ELECTRONIC MEDICAL RECORDS
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<th>Author</th>
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<td>AOHC</td>
<td>Instructions on how to replace migrated medications added to the Prescription Section</td>
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<tr>
<td>Aug 9th 2013</td>
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Electronic Medical Records

Overview of the Course

This manual has been created to ensure consistent training for providers and staff who need to document clinical and other information in the Nightingale on Demand (NOD) system. This manual can also be used as a reference manual for providers and Super Users at the Centres. This guide and practice exercises will enable providers to:

- Access and open patient charts
- Understand, create and use a Cumulative Patient Profile (CPP)
- Understand, document and manage encounters
- Understand and use flowsheets and profiles
- Understand and use chart histories
- Use messaging and task management
- Navigate the various client chart sections
- Manage document workflow
- Basic scheduling and registration

**SKILL LEVEL**—Users should have a working knowledge of Windows and Internet Explorer.

About This Course

A high-speed internet connection and specific Internet Explorer settings are required to use NOD. Before logging into the training site, use the **Getting Starting Guide** to make sure your computer is set up properly.

Throughout this manual, there are several conventions that are used to make the information easier to use and understand.

- Navigation is presented as bold text separated with a vertical line (|) e.g. Patients | Registration | New.

  This means the Module (found to the left of the screen) is clicked. The rest of the menu items are selected by pointing the mouse over the selection (hovering, not clicking) until the final menu item which is clicked.

- Modules and other specific buttons, windows, etc. of NOD are **Bold**; e.g. Click **Save** to save changes to a client demographics.

Boxes like this are included in the manual to provide hints or tips about a particular section. Many items are related to differences between NOD and Purkinje. Differences between NOD and Healthscreen will be added when known.
Open a Client Chart

Existing client charts are opened by doing a search from Patients | Registration | Select.

Advanced search options are accessed by clicking the Advanced button. The Advanced Search window provides additional criteria for searches such as Health Card Number and date of birth.

Enter the search criteria and click the Search button.

Highlight the client’s name and click the Details button (to see detailed information at the bottom of the active window for the selected client) or the No Details button (to hide the detailed information for the selected client). Select the correct client and click the OK button. The client’s name will appear in the orange bar under the Menu items.

Hot List

Previously opened charts can be quickly reopened by using the Hot List icon in the client search screen. The Hot List will display a drop down of clients who you have previously searched for. The number of entries in the Hot List is based on your Dashboard settings.

Cumulative Patient Profile

There are two major sections in a client’s chart - the Cumulative Patient Profile (CPP) and the Encounter. The CPP is used to record a client’s relevant medical history. An Encounter is used to record a client’s visit. The procedures, immunizations, and injections documented in an encounter are automatically flowed into the CPP. You can also choose the problems and prescribed medications from the encounter that you want to appear on the CPP. To update or add other data to a client’s

In Purkinje, the only way to enter data into a client’s CPP is through an encounter. In NOD, you can enter information directly into the CPP.
CPP, you must do it directly within the CPP itself. This is very useful for recording the past history of new clients.

**CPP Overview**

The CPP can be accessed by doing one of the following:

- From the Patients Module, search for a client to open their chart, then click CPP
- From the Dashboard | My Patients tab, click on a client’s name on your schedule, then within the Patient Activity area, click Review CPP.

The figure below shows all the available sections within a client’s CPP. You can click on any of the section names to see the information that exists in the CPP and get options to edit that information. The sections of the CPP that display, and the order in which they display, are configurable by going to Patients | Setup | Display Customization | CPP.

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**Enter and Remove Data in the CPP**

**Enter Data in the CPP**

1. Click the section name.
   While Allergies is used in the example below, almost all sections of the CPP give you two options to enter data into the CPP:

2. Click the Activity button (e.g. New Allergy)

   OR

3. Use the quick entry form on the main CPP page to enter data. Each section has a quick entry form to make data entry into a CPP quick and easy (especially if you have already created some predefined lists).

   *With the exception of Medications, the CPP section of this manual covers the quick entry form (#3). The encounter section of this manual covers the Activity buttons (#2).*
Remove Data from the Active CPP

There are two ways to remove data from the active CPP.

1. **Delete** – You can delete almost all entries added to the CPP (e.g. if the data was erroneous) with the exception of medications that were prescribed through an encounter which cannot be deleted. Since this is a legal chart, you will be asked for a reason why you are deleting the data. Depending on which section of the CPP you are in, you will either:
   a. Click the button beside the item to be deleted OR
   b. Select the item to be deleted by clicking the checkbox beside it and then click the button.

2. **Move to Past History** – Over time, a client’s CPP’s can become very large. You can archive data that is no longer required on the active CPP (e.g. a problem which has been resolved) by checking the box to the left of the field you wish to move and clicking the button. You can still access the data if you need to see and/or report on it; however it will not appear on the active CPP and it will not appear on any referral letters.

**Allergies**

Allergies entered into the CPP are used to determine drug-to-allergy interaction when prescribing in an encounter. In addition, allergies entered into the CPP can be reported on. There is an Allergies textbox on the Detailed Registration screen but it does not allow the drug-to-allergy interaction and cannot be reported on.

**Add Allergies to CPP**
1. Click **Allergies**.

2. Using the quick entry form, click on the **Type** drop down and choose **Allergy** or **Intolerance**.

3. Type the Allergen. If it is a drug allergen, you must check off the Drug Check box to activate the Multum drug database. The first option from the Multum drug database will appear in the drop down box underneath where you typed the allergen. Click the drop down list to see the options available, and click on the correct drug. Always use the smallest dose when entering a drug allergy.

4. Select the severity.

5. Type any comments.

6. Click the **ADD** button.

**No Known Allergies Added to CPP**

You can indicate that a client has no allergies or intolerances by selecting the checkbox for the category and clicking the **Review Done** button. NOD will display a message specifying the review was done and there are no known allergies.
Problem List in CPP

You can enter a client’s list of issues directly into this section using the Encode-FM classification system. In addition, when you document an encounter, you can choose which (if any) issues addressed during that encounter will be flowed to this section of the CPP.

Add Problem List to CPP

1. Click Problem List.
2. In the quick entry form, begin typing in the Description box. This will start a search of the ENCODE-FM codes. Select the correct code.
3. Choose a Status.
4. Enter a diagnosis date. This can be the year or life stage if the exact date is unknown.
5. Click the ADD button.

Medications in the CPP

Medications will display in the client’s CPP when a prescription is created from an encounter (depending on whether the provider chooses to flow it to the CPP) or from the Orders menu. You can
add other medications that your client is taking through the CPP (e.g. where medications were prescribed by a provider outside of the centre).

**Add Medications to CPP**

1. Click **Medications**.

2. Click the **New Medication** button.
   
   We recommend that you do not use the quick entry form. By using the **New Medication** button, you will build your Favorite medication list. Your Favorite List will make it easier to refill the medication and to prescribe in the future.

3. Your **Favorites** screen will appear.

4. If the medication is within your Favorite medication list, click the check box to the left of the medication and click the **Add to CPP** button.

5. If the medication is not found in your Favorite medication list, click on **Options | Select from Drug Database**.

6. Select either from **Trade Drugs** (brand name) or **Generic Drugs**. Click **Next**.
7. The **Edit Prescription** screen will appear. You can record the name of the provider that prescribed the medication, the date that medication was started, and the last time the medication was refilled. In addition, you can use the drop down options to document the dosing **Directions** e.g.: Take 2 tabs PO BID for 10 Days. Click **Save**.

Once a medication is added to the CPP, the details of the historical entry are maintained under the **hx** button.

---

**Remove Medication from CPP**
You can delete a medication that was added directly into the CPP (e.g. if a medication was entered in error) by clicking the X button to the right of the medication, and entering a reason for deletion. Alternately, you can archive the information by clicking the Move Medication to Past History button.

Medications prescribed through NOD do not have an X beside them because they cannot be deleted from the CPP.

