# EPIC IR Manual

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PATIENT CHART AND ENCOUNTERS IN EPIC

1. Patients have one chart in Epic but can have different encounters. You use different encounters to perform different tasks. When you open a chart or an encounter, the picture (or lack of picture) next to patient’s name on the open chart tab can give you a lot of information about what encounter you are in. A few key encounters used a lot by IR are explained below.

2. Patient Chart

   a. Main chart for patient that holds all encounters, notes, imaging, results, and demographic information.
   b. Can access this chart anytime, whether patient is inpatient or outpatient.
   c. Use this chart to look up information about patient. **Treat this chart as read-only.**
   d. Do NOT use this chart to place orders, write notes, or call a patient.
   e. Notice the blue folder icon "" next to patient’s name on the tab in the snip above. This icon indicates you are in this main patient chart.

3. Telephone encounter

   a. Notice the icon " " next to patient’s name on the tab in the snip above.
   b. Use this encounter/chart tab to document incoming or outgoing patient calls.
   c. This type of encounter is used to document the reason for call and any medical advice that is give to the patient by a nurse or provider.
   d. Rx refill requests called in by patient, ordering pre-procedure testing, or calling patient about lab or imaging results are other examples of times when telephone encounters are used.
4. Inpatient encounter

a. The inpatient encounter can be accessed through “Patient Lists” and opening an inpatient encounter from your rounding list, consult list, or searching all inpatients and opening a chart that way.
b. Notice the tab above does NOT have an icon next to patient’s name. Tab will only have patient’s name. In the example above, the patient name is blurred out but there is no icon on the tab like there was in the previous chart examples.
c. Use this encounter for all your inpatient ordering, writing notes, discharging patients.

5. Orders Only encounter

a. Notice the “✔” next to patient’s name.
b. Use this when you need to order anything (including labs, medications, imaging) for an outpatient or a patient that is not present. You also might need to use this option if you are ordering something to be done in the future, when the patient will be an outpatient.
c. Use only to place orders in advance. There is a rule in place that will not let you place anything unless it has a status of future.

d. Should not be used if provider is seeing a patient as it is a non-billable encounter

6. Procedural encounter

a. Open a Procedure encounter by double-clicking on patient from Snapboard/IR daily schedule.

b. Notice, like the inpatient chart, there is NO icon next to patient name. Patient name is blurred out in above example.

c. Use this encounter to document post-procedure brief op note and discharge/send back to floor/place patient in post-procedure recovery. Options circled in above example.
ADDING BUTTONS TO YOUR TOP HORIZONTAL TOOLBAR

1. Top horizontal Epic toolbar is seen below. Follow these instructions if you want to add/subtract buttons from this toolbar.

2. Select the Epic dropdown menu and choose the last option “Modify this Menu”

3. Choosing “Modify this Menu” will get the following screen to open. Notice how the options bracketed in red mimic the top horizontal Epic toolbar.

   You can use your mouse to “grab and drag” these buttons around. You can drag options to and from the dropdown menu and rearrange the order of the buttons.

   Once you are satisfied with your shortcut options and order, click Accept. This will update your top horizontal toolbar to your preferences.
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4. If you need to add “My SmartPhrases” you can click the wrench (circled below, looks like this “

   ![Wrench Icon]

”) and open this modify menu that way.

   Click on “Rarely Used” → “Personalize” → “My SmartPhrases” and “grab and drag” this to the upper row and place wherever you wish.

   You can choose any tool from the menu on the left below to add to your horizontal toolbar.

   If there is a tool on the toolbar that you do not need on a regular basis, “grab and drag” it off the toolbar.

   Once you are happy with the selection and order of your buttons, click “Accept” and your top horizontal Epic toolbar will reflect the order of the buttons you just modified.

5. You can also use the search field at the top right of your Epic screen to search for My SmartPhrases.
MANAGING SMARTPHRASES

1. Choose “My SmartPhrases” from top horizontal Epic toolbar.

   Zoomed in the “My SmartPhrases” button looks like this:

2. If you do not see this button in your top horizontal Epic toolbar, follow steps in previous section entitled, “ADDING BUTTONS TO YOUR EPIC TOP HORIZONTAL TOOLBAR” to get this button to appear on your screen.
3. You will see this screen come up when you click “My SmartPhrases.” By selecting “User” (circled below) you can type in any name into the box (circled below) and see their list of SmartPhrases and copy them for your own use. You will see ones that you made and ones that the original owner shared with you.
4. If you are trying to build your list, type Dr. Bishop’s name into the User box.

5. You can single click on an individual SmartPhrase which will highlight it in blue with a thin dark blue box around the entire row. If you want to select multiple SmartPhrases to act on, hold down the shift button and use the down arrow to select a group of phrases (or the whole list) to act on.

6. Click “Add to My SmartPhrases” to get any selected SmartPhrase to show up on your personal list. It will seem like nothing happens when you click “Add to My SmartPhrases” but all the selected SmartPhrases will have been copied to your list. You can also add a SmartPhrase to your list by hovering and clicking the “ ” icon next to the ID number (circled below).
7. If you have a SmartPhrase and you want to share with someone else, you can click “Share With” (circled below). You can only share certain SmartPhrases. This is partly determined by the original owner and what preferences they selected.

