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Course Length and Audience

This learning activity is for providers who access COMPASS to view electronic patient records, but who do not place orders or make patient rounds.

Learning Objectives

After completing this training session, the provider will be able to:

1. Access COMPASS
2. Describe an overview of the Toolbar in COMPASS
3. Create a Location Patient List (if applicable)
4. Navigate COMPASS to view patient data

Introduction to COMPASS

COMPASS is Seton Healthcare Family’s Electronic Medical Record (EMR). It is a Cerner product.

Seton Doctor Link is the external provider resource for gaining access to COMPASS and can be found by typing; doctors.seton.net into the web browser. This website is an excellent resource for Seton’s providers on many topics. The COMPASS section of this website contains information about downloading Citrix which is necessary before being able to log into COMPASS from personal devices and Seton site-based support staff for COMPASS.

The COMPASS login button provides a method to launch the Cerner Applications window.
From Cerner Applications window, select the Powerchart icon which is for inpatient clinicians.

A login screen will be completed to access COMPASS.

Login Information

You will receive 2 accounts; an AD account and a COMPASS account (which can be synchronized to be the same username and password). Your network password will expire every 365 days. Call the Seton Service Desk at 512-324-1675 for a password reset. However, your COMPASS password does not expire, but can be changed by using the Toolbar Task→Change Password, to match the AD account if desired.
The Tool Bar
There are 4 main sections which will be available in the Tool Bar. Patient List, Learning Live, Up to Date and Seton HIE.

Patient Lists
There are several Patient List types, but Location List is the list most suitable for your workflow.

How to Create a Location Patient List

1. Click the List Maintenance icon (wrench) on the Patient List toolbar at the top of the screen.


3. Select Location Type.

4. Select location groups from the List Location. Click on the ‘plus’ sign to open up more options. Select the hospital/work station. The name will default to the ‘Enter a name for the list’ box. This may be renamed as desired. Click Next.
5. Select Discharged Criteria. From the window, select Not Discharged.

![Image of Location Patient List window]

**Tip:** Using the Not Discharged filter allows patient names to automatically drop from your list upon their discharge.

6. Click Finish.

7. Select the list from the Available Lists window.

8. Click the Add arrow between the two columns to move the new list to the Active List window, then OK.

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**Learning Live**

The Learning Live resource contains current information regarding COMPASS functionality presented in video or document format. This site also includes recently published COMPASS updates called COMPASS Tips and Tricks which are explanations of new features within COMPASS.

**UpToDate**

This provides a link to national database utilizing an external wiki site while logged into COMPASS. Providers may register with UpToDate and receive CMEs for each search and review of any of the topics on that site after establishing an account.

**Seton HIE**

The Seton Health Information Exchange (HIE) allows Seton providers access to view patient clinic data from those clinics affiliated with Seton, (medications, allergies, problems/diagnoses and some diagnostic results), and also for providers from the ambulatory setting to access some portions of their patients Seton inpatient data. Accessing the HIE link will open another window in the Internet Explorer, called dbMotion Clinical Views. This window will need to be closed before returning to the PowerChart window.

![Image of dbMotion Clinical Views window]
Searching for a Patient EMR

1. The patient name or MRN may be entered into the search field.

   Or, using the Magnifier icon, enter search parameters such as Name, Date of Birth (DOB), Medical Record Number (MRN), or Financial Number (FIN) to locate the patient record and click Search.

2. The patient search window will open.

   ![Patient Search Window]

   **Stop, Think, Act and Review**
   Your search will retrieve a list of patients that meet search parameters. Review patient identifying details and select the correct patient for the correct encounter using two patient identifiers (Name, DOB).

3. The Recent dropdown box will display the names of the 5 most recent patient charts that you have opened.

   ![Recent Dropdown]

Establishing a Patient Relationship

Upon opening a patient record for the first time, you will be asked to establish a relationship with the patient as part of the medical record. The relationships will display inside the patient record.

![Assign a Relationship]

Compass

Seton Healthcare Family
Inside the EMR
There are 2 main sections within the patient EMR. The Banner Bar and the Menu.