**Injections in the CPP**

Injections are automatically flowed to the CPP from an encounter. You can also add an injection directly through the CPP.

**Add Injections to CPP**

1. Click Injections.
2. Using the quick entry form, type the Injection Name.
3. Enter a Date Given if known.
4. Enter Comments.
5. Click the ADD button.

**Immunizations in the CPP**

Immunizations are automatically flowed to the CPP from an encounter. You can also record previous immunizations directly into the CPP.

**Add Immunizations to CPP**

1. Click Immunizations.
2. Using the quick entry form, select the Immunization.
3. Enter a Date Given if known.
4. Enter Comments (e.g.: Immunization brand name).
5. Click the ADD button.
**Family History in CPP**

Family history must be added directly into the CPP; it does not flow from anywhere else within the client's chart.

Add Family History to CPP

1. Click **Family History**.
2. In the quick entry form, begin typing in the **Problem** box. This will start a search of the ENCODE-FM codes. Select the correct code.
3. Click the **Cause of Death** checkbox if appropriate.
4. Select the **Relation**.
5. Click the **ADD** button.
**Social History in CPP**

You can record information about your client’s social history directly in the CPP. NOD comes with a preset list of categories: Alcohol, Tobacco, Drugs, Hobby, and Stressors.

Additional categories can be added to the Social History list. It is highly recommended that providers at your centre work together to identify any additional entries to the Social History list to ensure that data is collected in the same way by all providers. Contact your Super Users to determine how to add to the Social History list.

**Add Social History to CPP**

1. Click **Social History**.
2. In the quick entry form, select a social history type from the **Category** drop down.
3. Add any relevant **Comments**.
4. Click the **ADD** button.

**Procedures in the CPP**

Procedures are automatically flowed to the CPP from an encounter. You can also record previous procedures that a client has had directly into the CPP.

**Add Procedure to CPP**

1. Click **Procedures**.
2. Using the quick entry form, begin typing in the **Procedure** box. This will start a search of the existing procedures. Select the correct procedure name.
   
   If the procedure you are looking for is not in the predefined list for your centre, you will be asked to pick the procedure type. This adds the procedure item to your list for future clients.

*Two Procedure lists have been pre-configured specifically for Community Health Centres. They are Common Office Procedures and MSAA Indicators. These lists have been set up in a specific way to meet CHC reporting requirements. Do not add your procedures to these procedure types. It is highly recommended that providers at your centre work together to identify any additional Procedures lists to ensure that data is collected in the same way by all providers. Contact your Super User.*
3. Add the **Date** of the procedure if known.
4. Add any relevant **Comments**.
5. Click the **ADD** button.

---

**Consultations in the CPP**

The creation of referral letters (using Consultations) will be discussed in the Encounter section.

**Alerts in the CPP**

Medical alerts are entered into the CPP. These alerts can have a start and end date. While there is an Alerts textbox on the Detailed Registration screen that is used by front end staff for administrative alerts. All alerts are displayed for a few seconds every time the client’s chart is opened.

**Add Alert to CPP**

1. Click **Alerts**.
2. Click the **New Alert** button.
3. Type the alert in **Description**.
4. Enter a **Start Date** and an **End Date** if applicable.
5. Click the **Save** button.

**Past Medical History**

The **Past Medical History** section of the CPP is a text box for comments only. Use this section only for information that cannot be entered anywhere else in the CPP such as the **Problem List**.
**View the patient’s Historical CPP**

You can see the information from the CPP that has been archived by clicking on **Options | View the patient’s Past Medical History**.

---

**Exercise 4 – CPP**

The client whose chart you opened in Exercise 3 has just come to your centre and provides the following information. Enter the information into the client’s CPP and ensure that you fill in all relevant fields.

1. **No known environment allergies**
2. **Allergic to penicillin since infancy**
3. **Diagnosed with depression in 1995**
4. **Mother also suffered from depression**
5. **Smokes 1 pack of cigarettes per day**
6. **Drinks occasionally**
7. **Takes Paxil 20 mg one per day since 1999**
8. **Knee surgery in 1994**

---

**Exercise 5 – Past Medical History**

1. **Using the client from Exercise 4, move the procedure to Past Medical History.**
2. **Close the chart.**
3. **Go back in to look for the historical procedure.**

---

**Manage Clinical Lists**

You can create your own unique clinical lists to make it easier to enter repetitive data in the CPP and encounters by going to **Patients | Setup | Manage Clinical Lists**. The figure below shows the Clinical List menu where lists are populated.

Two Procedure lists have been pre-configured.
specifically for Community Health Centres. They are Common Office Procedures and MSAA Indicators. These lists have been set up in a specific way to meet CHC reporting requirements. Do not change these lists. If you believe a procedure or indicator in these lists should be added or changed, contact your Super User.

It is highly recommended that providers at your centre work together to identify the contents for the other clinical lists to ensure that data is collected in the same way by all providers. Your centre may choose to add additional types of Procedure lists (e.g. Surgery). Please refer to your Super Users if you are interested in adding to your clinical lists.

**Encounter**

**Encounter Overview**

Encounters are used to record the clinical notes for client visits. Encounters are created each time there is a service provided to or for a client.

An Encounter in NOD is divided into nine sections, each of which has its own tab. You only need to use the tabs that are required for each individual client’s visit. The tabs are:

1. Clinical Notes – Used to record the reason for the client’s visit. Also used to record the services provided during the visit and the language of contact.
2. Assessment – Used to record the issues addressed in the course of a client visit.
3. Medications – Used to prescribe, renew or discontinue medications.
4. Consultations – Used to create external referral letters and can also be used for internal referrals.
5. Procedures – Used to record procedures performed as well as immunizations and injections given.
6. Requisitions – Used to create laboratory and other test requisitions.
7. Recalls/Follow Ups – Used to track clients who need to book a return appointment.
8. Plan Notes – Used to document any special care plan notes.
9. Invoices – Not discussed in this course.

The name of the active tab of the encounter is underlined. Relevant activity buttons are displayed at the top of the page similar to the CPP.

Some fields/functions are mandatory for CHC providers to complete to ensure proper reporting of MSAA indicators and to support the evaluation framework. As each section of the encounter is discussed, you will be told what those fields are. A quick reference guide summarizing these mandatory fields/functions is also available.

**Beginning an Encounter**

- Navigate to **Patients | Encounter | New** to open a new Encounter record.
  Or
• From Dashboard | My Patients, click on a client’s name on your schedule, then within the Patient Activity Area, click Start Encounter

At the top of the active window, you will see the Type, Date and Time.

1. Each encounter defaults to the current date and time (or the appointment date and time if you have started the encounter your schedule). You can change both the Date and Time.

2. An encounter can occur at various locations (e.g. home, office, street, satellites) and by various means (e.g. phone, third party). The encounter Type is used to document this information. The available options are shown to the right. Note: Third Party and On-call will be added as an option to this list.

The default is set to Office. This is used for encounters that are in-person at the centre. Note: You do not have to change Office to Community Health Centre. They are synonymous.

If your encounter is at a different location, select the correct location. You may be asked to specify the exact location from the Visit Type field. Your Super User will tell you if that is required for your centre.

If your encounter is by phone or is an on-call or third party visit, select the appropriate Type.

Clinical Notes in the Encounter

The Clinical Notes tab is the first tab that is active when you create an encounter. You record the client’s Reason for Visit / Chief Complaint as well as the subjective and objective clinical findings on this tab.

Reason for Visit

The client’s reason(s) for being seen is captured with an ENCODE-FM code. You can enter multiple reasons for the visit. You cannot
sign off an encounter without a reason for visit.

1. Begin typing the **Reason for Visit** in the **Description** box. This will start a search of the ENCODE-FM codes. Click the drop down box to see all available options. Select the correct code.

