Web Ambulatory Care User Manual

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Web Ambulatory Expanse Manual

Welcome to the MEDITECH Expanse Web Ambulatory user manual. This user manual is designed to support providers and non-providers and will accomplish the following:

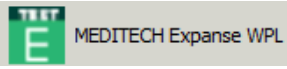
1. Orient users to the various screens and functionality in Web Ambulatory module
2. Explain the use of the various features and functionality
3. Act as resource aid during end user training

Accessing MEDITECH Expanse Web Ambulatory

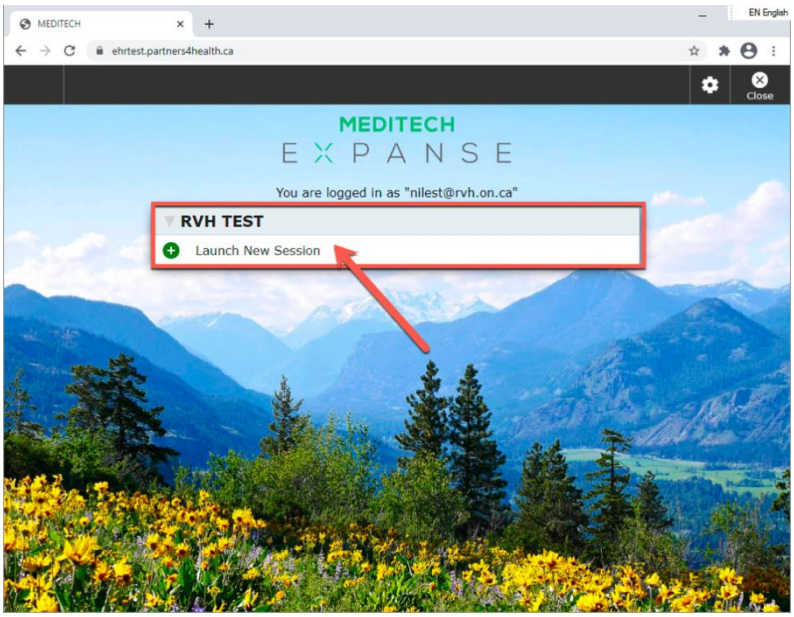
Logging into MEDITECH Expanse:

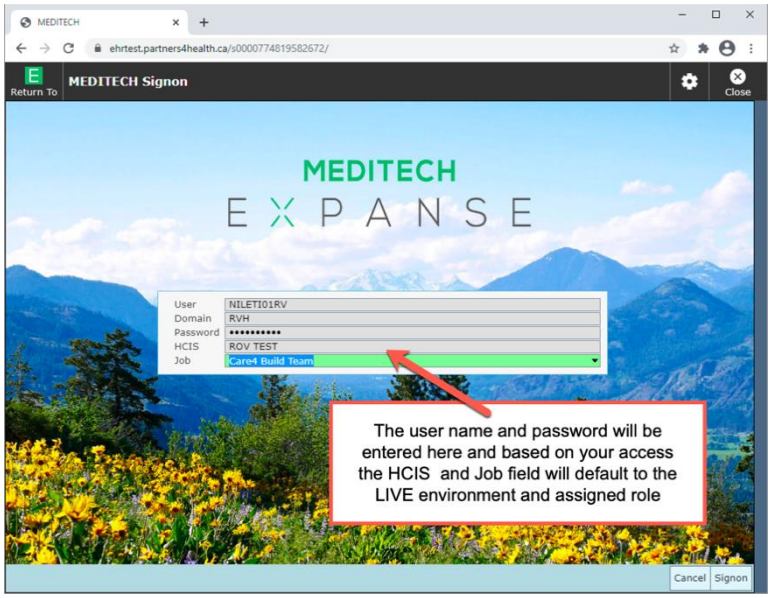
To access MEDITECH Expanse on your device click the MEDITECH Expanse icon on your desktop. The location and access to this icon may differ depending on each hospital site's set-up.

MEDITECH Expanse uses your network log-in and will automatically sign you in. From your computer, please pick Expanse WPL Test.

or MEDITECH Expanse WPL 

from your start menu. The MEDITECH EXPANSE screen will display. Next, select "Launch New Session"





If this is the first time using MEDITECH Expanse on a device, *or* when logging in via Citrix, you may be prompted to:

- Select your device type from menu of options
- In the client field, type your device ID (to assist MEDITECH in “remembering” your device for future uses

MEDITECH Expanse Web Ambulatory Overview

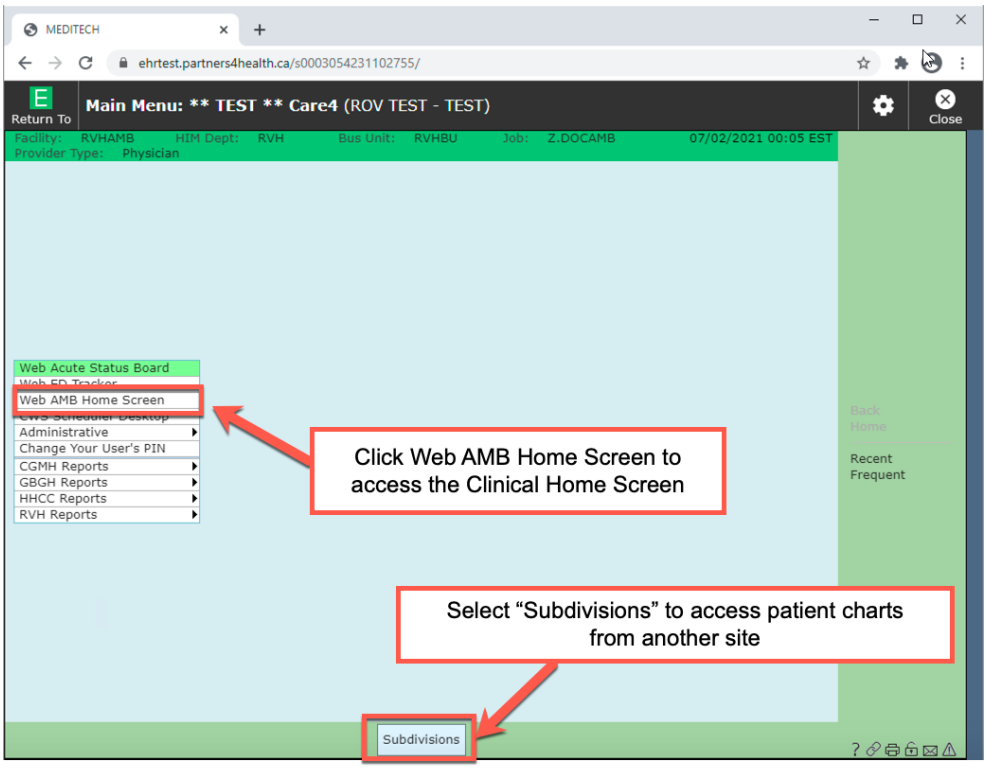
The MEDITECH Expanse Web Ambulatory module is designed to be a centralized hub of patient information for physicians, advanced care providers and members of the larger multidisciplinary clinic team. The Web Ambulatory module offers a default Clinical Home Screen where a user can see their upcoming patient appointment and pertinent patient data. A centralized schedule is also available where all patient appointments can be viewed and managed for each provider and clinic team.

From the main Home Screen, users can view the chart and monitor patient flow throughout the clinic. Workload tasks and messages can be reviewed, entered and managed. Once in a patient's chart user can access document templates to create individual or shared multidisciplinary reports, enter orders, prescribe medications and review lab and diagnostic test results.

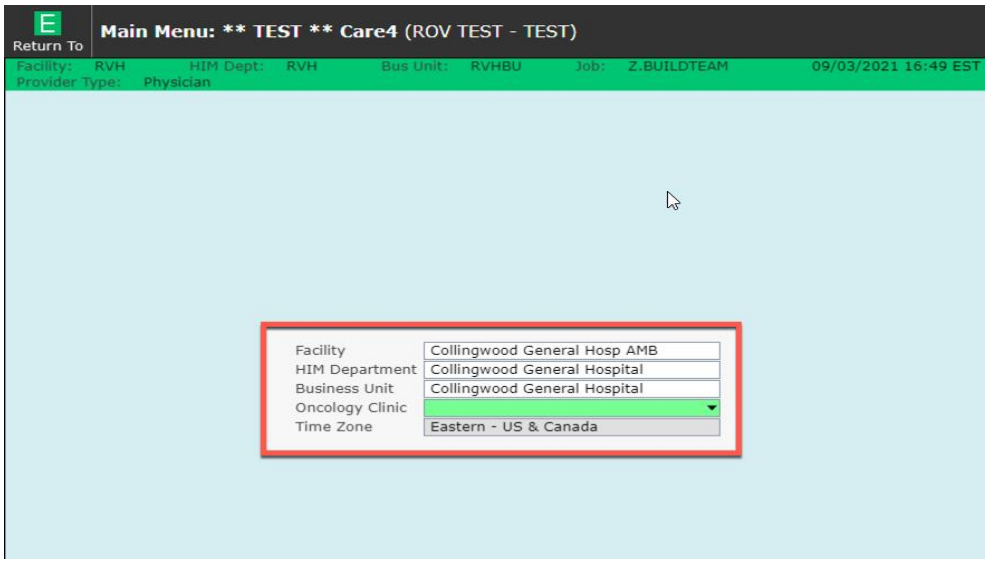
a. MEDITECH Main Menu: Provider

Navigating Expanse

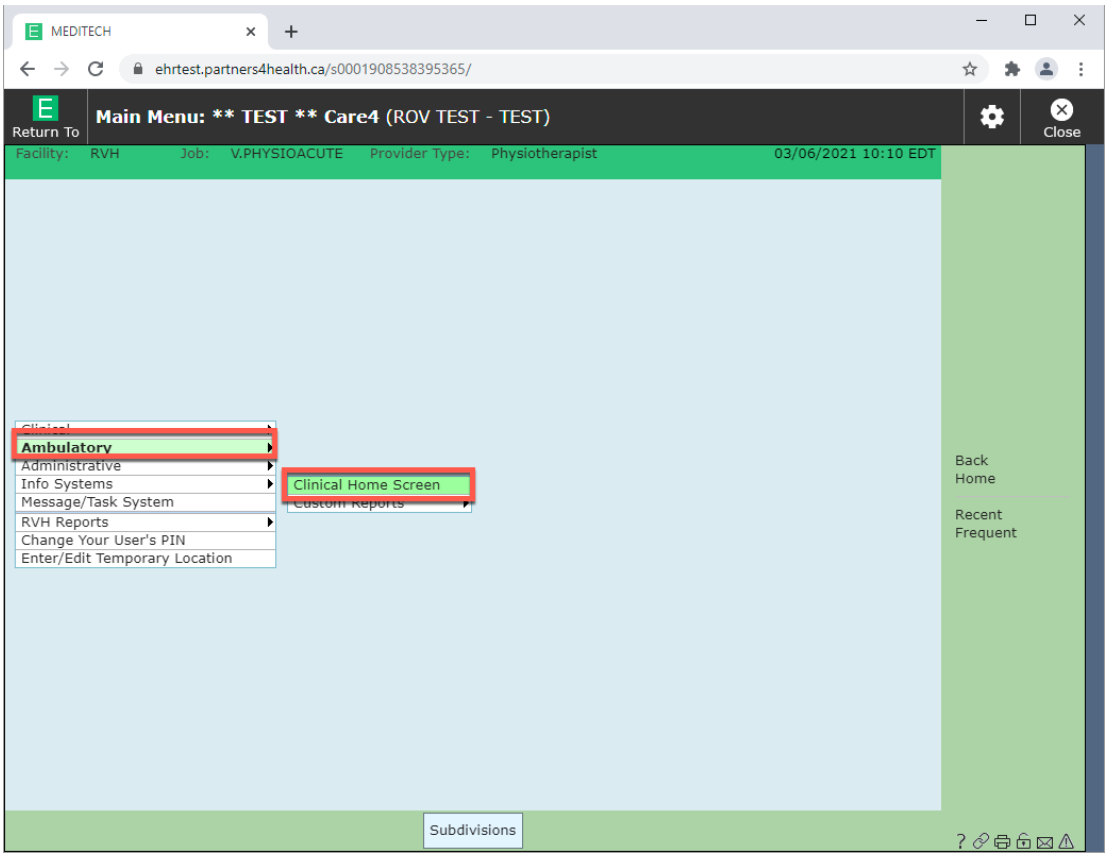
To access the Web Ambulatory module, select the option "Web AMB Home Screen" from the main menu. For most clinical functions, you will be working from your Clinical Home Screen.



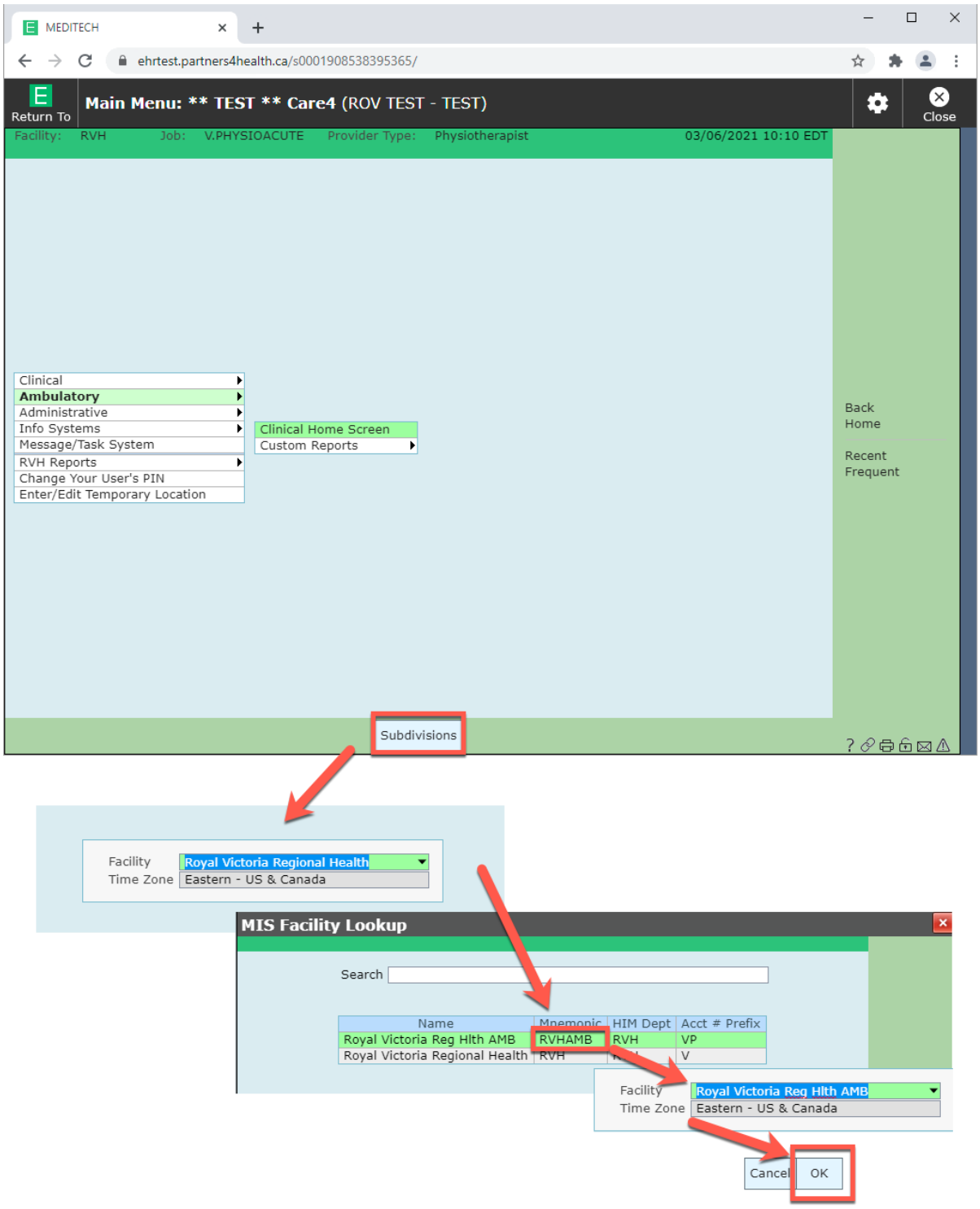
The Subdivisions screen defaults the settings to the primary facility of work. The settings can be changed to switch to the Ambulatory facility. Select the "Backspace key or delete key," on the keyboard to remove the default facility and input the new Facility, HIM Department and Business Unit.



b. MEDITECH Main Menu: Non-Provider

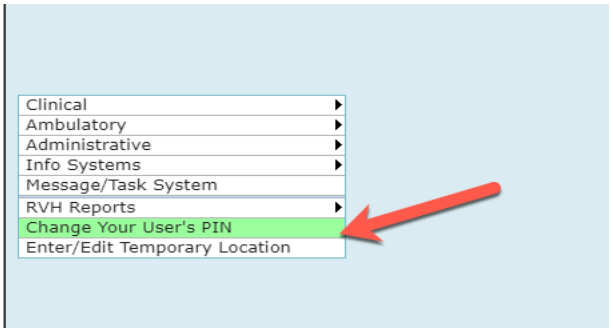


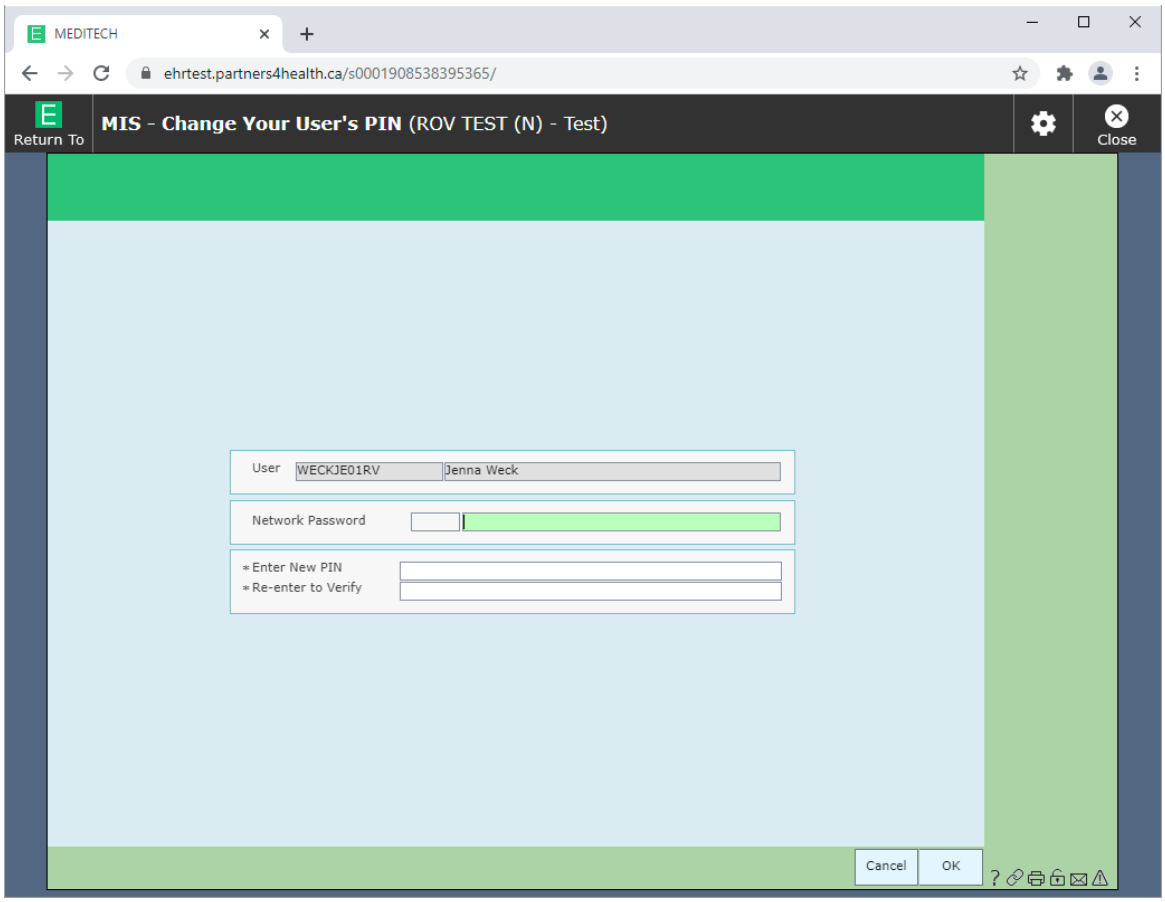
The Subdivisions screen defaults the settings to the primary facility of work. The settings can be changed to switch to the Ambulatory facility. Select the “Backspace key or delete key,” on the keyboard to remove the default facility and input the new Facility.


MEDITECH
ehrtest.partners4health.ca/s0001908538395365/
Return To
Main Menu: ** TEST ** Care4 (ROV TEST - TEST)
Close
Facility: RVH Job: V.PHYSIOACUTE Provider Type: Physiotherapist 03/06/2021 10:10 EDT
Clinical
Ambulatory
Administrative
Info Systems
Message/Task System
RVH Reports
Change Your User's PIN
Enter/Edit Temporary Location
Clinical Home Screen
Custom Reports
Back
Home
Recent
Frequent
Subdivisions
Facility Royal Victoria Regional Health
Time Zone Eastern - US & Canada
MIS Facility Lookup
Search
Name
Mnemonic
HIM Dept
Acct # Prefix
Royal Victoria Reg Hlth AMB
RVHAMB
RVH
VP
Royal Victoria Regional Health
RVH
V
Facility Royal Victoria Reg Hlth AMB
Time Zone Eastern - US & Canada
Cancel
OK

Setting a PIN

In order to sign off on client documentation with an electronic signature, clinicians will require a personalized PIN number. PINs consist of 4+ characters. It is a code unique to individual user. It can include alpha, numerical and special characters.





To set up a PIN:

- Click on the “Change Your User’s PIN” button on the Main Menu
- This will display MIS – Change Your user’s PIN

- Enter individual network password. This is the password clinicians use to log onto their device

- Enter 4+ character PIN (note: PIN can include alpha, numerical and special characters)

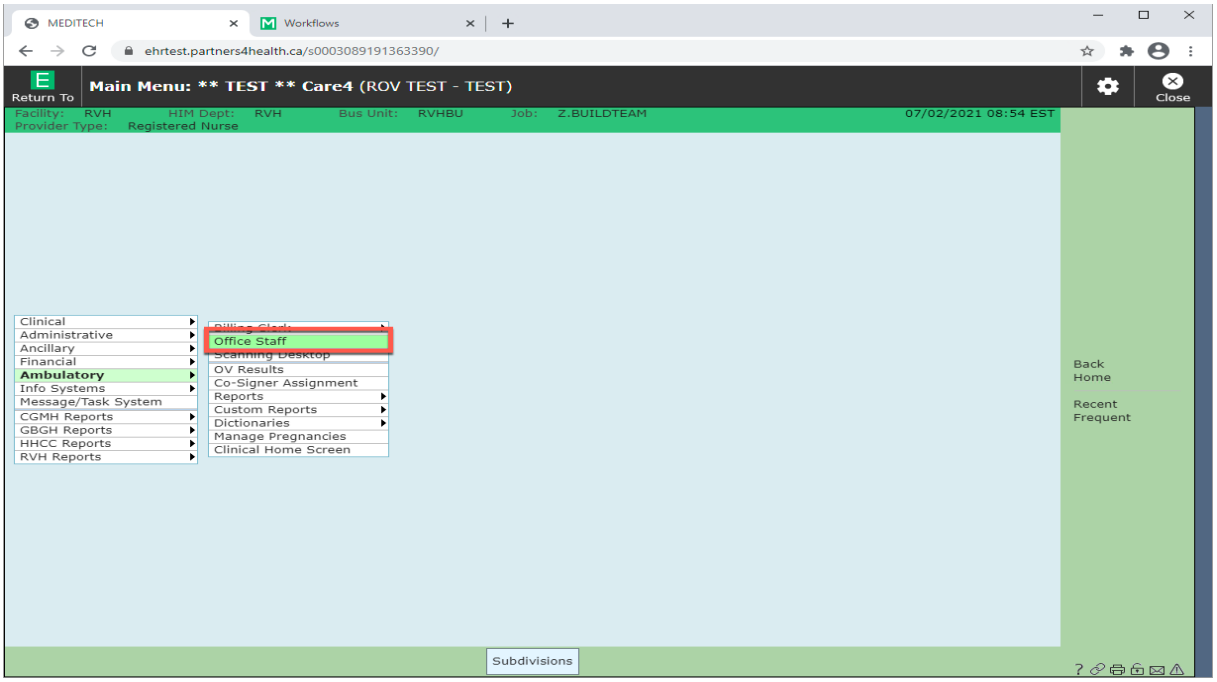
- Click “ok”

- Select “Return To” and “Close all”. Relaunch a new session to allow the PIN to be used.

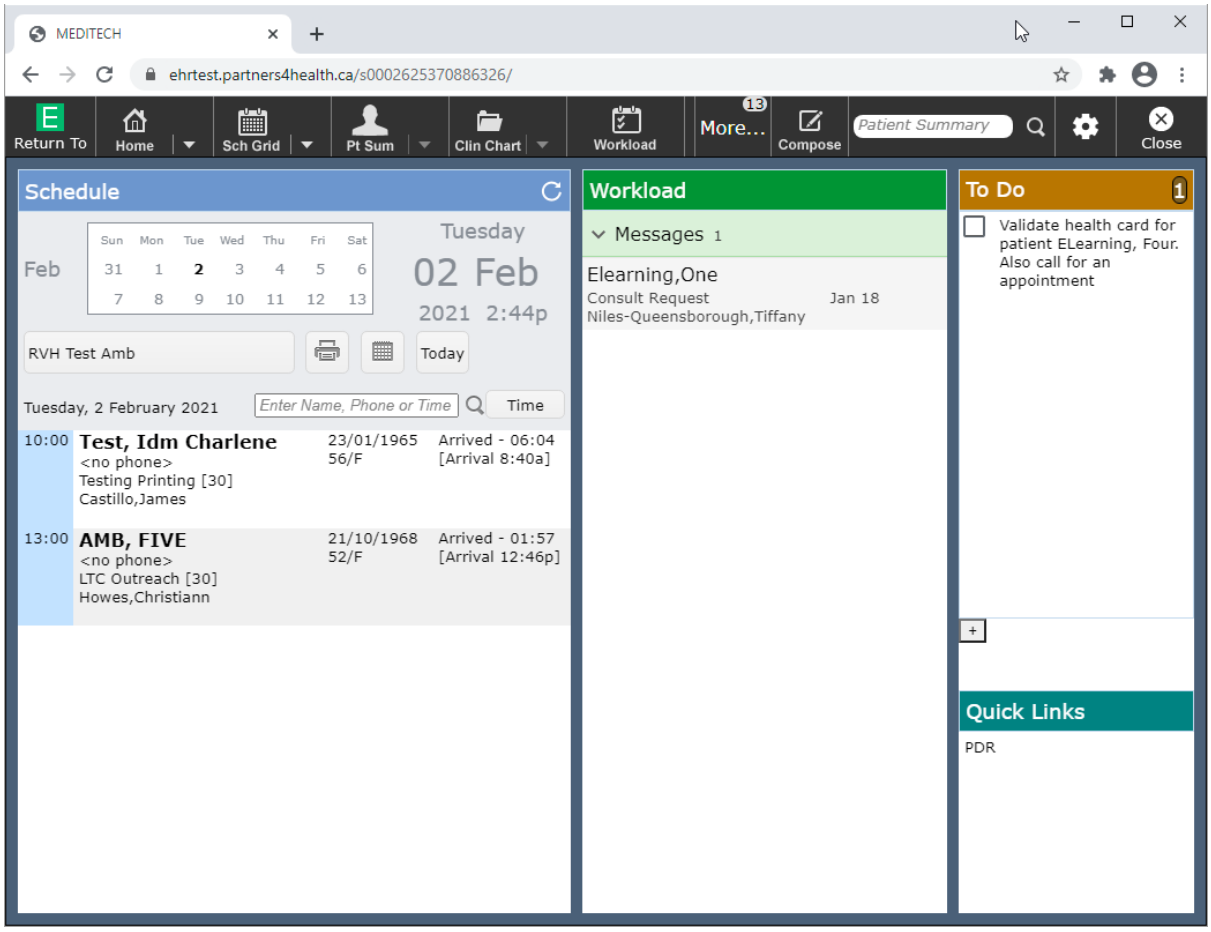
Ambulatory Office Staff:

Ambulatory Office Staff Home Screen

To access the Ambulatory Office Staff Home Screen, on the main menu select “Ambulatory” then select “Office Staff.”



This will open the Ambulatory Office Staff Home Screen



Use the Ambulatory Office Staff Home screen to:

- Manage tasks, schedules, worklists, and messages
- Launch other areas of the Ambulatory application

The Ambulatory Office Staff Home Screen includes a Navigation Bar and is further separated into four sections.

1. The Home Screen – Schedule
2. Workload

3. To Do
4. Quick Links – These links will vary based on a user's role within the practice, and can be customized by the user.

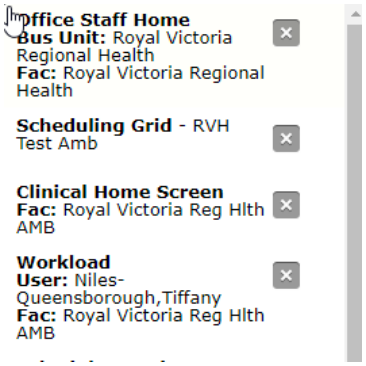
Navigation Bar

The Black Navigation Bar allows users to open, close and navigate between processes in the Ambulatory application. The Navigation Bar may change in appearance based on the type of device in use, screen size, browser resolution, routines selected, and your user-access.

For Office Staff, the Black Navigation Bar appears at the top or bottom of each screen depending on the device used, and always displays the “Return to” button on the left side, and the Status Bars icon and Utility Gear icon on the right side. Additional functions, to which you have access, appear across the middle of the bar. Functions that do not fit across the bar can be accessed by clicking on the “More...” button. The number on this button indicates the number of functions underneath it.

Return To

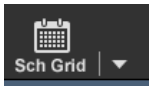
Click on the Return To button to access any process currently running in your browser session, including those that have pre-loaded for your convenience. Click on any process in the menu to bring it into focus. Processes appear in the order you accessed them, with the most recently accessed item on top. To access the process, click on the item or to close the process select the icon.



When you are in an Ambulatory Office Staff routine, such as Home, Scheduling Grid, Patient Summary, and Clinical Chart, the Return To button only shows active processes that are not Office Staff routines. This is because active Office Staff processes are available under the Drop-Down Arrows to the right of the functions.

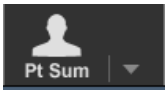
HOME

To access or return to the Ambulatory Office Staff Home screen, click on the Home Button. Use the downward arrow to reveal a menu that presents the option to toggle between other screens within the module.

SCHEDULING GRID 

Use the Scheduling Grid to manage the schedules of both resources and users.

Note: The drop-down arrow, which appear on the right of the Home, Scheduling Grid, Patient Summary, and Clinical Chart buttons, allow you to manage processes that are already running. To access a current process, click on the arrow, then click on the name of the process you want. To close a process, click on the arrow, then click on the red X next to the name of the process.

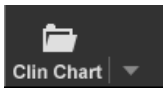
PATIENT SUMMARY 

Patient Summary provides front staff with a patient-specific workflow mode in which to do the following:

● View or edit data for a patient's active visits, or view data from a patient's historical appointments.

● View or edit data on the patient's permanent record.

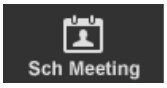
● Perform a variety of tasks such as booking appointments, create Walk In appointments, schedule meetings, create non clinic visits, cancel existing appointments, or consume Portal Pre-Registration edits submitted by patients.

CHART SUMMARY 

Use the Chart Summary page to view an overview of a patient's health status. The screen layout of the clinical chart is divided into the following areas as illustrated in the screen below:

WORKLOAD

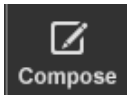
The main Workload screen allows you to manage your messages and tasks (or those for whom you are covering).

SCHEDULE MEETING 

Use this routine to book a new or edit an existing meeting. When you book a meeting, there is no associated patient. Meetings will appear on the Scheduling Grid and the Home Screen with a meeting title.

MENU

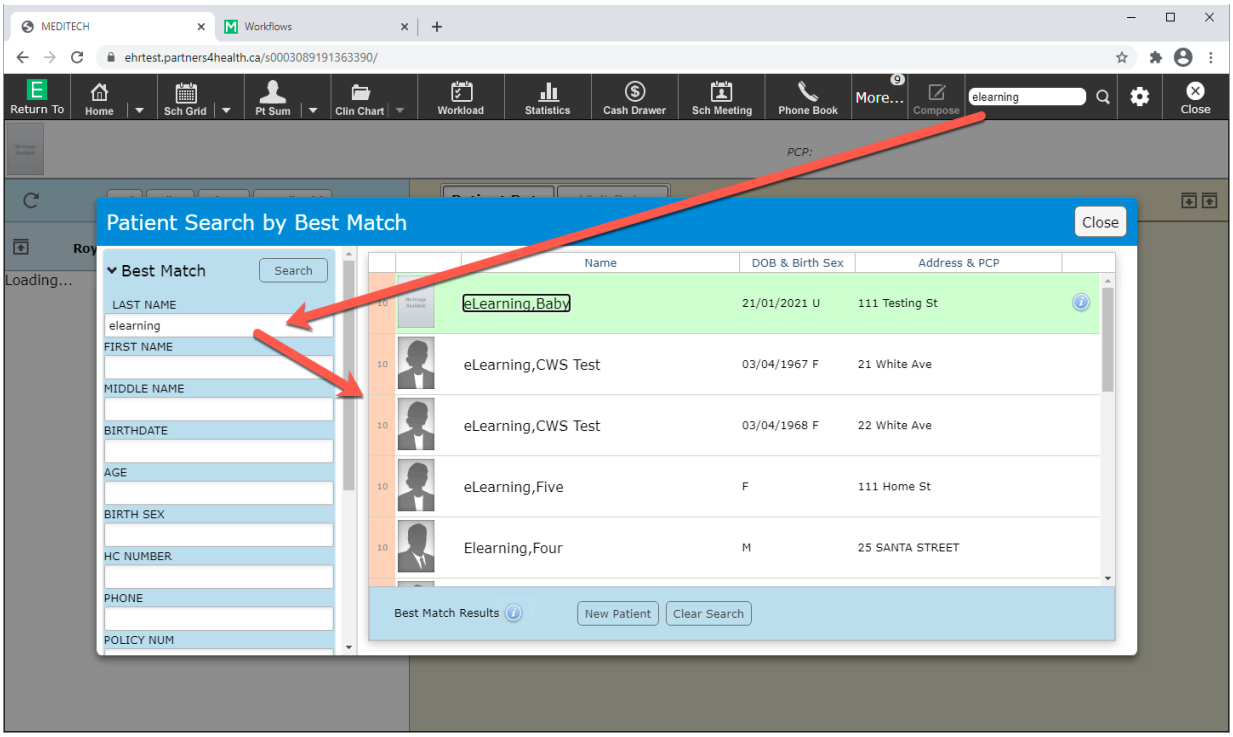
Use the More... button to access a menu of Ambulatory Office Staff functions that do not fit across the middle of the Black Navigation Bar. The number on this button indicates the number of functions in the menu. Click on any menu option to open a session of that type.

COMPOSE 

Select the Compose Message option to create and send a message to a recipient or workgroup. Use the Regarding field to associate the message to a patient, an account or neither (None) for non-patient related items.

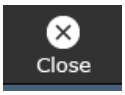
PATIENT SUMMARY SEARCH

Use the Patient Summary search field to launch the Patient Search by Best Match overlay screen for a particular patient. Enter data into the field to identify the patient. Then hit <enter> or click on the magnifying glass icon to the right of the field. This launches the Patient Search overlay and places the data in the appropriate search fields. Best practice is to input as many patient identifiers such as first and last name, patient birthdate and healthcare number to generate the most accurate search.



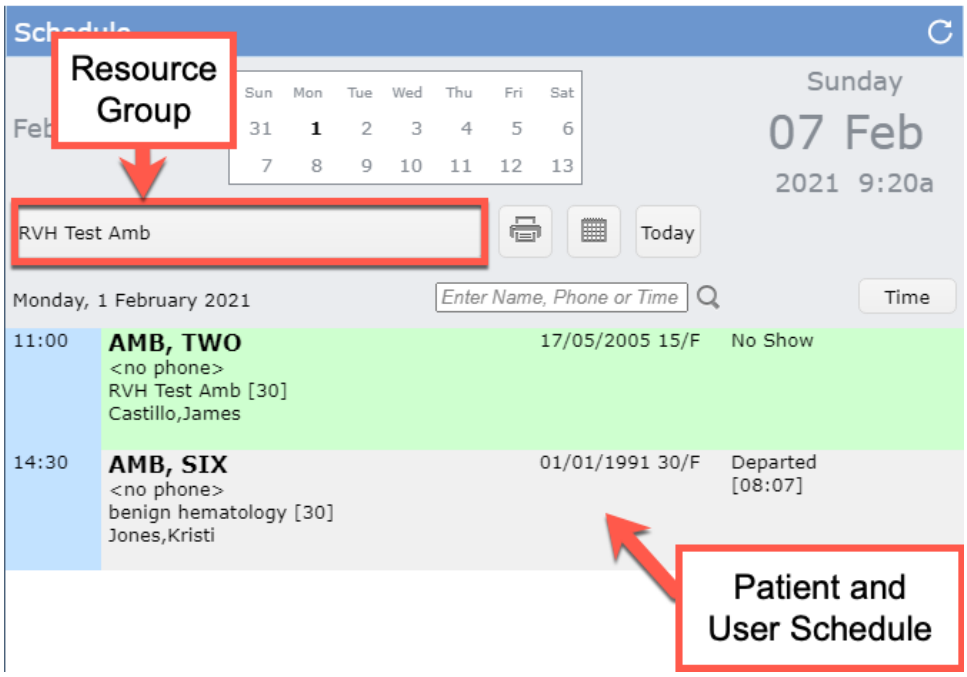
UTILITIES GEAR

Click on the Gear icon to access Utilities, such as Manage Files, Preview Documents, About MT, End Session, and Log Off.

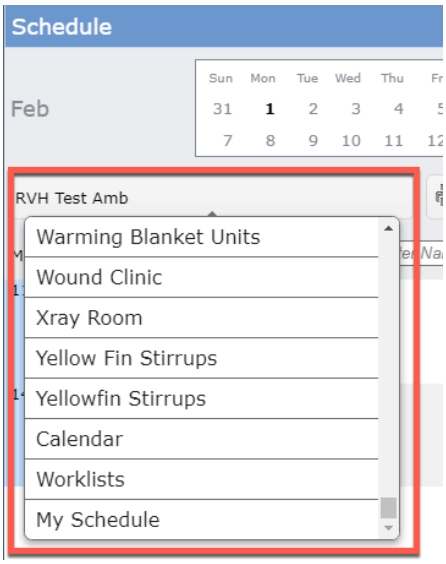
CLOSE 

Close is used to close the active screen in view.

Schedule

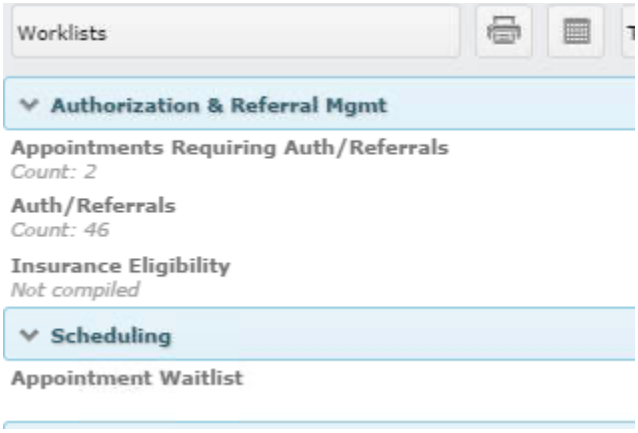


The Schedule Panel, on the Office Staff Home screen, automatically shows the Calendar by default. You may change your view by clicking the Calendar button.

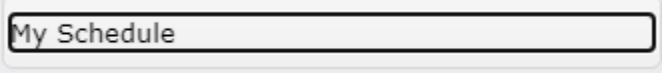


Upon clicking the Calendar button, a drop-down menu will display options including Resource Groups, Worklists, and a personal meeting schedule. Use the Resource Group Display of the Home screen Schedule panel to see the daily appointments for all of the resources within the selected group.

Use the Worklists display of the Home screen Schedule panel to see a list of worklists available.

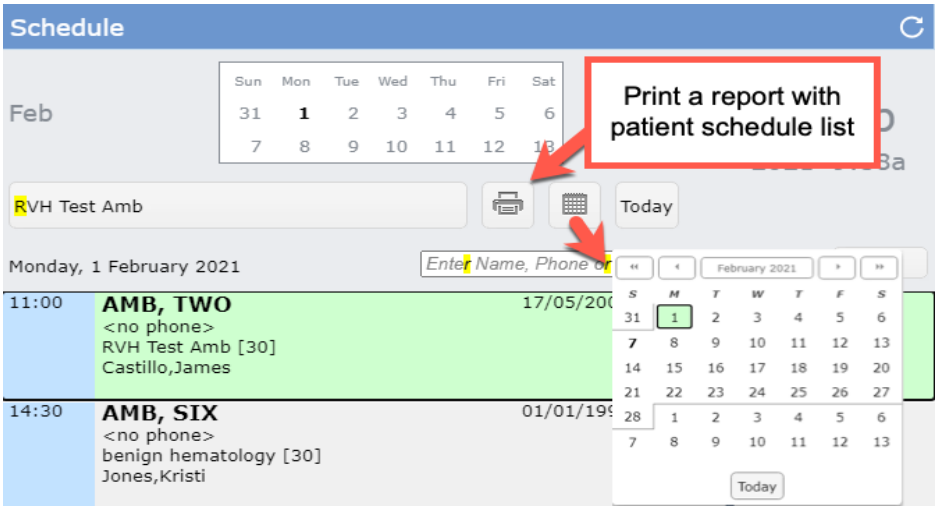


Click on an accordion header to expand the view of worklists within a category. Then click on the worklist title to launch the worklist itself.



Use the My Schedule display of the Office Staff Home screen Schedule panel to see your meetings for the day. The left

column shows the meeting time. The right column shows the meeting title in bold, the meeting duration in square brackets, participants below the title, and meeting location in the last line.

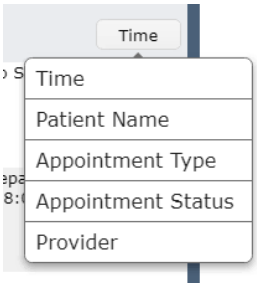


The printer icon presents a report preview of the schedule that can be printed.

Use the calendar view to view a specific date to view or print a schedule.

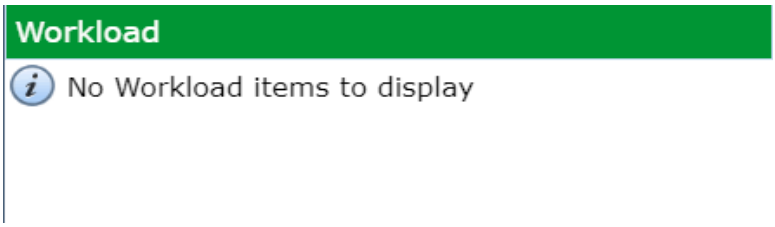
Clicking on an appointment places it in focus, indicated by the green highlight. When a patient-specific routine is selected, such as Patient Summary, Clinical Chart, Workload, or Compose, the patient will appear in that routine.

The appointment search feature is used to search for a particular patient appointment in the schedule.

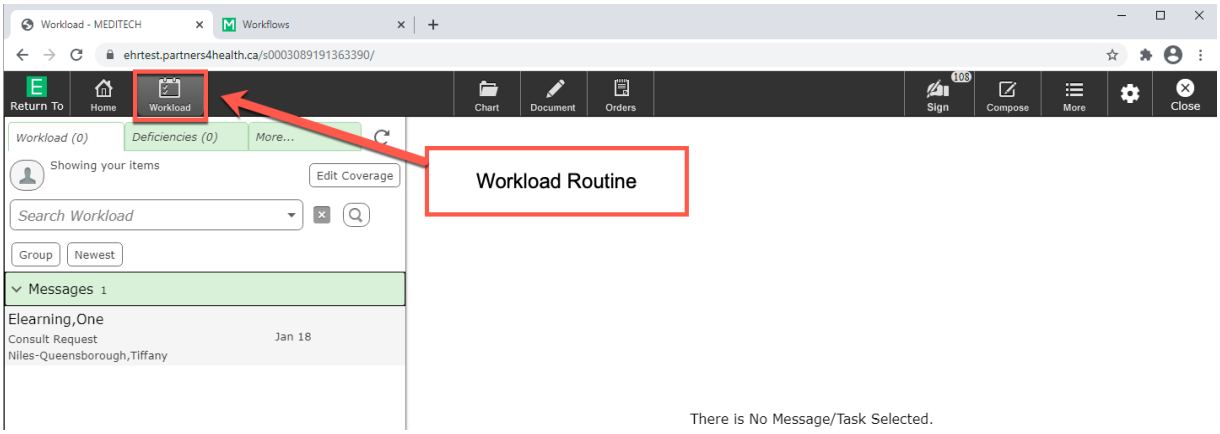


Use the Sort button to sort the currently displayed appointments by Time, Patient Name, Appointment Type, Appointment Status, or Provider.

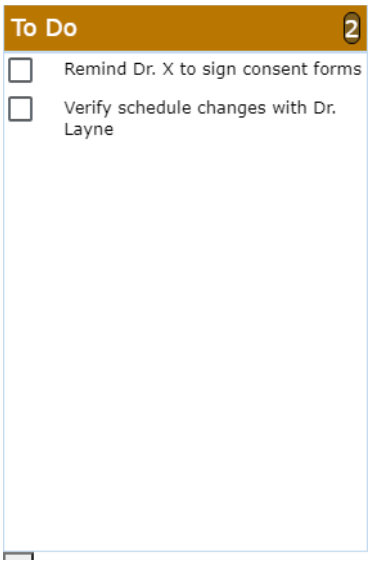
The Workload Panel, on the Office Staff Home screen, displays Messages and Tasks assigned to you as a user or as a member of a Recipient Group.



Select a Message or Task to launch the Workload routine, with the selected patient or topic in focus.



The To Do panel, on the Home screen, is used to create a personalized, free-text list of actionable items. The number of open items in the list appears in the header bar



Functions on the To Do Panel

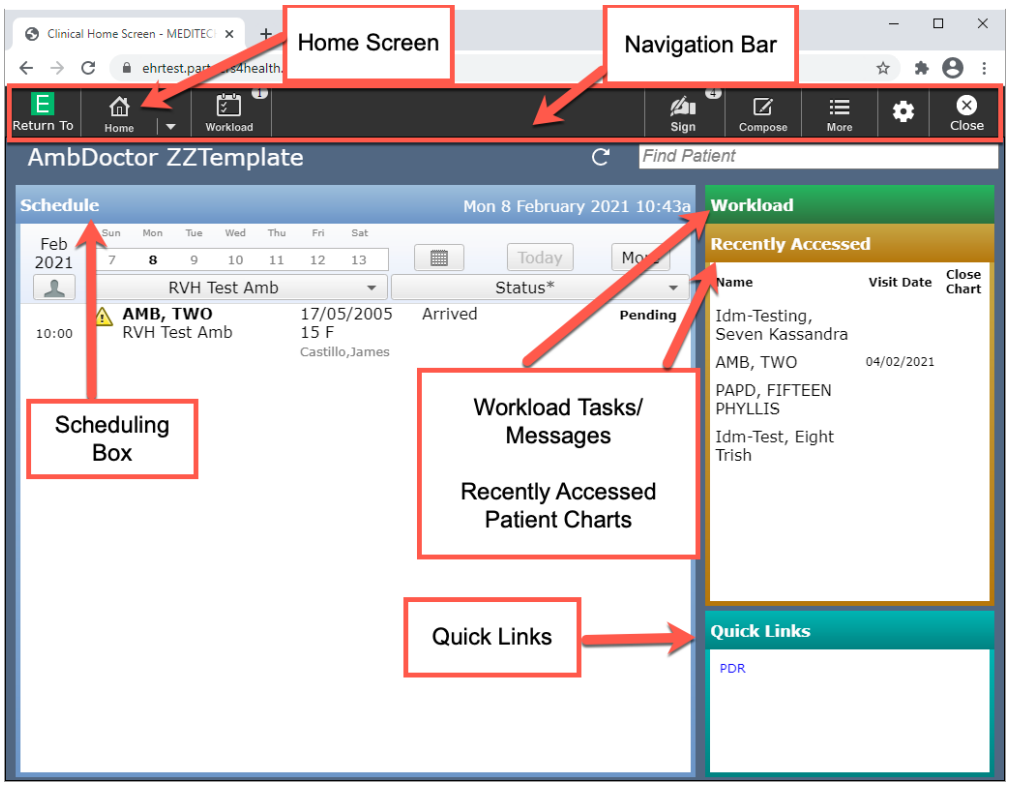
In order to...	Do this...
Create a new To Do item	Click on the + icon and type description in the text box.
Edit a To Do item	Click on the text of an existing item and edit the description in the text box.
Save a new or edited item	Click away from the text box.
Reorganize To Do list	Click and hold the item while moving the mouse to drag and drop it to a new position.
Mark an item as complete	Click on the box next on the left of the item. This places a checkmark in the

	box, draws a line through the text and move the item to the bottom of the list.
Mark an item as incomplete	Click on the checkmark on the left of item. This reverses the markings of complete.
Remove an item	Make sure the item is check marked as complete, then click the red x to the right of the description. Removing an item from the list deletes it permanently from the system.

