

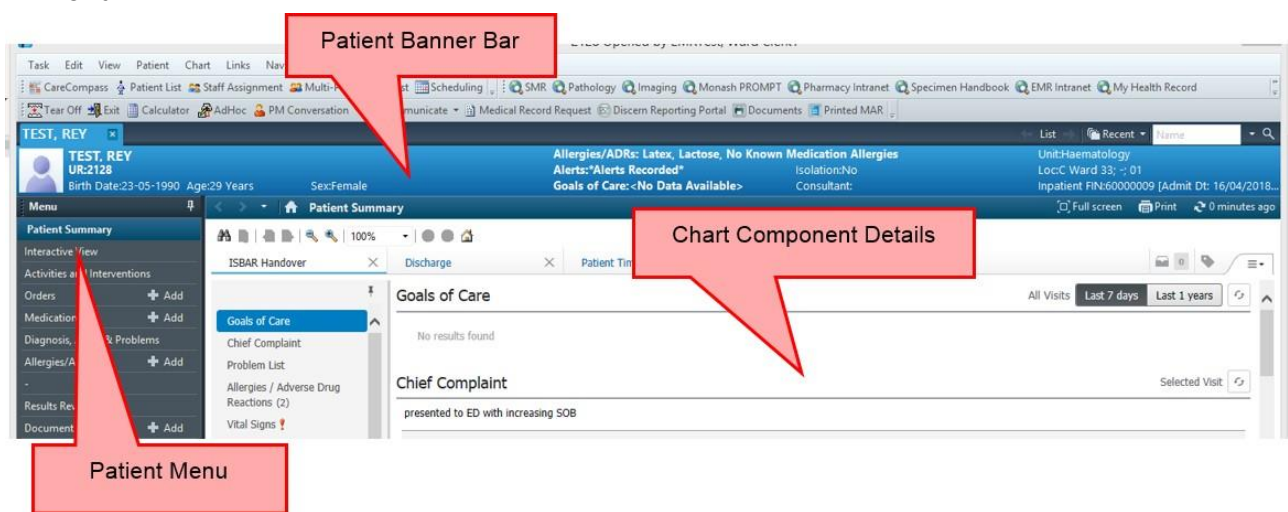
Quick Reference Guide (QRG)

Patient Chart Overview in PowerChart

This QRG is to assist HIS staff in navigating the patient's chart.

When viewing a **patient's chart**, the window is divided into three sections:

- **Patient Banner Bar** - Displays key patient demographics and encounter specific information for the selected patient chart
- **Patient Menu** - Is used to navigate the various chart components for the selected patient chart
- **Chart Component Details** - Displays specific chart components as selected from the Patient Menu



The Patient Banner Bar



The **Patient Banner Bar** contains patient demographics and encounter specific information. The Patient demographics include the 3 points of ID as entered in **iPM**:

- Patient's Full Name
- Patient's URN
- Patient's Date of Birth & Age

NOTE: You can also view the patient's gender.

The **patient specific** details include:

- **Allergies / ADRs** - These will display in alphabetical order when recorded
- **Alerts** - This notification will display only if an alert is recorded



The **encounter specific** details include:

