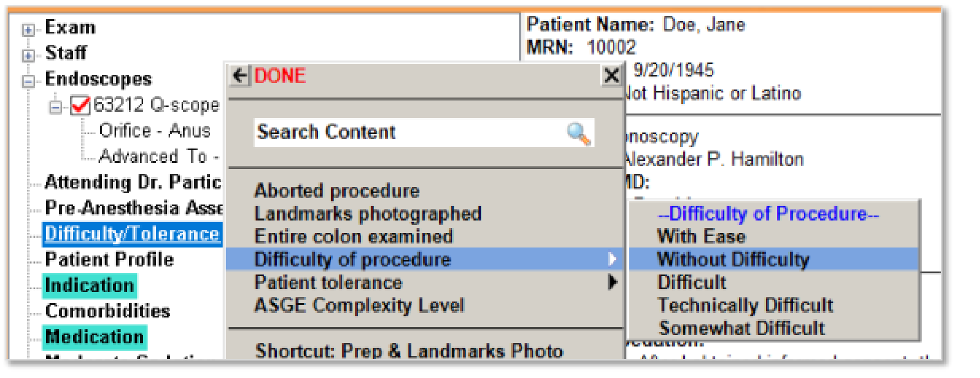
# ProVation Documentation for Endoscopy Procedures

*After a procedure is complete, the physician completes and signs the procedure note. As there are thousands of possible combinations in ProVation® MD, this tip sheet covers basic documentation.*

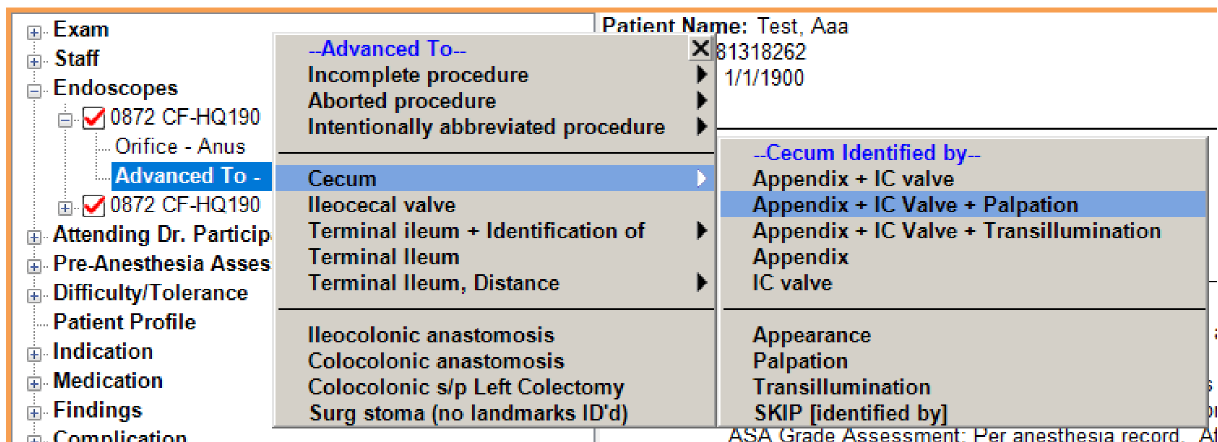
## Documenting a Basic Procedure Note

1. Log in to ProVation MD.
2. Select the GI header or Pulmonary on the left menu, then select Procedure Documentation.
3. Select the appropriate procedure note in progress.
4. Follow the anticipatory interface to document the procedure. This interface automatically navigates to the most commonly selected options in the menu tree, allowing the user to document a note quickly, without moving the cursor.

