EMR Training Manual Nurse





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Course Objectives

By the end of this presentation, the student will:

- 1. Have an increased knowledge of the principles that drive Clinical Transformation
- 2. Understand how the DMC integrates technology to support patient safety and clinical judgment, and achieve excellent outcomes for patients.
- 3. Understand basic EMR functionality

Introduction

When the DMC began its EMR journey in 2006, it made history. We became the first system across the country to implement EMR across all DMC facilities in 13 months. During the implementation of the EMR, it was apparent that the DMC was not only implementing technology, but the DMC was Transforming the way Patients Receive Care. We did this because at the DMC we intend for our care to be safer and better than any other system. While this video is to teach you how to use the system, its overriding purpose is the message that EMR at the DMC is really about excellence, for our clinicians and our patients.

Clinical Transformation was created during our EMR implementation process. It became obvious during our planning that EMR was not a project but an approach to excellent outcomes for our patients. Although our class today is going to provide you with education around using EMR and its functionality, our overall focus is to provide the safest care to our patients using current evidence that is available to the clinicians. All disciplines can see the story unfold and use the information to make decisions about patient care and treatment. As a clinician you will always rely on your clinical judgment and use the information gathered in the EMR to make clinical decisions that are best for your patient.

We are always looking for ways to improve the ease of use of electronic forms, and new information is also added based on evidence/ changes in regulatory standards. Therefore by the time you arrive for your clinical experience, the look of some forms may change due to these continuous improvements but the main elements and principles of documentation will remain the same - patient safety, clear documentation of assessment and planning and interdisciplinary communication are always paramount.

Information Security and Confidentiality

When dealing with computerized health care records, specific confidentiality and security issues must be followed to protect the patient. Also, there are increasing HIPAA and JCAHO regulations that dictate how these records are handled.

- When selecting a password, do not choose anything obvious, such as your birth date, social security number, or spouse and children's names.
- Do not tell anyone your password.
- The DMC system requires you to change your password every 90 days.
- When you open a chart you will be asked to identify your relationship to the patient, for example Staff Nurse or Chart Review.
- The system keeps an audit trail, or record, of who enters each chart and when. It records who read the chart and who recorded each piece of information in the chart.
- Every employee will not be allowed to see or perform every activity on the computer. For example, a lab technician will be able to see and do more in the lab application than a nurse will.
- Do not leave the computer while still signed on.
- Do not access any charts that do not apply to your current job and caseload.

Help Desk

To get help for any issue with *EMR*, please call the Help Desk at:

(313) 966-2400

Definition of Terms

- 1. Ad hoc: file cabinet for blank forms.
- 2. Alerts/warnings: pop-ups on screen to inform the users of possible adverse events.
- 3. **Demographic bar:** pink bar across top of chart displaying patient info such as, name, birth date, allergies, sex, etc.
- 4. **Discern alert:** an automatic alert informing users to perform a function based on assessment criteria that has been entered.
- 5. **Drop down arrow:** downward pointing arrow at the end of an entry box that when clicked displays entry options.
- 6. Encounter: a specific patient visit.
- 7. Favorites: a folder in which users can store frequently used items for easy recall at a later time.
- 8. Filter: a method of arranging data to view only what the user wants to view.
- 9. FIN number: financial information number used for billing purposes and separates visits.
- 10. Icon: a symbol.
- 11. **Medication wizard:** the screen from which medications are scanned and administrated; (marked with a barcode icon).
- 12. Menu bar: a list containing the sections of the chart.
- 13. **Navigator bar:** a list of areas within a section of the chart or power form; clicking on an item in the list will bring that area to the top of the screen.
- 14. **Overdue:** a task that has not been completed in the allotted timeframe.

- 15. **Patient access list (PAL):** a list of patients assigned to the caregiver that contains key information associated with each patient.
- 16. **Power chart:** the electronic medical record.
- 17. **Power form:** an electronic form in the medical record.
- 18. **Power orders:** electronic order entry.
- 19. **Refresh:** updating the current screen.
- 20. Scratch pad: the orders for signature window.
- 21. **Suspend:** a way of logging off for a short time while holding your place in the chart.
- 22. **Tab:** a section or heading in the chart.
- 23. Tasks: patient care items to be carried out for the patient.
- 24. **Time frame:** the date and time being viewed.
- 25. Toolbar: the bar at the top of the screen containing icons and charting options.

Logging in to CIS Powerchart

- 1. On your desktop, double-click the DMC Citrix Desk
- 2. Enter your DMC Enterprise User ID and Password.

D	MC Citrix Desktop Login
	Training Newsletters
	<u>CIS Spotlight on the DMC Citrix Desktop</u> <u>DMC Portal Pointers</u>
Login	Instructions:
Usemame: Password:	 Enter your DMC Enterprise (DMC NT Network) User ID and Password - This is the one you use for E-Mail, VPN, NetLearning for Physicians, or remote access to the DMC Intraweb.
(Note: Password is case sensitive)	 If you don't have an NT Network User ID/Password, you can obtain one by <u>direking here</u> or contact the Help Desk at (313) 966-2400

- 3. On your DMC Citrix Desktop, double-click the Start CIS ic
- 4. Enter your User Name and Password and click **OK**.

$0_{01} \\ 0_{01} \\ 0_{01} \\ 0_{10} \\ 0$
D000000000010101 01001100 0100010 <mark>Pessword</mark> 00100 01000111 01000101
Domain :
OK Cancel
© Cerner Corporation

Closing CIS and Citrix

You should always close confidential information before walking away from the PC. However, you don't want to close everything you're working on, log out of Citrix and CIS, and then have to re-open it all again later in your shift, repeating the process every time you step away to care for a patient. That's why you have several options for closing your work: one for only closing *PowerChart*, one for logging off Citrix completely, and one for holding your place in all open applications until you return.

Exit — When you are finished in *CIS*, but wish to leave your Citrix desktop open, click on the **Exit** button on the *PowerChart* toolbar. *CIS PowerChart* closes completely and returns you to your *Citrix Desktop*.



Suspend — When you need to walk away for a short time, click the **Suspend** button in your taskbar tray. Your Citrix session, CIS, and any other applications you have open will be closed for you; however, your exact location will be bookmarked. The next time you sign on to Citrix from any DMC computer, within four hours, you will be returned to the exact place you were before you clicked Suspend.

Log Off — Click the **Log Off** button on your taskbar tray when you are leaving at the end of your shift. This will close all your applications and log you out of the system entirely. When you return for your next shift, you will need to log in to any applications you wish to use.

Log Off and Suspend are located in the lower right corner of your screen, above the clock.	
	@@ *@@
💽 TRAIN Deskt 🖪 Microsoft Pow	📗 🤌 遲 (🤜 🐠 2:35 PM

Tool Bars and Icons

Toolbars can be customized to user preference.

Click and hold on the four vertical dots in front of the toolbar. A four point arrow will appear.

🕴 🔆 Patient List 🔐 Multi-Patient Task List 💿 Patient Access List 📸 Shift Assignment 🍃 🗔 CIS Intraweb 🗔 WIND 🗔 Lawson 🗔 4MEDICA 🗔 DMC Policy and Procedures 🖕
🗄 🔀 Tear Off 🛣 Attach 🤯 Charges 🍠 Charge Entry 🗐 Exit 📓 Calculator 🎬 AdHoc 🛲 Medication Administration 🔓 PM Conversation 🔹 📲 🕄 MEDLINE 🔍 VIS 🔍 Lippincott 🔍 SRM

While still holding the mouse button down drag the toolbar where desired and release the mouse button.

This will allow you to view all icons. If the toolbars are not showing all icons, you will have to use the dropdown arrow at the end to view hidden icons.

훈 Teal AT 🝸 Attach 👦 Charges	P Charge Entry A Exit
	Calculator AdHoc Calculator Administration Conversation Report Builder
	Add or Remove Buttons -

To customize the icons within the toolbar right click any where on the toolbar and choose customize.

🛔 🛉 Patient List	🚨 Multi-Patient Task	Determine	🕆st 📸 Shift Assignment 🥃
a.	Maria Maria	Customize	

The customize box will appear.

😓 Customize Tool Bars	×
To rearrange the order of the icons within a toolbar, click on the icon you wish to move and drag it into the desired position. Icons may not be moved between toolbars.	Close
My Custom Links Add Modify Remove	

Click and hold on the icon you wish to move. While holding the button down, drag the icon to the new location and release. (*Icons can only be moved within the same toolbar*). When finished, close the box.

Patient Search

- 1. Click on the binoculars icon 🛱 located to the right of the screen.
- 2. Enter the patient's FIN number and click search. (To practice use 613392984).



Verify you have the correct person by checking the birth date and other demographic information. Then select the encounter and click OK.

Recent shows the last nine charts the user has opened. Use the drop down arrow and select the patient's chart you wish to open.

Recent V MRN 1. Burnside, Rhonda 2. Duck, Daffy 3. Duck, Donald 4. Pan, Peter 5. Sailorman, Popeye 6. Bunny, Bugs 7. Simpson, Homer 8. Hook, Captain 9. Fudd, Elmer

Patient Access List (PAL)

The Patient Access List (PAL) is a list of patients assigned to a caregiver that contains key information associated with each patient, including location, allergies, attending physician, pharmacy orders, overdue tasks, and many other pieces of information.

Note: The PAL tab automatically updates every (one) minute, regardless of how many times you click on the refresh button.

Accessing the PAL Tab

1. In *PowerChart*, click the **Patient Access List** (**PAL**) on the toolbar.

🛉 Patient List 🚨 Multi-Patient Task List 🛅 Patient Access List 💕 Shift Assignment

2. The timeframe selection window will open. Select the appropriate shift by highlighting the row and click OK



3. Next, the establish relationship box will appear.



4. Uncheck any patients you are not assigned to by clicking in the box in front of their name.

5. Use the drop down arrow to select your relationship.

😓 Establish Relationship	
Select an appropriate relationship:	
Chart Review Cinical Nurse Specialist Coordinator CRNA Instructor Manager Staff Nurse I Flintstone, Fred I Hook, Captain I Oil, Olive I Simpson, Homer I Pan, Peter I Pan, Peter I Pan, Peter I Puck, Donald I Rubble, Betty I Bunny, Bugs I Flintstone, Wilma Duck, Daffy I Simpson, Marge	
Jetson, George	OK <u>C</u> lose Apply

NOTE: The relationship box will not appear or some names may not be listed if you have previously established relationship with the patients.

The sections of the PAL are as shown.

C				بخريها العربي
<u>T</u> ask <u>E</u> dit <u>V</u> iew <u>P</u> atient	⊆hart Links Options PatientList Hel;	2		
🧍 🛉 Patient List 🔉 🔐 Multi-Patient	Task List 🔟 Patient Access List 🥳 Shift As	signment 🖕		
i 🔝 ⊆alculator 🏾 🎦 AdHoc IIIII N	fedication Administration 🗐 Exit ଌ PM Con	wersation 👻 🍠 Charge Entry 😽 Ch	arges 🛣 Attach 🛣 Tear Off	🍟 🖸 🔃 MEDLINE 🔇 VIS 🔇 Lippincott 🔇 SRM
🗄 🗔 Pharmacy 🗔 WIND 🗔 CI	5 Intraweb 🔚 4MEDICA 🔚 DMC Policy and	Procedures 🗔 Lawson 🥃		
		_		强 Recent 🔹 🕅 MRN 🔹 🛱
Patient Access List				🕌 Print 💸 4 minutes ago
zz-DRHEMR			Shift: 20	January 2009 07:00 - 20 January 2009 15:00
Name	Location Visit LOS Sex A	New Pharr Lab Rad	Overdue PRN/Conti Currer	
	D 1'			
Name	Demographic	Notifications	Tasks	Results
Section	Section	Section	Section	Section
beenon				

Name section: displays patient's name

Demographic section: displays info such as, age, sex, rm. number, etc.

Notification section: displays new orders as soon as they are signed by provider. Also displays new lab and radiology reports.

Tasks section: Displays tasks that are due at a given time for a patient.

Results section: displays last entered vital signs.

PAL Icons

Icons displayed on your PAL were specifically chosen to give you a good idea of the type of activity they represent.

All icons on the PAL provide access to additional patient information. You must double-click on the icons for access. A single click only changes the patient you are focused on.

There are three icons that will display your patient's Allergy status in the demographics section:

Icon	Action
÷¢÷	No Known Allergies
*	Known Documented Allergy
÷¢.	Allergies not Recorded

In the Notification section, order or result notifications can appear as a clipboard or an eyeglass icon.

lcon	Action
1	The Clipboard icon indicates a new result. Double click to view details. Click Apply to acknowledge that the results have been reviewed.
60	The Eyeglass icon indicates an order that needs to reviewed/noted. Double click to review. Click Apply to acknowledge that the orders have been reviewed/noted.
<u>68 </u>	A Red icon indicates a STAT order or a result that is out of the normal range. Double click to view. Click Apply button to acknowledge that they have been reviewed.

Icons that appear in the Task section provide an indication of the type of activity that needs to be done.

8	Medications: Medication, PRN Response
ŇD.	Activity: Activity/Hygiene
%	Nursing Assessments/Treatments: Admitting, Audiology, Care Management, Communication Orders, Patient Assessment/Monitoring, Procedures, Discharge, Vital Signs
Ċ	Respiratory Nursing Tasks: Respiratory, Respiratory Assessment, Respiratory Treatments, Pulmonary Diagnostics
	IV's: IV, Parenteral Therapy
*	Interventions: Unit-Based Tests, Interventions, Dressings/Wound/Skin Care, Education, Tubes/Drains/Fluid/Elim Patterns, Safety Measures/Precautions
*1	Nurse Blood Draw: All blood draw orders where the nurse is indicated to draw the blood.
12/2	Unscheduled Task: This activity can be from any of the other types, but is unscheduled.
1	Communications: Communication Orders, Order Notification, Spiritual Care, Consults

Creating your own assignment list for your PAL

Each individual must create an assignment list if his/her area is using the Shift assignment function. This list will automatically contain any patients assigned using the shift assignment function.

Note: The following steps will only need to be completed the first time the PAL list is accessed.

1. From the PAL, right click on the green bar containing the unit name.

<u>T</u> ask <u>E</u> dit	⊻iew <u>P</u> atient ⊆harl	t <u>L</u> inks Options	s <u>P</u> atientList <u>H</u> elp)						
🍦 Patient Lis	st 🔉 Multi-Patient Task	List 🔟 Patient Ac	cess List 🧟 Shift As	signment 🖕						
Ealculator	r 🎬 AdHoc 💵 Medica	ation Administration	📲 🕵 The Con	versation 👻 🍠 Charge B	Entry 🖓 Charges 💈	Attach 🛣 Tear	off 📲 🖁 🖏	MEDLINE 🔍 VI	S 🕄 Lippincott 🔇	🔍 SRM 🖕
🗔 Pharmacy	🗸 🗔 WIND 🗔 CIS Intr	aweb 🗔 4MEDIC	A 卢 DMC Policy and	Procedures 🗔 Lawson	Ŧ		_			
			/					强 Recent 🔹	MRN	- 尚
Patient Ac	cess List								🎒 Print 🛷 4 mir	nutes ago
***	燕									
4R	Change Patient List.					S	ihift: 20 Januar	y 2009 07:00 -	20 January 200	9 15:00
Name	Change Timeframe		LOS Sex /	lew Pharr Lab Rad	Ove	rdue PRN/Con	ti Current	Temp Pulse R	R SBP DBF	-

- 2. Click on "change patient list"
- 3. Choose "New" at the bottom.
- 4. Click on "assignment" at the top. Then click next at the bottom.

Patient Lis : Type Select a patient list type: Assignment (Ancillary) Caref eam Lutom Lutom Location Group Medical Service Provider Group Quey Vist Relationship	
	Back Next Finish Cancel

5. Type the name of your list in the box and click **Finish**.

Charting From the PAL

The tasks section of the PAL includes multiple sub-columns for indicating different types of tasks as well as times that tasks are due, including:

- Overdue An icon in the Overdue column will indicate a scheduled task that is currently overdue.
- PRN/Continuous An icon in this column indicates a PRN or continuous treatment or medication is ordered for the patient.
- Current An icon in the Current column indicates a task is due at the current time. The type of icon in the column will indicate which type of task is due.
- Individual timeframes Columns are created to indicate specific times in your shift that treatments or medications are due. These columns are based on the frequency selected when the order was entered.

To access tasks for charting, double-click the task icon in the appropriate column. For example:



Click in the box for vital signs per protocol then click Chart at the bottom.