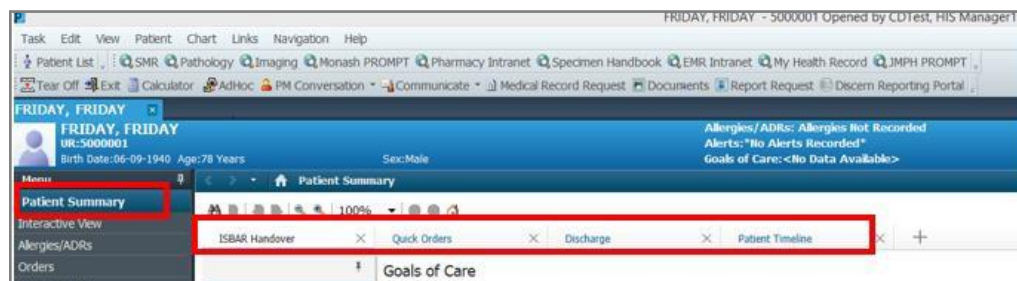
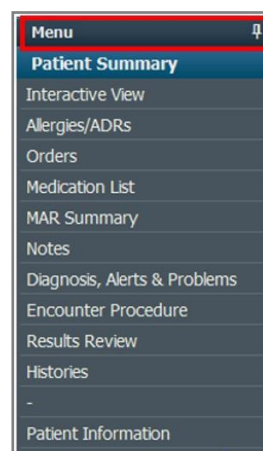
- **Goals of Care** – As documented by the treating clinician
- **Consultant** - The treating clinician for the encounter as entered in **iPM**
- **Unit** - Specialty in the encounter as entered in **iPM**
- **Location details** - Patient Location such as Facility, Building, Floor/Level, Ward/Unit, Room/Bay/Bed/Chair during the encounter as entered in **iPM**
- **Encounter details** - The encounter types such as Outpatient, Inpatient or Emergency, start date and time, and end date and time if applicable.

The Patient Menu

The **Patient Menu** is used to navigate through the various Chart Components for the selected patient chart. When a Chart Component is selected, the contents will display in the chart window.

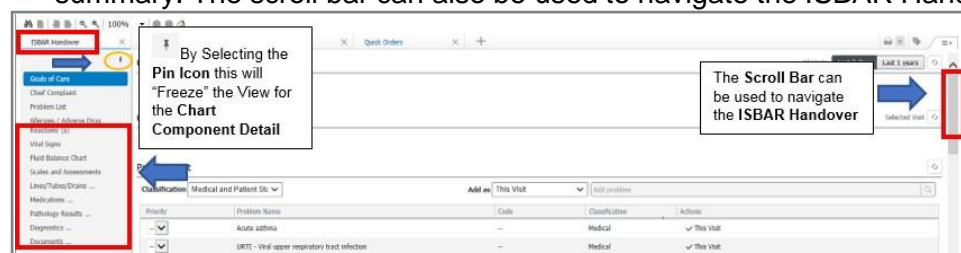
Patient Summary

Patient Summary acts as a dashboard for all clinical information entered in the selected patient chart. When the **Refresh** button is selected, information entered in the patient chart will feed through and populate the appropriate sections.



The **Patient Summary** displays the following tabs: ISBAR Handover, Quick Orders, Discharge, & Patient Timeline

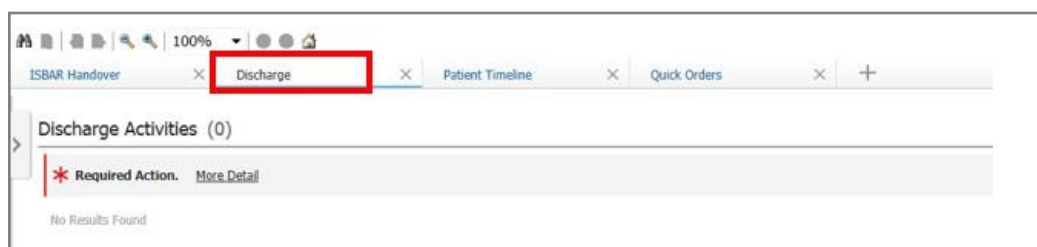
- **ISBAR Handover** has a Component List which can be pinned/unpinned on to the Chart Component Detail window. This allows the user to navigate directly to the required segment summary. The scroll bar can also be used to navigate the ISBAR Handover