***Note:*** *If useful, search for the appropriate terms in the menu's search box.*



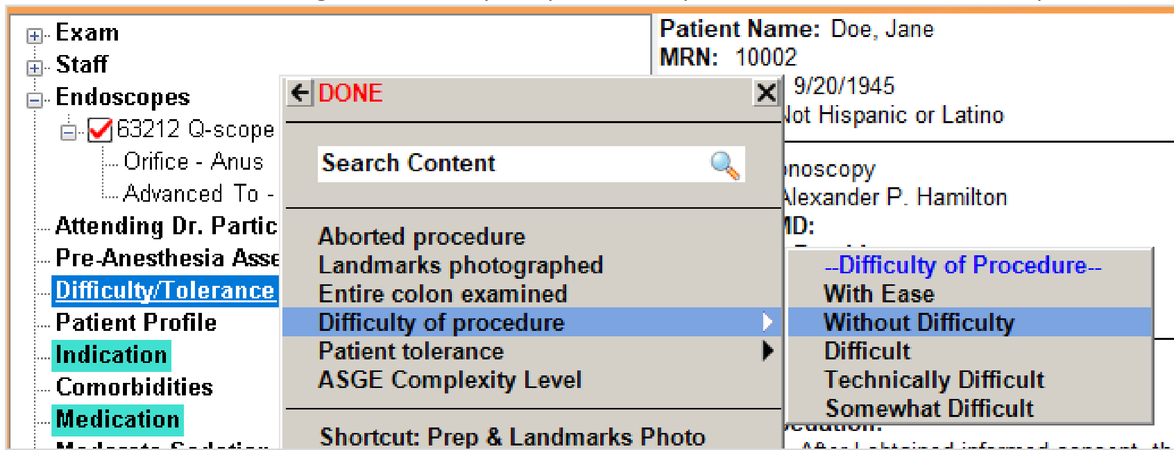

5. Select Endoscopes tab. Click on the Plus (+) indicator next to the scope to open the menu for the **Orifice** and **Advanced To** sections. Follow the mouse prompts to the necessary selections for appropriate documentation.
   a. In this example, the scope advanced to the Cecum, identified by the Appendix + IC Valve + Palpation.



   b. Once selections have been completed the system will advance you to the next tab to continue documentation.

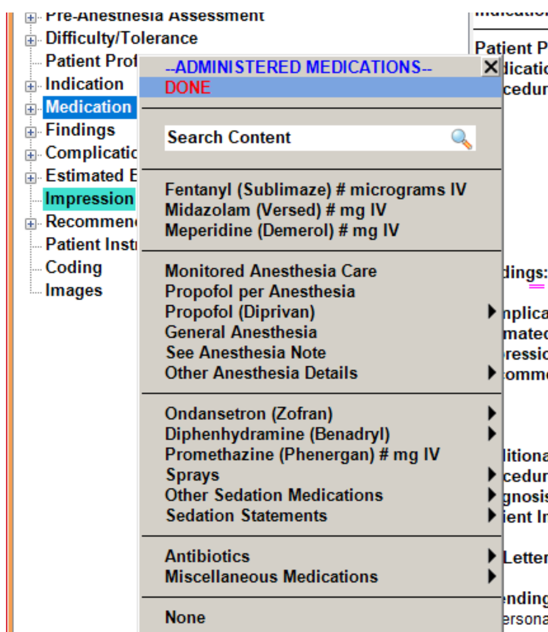
6. Pre-Anesthesia Assessment: ***Completed per Department Policy***. Once selections are made click DONE at top of segment.

7. **Difficulty/Tolerance** section:
   a. The procedure was performed Without Difficulty, and the patient tolerated it well. Continue following the mouse prompts to complete documentation of the procedure.




8. **Indication** section, is the medical necessity or preoperative diagnosis for the procedure. These are mapped to ICD-10 codes in ProVation MD. As this patient was coming in for a basic screening colonoscopy, the physician selects Screen for Colorectal CA, Average Risk.

9. **Medications** section: Document per department policy




10. **Findings** section: Documents any findings.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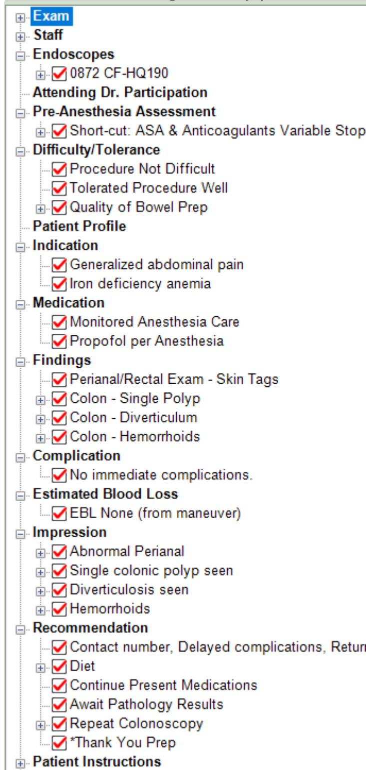
a. Example: The patient's Perianal and Digital Rectal Exam was Normal with no pertinent negatives. This patient had a single polyp in the sigmoid colon. It was 5mm in size, sessile, and was removed with a single polypectomy. The physician used a cold snare, resection and retrieval was complete.

