Attending Signoff of Resident Notes

We’ll review three general scenarios:

1) The attending will review the note, modify if desired, then sign; this is probably the most common workflow.

2) The attending will ask the resident to make some changes, then re-submit the revised note.

3) The attending will reject the note and instruct the resident to completely do it over.

Scenario 1: Attending reviews, edits note if desired, then signs.

In this example, a patient has been roomed by staff and seen by a Resident. The Resident has created a visit note using DynDoc. (This example uses an outpatient encounter, but an inpatient note works the same way.)

Some attendings/venues may wish the Resident to Save the note at this point. By doing that, the Resident and Attending can discuss the case further, and the Resident can further refine the note such that by the time it is submitted to the Attending, the Attending and Resident should be in agreement about the note’s contents, simplifying the Attending review and signoff process.

Other venues, especially outpatient settings working under the primary care exception, may wish the Resident to go ahead and Sign/Submit the note before discussion with the Attending. The Resident should be instructed which process is preferred by the Attending/venue.

Either way, the Resident will eventually click Sign/Submit, then select the Attending to submit to:
At this point, when viewed on the Documentation List on the Table of Contents, the note will appear with the status of **Unauth** (for Unauthenticated):

A view of the document itself shows the heading **Preliminary Report** at the top. The Resident’s electronic signature is added at the bottom. A line for the chosen Attending is added at the bottom, though it is blank, since the Attending hasn’t signed yet:
The Resident is done at this point. We’ll turn our attention to the Attending.

The Attending receives the signoff request in the Message Center inbox:

A single click previews the document below:
Double-clicking the note will display it in a new tab:

At this point the Attending might take a couple of approaches. If you recall the patient well enough to review the note from here, you can click the **Modify** button at the top to move on to signoff:
Alternately, if you’ve got a long patient list, or some time has passed since you discussed the patient, you may wish to review the chart to refresh your memory about the patient’s details (structured data, previous notes, etc.). To do this, right-click the signoff request in Message Center, click **Open Patient Chart**, then select an area of the chart to open, such as **Documentation**:

The chart opens:

You can review this note and prior notes, and use the Menu on left to review structured data like the Allergy, Medication, Past Histories, Problem, and Diagnosis lists.
Or if preferred, you can review data on the workflow tabs:

When you’re done with this review, go to the document list, and you’ll see a Modify button similar to the one mentioned above, which you can click to begin the signoff process:

Regardless of whether you clicked Modify from the chart or Message Center, the note opens to review, update if desired, and sign off:

At this point, if you’ve discussed the patient with the resident, and the resident has updated the note to reflect your recommendations, there should be little if anything you need to change. If you haven’t discussed the note yet, there may be things you wish to edit.

Click anywhere and type:
You can highlight a resident’s text:

…and delete it, adding your own replacement as desired:

You also have the ability to strike-through, or make various formatting changes if you wish:
When you’re done updating the document (or if you have no changes to make), use AutoText to add an attestation statement. In most documents there will be an Attestation section near the bottom where you can place this. If you don’t see such a section, you can place your attestation anywhere that you deem appropriate, e.g., after the Assessment/Plan section.

Bring up this AutoText by typing the + sign:

```
+attest_NP/PA *
+attest_NP/PA+POA *
+attest_Res AttdAvail *
+attest_Res AttdAvailOnsite *
+attest_Res AttdSaw *
+attest_Res AttdSaw+POA *
+attest_Scribe *
+attest_ScribeAttd *
+attest_StudProv *
+attest_StudProvScribe *
```

Double-click the one you want, and it will be added:

**Attending Attestation**

Attending Attestation: I was present during/ performed a history and physical examination of the patient and discussed the management with the resident. I reviewed the findings and assessment/plan outlined above by the resident and agree, with any exceptions and/or additions noted.

Finally, click **Sign/Submit** in the lower right corner:
In the following popup you have options to forward the note to another provider, or create a letter. In this example, we’ll just click **Sign**:

If you did all this from Message Center, you’ll drop back there, with your changes visible. If you did it from a Document list, you’ll also see the updated and signed-off document.

