

Chart*Smart* EMR User's Manual

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Logging In



The login screen for ChartSmart emr features a red header with the logo and title. Below the header, a blurred background image of a hospital hallway is visible. The login form includes a checkbox for 'I Am A Patient', input fields for 'Employee ID' (containing 'fnightingale1') and 'Password' (masked with dots), and a red 'LOG IN' button. A 3D nurse icon is on the left, and the 'Nursing' label is at the bottom left. The 'Custom Software Systems' logo is at the bottom right.

Please Login with your Employee ID and Password

I Am A Patient: ☐

Employee ID:

Password:

LOG IN

Nursing

Custom Software Systems

To log in: The Employee ID will consist of letters and numbers. The password must be at least six characters in length, will require one capital letter and at least one number.

Enter user login, type in the password, and click the Log In button. An error entering the password will create the following message:

Invalid credentials: -3 attempts left out

The system allows three attempts to enter the password correctly. If entered incorrectly three consecutive times, the system will place a lock on the account and a hospital or system administrator must unlock it before continuing.

Successful log in will take user to the Patient Selection screen.

Patient Selection

Patients may be selected by department or by Look Up.

The screenshot shows the 'Patient Selection' window. At the top, there are tabs for 'Patient Selection', 'Facility Maintenance', 'Care Giver Maintenance', and 'Change Hospital'. Below these are sub-tabs for 'AD HOC Query', 'Clinical Quality Measure', and 'MU Calculations'. The user 'Joe test Smith' is logged in, with a 'LOG OUT' button. The 'Select Department' dropdown is set to 'Medical Surgery'. The 'or Look Up' dropdown is set to '<--Select Search Option-->'. A 'Search' button is visible. Below the search area, the 'Patient List: Medical Surgery' is displayed as a table with checkboxes for each patient.

Check	LAST NAME	FIRST NAME	Room #	DOB	Primary Dx	Select for Removal
<input type="checkbox"/>	ANDERSON	ALLEN				
<input type="checkbox"/>	ABRAMCZYK	ANN				
<input type="checkbox"/>	ENRIGHT	ANN L				
<input type="checkbox"/>	LAMPHERE	ANTHONY M				
<input type="checkbox"/>	KELLY	BENJAMIN				
<input type="checkbox"/>	CRAFT	BETTY				
<input type="checkbox"/>	MORENUS	CATHERINE				
<input type="checkbox"/>	GUNSET	CECILE E				

At the bottom of the patient list, there are three buttons: 'Add to My Patient List', 'My Patients', and 'Empty Rooms'.

To Search by Department: Access a department via the drop down list. Click on the department and a list of all patients currently in that department will appear in the Patient List.

To create a Patient List: Select patient name(s) via the Patient List and click “Add to My Patient List.”

The screenshot shows the 'Patient Selection' window with the 'My Patient List' tab selected. The 'Select Department' dropdown is set to '<--Please Select Department-->'. The 'or Look Up' dropdown is set to '<--Select Search Option-->'. A 'Search' button is visible. Below the search area, the 'My Patient List' is displayed as a table with columns for LastName, FirstName, Room #, DOB, Primary Dx, and Select for Removal. The table contains six rows of patient data.

LastName	FirstName	Room #	DOB	Primary Dx	Select for Removal
ABAJIAN HULICK	DARLEEN		01/01/1994		<input type="checkbox"/>
ALPAUGH	ROBERT F		09/03/1937		<input type="checkbox"/>
ANDERSON	ALLEN		06/11/2008		<input type="checkbox"/>
ASHER	BRYNNA		1/11/1994		<input type="checkbox"/>
BLINEBRY	BRIANNA		06/07/2001		<input type="checkbox"/>
BONE	BEVERLY A		03/03/1939		<input type="checkbox"/>

At the bottom of the patient list, there is a button: 'Remove From My Patient List'.

All patient names chosen will populate onto this list. Each subsequent login will default to the created list.

To remove a patient from the list: Select the name of the patient and then click “Remove from My Patient List.”

LastName	Firstname	Room #	DOB	Primary Dx	Select for Removal
ABAJIAN HULICK	DARLEEN		01/01/1994		<input checked="" type="checkbox"/>
ALPAUGH	ROBERT F		09/03/1937		<input checked="" type="checkbox"/>
ANDERSON	ALLEN		06/11/2008		<input type="checkbox"/>
ASHER	BRYNNA		1/11/1994		<input type="checkbox"/>
BLINEBRY	BRIANNA		06/07/2001		<input type="checkbox"/>
BONE	BEVERLY A		03/03/1939		<input type="checkbox"/>

Remove From My Patient List

To Search by Look Up:

Click on the drop down list to select the search option.

or Look Up

- Name
- <--Select Search Option-->
- Name
- Visit Number
- DOB
- MRN
- SSN

Complete the information and click Search.

or Look Up

Name

Anderson

Search

Click on selection box and then “Add to My Patient List” to complete your unique patient list.

Selection	Lastname	Firstname	Room #	DOB	Primary Dx
<input type="checkbox"/>	ANDERSON	ALLEN		06/11/2008	

Basic ChartSmart Functions

ChartSmart is a very easy and user-friendly system of electronic documentation and order entry. Throughout the system there are drop-down boxes, text boxes, check boxes and radial buttons.

Drop-Down Boxes

To use the drop down function, click on the down arrow located to the right of the box and highlight the choice. If a choice is made in error, repeat the step and click on the correct choice.

Admission Data

Admitted From < Select >

Arrived < Select >

Admission Data

Admitted From < Select >

Arrived < Select >

Information

Clinic Emergency Department

Doctor's Office

Text Boxes

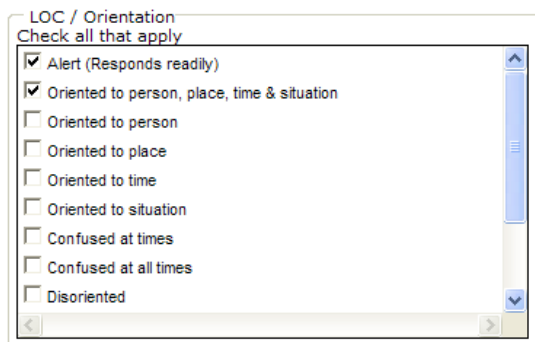
Text boxes are available to add more specific information on a patient. Text boxes have infinite character storage so narratives are not limited. A scroll bar will appear once a certain amount of space has been populated.

CNS Notes:

Pt c/o headache on exertion.

Checkboxes and Radio Buttons

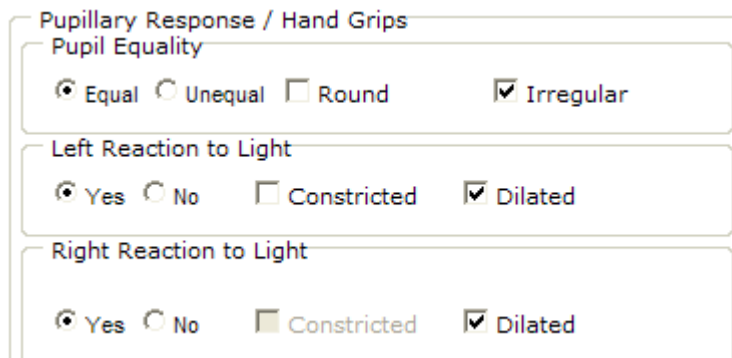
Checkboxes are quick and easy ways to document assessments and treatments. If a box has been checked by mistake, click that box again and the checkmark will disappear. Click on the correct choice.



LOC / Orientation
Check all that apply

- ☒ Alert (Responds readily)
- ☒ Oriented to person, place, time & situation
- ☐ Oriented to person
- ☐ Oriented to place
- ☐ Oriented to time
- ☐ Oriented to situation
- ☐ Confused at times
- ☐ Confused at all times
- ☐ Disoriented

Radio buttons allow one answer or another. Once a radio button has been clicked, you must select one of the provided choices.



Pupillary Response / Hand Grips
Pupil Equality

☒ Equal ☐ Unequal ☐ Round ☒ Irregular

Left Reaction to Light

☒ Yes ☐ No ☐ Constricted ☒ Dilated

Right Reaction to Light

☒ Yes ☐ No ☐ Constricted ☒ Dilated

The system was designed to use logic. Since the Pupil Equality was assessed as “Equal,” and “Dilated” was chosen for the Left Eye, the system automatically grays out “Constricted” and selects “Dilated” for the Right Eye. This saves clicks and time.

Grayed Out Areas

Areas that do not pertain to the patient stay, or become, grayed out. This saves time in documentation as the nurse may quickly move on to the next area.



Do you have challenges when learning?

☒ No ☐ Yes

☐ Hearing Problem ☐ Legally Blind

☐ Deaf Left Ear ☐ Trouble Speaking

☐ Deaf Right Ear ☐ Can't Understand



☐ Vision Problem

Additionally, some forms open up but stay grayed out until the previous box has been completed. This ensures not only thorough documentation but a thorough assessment on the patient as well.

Tube Placement	Peri-Drain/Tube Area	Suction
<input checked="" type="checkbox"/> Maintained <input checked="" type="checkbox"/> Chest Tube measured <input type="checkbox"/> Chest Tube seal intact	<input type="checkbox"/> No redness or swelling noted <input type="checkbox"/> Ecchymosis <input type="checkbox"/> Erythema <input type="checkbox"/> Excoriation <input type="checkbox"/> Maceration <input type="checkbox"/> Red <input type="checkbox"/> Warm to touch	<input type="checkbox"/> Continuous wall suction <input type="checkbox"/> Water-filled suction <input type="checkbox"/> Dry suction



Changing Date/Time


To change the date, click on the calendar icon to the right of the Change Date/Time box.

Change Date/Time
 02/11/2010 07:00 AM  

A calendar will pull up. Once a date has been selected, the new date will be highlighted, the calendar will disappear, and the desired date will appear in the Date/Time field.

Feb 2010						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

07 : 00 AM  

Change Date/Time
 02/11/2010 07:00 AM 

To exit out and not make a change, click on the X at the bottom right hand corner of the calendar.

To change the time, highlight the current time and type in the desired time. Change AM/PM as needed.

Anything recorded on the flow sheet up until clicking SAVE will have the newly chosen date and time stamp recorded in the patient's record. On a report level, it will state the time the nurse has chosen for documentation but will also state the actual time the documentation occurred.

Patient Banner

When a patient name has been selected from the Patient List, the record then opens up for use.

The Patient Banner contains at-a-glance important information:

Patient Identifiers: Name, Date of Birth, Medical Record Number, Visit Number, Gender

Vital Signs: The most recent set of Vital Signs with Date/Time stamp

Physician names: Attending Physician and Consulting Physician names are visible for easy reference

Additional: Height/Weight, Smoking Status, Diagnosis, Room #, Alerts, Diet, Glucose Reading, Code Status, and Isolations appear for quick views

BONE BEVERLY A	MRN: 1178859	Visit No: 11033757	Room: NONE	DOB: 03/03/1939	Gender: Female	LOG OUT	[-]
Diet:		Attending Physician: AGALIOTIS		No Consulting Physician		Code Status: Full Code	No Smoking Status
2 Drug Allergies: 4 Sure Slim,A/B Otic		1 Food Allergies: Bananas	No Environmental Allergies	2 Alerts: Confidential Patient,Diabetic		1 Isolations: Airborne	Acute appendicitis
Last Temp: 101(F)		Last BP: 134/98		Last Pulse: 76		Last Resp: 14	
02/28/11 14:53		02/28/11 14:53		02/28/11 14:53		02/28/11 14:53	

BONE BEVERLY A	MRN: 1178859	Visit No: 11033757	Room
Diet:	Attending Physician: AGALIOTIS No Consulting Physician		
2 Drug Allergies: 4 Sure Slim,A/B Otic	1 Food Allergies:	No Environmental Allergies	
Last Temp: 101(F)	Allergen: 4 Sure Slim Reaction: Urticaria Severity: Mild Entered Date: 1/10/2011 1:23:16 PM	Last Pulse: 76	
02/28/11 14:53		02/28/11 14:53	
Order Entry	Or	EMAR	Reports
Discharge	Allergen: A/B Otic Reaction: Depression, Eczema Severity: Mild Entered Date: 1/5/2011 1:09:43 PM		
Laboratory			
Radiology			

Allergies: Drug, Food, and Environmental allergens are noted. More detailed information about allergies may be found by holding your cursor over the allergen.

To Minimize banner: Click the [-] symbol on the right side of the banner:

BONE BEVERLY A	MRN: 1178859	Visit No: 11033757	Room: NONE	DOB: 03/03/1939	Gender: Female	LOG OUT	[+]	
Order Entry	Order Review	Documentation	EMAR	Reports	Patient Info	Patient Summary	Care Card	Floor Charges

Minimized banner has Patient Identification information only and allows larger viewing area of flow sheets.

To Maximize banner: Click the [+] symbol.

Switch patient: Click on patient name and return to the patient list.

Leave ChartSmart: Click the red “Log Out” button. Do not click X.

Order Entry

Orders are added by department (Lab, Radiology, etc) and will populate into an Order Chart by department. Submit as a whole to save time, or submit as each order set is completed.

Laboratory Order Chart

Remove All	Ordered By	Order Name	Priority	Frequency	Specimen Type	Special Instruction	Start Date/Time	Nurse Collected	Collected Date/Time
------------	------------	------------	----------	-----------	---------------	---------------------	-----------------	-----------------	---------------------

☐ AGALLOTIS CBC WITH DIFFERENTIAL Stat Blood 03/29/2011

Radiology Order Chart

Remove All	Ordered By	Order Name	Priority	Transport	IV	O2	Special Instruction	Reason For Procedure	Start Date/Time
------------	------------	------------	----------	-----------	----	----	---------------------	----------------------	-----------------

☐ AGALLOTIS CHEST 2-VIEW Routine Wheelchair Yes No post lung resection 03/29/2011 17:00

Pharmacy Order Chart

Remove All	Ordered By	Order Name	Order Type	Dosage	Unit	Flow Rate	Route	Frequency	Reason For Procedure	Start Date/Time
------------	------------	------------	------------	--------	------	-----------	-------	-----------	----------------------	-----------------

☐ AGALLOTIS Demerol Scheduled 50 mg Inj PM 03/29/2011 16:00

Submit Orders

Cancel Orders

To cancel an order in the cart, click on the order and then “Cancel Orders.” The following screen will appear:

Pharmacy Order Chart

Remove All	Ordered By	Order Name	Order Type	Dosage	Unit	Flow Rate	Route	Frequency	Reason For Procedure	Start Date/Time
------------	------------	------------	------------	--------	------	-----------	-------	-----------	----------------------	-----------------

☒ AGALLOTIS Demerol Scheduled 50 mg Inj PM 03/29/2011 16:00

Do you really want to cancel this order?

Yes

No

Submit Orders

Cancel Orders

Click the appropriate choice and the order will be deleted. Submit the remaining orders.

Lab Order Entry

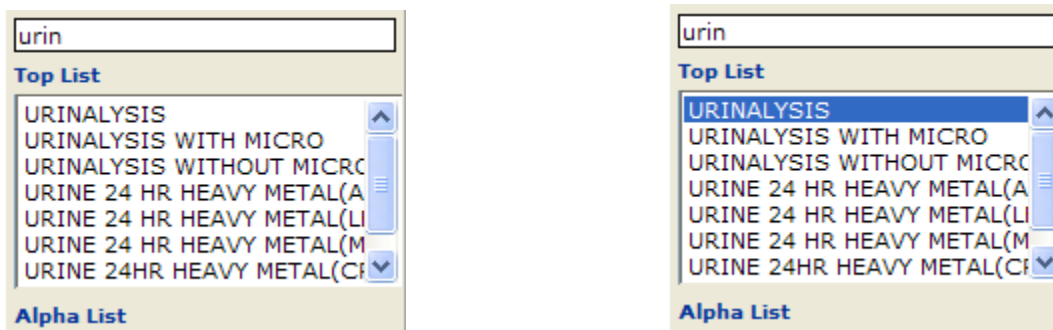
There are two lists available for Lab orders:

Top list: Contains the most frequently ordered labs for a specific unit, such as Med-Surg or OB. This list is the default list.

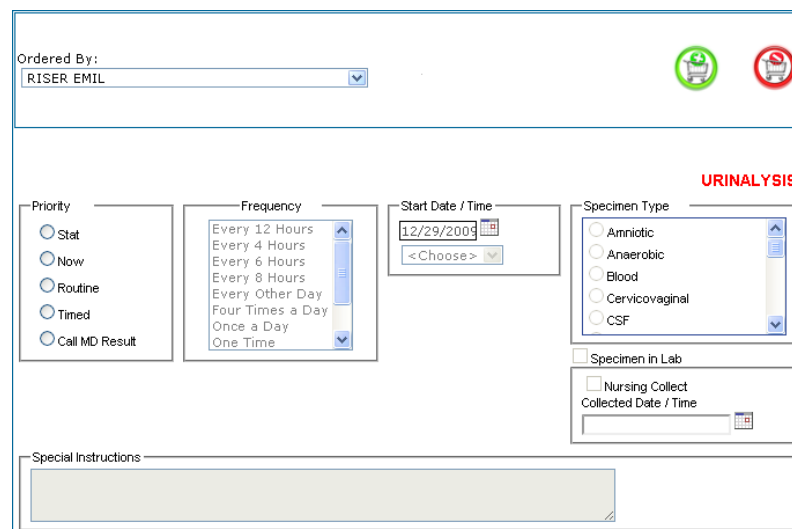
Alpha list: Contains all lab orders for the hospital.

Text box: For a more precise search, type in the specific order via the text box.

For example, if you want to search for a Urinalysis, type “urin” in the free text field and press enter. That will bring up all urinalysis orders for you to select.



Single click the desired lab test and the order form will appear:



The order screen gives the ordering physician’s name and lists the name of the lab in **RED**.

Multiple orders for the same Specimen Type may be ordered together. For example, single click on CBC and it will populate onto the order screen. Go back and click on Hemoglobin & Hematocrit and those tests will populate as well. Add more blood tests or continue with order.

CBC WITH DIFFERENTIAL, HEMOGLOBIN & HEMATOCRIT

Priority <input type="radio"/> Stat <input type="radio"/> Now <input type="radio"/> Routine <input type="radio"/> Timed	Frequency Every 12 Hours Every 4 Hours Every 6 Hours Every 8 Hours Every Other Day Four Times a Day Once a Day One Time	Start Date / Time 08/11/2010 <Choose>	Specimen Type <input type="radio"/> Amniotic <input type="radio"/> Anaerobic <input type="radio"/> Blood <input type="radio"/> Cervicovaginal <input type="radio"/> CSF <input type="checkbox"/> Specimen in Lab
--	--	--	---

Stat and Now Orders

After selecting tests, go to Priority and click “Stat.” The system will not ask for the Frequency or the Start Date/Time as they do not pertain to Stat or Now orders. The Specimen Type is the only other required field.

A completed Stat order will appear as follows:

Stat	Urine,Cath	URINALYSIS	
Priority <input checked="" type="radio"/> Stat <input type="radio"/> Now <input type="radio"/> Routine <input type="radio"/> Timed <input type="radio"/> Call MD Result	Frequency Every 12 Hours Every 4 Hours Every 6 Hours Every 8 Hours Every Other Day Four Times a Day Once a Day One Time	Start Date / Time 12/29/2009 <Choose>	Specimen Type <input type="radio"/> Synovial <input type="radio"/> Throat <input checked="" type="radio"/> Urine,Cath <input type="radio"/> Urine,Ci Catch <input type="radio"/> Wound <input type="checkbox"/> Specimen in Lab <input checked="" type="checkbox"/> Nursing Collect Collected Date / Time 12/29/2009 21:28
Special Instructions <div></div>			

If this is a specimen that Nursing will collect put a check mark in the box and enter the date and time of the collection. If this is an order where the specimen collection will take place in the future enter the date when the collection will take place. This order will then move over to the Care Card to remind the nurse that an item is due for collection.

Routine and Timed Orders

Go to Priority and click “Routine.” All fields including Frequency, Start Date/Time and Specimen Type will be required. For Lab orders which will occur for more than one day, select number of days for test to run. Choose Start Date/Time, Specimen Type, and Nurse or Lab to Collect (if desired) Add to Cart. The order will now populate into the cart.

To change the date/time a test is to begin, click on the Calendar icon and select date. Then change the time via the drop-down feature.

The screenshot shows the 'Routine' tab selected in the top navigation bar. The 'Priority' section has radio buttons for Stat, Now, Routine (selected), and Timed. The 'Frequency' section has a dropdown menu with options: Every 8 Hours, Every Other Day, Four Times a Day, Once a Day (selected), One Time, Other, Three Times a Day, and Twice a Day. Below this is a 'Select Number of Days' section with a dropdown menu showing 1 Day, 2 Days (selected), and 3 Days. The 'Start Date / Time' section shows a date of 03/24/2011 and a time of 18:00. The 'Specimen Type' section has radio buttons for Amniotic, Anaerobic, Blood (selected), Cervicovaginal, and CSF. Below this are three checkboxes: 'Specimen in Lab', 'Nurse To Collect', and 'Lab To Collect'. The title 'CBC WITH AUTO DIFF' is displayed in red at the top right.

Specimen in Lab: Check this box if the lab has already been collected and sent to lab.

Nursing Collect: Click on this feature if Nursing has collected or will collect the specimen

Lab Collect: Click on this feature if Lab has collected the specimen.

Add this order to the cart:



Laboratory Order

Laboratory Order has been added.