Quick Links

Quick Link provide convenient access to links frequently used by a user. These links are assigned based on user access settings.

Clinical Home Screen

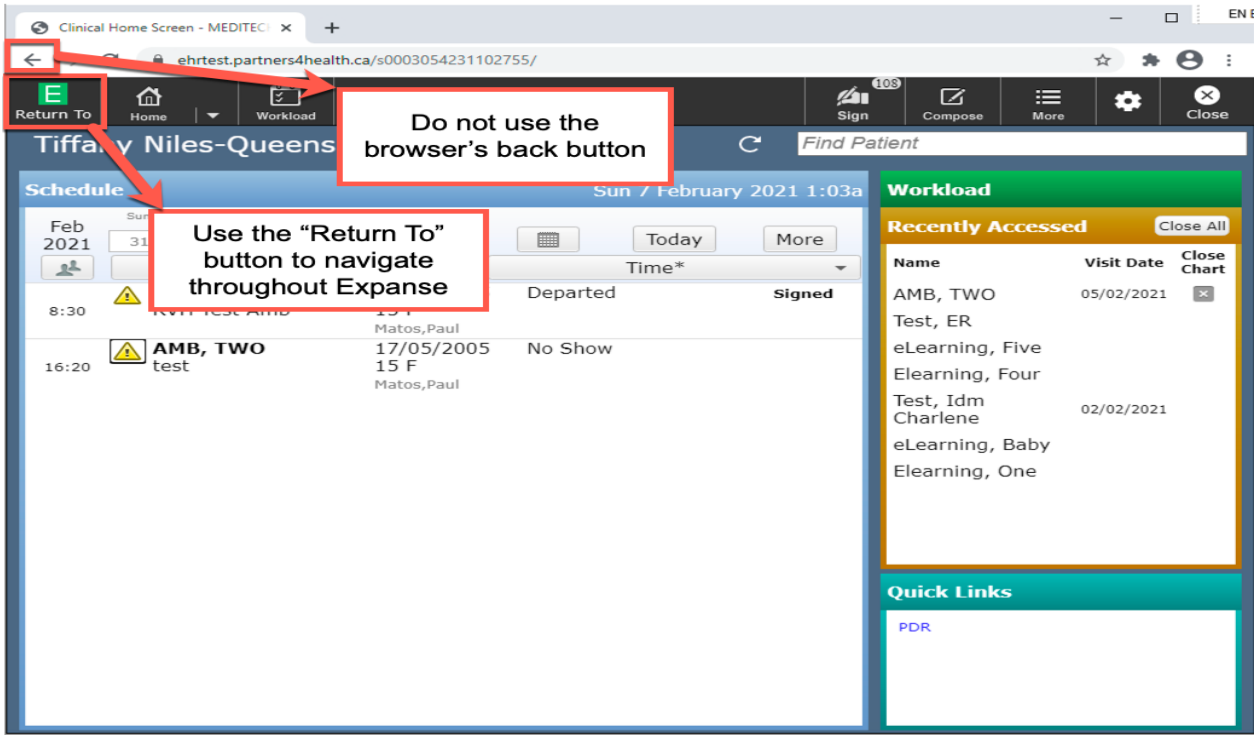


1. Navigation Bar

The navigation bar is located at the top of the screen. It contains different tabs to pe, close and navigates between processes in the Web Ambulatory Clinical Home screen.

The following screens demonstrate the various areas in the navigation bar, displaying information and providing access to functionalities.

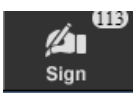
When selected, it provides a list of all locations opened in the system. You can navigate to the selected item, or close items by clicking the “X”. You can also close all patient’s charts from the “Return to Button” at the end of the shift as it could hamper flow for that patient & leave documents in limbo where the next provider can’t add new information until the system closes things out.



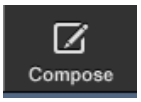
Important Note: Once you have logged into Expanse, DO NOT use your web browser's "back". If you want to return to a prior location within Expanse, use your "Return To" button at any time.

The home button with the drop-down menu lets you navigate between Web Acute, Web ED and the Web Ambulatory locations if you are working in the emergency department as well as on the floors or in outpatient clinics. Selecting the Home button will bring you back to the Clinical Home Screen.

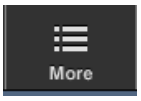
The Workload button takes you to your internal communications page where you can send and receive messages, tasks and review critical results.



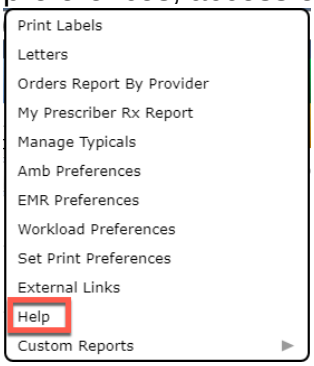
The Sign button allows you to sign orders or documents. The number in the top right corner tells you how many outstanding items you have to sign.



The Compose message button allows you to create and send a message or task to a recipient or work group.

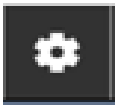


The menu button provides a variety of options where you can select preferences, access external links, print reports, manage Typicals for documentation, etc.



It also offers direct access to extra tools such as external referential links. The options appear by clicking on the drop-down menu. The options are also configured according to your access.

Online help is available at the bottom of the list. Selecting the "Help" option will access the online help feature and provide content about the screen on which the user is currently working.

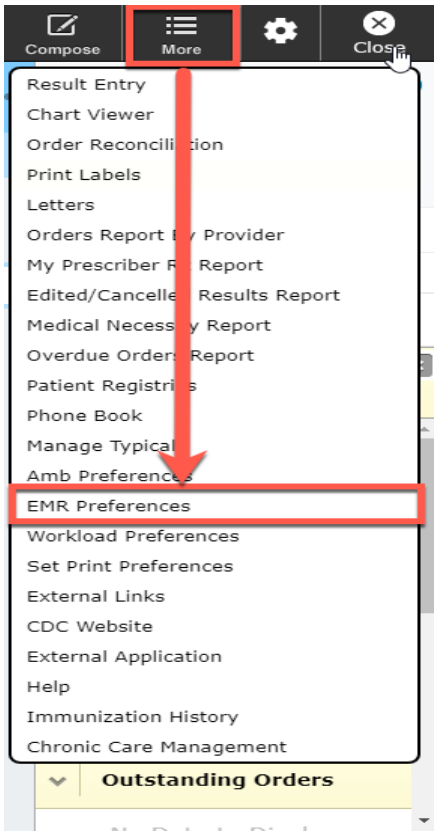


The gear presents a drop-down menu with options to report an issue using the Risk Management function, explore information about MEDITECH or Suspend the session (log off). The Suspend option secures your system so you log-back in and re-access the same screens at a later time or location.

To refresh the information on the screen prior to its natural refresh cycle, select the refresh button

EMR Preferences: Adding Notifications on the Clinical Home Screen and Quick Links

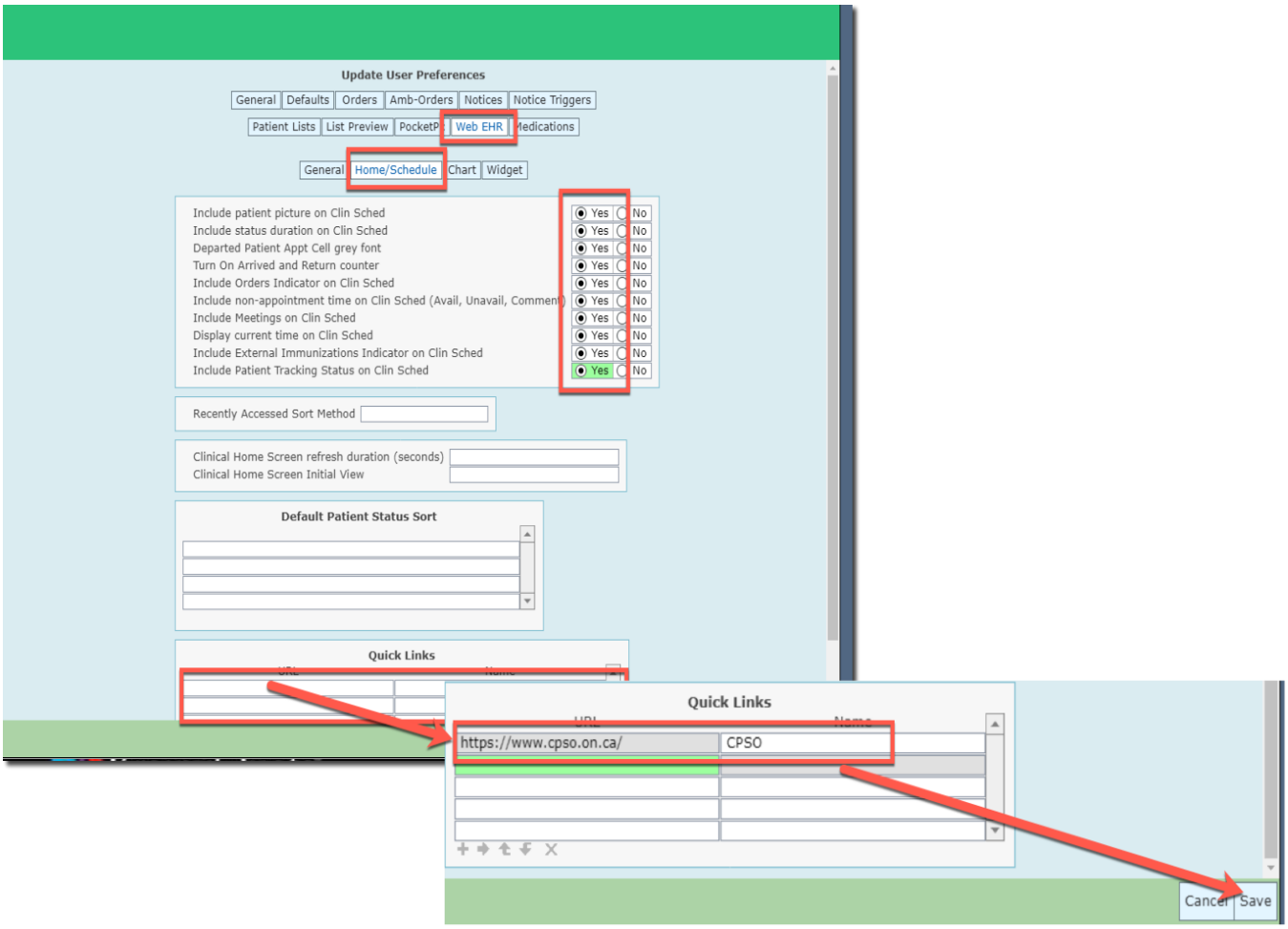
Within the More menu on the Navigation Bar, there is an option on to customize the Electronic Medical Record (EMR) view using EMR Preferences.



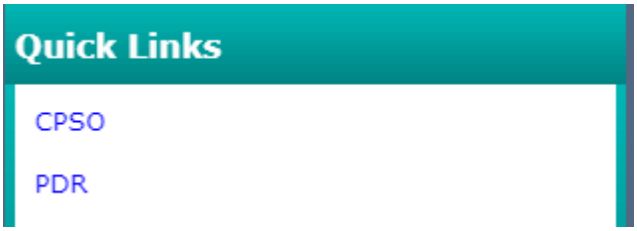
The EMR User Preference Dictionary presents parameter settings that the user can modify to manage their EMR view.

To be able to see all notifications for patient appointments on the Clinical Home Screen, within the Web EHR preferences -> Home/Schedule all of the settings with a Yes or No query need to be set to “Yes.”

Quick Links can be manually added at the bottom of the page by entering the URL and the link name title and then select Save.



Below is the newly added link



2. Clinical Home Screen Components:

1. **Clinical Schedule** – The Clinical Schedule displays the schedule for the current date. The current day, date and time will always display on the right side of the schedule bar, regardless of the schedule date selected.

2. **The Calendar Bar** - The current calendar displays the week highlighted in bold, and displays the schedule for the date selected. Selecting any of the dates in the Calendar Bar will change the schedule below to the date selected.

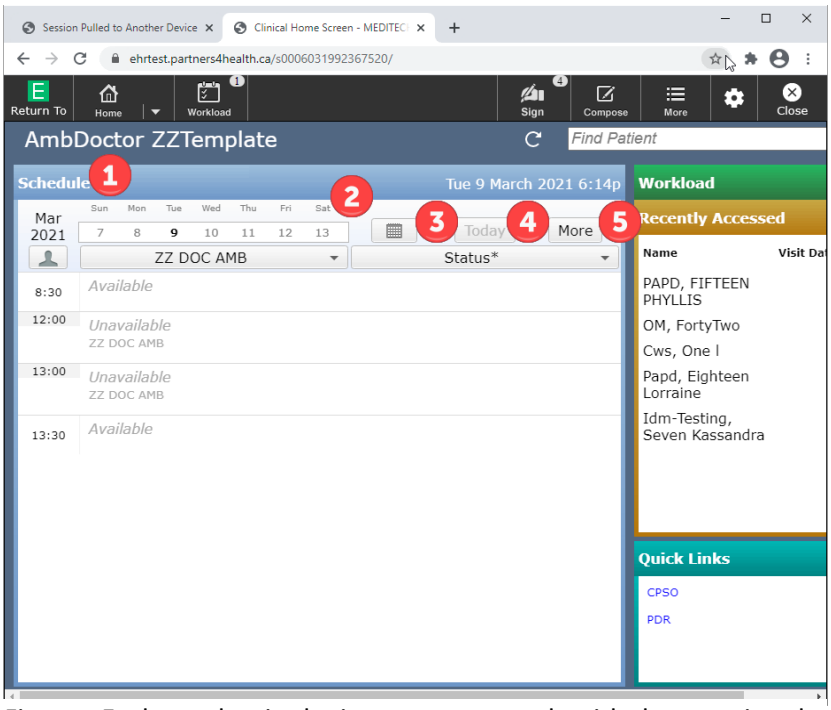
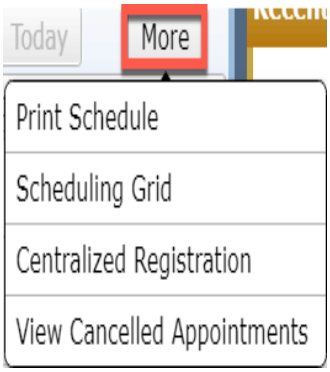


Figure - Each number in the image corresponds with the associated numbered text

3. **The Calendar Icon** - displays the current month's calendar. The arrows to the left or right of the current month and year are used to change the calendar one month at a time. The double arrows will move the calendar by years.

4. **Today** – The Today button at the bottom of the calendar returns the user to the current date.

5. The **More** button presents four options:



- **Print Schedule** - allows for the options of previewing the schedule in an overlay or printing the currently displayed schedule directly to a printer.

- **Scheduling Grid** - select the Scheduling Grid to view appointments and meetings. Appointments and meetings can be scheduled directly from the Scheduling Grid. Patients can also be checked in or out and the patient status can be changed directly from the grid.

- **Centralized Registration** – select this option to bring you to Central Registration where you can view and manage all patient appointments and visits across your healthcare organization.

- **View Cancelled Appointments** - allows you to view any appointments that were cancelled on the selected date. You can select a cancelled appointment to access the patient's chart or outstanding documentation so that you can take appropriate action.

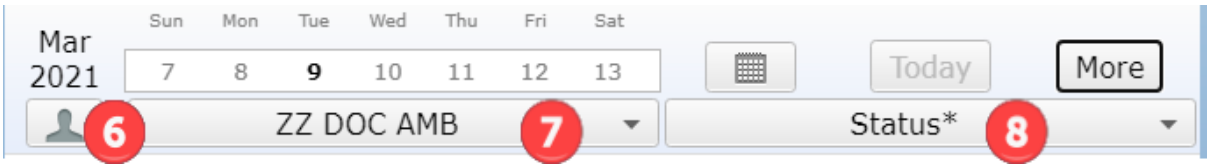
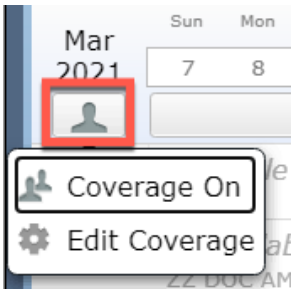
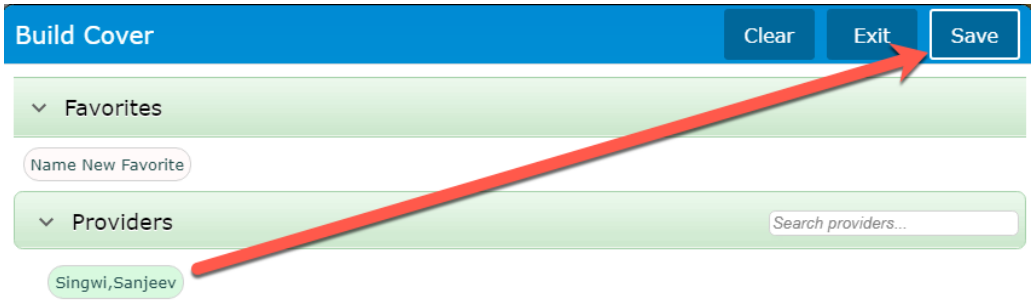


Figure - Each number in the image corresponds with the associated numbered text

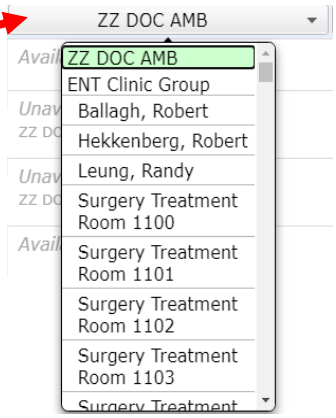
6. **Coverage** - The Coverage icon displays a single person silhouette profile on a user's schedule for the selected date. Selecting on the Coverage icon displays options to select Coverage Workload and Edit Coverage. Coverage Workload changes the clinical schedule and workload to incorporate into your clinical schedule and workload in addition to the clinical schedule and workload for all users being covered.



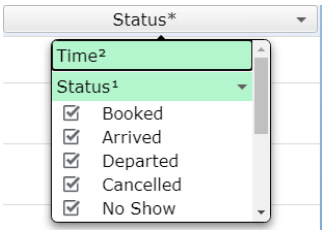
- **Edit Coverage -** presents the Build Cover overlay. Coverage can be changed to either add users or remove users. Once edits are made clicking the "Save" button will update the changes.



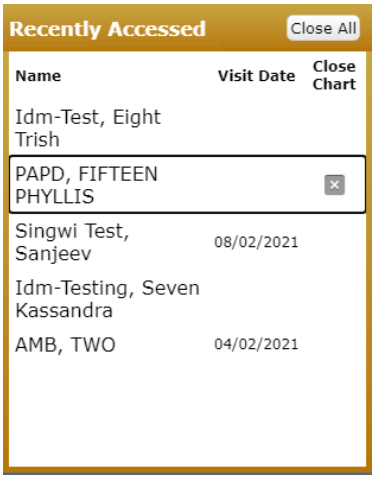
- **Coverage On –** When the coverage function is turned on a double person silhouette will appear on the coverage icon.



7. **Resource/Resource Group -** This drop-down menu displays all resources/resource groups linked to a user as defined by a user's access.



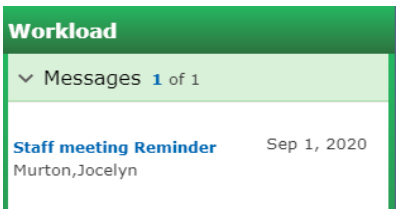
8. **Status -** The Sort drop down allows users to select a primary and secondary sort for the schedule. The schedule has a default primary sort of time and a secondary sort of patient name.



9. **Recently Accessed –** Recently Access presents a list of patient charts that the user has recently accessed. Charts that have been viewed, are in process, or that have been completed appear. A visit date indicates that the patient's chart was recently accessed for the visit account. If there is no visit date, the patient's chart was accessed at the patient level.

A gray X appears to indicate charts that are currently open. The X turns red when you hover the cursor over it. Select the red X to close the selected chart. In addition, you can select the Close All button to close all open charts at once.

10. **Workload –** For all of your incomplete/outstanding workload tasks and messages

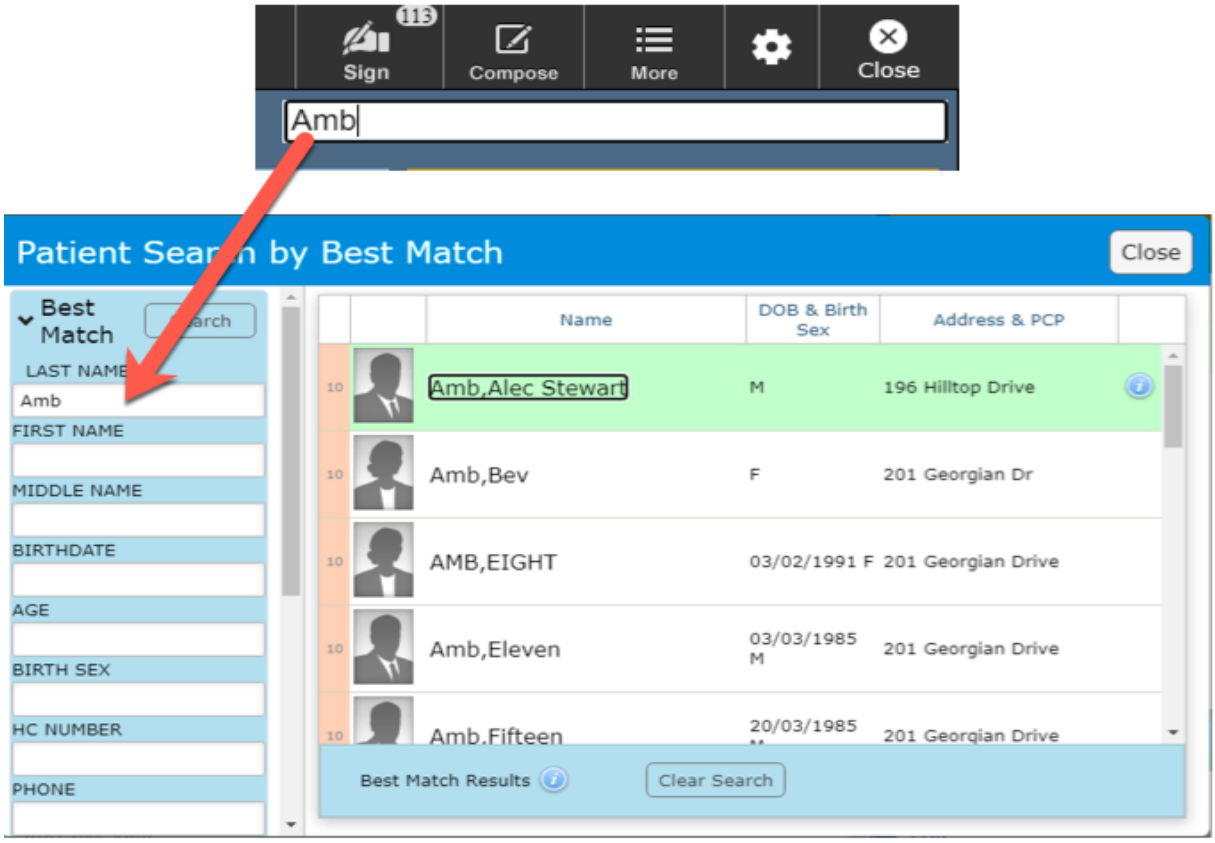


11. **Quick Links –** Provides organization-wide access to outside links that may be valuable/helpful to many clinicians (e.g., ECHN, Goldcare)

Find a Patient

Use the Find Patient field, located below the Menu bar at the right side of the search the database for a specific patient after entering identifying data (for example, full or partial name) and then select the “Enter” key on the keyboard.

Upon entering a patient name, the Patient Search by Best Match overlay screen will display with a list of patients. Highlight the patient record by selecting it. It is important to verify the correct patient has been selected before orders and/or documentation are entered. Click on the highlighted patient to open the chart.



Other search parameters can be set by scrolling to the bottom of the screen. Search parameters include:

- Med. Rec Number*
- EMR Number
- OV ID Number
- Account Number*
- MPM Enc Number
- 5.x EMR Number
- CSID
- Accessed

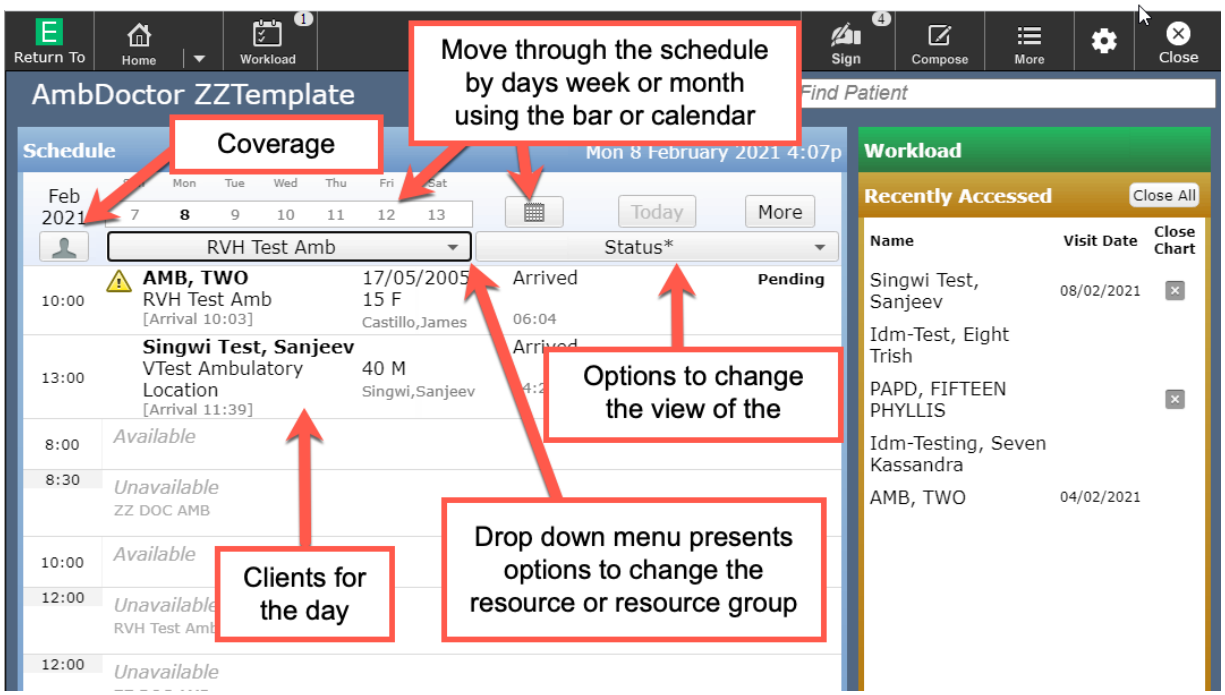
Note: Options with an asterisk beside it indicate the most common search parameter options chosen by users.

2. Clinical Home Screen: Schedule

The Schedule View

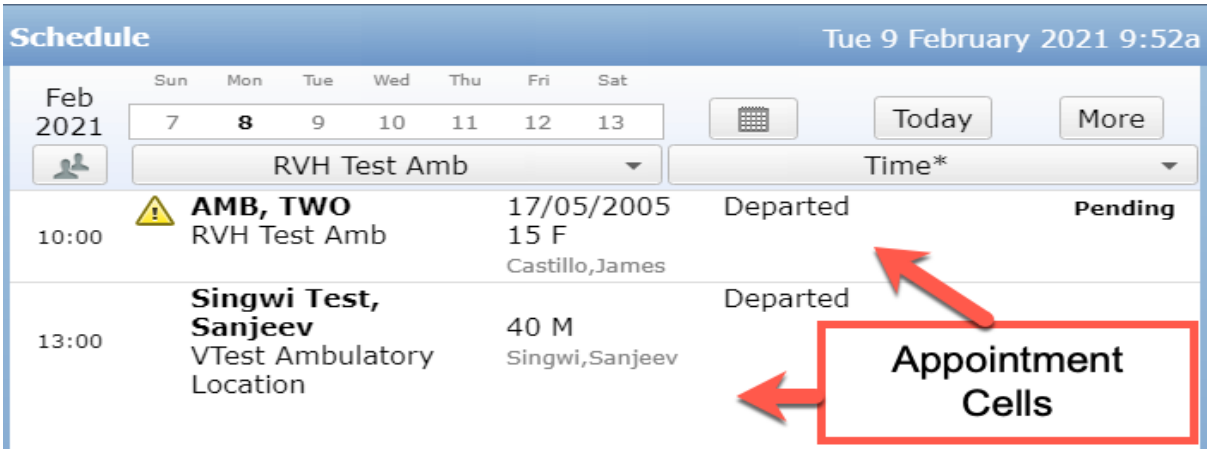
All clients for the day are displayed on a schedule on the Clinical Home Screen. Access to Patient Chart/Documentation for each client can be gained by clicking directly on a client for that day's visit.

- Displaying a different day's schedule can be accomplished by clicking on another day within the week bar, or by clicking on the calendar button to change by month
- Clicking on your name or resource group will allow you to change resources and look at another clinician's schedule (CTRL+F allows you to quickly search for a Resource or Resource Group by name)



Appointment Cell

The Appointment Cell displays the time of the appointment, special indicators, the patient's name, reason for visit, patient age/birth sex, visit status, and a link to documentation started for the visit.



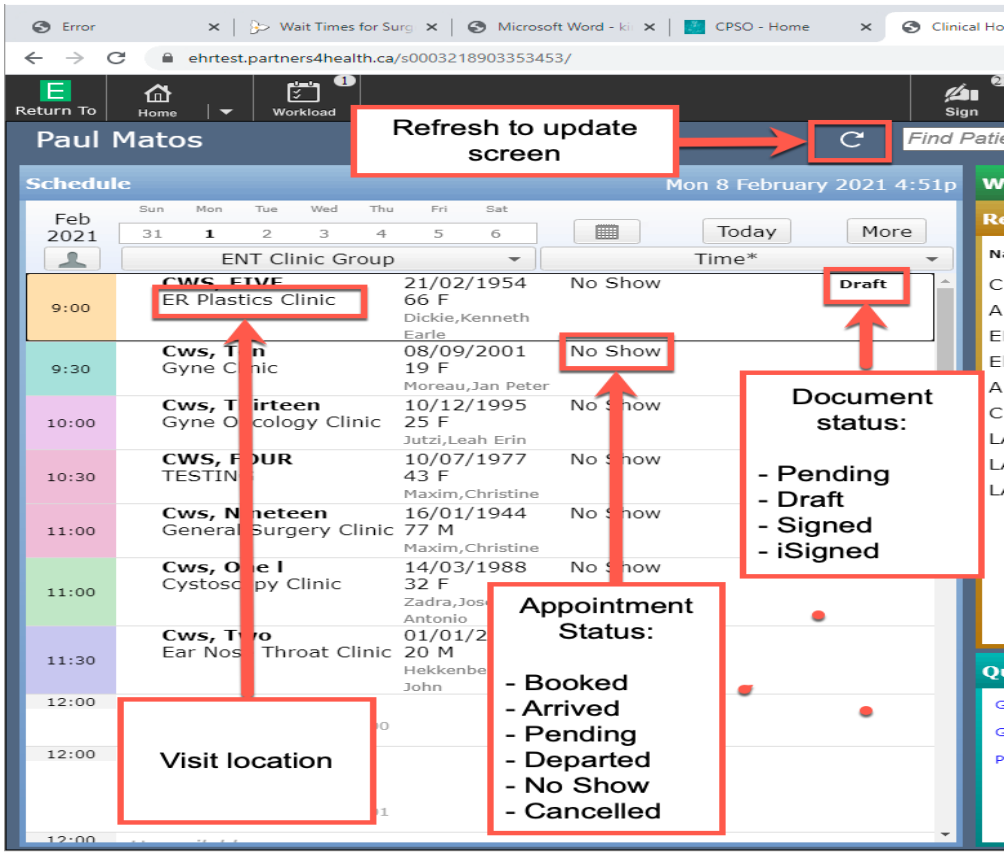
A special indicator flag (yellow triangle with an exclamation point ⚠) appears beside the patient's name if the patient has any clinically significant or high-risk information the clinic needs to be informed about. Such indicators include high risk behaviours, infection prevention and control precautions and falls risk.

The visit provider's name displays below the patient's name and will appear for any appointment linked to a covered provider or a resource that the user is covering. The user's name will not appear under the reason for visit if the appointment has been scheduled with the user.

Available times, unavailable times and meetings are incorporated into the user's schedule.

Visit Reason

The visit reason represents the reason for the patient's appointment. Each appointment equals a separate visit account.



Appointment Status:

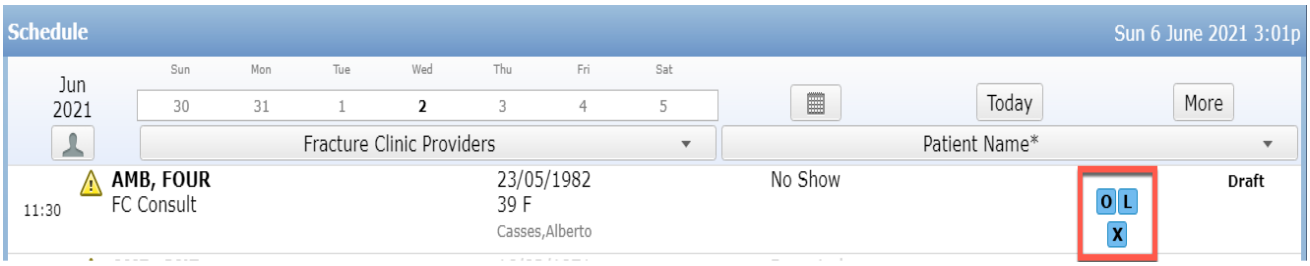
- Arrived - The patient is checked in at reception
- No show/cancel - The patient did not present to the clinic
- Departed - Appointment visit was attended then will show as departed one day post-appointment.

Note: Edits cannot be made by clerks on the attendance status once clients are in departed status.

Documentation Status:

- Will show if documentation has been started or completed for a particular visit. Each label represents the status of the document:
  - Draft - the document has been saved but not been electronically signed (esignature) by one or more parties. The document will appear in the EMR.
  - Signed – the document is esigned by one or all assigned documents signers.
  - iSigned – an esignature has been applied to the document however there are outstanding cosigners/co-contributors that are required to sign the document. The document will appear in the EMR
  - Pending - A document is opened but neither saved or signed by the user.

Notifications on Schedule Patient Cell: Orders



When orders are placed, notifications will display on the patient's appointment cell.

O = Office Procedure order for medication administration

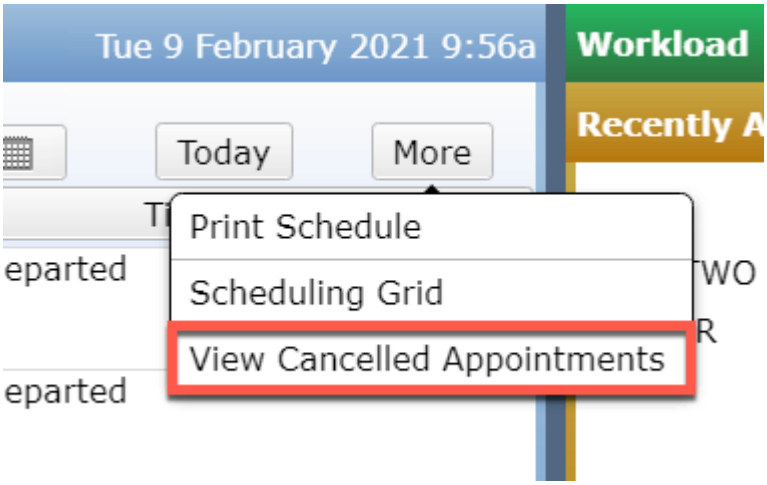
X = Diagnostic Imaging Order

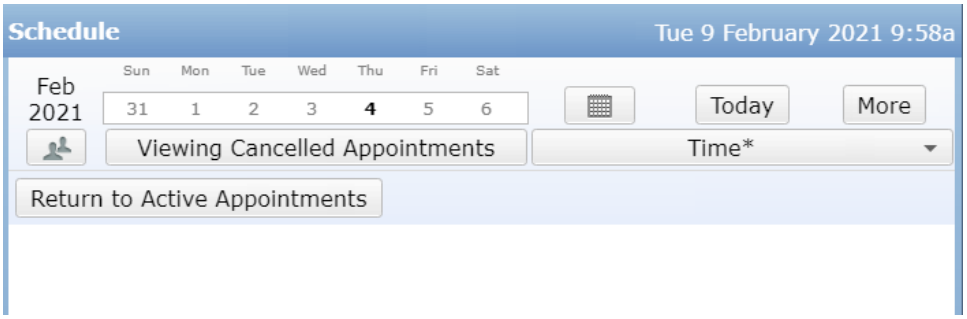
L = Lab Order

Note: The letter "L" only displays when the Order Specimen query is set to Office to Collect

Viewing Cancelled Appointments:

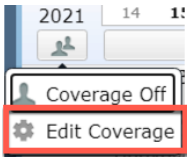
To view cancelled appointment from the Clinical Home Screen, click "More" and then select "View Cancelled Appointments." This will present the cancelled appointments into view. Select the "Return to Active Appointments" button to preview active and current appointments.





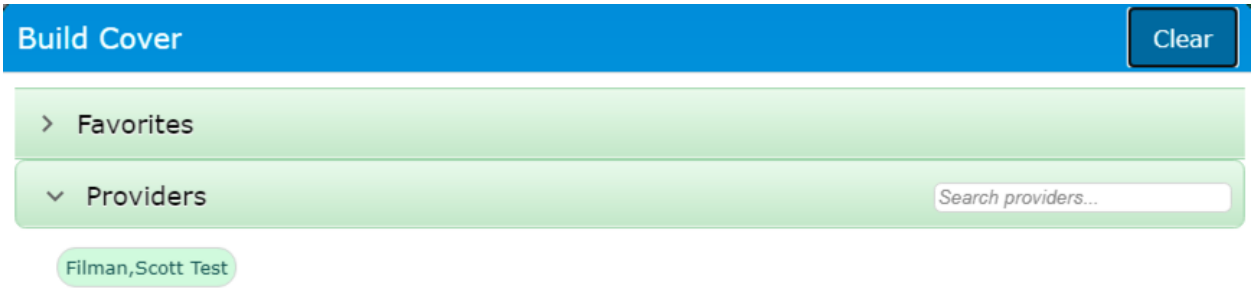
To return to the active appointment list select the Return to Active Appointment s button.

Build Coverage

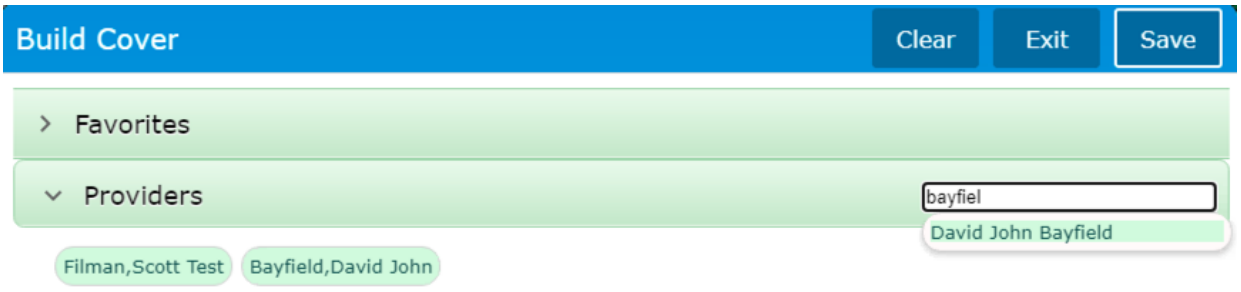


There are times when you may have to cover another care provider (resource). The Build Coverage functionality enables you to cover a resource's list while being able to view your own appointment list on the clinical home schedule view.

To apply or edit coverage, select the coverage button and then select the option Edit Coverage. This will take you display the Build Cover overlay screen.

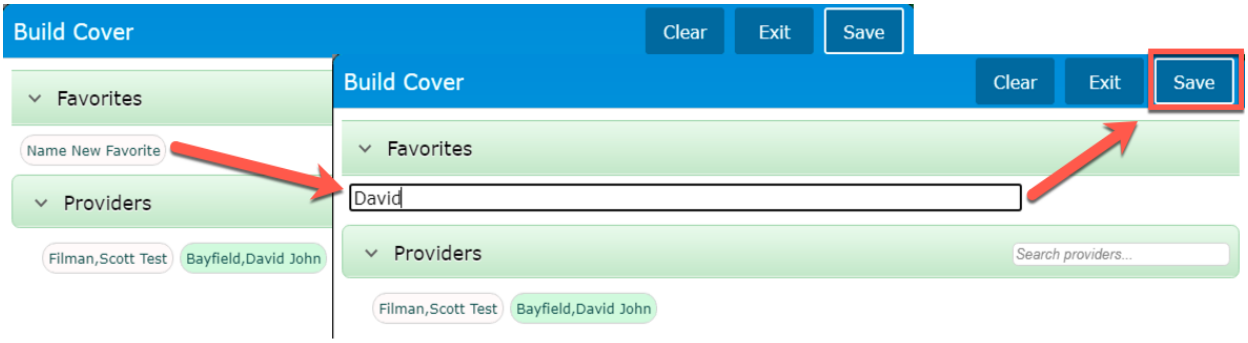


Use the Search Providers field to type in and search for the provider's name. Selecting the name will populate the name on the Provider list. Providers can be added to the Favourites list for quick coverage selection.

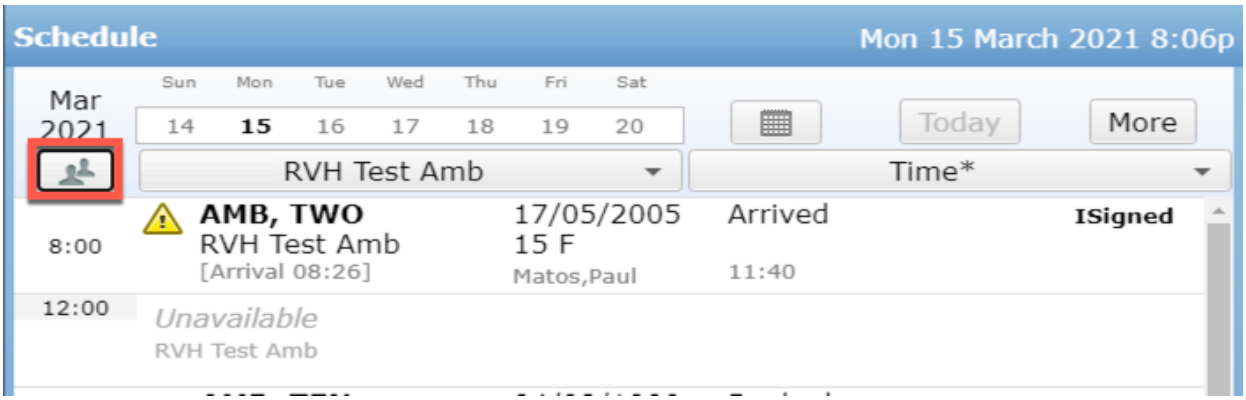


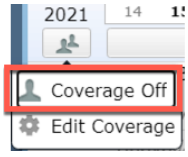
To add a provider to the favourite list, select the options to highlight them in green and deselect the others which will create a white background as seen below. Create a

favourite title for the individual or group of providers that you want to create a favourite coverage option for.



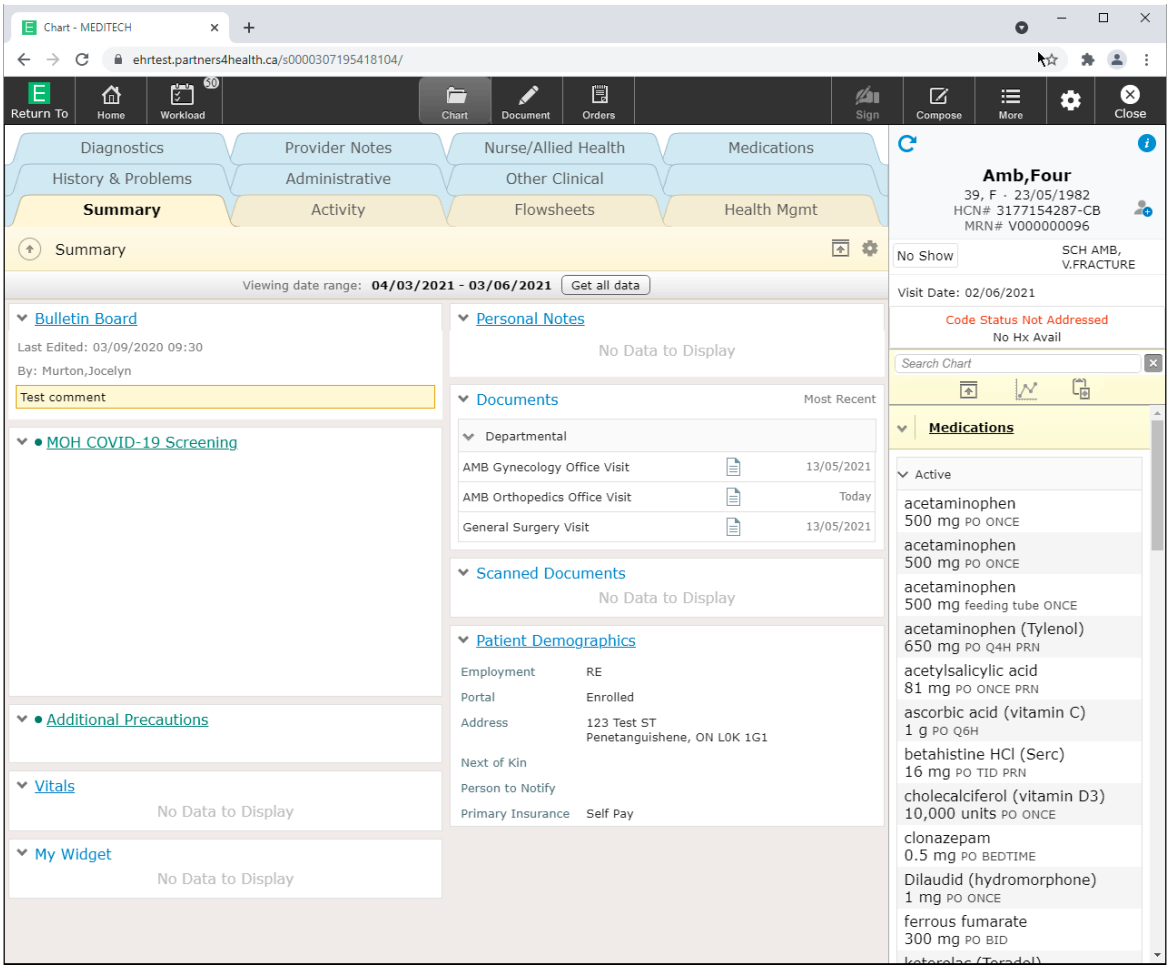
Once the Favourite is created and saved, you will return to the Clinical Home Screen. Notice that the Build Cover button displays a double silhouette indicating a list of patient appointment for both yourself and for whom you are covering.



