

Presbyterian St. Luke's Medical Center

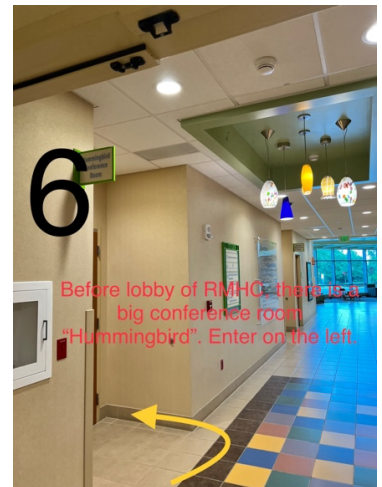
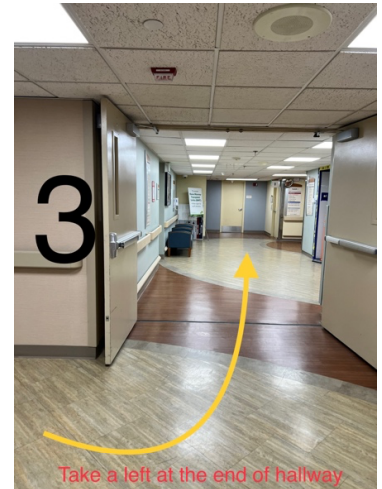
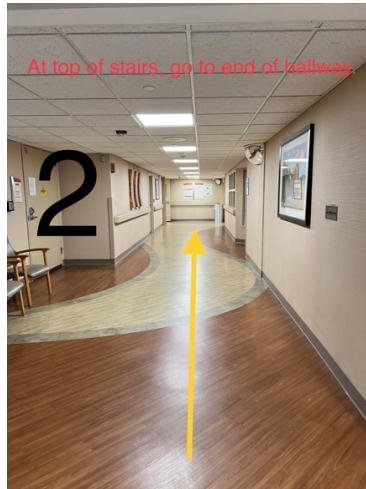
Information on the facility.

To get to the units (and all the floors) and to get to the cafeteria:

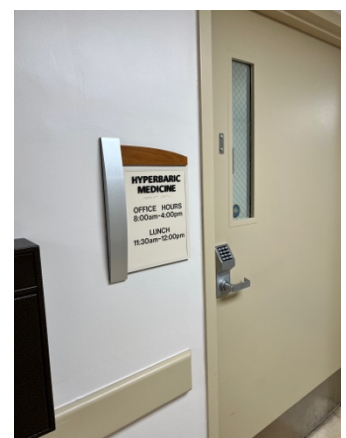


Presbyterian St. Luke's Medical Center

After 1700, the conference room on the Rocky Mountain Hospital for Children's side is usually empty. It can be used for our post conference. To get there:



To get to Hyperbaric Medicine, follow steps 1 to 5 on how to get to the conference room, but about halfway down the long hallway (picture 5), take a left (see pictures):



How to Upload COVID-19 and Flu Vaccine Documentation

HCA Healthcare Portal

1. Open Safari on iPhone (or other Android browser) and go to <https://hcacovidvaccine.com> or use the QR code to the right from your smartphone camera app to launch the website. You can do this from your personal phone or one of the shared iMobile phones.



2. Follow the prompts; you will be asked to login with your 3/4 ID and provide colleague information.

- a. Click "I have a 3/4 ID" – **Do not use "I do not have a 3/4 ID"**
- b. **New Students:** If you have not logged in before and set a network password, you will use your temporary password in the Password box. Your temporary password is the first letter of first name capitalized, the first letter of last name lowercase, and then @temp! So, if your name is Ann Jones, your temporary password is Aj@temp!

A passcode will be sent to your mobile device. Enter it and follow the prompts.

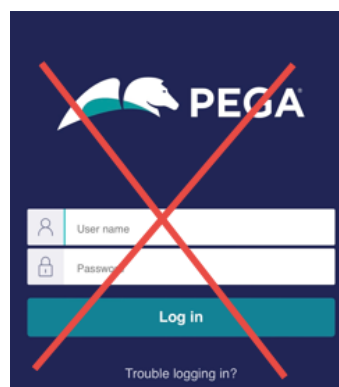
You'll be prompted to create a new, strong password. And, you're now enrolled in Identity Connect, which enables you to change your own password moving forward!

Please note: after this step it will automatically redirect you to the PEGA website. It will not allow you to log in. Please reopen the COVID portal using the QR Code above or <https://hcacovidvaccine.com>.

Returning Students: attempt your last known password to access the system

For password support, you can contact HCA IT&S Support Desk at 1-800-265-8422.

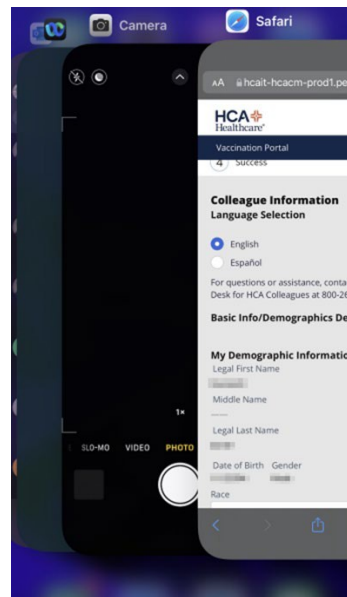
Once you're able to sign in, follow the steps to record your vaccination status or decision.



5. Once you've completed submitting your form, make sure to completely close the browser. On iPhones, click the double square in the bottom right corner then click the 'x' to close out that browser.
6. Complete this step to erase your session history and protect your personal information from anyone else that has access to that phone (this is especially true on a shared phone). When trying to connect to hcacovidvaccine.com, if you see someone else's information still logged on, close the browser the same way to clear them out then proceed with your information.

Once you log in, if the PEGA system doesn't allow you to submit vaccine documentation, please contact COVID vaccination support:

CORP.workforcehealthandsafety@hcahealthcare.com



For Flu: follow same process, but with this link instead**:

<https://s2.bl-1.com/h/dr177ky2?url=https://hcait-eecall-prod1.pegacloud.net/prweb/PRAuth/VaccineTrackerFlu>



Vaccination Portal

Welcome to HCA's Flu Vaccination Tracker

Resources

Follow the links below to consent to vaccination, document vaccination received external to HCA Healthcare, or request exemption

[I have a 3/4 ID >](#)

[I do not have a 3/4 ID >](#)

ATTENTION: COVID and Flu vaccination information is stored on a combined platform (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reached this screen in error (e.g., trying to access Flu and see COVID) please clear your cache (Ctrl+Shift+Delete in Chrome).

Thank you for your participation!

****ATTENTION:** COVID and Flu vaccination information is stored on a combined portal (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reach one of the screens in error (e.g., trying to access Flu and see COVID), please clear your cache (Ctrl+Shift+Delete in Chrome).

HCA/HealthOne Covid and Flu Verification via PEGA

Hello!

The 3-4 IDs in the table, which I will email to you once available, will be used for you to access Meditech (RMHC EHR), but will also be used to document your immunizations (COVID and Flu vaccine) within the HCA vaccine portal (PEGA). With the CMS mandate of the COVID vaccine for healthcare workers, HCA is required to ensure all our students are entered into the HCA vaccine portal (same requirement HCA has for all their employees). Please upload your COVID vaccine/exemption and Flu vaccine/exemption into the HCA system (**please note: this is SEPARATE and IN ADDITION to the documentation you have provided in MyClinicalExchange**).

Steps for you to take:

1. Please utilize your 3-4 ID (once provided) and review the attached instructions and links below for you to enter in your COVID/Flu vaccine status into the HCA vaccine system (PEGA).
 - a. Please complete your vaccine status in PEGA by end of clinical day #1 (ideally prior to your 1st day- link is accessible from outside hospital network)
 - b. If you have all documents ready (vaccine card or exemption paperwork), it should be quick to complete (5 minutes)
 - c. **If you are a current HealthONE employee or have completed a recent HealthONE rotation (and completed this process already), you can disregard as you do not need to complete again**
2. Please send me an email confirmation (sbenton@denvercollegeofnursing.edu) that you have completed this or screen shot of your submission screen (from PEGA) to me, so I can verify it was completed. Please do not submit vaccine cards/exemptions to me directly, as it needs to be in the HCA PEGA system.
3. If you are not complete by end of day #1, you cannot return to clinical until complete.
4. To document both COVID and Flu vaccine/exemption, you must use both links below. Please note: COVID and Flu vaccination information is stored on a combined portal (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reached one of the screens in error (e.g., trying to access Flu and see COVID) please clear your cache (Ctrl+Shift+Delete in Chrome).

Please see attached directions and click the separate links below for access to each vaccine application/portal page.

****ATTENTION:** COVID and Flu vaccination information is stored on a combined portal (PEGA). The platform will remember the last application (Flu or COVID) you accessed. Therefore, if you've reach one of the screens in error (e.g., trying to access Flu and see COVID) please clear your cache (Ctrl+Shift+Delete in Chrome).