The heading has changed to *Final Report*:
Since the Attending has now signed, the bottom of the document now contains the Attending’s electronic signature, and the status has changed to Auth (Verified):

If you look at the note on the Table of Contents Documentation list, the Status will have changed to Auth (Verified), and the Author; Contributor(s) column will now show the Attending as the Author, with the Resident as a Contributor:

[Note: Some venues, such as primary care clinics, may elect a configuration option that keeps the Resident as Author, and has the Attending become the Contributor. See Primary Care Addendum at the end of this Scenario.]
After the note has been signed, it drops out of the Attending’s inbox.

If you ever wish to review all of the versions of the document that have been created and signed, go to Notes on the Table of Contents, find the note, and click the Document History button:

A popup appears showing the existing versions of the document:
If you select an earlier version, it displays, prominently labeled:

*A Preliminary Report*

When you click Close you are notified that the latest version will now load:

…as it does after you click OK:

*Final Report*

Primary Care Addendum

Some venues, e.g. primary care outpatient clinics, may prefer that residents retain authorship of clinic documents in the interest of supporting continuity of care. Upon request, an alternate configuration may be implemented that will result in the following changes.

As soon as the resident creates and signs the note, the heading will say *Final Report* at the top:
At this point the Author is **Resident** & Status is **Auth (Verified)**, since it has been signed by the author:

When the attending receives the document, instead of being able to fully edit the document as illustrated above, the attending can strike out text, and make additions at the bottom under ***Insert Addendum Here***, then add attestation:

Then click **Sign/Submit**.

The top of the document will now say **Final Report** *Document Contains Addenda*, since the attending has added notes at the bottom:
When viewed on the Documentation list, the Resident will be the **Author**, the Attending will be a **Contributor**, and the Status will be **Modified**: 

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**Scenario 2:** Attending reviews note, asks Resident to make some changes and resubmit.

In some venues, rather than personally correcting the note, the Attending may wish to give educational advice to the Resident to improve the note, then have the Resident re-submit it. We don’t want to make the Resident totally recreate the note—just modify it to change/add a few things.
This would be fairly common in a setting working under the primary care exception, or any time there wasn’t direct conversation between the Resident and Attending during note creation.

The Resident creates note, then clicks **Sign/Submit**:

Search for/select the Attending, then click **Submit**.
The Attending receives the submission in Message Center inbox:

Double-click to review in a separate tab:
Suppose the Attending reviews the note, and would like a few changes, but doesn’t really need the Resident to start from scratch. To relay that to the Resident, click **Forward Only** at the top:

Click **Additional Forward Action; Review**; then search for and select resident. Add Comments:
When done, click OK.

Back in the inbox, right-click and select Set On Hold:

If you scroll to right you can see this status change:

This leaves it in your inbox as a reminder to check it again later, since you haven’t signed it off yet.

Back with the Resident, this message appears in the Review inbox:
To make the requested changes, right-click the message and **Open Patient Chart**. We’ll go straight to the **Documentation** section:

Click **Modify**:

Make the requested changes, then click **Sign/Submit**:
Select the Attending again if necessary, then click **Submit**:

Back with the Attending, the message is seen in the inbox again:
It has changed from the regular font “read” appears to the bold font “unread” appearance, since it has been updated. The status has also changed from **On Hold** to **Pending**, which you can see if you scroll all the way to the right:

Double-click the message and review as necessary. Then click the **Modify** button:

Review the note. If desired, make other edits. When you’re satisfied, use type + to bring up attestation AutoTexts:

```plaintext
+attest_NP/PA *
+attest_NP/PA+POA *
+attest_Res_AtdAvail *
+attest_Res_AtdAvailOnSite *
+attest_Res_AtdSaw *
+attest_Res_AtdSaw+POA *
+attest_Scribe *
+attest_ScribeAtd *
+attest_StudProv *
+attest_StudProvScribe *
```
Your chosen attestation is added. Click **Sign/Submit**: 

![Sign/Submit](image)

Then **Sign** again in the next window:

![Sign/Submit Note](image)

…and you’re done. The status becomes Authenticated (Final Report), and the message drops out of your inbox.

**Scenario 3: Attending rejects (refuses) the note and instructs the resident to do it over.**

In this scenario, the Attending reviews the note and finds it has multiple things the Resident needs to amend. These could be additional or revised billing diagnoses, historical items like the problem, med, or allergy list, or narrative components like the HPI or plan. The Attending will refuse the note, notifying the resident what needs to be corrected.