Laboratory Order Chart

Remove All	Ordered By	Order Name	Priority	Frequency	Specimen Type	Special Instruction	Start Date/Time	Nurse Collected	Collected Date/Time
<input type="checkbox"/>	AGALLOTIS	CBC WITH AUTO DIFF	Routine	Once a Day	Blood		03/24/2011 18:00		
<input type="checkbox"/>	AGALLOTIS	CBC WITH AUTO DIFF	Routine	Once a Day	Blood		03/25/2011 18:00		

Submit Orders

Cancel Orders

There are now two iterations of this order broken out from that one entry. As entered, the order will take place each day for the next two days at 18:00.

The nurse may now Submit, Cancel, or Continue with orders for other departments. Orders for other departments will populate into the order cart under the appropriate categories, such as Pharmacy or Radiology.

Radiology Order Entry

To enter a Radiology order, click on the Radiology button to see the Radiology items for the facility.

Top lists are common to a certain department, such as Med-Surg or OB. Alpha Listings are for the entire facility.



Tests may be typed in via the text box. Type “chest” into the text box, press enter and the answer choices will appear.

Top List
CHEST 1-VIEW
CHEST 2-VIEW
CHEST 4- VIEW
CHEST FLUOROSCOPY
CHEST-LORDOTIC
CHEST-TOMOGRAPHY

Alpha List

Clicking on Chest 2- View,

the following page appears:

Ordered By: ALPERT M		Reason for Procedure: Infection		 
CHEST 2-VIEW				
Priority <input checked="" type="radio"/> Stat <input type="radio"/> Now <input type="radio"/> Routine <input type="radio"/> Timed	Start Date / Time 02/09/2010	Transport: <input checked="" type="radio"/> Ambulatory w/assist <input type="radio"/> Wheelchair <input type="radio"/> Stretcher <input type="radio"/> Not Applicable	IV? <input checked="" type="radio"/> Yes <input type="radio"/> No	O2? <input type="radio"/> Yes <input checked="" type="radio"/> No
<input type="checkbox"/> Verbal Order				
Special Instructions <div style="border: 1px solid black; height: 30px;"></div>				

The name of the order appears in the center. Select Priority. For a Stat or Now order, the Start Date/Time field does not apply and remains grayed out. Check Transport, IV, and O2 as appropriate. The final step is to enter the reason for procedure. With the order completed, Add to the Cart or Cancel. A text box is available for special instructions as needed.

Pharmacy Order Entry

Medications are divided into two lists: Top List and Alpha List. The Top list contains medications common to a specific department in the hospital, such as Med-Surg. The Alpha list contains medications used hospital-wide.

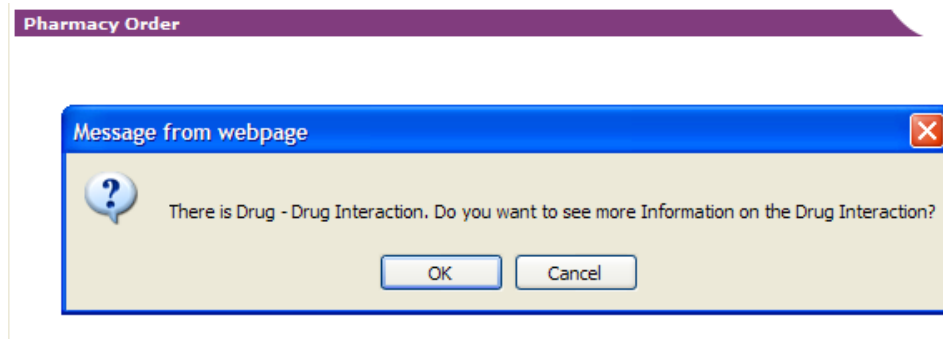
A text box is available as a quick search feature. Type the first few letters of a medication and press Enter. Then click on the correct medication and continue with the order.

albuterol

Top List
 Albuterol Sulfate
 Ipratropium-Albuterol
 Levalbuterol HCl
 Levalbuterol HCl (Bulk)
 Levalbuterol Tartrate

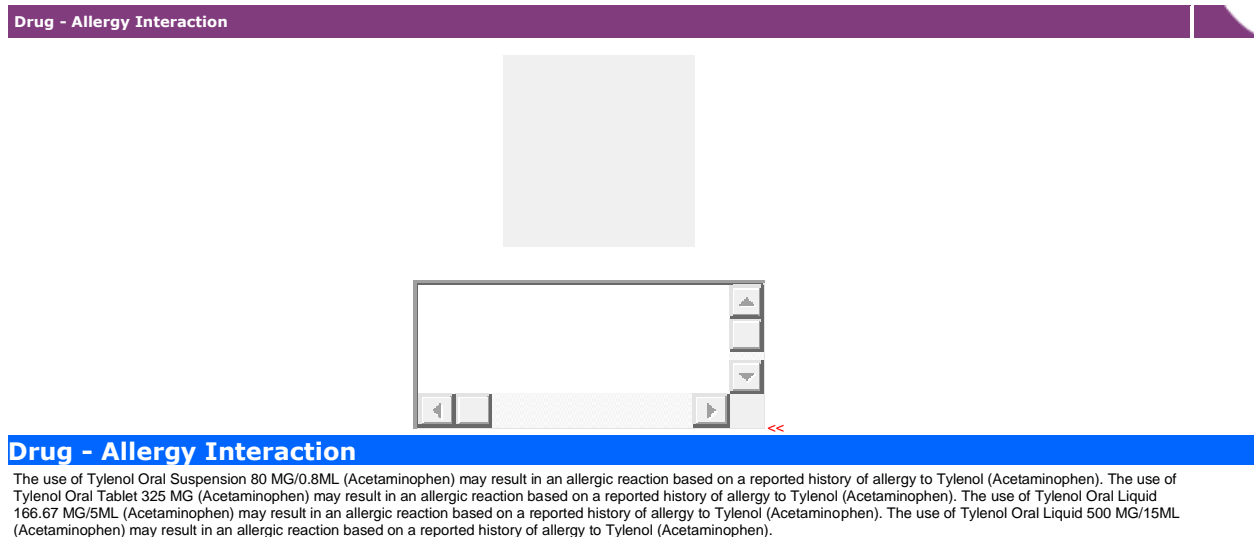
Drug/Drug and Drug/Allergy Alerts

When a medication is selected, the system will give an Alert if there is a drug-drug or drug-allergy interaction.



Click “Cancel” and the order screen will be removed.

Click “OK” and a drug monograph will appear giving information on this interaction plus the ability to cancel or override the order.



After referring to the monograph, user may “X” out of the form and cancel the order attempt. Click “Override” and type in a reason for overriding in the box, and the order screen for this medication will become available to the user.

Scheduled Orders

To enter a scheduled order, type the medication name into the text box and press enter. After selecting the medication, the following screen will appear:

The screenshot shows a web application window titled "Pharmacy Order". At the top, there is a purple header bar. Below it, a white box contains the text "Ordered By: AGALIOTIS" next to a dropdown arrow. To the right of this box are two circular icons: a green one with a shopping cart and a red one with a shopping cart and a slash. Below the white box is a blue header bar with the text "Albuterol Sulfate". Underneath, there are four rows of form fields: "Order Type" with a dropdown arrow, "Dose" with a dropdown arrow, "Route" with a dropdown arrow, and "Frequency" with a dropdown arrow. To the right of the "Frequency" dropdown is a link that says "Type Free Text".

Order Type: Utilize the drop-down feature to select Scheduled, PRN, etc.

The next field is the Dose and Unit field. A drop down box offers dosages that pertain to that specific drug.

The dosages that pull are those that currently exist within the pharmacy formulary. If the order dose is not available from this list, click on "Type Free Text." Any information previously filled in will disappear.

The screenshot shows a dropdown menu for the "Dose" field. The menu is open, showing a list of dosages: 2.5, <Dosage>, 0.63, 1.25, 2, 2.5 (highlighted), 2.5 mg, 200, 4, 5, 8, and 90. The dropdown arrow is visible at the top right of the menu.

Activate drop-down lists to complete the order with Route, Frequency, and Start Date/Time.

To enter orders manually:

Select the "Type Free Text" link on the order form. The following order form will appear:

The screenshot shows the same web application window as before, but with the "Type Free Text" link selected. The "Order Type" dropdown now shows "Scheduled". The "Dose" field is now a text input box. The "Route" field is also a text input box. The "Frequency" field is a text input box. The "Type Free Text" link is now a blue button labeled "Back".

To go back, select the [Back](#) link beside the Frequency field. All information filled in previously will reappear.

Albuterol Sulfate	
Order Type	<input type="text" value="Scheduled"/>
Dose	<input type="text" value="2.5"/> <input type="text" value="mg/5 mL"/>
Route	<input type="text" value="Inhl"/>
Frequency	<input type="text" value="Three times a Day"/> Type Free Text



Once completed, add this order to the cart.

One Time Orders

To enter a One Time order, select “One Time” from the Order Type section. Frequency will auto-populate “one time.” Select Start Date/Time to complete the order and Add to the Cart.

Lasix	
Order Type	<input type="text" value="One Time"/>
Dose	<input type="text" value="40"/> <input type="text" value="mg"/>
Route	<input type="text" value="By Mouth"/>
Frequency	<input type="text" value="One Time"/> Type Free Text
<input type="checkbox"/> Use Standard Times	Start Date <input type="text" value="02/09/2010"/> <input type="text" value="11:00"/>
	Start Time <input type="text" value="11:00"/>
<input type="checkbox"/> Verbal Order	
<div>Comments / Instructions</div> <div></div>	

PRN Orders

Select PRN Meds from the Order Type. This selection will prompt a “PRN reason” drop down box. Select the appropriate reason and complete the order.

Tylenol / Codeine No. 3

Order Type	<div style="border: 1px solid #ccc; padding: 2px;">PRN Meds</div>		
Dose	<div style="border: 1px solid #ccc; padding: 2px;">300/30</div>	<div style="border: 1px solid #ccc; padding: 2px;">mg</div>	
Route	<div style="border: 1px solid #ccc; padding: 2px;">By Mouth</div>		
Frequency	<div style="border: 1px solid #ccc; padding: 2px;">Every 4 hours</div>	Type Free Text	
PRN Reason	<div style="border: 1px solid #ccc; padding: 2px;"><PRN Reason></div>		

☐ Verbal Order

Comments / Instructions

IV/IV Piggy Orders

To enter an IV/IV Piggy order, select the medication additive from the formulary (i.e. Potassium Chloride).

To make this an IV/IV Piggy order, select IV/IV Piggy from the Order Type drop down menu.

Order Type	<div style="border: 1px solid #ccc; padding: 2px;">IV/IV Piggy</div>		
Dose	<div style="border: 1px solid #ccc; padding: 2px;">20</div>	<div style="border: 1px solid #ccc; padding: 2px;">MEQ/ML</div>	
	Flow Rate (ml/hr): <div style="border: 1px solid #ccc; width: 120px; height: 20px;"></div>		

Next, select dose and frequency from the respective drop-downs:

Order Type	<div style="border: 1px solid #ccc; padding: 2px;">IV/IV Piggy</div>		
Dose	<div style="border: 1px solid #ccc; padding: 2px;">20</div>	<div style="border: 1px solid #ccc; padding: 2px;">MEQ/ML</div>	
	Flow Rate (ml/hr): <div style="border: 1px solid #ccc; padding: 2px;">75</div>		
Frequency	<div style="border: 1px solid #ccc; padding: 2px;">Continuous Infusion IV</div> Type Free Text		

There is still an option to enter free text information by selecting the “Type Free Text” link to the right of the frequency field.

Enter the date and time the IV should start:

Start Date	<div style="border: 1px solid #ccc; padding: 2px;">02/09/2010</div>
Start Time	<div style="border: 1px solid #ccc; padding: 2px;">12:00</div>

The final step is to tell the system to dissolve this medication in 1000 ml of Normal Saline. To do this, enter this information into the Comments/Instructions field at the bottom of the screen. These instructions will be read, along with the rest of the order, by Pharmacy.

Comments / Instructions

1000 ml of NS

Add the completed order to the cart.

Sliding Scale Insulin Orders

To enter a sliding scale insulin order, first choose the type of insulin.

Type in the name of the insulin and press the enter key.

Click on the correct medication.

Novolin

Top List

- Novolin 70/30
- Novolin 70/30 Innolet
- Novolin 70/30 Penfill 3 MI Cartridge
- Novolin N
- Novolin N Innolet
- Novolin N Penfill 3 MI Cartridge
- Novolin R
- Novolin R Innolet
- Novolin R Penfill 3 MI Cartridge

The order will default to a one-time order. Change this by clicking on the Order Type drop down menu and selecting Sliding Scale.

Novolin R

Order Type	<Order Type>	
Dose	<Order Type>	
Route	One Time	
Frequency	Scheduled	
	IV/IV Piggy	
	PRN Meds	
	Sliding Scale	Type Free Text

After selecting Sliding Scale as the order type, there are three options. Enter a sliding scale set up by the hospital, enter a sliding scale set up by the physician, or enter an entirely new sliding scale from beginning to end.

Order Type Sliding Scale

One Time
Scheduled
IV/IV Piggy
PRN Meds
Sliding Scale

Sliding Scale (Hospital)
Sliding Scale (ALPERT M)
Enter New Sliding Scale

Novolin R

Order Type Sliding Scale

Select Sliding Scale HospSS

Sliding Scale (Hospital)
Sliding Scale (ACKINS PAT)
Enter New Sliding Scale

From	To	Unit
0	200	0
201	250	2
251	300	4
301	350	6
351	400	8

“Call MD” Feature

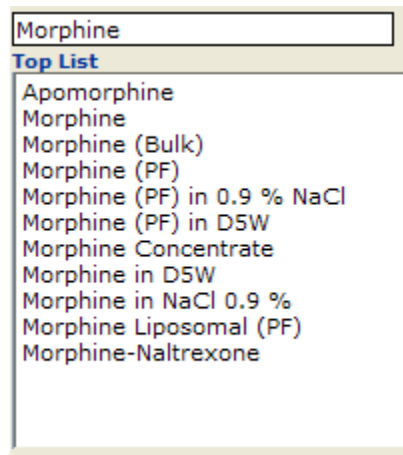
The “Call MD” feature may be added to any Sliding Scale order. When ordered, this will appear on the EMAR and will trigger an alert for the nurse when an out-of-range blood glucose value is entered (see EMAR).

From	To	Unit
0	200	0
201	250	2
251	300	4
301	350	6
351	400	8 Call MD
BG <60 Call MD		

In the body of the sliding scale order form, type in the details to notify the physician. Add order to the cart and SAVE.

PCA Medications

To enter a PCA Medication, select a PCA Medication from the formulary by single-clicking.

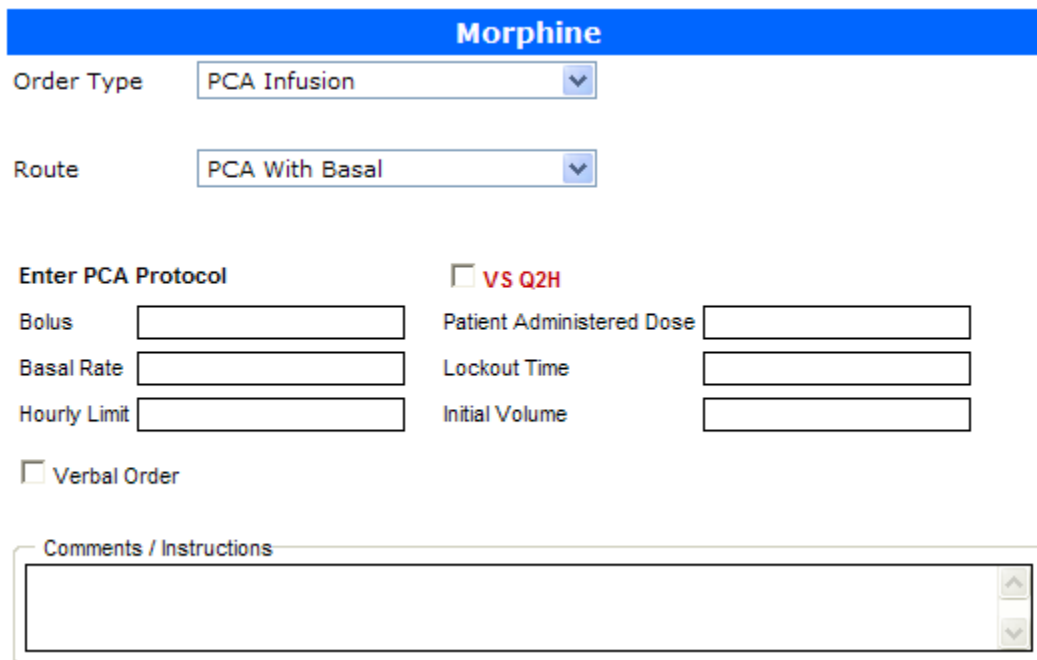


Morphine

[Top List](#)

- Apomorphine
- Morphine
- Morphine (Bulk)
- Morphine (PF)
- Morphine (PF) in 0.9 % NaCl
- Morphine (PF) in D5W
- Morphine Concentrate
- Morphine in D5W
- Morphine in NaCl 0.9 %
- Morphine Liposomal (PF)
- Morphine-Naltrexone

The order screen will appear:



Morphine

Order Type

Route

Enter PCA Protocol ☐ **VS Q2H**

Bolus Patient Administered Dose

Basal Rate Lockout Time

Hourly Limit Initial Volume

☐ Verbal Order

Comments / Instructions

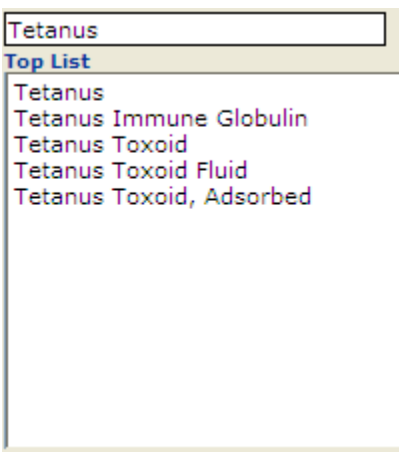
Enter the PCA protocol by clicking in the first field and tabbing over to complete each subsequent field. Add the order to the cart.

Immunizations

Ordering an Immunization is the same as placing a one time or scheduled order. To place an Immunization order, first select the medication from the formulary.

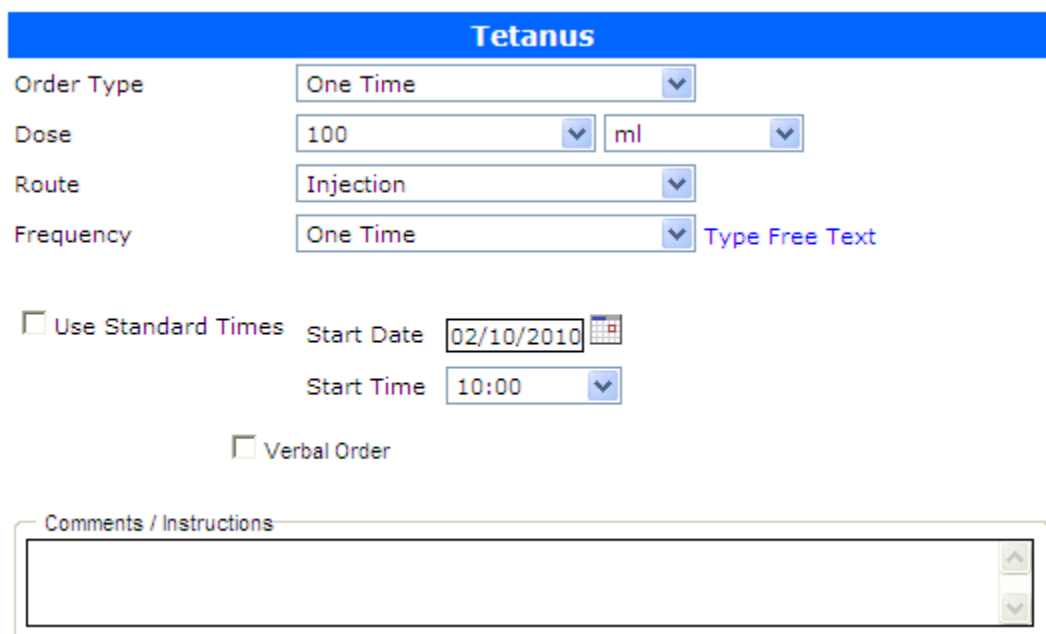
Type in “Tetanus” and press the enter key. The options listed appear as follows:

To select the order highlight the order and click one time.



A screenshot of a search dropdown menu. At the top, a search bar contains the text "Tetanus". Below the search bar, a list of results is displayed under the heading "Top List". The results are: "Tetanus", "Tetanus Immune Globulin", "Tetanus Toxoid", "Tetanus Toxoid Fluid", and "Tetanus Toxoid, Adsorbed".

Complete the order form including the scheduled time for the immunization. The completed order form should look like this:



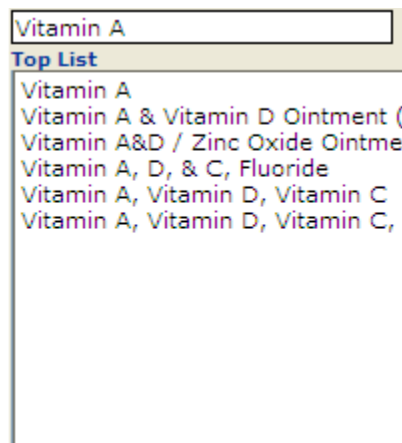
A screenshot of a completed order form for "Tetanus". The form has a blue header bar with the word "Tetanus" in white. Below the header, the form contains the following fields: "Order Type" (One Time), "Dose" (100 ml), "Route" (Injection), and "Frequency" (One Time). There is a checkbox for "Use Standard Times" which is unchecked, and a "Start Date" field (02/10/2010) with a calendar icon. Below the date field is a "Start Time" field (10:00). There is also a checkbox for "Verbal Order" which is unchecked. At the bottom, there is a "Comments / Instructions" text area.