8. This box will appear. You can type the name of the person you want to share with in the blank user box, in this case #2, and then check or uncheck the “can edit?” box. Click Accept when you are happy with your sharing options.
USING SMARTPHRASES

1. Open patient chart by clicking “Patient Lists” and start a new note by clicking “Notes” tab, then “New Note” as circled below. Use this method for inpatient charting.

Refer to sections in this manual entitled “PATIENT CHARTS IN EPIC” part #3 and “ORDERING PRE-PROCEDURE COVID TESTS” for ways to get to and use a blank note when using a Telephone Encounter.

Refer to “PATIENT CHARTS IN EPIC” part #6 about documenting in a Procedural Encounter.

2. In “My Note” window, where your blank note is, enter what type of note, i.e. progress note, consult note, plan of care, etc. If you choose consult as the type of note, you will be prompted with all pt’s active consults and you will check the box next to “IP Consult to Angio/IR” and your note will be attached to the consult and the consult will drop off the list.

Remember if you are planning to do a procedure you need to enter and approve an order and add patient to IR rounding list. Refer to “Inpatient consults” section of this manual for more detailed information.
3. There are two ways to add SmartPhrases to your notes. See a. and b. sections below for instructions on both ways.

   a. You can use dot phrases. For instance, all IR brief op-note templates (and many other IR templates) start with “.IR...” If you begin typing “.IR” in your blank note, a window with all options that start this way will popup. Notice in the snip below that “.ir” was typed in to a blank note box and a box popped up with a lot of template options to add to chart. You can select any template off the list by double-clicking to get it to populate in your note.
For a generic inpatient rounding note, you can use dot phrase “.inpt” and click enter. Double click “inptprogressjj” to use the note most often used for daily rounds.

For a generic brief op-note, you can use dot phrase “.jjirbriefprocedure note.”

Note, Dr. Bishop and Jenn are working to develop procedure-specific brief op notes that will be available for use that include important things for providers outside IR to look for after patient returns to floor. More to come on this...
Note will look like below and you can click F2 to scroll through the blank “***” areas that need to be filled in. Once all blanks have been filled in and your note is done. Click “Sign.”
b. The second way to use a SmartPhrase is to click the “?” icon to get the SmartPhrases window to open so you can select the template you want to use (circled below).
This will get the following window “SmartLink/Phrase Butler” to open with all your SmartPhrases. You can use the Search box to type in part of the SmartPhrase name or just scroll and choose one you need. Single click on the one you need. Use the buttons at the bottom of the screen to add the SmartPhrase to your note.

Preview will not add the SmartPhrase to your note but will show you what it will look like. Most of the time, clicking “Add and Close” (circled below) will be what you want to use to get SmartPhrase to populate in your blank note so you can use it.
USING SMARTLINKS

1. A SmartLink in Epic is a piece of dynamic code that enables a different message or text to display based on evaluation of certain criteria. In plain English, it is a way for you to pull in up-to-date lab data, imaging data, or add data from a medical calculator (i.e. MELD score) to a template you are using that does not already have the desired piece of data built-in.

   For example, you are evaluating a TIPS consult and want to add pt’s MELD score to your note. You can use a SmartLink to easily do that.

2. Use Steps 1-3 in the “Using SmartPhrases” section of this manual to open a new note and open the “SmartLink/Phrase Butler” window to open. In your note in progress have the cursor where you want to add the new data.

3. Now you want to use system-wide SmartPhrases and SmartLinks, so you need to check the following 3 boxes (circled below). Note, when you were using your SmartPhrases you only had to have the first box “My SmartPhrases” checked. Refer back to “Using SmartPhrases” section, step #4 of this manual.
4. As an example, type MELD into the search box. Only one option returned. Single click on MELDPELD and click “Preview” to bring up the window below. The SmartLink used pt’s most up-to-date labs to calculate the MELD. If you are happy with this, click OK. Then click “Add and Close.” This will get Epic to add all the text (in red box below) to the spot where your cursor is in your note.
5. The MELD has been added to your note. In this example, the MELD was added to a blank note. It can be added anywhere you place your cursor in the note you are working on.

My Note

Type: [ ]  Service: [Interventional Rs] [ ]

Date of Service: 3/2/2021 10:03 AM

☐ Cosign Required

MELD-Na score: 7 at 2/27/2021 7:47 PM
MELD score: 7 at 2/27/2021 7:47 PM
Calculated from:
Serum Creatinine: 0.92 mg/dL (Rounded to 1 mg/dL) at 2/27/2021 7:47 PM
Serum Sodium: 142 mmol/L (Rounded to 137 mmol/L) at 2/27/2021 7:47 PM
Total Bilirubin: 0.5 mg/dL (Rounded to 1 mg/dL) at 2/25/2021 7:39 PM
INR(ratio): 1.1 at 2/26/2021 5:06 AM
Age: 61 years 1 month
6. Some potentially useful SmartLinks are listed here.