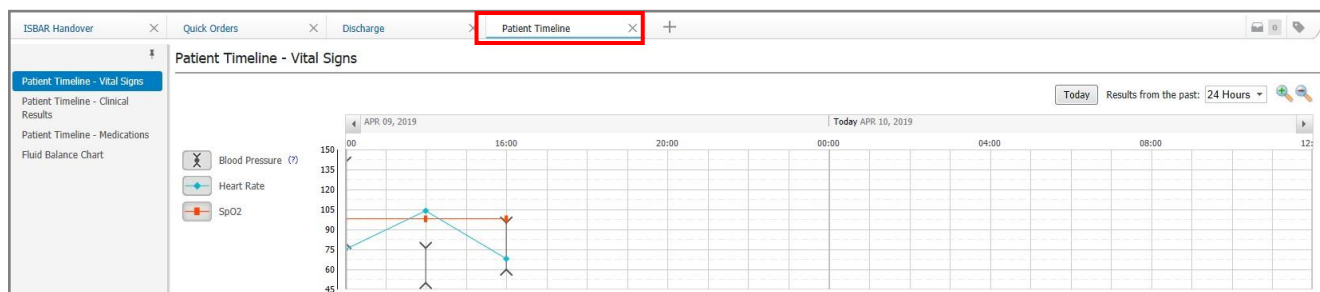
- **Quick Orders** enables the user quick access to Orders. Orders are categorised according to the patient's care types



- **Discharge** allows a view of the patient's progress towards discharge



- **Patient Timeline** provides a timeline and display of Vital Signs, Clinical Results and Medications. This page may be particularly useful in Recovery and Critical Care areas



Interactive View

Interactive View (also called iView) is divided into categories and sub-categories and will open differently depending on the user log in permissions. The iView categories act as an index to help the user move from one section to another, like moving down a form. Nurses can document observations, bowel sounds, restraints etc. under iView. For coders, ventilation hours will be housed here. The ventilation hours can be accessed in a summary view via the Results Review tab.

Allergies / ADRs

The Allergies section displays active or proposed allergies and the reactions/symptoms for the patient.

Orders

An order is a request for a procedure, test, or plan to be performed. Active and inactive orders are housed here, as well as the Document In Plan tab which allows the user to view the progress of the care plan.

Medication List

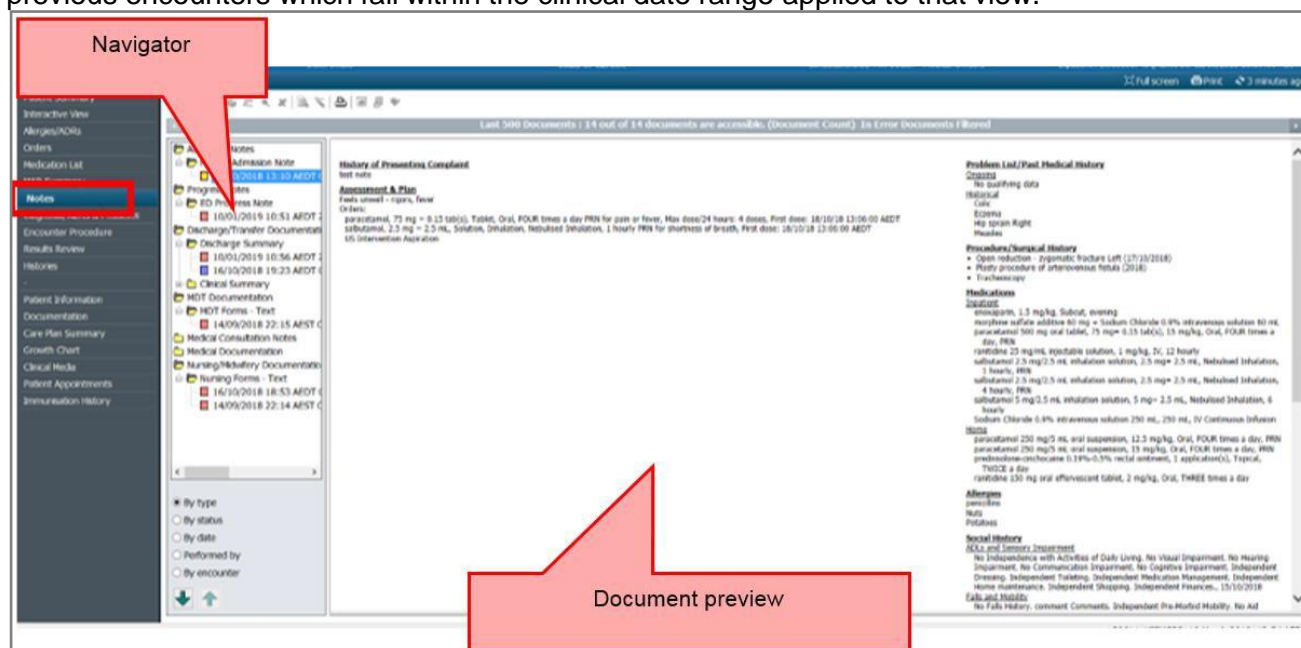
A list of medications and continuous infusions ordered for the patient.

