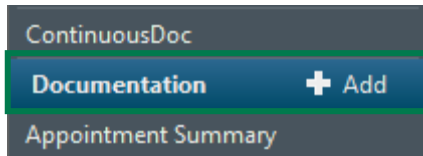


Creating and Modifying Documentation

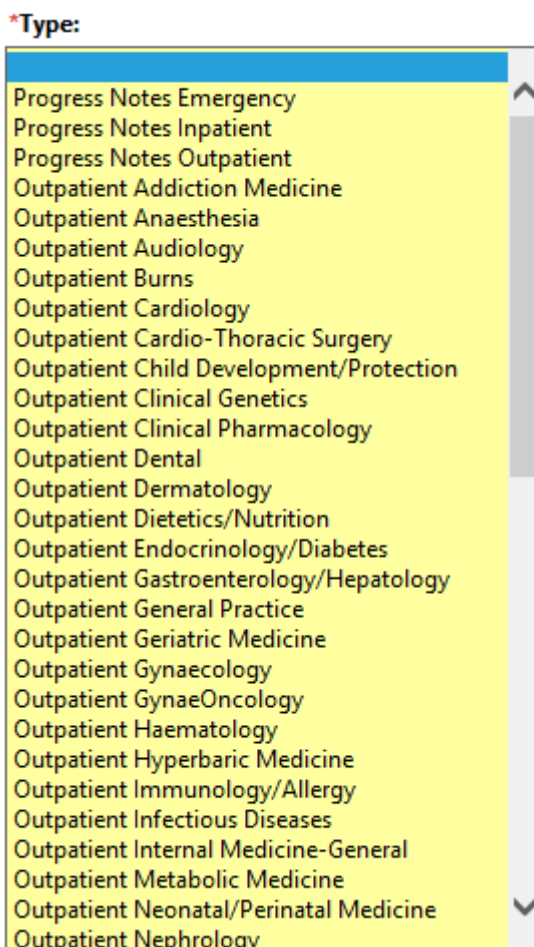
Adding Documentation

Documentation such as progress notes can be directly entered into a patient's medical record.

1. Select *Documentation* from the patient menu.



2. Click the *Add* icon + Add.
3. Select a note *Type* from the drop-down menu.



4. Enter a title for your document.

Creating and Modifying Documentation



The naming convention used for all documents at Townsville hospital is *Team, Role, Reason* e.g. Surg 2 RN AM Round.

5. Select a *Note Template*.

All (21)
Favorites (1)

Note Templates

	Name	Description
★	Admission Note Adult	Admission Note Adult
★	Admission Note Paediatric	Admission Note Paediatric
★	Clinic Note	Clinic Note
★	Clinical Event Summary	Clinical Event Summary
★	Clinical Handover - SBAR	Clinical Handover - SBAR
★	Consult Note	Consult Note
★	Consultant Ward Round	Consultant Ward Round
★	Consultant Ward Round - Brief	Consultant Ward Round - Brief
★	Consultant Ward Round Paediatric	Consultant Ward Round Paediatric
★	ED Note	ED Note
★	Letter Template	Letter Template
★	Medical Certificate	Medical Certificate



Frequently used templates can be marked as favourites by clicking on the star to the left of the template name. Click the *Favorites* button at the top of the *Note Templates* pane to access your favourites.