### Allergies

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.alg</td>
<td>Summary of patient’s allergies</td>
</tr>
<tr>
<td>.algen</td>
<td>Patient’s allergies as of the current encounter, with last reviewed date</td>
</tr>
<tr>
<td>.algp</td>
<td>Patient’s allergies in prose format</td>
</tr>
<tr>
<td>.allergy</td>
<td>Patient’s allergies presented in a table</td>
</tr>
</tbody>
</table>

### Date and time

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.ed</td>
<td>Date of the current encounter</td>
</tr>
<tr>
<td>.fdate</td>
<td>Formal date</td>
</tr>
<tr>
<td>.now</td>
<td>Current time</td>
</tr>
<tr>
<td>.td</td>
<td>Today’s date</td>
</tr>
</tbody>
</table>

### Demographics

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.fname</td>
<td>Patient’s first name</td>
</tr>
<tr>
<td>.lname</td>
<td>Patient’s last name</td>
</tr>
<tr>
<td>.name</td>
<td>Patient’s full name</td>
</tr>
<tr>
<td>.age</td>
<td>Patient’s age as of today</td>
</tr>
<tr>
<td>.sex</td>
<td>Patient’s sex</td>
</tr>
<tr>
<td>.add</td>
<td>Patient’s full address</td>
</tr>
<tr>
<td>.dob</td>
<td>Patient’s date of birth</td>
</tr>
<tr>
<td>.ph</td>
<td>Patient’s phone numbers</td>
</tr>
<tr>
<td>.hph</td>
<td>Patient’s home phone number</td>
</tr>
</tbody>
</table>
## SmartLink Description

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.mob</td>
<td>Patient’s mobile/cell phone number</td>
</tr>
<tr>
<td>.wkph</td>
<td>Patient’s work phone number</td>
</tr>
<tr>
<td>.payer</td>
<td>Patient’s payor and plan information</td>
</tr>
<tr>
<td>.pcp</td>
<td>Patient’s primary care provider</td>
</tr>
<tr>
<td>.ss</td>
<td>Patient’s Social Security number</td>
</tr>
<tr>
<td>.mrn</td>
<td>Patient’s medical record number</td>
</tr>
</tbody>
</table>

## Diagnoses

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.diag</td>
<td>Encounter diagnoses, along with the orders associated with each diagnosis</td>
</tr>
<tr>
<td>.diagx</td>
<td>Abbreviated encounter diagnoses</td>
</tr>
</tbody>
</table>

## Future appointments

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.afutappt</td>
<td>A list of all future appointments. If no appointments exist, the following text appears: &quot;No future appointments.&quot;</td>
</tr>
</tbody>
</table>

## Generic reference to patient

These SmartLinks are useful for creating SmartPhrases and SmartTexts.

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.his</td>
<td>&quot;his&quot; or &quot;her&quot;</td>
</tr>
<tr>
<td>.caphis</td>
<td>&quot;His&quot; or &quot;Her&quot;</td>
</tr>
<tr>
<td>.he</td>
<td>&quot;he&quot; or &quot;she&quot;</td>
</tr>
<tr>
<td>.caphe</td>
<td>&quot;He&quot; or &quot;She&quot;</td>
</tr>
<tr>
<td>.him</td>
<td>&quot;him&quot; or &quot;her&quot;</td>
</tr>
<tr>
<td>.m</td>
<td>&quot;Mr.&quot; or &quot;Ms.&quot;</td>
</tr>
</tbody>
</table>
# History

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.alchx</td>
<td>Alcohol history</td>
</tr>
<tr>
<td>.alchxp</td>
<td>Alcohol history in prose format</td>
</tr>
<tr>
<td>.drughx</td>
<td>Drug history</td>
</tr>
<tr>
<td>.drughxp</td>
<td>Drug history in prose format</td>
</tr>
<tr>
<td>.famhx</td>
<td>Family history</td>
</tr>
<tr>
<td>.famhxp</td>
<td>Family history in prose format</td>
</tr>
</tbody>
</table>

# Medications

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.cmed</td>
<td>Current medications</td>
</tr>
<tr>
<td>.cmeds</td>
<td>Current medications displayed on a single line</td>
</tr>
<tr>
<td>.dcmed</td>
<td>Medications discontinued in this encounter</td>
</tr>
<tr>
<td>.encmed</td>
<td>Encounter medication list</td>
</tr>
<tr>
<td>.encmedp</td>
<td>Encounter medications in prose format</td>
</tr>
<tr>
<td>.med</td>
<td>Current medications that were ordered before the current encounter</td>
</tr>
<tr>
<td>.ltmed</td>
<td>Long-term medication information</td>
</tr>
<tr>
<td>.refill</td>
<td>Requested medications</td>
</tr>
</tbody>
</table>

# Visit information

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.cc</td>
<td>Chief complaint/reason for visit</td>
</tr>
<tr>
<td>.rv</td>
<td></td>
</tr>
<tr>
<td>.enotes</td>
<td>Nursing notes (exam notes) that have been filed</td>
</tr>
<tr>
<td>.pnotes</td>
<td>Visit progress notes</td>
</tr>
</tbody>
</table>

# Patient instructions

<table>
<thead>
<tr>
<th>SmartLink</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>.patinstr</td>
<td>Patient instructions from the encounter</td>
</tr>
</tbody>
</table>
MOBILE MEDIA CAPTURE

1. Use these directions to access Epic Earth to search for and watch a video about using your mobile device to use Haiku or Canto app to take a clinical image. If you follow the video instructions and take the clinical picture using Haiku/Canto, the image will not be saved to your personal device. It will be saved in Epic and you can use a desktop computer to add the picture to a note. It is a very useful tool.

2. On the top horizontal Epic tool bar, click the Earth icon. Zoomed in the icon looks like:

3. Little background on Epic Earth: it is a way for clinicians to get tips and insights about Epic functionality. Clinicians can collaborate across organizational boundries and get help from the bigger Epic user-base.

