EMHS Clinical Informatics

Presents

Using PowerChart: Admission History PowerForms

In this eCourse we will look at Sub-forms or Conditional Sections, Allergies, Vaccination Screening, Using Grid Fields....

Problem History, Procedure History, Family History...

Medications at Home, Social History...

Completing the form, and Return to Care Compass.

Sub-Forms/Conditional Sections

As with the Basic Admission Info PowerForm, you will want to **click** the number in the Activities column to access the Admission History PowerForm task.

Click to highlight the Admission History task.

And then **click** Document.

As you can see, the Admission History PowerForms contain many sections. You may adjust the width of the navigator if desired.

Let's take a look at a few different types of data entry fields that we did not encounter in the Basic Admission Info PowerForm.

First, like many PowerForms, this form contains freetext fields. The Chief Complaint field, for example, is highlighted on-screen.

You may simply **click** with your mouse or use the TAB key on your keyboard to place the cursor in the field and then start typing. These fields can handle approximately 200 characters.

This PowerForm contains a sub-form or conditional section. If you look at the navigator, notice that the Interpreter Services section is dithered (grayed out).

As with contingent fields, conditional sections will only become available for charting if a certain response is entered.

Note how the section does not open when **click**ed.

The field to which the conditional section is tied is located near the bottom of the General Admission Information section.

When a language other than English is selected for the patient's Primary Language, the Interpreter Services sub-form will open.

Conditional sections will open as pop-up windows. Enter the pertinent information into the fields and then **click** the Return arrow icon in the upper left corner of the pop-up window.

Once the conditional section has been activated, it can be accessed in the navigator.

Click to access the sections in the navigator and enter patient data into all applicable fields.

Be sure to use the scroll bars.

Take heed of all required fields. These must be completed in order to successfully complete the task on Care Compass.

When you encounter grid fields like this one, it may be helpful to know that you can **click** the header of a column to answer all grid items at once.

If there is an item (or items) needing a different answer, you can then make that selection.

There will be sections in some PowerForms that are not applicable to all patients. This section is only pertinent to Post Partum patients.

The Admission History PowerForms contain sections that allow nurses to screen for certain vaccinations. These are important sections and should not be skipped.

The red and blue text contain instructions and helpful information.

The Influenza Vaccine Screening section requires that you review the patient's allergies. You may also remember that before the physician, APN, or PA can enter orders, the allergies must be entered.

Let's take a look at the Allergies section before we proceed any further in this section...

Allergies Documentation

No Known Allergies

When there are no active allergies on a patient's profile, the No Known Allergies and No Known Medication Allergies buttons will be available for use.

Click the No Known Allergies button when the patient has no known medication, food, environmental, or other allergies.

The Add Allergies window will open. Notice that NKA displays in the Substance field. To add NKA to the patient's profile, simply **click** OK.

NKA appears in the patient's active allergy profile.

Click the Mark All as Reviewed button to indicate that the profile has been reviewed.

This button should be used to indicate that the allergies have been reviewed, regardless of whether updates were needed.

No Known Medication Allergies

When a patient has only non-medication allergies, you will need to indicate that the patient has No Known Medication Allergies AND add the non-medication allergies.

To do this, start by **click**ing the No Known Medication Allergies button.

The Add Allergies window will open. Notice that No Known Medication Allergies displays in the Substance field. To add NKMA to the patient's profile, simply **click** OK.

No Known Medication Allergies appears in the patient's active allergies profile.

Click the Add button to add other allergies.

This time, the Add Allergies window opens, but the Substance and other fields are blank. Remember that all yellow fields

are required.

The fastest way to add allergies is to use the folders in the pane at the bottom of this window.

As you can see, there are different folders for the various allergy types. I want to document a Peanut allergy, so I'm going to **click** once on the Common Food Allergies folder.

The common allergy folders are organized in alphabetical order. Double-**click** to select the appropriate substance.

