Computerized Patient Record System (CPRS)

User Guide

GUI version

December 2004

Department of Veterans Affairs
Health Data Systems
Computerized Patient Record System Product Line

Revision History

The most recent entries in this list are linked to the location in the manual they describe. Click on a link or page number to go to that section.

Date	Patch	Page	Change	Project Manager	Technical Writer
12/29/04	n/a	Various	Updated graphics and other references to patient and provider identifiers to comply with SOP.	n/a	T. Robinson
11/29/04	OR*3.0*195	279	Updated instructions for creating JAWS configuration files.	n/a	T. Robinson
11/24/04	OR*3.0*195	various	Additional revisions	n/a	T. Robinson
11/16/04	OR*3.0*195	various	Added edits from various reviews	n/a	T. Robinson
11/4/04	OR*3.0*195	various	Made minor revisions based on team feedback.	n/a	T. Robinson
10/29/04	OR*3.0*222	189	Added a brief reference to the Group Notes Application.	A. Ebert	T. Robinson
10/25/04	OR*3.0*195	103, 148	Made revisions to the sections that deal with entering allergies.	A. Ebert	T. Robinson
9/3/04	OR*3.0*195	71	Revised the section describing when service connection and treatment factor exemption button display.	T. Baxter	T. Robinson
8/10/04	OR*3.0*195	173	Added a new screen shot and instructions for the new Duration/Total Volume field for IV Fluids.	M. Hendry	T. Robinson
7/26/04	OR*3.0*195	41	Editing the Patient Record Flag section to remove references to the information on the Patient Selection screen that was removed.	A. Ebert	T. Robinson

6/11/04	OR*3.0*195		Revised Postings information to reflect the way users create postings for allergies, as opposed to the way users create other types of postings.	A. Ebert	C. Walton
6/9/04	OR*3.0*195	,	Updated information about entering allergies from the **Orders** tabs and added information about entering allergies from the **Cover Sheet** tab.	A. Ebert	C. Walton
6/9/04	OR*3.0*195	, , ,	Updated information in sections that discuss entering inpatient medications for outpatients (IMO orders): specifically, deleted information stating that CPRS displays IMO orders as inpatient medication orders and added information about new Meds tab and Orders tab IMO displays. Also added information about how CPRS handles ADT movements for IMO orders.	M. Hendry	C. Walton
6/3/04	OR*3.0*195	57	Added official text to explain service connection and treatment factors.	T. Baxter	T. Robinson
5/27/04	OR*3.0*195	123, 126, 159, 161	Added new instructions regarding the removal of free text schedules and the ability to create customized day-of-week/administration time schedule for inpatient medications using the new Other schedule item on the Meds tab for simple dose or complex dose and from the Orders tab for simple dose or complex dose.	M. Hendry	T. Robinson
5/12/04	OR*3.0*195	82	Added information about the user setting the date ranges for Encounters.	M. Hendry	T. Robinson
5/3/04	OR*3.0*195	86, 89	Added a screen shot for the new option on the Lists/Teams tab of the Options dialog. Also added information and screen	T. Baxter	T. Robinson

			captures for creating and maintaining a Personal Diagnosis List.		
3/16/04	OR*3.0*195	61	Added overview of Clinical Indicators Data Capture changes to the GUI.	T. Baxter	T. Robinson
4/1/04	OR*3.0*190	137, 170	Added information about order checks for non-VA meds entered on the Meds tab and the orders tab.		
3/30/04	OR*3.0*190	235	Added section about the surgery tab in CPRS.		
3/24/04	OR*3.0*190	22	Added information about sorting Notifications using the keyboard only.		
3/3/04	OR*3.0*190		Modified content in the “Entering Allergies from the Orders Tab” section to reflect recent changes in the Adverse Reaction Tracking package. (Users can no longer enter free-text allergies.)		
2/20/04	OR*3.0*190		Replaced Meds tab screen shot with one showing Non-VA, Inpatient, and Outpatient Meds.		
2/5/04	OR*3.0*190		Added change to describe what type of remote data users can get (including Clinical Reports).		
2/4/04	OR*3.0*187		Added a change to the instructions and the screen capture about to how to place radiology/imaging orders to reflect the Pregnant field being mandatory.		
2/4/04	OR*3.0*187		Added a note that setting a default tab that CPRS should open to when changing patients or logging in again will not take effect without first exiting and logging back in to CPRS.		

2/2/04	OR*3.0*187	-15	Clarified that patient selection displays a list of possible matches when last names and last 4 digits of the social security number match.		
1/28/04	OR*3.0*190		Added information about the Recently Expired Orders view selection on the Orders tab.		
1/28/04	OR*3.0*190	, ,	Added general information about removing notifications and sorting. Also, added a note about Remove button only removing those notifications placed in the ORB REMOVE parameter.		
1/26/04	OR*3.0*190		Added text and screen shot for the new Patent Record Flag pop-up box.		
1/26/04	OR*3.0*190		Added a screen shot and text about Combat Veteran exemption on the Encounter form.		
1/26/04	OR*3.0*190	54-59	Added screenshots and information regarding the Combat Veteran co-pay exemption and the qualifications for Combat Veteran status on the signing dialogs.		
1/22/04	OR*3.0*190		Added an overview and instructions for entering Non-VA medications into CPRS.		
1/14/04	OR*3.0*190		Updated information about creating allergy orders to reflect ART changes to CPRS GUI version 24.		
9/16/03	OR*3.0*191	,	Added a note about DoD Consults information and the actual listing of the report.		
8/05/03	OR*3.0*187	, ,	Added to the Meds tab and Orders tab sections instructions for ordering inpatient medications for outpatients. This functionality is new with CPRS version 23. Added a		

			note about sites' ability to specify inpatient medication order stop dates. The note also mentions sites' ability to specify the status of inpatient medication orders when patients are transferred. Also added a note explaining what happens if users change their clinic selection after they have started an order.		
7/30/03	OR*3.0*187	, , , , , , ,	Added information about new functionality that makes it easier to distinguish between providers who have identical given names and surnames.		
8/27/03	OR*3.0*202	,	Added a note about provisional diagnosis and inactive codes.		
8/27/03	OR*3.0*202		Added a note and graphics as an example of a diagnosis or procedure code that needs to be changed on the Encounter form.		
8/27/03	OR*3.0*202	, ,	Added note about inactive problem codes for adding a new problem, annotating a problem, and verifying a problem.		
8/26/03	OR*3.0*202	,	Added Code Set Versioning overview. Added a brief note about inactive codes on the Cover sheet.		
8/19/03			Added an overview of Patient Record Flags and a section on how to view flags.		
7/1/03	OR*3.0*163		Minor edits to PKI information.		
6/17/03	OR*3.0*173		Added information on comments for forwarded Notifications.		
5/27/03	OR*3.0*173		Added instructions on how to print multiple Notes, Consults, or Discharge Summaries.		
5/27/03	OR*3.0*173	, ,,	Added changes for Give Additional Dose Now on Med tab for simple orders		

			and for complex orders. Also, added the changes to Give Additional Dose Now for Simple orders on the Orders tab and Give Additional Dose Now for Complex inpatient dosages on the orders tab.		
5/27/03	OR*3.0*173		Added sections about sorting notifications and alerts by column headings and the addition to the CPRS GUI of the Forward, Remove, and Renew actions familiar to List Manager users.		
5/27/03			Added information about creating additional patient data object in the CPRS Template Editor.		
5/19/03	OR*3.0*173		Added information about CCOW and application synchronization.		
5/16/03	OR*3.0*180		Added entry that Allergies will be included as part of the Federal Health Information Exchange (FHIE) project.		
3/1/03	OR*3.0*149	 144	Added *Appendix A – Accessibility, which* contains information about how to change the font size and window color in CPRS, as well as how to set up a JAWS configuration file. Added a description of the “Flagged” indicator to the *Flagging an Order* section. Added a new description of how unsigned orders are displayed on the Orders tab.		
		147	Added a note about viewing results and the results history using the right-click menu on the orders tab.		
2/13/03	OR*3.0*163		Added overview and instructions for digital		

			signatures for VA/DEA Digital signature (PKI) pilot project.		
2/4/03	OR*3.0*160		Added notations of reports that will be included as part of the Federal Health Information Exchange (FHIE) project.		
10/6/02	OR*3.0*141		Orders tab changes and event-delayed orders.		
6/4/02	OR*3.0*148		CPT modifiers can now be selected on the Visit tab of the Encounter form. A new screen shot was added to reflect this change.		
5/21/02	OR*3.0*148		Added Surgery tab documentation		
5/21/02	OR*3.0*148		Added Clinical Procedures documentation		
5/21/02	OR*3.0*148		Added documentation for the Copay/Millennium Bill phase II changes to the Problems tab		
5/8/2002	OR*3.0*148		Updated information about Remote Data Views and Reports, including Department of Defense remote data. Added information about problem list		

Table of Contents

Introduction

What is CPRS?

The Computerized Patient Record System (CPRS) is a Veterans Health Information Systems and Technology Architecture (VistA) computer application. CPRS enables you to enter, review, and continuously update all the information connected with any patient. With CPRS, you can order lab tests, medications, diets, radiology tests and procedures, record a patient's allergies or adverse reactions to medications, request and track consults, enter progress notes, diagnoses, and treatments for each encounter, and enter discharge summaries. In addition, CPRS supports clinical decision-making and enables you to review and analyze patient data.

Using CPRS Documentation

Related Manuals

Computerized Patient Record System Installation Guide

Computerized Patient Record System Setup Guide

Computerized Patient Record System Technical Manual

Computerized Patient Record System Online Help

Clinical Reminders Manager Manual

Clinical Reminders Clinician Guide

Text Integration Utility (TIU) Clinical Coordinator and User Manual

Consult/Request Tracking User Manual

VistA Intranet

CPRS documentation is also available on the VistA intranet. The intranet version is constantly updated and may contain more current information than this print version. CPRS documentation is available on the VistA intranet at http://vista.med.va.gov/cprs/.

Online Help

Instructions, procedures, and other information are available from the CPRS online help file. You may access the help file by clicking **Help | Contents** from the menu bar or by pressing the F1 key while you have any CPRS dialog open. Much of the information in this User Manual is also in the CPRS online help.

CPRS Graphical User Interface (GUI)

CPRS was designed to run in both the Microsoft Windows operating environment and on text-based terminals. The terminal or text-based version of CPRS (also known as the List Manager version) is not described in this manual. This manual describes the Windows version of CPRS.

The Organization of this Manual

This manual is organized in the way most people will use the CPRS GUI. It begins with how to log on to the system and then how to select a patient. The manual continues with an explanation of the features that are available from each CPRS tab.

We hope this organization will help you understand the basic layout of the CPRS GUI and provide you with information about the specific tasks you will perform.

Signing in to CPRS

Before you can login to CPRS, you will need to obtain an access code and a verify code. Typically, your Clinical Coordinator issues these codes.

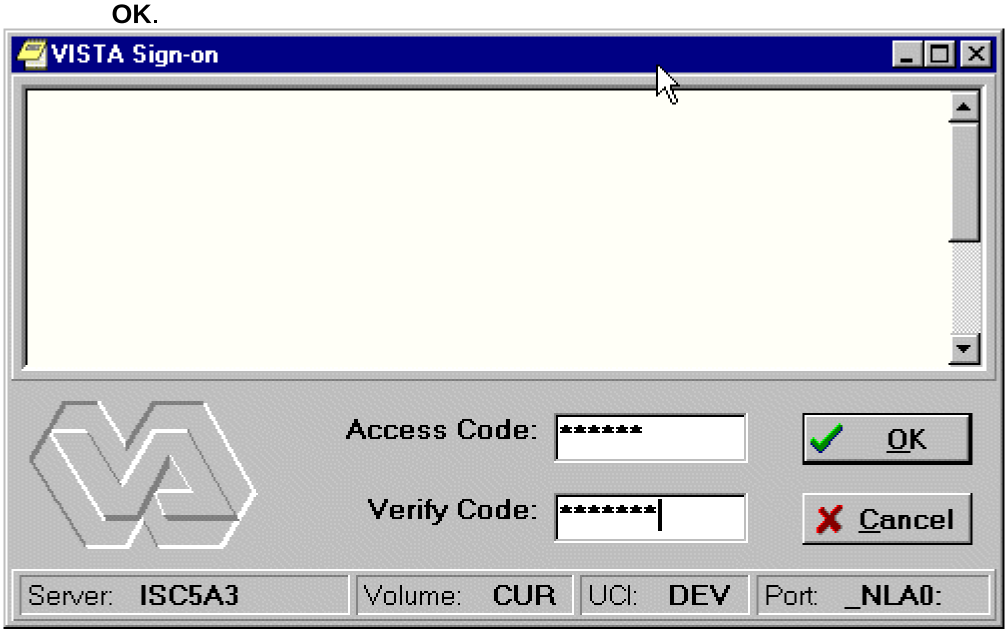
To login to CPRS, follow these steps:

1. Double-click the **CPRS** icon on your desktop.

   The VistA logo window and the VistA Sign-on dialog will appear.

2. If the Connect To dialog appears, click the **down-arrow**, select the appropriate account (if more than one exists), and click **OK**.
3. Type your access code into the Access Code field and press the **Tab** key.
4. Type the verify code into the verify code field and press the **Enter** key or click **OK**.

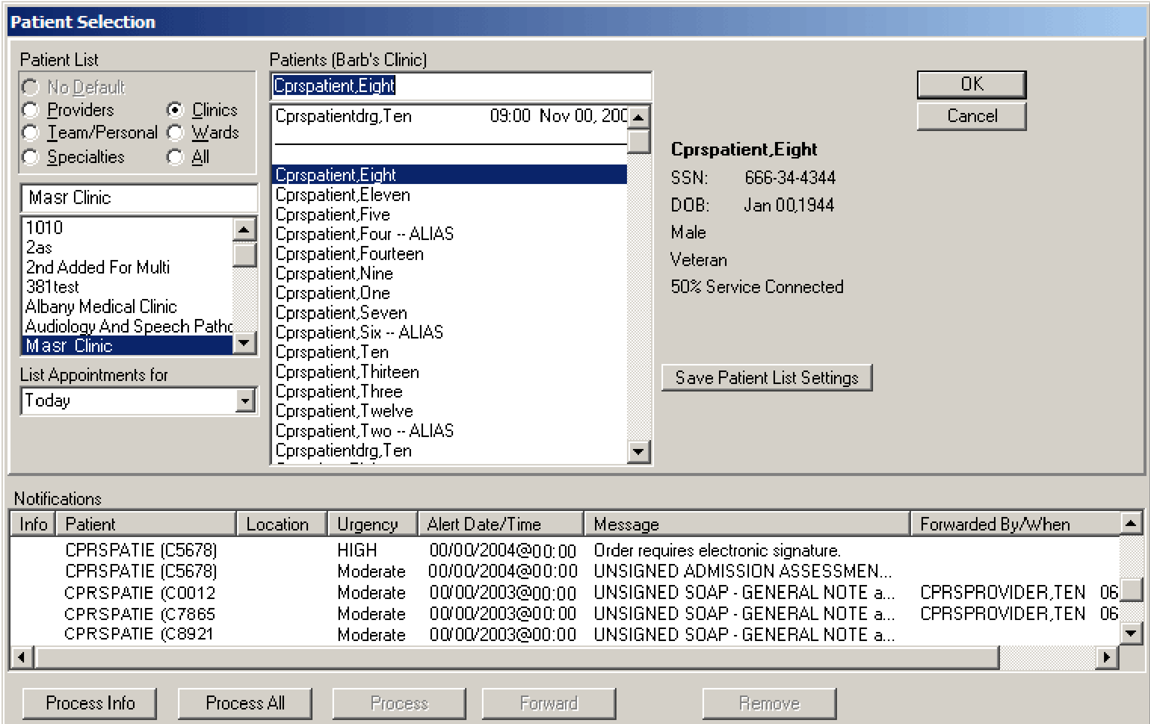
   Note: You can also type the access code, followed by a semicolon, followed by the verify code. Once you have done this press the **Enter** key or click **OK**.



The VISTA Sign-on screen

Selecting a Patient

After you log in to CPRS, the Patient Selection screen, shown below, is the first thing to appear. You should now select a patient record to view.



The Patient Selection screen

To select a patient record, follow these steps:

1. Do one of the following:

   a.) Type the patient's full social security number with or without dashes (000-44-4444 or 000444444) or type the full social security number with "P" as the last character (000-44-4444p, or 000444444p).

   b.) Type part of the patient's last name or the patient's entire name (e.g. "CPRSp" or "CPRSpatient,One").

   c.) Type the first letter of the patient's last name and the last four digits of the patient's Social Security number (c4444).

   CPRS will try to match what you entered to a patient and highlight that patient. The patient's name and other information will appear below the Cancel button.

2. Verify that the correct patient is highlighted. If the correct patient is highlighted, click OK. If the correct patient is not highlighted, scroll through to find the correct patient, highlight the name, and then click OK.

   Note: If CPRS finds more than one patient with the same last name and same last four digits of the social security numbers, a box will pop-up listing possible matches. Select the correct patient and click **OK**.

3. When you click OK, CPRS opens to the Cover Sheet (unless you have set it to open to a different tab).

You can also use the radio buttons under the Patient List heading (located on the left-side of the window) to group the patient list according to provider, team, specialty, clinic, or ward.

When you select a specific list for a provider, team, specialty, clinic, or ward, CPRS will display the associated patients in the Patients list box, followed by a line, and then the comprehensive patient list. You can then scroll to find the name. Your Clinical Coordinator will usually create the lists for the teams, wards, and so on.

Patient Selection Messages

When you select a patient record to open, you may receive one or more of the following messages:

- **Means Test Required –** This message tells you that the patient's ability to pay for medical services must be evaluated.
- **Legacy Data Available –** This message would be found only at a consolidated facility. It informs you that the selected patient has data from the system you used before your site was consolidated that is not being displayed and that you may want to access.
- **Sensitive Patient Record –** This indicates that the record is sensitive and may only be viewed by authorized users.
- **Deceased Patient –** This message tells you that the selected patient is deceased.
- **Patient with Similar Name or Social Security Number –** This message appears if you enter only part of a patient's name or the last four digits of a social security number. If CPRS finds more than one match for what you have entered, this message appears and CPRS presents the possible matches so that you can select the right one.

Patient Lists

You or your Clinical Coordinator can create patient lists or team lists that simplify tasks such as reviewing patient charts, ordering, and signing orders and notes. These lists can be based on wards, clinics, teams, or other groups. Patient lists are managed through the List Manager interface (the character-based version of CPRS).

With patient lists you can:

- Quickly locate your patients without going through all the patients in the list.
- Create lists for teams of clinicians who can sign or cosign for each other.
- Tie notifications to teams, ensuring that all team members receive necessary information about a patient.

Setting a Default Patient List

To make it easier for you to locate your patients, CPRS enables you to set a default patient list. This is the list that will appear when you launch CPRS. For example, if you work in a specific ward, you can set the default patient list to be the list for that ward.

To set the default patient list, use these steps:

1. If you are just opening CPRS, skip to step 2. Otherwise, select **File | Select New Patient...**.
2. In the Patient Selection screen, select the category in which you want to search for a patient's record by clicking the option button in front of the category (**Default, Providers, Teams, Specialties, Clinics, Wards,** or **All**).
3. In the list box below the option button, click the item that narrows the search further (such as a specific ward).
4. If you select something other than All, CPRS sorts the patient list and divides the list into two parts: The names above the line are the names for the category and item you selected; the names below the line make up a comprehensive patient list.
5. To save the patient list as your default list, click **Save Patient List Settings**.
6. If you selected "Clinics" in step 2, a dialog that resembles Figure A will appear.

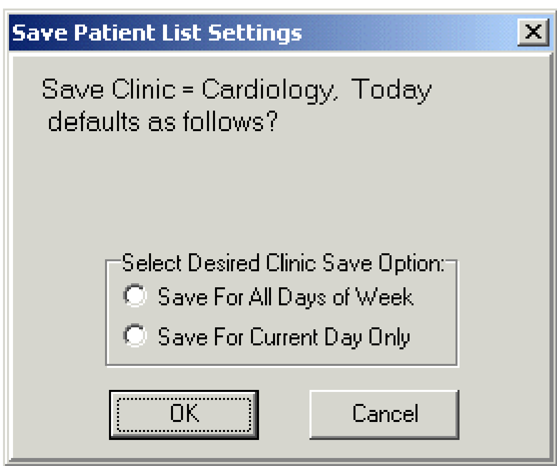


Figure A

7. Select "Save For All Days of Week" If you wish to set the clinic as the default patient list for all days of the week.

   -or-

   select "Save for Current Day Only" if you wish to set the clinic as the default for only the current day of the week.

8. Press **OK**.

Notifications

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (such as Lab, CPRS, or Radiology). The notifications are located at the bottom of the Patient Selection screen.

CPRS places an “I” before “information-only” notifications. Once you view (process) information-only notifications, CPRS deletes them. When you process notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that requires action.

From the main listing, users can also Remove, Renew, or Forward notifications.

- **Removing** notifications is the same as deleting them. A new parameter (ORB REMOVE) enables you site to identify which notifications can be removed without processing.
- **Renewing** notifications is useful when a user is processing a view alert, such as an abnormal lab result, and decides that the alert should not go away after the user views it. In this case, the user can renew the alert and it will still be there the next time the user logs in to CPRS.
- **Forwarding** notifications enables users to send an alert to someone else at the site. The user can choose from the list of names that is in your site’s New Person file.

Note: As a default, all Notifications are disabled. Information Resources Management (IRM) staff and Clinical Coordinators enable specific notifications by setting site parameters through the Notifications Management Menus in the List Manager version of CPRS. These specific Notifications are initially sent to all users. Users can then disable unwanted Notifications as desired, through List Manager’s Personal Preferences. Some notifications are mandatory and cannot be disabled.

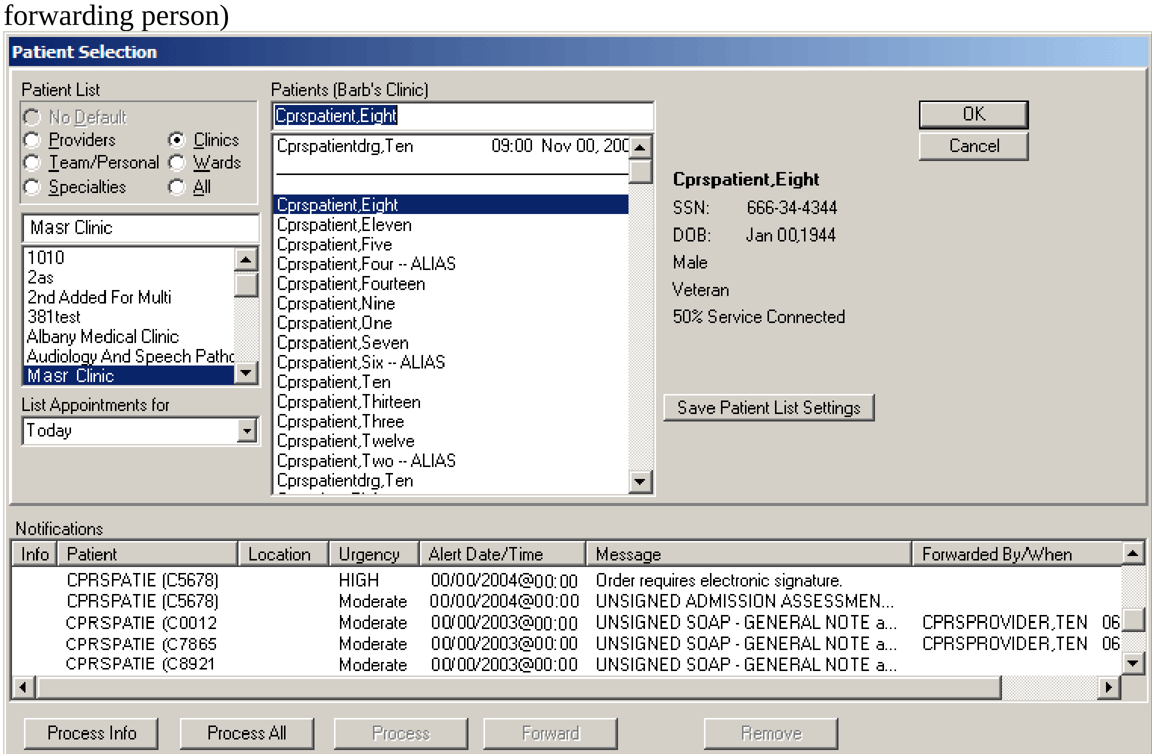
Notifications are retained for a predetermined amount of time (up to 30 days), after which they may be sent to another destination, such as your MailMan surrogate or your supervisor. Confer with your clinical coordinator to establish and set up these options. You can also confer with your clinical coordinator to select what types of notifications you will receive. Some notifications are mandatory, however, and cannot be disabled.

Clinical Notifications are displayed on the bottom of the Patient Selection screen when you log in to CPRS. Only notifications for *your* patients or notifications that have been forwarded to you are shown.

Sorting Notifications and Viewing Comments of Forwarded Alerts

To enable users to decide which of their Notifications or Alerts they would like to process first, the format for displaying Notifications in the CPRS GUI has been changed to columns that enable users to sort their Notifications based on column heading:

- Info (information alerts are preceded with an "I")
- Patient name (alphabetical or reverse alphabetical)
- Location (patient location, if known, alphabetical or reverse alphabetical)
- Urgency (valued HIGH, Moderate, or low as indicated by the CPRS parameter ORB URGENCY. TIU alerts are given a Moderate urgency value. Other alerts without a parameter value are given an urgency of low.)
- Alert Date/Time (date/time the alert was triggered, newest to oldest or oldest to newest)
- Message (alert message or text, alphabetical or reverse alphabetical)
- Forwarded By/When (sorts alerts alphabetically and then by time for the same forwarding person)



This graphic shows the alerts with the column display. Clicking a heading will sort the alerts by that heading.

When the user exits CPRS or changes patients, CPRS stores which column the user sorted by and sorts by that column again when the Patient Selection/Notifications screen is next displayed. By default after the user changes patients or enters CPRS again, the column that is saved will sort in ascending alphabetical order (A-Z) except for the Date/Time column that will sort by most recent date/time to oldest.

Sorting Notification Columns Using the Mouse

To sort Notifications using the mouse, click the column heading you want to sort by. To reverse the sort order, click the same heading again. For example, a user could decide to sort by date and time. Normally, the most recent alerts are listed first. The user could click the column heading to reverse the order and have the oldest alerts displayed first. Clicking the column heading again would list the most recent alerts first.

Sorting Notifications Using the Keyboard

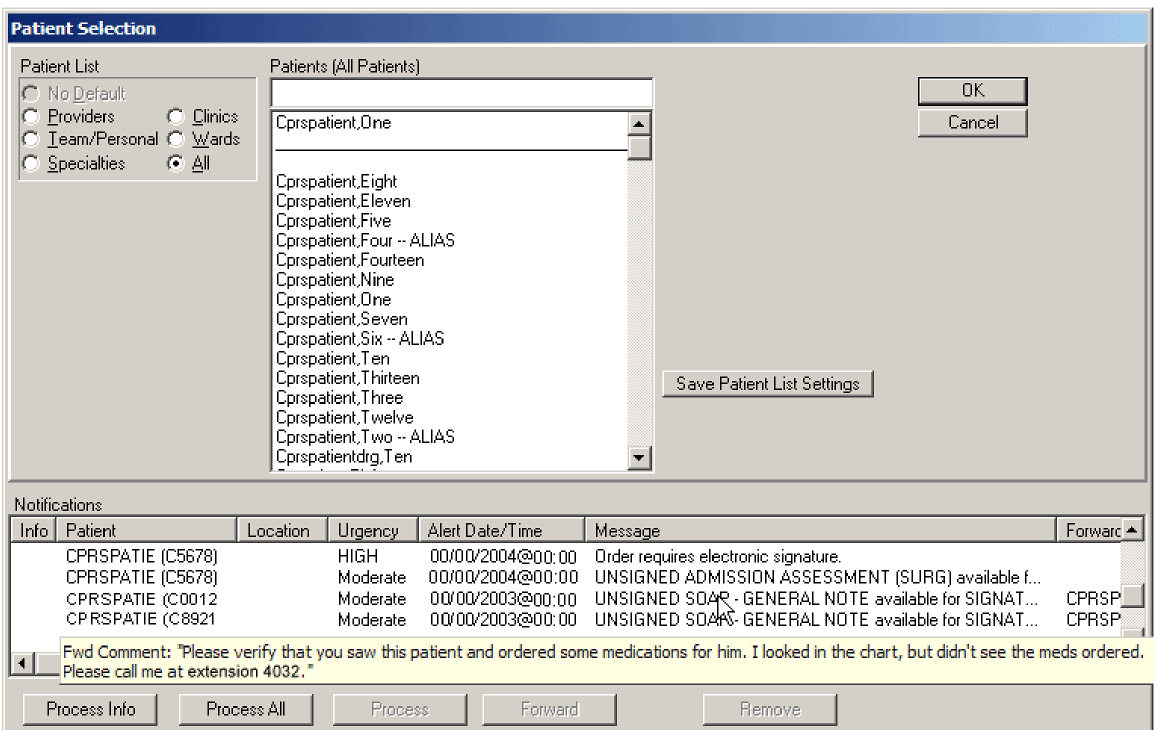
Users who do not use the mouse can sort Notifications in ascending order (alphabetical order or most recent Date/Time) using the keyboard only. When users sort using the Ctrl + <key> combination, CPRS will recognize either upper or lower case letters (this feature is not case-sensitive). Users can sort Notifications using the following Ctrl + <key> combinations:

Key Combinaton	**Column Sorted**
Ctrl + I	Info
Ctrl + P	Patient
Ctrl + L	Location
Ctrl + U	Urgency
Ctrl + R	Patient
Ctrl + M	Message
Ctrl + F	Forwarded By/When

Note: A limitation exists in the programming environment that does not allow the user to user the same key combination to then reverse the sort. Making this change would not be trivial and will not be addressed the CPRS GUI at this time.

Viewing Comments For Forwarded Alerts

Users may also want to view comments associated with forwarded alerts. To view a comment, simply place the cursor over the alert, leave it still for a few seconds, and the comment will display. Move the mouse and the comment will no longer be displayed.



This graphic shows that when you place the cursor over a forwarded alert the associated comment will display.

Processing, Removing, and Forwarding Notifications

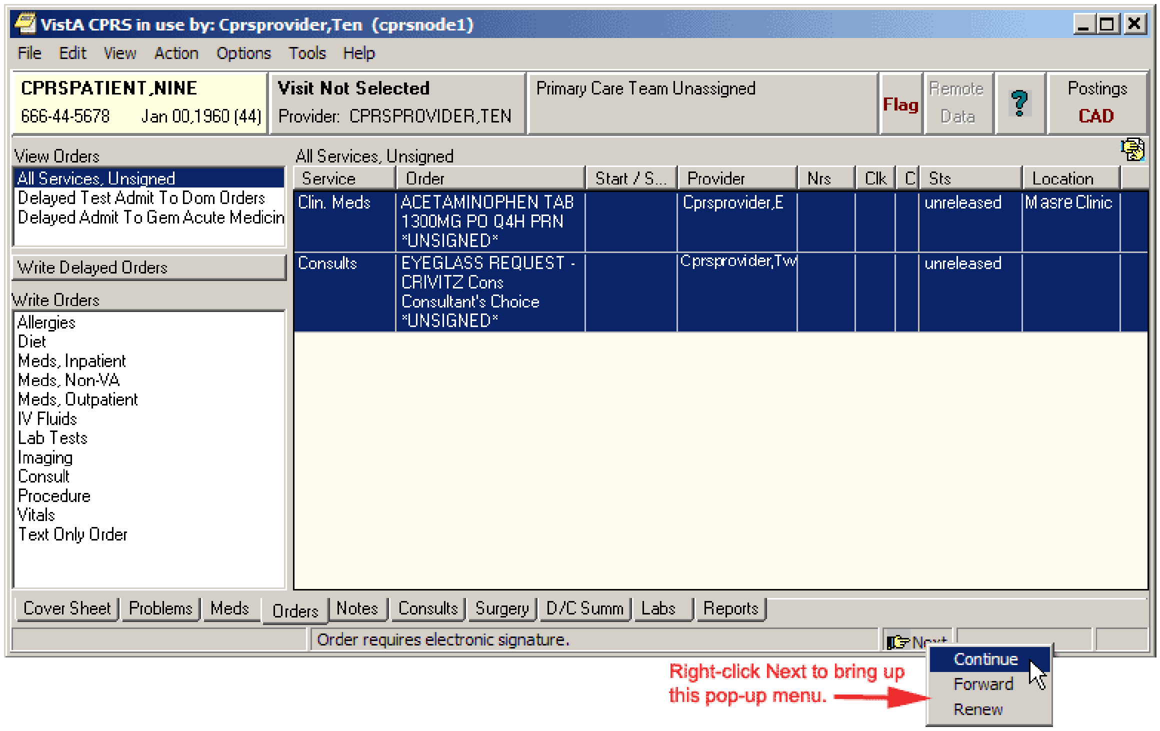
CPRS provides you with flexibility in processing, removing, and forwarding Notifications. First you select the alerts that you want to act on and then click the appropriate button. For processing notifications, you have three choices: Process Info, Process All, and Process, which will process those notifications that you have highlighted. When you are processing notifications, you can also renew a notification, which ensures that you will see the notification again the next time you log in, or forward the notification to one or more users.

To process notifications, use these steps:

1. Bring up the Patient Selection screen, either by launching CPRS or if you are already running CPRS, selecting File | Select New Patient.
2. Decide which notifications to process.
    - To process all information notifications (items preceded by an I.), click **Process Info**.
    - To process all notifications, click **Process All**.
    - To process specific notifications, highlight one or more notifications, and then click **Process**. You can also process a notification by double-clicking on it.

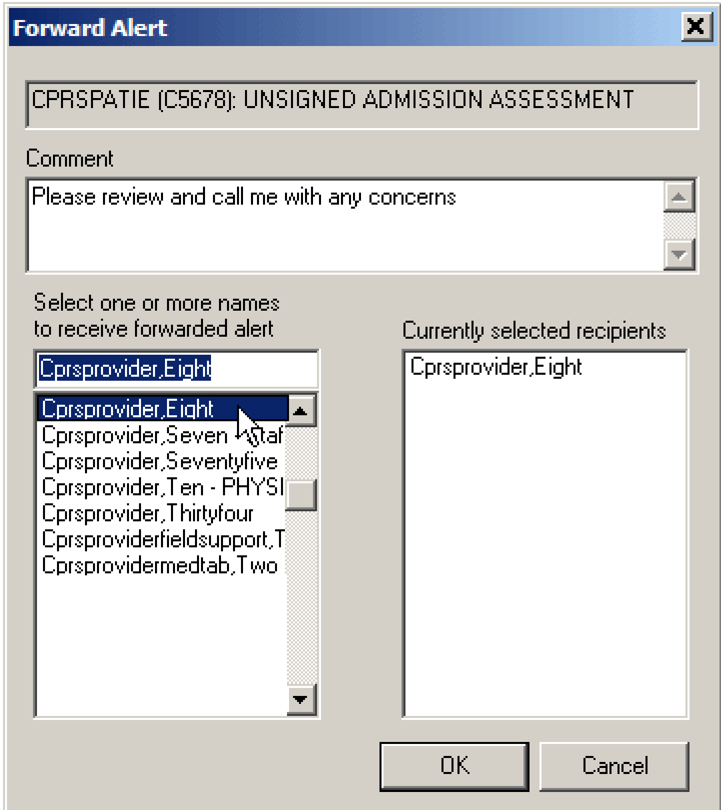
    Note: To select a number of notifications in a row, click the first item, hold down the Shift key, and click the last item. All items in the range will be selected. To select multiple items that are not in a row, click one, hold down the Control key, and click the other specific notifications.

3. Process the notification by completing the necessary task, such as signing an overdue order or viewing information notifications.
4. If you want to renew or forward this notification to someone else, right-click the Next button and select either Renew or Forward as shown in the graphic below. If you selected Forward, proceed to step 5. If you selected Renew, go to step 6.



This above graphic shows the pop-up menu items available by right-clicking the Next button.

5. Select the individuals that you want to receive this notification.



a.) In the field labeled Select or enter name, type the first few letters of the person's last name.

b.) Find the person's name in the list and click it to add it to the list of recipients.

c.) Repeat steps A and B until all those you want to forward this notification to are listed under Currently selected recipients.

d.) Type a comment if needed (comment length is limited to 180 characters including spaces).

e.) Click **OK**.

6. When finished with the current Notification, go to the next notification by clicking the Next button on the status bar.

7. Process the remaining notifications using steps 3-5.

8. When finished, you may select a new patient (File | Select New Patient…) or exit CPRS (File | Exit).

To remove notifications, use these steps:

1. Bring up the Patient Selection screen, either by launching CPRS or if you are already running CPRS, selecting File | Select New Patient.
2. Highlight the notifications that you want to remove.

   Note: To select a number of notifications in a row, click the first item, hold down the Shift key, and click the last item. All items in the range will be selected. To select multiple items that are not in a row, click one, hold down the Control key, and click the other specific notifications.

   Warning: Once you remove these notifications you cannot get them back. Be careful that you really want to remove or delete these notifications before you proceed.

3. Click Remove.

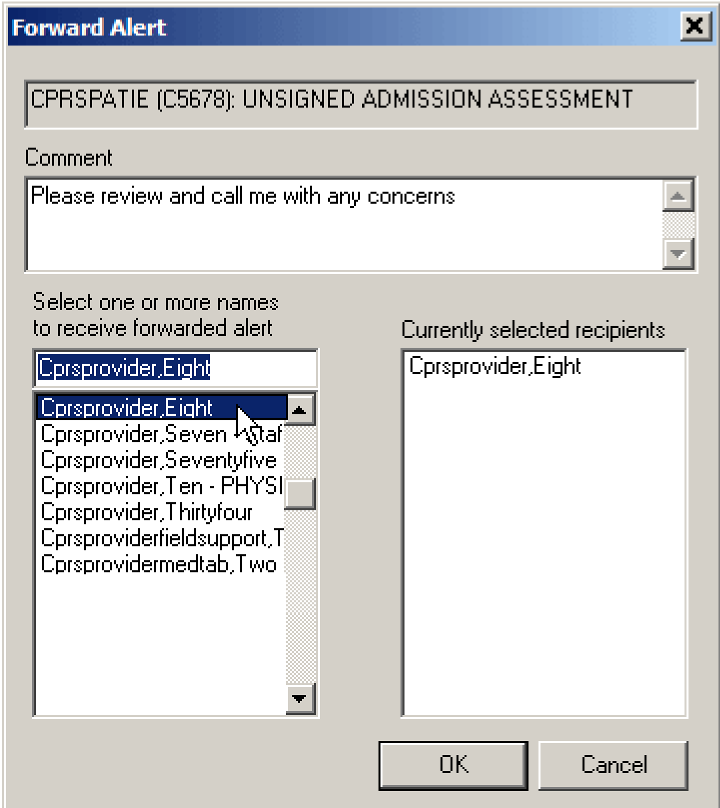
   Note: A new parameter ORB REMOVE enables sites to specify which notifications can be removed in this way. If the notification is not removed, you will have to process the notification.

To forward a notification to another user, use these steps:

1. Bring up the Patient Selection screen, either by launching CPRS or if you are already running CPRS, selecting File | Select New Patient.
2. Highlight the notifications that you want to forward and click Forward.

   Note: To select a number of notifications in a row, click the first item, hold down the Shift key, and click the last item. All items in the range will be selected. To select multiple items that are not in a row, click one, hold down the Control key, and click the other specific notifications.

3. When the dialog shown below displays for each notification, select the recipients' names for this notification.



a.) In the field labeled Select or enter name, type the first few letters of the person's last name.
b.) Find the person's name in the list and click it to add it to the list of recipients.
c.) Repeat steps A and B until all those you want to forward this notification to are listed under Currently selected recipients.
d.) Type a comment if needed (comment length is limited to 180 characters including spaces).
e.) Click **OK**.

4. Repeat the above steps as necessary for additional notifications you want to forward.

Refreshing a Patient Record

You can refresh a patient's information so that recent changes will be reflected. To refresh a patient's records, click **File | Refresh Patient Information**. This option will refresh the information of the currently selected patients in the same manner that changing patients looks for the latest information. Refreshing a patient's information will result in notes in progress being saved, and the review/sign changes screen will appear if changes are pending.

Keeping Diagnostic and Procedure Codes Current

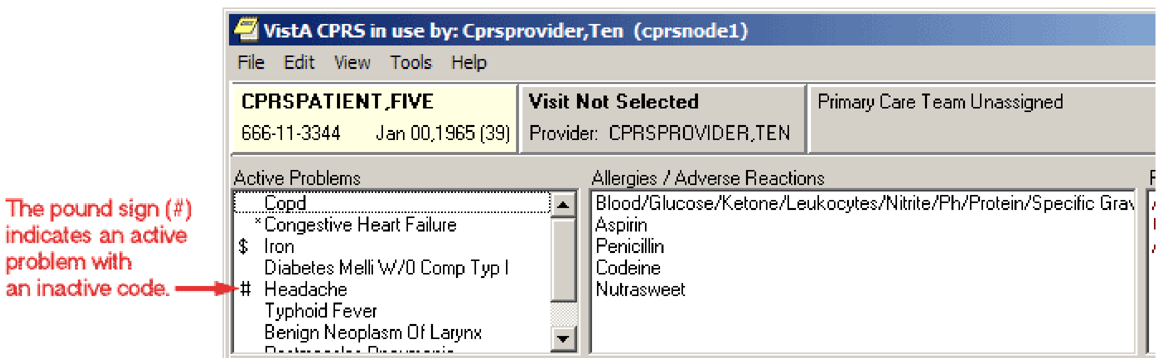
Code set versioning (CSV) modifies VistA to comply with the Health Insurance Portability and Accessibility Act (HIPAA) stipulations that diagnostic and procedure codes used for billing purposes must be the codes that were applicable at the time the service was provided. Because the codes change, CPRS currently checks ICD and CPT code validity as of a specified date when codes are entered, when a new code set is implemented, and whenever Clinical Application Coordinators (CACs) or IRM personnel choose to run the option.

CPRS GUI users will see indicators for inactive codes on the Cover Sheet, Problems tab, Encounter form, and in Clinical Reminders (although the Clinical Reminders changes may be less apparent).

In these GUI locations, any diagnosis or procedure codes that are inactive or will become inactive by a specified date because a new code set has been installed display with the "#" symbol in front of them as shown in the following examples.

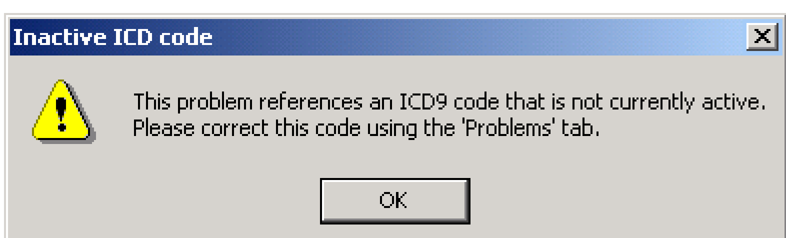
Cover Sheet Displays

On the Cover Sheet, the active problems display. Users can quickly see if the patient has any inactive codes for the active problems.



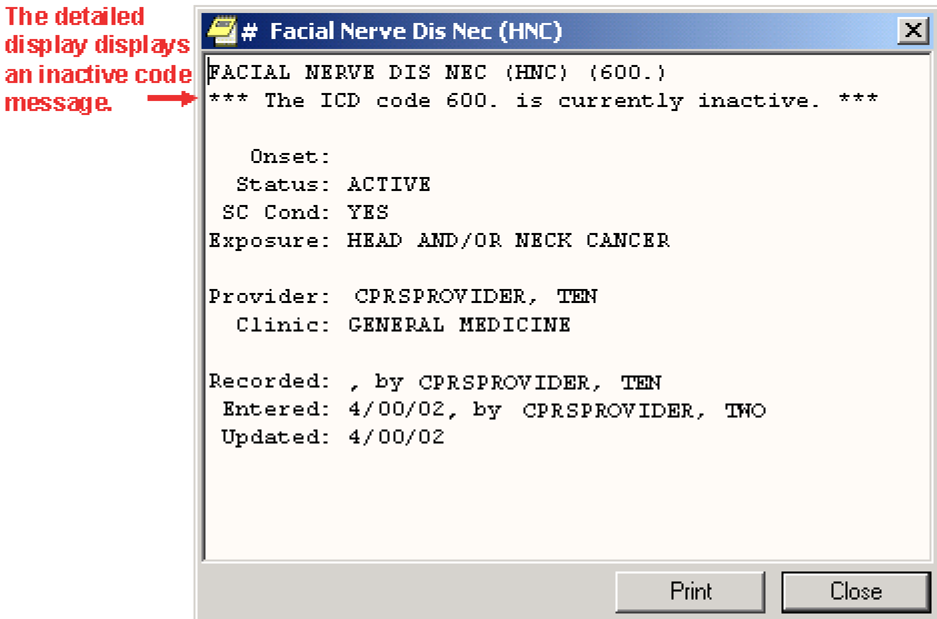
The '#' symbol shows the user that this active problem has an inactive code.

If the user tries to get a detailed display of the problem, the user first gets a warning about the inactive code.



This warning message informs the user that the current problem has an inactive code.

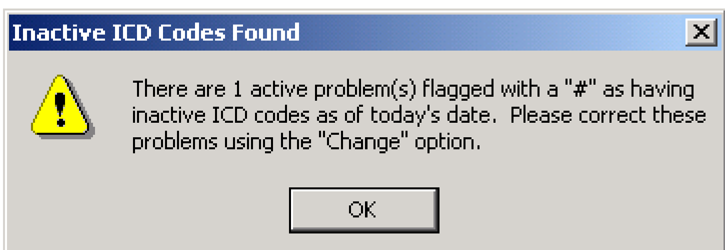
The warning message instructs the user to correct the inactive code from the Problems tab. When the user closes the warning dialog, the detailed display then comes up. The detailed display also shows that the code is inactive.



The detailed display of the problem clearly shows that the associated code is inactive.

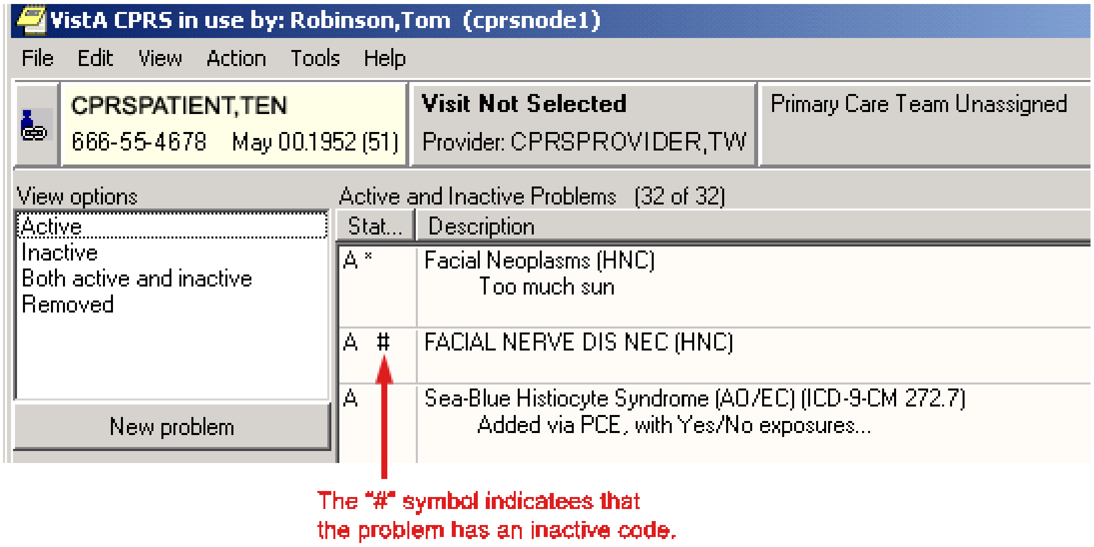
Problems Tab Display

On the Problems tab, users are alerted to inactive codes in two ways. The first time the user goes to the Problems tab if there are problems with inactive codes, a dialog, such as the example below displays.



This capture tells how many problems with inactive codes have been found.

Note: This dialog appears only the first time the user goes to the problems tab for that patient in a session. When the user closes the dialog, the Problems tab display. Problems with inactive codes have the “#” symbol in the status column.



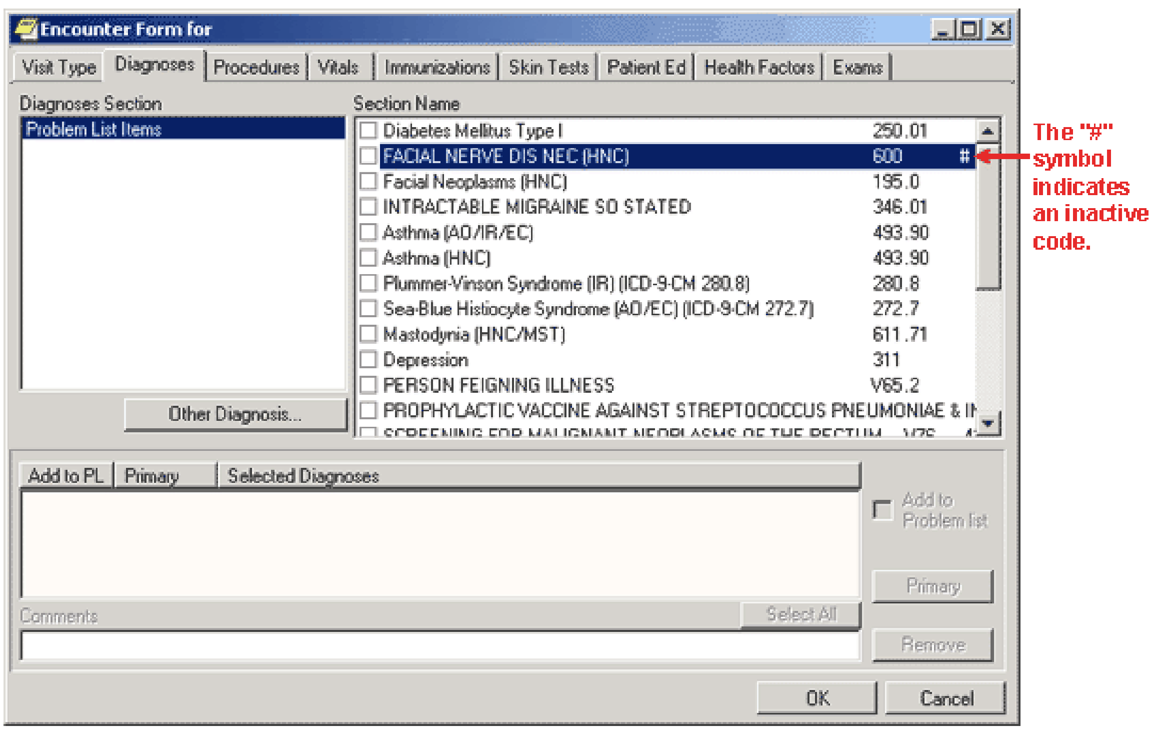
As on the Cover Sheet, the "#" symbol tells the users that the problem has an inactive code.

The detailed display of a problem also indicates that the current code is inactive.

Users should use the Change feature to associate the problem with an active code.

Encounter Form Display

The Diagnoses tab of the Encounter dialog displays a "#" next to the code if the code is inactive.



This screen shows the inactive code with the "#" or pound symbol.

If the user tries to select that diagnosis the following warning appears.

The warning in this dialog tells users about inactive codes that need to be updated through the Problems tab.

Consults Tab Display

For Consults and Procedures, only active codes will be allowed for the following functions:

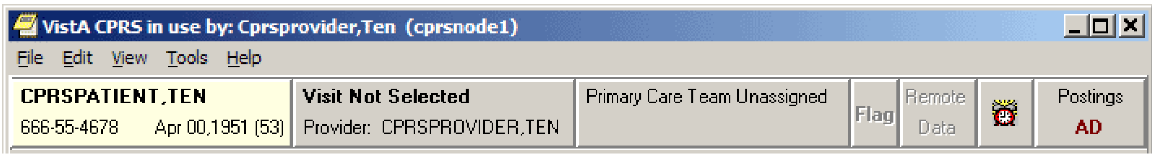
- Lexicon look up for provisional diagnosis as of the ordering date
- Copying or changing existing orders (the consult or procedure will not be accepted until a valid code is selected)
- Edit/Resubmit, the original code will be checked to see if it is active, if it is inactive an active code will need to be entered before CPRS will accept it

Clinical Reminders

CPRS GUI will only display codes that were active in the reminder date range.

Features Available from Any Tab

There are seven items located at the top of the CPRS window that are available from any tab. These items are: the CCOW icon, the Patient Inquiry button, the Encounter Provider and Location button, the Primary Care button, the Remote Data Views button, the Reminders button, and the Postings (CWAD) button. A detailed explanation of each of these buttons is included below.



Items available from any CPRS tab

Clinical Context Management (CCOW) Icon

Clinical Context Management (sometimes referred to as "CCOW") is a way for graphical user interface (GUI) applications to synchronize their clinical context based on the Health Level 7 CCOW standard. In simple terms, this means that if CCOW-compliant applications are sharing context and one of the applications changes to a different patient, the other applications will change to that patient as well.

The VA purchased Sentillion's Vergence context management software to work with VistA.

To use the CCOW standard, VistA set up must include these two components:

- a context vault, which is a server on the VA LAN that tracks context for each clinical workstation
- desktop components installed on each workstation that will use CCOW

To allow VistA GUI applications to use context management, the developers must make the necessary changes to HL7 messages for each application to allow synchronization. Current plans call for the following applications to be CCOW-compliant:

- CPRS *
- Health*e*Vet Desktop (Care Management) *
- Imaging *
- Clinical Procedures
- BCMA (Bar Code Medication Administration)
- Vitals
- FIM (Functional Independence Measure)
- Scheduling

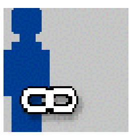
* These applications will be made CCOW compliant first.

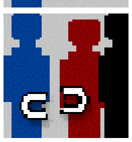
CPRS has been made CCOW-compliant and can now synchronize with other VistA CCOW-compliant applications. The first three applications that will be CCOW-compliant are CPRS, Care Management, and Imaging. Care Management provides one example of applications synchronization. If you were in Care Management, which is also CCOW-compliant, and clicked the CPRS Chart link, the CPRS GUI chart would be launched and would bring up the same patient that had focus in Care Management. You can also have two CPRS sessions synchronized. And, of course, you can bring up two different CPRS sessions and not synchronize them, thus allowing you to view two patients' charts at the same time.

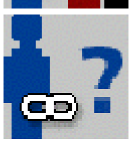
The CCOW icon shows whether the current application is linked with others on the desktop.

The above graphic shows the CCOW icon in outlined in red at the far left of the chart.

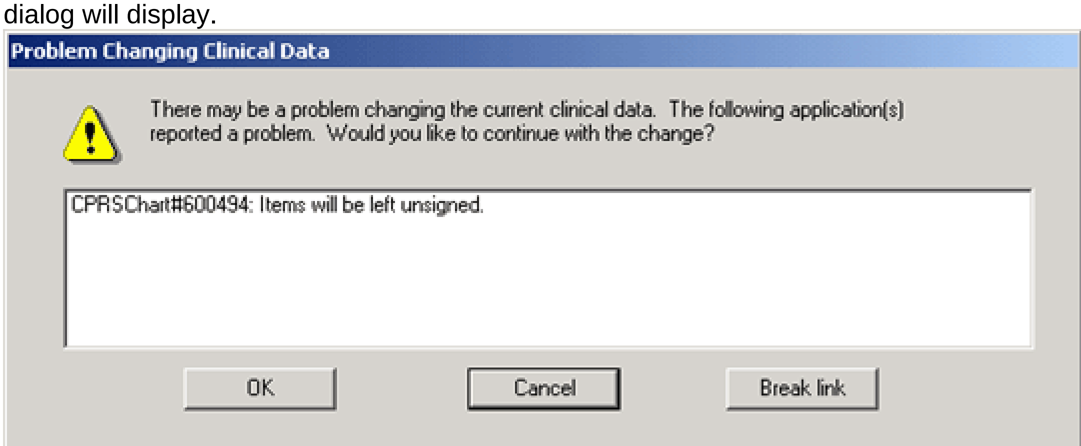
CPRS enables users to join or break context with other applications. The icon displays whether CPRS is joined in context or not. The following three icons will display based on the CCOW state:

 Linked

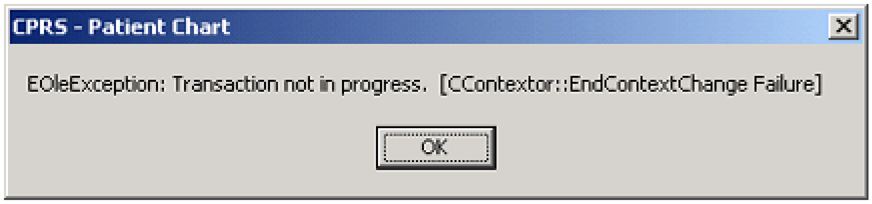
 Broken

 Changing

Note: There are a few cases when you cannot change context, such as when a print dialog is open or when you are trying to open an application from the Tools menu. If you try to change context with unsigned orders or notes, the following dialog will display.



This graphic shows what a warning message might look like.



If the application is busy doing something and cannot change context, CPRS will display a message such as the one above.

To join context, use the following steps:

1. Give focus to the application that you want to join context by either clicking on that application window or by holding down the Alt key and pressing tab until you highlight the appropriate application and then release the keys.
2. Choose **File | Rejoin patient link** .
3. If you want the other open applications to synchronize with the current patient in the application that has focus, choose **Set new context**. Or, if you want the current application to synchronize with the patient the other applications have open, choose **Use Existing Context**.

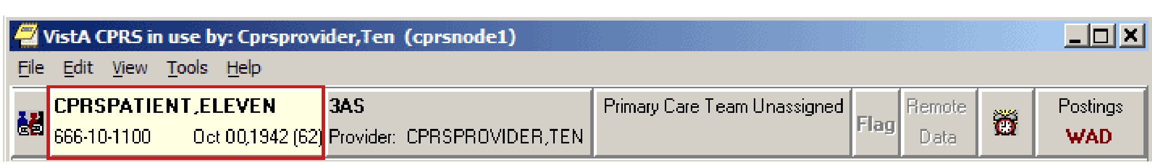
To break context between applications, follow these steps:

1. Give focus to the application that you want to remove from context by either clicking on that application window or by holding down the Alt key and pressing tab until you highlight the appropriate application and then release the keys.
2. Choose **File | Remove from link** .

Patient Inquiry Button

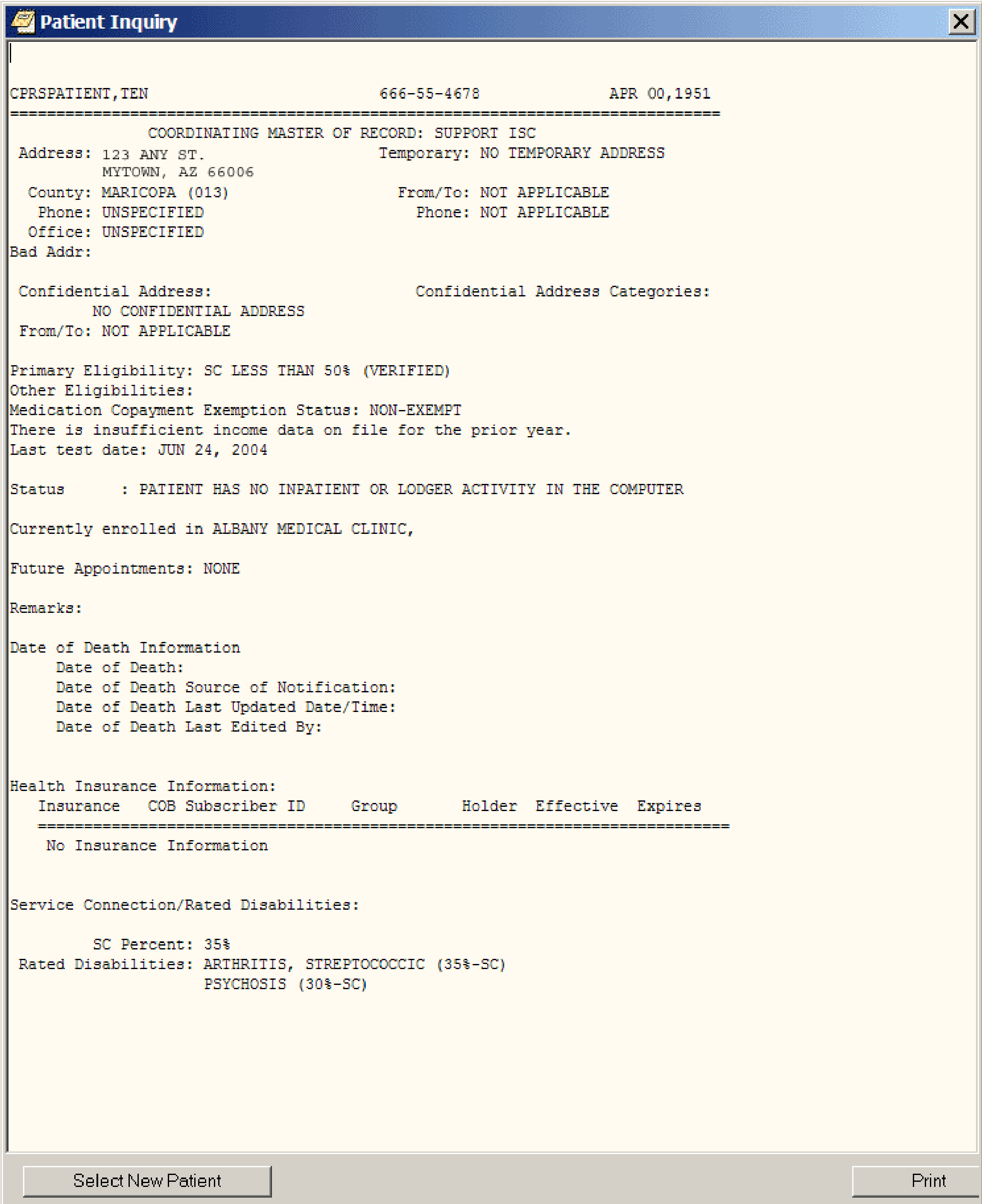
The Patient Inquiry button is located on the left side of the chart directly below the menu bar. The Patient Inquiry button displays the following information:

- Patient name
- Social Security number (or identification number if assigned by the site)
- Date of birth
- Age



The Patient Inquiry button

If you click the **Patient Inquiry** button, the Patient Inquiry dialog appears. The Patient Inquiry dialog includes additional information such as the patient's mailing address, telephone number(s), admission information, and other relevant data. While in the detailed display, you can select a new patient, print the detailed display, or close the detailed display.



```
Patient Inquiry

CPRSPATIENT,TEN                        666-55-4678            APR 00,1951
==========================================================================
               COORDINATING MASTER OF RECORD: SUPPORT ISC
 Address: 123 ANY ST.                  Temporary: NO TEMPORARY ADDRESS
          MYTOWN, AZ 66006
  County: MARICOPA (013)                 From/To: NOT APPLICABLE
   Phone: UNSPECIFIED                      Phone: NOT APPLICABLE
  Office: UNSPECIFIED
Bad Addr:

 Confidential Address:                     Confidential Address Categories:
        NO CONFIDENTIAL ADDRESS
 From/To: NOT APPLICABLE

Primary Eligibility: SC LESS THAN 50% (VERIFIED)
Other Eligibilities:
Medication Copayment Exemption Status: NON-EXEMPT
There is insufficient income data on file for the prior year.
Last test date: JUN 24, 2004

Status      : PATIENT HAS NO INPATIENT OR LODGER ACTIVITY IN THE COMPUTER

Currently enrolled in ALBANY MEDICAL CLINIC,

Future Appointments: NONE

Remarks:

Date of Death Information
     Date of Death:
     Date of Death Source of Notification:
     Date of Death Last Updated Date/Time:
     Date of Death Last Edited By:


Health Insurance Information:
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ========================================================================
    No Insurance Information


Service Connection/Rated Disabilities:

        SC Percent: 35%
 Rated Disabilities: ARTHRITIS, STREPTOCOCCIC (35%-SC)
                     PSYCHOSIS (30%-SC)

Select New Patient                                                    Print
```

The Patient Inquiry dialog

Encounter Information

CPRS has two kinds of encounter information: visit information and encounter form data. Encounter form data is explained later in this manual.

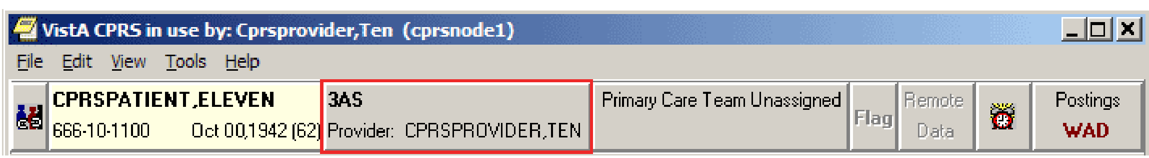
For each visit (or telephone call) with a patient, you must enter the provider, location, date, and time. CPRS requires this information before you can place orders, write notes, add to the problem list, and perform other activities.

To receive workload credit, you must enter the encounter form data, including the following information, for each encounter:

- Service connection
- Provider name
- Location
- Date
- Diagnosis
- Procedure

Visit / Encounter Information

CPRS shows the encounter provider and location for the visit on the Visit Encounter button. You can access this feature from any chart tab.



The Visit Encounter button

Entering Encounter Provider and Location

If an encounter provider or location has not been assigned, CPRS will prompt you for this information when you try to enter progress notes, create orders, and perform other tasks.

To enter or change the Encounter provider, follow these steps:

1. If you are already in the Provider & Location for Current Activities dialog skip to step 2. Otherwise, from any chart tab, click the **Provider / Encounter** box located in the top center portion of the dialog.
2. In the Encounter Provider list box, locate and select the provider for this encounter.

   Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

   - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
     - When no division is listed for a provider, no division is displayed.
     - If only one division is listed, this division is displayed.

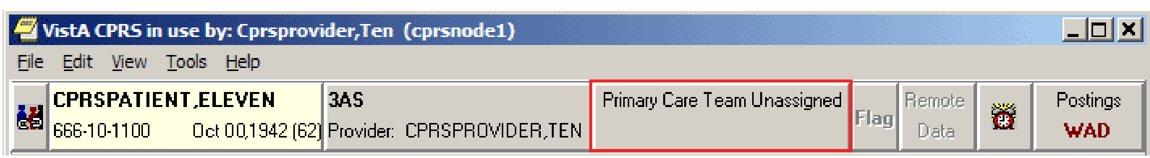
- If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
- If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.

- Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

3. Click the tab that corresponds to the appropriate encounter category (Clinic Appointments, Hospital Admissions or New Visit.) Select a location for the visit from the choices in the list box.
4. If you selected a clinic appointment or hospital admission, skip to step 7. If you are creating a New Visit, enter the date and time of the visit (the default is NOW).
5. Click a visit category from the available options (such as, Historical) and click **OK**.
6. When you have selected the correct encounter provider and location, click **OK**.
7. For more information and instructions on entering more encounter form data, refer to the Notes section of this manual.

Primary Care Information

To the immediate right of the Visit Encounter button is the Primary Care button, which displays the primary care team and attending physician assigned to this patient. The message “Primary Care Team Unassigned” is displayed if a primary care team has not been assigned.



The Primary Care button

For more information on the attending physician or the primary care team, click the **Primary Care** button.

Patient Record Flags

Patient Record Flags (PRF) are advisories that authorized users place on a patient's chart to improve employee safety and the efficient delivery of health care. Each advisory or flag includes a narrative that describes the reason for the flag and may include some suggested actions for users to take when they encounter the patient. In addition, authorized users must write a Progress Note for each flag that clinically justifies placing the flag on a patient's record.

Authorized users will enter, edit, maintain, activate, and inactivate flags in the Patient Record Flag software using the List Manager interface. If a patient's record has been flagged, a list of flags displays during patient look up. In addition, in the CPRS GUI, flags are available at any time from the Flag button.

To ensure that users notice them, a new Patient Record Flags pop-up box has now been added. After a user selects a patient, a pop-up box will appear containing all flags for the patient. Users can review the flags of their choice or close the box. The flags will still be available from other places within CPRS. Sites can help by using Patient Record Flags judiciously. Overusing these flags could make them cumbersome to users who might therefore choose to ignore them. Ignoring flags could put employees, other patients, and the health care environment at risk.

To avoid this situation, before placing a flag on a patient's record, sites must have in place a system for deciding when a flag is appropriate and when it will be reviewed. Sites should also have policies about how to handle questions about flags. To give sites some direction about implementing Patient Record Flags, VHA Directive 2003-048, dated August 28, 2003, titled: *National Patient Record Flags* has been issued.

National and Local Flags

Patient Record Flags are divided into types: the most critical flags—called Category I Patient Record Flags—are national and transmitted to all facilities, ensuring that these flags are universally available during patient look up. Category II Patient Record Flags are local.

Each Category I flag is owned by a single facility. The facility that placed the Category I flag on the patient's record would normally own the flag and maintain it. However, if a patient received the majority of their care at another VA facility, the second site could request that ownership of the flag be transferred to them. The site that owns the flag is solely responsible for reviewing, editing, activating, or inactivating the flag.

The Office of Information creates and distributes definitions for Category I PRF through national patches.

Currently, the only Category I Patient Record Flag is a Behavioral flag regarding violent or potentially violent patients. The Office of Information created this flag to help VHA properly protect its employees and maintain a safe environment for health care.

As mentioned, Category II flags are local. Each site will create and maintain its own set of local flags that are not transmitted to other sites. However, the purpose of Category II flags is similar to Category I—to provide important patient information that may affect the safety of staff or other patients or patient treatment. For example, a site could create a Category II Research Flag or a Category II Infectious Disease Flag.

In the forthcoming directive, VHA advises sites to create and use Patient Record Flags sparingly so that the users notice flags and pay careful attention to them. Creating a large number of flags for many different reasons might lessen the importance of flags and may cause staff to miss important information. Like Category I flags, Category II flags require a Progress Note to document the reason for placing a flag on the patient's record.

A list of all flags assigned to a patient's chart displays during patient look up. Users can then choose to review one or all of the flag narratives. The flag narrative gives the purpose of the flag. It may also contain examples of past behavior and instructions for users to follow when encountering the patient. For example, the narrative for a particular Behavioral flag might state that a patient has been known to carry weapons and has verbally threatened VHA staff in the past. It may also recommend that users call the VA police if this patient comes in for care. However, the purpose of Patient Record Flags is not to stigmatize or discriminate. Rather, their purpose is to protect the safety of VHA staff and patients and to ensure the efficient delivery of health care to this and other VHA patients.

Creating and Assigning PRF

Authorized users create, assign, activate, edit, and inactivate flags from the Patient Record Flag software through the List Manager interface. (Additional documentation for PRF creation, entry, and maintenance is available in the *Patient Record Flags User Guide*.) To make flags widely available to VHA employees who interact with patients, Patient Record Flags are tied to the patient look up. Whenever a user looks up a patient, the software checks to see if the patient's record has been flagged, and if a flag exists, the software displays the list of flag names.

Documenting PRF

Each Patient Record Flag must have an associated Progress Note that clinically justifies putting the flag on a patient's record. It might also contain references to supporting documentation.

Currently, there is only one Category I flag. The Progress Note title for documenting this flag is Patient Record Flag Category I. To write a note for this title, the user must belong to the DGPF PATIENT RECORD FLAG MGR user class. Each site will be responsible for populating this user class.

To help sites that will be creating local Category II flags, four partially customizable Progress Note titles have been created:

- Patient Record Flag Category II – Risk, Fall
- Patient Record Flag Category II – Risk, Wandering
- Patient Record Flag Category II – Research Study
- Patient Record Flag Category II – Infectious Disease

Clinical Application Coordinators (CACs) can customize the titles by changing the text after the dash using TIU utilities. For example, the first title could be changed from "Patient Record Flag Category II – Risk, Fall" to "Patient Record Flag Category II – Behavioral, Drug Seeking" or other titles sites create. Because Category II Patient Record Flag are local, each site must determine if the site will create a user class and business rules to govern what users can write these notes.

Viewing PRF in CPRS GUI

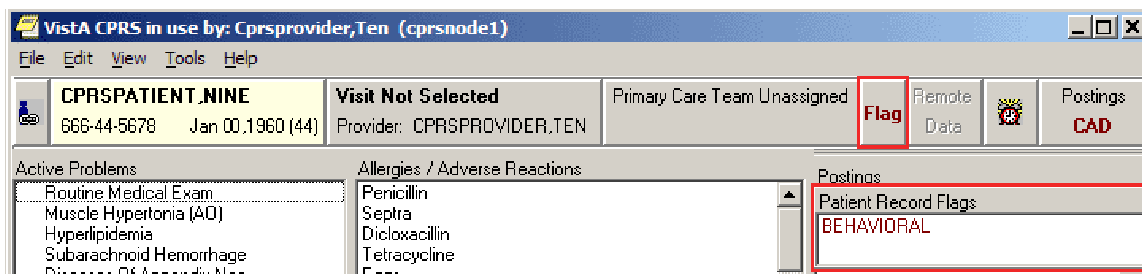
Patient Record Flags are displayed in the applications that use the patient look up, including the CPRS GUI. In the CPRS GUI, there are three places where users can see if a patient has PRF:

- The Patient Record Flag pop-up box
- The CPRS Cover Sheet
- The Flag button (available from any tab)

When the user selects a patient name from the Patient Selection Screen, CPRS begins to load the record, displays any relevant messages ("means test require", deceased patient, sensitive record, etc.), and then, if the record is flagged, displays a pop-up box with the flag titles for the selected patient to ensure that the user sees the flags. The pop-up box is shown below.

When the user is already in a patient record and wants to view Patient Record Flags, the user can use either the listing on the Cover Sheet or the Flag button. On the CPRS Cover Sheet, a new box called Patient Record Flags has been added above the Postings area. Flags for the selected patient are listed in the box.

The Flag button is visible from all CPRS tabs. If a patient's record has been flagged, the Flag button with its red text displays next to the Remote Data button. If the patient's record does not have any flags, the text on the button is grayed out instead of red. The Cover Sheet and Flag button are shown in the graphic below.



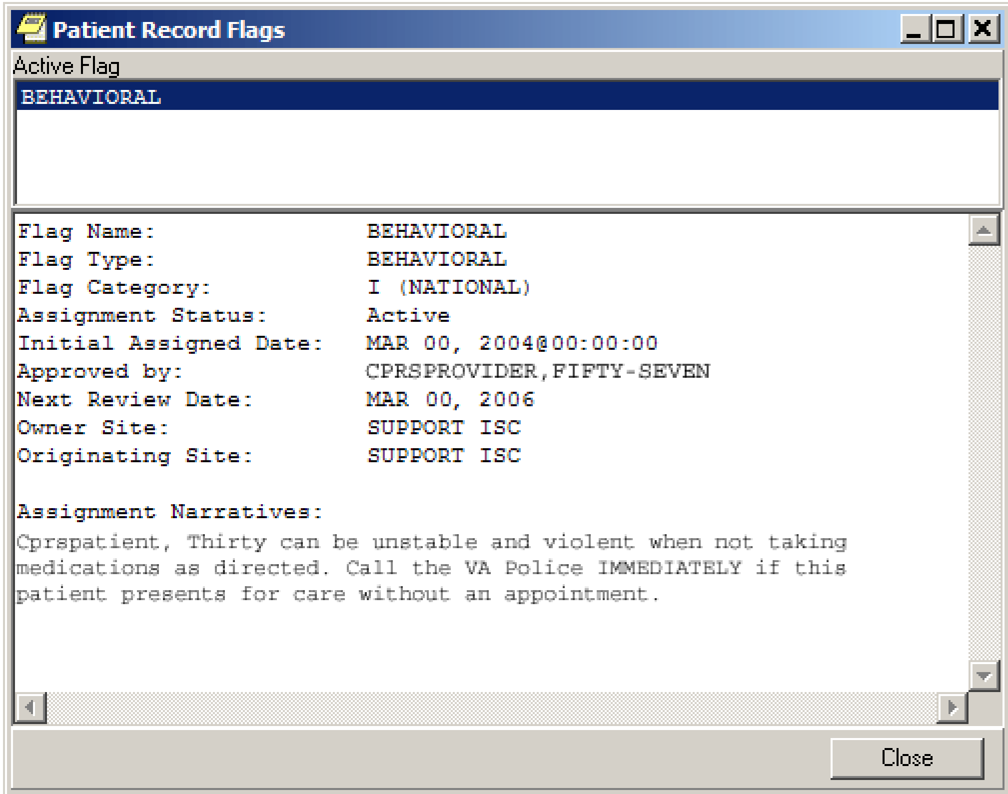
This screen capture shows the red text on the Flag button indicating this patient record has PRF and shows the flag list on the CPRS Cover Sheet.

To view a Patient Record Flag when entering a record, use the following steps:

1. Select a patient from the Patient Selection screen by either double-clicking on a patient name or highlighting the name and pressing the <Enter> key.

   Note: When the record loads, CPRS checks to see if the record is sensitive and displays a warning to the user that the user must acknowledge to proceed. Then, if the record has one or more flags, CPRS displays a pop-up box with the patient's record flags title. The first flag is highlighted and the narrative details displayed below. If CPRS displays the pop-up box, the user must close this box before CPRS will load the patient chart.

2. Then, select the Flag title to view the narrative by clicking the flag name or highlighting the flag name.



This graphic shows the Patient Record Flag pop-up box listing the patient's flag and the narrative details for the highlighted flag. Using the Flag button or clicking on a flag title on the Cover Sheet also displays this pop-up box.

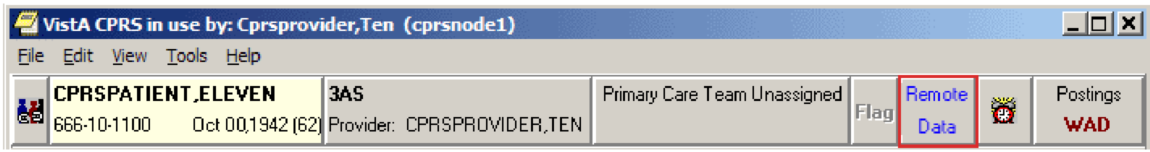
3. When finished viewing the narrative, close the narrative box by choosing **Close**.

To view a Patient Record Flag when already viewing a record, use the following steps:

1. Go the Cover Sheet by clicking the Cover Sheet tab or pressing **Ctrl** + **S** or use the Flag button by clicking Flag or pressing tab until you highlight the **Flag** button and press **<Enter>.**
2. Select the flag title to see the narrative details by clicking the title or using the Up and Down arrows to highlight the name and pressing **<Enter>**.
3. When finished, close the box by clicking **Close** or tabbing to Close and pressing **<Enter>**.

Remote Data

You can view remote patient data with CPRS if Master Patient Index/Patient Demographics (MPI/PD) and several other patches have been installed at your site. If these patches have been installed and the proper parameters have been set, you can access remote data generated at other VA and Department of Defense (DOD) facilities.

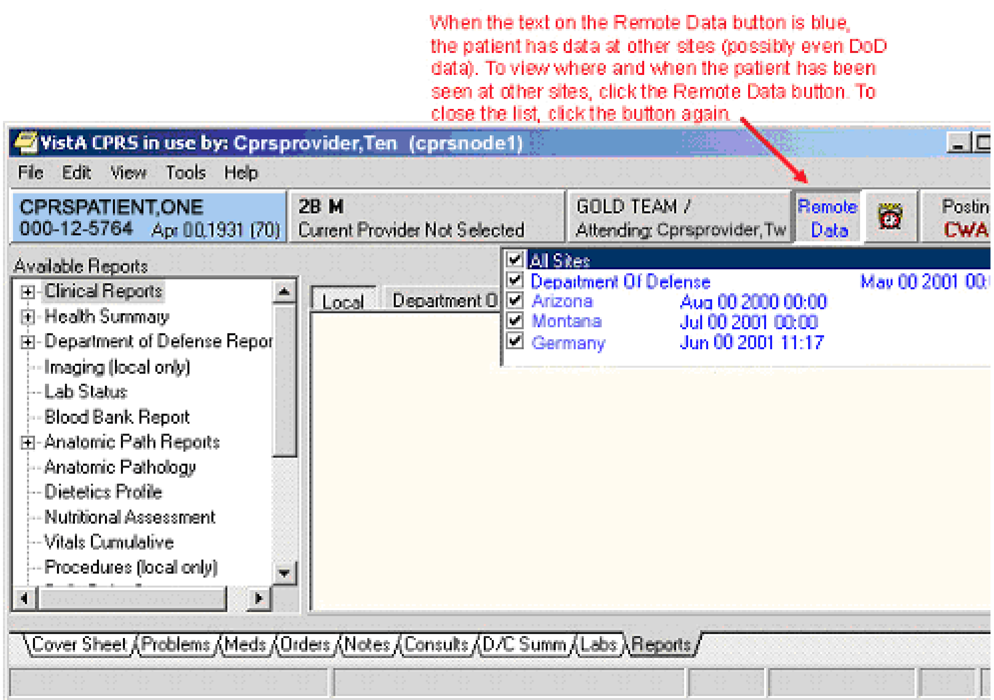


The Remote Data button

How Do I Know a Patient Has Remote Medical Data?

As part of opening a patient record, CPRS checks in the Treating Facility file to see if the selected patient has been seen in other facilities. If the patient has remote data, the words on the Remote Data button turn blue as shown in the image below. If there is no remote data for the selected patient, the letters are gray.

The graphic on the following page shows the Remote Data button with the blue text indicating that there is remote data, and it shows the list of sites that tells the user where and when the patient has been seen.



If the Remote Data button is blue, other facilities have data for the current patient.

What Does the List of Sites Represent?

If you click the **Remote Data** button, a drop-down list appears with the name(s) of sites where the patient has been seen. This list is based on either:

1. Sites that have been specifically designated for your facility to access. These sites are assigned in a parameter that your Clinical Applications Coordinator (CAC) can set up.
1. All sites where the patient has been seen and Department of Defense remote data if it is available.

What Kind of Data Can I View?

Currently with CPRS, you can view some lab data and all reports listed on the Reports tab unless they are labeled “local only”. For example, you can view any lab result that does not require input other than a date range. You can also view health summary components that have the same name on both the local and the remote site. Therefore, you can exchange national Health Summaries, but locally defined components may not be available unless the other site also has a component with the same name.

If it is available, CPRS can also show some Department of Defense remote data.

How Will the Remote Data Be Viewed?

Viewing remote data is a two-step process. First, you select which remote sites you want to see data from, and then you select the specific information you want to view, such as Clinical Reports or Health Summary components.

On the Reports tab, each site you select will have a separate tab for its data. Using the above graphic as an example, you would see five tabs on the Reports tab: Local, Dept. of Defense, Arizona, Montana, and Germany.

You would then select the reports you want to view and a date range (if necessary). After this, CPRS will attempt to retrieve those reports if they are available on the remote sites. You would then click each Treatment Facility’s tab to see the report from that site. While CPRS is attempting to retrieve the data, the message “Transmission in Progress:” is displayed until the data is retrieved.

Viewing Remote Data

To view a patient's remote data, use these steps:

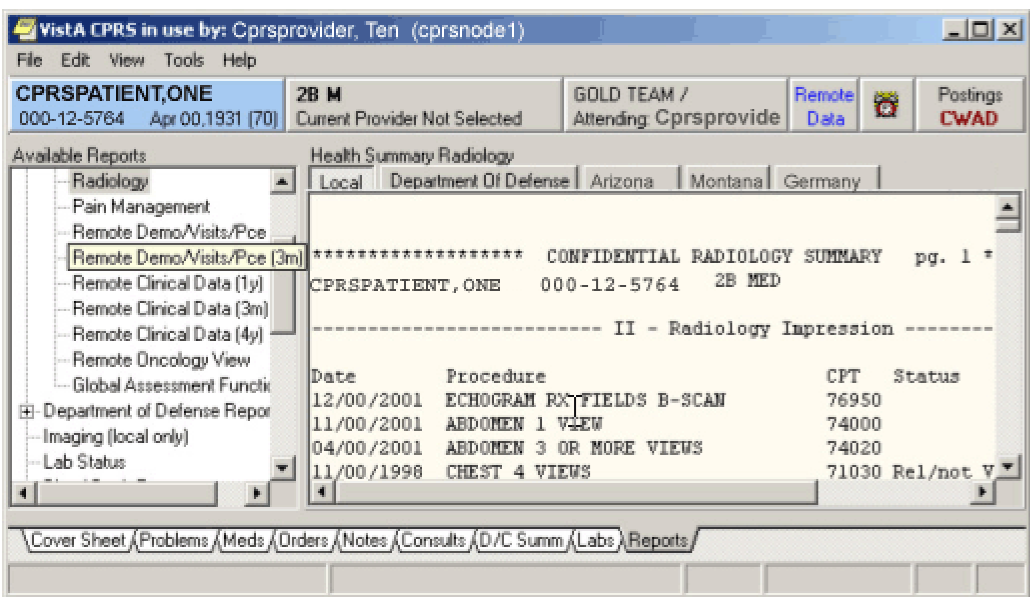
1. After opening the patient's record, see if the text on the Remote Data button is blue. If the text is blue, the patient has remote data.
2. Click the tab you want remote data from (e.g. Labs or Reports).
3. Click the **Remote Data** button to display a list of sites that have remote data for the patient.
4. Select the sites you want to view remote data from by clicking the check box in front of the site name or click All and click the **Remote Data** button again to close the list.
5. Select the report or lab you would like to view from the Available Reports or Lab Results section on the left side of the screen (click the "+" sign in order to expand a report heading)

   Note: With the exception of the DoD Consults report, choosing a Department of Defense (DoD) report does not limit you to DoD data. For example, if you choose Microbiology under Dept. of Defense, you will get DoD data and remote VAMC data. You do not have to run a separate report to get VA data.

