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. Some points to keep in mind include:

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. There are key fields in such notes for the attending to complete (their attestations). Don’t complete any of the attending only sections.

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. If you are an attending, you open the note and complete the attestations, then sign. Just remember that to get into the template of the note, you must use the “correct” option rather than the “modify” option (more on this later). Again, residents should not complete attending attestations.

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 initiated 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 specific folders, so the only decision the provider must make is to select the correct subfolder. When other caregivers look for a note, people usually search “By Type” and then open the folder/subfolder where they expect to find the note. 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. Outpatient pain notes go into the subfolder “Pain Management – Outpt Record” which is a subfolder of the “Outpatient Records” folder. Inpatient pain notes go in the subfolder “Pain Management – Inpt Record” which is a subfolder of the “Inpatient Documents – All Disciplines” folder. 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. Signing and forwarding notes.
IV. Anesthesia Preoperative and Postoperative Assessment powernotes, including the copy forward option and setting defaults for what is carried forward.
V. Understand the difference between Modifying a Powernote (creating an addendum) and Correcting a Powernote (re-entering into the template format).
VI. Understand how to negotiate the electronic yellow packet.
VII. EPIC via ORCA
VIII. Expanding the number of notes viewed in ORCA.
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 fictitious patient 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 notes you wish to make your favorites. You should consider adding the following notes:

![Image of the interface with selected 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:

![Image of the interface with selected notes]

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

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, the Anesthesia Attending Attestations note should be completed if a paper anesthetic recorded is used. When completed, the Anesthesia Attending Attestations note should be placed into the Anesthesia Record folder (and is the only note you should ever have to put in that folder).

Likely want:
- Procedure: Nerve Block
- Procedure: Neuraxial Catheter
- Procedure: Pain Catheter Reinjection
- Procedure: Tracheal Intubation

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

(Note: You can always add or remove notes as the rotation you are on dictates.)

Anesthesia Difficult Airway Note
Anesthesia Postoperative Assessment
Anesthesia Preoperative Assessment

In addition, for Attendings:
- Anesthesia Attending Attestations
- Anesthesia Echocardiography Note (cardiac)

For people involved with Pain:
- Pain Acute Inpatient Note
- Pain Chronic/Cancer Inpatient Note-UW

For people involved with OB:
- Anesthesia OB Assessment
- Anesthesia OB Caesarean Section
- Anesthesia OB Post-Partum Assessment
- Anesthesia OB High Risk Note
- Anesthesia OB Procedure Note
Now, to create a patient note of a type that is in your Favorites list, begin with steps 1 and 2 above, then select “Favorites” and doubleclick on the note you want.

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

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”.

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. For most OR related notes, they will end up in (sub)folders of the Surgical/Procedural 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”.

[Image of ORCA interface with highlighted options]

[Notes on ORCA interface are not necessary for the text, but could be included for context]
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.

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

   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)
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.

Any of these options will help you find a note.
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).

Once the right hand column is set as desired, click “Apply” (if changes were made) and “OK”. You are now ready to use these default lists to help you find commonly used notes and to be able to select the correct folder in which to place the completed note.
III. 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):

NOTE: You can (and should) change the date and time here to correspond to the actual date and time when the service was performed.
3. Clicking on 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 field where it says “Type”.

5. Select “Personal Note Type List” to look at your favorites. 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 (e.g., 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.
IV. Preoperative and Postoperative Notes, and Copy Forward Notes

Every patient who has an anesthetic is required to have a completed Anesthesia Preoperative Assessment note that is associated with that surgery, 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”.

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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 (see later for more information on this field). However, deviating from the default list should be done with care. **It is your responsibility to make sure that everything in your new note is current.** Click “OK”.

![Select Paragraphs to Copy dialog box](image)

If you have previously seen this field and have clicked the “Do not display this dialog box again” and so you do not see this field, you should check on whether the copy forward part contains more than the checked fields. If you need to change which paragraphs are copied forward, see the end of this section.

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. Some fields will be blank, just like on a blank template. Fill in the fields just as you would normally do. Shown below is one way to enter a date of surgery.

![Date of Surgery Screen](image)
6. Things to be careful of include:
   OR date, current diagnosis, current proposed surgical procedure.
   Type of visit,
   Enter the date when the patient was last evaluated in person or by phone. The most recent
   note may not be “in person” or “phone” so be careful what date you put. “N/A” may
   be the appropriate choice.
   Delete any information that you did not confirm from the chart or the patient.
   Similarly, delete information that was specific to the previous evaluation and no longer
   relevant (e.g., “pt getting over a cold” from the old note three months ago).
   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. Make sure any carried over items in the Summary are
   still valid.
   Make sure the note is stored in the Pre Anesthesia subfolder.
   Over the years, changes to the construction of the preop note have occurred. If you copy
   forward a note that has a different construction than the current format, some items
   might get duplicated. Entire sections may be out of order. Don’t worry about the
   order, but make sure the information in the note is understandable and makes sense.

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

8. 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, even
   though it is no longer visible.
In order to alter the paragraph selections to be copied forward, perform the following:

1. Open any PowerNote (pretend you are starting a new note).
2. On the top task bar, click on View, then select Customize.
3. Click on the More tab and click on the “Show Select paragraphs to Copy dialog box” check box. A check should appear in it.
4. Select OK.
5. Close the note you just opened.
6. Open an existing note. Select copy forward and the list should appear again.