The allergen will appear in the Substance field. Starting at the top of the window, make sure the information in the fields is correct.

Use the Type field to indicate whether it's a true allergy, adverse effect, sensitivity, intolerance, or other.

HINT: When you select an option from the dropdown, its definition will appear in the white space to the right of the dropdown window.

Next, **click** with your mouse inside the Reactions field.

Once you've **click**ed into the Reactions field, the Common Reactions folder will appear in the pane at the bottom of the window.

Click once to open the folder.

Find and double-**click** the reaction.

The selected reaction will appear in the reactions window above. Notice that the reaction shows with a gold key icon.

This icon indicates that the reaction is codified and therefore, is saved as discrete data within the patient's chart.

Next, address the Severity field.

There are several optional fields which can be used, if appropriate. The next required field is the Category field.

Click the dropdown arrow to see available options.

In order for the system to accurately report potential allergic reactions to ordered substances, allergies entered into the chart must be categorized correctly.

There are some food/non-medication substances that must be entered as "Drug" allergies in order for allergy checking to work.

Before entering any non-medication allergy, check the white space to the right of the Substance field to see if the sentence highlighted in yellow on-screen appears.

When this sentence displays, it means that the substance is NOT treated like a drug allergy in the system and you should enter it using the appropriate category.

In this case, there is no allergy checking for Peanut, so I'm going to choose "Food."

Click the OK button to add the allergy.

The new allergy appears on the allergy profile. **Click** Mark All as Reviewed to complete the process.

Documentation of Special Allergies - Non-Medication Allergies that act like Medication Allergies

As mentioned in the last section, sometimes a non-med allergy is not a non-med allergy. Let's take a look at this scenario now.

This patient has a shellfish allergy. To add the allergy, I will **click** the Add button.

Next, I will select the Common Food Allergies folder.

And here is shellfish. Before I double-**click** to select this, I want to draw your attention to the Terminology column.

In PowerChart, "Multum" is a word used to refer to allergy and other interaction checking.

Notice that shellfish displays Multum Allergy Category in this column, while the others on-screen simply say Allergy.

This is the first cue that the Category will need to be set to Drug when we get to that step.

Next, I will choose the Type.

This patient reports that he does not know what the reaction was. He was told at a young age that he was allergic to shellfish, so he's avoided it his whole life.

The most appropriate choice in this situation, is to choose Unknown.

Next, I will choose a Reaction. To do this, I **click** inside the Reactions field.

Next, I will **click** to open the Common Reactions folder.

The patient doesn't know what the reaction was, so I'm going to look for Unknown.

Next in the suggested fields, is Severity.

It's impossible to accurately choose a severity when the patient has no additional information. In this situation, it's best to leave this field blank.

The Comments field is optional and can be used to communicate additional information to pharmacists, physicians, and

other clinical staff.

To enter a comment, **click** the Add Comment button.

Type into the Comments field in the pop-up window.

Click the OK button when done.

Don't forget to select a Category.

Remember to check the white space next to the Substance field. The absence of the "No allergy checking..." sentence tells you that the substance has allergy checking built-in.

This means that the "Drug" category must be selected.

Click the OK button.

A pop-up window will appear to tell you that the patient has No Known Medication Allergies previously documented. **Click** the Yes button to instruct the system to add the new allergy and inactivate NKMA.

Shellfish now appears in the active allergy profile and NKMA is removed. **Click** Mark All as Reviewed to complete the process.

Medication Allergies

To add a medication allergy, **click** the Add button.

Click once on the Common Medication Allergies folder.

Double-**click** to select the substance.

Select the correct Type.

Click into the Reactions field to find the appropriate reaction.

Open the Common Reactions folder.

The patient reports Tremors.

Tremor is not included in the Common Reactions folder, so I will type this into the Reactions field above.

When searching the database for Substances OR Reactions, always use the singular term. For instance, search for Strawberry vs. Strawberries or Tremor vs. Tremors.

Click the binoculars button to search the database.