🧶 Tasks					×
Sailor	man, Popey 8-841078424	е		:	5S01 A
Tasks appea display.	ring in this window are acc	urate as of 01/20/2009 1	6:25. Please select the refresh butto	to update the	Refresh
	Date and Time	Task	Details		Status
<u>_60</u>	Continuous	Vital Signs per Protocol	01/13/09 7:48:00, CONTINUOUS		Pending
□ ? 60 (🎐	PRN	acetaminophen acetaminophen (Tyle	Start 01/13/09 7:50:00, Routine, 10	000 mg, Ay	Pending
				Quick Chart	Chart

This will bring up the vital signs form. After completing, use the green checkmark it is sign the form or the floppy disk to save it if you need to return to it later.

Note: Temperature is recorded in degrees Celsius and weight is recorded in kilograms.

** All tasks on the PAL list should be tasked off by the end of your shift. Things that are not yet completed should be reported off to the oncoming shift during handoff communication.

Tasking Off

As tasks become due for a patient, an icon will display in the tasks section of the PAL. These are reminders for the care provider. Once the task is completed, it must be tasked off.

Patient Access List					e	Print 💸 1 minutes ag
特等 督 %						
5S				Shift: 03 Febru	ary 2009 07:00 - 03	February 2009 19:0
Name	Location Visit LOS	Sex / New Pharr Lab	Rad	13:00 - 13: 15:00 - 15: 16:00 - 16	: Temp Pulse RR	SBP DBF
Sailorman, Popeye	5S01 A Inpatient-Acti 21.3	Male				150 80
Simpson, Bart	5502.A Inpatient-Acti 21.3	Male				
Coyote, Wile E.	5503 A Inpatient-Acti 21.3	Male I				120 76
Rubble, Barney	5504 A Inpatient-A 21	Male			1	
Flintstone, Fred	5505 A Inpatient-Acti 21.3	Male I				
Oil, Olive	5506 A Inpatient-Acti 21.3	Female				120 80
Dev. Dates	ECOLA June Vent And DL	Mala I		T		

First, double click on the icon to determine what needs to be completed.

🧶 Ta	sks				×
Ru	bble, Barne D-841078427	у		55	504 A
Tasks displa		are accurate as of 02/03/20	09 15:08. Please select the refres	h button to update the	Refresh
	Date and Time	Task	Details		Status
260	° 02/03/09 15:04	Collect Complete Blood Complete Blood Count	02/03/09 15:04:00, Routine, 1, Collect One lavender top tube.	2 · · ·	Pending
•					
				Quick Chart	Chart

After completing the task, click "chart" (*never click* "*quick chart*") at the bottom of the box. This will remove the task from all areas of the chart.

Orders For Nurse Review

As soon as an order is signed in the EMR an eyeglasses icon will appear in the notification section of the PAL. This alerts the nurse that there is a new order and it must be reviewed by the nurse.

Patient Access List			🎒 Print 🛷 0	minutes ago
特等 會 %				
4R			Shift: 04 February 2009 07:00 - 04 February 2	2009 19:00
Name	Location Visit LOS Sex	New Pharr Lab Rad	Overdue PRN/Conti Current Temp Pulse RR SBP DBF	A
Marks, Martha	4R04 A Inpatient-Acti 7.4 Female			
Jones, Leroy	4R03 A Inpatient-Acti 9.3 Male			
Johnson, Georgia	4R02 A Inpatient-Acti 9.3 Female	•		
Davis, Virginia	4R07 A Inpatient-Acti 9.3 Female			
Scope, Sally	4R04 A Inpatient-Acti 9.3 Female			
Johnson, Paul	4R08 A Inpatient-Acti 9.3 Male			
Burnside, Rhonda	4R05 A Inpatient-Acti 7.4 Female	60°		

1. To review the order, double click on the eyeglasses. This will display the order.

😓 Orders		×
Burnside, Rhonda D-841078457		4R05 A
Order Description	Order Display	Status
⊡ல்ல் Complete Blood Count with Diffe	02/04/09 16:13:00, Routine, 1, One Time Only, 1, Day(s), Blood, Nur Collect One lavender top tube. Order not more than one within a 24	Ordered
Deselect All		Apply

2. Click on the word "**apply**" _____

This will display the order in more detail.

urnside, lergies: No			Female Loc:DR - 4R; 4R05 I:D-8410Fin Number:	i; A
Action	Action Date/Tim	e Entered By	Order	Details
] Order	02/04/09 16:13:58	DRHPhysician, MD01	Complete Blood Count with Differential (CBC/Diff.)	02/04/09 16.13.00. Routine, 1, One Time Only, 1, Day(8), Blood, Nurse Collect
Select <u>A</u> ll			Burnside, Rhonda Review	Cancel

3. After reviewing the details of the order click on the word "**review**" The icon and the order are now removed from the PAL list. The order can still be viewed from the orders section of the chart.

Admission Documentation

When a patient is admitted an icon will appear on the PAL list that will contain the forms to be completed.

Patient Access List			🍊 Print 🛷 1 minutes ag
芥芥香 秀			
4R			Shift: 03 February 2009 07:00 - 03 February 2009 19:0
Name	Location Visit LOS Sex	New Pharr Lab Rad	09:00 - 09: 15:00 - 15: 17:00 - 17: Temp Pulse RR SBP DBF
Marks, Martha	4R04 A Inpatient-Acti 6.4 Female		
Jones, Leroy	4R03 A Inpatient-Acti 8.3 Male		
Johnson, Georgia	4R02 A Inpatient-Acti 8.3 Female		
Davis, Virginia	4R07 A Inpatient-Acti 8.3 Female		
Scope, Sally	4R04 A Inpatient-Acti 8.3 Female		
Johnson, Paul	4R08 A Inpatient-Acti 8.3 Male		
Burnside, Rhonda	4R05 A Inpatient-A 6. Female		

If there is no icon, **double click on the patient's name to open the chart**. The forms can be found by clicking the "**ad hoc**" icon on the toolbar.

🛣 Tear Off 🛣 Attach 🧏 Charges 🍠 Charge Entry	🗐 Exit 📓 Calculator 🎙	dHoc IIIIII Medication Administration 🔒	PM Conversation 🝷 🖪 Report Builder 🖕	
--	-----------------------	---	--------------------------------------	--

Next, click "EMR forms" and select the needed forms by clicking in the box to the left of them.

Ad Hoc Charcing - Burnsid	e, Rhonda		
 Ad Noc Charting – surnsto Charting EMR Forms Assessment Emergency Service Critical Care PCA Forms Rehab Services Respiratory Service EMR Forms - Adult EMR Forms - Adult EMR Forms - Peds/Nec Clinics ED Pharmacy Outpatient Pharmacy Archive Folder All Items 	Activity Adult Admission Assessment Adult Admission History Adult Nutritional Intake Adult Prain Assessment Adult Vials/Pain/GCS Advarce Directive Adult Vials/Pain/GCS Advarce Directive Adult Vials/Pain/GCS Advarce Directive Adult Vials/Pain/GCS Advarce Directive Advarce D	Cardiovascular Adult Assessment Cardiovascular ICU Assessment Cast Application Continuous Passive Motion ED Treatments and Procedures ED Triage and Assessment Adult - DRH ED Triage and Assessment Pediatric Education Wound Care FIM Gastrointestinal Adult Assessment Gastrointestinal Adult Assessment Genitourinary Dialysis Assessment Detailed Genitourinary Dialysis Assessment Simple Genitourinary ICU Assessment Gi Gascow Coma Scale	
 EMR Forms - Peds/Nec Clinics ED Pharmacy Outpatient Pharmacy 	Aldrete Aldrete Antepartum Assessment Anterial Blood Gas Analysis by Respiratory Asthma Assessment Behavioral Health Admission Assessment	FIM Gastrointestinal Adult Assessment Gastrointestinal ICU Assessment Gastrointestinal ICU Assessment Genitourinary Adult Assessment Genitourinary Dialysis Assessment Detailed	
n All Items		•	
	•		F
		Chart	Close

The necessary forms include:

Admission assessment

Admission history

Plan of care (will be demonstrated in daily documentation section)

Patient education (will be demonstrated in daily documentation section)

After selecting these forms, click "chart" at the bottom. The forms will come up one at a time to be completed.

Admission Assessment

When completing the admission assessment, use the navigator bar on the left to move from one section to the next until every necessary section has been completed.

*Performed on:		1551 🗧				By: DRI	inurse,
Female Reprc- Male Reprodu	2		Vital Si	gns-Detailed			
Musculoskele				-			
MS Detailed	Oral	DegC	Tympanic	DegC	Pain Score	O N/	7
Neurological					(Rest)		
Neuro Detaile	Rectal	DegC	Axillary	DegC	Pain Score		4
Seizures			í I		(Activity)		
Sleep/Rest /	Intravascular	DeqC		DeqC	Pain Scale		
Integumentar	Indavascular		Core		O VAS	O 0 · 10 Pain Scale	o o w
Integumentar	Temporal	DegC	RN Notified of	O Yes	O PABS O DUCHER	O NIPS O N-PASS	O FL O OI
IV			Pain Score			U N-PASS	_
Infiltration/Ph							•
Glasgow Corr	Systolic/ Diastolic BP	mmHg / mi	^{mHg} Mean Arterial Pressure	Apical Rate	Heart bpm	Fetal Heart Rate	
Schmid's Fall		O Arm, right O Thic	h, right O Wrist, Right O	–	have		
Functional As	Location of BP Collection	O Arm, left O Thig	h, left 🔿 Wrist, Left 🔿		bpm		
Functional As			•				
Belongings Consults	BP Cuff Size	O Infant (Orange cuff, som	e are White): Size 9.0 - 14.8 cm	Method of BP	O Auscultated (cuff)	Thigh (cuff) O Palp	ated
DC Needs		O Pediatric (Green cuff): Si O Small Adult (Roval Blue o		Collection	O Automated (cuff)	Arterial Line	Þ
Drains/Tubes		O Adult (Navy Blue cuff): S					
NIH Stroke		C Large Adult (Burgundy c	uff): Size 31 - 40 cm				
Safety/Care I		J					
Braden							

There are three areas of the navigator bar that are required fields. They are marked with \bigotimes . Those items are the Schmidt Fall Risk, Functional Assessment, and the Braden Score.

When the form is completed, use the green checkmark **v at the top left corner to sign your documentation or the floppy disk icon **v** to save if you need to return to it later.

Pressure Ulcers

Documenting that a pressure ulcer is present will place "**Impaired tissue integrity**" on the problem list. An auto alert (discern) will fire alerting the RN to order the "**pressure ulcer management**" orderset and a task will be placed on the PAL.

Discern			
Subject:	Discern Alert - In	npaired Tissue Integrity	
	Priority Status:	High Priority Value: 100	
Event Date	e/Time:	05/04/2009 8:16:27	
vlessage o	lass/subclass:	APPLICATION/DISCERN	
	. 🎒 86 🗐	🗟 🕞 🔍 🔍 🛛 100% 💦 🚽 🔿 🔿 🍪 🍪 🖓	_
		e a Pressure Ulcer : Yes as of May 04, 2009 08:15:00 EDT	•
Does	Patient have		
Does Your c ulcer. The pi the "P	Patient have	e a Pressure Ulcer : Yes as of May 04, 2009 08:15:00 EDT n has indicated this patient has an active or probable pressure lired tissue integrity" has been added to the Problem List. If Management Orderset" is not in place, please add it to the	

RN Responsibility:

1. Complete all assessment and documentation requirements of the wound.

Pressure Ulcer Car	e											
	Pressure Ulcer Stage	Pressure Ulcer Status	Present on admission	Location	Description	Color	Length (cm)	Width (cm)	Depth (cm)	Drainage	←	
Pressure Ulcer #1	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>		Pressure ulcer grid
Pressure Ulcer #2	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>		Ũ
Pressure Ulcer #3	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>		found in integumentary
Pressure Ulcer #4	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>	1	
Pressure Ulcer #5	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>		section of the assessment
Pressure Ulcer #6	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>	1 -	
Pressure Ulcer #7	<alpha></alpha>	<multialpha></multialpha>	<alpha></alpha>		<multialpha></multialpha>	<multialpha></multialpha>				<multialpha></multialpha>	1	
•							1	1		•		

2. Go to the Power Orders section of the chart and place the pressure ulcer management orderset.

Menu	ť
Overview	
24 Hour Summary	
Results Review	
I/O	
MAR	
Immunization Schedule	
PowerOrders	🕂 Add
Clin Doc	
Forms	
Tasks	
Pt. Info	

Pressure Dressing Pressure Garment Measure/Fit Pressure Infusion Bag Pressure Palsy Neuropathy Pressure Ulcer Management Pressure Ulcer Prevention Pressure Ulcer Treatment LIP and A... Pressure Wound Protocol Pressure, Close Pressure, Opening

See PowerOrders section of manual for further details about placing orders.

3. Complete the task on the PAL.

	asks appearing in this wind splay.	ow are accurate as of 5/4/20	09 08:21. Please select the refresh button to u	pdate the	Refresh
	Date and Time	Task	Details		Status
ন	5/4/2009 08:16	Go to Orders - Pressure	05/04/09 8:16:28		Pending
1		Go to Orders-Press. Ulc	Ordered by Discern Expert.		
			<u>و</u>	Luick Chart	Chart

- 4. Initiate "impaired tissue integrity" care plan. (See page 39 of this manual for explanation)
- 5. Complete patient education. (See page 38 of this manual for explanation)

Documenting a Braden score ≤ 18 will place "**risk for impaired tissue integrity**" on the problem list. An auto alert (discern) will fire alerting the RN to order the "**pressure ulcer prevention**" orderset and a task will be placed on the PAL.



RN Responsibility:

1. Go to the Power Orders section of the chart and place the **pressure ulcer prevention orderset**.

Pt. Info Pressure, Opening 2. Complete the task on the PAL.	Overview 24 Hour Summary Results Review 1/0 MAR Immunization Schedule PowerOrders Clin Doc Forms Tasks	Pressure Dressing Pressure Garment Measure/Fit Pressure Infusion Bag Pressure Palsy Neuropathy Pressure Ulcer Management Pressure Ulcer Prevention Pressure Ulcer Treatment LIP and A Pressure Wound Protocol Pressure, Close
	Date and Tin 5/4/2009 08	Task Details Status Go to Driders - Pressure

3. Initiate "**Risk for impaired tissue integrity**" care plan. (See page 39 of this manual for explanation)

Quick Chart Chart

4. Complete patient education. (see page 38 of this manual for explanation)

Admission History

Again, use the navigator bar on the left to complete each section. Be sure to complete the required fields that are marked with \bigotimes .

X General Info			General Information				
Preumococcol A Prosthetics/impli Allergy	Date & Time of Arrivatori Ur	at P	atient Unaccompanied by Family/Visitor	0			
TB Scieen	Admitted From		Mode of Arrival	Information Given	Ðy		
Disease Exposu Nutrition Earing Disorder 5 Home Environme Social Habits Family/Social Coping & Stress	C Direct Admission C M C Direct Admission C M C DMC Hospitel C C C DMC Nursing Unit C C C Doctor's Ullice C F C Emergency Department C F	fome Mental Hinath Facility Non DMC Huspital Disservation Unit DR /PACI J/Some Day Plocedure/Tisatoent Ashabilitation Facility Skilled Nursing Facility	O Articulatory O Bried O Clarind O Stratchel O Wrweichear O Utive:	Unable to obtain Doughtes Family member Friend Interpreter Legal Guardian Parent Patent	Patient Medical Re Patient Record Proven Sting Significant Other Son Spoure Vrat		
Sucado Honico Dubud/Spinud Learning Needs Advance Diversion C Yes C No		고 Reaso	n Unable to Obtain	Preferred Name			
		L CITATION		Reason for			

Vaccine Screening

Every patient at the DMC will be screened for the flu vaccine from October to March and every patient over the age of 65 will be screened for the pneumonia vaccine all year.

To complete the screening process, select the influenza or pneumococcal assessment from the navigator bar.



If the patient meets criteria, select the administer option. This will automatically place an order for the vaccine.

As a part of the admission process, every patient is screened and offered smoking cessation if appropriate. To begin the process, select the social habits section from the navigator bar of the admission history form.