11. The **Impressions** section is generated automatically based on the documented Findings and maneuvers. A physician can elect not to include something in the report by unchecking it.

12. **Recommendations**: In this section you record what you want the patient to do. This is part of your documentation that that feeds into the patient instructions. It prints separately from the procedure note and is delivered to the patient for their reference.
    a. Follow up information
    b. Resuming medications
    c. Other communications to the patient

***Note:*** *At this point, review the right side of the screen. If changes need to be made, make the changes using the node tree on the left, as opposed to free-typing on the right. This supports structured data capture, both to drive coding to support reimbursement, and for mining the database to support clinical research.*




13. Go to the **Capture** Button at the top of the screen .


14. The images captured during the procedure appear at the top. Select an image to view it larger.

15. Click the checkbox next to an image to associate it to the note. Select the magnifying glass to view the image full-screen or select the delete icon to delete the image.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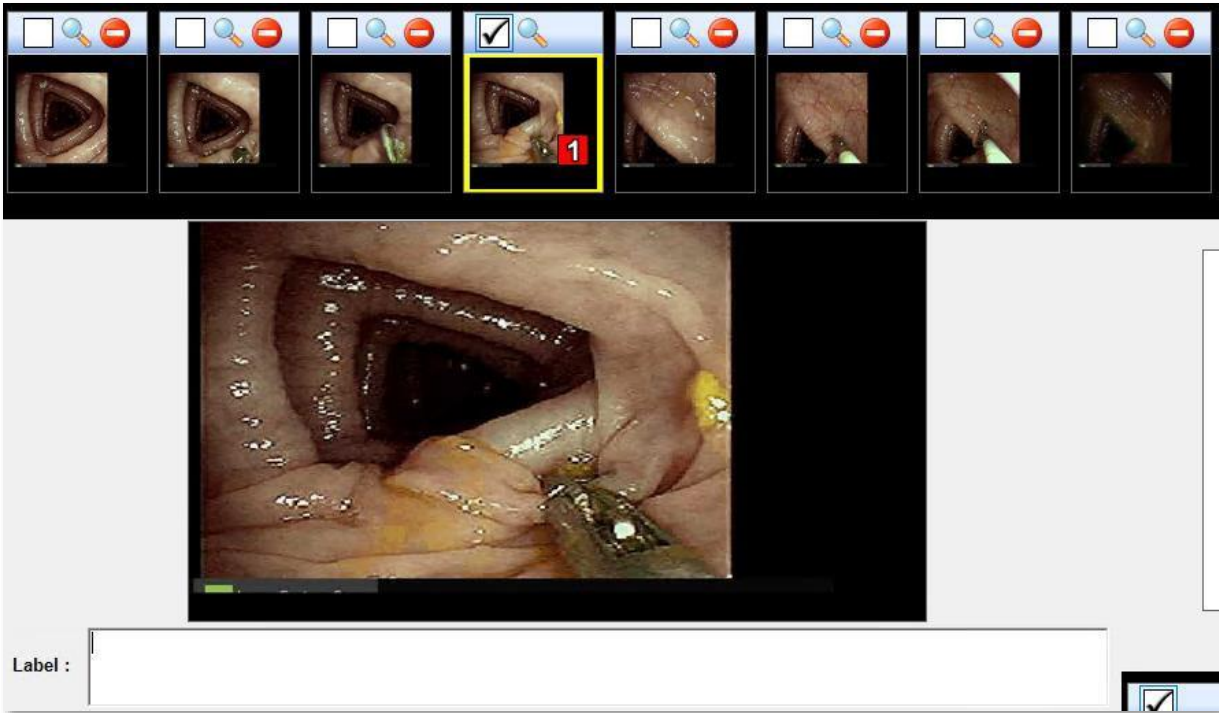
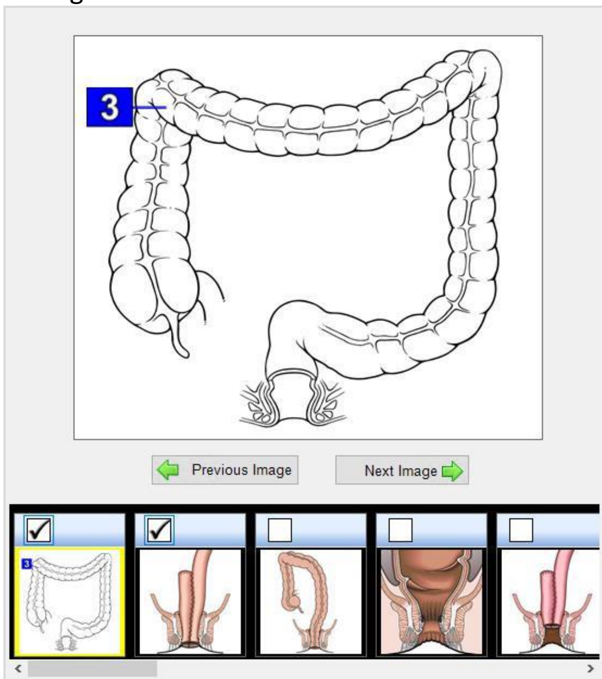