The Banner Bar

The blue bar across the top of the medical record is called the Banner Bar and indicates which patient record is active. Up to 4 patient records may be opened simultaneously. It is important to review/verify patient identifying data each time a patient record is opened.

As additional records are opened, the active banner bar color will change from blue to yellow, green, or purple. However, the colors indicate the number of records open and are NOT indicative of a specific patient record.

Most all of the items on the Banner Bar are hyperlinked to open sections of the chart, such as the patient name which opens a demographic section, Allergies which open the allergy profile and 'Inpatient' which opens a list of other encounters.

The Menu

The sections of the Menu which are most commonly used for your practice are outlined below.
How to Change Date Ranges

Several sections of the patient medical record will show a default date range for that section. The desired date range can be changed by right-clicking on the date range bar and by selecting Change Search Criteria. Clinical Range or Date Range is most common choice depending on which section of the record is being viewed.

Flowsheets

Flowsheets is the main repository for documented information. It allows for simple graphing and may permit retrieval of results from previous visits. The "MORE" button will display when there is additional information that is hidden. It will be dithered if there is no additional data to display.

Flowsheets Tabs – Definitions

<table>
<thead>
<tr>
<th>Tab</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quick View</td>
<td>First sub-tab in Flowsheets: Labs, (including reference labs), x-ray reports, vital signs, history &amp; physical, and other transcribed documents.</td>
</tr>
<tr>
<td>Lab</td>
<td>Lists lab results. If results are above normal, an (H) will be next to the result. If low, an (L) and if critical results are present, they are in red with an (!) next to the result. Note: Critical and reference ranges are defined by policy.</td>
</tr>
<tr>
<td>Diagnostics</td>
<td>Lists recently transcribed radiology, diagnostic reports and images.</td>
</tr>
<tr>
<td>Vitals/Pain</td>
<td>Lists vital signs and pain assessment findings.</td>
</tr>
<tr>
<td>Assessments</td>
<td>Lists assessments by members of the patient care team.</td>
</tr>
<tr>
<td>Blood Product</td>
<td>Displays blood product related labs and blood administration information.</td>
</tr>
</tbody>
</table>
Views in Flowsheets

Three View choices are available in Flowsheet: Table, Group or List.

☐ Table View is the default setting. This view displays data with time and date across the top of the sheet. The user may need to scroll left to right and up and down to see information.

☐ Group View displays data with time and date across the left column. This setting reduces the need to scroll across the screen, and displays allows for more easy viewing of data trends.

☐ List View displays data in reverse chronological order by result. It includes reference ranges (norms) to help clinicians compare values. It is a good teaching tool for new clinicians.

How to View a Diagnostic Test With or Without an Image (tracing or read-out)

1. Click on the Diagnostics tab.
2. Double click on the desired test.
3. The results Report will open.
4. If there is a scanned image related to this result, click on the View Image icon.
5. A PDF of the tracing or read-out will open up for ECGs.
Clinical Event Data

Nurses or other licensed clinicians will chart in a Clinical Event form should your patient have a Clinical Event while an inpatient (such as a fall, acute deterioration in medical status, or a critical lab value). The completed form will appear at the top of the Navigator band within Flowsheets within the search range. Double-click on the Clinical Event form to view the details. If Clinical Event is not listed as a category, this indicates that there is no documentation; you will not need to search for that category.

Overview

The most useful feature of Overview is the Since Last Time tab. This view will display most all actions that have occurred since the last time you opened this patient record.

Patient Summary

The Patient Summary page gives an overall clinical picture of the patient’s status at a glance, and is an ideal snap shot of the patient’s status for daily rounds. It shows the most common labs and spark diagrams to show trends and includes a quick link to Flowsheets for other lab results. It displays vital signs, 24 hour cumulative fluid status, patient information, and clinical documentation, all in one view.

Orders

The order page has a left and a right viewing window.

The upper left window displays medical/surgical power plans at the top of the window, and the current status of those plans, whether Initiated, Planned, Discontinued or Voided. The lower left section shows the clinical categories of orders that exist for the patient; if the category is bolded with a check mark, it denotes that there are orders within that clinical category.

