



Medical City
Alliance

Meditech Order Entry Manual












10/10/18





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PC Keys and GEMMS Toolbar

GEMMS Toolbar	KEY	DESCRIPTION	NOTES
	F12	"OK" ("File", "Save")	
	F11	"Exit"	
	F9	"Lookup" Displays a list of valid responses to a prompt	
	Enter	"Enter" ("Return") Moves the cursor forward one field or question	
	(Right) Ctrl	"Check mark" ("Block")	
	↓	"Down Arrow" key moves you down one item at a time for a list of items and moves the highlight bar down one item at a time	
	↑	"Up Arrow" key moves you up one item at a time for a list of items and moves the highlight bar up one item at a time	
	F10	"Delete Line" key deletes an entire line that appears in the field or question (May also use the "Backspace" key to delete one letter at a time)	
	Esc	"Escape" key gets you out when "Exit" does not work	
	F6	"Prev Field" key moves you back one field or question	
	→ (Right Arrow) ← (Left Arrow)	Used to view patient's record from PCI, navigating in MOX and Patient Notes routine. "Right Arrow" in and "Left Arrow" out. (sometimes you may have to use the "Shift" key with the Arrow key)	
	Page Up	Moves back one page or section	
	Page Down	Moves forward one page or section	

Combination Keys

GEMMS Toolbar	Keys	Description	Notes
	Ctrl/F12	Displays a Calculator or Calendar	
	F4/F9	Used for " Canned Text " when documenting patient notes (choose from a list of partially typed patient notes)	
	Shift/F12	Magic Key Used to get to the Hot Key Menu (another main menu) and Suspend Session (temporarily locks the computer screen when you have to leave and you do not want to log off)	
	Shift/F8	Displays Online Documentation about the field and routine where the cursor is located.	
	Shift/Ctrl	Select All and Deselect All	

Shortcuts and Miscellaneous Information

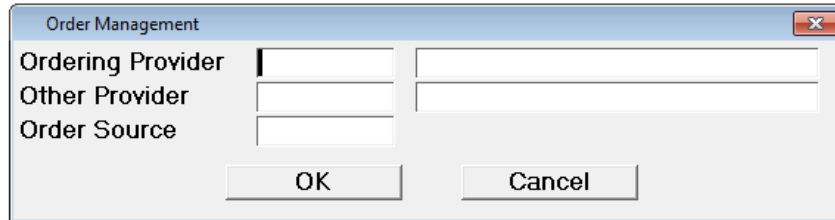
1. **CAPS Lock** – must be on at all times in Meditech (except when logging in)
2. **Date** – For today's date, type T enter and today's date will populate field.
Type T+1 for tomorrow or T-1 for yesterday.
3. **Time** – For now, type N enter and current time will drop in.
4. **Capital X** – Type X at any menu and the system will automatically log off.
5. **Spacebar Enter** – pulls up the last patient or printer you were working on
6. **cSmith,John** – A 'c' before the name identifies a confidential patient.
7. ***Smith,Jane** – A '*' before the name identifies a VIP patient.
8. To locate providers whose mnemonic is not easily found, type N\ and providers last name.

Tips for Entering Orders

1. It is preferred that providers enter their own orders into the computer. However, there will occasionally be a need for the nurse to enter an order. If entering a telephone or verbal order, it is very important to keep the ordering provider on the phone or next to the computer to answer questions regarding medications.
2. Order Sets are grouped by disease process and are orders that are commonly used together in-patient care i.e. Sepsis/Shock includes medications, IV fluids, nursing care orders, radiology and cardiology. Orders and Meds/Fluids buttons are for individual items ordered when not using an Order Set or that need to be added within a set.
3. POC before an order means 'Point of Care' or that the nurse is completing the test. This is used for Bedside Glucose Sticks, Transcutaneous Bilirubin, and various test in the Emergency Department.
4. All patients should have a diet order even if it is NPO. Each diet order has a primary diet with options of a secondary diet, modifiers, diet restrictions, and diet texture.
5. Consults are used for physician ordered consults. Nurses can request a 'screen' without a physician order. For instance, the physician would order a Lactation Consult but without a physician order, the nurse can order a Lactation Screen.
6. Lab orders can be entered up to 7 days in advance, Respiratory Therapy Orders are valid for 30 days, and all other orders can be entered up to 3 days in advance.
7. MMM or Medication Management Message should be used to contact pharmacy regarding medication needs. For example, Norco is ordered for the patient but needs to be stocked in the Pyxis.
8. Some orders will automatically reflex or add other orders. When ordering an inhaler, respiratory consult is automatically ordered. When ordering a Cardiac Stress Test, the Nuclear Medication portion of the test is automatically ordered.
9. Some test may be listed more than once due to aliases being added to make finding the test easier. Example: Chest X-Ray is listed as Chest X-Ray and CXR.
10. Some orders such as Dialysis, Restraints, TPN, Special Labs, Foley – Renewal Order, and Suicide Precautions continue as paper orders.
11. To look up a physicians' mnemonic when entering an order, type the first 3 letters of the physicians' last name and press F9. This will bring up a list of physicians. Enter the number to the left of the physicians name and press enter. If the physician name is hard to locate, type N\ and then the last name.