HCA/HealthOne Covid and Flu Verification via PEGA

COVID vaccine/exemption upload link or QR code:	How to Record your COVID-19 Vaccination Status or Decision Have your 3-4 ID. Go to https://hcacovidvaccine.com/ Web address must be entered as listed above. 3. Click "I have a 3-4 ID".
Flu vaccine/exemption upload link:	How to Record your Flu Vaccination Status or Decision 1. Have your 3-4 ID 2. Go to http://hcaflutrack.com/ Web address must be entered as listed above. 3. Click "I have a 3-4 ID".

If you are having issues with uploading or accessing the HCA portal/PEGA site: please contact the PEGA system support email: CORP.workforcehealthandsafety@hcahealthcare.com

If you are specifically having issues with the 3-4 ID username not working (i.e. "invalid user" message), please contact the facility's IT Help Desk (this is the number at the bottom of the hospital desktop).

If you continue to have issues, please contact Nicole Hill: Nicole.Hill@Healthonecares.com or Stacey Carroll: Stacey.Carroll@Healthonecares.com (Student coordinators for HealthONE)

We appreciate your help with this to ensure all our students are meeting the requirements and have these vaccinations/exemptions documented within our system.

Meditech Troubleshooting:

CONTACT EDUCATION IF...	EDUCATION	CONTACT IT IF...
<ul style="list-style-type: none"> For any access related issues (ex. Meditech(EDM, ORM), Pyxis, Vitals, CPN) <u>Please provide the following:</u> Name 3/4ID Facility Dept/Floor Hostname Application name Specific error message (screenshot) or description of what is happening 	<ul style="list-style-type: none"> Nursing Student Coordinators Stacey Carroll Stacey.Carroll@healthonecares.com 303-788-5395 Alex Smith (SRMC, SWED, ROSE, TMCA, PSL and NSUB) Alex.Smith@healthonecares.com 303-788-5389 	<ul style="list-style-type: none"> If unable to login to the network or reset password. Unable to pull up patients in Meditech or can not access a specific location. IT Helpdesk 303-584-2232

*Adult Missing Person + Description + location missing from	Missing person, age/dress/hair color, from Emergency Department, 1 st floor Delta Building
*Infant/Child Missing Person + Description + location missing from	Missing Infant/Child, 2 YOM/Blnd Hair/Blue Pants/Red Shirt/From 3rd Floor Alpha Building
Hostage Situation + Location	Hostage Situation, Emergency Department, 1 st floor Delta building, Do not enter area, secure departments. If in area, evacuate immediately.
Facility Lockdown+ instructions	Facility Lockdown, Restricted Access, Emergency Department, 1 st floor Delta Building - no one is to enter or exit the ED at this time.
Code Blue + Location	(Pediatric or Adult) Code Blue, Room 5102, 5 th floor Delta Building
Rapid Response Team + Location	(Pediatric or Adult) Rapid Response Team, 3 rd floor Bravo Bldg
Facility Emergency+ Description+ Directions	Facility Emergency, flood 1 st floor Alpha Building, please report to the EOC (admin conference room) at 3:15/ or as communicated

Dial *5555 to report **any of these emergencies**. Remember to specify Alpha (A building), Bravo (B building), Charlie (C building), or Delta (D building) when calling in a code.

Stroke Alert: *5556 for patients presenting with S/S of TIA or Stroke

Other Phone Numbers:

Security = *7000

Infection control = *6539

Hospital Operator= "00"

If you come upon a fire:

R = Remove patient/people from immediate danger

A = Activate the nearest alarm. First alarms are located near stairwells, elevators and doors leading outside.

C = Contain the fire by closing door to all patients' rooms and call "4" to give the location and nature of the fire. The following statement will be announced by the operator, "Mr. Gallagher (and the location of the fire)".

E = Extinguish the fire with a portable fire extinguisher.

To use a fire extinguisher, remember the work PASS, which is an acronym for:

P = pull the pin

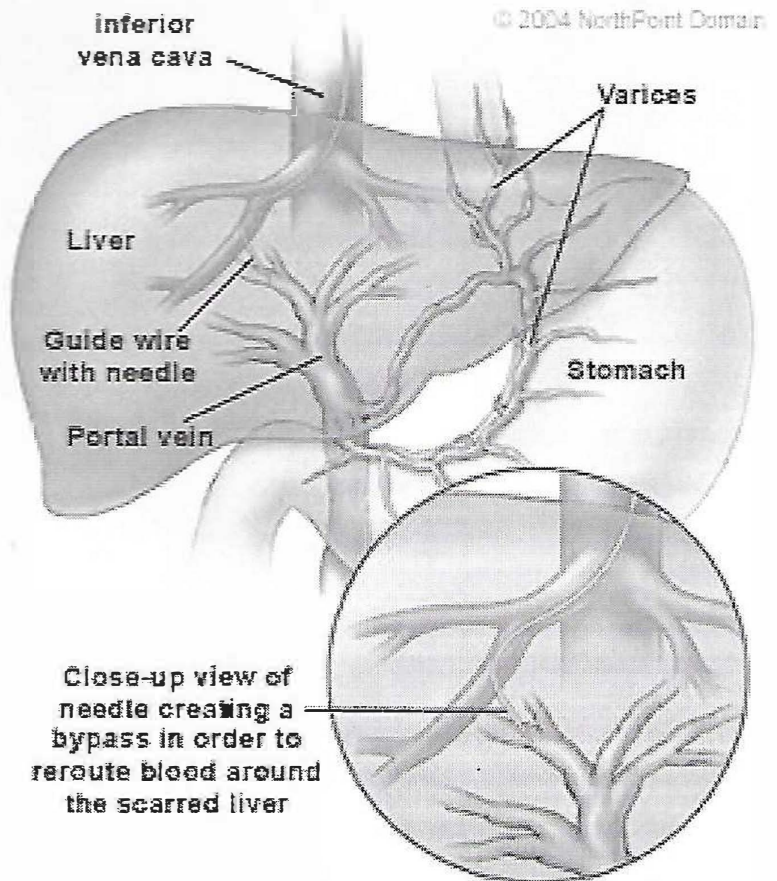
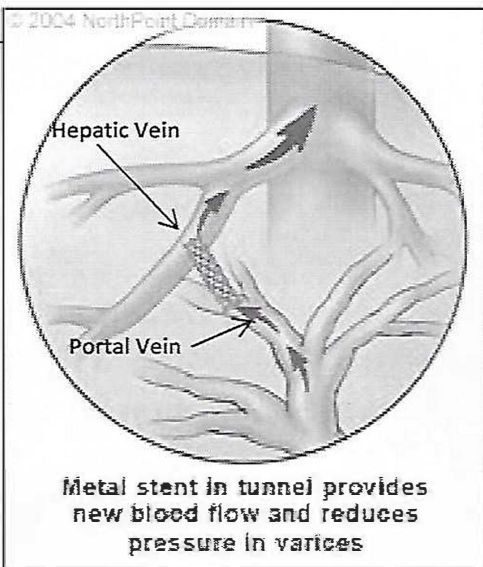
A = aim the nozzle

S = squeeze the handle

T I P S

Transjugular Intrahepatic Portosystemic Shunt

- ❖ A **TIPS** is a shunt that is placed between the **Portal vein** (which carries blood from the intestines to the liver) and the **Hepatic vein** (which carries blood from the liver to the vena cava and heart).
- ❖ The purpose of the shunt is to improve blood flow in the hepatic circulation, thus relieving portal hypertension.
- ❖ A **TIPS** is placed when the liver circulation is disrupted due to liver damage. A new route for blood flow is created. It helps prevent rupture of varices by relieving the high pressure.



Technique:

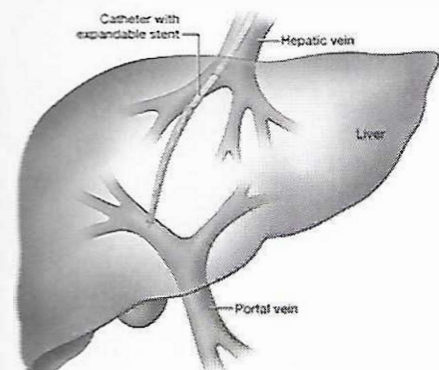
A catheter is threaded through the jugular vein into the hepatic vein within the liver.

A catheter with a small cutting needle is inserted through the guide catheter and into the liver. Once inside a hepatic vein, the needle is exposed and advanced into and through the liver tissue. The physician monitors the screens until the needle makes contact with and enters a branch of the portal vein, creating a narrow pathway between two veins.

The physician removes the needle, inserts a balloon-carrying catheter to the site of the pathway made by the needle, and inflates the balloon in order to dilate, or open wide, the shunt, or bypass.

Once the shunt is open wide, the physician inserts another catheter to place a stent, or expandable metal tube, inside the shunt. The stent helps keep the shunt widely open and allows blood to flow through the bypass between the blood vessels.