Double-**click** to select the reaction in the pop-up window.

The reaction appears in the Reactions pane with the gold key icon. Next, a word of caution...

When using the Reactions search feature, please avoid using the Enter key on your keyboard or the Add Freetext button.

Doing either of these things will place the reaction in the Reactions pane as a Free Text vs. Codified reaction.

Notice that the hand/pencil icon appears next to the new reaction, instead of the gold key.

If you do add a reaction as a free text by mistake, right-**click** with your mouse...

... And select Delete. Then, proceed with adding the codified reaction, instead.

Proceed with entering the Severity.

And set the Category.

Click the Add button.

And **click** the Mark All as Reviewed button to complete the process.

Let's go ahead and take a look at vaccination screening now...

Influenza Vaccine Screening

Once the patient's allergies have been reviewed, return to the Influenza screening section.

In this, and all vaccination screening sections, work from top to bottom.

Once the screening fields have been addressed, the appropriate vaccination or action will become available for selection.

As can be seen on-screen, this patient qualifies for the selected vaccination option. I will **click** to select this.

When I sign this PowerForm, an order for the selected vaccination will be placed automatically.

If a copy is not available to give the patient, the applicable Vaccination Information Sheets (VIS) can be accessed by right-**click**ing inside the white space of the field.

Select Reference Text.

The Reference Text window will open with links to the available documents. **Click** to open the appropriate webpage.

Access the needed VIS.

Print the document for the patient. Take note of the date stamp on the document.

Click the OK button to return to the PowerForm.

Complete the vaccination screening documentation.

Click the next section to proceed.

Pneumonia Vaccine Screening

Use the same process to perform all appropriate vaccination screenings. Keep in mind that vaccinations may or may not be appropriate for all patients.

Using Grids

The Pain History section contains grids with single-select, multi-select, and free-text fields.

Cells displaying <Alpha> are single-select. <MultiAlpha> indicates that a field is multi-select. The free-text cells are blank.

To begin documentation, **click** into a cell.

Make your selections from the pop-up window.

Comments are optional. **Click** OK to proceed.

To enter data into the free-text fields, simply **click** into the field and type the information.

Select the next section to continue.

Problem History

No Chronic Problems

This is the Problem History section.

This section displays the diagnosis or diagnoses for the current visit (as entered by the patient's physician) at the top. This portion should be treated as read-only.

Next is where you will review and enter the patient's problems.

Like the Allergies tool, the Problems tool has a button that can be **click**ed if the patient has no medical concerns. When this is the case, simply **click** the No Chronic Problems button.

This will place this information in the Problems profile.

Medical History Folders

To add patient problems, **click** the Add button.

The Problems tool consists of three sections. The Problems list appears at the top. The search, modify, and add section is in the middle, and the folders are at the bottom.

Use the scroll bar on the right to move around within the tool.

Click the Medical History folder to see all available folders.

Many people find that the folders section is a bit small. You may adjust the window sizes within the Problems tool, as needed.

The folders are organized by system or type. **Click** each folder to review the most common problems with the patient.

Click the Up button to return to the folder list.

Click to select a problem.

The selected problem will appear in the Problem field above. You can further adjust the window sizes, if desired.

If the patient has no further problems, you may **click** OK. This will place the problem on his/her profile and close the tool.

Otherwise, **click** OK & Add New.

NOTE: Do not use the Add Problem & Diagnosis button. Physicians, APNs, and PAs manage the Diagnosis list.

Proceed with selecting any additional applicable problems from the open folder.

Remember, to return to the folder list, **click** the Up button.

Searching for Problems

If the patient has a problem not listed in the Medical History folder, you may use the search function.

To search for a problem, **click** inside the Problem field at the top of the tool.

Typing the first few letters of several of the words will yield the best results.

Click the binoculars icon to search the database.

Double-**click** to select the correct term in the results window.

Click the OK button after adding the final problem. NOTE: You must close this tool prior to signing the PowerForm.

