

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 Desktop** icon.
2. Enter your DMC Enterprise User ID and Password.



DMC Citrix Desktop Login

Training Newsletters

- [CIS Spotlight on the DMC Citrix Desktop](#)
- [DMC Portal Pointers](#)

Login

• **Username:**

• **Password:**

(Note: Password is case sensitive)

Instructions:

- 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 Intranet.
- If you don't have an NT Network User ID/Password, you can obtain one by [clicking here](#) or contact the Help Desk at (313) 966-2400

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



CERNER 0100100 01000111 01000101 01000111
MILLENNIUM 01000111 01000111 01000111 01000111

User Name:

Password:

Domain:

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This program is being used under license from Cerner Corporation of Kansas City, Missouri, USA. Unauthorized use, reproduction, or distribution of any portion of this program may result in severe civil and criminal penalties. Further information can be found in Help>About.

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*.

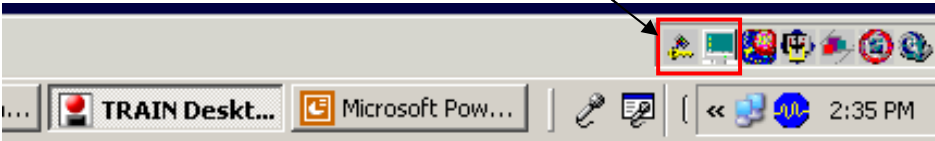


Suspend — When you need to walk away for a short time, click the **Suspend** button in your taskbar tray. Your Citrix session, CIS, and any other applications you have open will be closed for you; however, your exact location will be bookmarked. The next time you sign on to Citrix from any DMC computer,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



Tool Bars and Icons

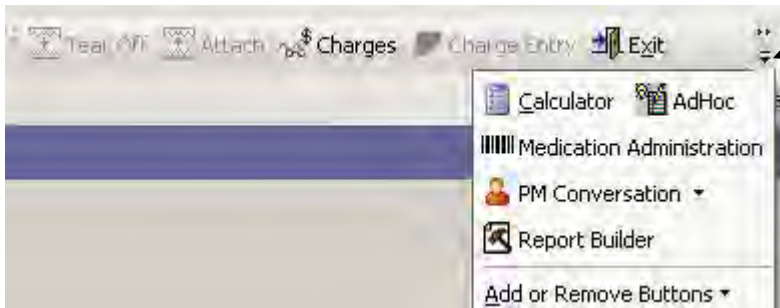
Toolbars can be customized to user preference.

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

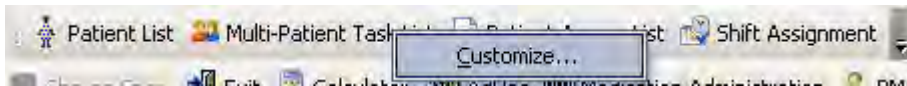


While still holding the mouse button down drag the toolbar where desired and release the mouse button.

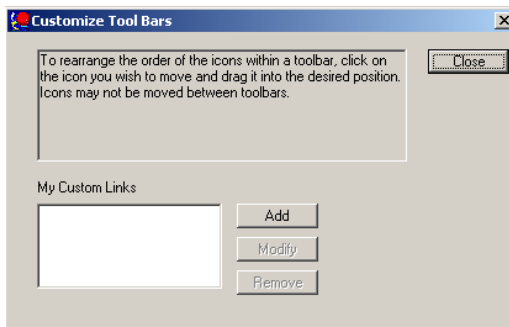
This will allow you to view all icons. If the toolbars are not showing all icons, you will have to use the dropdown arrow at the end to view hidden icons.



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




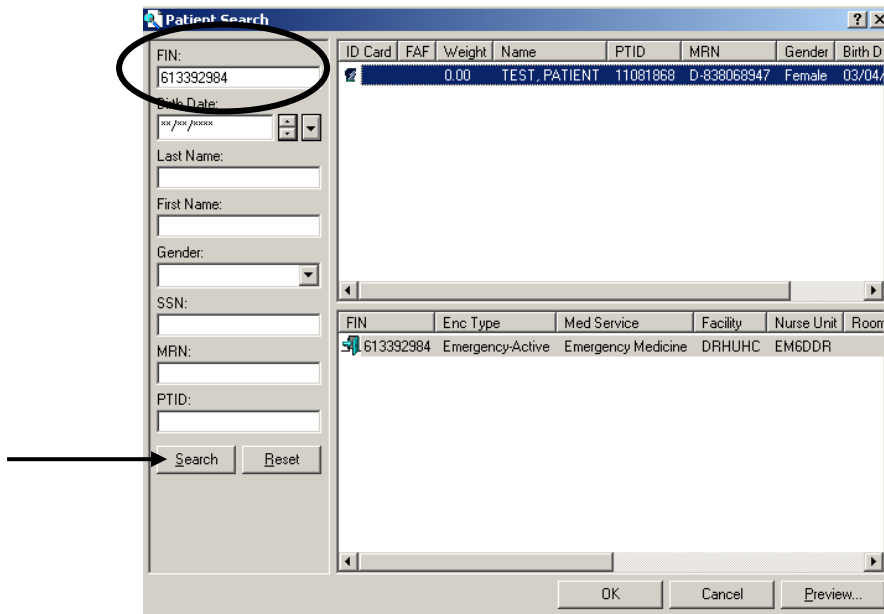
The customize box will appear.




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.



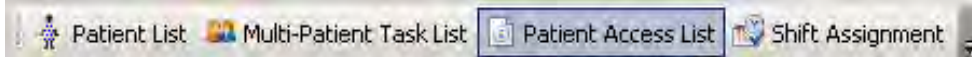
Patient Access List (PAL)

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.

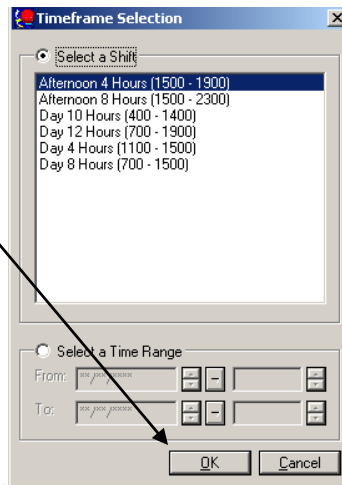
Note: The PAL tab automatically updates every (one) minute, regardless of how many times you click on the refresh button.

Accessing the PAL Tab

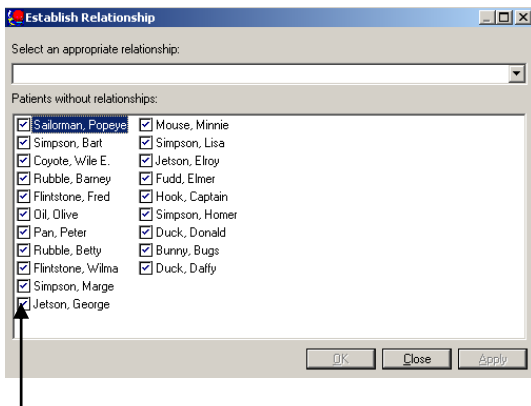
1. In *PowerChart*, click the **Patient Access List (PAL)** on the toolbar.



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

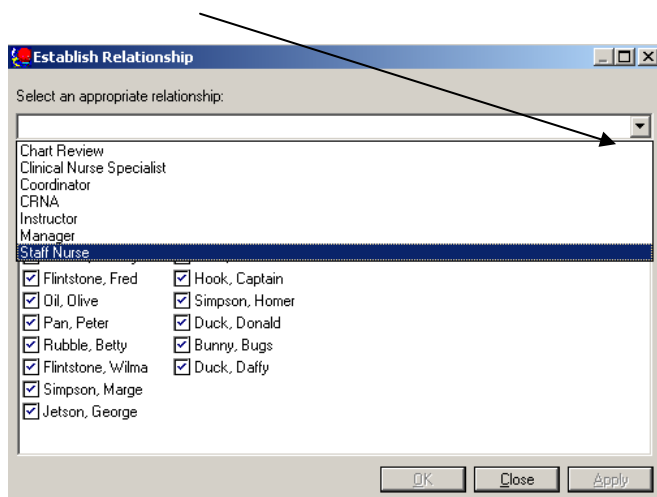


3. Next, the establish relationship box will appear.



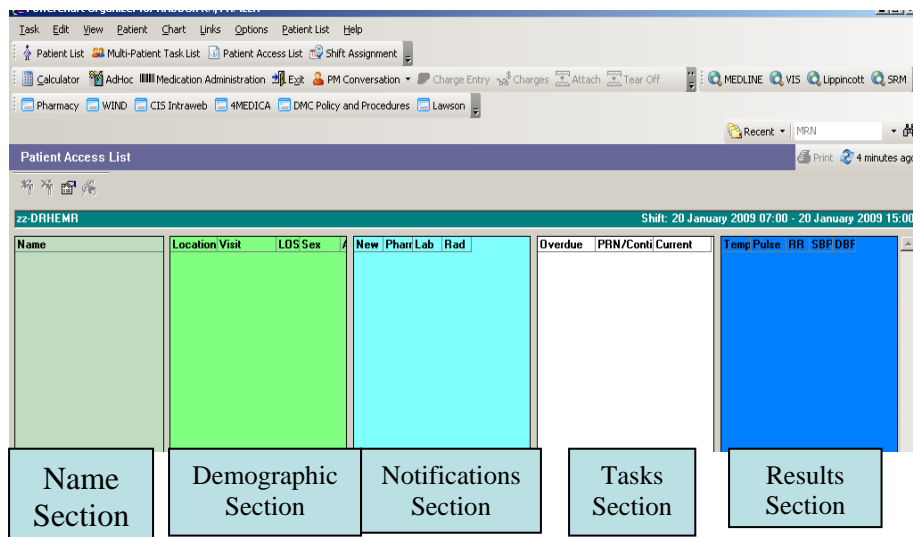
4. Uncheck any patients you are not assigned to by clicking in the box in front of their name.

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



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.



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.

Icon	Action
	The Clipboard icon indicates a new result. Double click to view details. Click Apply to acknowledge that the results have been reviewed.
	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.
	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.

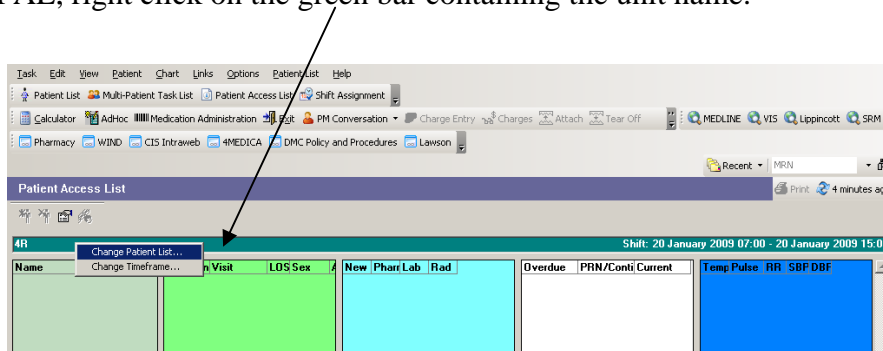
	Medications: Medication, PRN Response
	Activity: Activity/Hygiene
	Nursing Assessments/Treatments: Admitting, Audiology, Care Management, Communication Orders, Patient Assessment/Monitoring, Procedures, Discharge, Vital Signs
	Respiratory Nursing Tasks: Respiratory, Respiratory Assessment, Respiratory 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
	Nurse Blood Draw: All blood draw orders where the nurse is indicated to draw the blood.
	Unscheduled Task: This activity can be from any of the other types, but is unscheduled.
	Communications: Communication Orders, Order Notification, Spiritual Care, Consults

Creating your own assignment list for your PAL

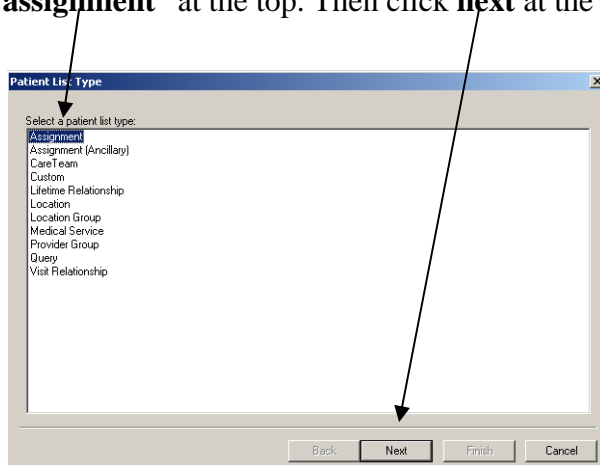
Each individual must create an assignment list if his/her area is using the Shift assignment function. This list will automatically contain any patients assigned using the shift assignment function.

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.



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.



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:

Vital signs are charted from the PAL by double clicking on the  icon in the PRN/ Cont. section

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



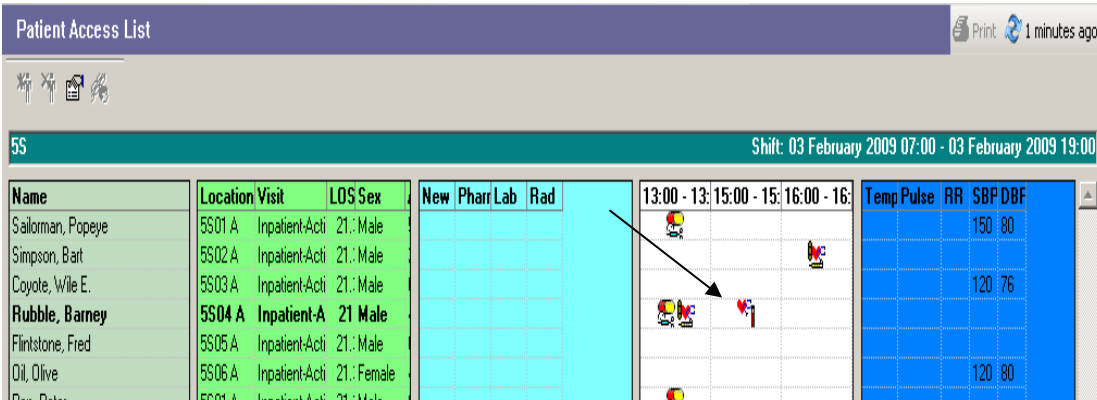
This will bring up the vital signs form. After completing, use the green checkmark  to sign the form or the floppy disk  to save it if you need to return to it later.

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

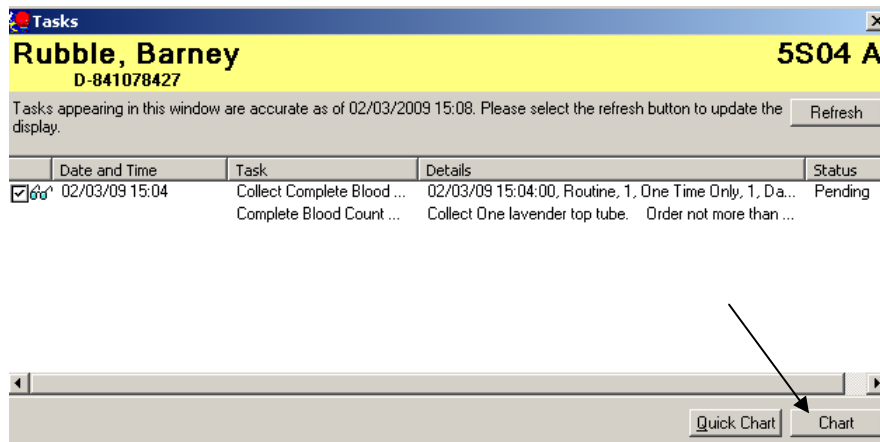
**** All tasks on the PAL list should be tasked off by the end of your shift. Things that are not yet completed should be reported off to the oncoming shift during handoff communication.**

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.




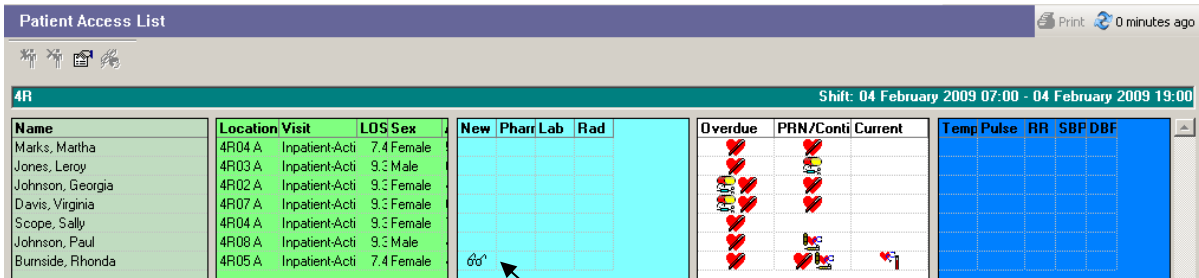
First, double click on the icon to determine what needs to be completed.




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.

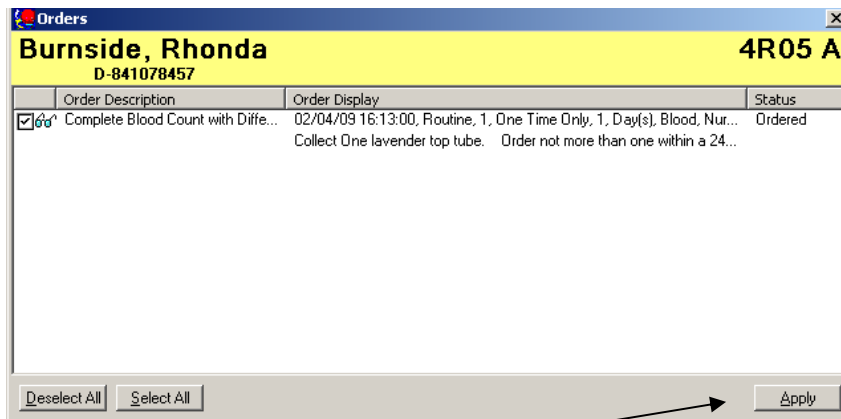
Orders For Nurse Review


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.



Name	Location Visit	LOS	Sex	New	Pharr	Lab	Rad	Overdue	PRN/Conti	Current	Temp	Pulse	RR	SBP	DBF
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												

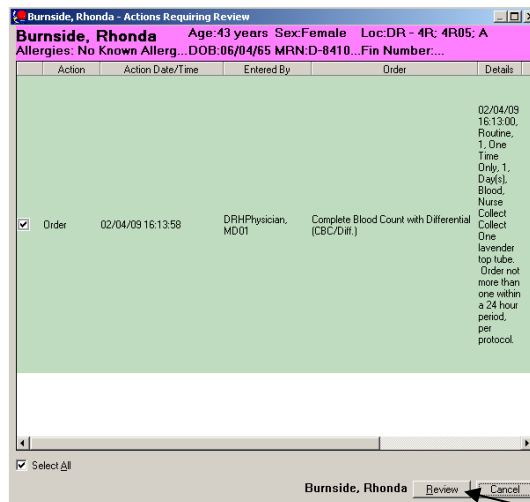
1. To review the order, double click on the **eyeglasses**. This will display the order.



Burnside, Rhonda		4R05 A
D-841078457		
Order Description	Order Display	Status
<input checked="" type="checkbox"/>  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

Buttons: Deselect All, Select All, Apply

2. Click on the word **“apply”**. This will display the order in more detail.



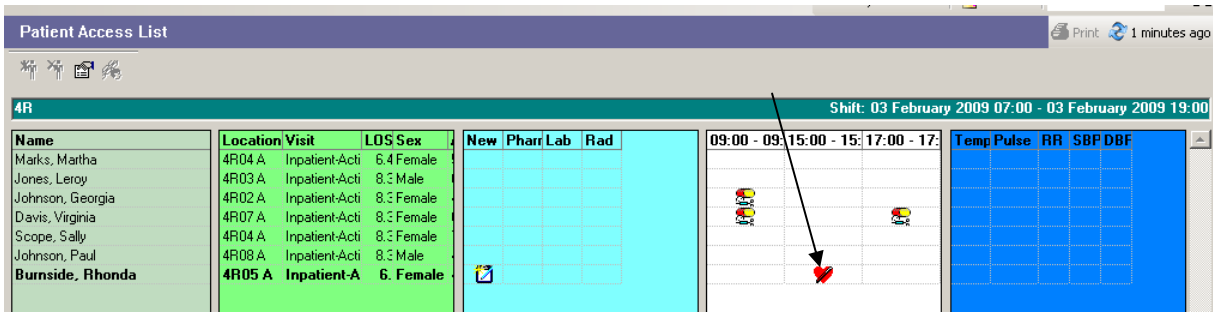
Action	Action Date/Time	Entered By	Order	Details
<input checked="" type="checkbox"/> Order	02/04/09 16:13:58	DRHPhysician, MD01	Complete Blood Count with Differential (CBC/D#)	02/04/09 16:13:00, Routine, 1, One Time Only, 1, Day(s), Blood, Nurse Collect One lavender top tube. Order not more than one within a 24 hour period, per protocol.

Buttons: 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

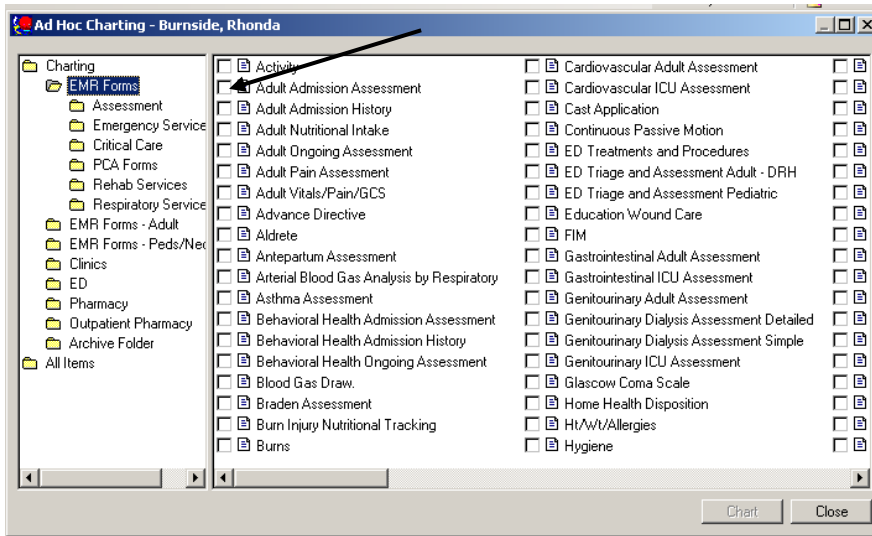
When a patient is admitted an icon will appear on the PAL list that will contain the forms to be completed.



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.



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



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

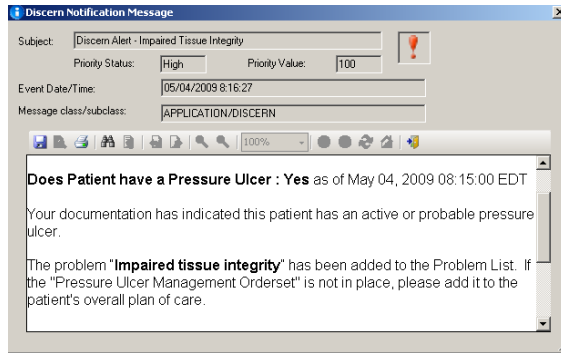
When completing the admission assessment, use the navigator bar on the left to move from one section to the next until every necessary section has been completed.

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

**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 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.



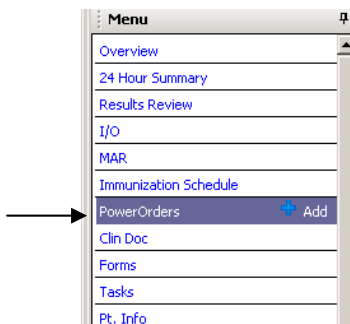
RN Responsibility:

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

Pressure Ulcer Care	Pressure Ulcer Stage	Pressure Ulcer Status	Present on admission	Location	Description	Color	Length (cm)	Width (cm)	Depth (cm)	Drainage
Pressure Ulcer #1	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>
Pressure Ulcer #2	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>
Pressure Ulcer #3	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>
Pressure Ulcer #4	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>
Pressure Ulcer #5	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>
Pressure Ulcer #6	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>
Pressure Ulcer #7	<Alpha>	<MultiAlpha>	<Alpha>		<MultiAlpha>	<MultiAlpha>				<MultiAlpha>

Pressure ulcer grid found in integumentary section of the assessment

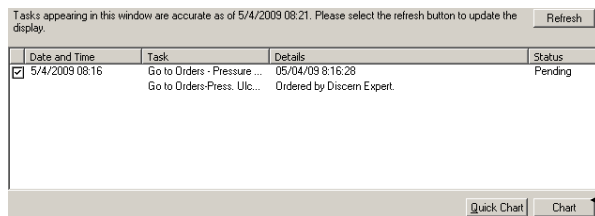
2. Go to the Power Orders section of the chart and place the **pressure ulcer management orderset**.



- 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

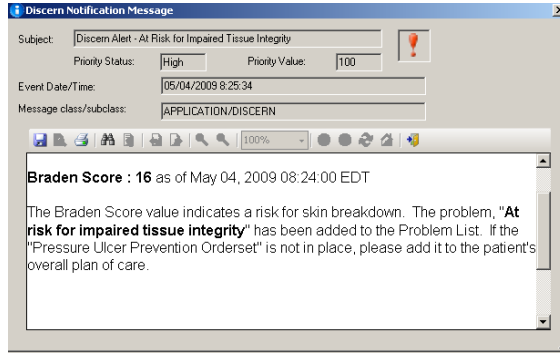
See PowerOrders section of manual for further details about placing orders.

3. Complete the task on the PAL.



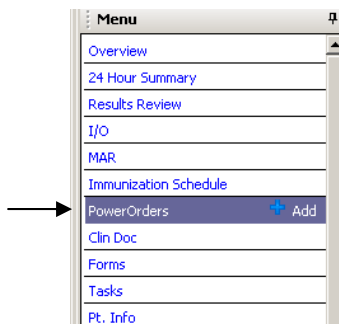
4. Initiate “**impaired tissue integrity**” care plan. (See page 39 of this manual for explanation)
5. Complete patient education. (See page 38 of this manual for explanation)

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:

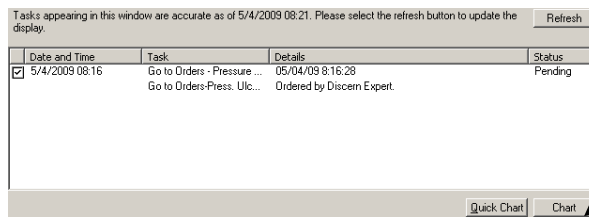
1. Go to the Power Orders section of the chart and place the **pressure ulcer prevention orderset**.



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.

2. Complete the task on the PAL.



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

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.

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).

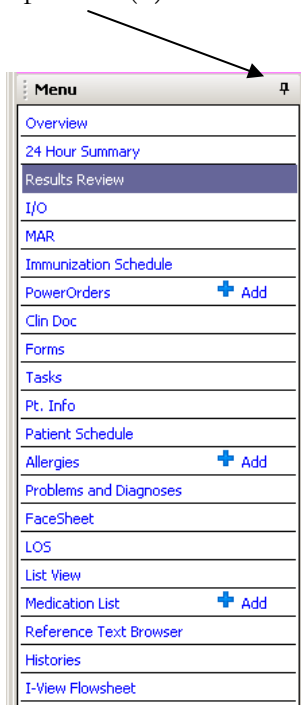
**When the form is completed, use the green checkmark  at the top left corner to sign your documentation or the floppy disk icon  to save it if you need to return to it later.

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

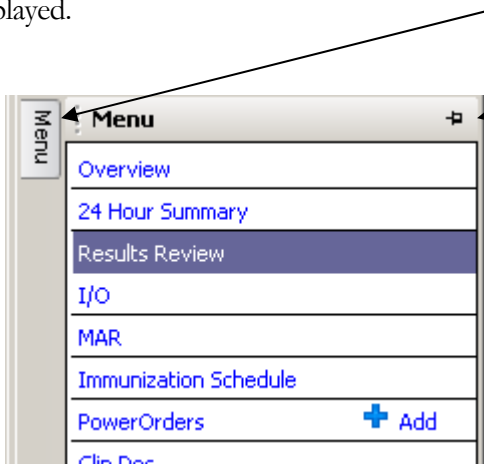
Once the admission history form is completed the nurse must collect information about the patient’s **past medical history and medications taken at home**. These items are documented from the menu bar inside the patient’s chart. **To open the patient’s chart, double click on their name.**

Menu 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 (📌) located on the top right of the menu bar.

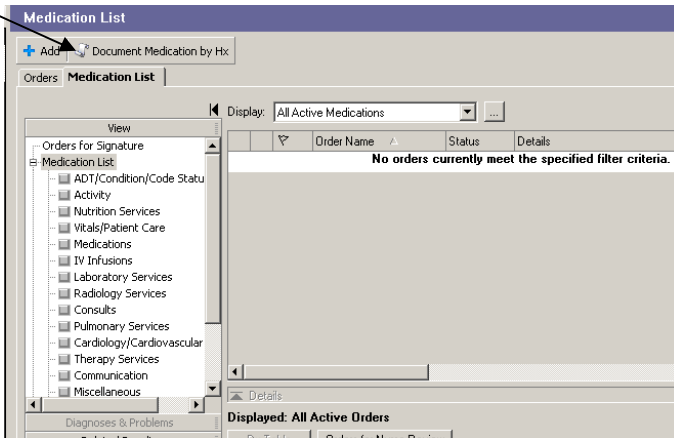


If menu bar is already hidden, hover mouse over the small tab on left that reads "menu" click on the pushpin to leave menu bar displayed.

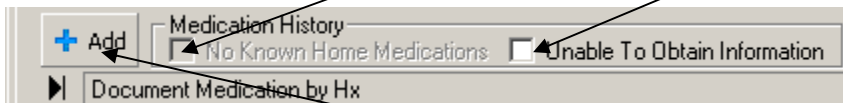


Medication List

To enter the list of medications, first go to the “medication list” on the menu bar and click “Document by History”

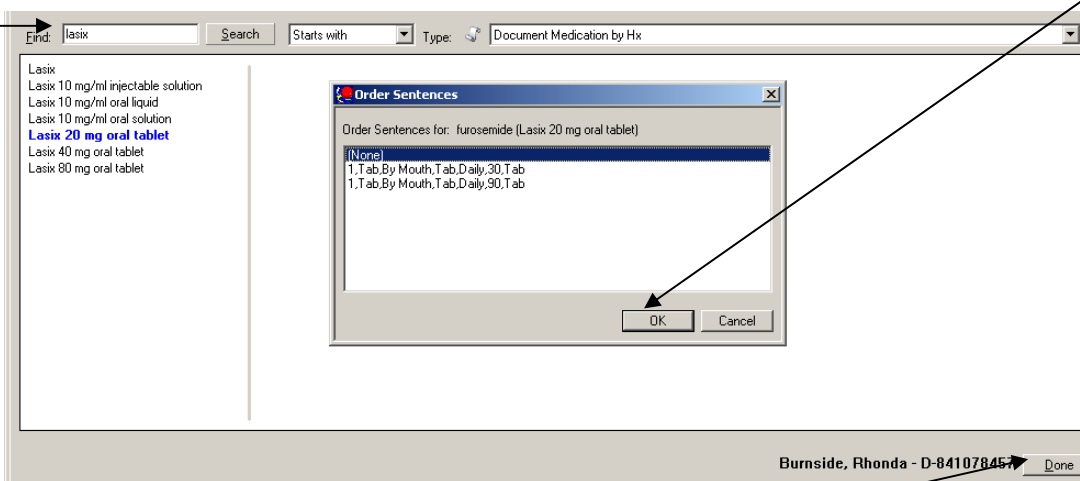


The options of “No known home medications” and “Unable to obtain information” are available if applicable.



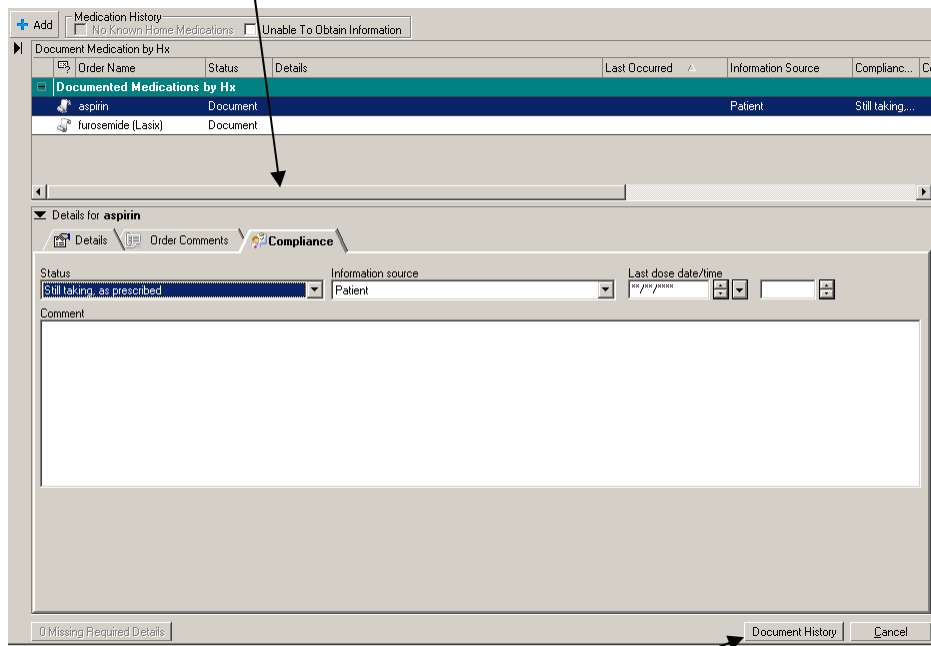
To begin adding a medication to the list, click .

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.



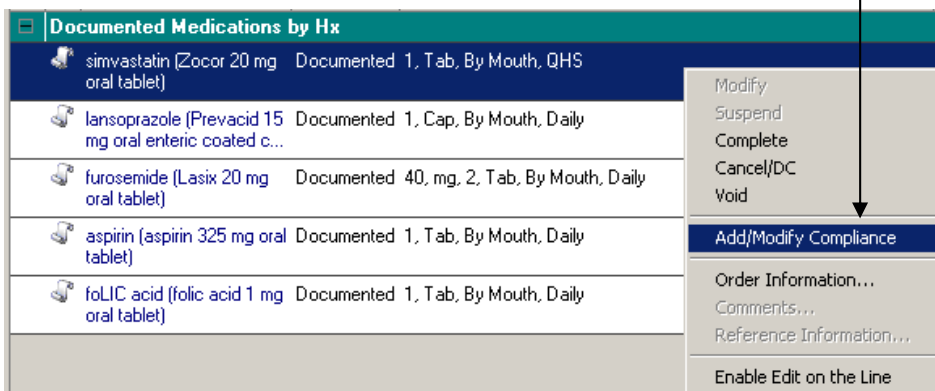
When all medications have been entered, click “DONE” at the bottom of the screen.

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.



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**”

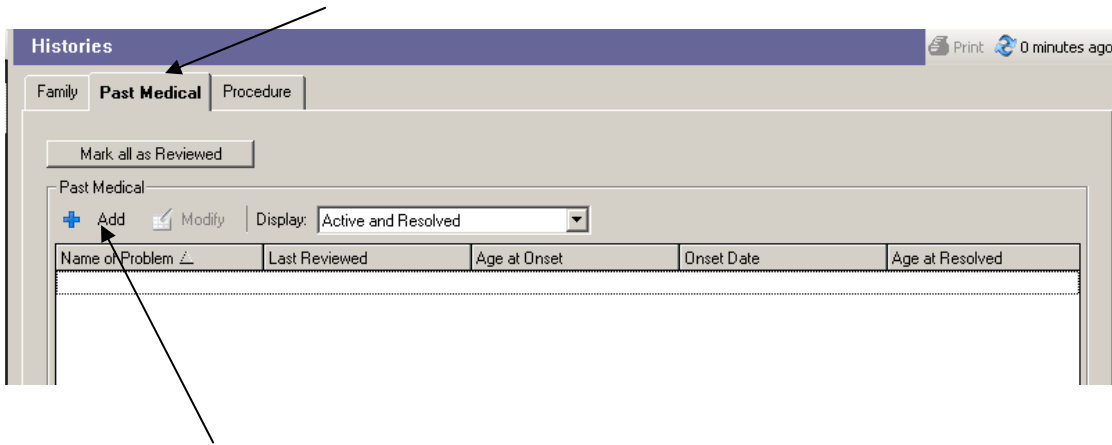


All those medications listed under the “prescriptions” section must also have compliance completed.

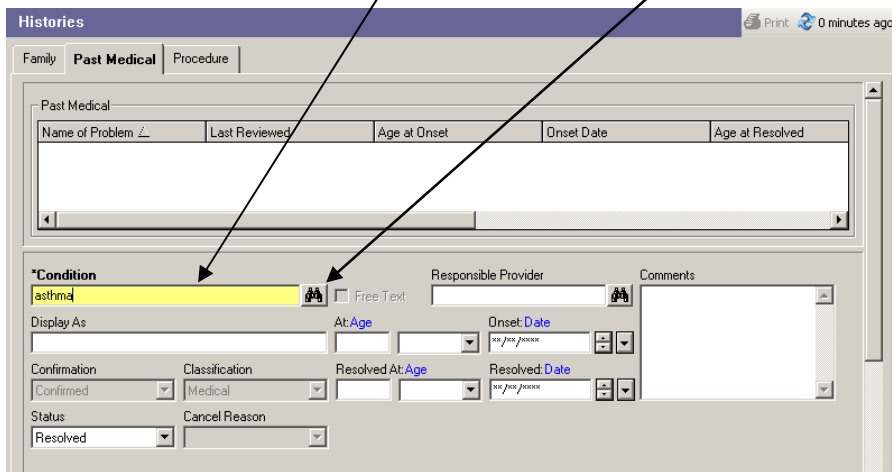
Physicians cannot perform medication reconciliation until compliance has been completed for all medications.

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.