2. Change the **Status** if applicable.

3. Enter any relevant **Comments**.

4. Click the **ADD** button.

---

**Create an ENCODE-FM Favorites List**

You can create a list of ENCODE-FM codes that you use the most, making it easier and faster for you to record client encounters. This list is called a Favorites List.

1. Within the **Reason for Visit** section, click on the caret symbol beside Description.

2. The **Searching Diagnosis Codes** screen open. This screen shows your current Favorites List.

3. Click **Options | Search for ICD code in Full ICD Lists**.

4. The search string from the **Description** field will display in the **Diagnosis Description** field. Click the **Search** button.

---

**ENCODE-FM is a hierarchical coding system comprised of three levels with each level being more refined in detail. You should select the code based on the description in the third level.**
5. To select an ENCODE-FM code to add to your Favorites List, check the box to the left of desired code(s). If desired, you can add an Alternate Description (e.g. counseling). Click the Add to Favorites button.

Note 1: If there is a plus sign beside a code, click on the plus sign to expand the list.
Note 2: If you click the ADD button beside the Alternate Description, you will add that code to the encounter but it will not be added to your Favorites List.

Subjective/Objective Notes

The Clinical Notes tab is used to record both subjective and objective findings. You have four options to record this information.

1. Use the free form text box to type in your findings. If you are using a tablet, you can enter data in the text box with a stylus.

2. Use a dictation program, such as Dragon Dictate, to dictate right into the free text field. Training is not provided on the use of dictation programs.

If you use the Subjective/Objective free form text box, your findings will not be reportable.

3. Use a Template. Templates are used to help you enter your subjective/objective findings easier. Templates are used to record mandatory fields. Templates created specifically for your
centre by AOHC or your Super Users will allow your centre to conduct better data analysis because the information is reportable.

To load a Template:

a. Click the **Load Template** button.

b. Click drop down on the **View** box to select from four options:
   - Master Templates - Templates that come with NOD. Templates created specifically for the CHC sector are prefixed AOHC.
   - Enterprise Templates - Templates created by your centre.
   - Provider Templates – Templates created specifically by or for you. Contact your Super User if you want to know more about creating your own templates.
   - All Templates – A list of all of templates.

   Click one of the four options.

c. Check the box to the left of the desired template and click Load in the top left corner.

d. The template will load. This may take a few seconds. Record your findings by checking the boxes, choosing from drop downs, typing into text boxes and/or by drawing on images (depending on the design of the template).
   - You can click the **Apply** button as you are filling out the template to save your changes and leave the template open to allow you to continue recording your findings.
   - Most templates in NOD default to saving the information in Narrative mode meaning that only the information you have entered into the template will be saved. You can choose to save the template in Template mode which will save the information in exactly the same format at the template you completed. It is recommended that you save your information in Narrative mode.
   - When you have recorded all your findings, click the **Save** button to return to the **Clinical Notes** tab.

4. **Load Past Encounter**. Your templates and recorded findings from a previous encounter will be loaded into the current encounter. When the reason for visit and issues addressed for a client’s visit are very similar to a previous encounter, this function allows you to easily populate the
To load a past encounter:
   a. Click the Load Past Encounter button.
   b. Check the box to the left of past encounter you want to load.
   c. Click the Load button.
Note: No other information from the previous encounter (such as medications, etc.) will be loaded.

**Services Provided**

In Exercise 2, you changed your dashboard settings to load the Services Provided template by default. This template is specific to CHCs and is used to record all services provided to the client during the visit.

1. Click on Services Provided to open the template.
2. Select all of the services that you provide during this session.
   You can hold down the Control key on your keyboard to select more than one service at a time.
3. Click Save.

**Assessment**

The issues that you address with the client are recorded on the Assessments tab of the encounter using ENCODE-FM codes. Often, there are multiple assessments. This is the provider’s assessment or diagnosis of the client’s issue which may or may not be the same as the client’s reason for visit. Refer to the Reason for Visit section of the Subjective/Objective tab on page XXX for instructions on how to find an Encode FM

**Procedures / Immunizations / Injections**

You record Procedures performed as well as Immunizations and/or Injections given on the Procedures tab of the encounter. Data entered into each of these three sections will automatically be added to the CPP. Click the Procedures tab.
New Procedure

Two Procedure lists have been pre-configured specifically for Community Health Centres. They are Common Office Procedures and MSAA Indicators. These lists have been set up in a specific way to meet CHC reporting requirements. Do not change these lists. If you believe a procedure or indicator in these lists should be added or changed, contact your Super User.

It is highly recommended that providers at your centre work together to identify any additional Procedures lists to ensure that data is collected in the same way by all providers. Contact your Super Users.

1. Click the New Procedure button.
2. From the Procedure Type drop down, select Common Office. Select the procedure you performed from the Procedure Item drop down. Complete the additional information as applicable. Click the Save button.
   Repeat for all procedures performed in this encounter.

3. From the Procedure Type drop down, select MSAA Indicators. Select the appropriate indicator from the Procedure Item drop down. Complete the additional information as applicable. Click the Save button.
   Repeat for all applicable MSAA Indicators.

There are several places in the encounter where MSAA Indicators can be recorded. A quick reference guide summarizing how to record the MSAA Indicators is available. Contact your Super User.

New Immunization

Flu Shots given or refused are an MSAA Indicator. To record these and other types of immunizations:
1. Click the **New Immunization** button from the **Procedures** tab.
2. Select the **Immunization** type from the drop down.
3. Search for the Immunization **Brand Name**.
4. Complete the additional information as applicable.
5. If the client refused the immunization, enter the **Date Refused**.
6. Click the **Save** button.

### Add Immunization

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immunization</td>
<td>Hepatitis A &amp; B</td>
</tr>
<tr>
<td>Brand Name</td>
<td>Twin</td>
</tr>
<tr>
<td>Manufacturer</td>
<td>GLAXOSMITHKLINE INC.</td>
</tr>
<tr>
<td>Lot Number</td>
<td>78394A12</td>
</tr>
<tr>
<td>Expiry Date</td>
<td>12 9 2013</td>
</tr>
<tr>
<td>Dosage</td>
<td>0.5 cc</td>
</tr>
<tr>
<td>Site</td>
<td>Left deltoid</td>
</tr>
<tr>
<td>Reaction</td>
<td>None</td>
</tr>
<tr>
<td>Route</td>
<td>INTRAMUSCULAR</td>
</tr>
<tr>
<td>Date Given</td>
<td>11 8 2012</td>
</tr>
<tr>
<td>Date Refused</td>
<td></td>
</tr>
<tr>
<td>Administered By</td>
<td>Indu Raju</td>
</tr>
<tr>
<td>CPT Code</td>
<td>-</td>
</tr>
<tr>
<td>Description</td>
<td></td>
</tr>
</tbody>
</table>

### Set up Default Immunizations

Common immunizations can be set up as defaults. Once you have filled out the known fields for a particular immunization (e.g. Brand Name, Lot Number, Expiry Date and Dosage), check the box beside **Setup Default** at the bottom of the screen. The next time you choose that particular immunization from the **Immunization** drop down, the remainder of the fields will populate with default settings.

When the lot number changes, you can update your default settings. Once a default immunization is set up, the **Setup Default** option changes to **Update Setup**. Check the box and click the **Save** button.

### New Injection

You can record injections such as B12 and allergy shots in this section of the encounter.

1. Click the **New Injection** button from the **Procedures** tab.
2. Pick the injection from drop down list (your Injection Favorites List), or type in the beginning of the brand name and click the **Search** button.
3. The **Date Given** and **Administered By** will default to the current date and your name.
4. Complete the additional information as applicable including any comments.
5. You can choose whether to add this injection to your **Injection Favorites List**.
6. Click the **Save** button.

### Recall/Follow Up

You can use the recall/follow up section of the encounter to track clients who need to book a return appointment. Recalls and follow ups can be created from 3 different areas of the application:

- From the **Encounter**
- From the **Office Actions** module
- By using the **New Recall** icon from the Main Menu or Shortcut Icons

Your centre may have created standard recall/follow up reasons for all providers to use. Check with your Super User for your centre’s policy on setting recall/follow up reasons.

