

Edit a Nurse Visit Template

Last Modified on 07/28/2021 4:10 pm EDT



OP sets all defaults to share all information Any individual decisions by Practice-users to restrict information sharing (access, use, or exchange) are the responsibility of the Practice in the implementation of its 21st Century Cures Act Information Blocking policies and procedures for its Practice and patients.

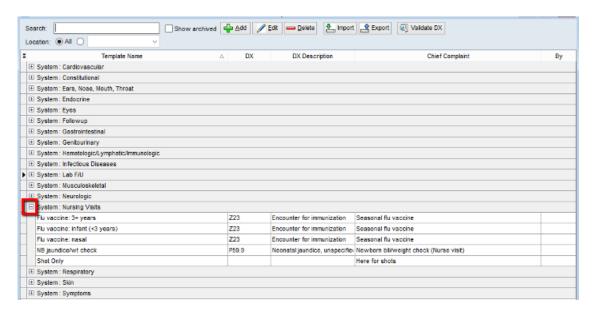
Version 14.19

Path: Clinical tab > Encounter Templates

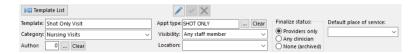
Overview

You will have an understanding of the content of a typical nurse visit template. You will be instructed on methods of customization to ensure the templates reflect the workflow of the practice.

- 1. Click the Clinical tab and select Encounter Templates. The Encounter Template Editor displays.
- 2. Click the plus to expand System: Nursing Visits.



- 3. Select a template and click the **Edit** button or double-click to open.
- 4. Click the Edit button.
- 5. Review the template properties in the table below



Property	Description
Template	Name given to a template. Should be named for ease of searching.
Category	Method of organizing like templates. All templates edited in this section will be located in the Nurse Visits category.
Author	Assignment of a template to a specific user. Templates assigned an author may only be edited by that user.





Appt Type Property	Selection of a default appointment type. Not a requirement to save the template.
Visibility	Ability to restrict who can view the selected template. All symptom templates will have a visibility of Any staff member.
Location	Assignment can be made to view templates by location.
Finalize Status	Selection set to who may finalize. Most templates will be set to Providers only but if the nurse staff may finalize their notes the status would be set to Clinical Staff Only.
Default place of service	The Default place of service is not a required field. This field can be used with templates that are non-office such as Telemedicine to automatically populate the Place of service on the Visit Information tab of an encounter note.

- 6. Click the Encounter Note tab if not already selected.
- 7. Review the **CC** field. Click into the text field to add or edit text of use the **Phrase Construction** button button phrases.
- 8. Review the **HPI** field. Click into the text field to add or edit text or use the **Phrase Construction** button to insert phrases.
- 9. Review the fields of the Encounter Note tab.

Field	Description
Counseling (optional)	Information entered includes counseling that is commonly done during the visit.
Coordination of care (optional)	Information entered includes activities between two or more participants (including the patient) involved in a patient's care to facilitate the appropriate delivery of health care services. Typically the information in this field is entered at time of visit.
Assessment (optional)	The likely diagnosis should be included in this section of the note. If a conclusive diagnosis has not been made yet, some possible diagnoses can be charted. It may include additional diagnoses that need to be ruled out.
Plan	This describes what will be done to treat the patient – ordering labs, referrals, procedures performed, medications prescribed, etc. This should address what was discussed or advised with the patient and timings for further review or follow-up are generally included.
Instructions	Instructions entered will be visible on the Patient Portal when the template is selected. Instructions are typically a summary of the visit written for understanding by the reader.

- 10. (Optional) Add a diagnosis code.
 - a. Click the Add button.

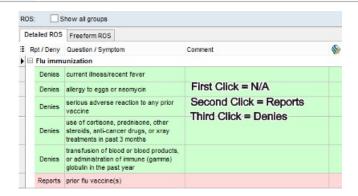


Note: Select the **Prim?** checkbox when the diagnosis code involves laterality, severity. You can add multiple Primary Diagnosis codes that will create a pop-up when the template is applied to select the most specific code for that visit.