Smoking Sta	itus: Tobacco use	in last year	Smoking cessation material/support offered
	O No	O Unable to obtain	Patient Accepts O Patient Refuses
Parent Smo	omeone who smokes		If "patient smokes" or "parent smokes" is selected, provide smoking cessation information.
 4			

Answering "YES" to tobacco use in the last year will require you to offer smoking cessation material/support to the patient. (The box to the right becomes yellow and is a required field).

Answering "patient accepts" the smoking cessation material will automatically place an order for a smoking cessation consult. (The consult is performed by respiratory, and should not be completed by nursing).

**When the form is completed, use the green checkmark 💉 at the top left corner to sign your documentation or the floppy disk icon 🖬 to save it if you need to return to it later.

Note: Plan of Care and Patient education will be covered in the daily documentation section of this manual.

Once the admission history form is completed the nurse must collect information about the patient's **past** medical history and medications taken at home. These items are documented from the menu bar inside the patient's chart. To open the patient's chart, double click on their name.

Menu	 р
Results Review	
I/O	
MAR	
Immunization Schedule	
PowerOrders + Add	
Clin Doc	
Forms	
Tasks	
Pt. Info	
Patient Schedule	
Allergies 🕂 Add	
Problems and Diagnoses	
FaceSheet	
LOS	
List View	
Medication List	
Reference Text Browser	
Histories	_
I-View Flowsheet	

DRH Clinical Transformation Pamela Haddox, RN, BSN May 2009

Menu Bar

The menu bar located on the left side of the patient's chart can be hidden to allow a larger viewing area.

Click on the pushpin icon (\mathbf{P}) located on the top right of the menu bar.

Menu	– 4
Overview	
24 Hour Summary	
Results Review	
I/O	
MAR	
Immunization Schedule	
PowerOrders	🕈 Add
Clin Doc	
Forms	
Tasks	
Pt. Info	
Patient Schedule	
Allergies	🕈 Add
Problems and Diagnoses	
FaceSheet	
LOS	
List View	
Medication List	🕈 Add
Reference Text Browser	
Histories	
I-View Flowsheet	

If menu bar is already hidden, hover mouse over the small tab on left that reads "menu" click on the pushpin to leave menu bar displayed.



Medication List

To enter the list of medications, first go to the "medication list" on the menu bar and click "Document by History" \searrow



The options of "No known home medications" and "Unable to obtain information" are available if applicable.



To begin adding a medication to the list, click + Add

Next, type the medication name into the find box and select the item with the correct detail. An order sentence box will display. The RN is only concerned with the details of how the med is taken. This will not place a prescription in the file. Choosing 30 tab or 90 tab will have no effect in this area. Click OK.

Eind: Jasix Searc Lasix Lasix 10 mg/ml injectable solution Lasix 10 mg/ml oral liquid Lasix 10 mg/ml oral solution Lasix 20 mg oral tablet Lasix 40 mg oral tablet Lasix 80 mg oral tablet Lasix 80 mg oral tablet Lasix 80 mg oral tablet Lasix 80 mg oral tablet	h Starts with Type: Document Medication by Hx Corder Sentences Order Sentences for: furosemide (Lasix 20 mg oral tablet) None T,T ab By Mouth, T ab Daily.30, T ab T,T ab By Mouth, T ab Daily.30, T ab OK Cancel
	Burnside, Rhonda - D-841078457 Done

When all medications have been entered, click "DONE" at the bottom of the screen.

The next step is to complete any details that are not already appropriate to the patient. Then compliance must be completed for each medication. The compliance indicates whether or not the patient is still taking the medication as prescribed.

÷	Add Medication History No Known Home Me	diantiana 🗖	Unable To Obt	nin Information					
	Document Medication by Hx			airmioinadon	 				
	Order Name	Status	Details		 	Last Occurred	∆ Info	ormation Source	Complianc C
	Documented Medication		Botallo			200100000000	- The		Compilation: O
	aspirin	Document					Pal	ient	Still taking,
	🔐 furosemide (Lasix)	Document							
	()								
			▼						
	•								F
	▼ Details for aspirin								
	🛛 / 😭 Details 🔪 📴 Order Co	mments 👌 👩	Compliance	1					
				· ·					1
	Status			nformation source		Last dose da			
	Still taking, as prescribed			Patient		• •	÷-		
	Comment								
	0 Missing Required Details						-	Document History	Cancel

When compliance is completed for every medication, click "document history" at the bottom right corner.

If there are previous medications in this section, the nurse is responsible for completing compliance for those meds as well. To do this, **right click** on the medication and select "**Add/Modify compliance**"

🔳 Do	cumented Medications	у Нх			
√ [*]	simvastatin (Zocor 20 mg oral tablet)	Documented 1, Tab, By Mout	h, QHS	Modify	
3	lansoprazole (Prevacid 15 mg oral enteric coated c	Documented 1, Cap, By Mout	h, Daily	Suspend Complete	
3	furosemide (Lasix 20 mg oral tablet)	Documented 40, mg, 2, Tab, I	3y Mouth, Daily	Cancel/DC Void	,
3	aspirin (aspirin 325 mg oral tablet)	Documented 1, Tab, By Mout	h, Daily	Add/Modify Compli	
	foLIC acid (folic acid 1 mg_Documented 1, Tab, By Mouth, Daily oral tablet)		h, Daily	Order Information. Comments Reference Informa	
				Enable Edit on the	Line

All those medications listed under the "prescriptions" section must also have compliance completed.

Physicians cannot perform medication reconciliation until compliance has been completed for all medications.

Past Medical History

1. To enter the patient's past medical history, first click on the **histories** section of the menu bar. Then choose the **past medical** tab.

Histories				🎒 Print 🛷 O minutes ago
Family Past Medical Proce	dure			
Mark all as Reviewed	Display: Active and Resolved	×		
	Last Reviewed	Age at Onset	Onset Date	Age at Resolved

- 2. Click the "Add" icon.
- 3. Type the disease/condition in the search box and click the **binoculars**.

	/		
Histories			🎒 Print 💸 O minutes ago
Family Past Medical Procedure			
Past Medical	/	/	^
Name of Problem ∠ Last Reviewe	d Age at Onset	Onset Date	Age at Resolved
*Condition	Responsible	Provider Comments	
asthma	🐴 🗖 Free Text	<u>#4</u>	<u> </u>
Display As		nset: Date ×/××/×××	
Confirmation Classification	Resolved At: Age R	esolved: Date	
Confirmed Medical		×/××/×××	V
Status Cancel Reason	V		

4. Choose the appropriate option from the list and click **OK**.

Gearch: asthma	ර්ජී Starts with	▼ Within:	Terminology 💌
Show Advanced Options			
🛓 View Synonym 👔 Concept Family 👔	🖁 Multi Axial 🛛 🔓	Cross Mapping	
Ferm ∠	Code	Terminology	Terminology 🔺
Asthma	301485011	SNOMED CT	Finding
ASTHMA	493	ICD-9-CM	Diseases & i
Asthma - cardiac	1495417010	SNOMED CT	Finding
Asthma - currently active	456163018	SNOMED CT	Finding
Asthma - currently dormant	456164012	SNOMED CT	Finding 📕
Asthma annual review	1488421017	SNOMED CT	Procedure
Asthma attack	396119015	SNOMED CT	Finding
Asthma care	2163236010	SNOMED CT	Procedure
Asthma causes daytime symptoms 1 to	1208954011	SNOMED CT	Finding
Asthma causes daytime symptoms 1 to	1208955012	SNOMED CT	Finding
Asthma causes daytime symptoms most	1208956013	SNOMED CT	Finding
Asthma causes night symptoms 1 to 2 ti	1208957016	SNOMED CT	Finding
Asthma causing night waking	264541019	SNOMED CT	Finding
Asthma clinical management plan	2474332015	SNOMED CT	Qualifier value
Asthma confirmed	1780388018	SNOMED CT	Context-dep
Asthma control step 0	282488010	SNOMED CT	Procedure
Asthma control step 1	282489019	SNOMED CT	Procedure
Asthma control step 2	282490011	SNOMED CT	Pocedure
Asthma control step 3	282491010	SNOMED CT	Frocedure
Asthma control step 4	282492015	SNOMED CT	Procedure
Asthma control step 5	282493013	SNOMED CT /	Procedure -

5. Next complete any of the details that are known and click **OK** if finished, or click **OK add new** if there is more history to add.

*Condition Asthma		#4 []	Free Text	Responsib	ble Provider	#4	Comments		
Display As Asthma		At	Age	•	Onset: Date				
Confirmation	Classification Medical	Re	esolved At:Age	•	Resolved: Date	÷.			v
Status Resolved	Cancel Reason	Ŧ							
Active Canceled Inactive							OK	1 Car	ncel

Note: The status will default to "resolved" and will need to be changed to reflect the current status.

Adding SNOMED Database

To be able to search for disease/conditions using acronyms such as COPD or AFIB you must first add the SNOMED database. This must only be completed one time per username.

- 1. To begin, click on the histories section of the menu bar and click the past medical tab.
- 2. Click the Add icon.
- 3. Next, click on the binoculars.



4. Click on "show advanced options."

Problem Search *Search:		砕山 Star	ts with 💌	Within: Termin	c nology 💌
Show Advanced	· · · · · · · · · · · · · · · · · · ·				
View Synonym	Concept Family	ង្ហ [្] ង Multi Axial	Terminolog		

...

5. Next, click on the ellipsis icon

Problem 9 *Search:	earch	ර්ත් Sta	arts with 💌	Within: Termino	kogy 💌	
Hide Ad Search by:	e Name C	34				
	ICD-9-CM, SNOMED C1			erminology axes>		
Term	Certimology		Cance	E eminology	Axis	

6. Place a checkmark in the box in front of **SNOMED CT** and click **OK**.

**You are now able to search using acronyms.

Adding Past Procedures

To add past procedures or surgeries first click on the histories section of the menu bar and select the procedure tab. \sim

Mark all as Reviewed			
- Procedures	·		
🕂 Add 🗹 Modif	y Display: Active	•	
Procedure	Last Reviewed	Procedure Date	<u>u</u>
/			
7			



Next, type the procedure in the yellow procedure field and click the bipoculars



Now, select the appropriate option from the list and click OK

Code ectomy; age 42821 ectomy; und 42820	Terminology CPT4	Terminology Axis Procedure	
ectomy; und 42820			
	CPT4	Procedure	
condary; ag 42826	CPT4 CPT4	Procedure	
econdary; un 42825	CPT4	Procedure	

May 2009

Next, complete any details known about the procedure.

Procedure		Provider		Comments
fonsillectomy and adenoidectomy; age 12 or over 🛛 🧯	🐴 🔲 Free Text	<u>#4</u>	Free Text	
isplay As	At: Age Age	Date Date		
onsillectomy and adenoidectomy; age 12 or over	0	××/××/××××	÷-	
ocation				
🙀 🗖 Free Text				

When finished, click "OK & Add New" to add another procedure or click "OK" if all procedures have been entered.

The procedures will now appear on the procedure tab in the history section for all to view.

	Histories				e	🖥 Print 💸 0 minutes ago
	Family Past Medical Proc	edure				
	Mark all as Reviewed	Dirblay: Active				
l	Procedure	Last Reviewed	Procedure Date	<u>u</u>		
L	Tonsillectomy and adenoide	02/09/2009				

Immunization Schedule

Documenting vaccines given at the DMC is done through the scanning process on the eMAR. Once the vaccine is scanned, required fields will display to enter the lot number, expiration date, info sheet given, and any state programs used for pediatric patients. Once the process is completed all vaccines will display on the immunization schedule section of the chart.

- 1. To document a vaccine that was given outside the DMC, first click on the **immunization schedule** section of the menu bar.
- 2. Next click on the word "**history**" at the bottom.



3. Next click "add to selections"

Immunization Details, Histo	orical Entry			×
Selected Immunizations	Add to Selections	History	Document In	munization Administration
Ready Immunization	Site Product	Source of Historical Info	Dose#	Administration Date
		History Location/Person	0	

4. Choose the vaccines from the list. (multiple vaccines can be chosen at once). Then click "add"



5. Next complete all the details that are known and click "chart"

Selected Immunizations	Add to Selections	History	tion						
Ready Inmunization Sile X influence veus vecon	e Product	"Source of Historical Info Dosett				*Administ 10/16/2008	*Administration Date 16/2003		
		*Immunization	- Vi5 Date		Veccines For Ch	iden Status		-	
dramistisken Notes		Monutachare	a Travel Der	Initor	Route		iden paration Doto 700 /1000	بر ح ا	
Exception Exception	2								
Palient toletance notes		1				↓			

If more than one vaccine is chosen, highlight each one in your list and complete the details before clicking chart.



The information entered will now display in the previous immunizations column,

The immunization schedule also displays the CDC schedule for immunizations for pediatric patients.

Entering Allergies

To begin entering allergies for a patient, first click on the **allergies** section on the menu bar.

		llergies										21 mi
Overview												
24 Hour Summary		Mark <u>A</u> ll as Reviewer	1									
Results Review		Allergies										
I/O		+Add / Modify	💥 No Kno	wn Allergies	Reverse	e Allergy Cl	heck		Display: Act	ive 💌	1	
MAR		<u> </u>						'	,			
Immunization Schedule		Ø Substance	Category	Reactions	Severity	Туре	C E	Est. Onset	Reaction S	Updated By	Source	Reviewe
PowerOrders	🕈 Add	/										
Clin Doc	— I /											
Forms	/											
Tasks	V											
Pt. Info	/											
Patient Schedule	/I											
Allergies	+ Add											
Problems and Diagnoses												

- 2. Next, click the "**add**" icon.
- 3. Then type the name of the allergen into the search field and click "search"

Scope, Sally (MRN: D-841078462) - Add Allergy/A	udverse Effect
My Favorites Search Search Search Search	Substance
Search by ○ Name ○ Code Search for: ○ Substance ○ Reaction	NKA Free tegt Category Drug
For items with these vocabularies/principal types:	C. Reaction type Alergy This is the explanation for Allergy.
Name Vocabul Code aspirin pseudoph MUL DR d00170 aspirin pseudoph MUL DR d03424 aspirin vocodene MUL DR d03424 aspirin vocodene MUL DR d03424 aspirin vocodene MUL DR d03423 aspirin vocodene MUL DR d03423 aspirin reprobam MUL DR d03423 aspirin reprobam MUL DR d03433 aspirin reprobam MUL DR d03449 aspirin reprobam MUL DR d03443 Bapirin reprodex MUL DR d03449 Bapirin reprodex MUL DR d03449 Bapirin reprodex MUL DR d03483 Bapirin reprint Aspirin MUL DR d03445 Baper Aspirin FM MUL DR d0327 Baper Aspirin Aspirin MUL DR d00170 St. Josept Aspirin MUL DR d00170 Baper Crickdrema A MUL DR d00170 Baper Crickdrema A	3. Beaction symptoms 4. Allergy details Statu: Add Free Text Add Free Text Statu: Add Free Text Reviewed: 02/04/03 Reviewed: Severity: Cnot entered • Info source: (not entered • Onset: (not entered • Add Comment • Add Comment • Preverse chronological •
	QK Qancel Apply New

4. Next double click on the appropriate item in the list.

My Favorites Search	Substance	
Search arpin Search by If Name IC Ede Search (or If Search (or Reaction	1. Sybiance (required) Second To remain Calegory Drug Almony	Y
or items with these vocabulaties/pincipal type locabulates ATVocabulates / Penopol Type	2. Reaction type Alegy This of the explanation to Allergy	-
Name (Viciatus (Cod		
1	5. Comments Add Consert C Openological P Reverse they stoppid	4

5. Complete all information known about the allergy and click **ok** when finished, or **apply** to add another allergy.

Daily Documentation

Ongoing assessment

Nursing documentation is a three part process to be completed each shift. The parts include the ongoing assessment, plan of care, and patient education.

To begin, click the "**ad hoc**" icon on the toolbar.

Next, click "EMR forms"

Select the forms needed; ongoing assessment, plan of care, patient education. Then click chart.