For the Anesthesia Preoperative Assessment note, the following paragraphs should be selected:

Once these are set, you can repeat the instructions and now uncheck the “Show Select paragraphs to Copy dialog box”. Doing so will stop the above field from appearing every time you copy forward a new note.
V. 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 may 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.
VI. The Electronic Yellow Packet

The electronic packet is used preoperatively 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.
VII. EPIC via ORCA

Now that most surgery clinics have transitioned to EPIC (SCCA is a notable exception – they still chart in ORCA), there is a need to be able to view EPIC documents in order to obtain information from the surgeon or medical consultant. Fortunately, it is pretty easy to view EPIC notes from ORCA. In addition, outside documents and the health questionnaire (if completed on paper) are often now scanned into the Media tab of EPIC instead of relying on access to the paper copy. This section will show you how to find the Media tab.

There are two ways to look at EPIC notes via ORCA. You can either click on ORCA/EpicCare Note, or click on EpicCare Link (EpicWeb).

If you click on ORCA/EpicCare Note, you will see something like this:

If you click on EpicCare Link (EpicWeb), you will enter EPIC in the SnapShot view:

To see the list of clinic notes click on “Chart Review” (see above red arrow).
Sometimes EpicCare Link (EpicWeb) fails. If this happens, open Internet Explorer and get into the Clinical Toolkit. There you click on EpicCare Link:

![EpicCare Link](image)

You use your usual login info to get in. Select Pre-Anesthesia Clinic if necessary, or whatever clinic seems best. Once in, you can find a patient via the MRN or via searches. This direct link uses a different server than Epic via ORCA, so if the server for ORCA fails, the above direct link might still be working.

Once in EpicCare Link and have selected Chart Review, you should see something as shown below. Unlike ORCA/EpicCare Notes, EpicCare Link also permits you to view any documents that have been scanned into the EPIC Media tab. Please understand that the Media tab may be not visible in the initial view in Chart Review. You may have to click a right pointing arrow (not shown below) to move the list of tabs to see the Media tab. Faxes from outside facilities or the anesthesia health questionnaire are often scanned into Media.
Any note that has a scanned document attached will have a paper clip icon. This could be anything – a health care directive, outside clinic notes, lab work or medical test results. But if you click on the Media tab (see red arrow above), you will now see a list of all notes with attachments and usually a description of what the attachment is:

Clicking on the date of the document you wish to examine (above, in this case the one with the red arrow) brings up a view of the following:

Clicking on the scan file link (above red arrow) will open the document.

Sometimes a note will not be completed, in which case it is marked “Open” (see below, red arrow). If that is the case, remember that some information may be missing.

It is possible that more of what is in an “Open” note will be visible when opened via ORCA/EpicCare Note, so you may want to look at the note in ORCA/EpicCare Note as well.
You should also be aware of some of the advantages of looking at the electronic yellow packet. It may help you find pertinent documents such as the surgical history and physical, or important medical test results.

First, you have to be able to get into it. Start with Chart Summary. You may see something like this:

You have to click on “more” to find the Surgery Yellow Packet option:

Once selected, you may wish to “Set current view as Default” so that you will automatically view the yellow packet whenever you click on Chart Summary.

The home page of the Surgery Yellow Packet looks like this:

Click on the YP Status status to open the yellow packet and the top will look like this:
If you scroll down, additional information will be visible:

“PAC Bypass Request and Support Documents” may list pertinent documents if a request had been made to not require the patient to visit the preop clinic. The “PAC Bypass Request” may also provide pertinent information on where to find information about the patient. Similarly, pertinent documents may be found in the “Assessments” section, and you may find the surgical H&P in the “History and Physical” section.
VIII. Expanding the Number of Notes Viewed

When you access ORCA, certain default settings exist for the number of notes that will be loaded into the Clinical Notes. The default is either by days or by the maximum number of notes. If days are selected, 90 days is the default. If notes are selected, 250 notes is the default. You can increase the number of days, or the number or notes, but for either option the maximum value is 999.

To change the default settings, in Clinical Notes, go to Documents, Options:

You will now see:

Click on Index Defaults.
I strongly recommend you use the number of notes option. This selection does not impose any date limits. So after entering Index Defaults, select Document Count (arrow). You can increase the number of documents (to up to 999) but the rationale for not doing so is to save time from loading excess numbers of documents into the computer.

When viewing the Clinical Notes for a specific patient, the gray bar (see arrow, below) will tell you how many notes are currently loaded. If the number of notes shown is near the value of the number of notes available (in this case, 238 out of 252 – see red arrow), it suggests there may be more notes. If those might be of interest, click the right point arrow in the gray bar (see green arrow). That will add more notes to your search.

You can keep doing this until the number of notes shown (red arrow) is much less than the number of “Last ___ Documents” (yellow arrow). At this point you should be seeing all the available notes:

The other option is to right click on the gray bar. Now you get the option to change the number of notes viewed or the date range for this ORCA session. If you are using this option, setting the date range may be the best option because it displays all the notes without a number limitation for the date range you select.

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).