

ready to complete the progress note, the provider must again right click on the body of the note and select the option “**Edit Progress Note.**”

If the progress note has an **expected co-signer** listed, once the note is signed by the author, the co-signer will be **alerted** to sign the note in the **Notifications area of the Patient Selection screen**. Another type of signature is an additional signature. To add an **Additional Signer**, right click in body of note and select **Identify Additional Signers**. Add provider’s name.

SAVE PREFERRED PROGRESS NOTE TITLES

To **save student note** that shows above the delimiter line in the **Progress Note Properties** box, select **Tools, Options, Notes, Document Titles**. In **Document Titles** box click under **Document Titles** and choose **Medical Student Documentation** note for Medical Students or PA students. For all other students, choose **Health Professional Student Documentation** note. Add to list and save changes.

CONSULTS

On **Consults Tab**, you can locate the **status** of a consult and type and see further information by scrolling within the body of the order. Consults status’ are also located in parentheses beside **date of order**.

(a)=Active; (p)=Pending; (s)=Scheduled;
(pr)=Incomplete; (c)=Completed; (x)=Cancelled;
and (dc)=Discontinued

The consult status is changed by the receiving service as they take specific actions on the consult. **Consult types** are: Inpatient, Outpatient, E-consults (chart reviews), Telehealth, Interfacility and Procedures.

SURGERY TAB

Contains **Major** and **Minor Operation reports**. To open surgery case folder, select the plus sign to expand. The “**N**” is a **non-OR** procedure and the “**O**” is an **OR** case.

DISCHARGE SUMMARY TAB

Contains Discharge Summary documents and Addendums.

LABS TAB

Can view **most recent to oldest labs** at top. **Cumulative labs** can be viewed by Headings and Data Range.

All Tests by Date are shown from most recent to oldest.

On **Selected Tests by Date**, can select labs needed to view from **Select Lab Tests** box, then **add** them to be displayed.

To **create a Worksheet**, select **Worksheet** heading, then **add** each lab to panel. Only **seven tests** can be on one panel. Click on the **New button** and then click **Yes** on Confirmation screen. Name of **Test Group** will appear (lab tests chosen) and click OK. This can be used for all patients to view these specific labs.

REPORTS TAB

Clinical Reports category expands (click on +) to show all viewable clinical reports. Data is viewable on other CPRS tabs also.

Pharmacy category sorts drugs by selecting the heading in the grid that looks like a spreadsheet. Selecting the **Status category** reverses the orders of the drugs presented.

Lab Orders category shows results, blood availability, Anatomic Pathology, etc.

Radiology “Imaging Local Only” category shows X-rays if they are displayed with an icon next to them. This icon is an indicator to you that this is an examination that has **digital images** available for viewing.

Health Summary category shows Reports, Scores, Reminders, etc. Click on the Procedure Name and the report will display at the bottom of the screen.

CPRS RESOURCES

Vista Imaging which is used to view Radiology images, pictures and consents, is found on **Tools Menu**.

To set up **radiology screen**: click on the **Tools**

Bar and select “**Imaging.**” Locate the word “**Options**” on the **Image List Tools Bar** and select “**User Preferences**” and “**Configure User Preferences.**”

In the **User Preferences** box, click on screen options as below:

Alternate viewer options: select use imaging video player and use alternate PDF viewer.

Abstract and image viewers: select in image list window and in image list window.

Patient selected: show image listing window.

Layout/style: show image list, show tree view, med speed, and double click to open an item.

Remote image view: auto-connect to the VA and display remote abstracts.

Annotation: show annotations with image.

iMed Consent, which is used to consent patients and for Advance Directives, is also found on **Tools Menu**. Selecting “**All Documents**” on the left will present list of consents by service. Can be saved to chart.

CP Flow sheets, which record totals for intake and outputs and IV fluids of patients is found on **Tools Menu, Vista Applications** and **CP Flow sheets**.

Wrong Notes: once a note is signed, it **cannot be deleted**. For notes entered in error, make & sign an addendum to note indicating reason; highlight top 5 lines (heading) of original note and copy; select Tools and Wrong Note. Paste information in box and send. Retraction takes 24-48 hours.

CONFIGURE CHART TAB SETTING

To open CPRS on the Notes Tab vs. the Cover Sheet, click on Tools, Options. On General tab click on **Other Parameters...** button. Under Chart Tabs choose **NOTES**. Then click OK & OK.

KEEP Protected Health Information [PHI & PII] Personally Identifiable Information SAFE! PHI &/or PII may not be taken from any VA Medical Facility.



VISTA & CPRS QUICK REFERENCE GUIDE FOR STUDENTS

**(THIS IS INTENDED AS A POCKET REMINDER,
NOT A REPLACEMENT FOR CPRS TRAINING)**

For Assistance, call:

IRM HELP: Help Desk 1-855-673-4357

- **Disused Network Accounts**
- **Network Account Username and/or Passwords**
- **CPRS/ Vista Access/Verify codes**
- **Signature codes**
- **Computer outages**

Clinical Informatics:

- **Other CPRS support or questions**

“**Hot Topics**” is information on CPRS subjects that is available under **Documents** on left side of Clinical Informatics SharePoint page.

Your **Service Information Manager (IM)** can also be a valuable resource!

KEEP VA CODES SAFE AND DON'T SHARE PIV CARDS!