To complete this order, add to the cart.

Vitamins/Herbal Supplement Orders

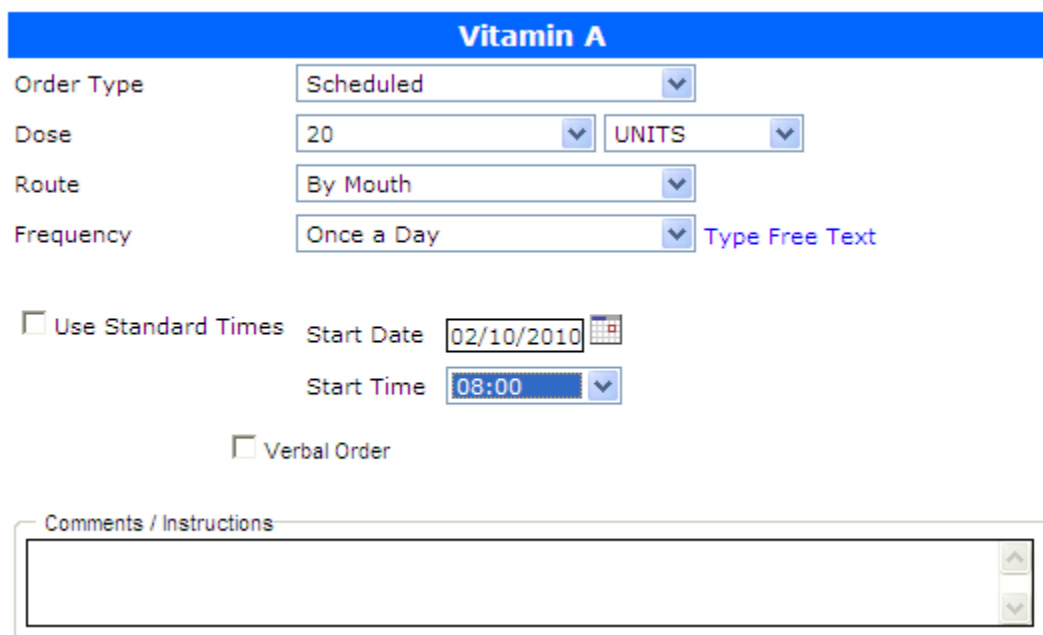
To place a Vitamin Order, type the name of the Vitamin and press the enter key.

Select the order with a single click and the order form will open up.



A screenshot of a dropdown menu. The top bar is labeled 'Vitamin A'. Below it, a 'Top List' is visible, containing the following items: 'Vitamin A', 'Vitamin A & Vitamin D Ointment (', 'Vitamin A&D / Zinc Oxide Ointme', 'Vitamin A, D, & C, Fluoride', 'Vitamin A, Vitamin D, Vitamin C', and 'Vitamin A, Vitamin D, Vitamin C,'.

When complete the order screen will look like this:



A screenshot of the 'Vitamin A' order form. The form has a blue header with the text 'Vitamin A'. Below the header, there are several fields: 'Order Type' with a dropdown menu set to 'Scheduled'; 'Dose' with a text box containing '20' and a dropdown menu set to 'UNITS'; 'Route' with a dropdown menu set to 'By Mouth'; and 'Frequency' with a dropdown menu set to 'Once a Day' and a link 'Type Free Text'. Below these fields, there are two checkboxes: 'Use Standard Times' and 'Verbal Order'. The 'Use Standard Times' checkbox is checked, and it has associated fields for 'Start Date' (02/10/2010) and 'Start Time' (08:00). At the bottom of the form, there is a large text area labeled 'Comments / Instructions'.

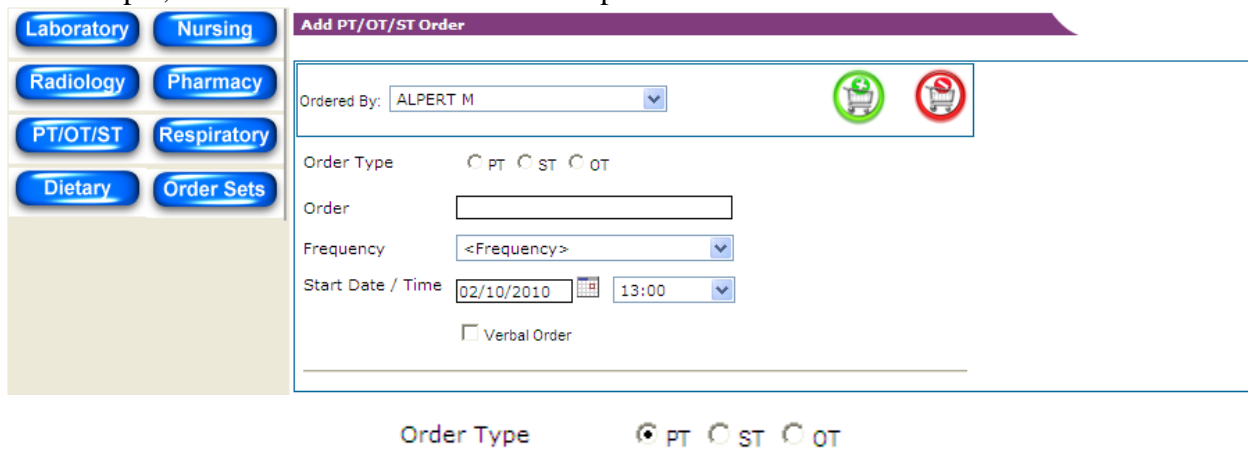
To save this order, Add to the Cart.

Ancillary Departments: PT/OT/ST, Dietary, Respiratory

To enter an order for any of the ancillary departments, simply click on the appropriate button and complete the order form.



For example, a PT/OT/ST order would be completed as follows:



Enter the Order Type first:

In the next field, type the order name into the order box:

Order

Next, enter the Frequency. Select the desired list from a drop down menu. To select the order, highlight the selection and click once.

Complete the Start Date and Time Fields. Leave the date as it is or change by clicking the calendar icon and selecting the desired start date.

Change the start time via the drop-down box. To exit out of the calendar and not make a change, click on the X at the bottom right hand corner of the calendar.

Start Date / Time: 02/10/2010 11:00

Feb 2010						
Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28						

X

When completely filled out, the order form will look like this:

Ordered By: ALPERT M

Order Type: ☒ PT ☐ ST ☐ OT

Order: ROM Exercises

Frequency: One Time

Start Date / Time: 02/10/2010 17:00

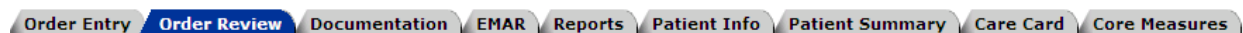
☐ Verbal Order

To save the order, click on the “Add to Cart”  button at the top of the screen.

Repeat this same procedure for any of the Ancillary Departments as needed.

Order Review

To see the status of orders placed through NurseSoft, go to the Order Review tab.



- ☒ Show All Orders
- ☐ Show Lab Orders
- ☐ Show Rad Orders
- ☐ Show Pharmacy Order
- ☐ Show Nursing Orders
- ☐ Show PT/ST/OT Orders
- ☐ Show Dietary Orders
- ☐ Show Respiratory Orders

Select which orders are to be viewed. The orders selected will display to the right of this list.

The scroll bar on the far right hand side of the screen gives the indication that there are further orders below the items listed. Scroll down to see the hidden orders below.

Type	Cancel All	Order	Scheduled Date	Priority	Frequency	Status	CP Ordered By		Reason	Instruct
Dietary	<input type="checkbox"/>	Regular Diet	2/10/2010 2:00:00 PM			Active				
Pharmacy	<input type="checkbox"/>	Digoxin	2/10/2010 7:00:00 PM		Once a Day	Active	ALPERT M			
Pharmacy	<input type="checkbox"/>	Tetanus	2/10/2010 10:37:00 AM		One Time	Active	ALPERT M			
Pharmacy	<input type="checkbox"/>	Novolin R	2/10/2010 10:01:00 AM		One Time	Active	ALPERT M			
Pharmacy	<input type="checkbox"/>	Morphine Sulfate For PCA Pump	2/10/2010 10:00:00 AM			Active	ALPERT M			
Pharmacy	<input type="checkbox"/>	Potassium	2/10/2010		Continuous	Active	ALPERT			4000 ml

To cancel a submitted order, locate the check box beside the order and click it. A check mark (✓) will appear in the box.

PT/ST/OT	<input checked="" type="checkbox"/>	ROM Exercises	2/10/2010 5:00:00 PM	One Time	Not Acknowledged				
----------	-------------------------------------	---------------	-------------------------	----------	------------------	--	--	--	--

Cancel/Exit

Click on the Cancel/Exit button at the bottom of the page

The system will request a reason for this cancellation.

Click the reason and the system will verify the cancellation.

Do you really want to cancel this order?

Yes
No

- ☐ MD Order
- ☐ Wrong Patient
- ☐ Wrong Schedule
- ☐ Wrong Item
- ☐ Pt Discharged
- ☐ Pt Not Available

Select “Yes” and the system will cancel the order.

To review the Order details, click on the name of the order to review. The detail screen appears in the following form:

Order Information			
Order Review		Result	
Original Order Information for :			
Medical Record Number :	259446	Priority :	Stat
Patient Last Name :	ABAJIAN HULICK	Frequency :	
Patient First Name :	DARLEEN	Start Date :	4/5/2012
Dept :	Radiology	Start Time :	13:50
Room number :	102B	Iterations :	
Patient visit Number :	11070388	Specimen Type :	Cervicovaginal
Item Number :		Nurse Collected :	Yes
Batch number :		Specimen in Lab :	No
Order Number :	4212		
Order Entry Questions/Answers :			
Special Instructions :			
GLUCOSE, CSF			
Ordered By CP :		ALEXANDER	
Entered D/T :		4/5/2012 1:50:08 PM	
Entered By :		Steven Summersell	
Cancelled D/T :			
Cancelled By :			
Cancelled Reason :			
<hr style="border: 1px solid blue;"/>			
Subsequent Order Information			
Status :		Not Acknowledged	
Sched Date/Time :		4/5/2012 1:50:00 PM	
Acknowledged Date/Time :			
Acknowledged By :			
Order Processed D/T :			
Order Processed :			
<div style="border: 1px solid black; padding: 5px; display: inline-block;">Print Order Detail</div>			

The user can also click the “Result” tab from this page and the user will be able to view all of the results for that particular lab order.

There is also a print function located at the bottom of this screen.

Physician Order Sheet (POS)

When a physician enters an order into the system, it must first come to ChartSmart through a Physician Order Sheet, or POS. Here, the nursing staff will verify the order and complete the information required to submit that order to the various Ancillary departments.

Highlighted patient names on the Patient List will notify the nurse that there are new orders:

Patient has Order(s) to be Acknowledged						
My Patient List						
Clarissa	Windham	9987099		93498677	506-90-7654	<input type="checkbox"/>

Select the highlighted patient and the “Physician Order Sheet” will open. Pending orders will display according to department:

Acknowledge - Windows Internet Explorer

Acknowledge Order(s)

Laboratory Order

Acknowledge	Ordered By	Order Name	Physician	Priority	Frequency	Specimen Type	Special Instruction	Start Date/Time	Nurse Collected	Collected Date/Time
<input type="checkbox"/>	ALPERT M	CBC WITH DIFFERENTIAL		Stat		--- Select ---		08/15/2010		
<input type="checkbox"/>	ALPERT M	HEMOGLOBIN & HEMATOCRIT		Stat		--- Select ---		08/15/2010		

Radiology Order

Acknowledge	Ordered By	Order Name	Physician	Priority	Transport	IV	02	Special Instruction	Reason For Procedure	Start Date/Time
<input type="checkbox"/>	ALPERT M	CHEST 2-VIEW		Now	--- Select ---	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No		cough	08/15/2010

Certain orders will require further information to be provided by the nurse such as Specimen Type and Transport to a study. Other orders will require only that a nurse acknowledge the order. Should a physician wish to discontinue an existing pharmacy order, nursing will acknowledge the order via the POS and then discontinue the order via the EMAR module.

Once all orders have been acknowledged by the nurse, the patient’s name on the patient list will no longer be highlighted.

Documentation

The following forms are pre-built into the software:

Admission History	Glasgow Child Scale	Pediatric Admission History
Adult Assessment	Glucose Monitoring	Pediatric Assessment
AIMS Test	Hygiene/Dressing	Pediatric Developmental
Alcohol Screen	In Case of Death	Pediatric Discharge Plan
APGAR Scoring for Newborns	Intake Assessment	Pediatric Discharge Summary
Braden Scale	IV Care	Physical Therapy Discharge
Cardio Treatments	Miscellaneous Nurses' Notes	Ramsey Sedation Scale
Case Management Discharge Plan	Mucositis Scale	Respiratory Therapy Discharge Plan
Clinical Participation Note	Multi-Line IV assessment	Respiratory Treatments
Discharge Plan	Neuro Treatments	Restraints
Dietary Discharge Plan	Neurovascular Checks	Richmond Agitation-Sedation Scale
Drains and Tubes Assessment	Nursing Care	Riker Agitation-Sedation Scale
Drug Screen	Nutrition Hydration	Skin Treatments
Elimination	Occupational Therapy	Smoking Screen
ER Admission	OR Count	Social Services Discharge
ER Assessment	OR Operative Flow Sheet	Speech Therapy Discharge
ER Discharge	OR Pre-OP Checklist	Teaching
Fall Risk Assessment	Ortho Treatments	Urinary Treatments
Family Assessment	Ostomy	Wounds
FLACC Behavioral Pain	Pain Assessment	
GI Treatments	Pain Treatments	
Glasgow Coma scale	Pastoral Care	
	Patient Activity	

Flow sheets may be found by clicking the “Documentation” tab and locating the desired form to the left of your screen. These same flow sheets are also located within other forms, such as the Admission History form.

Admission History

The Admission History form appears in broken out sections with links to all the other sections at the top of the page.

Home	Immunizations/Infectious Disease	PT Screen	Social Work Screen	Fall Risk
Planning	Drug Screen	OT Screen	Case Mgmt Screen	Organ Donation
Allergy Info	Smoking Screen	ST Screen	Pastoral	Valuables
Home Meds	Alcohol Screen	Diet Screen	Braden	Orient to Unit
			Pain Risk	Info Given

The current section is the one highlighted in black. The question and answer choices appear below:

Arrival Date/Time 2/11/2010 9:59:00 AM		
Admission Data Admitted: < Select > From: < Select > Arrived: < Select >	Vital Signs	Verbal Admission History Information Unavailable <input type="checkbox"/> Patient unable to respond AND no family/friends available for information Check Only if necessary
Informant/Historian Information Received From: < Select > Name: _____		
Past Hospital Admissions Last Hospital Admission: _____ Reason: _____ Where: _____		
Save Next		

After filling out this section, click Next to save your information and proceed to the next listed section. Alternately, if you wish to choose a screen out of the listed order, click Save and your documentation will be saved without advancing to the next screen. Then click on a link at the top of the screen for the next desired section. For example, click Save and then click the “Drug Screen” link.

Home	Immunizations/Infectious Disease	PT Screen	SocWk Screen	Fall Risk
Planning	Drug Screen	OT Screen	Case Mgmt Screen	Organ Donation
Allergy Info	Smoking Screen	ST Screen	Pastoral	Valuables
Home Meds	Alcohol Screen	Diet Screen	Braden	Orient to Unit
			Pain Risk	Info Given

Drug Screen is now the highlighted section and the form that appears below is the drug screen form:

Street and Recreational Drug Screen

Street/Recreational Drug Use

☐ I have never taken street/recreational drugs

☐ I currently take street/recreational drugs

☐ I have quit taking street/recreational drugs

Drug Use History

What type drugs do you take? < Select >

Amount per day: []

Have you used within the last 24 hours? < Select >

How long have you used street drugs? < Select >

Plan to quit? < Select >

When did you quit taking street drugs? < Select >

Drug Use Information and Teaching

☐ Printed information given with teaching.

What is your quit date? 2/11/2010

Care Provider notified of Positive Screen

Provider Name []

Teaching

Save Next Cancel/Exit

When completely filled out, the form looks like this:

Street and Recreational Drug Screen

Street/Recreational Drug Use

☐ I have never taken street/recreational drugs

☒ I currently take street/recreational drugs

☐ I have quit taking street/recreational drugs

Drug Use History

What type drugs do you take? Marijuana

Amount per day: 1-2

Have you used within the last 24 hours? Yes

How long have you used street drugs? 1-5 years

Plan to quit? I have no plans to quit

When did you quit taking street drugs? < Select >

Drug Use Information and Teaching

☐ Printed information given with teaching.

What is your quit date? []


Care Provider notified of Positive Screen

Provider Name Dr. Alpert

Teaching

Save Next Cancel/Exit

With the form completed, click the “Next” button to move to the next section. This action will save the data and display the next section of the form. Clicking the “Save” button will save the information and open another drug screen form.

The “Teaching” button – pictured here:  is a link and a reminder to the nurse to enter Teaching information. Once Teaching documentation is completed and Saved the user is taken back to the original form; in this case Admission History.

Home Medications

Home Medications may be pulled up and edited with each new hospital admission and throughout the patient’s stay. The Teaching button is present for quick access to medication teaching.

Do you take any medicines, vitamins or supplements at home?

☐ No ☐ Yes



To enter Home Medications Click “Yes” and the Home Medications button appears:

Do you take any medicines, vitamins or supplements at home?

☐ No ☒ Yes

The Home Medications button is now active. Click this form and the Home Medication form will open.

Use the drop down boxes to complete all fields.

Medication:

Dosage:

Unit:

Route:

Frequency:

Last Taken:

Compliant: ☐ Yes ☐ No ☐ Unknown

Comments:

Medication:

Dosage:

Unit:

Route:

Frequency:

Last Taken:

Compliant: ☒ Yes ☐ No ☐ Unknown

Comments:

For example, enter an Insulin order as a Home Medication for a diabetic patient.



Now add these medications to the cart.

When added, the medication will pull into the cart below.

Medication Cart:

	Entered Date	Medication	Dosage	Unit	Route	Frequency	Last Taken	Compliant	Comments
<input type="checkbox"/>	2/11/2010 2:07:19 PM	Nutropin Aq	70/30	UNITS	SubQ	As Needed	This morning	Yes	

If the medication is entered in error, click the checkbox beside the order and then click on the

“Remove from Cart” button.



This will remove the order from the cart.

Allergy Information

It is critical to add Allergy information as soon as assessed. Allergy information is needed to ensure Drug/Allergy interactions are alerted to users at the time of Order Entry.

Allergy information may be entered by accessing the Admission History form, the Patient Info tab, or in the Flow Chart section of Documentation.

To enter Allergy Information in the Admission History form, click on the Allergy Info link at the top of the form (this form may also be found independently via the Patient Info Tab).

The following form appears below:

A screenshot of a web form titled "Allergy Information" in a blue header. Below the header, the text "Allergies to Medicines, Foods or Materials" is displayed. The main question is "Do you have any allergies to drugs, food or materials (environmental allergies)?" with radio buttons for "No" (selected) and "Yes". Below this is a checkbox for "No Known Allergies". At the bottom, there are three buttons: "Save" (green), "Next" (blue), and "Cancel/Exit" (red).

Click "No" and the form will automatically check the "No Known Allergies" checkbox. Click Next to save and move on to the next screen.

Click "Yes" and the Allergies button will appear.


A screenshot of the same "Allergy Information" form, but with the "Yes" radio button selected. The "No Known Allergies" checkbox is now unchecked. A blue button labeled "Allergies" has appeared to the right of the "No" and "Yes" options.

Click on the Allergies button and a new form will populate over the Admission History form.

View Allergies

☒ Drug Allergies
 ☐ Food Allergies
 ☐ Environmental Allergies
 ☐ All Allergies

To Add an Allergy: Select Drug Allergies, Food Allergies, or Environmental Allergies and click “Add.” The following form will appear:

DateTime: 

☐ No Known Drug Allergies
☐ Unable to Assess

Reason to Assess:

Allergen:

Reactions:

<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Anaphylaxis	<input type="checkbox"/> Anemia	<input type="checkbox"/> Anorexia	<input type="checkbox"/> Arrhythmias
<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Bradycardia	<input type="checkbox"/> CNS Depression	<input type="checkbox"/> Confusion	<input type="checkbox"/> Constipation
<input type="checkbox"/> Cramping	<input type="checkbox"/> Depression	<input type="checkbox"/> Dermatitis	<input type="checkbox"/> Diaphoresis	<input type="checkbox"/> Diarrhea
<input type="checkbox"/> Difficulty Breathing	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Dry Mouth	<input type="checkbox"/> Dyspepsia	<input type="checkbox"/> Dysphoria
<input type="checkbox"/> Dyspnea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Erythema	<input type="checkbox"/> Euphoria	<input type="checkbox"/> Fainting
<input type="checkbox"/> Gastric Distress	<input type="checkbox"/> Gastric Ulceration	<input type="checkbox"/> Headache	<input type="checkbox"/> Hives	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Hypotension	<input type="checkbox"/> Increased ICP	<input type="checkbox"/> Itching	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Leukopenia
<input type="checkbox"/> Light-headedness	<input type="checkbox"/> Metallic Taste	<input type="checkbox"/> Muscle Cramps	<input type="checkbox"/> Nausea	<input type="checkbox"/> Nausea and Vomiting
<input type="checkbox"/> Neutropenia	<input type="checkbox"/> Paralytic Ileus	<input type="checkbox"/> Paresthesias	<input type="checkbox"/> Peripheral Edema	<input type="checkbox"/> Photosensitivity
<input type="checkbox"/> Postural Hypotension	<input type="checkbox"/> Pruritis	<input type="checkbox"/> Rash	<input type="checkbox"/> Renal Failure	<input type="checkbox"/> Respiratory Depression
<input type="checkbox"/> Rhinitis	<input type="checkbox"/> Rhinorrhea	<input type="checkbox"/> Sedation	<input type="checkbox"/> Seizures	<input type="checkbox"/> Swelling
<input type="checkbox"/> Syncope	<input type="checkbox"/> Tachycardia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Tingling Sensation	<input type="checkbox"/> Tinnitus
<input type="checkbox"/> Urinary Frequency	<input type="checkbox"/> Urinary Retention	<input type="checkbox"/> Urticaria	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Weakness

Severity:

Informant:

Confidence Level:

If unable to assess a patient’s allergies and there are no family members available to answer these questions, select: ☐ Unable to Assess and enter reason in the text box provided.

Reason to Assess:

The system will notify of the need to come back and assess this patient later:
Need to address allergies. This will be noted in the Patient Banner as a reminder.

If the patient has verifiable drug allergies begin by first selecting the medication.

Going to the Allergen field, click on the down arrow to the right of the medication. The list of medications will populate the drop down menu. To begin, type the first letter of the drug name, then scroll down until the desired medication is found.

Drug Allergy Setup	
DateTime:	<input type="text"/> <div> Nutropin AQ Nutropin AQ Nuspin Nutropin Depot NuvaRing Nuvigil Nuzon Nybcen Nydrazid NyQuil NyQuil Hot Therapy NyQuil Liquicaps O-Cal FA O-Cal Prenatal OA 1 Powder </div>
Reason to Assess:	<input type="text"/>

The selection displays in the box:

Allergen:

Next, select the patient's reaction(s) to that medication via the checklist provided on that screen.

Address level of severity, informant, and confidence level via the drop down boxes provided.

Severity:

Informant:

Confidence Level:

Once saved, this drug allergy information will appear in the patient banner.

To view complete allergy information in the patient banner, hover the cursor over the Allergy listed and an information box with that information will appear. Move the cursor away and the box disappears.

Allergen: Penicillin G Benzathine Reaction: Hives, Nausea, Severity: Moderate Entered Date: 2/11/2010 2:48:11 PM ---
--

To Remove an Allergy:

First select which type of allergy to remove: Drug, Food, Environmental, or All.

View Allergies

☒ Drug Allergies
☐ Food Allergies
☐ Environmental Allergies
☐ All Allergies

Click Remove and the complete list of allergies in that category will pull up:

View Allergies

☒ Drug Allergies
☐ Food Allergies
☐ Environmental Allergies
☐ All Allergies

	Allergen	Reaction	Severity	Informant	Confidence Level	Entered By	Date
<input checked="" type="checkbox"/>	Abilify	Anaphylaxis	Severe	Brother	Very Reliable	Joe Smith	6/8/2010 1:25:08 PM

Click on the entry to delete and then click Remove.

View Allergies

Selected records have been removed.

☒ Drug Allergies
☐ Food Allergies
☐ Environmental Allergies
☐ All Allergies

	Allergen	Reaction	Severity	Informant	Confidence Level	Entered Date/Time	Entered By	Removed By	Removed Date/Time
	Abilify	Anaphylaxis	Severe	Brother	Very Reliable	6/8/2010 1:25:08 PM	Joe Smith	Joe Smith	8/26/2010 12:12:57 PM

The allergy has been removed from the active record and placed in a view-only section where it will remain as a permanent part of the record.

Further Allergy entries will now be done in the Patient Info section of the chart.

When a patient chart is initially opened where allergies have not yet been addressed, the following alert will open up in the center of the chart:



Click "OK" and the Allergy section will open up. Proceed as described earlier. Once Allergies have been addressed for this patient, the alert will no longer pop up.

Adult Nursing Assessment

The Adult Nursing Assessment is broken out into body systems from head-to-toe. The default body system is the Neurological Assessment.

Neuro **Cardio** **Musculo-Skeletal** **GU** **IV** **Safety**
Sensory **Pulmonary** **GI** **Integument** **Pain** **Special Precautions**

Neurological Assessment

LOC / Orientation Check all that apply <input type="checkbox"/> Alert (Responds readily) <input type="checkbox"/> Oriented to person, place, time & situation <input type="checkbox"/> Oriented to person <input type="checkbox"/> Oriented to place <input type="checkbox"/> Oriented to time <input type="checkbox"/> Oriented to situation <input type="checkbox"/> Confused at times <input type="checkbox"/> Confused at all times <input type="checkbox"/> Disoriented	Emotional Check all that apply <input type="checkbox"/> Calm <input type="checkbox"/> Restless <input type="checkbox"/> Cooperative <input type="checkbox"/> Angry <input type="checkbox"/> Happy <input type="checkbox"/> Hostile <input type="checkbox"/> Uncooperative <input type="checkbox"/> Distressed <input type="checkbox"/> Combative <input type="checkbox"/> Withdrawn <input type="checkbox"/> Anxious <input type="checkbox"/> No eye contact <input type="checkbox"/> Sad <input type="checkbox"/> Flat affect <input type="checkbox"/> Crying <input type="checkbox"/> Labile <input type="checkbox"/> Agitated
LOC/Orientation Notes: <div></div>	Emotion Notes: <div></div>

Pupillary Response / Hand Grips Pupil Equality <input type="radio"/> Equal <input type="radio"/> Unequal <input type="checkbox"/> Round <input type="checkbox"/> Irregular Left Reaction to Light <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Constricted <input type="checkbox"/> Dilated Right Reaction to Light <input type="radio"/> Yes <input type="radio"/> No <input type="checkbox"/> Constricted <input type="checkbox"/> Dilated Hand Grip Equality <input type="radio"/> Equal <input type="radio"/> Unequal <input type="radio"/> Unable to assess Left Grip Strength <input type="radio"/> Strong <input type="radio"/> Weak <input type="radio"/> None Right Grip Strength <input type="radio"/> Strong <input type="radio"/> Weak <input type="radio"/> None	CNS Assessment <input type="checkbox"/> No CNS Problems evident Check all that apply <input type="checkbox"/> Headache <input type="checkbox"/> Syncope <input type="checkbox"/> Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Vertigo <input type="checkbox"/> Restlessness <input type="checkbox"/> Nystagmus <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Affected side neglect (Post TIA/CVA) <input type="checkbox"/> Does not move extremities on command <input type="checkbox"/> Does not follow commands
Pupillary Response / Hand Grips Notes: <div></div>	CNS Notes: <div></div>

Glasgow Coma Scale

Neuro Tx

Neuro Checks

Teaching

Save

Next

Cancel/Exit

Documentation is completed by clicking on selections as well as free text boxes with unlimited space for narrative notes. Areas that do not pertain will stay or become grayed out, expediting movement throughout the screens.

Once documentation is completed, clicking SAVE or NEXT will record the data as part of the patient's record.

SAVE will save the documentation but not advance to the next body system, allowing the nurse to choose which system to address next.

NEXT will save the documentation and advance to the next body system on the list.



Once saved, the system puts a link at the bottom of the page recording the date and time of the entry (see circled date/time stamp above). This link will provide a review of the documentation entered. If the care provider who authored this documentation is the one reviewing it, there is the ability to modify it. If not authored by that care provider, the documentation is reviewable by another care provider but that care provider cannot modify it.

Throughout the documentation process, there are "NurseMinder" buttons located in flow sheets that open up additional forms that pertain to this area of documentation. For instance, a Neuro Tx button appears at the bottom of the Neurological Assessment screen. These links will open up over the existing screen and once closed, the user will be taken right back to their last screen making navigation very quick and easy.

Reassessment

When the time comes to reassess the patient during a shift a new option becomes available:

A screenshot of the "Neurological Assessment" form. It has a blue header with the title. Below the header is a checkbox labeled "No Change From Previous Assessment". The form is divided into two main sections: "LOC / Orientation" and "Emotional". Each section has a list of checkboxes for various symptoms and states.

LOC / Orientation	Emotional	
<input type="checkbox"/> Alert (Responds readily)	<input type="checkbox"/> Calm	<input type="checkbox"/> Restless
<input type="checkbox"/> Oriented to person, place, time & situation	<input type="checkbox"/> Cooperative	<input type="checkbox"/> Angry
<input type="checkbox"/> Oriented to person	<input type="checkbox"/> Happy	<input type="checkbox"/> Hostile
<input type="checkbox"/> Oriented to place	<input type="checkbox"/> Uncooperative	<input type="checkbox"/> Distressed
<input type="checkbox"/> Oriented to time	<input type="checkbox"/> Combative	<input type="checkbox"/> Withdrawn
<input type="checkbox"/> Oriented to situation	<input type="checkbox"/> Anxious	<input type="checkbox"/> No eye contact
<input type="checkbox"/> Confused at times	<input type="checkbox"/> Sad	<input type="checkbox"/> Flat affect
<input type="checkbox"/> Confused at all times	<input type="checkbox"/> Crying	<input type="checkbox"/> Labile
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Agitated	

The “No Change From Previous Assessment” feature allows a caregiver to review previous documentation from that shift and choose to save that information if patient status is unchanged.

Click the “No Change From Previous Assessment” checkbox and the previous assessment will appear:

The image shows two side-by-side assessment forms. The left form is titled "LOC / Orientation" and has a sub-header "Check all that apply". It contains a list of checkboxes: "Alert (Responds readily)", "Oriented to person, place, time & situation", "Oriented to person", "Oriented to place", "Oriented to time", "Oriented to situation", "Confused at times", "Confused at all times", and "Disoriented". The right form is titled "Emotional" and also has a sub-header "Check all that apply". It contains a list of checkboxes: "Calm", "Restless", "Cooperative", "Angry", "Happy", "Hostile", "Uncooperative", "Distressed", "Combative", "Withdrawn", "Anxious", "No eye contact", "Sad", "Flat affect", "Crying", "Labile", and "Agitated". Below each list of checkboxes is a text area labeled "LOC/Orientation Notes:" and "Emotion Notes:" respectively.

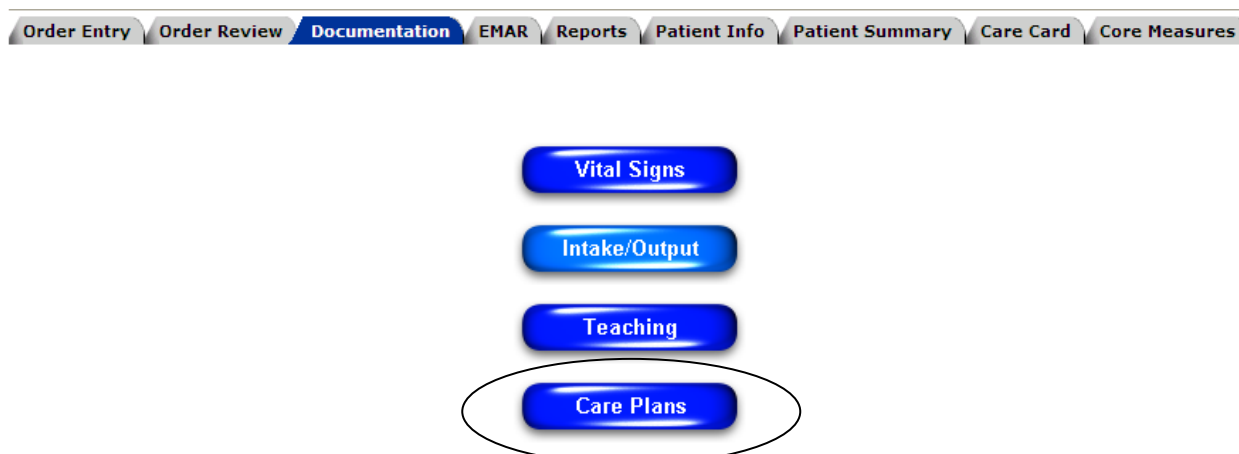
Previous documentation is reviewed and if there has been no change, click SAVE and move on to the next screen. In a report, the documentation will not include “No Change From Previous Assessment,” but will include those assessments that had been previously documented.

If an assessment reveals there has been a change in patient status, unclick the “No Change From Previous Assessment” checkbox and the screen will become active for documentation.

You may still access additional links at the bottom of the page as necessary.

Care Plans

To access the Care Plan module, click on the Documentation tab and click on the Care Plan link beneath the list of ChartSmart documentation forms.



All of the available Nursing Diagnoses pull at the top of the Care Plan form. The remaining fields will populate with information relative to the Diagnosis selected.

Care Plan

Change Date/Time
02/18/2010 01:24 PM

Alteration in Comfort: Pain

Actual or Potential
☒ Actual ☐ Potential

Nursing Diagnosis

- Alteration in Comfort: Pain
- Alteration in Family Processes
- Alteration in Health Maintenance
- Alteration in Nutrition: More Than Body Requirements
- Alteration in Nutrition: Less Than Body Requirements
- Alteration in Parenting
- Alteration in Patterns of Urinary Elimination: Incontinence
- Alteration in Patterns of Urinary Elimination: Retention
- Alteration in Sensory Perception
- Alteration in Thought Processes (Geriatrics)

Select Diagnosis and proceed with Care Plan.

Alteration in Comfort: Pain

Actual or Potential
☒ Actual ☐ Potential

Nursing Diagnosis

- Alteration in Comfort: Pain
- Alteration in Family Processes
- Alteration in Health Maintenance
- Alteration in Nutrition: More Than Body Requirements
- Alteration in Nutrition: Less Than Body Requirements
- Alteration in Parenting
- Alteration in Patterns of Urinary Elimination: Incontinence
- Alteration in Patterns of Urinary Elimination: Retention
- Alteration in Sensory Perception
- Alteration in Thought Processes (Geriatrics)

Related To:

- ☐ Musculoskeletal disorder
- ☐ Visceral disorder
- ☐ Cancer
- ☐ Information

As Evidenced By:

- ☐ Pt reports or demonstrates discomfort
- ☐ Autonomic response to acute pain
- ☐ Increased BP, P, R
- ☐ Diaphoresis

Other:

As with other forms, boxes remain inactive (grayed out) until the previous box has been addressed, to ensure that all areas are addressed.

All fields are required in the Care Plan flow sheet. A reminder will prompt the user to address a forgotten area.

Alteration in Comfort: Pain

Actual or Potential
☐ Actual ☐ Potential

Nursing Diagnosis

- Alteration in Comfort: Pain
- Alteration in Family Processes
- Alteration in Health Maintenance
- Alteration in Nutrition: More Than Body Requirements
- Alteration in Nutrition: Less Than Body Requirements
- Alteration in Parenting
- Alteration in Patterns of Urinary Elimination: Incontinence
- Alteration in Patterns of Urinary Elimination: Retention
- Alteration in Sensory Perception
- Alteration in Thought Processes (Geriatrics)


You need to address Actual or Potential

Narrative notations may be made in the text boxes provided.

Related To:

- ☒ Immobility/improper positioning
- ☐ Information
- ☐ Musculoskeletal disorder
- ☐ Overactivity

Other:

Pt states discomfort while sitting up in chair. Walking relieves pain. 

Example of a completed care plan:

Nursing Diagnosis:

Alteration in Comfort: Pain

Actual or Potential: ☒ Actual ☐ Potential

Related To:

- ☒ Musculoskeletal disorder
- ☐ Visceral disorder
- ☐ Cancer
- ☐ Information

Other:

As Evidenced By:

- ☒ Pt reports or demonstrates discomfort
- ☒ Autonomic response to acute pain
- ☐ Increased BP, P, R
- ☐ Diaphoresis

Other:

Plan and Outcome:

- ☒ The patient will experience relief of pain AEB
- ☒ The patient will verbalize reports of relief of pain
- ☒ The patient will have less autonomic responses to pain



Other:

Pt will ask for pain medication before pain gets severe.

Nursing Interventions:

- ☒ Assess characteristics of pain
- ☐ Assess location of pain
- ☒ Assess severity of pain on a scale of 1-10
- ☐ Assess frequency of pain

Other:

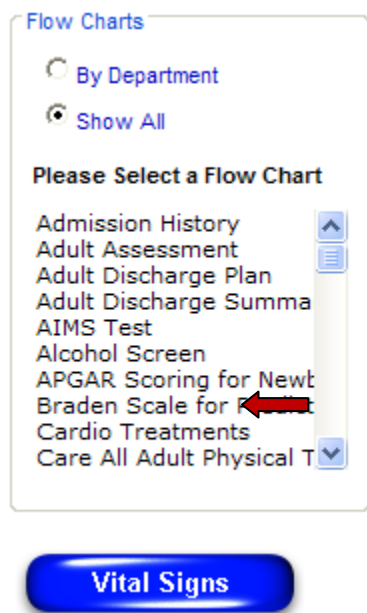
When a care plan is saved, it will populate at the bottom of the screen in a box of saved items.

Select	Nursing Diagnosis	Related To	As Evidenced By	Plan and Outcome	Nursing Interventions
<input type="checkbox"/>	Alteration in Comfort: Pain	Anxiety/stress	Abdominal heaviness; Autonomic response to acute pain	The patient will experience relief of pain AEB; The patient will have less autonomic responses to pain	Assess characteristics of pain; Assess frequency of pain; Assess location of pain

Assessment Scales: Basic Functions and Features

Throughout the system, there are links for scales such as the Braden Scale, Fall Risk Assessment, FLACC Scale, Glasgow Coma Scale, Pain Risk Assessment and others.

Scales are present in assessment forms such as the Admission History or Adult Assessment and may also be accessed separately via the Flow Chart selection box.






Flow Charts

☐ By Department

☒ Show All

Please Select a Flow Chart

- Admission History
- Adult Assessment
- Adult Discharge Plan
- Adult Discharge Summa
- AIMS Test
- Alcohol Screen
- APGAR Scoring for Newt
- Braden Scale for 
- Cardio Treatments
- Care All Adult Physical T

Vital Signs



Admission History

Change Date/Time
8/16/2010 11:44:32 AM 

Home	Immunizations/Infectious Disease	PT Screen	Social Work Screen	Fall Risk 
Planning	Drug Screen	OT Screen	Case Mgmt Screen	Organ Donation
Allergy Info	Smoking Screen	ST Screen	Pastoral	Valuables
Home Meds	Alcohol Screen	Diet Screen	Braden 	Orient to Unit
			Pain Risk 	Info Given

All risk assessment scales operate in the same manner:

- Each scale consists of a series of assessment questions.

- Each answer has a corresponding numeric value which the system will auto-populate. Note below, “No Impairment” has been selected and has a numeric value of “4.” The system auto populates the “4” into the Sensory Score.

Braden Scale for Predicting Pressure Sore Risk

Braden Scale for Predicting Pressure Sore Risk
 Copyright. Barbara Braden and Nancy Bergstrom, 1988. Reprinted with permission.

Change Date/Time

8/16/2010 12:21:25 PM

Sensory Perception

Sensory Perception

Ability to respond meaningfully to pressure-related discomfort

☒ NO IMPAIRMENT = 4 Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.

☐ SLIGHTLY LIMITED = 3 Responds to verbal commands but cannot always communicate discomfort or the need to be turned OR has some sensory impairment which limits ability to feel pain or discomfort in 1 or 2 extremities.

☐ VERY LIMITED = 2 Responds only to painful stimuli, cannot communicate discomfort by moaning or restlessness OR has a sensory impairment limiting ability to feel pain or discomfort over 1/2 of body.

☐ COMPLETELY LIMITED = 1 Unresponsive (does not moan, flinch, or grasp) to painful stimuli, due to diminished LOC or sedation OR limited ability to feel pain over most of body.

Sensory Score= 4

- The system will identify any questions that have been missed and alert you to complete.

■ Activity Not Entered - Please Address Activity

Activity

Activity

Degree of physical activity

- ☐ WALKS FREQUENTLY = 4 Walks outside room at least twice a day and inside room at least once every two hours during waking hours.
- ☐ WALKS OCCASIONALLY = 3 Walks occasionally during day, but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.
- ☐ CHAIRFAST = 2 Ability to walk severely limited or non-existent. Cannot bear own weight and/or must be assisted into chair or wheelchair.
- ☐ BEDFAST = 1 Confined to bed.

Activity Score=| <<

- Once complete, the system will compute the final assessment score for you, thereby eliminating calculation errors.
- Once a score has been calculated, a list of suggested nursing interventions will be given (such as with the Braden Scale and Fall Risk Assessment) based on that score.
- Risk assessments should be completed within 24 hours of admission and repeated as needed throughout the hospital stay.

Total Braden Scale Pressure Sore Risk Factor

Total Braden Scale Pressure Sore Risk Factor

Re-Calculate Braden Scale 15

- ☐ Scores of 19 and above indicate that the patient is not at risk for pressure sore development
- ☒ At Risk: Score 15 - 18; Turn frequently, maximize remobilization, protect heels, manage moisture, nutrition and friction/shear. Use pressure reduction support surface if bedbound or chairbound
- ☐ Moderate Risk: Score 13-14; Initiate "At Risk" measures along with specific turning schedule and use of foam wedges for 30 degree lateral positioning
- ☐ High Risk: Score 10 - 12; Initiate "Moderate Risk" measures along with supplementing turning schedule with small shifts in positioning
- ☐ Very High Risk: Score 9 or less; Initiate "High Risk" measures along with pressure relieving surface if patient has intractable pain or severe pain exacerbated by turning or other risk factors. NOTE: low air loss beds do not substitute for turning schedules

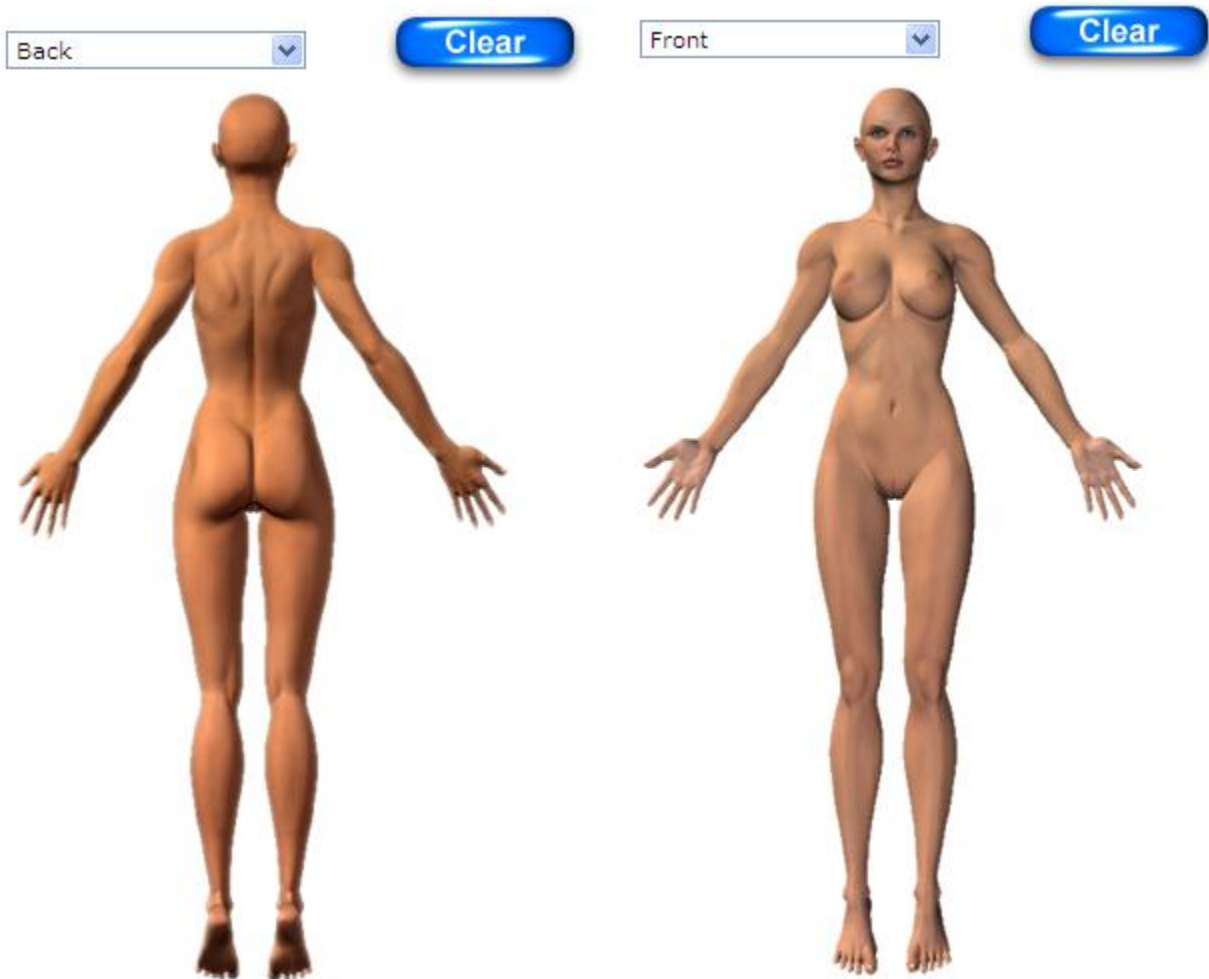
Wound Assessment

The Wound Assessment flow sheet may be accessed individually via the flow chart selection box or through the Integumentary and Musculo-skeletal links of the Adult Assessment flow sheet.

Wound Assessment

Body forms are gender-specific and will open up as per the patient's noted gender. There is the ability to turn this body 360 degrees. To do this, click on the drop down menu and select the desired view.

The new position will display.



To identify a wound site, click on the affected body site. A numeral will appear to number the wound.

The Wound Location will display to the right of the body.

Select Wound Type on the left. This will determine the information that will populate to further specify the type of wound or means of closure.

Wound Assessment

Back

Clear



1

Wound Location: Posterior Coccyx

Wound Type

☐ Surgical

☐ Lesion

☐ Decubitus

☐ Burn

☐ Body Modifications

Wound Type

Length(cm)

Width(cm)

Depth(cm)

Zoom to Save/Cancel

Healed

Surgical Wounds:



Wound Location: Posterior Coccyx

Wound Type

- ☒ Surgical
- ☐ Lesion
- ☐ Decubitus
- ☐ Burn
- ☐ Body Modifications

Means of Closure

- ☐ Sutures
- ☐ Staples
- ☐ Surgical Glue
- ☐ No Means of Closure

Length(cm)

Width(cm)

Depth(cm)

Surgical wound selection elicits Means of Closure to open up. Notice Length and Width are available for documentation; however, Depth is not necessary to record for a surgical wound.

Wound Type

- ☒ Surgical
- ☐ Lesion
- ☐ Decubitus
- ☐ Burn
- ☐ Body Modifications

Means of Closure

- ☐ Sutures
- ☒ Staples
- ☐ Surgical Glue
- ☐ No Means of Closure

Length(cm)

Width(cm)

Depth(cm)

The surgical wound has Staples documented as a means of closure.

The user will have the ability to upload a picture of the wound, if a picture of the wound has been saved to the computer.

1st the user will need to use the dropdown box to specify the wound for the picture being uploaded.

The “select” dropdown will populate the # corresponding with every wound that has been documented.

Once a wound is selected, the user can use the attach button to attach a picture the same way as attaching a document to an email.

Upload Documents

Please click on Browse to attach a document:

Select from the currently available wounds to attach the image (Only used to associate multiple images to 1 wound):

Please click on attach:

--Select--

Attach

Continue with documentation of care and assessment of the wound area.

Wound Area

<input type="checkbox"/> Sutures intact	<input type="checkbox"/> Edges are well approximated
<input type="checkbox"/> Sutures not intact	<input type="checkbox"/> Edges are not approximated
<input type="checkbox"/> Staples intact	<input type="checkbox"/> Dehiscence
<input type="checkbox"/> Staples not intact	<input type="checkbox"/> No odor
<input type="checkbox"/> Steri-strips in place	<input type="checkbox"/> Foul odor

Wound Drainage/Exudate

<input type="checkbox"/> No drainage noted	<input type="checkbox"/> Draining blood-tinged fluid
<input type="checkbox"/> Scant drainage/exudate	<input type="checkbox"/> Draining bloody fluid
<input type="checkbox"/> Minimal drainage/exudate	<input type="checkbox"/> Draining greenish fluid
<input type="checkbox"/> Moderate drainage/exudate	<input type="checkbox"/> Draining purulent fluid
<input type="checkbox"/> Copious drainage/exudate	<input type="checkbox"/> No odor

Peri-Wound Area

<input type="checkbox"/> No redness or swelling noted	<input type="checkbox"/> Red
<input type="checkbox"/> Ecchymosis	<input type="checkbox"/> Warm to touch
<input type="checkbox"/> Erythema	<input type="checkbox"/> Swollen
<input type="checkbox"/> Excoriation	<input type="checkbox"/> Painful
<input type="checkbox"/> Maceration	

Dressing and Wound Care

<input type="checkbox"/> No dressing, open to air	<input type="checkbox"/> Dressing change per MD orders
<input type="checkbox"/> Gauze dressing	<input type="checkbox"/> Steri-strips applied
<input type="checkbox"/> Occlusive dressing	<input type="checkbox"/> Aseptic technique during wound care
<input type="checkbox"/> Dressing clean, dry and intact	<input type="checkbox"/> Sutures removed per MD orders
<input type="checkbox"/> Dressing reinforced, MD to perform 1st drsg change	<input type="checkbox"/> Staples removed per MD orders

Solutions Used

<input type="checkbox"/> Normal Saline
<input type="checkbox"/> Betadine

Wound Notes

Drains and Tubes
Teaching
Review
Save
Cancel/Exit
[Zoom to Top](#)


Narrative notes may be charted via the infinite text box. Use this text box to record method of wound measurement and other pertinent data.

Other assessments may be documented or reviewed via the buttons provided.

Click SAVE to enter your documentation, otherwise click Cancel/Exit to exit the flow chart without saving data.

Notice the numbered wound is now Red. This is to signify an active wound.

Wound Type and Means of Closure are now grayed out and cannot be changed. Once a wound has been identified as a specific type of wound, it will always be known as that wound type even after it has been healed.



Wound Location: Posterior Coccyx

Wound Type

☐ Surgical
☐ Lesion
☐ Decubitus
☐ Burn
☐ Body Modifications

Means of Closure

☐ Sutures
☐ Staples
☐ Surgical Glue
☐ No Means of Closure

Decubitus Ulcers

Information for Decubitus Ulcers is entered in the same way as Surgical Wounds.

Identify the location of the wound on the body.

Identify the Wound Type as Decubitus. This will open up a box labeled Decubitus Stage. Select the correct stage based on the wound assessment.

The system will base further assessment questions on the information entered.

Wound Location: Posterior Sacrum

Wound Type

- ☐ Surgical
- ☐ Lesion
- ☒ Decubitus
- ☐ Burn
- ☐ Body Modifications

Decubitus Stage

- ☐ Stage I - Redness, no skin break
- ☒ Stage II - Blister, abrasion or skin break
- ☐ Stage III - Skin break; subcutaneous tissue exposed
- ☐ Stage IV - Skin break; subcutaneous tissue, muscle/bone exposed
- ☐ Stage V - Eschar: Dark, hard necrotic tissue
- ☐ Stage VI - Unstageable

Record the size and depth of the wound. In the Wound Care Notes at the bottom of the form, note the method of measurement used.

Length(cm)

2

Width(cm)

2

Depth(cm)

1

[Zoom to Save/Cancel](#)

Wound Area	
<input checked="" type="checkbox"/> Fluid-filled blister	<input type="checkbox"/> Tunneling
<input type="checkbox"/> Abrasion	<input type="checkbox"/> Dehiscence
<input type="checkbox"/> Skin tear	<input type="checkbox"/> Granulation tissue present at wound bed
<input type="checkbox"/> Skin break with subcutaneous tissue exposed	<input type="checkbox"/> Slough present at wound bed
<input type="checkbox"/> Skin break; subcutaneous tissue exposed and muscle/bone visible	<input checked="" type="checkbox"/> No odor
<input type="checkbox"/> Eschar present: dark, hard, necrotic tissue covering wound	<input type="checkbox"/> Foul odor

Wound Drainage/Exudate	
<input checked="" type="checkbox"/> No drainage noted	<input type="checkbox"/> Draining blood-tinged fluid
<input type="checkbox"/> Scant drainage/exudate	<input type="checkbox"/> Draining bloody fluid
<input type="checkbox"/> Minimal drainage/exudate	<input type="checkbox"/> Draining greenish fluid
<input type="checkbox"/> Moderate drainage/exudate	<input type="checkbox"/> Draining purulent fluid
<input type="checkbox"/> Copious drainage/exudate	<input type="checkbox"/> No odor

Peri-Wound Area	
<input type="checkbox"/> No redness or swelling noted	<input checked="" type="checkbox"/> Red
<input type="checkbox"/> Ecchymosis	<input checked="" type="checkbox"/> Warm to touch
<input type="checkbox"/> Erythema	<input checked="" type="checkbox"/> Swollen
<input type="checkbox"/> Excoriation	<input checked="" type="checkbox"/> Painful
<input type="checkbox"/> Maceration	

Dressing and Wound Care		Solutions Used	
<input type="checkbox"/> No dressing, open to air	<input checked="" type="checkbox"/> Dressing clean, dry and intact	<input checked="" type="checkbox"/> Normal Saline	
<input type="checkbox"/> Gauze dressing	<input type="checkbox"/> Dressing change per MD orders	<input type="checkbox"/> Betadine	
<input type="checkbox"/> Hydrocolloidal dressing	<input type="checkbox"/> Wet to dry dressing change per orders	<input type="checkbox"/> Dakin's Solution	
<input type="checkbox"/> Occlusive dressing	<input type="checkbox"/> Aseptic technique during wound care		

Interventions		Patient Response	
<input type="checkbox"/> Increase nutrition and hydration	<input type="checkbox"/> Protecting elbows and heels	<input type="checkbox"/> No complaints at this time	
<input checked="" type="checkbox"/> Keep skin clean and dry	<input type="checkbox"/> Using foam wedges	<input checked="" type="checkbox"/> Tolerated procedure well	
<input type="checkbox"/> Use paper tape	<input type="checkbox"/> Using pressure-reduction support	<input type="checkbox"/> Reports procedural pain	
<input type="checkbox"/> Tape removal done slowly	<input type="checkbox"/> Head of bed kept at less than 30 degrees	<input type="checkbox"/> Refused dressing change	
<input type="checkbox"/> Use absorbant dressings to absorb exudate	<input type="checkbox"/> Lift sheet used during turning	<input checked="" type="checkbox"/> Compliant with nursing regimen	
<input type="checkbox"/> Use debriding products	<input type="checkbox"/> Toileting offered during turning schedule	<input checked="" type="checkbox"/> Voices understanding of teaching	
<input type="checkbox"/> Pack wound to increase proper healing	<input type="checkbox"/> Pads used to wick moisture away from skin		

With the wound
assessment complete, click

Review


Save

Cancel/Exit

Save to record this as part of the patient's permanent record.

For further documentation on this wound, click on the wound and the assessment area will open up.

When the wound heals, document this by clicking into the "Healed" box just below the size boxes.



Wound Location: Posterior Sacrum

Wound Type

- ☐ Surgical
- ☐ Lesion
- ☐ Decubitus
- ☐ Burn
- ☐ Body Modifications

Decubitus Stage

- ☐ Stage I - Redness, no skin break
- ☐ Stage II - Blister, abrasion or skin break
- ☐ Stage III - Skin break; subcutaneous tissue exposed
- ☐ Stage IV - Skin break; subcutaneous tissue, muscle/bone exposed
- ☐ Stage V - Eschar: Dark, hard necrotic tissue
- ☐ Stage VI - Unstageable

Length(cm)

Width(cm)

Depth(cm)

[Zoom to Save/Cancel](#)

☒ Healed

When healed, the wound will turn green and is no longer an active wound. No further documentation may be entered on a healed wound. If the wound were to reoccur, click as close as possible to that same wound site and a new number will appear.



For review of care on all wounds or to Remove documentation, click on the Review button and the following screen will appear:

Wounds Review

Wounds Review

Select	Date/Time	Employee	No.	Healed	Location	Category	Type	Length (cm)	Width (cm)	Depth (cm)	Wound Area	Drainage	Peri-Wound
<input type="checkbox"/>	2/11/2010 4:36:40 PM	Joe Smith	1	No	Posterior Sacrum	Decubitus	Stage II - Blister, abrasion or skin break	2	2	1	Fluid-filled blister^No odor	No drainage noted	Red^Warm to touch^Swollen
<input type="checkbox"/>	2/11/2010 4:43:35 PM	Joe Smith	1	Yes	Posterior Sacrum	Decubitus	Stage II - Blister, abrasion or skin break	0	0	0			

Remove

Cancel/Exit

Click on the appropriate checkbox to remove an entry, if necessary. Only the user who entered the information may remove it. Other users will have read-only access.

Vital Signs

Vital Signs

Links are available throughout the software for

ChartSmart User's Manual

Temp: F C

--(Site)--

--(Site)--

Pulse:

--(Site)--

--(Site)--

Resp:

--(Site)--

--(Site)--

Bp: /


--(Site)--

--(Posture)--

O2 Sat (%):

--(Delivery)--

--(Delivery)--

DateTime: 


easy access to this much-used function.

To access, click on the link once and the form will open up.

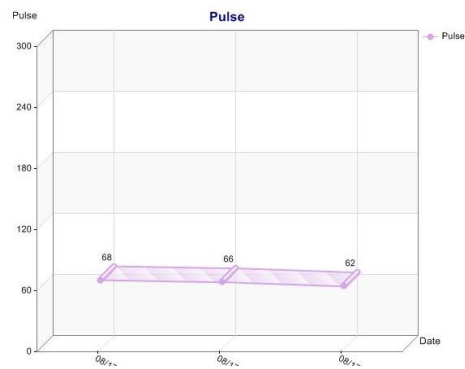
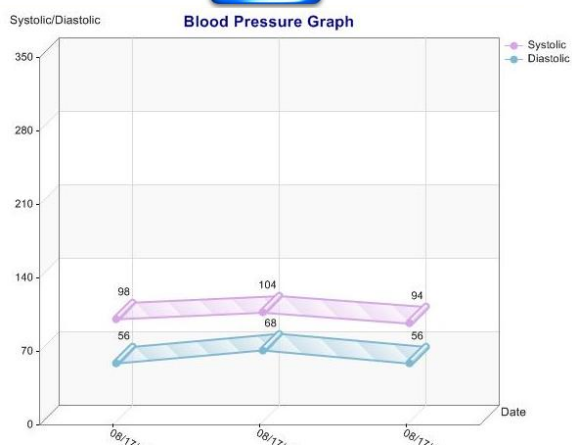
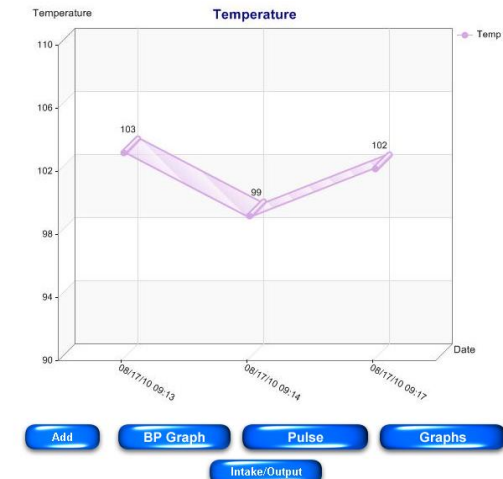
To enter a set of Vital Signs type in the value then hit the TAB key.

If there is a required site for that value, the TAB key will move to that field.

To enter a site, Tab over to the desired box and either use the down arrow on the computer keyboard, or click on the drop down arrow on the screen and make the selection from that menu.

Temp:	<input type="text" value="98.5"/>	F	<input type="text" value="Oral"/>	▼
	<input type="text" value="36.94"/>	C		
Pulse:	<input type="text" value="88"/>		<input type="text" value="Radial"/>	▼
Resp:	<input type="text" value="14"/>			
Bp:	<input type="text" value="120"/>	/	<input type="text" value="Left Arm"/>	▼
	<input type="text" value="45"/>		<input type="text" value="Lying"/>	▼
O2 Sat (%):	<input type="text" value="99"/>		<input type="text" value="None"/>	▼
DateTime:	<input type="text" value="2/12/2010 1:12:37 PM"/> 			
<input type="button" value="Save"/>		<input type="button" value="Cancel/Exit"/>		

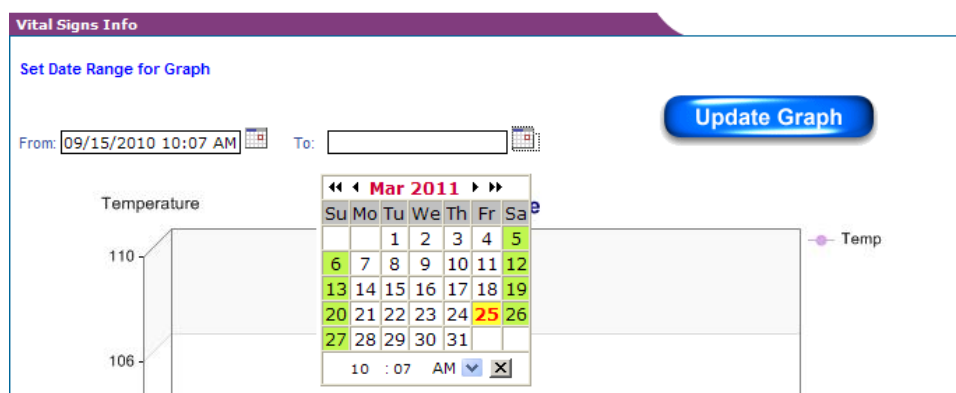
Once Vitals and site boxes have been entered, click Save. These values will be graphed and added to the patient's record.



Vitals are graphed by Temperature, BP, and Pulse. Graphs may be viewed separately by clicking the corresponding buttons. View all graphs at once by clicking Graphs button.



Vital sign information can be graphed in 5-day increments. Via calendar icons, user may choose begin and end dates and a graph showing the Vital Signs of those days will appear.



To remove a mistaken Vital Signs entry:

Shift: 7:00 A.M. to 7:00 P.M.								
	Entry Time	Temperature	Pulse	Respiratory	BP	O2 Sat (%)	Entered By	
<input type="checkbox"/>	03/29/2011 14:19	39.44 Tympanic	76 Radial	12	138/88	99	Joe Smith	Edit

Click the “Edit” link and the Vital Signs window with user’s most recent entry will populate. Correct the mistaken entry and click “Save Changes.”

Shift: 7:00 A.M. to 7:00 P.M.								
	Entry Time	Temperature	Pulse	Respiratory	BP	O2 Sat (%)	Entered By	
<input type="checkbox"/>	03/29/2011 14:19	39.44 Tympanic	76 Radial	12	142/88	99	Joe Smith	Edit

Intake and Output

Intake/Output

To access Intake and Output there are multiple links throughout the software.

DateTime: 2/12/2010 2:13:48 PM

INTAKE

PO: --PO Type-- Amt: Unit: --Unit--

IV Fluids: --IV Fluids-- Amt: ml

Misc: --Misc-- Amt: Unit: --Unit--

Meals: --Meals-- % Consumed: --Meals Consumed--

OUTPUT

☒ Volume ☐ Frequency

Type: --Output Type-- Amt: ml

Save

Cancel/Exit

Enter Intake: Select the Intake Type. Click on the drop down arrow to the right, highlight choice, and click once on that selection. Hit the TAB key on the keyboard to go to Amount and type in the amount. Hit the TAB key once more and select the unit value from the drop down menu.

PO: P.O. Fluids Amt: 250 Unit: ml

Enter

Output: Select Volume or Frequency. Select the desired output from the scroll down menu. Tab over to the Amount section and type in the amount.

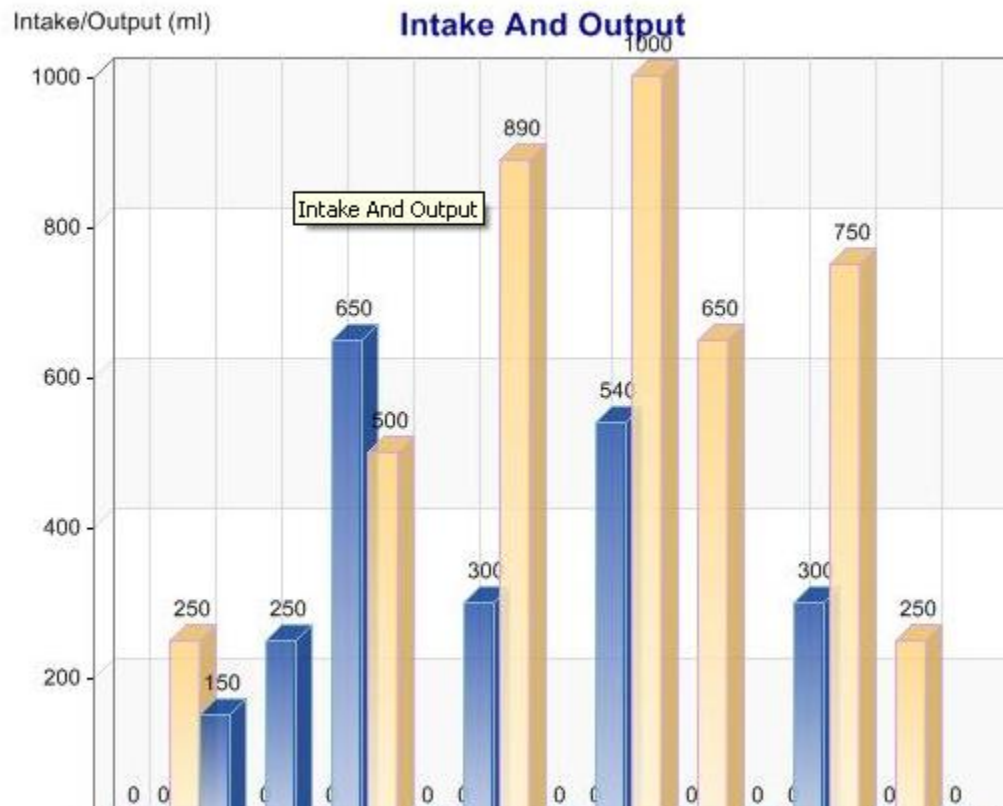
☒ Volume ☐ Frequency

Type: Urine Amt: 150 ml

☐ Volume ☒ Frequency

Type: Stool Times: 2 ml Size: Medium

To finish this entry, click “Save.” The entries graph at the bottom of the form. The gold bars are Intake Values and the Blue bars are output values.



All entries are also added in text format per shift (shown) and in 24 Shift Totals (not shown):

Shift: 7:00 A.M. to 7:00 P.M.			
INTAKE			
Entry Time	In Type	Amount	Entered By
08/17/2010 10:41	P.O. Fluids	240 ml	Joe Smith
08/17/2010 10:41	IV Fluids	75 ml	Joe Smith
Shift Total:		315 ml	
OUTPUT			
Entry Time	Out Type	Amount	Entered By
08/17/2010 10:41	Urine	460	Joe Smith
08/17/2010 10:42	JP Drain	20	Joe Smith
Shift Total:		480 ml	

Electronic Medication Administration Record (EMAR)

To document the patient's medications, click the EMAR tab to open this module:

The screenshot shows the EMAR module interface. At the top, there is a row of tabs: Order Entry, Order Review, Documentation, **EMAR**, Reports, Patient Info, Patient Summary, Care Card, and Floor Charges. Below the EMAR tab, there are two sub-tabs: Discharge and Documents. On the left, there are links for Order Verification, Administration History, Home Medications, Vital Signs, I and O, Pain Assessment, IV Assessment, and IV Care. On the right, there are buttons for Sliding Scale (set to None) and PCA (set to None). At the bottom, there are radio buttons for All Medications (selected), Scheduled, PRN, IV/PB, IV Fluid, Current, Forward 24 Hours, and Back 24 Hours. There is also a text field for Administration Date/Time set to 03/25/2011 16:31.

The EMAR contains links for various Medication Administration functions.

Order verification

Some hospitals have a policy that certain medications need to be verified by a second nurse prior to administration. In this case, new medication orders will first appear gray. To become active, Order Verification must be completed.

To verify that an order is correct, click on the “Order Verification”

Order Verification

button in the top left hand corner of the screen.

The unverified orders appear:

The screenshot shows a table of unverified medication orders. At the top left, there is a checkbox labeled "Select All". The table has six columns: Selection, Medication, Order Details, Start Date, Start Time, and Care Provider. There are six rows of medication orders, each with a checkbox in the Selection column. Below the table, there are two text fields for Co-signer User Name and Co-signer Password. At the bottom, there are three buttons: Save Changes (green), Cancel/Exit (red), and Cancel Orders (blue).

Selection	Medication	Order Details	Start Date	Start Time	Care Provider
<input type="checkbox"/>	Coumadin	10 mg By Mouth Once a Day	2/15/2010	12:00	ALPERT M
<input type="checkbox"/>	Crestor	20 mg By Mouth Once a Day	2/15/2010	10:00	ALPERT M
<input type="checkbox"/>	Humulin R	100 Units/ML SubQ One Time	2/15/2010	10:26	ALPERT M
<input type="checkbox"/>	Lasix, Furosemide	80 mg By Mouth One Time	2/15/2010	10:22	ALPERT M
<input type="checkbox"/>	Morphine Sulfate For PCA Pump		2/15/2010	10:00	ALPERT M
<input type="checkbox"/>	Potassium Chloride	20 MEQ/ML 75 By Mouth Continuous Infusion IV 100 ml	2/15/2010	10:24	ALPERT M

Co-signer User Name:

Co-signer Password:

Save Changes **Cancel/Exit** **Cancel Orders**

To Verify Orders: A second nurse will look at these orders and check them against the written order from the physician. If correct, each medication may be individually selected, or, click on the “Select All” box at the top of the page.

The second nurse will then sign in with user name and password.

Co-signer User Name:

Co-signer Password:

Once orders have been verified, the new medications become active in the EMAR.

Order Verification Vital Signs IV Assessment

Administration History I and O IV Care

Home Medications Pain Assessment

Sliding Scale
None

PCA
None

☒ All Medications
 ☐ Scheduled
 ☐ PRN
 ☐ IV/IV Piggy
 ☐ IV Fluid
 ☐ Current
 ☐ Forward 24 Hours
 ☐ Back 24 Hours

Administration Date/Time:

	Start Date	End Date	Details	Med. Due	Care Provider	Action Taken	Not Given/Disc Reason/Comments
Gentamicin in NaCl (Iso-osm) Info	3/25/2011 17:00	03/25/2011	100 mg/100 mL 75 IV Three times a Day	3/25/2011 17:00	AGALOTIS	<input type="radio"/> Address <input type="radio"/> Undo Action <input type="radio"/> Discontinue	<input type="text"/>
Albuterol Sulfate Info	3/25/2011 17:00	03/25/2011	2.5 mg mg/5 mL Inhl Four Times a Day	3/25/2011 17:00	AGALOTIS	<input type="radio"/> Given <input type="radio"/> Not Given <input type="radio"/> Discontinue <input type="radio"/> Undo Action	<input type="text"/>
Phenergan-Codeine Info	3/25/2011 17:00	03/25/2011	6.25-10 mg/5 mL Oral PM	3/25/2011 16:48	AGALOTIS	<input type="radio"/> Given <input type="radio"/> Not Given <input type="radio"/> Discontinue <input type="radio"/> Undo Action	<input type="text"/>

There are different color codes for different medication types:

- Green indicates that the order is currently due
- Gold is a One Time Order
- Yellow indicates that the Order is Overdue
- White is an active order but not currently due
- Black is an inactive or discontinued medication

A discontinued medication will remain on the EMAR for 24 hours before falling off.

Medication Administration

To document that a medication was “Given.” Click on the white circle labeled “Given”. Then click the Submit button below the form. To clear a mistaken entry, click “Undo Action.”

Albuterol Sulfate Info	3/25/2011 17:00	03/25/2011	2.5 mg mg/5 mL Inhl Four Times a Day	3/25/2011 17:00	AGALIOTIS	<input checked="" type="radio"/> Given <input type="radio"/> Not Given <input type="radio"/> Discontinue <input type="radio"/> Undo Action	
Phenergan-Codeine Info	3/25/2011 17:00	03/25/2011	6.25-10 mg/5 mL Oral PM	3/25/2011 16:48	AGALIOTIS	<input type="radio"/> Given <input type="radio"/> Not Given <input checked="" type="radio"/> Discontinue <input type="radio"/> Undo Action	Discontinued per MD order.

Submit Orders

Text boxes are available for any necessary narratives.

“One Time” ordered medication: Once this medication has been documented as “Given,” the medication order is no longer active. The system will discontinue the medication automatically:

Name	Med. Due	Action Taken	Administration Date	Details	Care Provider	Not Given/Disc Reason/Comments
Lasix; Furosemide	2/15/2010 10:22	Given	02/15/2010 10:28	80 mg By Mouth One-Time	ALPERT M	

To document that a medication was “Not Given.” Click on the circle labeled “Not Given” and provide a description of the reason in the free text box to the right:

Crestor	2/15/2010 10:00	02/15/2010	20 mg By Mouth Once a Day	2/15/2010 10:00	ALPERT M	<input type="radio"/> Given <input checked="" type="radio"/> Not Given <input type="radio"/> Discontinue <input type="radio"/> Undo Action	Patient Not on Floor
---------	-----------------	------------	---------------------------	-----------------	----------	---	----------------------

Click “Submit” and the order pulls to the bottom of the page. Administration details including the reason for not giving the medication are included.

Crestor	2/15/2010 10:00	Not Given	02/15/2010 10:28	20 mg By Mouth Once a Day	ALPERT M	Patient Not on Floor
---------	-----------------	-----------	------------------	---------------------------	----------	----------------------

To Discontinue an active medication: Click the “Discontinue” button and then provide the reason in the free text box provided. A discontinued medication will be inactive, but will remain on the EMAR for 24 hours before falling off:

	Start Date	End Date	Details	Med. Due	Care Provider	Action Taken	Not Given/Disc Reason/Comments
Lasix Info	3/29/2011 09:00	03/29/2011	40 mg Inj AM	3/29/2011 09:15	COUNSELMAN	<input type="radio"/> Given <input type="radio"/> Not Given <input checked="" type="radio"/> Discontinue <input type="radio"/> Undo Action	<div>Medication dosage changed per MD order.</div>


Click “Submit” and the medication order will turn black.

	Med. Due	Action Taken	Administration Date	Details	Care Provider	Not Given/Disc Reason/Comments
Lasix Info	3/29/2011 09:15	Discontinued	03/29/2011 09:15	40 mg Inj AM	COUNSELMAN	Medication dosage changed per MD order.

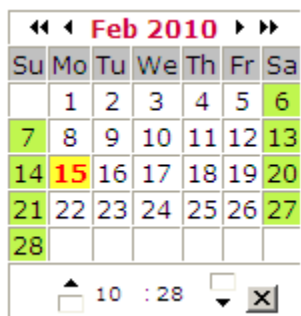
Changing Time of Administration

To Change Administration Date/Time:


Locate the Administration Date/Time at the top of the page:

Administration Date/Time: 02/15/2010 10:28 

Now click on the calendar Icon. The current date shows highlighted in yellow and red. Click on the desired date and the calendar will go away.



To change the time: Use the arrows in the time field to adjust to the desired time. To leave the calendar, click on the X.

Administration Date/Time: 02/15/2010 08:00 

Now the system shows that the documentation time is 0800.

EMAR Links

Above the primary form, there is a series of links which make verification and documentation of medications quick and easy:

Order Entry	Order Review	Documentation	EMAR	Reports	Patient Info	Patient Summary	Care Card	Floor Charges
Discharge								
Order Verification			Vital Signs	IV Assessment	Sliding Scale	PCA		
Administration History			I and O	IV Care	None	None		
Home Medications			Pain Assessment					

Sliding Scale and PCA orders are set apart because they require specific information when administered.

Click on the PCA order located on the EMAR and the PCA record box will open up over the EMAR. SAVE documentation and the box will close, enabling full view of the EMAR once again. Box is movable with your cursor.

Windham Clarissa | MRN: 93498677 | Visit No: 9987099 | Room: NONE | DOB: 06/29/1981 | Gender: Female | LOG O

Diet: NONE | Attending Physician: COUNSELMAN | Consulting Physician: | Code Status: Full | Smoking Status: I currently

No Drug Allergies

Last Temp: 101.1 | 01/20/11 14:26

Order Entry

Discharge

Order Verificat
Administration
Home Medicat

All Medications

No Orders found

Med. Due

3/29/2011

PCA Infusion

Morphine (PF) in 0.9 % NaCl

Ordered By: COUNSELMAN

Details: 25 mg/25 mL (1 mg/mL) IV AM

Administration Date/Time: 01/20/2011 14:26

Status: ☒ Given ☐ Not Given ☐ Discontinued

Bolus:

Patient Administered Dose:

Basal Rate:

Hourly Limit:

Lockout Time:

Initial Volume:

Previous Amount: 25ml

Amount Left in Syringe: 22

Volume Used by Patient: 3

Vital Signs

Pain Assessment

Reading Date 1/20/2011 2:24:32 PM

Temp 101

Pulse 68

BP 96/68

Respiration 12

O2 98

Save Cancel/Exit

PRN Administration

To document on a PRN order, find the section labeled PRN and select the desired medication from the list of medications present:

PRN


Tylenol / Codeine
No. 3

Once selected, the PRN form will open up:

Tylenol / Codeine No. 3

Ordered By: **ALPERT M**

Details: **300/30 mg By Mouth Every 4 hours Pain**

Administration Date/Time: 

Status: ☒ Given ☐ Not Given ☐ Discontinued

PRN Reason: ☒ Sleep ☐ Anxiety ☐ Pain ☐ Other

Route: ☒ PO
☐ IV
☐ Subcutaneous
☐ Intramuscular

Patient Tolerated Treatment Well: ☒ Yes ☐ No

Comments:

[Pain Assessment](#)
[Pain Assessment](#)

[Save](#)
[Cancel/Exit](#)

The medication order appears at the top of the screen. To the far right there is instant access to the Pain Assessment link. To open the form, just click on the link. When finished documenting the Pain Assessment, save the information and the form will close, returning to the medication screen.

Status:

Status is defaulted to “Given.” If choosing “Not Given” or “Discontinued,” the system will request a reason. This will be a free text field to type in any needed details.

Status: ☒ Given ☐ Not Given ☐ Discontinued

PRN Reason:

Choose just one reason per medication administration.

PRN Reason: ☒ Sleep ☐ Anxiety ☐ Pain ☐ Other

Route:

Click on the appropriate route and continue with documentation.

Patient Tolerated:

To complete the form, indicate how the patient tolerated the treatment and add any necessary comments into the comments section below.

Patient Tolerated Treatment Well: ☒ Yes ☐ No

Comments:

Save **Cancel/Exit**

Click “Save” to record this information as a permanent part of the patient’s chart.

Sliding Scale Administration

To administer a sliding scale based Insulin, locate and click on the Sliding Scale link.

Order Entry **Order Review** **Documentation** **EMAR** **Reports** **Patient Info** **Patient Su**
Discharge **Documents**

[Order Verification](#) [Vital Signs](#) [IV Assessment](#) [Sliding Scale](#)
[Administration History](#) [I and O](#) [IV Care](#) [Insulin Regular Human](#)
[Home Medications](#) [Pain Assessment](#)

Clicking on the link will bring up the record for this medication.

Sliding Scale

Insulin Regular Human

Ordered By: **SMITH PHOEBE J**

Details: **0 Injection Three times a Day**

Administration Date/Time:

Glucose Reading:

Status: ☒ Given ☐ Not Given ☐ Discontinued

☒ Subcutaneous ☐ Intramuscular

Subcutaneous:

Amount of Insulin (Units):

Other Nursing Interventions: ☐ Gave 1 Amp D50 Slow IV Push
☐ Gave Orange Juice
☐ Received New Order From Doctor
☐ Monitoring Glucose Levels Every 5 Minutes

Save **Cancel/Exit**

From	To	Unit
0	200	0
201	250	2
251	300	4
301	350	6
351	400	8 Call MD BG >400

The name of the medication in this form appears at the top of the page, the medication details appear below the medication name. In the center-right of the page, find the sliding scale displayed. Scroll down to see the entire sliding scale.

When entering the Glucose Reading, the system will pull over the corresponding insulin dose.

Glucose Reading:	<input type="text" value="275"/>		<table border="1"> <thead> <tr> <th>From</th> <th>To</th> <th>Unit</th> </tr> </thead> <tbody> <tr> <td>0</td> <td>200</td> <td>0</td> </tr> <tr> <td>201</td> <td>250</td> <td>2</td> </tr> <tr> <td>251</td> <td>300</td> <td>4</td> </tr> <tr> <td>301</td> <td>350</td> <td>6</td> </tr> <tr> <td>351</td> <td>400</td> <td>8 Call MD BG >400</td> </tr> </tbody> </table>	From	To	Unit	0	200	0	201	250	2	251	300	4	301	350	6	351	400	8 Call MD BG >400
From	To	Unit																			
0	200	0																			
201	250	2																			
251	300	4																			
301	350	6																			
351	400	8 Call MD BG >400																			
Status:	<input checked="" type="radio"/> Given <input type="radio"/> Not Given <input type="radio"/> Discontinued																				
Route:	<input checked="" type="radio"/> Subcutaneous <input type="radio"/> Intramuscular																				
Subcutaneous:	<input type="text" value="<Choose one of the following>"/>																				
Amount of Insulin (Units):	<input type="text" value="4"/>																				

Clicking on Subcutaneous or Intramuscular will prompt the drop down menu for administration sites.

Route:	<input checked="" type="radio"/> Subcutaneous <input type="radio"/> Intramuscular
Subcutaneous:	<input type="text" value="<Choose one of the following>"/>
Amount of Insulin (Units):	<input type="text" value="4"/>
Other Nursing Interventions:	<input type="text" value="Stomach"/>


“Save” the data and the Administration record will be created. To view, click on “Administration History” link on the EMAR. All insulin administration records will be visible.

Order Type	Admin. Date	Care Provider	Glucose Reading	Amt Given	Details
Insulin Regular Human	3/30/2011 9:44:00 AM	SMITH PHOEBE J	275	4	

Cancel/Exit


Call MD Feature

For extreme high or low values, there is the Call MD feature. When added in the order entry process, this feature prompts the nurse to call the physician when an out-of-range blood glucose value is entered in the administration record.