It may take a few minutes to retrieve the data. While CPRS retrieves the data, the message "Transmission in Progress" is displayed.

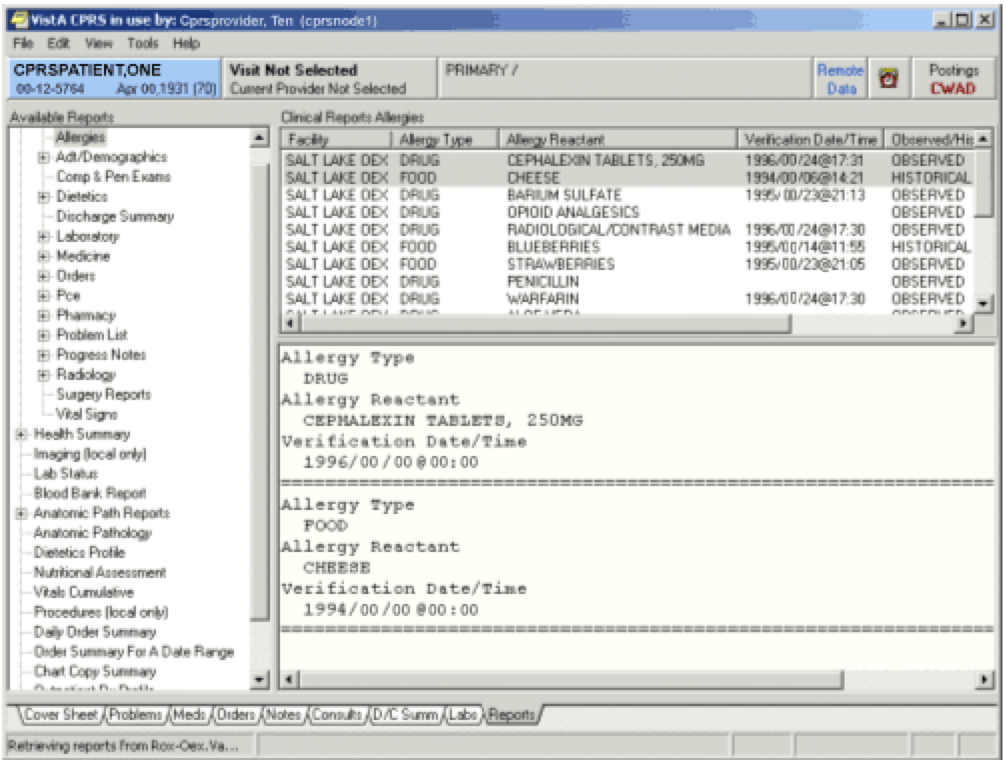
Depending on how the report or lab is configured, CPRS will return the remote data in one of two ways.

- **Text Format with Site Tabs**
  If the remote data is in text format, the data from each remote site will be displayed under a separate site tab. To view data from a particular site, click the appropriate tab.



Site tabs organize remote data from different sites.

- **Table format**
  If the report or lab is available in table format, CPRS will return data from all of the sites in a single table. The "facility" column indicates where the data in a particular row was collected. The table can be sorted by facility or by any other column heading (alphabetically, numerically, or by date) by clicking the appropriate heading. Clicking the heading again will sort the table in inverse order.



Remote data is displayed in a table format.

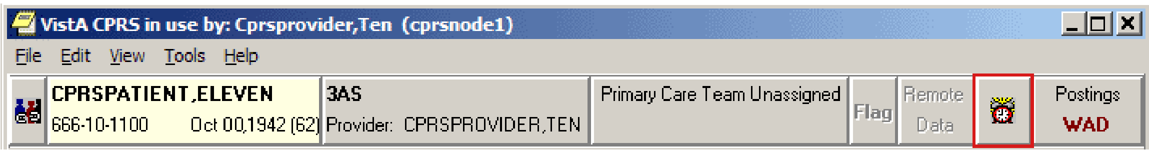
To see detailed information about a particular item in the table, click that item. If detailed information is available, it will be displayed in the bottom-half of the screen. To select multiple rows, press and hold the Shift or Control key.

The Reminders Button

The CPRS GUI includes functionality from Clinical Reminders. Reminders are used to aid physicians in performing tasks to fulfill Clinical Practice Guidelines and periodic procedures or education as needed for veteran patients.

Note: For more detailed information on Reminders, refer to the *Clinical Reminders Manager Manual* and the *Clinical Reminders Clinician Guide.*

The Reminders button highlighted in red below shows you at a glance whether the patient has reminders that are due.



The Reminders button

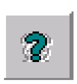
By observing the color and design of the icon on the Reminders button, the user receives immediate feedback on the most important types of Reminders available for the selected patient. Clinical Coordinators can set Reminders to be evaluated when you open the chart or they can set it to evaluate the Reminders only after you click the **Reminders** button or the **Reminders** drawer.

The following icons could be visible on the Reminders button:

 Due: The patient meets all the conditions for the reminder and the appropriate amount of time has elapsed.

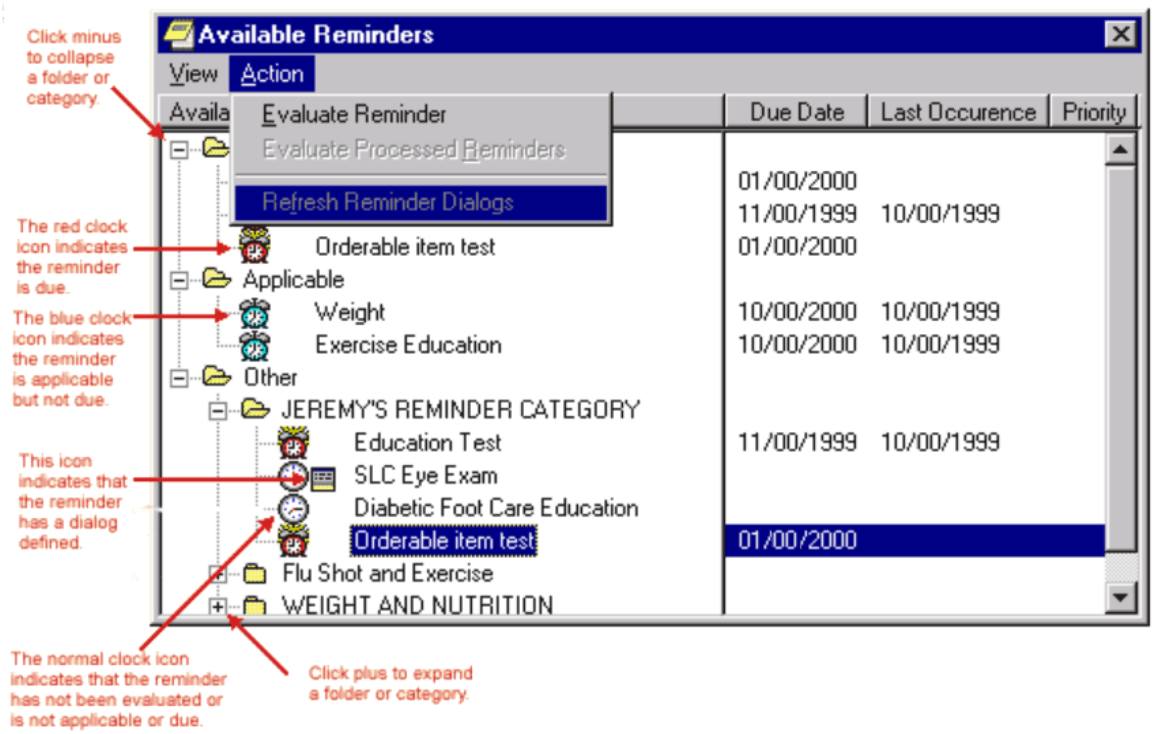
 Applicable: The patient meets all the conditions for the reminder, but the appropriate time has not elapsed. For example, a flu shot is given once a year, but it has not been a year yet.

 Other: Reminders have been defined, but were not specifically evaluated for the selected patient. An important education topic might be placed in Other.

 Question Mark: A question mark on the Reminders button indicates that the reminders have not yet been evaluated. This appears when the patient's chart is first opened to a tab other than the Cover Sheet. Click the **Reminders** button or the **Reminders** drawer on the Notes tab to evaluate the reminders.

 Grayed-out Alarm Clock: This icon indicates that there are no due nor applicable reminders, nor are there any reminder categories available.

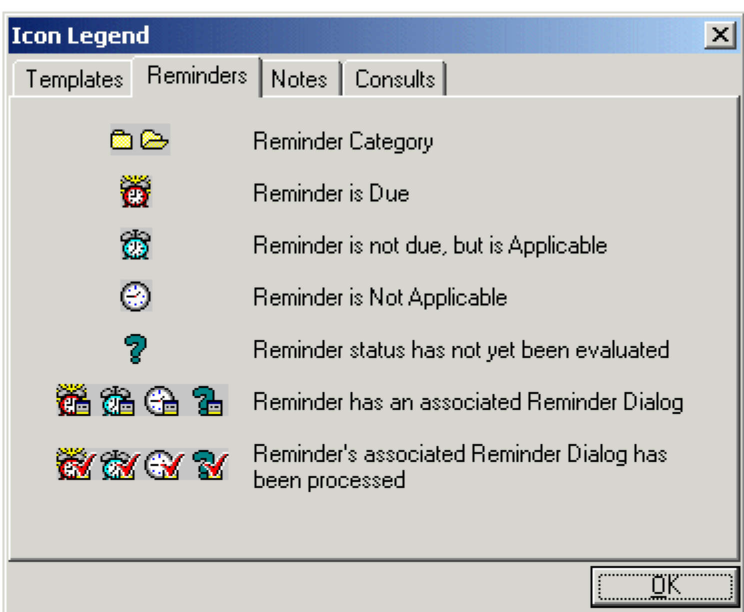
If you click the button, you will see a tree view of the patient's reminders such as the one shown below. The icons that appear on the Reminders button are also used in the tree view to identify the various types of reminders.



The Available Reminders tree view

Additional information on Reminders is located in the Cover Sheet section of this manual.

The Reminders tab on the Icon Legends dialog includes a description of the different icons that appear on the Reminders tree view. To access the Icon Legend, click **View** | **Reminder Icon Legend** | and the **Reminders** tab.



The Icon Legend

Postings (CWAD)

Postings Postings contain critical patient-related information about which hospital staffs need to be aware. The **Postings** button is visible on all tabs of the CPRS GUI window and is always located in the upper right corner of the window

If a patient record contains postings, the **Postings** button displays one or more of the following letters: **C**, **W**, **A, D**. These letters correspond to the four types of postings described below.

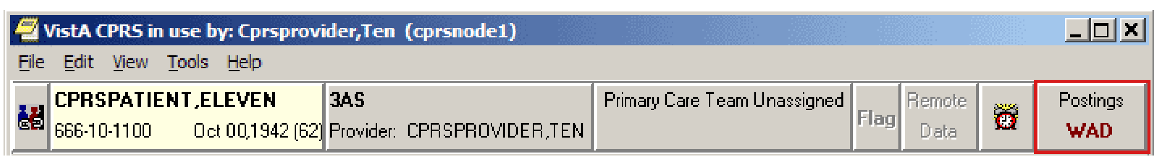
- **C (Crisis Notes)** – Cautionary information about critical behavior or patient health.
  Example: Suicidal attempts or threats.

- **W (Warnings)** – Notifications that inform medical center staff about possible risks associated with patients.
  Example: Patient can be violent.

- **A (Adverse Reactions/Allergies)** – Posting that displays information about medications, foods, and other items to which patients are allergic or to which they may have an adverse reaction. CPRS creates these postings automatically when users enter allergies.

- **D (Directives)** – Also called advanced directives, directives are recorded agreements that a patient and/or family have made with the clinical staff.

  Example: DNR (Do Not Resuscitate) directive on file.



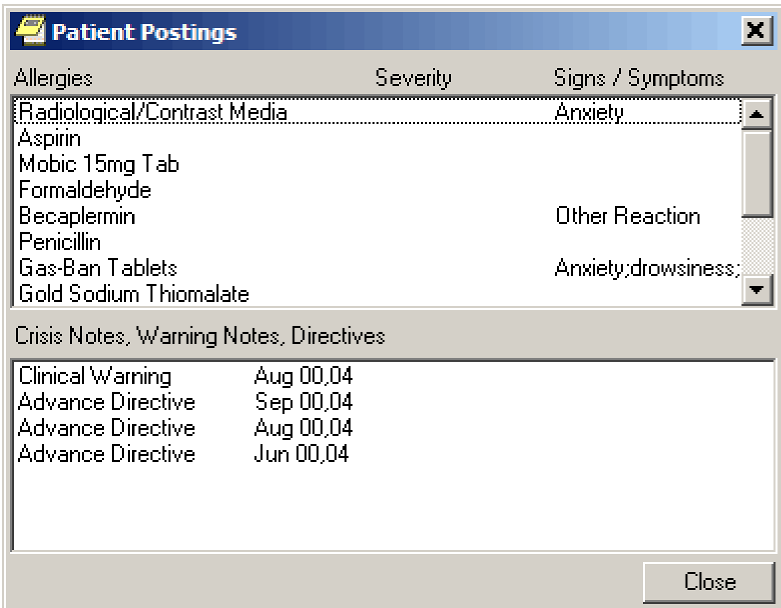
The **Postings** button

Viewing a Posting

CPRS offers two ways to View a posting. You can view a posting by clicking the Postings button from any chart tab, or you can select a specific posting from the **Cover Sheet** tab.

To view a posting by using the Postings button, follow these steps:

1. Click the **Postings** button or select **View** | **Postings** from the **Cover Sheet** tab. The **Patient Postings** dialog appears. The **Patient Postings** dialog contains all postings for the selected patient. The postings are divided into two categories. Allergies are listed in the top half of the dialog and crisis notes, warning notes, and directives are listed in the bottom half.



The **Patient Postings** dialog

2. Click a posting to see a detailed explanation.

   CPRS displays a new window that contains the full text of the posting.
3. When you are finished reading the posting, click **Close**.

To view a specific posting from the Cover Sheet, follow these steps:

1. Select a posting from the Postings or Allergies / Adverse Reactions area of the Cover Sheet.
2. CPRS displays a new window that contains the full text of the posting.
3. When you are finished reading the posting, click **Close**.

Electronic and Digital Signatures

CPRS now has two types of signatures: electronic and digital. Electronic signatures, which have been available for some time, require an electronic signature code that can be created at your site. Digital signatures are new to CPRS and are only in use in a pilot program.

Electronic Signatures

Most orders or documents, such as progress notes, reports, or health summaries, require an electronic signature. Generally, orders that require a signature are not released to services or activated until they are signed.

Note: There are two exceptions to this rule: 1) orders that can be designated as "signed on chart" and 2) generic orders that do not require a signature.

To electronically sign an order or a document, you must have an electronic signature code. If you do not have a signature code, your Clinical Coordinator can create one for you. You must keep your signature code secret and use it properly to help keep an accurate medical record.

Digital Signatures

Digital signatures are part of a Veterans Administration (VA)/Drug Enforcement Agency (DEA) Public Key Infrastructure (PKI) Pilot project to introduce electronic signature for outpatient medication orders of Schedule 2 and Schedule 2n controlled substances. DEA policy is that these controlled substances cannot be signed for electronically and require a "wet" signature or hand-written prescription that goes to the pharmacy. This pilot project uses smart cards, card readers attached to workstations, and digital certificates, and other technologies to electronically (digitally) sign outpatient orders for Schedule 2 and Schedule 2n controlled substances.

NOTE: Internet Explorer 5.5 or later with 128-bit encryption is required for PKI functionality.

What's on the Smart Card?

In the VA/DEA PKI Pilot, the clinician uses a smart card to digitally sign outpatient medication orders for Schedule 2 and Schedule 2n controlled substances after using the current electronic signature process within CPRS. The technologies used in PKI add security for these substances. Smart cards have the clinician's photo and an integrated circuit (a computer chip) that stores other information such as demographics, access and verify codes, a personal identification number (PIN), and a digital certificate.

The VA Issuing Station is responsible for creating the smart cards and sending each approved clinician a smart card with the appropriate information. Then, the VA Issuing Station separately sends each card user a personal identification number (PIN) that will enable access to the smart card's information during the signature process and for PIN verification or change. A digital certificate will also be placed on the card to verify that the user is currently authorized to write orders for these controlled substances.

To be authorized to order and sign for Schedule 2 and Schedule 2n controlled substances, clinicians must have either a DEA assigned to them or use a VA/DEA number for their facility.

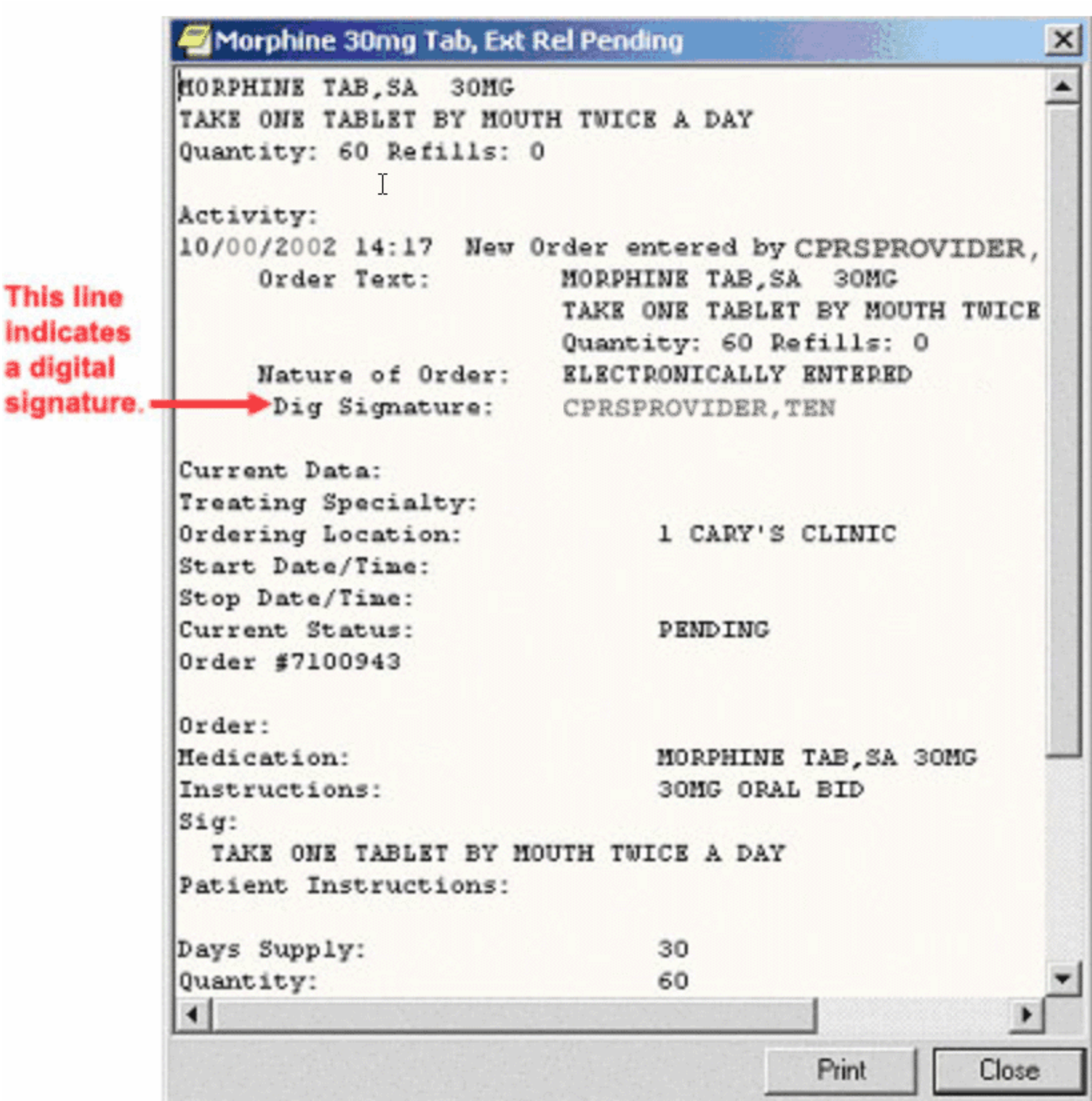
Once the user has a DEA or VA number, the user can apply for a smart card when your site rolls out this feature. The user will have to supply the needed information to the VA Issuing Station so that they can create and send a card.

Note: Currently the project is only a pilot program. If the pilot is a success, the VA will then decided whether to roll out the hardware and software to all sites and what that project would entail.

How Does CPRS Show a Digital Signature?

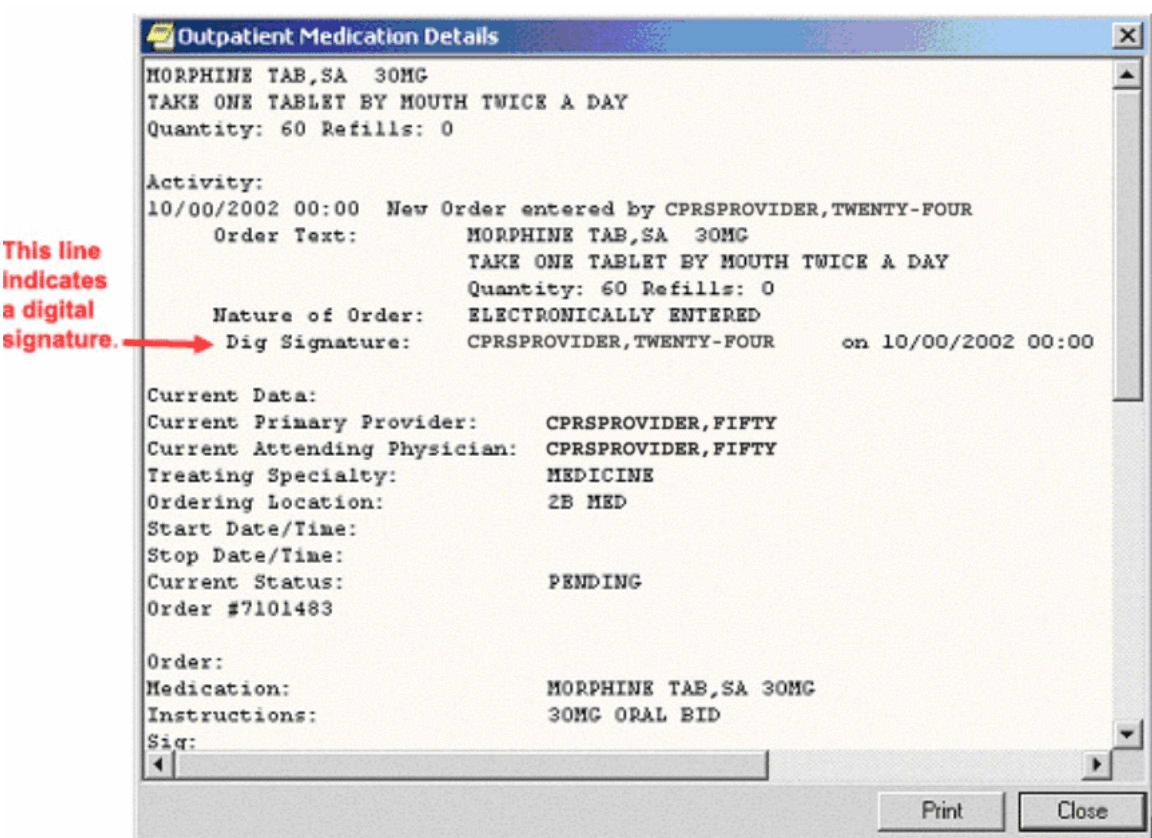
CPRS displays order information in several places where users will be able to see that an outpatient Schedule 2 or Schedule 2n order was digitally signed.

- **Cover Sheet:** If the order has been digitally signed, the detailed order display from right-clicking the order on the Cover Sheet where it currently shows "Elec Signature:" will show "Dig Signature:".



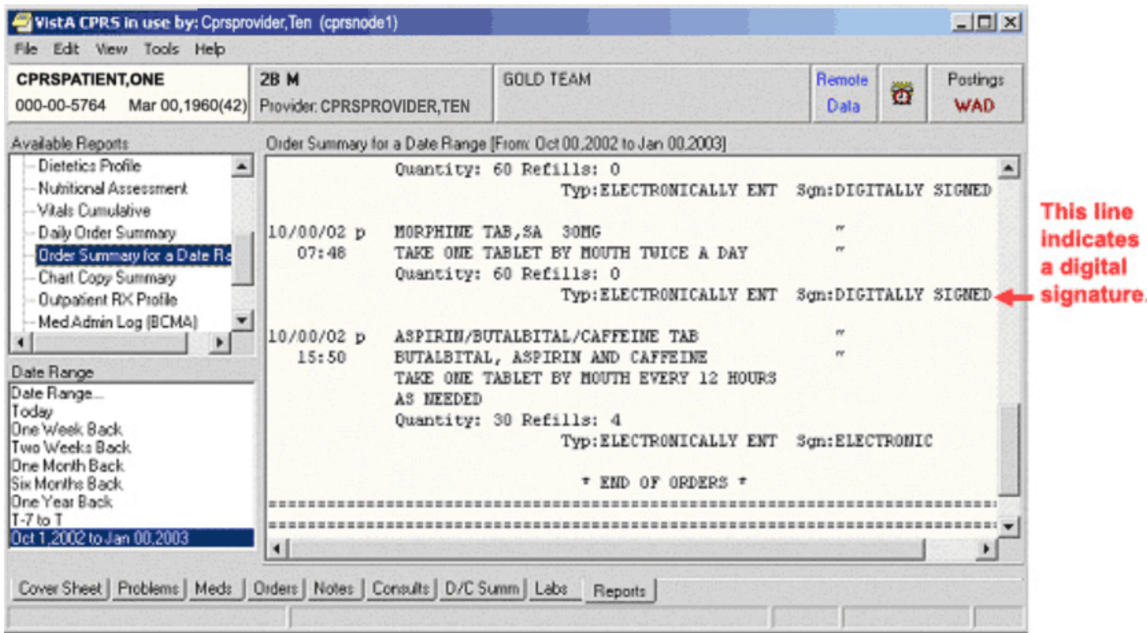
This graphic is a detailed display of an order on the CPRS Cover Sheet. Note the text change from "Elec. Signature," to "Dig Signature."

- **Orders Tab and Meds Tab:** If the order has been digitally signed, the detailed order display from right-clicking the order on the Orders tab or from selecting it and choosing Details from the View menu where it currently shows "Elec Signature:" will show "Dig Signature:".



The above graphic shows the detailed display of an order off the Meds or Orders tab. The text has been changed from "Elec Signature," to "Dig Signature."

- **Reports Tab:** On the Daily Order Summary and Order Summary by a Date Range reports, the signature type will be Digital. On the Chart Copy Summary report, the indicator shows that the order was digitally signed.



The above capture of the Reports tab indicates that the orders shown were digitally signed.

Digitally Signing Orders

A Personal Identification Number (PIN) controls access to the smart card. When a user needs to change the verify and access codes on the card, digitally sign an order, or change the card's PIN, the user must be at a workstation with a card reader and must enter the card's current PIN.

If you are using PKI and have entered an order for a Schedule 2 and Schedule 2n controlled substance, digitally sign the order by

- Proceeding with the normal electronic signature process.
- Inserting the smart card into the card reader.
- When prompted, enter your PIN and click **OK** or press **<Enter>**.

  Note: The provider will have to enter their PIN for each order that requires a digital signature.

Several things can cause you to have problems signing the orders digitally. If a problem occurs, a dialog such as the following is displayed.

If the digital signature fails, the user gets a dialog with the reason as shown in this graphic.

Contact IRM or a CAC to have the problem corrected. The following is a list of error messages that users might encounter:

- Order Text is blank
- DEA # missing
- Drug Schedule missing
- DEA # not valid
- Valid Certificate not found
- Couldn't load CSP
- Smart card Reader not found
- Certificate with DEA # not found
- Certificate not valid for schedule
- Crypto Error (contact IRM)
- Corrupted (Decode failure)
- Corrupted (Hash mismatch)
- Certificate revoked
- Verification failure
- Before Cert effective date
- Certificate expired

Changing Your Personal Identification Number (PIN)

Keeping your smart card PIN confidential is extremely important because if your site implements the sign on function, you will be able to log on to a workstation by inserting your smart card and entering your PIN. Protecting the PIN will also ensure that Schedule 2 and Schedule 2n orders will be signed only by authorized providers.

Note: When a clinician writes a Schedule 2 or Schedule 2n outpatient medication order, the clinician will be prompted for his or her electronic signature and then for the digital signature.

To change your PIN, use the following steps:

1. Bring up the Passage Control Center by selecting Start | Programs | RSA SecurID Passage | Control Center.
2. On the General Tab under Card PIN Management, choose Change.
3. Enter your current PIN in the Old PIN and tab to New PIN. Enter your New PIN, remember to use strong passwords that include upper and lower case letters, numbers, and special characters. Tab to Confirm New PIN and enter the same new PIN.
4. Click or choose Change.
5. Insert your smart card into the card reader if you have not already done so and click OK.

CPRS provides three methods for signing orders and documents. You can sign orders and documents together from the Review / Sign Changes dialog or you can sign orders and documents separately using the Sign Selected Orders and Sign Documents Now commands.

Understanding Service Connection and Treatment Factors

Upon electronic signature, providers will need to deal with the various exemptions for copayment for qualified veterans. To help providers better understand service connection and treatment factors, the following information is provided.

Service Connected

The assignment of service connected percentage and disability code is based on the degree of disability as determined by the rating board decision following the submission of a claim that a veteran's illness or injury was incurred in or aggravated by military service.

An adjunct condition, although not service connected, is medically determined to be associated with or is aggravating a disease or condition, which is service connected. A veteran is eligible to receive treatment for an adjunct condition; however, because the adjunct is not a condition that is specifically rated, VA can bill the insurance carrier as well as those veterans responsible for copayments for treatment provided for the adjunct condition.

A secondary condition is defined as a condition that has been caused or is the result of a service-connected condition. This condition is also nonservice-connected and treatment provided is also billable.

It is important that the clinician be aware of the patient's service-connected conditions. This information is available by clicking the patient's name in the blue square in the upper left corner in CPRS. It is also found on the encounter form. If a patient is being treated for a service-connected condition during a visit, the provider should check the service-connected box on the encounter form "yes".

Compensable service-connected veterans are not charged an outpatient copayment. However, nonservice-connected veterans and veterans rated less than 50% service-connected with income above the existing threshold may be charged a medication copayment if the medication is for a nonservice-connected condition. If the veteran has health insurance, a claim will be submitted to the insurance carrier for the treatment of nonservice-connected conditions.

General Instructions

The provider must make a clinical decision to determine if an encounter is for a SC condition or one of a number of special categories. If the veteran is being treated during the encounter for a condition that the provider believes is for SC or a special category, the provider should check "Yes" next to the appropriate category on the encounter form. The veteran will not be billed for the encounter if "Yes" is checked.

Medication(s) for one of these conditions should be indicated during the outpatient medication ordering process. The veteran will not be charged a copayment for a medication that is for SC or a special category.

The Special Categories included are:

- Combat Veteran (CV)
- Agent Orange (AO)
- Environmental Contamination (EC) – includes Gulf War veterans
- Ionizing Radiation (IR)
- Military Sexual Trauma (MST)
- Head and Neck Cancer (HNC), after nasopharyngeal radium treatment in service.

Combat Veteran

To qualify for the Combat Veteran (CV) exemption, the veteran must have served in combat operations after the Gulf War or in combat against a hostile force after November 11, 1998. In addition, the condition for which the veteran is treated must be related to that combat, the veteran must have registered as a combat veteran, and be within two years of separation from active military service. Finally, the condition must not be already considered to be service related or that exemption should apply.

Note: The Combat Veteran exemption is valid for two years from the date of separation from military service, not the registration date. For example, if a veteran registers for Combat Veteran status 18 months after the date of his or her separation, the veteran would be eligible for Combat Veteran exemption for six months only. For further details, see VHA Directive 2002-049, Combat Veterans Are Eligible for Medical Services for 2-Years after Separation from Military Service Notwithstanding Lack of Evidence for Service Connection.

Agent Orange

Agent Orange (AO) is an herbicide that was used in Vietnam between 1962 and 1971 to remove unwanted plant life that provided cover for enemy forces. The VA has recognized the following conditions as associated with but not necessarily caused by exposure to Agent Orange:

- Diabetes (type 2)
- Chloracne or other acneform disease consistent with chloracne (must occur within one year of exposure to AO).
- Porphyria cutanea tarda (must occur within one year of exposure to AO).
- Acute and subacute peripheral neuropathy. (For purposes of this section, the term acute and subacute peripheral neuropathy means temporary peripheral neuropathy that appears within weeks or months of exposure to an herbicide agent and resolves within two years of the date of onset.)
- Numerous cancers:
  - Prostate cancer
  - Hodgkin's disease.
  - Multiple myeloma.
  - Non-Hodgkin's lymphoma.
  - Respiratory cancers (cancer of the lung, bronchus, larynx, or trachea). (Must occur within 30 years of exposure to Agent Orange.)
  - Soft-tissue sarcoma (other than osteosarcoma, chondrosarcoma, Kaposi's sarcoma, or mesothelioma).
  - Chronic lymphocytic leukemia

Ionizing Radiation

Atomic veterans may have been exposed to ionizing radiation in a variety of ways at various locations. Veterans exposed at a nuclear device testing site (the Pacific Islands, e.g., Bikini, NM, NV, etc.) or in Hiroshima and/or Nagasaki, Japan, may be included. Atomic veterans with exposure to ionizing radiation are entitled to receive treatment for conditions for this exposure. VA has recognized the following conditions by statute or regulation as being associated with radiation exposure:

Conditions Associated with Ionizing Radiation:

- All cancers/malignancies
- Posterior subcapsular cataracts
- Non-mailgnant thyroid nodular disease
- Parathyroid adenoma
- Tumors of the brain and central nervous system

Note: Atomic veterans do not have to receive an Ionizing Radiation Registry Exam to have these special treatment eligibilities.

Environmental Contaminants

Gulf War veterans were exposed to a wide variety of environmental hazards and potential harmful substances during their service in Southwest Asia. These include depleted uranium, pesticides, the anti-nerve gas pill pyridostigmine bromide, infectious diseases, chemical and biological warfare agents, and vaccinations (including anthrax and botulinum toxoid), and oil well free smoke and petroleum products. VA recognizes that there are other health risk factors encountered by Gulf War veterans. Veterans with service during the Gulf War are entitled to receive treatment for conditions for this service.

If the treatment provided during the encounter is for an illness or symptom that may possibly be associated with environmental contamination this should be indicated on the encounter form or medication order

Conditions Associated with Environmental Contaminants:

- Persistent fatigue
- Skin rash
- Headache
- Arthralgias/myalgias
- Sleep disturbance
- Forgetfulness
- Joint pain
- Shortness of breath/chest pain
- Feverishness
- Amyotrophic Lateral Sclerosis

Military Sexual Trauma

VA is authorized by law to provide counseling services to women and men veterans who experienced incidents of sexual trauma while they served on active duty in the military. This Law defines a sexual trauma as sexual harassment, sexual assault, rape and other acts of violence. It further defines sexual harassment as repeated unsolicited, verbal or physical contact of a sexual nature, which is threatening in nature.

The provider must make a clinical decision to determine if a visit or medication is for MST. If the veteran is being treated for any condition during this episode of care that the provider believes is for MST; the visit should be checked as related on the encounter form and the medication should be designated as for MST. This will mean that the veteran does not have to pay a copayment for the visit or the medication.

Head and Neck Cancer

Veterans with cancer of the head and neck and a history of receipt of Nasopharyngeal (NP) radium therapy are eligible to receive treatment. There are very specific dates and locations where this activity occurred. Eligibility for this special class needs to be verified by HAS. (Not all veterans receiving head and neck cancer treatment fall into this treatment category.)

During the 1920s, nasopharyngeal (NP) radium therapy was developed to treat hearing loss caused by repeated ear infections. Radium-tipped rods were inserted into the nostrils and left in place for several minutes. Military physicians used NP radium to treat aerotitis media (barotrauma) in submariners, aviators, and divers. It is estimated that between 8,000 and 20,000 military personnel received NP radium treatments during World War II and until the 1960s. Veterans also included are those with documentation of NP radium treatment in active military, naval or air service; those who served as an aviator in the active military, naval or air service before the end of the Korean conflict; or underwent submarine training in active naval service before January 1, 1965. Veterans with exposure to NP radium treatments are eligible to receive treatment for conditions related head and neck cancer

If the veteran is being treated for any condition during this episode of care that is for Head and Neck Cancer; the visit should be checked as related on the encounter form and the medication should be designated for Head and Neck Cancer. This will mean that the veteran does not have to pay a copayment for the visit or the medication.

Entering Diagnosis Codes for Specific Orders

Note: Providers will not see most CIDC changes in CPRS until the site enables a system-level switch and IRM or CAC staff enables a user-level switch (parameter) for specific providers. Some changes for co-pay on service connection will be available as soon as CIDC patches from other packages are installed.

With Clinical Indicators Data Capture (CIDC), clinicians who hold the Provider key and the ORES key must enter at least one diagnosis, required service connection, and the appropriate treatment factors for specific types of orders, while clinicians who hold the Provider key and the ORELSE key will be prompted for the same information but not required to enter it before signature. CPRS will prompt for CIDC information for the following types of orders:

- Laboratory (outpatient only)
- Outpatient Pharmacy (outpatient only)
- Radiology (inpatient and outpatient)
- Prosthetic Consults (inpatient and outpatient)

Clinicians may enter up to four diagnoses for each order and designate one as the primary diagnosis.

Clinicians should use their best judgment to enter diagnoses that might be symptomatic when ordering tests rather than the resulting diagnosis after a test. They are not entering the suspected diagnosis, but the actual reason the patient was sent for the lab test or radiology procedure. For example, if a clinician sees a patient with a high fever and difficulty breathing, the clinician may believe that the patient has pneumonia, but if the clinician orders tests to verify the pneumonia, the clinician would enter a diagnosis of “fever”, not “pneumonia”.

When Will Providers See CIDC Changes?

For clinicians to use the new features to enter at least one diagnosis for these orders, the following four conditions must be met:

- The site must have installed the necessary patches.
- The clinician must have the Provider key and the ORES key (CIDC entry required) or the ORELSE key (CIDC entry optional).
- The site must enable the master Clinical Indicators Data Capture switch.
- The individual Clinical Indicators Data Capture switch enabled for the clinician.

Instructions for enabling Clinical Indicators Data Capture at both the site and individual level are available in the *CPRS Technical Manual: GUI Version*.

Where Will Users See the Changes?

When the site enables the master CIDC switch at the site level and for individual clinicians, the clinicians who hold the Provider key will see the following changes in the CPRS GUI:

- The Review / Sign Changes and Sign Selected dialogs will now have areas where diagnoses will be captured for the specified orders. These diagnoses and treatment factors will then be available on the Encounter form if the clinician signs the orders first.
- The Encounter Form's Diagnosis tab will enable clinicians to enter diagnoses for the encounter. These diagnoses will then be available on the Orders tab if the clinician does the encounter form first.
- Order detailed displays will now display the associated treatment factors and diagnoses.
- A new Assign Diagnosis to Order(s) dialog has been added for clinicians to use in designating one or more diagnoses for each of the types listed above.
- A new Personal Diagnosis List dialog to create a personal diagnosis list that providers can use as a source on the new Assign Diagnosis to Order(s) dialog.

What Features in CPRS Make Entering Diagnoses Easier?

CPRS has the following features to help clinicians assign diagnoses to orders:

- **Automatically copying the diagnoses, service-connection, and treatment factors when a user copies, renews, or changes an order.**
- **Selecting a group of orders to assign diagnoses at the same time.** Clinicians can select a group of orders using the Windows conventions of Shift + Click to highlight a contiguous group of orders and Crtl + Click to add individual orders to the group. All of the orders can then be assigned the same primary and secondary diagnoses.
- **Copying and pasting diagnoses from one order to others.** Clinicians can highlight an order on the signature dialogs, copy the diagnosis and any treatment factors, highlight one or more additional orders, and paste the same diagnosis and treatment factors for them.
- **Providing multiple sources for diagnoses.** CPRS displays multiple diagnosis sources for clinicians to locate the appropriate diagnoses:
    - Orders written today if on the Encounter form
    - Encounter diagnoses from today if writing orders
    - Personal Diagnosis List
    - National Encounter forms if defined by your site
    - Problem List entries
    - The Lexicon search.
- **Automatically populating treatment factors for diagnoses selected from the Problem List.** One possible source for diagnoses is the patient's Problem List entries. If a problem has service connection and treatment factor information associated with it on the Problem List and the user selects that Problem List entry as the diagnosis, CPRS automatically places checks in the appropriate checkboxes on the signature forms. The provider can, of course, edit the checks.
- **Creating a personal diagnosis list.** Developers provided a personal diagnosis list that is specific to each clinician. Each clinician can quickly add diagnoses that he or she frequently uses to the list so that they can be assigned quickly.

Review / Sign Changes Dialog

The Review / Sign Changes dialog allows you to simultaneously sign several orders and documents.

To sign orders and documents with the Review / Sign Changes dialog, follow these steps:

1. Do one of the following:

   a.) Select **File** | **Review** / **Sign Changes....** to sign orders or documents and stay in the current patient record.

   b.) Choose **File** | **Select New Patient** to sign orders or documents and select a new patient.

   c.) Choose **File** | **Exit** to sign orders and documents and exit CPRS.

   After performing a, b, or c, one of the Review/Sign Changes dialogs shown below will appear. Each item that requires a signature will have a check box in front of it.

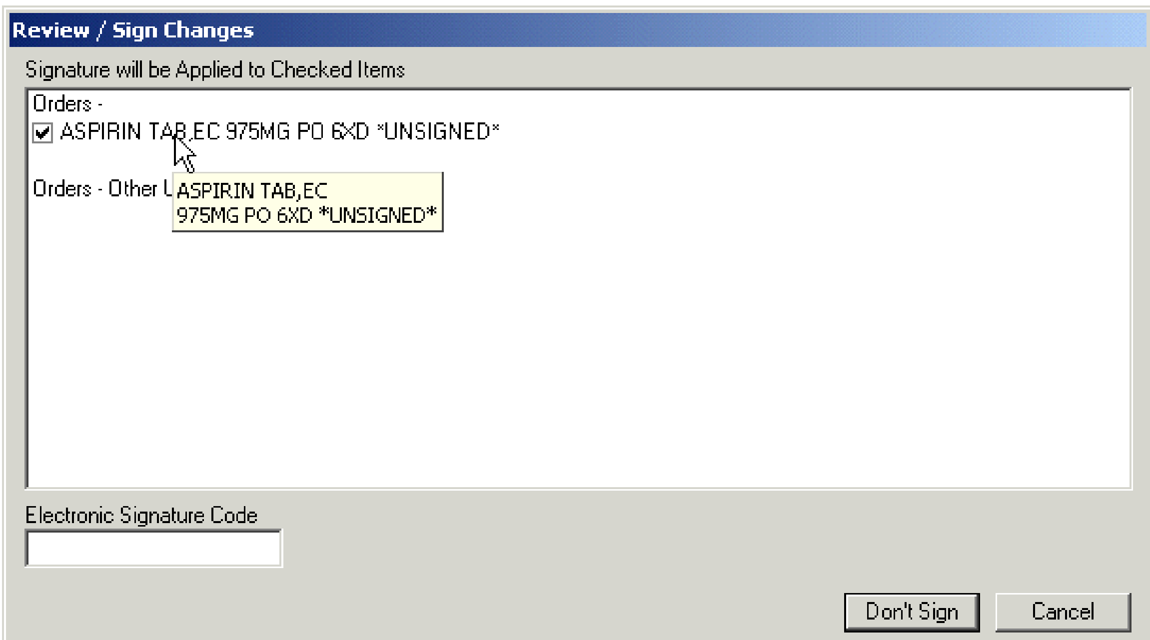


Figure A

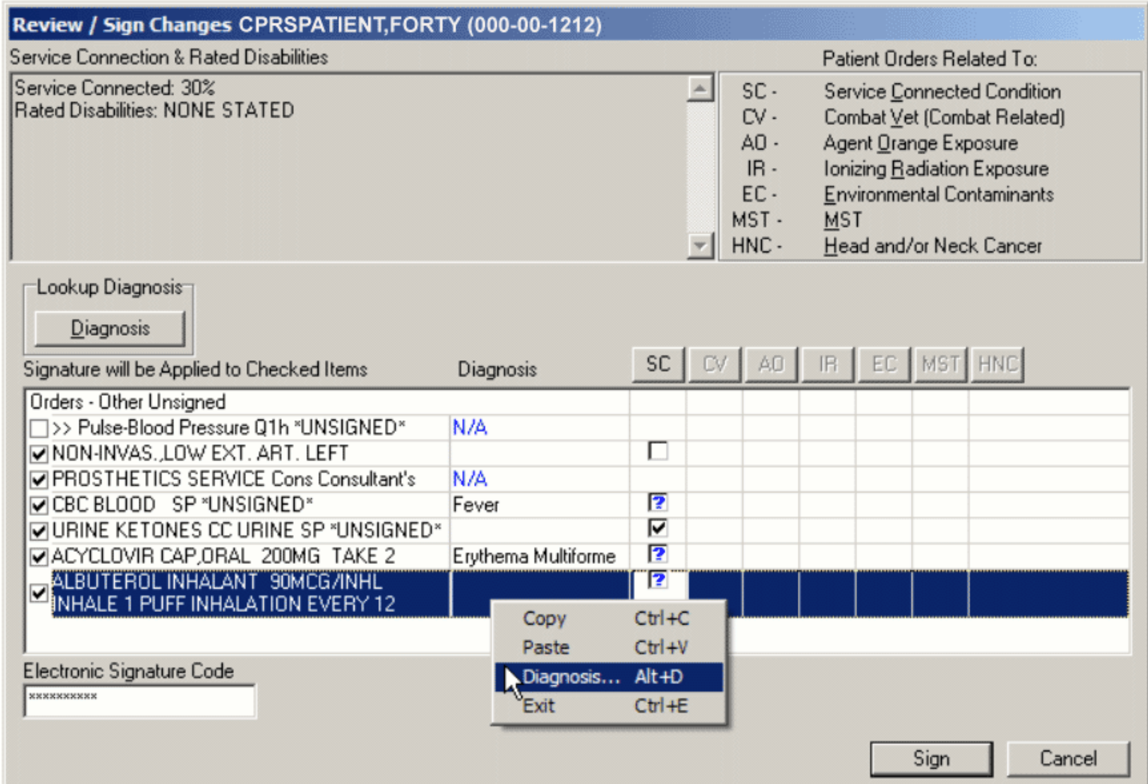


Figure B: Combat Veteran status and Clinical Indicators Data Capture information is now gathered on the signature screens.

2. Deselect any items that you do not want to sign by clicking the check box to the left of the order or document.

3. If the Review / Sign Changes dialog resembles Figure A, enter your electronic signature code and click **Sign**. The documents and orders will now be signed.

   If the Review / Sign Changes dialog resembles Figure B and contains question marks, continue to step 4.

4. The question marks inside the boxes in Figure B indicate that you need to specify how that order is related to the medical condition in that column. (SC = Service Connected Condition, CV=Combat Veteran, AO=Agent Orange Exposure, IR=Ionizing Radiation Exposure, EC=Environmental Contaminants, MST=Military Sexual Trauma, and HNC=Head or Neck Cancer). If you place a check in a box, you are indicating that a medication order is related to the condition in that column. If you create an empty box, you are indicating that the medication order is not related to the condition in that column. You must either check or uncheck every box that contains a question mark before you can sign the order.

Note: Definitions for service connection and treatment factors are available to users by hovering the cursor over the term or using the appropriate keyboard shortcut as shown in the list below:

- Service connection (SC) .... Alt + c
- Combat Veteran (CV) .... Alt + v
- Agent Orange (AO) .... Alt + o
- Ionizing Radiation (IR) .... Alt + r
- Environmental contaminants(EC) .... Alt + e
- Military Sexual Trauma (MST) .... Alt + m
- Head and/or Neck Cancer (HNC) .... Alt + n

You can toggle the check boxes by:

- o **Clicking an individual check box**.
  This will toggle the box between checked and unchecked.
- o **Pressing the appropriate Copay button**
  (SC CV AO IR EC MST or HNC)
  This will toggle all the check boxes in that column.
- o **Pressing the** All **button.**
  This will toggle all the check boxes on the screen.

5. When you have dealt with the co-pay exemptions, begin the process of entering diagnoses by highlighting the orders using Shift + Click and Ctrl + Click to make a group of orders that will have the same diagnoses.

6. Bring up the Assign Diagnoses to Order(s) dialog by clicking **Diagnosis** or by right-clicking on the highlighted orders and choosing **Diagnosis** on the pop-up menu.

7. When the dialog displays, choose the source from which you would like to look for a diagnosis: under Diagnosis Section, you can choose from the Problem List, Personal Diagnosis list (if you have entered any items on your list), or the Encounter Form for the clinic location you are in (if one has been defined by your site) or you can click Other Diagnosis… to search the Lexicon.

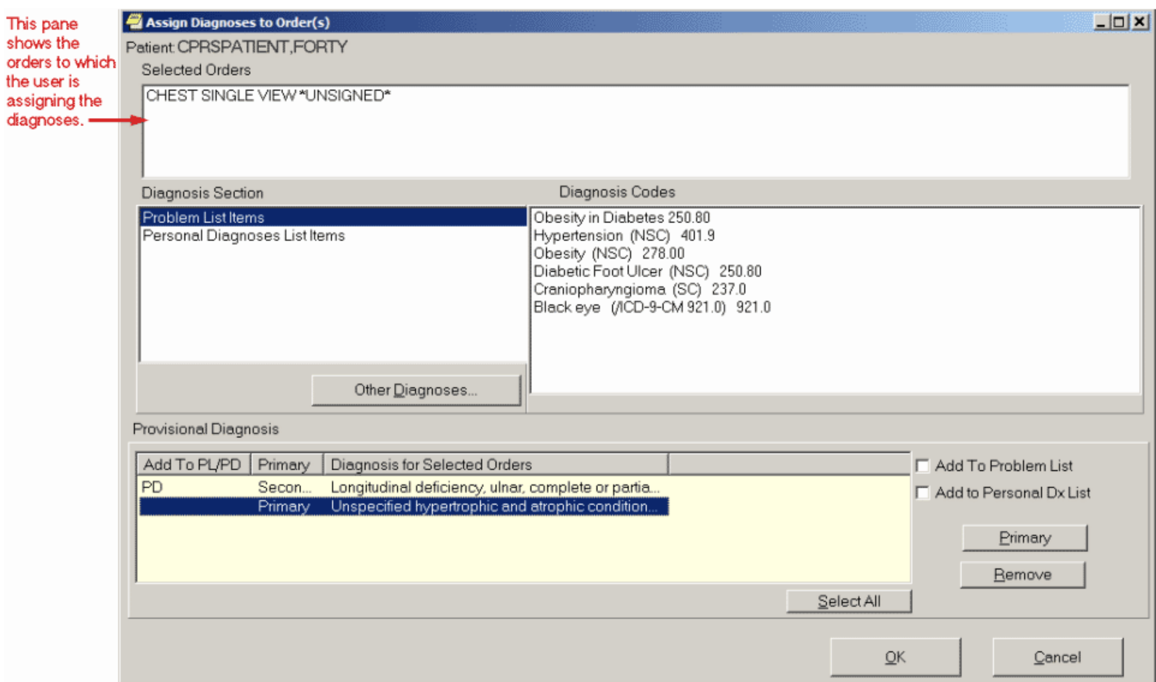
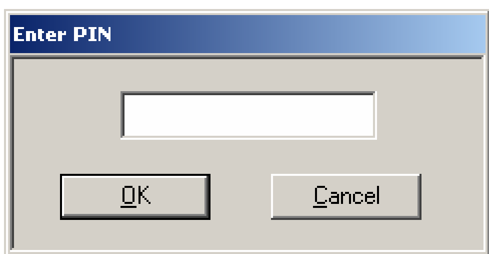


Figure C: The Assign Diagnosis to Order(s) dialog enables providers to select as many as four diagnoses for each order. Also shown is the check box to add a diagnosis to the user's Personal Diagnosis List.

8. After choosing a source, select the appropriate diagnoses for the selected orders under Diagnosis Codes. You can select as many as four diagnoses although only one is required.

   Note: The first diagnosis you enter is automatically assigned as the primary diagnosis.

9. If you want to change the primary diagnosis to another you have selected, highlight the diagnosis by clicking it and click **Primary**.
10. (Optional) If you want to add one or more diagnoses to the problem list, highlight the diagnoses and click the Add to Problem List checkbox.
11. (Optional) If you want to add one or more of the diagnoses to your Personal Diagnosis List, highlight the diagnoses and click the Add to Personal Dx List check box.
12. When you have assigned the diagnoses correctly, choose **OK**.
13. Repeat steps 5-10 for all orders or groups of orders that require a diagnosis.
14. When you have removed all of the question marks from the dialog and entered a diagnosis for all appropriate orders, enter your electronic signature code and click **Sign**.
15. If PKI is enabled and you have entered Outpatient Schedule 2 or 2n Medication orders, digitally sign the orders by inserting your smart card if you have not already done so and clicking OK, and then entering your PIN in dialog box and clicking **OK** for each order as necessary.



Sign Selected Orders Command

The Sign Selected Orders command allows you to select a number of orders and sign them all simultaneously. However, you cannot sign documents with this command.

To sign a number of orders, use these steps:

1. Click the **Orders** tab.
2. Highlight the orders you want to sign.

   To select a range of items, click the order at the beginning of the range; then hold down the **SHIFT** key and click the order at the end of the range. To select multiple, individual orders, select the first order, hold down the **CTRL** key, and click the next order.
3. Select Action | Sign Selected…

   -or-

   right-click and select **Sign**…

   One of the Electronic Signature dialog boxes shown below will appear.

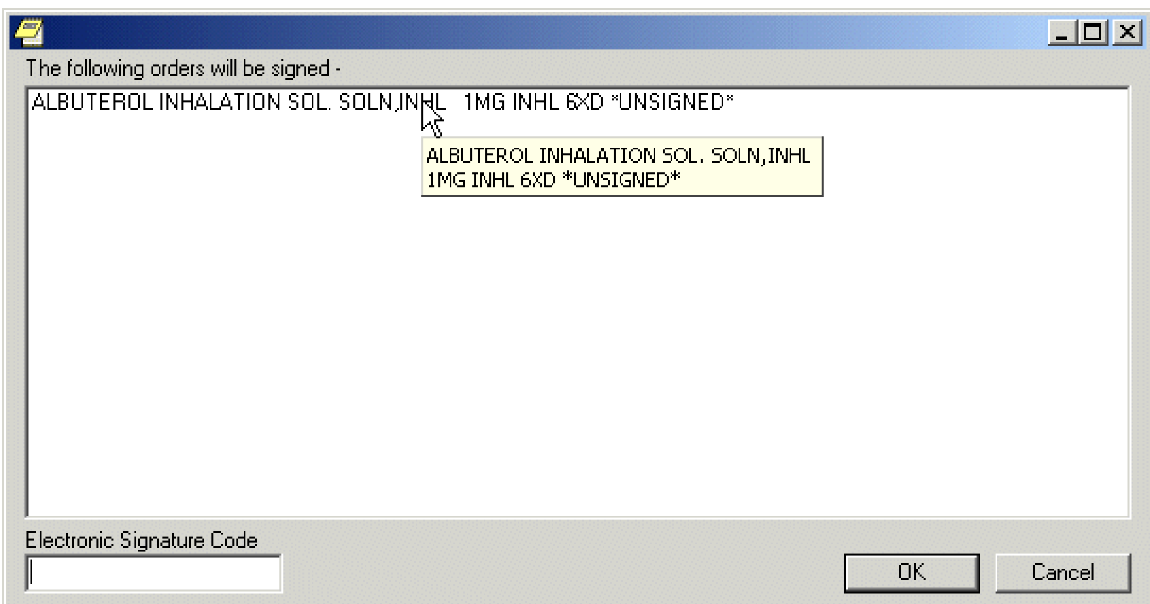


Figure A

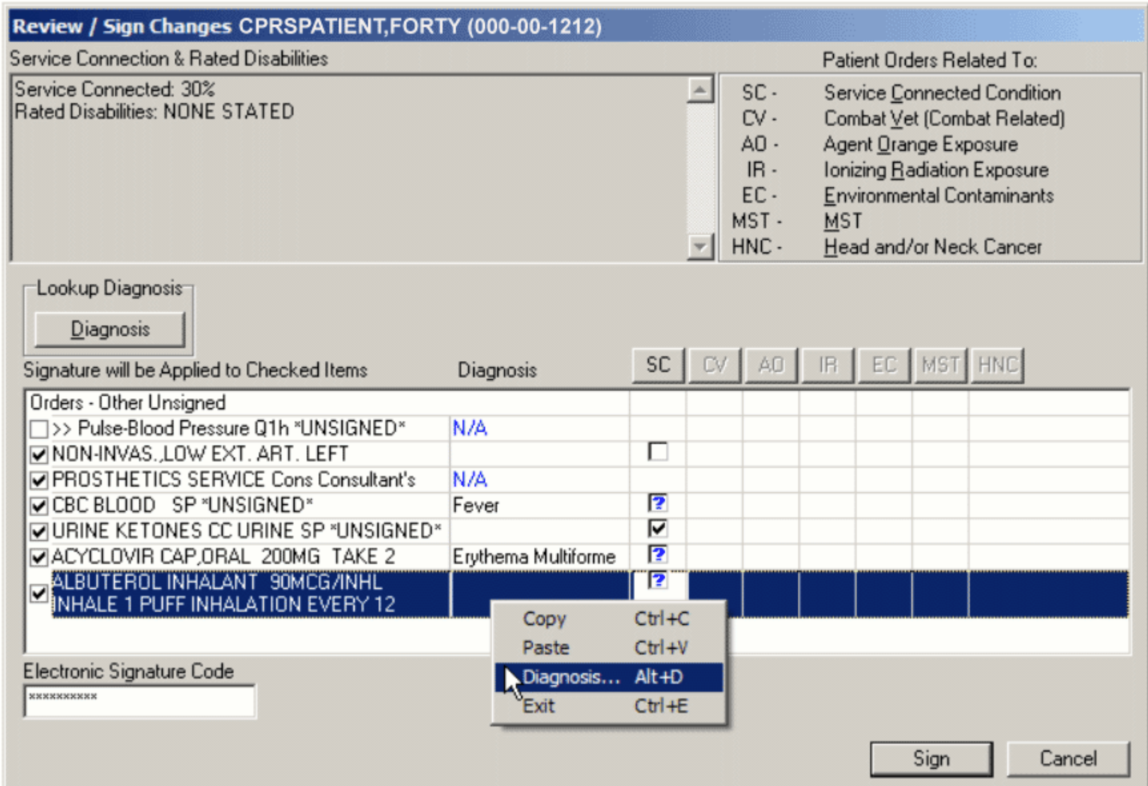


Figure B: Combat Veteran Status and Clinical Indicators Data Capture information is now gathered on the signature screens.

4. If the Electronic Signature dialog resembles Figure A, enter your electronic signature code (if necessary) and click **Sign**. The orders will now be signed.

   If the Electronic Signature dialog resembles Figure B and contains blue question marks, continue to step 5.

5. The question marks inside the boxes in Figure B indicate that you need to specify how that order is related to the medical condition in that column. (SC = Service Connected Condition, CV=Combat Veteran, AO=Agent Orange Exposure, IR=Ionizing Radiation Exposure, EC=Environmental Contaminants, MST=Military Sexual Trauma, and HNC=Head and/or Neck Cancer). If you place a check in a box, you are indicating that a medication order **is** related to the condition in that column. If you create an empty box, you are indicating that the medication order is **not** related to the condition in that column. *You must either check or uncheck every box that contains a question mark before you can sign the order*.

   Note: Definitions for service connection and treatment factors are available to users by hovering the cursor over the term or using the appropriate keyboard shortcut as shown in the list below:

   - Service connection (SC) .... Alt + c
   - Combat Veteran (CV) .... Alt + v
   - Agent Orange (AO) .... Alt + o
   - Ionizing Radiation (IR) .... Alt + r
   - Environmental contaminants(EC) .... Alt + e
   - Military Sexual Trauma (MST) .... Alt + m
   - Head and/or Neck Cancer (HNC) .... Alt + n

You can toggle the check boxes by:

- **Clicking an individual check box**.
  This will toggle the box between checked and unchecked.
- **Pressing the appropriate Copay button.**
  (SC CV AO IR EC MST or HNC)
  This will toggle all the check boxes in that column.
- **Pressing the** All **button.**
  This will toggle all the check boxes on the screen.

6. When you have dealt with the co-pay exemptions, begin the process of entering diagnoses by highlighting the orders using Shift + Click and Ctrl + Click to make a group of orders that will have the same diagnoses.

7. Bring up the Assign Diagnoses to Order(s) dialog by clicking **Diagnosis** or by right-clicking on the highlighted orders and choosing **Diagnosis** on the pop-up menu.

8. When the dialog displays, choose the source from which you would like to look for a diagnosis: under Diagnosis Section, you can choose from the Problem List, Personal Diagnosis list (if you have entered any items on your list), or the Encounter Form for the clinic location you are in (if one has been defined by your site) or you can click Other Diagnosis… to search the Lexicon.

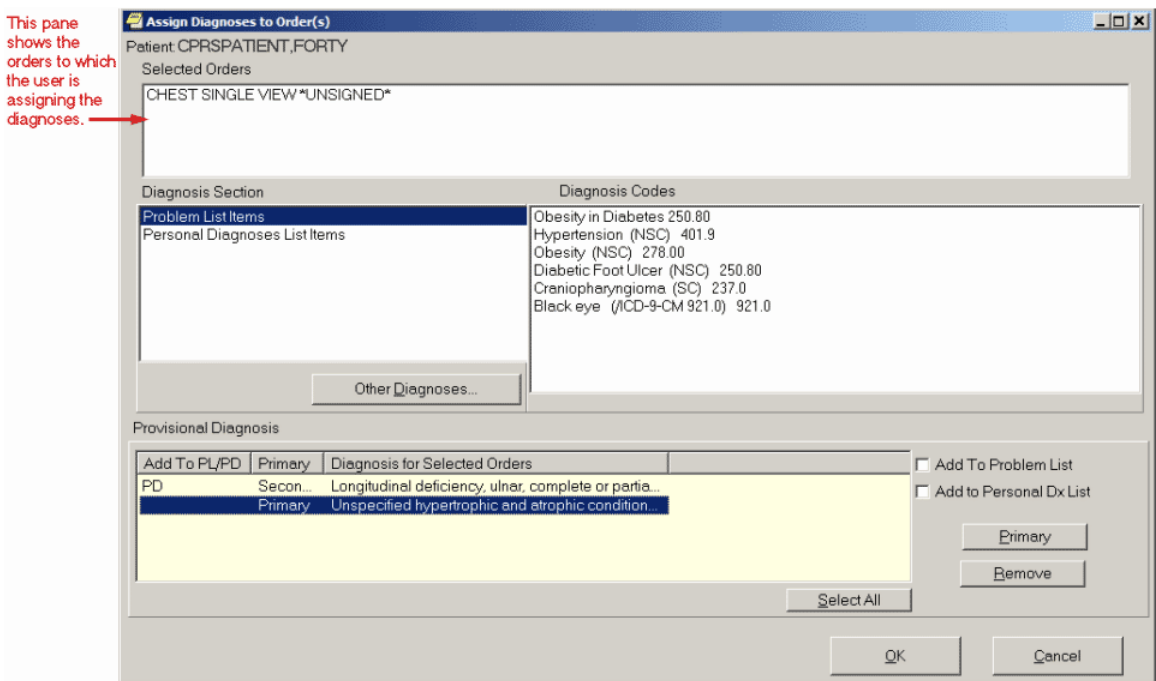


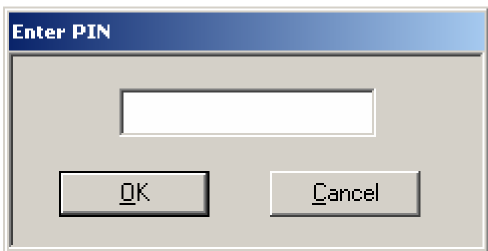
Figure C: The Assign Diagnosis to Order(s) dialog enables providers to select as many as four diagnoses for each order. Also shown is the check box to add a diagnosis to the user's Personal Diagnosis List.

9. After choosing a source, select the appropriate diagnoses for the selected orders under Diagnosis Codes. You can select as many as four diagnoses although only one is required.

   Note: The first diagnosis you enter is automatically assigned as the primary diagnosis.

10. If you want to change the primary diagnosis to another you have selected, highlight the diagnosis by clicking it and click **Primary**.

11. (Optional) If you want to add one or more diagnoses to the problem list, highlight the diagnoses and click the Add to Problem List checkbox.
12. (Optional) If you want to add one or more of the diagnoses to your Personal Diagnosis List, highlight the diagnoses and click the Add to Personal Dx List check box.
13. When you have assigned the diagnoses correctly, choose **OK**.
14. Repeat steps 5-10 for all orders or groups of orders that require a diagnosis.
15. When you have removed all of the question marks from the dialog and entered a diagnosis for all appropriate orders, enter your electronic signature code and click **Sign**.
16. If PKI is enabled and you have entered Outpatient Schedule 2 or 2n Medication orders, digitally sign the orders by inserting your smart card if you have not already done so and clicking OK, and then entering your PIN in dialog box and clicking **OK** for each order as required.



Criteria Used to Determine if the Service Connection and Treatment Factor Buttons are Displayed in the Review/Sign Changes Dialog

The Review/Sign Changes dialog may contain the service connection and treatment factor (formerly called the "Copay") buttons (SC CV AO IR EC MST and HNC) if the current patient has outpatient medication orders that need to be signed and certain additional conditions are met. The additional conditions are explained below.

Note: These buttons will not display until after December 31, 2001 and PSO*7*71 is released and installed.

Note: Previously, CPRS did not display the buttons if a veteran was 50% or more service connected. If Clinical Indicators Data Capture (CIDC) is installed and the user is *not* enabled for CIDC, the buttons display for outpatient medications regardless of the patient's level of service connection based on the criteria below. ***The 50% criterion below does not apply with CIDC installed.***

- If a patient is a veteran *and* 50% service connected *or greater,* then the Copay buttons will not be displayed on the Review / Sign Changes dialog.
- If a patient is a veteran *and* less than 50% service connected *and* the patient is exempt from copay then the Copay buttons will not be displayed.
- If a patient is a veteran *and* less than 50% service connected, *and* the patient is *not exempt* from copay then the Pharmacy package checks to see if the drug specified in the medication order is marked as supply or investigational. If the drug is marked as supply or investigational, the Copay buttons will not appear.

  However, if the drug specified in the order is not marked as supply or investigational, then CPRS checks if the patient has any other exemptions (Service Connected Condition, Combat Veteran, Agent Orange Exposure, Ionizing Radiation Exposure, Environmental Contaminants, Head and/or Neck Cancer or Military Sexual Trauma). If a patient has any of these exemptions, then CPRS displays the buttons.

The Sign Note Now and Sign Discharge Summary Now Commands

The Sign Note Now and Sign Discharge Summary Now menu items let you sign the currently selected note or discharge summary.

> **Note**: Notes and discharge summaries cannot be altered once they are signed.

To sign a note or discharge summary, use these steps:

1. Click the **Notes** or **DC/Summ** tab.
2. Select the note or discharge summary that you would like to sign.
3. Select Action | Sign Note Now (or Sign Discharge Summary Now).

   -or-
   right-click in the document area and select **Sign Note Now** (or **Sign Discharge Summary Now**).
4. Type in your electronic signature code.
5. Click **OK**.

Add to Signature List

With the Add to Signature List command, you can place notes or discharge summaries for the same patient on a list where you can simultaneously sign them.

To add a note or discharge summary to your signature list, follow these steps:

1. Click the **Notes** or **DC/Summ** tab.
2. Select the note or discharge summary that you would like to add to your signature list.
3. Choose **Action** | **Add to Signature List**.
   The note or discharge summary will be added to your signature list. To sign all of the notes or discharge summaries on your signature list select **File** | **Review / Sign Changes**.

Viewing Unsigned Notes or Discharge Summaries

With the View Unsigned Notes or View Unsigned Discharge Summaries command you can view all the notes and discharge summaries that you have not yet signed.

To view unsigned notes or discharge summaries, follow these steps:

1. Click the **Notes** or **DC/Summ** tab.
2. Select either View | Unsigned Notes, View | Uncosigned Notes, View | Unsigned Summaries or View | Uncosigned Summaries.

   The unsigned notes or discharge summaries will appear in the detail portion of the window.

Identify Additional Signers

With the Identify Additional Signers feature, you can select other individuals that you want to sign a note or discharge summary. Once you have selected the additional signers, CPRS will send them an alert that indicates a note is ready for them to sign.

The Identify Additional Signers feature helps you ensure that team members see a note. For example, one psychiatrist might identify another psychiatrist to sign the note to ensure that he or she agrees with an assessment.

To identify additional signers, use these steps:

1. Click the **Notes** or **DC/Summ** tab.
2. Select a signed note or discharge summary.
3. Select Action | Identify Additional Signers
   -or-
   right-click in the main text area and select Identify Additional Signers.
4. To identify a signer, locate the person's name (scroll or type in the first few letters of the last name) and click it.

   Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

   - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
     - When no division is listed for a provider, no division is displayed.
     - If only one division is listed, this division is displayed.
     - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
     - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
   - Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

5. Repeat step 4 as needed.
6. (Optional) To remove a name click the name under Current Additional Signers and click **Remove**.
7. When finished, click **OK**.

Printing from Within CPRS

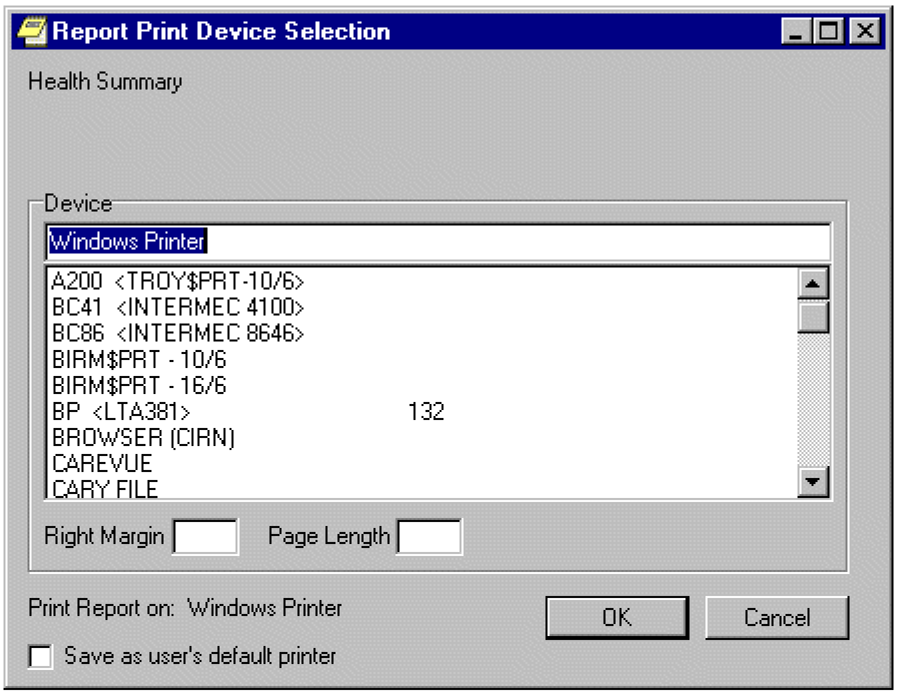
You can print most reports, notes, and detailed displays from within the CPRS GUI.

To print graphics and charts, you will need to print to a Windows printer. To print text documents, you can print to either a Windows printer or a VistA printer. The printer language used by Windows printers can accommodate graphics, while the language used by VistA printers cannot.

Printing Single Items

You can also print graphics on a Windows printer from the Labs tab and the Vitals screen. You can use **File | Print Setup...** to set up a preferred printer for the current session and save it as the default for the user.

The dialog box shown below opens when you select **File | Print** from the Notes tab. A similar dialog appears for items on other tabs.



The Report Print Device Selection dialog

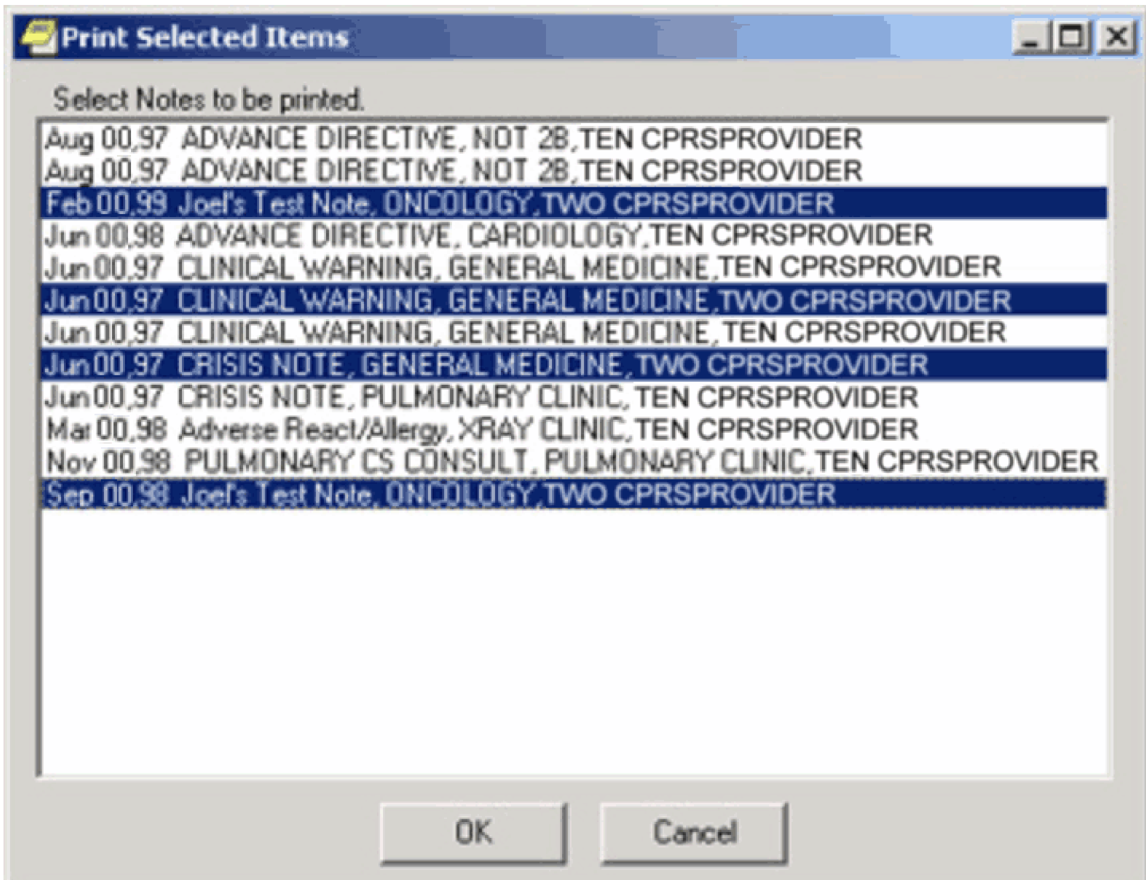
Normally, the right margin and page length values (measured in characters) are already defined by the printer.

Printing Multiple Notes, Consults, or Discharge Summaries

The ability to print multiple Progress Notes, Consults, and Discharge Summaries has been added to the CPRS GUI. This feature is available from those tabs only.

To print multiple Notes, Consults, or Discharge Summaries, use these steps:

1. Go to the appropriate tab (Notes, Consults, or DC/Summ) by clicking on the tab or using the keyboard commands to locate the tab.
2. Select **File | Print Selected Items…** to bring up the dialog shown below.



This graphic shows a number of Progress Notes that can be printed and several highlighted.

3. Select the documents you want to print.

   Note: To select a number of items in a row, click the first item, hold down the Shift key, and click the last item. All items in the range will be selected. To select multiple items that are not in a row, click one, hold down the Control key, and click the other specific notifications.

4. Click **OK**.

Tools Menu

The Tools menu allows you to quickly access other applications and utilities from within CPRS. Depending on the configuration of your site, the Tools menu may allow you to access other VistA applications such as VistA Imaging or connect you to third-party applications such as word-processing programs or Internet browsers. Talk to your clinical coordinator if you wish to add an application or utility to the Tools menu.

The Tools menu also contains two standard menu items: Lab Test Information and Options… These menu items are explained below.

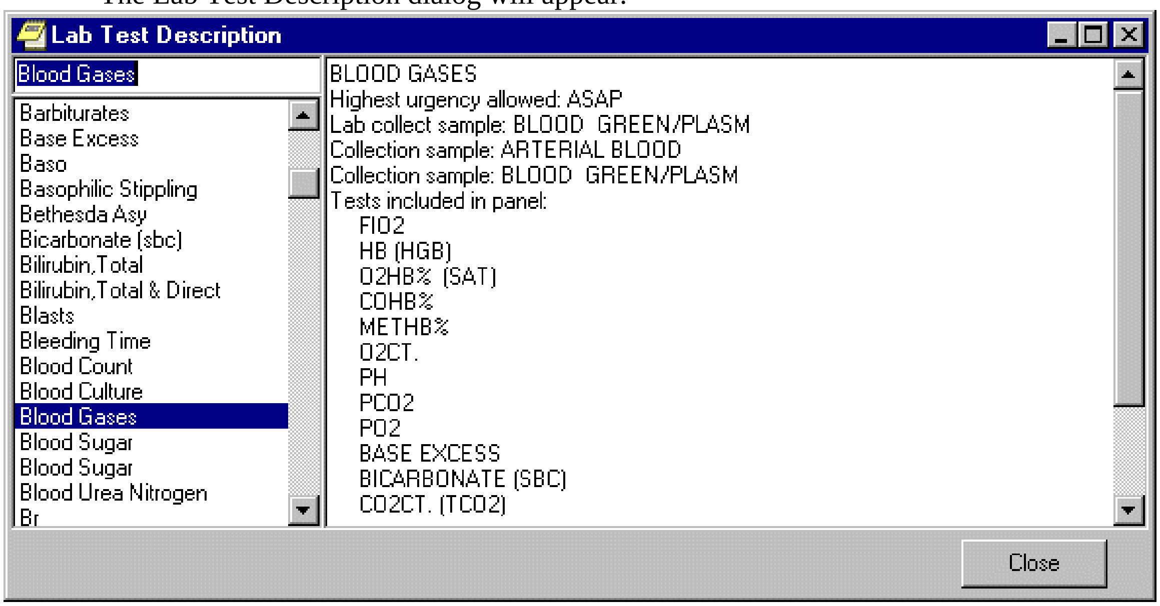
Lab Test Information

The Lab Test Information menu option displays information about various lab tests.

To display lab test information:

1. Select Tools | Lab Test Information.

   The Lab Test Description dialog will appear.



The Lab Test Description dialog

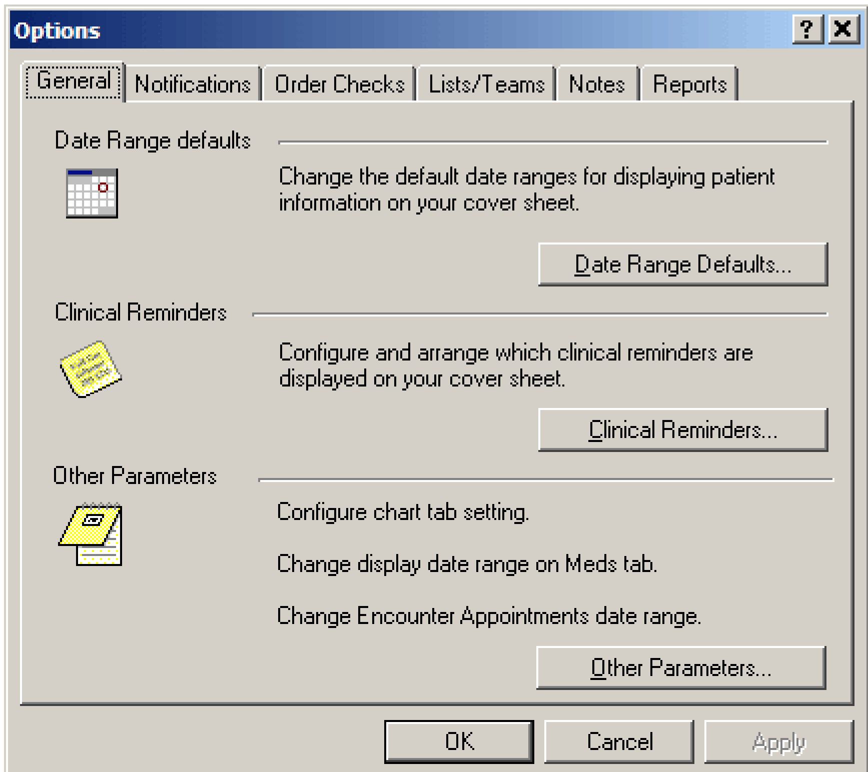
2. Select a lab test from the panel on the left side of the dialog.

   A description of the lab test you selected will be displayed in the right side of the dialog.

Options

You can change many of the settings that control the way CPRS works. The Options choice on the Tools menu contains dialogs that allow you to change which notifications and order checking messages you get, manage team and personal lists, assign your default patient selection settings, and modify your default tab preferences. To access the personal preferences settings, click **Tools | Options** from any CPRS tab.

The Options dialog consists of a number of tabs, each of which allows access to a category or type of preference settings.



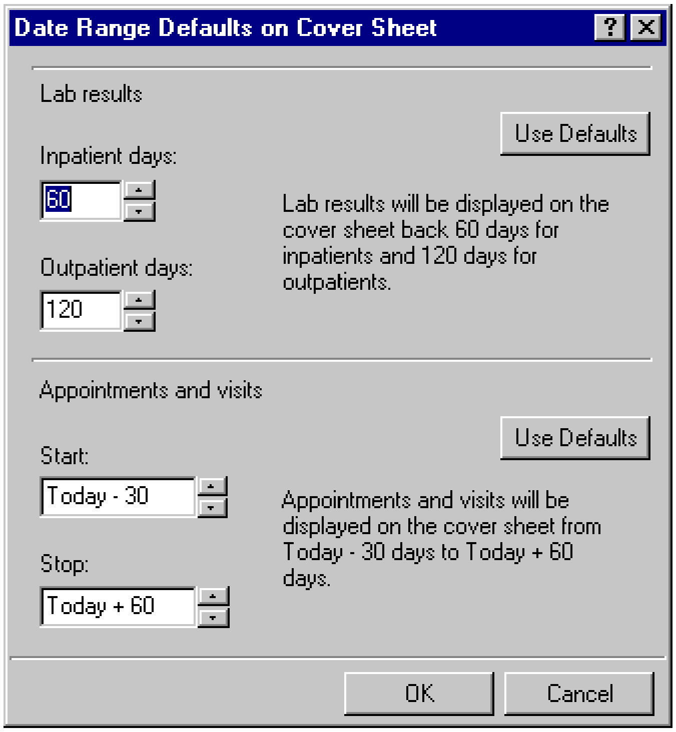
The Tools | Options dialog

General Tab

The General tab includes the **Date Range Defaults…**button which allows you to limit the date range for lab results as well as appointments and visits that appear on the cover sheet, the **Clinical Reminders…** button which allows you to configure and arrange which clinical reminders are displayed on the cover sheet, and the **Other Parameters…**button which allows you to set which tab is active when CPRS starts, set the date range for items on the Meds tab, and set the date range for Encounter appointments. The buttons on the General tab are explained in more detail below.