Click the Recall/Follow Up tab.

1. Click the **New Recall/Follow Up** button.
2. Enter the reason for the recall / follow up.
   a. If your centre has already created a list of reasons, ensure the Favorite Type is Global, and select the correct reason from the Favorites drop down.
   b. If you want to use one of your personal recall / follow up reasons, change the Favorite Type to Personal, and select the correct reason from the Favorites drop down.
   c. If your centre has not created a list of reasons or your reason for the recall / follow up is not in that list, enter your reason for the recall / follow up in the Reason textbox. Click the Add To Favorites button if you will need to create the same or similar recall/follow up in the future. A screen will appear for you to provide additional information about the new Favorite Recall / Follow up Reason. Type a name of the Favorite reason in Title field (e.g. Test Results Review), select the Personal option for Favorite Type and click the Add button. The favorite is added to your Personal list of favorites.

3. Select the name of the person or role who will manage the recall/follow up request from the Assign to drop down.
4. Select the date that you want the client to be recalled/followed up with using the Schedule in drop downs.
   Specify when the notification to schedule this appointment should display in the assigned person’s To Do List using the Add to To Do List drop downs. Alternately, click the Immediately checkbox if the appointment should be scheduled as soon as possible.
5. Select the comments associated with this recall from the second Favorites drop down.
6. Add Additional Comments if required.
7. Click the Save button.
8. A new recall/follow up will be added to the list of recall/follow up request and the To Do List of that assigned user on the selected date.
**Encounter Plan Notes**

You will record parts of your plan for managing the client’s condition in other tabs of the encounter such as Medications, Requisitions and Consultations. Information which does not fit into the other tabs can be added by clicking the **Plan Notes** tab. However, you are advised to use the other tabs of the encounter as much as possible because you cannot search or report on the Plan Notes.

Plan notes is a text box in which you can type, write using a tablet and/or dictate into using Dragon Dictate. If you have plan notes that you will use in the future, save the note as a favorite by clicking on **Add to Favorites** and giving your plan note favorite a title.

**Encounter Sign Off**

The sign off options at the bottom of each encounter are:

- **Sign Off Now**
  - Click the **Sign off Now** button when you have completed documenting the client visit.

  *It is important to sign off your encounter. Encounters that are not signed off CANNOT be seen by other providers or staff. Signed off encounters are not editable. A text addendum may be added to a signed off encounter later.*

- **Sign Off Later**
  - Click the **Sign Off Later** button if you have not recorded all of the information in encounter.
Remember: Other providers and staff cannot see your notes until you click the **Sign Off Now** button.

- Type a sign off later reason and, if appropriate, add this sign off later reason to your favorite list.
- Click the **Sign Off Later** button.

- Click the **Print Encounter** button to print the encounter. You will still need to sign off the encounter.

- Click the **Delete Encounter** button to delete all information recorded for this encounter.
- Click the **OK** button.

**Exercise 6 – Basic Encounter**

Record the following information for the client whose chart you opened in Exercise 3.

1. **Choose 'Reason for Visit'** from your Favorites. If you do not have any Favorites, select from the ICD list and create a favorite.
2. **Select an ENCODE-FM Code for the Assessment**
3. **Choose an appropriate template and complete**
4. **Complete the Services Provided template**
5. **Indicate that a B12 Injection was given**
6. **Complete the Plan Notes**
7. **Sign Off Encounter**

**Referral/Consultation Letters**

You can create external referral/consult letters from within an encounter in the same way as from the CPP. You can also create internal referrals in the same way.

---

This manual explains how to do a referral when you select the provider that you are referring your client to. Some centres have chosen to have you assign referrals to a provider type (e.g. ENT) instead of a specific provider. In this case, an administrative person will determine which specific provider to send your referral. Your Super User and/or trainer will adjust the training in this section of the course to reflect your centre’s workflow.

1. Select the **Consultations** tab and click the **New Consultation** activity button.
2. Click on the Add Consultant button. Choose the desired contact from the Global Address Book in the bottom half of the window. Do not use the Provincial Directory. You can use the Department field to search for a provider type (e.g. social worker). You can also search the address book by last name, etc.

3. Choose from the list of letter templates created by your centre and type the body of your letter in the Referral Letter area.

4. For external referrals, add Supporting EMR Content to the letter by clicking on the Select button. You do not have to add this content for internal referrals because internal providers have access to the client’s chart.

5. Check for report in: When the referral letter is completed, a reminder will appear on your Dashboard under Outstanding Consultations at the end of the time you select.

6. Add Referral to CPP: Check this box to put the referral on the CPP.

7. Priority: You can select one of the boxes for Routine, Stat, or ASAP, this priority will print at the top of the letter.

8. Once you complete the letter, you can check the box beside Send message to staff? to send a message the person at your centre who manages the external referral letters.

9. Click Sign & Print. Always click Sign & Print when the letter is completed, even if you do not

Scanned documents will not attach to a letter. Scanned documents will need to be printed out and faxed along with or separate from the letter.
want the letter to physically print. This will save the letter and you can print it later. Once you click **Sign & Print**, the letter cannot be changed.

If you sign off the encounter without doing a **Sign & Print**, the letter will be deleted.

Some of the other options are:

<table>
<thead>
<tr>
<th>Preview</th>
<th>Apply</th>
<th>Save</th>
<th>Sign &amp; Print</th>
<th>Rich Text Print</th>
<th>Cancel</th>
</tr>
</thead>
</table>

**Preview**: You can preview the letter in a separate window prior to printing.

**Apply**: The body of the letter will be saved without closing the letter.

**Save**: Your letter will be saved and closed. You can go back and continue it at a later time. If the letter is saved for later completion, **do not** sign off the encounter until the letter has been completed and you click **Sign & Print**.

**Rich Text Print**: You can open the letter in a rich text editor (such as Word) to perform additional customizations. This should be done after all information has been added to the referral letter. Once your letter is opened in Rich Text Print, you cannot go back to the previous screen (e.g. to select **Supporting EMR Content** or send a message to staff).

**Cancel**: Your letter will be cancelled and you will be returned to the encounter.

Internal referrals can also be created through a task. You will be shown how to create tasks later in this course. Your Super User will tell you if this option has been set up for your centre.

**Exercise 7 - Referral/Consultation Letters**

Record the following information for the client whose chart you opened in Exercise 3.

1. **Begin an encounter.**
2. **Select an ENCODE-FM Code for ‘Reason for Visit’**
3. **Load a clinical template**
4. **Complete the clinical template**
5. **Select an ENCODE-FM Code for the Assessment**
6. **Create a referral to an external Chiropodist for foot care.**
7. **Create a follow up for 6 months assigning it to reception.**
8. **Complete the Services Provided template. Make sure you record the referral as one of the services.**
9. **Complete the Plan Notes.**
10. **Sign Off Encounter.**

**Managing Referrals**

Once a referral letter is signed and printed, you can manage it under **Office Actions | Administration | Outstanding Reports | Correspondence**. You can also get to this list from the shortcut on your dashboard **Dashboard | Notifications | Outstanding Consultations**. The letter can be accessed from
the client’s chart at any time Patients | Reports | Correspondence | Outgoing.

- The initial status of all referral letters is Pending.
- Change the status to Sent when the referral letter is sent to a provider.
- Change the status to Booked when you receive the appointment date and time.
- To see the letter, click on the client’s name. You can then choose to reprint the letter.
- To remove a letter from this list based on the criteria used by your centre (e.g. a letter is received from the referred to provider), check the box to the left of the letter and click the Received button.

### Exercise 8 – Referral Management

For the referral you created in Exercise 7:

1. Go to your Dashboard.
2. Find the referral; it should have a status of ‘Pending’.
3. Reprint the referral letter and change its status to ‘Sent’.
4. Mark another referral as ‘Booked’.
5. Review in the client’s chart where you would see this information.