From MVS website



Vascular and Interventional Radiology Website

Nursing Care:

Pre-Procedure Education

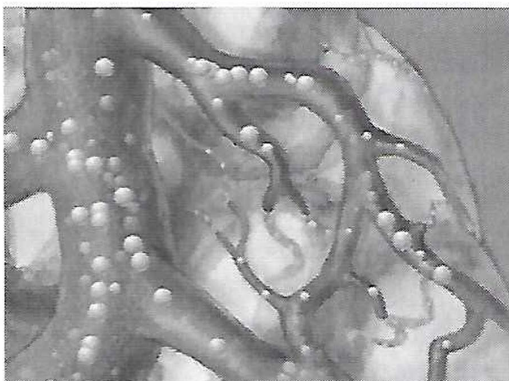
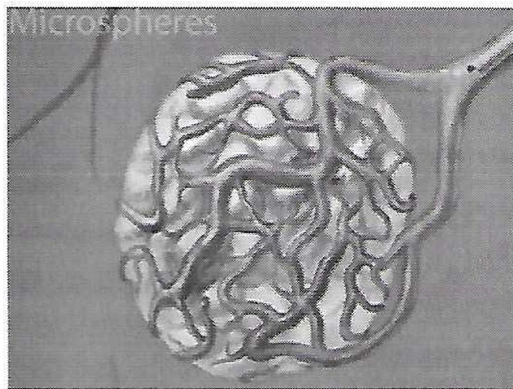
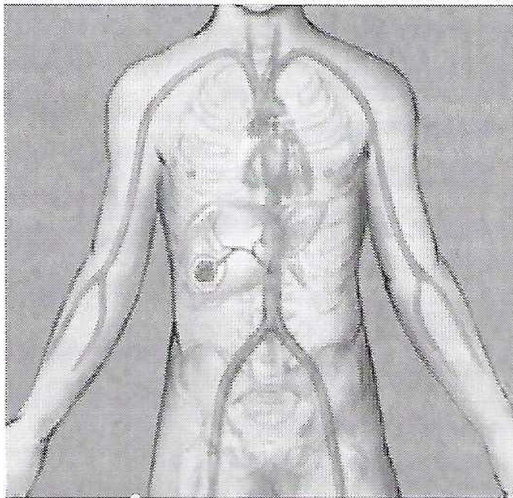
- The procedure will occur in the Interventional Radiology Department.
- The site will be numbed with a local anesthetic and a large IV (sheath) will be placed in the neck (Jugular vein) for the procedure.
- The patient can expect to be placed on monitor and will be monitored throughout the procedure.
- Medications will be administered throughout the procedure to keep the patient comfortable.
- The Patient will go to the ICU after the procedure for close monitoring.

Post-Procedure Care and Monitoring

Potential Complications of the procedure include:

- Bleeding within the liver capsule (not common, but serious when it occurs). *Monitor for signs and symptoms of bleeding.*
 - VS: Decreased BP and increased HR.
 - Abdominal pain
 - Decreased Hematocrit (especially with the above symptoms.)
 - Increased abdominal circumference
- Encephalopathy. (Can affect 20%-30% of patients). Believed to occur as blood from the intestines (along with the toxins) bypasses the liver and remain in the systemic circulation. *Monitor for signs of encephalopathy.*
 - Symptoms can include: Inability to concentrate, slow speech, irritability, disorientation, lethargy.
 - Treatments
 - Lactulose (laxative effect removes toxins and decreases the absorption of ammonia).
 - Adjust Diet (decreasing protein, however most patients are malnourished and this must be considered carefully with support from the dietician.)
 - Stent Revision: Decreasing the size of the stent. (This decreases the amount of blood shunted away from the liver.)
- Stent Occlusion. (Low incidence). Patency will be assessed by Doppler studies.
 - Monitor for signs of worsening liver failure (ascites, increased portal hypertension, etc.)
- Hematoma in the neck. Monitor access site for bruising and swelling.
- Infection. (Low incidence, but very serious if it occurs.) Monitor temperature, VS.

T *Trans-* **A** *Arterial* **C** *Chemo-* **E** *Embolization*



- ❖ TACE is a procedure used to slow down the growth or decrease the spread of liver tumors in hepatocellular carcinoma. It is sometimes used to treat a patient while they are waiting for a liver transplant.
- ❖ TACE involves embolizing the blood vessels feeding the tumor and then administering chemotherapy to the site with chemo-infused biospheres.
- ❖ Liver tumors receive most of their blood flow from the hepatic artery. The liver tissue receives most of its blood flow from the portal vein. Therefore, if the chemotherapy drug is injected into the hepatic artery, little of the drug reaches the healthy liver.

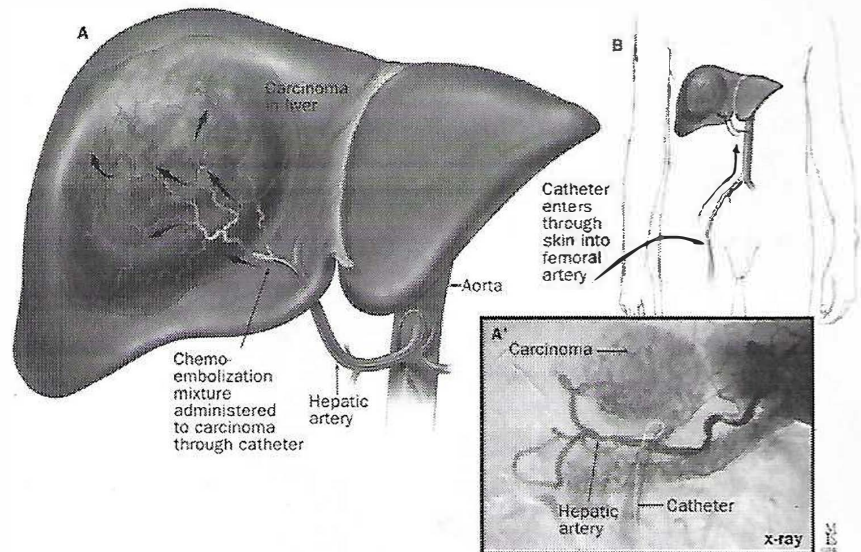
PROCEDURE

- ❖ A catheter is placed in the femoral artery and threaded up into the hepatic artery.
- ❖ Prior to injecting the chemotherapy, a mapping angiogram is done to determine that the placement of the catheter (and subsequently, the chemotherapy) will be in a place that is most effective.
- ❖ Once the catheter is correctly placed to target the tumor, tiny biospheres that are mixed with chemotherapy (doxorubicin) are injected into the catheter. The beads block the blood supply to the tumor and the chemotherapy slowly diffuses out to attack the tumor.
- ❖ The process takes about an hour.
- ❖ The effectiveness of the treatment will be monitored throughout the following weeks. Patients can receive multiple treatments to control the growth of the tumor.

Nursing Care:

Pre-Procedure Education

- ❖ Educate the patient as to the reason for the treatment.
- ❖ Patient is NPO except meds
- ❖ Check labs, especially coags and treat if necessary.
- ❖ Medications for comfort and sedation will be given during the procedure.



Post-Procedure Care and Monitoring

❖ Nursing Precautions

- Nurses glove and gown when handling body fluids to minimize chemo exposure.

❖ Post-procedure assessment

- Vital Signs
- Pulse checks: These patients are similar to cath lab patients. Monitor the groin for signs of hematoma or bleeding. Check for bruit. Check circulation distal to the puncture site.

❖ Complications

- Groin Complications: Watch for bleeding in the groin. Apply pressure to site and notify MD. Note that the site where the artery is punctured is usually above the skin puncture site.
 - ✧ Arterial Dissection: Listen for a bruit with the stethoscope. Assess for increased pain at site and decrease in pulses. Notify MD of abnormal findings.
- Pain: The embolization of the vessels will affect the healthy liver, as well as, the tumor. Inflammation can occur and cause pain. Medicate as ordered for pain. Dexamethasone is given for inflammation and nausea caused by the procedure.
- Nausea: Nausea can occur post procedure. Dexamethasone is given during the procedure and every 8 hours afterwards. Nausea can also occur later as the doxorubicin begins to leach out of the microspheres, generally several days after the procedure. Patients will begin to feel "fluish". These symptoms can last more than a week.
- Infection: Infection can occur as the chemo may cause small areas in the liver to become necrotic and an abscess can form. Antibiotics are given as a preventative measure.
- Allergic Reaction to the dye: Watch for signs of developing allergic reaction.

❖ Discharge Teaching

- Patient may shower, but no baths or hot tubs for one week post procedure.
- Medications: Patients are generally sent home with antibiotics and pain medication.
- Patients do not need to follow special precautions regarding chemo exposure.



