Visit Summary Workflow

Visit Summary Overview

The **Visit Summary** is populated with information that is documented within the components on the Outpatient Workflow page during the patent's visit. Any orders that are placed, POC test results, and any medications or immunizations given during the visit will also pull in. The Visit Summary should be offered to the patient at end of the each visit.

The Visit Summary Includes:

Sections	Information that Displays
• Patient Instructions	Free text instructions entered by the Provider/Staff via the multi-contributor component on the Workflow Page
• Home Medications	Medications, dosage, and pharmacy information
• Reason for Visit	Chief Complaint for current visit
• Vitals & Measurements	Temp, Heart Rate, Resp Rate, BP, HT/WT (from this visit)
• Allergies	Current Allergies
• Diagnosis and Orders	This Visit Diagnoses. Orders placed during the visit: lab, radiology, referrals
• Medications Given Today	Any medications given or declined during the visit
• Test Results (POC)	POC tests/results performed during the visit
• Future Appointments	Any future appointments that the patient has scheduled at a McLaren facility
• Health Maintenance	Health Maintenance items that were ordered or addressed during the visit
• Immunizations	Immunizations that were given or declined during the visit

These statements will also display at the bottom of the Visit Summary:

- Patient/Caregiver/Family demonstrates understanding of instructions given
- If 14 days have passed since your test and you have not received results, please contact the office.

  - ***Note:*** *The Visit Summary is automatically sent to the patient's portal account at midnight. Users can check the Banner Bar to see if the patient is enrolled in the HealtheLife portal or ask the patient if they have portal access prior to printing the Visit Summary. If so, instruct the patient to check their portal account in lieu of printing the summary.*

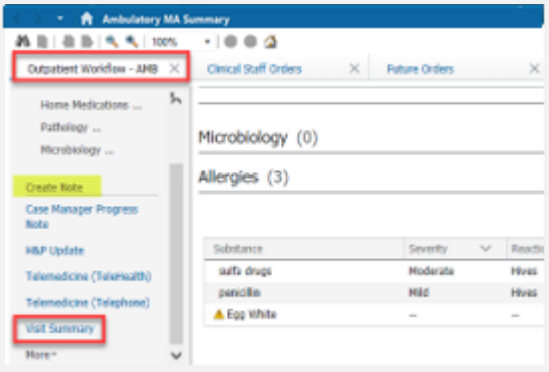
To create and print the visit summary, please follow the instructions below.

Create and Print the Visit Summary in PowerChart

1) Access the **Visit Summary** Link in one of two ways:

Providers and Clinical Staff:

a. From the **Outpatient Workflow** page, scroll down to the **Create Note Section** of the **Navigation Pane** and select the **Visit Summary** link.

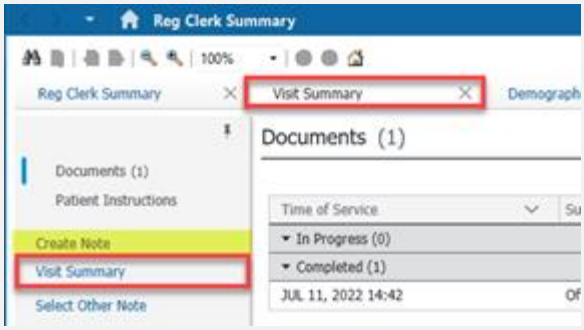


Front Office Staff:

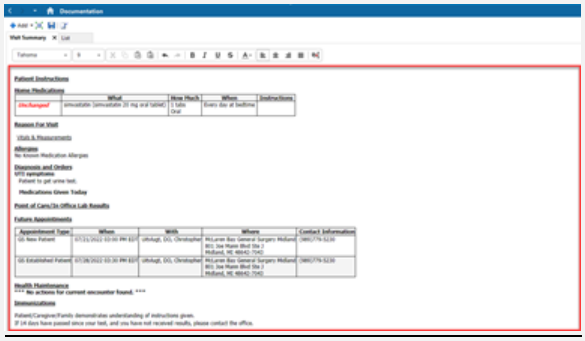
b. From the **Visit Summary** page in the **Create Note** section of the **Navigation Pane**, select the **Visit Summary** link.

