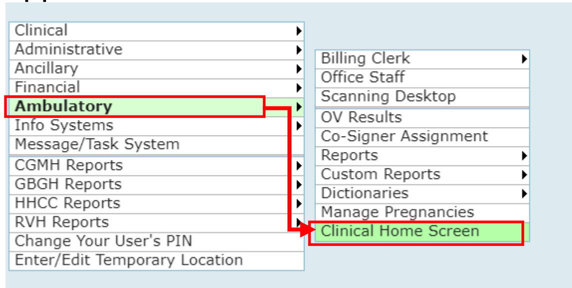
# CARE4 MODULE NAME: AMBULATORY

## OP Physiotherapy

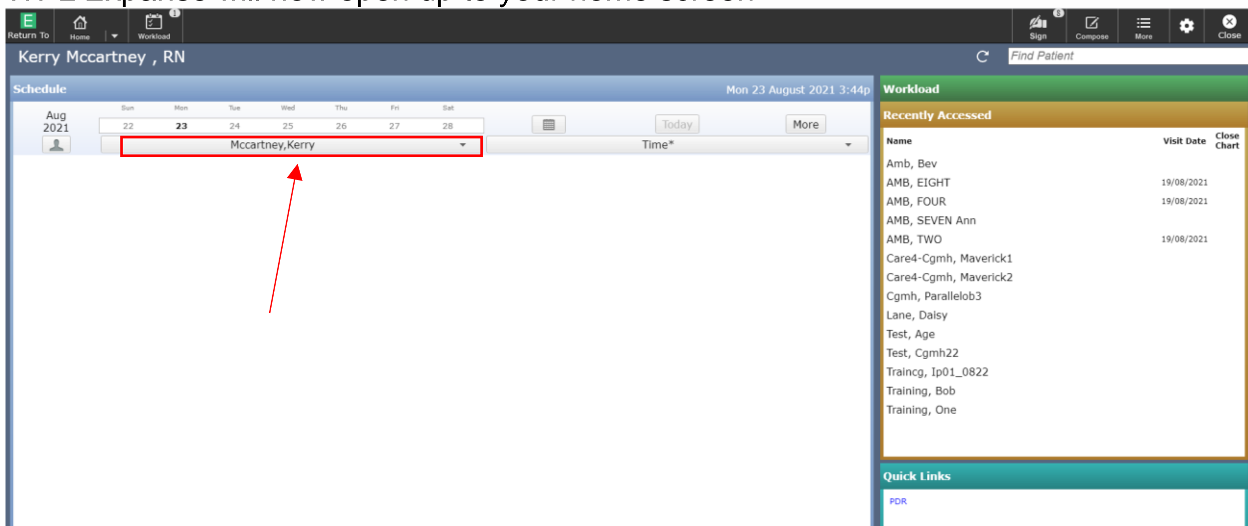
Once you log into Expanse, under the physiotherapy job, you want to ensure that you change your subdivision if needed to an AMB facility; if RVH then RVH AMB, if CGMH then CGMH AMB. Some of you have been set to automatically go to your AMB facility. If you haven't then you will need to change this every time you log in.

Once you have picked the correct subdivision, click "ok" on the bottom right corner of the screen.

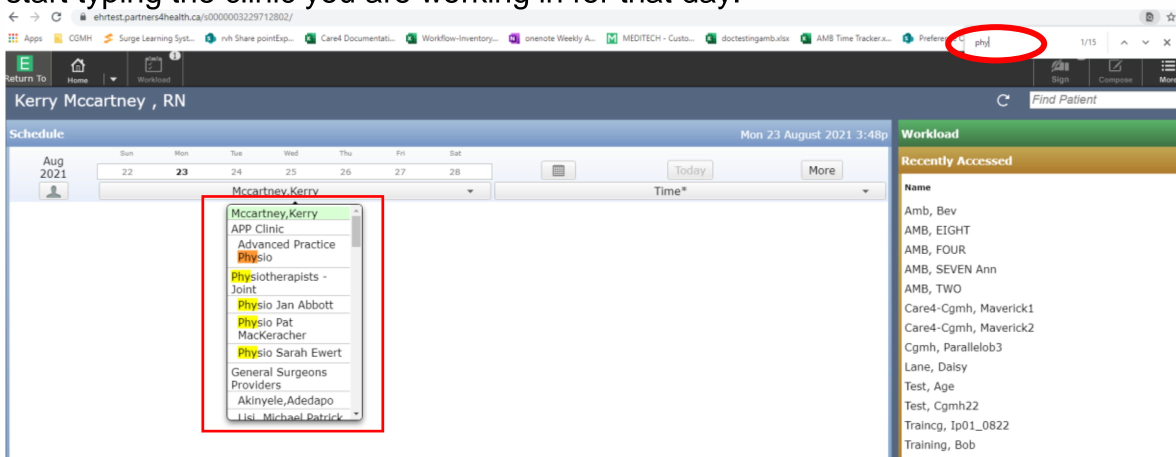
You will then proceed to click Ambulatory then clinical home screen to open the application.



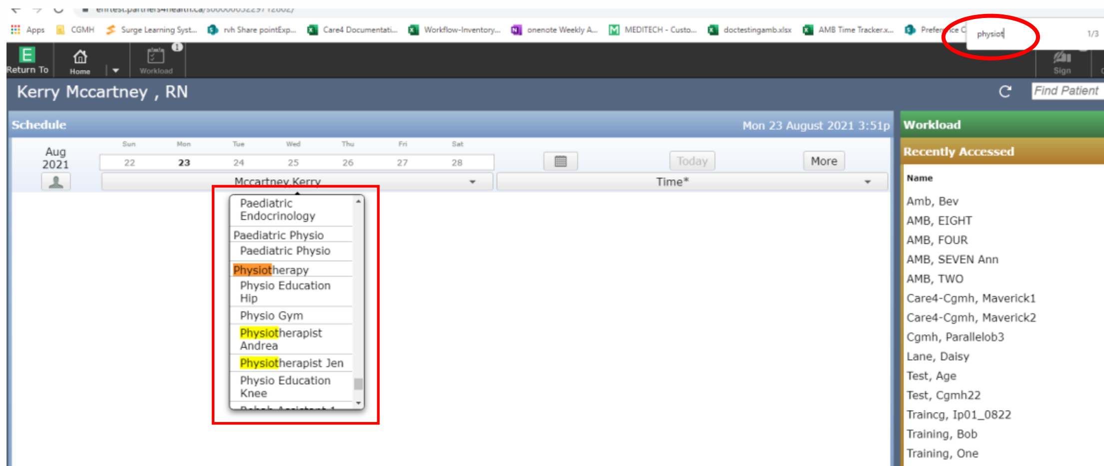

WPL Expanse will now open up to your home screen



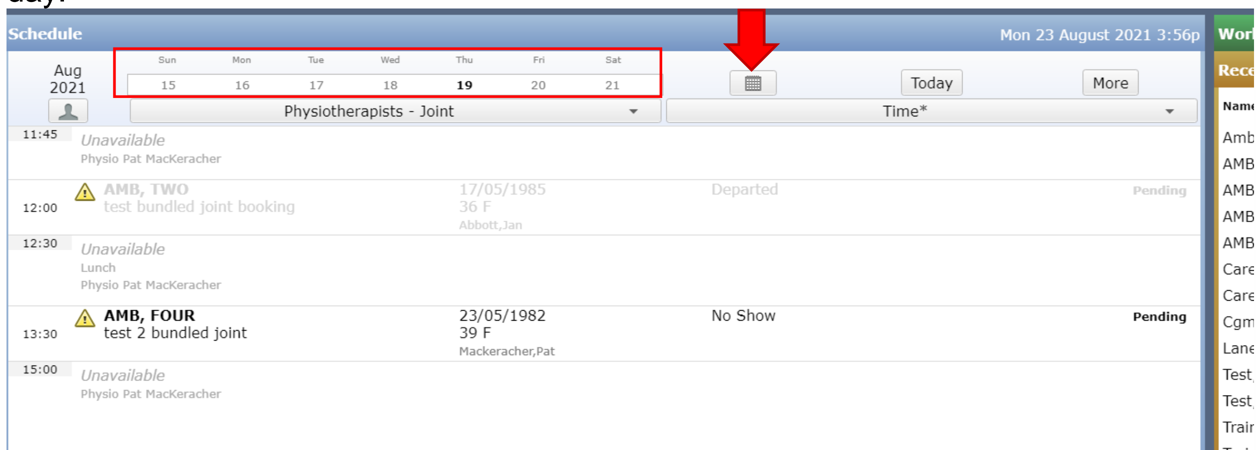

You are now going to click on your name and find the appropriate clinic you are looking for. * Hint, once you have the menu open press Ctrl + F to bring up a search menu and start typing the clinic you are working in for that day.




Or



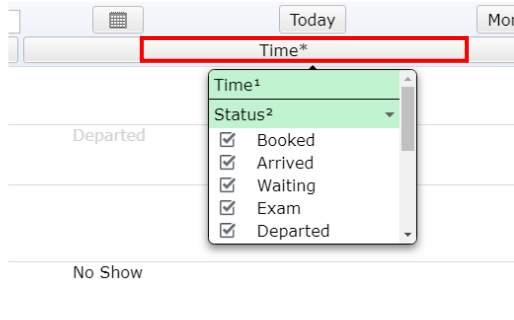

Or you are free to scroll through the list until you find the clinic you are looking for. Once you have selected a clinic, the list of patients booked/arrived will appear for that day.