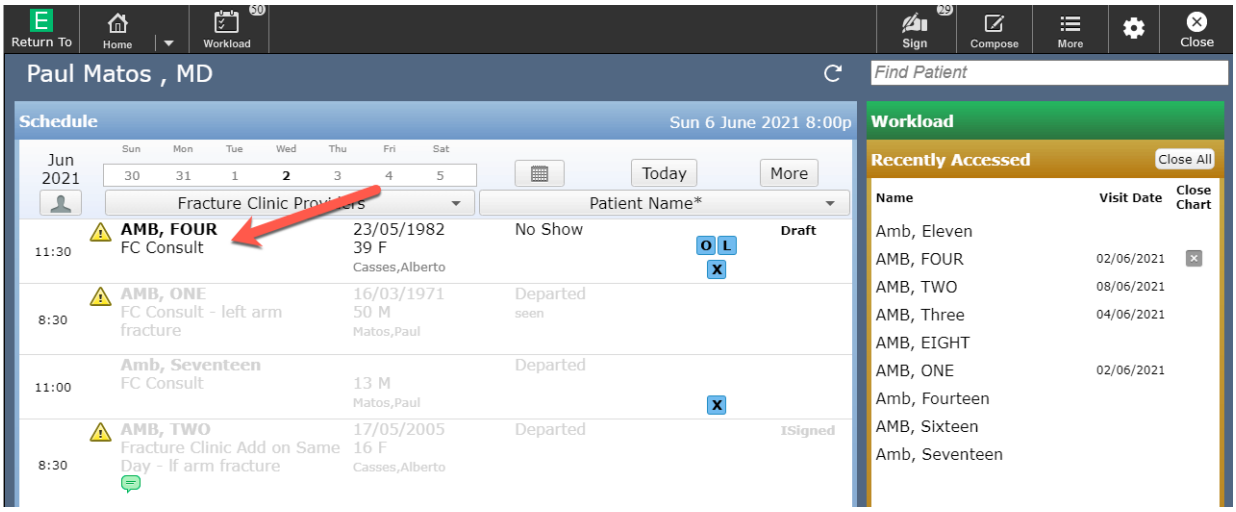


To remove this coverage, select Coverage off which will return the Build Cover button to a single silhouette.

Chart



In order to view client charts, clinicians should select a client from their schedule view or scheduling grid and then select “Chart” from the navigation bar after choosing a client.



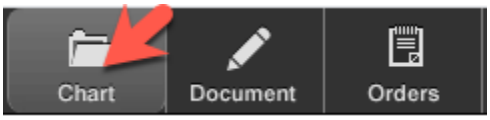


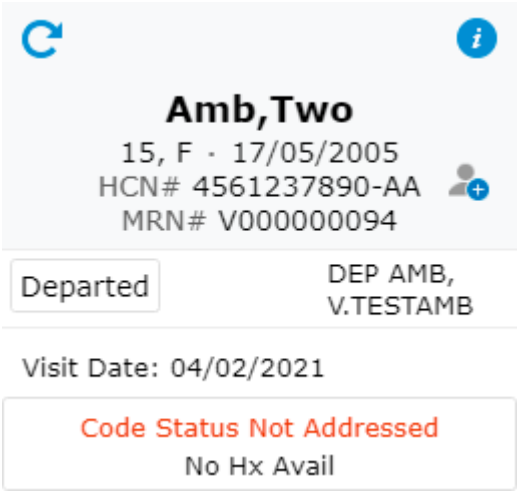
Chart Navigation - Clinical Chart Patient Header and Reference Region Overview

Navigation bar - the black bar that appears across the top/bottom of the screen.

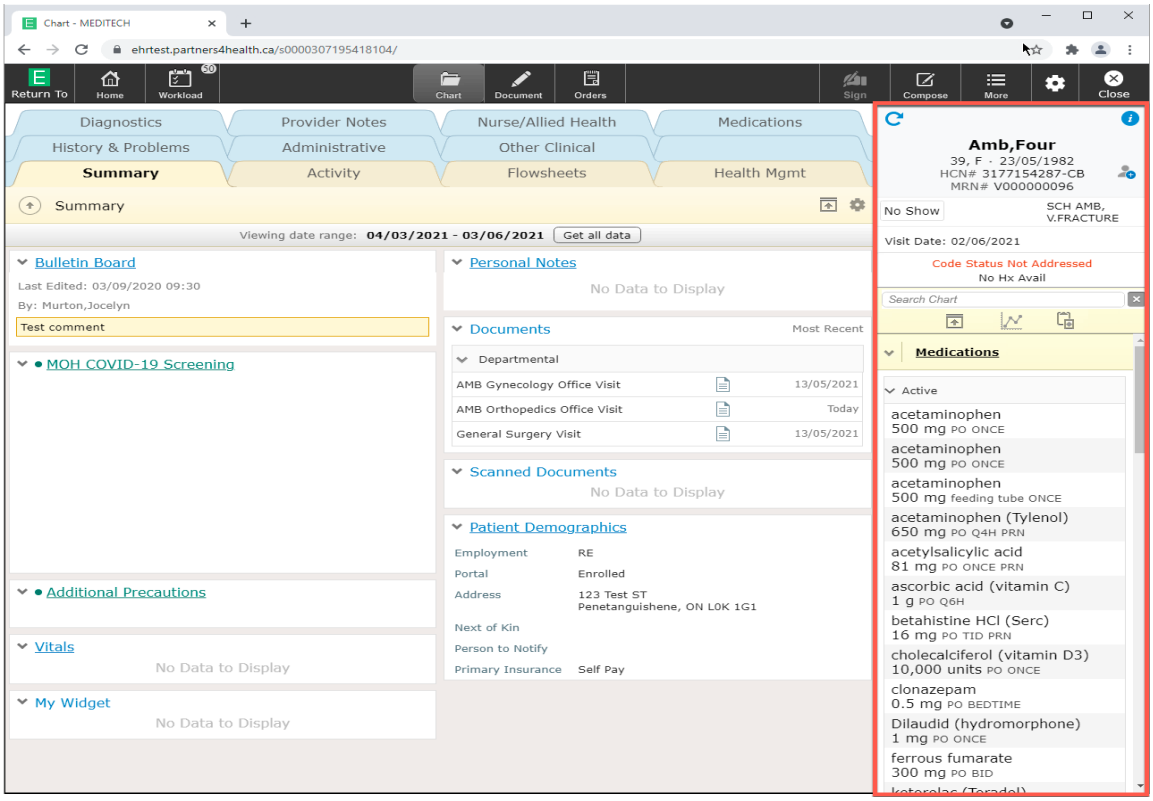
Body - the main area of the chart that appears on the left of the screen. When you select multiple visits, choose the visit you want to populate visit level widget data. The active visit data appears in teal text with a teal dot.

Patient Header

The patient Header appears on the top of the reference area on the right of the screen in the chart. You can view the patient's name, birth sex, age, date of birth, and picture. Click on the blue information "i" icon to view the patient's account numbers, medical record numbers, all insurances and associated policy numbers. The patient's primary care physician and phone number also appear.



Reference Region



The Reference Region

The Reference Region at the right side of the screen consists of "widgets" of information for display, access and to edit. This data region remains present while documenting, ordering and reviewing the patients records. This allows a user to quickly view the patient's data without having to navigate to the clinical chart. It highlights critical information about the patient including:

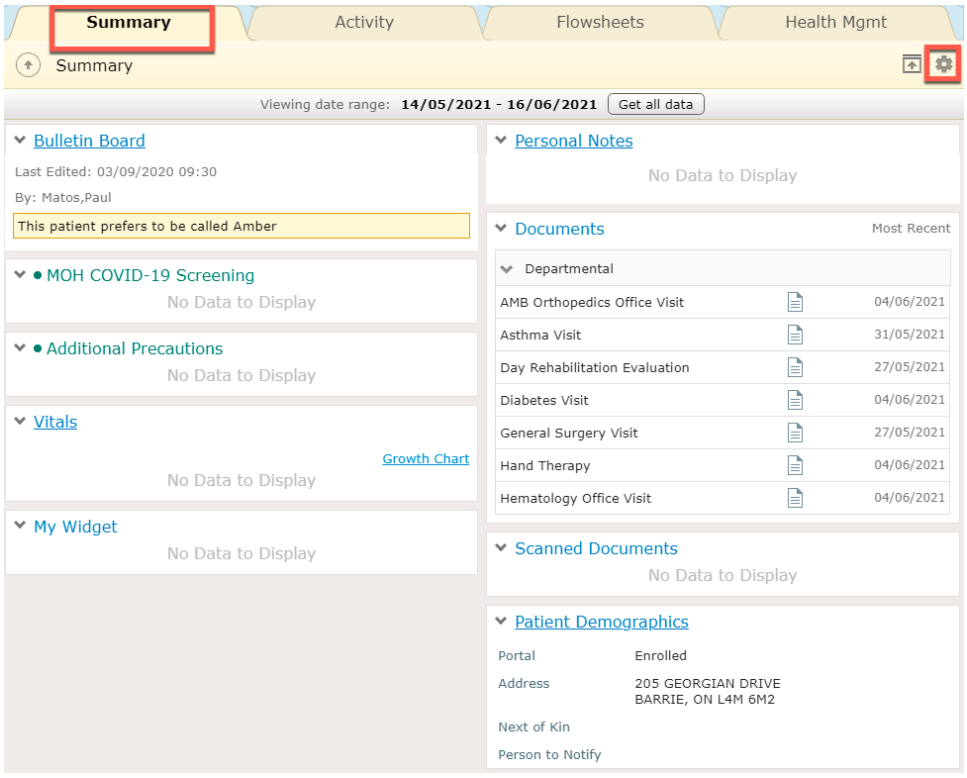
- Visit date
- Allergies
- Special Indicators
- Problem List
- Active Orders
- Medications

Review Chart Tabs

Chart Tabs - provides detailed information for the different categories of the patient's data.

Summary Tab

The Summary Tab provides a quick view of client information. Use the Chart Summary page to view an overview of a patient's health status. The screen layout of the clinical chart is divided into the following areas as illustrated in the screen below:



Several links within the summary tab flows to other tabs within the client chart (detailed below), where more detailed information can be accessed:

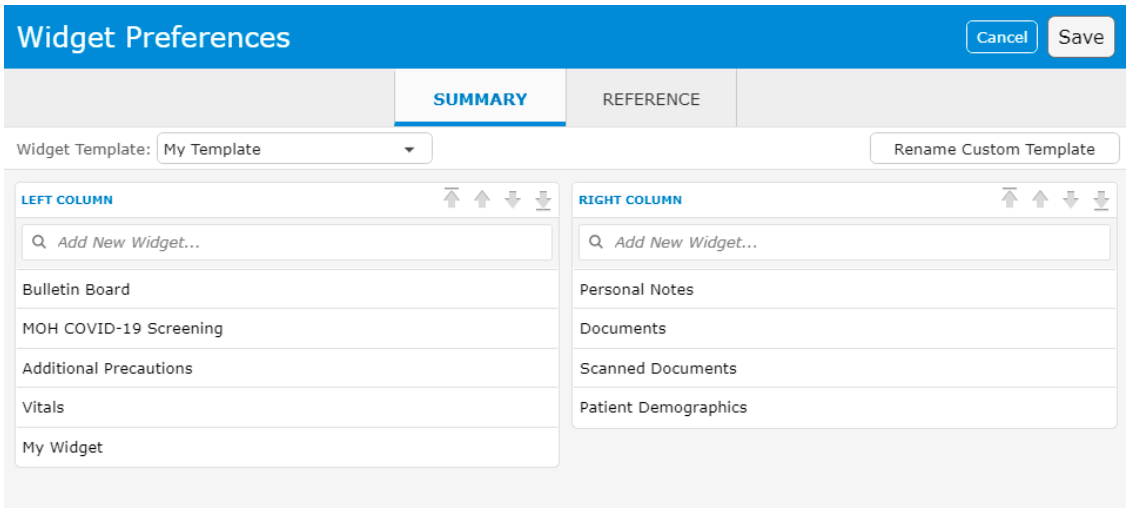
- Patient Demographics (History and Problems Tab)
- Equipment (displayed in Summary entirely)
- PFSH (History and Problems Tab)
- Visits (Activity Tab)
- Bulletin Board (Summary Tab – Visible to all clinicians)
- Personal Notes (Summary Tab – Visible to individual clinicians only)

- Funding Assistance Resources (Summary Tab)

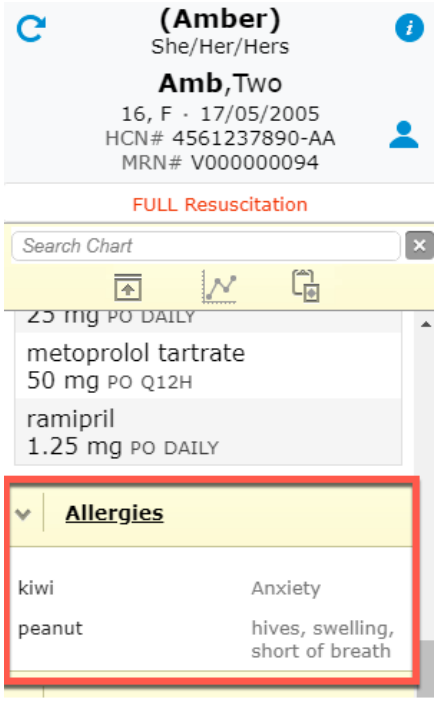
- Scanned Document (Summary Tab, Activity Tab)

Gear Wheel on the Summary Tab: Access the Widget Preferences to modify the display of widgets on the Chart Summary tab.

Widgets and Widget Preferences – Use the Gear wheel to add new widgets or manage existing ones on the reference region or on the Summary Tab.



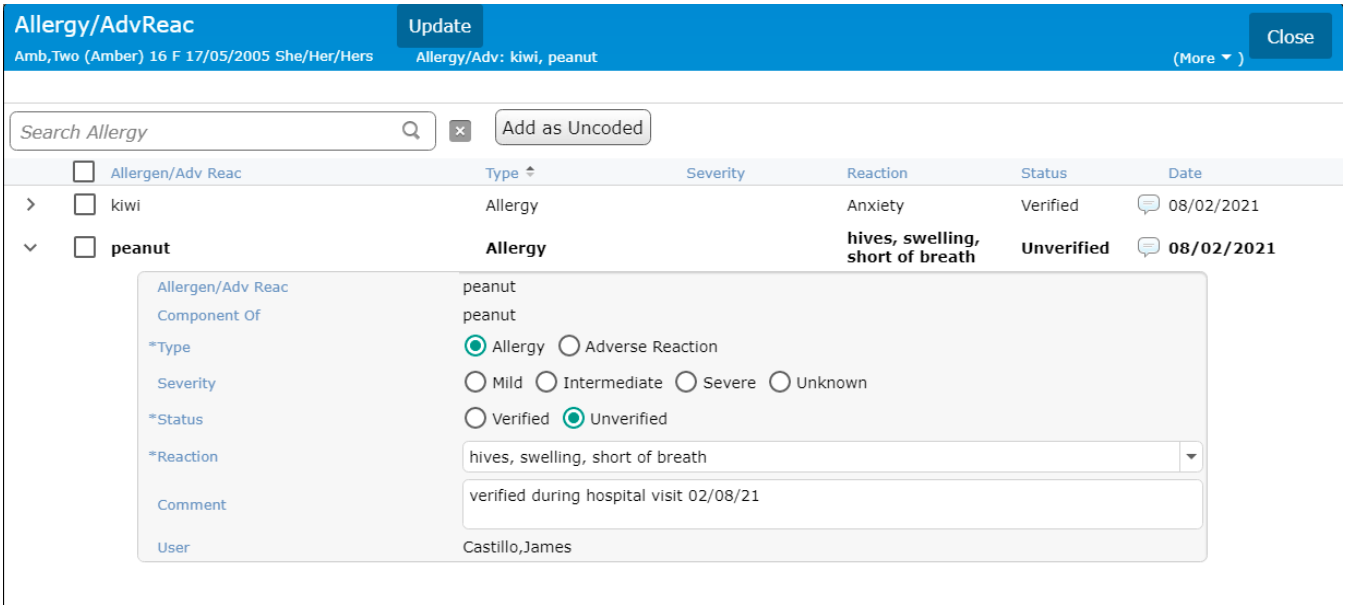
Allergies



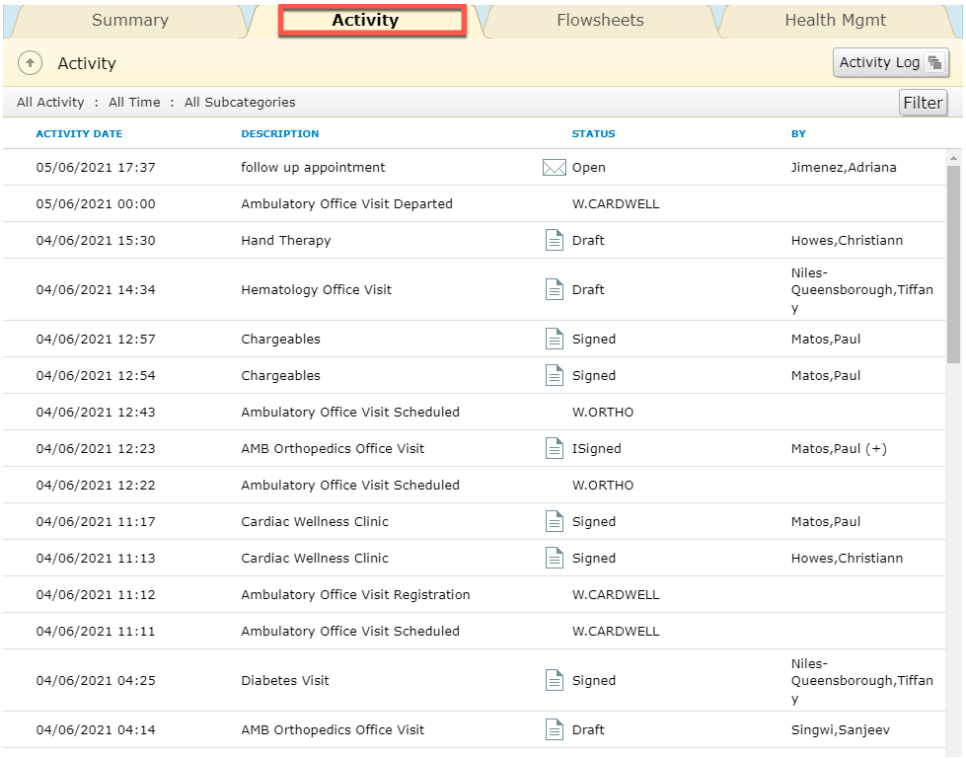
Use this screen to enter or update allergies or adverse reactions for the selected patient. For each allergy or adverse reaction, you can:

- verify, confirm, or remove allergen information
- view the changes made to a patient's allergen information
- view how a patient's allergen information appeared on a certain date

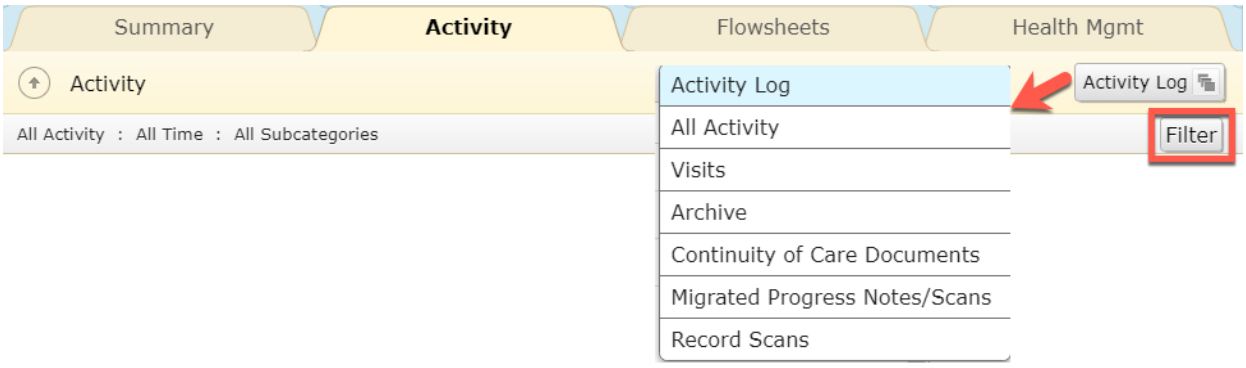
Although you can view patient allergies from a number of different screens, you can access this routine only if you are authorized to do so, otherwise the edit option does not appear.



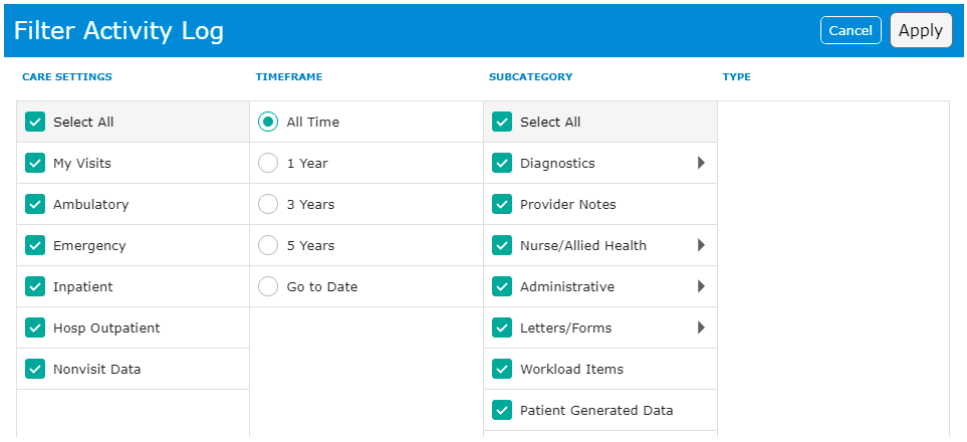
Activity Tab



Activity Tab – Contains chronological documentation from Provider Notes in addition to client specific workload messages and scanned documents

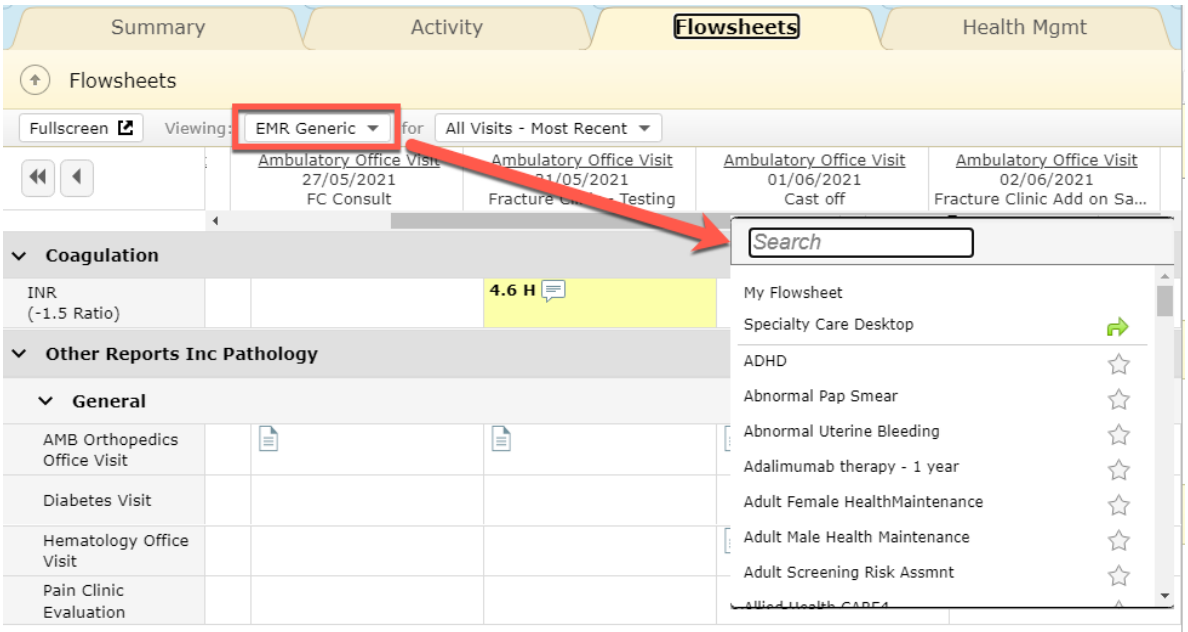


- Can be filtered by time and care setting subcategories. To filter, select filter button within grey bar located on the right-hand side above listed activity

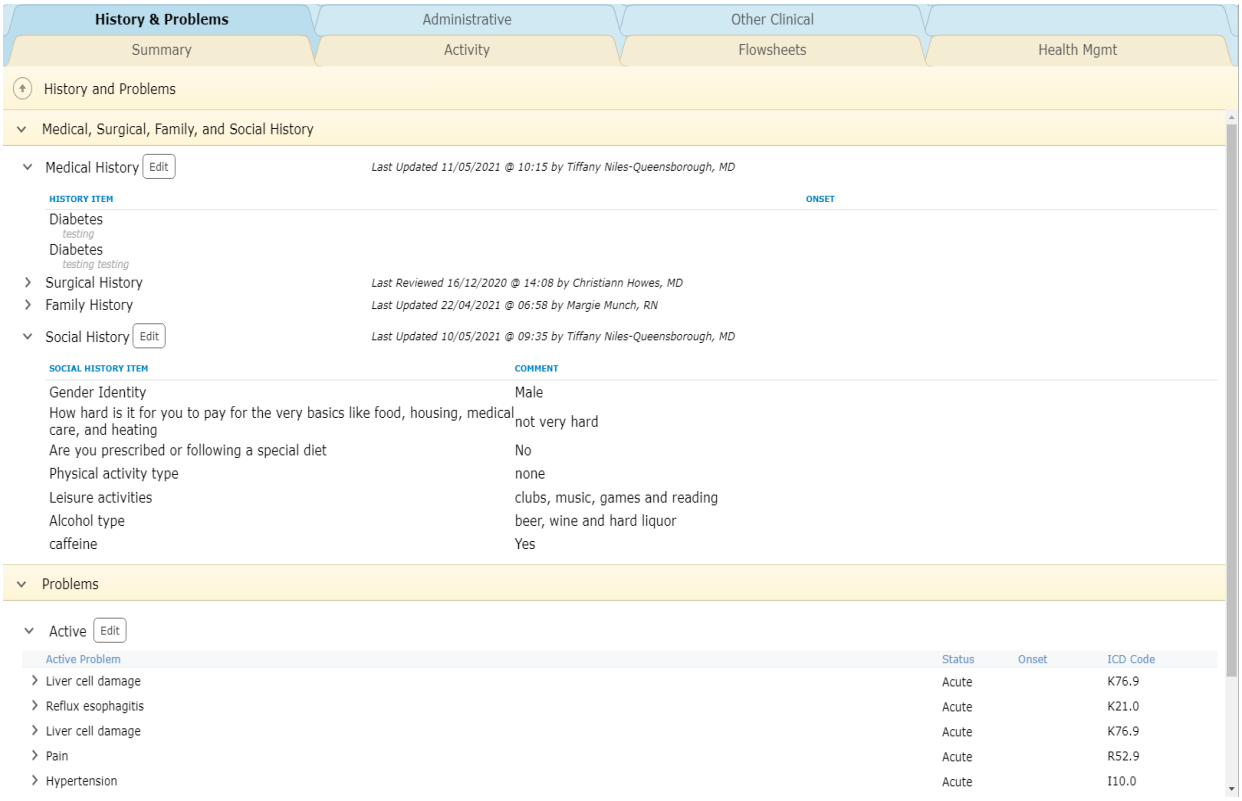


Flowsheet Tab

Data captured by nursing staff (e.g., height/weight) will flow to the Flowsheets tab

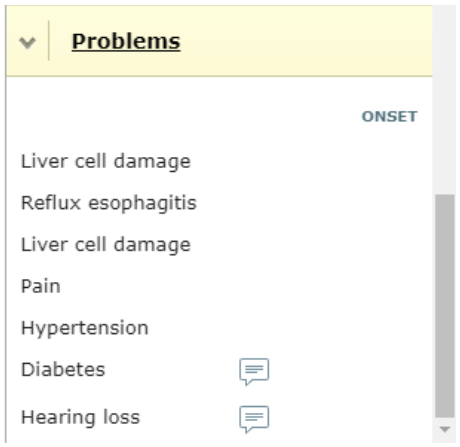


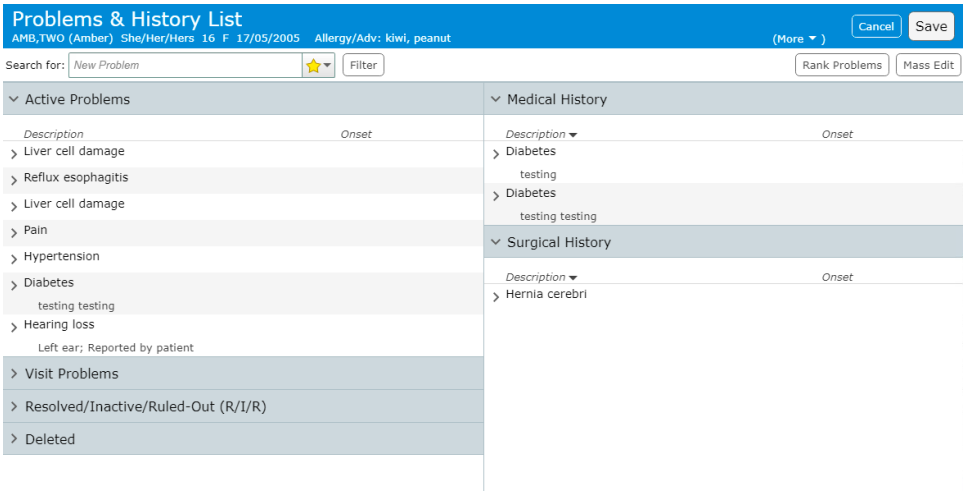
History and Problems Tab – Contains Expanded information from Patient Family Social History (PFSH)



Problems

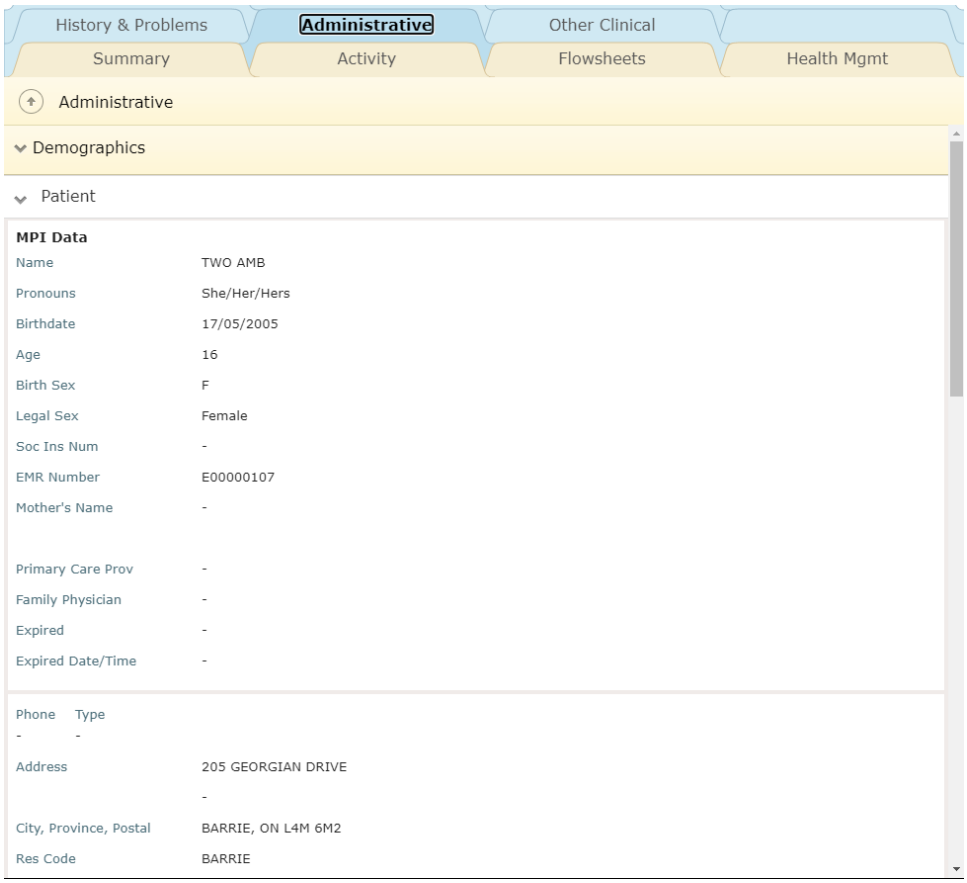
Patient problems can be edited by appropriate staff within this section. Clinicians should attend to comments of “caregiver reported” or not to distinguish physician confirmed vs caregiver reported ones.





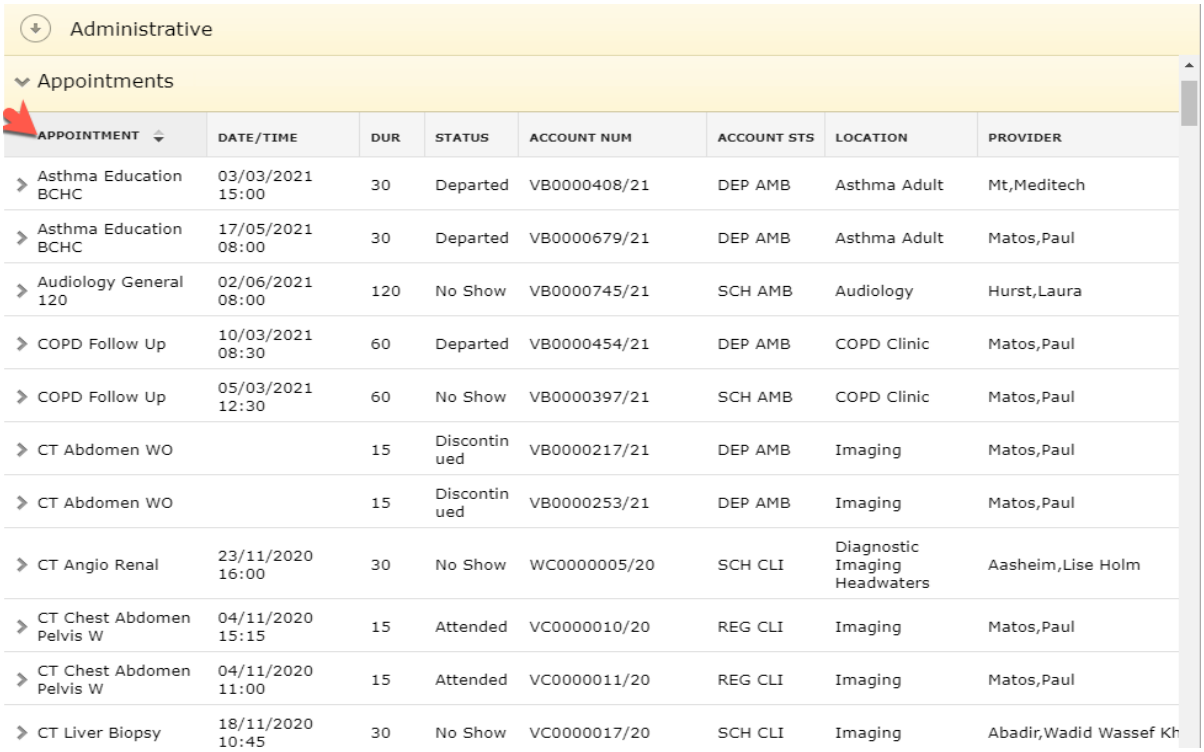
Administrative Tab

Consists of a list of client's past and upcoming appointments, and expanded client demographics



To filter by appointment type:

- Select “appointment” on grey bar located above appointment list
- Select any applicable filters

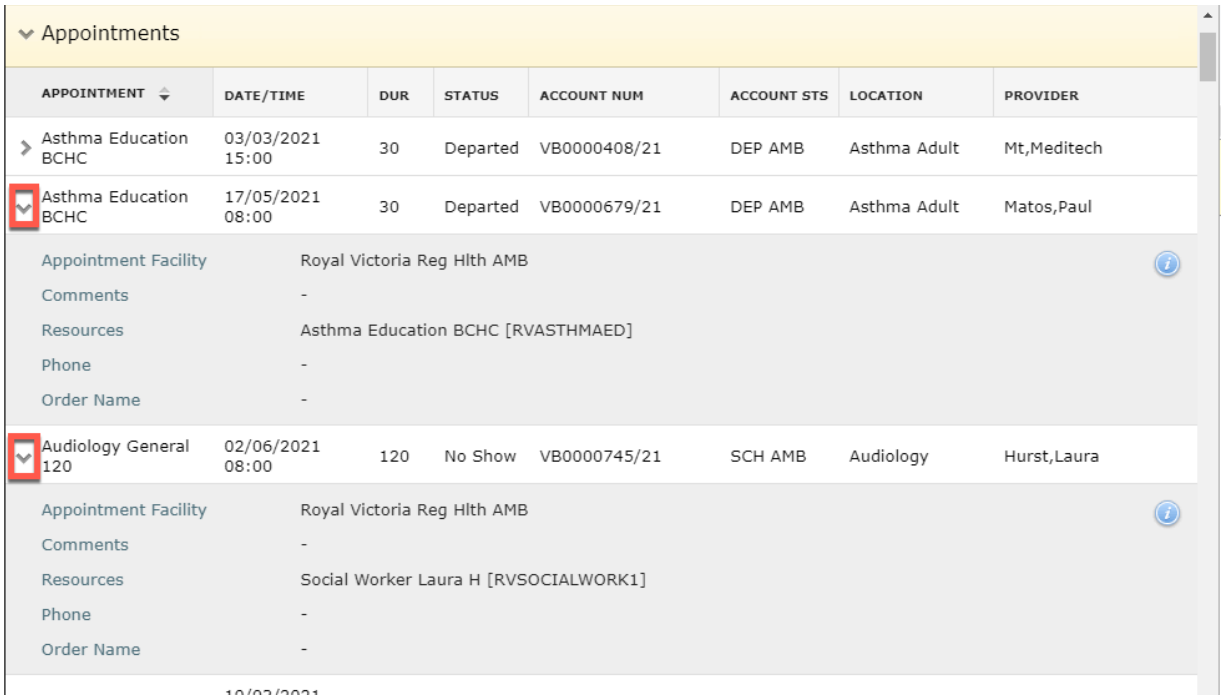


Administrative

Appointments

APPOINTMENT	DATE/TIME	DUR	STATUS	ACCOUNT NUM	ACCOUNT STS	LOCATION	PROVIDER
Asthma Education BCHC	03/03/2021 15:00	30	Departed	VB0000408/21	DEP AMB	Asthma Adult	Mt,Meditech
Asthma Education BCHC	17/05/2021 08:00	30	Departed	VB0000679/21	DEP AMB	Asthma Adult	Matos,Paul
Audiology General 120	02/06/2021 08:00	120	No Show	VB0000745/21	SCH AMB	Audiology	Hurst,Laura
COPD Follow Up	10/03/2021 08:30	60	Departed	VB0000454/21	DEP AMB	COPD Clinic	Matos,Paul
COPD Follow Up	05/03/2021 12:30	60	No Show	VB0000397/21	SCH AMB	COPD Clinic	Matos,Paul
CT Abdomen WO		15	Discontinued	VB0000217/21	DEP AMB	Imaging	Matos,Paul
CT Abdomen WO		15	Discontinued	VB0000253/21	DEP AMB	Imaging	Matos,Paul
CT Angio Renal	23/11/2020 16:00	30	No Show	WC0000005/20	SCH CLI	Diagnostic Imaging Headwaters	Aasheim,Lise Holm
CT Chest Abdomen Pelvis W	04/11/2020 15:15	15	Attended	VC0000010/20	REG CLI	Imaging	Matos,Paul
CT Chest Abdomen Pelvis W	04/11/2020 11:00	15	Attended	VC0000011/20	REG CLI	Imaging	Matos,Paul
CT Liver Biopsy	18/11/2020 10:45	30	No Show	VC0000017/20	SCH CLI	Imaging	Abadir,Wadid Wassef Kh

To view individual appointment information, click on arrow beside the desired appointment to view expanded information



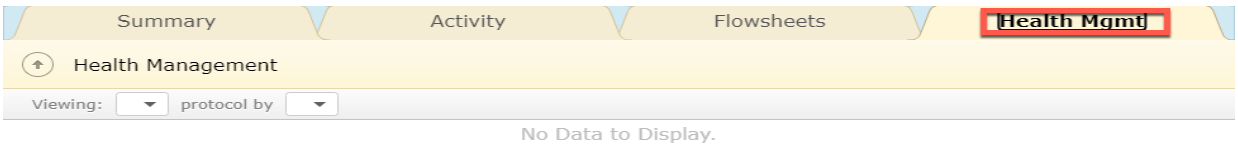
Administrative Tab – Demographics: contains more detailed contact information than located within the Summary Tab. It also includes additional contact information for clients, if provided

Other Clinical Tab: contains a miscellaneous list of information:

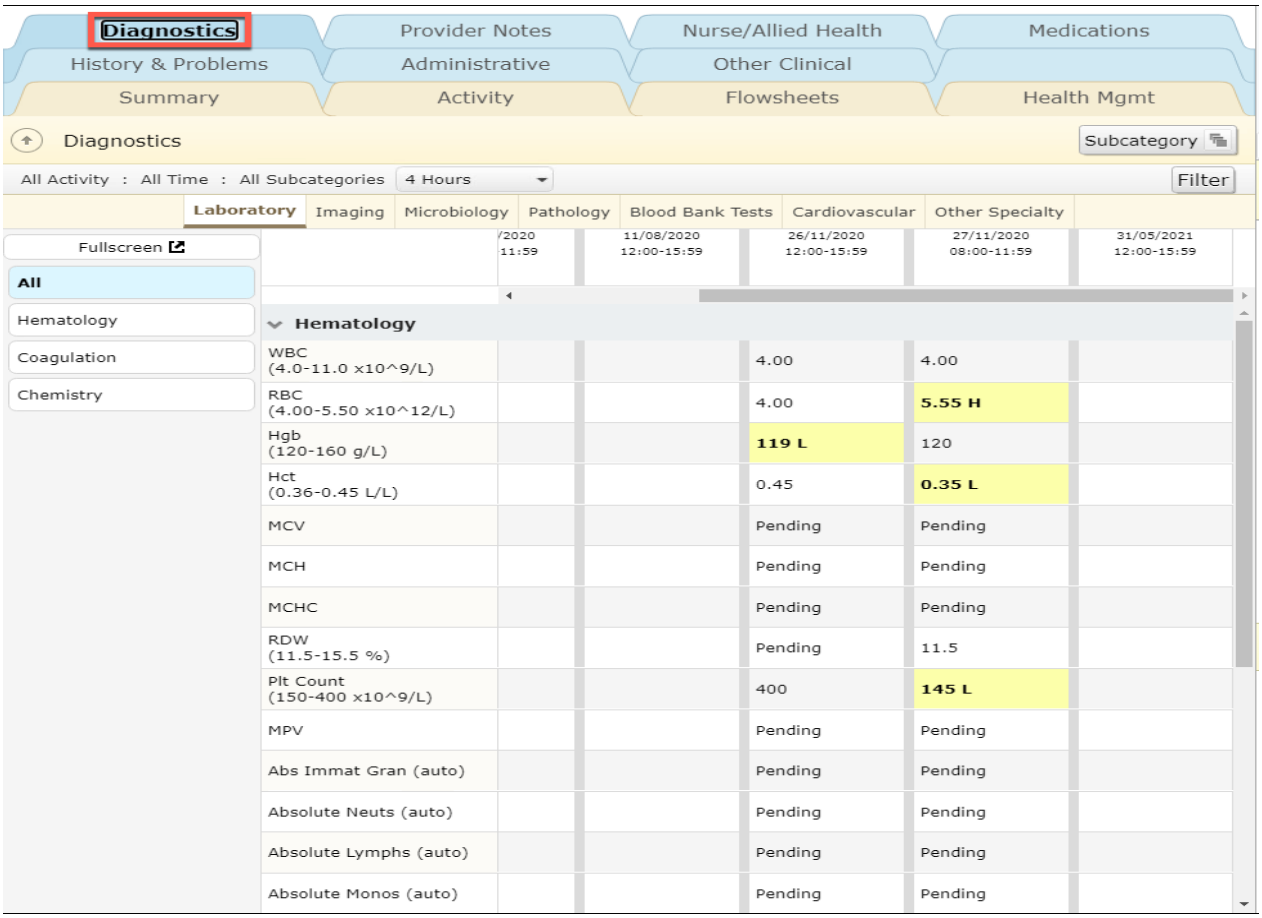
- Referrals
- Growth Chart
- Care Team
- Client-Specific Workload Items
- Order List

- Allergies/Adverse Reactions
- Bulletin Board
- Other sections related to Acute Care in hospital settings

Health Management Tab - No current uses for the Health Management Tab (possible future functionalities)



Diagnostics Tab - will contain Diagnostic Imaging results and images



Provider Notes Tab

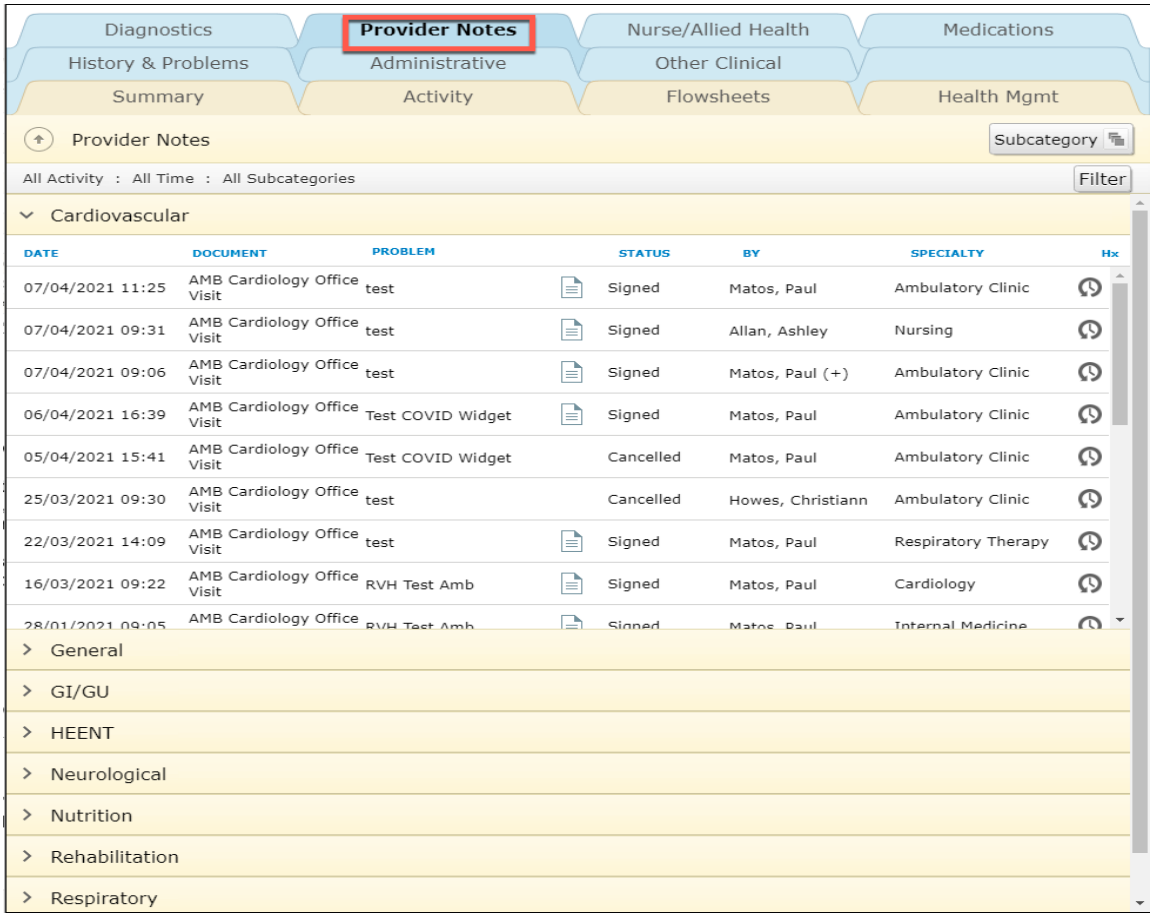
The Provider Notes Tab provides a comprehensive list of notes documented within client chart, including:

1. Date of each visit note was documented on

2. Audit trail of document

3. Document status

4. Appointment type (listed under “problem”; corresponds to “visit reason” when appointment was booked



Provider notes can be sorted by:

- Specialty
- Date
- Subcategory

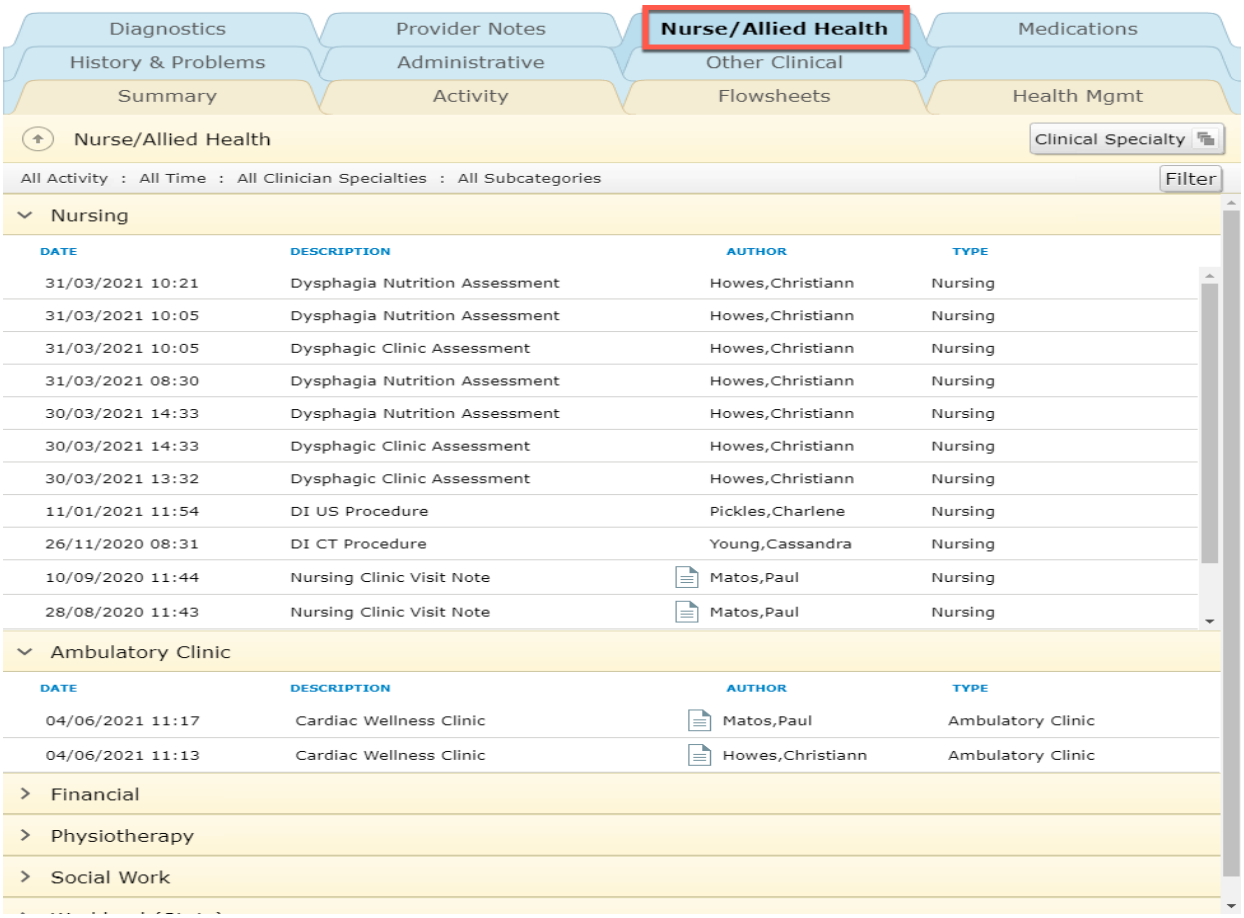
Additional sorting can be done by:

- Clicking on the “date” button located in the grey bar above the list of notes
- Selecting the desired sorting mechanism (specialty, date, or subcategory)

Provider notes can be filtered by:

- Clicking on the “filter” button
- Filter by any/all desired filters (care settings, time frame, subcategory)

Nurse/Allied Health Tab



Nurse/Allied Health Tab contains a comprehensive list of all scanned documents within the client chart. All scanned documents are visible in chronological order.

