Family History Form.

If information needs to be added or updated:

1. Click arrow next to heading.
2. Select Provider Family & Social Hx.
3. Update information on the Power Form.
4. Click the green check mark to Sign.

It is added to the workflow and will pull into your note under Social and Family History.
MAU Workflow

Allergies
Displays any documented allergy information
You can add and modify allergies directly in the workflow.
1. Type the allergy into the Add Allergy field.
2. Select the Allergy category.
3. Click Save.

4. Once added, view the detail pane for more information by clicking on the allergy.
5. To change information about that allergy, click Modify.
6. Change information in the fields provided.
7. Click Save to save changes; click Cancel to discard Changes.

Vital Signs
Displays vital signs documented during this visit
To see set of vitals or lab results over time, click on the row to display graph.
To add a new set of vitals, click the blue down arrow next to the heading Vital Signs. Then select Vitals Signs from the list. Complete the form and click the green
MAU Workflow

**Chief Complaint**
Free text section to provide the patient's chief complaint, preferably in their own words, or the reason for the encounter.

**History of Present Illness**
Free text section to provide a detailed characterization of the patient's current problem. Use Dragon/ macros/ auto-text/ free-text to add the information.

**Review of Systems**
Documentation of systems reviewed. Use Dragon/ macros/ auto-text/ free-text to add the information.

**Physical Exam**
Section for your observations during the physical exam. Use Dragon macros, dictate or free text your findings.
Increase documentation efficiency by using split screen view

When using a horizontal 24 inch monitor, document on the right side of screen while reviewing chart information on the left. For example, you can review previous notes in preview mode on the left and dictate your new information on the right; no need to scroll down the workflow.

This icon indicates documentation components that can be moved to the right (i.e., Chief Complaint, History of Present Illness, Review of Systems, Physical Exam and Assessment and Plan). **Click the icon to move the component to the right. You'll only need to set this up once.**

**Note: Move the components in the order in which you want them to display on the right.**

On the left, the component heading will remain and you can click the icon to move the component back. The same icon displays on the right side component to easily move it back to the left.

On the workflow, you can drag the moved component headings to the bottom of the list so they don't interfere with your left side review.

**Tip:** Don't pin the navigation menu so that you have more room on your screen for documentation.

*It should look like this so the menu will auto-hide when you are not hovering over it.*
MAU Workflow

**Labs**
Displays results across encounters. POC testing resulted in office will pull into your note automatically. Functionality such as graphing, previewing, and multi-select tagging are available.

To view a set of labs over time, click on the test name to display graph.

To close the preview, click the test name again or click the X.

To see information about a single result, click on the result to open the Detail pane.

You can tag a single result by right clicking the value and clicking Tag.
**MAU Workflow**

**Multi-select Lab results**
You can select multiple results and tag once.

To select multiple results that are displayed next to each other, click the first result, then press Shift and click the last result.

All results between the first and last are highlighted and selected for tagging. Right click and select Tag.

To select multiple results that are separated in the table, click the first result, press and hold Ctrl and click the other results you wish to tag. Right click and select Tag.

**Diagnostics**
Displays the last 3 months of results across encounter. Click on a report to open it and tag information, if needed.
Consolidated Problems

In both the Admit and Manage workflows, the Consolidated Problems section has been redesigned to make it easier to add and manage problems; both Chronic (past medical history) and This Visit (problems/working diagnoses being addressed this encounter).

Tip: When you first access the new list, change the Classification filter to All (from Medical and Patient Stated) by clicking the arrow next to the Classification and clicking All. This allows you to view all problems. Once you make this selection, it will remain selected for you.

This Visit and Chronic problems display at the top of the list (A).
Historical problems (problems from previous encounters, not chronic) can be viewed by clicking the triangle next to historical (B).

The Actions column makes managing problems easier.

In the This Visit and Chronic section:
- Blue indicates an active, current selection.
  To remove it, hover over it. A blue line appears, which means remove the selection. Click to remove.
  Note: This removes/cancels the problem from the Problem list, not just your note. You could remove another provider's problem, so use with caution.
- White indicates a choice.
  Hover over a white choice and it turns blue. Click it to make it active.
- Resolve will only display for chronic problems. Clicking it will move the problem to the historical section.

In the Historical section:
White indicates a choice to select.
Gray indicates a status of the problem before it was resolved (made historical). You may click to renew the status back to an ongoing chronic problem.

Add a new problem
Next to Add new as: choose This Visit or This Visit and Chronic.
Then, begin typing in the search field. A list of possible results appears.
Click on the desired problem.
MAU Workflow

The problem preview pane allows you to quickly see details of the problem without leaving the workflow. Click on a problem to view the preview pane.

When you preview Chronic Problems you will have action options.

- **Use This Visit and Chronic buttons to change status.**
- **Modify** allows you to make changes to a Chronic problem directly in the workflow.
- **Resolve** will move the problem to Historical.

Click the problem again to close the preview.

Assessment and Plan

As you manipulate the problems list, the Assessment and plan section updates real time and pulls in each This Visit problem. This allows you to document your plan of care for each directly in the workflow. When you create your note, all documentation will pull into the Assessment/Plan section of the note automatically under the problem.

- Don’t want to include a problem in your note? Hover over the problem name and click the X.  
  *Tip: If you removed a problem from Assessment and Plan by mistake, click the main refresh button to bring the problems back.*

- In the box below each problem, use Dragon and Auto-text to dictate your plan.  
  *Tip: To quickly move from field to field, press the tab key on the keyboard or the Tab forward button on the Dragon microphone.*

- **Click Save when finished.**
**Patient Education**

**REQUIRED to complete prior to discharge**

The Patient Education section allows you to select appropriate education for your patients post-discharge. Based on the diagnosis, a list of suggested patient education will default. To add the education, click on the name once. It will be added to the “Added Education” field.

You can also save education as Favorites. Click on the star next to the title and select Personal Favorites. Then, you can click the Favorites button to see the list of those you have selected.
Work/School Release
If a Work/School Release note is needed, or general departure instructions need to be included in the Discharge Instructions, click the blue dropdown arrow next to Work/School Release. Select MAU Provider Depart.

On the PowerForm, complete the needed fields. When finished, click the green check mark in the upper left corner to sign and save.

Follow Up
**REQUIRED to complete prior to discharge**
The Follow Up section provides Quick Picks of follow up providers and timeframes. This information will display in the Discharge Instructions.

Under Quick Picks the name of the patient’s PCP (if identified) will be listed, as well as several other types of follow-up. To choose the follow-up provider, click on the name. If you need to change the details of the follow-up, click Modify. The change the information, including the Timeframe and any pre-defined comments you wish to add.
### Discharge Med Rec

Prior to discharging the patient, you should perform discharge medication reconciliation to indicate of any medication should be stopped and to order any prescriptions for the patient.

1. On the MAU workflow, click on the Home Medications/Med Rec/Rx component.
2. Click the Outpatient link.
3. On the Order Reconciliation: Outpatient window, the left side shows any home meds and meds administered during the visit. The right side will display any meds you add to be taken after discharge.
4. If you want the patient to stop talking a medication, click the circle under the column with the red square, next to the medication.
5. If you want to prescribe a new medication, click the Add button. Select from the list or search for the medication.
6. After adding it, associate the correct diagnosis.
7. Select the Routing for the prescription by clicking the dropdown next to Send To:. The patient’s preferred pharmacy should be listed. You could also select to print the prescription.
8. Click Reconcile and Sign to finish.
Carbon Copy (CC)
You will now have the ability to send a copy of your notes to other providers directly from FirstNet. A list of providers and groups/practice related to CCHS is pre-loaded. After you click Sign/Submit, this window appears.

1. Type the name of the provider you wish to copy in the Provider Name field.
   - If there is only one provider by that name, it will automatically be added to the Recipients list.
   - If there is more than one provider by that name, you can choose the correct provider on the provider Selection window.
   - If the provider you entered is not available, no name or selection window will appear.

2. For providers who are not on our list, the HIMS team can carbon copy the note.
   a. To send the name of the provider to the HIMS team, type HIMS in the provider name window.
   b. Select HIMS, Carbon Copy from the list.
   c. On the Recipient list, HIMS, Carbon Copy is added. Click the star to save it as a favorite so you don’t have to search for it again. The next time you need to use HIMS, Carbon copy, under Contacts, you simply click the Blue plus sign next to the name.
   d. To add the name of the provider you would like HIMS to send copies to, double click in the column under Comment.
   e. Type at least the name of the provider you wish to copy. You can enter the address and/or phone number if you know it.
   f. If there is more than one provider to cc, type all of the names, separated by a comma.

3. Be sure the Review/CC circle is filled in.
   (Mid-level providers should check carefully, as your option defaults to Sign.)

4. You can remove a provider from your recipient list, by hovering over the name and clicking the X.

5. Click Sign.
**Carbon Copy (CC)- continued**

Carbon Copy can also be completed from Message Center when signing a forwarded document.

You can see if anyone has already been sent the document by opening the Action List.

- Click and hold on the line between the note and the Action Pane.
- Slide up to open the Action List.

1. Check the box next to Additional Forward actions.
2. Ensure the Action is set to Review.
3. Type the name of the provider in the To: field.
4. If it is an external provider not on the list, type HIMS, Carbon Copy. In the comments section, enter the name and information of the provider.
5. Click OK.

**Provider Letter**

When you use HIMS, Carbon Copy to carbon copy an external provider not in the PowerChart database, HIMS will create a Provider Letter to send with your document. It displays to whom the document was sent via fax/U.S. mail.

You will see this provider letter under **Documents > Provider Letter**. There will be one Letter per carbon copied provider. Double click to open and view details.
Refusing a Note
In some cases, you may receive a document in your Message Center inbox that you feel should not be there.

1. Refuse a document by clicking the **Refuse** circle.
2. Click the dropdown next to reason.
3. Select a reason for refusal from the list.
4. Click OK or OK and Next.
**MAU Workflow**

**MAU Quick Orders**

The Quick Orders tab is a list of commonly ordered tests, procedures, medications and E&M charges. **Before completing an order, you must add a diagnosis.**

To order, click once on the name of the order.

As you select orders, the order inbox will turn green and tally the number of orders. **Click the green inbox.**

Associate the order with the diagnosis by clicking in the column under the diagnosis. Then click **Sign.**

The order may require additional details to complete it. The Order sentence window will appear. **Select from the list and then click OK.**
Sync Patient Information on the EKG machine

1. On the EKG machine, click the Orange tab.
2. Click the MWL (Modality Worklist) button.
3. Click on drop down next to query code and select location.
4. If the patient isn’t displayed, click the Sync button. The Transmit screen will sync.
5. Highlight the patient name on the list.
6. In Operator box, type your 801#.
7. Select Done.

Perform the EKG

1. Attach the leads to the patient.
2. On the EKG machine, select the ECG button.

This begins capturing the EKG. It will display on the screen of the machine.
3. When you are satisfied with the EKG, click Transmit. The screen displays Transmission status 1 out of 1 EKG transmitted.
4. Click Done. This ends the EKG process.
Performing an EKG

Mark the EKG as completed in FirstNet

1. In the toolbar above the Tracking Board, click the Cardiovascular button.
2. On the Cardiovascular work list, find your patient.
3. Click once to highlight.
4. In the Steps sections, the status should be Completed under the Status column.
5. Right mouse click on the word Completed.
6. Click Edit Performing Information.

7. In the Modify Performed Step box, add your name under Provider, if not defaulted.
8. Select OK. The Tech name will display under Performed by.

Interpreting/Signing the EKG

The status of EKGs will be displayed in the EKG column of the Tracking Shell. The column shows the number of ordered tests/number completed tests.

1. Double click on the status of 1/1 to see the transmitted EKG.

2. The ECGs for the patient are displayed in the viewer. Software generated interpretation will be listed under the Interpretation tab.
3. In the ECG Waveform toolbar, click the magnify button and position your pointer over the waveform to see a magnified view.
4. To add calipers, click, hold and drag along the waveform. Blue calipers will appear. Remove the calipers by right clicking and select Remove Calipers.
Performing an EKG

Interpreting/ Signing the EKG

5. To compare another ECG to the active ECG, check the box next to the previous.
6. Click the compare button. The previous EKG will be displayed under the current for comparison.

7. If necessary, edit the ECG interpretation in the Interpretation tab. Click the interpretation text to edit it directly. You can also view and edit information in the History tab.
8. You can also add a Normalcy indicator. Next to Mark ECG as, click the dropdown. Select from the list: None, Abnormal, Critical. Save as appropriate.
9. When you are done editing the ECG, click one of the following button options to save your changes and exit PowerChart ECG viewer:
   - Save and Close: Save the ECG and close PowerChart ECG viewer.
   - Ready to Sign and Close: Save the ECG as Ready to Sign and closes PowerChart ECG Viewer.
   - Sign and Close: Signs the ECG and closes PowerChart ECG Viewer.
   - Prelim and Close: performs a preliminary read on an ECG and closed PowerChart ECG viewer.

5. To change interpretation or add and addendum, right-click on the interpretation step and select Undo Completed.
6. Click the Print button to print the ECG (if needed).
Medications

1. Hover over the number in the Med Column to see the actual orders.

<table>
<thead>
<tr>
<th>Orders</th>
<th>Med Lab</th>
<th>Rad</th>
<th>EKG</th>
<th>Stop</th>
<th>Provider</th>
<th>Nurse</th>
<th>Ancillary</th>
<th>Real Time</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>18:37</td>
<td></td>
</tr>
</tbody>
</table>

IV Medications
- Sodium Chloride 0.9% 1,000 mL 06/19/2014 21:47 Ordered Ordered Shiu M.D., Timothy Y.

Scheduled Medications
- Oxymetazoline 4 Mg Oral Disintegrating Tab 06/19/2014 21:43 Ordered Ordered Shiu M.D., Timothy Y.
- Hydromorphone 1 Mg Oral syr 06/19/2014 21:43 Ordered Ordered Shiu M.D., Timothy Y.
- Acetaminophen 325 Mg Tab 06/19/2014 21:47 Ordered Ordered Shiu M.D., Timothy Y.

2. Double click in the Meds column to access MAR and see a list of all medications that were ordered.
3. Review orders before administering meds to patient. Confirm the medication you will administer matches what was ordered.

4. After giving the med, document administration directly from MAR. Double click on the time column (should be listed as NOW).

5. In the Medication window, complete any required details (depending on the medication, some fields may be yellow and must be completed prior to signing).
6. You can also document if the medication was not given. Check the box next to Not Given and select a reason from the list.
7. Click the green check mark to sign.
The Lab and Rad columns show the number of ordered tests/number of processing tests/number of resulted tests.

<table>
<thead>
<tr>
<th>Lab</th>
<th>Rad</th>
<th>EKG</th>
<th>Stop</th>
<th>Provider</th>
<th>Nurse</th>
<th>Ancillary</th>
<th>Real Time Lo/Rm Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/0</td>
<td>2/0/0</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hover over the column to see the actual orders.

- **Order**: CBC with diff
- **Time**: 06/02/2014 16:59
- **Order Status**: Ordered
- **Departmental Status**: Ordered
- **User**: EDDoc, Test
Discharge (Depart)

1. From the FirstNet toolbar, right click on the patient you wish to discharge.
2. Click **Discharge Process**.
3. The **Depart Process** window opens.
4. Ensure all of the Depart items are completed (there is not yellow).
5. Print the Discharge Instructions by clicking Print.
6. Explain the Discharge Instructions to the patient and get signature for chart scan.
7. Click the pencil next to Discharge patient.
8. The patient will then drop from the First Net Tracking Board.
Review the list and call patients who have abnormal lab results (from CCHS).

1. Click the Results Callback Worklist in the toolbar.
2. Under Facility, click the dropdown arrow and select the Facility for which you are reviewing results. Click Submit.
3. Under Nurse units, click the dropdown and select the unit. Click Submit.
4. Click the Update List button.
5. On the Callback List tab, the total number of patients will be displayed.
6. The Patient Name, Result, Status, Comments and last updated will be displayed in columns.
7. Each row is a different patient.
8. To document the call to the patient, click the right facing arrow next to the patient name.
9. Information about the patient’s results and callback information displays.

**Results Callback Worklist**

A. The blue banner bar has information about the patient.
B. The test name and normal range is listed
C. Test result
D. The date the test was completed is displayed.
E. Encounter details are listed down the right side:
   - Encounter Date and Location
   - Discharge Diagnosis
   - Encounter Diagnostics
   - Encounter Treatment
   - Encounter Provider
   - Discharge Medications
   - Allergies
   - Home Medications

F. The Callbacks tab lists the patient’s Phone numbers and the PCP name and phone number. Options to select are:
   - No Answer
   - Left message
   - Patient Contacted
   - A free text box allows you to add additional information.

If you contacted the patient, and nothing else is required, you can check the No further action required box. Then click Sign. The patient is removed from the list. You can see them on the Completed Callbacks tab.
Document Patient Refusal of Treatment

1. Select the patient from the Tracking List.
2. Double-click the Patient Care icon in the Activities column.

3. In the Document Activities window, click the check box next to the Patient Care that was not performed.
4. Click Not Done at the bottom of the window.
5. In the dialog box, select an option from the Reason Not Done dropdown (Patient Refused).
6. Click Sign.
7. Close the Document Activities box to return to the Tracking List.