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



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

Problem Search

*Search: asthma Starts with Within: Terminology

Show Advanced Options

View Synonym Concept Family Multi Axial Cross Mapping

Term	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	Procedure
Asthma control step 3	282491010	SNOMED CT	Procedure
Asthma control step 4	282492015	SNOMED CT	Procedure
Asthma control step 5	282493013	SNOMED CT	Procedure

Add to Favorites OK Cancel

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 Free Text Responsible Provider Comments

Display As At: Age Onset: Date

Asthma

Confirmation Classification Resolved At: Age Resolved: Date

Confirmed Medical

Status Cancel Reason

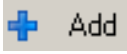
Resolved Active Canceled Inactive

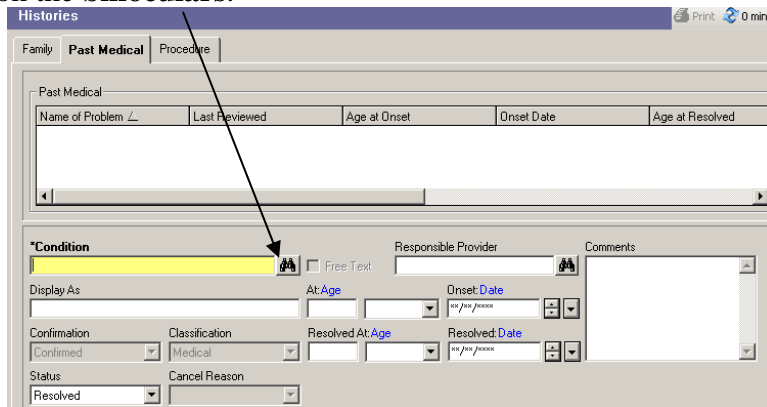
OK Cancel

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

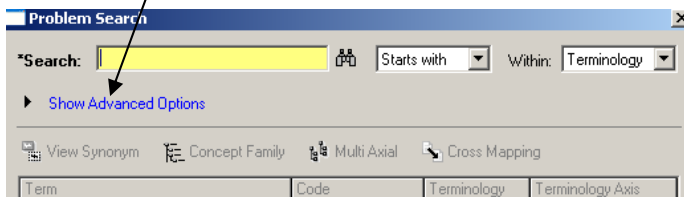
Adding SNOMED Database


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.

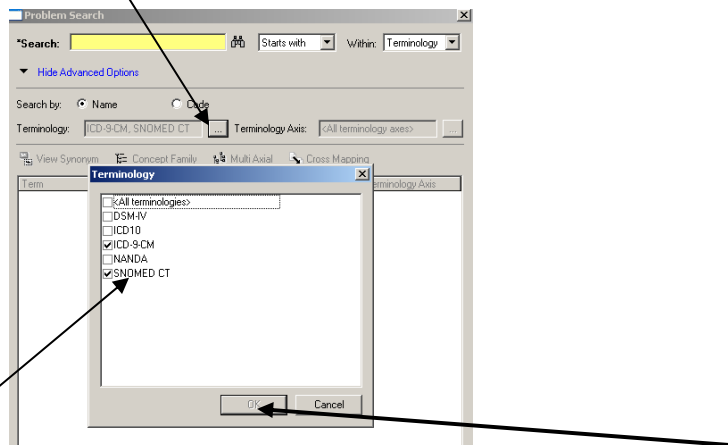
1. To begin, click on the **histories** section of the menu bar and click the **past medical** tab.
2. Click the  icon.
3. Next, click on the **binoculars**.



4. Click on “show advanced options.”



5. Next, click on the ellipsis icon 

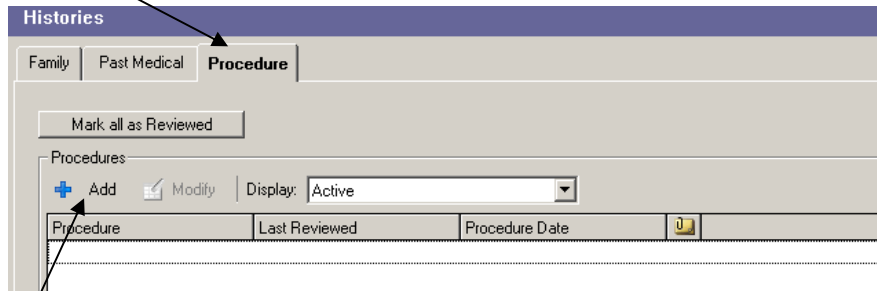


6. Place a checkmark in the box in front of **SNOMED CT** and click **OK**.

**You are now able to search using acronyms.

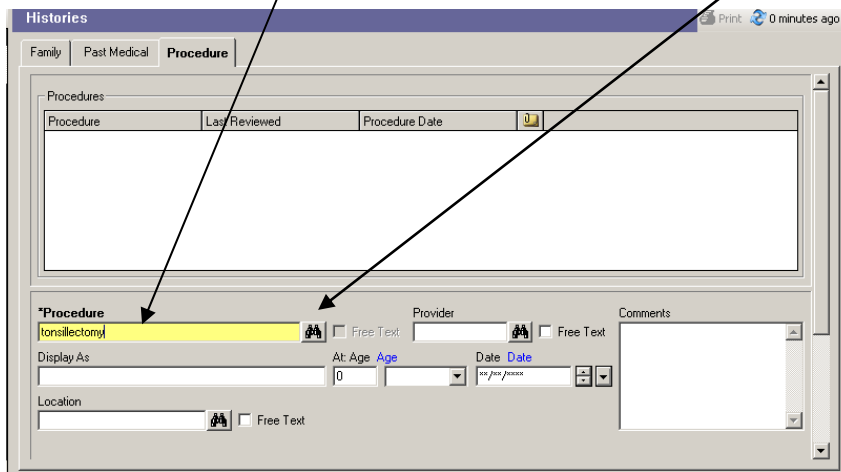
Adding Past Procedures

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

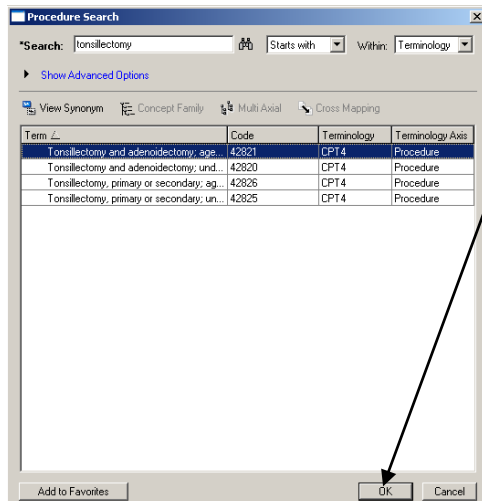


Click the **+** Add icon.

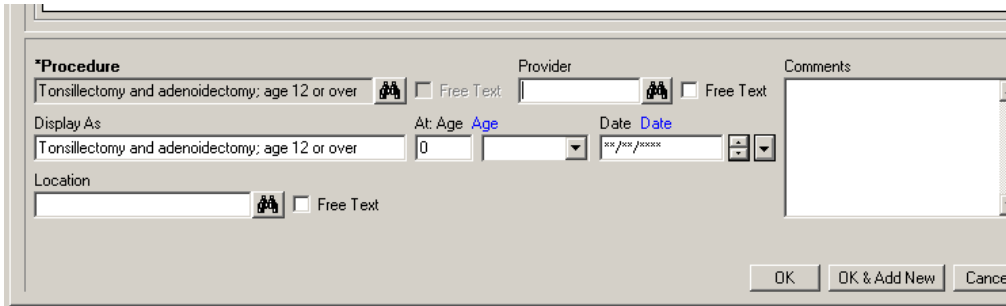
Next, type the procedure in the yellow procedure field and click the binoculars



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



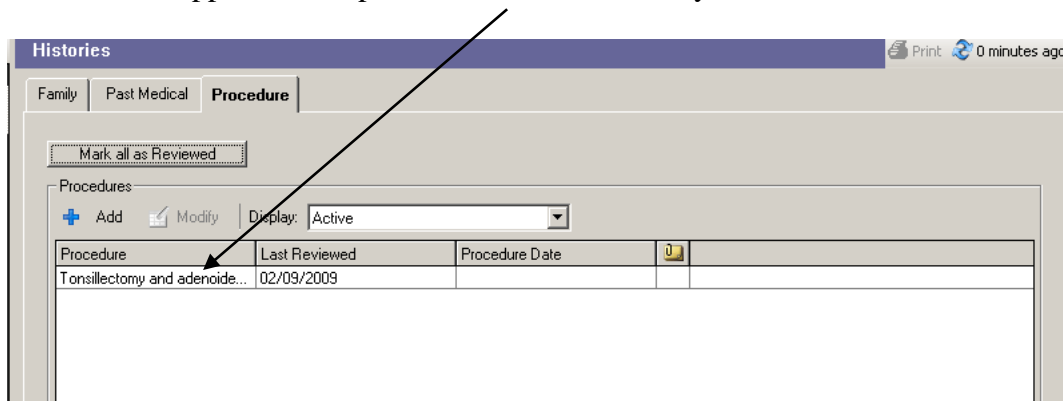
Next, complete any details known about the procedure.



The screenshot shows a form for entering procedure details. It includes fields for "Procedure" (containing "Tonsillectomy and adenoidectomy; age 12 or over"), "Provider", "Display As", "At: Age" (set to 0), "Date", and "Location". There are also checkboxes for "Free Text" and a "Comments" text area. At the bottom right, there are buttons for "OK", "OK & Add New", and "Cancel".

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.



The screenshot shows the "Histories" section with tabs for "Family", "Past Medical", and "Procedure". A "Mark all as Reviewed" button is visible. Below, there is a "Procedures" section with "Add" and "Modify" buttons and a "Display: Active" dropdown. A table lists the procedure details:

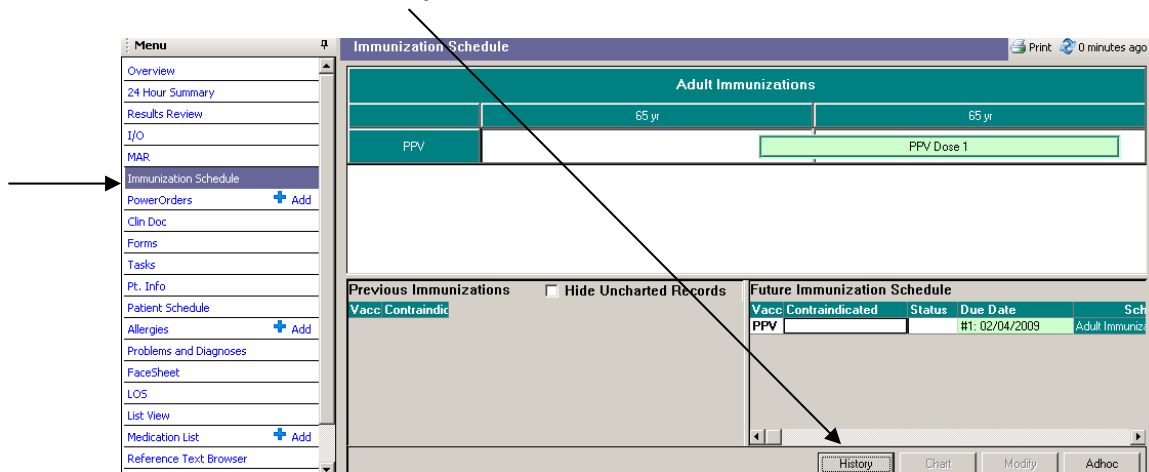
Procedure	Last Reviewed	Procedure Date	
Tonsillectomy and adenoide...	02/09/2009		

An arrow points from the text above to the "Procedure" column header in the table.

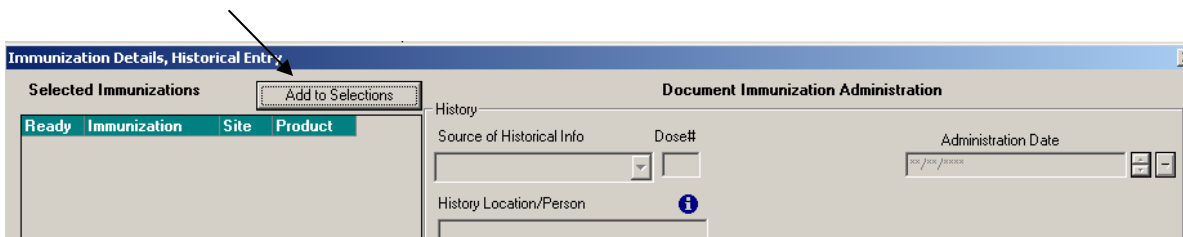
Immunization Schedule

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.

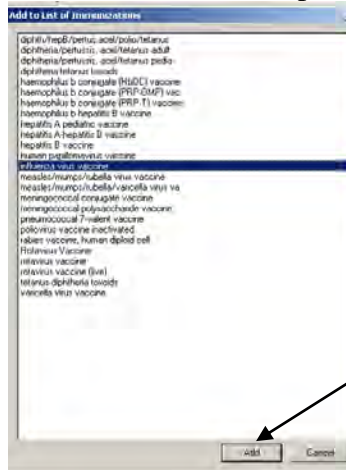
1. To document a vaccine that was given outside the DMC, first click on the **immunization schedule** section of the menu bar.
2. Next click on the word “**history**” at the bottom.



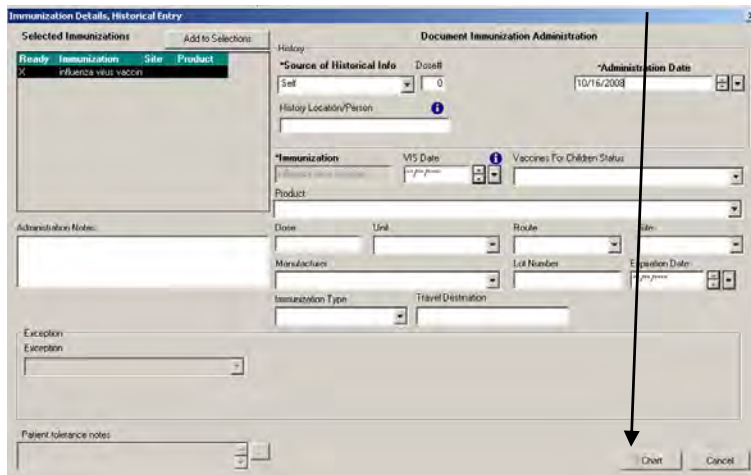
3. Next click “**add to selections**”



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

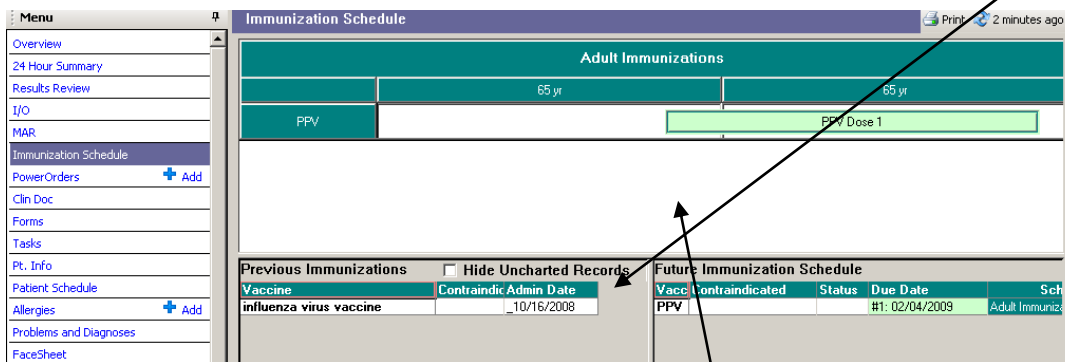


5. Next complete all the details that are known and click “**chart**”



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

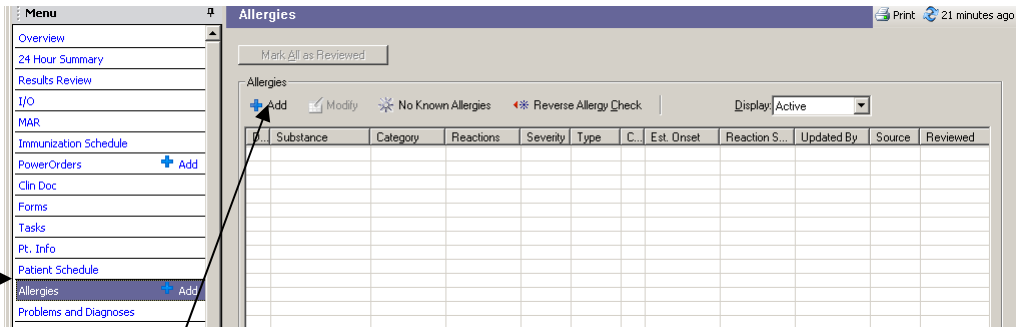
The information entered will now display in the previous immunizations column.



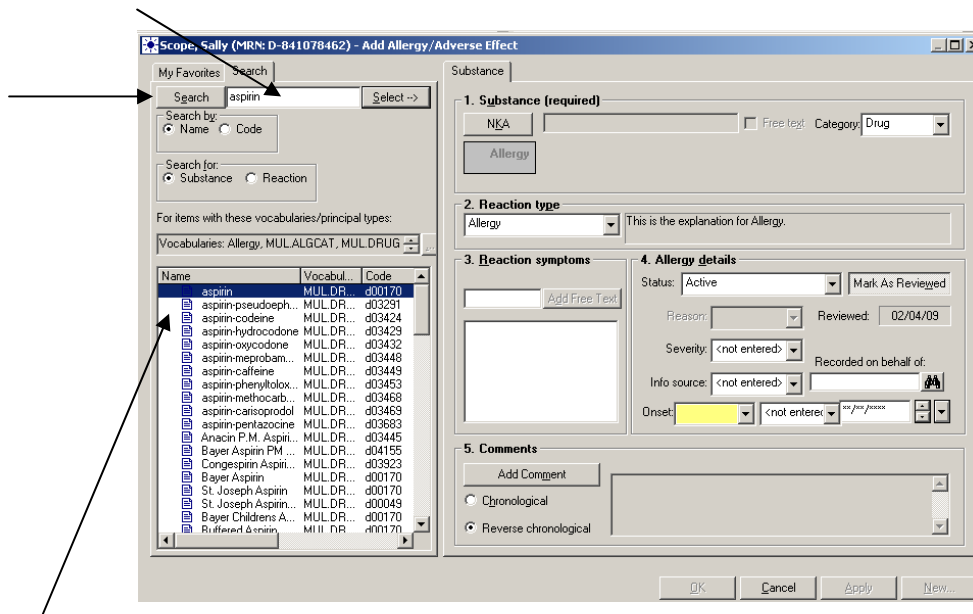
The immunization schedule also displays the CDC schedule for immunizations for pediatric patients.

Entering Allergies

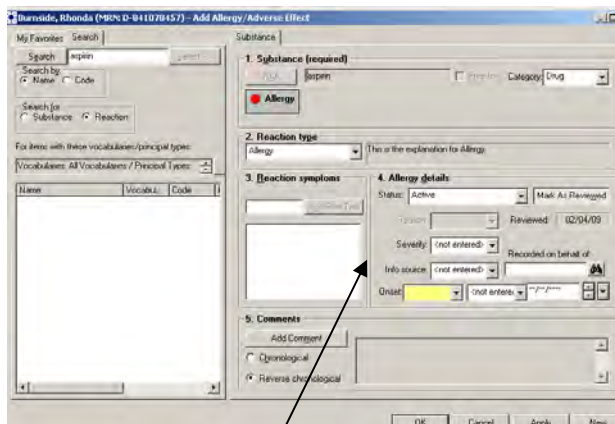
To begin entering allergies for a patient, first click on the **allergies** section on the menu bar.



- Next, click the “add” icon.
- Then **type the name** of the allergen into the search field and click “search”



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



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

Daily Documentation

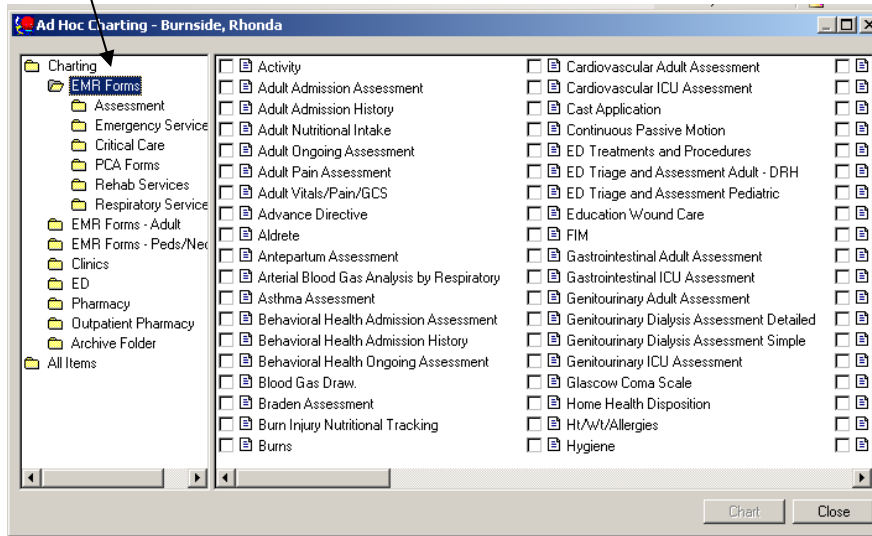
Ongoing assessment

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.