- ***Note:*** *Select the + icon to add the Visit Summary page if needed.*

- ***Note:*** *Clicking this link will create a new document each time. To avoid duplicates, do not click the link more than once. See the Reprint the Visit Summary section if additional copies are needed.*



2) The **Visit Summary** will display and populate with the items that were documented during the visit.



3) At the provider's discretion, make any needed edits to the **Visit Summary** before providing it to the patient.

- *The Visit Summary contains functionality that allows information to be added or removed if deemed appropriate by the provider. Items are usually removed if the provider believes harm may arise from the disclosure of certain information.*

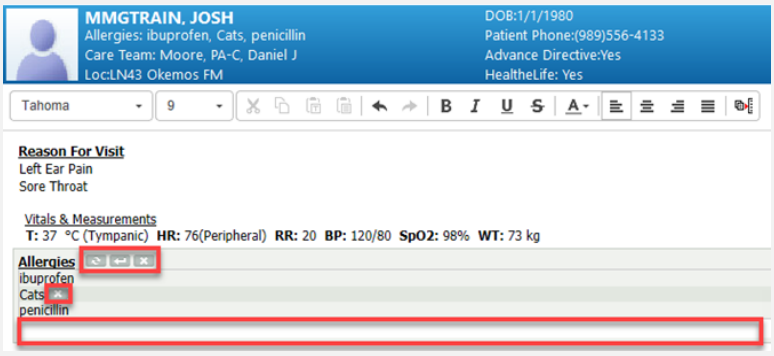
4) To **add**, **edit**, **remove,** or **refresh** information within the Visit Summary, hover over the section requiring modification. A lightbox will appear around the section and display three icons to the right.

a. To **Refresh** the section and pull in any additional updates that have been made to the patient's chart, click the **Refresh** (double arrow) icon.

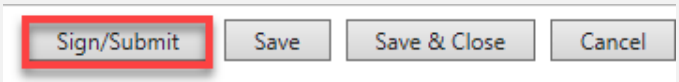
b. To **add** additional free text to the section, click the **Insert Free Text** (left-facing arrow) icon. Users can add additional information by typing, pasting information that has been copied from external sources, auto text, or Dragon Dictation.

c. To **remove the section** completely, click the **X** icon.

d. To **remove certain data** within a section, hover over the line of text requiring removal, and an **X** will appear.

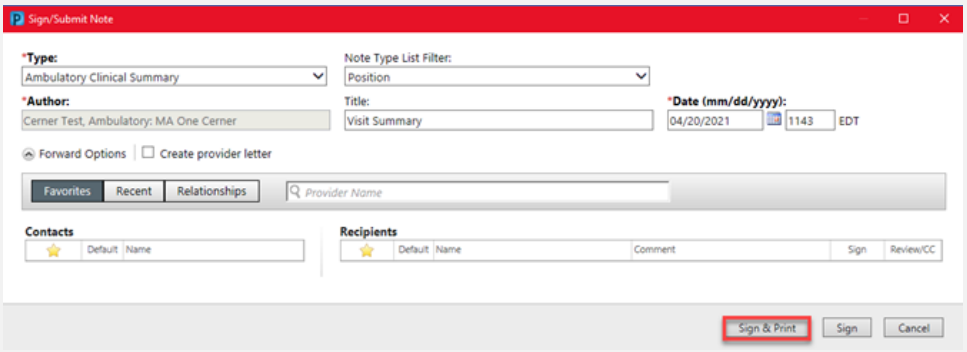


5) When complete, click the **Sign/Submit** button on the bottom right.



6) The **Sign/Submit Note** window displays.

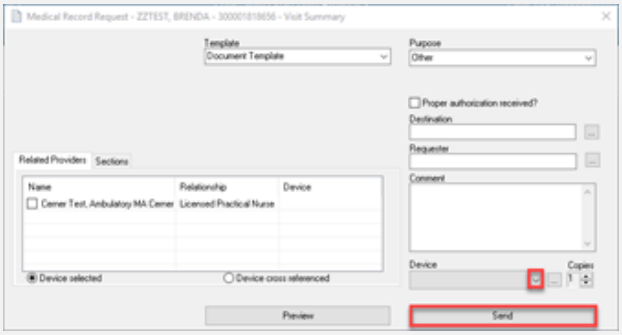
   a. Ensure the **Date** is set for the correct date of service.
   b. Click **Sign & Print** when done.