In the search box, type in “mobile media capture” as is circled below.
4. Select the video “It’s Possible...Mobile Media Capture” and watch the video (video is a few minutes long). If you can’t watch through the Epic Earth browser, choose the “Email me the link” button circled below and watch through your partners.org email link it will send you. Video is only a couple minutes and will walk you through steps of taking a clinical image once you are logged into Haiku/Canto and in a patient’s chart. Once you take an image, you can label/annotate the image in the mobile app, but you will need to in Epic on a desktop computer to add the picture to a patient note.
5. Refer to the following instructions for how to capture and review patient photos and media using **Canto** (source = Partners eCare, Epic Canto, User Guide, 2/21/2021)

### Capture and Review Patient Photos and Media

#### Update a patient’s photo

1. In the patient’s chart, tap the patient photo or camera icon in the upper-left corner of the screen.
2. Tap **Update ID Photo** and use the camera on your device to take a picture.
3. Tap **Use Photo** to save the photo to the Demographics activity in the chart.

#### Capture clinical images

1. In the Media Capture activity, tap **Capture Clinical Image** and use the camera on your device to take a picture.
2. Tap **Use Photo**, select a document type, such as **Annotation**, and enter a description.
3. Tap **Save and enter a comment and document type** to save the media to the chart. You can review media captures in the Media Manager or the Chart Review activity in Hyperspace.

#### Review clinical images and media

1. In the patient’s chart, tap **Media**.
2. Scroll through the list of media files or, to find a specific media file, search using information such as:
   
   - **Document type**
   - The user who imported the file
   - Keywords from the image’s description
   - The date the file was imported

3. Tap a photo or document to see a full-screen view, where you can zoom in and out or pan around the image.
6. Refer to the following instructions for how to capture and review patient photos and media using **Haiku** (source = Partners eCare, Haiku User Guide, Version 4)

### Capture Patient Photos and Media

You can update patient demographic photos and capture clinical images from the patient's chart in Haiku.

![Haiku interface screenshot](image)

#### Update a patient's photo

You can update a patient's demographic photo by taking her picture with your device.

1. In the patient's chart, tap the patient photo or camera icon in the upper-left corner of the screen. The Media Capture activity opens.
2. Tap **Take Patient Photo**.
3. Use the camera on your device to take a picture.
4. Tap **Use Photo** to save the photo to the Demographics activity in the chart.

#### Capture clinical images

1. In the Media Capture activity, tap **Take Clinical Image**.
2. Use the camera on your device to take a picture.
3. Tap **Use Photo**. The Media Properties screen appears.
4. Select a document type and enter a description.
5. Tap **Save** to save the media to the chart. You can review media captures in the Media Manager or the Chart Review activity in Hyperspace.
ADDING CLINICAL PICTURE TO A NOTE

1. Open a new note and click the icon “ ” (circled below)
2. This will open a window with all of patient’s clinical images, including any picture you recently took using your mobile Haiku/Canto app. Follow instructions in this manual section “Mobile Media Capture” to learn how to use Haiku/Canto to take clinical pictures.

3. Use “Thumbnail View” to see preview of images and easily select the image(s) you want to add to your note.
4. Single click on the image you want to add to your note and image will show up on the right in the “Selected images:” section as below, the “Post ear” picture was selected in the example below. Use the dropdown menu in the bottom right of the box to select what size you want. Medium (50% of page width) is a good size for progress notes. Click Accept. This will get the image to appear wherever your cursor is in your progress note.
5. Image in note is seen below. Image was added to a blank note in this example, but you can add image to any note or template by putting your cursor wherever in the note you want your image to appear.
ADDING ORDER SETS TO FAVORITES

1. Once in patient’s chart, click on Order tab, then “Order Sets.” Both are circled in red below.

2. Clicking on “Order Sets,” will get this box to open. If you do not see the order set that you need under your “Favorites” section in purple below, you need to search for it in the column on the right. Make sure “Order Sets” (circled in red below) is selected. You do NOT want “Manage Orders” selected.

3. As an example, we will add post-gastrostomy tube insertion order set to our favorites list. In the search bar circled in red above, type “IR gastrostomy” and press enter.
4. Right click on “IR Non Vascular Gastrostomy/Gastrojejunostomy Post Procedure” (circled in red below) and select “Add to Favorites.” This will get the order set to show up on your Favorites list so you can easily access it in future.

5. Sometimes you need an order that is not included in an order set. It can be useful to type “Drain care” or “Urinary drain care” or “Chest tube care” into a regular order (NOT order set) search box if you just need orders for nursing to manage tubes.

6. If you have no favorites and want to copy all of another provider’s or several order sets at once. Go to order section of a chart and then click “Order Sets” (circled below).

7. Type in “ir” to search box as below and press Enter.
8. This window will open. Any order set with “ir” in its title will show up on this list. You can type any user name into the search box (circled in red below) and see their favorites.