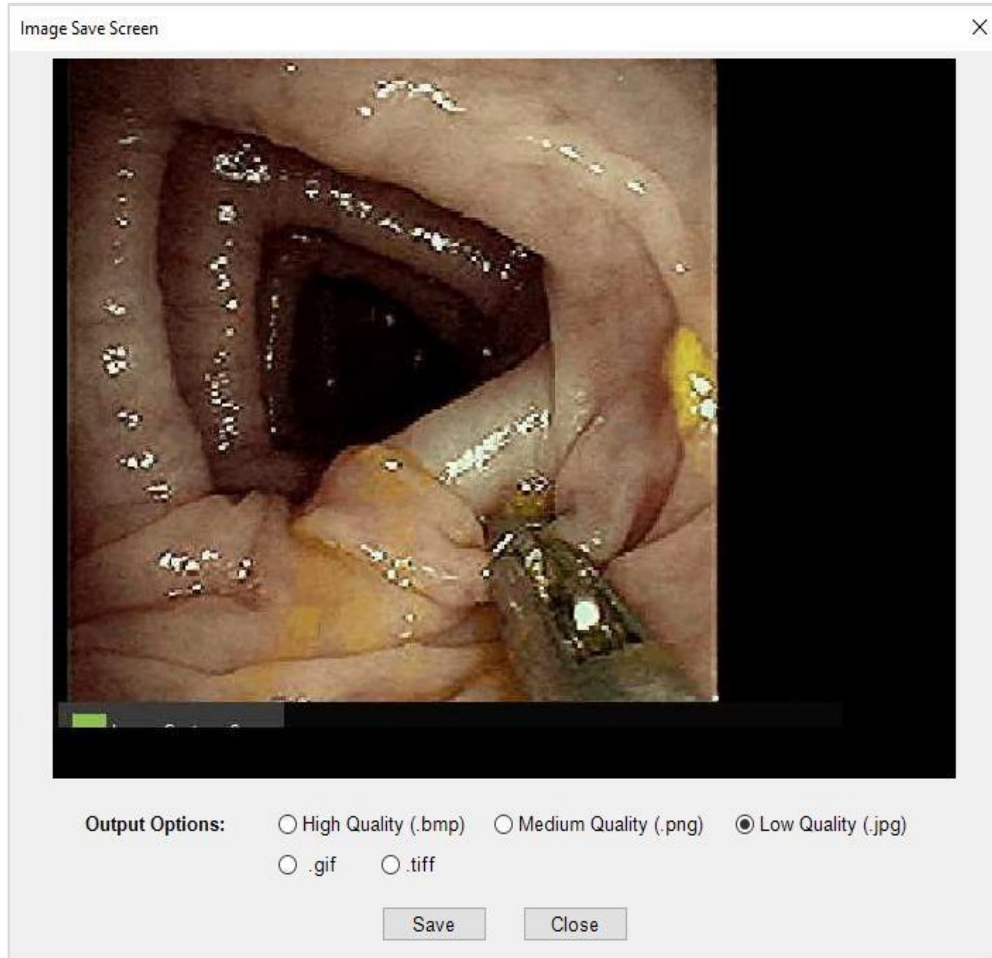

16. Select the location on the diagram that corresponds to the image.

17. If necessary, select a Finding at the bottom of the screen to associate the image to the documented finding.




18. If the default diagram is insufficient for the needs of the procedure note, select an alternate or additional diagram in the bottom right corner.

19. If necessary, annotate the image using the Arrow, Line, Box, and/or Ellipse options on the top toolbar.
    a. If an image is associated to a Finding, the number of the image appears in the Findings section of the note.




20. Once annotations are complete click **Close.** at the top of the screen.

21. Click **Sign** at the top of the screen to finalize the note.

22. If any required elements were not documented, they appear now. Complete those elements and click **Save**.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Required Documentation Checklist

Checked Items are required for Documentation

Unchecked Items are suggested documentation elements

- Difficulty/Tolerance
  - Landmarks Photographed
    - Anatomical Structures -

Save Cancel

23. If necessary, select one or more documents to print.

Close Edit Note Finalize Print Fax E-mail Preview Imag

Patient Name: Test, Corbin
Patient MRN: 63780181743
Procedure: Upper GI endoscopy
Procedure Date: 2/24/2022 4:21 PM
E-signed By:

Attending MD: Doctor Test Admin.
Referring MD:
CC Provider:
Nursing Staff:
Submitted By:

| Available Documents | Copies | Printer |
|---|---|---|
| ☑ Procedure Note | 1 | |
| ☐ Procedure Note (No Images) | 1 | |
| ☐ Referring Letter | 1 | |
| ☐ Patient Letter | 1 | |
| ☐ Patient Instructions | 1 | |
| ☐ Coding Report | 1 | |

24. Click Finalize and complete the **E-sign** on the next page.