Meditech Keyboard	PC Keyboard	Function
F5	F4	Get Needed to retrieve comments.
F12	F6	Prev Fld Use to move the cursor to the previous field.
F13	Page Up	Prev Use to move cursor to previous area on the screen.
F14	Page Down	Next Use to move cursor to next area on the screen.
F17	F9	Lookup Allows access to a description of the prompt's response or a list of possible choices.
Shift+F17	Shift+F8	Documentation Allows access to pre-programmed information in the system.
F18	F5	Recall Recalls the last response entered in the same field.
Shift+F18	Shift+F7	Help Allows on-line help for explanations on how to use the system.
F19	F11	Exit Exits the menu or routine. Does NOT save your work
F20	F12	File/Save Use to save your work (OK) Press OK or file verified "Y" must be entered to save your work.
Shift+F20	Shift+F12	Magic Allows you to freeze the screen, return to your menu to perform another function, then return to the original screen.
Esc	Esc	Escape Use to exit when F11 or left arrow key doesn't work.
Del	Delete	Delete This key erases the character the cursor is currently on.
Enter/Return	Enter/Enter	Interchangeable keys. Use to input a command or move the cursor to the next field.
Arrow Keys	Arrow Keys	The four directional arrow keys move the cursor around the screen in PCI. Right arrow beginning of next screen Left arrow return to previous screen Up arrow moves highlight bar up Down arrow moves highlight bar down
Right arrow	Shift + Right Arrow	Insert comments into highlighted record.
Line Feed	F10	Use to pull up the meditech calculator.
Left Ctrl+F20	Left Ctrl+F12	This key deletes an entire line of text or an entire field.
Backspace	Backspace	This key erases the character to the immediate left of the cursor.
Special Function/ Home/Block Key	Right Ctrl Key	Use for checkmarking a highlighted item. Pressing a second time deletes the check mark.
Shift+Special Function/ Home/ Block Key	Left Shift+ Right Ctrl Key	Use for check marking all items. If pressed a second time, all check marks are removed.



MEDITECH Toolbar Menu Keys and Commands

This illustration displays the MEDITECH Toolbar Menu Keys and its commands.



MEDITECH Navigation Mouse or Keyboard		
Toolbar	Description of Functionality	Key Stroke
	FILE/SEND/SAVE; to file your work	<F12>
	EXIT; to close or exit a window or screen	<F11>
	ONLINE HELP; to access online help	<Shift> <F8>
	LOOKUP; to lookup preprogrammed responses for a field	<F9>
	SESSION MANAGEMENT; <u>M</u> agic Menu, <u>S</u> uspend Session, to lock the computer 5 minutes at a time	<Shift> <F12>
	TOOLS; to access the Calculator with the first click and with the second click access a perpetual Calendar	<Ctrl> <F12>
	SELECT (Check); to select a single item on a list	Right <Ctrl>
	SELECT ALL (Check All); to select all items on a list	<Shift> Right <Ctrl>
	SHIFT LEFT ARROW; "Be Left Out"	Left Arrow key
	SHIFT RIGHT ARROW; "Go Right In"	Right Arrow key
	UP; to move highlight bar up before selecting a specific item	Up Arrow key
	DOWN; to move highlight bar down before selecting a specific item	Down Arrow key
	SHIFT UP ARROW; to change a list of items a page at a time	Shift Up key
	SHIFT DOWN ARROW; to change a list of items a page at a time	Shift Down key

Nursing students: What can they do/not do?

Students can (with demonstrated competency) perform:

- ✓ Patient assessment
- ✓ Vital signs
- ✓ Empty drains/Foleys
- ✓ Assist patient to bathroom/toilet
- ✓ Assist with patient ADLs (i.e. bathing)
- ✓ Transfer patient to bed/chair
- ✓ Walk with patient
- ✓ Answer call lights
- ✓ Provide education to patient/family
- ✓ Start IVs on adult patients
- ✓ Documentation- please see Student Documentation on page 3 for details
- Students can only perform clinical technical skills/procedures that are taught by the school. The instructor/nurse clinician must be present if the student has not performed a procedure/skill previously. Supervision on subsequent occasions will depend upon competency of the student and risk of the procedure/skill. However, changing tubing on central lines or discontinuing central line infusions may **only** be done under the direct supervision of the RN. In addition, drawing blood or starting IVs on pediatric patients must always be done under the direct supervision of the RN.
- Discuss the procedure with the students prior to going into the room to minimize discussion over the patient.

Students cannot:

- Access the Pyxis medication management system
- Witness, waste, or count controlled medications in Pyxis
- Perform double checks (i.e. insulin, PCA/epidural, calculated doses, chemo, pediatric narcotics)
- Perform POC (point of care) testing- includes glucometer, urine dipsticks, and ISTAT
- Administer drugs via endotracheal tubes
- Administer vasoactive IV drugs – may monitor the patient under direct RN supervision
- Administer conscious sedation medications – may assist the RN with monitoring the patient
- Administer medications or treatments (i.e., insulin or fractional dosages) prescribed by pre-printed orders that required diagnosis (as defined by the Colorado Nurse Practice Act) without consultation with the supervising RN preceptor.
- Administer narcotics (all routes)
- Witness consent forms
- Verify blood administration and/or witness blood administration forms
- Hang blood or blood products (students encouraged to observe blood admin process)
- Perform any task that requires certification or advanced competency (chemotherapy, ABG, removal of central lines)
- Accept telephone or verbal orders from physicians or transcribe chart orders.
- Administer chemotherapy- may monitor patients receiving it
- Initiate, change settings on, or discontinue PCA pumps/Epidurals
- Initiate or perform advanced life support protocols
- Perform any skill/procedure that has not been covered in a school lab
- Perform any task outside of the discipline's scope of practice

- All students must wear a school provided photo ID badge and a temporary student P/SL badge (checked out from the P/SL education department) at all times.
- Students are expected to maintain active and ongoing communication with the primary caregiver assigned to their patient(s). Staff members of Presbyterian/St. Luke's Medical Center supervise students when they provide patient care, treatment, and services as part of their training. At all times, patient care remains the responsibility of the staff of P/SL and RMHC.
- The hospital reserves the right to request removal of faculty members and/or students at any given time. Any concerns involving students will be brought to the attention of the Clinical Instructor, Course Faculty, Department Supervisor/CNC/Manager/Director, Student Placement Coordinator, Director of Education, and administration, as appropriate.
- Students and instructors are expected to follow all policies and procedures of Presbyterian/St. Luke's Medical Center and the department in which they are assigned.

Medications:

- Students are to demonstrate safe medication practices. This includes knowledge of the six rights, medication action, safe dosage for adults, seniors and children, side effects, and special considerations for administration. Students are expected to read PSLMC Medication Administration policy prior to their clinical experience.
 - Prior to administering any medication, the student is expected to review the type of medication, indication for use, and dosage with the instructor/nurse clinician. The Medication Administration Record (MAR) will be accessed via computer at the patient bedside and patient identification will be verified by at least two of the following methods: the Medical Record # (MR#) on the patient ID band will be checked against the MAR, and the patient or proxy will be asked to state the patient's name and/or date of birth prior to each and every instance of medication administration or procedure.
 - Certain medications must be double checked by two *licensed* individuals (not a student!) prior to administration. At PSLMC, these include:
 - ✓ Insulin
 - ✓ IV Heparin
 - ✓ Calculated doses
 - ✓ PCA/Epidural
 - ✓ Chemotherapy
 - ✓ Pediatric medications (narcotics or meds drawn up from larger quantities)
 - ✓ Other medications per unit guidelines
 - All intravenous medications are to be prepared and administered under the *direct supervision of a registered nurse*. Preparation includes reconstitution, aspirating medication from vials and confirming premixed pharmacy doses. Direct supervision is defined as being in immediate proximity and observing the preparation process. RN students may only give IV drugs by the "push" or "piggyback" method when

- ✓ Those drugs have been identified as safe for administration by the general nursing staff in accordance with the Unit Specific Practice Standards (See Medication Use Policy, Policy Stat ID: 3363025)
 - ✓ Only after they have been double checked by the Staff RN
- Students do not have access to the medication dispensing system (Pyxis). A licensed nurse must remove the medications. Students cannot leave the unit until any narcotic discrepancies are accounted for.

Blood Administration

- Student may not hang blood or blood products. They are encouraged to observe the blood administration process. They may monitor vital signs during the transfusion and provide care to the patient.

Point of Care Testing (POC)

- Students may not perform POC using access codes of PSLMC employees. Performance of blood glucose monitoring, urine dipsticks, and any point of care testing are limited to employees of PSLMC who have demonstrated competency. Students are encouraged to observe POC as a learning activity.

Doctor orders

- Students are not permitted to receive telephone/verbal orders or witness consents.

Lab/Diagnostic Results

- Students cannot receive critical (lab, micro, radiology, etc.) results

Student Documentation

- M/S, pediatric, and senior practicum students (OB rotations and NICU excluded) are given Meditech access and are required to attend Meditech training. Students should only be documenting under their own log-in and not under their preceptor's or instructor's log-in.
- Students should not document (but are encouraged to observe documentation):
 - Plan of care
 - Orders
 - Acknowledgement of orders
 - Restraints
- Students must review their documentation with faculty/nurse clinician. Student's signature shall include the first name, last name, and student status (i.e., Jane Smith, SN) or if computer charting it must be under the student's own 3-4 ID. Preceptor or clinical instructor completion of the "canned text" – SN/INSTRUC or SN/PRECEPT (or equivalent note) is required.

Questions?

Contact unit specific educator or student placement coordinator



HCA / HealthOne Meditech Review

The Tool Bar and F keys

F6	Moves cursor to the previous field
F7	Moves cursor to the beginning of a list or top of page/section
F8	Moves cursor to the end of a list or end of the page/section
^F8	Shows parameters (related to Within Defined Parameters)
F11	Exits current screen (WITHOUT SAVING!)
F12	Saves and Files documented information
Rt CTRL	Makes a checkmark to select highlighted item. Press again to remove checkmark.
^Rt CTRL	Checkmarks entire list. Press again to remove all checkmarks.

File/Save (F12)

Exit (F11)

Lookup (F9)

Magic Key (^F12)

Calculator

Select (Rt CTRL)

Select All (^Rt CTRL)



Setting Up the Status Board

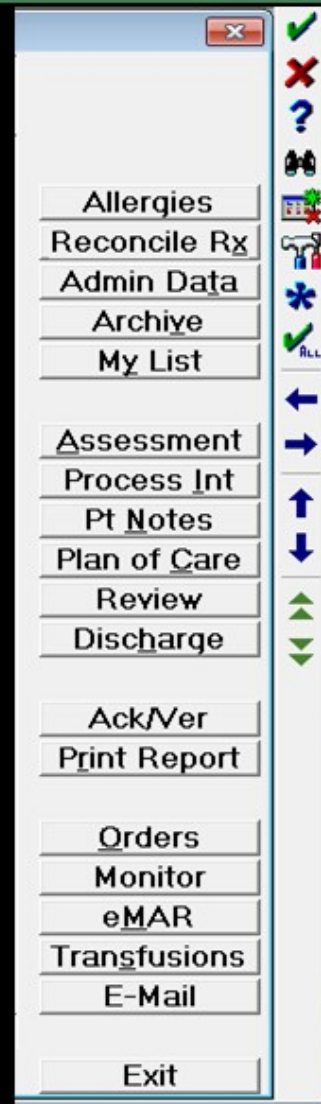
Note: if you use the “location” or “find patient” options, your patients will only display during the current session

1. By Location – to view all patients on a specific unit
2. Find Patient– useful when trying to find a certain patient.
3. By Manage List – useful for making your daily assignments

MENU Keys

Other important Menu Keys:

- "Allergies" displays a list of patient allergies.
- "My List" refreshes the status board to show your assigned patients.
- "Process Interventions" is where you will document assessments and vital signs.
- "Pt Notes" is to add a note or view notes.
- "Review" This allows you to view test/lab results, vitals signs, dictated reports, etc.
- "eMAR" is used to view the medication list and to give meds.



Manage List/Assigning Patients

NUR.CCSR (COAUDED/COA.TEST.MIS/525/CCSR) - Trng ID CCSR/NEWEMP

Patient Assignment

User Clear 1 of 1

	User Name	Mgn	Type	Skills
	Trng ID CCSR/NEWEMP	TP	RM	

Patient Clear 2 of 4

✓ Room/Bed	✓ Current Patient	Age/Sex	Acuity	Assigned
AS.6403	A SKYRIDGE,LESS	46 M	TP	
AS.5408	A SKYRIDGE,JERRY	44 M	TP	
AS.4103	A SKYRIDGE,ORLANDO	65 M	TP	
AS.4109	A SKYRIDGE,PETER	45 M	TP	

Location Assign Unassign File

After you have selected all the patients you want to assign to yourself for the shift:

- Click on 'Assign'
- Click on 'File'

Replace will add the selected patients to the status board and remove any patients that were previously assigned.

Append will add selected patients to the status board without deleting previously assigned patients.

Cancel returns you to the patient assignment board

NUR.CCSR (COAUDED/COA.TEST.MIS/525/CCSR) - Trng ID CCSR/NEWEMP

Patient Assignment

User Clear 1 of 1

	User Name	Mgn	Type	Skills
	Trng ID CCSR/NEWEMP	TP	RM	

Patient Clear 2 of 4

✓ Room/Bed	✓	Assigned
AS.6403	A SKYRIDGE,LESS	
AS.5408	A SKYRIDGE,JERRY	
AS.4103	A SKYRIDGE,ORLANDO	
AS.4109	A SKYRIDGE,PETER	

File Options

What would you like to do with pre-existing assignments?

Replace Append Cancel

Location Assign Unassign

Status Board

NUR.COCSR (COAUDEZN/COA.TEST.MIS/118/COCSR) - MORRIS,MARDI *** TEST *** - Vergence Link On

My List of Patients - Nurse Status Board - CPOE (Last Updated: 02/03/14 1009)

Room/Bed	Patient Name	New Order	Next Med Due	Temp	P	R	PEW	
Temp Loc	Age	Sex	New Result	Transfusion	BP	Sat	MEW	
AS.CL05▶	SKYRIDGE,ALEX	Stat		98.6	45	20		
	53	M	Res	Ready	120/80	99	1	Allergies
AS.CL11▶	SKYRIDGE,BETTY	Stat		99.0	96	26		Reconcile Rx
	90	F	Res		100/55	95	3	Admin Data
AS.CL24▶	SKYRIDGE,GAYLE	Stat		98.0	60	20		Archive
	57	F	Res	Trans 1131	120/80	95	1	My List
AS.CL32▶	SKYRIDGE,DAVID	Unc		98.6	80	21		Assessment
	9	M	Lab		176/78	100		Process Int

- The status board screen is similar to a white board, enabling you to view current information about you patients.
- The first 3 columns remain static and remain visible at all times.

Clinical Review

The screenshot displays the NUR.COCSR application window. The title bar includes the text "NUR.COCSR (COALDEZN/COA_TEST.MIS/237/COCSR) - RN TEMPLATE 4R6 FLEX" and "*** TEST *** - Vergence Link Susp...". The main window header reads "My List of Patients - Nurse Status Board - CPOE (Last Updated: 01/08/14 1007)".

The main data table has the following columns: Room/Bed, Temp Loc, Patient Name, Age, Sex, New Order, New Result, Next Med Due, Transfusion, Temp, P, R, PEW, BP, Sat, MEW. The table contains three rows of patient data:

Room/Bed	Temp Loc	Patient Name	Age	Sex	New Order	New Result	Next Med Due	Transfusion	Temp	P	R	PEW	BP	Sat	MEW
AS. ED19▶		CPOEADULT, SR1	68	M	Unv	Rad									
AS. IC15▶		SRMC, CR1	68	M	Ack	Res			96.3	95	12		132/85	90	0
AS. EN00▶		CPOEADULT, SR57	56	M											

Below the table are two "More" buttons with input fields and a right arrow button. At the bottom, there are buttons for "Location", "Find Patient", "Manage List", "Options", and "Exit".

On the right side, there is a vertical sidebar menu with the following options: Allergies, Reconcile Rx, Admin Data, Archive, My List, Assessment, Process Int, Pt Notes, Plan of Care, Review (highlighted with a red circle), Discharge, Ack/Ver, Print Report, Orders, Monitor, eMAR, Transfusions, and E-Mail.

Black tabs:
Information
available

Grey tabs: NO
Information
available

Blue tabs: New Information available

Clinical Review is simply the PATIENT'S chart, just in electronic form.

Pt Summary	
Problem List	
Special Panel	
Daily Review	
Order History	
Vital Signs	
I + O	
LAB	
Microbiology	
Blood Bank	
Pathology	
Medications	
Imaging	
Other Reports	
Notes History	
Assessments	
Other Menu	
Reconcile Meds	
More	Less
Other Visits	
Return	

Other Reports

Selected Visit Lifetime Summary

Previous Page Next Page

Date / Time	Department Report	Dictated By Dictated Dt/Tm	Status	I	✓
Aug 30,13 09:27	General Reports: Pulmonology Progress Note	GOBBLE,JO ANNE Aug 30,13 09:27	Draft		
Aug 29,13 10:07	Respiratory System: Pulmonary Consultation	GREER,SHERRY Aug 29,13 10:07	Draft		
Aug 26,13 10:39	General Reports: Hospitalist Progress Note	WINCHESTER,C... Aug 26,13 10:39	Signed		
Aug 26,13 10:36	General Reports: Infectious Disease Consultation	GOBBLE,JO ANNE Aug 26,13 10:36	Signed		

Pt Summary

Problem List

Special Panel

Daily Review

Order History

Vital Signs

I + O

LAB

Microbiology

Blood Bank

Pathology

Medications

Imaging

Other Reports

Notes History

Assessments

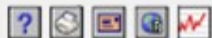
Other Menu

More Less

Other Visits

Return

Includes
Provider
Reports,
H&Ps, Echo
Reports, MD
Notes



PCI

Order

Document

Discharge

Sign

Notes History

Notes Assessments and Notes Messages

Previous Page Next Page

Date / Time	Category	Description	User	I	
Aug 30, 13 09:27	Provider	Pulmonology Progress Note	GOBBLE, JO ANNE MEDICAL CENTER		
Aug 29, 13 10:07	Provider	Pulmonary Consultation	GREER, SHERRY MEDICAL CENTER		
Aug 26, 13 10:39	Provider	Hospitalist Progress Note	WINCHESTER, CHARLES MEDICAL CENTER		
Aug 26, 13 10:36	Provider	Infectious Disease Consult	GOBBLE, JO ANNE MEDICAL CENTER		
Aug 26, 13 10:18	NURSE NOTES	Nurse Notes	SHAW, TRAVIS PT READMITTED TO INPATIENT...		

Pt Summary
Problem List
Special Panel
Daily Review
Order History
Vital Signs
I + O
LAB
Microbiology
Blood Bank
Pathology
Medications
Imaging
Other Reports
Notes History
Assessments
Other Menu
More Less
Other Visits
Return

PCI Order Document Discharge Sign

Includes:

- Consult notes
- Nurse notes
- PT/OT notes
- Resp notes
- Dietary notes
- D/C summary
- Case Mgmt.

Click on the
grey box to
view the
report

Process Interventions

“The Verb Strip” = menu items

- “Document Now” (DN) – to document.
- “Add Interv’s” (AI) – to add new interventions
- “View History” (VH) – to view history of documentation; also used to edit or undo documentation errors.

Process Interventions

Current Date/Time LMH

Int: 04 of 14

Document Now Document Interv's Add Interv Select Interv's Change Status View History Order Detail Edit Text ≥More

Patient AS0000025329 SRMCEBCD, TEST53 Status ADM IN Room AS.5205

Resuscitation Status Admit 04/02/17 Bed A

Attend Dr ZCPOESR Zcpoe, Sr Age/Sex 41 F Loc AS.5200

Start Date 04/03/17 at 0000 End Date 04/03/17 at 2359 Med Edit Unit# AS00000470

Include A,D,S AS,CP,MO,OE,PS 1:99 ALL INT Acuity

Interventions Sts Directions OD Doc Src D C/N KI Prt

Assessments

-Admission/Shift Assessment +

-Quick Start +

-Safety/Risk/Regulatory +

-1st Point of Contact MRSA/TB/RESP +

-Pain Assessment +

Routine Care

-Vitals/Ht/ Wt/ Measurements +

-Routine Daily Care +

-Intake and Output +

-Lines/Drains/Airways +

-Teach/Educate +

-Manage/Refer/Contact/ Notify +

Plan of Care

-Plan of Care +

~~~~~ DISCHARGE PLANNING/EDUCATION ~~~~~

You will document in all of these interventions throughout your shift at least once and as needed.

To document on an intervention:

1. Highlight the intervention
2. Select Document Now

# Other Daily Documentation

- Update Admin Data
- Pt Notes
- Review Status Board & Acknowledge Orders with preceptor (at **LEAST** every 2 hours)
- eMAR- medication administration
- Clinical Review



# Documenting Vital Signs

| Interventions                            | Sts | Directions | OD | Doc | Src | D | C/N | KI | Prt |
|------------------------------------------|-----|------------|----|-----|-----|---|-----|----|-----|
| Assessments                              |     |            |    |     |     |   |     |    |     |
| -Admission/Shift Assessment +            | A   |            |    |     | CP  |   |     |    |     |
| -Quick Start +                           | A   |            |    | 1m  | PS  |   |     |    |     |
| -Safety/Risk/Regulatory +                | A   |            |    |     | CP  |   |     |    |     |
| -1st Point of Contact MRSA/TB/RESP +     | A   |            |    |     | CP  |   |     |    |     |
| -Pain Assessment +                       | A   |            |    |     | CP  |   |     |    |     |
| Routine Care                             |     |            |    |     |     |   |     |    |     |
| -Vitals/Ht/ Wt/ Measurements +           | A   |            |    |     | CP  |   |     |    |     |
| -Routine Daily Care +                    | A   |            |    |     | CP  |   |     |    |     |
| -Intake and Output +                     | A   |            |    |     | CP  |   |     |    |     |
| -Lines/Drains/Airways +                  | A   |            |    |     | CP  |   |     |    |     |
| -Teach/Educate +                         | A   |            |    |     | CP  |   |     |    |     |
| -Manage/Refer/Contact/ Notify +          | A   |            |    |     | CP  |   |     |    |     |
| Plan of Care                             |     |            |    |     |     |   |     |    |     |
| -Plan of Care +                          | A   |            |    |     | CP  |   |     |    |     |
| ~~~~~ DISCHARGE PLANNING/EDUCATION ~~~~~ |     |            |    |     |     |   |     |    |     |

You can document Vital signs, Height, Weight, and other measurements from the above intervention.



# Documenting Continued

Vital signs: 04/03/0943 AS0000025329 SRMCEBCD,TEST53

Document vital signs:

1 Yes

Document vital signs:

Document pre transfusion vitals:

Document height/weight measurements:  \*

Document hemodynamic monitoring:

Document orthostatic vital signs:

Document ICP/ CPP monitoring:

(End)

You will utilize the OK button to move between fields. To Document VS or in any of the other fields below you choose YES. The screen will automatically take you to your documentation screen.

When you are finished documenting you will click in the END box below to file your documentation.

\* Indicates that this is a required field. You will not be allowed to save documentation until that field has been documented in.

# New Admissions Assessment/ Daily Assessments/ Focused Reassessments

Process Interventions

Current Date/Time LMH Int: 0/ of 14

| Document Now | Document Interv's | Add Interv | Select Interv's | Change Status | View History | Order Detail | Edit Text | >More |
|--------------|-------------------|------------|-----------------|---------------|--------------|--------------|-----------|-------|
|--------------|-------------------|------------|-----------------|---------------|--------------|--------------|-----------|-------|

Patient AS0000025329 SRNCEBCD, TEST53 Status ADM IN Room AS.5205

Resuscitation Status Admit 04/02/17 Bed A

Attend Dr ZCPOESR Zcpoe, Sr Age/Sex 41 F Loc AS.5200

Start Date 04/03/17 at 0000 End Date 04/03/17 at 2359 Med Edit Unit# AS00000470

Include A,D,S AS,CP,MO,OE,PS 1:99 ALL INT Acuity

| Interventions                 | Sts | Directions | OD | Doc | Src | D | C/N | KI | Prt |
|-------------------------------|-----|------------|----|-----|-----|---|-----|----|-----|
| History                       |     |            |    |     |     |   |     |    |     |
| -Admission Health History +   | A   |            |    |     | CP  |   |     |    |     |
| Assessments                   |     |            |    |     |     |   |     |    |     |
| -Admission/Shift Assessment + | A   |            |    |     | CP  |   |     |    |     |
| -Quick Start +                | A   |            |    | 2h  | PS  |   |     |    |     |
| -Safety/Risk/Regulatory +     | A   |            |    |     | CP  |   |     |    |     |
| -1st Point of                 |     |            |    |     |     |   |     |    |     |
| -Pain Assessment              |     |            |    |     |     |   |     |    |     |
| Routing Care                  |     |            |    |     |     |   |     |    |     |

Make selection below

Select ☐

- 1 Full (All) Systems
- 2 Selected Focus Systems

Admission assessment, daily shift assessments and focused reassessments are in the same intervention. You will choose which you would like to do from the options screen.

# Intake and Output

Intake and Output 04/03 1047 AS0000025329 SRMCEBCD,TEST53

OK

Oral ml:

|   |   |   |      |
|---|---|---|------|
| 7 | 8 | 9 | Del  |
| 4 | 5 | 6 |      |
| 1 | 2 | 3 |      |
|   | 0 |   | Calc |

1. Complete your documentation
2. Utilize the green OK button to skip fields
3. Click END to save documentation

Oral ml:

IV intake:

Nutrition amount:

Meals consumed:

Procedure intake:

Other measured intake:

Non BCTA blood:

Urine:

Stool:

Output not measured:

Emesis:

Gastric drainage:

Drain:

Procedure output:

Post void residual amount ml:

Peritoneal dialysis:

Hemodialysis:

CRRT:

(End)



# To Edit , Undo or Finish Documenting

Process Interventions

Current Date/Time LMH

Int: 04 of 14

Document Document Add Select Change View Order Edit ≥More  
Now Interv's Interv Interv's Status History Detail Text

Patient AS0000025329 SRMCEBCD,IES153 Status ADM IN Room AS.5205  
Resuscitation Status Admit 04/02/17 Bed A  
Attend Dr ZCPOESR Zcpoe,Sr Age/Sex 41 F Loc AS.5200  
Start Date 04/03/17 at 0000 End Date 04/03/17 at 2359 Med Edit Unit# AS00000470  
Include A,D,S AS,CP,MO,OE,PS 1:99 ALL INT Acuity

Interventions Sts Directions OD Doc Src D C/N KI Prt

Assessments  
-Admission/Shift Assessment + A  
-Quick Start + A  
-Safety/Risk/Regulatory + A  
-1st Point of Contact MARS/TB/RESP + A  
-Pain Assessment + A  
Routine Care  
-Vitals/Int/ Wt/ Measurements + A  
-Routine Daily Care + A  
-Intake and Output + A  
-Lines/Drains/Airways + A  
-Teach/Educate + A  
-Manage/Refer/Contact/ Notify + A  
Plan of Care  
-Plan of Care + A  
~~~~~ DISCHARGE PLANNING/EDUCATION ~~~~~