Entering Orders

To enter orders, select your patient from the 'Status Board' and click on 'Orders'. This will display the 'Order Summary' with the order buttons located on the right hand side of the screen - 'Order Sets', 'Orders', and 'Meds/Fluids'. Select the type of order needed. Once in the order type, you must enter the physicians mnemonic or type the first 3 letters of the physician's last name and press F9. Select the correct provider and press 'enter'.



The screenshot shows a dialog box titled "Order Management" with a close button (X) in the top right corner. It contains three input fields: "Ordering Provider", "Other Provider", and "Order Source". Below these fields are two buttons: "OK" and "Cancel".

'Ordering Provider' is the Physician, Physicians' Assistant, or Nurse Practitioner who gave the order. 'Other Provider' is where you enter the physician with whom the Physicians' Assistant or Nurse Practitioner is associated with so they can co-sign the order. Use the F9 function key to look up the persons mnemonic. 'Order Source' is the type of order received.

C – Plan of Care - Will be used by therapy services at this time. Their plan of care for the patient will queue back to the provider for a signature.

P – Protocol - These orders queue back to the provider for a signature and "Protocol" is used for example when we order Flu and Pneumonia vaccines and/or MRSA swabs on admission.

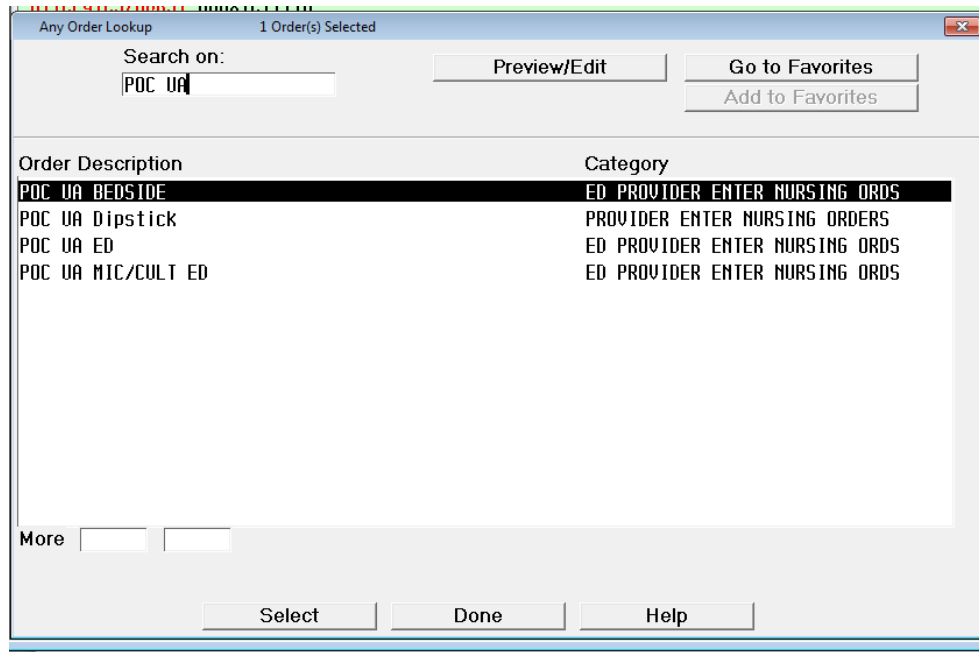
T – Telephone - Order documentation is originated by a clinician authorized to accept telephone orders and includes documentation of ordering provider and clinician.

V – Verbal - Order documentation is originated by clinician authorized to accept verbal orders and includes documentation of ordering provider and clinician. Verbal orders should only be entered by the nurse in emergency situations.

W – Written - : Order documentation is originated by provider and includes the provider's written signature.

Z – Department/Process - **Orders sourced as "Z-process" do not queue back to the provider for electronic signature and should only be used when the original order gives titration variables or specific conditions.** The original order should be entered by the provider or sourced as Telephone, Verbal or Written. A good example of this is when the provider orders "Transfuse 2 units of packed cells *if* the hemoglobin drops less than 8.0". We have the order to transfuse and 2 days after the order was written, the patient's hemoglobin drops. The nurse would order the transfusion and source the order as "Z-process" because we have the original transfusion order that was signed when entered.

Once in Order Entry, begin typing the name of the order needed. When the item is on the screen, use the mouse to highlight the item by clicking on it. Click 'Select' at the bottom of the screen or double click order and enter another item if needed using the same process of highlighting the item and clicking 'Select'. When complete, click 'Done' and complete all required fields.



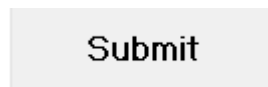
Click 'Select' button to choose the needed item or double click the item.

Once all orders have been selected, click the 'Done' button to proceed to 'Review Patient's Orders'.

Required fields include Priority, Start/Service date and time, Series if needed, and red "Req" fields.