### Prescriptions

#### Prescribing Medications

The Medications tab within an encounter is used to prescribe and manage a client’s medications. There are three ways to prescribe medications.

1. Using the drug databases in Nightingale that have brand name and generic name drug lists.
2. From the Active Medications List within a client’s chart.
3. Using a Favorites list that you develop over time.
**Start a Prescription**

In all cases, the first step is to select the **Medications** tab.

![Medications tab](image)

If the Drug Plan was recorded on the Demographics screen, it will be prepopulated here. If the Drug Plan has not been recorded before, you can add it here. If you change/add the Drug Plan in the Medications tab, it will modify the information on the Demographics screen.

**Prescribing from the Drug Database**

Click the **New Medication** button.

![New Medication button](image)

From the New Medication window, you will choose the **Options** button and click **select from Drug Database**.

![Select from Drug Database](image)

1. Type in the first few letters of the drug you are prescribing in the **Search for** field. By default, the system will search for drugs that start with letters you have typed. You can change the **Search Criteria** to **Contains the word above** if what you are searching for is in the middle of the drug name.

2. Select one of the following options: **Brand Name** drugs or **Generic Name** drugs or **Drug Class**.

3. Click the **Search** button.

4. Select the correct drug and click the **Next >>** button for the directions page.
5. Fill in the prescription details.

If this is a medication for a long-term condition, check the box beside **Long Term**. This will keep the drug on the client’s CPP, even if the prescription medication expires.

You can click **Advanced** to get additional options for more complex prescriptions.

6. In the Instructions box, type the instructions to the client for this medication. Check the **Add to Favorites** check box to add the current medication, along with the instructions, to your Favorites list. The Favorites list will save you time in the future. Each provider has to create their own Favorites list.

Creating Favorites lists makes prescribing much easier!!
If it is only the instruction that you will use frequently, click the **Add Inst. To Fav.** button. When you are prompted, type in a **Title** for the instructions and click the **Add** button.

7. If you are going to prescribe additional medications and you want all of the medications you prescribe to print on the same page, click the **Add To Pending** button. Add all the additional medications you want to prescribe.

8. Click **Preview Rx** to see a print preview of the prescription.

9. Click **Print** to prescribe the drug(s) and print the prescription. This saves the prescription to the chart.

10. Click **Interaction** to manually check for drug interactions. If automatic interaction is set on your Dashboard settings, this interaction button will not be available as the interactions will automatically appear.

11. Click **Cancel** to return to your medications favorites page.

**Prescribing from the Active Medications List**

Select the **Medications** tab. Click the **New Medication** action button. A list of Active, Expired and Discontinued Medications for the client will be displayed. You may prescribe directly from this list by clicking on the desired medication name, altering directions if required, and then clicking print. To refill a prescription from this page, select the checkbox next to the appropriate medication and click the **Refill** action button.
Medications prescribed are defaulted to flow to the client’s CPP. If you do not want a particular medication to populate the CPP, uncheck the CPP check box.

**Prescribing from a Favorites list**

As described in the Prescribing from the Drug Database section, you can build your own Favorites list to save time when prescribing. These lists cannot be shared or copied between providers. From the Medications tab, type the name of the medication in the Drug Name field to pull up a favorite prescription as shown below. This is called the quick form method. Find the medication and click the ADD button. When you have finished adding medications, click the Print activity button.

**Drug Interactions**

Drug-to-drug, drug-to-allergy, and drug-to-food interactions are checked by NOD. You can select how these interactions will work through your Dashboard.

1. You can choose whether the interactions appear automatically or when you request them manually.
2. You can also choose whether to be alerted based on the severity of the interactions: mild, moderate or severe.
If you choose the **Automatic** setting, a check based on your severity setting is run when you click **Print** to prescribe medications. If you choose the **Manual** setting, you will need to remember to run the interaction check by clicking the **Interaction** activity button.

You are able to override interaction alerts by entering a reason for the override and clicking the **Prescribe** button.

- NOTE: If interactions are not available, the medication will be flagged with a ‘*’ Due to software differences interactions are not available for many migrated medications

### Replacing Migrated Medications

During the migration of Purkinje medications, medications without DIN numbers appear in the NOD application as formulary medications. Because they are text based (rather than selected from the Multum Drug Database), **formulary medications do not provide drug to drug, drug to food, or drug to allergy interactions.** Formulary medications are differentiated by having a C# beside the drug name.

It is recommended that providers replace migrated medications with medications from the Multum Drug Database in Nightingale on Demand to ensure **drug to drug, drug to food, or drug to allergy interactions** are provided. This can be accomplished in the following ways:

#### Replacing medications without refilling the medication

Replacing the medication with a drug from the Multum Drug Database prior to the medication being refilled can be completed within the CPP. First select the appropriate drug from the Multum Drug Database, and then discontinue the formulary medication.

1) Select the appropriate drug from the Multum Drug Database using one of the two options below:

**From the Drug Database**

a. Within client’s CPP click on Medications – New Medication
b. Click on Options and select Drug Database

d. Enter the Original Date prescribed and/or the Last refill/start date
e. Enter the drug directions
f. Check the box beside Add to Favorites; to help build your favorite medication list for future use
g. Click save

From a favorite medication list
a. Within the client’s CPP go to the medications section and click on New Medication
b. Click on the name of the favorite medication
c. Enter the Original Date prescribed and/or the Last refill/start date
d. Enter or edit the directions of the favorite medication
e. Click Add to CPP (if you click save it will only update the directions of your favorite medication) you must click Add to CPP

This adds a medication to the CPP without having to re-prescribe. The date that appears in the CPP is that of the last refilled date and/or original date prescribed.

2) Once the medication is added to the CPP the matching formulary medication can be discontinued.
   a. To the right of the formulary drug you will find
   b. Click on the D which stands for discontinue.
   c. Choose a reason for discontinuing the medication
   d. Do not select the check box beside Replace discontinued drug with another (see below for when this is appropriate)

   If you choose to replace a discontinued drug with another the date of refill would show as today. This option would only ever be chosen if you were with a client and needed to discontinue and prescribe a new medication that day (see below).

   **Replacing medications while refilling the medication**

   From a client’s medication list discontinue the formulary medication and replace it with a new medication from the Multum Drug Database.

   1) Discontinue the medication
a. From the **OPTIONS** menu on the right hand side of the medications list, select **discontinue**.
b. Select a reason for discontinuing the medication and select “Replace discontinued drug with another”

![](Replace discontinued drug with another)

2) **Prescribe from the Multum Drug Database**
a. After clicking “Replace discontinued drug with another” you will be brought to your list of favorite medications. Use the options button to select from the drug database.

![](Select from your Favorite drugs)

b. Select a drug from the database and when completing the medication directions select the appropriate start date:

![](Amox 500 mg capsule)

c. After clicking “Replace” you will be brought back to the discontinue window. If you check off “Sign and print” the medication will be saved immediately, otherwise it will be left pending.

**Exercise 9 – Medication Management**

1. *In the client chart you used in Exercise 8, search for three medications that you prescribe frequently and add them to your favourites list.*
Creating Lab Requisitions

The **Requisitions** tab within an encounter is used to create laboratory requisitions. You can also create a lab requisition by going to **Patients | Plan | Orders | Requisitions**.

1. Click the **New Requisition** activity button.
2. If you have a **Favorites** list of lab requisitions, it will appear (see the next section for more information). Otherwise, the **Laboratory Requisition** page displays.

**Laboratory Requisition**

You may generate the requisition by clicking on the "Sign & Print" button at the bottom.

3. Click the **Open** button beside the **ON General eForm**. (Note: If you do not see this on your screen, contact your Super User.) An electronic version of the Ontario lab requisition will appear.
4. Check the boxes beside the required tests.
5. Type in any additional tests that are not listed (e.g. Pap Test).
6. Click the **Save and Close** button.
7. If the tests on this
requisition are ordered frequently for a particular condition, you can add the requisition to your Favorites list by clicking on the Add to Favorites check box.

