How to complete charting for Dr. Barron

1.) Patients who are ready to be seen will have a check-in paper in the box in the supply room (same place where charts were placed pre-EPIC)
2.) Log in to Pelican.
3.) Double click on patient’s name
4.) You will enter the patient’s chart under a “Visit Navigator” to chart today’s visit
5.) The tech’s will have already entered the chief complaint and a brief HPI, history, and base exam (Vision, Refraction, IOP, pupils)
6.) Review the eye medications and make any changes as necessary
7.) Perform your exam and chart under “Ophth Exam”
8.) Record the results of any ancillary testing (HVF, OCT, Last IOP, Schirmers, Hertel, etc) in the free text box under the “Addl tests” tab under “Ophth Exam”
9.) Enter all visit diagnoses under “Visit diagnosis”
   a. Particularly, if a diabetic patient does not have retinopathy, that diagnosis should be entered as “diabetes mellitus without ophthalmic complications”
10.) Write A/P under “Progress Notes”
   a. Click on “Create Note” and NOT “Create Note in Note Writer”
   b. This is where you can enter smart phrases for commonly encountered diagnoses such as NVS cataracts or DM without retinopathy.
11.) Complete Level of Service and Follow-up
   a. Click the wand next to “LOS” and select the appropriate billing level
   b. Enter Dr. Barron’s name in the “Auth prov” box
   c. Type “gc” in the modifier box to enter that the patient was seen by a resident
   d. Select appropriate follow-up time and enter if it is for a specialty clinic in the “For” box (retina, glaucoma, etc)
   e. Residents cannot enter billing for procedures performed (OCT, Refraction, etc) so Dr. Barron will do that
12.) Make all necessary medication changes under the “Medications” tab
   a. When refilling prescriptions, be sure to change the “Class” to “Print” so it will print in Dr. Barron’s room
13.) Once you are done charting and ready to present to Dr. Barron, click the “X” next to the patient’s name
14.) DO NOT CLOSE THE ENCOUNTER
   a. Dr. Barron will complete his charting after he sees the patient and will close the encounter when the patient is ready to leave
How to order an OCT
1.) Click “Order entry” then “New Order”
2.) Search for “OCT”
3.) Be sure the “Meds to be given TODAY in clinic” box with the bed is checked and select “GDX/OCT/HRT” with the bed icon
   a. If you select the one with the house icon, that is indicating it is a future order to be completed after today’s encounter and it will not be done
4.) Click “Sign/Nav” on upper toolbar

How to order a Humphrey Visual Field
1.) Click “Order entry” then “New Order”
2.) Search for “Vis field”
3.) Be sure the “Meds to be given TODAY in clinic” box with the bed is checked and select “VF Extended” with the bed icon
   a. If you select the one with the house icon, that is indicating it is a future order to be completed after today’s encounter and it will not be done
4.) Click “Sign/Nav” on upper toolbar

How to sign up a patient for surgery
b. Open patient’s chart
c. Complete charting for patient’s visit as usual
d. On upper navigation bar on the right, click on the down arrow next to “Helper Navigator”
e. Click “Surgical Helper Navigator”
   i. This will open a new navigator on the left titled “Surgical Consult.”
      This essentially adds a few more options to the regular “Visit Navigator” tab from the clinic visit
f. Complete the H&P
   i. Click the arrow next to “H & P Notes”
   ii. Click “Create Note” under the “H & P Notes” Header to the right
   iii. In the “Insert Smart Text” box, type “sur gen pre” (or .OPHHP)
   iv. Select “Sur Generic Pre-Op History and Physical” and click “Accept”
   v. Click in the text of the template and click “F2”
      1. This will highlight the first wildcard, which is the chief complaint. For a cataract surgery, I would usually just type “blurred vision, glare, etc” or whatever their complaint was and then delete the rest of the paragraph.
   vi. Delete yellow-highlighted text that says “{HPI:18514}”
   vii. Hit F2 to highlight past history. Left click “Past medical history, Past surgical history, Family History, Social History, Current Medications, and Allergies” then “right click to stick”
   viii. The Review of Systems will then be automatically selected. I usually just select “a comprehensive review of systems was negative” and then right click
xi. The physical exam selections will then be automatically selected. The “normal” findings are pre-selected. I usually just change the eye exam to reflect the patient’s exam. Complete the physical exam.

xii. The assessment will automatically pre-populate with the diagnosis from your clinic/consult note.

xiii. Complete the plan with the risks of surgery.

xiv. For the wildcard under number 2, I would usually type what surgery was planned and on what date

xv. Erase the rest of the note, including the attending attestation.

