Contents

• Pre-rounding
  • Finding your patients
  • Creating a Patient List
  • Gathering Data
• Note Writing
• Dot Phrases and Templates
• Epic Secure Chat
The Mount Sinai EHR

• Epic is Mount Sinai’s EHR
• Epic is customizable – The EHR at Mount Sinai may not look like the EHR at Elmhurst, or elsewhere
• Each visit (an office visit, hospital admission etc.) is called an ‘Encounter’
• These ‘Encounters’ hold all of the patient’s data for that specific visit
  • E.g – A hospital admission contains all of the data (vitals, labs, notes) for that patient’s admission.

This basic structure is helpful to understand.
When you open a patient’s chart, you want to be in the correct Encounter, or visit.
The manner in which you find a patient changes whether you will be in the right ‘Encounter’ to document and review the patient’s data.
Logging in

• **The Department** you log into will change how your screen appears, what items you have access to

• Ask your resident which context to log into at the start of each clerkship
Pre-Rounding in 7 Steps

1. Find your patients and make a patient list
2. Get sign out
3. Vitals and Data (Labs/Radiology/Micro)
4. Review Medications (Ordered/Given)
5. Intake and Output
6. Notes from overnight
7. See the patient!
Make a patient list

• Click Patient lists -> Edit List -> Create My List

• Name your list -> Copy Columns -> select Inpatient List Template
  • Selected Columns will appear (see #4)
Make a patient list

• Your list will appear on the sidebar
• Add patients by finding them on the “Units” list or the “Services” List and dragging and dropping them into your own personal list

Drag and Drop individual patients or lists from Available lists into the lists under ‘My lists’
Alternate way to Find Patients

- Can also search by MRN, name or Date of Birth via Patient Station
- This however will not open the correct visit or ‘Encounter’ for you!

Therefore if a patient is admitted to the hospital, you should find them using the Available List functionality.

1 – Click Patient Station
2 – Search by at least 2 patient identifiers

These are all of Alice’s Encounters, or visits within Mount Sinai. You will not be able to document until you select the correct visit.

You must be in the correct encounter when you document!
Get sign out

- Some services will use the handoff tab to write sign out.

1 – Click Write Handoff

2 – Type the service you are on. Ask your resident

3 – The handoff sidebar will appear with pre-populated text
Where do I find data?

- Most of the basic information on your patient can be found under the Summary tab
- The IP Overview report shows you a quick snapshot of data
This is a report that shows the past 24 hours of vital signs with minimum, maximum and abnormal values highlighted in red.

When presenting patients it is important to present ranges over the past 24 hours as well as most recent and if febrile, the maximum temp (tmax).
• Results Review is the quickest way to find labs

1 – Click results review

2 – Click Current Hospitalization

3 – Uncheck both checkboxes

4 – Click Accept
Labs

• Can search for labs however search is not very forgiving. Easier way is to click on each node and become familiar with the labs beneath each node.

• The Common Labs Node contains most of the daily labs you will follow in a clinically intuitive way.

Highlight one lab value, then click Flowsheet. This allows you to see an individual lab trended over time.
Microbiology

1 – Click on Summary

2 – Search for IP Micro then select MS IP Microbiology results

This report will allow you to see Microbiology results
Chart Review -> Imaging will show you all of the Imaging studies a patient has undergone within this Mount Sinai system.

Chart Review -> Procedures will show you any procedures including Echocardiograms, Bronchoscopies, Endoscopies etc.

Clicking on an individual study will allow you to see the actual image.
Intake and Output

1. Click Summary

2. Click Intake Output

3. Click Table

4. You may change the time frame
Orders

Orders tab will show all active therapies on a patient – medications, nursing orders, diet etc. Always review this for your patients daily!

Can sort by the order type

Each order will specify the dose, route (Oral i.e PO, Intravenous i.e IV, or Intramuscular i.e IM) and the frequency. PRN means as needed.
Medications Administered

• Despite medications being ordered, they are not always given.
  • E.g. - A patient could have Morphine ordered every 4 hours as needed (PRN) – but not have taken it in 1 day.

• To see what’s actually administered you must check the MAR.

1 – Click Summary

2 – Search for ‘MAR’

There are a few reports that will appear

Meds History will allow you to see all prior medications administered

Active MAR will help you see future meds
MAR History report

Hovering over each time will reveal the person who gave the medicine, the dose, as well as any comments.
Notes

- You will mostly write Progress Notes and H&Ps
  - At times you may write consult notes and discharge summaries as you progress through Clerkships

1-Click Notes

2-Click New Note

3-Fill in Either Progress Note or H&P

4-Ensure the Service is appropriate as well (Surgery, Medicine etc.)

5-Click on the icon

6-Search for the template you desire

7-Click Accept. This will pull the template into your note
Dot Phrases

- Add a template to your notes by typing “.” then the name of the template
- Templates can be shared between users

3 - Create new SmartPhrases by clicking here

All SmartPhrases that you are able to use will appear here. When your resident shares a SmartPhrase with you, it will appear here.
De-stigmatizing Notes

The 21st Century Cures Act is a new Health IT act. Within is a component called “Open Notes” which indicates health systems must provide the option for patients to see their medical records – including Notes – electronically. This means patients can see all notes including yours!

In light of this we recommend you:

- Avoid terms such as “Sickler,” “Cirrhotic,” and “Alcoholic”
- Avoid stigmatizing terms related to substance use disorder
- “Patient declines” or “chooses note to,” rather than “patient refuses”
- Avoid certain descriptions in the physical exam (e.g. – “Pleasantly demented”)
- Avoid casting doubt on patient’s symptoms or subjective experience
- Reconsider documenting personality type descriptions.
Epic Secure Chat

During the course of your day Nurses, other physicians will contact you via Epic Secure Chat
Epic Secure Chat

- Messaging system to aid in closed loop communication within the EHR

- Add individual providers as needed and leave the thread as desired.

- Please do NOT use this akin to a text; keep communication relevant and brief.
  - No need to say thank you each time a nurse or social worker messages
  - This can result in secure chat overload.

- This is not part of the medical record and messages are purged every 7 days
Epic Secure Chat

Create a new conversation

Patient's name and MRN

Conversation appears here

All participants appears here