If there are no further problems to add, you may **click** the Cancel button to close it.

The selected problems display now in the Problems profile/list.

Most Recent Hospitalizations

After reviewing and/or updating the patient's problem list, update the patient's recent hospitalization information at the bottom of the section.

This is another free-text grid. **Click** into the cells to enter data.

As with the Allergies section, be sure to **click** the Mark All as Reviewed button to complete the section.

Click the next section to proceed.

Procedure History

Common Procedures Folders

This is the Procedure History section.

The pane on the left side of the window may show historical information. If present, information here should be transcribed into the Procedure History tool.

If blank, **click** the arrow in the upper right corner of the pane to collapse it out of view.

To add procedures, **click** the Add button.

This tool is similar to the Problem History tool. **Click** the Procedures folder to view the common procedures folders.

Adjust the window sizes, as needed.

Click any folder to open and view its contents.

Double-**click** to select a procedure.

If known (and time-allowing) use the available fields to add details.

Click the OK & Add New button if additional procedures need to be added.

Searching for Procedures

To search for a procedure, **click** into the Procedure field.

Type the first few letter of the word or words.

Click the binoculars icon.

Double-**click** to select the problem or single-**click**...

... And **click** the OK button.

Use the available fields to add details, as needed.

If adding the last procedure, **click** the OK button to close the tool. The Cancel button can also be used to close the tool without adding another procedure.

Notice that I forgot to record laterality for this knee replacement. To update an existing problem or procedure in these tools, you may **click** the Modify button.

The procedures list has been updated.

Completing Procedure History Documentation

The patient's medical device and prosthetics data can be entered at the bottom of this section.

Click the next section to continue.

Family History

Using the QuickList

The Family History section also has a historical information pane that can be closed to increase screen space for the tool.

There are fields to the right at the top of this section to document when you are unable to obtain a family history and/or when the patient is adopted.

Click the Add button to open the tool.

To add a condition to the Family History profile, **click** the Magnifying Glass icon in the Quick List section of the tool.

Click the Search tab.

Click into the Search field.

Type part of the condition's name.

Click Search by Name.

Double-**click** to select the condition from the results.

The condition will appear in the Scratch Pad at the bottom of the window. If needed, you may add more conditions.

Once done, **click** the OK button to close the pop-up window.

Each cell, corresponding to a condition and family member, is divided into two parts. This is a little hard to see, so let me zoom in on one...

The white on the left can be **click**ed to indicate a negative history.

The gray on the right can be **click**ed to indicate a positive history.

If a cell is **click**ed in error, right-**click** in the field...

And select Clear.

Using Add Group

If desired, you may also use the Add Group button in the lower left corner of the tool.

This feature contains groups of conditions, organized by system.

When you are finished adding or updating the family history, **click** the OK button to close the tool.

As with the other tools, **click** the Mark All as Reviewed button after you have reviewed and/or updated the Family History.

Click the next section to proceed.

Medications at Home

Using the Brand Folder

This is the Medications at Home section.

Click the Document Medications by Hx button to proceed with documentation of the patient's home medications.

Click the Add button in the upper left corner to open the Add Order window.

When entering the patient's home medications list, always be sure to check the Type field. This should display "Document Home Medications."

If not, you may end up adding Inpatient Medication Orders in error.

Documentation of the patient's home medication list is the first, and most critical, piece of the Medication Reconciliation process.

When entered correctly, home medications can be converted to inpatient medications by the patient's physician, APN, or PA.

The patient's physician team is responsible for reconciling the medication list at Admission, with each Transfer to a new

level of care, and again at Discharge.

Ideally, the patient's medication list will flow seamlessly through this process, to the outpatient provider, and back.

In order for this to work, however, the medications must be entered correctly. As you can see, the folders in the Document Home Medications catalog are organized according to chemical names.

There is also a folder called, "Brand." This is the recommended folder for documentation of the home medication list.

