

# Worklist and Documentation Tip Sheet

## Add Assessment/Treatment to Worklist

1. From the Worklist, click
2. Select the item to add. Selected Items will display in a list. To remove something that has been clicked un-check the item from the Selected Items list.

**Note:** Low-lit items are already on the Worklist

3. Click **Save** and the items will be added to the Worklist.

## Item Detail Column

### Some Examples of Care Item on the Worklist

A - Assessment    Ao - Ordered Assessment


I - Intervention    Io - Ordered Intervention

### Flags on the Worklist

- I Intervention Text     P Protocol  
 R Associated Data     O Order detail by providers


### Add Intervention Text

Intervention Text is communication note only for nurse to nurse and not part of the legal record

1. Click in the Item Detail column  for the Assessment
2. Click on the  button on the Text line
3. Add the note and click **Save**
4. Click **Back**.

## Edit Frequency

1. From the Worklist click on the frequency for the Assessment.
2. A drop down box will display. Select or type in the new frequency.

**Note:** Add frequency to manually added Treatments and Assessments by clicking in the  column

## Document Tips

### Single Select

Responses with radial buttons only allow one response to be selected     Thick     Thin

### Multiple Select

Responses with rectangular buttons allow multiple responses to be selected


- Ache     Dull     Pressure     Sharp

## Edit Status

1. From the Worklist click on the **Status/Due** column for the Assessment.
2. A drop down box will display. Select the new status.
3. The status update will appear on the Worklist.

## Not Done Documentation

Clocks are reminders that an action is due to be completed and that documentation should occur. There may be occasion when documentation will not occur and clocks should be cleared off prior to the end of shift.

1. To clear a clock, click on the clock  to be cleared.
2. A check mark will appear next to the clock.
3. Click the  footer button.
4. A pop up box will display. Select the reason.
5. The clock will display with a red X until the screen is refreshed.



## Document Modes

After selecting document on worklist, use the button  to switch between Modes.

**Flowsheet Mode** - Shows previous documentation, click on the drop down to view options, type ahead will default responses.

**Single Assessment Mode** - Can be answered with tick

## Document an Assessment



1. From the Worklist, check off the Now column  or the clock   for the scheduled time for the assessment to document on.
2. Click
3. The documentation date/time displays at the top of the assessment. Click the arrow  to change the date/time that the patient interaction occurred.
4. Enter the documentation.
5. Click

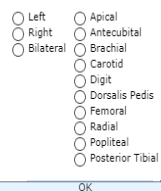
## View Assessments

1. Go to the Patient Care  tab.
2. Check off the assessment and click **View Snapshot** to view a single documentation. Click **View History** to see all documentation for the same assessment from the same visit.
3. Click **Back** to return to the documentation list.



## Document an Instance Type

Instance Types allow you to enter multiple instances. For example, you can document both a Radial Pulse and Femoral Pulse on the same assessment.

1. To add a new Pulse instance click on **Add a pulse location or New Pulse Location** 
2. The  list of available locations display. If a location has already been added it will be low lit. Click the location to add.
3. The new instance will display to document. An already documented instance will default in within





## Edit an Assessment

1. From the Worklist, click on the time under the  Last Done column
2. The Item Detail will display. Select the line where Activity Type is "Document"
3. Click **Edit**
4. Make the required changes and click **Save and Exit**
5. A new line displays with Activity Type equal to "Edit Result". Click the  icon to view the changes
6. Both the old and new documentation will display
7. Click **Back** to return to the Worklist

## Add a Note to an Assessment

1. From within the assessment/intervention click the **Add Note** footer button (at least one query needs to be documented)
2. Select the desired Note Type from the list.
3. Click the **Text** footer button to choose the focus for the note.
4. Document that note using SOAPE and click **OK**
5. Finish documenting, click **SAVE/SAVE Exit**

## Undo an Assessment


1. From the Worklist, click on the time under the  Last Done column.
2. The Item Detail will display. Select the line where Activity Type is "Document".
3. Click **Undo and Save**
4. A confirmation screen will appear. Click **Yes**.
5. Select a reason for undoing the assessment. You can also enter free text and press Enter.
6. A new line displays with Activity Type equal to "Undo". Click the  icon to view to documentation that was undone.
7. Click **Back** to return to the Worklist.

## Write a Note


1. Click the **Write Note** tab
2. Select the desired Note Type from the list
3. Enter a focus for the note
4. Document that note using SOAPE and click **OK**

## Add Addendum to a Note

You cannot edit original notes, only add an addendum.

1. Select **Notes** tab in EMR and select the note
2. Select **View Selected**
3. Click the note to view it
4. Select  the footer button
5. Add the addendum text and click **OK**

## Undo to a Note

1. Select **Notes** tab in EMR and select the note
2. Select **View Selected** on the footer
3. Select  the footer button
4. Provide the Undo reason (e.g. Wrong Patient)
5. Select **Save**
6. Select **Yes** when confirmation appears

## Add a Group Note (Only for Specific Users)

Group Notes provide ability to document on a group session.

1. From the PCS Status Board select **Group Notes**
2. Select **New Note**. The patients that display are based on My List.
3. To add patients, click **Add Accounts**. Search for patients and click **Add**. Click **Save**.
4. Select the patients from the list to include on the group note.
5. Enter Date/Time, Duration, Facilitator and Group Note prior to documenting the note.
6. Click **Document Note** footer button.
7. Enter Note to be attached to all patients and click **Save Draft or enter individual note**.
8. To enter Individual notes click the **Individual Notes** footer button, complete note on individuals, Save will only appear once group and individual notes are completed (Toggle between individual and group note)