# Setting Up a Progress Note in ECW 11

In this document, I will explain how to set up a progress note in ECW 11. When the visit is first opened, ECW asks if the medications should be carried into the note – the answer is always "Yes". If there are any errors in the medication list from prior encounters, they will be pulled into this note as well, which is why reconciling medications is one of the most important steps in setting up a note properly.
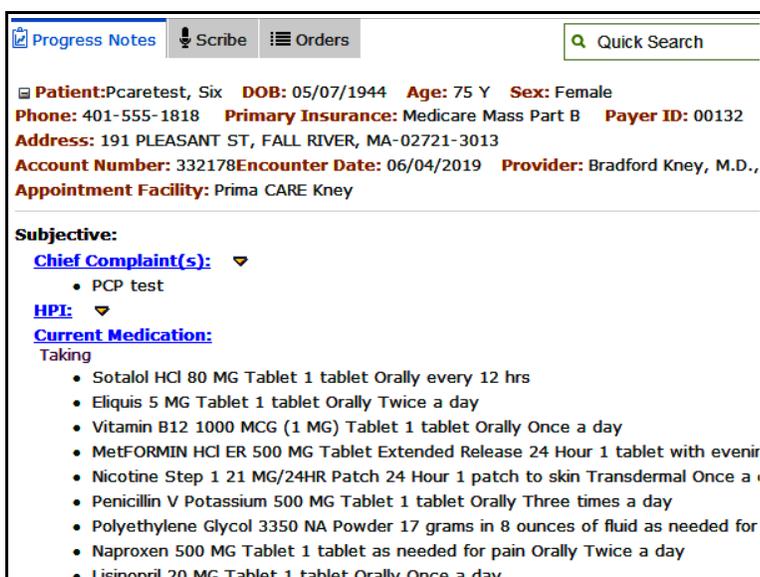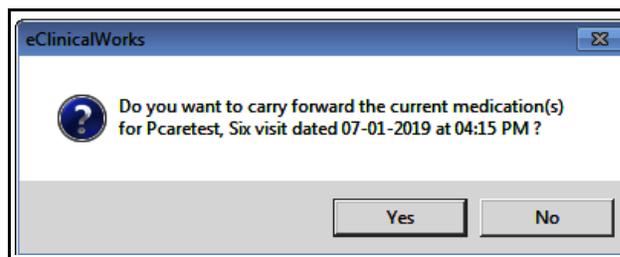

We start with the basic framework of a SOAP note. The chief complaint is pulled from the schedule - when this appointment was made, someone entered a reason, and this is pulled in as the chief complaint.

The next step in most offices is to add a template to the note.

At the bottom of the progress note is a panel of options. Clicking on the "Template" button opens the template screen.
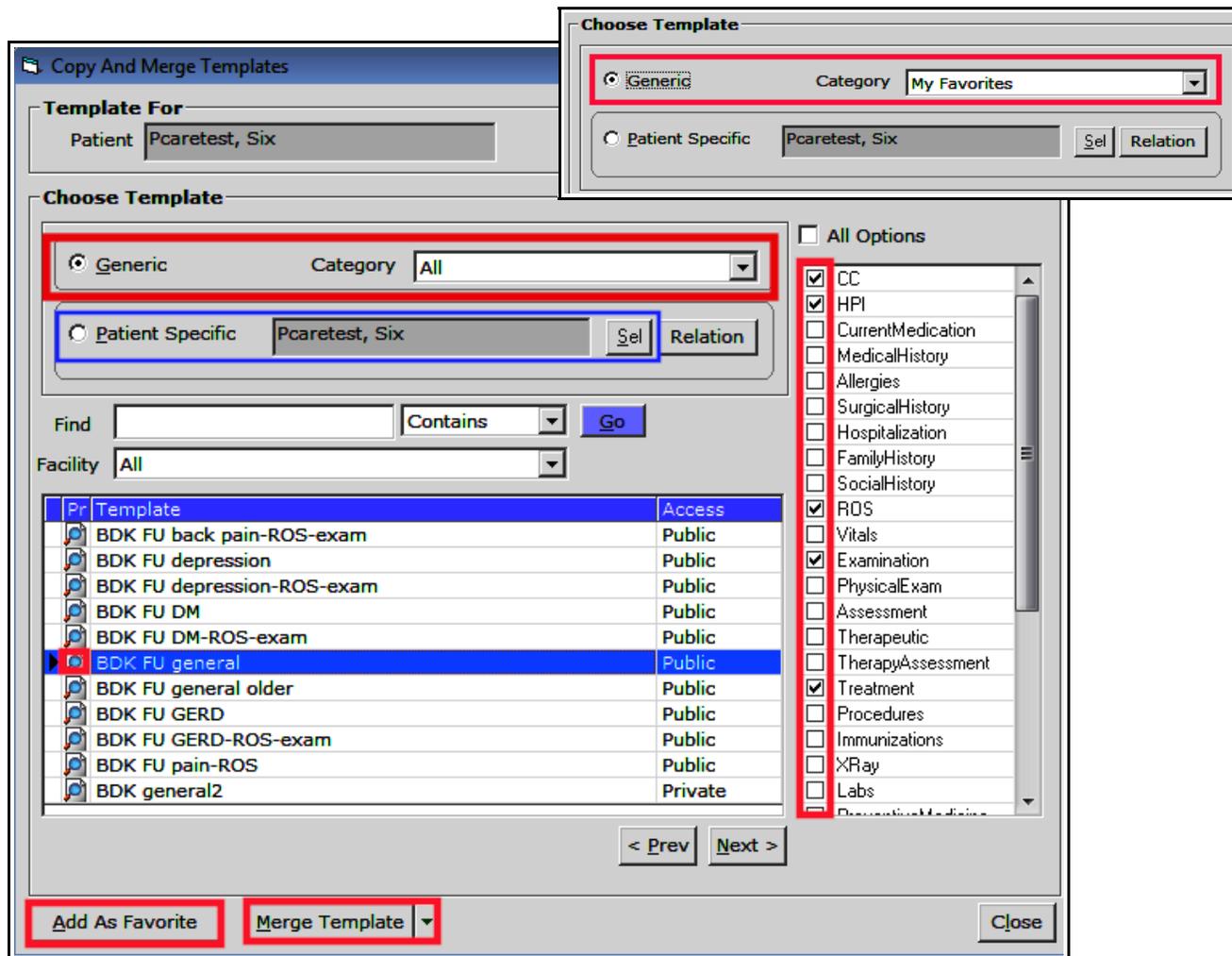
The current filter in the template screen is "Generic" and "All". Once you set up your favorites, it will be much easier to quickly locate the template you wish to use by selecting "My Favorites" rather than "All" as a filter. When you find a template you like, click on "Add As Favorite" and this template will be added to your template favorites. Clicking on the magnifying glass will open a view of the template, allowing you to see what you are importing into the note. The panel at the right shows you which sections of the template will be added to the note.
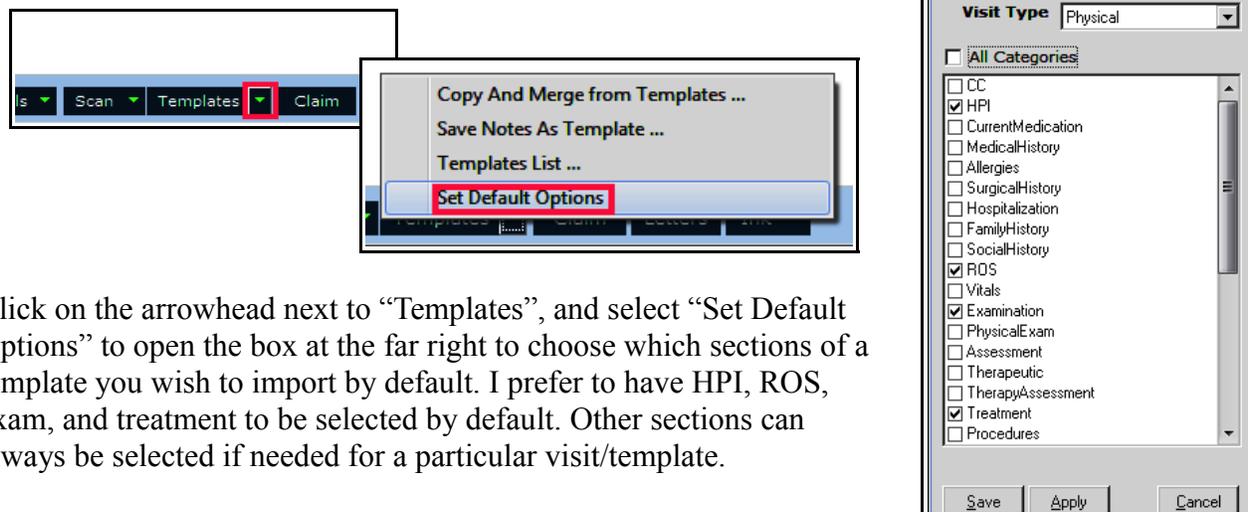