Click to open the Brand folder.

The most commonly used home medications are listed in folders labeled with brand names. **Click** and drag to adjust column width, as desired.

My patient is taking Diovan, 40 mg, daily. So, I'm going to open the Diovan folder.

Next, **click** to select the appropriate order sentence.

Click the Up button to return to the Brand folder.

This patient also uses a Spiriva inhaler.

The Order Sentences window will open for many medications. There is only one pre-formed order sentence for Spiriva. Others may have several.

Always choose the order sentence that most closely matches the patient's dosing and frequency information.

Avoid using the (None) option, as this will require that you build the sentence from scratch.

This process can be time-consuming and greatly increases the risk that the medication will not successfully convert during medication reconciliation, essentially "breaking" the medication list cycle.

You will have an opportunity to modify the details of the order sentence, so choose the closest fit.

Click OK to close the window.

Let's take a look at a complicated medication. Imagine this patient takes Coumadin with different doses on different days.

The patient takes 2 mg on some days and 5 mg on others. This means I will need to add at least two separate sentences. First, I'm going to select the 2 mg dosage.

There are two possible sentences in the pop-up window. Notice that the only difference is the duration.

This is the same tool physicians, APNs, and PAs use to prescribe home medications. This is why the duration shows.

Do not be concerned about duration when creating the home medication list. This is not applicable to your process.

Either sentence is perfectly appropriate.

Remember, this patient is taking the 2 mg dose on only certain days of the week, so "Daily" is not correct. However, this can be corrected in the next step.

I'm going to choose the first order sentence.

Next, I'm going to select the 5 mg dosage.

The home medication list should include all prescribed and over the counter medications, as well as all supplements and herbal remedies.

Let's imagine that this patient also takes a ginseng preparation. There is no Brand folder for this, so I'm going to **click** the Up button.

To search, **click** with the mouse into the Search field at the top of the window.

Herbal Supplements

Search should only be used for home medications when there is not an appropriate Brand or Chemical folder available.

To search, **click** with the mouse into the Search field at the top of the window.

Type the first few letters.

Click to select the correct option from the results.

The Home button can be **click**ed to return to the list of chemical folders.

Freetext Item Name

When the patient cannot remember the name of a medication they are taking, you will need to use the Freetext Item Name option.

Type the word "free" into the Search field.

Select "Freetext Item Name."

This is the one time it is appropriate to select the (None) sentence.

When you have selected all of the medications to be added to the patient's list. **Click** the Done button in the bottom right corner of the Add Order window.

Scratch Pad

The medications you have selected will appear on the Scratch Pad. This is where you will need to make any changes AND document Compliance.

Start by confirming that all of the medications are correct. If you have any unwanted duplicates, this is when you will want to remove them.

To remove an unwanted medication, right-**click**...

... And select Remove.

I like to start at the top of the scratch pad list and make the necessary updates to each medication.

Click to select the first medication.

The Order Details pane will open at the bottom of the window. Adjust the height of this pane, as needed.

The primary details are shown at the top of the Details tab and can be adjusted, if needed.

Additional fields display below and can also be changed, if indicated.

Had we not selected the pre-formed sentence, we would need to complete these fields from scratch.

Once any necessary adjustments are made, **click** to select the Compliance tab.

Update the Status and Information Source fields, as needed, and then enter the Last Dose Date/Time.

Once the selected medication has been completely updated, move on to the next medication in the list.

Review the details of the medication and make any necessary updates.

Next, update the Compliance.

Complex Medications

Next, let's look at the Coumadin orders. In our scenario, the patient takes 2 mg on Monday, Wednesday, and Friday. On Tuesday and Thursday, he takes 5 mg.

First, let's look at the 2 mg dosage.

We need to change the frequency. To do this, I'm going to **click** where it says "Daily."

When you open these fields, the most common options appear at the top. **Click** Show All to see additional options.

Scroll to find the desired frequency.