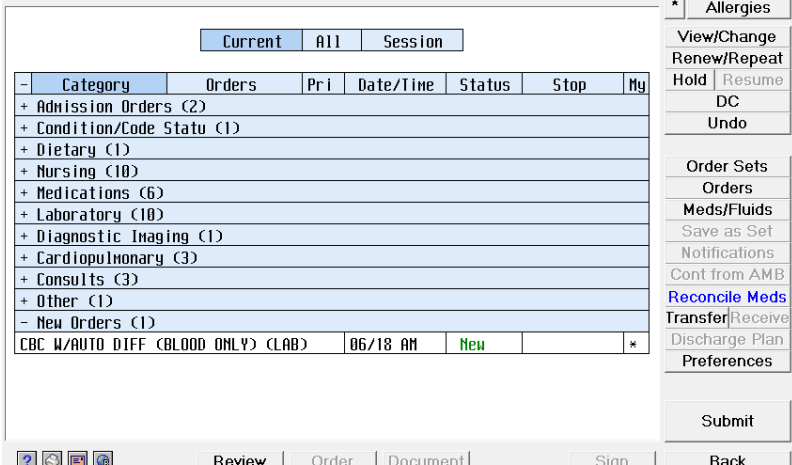
Orders	Pri	Start/Service	Series	Directions	Qty	Details
<input checked="" type="checkbox"/> CBC W/AUTO DIFF (BLOOD ONLY...	R	06/09				Req

Make sure you click 'Submit' to complete the order process.



Editing Orders

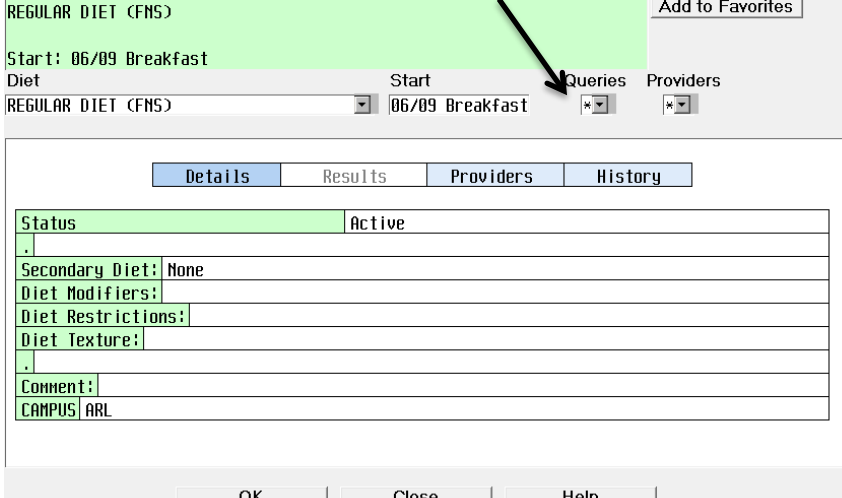
Once entered, orders may need to be edited. One example of this would be to update/change information before the order is submitted. Meditech allows the user several opportunities to review orders before they are submitted. From the review screen, highlight the item that needs to be corrected by clicking the item, click the **'View/Change'** button. This will take you back to the 'Preview/Edit' screen. Please note that completed orders cannot be edited or discontinued.



The screenshot shows a software interface with a table of orders and a sidebar menu. The table has columns for Category, Orders, Pri, Date/Time, Status, Stop, and My. The 'Status' column for the selected row contains the word 'New' in green. The sidebar menu includes buttons for 'View/Change', 'Renew/Repeat', 'Hold', 'Resume', 'DC', 'Undo', 'Order Sets', 'Orders', 'Meds/Fluids', 'Save as Set', 'Notifications', 'Cont from AMB', 'Reconcile Meds', 'Transfer/Receive', 'Discharge Plan', 'Preferences', and 'Submit'. A 'Back' button is at the bottom right. Two black arrows point to the 'View/Change' button and the 'New' status text.

Category	Orders	Pri	Date/Time	Status	Stop	My
+ Admission Orders (2)						
+ Condition/Code Statu (1)						
+ Dietary (1)						
+ Nursing (10)						
+ Medications (6)						
+ Laboratory (10)						
+ Diagnostic Imaging (1)						
+ Cardiopulmonary (3)						
+ Consults (3)						
+ Other (1)						
- New Orders (1)						
CBC W/AUTO DIFF (BLOOD ONLY) (LAB)			06/18 AM	New		*

Some orders can be updated after being 'Submitted'. After selecting the patient, click 'Order', locate the order to be updated, highlight it, and click the **'View/Change'** button. If there is an asterisk in the **'Queries'** box, the order can be updated. Click the 'Queries' drop down box and the ordering information will open, and updates can be made. Once updates are completed, click 'OK' and 'Submit' order.



The screenshot shows a detailed view of a 'REGULAR DIET (FNS)' order. The 'Queries' dropdown menu is open, showing an asterisk. The 'Providers' dropdown menu is also open. The 'Details' tab is selected, showing fields for Status (Active), Secondary Diet (None), Diet Modifiers, Diet Restrictions, Diet Texture, Comment, and CAMPUS (ARL). Buttons for 'OK', 'Close', and 'Help' are at the bottom.