MAR Summary

An overview summary of all the patient's medication ordered. Medications cannot be administered through this view.

Notes View

The Notes View is designed to display all clinical results for the selected patient encounter and all previous encounters which fall within the clinical date range applied to that view.



The Navigator displays the documents grouped by type. To change the grouping type, select the required radio button at the bottom of the Navigator (By type, By status, By date, etc). To see a document, double click on the required type, sub-type, and document name. The arrows allow the user to navigate between documents.

Diagnosis, Alerts & Problems

The diagnosis for the open encounter and all the current alerts and problems recorded against the selected patient. Clinicians can add diagnoses addressed in the encounter, prioritise the problem list, and annotate each entry if applicable. This information is pulled into the Patient Summary → Discharge menu tab. Entries are classified under SNOMED codes.

Encounter Procedure

Overview of patient's diagnosis and the procedures for the current encounter / episode. Further information regarding the procedures will be found in the Documentation tab.

Results Review

Overview of results for all assessments, measurements, Pathology, and Radiology tests performed for the patient. For coders, a summary of the ventilation details will be housed in the Assessments – Recent tab. The same information can be access via the iView.

Histories

Overview of the patient s history including family, past medical, procedure, and social history.

Patient Information

Patient Information is designed to provide a summary of the patient's contacts, visit and encounter history.

Menu

- Doctor View
- Observation Chart
- Results Review
- Orders + Add
- MAR
- MAR Summary
- Documentation + Add
- Notes
-
- Interactive View
- Activities and Interventions
- Alerts Summary
- Diagnosis, Alerts & Problems
- Encounter Procedure
- Histories
- Allergies/ADRs + Add
- Medication List + Add
- Patient Information**
- My Health Record

Patient Information Full screen Print 1 minutes ago

Patient Contacts Visit List Encounter Location History PPR Summary

Trainervhh, Inpatpharm
UR: 9309903

Sex: Female	Date of Birth: 27/05/1995 (27 Years)
Interpreter: No	Deceased: No
Language: English	Religion: No Religion
Country of Birth: Australia	Marital Status: Never Married
Indigenous Status: Neither Aboriginal nor Torres Strait	PBS Eligibility: PBS Eligible
Address: 25 Emr St Clayton South VIC 3169	Phone: Home: No land line Mobile: 0400 000 000

Identifiers
Medicare Number: 999999999999

Documentation

The Documentation section displays documents related to the patient's care. Documents such as perioperative reports, discharge summary, and allied health assessments are housed here.

The screenshot displays the PowerChart interface for a patient named MARIJULES, ELEVEN. The main window shows a 'List' of care plans with columns for Service Date/Time, Subject, Type, and Facility. A specific care plan is highlighted in blue. To the right, a detailed view of a care plan is shown, including a 'Final Report' warning, 'Clinical Synopsis', 'Patient and Hospital Details', 'Presentation Details', 'Discharge Destination', 'Additional History', 'Birth History', 'Recommendation', 'Investigation Results', 'Tests Awaiting Results', 'Principal Diagnosis', 'Additional Diseases', 'Procedures/Operations', 'Problem List', and 'Medications on Discharge'.

Care Plan Summary

Overview of all care plans initiated for the patient. Patient's interventions and progress towards achieving their goals is also displayed.

Growth Chart

The Measurements and Weights Section displays any measurements plotted on the patient's Growth Chart. (*Note: this is used on Paediatric and Neonatal Wards*)

Clinical Media

Images such as a patient's photograph can be added to Clinical Media. The photograph will be displayed on the patient's Banner Bar and used as a form of identification.

Patient Appointments

Appointments created in IPM in the past 365 days.

Immunisation History

All the immunisation history for paediatric patients