Medications Tab

The Medications Tab contains a list of all confirmed medications, as entered by appropriate clinicians

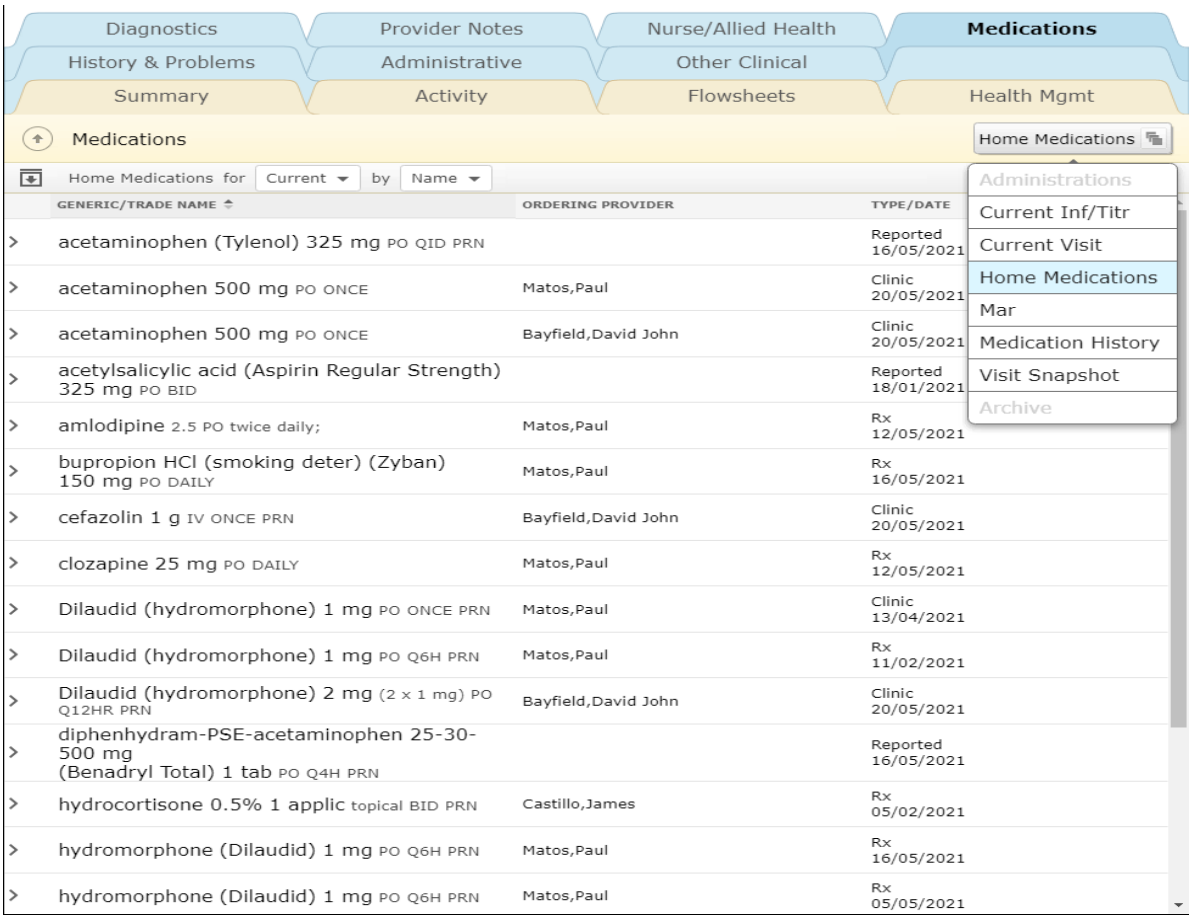
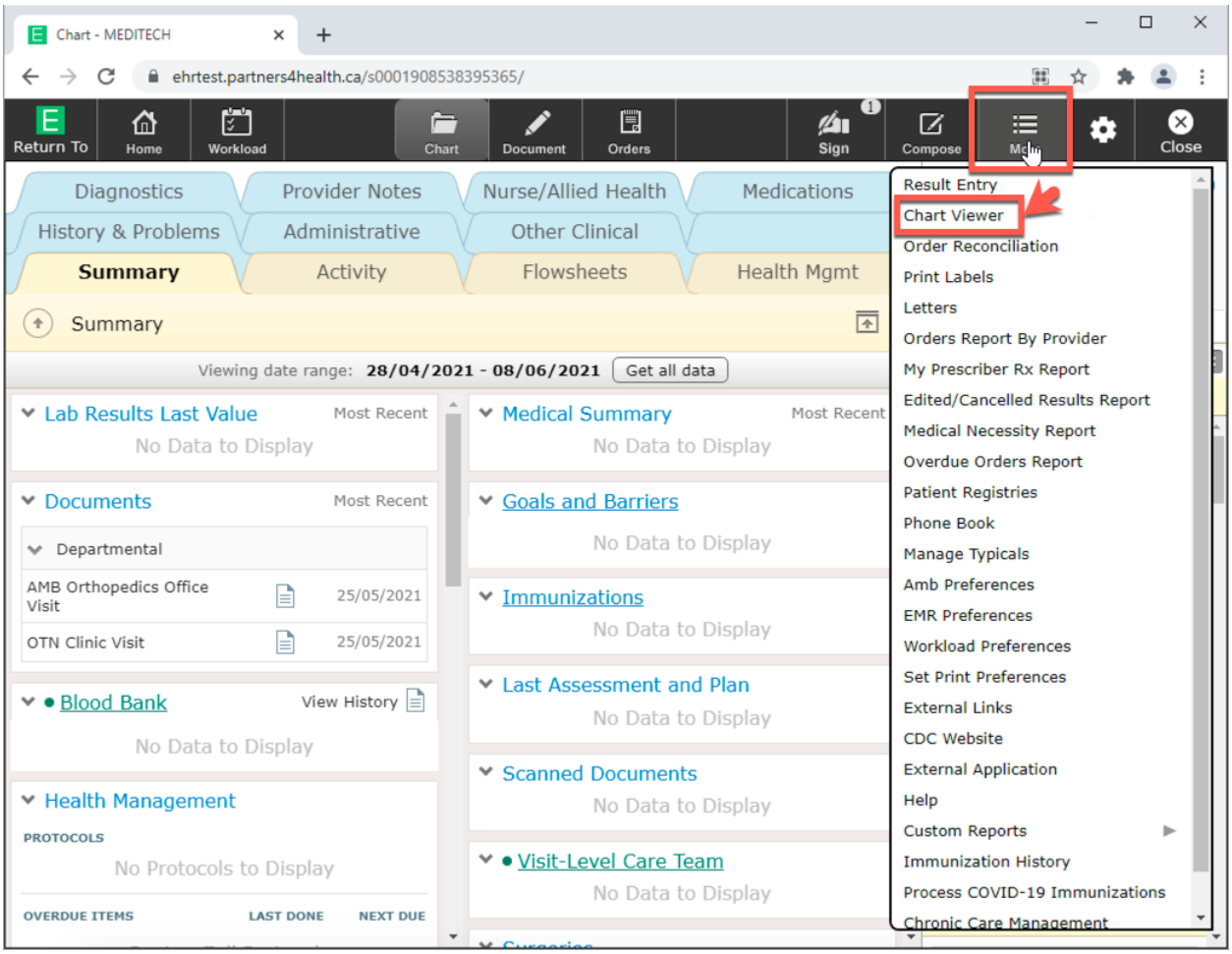
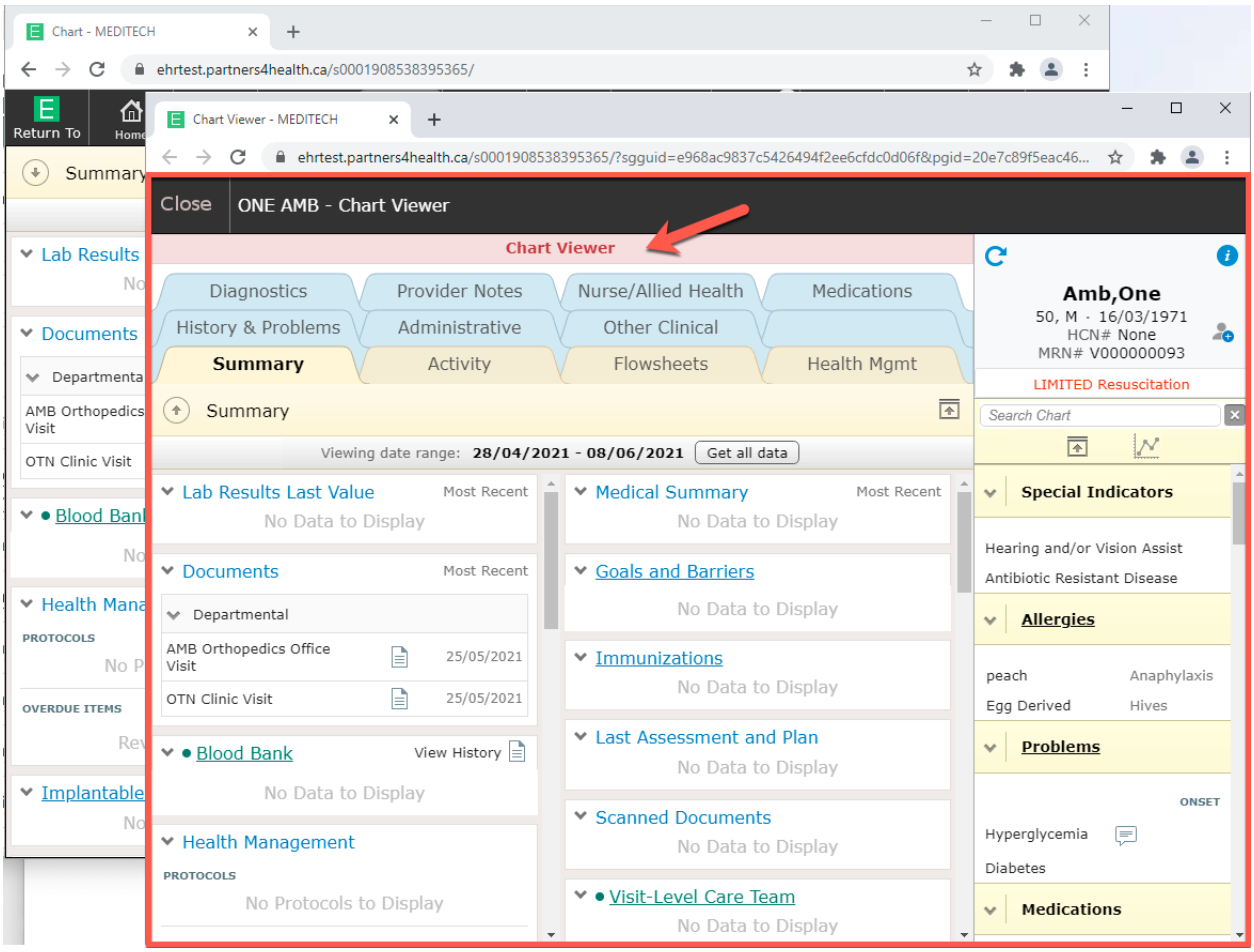


Chart Viewer

The Chart View is used to review a patient chart while simultaneously working on other EHR tasks. Within the ambulatory module it is possible to place orders and keep the chart open for reference while doing so. By selecting the More Menu in the black navigation bar, click on the Chart Viewer option.



The Chart Viewer opens in a separate browser tab. The pink ribbon indicates that you are in the Chart Viewer version of the Chart. Notice the chart, document, and orders icons do not display in the Chart viewer. In the Ambulatory setting, you can only view the various tabs of the chart in Chart Viewer to access additional information. Your original tab with Expanse remains open. The browser tab for the chart viewer can be dragged to a second monitor if available.

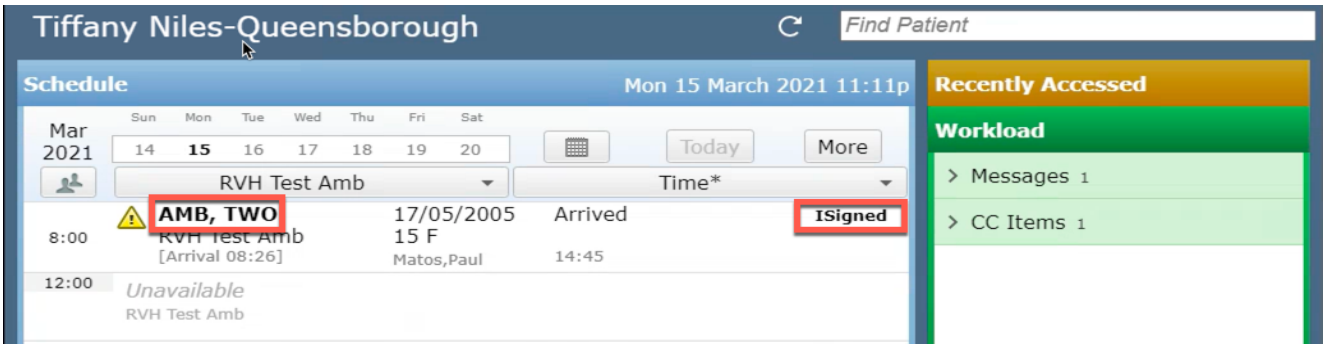


Documentation

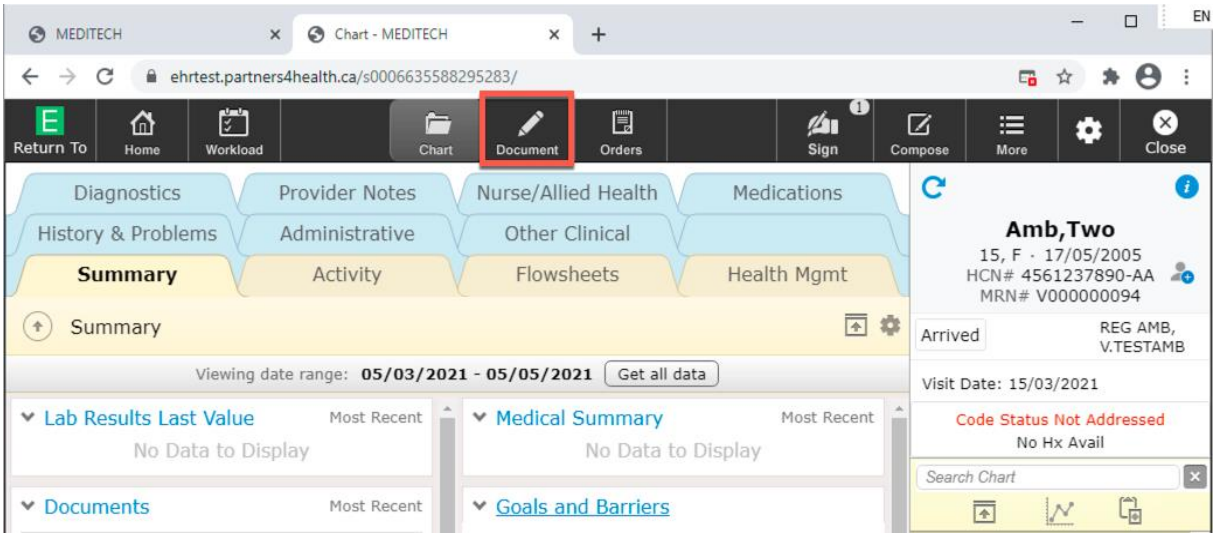
Access to Documentation

To initiate or manage an existing document report, there are two best practices to ensure documentation occurs on the correct client visit. The first way is to click on the patients name from the Clinical Home Schedule. The second way to access a document is by clicking on the status of the document associated with the patient within the appointment cell. For example, the status for the document associated with the patient below is in Isigned status. By clicking on the word ISigned it will take you directly to the clinic specific document report. It is strongly recommended to access documentation

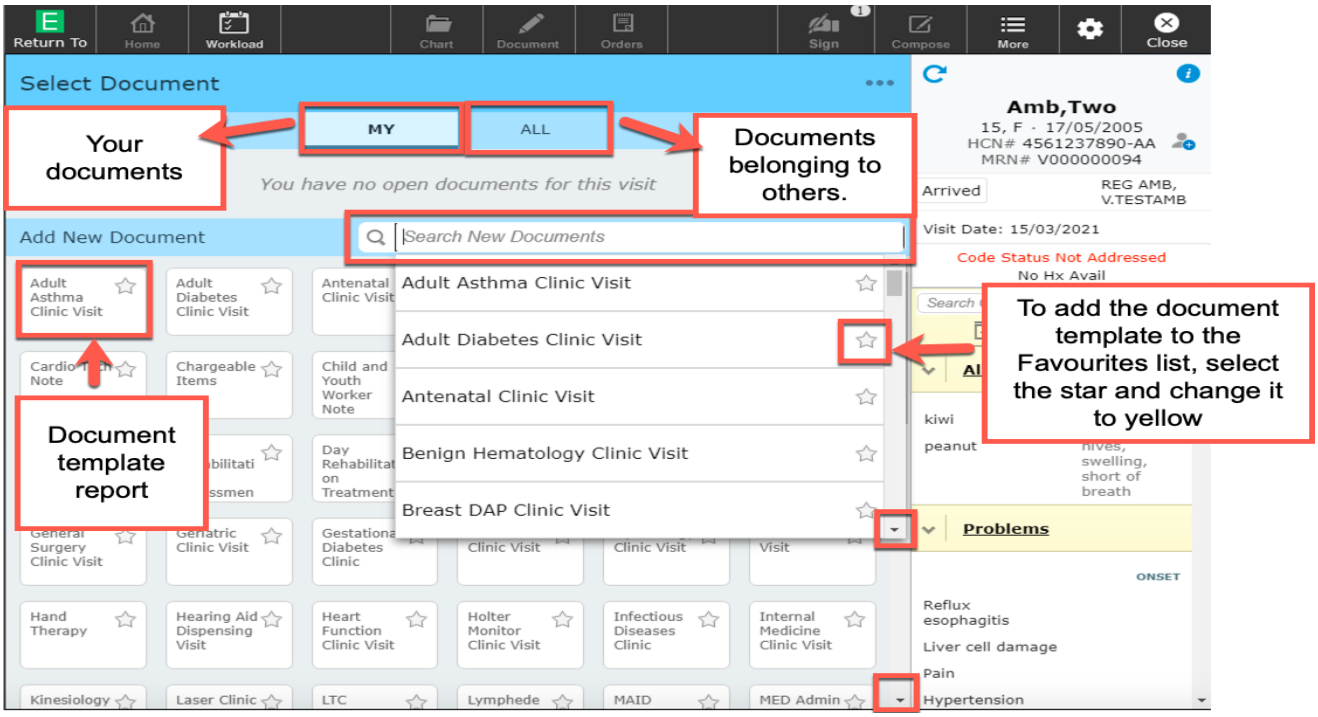
from the Clinical Home Screen or the Scheduling Grid appointment to enable access to the right visit.



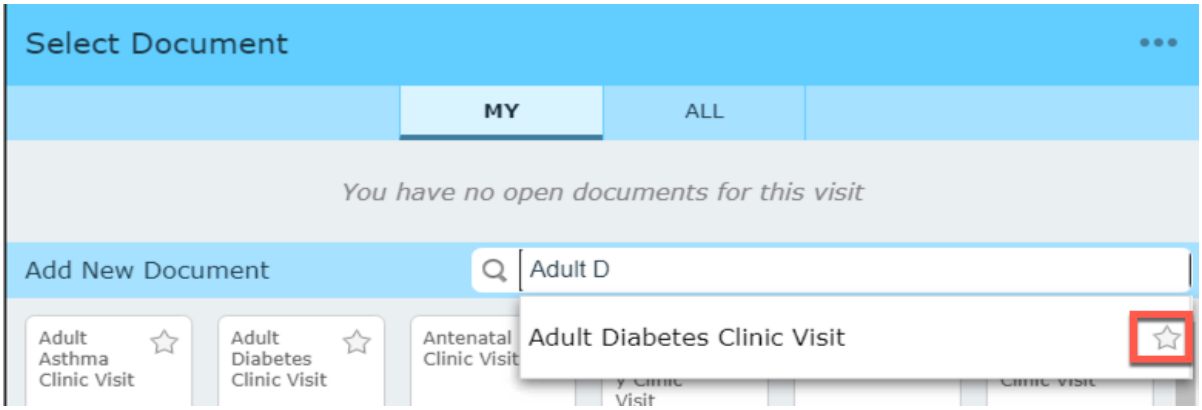
Once the patient visit is selected, the Chart will open and display. To access Documentation, select the Documentation icon on the Black Navigation Bar.



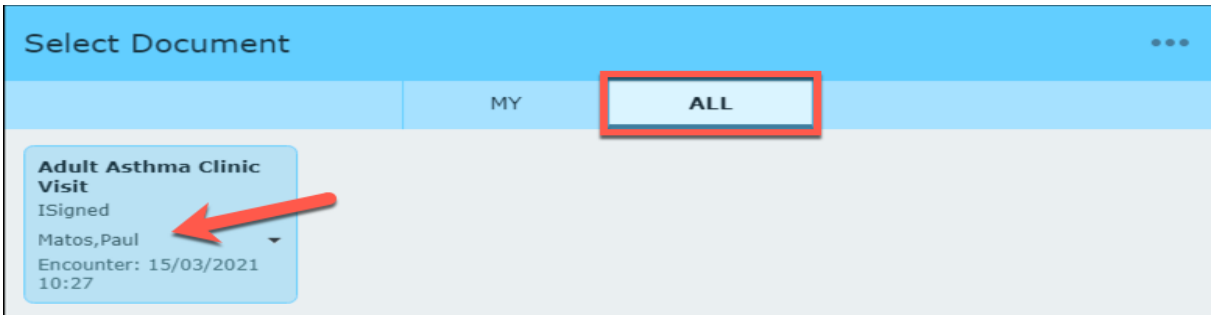
The Document button will open the Select Document screen. Upon first entry, the Select Document screen present two tabs, My and All, text that indicates “You have no open documents for this visit,” A Search New Documents search field and a series of square tiles labeled with document report titles. Each tile represents a documents report templates also known as Clinic Notes. Use the scroll bar on the right of the screen to view all of the Ambulatory Clinic note report templates. The alternative option to find a report is to use the Search New Documents. Select the field to expose the drop-down menu.



To search for a document, type in the name title in the search field.

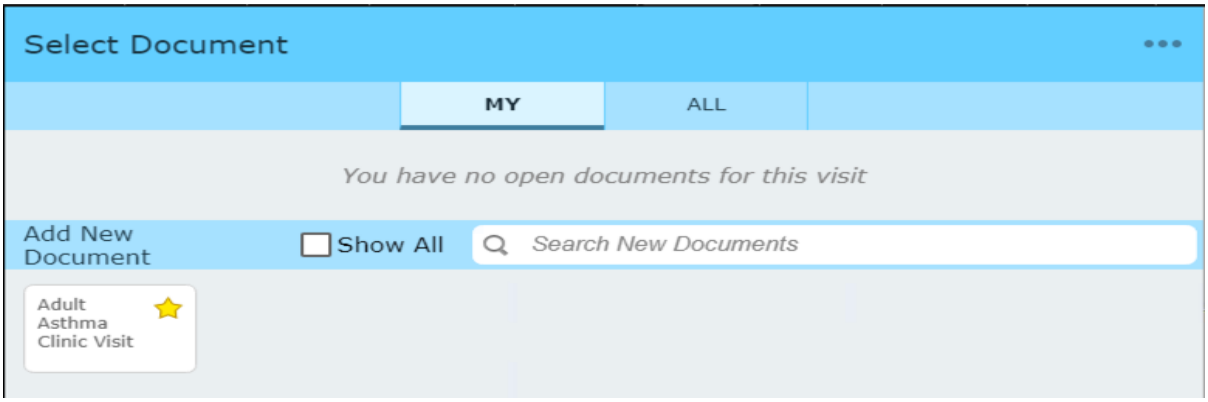


Note: Prior to beginning a new document or selecting a draft, it is critical that clinicians ensure that the “MY” section of the “select document” page is highlighted. The selection of the “ALL” button will allow clinicians to see all other clinical documents authored by other clinicians. If you document on a draft document under the “ALL” button, it will add you as a contributor and may result in documentation errors.



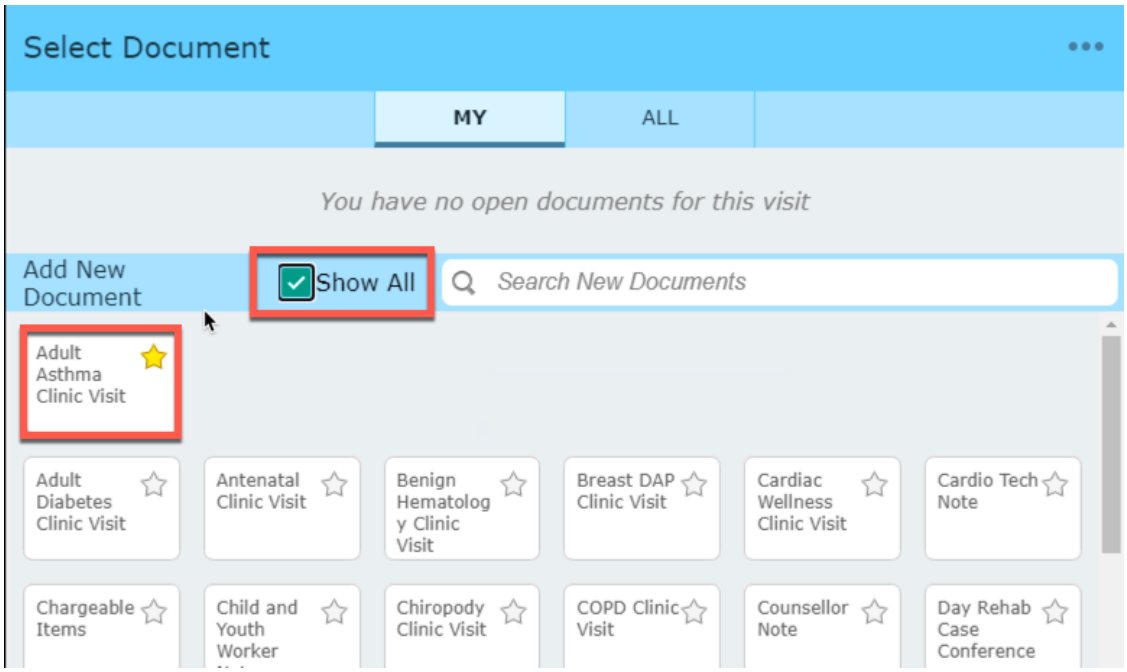
Favourite Documentation

To add a document to the favourite list, type the name of the desired document within the free text box. Prior to clicking on the title of the document, click to highlight the star on the right-hand side of the document title. This will automatically add the document to the Favourite list.

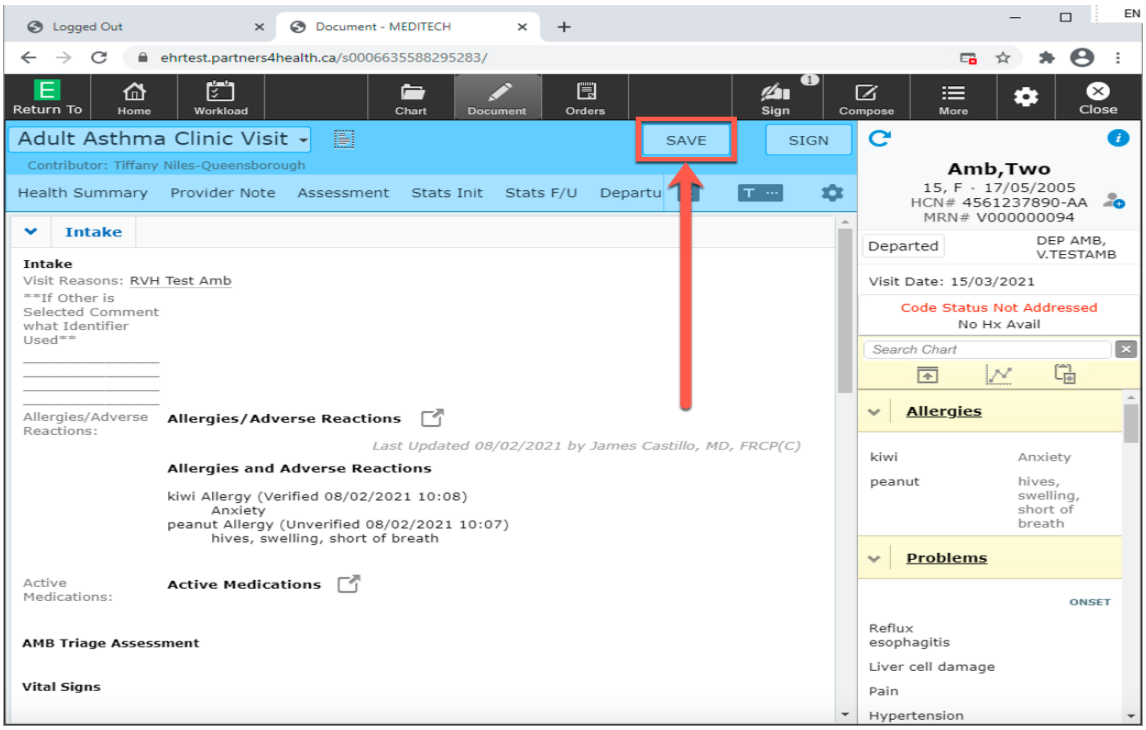


When documents are starred, they will appear as a clinician's preferred or favourite documents and will become available on the document home screen of each client that clinician sees

After adding a favourite document to the list, to return to the view with all document report templates, return to the "My" section of the Select Document screen. On this screen click on the box beside "Show All" label which will display all of the tiles again.

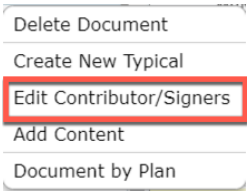


As mentioned, to begin documentation, type into the free text box within the “select document” section, and click on the desired title to open a new document. Or select it from the list of favourites if they have already been starred.

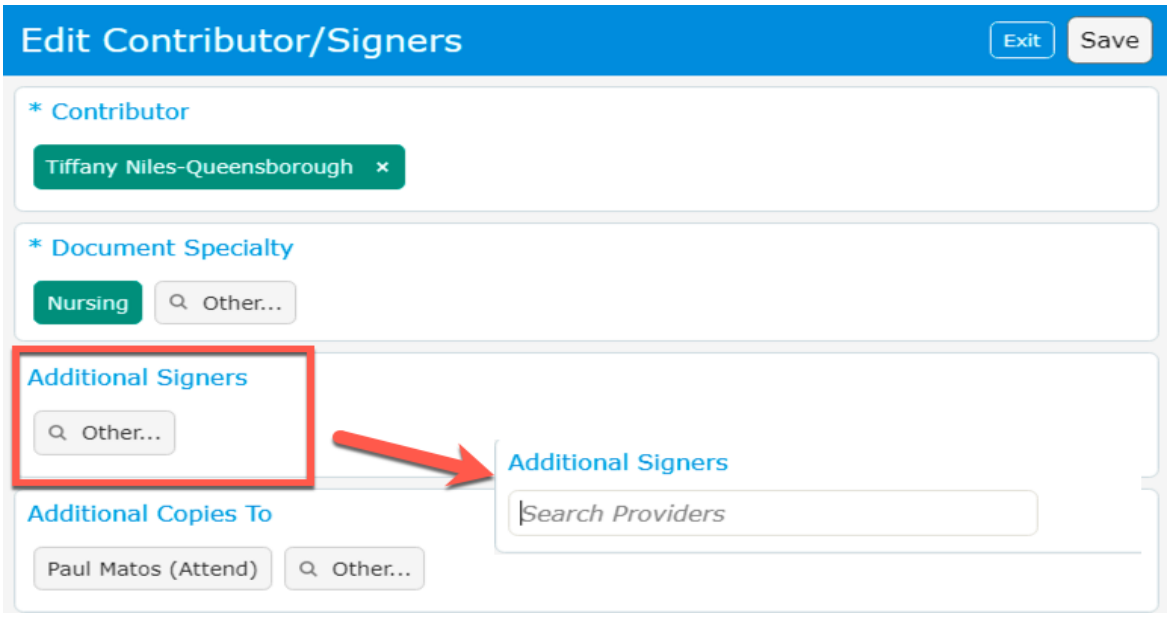


Upon entering the document click “Save” immediately to ensure the document is saved and to automatically add yourself as the document’s author.

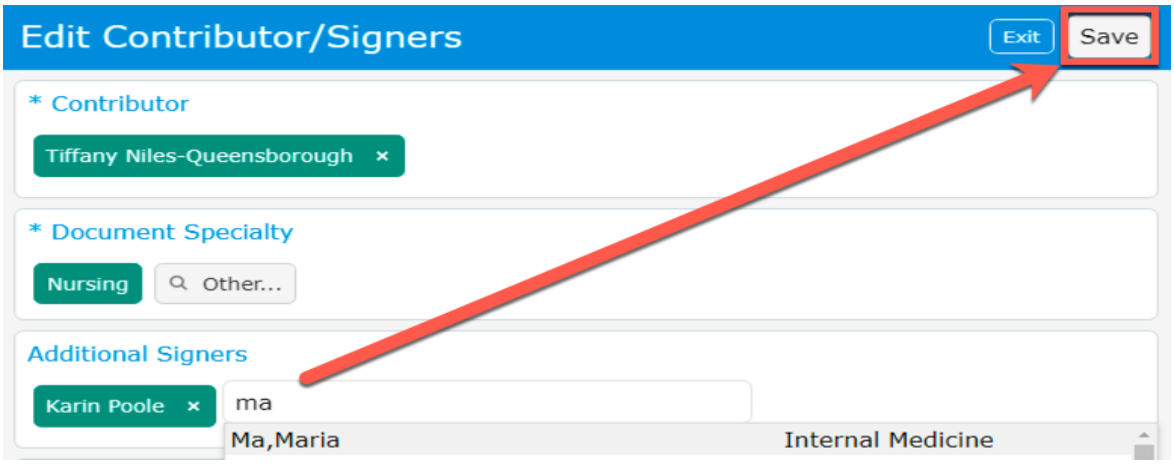
Co-signers should also be assigned immediately to support multidisciplinary documentation. To add a Co-signer, select the gear icon and then select the option to “Edit Contributor/Signers”.



The Edit Contributor/Signers overlay will display. Locate the Additional Signers section and select the “Other” button.

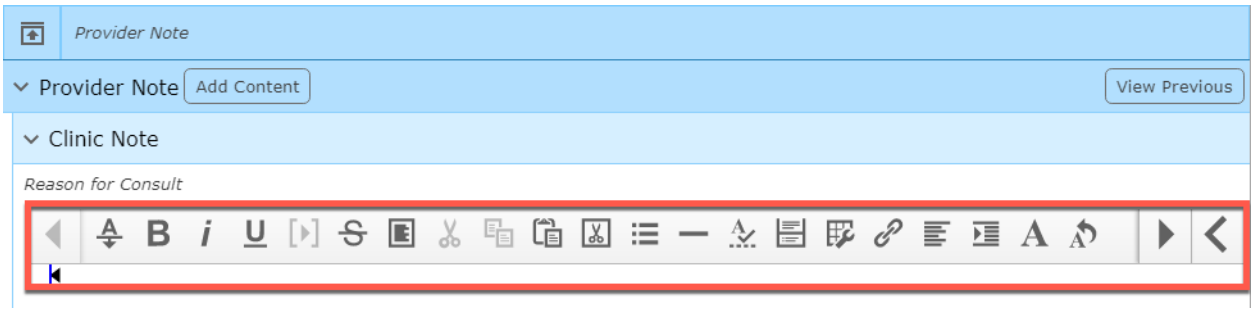


Search for each provider and select the name from list to add them as an Additional Signer. Select Save once complete.



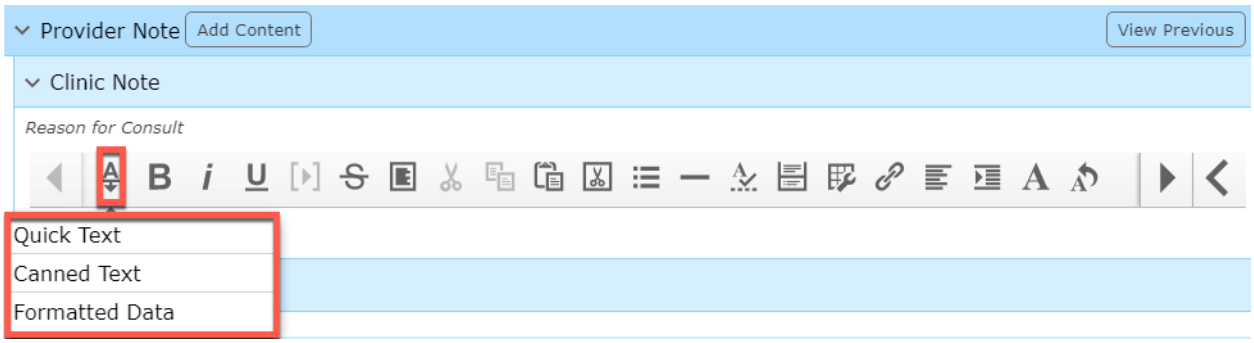
Documentation Navigation, Layout and Associated Functionality

Meditor



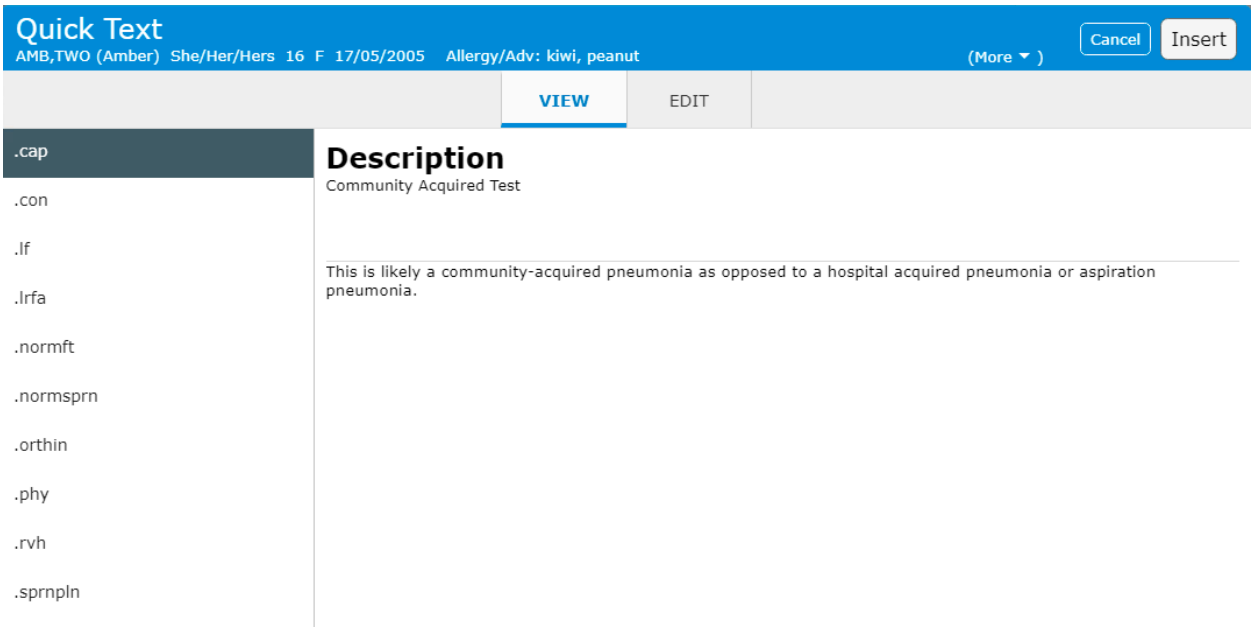
Use the Meditech Word Processor (Meditor) to enter and format free text within a patient's chart. Click inside the comment box to access the text toolbar. Use the Insert Additional Text button to quickly pull in previously captured quick text, canned text, formatted data, and saved data quickly.

Quick Text



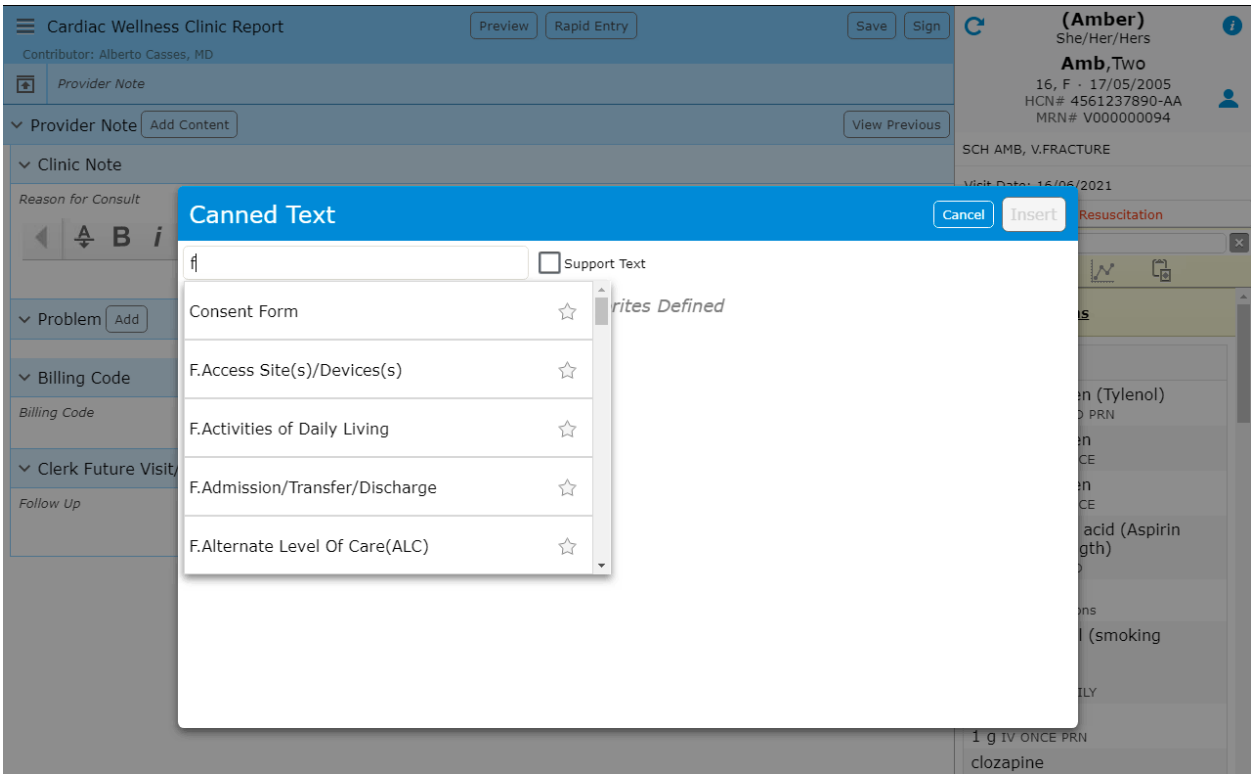
Use the Meditech Word Processor (Meditor) to enter and format free text within a patient's chart. Select inside the comment box to access the text toolbar. Use the Insert Additional Text button to pull in previously captured quick text, canned text, formatted data, and saved data quickly.

This screen appears when you select the Quick Text option from the Meditor when documenting a patient's chart. Use this function to access the Quick Text Popover. Use Quick Text to access pre- defined text by entering trigger characters.



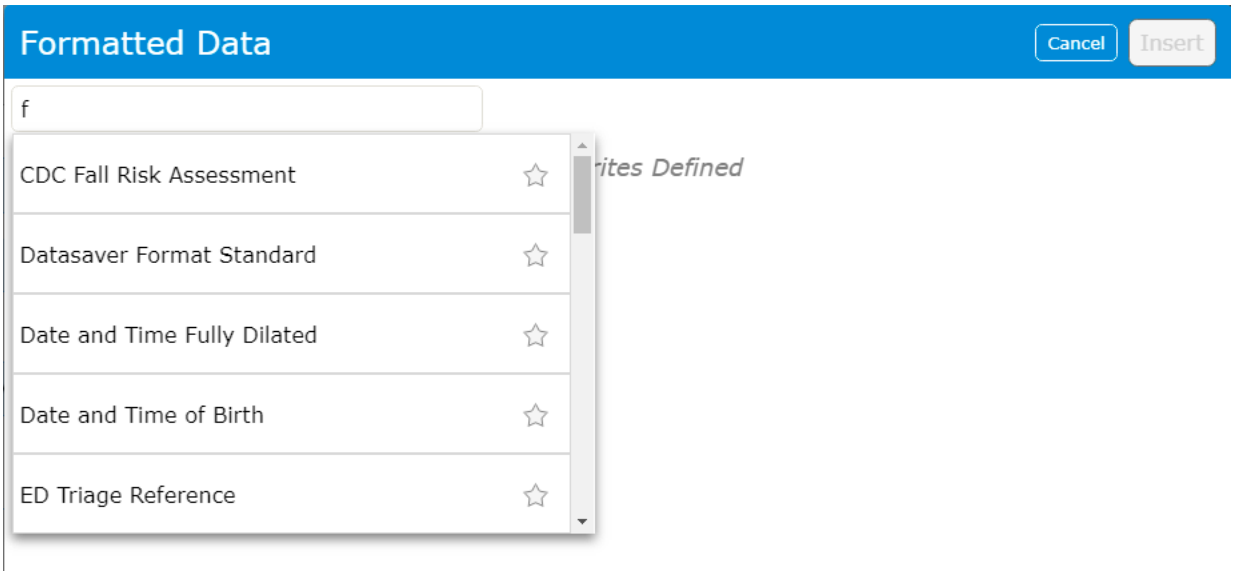
Canned Text Popover

This screen appears when you select the Canned Text option from the Meditor when documenting in a patient's chart. Canned texts are frequently used text passages that you can store and use as needed. Canned text can include data fields that are replaced by data from the application database when you insert the canned text into a text file. Canned text allows you to enter documentation once and then retrieve it from wherever you are working. Using canned text eliminates the repetitive, time-consuming task of entering the same documentation in several places.