6. Click *OK* to start documenting.

Team Role Reason X
List

Tahoma
Size

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|

7. Once complete, select *Sign/Submit* in the bottom right corner.

Sign/Submit

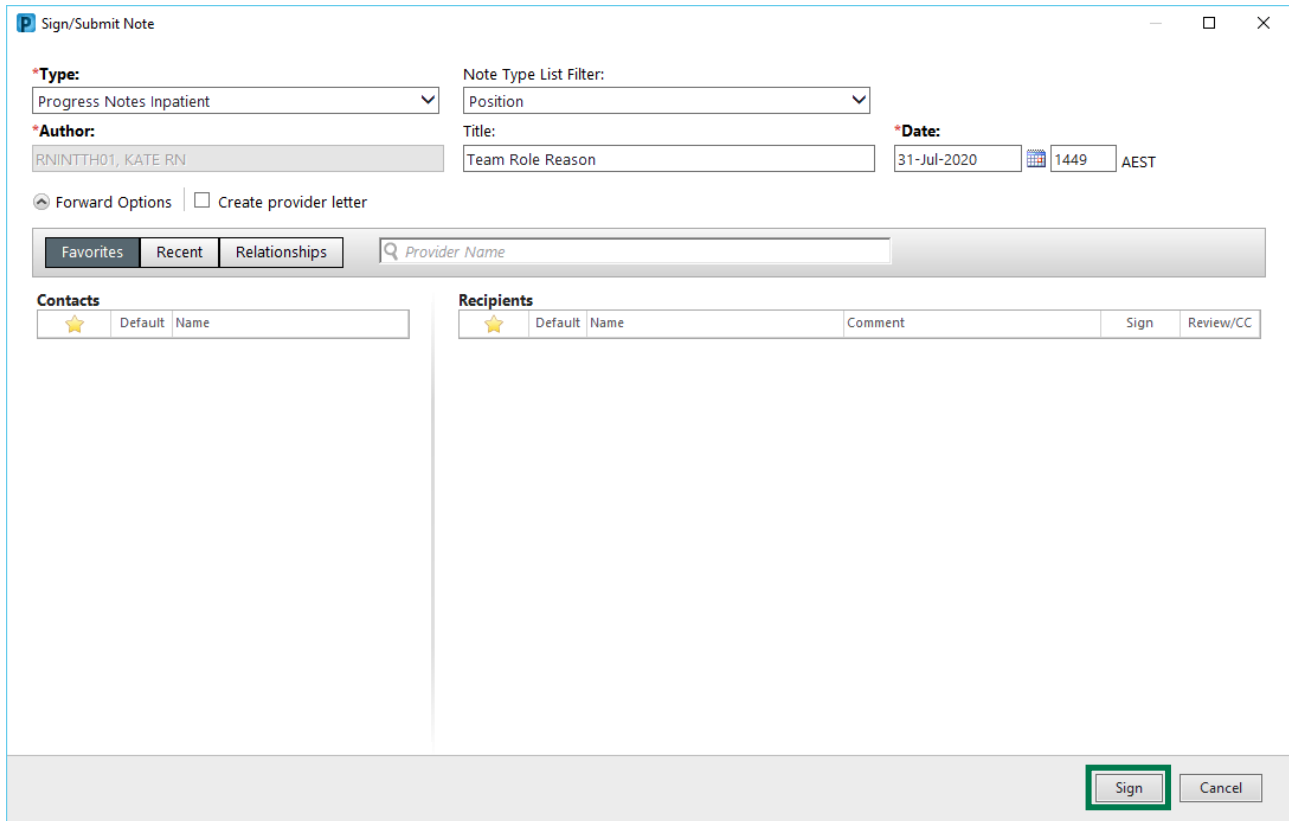
Save

Save & Close

Cancel

Creating and Modifying Documentation

- The *Sign/Submit Note* window will display. Ensure that the document *Type* and *Title* are correct and click *Sign*.




You can also forward this document to another provider for sign or review at this point.

The document will now be marked as a *Final Report* and will be available to all clinicians.



Finalised documents cannot be edited. However, addenda can be added.

Saving a Document

If a document cannot be completed at the time it is started, it can be saved and then signed prior to the end of your shift.

- Begin your document as discussed above.

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Creating and Modifying Documentation

2. Click *Save & Close*
3. Ensure that the document *Type* and *Title* are correct and click *OK*.



Saved documents are marked as a *Preliminary Report* and are visible to all clinicians as soon as they are saved. **This is not recommended workflow.** All documentation should be signed as soon as possible, at the latest, prior to the end of your shift.

Finalising Saved Documentation

All saved documentation must be signed. Signing will mark the document as a *Final Report* in the patient's medical record.

1. Locate the document in the *Documentation* menu.
2. Click to select the required document and select *Modify* or double click to open the required document.



3. Make any necessary changes.
4. Once complete, select *Sign/Submit* in the bottom right corner.



5. The *Sign/Submit Note* window will display. Ensure that the document *Type* and *Title* are correct and click *Sign*.



Saved documents can also be reviewed and signed through *Message Centre*.

Modifying Documentation

All documents can be modified. However, finalised or signed documentation can only have addenda added. The finalised portion cannot be modified.

1. Locate the document in the *Documentation* menu.
2. Click to select the required document and select *Modify* or double click to open the required document.

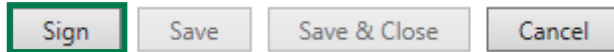


3. Make any necessary changes.

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Creating and Modifying Documentation

- Once complete, select *Sign* in the bottom right corner.



- The document will close immediately and be marked as containing addenda.