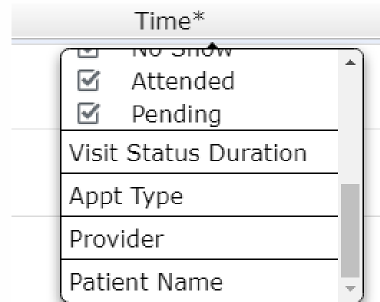


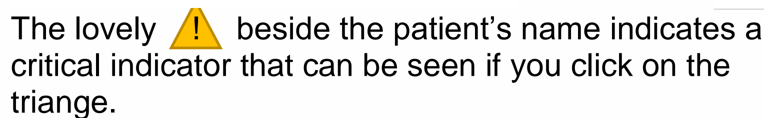

From this schedule you are able to change the date to view other dates if wanted by either clicking on the date you want within the top header or by clicking on the calendar and choosing a date. **Caution with doing this please ensure you do not document on the wrong date; nothing will stop you from documenting on the wrong date if you select that date and open documentation/the chart under that visit date. **

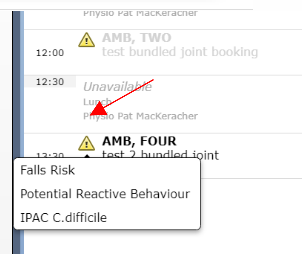
The patient's status will remain in "Booked" status until they arrive and are registered. Once registered, the status will change to "Arrived". The patients will automatically be set to departed/no show at midnight if not done so.

*Note, you can change the way that your home screen is displayed by clicking on the "Time" bar and selecting how you would like to appointments to appear. In this example, they are appearing by time first then by status.

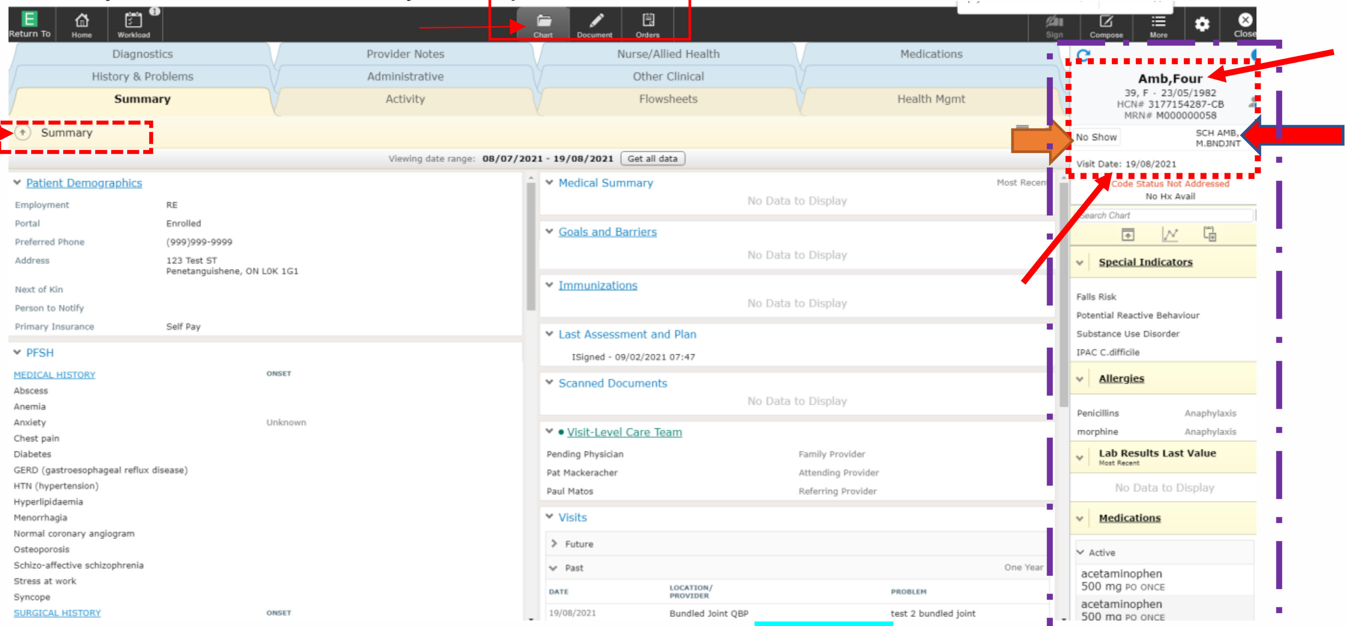



The lovely  beside the patient's name indicates a critical indicator that can be seen if you click on the triange.



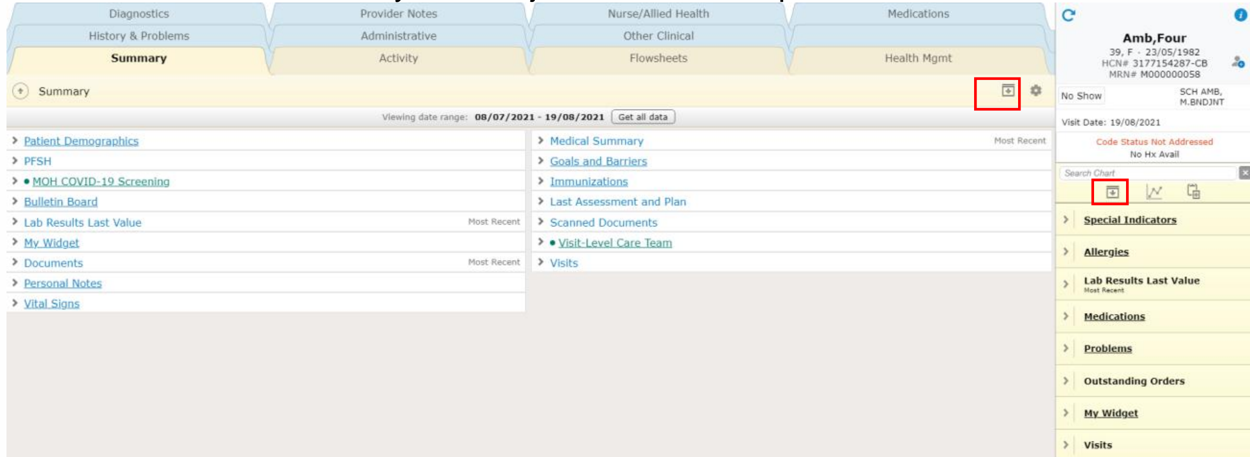

Once ready, select the patient you would like to chart on/see chart. You can click anywhere in the box with the patient's information in it. This will launch you into the patient's chart. You can tell where you are in the chart by the top folders.



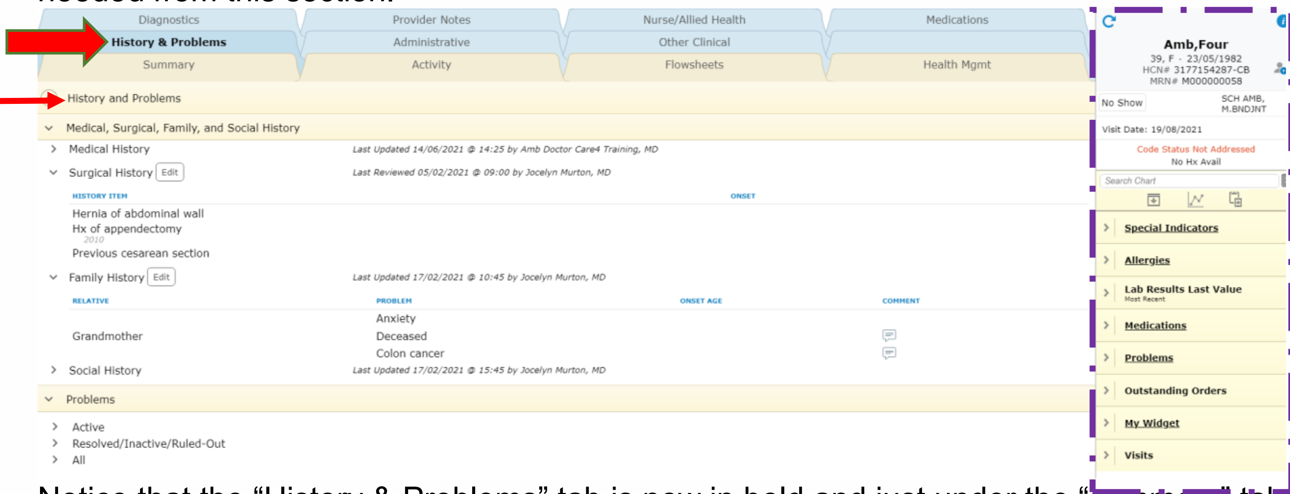

When you look at the top black tool bar you see that chart icon is highlighted in grey; this indicates that you have the chart open. The summary section of the chart is open indicated by the word "Summary" appearing on the left side of the chart. If you were to click on another tab in the chart this will change.

The right side of the screen is the reference region of the chart. This section will remain the same no matter what you are doing in this patient's chart or documents. It will display the patient's demographics, the status of the appointment, the appointment type and visit date, all at the top of the reference region. Under that are widgets that are used for a quick reference while you are navigating the chart. The reference area includes special indicators, allergies, lab results, home medications, any orders that are

on the patient. Some of these “widgets” can be customized. To close all the widgets so that it is easier to find what you want just hit the little square with the arrow in it.




This makes it easier to see what is within each section. You can click on the side > to open each section individually when needed. To view other sections of the chart just click on the tab that you would like to open. The “History and Problems” tab will include the patient’s medical, surgical, social and family history, which can also be updated if needed from this section.