Click on the arrowhead next to "Templates", and select "Set Default Options" to open the box at the far right to choose which sections of a template you wish to import by default. I prefer to have HPI, ROS, exam, and treatment to be selected by default. Other sections can always be selected if needed for a particular visit/template.
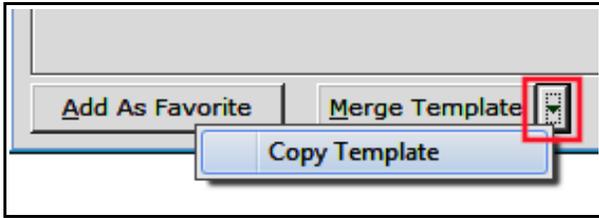
Clicking on "Merge Template" will merge the template into the note – meaning that if there is any data in any of the selected sections of the note, whatever is in the template will be added/merged with that data. If you click on the arrowhead next to merge, you will see the option to "Copy Template". Whenever ECW uses the word "copy", it means that whatever you are selecting will write over the current data – what is there will be erased after you copy something over it. So be careful when you select the copy option in ECW. In some cases, this is what you want, but in other cases, it might not be exactly what you are looking for.
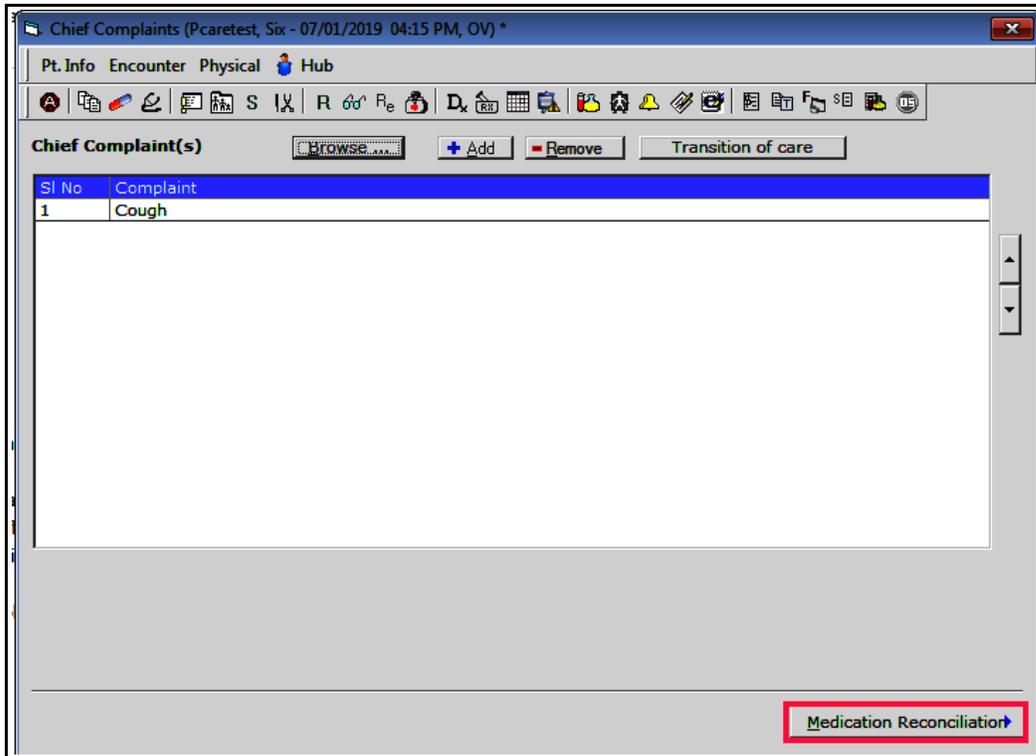

Next, click on "Chief Complaint" and free text a more accurate reason for the visit – there are other ways to enter a chief complaint, but free texting into the box is by far the easiest method.