The Resident sees patient, generates note, signs and submits to Attending.
The Attending receives the signoff request. Using any method illustrated above, the Attending reviews the Resident’s note, but finds it unsatisfactory. Return to Message Center and double click the sign-off request in question:

This opens the document. Note the Action Pane at the bottom:

Select the Refuse bullet. You can also select a Reason from the dropdown box:

The Additional Forward Action checkbox will be checked; select Review in the dropdown list next to it. If the Resident’s name is not already in the To box, search for the Resident’s name in the To box. Then click in the Comments box and add comments to the Resident. For example:
Click OK & Close (or OK & Next to move to next message). The Resident will receive your instructions to revise and resubmit the note, and the message will be removed from your inbox. Since the Attending has not signed the document, it remains in an Unauthenticated status, with a Preliminary Report label at the top. Medical records and/or the billing office would categorize this as an incomplete chart, and prompt for record completion if the resident does not respond in a timely fashion.

Now we’ll look at the Resident’s workflow to address a refused document.

The Resident sees the notice in Inbox | Documents | Review. The comments the attending added are in the Notification Comment column, and there is hover-over text to reveal the full text.

If desired, the Resident can double-click to open the note in another window. Notice the Paper Clip icon next to Comments. Hover over it and you’ll again see the comments the attending provided:
So Resident needs to open the chart and do some work. Back in Message Center, right-click the message and select **Open Chart**; pick a chart component to start with, such as **Inpatient Workflow**:

Go to the Problem List, Medication List, etc—all the places you need to go to make the necessary additions and corrections.

You may also need to change things in the **HPI, ROS, Physical Exam**, or **Assessment & Plan** sections as well. But notice this:
All of those sections on the workflow tab are BLANK, no longer containing your previous entries. (Once you’ve generated a note all those fields go blank so they can be used again to create the next note.) So how do you revise your note?

One option would be to do all these sections over from scratch, which would be pretty frustrating if you only needed to change 1-2 of them.

A better option that allows you to re-use the sections you previously documented would be to go to the Documents section and find your previous note:

Double-click this document to open it:
[In this example only brief placeholder text has been typed in the HPI, ROS, Physical Exam, or Assessment & Plan sections; in reality, they would be the entries you originally made.]

Select your HPI text. The Tag icon will appear. Click that to tag your HPI text:

**History of Present Illness**

ROS text, do dah day.

Do the same thing for the ROS, Physical Exam, or Assessment & Plan texts:
Close the document. Back on the workflow page Documents section, click the + sign to add a new note:

Generate your desired document, in this example Admission H&P:

Changes/additions you’ve made already now appear in the note; for example:

Also note your tagged text on the left. Click on the HPI text and drag under the History of Present Illness heading:
Again, recognize there is just placeholder text in this example; it would actually contain the text from your previous HPI.

Remove/update/add text as needed. In our example you only needed to change “right” to “left” in the HPI; I’ll flesh the rest of that out here:

**Chief Complaint**
Left ankle pain & swelling.

**History of Present Illness**
62 YOM in w/ c/o pain & swelling left lateral ankle. He twisted it 2 days ago playing basketball w/ the grandkids. Has been able to limp around since then, but w/ continued pain & worsening swelling, he thought he should have it checked. No previous troubles w/ that ankle.

**Review of Systems**

**Physical Exam**

Your ROS, Physical Exam, and Assessment & Plan text don’t need any changes, so just drag them from the Tagged Text area to the correct headings, resulting in:
Click **Sign/Submit** to send the revised note back to your attending:
Click **Sign**, and that is done. The Attending will receive a new signoff request.

There’s one last thing you need to do. Since you’ve done this note over, you need to void the original version that was not signed by your attending. You can’t actually remove a document, but you can mark it **In Error**, which indicates it is not part of the final record. This is similar to drawing a line through a written note, then signing and dating it as In Error.

Select the first version of the note and click **In Error** at the top:

If such a document appears on a document list, the Status will appear as **Uncharted**:

If you click on the document, you’ll be notified that it has been marked **In Error**:
If you click Yes, the document will display prominently labeled as In Error: