ORCA for Anesthesiology
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There are many aspects of using ORCA that are important for patient care and for billing, but unfortunately, many of these aspects are not intuitively obvious. A few points before getting into the details of customizing ORCA for your personal use.

1. Some notes are billable (e.g. Procedure Notes such as nerve blocks, epidurals, intubations, Pain notes) and some are not billable (e.g., preop and postop notes). When a resident writes a billable note, the resident should forward a billable note to the attending who supervised the procedure.

2. All billable notes must be more than just signed by an attending. Usually there must be an attestation stating the attending’s involvement in the procedure, and sometimes an attestation to the medical necessity of the procedure. The notes are designed to make it easy to complete the necessary attestations. Just remember that all note revisions should be made via the “correct” option rather than the “modify” option (more on this later).

3. All anesthetic records MUST have an Anesthesia Preoperative Assessment note associated with that anesthetic. A preop note used for an earlier surgery does not count, even if it was the day before. A new note must be written. Fortunately, a new note can be created from the old note (see the “copy forward” option described later).

Customization is helpful because it directs you to the notes and folders you commonly use. All ORCA notes get placed into a folder, and typically that folder is a subfolder of another folder. Subfolders are assigned to folders, so the only decision the provider must make is to select the correct subfolder. When other caregivers (or the coders/billers) look for a note, people usually search “By Type” and then open the folder/subfolder where they expect the note to be. For example, the Surgical/Procedural Documentation folder contains the Pre Anesthesia, Post Anesthesia, and Procedure Note subfolders. Also in the Surgical/Procedural Documentation folder is the Anesthesia Record subfolder where you will find the Docusys generated anesthetic record. Pain notes should be in the folder “Inpatient Documents – All Disciplines” or the folder “Outpatient Records”, and then in the appropriate subfolder “Pain Management – Inpt Record” or “Pain Management – Outpt Record”, respectively. If notes are not in the expected location, it makes them harder to find.

Topics included in this handout are:

I. Setting up a default list for commonly used Powernotes.
II. Setting up a default list for the correct (sub)folders into which notes should be placed.
III. Creating autotext (such as for your signature line).
IV. Signing and forwarding notes.
V. Anesthesia Preoperative and Postoperative Assessment powernotes, including the copy forward option.
VI. Understand the difference between Modifying (creating an addendum) and Correcting (re-entering the template format) a Powernote.
VII. Understand how to negotiate the electronic yellow packet.
I. Setting up your default list of commonly used Powernotes

ORCA has many different Powernotes. It is easier to find the note you want if you define a default list of preferences. This section will explain how to set up a recommended default list, although you are always welcome to alter that list as you see fit.

1. Open ORCA and any patient (real or fake such as zzstorm or any zztest).

2. Open PowerNote (click on “Iview & Powernote” in the left hand menu (easiest method) or click on “Chart, Iview Powernote”).

3. Open a new Powernote by clicking on the folder icon (easiest method). (Alternatively, click on “Documentation, Open, Open”.)
4. Click on “Catalog”, select “Procedures”.

5. Holding down the CTRL key, select the following notes:

Then click “Add to Favorites”, and click “OK”.

6. Now select “Anesthesia” in Catalog, and open the Pain Relief Service subsection as well. Select the following notes while holding down the Ctrl key:

Then click “Add to Favorites”, and click “OK”.

Likely want:
Procedure: Nerve Block
Procedure: Neuraxial Catheter
Procedure: Pain Catheter Reinsertion
Procedure: Tracheal Intubation

May want:
Procedure: Arterial Line
Procedure: Central Line/CVC Insertion
Procedure: Epidural Blood Patch
Procedure: Pulmonary Artery Catheter

(Note: You do not need to select all of these notes if there are some you do not think you will use.)
7 There may be additional notes from the entire list of options depending on what services you cover. You can search for such notes within Catalog or by opening “Encounter Pathway”, typing a search term in “Search” and clicking on the binoculars. Also, for attendings, a comment about the Anesthesia Attending PreOp Attestation. This note must be completed if an anesthetic is recorded on paper instead of a Docusys record. The Anesthesia Attending PreOp Attestation should go into the Anesthesia Record folder (and is the only note you should ever have to actively put in that folder).