NUR.COCSR (COAUDED/COA.LIVE.MIS/421/COCSR) - Chirinos,Tara

View Intervention History

→View Select Undo Edit ←Exit

| Number | Description |
|---------|-------------------------|
| 1702002 | 180: Monitor - Complex+ |

| Activity Type | Occurred Date | Occurred Time | by | Recorded Date | Recorded Time |
|---------------|---------------|---------------|-----|---------------|---------------|
| Create | 05/02/11 | 1108 | CL | 05/02/11 | 1108 |
| Document | 05/04/11 | 0546 | NWL | 05/04/11 | 0548 |
| Document | 05/04/11 | 1759 | REK | 05/04/11 | 2045 |
| Document | 05/05/11 | 0559 | KSO | 05/05/11 | 0707 |
| Document | 05/05/11 | 1759 | PGW | 05/05/11 | 1804 |
| Document | 05/05/11 | 1759 | PGW | 05/05/11 | 2047 |
| Document | 05/06/11 | 0559 | KSO | 05/06/11 | 0705 |
| Document | 05/06/11 | 1830 | AKD | 05/06/11 | 1831 |
| Document | 05/07/11 | 0559 | KSO | 05/07/11 | 0649 |
| Document | 05/07/11 | 1820 | KKW | 05/07/11 | 1823 |
| Document | 05/08/11 | 0559 | JDN | 05/08/11 | 0705 |
| Document | 05/08/11 | 1730 | MLM | 05/08/11 | 1834 |
| Document | 05/09/11 | 0559 | JDN | 05/09/11 | 0654 |
| Document | 05/10/11 | 0559 | MLM | 05/10/11 | 0735 |

1. Select the intervention you want to undo or edit/finish.
2. Click on View History.
3. Highlight the one you want to undo/edit and click on corresponding menu item at the top of the screen.
4. You will have to enter a reason. (e.g. wrong patient, wrong time, etc.)

Manage/Refer/ Contact/ Notify

Interventions

Assessments

- Admission/Shift Assessment +
- Quick Start +
- Safety/Risk/Regulatory +
- 1st Point of Contact MRSA/TB/RESP +
- Pain Assessment +

Routine Care

- Vitals/Ht/ Wt/ Measurements +
- Routine Daily Care +
- Intake and Output +
- Lines/Drains/Airways +
- Teach/Educate +
- Manage/Refer/Contact/ Notify +