*** Final Report ***
Document Contains Addenda

'In Error' Documentation

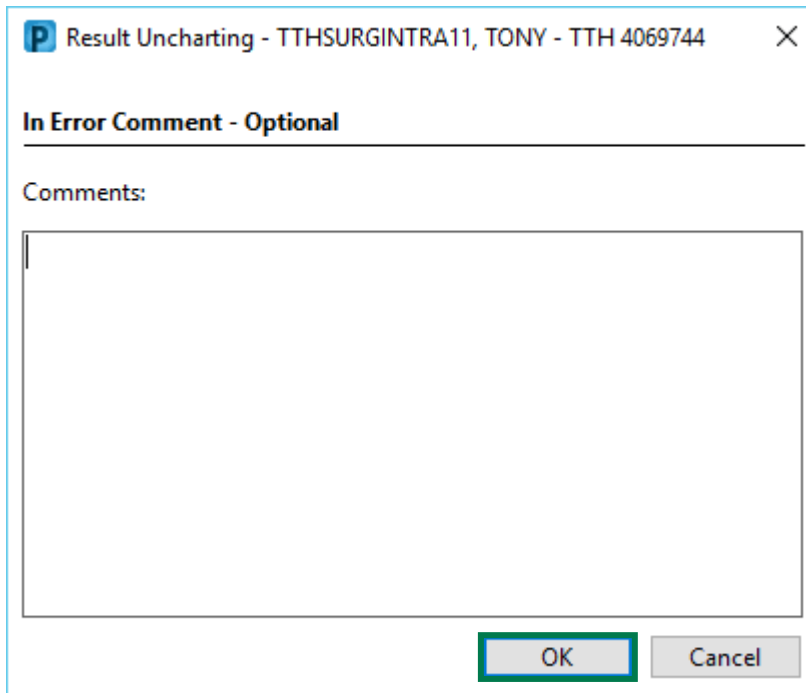
Documentation that contains an error, e.g. incorrect information, wrong patient, wrong encounter, etc. can be marked *In Error*. This documentation will remain as a part of the patient's chart; however, any user that views the document will see an alert indicating that the content has been marked *In Error*.

- Locate the document in the *Documentation* menu.
- Click to select the required document and select *In Error*.

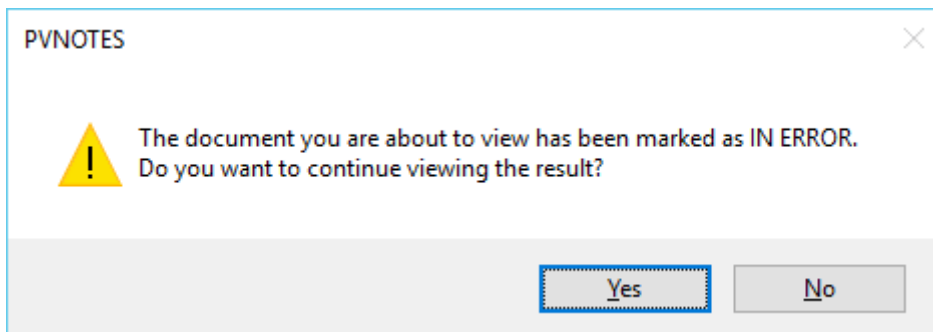


- Enter the reason you are marking the document *In Error* and click *OK*. This *Comment* will be attached to the *In Error* document.

Creating and Modifying Documentation



- An alert indicating the document has been marked *In Error* will pop-up. Click *Yes* to see the document or *No* if you do not want to see the document.



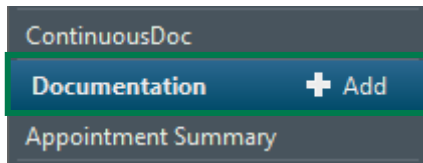
Documents can only be marked *In Error* by the original author. If you find an error in a document created by another user, please contact the clinician involved and ask them to correct it. If you find an error in a scanned document, please contact the scanning unit.


Setting a Personal Note Type List Filter

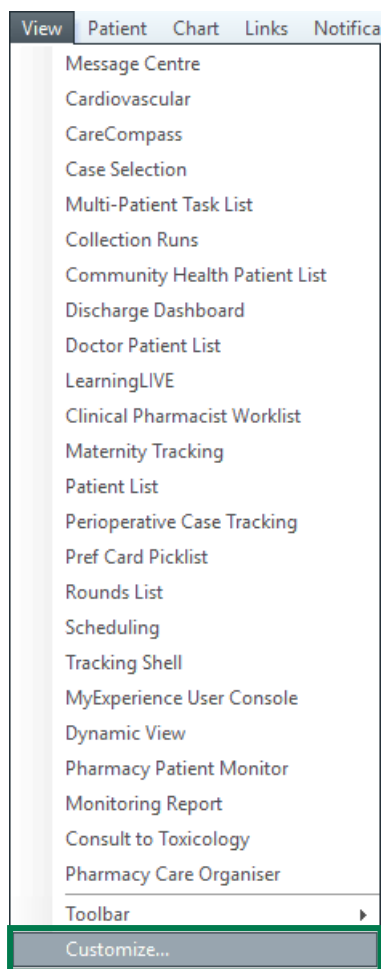
You can set a *Personal Note Type List Filter* so that the *Type* drop-down menu shows only items that are relevant to you.