8 Now, to create a note that is on your Favorites list, begin with steps 1 and 2 above, then select “Favorites” and double-click on the note you want.

The Powernote will appear in a new window, ready for you to complete.

9 If you ever want to delete a note from your preferences, get to step 8 above, then highlight the note you wish to delete, and click on “Remove from Favorites”.

10 When you close ORCA, make sure you do so using the “Exit” button, not the “X” in the upper right hand corner of the screen, otherwise you lose all these changes.
II. Setting up your default list of Commonly Used (sub)Folders

There are only certain folders into which your notes should be placed. You choose the (sub)folder as each (sub)folder goes into a pre-designated folder. In order to facilitate using the correct (sub)folders (and avoid using incorrect subfolders), please create a Personal Note Type List as follows:

1. Open any fake patient in ORCA (eg. zzstorm, zztwain or any zztest).

2. Select “Clinical Notes” from the menu, then select “Documents, Options”.

3. Set the “Default Document Type” to “none”. This will require you to actively select the (sub)folder into which you are placing a note, instead of defaulting to the last used folder (which may be the wrong folder for the new note).

   The left hand column contains every available (sub)folder type. The column on the right shows your favorites. The note types you want are: Pre Anesthesia, Post Anesthesia, Procedure Note, Alert Care Plan (put the Anesthesia Difficult Airway note in this folder), and possibly Pain Management - Inpt Record, Pain Management - Outpt Record. Anesthesia attendings should also add the Anesthesia Record.

   Double clicking on a note type will move it from one column to the other (or highlight it and click on the single arrow). Make sure you delete unwanted folder types from your Personal Document Type List (e.g. Procedure Report, Preop Assessment, Anesthesia Report).

   Click “OK” when done.

   Post Anesthesia
   Pre Anesthesia
   Procedure Note
   Alert Care Plan

   If involved with Pain:
   Pain Management – Inpt Record
   Pain Management – Outpt Record

   Attendings only:
   Anesthesia Record (used only for the attestation note with paper anesthetic records)
4. Open PowerNote (click on “Iview & Powernote” in the left hand menu or click on “Chart, Iview Powernote”).

5. Open a new Powernote by clicking on the folder icon (easiest method) or by clicking on “Documentation, Open, Open”. Then open any available note.

6. Click on “View” near the left hand top of the screen and select “Customize” from the list.
7. Select the Document Types tab.

8. Set the “Default Document Type” to “none”. This will require you to actively select the folder into which you are placing a note, instead of defaulting to the last used folder (which may be the wrong folder for the new note).
   Set the “Default List Type” to “Personal Note Type List”.
   Make sure the “Display last document type used as default” is unchecked.
   The left hand column contains every available folder type. The column on the right shows your favorites. If you did step 3 above, you should see your chosen (sub)folders on the right.
   As above, the note types you want are: Anesthesia Record (attendings only, for the Anesthesia Attending PreOp Attestation), Post Anesthesia, Pre Anesthesia, Procedure Note, and possibly Pain Management - Inpt Record and/or Pain Management - Outpt Record.
   Double clicking on a note type will move it from one column to the other (or highlight it and click on the single arrow). Make sure you delete unwanted folder types from your Personal Document Type List (e.g. Procedure Report, Preop Assessment, Anesthesia Report).

9. When you close ORCA, make sure you do so using the “Exit” button, not the “X” in the upper right hand corner of the screen, otherwise you lose all these changes.
III. Setting up your Signature (autotext)

Note: ORCA now automatically adds your name to the note when you sign a note, thus it is not necessary to actively add your signature text to the note. Therefore, you do not need to set up an autotext signature. However, sometimes it is useful to know how to create autotext. Although this describes an autotext for your signature, these steps can be used to create any autotext.

1. Once you get to the part of a Powernote where your name goes, click where it says “Signature Block” and a field will pop up where you can type in what you want:

2. Highlight the text and then right click on it. You will now be given the option to “Save as Autotext”, which you should click on.
3. Start by defining your abbreviation code (eg. .sig). Add a description if you like. Click “Save” and then “Close”. Your autotext is ready to use.

4. Now, when you open a signature block, you can start typing .sig, and then click on it and your signature autotext will be inserted.

5. When you close ORCA, make sure you do so using the “Exit” button, not the “X” in the upper right hand corner of the screen, otherwise you lose all these changes.
IV. Signing and Forwarding Notes

1. The most important part of this section is to make sure you do not forward a note to the wrong person. When you are ready to sign a note, you either click on “Documentation”, “Sign” or click on the Signature icon (easiest).

2. If you have correctly set up your preferences, you should now see the following (using the tracheal intubation powernote as an example):

   ![Image of IVIEW & PowerNote interface]

   NOTE: You can change the date and time here to better reflect when the service was actually performed.

3. Clicking on the down arrow in the “Type” field should display your folder favorites. Select the appropriate folder for the note you are creating. The choice should be intuitively obvious with procedures going into Procedure Notes, Anesthesia Preoperative Assessment Note going into Pre-Anesthesia, and so on.
4. If your view is not as above, then you need to fix your defaults as described in Section II. However, all is not lost. Right click in the blue field where it says “Type”.

5. Select “Personal Note Type List”, or, if you have to find a (sub)folder that is not in your personal note type list, you can select All Note Type List and get every possible subfolder from which to choose. (Now go to section II and fix your preferences.)

6. BEFORE CLICKING “OK”, you must decide whether or not the note should be forwarded. If you do not want to forward, you must make sure that the “Request Endorsement” box is unchecked. As a general rule, any non-billable note (eg. preop or postop note) does not need to be forwarded since an attending signature is not required.

Then click “OK”.
7. In contrast, billable notes (all procedure notes, for example) need attending signatures, so residents should forward them to the correct (supervising) attending unless you know that the attending will be accessing the note on their own (always suspect!). To forward, click on “Request Endorsement” and then make sure that the visible list only contains the attending you want. You can remove someone from the list by clicking on their name, then click on the “Remove Endorser” box. To find a person, click on the far left of the first blank line in the Endorser box and the binoculars will appear. Type the last name in the white box. If there are multiple matches, it will say so. Click on the binoculars and another window will pop up that will allow you to choose from a list (or revise your search).

8. You must now select whether the endorser should sign or merely review the note. Usually you will choose “sign”. You can also add a due date and comments, but these are not required. Click “submit”.

9. When you close ORCA, make sure you do so using the “Exit” button, not the “X” in the upper right hand corner of the screen, otherwise you will remain logged into ORCA.
V. Preoperative and Postoperative Notes, and Copy Forward Notes

Every patient who has an anesthetic is required to have a completed Anesthesia Preoperative Assessment note (and an Anesthesia Postoperative Assessment note). If a patient returns for another surgery, another Preoperative Assessment note must be created. The good news, though, is that it is easy to copy forward a prior Anesthesia Preoperative Assessment note and merely update the information. Here is how:

1. Begin by opening the patient’s electronic chart and identify the prior Preoperative Assessment note that you want to copy forward (should be in the Surgical/Procedural Documentation folder, Pre Anesthesia subfolder).

2. Now get into Iview/Powernote and select the new note icon or Documentation, Open, Open.

3. Click on “Existing” tab, select “All Encounters”, check “Copy to new note”, highlight the note you want to copy forward and click “OK”.