Date Range Defaults…

Click **Date Range Defaults…** to set how long lab results, appointments, and visits will be displayed on the Cover Sheet.



The Date Range Defaults on Cover Sheet dialog allows you to set the default date range for lab results and appointments and visits.

Clinical Reminders…

Click **Clinical Reminders…** to configure and arrange which clinical reminders are displayed on the Cover Sheet.

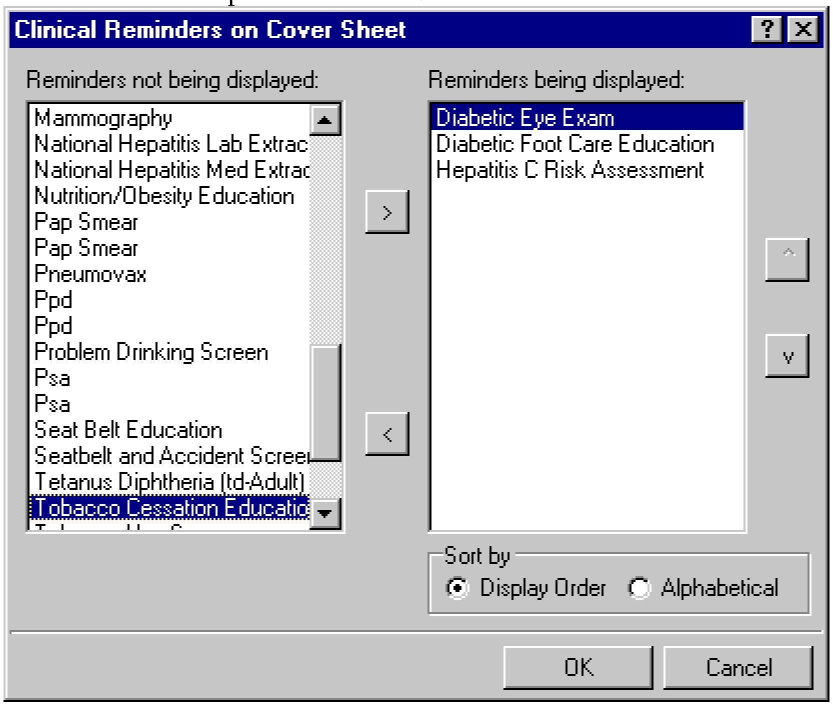
Based on the setting of the parameter ORQQPX NEW REMINDER PARAMS, you see one of two dialogs for configuring and arranging clinical reminders on your coversheet. If this parameter is set to “Off,” you will see the “Clinical Reminders on Cover Sheet” dialog. If the parameter is set to “On,” you will see the “Clinical Reminders and Reminder Categories Displayed on Cover Sheet” dialog. Your Clinical Coordinator sets the ORQQPX NEW REMINDERS PARAMS parameter.

Clinical Reminders on Cover Sheet

To select the clinical reminders you want displayed on the Cover Sheet, follow these steps:

1. From the Clinical Reminders on Cover Sheet dialog, highlight an item in the “Reminders not being displayed:” field.
2. Click > to add the clinical reminder to the “Reminders being displayed:” field. (Hold down the control key to select more than one reminder at a time.) The reminders in this field will be displayed on the Cover Sheet. Click > to remove an item.
3. To control how the reminders are displayed on the Cover Sheet, do one of the following:
    - click the “**Display Order**” option (at the bottom of the dialog) to display the reminders in their current order. To move a reminder up or down the list, select the reminder and click either the up or down arrow.

- click the “Alphabetical” option (at the bottom of the dialog) To display the reminders in alphabetical order.



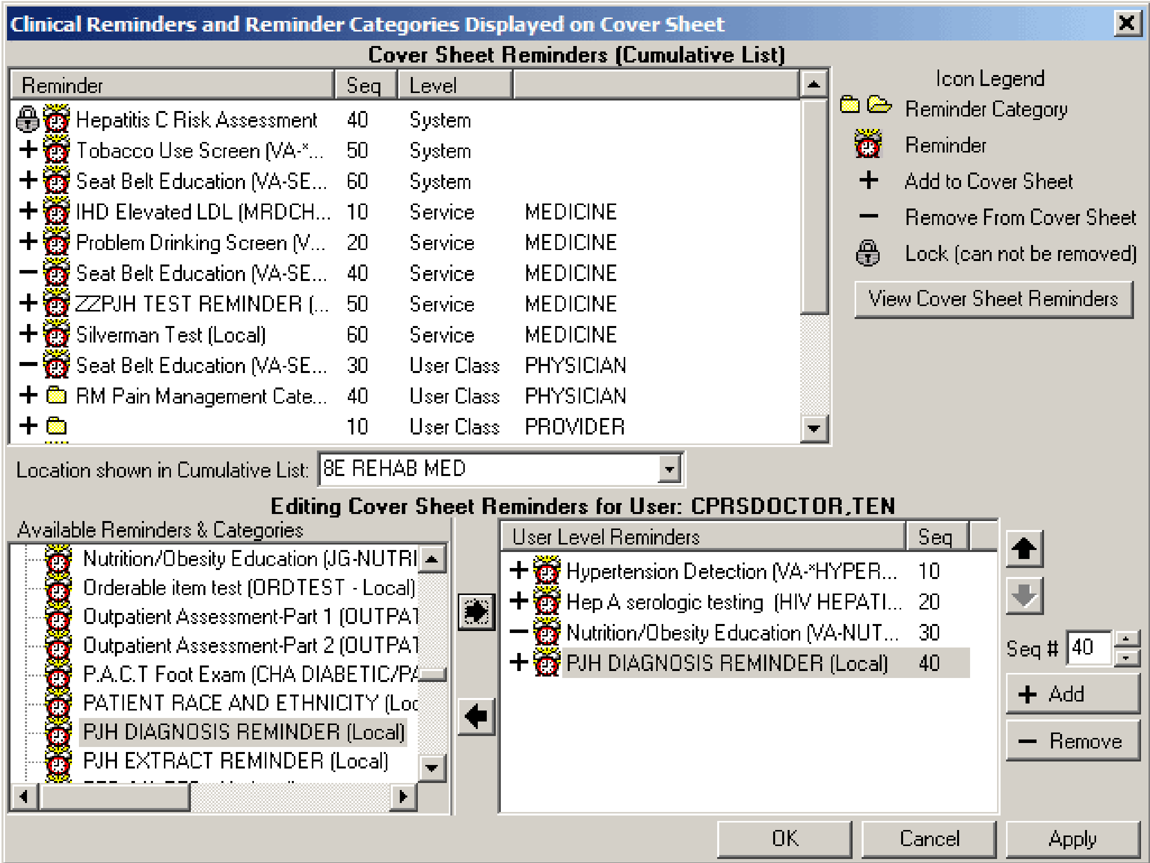
Clinical Reminders on Cover Sheet dialog

Clinical Reminders and Reminder Categories Displayed on Cover Sheet

This advanced dialog displays reminders in a way that allows the user to better manage the reminders that are displayed on the Cover Sheet. The dialog consists mainly of three large list fields. The “Cover Sheet Reminders (Cumulative List)” field displays selected information on the Reminders that will be displayed on the Cover Sheet. The “Available Reminders & Categories” field lists all available reminders and serves as a selection list. The “User Level Reminders” field displays the reminders that you have added to or removed from the cumulative list.

You may sort the reminders in the “Cover Sheet Reminders (Cumulative List)” field by clicking any of the column headers. Click the **Seq** (Sequence) column header to view the reminders in the order in which they will be displayed on your Cover Sheet.

An icon legend is displayed to the right of the “Cover Sheet Reminders (Cumulative List)” field. A folder icon represents a group of Reminders while a red alarm clock represents an individual Reminder. A Reminder with a plus sign in the first column has been added to the list while a Reminder with a minus sign in the first column has been removed from the list. The user cannot remove reminders with a padlock icon in the first column.



The Clinical Reminders and Reminder Categories Displayed on Cover Sheet dialog

Cover Sheet Reminders (Cumulative List)

The Level column of the “Cover Sheet Reminders (Cumulative List)” field displays the originating authority of the Reminder, which can include System, Division, Location, User Class, and User. Reminders on this list that display a small gray padlock icon at the beginning of the line cannot be removed. These Reminders are mandatory. The Seq (Sequence) column defines the order in which the Reminders will be displayed on the Cover Sheet. If there are two or more Reminders with the same sequence number, the Reminders will be listed by level (System, Division, Service, Location, User class, User).

Location shown in Cumulative List

Click this drop-down box and select a location. The Reminders assigned to that location appear on the Cumulative List.

Available Reminders & Categories

This field displays all of the Reminders and Categories available to the user. Notice that the reminder name is in parentheses after the print name. Categories are groups of related Reminders that can be added as a group. Individual reminders within a category can be removed from the User Level Reminders field. Highlight a Reminder or Category from the field and click the right arrow to add them to the User Level Reminders field.

User Level Reminders

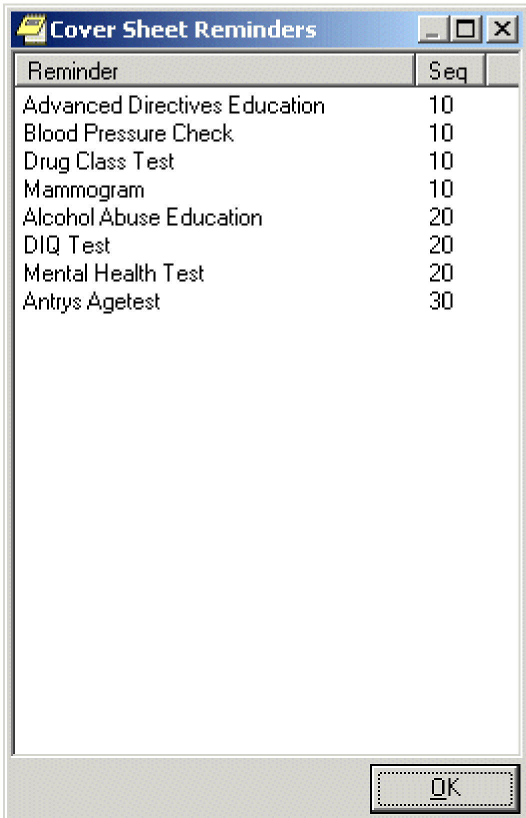
This field displays all of the Reminders selected by the user. To add a Reminder to your User Level Reminders, highlight the desired Reminder in the Available Reminders & Categories field and click the right arrow button. To delete a Reminder from your User Level Reminders field, highlight the Reminder in the User Level Reminders field and click the left arrow.

You may determine the order in which the Reminders will be displayed on the Cover Sheet by changing the Reminder's sequence number. For example, to place a Reminder at the top of the Reminders list, assign it a number less than 10. To change the order of User Level Reminders, highlight Reminders and click the up arrow or down arrow until the desired order is achieved.

You may remove any or all non-mandatory Reminders assigned at any level by adding the Reminder to your User Level and then clicking the **Remove** button.

Cover Sheet Reminders

Once you have the cumulative list, as you want it, click **View Cover Sheet Reminders** to view how the reminders will be displayed on your Cover Sheet for the specified locations.



The Cover Sheet Reminders dialog

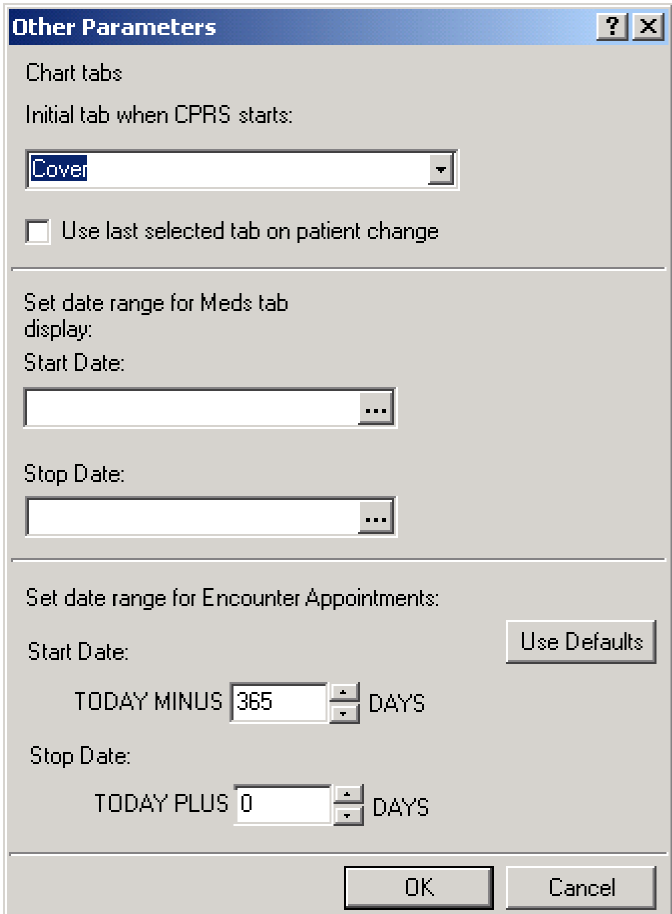
Once you have made all of the desired changes to the Reminders that will be displayed on the Cover Sheet, click **OK.**

Other Parameters…

To set the initial chart tab, Meds tab date range, or Encounter date range preferences click **Other Parameters**.

Chart Tabs

Click the drop-down field and select the chart tab with which CPRS should open. Click the check box if you want CPRS to remain on the last selected tab when you change patients.



The Other Parameters dialog

Note: For this change to take effect, you must exit CPRS and log back in.

Meds Tab Date Ranges

1. Enter a start date by doing one of the following:
   - Typing a date (e.g. 6/21/01 or June 21, 2001).
   - Typing a date formula (e.g. t-200).
   - Pressing the ... button to bring up a calendar and select a date.

2. Enter a stop date by doing one of the following:
   - Typing a date (e.g. 6/21/01 or June 21, 2001).
   - Typing a date formula (e.g. t-200).
   - Pressing the ... button to bring up a calendar and select a date.

3. When you have entered the dates, go to another option on this dialog or select OK.

Encounter Appointments Date Range

This option enables users to set the date range for Encounter appointments that CPRS displays on the Cover Sheet and the Encounter form. The two values are based on today's date and represent how many days in the past and how many days in the future the user may set for CPRS to display appointments.

To set these values, use the following steps:

1. In the Start Date field, type or use the arrows to select a number of days in the past CPRS should display appointments.

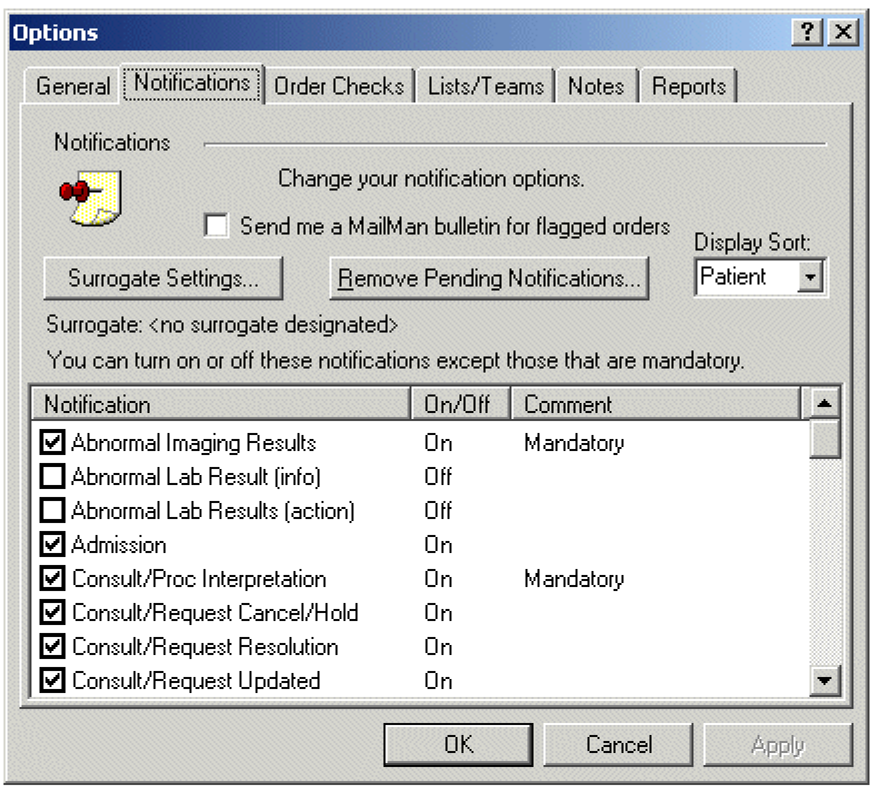
2. In the Stop Date field, type or use the arrows to select a number of days in the future CPRS should display appointments.

   Note: Your site can set a parameter to give you a warning if you select an appointment too far in the future. CPRS will display a warning to let you know that you may be going against local policy. This message is just a warning and you may proceed.

3. When you have entered the dates, go to another option on this dialog or select **OK**.

Notifications Tab

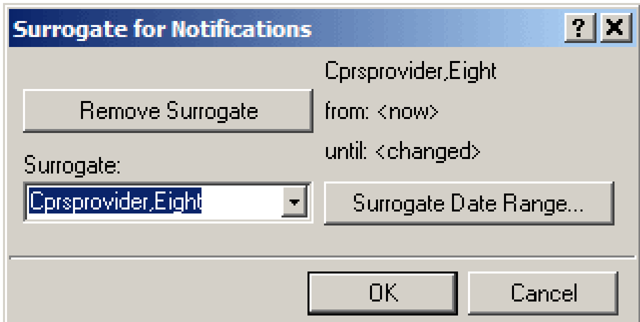
This tab allows you to change your notification options. Click the check box if you wish to have MailMan send you a bulletin for flagged orders.



The Notifications tab

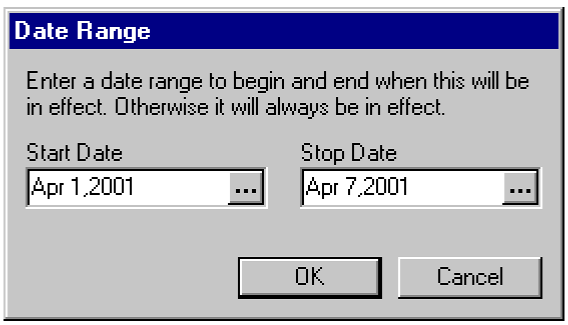
Surrogate Settings…

To set a surrogate, click **Surrogate Settings…** From the Surrogate for Notifications dialog, select a surrogate from the drop-down list. When saved, the surrogate information is displayed on the Notifications tab.



The Surrogate for Notifications dialog

To set a surrogate date range, click **Surrogate Date Range…** From the Date Range dialog, click the ... button and select a start date and a stop date. You may also select a start time and a stop time for the surrogate. When saved, the surrogate date range information is displayed on the Surrogate for Notifications dialog.



The Date Range dialog

Remove Pending Notifications…

Click the **Remove Pending Notifications** button and then on **Yes** on the Warning dialog to clear all of your current pending notifications. This button is enabled only if you are authorized to use it.

Display Sort

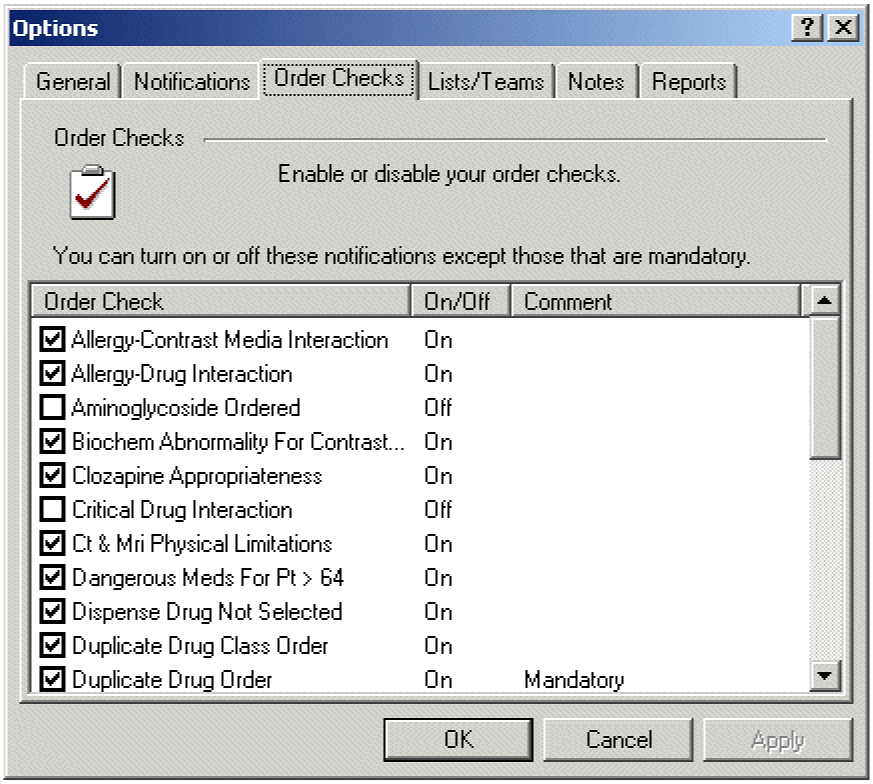
Click the **Display Sort** drop-down field to select the sort method for your notifications. Choices include Patient, Type, and Urgency.

Notifications list

Click the check box next to any notification to enable or disable it. Notifications with "Mandatory" in the Comment column cannot be turned off or disabled. Click the heading to sort notifications so that you can see which are turned on and which are turned off.

Order Checks Tab

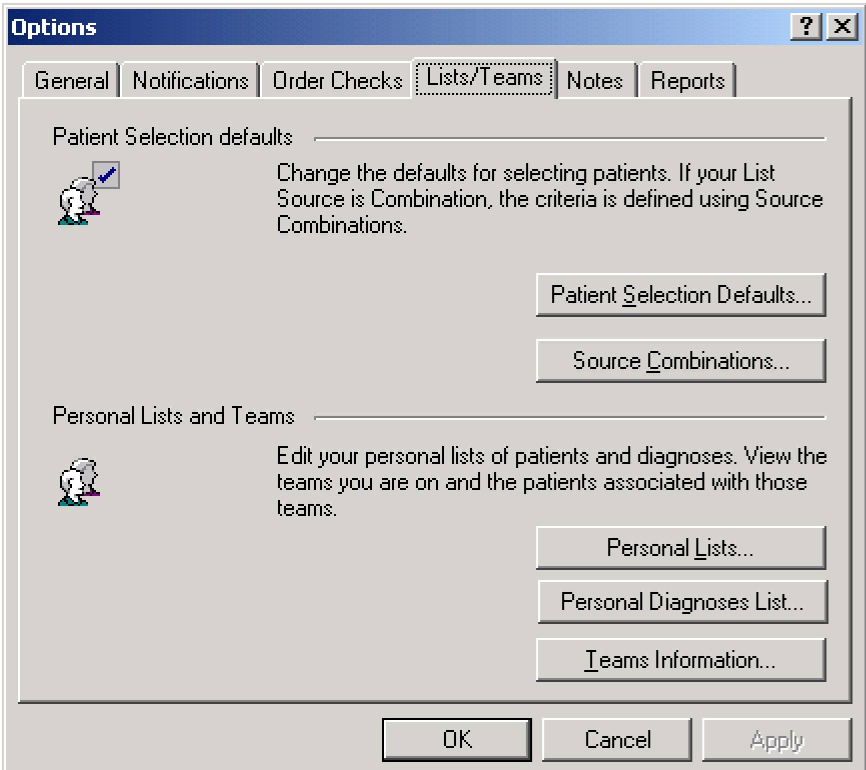
Click the check box next to any order check to enable or disable it. Order checks with "Mandatory" in the Comment column cannot be turned off or disabled. Click the heading to sort order checks so that you can see which are turned on and which are turned off.



This dialog indicates that the Duplicate Drug Order order check is mandatory and cannot be turned off.

Lists/Teams Tab

The Lists/Teams tab allows you to set defaults for selecting patients. It also contains your personal lists and the teams of which you are a member.



The Lists/Teams tab

Patient Selection Defaults…

Click **Patient Selection Defaults…** to change your defaults for selecting patients. Click a radio button in the List Source group. If you select Combination, you will be able to select from more than one source. After selecting a list source, click the appropriate drop-down button (or buttons if Combination is selected) and select the criteria for that source. If you select Clinic or if Clinic is one of the sources in your combination of sources, you will need to select a clinic for each applicable day of the week. If you do not work in any clinic on a particular day, leave the field for that day empty.

Click a radio button in the Sort Order group to determine the sort order for the patients. If an item is dimmed, it is not available with the list source(s) you have selected.

To display patients who have clinic appointments within a specific date range, click the selection buttons. The Start and Stop fields denote the number of days before or after today that appointments should be displayed.

The defaults that are set here are used when you select patients from the Patient Selection dialog in the CPRS chart. Therefore, if you choose Ward, it will display the patients for the ward you have set as your default and if you choose Clinic, it will display the clinic patients for that day.

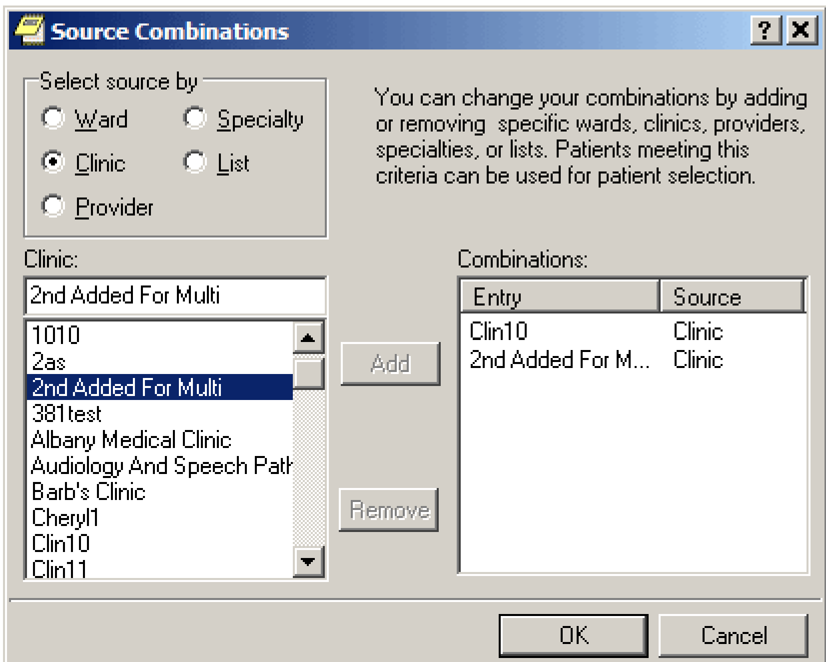
Source Combinations…

Click **Source Combinations…** to edit or create a list of sources from which your patients can be selected. You can change you combinations by adding or removing specific wards, clinics, providers, specialties or lists.

To create a source combination:

1. Click a radio button in the "Select source by" group.
2. Click an entry in the selection field below the "Select source by" group.
3. Click **Add**.
4. Repeat steps 1 through 3 for each desired source.
5. When all desired entries are in the Combinations field, click **OK**.

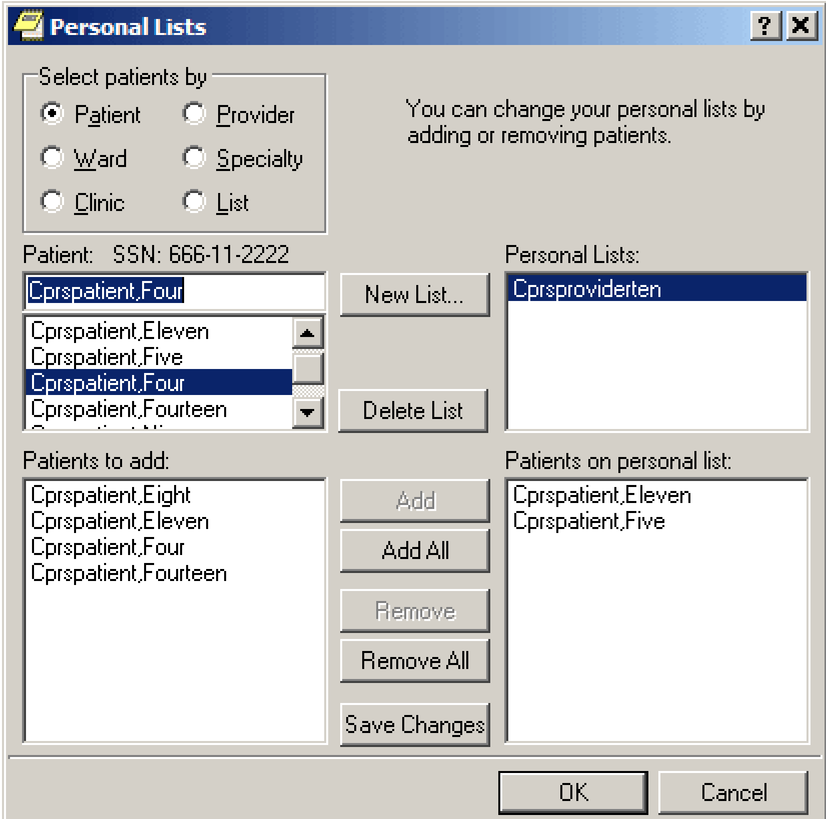
You can create only one combination list. The Combination list can be set as your default using the Patient Selection dialog.



The Source Combinations dialog

Personal Lists…

This option allows you to edit your personal lists of patients or combinations of wards, clinics, providers, specialties, or lists.

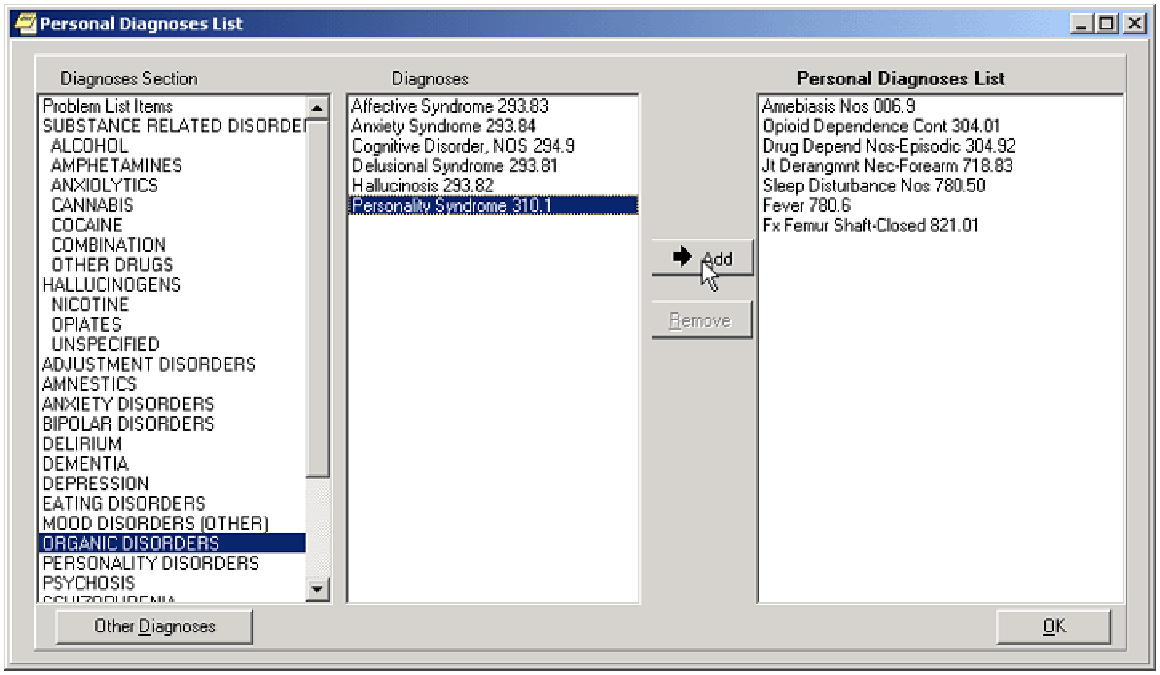


The Personal Lists dialog allows you to create a personalized patient list.

Click **Personal Lists...** to edit or create list of patients. To create a list, click **New List...** and type in a name for your list. Click a radio button in “Select patients by” group to select a method for defining patients on your list. The selection box below the “Select patients by” group lists the available choices for the selection method. The Patients to add field lists all of the patients that can be added from the particular selection method. With the desired patients in the Patients to add field, click Add (which adds the highlighted patient or patients) or Add All to copy the patients to Patients on personal list. Click **Save Changes** if you plan to make other changes on the Personal List dialog such as creating one or more additional Personal Lists. Click **OK** when you have finished making all desired changes and additions to this dialog.

Personal Diagnosis List…

This option enables users to create and maintain a Personal Diagnosis List that displays as one option in the Assign Diagnosis to Order(s) dialog used with Clinical Indicators Data Capture (CIDC) features to assign a diagnosis to specific kinds of orders.



The Personal Diagnosis List dialog enables users to choose diagnoses from the patient's Problem List entries, nationally defined encounter forms, and the Lexicon and add them to a personal diagnosis list for quicker entry of CIDC information.

To create or edit a Personal Diagnoses List, use the following steps:

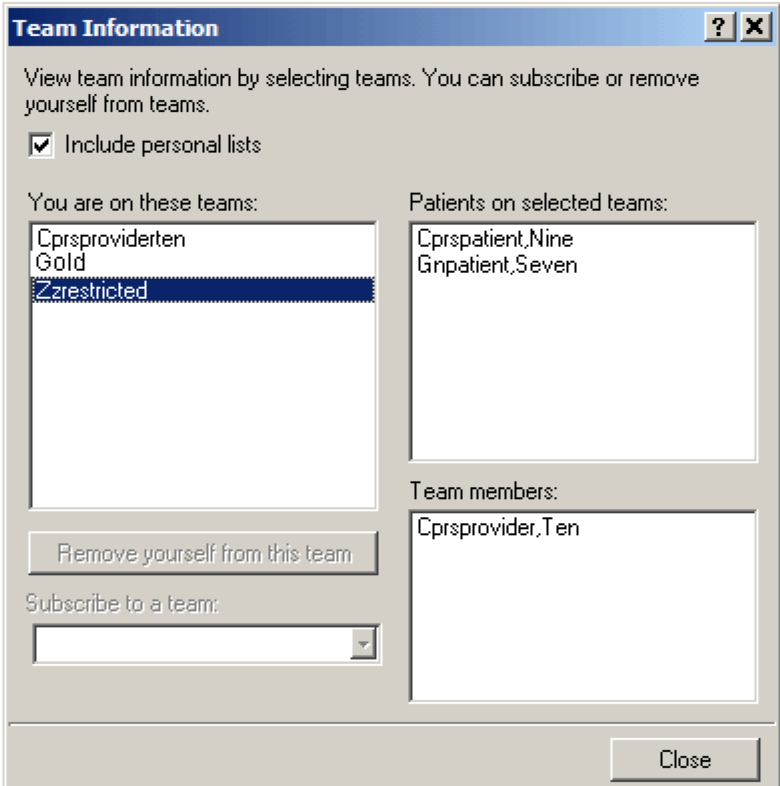
1. Bring up the Options dialog by choosing **Tools | Options…**.
2. Select the **Lists/Teams** tab by either clicking on it or pressing Ctrl + Tab until that tab is selected.
3. Bring up the Personal Diagnoses List dialog by either clicking **Personal Diagnoses List…** or tabbing to that selection and pressing **Space**.
4. To add diagnoses to your personal list using available sources other than the Lexicon, select a category (Problem List, national encounter form or today's Orders) from the Diagnoses Section pane, highlight one or more diagnoses, and click **Add** or tab to that button and press **Space**. Repeat until you have the entries you want in your personal list.

   Or
   To add diagnoses to your personal list using the Lexicon, click **Other diagnoses…** or tab to that button and press **Space**, type some letters that will help you find the appropriate diagnosis, and click **Search** or tab to Search and press **Space**. When you find the diagnosis, select it and press OK. Repeat until you have the entries you want in your personal list.

5. To remove an unwanted item from your personal list, highlight the item (which will make the Remove button display) and click **Remove** or tab to that button and press **Space**.
6. When you have the items you want on your personal list, click **OK** or tab to that button and press **Space**.

Teams Information…

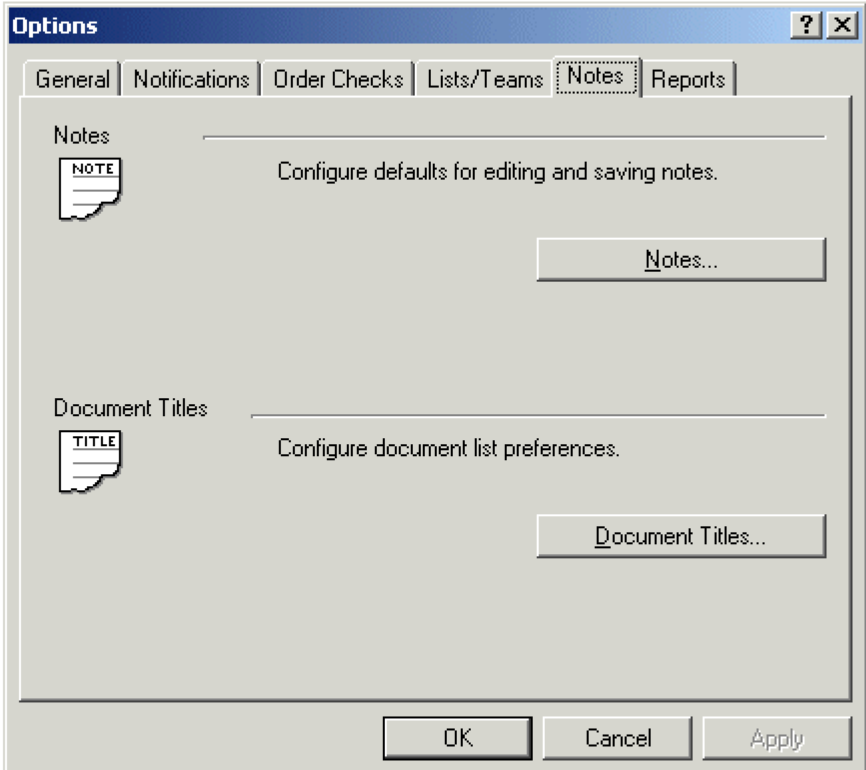
This option allows you to view the teams you are on and the patients associated with those teams.



The Team Information dialog

Click a team to view the patients associated with it and other team members. Click the check box to include your personal lists. Click **Remove yourself from this team** to remove yourself from the highlighted team. Click the drop-down button on the “Subscribe to a team” field and select a team to which you wish to be added. You can only subscribe yourself to or remove yourself from teams that have been defined as "subscribable."

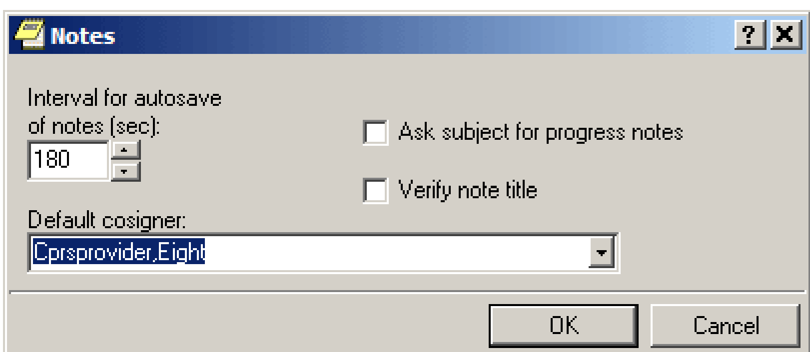
Notes Tab



The Notes tab

Notes…

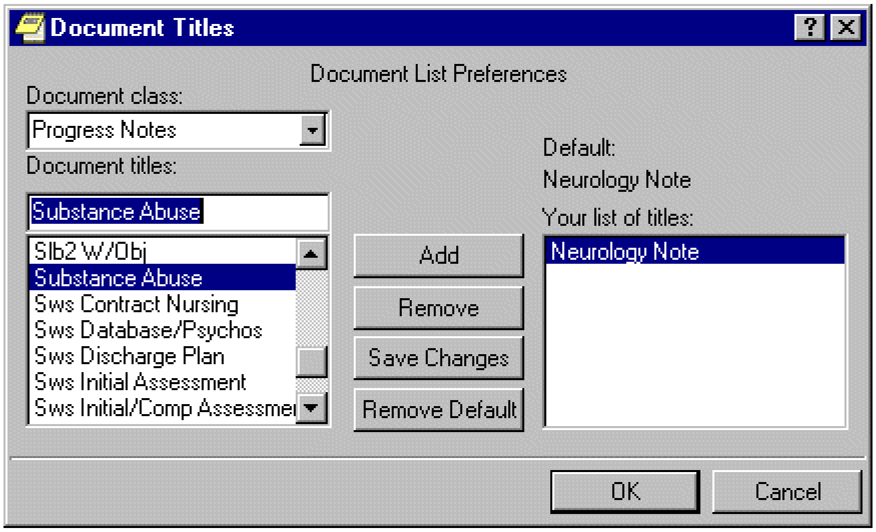
This option on the Notes tab allows you to configure defaults for editing and saving notes. Click the selection arrows to change the number of seconds between auto save intervals. You may also assign a default cosigner for notes by clicking the drop-down button and selecting a provider. You may also click either of the two check boxes, if you wish to be prompted for a subject for progress notes and if you wish to verify note titles.



The Notes dialog

Document Titles…

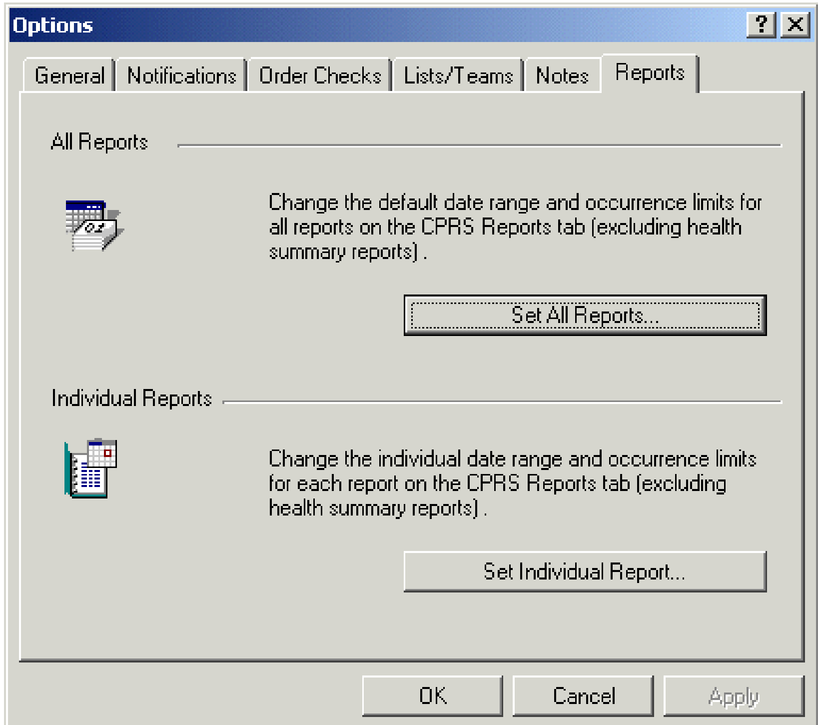
You may select a personal list of document titles to be displayed for several different types of documents. Click the drop-down button on the Document class field and select the class of document for which you would like to create a list. When you have selected a document class, the Document titles field is automatically populated with all available choices. Highlight one and click **Add**. Hold down the Control key to select more than one title at a time. To select a title from your list as your default, highlight it and click **Set as Default.** Click **Save Changes** if you will be making more changes on this dialog before you click **OK**.



The Document Titles dialog

Reports Tab

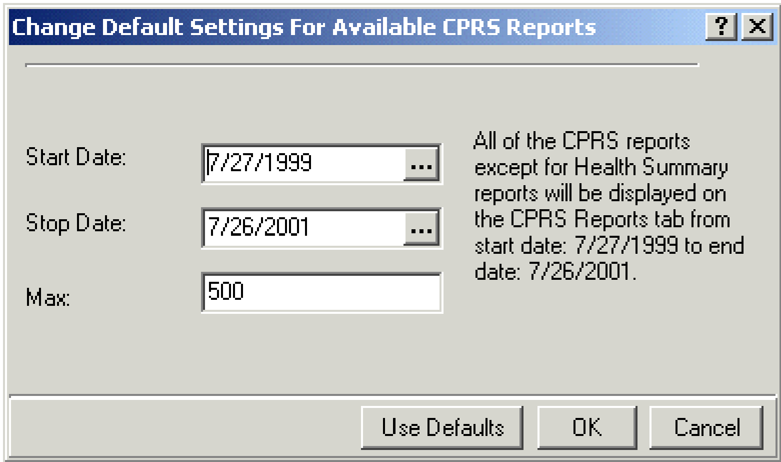
This tab allows you to set the date ranges and the maximum number of occurrences for CPRS reports. You can change the settings for all reports or for individual reports.



The Reports tab

Set All Reports …

This option allows you to set a start date, a stop date, and a maximum number of occurrences for all CPRS reports. After you press the **Set All Reports…** button the “Change Default Settings For Available CPRS Reports” dialog will appear.



The Change Default Setting For Available CPRS Reports dialog

When this dialog appears follow these steps:

1. Change the value in the Start Date and Stop Date fields by clicking in the appropriate field and by doing one of the following:

   a.) entering a date (e.g. 6/21/01 or June 21, 2001).

   b.) entering a date formula (e.g. t-200).

   c.) pressing the  button to bring up a calendar.

2. After you have entered a start and stop date, you can change the maximum number of occurrences (if necessary) by clicking in the **Max** field.

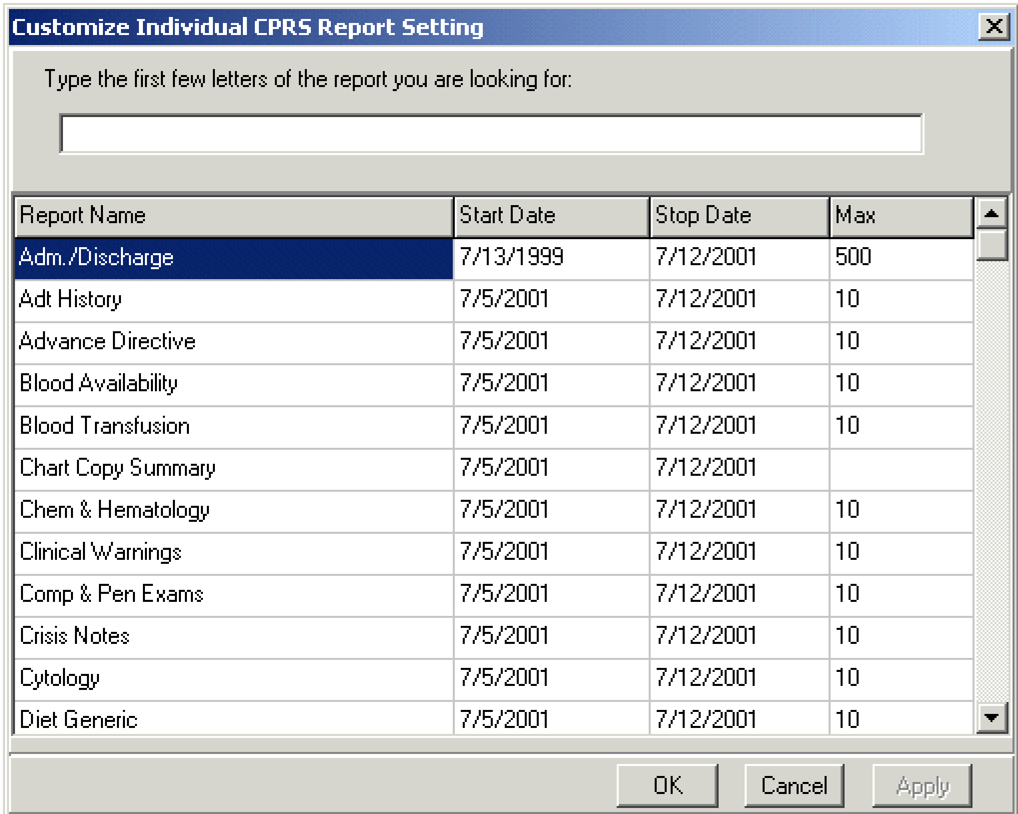
3. Click **OK**.

4. A confirmation dialog box will appear. Click **Yes** to confirm and save your changes.

5. Click **OK** to close the Options dialog box.

Set Individual Report …

This option allows you to set a start date, a stop date, and a maximum number of occurrences for individual CPRS reports. After you press the **Set Individual Report…** button the “Customize Individual CPRS Report Setting” dialog box will appear.



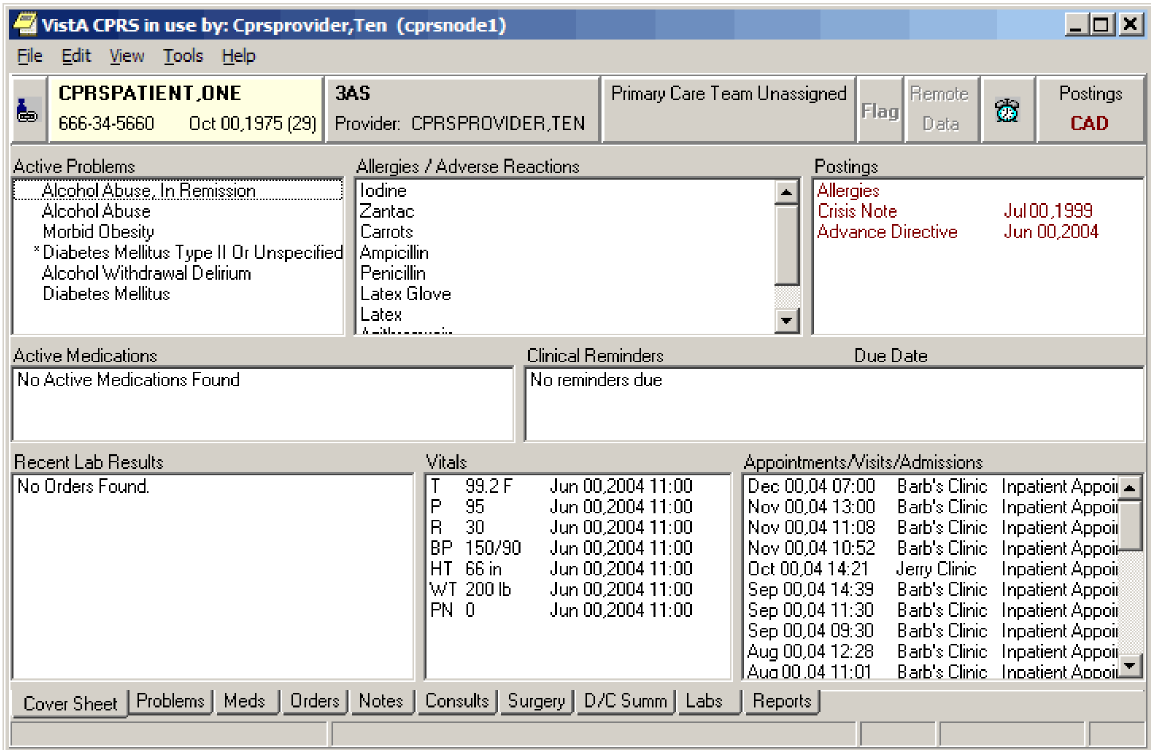
You can customize individual CPRS reports from this screen.

When this dialog appears follow these steps:

1. Place the cursor in the “Type the first few letters of the report you are looking for:” field (located at the top of the dialog box) and type the name of the report that you would like to change
   -or-
   use the scroll bars to find the report.
2. Change the value in the Start Date and/or Stop Date field by clicking in the appropriate column and doing one of the following:
   a.) entering a date (e.g. 6/21/01 or June 21, 2001).
   b.) entering a date formula (e.g. t-200).
   c.) pressing the ... button to bring up a calendar.
3. After you have entered a start and stop date, you can change the maximum number of occurrences (if necessary) by clicking in the Max field.
4. Click Apply to save your changes
   -or-
   click OK to save your changes and close the dialog box.
5. Click OK to close the “Options” dialog box.

Cover Sheet

The Cover Sheet is the first screen you see after opening a patient record (unless the site or user defines another tab as the initial screen). The Cover Sheet displays an overview of a patient's condition and history. It shows active problems, allergies and postings, active medications, clinical reminders, lab results, vitals, and a list of appointments or visits.



The CPRS Cover Sheet displays a variety of information about a patient.

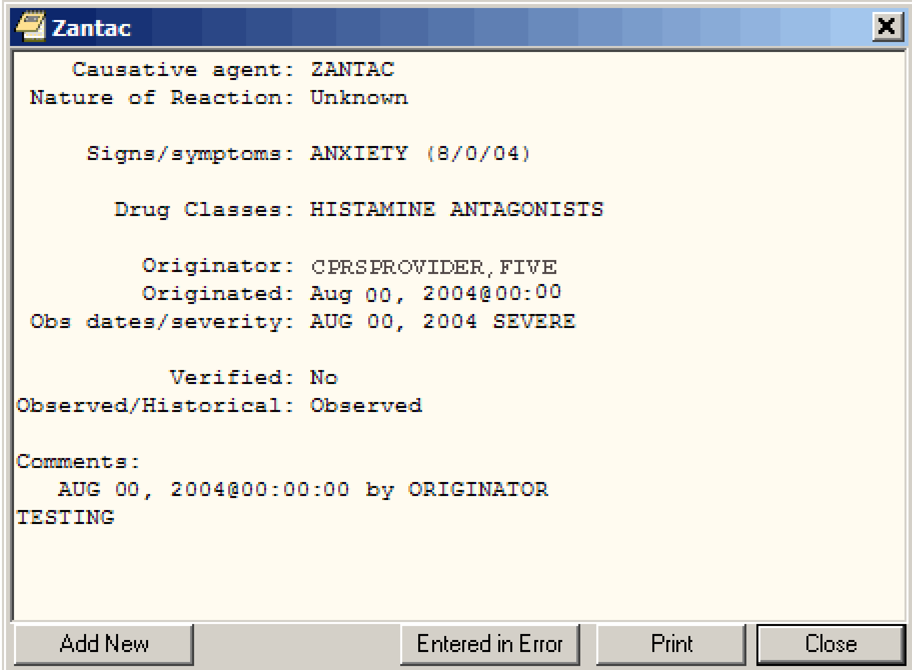
You can quickly review the active problems (asterisks identify acute problems, and dollar signs identify unverified problems. Service Connected conditions are indicated by abbreviations in parentheses if Problem List patch GMPL*2.0*26 is installed. The pound symbol "#" shows problems that have inactive codes, which users can update using the Change action on the problems tab). Scroll bars beside a box mean that more information is available if you scroll up or down.

The File menu contains three menu items that you will use often:

- **Select New Patient**
  This menu item opens the Patient Selection dialog.
- **Update/Provider/Location**
  This menu item opens the Provider & Location for Current Activities dialog. This dialog enables you to change the clinician or location associated with an encounter.
- **Review/Sign Changes**
  This menu item enables you to view the orders you have placed that require an electronic signature, select the orders you want to sign at this time, and enter your electronic signature code (if you are an authorized signer).

Click any item to get more detailed information. For example, you can click the **Patient Identification** box (or button) to get more information about the patient. You can click a

Visit to see details. For example, a patient could have Zantac listed in the Allergies/Adverse Reactions dialog. By clicking on it, you would see the following detail window.



The Detail window displays additional information about an allergy.

Click a tab at the bottom of the screen to go to that section of the patient chart.

The CPRS tabs allow you to easily navigate to another area of the patient chart.

Navigating a Patient Chart

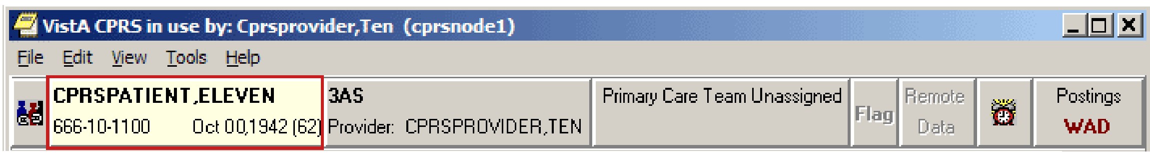
The CPRS Windows interface mimics the paper chart of a patient’s record, but CPRS makes locating information easier. With the Patient Selection screen, you can quickly bring up a record for any patient on the system. The Cover Sheet summarizes important information about the patient. Along the bottom of this dialog or page are a number of tabs that will quickly take you to the part of the chart you need to see. For example, you might want to see progress motes, Problems, Summaries, Medications, Lab Tests, or place new orders:

To go to a different part of the patient chart, click the appropriate tab at the bottom of the chart or choose **View | Chart Tab**, and then select the desired tab.

Additional Patient Information

You can obtain additional patient information by clicking the **Patient ID** box located on the upper left of the dialog. You can access this button from any chart tab.

The button shows the patient's name (in bold), Social Security number, date of birth, and age (as shown in the graphic below). If you click the button, CPRS brings up a window containing additional information such as the patient's address, the attending physician, and/or the date of admittance.



Information about a patient is displayed in the Patient ID box.

To obtain additional information about a patient, follow these steps:

1. Click the **Patient ID** box.

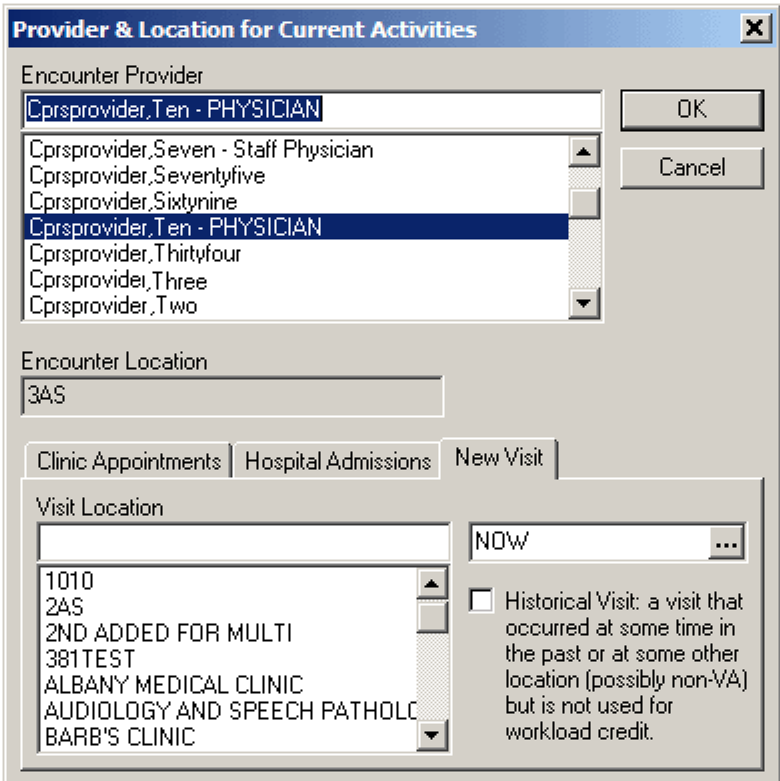
   The Patient Inquiry dialog will appear.
2. To print a copy of the Patient Inquiry dialog, click **Print**.
3. To close the Patient Inquiry window and return to the Cover Sheet, click **Close**.
   -or-
   select a new patient by clicking **Select New Patient**.

```
Patient Inquiry

CPRSPATIENT,TEN                         666-55-4678            APR 00,1951
===============================================================================
               COORDINATING MASTER OF RECORD: SUPPORT ISC
 Address: 123 ANY ST.                   Temporary: NO TEMPORARY ADDRESS
          MYTOWN, AZ 66006
  County: MARICOPA (013)                  From/To: NOT APPLICABLE
   Phone: UNSPECIFIED                       Phone: NOT APPLICABLE
  Office: UNSPECIFIED
Bad Addr:

 Confidential Address:                      Confidential Address Categories:
         NO CONFIDENTIAL ADDRESS
 From/To: NOT APPLICABLE

Primary Eligibility: SC LESS THAN 50% (VERIFIED)
Other Eligibilities:
Medication Copayment Exemption Status: NON-EXEMPT
There is insufficient income data on file for the prior year.
Last test date: JUN 24, 2004

Status      : PATIENT HAS NO INPATIENT OR LODGER ACTIVITY IN THE COMPUTER

Currently enrolled in ALBANY MEDICAL CLINIC,

Future Appointments: NONE

Remarks:

Date of Death Information
     Date of Death:
     Date of Death Source of Notification:
     Date of Death Last Updated Date/Time:
     Date of Death Last Edited By:


Health Insurance Information:
   Insurance   COB Subscriber ID     Group       Holder  Effective  Expires
   ===========================================================================
    No Insurance Information


Service Connection/Rated Disabilities:

         SC Percent: 35%
 Rated Disabilities: ARTHRITIS, STREPTOCOCCIC (35%-SC)
                     PSYCHOSIS (30%-SC)

Select New Patient                                                     Print
```

You can retrieve additional information about a patient by clicking the Patient ID button.

Entering or Changing Encounter Information

In order to receive workload credit, you must enter encounter information before you can enter orders, write progress notes, complete a consult, write a discharge summary, or perform other activities.



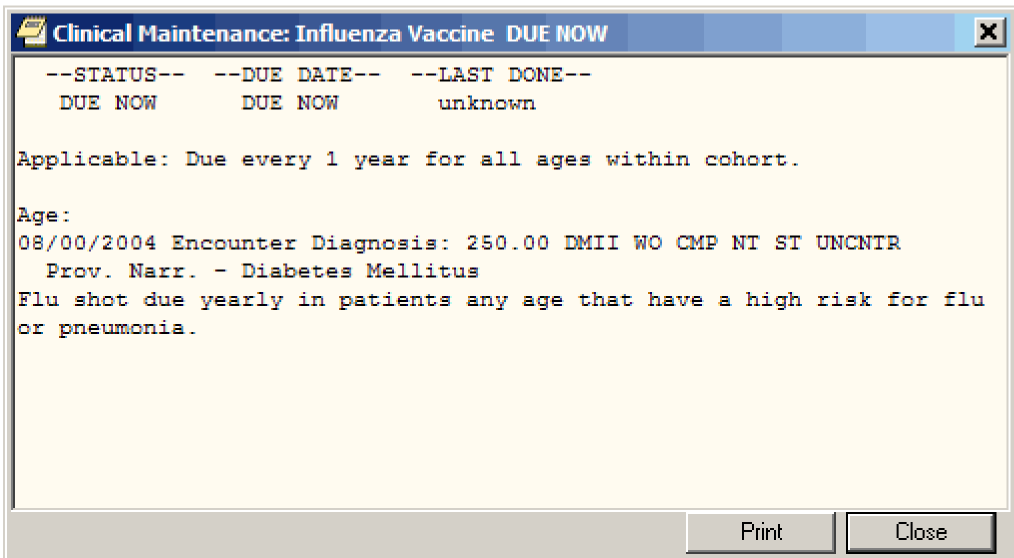
You must complete the Provider & Location for Current Activities dialog before you can perform certain activities.

To enter or change the Encounter provider, follow the steps below:

1. If you are already in the Provider / Encounter dialog skip to step 2. Otherwise, from any chart tab, click the **Provider / Encounter** box located in the top center portion of the dialog.
2. Locate and click the provider for this encounter in the list box.
3. Click the tab of the correct encounter category for this visit:
   - Clinic Appointments
   - Hospital Admissions
   - New Visit
4. Select a location for the visit from the choices in the list box.
5. If you selected a Clinic Appointment or Hospital Admission, skip to step 7. If you are creating a New Visit, enter the date and time of the visit (the default is NOW).
6. Click a visit category from the available options (such as, Historical) and click **OK**.
7. When you have the correct provider and location, click **OK**.

Viewing Clinical Reminders

From the Cover Sheet, you can double-click any of the Clinical Reminders listed to obtain a description of the reminder and an explanation of why the reminder applies to the current patient. To process reminders, you must go to the Notes tab.



You can view a description of a reminder from the Cover Sheet.

Viewing and Entering Vitals

CPRS displays the patient’s most recent vitals in the vitals area of the Cover Sheet (the vitals area is in the lower center).

To view the selected patient’s vitals history, use these steps:

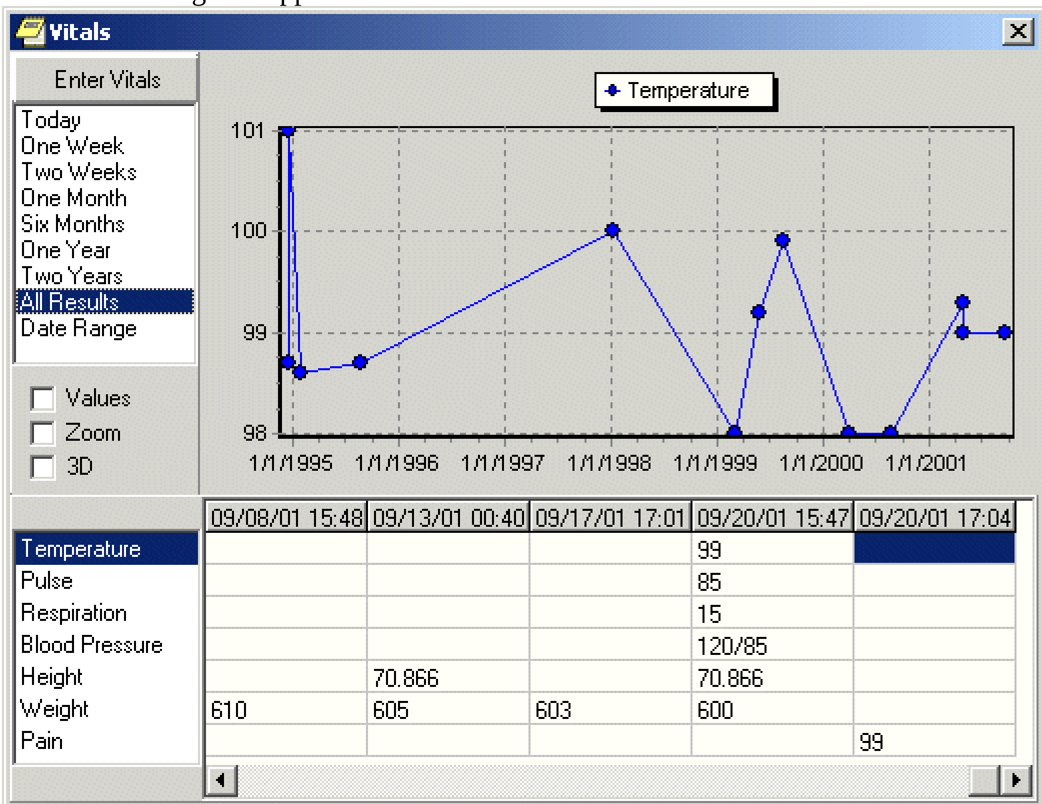
1. Click a value in the Cover Sheet’s Vitals area.

   The Vitals dialog appears.
2. In the dialog’s upper left corner, click the time period you want to view (**Today, All Results, Date Range**, etc.).
3. Click the vital category you want to view (Temperature, Pulse, Respiration, Blood Pressure, Height, Weight, or Pain).
4. Adjust the graph features as desired:
   - Click **Zoom** and then enlarge a part of the graph by clicking and dragging from above and left of the area to below and to the right of it.
   - Click **3D** to make the graph into a simple three-dimensional representation.
   - Click **Values** to show the numerical value of each graph point.

To enter a patient's vitals information, follow these steps:

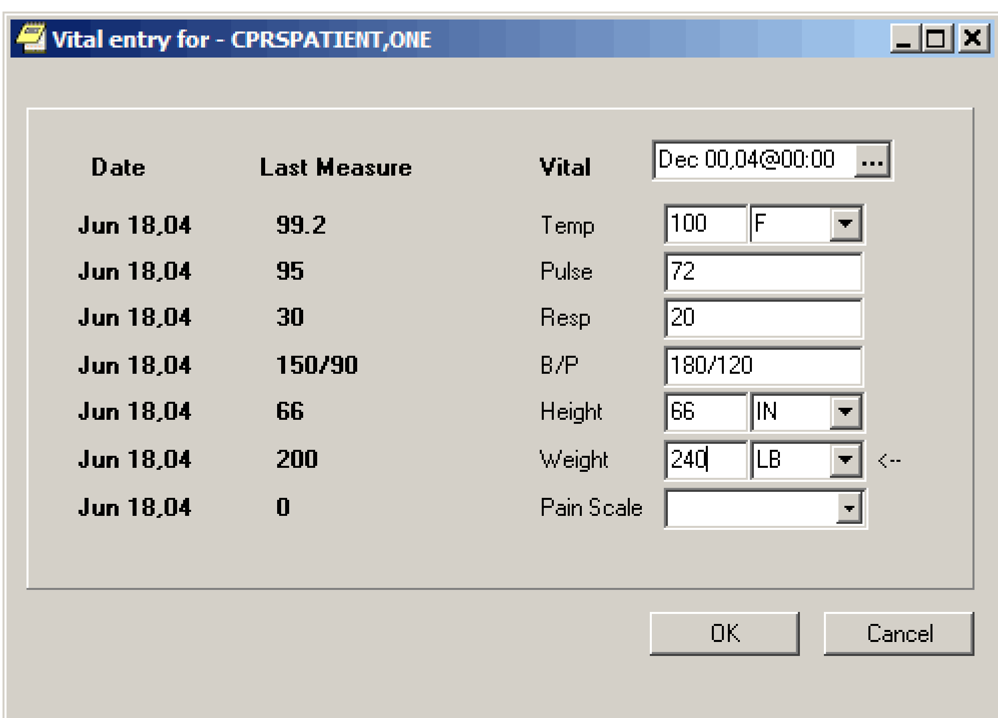
1. Click a value in the Cover Sheet's Vitals area.

   The Vitals dialog will appear.



The Vitals Dialog

2. Click the Enter Vitals button in the upper left corner of the dialog. The Vitals entry for - [Patient Name} dialog appears.



The Vital entry dialog for Cprspatient, One.

Note: If the visit has not been defined, the Visit Selection dialog appears. You must choose either a previous visit or define a new visit to enter the vitals.

Note: If encounter information has not been entered, the encounter information dialog will appear before the Vitals entry for - [Patient Name} dialog. You must complete the encounter information dialog before proceeding.

3. Enter the desired information.

   Note: You can change the height and weight units by clicking on the drop-down list and selecting the units you want.

4. Click **OK**.
5. Close the Vitals dialog by clicking the close box **(X)** in the dialog's upper right corner.

Assessing, Entering, and Reviewing Allergies/Adverse Reactions

In the **Allergies/Adverse Reactions** pane on the **Cover Sheet** tab, CPRS displays a list of causative agents associated with patients' allergies or adverse reactions. If patients have causative agents listed in this pane, CPRS also displays the word *Allergies* in the **Postings** pane and the letter **A** (for allergies) on the **Postings** button. To view more information about allergies or adverse reactions associated with the causative agents listed in the **Allergies/Adverse Reactions** pane, simply click on the causative agent in which you are interested. CPRS then displays a comprehensive listing of the details associated with this causative agent.

You can obtain less comprehensive information about allergies and adverse reactions by clicking the word *Allergies* in the **Postings** pane. When you do this, CPRS displays information about the causative agents, severity, and signs/symptoms associated with patients' allergies and adverse reactions.

From the **Cover Sheet** tab, you can also:

- Enter new allergies
- Mark existing allergies or adverse reactions as having been entered in error
- Enter no-known-allergies (NKA) assessments

Entering Allergies

You can enter a new allergy or adverse reaction from the **Cover Sheet** tab in either of two ways:

- Right-click anywhere within the **Allergies/Adverse Reactions** pane.
- Click to display more information about a causative agent listed in the **Allergies/Adverse Reactions** pane.

Method One

Take the following steps to enter new allergies using the first of the two methods mentioned above:

1. Move your mouse arrow to a location anywhere within the **Allergies/Adverse Reactions** pane.
2. Right click to display a pop-up menu.
3. From this menu, select **Enter new allergy**. CPRS displays the **Allergy Reactant Lookup** dialog.
4. In the **Enter causative agent for Allergy or Adverse Drug Reaction** field, type the first three characters (minimum) of the causative agent's name.
5. Click **Search.** CPRS displays a list of possible matches.
6. If the causative agent you typed does not match any of the agents currently available for your site, CPRS displays the **Causative Agent Not On File** dialog, from which you can select one of the following three options:

Note: The patient's chart will not be updated unless you choose a causative agent that is on file.

a. **Yes**: Use this option to request that the causative agent be added to your site's ALLERGIES file. When you click **Yes**, CPRS displays the **Enter Optional Comments** dialog, which enables you to type additional comments (optional), such as the signs or symptoms that occurred as a result of contact with this causative agent, or whether you observed these symptoms firsthand. After you type your comments, click **Continue**. CPRS then sends to members of your site's GMRA Request New Reactant mail group a message that includes the following items:

   - The causative agent you attempted to enter
   - The name of the patient for whom you attempted to make this entry
   - Your name, title, and contact information
   - Your comments (if any)

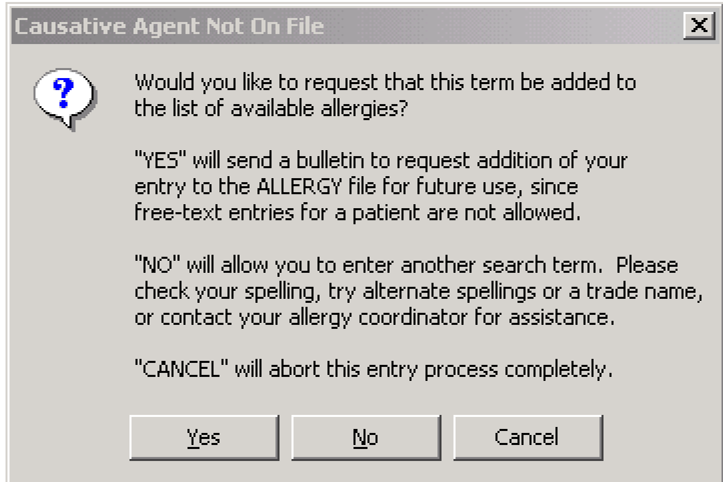
   Members of your site's GMRA Request New Reactant mail group will review this message and, if appropriate, add the causative agent to your site's ALLERGIES file.

   Note: If your site's IRM staff has not yet added members to your site's GMRA Request New Reactant mail group, CPRS displays the following message:

CPRS displays this message if your IRM staff has not yet added members to the GMRA Request New Reactant mail group.

b. **No**: Clicking **No** enables you to try an alternate spelling or trade name for your causative agent, or to type another causative agent.

c. **Cancel**: Use this option if you want to cancel your allergy entry.

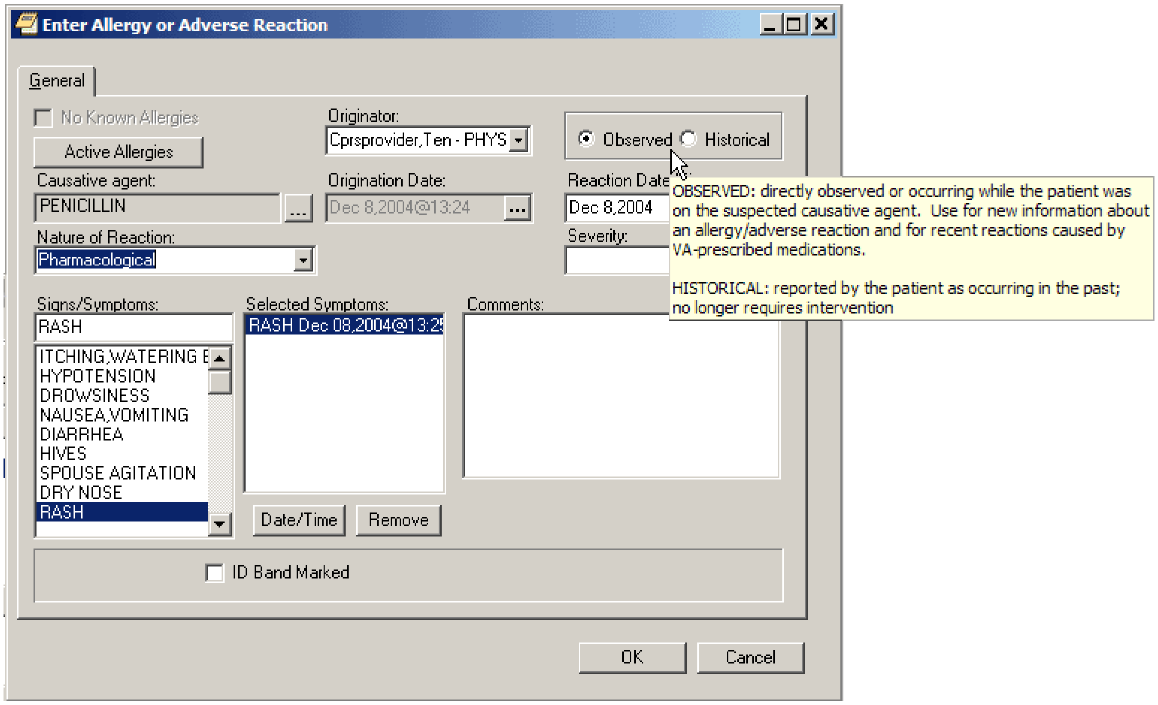


The **Causative Agent Not On File** dialog.

7. If the causative agent you typed matches an agent that is currently available for your site, select the agent. (Click **+** to expand a heading.)

Note: With CPRS GUI 24 or later, you may not add free-text causative agents. If you select an item under the "Add new free-text allergy" heading, CPRS displays the *Causative Agent Not On File* dialog. (See Step 6 above.)

8. Click **OK**. The **Enter Allergy or Adverse Reaction** dialog appears.



The Enter Allergy or Adverse Reaction dialog displaying a hover hint.

> **Note**: You can view a patient's current allergies or adverse reactions by clicking the **Active Allergies** button.

9. Using the **Originator** box, select an originator.
10. Use the **Observed** or **Historical** option button to indicate whether the entry is for an observed or historical allergy, respectively. (If you point your mouse at either of these option buttons, CPRS displays a hover hint that defines observed and historical.)

> **Note:** CPRS does not allow you to select future dates for observed allergy/adverse reaction entries.

> **Note:** When you select Observed for a drug reaction, CPRS generates a Progress Note. Once this note is signed by the user entering the allergy or by an administrative update user, the note will be viewable by all users.

11. Select the **Nature of Reaction** (**Allergy**, **Pharmacological**, or **Unknown**).

The Nature of Reaction can be Allergy, Pharmacologic, or Unknown. An allergic reaction occurs because the patient is sensitive to a causative agent, regardless of the amount the patient is exposed to. A pharmacologic (non-allergic) reaction occurs when the patient is sensitive to an agent under certain conditions, such as exposure to a large amount. Unknown is provided if you are not sure what Nature of Reaction (mechanism) to enter.

> **Note:** Allergies are a subset of adverse reactions. All allergies are adverse reactions, but not all adverse reactions are allergies.

12. If you are entering an observed allergy, use the **Reaction Date/Time** and **Severity** boxes to select a reaction date, time, and severity. (The **Severity** box is not visible for historical allergies. If the **Severity** box is visible, CPRS displays a **?** button at its side. If you click this button, CPRS displays text explaining severity selections.)
13. Using the **Signs/Symptoms** box, select one or more signs or symptoms. The signs and symptoms you select appear in the **Selected Symptoms** pane.
14. To associate a date and time with a symptom (optional), click to select the symptom in the **Selected Symptoms** pane.
15. Click the **Date/Time** button located below the **Selected Symptoms** pane. CPRS displays the **Select Date/Time** dialog, from which you can select the date and time that the symptom first appeared.

    Note: If you mistakenly enter a sign or symptom but have not yet accepted it by selecting OK, select the symptom in the **Selected Symptoms** pane and click the **Remove** button located beneath the pane.

16. Type comments for the allergy in the **Comments** box.
17. If you have marked the allergy or adverse reaction on the patient's identification (ID) band (or if you know that someone else has), select the **ID Band Marked** check box.

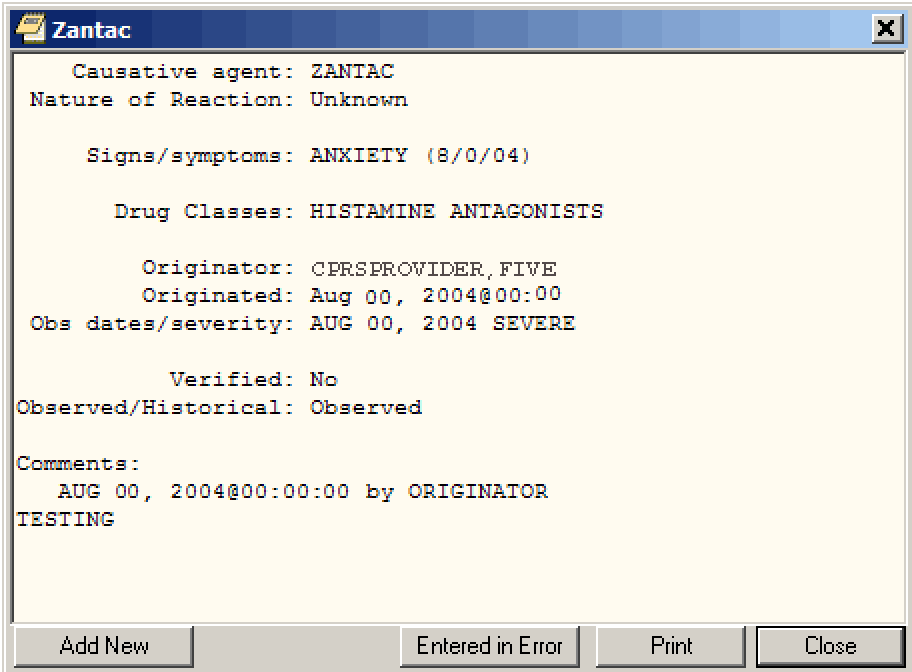
    Note: CPRS activates the **ID Band Marked** check box only for inpatients and then only if your site's IRM staff has set a parameter indicating that your site wants to track this information. Depending on whether your IRM staff has set related parameters, if you do *not* select activated **ID Band Marked** check box, the system may send a bulletin notifying a mail group that the patient's allergy or adverse reaction is not marked on his or her ID band.

18. Click **OK**. CPRS displays the newly entered causative agent in the **Allergies/Adverse Reactions** pane. If you click on the causative agent, CPRS displays all of the information you just entered about the associated allergy or adverse reaction. CPRS also displays the letter **A** (for allergies) on the **Postings** button and the word *Allergies* in the **Postings** pane. If you click the word *Allergies* in the **Postings** pane, CPRS displays selected information about all of the patient's active allergies and adverse reactions, including the allergy or adverse reaction you just entered.

Method Two

Take the following steps to enter a new allergy using the second of the two methods mentioned above:

1. Click to select a causative agent listed in the **Allergies/Adverse Reactions** pane. CPRS displays a dialog that includes details about the allergy or adverse reaction associated with the selected causative agent. The dialog also includes four buttons.



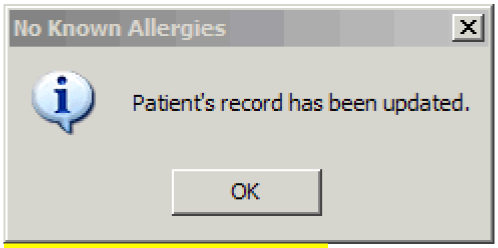
The causative agent dialog contains details about the allergy or adverse reaction associated with the selected causative agent. In addition, it includes four buttons.

2. Click the **Add New** button. CPRS displays the **Allergy Reactant Lookup** dialog.
3. Follow steps 4 through 18 of the instructions for entering allergies using the first method. CPRS displays the newly entered causative agent in the **Allergies/Adverse Reactions** pane. If you click on the causative agent, CPRS displays all of the information you just entered about the associated allergy or adverse reaction. CPRS also displays the letter **A** (for allergies) on the **Postings** button and the word *Allergies* in the **Postings** pane. If you click the word *Allergies* in the **Postings** pane, CPRS displays selected information about all of the patient's allergies or adverse reactions, including the allergy or adverse reaction you just entered.

Entering No-Known-Allergies Assessments

You can enter no-known-allergies (NKA) assessments for patients who have no active allergies by taking the following steps:

1. Right-click within the **Allergies/Adverse Reactions** pane.
2. From this menu, select **Mark patient as having No Known Allergies (NKA).** CPRS displays the **No Known Allergies** dialog.



The **No Known Allergies** dialog.