Glucose Reading: 

Amount of Insulin (Units): **Call MD**
[New Order Received](#)

Other Nursing Interventions: ☐ Gave 1 Amp D50 Slow IV Push
☐ Gave Orange Juice

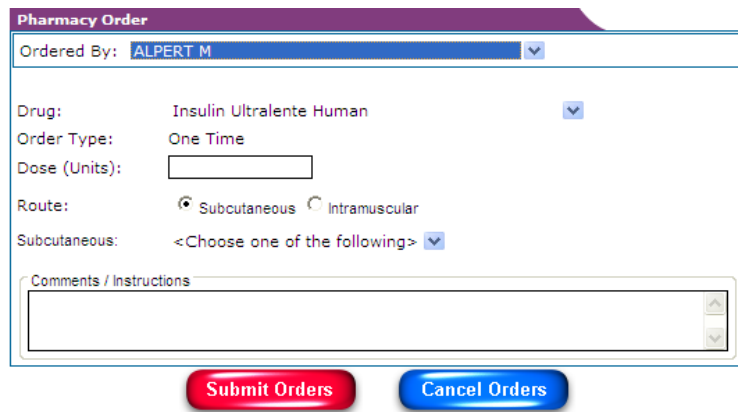


From	To	Unit
0	200	0
201	250	2
251	300	4
301	350	6
351	400	8
		Call MD BG >400

To enter the new order, click the blue link:

Call MD
[New Order Received](#)

The following screen will open up for quick entry of a new One Time order:



Pharmacy Order

Ordered By: ALPERT M

Drug: Insulin Ultralente Human

Order Type: One Time

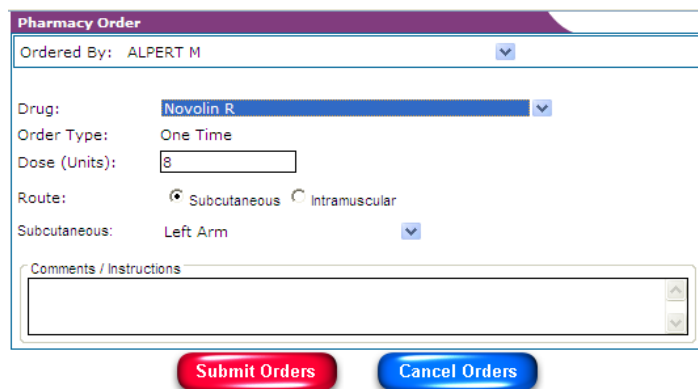
Dose (Units):

Route: ☒ Subcutaneous ☐ Intramuscular

Subcutaneous: <Choose one of the following>

Comments / Instructions

Select the drug via the drop down feature. Enter the dose and the site. When complete, the order screen should look like this:



Pharmacy Order

Ordered By: ALPERT M

Drug: Novolin R

Order Type: One Time

Dose (Units):

Route: ☒ Subcutaneous ☐ Intramuscular

Subcutaneous: Left Arm

Comments / Instructions

To complete the order click Submit.

Sliding Scale Insulins

Humulin R
~~Novolin R~~

The Novolin R was the one-time order issued by the physician. The system documents that the care provider gave this insulin in the Left Arm and discontinues the medication because it was a one-time order.

PCA Medication Administration

To document on a PCA pump, find the area at the top of the page labeled:

PCA Medications

Morphine Sulfate For PCA Pump (VS Q2H)

Click one time and the form will open.

The screenshot shows a web-based form titled "PCA Infusion" with a sub-header "Morphine Sulfate For PCA Pump". The form contains the following fields and buttons:

- Ordered By:** STELLY T
- Details:** Right Arm
- Administration Date/Time:** 02/15/2010 15:08 (with a calendar icon)
- Status:** ☒ Given ☐ Not Given ☐ Discontinued
- Protocol Box (center):**
 - Bolus: 2
 - Patient Administered Dose: 1
 - Basal Rate: 1
 - Hourly Limit: 3
 - Lockout Time: 5
- Initial Volume:** 30
- Previous Amount:** 28
- Amount Left in Syringe:** (empty text box)
- Volume Used by Patient:** (empty text box)
- Buttons:** Save (green), Cancel/Exit (red)
- Vital Signs Module (right):** Vital Signs (blue button)
- Pain Assessment Module (right):** Pain Assessment (blue button)
- Vital Signs Data (right):**
 - Reading Date: 2/15/2010 3:07:40 PM
 - Temp: 98.6
 - Pulse: 78
 - BP: 130/40
 - Respiration: 14
 - O2: 99

The name of the medication appears in the top of the screen. The protocol entered during the order entry process is located in the box in the center of the screen.

The most recent Vital Signs appear on the far right side with a link to the Vital Signs Module to enter a new set of vitals.

The Pain Assessment link is there for the care provider's convenience to assess the patient's pain level.

Syringe Volume: When "Amount Left in Syringe" is entered, the system will auto-calculate the "Volume Used by Patient" and enter that in the space provided.

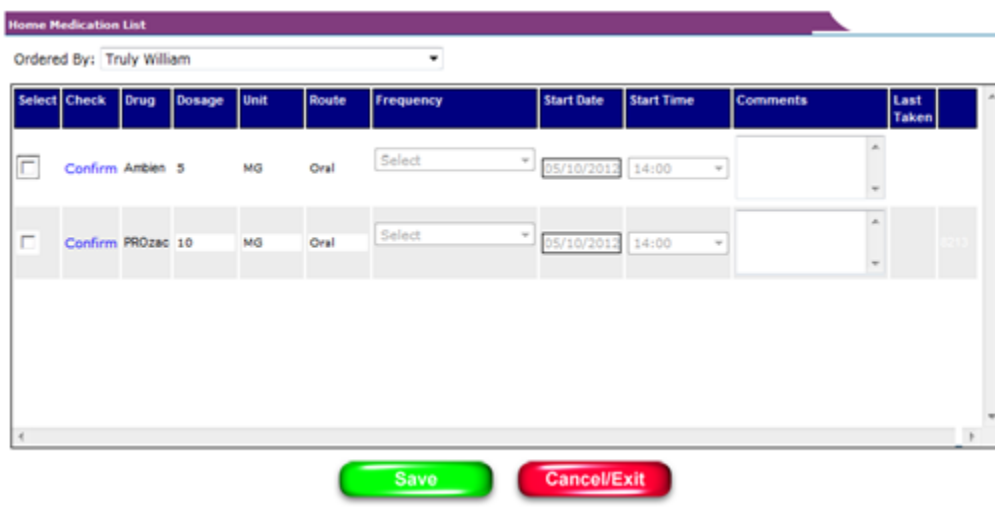
Home Medications

The ChartSmart EMAR allows the care provider to activate Home Medications from the EMAR page without having to return to the Order Entry module.

To begin, find the "Home Medications" button on the left side of the screen.



Click once and the form will open.

The form is titled "Home Medication List" in a purple header bar. Below the header, there is a dropdown menu labeled "Ordered By: Truly William". The main area contains a table with columns: Select, Check, Drug, Dosage, Unit, Route, Frequency, Start Date, Start Time, Comments, and Last Taken. There are two rows of medication orders. The first row shows "Confirm Ambien 5 MG Oral" with a "Select" dropdown for frequency, "05/10/2012" for start date, and "14:00" for start time. The second row shows "Confirm PROzac 10 MG Oral" with a "Select" dropdown for frequency, "05/10/2012" for start date, and "14:00" for start time. At the bottom of the form are two buttons: a green "Save" button and a red "Cancel/Exit" button.

The Home Medication list will pull from the Home Medication assessment in the Admission History form or the Patient Info section.

The top of the Home Medications page shows the ordering physician and the date and time to start the medication.

Click the "Select" box at the left of the order and then select the frequency. Click "Save" to set up this New Order. This will populate as a verbal order in CPOE for the ordering physician to sign.

Based on the protocol of the facility, there might be a need to have a second nurse verify this order. Once verified the order appears on the EMAR.

Name	Start Date	End Date	Details	Med. Due	Care Provider	Action Taken	Not Given/Disc Reason/Comments
Nutrilite	2/15/2010 15:00	Not Given	70/30 UNITS SubQ Once a Day Home Medication:	2/15/2010 15:00	ALPERT M	<input type="radio"/> Given <input type="radio"/> Not Given <input type="radio"/> Discontinue <input type="radio"/> Undo Action	

Administration History

To review a complete history of a patient's drug profile throughout the length of stay, select the "Administration History" button on the left side of the EMAR screen.

Medications display according to Order Type (Immunization, Sliding Scales, etc.)

Immunizations						
Order Type	Admin. Date	Care Provider	Status	Reason	Decider	Relation to Patient
Tetanus	2/15/2010 11:57:00 AM	ALPERT M	Consent		Alicia Lott	Self
Sliding Scale Insulins						
Order Type	Admin. Date	Care Provider	Glucose Reading	Amount Given	Details	
Novolin R	2/15/2010 1:58:00 PM	ALPERT M	350	8	Received New Order From Doctor	
Novolin R	2/15/2010 1:46:00 PM	ALPERT M	350	8		
Medication List						
Order Type	Admin. Date	Care Provider	Action Taken	Details	Comments	
Lasix, Furosemide	2/15/2010 10:28:00 AM	ALPERT M	Given	80 mg By Mouth One Time		
Crestor	2/15/2010 10:28:00 AM	ALPERT M	Not Given	20 mg By Mouth Once a Day	Patient Not on Floor	

To view the Administration for a particular medication, click on the name of a medication in the EMAR. A complete Administration History will open up for that particular medication.

EMAR						
Albuterol Sulfate						
Name	Med. Due	Action Taken	Administration Date	Details	Care Provider	Not Given/Disc Reason/Comments
Albuterol Sulfate	3/25/2011 12:00:00 AM 17:00	Scheduled		2.5 mg mg/5 mL Inhl Four Times a Day	AGALIOTIS	
Albuterol Sulfate	3/25/2011 12:00:00 AM 23:00	Scheduled		2.5 mg mg/5 mL Inhl Four Times a Day	AGALIOTIS	
Albuterol Sulfate	3/26/2011 12:00:00 AM 05:00	Scheduled		2.5 mg mg/5 mL Inhl Four Times a Day	AGALIOTIS	
Albuterol Sulfate	3/26/2011 12:00:00 AM 11:00	Scheduled		2.5 mg mg/5 mL Inhl Four Times a Day	AGALIOTIS	

Care Card

The Care Card is a real-time guide to patient care and should be referred to frequently via ChartSmart rather than printing out the Care Card to plan out patient care.

The Care Card is divided into Nursing Categories which may be viewed by groups as show below, or as one continuous flow sheet with the ability to scroll down to each category and view orders.

Order Entry | Order Review | Documentation | EMAR | Reports | Patient Info | Patient Summary | **Care Card** | Core Measures

Floor Charges | Discharge

All Nursing Categories

- Alerts/Code St/Iso
- Act/Hyg/Pos/Safety
- Vital Signs/I & O/Gluc
- Nutr/Hydr/Elim
- Skin/Drsg/Drain/Ost
- IV/Pain
- Consults/Consents
- Cond Orders/Misc
- Blood/Pre- & Post-Op
- Cardio/Respiratory
- GI/GU
- Neuro/Ortho
- NurseCollect

Care Card - All Categories

Alerts

Select	Order	Status	Start Date	Date
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Completed Performed Discontinued

Code Status

Select	Order	Status	Start Date	Date
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Completed Performed Discontinued

Isolation

Select	Order	Status	Start Date	Date
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Completed Performed Discontinued

Orders on the Care Card are generated from the Order Entry system either directly from the Nursing Order section:

Nursing Order

Ordered By: ALPERT M

Alerts

<input type="checkbox"/> Admit to Dr. :_	<input type="checkbox"/> History of :_
<input type="checkbox"/> Admit to ICU	<input checked="" type="checkbox"/> No B/P or sticks in Left arm
<input type="checkbox"/> Admit to L&D	<input type="checkbox"/> No B/P or sticks in Right arm
<input checked="" type="checkbox"/> Admit to Med Surg	<input type="checkbox"/> Notify Dr. :_ of Admission and Room #
<input type="checkbox"/> Admit to Nursery	<input checked="" type="checkbox"/> Old Charts to floor
<input type="checkbox"/> Admit to Peds	

Alerts Other

Or by selecting “Nursing to Collect” in a standard lab order:

Laboratory Order

Ordered By: ALPERT M

Now

Priority
☐ Stat
☒ Now
☐ Routine
☐ Timed

Urine, CI Catch

Frequency
 Every 12 Hours
 Every 4 Hours
 Every 6 Hours
 Every 8 Hours
 Every Other Day
 Four Times a Day
 Once a Day
 One Time

Start Date / Time
 08/19/2010
 <Choose>

URINALYSIS

Specimen Type
☐ Synovial
☐ Throat
☐ Urine, Cath
☒ Urine, CI Catch
☐ Wound

Specimen in Lab
☒ Nurse To Collect
 Collected Date / Time
 08/19/2010 14:30

Orders flow to the Care Card and are separated by category.

All Nursing Categories
 Alerts/Code St/Iso
 Act/Hyg/Pos/Safety
 Vital Signs/I & O/Gluc
 Nutr/Hydr/Elim
 Skin/Drsg/Drain/Ost
 IV/Pain
 Consults/Consents
 Cond Orders/Misc
 Blood/Pre- & Post-Op
 Cardio/Respiratory
 GI/GU
 Neuro/Ortho
 NurseCollect

Care Card - All Categories

Alerts

Select	Order	Status	Start Date	Date
<input type="checkbox"/>	Admit to Med Surg		6/14/2010 6:43:47 PM	
<input type="checkbox"/>	No B/P or sticks in Left arm		6/14/2010 6:43:47 PM	
<input type="checkbox"/>	Admit to Med Surg		8/19/2010 2:38:50 PM	
<input type="checkbox"/>	No B/P or			

Code Status

Select	Order	Status	Start Date	Date
<input type="checkbox"/>	Chemical Code Only		8/20/2010 1:54:23 PM	
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Completed **Performed** **Discontinued**

An alert for specimen collection shows up in **RED** at the top of the Care Card and may be accessed by clicking the **NurseCollect** link which will take user to the specimen collection list.

All Nursing Categories
 Alerts/Code St/Iso
 Act/Hyg/Pos/Safety
 Vital Signs/I & O/Gluc
 Nutr/Hydr/Elim
 Skin/Drsg/Drain/Ost
 IV/Pain
 Consults/Consents
 Cond Orders/Misc
 Blood/Pre- & Post-Op
 Cardio/Respiratory
 GI/GU
 Neuro/Ortho
 NurseCollect

Care Card - All Categories

Items remaining to be collected by Nurse

Alerts

Select	Order	Status	Start Date	Date
<input type="checkbox"/>	Admit to Med Surg		6/14/2010 6:43:47 PM	
<input type="checkbox"/>	No B/P or sticks in Left arm		6/14/2010 6:43:47 PM	
<input type="checkbox"/>	Admit			

Code Status

Select	Order	Status	Start Date	Date
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

All specimens for Nursing collection will populate in this section:

All Nursing Categories
 Alerts/Code St/Iso
 Act/Hyg/Pos/Safety
 Vital Signs/I & O/Gluc
 Nutr/Hydr/Elim
 Skin/Drsg/Drain/Ost
 IV/Pain
 Consults/Consents
 Cond Orders/Misc
 Blood/Pre- & Post-Op
 Cardio/Respiratory
 GI/GU
 Neuro/Ortho
 NurseCollect

Nurse Collect

Items remaining to be collected by Nurse

Nurse Collected

Select	Specimen Type	Collect Date	Status	Order Date
<input type="checkbox"/>	Blood	06/29/2010 14:01	Nurse to collect	6/29/2010 2:01:29 PM
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Completed

Select the specimen and press the “Completed” button to show this order has been filled. Orders will cross out in green but will remain on the list for easy reference of all past specimen orders.

All Nursing Categories
 Alerts/Code St/Iso
 Act/Hyg/Pos/Safety
 Vital Signs/I & O/Gluc
 Nutr/Hydr/Elim
 Skin/Drsg/Drain/Ost
 IV/Pain
 Consults/Consents
 Cond Orders/Misc
 Blood/Pre- & Post-Op
 Cardio/Respiratory
 GI/GU
 Neuro/Ortho
 NurseCollect

Nurse Collect

Items remaining to be collected by Nurse

Nurse Collected

Select	Specimen Type	Collect Date	Status	Order Date
<input type="checkbox"/>	Blood	06/29/2010 1:49:40 PM	Nurse Collected	6/29/2010 2:01:29 PM
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				
<input type="checkbox"/>				

Completed

All Nursing Categories
 Alerts/Code St/Iso
 Act/Hyg/Pos/Safety
 Vital Signs/I & O/Gluc
 Nutr/Hydr/Elim
 Skin/Drsg/Drain/Ost
 IV/Pain
 Consults/Consents

Care Card - All Categories

Alerts

Select	Order	Status	Start Date	Date
<input type="checkbox"/>	Admit to Med Surg		6/14/2010 6:43:47 PM	

Code Status

Select	Order	Status	Start Date	Date
<input type="checkbox"/>	Chemical Code Only		8/20/2010 1:54:23 PM	

Once all specimens have been collected, the alert at the top of the page disappears.

Patient Info

This section allows the user to enter many different types of information under the same Tab. Much of this information populates onto the Patient Banner such as Code Status, Diagnosis, and most recent Height/Weight and Vital Signs.

Other information under this section includes patient demographic information which populates over from the registration process and may only be viewed in the EMR.

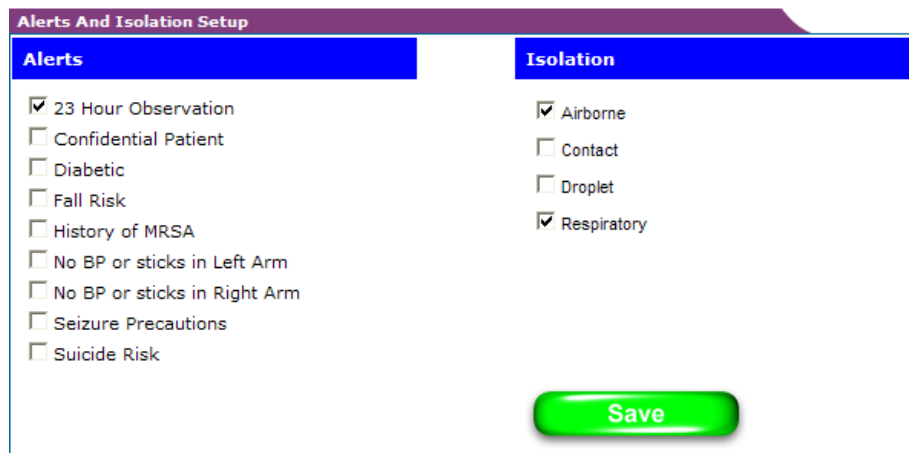
Many of the links have already been covered in this manual (such as Allergies and Home Meds). Tabs are presented in order of appearance in this section:

Review

This link gives an overview of all the links in the Patient Info section. This is a read-only section. No documentation is done under the Review section.

Alerts and Isolation

Select the appropriate checkboxes and click “Save.” Content will populate onto the banner.



The form is titled "Alerts And Isolation Setup" and is divided into two main sections: "Alerts" and "Isolation".

Alerts Section:

- ☒ 23 Hour Observation
- ☐ Confidential Patient
- ☐ Diabetic
- ☐ Fall Risk
- ☐ History of MRSA
- ☐ No BP or sticks in Left Arm
- ☐ No BP or sticks in Right Arm
- ☐ Seizure Precautions
- ☐ Suicide Risk

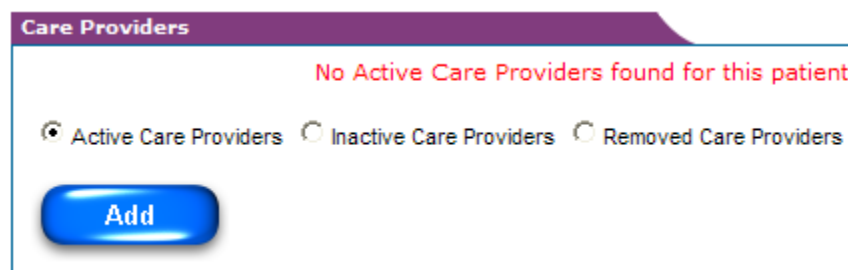
Isolation Section:

- ☒ Airborne
- ☐ Contact
- ☐ Droplet
- ☒ Respiratory

A green "Save" button is located at the bottom right of the form.

Care Providers

Click “Add” to list a care provider’s name.



The form is titled "Care Providers" and displays a message: "No Active Care Providers found for this patient".

Below the message are three radio buttons:

- ☒ Active Care Providers
- ☐ Inactive Care Providers
- ☐ Removed Care Providers

A blue "Add" button is located at the bottom left of the form.

Use the drop-down feature to select a provider.

Click the checkbox if this is the Primary Care Provider and Select Provider’s Role.

Care Provider Setup

Care Provider:

☐ Primary Care Provider

Role:

Start DateTime:

The completed entry will contain the following information:

Care Provider Setup

Care Provider:

☒ Primary Care Provider

Role:

Start DateTime:

Information may be viewed and edited. To remove a care provider, click Remove and enter a reason in the box provided. Click Save and the provider will be removed from the banner.