Notice that the “History & Problems” tab is now in bold and just under the “summary” tab now states History and Problems, indicating that you are currently in the History and Problems tab of the chart. Also note that the “reference” region remained unchanged letting you know whose chart you are currently navigating. The “Diagnostics” tab will house any lab work and imaging results. Any reports can be found under the “Provider Notes” tab (including other physiotherapy/rehab visits). “Nursing/Allied Health” tab will show any nursing/allied providers notes, or documentation from other outpatient visits, as well as financial statements. “Activity” tab houses all the patient’s activity, including booked appointments, hospital stays…

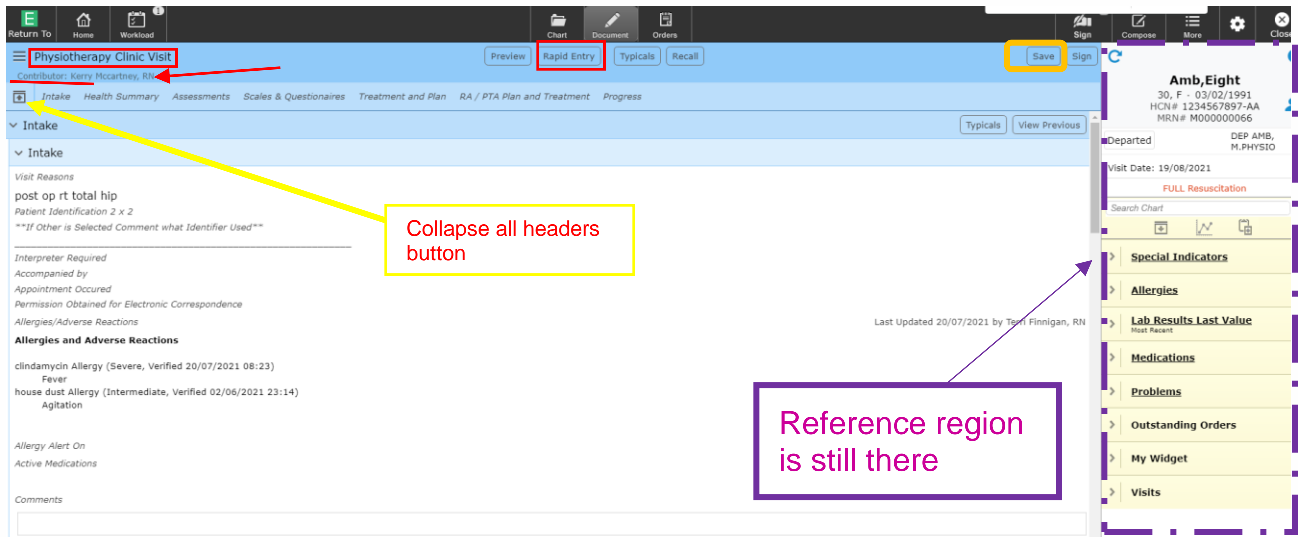
To start documenting on this patient's current visit, click on the document tab found in the middle of the black tool bar located at the top of the screen. Then you will click on “ALL” to see if a document has been started by another team member.

Select the document that is already opened if you want to chart on the same document. If not open another document or note.

If no other document for this Patient visit has been initiated, then select the document type that you would like to use. For a note, please select the note type document and for the visit document, select the visit document or report.

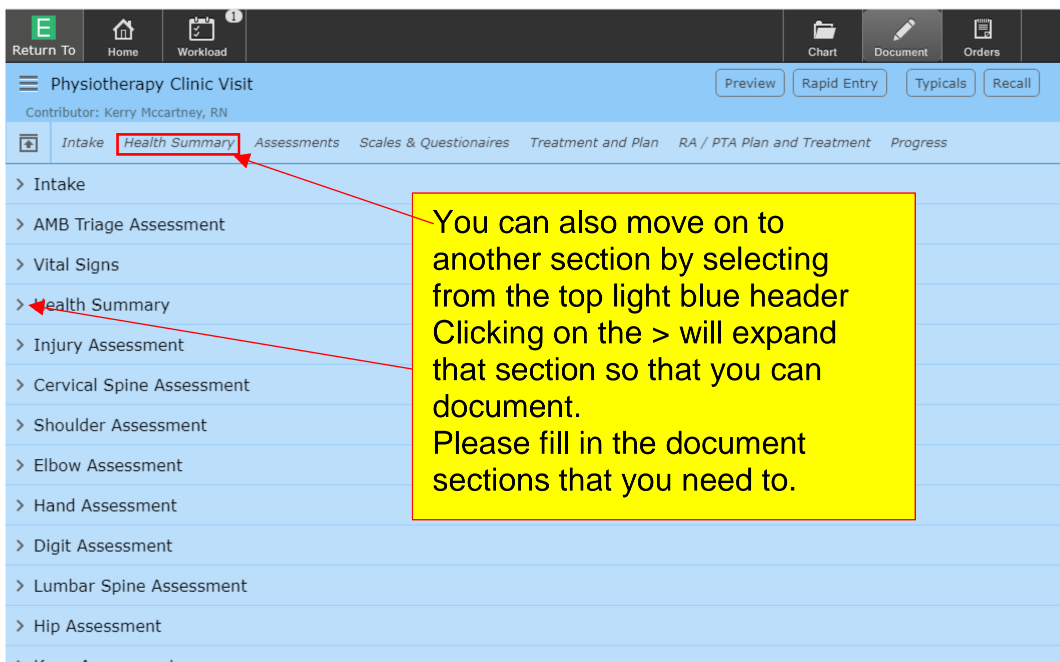
Search

You can use the search bar to find your document, or you may scroll through until you find what you are looking for. To save a document to your favorites click on the star, it will turn yellow and from now on when you open documents, your stared documents will be the only ones that appear, unless you hit the "show all" box.




Now you have a document open. The name of the document appears in the top left corner "Physiotherapy Clinic Visit".

1. The first thing you need to do is hit the "Save" button at the top right corner of the document, this will then add you as a "Contributor" to this documentation, which will appear under the document name in the top left corner
2. You then will want to hit the "Rapid Entry" button in the top middle of the document. This will change the look of your documentation, and will be easier to fill in.
3. If the screen looks too busy then hit the square with the arrow; that will collapse all the headings. Now you can open what you would like to by picking it out of the blue header or pick it out from the list you just created down the left side of the screen.



**Note you can also edit the patient's history from this section of the document, and it will update the "History & Problems" tab of chart as well. If you updated the patient's history under the "History & Problems" tab of the chart section it will update in this section as well and show by whom and when it was last updated.

Physiotherapy Clinic Visit | Preview | Review and Refine | Typicals | Recall | Save

Contributor: Kerry Mccartney, RN

Intake | Health Summary | Assessments | Scales & Questionaires | Treatment and Plan | RA / PTA Plan and Treatment | Progress

Vital Signs

Health Summary | Reviewed All | Add Content

PMFSH

*Medical History* | Reviewed — Last Reviewed 09/03/2021 @ 09:23 by Kerry Mccartney, RN — *Onset Date*

Asthma
BCC (basal cell carcinoma of skin)
Carpal tunnel syndrome
Gallbladder & bile duct stone with obstruction

*Surgical History* | Reviewed — Last Reviewed 09/03/2021 @ 09:23 by Kerry Mccartney, RN — *Onset Date*

*Family History* | Reviewed | View By Problem — Last Updated 13/07/2021 @ 15:43 by Paul Matos, MD — *Onset Age*

| | |
|---|---|
| Mother | Congestive heart failure |
| Father | Diabetes |
| Brother | No problems noted |

*Social History* | Reviewed — Last Updated 02/06/2021 @ 23:32 by Tiffany Niles-Queensborough, MD

| | |
|---|---|
| How often does anyone, including family, friends and others, physically hurt you | frequently |
| How often does anyone, including family, friends and others, insult or talk down to you | fairly often |
| How often does anyone, including family, friends and others, threaten you with harm | frequently |
| How often does anyone, including family, friends and others, scream or curse at you | fairly often |

Return To | Home | Workload | Chart | Document | Orders

Physiotherapy Clinic Visit | Preview | Review and Refine | Typicals | Recall

Contributor: Kerry Mccartney, RN

Intake | Health Summary | Assessments | Scales & Questionaires | Treatment and Plan | RA / PTA Plan and Treatment | Progress

- Injury Assessment
  - Referral Info
  - Symptoms/ Assessments
- Cervical Spine Assessment
  - Objective Data
  - Neurological Examination
  - Movement Testing
- Shoulder Assessment
  - Shoulder Goniometric ROM
  - Gross Shoulder Strength
- Elbow Assessment
  - Girth
  - ROM
  - Strength
- Hand Assessment
  - Hand Functional Scale
  - Mallet
  - Composite Fist
  - Wrist ROM

The Assessment section of the physiotherapy document is for recording referral information as well as general symptoms. It then is broken down further by joint/body part. Again, only fill in the documentation sections that you require.

If you open a section and you see an "Add" button, click on it to pick an "instance", then hit save for the rest of the documentation to appear. Please note you can only pick each "instance" once. i.e., you can only pick right once, or left once, but you can pick both if you require, but only one at a time, then go back to add and pick the other.

If the box has three little lines at the end (looks like a “hamburger”) it indicates that you may add a comment if you would like. You just need to click on that “hamburger” button and a text box will appear. Please note that most of these boxes are limited to 75 characters, but there are plenty of other comment sections in the documentation if you need it.

When the answer/bubble is light green that indicates that you have selected it and it will appear on the output of the document.

When you see an arrow instead of the “hamburger” button and you want to select that option as one of your answers then click on the arrow. It will expand and more documentation will appear to be filled out that is associated with that answer. If the arrow is bolded in green that means that you have filled in information in that section.

Physiotherapy Clinic Visit | Preview | Review an...
Contributor: Kerry Mccartney, RN
Intake | Health Summary | Assessments | Scales & Questionaires | Treatment and Plan | RA / PTA Plan and Treatm...

- Berg Balance Assessment — Add Questionnaire
  - Evaluation
- Lower Extremity Scale — Add Questionnaire
  - Lower Extremity Scale
- Neck Disability Index — Add Questionnaire
  - Questions
- Patient Rated Wrist Evaluation — Add Questionnaire
  - Instructions
  - Pain
  - Function - Specific Activities
  - Function - Usual Activities
  - Score
- Quick DASH — Add Questionnaire
  - Instructions
  - The Quick DASH: Questions
  - DASH Score
- Roland Morris Questionaire — Add Questionnaire

The Scales & Questionnaires section houses scales that can be used for assessing a patient's condition, and are set to calculate for you. *Again, only use what you need, not every scale is required for you assessment.