Note: CPRS activates **The Mark patient as having No Known Allergies (NKA)** menu selection only for patients who have no active allergies. When patients have active allergies, CPRS deactivates this selection.

3. Click **OK**.

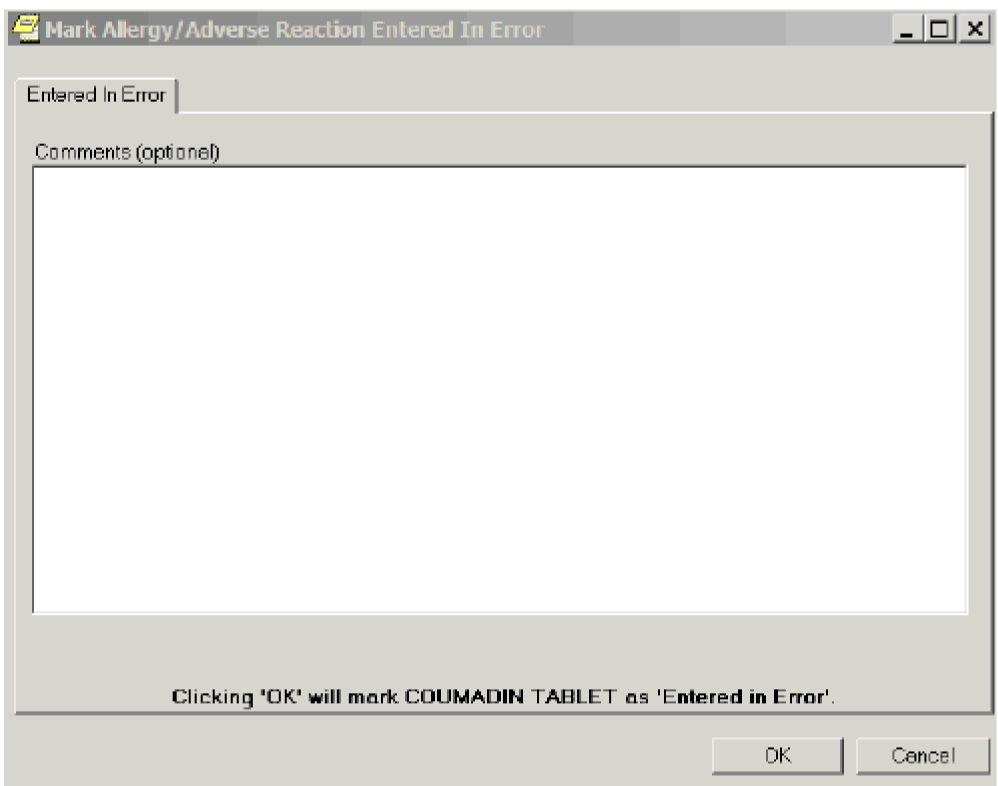
Marking Allergies as Entered in Error

CPRS offers two methods for marking allergies as having been entered in error:

Method One

Take the following steps to use the first method:

1. In the **Allergies/Adverse Reactions** pane, place your mouse pointer over an erroneously entered causative agent and right-click to display a menu.
2. From this menu, select **Mark selected allergy as entered in error**. CPRS displays the **Mark Allergy/Adverse Reaction Entered In Error** dialog.



The **Mark Allergy/Adverse Reaction Entered in Error** dialog.

3. If your site has enabled the *Comments* feature, you may (optionally) type comments in the **Comments (optional)** text box.

Note: If your site has not enabled the *Comments* feature, CPRS disables the dialog, which in this case is named **Comments (disabled)**.

4. Click **OK**. CPRS displays an **Are you Sure?** dialog.
5. If you are sure the causative agent was entered in error, click **Yes.** CPRS removes the causative agent from the **Allergies/Adverse Reactions** pane and from the list of allergies it displays when you click *Allergies* in the **Postings** pane.

Note: CPRS also generates a Progress Note when an allergy is marked "Entered in Error". When this note is signed by the user who marked the allergy as entered in error or by an administrative update user, the note will be viewable by all CPRS users.

Method Two

Take the following steps to use the second method:

1. Click a causative agent (or highlight using the Tab and arrow keys and press <Enter>) that appears in the **Allergies/Adverse Reactions** pane. CPRS displays a dialog that contains detailed information about the allergy or adverse reaction. This dialog includes four buttons.
2. Click the **Entered in Error** button. CPRS displays the **Mark Allergy/Adverse Reaction Entered In Error** dialog.
3. If your site has enabled the *Comments* feature, you may (optionally) type comments in the **Comments (optional)** dialog.
4. Click **OK**. CPRS displays an **Are you Sure?** dialog.
5. If you are sure the causative agent was entered in error, click **Yes.** CPRS removes the causative agent from the **Allergies/Adverse Reactions** pane and from the list of allergies it displays when you click *Allergies* in the **Postings** pane.

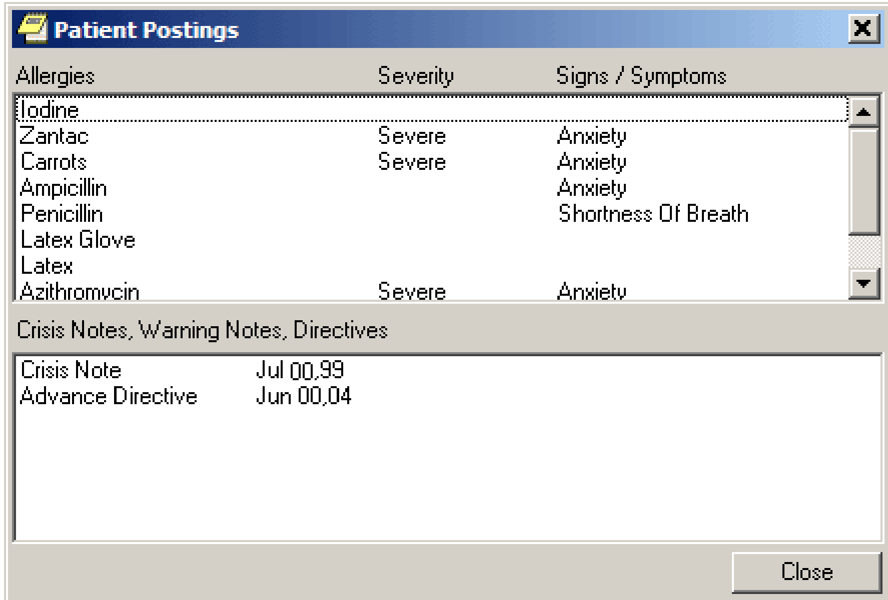
Note: CPRS also generates a Progress Note when an allergy is marked "Entered in Error". When this note is signed by the user who marked the allergy as entered in error or by an administrative update user, the note will be viewable by all CPRS users.

Reviewing and Creating Postings

Postings contain critical patient-related information about which hospital staffs need to be aware. The **Postings** button is visible on all tabs of the CPRS GUI window and is always located in the upper right corner of the window.

To view a posting using the Postings (CWAD) button, use these steps:

1. Click the **Postings** button (available from any tab) to display the **Patient Postings** dialog.



The **Patient Postings** dialog.

2. From the **Patient Postings** dialog, click to select the particular posting in which you are interested and view the details.
3. When finished, click **Close**.

To view the posting from the Cover Sheet, use the following steps:

1. On the **Cover Sheet** tab, click on a specific posting that appears in the **Postings** pane to display the details.
2. When finished, click **Close**.

Creating Postings

You create the following types of postings by creating progress notes using note titles that your site's IRM staff has configured for this purpose. (Check with your site's IRM staff if you don't know which note titles create which types of postings.)

- Clinical Warning (which is the same as Warning)
- Crisis Note
- Directive
- Warning

For example, to create a posting for a crisis note, take the following steps:

1. Select the **Notes** tab.
2. Select **New Note**. CPRS displays the **Progress Note Properties** dialog.
3. In the **Progress Note Title** pane, select CRISIS NOTE.
4. In the **Date/Time of Note** field, select a date.
5. In the **Author** field, select an author.
6. Click **OK.**

7. From the main menu, select **File | Refresh Patient Information**. CPRS displays the letter **C** (for crisis note) on the **Postings** button and, in the **Postings** pane on the **Cover Sheet Tab**, displays the title *Crisis Note* and the date you selected for the note.

To create a posting for an allergy or adverse reaction, enter the allergy from either the **Cover Sheet** tab or the **Orders** tab. (See “Entering Allergies” in the “Assessing, Entering, and Reviewing Allergies/Adverse Reactions” section of this manual or “Entering Allergies from the Orders Tab” in the “Orders” section of this manual, respectively.)

Note: Although you may be able to enter progress notes for allergies and adverse reactions, doing so does not create an *Allergies* postings. As mentioned above, you can create *Allergies* postings only by entering allergies via the **Cover Sheet** or **Orders** tab. Furthermore, CPRS cannot perform order checks on allergies you document via progress notes.

Notifications and Alerts

Notifications are messages that provide information or prompt you to act on a clinical event. Clinical events, such as a critical lab value or a change in orders trigger a notification to be sent to all recipients identified by the triggering package (Lab, CPRS, Radiology, and so on).

CPRS places an “I” before information notifications. Once you view (process) information notifications, CPRS deletes them. When you process notifications that require an action, such as signing an order, CPRS brings up the chart tab and the specific item (such as a note requiring a signature) that you need to see.

Note: When CPRS is installed, all notifications are disabled. IRM staff and clinical coordinators set site parameters through the Notifications Management Menus in the List Manager version of CPRS that enable specific notifications. Notifications are initially sent to all users. Users can then disable unwanted notifications through List Manager’s Personal Preferences.

Clinical Notifications are displayed on the bottom of the Patient Selection screen when you log in to CPRS. Only notifications for your patients are shown.

Problems Tab

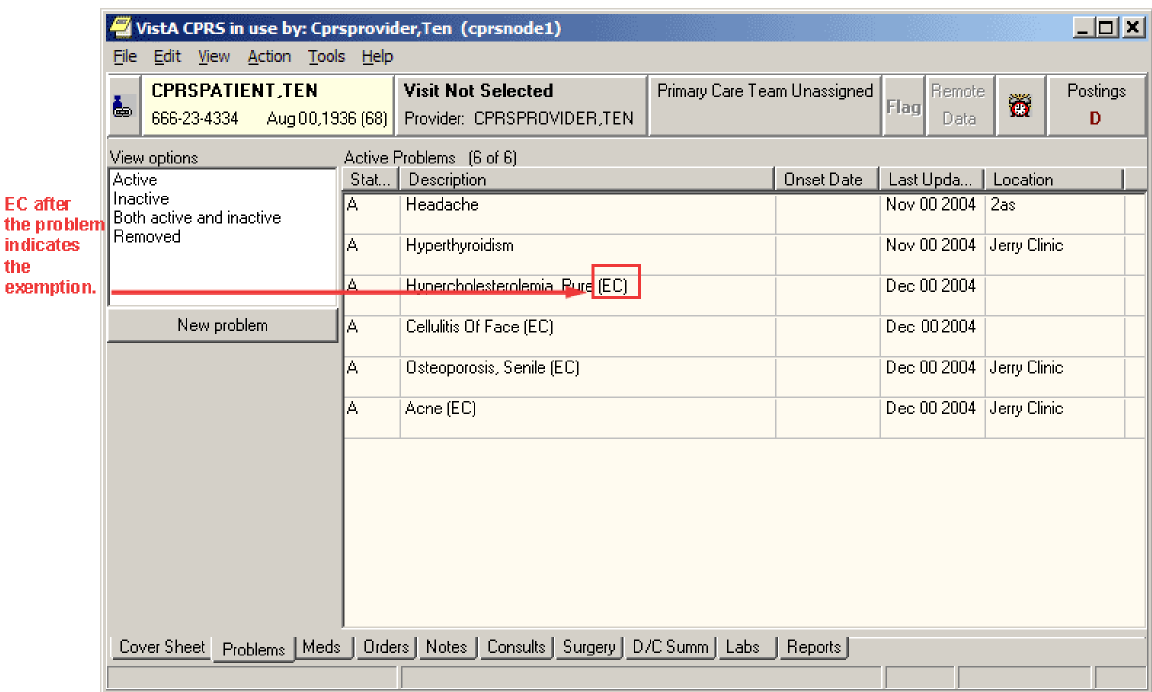
The problems list on the Problems tab displays a patient's current and historical health care problems. The problems list allows each identified problem to be traced through the VISTA system.

Service Connected Conditions

If a problem is service connected, the problem's service connected status is displayed in parentheses in the Description column.

Service Connected Condition Abbreviations

- SC - Service Connected Condition
- AO - Agent Orange Exposure
- IR - Ionizing Radiation Exposure
- EC - Environmental Contaminants
- MST - Military Sexual Trauma,
- HNC - Head or Neck Cancer



The problems list on the Problems tab

Customizing the Problems List

You can control which problems appear on the problems list by defining specific criteria. For example, you can specify that only inactive problems associated with a specific clinic appear on the problems list.

To control which problems appear on the problems list, follow these steps:

1. From the Problems tab, click any of the options listed in the View options field (Active, Inactive, Both active and inactive, or Removed)

   -or-

   select View | Active Problems, View | Inactive Problems, View | Both Active/Inactive Problems, or View | Removed Problems.

   The appropriate problems will appear on the problems list.

   If you would like to filter the problems list further, continue with step 2.

2. Select View | Filters…

   The Problem List View Filters dialog appears.

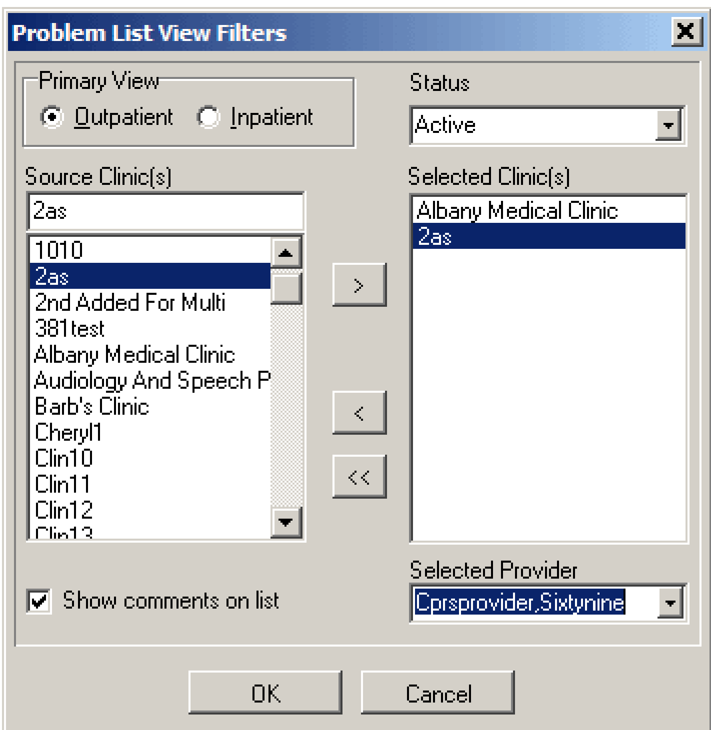
3. Select the criteria for the problems that you want to display on the problems list by doing some or all of the following:

   a.) Select either Outpatient or Inpatient from the Primary View option group.

   b.) Select a status from the Status drop-down list.

   c.) Move the appropriate source services or source clinics to the Selected Service(s) or Selected Clinic(s) field by clicking the > button.

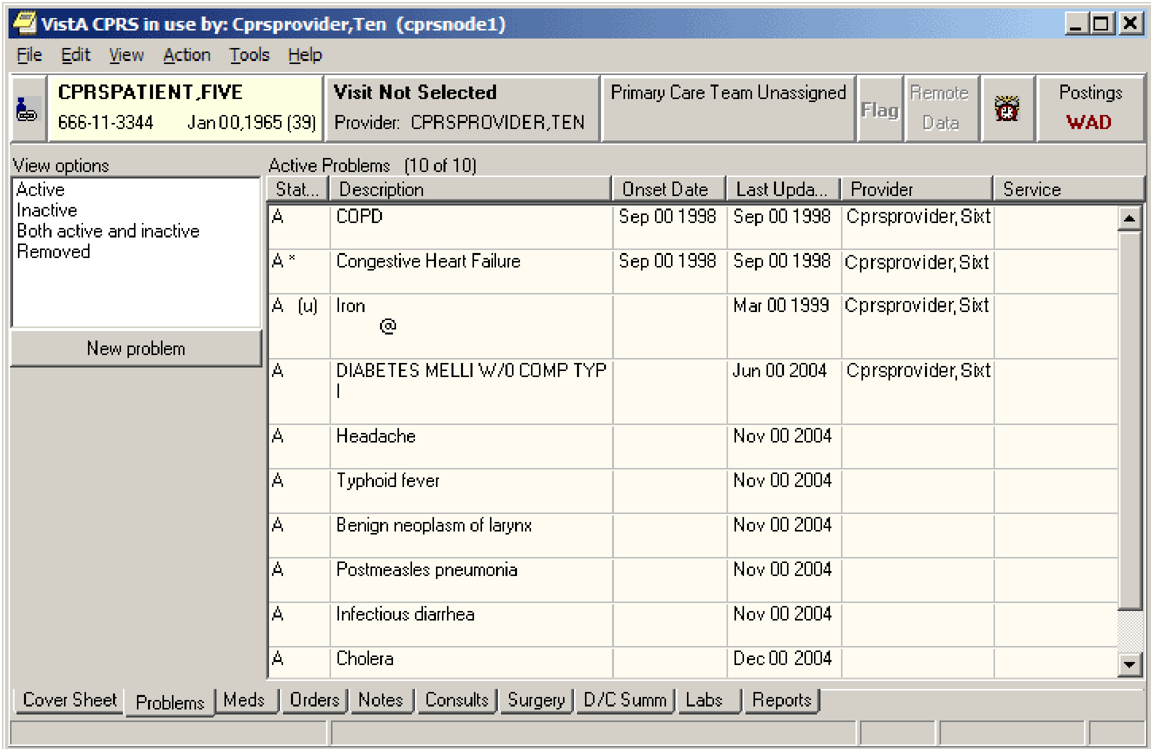
   d.) Choose a provider from the Selected Provider drop-down list.



You can use the Problem List View Filters dialog to select the criteria for the problems that you want to display on the Problems tab.

4. Click **OK**.

The problems that meet the criteria you specified on the Problem List View Filters dialog will appear on the Problems tab as shown below.



Active problems associated with inpatients and Cprsprovider, Sixtynine are displayed in the problems list.

Adding a Problem

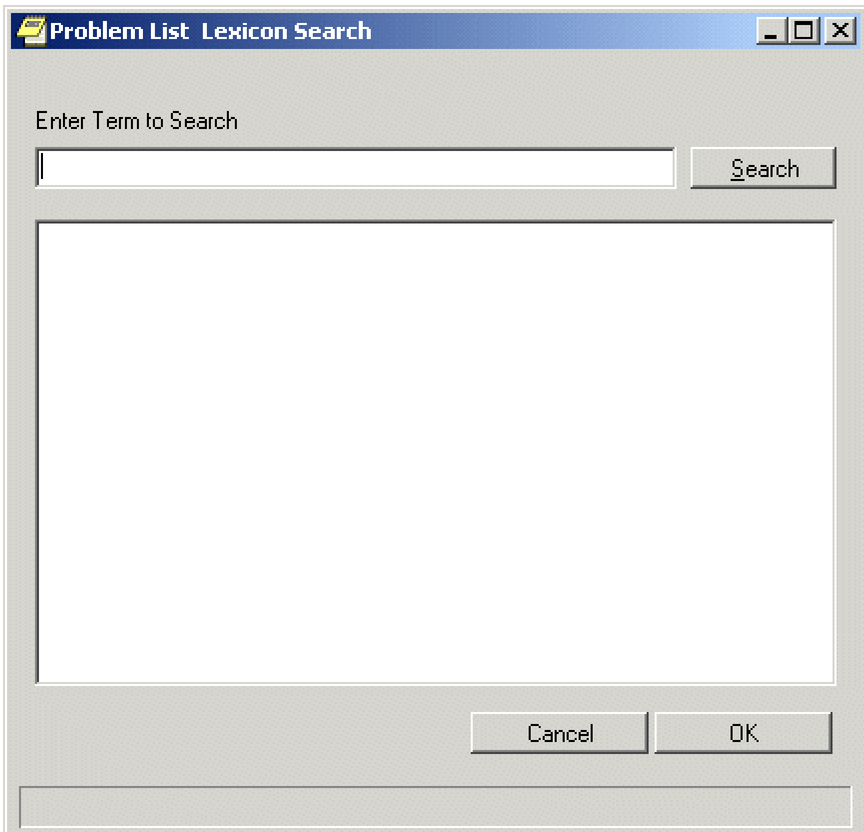
To add a new problem to a patient's problem list, use these steps:

1. Click the **Problems** tab.
2. Click New Problem.

   -or-

   select Action | New Problem…

   The Problem List Lexicon Search dialog will appear.



The Problem List Lexicon Search dialog

Note: If encounter information has not been entered, the encounter information dialog will appear before the Problem List Lexicon Search dialog. You must complete the encounter information dialog before proceeding.

3. Enter a term that describes the problem in the Enter Term to Search field.
4. Press <**Enter**>

   -or-

   click **Search**.

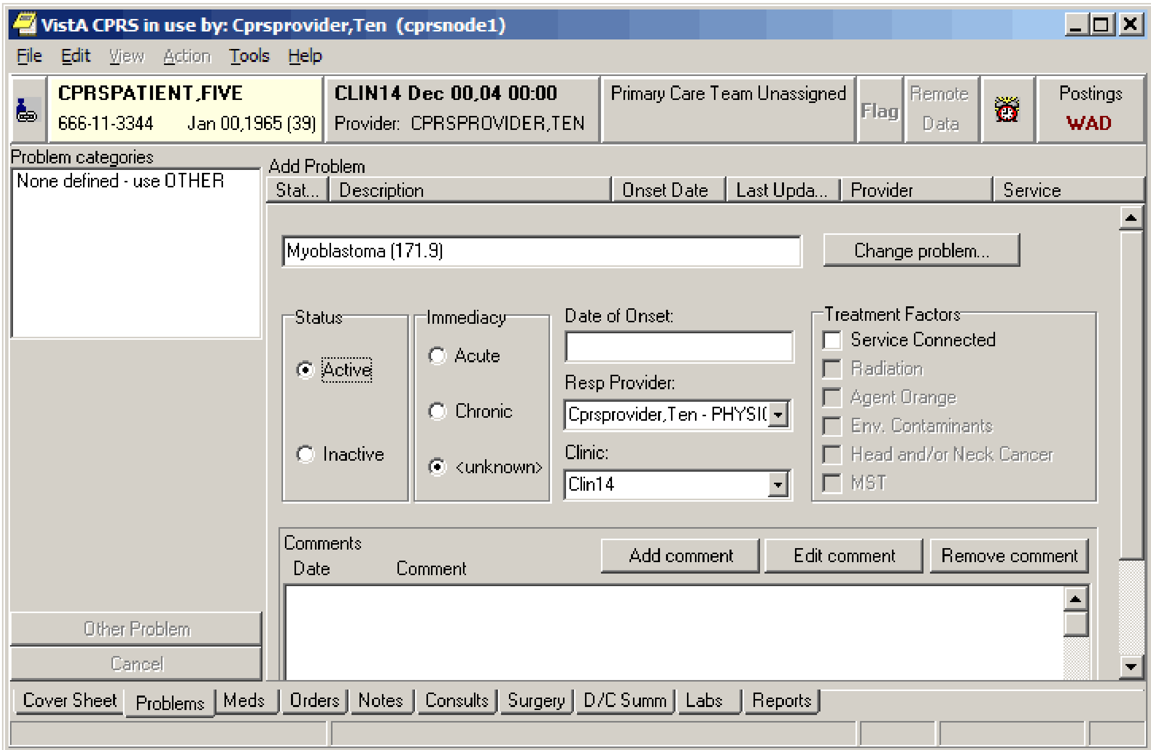
   CPRS will search the lexicon for problems that contain the search term. The matching problems will appear in the bottom half of the Problem List Lexicon Search dialog.

5. Select the appropriate problem.

   Note: If you try to select a problem that has an inactive diagnosis or procedure code, you will be prompted to select a problem with an active code.

6. Click OK.

The New Problem form will appear.



The New Problem form

7. Complete the New Problem form by following the steps below:

   a.) Select a status for the problem (Active or Inactive).
   b.) Choose an immediacy for the problem (Active or Acute).
   c.) Enter the date of onset.
   d.) Select a responsible provider.
   e.) Choose a service.
   f.) Check any applicable treatment factors.
   g.) Enter any comments (if necessary) by pressing the **Add comment** button.

8. Click **OK**.

Annotating a Problem

To annotate a problem, use these steps:

1. Click the **Problems** tab.
2. Select a problem from the problems list.
3. Select **Action | Annotate...** or right-click the problem and select **Annotate...** from the pop-up menu.

   Note: If you try to select a problem that has an inactive diagnosis or procedure code, you will be prompted to select a problem with an active code.
4. Enter your annotation in the dialog that appears (up to 60 characters).
5. Click **OK**.

Changing a Problem

To change a problem on a patient's problem list, use these steps:

1. Click the **Problems** tab.
2. Select a problem from the problems list.
3. Select Action | Change…
4. Enter the desired changes.
5. Add or remove a comment (if desired).

   Note: A comment can be as many as 60 characters (including spaces) in length.
6. Click **OK**.

Deactivating a Problem

To deactivate a problem on a patient's problem list, use the following steps:

1. Click the **Problems** tab
2. Select a problem from the problems list.
3. Select **Action** | **Inactivate**

   -or-

   right-click a problem and select inactive.

Removing a Problem

To remove a problem from a patient's problem list, use these steps:

1. Click the **Problems** tab.
2. Select a problem from the problems list.
3. Select **Action | Remove** or right-click the problem and click **Remove**.

   Note: Deleted problems are not actually removed from the database. Rather, a deleted problem is flagged with a hidden tag. The hidden tag prevents the problem from appearing on any reports or lists.

Verifying a Problem

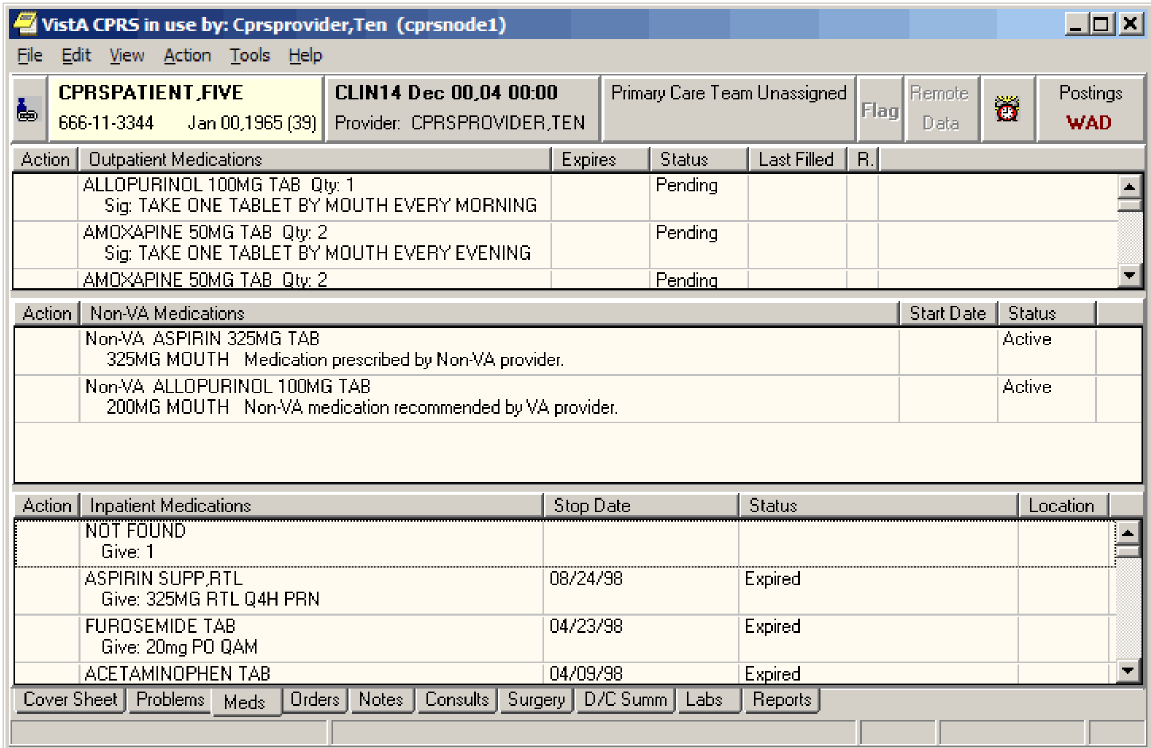
To verify a problem on a patient's problem list, use these steps:

1. Click the **Problems** tab.
2. Select a problem from the problems list.
3. Select **Action | Verify** or right-click the problem and click **Verify** on the pop up menu.

   Note: If you try to select a problem that has an inactive diagnosis or procedure code, you will be prompted to select a problem with an active code.

Meds

The Meds tab contains a list of medications for the selected patient. Inpatient, outpatient, and Non-VA (including non-prescription and herbal) medications are listed in separate sections of the window.



The Meds tab

Medication Details

If you would like to view additional information about a medication, double click the medication entry or select a medication and choose **View | Details**.

Medication Administration History

You can view the administration history for a medication in three ways:

- Double-click a medication. The administration history will be listed at the bottom of the details screen.
- Select a medication and then select **View | Administration History**.
- Select a medication and then right-click. Choose **Administration History** from the pop up menu.

Other Actions

To take other actions, such as ordering a new medication, changing a medication order, or changing a medication order status (discontinue, hold, or renew), you use the Action menu or right-click a medication. You can also place orders for new medications from the Orders tab.

Ordering Inpatient Medications

Ordering medications now uses two dialogs in the ordering process and eliminates the dispense drug prompt. Inpatient medication orders now require a valid schedule. If users do not find the appropriate schedule in the list, they can choose to create a day-of-week/administration time schedule using the new Schedule builder. This feature also works for renewing, copying, and changing inpatient medication orders.

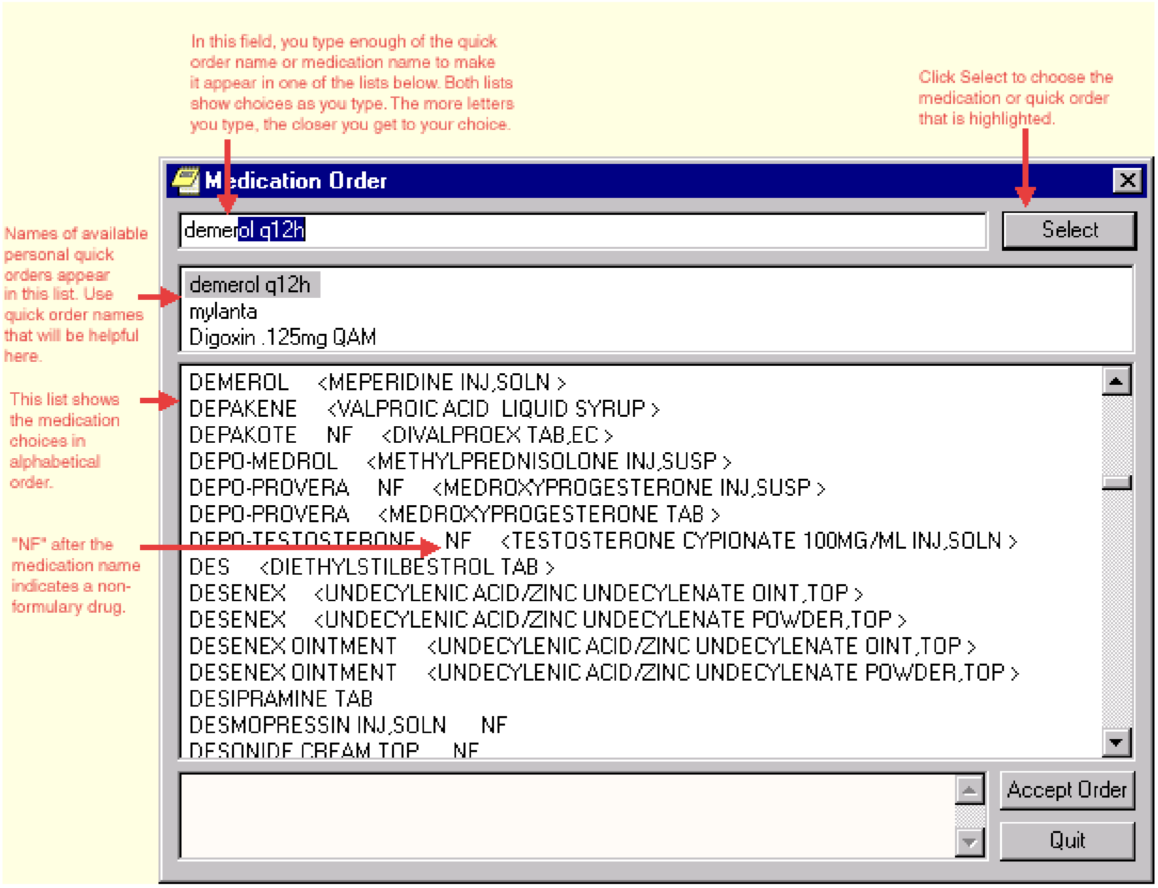
Note: Because a valid schedule is required, if you attempt to modify an existing medication order that does not have a valid schedule, you will receive a message box stating that and will have to enter a valid schedule.

Simple Dose

Note: If the user attempts to order inpatient medications for an inpatient from an outpatient location, CPRS discontinues the order process and returns the user to original Orders or Meds tab display.

To write a new simple dose Inpatient Medications order, use these steps:

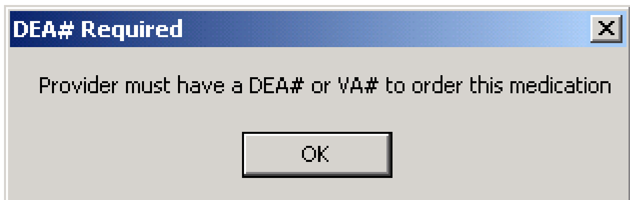
1. Click the **Meds** tab and select **Action | New Medication.**
   -or-
   click the **Orders** tab and bring up the inpatient dialog by clicking the appropriate item in the **Write Orders** pane. CPRS displays the *Medication Order* dialog as show in the graphic below.



The Medication Order dialog allows you to select from a list of medications.

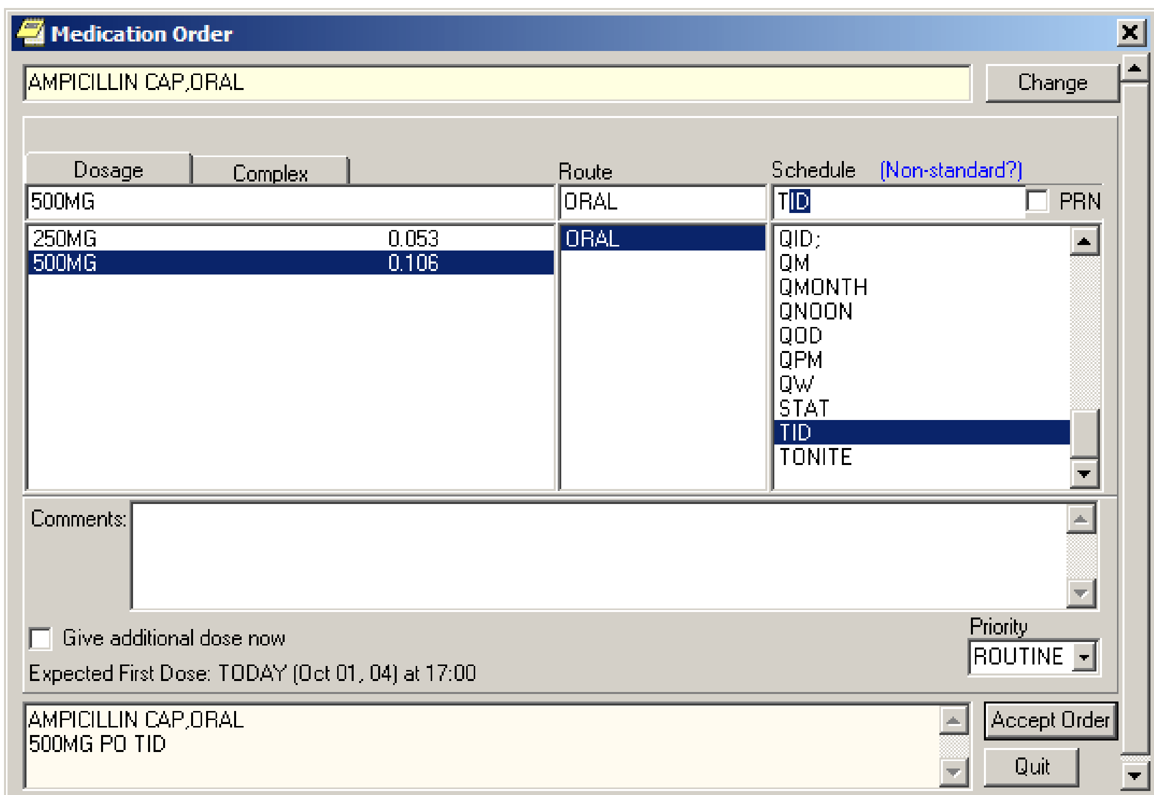
2. Locate the desired medication or medication quick order. Click the quick order or medication name.

   Note: CPRS now uses a look up from Pharmacy to determine whether the selected medication is a controlled substance that requires the signature of a provider with a DEA or VA number. For controlled substances, CPRS displays a message—"Provider must have DEA# or VA# to order this medication"—as shown in the graphic below. CPRS allows orders for controlled substances only when selected providers are able to sign the orders. You may need to exit the dialog, change the provider selection, and then reenter the dialog.



You must have a DEA# or VA# to order certain medications.

3. Click the **Dosage** field and select or type a dosage. (The associated cost is displayed to the right of the dosage.)



Medication dosages are displayed on the left side of the Medication Order dialog.

4. Select a value for the **Route** field.

5. In the **Schedule** pane, select an existing schedule from the list or, to use a day-of-week/administration time schedule not on the list, select **OTHER** (you can also click the Non-Standard? link and then click OK on the dialog that displays).

6. If you selected an existing schedule, skip to step 7. If you selected **OTHER**, the *Order with Schedule 'OTHER'* dialog appears. Take the following steps:

   a.) If the schedule requires specific days of the week, click one or more checkboxes to select appropriate days of the week.

   b.) If the schedule requires specific administration times, select an appropriate time, hour and minutes (when you select the minutes, the time will be added to the Schedule field).

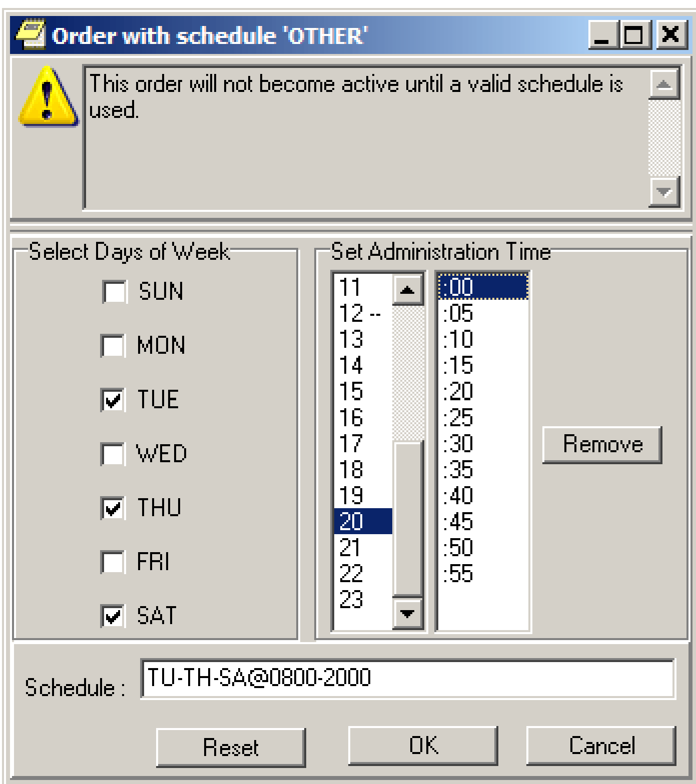
   c.) Repeat step b until you have entered all required administration times.

   Warning: The administration times in the Schedule field apply to each day of the week that is listed, such as TU-TH-SA@0800-2000, for example. To create a schedule such as TU@0800 TH@2000, users would have to enter two separate orders using the complex medication order dialog. Also, users may not enter a schedule that only has administration times and PRN but no days.

   d.) If you make a mistake while selecting an administration time, select the time in the Set Administration Time fields and click **Remove** (so to remove 08:00, you would have to select that time in the Set Administration Time fields not in the Schedule text box.) To remove the entire schedule and begin again with step a, Click **Reset**.

   e.) Review the **Schedule** field.

   f.) When you have the correct schedule, click **OK**.



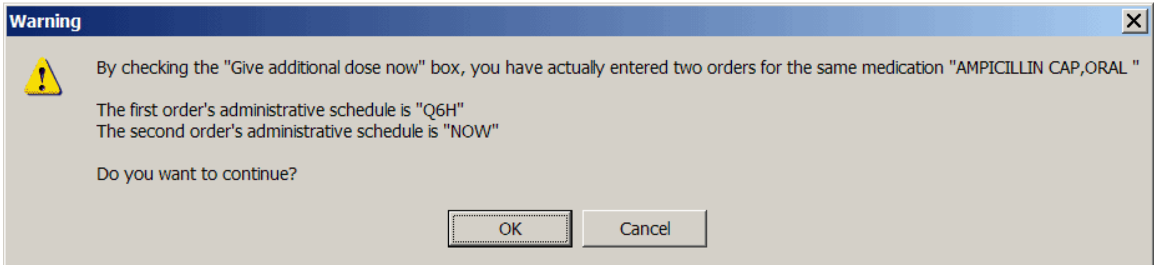
The *Order with Schedule 'OTHER'* dialog allows you to enter a customized day-of-week/administration time schedule.

7. Select **PRN** if necessary.

8. Add comments (optional).

9. CPRS displays the date and time of the expected first dose. If you want to give an additional dose now, select the **Give additional dose now** check box.

Note: Make sure that you are careful about using give-additional-dose-now functionality. When you click the check box, CPRS creates a new order and sends it to Inpatient Medications. Make sure this new order and the original schedule you entered do not overmedicate the patient.



10. Click the drop-down arrow and select a value for the **Priority** field.
11. Click **Accept Order**.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message that tells you the information is incorrect and shows you the correct type of response.

12. Enter another medication order or click **Quit**.

Note: CPRS requires a signature before it sends the order to pharmacy. You can either sign the order now or wait until later.

Complex Dose

Note: If the user attempts to order inpatient medications for an inpatient from an outpatient location, CPRS discontinues the order process and returns the user to original Orders or Meds tab display.

To write a new complex dose Inpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

   -or-

   click the **Orders** tab and bring up the inpatient *Medication Order* dialog by clicking the appropriate item in the **Write Orders** pane.

2. Locate the desired medication or medication quick order. Click the quick order or medication name.

   Note: CPRS now uses a look up from the Pharmacy package to determine whether the selected medication is a controlled substance that requires the signature of a provider with a DEA or VA number. For controlled substances, CPRS displays a message—"Provider must have DEA# or VA# to order this medication"—as shown in the graphic below. CPRS allows orders for controlled substances only when selected providers are able to sign the orders. You may need to exit the dialog, change the provider selection, and then reenter the dialog.

You must have a DEA# or VA# to order certain medications.

3. Click the **Complex** dose tab.

   Note: After you begin a complex order, you must remain on the **Complex** tab until you finish the order. Do not attempt to start from or switch back to the **Dosage** tab. If you do, all complex dosages will be erased and you will be forced to start again.

4. In the **Dosage** field, select or type the appropriate dosage.

5. In the **Route** field, select the appropriate delivery route for the medication. (The default route should be the most common).

6. In the **Schedule** field, select an existing schedule from the list or, to use a day-of-week/administration time schedule not on the list, select **OTHER**.

7. If you entered an existing schedule, skip to step 8. If you selected **OTHER**, CPRS displays the *Order with Schedule 'OTHER'* dialog. Take the following steps:

   a.) If the schedule requires specific days of the week, click one or more check boxes to select appropriate days of the week.

   b.) If the schedule requires specific administration times, select an appropriate time, hour and minutes (when you select the minutes, the time will be added to the Schedule field).

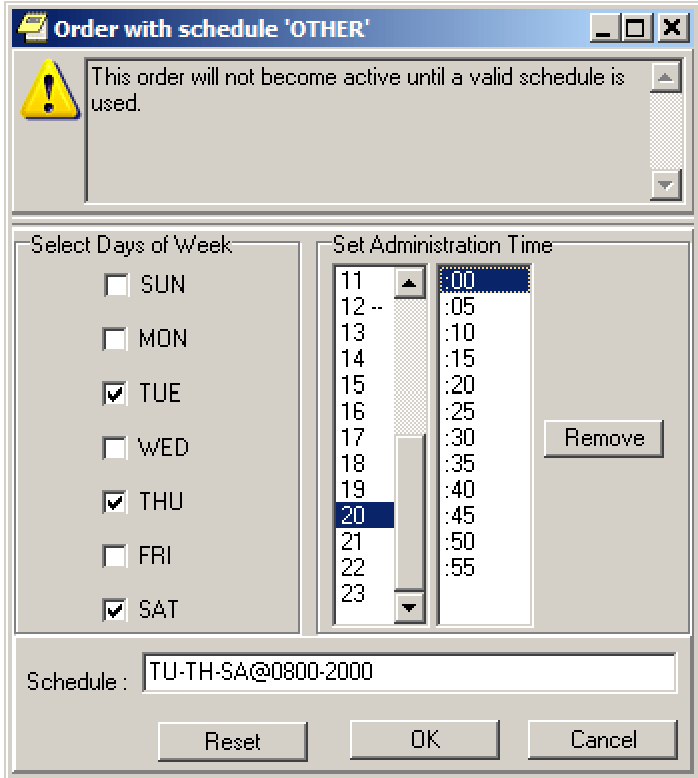
   c.) Repeat step b until you have entered all required administration times.

   Warning: The administration times in the Schedule field apply to each day of the week that is listed, such as TU-TH-SA@0800-2000, for example. To create a schedule such as TU@0800 TH@2000, users would have to enter two separate orders using the complex medication order dialog. Also, users may not enter a schedule that only has administration times and PRN but no days.

   d.) If you make a mistake while selecting an administration time, select the time in the Set Administration Time fields and click **Remove** (so to remove 08:00, you would have to select that time in the Set Administration Time fields not in the Schedule text box.) To remove the entire schedule and begin again with step a, Click **Reset**.

   e.) Review the **Schedule** field.

   f.) When you have selected the desired schedule, click **OK**.



The *Order with Schedule 'OTHER'* dialog allows you to enter a customized day-of-week/administration time schedule.

8. Select PRN if necessary.
9. Click the **Duration** field. Enter a number and select units (the default unit is days) a patient should use the specified dose.
10. Add the appropriate conjunction: **And, Then, Except** (Except is only for Outpatient Meds) or **no conjunction** for the final line.
11. Click in the **Dosage field** in the next row and select a dosage.
12. CPRS fills in the **Route** and **Schedule** fields. If necessary, change the values in **Route** and **Schedule** fields.
13. Click and enter the duration and a conjunction.

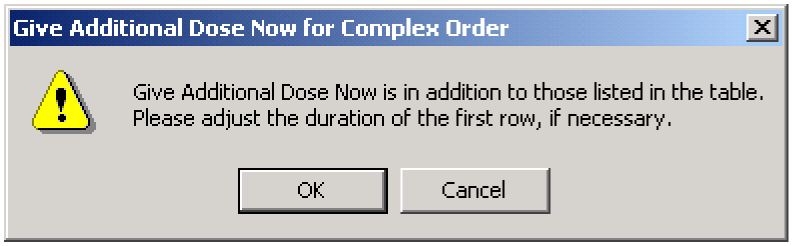
Note: Your site's IRM staff may have specified rules governing the status of inpatient medication orders when patients are transferred from one ward or service to another. It may have also specified the number of days an inpatient medication order remains active. Please check with your site's IRM staff for information about these rules.

14. Repeat steps 10-12 until you have completed the complex dose.

Note: You can also add or remove a row in the complex dosage. If you add a row, CPRS places the new row above the selected row. To add a row, click the gray area in front of the row and click **Add Row**. To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

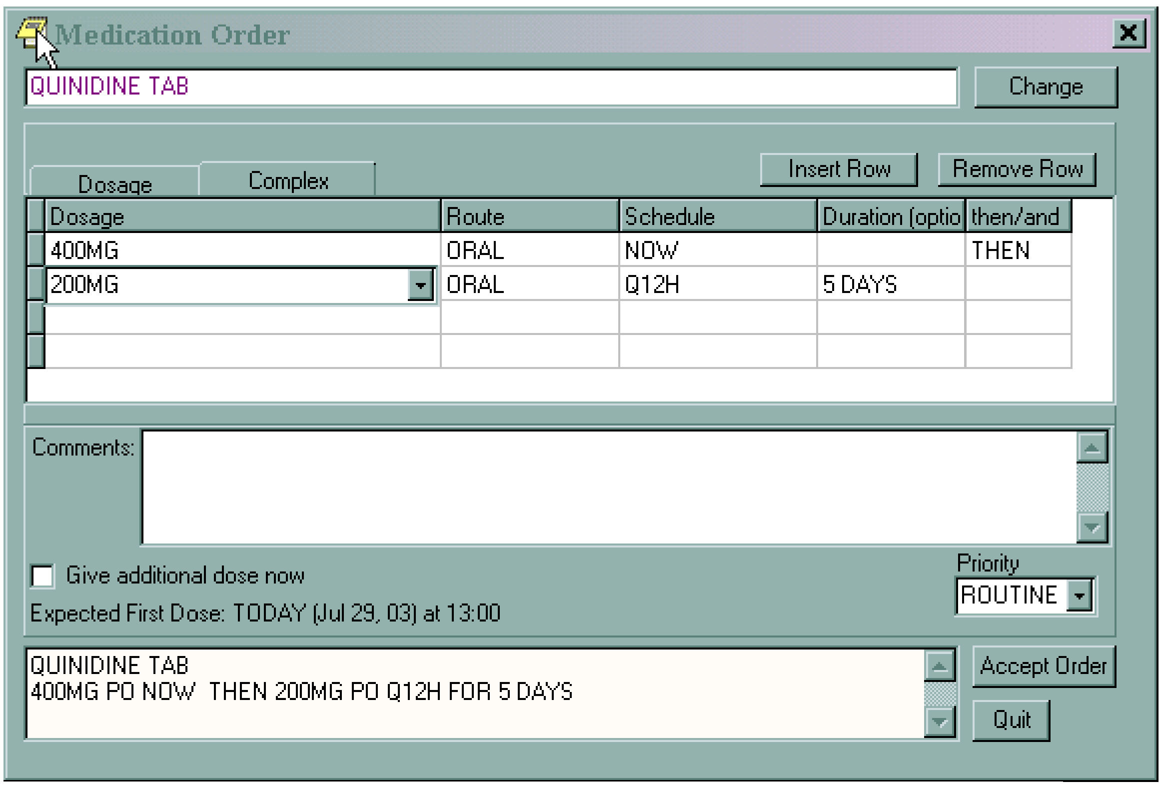
15. Add comments (optional).

CPRS displays the expected date and time of the first dose. If you want to give an additional dose now, select the Give-additional-dose-now check box.



CPRS displays a warning to providers who select **Give additional dose now**.

16. As the warning message advises, check to ensure that the orders you created will not overmedicate the patient. If the orders are acceptable, click **OK**. If not, click **Cancel** to remove the Give-additional-dose-now order.
17. Click the drop-down arrow and select a Priority.



You should specify the duration for a medication order.

18. Click **Accept Order**.

    Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message telling you that the information is incorrect and showing you the correct type of response.

19. Enter another medication order or click **Quit**.

    Note: You must sign the order before CPRS sends it to the Pharmacy package. You can either sign the order now or wait until later.

Ordering Inpatient Medications for Outpatients

Note: IMO features will not be available in the CPRS until patch SD*5.3*285 is installed in your account. This patch is currently under development.

From authorized hospital locations, you can electronically order inpatient (unit-dose and intravenous (IV)) medications for outpatients. These orders have a status identical to that of inpatient-medication orders for inpatients. That is, the inpatient pharmacy checks, fills, and dispenses IMO (inpatient-medications for outpatients) orders.

Note: IMO orders are affected by both CPRS auto-DC rules and Inpatient Medications rules for auto-discontinuing orders on admission and discharge. If sites do not want IMO orders to auto-discontinue on admission and discharge, sites will have to ensure that neither CPRS nor Inpatient Medications discontinues IMO orders. Inpatient Medications uses the AUTO-DC IMO ORDERS parameter to exclude IMO orders from being discontinued.

Criteria for Ordering Inpatient Medications for Outpatients

To successfully write inpatient-medication orders for outpatients, the outpatients must meet at least one of the following criteria:

- They must have a scheduled appointment at an authorized hospital location for the current day or a day in the future
- They must be currently checked in at an authorized hospital location

  Note: If patients do not meet either of these criteria, you can create a new visit for them at an authorized hospital location.

In addition, before you can use the **Meds** tab to place IMO orders, your site's IRM staff must set up the new-medication order dialog to include inpatient medications.

Simple and Complex Doses

Take the following steps to write IMO orders:

1) Click the **Meds** tab
2) From the main menu, click to select **Action | New Medication**

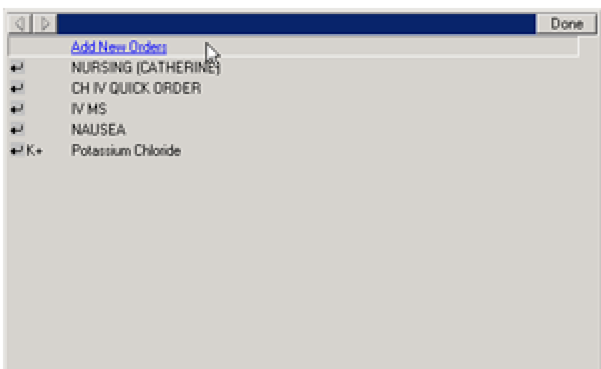
   or

   click to select the area within the Inpatient Medications window, then right click and select **New Medication** from the shortcut menu. (You can also place inpatient-medication orders for outpatients via the **Orders** tab. For detailed instructions, see "Ordering Inpatient Medications for Outpatients" in the "Orders" section of this manual.)

3) CPRS prompts you to select a location for current activities. Select a scheduled (current or future) appointment at an authorized hospital/clinic location, or create a new visit in an authorized hospital/clinic location using the default time for new visits (NOW).

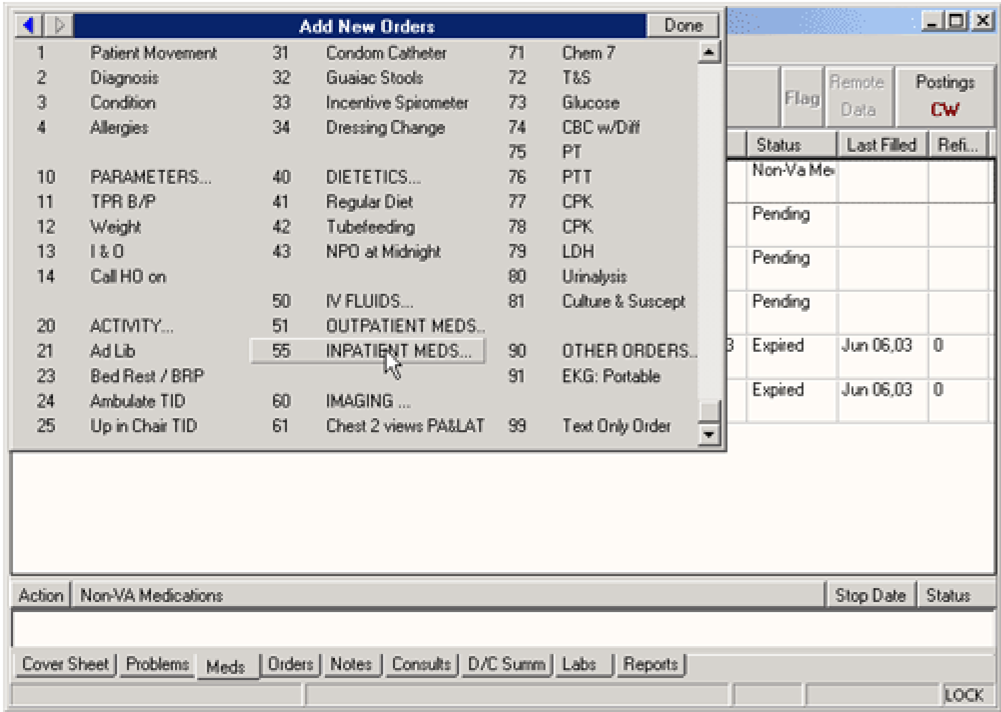
Note: CPRS allows you to change your clinic selection after you have started an order. However, if you are in the process of placing an order and change clinic locations midstream, CPRS does not reflect this change in the finished order. For example, suppose you are in the process of placing an IMO order using an authorized clinic. Now suppose you change your mind and select instead a clinic that is not authorized for placing these orders. In this case, your order will finish as an IMO order using the authorized clinic. On the other hand, if you are in the process of placing an IMO order from an unauthorized clinic, then change the location to an authorized clinic, CPRS does not display a complete list of inpatient (unit-dose) medications. Instead, it continues to display the list of injectable inpatient medications available for the unauthorized clinic. Furthermore, CPRS does not reflect this clinic change in the finished order.

4) CPRS displays one or more new medication dialogs. These dialogs are site—and sometimes user—specific. For example, the person who manages information resources at your site may have set the ORWDX NEW MEDS parameter (which controls the new-medication order dialog) to display a list of your inpatient and outpatient quick orders.



New-medication dialogs can vary widely. This sample dialog enables a specific user to select from a list of his inpatient and outpatient quick orders, among other things.

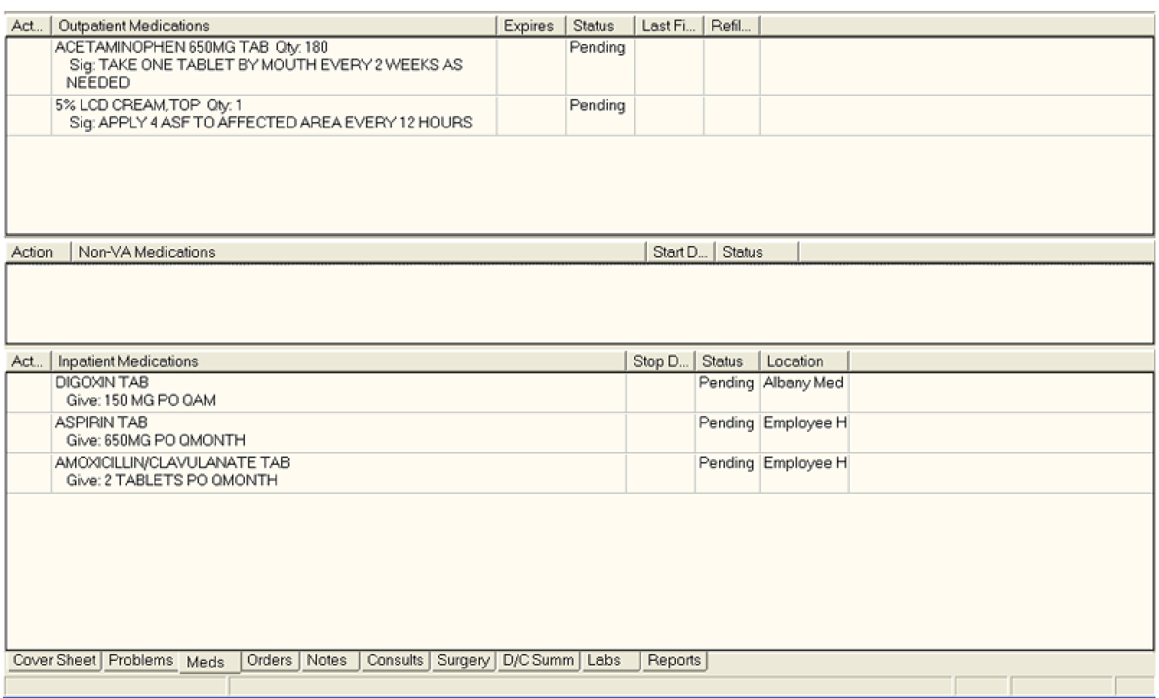
However, the person who manages information resources at your site could also define a generic dialog for all applicable users.



This new-medication order dialog offers a variety of options that are not user-specific.

5) Select an inpatient medication.
6) To place a simple-dose or complex-dose order for this medication, follow the steps outlined in the "Simple Dose" or "Complex Dose" sections of this manual, respectively.

On the **Meds** tab, CPRS displays IMO orders sorted at the top of the **Inpatient Medications** window with corresponding authorized hospital/clinic locations in the **Location** column.



CPRS displays IMO orders at the top of the **Inpatient Medications** window on the **Meds** tab.

Changing or Copying Orders

Users can also change, copy, and renew inpatient medication orders for outpatients (IMO) if the user is ordering from an authorized IMO location. If the patient's location is not an authorized IMO location (even if the patient is an inpatient), users will not be able to change, copy, or renew the IMO orders. To change or copy inpatient medication orders for outpatients, follow the instructions in the "Changing Orders" or "Copying Existing Orders" section of this manual, respectively.

Outpatient Medications

Outpatient meds can be written as simple doses or complex doses. To write a new Outpatient Medications order, use these steps:

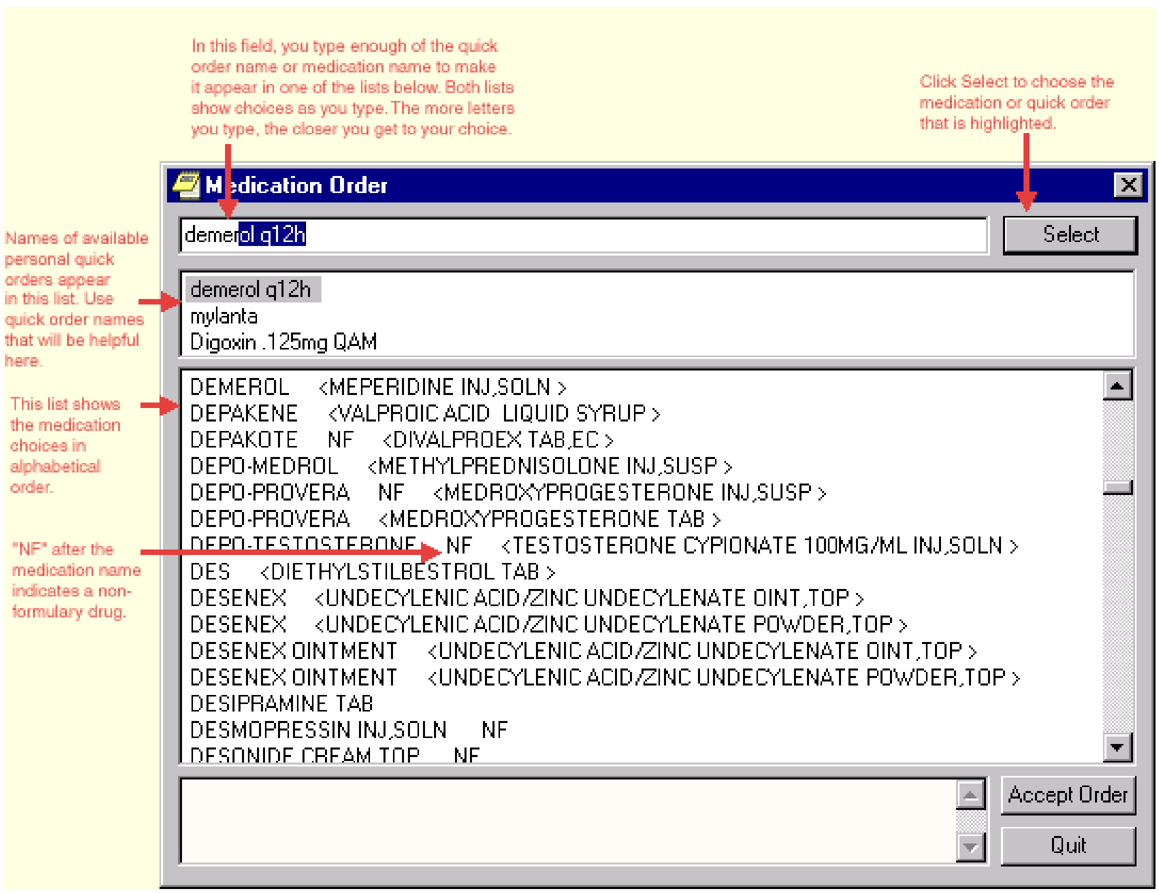
Simple Dose

To write a new simple dose Outpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**.

-or-

Click the **Orders** tab and bring up the Outpatient dialog by clicking the appropriate item under the Write Orders box. CPRS will display the Medication Order dialog as shown in the graphic below.

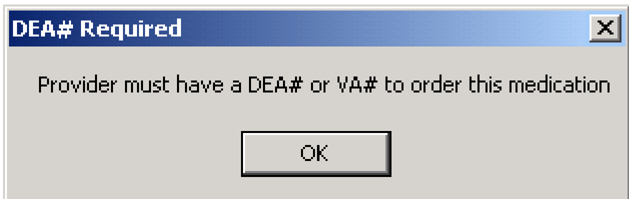


The Medication Order dialog

Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate the medication name or quick order name in the list box and then click it.

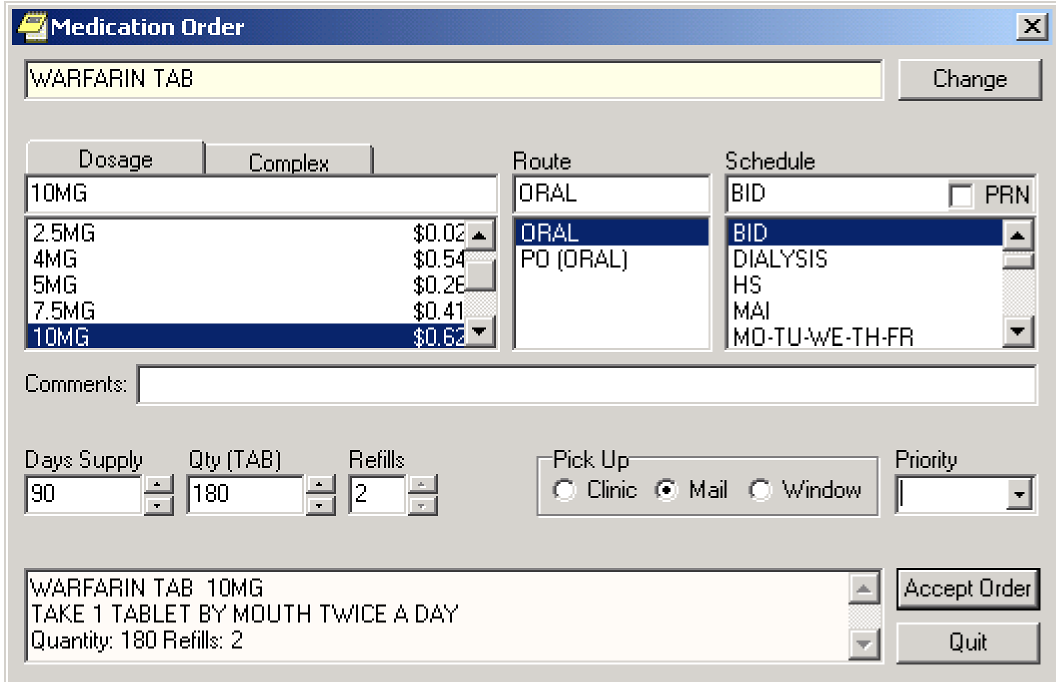
Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.



You must have a DEA# or VA# to order certain medications.

3. Select the dosage. (The associated cost is displayed to the right of the dosage, see graphic under step 9 for an example.)
4. Select values for the Route and Schedule fields (select PRN, if desired).
5. CPRS puts in the default days supply and calculates the quantity based on the formula Days Supply x Schedule = Quantity. If necessary, highlight and change the numbers in these fields.

   Note: If you change a number, CPRS will attempt to recalculate the other field, if possible.
6. Enter the number of refills.
7. Select where the patient should pick up the medication and the Priority.
8. You can also add a comment if desired.



You should choose a priority for the order from the Priority drop-down list.

9. Click **Accept Order**.
10. If you are finished ordering outpatient medications, click **Quit**.

Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Complex Dose

To write a new Outpatient Medications order, use these steps:

1. Click the **Meds** tab and select **Action | New Medication**

   -or-

   click the **Orders** tab and bring up the Outpatient dialog by clicking the appropriate item under the Write Orders box.

   Note: If no encounter information has been entered, the Encounter Information dialog appears. Also, a preliminary order check is done and a dialog may appear to provide you with pertinent information.

2. Locate the medication name or quick order name in the list box and then click it.

   Note: CPRS now uses a look up from Pharmacy to check if the selected medication is a controlled substance that will require the signature of a provider with a DEA or VA number. A message will appear to the provider "Provider must have DEA# or VA# to order this medication" as shown in the graphic below. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the dialog, change the provider, and then reenter the dialog.

You must have a DEA# or VA# to order certain medications.

3. Click the **Complex** dose tab.

   Note: Once you begin a complex order, you must remain on the Complex tab until you finish that order. Do not attempt to start from or switch back to the Dosage tab. If you do, all complex dosages will be erased and you will be forced to start again.

4. Click the **Dosage** field and select the appropriate dosage.
5. Click the **Route** cell and enter the route (The default route should be the most common).
6. Click the **Schedule** cell and enter how often the medication should be taken (click PRN if desired).
7. Click the Duration cell and enter a number and select units (days is the default) a patient should use the specified dose.
8. Add the appropriate conjunction: And, Then, Except (Except is only for Outpatient Meds) or no conjunction for the final line.
9. Click in the dosage field in the next row and select a dosage.
10. CPRS will fill in the Route and Schedule fields. If necessary, click in and change the Route and Schedule cells.
11. Click and enter a duration and a conjunction.
12. Repeat steps 10-12 until you have completed the complex dose.

    Note: You can also add or remove a row in the complex dosage. If you add a row, the new row will be placed above the selected row. To add a row, click the gray area in front of the row and click **Add Row**. To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

13. CPRS puts in the default days supply and calculates the quantity based on the Days Supply x Schedule = Quantity. If necessary, highlight and change the number in these fields.

    Note: If you change a number, CPRS will attempt to recalculate the other field, if possible.

14. Enter the number of refills.
15. Select where the patient should pick up the medication and the Priority.
16. You can also add a comment if desired.
17. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked.
18. Click **Accept Order**.
19. If you are finished ordering outpatient medications, click **Quit**.

    Note: The order must be signed before it is sent to pharmacy. You can either sign the order now or wait until later.

Adding Non-VA Medications

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has indicated that all medications, including herbal supplements, over-the-counter (OTC) non-prescription medications, and medications prescribed by providers outside the VA (collectively known as “Non-VA medications”) should be entered in the medical record. CPRS, Outpatient Pharmacy, and Inpatient Medications developers have made changes that enable users to enter this information into the medical record so that providers have a better picture of the medications the patient is taking and that order checks against these medications can occur.

Entering Non-VA Medications will trigger the following order checks:

- Duplicate Drug (shows as Duplicate Order check)
- Duplicate Drug Class
- Critical Drug Interaction
- Significant Drug Interaction
- Allergy checks

Note: For Non-VA meds, inpatient orders are not checked against non-VA medications and the allergy check is slightly different. The duplicate drug class check will not be triggered for two pure herbal medications, such as ginger and gingko. All pure herbal medications belong to the same drug class (HA000). If these checks were made, every time a clinician entered a pure herbal medication, the user would receive a duplicate drug class warning. Allergy checks will still occur for non-VA medications that do not belong to this drug class.

Making Non-VA Meds Available for Entry

For users to be able to enter these medications through CPRS, they must be in the CPRS Orderable Items file so that they appear when the user chooses the new order sheet. The Pharmacy patch (PSS*1.0*68) enables sites to mark items as Non-VA Medications. Initially, all Pharmacy orderable items that are marked as “outpatient” and are not supply items will be automatically made Non-VA medications also. Subsequently, Pharmacy coordinators can use the Pharmacy option Drug Enter/Edit [PSS DRUG ENTER/EDIT] to identify items as Non-VA Meds or remove the designation.

Note: For more information about how to get Non-VA Medications added to the appropriate file, please see “Section 5.1: Communicating New Non-VA Meds Entries to the Pharmacist” in the *Herbal/OTC/Non-VA Meds Documentation Release Notes* that will be located on the VistA Documentation Library at http://www.va.gov/vdl under the Outpatient Pharmacy listings.

Items identified as “Non-VA Meds” are copied into the CPRS Orderable Items file when the Order Entry patch (OR*3.0*176) is installed at your site. Then, when CPRS GUI version 24 is installed, the item “Meds, Non-VA” is added under the Write Orders pane on the Orders tab. When the user selects the Meds, Non-VA option, the dialog displays the items that were marked as Non-VA Meds and copied into the CPRS Orderable Items file.

Different from Ordering Medications

Remember that entering Non-VA Medications is not the same as placing orders. Users simply enter information to provide a more complete view of what the patient is taking. However, once the items are available in the CPRS Orderable Items file, the process for entering Non-VA Medications is similar to entering other orders, but there are a few differences:

- Almost any CPRS user can enter Non-VA medication information. However, sites can restrict access for those holding the OREMAS key by using the OR OREMAS NON-VA MEDS parameter. For more information about this parameter, please see the *CPRS Technical Manual: GUI Version*.
- Electronic signature is not required for Non-VA medications.
- Users can enter Non-VA medication even if they only have partial information.
- Non-VA medications are listed separately on the orders tab and the designation Non-VA Med is displayed at the beginning of the entry.
- Users may pick a reason why the patient is taking the Non-VA medication.

For the reason/statement that users should enter, developers sent out four reasons or statements at the package level of the parameter GUI Non-VA Med Statements/Reasons that were agreed upon by a workgroup:

- Non-VA medication not recommended by VA provider.
- Non-VA medication recommended by VA provider.
- Patient wants to buy from Non-VA pharmacy.
- Medication prescribed by Non-VA provider.

Authorized users can enter their own reasons/statements in the parameter by entering new statements at the System or Division level for this parameter. For more information about changing this parameter, see the *CPRS Technical Manual: List Manager*.

Entering Non-VA Medication Information

To enter Non-VA medication information, use the following steps:

1. If you are not already there, go to the Orders tab by either clicking **Orders** or pressing **Ctrl + O**.
2. In the Writer Orders list, select **Meds, Non-VA**.
   Note: If encounter information has not been entered, the encounter information dialog will appear before the Medication Order dialog. You must complete the encounter information dialog before proceeding.
3. In the Document Herbal/OTC/Non-VA Medications dialog, select the medication or herbal supplement by
   A.) Typing a few letters of name.
   B.) Selecting the correct name from the list by double-clicking it or highlighting it and pressing <Enter>. You may need to scroll down to find the name.
   Note: If you do not know other information such as dosage, route, or schedule, you may enter only the name of the medication or herbal supplement.

4. Enter a dosage (if known).
5. Enter a route (if known).
6. Enter a schedule, including PRN if necessary (if known).
7. Enter any comments.
8. If you want to enter one, select one or more Statements/Explanations as to why the patient is taking the medication or supplement (optional).
9. Enter a start date (if known).
10. Review the information entered in the text box at the bottom of the dialog.
11. Place the information into the patient's record by clicking **Accept Order** or by tabbing to **Accept Order** and pressing **<Enter>**.
12. To enter additional Non-VA Medications into the patient's record, repeat steps 3-11.
13. When you are through entering Non-VA medications, exit the dialog using the Quit button.

Note: Non-VA Meds do not require an electronic signature, but they will be presented at the end of the current CPRS session on the Sign screen. You can do the normal signing process or if you only have Non-VA meds, you might get OK and Cancel buttons on a dialog instead of the normal Sign screen. You cannot click on the checkbox in front of a Non-VA Med to deselect and not approve it. Non-VA Meds because they do not require electronic signature will be automatically entered when you click OK or enter you electronic signature.

Hold Orders

Only active orders may be placed on hold. Orders placed on hold will continue to show under the ACTIVE heading on the profiles until it is removed from hold. An entry is placed in the order's Activity Log recording the person who placed/removed the order from hold and when the action was taken.

To place a medication on hold, use these steps:

1. Click the **Meds** tab.
2. Locate and click the medication.
3. Select **Action** | **Hold**.

Renewing Orders

Active orders may be renewed. In addition, inpatient medication orders that have expired in the last four days and outpatient medication orders that have expired in the last 120 days may be renewed. The default Start Date/Time for a renewal order is determined as follows:

Default Start Date Calculation = NOW

The default start date/time for the renewal order will be the order's Login Date/time.

Default Start Date Calculation = USE NEXT ADMIN TIME

The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the next date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN" any administration times for the order are ignored.

Default Start Date Calculation = USE CLOSEST ADMIN TIME

The original order's Start Date/Time, the new order's Login Date/Time, Schedule, and Administration Times are used to find the closest date/time the order is to be administered after the new order's Login Date/Time. If the schedule contains "PRN" any administration times for the order are ignored.

After the new (renewal) order is accepted, the Start Date/Time for the new order becomes the Stop Date/Time for the original (renewed) order. The original order's status is changed to RENEWED. The renewal and renewed orders are linked and may be viewed using the History Log function. Once an order has been renewed it may not be renewed again or edited.

Discontinuing Orders

When an order is discontinued, the order’s Stop Date/Time is changed to the date/time the action is taken. An entry is placed in the order’s Activity Log recording who discontinued the order and when the action was taken. Pending and Non-verified orders are deleted when discontinued and will no longer appear on the patient’s profile.

To discontinue an order, use these steps:

1. Click the **Orders** tab.
2. Click the order you want to discontinue.
3. Select **Action | Discontinue/Cancel.** A dialog may appear asking for the clinician’s name and the location (encounter information).
4. Click the name of the clinician (you may need to scroll through the list), click the encounter location, and then click **OK**. Another dialog will appear asking for the reason why the order is being discontinued.
5. Select the appropriate reason from the box in the lower left of the dialog and click **OK**.

Changing Orders

To change a Medication order:

1. Click either the **Meds** tab or the **Orders** tab.
2. Click the medication order to select it.
3. Select **Action | Change...** or right-click the order and click **Change....**

   Note: If the provider or location has not been defined, you will be prompted for that information.
4. Complete the changes as appropriate in the dialog box that appears on the screen.
5. Click **Accept**.
6. You may sign the order now or later.

Viewing a Medication Order

When you select the Meds tab, you see a list of medications that have been ordered for this patient. You can get a more detailed display of each order by double-clicking the order.

Note: You can also review or add medication orders from the Orders tab.

When ordering medications, you can order Outpatient Pharmacy or Inpatient Meds, which includes IV Fluids and Unit Dose.

Transfer Outpatient Meds Order to Inpatient

You can transfer outpatient medications to inpatient medications with CPRS. CPRS will tell you if the medication cannot be changed to an inpatient medication.

Because of the differences, you will go through each order and make the necessary changes.

To transfer the medication to inpatient, use these steps:

1. Click the **Meds** tab.
2. Select the outpatient medications you want to transfer. Hold down the CTRL key to select more than one medication. Hold down the SHIFT key and click the first and last medications to select a range.
3. Select **Action | Transfer** to Inpatient.
4. Enter the necessary information for the first order and click Accept.
5. Repeat step 4 as needed for the selected medications.
6. When finished, you can sign the orders now or wait until later.

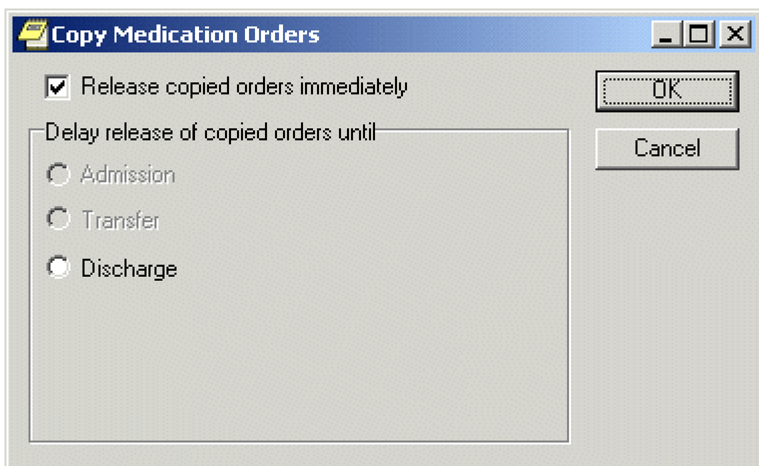
Transfer Inpatient Meds Order to Outpatient

You can transfer inpatient medications to outpatient medications with CPRS. CPRS will tell you if the medication cannot be changed to an outpatient medication.

Because of the differences, you will go through each order and make the necessary changes.

To transfer the medication to outpatient, use these steps:

1. Click the **Meds** tab.
2. Select the inpatient medications you want to transfer. Hold down the CTRL key to select more than one medication. Hold down the SHIFT key and click the first and last medications to select a range.
3. Select **Action | Transfer to Outpatient**.
   The Copy Medication Orders dialog will appear.

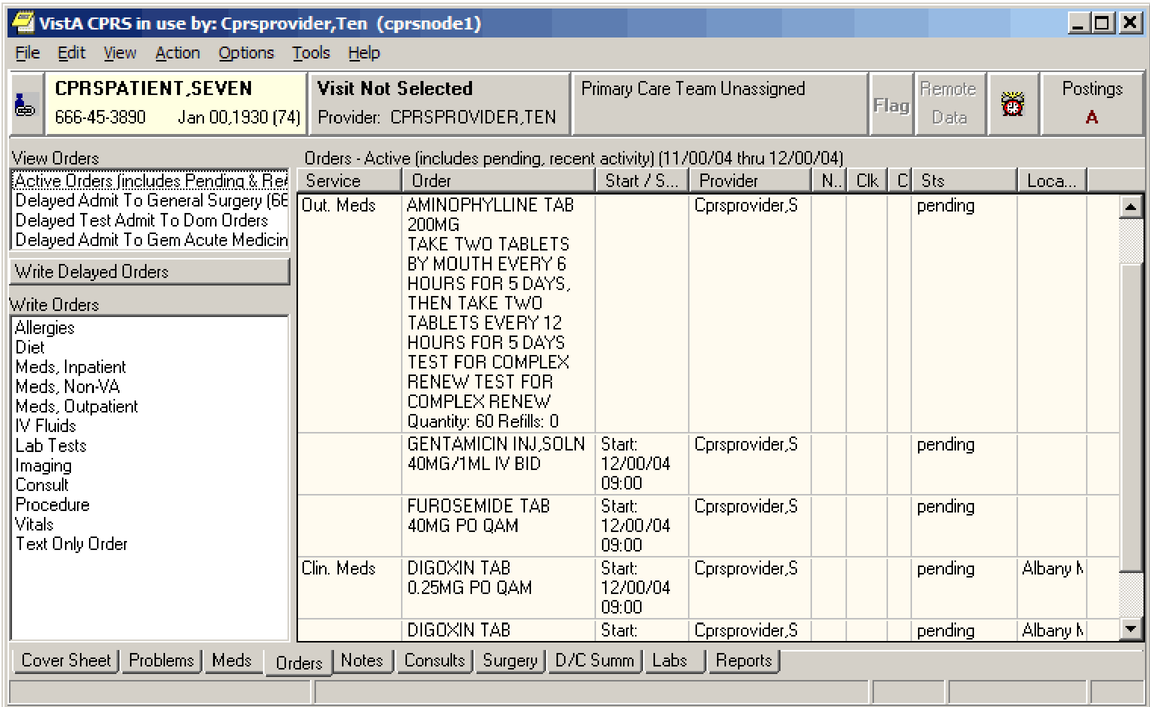


The Copy Medication Orders dialog

4. If you would like to release the copied order(s) immediately, check the "Released copied orders immediately" option. If you would like to delay the release of the copied order(s), select one of the options in the "Delay release of copied orders until" group.
5. Click **OK**.
   The Medication Order dialog will appear.
6. Enter the necessary information in the Medication Order dialog for the first order and click **Accept**.
7. Repeat Step 6 as needed for the selected medications.
8. When finished, you can sign the orders now or wait until later.