- Select *Documentation* from the patient menu.

Creating and Modifying Documentation

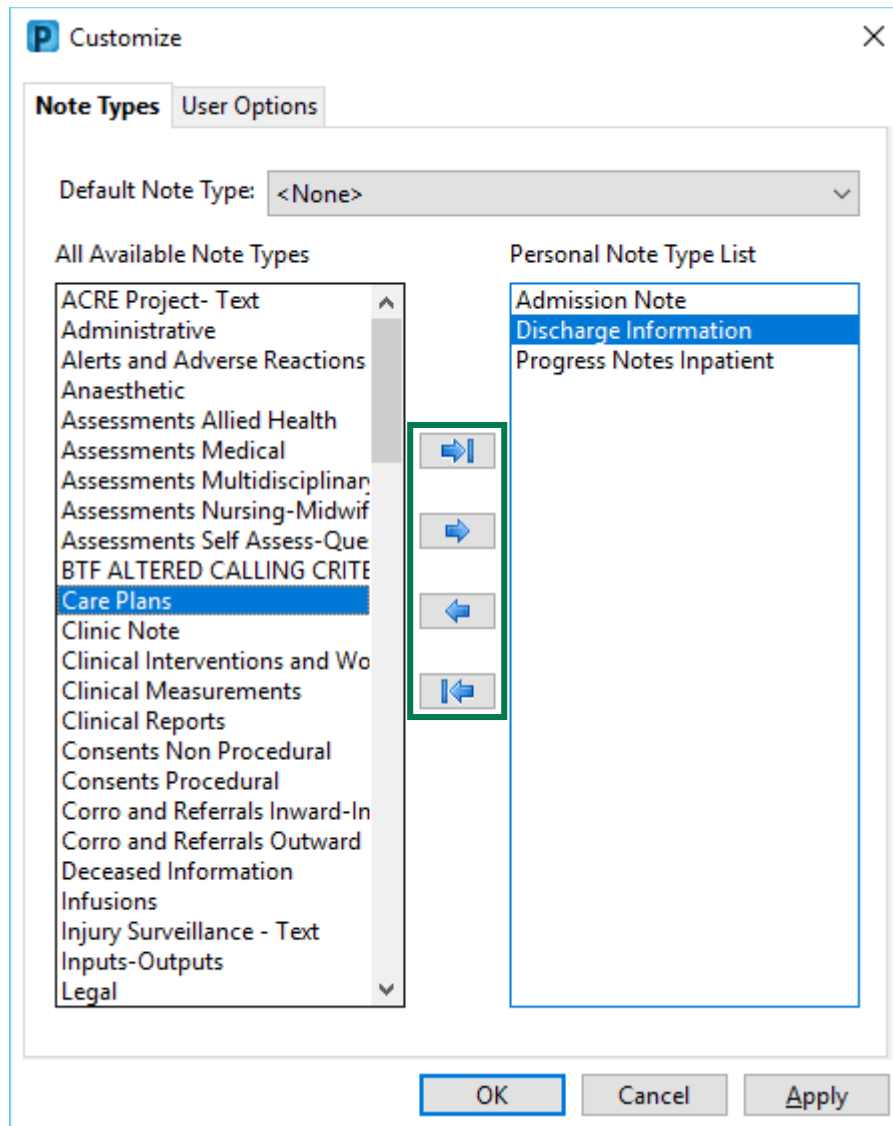




2. Click the *Add* icon .
3. Click *View* in the top toolbar.
4. Select *Customize...*



5. Select the required *Note Type* from *All Available Note Types* on the left and click on the  arrow icon to move the *Note Type* to your *Personal Note Type List*. *Note Types* can be removed from your *Personal Note Type List* by selecting the item and clicking the  arrow icon.

Creating and Modifying Documentation



The  and  icons will move all items to or from your *Personal Note Type List*.

6. Once you are satisfied with your *Personal Note Type List*, click *OK*.
7. Select *Personal* under the *Note Type List Filter* drop-down menu.

Note Type List Filter:



8. The *Type* drop-down menu will populate with only the items in your *Personal Note Type List*.



Creating and Modifying Documentation

Note Type List Filter:

***Type:**

- Admission Note
- Discharge Information
- Progress Notes Inpatient