It is very important to go to medication reconciliation NEXT. Meaningful use benchmarks REQUIRE that the user move from the chief complaint to medication reconciliation. I know this sounds a little ridiculous, but that is what we are required to do to accrue our Meaningful Use points.

Medications are listed as "T" for taking, "N" for not taking, "D" for discontinued, and "U" for unknown. Another way to get to this section is to click on the picture of the capsule in the navigation bar across the top of the note – BUT for Meaningful Use, you MUST move to the medication list by clicking on "Medication Reconciliation" in the screen above.
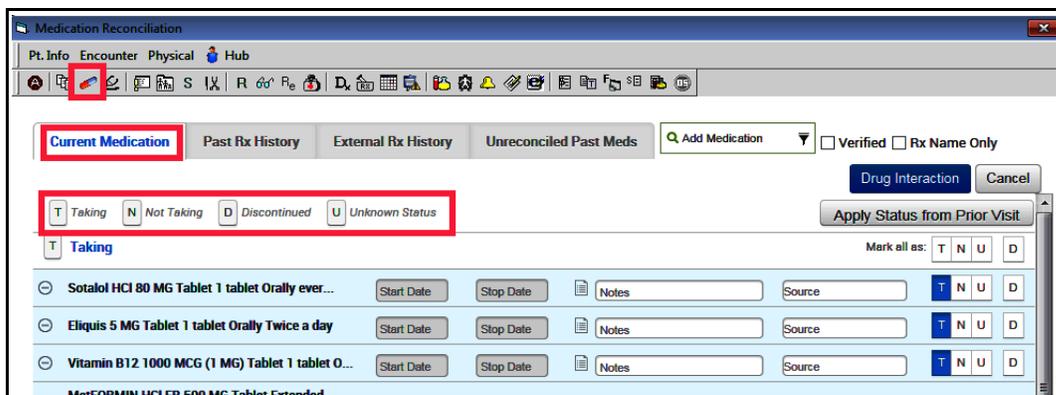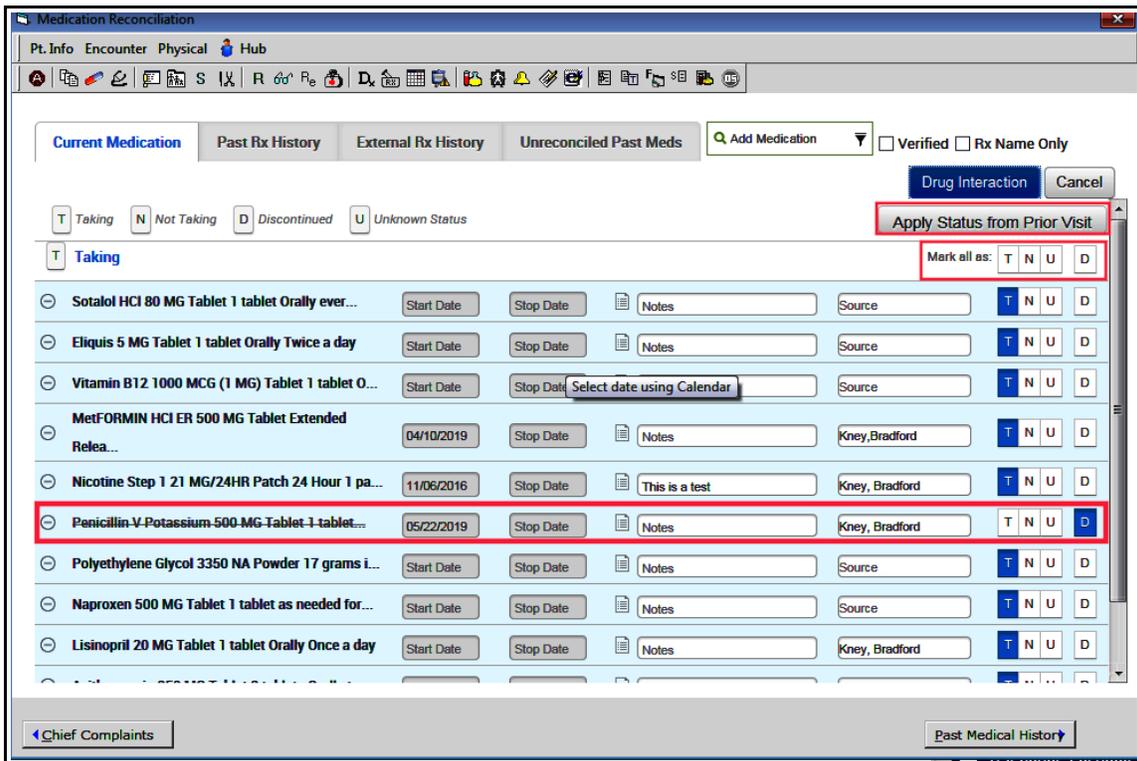
Two quick ways to update a medication list:
- "Apply Status from Prior Visit" – if the medication list got a bit messed up since the last visit (things happen in ECW), try clicking on this button to revert the list to mirror the list from the last visit.
- "Mark all as": If some medications were listed as unknown or not taking at the last visit, but today the patient reports taking all the medications, just click on the "T", and all medications will be associated with a "T".

If a medication was discontinued since the last visit, mark it with a "D", as I did with penicillin in this example. Medical assistants and nurses should never discontinue any medication without the knowledge and approval of the provider. But duplicate entries and expired antibiotics SHOULD be discontinued when reconciling medications.