The Treatment and Plan, houses the Treatment Analysis, Goals and their status, Physiotherapist Treatment, and the Home Treatment Plan. Which are areas to be filled in by the Physiotherapist.

- Treatment and Plan — Add Content — View Previous
  - Treatment Analysis
  - Goals
  - Physiotherapist Treatment
  - Home Treatment Plan

Note the "View Previous" box located on the right-hand corner of the section. This can be used to view the previous documentation in the section of the document, including who documented it and when. From this the ability to recall this documentation into your current document is also possible for things that remain the same from treatment to treatment, such as goals. Once recalled into your document you have to ability to alter or change this documentation, i.e., change a goal from created to continued or reassessed…, or if the same treatment was provided and just the weight and reps changed, you can recall it and change the variables that need changing.

19/08/2021 Kerry Mccartney | Recall

The ability to scroll back to look at earlier documentation is also an option by pressing this arrow. The other side will turn white indicating you can scroll forward again. This is a quick way to look at the last visit

Recall is available when it is bolded in white like you see here. When recall is clicked, all the information in the overlay will be added to the current document. *Note that the overlay displays when this was documented and by whom at the top in the middle.

The Recall function can also be utilized when leaving instruction or treatments for the RA/PTA to fulfill at the next scheduled appointment. The assistant can recall the instructions into their documentation and complete their treatment.

19/08/2021 Kerry Mccartney
Recall

Document: Physiotherapy Clinic Visit

**RA / PTA Plan and Treatment**
**Assigned Treatment Plan**
RA to continue with THA protocol on next appointment, start with icing outer hip x 10 min, followed by AA Abductions of the right leg in the side lying position....
test t
test or you can fill in treatment in the next section for the RA to recall into the next visit.
**Rehab/Physio Assistant Treatment**
1:
Treatment: Other Treatments , Alternate Modalities to be Utilized: Ice/Heat Location: rt outer hip
Ice Pack Duration (Min): 10 Minutes
Position: Supine
Recommendations / Instructions:
do before other treatments, ensure ice is not dirrectly on skin
2:
Treatment: Hip , Hip Abduction , Range of Motion Type: Active Assisted Range of Motion
Position: Sidelying
Number of Reps: 10

The "Progress" section of the document includes a SOAP note type format to be filled in.

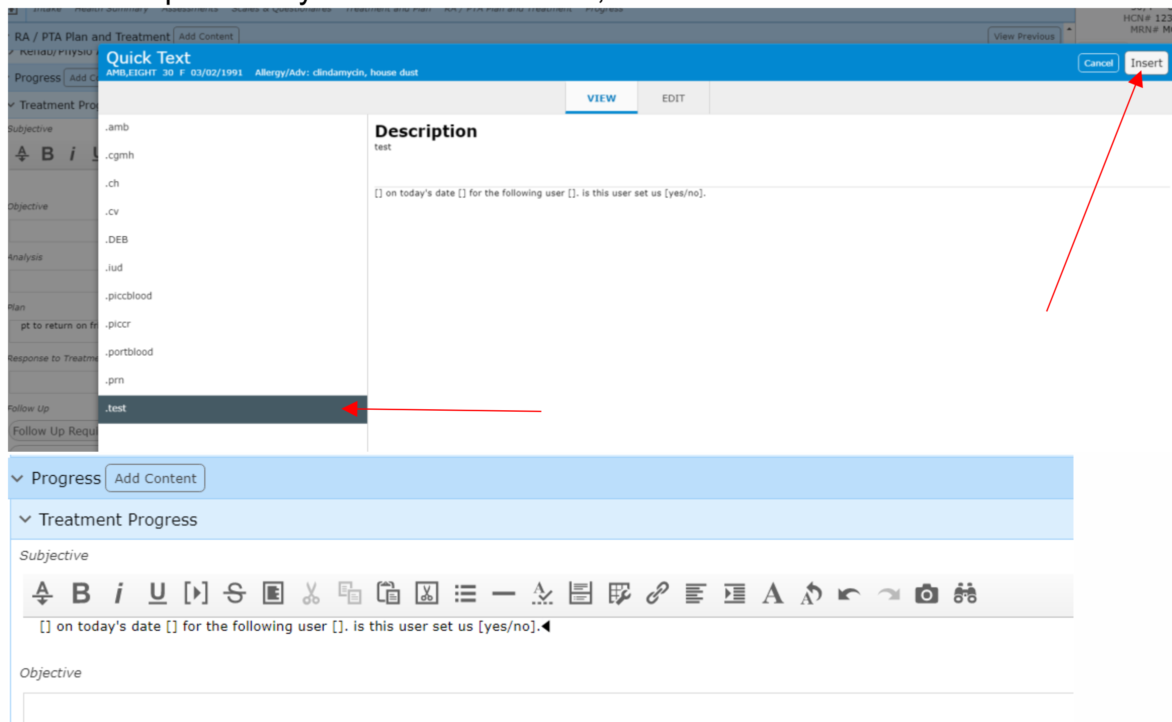
Progress | Add Content | View Previous
Treatment Progress
Subjective
Objective
Analysis
Plan
Response to Treatment
Follow Up
Follow Up Required in 1 Week | Follow Up Required in 2 Week to Progress Exercises | Goals Reached
Patient Discharge | Patient to Call if Problems, if No Contact Within 1 Month Discharge | Other

Again, you have the option to view previous documentation, and recall if needed.

Treatment Progress
Subjective
Objective

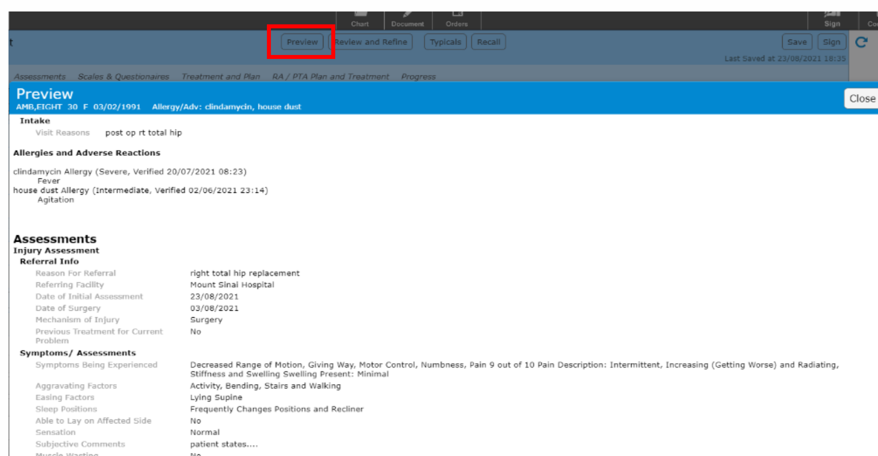
*Note, the tool bar that appears in the text box sections when they are clicked in. In this type of "text boxes" you are able to use "Quick Text" which is a pre made text that you have saved to insert when you need it. You can alter this text after it is inserted into the text box if needed. There are two ways you can add a "quick text" to a text box;

1. You can click on the A and a drop-down box will appear, pick quick text, then select the quick text you would like to add, and select “Insert”.



2. Or, you can type the trigger word that you have created for the quick text and hit space bar, and your quick text will appear. Note for this reason it is suggested that you place a “.” at the front of your quick text so that you do not activate it by mistake. (ex .THA)

From this quick text over lay box, you are also able to create new quick text or edit ones you have already created.  These quick texts are only for your use, they will not be available for everyone to use. If you create it, you are the one who can use it.
If you would like to see what the document will look like before you sign it, click on the “Preview” button at the top right middle of the blue tool bar. An overlay will appear with the document as it will look when it is signed, showing only responses selected by you and other contributors. Note that the document will be split up by section, but will list which user documented what.



**Goals**

Goal 1:

| | |
|---|---|
| Goals | Improve Gait |
| Percent Changed | 50 |
| Number of Weeks | 5 |
| Goal Progress | Created |

Goal 2:

| | |
|---|---|
| Goals | Increase ROM |
| Percent Changed | 30 |
| Number of Weeks | 6 |
| Goals of Treatment Agreed to By Patient | Yes |
| Goal Progress | Created |
| Goal Comments | comment section of the goals, has spell check in these boxes |

**Physiotherapist Treatment**

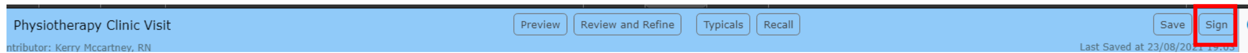
1:

| | |
|---|---|
| Treatment | Hip Hip Exercises: Calf Raises Range of Motion Type: Active Assisted Range of Motion |
| Position | Standing |
| Recommend Outpatient Physiotherapy Gym Program | Yes |
| Recommendations / Instructions | stand against the wall for support, or use a chair |
| Treatment Completed This Visit? | Yes Tolerance: Fair |
| Exercise Handout Given to Patient | Yes |

2:

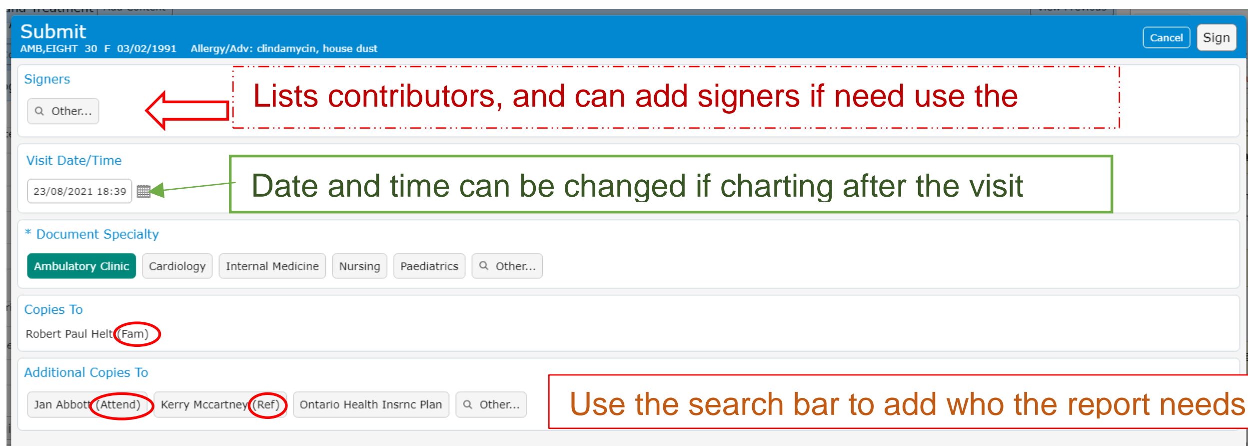
| | |
|---|---|
| Treatment | Hip Hip Exercises: Hip Abduction Range of Motion Type: Active Assisted Range of Motion |
| Position | Sidelying |
| Number of Reps | 10 Reps |
| Recommend Outpatient Physiotherapy Gym Program | Yes |
| Treatment Completed This Visit? | Yes Tolerance: Fair |
| Exercise Handout Given to Patient | Yes |

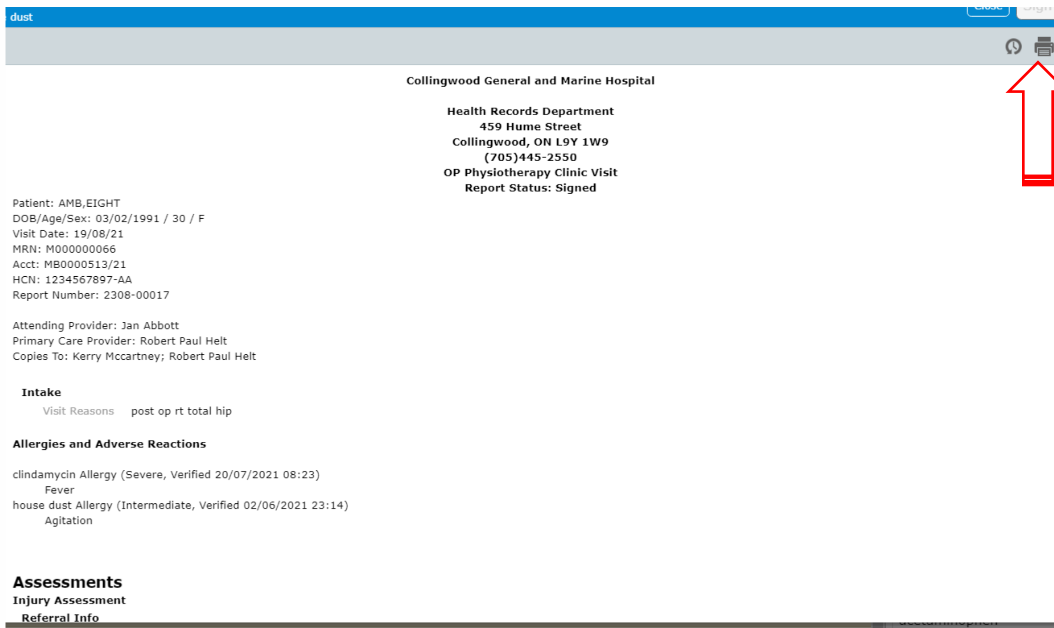
When you are finished documenting you can now sign your document. After you sign your document, you will not be able to alter it, you will only be able to add an addendum to it.




When you click on "sign" you will see an overlay that will offer information on the document, such as all the signers/ contributors to this document. Keeping that in mind if you know that someone still needs to add to the document you can add them as a signer so that they can access the document after you sign it.
It also shows the date and time of the visit, the document specialty, which can be changed if needed.

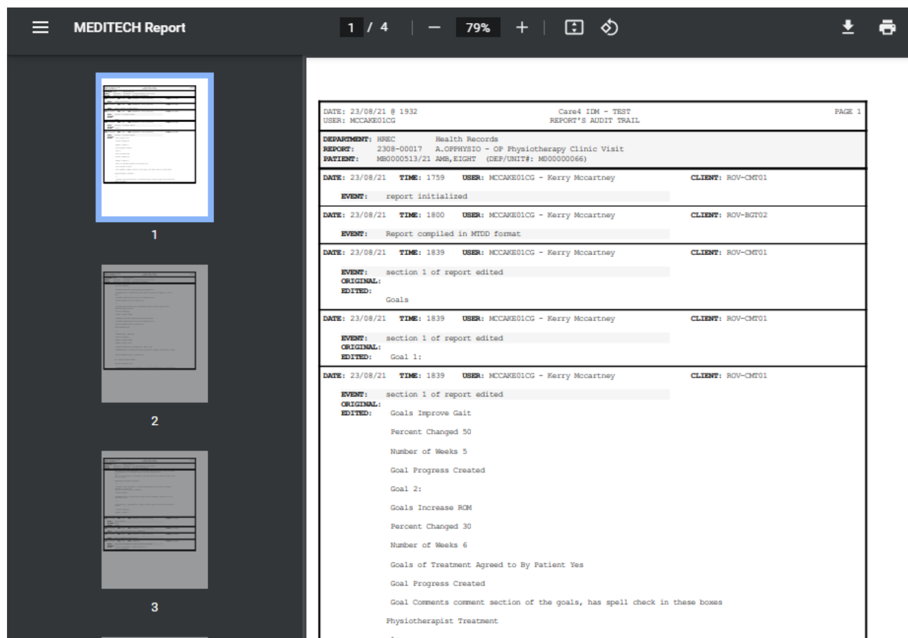
It shows who is going to receive copies of this document/report and how they are related to the patient's circle of care.
Then the option to add who you would like the report to go to is also here if a cc required.

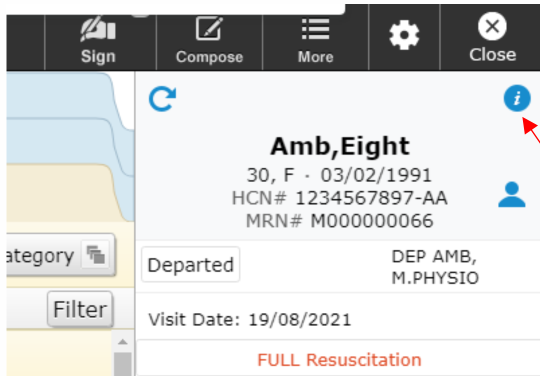





This is what the report will look like once it is signed.
You can find this under the provider notes.
The ability to print this report is possible if needed by hitting the “printer” icon in the top right of the overlay.

The little clock beside the printer icon, will show the audit trail of the report if that is needed.






*Note that there will no longer be recurrent visits. To see the account number, you must hit the little blue circle with the “ in it in the reference region.

**More Patient Information**
AMB,EIGHT 30 F 03/02/1991 Allergy/Adv: clindamycin, house dust

Close

MAIN | CODE STATUS

Account Number: MB0000513/21 Med Rec Num: M000000066 Health Care Num: 1234567897-AA EMR Num: E00000228

Location
M.PHYSIO

Insurances
Ontario Health Insrnc Plan - 5322811273-KB
Self Pay

Preferred Phone
(999)999-9999

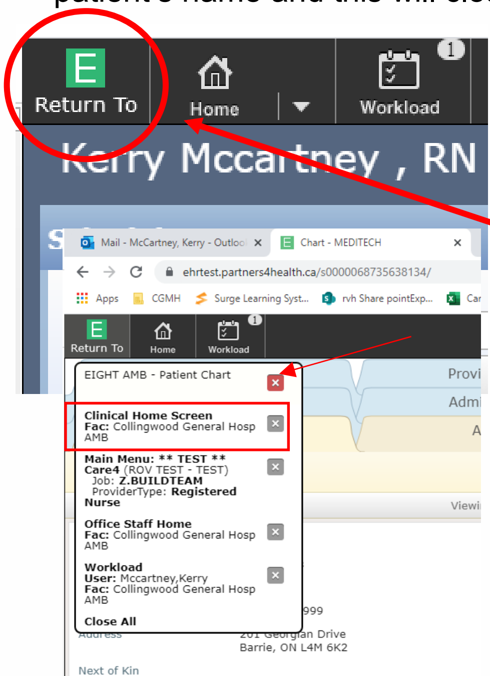
Special Indicators
Potential Reactive Behaviour; Malignant Hyperthermia; Falls Risk

| PORTAL USER | RELATIONSHIP | LAST ACCESSED DATE/TIME |
|---|---|---|
| AMB,EIGHT | Self / Same As Patient | 19/08/2021 17:56 |

Allergies

| ALLERGY/ADVERSE REACTION | TYPE | SEVERITY | REACTION | STATUS | DATE |
|---|---|---|---|---|---|
| clindamycin | Allergy | Severe | Fever | Verified | 20/07/2021 |
| house dust | Allergy | Intermediate | Agitation | Verified | 02/06/2021 |

A “More Patient Information” overlay will appear, you will need the account number if you are going to print off a chargeable item bill/receipt
To return to the home screen and close the chart click the green box with the white E in it, located in the top right of the screen, then you can either click the x beside the patient’s name and this will close the chart, or you can just return click on home screen.