Orders

From the Orders tab, you can write new orders and view existing orders for the selected patient. You can also create quick orders and order sets that make the ordering process more efficient. The Orders tab also allows you to quickly access information about each order such as which services the orders are associated with, the start and stop dates for each order, the name of the provider (or nurse or clerk) that entered the order, and the status of the order.



The Orders tab

Viewing Orders on the Orders Tab

You can control which orders appear on the Orders tab by defining specific criteria. For example, you can specify that only unsigned orders associated with a specific service or section appear on the Orders tab.

Unsigned orders are underlined on the Orders tab. Unsigned orders for the current provider are bold and underlined.

To view orders on the Orders tab, follow these steps:

1. Select the **Orders** tab.

2. Select **View** | **Active Orders (includes pending, recent activity)**, **View** | **Current Orders (active/pending status only)**, **View** | **Auto DC/Release Event Orders**, **View | Expiring Orders**, **View** | **Unsigned Orders**, or **View | Recently Expired Orders.**
   -or-
   Select the type of order you want to view from the **View Orders** pane on the left side of the **Orders** tab.

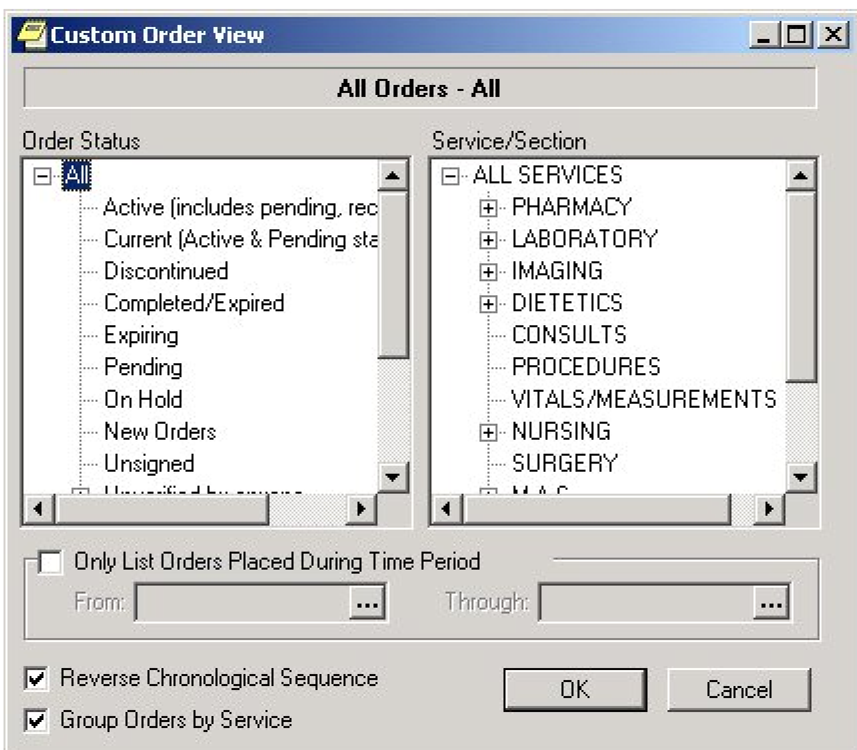
   Note: If you select **View | Auto DC/Release Event Orders** the *Auto DC/Release Event Orders* dialog box appears Select the release event associated with the orders you would like to view and click **OK**.

   If you select **View | Recently Expired Orders,** the parameter ORWOR EXPIRED ORDERS stores the number of hours in the past that CPRS will look for expired orders. A coordinator can set this value for your site.

   The appropriate orders will appear on the Orders tab.

   If you would like to filter the orders further, continue with step 3.

3. Select **View** | **Custom Order View**…
   The *Custom Order View* dialog box appears.



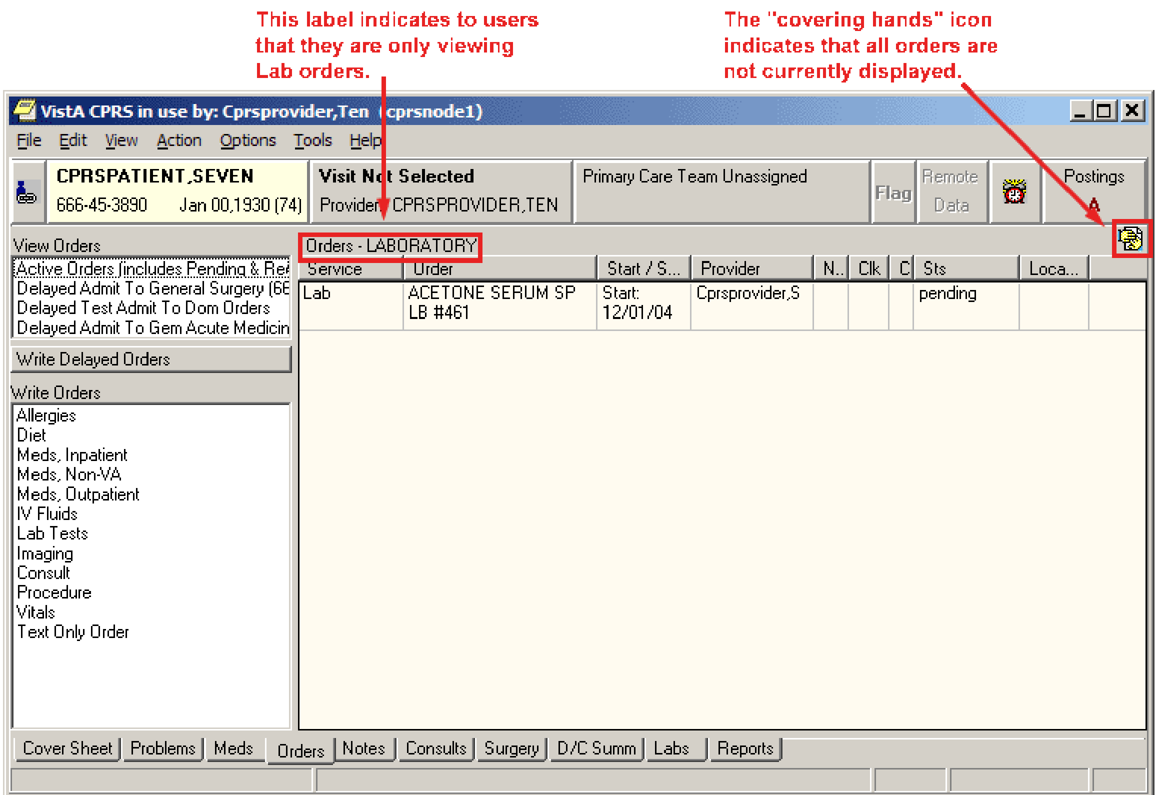
The Custom Order View dialog

4. Select the criteria for the orders that you want to display on the **Orders** tab by taking some or all of the following steps:
   - Select an order status from the left pane. (Click **+** to expand a heading.)
   - Select a service or section from the right pane. (Click **+** sign to expand a heading.)

- If you want to limit the orders to a specific date range, select the **Only List Orders Placed During Time Period** checkbox and enter a from and through date. Click ... to choose a date from a calendar.
- Click **Reverse Chronological Sequence** if you want the oldest orders to appear at the top of the Orders tab.
- Click **Group Orders by Service** if you want the orders to be sorted according to the service they are associated with.

5. Click **OK**.
   The orders that meet the criteria you specified on the Custom Order View dialog will appear on the Orders tab. The criteria for the displayed orders will appear above the Service column.

   Note: If all of the active orders are not displayed on the Orders tab, the icon appears below the **Postings** button (on the right side of the screen).



The Orders tab can be customized to display specific orders.

Viewing Results

To view the results of an order, follow these steps:

1. Select the **Orders** tab.
2. Highlight the appropriate order.
3. Select **View** | **Results**.
   The results of the order will be displayed.

   Note: You can also right-click on the appropriate order and select **Results…** from the right-click menu.

To view a history of results, follow these steps:

1. Select the **Orders** tab.
2. Highlight the appropriate order.
3. Select **View** | **Results History…**
   The results history will be displayed.

   Note: You can also right-click on the appropriate order and select **Results History…** from the right-click menu.

To set a default view for the Orders tab, follow these steps:

1. Customize the Orders tab by following the steps above.
2. Select **View** | **Save as Default View**.
   The *Save Default Order View* dialog box appears.
3. Click **OK**.
   The current view will be set as the default view for the Orders tab.

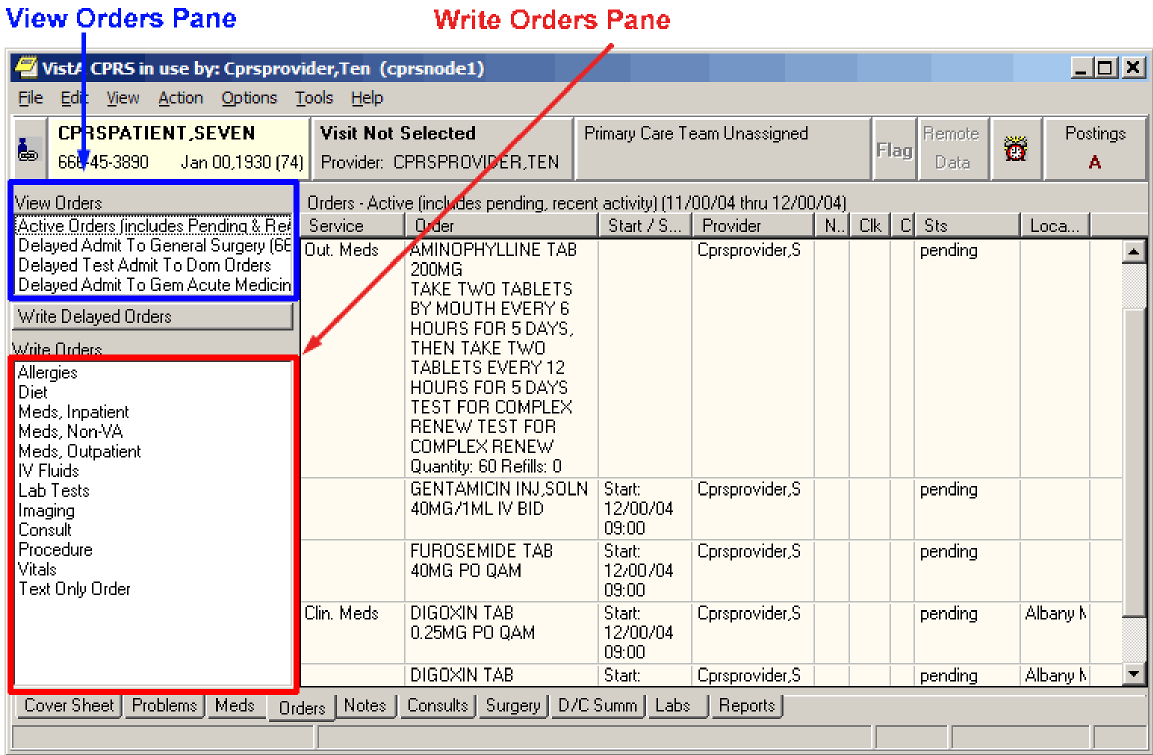
Writing Orders

Orders are placed from the Write Orders pane on the Orders tab. You can place orders for a variety of items and procedures including medications, consults, and lab tests. You can also enter information about a patient’s allergies.

Order checks are performed on all orders (after you click Accept Order and before you sign the order) to prevent errors from occurring (such as duplicate orders).

You can also specify that an order become active immediately, or specify that an order be event-delayed and activated only after a specific event occurs, such as when a patient is admitted, transferred, or discharged. You can also save common or standard orders as quick orders or order sets so that they can be placed more quickly.

Note: The orders listed in the Write Orders pane vary from site to site. Because of this, the orders discussed in this section may not be available from your Write Orders pane.



You can place an order by selecting the name of the order from the write orders pane.

Entering Allergies from the Orders tab

Although allergies and adverse reactions are not orders and CPRS does not display them on the **Orders** tab, you can enter allergies and adverse reactions from the **Orders** tab. You can also enter allergies from the **Cover Sheet** tab. (See “Entering Allergies” in the Assessing, Entering, and Reviewing Allergies/Adverse Reactions” section of this manual.)

Entering New Allergies

To enter allergies or adverse reactions from the **Orders** tab, take the following steps:

1. Click the **Orders** tab.
2. Select **Allergies** from the **Write Orders** pane.
   The **Allergy Reactant Lookup** dialog appears.

   Note: Your site may have defined and configured other order menus to include allergy-entry dialogs. Regardless of the allergy-entry menu you select, if you haven’t entered encounter information, the **Location for Current Activities** dialog appears before the **Allergy Reactant Lookup** dialog appears. You must complete the **Location for Current Activities** dialog before proceeding.

3. Type the causative agent in the search field. (You must enter the first three letters (minimum) of the agent’s name.)
4. Click **Search**.
   Matching agents appear in the **Select from one of the following items** pane. If the causative agent you typed does not match any of the agents currently

available for your site, CPRS displays the **Causative Agent Not On File** dialog, from which you can select one of the following options:

Note: The patient's chart will not be updated unless you choose a causative agent that is on file.

a. **Yes**: Use this option to request that the causative agent be added for your site. When you click **Yes**, CPRS displays the **Enter Optional Comments** dialog, which enables you to type additional comments (optional), such as the signs or symptoms that occurred as a result of contact with this causative agent, or whether you observed these symptoms firsthand. After you type your comments, click **Continue**. CPRS then sends to members of your site's GMRA Request New Reactant mail group a message that includes the following items:

- The causative agent you attempted to enter
- The name of the patient for whom you attempted to make this entry
- Your name, title, and contact information
- Your comments

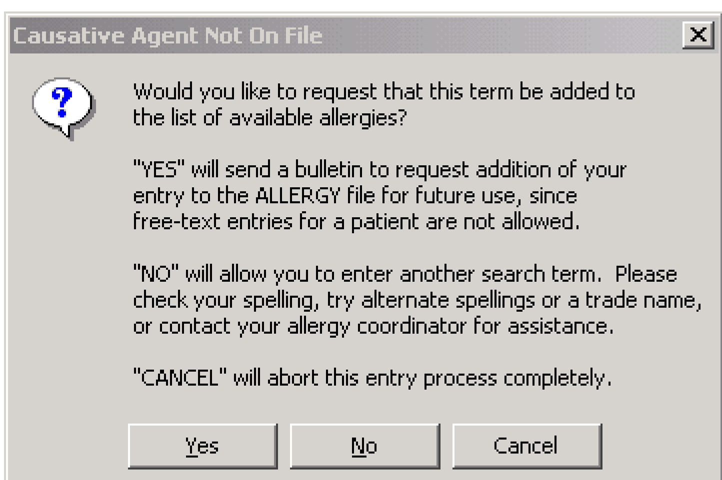
Members of your site's GMRA Request New Reactant mail group will review this message and, if appropriate, add the causative agent to your site's ALLERGIES file.

Note: If your site's IRM staff has not yet added members to your site's GMRA Request New Reactant mail group, CPRS displays the following message:

CPRS displays this message if your IRM staff has not yet added members to the GMRA Request New Reactant mail group.

b. **No**: Use this option if you want to try an alternate spelling or trade name for your causative agent, or if you want to type another causative agent.

c. **Cancel**: Use this option if you want to cancel your allergy order.

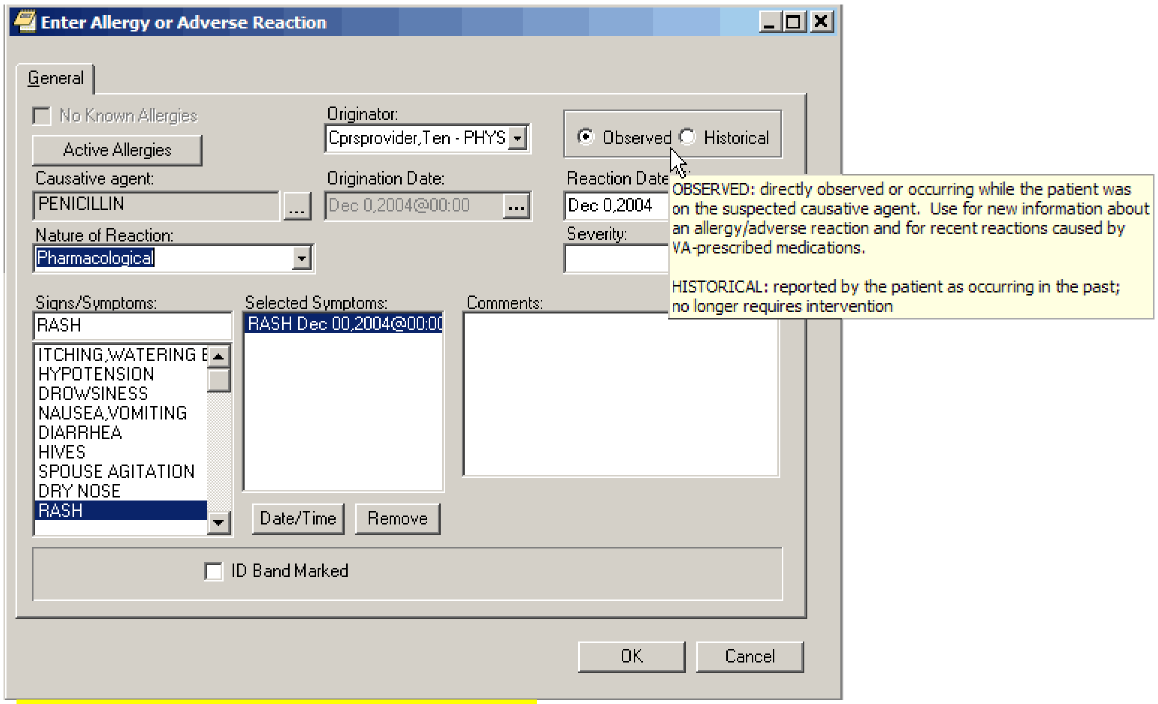


The Causative Agent Not On File dialog.

5. If the causative agent you typed matches an agent that is currently available for your site, select the agent. (Click + to expand a heading.)

   Note: With CPRS GUI 24 or later, you may not add free-text causative agents. If you select an item under the "Add new free-text allergy" heading, CPRS displays the **Causative Agent Not On File** dialog. (See Step 4 above.)

6. Click **OK**.
   The **Enter Allergy or Adverse Reaction** dialog appears.



The *Enter Allergy or Adverse Reaction* dialog with hover hint.

   Note: You can view a patient's current allergies or adverse reactions by clicking the **Active Allergies** button.

7. Using the **Originator** box, select an originator.

8. Use the **Observed** or **Historical** option button to indicate whether the entry is for an observed or historical allergy, respectively. (When you point your mouse at either of these buttons, CPRS displays a hover hint explaining the observed and historical options.)

   Note: CPRS does not allow you to select future dates for observed allergy/adverse reaction entries.

   Note: When you select Observed for a drug reaction, CPRS generates a Progress Note. Once this note is signed by the user entering the allergy or by an administrative update user, the note will be viewable by all users.

9. Select the **Nature of Reaction** (**Allergy**, **Pharmacological**, or **Unknown**).

   The Nature of Reaction (also known as mechanism)can be Allergy, Pharmacologic, or Unknown. An allergic reaction occurs because the patient is sensitive to a causative agent, regardless of the amount the patient is exposed to. A pharmacologic (non-allergic) reaction occurs when the patient is sensitive to an agent under certain conditions, such as exposure to a large amount. Unknown is provided if you are not sure what mechanism to enter.

   Note: Allergies are a subset of the world of adverse reactions. All allergies are adverse reactions, but not all adverse reactions are allergies.

10. If you are entering an observed allergy, use the **Reaction Date/Time** and **Severity** boxes to select a reaction date, time, and severity. (The **Severity** text box is not visible for historical allergies. When the Severity box is visible, CPRS displays a **?** button next to it. If you click this button, CPRS displays text that provides information about available severity selections.)

    Note: CPRS does not allow you to enter future dates for observed reactions.

11. Using the **Signs/Symptoms** box, select one or more signs or symptoms. The signs and symptoms you select appear in the **Selected Symptoms** pane.

12. To associate a date and time with a symptom (optional), click to select the symptom in the **Selected Symptoms** pane.

13. Click the **Date/Time** button located below the **Selected Symptoms** pane. CPRS displays the **Select Date/Time** dialog, from which you can select the date and time that the symptom first appeared.

    Note: If you mistakenly entered a sign or symptom but have not yet accepted it by selecting OK, select the symptom in the **Selected Symptoms** pane and click the **Remove** button located beneath the pane.

14. Type comments for the allergy in the **Comments** box.

15. If you have marked the allergy or adverse reaction on the patient's identification (ID) band (or if you know someone else has), select the **ID Band Marked** check box.

    Note: CPRS activates the **ID Band Marked** check box only for inpatients and then only if your site's IRM staff has set a parameter indicating your site wants to track this information. Depending on whether your IRM staff has set related parameters, if you do *not* select activated **ID Band Marked** check box, the system may send a bulletin notifying a mail group that the patient's allergy or adverse reaction is not marked on his or her ID band.

16. Click **OK**.

Although CPRS does not display allergy-related assessments on the **Orders** tab, you can also enter an assessment of no known allergies (NKA) from the **Orders** tab.

Entering No Known Allergies

To enter a no-known allergies assessment from the **Orders** tab, follow these steps:

1. Click the **Orders** tab.
2. Select **Allergies** from the **Write Orders** pane.
   The **Allergy Reactant Lookup** dialog appears.

   Note: Your site may have defined and configured other order menus to include allergy-entry dialogs. Regardless of the allergy-entry menu you select, if you haven't entered encounter information, the **Location for Current Activities** dialog appears before the **Allergy Reactant Lookup** dialog appears. You must complete the **Location for Current Activities** dialog before proceeding.

3. Select the **No Known Allergies** check box in the lower portion of the dialog box.
4. Click **OK**.

   Note: You can also enter a no-known-allergies assessment from the **Cover Sheet** tab.

Ordering a Diet

You can place several different types of diet orders from the Orders tab, including regular diet orders, tubefeeding orders, early/late tray orders, isolations/precautions orders, and additional orders.

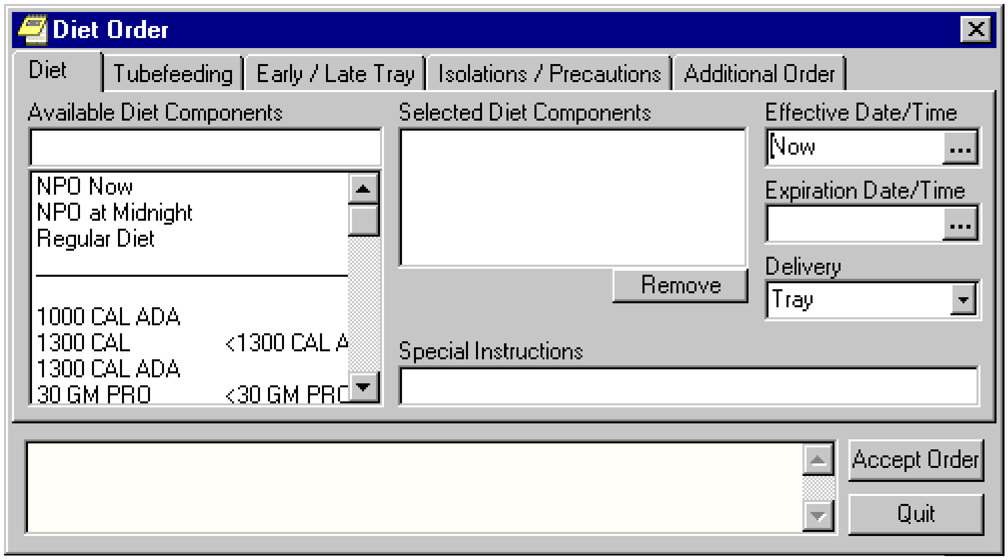
Regular Diet Orders

To place a regular diet order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane.
   -or-
   select **View** | **Active Orders (includes pending, recent activity)**.
3. Click **Diet** in the Write Orders list box.
   The Diet Order dialog box appears.

   Note: The diet order may be labeled differently or may not be available from your Write Orders list box.

   Note: If encounter information has not been entered, the encounter information dialog box appears before the *Diet Order* dialog box. You must complete the encounter information dialog box before proceeding.



The Diet Order dialog allows you to order several different types of diets.

4. Choose a diet from the Available Diet Components list box on the Diet tab. (Quick orders are at the top of the list).

   The component that you select will be displayed in the Selected Diet Components field. You can remove the component by selecting it and clicking **Remove**.

5. Enter the effective date and time and the expiration date and time by doing one of the following:

   a.) entering a date (e.g. 6/21/01 or June 21, 2001).

   b.) entering a date formula (e.g. t-200).

   c.) clicking the  button to bring up a calendar.

6. Select a delivery method from the Delivery field.
7. Type in any special instructions.
8. Click **Accept Order**.

   Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Tubefeeding Diet Orders

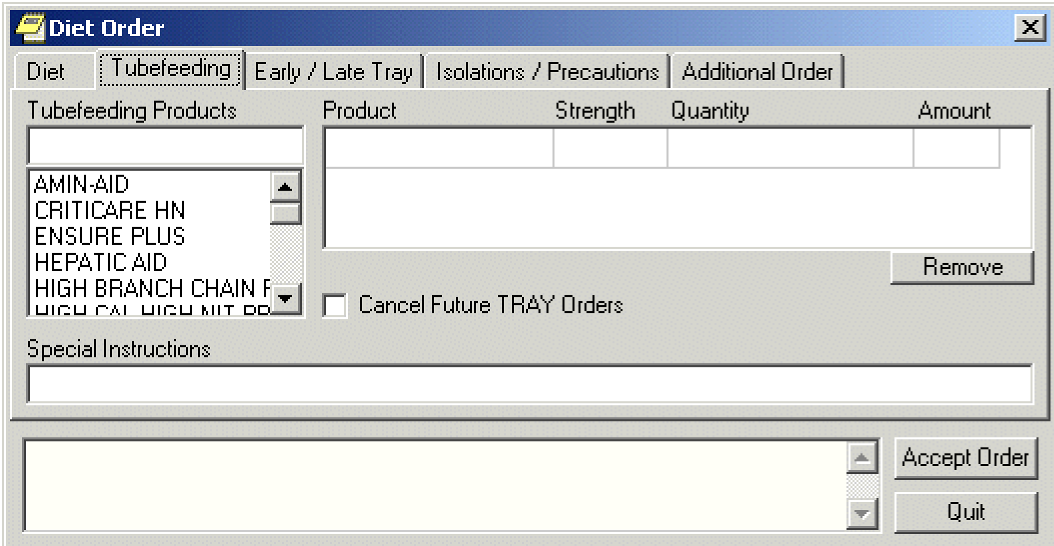
To place a tubefeeding diet order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane.
   -or-
   select **View | Active Orders (includes pending, recent activity)**.
3. Click **Diet** in the Write Orders list box.
   The Diet Order dialog will appear.

   Note: The diet order may be labeled differently or may not be available from your Write Orders field.

Note: If encounter information has not been entered, the encounter information dialog appears before the *Diet Order* dialog. You must complete the encounter information dialog before proceeding.

4. Select the **Tubefeeding** tab.



The Tubefeeding tab on the *Diet Order* dialog.

5. Select a tubefeeding product from the list.
6. Select strength and a quantity from the grid on the right side of the dialog.
   CPRS will automatically complete the Amount field.

   Note: You can remove a product by selecting the product and clicking **Remove**.
7. If you would like to cancel future tray orders, click the "Cancel Future TRAY Orders" checkbox.
8. Enter any special instructions.
9. Click **Accept Order**.

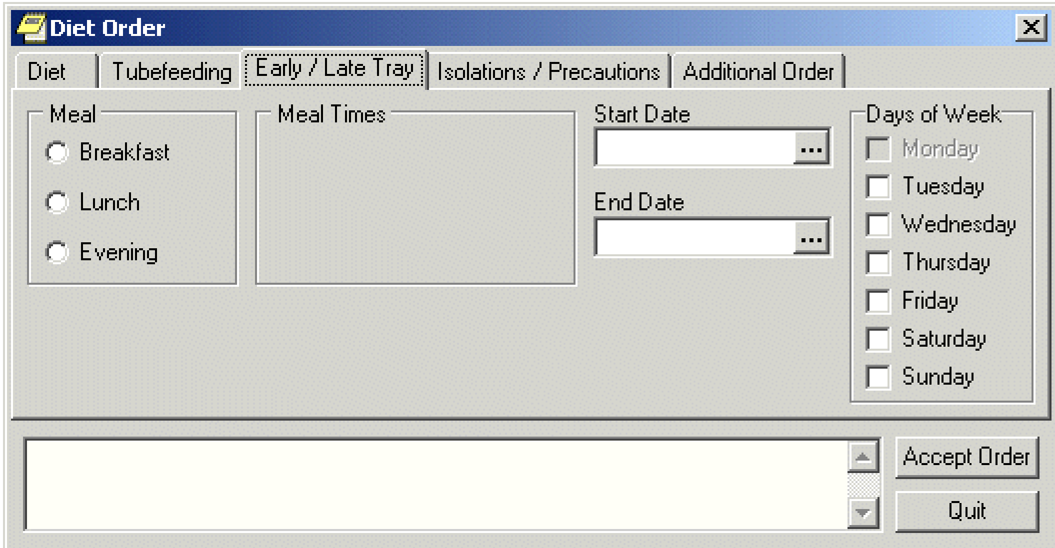
Early / Late Tray Diet Order

To place an early / late tray diet order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View | Active Orders (includes pending, recent activity)**.
3. Click **Diet** in the Write Orders list box.
   The *Diet Order* dialog will appear.

   Note: The diet order may be labeled differently or may not be available from your Write Orders list box.

   Note: The encounter information dialog may appear before the Diet Order dialog if you have not entered encounter information. If the encounter information dialog appears, enter the necessary information and click **OK**.
4. Click the **Early / Late Tray** tab.



The Early / Late Tray tab

5. Select **Breakfast**, **Lunch**, or **Evening** from the Meal option group.
   The appropriate meal times will appear in the Meal Times option group.
6. Select a meal time.
7. Select a start and end date by doing one of the following:
   a.) entering a date (e.g. 6/21/01 or June 21, 2001)
   b.) entering a date formula (e.g. t-200)
   c.) clicking the ... button to bring up a calendar
8. Select which days the order will be effective from the Days of Week option group.
9. Click **Accept Order**.

Isolations / Precautions Order

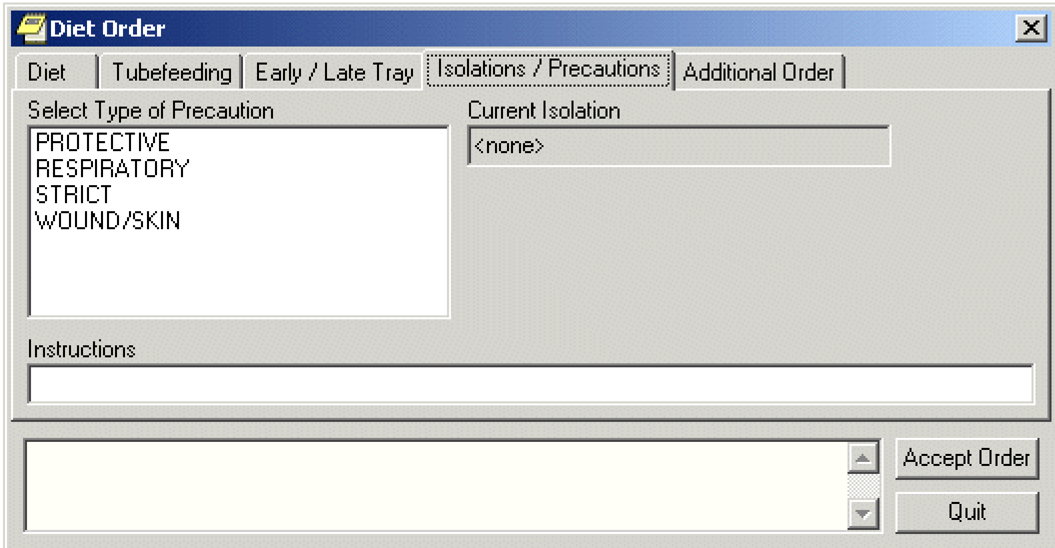
To place a isolations / precautions order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View | Active Orders (includes pending, recent activity)**.
3. Click **Diet** in the Write Orders list box.
   The *Diet Order* dialog will appear.

   Note: The diet order may be labeled differently or may not be available from your Write Orders field.

   Note: If encounter information has not been entered, the encounter information dialog appears before the *Diet Order* dialog. You must complete the encounter information dialog before proceeding.

4. Select the **Isolations / Precautions** tab.



The Isolations / Precautions tab on the *Diet Order* dialog box.

5. Select a type of precaution.
6. Enter any necessary instructions in the Instructions field.
7. Click **Accept Order**.

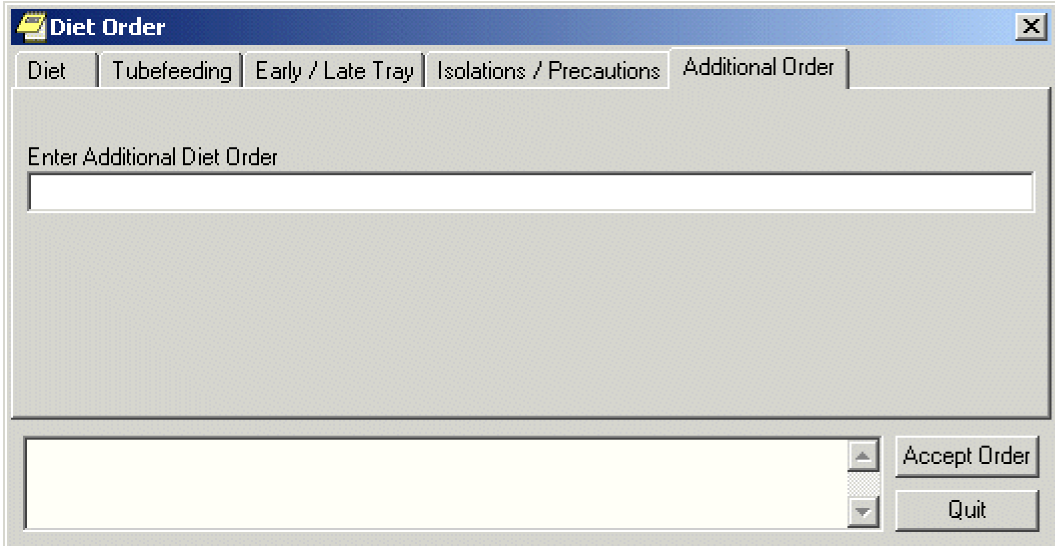
Additional Diet Order

To place an additional diet order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View | Active Orders (includes pending, recent activity)**.
3. Click **Diet** in the Write Orders list box.
   The Diet Order dialog box will appear

   Note: The diet order may be labeled differently or may not be available from your Write Orders field.

   Note: If encounter information has not been entered, the encounter information dialog appears before the *Diet Order* dialog. You must complete the encounter information dialog before proceeding.
4. Select the **Additional Order** tab.



The Additional Diet Order tab.

5. Enter the text for the order in the Additional Diet Order field.
6. Click **Accept Order**.

Ordering Medications

Both inpatient and outpatient medication orders can be placed from the Orders tab. Medications can be ordered in a simple dose or a complex dose. Inpatient medication orders now require a valid schedule. If users do not find the appropriate schedule in the list, they can choose to create a day-of-week/administration time schedule using the new Schedule builder. This feature also works for renewing, copying, and changing inpatient medication orders. The procedure for ordering medications is described below.

Note: Because a valid schedule is required, if you attempt to modify an existing medication order that does not have a valid schedule, you will receive a message box stating that and will have to enter a valid schedule.

Ordering Inpatient Medications (Simple Dose)

Note: If the user attempts to order inpatient medications for an inpatient from an outpatient location, CPRS discontinues the order process and returns the user to original Orders or Meds tab display.

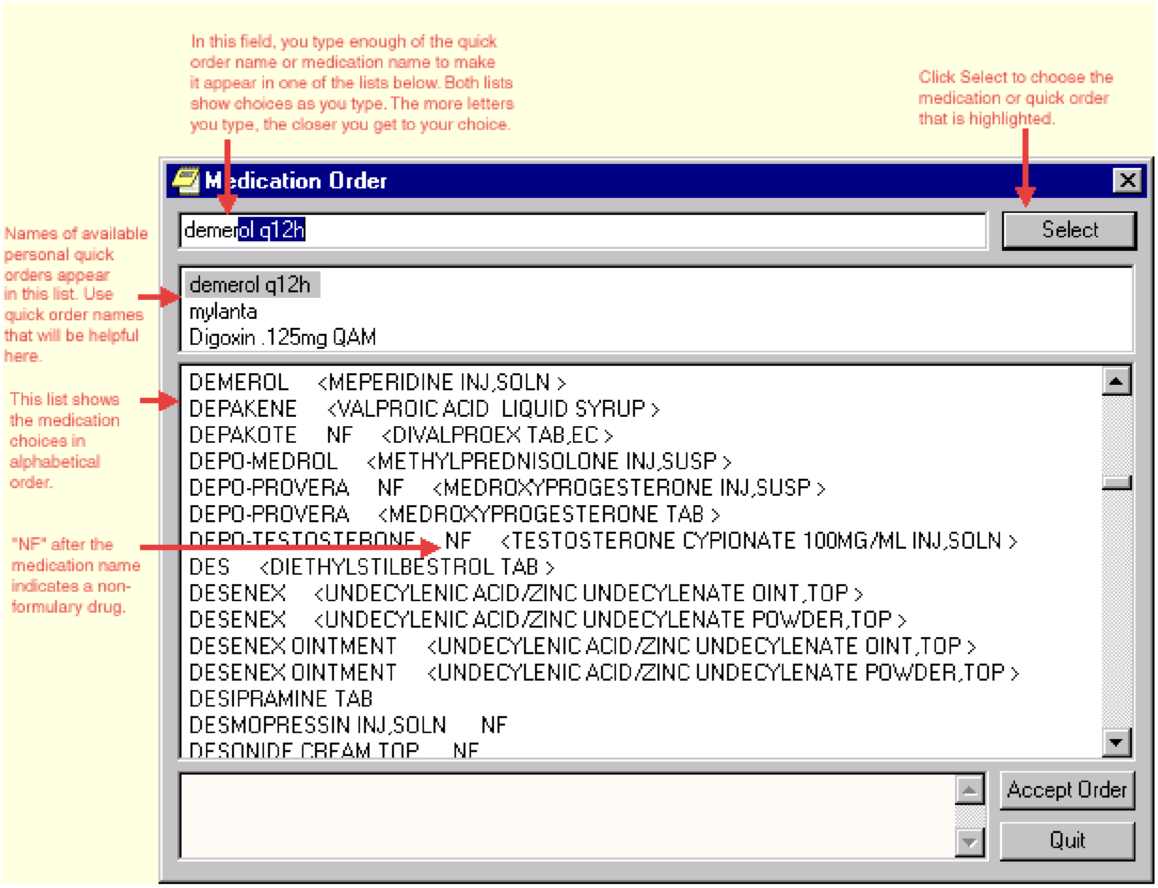
To write a new inpatient medication order with a simple dose, follow these steps:

1. Click the **Meds** tab and select **Action | New Medication**…

   -or-

   click the **Orders** tab and click the appropriate item in the **Write Orders** pane.

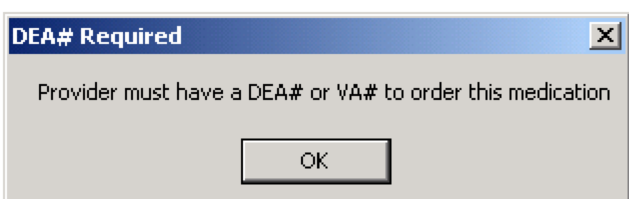
   The *Medication Order* dialog appears.



You can select an inpatient medication from the *Medication Order* dialog.

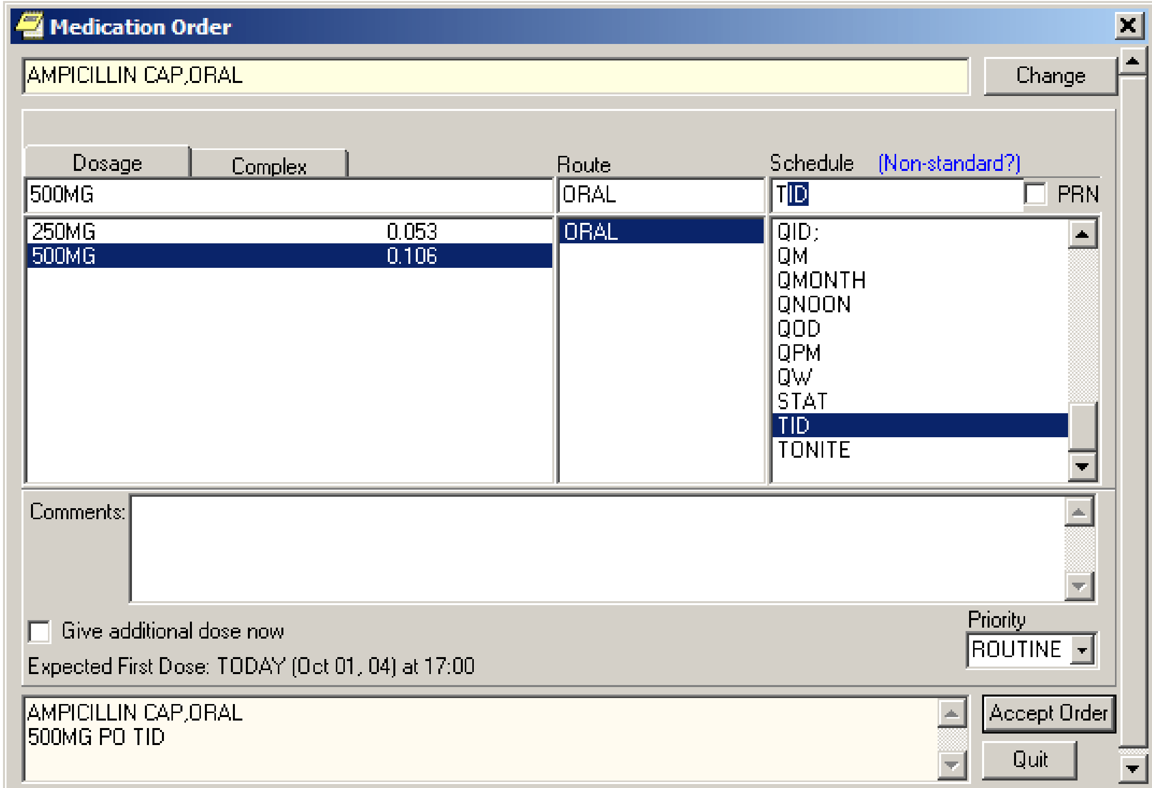
2. Select the medication name or quick order name.

Note: If the selected medication is a controlled substance that requires the signature of a provider with a DEA or VA number, the **DEA# Required** dialog appears. CPRS allows orders for controlled substances only when selected providers are able to sign the orders. You may need to exit the dialog, change the provider selection, and then reenter the dialog.



You must have a DEA# or VA# to order certain medications.

3. Click the **Dosage** field and select a dosage. (The associated cost is displayed on the right of the dosage.)



Select a dosage for the Dosage field.

4. Select a value for the **Route** field.

5. In the **Schedule** pane, select an existing schedule from the list or, to use a day-of-week/administration time schedule not on the list, select **OTHER** (you can also click the Non-Standard? link and then click OK on the dialog that displays).

6. If you selected an existing schedule, skip to step 7. If you selected **OTHER**, CPRS displays the *Order with Schedule 'OTHER'* dialog. Take the following steps:

   a.) If the schedule requires specific days of the week, click one or more check boxes to select appropriate days of the week.

   b.) If the schedule requires specific administration times, select an appropriate time, hour and minutes (when you select the minutes, the time will be added to the Schedule field).

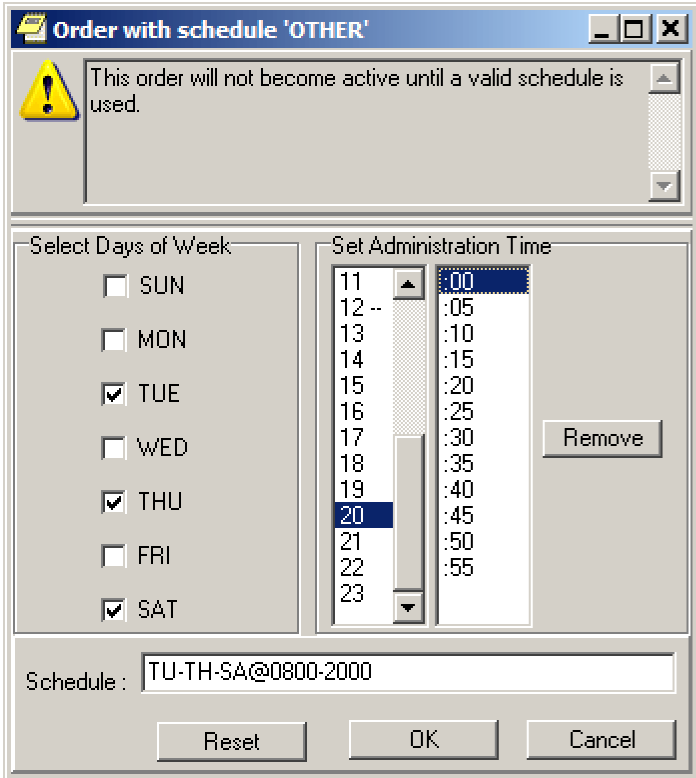
   c.) Repeat step b until you have entered all required administration times.

   Warning: The administration times in the Schedule field apply to each day of the week that is listed, such as TU-TH-SA@0800-2000, for example. To create a schedule such as TU@0800 TH@2000, users would have to enter two separate orders using the complex medication order dialog. Also, users may not enter a schedule that only has administration times and PRN but no days.

   d.) If you make a mistake while selecting an administration time, select the time in the Set Administration Time fields and click **Remove** (so to remove 08:00, you would have to select that time in the Set Administration Time fields not in the Schedule text box.) To remove the entire schedule and begin again with step a, Click **Reset**.

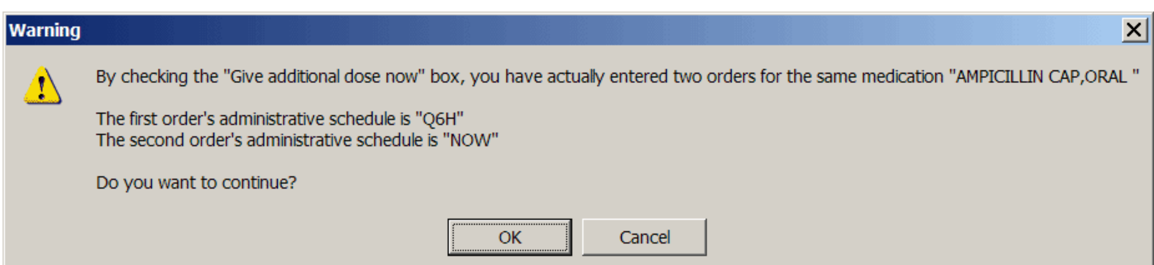
   e.) Review the **Schedule** field.

   f.) When you have selected the desired schedule, click **OK**.



The *Order with Schedule 'OTHER'* dialog allows you to enter a customized day-or-week and/or administration-time schedule.

7. Select **PRN** if necessary.
8. Enter comments (optional).
9. The date and time that the patient is scheduled to receive the first dose of the medication appears under the **Comments** field. If you want the patient to receive an additional dose now, check the **Give additional dose now** check box. CPRS displays a warning box such as the one shown below.



This graphic shows the warning that ordering providers receive if they select the **Give additional dose now** check box. The warning makes it clear that CPRS is creating two orders with different schedules.

Note: When you select **Give additional dose now**, CPRS creates a new order and sends it to the Inpatient Medications package. Check to make sure the Now order and the original schedule you entered do not overmedicate the patient.

10. Check the warning message to ensure that the orders you created are what you expected. If the orders are acceptable, click **OK**. If not, click **Cancel** to clear the **Give additional dose now** check box.
11. Click **Accept Order**.

Note: If you do not complete the mandatory items or if the information is incorrect, CPRS sends a message telling you that the information is incorrect and showing you the correct type of response.

12. Enter another medication order

    -or-

    click **Quit**.

    Note: You must sign the order before CPRS sends it to Pharmacy. You can either sign the order now or wait until later.

Ordering Inpatient Medications (Complex Dose)

Note: If the user attempts to order inpatient medications for an inpatient from an outpatient location, CPRS discontinues the order process and returns the user to original Orders or Meds tab display.

To write a new Inpatient Medications order with a complex dose, follow these steps:

1. Click the **Meds** tab and select **Action | New Medication…**

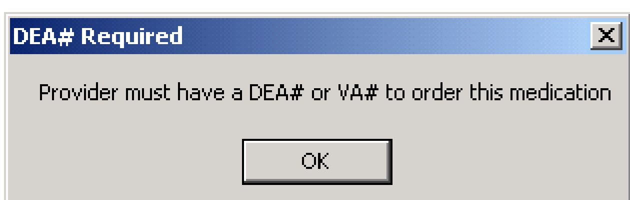
   -or-

   click the **Orders** tab and select the appropriate item under the **Write Orders** list box.

   The *Medication Order* dialog box appears.

2. Select the medication name or quick order name.

   Note: If the selected medication is a controlled substance that requires the signature of a provider with a DEA or VA number, the *DEA# Required* dialog appears. CPRS allows orders for controlled substances only when selected providers are able to sign the orders. You may need to exit the *Medication Order* dialog, change the provider selection, and then reenter the dialog.

   You must have a DEA# or VA# to order certain medications.

3. Select the **Complex** tab.

   Note: After you begin a complex dose medication order, you must remain on the **Complex** tab until you finish the order. If you switch to the **Dosage** tab, CPRS clears all complex dosages and you will be forced to start again.
4. Click the **Dosage** field and select the appropriate dosage.
5. Select a value for the **Route** field.
6. In the **Schedule** pane, select an existing schedule from the list or, to use a day-of-week/administration time schedule not on the list, select **OTHER**.

7. If you selected an existing schedule, skip to step 7. If you selected **OTHER**, CPRS displays the *Order with Schedule 'OTHER'* dialog. Take the following steps:

    a.) If the schedule requires specific days of the week, click one or more checkboxes to select appropriate days of the week.

    b.) If the schedule requires specific administration times, select an appropriate time, hour and minutes (when you select the minutes, the time will be added to the schedule field).

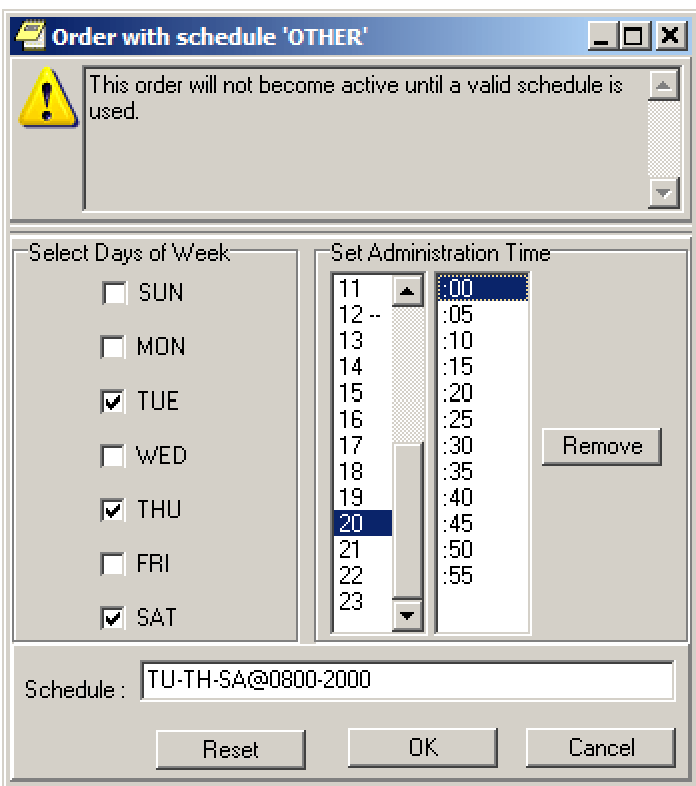
    c.) Repeat step b until you have entered all required administration times.

    Warning: The administration times in the Schedule field apply to each day of the week that is listed, such as TU-TH-SA@0800-2000, for example. To create a schedule such as TU@0800 TH@2000, users would have to enter two separate orders using the complex medication order dialog. Also, users may not enter a schedule that only has administration times and PRN but no days.

    d.) If you make a mistake while selecting an administration time, select the time in the Set Administration Time fields and click **Remove** (so to remove 08:00, you would have to select that time in the Set Administration Time fields not in the Schedule text box.) To remove the entire schedule and begin again with step a, Click **Reset**.

    e.) Review the **Schedule** field.

    f.) When you have selected the correct schedule, click **OK**.



The Order with Schedule 'OTHER' dialog allows you to enter a customized day-of-week/administration time schedule.

8. Select **PRN** if necessary.

9. Click the **Duration** field and select the amount of time that the patient should use the specified dose.
10. In the **then/and** field, select the appropriate conjunction for the order.
11. Click the next row in the **Dosage** field and type or select a dosage.
12. CPRS fills in the **Route** and **Schedule** fields. You can change the values in these fields if necessary.
13. Select a duration and a conjunction (then or and).

Note: Your site's IRM staff may have specified rules governing the status of inpatient medication orders when patients are transferred from one ward or service to another. It may have also specified the number of days an inpatient medication order remains active. Please check with your site's IRM staff for information about these rules.

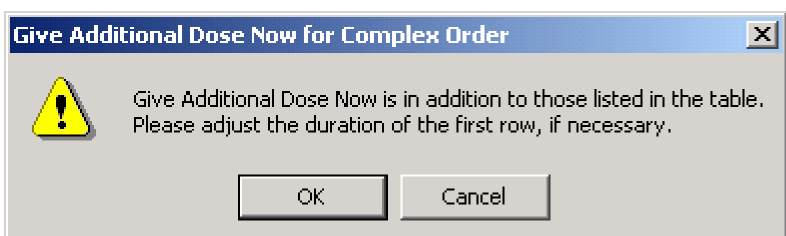
14. Repeat steps 9-10 until you have completed the complex dose.

Note: You can also add or remove a row in the complex dose. To add a row, click the gray area in front of the row and click **Add Row** (CPRS places the new row above the selected row). To delete a row, click the gray area in front of the row you wish to delete and click **Delete Row**.

15. Add comments (optional).

The date and time that the patient is scheduled to receive the first dose of the medication appears under the **Comments** field.

16. If you want the patient to receive an additional dose now, select the **Give additional dose now** check box. If you select the check box, the *Give Additional Dose Now for Complex Order* warning dialog box appears, as shown below.



This graphic shows an example of the *Give Additional Dose Now for Complex Order* warning.

Note: When you click "Give additional dose now," CPRS creates a new order and sends it to Inpatient Medications. Check to make sure the Now order and the original schedule you entered do not overmedicate the patient.

17. Check the orders and then click **OK** to close the warning dialog.
18. Choose a priority from the **Priority** drop-down list.
19. Click **Accept Order**.

Note: If you do not complete the mandatory items, or if the information is incorrect, CPRS sends a message to tell you that the information is incorrect and shows you the correct type of response.

20. Enter another medication order

-or-

click **Quit**.

Note: You must sign the order before CPRS sends it to the Pharmacy package. You can either sign the order now or wait until later.

Ordering Inpatient Medications for Outpatients

From authorized hospital locations, you can electronically order inpatient (unit-dose and intravenous (IV)) medications for outpatients. These orders have a status identical to that of inpatient-medication orders for inpatients. That is, the inpatient pharmacy checks, fills, and dispenses IMO (inpatient medications for outpatients) orders.

Note: IMO orders are affected by both CPRS auto-DC rules and Inpatient Medications rules for auto-discontinuing orders on admission and discharge. If sites do not want IMO orders to auto-discontinue on admission and discharge, sites will have to ensure that neither CPRS nor Inpatient Medications discontinues IMO orders. Inpatient Medications uses the AUTO-DC IMO ORDERS parameter to exclude IMO orders from being discontinued.

Criteria for Ordering Inpatient Medications for Outpatients

To successfully write IMO orders, outpatients must meet at least one of the following criteria:

- They must have a scheduled appointment at an authorized hospital/clinic location for the current day or a day in the future.
- They must be currently checked in at an authorized hospital/clinic location

Note: If patients do not meet either of these criteria, you can create a new visit for them at an authorized hospital location.

Simple and Complex Doses

Take the following steps to write IMO orders:

1. Click the **Orders** tab. (You can also place IMO orders via the **Meds** tab. For detailed instructions, see Ordering Inpatient Medications for Outpatients in the Meds section of this manual.)
2. From the **Write Orders** pane, select **Meds, Inpatient**. CPRS prompts you to select a location for current activities.

   Note: Depending on how menus are set up at your particular site, you may need to select a different option from the **Write Orders** pane. Check with your CAC (or the person who manages information resources at your site) to find out which **Write Orders** selection provides a complete list of inpatient medications.

3. Select a scheduled current or future appointment in an authorized hospital location, or create a new visit by selecting an authorized hospital/clinic location and accepting the default time (NOW). CPRS displays a comprehensive list of available inpatient medications.

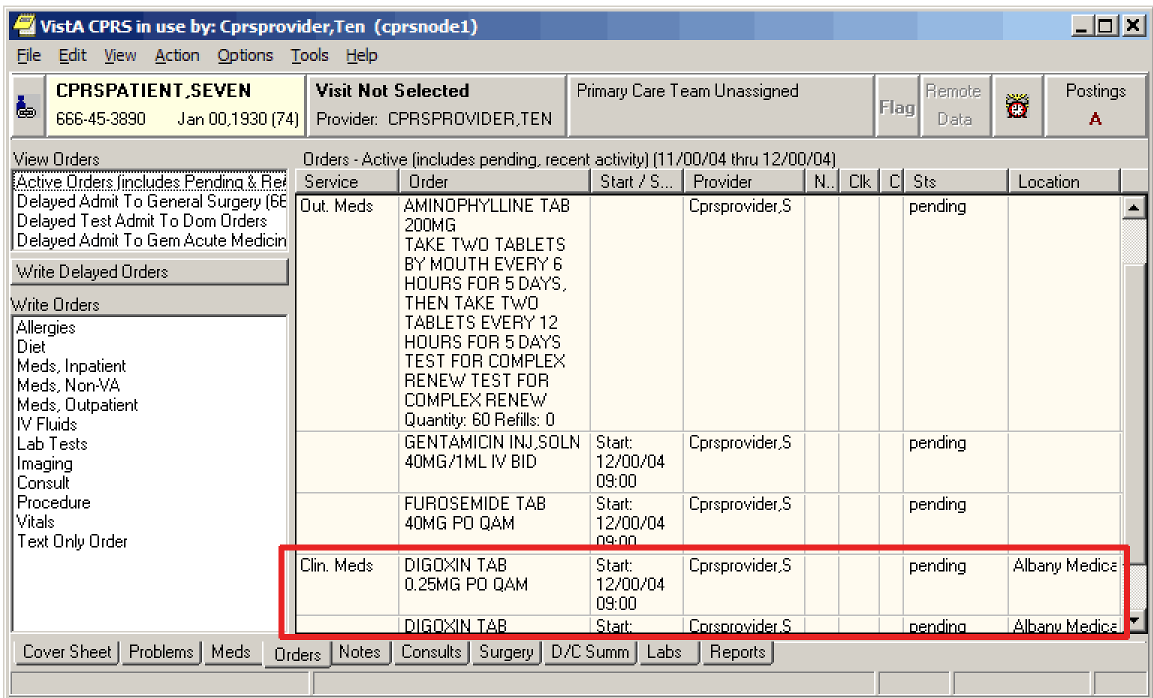
   Note: If you select a hospital location that is not authorized for IMO orders, or if the patient does not meet the criteria delineated above, CPRS displays a list comprised only of IV (injectable) inpatient medications.

   Note: CPRS allows you to change your clinic selection after you have started an order. However, if you are in the process of placing an order and change clinic locations midstream, CPRS does not reflect this change in the finished order.

For example, suppose you are in the process of placing an IMO order using an authorized clinic. Now suppose you change your mind and select instead a clinic that is not authorized for placing IMO orders. Your order will finish as an IMO order using the authorized clinic. If you are in the process of placing an IMO order using an unauthorized clinic, then change the location to an authorized clinic, CPRS does not display a complete list of inpatient (unit-dose and IV) medications. Instead, it continues to display the list of IV medications available for the unauthorized clinic. Furthermore, CPRS will not reflect this clinic change in the finished order.

4. Select a medication and follow the instructions for completing simple- or complex-dose medication orders, which appear in the "Ordering Inpatient Medications (Simple Dose)" and "Ordering Inpatient Medications (Complex Dose)" sections of this manual, respectively.

On the **Orders** tab, CPRS displays inpatient medication orders for outpatients in the **Clin. Meds** display group, with the ordering location in the **Location** column.



On the **Orders** tab, CPRS displays IMO orders under the **Clin. Meds** display group, with the ordering location in the **Location** column.

Changing or Copying Orders

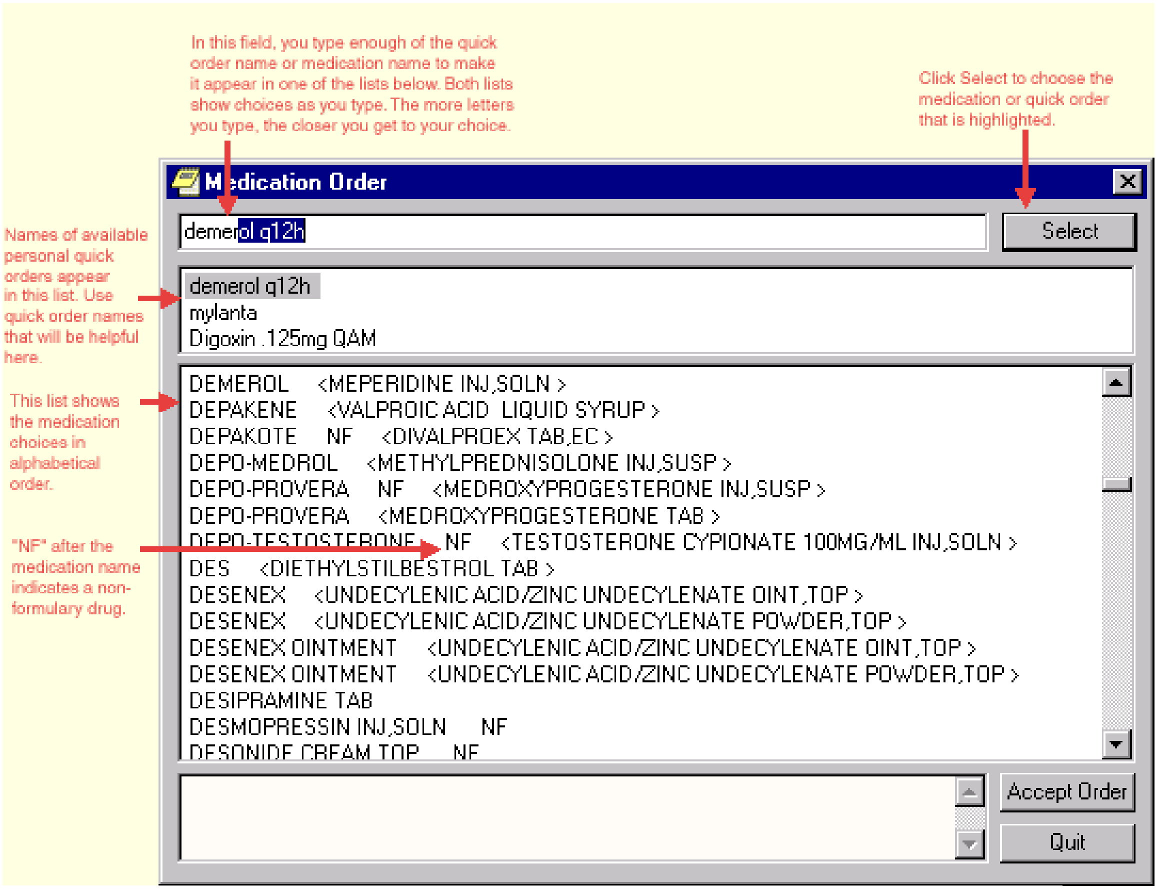
Users can also change, copy, and renew inpatient medication orders for outpatients (IMO) if the user is ordering from an authorized IMO location. If the patient's location is not an authorized IMO location (even if the patient is an inpatient), users will not be able to change, copy, or renew the IMO orders. To change inpatient medication orders for outpatients, follow the instructions in the "Changing Orders." section of this manual. To copy these orders to new orders, follow the instructions in the "Copying Existing Orders" section.

Ordering Outpatient Medications (Simple Dose)

To write a new outpatient medication order with a simple dose, follow these steps:

1. Select the **Meds** tab and select **Action | New Medication…**
 -or-
select the **Orders** tab and click the appropriate item under the Write Orders list.

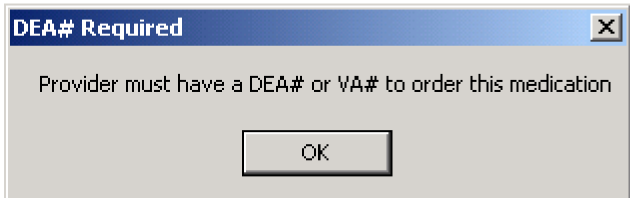
The *Medication Order* dialog box appears (as shown in the graphic below).



The Medication Order dialog

Note: If encounter information has not been entered, the encounter information dialog will appear before the Medication Order dialog box. You must complete the encounter information dialog box before proceeding.

Note: If the selected medication is a controlled substance that requires the signature of a provider with a DEA or VA number, the DEA# Required dialog appears. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the Medication Order dialog, change the provider, and reenter the Medication Order dialog.



You must have a DEA# or VA# to order certain medications.

2. Select the medication name or quick order name.
3. Select the dosage. (The associated cost is displayed to the right of the dosage).
4. Select a route from the Route field.
5. Choose a schedule from the Schedule field. (Select PRN, if desired.)
6. CPRS completes the default days supply field and calculates the quantity field based on the formula days supply x schedule = quantity. If necessary, highlight and change the numbers in these fields.

   Note: If you change a number, CPRS will attempt to recalculate the other field. If you check PRN, be sure that the quantity field is correct before accepting the order.
7. Enter the number of refills.
8. Select the location where the patient should pick up the medication from the Pick Up field.
9. Choose a priority.
10. Add comments in the Comments field (if desired).
11. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked
12. Click **Accept Order**.
13. If you are finished ordering outpatient medications, click **Quit**.

    Note: The order must be signed before it is sent to the Pharmacy package. You can either sign the order now or wait until later.

Ordering Outpatient Medications (Complex Dose)

To write a new Outpatient Medication order with a complex dose, follow these steps:

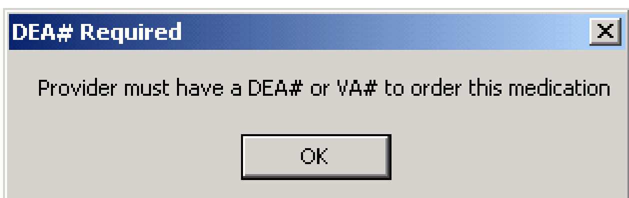
1. Click the Meds tab and select Action | New Medication…

   -or-

   click the **Orders** tab and click the appropriate item under the Write Orders list box. CPRS will display the Medication Order dialog.
   Note: If encounter information has not been entered, the encounter information dialog will appear before the Medication Order dialog. You must complete the encounter information dialog before proceeding.

2. Select a medication or quick order from the list box.

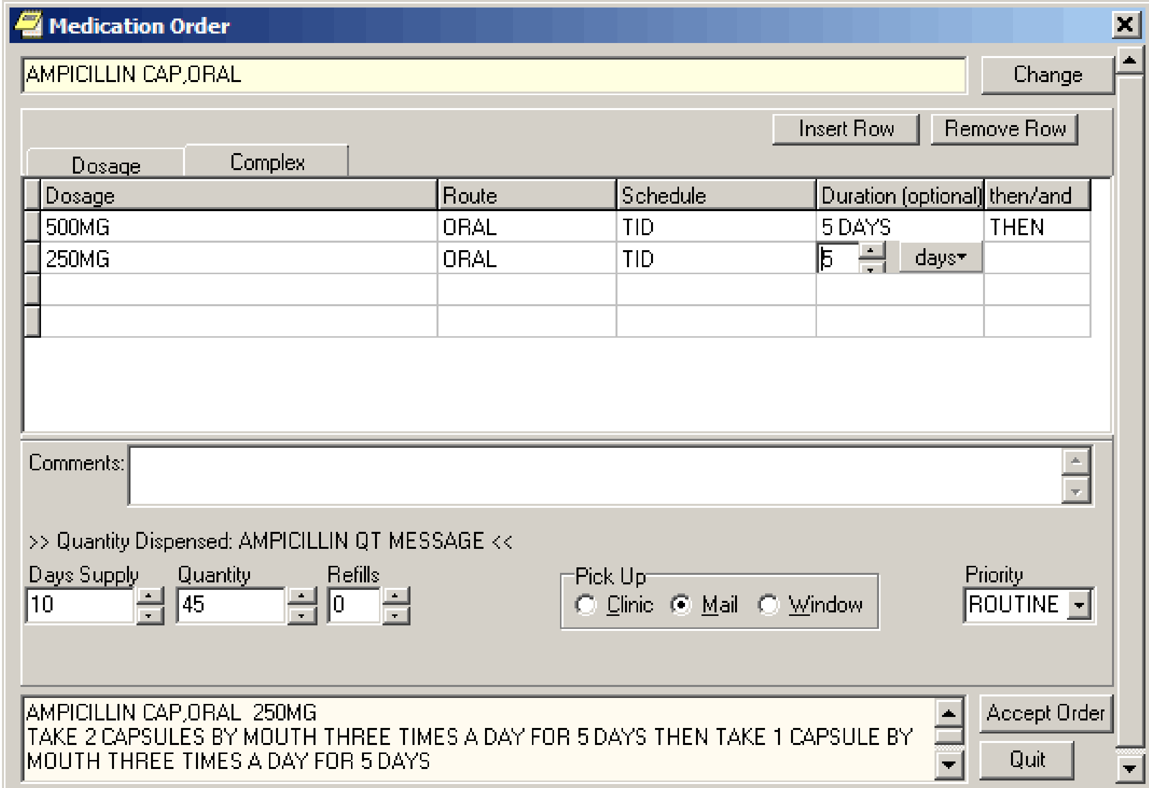
   Note: If the selected medication is a controlled substance that requires the signature of a provider with a DEA or VA number, the DEA# Required dialog will appear. Before an order for a controlled substance can be entered, the provider selected for the encounter must be able to sign the order. You may need to exit the Medication Order dialog, change the provider, and then reenter the Medication Order dialog.

   You must have a DEA# or VA# to order certain medications.

3. Click the **Complex** dose tab.

Note: Once you begin a complex medication order, you must remain on the Complex tab until you finish the order. If you switch tabs, all complex dosages will be erased, and you will be forced to start the order again.



You can enter a complex medication order from the Medication Order dialog.

4. Click the Dosage field and select the appropriate dosage.
5. Click the Route field and enter a route.
6. Enter a schedule in the Schedule field. (Select PRN if desired).
7. Enter duration in the Duration field.
8. Enter the appropriate conjunction in the then/and field.
9. Click the dosage field in the next row and select a dosage.
10. Repeat steps 4-9 until you have completed the complex dose.

    Note: You can add or remove a row in the complex dosage. To add a row, click the gray area in front of the row and click **Add Row**. (The new row will be placed above the selected row.) To delete a row, click the gray area in front of the row to be deleted and click **Delete Row**.

11. CPRS will display a default value in the Days Supply and Quantity fields. The quantity is calculated based on the formula Days Supply x Schedule = Quantity. If necessary, you can change the value in these fields.

    Note: If you change a number, CPRS will attempt to recalculate the other field.

12. Enter the number of refills.
13. Select the location where the patient should pick up the medication from the Pick Up field.
14. Add comments if necessary.

15. Under certain circumstances, a check box may appear under the Days Supply field. If the medication is service-connected, make sure the box is checked.
16. Click Accept Order.
17. If you are finished ordering outpatient medications, click **Quit**.

    Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Adding Non-VA Medications

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) has indicated that all medications, including herbal supplements, over-the-counter (OTC) non-prescription medications, and medications prescribed by providers outside the VA (collectively known as "Non-VA medications") should be entered in the medical record. CPRS, Outpatient Pharmacy, and Inpatient Medications developers have made changes that enable users to enter this information into the medical record so that providers have a better picture of the medications the patient is taking and that order checks against these medications can occur.

Entering Non-VA Medications will trigger the following order checks:

- Duplicate Drug (shows as Duplicate Order check)
- Duplicate Drug Class
- Critical Drug Interaction
- Significant Drug Interaction
- Allergy checks

Note: For Non-VA meds, inpatient orders are not checked against non-VA medications and the allergy check is slightly different. The duplicate drug class check will not be triggered for two pure herbal medications, such as ginger and gingko. All pure herbal medications belong to the same drug class (HA000). If these checks were made, every time a clinician entered a pure herbal medication, the user would receive a duplicate drug class warning. Allergy checks will still occur for non-VA medications that do not belong to this drug class.

Making Non-VA Meds Available for Entry

For users to be able to enter these medications through CPRS, they must be in the CPRS Orderable Items file so that they appear when the user chooses the new order sheet. The Pharmacy patch (PSS*1.0*68) enables sites to mark items as Non-VA Medications. Initially, all Pharmacy orderable items that are marked as "outpatient" and are not supply items will be automatically made Non-VA medications. Subsequently, Pharmacy coordinators can use the Pharmacy option Drug Enter/Edit [PSS DRUG ENTER/EDIT] to identify items as Non-VA Meds or remove the designation.

Note: For more information about how to get Non-VA Medications added to the appropriate file, please see "Section 5.1: Communicating New Non-VA Meds Entries to the Pharmacist" in the *Herbal/OTC/Non-VA Meds Documentation Release Notes* that will be located on the VistA Documentation Library at http://www.va.gov/vdl under the Outpatient Pharmacy listings.

Items identified as “Non-VA Meds” are copied into the CPRS Orderable Items file when the Order Entry patch (OR*3.0*176) is installed at your site. Then, when CPRS GUI version 24 is installed, the item “Meds, Non-VA” is added under the Write Orders pane on the Orders tab. When the user selects the Meds, Non-VA option, the dialog displays the items that were marked as Non-VA Meds and copied into the CPRS Orderable Items file.

Different from Ordering Medications

Remember that entering Non-VA Medications is not the same as placing orders. Users simply enter information to provide a more complete view of what the patient is taking. However, once the items are available in the CPRS Orderable Items file, the process for entering Non-VA Medications is similar to entering other orders, but there are a few differences:

- Almost any CPRS user can enter Non-VA medication information. However, sites can restrict access for those holding the OREMAS key by using the OR OREMAS NON-VA MEDS parameter. For more information about this parameter, please see the *CPRS Technical Manual: GUI Version*.
- Users can enter Non-VA medication even if they only have partial information.
- Non-VA medications are listed separately on the orders tab and the designation “Non-VA Med” is displayed at the beginning of the entry.
- Users may to pick a reason why the patient is taking the Non-VA medication.

For the reason/statement that users should enter, developers sent out four reasons or statements at the package level of the parameter GUI Non-VA Med Statements/Reasons that were agreed upon by a workgroup:

- Non-VA medication not recommended by VA provider.
- Non-VA medication recommended by VA provider.
- Patient wants to buy from Non-VA pharmacy.
- Medication prescribed by Non-VA provider.

Authorized users can enter their own reasons/statements in the parameter by entering new statements at the System or Division level for this parameter. For more information about changing this parameter, see the *CPRS Technical Manual: List Manager*.

Entering Non-VA Medication Information

To enter Non-VA medication information, use the following steps:

1. If you are not already there, go to the Orders tab by either clicking **Orders** or pressing **Ctrl + O**.
2. In the Writer Orders list, select **Meds, Non-VA**.

   Note: If encounter information has not been entered, the encounter information dialog will appear before the Medication Order dialog. You must complete the encounter information dialog before proceeding.

3. In the Document Herbal/OTC/Non-VA Medications dialog, select the medication or herbal supplement by
   A.) Typing a few letters of name.
   B.) Selecting the correct name from the list by double-clicking it or highlighting it and pressing <Enter>. You may need to scroll down to find the name.

   Note: If you do not know other information such as dosage, route, or schedule, you may enter only the name of the medication or herbal supplement.

4. Enter a dosage (if known).
5. Enter a route (if known).
6. Enter a schedule, including PRN if necessary (if known).
7. Enter any comments.
8. If you want to enter one, select one or more Statements/Explanations as to why the patient is taking the medication or supplement.
9. Enter a start date (if known).
10. Review the information entered in the text box at the bottom of the dialog.
11. Place the information into the patient's record by clicking **Accept Order** or by tabbing to **Accept Order** and pressing **<Enter>**.
12. To enter additional Non-VA Medications into the patient's record, repeat steps 3-11.
13. When you are through entering Non-VA medications, exit the dialog using the Quit button.

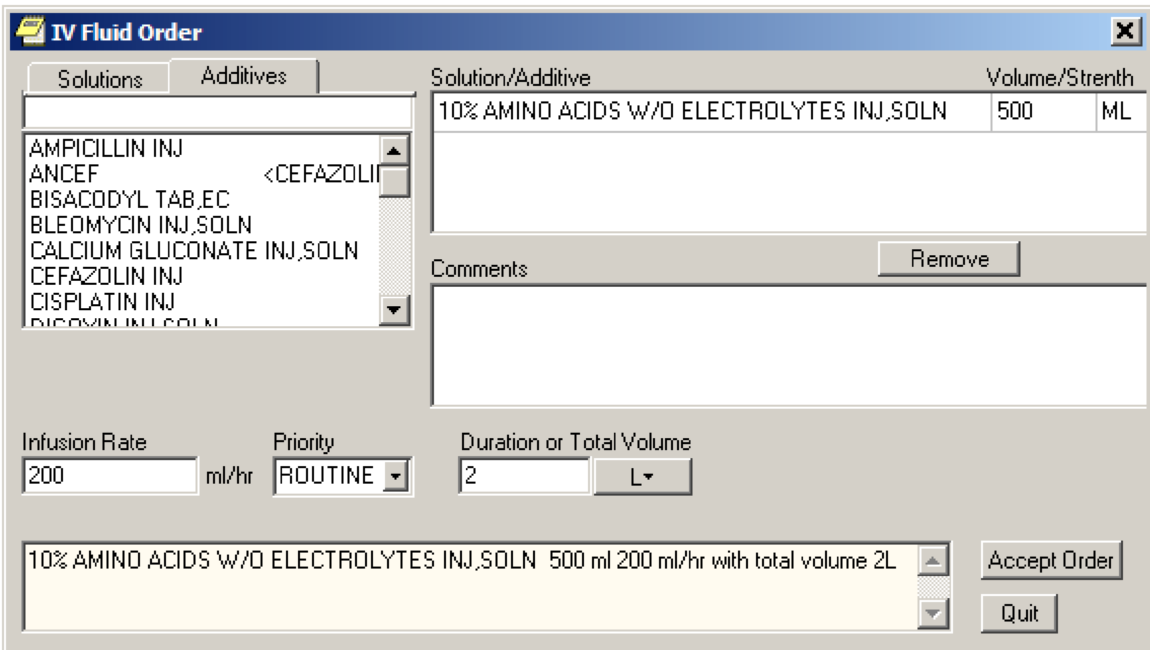
Note: Non-VA Meds do not require an electronic signature, but they will be presented at the end of the current CPRS session on the Sign screen. You can do the normal signing process or if you only have Non-VA meds, you might get OK and Cancel buttons on a dialog instead of the normal Sign screen. You cannot click on the checkbox in front of a Non-VA Med to deselect and not approve it. Non-VA Meds because they do not require electronic signature will be automatically entered when you click OK or enter you electronic signature.

IV Fluids

To order IV fluids, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View | Active Orders (includes pending, recent activity)**.
3. Click **IV Fluids** in the Write Orders list box.
   Note: The IV fluids order may be labeled differently or may not be available from your Write Orders list box.

   The IV Fluid Order dialog will appear.



The IV Fluid Order dialog

Note: If encounter information has not been entered, the encounter information dialog will appear before the IV Fluid Order dialog. You must complete the encounter information dialog before proceeding.

4. Select a solution from the Solutions tab.
   After you select a solution, CPRS automatically moves to the Additives tab.
5. Select an additive from the list (if necessary).
   The solution and additives you select will appear in the Solution/Additive grid.
   Note: To remove an item, select the solution or additive and click **Remove**.
6. Enter a volume and strength in the Solution/Additive grid (if necessary).
7. Enter an infusion rate.
8. Select a priority.
9. Enter a number for the duration or total volume.
10. Select the appropriate unit (liters-L, milliliters-ml, days, or hours).
11. Enter any comments (if necessary).
12. Click Accept **Order**.

13. Enter another order
    -or-
    click **Quit**.

    Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

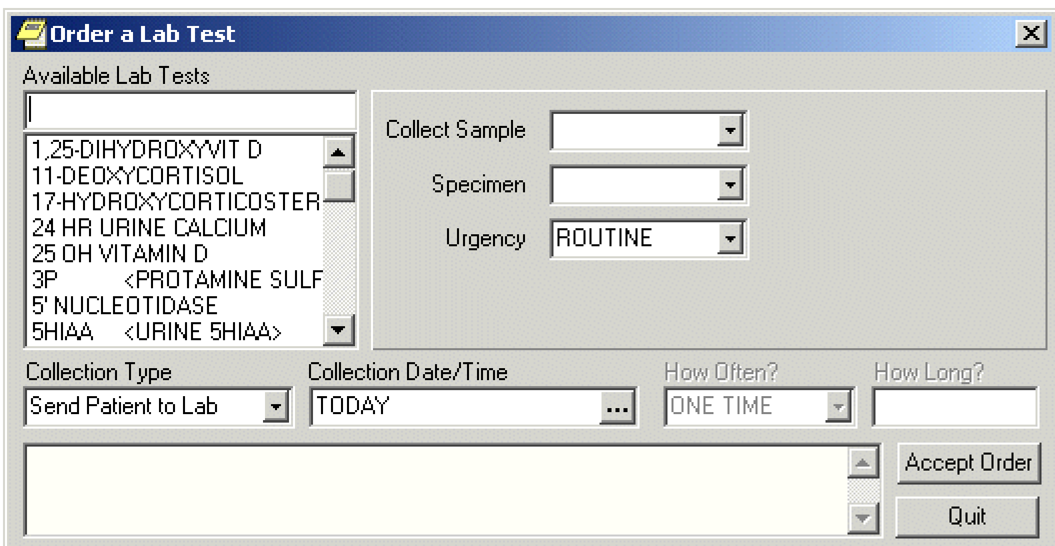
Lab Tests

To place an order for a lab test, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View | Active Orders (includes pending, recent activity)**.
3. Click **Lab Tests** in the Write Orders list.

   Note: The lab tests order may be labeled differently or may not be available from your Write Orders field.

   The Order a Lab Test dialog will appear.



The Order a Lab Test dialog

Note: If encounter information has not been entered, the encounter information dialog will appear before the Order a Lab Test dialog. You must complete the encounter information dialog before proceeding.

4. Select the desired lab test in the Available Lab Tests list box.
5. If desired, change the default values for the Collection Sample, Specimen, and/or Urgency fields. If you cannot change a field, the text label (to the left of the field) will be dimmed.
6. Select the collection type.
7. Choose a collection date and time.
8. Complete the How Often? and How Long? fields (if necessary).
9. Click **Accept Order**.

10. Enter another lab test
    -or-
    click **Quit**.

    Note: The Lab Test order must be signed before it is sent. You can either sign the order now or wait until later.

