

Go! Guide: The Orders Tab in the EHR

Introduction

The Orders tab in the EHR is where all members of the healthcare team find orders, or instructions, to care for, diagnose, and treat each patient. State, local, and professional guidelines determine who can enter and complete orders in a patient chart. Typically, orders are entered by provider-level professionals such as medical doctors, nurse practitioners, and physician assistants. Other healthcare professionals may be able to enter orders on behalf of a provider if they are called-in or cosigned by a provider after they are entered. In Neehr Perfect Go!, all users can modify orders and enter new orders into a chart for educational purposes.

There are different types, or categories, of orders in a chart including: Care, Procedures, Consults, Therapy, Scheduling, Location, Medications, Diet, Laboratory, and more. Orders are categorized in the chart to make it easy for members of the healthcare team to find the orders they are responsible for when caring for the patient. For example, a nurse may focus on the Care, Diet, and Scheduled Medication orders when making their rounds to patients in a hospital setting, whereas a physical therapist will look for the Therapy orders. As a healthcare professional, it is important to always review all patient orders for a holistic view of the patient's treatment and ensure there aren't any potential conflicts.

In practice, you may hear the term Computerized Provider Order Entry (CPOE) which refers to electronic order entry (versus paper charting) in a certified EHR system. Certified EHRs have built-in error checking to improve patient safety. For example, new medication orders are checked with the patient's allergies and other existing medications to ensure there aren't risks. Overall, EHRs reduce errors by providing up-to-date patient information and visibility to the whole team with each visit.

Additional resources

Please refer to the *Student Guide to Neehr Perfect Go!* for information on logging in to Go! and launching the EHR for an activity. Refer to the *Go! Guide: Completing and Submitting Work* for information on submitting your work in the EHR to your instructor.

FAQs about orders

1. Can I delete an order from a chart?

a. Yes, if you originally added the order to the chart, you may delete the order, if necessary. See *Accessing Orders in the EHR section* to learn more about actions such as delete. If you did not add the order, you may not delete the order, but you can change the status of the order to 'Discontinued'. See *Editing an Order* section to learn more.

2. How does my instructor review the orders I've added?

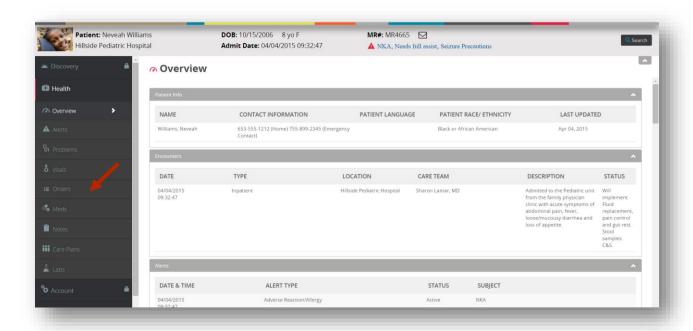
a. All changes you make to the chart in each EHR session are tracked in the session Progress Report. After completing all of your work in the EHR, select Close



Session then go to Download Work for the activity. Select **Download** for your desired EHR session and submit the PDF document to your instructor.

Accessing orders in the EHR

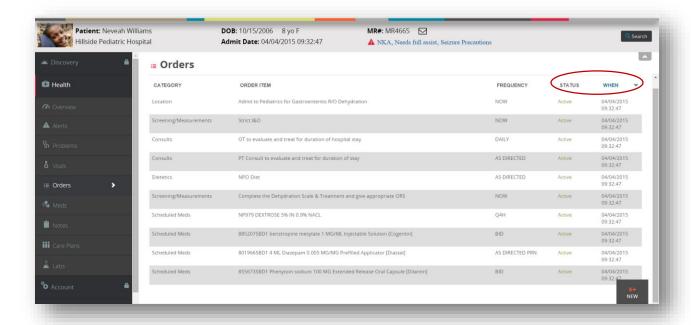
After launching the EHR for any patient chart, select the Orders tab on the left side of the screen:



The order summary view shown below includes all orders in a table view with columns for the Category, Order Item, Frequency, Status, and When (the date/time the order was entered in the chart).

By default, the list is sorted by the 'When' column with the most recent order at the top. You can tell the sort order because 'When' appears in blue and has an arrow pointing down, indicating a descending order.