Details	Results	Providers	History
Status			
Active			
Secondary Diet:	None		
Diet Modifiers:			
Diet Restrictions:			
Diet Texture:			
Comment:			
CAMPUS	ARL		

Patient Admission & Level of Care

- ** This is very important for billing purposes and needs to be entered as soon as possible.**
- ** Complete all fields within the Admission Status & the Level of Care Order. Please note that the Admission Status order has multiple pages.**

Enter/Edit Responses : Admission Status

Procedure Ordered
Admission Status

Patient Status:

- 1 Admit to Inpatient
- 2 Place in Outpatient
- 3 OP begin Observation

Patient Status: _____ *

Assign to Physician: _____ *

Medical Reason: _____ *

Ok Cancel Help <5 Page Screen> Prev Next

Enter/Edit Responses : Level of Care

Procedure Ordered
Level of Care

Patient Type:

1 MEDICAL/SURGICAL	5 PCU	9 NURSERY
2 MEDICAL/SURGICAL/TELE	6 LABOR & DELIVERY	10 SPECIAL CARE NURSERY
3 ORTHO	7 GYN	11 NEONATAL ICU
4 ICU	8 POST PARTUM	12 CARDIAC CATH LAB

Patient Type: _____ *

I certify that the Preadmission Assessment is complete and signed:

Comment: _____

Ok Cancel Help Prev Next

Change Status

Complete the Change Status order when the patients admission status changes. i.e. Outpatient to Inpatient or Observation to Inpatient status. This is very important for Case Management as well as for billing purposes.

Procedure Ordered
CHANGE STATUS

Status to

- 1 Admit to Inpatient
- 2 Place in Outpatient
- 3 OP begin Observation

Convert current ADM IN status to: _____

Assign to Physician: _____

Medical Reason: _____ Effective Date: _____ Effective Time: _____

Comment: _____

Ok Cancel Help <3 Page Screen> Prev Next

Update Attending

This order is used to change the current listed physician to the patients attending physician.

Procedure Ordered
CHANGE ATTENDING

Change Attending:

1 2 3 4 5 6 7 8 9 0 Del

Q W E R T Y U I O P \

A S D F G H J K L

Z X C V B N M , . Lookup

Change Attending: _____ *

Comment: _____ *

Ok Cancel Help Prev Next

Entering Allergies and Adverse Reactions

Allergy and adverse reaction history must be obtained and entered into Meditech for all new patients in order for the Pharmacy to process medications. Allergies must be spelled correctly in order for the system to cross check allergies with medications.

The 'New' button is used to enter new allergies.

'NKA' button is used when the patient does not have any allergies to food, medications, etc.

All information must be filed (saved) once entered into the system. This button will be accessible once information is entered.

To enter allergies, click the 'New' button and type in the first three letters of the allergen.

Allergy/Adverse Drug Reaction Uncoded Drug Non - Drug
Multiple All

Allergy/Adverse Drug Reaction Other Name Category

More Type Severity Verified
 Allergy Adverse Reaction Mild Severe
 Intermediate Unknown Yes
 No

Reaction Comment

OK Cancel

All fields must be completed and spelled correctly. Once entered, Meditech should be able to check for medication interactions. Allergies listed in brackets [] are not listed in the dictionary and cannot be checked for interactions. If you notice a bracketed allergy, please double check the spelling and correct if needed.

Updating Allergies and Adverse Reactions

Allergies and reactions should be updated as needed. Once in the Allergy screen, use the 'New' button to add new allergies. Previously entered allergies can be updated by using the 'Delete' and the 'Edit' function. To use 'Delete' or 'Edit', first click on the allergy that needs to be changed then click the 'Delete' or 'Edit' function and update the information making sure to spell all information correctly.

- Allergy/ADR for Interaction Checks(C)	Type	Severity	Date	Ver	Cnt
iodine ANAPHYLAXIS	Allergy	Mild	01/20/14	Yes	
- Uncoded Allergy/ADR(C)					
PENCILLIN ANXIETY	Allergy	Mild	02/18/14		

View Details
New
Delete
Edit
Confirm
Verify
NKA Unobtn
Audit Trail
Select All
Deselect All
Undo All
File
Return

'Delete' is used to delete incorrect allergies that were entered

'Edit' is used to edit previously entered information such as spelling.

MEDICATION RECONCILIATION

When a patient is admitted, the Medication Reconciliation or Med Rec must be filled out completely and accurately as soon as possible. Entering the patients' allergies before starting the Med Rec will prevent pop-ups during this process. From the Status Board, highlight the patients name and click Reconciliation Rx. Medical City contracts with PAYORENGINE which pulls the patients medication information from community pharmacies. This is an automatic query once the patient is added into the computer system. This information needs to be verified with the patient and added to the Med Rec if applicable with the last date and time completed.

For period 12/04/13 - 06/02/14 (180 days)	Add	Disclaimer	Update
[Clonidine Tab 0.1MG]	06/02/14		PAYORENGINE
Benicar HCT 40/25 MG TAB 1 TAB	06/02/14		PAYORENGINE
+ [Losartan/Hct Tab 100-25]	05/16/14		PAYORENGINE

To add medications, click Update Med List button located on the right of the screen. Type the name of the medication making sure to spell it correctly and select the appropriate medicationstring. Click 'Select' and the computer will have you click the medication string with the correct dose and directions then click 'Done'.

Name	Strength	Dispense Form	Trade Name
Benicar	5 MG	TAB	
Benicar	20 MG	TAB	
Benicar	40 MG	TAB	
Benicar HCT 20/12.5 MG	1 TAB	TAB	
Benicar HCT 40/12.5 MG	1 TAB	TAB	
Benicar HCT 40/25 MG	1 TAB	TAB	

All information on this screen should be completed as accurately and as soon as possible. If unable to obtain the information, the Unknown Date/Time or Unknown Dose queries can be used and attention required should be changed to "Yes". This information needs to be completed as soon as possible and the need for information should be passed on in report to the next nurse. Not completing this information can delay the patient's medications.

Olanesartan (Benicar) 40 MG TAB
40 MG PO DAILY TAB

Date: 2014

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30					

Time:

Dose:

Information Source:

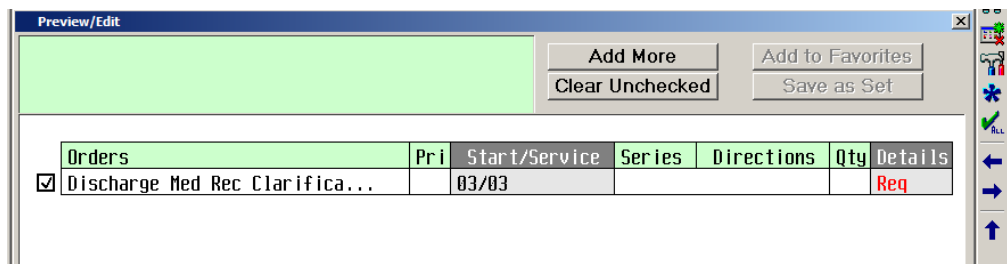
Medication Purpose:

Comments:

Attention Required? Yes No

- Home Meds (2)	Trade	Last Taken	Review	DC	Cont	Hold
Esomeprazole Mag Trihydrate (NexIUM) 20 MG CAPSULE.D 20 MG PO BID	Reported	▼ Unk DT/TM Unk Dose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
Levalbuterol Tartrate (Xopenex HFA 45 MCG/ACT) 15 GM 1 PUFF INH RTQ4H	Reported	▼ Unk DT/TM Unk Dose	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

It is preferred that the physician reviews the Admission and the Discharge Med Rec and makes the decision to Continue, Hold, Discontinue, or Cancel medications; however, the nurse does have the capability to complete the Med Rec based on the physicians order. The Admission Med Rec will prompt for an ordering physician and source. The Discharge Med Rec does not prompt for a physician or source. Therefore, if the nurse completes the Discharge Med Rec, a Discharge Med Rec Clarification order must be entered detailing the changes made to the Med Rec and this order will need to be signed by the physician.



Definitions for Med Rec

Hold = Provider has indicated to hold this medication.

Cancel = removes the medication from the process med screen. This medication will not appear on the patient's printed home med list.

Discontinue = use discontinue if a patient is no longer taking a medication reported in prior visits.

Ordering Medications

To order medications, chose the 'Meds/Fluids' option. Type the name of the medication which should display on the screen. Click on the medication and select the route.

The screenshot shows a window titled "All Medications" with "0 Order(s) Selected". A search box contains "ACE". There are buttons for "Compounds", "Non-Formulary", "Lookup by Type", and "Monograph". Below the search box are navigation buttons: "Prev Page", "Favorites", "Full Formulary", "Next Page", "Medications", and "Fluids". A table lists medication options:

-	Acetaminophen Tab
<input type="radio"/>	GTUBE
<input type="radio"/>	MG
<input type="radio"/>	OG
<input type="radio"/>	PEG
<input type="radio"/>	PO

Once the route is selected the common medication doses or 'Strings' will be displayed. Select a string and make adjustments if needed.

The screenshot shows a window titled "Strings for location: I.CICU". The medication "Acetaminophen Tab (Tylenol Tab)" is selected with route "PO". There are buttons for "Add to Favorites", "Monograph", and "Show All Locations". Below are fields for "Dose", "Directions", "PRN", "Start", and "Stop". A table lists medication strings:

Inst	Admin Criteria	Taper	Pending
325	MG	Q4H PRN	
325	MG	Q6H PRN	
650	MG	Q4H PRN	
650	MG	Q6H PRN	

An arrow points to the "Q4H PRN" string in the third row, labeled "Medication String".

Weight-based Medications - Some medications such as Lovenox are weight based and require the patient's current weight to calculate the medication dose.

The screenshot shows a window titled "Calculate Dose" for "Enoxaparin Inj (Lovenox Inj)". It has fields for "Ordered Dose", "Dosing Weight", and "Final Dose". A "Recalculate" button is present. Below is "Patient Information":

Weight	54.431085 kg
Height	175.26 cm
BSA	1.66 M2
Updated	01/24/2014 14:06

Buttons for "OK", "Cancel", and "Help" are at the bottom.