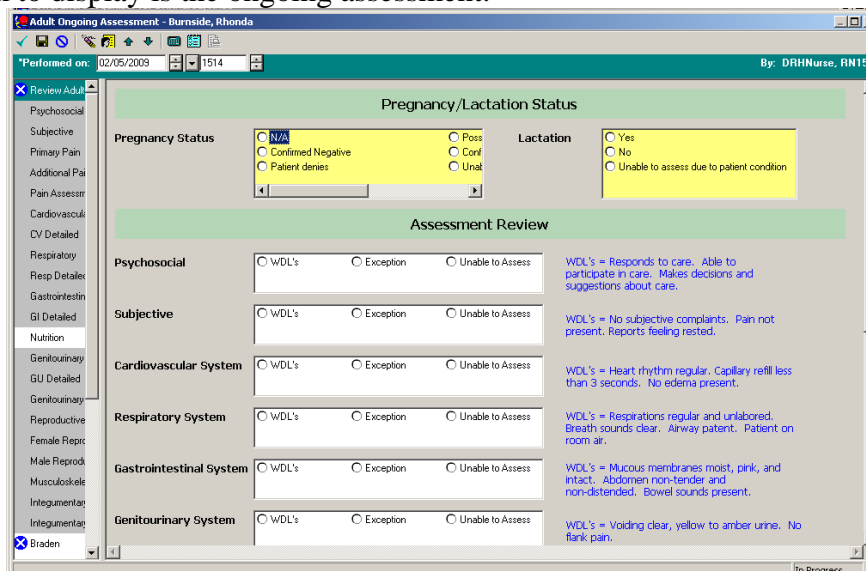


Next, click “EMR forms”



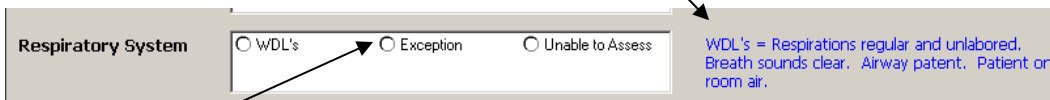
Select the forms needed; ongoing assessment, plan of care, patient education. Then click **chart**.

The first form to display is the ongoing assessment.

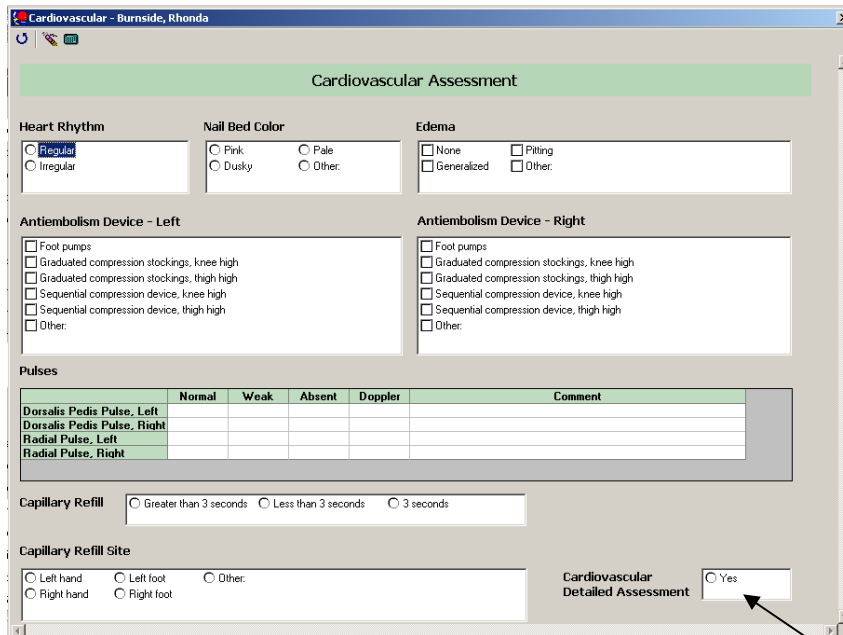
A screenshot of the 'Adult Ongoing Assessment - Burnside, Rhonda' form. The form is titled 'Pregnancy/Lactation Status' and 'Assessment Review'. It contains several sections with radio button options: 'Pregnancy Status' (N/A, Confirmed Negative, Patient denies, Poss, Conf, Unat), 'Lactation' (Yes, No, Unable to assess due to patient condition), 'Psychosocial', 'Subjective', 'Cardiovascular System', 'Respiratory System', 'Gastrointestinal System', and 'Genitourinary System'. Each section has 'WDL's', 'Exception', and 'Unable to Assess' options. A sidebar on the left lists various assessment categories, with 'Braden' selected. The top of the form shows 'Performed on: 02/05/2009' and 'By: DRHNurse, RN15'. The bottom right corner says 'In Progress'.

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.

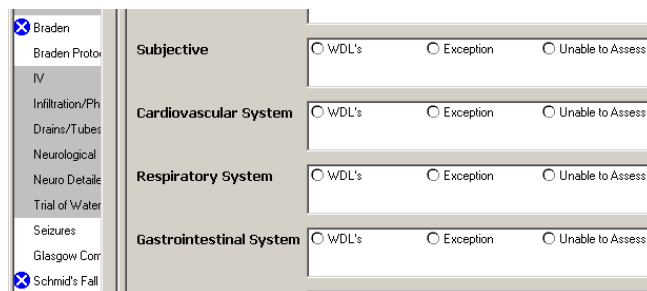



Clicking the exception option will open another page for you to document the findings.





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 , called the circle back button, located in the upper left corner, to return to the previous page.




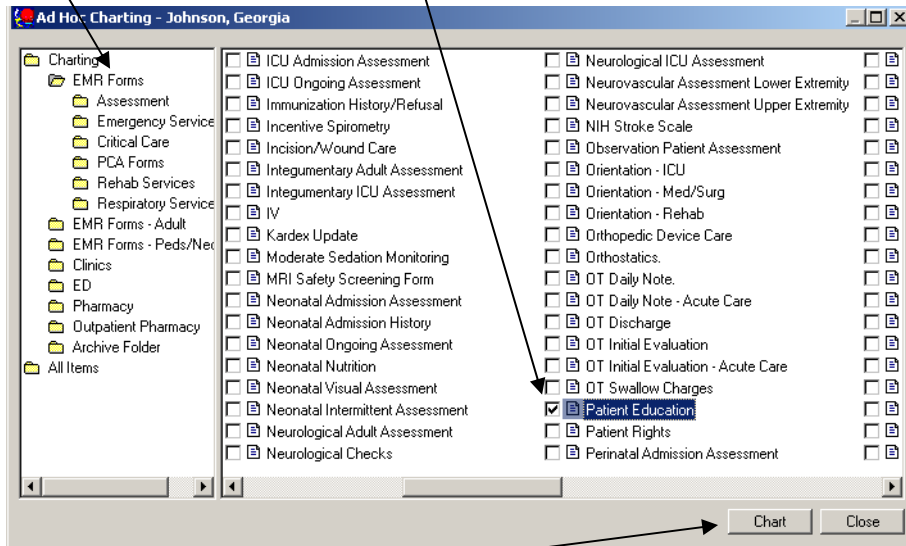
The left side of the ongoing assessment is the navigator bar. This contains sections that may need to be documented based on the patient condition. It also contains two required fields that are marked by a blue circle containing a white X . These items are the Braden Scale and the Schmidt Fall Risk.

When the form is completed, use the green checkmark  in the top left corner to sign the documentation, or use the floppy disk icon  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  AdHoc 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.


Education

No education data available.


Topics	Individuals Taught	Barriers to Learning	Teaching Method	Learning Response / Teaching Evaluation	Comment
<Alpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	
<Alpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	

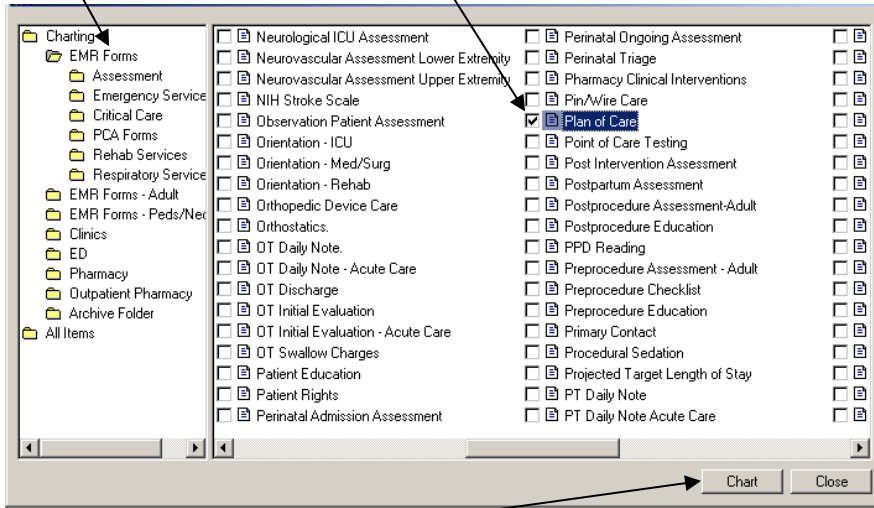
The comment box allows free text and should be used to provide some specifics about what was taught.

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  in the top left corner to sign the form or use the  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  icon on the toolbar. Next select “EMR forms” and select the plan of care form.



Next, click chart.

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

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
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<Alpha>	
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<Alpha>	
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<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>	<Alpha>	
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<Alpha>	
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<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 - 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	02/09/09	02/12/09	Initiated	2/9 2+ pitting edema BLE's
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<Alpha>	
<Alpha>	<Alpha>	<MultiAlpha>	<Date>	<Date>	<Alpha>	

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

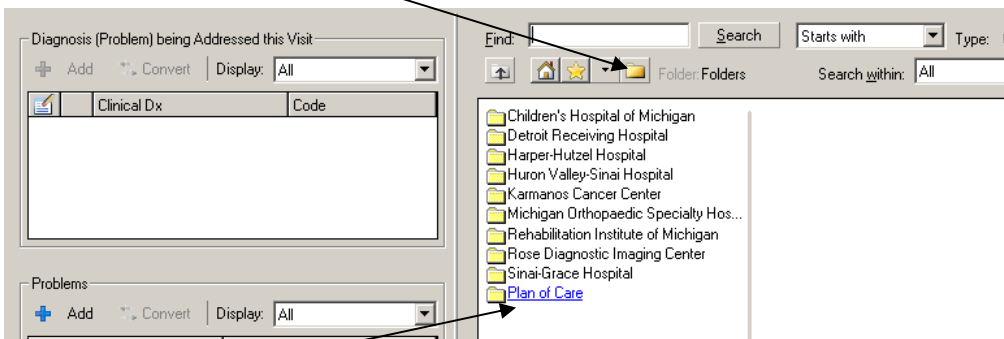
When finished with the form, use the  in the top left corner to sign the form or use the  to save it if you need to return to it later.

Nursing Interventions

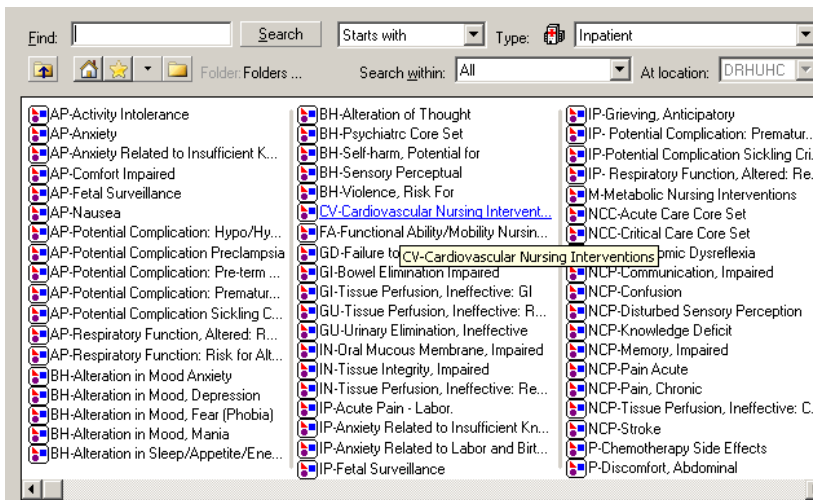
After initiating a care plan, you must order nursing interventions. These only need to be ordered one time and will remain on the orders profile for all to see until discontinued.

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.

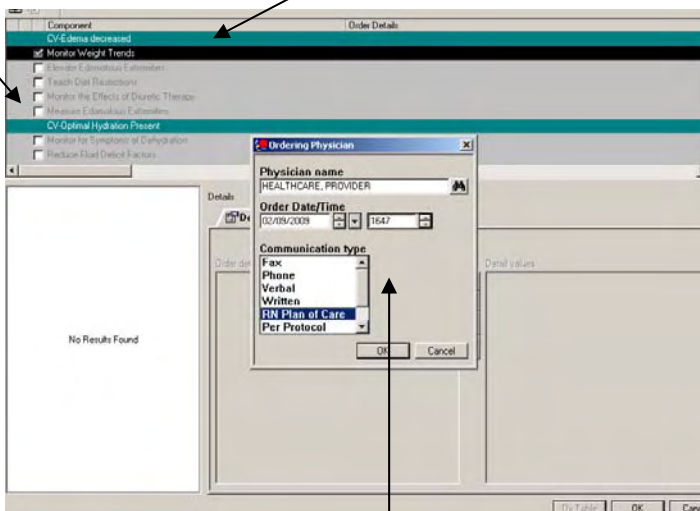


Now, select plan of care from the list.



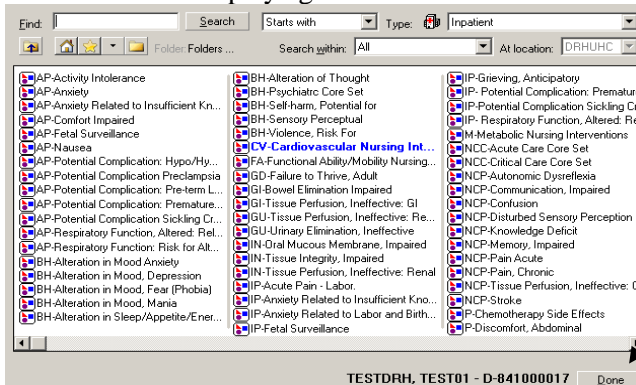
Now choose the category that matches your plan of care.

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

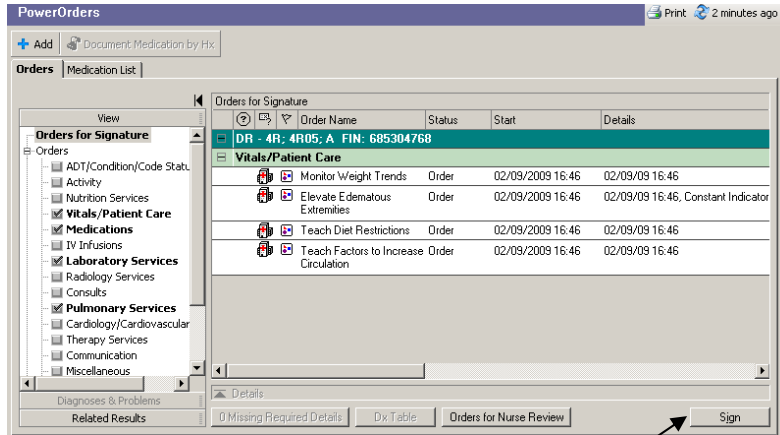


After clicking on the first intervention a communication box will appear. You must enter the name of the provider. In this case, it would be "Healthcare Provider" since this is a nursing order. The communication type should be entered as "RN Plan of Care." Then click OK and continue selecting the rest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

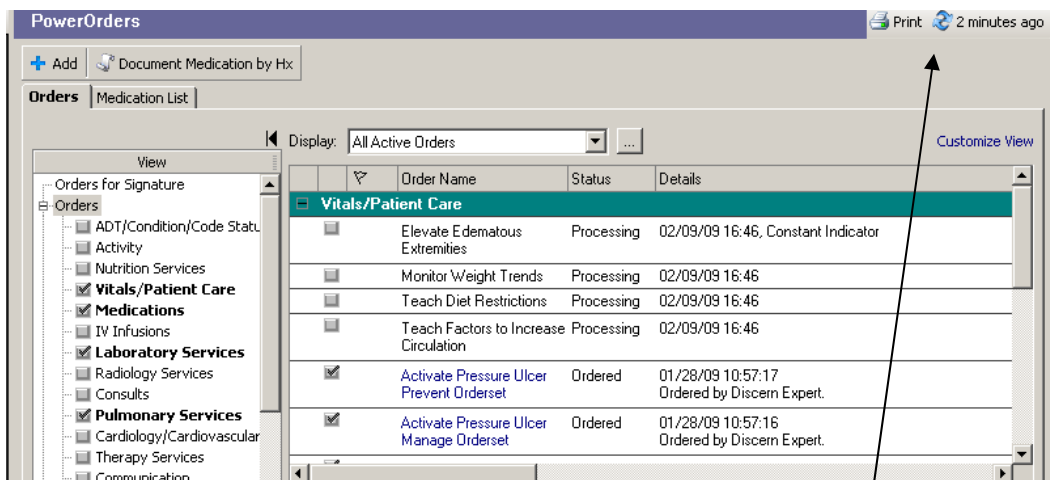
Next, the add orders screen will display again. If there are no more orders to enter, click done.




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.