The first form to display is the ongoing assessment.

formed on:	02/05/2009					By: DRHNurs
Review Adult			Pregna	ancy/Lactat	ion Status	
Subjective Primary Pain Additional Pai Pain Assessm	Pregnancy Status	O N/A O Confirmed Nej O Patient denies		O Poss O Conf O Unat	Lactation	O Yes O No O Unable to assess due to patient condition
Cardiovascuk CV Detailed			As	sessment P	eview	
Respiratory Resp Detailer Destrointestin	Psychosocial	O WDL's	O Exception	O Unable to A	partic	's = Responds to care. Able to cipate in care. Makes decisions and estions about care.
GI Detailed Nutrition	Subjective	O WDL's	C Exception	O Unable to /	WDL	's = No subjective complaints. Pain not ant. Reports feeling rested.
Genitourinary GU Detailed	Cardiovascular System	O WDL's	C Exception	O Unable to A	WDL	's = Heart rhythm regular. Capillary refill less 3 seconds. No edema present.
Genitourinary Reproductive Female Repro	Respiratory System	O WDL's	C Exception	O Unable to /		's = Respirations regular and unlabored. th sounds clear. Airway patent. Patient on Fair.
Male Reprodi Musculoskele	Gastrointestinal System	O WDL's	C Exception	O Unable to A	intac	's = Mucous membranes moist, pink, and t. Abdomen non-tender and distended. Bowel sounds present.
Integumentar Integumentar Braden	Genitourinary System	O WDL's	C Exception	O Unable to /	WDL	's = Voiding clear, yellow to amber urine. No pain.

Yellow Fields are required fields. The form will not display as completed until all required fields are addressed.
The ongoing assessment is charted by exception. This means only variances are documented in detail. If a particular system does not have any variances, then the WDL (within defined limits) option is selected. The limits are defined in the blue lettering to the right of the row.

Respiratory System	O WDL's O Exception	O Unable to Assess	 WDL's = Respirations regular and unlabored. Breath sounds clear. Airway patent. Patient on room air.
/			

Clicking the exception option will open another page for you to document the findings.

Cardiovascular - Burnside, 🌂 🖿	Rhohda			
		Ca	rdiovascu	lar Assessment
eart Rhythm	Nail Be			Edema
) Irregular	O Dus	sky OOH	er:	Generalized Other:
ntiembolism Device - Le	eft			Antiembolism Device - Right
Graduated compression stock Graduated compression stock Sequential compression devic Sequential compression devic	kings, thigh high ce, knee high			Graduated compression stockings, knee high Graduated compression stockings, thigh high Sequential compression device, knee high Sequential compression device, thigh high
] Other:	ce, thigh high			0 Office:
Other:		Weak Abse	nt Doppler	
] Other: Ilses orsalis Pedis Pulse, Left	Normal	Weak Abse	nt Doppler	Duhe:
] Other: Ilses orsalis Pedis Pulse, Left orsalis Pedis Pulse, Right	Normal	Weak Abse	nt Doppler	Duhe:
] Other: Ilses orsalis Pedis Pulse, Left	Normal	Weak Abse	nt Doppler	Duhe:

The bottom right corner of each system assessment contains an option for a detailed assessment. If what you need to document is not found on the first page, then choose the "detailed assessment" option.

When finished documenting on the page, use the blue curved arrow \bigcirc , called the circle back button, located in the upper left corner, to return to the previous page.

🔀 Braden		I		
Braden Proto	Subjective	O WDL's	O Exception	O Unable to Assess
IV				
Infiltration/Ph	Cardiovascular System	O WDL's	O Exception	O Unable to Assess
Drains/Tubes	caralorascalar system	[
Neurological				
Neuro Detaile	Respiratory System	O WDL's	C Exception	O Unable to Assess
Trial of Water				
Seizures	Gastrointestinal System	O WDL's	O Exception	O Unable to Assess
Glasgow Corr				
🔀 Schmid's Fall		1		
-			-	-

The left side of the ongoing assessment is the navigator bar. This contains sections that may need to be documented based on the patient condition. It also contains two required fields that are marked by a blue circle containing a white X^{\bigotimes} . These items are the Braden Scale and the Schmidt Fall Risk.

When the form is completed, use the green checkmark **v** in the top left corner to sign the documentation, or use the floppy disk icon **v** to save the form if you need to return to it later..

Patient Education

Patient education is an important part of caring for the patient. Education should be completed every shift for every patient.

To begin documenting education, first click on the ^{MAdHoc} icon on the toolbar. Next select "EMR forms" and select the patient education form.



Then, click chart.---

To complete the form, click on the term "alpha" in each box and complete the appropriate details.



The comment box allows free text and should be used to provide some specifics about what was taught.

NOTE: If a field contains circles in front of the options, only one selection may be chosen. If a field contains squares in front of the options, multiple selections may be chosen.

When finished with the form, use the \checkmark in the top left corner to sign the form or use the \square to save it if you need to return to it later.

Nursing Plan Of Care

To begin documenting plan of care, first click on the ^{MadHoc} icon on the toolbar. Next select "EMR forms" and select the plan of care form.

🛅 Charting	B Neurological ICU Assessment	🔲 🖹 Perinatal Ongoing Assessment	
EMR Forms	🔲 🖹 Neurovascular Assessment Lower Extremity		
Assessment	🔲 🖻 Neurovascular Assessment Upper Extremity	🗖 🖹 Pharmacy Clinical Interventions	
Emergency Service	NIH Stroke Scale	🔰 🖻 Pin/Wire Care	
💼 Critical Care	🔲 🖹 Observation Patient Assessment	Plan of Care	
PCA Forms	🗖 🖹 Orientation - ICU	🗖 🖹 Point of Care Testing	
💼 Rehab Services	🗖 🖹 Orientation - Med/Surg	🔲 🖹 Post Intervention Assessment	
Respiratory Service EMR Forms - Adult	🗖 🖻 Orientation - Rehab	🗖 🖹 Postpartum Assessment	
EMB Forms - Adult	🗖 🗈 Orthopedic Device Care	🔲 🖹 Postprocedure Assessment-Adult	
Clinics	🗖 🖻 Orthostatics.	🗖 🖹 Postprocedure Education	
n ED	🗖 🖻 OT Daily Note.	🗖 🖹 PPD Reading	
Pharmacy	🔲 🗈 OT Daily Note - Acute Care	🔲 🖻 Preprocedure Assessment - Adult	
Outpatient Pharmacy	🗖 🖹 OT Discharge	🗖 🖹 Preprocedure Checklist	
Archive Folder	OT Initial Evaluation	🗖 🗈 Preprocedure Education	
	B OT Initial Evaluation - Acute Care	🗖 🗈 Primary Contact	
	OT Swallow Charges	B Procedural Sedation	
	B Patient Education	Projected Target Length of Stay	
	B Patient Rights	Proposed range being roll only	
	B Perinatal Admission Assessment	PT Daily Note Acute Care	
			•
		Chart	Close

Next, click chart.---

To begin, click in the category field and make your selection.

	/	Plan of Care	- Adult Media	ar/Renap		
Plan of Care Category	Problem	Plan of Care Goals	Plan of Care Initiated	Expected Resolution Date	Resolution	Plan of Care Comments
Alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>	
Alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>	
:Alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>	

Next, choose your problem and goals. Be sure that the suffix in the category field matches the prefixes of the other fields.

Plan of Care - Adult Medical/Rehab							
Plan of Care Category	Problem	Plan of Care Goals	Plan of Care Initiated	Expected Resolution Date	Resolution	Plan of Care Comments	
Cardiovascular -CV	CV-Fluid Volume, Excess	CV-Edema decreased	<date></date>	<date></date>	<alpha></alpha>		
<alpha></alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>		
<alpha></alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>		

When choosing goals for your care plan, keep in mind that these must be evaluated and a resolution applied to them. Please be sure that if you choose more than one goal per plan that these goals will always be met at the same time. If not, you will need to list them on separate lines.

The comment section allows for free text and it should contain assessment data to aid in the evaluation of the care plan. Please see example below.

Plan of Care Category	Problem	Plan of Care Goals	Plan of Care Initiated	Expected Resolution	Resolution	Plan of Care Comments
				Date		
Cardiovascular -CV	CV-Fluid Volume, Excess	CV-Edema decreased	02/09/09	02/12/09	Initiated	2/9 2+ pitting edema BLE's
<alpha></alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>	
<alpha></alpha>	<alpha></alpha>	<multialpha></multialpha>	<date></date>	<date></date>	<alpha></alpha>	

The care plan will be continued and updated daily by each nurse until the goals are met or the patient is discharged.

When finished with the form, use the \checkmark in the top left corner to sign the form or use the \blacksquare to save it if you need to return to it later.

Nursing Interventions

After initiating a care plan, you must order nursing interventions. These only need to be ordered one time and will remain on the orders profile for all to see until discontinued.

To order nursing interventions, first click on the "Powerorders" section of the menu bar and click the 🕂 Add icon.

Next, click on the folder icon below the find box.

Diagnosis (Problem) being Addressed this Visit	Find Starts with Type: f
Clinical Dx Code	Children's Hospital of Michigan Detroit Receiving Hospital Harper-Hutzel Hospital Huron Valley-Sinai Hospital Karmanos Cancer Center Michigan Orthopaedic Specialty Hos Rehabilitation Institute of Michigan Rose Diagnostic Imaging Center Sinai-Grace Hospital Plan of Care

Now, select plan of care from the list.

Eind: Searc		At location: DRHUHC
AP-Activity Intolerance AP-Anxiety AP-Anxiety Related to Insufficient K AP-Comfort Impaired AP-Fetal Surveillance AP-Potential Complication: Hypo/Hy AP-Potential Complication Preclampsia AP-Potential Complication: Pre-term AP-Potential Complication: Pre-term AP-Potential Complication: Pre-term AP-Potential Complication: Pre-term AP-Potential Complication: Pre-term AP-Potential Complication: Sickling C AP-Respiratory Function, Altered: R AP-Respiratory Function, Altered: R BH-Alteration in Mood, Depression BH-Alteration in Mood, Mania BH-Alteration in Mood, Mania BH-Alteration in Sleep/Appetite/Ene	 BH-Alteration of Thought BH-Sychiatra Core Set BH-Self-ham, Potential for BH-Sensory Perceptual BH-Violence, Risk For CV-Cardiovascular Nursing Intervent GA-Failure to CV-cardiovascular Nursin GB-Failure to CV-cardiovascular Nursin GB-Failure to CV-cardiovascular Nursin GI-Tissue Perfusion, Ineffective: GI GU-Urinary Elimination, Ineffective: GU-Urinary Elimination, Ineffective: IN-Tissue Perfusion, Ineffective: Re IN-Tissue Perfusion, Ineffective: Re IN-Tissue Perfusion, Ineffective: Re IP-Anxiety Related to Labor and Bitr IP-Fetal Surveillance 	PIP-Grieving, Anticipatory P-Potential Complication: Prematur. IP-Potential Complication Sickling Cri IP-Respiratory Function, Altered: Re M-Metabolic Nursing Interventions NCC-Acute Care Core Set NCC-Critical Care Core Set INCP-Contruction, Impaired NCP-Disturbed Sensory Perception NCP-Noisurbed Sensory Perception NCP-Noisurbed Sensory Perception NCP-Ain, Impaired NCP-Pain, Chronic NCP-Pain, Chronic NCP-Stoke P-Discomberapy Side Effects P-Discomfort, Abdominal

Now choose the category that matches your plan of care.

Each green line represents a goal for that problem. Find the goal(s) you selected and choose the appropriate interventions listed beneath the goal.



After clicking on the first intervention a communication box will appear. You must enter the name of the provider. In this case, it would be "Healthcare Provider" since this is a nursing order. The communication type should be entered as "RN Plan of Care." Then click OK and continue selecting the rest of your interventions. When finished selecting the interventions, click OK at the bottom.

Next, the add orders screen will display again. If there are no more orders to enter, click done.

<u>F</u> ind:	Sear	ch Starts with 💌 Type: 👘	Inpatient	/
	🚮 👷 🔹 🗀 Folder: Folders	Search <u>w</u> ithin: All	At location: DRHUHC	/
	PActivity Intelerance Parvisity Parvisity Parvisity Parvisity Related to Insufficient Kn Parvisity Parvisity Related to Insufficient Paterial Complication: Hypo/Hy Potential Complication: Preclampia Paterial Complication: Preclampia Paterial Complication: Preclampia Paterial Complication: Network Mark Paterial Complication Schlampia Paterial Complication Schlampia Paterial Complication Schlampia Paterial Institution Mark Pateriation in Mood, Depression Hakteration in Mood, Maria Hakteration in Sleep/Appetite/Ene	BHI-Sensory Perceptual BH-Sensory Perceptual BH-Sensory Perceptual CV-Cardiovascular Nursing Int FA-functional Ability/Mobility Nursing GO-Falue to Thrive, Adult Gil-Bowel Elimination Impaired Gil-Tissue Perfusion, Ineffective: Gl. Gil-Tissue Perfusion, Ineffective: Re	PERFORMENT Potential Complication: Premature. PP-Potential Complication: Stoking Dris Potential Complication: Stoking Dris Potential Complication: Altered Field Potential Complication: Premature. Potential Complised Premature. Potential Complication: Prematu	
•				
		TESTDRH, TES	ST01 - D-841000017 Done	
		DRH C	linical Transformatio	n

DRH Clinical Transformation Pamela Haddox, RN, BSN May 2009 Next the orders will display on the scratchpad for you to view before signing. This is your chance to correct any mistakes before signing the orders.

PowerOrders		ᢖ Print 💸 2 minutes ago
Add Document Medication by H Orders Medication List		
K	Orders for Signature	
View	⑦ ➡ ♥ Order Name Status Start	Details
Orders for Signature	DR - 4R; 4R05; A FIN: 685304768	
Orders ADT/Condition/Code Statu	Vitals/Patient Care	
- Activity	👘 🗈 Monitor Weight Trends 🛛 Order 🔹 02/09/2009 16:46	02/09/09 16:46
Nutrition Services Witals/Patient Care	👘 🗈 Elevate Edematous Order 02/09/2009 16:46 Extremities	02/09/09 16:46, Constant Indicator
Medications	👘 🗈 Teach Diet Restrictions Order 02/09/2009 16:46	02/09/09 16:46
IV Infusions Id Laboratory Services Radiology Services	E Teach Factors to Increase Order 02/09/2009 16:46 Circulation	02/09/09 16:46
Consults		
Pumonary services Gardiology/Cardiovascular H Therapy Services Gommunication		
Miscellaneous Diagnoses & Problems	Details	<u> </u>
Related Results	0 Missing Required Details Dx Table Orders for Nurse Review	▼Sign

If the orders are correct, click sign at the bottom right corner.

PowerOrders	Hx				e	🚽 Print 🛷 2 minutes
· · · · · · · · · · · · · · · · · · ·						Γ
Irders Medication List						
K	Display:	All Acti	ve Orders	▼		Customize Vie
View		7	Order Name	Status	Details	- L
⊖-Orders	🗉 Vit	als/Pati	ient Care			
🖬 ADT/Condition/Code Statu 🖬 Activity			Elevate Edematous Extremities	Processing	02/09/09 16:46, Constant Indicato	ır
- I Nutrition Services			Monitor Weight Trends	Processing	02/09/09 16:46	
Vitals/Patient Care Medications			Teach Diet Restrictions	Processing	02/09/09 16:46	
IV Infusions Identify Services			Teach Factors to Increase Circulation	Processing	02/09/09 16:46	
			Activate Pressure Ulcer Prevent Orderset	Ordered	01/28/09 10:57:17 Ordered by Discern Expert.	
			Activate Pressure Ulcer Manage Orderset	Ordered	01/28/09 10:57:16 Ordered by Discern Expert.	1
Therapy Services Communication	•		1			F

The orders are now in the processing status. You must now click the refresh icon it to complete the order signature process.

Forms

Completed Forms may be viewed, modified, or uncharted from the Forms section of the menu bar. The options available to you will vary according to your needs. For example, you may be able to modify forms for which you are the author, but not forms with another person as the author. You are only allowed the option to view documents completed by someone else.

Whenever a form is modified or uncharted, the system tracks the care provider and the changes they make in the system. This ensures accurate documentation. It is important that you do not complete the documentation for care you did not perform since the system will always associate it with you.

Note: To complete Patient Admission Assessment/History forms if started by another nurse, you must open up a **new** form and complete the required information. **Do not open and modify another nurse's form**.

View Documents in the Forms section

The Forms section within a patient's chart lists all of the forms started or completed for that patient. They are displayed in a tree format with folders grouping forms by similar criteria. Double click or right click and select **View**, to view the details on a form.

D	All Forms
ė.	🗁 Monday, February 09, 2009
	🔚 15:28 Vital Signs (Auth (Verified)) - DRHNurse, RN15
	15:28 Incision/Wound Care (Auth (Verified)) - DRHNurse, RN15
÷	🗁 Thursday, February 05, 2009
	📙 09:27 Plan of Care. (Auth (Verified)) - Multi Contributors
÷	🗁 Wednesday, January 28, 2009
	10:52 Adult Admission Assessment (Auth (Verified)) - DRHNurse, RN20
	10:11 Adult Admission History (In Error) - Multi Contributors

Sort Forms

- 1. From within your patient's chart, click on the Forms section of the menu bar.
- 2. Review the different sort options by clicking the sort drop down box. Notice how the display changes as you try each option.