- ***Note:*** *Clinical and Front Office staff will not have the ability to modify the Visit Summary after it has been created and signed. If any documentation needs to be added or removed after signature, the Visit Summary will need to be placed In-Error and recreated. Only Providers will have the ability to Modify dynamic documentation.*

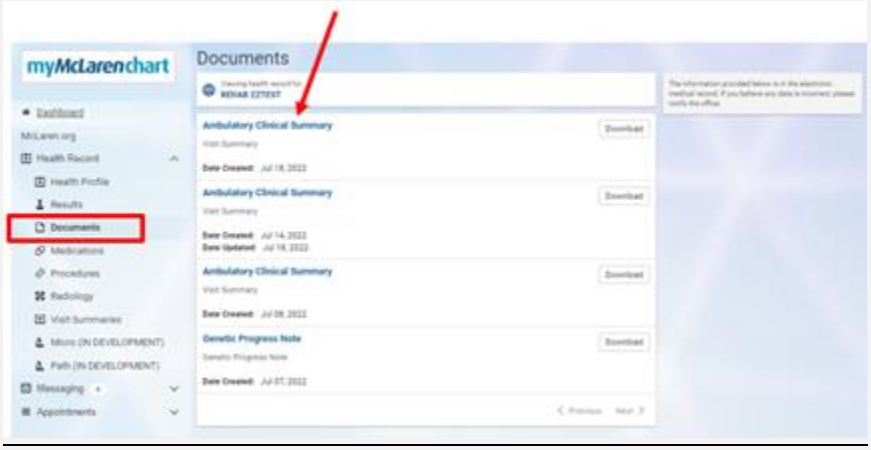
7) The **Medical Record Request** window will display.

   a. Select the appropriate printer from the **Device** dropdown.
   b. Click **Preview** to preview the docment if desired.
   c. Click **Send** to print the document and give to the patient before their departure.



8) The Visit Summary will also save to the patient's chart and can be found within the **Documentation** and/or **Notes** tab on the Menu Bar.

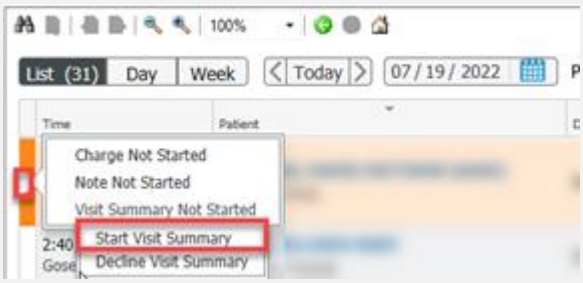
9) If the patient uses the Cerner Healthelife patient portal, the **Visit Summary** is sent automatically to their MyMcLarenChart portal account after the encounter is discharged (midnight). Patients can access their Visit Summary through their HealtheLife Patient Portal in the Documents section.



Generate the Visit Summary From the Ambulatory Organizer

1) From the **Ambulatory Organizer**, find the patient's name and hover over the light indicator.

2) Hover the curser over **Visit Summary**, then select **Start Visit Summary**.



3) The **Summary** page will display.

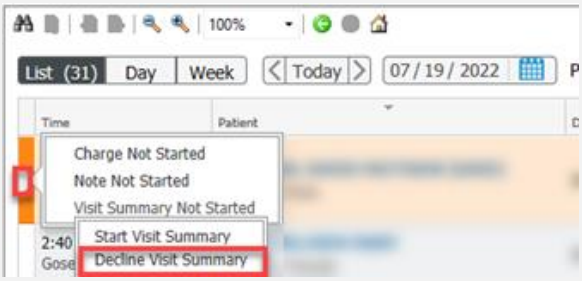
   a. Scroll down to the **Create Note** section of the **Navigation Pane** and select the **Visit Summary** link.