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



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

Forms

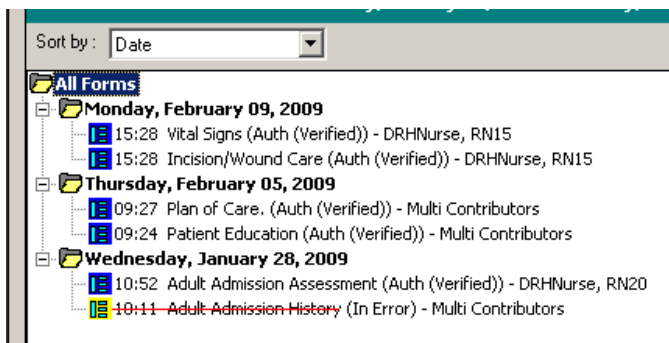
Completed Forms may be viewed, modified, or uncharted from the Forms section of the menu bar. The options available to you will vary according to your needs. For example, you may be able to modify forms for which you are the author, but not forms with another person as the author. You are only allowed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

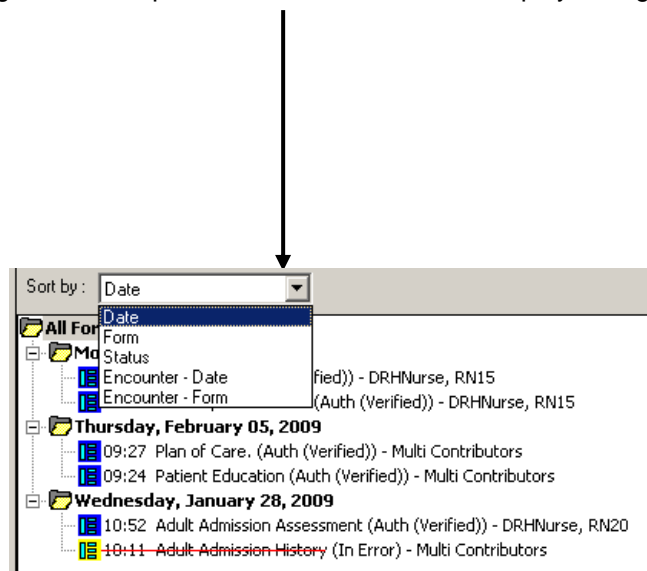
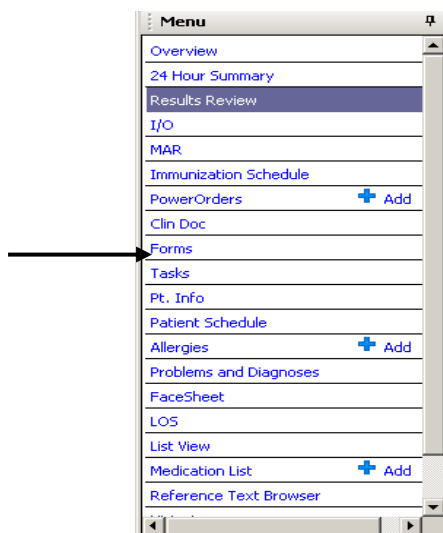
View Documents in the Forms section

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.



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.




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.

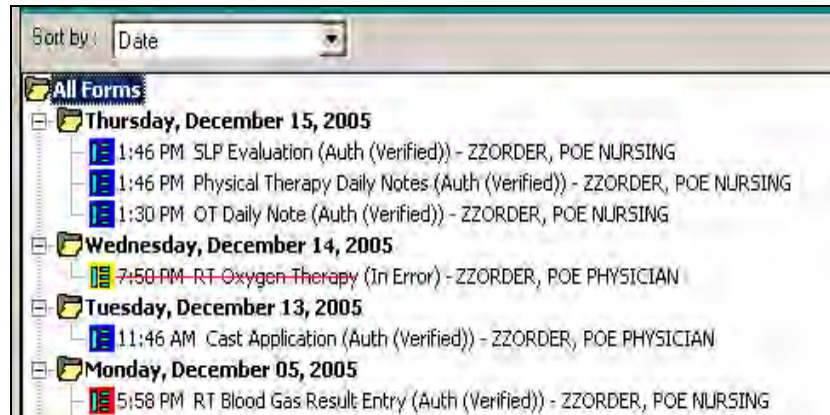

Red: Incomplete



Blue: Complete



Yellow: In Error/uncharted



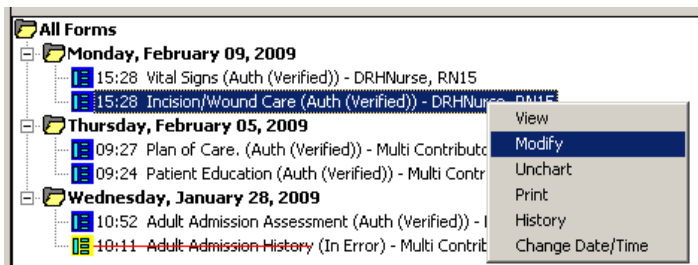
Modify Forms


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**.



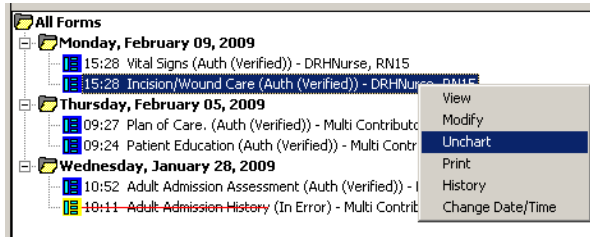
3. Make the necessary changes.
4. When you are finished, click the **Sign Form** icon  to chart the information.
5. Find the form you just modified in Forms. Notice that the status is displayed at the end of the form in parentheses. If the form was saved and not signed, the status will display as (In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

Unchart Results

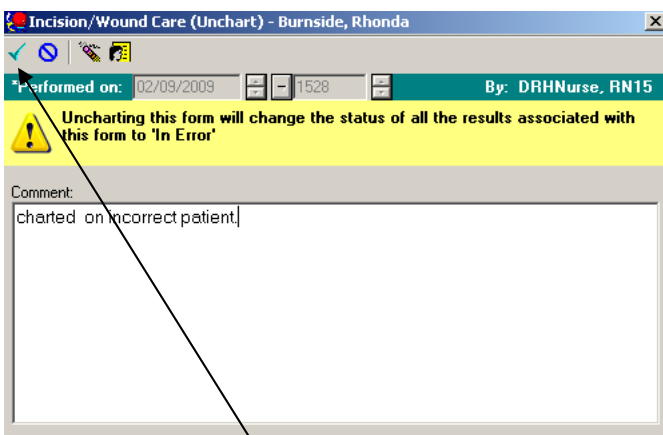
Results that were entered in error, such as charted to the wrong patient, can be uncharted from the original form. An audit trail tracking who uncharted it, and why, is maintained.

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.



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

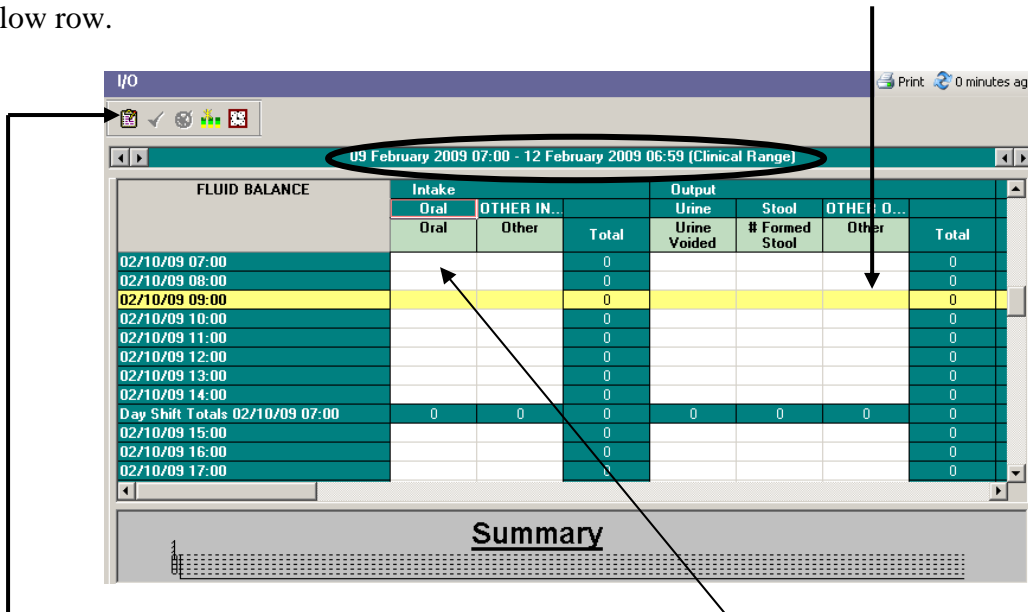
Note: Look in Forms to confirm the form was uncharted. If you do not see the information, remember to refresh the screen by clicking the **refresh icon**. 

Intake and Output

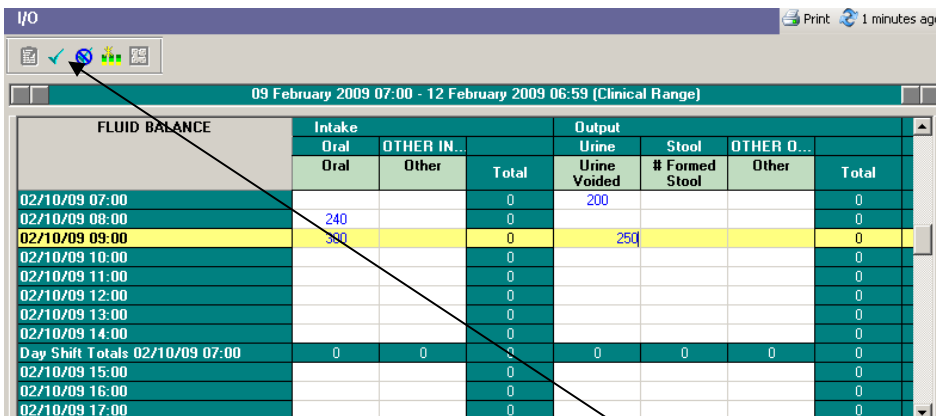
Intake and output is an important element of patient care. I/O should be documented for every patient as the incident occurs or as ordered by the physician.


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.

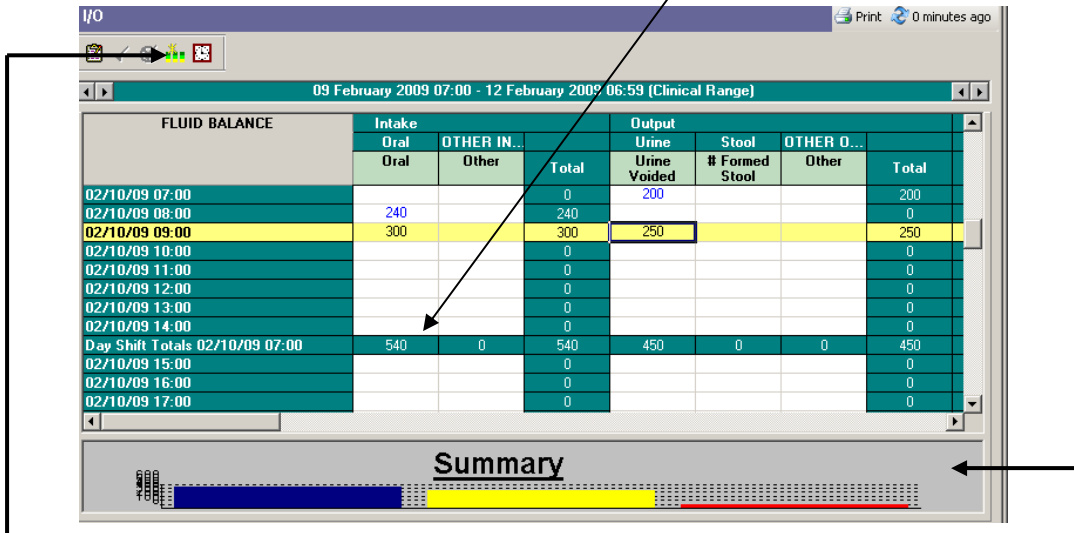



First, click on the start charting icon . Now click in the field and enter the values.

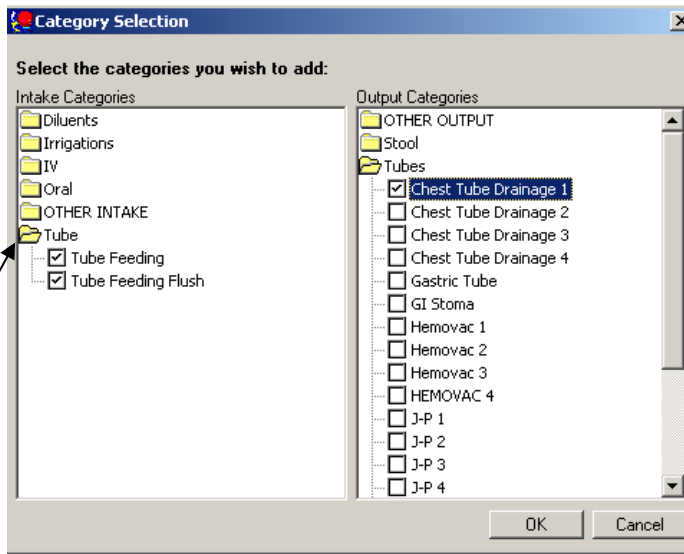


When finished entering all the values click the green checkmark  to sign the documentation.

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.



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 .



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.

Users can only modify their own entries.

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			
02/10/09 09:00	300			
02/10/09 10:00				
02/10/09 11:00				
02/10/09 12:00				
02/10/09 13:00				
02/10/09 14:00				
Day Shift Totals 02/10/09 07:00	540			0
02/10/09 15:00				

Oral

mL

Comments:

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.

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			
02/10/09 09:00	300			
02/10/09 10:00				
02/10/09 11:00				
02/10/09 12:00				
02/10/09 13:00				
02/10/09 14:00				
Day Shift Totals 02/10/09 07:00	540			0
02/10/09 15:00				

Result Uncharting - Jones, Leroy - D-841078459

Oral

Comments:

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

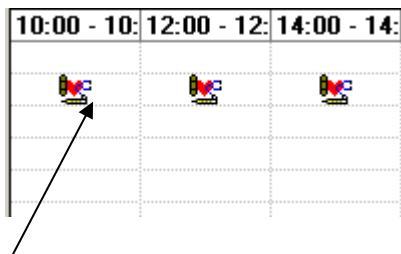
1. Restraint Assessment
2. Restraint Monitoring
3. Restraint Education

Restraint Assessment

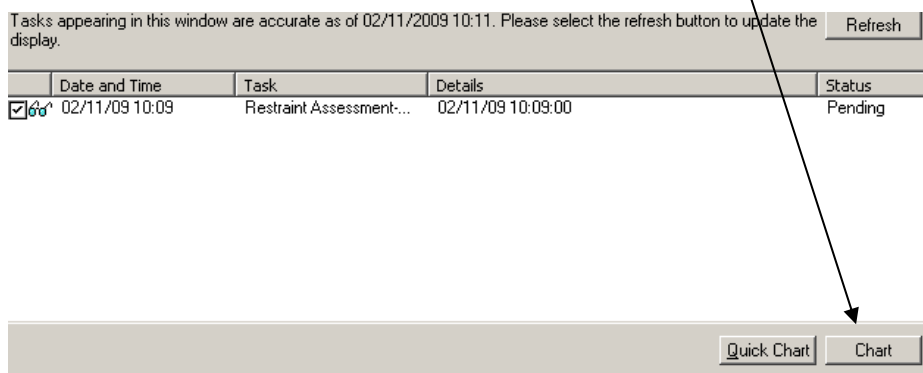
Restraint assessments are completed every two hours and are tasked off from the PAL list. The RN must go in and check the patient every two hours checking for the following things:

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

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



Double click on the icon. Be sure the box in front is checked and click 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/conti section of the PAL. Double click on the icon .

Overdue	PRN/Conti	Current
	 	
	 	
	 	

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

	Date and Time	Task	Details	Status	
<input type="checkbox"/>		PRN	acetaminophen-hydroc...	Start 01/28/09 12:31:00, Routine, 1 Tab, By Mouth...	Pending
<input checked="" type="checkbox"/>		Continuous	Restraint Monitoring/Di...	02/11/09 10:09:00, CONTINUOUS	Pending
			Restraint Monitoring.		

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

Performed on: 02/11/2009 1012

Monitoring

Discontinuation

Education

Basic Interventions For Patient In Restraints

- * Verbal Reminders
- * Exercise/Ambulation/Repositioning
- * Patients allowed to make choices
- * Incontinence
- * Consider relocation of patient
- * Sensory Aids (Glasses, Hearing Aids)

Patient Specific Interventions:

RN documentation of additional interventions initiated (check all that apply)

Treatment	Comfort
<input type="checkbox"/> Wrap/Hide IV sites <input type="checkbox"/> Limit access to tubes and drains <input type="checkbox"/> Alter placement/cover lines/tubes <input type="checkbox"/> IV pole/pump/tubes out of visual field <input type="checkbox"/> Tuck gown in pant bottoms to hide tubes	<input type="checkbox"/> Provide familiar items from home <input type="checkbox"/> Reduce stimuli/intrusions; promote rest <input type="checkbox"/> Position patient for comfort
Diversional	Other
<input type="checkbox"/> Include in activities (e.g., ADL's) <input type="checkbox"/> Repetitive activities <input type="checkbox"/> Music, television <input type="checkbox"/> Give items to hold <input type="checkbox"/> Encourage family involvement/diversion	
Plan Of Care	
<input type="checkbox"/> Continue Restraint Use <input type="checkbox"/> Discontinue Restraint Use	

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.

*Performed on: 02/17/2009 1223

Monitoring
Discontinuation
Education

Education Topics

- Hospital policy regarding use
- Reason for restraint
- Release criteria
- Other:

Individuals Taught

- Patient
- Caregiver(s)
- Daughter(s)
- Friend
- Foster Parent(s)
- Grandchild(ren)
- Grandparent(s)
- Legal Guardian
- Parent
- Son(s)
- Spouse
- Step-parent(s)
- Other:

Barriers to Learning

- None
- Acuity of illness
- Awareness of deficits
- Cognitive deficit
- Cultural barrier
- Desire/Motivation
- Emotional state
- Financial concerns
- Hearing deficit
- Language barrier
- Learning disabled
- Literacy
- Religious
- Speech barrier


Teaching Method

- Audio
- Class
- Computer-assisted
- Demonstration
- Explanation
- Interactive internet
- Practice
- Printed materials
- Telephone
- Verbal
- Video/Educational TV
- Written/Handouts
- Vendor Support
- Other:

Teaching Evaluation

- Met
- Follow-Up Needed
- Teaching Ongoing
- Teaching Deferred
- Other:

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.

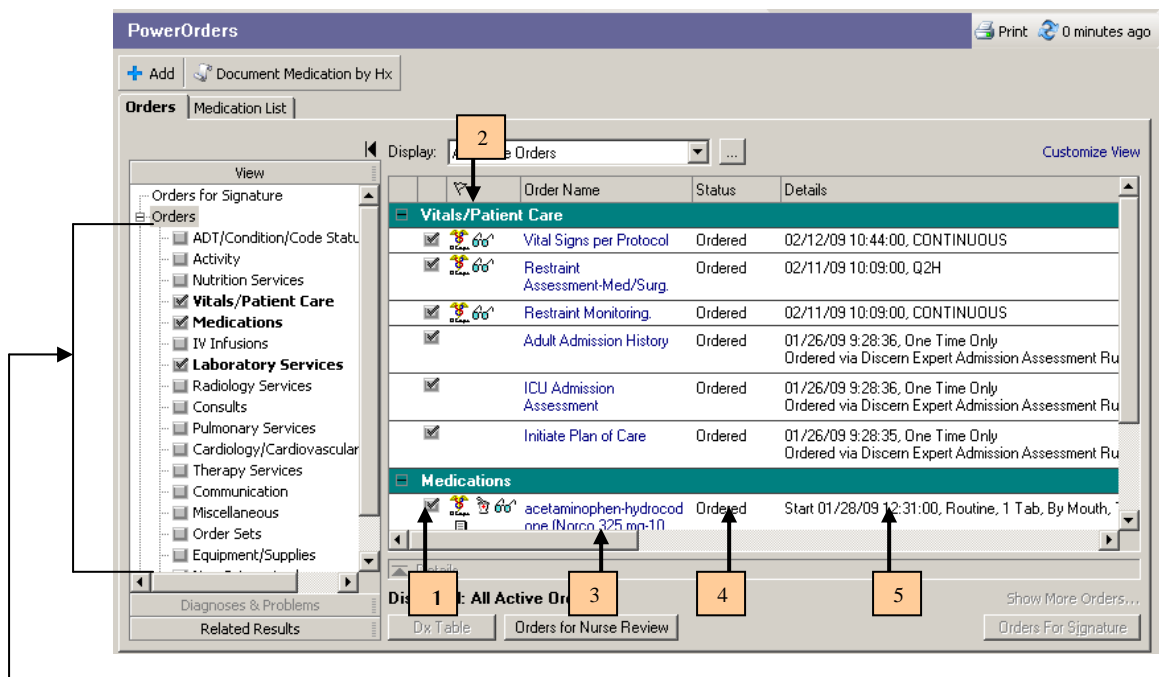
After completing all necessary sections of the form, click the green checkmark  in the top left corner.