Menu	
Overview	
24 Hour Summary	
Results Review	
I/O	
MAR	
Immunization Schedule	
PowerOrders	🕈 Add
Clin Doc	
Forms	
Tasks	
Pt. Info	
Patient Schedule	
Allergies	🕈 Add
Problems and Diagnoses	
FaceSheet	
LOS	
List View	
Medication List	🕈 Add
Reference Text Browser	



Form Icons

Icon colors are used to represent whether or not all of the required fields have been completed on a form. A blue icon indicates the required documentation is complete, a red icon indicates required documentation has not been completed, and a yellow icon indicates an Uncharted form.

Image: Complete Image: Complete	
Blue: Complete Il: 1:46 PM SLP Evaluation (Auth (Verified)) - ZZORDER, POE NUF Il: 1:46 PM Physical Therapy Daily Notes (Auth (Verified)) - ZZORDER, POE NUR Il: 1:30 PM OT Daily Note (Auth (Verified)) - ZZORDER, POE NUR II: 1:30 PM OT Daily Note (Auth (Verified)) - ZZORDER, POE NUR	
E Wednesday, December 14, 2005	SING
🖹 🗁 🗁 Wednesday, December 14, 2005	
	3ING
	CIAN
🖃 📴 Tuesday, December 13, 2005	
ellow: In	HYSICIAN
E- Monday, December 05, 2005	
Crror/uncharted	

Modify Forms

Depending upon your security, you may be able to modify forms from the Forms tab.

Note: You may modify a form that has an error or incomplete information. However, you should not modify an Ongoing Assessment form as a way to update a patient's condition. An update should be entered by opening a new form and adding the information.

Modify a form by completing the following steps.

- 1. Select a form.
- 2. Right-click the form and select Modify.



- 3. Make the necessary changes.
- 4. When you are finished, click the **Sign Form** icon **1** to chart the information.
- 5. Find the form you just modified in Forms. Notice that the status is displayed at the end of the form in parentheses. If the form was saved and not signed, the status will display as (In Progress). If the form was signed, the status will display as modified.

Unchart Results

Results that were entered in error, such as charted to the wrong patient, can be uncharted from the original form. An audit trail tracking who uncharted it, and why, is maintained.

To Unchart results that were entered in error, complete the following steps:

- 1. Select a form.
- 2. Right-click on the form, and select Unchart to open a comments dialog box.



3. Type an explanation in the comments box below describing why you are uncharting the form.

😓 Incision/Wound Care (Unc	hart) - Burnside, I	Rhonda	×
🗸 🛇 🕱 🗖			
*Performed on: 02/09/2009	- 1528		By: DRHNurse, RN15
Uncharting this form v this form to 'In Error'	vill change the st	atus of all	the results associated with
Comment:			
charted on acorrect patier	nt.		
	、		
	\backslash		

4. Click the **Sign Form** icon **I** to unchart the information. Notice that the form is displayed as "In Error."

Note: Look in Forms to confirm the form was uncharted. If you do not see the information, remember to refresh the screen by clicking the **refresh icon.**

Intake and Output

Intake and output is an important element of patient care. I/O should be documented for every patient as the incident occurs or as ordered by the physician.

To begin documenting I/O, click on the I/O section of the menu bar.

Notice that the clinical range or timeframe begins on the previous day. Scroll down to find the yellow highlighted row. The highlighted yellow row/line serves as your place holder to help keep you on the right date and time. Charting can take place on any row before the yellow row. Charting can not take place after the yellow row.

2 🗸 🛯 👬 🔛								
	bruary 2009	07:00 - 12 Fe	bruary 2009	D6:59 (Clinic	al Range]	>		
FLUID BALANCE	Intake Dutput							
	Oral	OTHER IN		Urine	Stool	OTHE	0	
	Oral	Other	Total	Urine Voided	# Formed Stool	Oth		Total
02/10/09 07:00			0					0
02/10/09 08:00							*	
02/10/09 09:00			0					0
02/10/09 10:00		\backslash	0					0
02/10/09 11:00		\mathbf{i}	0					0
02/10/09 12:00			0					0
02/10/09 13:00			0					0
02/10/09 14:00		\backslash	0					0
Day Shift Totals 02/10/09 07:00	0	0	0	0	0	0		0
02/10/09 15:00								0
02/10/09 16:00								0
02/10/09 17:00			<u> </u>					0
•								
		Summa	ary					

First, click on the start charting icon 😰. Now click in the field and enter the values.

1/0						🕣 Pri	nt 📀 1 minu	utes a
🖻 🗸 👰 🁬 🔛								
091	ebruary 2009	07:00 - 12 Fel	bruary 2009 ()6:59 (Clinica	al Range)			
FLUID BALANCE	Intake			Output				
	Oral	OTHER IN		Urine	Stool	OTHER O		
	Oral	Other	Total	Urine Voided	# Formed Stool	Other	Total	Π
02/10/09 07:00			0	200			0	T
02/10/09 08:00	240		0				0	T
02/10/09 09:00	380		0	250			0	Т
02/10/09 10:00			0				0	Τ-
02/10/09 11:00								
02/10/09 12:00			0				0	
02/10/09 13:00			0				0	
02/10/09 14:00			0				0	
Day Shift Totals 02/10/09 07:00	0	0	۶	0	0	0	0	
02/10/09 15:00			0				0	
02/10/09 16:00			0				0	
02/10/09 17:00			0				0	Τ.

When finished entering all the values click the green checkmark \checkmark to sign the documentation.

Notice that the values are added together in the row titled shift totals. There is also a graph that will display at the bottom of the screen to show the intake and output balance for the patient.

• • 09	February 2009) 07:00 - 12 Fe	bruary 2009	06:59 (Clinic	al Range)			4 >
FLUID BALANCE	Intake			Output				
	Oral	OTHER IN	_/	Urine	Stool	OTHER O		
	Oral	Other	Total	Urine Voided	# Formed Stool	Other	Total	
02/10/09 07:00			0	200			200	
02/10/09 08:00	240		240					
02/10/09 09:00	300		300	250			250	
02/10/09 10:00			0				0	
02/10/09 11:00			0				0	
02/10/09 12:00		/	0				0	
02/10/09 13:00			0				0	
02/10/09 14:00			0				0	
Day Shift Totals 02/10/09 07:00	540	0	540	450	0	0	450	
02/10/09 15:00			0				0	
02/10/09 16:00			0				0	
02/10/09 17:00			0				0	

If the patient has other sources of intake or output that are not listed in the I/O section, those columns can be added by clicking the display hidden category icon.

_	ries you wish to add:
Intake Categories Diluents Irrigations V Oral OTHER INTAKE Tube Tube Feeding Tube Feeding	
	OK Cancel

Double click on the folder to display the items. Next, select the appropriate options and click OK. These columns will now display on the I/O section.

Modify/Unchart Results

Previously charted results can be modified by doing the following:

- 1. Right-click on the result to be modified.
- 2. Select modify.
- 3. Enter the corrected value.
- 4. Enter a comment in the comments field.
- 5. Click OK.

4 🕨 09 Fet				
FLUID BALANCE		Intake		
	Oral	Tube		OTHER IN.
	Oral	Tube Feeding	Tube Feeding Flush	Other
Day Total 02/09/09 07:00 - 02/10/09 06:59	0	0	0	0
02/10/09 07:00				
02/10/09 08:00	240	7		1
02/10/09 09:00	300	View <u>D</u> etails		
02/10/09 10:00		⊻jew Comm		
02/10/09 11:00		Add Comme	nt	
02/10/09 12:00		<u>M</u> odify		
02/10/09 13:00		Unchart		
02/10/09 14:00		Change Dat	e/Time	
Day Shift Totals 02/10/09 07:00	540	<u>A</u> dd Additio	nal Result	0

The unchart function should be used when results have been charted in error. Results can be uncharted by doing the following:

- 1. Right-click on the result to be uncharted.
- 2. Select unchart.
- 3. Enter a comment in the comments field.
- 4. Click OK.

	Oral Tube OTHER Oral Tube Tube Tube Feeding Feeding Flush Other					
🕩 09 Fet	oruary 2009	07:00 - 12 Fe	bruary 2009	06:59 (Clinica		
FLUID BALANCE		Intake				
	Oral	Tube		OTHER IN		
	Oral		Feeding	Other		
Day Total 02/09/09 07:00 - 02/10/09 06:59	0	0	0	0		
02/10/09 07:00						
02/10/09 08:00	240					
02/10/09 09:00	300	Litere Debelle				
02/10/09 10:00		View <u>D</u> etails.				
2/10/09 11:00		⊻iew Comme				
2/10/09 12:00		Add Commer	ıt			
02/10/09 13:00		Modify				
02/10/09 14:00		Unchart				
Day Shift Totals 02/10/09 07:00	540	hange Date	/Time	0		
		<u>A</u> dd Addition	al Result			

NOTE: Users can only modify or unchart their own entries.

Restraints

Restraints should always be used as a last resort after all other measures have been exhausted. If restraints are needed the documentation is a three part process which includes

- 1. Restraint Assessment
- 2. Restraint Monitoring
- 3. Restraint Education

Restraint Assessment

Restraint assessments are completed every two hours and are tasked off from the PAL list. The RN must go in and check the patient every two hours checking for the following things:

- Skin integrity
- Repositioning
- Nutrition
- Circulation
- Hygiene
- Toileting
- Reassessing the need for continued restraint use

An icon kill appear on the PAL list every two hours.

10:00 - 10:	12:00 - 12:	14:00 - 14:
!	<u>k</u>	<u>k</u>

Double click on the icon. Be sure the box in front is checked and click Chart.

Tasks appearing in this wind display.	ow are accurate as of 02/11/2	009 10:11. Please select the refr	esh button to update the	Refresh
Date and Time	Task	Details		Status
, 02/11/09 10:09	Restraint Assessment	02/11/09 10:09:00		Pending
			Quick Chart	Chart

The item will be removed from all areas of the chart and your name will be attached to the documentation as having completed your restraint assessment.

Restraint Monitoring

The restraint monitoring form should be completed every shift.

The RN must assess the need for continued restraint use and record the findings on the restraint monitoring form.

The form can be completed from the prn/cont section of the PAL. Double click on the icon .

Be sure the box in front is checked and click Chart.

	Date and Time	Task	Details	Status				
6~(§	PRN	acetaminophen-hydroc acetaminophen-hydroc	Start 01/28/89 12:31:00, Routine, 1 Tab, By Mouth	Pending				
1 60°	Continuous	Restraint Monitoring/Di Restraint Monitoring.	02/11/09 10:09:00, CONTINUOUS	Pending				
-								
			Quick Chart	Chart				

Next, complete the sections of the form to show the methods used before applying restraints.

🗸 🖬 🚫 🖄 İ	1 🛧 🔸 🔲 🗒 🖳				
*Performed on: 0	2/11/2009 🗧 🖬 1012 📑				
Monitoring Discontinuation	Basic Interventions For Patient In Restraints				
Education	Verbal Reminders Exercise/Ambulation/Re Consider relocation of p Patient Specific Interventions: RN documentation of additional interventions initia	atient * Sensory Aids (Glasses, Hearing Aids)			
	Treatment	Comfort			
	Wrap/hide IV sites Limit access to tubes and drains Limit access to tubes and drains Alter placement/cover lines/tubes IV pole/pump/tubes out of visual field Tuck gown in pant bottoms to hide tubes	Provide familiar items from home Reduce stimul/intrusions: promote rest Position patient for comfort			
	Diversional Include in activities (e.g., ADL's) Repetitive activities Music, television Grive items to hold Encourage family involvement/diversion	Other			
	Plan Of Care				

If you choose to discontinue the restraints you must complete the discontinuation section of this form.

Restraint Education

The restraint education is completed from the same form.



Each day a patient is in restraints they must be educated on the reason for restraint use and the release criteria. These can both be selected at the same time.

After completing all necessary sections of the form, click the green checkmark *i* in the top left corner.

NOTE: When restraints are discontinued, it is nursing's responsibility to discontinue the order for the restraint assessment and the restraint monitoring. If these are not discontinued, it will continue to fire a task to the PAL list.

NOTE: The restraint order must be renewed each day the patient is in restraints. This order must be entered by a physician. The renewal order can not be taken by a nurse.

PowerOrders

The orders section of the patient's electronic medical record allows physicians and clinicians to place medication, continuous infusion, consults, lab, radiology, and care orders. In addition to placing orders on a patient, power orders contains a display that shows all existing orders that were placed on the patient during a specific encounter. Power orders also enables designated clinicians the ability to review, cancel/discontinue, cancel/reorder, and void existing orders.

Add Orders Medication List	+x	_		
View	Display: A	e Orders	•	Customiz
··· Orders for Signature		Order Name	Status	Details
B-Orders	Vitals/Pal	tient Care		
- 🖬 ADT/Condition/Code Statu	🗹 🏂 66	Vital Signs per Protocol	Ordered	02/12/09 10:44:00, CONTINUOUS
- Activity	1 2 60		Ordered	02/11/09 10:09:00, Q2H
✓ Vitals/Patient Care	🗹 🌋 66	Restraint Monitoring.	Ordered	02/11/09 10:09:00, CONTINUOUS
Infusions If and actions If a second s	M	Adult Admission History	Ordered	01/26/09 9:28:36, One Time Only Ordered via Discern Expert Admission Assessment
- Consults	M	ICU Admission Assessment	Ordered	01/26/09 9:28:36, One Time Only Ordered via Discern Expert Admission Assessment
- 🛄 Pulmonary Services - 🔲 Cardiology/Cardiovascular	M	Initiate Plan of Care	Ordered	01/26/09 9:28:35, One Time Only Ordered via Discern Expert Admission Assessment
Therapy Services	🗏 Medicatio	ins		
Communication Miscellaneous Order Sets Order Sets		acetaminophen-hydrocor one (Norco 325 mp-10	d Ordered	Start 01/28/09 12:31:00, Routine, 1 Tab, By Moul
	Dis 1 L All	Active Or 3	4	5 Show More Or

The navigator bar on the left helps move through the orders profile with little scrolling. The bolded sections contain orders. Clicking on a section will bring it to the top of the profile.

Columns of the orders profile window

1. Indicates the order has an active status.

Q

2. Indicator column.

- The Mortar and Pestle indicates the order requires pharmacy verification.
- The Caduceus (Physician Cosign) indicates the order requires a physician's co-signature.

The Eyeglass Icon indicates the order requires nurse review/electronic notation.

The Decision Support icon indicates that reference information/decision support is associated with the order.

(These icons only display if they apply to the order)

- 3 Order name: Displays orders that were placed below each clinical category
- **4.** Order status: Displays order status. For example, Ordered, Discontinued, Transfer/Canceled, Pending, and Complete.
- 5. Order details: Displays the details associated with the order.

The orders profile contains a filter to enable the user to see different views of the orders profile.

PowerOrders	🚽 Print 🧔	장 1 minutes ag
🕇 Add 🛛 🖓 Document Medication by H	\backslash	
Orders Medication List		
View Orders for Signature Orders Or	All Active Drders All Active Drders All Active Drders 24 Hours Back Tetails All Active Orders (All Statuses) All North-Medications (All Statuses) All Orders (All Statuses)	Customize View
Vitals/Patient Care Vitals/Patient Care Vitalions Vitalions Vitaboratory Services	Restraint Monitoring, Ordered 02/11/0910:0900, CONTINUOUS Adult Admission History Ordered 01/26/09 9:28:36, One Time Only Ordered via Discern Expert Admission Ass	essment Ru
Radiology Services	M ICH Admission Ordered 01/26/09.929:36 One Time Only	

Click the dropdown arrow and choose the selection you wish to see.

If orders are not reviewed from the PAL list they will display in a section of the orders profile.

					🚽 Print 🛷 O minutes ago				
🕂 Add 🛛 🚽 Document Medication by H	Hx								
Orders Medication List									
,N	Display:	All Active	Orders	■ …	Customize View				
View		7	Order Name	Status	Details				
Orders for Signature Orders	E Vit	als/Patier		Status					
- ADT/Condition/Code Statu		∑ 6€^	Vital Signs per Protocol	Ordered	02/12/09 10:44:00. CONTINUOUS				
🔲 Activity 🛄 Nutrition Services		2.60	Restraint Assessment-Med/Surg.	Ordered	02/11/09 10:09:00, Q2H				
✓ ¥itals/Patient Care ✓ Medications		260	Restraint Monitoring.	Ordered	02/11/09 10:09:00, CONTINUOUS				
IV Infusions IV Laboratory Services			Adult Admission History	Ordered	01/26/09 9:28:36, One Time Only Ordered via Discern Expert Admission Assessment Ru				
Radiology Services			ICU Admission Assessment	Ordered	01/26/09 9:28:36, One Time Only Ordered via Discern Expert Admission Assessment Ru				
🛄 Pulmonary Services 🛄 Cardiology/Cardiovascular			Initiate Plan of Care	Ordered	01/26/09 9:28:35, One Time Only Ordered via Discern Expert Admission Assessment Ru				
Therapy Services Communication	🗄 Me	dications							
- Miscellaneous		2 9 60	acetaminophen-hydrocod one (Norco 325 mg-10	Ordered	Start 01/28/09 12:31:00, Routine, 1 Tab, By Mouth,				
- Order Sets					Þ				
	🔳 Deta	ails							
Diagnoses & Problems	Display	ed: All Ac	tive Orders		Show More Orders				
Related Results	Dx T	able	Orders for Nurse Review		Orders For Signature				

To review these orders, click on the orders for nurse review button at the bottom of the window.

	Action	Action Date/Time	Entered By	Order	Detz 🛎
×	Order	02/12/09 10:44:52	DRHNurse, RN15	Vital Signs per Protocol	02/12/09 10:44:00, CONTINU
V	Order	02/11/09 10:10:11	DRHNurse, RN15	Restraint Monitoring.	02/11/09 10.09:00. CONTINU
~	Order	02/11/09 10:10:11	DRHNurse, RN15	Restraint Assessment Med/Surg	02/11/09 10:09:00,
•					02/11/09 10/03/00, Soft Linté Restrict Movemen, Facilitate,
I▼ S	ielect <u>A</u> ll			Jones, Lesay Beview	Cancel

After reviewing the orders, click the review button at the bottom.

Entering Orders

Click on the Power Orders section of the menu bar. Click the add order icon.

PowerOrders					🚭 P	rint 👌 0 minutes a(
🕂 Add 🦪 Document Medication by Hx						
Orders Medication List						
View III)isplay:	All Active	Drders	•]]	Customize Viev
Orders for Signature		7	Order Name	Status	Details	<u> </u>
₿-Orders	🗉 Vita	als/Patien	t Care			
- 🔲 ADT/Condition/Code Statu	V	8	Vital Signs per Protocol	Ordered	02/12/09 10:44:00, CONTINUOUS	
- 🖬 Activity		3	Restraint	Ordered	02/11/09 10:09:00, Q2H	

Next, type what you are looking for in the find box and choose the appropriate option from the list.

Diagnosis (Problem) being Addressed this Visit Add *, Convert Display: All Cinical Dx Code	Eind: cbc Search Starts with Type: Inpatient CBC/Diff.
Problems	
1	TEST, PATIENT - D-838068947 Done

Then the ordering physician box will appear. Type in the physician name. If the display reads multiple matches, click the binoculars and make your selection from the list. This box will only appear for the first order entered.



DRH Clinical Transformation Pamela Haddox, RN, BSN May 2009 Next, choose a communication type from the list and click OK.

Communication types

- 1. Written Order: An order that is written by a physician/provider.
- 2. Per Protocol: An order that is based on DMC policy, protocol, and/or falls within a clinician's scope of practice per licensure and policy.
- 3. Order Clarification: An order that clarifies an existing diagnostic test, procedure, or intervention order placed by a provider.
- 4. RN Plan of Care: An order placed by a Registered Nurse for interventions to support the nursing plan of care.
- 5. Verbal Order: An order that is given to a clinician verbally by a physician/provider who has the authority to give a verbal order per CLN 045A Verbal and Telephone Orders EMR. *This communication must be face to face*.
- 6. Phone Order: An order that is communicated to a clinician via the telephone. Only clinicians eligible to receive verbal orders per 1 CLN 045A Verbal and Telephone Orders EMR accept this order communication type.
- 7. Supply Order: An order for patient care supplies.
- 8. Order Clarification: An order that clarifies an existing diagnostic test, procedure, or intervention order placed by a provider. Order Clarification is used to change order sentence details only and not the original order (e.g. changing "RN Draw" to "Lab to Draw" for a laboratory specimen order). If changes need to be made to the original order other than the order details, the provider or covering service provider will be contacted to change the order.
- 9. Fax Order: An order that is received via facsimile machine to the clinician/site from another health care provider. The faxed order must have a physician/provider signature, date, and time.

If there are more orders from the same physician you can enter them now.

When entering a medication order an order sentence box will appear. Select the appropriate details from the list and click OK /



Next, the scratchpad will display the orders you have entered. Here you have a chance to review the orders and make corrections before signing them. Complete any details that are missing by highlighting the order and then completing the information at the bottom.

by H	x					
M	Orders for Signal	ure				
	? B P		Status	Start	Details	
\ 4	🔲 DR - 4R; 4	IR03; A FIN: 6853047	B4			
	🗄 Medication	าร				
		gabapentin (Neurontin)	Order	02/12/2009 13:00	Start 02/12/09 13:00, Routine, 300	
	E Laboratory	Services				\mathbb{I}
	•	Complete Blood Count with Differential (CBC/Di	Order	02/12/2009 11:52	02/12/09 11:52, Routine, 1, One Ti Collect One lavender top tube. On	M
	Ð	Complete Blood Count with Differential (CBC/Di	Order Rem	02/12/2009 11:54 iove	02/12/09 11:54, Routine, 1, One Ti Collect One lavender top tube. On	
	<u> </u>		Ord	ering Physician		
	Details for Co	omplete Blood Count wi	th Di Refe	erence Information		
	Details	0rder Comments	1 us	To Favorites ble Edit on the Line		
	Order details	+	1 I	Detail values		
_		itart Date/Time [02/1 ollected [No] utine]	2/09 🔺 🔻		÷• 1154 ÷	

If an unwanted order is on the scratchpad it can be removed by right clicking on the order and selecting remove.

When all the information has been verified and is correct, click Sign.

PowerOrders					🛁 Print 🔗 5 minutes
+ Add 🗐 🗬 Document Medication by H	Ix				
Orders Medication List					
K	Display: All Active	Orders	1	-	Customize Vie
View	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Order Name	Status	Details	-/
Orders	Medications				
- 🔲 ADT/Condition/Code Statu		gabapentin (Neurontin)	Processing	Start 02/12/09 13:00, Routin	e 300 mg, By Mouth, Ca
🖬 Activity 🖬 Nutrition Services	🗹 👌 🏌 🖬	acetaminophen-hydrocod one (Norco 325 mg-10	Ordered	Start 01/28/09 12:31:00, Ro	itine, 1 Tab, By Mouth,
✓ Vitals/Patient Care ✓ Medications	Laboratory S	ervices			
		Complete Blood Count with Differential (CBC/Di	Processing	02/12/09 11:52, Routine 1, I Collect One lavender top tube	
- Radiology Services - Consults	M 🏂	Troponin	Ordered	01/28/09 12:39:00, Routine, Tube Type and Volume: Gree	
- 🔲 Pulmonary Services					

The orders are now in a processing status. Click the refresh icon to place the orders in an ordered and active status.

Nursing Orders

Some orders can be placed by the nurse. They include:

- 1. Social work consult
- 2. CMS consult
- 3. wound care nurse consult
- 4. nutrition consult
- 5. nurse to nurse psych consult
- 6. immunizations
- 7. initial restraint orders (can not order restraint renewal)
- 8. nursing interventions (includes pressure ulcer ordersets)
- 9. supply orders

To enter a nursing order click the power orders section of the menu bar, then click ADD.

PowerOrders					🛃 Pri	nt 👌 0 minutes ago
+ Add S Document Medication by H	łx					
Orders Medication List						
View	Displa	y: All Active I	Orders		-	Customize View
····Orders for Signature		8	Order Name	Status	Details	
		/itals/Patien	t Care			
- 🔲 ADT/Condition/Code Statu	Í	🗹 🌋	Vital Signs per Protocol	Ordered	02/12/09 10:44:00, CONTINUOUS	
🖬 Activity	i	¥ 🏌	Restraint	Ordered	02/11/09 10:09:00. 02H	

Next, enter the order in the find box and choose the appropriate option from the list.

	/			-
Eind: social	<u>S</u> earch	Starts with Type: Search within: All	At location:	RHUHC V
Social Isolation				
Social Work Consult				
		Jone	s, Leroy - D-841078459	Done

Next the physician name box will display. For nursing orders the physician name is entered as "Healthcare Provider"

\backslash	Crdering Physician	×
	Physician name HEALTHCARE, PROVIDER	# 4
	Order Date/Time	
	Communication type	
	Fax A Phone Verbal	
	Written RN Plan of Care	
	Per Protocol OK Cance	. 1

The communication type for most nursing orders should be per protocol since policy allows nurses to enter the orders.

When entering an order for a social work consult the decision support box will appear.

cision Support						
Social Work Consult						
Relevence						
Social Work Consul	C Salue	Nume preparation	C MODELLAN	F.F LOUIS	F Sandal and Commerce	2
Requests for Discharge are handled by the Care	Planning/Home Hea Management Speciali	th Care and/or Medical E do				2
Please place a Care Ma are headed.	nagement Specialist	Referral order if those ser	vices			-
					Beference	Text

This box is giving you information to help you make a decision. It is letting you know what things require a social work consult and which would require a CMS consult, since they are often confused. After reading the information, click OK. If you have entered the wrong consult by mistake you can remove it from the scratchpad.

Now you are returned to your order window.

Eind: Search	Starts with 💌 Type: 🔀 Inpatient
💿 🙆 😒 🔹 Folder:	Search within: All 💽 At location: DRHUHC 💌
Social Isolation	
	Jones, Leroy - D-841078459

Enter any other nursing orders, when finished click Done. /

Next, complete the necessary details from the scratchpad. The indicates there are required details that must be completed before signing the order.

PowerOrders						ᢖ Print 🛷 1 minutes aq
🕂 Add 🛛 🖨 Document Med	lication by H	x		/		
Orders Medication List						
	I.	Orders for Signature	/	/		
View	- 1	⑦ □ ♥	Order Name	Status	Start	Details
··· Orders for Signature			3; A FIN: 68530478		U.G.	D OTANO
⊖ Orders				-		
 ADT/Condition	de Statu		Social Work Consult	Order	02/12/2009 11:57	02/12/09 11:57, Routine
- 🔲 Nutrition Services						NOTE: For stat consults page d
– 🗹 ¥itals/Patient C	are					
Medications						
– 🔟 IV Infusions – 🗹 Laboratory Serv						
- 🔤 Radiology Services						
- Consults	,	•				•
- 🔲 Pulmonary Service	s	Details for Socia	al Work Consult			
– 🔲 Cardiology/Cardio	vascular			V		
– 🔲 Therapy Services		Details 🖸	Drder Comments	\le Diagni	osis 🔪	
- 🔲 Communication			-	1 In.		
– 🛄 Miscellaneous – 🔲 Order Sets		Order details	т	iii Illi.	Detail values	
- Craer Sets		Reason for Con		▲	 Adjustment to Illne: 	ss/Tx/Dx
Columnity Supplie	° –	Special Instruction	S	•		
Diagnoses & Problen					*	
Related Results	15	1 Missing Required	Details Dx Table	0 rders for	r Nurse Review	Sign
Rolated Results	E	Thequiled	D W T ODIC			- Sign

Click on the required field on the left side, and then select the appropriate details from the list on the right.

When all the required fields and details are completed, click Sign. Remember to refresh in order to change the order status from processing to ordered.



Discontinuing Orders

To cancel an order that is no longer needed, right click on the order and select Cancel/DC.

A 8	Order Name	Statue	Details	4
🔲 🗉 Vitals/	Patient Care			
· 🛛 🗹 👮	Vital Signs per Pretocol	Ordered	02/12/09 10:44:00, CONTINUC	JUS
	Restraint Assessment-Med/Surg.	Ordered	02/11/09 10:09:00, Q2H	
M 🕺	Restraint Monitoring.	Or Mod		
	Adult Admission History	Or Copy Cano	/ :el/Reorder	ion Assessment Ru
	ICU Admission Assessment	Or Susp Activ		ion Assessment Ru
	Initiate Plan of Care	Ur	plete cel/DC	ion Assessment Ru
🔳 Medica	ations	Void		
	2661 gabapentin (Neurontin)		hedule Task Times gn (No Dose Range Checking)	300 mg, By Mouth,
Details Displayed:	All Active Orders		er Information ments	Show More Orders,

Again, the physician name box will appear. Enter the physician's name that authorized the discontinuation.

	🐙 Ordering Physician 📃 🔀
	Physician name DRHPhysician, MD01
	Order Date/Time 02/12/2009 + ▼ 1502 +
	Communication type
1	Phone Verbal Written
	RN Plan of Care Per Protocol
	OK Cancel
/	

Enter the appropriate communication type and click OK.

The order will display with lines through it and the status will read discontinue.

=	-		. 1				
÷.				Ÿ	Order Name	Status	Details
1	E	- V	⁄ita	ls/Pa	tient Care		
		1		Y.	Restraint- Assessment-Med/Surg.	Discontinue	02/12/09 15:02
I	Г	į.	4	<u>¥</u> _	Vital Signs per Protocol	Ordered	02/12/09 10:44:00, CONTINUOUS
I	Е	Ī	4	8	Restraint Monitoring.	Ordered	02/11/09 10:09:00, CONTINUOUS
		100.00	/		Adult Admission History	Ordered	01/26/09 9:28:36, One Time Only Ordered via Discern Expert Admission Assessment Ru
	•		4		IFH Admission	Ordered	01/26/09 9-28-36 One Time Onlu
I		Z D	etail	s for R	lestraint Assessment-Me	d/Surg.	
		6	PD	etails	Dirder Comments	Diagnosis 👔	\
				ətails	+	* It.	Detail values
-1		Dis	COL	ntinue	Date and Time [02/12	2/09 1 <mark></mark> 🗧 🛓	
	D	ispl	aye	d: All	Active Orders		Show More Orders.
-	L	D	:Ta	ble	Orders for Nurse Review]	Orders For Signature

Click the "orders for signature" button at the bottom.

								🛃 Print 🛷 1	minutes ago
by H	x							4	
								/	
M	Ore	ders fo	or Sig	nature				/	
I		?	₽?	7	Order Name	Status	Start	Detail	
-					13; A FIN: 685304784				
	8			atien				_/	
			()	2 .	Restraint Assessment-Med/Surg.	Discontinue	02/12/2009 15:02	d2/12/09 15:02	
	•							/	•
		Detai	ils				/		
I	0	Missin	g Re	equired	Details Dix Table	Orders for	lurse Review		Sjgn

Next, click Sign. Remember to refresh. The order will now display as discontinued in the orders profile.

Cancel/Reorder

The cancel/reorder option should be used when you would like to keep the same order, but change some of the order details. This option is available so that you don't have to cancel the order, and then completely re-enter the same order.

To cancel/reorder, right-click on the order and select Cancel/Reorder.

		7	Order Name	Status	Details	
ĺ	2	<u>))</u> 😧 🏠	🖞 gabapentin (Neurontin)	Order	Renew	<u>20. Devitine, 20</u> 0 mg, By Mou
Ì	V	2 d I	acetaminophen-hydrocod one (Norco 325 mg-10	Orden	Modify Copy	ab, By Mouth
	.ab	oratory 9	Services		Cancel/Reorder	
Ì	V	<u>¥</u> 60'	Complete Blood Count with Differential (CBC/Di	Orden	Suspend Activate	ime Only, 1, r not more tha
ĺ	V	%	Troponin I	Orden	Complete	ime Only, 1,
_				_	Cancel/DC	m Heparin) S
8	Con	sults			Void	
1	1	66^ 🛛	Social Work Consult	Orden	Reschedule Administration Medication Request	Times ity Resource ted Social W
I	V	66° 🛛	Social Work Consult	Orden -	Cosign (No Dose Range Ch	recking) ity Resource ted Social W
•					Order Information	
_					Comments	
T D	etai	ls			Results Ingredients	
)ispl	aye	ed: All A	ctive Orders		Print	ow More Ord
D	к Та	able	Orders for Nurse Review		Reference Information	ers For Signa
					Advanced Filters	Jary 2009 1
_	_)		Enable Edit on the Line	1017 2005 11

The ordering physician box will appear. Enter the name of the physician whom asked for the changes.