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25. Enter the user's password at the bottom of the screen to sign the note.

E-sign Procedure Documentation

Close | 100% | 1/1 | Backward | Forward

provation®

| Patient Name: | Jane Doe | Procedure Date: | 8/5/2019 11:35 AM |
|---|---|---|---|
| MRN: | 10002 | Date of Birth: | 9/20/1945 |
| Admit Type: | Outpatient | Age: | 73 |
| Gender: | Female | | |

Providers: Alexander P. Hamilton
Referring Provider:
Exam Type: Colonoscopy

Indications: Screening for colorectal malignant neoplasm
Medications: Midazolam 2 mg IV, Fentanyl 100 micrograms IV
Complications: No immediate complications.

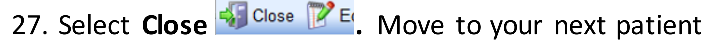
Procedure:
After I obtained informed consent, the scope was passed under direct vision. Throughout the procedure, the patient's blood pressure, pulse, and oxygen saturations were monitored continuously.The Olympus adult colonoscope was introduced through the anus and advanced to the cecum, identified by the appendiceal orifice, ileocecal valve and palpation. The colonoscopy was performed without difficulty. The patient tolerated the procedure well. The quality of the bowel preparation was good. The ileocecal valve, appendiceal orifice, and rectum were photographed.

The physician is responsible for ensuring the accuracy of the documentation. Review the Procedure Note, Patient Instructions, Post-op Orders and other documentation in Print Preview prior t

| Provider | Responsible Provider |
|---|---|
| Hamilton, Alexander (Doctor) | Yes |

User Name: ahamilton [E-sign]
Password:
Include Electronic Signature Paragraph

26. Click **E-sign.**

27. Select **Close** **.** Move to your next patient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