- b. Click into the ICD10 Description field and click the **Search** button. The ICD10 search window displays.
- c. Enter a description or code in the ICD10 Code/Description field and select the diagnosis code.
- d. Click into the SNOMED Description field, begin typing and click the Search button. Select the SNOMED code.
- e. Click the Save button.
- 11. Click the **Detailed ROS** tab. Set the ROS Questions/Symptoms using the table definitions below.







Setting	Description
Pert	Relevant symptom/question to display when template is opened.
Reports	Positive for the symptom/question.
Denies	Denies the symptom/question.
N/A	Not applicable for the template. Removes from the group list.



Note: Select the Show all groups checkbox to see other Review of System groups.

- 12. For detail information on the Orders/Workflow tabs, select from the list below.
- Medications
- Diag Tests
- Immunizations
- Resources
- Surveys
- Followup
- Other Tasks
- 13. (Optional) Click the Procedures tab. For detail information clickhere.
- 14. Click the Save button.

Version 14.10

Utilities > Manage Clinical Features > Encounter Template Editor

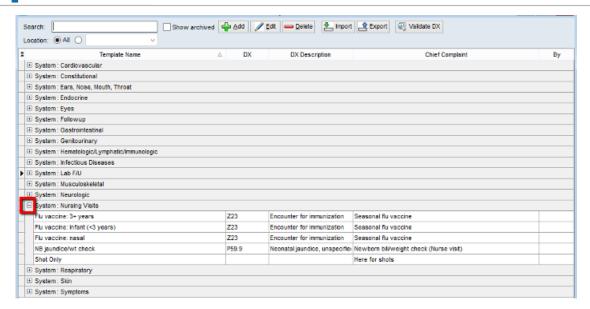
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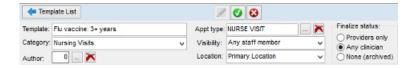
- 1. Click **Utilities** in the main menu.
- 2. Select Manage Clinical Features.
- 3. Select Encounter Template Editor. The template list displays.
- 4. Click the plus to expand System: Nursing Visits.







- 6. Review the template properties using the table definitions below.



Property	Description
Template	Name given to a template. Should be named for ease of searching.
Category	Method of organizing like templates. All templates edited in this section will be located in the Nurse Visits category.
Author	Assignment of a template to a specific user. Templates assigned an author may only be edited by that user.
Appt Type	Selection of a default appointment type. Not a requirement to save the template.
Visibility	Ability to restrict who can view the selected template. All symptom templates will have a visibility of Any staff member.
Location	Assignment can be made to view templates by location.
Finalize Status	Selection set to who may finalize. Most templates will be set to Providers only but if the nurse staff may finalize their notes the status would be set to Clinical Staff Only.

- 7. Click the **Encounter Note** tab if not already selected.
- 8. Review the **CC** field. Click into the text field to add or edit text of use the **Phrase Construction** button button phrases.
- 9. Review the **HPI** field. Click into the text field to add or edit text or use the **Phrase Construction** button to insert phrases.
- 10. Review the fields of the Encounter Note tab.

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Instructions	Instructions entered will be visible on the Patient Portal when the template is selected. Instructions are typically a summary of the visit written for understanding by the reader.

- 11. (Optional) Add a diagnosis code.
 - a. Click the **Add** button 🔒 .



Note: Click the Prim? checkbox when the diagnosis code involves laterality, severity, etc., you can add multiple Primary Diagnosis codes that will create a pop-up when the template is applied to select the most specific code for that visit.

- b. Click into the ICD10 Description field and click the Search button. The ICD10 search window displays.
- c. Enter a description or code in the ICD10 Code/Description field and select the diagnosis code.
- d. Click into the SNOMED Description field, begin typing and click the Search button. Select the SNOMED code.
- e. Click the Save button.
- 12. Click the Detailed ROS tab. Set the ROS Questions/Symptoms using the table definitions below.



Setting	Description
Pert	Relevant symptom/question to display when template is opened.
Reports	Positive for the symptom/question.
Denies	Denies the symptom/question.
N/A	Not applicable for the template. Removes from the group list.

- Note: Select the checkbox Show all groups to see other Review of System groups.
- 13. Click the Orders/Workflow Tab. Click here for detailed information on each tab in Orders/Workflow.
- 14. Click the Procedures tab. Click here for detailed information on completing the Procedures tab.
- 15. Click the Save Changes to template button 🙋 .