	Crdering Physician
	Physician name DRHPhysician, MD01
	Order Date/Time 02/12/2009 ↔ ▼ 1523 ↔
	Communication type Fax
/	Verbal Written RN Plan of Care
	OK Cancel
	RN Plan of Care Per Protocol

Enter the appropriate communication type and click OK.

The orders profile will display the order to be discontinued and the new order.

100				/		
		17	Order Name	S tatus	Details	-
1		Medications		1		
I			gabapentin (Neurontin)	Order	Start 02/12/09 17:00, Routine, 3	300 mg, By Mouth, Ca
I		🔲 🁌 🌋 🚳	gabapentin (Neurontin) 🚩	Discontinue	02/12/09 15:23	
I		M 🤌 🏌 🛛	acetaminophen-hydrocod one (Norco 325 mg-10	Ordered	Start 01/28/09 12:31:00, Routin	e, 1 Tab, By Mouth, ⁻
I		Laboratory S	ervices			
	•	⊻ ‱	Complete Blood Count with Differential (CBC/Di	Ordered	02/12/09 11:52:00, Routine, 1, Collect One lavender top tube.	
	•		apentin (Neurontin)) Diagnosis	\	
					g Administrations: (Unknowr	i) Stop: (Unknown)
	0	Irder details	+ •	🔓 ltr.	Detail values	
Ч						
=	Dis	played: All Ac	tive Orders			Show More Orders
-		Dx Table	Orders for Nurse Review			Orders For Signature

Click the "Orders for signature" button at the bottom.

Next, the scratchpad will display. This is where you can make the changes to the order.

(?) 🖳 🖗	Order Name	Status	Start	Details
🗏 DR - 4R; 4R0	13; A FIN: 685304784			
Hedications				
🕀 🖢 🏌	66' gabapentin (Neurontin)	Discontinue	02/12/2009 13:00	02/12/08 15:23
din 👘	gabapentin (Neurontin)	Order	02/12/2009 17:00	Start 02/12/09 17:00, Rd
-				
•	1			
< ▼ Details for gaba	pentin (Neurontin)			
-		Diagnosis		
-	Drder Comments	- \	ministrations: (Unk	nown) Stop: (Unknown
Details	Drder Comments	emaining Ad		nown) Stop: (Unknown
Order details	B Order Comments	emaining Ad	letail values	
Details	Conter Comments	emaining Ad		

When the details are completed, click Sign. Remember to refresh the screen to change the order status from processing to ordered.

Voiding Orders

Use the void order option when the order that was entered and signed, was done so in error or on the wrong patient. It is meant to completely cancel the original order. Only orders that have not been acted upon can be voided (orders with status of *Ordered* or *Pending*). Orders with a status of *Completed* can not be voided.



To void an order, right-click on the order and select Void.

The orders profile will display the order status as Void with a line through the order.

		/	·
9	Order Name	Status	Details
🗉 Laborato	y Services		
🗹 🌋 fi	Complete Blood Count with Differential (CBC/Di	Ordered	02/12/09 11:52:00, Routine, 1, One Time Only, 1, Da Collect One lavender top tube. Order not more than
M 🕺	Troponin I	Ordered	01/28/09 12:39:00, Routine, 1, One Time Only, 1, Da Tube Type and Volume: Green (Lithium Heparin) SST
Consults			
🔳 🎶 🛛	Social Work Consult	¥eid	02/12/09 16:09
 ✓ 661 0 	Social Work Consult	Ordered	02/12/09 11:57:00. Boutine. Community Besources
▼ Details for 9	iocial Work Consult		
Detail:	SVIE Order Comments VI	📄 Diagnosis	\
order details	+	8 II.	Detail values
Void Date a	and Time [02/12/09 16:0	9 🗄	▲ 102/12/2009 ↓ ↓ 1609 ↓
Displayed: All	Active Orders		Show More Orders.
Dx Table	Orders for Nurse Review		Orders For Signature

Complete any necessary details. Click the "Orders For Signature" at the bottom.



Sign the order and refresh the screen.

DRH Clinical Transformation Pamela Haddox, RN, BSN May 2009

Medication Administration

Medications are viewable from the electronic medication administration record or **MAR** section of the chart as soon as the orders are entered. Medication administration is charted on the MAR by using the scanning process. The scanning process must be used to ensure patient safety. Benefits of the scanning process include:

- 1. Improves patient safety through reduction of human errors in the patient care process.
- 2. Automates positive patient identification.
- 3. Verifies the five rights through barcode technology.
- 4. Eliminates illegible notations
- 5. Automates the documentation of medication administration.
- 6. Automates the documentation of tasks at the point of care related to specific physician and/or nursing orders.



MAR Overview

Medications are divided into four categories:

- Scheduled: A medication order that has fixed dose times.
- Unscheduled: A medication that does not have a scheduled time. It is always displayed as available to administer at the current time.
- PRN: Medications that are not scheduled but should be carried out in specific circumstances or on an as needed basis.
- Continuous infusions: A continuous infusion order displays as pending so additional infusions can be added at any time.

Medication Column Indicators

Administration events are designated by a color under the appropriate date and time column.

- Yellow represents the current date/time column.
- Teal represents current or future medication.
- Red represents past due or STAT medication.
- Gray represents canceled, voided, and discontinued medications.

MAR Icons

^b Pharmacy needs to verify the medication order.

Pharmacy rejected the medication order.

Pharmacy comment has been entered. Right click on the medication details and select **Order Info** then select the **Comments** tab to view the comment.

Administrative note will display a nurse to nurse communication. Right click on the medication details and select **Create Admin Note** or **View Admin Note**. Only one Admin Note icon will display on the MAR but multiple entries can be displayed on the same note.

Meeds Nurse to Review. Review/Note orders from the Orders section or the PAL.

Medication Scanning

To begin medication administration, first review the MAR and collect the medications needed.

Proceed to the patient's room with scanning device in tow.

Perform the Five Rights.

From the toolbar, click on the barcode icon.



Next, a screen will display telling you to scan the patient's armband.



Now, all medications that can be given will display. Medications can be given up to one hour before the scheduled time. Medications that are overdue and have not been charted will also display. They will not drop off the list until they are charted.

	Scheduled	Mnemonic	Details	Result
T 8	🏽 👌 🎸 🍊 02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
- ···	🗑 ፊራ 🍎 02/16/09 09:00	furosemide furosemide (Lasix)	Start 02/16/09 9:00:00, 40 mg, IV PUSH, Injection	
	👌 🔐 🍊 02/16/09 09:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
	👌 🔐 🍊 02/16/09 09:00 🗌	metoprolol	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
	[†] 👸 ଜେ 🝊 02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
🗆 🗹	<u>ን</u> ራራ ⁶ 02/16/09 12:00	insulin aspart insulin aspart (insulin aspart correction dose - low	Start 02/16/09 12:00:00, 0-5 Units, Subcutaneous, Injection)Low dose correction dose BG 120-200, give 0 Units BG 201	
	<u></u> የምር 12/16/09 12:00	insulin aspart insulin aspart (insulin aspart correction dose - low	Start 02/16/09 17:00:00, 0-5 Units, Subcutaneous, Injection)Low dose correction dose BG 120-200, give 0 Units BG 201	
	👌 ፊራ 🏈 02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
	🦻 ଜେ 🍊 PRN	acetaminophen acetaminophen (Tylenol)	Start 02/16/09 9:56:00, Routine, 1000 mg, By Mouth, Tab, Q	

Next, scan the medications to be given.

As you scan you will notice several icons appearing on the screen.

	геш	ane		1 1141. 00000 1000	ngo. oo yeuro	Allery	les
Γ			Scheduled	Mnemonic	Details	Result	
	- ^	Ĵ 🖱 60 🐣	02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab		
F	7 0	3 👌 & & 🌖	02/16/09 09:00	furosemide furosemide (Lasix)	Start 02/16/09 9:00:00, 40 mg, IV PUSH, Injection	furosemide 40 mg, IV PUSH	•
1	۹ ا	3 🗟 🖓 👘	02/16/09 09:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab		
	7 🖡	/ 🕅 🤋 👸 🏈	02/16/09 09:00	metoprolol	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	metoprolol 25 mg, By Mouth	
Î	7 ,	1 🚡 66 🍊 🗍	02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	ranitidine 150 mg, By Mouth	•
ľ	- °	3° 966° –	02/16/09 12:00	insulin aspart insulin aspart (insulin aspart correction dose - low)	Start 02/16/09 12:00:00, 0-5 Units, Subcutaneous, Injection Low dose correction dose BG 120-200, give 0 Units BG 201		
ľ		19 A	02/16/09 17:00		Start 02/16/09 17:00:00, 0-5 Units, Subcutaneous, Injection Low dose correction dose BG 120-200, give 0 Units BG 201		
		≥ 60∕3	02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab		
F	7	/ 🗖 🖻 🕅 🖗	PRN	acetaminophen acetaminophen (Tylenol)	Start 02/16/09 9:56:00, Routine, 1000 mg, By Mo	acetaminophen 1,000 mg, By Mouth,	Pain ,
	/	/ \					

The blue circle \bigotimes indicates there are required fields to be completed before signing the medication.

The \square indicates there is additional information to be entered. The information is as follows:

- For blood pressure medication, you must enter a blood pressure and heart rate.
- For insulin, you must enter a blood glucose level (CBG).
- For pain medications, you must enter a pain score.
- For any injections or infusions, you must enter the site it was given.

To enter these values, click on the icon. For the site, use the dropdown arrow. For all others, enter the values in the labeled fields.



To chart a medication was not taken, click on the blue checkmark.

							/
				Scheduled	Mnemonic	Details	Result
	18	ď	🖻 66 🟈	02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
	7	1	ን 66 🏈	02/16/09 09:00	furosemide furo sem ide (Lasix)	Start 02/16/09 9:00:00, 40 mg, IV PUSH, Injection	furosemide 40 mg, IV PUSH
	18	ଞ	🖻 66 🟈	02/16/09-89:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
F	7	/		02/16/09 09:00	metoprolol -	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	metoprolol 25 mg, By Mouth Systolic Blood Pressure: 185 mmHg, Diasto
		1		02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
	ð	ď	<u>છ</u> 66			Start 02/16/09 12:00:00, 0-5 Units, Subcutaneous, Injection Low dose correction dose BG 120-200, give 0 Units BG 201	
			፻ 66			Start 02/16/09 17:00:00, 0-5 Units, Subcutaneous, Injection Low dose correction dose BG 120-200, give 0 Units BG 201	
			👌 60 🟈	02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
	7	/	7 🖻 😚 🏈	PRN	acetaminophen acetaminophen (Tylenol)	Start 02/16/09 9:56:00, Routine, 1000 mg, By Mo	acetaminophen 1,000 mg, By Mouth, Pain Pain Scale Score: 9

.

When the medication window opens, Click the not given box at the bottom.

≩ 6+- € ranitidine Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
Performed date / time 02/16/2009 Performed by DRHNurse, RN/5	
*ranitidine 150 Diluent: ≤none> ✓ ml *Route: Dr.Mouth ✓ Not Given	
Reason No Blood Return Comment. Order Changed Patient Not Available Patient Not Available Patient NP0 Patent Refused Patent Sedated	•

Choose the reason the medication was not given from the drop down menu and click OK.

			Scheduled	Mnemonic	Details	Result
		🖻 66 🏈		digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
7		🖻 60 🏈		furosemide furosemide (Lasix)	Start 02/16/09 9:00:00, 40 mg, IV PUSH, Injection	furosemide 40 mg, IV PUSH
		🖻 66 🏈		hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
7			02/16/09 09:00	_	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	metoprolol 25 mg, By Mouth Systolic Blood Pressure: 185 mmHg, Diasta
5		🖻 66 🍊	02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
	፟፟፟፟፟	3 60		insulin aspart insulin aspart (insulin aspart correction dose - low)	Start 02/16/09 12:00:00, 0-5 Units, Subcutaneous, Injection Low dose correction dose BG 120-200, give 0 Units BG 201	
		g 60°		insulin aspart insulin aspart (insulin aspart correction dose - low)	Start 02/16/09 17:00:00, 0-5 Units, Subcutaneous, Injection)Low dose correction dose BG 120-200, give 0 Units BG 201	
		🔊 66 🍊		metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
7	1	7 🖻 🚱 🏈	PBN	acetaminophen acetaminophen (Tylenol)	Start 02/16/09 9:56:00, Routine, 1000 mg, By Mo	acetaminophen 1,000 mg, By Mouth, Pain Pain Scale Score: 9
•[
lea	idy ti	o Scan			2 of 2	<u>B</u> ack <u>Sign</u>

When all medications have been scanned and all required fields and values have been entered, click Sign.

Notice how the given medications display on the MAR. They will display in a column marked with the actual time it was scanned and will be listed beneath the teal line.

~		\			_		
MAR					🚽 Pi	rint 💸 O minut	es ago
×4		\sim					
•			\				
0	•	15 February 2009-16:04 - 17 February	2009 16:04 (CI	inical Range)	l		4 🕨
	Time View	Medications	02/16/09	02/16/09 16:23	02/16/09 16:57	02/16/09 17:00	_
⊻ [Scheduled	insulin aspart	10.22	10.25	10.51	11.00	
⊿ 🗌	Unscheduled	CBG-Nursing					
		260					
× _	PRN	■ metoprolol ■ Start 01/26/09 17:00:00, Routine, 25 mg, By				25 mg	
≤	Continuous Infusions	Mouth, Tab, BID					
		metoprolol	25 mg By Mouth				
		Systolic Blood Pressure	185 mmHq Auth				
		Diastolic Blood Pressure	96 mmHq Auth (
		Monitored HR	102 Auth (Verifie				
		3 60 ()					
		ranitidine					
		Start 01/26/09 17:00:00, Routine, 150 mg, By Mouth, Tab, BID					
		ranitidine	1	Not Given: Pati			_
		PRN		Not Given. Fau	5		
		<u>ቅ</u> ሐላላቅ PBI	N		1,000 mg		
		acetaminophen (Tylenol)			Last given:		
		Start 02/16/09 9:56:00, Routine, 1000 mg, By			02/16/2009		a
		Mouth, Tab, Q6, PRN, Pain			16:22		
		acetaminophen	* 1,000 mg By M	•			
		Pain Scale Score	9 Auth (Verified)	~			
							— <u> </u>
		I					ЪĊ
					`		<u> </u>

The PRN medications that are given are listed the same as other medications. However, they are also still listed in the current date/time column and ready to be given again. This column will list the last time the PRN medication was given. The RN must read the medication details to determine if it is time for another dose before administering. *The computer will not stop you from giving the medication sooner than what the order states because it is ordered as a PRN*.

Warnings and Cautions

The **Warning** icon **S** will display if the medication scanned:

- Has a dose greater (overdose) than what has been ordered (Dosage sent needs to be divided, ex. give half tab).
- Is from a multi-dose container (the total container dosage is scanned, therefore not the dosage that is ordered, ex. insulin).
- Is in a different form (liquid vs. tablet) than what has been ordered (medication needs to be reordered in correct form).

The scanned line will be highlighted in **RED**. A pop up warning message will display the reason for the warning. The **Sign** button will not be active.



Click OK on the warning page.

Click in the red line. The medication administration details form will display. If the warning is dose related, the dose number field will be highlighted, indicating that field needs to be corrected.

Change the amount to be administered and click OK.

*Performed date / t		•
*Performed by	DRHNurse, RN15	<i>4</i> 4
Systolic Blood Pressure	186 mmHg	
Diastolic Blood Pressur		
Monitored HR	102	
*metopro	mg 💌	
Diluent: <none></none>	▼ mi	
	▼ Site:	
*Route: By Mouth		
Not Given		

Caution Icon

The **Caution** icon will display if the scanned medication dosage is less than what was ordered. If two Tabs of the medication were ordered and only one Tab was scanned, then the Caution icon will display.