xvi. Click “Sign”

g. Complete the surgical orders and case request

i. Click “Visit Navigator” on left-most column

ii. Click “Smartsets” and type “oph” in search bar

iii. Select “LSU OPH CORNEA SERVICE ADMISSION PRE-OP”

   1. There is no cataract smart set. Go figure

iv. Click “Open Smart sets”

v. Click the blue text under “Case request”

vi. Primary Provider: Barron

vii. Department: ILH OR Periop Services

viii. Procedure Date: Date of surgery

ix. Patient Class: Hospital Outpatient Surgery

x. Procedure: Phaco, Vitrectomy, etc

xi. Laterality: Left/Right

xii. Operating Region: Eye

xiii. Anesthesia: MAC/General/Local

xiv. Questions: Skip unless not being discharged home after surgery

xv. Status: Future -> Expected: Date of surgery

xvi. Change “Diet NPO time specified” date to day of surgery and unselect “POCT glucose” if patient is not diabetic. Leave the rest of the boxes checked and unchanged.

xvii. Medications Tab

   1. LSU Intravenous Fluids: Select Saline Flush

   2. DVT Risk: Select Low Risk

   3. Vitreo-Retinal Procedure Medications

      a. Mydriatics Pre-Op

         i. Select Tropicamide and Phenylephrine

         ii. Under each, select eye, change date to date of surgery, and type “60” for wildcard under “Admin. Inst.”

         iii. Click Accept

xviii. Additional Smartset Orders

   1. You must order a BMP, CBC, and EKG on every patient. This is the place to do it

   2. Click “Add Order”

   3. Order above tests. Click Accept.

xix. Click Sign
xx. Associate all orders with eye diagnosis with the exception of the labs, ekg, and cxr. Add a diagnosis called “pre op testing” and associate the labs, ekg and cxr with that diagnosis and click accept

xxi. Phases of care:
   1. Case request must be “Procedure Scheduling Request”
   2. CBC, BMP, and EKG must be “Pre-Admission Testing” which you usually have to add on bottom left
   3. Remaining orders can be “Pre-Op”
   4. Click Accept

h. Have patient sign consent form. Robin must witness it before it is scanned.

i. Complete lens order (found in cabinet near Dr. Barron) form and fax to OR

j. Have patient meet with nurse so they can schedule their outpatient pre-op appointment in EAC on 3rd floor at ILH

How to Pre-op Patients on day of surgery
1.) After logging in to EPIC, click on “ORs at a glance” on the top toolbar
2.) Select today’s date and double click on your patient’s name in the schedule (should be in OR 07)
3.) Select Pre-op Navigator on left side bar
4.) Complete H&P Interval note
   a. I usually just write “No changes to H&P since note dated ___” and sign it
5.) Mark patient
6.) Confirm consent has been signed under “Media” tab under chart review tab

How to Discharge Patients home on day of surgery
1.) After completing surgery, log in to EPIC and click on “ORs at a glance” on the top toolbar
7.) Select today’s date and double click on your patient’s name in the schedule (should be in OR 07)
2.) Select Post-op Discharge Navigator on left side bar
3.) Complete Brief Op note
4.) Complete Op Note
   a. You can dictate but Dr. Barron has several Smart Set templates that he will likely prefer you use
5.) Complete discharge orders
   a. Click on Med Reconciliation
   b. Choose which medications to continue or discontinue and click next
   c. Open Gen Discharge to Home order set and complete orders
   d. Add post-op drops to Additional orders and change the start date to POD 1
   e. Sign orders
6.) Complete discharge summary
   a. Every patient needs a discharge summary, even if they have outpatient surgery
b. To do a D/C summary, click on “notes” on the side navigator, then D/C Summaries, then new note

c. Complete the D/C summary. There is a Smart Set template titled “Gen Medicine IP Discharge” or something similar that I use.

d. I have not figured out how the D/C summary is linked to that stay, but Dr. Barron is looking in to it. This outline can be updated once that is figured out.

7.) Give the drops to the patient’s family to bring to clinic tomorrow.

Pre-saved templates

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>.OPHHP</td>
<td>Pre-OP H&amp;P</td>
</tr>
<tr>
<td>.OPHCATOPNOTE</td>
<td>Cataract OP note</td>
</tr>
<tr>
<td>.OPHDISCH</td>
<td>OR Discharge summary</td>
</tr>
<tr>
<td>.OPHCONSULT</td>
<td>Useful for inpatient/ER consults</td>
</tr>
</tbody>
</table>