9. Here are Dr. Bishop’s saved order sets. You can right click on any one and select “Add to Favorites” so it will come up on your list when you open order sets. Note, many of the original order sets are under Dr. Neuman’s name. Searching by her name will give you a more inclusive list.
1. Click “Protocol Work List” circled in red below. If this button is not on your Epic top tool bar, select the left-upper corner Epic dropdown menu and find it off that menu. You can also follow instructions in section of this manual entitled, “ADDING BUTTONS TO YOUR EPIC TOP HORIZONTAL TOOLBAR” to get this button to appear on your screen.
2. Click to open Protocol Work List which will open a list of patients and procedures (as seen below) that have been ordered but not yet reviewed for approval. All the studies in the list below need to be reviewed for approval by a provider. You can easily tell this because there are no green check marks in the Rad Approved column (circled in red below).

Rarely, you will click on this list and it will be empty. This means there are no orders pending approval by provider or nursing.

To protocol a case, you need to change it from an “IR” procedure to a specific modality (FL, US, or CT) to make procedure “schedulable.” Cases with IR in the procedure title are NOT schedulable. There will be more on this in subsequent steps below.

Cases in IR need to be reviewed by a provider (MD or PA) and a nurse. Once both columns (Rad Approved and Nurse Approved) have green check marks, the scheduler will be able to schedule the case. Cases scheduled will automatically drop off the Protocol Work List.

Once provider reviews order and clicks “yes” in the bottom right box “Radiologist Approved” section, the green check mark will appear. You should also select a Sedation option.
3. In the Protocol Work List example below, there are two orders. Both orders have been approved by nursing because there is a green check mark in both RN Approved columns. Both orders still need to be approved by a provider because there is NOT green check mark in the Rad Approved column.

The “US Thyroid Biopsy” is all set to be approved by a provider because its modality (US) is specified in the Procedure title. The “IR Lumbar Puncture Diagnostic” order needs to be changed from IR to FL before it can be approved. If you leave it as IR, the schedulers will not be able to schedule this exam after it is approved.
4. The order example below is taken from the bottom left corner of the protocol work list screen (see entire screen snip can be seen in step #2 of this section). In the order example below, the “Ordering User” (circled in red) is Dr. Kaulbach. This means that Dr. Kaulbach personally entered the order into Epic and this is the original/source order.

If you see an IR scheduler name in this area, it means that the order was received another way (fax or mail) and was transcribed into Epic. Part of protocol process is reviewing the original order and making sure it was transcribed correctly. Ask scheduler for original order or look in Media Manager (off top horizontal Epic toolbar or Epic dropdown menu) for scanned order.

If you see the following IR schedulers names listed as the Ordering User, look for and review the original order: Louise M. Cyr, Brenda Maestre, Kathleen Sharib, or Vanessa Cabrera.

![Protocol Report](image-url)
5. Before you click buttons to approve a case, you need to make sure order is in correct format so our schedulers will be able to drag it onto Snapboard (the IR schedule).

Cases need to have FL, US, or CT in front of them to be “schedulable.” They cannot have IR in front of the case. The example below with red arrow is NOT schedulable, because it says “IR” in front of the procedure and needs to be changed.

6. To change order from IR Head/Neck Thyroid Nodule Aspiration/Biopsy, single click on order to get it highlighted in blue (like above). Then click “Change Order” circled in red below.
7. Clicking “Change Order” will get below window to open. In the Procedure box, type “US thyroid” and press enter.

8. Typing “US thyroid” and pressing enter will get the below window to open. Single click an US option that works (either in this case) and click Accept. If you do not see an acceptable procedure, you might need to click the “Facility List” tab in the top right corner to see more options.
9. Single click US Thyroid Aspiration/FNA and then click Accept.
10. This will change the order to appear as below. Note the new hard stop that needs to be filled out, seen circled in red below. If “North Shore Medical Center” is not an option for the question, “Exam to be performed at” – you NEED to choose a different Procedure (even if it’s not a perfect match for what you’re doing).

If you continue, the procedure will NOT be visible to our NSMC schedulers to book the procedure and it will get “lost.” “Lost” in quotes because we will still be able to find it but will need to know patient name, MRN, DOB (which we will not have unless you used pen/paper and wrote it down or remember it and tell us). The order will fall off NSMC scheduling lists so will very easily get lost.

11. Sometimes there just is not a perfect option and you have to select one similar and write in your protocol comments what the actual procedure needs to be. Only certain procedures are “allowed” to be scheduled at NSMC. For example, there is no FL Nephrostogram order. If you need to do a nephrostogram, just pick FL Nephrostomy Rescue or Exchange and the laterality and write in your order comments the specifics of the planned procedure.
12. Once you fill out hard stops and click Accept, you will be taken back to this screen and your approval buttons.

13. If you simply approve, put your initials and the date in the “Comments” section circled above. You can click “Finalize” if nursing has already checked off and approved this section. Note that this comment section cannot be edited once order is finalized, so do not use this section to communicate with the team. The team will not be able to answer in this section and scheduler will not know if the case is OK to schedule.

14. Procedures approved by both provider and RN can be “Finalized” (as described above). By finalizing, the order will automatically drop off the Protocol Work List and our schedulers will have green light to book.
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15. If there is info pending or info that needs to be edited and is waiting for response from a message sent to an ordering provider, choose the “Route protocol to” option and select “NSM IR planning” as circled below. This will get order to stay on the Protocol Work List until unresolved issues get answers/requested imaging is received/etc.
16. Once you route the order back to the Protocol Work List, use the “Order Notes” section (circled in red below) to add notes to communicate with the IR team. Examples include: Please book consult first; Messaging ordering MD about other possible target and awaiting response.