4) Follow the instructions in the scenario above to add, edit, or remove items and print the summary for the patient.

If Patient Declines the Visit Summary

1) From the **Ambulatory Organizer**, find the patient's name and hover over the light indicator.

   a. Hover the curser over **Visit Summary**, then select **Decline Visit Summary**.



2) The **Visit Summary Withheld** window will display.

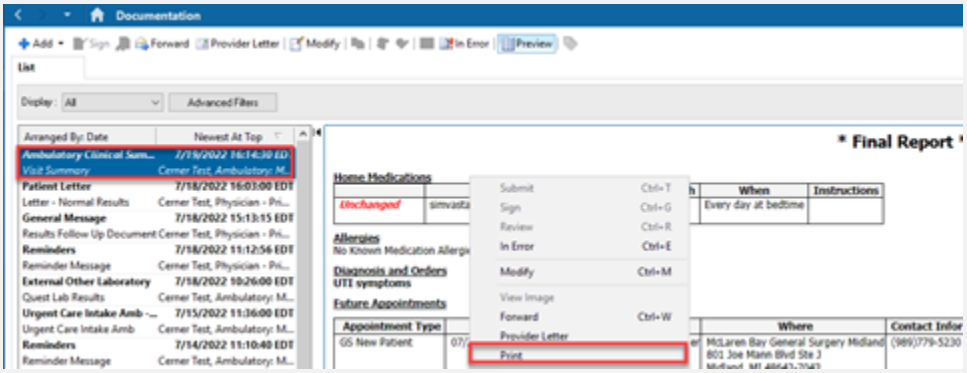
   a. From the dropdown, choose **Yes**.
   b. Click the green **Sign Form** checkmark icon when done.

Reprint the Visit Summary

To reprint the Visit Summary, follow the instructions below.

1) Select the **Documentation** tab from the Menu Bar.
   - ***Note:*** *Users can also reprint the Visit Summary from the Notes tab.*

2) **Select** the Visit Summary from the left pane to display it on the right.
   a. **Right-click** on the document and choose **Print.**
      - ***Note:*** *Users may also use the Print icon in the upper right-hand corner.*



3) The **Medical Record Request** window will display.

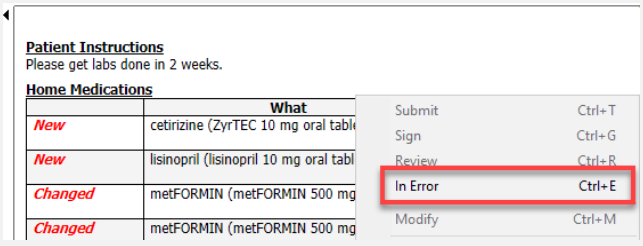
   a. Select the appropriate printer from the **Device** dropdown.
   b. Click **Preview** to preview the docment if desired.
   c. Click **Send** to reprint the document.

In-Error the Visit Summary to Generate a New Visit Summary

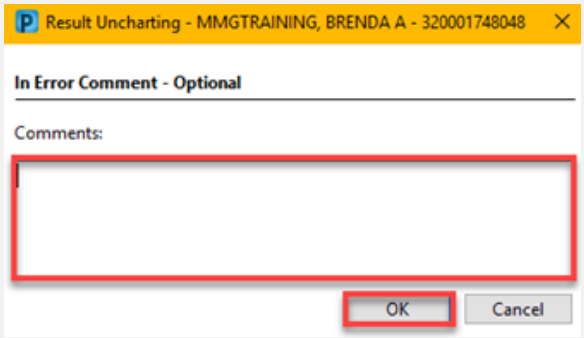
If additional information has been documented in the patinet's chart after the Visit Summary was created, users will need to In-Error the Visit Summary and create a new one for that information to pull in. To In-Error the Visit Summary, follow the instructions below.

1) Select the **Documentation** tab from the Menu Bar and single-click the Visit Summary to in-error.

2) **Right-click** anywhere on the document and choose In-Error**.**



3) Enter a reason for entering the document in error in the **Comments** section, then click **OK**.



4) If the document is viewed in the future, an alert will display notifying the users that this was entered in error.