8. **Check for Report**: When the lab requisition has been completed, a reminder will appear on your Dashboard under Outstanding Requisitions at the end of the time you select here.

9. Click the Sign and Print button (if adding as a favorite you will be asked to enter a name for your favorite).

Creating Favorites lists will save you a lot of time in the future.

---

**Exercise 10 – Laboratory Requisitions**

In the client chart you used in Exercise 9, create an Ontario Laboratory Requisition for diabetes lab work. Save the requisition as a Favorite.

**Ordering Labs Using a Favorite Requisition**

1. From the Requisition tab of the encounter, click on New Requisition.

2. From the list of Favorite requisitions, check the box beside your correct requisition and click the Sign & Print button.

3. If you want to modify the tests in your Favorite requisition for a specific client, click on the name of the requisition. Click the Open button beside the ON General eForm. Once opened you can add or remove lab test from your requisition. Click the Save and Close button. Click on the Sign & Print.

---

**Exercise 11 – Laboratory Requisitions**
In the client chart you used in Exercise 10, create another favourite Ontario Laboratory Requisition for standard blood work.

**Ontario Laboratories Information System (OLIS) Patient Query**

This section of the manual will be added when it is available.

**Exercise 12 – Searching OLIS for Lab Results**

*Check with your instructor to determine the information to use to run an OLIS Patient Query.*

**Flowsheets**

Flowsheets are used in the client’s CPP to view data over time (e.g. vital signs and weight, or treatments and medications). Flowsheets are useful for managing chronic conditions and screening.

1. Go to the client’s CPP.

2. To add the first flowsheet to a client’s chart, click the Flowsheet icon located in the orange bar that contains the client’s name. You will see a message asking if you want to add one. Select Yes.

3. From the Add Flowsheet screen, select the checkbox for the flowsheet you want and click the Add button.

4. The selected flowsheet displays.
5. To load additional flowsheets, click on the Flowsheet link and click the Add activity button. Repeat steps 3 and 4 above.

Once a flowsheet is attached to a client’s chart, it can be accessed at any time by clicking on the Flowsheet icon in the orange bar. CDM flowsheets will populate each time lab results come into NOD electronically from the specified lab as well as the values entered into the corresponding clinical template.

**Exercise 13 – Flowsheets**

*In the client chart you used in Exercise 12, choose a Flowsheet and add it to the client’s chart.*

**Profiles**

A Clinical Profile can be thought of as a predefined encounter for a particular medical condition. When a Profile is loaded into an encounter, it automatically fills various sections within the encounter based on its predefined values.

Profiles are created per provider. However, each provider in a centre can access other providers’
Profiles. Profiles that have been created by your Super Users for all providers to use are accessed through a default provider – A, Provider – so they appear at the top of the list.

When a Profile is loaded into an encounter, it can populate multiple sections of an encounter at once. Depending on the profile, some of all of the following sections will populate the encounter:

- Assessment
- Medications (medications load as pending)
- Consultations/Referral letter (letter loads as pending, to be edited before being signed and printed)
- Lab Requisition (requisitions load as pending and you must print a label to put on the lab requisition once printed)
- Plan Notes

To load a Profile, open an encounter and click the Profile button.

Click the box next to the Profile you want and click Load. You can also change the provider’s name to choose a Profile from another provider’s list.

**Exercise 14 – Profiles**

In the client chart you used in Exercise 13:

1. Choose a Profile and add it to the client’s chart.
2. Enter the Reason for Visit
3. Select the Services Provided
4. Modify the Lab Requisition
5. Modify the Medication directions
6. Sign Off Encounter

**Complicated Encounter Exercises**

**Exercise 15 - Clinical Providers**

**Exercise 15 - Non-Clinical Providers**
Select a client and enter encounter data as follows:

Prescribe 2 new medications and 1 prescription renewal
Create a Lab Requisition
Create an External Referral

Select a client and enter encounter data as follows:

1. Choose ‘Reason for Visit’ and add to your Favorites
2. Select the appropriate Assessment from the ENCODE-FM codes
3. Complete the Services Provided template
4. Choose an appropriate template and complete
5. Complete the Plan Notes
6. Sign Off Encounter

Exercise 16 – Referrals

In the client chart you used in Exercise 13, create an External Referral.

Exercise 17 – Complicated Encounter

Select a client and enter encounter data as follows:

1. Record a Phone Call Encounter
2. Choose a Reason for Visit
3. Select the appropriate Assessment
4. Complete the Services Provided
5. Create an Internal Referral
6. Enter the Plan Notes
7. Sign Off Encounter

Chart Review

Accessing Encounters

You can access outstanding or completed encounters using Patients | Encounters.

<table>
<thead>
<tr>
<th>Menu Selection</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>New</td>
<td>Opens a new Encounter for the active client.</td>
</tr>
<tr>
<td>Unsigned</td>
<td>Shows a list of all Unsigned Encounters for the active client.</td>
</tr>
</tbody>
</table>
Adding Addendums to Signed off Encounters

Once an encounter is signed off, it cannot be edited. Details can be added to a signed off encounter in the form of an addendum. The addendum is text-based and will not change the values within the encounter itself. To add an addendum to a client’s signed off encounter:

1. Select Patients | Encounter | Signed Off. A list of signed off encounters will be displayed.
2. Click the Add.. button next to the appropriate encounter that you want to create an addendum for.
3. Click the New. button from the Encounter Addendum page.
4. Add addendum details by typing the addendum in the text area. If you want to add this to your Favorites list, click the Add To Favorites. button.
5. Click the Save. button to save the addendum. You can make additional changes to the addendum at any time. However, other providers will not be able to see the addendum until it is signed off.
6. Click the Save & Sign Off. button. Once an addendum is signed off, it cannot be changed.
7. Click the Cancel. button to return to the Signed Off Encounters page without saving changes.
8. To see addendums, select the signed off encounter and scroll to the bottom.

Exercise 18 – Adding Addendums

In the client chart you used in the previous exercises:
1. Select an encounter you had previously signed off.
2. View the original encounter on the left side of the screen.
3. Enter the information into the addendum on the right area of the screen.
4. Sign off the addendum.
5. Open the encounter and review addendum.

Chart History
All aspects of a client’s visits can be searched for and viewed. This can be done by going to Patients | Details | History | Chart History. You can refine your search based on the Provider, Event Type and date range.

Exercise 19 – Chart History

In the client chart you used in the previous exercises:

1. Search for lab requisitions.
2. Select a lab requisition from a signed off encounter.
3. Reprint the lab requisition.

Securing Data

Client data in NOD can be masked so specific details about a client are hidden from one or more users. Only users that have masking privileges can mask client data. The image below is what a CPP would look like with masked data.

For further information on how to mask or unmask client information, please see your Super User.

Practice
Management Tools

Tasks and To Do List

You can assign tasks to yourself, to other specific staff or providers, or to a role within the centre (for example, Front Office). A task can be associated to a client’s chart or it can be created separate from any client chart. Tasks are managed from the To Do list.

There are two ways to see your current list of To Do items.
1. Go to Office Actions | Actions | To Do List.
2. From the notifications area on the Dashboard.

You can sort the To Do List by status (!), Requested By, Action, Concerning and (Due) Date by clicking on the appropriate column heading. Clicking the column heading a second time will reverse the order that the items are shown. A ^ shows that the tasks are sorted in ascending order. A v shows that the tasks are sorted in descending order.

Assigning Tasks to Yourself or Others

1. Go to Office Actions | Actions | To Do List and click New activity button. You can also create a task using the Main Menu icons.

2. If the task is related to a client, search for and click on the client’s name. Tasks do not need to be associated to a client’s chart. If you do not select a client’s name, the task will not be stored in any client’s chart.
3. **Select Action** from the drop-down box. This list of actions is customizable and shared by the centre. If your centre has a standard Action list, please consult your Super User before you use the **Add** or **Remove** options.