Formatted Data Popover

This screen appears when you select the Formatted Data option from the Meditor when documenting a patient's chart. This is a compilation of free data sets.



DataSaver Overlay

Use this screen to select a patient's information while you review their medical record, and then insert that information into your documentation.

Right-click Chart items to add them to the DataSaver. A diamond appears next to the selected items. Select the **Add to Saved Data** option to save the data.

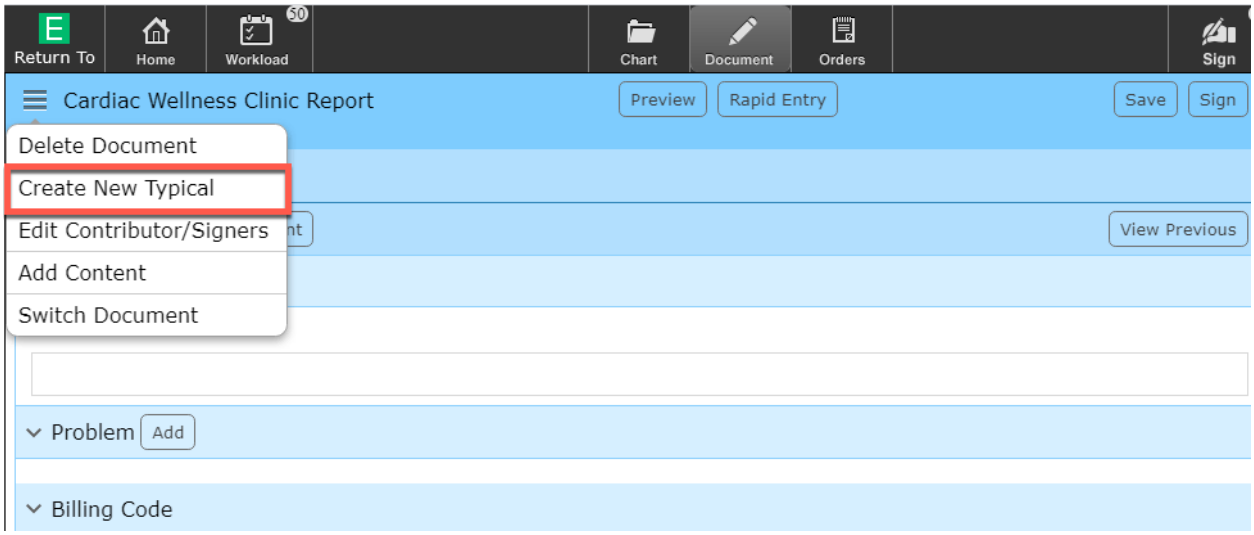
Once in the text editor of the document, you can insert the saved items by selecting the Additional Text icon, and then select the Saved Data option. Select the items you want to insert from the Saved Data Screen. DataSaver information inserted into notes appears in a table format. You can edit the text if necessary. The DataSaver includes only the data saved by you for the current patient.

In addition, when this screen appears, you have the option of adding data to your widget or the patient widget, or accessing websites for reference. If you right click on a value, for example, a patient's weight, you can quickly add values to the My Widget or Patient Widget. Click the red **X** to remove the value from the widget.

Typicals

Typicals are pre-set response sets that can be created by clinicians and quickly inserted into documents. This may be useful for commonly used phrases and recommendations:

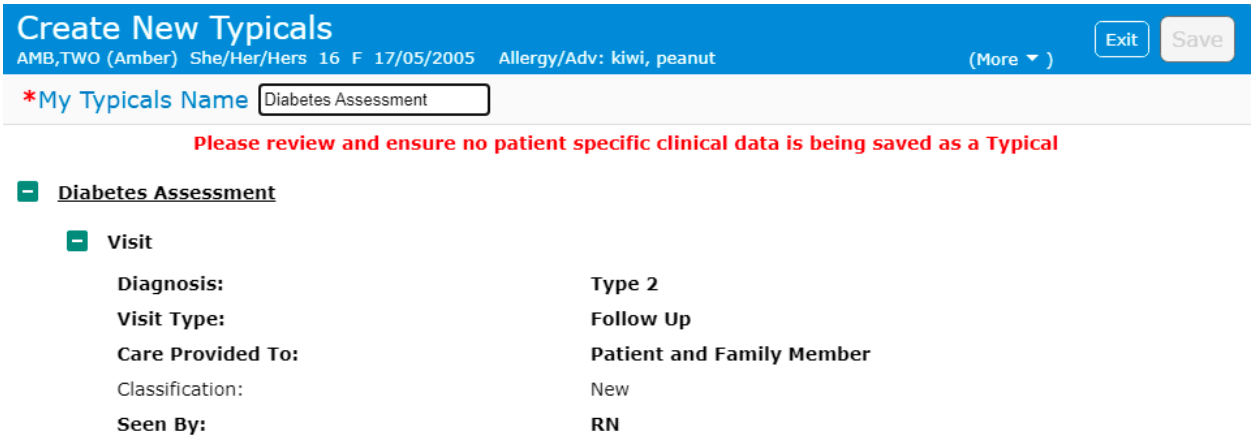
- Typicals are designed to increase efficiency in documentation
- As with any data pull, the clinician is responsible for reviewing pulled information to ensure it is accurate
- Once set, typicals are available to use on any client a clinician sees, when using that document



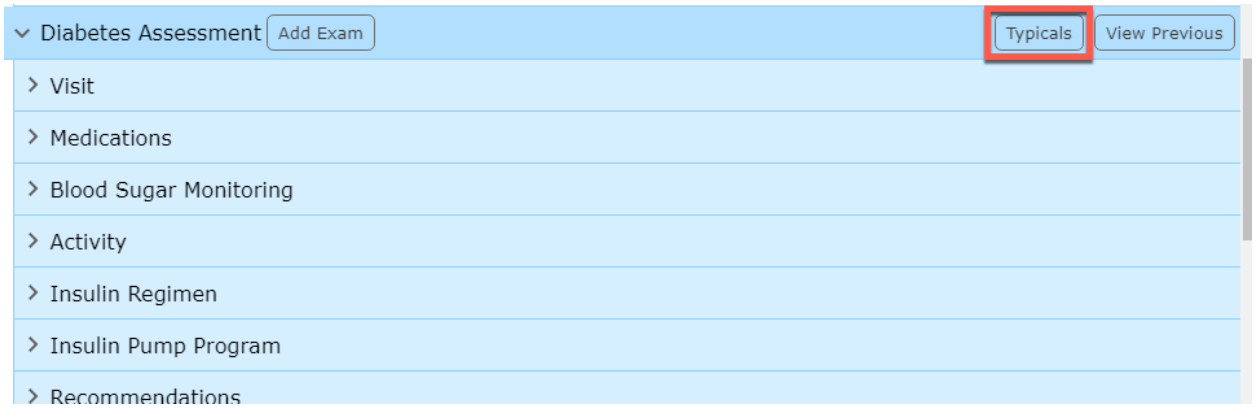
To create a Typical:

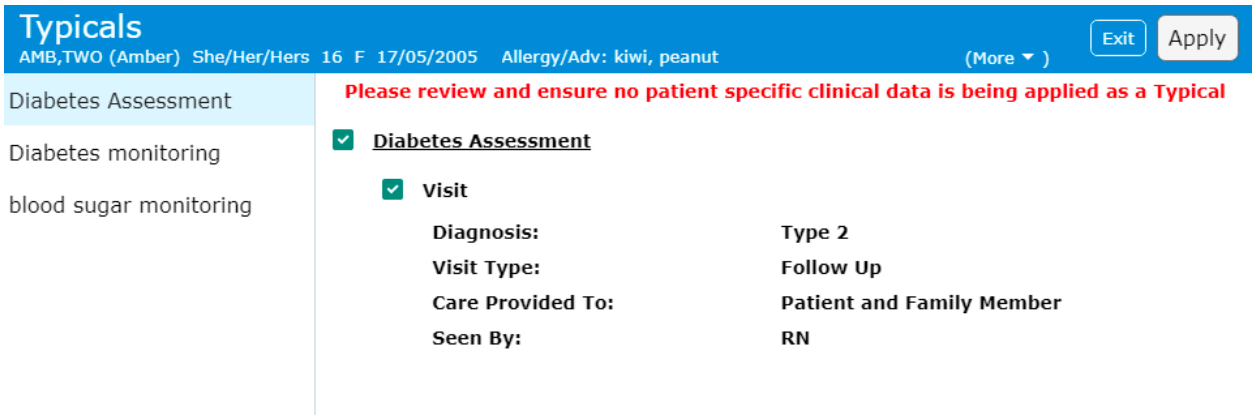
1. Open a desired document within the documentation section
2. Type any desired response/data into sections within the document
3. Select the gear icon from the right-hand corner of the light blue bar at the top of the document
4. Select “create new typical”

5. De-select (uncheck) any undesired sections from the menu
6. Review typical information to ensure no client-specific information is being saved
7. Click “save” in the upper right-hand corner of the blue bar



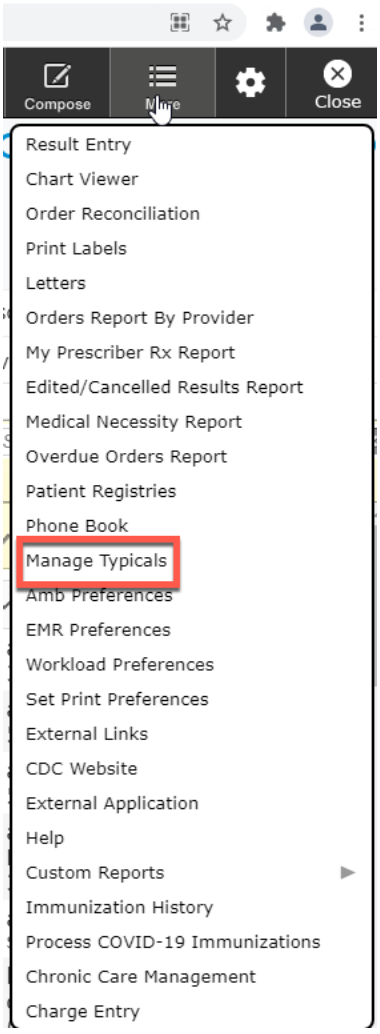
- To insert a previously created typical into a document:
  1. Open the desired document
  2. Select the “typical” icon from the right-hand side of the darker blue bar at the top of the document
  3. Select desired typical





- To manage/ delete typicals:

1. To delete typicals set in specific documents click the ‘More’ button from the black bar
2. Select ‘Manage Typicals’.
3. A drop-down menu will display the list of created typicals. Click the ‘X’ located beside a desired typical to remove (delete)
4. Select ‘Yes’ from the confirmation pop-up to confirm the deletion
5. Click “save” to save changes to typicals list



Quick Text
Quick Text can be accessed within Meditor boxes, by clicking on the icon on the left-hand side of the menu and selecting “Quick Text”

- To create quick text after selecting the option within Meditor Boxes:

  1. Click EDIT from the grey bar

  2. Enter desired trigger in the text box that opens it.

  NOTE: It is recommended that triggers start with a period followed immediately by a trigger word/ letters (i.e., “.text”)

  3. Add a description to indicate what content the quick text contains. Note that there is a character limitation of 30 characters for your title description.

  4. Write desired text within text box. This will be the text that appears after triggers are selected

  5. Click INSERT from the upper right-hand corner of the blue bar to allow for the changes to be saved.

- To Delete Quick Text:

  1. From the view tab, highlight the desired trigger and click “edit” from within the grey bar

  2. Click the red X beside the highlighted trigger to delete

Documentation Navigation

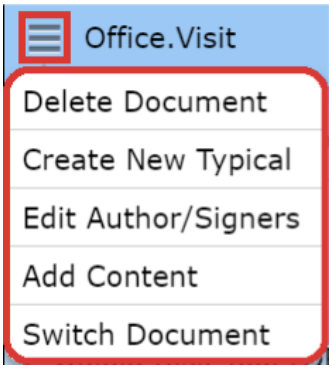
Every document will have tabs across the top within a light blue bar. These tabs denote different areas where clinicians can document. The tabs are also displayed in blue bars (accordions) throughout the document as you scroll down for ease of navigation. To

review the content in the various sections relevant to requirements for patient data capture, click on the queries or comment box fields. Any unselected tabs, sections, buttons, or boxes that are not written in will not appear in the document once signed (i.e., will not re-appear if adding an addendum or when printing).

The document template is divided into various sections

Document Tool Regions

1. **Document Button:** This button is used to launch the Select Document Routi78ne, which serves as a way to view all unsigned visit documentation and start new documents for the visit.
2. **Document Menu:** This menu provides access to options to:
    a. Delete a document
    b. Create a New Typical
    c. Edit Author/Signers
    d. Add new content (which adds a new section)
        e. Switch Documents (if a entered into a new document accidentally)



Document Menu Options Details:

The following features on the menu are further explained:

Delete/Cancel Document: Delete or cancel a document depending on whether it is in a Pending or Draft78 status.

Note: If this is a joint document, deleting or cancelling a document will do so for all users.

- To delete the current document that is in Pending status, select Delete Document from the list.
    - A confirmation message displays telling the user that this pending document will be deleted. Select “Yes” or “No” on this overlay to proceed.
- To remove a document that is in Draft79 status, users must cancel the document. This ensures the document has an audit trail.
    - A confirmation message displays asking whether the user wants to cancel the Draft79 document. Select “Yes” or “No” on this overlay to proceed.

- **Create New Typical:** Use this option to create a new Typicals entry on the fly. Typicals will be explained later in this guide.

- **Edit Author/Signers:** Use these options to change the author, additional signers, and secondary recipients of the document.

- **Add Content:** Use this option to add documentation sections to the current document template.

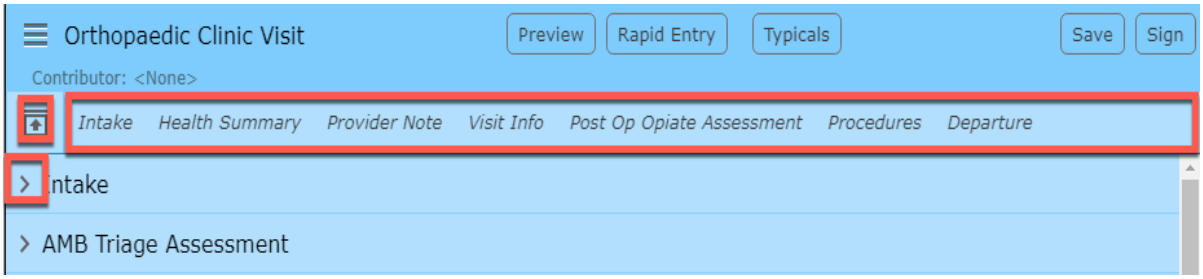
- **Switch Document:** Use this option to switch to another template if the incorrect one was selected or a different document is needed.

3. **Document Header Region:** This region provides the user with the current document template name and author. **It will display the title of the template and the co-authors also known as co-contributors.**

4. **Document Preview:** This button allows access the Preview Overlay to view the document output of what data was entered.
5. **Document Edit Mode:** Upon entering into a document template, the default view is the Review and Refine mode. The review and refine edit mode allow direct entry into the form and allows the user to toggle between the Review and Refine mode and Rapid entry view which displays all of the query bubbles and text field for ease of user data entry.
6. **Typicals:** This feature allows providers to pull in typical document responses to save me while performing documentation.
7. **Save & Sign Region:** This region of the tool allows the user to Save, Draft status80, or Sign the document. It also displays the last saved date/80me stamp. If a document has multiple contributors, until the document is signed by the last person, it will remain in “isigned” status, otherwise once signed will go into “signed” status.

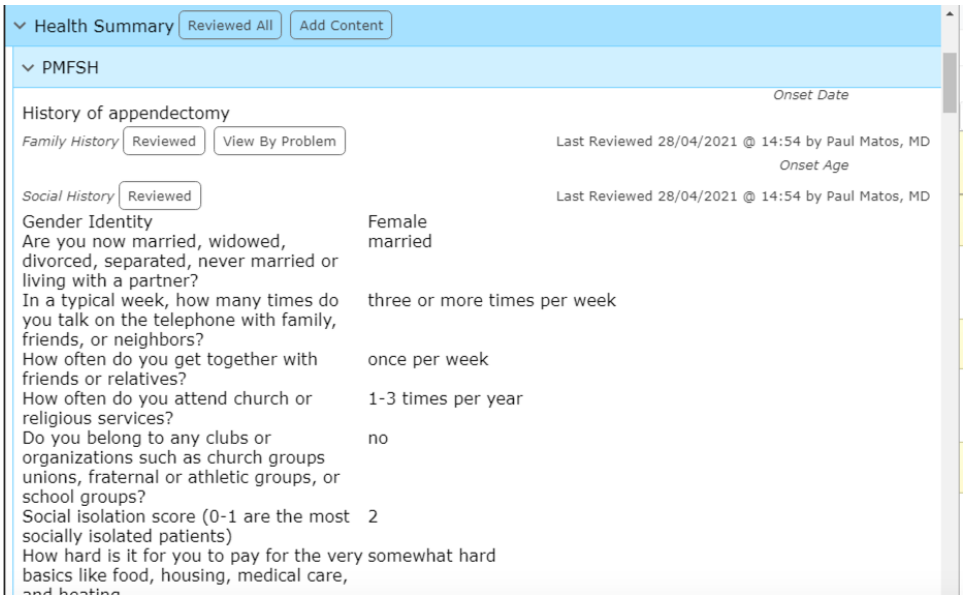
Documentation Navigation

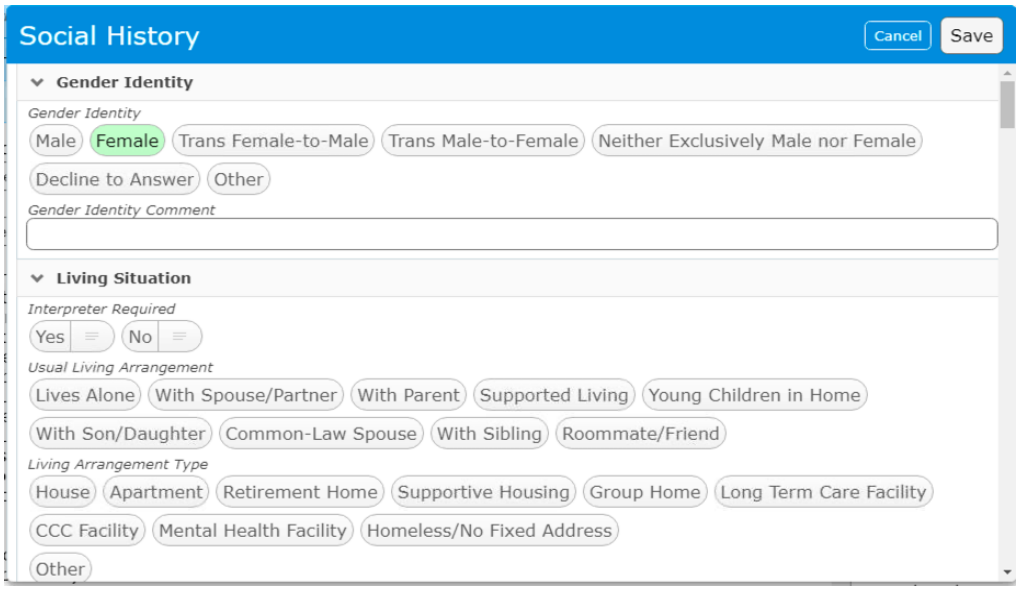
Section Slider and Section Accordion:



Common sections within Ambulatory notes:

The first tab in most notes is the Health Summary section, which offers clinicians the opportunity to edit the client’s Personal Family and Social History (PFSH).





The Patient Family Social History (PFSH) tab is accessible from every document. This allows clinicians to update any relevant client information that has changed between visits. The PFSH data will flow to the appropriate widgets on the client's chart

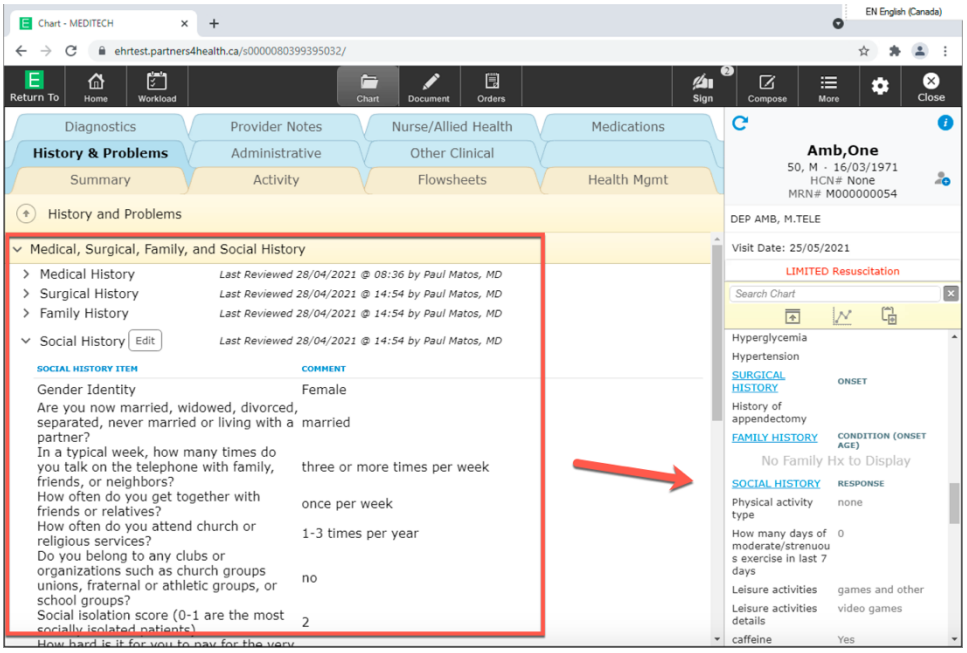
To review and edit the PFSH:

- Providers will need to review the PFSH. If you have reviewed and confirmed the information with the family, select “reviewed” under any section. That PFSH section will update with your name and the current date.

If you need edit any section of the PFSH

- In Documents and the History and Problems tab in the chart select the “edit’ button to launch an overlay in which you can document.

- Entering medical history (including diagnosis), surgical history, family history and social history (e.g., language and school information), it is recommended clinicians access the PFSH Quick Reference.



Documentation Layout

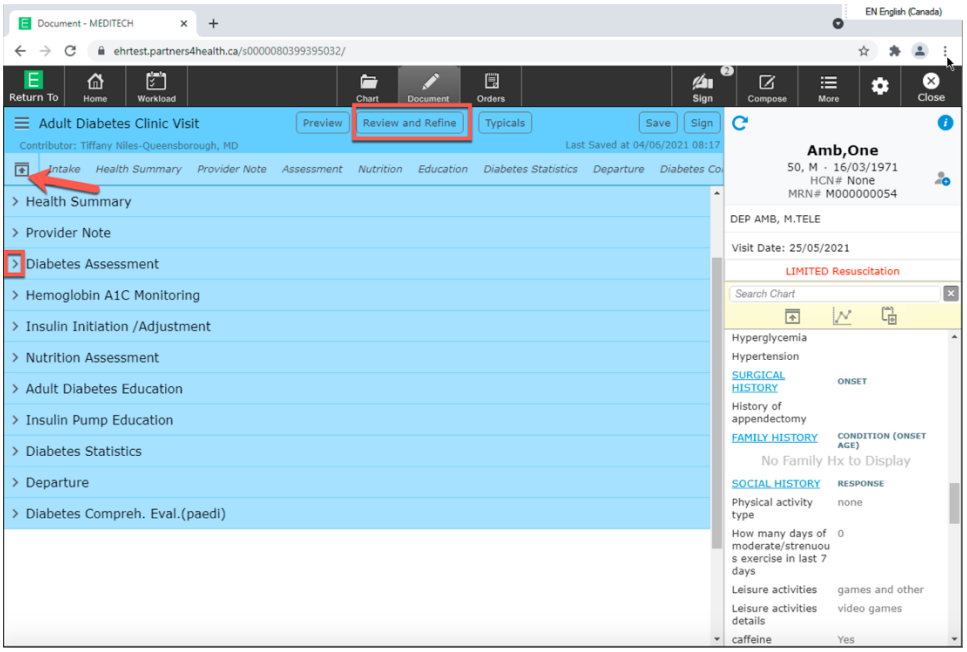
Document templates are built with section headers and accordions within each section.

- The accordions are titled to give the user an idea of what is included in that section (e.g., the “Visit Details” tab often includes information about when the visit occurred, who was present, etc.)

- To document fields within a given section: Click on the desired section header or the chevron blue accordion. Relevant queries for that section will be presented

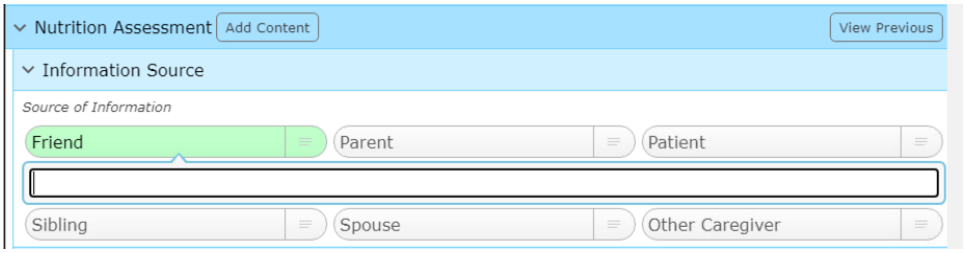
with various input options (e.g., buttons, text boxes, meditor boxes, etc.). There is a different in view based on the Review and Refine view or Rapid Entry View.

Note: Documenting in Rapid Entry View will decrease the amount of clicking for the user.



In Expanse, there various types of data entry that can be completed for inputting discrete and free text type information:

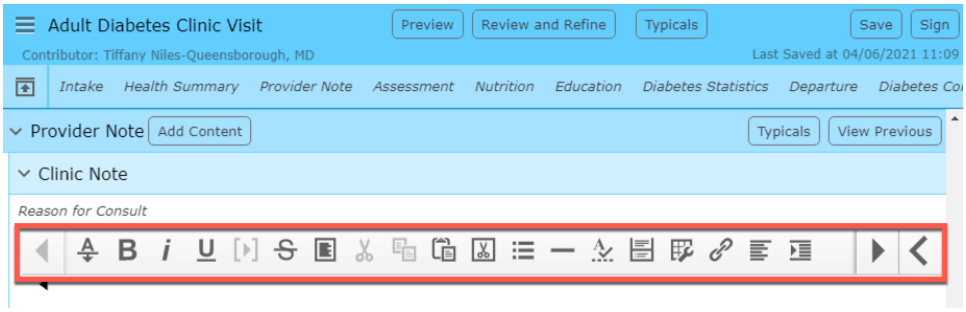
Queries and associated free text fields



To add free text within group response sections, clinicians can select the “burger buttons” allow for the documentation of extra information if required. Group responses allow users to select from multiple options.

Text boxes and Meditor boxes. Meditor boxes have new functionality a tool bar with an expanded tool bar with editing options including spell check, bold, italics, underline.

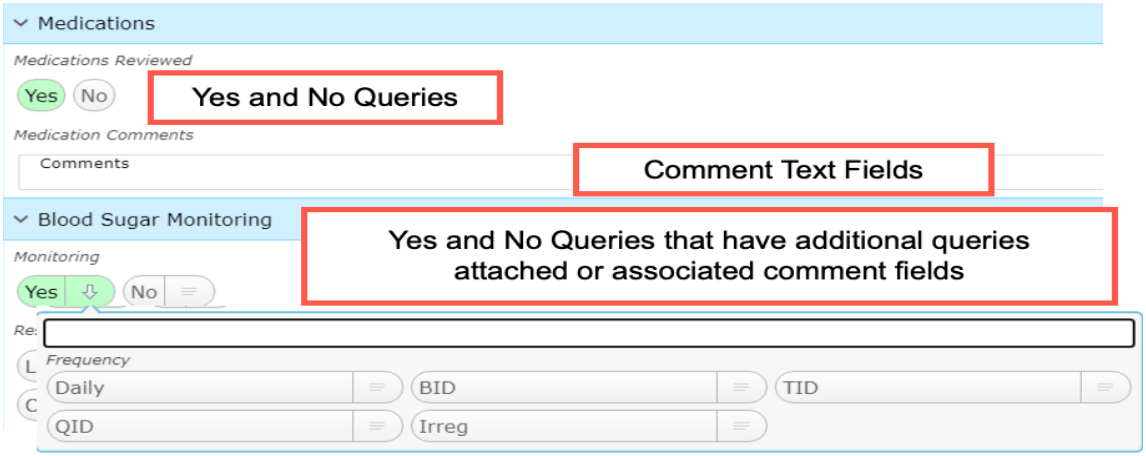
Pictures can also be inserted in Meditor boxes. Spell Check is available in Meditor boxes and in text boxes.



Text fields allow users to free-type text to provide desired information.

Some documents also contain branching responses and/or query responses:

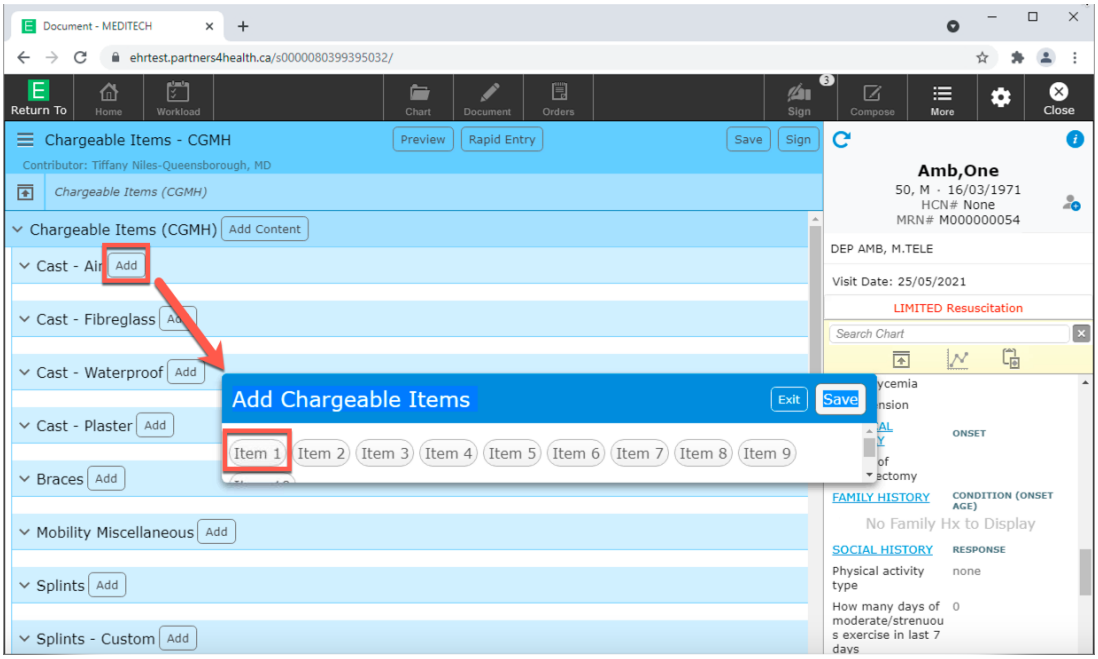
- Branching responses can be identified by the drop-down arrow on the right of the button. Clinicians must select the arrow and complete the next level of response in order to fully complete that response.

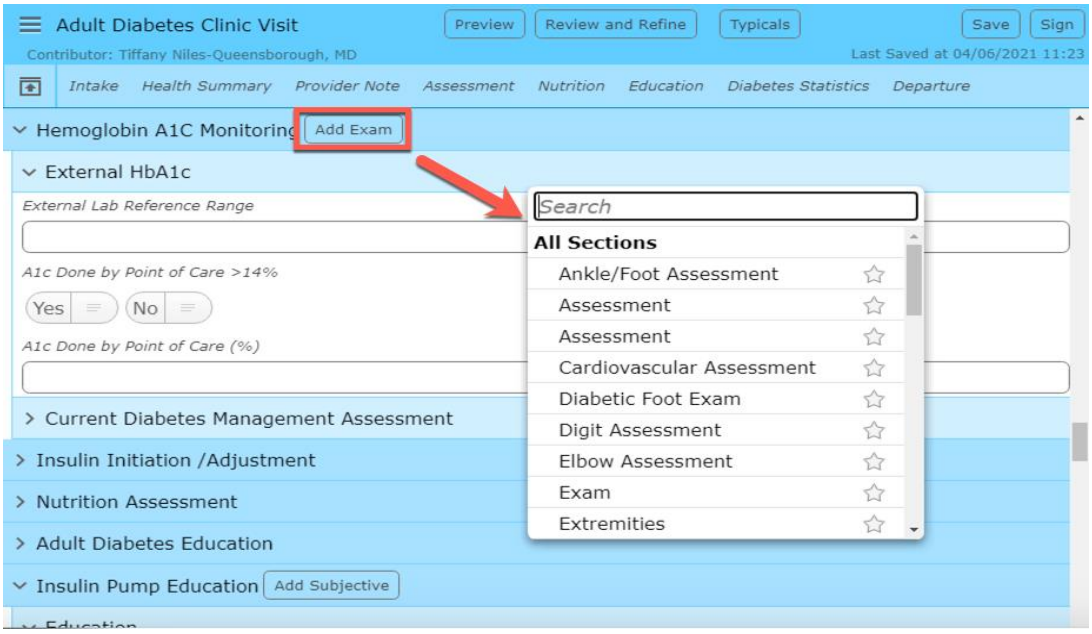


- Query Responses are often yes/no and require clinicians to select one response or the other. They may include a burger button or additional text box for details.

Instances can be added in documentation (e.g., date in assessments, new procedures, item in Mealtime Assessments, equipment items, etc.). Look for an “add” type button

beside an item on the accordion. In the example of Chargeables, each instance is an item that be itemized and charged.

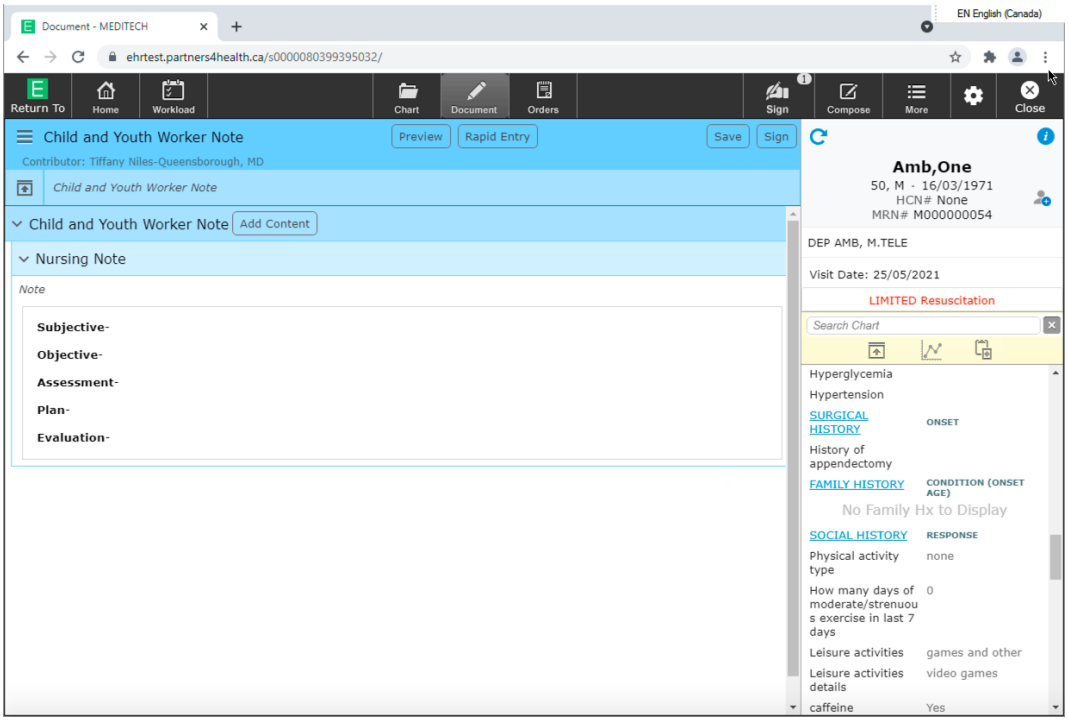




Nursing and Allied Health Progress Notes

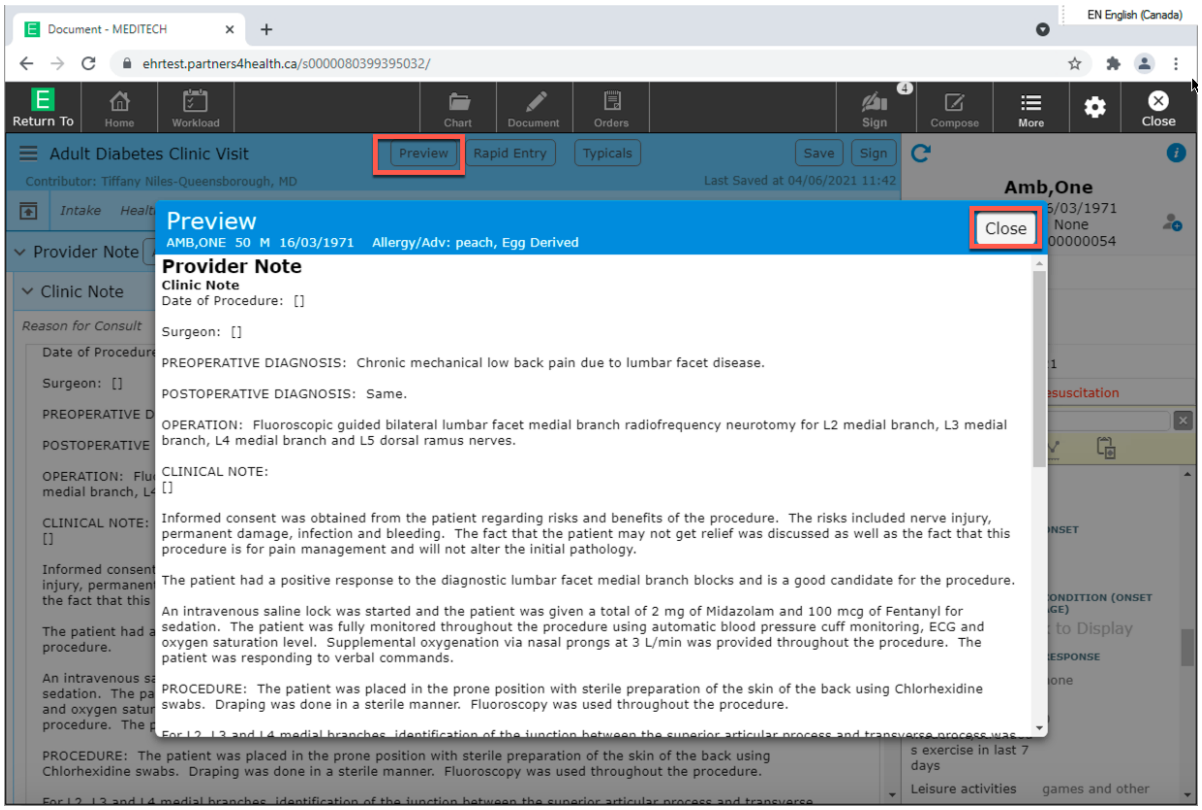
An alternative to structured document templates is structured open text notes where users can type in or use speech recognition software to enter documentation. These notes are organized according to the SOAPE documentation methodology.

S - Subjective O - Objective A - Assessment
P - Plan E - Evaluation



To preview a document prior to signing:

- Select the “Preview” button. To exit select the close button.

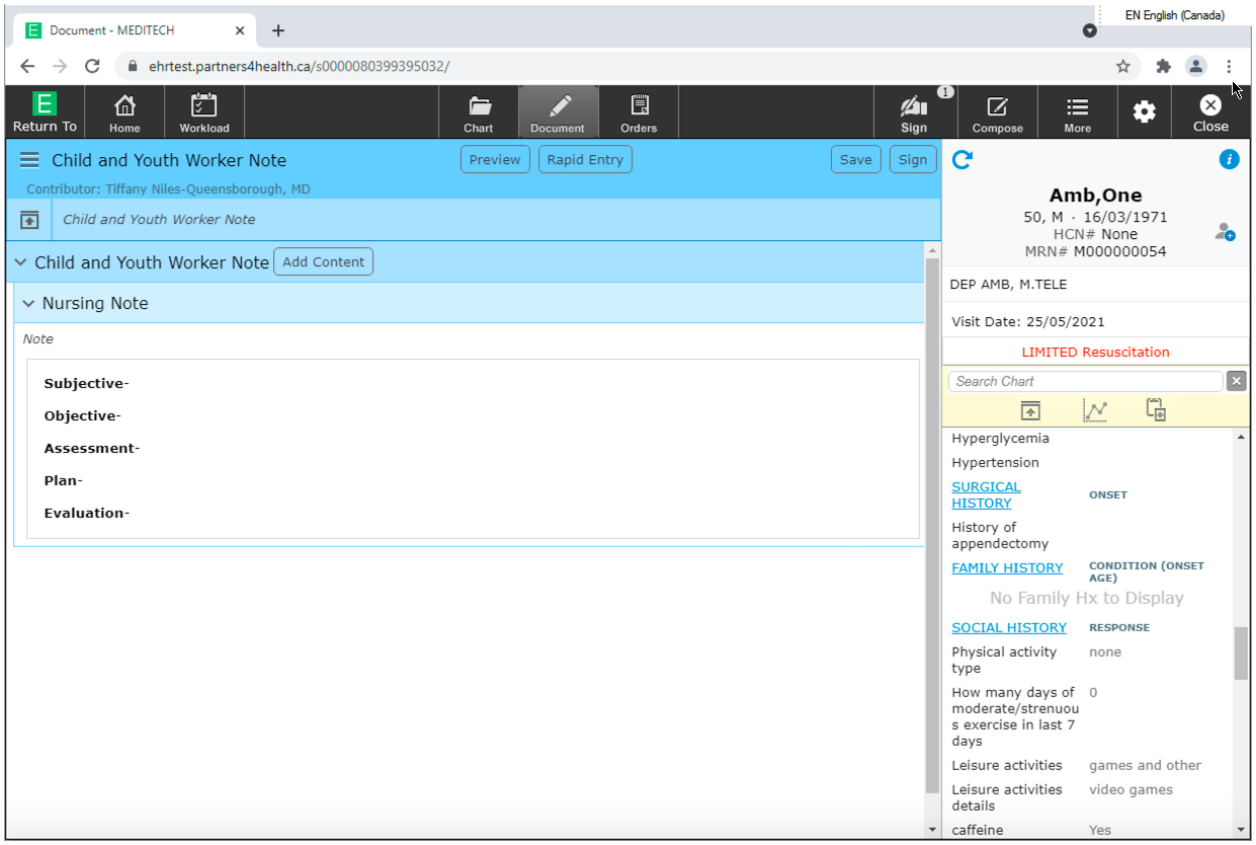


Save and Sign Documents

- Documents need to be saved, even if they are not signed
    - To save documents: Click on the “save” button in the top right-hand corner of the blue bar at the top of the screen
    - Documents do autosave every two minutes however it is important to select the save button
- When a clinician has fully completed a document and does not wish to edit it further, that document can be signed
- To sign documents:
    - Click on the “sign” button in the top right-hand corner of the blue bar at the top of the screen
    - Enter PIN into text box

- Press enter to save. Note that clicking “Save” will require you to re-enter your PIN and click enter on your keyboard.

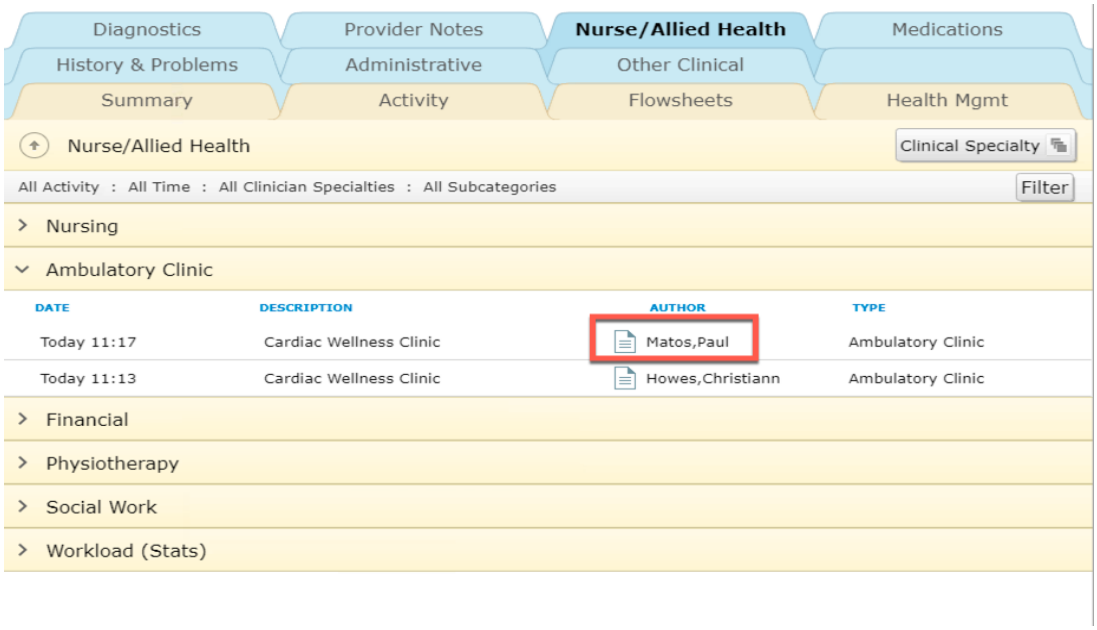
- Note that once a document is signed, the only way to edit it is to add an addendum.

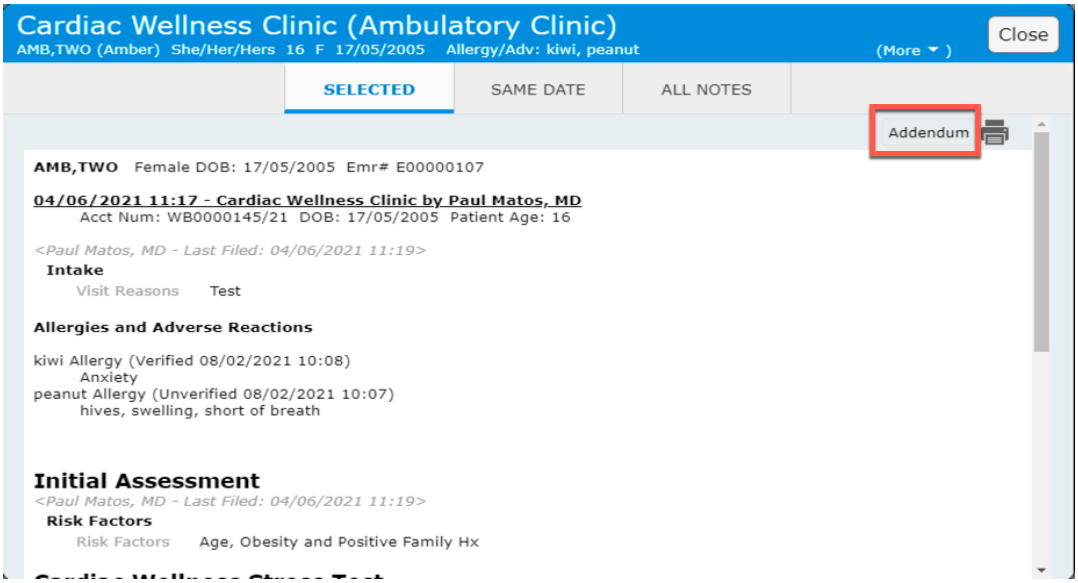


Add an Addendum

After a note has been signed, it cannot be edited. An addendum can be added to the document.