Titration Medications - Medications such as Dopamine require Titration information. The provider needs to set the parameters for this medication and if not entering this order themselves, need to be accessible to the nurse and to answer appropriate questions.

DOPamine Drip MG IV *Per Bag

Premixed at 800 MG/250 ML

<see Admin Crit> ASDIR TITRATE

Rate/Dose	Directions	PRN	Start
TITRATE	ASDIR	N	02/10 1504
Inst	Admin Criteria	Taper	Additives
			Fluid
			Alt IV
			Pending

TITRATE ASDIR

** STANDARD CONC ** CONC = 3200 MCG/ML **

Initial rate: 5 * mcg/kg/min

Titrate by: 2 * mcg/kg/min every 15* minutes

** Maximum titration amount 2.5 mcg/kg/min **

Goal: (At least ONE goal parameter line is REQUIRED)

Maintain SBP between 90 * - 110* mmHg

Maintain HR between 50 * - 100* BPM

Maintain MAP greater than 65 mmHg

Goal:

** Maximum rate: 40 mcg/kg/min **

Premixed Medications - Various medications are premixed and the dosages are pre-set and cannot be changed. If you attempt to change the dose an error message will appear as shown below.


Strings for location: LCICU

Levofloxacin 750MG IV (Levaquin 750MG IV)

IV

Rate/Dose	Directions	PRN	Start
750	MG	X1	02/10 1520
Inst	Admin Criteria	Taper	Additives
			Fluid
			Alt IV
			Pending

Error

 The selected drug is a premixed item. It is not possible to add other medications into the mix.

Ok

Non-Formulary Medications - If there is an (NF) beside the name of the medication, it means that the medication is not stocked at this facility but will be therapeutically substituted by pharmacy. You can click on 'Inst' or Instruction drop down box to review the substituted medication.

Lansoprazole Cap (NF) (Prevacid Cap (NF))

PO 15 MG BID

<see Instructions>

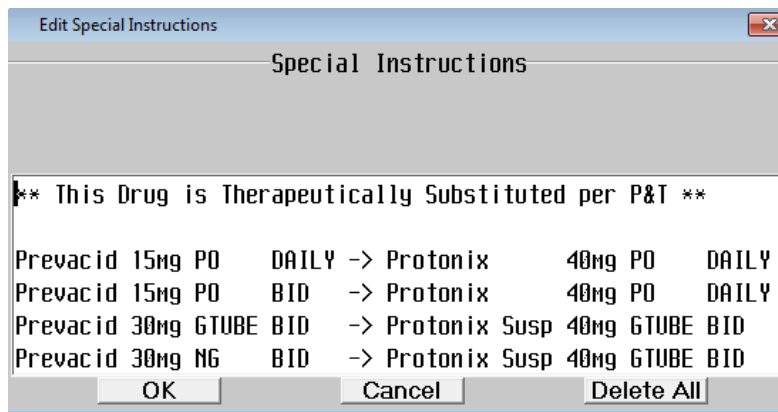
Dose	Directions	PRN	Start	Stop
15	MG	BID 09, 21	N	06/03 2100
Inst	Admin Criteria	Taper	Pending	

MG

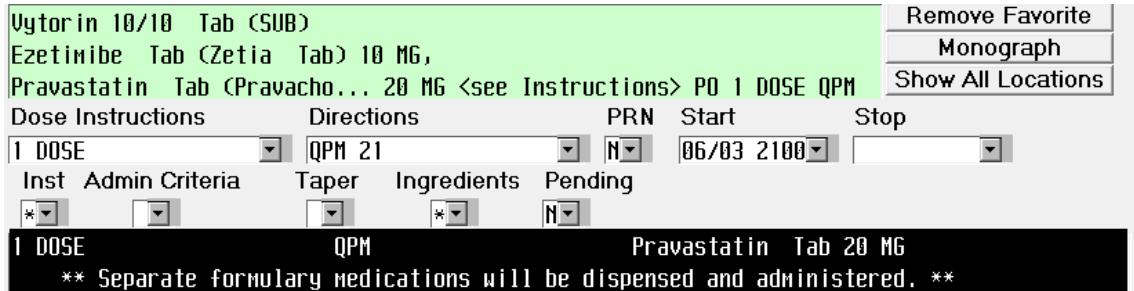
** This Medication is Non-Formulary! Pharmacy will Substitute. **