When you click on the "D", the box to the right opens up. A glitch in multiple iterations of ECW results in the "Notes" section never being visible again – so don't bother writing anything here. If you choose allergy, intolerance,
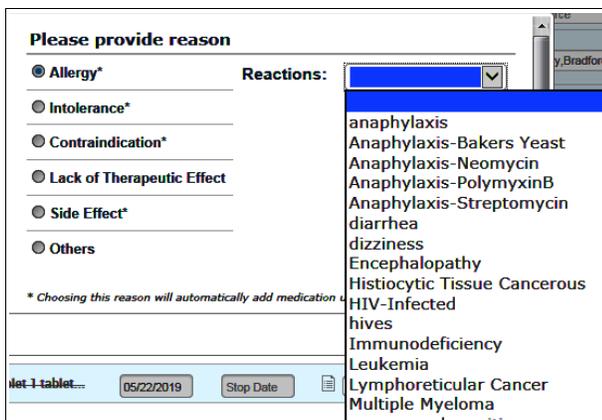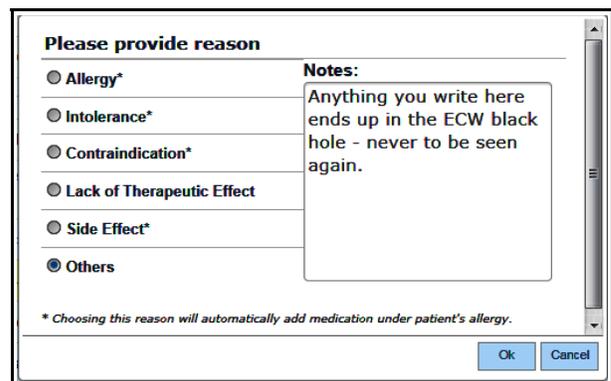

contraindication, or side effect, a reaction option opens. This will be added automatically to the allergy list for the patient. The reaction choices are limited, so I usually modify this when updating/confirming allergies.

You can also add medications to the list during reconciliation. Make sure to always use MedispanRx so the drug interaction program will work properly.


Suppose the patient was seen elsewhere and a provider added clarithromycin for the patient's cough. You can add this to the medication list in the current visit. The yellow star indicates a medication favorite.
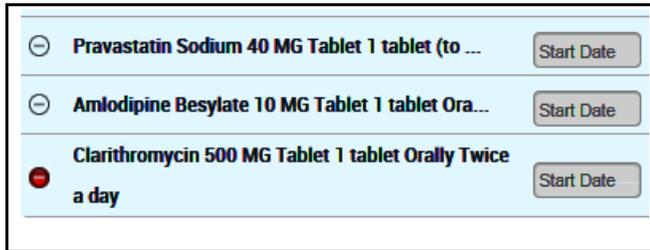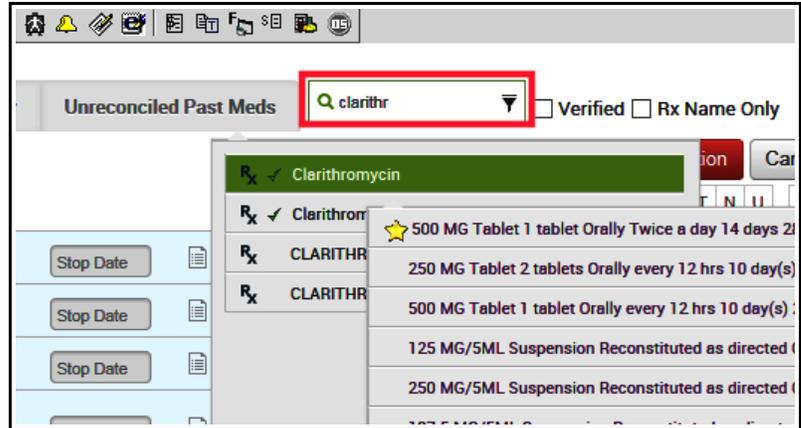

The minus sign (allowing you to delete the medication) to the left of a medication is active ONLY when a medication is first added to the list. You can delete this medication immediately if you made an error, but as soon as you leave this screen, the minus sign is grayed out, and the only way to get rid of it is to "D" discontinue it.

After adding a new medication here, the provider can check for new drug interactions. To do this, click on "Drug Interaction" - select "All Active Drugs". ECW warns the user of significant drug interactions with both naproxen and clarithromycin. Any medication added to the medication list by a medical assistant