As you become more familiar with the available options, you may find it's easier to simply type the first letter or letters of

the desired frequency to skip to it in the dropdown list.

Click to select the frequency.

Update the Compliance.

Repeat for the 5 mg dose.

When placing orders for medications where the doses vary by day, it is necessary to enter separate lines for each dosage.

Building Order Sentences

Next, let's look at the orders we have to build from scratch. First up, ginseng.

Start by **click**ing into the Dose field.

Address any additional fields.

And then, update the Compliance.

Incomplete Medication List

The "Freetext Item Name" order should be used when the patient does not remember the name of a medication or in the very rare event that the medication is not available in the catalog.

The catalog is expansive and is updated on an ongoing basis. So if you are not finding a medication, it is likely due to a spelling error.

These medications will NEVER reconcile or convert, so they are to be used temporarily until the medication information can be obtained from the ordering physician or patient pharmacy.

This is a nursing responsibility. Please keep this in mind and actively work to get the medication information into the profile as quickly as possible.

Enter as much descriptive information as is available. This will be helpful to nurses and pharmacists who follow you to assist with obtaining the drug information.

When you have entered all of the available medication history into the tool, you are ready to **click** the Document History button in the lower right corner of the window.

IMPORTANT: The patient’s Medication History (Home Medication List documentation) is NOT complete until ALL medications have been added in their entirety.

It is the responsibility of the nurse to obtain and document missing medication information, as soon as possible. The presence of a FREETEXT ITEM NAME order is indicative of an incomplete Medication History.

It's important to alert other caregivers when the home medication list is incomplete. To do that, place a checkmark in the box highlighted on-screen.

Next, **click** the Document History button.

Here we are, back in the PowerForm view. Notice that the Reconciliation Status of Medication History is showing as Incomplete.

Once the missing information is added and the Freetext Item is removed, the nurse can update the status to Complete. This will change the Blue Exclamation Point icon to a Green Checkmark.

The patient's home medication list appears in the list below.

Updating Existing Documented Medications

In addition to being able to add medications to the patient's home medication list, you need to know how to manage medications already on the list.

Best practice is to start by **click**ing the Document Medication by History button.

To remove a Documented medication from the list, right-**click**...

... And choose Complete or Cancel/DC. Either will remove the medication.

If a patient reports that he/she still takes a medication already on the list, but that it is taken in some other way than what is recorded, then you will need to Modify the sentence.

To do this, right-**click** the sentence...

... And select Modify.

This patient reports that the PCP increased the dosage to 2 TAB. So, I'm going to **click** into the Dose field.

Let's choose "2 TAB" from the frequently used doses dropdown.

I will finish by updating the Compliance.

Click Document History to update the modified medication and mark the other medication Completed.

Decimals, Not Fractions!

When entering the patient's home medications, there are a couple key concepts to keep in mind.

First, to ensure that the medication list follows the Medication List Cycle circuit without interruption, please enter the medications AS THE PATIENT TAKES THEM.

If the patient takes two 10 mg TAB, then select the 10 mg sentence and change the Dose to 2 TAB. Selecting the 20 mg dose will very likely cause confusion for the patient at discharge.

Second, all partial doses must be entered using decimal points, never fractions. It is 0.5 TAB NOT 1/2 TAB.

Let's take a look at an example incorporating both of these concepts.

The patient takes Ativan 0.5 mg. He has 1 mg tablets at home.

I'm going to select the Brand Folder.

Next, I'll select the appropriate folder.

As you can see, there is a sentence pre-built with a dose of 0.5 mg.

However, the patient uses a 1 mg tablet, so I'm going to choose that sentence.

I need to update the Dose field.

0.5 TAB appears in the common dose dropdown, so I'm going to select that.

I can now proceed with documenting the patient's Compliance.

Managing Prescribed Medications

So far, we've been looking at Documented medications. These are medications entered by nurses and/or MAs during patient interview.