When the follow-up action is taken, this “Order Notes” section (circled in red below) can be updated by anyone (unlike the order comments section). Once note is updated, go back and update note with your initials and date, so everyone knows who to direct questions to if they arise. Steps #18 and 19 of this section will have more information about writing/editing order notes.

Nursing will initial this “Order Notes” area if they have reviewed the order BEFORE a provider changed the order to the correct modality. If a nurse or a provider approves an order while it still says “IR” instead of the correct “US,” “CT,” or “FL” modality then the approval will be automatically deleted. Nursing initialing this area is their way of knowing they already reviewed an order and it’s just waiting for provider review, change to correct modality, and approve.
17. Going back to the example below, note how the order changed to “US Thyroid Gland (Order 782628925)” from the original “IR Head/Neck Thyroid Aspiration/Biopsy (No Catheter)”

18. If you need to add notes to an order, go to Protocol Work List. Use the “Order Notes” section (in red box below) to add/modify notes. IR uses this area to keep track of procedure specifics and communication about order because it can be modified after the order has been approved and when order is already on schedule. This was discussed in more detail in step #16 above.
19. To add/modify a note, right click on an order and select “Notes” off the menu. That will bring up this window. Click the little pencil icon (circled below) to edit a note.

```
2/23 zoom call 2/25 at 1:30pm patient HOH. 2/23- Tsai agreed not surg candidate.
```
INPATIENT CONSULTS

1. Click “Patient Lists” on top horizontal Epic toolbar. If you do not have that button, use the top left Epic dropdown menu to find “Patient Lists.”

2. Select “Interventional Radiology Consult SH” as circled in red below. List may be empty. In example below, there is one new inpatient consult that needs to be addressed.

3. If you do not have “Interventional Radiology Consult SH” as an option under the upper “My Lists” section, use the lower “Available Lists” section to find it. Expand the “NSM SH Entity” → “Interventional Radiology” → “Interventional Radiology Consult SH”
4. Once you find the list via “Available Lists,” you can right click and add the desired list to “My Lists” so they will be easily available from the upper part of the patient list screen with the “My Lists” section.
5. Double click on patient name and information on consult list to open their inpatient chart.
6. Click “Notes” tab

7. Open new note and for the new note “Type” choose “Consults.” Click the small box next to “IP Consult to Angio/IR” and write/sign your note. Remember you can use your templates. By labeling a note as “Consult,” it will get the patient’s name to drop off the “Interventional Radiology Consult SH” list. All this means is the consult was addressed.

8. If you plan to do a procedure, you will need to ENTER AND SIGN AN ORDER, then protocol and approve the case as described in the “Protociling Exams” section of this Manual.

9. If procedure is to be done or you want patient followed by IR, make sure to add patient to the “Rounding SH” list. See the next section of this manual entitled “Managing Inpatient Lists” for information on how to add patient to list.
10. When you’ve successfully created a consult note, it will look like the following note. Notice how the note is labeled as “Consults” and the consult order is linked in the top part of the note (areas circled in red).
MANAGING INPATIENT LISTS

1. There are two main patient lists that we monitor in IR: the rounding list and the consult list. In order to find and favorite the lists, do the following: Click “Patient Lists” on top horizontal Epic toolbar. If you do not have that button, use the top left Epic dropdown menu to find “Patient Lists.”

2. This window will open. Click arrow next to “My patients” (circled below) to expand this list.
3. Expanded list will look like this. Single click “Rounding SH” for the shared rounding list or click “Interventional Radiology Consult SH” to check for any new, unaddressed IR consults. Consult list should be checked frequently and list should be empty – meaning all consults should be addressed. This is especially true on weekends. See separate section “Inpatient Consults” of this Manual for much more information on this.
4. Dr. Bishop created a Shared Patient List that acts as an alternative to the rounding list but is more user- and printer-friendly. It automatically updates when any IR provider add/removes a patient from the “Rounding SH” list. Likewise, if you add/remove a patient from Dr. Bishop’s shared list, the “Rounding SH” list will automatically update. To access this list, click the arrow next to “Shared Patient Lists” and select “IR Rounding pb.” In the example below, there are 10 patients currently on the list.

**Patient Lists**

- Edit List
- Wrap Text
- Rounding Report

**My Lists**

- ☎ IO Follow-up
- ☎ IR Outpatient Drains
- ☎ My patients
- ☎ My Unit
- ★ My Favorite Lists

**Shared Patient Lists**

- ☎ Chronic Liver-TIPS?
- ☎ IR Rounding pb
  - 10
- ☎ TIPS_PHTN

**Shared Reminder Lists**
5. The “IR Rounding pb” list includes columns with information that is relevant to IR and is useful when rounding. To print this list, click “Rounding Report” (circled below).

Clicking rounding report, will get this “Patient Report Print” window to open. Select a local printer and print your report.
6. Be aware that Admitting has different options for how to classify a patient. Some options are confidential, anonymous, or employee. Depending on how a patient is classified, their name may or may not show up on a printed rounding list. Also depending on their classification, you may need to “Break the Glass” when you enter their chart by documenting your reason for accessing the chart and typing in your Epic password.

Sometimes a patient is on the rounding list, but their actual name appears as “**********.” These are things to keep in mind if you suspect your list is missing a patient or you are having trouble finding an inpatient.
7. To update the Action Plan/To-Do, which IR usually does daily or when signing out for weekend or to someone else, single click on a patient row to get row to highlight in blue.