or nurse MUST be checked and approved by the provider. If a medication is added with the wrong strength or directions, it may be refilled at a later date with incorrect information.
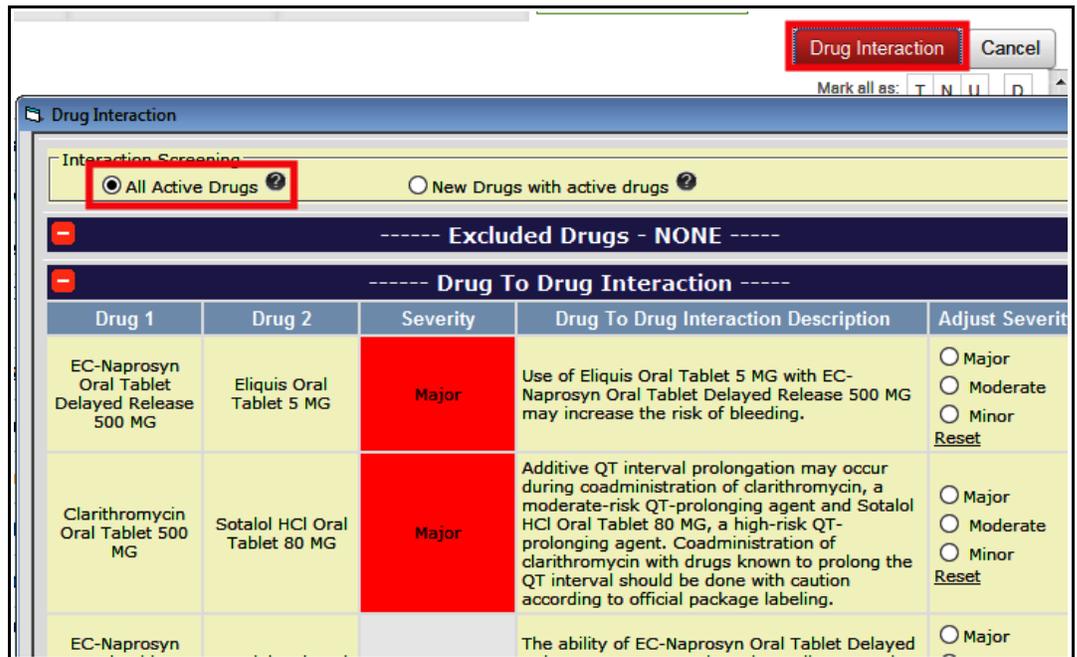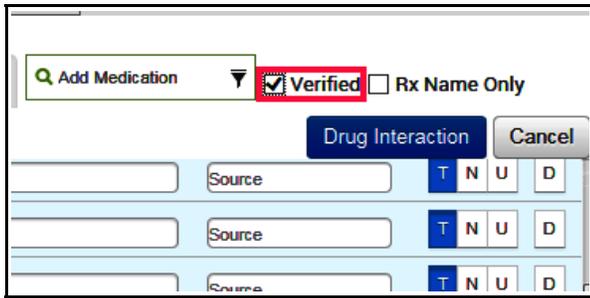
Once the medications have been updated and verified, check the box next to "Verified". Occasionally, I have checked the "Rx Name Only" box in error as I was hurrying to move to other areas of the chart – make sure you check the correct box.
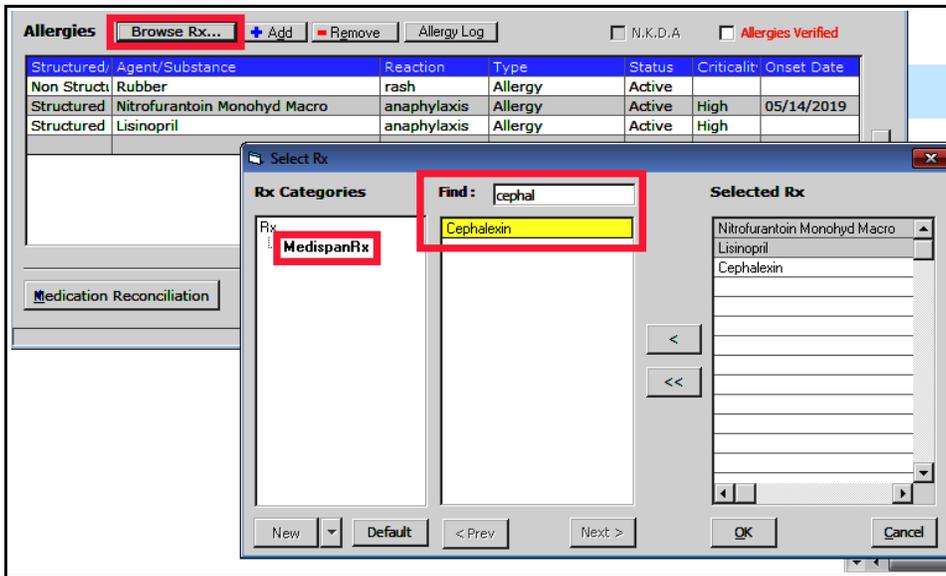
Verifying allergies at every visit is very important. When adding a new medication allergy, ALWAYS use the "Browse Rx..." button rather than the "Add" button. MedispanRx is a database of medications linked to NDC codes. This allows the allergy alert system to work properly. Just search for the medication and click on it to add it to the allergy list, then click "OK".

Now add a reaction – I usually just type into the box because I like more detail a single word provides, but you can use the dropdown list if you wish. Also add the type of reaction, the status, how critical the reaction was, and ideally when the reaction occurred if the patient can provide a date. When you are all done reviewing/adding allergies, click on the box "Allergies verified".
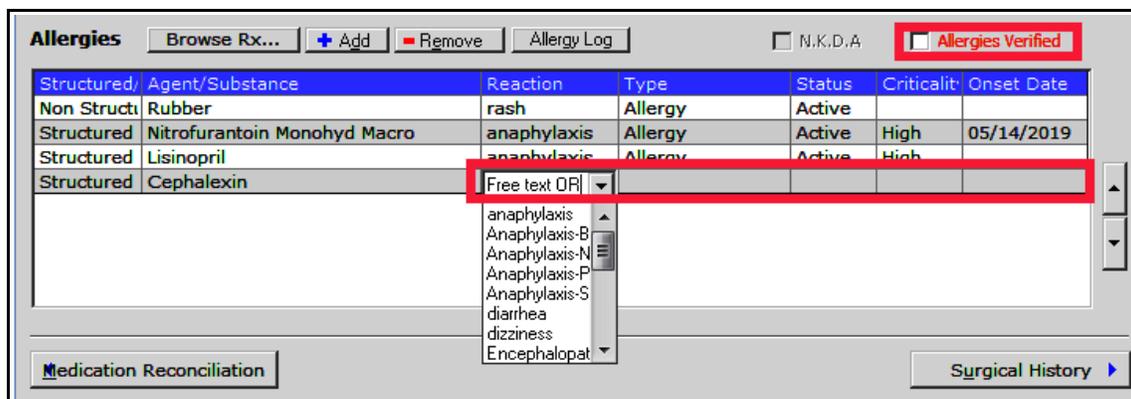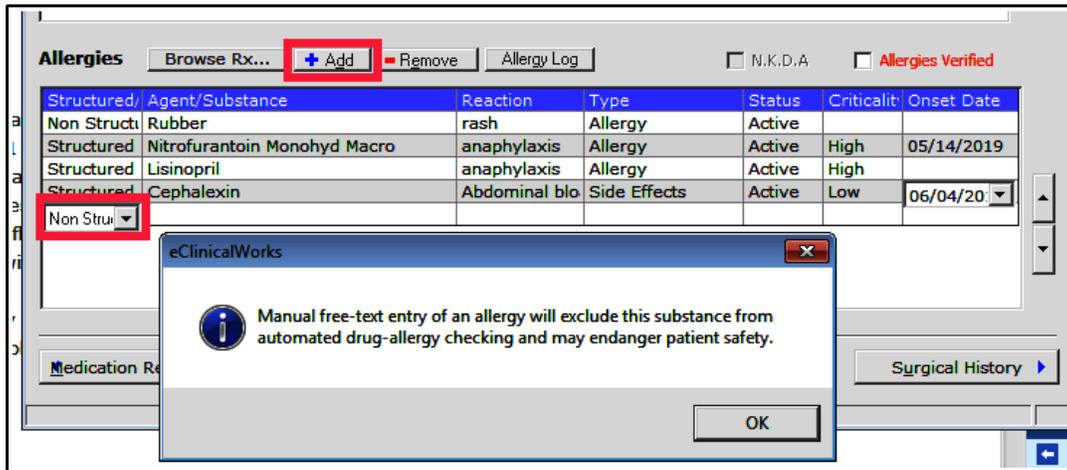
If you try to add a nonstructured allergy, ECW will alert you to the fact that the drug allergy alert system will not be able to recognize this entry and it could result in serious patient injury. Some allergies have to be entered as nonstructured (like allergies to cats, or ragweed, or politics), but all drug allergies should be entered as structured data.