4. Assign a **Priority** from the drop-down list (Low, Normal, or Urgent).

5. **Assign To**: Assign the task to a staff member or a user role from the drop-down box.

6. Select the **Start Date**. This is the date that you want the assigned person to start working on the task.

7. Select the **Due Date**. This is the date that you want the task to be finished by.

8. You can add comments in the **Comments** section.

9. Click **Save** button to complete assigning the task.

**Outstanding Tasks**

Tasks that you assign are tracked so that you can make sure they are completed. There are two ways to see your current list of assigned tasks.

1. Go to **Office Actions | Actions | Outstanding Tasks**.
2. Access them from the notifications area on the **Dashboard (Assigned Tasks)**.

By selecting the checkbox beside a task, you can:
- Mark a task as **Complete**. The task will be removed from this list.
- **Delete** a task.
- **Re-assign** a task to someone else.

Only the person who creates the task can delete or re-assign it.


**Recording Completed Tasks**

1. Go to your Office Actions | Actions | To Do List or click To Do from the Reminders area on the Dashboard.
2. Select the task that you have completed by checking the check box next to the task.
3. Click the Complete button.

   ![Actions - To Do List](image)

4. A Completion Note dialog box displays. Type in your notes regarding the task.

   ![Completion Note - Webpage Dialog](image)

5. Click the OK button to complete the task.

**Administration Phone Actions**

Adding a client call from the Record Phone Call icon is only used for administrative activities such as phoning a client to remind them of their appointment. If a service is provided over the phone, providers need to record these conversations as an Encounter with Type Phone.

1. Click the phone icon from the Main Menu icons. The Record Phone Call To Patient page displays.
2. Search for and select the client.
3. Select the Call Action from the drop-down field. This list will be populated by your centre.
4. Select the person who the client was Contacted By.
5. Record a Call Summary in the text area. (This information cannot be extracted later to appear.

   ![Record Phone Call To Patient](image)

You will not be notified when tasks you assigned to other staff are marked complete by those individuals. However, you can see whether the task was completed through the chart history.
in reports.)

6. Click the **Save** button to save the record.

**Messages**

Messages are similar to an e-mail message between providers and staff inside your centre. You can send messages to yourself or to specific staff or providers in your centre, but not to a role within the centre (for example, Front Office). A message can be associated to a client’s chart or it can be created separate from any client chart. Messages are managed from the **Messages** list.

There are two ways to see your current list of **To Do** items.

1. Go to **Office Actions | Messages | Staff Messages**.
2. From the **Messages** area on the **Dashboard**.

You can sort the **Messages** by status (!), **From**, **Subject**, **Concerning** and **Date/Time** by clicking on the appropriate column heading. Clicking the column heading a second time will reverse the order that the items are shown. A ^ shows that the tasks are sorted in ascending order. A v shows that the tasks are sorted in descending order.

**Managing Messages**

1. Click the message link to see details about the messages. Priority messages are marked with a red exclamation mark.
2. You can Reply or Forward the message similar to email.
3. You can also use the **OPTIONS** menu to access Deleted, Sent and Draft message folders.

**Creating a New Message**

1. Go to your **Messages** list, click **New** activity button or create a **Staff Message** using your shortcut icons.
2. If the message is related to a client, search for and click on the client’s name. Messages do not need to be associated to a client’s chart. If you do not select a client’s name, the message will not be stored in any client’s chart.
3. You can send a message to a maximum of 2 people. You cannot send a message to a group of people (e.g. Reception).
   - **Recipient**: Select the recipient from the drop-down list. This list contains providers
and staff at your centre. Use the Advanced link to send a message to another Location in the same Enterprise (e.g. a satellite office), and select the location from the drop-down list.

- **Copy To**: To copy the message to another provider or staff member, select the individual that needs to be copied from the CC drop-down box.

4. Assign a **Priority** from the drop-down list (Low, Normal, or Urgent).
5. Enter a subject in the **Subject** box.
6. Type the message in the **Message** box.
7. Click the **Send** button.

**Patient Summary:**

**Non Clinical Sections of Client’s Chart**

All the non-clinical sections in a client’s chart can be found in **Patients | Details | Summary**. The **Patient Summary** page displays current and future Scheduled Appointments, Follow-ups, Tasks or Messages, Health Maintenance Alerts and Recalls for the client. You can find completed tasks and deleted message by clicking **OPTIONS**.

**Patient Contact Summary**

NOD enables you to track all administrative communication that the centre has had with a client. The **Patient Contact Summary** is accessed from **Patients | Details | Patient Contact**. The **Patient Contact Summary** page displays.
Exercise 20 – Tasks / To Do List

From your To Do List:
1. Create a task for a client and assign it to another person in the class.
2. Create a task for yourself that is not linked to a client.
3. Review your list of tasks and sort them in different ways.
4. Record the task that you created for yourself is complete.

Exercise 21 – Messages

From your Dashboard:
1. Send a message attached to a client’s chart to another person in the class.
2. Send a message to yourself that is not attached to a client’s chart.

Exercise 22 – Phone Actions

From your Dashboard:
1. Create a phone action.
2. Select client.
3. Select Call Action.
4. Record call summary.

Document Workflow

Reviewing Lab and DI Reports

Your Dashboard Reminders area has a section called For Review that provides a summary of newly-received reports that you need to review and sign off, and the number of each report. This will include reports that have been received electronically as well as reports that have been scanned by staff at your centre. The For Review section can also be reached by going to Office Action | Administration | Review Reports.

Clicking the Lab reports or DI report links will take you to the Filed Reports (To Be Signed off) screen.
The list of reports in the **Filed Reports** page is specific to you. If you need to check another provider’s results, you can change the provider name at the top of the screen.

1. Click the name of a client to see the report details.
2. Click the **Comments** hyperlink to enter your comments.
3. Select any subset of results by checking the box next to each result and click the **Tabular** or **Graphic** activity buttons to see the results trended. You need more than one set of results to produce a useful table or graph.
4. To add results to a client’s CPP, select any subset of results by checking the box to the left of the results and click the **Add to CPP** button.
5. Use the **Office Action** button to create a task (e.g. if a follow-up is required) and send it to yourself or to another staff member.
6. Click the **Sign & File** button to sign off the lab results.
7. Click the **Patient copy** button to create a report for the client that includes your impression and interpretation of the selected results.

You can use the arrow keys on your keyboard for a faster way to review lab results.

- **Right Arrow**: Files and signs off the report in view into the client chart.
- **Left Arrow**: Opens the Office Actions screen so you can assign a task.
- **Down Arrow**: Closes the report in view and opens the next report in the review list.
- **Up Arrow**: Closes the report in view and opens the previous report in the review list.

Be sure to change the provider name to your name when you have completed the reviews on behalf of the other provider(s).
**View Previously Signed off Labs**

To view previously signed off lab results while you are in the Filed Reports (To be Signed Off) screen, click on **Options | View Previously Signed Reports | Lab Reports**.

In addition, signed off reports can be accessed by going to **Patients | Reports | Lab Reports**. You can see lab results that have already been signed off at the same (in a split screen) by using the **Display Patient Details** icon in the orange bar under the **Menu**.

**Managing Unmatched Lab and DI Reports**

Lab results that come in electronically for various reasons can end up in an unmatched queue. This happens when the lab result was not able to be matched to existing clients within NOD. For example, the client doesn’t exist or the client’s date of birth or health card number have not been entered in the **Demographics** section.

*Reports for non-insured clients will be found here until they are matched.*

1. To view the unmatched reports click on **Dashboard | For Review**. You will be taken to the Filed Reports (To be Signed off) page, click the **14 Unmatched Reports** link.

2. In the **Unmatched Laboratory Reports** screen click the button located to the left of the client’s name to bring up a client search window. Search the existing client list within NOD.
If the client is not registered, use the **New Patient** button, to register a new client. You can then match the report to the new client’s chart.