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.



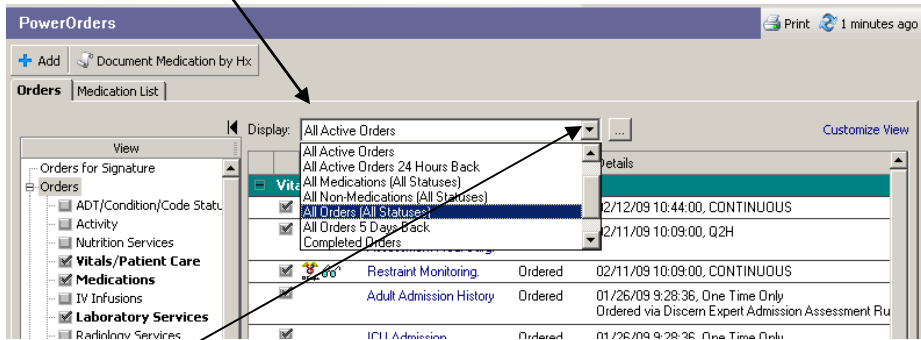
The navigator bar on the left helps move through the orders profile with little scrolling. The bolded sections contain orders. Clicking on a section will bring it to the top of the profile.

Columns of the orders profile window

1. Indicates the order has an active status.
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.

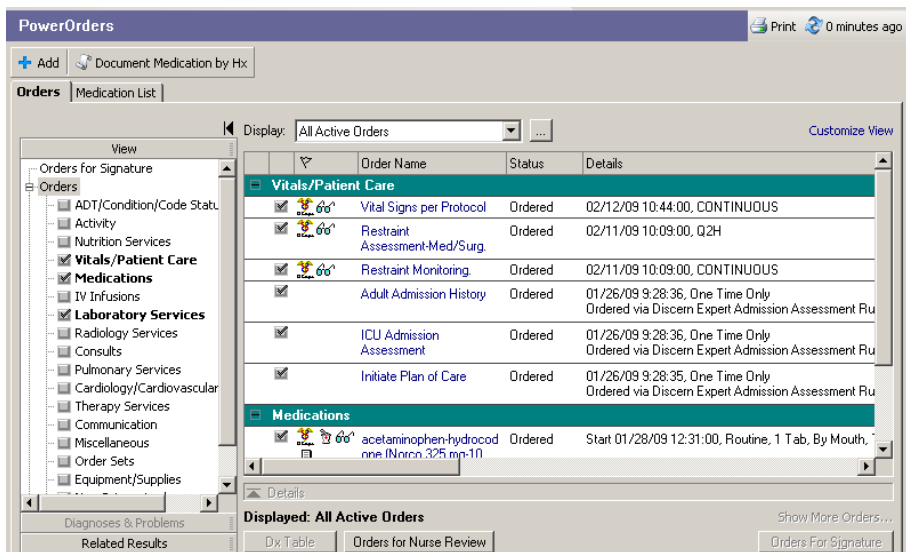
(These icons only display if they apply to the order)
- 3 Order name: Displays orders that were placed below each clinical category
4. Order status: Displays order status. For example, Ordered, Discontinued, Transfer/Canceled, Pending, and Complete.
5. Order details: Displays the details associated with the order.

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



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.



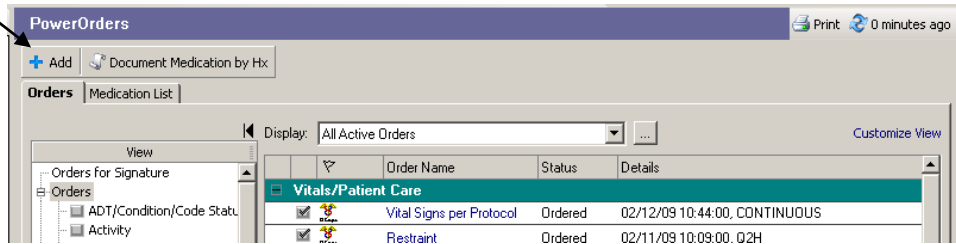
To review these orders, click on the orders for nurse review button at the bottom of the window.



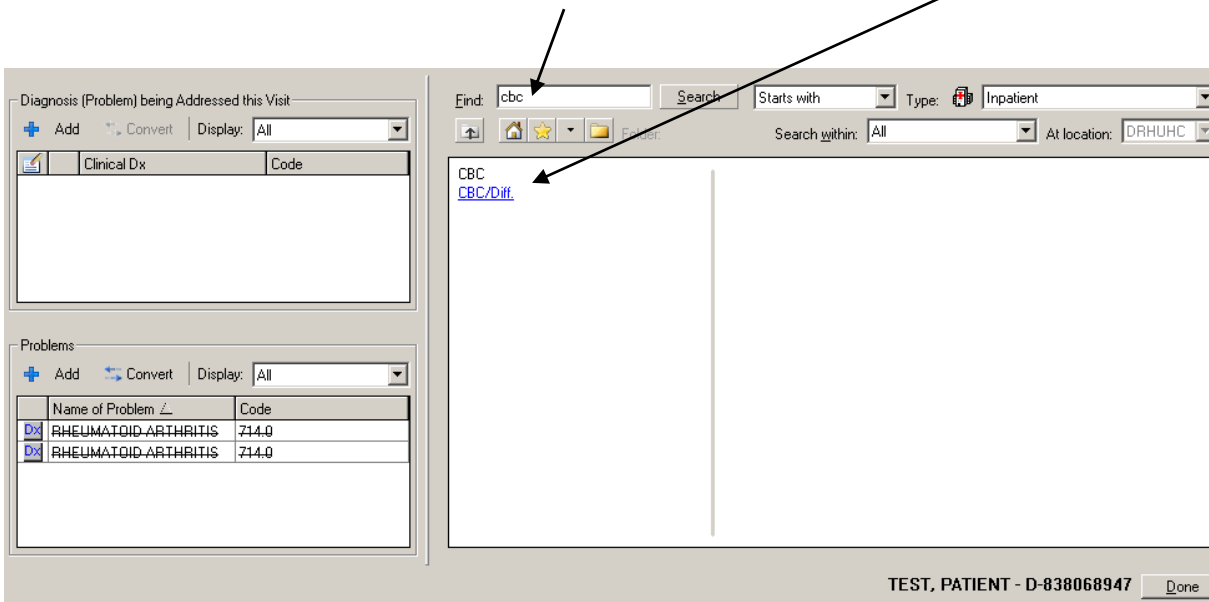
After reviewing the orders, click the review button at the bottom.

Entering Orders

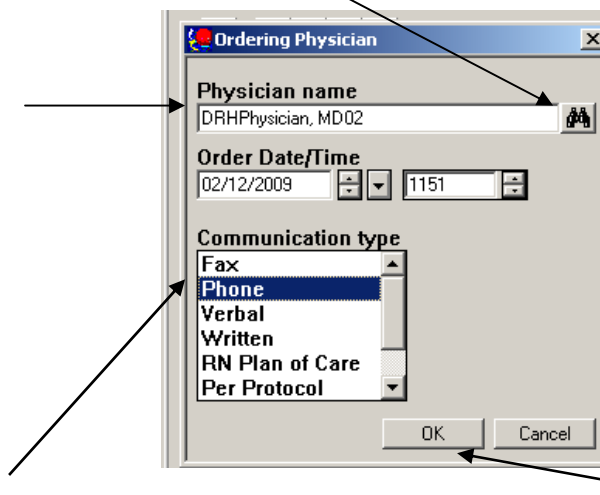
Click on the Power Orders section of the menu bar.
Click the add order icon.



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



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.



Verbal orders are considered a face to face communication and should only be used in emergency situations.

Phone orders are orders given to the nurse over the phone.

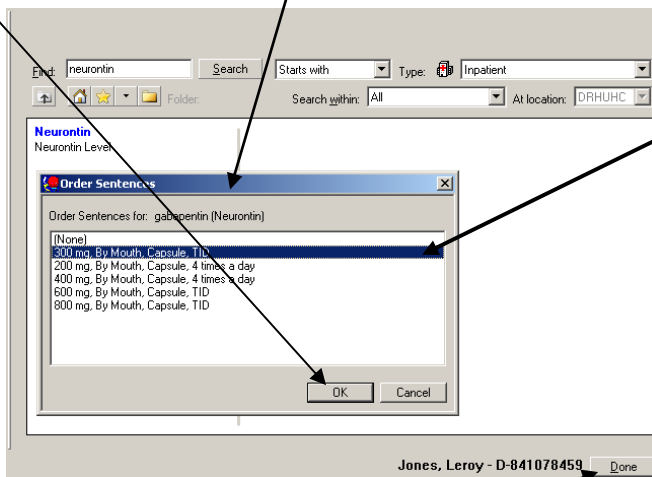
Next, choose a communication type from the list and click OK.

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.

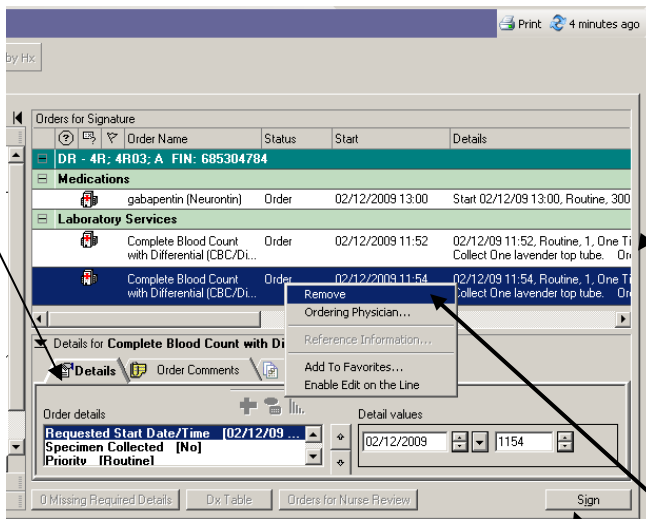
If there are more orders from the same physician you can enter them now.

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

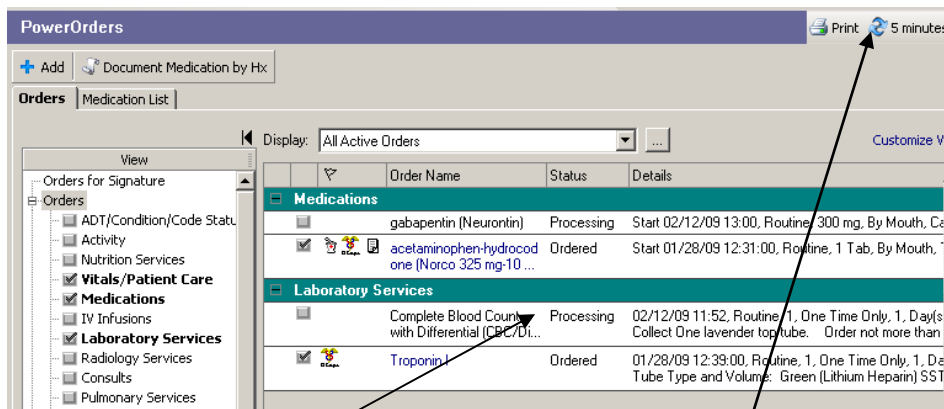



When all orders have been entered, click Done.

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.



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.



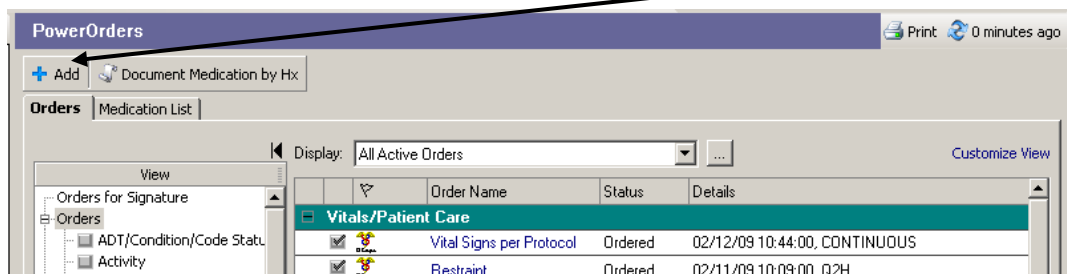
The orders are now in a processing status. Click the refresh icon  to place the orders in an ordered and active status.

Nursing Orders

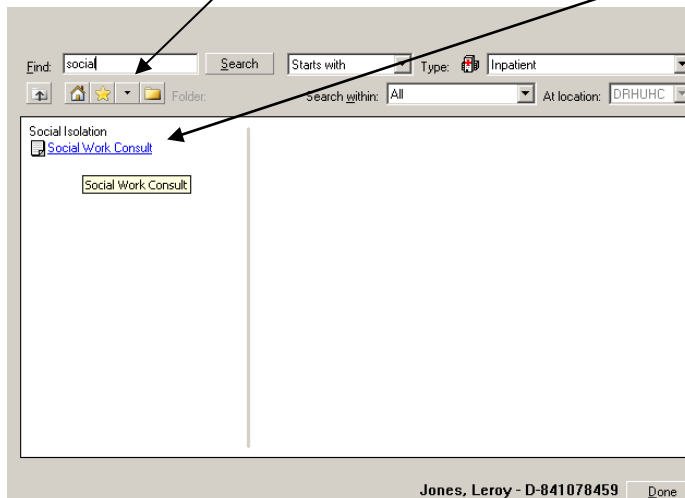
Some orders can be placed by the nurse. They include:

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

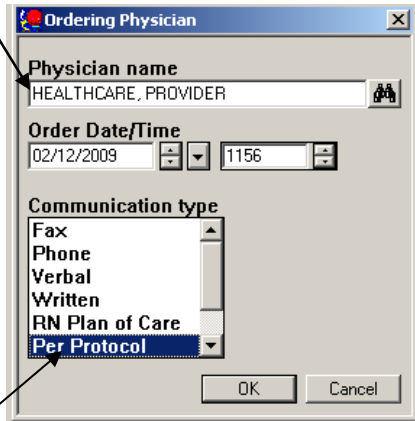
To enter a nursing order click the power orders section of the menu bar, then click **ADD**.



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

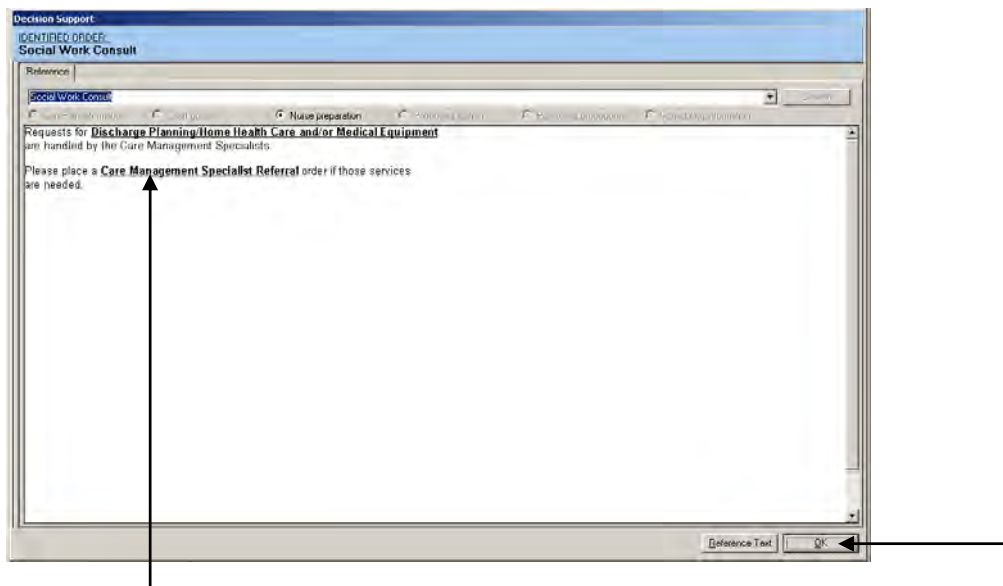


Next the physician name box will display. For nursing orders the physician name is entered as “Healthcare Provider”



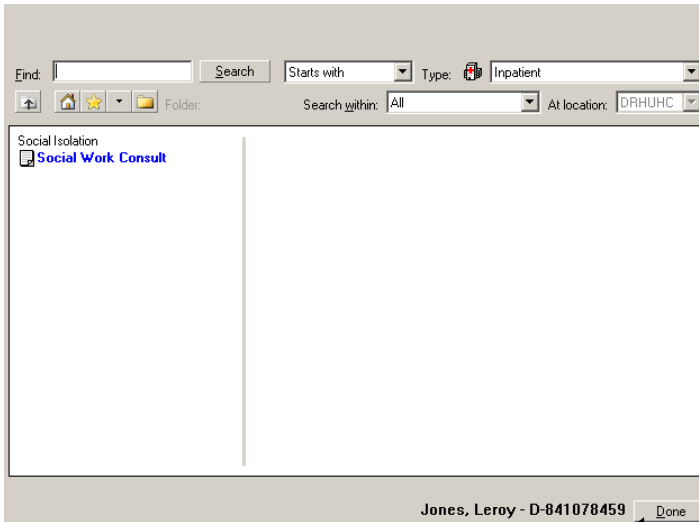
The communication type for most nursing orders should be per protocol since policy allows nurses to enter the orders.

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




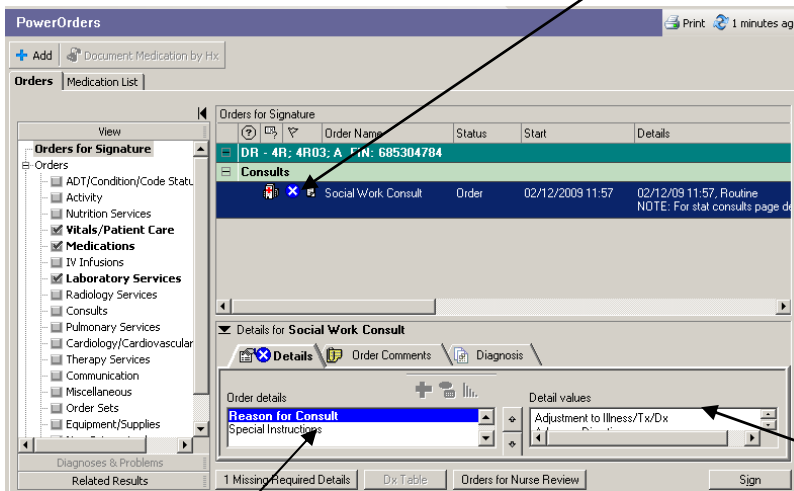
This box is giving you information to help you make a decision. It is letting you know what things require a social work consult and which would require a CMS consult, since they are often confused. After reading the information, click OK. If you have entered the wrong consult by mistake you can remove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

Now you are returned to your order window.



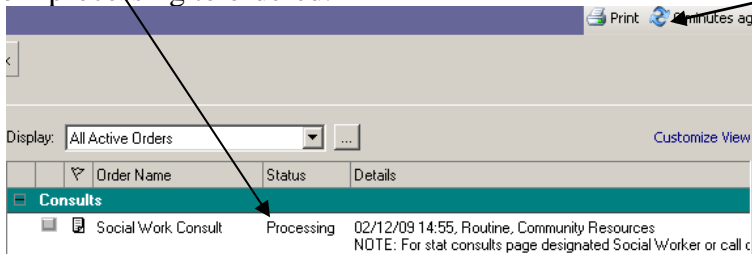
Enter any other nursing orders, when finished click Done.