Radiology and Imaging

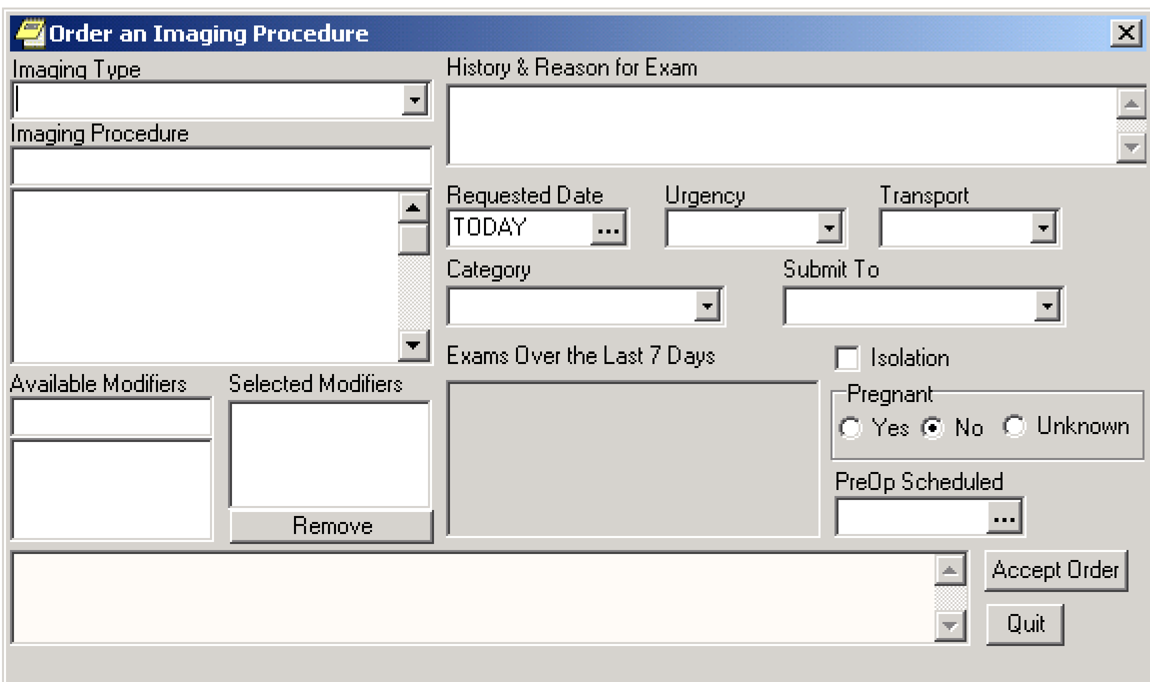
To order any type of imaging, such as an x-ray or a nuclear medicine exam or procedure, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View | Active Orders (includes pending, recent activity)**.

Select Imaging in the Write Orders list box.

Note: The imaging order may be labeled differently or may not be available from your Write Orders field.

The Order an Imaging Procedure dialog appears.



Order an Imaging Procedure dialog

Note: If encounter information has not been entered, the encounter information dialog will appear before the Order an Imaging Procedure dialog. You must complete the encounter information dialog before proceeding.

3. Select the desired imaging type in the Imaging Type field.
4. Select a procedure from the Imaging Procedure list box.

5. Select an available modifier from the Available Modifiers field.
   The modifier(s) you select will be displayed in the Selected Modifiers field.

   Note: You can remove a modifier by selecting the modifier and clicking **Remove**.

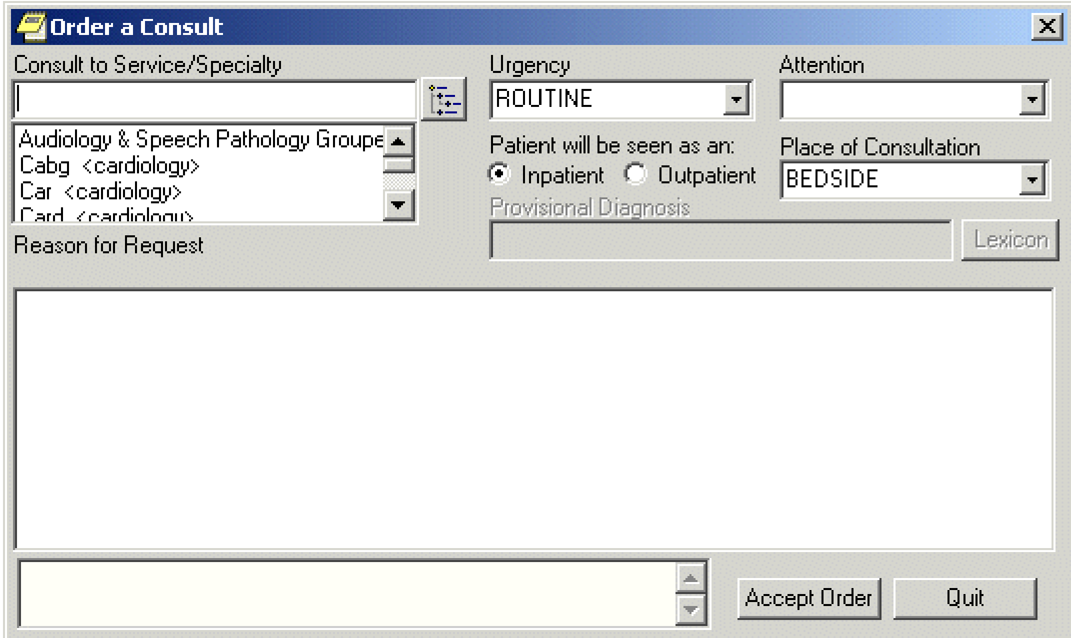
6. Enter a history and a reason for the exam in the History & Reason for Exam field.
7. If necessary, change the Requested Date, Urgency, Transport, and Category fields.
8. Complete the Submit To field (if necessary).
9. Check the Isolation checkbox (if necessary).
10. Select the appropriate response (Yes, No, or Unknown) in the Pregnant field.
11. Select the time that the PreOp is scheduled by doing one of the following:
    - entering a date (e.g. 6/21/01 or June 21, 2001)
    - entering a date formula (e.g. t-200)
    - pressing the ... button to bring up a calendar

12. Click **Accept Order**.
13. Enter another order
    -or-
    click **Quit**.

Ordering a Consult

To order a consult from the Orders tab follow these steps:

1. Select the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View** | **Active Orders (includes pending, recent activity)**.
3. Select **Consult** in the Write Orders list.
   The Order a Consult dialog appears.



The Order a Consult dialog

Note: The consults order may be labeled differently or may not be available from your Write Orders field.

Note: If encounter information has not been entered, the encounter information dialog will appear before the Order a Consult dialog. You must complete the encounter information dialog before proceeding.

4. Select a type of consult from the Consult to Service/Specialty field.
5. Select an urgency from the Urgency field.
6. Select an individual from the Attention field.

Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

- The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
    - When no division is listed for a provider, no division is displayed.
    - If only one division is listed, this division is displayed.
    - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
    - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
- Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

7. Choose inpatient or outpatient from the “Patient will be seen as an:” option group.

8. Choose a location from the Place of Consultation field.
9. Enter a provisional diagnosis.
10. Enter a reason for the request in the Reason for Request field.
10. Click **Accept Order**.
11. Enter another procedure
    -or-
    click **Quit**.
12. You may sign the consult now or wait to later.

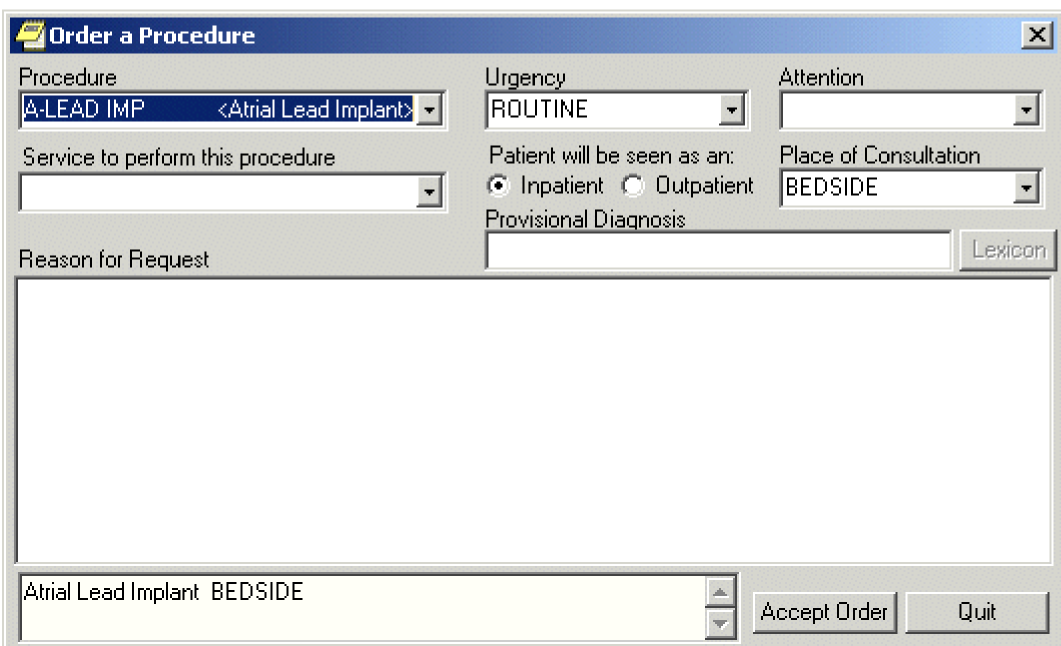
Procedures

To order a procedure, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane.
3. Click **Procedure** in the Write Orders list.

   Note: The procedure order may be labeled differently or may not be available from your Write Orders list box.

   The Order a Procedure dialog appears.



The Order a Procedure dialog

   Note: If encounter information has not been entered, the encounter information dialog will appear before the Order a Procedure dialog. You must complete the encounter information dialog before proceeding.

4. Locate and click the desired procedure in the Procedure list box.
5. Select an urgency from the Urgency field.

6. Select an individual from the Attention field.

   Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

   - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
     - When no division is listed for a provider, no division is displayed.
     - If only one division is listed, this division is displayed.
     - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
     - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
   - Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

7. Select a service that will perform the procedure.
8. Select whether the patient is an inpatient or outpatient.
9. Select a place of consultation from the Place of Consultation drop-down list.
10. Enter a provisional diagnosis in the Provisional Diagnosis field. (Click the Lexicon button to access the lexicon.)
11. Enter a reason for this request in the Reason for request field.
12. Click **Accept Order**.
13. Enter another order
    -or-
    click **Quit**.

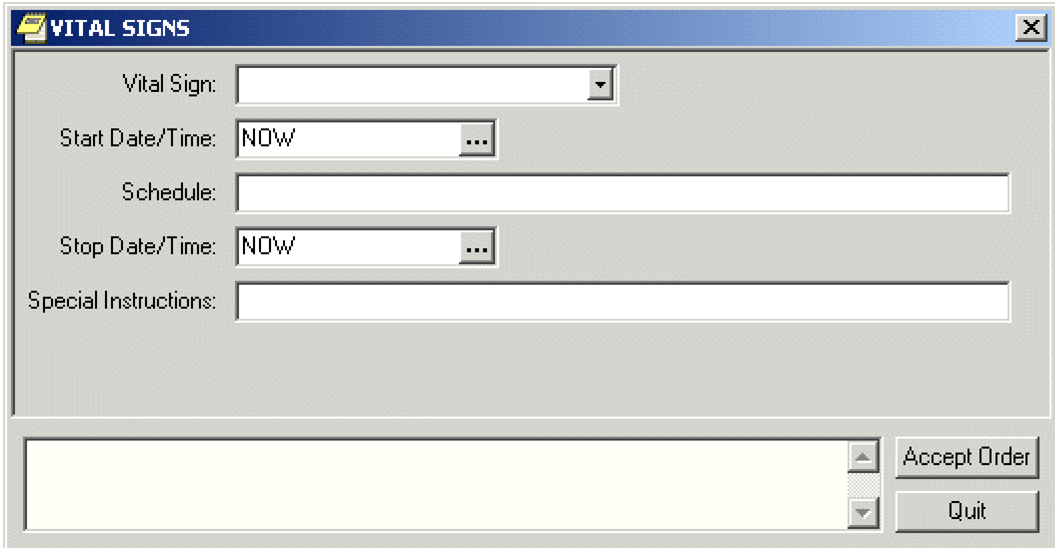
    Note: The order must be signed before it is sent. You can either sign the order now or wait until later.

Vitals

To enter a vitals order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane
   -or-
   select **View** | **Active Orders (includes pending, recent activity)**.
3. Click **Vitals** in the Write Orders list box.
   The VITAL SIGNS dialog appears.

   Note: The vitals order may be labeled differently or may not be available from your Write Orders list.



The VITAL SIGNS dialog box

Note: If encounter information has not been entered, the encounter information dialog will appear before the VITAL SIGNS dialog. You must complete the encounter information dialog before proceeding.

4. Select a vital sign from the Vital Sign drop-down list.
5. Select a date and time from the Start Date/Time field by doing one of the following:
   - entering a date (e.g. 6/21/01 or June 21, 2001).
   - entering a date formula (e.g. t-200).
   - pressing the ... button to bring up a calendar.
6. Enter a schedule in the Schedule field.
7. Select a stop date and time from the Stop Date/Time field by doing one of the following:
   - entering a date (e.g. 6/21/01 or June 21, 2001).
   - entering a date formula (e.g. t-200).
   - pressing the ... button to bring up a calendar.
8. Enter any special instructions in the Special Instructions field.
9. Click **Accept Order**.

Text Only Order

Text only orders such as Parameters, Activity, Patient Care, and Free Text orders are different kinds of orders that are placed for nursing and ward staff to take action on. They print only at the patient's ward/location, and are not transmitted electronically to other services.

Examples of text only orders include:

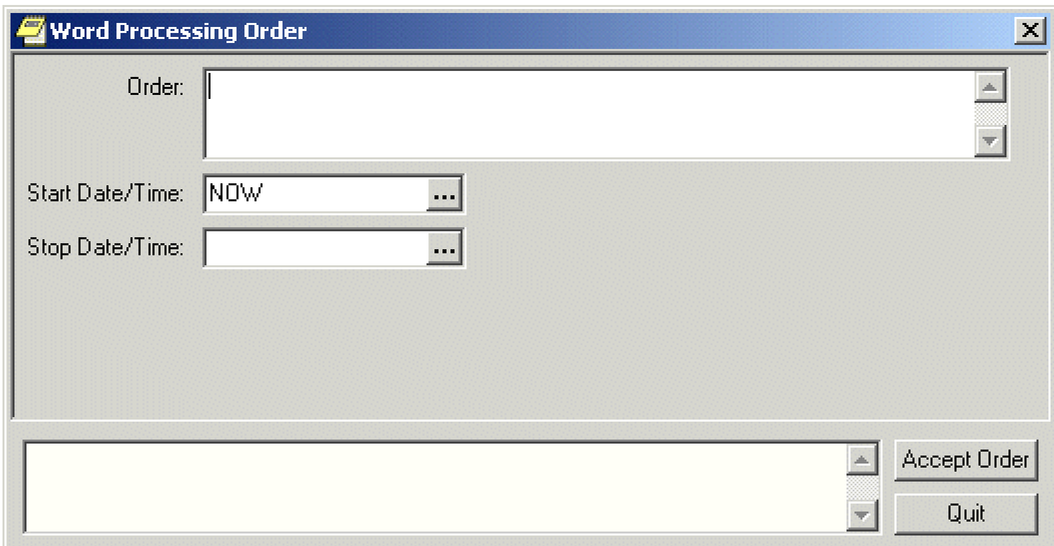
Order Type	Order
Parameters	Vital signs
Activity	Bed rest, ambulate, up in chair
Patient Care	Skin and wound care, drains, hemodynamics
Free text	Immunizations

Predefined nursing orders (quick orders) may be available under various sub-menus.

To place a text only order, follow these steps:

1. Click the **Orders** tab.
2. Select the active orders view from the View Orders pane.
3. Click **Text Only Order** in the Write Orders list box.
   The Word Processing Order dialog will appear.

   Note: The text only order may be labeled differently or may not be available from your Write Orders list.



The Text Only Order dialog

4. Enter the text for the order in the Order field.
5. Enter a start date and time and a stop date and time by doing one of the following:
   - entering a date (e.g. 6/21/01 or June 21, 2001).
   - entering a date formula (e.g. t-200).
   - pressing the button to bring up a calendar.
6. Click **Accept Order**.
7. Enter another order
   -or-
   click **Quit**.

Event-Delayed Orders

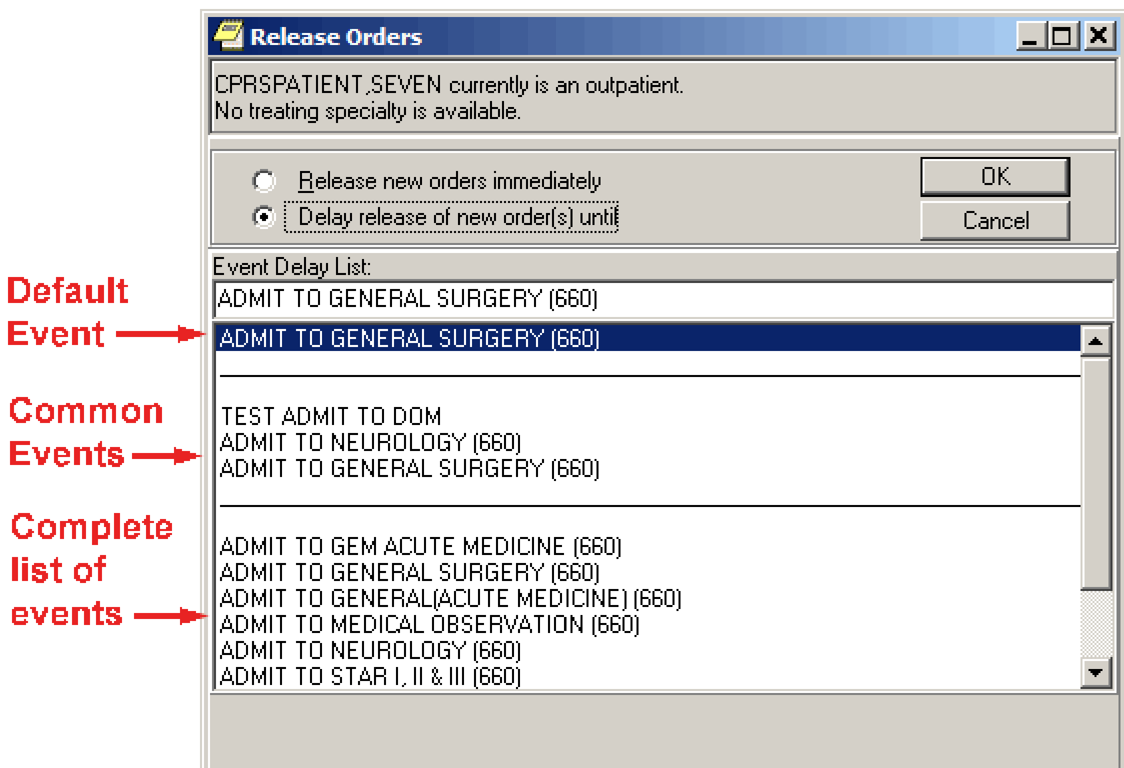
An event-delayed order is an order that is executed only after a predefined event (known as a release event) occurs. A release event can be an event such as an admission, discharge, or transfer. For example, you can write an event-delayed diet order that will not execute until a patient is transferred to a specific ward.

A CAC defines the release events at your site. (For more information on defining release events, see Appendix F of the *CPRS List Manager Technical Manual* or the Event-Delayed Orders topic in the *CPRS GUI Technical Manual*). Once a CAC has defined a release event, you can write an order that will not execute until that release event occurs.

Writing an Event-Delayed Order

To write an event-delayed order, follow these steps:

1. Click the **Orders** tab.
2. Click the **Write Delayed Orders** button located below the View Orders pane. The *Release Orders* dialog box appears. The available release events will appear in a list. Your list may contain a highlighted default release event and a common release event list. Your CAC defines the default release event and the common release event list. (For more information about defining a default release event and a common release event list, please see the Event-Delayed Orders topic in the *CPRS GUI Technical Manual* or Appendix F in the *CPRS List Manager Technical Manual*).

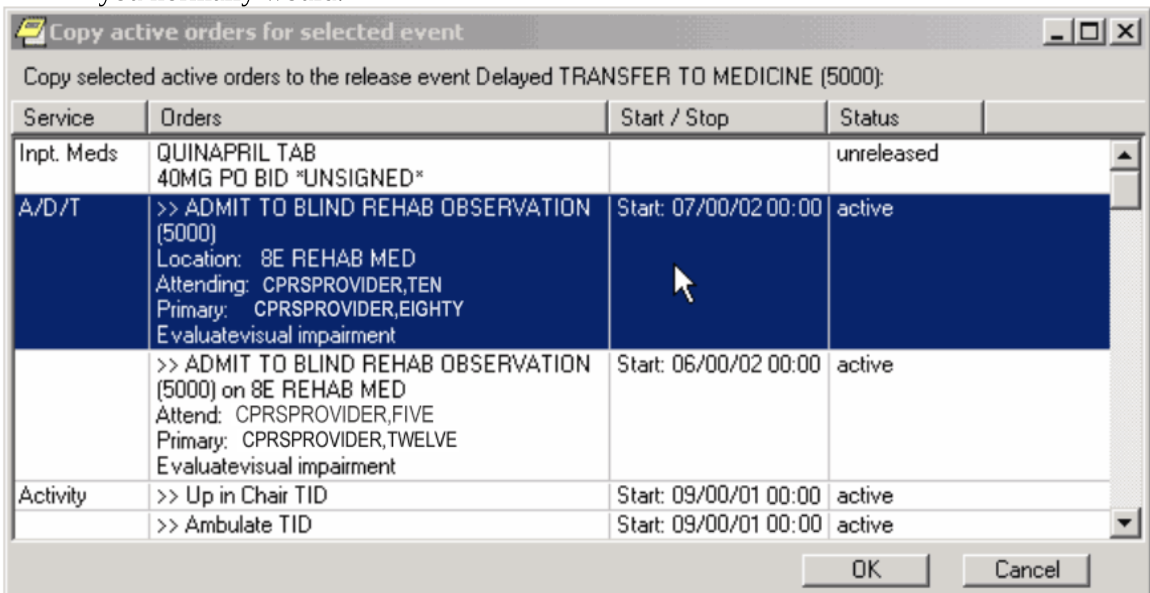


Your CAC can define a default release event and a common release event list.

3. Select Delay Release of New Order(s) until.
4. Select the appropriate release event.

5. Click **OK**.

   If the *Copy active orders for selected event* dialog box appears, continue to step 5. Otherwise, the *Release Orders* dialog will close and the name of the release event will now appear below the Write Delayed Orders button. Enter the order as you normally would.



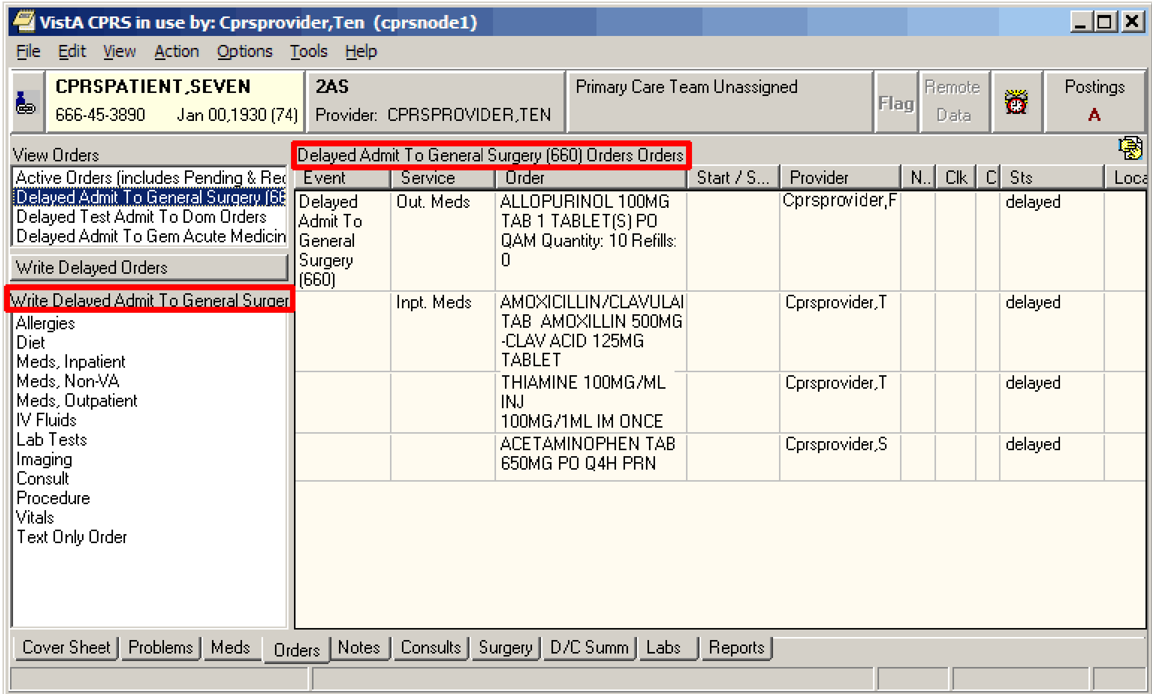
The *Copy active orders for selected event* dialog box

6. Select the active orders that you would like to delay in the *Copy active orders for selected release event* dialog box. These orders will be delayed until the release event specified at the top of the dialog occurs. You can press and hold **shift** to select a range of orders or you can press and hold **ctrl** to select multiple individual orders.

7. Click **OK**.
   The *Ordering Information* dialog box appears. This dialog contains the release event that you have selected. Make sure that you selected the correct release event.

8. Click **OK**.

9. Enter the order as you normally would.



The name of the release event appears below the Write Delayed Orders button and above the list of orders.

Assigning/Changing the Release Event

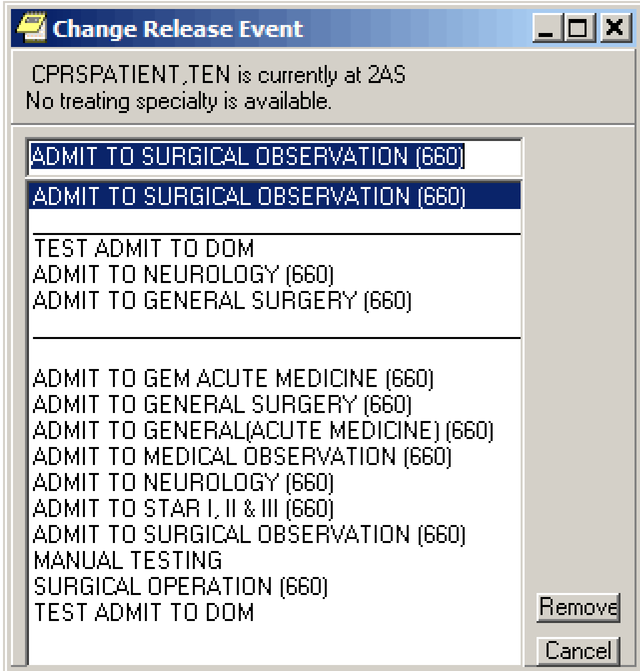
If an order is not signed, you can change the order's current release event or assign a release event to a regular order. However, once an order has been signed, you cannot make further changes.

To assign or change a release event, follow these steps:

1. Select the **Orders** tab.
2. Select the type of order you would like to change from the *View Orders* pane. The orders for the type you select will be displayed in the details pane on the right side of the screen.
3. Highlight the order you would like to change from the details pane.

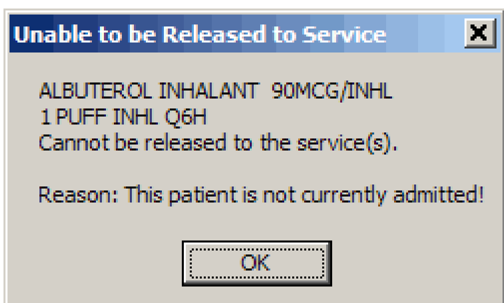
Select **Action** | **Change Release Event**
-or-
right-click on the order and select **Change Release Event** from the right-click menu.

The *Change Release Event* dialog box will appear. The current release event will be highlighted.



The current release event is highlighted in the *Change Release Event* dialog.

Note: If the release event cannot be changed, the *Unable to be Released to Service* dialog box appears. The reason that the release event cannot be changed is listed at the bottom of the dialog box. Press **OK** to close the dialog box.



This dialog box will appear if an order's release event cannot be changed.

4. To change the release event, select another event and click **Change**. To simply remove the existing event, click **Remove**.

   A confirmation dialog appears.

5. Click **OK** to confirm your changes.

Manually Releasing an Event-Delayed Order

To release an event-delayed order manually (before the release event occurs), follow these steps:

1. Select the **Orders** tab.
2. Select the type of order you would like to release from the *View Orders* pane. The corresponding orders will appear on the right side of the screen.
3. Highlight the order you would like to release from the details pane on the right side of the screen.
4. Select **Action** | **Release Delayed Orders**
   -or-
   right-click on the order and select **Release Delayed Orders**.

   Note: You must sign an order before it can be released.
5. The *Release to Service* dialog box will appear. Review the orders you wish to release and click **OK**.
6. If the *Print Orders* dialog box appears, select the appropriate prints and devices and press **Print All Checked Items** or **Print Highlighted Items Only**.

Viewing an Event-Delayed Order After it is Released

To view an event-delayed order after it has been released, follow these steps:

1. Click the **Orders** tab.
2. Select **View** | **Auto-DC/Release Event Orders**
   The *Auto-DC/Release Event Orders* dialog appears.
3. Choose the event the order is associated with.
4. Click **OK**.
   The appropriate orders will appear on the Orders tab.

Notifying a User when Order Results are Available

To notify a user when the results of an order are available, follow these steps:

1. Click the Orders tab.
2. Select the desired type of order in the View Orders list box.
3. Select an order from the list of orders on the right-hand side of the screen.
4. Select **Action | Alert when Results...**
   The Alert when Results dialog will appear.
5. Choose an alert recipient from the Alert Recipient drop-down field.

   Note: a recipient must have the FLAG ORDER FOR CLARIFICATION notification/alert enabled in order to receive the alert.

6. Click **OK**.

Flagging an Order

With CPRS, you can flag an order to draw attention to it. When an order is flagged, the word “Flagged” will appear in the Orders column and a red box will appear in the Service or Event column. The order will remain flagged until someone "unflags" the order. CPRS records the name of the person who flagged the order and the date and time that it was flagged.

To flag an order, use these steps:

1. Click the **Orders** tab.
2. Select the desired type of orders in the View Orders list box.
3. Select the individual order that you would like to flag from the list of orders on the right-hand side of the screen.
4. Select **Action | Flag**...
   The Flag Order dialog will appear.
5. Enter a reason for the flag in the Reason for Flag field.
6. Choose an alert recipient from the Alert Recipient drop-down field.

   Note: a recipient must have the FLAG ORDER FOR CLARIFICATION notification/alert enabled in order to receive the alert.
7. Click **OK**.

Copying Existing Orders

To copy an existing order to a new order, follow these steps:

1. Click the **Orders** tab.
2. Select the type of order you would like to copy from the *View Orders* pane.
3. Select the order or orders you want to copy from the detail pane on the right side of the screen. Hold down the CTRL key and click on the desired orders to select more than one order. Hold down the SHIFT key and click on the first and last desired orders to select a range of orders.
4. Select **Action | Copy to New Order…**

   -or-

   right-click on a selected order and select **Copy to New Order…**

   The *Copy Orders* dialog appears.
5. From the *Copy Orders* dialog, select either **Release copied orders immediately** or **Delay release of copied orders**.
6. If you chose Release copied orders immediately, skip to step 8. If you chose Delay release of copied orders, select the release event that should occur before the order(s) are released.
7. Click **OK**.
8. If necessary, choose the specialty or admission location.

9. An order verification dialog box will appear. If the order does not require changes, click **Accept (or Accept Order)**. If the order requires changes, click **Edit** (or make the appropriate changes) and click **Accept Order**.
10. When finished, you can sign the orders or wait until later.

Overview of New CPRS/POE Functionality

To make it easier for providers to enter medication orders and have fewer orders that need to be changed by pharmacy and returned for a provider's signature, the Pharmacy Ordering Enhancement (POE) project was undertaken. The aim of this project was to make it easier for clinicians to enter medication orders and have the computer do the work in the background to provide pharmacists with the information they need to fill orders.

Ordering dialogs were redesigned in an attempt to reduce the number of orders that need to be edited and returned for signature. Changes include replacing the dispense drug prompt with a dose prompt, automatically calculating the quantity of commonly dispensed drugs that are prescribed on standard schedules, and providing more standard schedule options. With the new ordering dialogs, CPRS uses an API to verify that the ordering provider has been assigned a VA or DEA number when the provider attempts to order a controlled substance. If the provider has not been assigned a VA or DEA number, the provider is prevented from ordering the controlled substance.

In addition, a new tab for complex orders enables providers to create complex doses for medications. The interface displays the expected time of next administration and a check box enables you to place an order for “Give First Dose Now.” (You must be careful, however, that the combination of the NOW order and the original schedule do not overmedicate the patient.) In addition, another Medications item called Medications may have been added to your ordering menu. The Medications item can be used in addition to the existing dialogs for INPATIENT MEDS, OUTPATIENT MEDS, and IV FLUIDS. The only difference between this new dialog and the Inpatient and Outpatient dialogs is that Medications will automatically assign the ordering context (Inpatient vs. Outpatient) based on the selected patient's current admission/visit status. The Medications item provides a single dialog for medication orders instead of forcing the provider to pick among the INPATIENT MEDS, OUTPATIENT MEDS, and IV FLUIDS order dialogs. If the provider wants to use those specific dialogs, they are still available.

Note: With the new Medications item, the provider will not be able to write a prescription if the patient is currently admitted or order an inpatient IV med for a patient in an outpatient clinic (i.e. you won't be able to write an order for the opposite context). Therefore, the old INPATIENT MEDS, OUTPATIENT MEDS, and IV FLUIDS items should still be available for the provider to use.

There are several other changes that are explained in the POE Release Notes.

Notes

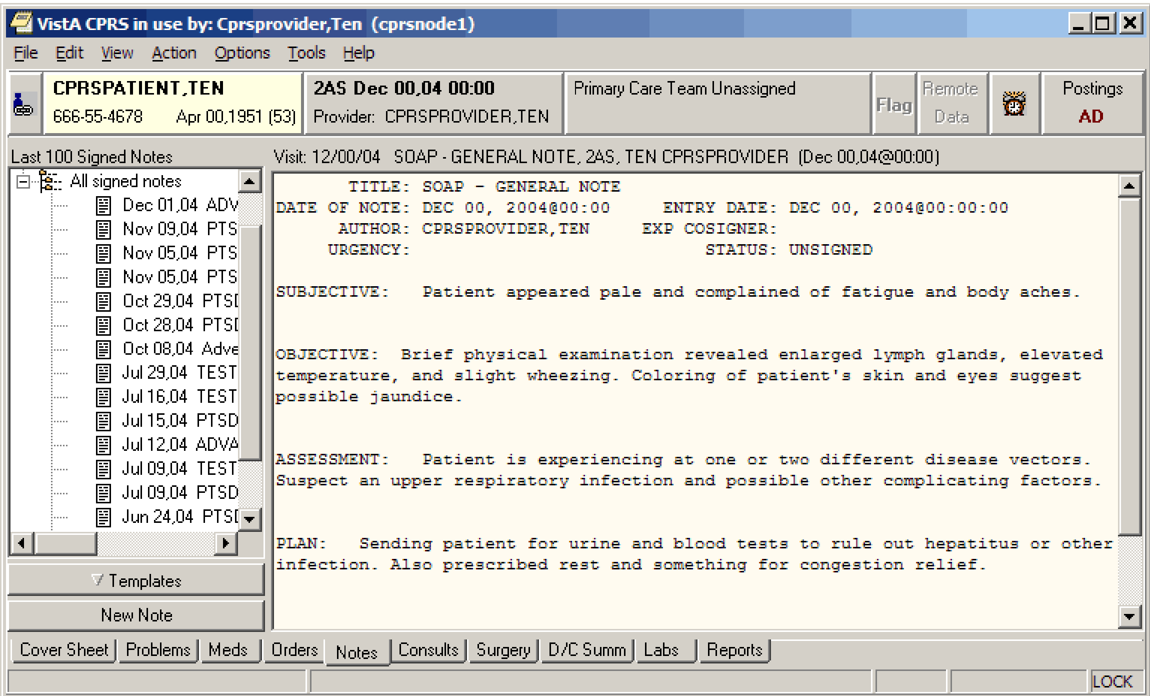
From the Notes tab you can create new progress notes for a patient and view existing progress notes and documents. You can also create templates to allow you to quickly and efficiently enter progress notes. Documents on the Notes tab are organized in a tree structure on the left side of the screen.

Group Notes

A new application called Group Notes enables authorized users to write progress notes and enter encounter information for a group of patients. Users can enter text and encounter information that applies to the entire group of patients and then add information to individual patient's notes and encounters, but sign all the notes at the same time.

Group Notes is a separate application from CPRS. Sites can put an icon on the desktop or authorized personnel at the site can place an item Tools menu. To use the Group Notes application, a user must be given a key (OR GN ACCESS) and choose a location that allows group notes (set in the OR GN LOCATIONS parameter). To find out more about Group Notes, please look for the manuals under Group Notes on the VistA Documentation Library (http://www.va.gov/vdl/).

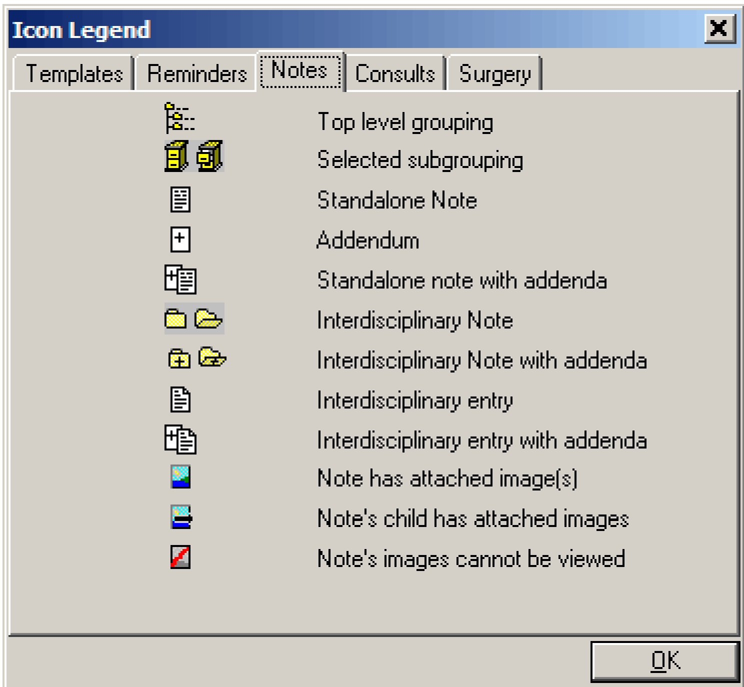
Once the notes are signed in the Group Notes application, they are stored in TIU and displayed in CPRS like any other progress note. Thus, they are not a different kind of note, but simply notes created in a way that speeds text entry and signing for a group of patients that have the same treatment or therapy while still allowing personalization of each note and encounter for the patient.



Templates can be displayed on the Notes tab.

Icons on the Notes Tab

The icons in front of the document titles on the Notes tab help identify and categorize documents. A description of the icons is available from the Icon Legend (shown below). To access the Icon Legend, click **View | Icon Legend**.



The Icon Legend dialog box displays a description of the various icons in CPRS.

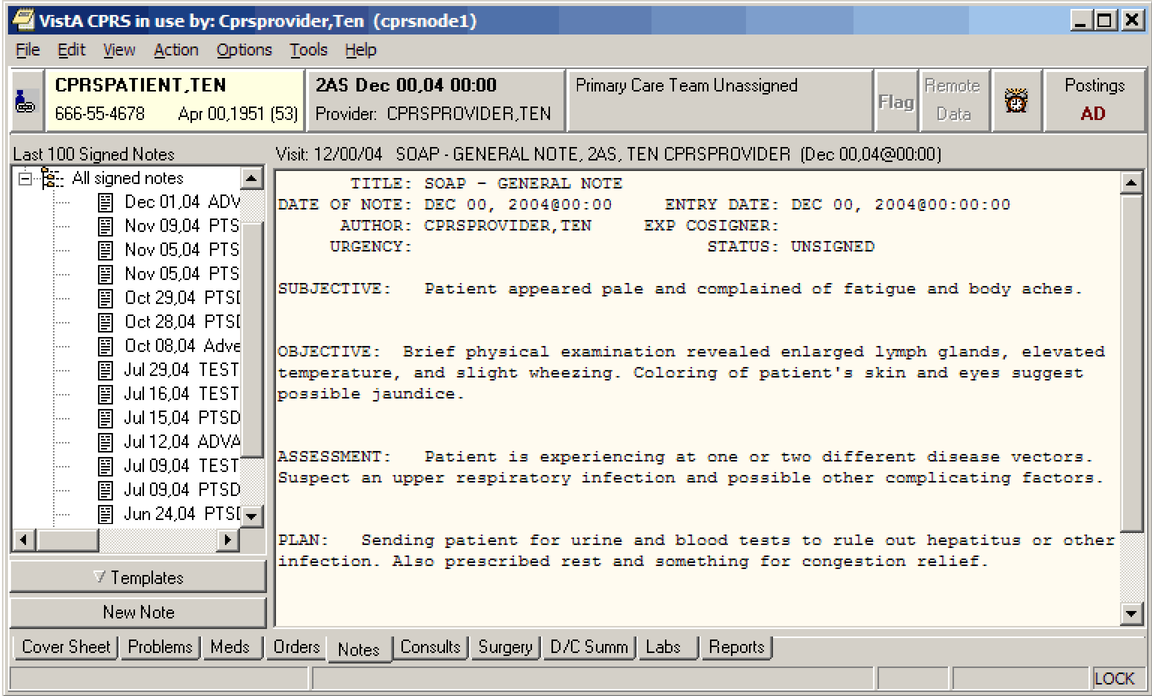
Viewing Progress Notes

To view the text of a progress note, follow these steps:

1. Click the **Notes** tab.
2. Select a document title from the left side of the screen. (Click the “+” sign to expand a heading.)

   Note: If a note has an addendum, the  icon will appear in front of the note title. You may view the addendum by clicking the “+” sign to expand the note title and then selecting the appropriate addendum.

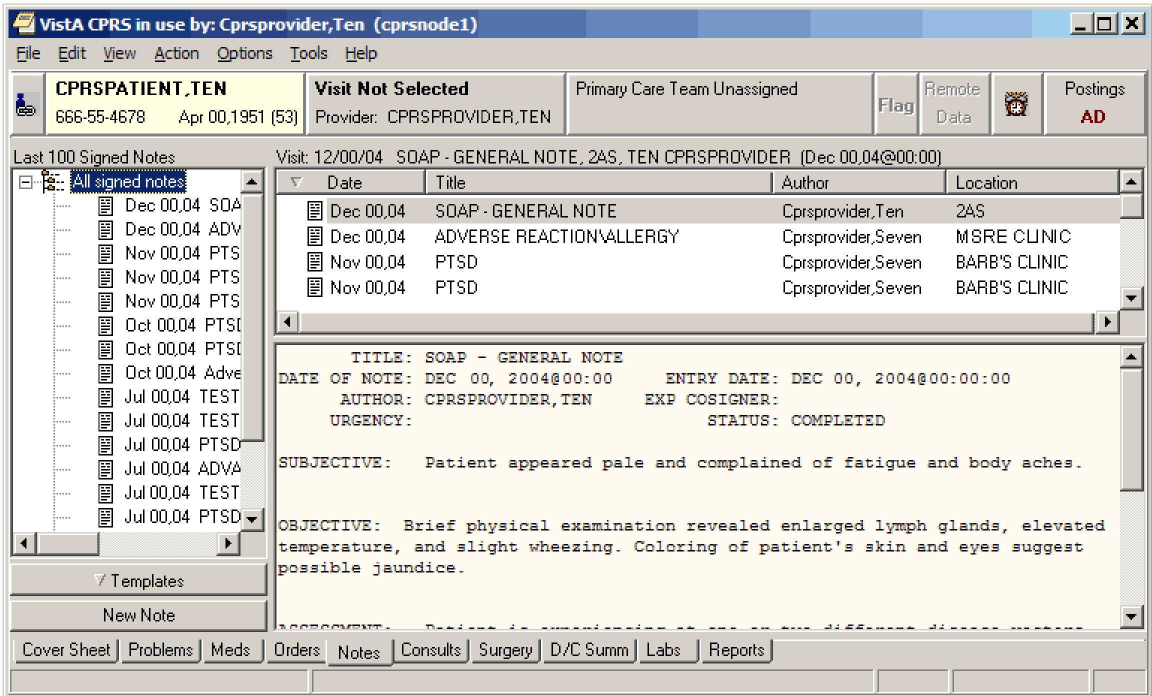
   The text of the progress note will be displayed on the right side of the screen.



The text of a document is displayed on the right side of the Notes tab.

To view all the progress notes under a particular heading, follow these steps:

1. Click the **Notes** tab.
2. Double click the heading that you would like to view.
3. The notes that are related to that heading will appear in a table on the right side of the screen.
4. To view the details of a specific note, select the note from the table. You can also sort the table by clicking on the column you wish to sort by (click the column again to sort the table in inverse order).



CPRS Notes Dialog viewing notes under a specific heading

Customizing the Notes Tab

CPRS allows you to control which documents appear on the Notes tab. From the View menu you can specify that only the following note types appear on the tab:

- All signed notes
- Signed notes by a particular author
- Signed notes for a particular date range
- Uncosigned notes
- Unsigned notes

In addition, you can use the **View** | **Custom View** option to further customize the Notes tab.

Viewing All Signed Notes, All Unsigned Notes, or All Uncosigned Notes

To view all signed notes, all unsigned notes, or all uncosigned notes, follow these steps:

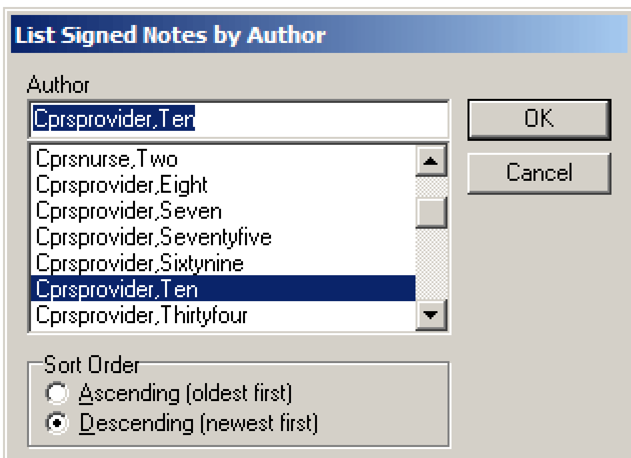
1. Select the **Notes** tab.
2. Select **View** | **Signed Notes (All), View | Uncosigned Notes,** or **View | Unsigned Notes**.
   The appropriate progress notes will appear on the Notes tab.

If you would like to further limit the notes that are displayed on the Notes tab, continue with the "Additional Customization" topic (below).

Viewing All Signed Notes by a Specific Author

To view all signed notes by a specific author, follow these steps:

1. Select the **Notes** tab.
2. Select **View** | **Signed Notes by Author**.
   The List Signed Notes by Author dialog appears.



The List Signed Notes by Author dialog

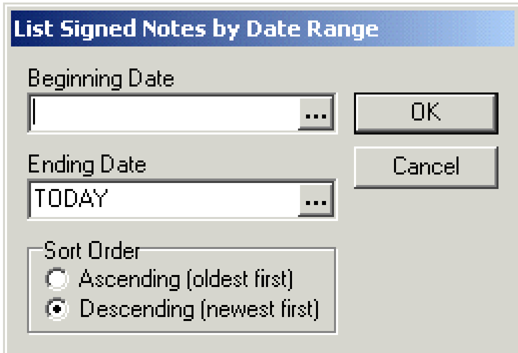
3. Select the author of the note(s) that you would like to view.
4. In the Sort Order option group, select Ascending (oldest first) to view the oldest notes first, or Descending (newest first) to view the newest notes first.
5. Click **OK**.
   The appropriate notes will appear on the Notes tab.

If you would like to further limit the notes that are displayed on the notes tab, continue with the "Additional Customization" topic (below).

Viewing All Signed Notes for a Date Range

To view all signed notes by a specific author, follow these steps**:**

1. Select **View** | **Signed Notes by Date Range**.
   The List Signed Notes by Date Range dialog will appear.



The List Signed Notes by Date Range dialog

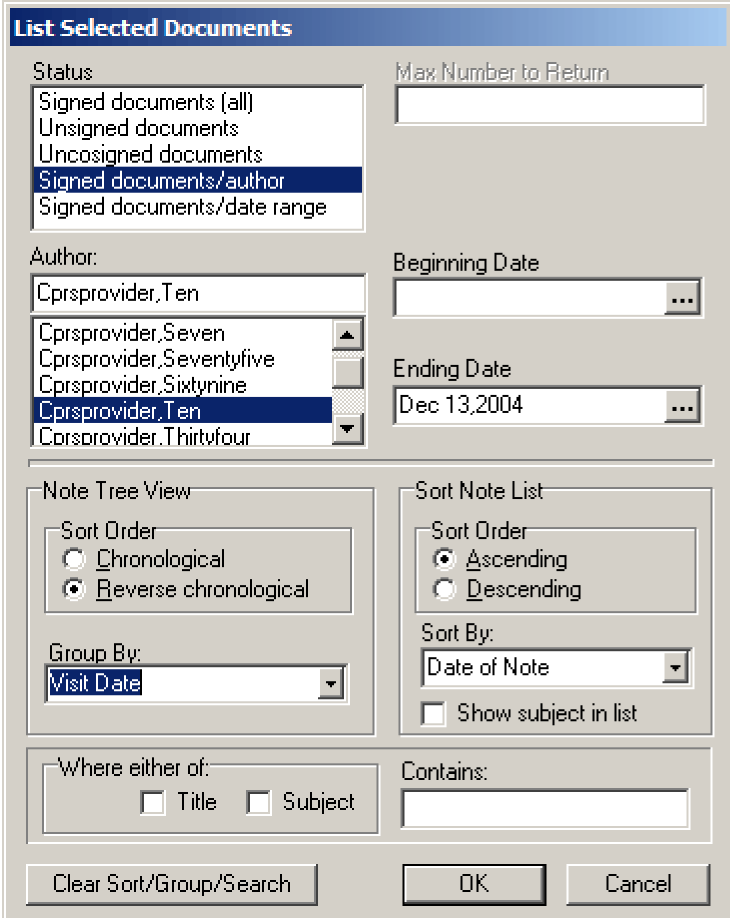
2. Enter a beginning and ending date by doing one of the following:
   - entering a date (e.g. 6/21/01 or June 21, 2001).
   - entering a date formula (e.g. t-200).
   - pressing the button to bring up a calendar.
3. Click **OK**.
   The appropriate notes will be displayed on the Notes tab.

Additional Customization

If you would like to further limit the notes that are displayed on the Notes tab, follow these steps:

1. From the Notes tab, select **View** | **Custom View**.

   The List Selected Documents dialog will appear.



The List Selected Documents dialog

2. Select the criteria for the documents that you want to display on the Notes tab by doing some or all of the following:

Note: You cannot set all of the fields at the same time. For example, if you choose one of the options for "all notes", then you are given the option of a date range because that conflicts with the other choice.

a.) Select a status from the left side of the window.

b.) Enter the maximum number of notes that you would like to display in the Max Number to Return field.

c.) Select an author or expected cosigner from the Author or Expected Cosigner field.

d.) Select a beginning and ending date by doing one of the following:

- entering a date (e.g. 6/21/01 or June 21, 2001)
- entering a date formula (e.g. t-200)
- pressing the button to bring up a calendar

e.) Select a sort order from the Note Tree View option group.

f.) If you would like to group the notes, make a selection from the Group By drop-down list.

g.) If you would like to further sort the notes that have been grouped in step f, select the criteria to sort by in the Sort By drop-down list.

h.) If you would like the subject of the notes to be displayed in the tree view, check the “Show subject in list” check box.

i.) If you would like to limit the notes that are displayed to notes that contain specific text in the title or in the subject line, click the appropriate check box and enter the text in the Contains field.

Note: You can erase the contents of the List Selected Documents dialog by clicking the Clear Sort/Group/Search button.

3. Click **OK**.
   The notes that meet the criteria you specified will appear on the Notes tab.

Setting a Default View

To set a default view for the Notes tab, follow these steps:

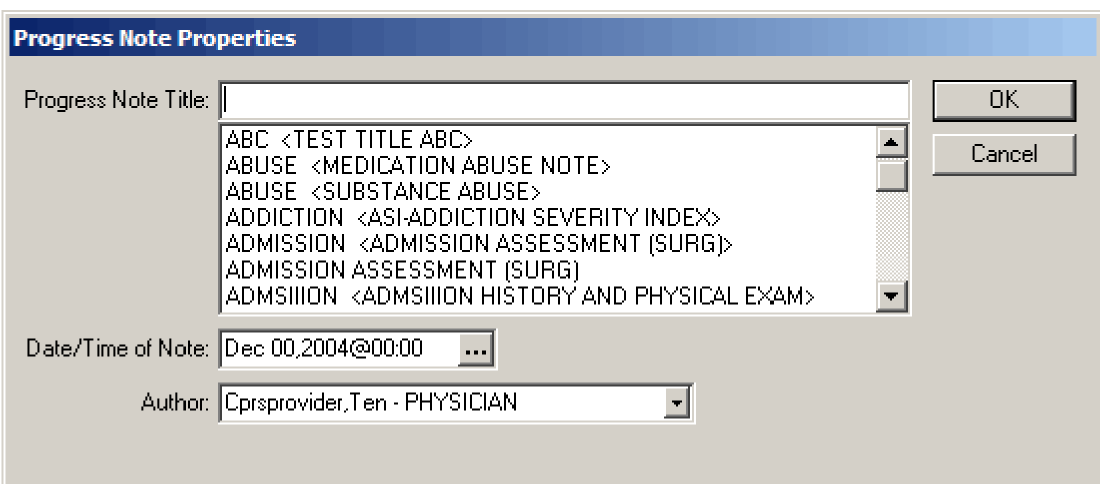
1. Customize the Notes tab by following the steps above.
2. Select **View** | **Save as Default View**.
   A warning dialog will appear.
3. Click **OK**.
   The current view will be set as the default view for the Notes tab.

Creating and Editing Progress Notes

To create a new progress note, follow these steps:

1. Click the **Notes** tab.
2. Click the **New Note** button.
   The Progress Note Properties dialog will appear.

   Note: The encounter information dialog may appear before the Progress Note Properties dialog if you have not entered encounter information. If the encounter information dialog appears, enter the necessary information and click **OK**.



The Progress Note Properties Dialog

3. Select a title for the progress note from the Progress Note Title drop-down list.
4. Select a date and time for the progress note by doing one of the following:
   a.) entering a date (e.g. 6/21/01 or June 21, 2001)
   b.) entering a date formula (e.g. t-200)
   c.) pressing the button to bring up a calendar
5. Select an author for the progress note.

   Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

   - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
     - When no division is listed for a provider, no division is displayed.
     - If only one division is listed, this division is displayed.
     - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
     - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
   - Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)
6. Click **OK**.

To edit a progress note, follow these steps:

Note: Progress Notes can only be edited if they have not been signed. Signed notes cannot be editing. To add to that, an addendum would have to be created.

1. Click the **Notes** tab.
2. Select a document title from the left side of the screen. (Click the “+” sign to expand a heading.)

   Note: If a note has an addendum, the icon will appear in front of the note title. You may view the addendum by clicking the “+” sign to expand the note title and then selecting the appropriate addendum.

   The text of the progress note will be displayed on the right side of the screen.

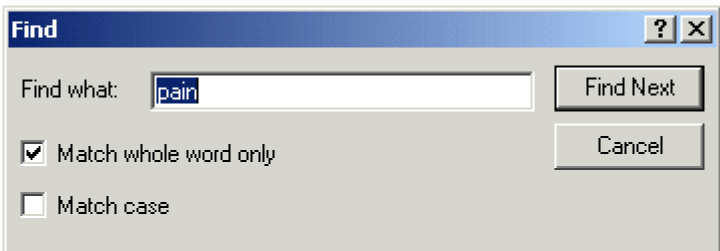
3. Select **Action | Edit Progress Note…**
   You can now edit the progress note.

To find specific text in a progress note, follow these steps:

1. Click the **Notes** tab.
2. Select a document title from the left side of the screen. (Click the "+" sign to expand a heading.)
   The text of the progress note will be displayed on the right side of the screen.

   Note: If a note has an addendum, the  icon will appear in front of the note title. You may view the addendum by clicking the "+" sign to expand the note title and then selecting the appropriate addendum.

3. Right-click the text of the progress note and select "Find in Selected Note."
   The Find dialog appears.

   The Find dialog allows you to replace text in a progress note.

4. Enter the text that you want to find.

   Note: Check the Match whole world only or Match case check boxes to search using these options.

5. Click **Find Next**.
   If the text is found, it will be highlighted in the progress note.

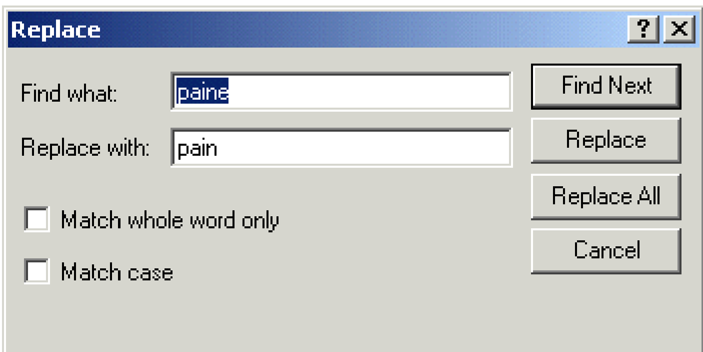
To replace specific text in a progress note, follow these steps:

Note: Users can edit only unsigned progress notes. Once a note is signed, it cannot be edited.

1. Click the **Notes** tab.
2. Select a document title from the left side of the screen. (Click the "+" sign to expand a heading.)
   The text of the progress note will be displayed on the right side of the screen.

   Note: If a note has an addendum, the icon will appear in front of the note title. You may view the addendum by clicking the "+" sign to expand the note title and then selecting the appropriate addendum.

3. Select **Action** | **Edit Progress Note…**
4. Right-click the text of the progress note and select "Replace Text."
   The Replace dialog will appear.
5. Enter the text you wish to replace in the Find what field.
6. Enter the new text in the Replace with field.



The Replace dialog allows you to replace text in a progress note.

Note: Check the Match whole world only or Match case check boxes to search using these options.

7. Click either **Find Next**, **Replace,** or **Replace All**.
   If the text is found it will be highlighted (if you selected Find Next) or changed (if you selected Replace or Replace All).

Encounter Information

CPRS has two kinds of encounter information: visit information and encounter form data.

For each visit (or telephone call) with a patient, you need to enter the provider, location, date, and time. CPRS requires this information before you can place orders, write notes, add to the problem list, and so on.

The parameter, ORWPCE ANYTIME ENCOUNTERS, can be set to allow encounters to be entered on the Notes tab when no note is being entered. This will allow encounter entry (at the time of the visit) for dictated notes. This parameter can be set at the User, Service, Division, and System levels. Note that this will edit the encounter associated with the current location and time, which is not necessarily the encounter associated with the currently displayed note.

To receive workload credit, you must enter the encounter form data, including the following information, for each encounter:

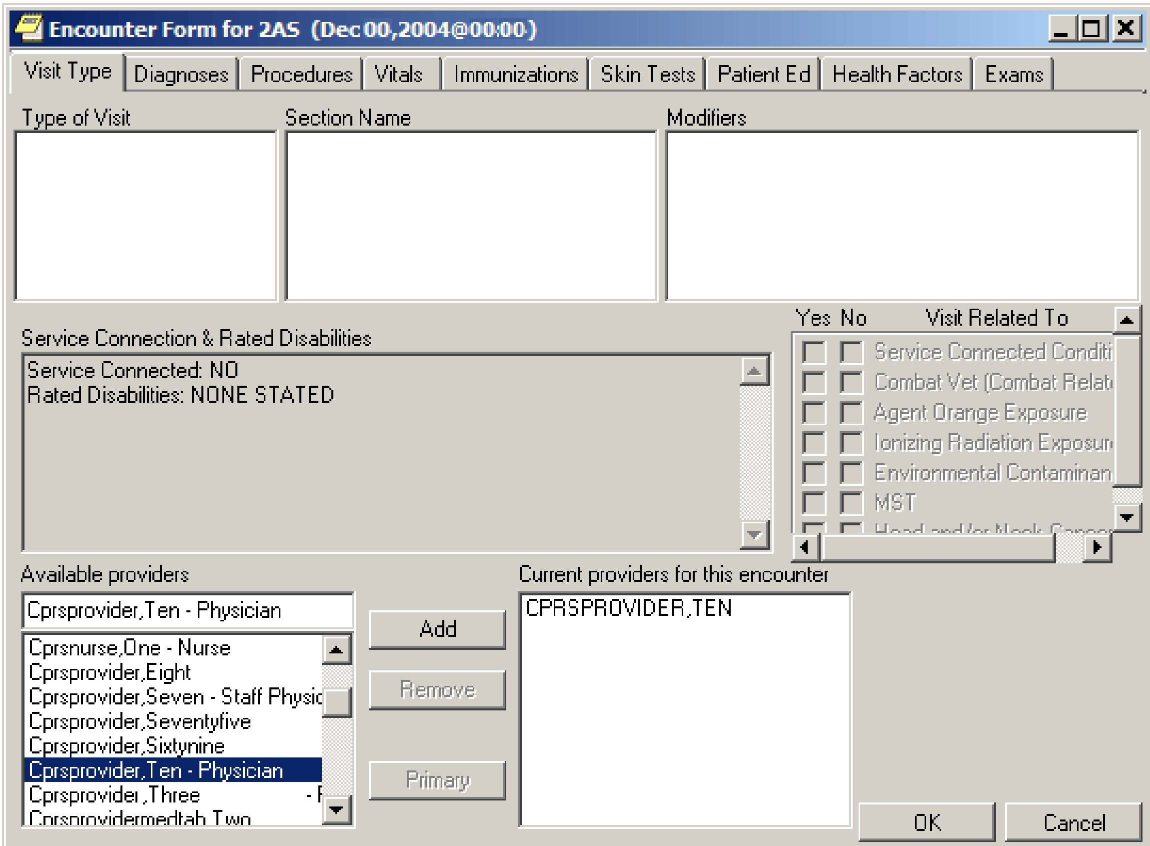
- Service connection
- Provider name
- Location
- Date
- Diagnosis
- Procedure
- Visit Information

CPRS shows the encounter provider and location for the visit on the Visit Encounter box, identified in the graphic by the pointer. You can access this box from any chart tab.

If a provider or location has not been assigned, CPRS will prompt you for this information when you try to enter progress notes, create orders, and perform other tasks.

Encounter Form Data

To get workload credit and gather information, enter encounter form data whenever you create a progress note, complete a consult, or write a discharge summary. When you create one of these documents, an Encounter button appears. Click this button to bring up the Encounter Form. (Otherwise, you will be prompted for encounter information when you try to sign the note or exit the current patient's chart.)



The Encounter Form

The Encounter Form has the following eight tabs:

- Visit Type
- Diagnoses
- Procedures
- Vitals
- Immunizations
- Skin Tests
- Patient Education
- Health Factors
- Exams
- Global Assessment of Functioning (GAF) (The GAF tab is available only if specific Mental Health patches are installed and if the location is a mental health clinic.)

Your site defines forms from the Automated Information Collection System (AICS) application to be used with the Encounter Form. Once your site has defined the necessary forms and associated them with the Encounter Form, each tab has a number of general categories on the left. When you click a general category, the corresponding items appear in the list box on the right.

For example, the Visit Type tab might have New Patient, Established Patient, and so on listed in the left list box. The list box on the right would then have check boxes for the different types of patient appointments, such as Brief Exam, Limited Exam, Intermediate Exam, Extended Exam, and Comprehensive exam.

Even if you haven't defined the form, you can click the Other button to get a list of choices that are active on your system.

When the forms are defined and associated with the Encounter Form, you can use the Encounter Form just as you would a paper form: just click the appropriate tab, category, and check boxes to mark items or click Other and select the appropriate choice. On the Visit Type tab, a provider can indicate if the encounter is related to the various exemption categories, such as Service Connected, Combat Veteran, Agent Orange exposure, Ionizing Radiation exposure, Environmental Contaminants, Military Sexual Trauma, and Head and/or Neck Cancer. If these forms have not yet been defined, ask your Clinical Coordinator for assistance.

Entering Encounter Form Data

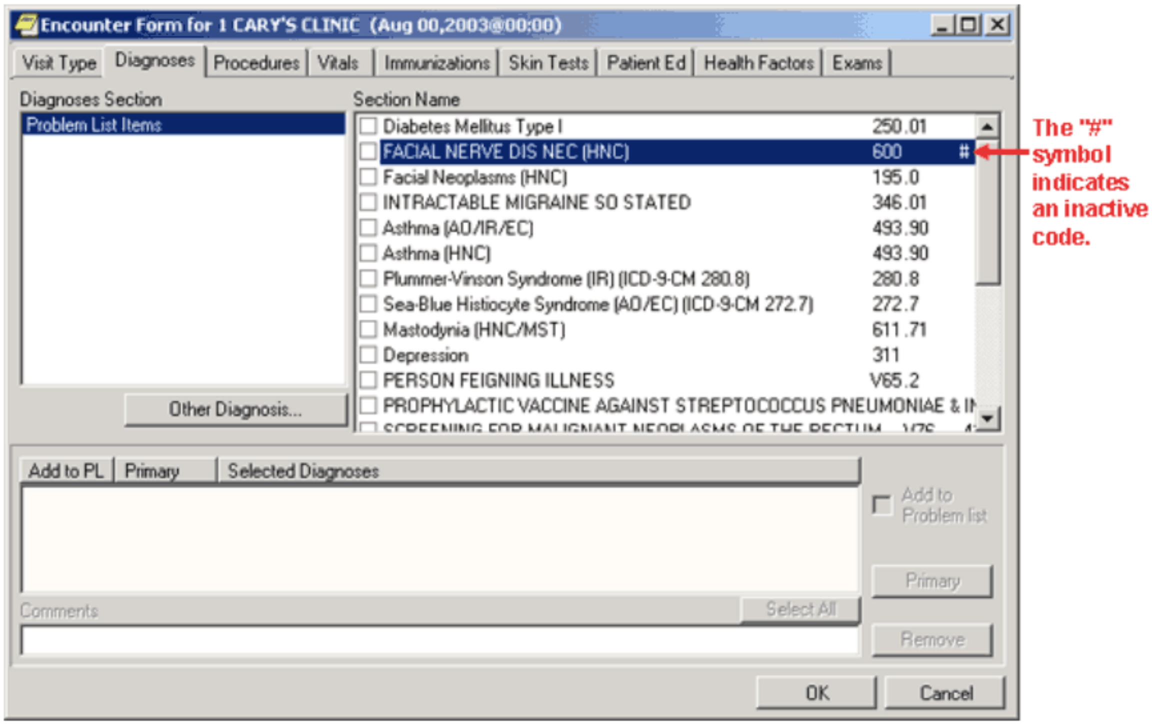
In order to receive workload credit, you must enter encounter form data when you create a new progress notes, complete a consult, or write a discharge summary.

> **Note**: Once a note, summary, or consult has been completed, you can only change encounter information directly through Patient Care Encounter (PCE.)

To enter encounter form data, follow these steps:

1. Click the appropriate tab: Notes, Consults, or D/C Summ.
2. Click New Note, New Summary or select Action | Consult Results....
3. Type in a title for the note or summary or select one from the list.
4. Click Encounter.
5. Click the tab where you want to enter information (Type of Visit, where you can also enter the primary and secondary providers, Diagnoses, where you can have diagnoses automatically be added to the Problem List, Procedures, Vitals, Immunizations, Skin Tests, Patient Ed., Health Factors, or Exams).
6. Click the appropriate category in the list box on the left and then click the check boxes by the appropriate items in the list box on the right. If the section name you want is not shown or the list boxes are empty, use the search feature. To search, click on the Other <Tab Name>. (Each tab's button will be labeled differently.) Locate and double-click the needed item. Some tabs have a simple list to choose from. Diagnoses and Procedures have a search function. On these tabs, you need to enter the beginning of a term and click Search before double-clicking.

   > **Note**: If a user tries to enter a diagnosis or procedure that has an inactive code associated with it, CPRS will not accept that selection and will request that the user change it.



This screen shows a diagnosis on the Encounter form with an inactive code.

If a user selects a diagnosis or procedure with an inactive code, the above dialog will display telling the user that the code is inactive and that the user should change it.

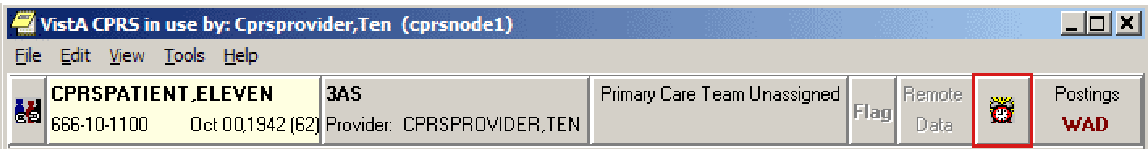
Note: The Type of Visit and Vitals tabs are different. Type of Visit has no button, and Vitals has a Historical Vitals Details button that brings up a dialog containing a graph and a listing of past vitals taken.

7. Enter any additional information as needed. Several tabs have additional features, such as drop-down lists for results of exams, severity of problems, and so on.
8. Fill in information for other tabs as needed by repeating steps 2-6.
9. When finished, click **OK**.

Clinical Reminders

You can find out if a patient has reminders by doing one of the following:

- Clicking the **Reminders** button near the top right of the CPRS form. When you click this button, a dialog with a reminders tree view will be displayed. The reminders button may display one of five icons. When it displays a red clock, the patient has reminders due.



The Reminders button indicates whether there are reminders for the current patient.

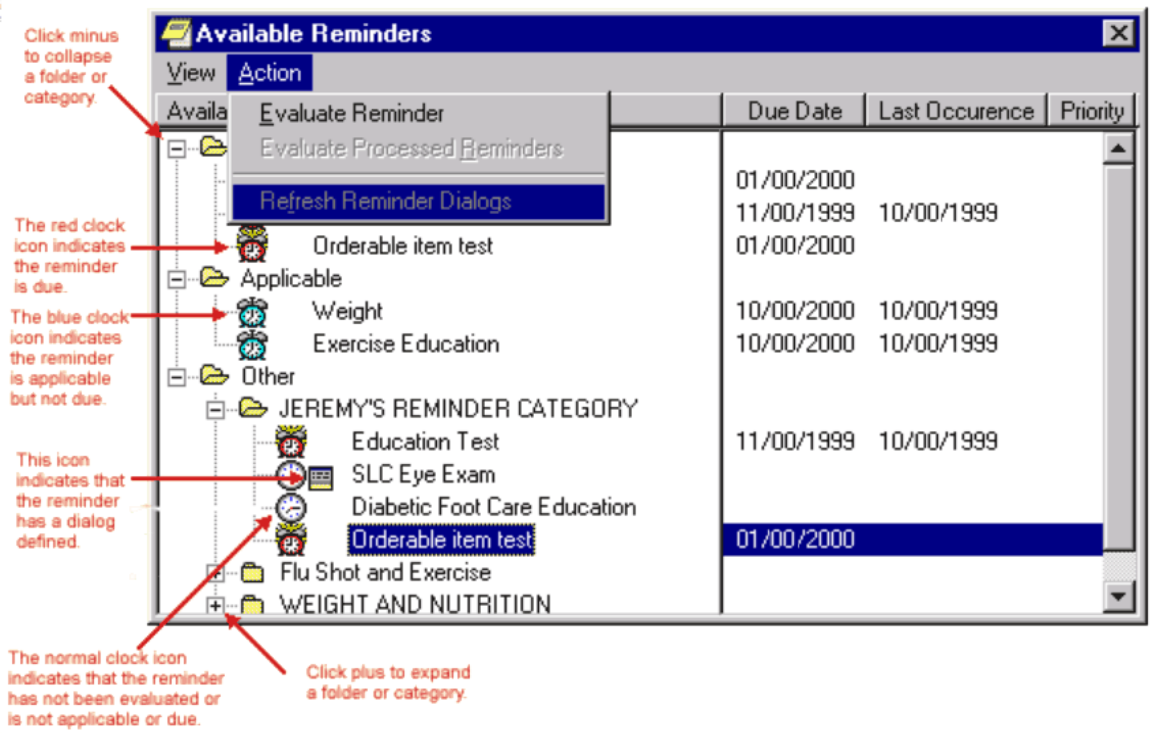
- Looking on the coversheet that has an area specifically for reminders.
- Opening a reminders drawer to check on the reminders for a patient after you have begun a new progress note. When you click the **Reminders** drawer, you will see a dialog with a tree view of due, applicable, and other reminders.

The Reminders Drawer

After you begin a new progress note, you will see the reminders drawer. If you click the drawer, a tree view of due, applicable, and other reminders will be displayed. The Due category automatically expands when you open the Reminders drawer, while the Applicable and Other categories do not.

Note: Before you can process a reminder, a CAC or someone else must create a dialog in a similar position at your site. A dialog image over the clock or question mark icon shows that a reminder has an associated dialog.

After you process a reminder but before you reevaluate it, a check is placed over the reminder to show it has been processed. Once you reevaluate the reminder, it will be moved to the category for reminders that are applicable but not due.



The Reminders drawer

Click a reminder to bring up the Reminders Processing dialog and process the reminder.

Right-click a reminder to get the following options:

- Clinical Maintenance—shows the possible resolutions and the findings associated with the reminder.
- Education Topic Definition—lists the education topics that have been defined for a reminder. You can select a topic to view the desired education outcome and any standards.
- Reminder Inquiry—shows the reminder definition describing which patients are selected for this reminder.
- Reference Information—lists Web sites with additional information.
- Evaluate Reminder–tells you if a reminder is due, applicable or other.
- Reminder Icon Legend–displays icon legend screen with icons and meanings.

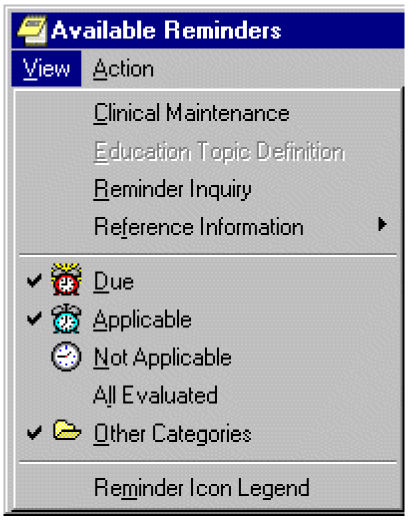
Each of these options brings up a window. When you are finished with the window, click Close. For more information on Clinical Reminders, refer to the *Clinical Reminders Manager Manual* and *Clinical Reminders Clinician Guide.*

Reminders Processing

You process Reminders using the Reminders Processing dialog. The dialog displays the possible activities that can occur during a visit and that can satisfy the reminder. You may need to enter additional information.

If a Reminder dialog generates Primary Care Encounter (PCE) data for the current encounter, the user is prompted to enter the primary encounter provider when clicking the FINISH button, if one is needed (depending on the PCE data created, and the setting of the ORWPCE DISABLE AUTO CHECKOUT parameter).

In the reminder tree dialog, under the View menu, there are now five new menu options for determining which folders will appear in the reminder tree. These menu options, Due, Applicable, Not Applicable, All Evaluated, and Other Categories, will be checked if that folder is to appear in the tree. Individual users can set which folders will appear by selecting the corresponding menu item.

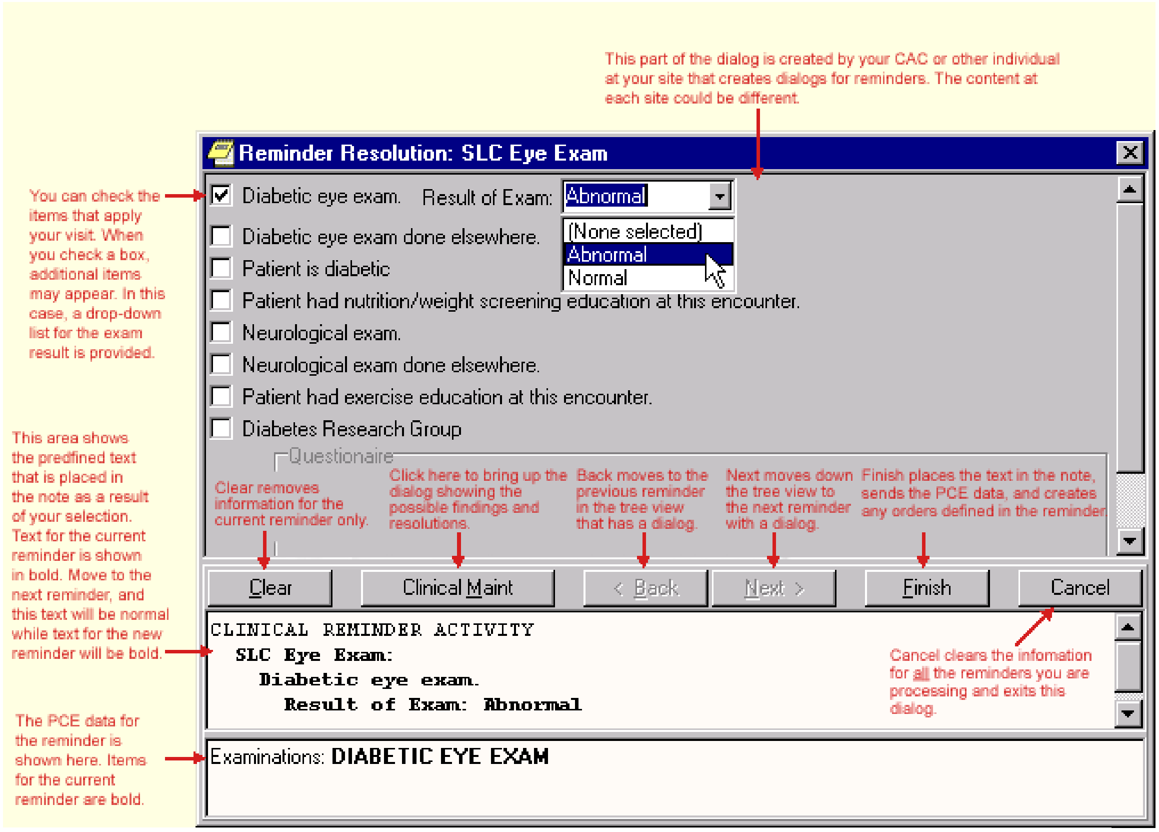


The Available Reminders dialog

When you check an item on a Reminder dialog, it may expand to enable entry of more detailed information, such as dates, locations, test results, and orders that you could place based on a response. The information depends on how the dialog was created at your site. Reminder dialog elements that allow only one choice per dialog group appear as radio buttons.
When you click a check box or item, the associated text that will be placed in the progress note is shown in the area below the buttons. Patient Care Encounter (PCE) data for the item is shown in the area below that.

Text and PCE data for the reminder that you are currently processing are in bold.

When you click the Finish button after entering vital signs in Reminder dialogs, a prompt appears requesting the date and time the vital signs were taken. This prompt defaults to the date of the encounter.



Reminder Resolution dialog

- Required fields are no longer checked on a Reminder dialog unless at least one entry has been made on the dialog. This allows users to skip Reminders that are not intended for processing.
- Reminder dialog groups can now be set to NONE OR ONE SELECTION, which allows up to one entry in a group, but does not require an entry. PX*1.5*2 is required to change the reminder dialog definition.
- Required prompts and template fields will be marked with an asterisk (*) to indicate that they are required. A message at the bottom of the Reminder dialog states "* Indicates a Required Field."

Reminder dialogs have a Visit Info button. It opens a dialog that allows the user to enter service-connected information, as well as the vital sign entry date and time. If service-connected information is required for the encounter and note title, this dialog automatically appears when you click **Finish**.

Processing a Reminder

To process a reminder for a patient, complete the following steps:

1. If you have not already, begin a new progress note by clicking the Notes tab, then New Note, and then select a note title. (If prompted, enter the encounter location and provider.)
2. Click the Reminders drawer or the Reminders button to open a tree view of the reminders for this patient.
3. Click the plus sign to expand the tree hierarchy where needed and then click the reminder you will process. You will then be presented with the dialog for processing reminders.

   Note: If you click the Reminders button, choose Action | Process Reminders Due to begin with the first reminder due.

4. Click the check boxes in front of the items that apply to this patient, and enter any additional information requested such as comments, diagnoses, and so forth.
5. When you are finished with this reminder, click another reminder or click Next to move to the next reminder.
6. Repeat steps 4 and 5 as necessary to process the desired reminders.
7. When you have processed all the reminders you want to process, click **Finish.**
8. Review and finish your progress note and enter any information necessary in order dialogs.

Completing Reminder Processing

After you have entered all the information, you can finish processing the reminders.

When you finish, the following things will happen:

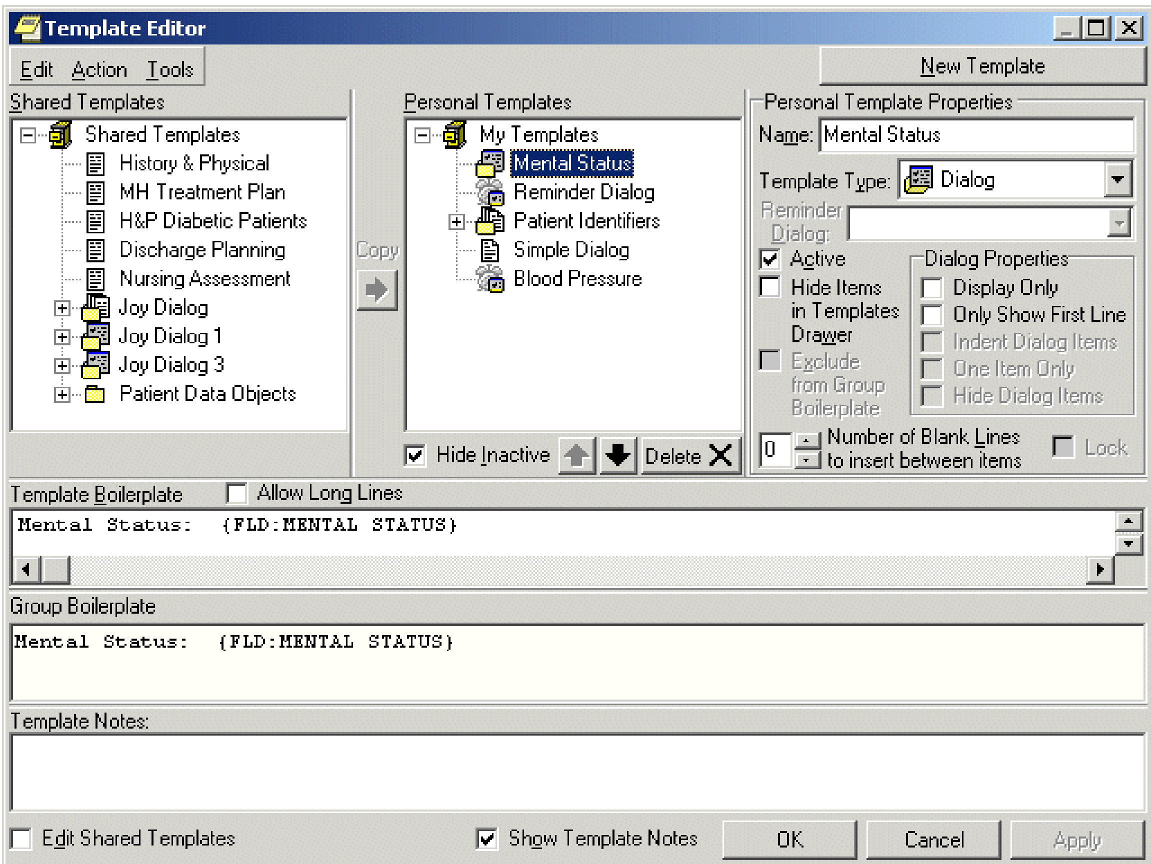
- The predefined text is placed in the note you started to write.
- The encounter information to is sent to Patient Care Encounter (PCE) application for storage.
- If there are orders defined in the dialog, the orders will also be created. If the orders require input, the order dialogs will appear so that you can complete the orders. You must sign any orders that are created. After you have signed the orders, click **Finish** to finish processing remainders.

Document Templates

With the CPRS GUI, you can create document templates to make writing or editing progress notes, completing consults, or writing discharge summaries quicker and easier. In addition, you can import or export templates and convert Microsoft Word files to document templates.