The Medication List also contains Prescribed medications. These are those entered by a physician, APN, or PA and either printed for the patient or ePrescribed (sent to the pharmacy electronically).

This patient has two Prescribed medications on his list. Let's take a look. To do this, we will **click** the Document Meds by History button.

Documented medications have a Scroll icon. Prescribed medications have a Pill Bottle icon.

Because Prescribed medications are, essentially, physician orders, nurses and MAs may not Modify or Cancel/DC these medications.

If a patient reports that he is no longer taking a Prescribed Medication, right-**click** its sentence,

determine whether the medication is a maintenance medication (one that's taken on an ongoing basis) or a short-term medication (e.g. antibiotics, post-op analgesics, prednisone tapers).

If the patient has completed the course of a short-term medication, then it makes sense to complete that medication. In our example, the patient has completed the Ciprofloxacin. To proceed, we will right-**click** its sentence...

And select Complete. (Remember: Do not choose Cancel/DC, as this generates a provider order.)

There, the Cipro is marked complete and displays with a strikethrough.

Now, if a patient reports that he is taking any Prescribed Medication in a manner other than as it is ordered, right-**click** the Prescribed medication...

... Then select Add/Modify Compliance.

The Compliance tab allows us to add the status and comments.

When the provider performs Med Rec, the status and comments display.

Everything except "Still Taking" and "Unable to obtain" will display in Red. Use the dropdown to select an appropriate status.

If the patient has stopped taking the medication, we would select Not Taking.

Some other options are available when a medication has been placed "On hold for procedure" or "Investigating" if we are waiting for information from another source.

Our patient is still taking the medication but not as prescribed.

Select, Still Taking, not as prescribed.

In the Comments field, document how the patient is taking the medication.

The provider will see the status and comments in red and will make the decision as to what action should be taken for this medication.

Update the Last dose date and time.

Use this process whenever a patient reports that (s)he is no longer taking a Maintenance medication. Do not Complete a maintenance medication, as this removes it from the list seen and managed by the medical staff and can create breakdowns in communication between the providers in the acute care and ambulatory care settings.

Click the Sign button to sign and complete Medication History.

Social History

Adding Social History Data

The Social History section contains a tool which can be used to address a multitude of social history data.

As with the other tools in this PowerForm, **click** the Add button to open the tool.

Tobacco, Alcohol, and Substance Abuse will open automatically.

Start at the top, being sure to document in all sections required by your institution's policies.

As with the other tools, you may find that adjusting the window sizes improves visibility.

The Alcohol section contains the CAGE assessment.

The Home/Environment section contains abuse screening questions.

Click the plus sign icon to open this and the other sections that did not default open.

When you have completed data entry into the tool, **click** OK to proceed.

Completing Social History Documentation

The Social History data will display in the tool window at the top of the section. Use the scroll bar all the way to the right to scroll down and address the remaining fields.

There are several fields here. Notice that there is an item asking whether the CAGE assessment was completed.

Remember, in order to successfully complete the Admission History PowerForm task on Care Compass, you must address all required fields.

This item reminds you to go back and do the CAGE assessment, if you have not already done so.

Once it is complete, be sure to mark it complete here.

Completing the Form

Continue through the remaining sections, paying attention to any required fields.

When you have completed your documentation, **click** the green checkmark in the upper left corner of the PowerForm window to sign the document into the patient's permanent medical record.

Return to Care Compass

Provided all required (yellow) fields within the PowerForm were completed, the Admission History PowerForm task will be gone upon your return to Care Compass.

Tasks corresponding to any vaccines ordered as a result of your vaccination screening will appear.

Always remember to refresh Care Compass to ensure that all fields are up-to-date with the most recently charted data.

The Admission History PowerForms are, by far, the most complex forms in PowerChart. Congratulations on successfully completing this activity!

In the next eCourse, we are going to briefly review a few additional PowerForms and talk about how to manage PowerForms after they have been signed.

I'll see you there!

Click the button on-screen to view and print your certificate of completion.