The right side of the viewing window shows the orders, order details and the status of the orders.

Clinical Categories and Order Details:
Changing Orders View

Changing the Order View allows control to viewing the category of orders, whether active, completed, discontinued, etc. Click on the Displayed blue text to open the Advanced Filters box.

1. Click on the Display drop box and choose the desired display. Click Apply.

Orders Summary View

This section is organized to show the history of orders over a defined time frame. This can be especially useful when returning to the patient record after several days have elapsed since last looking at the patient orders.

Micro Results

The Micro page displays all culture results: wound, blood, sputum, stool, urine, etc. from the last 120 days. The results display in reverse chronological order, and include susceptibilities once determined from the culture. When searching for a culture older than 120 days, it is necessary to open Flowsheets and change the Search Criteria date range to be able to see older results.
MAR Summary

The MAR Summary will display current medication orders and dose administration time details for this encounter. Using the mouse-hover feature will display details about blood glucose, vital signs or comments from nursing documentation.

Graphic View

Graphic View for viewing trends to vital signs, detailed I/O, clinical weights, drip titrations, and details of documented tubes and drains. It is very much like a critical care graphic sheet. The page does take more time to load, and takes up the entire screen once opened. To close this view click the Close Window sentence (top right of screen). A blank screen will display. Select another menu item to fully exit this view.

Multidisciplinary View

The Multidisciplinary Page displays the notes and goals of members of the multidisciplinary team, progress towards goals, notes related to discharge planning, and any other needs as noted by case management and social services.

Documents

Information within Documents is filed into 3 main categories, Clinical Documents, Radiology Reports, and Pathology Reports.

Examples of reports and scanned documents:
(see status colors legend to the right)
  o Radiology results
  o ED physician documentation
  o Operative reports
  o Procedure notes
  o History and Physicals
  o Discharge Summary
  o Progress notes
  o Admission Notes, etc.

Examples of documentation on electronic forms:
  o Documentation from clinical support staff
  o Clinical events
  o Triage notes
  o Nursing Discharge Summaries

Blood Product View

The Blood Product view provides general information regarding patient blood type, T&S expiration dates as well as cumulative views of blood product related orders, blood administration values and reaction history documentation.

Diagnoses and Problems

Patients should have their medical diagnoses documented in COMPASS to promote the best patient care. Documenting the patient’s diagnosis is the responsibility of all members of the medical team.

**Diagnosis:** Diagnoses are encounter-specific and pertain what is going on this visit. Examples: Otitis Media, pneumonia, acute CVA. Diagnoses entered by nurses will be listed as “Reason for Visit”
Problems: Problems are patient-centric which means they remain in COMPASS unless resolved or inactivated, and flow to every patient encounter. Problems are the chronic or long-term patient conditions that require care or consideration at every patient visit. Problems entered by nurses will be listed as “Patient Stated”.

If problems have been resolved or inactivated, they will be seen in the Past Medical History section of the record.

Histories

This Histories section contains 4 categories of information collected by nursing as part of the admission assessment. It will include family history, the nutrition screen, past procedures and social history to include smoking status, preferred language and medical devices.

Allergies

Patient allergies can be viewed through the Allergy Profile and may have details related to the severity of the allergy and when the information was last updated.

Patient Information

This section contains information regarding patient demographics, patient visits, health provider relationships, the face sheet, and immunizations received at Seton facilities. In the event you inadvertently open the wrong patient’s chart, you may remove your assigned relationship to that medical record by highlighting your name, right-clicking and selecting Inactivate.

Power Plans and Care Sets

Power Plans are electronic order sets. They are written to follow evidenced-based practice guidelines and are designed to manage care for specific patient populations; ED, OB, Adult inpatient, surgical, procedural, critical care, pediatrics, etc.

Care Sets are smaller groups of orders that are grouped by purpose or to facilitate inclusion of all needed tests or dosing parameters. For example: Tests that include more than one order such as a Dobutamine Stress test or a Modified Barium Swallow, may be ordered as a Care set.