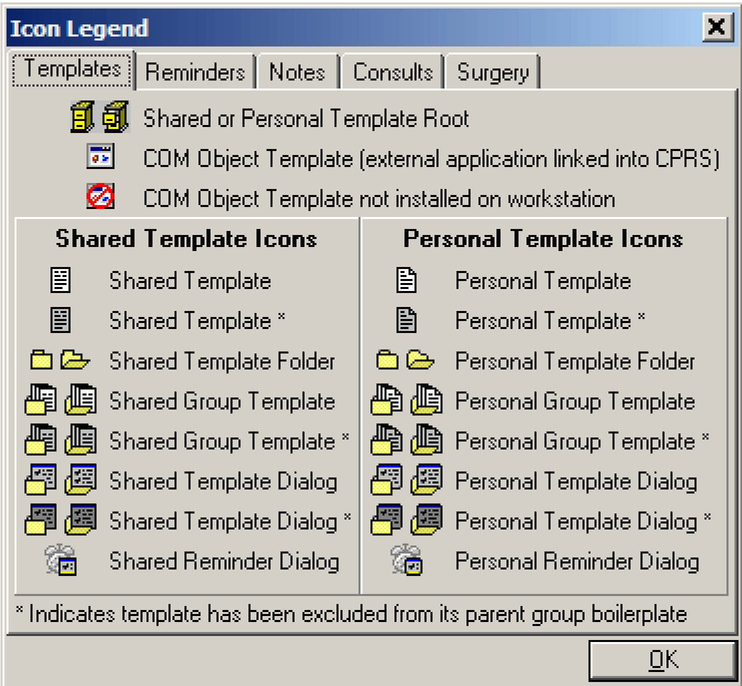
Template Editor

The Template Editor is used to create and manage document templates. To access the Template Editor select **Options | Create New Template…**from the Notes, Consults, or D/C Summ tab.



The Template Editor window

For an explanation of the icons used in the Template Editor, select **Tools** | **Template Icon Legend** and click the **Templates** tab.



The Icon Legend

Personal and Shared Templates

You can create and use your own templates or you can use shared templates created by your Clinical Coordinator.

Personal Templates

Authorized users can create personal templates. You can copy and paste text into a template, type in new content, add template fields, or copy a shared template into your personal templates folder. A shared template that you simply copy into your personal templates folder without changing continues to be updated whenever the original template is changed or modified in the Shared Templates folder. Once you personalize or change the copy of the shared template in your personal templates field, the icon used to represent it changes and it becomes a personal template. From that moment on, the personal template is not related to the shared template and is not updated with the original. In the tree view, personal template and folder icons have a folded upper right corner.

Shared Templates.

Only members of the Clinical Coordinator Authorization/Subscription Utility (ASU) class can create shared templates. Shared templates are available to all users. Clinical Coordinators can copy and paste text into a template, type in new content, add Template Fields, or copy a personal template and then modify it as needed. In the tree view, shared template and folder icons do not have a folded corner.

> **Note**: When you install CPRS, a copy of all your existing boilerplate titles is placed in the inactive boilerplates folder under shared templates.

Clinical Coordinators can arrange the boilerplate titles that have been copied into the shared templates, use them to create new shared templates, or make them available to users by moving them out of the inactive boilerplates folder. Users will not see the inactive boilerplates folder or its templates unless you choose to make the folder active.

To activate the boilerplates folder, Clinical Coordinators should follow these steps:

1. Open the Templates Editor.
2. Verify that Edit Shared Templates is checked.
3. Uncheck Hide Inactive (under shared templates).
4. Click the plus sign beside the shared icon.

Shared Templates includes a lock property that prevents users from making personal changes when it has been set. The status of the lock property is displayed in a check box on the Template Editor dialog. When the Shared Templates root template is locked, no shared templates can be modified.

For more information on boilerplates, refer to the *Text Integration Utility User Manual*.

Another area of shared templates is creating Patient Data Object templates for newly created TIU objects that will enable users to place these objects into their other templates.

To create a new Patient Data Object template, use the following steps:

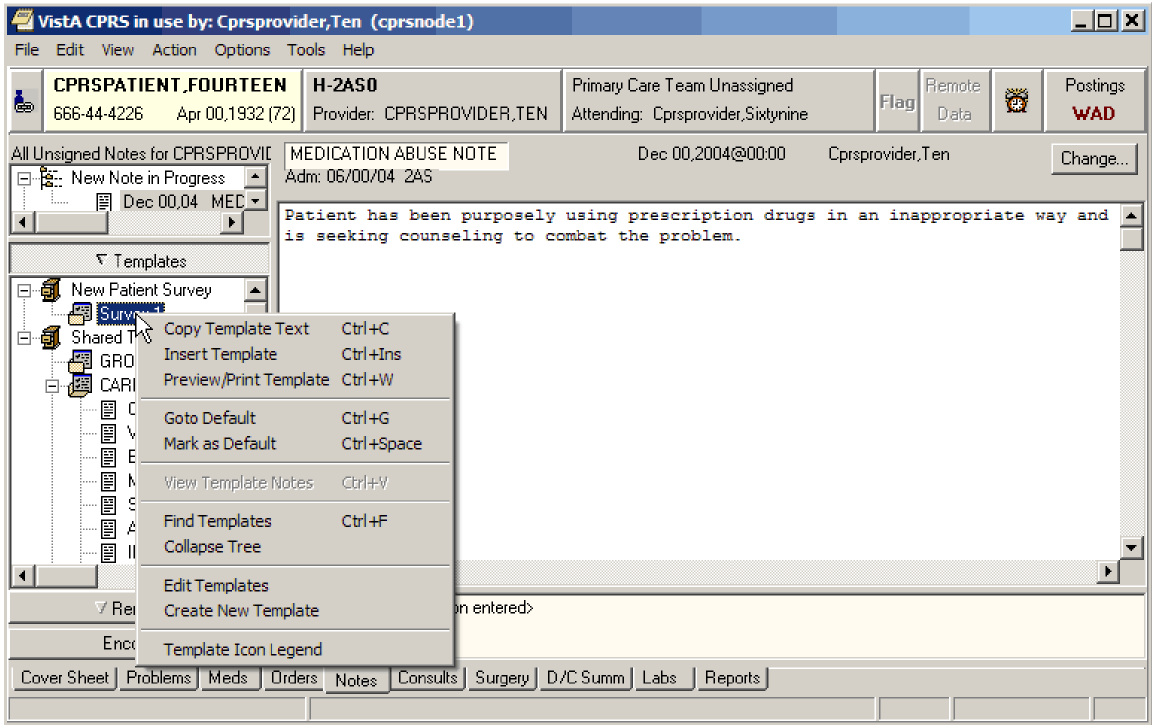
1. Open the Template Editor by selecting from the Notes, Consults, or DC/Summ tab by selecting **Options | Edit Shared Templates…**.
2. Verify that Edit Shared Templates is checked.
3. Expand the treeview of Shared Templates and then Patient Data Objects by clicking on the plus sign beside each.
4. Click on the existing object above which you want your new object to be.
5. Click New Template and edit the name of the template.
6. Place the cursor in the Template Boilerplate box and select Edit | Insert Patient Data Object or right-click and select Insert Patient Data Object to bring up a dialog containing a list of TUI objects.
7. Click the appropriate TIU object (that was probably just created).
8. Click **Apply** or **OK** to make the new object available in GUI templates.

Mark a Template as Default

A default template will automatically be selected the first time you open the Templates Drawer. The default template can also be accessed at any time with the Go to Default Template option. Each tab (Notes, Consults, and D/C Summ) can have its own default templates.

To set a template as your default template, follow these steps:

1. Open the Template Drawer on the Notes tab by clicking on it.
   The available templates will be displayed in a tree view.
2. Right-click on any template and select Mark as Default from the right-click menu.



You can set a template as your default template with a right click menu option.

Hide Child Templates

To make child templates unavailable from the template drawer, follow these steps:

1. Start the Template Editor by selecting **Options** | **Edit Templates** from the Notes tab.
2. Click Hide Dialog Items from the Dialog Properties option group.
3. Click **OK**.

Display Only

Click this check box to make individual parts of a dialog as display only. When a template is display only, the check box is removed and the item is used for information or instructions

Only Show First Line

Click on this check box and the template will display only the first line of text followed by an ellipsis (...). The ellipsis indicates that more text exists. Hold the cursor over the line of text and a Hint box displays the complete text. This feature gives you the ability to have long paragraphs of text that do not take up a lot of room on the template. If selected, the entire paragraph is be inserted into the note.

Indent Dialog Items

Clicking on this check box affects the way that children items are displayed on the template. When selected, this feature gives the ability to show hierarchical structure in the dialog. All of the subordinate items for the selected item are indented.

One Item Only

Clicking on this check box affects the way that children items are displayed on the template. Click on this check box if you want to allow only one of the subordinate items to be selectable. Clicking on this check box changes the check boxes into radio buttons so that only one item can be selected at a time. To deselect all items, click on the one that is selected and the radio button will be cleared.

Hide Dialog Items

Clicking on this check box affects the way that children items are displayed on the template. Click on this option to have subordinate items appear only if the parent item is selected. This feature allows for custom user input. The user only sees the options related to the items selected. This feature requires boilerplated text at the parent level.

Allow Long Lines

A check box in the Template Editor named "Allow Long Lines" allows template lines to be up to 240 characters in length. This feature mainly accommodates template field markup.

Types of Templates

When you create templates, you can go directly into the Template Editor. There, you can type in text, and add Template Fields. If you are in a document and type in something you will use repeatedly, you simply select that text, right-click, select Create New Template, and the editor comes up with the selected text in the editing area. You can create individual templates, group templates, dialog templates, folders, or link templates to Reminder dialogs. Template dialogs are resizable.

Templates

Templates contain text, TIU objects, and Template Fields that you can place in a document.

Group Templates

Group templates contain text and TIU objects and can also contain other templates. If you place a group template in a document, all text and objects in the group template and all the templates it contains (unless they are excluded from the group template) will be placed in the document. You can also expand the view of the group template and place the individual templates it contains in a document one at a time.

Dialog Templates

Dialog templates are like group templates in that they contain other templates. You can place a number of other templates under a dialog template. Then, when you drag the dialog template into your document, a dialog appears that has a checkbox for each template under the Dialog template. The person writing the document can check the items they want and click OK to place them in the note.

Folders

Folders are used to group and organize templates and assist in navigating the template tree view. For example, you could create a folder called "radiology" for all of the templates relating to radiology.

Reminder Dialog

Reminder dialogs can be linked to templates. This allows you to place orders and enter PCE information, vitals information, and mental health data from a template. (Refer to Creating Reminder Dialogs for this procedure.)

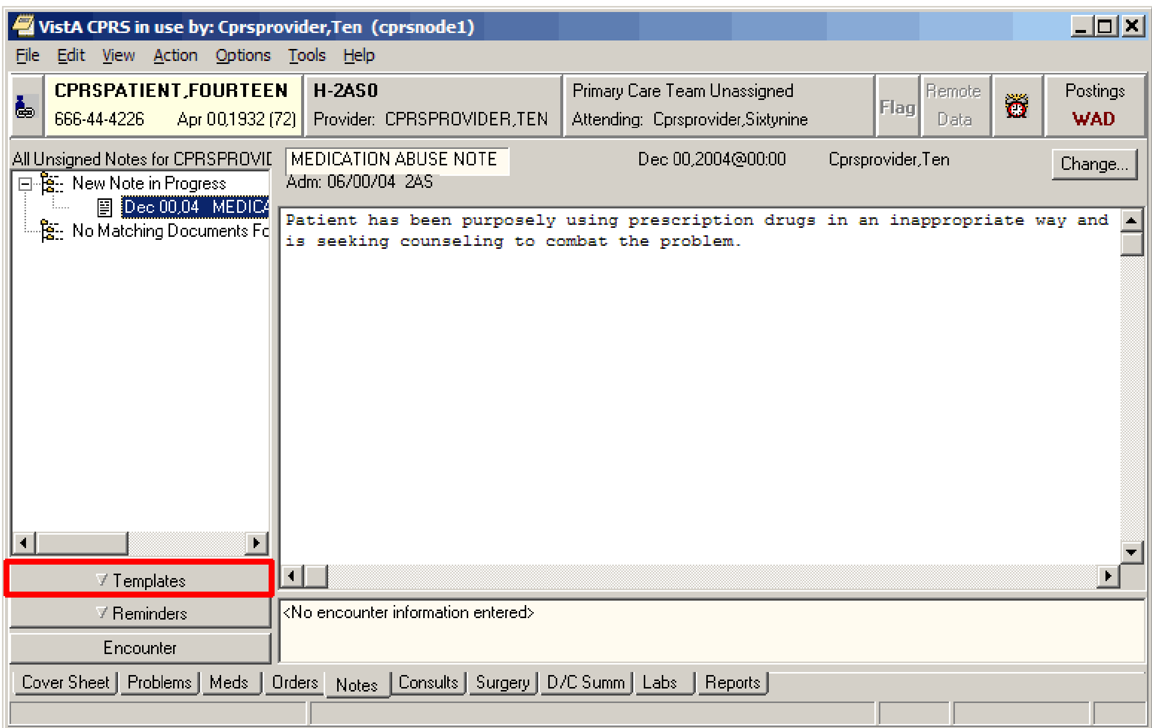
Arranging Templates for Ease of Use

You can use file cabinets and folders to group similar templates together to make them easier to find and use. For example, you may want to place all of the pulmonary templates together rather than listing the templates in alphabetical order.

Adding a Template to a Note

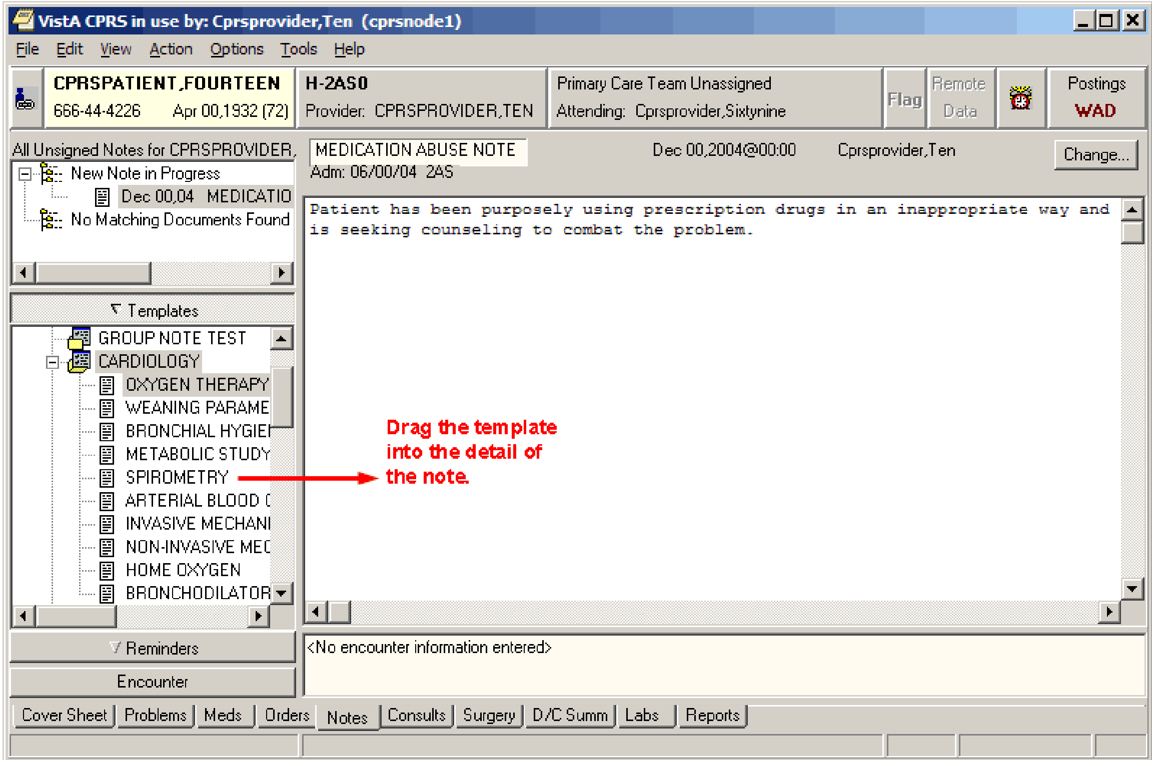
To add a template to a Note, use the following steps:

1. From the Notes tab, create a new note by clicking on **New Note**.
2. Complete the Progress Note Properties dialog.
3. Click **OK**.
   The Progress Note Properties dialog will close and the Templates Drawer will appear above the Reminder Drawer.



The Templates Drawer

4. Click the **Templates** drawer
   The available templates will appear.
5. Select the template that you would like to use (click the + to expand a heading)
6. Drag the template into the detail area of the note
   -or-
   double click on the template
   -or-
   right click on the template and select Insert Template.



Drag the template into the detail area of the note.

Searching for Templates

To search for a template, use the following steps:

1. Right-click in the tree view (in either the Template Editor or the Templates drawer).
2. Select the appropriate option: Find Templates, Find Personal Templates, or Find Shared Templates (depending on which tree view you are in).
   A search screen will appear.

Note: You may want to narrow your search by using the Find Options feature.

3. Enter the word or words you want to find and check the appropriate boxes.
4. Click **Find**.
5. If you do not find the template you want, scan the list or click **Find Next**.
6. Repeat step 5 until you find the desired template.

Previewing a Template

To preview a template before inserting it into your document, follow these steps:

1. Right-click the template in the Templates drawer on the Notes tab.
2. Select Preview/Print Template.
   The preview dialog will appear.

   Note: You can print a copy of the template by pressing the Print button.

Deleting Document Templates

To delete a document template, follow these steps:

1. Click the **Notes**, **Consults**, or **D/C Summ** tab.
2. Select **Options | Edit Templates**
   -or-
   if the Templates drawer is open, right-click in the drawer and select **Edit Templates**.
3. Find the template you want to delete. (Click the + sign to expand a heading.)
4. Right-click the template you want to delete and select **Delete**.
   -or-
   select the template you want to delete and then click the **Delete** button under the tree view.
5. Click **Yes** to confirm the deletion.

Creating Personal Document Templates

To speed document creation, you can create personal templates consisting of text, Template Fields, and Patient Data Objects. You can use the templates to create progress notes, complete consults, and write discharge summaries.

Personal Template

To create a personal document template, follow these steps**:**

1. Click the **Notes**, **Consults**, or **D/C Summ** tab.
2. Start the Template Editor by selecting **Options** | **Create New Template**
   -or-
   Select the text that you would like to save as a template, right-click the text, and select **Copy into New Template**.
3. Type in a name for the new template in the Name field under Personal Template Properties.

   Note: Template names must begin with a letter or a number, be between 3 and 30 characters in length (including spaces), and cannot be named "New Template."
4. Click the drop-down button in the Template Type field and select **Template**.
5. Enter the content for the template by copying and pasting from documents outside CPRS, typing in text, and/or inserting Template Fields.

   Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or check for errors (which looks for invalid Template Fields).
6. Place the template in the tree view in the desired location. (To do this, click the plus sign next to an item to view its subordinate objects and then drag-and-drop the template to its desired location. You can also move the template by using the arrows below the personal templates tree view.)
7. Click **Apply** to save the template.
8. Click **OK** to save and exit the editor.

Note: You are not required to click Apply after each template, but it is recommended. If you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Group Template

You can create group templates which contain other templates. You can then place the entire group template in the note, which brings in the text and Template Fields from all templates in that group, or expands the tree view in the Templates drawer and places the individual templates under the group template in the note.

To create a personal Group Template, follow these steps:

1. Click the **Notes**, **Consults**, or **D/C Summ** tab
2. Select **Options** | **Create New Template**
   -or-
   Select the text that you would like to save as a template, right-click the text, and select **Copy into New Template.**
3. Enter a name for the new template in the Name field under Personal Template Properties.

   Note: Template names must begin with a letter or a number, be between 3 and 30 characters in length (including spaces), and cannot be named "New Template."

4. Click the drop-down button in the Template Type field and select Group Template.
5. Enter the text and Template Fields to create content in the main text area of the group template, if desired. (You can enter content by copying and pasting from documents outside CPRS, typing in text, and/or inserting Template Fields.)

   Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid Template Fields.

   Note: You can also create additional templates under the Group Template that you just created. To do this, simply highlight the appropriate group template and click New Template. Then complete the steps for creating a new template outlined above.
6. Place the template in the tree view in the desired location. (To do this, click the plus sign next to an item to view its subordinate objects and then drag-and-drop the template to its desired location. You can also move the template by using the arrows below the personal templates tree view.)
7. Click **Apply** to save the template.
8. Click **OK** to exit the template editor.

   Note: You are not required to click Apply after each template, but it is recommended. If you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Associating a Template with a Document Title, Consult, or Procedure

Clinical Coordinators and others who are authorized to edit shared templates and who are also members of the appropriate user class (specified in the EDITOR CLASS field, #.07 of the TIU TEMPLATE file #8927) may see the Document Titles, Consult Reasons for Request, and/or the Procedure Reasons for Request template folders. These folders allow you to associate a template with a progress note title, a procedure, or a type of consult. After an association is created, the appropriate template content is inserted in either the body of a note (when a new note is started) or in the Reason for Request field (when a new consult or procedure is ordered).

To associate a template with a document title, type of consult, or a procedure, follow these steps:

1. Create a new template (by following the instructions above for either the personal template or the group template)
   -or-
   edit an existing template by selecting **Options | Edit Templates**….from the Notes, Consults, or D/C Summ tab.
2. Click the Edit Shared Templates check box located in the lower lefthand corner of the Template Editor window.
3. Select the template you would like to associate from the Personal Templates section of the Template Editor window.
4. Drag and drop the template into either the Document Titles, Consult Reasons for Request, or Procedure Reasons for Request folder in the Shared Templates area of the window.
5. Select the template that you just moved (click "+" to expand a heading) in the Shared Templates area of the window.
6. Select a procedure from the Associated Procedure drop-down list
   -or-
   select a consult service from the Associated Consult Service drop-down list.
7. Click **OK**.
   The template is now associated.

When you order a consult or a procedure, the associated template text will appear in the Reason for Request field. When you enter a new progress note the associated template text will appear in the text of the note.

Importing a Document Template

You can import existing template files (.txml), Microsoft Word files (Word 97 or higher), or XML files into the CPRS Template Editor.

To import a template, follow these steps:

1. Start the Template Editor.
2. Browse to the file cabinet or folder where you would like to store the imported template (click "+" to expand a heading).

   Note: In order to import a template to the Shared Templates area of the screen, you must be authorized to edit shared temples *and* place a checkmark in the Edit Shared Templates check box (located in the lower left side of the Template Editor).

3. Select Tools | Import Template.
4. Select the file you would like to import and click Open.
5. The template will appear in the Template Editor.
6. If you press OK, the template will be imported without the new fields. If you press Cancel, the import process will be cancelled.

   Note: If you do not have authorization to edit template fields, you may see this dialog.

The template field warning dialog

Exporting a Document Template

You can also export a template or a group of templates with the Template Editor. Exported templates are saved with the .txml file extension.

Note: Patient data objects are not exported with a template.

To export a template or a group of templates, follow these steps:

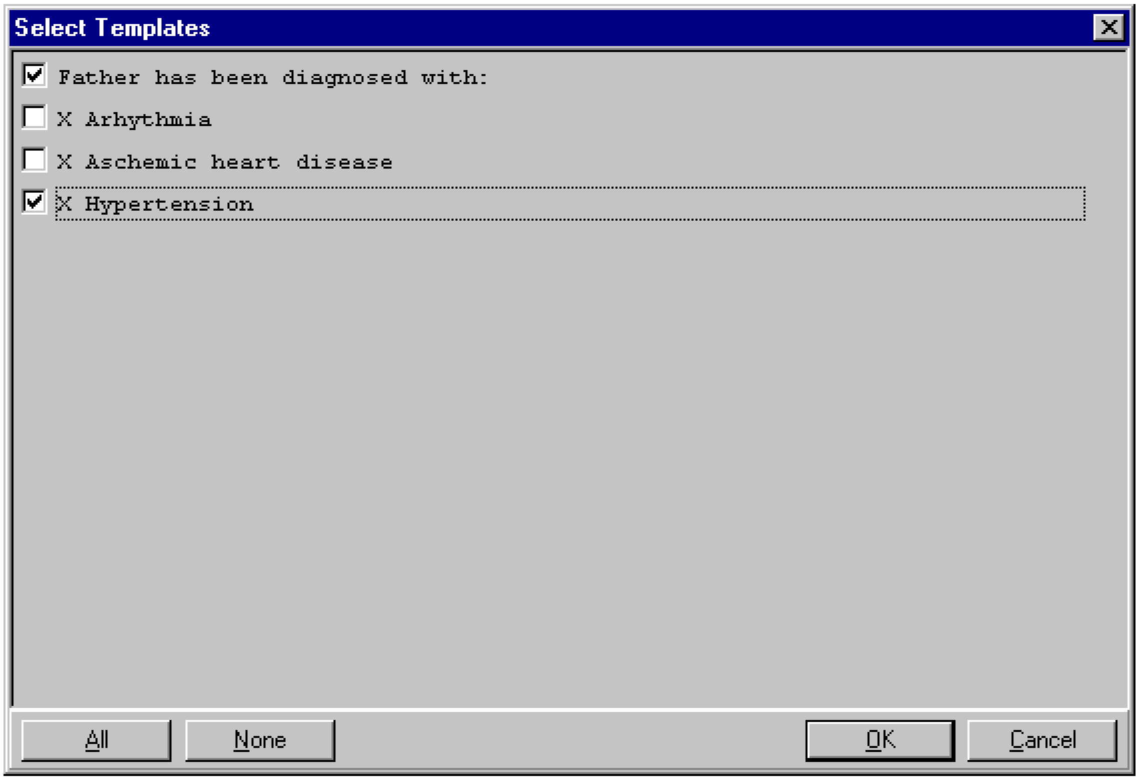
1. Start the Template Editor.
2. Select the template or group of templates (file cabinet) that you would like to export.
3. Select **Tools | Export Template**.
4. Choose a destination and file name for the template file.
5. Click **Save**.

Dialog Template

Dialog templates contain other templates. If there is more than one template, each template under a dialog template will have a check box next to it when the template is placed in a document. A single template under a dialog template will not have a check box. Pressing the OK button inserts the dialog element into the note.

If you double-click a dialog template or drag it onto the note, a dialog appears. The dialog shows the text for each template preceded by a check box.

Click the box to check which items are to be included in the note. You can click All to select all of the elements or None to start over. Click OK when you have completed your selection.



A dialog template

To create a personal Dialog Template, follow these steps:

1. Select **Options** | **Create New Template** on the Notes, Consults, or D/C Summ tab to bring up the Template Editor
   -or-
   Select the text that you would like to save as a template, right-click the text, and select **Copy into New Template.**
2. Enter a name for the new template in the Name field under Personal Template Properties.

   Note: Template names must begin with a letter or a number, be between 3 and 30 characters in length (including spaces), and cannot be named "New Template."

3. Click the drop-down button in the Template Type field and select **Dialog**.

4. Enter the text and Template Fields to create content in the main text area of the template, if desired. You can enter content by copying and pasting from documents outside CPRS, typing in text, and/or inserting Template Fields.

   Note: After you enter the content, you can right-click in the Template Boilerplate area to select spell check, grammar check, or Check Boilerplate for Errors, which looks for invalid Template Fields.

   Note: You can also create additional templates under the Group Template that you just created. To do this, simply highlight the appropriate group template and click New Template. Then complete the steps for creating a new template outlined above.

5. Place the template in the tree view in the desired location. (To do this, click the plus sign next to an item to view its subordinate objects and then drag-and-drop the template to its desired location. You can also move the template by using the arrows below the personal templates tree view.)
6. Click **Apply** to save the template.
7. Click **OK** to exit the template editor.

   Note: You are not required to click Apply after each template, but it is recommended. If you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Reminder Dialog

Templates can be linked to Reminder dialogs that are listed in the TIU Reminder Dialogs parameter. This enables you to use templates to place orders, enter PCE information, and enter vital signs and mental health data. If there are no Reminder Dialogs in the TIU Reminders Dialog parameter, the Reminder Dialog template type will not be available.

To create a Reminder Dialog, follow these steps:

1. Select **Options** | **Create New Template**… on the Notes, Consults, or D/C Summ tab
   The Template Editor will appear.
2. Type in a name for the new template in the *Name* field under Personal Template Properties.

   Note: Template names must begin with a letter or a number, be between 3 and 30 characters in length (including spaces), and cannot be named "New Template."
3. Click the drop-down button in the Template Type field and select Reminder Dialog.
4. Click the drop-down button in the Dialog field and select the Reminder Dialog desired.
5. Place the template in the tree view in the desired location. (To do this, click the plus sign next to an item to view its subordinate objects and then drag-and-drop the template to its desired location. You can also move the template by using the arrows below the personal templates tree view.)
6. Click Apply to save the template.
7. Click OK to exit the editor.

   Note: You do not have to click Apply after each template, but it is recommended because if you click Cancel, you will lose all changes you have made since the last time you clicked Apply or OK.

Folder

Folders are simply containers that allow you to organize and categorize your templates. For example, you might want to create a folder for templates about diabetes or one for templates about mental health issues.

To create a personal template folder, complete the following steps:

1. Select **Options** | **Create New Template** on the Notes, Consults, or D/C Summ tab to bring up the Template Editor
   -or-
   Select the text that you would like to save as a template, right-click the text, and select **Copy into New Template**.
2. In the Name field under Personal Template Properties, enter a name for the new folder. For ease of use, you should create a name that describes the content of the template.

3. Click the template type: Folder.
4. Drag-and-drop relevant templates into the template folder that you have created.

   Note: It is recommended that you click Apply after adding a template to save your changes. If you accidentally click Cancel, you will lose all the changes you have made since the last time you clicked Apply or OK.

View Template Notes

Template Notes can be used to describe what is in the template or to track changes to the template.

To add or display Template Notes, follow these steps:

1. Click the **Notes** tab.
2. Click **Options** | **Edit Templates**.
3. Select the shared or personal template for which you wish to add or change the Template Notes.
4. Click the Show Template Notes check box at the bottom of the dialog. The *Template Notes* field appears below the *Template Boilerplate* field.
5. Add or change the note as much as you wish.

   Note: If the template you wish to edit is a shared template and you have the authority to edit it, you will need to click the Edit Shared Templates check box on the lower left corner of the Template Editor dialog.

To add or display Template Notes from the Template Drawer, complete the following steps:

1. Select **Options** | **Edit Templates…** from the Notes, Orders, or D/C Summ tab. The Template Editor will appear.
2. Select the shared or personal template for which you wish to add or change the Template Notes.
3. Click the Show Template Notes check box at the bottom of the dialog. The *Template Notes* field appears below the *Template Boilerplate* field.
4. Add or change the note as much as you wish.

   Note: If the template you wish to edit is a shared template and you have the authority to edit it, you will need to click the Edit Shared Templates check box on the lower left corner of the Template Editor dialog.

Copying Template Text

To copy text from a template to any text field, complete the following steps:

1. Open a new note, consult or discharge summary.
2. Select a note, consult or discharge summary title.
3. Click the **Notes** tab
4. Click the Templates drawer button.

5. Expand either the Shared Template or Personal Templates tree.
6. Right-click the desired template.
7. Click **Copy Template Text** (or press Control+C) to copy the text to the clipboard.

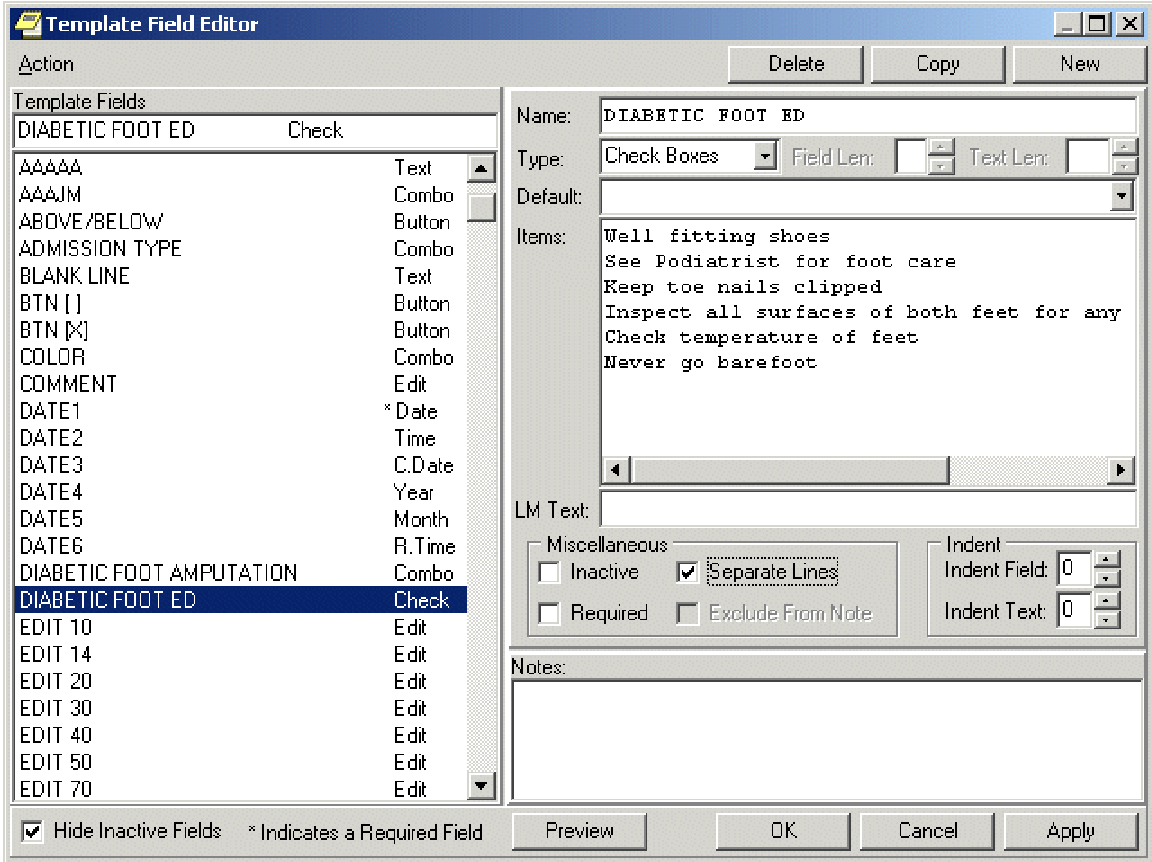
Note: You can paste the copied text into any text field by right clicking in the desired field and selecting Paste.

Template Fields

Template fields allow you to create text edit boxes and lists of text that can be selected via combo boxes, buttons, check boxes, or radio buttons. Through a new type of markup syntax {FLD:TemplateFieldName}, these controls can be added to templates, boilerplate titles, boiler plate reasons for request, and reminder dialogs. A Template field editor has also been added that can be used by members of the ASU user classes listed in the new TIU FIELD EDITOR CLASSES parameter. You can access the template field editor through the options menu on Notes, Consults and D/C Summaries tabs, as well as through the new Template Editor Tools menu. There is also a new Insert Template Field menu option in the Template Editor, following the Insert Patient Data Object menu option. You can enter free text into Template Field Combo boxes.

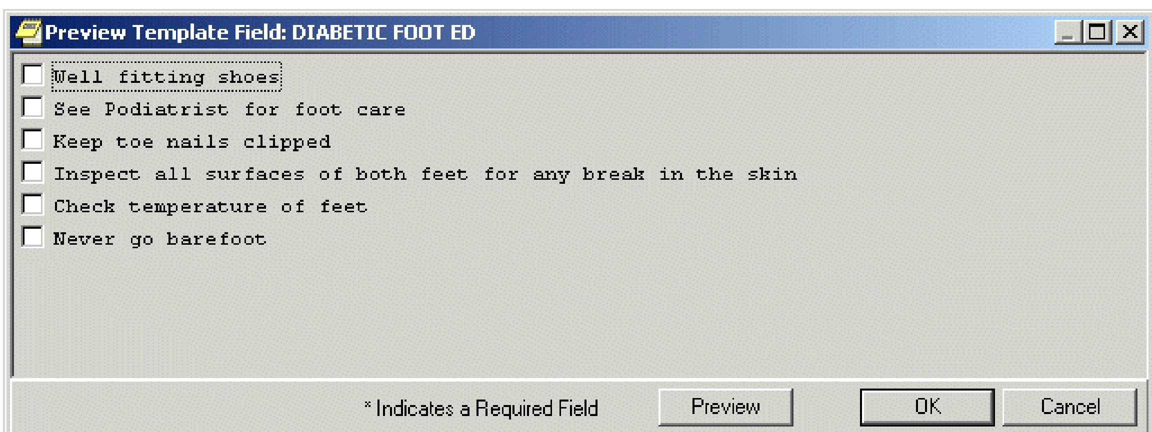
Template Dialogs will now show an asterisk (*) before required template fields, and will not allow you to press the OK button if you have not completed the required fields. A message has also been added at the bottom of the template dialogs that states "* Indicates a Required Field.”

Template Fields can also be used in boilerplate text that can be associated to a new Note, Consult, or Discharge Summary.



The Template Field Editor

When you click the Preview button, you can view how the template dialog will appear. Since the Separate Lines check box is enabled on the Template field Editor dialog, the check box items on the preview are listed on a separate line. You can mark these fields as required if desired. Template Field Preview forms are resizable.



You can use the Preview button to preview a template dialog.

Using the Template Field Editor

You can reduce the time required to complete a note, consult, or discharge summary by adding template fields to your templates and dialogs. Information that you would normally have to look up can be pulled directly into your note, consult, or discharge summary from the template fields in your templates.

To view the predefined characteristics of the template fields:

1. Click either the **Notes**, **Consults**, or **D/C Summ** tab.
2. Select **Options** | **Edit Templates**.
   Click the desired template field in the Template Fields list on the left side of the dialog. The field is copied to the Name field on the right side of the dialog and all of the existing elements of the field are displayed.
3. Click Preview to see how the Template Field will appear on a template or click **OK** to complete the procedure.
4. To create a new template field:
5. Click either the **Notes**, **Consults**, or **D/C Summ tab**.
6. Select **Options** | **Edit Templates**.
7. Click New Template in the upper right corner of the Template Field Editor dialog.
8. Type a unique name for the new template field.
9. Select a Type.

If Edit Box is selected, type or select a number between 1 and 70 into the Maximum Number of Characters field. If Combo Box, Button, Check Boxes or Radio Buttons are selected as the Type, the Default field and Maximum Number of Characters fields are unavailable. The Items field and the Default field below Items are active.

The Default field below the Type field is available only when Edit Box is the Type selected. Type the text that you wish to have appears in the Edit Box by default. On the template, the user can accept the default text or change it, as long as the new text is within the Maximum Number of Characters limit.

If the Type is Combo Box, Button, Check Boxes, or Radio Buttons, the Items field will be active. Type the different choices from which you wish to let the user choose. Each item must be on a separate line in the Items field. However, if you wish to have the Items listed on separate lines in the template, you must enable the Separate Lines check box.

If the Type is Combo Box, Button, Check Boxes, or Radio Buttons, the second Default field will be active. If you wish, you may click the drop-down button and select one of the items as the default.

If you wish, you may type text in the LM Text field and it will appear in the List Manager version. Template Fields have been developed strictly for GUI functionality. If you are still using LM, the text {FLD:TEMPLATE FIELD NAME} will appear in LM body of the note. To avoid this, type text in this field.

If the field being created on the template is required, enable the Required check box, which will prevent the template from being closed without the field being selected or completed.

You may include text in the Notes field that will explain or describe the Template Field. You may also use it to record changes that have been made to the Template field. The text typed into this field will not appear on the template. These notes will not appear to a user when entering a note. They are for development use only as notes to the creator.

Click Preview to see how the Template Field will appear on a template or click OK to complete the procedure.

Inserting Template Fields into a Template

Once you have decided which Template fields to use or you have defined the Template Field that you need, you can add them into a template. With the Template field in the Template, you can quickly and easily select the items you wish to add to a note, consult or discharge summary.

To add a Template Field into a Template:

1. From the **Notes**, **Consults** or D**/C Summ tab**, click **Options** | **Edit Templates**... or **Create Templates**, **Edit Shared Templates**, or **Create New Shared Template**...
2. From the Template Editor, select the template to which you wish to add a Template Field.
3. Insert the cursor at the place in the Template Boilerplate field where you wish to insert the Template Field.
4. From the toolbar, click **Edit** | **Insert Template** Field or right-click in the template and select Insert Template Field.
5. On the Insert Template Field dialog, type the first few letters of the desired field or scroll through the list until the desired field is located.
6. Click the field you wish to insert.
7. Click **Insert Field**.
8. Repeat steps 5 through 7 for each additional Template Field you wish to insert.
9. Click Done when you have added all of the desired template fields.
10. From the tool bar, click **Edit** | **Preview/Print Template** or right-click in the template and select Preview/Print Template. This will preview the template. If the template does not display with the desired appearance, you may continue to edit it.
11. On the Template Editor dialog, click **OK** to save the changes to the template.

    Note: The Insert Template Field dialog is non-modal and can be used as a boilerplate if desired.

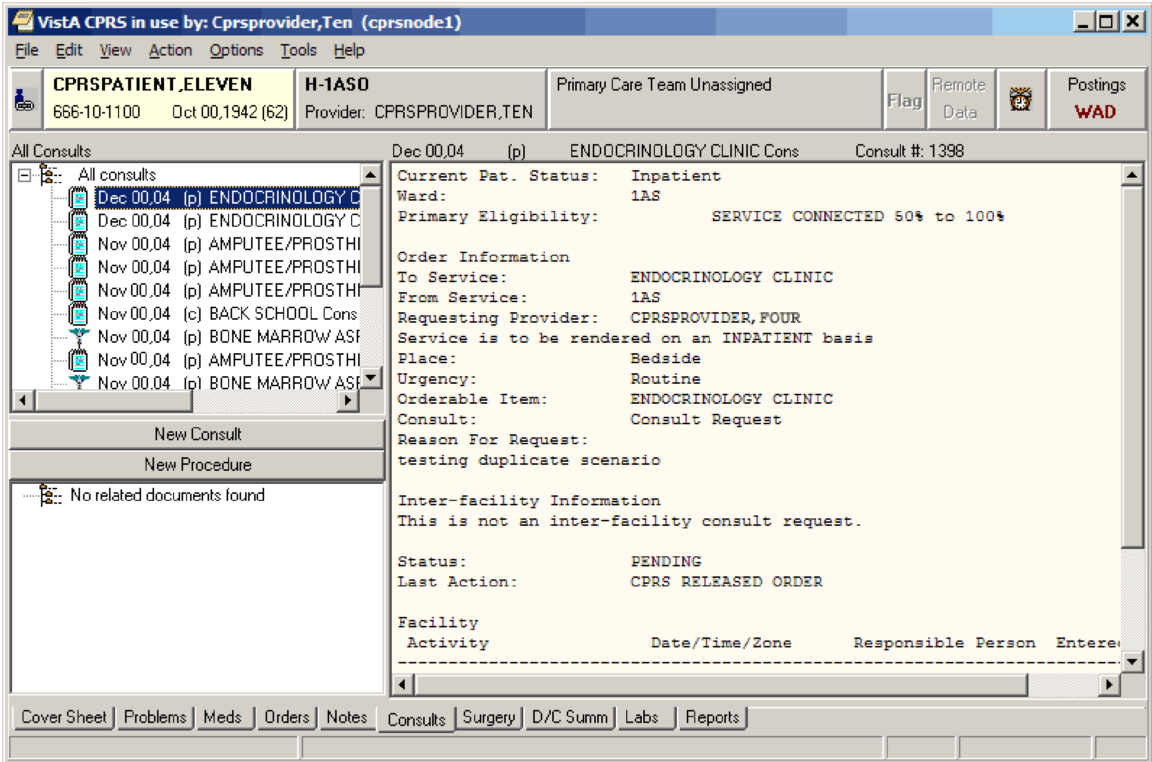
Consults

Consults are requests from one clinician to a hospital, service or specialty for a procedure or other service.

The Consults process involves the following steps. A single individual or service does not take all of the steps.

1. The clinician orders a consult. From within the patient's CPRS medical record, the clinician enters an order for a consultation or procedure. The ordering clinician may first have to enter Encounter Information.
2. The consult service receives an alert and a printed SF 513. The receiving service can then accept the consult, forward it to another service, or send it back to the originating clinician for more information.
3. The consult service accepts or rejects the consult request. To accept the consult, the service uses the receive action. The service can also discontinue or cancel the consult. Cancelled consults can be edited and resubmitted by the ordering clinician. A consult service clinician sees the patient.

   The consult service enters results and comments. Resulting is primarily handled through TIU.
4. The originating clinician receives a CONSULT/REQUEST UPDATED alert that the consult is complete. The results can now be examined and further action taken on behalf of the patient.
5. The SF 513 report becomes part of the patient's medical record. A hard copy can be filed and the electronic copy is on line for paperless access.
6. Results from the Medicine package can be attached to complete consults involving procedures. This function is available through the GUI for the Consults package, but will only be seen when the supporting Consults patch GMRC*3.0*15 is installed. The absence of these patches will result only in the function not being present.
7. If Consults patch GMRC*3.0*18 has been installed, the Edit/Resubmit action is available for cancelled consults. The consult must be "resubmittable" and the user must be authorized to resubmit consults.
8. The Consults tab has a list of consults in a tree view similar to the ones found on the Notes tab and the Discharge Summary tab. However, the list view feature is not available due to differences in the tabs functions. Consults are differentiated from procedures in the tree by the type of icon displayed. Consults are represented by a notepad, while procedures are represented by a caduceus-like symbol.
9. Right-click in the Consults text and you may select the "Find in Selected Consult" option from the popup menu. This option allows you to search the displayed text. A "Replace Text" option is also available, but it is only active when a consult is being edited.
10. The field below the list of consults displays a list of documents related to the highlighted consult or procedure. These related documents are also in a tree view.



The Consults tab

Changing the View on the Consults tab

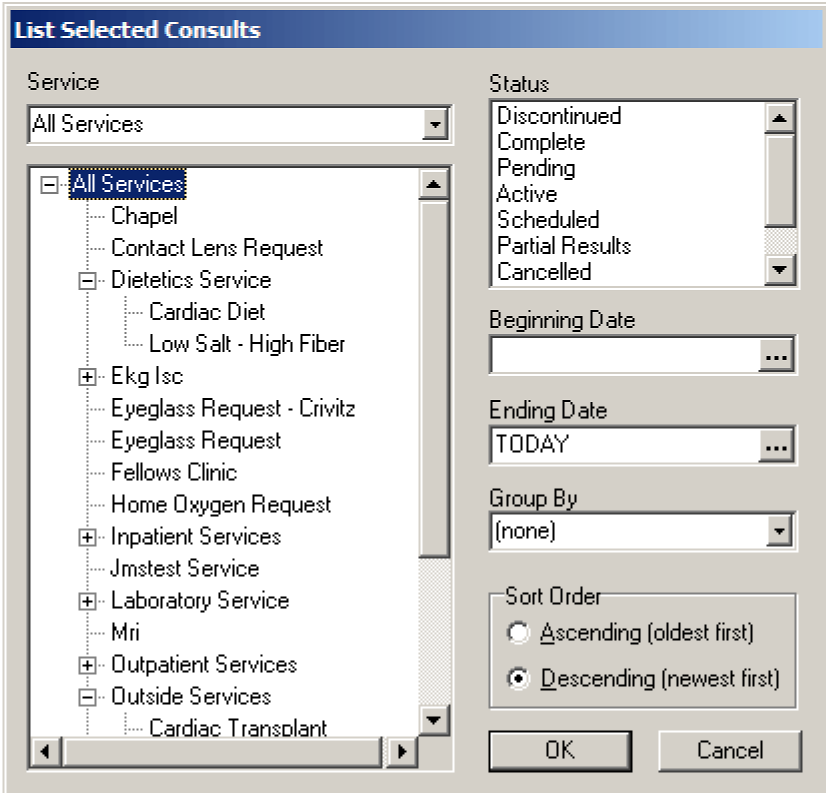
Changing the view of the Consults tab allows you to focus the list of consults on one of several criteria. Focusing the list will speed up the selection process.

You may change the Consults view to only include the following problems:

- All Consults
- Consults by Status
- Consults by Service
- Consults by Date Range

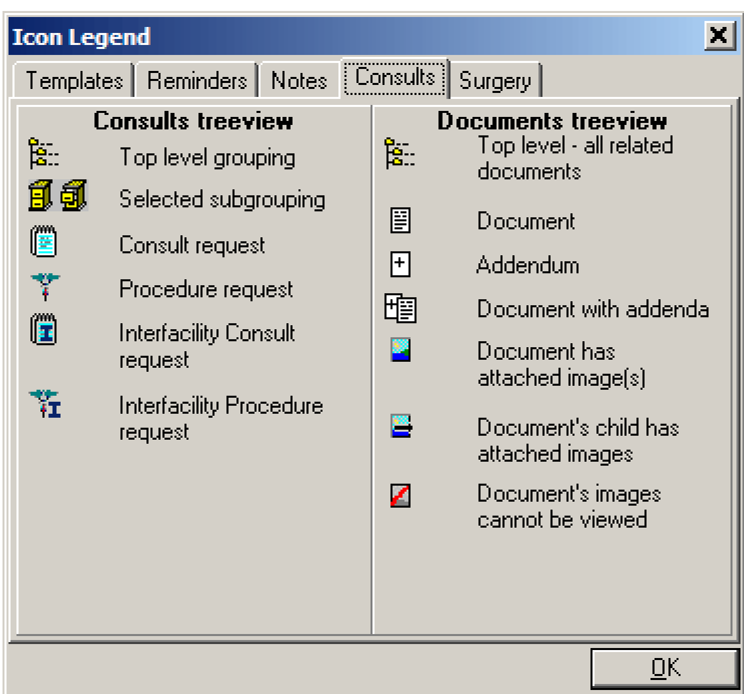
To change the view, click View on the menu and select the desired list items.

You may select the Custom list option on the menu to further focus the list of notes you wish to have displayed. From the List Selected Consults dialog, you may choose to display consults by any combination of service, status, and date range. You can also group your results by consults versus procedures, by service, or by status.



From the List Selected Consults dialog, you may choose to display consults by any combination of service, status, and date range.

The Consults tab on the Icon Legends dialog includes a description and explanation of the different icons that appear on the Consults tree view. To access the Icon Legend, click View | Icon Legend and the click the Consults tab.

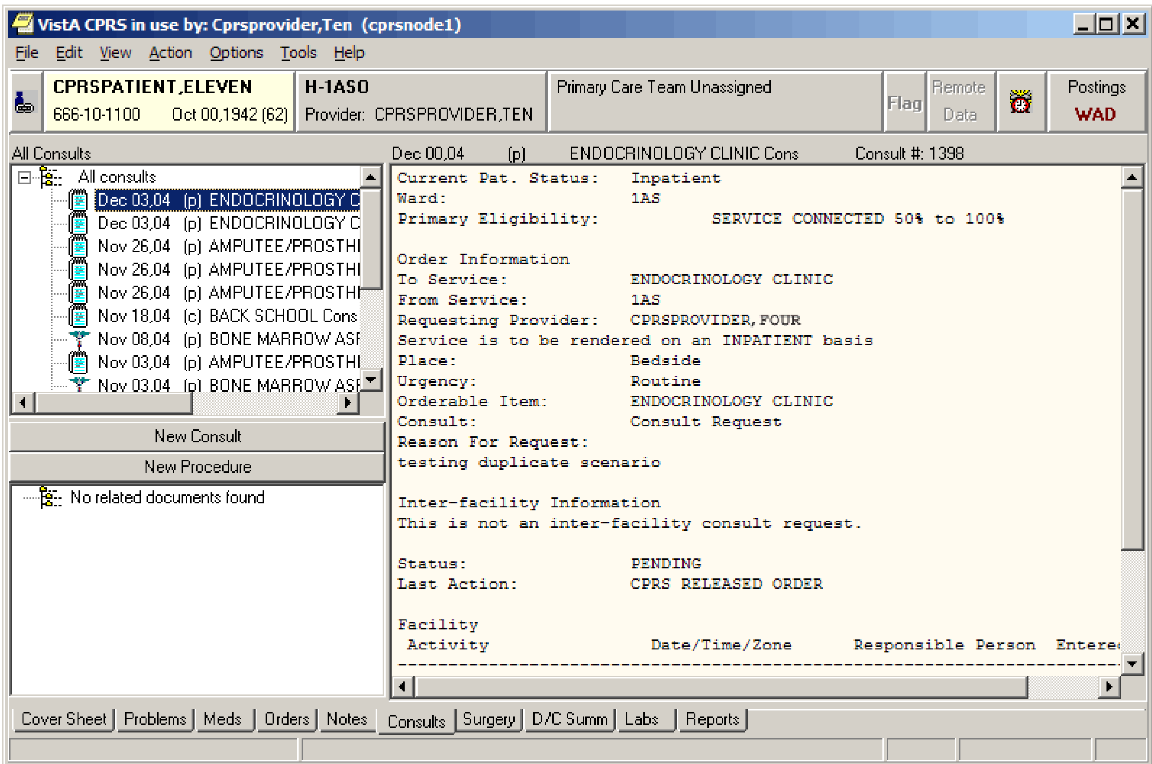


The Consults tab on the Icon Legends dialog includes a description and explanation of the different icons that appear on the consults tree view.

Ordering Consults

You can order a consult or procedure from either the Consults or the Orders tab. As you fill in the options, the consult request will be displayed in the text box at the bottom center of the dialog.

The list of Consults has been changed to a tree view. Consults are distinguished from procedures in the tree by the icon displayed in the tree. Consults are represented by a notepad, while procedures are represented by a caduceus-like symbol.



Consults and procedures are listed on the Consults tab.

Viewing Consults

To view the consults or procedures for the selected patient, use the steps below. When you select a specific consult, you will see an area that lists any notes associated with the consult. You can also click a note entry to view the full text of the note.

The All Consults list box shows the date, status (p=pending, c=complete, dc=discontinued, and x=cancelled), and title of each consult. An asterisk preceding the title tells you that there are significant findings for that consult.

To view consults, follow these steps:

1. Click the **Consults** tab.
2. Select the consult you would like to view from the All Consults list.
   The text of the consult will appear in the details pane. Any notes associated with that consult or procedure will appear in the Related Documents pane. To view the text of a related note, click on the note.

   Note: The All Consults list shows the date, status (p=pending, c=complete, dc=discontinued, and x=cancelled), and title of each consult. An asterisk preceding the title tells you that there are significant findings for that consult. If a note listed in the related documents pane is a CP-class document, the *Date/Time Performed* and *Procedure Summary Code* fields will appear in the full text of the document.

Complete a Consult or Clinical Procedure the Consults tab

Note: Until Clinical Procedures 1.0 is released, completion of all consults and procedures will continue to function as it does currently. After the installation and implementation of Clinical Procedures 1.0, any procedure defined as a Clinical Procedure will be completed using a document from the "Clinical Procedures" TIU class, which has some unique properties. In addition, to complete a Clinical Procedure, a person must be defined as an interpreter (update user) for the consult service to which the Clinical Procedure was directed.

To complete a consult from the Consults tab, complete the following steps:

1. Click the Consults tab.
2. Click Action | Consult Results | Complete/Update Results.

   Note: If this visit is undefined, you will be prompted for encounter type and location, clinician, date, and type of visit, such as Ambulatory, Telephone, or Historical.
3. In the Progress Note Properties dialog, select Progress Note Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.
4. If necessary, change the note date by clicking the button next to the date and entering a new date.
5. If necessary, change the note author by selecting the author from the Author drop-down list.
6. Enter any additional information, such as an associated consult or expected cosigner. Completing these steps will allow the note to be automatically saved.

   Note: Occasionally a problem occurs if a cosigner’s access lapses and they have become “disusered”. If this occurs, you can click OK and proceed with that selection or click Cancel and choose another cosigner.
7. Click **OK**.
8. Create your note by typing text, using templates, and including any test results.
9. From the Action menu, select either **Sign Note Now** or **Save without Signature**.

   Note: The *Date/Time Performed* and *Procedure Summary Code* fields must also be completed on the first CP document that completes the procedure request. Completing the *Date/Time Performed* and *Procedure Summary Code* fields is optional on subsequent CP documents.

Creating a New Consult from the Consults tab

To create a new consult from the Consults tab, complete the following steps:

1. Click the **Consults** tab.
2. Click the **New Consult** button.
3. If the Provider and Location for Current Activities dialog opens, fill in the Visit Location and other information and click OK.
4. Select a service from in the Consult to Service/Specialty window.
5. Fill in a Reason for Consult.
6. Make sure the following have the correct value:
    a. Service to perform this procedure
    b. Service rendered on
    c. Urgency
    d. Place of Consultation
    e. Attention

    Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

    - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
        - When no division is listed for a provider, no division is displayed.
        - If only one division is listed, this division is displayed.
        - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
        - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
    - Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

    f. Provisional Diagnosis

    Note: If a user tries to enter a diagnosis with an inactive code, CPRS will bring up a message indicating that the code must be changed and giving the user the chance to choose a diagnosis with and active code.
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.
   You may sign the consult now or later.

Requesting a New Procedure from the Consults tab

To request a new consult from the Consults tab, complete the following steps:

1. Select the **Consults** Tab.
2. Click the **New Procedu**re button.
3. If the Provider & Location for Current Activities dialog opens, fill in contact information, and click **OK**.
4. Select a procedure.
5. Fill in a Reason for consult.
6. Make sure the following fields show the correct information:
   - Service to perform this procedure
   - Service rendered on
   - Urgency
   - Place of Consultation
   - Attention

   Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

   - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
     - When no division is listed for a provider, no division is displayed.
     - If only one division is listed, this division is displayed.
     - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.
     - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
   - Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

   - Provisional Diagnosis

     Note: If a user tries to enter a diagnosis with an inactive code, CPRS will bring up a message indicating that the code must be changed and giving the user the chance to choose a diagnosis with and active code.

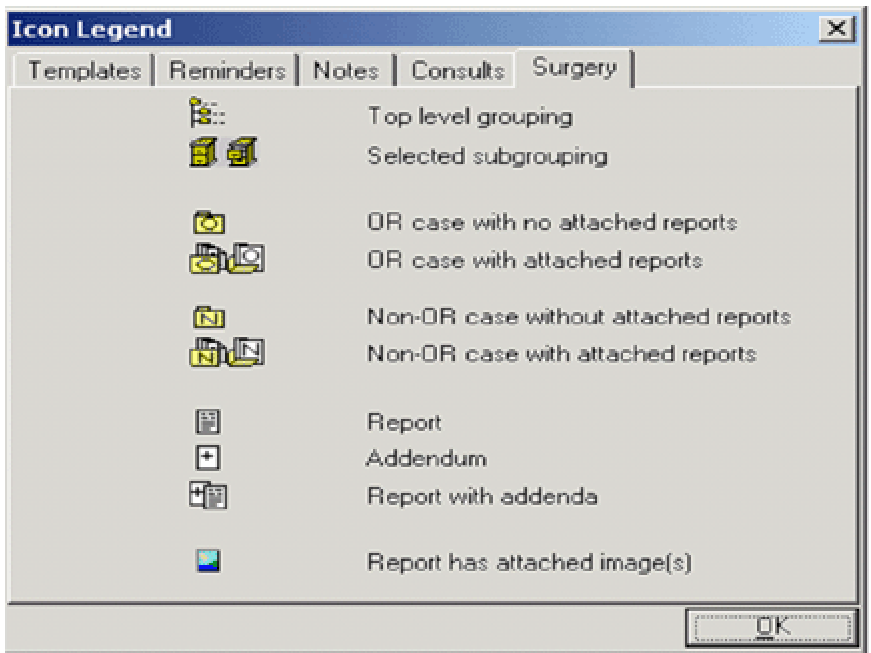
7. Click **Accept Order**.
8. If there are no other procedure orders for this patient, click **Quit**.
9. You may sign the consult now or later.

Surgery Tab

Note: Until Surgery patch SR*3.0*100 is released, sites will not see the Surgery tab. When a user launches the application, CPRS checks to see if the patch is installed, and if it is, users will see the Surgery tab. Display of the surgery tab is controlled by the parameter ORWOR SHOW SURGERY TAB, which can be set at the User, Division, or System level.

Depending on the configuration of your site and your access permission, the CPRS Surgery tab may be visible. The Surgery tab allows you to view signed operative reports generated in the VistA Surgery package. These reports include the Operation Report, Nurse Intraoperative Report, Anesthesia Report, and Procedure Report (Non-O.R.).

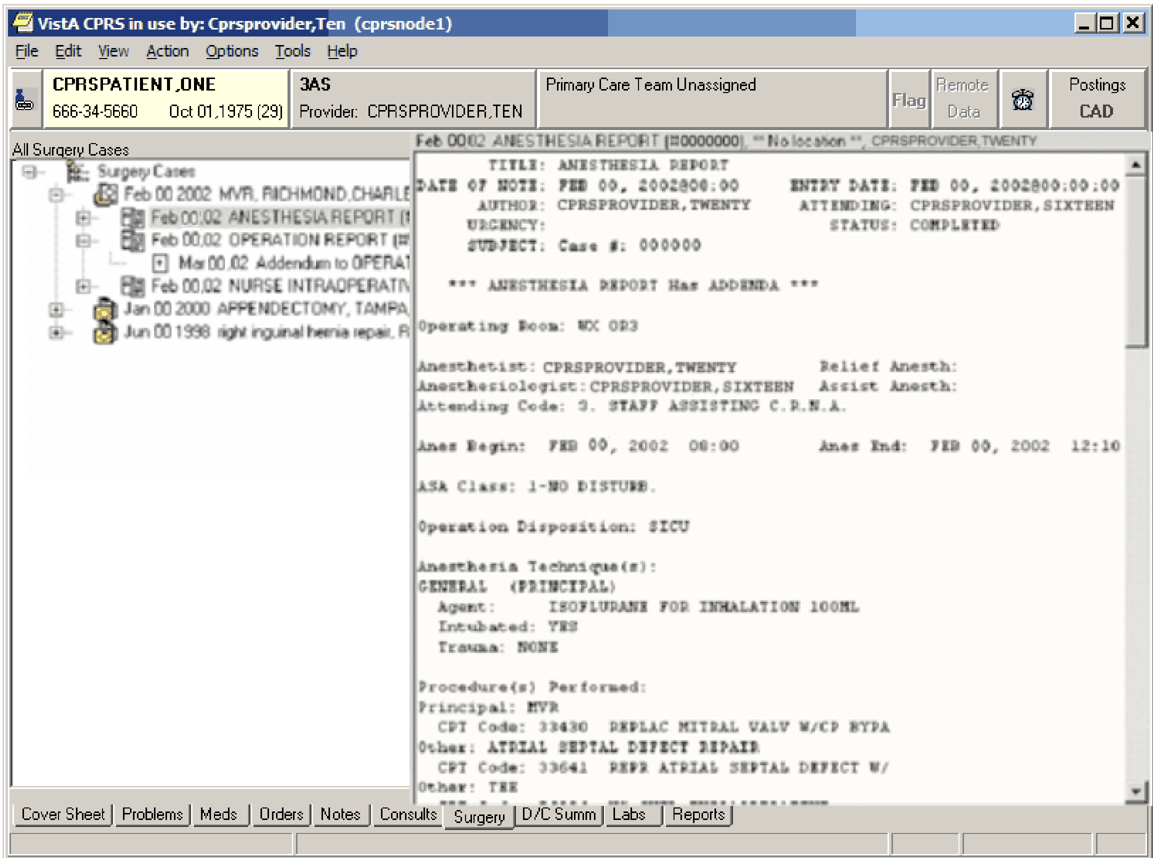
The following graphic shows the icon legend and the various icons on the Surgery tab and their meanings.



This tab of the icon legend defines the surgery icons

To view a surgery report, follow these steps:

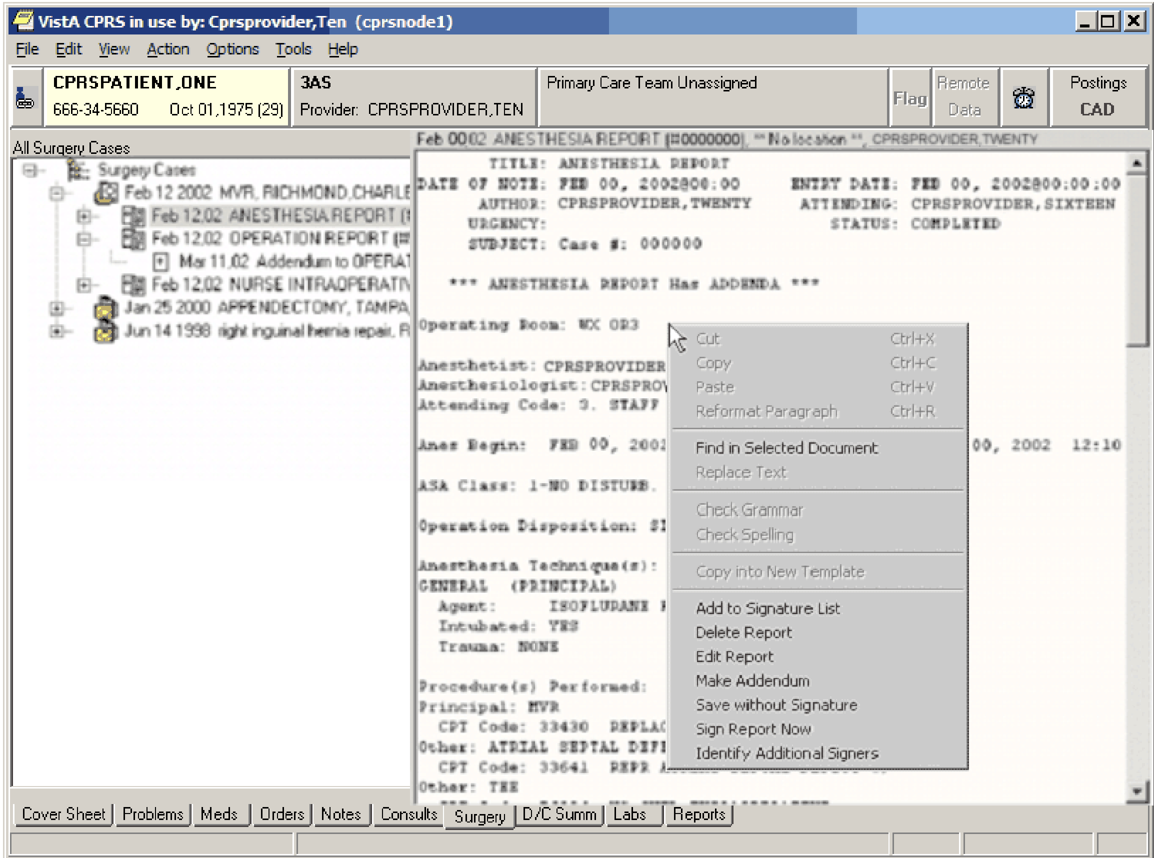
1. Click the **Surgery** tab.
2. Select a report title from the All Surgery Cases section of the window. Click the "+" sign to expand a heading (if necessary).
3. The text of the report will be displayed in the right side of the window.



A report displayed on the CPRS Surgery tab

To search a surgery report for specific text, follow these steps:

1. Click the **Surgery** tab.
2. Select a report title from the All Surgery Cases section of the window.
3. Right-click in the right-hand section of the window.
4. Select Find in Selected Document.
5. Type in the text you wish to find in the "Find what" field of the Find dialog box.
6. Click Find Next.
7. The appropriate text will be highlighted if it is found in the surgery report.



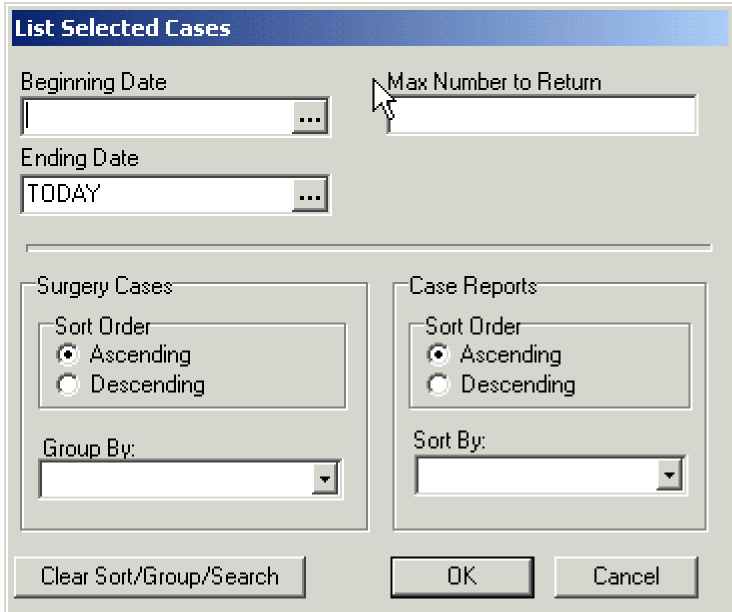
To find specific text in a surgery report, right-click in the right-hand section of the window.

Customizing the Surgery Tab

You can limit the surgery cases that appear on the Surgery tab. You can specify that only surgery cases from a specific date or date range appear on the tab, or you can specify that all available surgery cases appear.

To limit the surgery cases displayed to a specific date range, follow these steps:

1. Click the **Surgery** tab.
2. Select **View | Custom View**.
   The List Selected Cases dialog box appears.



The List Selected Cases dialog

7) Select a beginning date and ending date by clicking in the appropriate field and doing one of the following:

   a. entering a date (e.g. 6/21/01 or June 21, 2001).
   b. entering a date formula (e.g. t-200).
   c. pressing the ... button to bring up a calendar.

8) Enter a maximum number of occurrences in the Max Number to Return field.

9) Select a surgery case sort order (ascending or descending).

10) Select a category to group the surgery cases by (from the Group By drop-down list).

11) Select a case report sort order (ascending or descending).

12) Select a category to sort case reports by (from the Sort By drop-down list).

13) Click **OK**.

14) The appropriate surgery cases will appear in the left side of the screen.

15) Click the "+" sign to expand a heading (if necessary).

To view all the surgery cases for a patient, follow these steps:

1. Click the **Surgery** tab.
2. Select View | All Cases.

Signing a Surgery Report

Depending on the configuration of your site and your access permission, you may be able to sign certain surgery reports.

To sign a surgery report, follow these steps:

1. Click the **Surgery** tab.
2. Select a surgery report from the All Surgery Cases section of the window.
3. Select **Action | Sign Report Now…**
   -or-
   right click in the right-side of the window and select **Sign Report Now**.
4. Enter your electronic signature code.
5. Click **Sign**.

Creating Surgery Report Addenda

Depending on the configuration of your site and your access permission, you may be able to make addenda to certain surgery reports.

To make an addendum to a surgery report, follow these steps:

1. Click the **Surgery** tab.
2. Select a surgery report from the All Surgery Cases section of the window.
3. Select Action | Make Addendum…
4. Type the text for the addendum.

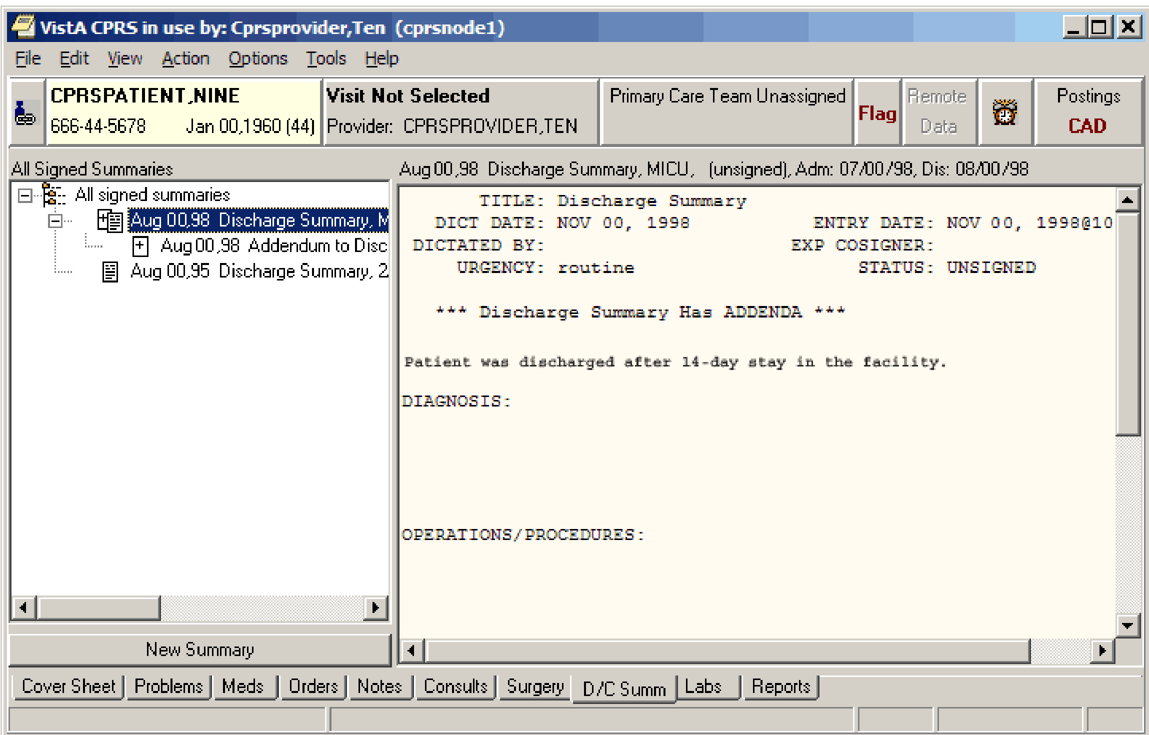
Discharge Summary

Discharge Orders are sets of orders to be placed for a patient when checking out of the hospital. The Discharge Summary tab gives you quick access to the Discharge Summary for a specific patient. The list of documents in the D/C Summ tab is in a tree structure instead of a simple list. Highlight any discharge summary listed in the left field to view the text of the summary in the right field. Addenda are separately selectable and are displayed as a page with a plus sign behind a note page (See highlight below.) Discharge Summaries with Addenda have a clickable plus sign. Hold the mouse pointer over a listing to see the entire line of the listing. The Discharge Summary that is highlighted is displayed on the right.

Right-click in the Discharge Summary text and you may select the “Find in Selected Summary” option from the popup menu. This option allows you to search the displayed text. A “Replace Text” option is also available, but it is only active when a discharge summary is being edited.

Click the View and Action menus to see the available options. Double click the plus sign to expand the list. Once expanded, any discharge summary may be selected and viewed.

You can also click the New Summary button to create a Discharge Summary. You may also have to enter encounter information if the visit has not been defined.



Discharge Summaries are listed on the D/C Summ tab.

Select a grouping node (for example "All signed notes") in the tree to display a second list of all the documents falling under that grouping node. This second list can be sorted by clicking on the column headings (Date, Title, Author, Location).

Changing Views on the Discharge Summaries tab

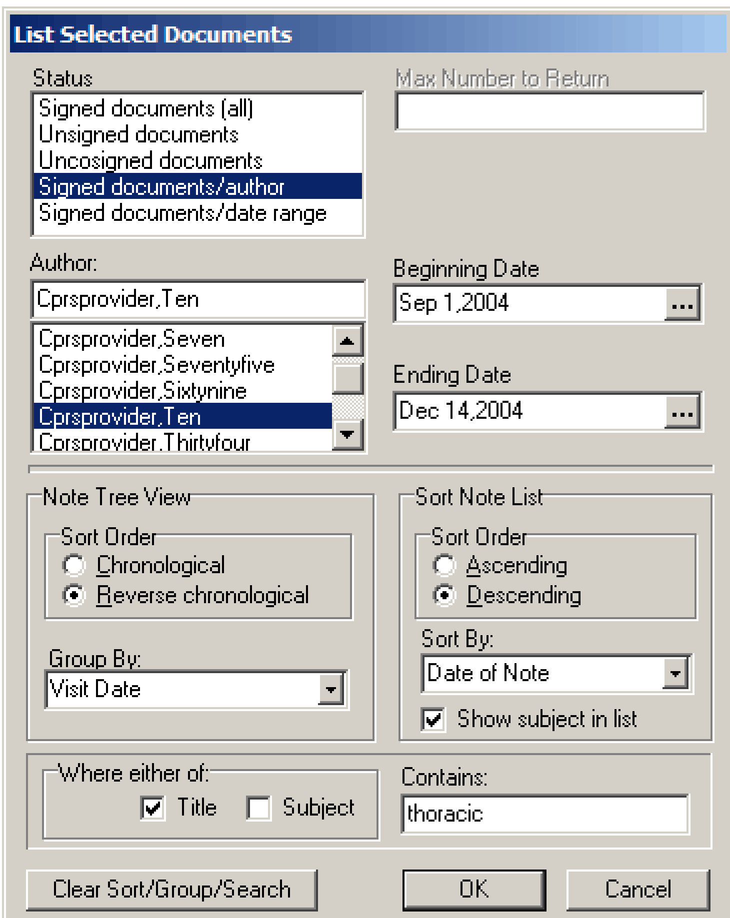
Changing the view of the Discharge Summary tab allows you to focus the list of summaries on one of several criteria. Focusing the list will speed up the selection process.

You may change the Discharge Summaries List view to only include the following summaries:

- Signed Summaries (All)
- Signed Summaries by Author
- Signed Summaries by Date Range
- Uncosigned Summaries
- Unsigned Summaries

To change the view, click View on the menu and select the desired list items.

The Custom View dialog (**View | Custom View**) has been greatly expanded, allowing the items in the tree to be grouped and sorted in a variety of ways. All custom view selections can be saved as the user's default view (**View | Save as Default View**).



The List Selected Documents dialog

To view a discharge summary, use these steps:

1. Click the **D/C Summ** tab.
2. Click the summary in the list box.
3. To sort the list, select View and the appropriate choice below:
   - Signed Summaries (All)
   - Signed Summaries by Author
   - Signed Summaries by Date Range
   - Uncosigned Summaries
   - Unsigned Summaries
   - Custom View

   Note: To set one of these views as the default, select **View | Save as Default**.
4. Locate the summary and click it.

Writing Discharge Summaries

You can enter discharge summaries through CPRS. The document templates and TIU titles that your site can create should make creating these documents much faster and easier.

To write a discharge summary, use these steps:

1. Click the **D/C Summ** tab.
2. Click New Summary or select **Action | New Discharge Summary**.

   Note: If this visit is undefined, you will prompted for encounter type and location, clinician, date, and type of visit, such as Ambulatory, Telephone, or Historical.
3. In the Discharge Summary Properties dialog, select Discharge Summary Title (e.g., General, SOAP, Warning, etc.). Additional items will appear on the dialog for titles that require entry of a cosigner or an associated consult.
4. If necessary, change the note date by clicking the button next to the date and entering a new date.
5. If necessary, change the note author by selecting the author from the Author drop-down list.

   Note: To help you distinguish between providers, CPRS displays their titles (if available). When two or more providers have identical names, CPRS also displays:

   - The service/section and site division (if any) associated with these providers; site divisions are displayed based on the following rules:
     - When no division is listed for a provider, no division is displayed.
     - If only one division is listed, this division is displayed.
     - If the site has multiple divisions or more than one division is listed **and** one of these listed divisions is marked as Default, CPRS displays the division marked as Default.

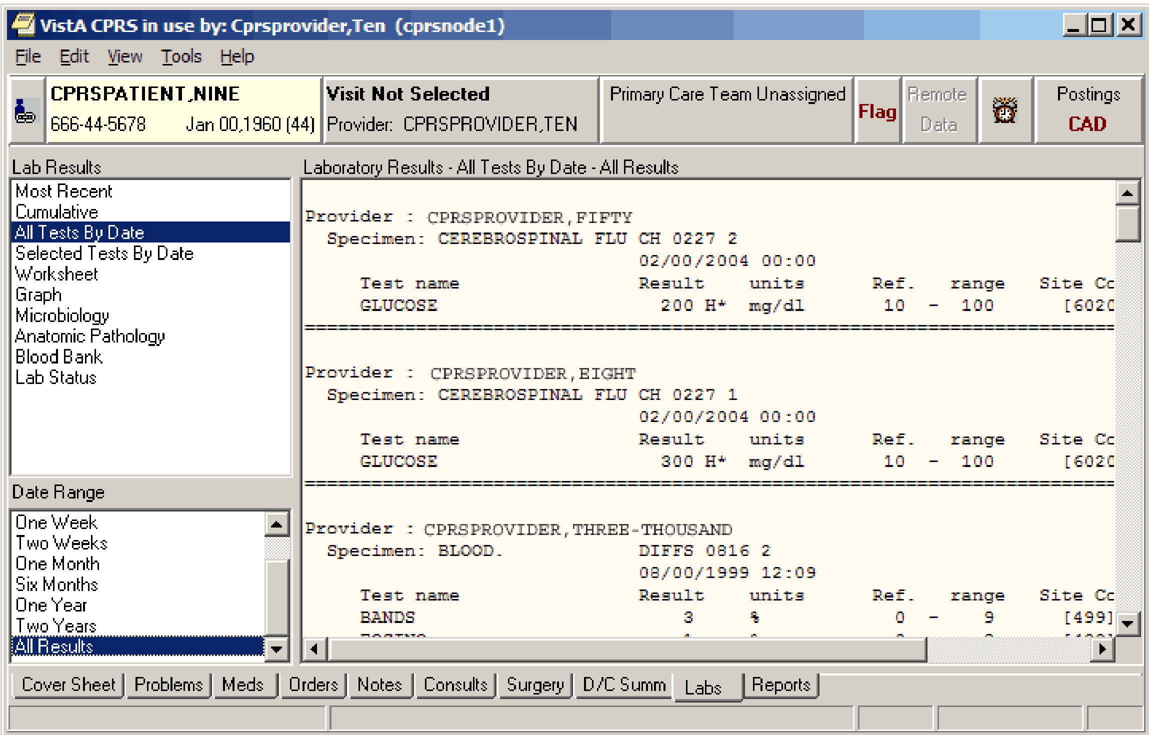
    - If more than one division is listed for a provider and none is marked as Default, CPRS does not display division information for this provider.
  - Providers who are listed in the New Person file as Visitors are screened out from the provider list. (These screened-out providers are listed as Visitors because their entries were created as a result of a Remote Data View.)

6. Enter the attending physician.
7. Click the admission related to this Discharge Summary.
8. Enter any additional information, such as an expected cosigner. Completing these steps will allow the note to be automatically saved.

   Note: Occasionally a problem occurs if a cosigner's access lapses and they have become "disusered". If this occurs, you can click OK and proceed with that selection or click Cancel and choose another cosigner.
9. Click **OK**.
10. Create the summary content by typing in text, copying and pasting, and/or inserting templates into the document.
11. Click the template drawer if it is not open.
12. Locate the appropriate templates.
13. Double-click the template (You can also drag-and-drop or right-click the template and select Insert Template) and modify as needed.
14. When finished entering text, you may (optional) right-click in the text area and select Check Spelling and Check Grammar.
15. When complete, decide when you will sign the summary and choose the appropriate option.
16. Click **Add to Signature List** (to place it with other orders or documents you need to sign for this patient). You can also click Save Without Signature or Sign Discharge Summary Now to sign the summary immediately.

Labs

On the Labs tab, you can view the results of lab tests that were ordered for a selected patient. Ordering of lab tests is performed on the Orders tab. The Cover Sheet tab displays results of some of the patient's most recent orders. Some of the lab reports are also found on the Reports tab. The fields on the left side of the Labs tab list available lab results. For some reports, you may need to specify a date range or other criteria. Some reports will prompt for specific tests to be displayed.



The Labs tab

Viewing Laboratory Test Results

Through CPRS, you can review lab test results in many formats.

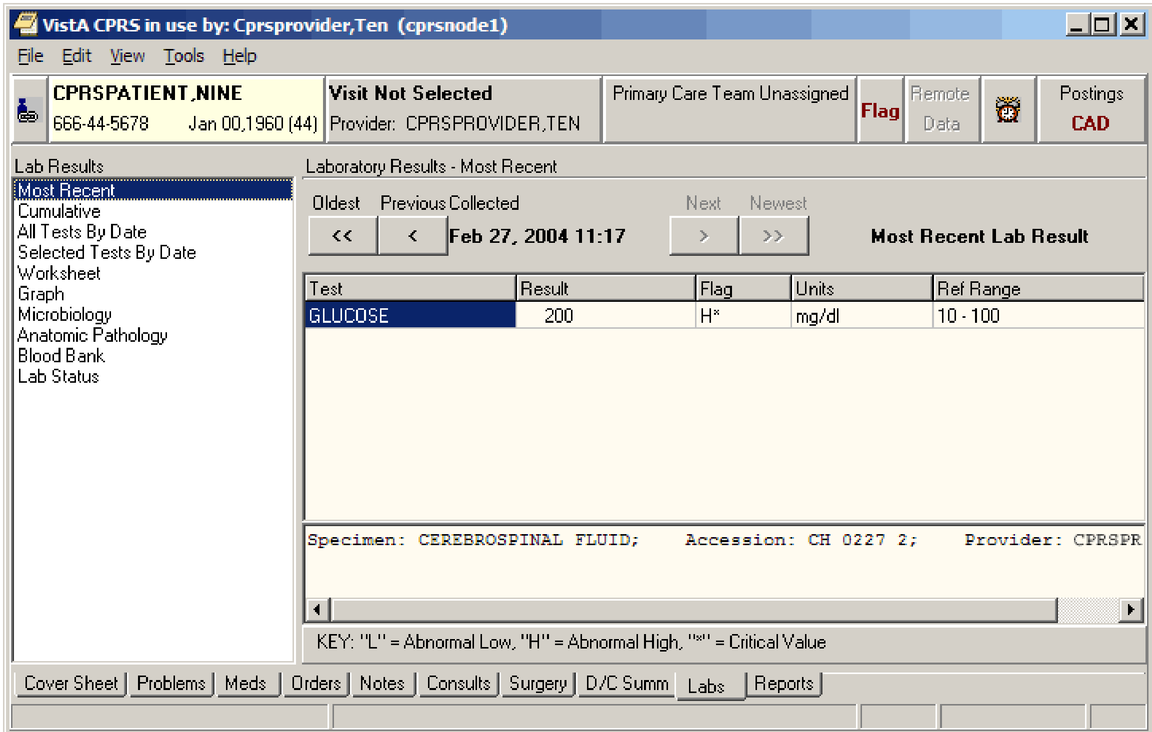
To view lab test results, use these steps:

1. Click the **Labs** tab.
2. In the Lab Results box, click the type of results you want to see. Some of the results will need you to determine which test results you want to see. If the Select Lab Test dialog appears, you need to choose the tests you want to see.