15	MG	BID
15	MG	DAILY
30	MG	BID
30	MG	DAILY

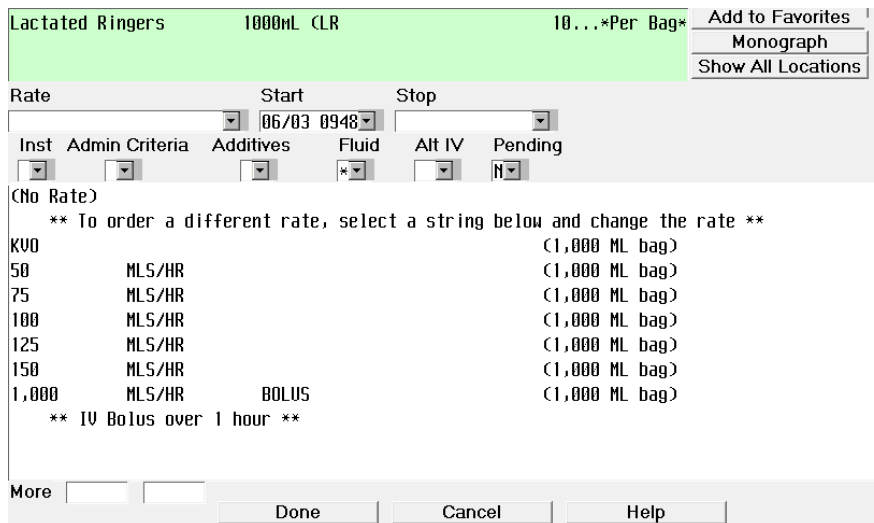
This is an example of the information contained in the 'Inst' drop down box.



Combination Medications - Combination medications may be provided separately instead of being a compound medication. When pharmacy is supplying separate medications, they are listed in the medication window as shown below.



IV Fluids – IV Fluids that contain medications are ordered under the 'Medications' tab. Plain IV Fluids are ordered under the 'Fluids' tab. Bolus' and continuous rates are entered as separate orders even when they are the same fluid.



When entering medications various items are adjustable. Items with a pop-down box can be changed or special instructions can be added in the 'Inst' box.

Status Board

Once orders have been entered, the nurse is notified of the order by a 'Flag' that appears on the Status Board to the right of the patients name.

Room/Bed		Patient Name		New	Dr	Res	OSA	RR	C	Med Due	Protocol
Temp	Loc	Age	Sex	Phy	Transfusion	MEWS	SPO2	HR	BP	Interv Due	
BB.313-A						Ack	Res	2	18	36.2	1554 Reass▶
								96	80	162/85	PRN
BB.314-A						Res		20	36.3	1700 HUMAL▶	
								96	91	139/76	PRN
BB.316-A						Res	No	18	36.6	1700 TOBRA▶	
								98	77	122/62	PRN
BB.317-A						Res	No	20	37.1	1700 MERRE▶	
								98	94	116/56	PRN
BB.328-A						Res	Yes	15			
								97	56	115/56	
BB.329-A						Ack	Res	No	19	36.7	1700 HUMAL▶
								96	85	112/64	PRN
BB.330-A						Stat	Res	No	22	36.4	1600 XOPEN▶
								95	104	164/81	PRN
BB.332-A						New	Res		20		1402 AUGME▶
3 FLR P▶								2	98	63	130/71

The Order Management Flags follow a hierarchy of importance and flags may be stacked if multiple flags are needed.

- Stat Stat order not yet acknowledged
- Unv Unverified order
- Ack New order not yet acknowledged
- Xfer Transfer order
- Unc Uncollected specimen order
- New New-to-user order, acknowledged

Acknowledging and Verifying Orders

To process a new order, begin by clicking the order flag on Status Board. Then we view the orders that are waiting to be acknowledged. We check the order or orders that we would like to acknowledge, and then we click the Ack/Ver button.

Acknowledging and Verifying Orders

To process a new order, begin by clicking the order flag on Status Board. Then we view the orders that are waiting to be acknowledged. Check the order or orders that need to be acknowledged and click the Ack/Ver button.

All Orders		Meds		Non-meds			
Order	Category	Src	Svc Dt/Tm	Pri	Event	Status	Event Dt/Tm
<input checked="" type="checkbox"/> DUONEB NEB SOLN	MED	E	10/10 1430	R	New	Active	10/10 1425
<input type="checkbox"/> RESPIRATORY VIRUS MU...	LAB	E	10/10 1514	R	New	Active	10/10 1514
<input type="checkbox"/> RT: Nebulizer Treatment RT.PHYS	E	E	10/10	R	New	Active	10/10 1425
<input type="checkbox"/> RT: Nebulizer Treatment RT.PHYS	E	E	10/10	R	New	Active	10/10 1425

****NEW ORDER****

Order Info	Instructions	Other Detail
Edit: STATUS CHANGE by Ali,Babiker MD on 10/10/18 @ 1430 (More...)		
RX: 00814578 ACTIVE		Start: 10/10/18 1430 Stop: 11/09/18 1431
DUONEB U/D (ALBUTEROL SULFATE/IPRATROPIUM 3 ML UDBOT) 3 ML INH RTQ4H PRN PRN (Daily @ RT- EVERY 4 HOURS AS NEEDED)		
PRN Reason: DYSPNEA		

Once we click the Ack/Ver button, we are brought to the Order Record screen where we can view additional details regarding the order. After reviewing the details, press F12 and confirm the order with “yes” or “no”. Clicking “yes” completes the acknowledgement process for a non-med order. Medication orders must be verified through pharmacy prior to administration to patient.