### Review External Documents

Your Super User or Training Consultant will discuss this during your training session.

### Exercise 23 – Lab Results

*From your Dashboard:*

1. Select a Lab Result to review.
2. Add a comment.
4. Switch over to another Provider.
5. Review one of their lab results.
6. Split screen so you can see CPP at same time.
7. Send task to front office staff to book an appointment with original provider.
8. Send a message attached to a client’s chart to another person in the class.
9. Send a message to yourself that is not attached to a client’s chart.
Exercise 24 – Correspondence Review

From your Dashboard:
1. Select correspondence for review
2. Sign & File

Client Registration and Chart Management

Each of your clients will be registered in NOD. The process of registration creates a client chart.

Editing a Client’s Chart

To edit or add to a client demographics page, go to Patients | Details | Demographics. The Detailed Registration page displays. If it does not, you must change your Dashboard Settings for Demographics to the Detailed option.

Client Data Recorded by Community Health Centres

Community Health Centres track specific demographic, socio-demographic and other information of their clients to assess how well they are serving the needs of their priority populations. You can find this information on the client’s demographics screen (Patient | Details | Demographics). These include:

- Spoken Language
- Office Language
- Race
- Religion
- Ethnicity
- Place of Birth
- Arrival to Canada (Date of Arrival)
- Socio-demographics (found under Patient Identifiers)

Closing a Client Chart

A client’s chart is open and active when selected. While in the Patients module, the orange bar on top of the page displays the active client’s information.

A client chart can be closed in two ways:

- Manually - Go to Patients | Registration | Close Chart.
- Automatically - Active charts close automatically when you open another client chart.
Exercise 25 – Client Registration

1. Find a client’s record using the Hot List function.
2. Record a change to the client’s telephone number and household composition.
3. Using the Advanced Search feature, find a client using their first name.

Scheduling and Appointment Management

The Schedule module, allows you to manage simple or multiple schedules with ease, connects client data to each appointment, and enables quick access to client information.

- Grayed out time slots represent blocked time. Appointments cannot be booked into blocked time.
- To unblock/block time slots, check the box to the left of the time and click the Block or Unblock activity buttons.

Schedule Navigation Bar

The Schedule Navigation bar allows you to browse from one day to another and view the schedule in multiple ways:

- Click the to display schedule in daily, weekly and monthly view.
- Use the arrows beside the 1, 7, or 31 to go ahead or back by 1, 7, or 31 days.
- Click the Today button to return to today’s date and refresh the schedule.
Booking Appointments

There are two easy ways to book appointments.

1. By clicking the blue time hyperlink 10:30 AM
2. By clicking the empty area associated with each time slot.

After using either method, the New Appointment page displays and you can search for the client you are booking the appointment for.

1. Select from the Appointment Type drop down. This appointment type list is created and maintained by your centre. You will only see the types of appointments that are appropriate to you.
2. You can change the Appt. End Time if needed to allow additional time or shorten the time of the appointment.
3. Appointment Priority must be selected to record the type of contact; e.g. walk in, scheduled, crisis/emergency, urgent/same day. This information is used by the sector as one of their evaluation criteria.
4. If the appointment is recurring, check the box to the left of Recurring appointment. An example of a recurring pattern - four appointments every three days – is shown below.
5. Reason for visit is a text field where you can type why the client is coming in for a visit. This does not flow into an encounter. It is just text that appears on the schedule.
6. Comments is a text box for additional comments regarding the appointment that will appear on the schedule.
7. Click the Schedule Patient button when you have completed the appointment details.

Appointment Management

Each appointment in your schedule will look similar to the figure below.

![Schedule Appointment Example](image)

The table below describes the icons, symbols and menus that are displayed on the Schedule with each appointment:

<table>
<thead>
<tr>
<th>Icons</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><img src="image" alt="Red Exclamation Mark" /></td>
<td>A red exclamation mark before a client’s name indicates they have an alert. Click the exclamation mark to see the alert.</td>
</tr>
<tr>
<td><img src="image" alt="Recurrence Pattern" /></td>
<td>This symbol indicates the appointment is part of a recurrence pattern. Click the appointment time (for example, 2:00 pm) to view or edit the recurrence pattern.</td>
</tr>
<tr>
<td><img src="image" alt="Appointment Status" /></td>
<td>Appointment status. All appointments are defaulted to TBC (To Be Confirmed). Change the appointment status by selecting from the drop down. L/M – left message; OK – confirmed; IN; OUT; NS – No show. You may see different options depending on how your centre has decided to use this field. Contact your super user for additional information.</td>
</tr>
<tr>
<td><img src="image" alt="Reschedule Appointment" /></td>
<td>To reschedule an appointment, click the scissors icon, then click the time hyperlink to indicate where you wish to reschedule this appointment.</td>
</tr>
<tr>
<td><img src="image" alt="Copy Appointment" /></td>
<td>To copy an appointment, click copy icon, then click the time hyperlink to indicate where you wish to make a copy of this appointment.</td>
</tr>
<tr>
<td><img src="image" alt="Print" /></td>
<td>The print icon can be used to print lab labels, address labels, the Health Information Act, consent forms, Patient Handouts and general letters.</td>
</tr>
<tr>
<td><img src="image" alt="Edit Appointment" /></td>
<td>To edit appointment details, click the time hyperlink.</td>
</tr>
<tr>
<td><img src="image" alt="Cancel" /></td>
<td>To cancel an appointment, click the check box next to the time, then click the button. You must select or type in a cancellation reason to complete this action.</td>
</tr>
</tbody>
</table>
Creating and Viewing Schedule Groups

Schedule groups can be used to view more than one schedule at the same time on the same page as shown below.

Only three schedules will appear in the active window at one time.

If you have more than three schedules in the group, you can scroll across to see the additional ones.

To Create a Group Schedule

Group schedules are set up for each provider. Only you will see the group schedules that you create.

1. Go to Schedule | Setup | Groups | Schedule to display the Manage Schedule Groups page. If there are any, saved Schedule Groups will be displayed on the screen and may be edited by clicking the Schedule Group Name link (for example, All Providers).

2. To create a new Schedule Group, click the button.

   ![Create New Schedule Group](image)

   - Type a name in the Group Name text box.
   - Highlight the desired schedule(s) from the list in the Schedules window and click the Add button.

3. Display group of schedules in condensed view
4. Synchronize schedule times
5. When all schedules you desire are listed in the **Selected Schedules** window, click the **Save** button.

To view a Group Schedule, select the group from the **Schedule** drop down menu on the **Appointments** page.

![Schedule Search Example](image)

**Searching the Schedule**

There are two different types of searches on one or more schedules.

1. Patient Appointment Search
2. Next Available Appointment Search.

**Patient Appointment Search**

**Patient Appointment Search** allows you to search for any previous, current, and future appointments for any client. A search can be performed by going to the **Schedule | Search Schedule | Patient Appt. Search**.

![Patient Appointment Search](image)

From the **Patient Appointment Search** page, search on a specific schedule or on all schedules for all of the client’s appointments, or a specific appointment for any date (past or present).

**Note:** If **Appointment Date** field is set to **Any date**, the system returns the complete scheduling history for the client. Click any **date-hyperlink** in the search results to see the appointment details.
Next Available Appointment Search

This feature allows for the searching of available slots by provider, day of week, and time of day. The definition of time of day is as follows:

- Morning: 6:00am – 11:55am
- Afternoon: 12:00pm – 5:55pm
- Evening: 6:00pm – 11:55pm
- Night: 12:00am – 5:55am

Exercise 26 – Schedule Management

1. **Book a regular appointment for one of your clients later today.** Make sure you put in the Appointment Type and the Priority fields.
2. **Reschedule this appointment for tomorrow.**
3. **Cancel the appointment.**
4. **Create a Schedule Group with 3 or more providers.**