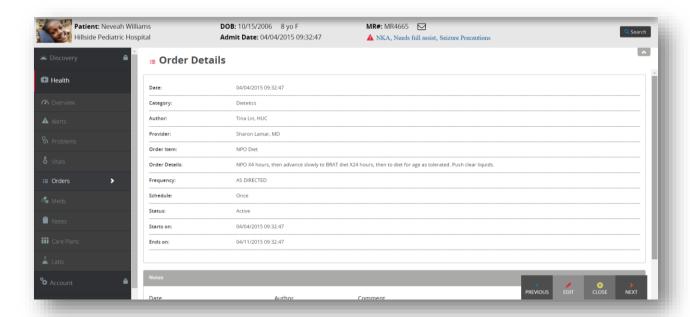


You may sort via any of the columns by clicking on the heading then the arrow that appears next to it.



Click on any order item in the listing to access the order details:





The order details view includes the same information as found in the orders summary with the addition of an Order Details, Schedule, End date, Author, Provider, and optional Notes section for comments and/or attachments. For medication orders, the details also provides more information about the route and quantity. It is important to review the details of each order before completing it with the patient.

From this details view, you may select from the following menu options found in the bottom, right corner of the screen:

Previous: Brings you to the previous order in the list if you're not already looking at the first order.

Delete: This option will appear only for orders that you have entered allowing you to completely remove the order listing. **Warning:** Deleting the order completely removes it from the chart and it cannot be recovered.

Administer: This option only appears for scheduled medication orders. See separate guide on medication administration.

Edit: Allows you to modify an existing order. See next section on *Editing an Order* for more information.

Close: Exits the details view of the specific order and returns to the summary list.

Next: Brings you to the next order in the list if you're not already looking at the last problem.



Editing an order

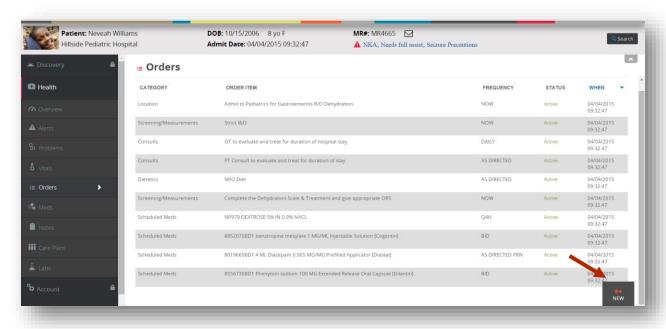
You may edit an existing order in the order details view, i.e. after selecting it from the summary list. Click on the **Edit** button in the lower right corner of the screen to edit the order. Orders may not be edited if they have a status of Complete.

Most often, an existing order is edited to update the status to keep the order list up-to-date. You may edit an order to modify any of the existing field entries and/or add a new comment to the order. Note: It is not possible to edit existing comments.

For more information about the order fields, please see the *Writing a New Order* section below. After making edits to the order, select **Save**. The order edits are only applied to your instance of the chart and no other users will see your changes. Order edits are tracked in the Progress Report which can be submitted to your instructor for review. The Progress Report is found under Download Work (see separate *Go! Guide to Completing and Submitting your Work*).

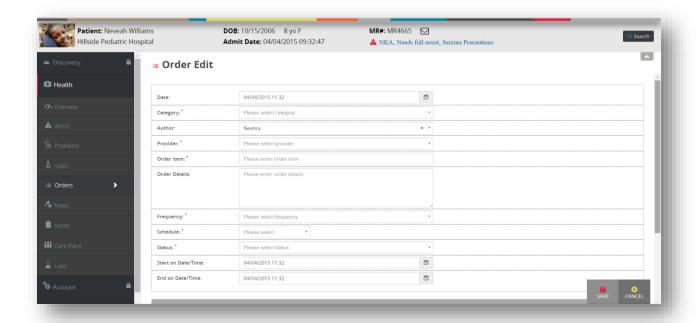
Entering a new (non-medication) order

After selecting the Orders tab in any patient chart, select **New** in the bottom-right corner to author a new order in the chart.



The following Order entry screen will appear:





If you would like to exit the new order without saving your work, select **Cancel** in the bottom right corner of the screen.

Otherwise, for all non-medication orders, complete the following sections, then select **Save.**

Keep in mind, as long as the order isn't marked with a status of completed, you can delete or edit and continue your order at a later time (see *Editing an Order* section).

Date: This field reflects the date the order was entered in the chart. The current date will populate by default or another date may be entered. The start and end date of the order is documented separately, see **Start on Date/Time** and **End on Date/Time**.