The next step in setting up a visit for a provider is to add the vital signs.
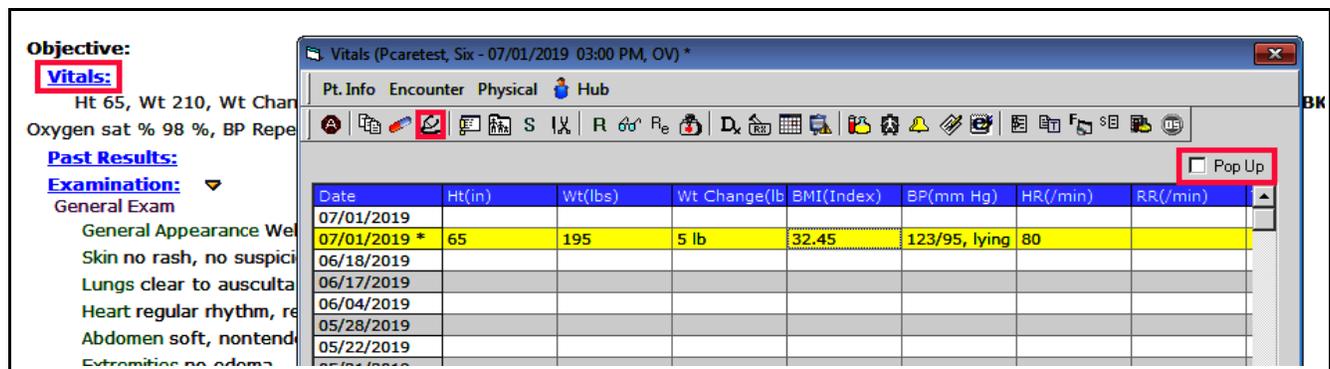
Open the VS area by clicking on "Vitals" or on the stethoscope icon in the navigation bar. I generally prefer free texting into the VS boxes, but click on the "Pop Up" option when adding multiple results to a particular area – most often when multiple blood pressures are taken.

There is an area for repeat BP, but often multiple repeat BP need to be recorded – these can be entered using the "Pop Up" function. Free text into the box, or use the keypad, then click the arrow, and then click "Apply".
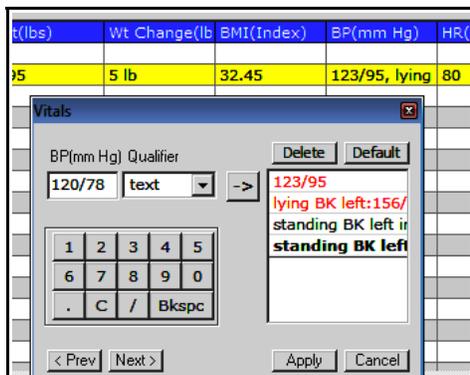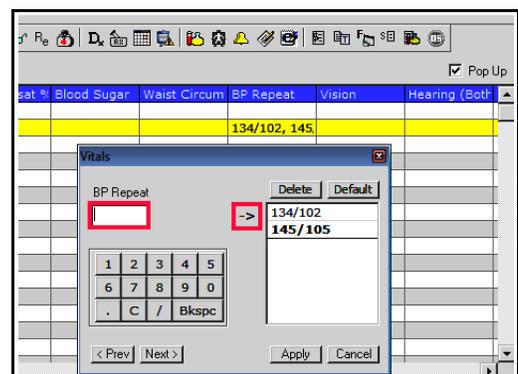

Another place in which I find the pop-up function useful is when entering orthostatic BP readings – under to original BP area, there is box where qualifying text can be added.
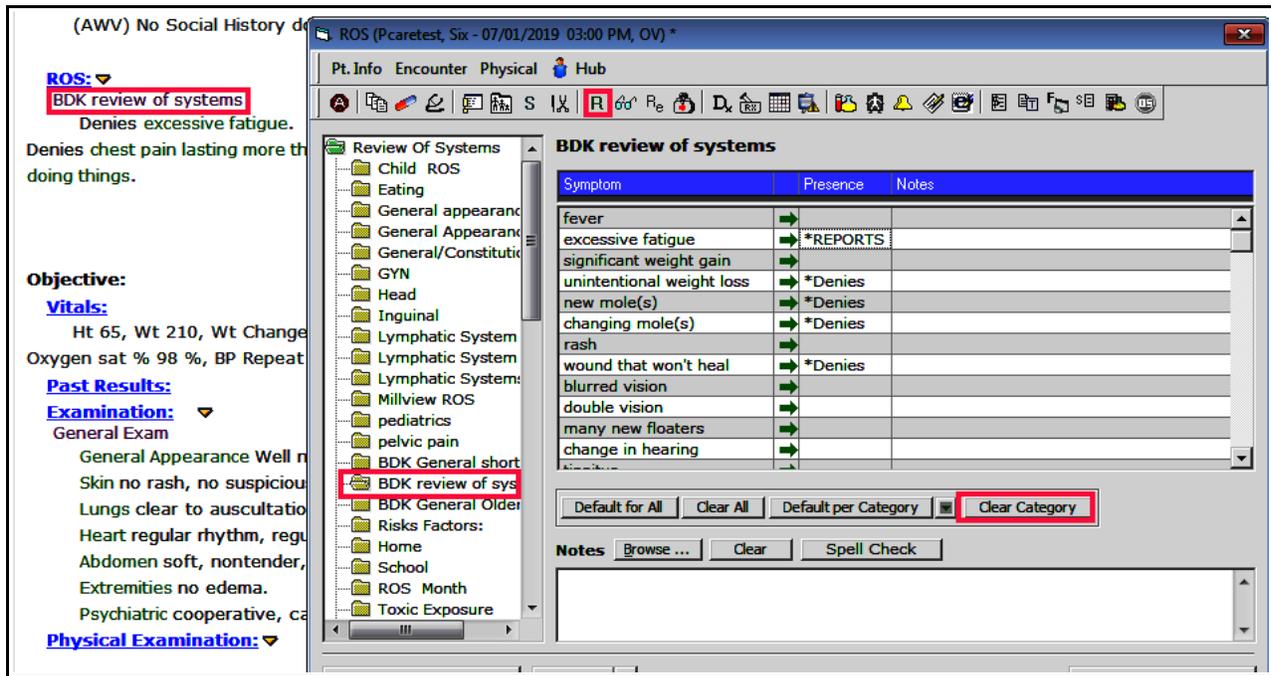
The review of systems area in ECW is a bit overwhelming (I think there are about 60 folders). I use only the 3 BDK folders. You really can get by with one folder – as you can customize the choices very easily in the note as well as in the templates. Clicking on a problem that reports "Denies" once changes it to "Reports" in this ROS template. Click it again, and it will be blank. Any blank entry does not show up in the note. So ONE list with many choices could be used for all situations. Clicking "Clear Category" clears the current ROS completely. Clicking "Default per Category" selects the default choices for the current folder. Both the "All" buttons to the left affect ALL the folders – not particularly useful in my view. The "Notes" section at the **bottom** is pulled into all future notes – like similar sections in the family history and social history sections. I have NEVER added anything to this area. Clicking on the "Notes" section **next** to the ROS symptoms opens a box in which you can add details about the symptom – though I usually do this in the HPI.

