

Creating Templates in Most EMR's, Even the Dreaded Ones

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Disclosures

- None, but my main hospital uses EPIC for its EMR

Key Points

- Templates will save you time (10 min vs 2 min)
- Works best for repetitive tasks/documentation
- Good chance you already have them (in your head)

- Describe how to make your first template
- It's easier than you think

Challenges

- It takes too much time to set up
 - It won't help me in my practice
 - The EMR makes it too hard
 - I never thought of doing it
 - It's easier to dictate into the phone
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- I've said all of these.... Over time I realized I was lying to myself

What Does a Template Look Like?

Anything you want it to be

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Brief Op Note
Date: @TD@
Pre-operative diagnosis: ***
Post-operative diagnosis: ***
Procedure: ***
Surgeon: Ryan Will MD
Assistant: ***
Anesthesia: {Anesthesia Type :23749}
Intravenous Fluids: {NUMBERS; 100-1000 BY 100:60028} cc
Estimated Blood Loss: *** cc
Urine Output: *** cc
Drains: ***
Tourniquet Time: *** min at 250 mmHg
Implants used: ***
Condition:stable
Specimens: ***
Findings: ***
Complications: None
Plan: Post-op antibiotics : {abx:18625} x 24 hours
      Weight bearing status : {Weight bearing restriction:15914} operative extremity
      Post-op pain ctrl
      PT/OT services
      Anticipated discharge: {disposition:18248}
      DVT prophylaxis: lovenox x *** days
Note dictated. Confirmation number is ***
Ryan Will MD
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Wildcard

Smartlist

Template Examples or Uses

- Operative notes
- Operative consults
- Non-operative consults
- Rounding notes
- Implants
- Physical exam findings (ROM, wound dimensions, routine findings)
- Anticoagulation stems, consent stems, ambulatory status/aids
- Perioperative preferences/requests (bed, position, regional blocks)
- Annoying things (“pilon” vs “intraarticular distal tibia fracture involving the weight bearing surface”)

How to make the First Operative Note Template

- Should be something that is routine in your practice
- Review about 4-6 operative notes and pick the one that best represents your practice
- Use copy and paste function and put the op note in your smartphrase editor
- Find your right/left and replace with appropriate smartlist
- Add antibiotic smartlist
- Make it gender neutral (ie make “he/she” into “the patient”)
- As you use it you will then naturally begin to edit it to make it better

Hip Hemi Operative Note

Operative note

PREOPERATIVE DIAGNOSIS: Closed {RIGHT LEFT BILATERAL:21991} displaced femoral neck fracture.

POSTOPERATIVE DIAGNOSIS: Same

OPERATIVE PROCEDURE: Open treatment {RIGHT LEFT BILATERAL:21991} femoral neck fracture with prosthetic replacement.

ASSISTANT: ***

ANESTHESIA: General plus single shot femoral nerve block.

INTRAVENOUS FLUIDS: {NUMBERS; 100-1000 BY 100:60028} mL crystalloid.

ESTIMATED BLOOD LOSS: {NUMBERS; 100-1000 BY 100:60028} mL.

URINE OUTPUT: {NUMBERS; 100-1000 BY 100:60028} mL.

TOURNIQUET TIME: Not used.

IMPLANTS: Biomet Echo size *** pressfit stem with standard offset and a *** mm outer diameter *** head and a *** length neck.

CONDITION: Stable.

SPECIMENS: None.

FINDINGS: Displaced femoral neck fracture.

COMPLICATIONS: None.

DESCRIPTION OF PROCEDURE: The patient was identified in the preoperative holding area by me. I marked the {RIGHT LEFT BILATERAL:21991} hip with my initials. The patient was then transferred safely to the operating room and onto the operating table where the patient was induced under general anesthesia. The patient was positioned in a {RIGHT LEFT BILATERAL:21991} lateral decubitus position with the {RIGHT LEFT BILATERAL:21991} hip pointed towards the ceiling. Following induction of anesthesia, the pelvis was stabilized with a Stuhlberg style hip positioner. The injured lower extremity was then prepped and draped in sterile orthopedic fashion. Surgical pause was conducted between surgeon, OR staff, and anesthesia. Site and surgery were agreed upon. The patient did receive {0-3:60949} gram(s) of {abx:18259} prior to beginning the case. We then made an anterolateral approach to the hip. We had an incision approximately 10 cm in length, centered over the greater trochanter of the proximal femur. We incised through the skin and subcutaneous tissue. We identified the iliotibial band and made an incision through this. We then identified the abductor mechanism. Using electrocautery, we were able to lift this off which revealed the hip capsule underneath and the fracture. We removed a majority of the capsule we could identify. We then, using a reciprocating saw, made a cut 1 fingerbreadth proximal to the lesser trochanter to remove the remaining femoral neck. We then were able to identify and remove the femoral head utilizing an

osteotome. This measured *** mm in diameter. Any other debris was removed from the hip joint at this time. We then positioned the leg flexed and externally rotated. We were then able to use a box cutter and prepared the proximal femur. We were able to broach and ream this up to a size ***. We then trialed this with a standard offset head and neck. This reduced easily. There was a good toggle sign and was stable in both extension with external rotation and flexion with internal rotation. We then redislocated the hip and removed our trial system. We then selected our final implants. A formal implant time out was performed and the implants were confirmed personally by myself. We then placed our final stem. Once we relocated it, it was stable, just as our trial was. We then irrigated the wound copiously with sterile saline.