8. Then expand the right box by clicking the arrow circled above which will get the right side of the screen to open. You can modify the Action Plan/To-Do box (circled in red below) and click “Close” when you are done editing.

In the upper red circled area below, make sure you are documenting under “Interventional Radiology General.” There are multiple lists that sound like they could belong to IR, but your team members will not be able to see your notes if you document under the wrong list.
9. To add a patient to the rounding list, type at least 3 letters of patient name or MRN into search box (circled below). This search box is ONLY searching from the pool of admitted patients at Salem Hospital, so usually entering only 3 or 4 letters will result in finding your desired patient.

10. When patient comes up, right click and select “Assign Teams” and the following box will come up.
11. You can search by ID number (type “391” and press enter) or type in interventional radiology and select the correct list (in red box below). By clicking “Accept” patient will now be on the “Rounding SH” list. Pt will also be on Dr. Bishop’s shared list “IR Rounding pb.”
12. To remove a patient from the rounding list, from the patient list view, right click on patient you wish to remove from list and select “Remove Teams” and the following window will come up. Single click on NSM SH Interventional Radiol... and click Accept. Patient’s name will no longer appear on “Rounding SH” list or “IR Rounding pb” list.

Patients will automatically be removed from rounding lists if they are discharged.
DISCHARGES

1. Through “Patient Lists” and, most likely, the “Rounding SH” list, find the admitted patient you wish to discharge (circled in red below). If patient is not on the rounding list, use the search box (red star below) to find patient and open inpatient chart that way.

   Double click on patient name/row to open their inpatient chart.

2. Once in patient’s chart, click “Inpatient Tools” tab, then click “Discharge” on secondary row of tabs. Both circled in red below. If you do not have the “Inpatient Tools” tab, see the next step.
3. If you do not have the "Inpatient Tools" tab, use the down arrow drop-down menu to find and select. Arrow is circled in red below.
4. Click “D/C Order Rec” in the second column from left. This will allow you to reconcile medications for discharge. Circled below.
5. Acknowledge sections in horizontal tool bar under “Discharge” in example below. Click through steps 0. Review Home Medications, 1. Review Orders for Discharge, and 2. Order sets (circled in red below). The order box on the right of the screen below will show orders that are good to go in GREEN and orders that need to be addressed in RED. The example below has all green orders so everything is good to go. Note, this is different from the green “prescribed” and red “not prescribed” inpatient medication seen below.

Use this section to start, stop, continue, and/or modify patient’s discharge/home medications.

Note that you also need to have the actual “Discharge Patient” order in this section (red arrow to right of screen in image below). You can open that order to modify the order to include home with services, home with hospice, etc. as needed.

Once your orders column has all green, click “Sign” in bottom right corner.

6. Once orders are signed, click “Finalize DC sum” in the second column from left (see next image). This will pull in the “Physician Discharge Summary” seen on the right in the example below. Fill out the note and sign.

You will not be able to do the DC summary until you reconcile your orders because the DC summary pulls in the medication orders from the previous steps.
Once you sign/finalize your DC summary, you should be all set.
E-PRESCRIPTIONS

Note, at the end of this section there is additional information about how to e-prescribe. Section includes: (A) using MassPAT to check for patient’s other controlled substance prescriptions, (B) checking and/or changing patient’s preferred pharmacy for e-prescribing, and (C) RSA Token.

1. Use e-prescriptions for outpatients or same-day procedure patients being discharged.
2. Use “Orders Only” button.

3. If “Orders Only” is not visible on your top tool bar, use the “>>” to find “Orders Only” in the drop down menu.
4. Once you find your patient using MRN or recent patient options, select “+ Add Order” at the bottom of the screen. Circled in red below.
5. Clicking “+ Add order” will get this text box to come up. Type name of medication into box and press Enter.

6. You will get this screen.

7. If you do not see what you are looking for, or only IV form is coming up and you need PO, you can try clicking different tabs in the upper right corner. In the above example, the box defaults to “Preference List” tab, but “Facility List” tab might have what you need (circled in red in image above).
8. When searching for a medication, you may also see a screen like the one picture below. Note the different sections entitled “After Visit Medications” with a HOUSE icon before the words and “During Visit Medications” with a BED icon before the words (circled in red below).

When prescribing medication for an outpatient, you always want to choose an option from the “After Visit Medications” section with the house icon. The “During Visit Medications” with the bed icon is for inpatient ordering. This example discusses ordering medications, but this same HOUSE icon and BED icon concept holds true when ordering imaging and procedures.

If you type in a medication name and you see the following screen, you may need to click the double arrow icon to get a section to expand (circled in red below).
9. Per MA law, to prescribe any controlled substance, you will need to check MassPAT (See additional Note A at end of this section) and mark in the BestPractice Advisory window that it was reviewed. May be easiest to “Mark as Reviewed” in the window and then check MassPAT right after this step but before finalizing the order.
10. After checking MassPAT, return to your Epic order. Click on order in right column to open order box and fill out specifics and all hard-stops. Where it says {PARTIAL FILL:25207}, you need to write something. For example, “Partial fill OK” or “Partial fill not OK.”
11. Note “Class” in the above order: Epic will default to “Normal” selected which means it will electronically-prescribe this order and send it directly to patient’s preferred pharmacy (see additional info Note B at end of this section to check and/or change preferred pharmacy).