Note that if you click on either the "R" in the navigation bar across the top of the screen, or the blue "ROS" in the progress note, the window opens with the first ROS selected – in this case, that would be "Child ROS". Clicking on the purple "BDK review of systems" in the note opens to the correct ROS pulled in when the template was merged earlier. In your office, the administrator may have made it so only a few ROS folders are seen.
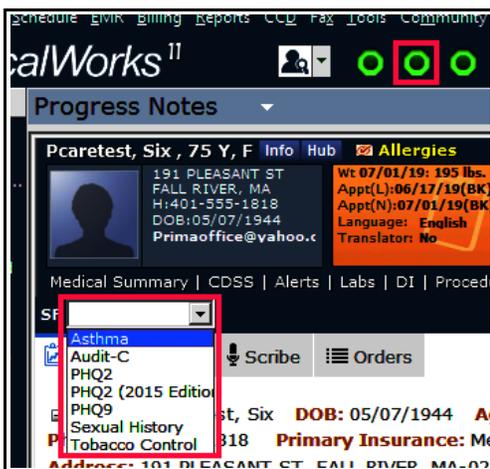
One caveat when using a template for ROS – make sure that what the patient reports has been correctly entered in the ROS. It looks a bit odd when chest pain is the chief complaint, and "Denies chest pain" is in the ROS.

The medical assistant or nurse is often responsible for completing smart forms necessary for a visit. Meaningful Use requires documentation of a PHQ2 or PHQ9 at least once a year for all patients. To access the smart forms, make sure the top panel is visible – if the middle green olive is red, just click it to get it back to green, so the smart form box will be visible.

The smoking and alcohol smart forms can be accessed from the social history as well as from the smart form box. In this case, I chose PHQ2 (2015 Edition):

Complete the form, and hit "Save".

Different providers/offices document social history in a wide variety of ways. I want to highlight just a few points. Anything written in the "Notes" section at the bottom is carried forward in all future notes – so add to this area sparingly. A glitch in ECW has led to some "Notes" sections with dozens of slashes - "///////////" - if you see this, delete the slashes please. The "S" seen to the left of the first two tobacco entries means that these link to smart forms. Click on the first one, and the screen to the right opens – just as it would if you clicked on this in the smart form box shown earlier. Document smoking history at least once a year with a smart form to meet the Meaningful Use benchmark. This also needs to be documented at least annually in the "Preventive Medicine" area.


Other parts of the social history of used differently by different offices, so I will leave this topic here.

In some offices, the medical assistant or nurse contributes to the history of present illness section of the note.
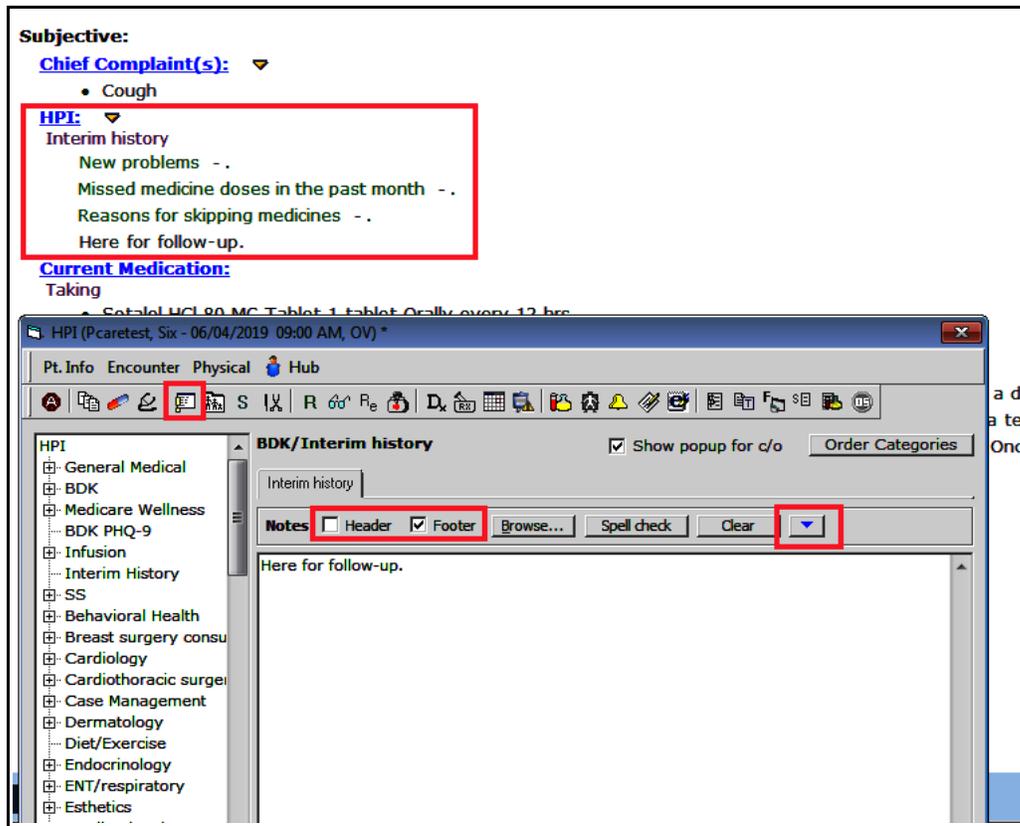
The HPI icon in the top navigation panel is highlighted by a red square. Note that other than the text in the HPI box, the rest of the HPI template is missing in the screen above. Click on the blue arrowhead, and the entire HPI template becomes visible. Remember this when the template information disappears – this has confused me more than a few times in the past.