![Image of Iview/Powernote interface for copying forward notes](image-url)
4. A list of components of the note will appear, with checkmarks in the boxes of those sections that will be copied into the new note. You can change which sections are copied by clicking or unclicking the various boxes. However, deviating from the default list should be done with care. It is your responsibility to make sure that everything in the note is current. Click “OK”

5. The information selected from the old note will now appear in the new note. As with any Powernote, you can go into each section and redisplay any of the templated sections. Each section needs to be reviewed for accuracy and updating. Shown below is one way to enter a new date.
6. Things to be careful of include:
   - OR date, current diagnosis, current proposed surgical procedure.
   - Type of visit, enter date when the patient was last evaluated in person or by phone.
   - Delete any information that you did not confirm from the chart or the patient.
   - Update the past surgical history (presumably at least one surgery has transpired since the last preop evaluation).
   - Confirm medications (import current meds from ORCA).
   - Update the review of systems.
   - Include only those physical exam findings you performed (don’t leave old data).
   - Update Results and Procedures sections.
   - Put in your summary comments.
   - Delete all prior signatures (and insert your own, if you want to).
   - Make sure the note is stored in the Pre Anesthesia subfolder.

7. Postoperative notes are templated and easy to complete. Again, make sure they are stored in the Post Anesthesia subfolder.

VIII. When you close ORCA, make sure you do so using the “Exit” button, not the “X” in the upper right hand corner of the screen, otherwise you will remain logged into ORCA.
VI. Alteration of Notes

There are two ways a Powernote can be altered: “Modify” and “Correct”. Modification creates an addendum to the note. This is a perfectly acceptable method to alter any note, but there are two big disadvantages. First, once a Powernote has been altered via “Modify”, it can no longer be altered via “Correct” (in other words, you can no longer get into the template mode). Second, any addendum to a Powernote will not be included if the note is used to “copy forward” into a new note. Using the “Correct” method of alteration works by re-opening the note in its original, templated format. This permits the original note to be changed just as if it were being created for the first time. The “Correct” method can be applied over and over without limit, allowing ample opportunities to fix any errors in the note. It also permits the note with the new revisions to be part of any “copy forward” operation.

If you wish to change a note, perform the following:

1. Open the note you wish to alter.

2. Choose “Modify” (add an addendum) or “Correct” (reenter the template) as desired by clicking on the appropriate icon or clicking on “Documents”. Again, there is almost no reason to ever use “modify” if “correct” can be selected.

3. To re-emphasize the distinction, the biggest problem with using “Modify” is that once used, you can no longer use “Correct” and therefore cannot enter the template again. If you use “Correct”, you will be able to enter the template and revise the note just as you would if you were creating the note for the first time. There is no limit as to how often you can “Correct” a note. However, once the attending has signed the note, the resident can no longer use “Correct” (but the attending can).

4. If you use “Modify”, the first time you use it you will be able to make freetext changes to the note. Thereafter, any other time you use “Modify”, you will get an Addendum added to the bottom of the note where you make your comments. Again, the only time you should use “Modify” is if you cannot use “Correct”.

5. When you close ORCA, make sure you do so using the “Exit” button, not the “X” in the upper right hand corner of the screen, otherwise you will remain logged into ORCA.
VII. The Electronic Yellow Packet

The electronic packet is used preoperative by the surgical services and pre-anesthesia service to better organize the pertinent documents for the upcoming surgery, and as a simple way to track which of the required items have or have not been completed.

For the anesthesia user, the electronic yellow packet provides a convenient way to access pertinent documents, such as the pre-anesthesia note, the surgical H&P, and any consults (eg Medicine or Cardiology consults).

1. Starting with an open patient record, click on “Chart Summary” and the beginning of the electronic yellow packet will appear. Click on the surgery in question.

2. Scroll down so that you can see the various categories. The most useful are likely to be the Assessments and the Consults and Diagnostics.
3. Here is an example of the Assessments. Things like the H&P and anesthesia preop assessment should appear here. Click on any item you want to review.

Question or problems? Call Alec Rooke on pager 680-1220 or call the ORCA help line at 206 543-7012 (they are open 24/7; I am not).