Category: Select the type of order being entered from the pre-defined list. Some of the order categories include Prescriptions (outpatient meds), Scheduled Meds (inpatient meds), Laboratory, Procedures, Care, etc.

**If Prescription or Scheduled Medication category is chosen, some of the order entry fields will be different from what is described in this section. Please see next sections.

Author: This field is intended to reflect the person who entered the order in the chart. This field will default to you or the user entering the order. You may also select one of the pre-defined providers from the list. The author may be different than the provider who may have called-in the order or is otherwise responsible for reviewing the patient's orders, see **Provider** field.

Provider: A licensed provider must be selected as the responsible party for any new order. Select any of the pre-defined provider options from the list.



Order Item: Enter a short text description of the order here. Refer to your training on accurate and meaningful order entry. Some examples include: "NPO Diet", "Strict I&O", "XRay of the head", "CBC", and "Physical Therapy".

Order Details: Enter all information for the intended healthcare professional responsible of the order here. Refer to your training on meaningful order entry and ensure the healthcare professional completing the order has all of the information they need to do so accurately and efficiently.

Frequency: Select a standard frequency for when the order should be conducted for the patient. Pre-defined options are provided including: As Directed, Now, Once, Daily, Q4H, etc. Refer to a medical terminology guide if you're unsure which frequency to select.

Schedule: Select *how often* the order should be conducted. Pre-defined options are provided including: Once, Hourly, Daily, Weekly, etc.

Status: Select from one of the following options:

Expired: The Stop Date of the order has been reached and the order is no longer valid.

Discontinued: The order is no longer applicable and should no longer be completed.

Complete: This order was fulfilled and is no longer active.

Changed: This order has been modified from its original form.

Active: This order is active and should be completed per the ordered schedule.

Pending: This order is waiting for more information or other action from a member of the healthcare team before becoming active.

Unsigned: This order is waiting for the provider to review and sign before becoming active.

On Hold: This order is temporarily on hold and may become active again in the future.

Start Date/Time: Enter the date and time the order should take effect. By default, the current date/time will populate as most orders will begin right away.

End Date/Time: Determine how long the order should last and enter the end date and time accordingly. By default, the current date/time will populate and should be adjusted to a longer period so the order remains active. Be sure to choose an End on Date/Time that allows for the order to be completed before it automatically expires.



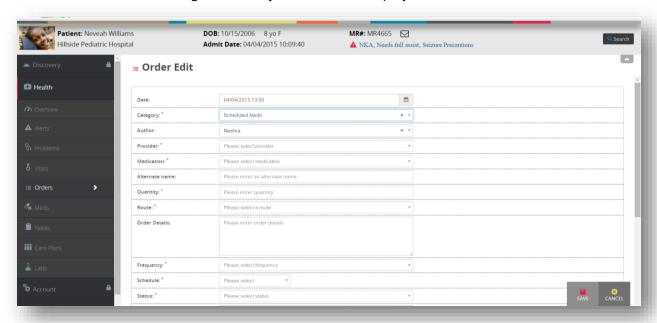
Notes: This section allows the author to make additional free-text comments about the order and/or add an attachment. Multiple notes may be added. Notes and photos may also be used to document the progress of an order over time. For example, add photos and descriptions of a wound or lesion to document healing progress.

After completing the required fields (indicated with *) and selecting **Save**, the new or updated orders will be added to your instance of the patient chart. No other users will see these changes in the patient chart since all users have their own, private instance of the chart.

The Progress Report for this EHR session will be updated with the new or edited orders and you may submit the report to your instructor when you have completed the assignment. If you make edits to the orders in future work on this EHR session, the Progress Report will be updated accordingly.

Entering a scheduled meds order

Scheduled medications are a type of medication that the patient will receive as an inpatient while admitted to the hospital or being seen in the clinic. If an order category of Scheduled Meds is selected, the following order entry fields will be displayed:



Please refer to the previous section on information about the Date, Category, Author, Provider, Status, Start on and End on fields. The fields described below are unique to the Scheduled Medication order category.

Medication: Here you will select your drug from the Go! formulary, which is based on the National Drug File. Begin typing the name of the drug (either brand name or generic) in this



field. Matching options will appear. The more you type, the narrower the results. Be sure to spell the drug name correctly. Select the appropriate medication from the list.

Alternate Name: Manually type any alternate name(s) for the medication selected above. An example might be an order for aspirin. Aspirin is also sometimes referred to in practice as ASA. ASA is the Alternate Name.