Now the full HPI template is visible. Note that anything in the footer shows up below the HPI template, and anything in the header will show up in the note above the HPI template. "Clear All" clears the placeholders (the dashes highlighted by the red rectangle) as well as anything else in this "Notes" section to the right of the template questions. "Clear" deletes everything in the lower "Notes" section. My preference when completing templates with placeholders is to "Clear All", and then enter the data.
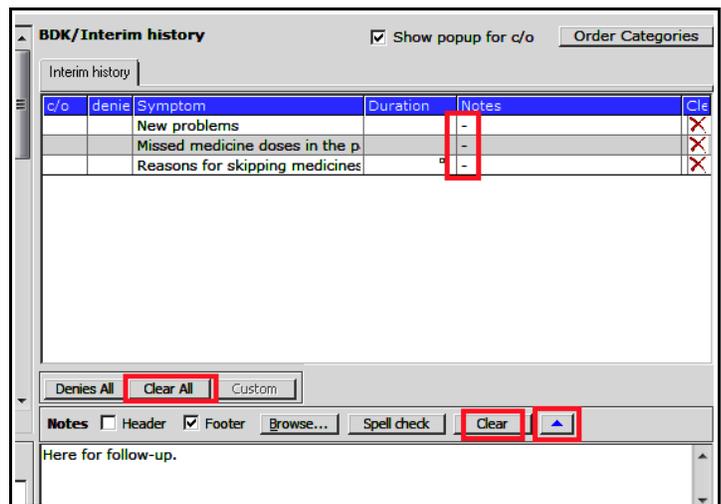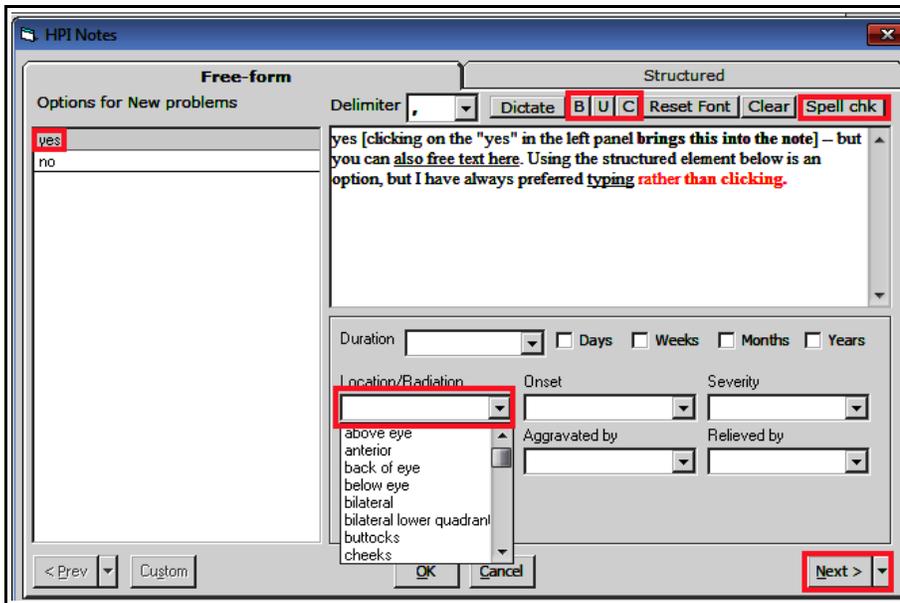
Clicking on "New Problems" in the "Interim History" (shown on the previous page) opens the screen to the left. There are some formatting options – bold, underline, color. Spell check is also an option. There are dropdown menus at the bottom of the box, but I have always preferred typing rather than clicking multiple times to populate the note. Click "Next" to move forward in the template.

Six Pcaretest takes her medications faithfully -
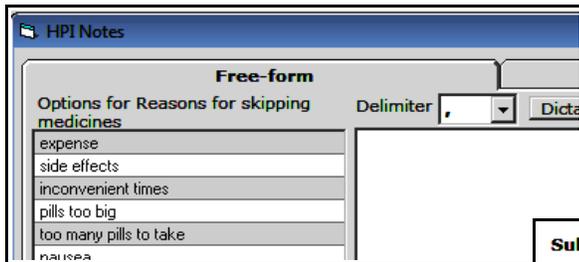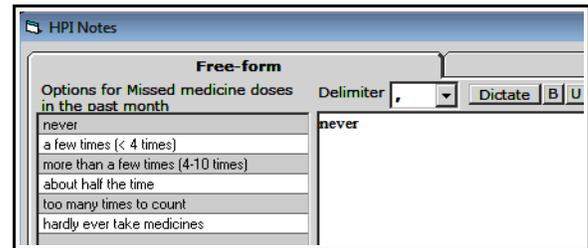
so I left this last screen blank (reason for skipping meds)...

and this portion of the template disappears from the note.
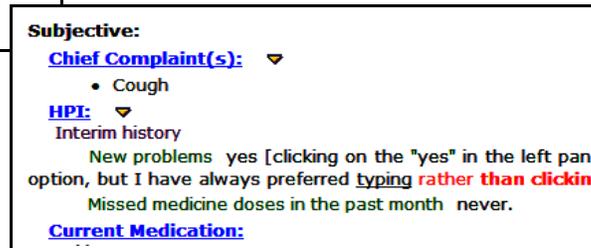
Family history, surgical history, and hospitalizations need to be updated periodically (and verified at least once a year to meet Meaningful Use benchmarks). The assessment and treatment areas are managed by providers and are outside the scope of this document.

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July 1, 2019