   If you want to give patient a hard copy, select “Print” and it should print to a local printer. It can be hard to find where your Rx printed. You might need to use a printer in PACU or on patient’s floor to be sure you know what printer will print. You can use Jenn’s computer in IR2 control room which will usually print to the printer next to Abbey’s desk. You will need to sign the hard copy before giving it to patient.

   All controlled substances in MA need to be sent electronically, so utilize the print option only for NON-controlled substance prescriptions.

12. Once you fill out prescription details, click accept. Check that patient’s preferred pharmacy is correct (see Note B at end of this section to check and/or change preferred pharmacy) and sign your order.

13. Once you sign your order, Epic will ask you to enter your Epic password and then your RSA token. See “E-PRESCRIPTIONS, Note C: RSA Token” for more information about this.
E-PRESCRIPTIONS

Additional Note A: Checking MassPAT when prescribing controlled substances

1. In the top right corner of Epic screen, select the double-arrows icon as seen circled in red below:

2. From the double-arrows dropdown menu, hover over “Resources” which will open another drop-down menu. From the last drop-down menu, select “MassPAT Web Portal.” This will open the MassPAT in a browser window as seen below. Enter (or create an account and then enter) your email and password.
3. Once signed in, the home page will show recent searches. Select “Rx Search – Patient Request” as circled in red below to start a new search.
4. Enter patient first and last name and DOB to start search. You can leave the “Prescription Fill Dates” section to the default. You also do not need to click any States. Just enter first and last name and DOB and click the green “Search” button.
5. If you get this warning, you check that you entered name/DOB correctly. You may have entered everything correctly and patient just might not have any record of controlled substance prescriptions.

6. If patient has had recent controlled substances prescribed, review to make sure you are not giving duplicates or too many.
E-PRESCRIPTIONS

Additional Note B: Checking and changing patient’s preferred pharmacy

1. At the bottom right of Epic screen orders screen, above where you sign orders, you will see patient’s preferred pharmacy. Circled in red below. If you are e-prescribing a medication (by selecting “Normal” in the prescribing instructions above), the prescription will be sent to whatever pharmacy is listed here. Sometimes, it will be a non-local/mail order pharmacy. Vast majority of time that IR is prescribing, medication needs to be sent to a local pharmacy for same-day pick-up.
2. If pharmacy listed needs to be changed, click on the blue pharmacy hypertext link and it will open the following box with patient’s “suggested” pharmacies. Whatever pharmacy has yellow star next to it will show up as patient’s preferred pharmacy at the bottom of the order column. You might need to add a pharmacy using the search tool or just switch star from pharmacies already on suggested list. Click accept to go back to order page and then sign your order.
E-PRESCRIPTIONS

Additional Note C: RSA Token

1. Your MGB password and the RSA Token are part of a 2-step verification process needed for you to sign prescriptions for controlled substances.
2. RSA Token is an app you must have installed on your smartphone. You must also have MobileIron installed on your smartphone.
3. The RSA Token needs to be installed and activated by the RSA team at MGB for it to work. Once activated, the RSA app will continuously display 6 digits that change every 60 seconds.
4. When you are ready to sign a controlled substance order, Epic will prompt you for your MGB password and then for the RSA token. You will go to your app and enter the 6-digit code into Epic to sign your prescription.
5. If you do not have MobileIron or RSA Token on your smartphone or you need RSA Token activated by MGB, please contact Christine Lyman (CMLYMAN@PARTNERS.ORG) for assistance.
ORDERING PRE-PROCEDURE COVID TESTS

1. Open Telephone encounter by clicking on “Telephone Call” shortcut or going to Epic dropdown menu, Encounter, find patient, select “New” and then “Telephone” as type of encounter.

2. In the “Contacts” section, choose outgoing call and call patient.
3. In the “Reason for Call” section, add “Covid-19 Inquiry” and click “Next” to get it to accept your answer.
4. In the “COVID-19 Triage” section, ask patient about symptoms and [most likely] answer will be “None.” If they are having symptoms, you will get to a different set of screens and will get “Cov-Risk” added to pt’s chart and enact Enhanced Respiratory Isolation for patient when the come to hospital. At that point, check priority level of case, does it need to be done anyway, etc. **Note:** adding Cov-Risk to patient’s chart will also result in all future outpatient appointments being cancelled.
5. Select “Order COVID-19 PCR testing” and click “Next.”

6. Clicking “Next” will get BestPractice to highlight in yellow. Click it.
7. Leave default buttons selected and click “Accept.”

8. Select “All Testing Locations...”
9. Fill out order and be sure to select the correct “Date of Procedure” so testing clinic knows to have pt tested within 72 hours.
10. If patient needs a home COVID test, write in in the comment section of the order to please arrange home test. Generally, this needs to be ordered with at least 48 hours prior to procedure to allow clinic to arrange for ambulance, perform test, and get result.

11. Click “Accept” and sign your order.

12. Click on “Note” section and click “COVID-19 Triage” which will get note to auto-populate your responses from the Triage symptom buttons. All you need to do here is write anything on a note. It is just to satisfy Epic’s requirement that a note is written when you go to sign the encounter. If the Triage one is not working, just “Create Note” and write one sentence.

13. Sign Encounter. Epic will alert you if it cannot close the encounter and you can add whatever is missing.