   Note: A plus sign (+) by a lab test means it has a schedule.
3. If necessary, select the tests for which you want to see the results.
4. Also, you may need to choose a date range (Today, One Week, Two Weeks, One Month, Six Months, One Year, Two Years, or All Results.)

Most Recent

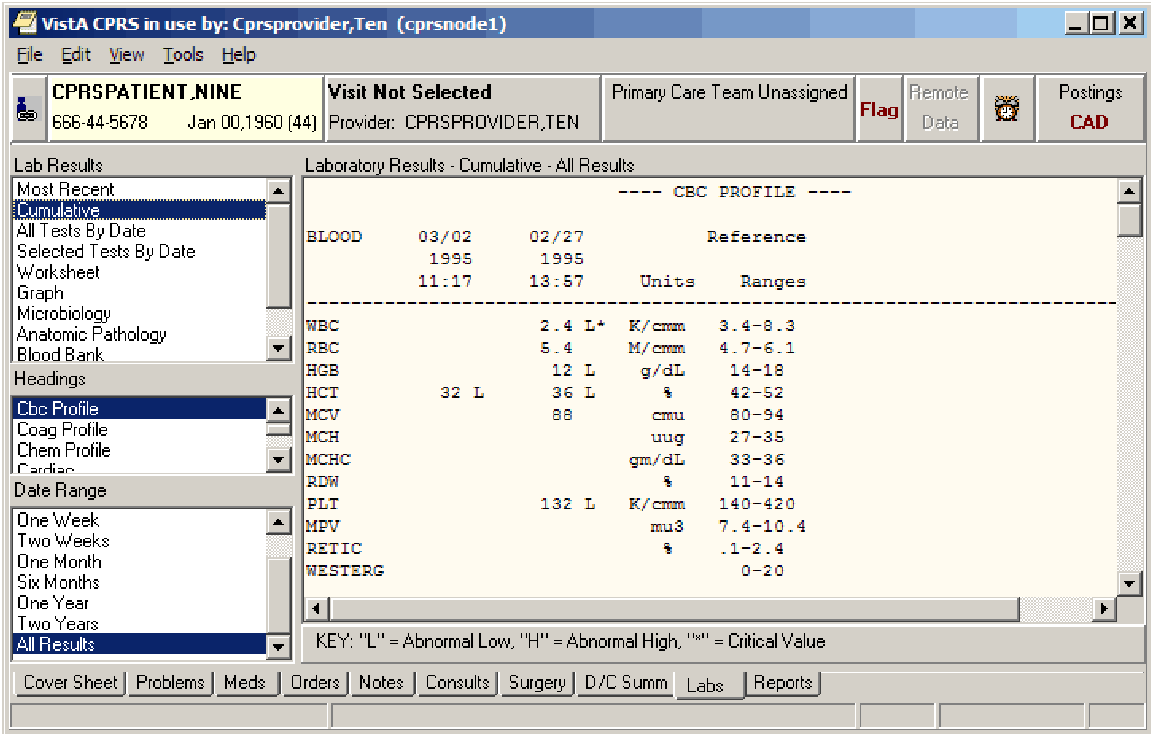
This report allows sequencing back through the most recent results. It displays each set of lab tests in the time they were collected/ it also displays microbiology results and any comments on the collection.



The most recent lab results are displayed for a particular patient.

Cumulative

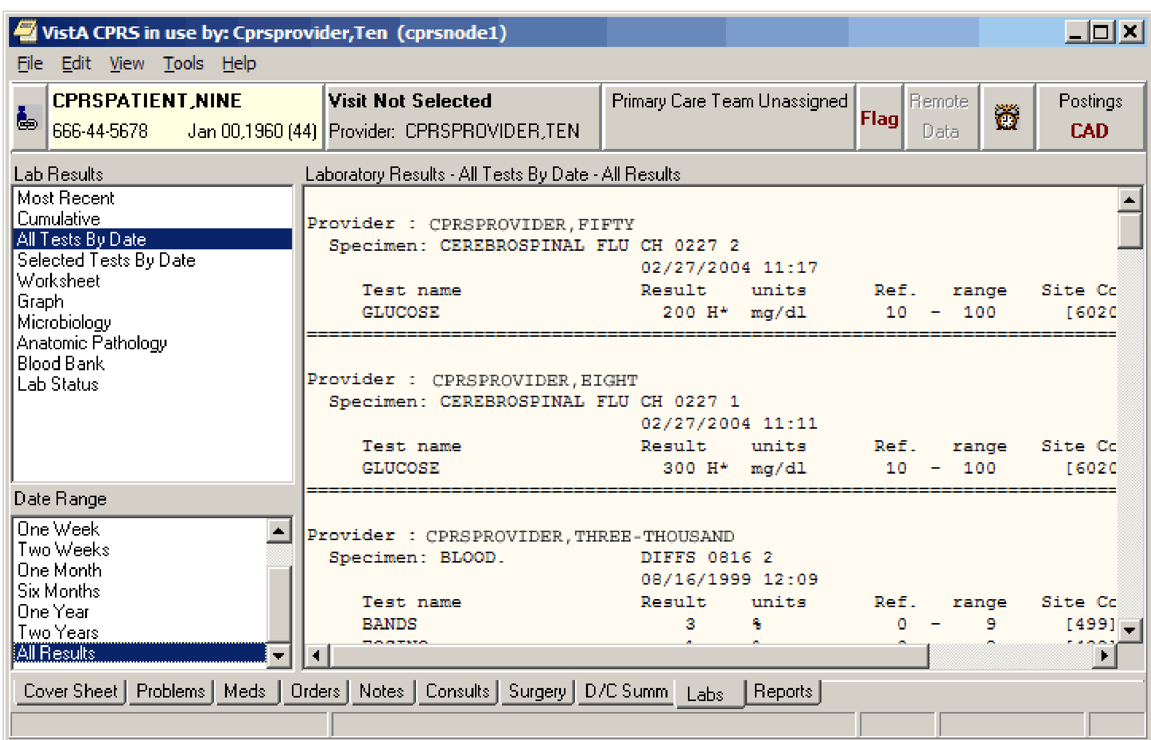
The cumulative report is the most comprehensive lab report. It displays all of the patient’s lab results. When selecting a large data range, this report may take some time before being displayed. The results are organized into sections. You can automatically scroll to that section by selecting it in the Headings list box.



Cumulative lab results are displayed on the Labs tab.

All Tests by Date

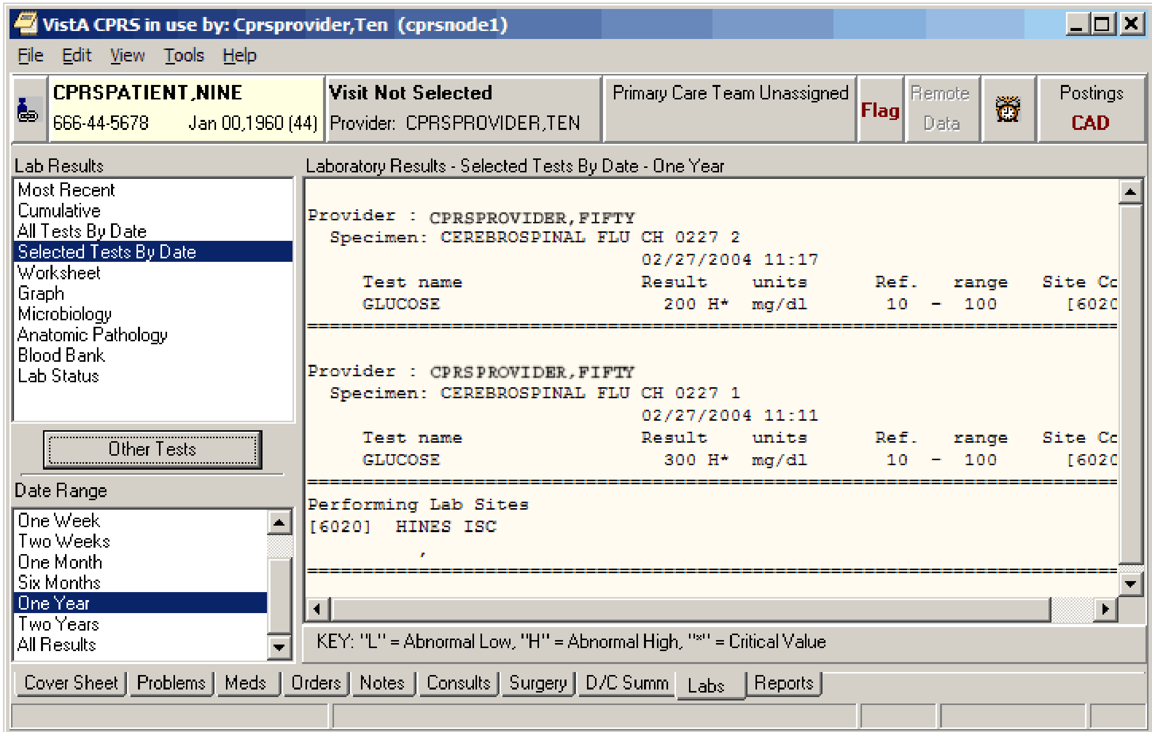
This report displays all lab results (except anatomic pathology and blood bank). The data is displayed in the order of the time of collection.



All lab tests are listed by date.

Selected Tests by Date

This report is useful when you only wish to review only specific tests. Microbiology results can also be selected. You will be prompted to select any lab tests. For example, if you select CBC, Chem 7, Lithium, and Liver Profile, only the results for those tests would be displayed.



Test results are displayed for one year.

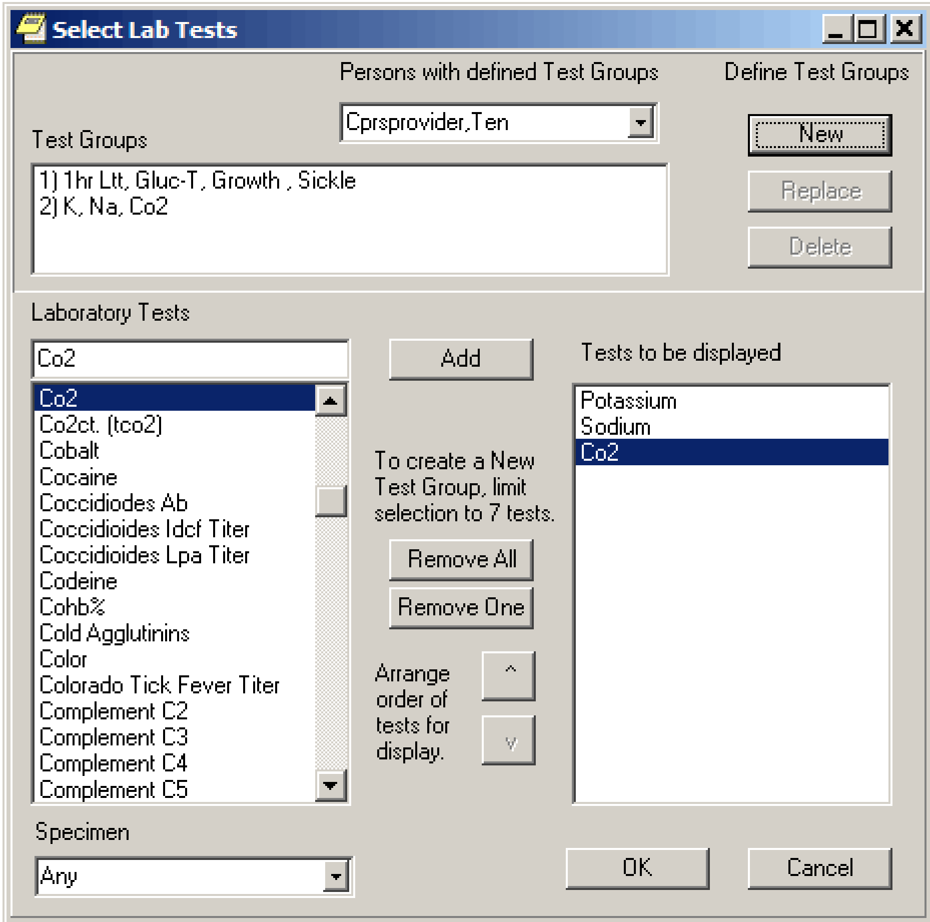
Worksheet

The Worksheet is similar to the Selected Test by Date report. It does not display microbiology results, but it has many features for viewing lab results. It is very useful for displaying particular types of patterns of results.

Tests can be selected individually or by test groups. Any number of tests can be displayed. When selecting a panel test, such as CBC, the panel will be expanded to show the individual tests. Tests can be restricted to only display results for a specific specimen type. For example, displaying glucose results only on CSF can be accomplished by selecting the specimen CSF and then selecting the test Glucose.

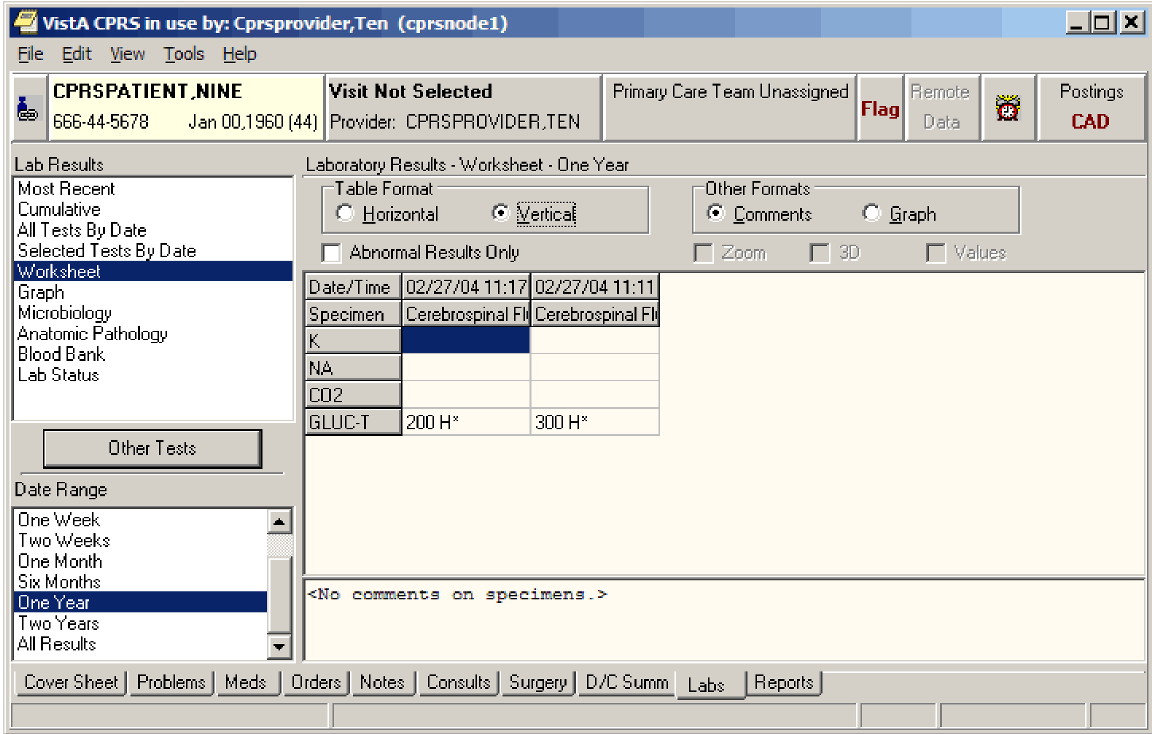
Test groups allow you to combine tests in any manner. For example, a test group could combine CWBC, BUN, Creatinine, and Platelet count. You can save those test groups for later use. You can also select test groups that other users have created. You cannot exchange or delete other's test groups, only your own. Test groups are limited to seven tests, but you may have an unlimited number of test groups. To define your own test groups, select those tests you want and click the New button. If more than seven tests are selected, the New button will be disabled. If you want to delete a test group, deselect it and click the Delete button. If you want to replace an existing test group with other tests, select the test group, make any changes to the tests to be displayed and click the Replace button.

> **Note**: These test groups are the same as those you may have already created using the Lab package. The seven-test restriction is a limitation of the Lab package.



The Select Lab Tests dialog

The Worksheet display is a table of results that can be displayed vertically or horizontally. Since only results are displayed in a table, comments are footnoted with a ** and shows in the panel below the table. You can filter the results to only show abnormal values. This will quickly show tests that have results beyond their reference values.

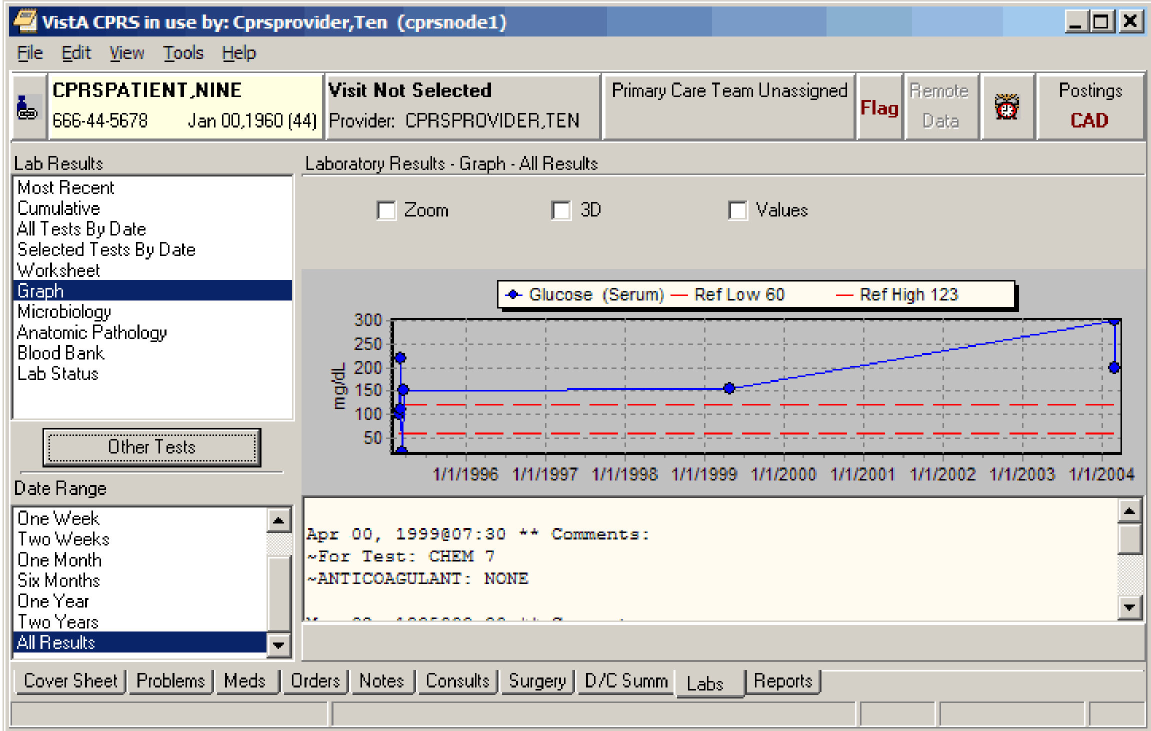


Lab results displayed on a worksheet.

You can toggle between view comments and graph view. The graph format displays each test separately. By selecting each test, you see the trend in values for each time range. You may also use features to Zoom, apply 3D, and display values on graph. Zooming is allowed when checking the Zoom check box. You may then click the graph and drag a rectangular area to zoom in on. To undo the zoom feature, you can uncheck the Zoom check box or drag a rectangular area in the upper left corner of the graph and then release the mouse button.

Note: Zoom will retain the selected date range when you change to other tests or test groups. This is helpful when you are looking for trends within a given time period.

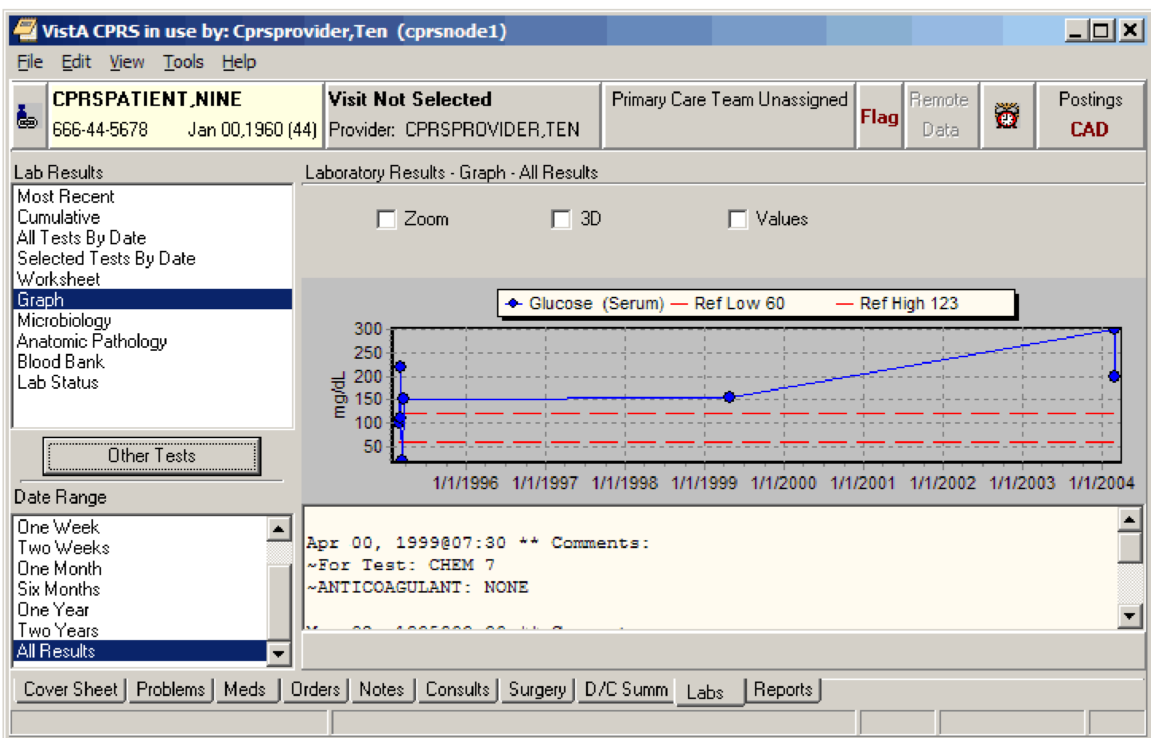
A right-click on the graph will bring up a pop-up menu with other actions. You can display details of the lab test by right-clicking a point on the graph and then selecting Details. This will display all test values for this collection time. Right-clicking on the graph will display all values for the selected test.



Glucose (Serum) levels displayed on a graph.

Graph

This report displays a single test in a graph. Comments are included. Zoom, 3D, and Values function the same as in the Worksheet graph. The right-click actions are also the same.



The results of a lab test displayed in a graph.

Microbiology, Anatomic Pathology, Blood Bank, Lab Status

These reports display only the results from these portions of the laboratory. The Lab Status report displays the status on current orders.

Changing Views on the Labs tab

The View menu on the Labs tab is different from most of the other tabs in that the menu options do not sort or focus the listed items. The menu items are a way to open different windows and displays with information the clinician may need to see in conjunction with the lab results.

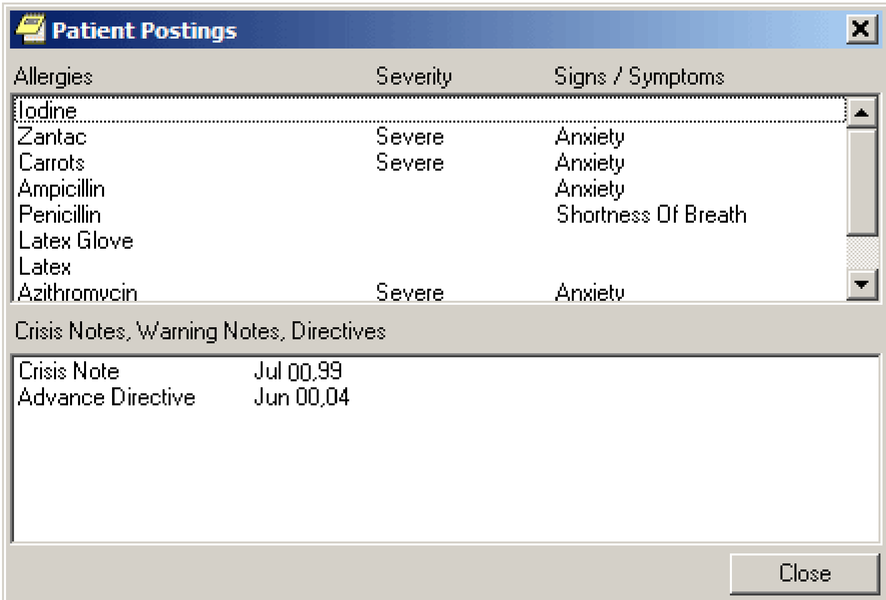
Demographics

From the Labs tab, click View | Demographics to display the Patient Inquiry screen of the currently selected patient.

The Patient Inquiry screen displays demographic data for a patient.

Postings

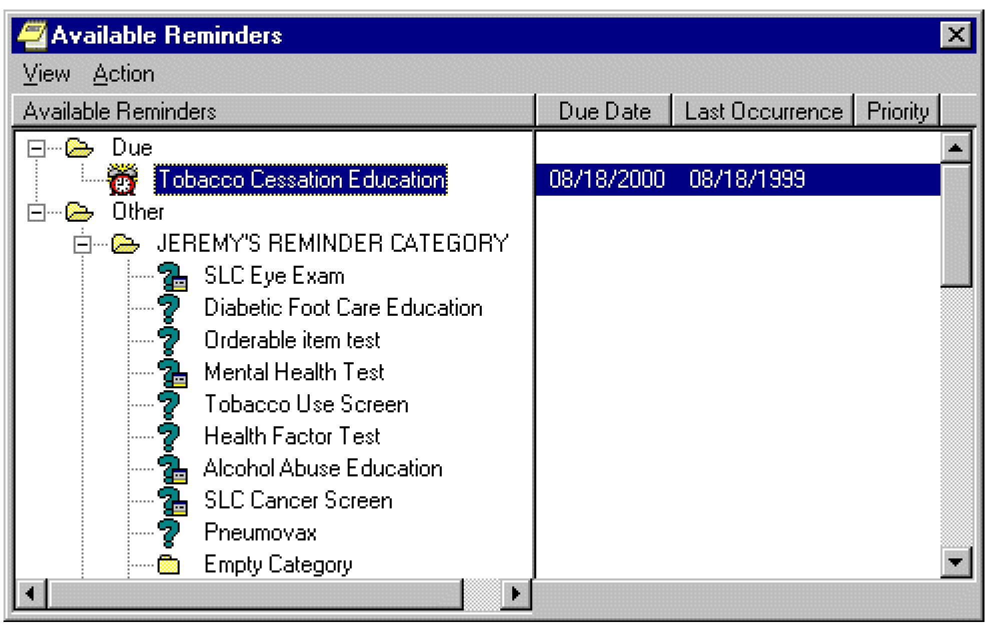
From the Labs tab, click View | Postings to display the Patient Postings screen of the currently selected patient. The Patient Postings windows displays information about the patient's allergies, and any Crisis Notes, Warning Notes, and Directives that may apply to the patient.



The Patient Postings dialog displays Allergies, Crisis Notes, Warning Notes, and Directives.

Reminders

From the Labs tab, click View | Reminders to display the Available Reminders dialog for the currently selected patient. The Available Reminders dialog allows you to review all reminders including the ones that apply to the currently selected patient.



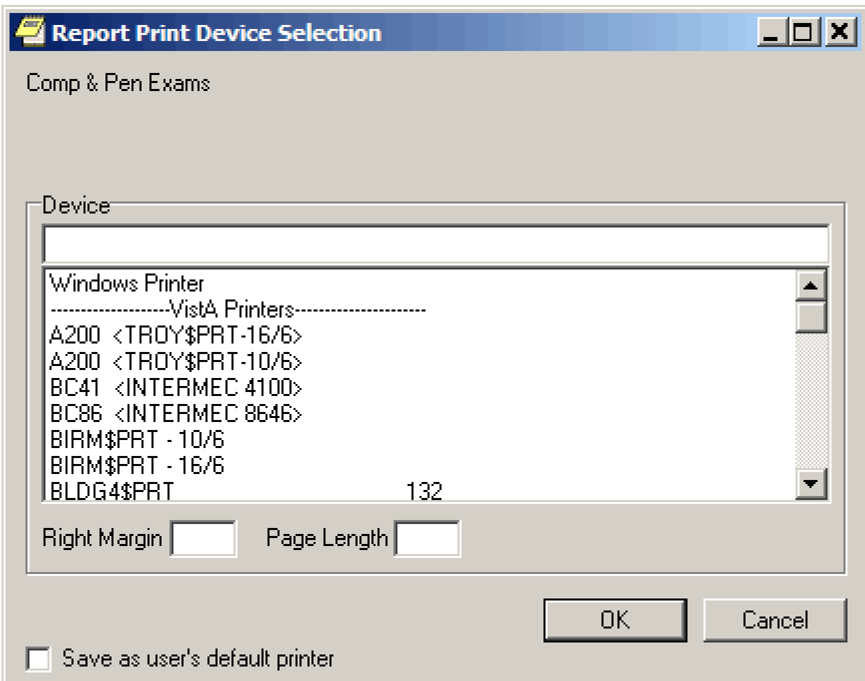
A patient's available reminders are displayed on the Available Reminders dialog.

Reports

Currently, you can print reports from the Problems, Consults, Labs, Notes, Discharge Summary, and Reports tabs to any VISTA printer defined on the server or to a Windows printer.

You can also now print graphics on a Windows printer from the Labs tab and the Vitals screen. You can use **File | Print Setup...** to set up a preferred printer for the current session and save it as the default for the user.

The dialog box shown below comes up when you select **File | Print** from the Notes tab. A similar dialog, without the Chart copy / Work copy option appears for items on other tabs. Many report boxes now have Print button on them to make it easier for you to print the information you need. With most reports you can select a date range and sub-topics to customize your reports.



The Print dialog

Normally, you do not need to enter a right margin or page length value. These values are measured in characters and normally are already defined by the device.

You will also still have the options to print your regular tasked jobs.

Viewing a Report

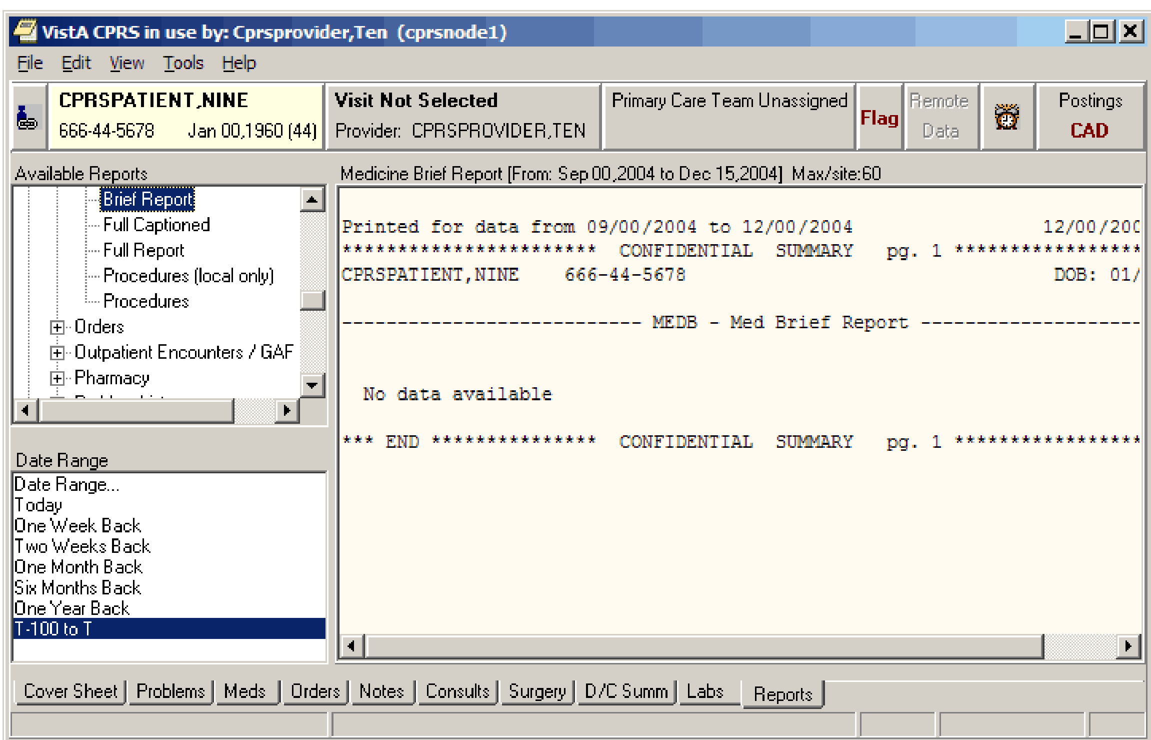
To display a report, follow these steps:

1. Click the **Reports** tab.
2. See if the text on the Remote Data button is blue. If the text is blue, the patient has remote data.
3. To view remote data, which may include Department of Defense data, click the **Remote Data** button to display a list of sites that have remote data for the selected patient. If you do not want remote data, skip to step 5.
4. Click **All** if you want data from all the sites listed, or click the check box in front of the site names you want to view remote data from and close the Remote Data button by clicking the button again.
5. Select the report you want to view from the Available Reports box (click the "+" sign to expand a heading).

   Note: All of the reports available in CPRS GUI version 15 are available in this version of CPRS in the new tree view format. The next section, "Available Reports on the Reports Tab," lists the location of each report when they are exported. The list is configurable and your list may be different.

6. If necessary, select a date range from the Date Range box located in the lower left corner of the screen.

   The report should be displayed either after step 5 or step 6. You can then scroll through and read the report. If the report is in tabular form, click a row to reveal details about that row. (To select more than one row, press and hold the **Control** or **Shift** key.)



The Medicine Brief Clinical Report is displayed on the Reports tab.

Available Reports on the Reports Tab

The table below lists the reports available from the Reports tab. A "+" sign indicates that the topic is a heading that can be expanded. Some of these reports may have remote data.

In the list below, those reports that may have remote data from the Department of Defense are noted. Also, there is a part of the tree that lists Department of Defense reports.

Note: A new Consults (DoD remote data only) report has been added under Department of Defense (DoD) in the reports tree view. This report has only DoD data. Unlike other items under the Department of Defense heading, this report has no VA data.

Please note that the order of the reports may be different depending on the configuration of your site. This list is exported from CPRS.

+ Clinical Reports
    - Allergies ***(can contain remote data from Department of Defense)***
    - + Patient information
        - Demographics
        - Insurance
        - Disabilities
    - + Visits / Admissions
        - Adm./Discharge
        - Expanded ADT ***(can contain remote data from Department of Defense)***
        - Discharge Diagnosis
        - Discharges
        - Future Clinic Visits
        - Past Clinic Visits
        - ICD Procedures
        - ICD Surgeries
        - Transfers
        - Treating Specialty
    - Comp & Pen Exams
    - + Dietetics
        - Generic
        - Diet
        - Nutritional Status
        - Supp. Feedings
        - Tube Feeding
        - Dietetics Profile
        - Nutritional Assessment

Discharge Summary ***(can contain remote data from Department of Defense)***

+ Laboratory
    - Blood Availability
    - Blood Transfusion
    - Blood Bank Report
    - Surgical Pathology ***(can contain remote data from Department of Defense)***
    - Cytology ***(can contain remote data from Department of Defense)***
    - Electron Microscopy
    - Lab Orders ***(can contain remote data from Department of Defense)***
    - Chem & Hematology ***(can contain remote data from Department of Defense)***
    - Microbiology ***(can contain remote data from Department of Defense)***
+ Medicine
    - Abnormal
    - Brief Report
    - Full Captioned
    - Full Report
    - Procedures (local only)
    - Procedures
+ Orders
    - Orders Current
    - Daily Order Summary
    - Order Summary for a Date Range
    - Chart Copy Summary
+ Outpatient Encounters / GAF Scores
    - Education
    - Education Latest
    - Exam Latest
    - GAF Scores
    - Health Factors
    - Immunizations
    - Outpatient Diagnosis
    - Outpatient Encounter
    - Skin Tests
    - Treatment Provided

- + Pharmacy
  - Active Outpatient
  - All Outpatient ***(can contain remote data from Department of Defense)***
  - Outpatient RX Profile
  - Active IV
  - All IV
  - Unit Dose
  - Med Admin History (BCMA)
  - Med Admin Log (BCMA)
- + Problem List
  - Active Problems
  - All Problems
  - Inactive Problems
- + Progress Notes
  - Progress Notes
  - Advance Directive
  - Clinical Warnings
  - Crisis Notes
- + Radiology
  - Report ***(can contain remote data from Department of Defense)***
  - Status
  - Imaging (local only)
  - Imaging
- Surgery Reports
- Vital Signs

+ **Health Summary**
  - Adhoc Report
  - Ac Clinical Summary
  - Discharge Summary
  - Radiology
  - Pain Management
  - Remote Demo/Visits/Pce (1y)
  - Remote Demo/Vists/Pce (3m)
  - Remote Clinical Data (1y)
  - Remote Clinical Data (3m)
  - Remote Clinical Data (4y)
  - Remote Oncology View
  - Remote Oncology View
  - Global Assessment Functioning

- + Department of Defense Reports
  - Allergies
  - Expanded ADT
  - Consults (contains DoD remote data only)
  - Discharge Summary
  - + Laboratory
    - Lab Orders
    - Chem & Hematology
    - Surgical Pathology
    - Cytology
    - Microbiology
  - Pharmacy All Outpatient
  - Radiology Report
- Imaging (local only)
- Lab Status
- Blood Bank Report
- + **Anatomic Path Reports**
  - Electron Microscopy
  - Surgical Pathology
  - Cytopathology
  - Autopsy
- **Anatomic Pathology**
- **Dietetics Profile**
- **Nutritional Assessment**
- **Vitals Cumulative**
- **Procedures (local only)**
- **Daily Order Summary**
- **Order Summary for a Date Range**
- **Chart Copy Summary**
- **Outpatient RX Profile**
- **Med Admin Log (BCMA)**
- **Med Admin History (BCMA)**
- **Surgery (local only)**

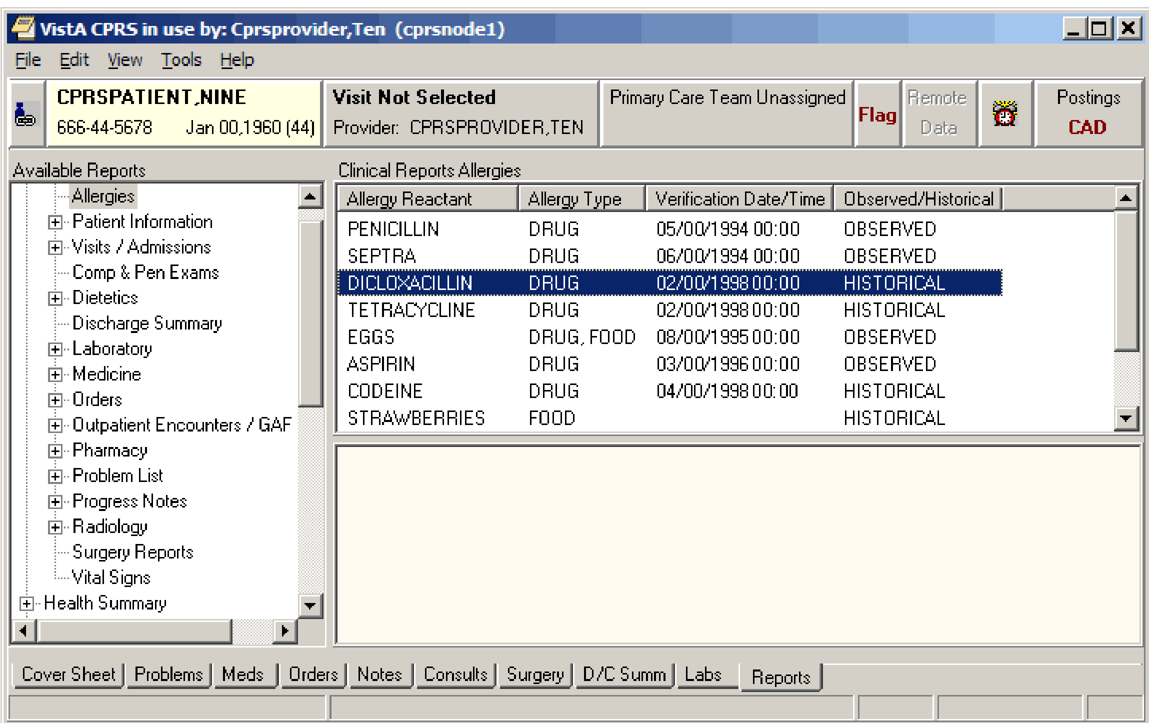
Sorting a Report (Table View)

If a report is available in a table view, the table can be sorted alphabetically, numerically, or by date.

To sort data in a report table:

1. Click the column heading you wish to sort by.
2. The table will be sorted alphabetically (A-Z), numerically (0-9), or by date (most recent-least recent).
3. If you click the column heading again, the table will be sorted in inverse order (Z-A, 9-0, or least recent-most recent).
4. To perform a secondary sort, click another column heading.

Note: If you hold the pointer over the table, a hover hint will appear with the criteria used to sort the table.

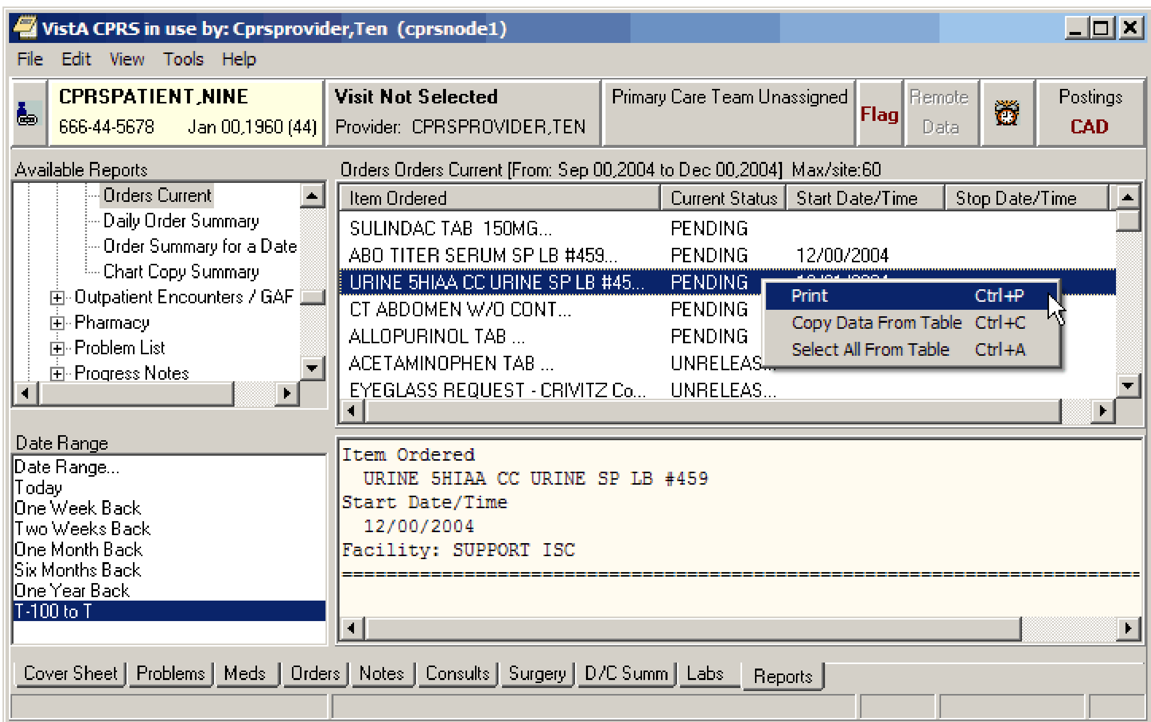


You can easily sort report data in a tabular view.

Printing a Report

To print a report, follow these steps:

1. From the Reports tab, select the report you would like to print.
2. If the report is in text format, right-click the text of the report
   -or-
   if the report is in table format, click the row that contains the data you would like to print (to select more than one row, press and hold either the **Shift** or **Control** key). After you have selected the appropriate row(s), right-click the area or row you have selected.
3. Select **Print** (text format) **or Print Data From Table** (table format).

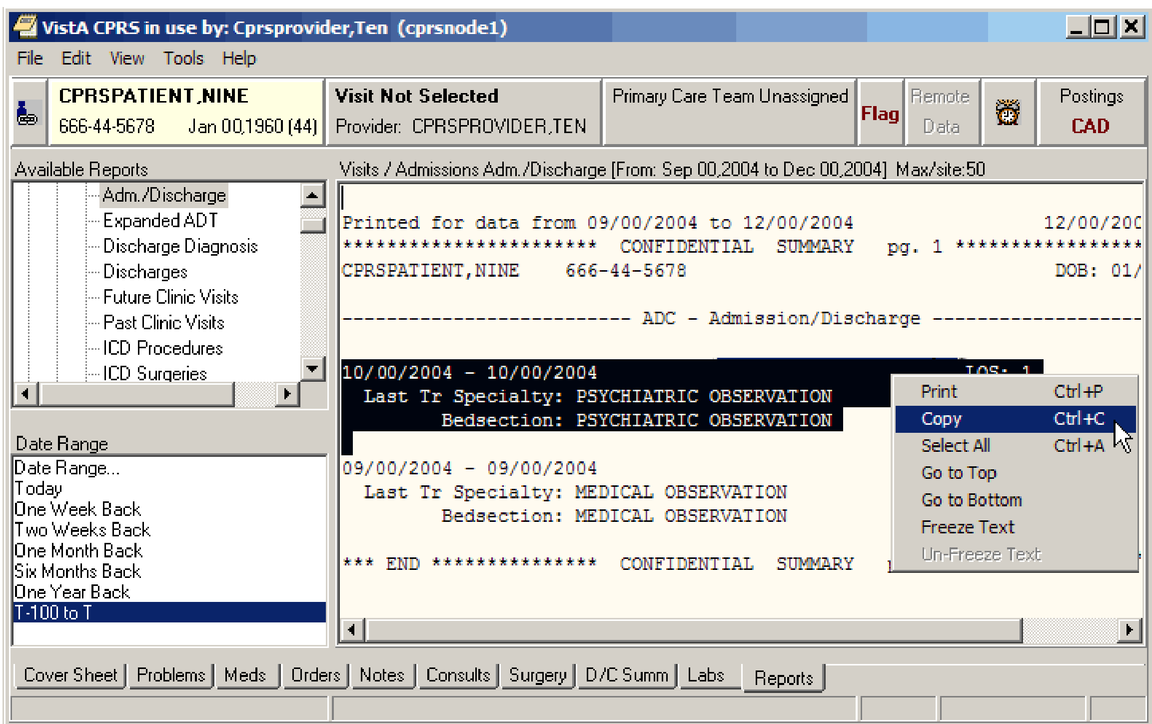


You can print data from a table by right-clicking on the appropriate row and selecting the Print option.

Copying Data from a Report

To copy data from a report, follow these steps:

1. From the Reports tab, select the report you would like to copy data from.
2. If the report is in text format, select the text you would like to copy and then right-click
   -or-
   if the report is in table format, click the row that contains the data you would like to copy (to select more than one row, press and hold either the **Shift** or **Control** key). After you have selected the appropriate rows, right-click the area or row you have selected.
3. Select **Copy** (text format) or **Copy Data From Table** (table format).
4. You can now paste the data into another area in CPRS or into another program.



You can copy data from a report by right-clicking and selecting Copy.

Viewing a Health Summary

To display a Health Summary, follow these steps:

1. Select a patient after you enter the CPRS system.
2. Select the **Reports** tab.
3. Under the Available Reports box on the left side of the screen, click the “+” sign in order to expand the Health Summary heading.
4. Select a Health Summary by clicking on the summary that you would like to see. After you have selected a summary, the appropriate data is displayed on the right side of the screen.
5. Use the scroll bar on the right to scroll through the different sections of the Health Summary.

Appendix A – Accessibility for Individuals with Disabilities

This appendix discusses the features of CPRS that allow people who are blind, who have limited vision, or who have limited dexterity to use the software effectively. The features discussed include changing the font and window sizes, changing the background color, configuring a screen reader, and keyboard equivalents for common CPRS commands.

Changing the Font Size

Changing the size of the fonts used in CPRS is a two-step process. The instructions in CPRS Windows and Dialog Boxes will change the size of most of the fonts displayed in CPRS windows and dialog boxes. However, to change the font size used for CPRS menus and Windows alert boxes, you will also need to follow the steps in CPRS Menus and Windows Alert boxes.

CPRS Widows and Dialog Boxes

You can adjust the font size for most windows and dialog boxes that appear in CPRS. If you change the font size, some screen components will be resized to fit the new font size. If this occurs, you will need to manually resize some dialog boxes and screen components. CPRS will save the dimensions for the resized components so you will only have to resize them once.

To change the font size for CPRS windows and dialog boxes, follow these steps:

1. Select **Edit** | **Preferences** | **Fonts** and choose the appropriate font size.
   The font size will be changed.

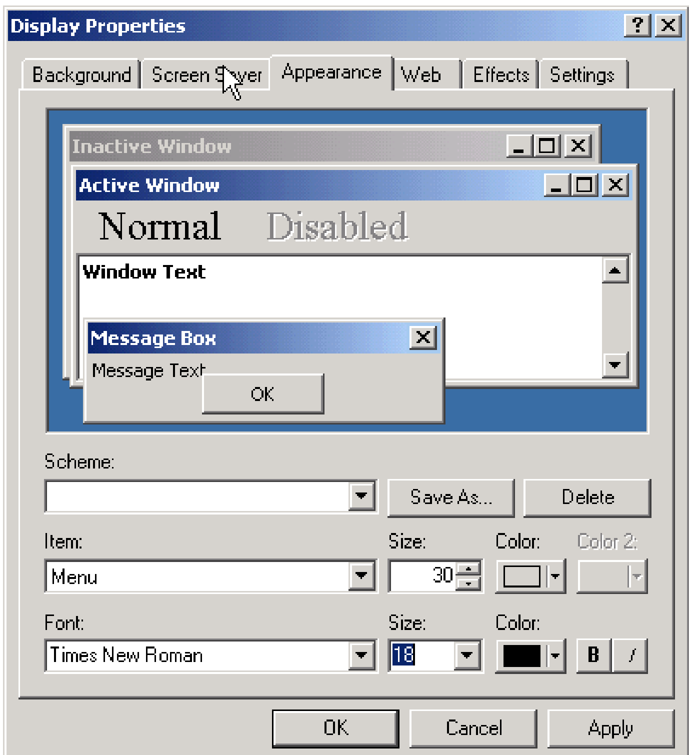
   Note: The menu fonts and alert box fonts will not be changed until you follow the steps in CPRS Menus and Windows Alert boxes (below).

CPRS Menus and Windows Alert Boxes

To change the font size used for CPRS menus and Windows alert boxes, follow these steps:

Note: The steps below will change the font used in menus and Windows boxes for ALL of the applications on your computer.

1. Click **Start** | **Settings** | **Control Panel**.
2. Double-click on the **Display** icon.
3. Click the **Appearance** tab.



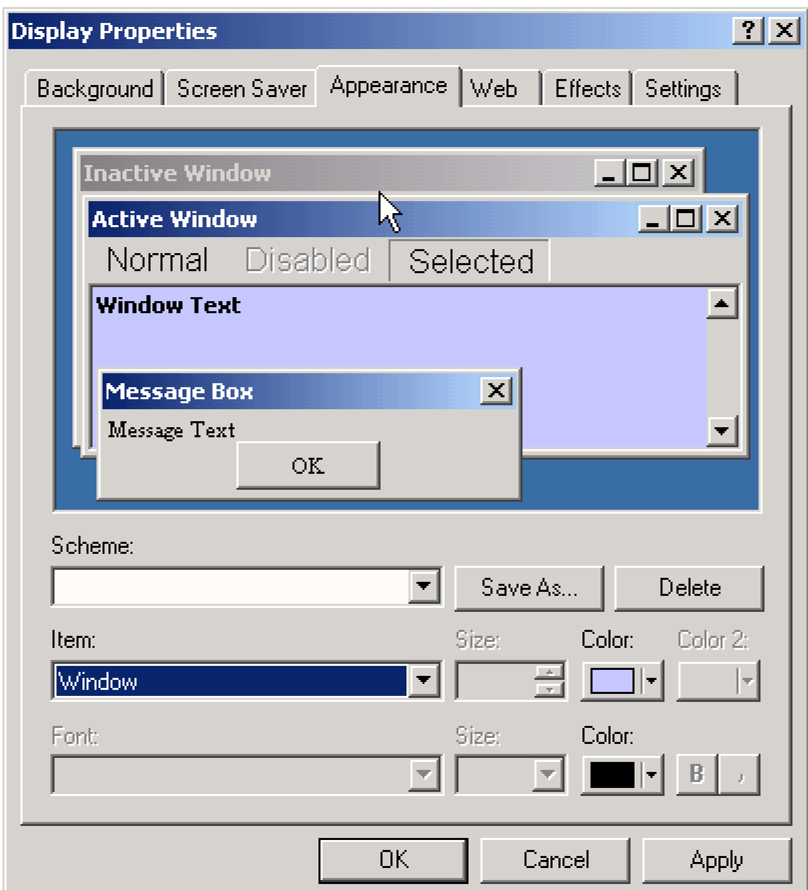
4. From the Item drop-down list box, select either **Menu** or **Message Box**.
5. Select a font from the Font drop-down list.
6. Select a size from the Size drop-down list.
7. Select a color from the Color drop-down list.
8. Click **Apply**.
9. If necessary, repeat steps 4-8 to change the display settings for another item.
10. Press **OK**.

Changing the Window Background Color

To change the background color of CPRS windows and dialog boxes, follow these steps:

Note: The steps below will change the background color of windows and dialog boxes for ALL applications on your computer.

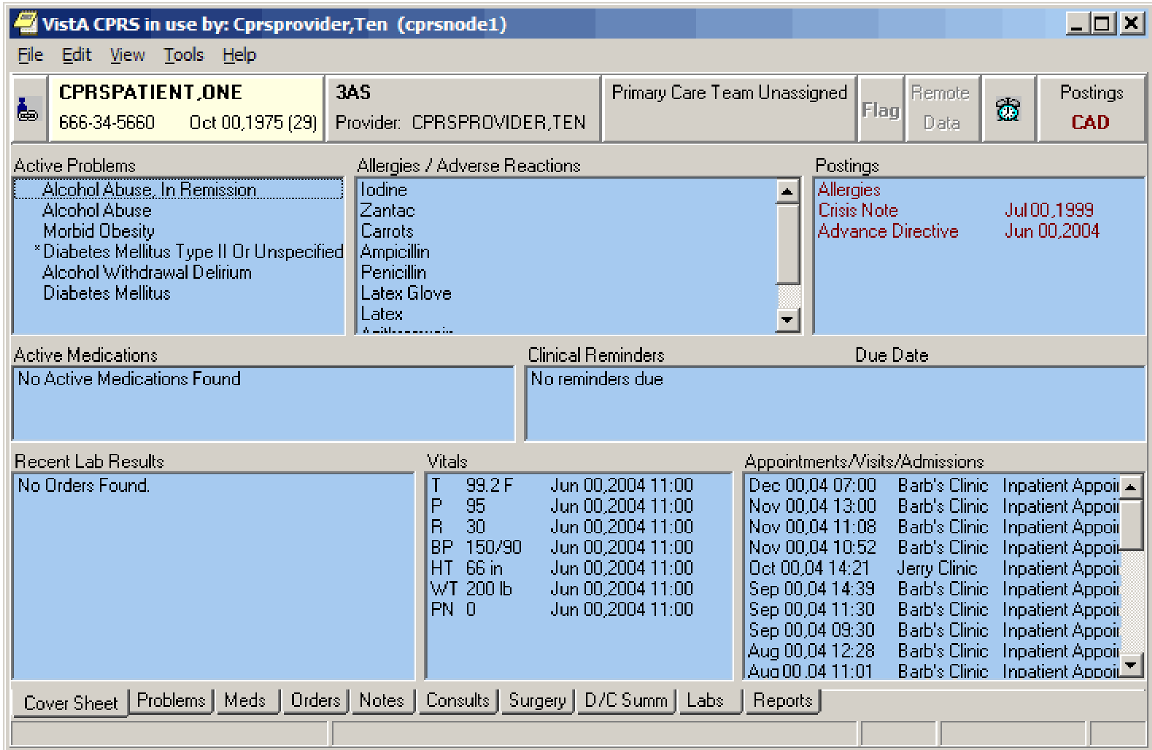
1. Click **Start** | **Settings** | **Control Panel**.
2. Double-click on the **Display** icon.
   The *Display Properties* dialog box will appear.
3. Click the **Appearance** tab.
4. From the Item drop-down list box, select **Window**.
5. Select a color from the Color drop-down list box.
6. Click **Apply**.



The Appearance tab of the Display Properties dialog box

7. If necessary, repeat steps 4-6 to change the display settings for another item.

8. Press **OK**.



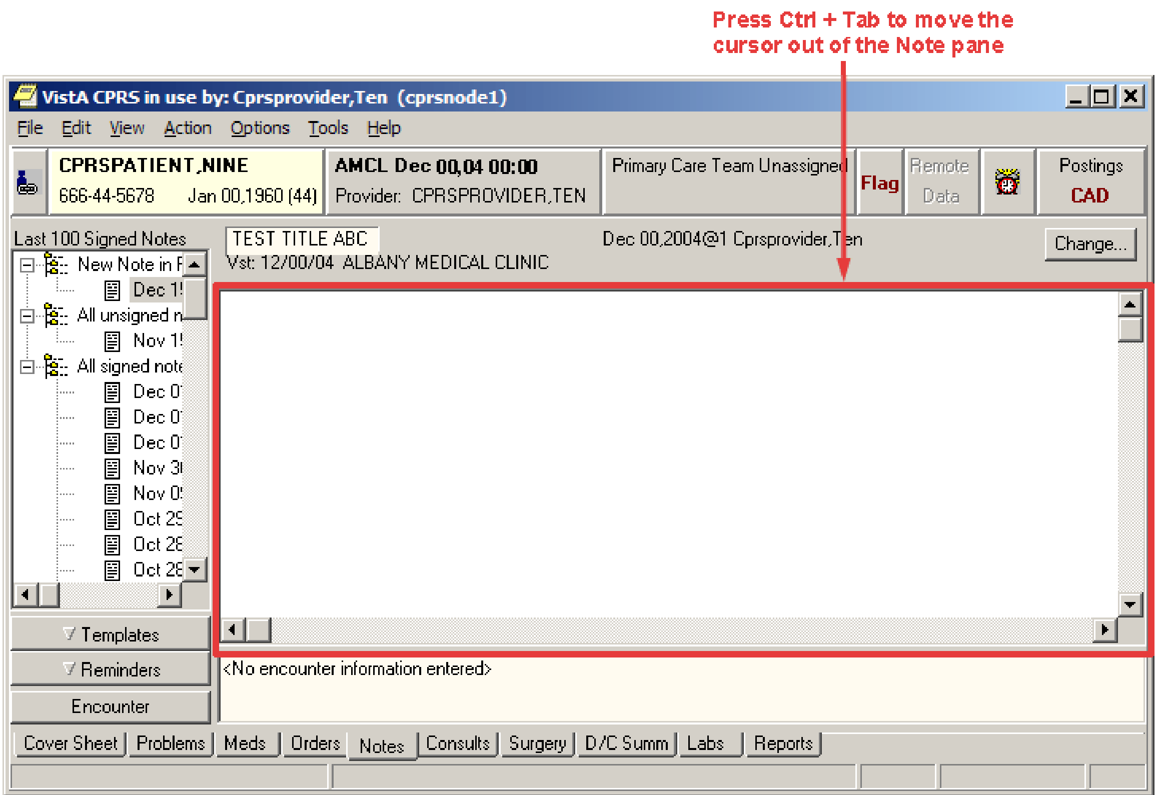
In this example, the Window color has been changed to blue.

Keyboard Shortcuts for Common CPRS Commands

Navigation

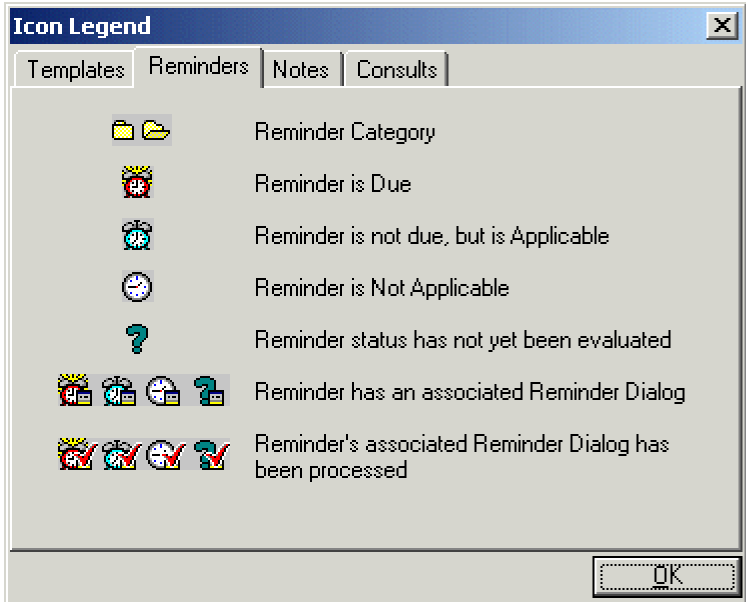
Select the Cover Sheet tab	**Ctrl** + **S**
Select the Problems tab	**Ctrl** + **P**
Select the Meds tab	**Ctrl** + **M**
Select the Orders tab	**Ctrl** + **O**
Select the Notes tab	**Ctrl** + **N**
Select the Consults tab	**Ctrl** + **T**
Select the D/C Summ tab	**Ctrl** + **D**
Select the Labs tab	**Ctrl** + **L**
Select the Reports tab	**Ctrl** + **R**
Advance to the next field, button, or control (left to right)	**Tab**

To exit a field that accepts tabs
(e.g. the details pane of the Notes tab)
and move to the next control (left to right) **Control** + **Tab**



To exit a field that accepts tabs and move to the previous control (right to left)	**Shift** + **Control** + **Tab**
Pull down a list box	**Down Arrow**
Navigate a list box	**Up Arrow** or **Down Arrow**
Select an item in a list box	**Return** or **Enter**
Expand a tree view	**Right Arrow**
Collapse a tree view	**Left Arrow**

To advance (left-right) to the next tabbed page of a dialog box	**Control** + **Tab**



An example of a dialog box with tabbed pages. Press **Control** + **Tab** to move from left to right (from the Solutions tab to the Additives tab). Press **Shift** + **Control** + **Tab** to move from right to left (from the Additives tab to the Solutions tab).

To move backwards (right to left) between tabbed pages of a dialog box	**Shift** + **Control** + **Tab**
To toggle a check box on or off	**Spacebar**

Common Commands

File Menu

Select New Patient	**Alt-F-N**
Display demographic information in the Patient Selection dialog box so it can be read by a screen reader	**Ctrl** + **D**
Refresh Patient Information	**Alt-F-I**
Update Provider / Location	**Alt-F-U**
Review/Sign Changes	**Alt-F-R**
Next Notification	**Alt-F-F**
Remove Current Notification	**Alt-F-V**
Print Setup	**Alt-F-S**
Print	**Alt-F-P**

Exit **Alt-F-X**

Edit Menu

Undo	Ctrl + Z
Cut	Ctrl + X
Copy	Ctrl + C
Paste	Ctrl + V
Preferences | Fonts | 8 pt	**Alt-E-R-F-8**
Preferences | Fonts | 10 pt	**Alt-E-R-F-1**
Preferences | Fonts | 12 pt	**Alt-E-R-F-2**
Preferences | Fonts | 14 pt	**Alt-E-R-F-4**
Preferences | Fonts | 18 pt	**Alt-E-R-F-P**
Preferences | Fonts | 24 pt	**Alt-E-R-F-T**

Help

Contents	**Alt-H-C**
About CPRS	**Alt-H-A**

Cover Sheet

View Menu

Demographics	**Alt-V-M**
Postings	**Alt-V-P**
Reminders	**Alt-V-R**

Problems Tab

View Menu

Active Problems	**Alt-V-A**
Inactive Problems	**Alt-V-I**
Both Active/Inactive Problems	**Alt-V-B**
Removed Problems	**Alt-V-R**
Filters	**Alt-V-L**
Show Comments	**Alt-V-C**
Save as Default View	**Alt-V-V**
Return to Default View	**Alt-V-F**

Action Menu

New Problems	**Alt-A-N**
Change	**Alt-A-C**
Inactive	**Alt-A-I**
Verify	**Alt-A-V**
Annotate	**Alt-A-A**
Remove	**Alt-A-R**
Restore	**Alt-A-S**
View Details	**Alt-A-D**

Meds Tab

View Menu

Details	**Alt-V-D**
Administration History	**Alt-V-H**

Action Menu

New Medication	**Alt-A-N**
Change	**Alt-A-C**
Discontinue/Cancel	**Alt-A-D**
Hold	Alt-A-H
Renew	Alt-A-W
Copy to New Order	**Alt-A-P**
Transfer to	**Alt-A-T**
Refill	**Alt-A-E**

Orders Tab

View Menu

Active Orders (includes pending, recent activity)	**Alt-V-A**
Current Orders (active/pending status only)	**Alt-V-O**
Auto DC/Release Event Orders	**Alt-V-V**
Expiring Orders	**Alt-V-E**
Unsigned Orders	**Alt-V-U**
Custom Order View	**Alt-V-C**
Save as Default View	**Alt-V-S**
Return to Default View	**Alt-V-R**
Details	**Alt-V-D**
Results	**Alt-V-L**
Results History	**Alt-V-H**

Action Menu

Change	**Alt-A-C**
Copy to New Order	**Alt-A-N**
Discontinue / Cancel	**Alt-A-D**
Change Release Event	**Alt-A-G**
Hold	**Alt-A-H**
Release Hold	**Alt-A-L**
Renew	**Alt-A-W**
Alert when Results	**Alt-A-A**
Complete	**Alt-A-M**
Flag	**Alt-A-F**
Unflag	**Alt-A-U**
Order Comments	**Alt-A-R**
Sign Selected	**Alt-A-S**

Options Menu

Save as Quick Order	**Alt-O-S**
Edit Common List	**Alt-O-E**

Complex Tab of the Medication Order Dialog

Enter a field in a grid	**Spacebar**
Insert a row in a grid	Select the row and then press **Insert**.
Delete a row in a grid	Select the row and then press **Delete**.
Drop down the then/and list	**Spacebar**

Notes Tab

View Menu

Signed Notes (All)	**Alt-V-S**
Signed Notes by Author	**Alt-V-A**
Signed Notes by Date Range	**Alt-V-R**
Uncosigned Notes	**Alt-V-C**
Unsigned Notes	**Alt-V-U**
Custom View	**Alt-V-M**
Save as Default View	**Alt-V-V**
Return to Default View	**Alt-V-F**
Details	**Alt-V-D**
Icon Legend	**Alt-V-I**

Action Menu

New Progress Note	Alt-A-N or Shift + Ctrl + N
Make Addendum	Alt-A-M or Shift + Ctrl + M
Add New Entry to Interdisciplinary Note	**Alt-A-W**
Attach to Interdisciplinary Note	**Alt-A-T**
Detach fm Interdisciplinary Note	**Alt-A-H**
Change Title	**Alt-A-C**
Reload Boilerplate Text	**Alt-A-B**
Add to Signature List	**Alt-A-L**
Delete Progress Note	**Alt-A-D** or **Shift + Ctrl + D**
Edit Progress Note	**Alt-A-E** or **Shift + Ctrl + E**
Save Without Signature	**Alt-A-A** or **Shift + Ctrl + A**
Sign Note Now	**Alt-A-G** or **Shift + Ctrl + G**
Identify Additional Signers	**Alt-A-I**

Options Menu

Edit Templates	**Alt-O-T**
Create New Template	**Alt-O-N**
Edit Shared Templates	**Alt-O-S**
Create New Shared Template	**Alt-O-C**
Edit Template Fields	**Alt-O-F**

Details Pane Right-Click Menu

Reformat Paragraph	**Shift + Ctrl + R**
Preview/Print Current Template	**Ctrl + W**
Insert Current Template	**Ctrl + Insert**

Template Pane

Open the templates drawer **Spacebar**

To expand a template file cabinet or tree view **Left Arrow**

To collapse a template file cabinet or tree view **Right Arrow**

Find Templates Select a template or template file cabinet and press **Ctrl + F**

Copy Template Text	Select the template and then press **Ctrl + C**
Insert Template	Select a template and then press **Ctrl + Insert**
Preview/Print Template	Select a template and then press **Ctrl + W**
Goto Default	Select a template or template file cabinet and press **Ctrl + G**
Mark as Default	Select a template and then press **Ctrl + Space**
View Template Notes	**Ctrl + V**

Template Editor

Edit Menu

Undo	**Ctrl** + **Z**
Cut	**Ctrl** + **X**
Copy	**Ctrl** + **C**
Paste	**Ctrl** + **V**
Select All	**Ctrl** + **A**
Insert Patient Data (Object)	**Ctrl** + **I**
Insert Template Field	**Ctrl** + **F**
Check for Errors	**Ctrl** + **E**
Preview/Print Template	**Ctrl** + **T**
Check Grammar	**Ctrl** + **G**
Check Spelling	**Ctrl** + **S**

Action Menu

New Template	**Alt-A-N**
Generate Template	**Alt-A-G**
Copy Template	**Alt-A-C**
Paste Template	**Alt-A-P**
Delete Template	**Alt-A-D**
Sort	**Alt-A-O**
Find Shared Templates	**Alt-A-S**
Find Personal Templates	**Alt-A-F**
Collapse Shared Tree	**Alt-A-L**
Collapse Personal Tree	**Alt-A-A**

Tools Menu

Edit Template Fields	**Alt-T-F**
Import Template	**Alt-T-I**
Export Template	**Alt-T-E**
Refresh Templates	**Alt-T-R**
Template Icon Legend	**Alt-T-T**

Consults Tab

View Menu

All Consults	**Alt-V-A**
Consults by Status	**Alt-V-U**
Consults by Service	**Alt-V-S**
Consults by Date Range	**Alt-V-R**
Custom View	**Alt-V-M**
Save as Default View	**Alt-V-V**
Return to Default View	**Alt-V-F**
Icon Legend	**Alt-V-I**

Action Menu

New | Consult	**Alt-A-N-C**
New | Procedure	**Alt-A-N-P**
Consult Tracking | Receive	**Alt-A-C-R**
Consult Tracking | Schedule	**Alt-A-C-L**
Consult Tracking | Cancel (Deny)	**Alt-A-C-C**
Consult Tracking | Edit/Resubmit	**Alt-A-C-E**
Consult Tracking | Discontinue	**Alt-A-C-D**
Consult Tracking | Forward	**Alt-A-C-F**
Consult Tracking | Add Comment	**Alt-A-C-A**
Consult Tracking | Significant Findings	**Alt-A-C-S**
Consult Tracking | Administrative Complete	**Alt-A-C-M**
Consult Tracking | Display Details	**Alt-A-C-T**
Consult Tracking | Display Results	**Alt-A-C-U**
Consult Tracking | Display SF 513	**Alt-A-C-5**
Consult Tracking | Print SF 513	**Alt-A-C-P**
Consult Results:	

Options Menu

Edit Templates	**Alt-O-T**
Create New Template	**Alt-O-N**
Edit Shared Templates	**Alt-O-S**
Create New Shared Template	**Alt-O-C**
Edit Template Fields	**Alt-O-F**

DC/Summ Tab

View Menu

Signed Summaries (All)	**Alt-V-S**
Signed Summaries by Author	**Alt-V-A**
Signed Summaries by Date Range	**Alt-V-R**
Uncosigned Summaries	**Alt-V-C**
Unsigned Summaries	**Alt-V-U**
Custom View	**Alt-V-M**
Save as Default View	**Alt-V-V**
Return to Default View	**Alt-V-F**
Details	**Alt-V-D**
Icon Legend	**Alt-V-I**

Action Menu

New Discharge Summary	**Alt-A-N** or **Shift** + **Ctrl** + **N**
Make Addendum	Alt-A-M or Shift + Ctrl + M
Change Title	Alt-A-C or Shift + Ctrl + C
Reload Boilerplate Text	**Alt-A-B**
Add to Signature List	**Alt-A-L**
Delete Discharge Summary	**Alt-A-D** or **Shift** + **Ctrl** + **D**
Edit Discharge Summary	**Alt-A-E** or **Shift** + **Ctrl** + **E**
Save without Signature	**Alt-A-A** or **Shift** + **Ctrl** + **A**
Sign Discharge Summary Now	**Alt-A-G** or **Shift** + **Ctrl** + **G**
Identify Additional Signers	**Alt-A-I**

Options Menu

Edit Templates	**Alt-O-T**
Create New Template	**Alt-O-N**
Edit Shared Templates	**Alt-O-S**
Create New Shared Template	**Alt-O-C**
Edit Template Fields	**Alt-O-F**

Labs Tab

View Menu

Demographics	**Alt-V-M**
Postings	**Alt-V-P**
Reminder	**Alt-V-R**

Reports Tab

View Menu

Demographics	**Alt-V-M**
Postings	**Alt-V-P**
Reminder	**Alt-V-R**
View a selected report	**Spacebar**

JAWS Configuration Files

Users can create a JAWS custom configuration file for any application. The configuration file tells JAWS how to behave for certain elements in the application, including elements it may not know how to process. The configuration file will also help JAWS recognize many of the custom screen elements in CPRS.

Screen elements in Windows are commonly called "screen controls" or just "controls". Several custom controls were developed to make CPRS more functional and easier to program. Most of these controls were built on pre-defined Windows controls (like buttons and drop-down lists.) The instructions in this appendix tell you how to update the JAWS configuration file to tell JAWS to treat these custom controls like the standard Windows controls.

For example, one of the custom buttons in CPRS is the "New Note" button on the Notes tab. If you use JAWS and use the Tab key to reach this button, JAWS only says "New Note". At this point, if you're a visually impaired person, you're not sure what the component is that you've landed on. After implementing one of the options below, when you tab to that button, JAWS will say "New Note button". This scenario is the same with the other controls listed in the instructions below.

There are 4 ways to set up the JAWS configuration file for CPRS.

- The first, and easiest, option is to download a ready-made configuration file from one of the ANONYMOUS FTP directories.

- The second is to cut and paste text into an existing configuration file.

- The third to create a new file and cut and paste the text into it.

- The fourth method, creating the file while running the JAWS application, is in case you have difficulty with the first three.

Download the Configuration File from the FTP Site

1. Download a file named CPRSChart.JCF from the ANONYMOUS directory. The preferred method is to FTP the files from:

   download.vista.med.va.gov.

   This transmits the files from the first available FTP server. Sites may also elect to retrieve software directly from a specific server as follows:

CIO Field Office	FTP Address	Directory
Albany	ftp.fo-albany.med.va.gov	[anonymous.software]
Hines	ftp.fo-hines.med.va.gov	[anonymous.software]
Salt Lake City	ftp.fo-slc.med.va.gov	[anonymous.software]

2. On your workstation, navigate to the appropriate directory. (The standard location for JAWS version 3.7 is C:\JAWS37U\SETTINGS\ENU and for the new JAWS version 5.1, it is C:\JAWS510\SETTINGS\ENU.)

   Note: If there is already a CPRSChart.JCF file on the workstation, you probably do not want to overwrite it. To preserve the current settings plus add information about CPRS controls, use the steps under "Cut and Paste Information into the Existing Configuration File".

3. If there is no CPRSChart.JCF file in the directory, save the file.

Cut and Paste Information into the Existing Configuration File

1. Open CPRSChart.JCF using Notepad. (The standard location for JAWS version 3.7 is C:\JAWS37U\SETTINGS\ENU and for the new JAWS version 5.1, it is C:\JAWS510\SETTINGS\ENU.)

2. Copy and paste the following text at the end of the Notepad document:
   [WindowClasses]
   TORComboEdit=EditCombo
   TORAlignButton=Button
   TORTreeView=TreeView
   TORAlignEdit=Edit
   TORListView=ListView
   TORCheckBox=CheckBox
   TCaptionMemo=Edit
   TCaptionRichEdit=Edit
   TCaptionTreeView=TreeView

   TRadioGroup=GroupBox
   TGroupBox=GroupBox
   TKeyClickPanel=Button
   TKeyClickRadioGroup=GroupBox
   TORListBox=ListBox
   TCaptionListView=ListView

   [Options]
   SayNumericDates=0

```
[MSAAClasses]
TCaptionListBox=1
TCaptionCheckListBox=1

[OSM]
EditPromptSearch=2
```

3. Save the document.

Create a New Configuration File Manually

1. Start Notepad.
2. Select the following text and Copy and paste it into the Notepad document:

```
[WindowClasses]
TORComboEdit=EditCombo
TORAlignButton=Button
TORTreeView=TreeView
TORAlignEdit=Edit
TORListView=ListView
TORCheckBox=CheckBox
TCaptionMemo=Edit
TCaptionRichEdit=Edit
TCaptionTreeView=TreeView
TRadioGroup=GroupBox
TGroupBox=GroupBox
TKeyClickPanel=Button
TKeyClickRadioGroup=GroupBox
TORListBox=ListBox
TCaptionListView=ListView

[Options]
SayNumericDates=0

[MSAAClasses]
TCaptionListBox=1
TCaptionCheckListBox=1

[OSM]
EditPromptSearch=2
```

3. Save the document as "CPRSChart.JCF" in the appropriate JAWS folder.

   Note: Use the quotes when entering the file name in Notepad, otherwise Notepad will try to save it with a .txt extension.

   (The standard location for JAWS version 3.7 is C:\JAWS37U\SETTINGS\ENU and for the new JAWS version 5.1, it is C:\JAWS510\SETTINGS\ENU.)

Create the Configuration File while Running JAWS

1. Start JAWS and CPRS.
2. On the patient selection list box, place the cursor in the edit box where you type the patient name.
3. Press **Insert** + **F2** to open a dialog called "Run JAWS Manager".
4. Cursor down to "Window Class Reassign", and select the **OK** button.
   JAWS then opens the "JAWS Configuration Manager" and a "Window Classes" dialog.
5. Ensure that in the Window Classes dialog, the New Class edit box reads "TORComboEdit".
6. Go to the Assign to: list box, and select **EditCombo**. Then, select the **Add Class** button.
   The assignment should show up in the "Assigned Classes" list box.
7. Repeat the above two steps, each time substituting the values below for the "New Class" and "Assign to" entries:
   TORListBox Assign to: ListBox
   TORAlignButton Assign to: Button
   TORTreeView Assign to: TreeView
   TORAlignEdit Assign to: Edit
   TORListView Assign to: ListView
   TORCheckBox Assign to: CheckBox
   TORComboEdit Assign to: EditCombo
   TORAlignButton Assign to: Button
   TORTreeView Assign to: TreeView
   TORAlignEdit Assign to: Edit
   TORListView Assign to: ListView
   TORCheckBox Assign to: CheckBox
   TCaptionMemo Assign to: Edit
   TCaptionRichEdit Assign to: Edit
   TCaptionTreeView Assign to: TreeView

   TRadioGroup Assign to: GroupBox
   TGroupBox Assign to: GroupBox
   TKeyClickPanel Assign to: Button
   TKeyClickRadioGroup Assign to: GroupBox
   TORListBox Assign to: ListBox
   TCaptionListView Assign to: ListView
   TCaptionListBox Assign to: MS Active Accessibility
   TCaptionCheckListBox Assign to: MS Active Accessiblitiy
8. When the entire list is entered, select the **OK** button.
   JAWS will now use this configuration file when using CPRS, and will recognize the custom controls in CPRS.

Glossary

CPRS	Computerized Patient Record System, the VistA package (in both GUI and character-based formats) that provides access to most components of the patient chart.
AICS	Automated Information Collection System, formerly called Integrated Billing; software developed at Albany IRMFO, supported by MCCR, producing scannable Encounter Forms.
ASU	Authorization/Subscription Utility, a VistA application (initially released with TIU) that allows VAMCs to assign privileges such as who can do what in ordering, signing, releasing orders, etc.
CAC	Clinical Applications Coordinator. The CAC is a person at a hospital or clinic assigned to coordinate the installation, maintenance and upgrading of CPRS and other VistA software programs for the end users.
Chart Contents	The various components of the Patient Record, equivalent to the major categories of a paper record; for example, Problem List, Progress Notes, Orders, Labs, Meds, Reports, etc. In CPRS, these components are listed at the bottom of the screen, to be selected individually for performing actions.
Consults	Consult/Request Tracking, a VistA product that is also part of CPRS (it can function as part of CPRS, independently as a standalone package, or as part of TIU). It's used to request and track consultations or procedures from one clinician to another clinician or service.
Cover Sheet	A screen of the CPRS patient chart that displays an overview of the patient's record.
CWAD	Crises, Warnings, Allergies/Adverse Reactions, and Directives. These are displayed on the Cover Sheet of a patient's computerized record, and can be edited, displayed in greater detail, or added to. *See Patient Postings.*
D/C Summary	Discharge Summary; see below.
Discharge Summary	A component of TIU that can function as part of CPRS, Discharge Summaries are recapitulations of a patient's course of care while in the hospital.
GAF	Global Assessment of Functioning is a rating of overall psychological functioning on a scale of 0 – 100. The GAF tab is available in the CPRS GUI in VA Mental Health facilities.
GUI	Graphical User Interface—a Windows-like screen with pull-down menus, icons, pointer device, etc.
Health Summary	A **V*IST*A** product that can be viewed through CPRS, Health Summaries are components of patient information extracted from other VistA applications.
Imaging	A VistA product that is also a component of CPRS; it includes Radiology, X-rays, Nuclear Medicine, etc.

Notifications	Alerts regarding specific patients that appear on the CPRS patient chart. They can be responded to through “VA View Alerts.”
OE/RR	Order Entry/Results Reporting, a VistA product that evolved into the more comprehensive CPRS.
Order Checking	A component of CPRS that reviews orders as they are placed to see if they meet certain defined criteria that might cause the clinician placing the order to change or cancel the order (e.g., duplicate orders, drug-drug/diet/lab test interactions, etc.).
Order Sets	Order Sets are collections of related orders or Quick Orders, (such as Admission Orders or Pre-Op Orders).
PCE	Patient Care Encounter is a VistA program that is part of the Ambulatory Data Capture Project (ADCP) and also provides Clinical Reminders, which appear on Health summaries.
PCMM	Patient Care Management Module, a VistA product that manages patient/provider lists.
Patient Postings	A component of CPRS that includes messages about patients; an expanded version of CWAD (see above).
Progress Notes	A component of TIU that can function as part of CPRS.
Quick Orders	Quick Orders allow you to enter many kinds of orders without going through as many steps. They are types of orders that physicians have determined to be their most commonly ordered items and that have standard collection times, routes, and other conditions.
Reports	A component of CPRS that includes Health Summary, Action Profile, and other summarized reports of patient care.
TIU	Text Integration Utilities; a package for document handling, that includes Consults, Discharge Summary, and Progress Notes, and will later add other document types such as surgical pathology reports. TIU components can be accessed for individual patients through the CPRS, or for multiple patients through the TIU interface.
VISN	Veterans Information System Network is the collective name of the regional organizations that manage computerization within a region.
VistA	Veterans Information Systems Technology Architecture, the new name for DHCP.

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