	Scheduled	Mnemonic	Details	
1 🗑 🚱	08-Jun-2006 09:00	moxifloxacin	400 mg = 1 Tab, Tab, By Mouth, Other: Reason in comme	
1 W	08-Jun-2006 17:00	ampicillin	First Dose 06/08/06 17:00:00, 1 gm = 4 mL, IVPB, 0 RT - Stable 8hrs. Refrigerated stable 72hrs.	
6	09-Jun-2006 01:00		First Dose 06/09/06 1:00:00, 1 gm = 4 mL, IVPB, 0 RT - Stable 8hrs. Refrigerated stable 72hrs.	
6	09-Jun-2006 09:00		First Dose 06/09/06 9:00:00, 1 gm = 4 mL, IVPB, 0 RT - Stable 8hrs. Refrigerated stable 72hrs.	
10 60	09-Jun-2006 09:00	micafungin micafungin + Sodium Chloride 0.9% 100 mL	150 mg = 15 mL, IVPB, Other: Reason in comments, Rx to	
88 🚱	09-Jun-2006 09:00	moxifloxacin	400 mg = 1 Tab, Tab, By Mouth, Other: Reason in comme	
6	09Jun-2006 10:24	ranitidine	First Dose 06/09/06 10:24:00, 75 mg, By Mouth	
🗛 🕅 🕅	PRN	acetaminophen	First Dose 06/09/06 10:23:00, Routine, 650 mg	acetaminophen 325 mg, By
				F
ady to Sc				Back Sign

Scan the additional dose(s) to get the ordered dosage. The caution icon will disappear when the scanned amount matches the ordered amount. Then click Sign.

Unchart a Medication

To unchart a medication that has been charted, **right click** in the cell containing the charted medication and select **unchart**.

			۱				
MAR					🛃 Pi	rint 🍣 0 minu	utes ago
*							
💆 🖸		17 February 2009 07:41 - 19 February	2009 07:41 (0	(linical Range)			4 🕨
	Time View	Medications	02/18/09	02/18/09 07:48	02/18/09 07:49	02/18/09 08:00	-
	Scheduled	Scheduist	07.41	07.40	07.43	00.00	
	Unscheduled	Ìù đư 🊱 digoxin		\backslash			
	PRN	Start 01/27/09 9:00:00, Routive, 0.125 mg, By Mouth, Tab, Daily		\mathbf{A}			
	Continuous Infusions	digoxin Monitored HR		0.125 mg By M	View Details		
		♦ 64 hydrochlorothiazide Start 01/27/09 9:00:00, Routine, 25 mg, By Mouth, Tab, Daily			View Commen View Order In Add Comment Modify	fo	
		hydrochlorothiazide Systolic Blood Pressure		25 mg By Mau	Unchart		
		Diastolic Blood Pressure					

Enter a reason for uncharting in the comment box.

		/		
	🗸 🚫 🕱 🌠	/		
4	*Performed on: 02/18/2009	÷ - 090	а Т	By: DRHNurse, RN15
	Uncharting this form w this form to 'In Error'	vill change/the sta	atus of all th	e results associated with
	Comment:			
	drapped on floor	*		

Then, click the green checkmark \checkmark to sign the form.

Modify a Medication

A charted medication can be modified to make corrections. To modify a charted dose, **right click** in the cell containing the charted medication and select **modify**.

	🚽 Print 💸 O minutes ago
17 February 2009 07:41 - 19 February	2009 07:41 (Clinical Range)
Medications	02/18/09 02/18/09 02/18/09 02/18/09 ▲ 07:41 07:48 07:50 08:00 ▲
Scheduled	
<u>b</u> 67 🚱	
ligoxin	
Start 01/27/09 9:00:00, Routine, 0.125 mg, By	
Mouth, Tab, Daily	* In Erro N
digoxin Monitored HR	In Erro N
Nonitored Hn	
y oo 🌱 hydrochlorothiazide	
Start 01/27/09 9:00:00, Routine, 25 mg, By	
Mouth, Tab, Daily	
hydrochlorothiazide	25 mg By Mput
Systolic Blood Pressure	View Details
Diastolic Blood Pressure	<u>View Comments</u>
360	View Order Info
insulin aspart (insulin aspart correction	Add Comment
dose - low)	Modify hits
Start 02/16/09 12:00:00, Routine, 0-5 Units, Subcutaneous, Injection, TIDAC	Unchart
Low dose correction dose BG 120-200, give 0 L	

Enter the necessary changes.

*Performed date / ti	me 02/18/2009	÷ • ()748 🕂	
*Performed by	DRHNurse, F	RN15	种	
Systolic Blood Pressure	mmHg			
Diastolic Blood Pressure	mmHg			
*hydrochlorothiazide	25 m	g 💌		
Diluent: <none></none>	•	ml		
*Route: By Mouth	•	Site:		
	_	· · ·		

Then click the green checkmark \checkmark to sign the form.

Reschedule a Medication

To reschedule a medication dose, **right click** on the cell containing the dose to be rescheduled and select **reschedule this dose**.

MA	٩				🛃 P	rint 💸 O minul	tes ago
*1							
<u>10</u>		17 February 2009 07:41 - 19 February	2009 07:41 (C	linical Range)			4 ►
	Time View	Medications	02/18/09	02/18/09 09:00	02/18/09 12:00	02/18/09 17:00	-
	Scheduled	Scheduled					
	Unscheduled	Ìà ớr∕∳ digoxin					
	PRN	Start 01/27/09 9:00:00, Rowtine, 0.125 mg, By Mouth, Tab, Daily		0.125 mg			
	Continuous Infusions	digoxin			Order Info Task Info		
		Monitored HR			Chart Details.		
		😧 dr 🊱 hydrochlorothiazide	\sim		Quick Chart,		
		Start 01/27/09 9:00:00, Routine, 25 mg, By			Chart Done		
		Mouth, Tab, Daily		<hr/>	Chart Not Dor		
		hydrochlorothiazide			Unchart		
		Systolic Blood Pressure			Reschedule Th	nis Dose	
		Diastolic Blood Pressure		-	_		

Enter the new date and time for the medication.

	Reschedule digoxin for
	Currently scheduled date and time 02/18/09 09:00
	Rescheduled date and time
	Rescheduling reason
	OK Cancel
Then, click OK.	

NOTE: Nursing can only reschedule one dose. If the entire schedule needs to be adjusted (e.g. antibiotic dosing) then pharmacy must be notified.

Requesting a Medication

If a medication is missing or another dose is needed, it can be requested from pharmacy through the electronic MAR.

MAR 률 Print 🛷 2 minutes ago ⁹6 17 February 2009 07:41 - 19 February 2009 07:41 (Clinical Range) 🔟 🕩 4 🕨 02/18/09 07:48 02/18/09 08:00 02/18/09 02/18/09 09:00 Time View . Medications 08:19 Schedule ቅ የባ 🏈 Unscheduled **digoxin** Start 01/27/09 9:00:00, Routine, 0.125 mg, Mouth, Tab, Daily Order Info.. 0.125 mg Event/Task Summary Reference Manual.. Continuous Infus digoxin Med Request. Monitored HR Mornus Mornus Mydrochlorothiazide Start 01/27/09 9:00:00, Routine, 25 mg, By Houth, Tab, Daily Additional Dose... ⊆reate Admin Note..

To request a medication, right click on the medication details and select med request.

Select a reason for the request from the list.



Then, click OK. /

NOTE: Pharmacy has scheduled delivery times and will deliver the medication at the next scheduled time. Please do not perform a med request more than once, as this will delay delivery.

Reference Manual and Education Leaflets

The electronic MAR also serves as a reference guide for medications.

To access the reference manual, **right click** on the medication details and select **reference manual**.



The first to display will be information for the healthcare provider. After reading the information, click OK to return to the MAR.



The information can also be displayed in terminology appropriate for the patient by clicking the tab labeled education leaflet.

To print the information for the patient, right click any where in the window. The only option available is print.

Pain Response

After giving any pain medication, the patient's pain must be reassessed to determine if the current interventions are controlling the pain. The electronic MAR will aid the nurse in this process by sending a task to the MAR and the PAL list.

To complete the pain response from the MAR, click on the cell labeled pain response.

Monitored HR	
PRN	
ම හැදීම් PRN acetaminophen (Tylenol) Start 02/16/09 9:56:00, Routine, 1000 mg, By Mouth, Tab, Q6, PRN, Pain	1,000 mg Last given: 02/18/2009 12:07
acetaminophen	* 1,000 mg By M
Pain Scale Score	10 Auth (Verified

Next, enter the patient's pain level after receiving the medication.

	📒 Pain Response	- Davis, Yirginia	<u>_ X</u>
	🖌 🖬 🚫 🕅	🌠 🛧 🔸 💷 📓 🖳	
	*Performed on:	12/18/2009 🗧 🚽 1307 🗧	By: DRHNurse, RN15
	Pain Response	Intervention Info: acetaminophen Performed by DRHNurse, RN15 on 02/18/09 12:07:00 acetaminophen, 1000mg By Mouth, Pain	
/		Pain Score after Pain Medication is given: 3	

Then, click the green checkmark \checkmark to sign the form.

NOTE: Pain should be re-assessed after 30 minutes for any IV medications given and after 60 minutes for any oral medications given.

Handoff Communication

When giving or receiving report, the nurse must use the information in the EMR. Using the EMR gives the nurse the opportunity to ask questions as well as making sure all tasks have been completed before transfer of care.

During handoff communication, several of the tabs within the EMR are utilized. There is also a flowsheet available to aid in the process.

To access the flowsheet, first click on the **results review** section of the menu bar. From the **all results tab**, click the **dropdown arrow**.



Select handoff from the list.

esults	Review				ᢖ Print & O mi	nute
h 🛄 🤅	8 √ ⊗					
ll Resul	ts 48 hr Summary	Lab Radiology Vitals				
Flowshee	et: Hand-Off	💌 Levet Hand-Off	•	Table	C Group C List	
4 F		17 February 2009 11:46 - 19 February 200	9 11:46 (Clinical I	Range)		•
Naviga	ator	Hand-Off	02/18/09 12:29	02/18/09 12:25	02/18/09 07:41	
	Vital Signs	Vital Signs	12.20			
	Pain	Systolic Blood Pressure	136		186	
	Integumentary	Diastolic Blood Pressure	78		95	
		Peripheral Pulse Rate	85			
	Peripheral IVs	Respiratory Rate	16 37.0			
		Imperature Oral Pulse Oximetry	37.0			
		Oxygen Therapy	Room air			
		Pain	HOOM all			
		Pain Score (Rest)	4			
		Pain Score (Activity)	6			
		Integumentary				
		INCISION/WOUND CARE GRID		Incision/Wound	1	
		Peripheral IVs				
		PERIPHERAL IV ASSESS/INTERVENTION	GRI	Peripheral IV As	5	

The handoff flowsheet will display information that was recorded from nursing assessments.

Downtime Documentation

Occasionally, the system needs to be taken down temporarily to be updated. During this time, there is one computer on each unit that is available for viewing patient information if needed. The *PowerChart local Access* (*PCLA*) application provides access to view patient results for different categories (i.e. labs, medications, radiology, etc) during downtime. PCLA is strictly a **view only** application. It does not allow for any changes (such as changing the clinical date range, entering orders and sorting patient results.)

Each designated computer will have a card displayed next to it with the instructions for logging in to the system. In the event this happens, all documentation must be entered into the computer when the system is back up.

	PCLA Monitor Card						
PI	ease find the monitor card on PCLA device for instructions to login into PCLA.						
Inst	ruction for PowerChart Local Access (PCLA) for Downtime Only						
Usernar	Username:						
Passwo	rd:						
How to /	Access PCLA:						
Step 1:	Double-click on the DT Viewer icon on the 🔊						
Step 2:	The PowerChart LA Login dialog box will appear. Enter the Username and Password written above, then click OK.						
Step 3:	Click on the patient's name from the list on the left to view a snapshot of the patient's Medical Electronic Record.						
Step 4:	Enter <u>your</u> CIS PowerChart Username and a reason for viewing the patient's chart, then click OK. Results will appear on the right.						
Step 5:	Click on the desired hyperlink at the top to view different categories (i.e. Labs, Meds, Rads etc)						
How to I	Print from PCLA:						
Step 1:	Select File menu in the menu bar (at the top left corner), then select Print.						
Step 2:	Click on the Print button and the results will print to the local default printer.						
be mad	PCLA is a View Only application. No changes can e nor orders entered into CIS. The list of patients ults appear in alphabetical order and the list cannot ed.						
313-96	ncounter any problem please call the Help Desk at 8-2400. Make sure to mention in the help desk ticket a are using PCLA to expedite your problem.						

Transcribing Documentation By Proxy

If you are completing your own documentation, you would complete the items as you would normally. Only the date/time section would need to be changed.

If the downtime crosses shifts, you may have to enter the documentation for someone else. This is called entering information **"by proxy."** You will be entering only the information that has been documented on paper.

I 🚫 🗞 🇖 4							
med on: / 9/16/	2009 🕂 🔽 10	123 🕂					By: DRHNurse
Signs ostatics				vital Signs			
Or	al	DegC	Tympanic	DegC	Pain Score (Rest)	O N/A
Re	ectal	DegC	Axillary	DegC	Pain Score (Pain Scale		O PABS
	ripheral Ise Rate	bpm Apical H Rate	leart bpm		(Adult) Pain Scale	O 0 - 10 Pain Scale	
Fe Ra	tal Heart ite		RN Notified of	O Yes	(Pediatric)	O Wong-Baker O OUCHER O FLACC	O N-PASS O NIPS
			Pain Score				
Dia	stolic/ astolic BP	^{mmHg}	mmHg Location of BP Collection	O Arm, right O Arm, left O Thigh, right	O Thigh, left O Wrist, Right O Wrist, Left	Method of BP Collection	Auscultated (cuff) Automated (cuff) Thigh (cuff)
	essure			T	Þ		1
w	eight (kg)		kg Calculated (lbs)		0	Actual Enter	only one
		lt Informatic				×	
		d by: DRHNu		-			
	Date/Tin			1000	1		
		portore		1023	∃ ←		
			of Current Documer of Previous and Cur				
	Commen	-	n Frevious and Cui	rent Documer	nation		
	1			04			
				<u> </u>		ncel	

1. Open the form from ad hoc or from the PAL as appropriate.

3. Type in the name of the person you are transcribing for and change the date/time field to reflect the date/time the documentation was completed on paper and click OK. After completing the form, sign the documentation.

The information will now display completed by you for someone else. The paper documentation is placed in the paper chart and retained as the original documentation.

Documenting Medications By Proxy

Prior to downtime, pharmacy will print paper MARs for all patients. Medication administration will be documented on the paper forms during downtime. When the system is back up, the medications from the paper MAR must be documented on eMAR.

If you are documenting medications that you administered, then you will enter the medications manually (without scanning). If you are entering medications that were administered by another nurse, then they are being entered **by proxy**.

To begin click on the dose you wish to document.

MA	R								
*	ĵ								
4	•	15 August 2009 10:26 - 17 September 2009 10:26 (Clinical Range)							
	Time View	Medications	09/16/09 09:00	09/16/09 11:00	09/16/09 17:00	09/17/09 09:00			
	Scheduled	Scheduled	00.00	11.00	11.00	00.00			
	Unscheduled	े के lisinopril	10			10			
	PBN	Start 09/16/09 9:00:00, Routine, 10 mg, By Mouth, Tab, Daily	10 mg			10 mg			
	Continuous Infusions	lisinopril							
		Systolic Blood Pressure							
		Diastolic Blood Pressure							
				150 mg	150 mg	150 mg			
		ranitidine							
		Start Q settraline (Zoloft) Start 09/16/09 11:00:00, Routine, 25 mg, By Mouth, Tab, Daily settraline		25 mg		25 mg			

Enter the any details required for the medication. Then entered the name of the nurse who administered the medication and the date/time reflected on the paper MAR. sign the documentation

✓ Ø	
`n Arv ⊘ r anitidine (Zantac) Stat 09/16/09 11:00:00, 150 mg, By Mowth, Tab	
*Performed date / time 09/16/2009 + 1100 +	
*Performed by DRHNurse, RN15	
*ranitidine 150 mg	
Diluent: <none> ml</none>	
*Route: By Mouth Site:	
Not Given	
Reason:	
Comment	

The paper MAR is placed in the paper chart and retained as the original documentation.

What's Next?

At the DMC, we are committed to improving our technology to ensure patient safety, support clinical judgment, and achieve excellent outcomes for our patients. One of the ways in which we do that is by listening to those individuals taking care of the patients at the bedside. If you have an idea that would support our goals then we want to hear from you. Please find a super user and submit your idea for the quarterly EMR awards.

If you need further assistance understanding any portion of the material covered in this manual please contact your site clinical transformation team at (313) 745-7796 for other resources that may be available.