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



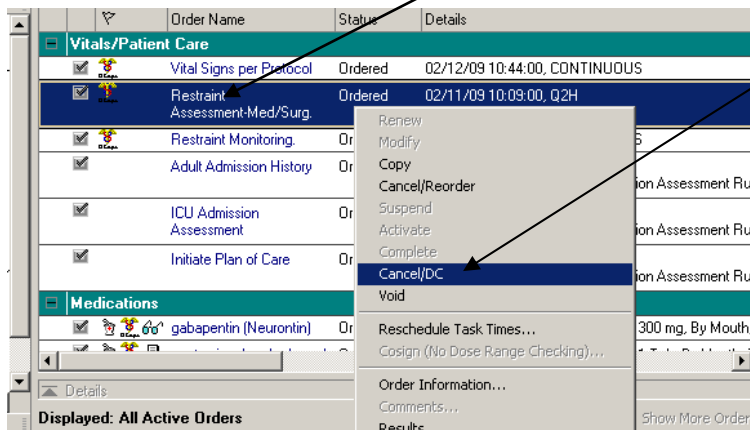
Click on the required field on the left side, and then select the appropriate details from the list on the right.

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.

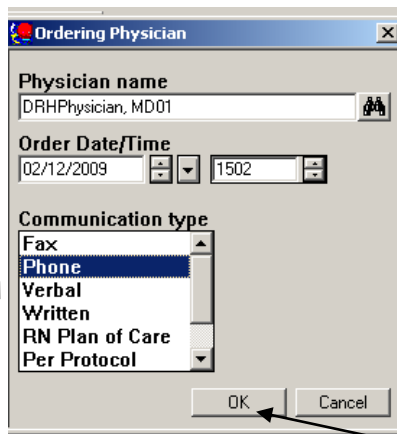


Discontinuing Orders

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

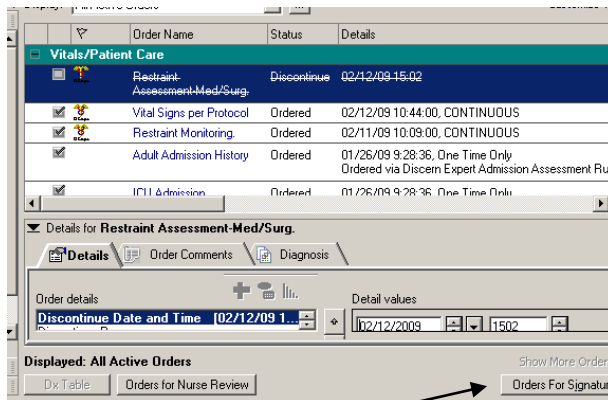


Again, the physician name box will appear. Enter the physician's name that authorized the discontinuation.

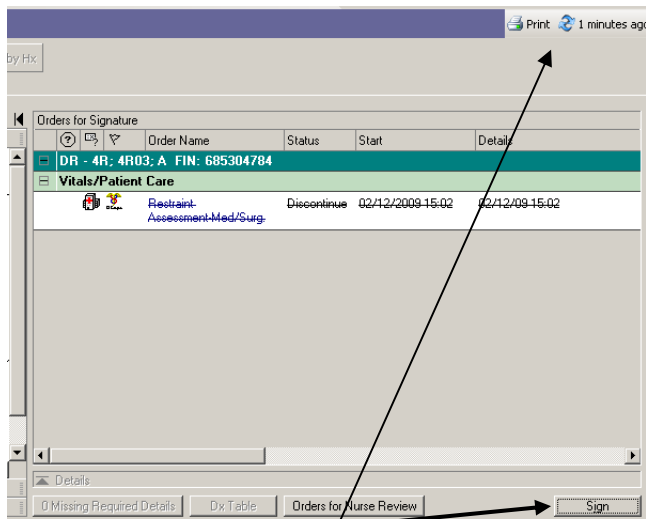


Enter the appropriate communication type and click OK.

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



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

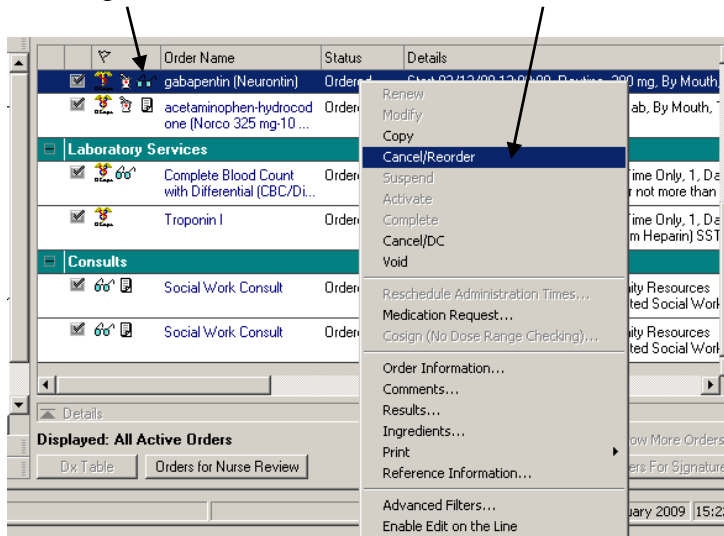


Next, click Sign. Remember to refresh. The order will now display as discontinued in the orders profile.

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.



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

Ordering Physician

Physician name
DRHPhysician, MD01

Order Date/Time
02/12/2009 1523

Communication type
Fax
Phone
Verbal
Written
RN Plan of Care
Per Protocol

OK Cancel

Enter the appropriate communication type and click OK.

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

Order Name Status Details

Medications

gabapentin (Neurontin)	Order	Start 02/12/09 17:00, Routine, 300 mg, By Mouth, Ca
gabapentin (Neurontin)	Discontinue	02/12/09-15:23
acetaminophen-hydrocodone (Norco 325 mg-10 ...)	Ordered	Start 01/28/09 12:31:00, Routine, 1 Tab, By Mouth, 1

Laboratory Services

Complete Blood Count with Differential (CBC/Di...	Ordered	02/12/09 11:52:00, Routine, 1, One Time Only, 1, De Collect One lavender top tube. Order not more than
---	---------	---

Details for gabapentin (Neurontin)

Remaining Administrations: (Unknown) Stop: (Unknown)

Order details

Displayed: All Active 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.

Orders for Signature

DR - 4R: 4R03, A FIN: 685304784	Status	Start	Details
---------------------------------	--------	-------	---------

Medications

gabapentin (Neurontin)	Discontinue	02/12/2009-13:00	02/12/2009-15:23
gabapentin (Neurontin)	Order	02/12/2009 17:00	Start 02/12/09 17:00, Rou

Details for gabapentin (Neurontin)

Remaining Administrations: (Unknown) Stop: (Unknown)

Order details

Start 02/12/09 17:00 Requested Start Date/Time

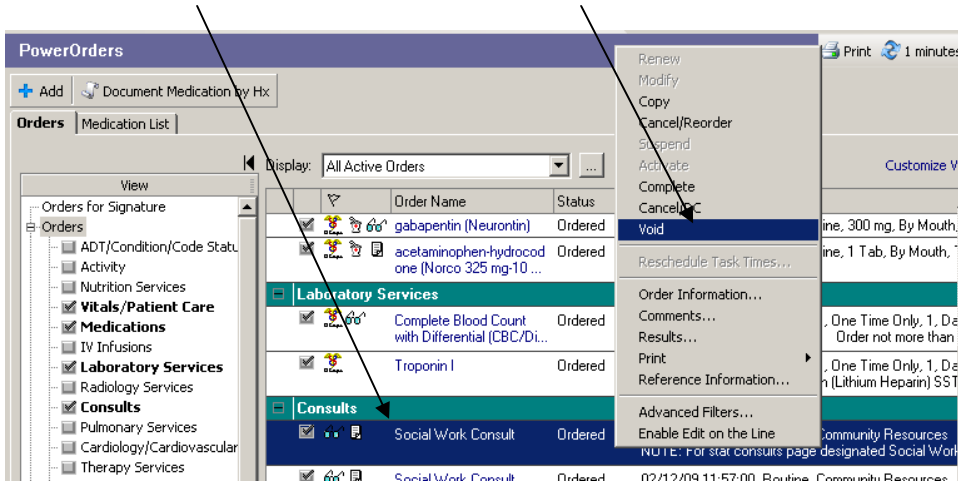
0 Missing Required Details Dx Table Orders for Nurse Review Sign

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

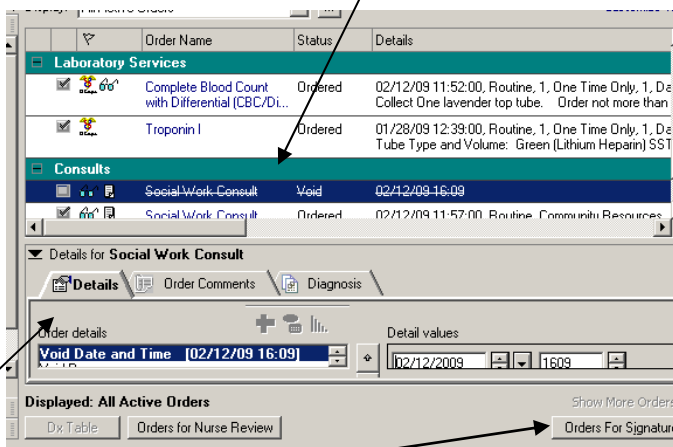
Voiding Orders

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.

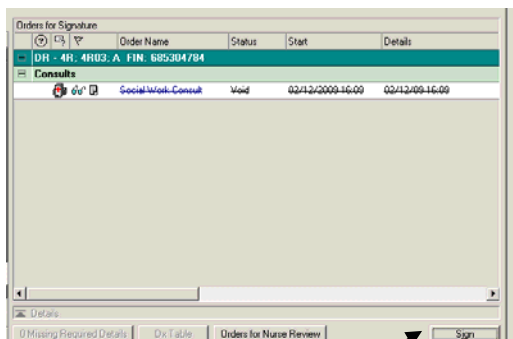
To void an order, right-click on the order and select **Void**.



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



Complete any necessary details. Click the “**Orders For Signature**” at the bottom.



Sign the order and refresh the screen.

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

The screenshot shows the MAR interface for the period of 15 February 2009 09:54 to 17 February 2009 09:54. The interface includes a 'Time View' sidebar with categories: Scheduled, Unscheduled, PRN, and Continuous Infusions. The main table displays medication orders with columns for dates and times. Callouts identify key features: 'Scheduled dose' points to a yellow cell; 'Current date/time' points to the active date column; 'Overdue dose' points to a red cell; 'Discontinued med' points to a greyed-out row; 'Navigator bar' points to the sidebar; and 'Medication details' points to the expanded view of an acetaminophen order.

Medications	02/15/09 17:00	02/16/09 09:00	02/16/09 09:56	02/16/09 12:00
insulin aspart CBG-Nursing				
metoprolol Start 01/26/09 17:00:00, Routine, 25 mg, By Mouth, Tab, BID	25 mg	25 mg		
metoprolol Systolic Blood Pressure				
Diastolic Blood Pressure				
Monitored HR				
ranitidine Start 01/26/09 17:00:00, Routine, 150 mg, By Mouth, Tab, BID	150 mg	150 mg		
ranitidine				
PRN acetaminophen (Tylenol) Start 02/16/09 9:56:00, Routine, 1000 mg, By Mouth, Tab, Q6, PRN, Pain			1,000 mg Not previously given	
acetaminophen Pain Scale Score				

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


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

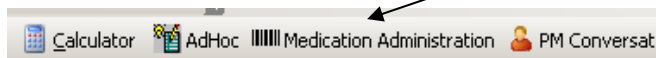
Medication Scanning

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

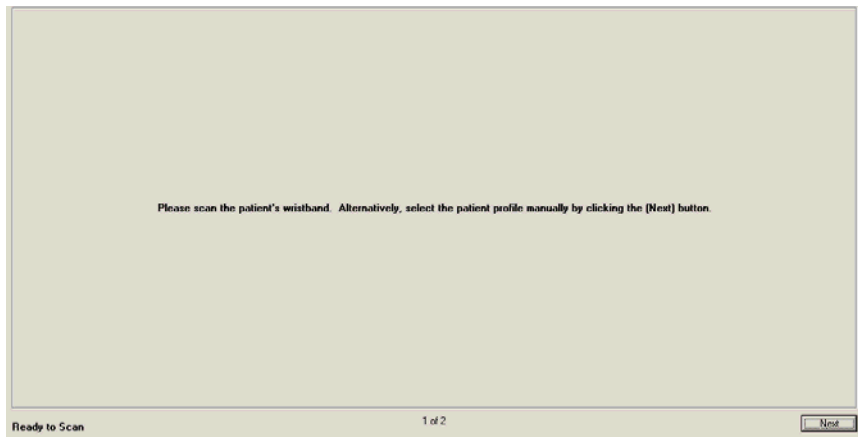
Proceed to the patient's room with scanning device in tow.

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
<input type="checkbox"/>	02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
<input type="checkbox"/>	02/16/09 09:00	furosemide furosemide (Lasix)	Start 02/16/09 9:00:00, 40 mg, IV PUSH, Injection	
<input type="checkbox"/>	02/16/09 09:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
<input type="checkbox"/>	02/16/09 09:00	metoprolol	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
<input type="checkbox"/>	02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
<input type="checkbox"/>	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...	
<input type="checkbox"/>	02/16/09 17:00	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...	
<input type="checkbox"/>	02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
<input type="checkbox"/>	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.

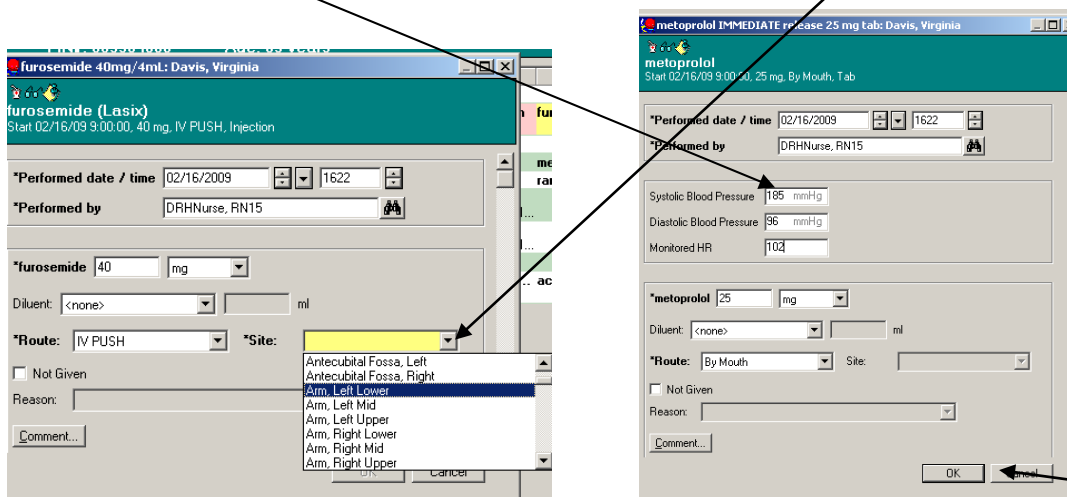
	Scheduled	Mnemonic	Details	Result
<input type="checkbox"/>	02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	02/16/09 09:00	furosemide furosemide (Lasix)	Start 02/16/09 9:00:00, 40 mg, IV PUSH, Injection	furosemide 40 mg, IV PUSH
<input type="checkbox"/>	02/16/09 09:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	02/16/09 09:00	metoprolol	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	metoprolol 25 mg, By Mouth
<input checked="" type="checkbox"/>	02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	ranitidine 150 mg, By Mouth
<input type="checkbox"/>	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...	
<input type="checkbox"/>	02/16/09 17:00	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...	
<input type="checkbox"/>	02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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  indicates there are required fields to be completed before signing the medication.

The  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.



Click OK when done.

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

	Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/>	02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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
<input checked="" type="checkbox"/>	02/16/09 09:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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
<input checked="" type="checkbox"/>	02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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...	
<input checked="" type="checkbox"/>	02/16/09 17:00	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...	
<input checked="" type="checkbox"/>	02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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.

ranitidine
Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab

*Performed date / time 02/16/2009 1623

*Performed by DRH Nurse, RN15

*ranitidine 150 mg

Diluent: <none> ml

*Route: By Mouth Site:

Not Given

*Reason

- No Blood Return
- Order Being Clarified
- Order Changed
- Patient nauseated
- Patient Not Available
- Patient NPO
- Patient Refused
- Patient Sedated

Comment

Cancel

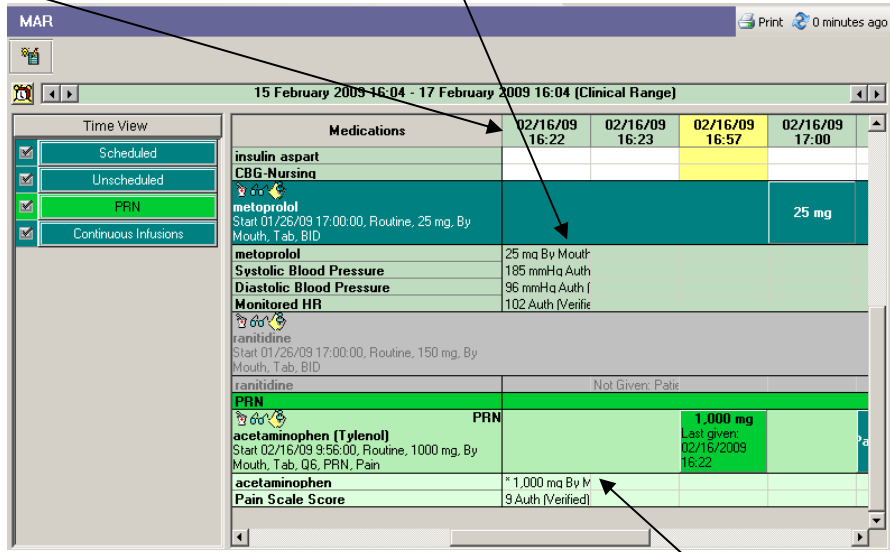
Choose the reason the medication was not given from the drop down menu and click OK.

	Scheduled	Mnemonic	Details	Result
<input checked="" type="checkbox"/>	02/16/09 09:00	digoxin	Start 02/16/09 9:00:00, 0.125 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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
<input checked="" type="checkbox"/>	02/16/09 09:00	hydrochlorothiazide	Start 02/16/09 9:00:00, 25 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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
<input checked="" type="checkbox"/>	02/16/09 09:00	ranitidine	Start 02/16/09 9:00:00, 150 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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...	
<input checked="" type="checkbox"/>	02/16/09 17:00	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...	
<input checked="" type="checkbox"/>	02/16/09 17:00	metoprolol	Start 02/16/09 17:00:00, 25 mg, By Mouth, Tab	
<input checked="" type="checkbox"/>	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

Ready to Scan 2 of 2 Back Sign

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.



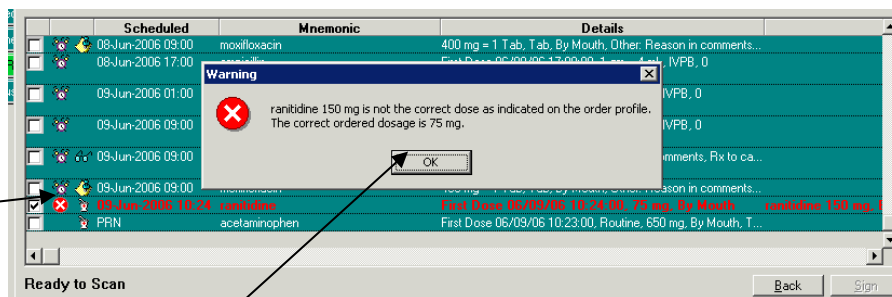
The PRN medications that are given are listed the same as other medications. However, they are also still listed in the current date/time column and ready to be given again. This column will list the last time the PRN medication was given. The RN must read the medication details to determine if it is 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  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.