VA NETWORK ACCESS **VISTA/CPRS SYSTEM ACCESS**

Prior to accessing the VA network, all users must receive a VA network username and temporary password. Your username and temporary password will be provided to you by your service:

Medical Service: 315-425-4400 X 56520

Surgical Service: 315-425-4400 X 52640

Psychiatry Service: 315-425-4400 X 56500

To sign-in to the VA network, Click **CTRL + ALT + DELETE** to display log in screen; Enter **network username and temporary password**; then **create a new password**. Must be at least 8 characters (letters, numbers & special character).

Prior to accessing **CPRS or VistA**, (same codes are used for both programs), all users must receive an **access code and temporary verify code**. Your access code and temporary verify code will be provided to you by your VA point of contact.

The **first time** you sign-in to the electronic medical record system, find the **VistA** icon on desktop. Enter **access code and temporary verify code**. The characters will be displayed as **stars (*)**. You will be asked to **change verify code, create an electronic signature code** and sign the **“Rules of Behavior.”**

Verify code must be at least 8 characters (letters, numbers & special character).

The **electronic signature code** must be at least 6 characters (letters and numbers) and cannot contain any special characters. **The caps lock MUST be on to create the electronic signature code for the first time**, but you do NOT have to use caps lock after creation of electronic signature code. Instead of seeing the star symbol when typing signature code, the cursor will remain still with no text/symbols displaying.

Access code and electronic signature code will never change.

The network password and CPRS/VistA verify

code will change every 90 days. If your account becomes locked, call 315-425-7637 for assistance.

PATIENT SELECTION

To **select a patient record**, click on a clinic/team/ward/specialty and choose patient or in the input box located on the top center of the Patient Selection screen, type **patient’s full name, SSN or first letter of last name and last 4 of their SSN** to bring up patient information (which shows under the “OK” button for verification of correct patient) and open the CPRS chart.

To **save a list of patients** as a default patient list, **select one clinic** and click the **Save Patient List Settings** button and a new patient list will be visible daily.

If you work from several clinics however, you can create a **Patient Combination List**. Click on **Tools, Options, List/Teams, Source Combinations**. In this box, click on **Clinic** and **add** your clinics. Select **Patient Selection Defaults** and choose **Combination** under **List Source** and under **Sort Order** select **Appt. Date** and **date range** you prefer.

This patient list is now the default list available **Default: Combination**. If a patient is marked **“SENSITIVE”** the SSN and Date of Birth will not display. Open this medical record only if this is your patient.

NOTIFICATIONS / ALERTS

These are messages that prompt you to **act on clinical events** such as notes to sign. To **process**, click on **notification** and complete necessary task.

COVER SHEET

Summarizes important information about the patient. Double-click on any item to get more detailed information.

Informational Header includes name, SSN, DOB, Visit Location, and Providers assigned to

patient. If Remote Data icon is **blue**, patient has records available from other VAs.

Default Data Grids include Problems, Allergies, Patient Record Flags, Postings, Medications, Labs, Reminders, Vitals, and appointments.

Electronic Tabs are at the bottom of the CPRS window: Cover Sheet, Problems, Meds, Orders, Notes, Consults, Surgery, Discharge Summaries, Labs and Reports.

PATIENT CONTEXT (CCOW)

The Patient Context must be active to view programs such as Imaging or iMed. If there is a little blue person with a chain link icon in upper left corner, CPRS is in **patient context**. If not, you will see a crowd of people with a broken chain link icon.

To fix this, click on **File, Rejoin Patient Link, & Set New Context**.

PROBLEMS TAB

Used to document and track patient’s problems. Provides current and historical view across clinical subspecialties. **Right click** on any problem to view details or make changes.

MEDS TAB

Displays inpatient, outpatient and non-VA medications. Medications are active, pending, suspended, discontinued or expired. **Can sort** medications by different views.

ORDERS TAB

The Orders tab provides detailed information on orders of all status’. Common orders include **admission and discharge, nursing orders, clerk orders, diet orders, medication orders, lab orders, consults, and procedures**.

The orders tab is separated into multiple columns. They include **service, order, start and stop date, ordering provider, nurse verification, clerk verification, chart verification, status, and ordering location**. To view **additional details** on any order, simply double click on the specific order from the list.

You can **sort and view** your patient’s orders. To change from the default view, select the **option view from the tools bar**. If you want to keep changes for all patient’s you must select the option **“save as default view”** prior to exiting the patient record.

NOTES TAB

Progress Note views can be changed by clicking **View** on Tools Bar, **Custom View**.

To **change number of notes seen**, click in space under **Max Number to Return**. **Never leave blank or select more than 150**.

To **Bold** note titles, place a **check mark** in front of the word **“title”** and type name of note title in **“contains”** section.

Notes are set by default to be seen from **most recent date**. To set notes in a **File Cabinet** view, click under **“Group by”** and choose **title**. This will allow you to see signed notes by title.

To **save these new settings**, you must go back up to the Tools bar and click on **Save As Default View**. If you do not save, your view will go back to your previous default view.

ENTER NEW NOTE

Select **New Note**, choose the **patient’s appointment or visit location** to associate orders and progress notes to this patient’s encounter. **It is important to remember to assign a co-signer on your note**.

Select the **Student note title** from the **Progress Note Properties** dialog box. Those notes with a **“T”** following the name have an established template. Otherwise, in the **main text box**, type note and/or insert predefined templates such as **Shared Templates**.

SIGN A NOTE

To sign a note, **right-click** on body of note and choose **Sign Note Now** and a box appears for you to enter your **electronic signature**.

If you are asked to have your preceptor review your note **prior to signing it**, you can choose **Save without Signature** which is available by right clicking on body of note. When the provider is