



MOUNT SINAI HOSPITAL MEDICAL CENTER
MEDITECH TRAINING

This orientation manual is designed to ensure all per diem and contract agency personnel receive an orientation to Meditech prior to working at Mount Sinai Hospital Medical Center. All per diem and contracted agency employees are expected to read, acknowledge and adhere to the clinical documentation procedures provided within the Mount Sinai Hospital Medical Center – Meditech Training.

TABLE OF CONTENTS

MEDITECH..... 2

GETTING STARTED 3

THE STATUS BOARD 5

YOUR PATIENT LIST..... 6

ASSESSING YOUR PATIENT 12

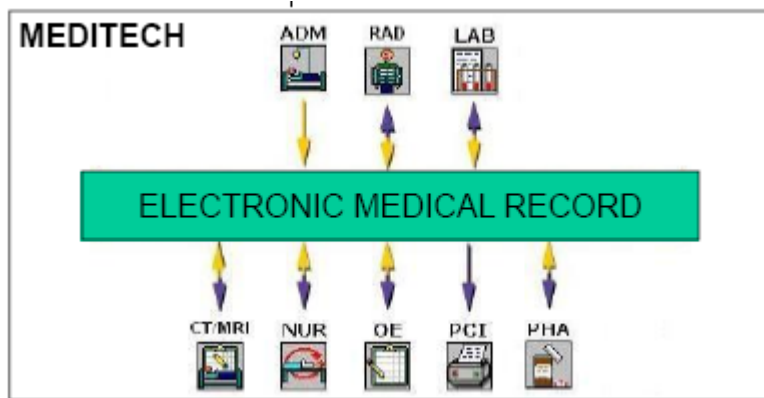
CHARTING PATIENT CARE..... 26

DOCUMENTING PATIENT NOTES 59

ACKNOWLEDGING PATIENT ORDERS 61

MEDITECH

- Meditech is Mt. Sinai Hospital's Health Information Management System.
- It integrates all functions associated with the requisition and delivery of patient care.
 - Nursing
 - Laboratory
 - Imaging / Diagnostic Services
 - Pharmacy
 - Dietary Services
 - Ancillary Subspecialties – Social Work, PT, OT, RT, Pastoral Care
- It uses multi-directional communication to permit all care givers to know the status of any given element of a patient's plan of care.
- Activity within Meditech on any patient record is written to that patient's Electronic Medical Record.



- Meditech has 'hot' charting several hot keys that save time when charting.
 - F9 → initiates a lookup.
 - F11 → exits the current screen and does not save the data entered
 - F12 → files the data entered and exits the current screen.
 - F6 → moves the cursor to the previous field.
 - N → when entered in a 'TIME' field, enters the current clock time.
 - T → when entered in a 'DATE' field, enters the current date.
Example: if today is 5/19/09, entering 'T' in any date field will autopopulate that field with 05/19/09.
 - T +/- '#' → when entered in a 'DATE' field, will enter a date # number of days before or after the current date.
Example: if today is 5/19/09, entering 'T-2' in any date field will autopopulate that field with 05/17/09, two days PRIOR to the current date.
- Use these keystrokes to expedite your charting.



GETTING STARTED

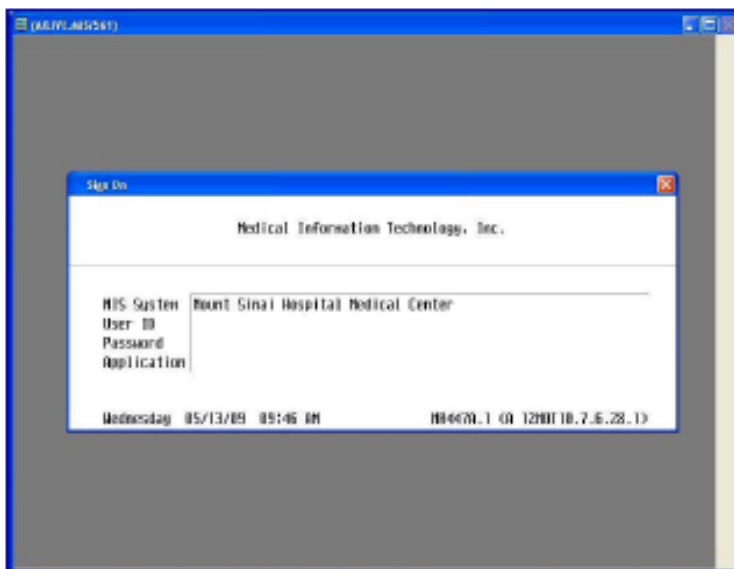
This is the Splash Screen.

- It is the first screen shown after opening Meditech.
- It displays messages for downtime or changes in IS policies.
- Hit ENTER from this screen to log in.

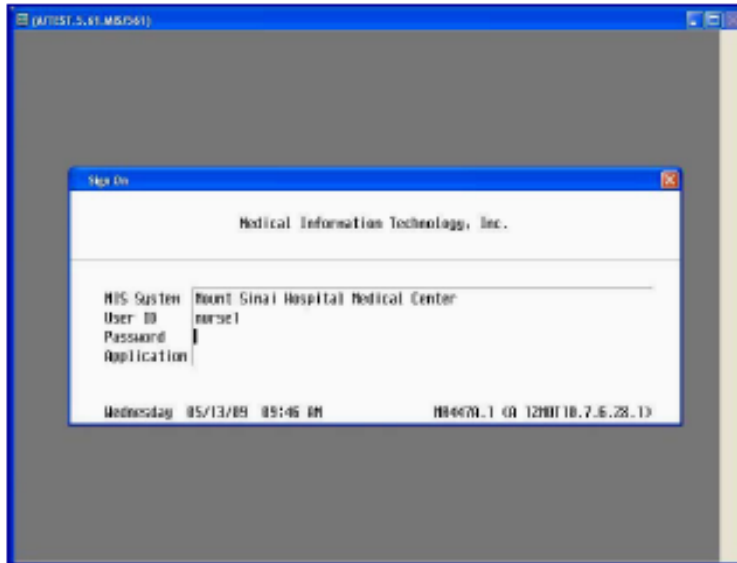


This is the main Sign On screen.

- Enter your User ID in the labeled field.
- Hit ENTER.
- The cursor will move to the Password field.

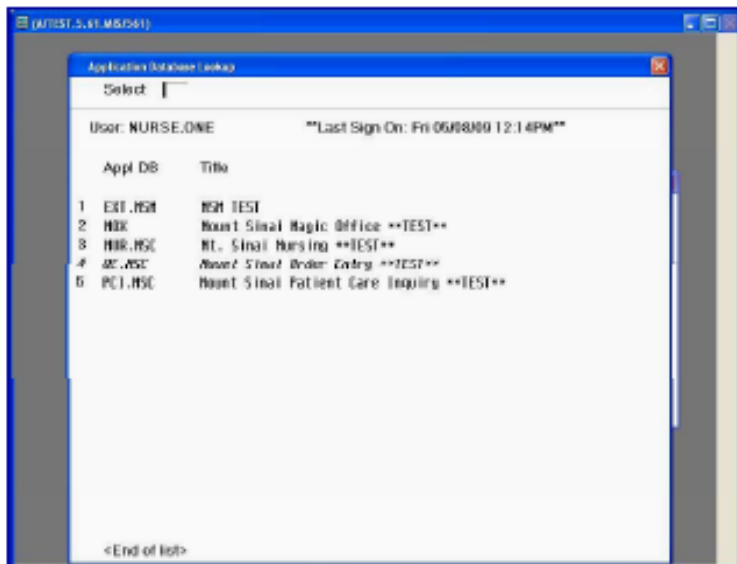


- Enter your password in the labeled field.
- **NOTE:** No characters or space holders will indicate you have entered any data.
- If logging in for the first time, you will be prompted to change your password.
- Follow the prompts to change your password.



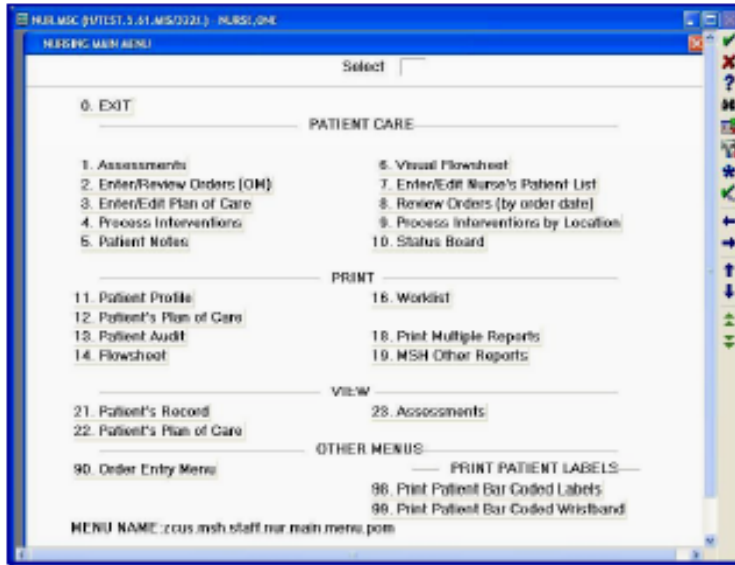
This is the Main Application screen.

- Access the Nursing application (NUR) either by using your mouse to click on the menu item, or by entering its number in the SELECT field and hitting ENTER.



This is the Nursing Main Menu screen.

- Access the Status Board from this screen either by using your mouse to click on the menu item, or by entering its number in the SELECT field and hitting ENTER.



THE STATUS BOARD

- The Status Board is an electronic whiteboard.
- It allows a nurse to visualize and coordinate all of the clinical and administrative aspects pertaining to patient care from one screen.
- Patient data is displayed in a set format with columns containing the room and bed number and the patient name (presented LAST NAME, FIRST NAME) being the first data presented.
- Additional data presented on the status board include, but are not limited to, tentative discharge date, attending physician, last documented vital signs, plan of care, diagnosis, etc.
- Patient data presented is based on the patient list a nurse creates at the start of the shift.
- Screen indicators are used to highlight the existence of past-due interventions, new orders and / or new clinical results.

Clicking on the indicators open screens that permit nurses to item review and / or document on an item.

Room/Bed	Patient Name	Res Order	Next Interva	Diast
4200-01	WALTON, JANE	Test BC	Next Pain Ev	Attend NO
4210-01	BARROTT, TEST	Stat	1000 Shift*	FULL LAB*
4201-02	TEST, CONSERGEE		0600 Intake*	Test-Order*
4202-01	WISCHER, HELENA	03/01/09	0600 Active*	TEST, AT #*
4207-01	TEST, CONSERGEE2			DIABETIC #*
4205-01	LARBERT, JASON		0600 Feeds*	Ures, Char*
4200-01	WANG, PEGGIE	Stat	1200 Shift*	TEST, AT #*
4419-01	LARBERT, BARBARA	Risk	0600 Intake*	REGULAR #*
4504-02	BEI, DANIELE	Risk	1200 Intake*	REGULAR #*
4100-01	STROUSBAROOKS, TEST	Risk	1130 Diabet*	App In, Car*
4100-02	STROUSBAROOK7, TEST	Lab		CARDIAC #*
		Lab	0600 Weight*	Meal Eat #*

Intervention Indicator: Points to 'Stat' in row 4210-01.
 Name Alert Indicator: Points to '0600 Intake*' in row 4201-02.
 Order Indicator: Points to '1200 Shift*' in row 4200-01.
 Result Indicator: Points to 'Lab' in row 4100-02.

- The colors of the various indicators indicate the priority of the associated item.
- RED = STAT or CRITICAL
- YELLOW = ABNORMAL
- GREEN = REGULAR or NORMAL

Several additional administrative or clinical functions are accessed from the Status Board. Clicking on any of these buttons will open the screens associated with these functions.

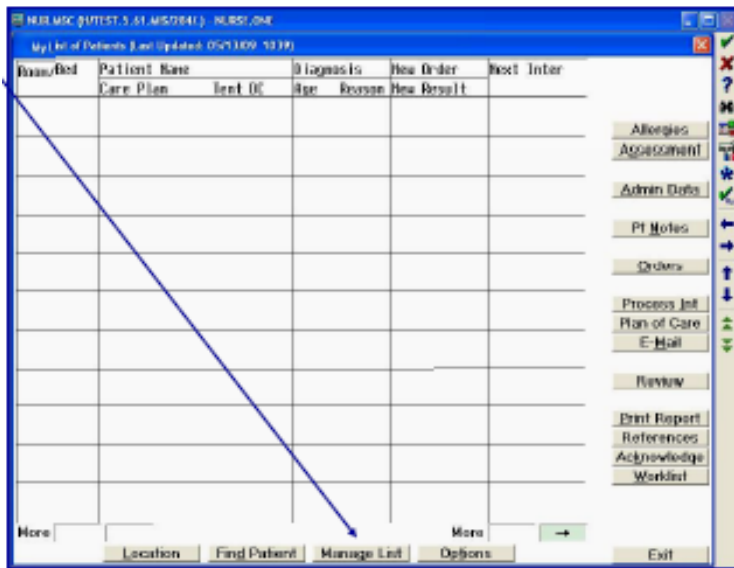
- **Assessment** → Initiates Process Patient Assessment functions, used to complete Admission or Shift Assessments
- **Admin Data** → Displays the Enter / Edit Administrative Data screen
- **Pt Notes** → Initiates the Process Patient Notes function, used to complete narrative notes on one's patients
- **Order** → Initiates Order Management function for the selected patient.
- **Process Int** → Displays the Process Interventions screen for the selected patient
- **E-Mail** → Opens MOX, from which a user may access e-mail sent to them
- **Review** → Opens Patient Care Inquiry for the selected patient, allowing the nurse to review historical clinical data

- Assessment
- Admin Data
- Pt Notes
- Orders
- Process Int
- E-Mail
- Review

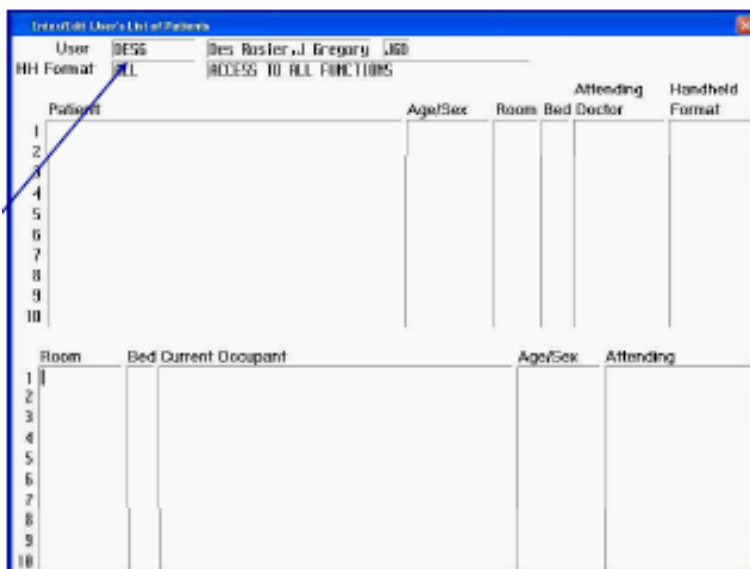
YOUR PATIENT LIST

- The Status Board will be blank when you first log in.
- Creating your patient list at the start of the shift determines which patients appear on your Status Board.
- A patient list allows a nurse to document care on and view the clinical data for their assigned patients.

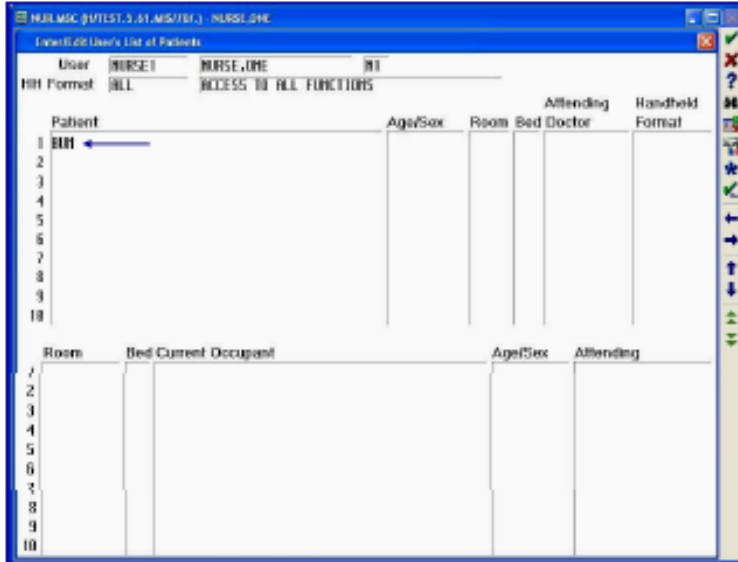
To start, click on Manage List.



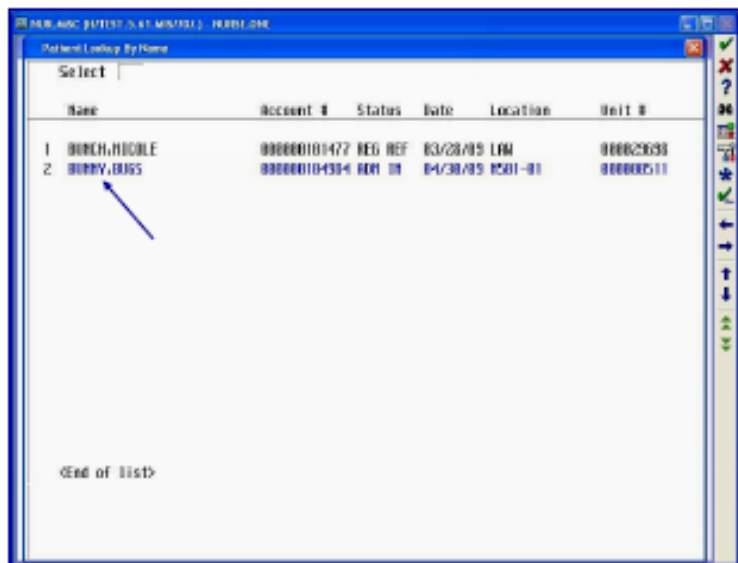
- The Enter / Edit User's List of Patients screen is displayed.
- With the CAPS LOCK on, enter your Meditech User ID in the User field.
- Hit ENTER.
- The cursor will move to the first row in the Patient area.



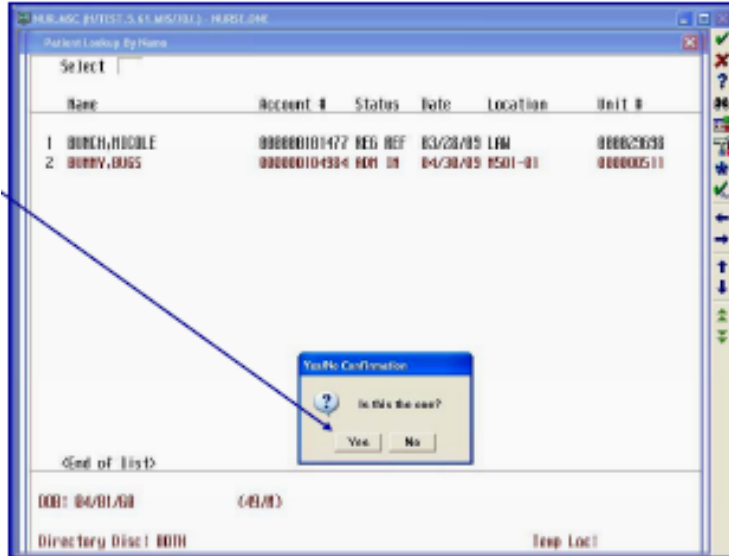
- Type the first three letters of the patient's LAST NAME in the first row of the PATIENT field.
- Hit F9 to initiate a search.



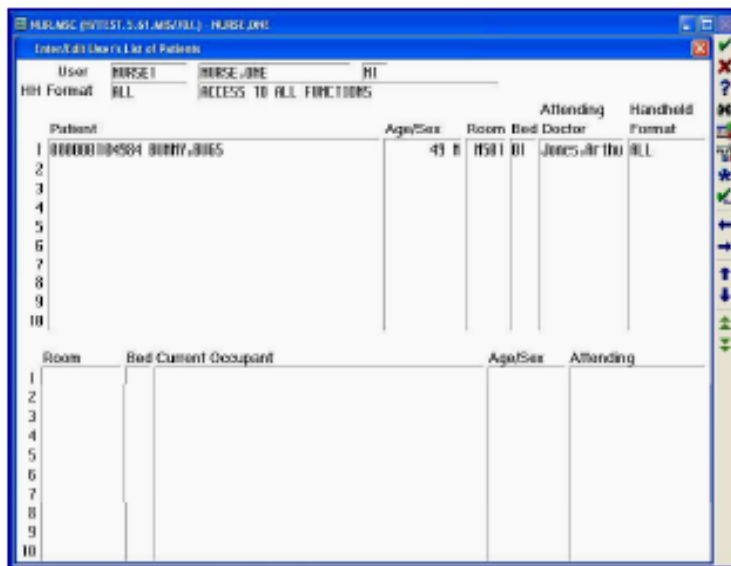
- On the Patient Lookup by Name screen, find the patient you wish to add to your Status Board list.
- Add that patient to your list either by using your mouse to click on their name, or by entering the number corresponding to their name in the SELECT field and hitting ENTER.



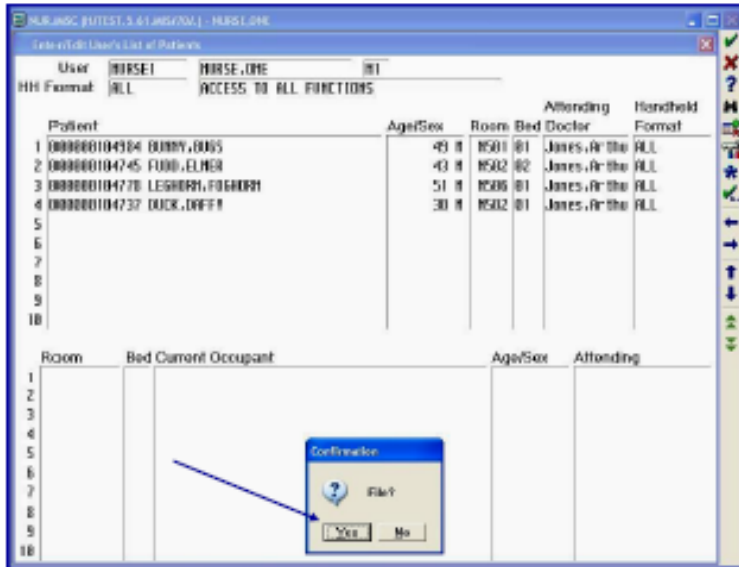
- Confirm you have selected the correct patient by using your mouse to click on the YES button.
- Alternately, you may hit the 'Y' key.



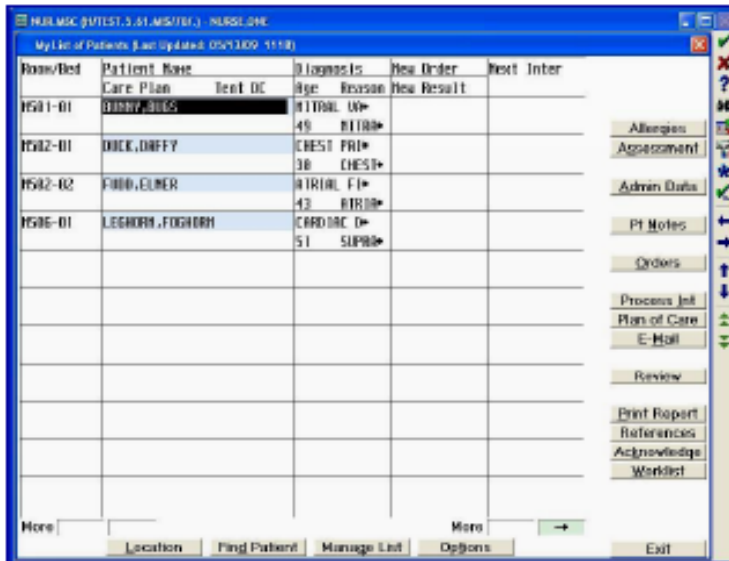
- Your patient will be added to the list.
- Hit ENTER to move to row 2.
- Repeat the previously defined steps to add all assigned patients to your list.



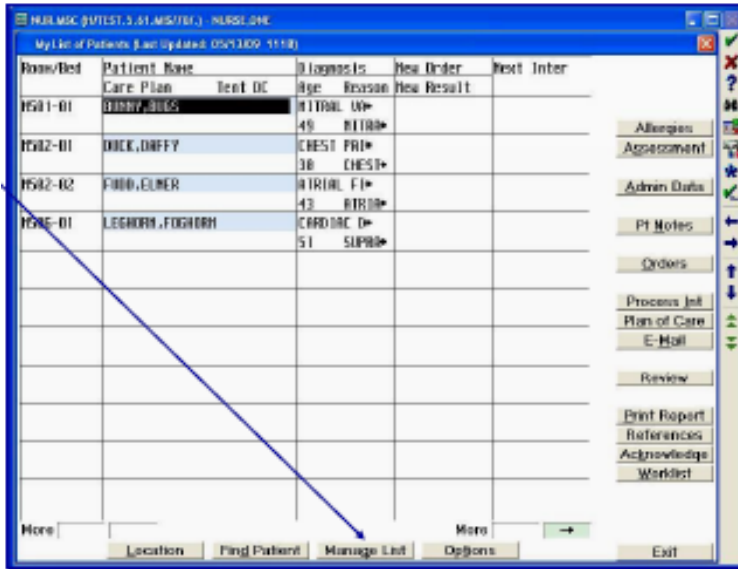
- When you have added all of your assigned patients, hit F12 to confirm and file your list.
- The screen will appear blank after hitting F12.
- Hit F11 to close the Enter / Edit User's List of Patients screen and to return to the Status Board.



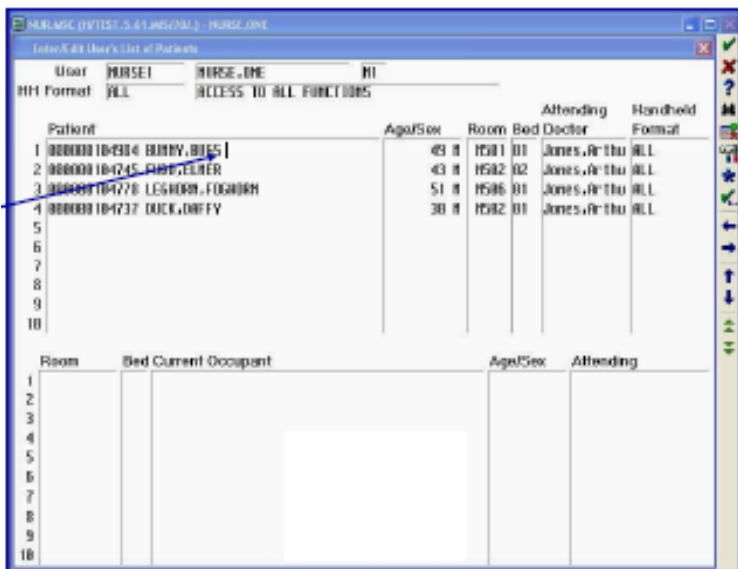
- When you have finished, all of the patients you selected will appear on your Status Board.



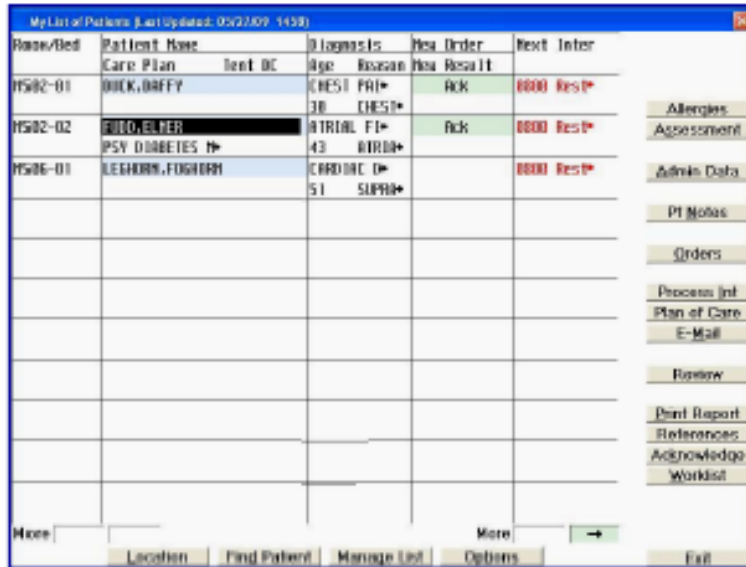
- To remove a patient from your Status Board, click on Manage List.



- Enter your User ID in the USER field and hit ENTER. This retrieves your patient list.
- Hit ENTER to move the cursor to the end of the name of the patient to be removed.
- Hit F10.
- Hit ENTER.
- Hit F12 to file the revised list of patients.



- The updated Patient List will be displayed upon returning to the Status Board.

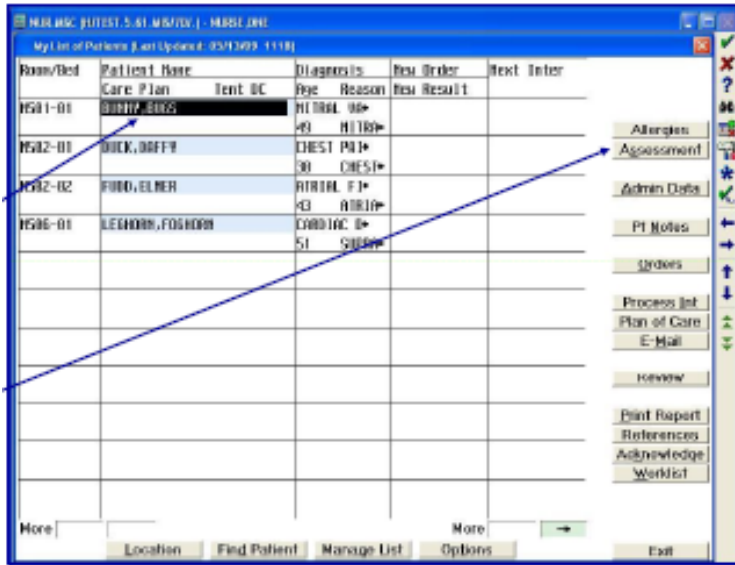


Room/Bed	Patient Name	Care Plan	Unit DC	Diagnosis	Age	Reason	New Order	New Result	Next Inter
1502-01	BUCK, DAFFY			CHEST PAIN	38	CHEST	ACK	0000	Res
1502-02	GOLD, ELDER			ATRIAL FIB	43	ATRIB	ACK	0000	Res
1506-01	LEGHORN, FOGHORN			CARDIAC D	51	SUPRA		0000	Res

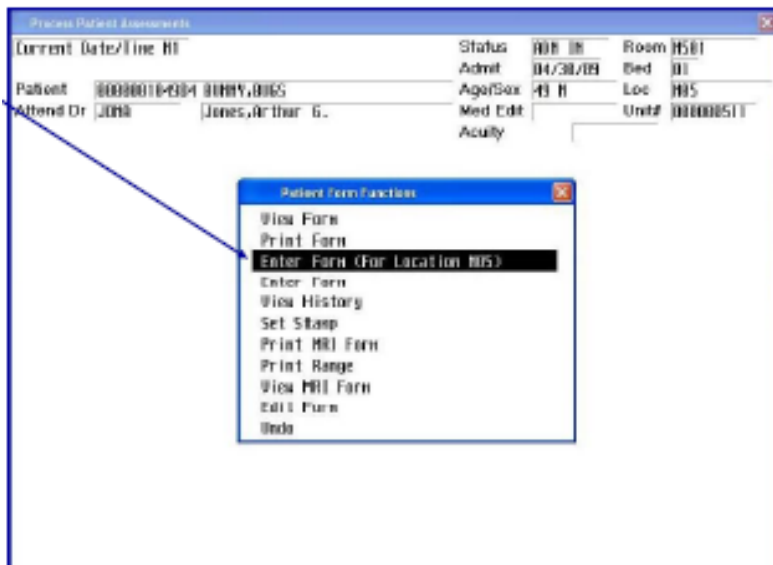
ASSESSING YOUR PATIENT

- All of the nursing assessment functionality may be accessed from the Status Board by using the Assessments button.
- The content of the two different assessments is customized based on the unit to which the patient has been admitted.
- The Admission History, which must be completed within the first 12 hours of a patient's admission, incorporates several different key data elements.
- Completion of the Admission History also determines the baseline Plan of Care that is created for the patient.
- The Shift Assessment must be completed at least every shift (more frequently in the Intensive Care Units).

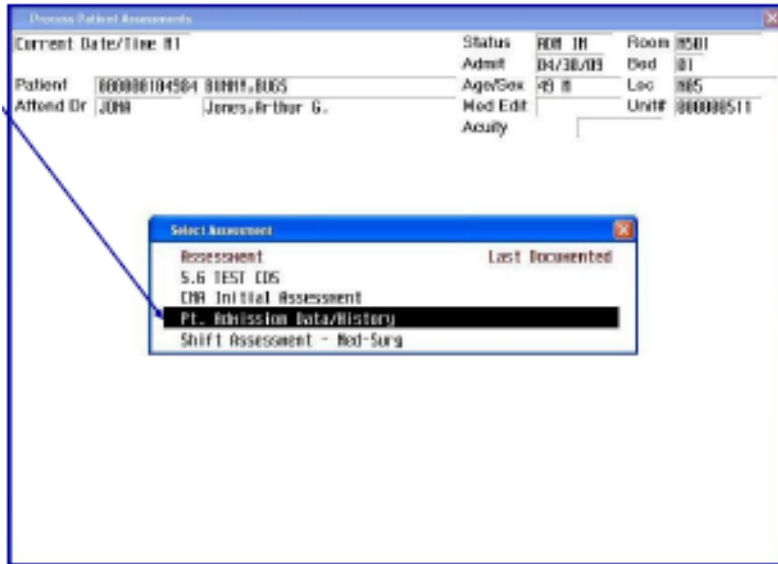
- Select the patient on whom you wish to complete an assessment by using your mouse to click on their name.
- Start an assessment by using your mouse to click on the ASSESSMENT button.



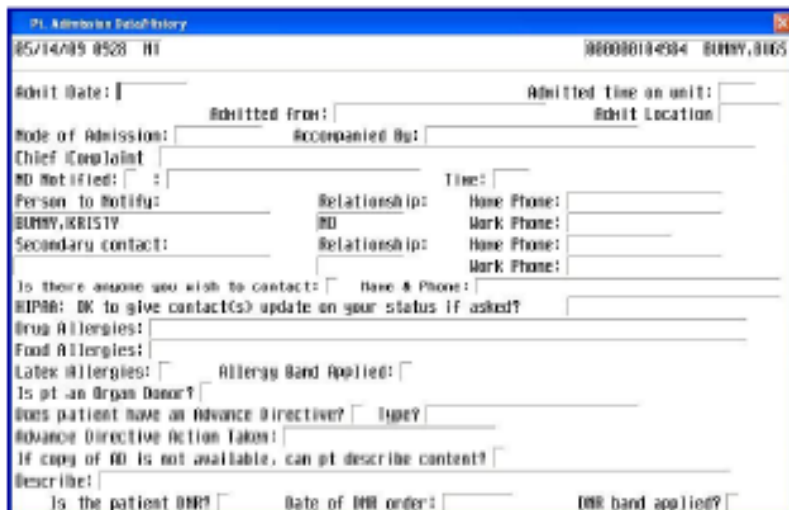
- Use the DOWN ARROW key to navigate to the Enter Form (For Location) menu option.
- Hit the RIGHT ARROW key to display the submenu contents.



- Use the DOWN ARROW key to navigate to the Pt Admission Data / History menu option.
- Hit the RIGHT ARROW key to open and start the admission assessment.



- The Admission Assessment is comprised of several different parts.
- Page 1 of the assessment captures data pertaining to the date, time, and reason for admission; contact information; allergies; and advanced directives.



- Some fields on the assessment have look up functionality.
- Hitting the F9 key displays a list of options for the field.
- To select an entry, enter the number of the entry in the SELECT field and hit ENTER.

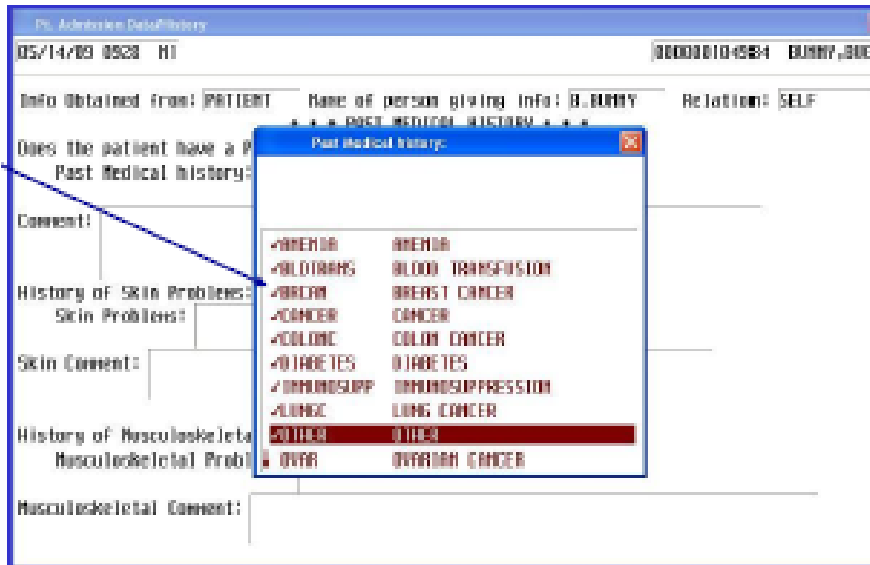
Select	Mnemonic	Responses
1	AMOXICIL	Amoxicillin
2	AMPICILLON	Ampicillin
3	ASA	Aspirin
4	CODEINE	Codeine
5	BEN	Benzal
6	OIL	Olanfin
7	CES	Crythromycin
8	IODINE	Iodine
9	MSO4	Morphine
10	NKA	No Known Allergies
11	PEN	PENICILLON
12	PNEMO	PENICILLON
13	SULFA	SULFA DRUGS

- Some fields on the assessment are 'YES / NO' questions.
- Enter either 'Y' for 'YES' or 'N' for 'NO'.
- When in doubt as to the type of data a field requires, start by hitting F9.
- Either a list or a message telling you the type of data required will appear.

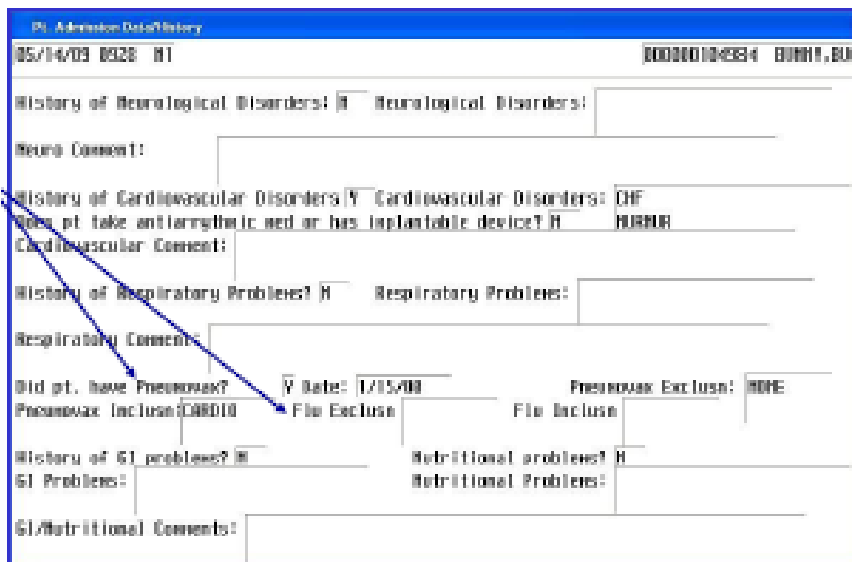
- The medical history starts on page 2 of the Admission Assessment.
- It continues on pages 3 and 4.

- The medical history is charted by exception: if you enter 'Y' in any 'History' field, a multi-select list will appear for that system.
- Multi-select lists are used frequently in the Admission Assessment.

- Hitting the CTRL key on the lower right corner of your keyboard selects an entry on the list.
- Use the DOWN ARROW key to navigate through the list.
- Hit F12 to populate the field with your choice(s).



- Current policy allows nurses to screen for and initiate orders for both the flu and pneumonia vaccines during the Admission Assessment.
- If positive, orders for vaccine supply are autogenerated.
- Assessing and administering vaccines applies to ADULTS only.



- The psychosocial part of the Admission Assessment starts on page 4.
- If a patient answers 'YES' to any questions pertaining to domestic or sexual violence, a referral for Social Services is generated.

05/14/09 0928 HI 00000104984 BUNNY,BUGS

History of Urinary Problems?
 Urinary Problems: _____ Dialysis Access: + _____
 Location: _____
 Urinary Comment: _____

History of Reproductive Problems? Reproductive Problems: _____
 FEMALE LMP: _____ Last Pap Smear: _____
 Delivered or Miscarried in last 12 months _____
 Reproductive Comment: _____

Error
 Notification will be sent to Social Service

==PSYCHOSOCIAL==
 Have you had any major changes or recent life stressors in the past year?
 Describe: _____
 Would you describe yourself in a crisis at this time and in need of support?
 Who/What do rely on for support? Family _____
 Friends _____
 Are you afraid of your partner or someone close to you?

- The Infection Assessment starts on page 5 of the Admission Assessment.
- The history of infections, as well as screening questions about TB exposure / symptoms and current active infections appear here.

05/14/09 0928 HI 00000104984 BUNNY,BUGS

Was your partner ever hit, kicked, slapped, or physically hurt you?
 Was your partner pressured you into uncomfortable sexual activities?
 Would you like information on domestic violence?
 Would you like to speak with a Social Worker?
 Comment: _____ NO Informed
 Religion: _____
 Do you have any religious/cultural request during this hospitalization?
 Describe: _____

*** INFECTION ***
 History of Infections? Do 2 or more of the following apply? (After exposure
 /isolations _____ to TB, productive cough, night sweats, unexplained
 loss, foreign born, homeless/communal living situation?
 *** ORGANISMS ***

Pt list: _____	Source: SCHOOL	Organize: MESA
Pt list: _____	Source: _____	Organize: _____
Pt list: _____	Source: _____	Organize: _____
Pt list: _____	Source: _____	Organize: _____
Pt list: _____	Source: _____	Organize: _____
Pt list: _____	Source: _____	Organize: _____

Infection Comment: _____

- Pages 6, 7, and 8 address medication reconciliation.
- Please make every effort to obtain an accurate medication list.
- Compare this list with the MD orders to assure all home medications have been included in the inpatient orders.
- If not, please notify the ordering doctor.

***** CURRENT MEDICATIONS ***** Refer to transfer form:

Is patient taking any over the counter medications? or Herbal? Did pt bring meds?

Home Medications? Yes. Completed list below Data Source: Patient

Drug:	Dose:	Last dose:
Drug: _____	Dose: _____	Last dose: _____
Drug: _____	Dose: _____	Last dose: _____
Drug: _____	Dose: _____	Last dose: _____
Drug: _____	Dose: _____	Last dose: _____
Drug: MELOXICAM	Dose: 25 MG	Last dose: 5/15/08
Drug: GLUCOPHAGE	Dose: 300 MG	Last dose: 5/15/08
Drug: ALLOPRIMOL	Dose: 300 MG	Last dose: 5/15/08
Drug: ALLOPRIMOL	Dose: 300 MG	Last dose: 5/15/08
Drug: ALLOPRIMOL	Dose: 20 MG	Last dose: 5/15/08

- Substance Use History starts on page 8 of the Admission Assessment.
- If a patient affirms they smoke, a referral is sent to the Respiratory Department for Smoking Cessation counseling.

***** SUBSTANCE USE HISTORY *****

Current Meds Comment: _____

Disposition of Medications: Sent None

PRESENT	PAST	Amount:
TOBACCO: <input checked="" type="checkbox"/>	: <input type="checkbox"/> Has [X], smoked in the last year?	
ALCOHOL: <input type="checkbox"/>	: <input type="checkbox"/> Last Use _____	Amount: _____
Drug Use: <input type="checkbox"/>	: <input type="checkbox"/> Date Last Used _____	Type: _____
	Route: _____	Anti/Freq: _____

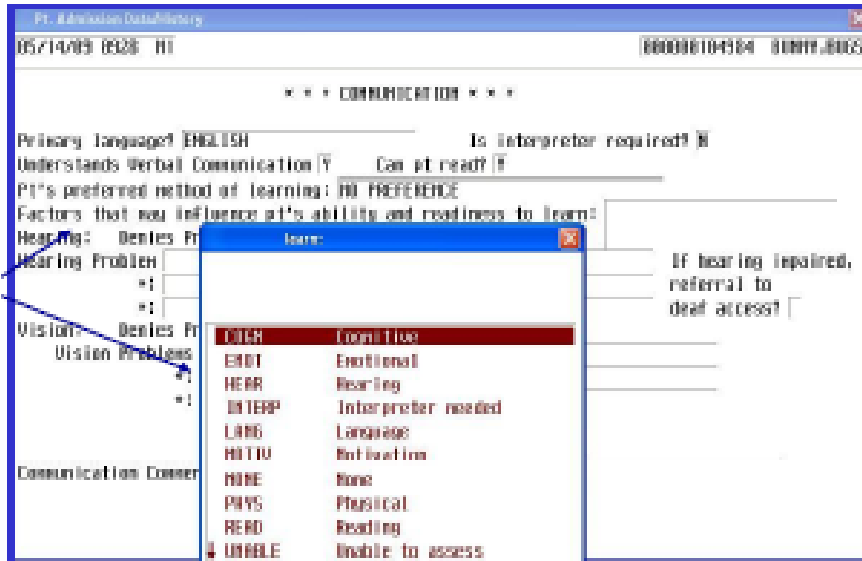
Recd:

Error

Notification will be sent to Resp. Dept for Smoking Cessation.

OK

- Page 9 collects data on the patient's communications skills, learning preferences, and barriers to learning.
- The Factors field is a multiselect lookup. Use the CTRL key in the lower right corner to select items.
- Use the DOWN ARROW to move through the list F12 to the selected items



*** COMMUNICATION ***

Primary language? ENGLISH Is interpreter required?

Understands Verbal Communication? Can pt read?

Pt's preferred method of learning: NO PREFERENCE

Factors that may influence pt's ability and readiness to learn:

Hearing: Denies Pt Hearing Problem:

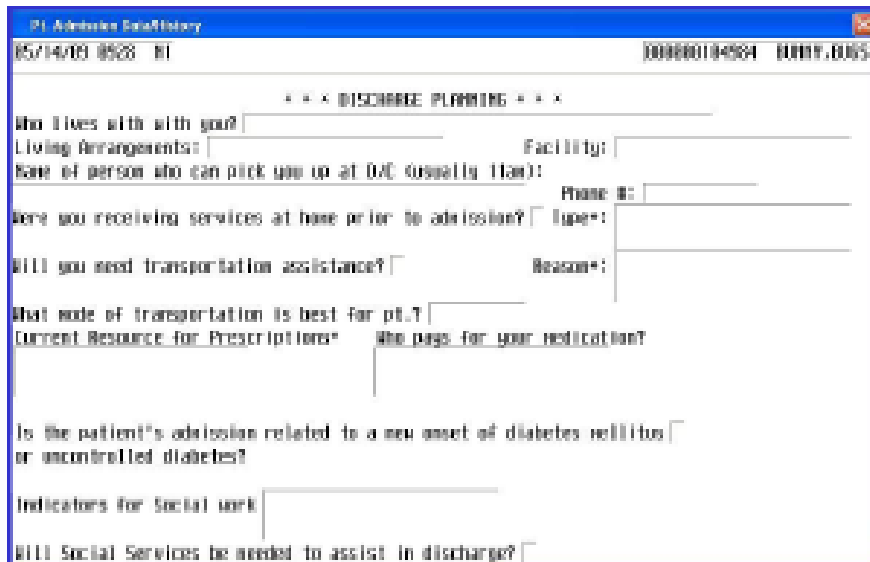
Vision: Denies Pt Vision Problems:

Communication Center:

IF hearing impaired, referral to deaf access?

TOUCH	Touch
EMO	Emotional
HEAR	Hearing
INTERP	Interpreter needed
LANG	Language
HRTIV	Intuition
NONE	None
PNY	Physical
READ	Reading
UNABLE	Inable to assess

- Discharge planning starts on page 10.
- Having this information at the start of a patient stay facilitates both planning for discharge as well as procuring home health support the patient may need.



*** DISCHARGE PLANNING ***

Who lives with with you? _____ Facility: _____

Living Arrangements: _____

Name of person who can pick you up at D/C (usually 11am): _____ Phone #: _____

Were you receiving services at home prior to admission? Type: _____

Will you need transportation assistance? Reason: _____

What mode of transportation is best for pt.? _____

Current Resource for Prescriptions? _____ Who pays for your medication? _____

Is the patient's admission related to a new onset of diabetes mellitus or uncontrolled diabetes?

Indicators for Social work _____

Will Social Services be needed to assist in discharge?

- The discharge planning section assesses if the admission is the result of new onset diabetes.
- If 'YES' is entered here, and / or if 'Glucometer' is listed as an indicator, a SW referral is placed and the Diabetes Care Plan is added to the patients Plan of Care.

P1 Admission Details History
 05/14/09 0928 HI 0000010-004 BUNNY, BUCS

* * * DISCHARGE PLANNING * * *
 Who lives with with you? (MOE) _____
 Living Arrangements: (R) Home With Family _____ Facility: _____
 Name of person who can pick you up at (MC) (usually Home): _____
 (NAME) (DICK) Phone #: _____
 Were you receiving services at home prior to admission? (R) Type: _____
 Will you need transportation assistance? (R) Reason: _____
 What mode of transportation is best for pt.? (DR) _____
 Current Resources for Prescriptions? _____ Who pays for your medication? _____
 Insurance _____ Insurance _____
 Is the patient's admission related to a new onset of diabetes mellitus (Y or uncontrolled diabetes)? _____
 Indicators for Social work (Glucometer) _____
 Will Social Services be needed to assist in discharge? (R) _____

- Admission education is captured on page 11.
- This patient education content is defined by National Patient Safety Goal 13.

P1 Admission Details History
 05/14/09 0928 HI 0000010-004 BUNNY, BUCS

* * * ADMISSION EDUCATION * * *
 National Patient Safety Goal #13 Education

ACTION	OUTCOME	REASON
1. The patient/family was educated regarding reporting treatment, service, or safety issues. Comment:	(BROCHURE) (YES)	
2. The patient/family was educated on proper hand and respiratory hygiene practices. Comment:	(FOLDER) (NO)	(FAMILY)
3. The patient/family was educated on the need for isolation precautions. Comment:	(NA) (NA)	

- Orders may be auto-generated as a result of the answers to the questions on the Admission Assessment.

Enter Care Area Orders

User: NURSE1 NURSE,ONE A/S 51 B Admit 04/27/09
 Loc 005 Status ADM IN
 Patient: 00000104778 LEGHORN, FUGHERN Rm 0505
 Bd 01 Unit No. 000030221

Attend Dr: JENN Jones, Arthur G.
 Order Dr: Order Source: |
 Other Pw:

Category	Procedure	Procedure Name	Pri	Qty	Date	Time Here
2 SW	RFSS	REQUEST FOR SOCIAL SERVICES	R		T+ 05/14	1309
2 VACCINE	PNEUM	Pneumococcal Vaccination - Adm			T+ 05/14	1309
3						
4						
5						
6						
7						

- Enter the ID of the Attending MD for the Ordering MD.
- Enter 'W' (written) as the order source.
- Hit ENTER to move through the orders to answer any order-related queries.
- Once done, file and submit the orders

Enter Care Area Orders

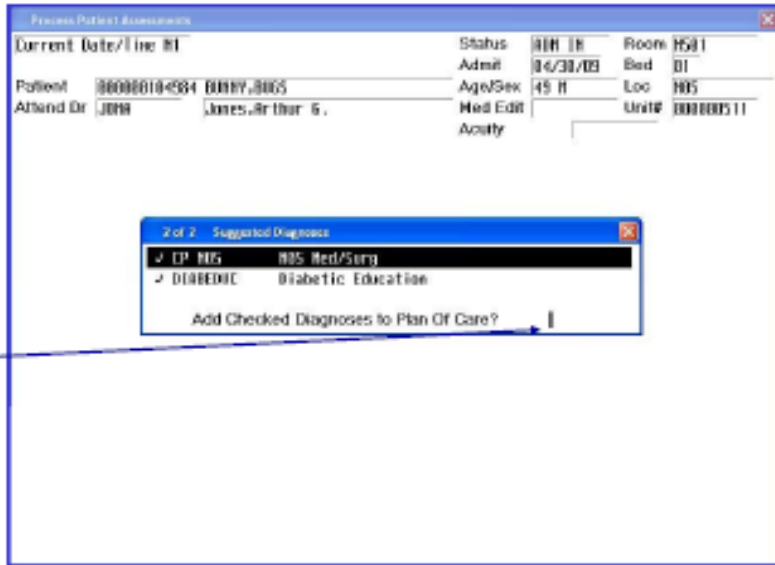
User: NURSE1 NURSE,ONE A/S 51 B Admit 04/27/09
 Loc 005 Status ADM IN
 Patient: 00000104778 LEGHORN, FUGHERN Rm 0505
 Bd 01 Unit No. 000030221

Attend Dr: JENN Jones, Arthur G.
 Order Dr: JENN Jones, Arthur G. → Order Source: |

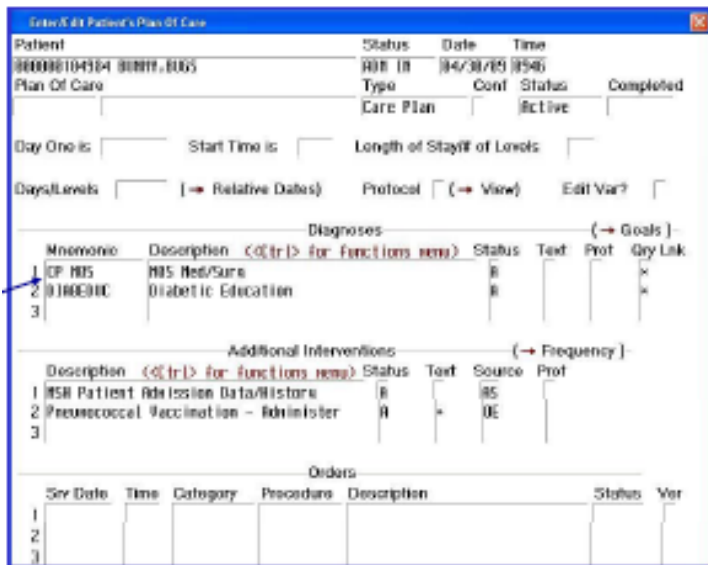
Other Pw:

Category	Procedure	Procedure Name	Pri	Qty	Date	Time Here
2 SW	RFSS	REQUEST FOR SOCIAL SERVICES	R		T+ 05/14	1309
2 VACCINE	PNEUM	Pneumococcal Vaccination - Adm			T+ 05/14	1309
3						
4						
5						
6						
7						

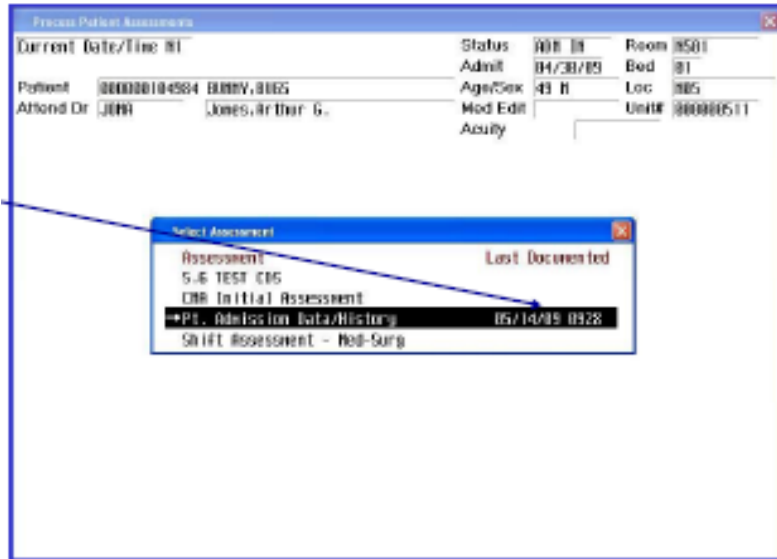
- After you have completed the assessment, you will be prompted to confirm the contents of the patient's Plan of Care.
- Enter 'Y' to add the suggested diagnoses to the Plan of Care.



- On the Enter / Edit Patient's Plan of Care screen, hit ENTER through all of the fields until both plans of care are listed in the Diagnoses table.
- Hit F12 to file the final Plan of Care.

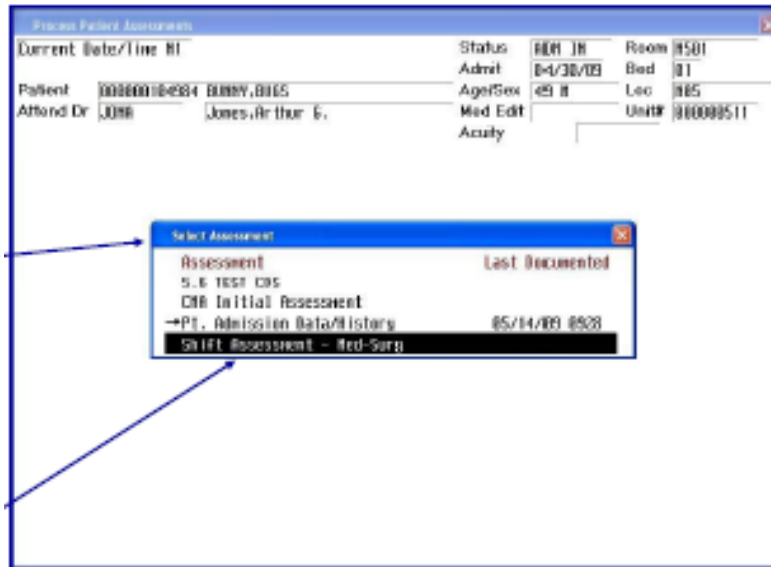


- Once done, you are returned to the Select Assessment screen.
- The date and time when the Admission Assessment was completed will appear.
- Hit F11 to return to the Status Board.

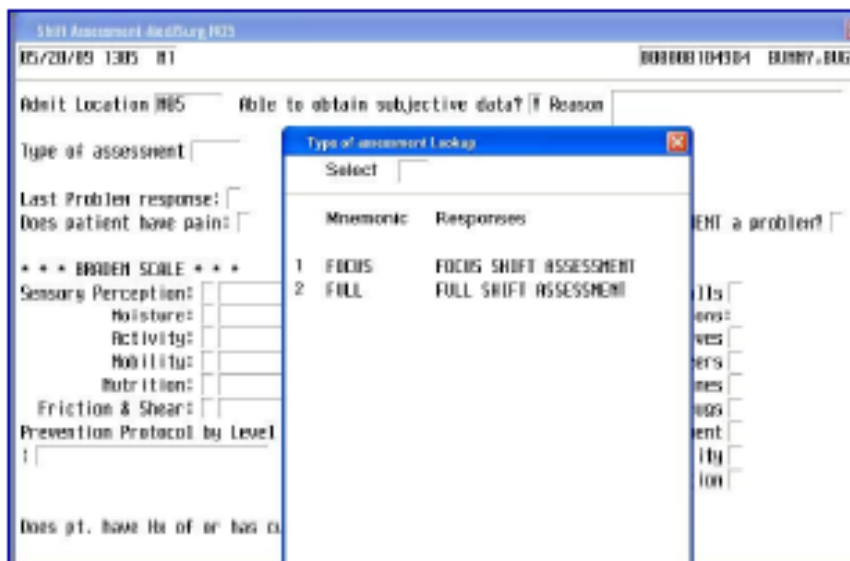


- There are two types of Shift Assessments:
 - Full Assessment – this is a complete head-to-toe physical assessment that must be completed every shift
 - Focused Assessment – this targets a specific anatomical system and may be completed as needed.
- Users access both types of assessments in the same way.
- The full assessment also incorporates:
 - Pain assessment
 - Braden scale assessment
 - Fall risk assessment
 - Suicide risk and Behavioral Health assessment
- The full assessment also is charted by exception.
 - If you indicate that any individual system deviates from its physiological norm, a window pops up, requiring the user to complete an assessment on that system.

- Initiate the Shift Assessment by clicking the ASSESSMENT button.
- Navigate to the Select Assessment screen using the DOWN and RIGHT ARROW keys.
- Highlight and use the RIGHT ARROW key to start the Shift Assessment.



- The shift assessment function allows a user to complete either a FULL or FOCUSED assessment.
- A full assessment must be completed each shift.



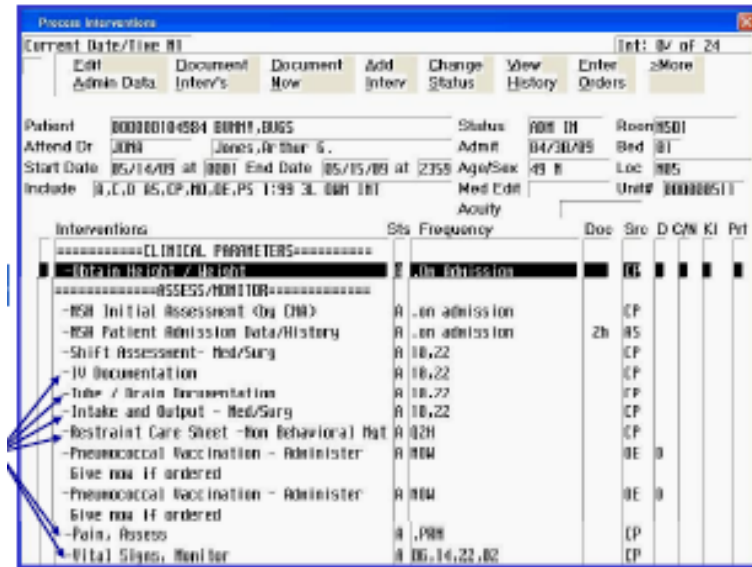
CHARTING PATIENT CARE

- As previously discussed, the patient's Plan of Care is created on admission and is made up of several specific nursing interventions and physician orders.
- Over the course of the patient's stay, nurses document on these interventions, providing pertinent clinical data for ongoing clinical management.
- Nurses initiate documenting on interventions on the Plan of Care from the Status Board.
- Three terms that are frequently used in this portion of the presentation require definition:
 - Patient Interventions: elements of care that result from physician orders (e.g. vital signs, I & O, etc.) or the provisioning of generally accepted standards of nursing care (e.g. rest, ambulation, etc.).
 - Care Plan: a patient-specific aggregation of patient interventions designed to return the patient to optimum health.
 - Process Interventions: the Meditech function and screen through which a user charts data on certain patient interventions in the care plan.
- Key interventions that will be reviewed here include:
 - IV's
 - Tubes and Drains
 - I&O
 - Pain
 - Vital Signs
 - Patient Education
 - Problem List
 - Patient Acuity
 - Wound Management
 - Non-Behavioral Restraints

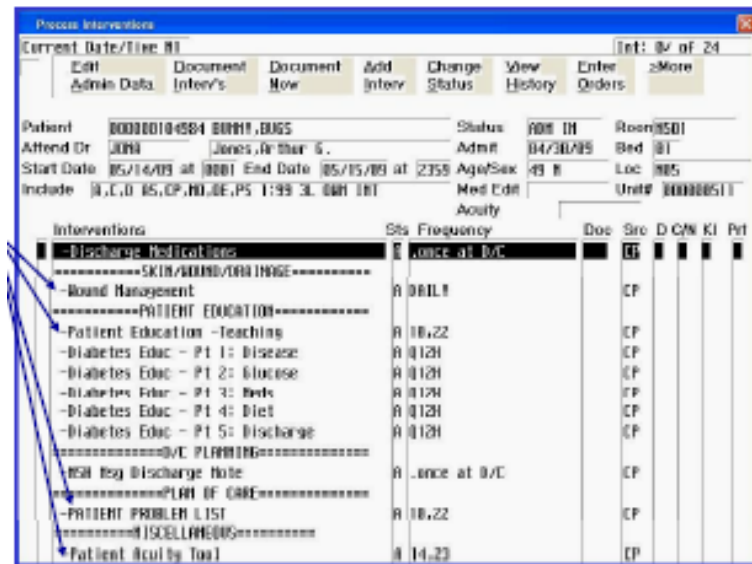
- Documenting on interventions starts on the Status Board.
- Use your mouse to click on the Process Int button.

Room/Bed	Patient Name	Diagnosis	Phys Order	Next Inter
Care Plan	Test DC	Age Reason	Resu Result	
MS01-01	DOBBS, JUDY	ATRIAL VR	ICK	0400 Rest*
MS01-02	PIG, PERRY	CONGESTIO		
MS02-01	DICK, DUFFY	CHEST PAI		
MS02-02	FIND, ELBER	ATRIAL FI		
MS03-01	SAN, ROSENTE	ENDOCARD		
MS04-01	LEPEN, PEPE	AORTIC VR		
MS05-01	LEHMAN, FOSBORN	CARDIAC B		0400 Rest*
MS08-01	CONOTE, WILEY	ENDOCARD		PRN

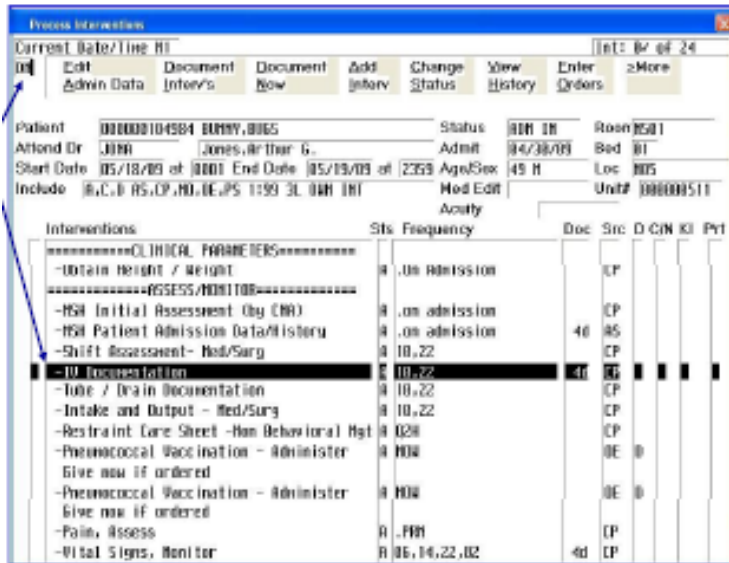
- Clicking on the Process Int button opens the Process Interventions screen.
- This screen displays all of the interventions added to the plan of care.
- Interventions visible on this page include IVs, Tube/Drain, IO, Pain, Vital Signs, and Restraint Care.



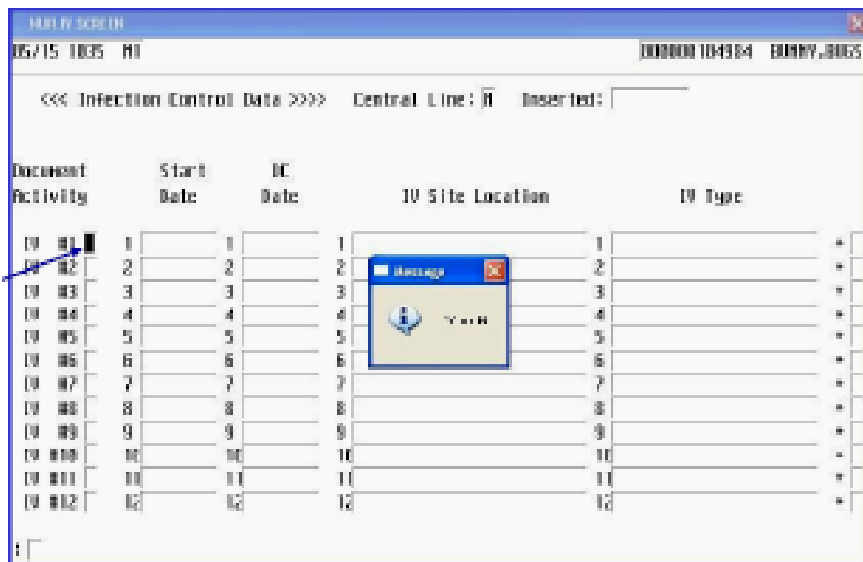
- Use the DOWN ARROW to scroll to page 2.
- Interventions visible on this page include Wound Management, Patient Education, Patient Problem List, and Patient Acuity.
- Each of these interventions will be examined separately.



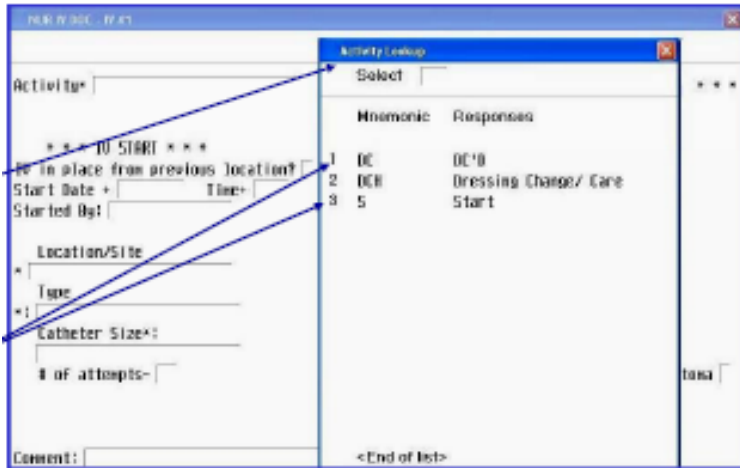
- To chart on the **IV Documentation** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.



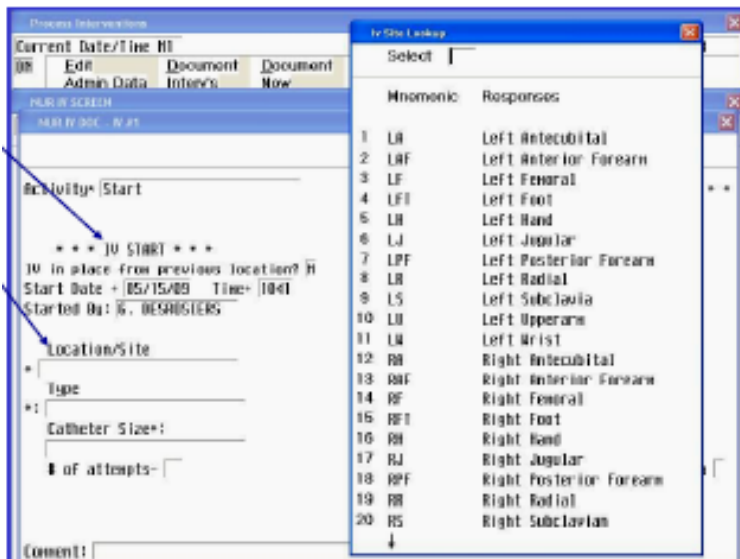
- This is the screen for the IV intervention.
- To document on either a new or existing IV site, enter 'Y' in the 'Document Activity' column for either the new or existing IV and hit ENTER.
- To bypass documenting on an existing IV, enter 'N'.



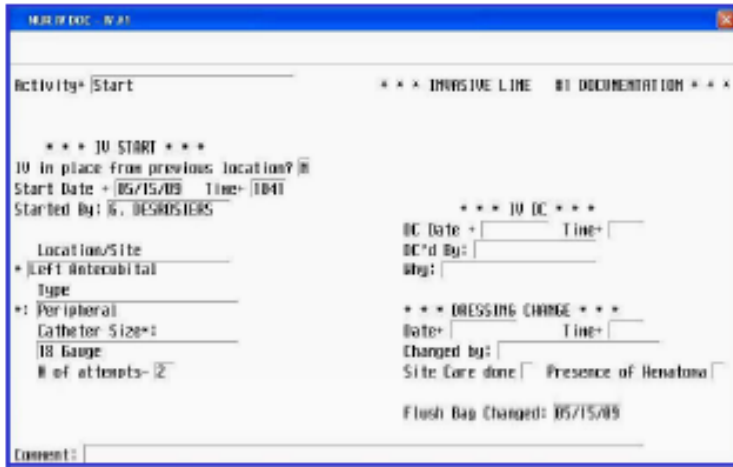
- The IV documentation screen will open.
- The Activity Lookup list is presented.
- If inserting a new IV, select 'S'. If changing the dressing on or discontinuing an existing IV, select either 'DCH' or 'DC' respectively.



- When starting a new IV, enter the data in the IV Start fields.
- The Location, Type, and Catheter Size fields are lookups.
- Hit F9 to open the list of values for each field and select a value from the list.



- Complete all required fields for the IV on which you are charting.



Activity: Start *** INVASIVE LINE #1 DOCUMENTATION ***

*** IV START ***
 IV in place from previous location?
 Start Date: 05/15/09 Time: 1041
 Started By: W. DESROSIERS

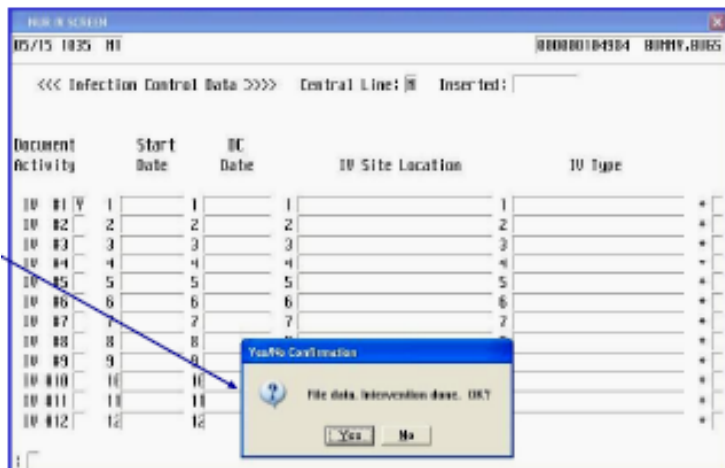
Location/Site: Left Antecubital
 Type: Peripheral
 Catheter Size:
 IB Gauge:
 # of attempts: 2

*** IV DC ***
 DC Date:
 DC'd By:
 Why:
 *** DRESSING CHANGE ***
 Date:
 Time:
 Changed by:
 Site Care done: Presence of Hematoma:

Flush Bag Changed: 05/15/09

Comment:

- At this point, you may either document on additional IV sites or you may file your data.
- When you have finished documenting, file your data by hitting F12 and confirming your activity.



05/15 1035 #1 00000104304 BARRY,BIGGS

<<< Infection Control Data >>> Central Line: Inserted:

Document Activity	Start Date	DC Date	IV Site Location	IV Type
IV #1	1	1	1	1
IV #2	2	2	2	2
IV #3	3	3	3	3
IV #4	4	4	4	4
IV #5	5	5	5	5
IV #6	6	6	6	6
IV #7	7	7	7	7
IV #8	8	8	8	8
IV #9	9	9	9	9
IV #10	10	10	10	10
IV #11	11	11	11	11
IV #12	12	12	12	12

Yes/No Confirmation
 File data: Infection data. DRY

- When you return later to document on IVs for that patient, your existing entry will be presented to you.

Document Activities	Start Date	DC Date	IV Site Location	IV Type
IV #1	05/15/09		1 Left Antecubital	1 Peripheral
IV #2	2	2		
IV #3	3	3		
IV #4	4	4		
IV #5	5	5		
IV #6	6	6		
IV #7	7	7		
IV #8	8	8		
IV #9	9	9		
IV #10	10	10		
IV #11	11	11		
IV #12	12	12		

- To chart on the Tubes & Drains intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.

Interventions	Srs	Frequency	Doc	Sto	D	CW	KI	Prt
*****CLINICAL PARAMETERS*****								
-Obtain Height / Weight	0	.on admission		CP				
*****ASSESS/MONITOR*****								
-PSI Initial Assessment (On DRG)	0	.on admission		CP				
-PSI Patient Admission Data/History	0	.on admission	40	RS				
-Shift Assessment- Med/Surg	0	10.22		CP				
-IV Documentation	0	10.22	40	CP				
-Intake and Output - Med/Surg	0	10.22		CP				
-Restraint Care Sheet - Non Behavioral Mgt	0	02H		CP				
-Pneumococcal Vaccination - Administer	0	00H		BE	0			
Give now if ordered								
-Pneumococcal Vaccination - Administer	0	00H		BE	0			
Give now if ordered								
-Pain, Assess	0	.PSI		CP				
-Vital Signs, Monitor	0	06.14.22.02	40	CP				

- This is the screen for the Tube & Drain intervention.
- To document on either a new or existing tube or drain site, enter 'Y' in the 'Document Activity' column for either the new or existing drain and hit ENTER.
- To bypass documenting on an existing drain, enter 'N'.

*** TUBE / DRAIN DOCUMENTATION ***

Document Activity	DC Date	Type	Location / Site	
#1	1			*
#2	2			*
#3	3			*
#4	4			*
#5	5			*
#6	6			*
#7	7			*
#8	8			*
#9	9			*
#10	10			*
#11	11			*
#12	12			*

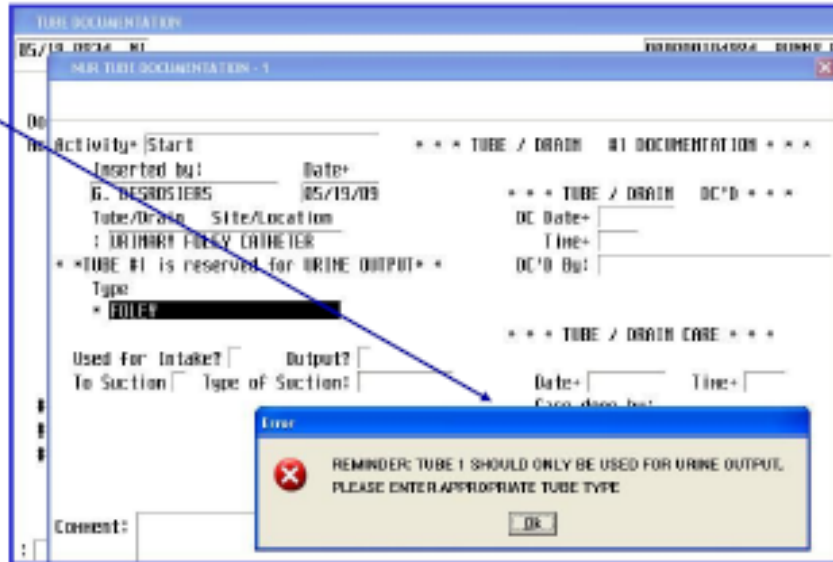
- Documenting on tubes & drains essentially is the same process as that for IVs.
- Once you decide to document on a tube or drain, the data screen for that specific tube or drain is displayed, along with the Activity Lookup.

Activity Lookup

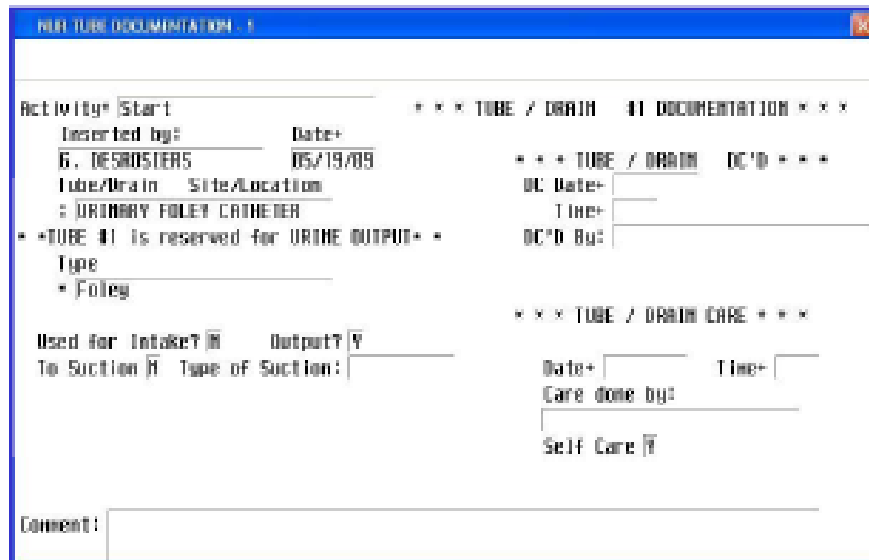
Select	Mnemonic	Responses
1	C	Tube / Drain Care
2	DC	DC'd
3	S	Start

The main screen shows fields for: Activity, Date, Tube/Drain, Site/Location, Type, Used For Intake?, Output?, To Suction?, Type of Suction?, and Comment.

- Be aware that the first entry in the Tube / Drain table will ALWAYS be for Foley urinary catheters.



- Complete all required fields for the tube / drain on which you are documenting.



- After filing the original tube / drain intervention, the data for the first tube / drain will appear on the Tube / Drain documentation screen.
- It is possible to create, and be able to chart on, many different tubes and drains, used either for input or output.

Document Activity	DC Date	Type	Location / Site
#1	1	Foley	PRIMARY FOLEY CATHETER
#2	2	JP	LEFT JP BULB
#3	3	J tube	J TUBE
#4	4		
#5	5		
#6	6		
#7	7		
#8	8		
#9	9		
#10	10		
#11	11		
#12	12		

- To chart on the **Intake and Output** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.

Interventions	Sits	Frequency	Doc	Src	D	CIN	KI	Prt
=====CLINICAL PARAMETERS=====								
-Obtain Height / Weight	0	In Admission		FP				
=====ASSESS/MONITOR=====								
-NSR Initial Assessment (by CN)	4	on admission		CP				
-NSR Patient Admission Data/History	4	on admission	40	BS				
-Shift Assessment- Med/Surg	4	10,22	40	CP				
-I# Documentation	4	10,22	40	CP				
-Tube / Drain Documentation	4	10,22	12h	CP				
-Intake and Output - ResCare	4	10,22	40	BS	4	4	4	4
-Restraint Care Sheet -Non Behavioral Mgt	4	QD		CP				
-Pneumococcal Vaccination - Administer	4	MO		BE	0			
Give now if ordered								
-Pneumococcal Vaccination - Administer	4	MO		BE	0			
Give now if ordered								
-Pain, Assess	4	PRN		CP				
-Vital Signs, Monitor	4	06,14,22,30	40	CP				

- The first section of the I & O screen collects data on fluid intake.

Intake and Output Mod/Sang
05/19 0852 HI 000000104984 BUNNY,BUGS

Intake and Output Flowsheet

----- INTAKE -----

Fluid Type	IV Site	Amount	Tubing Change
A:	A:	10 A	TC A
B:	B:	10 B	TC B
C:	C:	10 C	TC C
D:	D:	10 D	TC D
E:	E:	10 E	TC E
F:	F:	10 F	TC F
G:	G:	10 G	TC G
H:	H:	10 H	TC H
I:	I:	10 I	TC I
J:	J:	10 J	TC J
K:	K:	10 K	TC K
L:	L:	10 L	TC L

PD: 250 Breastfed? _____
 Flush Used 25 _____
 CBI Infusion 0 _____
 Free H2O: 0 _____
 WWP: 50 _____

Blood Products: Ccc) _____ Type: _____ Unit #: _____

Comment: _____

NOTE: IV Dressing Change to be doc. on IV Docum.

***** DOCUMENT DRAINS / TUBES ON THIRD PAGE *****

- On the I & O screen, the Fluid Type field is a lookup.
- Hit F9 to display the list of values.
- To select an entry, enter the number of the entry in the SELECT field and hit ENTER.

Intake and Output Mod/Sang
05/19 0852 HI

Intake and Output

----- INTAKE -----

Fluid Type

PD: 250 Breastfed? _____
 Flush Used 25 _____
 CBI Infusion 0 _____
 Free H2O: 0 _____
 WWP: 50 _____

Blood Products: Ccc) _____ Type: _____

Comment: _____

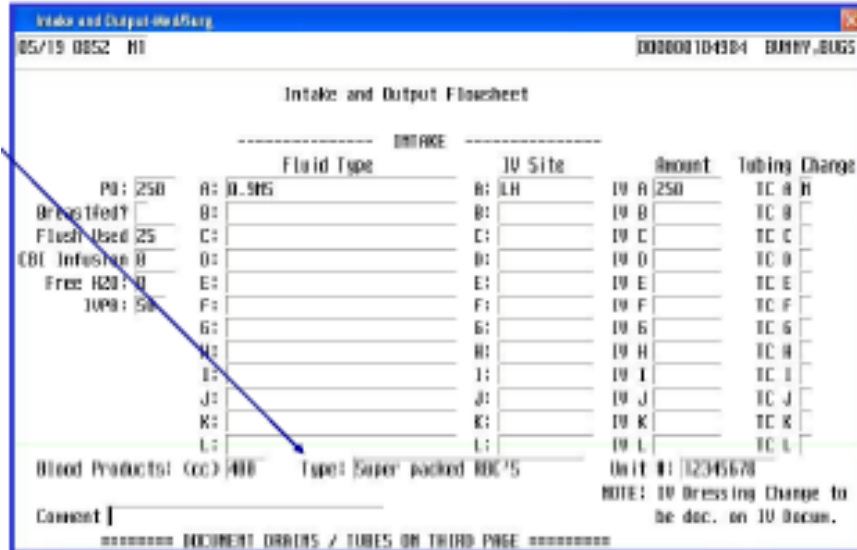
***** DOCUMENT DRAINS / TUBES ON TH

W Fluids Lookup

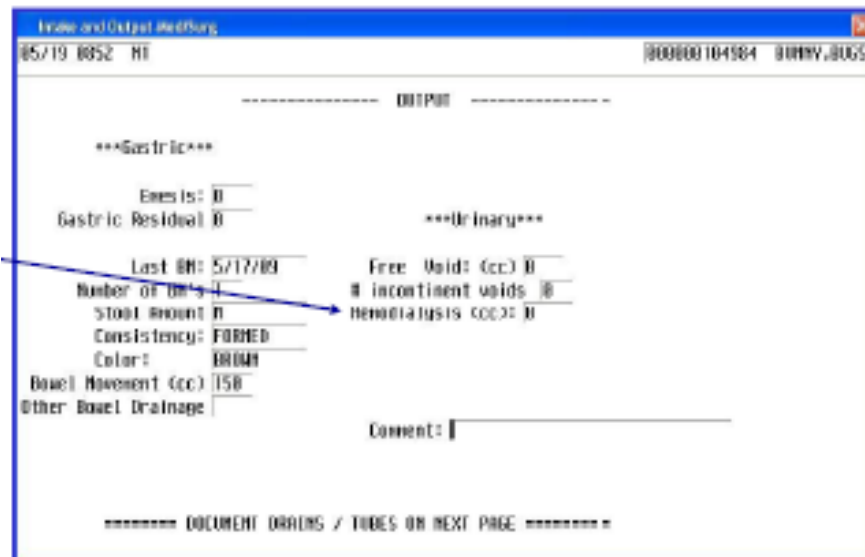
Select: _____

Mnemonic	Responses
1 1	0.45 05
2 2	0.905
3 3	Albumin 52
4 4	Albumin 252
5 5	0100
6 6	05 LR
7 7	05.4505
8 8	05.905
9 9	050
10 10	050.205
11 11	050.4505 w/20med0CL
12 12	Robetaxine 500mg/250 050
13 13	Robetaxine 800mg/250 050
14 14	Roaparine 400mg/250 050
15 15	Roaparine 800mg/250 050
16 16	Roaparin 25.0000/250 050
17 17	Retastarch

- On the I & O screen, the data for blood products (volume, type, and unit number) are captured on page 1.
- The Type field is a lookup.



- Page 2 of the I & O screen captures output unrelated to that resulting from a tube or drain.
- Total volume removed during hemodialysis is charted on this page.



- If tubes or drains have been set up previously, that data will autopopulate the Drains / Tubes screen.
- Only the input or output amounts need to be charted.

Intake and Output Monitoring
05/19/0901 RT 00000010-0904 BARRY, BASS

Drains/Tubes

Location	Type	Output?	Output Amount	Intake?	Intake Amount
PRIMARY FOLEY CATHETER	Foley	(# 1/0 #1	135	(# 1/0 #A	
LEFT JP BUBB	JP	(# 1/0 #9	19	(# 1/0 #B	
		(# 1/0 #3		(# 1/0 #C	
		(# 1/0 #4		(# 1/0 #D	
		(# 1/0 #5		(# 1/0 #E	
		(# 1/0 #6		(# 1/0 #F	
		(# 1/0 #7		(# 1/0 #G	
		(# 1/0 #8		(# 1/0 #H	
		(# 1/0 #9		(# 1/0 #I	
		(# 1/0 #10		(# 1/0 #J	
		(# 1/0 #11		(# 1/0 #K	
		(# 1/0 #12		(# 1/0 #L	

==PERITONEAL DIALYSIS ON THE NEXT PAGE==

- Page 4 captures data pertaining to peritoneal dialysis.
- Once you have finished charting all intake and output volumes, hit F12 to file the intervention data.

Intake and Output Monitoring
05/19/0901 RT 00000010-0904 BARRY, BASS

* -PERITONEAL DIALYSIS* *

Dialysate: _____ Amount In (ml): _____

Start time: _____

Absorbed time: _____

Drain Time: _____

Completed Drain Time: _____

Amount Out (ml): _____

Comments: _____

File Data Intervention Data
File data, intervention data. OK?

Yes No

- To chart on the **Pain** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.

Interventions	Sls	Frequency	Doc	Src	D	CIN	KL	Prt
*****CLINICAL PARAMETERS*****								
-Obtain Height / Weight	0	on admission		EP				
*****ASSESS/NOTIFY*****								
-ASH Initial Assessment (by CMO)	0	on admission		EP				
-ASH Patient Admission Data/History	0	on admission	4d	RS				
-Shift Assessment- Med/Surg	0	10,22		EP				
-IV Documentation	0	10,22	4d	EP				
-Intake / Drain Documentation	0	10,22	1h	EP				
-Intake and Output - Med/Surg	0	10,22	6h	EP				
-Restraint Care Sheet -Non Behavioral Mtg	0	Q2H		EP				
-Pneumococcal Vaccination - Administer	0	NOW		BE	0			
Give now if ordered								
-Pneumococcal Vaccination - Administer	0	NOW		BE	0			
Give now if ordered								
-Pain, Assess	0	PRN		DN				
-Vital Signs, Monitor	0	06,14,22,02	4d	EP				

- When initiated, the Pain intervention will prompt the user to identify what type of pain assessment is being completed.
- Choose a value from the lookup list.
- To select an entry, enter the number of the entry in the SELECT field and hit ENTER.

ASH Pain Assessment

05/19/09 08:00 AM

Type of pain assessment: []

Intensity (1=least, 10=worst) [] Scale used []

How long has pain been present? []

Location: [] Descr [] Freq []

Pain Tx provided: []

Post Treatment Pain Intensity (0=None, 10=Worst) []

Side Effects: []

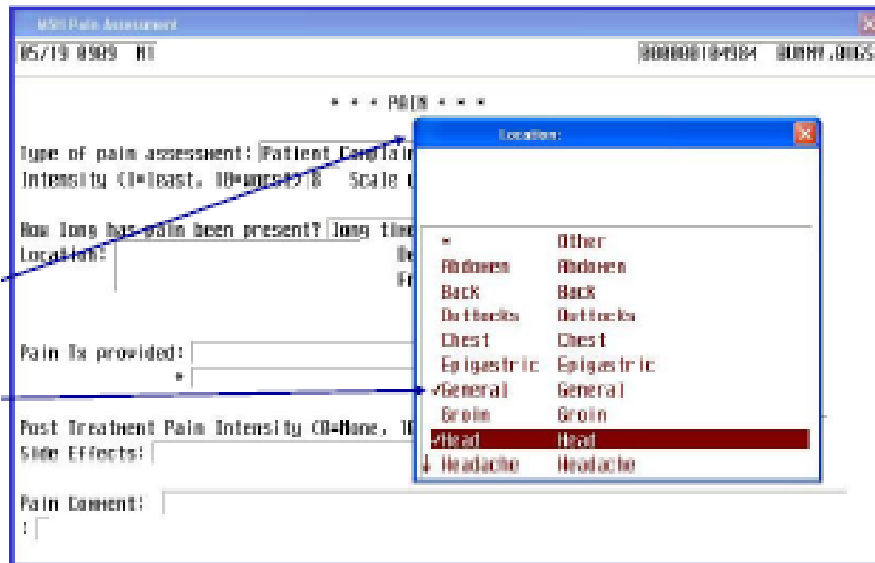
Pain Comment: []

Type Of Pain Assessment [Sel] Lookup

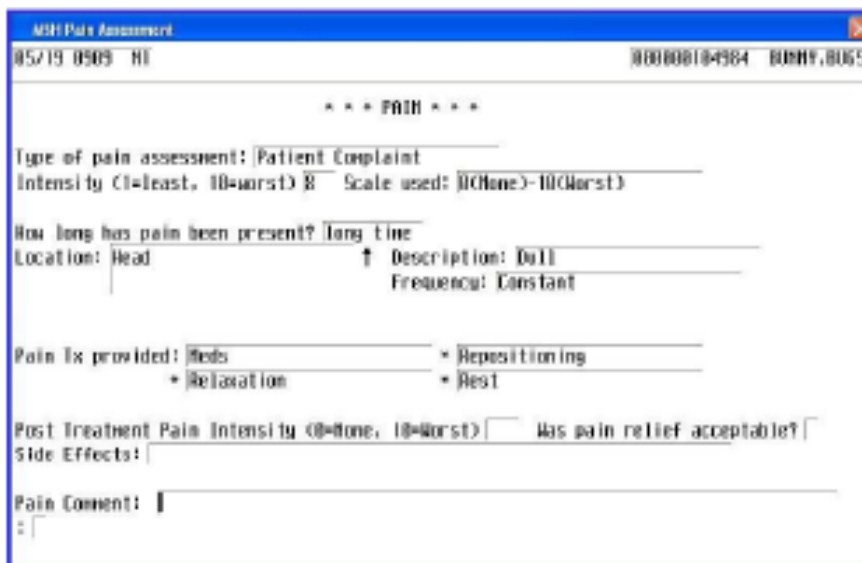
Select []

Mnemonic	Responses
1 C/O	Patient Complaint
2 POST	Post Treatment
3 ROUT	Routine Check

- Most of the fields on the Pain Assessment intervention are lookups.
- The Location is a multi-select lookup. Use the CTRL key in the lower right corner to select items. Use the DOWN ARROW to navigate between items. Use F12 to file selected items.



- Complete all required field for the Pain Assessment Intervention.
- When finished, you will be prompted to file the intervention data.



- To chart on the **Vital Signs** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.

Process Intervention

Current Date/Time: 05/19/09 11:00 AM (Int: 04 of 24)

Patient: 00000104584 BUNNY,BUGS Status: Y00E Int: Room:0501
 Attend Dr: J000A Jones, Arthur E. Admit: 04/30/09 Bed: 01
 Start Date: 05/18/09 at 0001 End Date: 05/19/09 at 2359 Age/Sex: 49 M Loc: 005
 Include: 0,C,0,05,CP,NO,DE,PS 1:00 3L 000 001 Mod Edit: Acuity:

Interventions	Sets	Frequency	Doc	Src	D	Q	M	R	PI
-Intake and Output - Med/Surg	R	10,22	5m	CP					
-Restrictive Zone Sheet - New Bedside Care? Myd	0	000		CP					
-Pneumococcal Vaccination - Administer	R	000		0E	0				
Give now if ordered									
-Pneumococcal Vaccination - Administer	R	000		0E	0				
Give now if ordered									
-Pain, Assess	R	_PRN	5m	CP					
-Vital Signs - Monitor	0	05,14,22,02	4L	0E	0	0	0	0	0
-----MED'S/DR'S-----									
-Home Medication Reconciliation	R	on admission		CP					
-Discharge Medications	R	once at D/C		CP					
-----SKIN/WOUND/CARRIAGE-----									
-Wound Management	R	DAILY	4L	CP					
-----PATIENT EDUCATION-----									
-Patient Education -Teaching	R	10,22	4L	CP					
-Diabetes Educ - Pt 1: Disease	R	0120		CP					

- The Vital Signs intervention screen is composed of a combination of data entry and lookup fields.

Process Interventions

Current Date/Time: 05/19/09 11:00 AM (Int: 04 of 24)

Patient: 00000104584 BUNNY,BUGS Status: Y00E Int: Room:0501
 Attend Dr: J000A Jones, Arthur E. Admit: 04/30/09 Bed: 01
 Start Date: 05/18/09 at 0001 End Date: 05/19/09 at 2359 Age/Sex: 49 M Loc: 005
 Include: 0,C,0,05,CP,NO,DE,PS 1:00 3L 000 001 Mod Edit: Acuity:

401 Vital Signs

05/19 09:00 AM 00000104584 BUNNY,BUGS

Temp: F T Site:
 Pulse: P Site:
 Resp:
 B/P: B/P Site: Patient's Position:

(Pulse bx) SpO2: FLOWRATE OR 2: i.e. 2L or 35L or RA (Room Air)

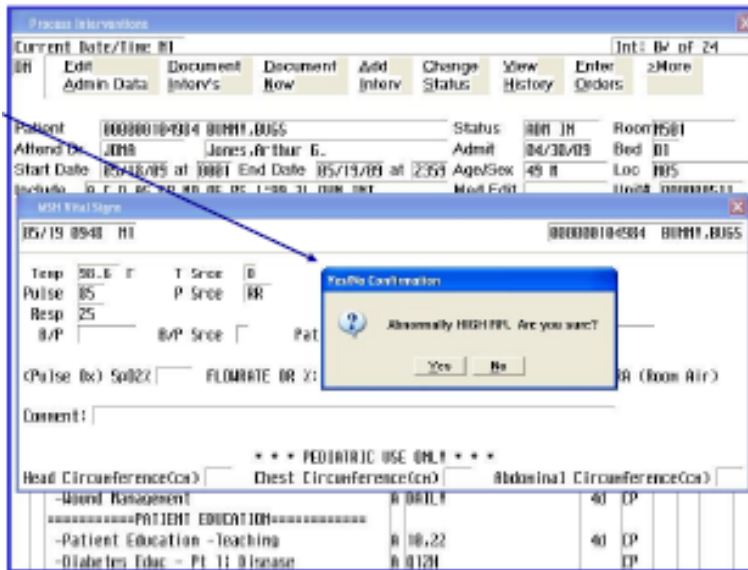
Comment:

*** PEDIATRIC USE ONLY ***

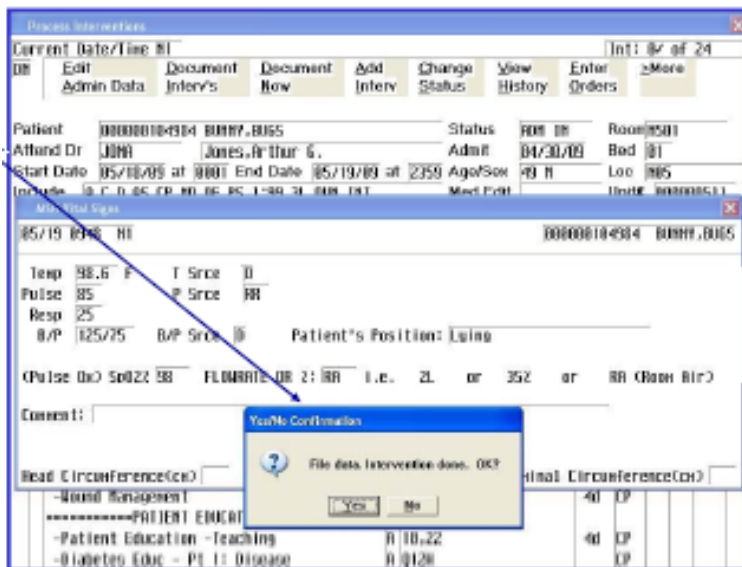
Head Circumference(Cm): Chest Circumference(Cm): Abdominal Circumference(Cm):

-Wound Management	R	DAILY	4L	CP					
-----PATIENT EDUCATION-----									
-Patient Education -Teaching	R	10,22	4L	CP					
-Diabetes Educ - Pt 1: Disease	R	0120		CP					

- Messages for abnormal vital signs values may be presented.



- When finished entering the vital sign data, file the intervention.



- To chart on the **Patient Education** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.

Interventions	Sts	Frequency	Doc	Sec	D	CAN	KL	Prt
-Pain, ASSES	1	PBR	50	CP				
-Vital Signs, Monitor	1	06, 14, 22, 02	50	CP				
=====MED 'S/10'S=====								
-Wound Medication Reconciliation	1	on admission		CP				
-Discharge Medications	1	once at D/C		CP				
=====SKIN/MOUND/DRAINAGE=====								
-Wound Management	1	DAILY	40	CP				
=====PATIENT EDUCATION=====								
-Patient Education - Teaching	1	06, 22	40	CP				
-Diabetes Educ - Pt 1: Disease	1	0120		CP				
-Diabetes Educ - Pt 2: Glucose	1	0120		CP				
-Diabetes Educ - Pt 3: Meds	1	0120		CP				
-Diabetes Educ - Pt 4: Diet	1	0120		CP				
-Diabetes Educ - Pt 5: Discharge	1	0120		CP				
=====D/C PLANNING=====								
-ASH Reg Discharge Note	1	once at D/C		CP				

- The Patient Education intervention screen is composed of a combination of data entry and lookup fields.
- There are several different general areas about which patient education may be completed.

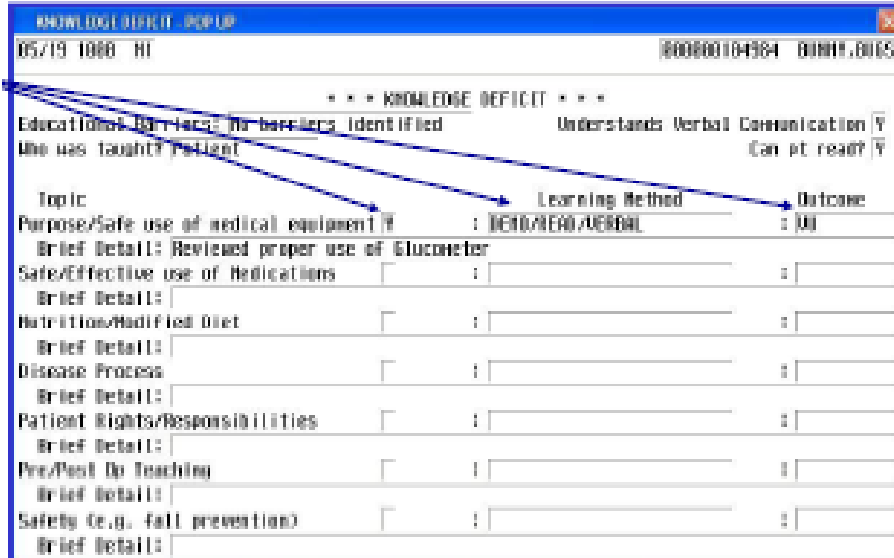
*** KNOWLEDGE DEFICIT ***

Educational Barriers: _____ Understands Verbal Communication

Who was taught? _____ Can get read?

Topic	Learning Method	Outcome
Purpose/Safe use of medical equipment <input type="checkbox"/>	_____	_____
Brief Detail: _____		
Safe/Effective use of Medications <input type="checkbox"/>	_____	_____
Brief Detail: _____		
Nutrition/Modified Diet <input type="checkbox"/>	_____	_____
Brief Detail: _____		
Disease Process <input type="checkbox"/>	_____	_____
Brief Detail: _____		
Patient Rights/Responsibilities <input type="checkbox"/>	_____	_____
Brief Detail: _____		
Pre/Post Op Teaching <input type="checkbox"/>	_____	_____
Brief Detail: _____		
Safety (e.g., fall prevention) <input type="checkbox"/>	_____	_____
Brief Detail: _____		

- Once an education topic has been identified, the remaining fields associated with that topic must be completed.
- A user may document on one, many, or all educational topics available on the screen.



KNOWLEDGE DEFICIT POPUP

05/19/1000 HI 000000104984 BUNNY,BUES

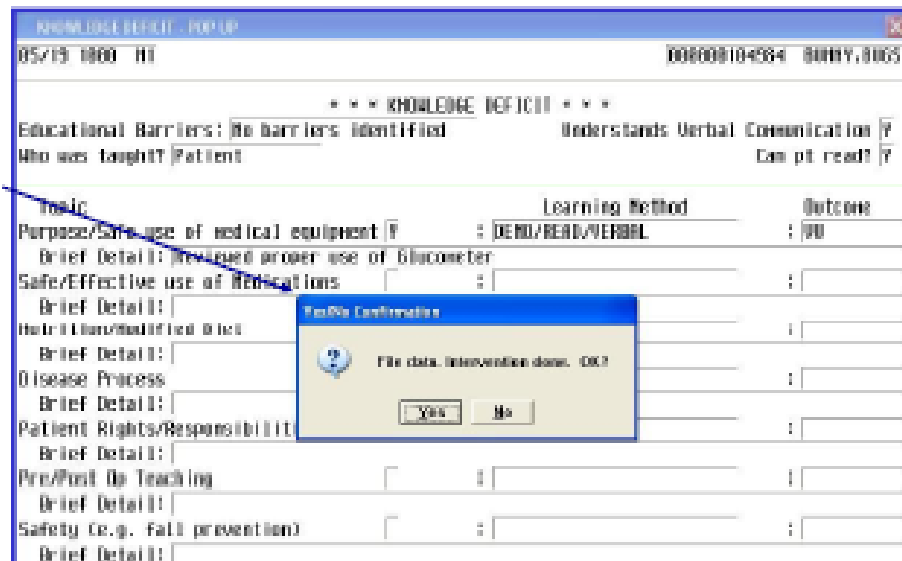
*** KNOWLEDGE DEFICIT ***

Educational Barriers: No barriers identified Understands Verbal Communication

Who was taught? Patient Can pt read?

Topic	Learning Method	Outcome
Purpose/Safe use of medical equipment <input type="checkbox"/>	: <u>DEMO/READ/VERBAL</u>	: <u>NO</u>
Brief Detail: <u>Reviewed proper use of Glucometer</u>		
Safe/Effective use of Medications <input type="checkbox"/>	:	:
Brief Detail:		
Nutrition/Modified Diet <input type="checkbox"/>	:	:
Brief Detail:		
Disease Process <input type="checkbox"/>	:	:
Brief Detail:		
Patient Rights/Responsibilities <input type="checkbox"/>	:	:
Brief Detail:		
Pre/Post Op Teaching <input type="checkbox"/>	:	:
Brief Detail:		
Safety (e.g., fall prevention) <input type="checkbox"/>	:	:
Brief Detail:		

- Once you have finished documenting your patient education, be certain to file your data.
- Hit F12 to file the data, then click on the YES button with your mouse to confirm.



KNOWLEDGE DEFICIT POPUP

05/19/1000 HI 000000104984 BUNNY,BUES

*** KNOWLEDGE DEFICIT ***

Educational Barriers: No barriers identified Understands Verbal Communication

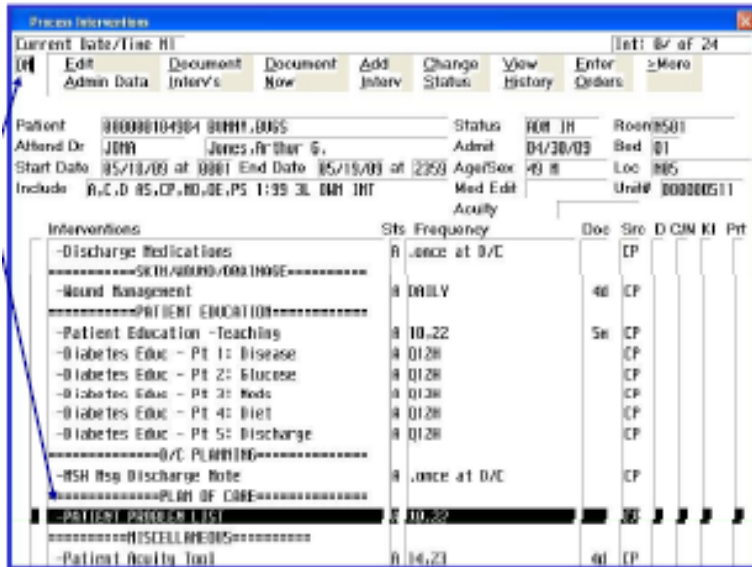
Who was taught? Patient Can pt read?

Topic	Learning Method	Outcome
Purpose/Safe use of medical equipment <input type="checkbox"/>	: <u>DEMO/READ/VERBAL</u>	: <u>NO</u>
Brief Detail: <u>Reviewed proper use of Glucometer</u>		
Safe/Effective use of Medications <input type="checkbox"/>	:	:
Brief Detail:		
Nutrition/Modified Diet <input type="checkbox"/>	:	:
Brief Detail:		
Disease Process <input type="checkbox"/>	:	:
Brief Detail:		
Patient Rights/Responsibilities <input type="checkbox"/>	:	:
Brief Detail:		
Pre/Post Op Teaching <input type="checkbox"/>	:	:
Brief Detail:		
Safety (e.g., fall prevention) <input type="checkbox"/>	:	:
Brief Detail:		

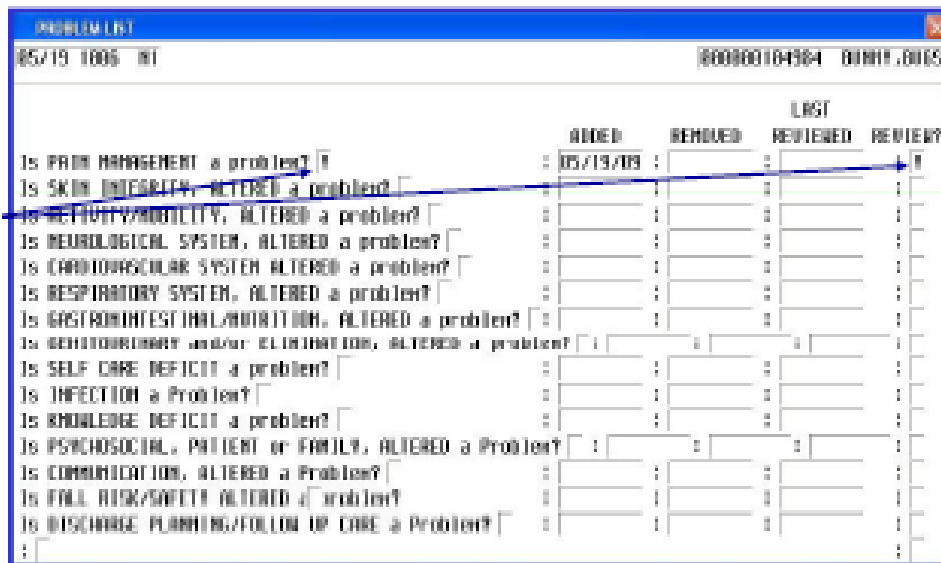
File Confirmation

File data. Intervention done. OK?

- To chart on the **Patient Problem List** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.



- This is the Problem List screen.
- One starts charting by entering 'Y' next to the problem, then entering 'Y' in the REVIEW column.



- Reviewing the problem data by entering 'Y' in the REVIEW column opens the GOAL/INT page.
- On this page, one describes the problem, and defines the goals to resolve that problem.

PAIN PROBLEM/INT LIST

*** PAIN MANAGEMENT ***

Describe Problem: PT has bilateral hip pain s/p bilateral hip replacement

GOALS	TARGET DATE
1: For pain to remain within patient's comfort level	: 5/18/09
2: For patient to articulate pain level using appr. pain scale	: 5/18/09
3:	:

INTERVENTIONS	OUTCOME	DATE PERFORMED
1:	:	:
2:	:	:
3:	:	:
4:	:	:
5:	:	:

LAST REVIEWED - DATE: | TIME: |

Additional Narrative Note? |

- Once goals have been defined, interventions can be identified and charted, along with their associated outcome and dates performed.

PAIN PROBLEM/INT LIST

*** PAIN MANAGEMENT ***

Describe Problem: PT has bilateral hip pain s/p bilateral hip replacement

GOALS	TARGET DATE
1: For pain to remain within patient's comfort level	: 5/18/09
2: For patient to articulate pain level using appr. pain scale	: 5/18/09
3:	:

INTERVENTIONS	OUTCOME	DATE PERFORMED
1: Position Change	:	:
2:	:	:
3:	:	:
4:	:	:
5:	:	:

Intervention Outcome Lookup

Select |

Mnemonic	Response
1 E	Effective
2 I	Ineffective

LAST REVIEWED - DATE: | TIME: |

Additional Narrative Note? |

- Complete your charting on the Problem Goal/Int screen by identifying the date and time the data was last reviewed.

PROBLEM GOAL/INT LIST

*** PAIN MANAGEMENT ***

Describe Problem: PT has bilateral hip pain s/p bilateral hip replacement

GOALS

GOALS	TARGET DATE
1: For pain to remain within patient's comfort level	: 5/18/09
2: For patient to articulate pain level using appr. pain scale	: 5/18/09
3:	:

INTERVENTIONS

INTERVENTIONS	OUTCOME	DATE PERFORMED
1: Position Change	: E	: 05/19/09
2: Give Medication	: E	: 05/19/09
3: Relaxation Techniques	: E	: 05/19/09
4:	:	:
5:	:	:

LAST REVIEWED - DATE: / TIME: 0000

Additional Narrative Note? N

- It is possible to chart on one, many, or all of the problems in the list, provided doing so paints an accurate picture of the patient's status.
- Be certain to file and save your charted data.

PROBLEM LIST

05/19 1006 HI 0000010-4984 BUNNY, BRIS

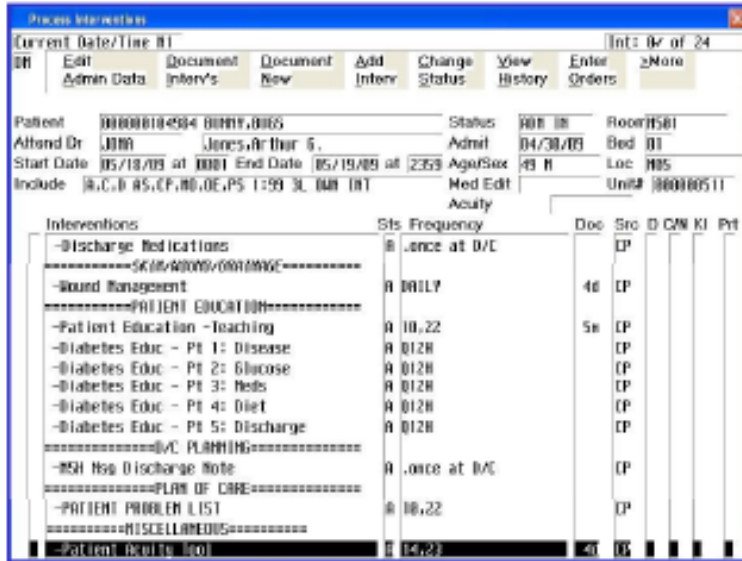
	ADDED	REMOVED	LAST	
			REVIEWED	REVIEW?
Is PAIN MANAGEMENT a problem? <input checked="" type="checkbox"/>	05/19/09	:	:	<input checked="" type="checkbox"/>
Is SKIN INTEGRITY, ALTERED a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is ACTIVITY/MOBILITY, ALTERED a problem? <input checked="" type="checkbox"/>	05/19/09	:	:	<input checked="" type="checkbox"/>
Is NEUROLOGICAL SYSTEM, ALTERED a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is CARDIOVASCULAR SYSTEM, ALTERED a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is RESPIRATORY SYSTEM, ALTERED a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is GASTROINTESTINAL/NUTRITION, ALTERED a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is GENITOURINARY and/or ELIMINATION, ALTERED a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is SELF CARE DEFICIT a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is INFECTION a Problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is KNOWLEDGE DEFICIT a problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is PSYCHOSOCIAL, PATIENT or FAM <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is COMMUNICATION, ALTERED a Problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is FALL RISK/SAFETY ALTERED a Problem? <input type="checkbox"/>	:	:	:	<input type="checkbox"/>
Is DISCHARGE PLANNING/FOLLOW UP <input type="checkbox"/>	:	:	:	<input type="checkbox"/>

Yes/No Confirmation

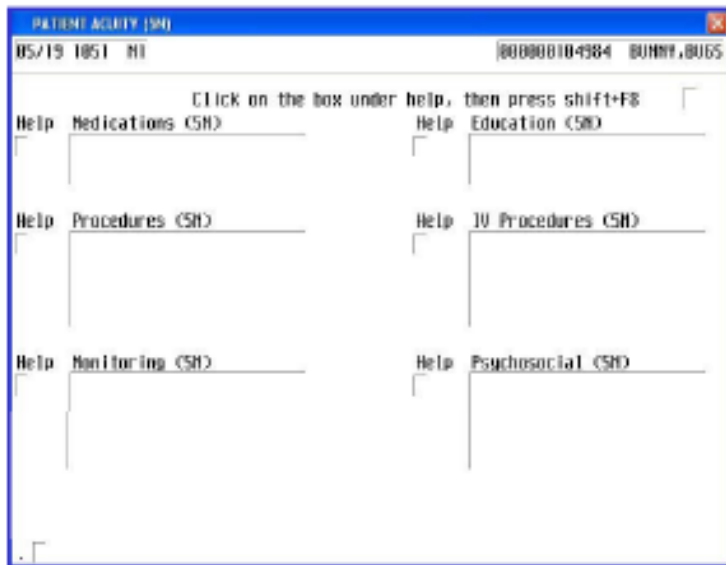
File data. Intervention done, OK?

Yes No

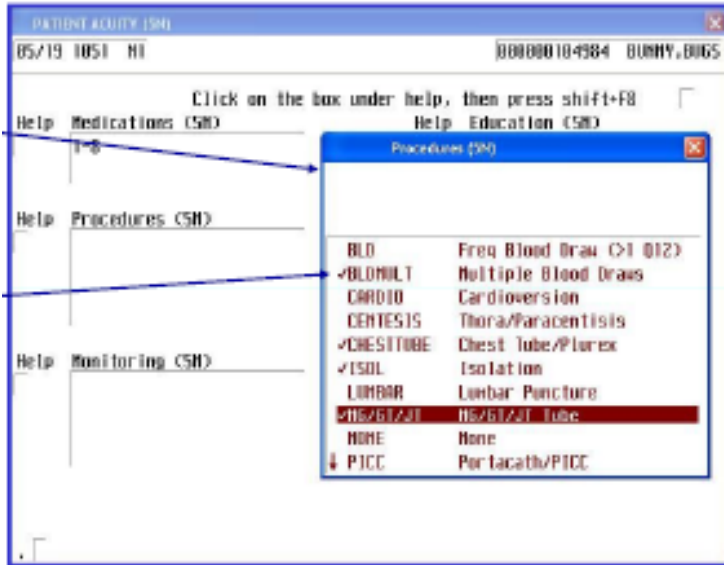
- To chart on the **Patient Acuity** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.



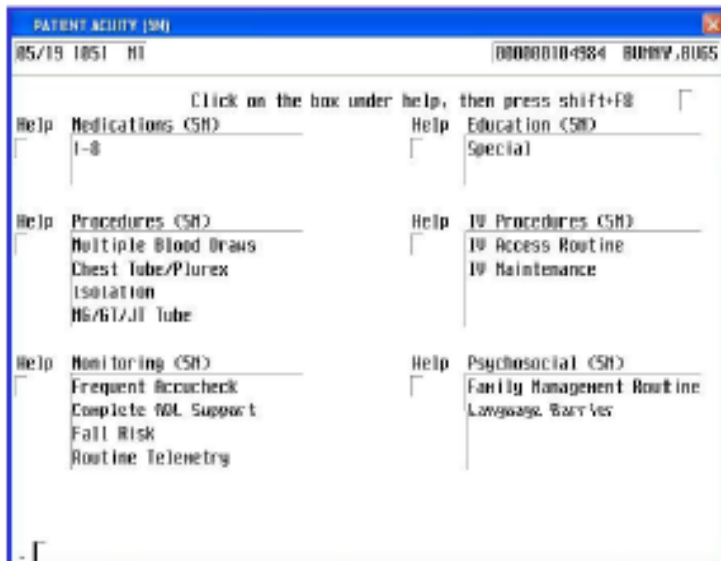
- This is the patient acuity screen.
- This intervention assures correct unit staffing levels based on individual and aggregate unit patient acuity scores.
- To be useful in leveling staffing, it **MUST** be completed at its defined times.



- Each acuity subsection is comprised of a multi-select lookup.
- Use the CTRL key in the lower right corner to select an item. Use the DOWN ARROW to move between items. Use F12 to populate the field with the selected items.



- Once each acuity field is completed, file the charted data.



- To chart on the **Wound Management** intervention, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.

Process Interventions

Current Date/Time: 05/19/09 Int: 12 of 24

Patient: 00000104904 BUNNY, BURG Status: ADM IN Room: 501
 Attend Dr: JONES, Arthur E. Admit: 04/30/09 Bed: 81
 Start Date: 05/18/09 of 0001 End Date: 05/19/09 at 2359 Age/Sex: 68 M Loc: 005
 Include: R,C,B,R5,CP,RS,DE,PS 1:99 3L 048 001 Mod Edit: Unit#: 00000511
 Acuity:

Interventions	Sls	Frequency	Doc	Src	D	C	M	K	P
-Discharge Medications	R	once at B/C		CP					
-Wound Management		0017	DN	CP					
-----PATIENT EDUCATION-----									
-Patient Education -Teaching	R	00,22	5h	CP					
-Diabetes Educ - Pt 1: Disease	R	012H		CP					
-Diabetes Educ - Pt 2: Glucose	R	012H		CP					
-Diabetes Educ - Pt 3: Medic	R	012H		CP					
-Diabetes Educ - Pt 4: Diet	R	012H		CP					
-Diabetes Educ - Pt 5: Discharge	R	012H		CP					
-----WOUND PLANNING-----									
-PSH Hsg Discharge Note	R	once at B/C		CP					
-----PLAN OF CARE-----									
-PATIENT PROBLEM LIST	R	00,22		CP					
-----MISCELLANEOUS-----									
-Patient Acuity Tool	R	14,23	6h	CP					

- This is the screen for the Wound Mgmt intervention.
- If a patient does NOT have any wounds, enter 'N' and file your charted data.
- If a patient DOES have wounds, enter 'Y' and complete all required fields for that specific wound.

WOUND DOCUMENTATION

05/19/09 11:06 AM 00000104904 BUNNY, BURG

Current Date: 05/19/09 Are there any wounds present?

DATE	IST	DN	WOUND	LOCATION	STAGE	LA	WD	DP	WH	TISSUE	ESIDE	ESIDE
ID#	NO		TYPE			CH	CA	CA	CA	DESC.	AMOUNT	TYPE
1												
CARE:				COMMENT:								
				HIT ESC to exit								
2												
CARE:				COMMENT:								
				HIT ESC to exit								
3												
CARE:				COMMENT:								
				HIT ESC to exit								
4												
CARE:				COMMENT:								
				HIT ESC to exit								
5												
CARE:				COMMENT:								
				HIT ESC to exit								

- Enter the date on which the wound was first identified here.
- All existing wounds should be identified on admission.
- Select the wound type from the lookup field.
- If 'OTHER' is selected, a flag appears instructing you to provide more data.

The screenshot shows the 'WOUND DOCUMENTATION' form with a 'Wound Type Lookup' dialog box open. The form has a 'Current Date' field set to 05/19/09. The 'Wound Type Lookup' dialog lists the following options:

Mnemonic	Responses
1 BURN	Burn
2 DIABETIC	Diabetic Ulcer
3 WOUND	Wound
4 OPEN	Open Surgical Wound
5 OTHER	Other
6 PRESSURE	Pressure Ulcer
7 TRAUMA	Traumatic Wound
8 VASCULAR	Vascular Wound

The form also includes columns for 'DATE 1ST ON WOUND', 'WOUND', 'SITE', 'ESIDE', 'ESIDE', 'SC.', 'AROUND', and 'TYPE'. Blue arrows point from the 'DATE 1ST ON WOUND' field to the 'Current Date' field, and from the 'WOUND' field to the 'Wound Type Lookup' dialog.

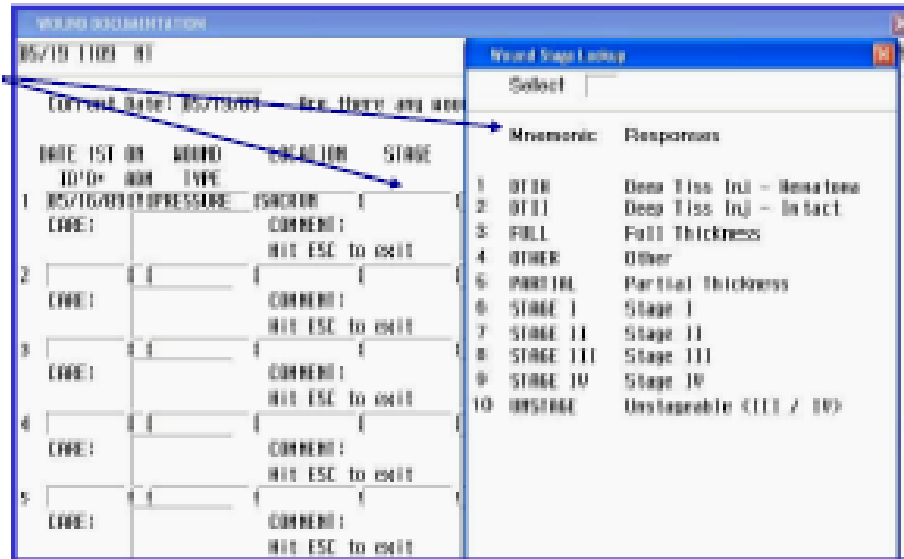
- You may either enter the location as free text or select a value from the lookup.

The screenshot shows the 'WOUND DOCUMENTATION' form with a 'Wound Location Lookup' dialog box open. The form has a 'Current Date' field set to 05/19/09. The 'Wound Location Lookup' dialog lists the following options:

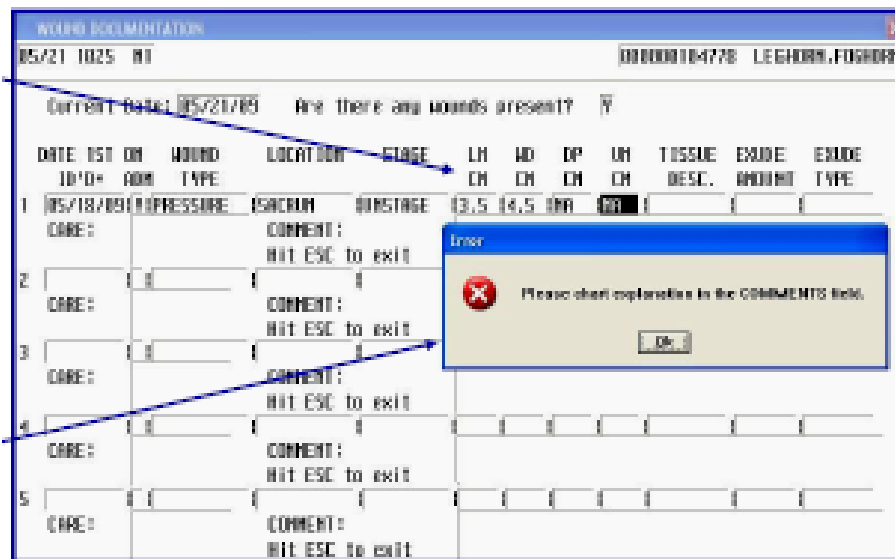
Mnemonic	Responses
1 BACK	BACK
2 CHEST	CHEST
3 EAR	EAR
4 CECUM	CECUM
5 FACE	FACE
6 FOREARM	FOREARM
7 GENERAL	GENERALIZED
8 L. ANKLE	LEFT ANKLE
9 L. BUTTOCK	LEFT BUTTOCK
10 L. CALF	LEFT CALF
11 L. CHEEK	LEFT CHEEK
12 L. D. FOOT	LEFT DORSAL FOOT
13 L. D. HAND	LEFT DORSAL HAND
14 L. D. WRIST	LEFT DORSAL WRIST

The form also includes columns for 'DATE 1ST ON WOUND', 'WOUND', 'LOCATION', 'ESIDE', and 'TYPE'. Blue arrows point from the 'DATE 1ST ON WOUND' field to the 'Current Date' field, and from the 'LOCATION' field to the 'Wound Location Lookup' dialog.

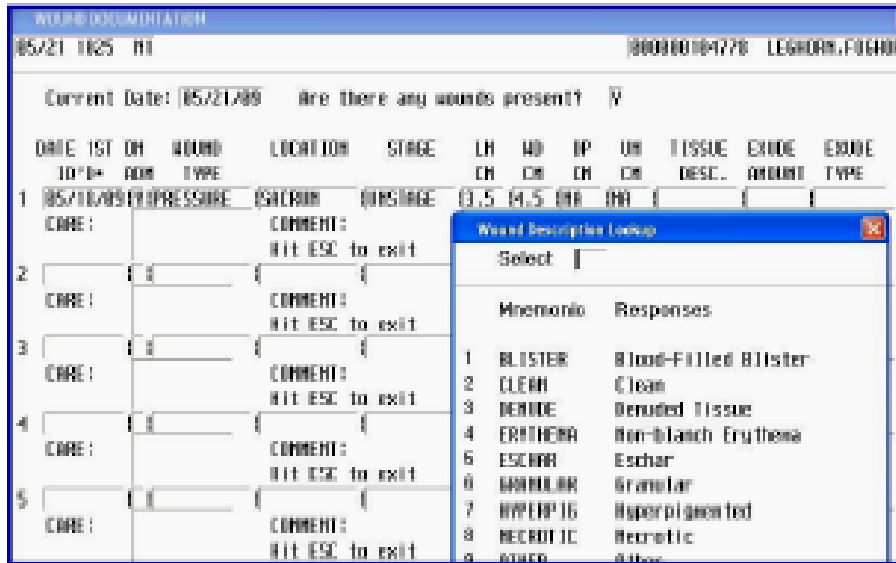
- The stages in the lookup list reflect the staging of both pressure and non-pressure wounds.
- Context-based logic helps identify the right stage based on the wound type selected.
- Error messages prompt you to correct any errors in staging.



- You may enter measurements – Length, Width, Depth, and Undermine – either as numbers between 0.0 and 99.9 or NA.
- If 'NA' is entered, a message is displayed.

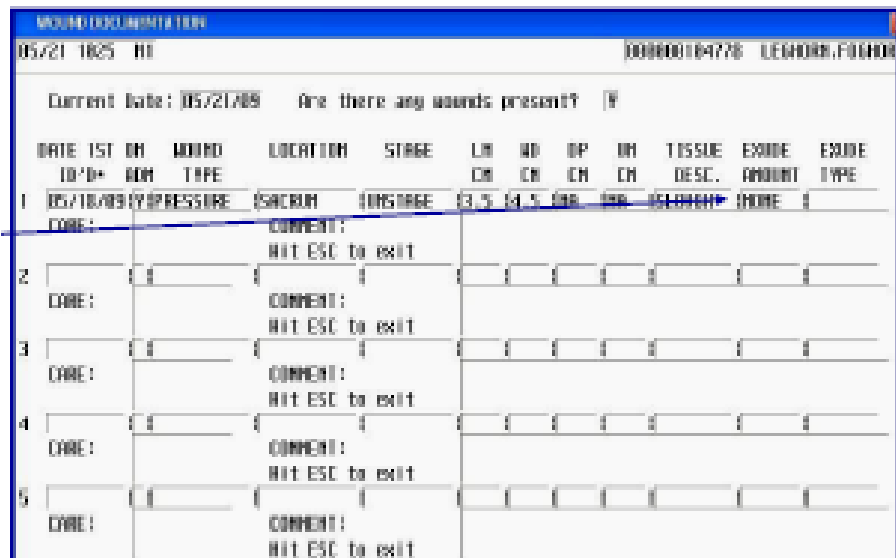


- The descriptions in the lookup list reflect those for both pressure and nonpressure wounds.



The screenshot shows the 'WOUND DOCUMENTATION' interface. At the top, it displays '05/21/09 11:25 AM' and '00000104770 LEGHORN, FOLGHOE'. Below this, it asks 'Current Date: 05/21/09 Are there any wounds present?' with a 'Y' selected. A table lists wound entries with columns for DATE, TIME, AMOUNT, WOUND TYPE, LOCATION, STAGE, and EXUDE. An overlay window titled 'Wound Description Lookup' is open, showing a list of wound types and their corresponding exudate amounts and types. The list includes: 1 BLISTER (Blood-Filled Blister), 2 CLEAN (Clean), 3 DENUDE (Denuded Tissue), 4 ERUTHERA (Non-blanch Erythema), 6 ESCARR (Eschar), 0 GRANULAR (Granular), 7 HYPERPIG (Hyperpigmented), 8 NECROTIC (Necrotic), and 9 OTHER (Other).

- Exudate amount and exudates type are both lookup fields.
- In you select 'NONE' in the AMOUNT field, the cursor skips the TYPE field.



This screenshot shows the same 'WOUND DOCUMENTATION' interface as the previous one. The 'Wound Description Lookup' window is no longer present. In the first row of the table, the 'EXUDE AMOUNT' field is set to 'NONE'. The 'EXUDE TYPE' field is currently empty, indicating that the cursor has skipped this field due to the 'NONE' selection in the amount field.

- The CARE field is a multi-select lookup.
- Some entries will prompt you to enter more data in the COMMENTS field.

WOUND DOCUMENTATION

05/21/09 0825 HI 00000104770 LECHORN, FOGHOR

Current Date: 05/21/09 Are there any wounds present? [Y]

DATE	TIME	WOUND	LOCATION	STAGE	LN	WD	DP	DN	TISSUE	ESIDE	ESIDE
MM/DD/YY	MM	WOUND TYPE			CM	CM	CM	CM	DESC.	AMOUNT	TYPE
05/18/09	09	(V)PRESSURE	(S)ACROM	(U)STAGE	03.5	04.5	000	000	(S)LOUGH	(R)ONE	()
CARE:	SKIN	↑	COMMENT:	Hit ESC to exit							
05/18/09	09	(V)PRESSURE	(S)ACROM	(U)STAGE	03.5	04.5	000	000	(S)LOUGH	(R)ONE	()
CARE:			COMMENT:	Hit ESC to exit							
05/18/09	09	(V)PRESSURE	(S)ACROM	(U)STAGE	03.5	04.5	000	000	(S)LOUGH	(R)ONE	()
CARE:			COMMENT:	Hit ESC to exit							
05/18/09	09	(V)PRESSURE	(S)ACROM	(U)STAGE	03.5	04.5	000	000	(S)LOUGH	(R)ONE	()
CARE:			COMMENT:	Hit ESC to exit							

Error: Chart the name and number of MD and date/time of MD notification.

- A user may enter data on up to 20 different wounds on this screen.
- Users are encouraged to enter comments that provide additional details on the treatment or care provided for the wound.
- When done, file your charted data.

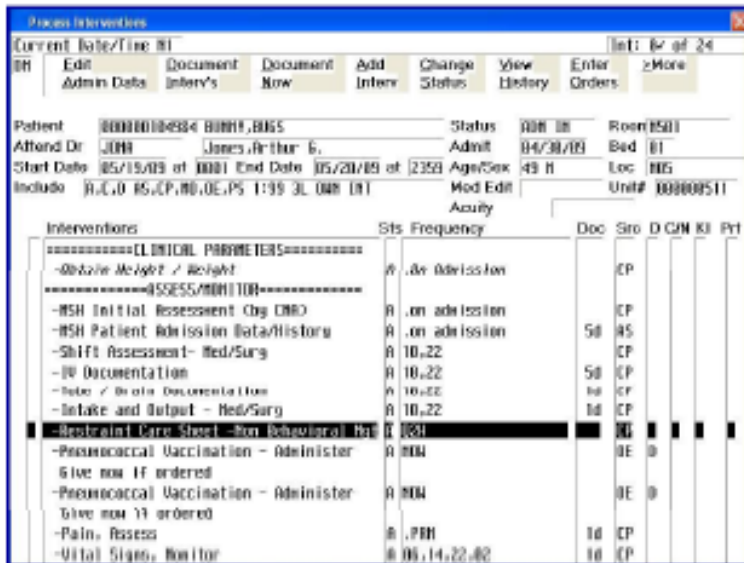
WOUND DOCUMENTATION

05/21/09 0825 HI 00000104770 LECHORN, FOGHOR

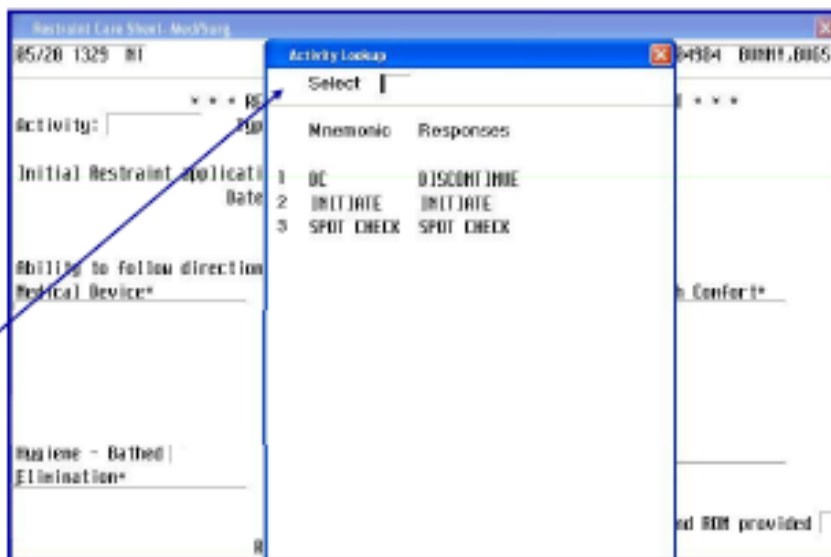
Current Date: 05/21/09 Are there any wounds present? [Y]

DATE	TIME	WOUND	LOCATION	STAGE	LN	WD	DP	DN	TISSUE	ESIDE	ESIDE
MM/DD/YY	MM	WOUND TYPE			CM	CM	CM	CM	DESC.	AMOUNT	TYPE
05/18/09	09	(V)PRESSURE	(S)ACROM	(U)STAGE	03.5	04.5	000	000	(S)LOUGH	(R)ONE	()
CARE:	NO	↑	COMMENT:	This field allows a nurse to enter free-form notes pertaining to the wound.							
05/18/09	09	(V)PRESSURE	(L) L ANKLE	(S)TAGE II	01.5	01.0	00	00	(S)LEARN	(R)ONE	()
CARE:	SKIN	↑	COMMENT:	This is the note entered by the nurse on the second wound.							
05/18/09	09	(V)DIABETIC	(L) FIFTH	(F)ULL	02.5	02.5	00.1	00	(S)ESCHAR	(R)ONE	()
CARE:	SURG		COMMENT:	Surgical dressing in place s/p debridement of the wound. Dressing t/b changed by							
05/18/09	09	(V)VASCULAR	(L) L LEG	(P)ARTIAL	06.5	03.5	00	00	(S)LEARN	(S)MALL	(S)ERUSH
CARE:	DRESS		COMMENT:	Area of drainage covered with sterile gauze and non-healing skin tape							
05/18/09	09	(V)PRESSURE	(S)ACROM	(U)STAGE	03.5	04.5	000	000	(S)LOUGH	(R)ONE	()
CARE:			COMMENT:	Hit ESC to exit							

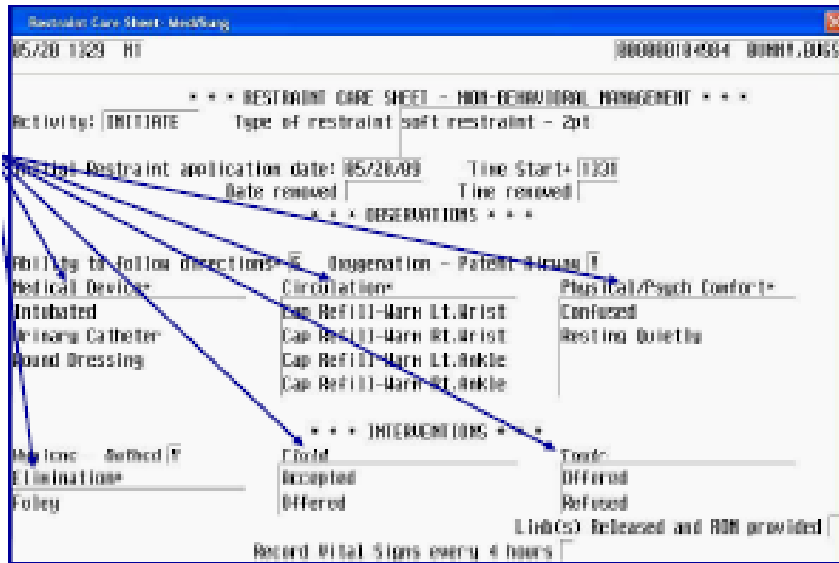
- To chart on the **Restraint Care Sheet for Non-Behavioral Restraints**, highlight the intervention.
- Type DN (Document Now) in the SELECT field.
- Hit ENTER.



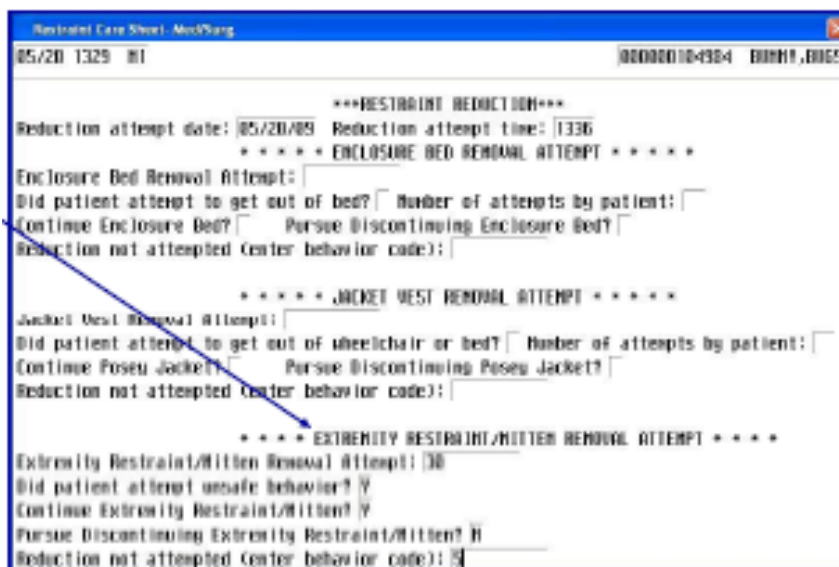
- The Restraint Care Sheet screen is composed of a combination of data entry and single and multi-lookup fields.
- When starting, the Activity lookup appears. Select the type of restraint activity you wish to chart on.



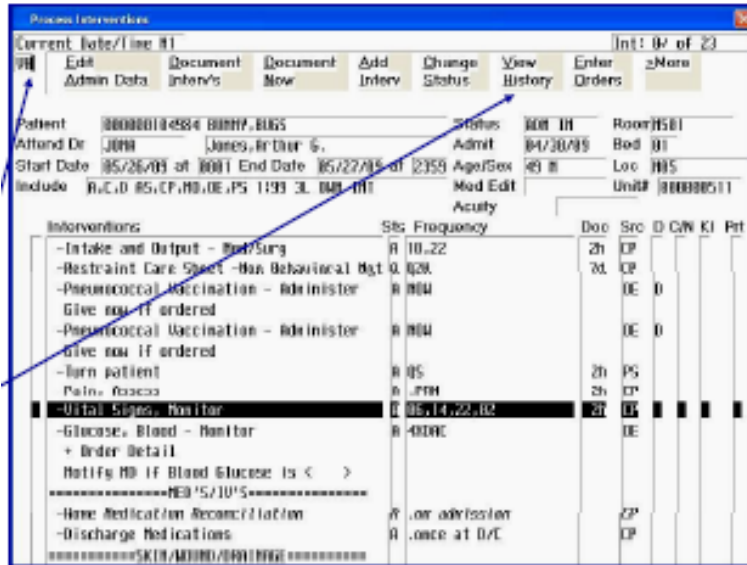
- Complete all required fields.
- NOTE: several fields are multiselect lookups.
 - Use the CTRL key in the lower right corner to select an item.
 - Use the DOWN ARROW to move between items.
 - Use F12 to populate the field with the selected items.



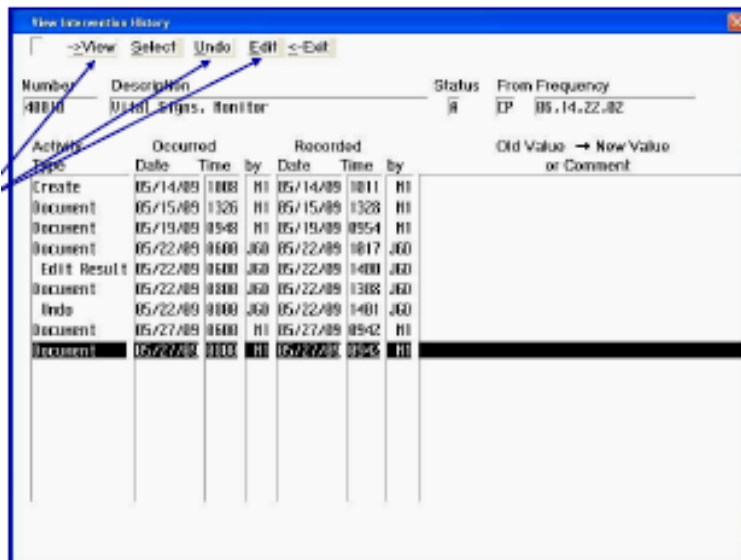
- On page 2 of the Restraint Care Sheet, chart data pertaining to the restraint removal attempt or the type of restraint(s) used.
- When finished, file and save the charted data by hitting F12.



- Once you have documented on an intervention, you are able to perform three additional functions: **VIEW HISTORY**, **EDIT**, and **UNDO**.
- All three are accessed through the View History function on the Process Interventions screen



- From the View Intervention History screen, a user may view past intervention data, edit and/or undo data they have charted in the past 12 hours.
- To **view** past data, highlight the entry and hit the RIGHT ARROW key.
- A static screen will display the charted data.

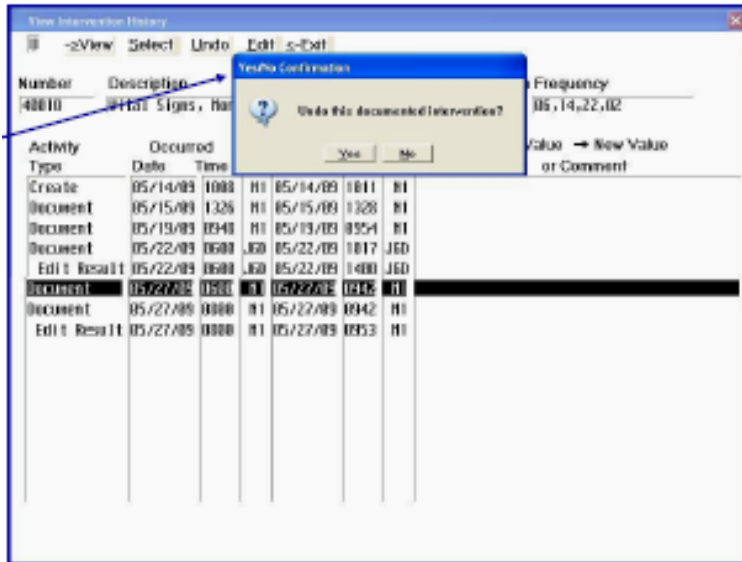


- Selecting **Edit** on the View Intervention History screen opens the Edit Previous Documentation screen.
- A user may change any or all values originally charted.
- Hit F12 to file the revisions.

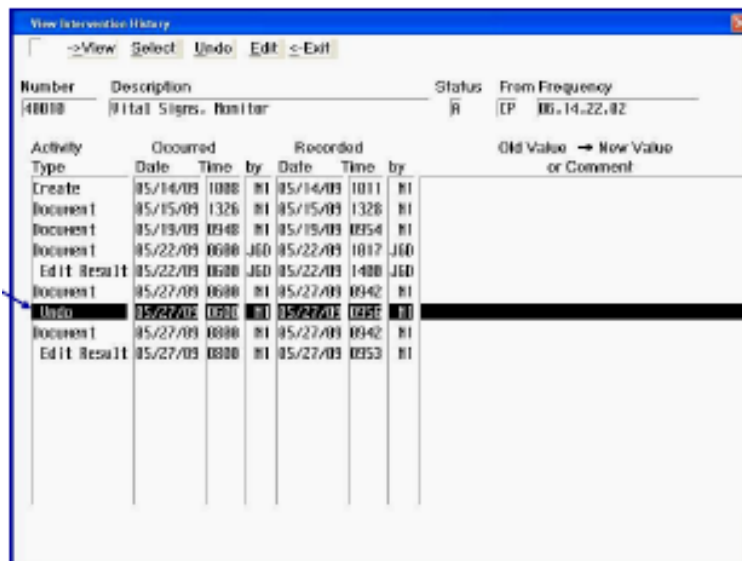
- Once filed, the edited data appears on the View Intervention History screen with audit information showing the date and time the data was edited as well as the nurse responsible for editing the data.

Number	Description	Status	From Frequency		
48810	Vital Signs, Nonbar	A	IP 06, 14, 22, 02		
Activity Type	Occurred Date	Time	Recorded Date	Time	Old Value -> New Value or Comment
Create	05/14/09	0808	05/14/09	0811	
Document	05/15/09	1326	05/15/09	1328	
Document	05/19/09	0948	05/19/09	0954	
Document	05/22/09	0800	05/22/09	0817	JED
Edit Result	05/22/09	0600	05/22/09	1400	JED
Document	05/27/09	0600	05/27/09	0942	
Document	05/27/09	0800	05/27/09	0942	
Edit Result	05/27/09	0100	05/27/09	0108	

- Selecting **Undo** on the View Intervention History screen prompts the user to confirm this action.
- Undoing the charting of data is comparable to striking through an entry on a paper chart.

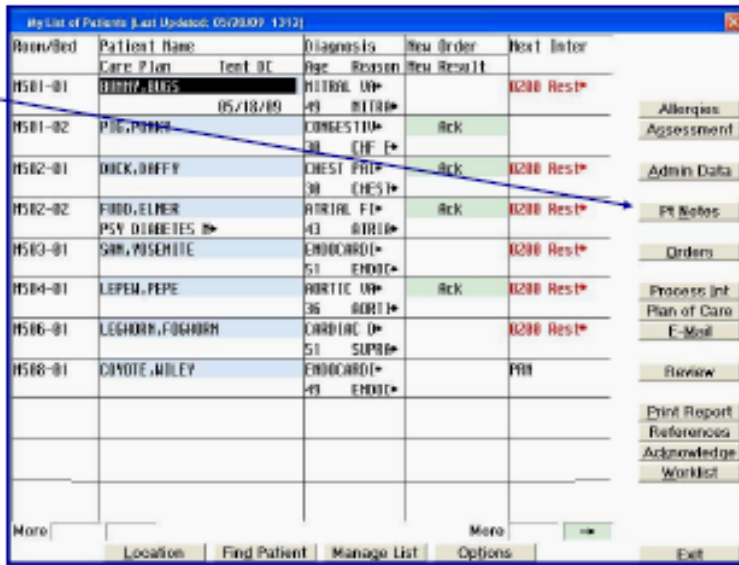


- Once filed, the undone / deleted data appears on the View Intervention History screen with audit information showing the date and time the data was deleted as well as the nurse responsible for deleting the data.

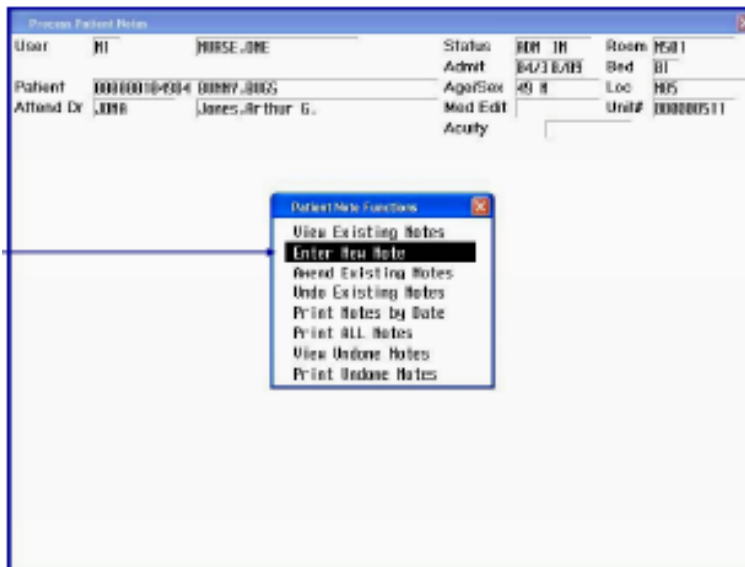


DOCUMENTING PATIENT NOTES

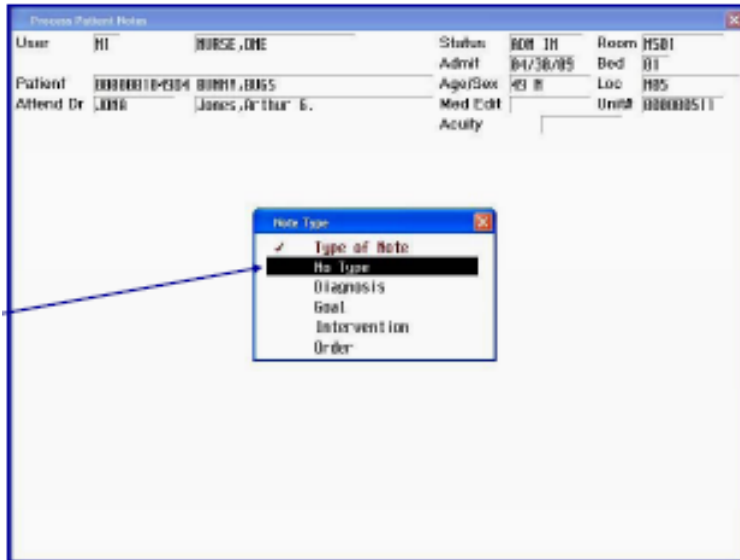
- Including patient notes as part of the patient's care not only supplements the data that is documented on specific interventions, but also allows the nurse to provide additional supporting material, relating to the patient's care, their reactions to their disease or care, information received from the attending or consulting physician(s) pertaining to the patient, etc.
- No specific note format – e.g. PIE, SOAP, etc. – is required at Mt. Sinai Hospital.
- Documenting a note starts on the Status Board.
- Use your mouse to click on the Pt Notes button.



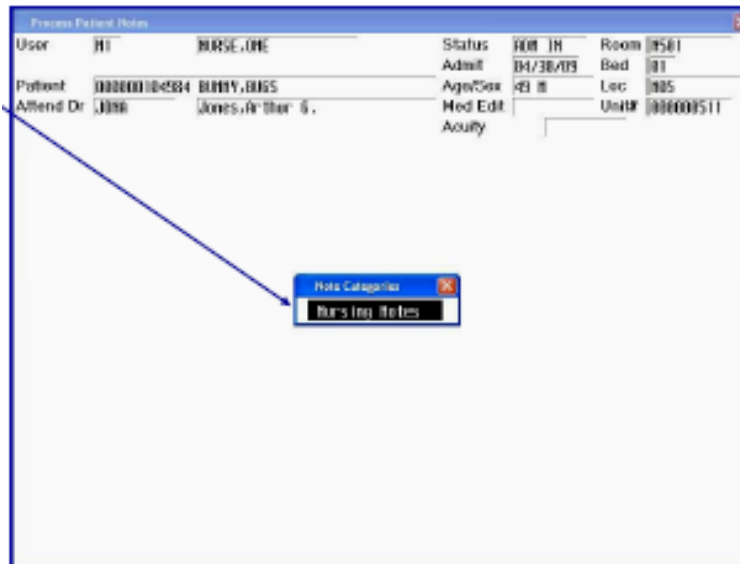
- Clicking on Pt Notes opens the Patient Note Functions screen.
- Use your mouse to click on Enter New Note.
- Hit the RIGHT ARROW key to open the submenu.



- Initiating a new note from the Enter New Note menu displays the Note Type screen.
- Highlight and use the RIGHT ARROW key to open the No Type menu option.



- Use the RIGHT ARROW key to select Nursing Note as the Note Category.



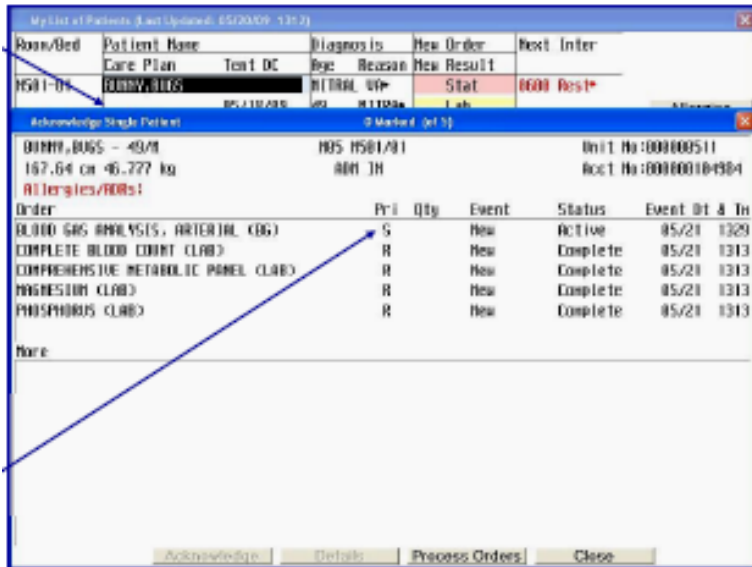
- This is the Enter Note screen.
- It displays the administrative data relevant to the note: date, time, nurse, and patient.
- In the free-form text field, enter the text of the note.
- Hit F12 to file the note & Hit F11 to exit the note function.

ACKNOWLEDGING PATIENT ORDERS

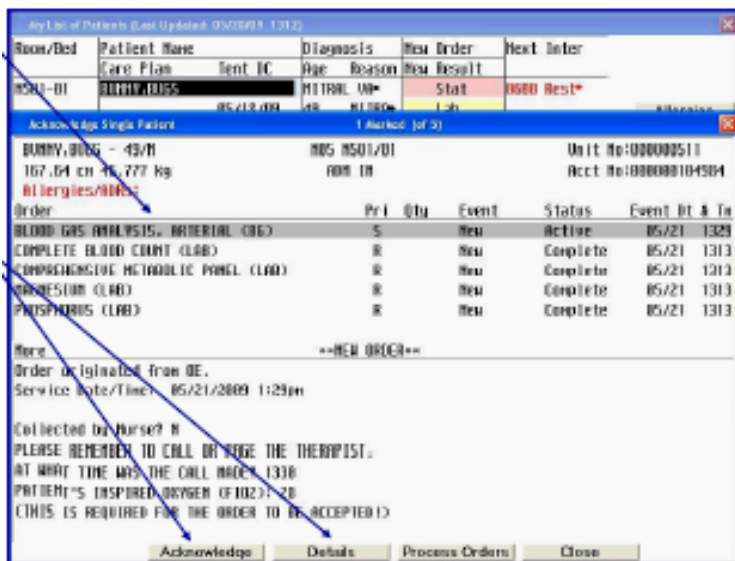
- Whenever new orders patient are placed on a patient, a visual indicator appears on the Status Board.
- Nurses must acknowledge patient orders during their shift.
- Acknowledging orders is the process by which nurses indicate they are aware of the order's existence.
- The process also provides an audit trail that the order was transmitted to the receiving department and was viewed properly by the nurse assigned to the patient.
- New order indicators may appear either in RED (for STAT orders) or GREEN (for all other orders).

Room/Bed	Patient Name	Last DE	Diagnosis	New Order	Next Inter
5501-01	BUNNY,BUGS	05/28/09	RT ORL 99*	Stat	0600 Res*
5501-02	PIG,PORCY		ORIGEST 9*	ack	
5502-01	DUCK,DUFTY		ORIGEST 9*	ack	
5502-02	FIND,ELMER		ORIGEST 9*	ack	
5503-01	SWN,VOSEWITE		ENDOCARDI*	ack	
5504-01	LEPEN,PEPE		ORIGEST 9*	ack	
5506-01	LESDORN,FOGHORN		ORIGEST 9*	ack	
5508-01	LODGE,WILEY		ORIGEST 9*	ack	

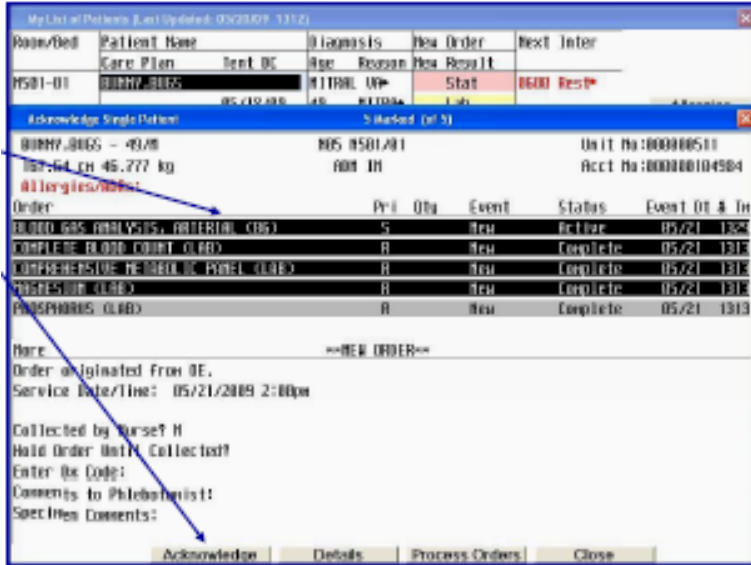
- Clicking on the New Order Indicator opens the Acknowledge Single Patient screen.
- This screen displays all orders for a given patient that the nurse has not acknowledged.
- STAT orders are displayed first.



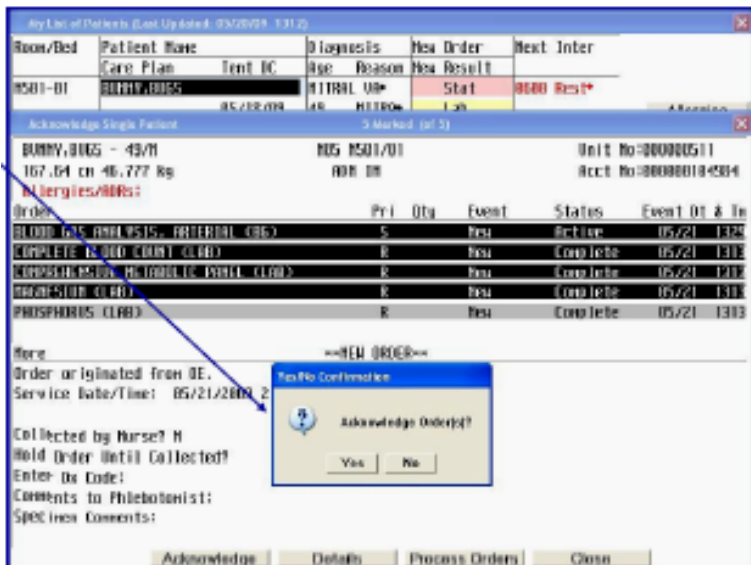
- Select an order by clicking on it with the mouse.
- Once selected, the Details and Acknowledge buttons become enabled.



- Continue clicking on individual orders until all orders are highlighted.
- Click on the Acknowledge button.



- A confirmation message will appear.
- Click 'YES' to confirm acknowledging the orders.



- Click 'OK' to close the orders acknowledged screen.

My List of Patients (Last Updated: 05/20/09 13:23)

Room/Bed	Patient Name	Diagnosis	New Order	Next Inter
NS01-01	BURRY, BILLY	MITRAL WP	Stat Lab	0600 Res

Acknowledge Single Patient

BURRY, BILLY - 49/M
 05/20/09 08:45:19 AM 46.777 kg
 Unit No: 000000511
 Acct No: 00000004584

Order | Pri | Qty | Event | Status | Event Dt & Tm

BLOOD GAS ANALYSIS, ARTERIAL (BG)	5	Res	Active	05/21 1329
COMPLETE BLOOD COUNT (CBC)	8	Res	Complete	05/21 1313
DIFFERENTIAL BLOOD COUNT (CBC)	8	Res	Complete	05/21 1313
PHOSPHORUS (LAB)	8	Res	Complete	05/21 1313
PHOSPHORUS (LAB)	8	Res	Complete	05/21 1313

More --NEW ORDER--

Order originated from
 Service Date/Time: 05/20/09 08:45:19 AM
 Collected by Nurse H
 Hold Order until Collected
 Enter Rx Code:
 Comments to Phlebotomist:
 Specimen Comments:

Message: 5 procedure(s) verified/acknowledged as requested

Acknowledge | Details | Process Orders | Close

- Once all orders have been acknowledged, the new order indicator disappears from the Status Board.

My List of Patients (Last Updated: 05/20/09 13:23)

Room/Bed	Patient Name	Diagnosis	New Order	Next Inter
NS01-01	BURRY, BILLY	MITRAL WP	Lab	0600 Res
NS01-02	PIG, PERRY	CONGESTIVE HEART FAILURE	Lab	
NS02-01	BUCK, DAFFY	CHEST PAIN	Lab	
NS02-02	FROELICHER	MITRAL FAILURE	Lab	
NS03-01	SAM, ROSENTE	ENDOCARDITIS	Lab	
NS04-01	LEPER, PEPE	BOTHIC WEAKNESS	Lab	
NS06-01	LEGARRA, FOGHORN	CHRONIC DISEASE	Lab	0600 Res
NS08-01	EDWITE, WILEY	ENDOCARDITIS		PRN

More | Location | Find Patient | Manage List | Options | Exit

More →