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
<input type="checkbox"/>	08-Jun-2006 09:00	moxifloxacin	400 mg = 1 Tab, Tab, By Mouth, Other: Reason in comme...
<input type="checkbox"/>	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.
<input type="checkbox"/>	09-Jun-2006 01:00	ampicillin	First Dose 06/09/06 1:00:00, 1 gm = 4 mL, IVPB, 0 RT - Stable 8hrs. Refrigerated stable 72hrs.
<input type="checkbox"/>	09-Jun-2006 09:00	ampicillin	First Dose 06/09/06 9:00:00, 1 gm = 4 mL, IVPB, 0 RT - Stable 8hrs. Refrigerated stable 72hrs.
<input type="checkbox"/>	09-Jun-2006 09:00	micafungin micafungin + Sodium Chloride 0.9% 100 mL	150 mg = 15 mL, IVPB, Other: Reason in comments, Rx to...
<input type="checkbox"/>	09-Jun-2006 09:00	moxifloxacin	400 mg = 1 Tab, Tab, By Mouth, Other: Reason in comme...
<input type="checkbox"/>	09-Jun-2006 10:24	ranitidine	First Dose 06/09/06 10:24:00, 75 mg, By Mouth
<input checked="" type="checkbox"/>	PRN	acetaminophen	First Dose 06/09/06 10:23:00, Routine, 650 mg... acetaminophen 325 mg, By

Ready to Scan 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**.

The screenshot shows the MAR interface with a table of medications. A right-click context menu is open over the 'digoxin' entry for 02/18/09 07:48. The menu options are: View Details..., View Comments..., View Order Info..., Add Comment..., Modify..., and Unchart... (highlighted in blue). The table columns are labeled with dates and times: 02/18/09 07:41, 02/18/09 07:48, 02/18/09 07:49, and 02/18/09 08:00. The medication entry for digoxin includes the text 'Start 01/27/09 9:00:00, Routine, 0.125 mg, By Mouth, Tab, Daily'.

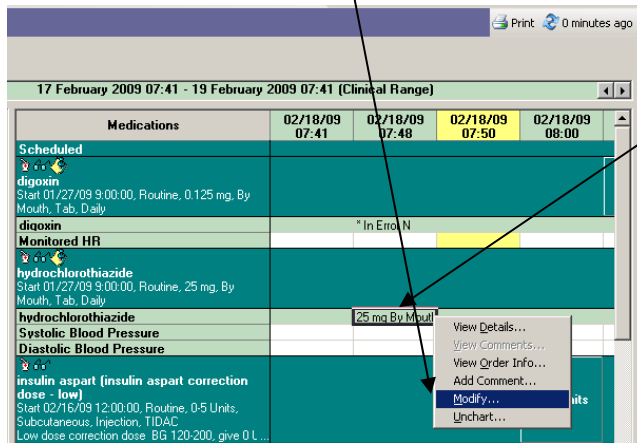
Enter a reason for uncharting in the comment box.

The dialog box shows the 'Performed on' date as 02/18/2009 and the user as 'By: DRHNurse, RN15'. A yellow warning banner states: 'Uncharting this form will change the status of all the results associated with this form to 'In Error''. Below this is a 'Comment:' text area containing the text 'dropped on floor'. At the top left of the dialog are icons for a checkmark, a red X, a pencil, and a trash can.

Then, click the green 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**.



Enter the necessary changes.

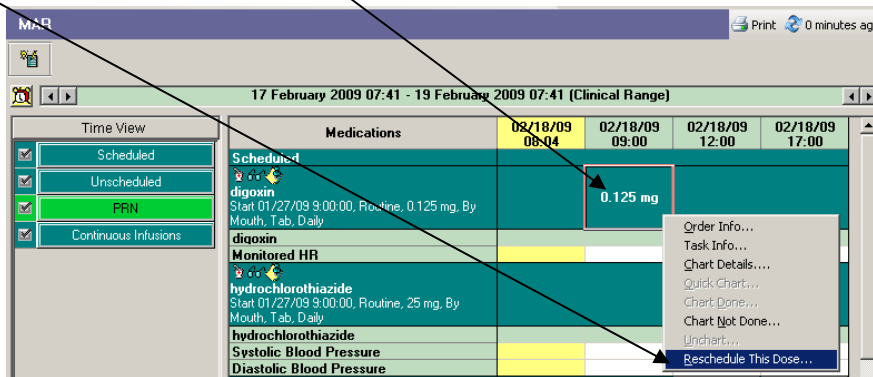
The screenshot shows the 'hydrochlorothiazide' medication modification form. At the top left, there is a green checkmark icon. The form includes the following fields:

- hydrochlorothiazide** (medication name)
- Start 02/18/09 9:00:00, 25 mg, By Mouth, Tab
- *Performed date / time**: 02/18/2009 0748
- *Performed by**: DRHNurse, RN15
- Systolic Blood Pressure: [] mmHg
- Diastolic Blood Pressure: [] mmHg
- *hydrochlorothiazide**: 25 mg
- Diluent: <none> ml
- *Route**: By Mouth Site: []
- Not Given
- Reason: []
- Comment: []

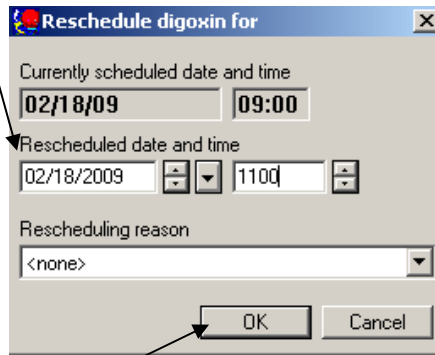
Then click the green checkmark  to sign the form.

Reschedule a Medication

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



Enter the new date and time for the medication.



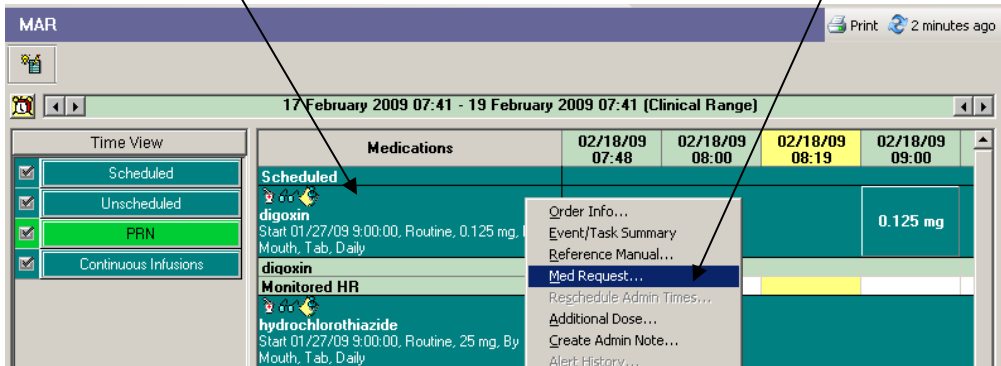
Then, click OK.

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

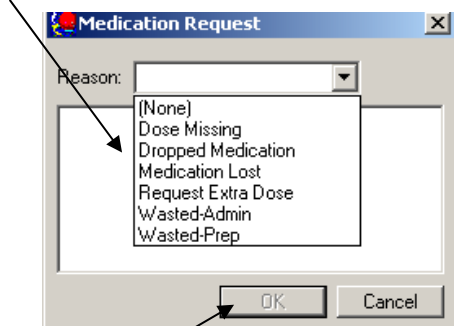
Requesting a Medication

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

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



Select a reason for the request from the list.



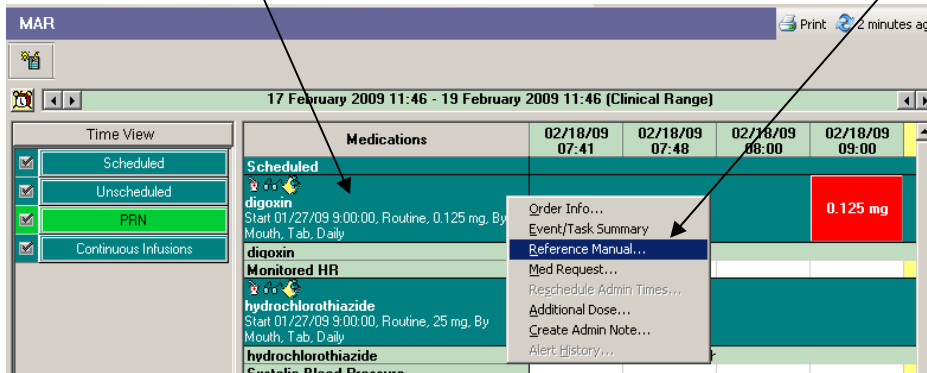
Then, click OK.

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.

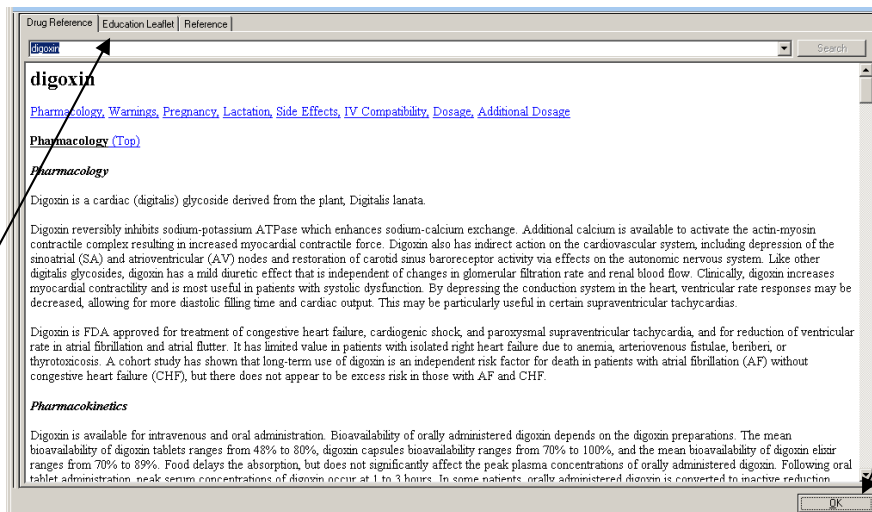
Reference Manual and Education Leaflets

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.

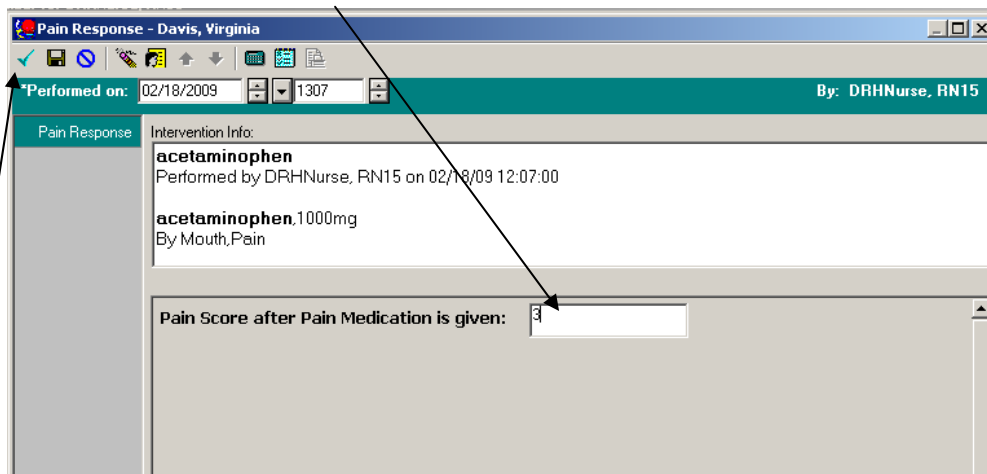
Pain Response

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	
 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 Verific

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



Then, click the green checkmark  to sign the form.

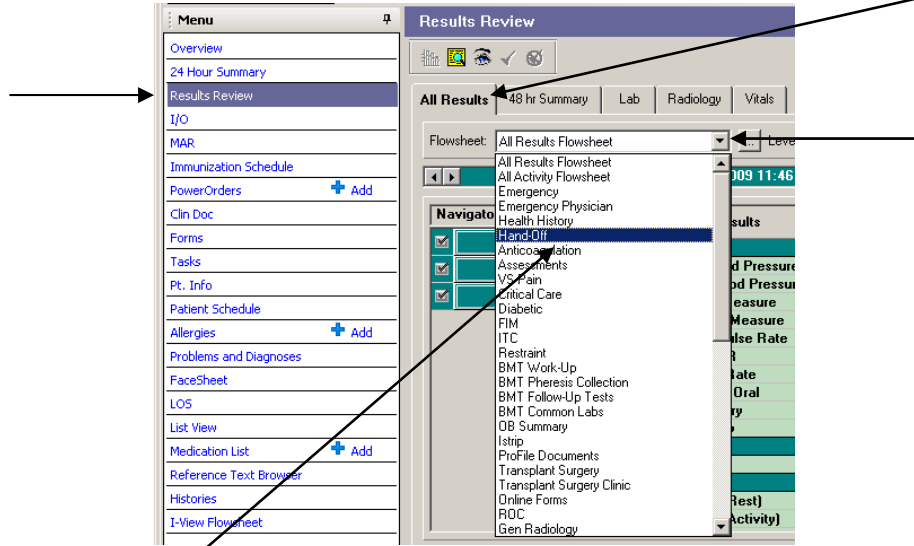
NOTE: Pain should be re-assessed after 30 minutes for any IV medications given and after 60 minutes for any oral medications given.

Handoff Communication

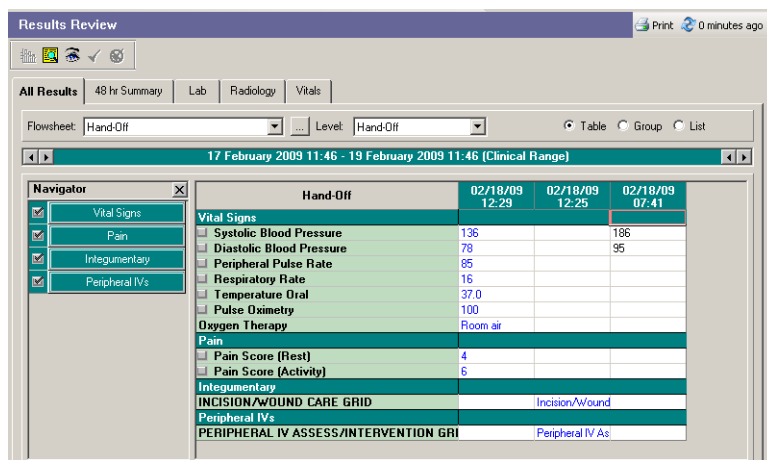
When giving or receiving report, the nurse must use the information in the EMR. Using the EMR gives the nurse the opportunity to ask questions as well as making sure all tasks have been completed before transfer of care.

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.



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


Please find the monitor card on PCLA device for instructions to login into PCLA.

Instruction for PowerChart Local Access (PCLA) for Downtime Only

Username: _____

Password: _____

How to Access PCLA:

Step 1: Double-click on the DT Viewer icon on the Desktop. 

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 your 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 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.

NOTE: PCLA is a **View Only** application. No changes can be made nor orders entered into CIS. The list of patients and results appear in alphabetical order and the list cannot be sorted.

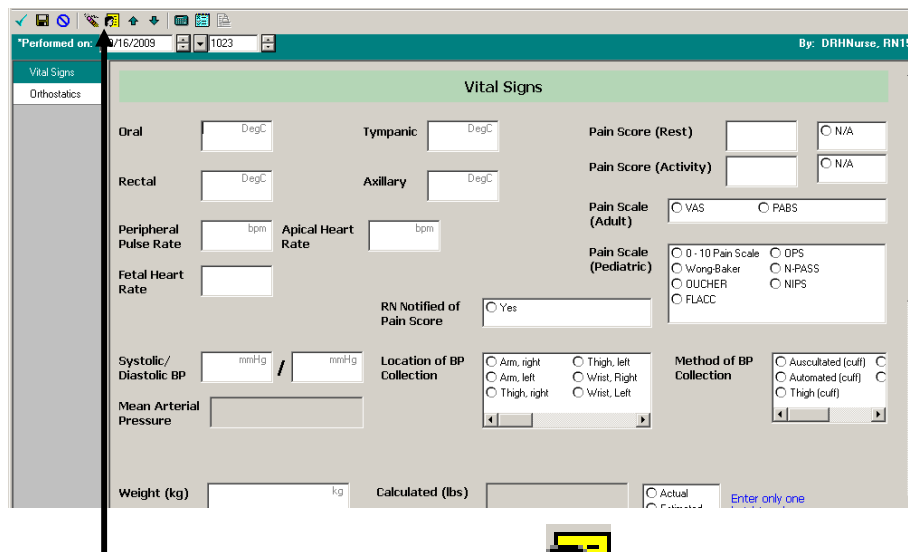
If you encounter any problem please call the **Help Desk** at 313-966-2400. Make sure to mention in the help desk ticket that you are using PCLA to expedite your problem.

Transcribing Documentation By Proxy

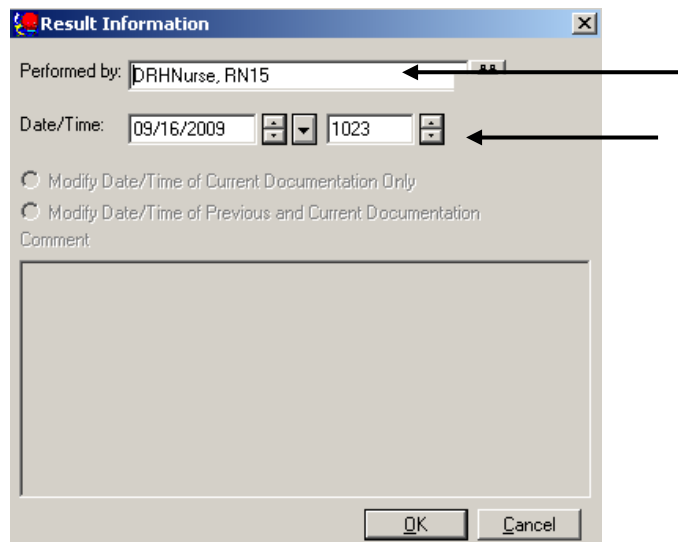
If you are completing your own documentation, you would complete the items as you would normally. Only the date/time section would need to be changed.

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.

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



2. Click on the Results Information icon .



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.

Medications	09/16/09 09:00	09/16/09 11:00	09/16/09 17:00	09/17/09 09:00
Scheduled				
lisinopril Start 09/16/09 9:00:00, Routine, 10 mg, By Mouth, Tab, Daily	10 mg			10 mg
lisinopril Systolic Blood Pressure				
lisinopril Diastolic Blood Pressure				
ranitidine (Zantac) Start 09/16/09 11:00:00, Routine, 150 mg, By Mouth, Tab, BID		150 mg	150 mg	150 mg
ranitidine				
sertraline (Zoloft) Start 09/16/09 11:00:00, Routine, 25 mg, By Mouth, Tab, Daily		25 mg		25 mg
sertraline				

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

ranitidine (Zantac)
Start 09/16/09 11:00:00, 150 mg, By Mouth, Tab

*Performed date / time: 09/16/2009 1100

*Performed by: DRHNurse, RN15

*ranitidine: 150 mg

Diluent: <none> ml

*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.