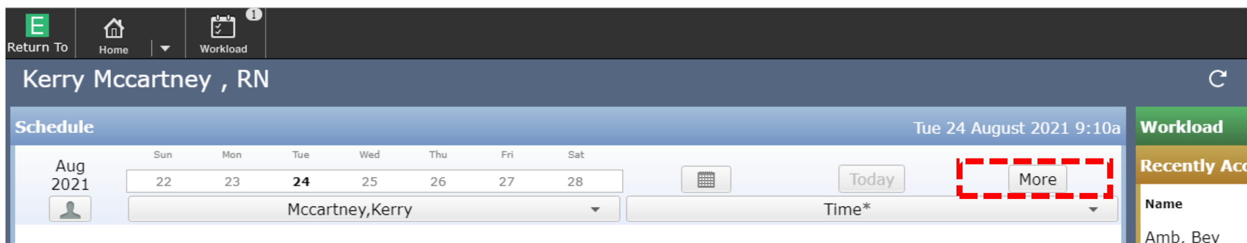


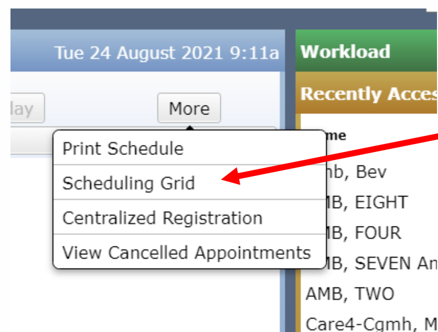

**Please remember the more items open in the return menu the slower the system will run.**
Or you can just click on the house (home) button. This will not close the patient’s chart.

From clicking the “Return To” button, you can then click on the x to close the chart, or click on what you would like to open. The list of items open will be in chronological order, so the last application or chart you were in will be on the top.
It is possible to have multiple charts open at the same time, so always ensure you are documenting on the correct chart by checking in the reference region for account details.

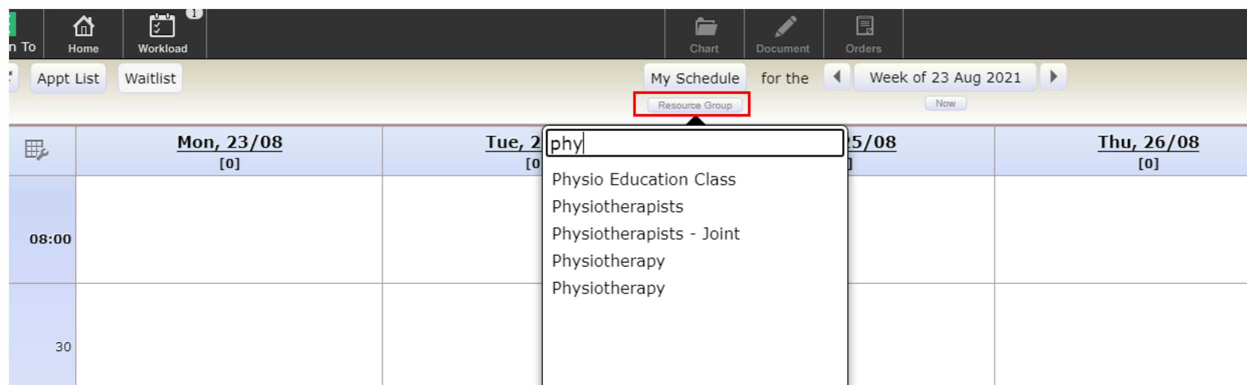
CARE4

Log into Expanse and open your Ambulatory Clinical Home Screen.  Once on the clinical home screen you can hit the "more" button located under the date and time.



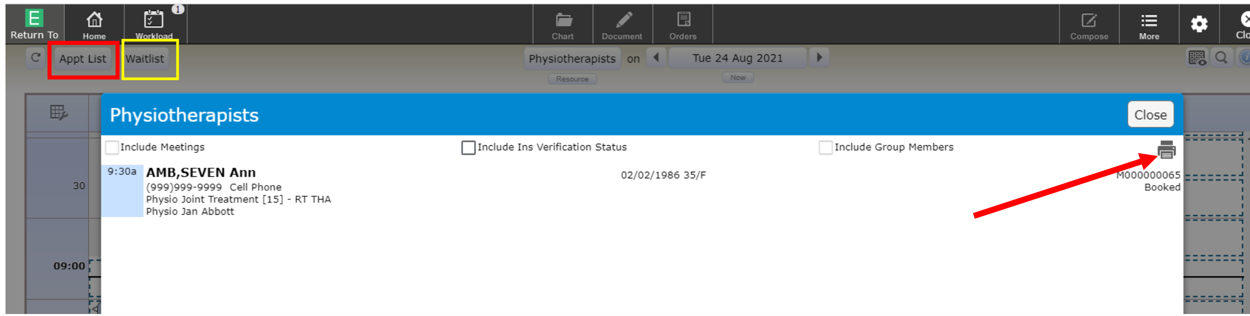




From the "more" menu select "Scheduling Grid" This will launch you to the Scheduling Grid. From the grid you need to click on the "Resource Group" box and select the correct resource group that you would like to see the schedule for.




From this grid you have the ability to print the daily schedule, by clicking on the "Appt List" button located in the left upper corner under the home button. You also have access to the wait list, if there is one.

CARE4



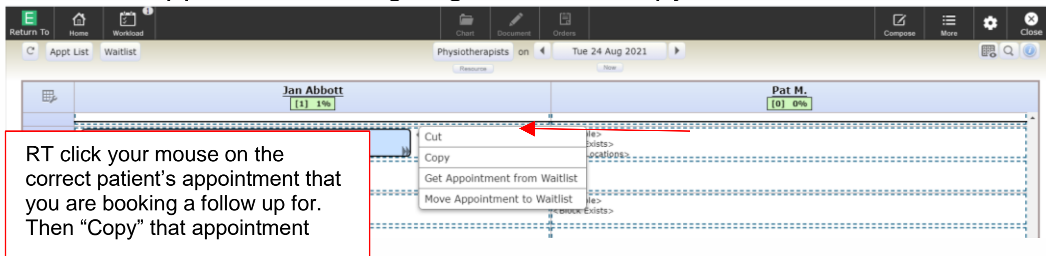

Appointments on Waitlist

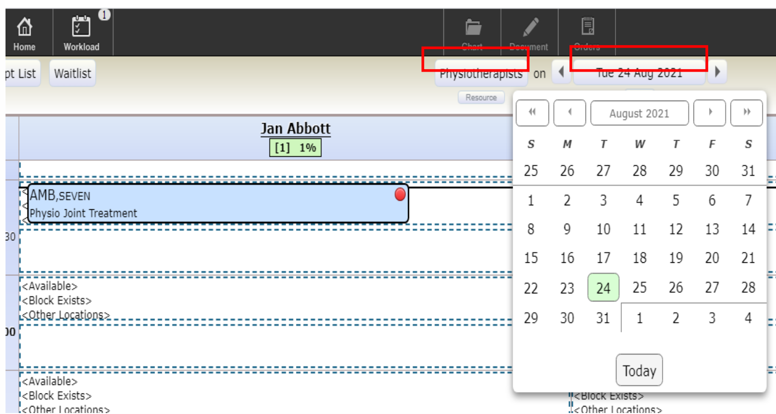
Filter

| Patient | | Appointment [Duration] Reason for Visit | Set | Status Appt Date | Priority | Short Notice | Wait | Resource |
|---|---|---|---|---|---|---|---|---|
| Cgmh,Intfive (555)555-5555 | 06/06/1956 M | Physio Treatment [15] follow up | | Rebook | | | 60 | Physio Jan Abbott |
| TRAINCG,AMB10 | Unrecorded M | Physio Treatment [15] follow up | | Rebook | Priority 1 | Yes | 63 | Physio Jan Abbott |

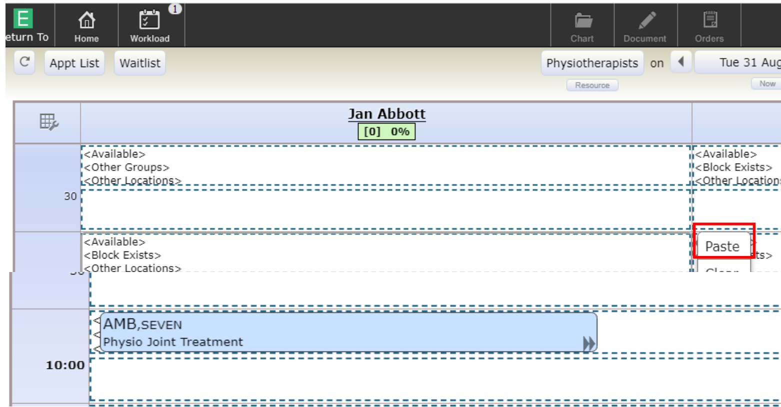
## Booking a Follow Up Appointment Using the Copy Feature

If you are booking a follow up appointment using the same appointment type and reason, you need to Right click your mouse on the current appointment booking, and a menu will appear. You are going to choose copy.



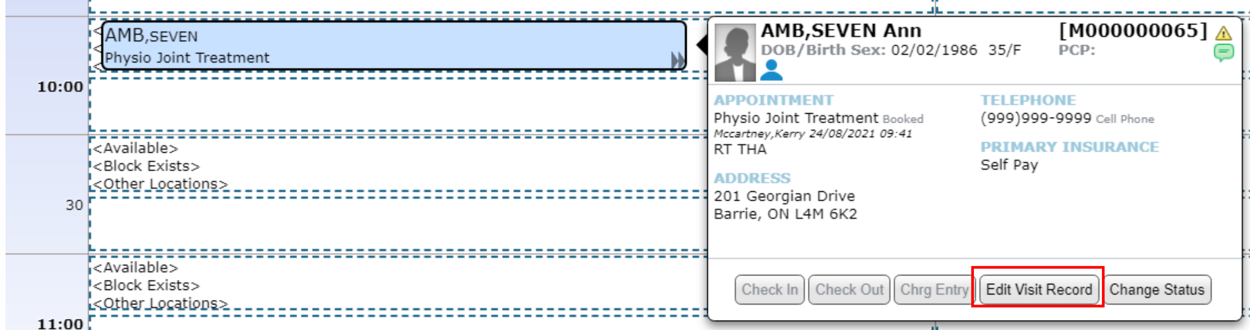

Then click on the date located at the top in the middle of the screen under the black tool bar, and find the date you would like to book the follow up for.
Select that date. The scheduling grid for that date will open with available appointment times, blocked off in the blue dotted lines.