Plan of Care

- Plan of Care +

~~~~~ DISCHARGE PLANNING/EDUCATION ~~~~

## Sts Directions

## OD Doc Src D C/N KI Prt

Use this Intervention to document all notifications related to patient care.

Manage Refer Contact Notify 04/03 1113 AS0000025329 SRMCEBCD,TEST53

| Entity attempted/notified: |                        |                              |  |
|----------------------------|------------------------|------------------------------|--|
| 1 Family member            | 7 Occupational therapy | 13 Environmental services    |  |
| 2 Listed emergency contact | 8 Speech therapy       | 14 Respiratory therapy       |  |
| 3 Significant other        | 9 Social work          | 15 Child protective services |  |
| 4 Nurse                    | 10 Case management     | 16 Coroner                   |  |
| 5 Wound/ostomy care        | 11 Pastoral care       | 17 Funeral home              |  |
| 6 Nutrition                | 12 Security            | 18 or <F9> For More Options  |  |

Action:>Notified

Provider attempted/notified:>

Entity attempted/notified:>

Family member notified:

Reason notified:

Chain of command contact name:

# Patient Notes

The main application window displays a menu on the left with various options. The 'Pt Notes' option is circled in green. Other options include Allergies, Admin Data, Archive, My List, Assessment, Process Int, Plan of Care, Review, Flowsheet, Print Report, Orders, eMAR, Transfusions, E-Mail, References, and Exit.

**Patient Note Functions**

- View Existing Notes
- Enter New Note
- Amend Existing Notes
- Undo Existing Notes
- Print Notes by Date
- Print ALL Notes
- View Undone Notes
- Print Undone Notes

**Note Type**

- Type of Note
- No Type
- Problem
- Outcome
- Intervention

**Note Categories**

- LACTATION CONSULTANT
- NURSE NOTES

**Enter Note**

| Date     | Time by | Mgm     | Author's Name        | Note Category |
|----------|---------|---------|----------------------|---------------|
| 09/12/13 | 1656    | ASNE.NH | MKM Morris, Nardi K. | NURSE NOTES   |

Patient: AS1500005288 SKYRIDGE, BETTY

Resuscitation Status:

Use F6 to go back to the TIME box and change to the actual time you need



# No Known Allergies/ Unobtainable

MIS (COAUDED/COA.TEST.MIS/659/COC5R) - Perez, Theresa A.M.

Allergy Management

SKYRIDGE, BETTY - 45/M AS, ICUW AS, IC29/A Unit No: AS00000015  
ADM IN Acct No: AS9360006687

| Allergies for Interaction Checks (C) | Type    | Severity | Date     | Ver | Cnt |
|--------------------------------------|---------|----------|----------|-----|-----|
| No Known Allergies                   | Allergy |          | 12/27/10 | No  |     |

Uncoded Allergies (0)

Click on "NKA" if patient has no drug, food, environmental or other allergies.

Once "NKA" is clicked, No Known Allergies is added on the list. The NKA button is then grayed out.

View Details

New

Delete

Edit

Confirm

Verify

NKA Unobtn

Audit Trail

Select All

Deselect All

Undo All

Allergies must be validated on all patients

- ❖ Click the Verify, Confirm, and File buttons if allergies are correct
- ❖ Any **UNCODED** allergies must be **deleted & re-entered as Coded allergies** in order to have allergy interaction checks.
- ❖ Misspelled or free text allergies will drop to **UNCODED** allergy list and will not be checked for interaction.

Allergy Management

SKYRIDGE, BETTY - 45/M AS, ICUW AS, IC29/A Unit No: AS00000015  
ADM IN Acct No: AS9360006687

Allergy Management

SKYRIDGE, BETTY - 45/M AS, ICUW AS, IC29/A Unit No: AS00000015

Allergy/Adverse Drug Reaction Lookup - All

Uncoded Drug Non-Drug  
Multiple All

Allergy Information Available

Other Name Category

Intermediate Unknown No

Comment

OK Cancel

View Details

New

Delete

Edit

Confirm

Verify

NKA Unobtn

Audit Trail

Select All

Deselect All

Undo All

File

Return

If allergy information is not obtainable, use the "Unobtn" button

Enter a comment by clicking on the comment button.

# eMAR OVERVIEW

- ◆ Light Grey: Previously Given
- ◆ Green: Next dose due
- ◆ Red: Due now or overdue
- ◆ Full Grey Box: Dose note given
- ◆ Black: Future Doses
- ◆ Yellow: Medication D/C'd

| Medication    |                                         |        |       |          |  | Sched Time | Today     |           |
|---------------|-----------------------------------------|--------|-------|----------|--|------------|-----------|-----------|
| Start         | Stop                                    | Status | Route | Schedule |  | Mon 05/02  | Tue 05/03 | Wed 05/04 |
| 05/01/11 2100 | Klonopin 2 mg PO TID                    | Active |       |          |  | 0900       | 0855      | 0643      |
| 05/11/11 2101 | Clozapem 0... (Give 4 TABS of 0.5 mg)   |        |       |          |  | 1300       | 1312      | 1300      |
|               |                                         |        |       |          |  | 2100       | 2026      | 2100      |
| 05/01/11 1830 | Amylase/Lipase/Prot... 6 cap PO TIDMEAL | Active |       |          |  | 0800       | 0856      | 0806      |
| 10/28/11 1831 | Pancrell... (Give 6 CAPSULE.DRS of ...) |        |       |          |  | 1200       | 1311      | 1206      |
|               |                                         |        |       |          |  | 1700       | 1819      | 1700      |
| 05/02/11 1800 | Cubicin 390 mg in NaCl-0.9% IV Q24H     | Active |       |          |  |            | 1738      | 1800      |
| 05/22/11 1801 | DAPIONYCIN 39... (100 mls @ 100 mls/hr) |        |       |          |  |            |           |           |
|               | **6 MG/KG DOSING**...                   |        |       |          |  |            |           |           |
| 05/02/11 2000 | TPN Solution IV DAILY#20                | Active |       |          |  | 2000       | 2101      | 2000      |
| 10/29/11 2001 | TPN Solution 1690 ml (1690 mls @ 100)   |        |       |          |  |            |           |           |
|               | 5/2 CYCLE SEE ORDER FOR RATE...         |        |       |          |  |            |           |           |

**Allergies**

**Admin Data**

**Archive**

**My List**

---

**Assessment**

**Process Int**

**Pt Notes**

**Plan of Care**

**Review**

---

**Flowsheet**

**Print Report**

---

**Orders**

---

**eMAR**

**Transfusions**

**E-Mail**

**References**

ment Ack Preferences Drug Data eMAR Reports Change Order Other Submit Exit



# eMAR

Start Date/Time  
and Stop  
Date/Time

Medication Profile Icons: Clicking on these icons will display information linked to that drug. This includes linked medications, required co-signatures, dose instructions

Confirm name  
and DOB

Allergies

"A" means  
acknowledged

Label comments display  
beneath medication name  
directly on profile and also  
with dose instructions.

PHA.COC SR (COAUDIT/COA.LIVE.MIS/478/COC SR) - Chirinos,Tara L.

eMAR Desktop Total # orders 18

AS9361010652/AS00028107 AS.5200 AS.5202-A ADM IN  
185.42 cm 63.957 kg 1.81 m2 CrCl 99.88 ml/min Cr 0.9 mg/dl

Patients Name

Allergy Droperidol, Ketorolac tromethamine, Butorphanol Tartrate, Codeine, Glucocorticoid... AdvReac ...

Diagnosis Fever, Abd Pain Tuesday May 3, 2011 1341

| Start         | Stop          | Status | Route | Medication                                                                                              | Sched Time           | Today                |                      |                      |
|---------------|---------------|--------|-------|---------------------------------------------------------------------------------------------------------|----------------------|----------------------|----------------------|----------------------|
|               |               |        |       |                                                                                                         |                      | Mon                  | Tue                  | Wed                  |
| 05/01/11 2100 | 05/11/11 2101 | Active |       | Klonopin 2 mg PO TID<br>Clonazepam 0... (Give 4 TABS of 0.5 mg)                                         | 0900<br>1300<br>2100 | 0855<br>1312<br>2026 | 0643<br>1300<br>2100 | 0900<br>1300<br>2100 |
| 05/01/11 1830 | 10/28/11 1831 | Active |       | Amylase/Lipase/Prot... 6 cap PO TIDMEAL<br>Pancrelli... (Give 6 CAPSULE.DRS of ...)                     | 0800<br>1200<br>1700 | 0856<br>1311<br>1819 | 0806<br>1206<br>1700 | 0800<br>1200<br>1700 |
| 05/02/11 1800 | 05/22/11 1801 | Active |       | Cubicin 390 mg in NaCl-0.9% IV Q24H<br>DAPTOMYCIN 39... (100 mls @ 100 mls/hr)<br>**6 MG/KG DOSING**... |                      | 1738                 | 1800                 | 1800                 |
| 05/02/11 2000 | 10/29/11 2001 | Active |       | TPN Solution IV DAILY@20<br>TPN Solution 1690 ml (1690 mls @ UD)<br>5/2 CYCLE SEE ORDER FOR RATE...     | 2000                 | 2101                 | 2000                 | 2000                 |

Document Ack Preferences Drug Data eMAR Reports Change Order Other Submit Exit



# Medication Reconciliation

My List of Patients (Last Updated: 04/03/17 0923) Nurse Status Board - CPOE

| Room/Bed  | Patient Name     | New Order  | Link | Next Med Due | Temp P R PEW |
|-----------|------------------|------------|------|--------------|--------------|
| Temp Loc  | DOB S Age        | New Result |      | Transfusion  | BP Sat MEW   |
| AS.5205-A | SRMCEBCD, TEST53 |            |      |              |              |
|           | 10/10/75 F 41    |            |      |              |              |
|           |                  |            |      |              |              |
|           |                  |            |      |              |              |
|           |                  |            |      |              |              |
|           |                  |            |      |              |              |
|           |                  |            |      |              |              |
|           |                  |            |      |              |              |
|           |                  |            |      |              |              |

Protocol  
Allergies  
Reconcile Rx  
Admin Data  
Archive  
My List  
Assessment  
Process Int  
Pt Notes

Med Rec MUST be completed:

- Admission
- Transfer
- Discharge

## ➤ Review

- You must review each medication
- ADD THE DATE & TIME IT WAS LAST TAKEN

# Reviewing and Adding Home Meds

## ➤ Review

- You must review each medication
- ADD THE DATE & TIME IT WAS LAST TAKEN

Medication Reconciliation

TRAIN, BETTY - 79/F  
180.3 cm 79.838 kg  
Allergies/ADRs: oxycodone HCl (From PERCOCET), Sulfa (Sulfonamide Antibiotics), Peanut, Acetaminophen (From PERCOCET), ... (More)

AS.CLASS  
U/A AS00000012/AS1500016894

Last updated by: Trng ID COCSR/NEWEMP on 11/13/14 @ 1242

| Home Meds (6)                            | Trade    | Last Taken   | Review     | DC                    | Cont                  | HOLD                  |
|------------------------------------------|----------|--------------|------------|-----------------------|-----------------------|-----------------------|
| ASPIRIN 325 MG TABLET                    | Reported | <Last Taken> | 11/13 1241 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 325 MG ORAL DAILY PRN Anxiety            |          |              |            |                       |                       |                       |
| HYDROMORPHONE HCL (DILAUDID) 8 MG TABLET |          | <Last Taken> | 11/13      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| FURSEMIDE (LASIX) 20 MG                  |          |              |            |                       |                       |                       |
| 40 MG PO DAILY                           |          |              |            |                       |                       |                       |
| FAMOTIDINE (PEPCID 20MG)                 |          |              |            |                       |                       |                       |
| 40 MG PO DAILY                           |          |              |            |                       |                       |                       |
| METOPROLOL SUCCINATE (LOPRO)             |          |              |            |                       |                       |                       |
| 50 MG PO BID                             |          |              |            |                       |                       |                       |
| ONDANSETRON HCL (ZOFRAM)                 |          |              |            |                       |                       |                       |
| 4 MG PO BID                              |          |              |            |                       |                       |                       |
| + Discontinued Home Meds                 |          |              |            |                       |                       |                       |

**Last Taken**

ASPIRIN 325 MG TABLET  
325 MG ORAL DAILY PRN Anxiety

Date: 11/13/14

Time: 0900

Dose:

Information Source: SAME AS PATIENT

Medication Purpose: Anxiety

Comments:

Attention Required? ☐ Yes ☒ No

OK Cancel Clear

Update Med List - Favorite Strings

WARFARIN (COUMADIN) 1 MG TAB  
1 MG PO DAILY 0 Refills  
Takes M, W, Sat

☐ Unknown Strength

Dose: 1 MG Units: PO Route: DAILY Frequency: N PRN Reason for Use:

Qty: Days: Disp Unit: Refills: NS

Instructions: Takes M, W, Sat Diagnosis:

Comments: Date: Source:

I MG PO DAILY N TAB

Done Cancel

Remove Favorite  
Monograph  
Replace/Change  
Daily Dosing

View Detail  
Renew/Change  
Cancel  
Prescriptions  
Inpatient Meds  
Upd Med List  
Associate  
Remove Assoc.  
Print  
? Check  
Remove  
Reset Review  
Submit

Submit

# Scanning Patients & Meds

Scan patient  
armband.

- Barcode appears

## Scan medication

- ◆ Barcode appears
- ◆ Asterisk appears

- **“Return to eMAR”**- Returns to eMAR desktop (Does not file your work)
- **“Save & Exit”**- Files your work and returns to status board
- **“Save & Recompile”**- Files your work and returns you to that patient's eMAR

The screenshot displays the eMAR application interface. At the top, a header bar contains patient information: ED, ENARI, 55/F, 05/05/57, AQ1000012129/AQ00000556, No Height or Weight entered, AQ.ER - CrCI INVALID RESULT, and REG ER. Below this, a status bar indicates 'Allergy Allergies Have Not Been Entered in Pha' and 'AdvReac ADRs HAVE NOT BEEN ENTERED IN PHA'.

The main table lists medication orders. The first order is for Sulfamethoxazole/Trimethoprim (Ss PO .5TK-MED ONE) with a scheduled time of 08/30/12 1052. The dose field '1052' is highlighted in green. A red arrow points from this field to the 'Return to eMAR' button at the bottom.

The right-hand sidebar contains a vertical list of buttons: Allergies, Admin Data, Orders, My List, eMAR, Reconcile Rx, Assessment, Process Int, Pt Loc/List, Pt Notes, Plan of Care, Transfusions, Review, and Flowsheet.

At the bottom, a navigation bar contains four buttons: 'Return to eMAR', 'Save and Exit', 'Save and Recompile', and 'Manual Barcode'.