- To add an addendum either:
  - View the note under the “Provider Notes” tab within the client chart
    - Click “Addendum” in the top left-hand corner of the note
    - Document any relevant points within the addendum
    - Save and sign off on addendum



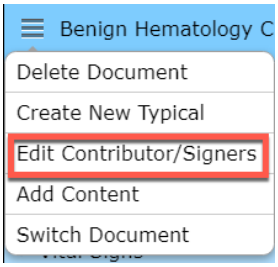


Or

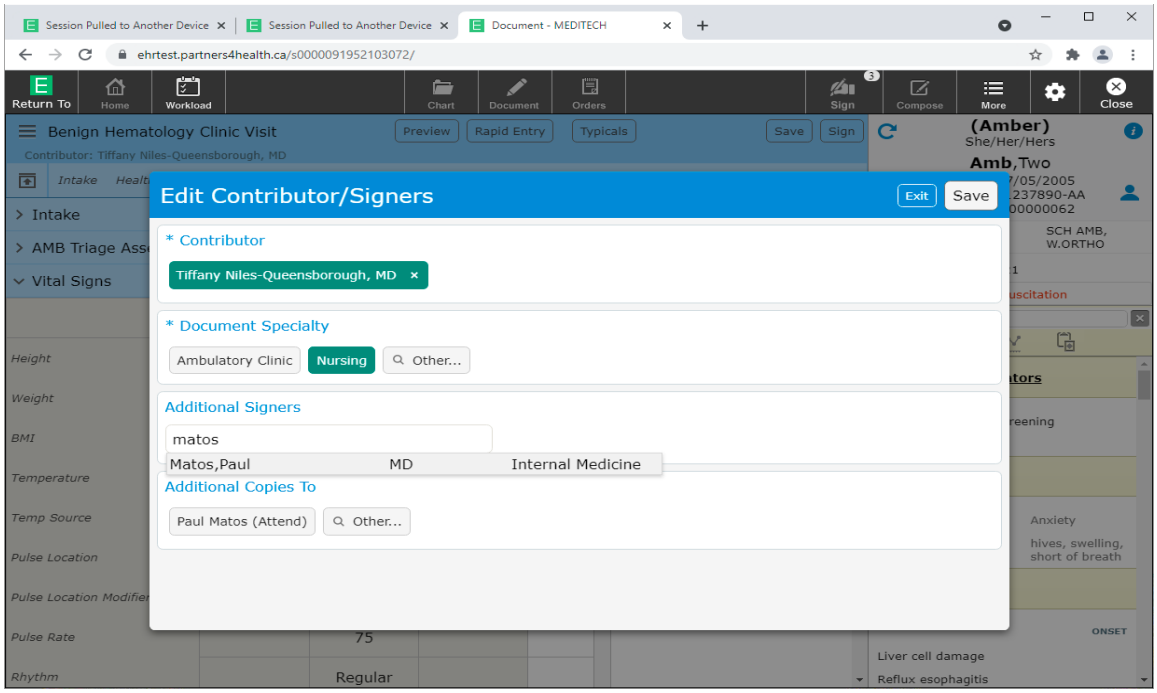
- Within a document the button “addendum” will appear as an option on the upper right-hand corner of screen:
  - Click “Addendum” button
  - Document any relevant points within the addendum
  - Save and sign off on addendum

Cosigners

It is recommended that clinicians add required co-contributors to documentation as soon as they open the note to decrease the chances of forgetting to do so. To add a co-contributor (also known as co-signer), clinicians can click the blue gear and then select “Edit Authors/Signers”. To add a co-signer to a document:



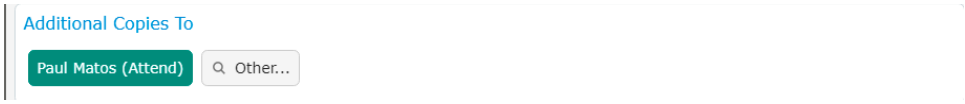
1. Click on the “menu” button located on the left-hand side of the screen
2. Select “Edit Contributor/Signers”
3. Click on the “other” button under “additional signers”



4. Type the name of desired co-signer(s), and select as they appear
5. Click “save” in the upper-right hand corner of the “Edit Contributor/Signers” box

Note: documents requiring a co-contributor’s signature will appear in that clinician’s sign queue until they are signed

Clinicians can also add other clinicians under “Additional Copies To” if they wish to CC another clinician. If a name is entered and highlighted green, a copy of that note will be sent to the receiving clinician’s workload message queue.



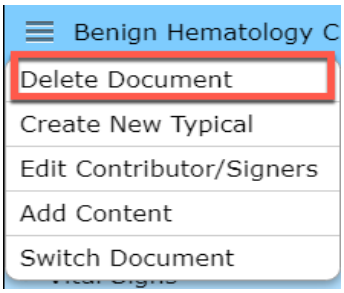
Cancel or Delete a Document

If a clinician starts a document in error, it can be either cancelled or deleted

Note there are two scenarios for this:

1. Unsaved documents can be deleted
2. Saved documents can only be cancelled

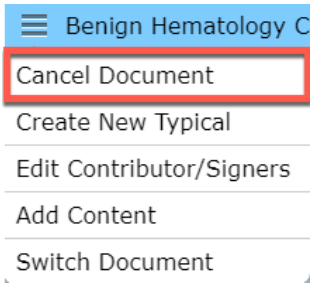
Both cancelled and deleted documents continue to have an audit trail, and therefore will be part of the client's record. Only cancelled documents show up in a client's chart. Content of the document does not show, just the document itself.



- To delete a document (unsaved documents only):
  - Select the Delete Document from the document menu
  - Click on "Delete Document"
  - Confirm wish to delete document when Confirmation pop-up arises "This "Pending document will be deleted. Proceed?" Click "yes."

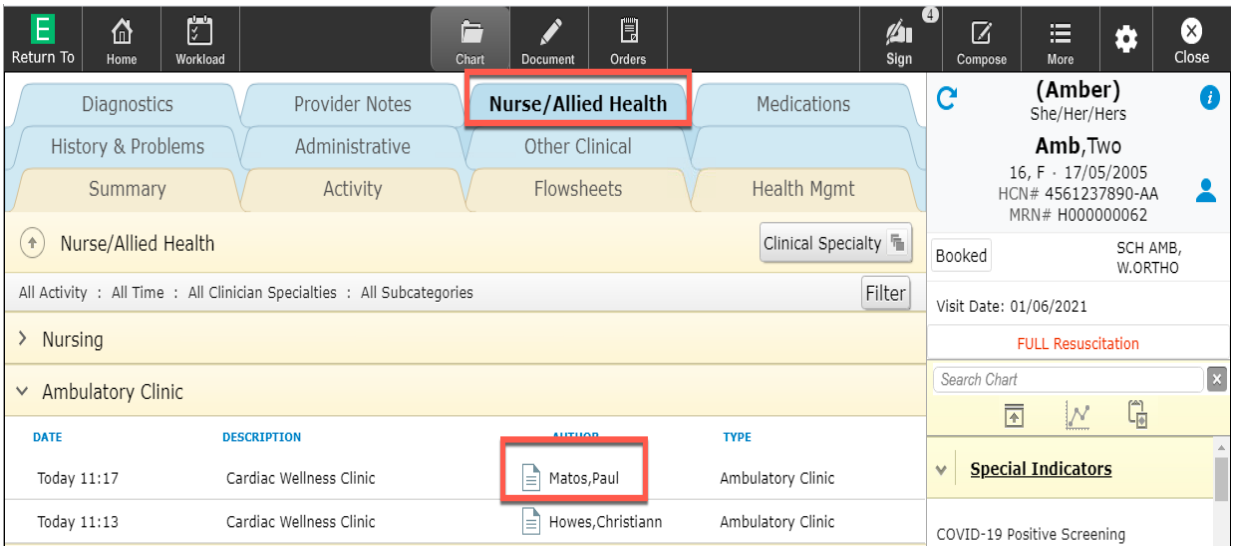
- To cancel a document (saved documents only):
  - Select the Cancel Document from the document menu
  - Click on "Cancel Document"

- Confirm wish to cancel document when Confirmation pop-up arises by clicking “yes”

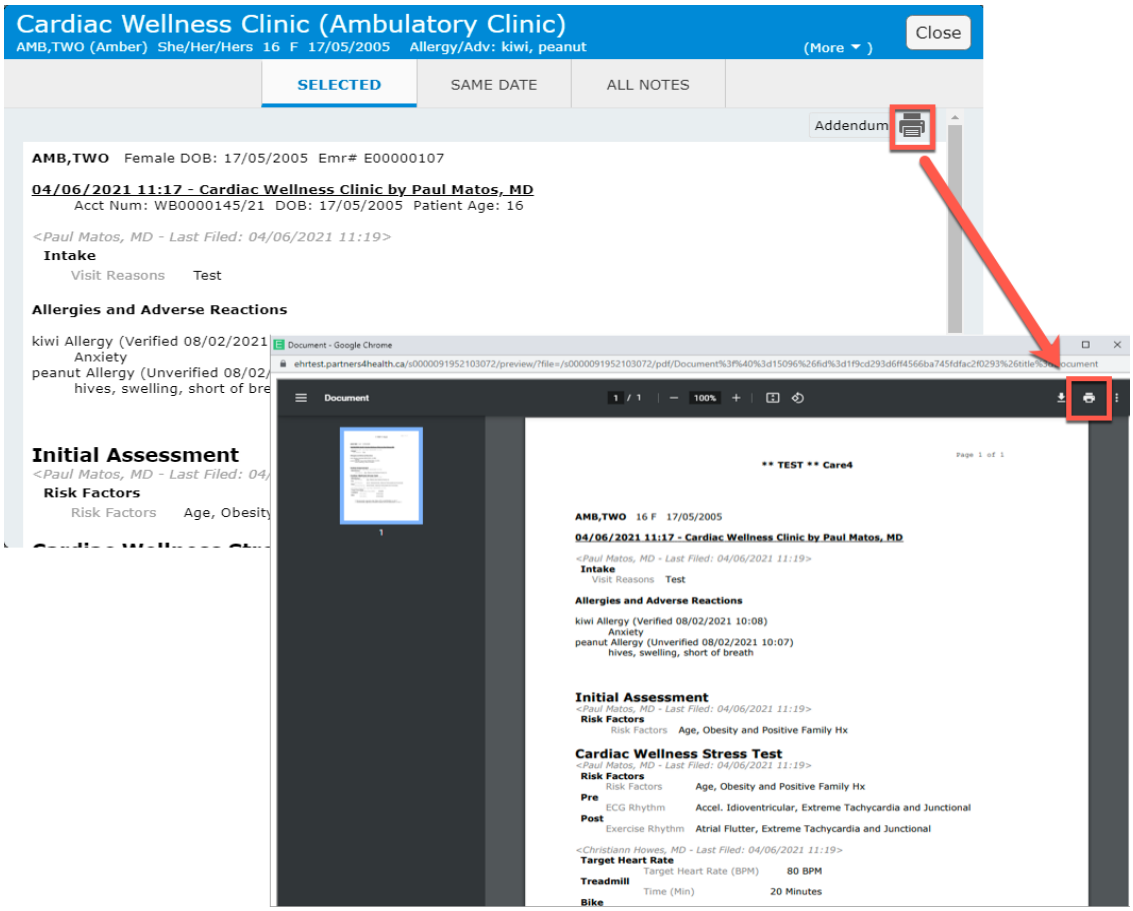


Printing documents

To print a document, select the document from the Nursing/Allied Tab in the chart or from the Provider Tab. Select the document you want to print.



Within the document locate the printer icon and click on it. The print preview will display the document. Next select the printer icon again to print the document to your local computer.

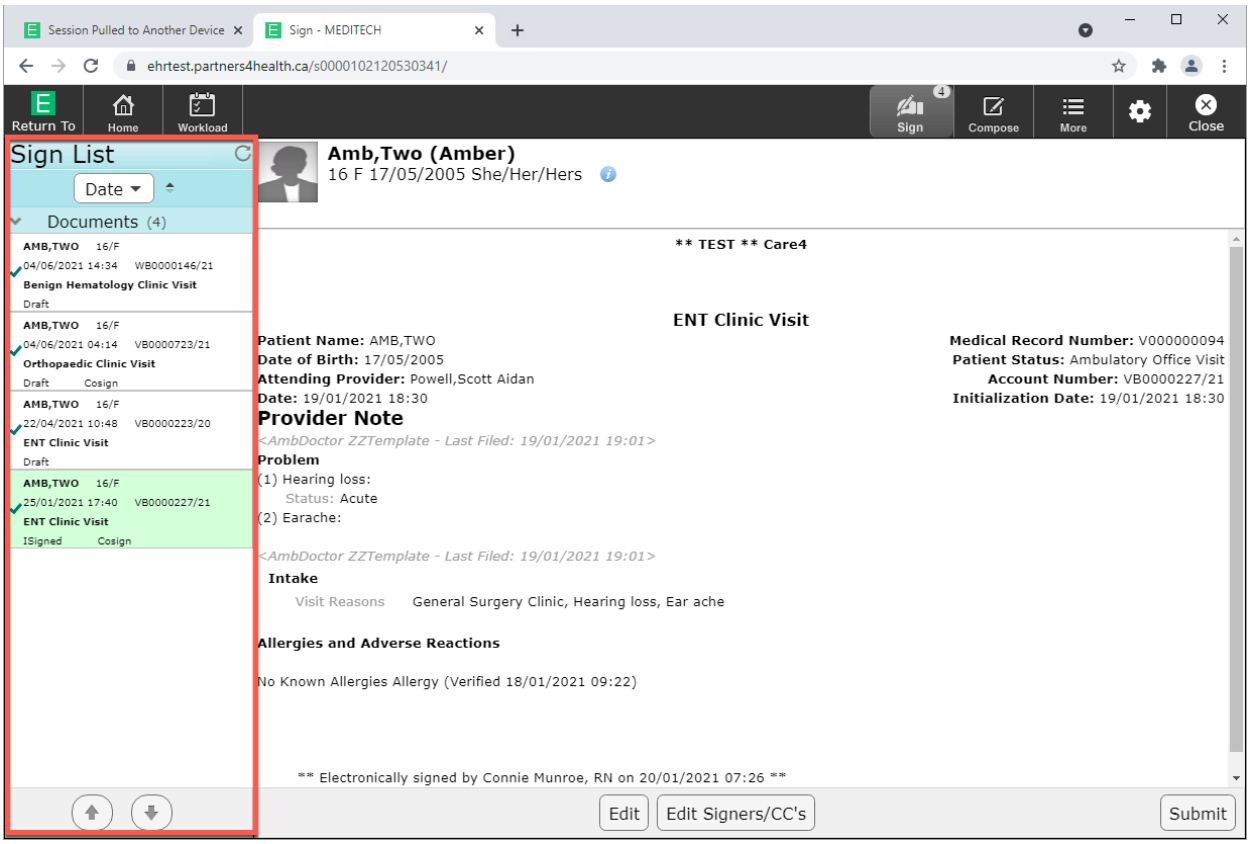


Sign List

The Sign Routine is used to electronically sign patient's notes, documents, orders, and transcribed/scanned items. The list displays the category for what needs to be signed (orders and documents). Both Acute and Ambulatory patient visits appear on this list.

The list can be sorted by:

- Date
- Patient
- Status
- Priority
- Reason



A count of items appears listed on each accordion for orders and documents.

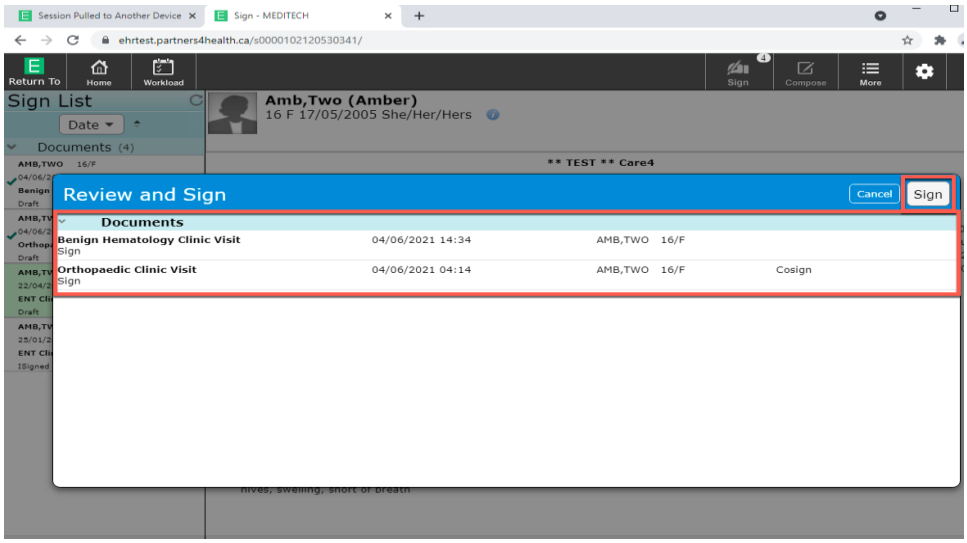
The sign icon that appears in the black header displays a count of items to be signed, whether the user is viewing the items they need to sign, items to sign for another user, or items requiring signing for a selected patient.

The Sign List refreshes automatically to reflect the most recent count of items. You can also view and sign Pathology (PTH) reports from this routine. After you check the PTH report from the list on the left, select the Submit button to access the Review and Sign screen.

A green checkmark appears next to items that you queued to sign. When you select an item, its detail appears in the right panel. Items can be selected for signature or rejection. The Reject option is available only for orders or scanned documents. A red **X** and the rejected reason appear next to rejected items. Use the **Prior** and **Next** buttons to move to the next item on the list or go back to the previous item on the list.

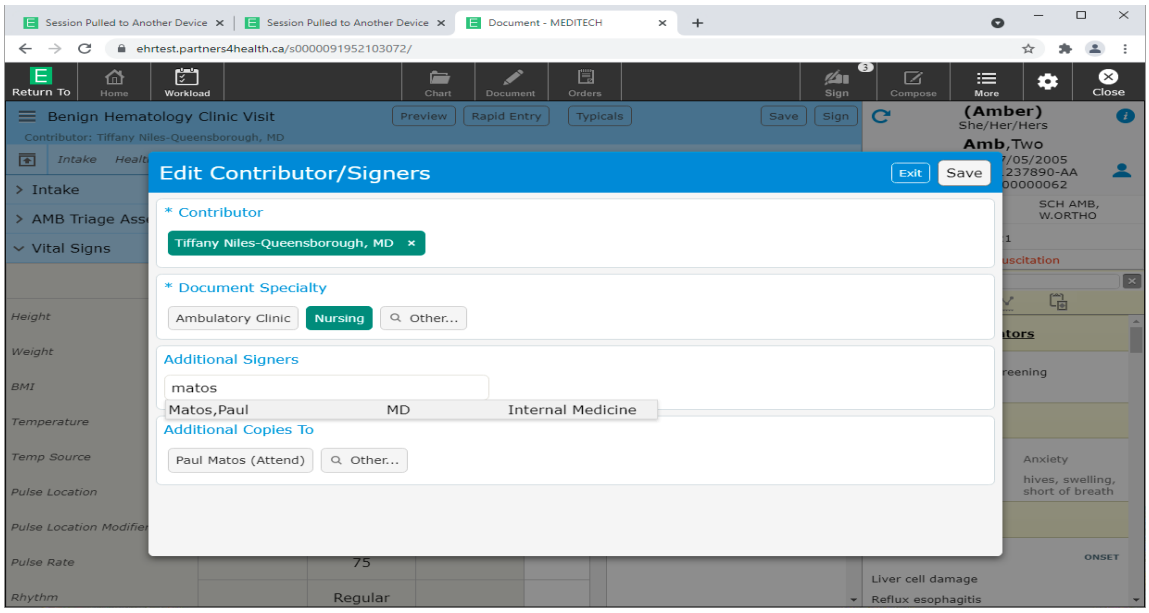
All reports in the accordion can be simultaneously by placing a checkmark in the box next to the document/report status. You can also automatically select all orders in the

Orders accordion simultaneously by placing a checkmark in the box next to the **Sort** field. Multiple items can be signed at one time.



Special Note:

If a signer is added to a document in error, select “Additional Signers” to remove the incorrect signer on a report with an ISigned status. Any additional CC's from the Patient Care Manager appear on the body of the report. If a report is signed in PCM, an electronic signature time stamp appears.

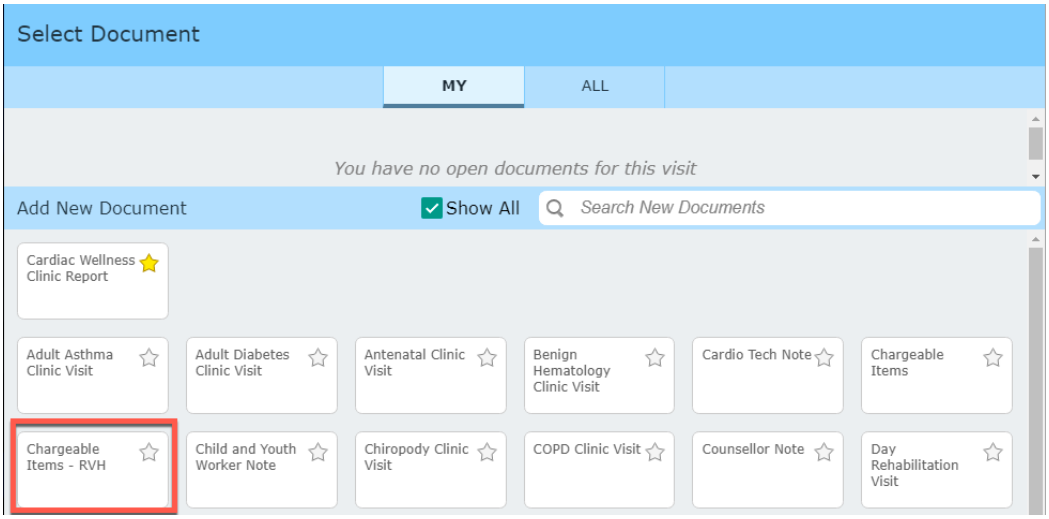


Speech Recognition (Front-End dictation)

If your organization has purchased front-end dictation technology, you may use your microphone (Dictaphone or computer microphone) to verbally enter your narrative documentation and utilize voice commands to skip from one field to the next.

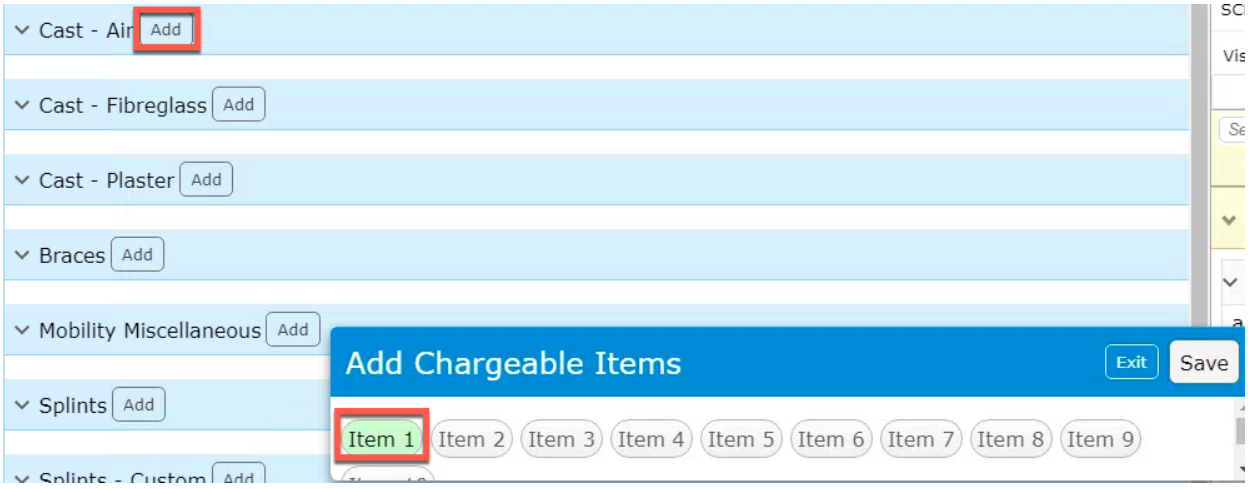
Chargeables

For items that are provided to the patient at the clinic that the patient will be charged for, use the Chargeable items – site specific Chargeable document.



To document

Chargeable items, select an item on the list and then select the “Add” button. Next select the first item by indicating the first item “Item 1” and then click Save.



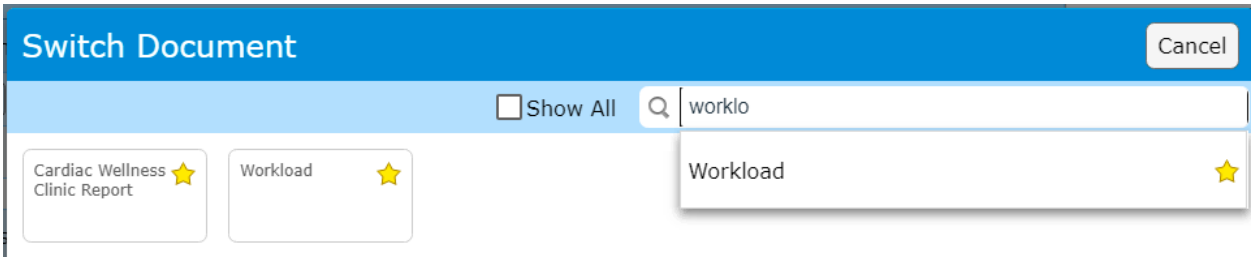
Click on the item on the document and specify more details by documenting on the associated queries.

Case Load Statistics Documentation

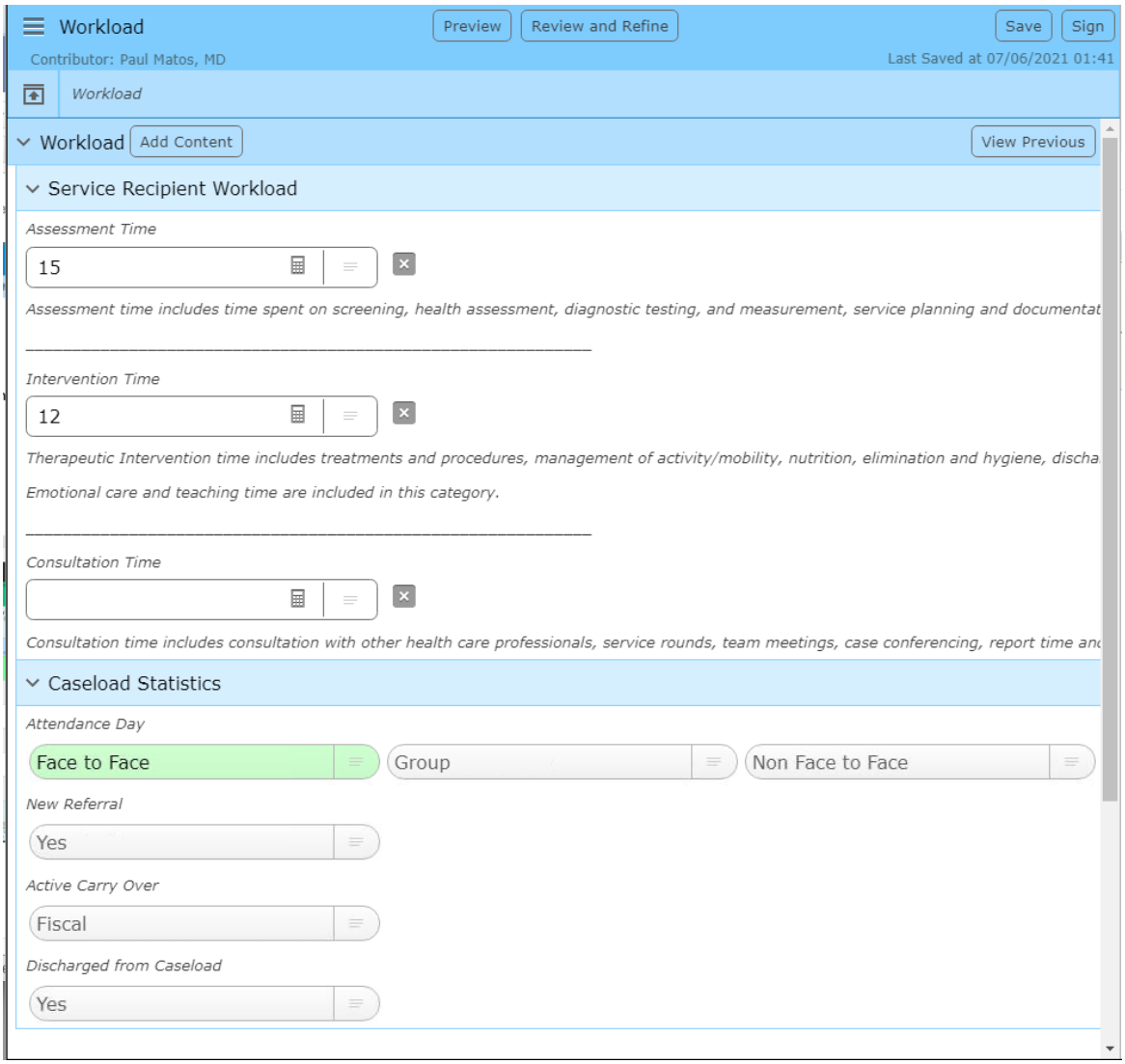
Non-provider staff can document their workload statistics in Expanse. To document:

Service Recipient

- **Search for the document template Workload and add it as a favourite document.**

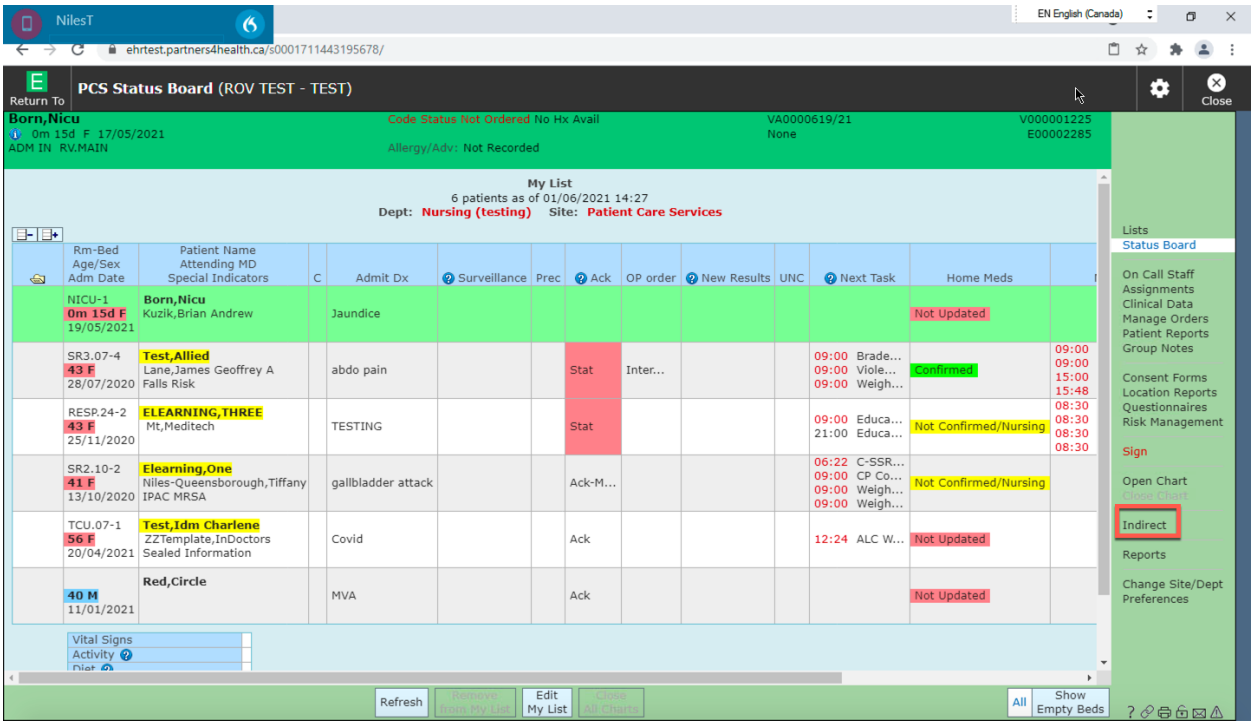


There are two ways to view the document. Depending on user preference, whether to use Rapid entry or Review and Refine mode. In Rapid view, the fields with calculators and free text boxes are easily visible for data entry. Once entries are made, the document can be signed like any other document.



Non-Service Recipient

Non-Service Recipient (NSR) workload is documented in the Expanse Patient Care System (PCS). The user is required to log time for how long was spent for teaching, research, and meetings.

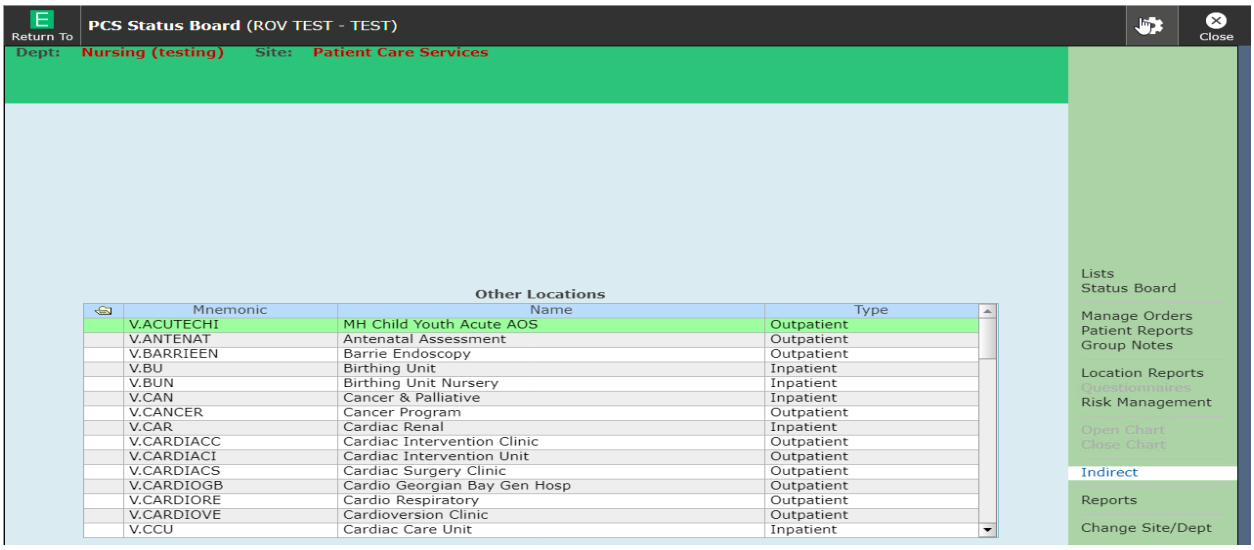


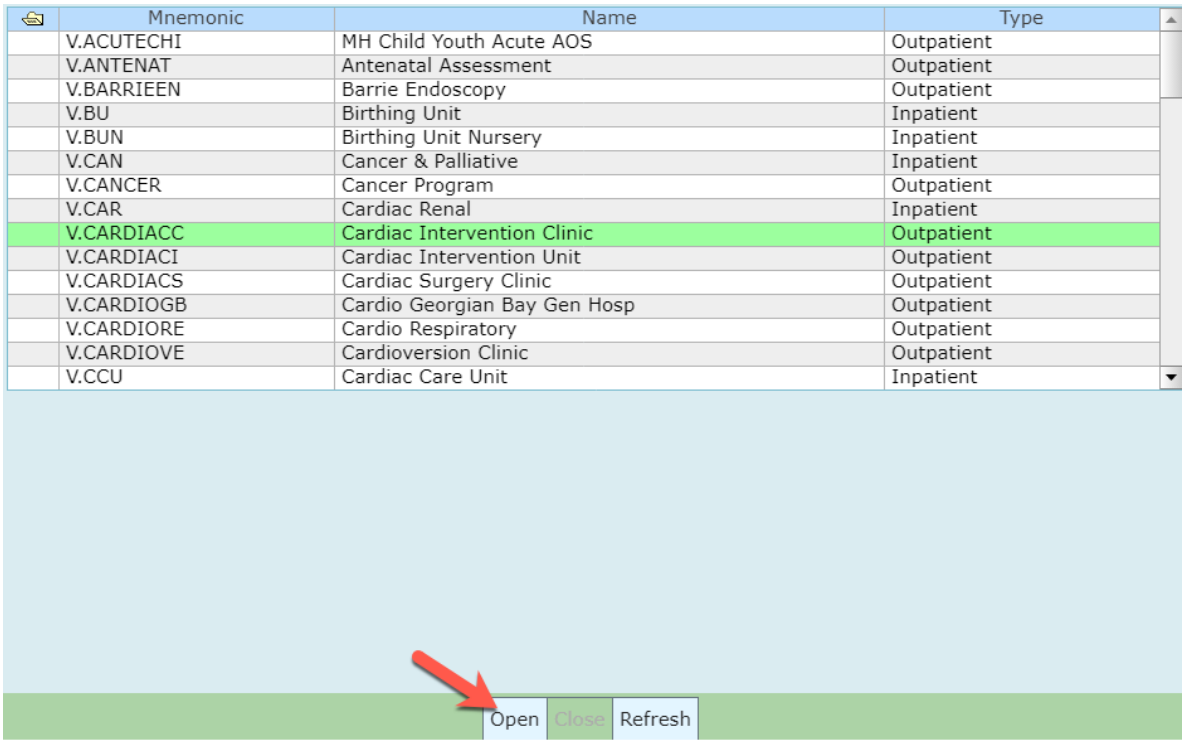
To access the NSR screens:

- Return To Click the Return To button
- Main Menu: ** TEST **
  Care4 (ROV TEST - TEST)
  Job: Z.BUILDTEAM
  ProviderType: Physician

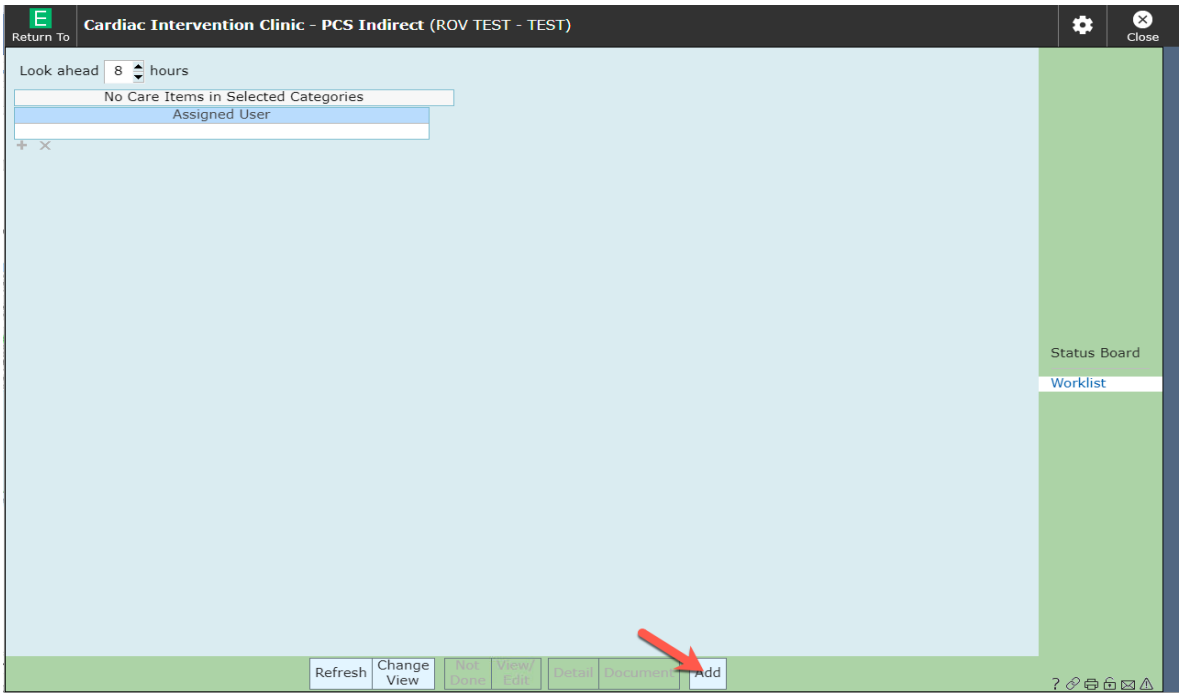
  Select Main Menu from the drop down list
- Clinical
  Administrative
  Ancillary
  Web Acute Status Board
  OM Status Board
  PCS Status Board
  Specialty Care Desktop

  Select Clinical – PCS Status Board from your menu
- Select the Indirect menu option
- Select the clinic to input the time against

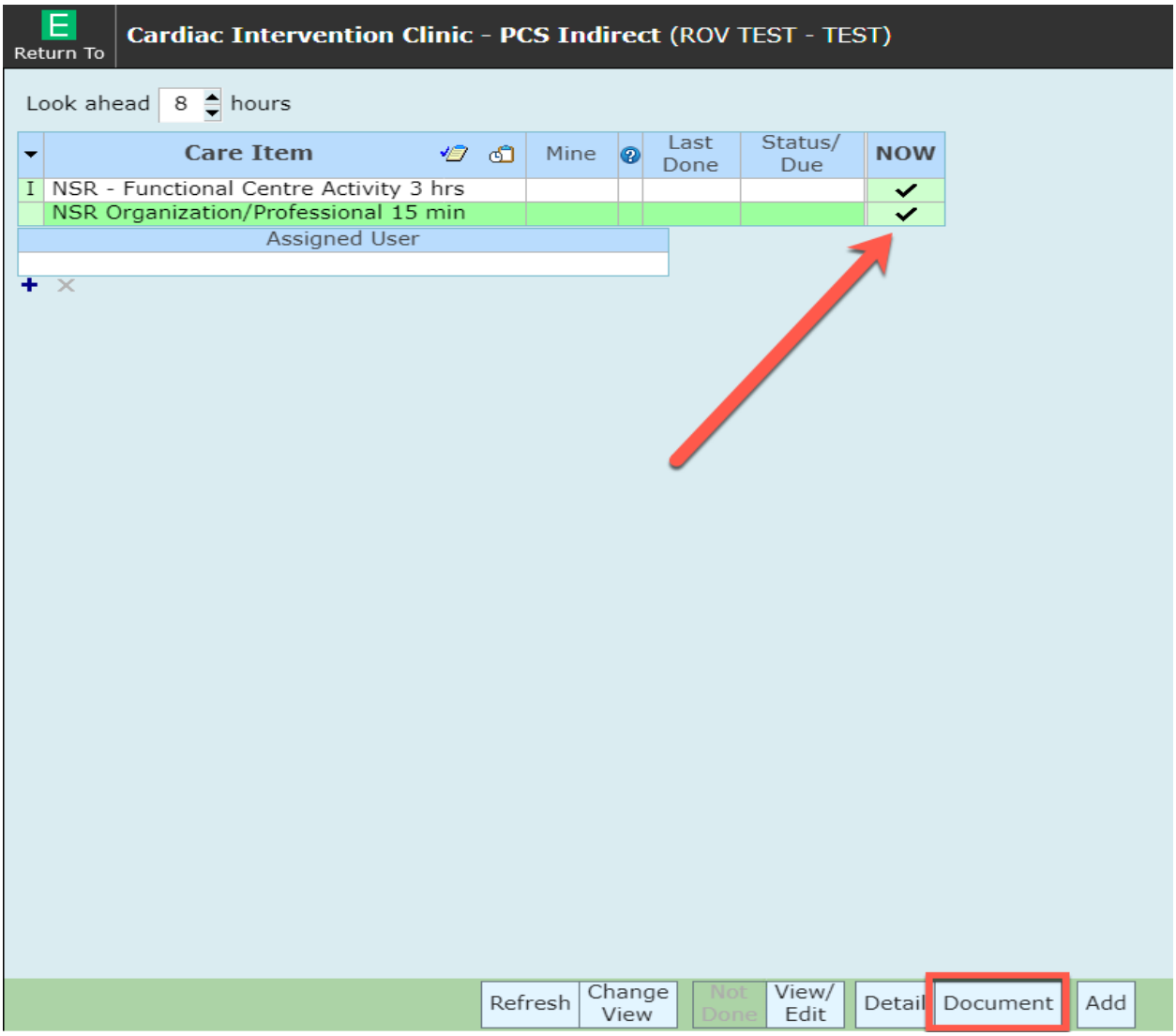




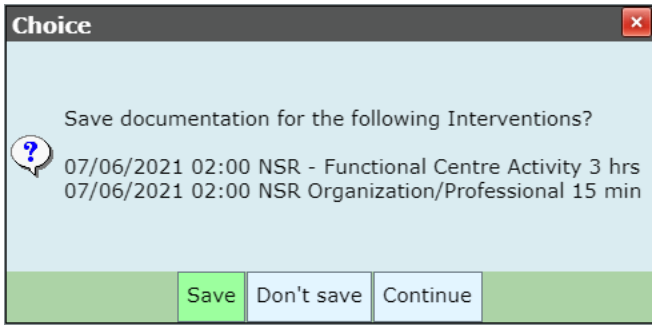
- Click the open button the click the Add button.



- Next select the functional activities and then click the Next button for the next page or the “Ok” button to add the interventions to the list to document against.

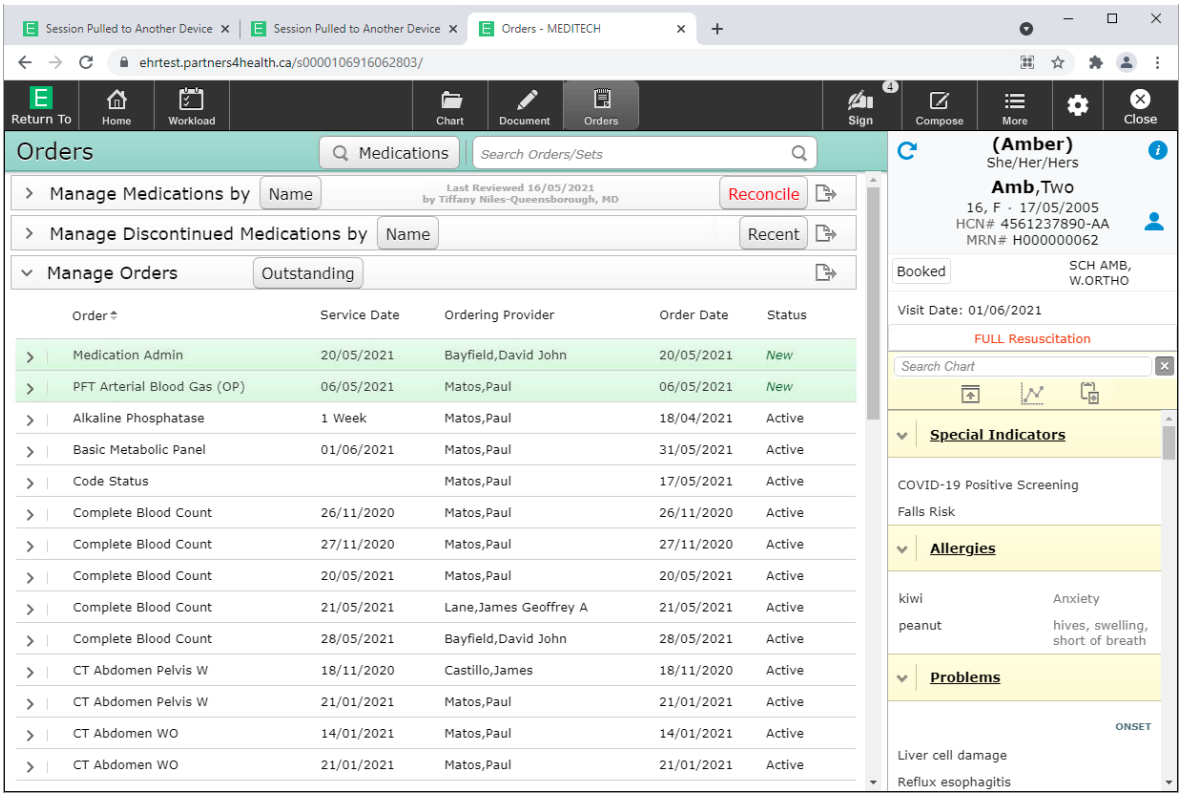


- Select the button “Document” to register the interventions. A choice pop up will display to determine if to proceed with saving. Select “Save” and then click the “Close” button to return to the main menu.



Orders

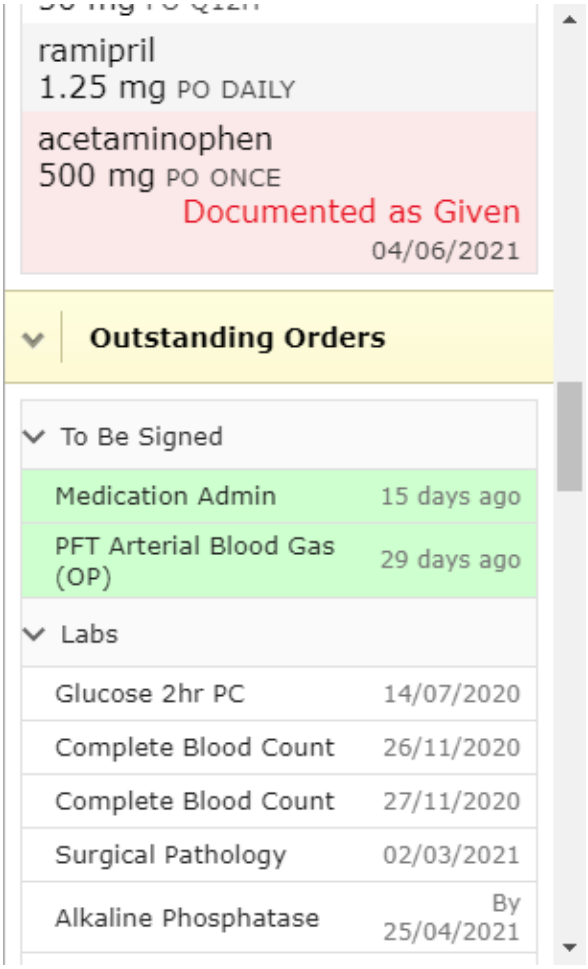
Orders are accessed through a client's chart. The Orders Routine is used to enter and process patient medication and non-medication orders. Within the orders routine, the Manage Medications and Manage Discontinued Medications accordions are used to manage existing prescription medications on file for the patient.

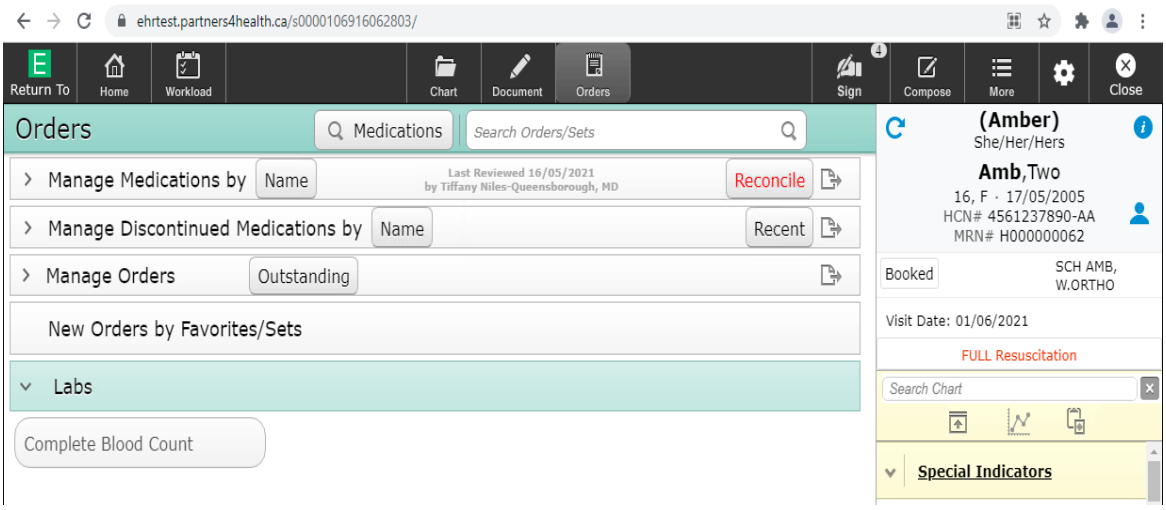


Orders can be seen in the Reference Region under Active Service Orders from any place in the client's chart. They can also be viewed under the "Manage Orders" section with the "orders" icon in the black bar. In the "Manage Orders" accordion, the "OUTSTANDING" button should be changed to "View All", to allow clinicians to see current orders.

Note: To avoid duplicate orders of the same type clinicians are encouraged review client's order histories prior to entering a new order

Orders in the Reference Region

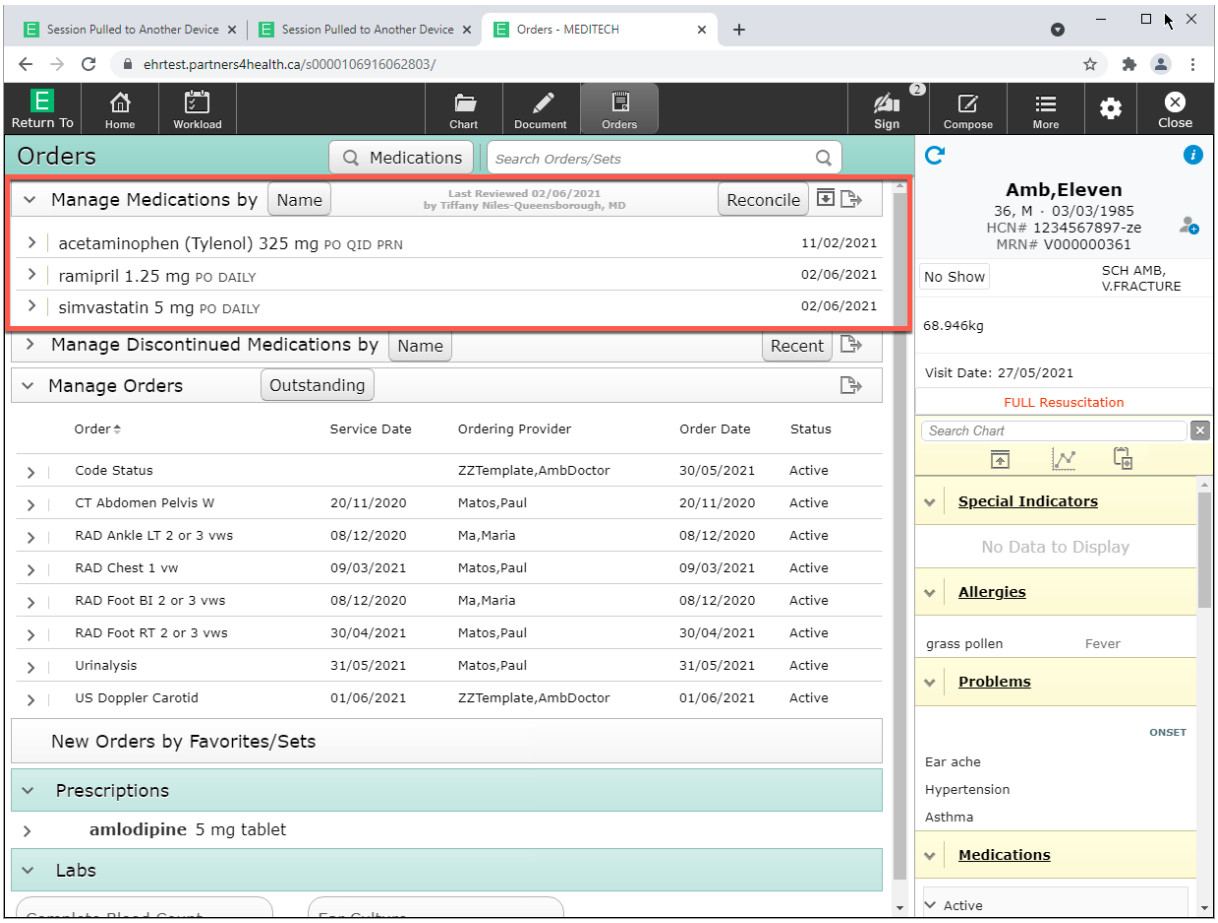




Use the Manage Orders accordion to manage existing non-medication orders. The New Orders by Favorites/Sets section contains new orders that were placed as favorite orders. Within the Orders Routine, you can:

- Search existing orders for non-medication orders and order sets.
- Select the Sign or Save button to view the Order Summary.
- Personalize your favorite orders and order sets using the Orders Star icon, or make your edits in the Favorites Dictionary.
- Place orders by problem using the Problem widget in the reference area.
- Define a default ordering provider and source for current and new orders.
- Place orders for Medication Admin orders to order medications to be administered in the clinic.
- Choose the column names to sort by ascending or descending order.

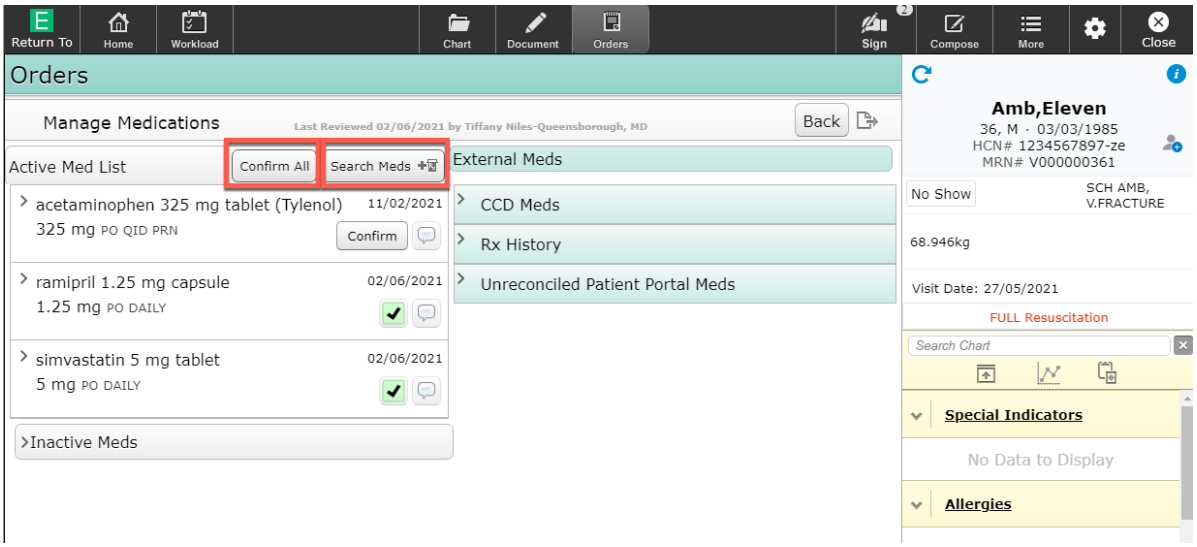
The Manage Medications accordion allows the user to expand the medication order list of the patient. This can be further viewed by selecting the Medications by (Name) button to change the display options for the accordion. Select the chevron on the accordion to display the patient's home medications.



Review and Manage the Home Medication List

To review and manage the Home Medication List, select the “Reconcile” button.

Use this screen to confirm home medications and search for new medications to add to the home medication list.

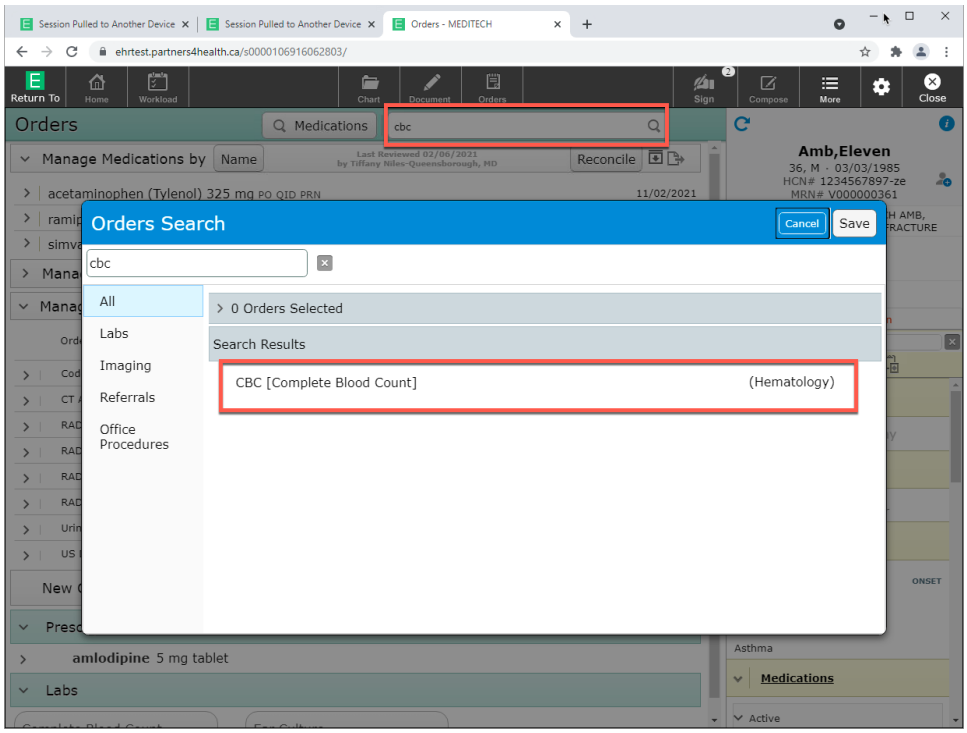


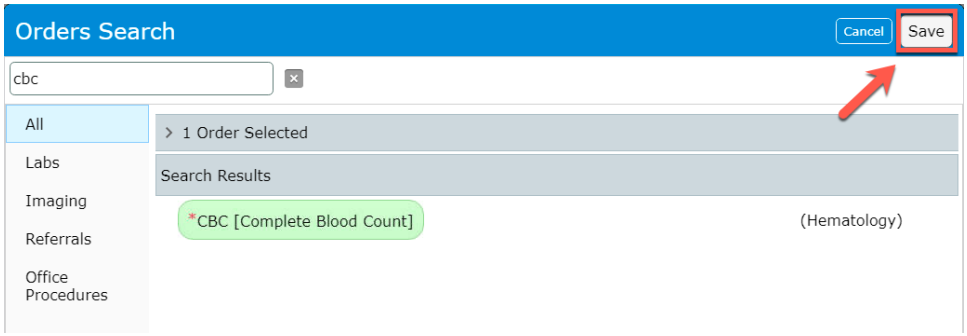
Entering Orders

Orders can be entered by providers and clinicians such as non-medication and Medication Admin orders.

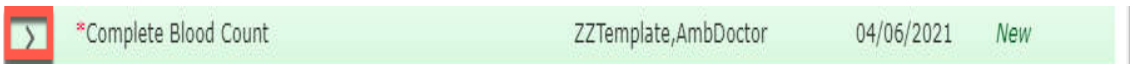
To place a new order for Lab:

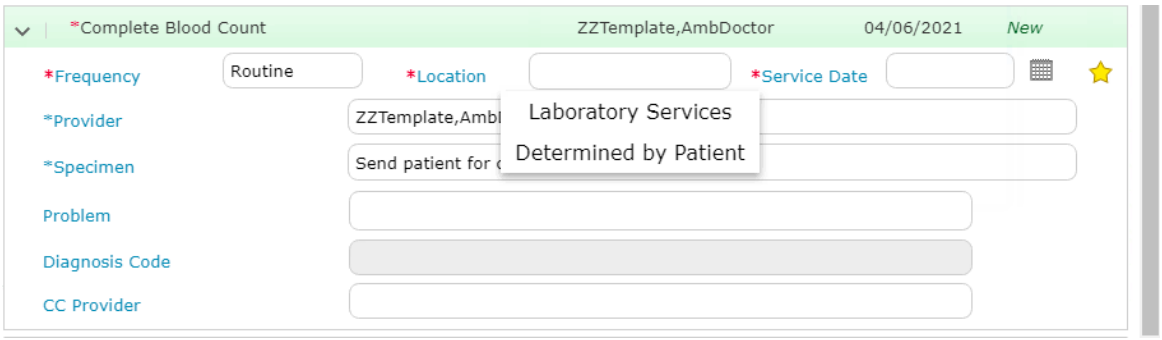
- Type in the order name in the search bar, the Orders Search overall will display
- Select the order on the list, this will highlight the order in green. The select the “Save” button.



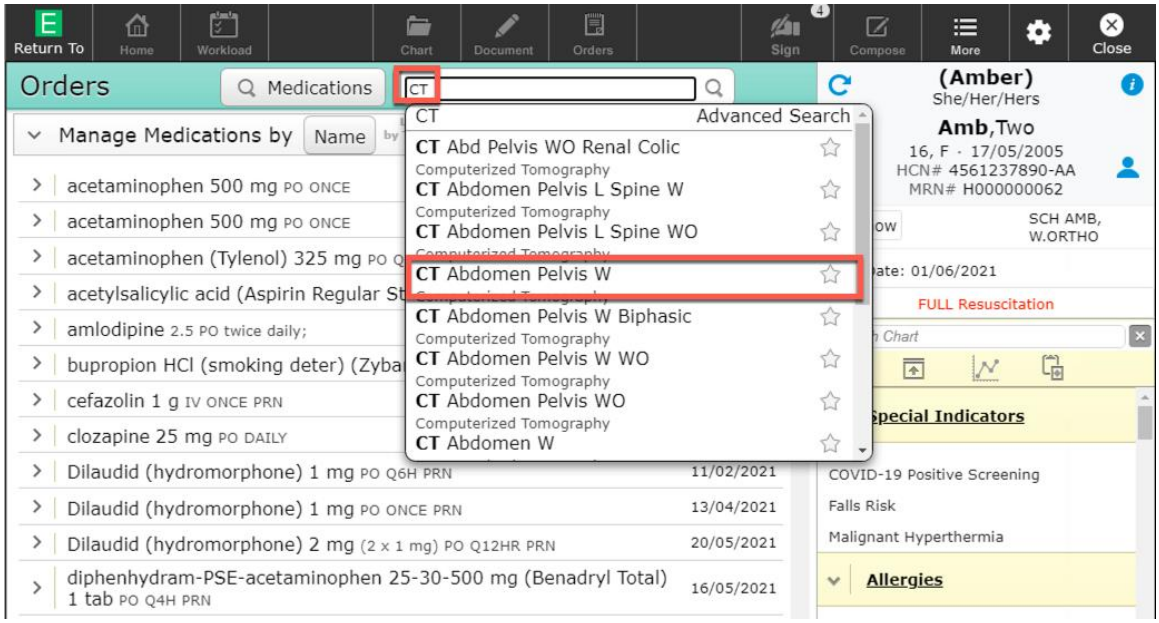


The order will populate the Manage Orders list. To view the order screen field details, click on the chevron. Within the order enter the appropriate data in the required field noted by a red asterisk. Required fields include Frequency, Location, Service Date, Provider Name and Specimen Collection instructions.

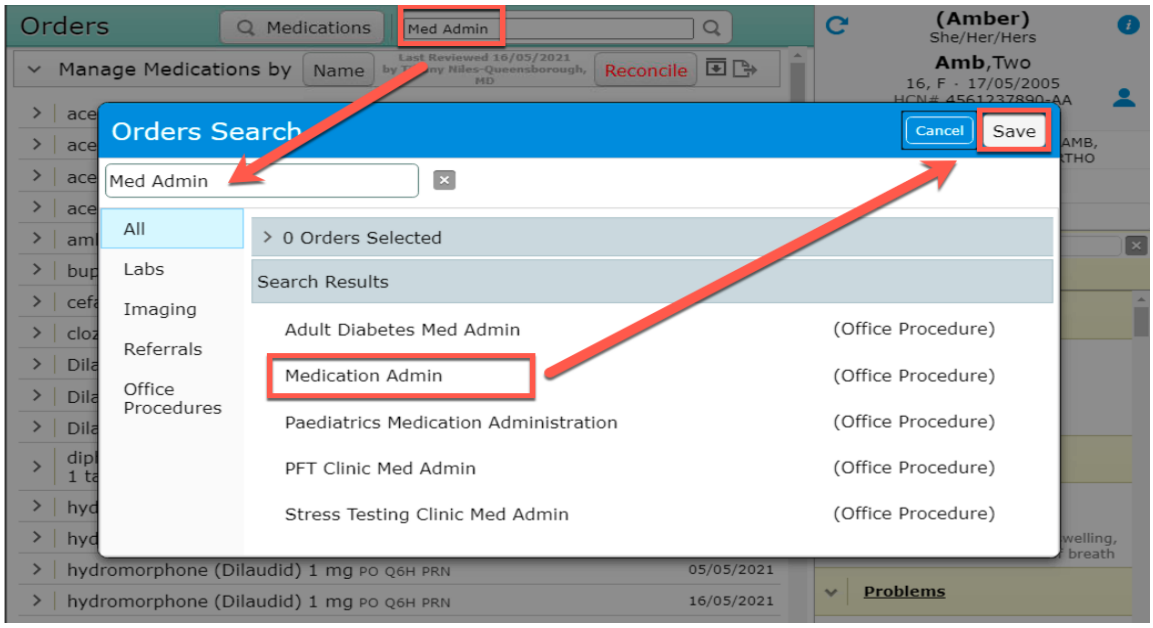




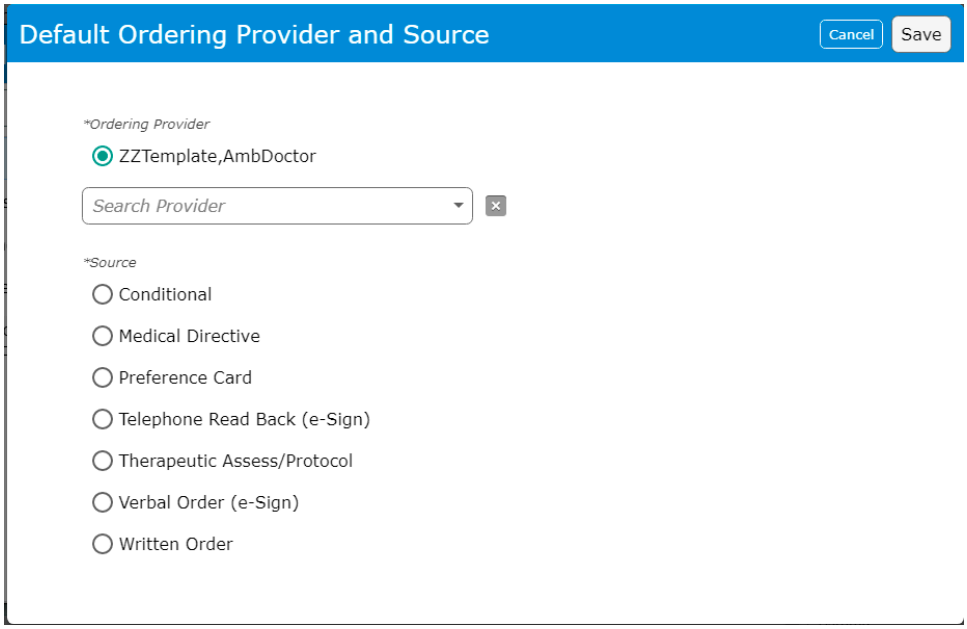
To place a new order for DI



To place a new order for Med Admin Order



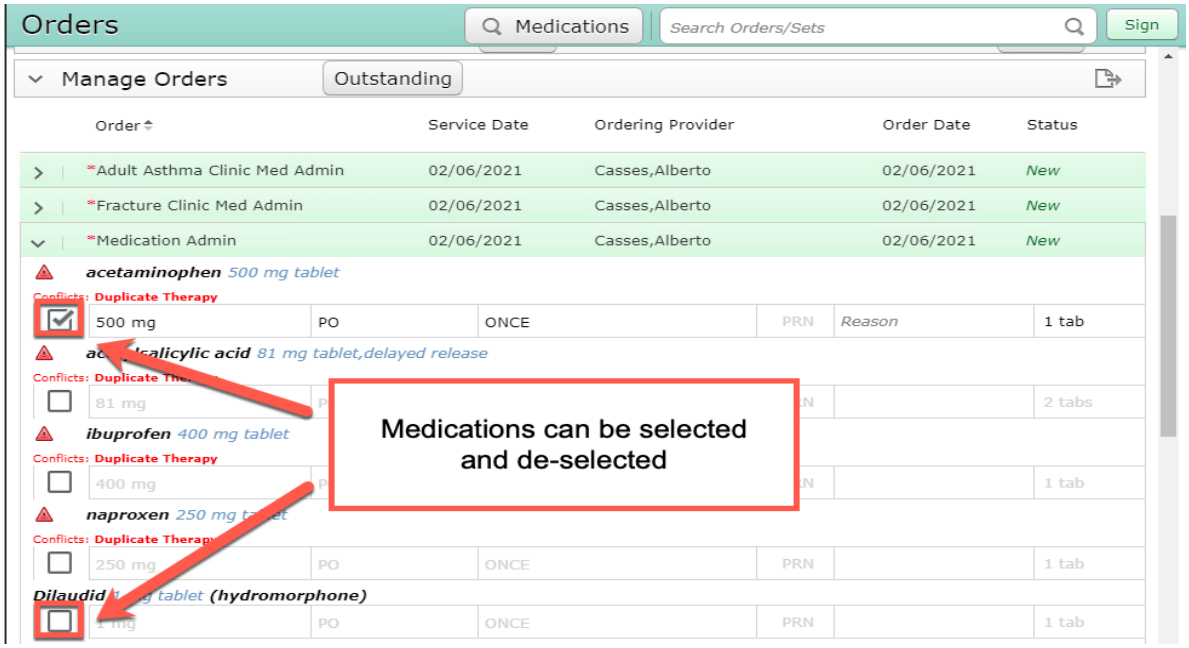
For Non-Providers who Enter Orders: Non-providers will receive the “Default Ordering Provider and Source screen upon entering in an order. Enter in the ordering provider’s name and the source of the order.



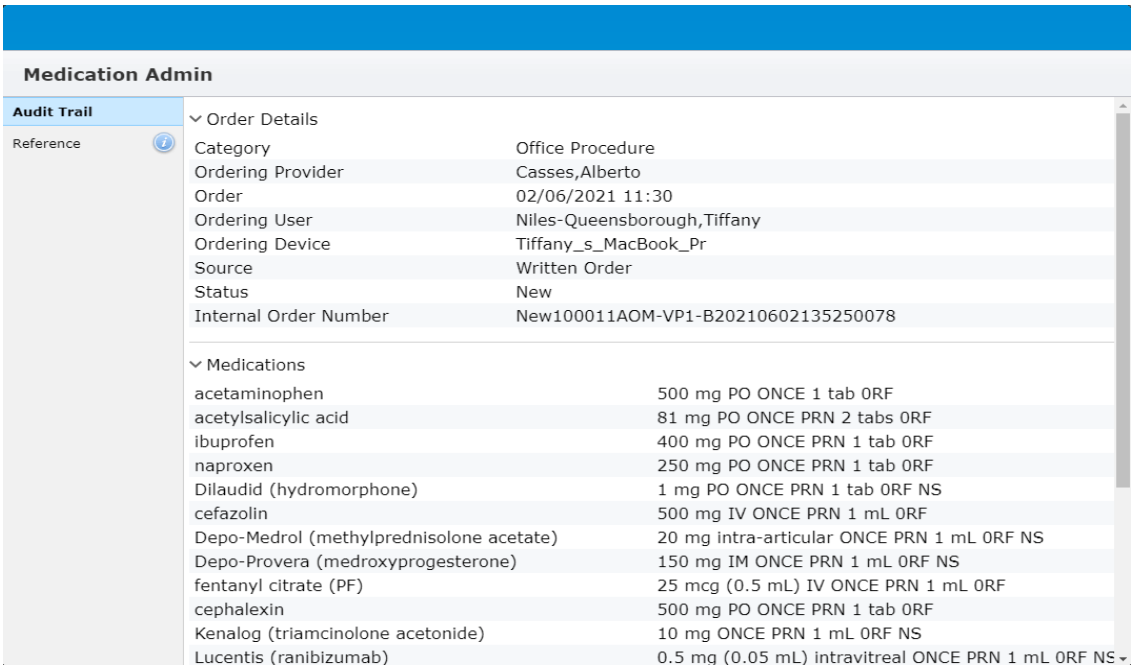
Manage Orders

Use the Manage Orders accordion to view a patient's non-medication and medication administration orders. Select the chevrons to the left of an order to view or edit order details.

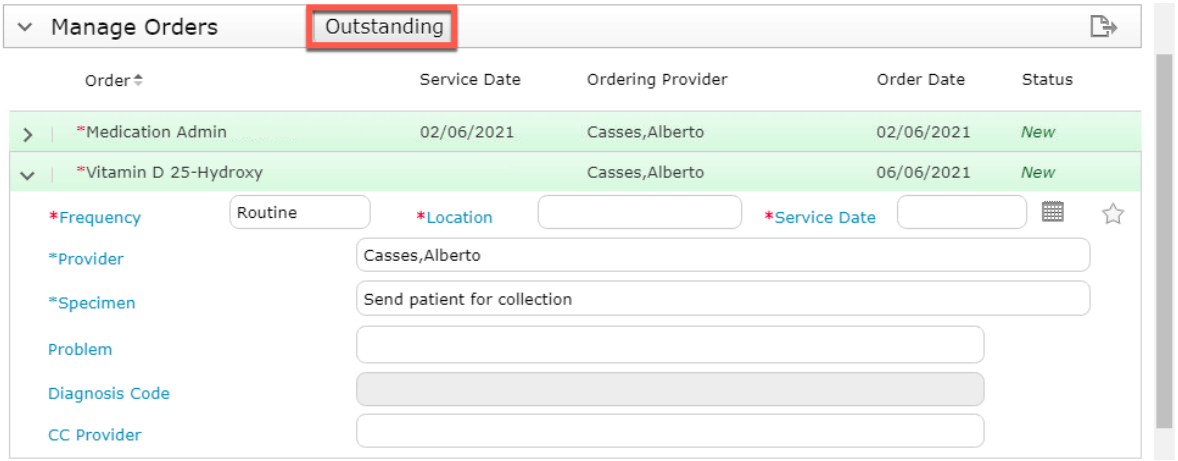
If there are pre-selected medications or devices that are associated with an office procedure, they appear with a checkmark so that you can easily de-select what you do not want to order.



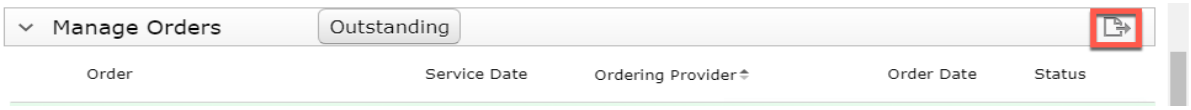
Select the order accordion to display the order's audit information. Use the following functions and buttons to view additional information:

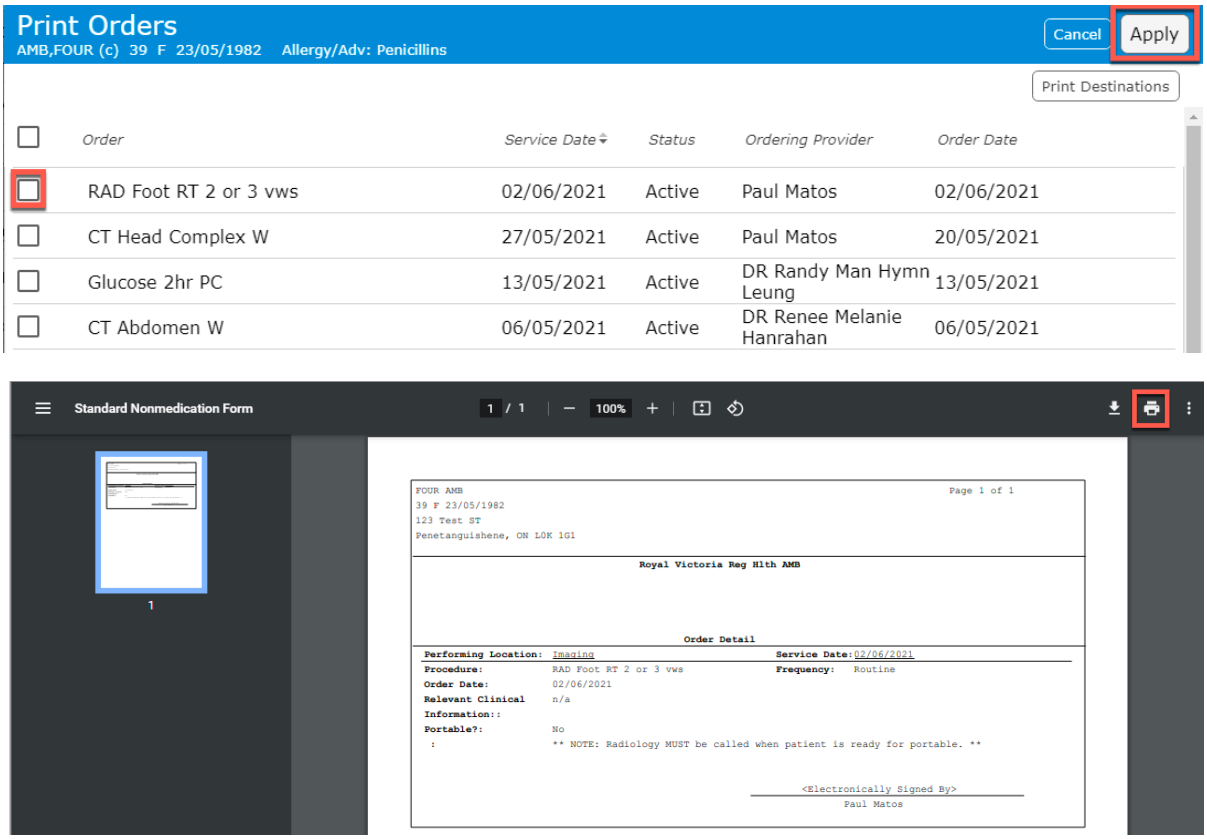


Outstanding button - Displays the current view of outstanding orders. Select the button to view options for the order history.

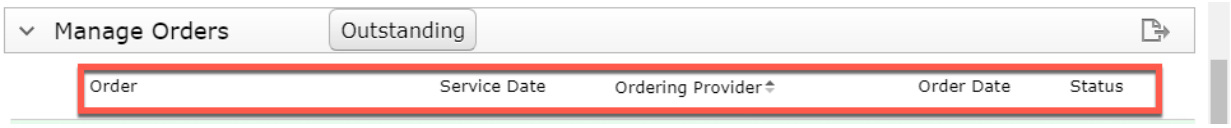


Output icon - Allows the user to print the order(s).



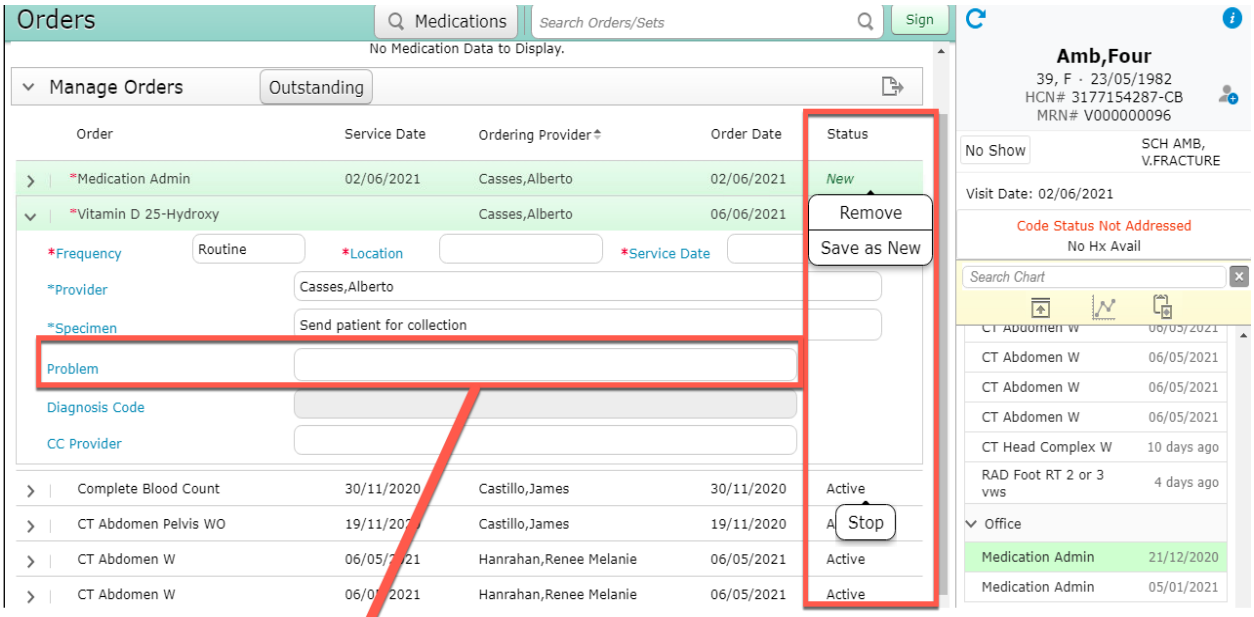


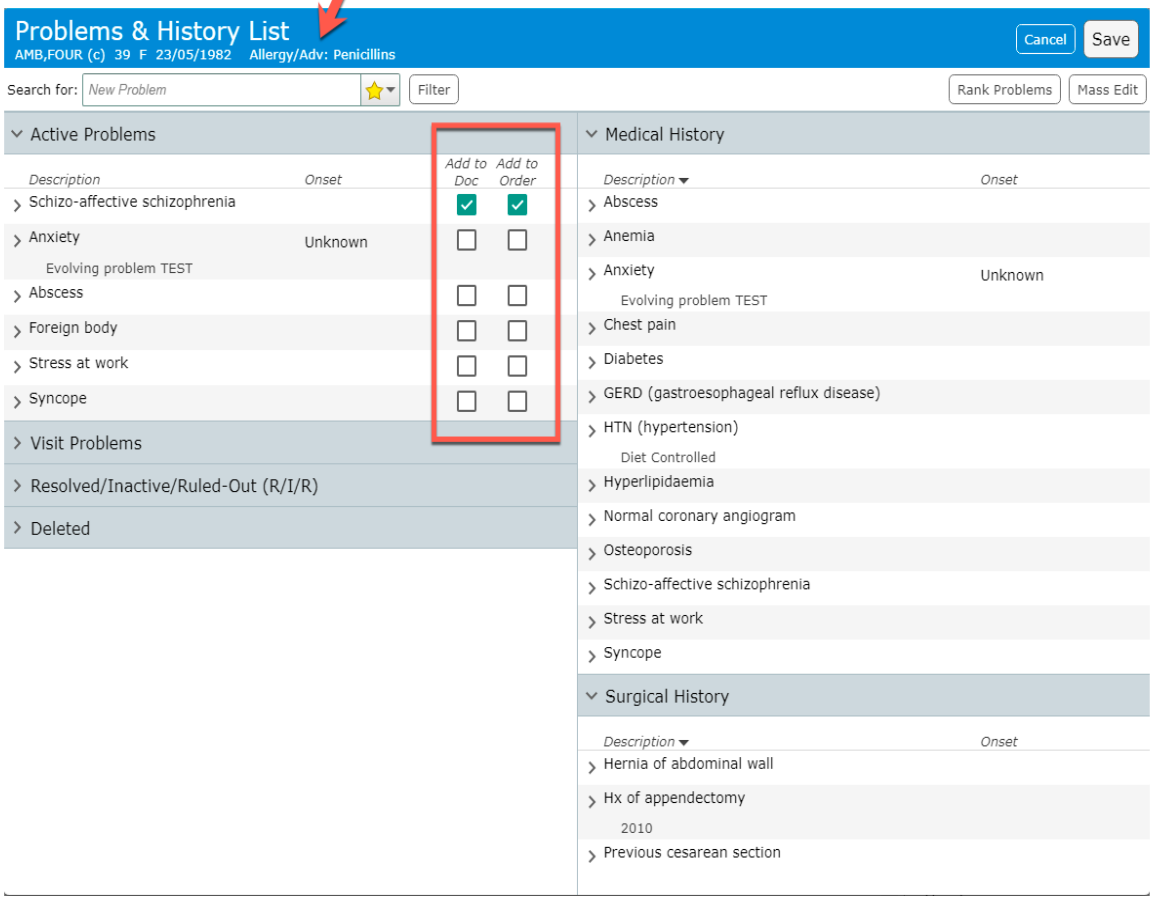
Column names - Choose the column names to sort by ascending or descending order.



Order Status

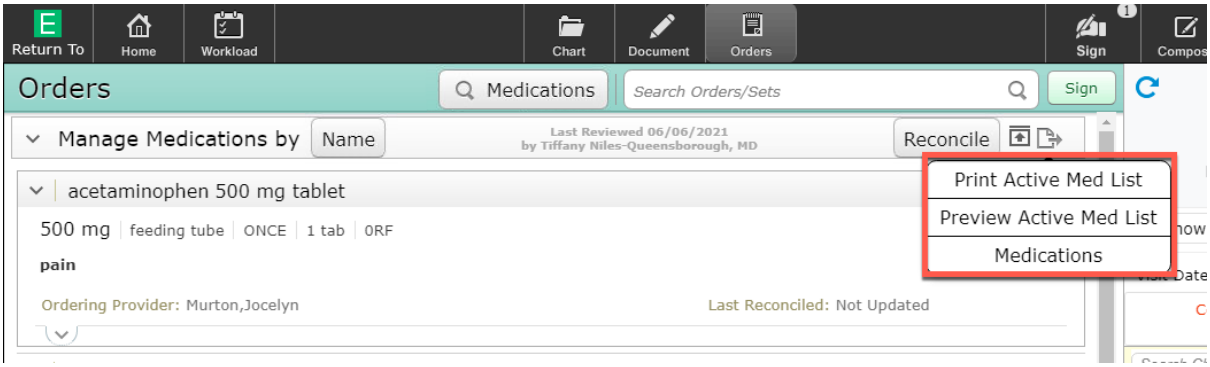
Select the status for each order to display options to cancel, remove, or complete orders. Status options are specific to the orders and the user's access. Select within the Problem field to launch the Add Problems screen for orders.

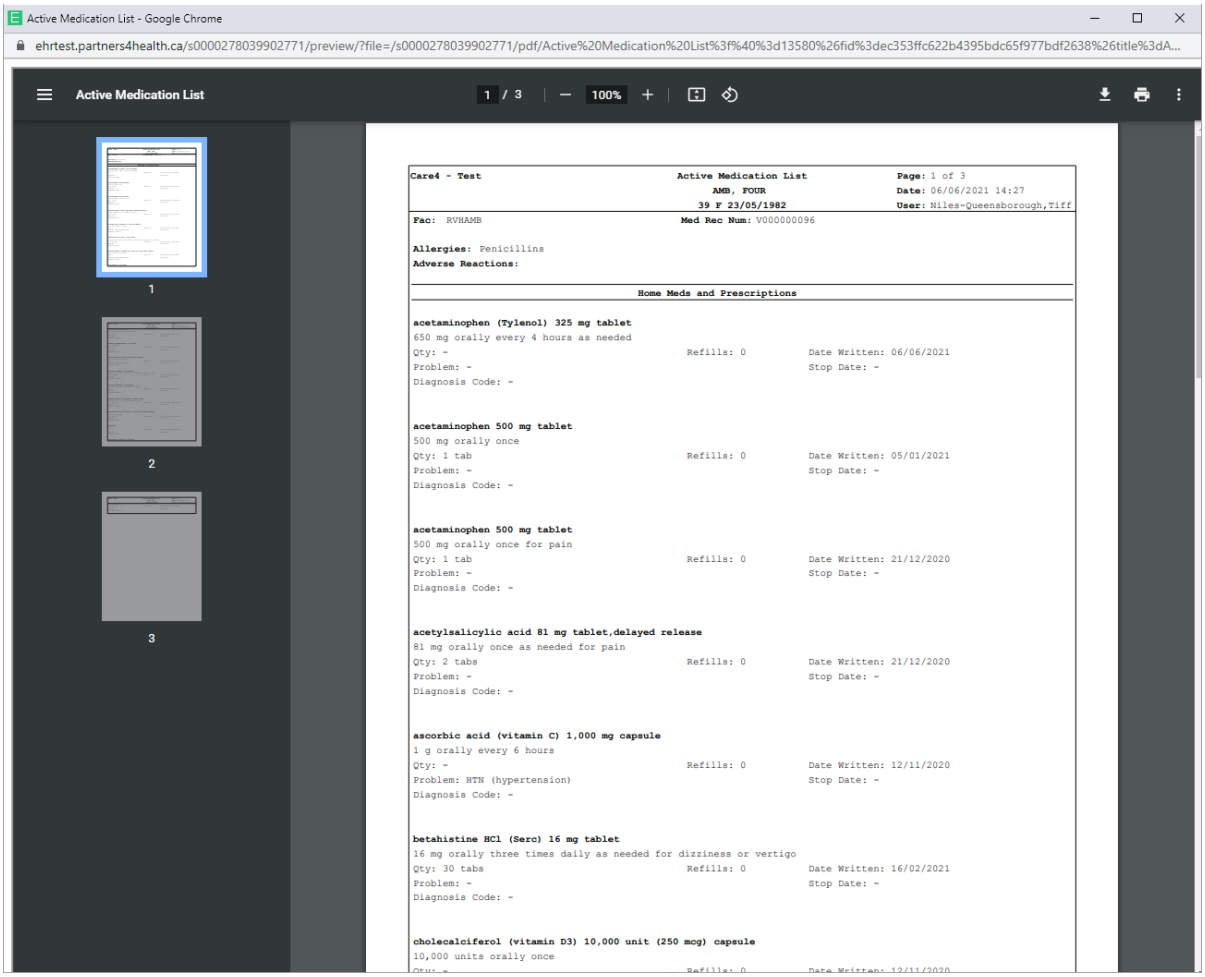

Orders
Medications
Search Orders/Sets
Sign
No Medication Data to Display.
Manage Orders
Outstanding
Order
Service Date
Ordering Provider
Order Date
Status
*Medication Admin
02/06/2021
Casses,Alberto
02/06/2021
New
*Vitamin D 25-Hydroxy
Casses,Alberto
06/06/2021
Remove
Save as New
*Frequency
Routine
*Location
*Service Date
*Provider
Casses,Alberto
*Specimen
Send patient for collection
Problem
Diagnosis Code
CC Provider
Complete Blood Count
30/11/2020
Castillo,James
30/11/2020
Active
CT Abdomen Pelvis WO
Castillo,James
Stop
CT Abdomen W
Hanrahan,Renee Melanie
06/05/2021
Active
Amb,Four
39, F · 23/05/1982
HCN# 3177154287-CB
MRN# V000000096
No Show
SCH AMB, V.FRACTURE
Visit Date: 02/06/2021
Code Status Not Addressed
No Hx Avail
Search Chart
CT Abdomen W 06/05/2021
CT Abdomen W 06/05/2021
CT Abdomen W 06/05/2021
CT Head Complex W 10 days ago
RAD Foot RT 2 or 3 vws 4 days ago
Office
Medication Admin 21/12/2020
Medication Admin 05/01/2021


Problems & History List
AMB,FOUR (c) 39 F 23/05/1982 Allergy/Adv: Penicillins
Cancel
Save
Search for: New Problem
Filter
Rank Problems
Mass Edit
Active Problems
Description
Onset
Add to Doc
Add to Order
Schizo-affective schizophrenia
Anxiety
Unknown
Evolving problem TEST
Abscess
Foreign body
Stress at work
Syncope
Visit Problems
Resolved/Inactive/Ruled-Out (R/I/R)
Deleted
Medical History
Description
Onset
Abscess
Anemia
Anxiety
Unknown
Evolving problem TEST
Chest pain
Diabetes
GERD (gastroesophageal reflux disease)
HTN (hypertension)
Diet Controlled
Hyperlipidaemia
Normal coronary angiogram
Osteoporosis
Schizo-affective schizophrenia
Stress at work
Syncope
Surgical History
Description
Onset
Hernia of abdominal wall
Hx of appendectomy
2010
Previous cesarean section

Print the Active Home Medication List

To print an active medication list, select the output icon and then select the Print Active Med List or Preview Active Med List.