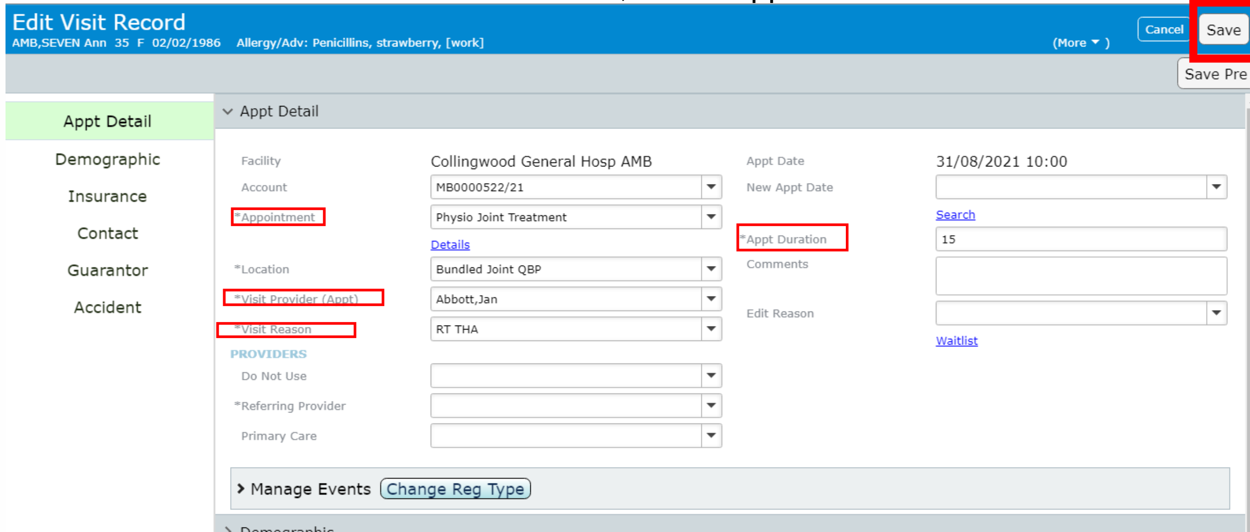

You then want to Right click on the time slot you want to select. (it is hard to see but the time slot is highlighted in grey) and then you are going to paste.

That same appointment type will be added to the time slot selected.

If there are any changes that need to be made to that appointment type you then have to click (left click) on the appointment and choose "Edit Visit Record".




You will notice that check in is not available, as the appointment is set in the future.

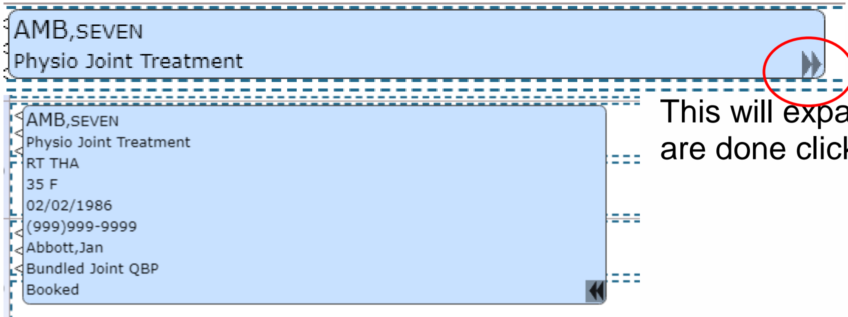



From this layover, you are able to edit things like, the appointment type, i.e., going from an initial appointment, now to a treatment appointment. You are also able to change the provider, if someone else is going to see the patient that day for whatever reason, you may also change the appointment time, and duration if that patient requires more time or less time than what auto populates for that appointment type.

When you are finished changing the details of the appointment you can hit "Save" in the top right corner of the visit record box.

CARE4

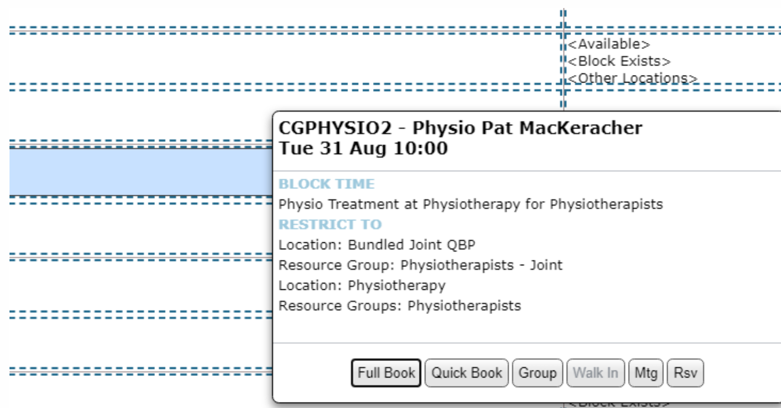
You have now successfully booked another appointment for your patient.
To see more details about the appointment from the scheduling grid you may click on the double grey arrows located in the right bottom corner of the appointment block.




This will expand the box. And when you are done click it again to shrink it back.

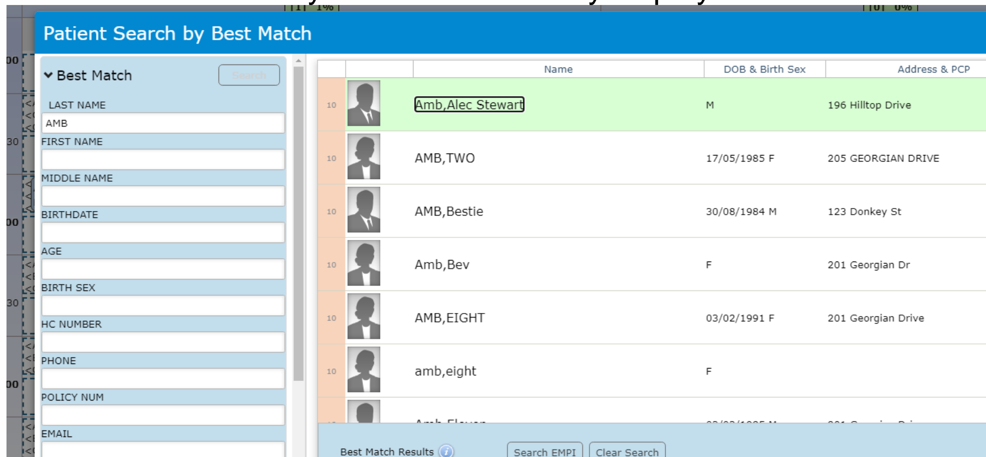
If you would like to book several appointments, you will need to copy and then paste each one, you cannot paste several times, only once per copy.

## Booking a New Appointment




Follow the same instructions to get to the scheduling grid and find the resource group you want to book under. Then select the date that you want to book for. This time you are going to choose your time slot and go to full book or quick book.

The Patient Search by Best Match overlay displays




You then can search for your patient by any of the means listed. Health card number is probably the most accurate way to verify the correct patient.

You then click continue with patient selected from local MPI, and it takes you into the booking screen.

The difference between quick book and full book is the amount of information that is available to put in while booking the appointment. Quick book is the minimum amount of info needed to book the appointment, but when in quick book there is always the option to go into full book from that screen if required.

Click the arrows to search for required information. Anything with an * is a required field and you cannot book without filling in these fields.

NOTE: The Referring Provider should be entered as it's required when the patient is being registered

As mentioned, you have the ability to add more information to the visit when you book in full book than in quick book, but all the mandatory information remains the same. The comment box in the appointment booking section is for comments that are relevant to that appointment only. You can see these comments when you click on the green comment bubble on the home screen.

The comment section in the reference section (right column), stay on the patient's registration record and will appear every time an appointment is booked and when the patient gets registered for an appointment.

The Reg type should auto populate based on the appointment that you choose.
You will have to type in at least 2 letters of the provider's name before the search function will work.

When you are done putting in all the information you can click save or book sch in the top right corner of the overlay screen. And if you notice during the booking process that you have the wrong patient, then beside that save or book sch button is a cancel button, so you can always cancel and start over again.

NOTE: If changing the appointment duration you have to ensure that the duration is also changed within the Details (See above Details button is located above the Location field). If the duration doesn't match you will get a warning.

## Checking in your patient for their appointment

To check a patient in for their appointment you are going to follow all the same steps described above to get to the scheduling grid. Once on the scheduling grid you are going to select the appointment that you wish to register (Check In).

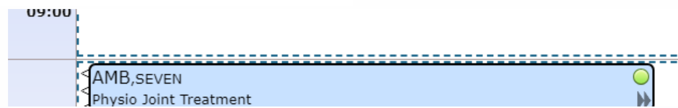
In the example below you will notice a red dot on the visit, this means that the patient has not yet registered and the appointment start time has passed, this dot will turn green when the patient is registered. The dot remains if the patient No Shows to their appointment.

Right Click the appointment you want to Check In. Select the "Check In" box. A screen listing special indicators will appear, review and click close to continue.

The check in screen displays, like the booking screen, there is an * by everything that is required before you are able to complete the check in process.

When you are done click on the "Check In" box on the top right. If you have missed any mandatory information a warning will appear for you to complete.

Once everything is filled in, a pop up to validate health care number will come up. You will have to then validate the Health Card Number.