Care Providers

☒ Active Care Providers ☐ Inactive Care Providers ☐ Removed Care Providers

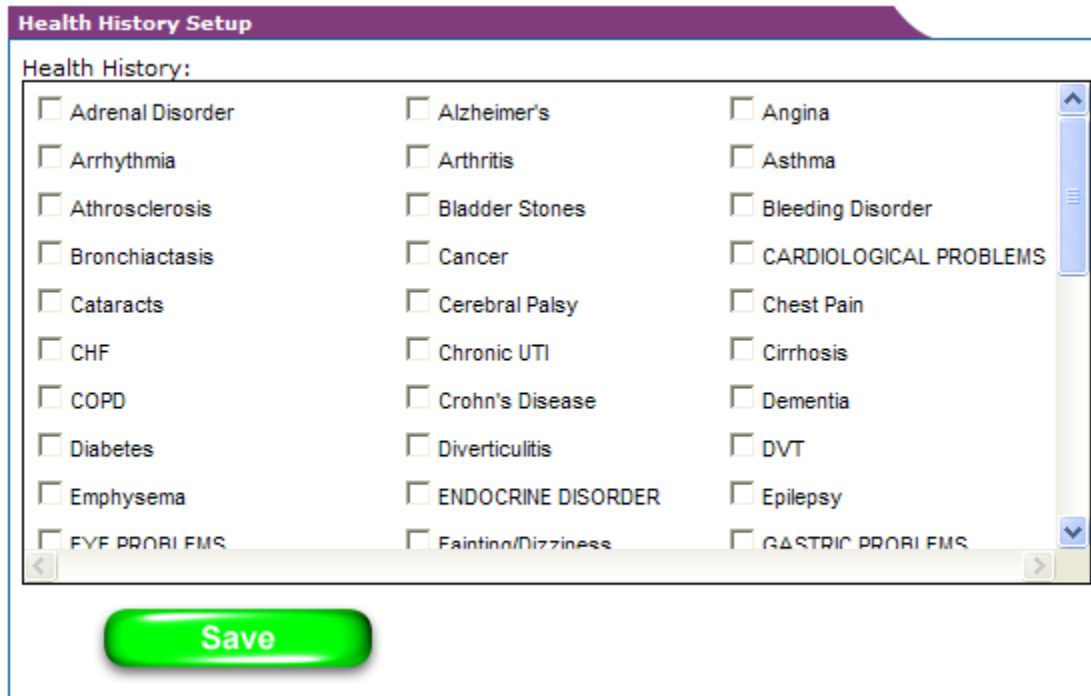
	Care Provider	Credentials	Role	Start Date	End Date	Reason
<input type="checkbox"/>	ALLEN HERB		Admitting	3/29/2011 4:05:52 PM		<input type="text"/>

Health Hx



A dialog box titled "View Health History" with a purple header. It contains two blue buttons: "Add" and "Remove".

Click "Add" to add any health problems the patient may report. The following screen will open up:



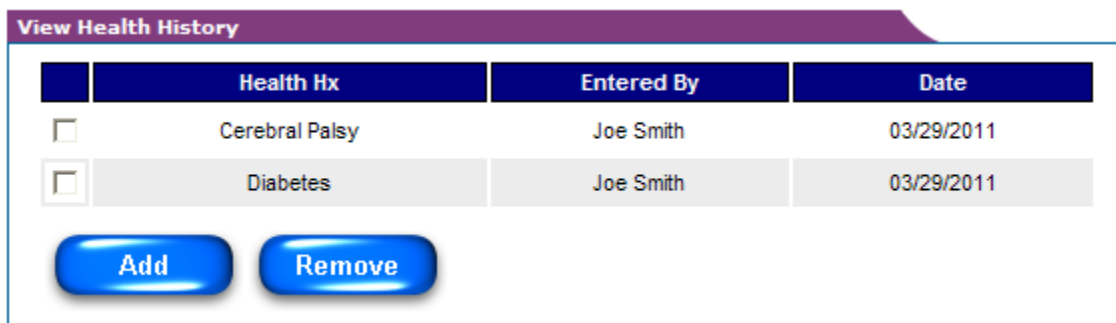
A dialog box titled "Health History Setup" with a purple header. It contains a list of health conditions with checkboxes. A green "Save" button is at the bottom.

Health History:

<input type="checkbox"/> Adrenal Disorder	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Angina
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Asthma
<input type="checkbox"/> Atherosclerosis	<input type="checkbox"/> Bladder Stones	<input type="checkbox"/> Bleeding Disorder
<input type="checkbox"/> Bronchiectasis	<input type="checkbox"/> Cancer	<input type="checkbox"/> CARDIOLOGICAL PROBLEMS
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Chest Pain
<input type="checkbox"/> CHF	<input type="checkbox"/> Chronic UTI	<input type="checkbox"/> Cirrhosis
<input type="checkbox"/> COPD	<input type="checkbox"/> Crohn's Disease	<input type="checkbox"/> Dementia
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Diverticulitis	<input type="checkbox"/> DVT
<input type="checkbox"/> Emphysema	<input type="checkbox"/> ENDOCRINE DISORDER	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> EYE PROBLEMS	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> GASTRIC PROBLEMS

Save

Saved information will appear as noted and may be edited as necessary:



A dialog box titled "View Health History" with a purple header. It displays a table of saved health history entries. Below the table are "Add" and "Remove" buttons.

	Health Hx	Entered By	Date
<input type="checkbox"/>	Cerebral Palsy	Joe Smith	03/29/2011
<input type="checkbox"/>	Diabetes	Joe Smith	03/29/2011

Add Remove

Visit Hx

This is read-only information which populates from the ADT (Admission, Discharge, and Transfer) part of the electronic system. A sample visit history would include the following information:

View Visit Info			
Visit #	Primary Care provider	Admit Date	Discharge Date
9987099	COUNSELMAN	01/16/2010 2:49PM	
04	ALPERT M	07/15/2009 09:45 AM	07/22/2009 09:45 AM

Diagnosis

To enter a Diagnosis, click on the link and the following box will appear if no diagnosis already exists:

View Diagnoses

Click the “Add” button and the order screen will appear. You can search for a diagnosis by text or by ICD9 code. You key in characters in the “filter” box, hit enter, and the list of options will populate in the dropdown box next to “diagnosis”.

Diagnosis Setup

By Text

By ICD9

Type in to filter Diagnosis:

Diagnosis:

Is Primary Diagnosis: ☐

Name:

ICD9:

Date Observed:

Click “Save” and the diagnosis will be saved in three areas: Patient Banner, Diagnosis link, and Problem List.

	Primary Diagnosis	Secondary Diagnosis	Diagnosis	ICD9	Nurse Name	Entered Date
<input type="checkbox"/>	Diseases of the respiratory system (460-519)	chronic obstructive pulmonary disease and allied conditions (490-496)	COPD, NOS	496.0	Joe test Smith	3/29/2011 2:54:25 PM

Add **Remove**

To remove a diagnosis, click the checkbox and then click “Remove.”

To add another diagnosis, click “Add” and proceed as noted above.

Problem List

The Problem List is derived in the same way diagnoses are generated via a 3-tier system and include much of the same information; however, there is also a section to Change Status to Resolved, Active, or Inactive.

Primary Diagnosis	Secondary Diagnosis	Diagnosis	ICD9	Status	Status Date	Entered By	Entered Date	Change Status
Diseases of the skin and subcutaneous tissue (680-709)	infections of skin and subcutaneous tissue (680-686)	Cellulitis/abscess, leg	682.0	Resolved	3/29/2011 3:01:18 PM	Joe test Smith	3/29/2011 3:00:57 PM	<input type="radio"/> Resolved <input type="radio"/> Active <input type="radio"/> Inactive
Diseases of the respiratory system (460-519)	chronic obstructive pulmonary disease and allied conditions (490-496)	COPD, NOS	496.0	Active	3/29/2011 2:54:25 PM	Joe test Smith	3/29/2011 2:54:25 PM	<input type="radio"/> Resolved <input type="radio"/> Active <input type="radio"/> Inactive

Add **Save**

All diagnoses will flow into the Problem List.

Problem List entries will not flow into the Diagnosis section.

Height/Weight

Entries will be stored in this section and will populate onto the Patient Banner.

Click the Height/Weight link and the following box will appear:

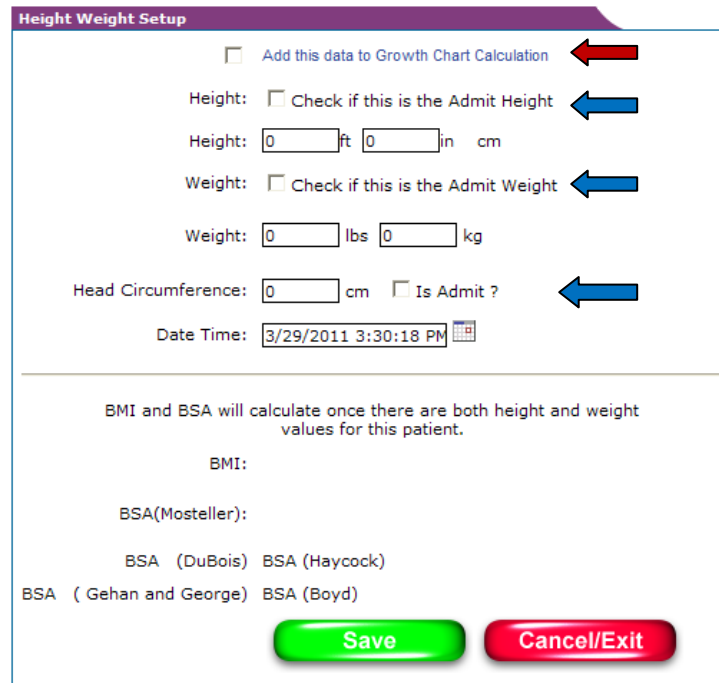


A dialog box titled "View Height/Weight" with a purple header. It contains two sections: "Patient Height" and "Patient Weight", each with a light blue background. Below these sections is a large blue button labeled "Add".

Click "Add" to make the initial entry.

To add this data to a Growth Chart, click the checkbox noted below.

Check appropriate boxes for Admit information.



A dialog box titled "Height Weight Setup" with a purple header. It contains several input fields and checkboxes. A red arrow points to the checkbox "Add this data to Growth Chart Calculation". Blue arrows point to the checkboxes "Check if this is the Admit Height", "Check if this is the Admit Weight", and "Is Admit?". The input fields are: Height (0 ft 0 in cm), Weight (0 lbs 0 kg), and Head Circumference (0 cm). The Date Time field shows "3/29/2011 3:30:18 PM". Below the input fields, there is a section for BMI and BSA calculations, with text stating "BMI and BSA will calculate once there are both height and weight values for this patient." The BSA section lists four methods: BSA (Mosteller), BSA (DuBois), BSA (Haycock), and BSA (Gehan and George), BSA (Boyd). At the bottom are two buttons: "Save" (green) and "Cancel/Exit" (red).

Add Height and hit enter key. Metric measurement will auto-populate.

Add Weight and hit enter key. Now that Height/Weight are entered, BMI and BSA values appear.

Height Weight Setup

☒ Add this data to Growth Chart Calculation

Height: ☒ Check if this is the Admit Height

Height: ft in 96.52 cm

Weight: ☒ Check if this is the Admit Weight

Weight: lbs kg

Head Circumference: cm ☐ Is Admit ?

Date Time:

BMI and BSA will calculate once there are both height and weight values for this patient.

BMI: 15.09

BSA(Mosteller): 0.61

BSA (DuBois) BSA (Haycock)

BSA (Gehan and George) BSA (Boyd)

Save **Cancel/Exit**

Click “Save” and information becomes part of the permanent record.

Immunizations

Immunization

No Data Found

☒ Received ☐ Not Received ☐ All Immunizations

Recommended Immunization Schedule Review

0 years through 6 years
7 years through 18 years

Recommended Immunization Catch up Schedule

4 months through 6 years
Over 18 years

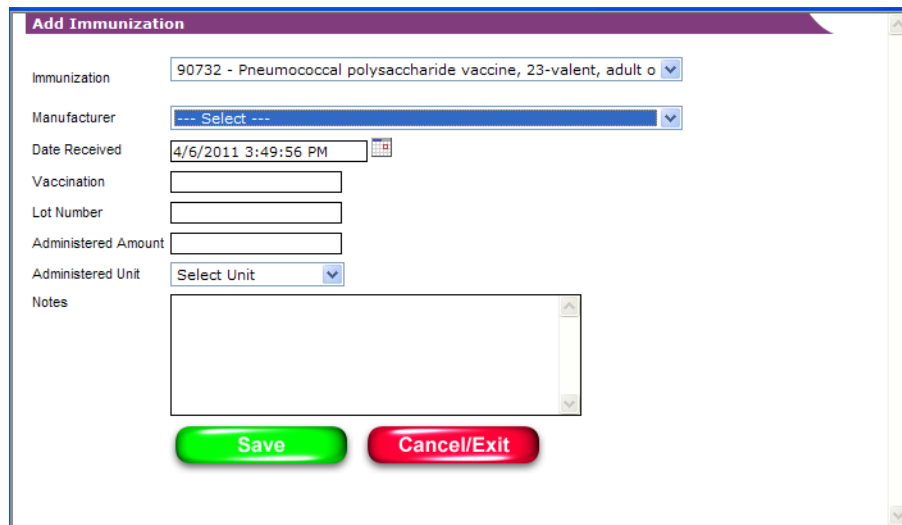
CPT CODE	CPT Description	CVX Code	Vaccine Name	History
----------	-----------------	----------	--------------	---------

Record

Current Recommended Immunization Schedules are available for pediatric and adult patients. Click on an age link to pull up a PDF with literature on these schedules.

Record all immunizations given during hospital stay.

To record an immunization, click the “Record” button.



The screenshot shows a web-based form titled "Add Immunization". The form contains the following fields and controls:

- Immunization:** A dropdown menu with the selected value "90732 - Pneumococcal polysaccharide vaccine, 23-valent, adult o".
- Manufacturer:** A dropdown menu with the value "--- Select ---".
- Date Received:** A text box containing "4/6/2011 3:49:56 PM" with a small calendar icon to its right.
- Vaccination:** An empty text box.
- Lot Number:** An empty text box.
- Administered Amount:** An empty text box.
- Administered Unit:** A dropdown menu with the value "Select Unit".
- Notes:** A large, empty text area with a vertical scrollbar.
- Buttons:** At the bottom of the form are two buttons: a green "Save" button and a red "Cancel/Exit" button.

Select the immunization via the drop-down window. Use the calendar icon if the immunization occurred on a different date. Complete Vaccination and Lot Number information. Use the Note box for any narrative information.

Click “Save” to make this a part of the patient record. Click “Cancel/Exit” to leave this section without saving any data.

Internal Patient Messaging

[Patient Selection](#)
[Change Hospital](#)
[AD HOC Query](#)
[Clinical Quality Measure](#)
[LOG OUT](#)

[MU Calculations](#)
[Out Patients](#)
[Discharged Patients](#)
[BI Reports](#)

Patient Selection
 Select Department <--Please Select Department--> or Look Up <--Select Search Option-->

[Check Patient Messages](#)

My Patient List

LastName	FirstName	Room #	DOB	Primary Dx	Select for Removal
ALPAUGH	ROBERT F	102	09/03/1937	Presenile dementia (290.1)	<input type="checkbox"/>
BAKER	ZOE	102	02/14/1974	No Primary Diagnosis Entered	<input type="checkbox"/>
CARPENTER	VIVIAN M	102	10/10/1931	Acquired hemolytic anemias (283)	<input type="checkbox"/>
RASMUSSEN	NANCY L	102	05/05/1943	No Primary Diagnosis Entered	<input type="checkbox"/>
SCOTT JR	WALLACE A	102	07/01/1962	No Primary Diagnosis Entered	<input type="checkbox"/>

This system of messaging allows for confidential information to be passed along to caregivers without becoming a permanent part of the patient record.

Click on the “Check Patient Messages” link and a listing of all messages will appear:

[Patient Selection](#)
[Change Hospital](#)
[AD HOC Query](#)
[Clinical Quality Measure](#)

[MU Calculations](#)
[Out Patients](#)
[Discharged Patients](#)
[BI Reports](#)

Below are a list of patients with messages that have been assigned to them.

Name	Messages
ROBERT F ALPAUGH	1
NANCY L RASMUSSEN	1

Click on a patient’s name and you will be taken to the message within the patient’s chart:

[RASMUSSEN NANCY L](#)
MRN: 150164
 Visit No: 10645443
 Room: 102
 DOB: 05/05/1943
 Gender: Female
 [LOG OUT](#)

Admit Datetime: 15/12/2008 08:09
 No Attending Physician
 No Consulting Physician

Diet: NONE
 No Code Status
 No Smoking Status

1 Drug Allergies:
 No Food Allergies
 No Environmental Allergies
 No Alerts
 No Isolations
 No Diagnosis

Last Temp:
 Last BP:
 Last Pulse:
 Last Resp:
 Admit Wt: N/A
 Last Wt:
 Last BG:

Admit Ht: N/A

[Order Entry](#)
[Order Review](#)
[Documentation](#)
[EMAR](#)
[Reports](#)
[Patient Info](#)
[Patient Summary](#)
[Care Card](#)
[Floor Charges](#)

[Discharge](#)
[Documents](#)
[Messages](#)
[H & P](#)
[Progress Notes](#)

	Created By	Messages	Acknowledged	Creation Date
<input type="button" value="Edit"/> <input type="button" value="Delete"/>	Joe Smith	Patient's husband will be staying with her tonight as she is nervous about treatment tomorrow.	<input type="checkbox"/>	8/18/2011 3:57:59 PM

User is able to acknowledge and answer messages from this screen. Only the author of a message is able to delete the message. Once a message has been acknowledged by another user, however, the message cannot be deleted.

Documents

A CCD/CCR document is an electronic form of the patient's record which can be sent to another facility upon patient discharge.

To create the document, click the "Create CCR" button. (Currently not functioning)

The screenshot shows the patient record for RASMUSSEN, NANCY L. with MRN: 150164. The 'Documents' tab is selected in the navigation bar. A dialog box titled 'Upload Documents' is open, prompting the user to click 'Browse' to attach a document or 'Attach' to attach a file. Below the dialog box, there is a section for 'Create CCR Documents' with a button labeled 'Create CCR'.

History & Physical

To access physician History and Physical entries, click the H&P Tab and the following screen appears:

The screenshot shows the 'History and Physical' screen. The 'H & P' tab is selected in the navigation bar. The 'Current Visit' section shows the date and time: 8/19/2011 1:39:00 PM. The 'Selected Radiology Transcriptions' section is empty. A 'Next' button is visible at the bottom right.

Click on the date under "Current Visit" and the note for that date/time will appear:

Current Visit
8/19/2011 1:39:00 PM

History and Physical

History Allergies Current Medication
Review of Systems Physical Exam Lab Results
Radiology Transcription Current Problem List Physician Notes

Entered Date & Time: 8/19/2011 1:39:00 PM

History

Chief Complaint :
Pt presented with mild confusion, headache, and dizziness. Contralateral paralysis for 2 hours this morning; left side affected.

History of Present Illness (HPI) :
History of one stroke 2 years ago. Left-sided weakness resulted, much improved with PT and medication.

Past Medical History (PMH) :
Stroke - 2 years ago; aortic valve replacement one year ago.

Past Surgical History (PSH) :
Aortic valve replacement by Dr. Beaver June 2010.

Family History (FH) :
No Hx stroke in family. Positive for cardiac "conditions."

As with all documentation, this is a read-only document for anyone other than the physician who authored the entry.

Access other physician-entered information via the blue links located within this tab.

Progress Notes

To access physician Progress Note entries, click the Progress Note Tab and the following screen appears:

Order Entry Order Review Discharge Documents Documentation Messages EMAR H & P Reports **Progress Notes** Patient Info Patient Summary Care Card Floor Charges

Current Visit
8/19/2011 2:06:07 PM

Progress Notes

Click on the date under "Current Visit" and the note for that date/time will appear:

Order Entry	Order Review	Documentation	EMAR	Reports	Patient Info	Patient Summary	Care Card	Floor Charges
Discharge	Documents	Messages	H & P	Progress Notes				

Current Visit
8/19/2011 2:06:07 PM

Progress Notes
LUE paralysis resolved. Patient able to squeeze my hand, albeit weakly, but with purpose and improved strength. Consult to Neuro phoned in.

Clinical Decision Support and Alerts in ChartSmart

ChartSmart includes a number of Alerts and Clinical Decision Support features which serve to both aid care givers in documentation and order entry as well as improve patient care.

New Order Acknowledgment

Nurses will be alerted to new orders, patient messages, and critical lab values with each log in.

Clicking on the patient name brings the nurse to the Physician Order Screen where all new orders are waiting to be acknowledged before continuing on to respective departments (see pg. 29).

Patient Selection

Select Department <--Please Select Department--> or Look Up <--Select Search Option-->

Search

Check Patient Messages Patient has Order(s) to be Acknowledged

My Patient List

LastName	Firstname	Room #	DOB	Primary Dx	Select for Removal
ALPAUGH	ROBERT F	102	09/03/1937	Presenile dementia (290.1)	<input type="checkbox"/>
BAKER	ZOE	102	02/14/1974	No Primary Diagnosis Entered	<input type="checkbox"/>
CARPENTER	VIVIAN M	102	10/10/1931	Acquired hemolytic anemias (283)	<input type="checkbox"/>
RASMUSSEN	NANCY L	102	05/05/1943	No Primary Diagnosis Entered	<input type="checkbox"/>
SCOTT JR	WALLACE A	102	07/01/1962	No Primary Diagnosis Entered	<input type="checkbox"/>

Critical Lab Values

Critical Lab Value alerts are also noted on the Patient Selection Screen.

Select Department <--Please Select Department--> or Look Up <--Select Search Option-->

Search

Critical Lab Values

My Out Patient List

LastName	Firstname	Room #	DOB	Primary Dx	Select for Removal
ANDERSON	ALLEN	102	06/11/2008	No Primary Diagnosis Entered	<input type="checkbox"/>

Click on the red link and a message box with all alerts will open up.

Out Patient Selection

Select Department <--Please Select Department--> or Look Up <--Select Search Option-->

Search

Critical Lab Values

	Last Name	First Name	Visit Number	Critical Lab Value	Critical Value
<input type="checkbox"/>	ANDERSON	ALLEN	10672911	CULTURE, EAR	204

My Out P

Last

ANDERSON

Select for Removal

☐

Acknowledged

Alert messages are removed by selecting the box next to the patient's name and then click "Acknowledged."

Select Department <--Please Select Department--> or Look Up <--Select Search Option-->

Search

Acknowledged Successfully

Acknowledged

My Out P

Last

ANDERSON

Select for Removal

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