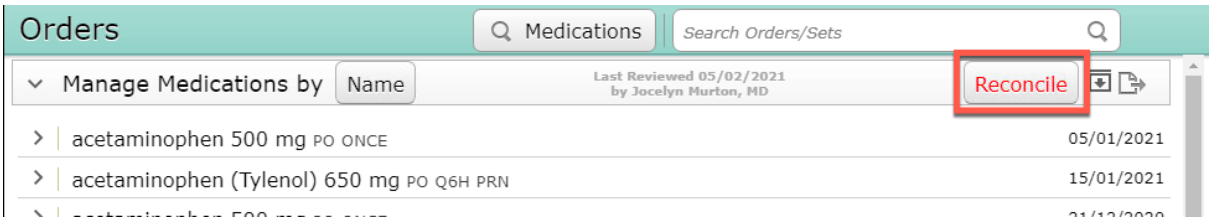


Removing Orders

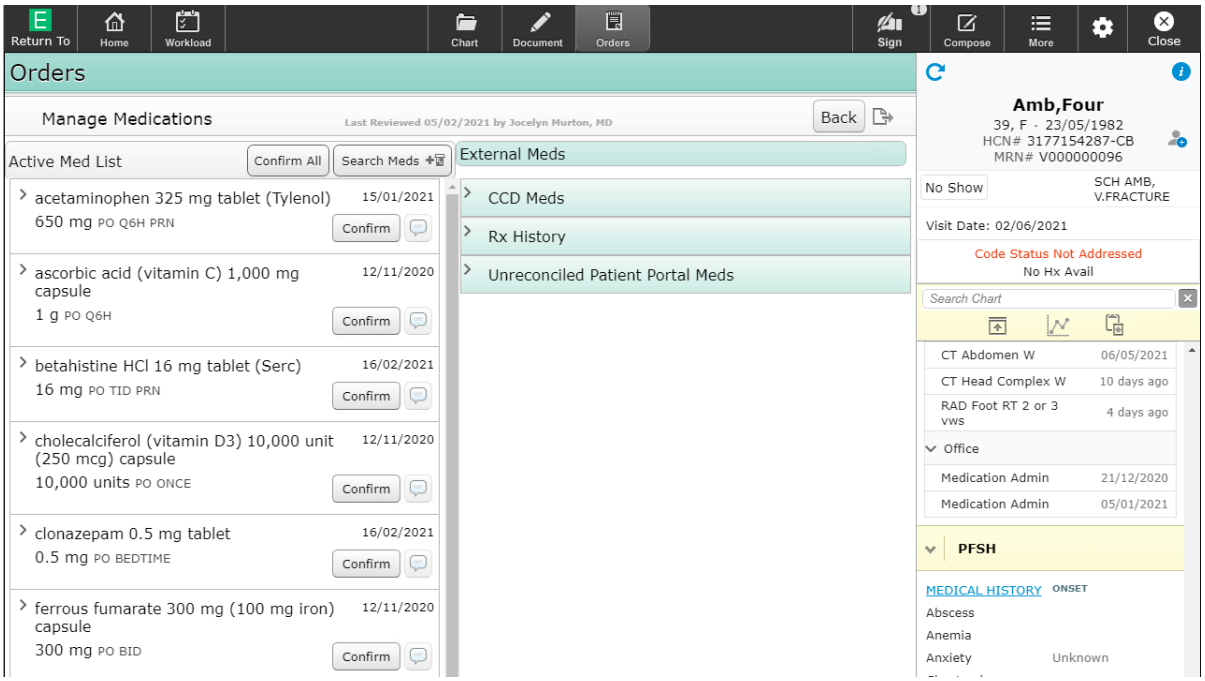
If an order is placed incorrectly, the order can be removed by clicking “new” and then “remove.”

Note: only orders with a “new” status can be removed. If the order is active, it must be discharged

Reconcile Home Medications

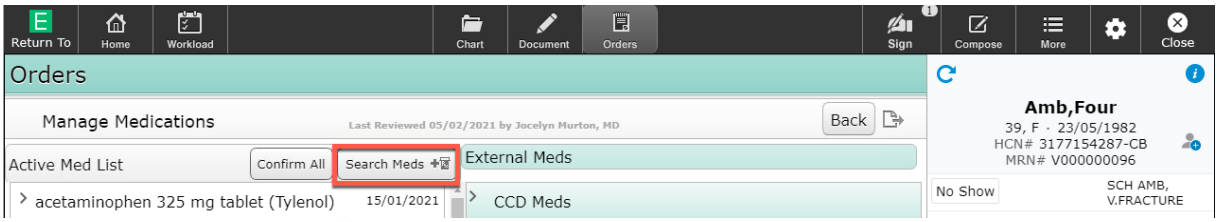


The Reconcile orders screen appears when by selecting the Reconcile button. Use this routine to confirm, edit, add, or remove active home medications from a patient's chart. You can add a last taken date and enter internal comments that are account specific for each medication.



When reconciling, users have the option to prescribe, stop, or confirm the reported medication or opt to re-prescribe the original discontinued Rx. The original discontinued home medications no longer appear when you use the Prescribe, Stop, or Confirm buttons. Likewise, if the original Rx is re-prescribed, the reported home medications no longer display.

Home medications can be confirmed individually or all at once using the Confirm All button. To add a new reported home medication, select the prescription bottle icon to access the Search Medications function.

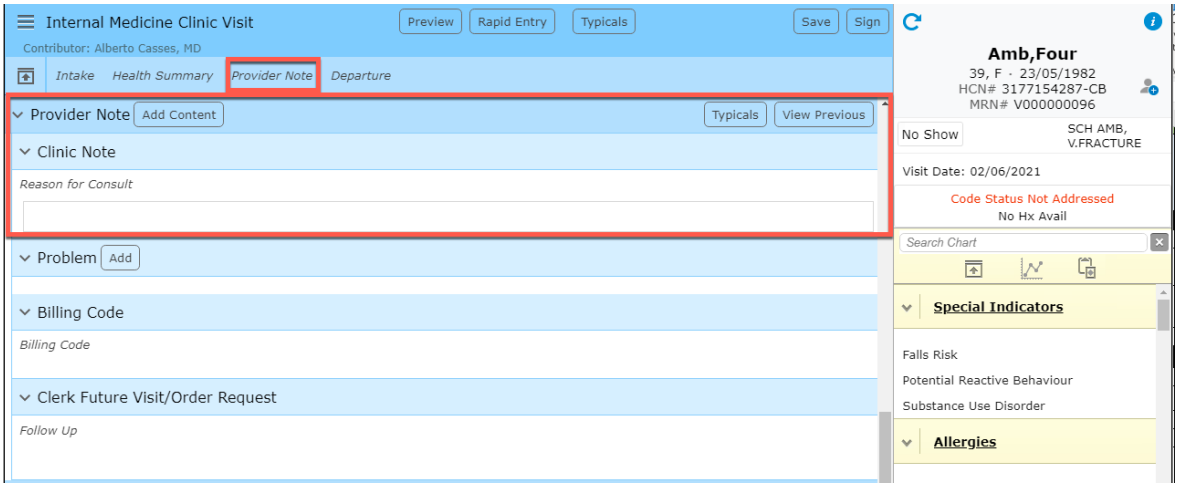


You can also view any external home medications for the patient on this screen.

Documented Administration of Medication

The documentation of medication within Ambulatory expanse differs for provider and non-providers. If a provider administers medication to a patient while in the in the clinic, this administration is documented in the provider-based notes. For non-providers they will document the administration of medications using the “Office Procedures” functionality.

Providers - Documentation of Administered Medications

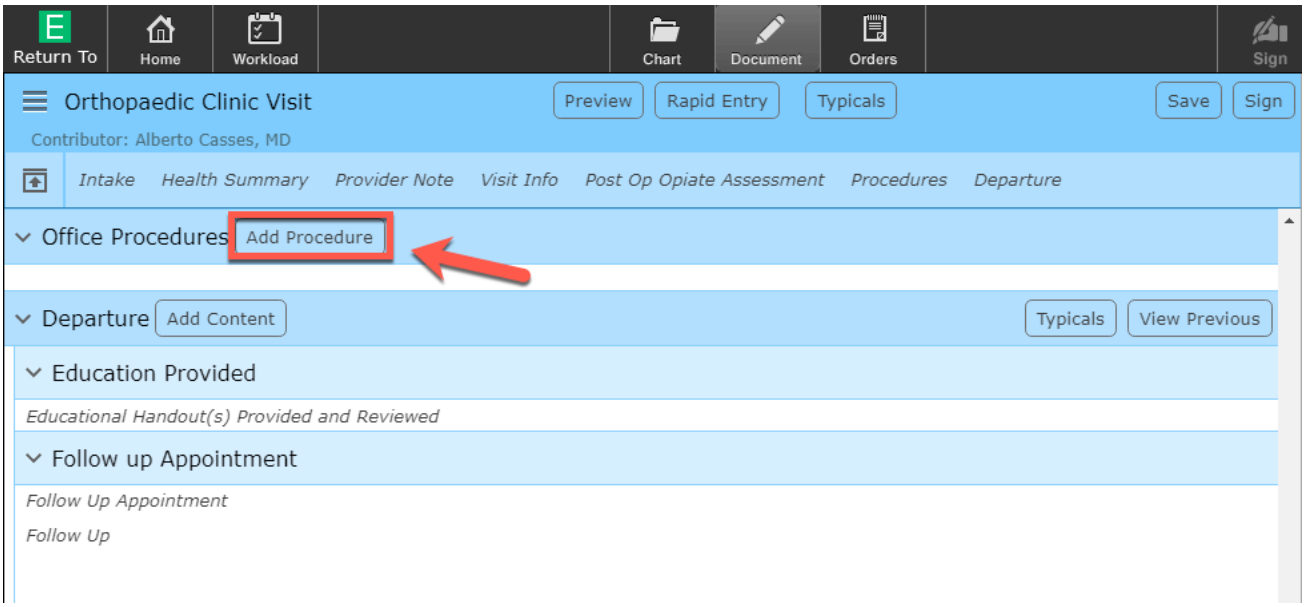


Non-Providers - Documentation of Administered Medications

For non-providers who administer medications:

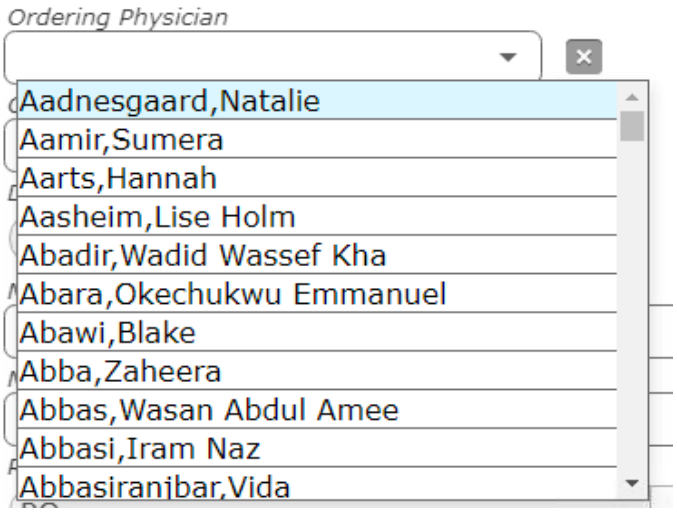
- Non-formulary medications that require a physician’s paper order written to pharmacy
- Medications that are owned by the client and administered in the clinic

Document the administration in Office Procedures in the Ambulatory Document Template

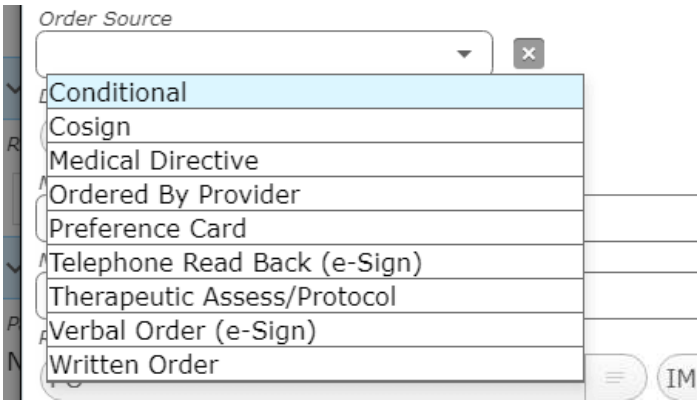


Select the Medication Administration procedure, click on the chevron on the Medication Administrative accordion and then enter the fields:

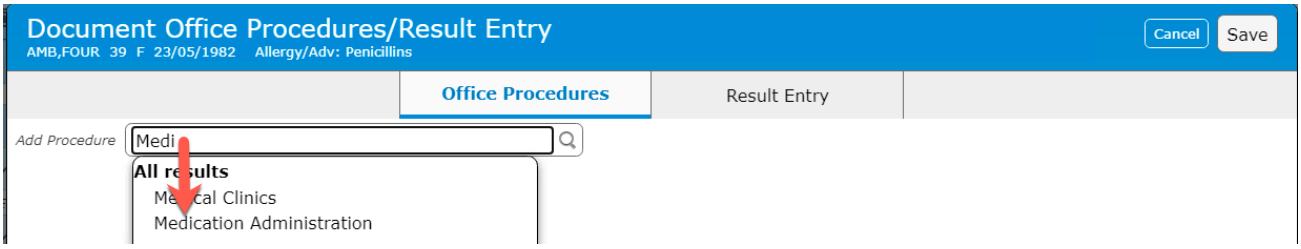
- Ordering Physician (Drop down menu)

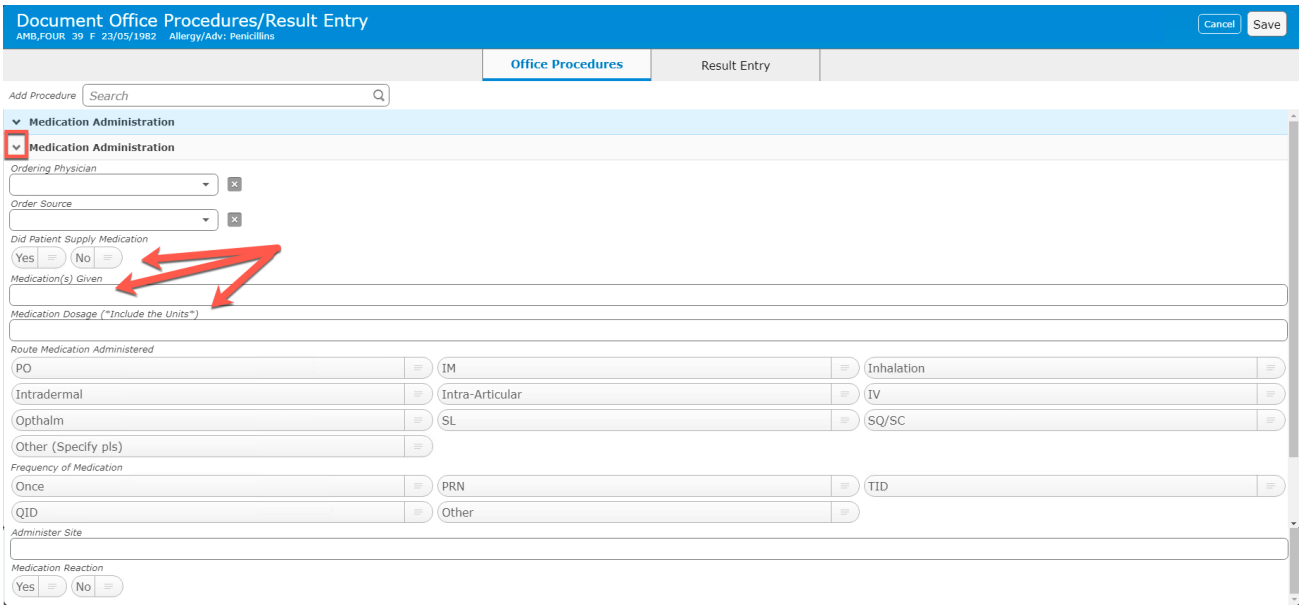


- Order Source (Drop down menu)

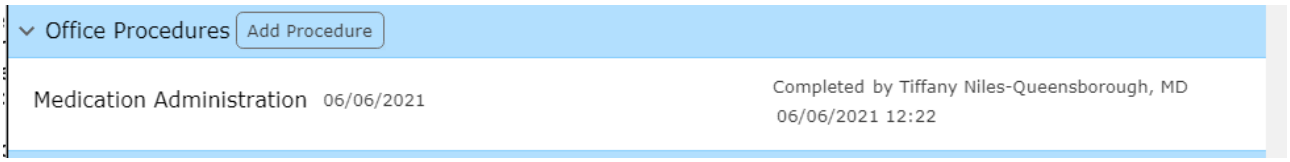


- Did Patient Supply Medication
- Medication(s) Given (Free text)
- Medication Dosage (“Include the Units”) (Free text)
- Routine Medication Administered (Query fields)
- Frequency of Medication (Query fields)
- Administer Site (Free text field)
- Medication Reaction (Yes or No)



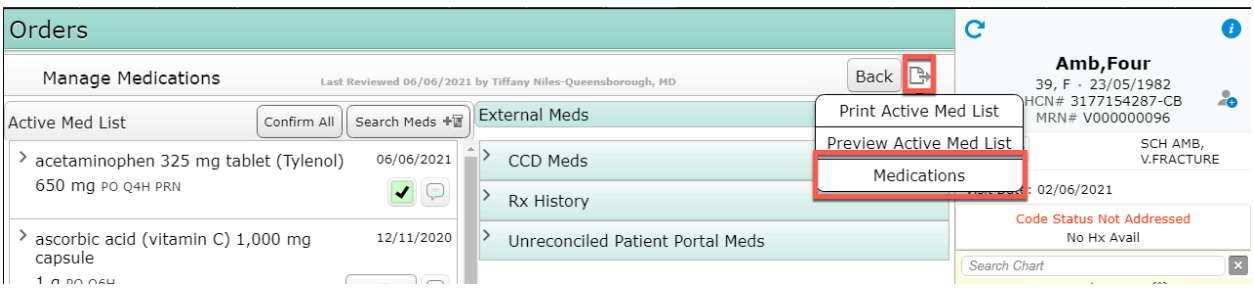


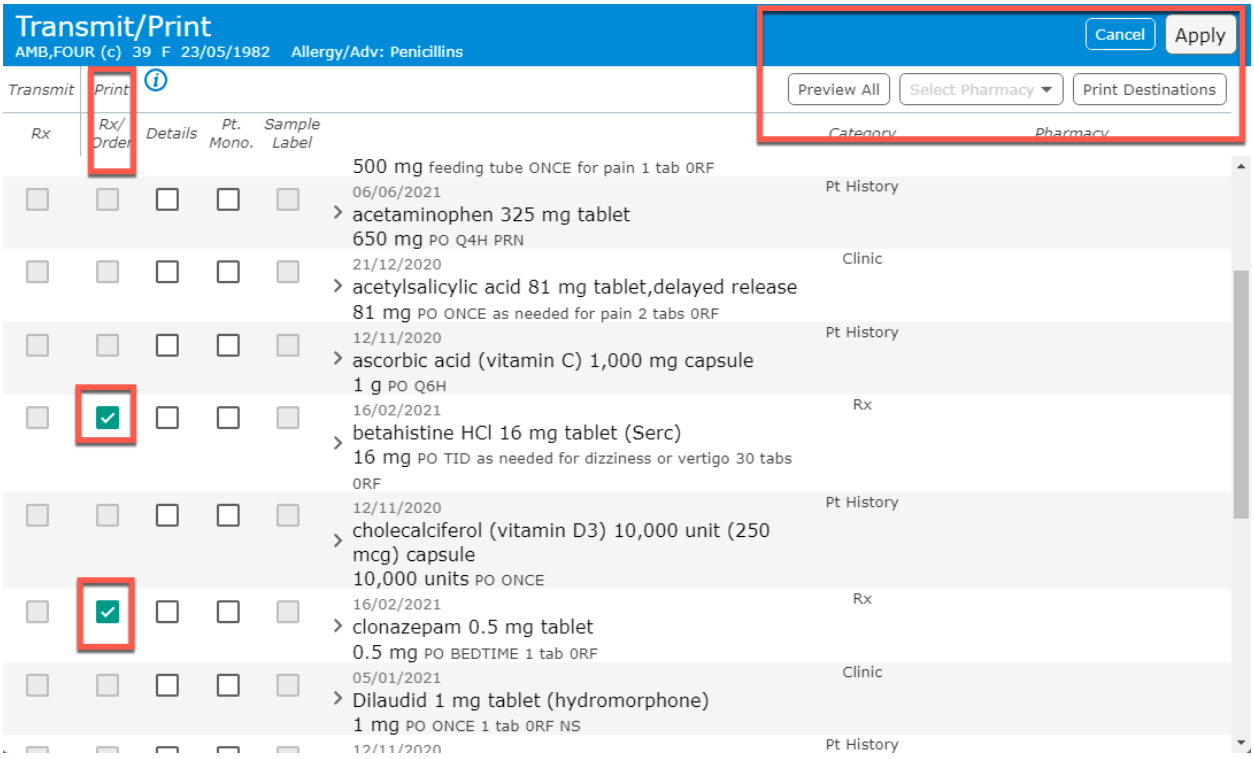
After saving the entries entered in the “Office Procedures” section of the document. It will appear in the document as below:

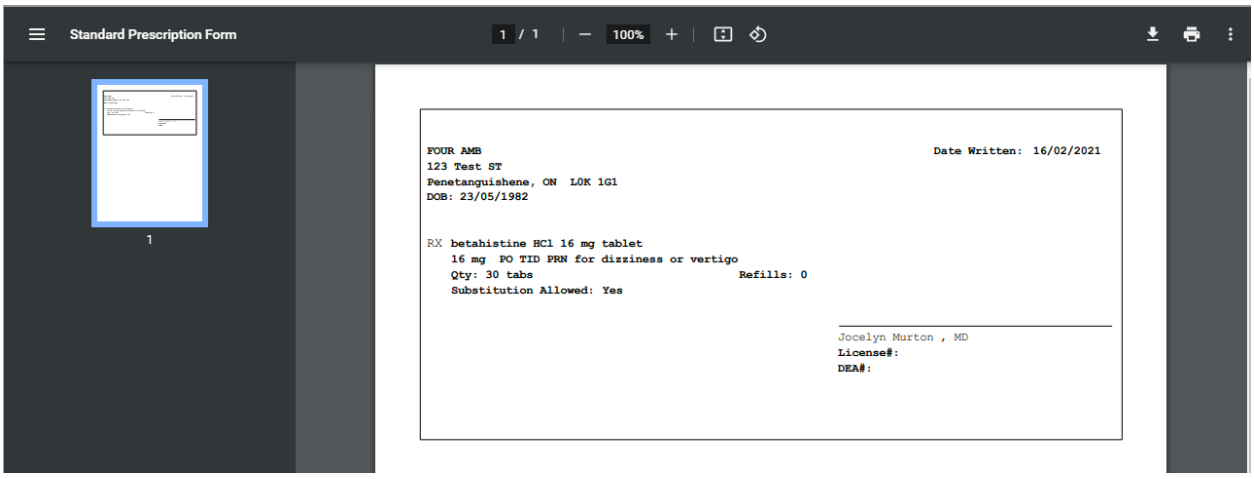


Print Prescriptions

Prescriptions can be printed from the reconciliation screen. Click on the link to access medications. Next indicate what prescriptions you want to print. There are options to Preview all or print the prescriptions. Below is an example of what a report will display.



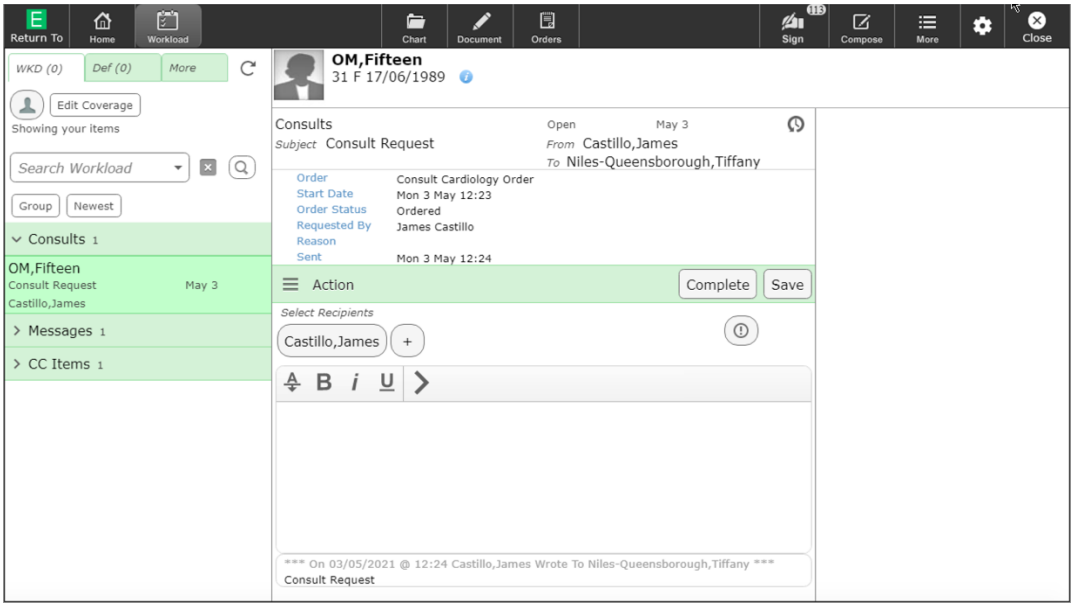




Workload

Workload is an internal messaging and task system within the Expanse system. The main Workload screen allows you to manage your messages and tasks (or those for

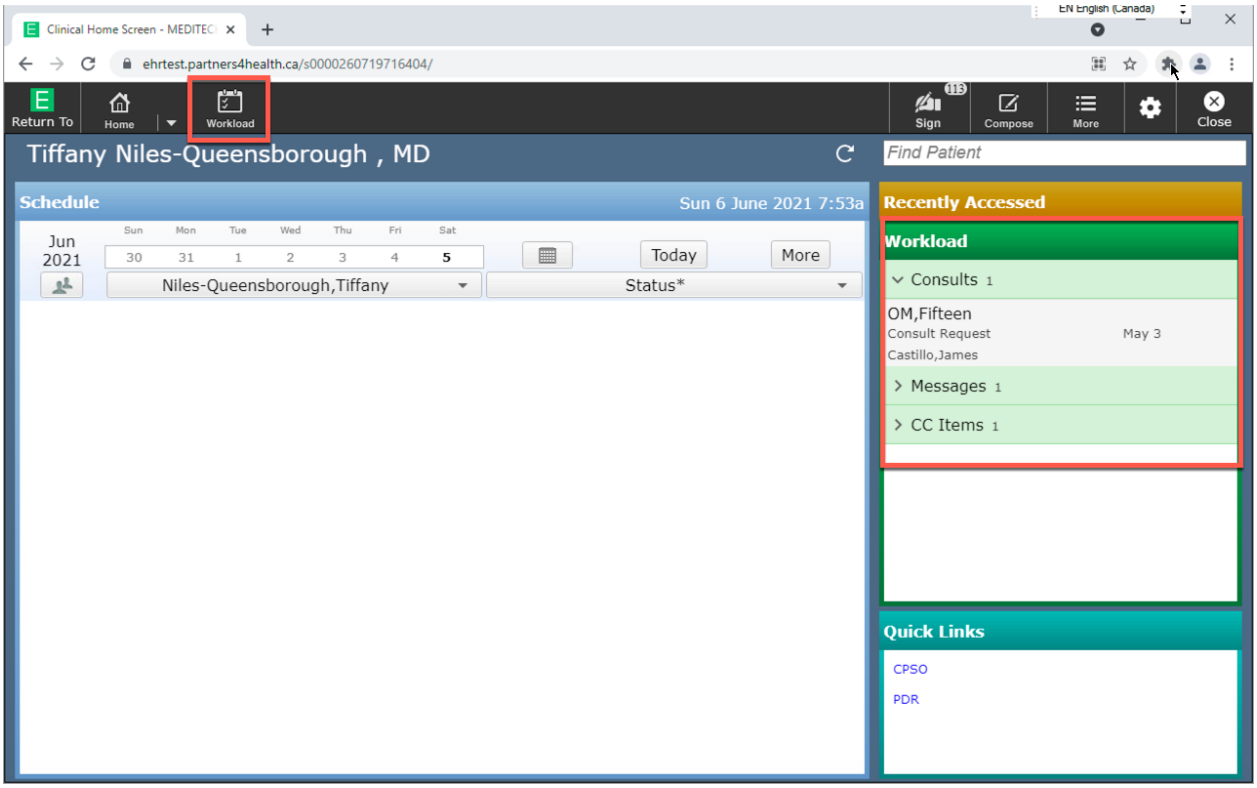
whom you are covering). The Workload screen can be accessed by selecting a message on the message list or by selecting the Workload button on the Black Navigation Bar.



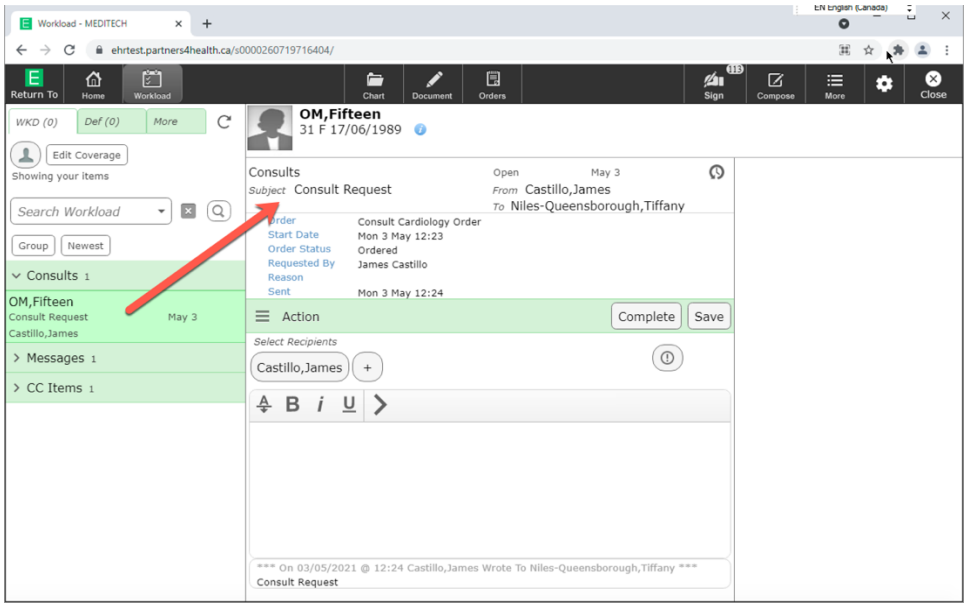
Key features:

- Send messages and tasks to others
- Set reminders to yourself
- Messages can be placed that are patient and account specific
- Workload keeps track of messages, viewed messages, updated messages and sent items.
- Chart deficiencies can be managed from one of the three main tabs in the Workload screen

Workload can be accessed from the “Clinical Home Screen” or from the Navigation Bar.



The green panel box on the right-hand side of the Clinical Home Screen will indicate when a clinician has outstanding workload tasks. Workload messages are accessible by selecting the workload item.



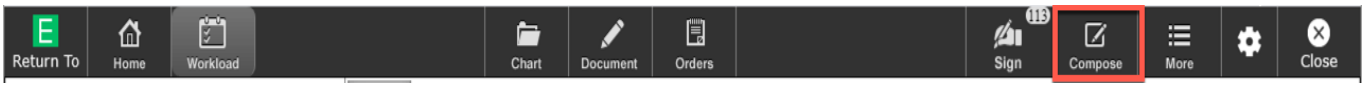
Within the Workload Routine, messages and tasks are organized by message type within the message queue on the left-hand side of the screen (e.g., all messages sent as cc's are grouped together).

To generate reminder messages, users can send messages to themselves. These messages will appear in the message list on the left-hand side of the message queue. Messages can be opened by clicking on them from this queue; this will result in the selected message being visible in the large window on the right side of the screen.

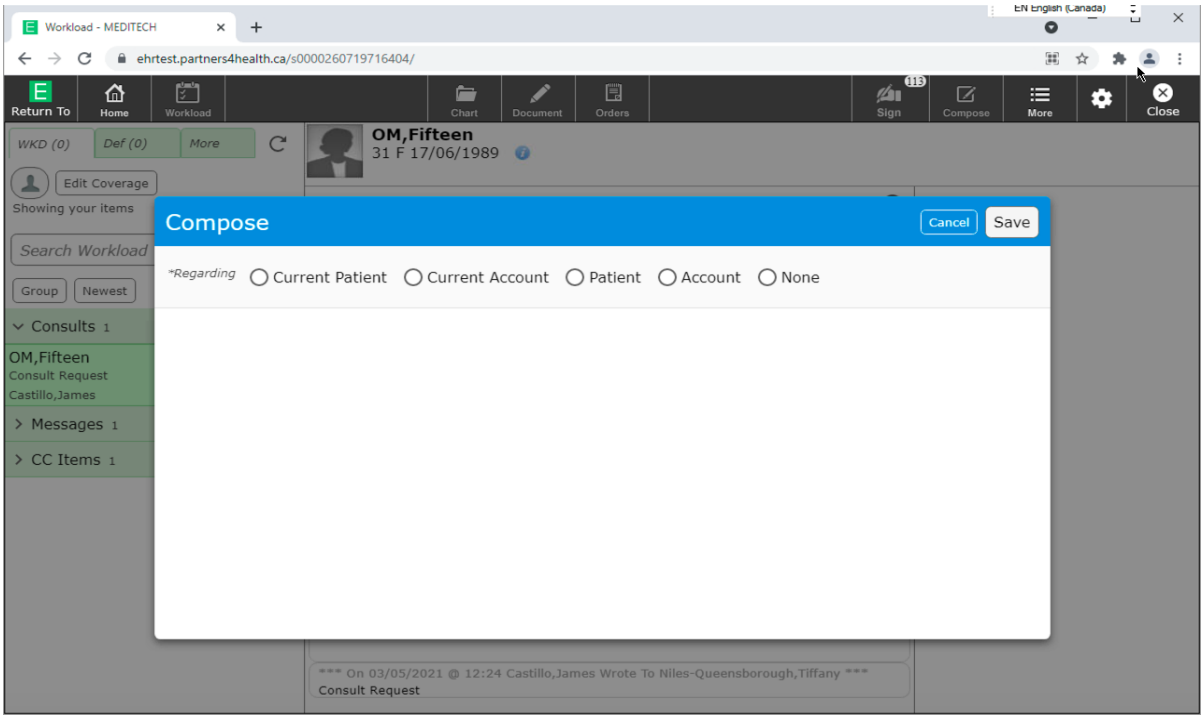
Messages can be post-dated. These reminders will move into the workload queue on the date they were set to appear.

To Compose a Message

Workload messages can be composed by clicking on "Compose" icon on the right-hand side of the black navigation bar

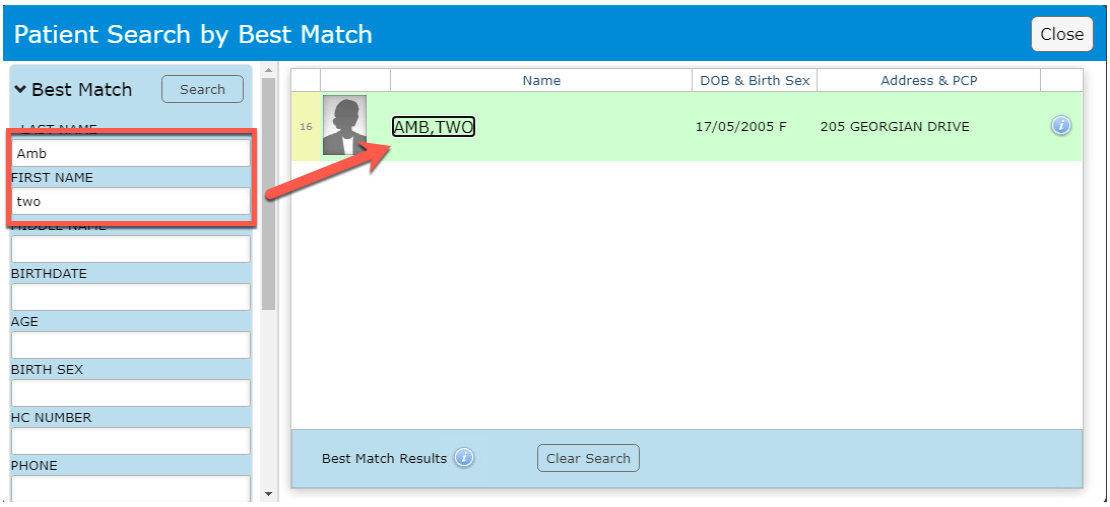


Messages can be composed that are independent of a client and are colleague to colleague. They can also be composed to be directly linked to a client chart (with the option to send to a colleague or file directly to the chart).

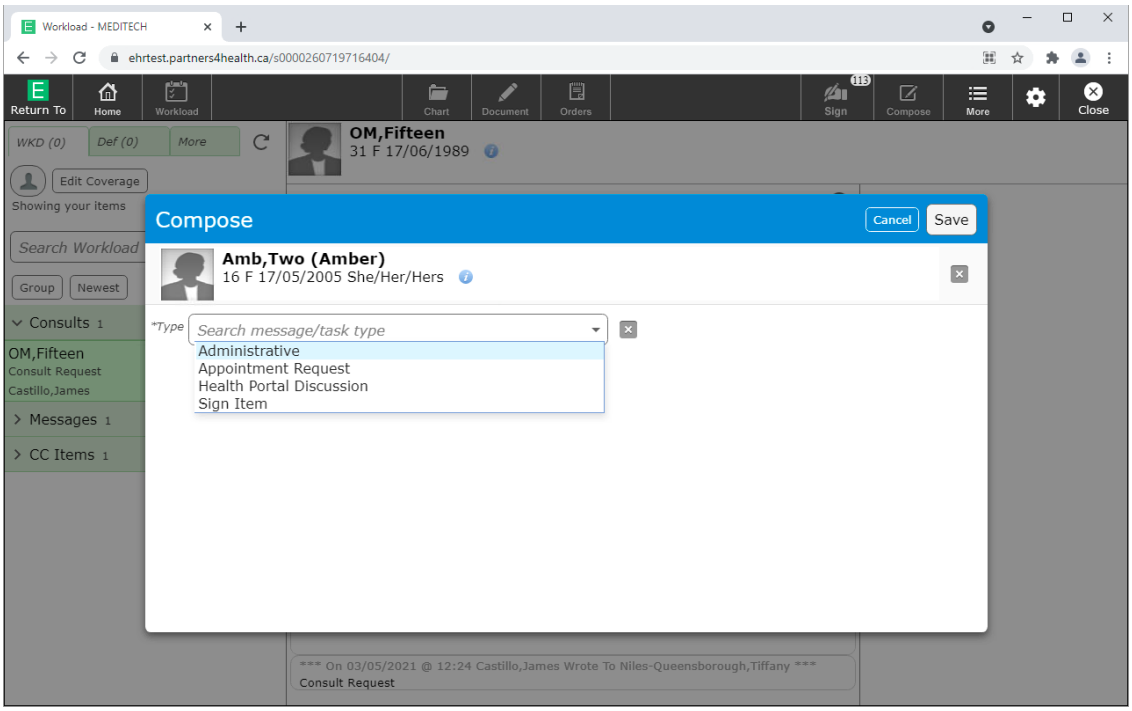


To compose messages that are linked to the client, follow all steps above, except:

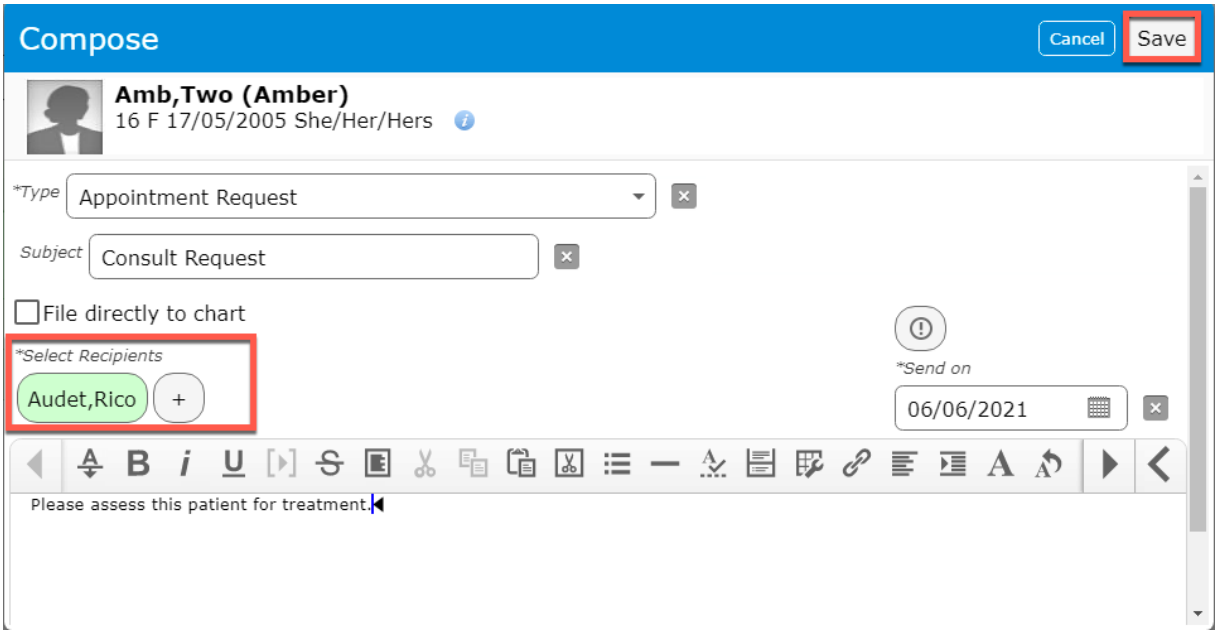
1. Select “patient” from the message type options
2. Search for the desired client



3. Select note type from drop down menu that best describes the reason for composing message related to client

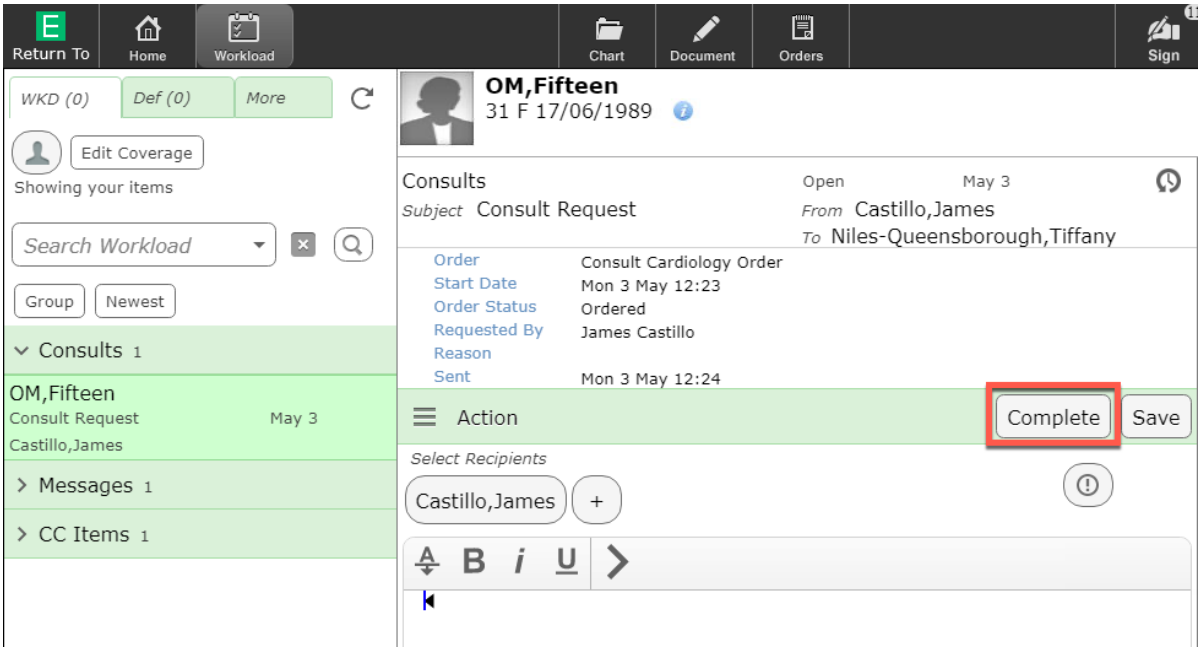


Note: Client specific messages can also be sent by clicking “Compose” while in a client’s chart. In this case, clinicians can either send an interprofessional message by adding recipients, or clicking “file directly to chart” to send to the chart directly. In both cases, client specific workload messages generated from the chart will be visible in the client’s chart.



Reply to messages by typing directly into the Meditor box located within the message window. Press Save button when complete to send a message back to the person it was received from. Ensure their name is selected green.

When a message thread is no longer required, clinicians can remove it from their workload queue by selecting the “complete” button.



To Set Reminders

To send reminders to oneself:

1. Compose a message, selecting yourself as the recipient
2. Either save message immediately to send at the current time, or select a desired date from the date bar located just above the Meditor Box. If a future date is chosen, Workload will send the message on the date selected.

Appendix

Meditech Terminology

- **PCS** – Patient Care System. – Clinical (Nursing, Ancillary staff module)
- **EDM** – Emergency Department Management – ED module
- **Web Acute** – Web-based Acute/Inpatient Module
- **WebED** – Web-based Emergency Department module
- **CPOE** – Computerized Provider Order Entry – Provider Order Entry Module
- **PDOC** – Physician documentation
- **eMAR** – Electronic Medication Administration Record – MAR
- **BMV** – Bedside Medication Verification
- **PHA** – Pharmacy module
- **Dictionary** – Database used in the build of MEDITECH modules
- **Access** – Built-in the background. Used to define user access to MEDITECH
- **EMR** – Electronic Medical Record - a partial health record under the custodianship of a health care provider(s) that holds a portion of the relevant health information about a person over their lifetime. This is often described as a provider-centric or health organization-centric health record of a person.
- **EHR** – Electronic Health Record - a complete health record under the custodianship of a health care provider(s) that holds all relevant health information about a person over their lifetime. This is often described as a person-centric health record, which can be used by many approved health care providers or health care organizations.
- **Query** – Question. MEDITECH templates are made up of multiple queries
- **Query types**;
  - **Single group response** – the user is able to select just one query response
  - Multiple group response – the user may select several of the responses provided
  - **Yes/No** – response is either yes or no. This query type may be accompanied by a comment field.
  - **Date** – provides a calendar to select the date
  - **Time** – provides a clock to select a time
  - **Comment** – free text of 75 characters or less.

  - **Text** – free text of greater than 75 characters. It allows almost an unlimited amount of text.
  - **Quantity** – number including a decimal
  - **Number** – whole numbers

    - **Optional** – single group response with the ability to add a comment.
- **Clinical Panel/Flowsheet in Web Acute** – Groups of data elements displayed in flowsheet format. Elements may be coming from any module, Lab, PHA, PCS, etc. This tool is not bi-direction. Information flows into the panel only.
- **Status Board** – Used primarily by nursing and ancillary staff. Status boards are patient lists generally for a specific location. Provides a high-level overview of patient condition. Status boards may also reflect a specific department (Maternal Child, Mental Health, Infection Control)
- **Critical Care Flowsheet** – Not to be confused with a Clinical Panel/Web Acute flowsheet the Critical Care flowsheet has been designed specifically for high acuity areas (ICU, PACU, and NICU) where viewing patient condition in flowsheet format is optimal. Data may be pulled onto flowsheet for organizations/departments where monitors are interfaced.
- **Snapshot (PCS)** – Part of the patient EMR. A collection of widgets, grouped together to pull data from documentation, lab, pharmacy, etc. Will be used during the Transfer of Care (TOA) process
- **Widget (Web Acute, PCS)** – Grouping of data which may be customized (Web Acute) Provides a comprehensive overview of patient condition. Will be used for shift handover for nursing.

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    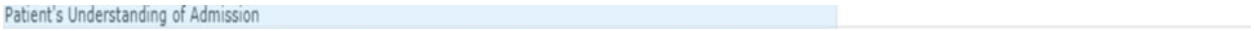

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- **PIN –** Personal Identification Number is a security code used to authenticate user's access to system functions.
- **E-signature** – a feature that allows users to "sign" reports, notes, orders in the electronic system by using a PIN or personal identification number. – a feature that allows users to "sign" reports, notes, orders in the electronic system by using a PIN or personal identification number.
    - **Order String** – common order directions for a medication that is available for a quick selection. These are shown when selecting a medication order in Web Acute, Web ED or PCS.
- **CDS Order String** – common order directions for a medication that is available for a quick selection. These are shown when selecting a medication order in Web Acute, Web ED or PCS.
- **CDS** – Clinical decision statements are pieces of information to support the decision making for the order selected. These are usually followed by an icon that opens an external link to Evidence-based documents.

- **Deficiency** – lack of completeness of a patient chart; it can be due to a lack of e-signature of a document or an order.
- **Plan of Care** – A set of tasks and goals intended to manage a specific patient condition. Plans of care can contain problems, outcomes, and interventions. – A set of tasks and goals intended to manage a specific patient condition. Plans of care can contain problems, outcomes, and interventions.
- **Reflex order** – Automatic ordering of tests or procedures that are added to orders under specific conditions. For example, an indwelling urinary catheter with a reflexed order for removal.
- **CWS** - Community-wide scheduling - module that simplifies appointment scheduling - Community-wide scheduling - module that simplifies appointment scheduling