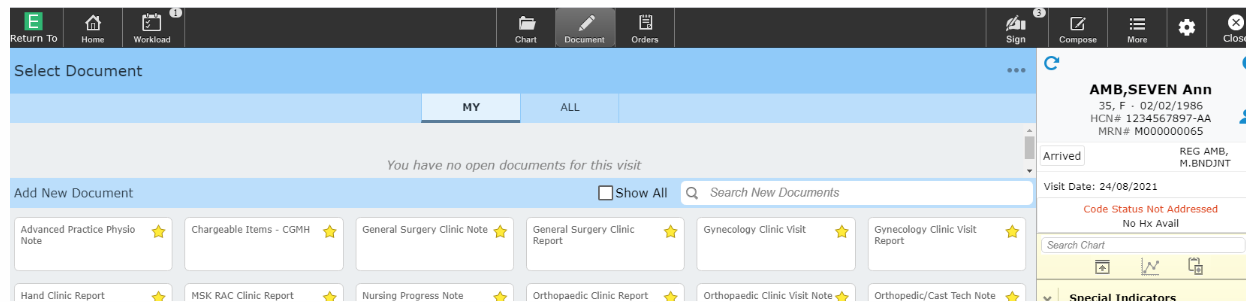

Now that the patient is checked in the dot on the patients booked appointment has turned to green.

Check in is complete, and the patient will show in an Arrived status on the home screen.

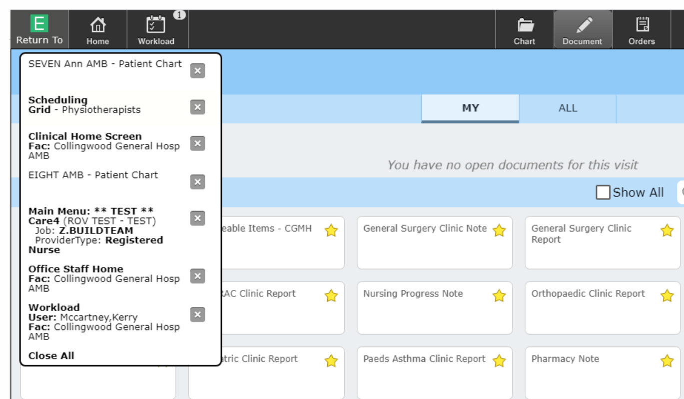
## Accessing the Chart from the Schedulling Grid

Navigating to select a document or opening the chart from the scheduling grid is also possible. You will notice that the black navigation bar is still there, with the options of, chart, document, and orders. Click on the patient you wish to document on or open chart, then go to the black navigation bar and click on documtent or chart, ignore the visit information that will pop up.

Clicking on Chart or Document launches you into the patient's visit record, in the example below Document was selected which launched the user into the “Select Document” screen.




From there you can continue to select all, then choose which document or note type you would like. And to return to the Scheduling grid use the “Return To” in the top left corner of the black navigation bar to either close the chart and return or just return and leave this chart open.



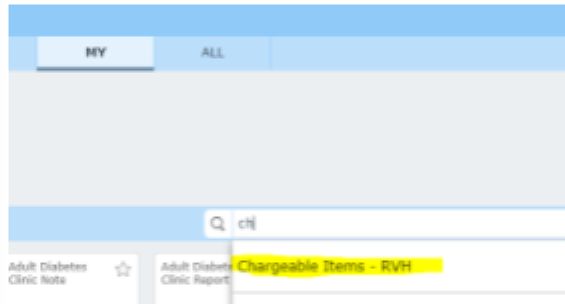

## Entering charges

In Ambulatory chargeable items will be documented using the Chargeable Items document. Once the document is “Completed” the charges drop to finance and a report can be printed and provided to the patient to take to the payment office within your facility.

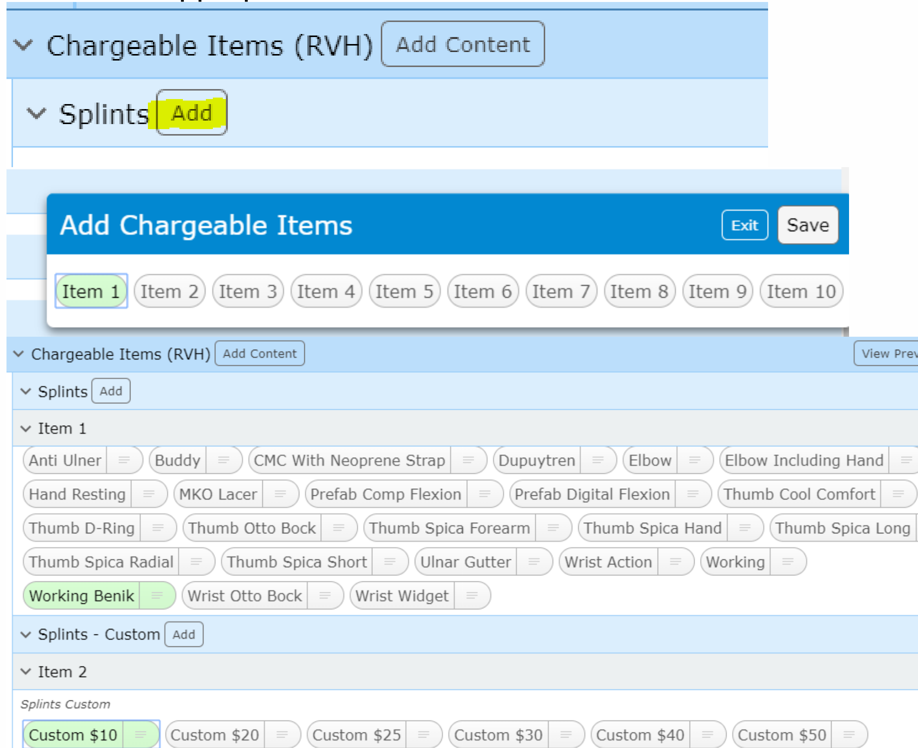
NOTE: It’s Extremely Important to Review the Document before clicking the “Completed” button. Entry errors will require you to submit a retraction request to finance. Please see the Chargeable Retraction of a Charge tip sheet.

## ***Documentation***

In the Document tab locate the document “Chargeable Items”



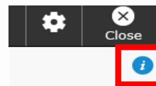

Document appropriate items within the document.




Once you have completed your documentation click “Complete”or “Sign” depending on your access.

## *Print the report*

**OR**

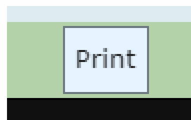



Click on the *i* icon in the right corner or the reference region to open the patient information overlay and copy the account number from there.

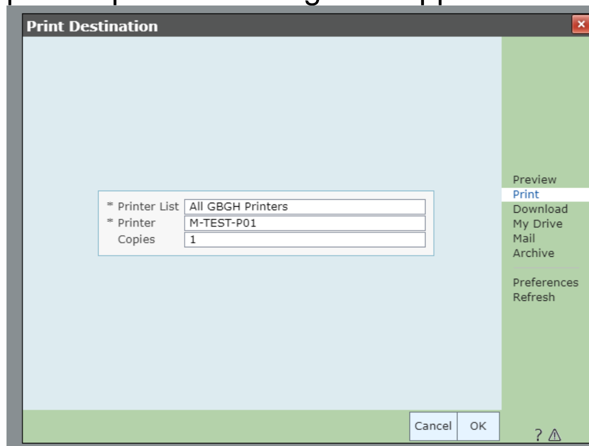
After you copy the account Number you then go to the "More" menu on the top right in the black navigation bar. You then click on "Custom Reports", and then click on "Retail Goods Invoice"

You then paste the account number into the account number field.
The "Ambulatory Retractions For Finance" field is left blank, it's only used to indicate any retractions – see the Chargeable Retraction of a Charge tip sheet for details.

Once the account number is entered, click “Print” located at the bottom of the “Retail Goods Invoice” screen




Select the printer to send the invoice to and click “ok”, ensure that it is given to the patient prior to leaving their appointment.




The Invoice will look similar to this, with a spot for the patient’s signature on the bottom.

MB0000521/21
M000000065
AMB,SEVEN Ann
201 Georgian Drive
Barrie, ON L4M 6K2
CAN

**Ambulatory Retractions For Finance**

| Service Date | Physician | Name | Qty | Amt |
|---|---|---|---|---|
| 24/08/2021 | Abbott,Jan | Splint-Thumb Spica Radial | 1 | 0.00 |
| | | Bandage - Tensor | 1 | 5.00 |
| | | Cast-Above Knee FiberGls Adult | 1 | 110.00 |
| | | | **Total** | 115.00 |

If required by your facility, you can print off two copies of the invoice and have the patient sign both copies, one for the patient to keep and one for Medical Records.

***Alternative method of printing the "Retail Goods Invoice", you will need to follow these steps.***

Copy the account number, go "Return To"

Click on the "Main Menu", this will take you back to where you started. Then follow the pathway in green.

Return To | Home | Workload

Clinical Home Screen
Fac: Collingwood General Hosp AMB

Scheduling Grid - Urgent Stress Clinic

Main Menu: ** TEST **
Care4 (ROV TEST - TEST)
Job: Z.BUILDTEAM
ProviderType: Registered Nurse

Workload

- Clinical
- Administrative
- Ancillary
- Financial
- **Ambulatory**
- Info Systems
- Message/Task System
- CGMH Reports
- GBGH Reports
- HHCC Reports
- RVH Reports
- Change Your User's PIN
- Enter/Edit Temporary Location

- Billing Clerk
- Office Staff
- Scanning Desktop
- OV Results
- Co-Signer Assignment
- Reports
- **Custom Reports**
- Dictionaries
- Manage Pregnancies
- Clinical Home Screen

Retail Goods Invoice

- CGMH
- GBGH
- HHCC
- RVH

Input the account number and what is to be retracted.

* Account Number
Ambulatory Retractions For Finance