Quantity: Enter the amount the patient should receive with each dose. Be sure to include units of measure (i.e. MG).

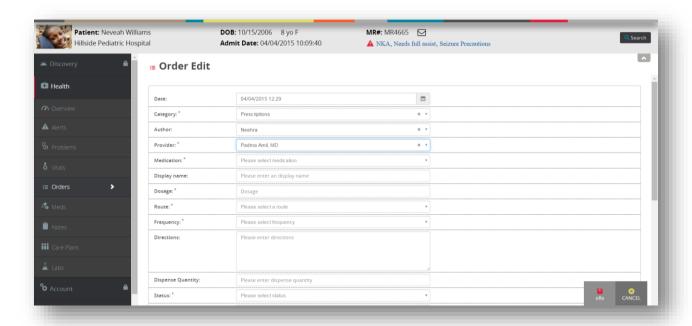
Route: Select how the drug is administered from the pre-defined list. For example, if the drug is taken orally, select 'By mouth (PO)'.

Frequency: Select a standard frequency for when the order should be conducted for the patient. Pre-defined options are provided, including: As Directed, Now, Once, Daily, Q4H, etc. Refer to a medical terminology guide if you're unsure which frequency to select.

Schedule: Select *how often* the order should be conducted. Pre-defined options are provided including: Once, Hourly, Daily, Weekly, etc.

Entering a prescription order

Prescriptions are medications the patient will typically administer themselves and should receive as an outpatient. If an order category of Prescription is selected, the following order entry fields will be displayed:





Please refer to the *Entering a new (non-medication) order* section on information about the Date, Category, Author, Provider, Status, Start on and End on fields. The fields described below are unique to the Prescription order category.

Medication: Select the drug from the Go! formulary, which is based on the National Drug File. Begin typing the name of the drug (either brand name or generic) in this field and matching options will appear. The more you type, the narrower the results. Be sure to spell the drug name correctly!

Display Name: Manually type how you would like medication name to be displayed on the prescription.

Dosage: Enter the amount the patient should receive with each dose. Be sure to include units of measure (i.e. MG).

Route: Select how the drug is administered from the pre-defined list. For example, if the drug is taken orally, select 'By mouth (PO)'.

Frequency: Select how often the patient should take or be given the medication from the predefined list. Consult a medical terminology guide if you're unsure which schedule to select.

Directions: Also known as "SIG," which is medical shorthand for "Signa", which in Latin literally means, "write". In simple English, it basically means, "Please write these instructions for taking the medication." Add information for the patient regarding how the medication should be administered in plain English.

Dispense Quantity: Enter the amount the pharmacist should dispense to fulfill the order.

Days Supply: Enter the number of days this prescription should be valid for so the pharmacist can ensure the correct quantity is provided.

Refills: Check this box if refills are authorized. Leave it unchecked if the patient cannot have a refill of the medication. If refills are allowed, enter the number of refills that are authorized under this prescription.

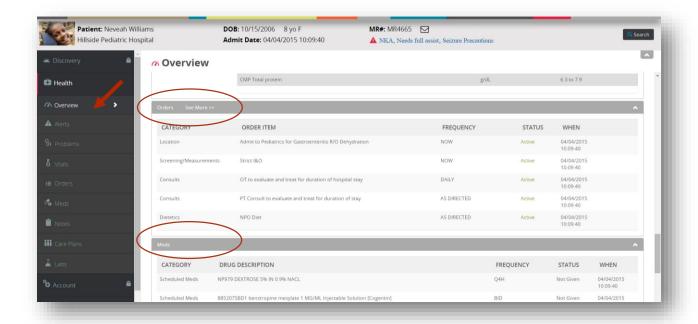
Substitution Allowed: Can the pharmacist choose a different drug (i.e. the generic version) to fulfill the order? Select Yes or No.

After completing the prescription order, select **eRX** to save the order and submit it electronically to the simulated pharmacy. This prescription is now an order in the patient's EHR. The prescription order will not appear on the Meds tab, which is covered in the *Go! Guide to the Meds Tab*, because prescriptions are typically not administered in the hospital or clinic.



Orders on the Overview tab

The Overview tab of the patient chart also includes the summary view of up to five of the orders. Scheduled medication orders, i.e. medications that will be administered in the hospital or clinic, are listed separately so they are easily viewed:



It is not possible to edit orders or create a new order for an order from the Overview tab. If there are more than five orders in the patient chart, you may select **See More** to be brought to the Orders tab to see the full list of problems or to edit or add new orders.