After this we obtained an intraoperative AP hip portable xrays that demonstrated anatomic reduction of the hip joint and stem without an femoral fracture and appropriate limb length. This image was saved to the Providence PACS system.

We then approximated the abductor mechanism with three #5 FiberWire sutures placed through transosseous tunnels in the proximal femur. These were passed through the abductor mechanism in modified Mason-Allen fashion. These were then tied down and this repair was reinforced with #1 Vicryl in a figure-of-eight fashion. We then closed the IT band with #0 Vicryl in running fashion. Skin was repaired with a combination of 2-0 Vicryl in inverted interrupted fashion and 3-0 Monocryl in a subcuticular fashion. Wound was then dressed with Dermabond and island type dressing. The patient was reversed from anesthesia, transferred safely onto a stretcher, and taken back to PACU in stable condition.

***Surgical Asst. responsibilities:

Because the technical nature of this procedure a surgical assistant was needed to assure as good an outcome as possible. Responsibilities included assistance with positioning of the patient, helping with hemostasis, helping with irrigation during the procedure, helping with exposure, assisting with preparation of bone and soft tissue for this surgical technique. As the surgeon I felt it was imperative to ensure success for this patient to have this necessary help in performing this surgery.

POSTOPERATIVE PLAN: The patient will require Ancef for 24 hours. Adequate multimodal pain control will be provided. The patient will be weightbearing as tolerated on the operated lower extremity. The patient will require services of PT and OT and will likely require SNF at discharge. The patient will be on Lovenox for 21 days for chemical DVT prophylaxis. The patient will follow up with our office in 2-3 weeks, at which time the patient will need an AP pelvis and crosstable lateral the injured hip.

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Benefits

- Save time each day not dictating
- Save time each day documenting efficiently
- Feels like I am stealing time each time I use a template for either operative note or a consult, especially non op consult
- Internal checklist for me
- Can be more thorough in documentation in less time
- Better communication with team members (anaesthesia, nursing, etc)
- Can improve templates over time with editing

Documentation

Olecranon Bursitis Consult Example

A/P) This is a @AGE@ @SEX@ with {RIGHT LEFT BILATERAL:21991} septic olecranon bursitis. Pt would benefit from non operative treatment; in this case observation and continue IV antibiotics per primary team. Per a review of 29 studies with about 1278 patients, the non operative treatment of septic olecranon bursitis was more likely to clinically resolve and demonstrated lower rates of overall complications. Surgical management was more likely to result in persistent drainage, and continued bursal infection than nonsurgical management (Arch Orthop Trauma Surg 2014 Nov;134(11):1517-36).

Osteoporosis Documentation

This patient's fracture is pathologic in nature secondary to osteoporosis as this patient fell from a standing height or less. Pt will benefit from appropriate calcium and Vitamin D supplementation, work up for secondary causes of osteoporosis and a DEXA scan as an outpatient to determine this patient's future fracture risk. If risk is large enough then this patient may benefit from dedicated bone health medication, such as bisphosphonates.

Communication

Surgical Positioning Stem

Does patient require a foley catheter: {YES/NO:21615}
Position: {DESC; PRONE / SUPINE / LATERAL:19389}
Operating room table : ***
Order Transexamic Acid (TXA) pre-op: {YES/NO:21615}
Pre-operative regional block: {yes:21565} Type of block requested: ***

Post-op Plan Stem

Plan: Post-op antibiotics : {abx:18625} x 24 hours
Weight bearing status : {Weight bearing restriction:15914} operative extremity
Post-op pain ctrl
PT/OT services
Anticipated discharge: {disposition:18248}
DVT prophylaxis: lovenox x *** days
Note dictated. Confirmation number is ***

Benefits: Fewer pages from staff, better flow into the operating room,
prompts me to dictate notes ASAP

Conclusion

- If you are here at this conference, you are looking to get better and being more efficient is part of that process
- Make a template of the your most frequent surgery and see how you feel afterwards
- You will want to make more

Questions?

- Happy to share tips and tricks and even templates
- Email me if you want to find out more
- rwillgigharbor@gmail.com