Category	MED.COCCB Procedure RT - RESPIRATORY MED	Status	ACT POE
Order No.	1010-0542	Pri	ROUTINE Qty
	Date	10/10/18	Time 1430 Order Source E - E
Signed by			
1	Ali,Babiker MD	10/10/18	1425
2			
Audit Trail			
6	10/10/18 1425 BBPHY.BA	RT: Nebulizer Treatment (RT.PHYS)	
7	10/10/18 1430 BBPHA.QT	VERIFIED in PHA	
RX: 00814578 DUON3AMP - Albuterol/Ipratrop Neb Soln (Duoneb Neb Soln) 3 ML UD START 10/10/2018 1430 STOP 11/09/2018 1431 TOTAL DOSES DOSE 3 (ML) ROUTE INH INHALATION SIG RTQ4H PRN Daily @ RT- EVERY 4 HOURS AS NEEDED SCH PRN			
↓	Admin Cr	Dose Inst	Taper Sch Comments PRN *

Transfer Process

When a Transfer order has been entered, the 'X-fer' flag will appear on the Status Board. The Transfer process is a two-step process which includes actions for the Sending Nurse and the Receiving Nurse. The Sending Nurse clicks the 'X-fer' flag, clicks 'Bypass Transfer Orders', reviews the details of the transfer order, and follows the acknowledgement process.

Room/Bed	Patient Name	MEWS	T	P	New Orders	Pin
Temp Loc	Age /S Srv.	LANG	R	BP	Next Med Time	New
	CPOE, JIMMIE	4	37.1	120	Xfer	
	57 F	ENG	48	98/22	PRN	Lab

Sending RN: Click Transfer Flag

Once report has been received, the Receiving Nurse should click the 'Receive' button. This will release the orders from the 'Transfer' process and allow other departments to process their orders. Example – medications will be sent to Pharmacy and lab orders will print in Lab. The Receiving Nurse can also Acknowledge the orders from the Status Board to release them.

The screenshot shows a software window titled "Acknowledge/Verify Single Patient" for patient "NUR-TEST, MAX - 39/M". It displays a list of orders with checkboxes, including NS, AZITHROMYCIN, ENOXAPARIN, ADMIT ORDER, Case Management, CHEST AP/PA & LATERAL, REGULAR, and CBC W/DIFF. A red callout box points to the "ACK/VER" button at the bottom of the window, with the text "Receiving nurse selects orders to 'acknowledge'". Another red callout box points to the "CBC W/DIFF" order in the list, with the text "Click Ack/Ver". The detailed view for the CBC W/DIFF order shows it is a LABORATORY procedure, ordered by DeBaun, J Alex MD, and signed on 05/09/13 at 1400.

Transfer orders are not activated until the Receiving Nurse either 'Receives' the patient or acknowledges the Transfer Orders. Remember: A delay in receipt of orders will cause a delay in patient medication being available.

Discharge Process

When a patient is being discharged, the 'Discharge' process must be completed. Click the 'Discharge' or 'Discharge Plan' button and complete all fields. You know you have completed all fields when the red fields have turned blue.

4 sections not complete	
- DISPOSITION	
Planned DC Date	Tuesday October 03, 2017
* DC Disposition	<input type="radio"/> 01 ROUTINE HOME/SELF CARE <input type="radio"/> 51 HOSPICE - MEDICAL FACILITY <input type="radio"/> 02 DISCH SHORT TERM GEN HOSP <input type="radio"/> 62 REHAB FACILITY/REHAB UNIT <input type="radio"/> 03 SNF MEDICARE CERT BED <input type="radio"/> 63 LONG TERM CARE HOSPITAL <input type="radio"/> 04 NON MEDICARE-CAID CE NH BED <input type="radio"/> 65 PSYCHIATRIC HOSP/HOSP UNIT <input type="radio"/> 06 DISCH C/O HOME HEALTH SERV <input type="radio"/> 70 DISCH ANOTHER TYPE FACILITY <input type="radio"/> 20 EXPIRED <input type="radio"/> Against Medical Advice <input type="radio"/> 50 HOSPICE - HOME Required
- DISCHARGE ASSESSMENTS	
* Assessments	<input checked="" type="checkbox"/> DISCHARGE INSTRUCTIONS Required
Forms	Custom forms
- ORDERS/MEDICATION	
* Discharge Order	Discharge Order Required
	<input type="button" value="Preview Pt Report"/> <input type="button" value="Print Packet"/> <input type="button" value="Print Sections"/> <input type="button" value="Finalize RX/Orders"/> <input type="button" value="Exit"/> <input type="button" value="Submit & Refresh"/> <input type="button" value="Submit & Exit"/>

The Discharge Order within the 'Discharge Plan' notifies the nurse that the patient needs to be discharged. This is not the order that notifies Registration that the patient has left the building.

Unconditional Discharge – the patient may be discharged as soon as the paperwork is completed. This will appear as a "STAT" order that the nurse will acknowledge. From there, the nurse will proceed with the normal discharge process.

- NOTE: Discharge Orders expire in 24 hours.

Discharge Order with Parameters - this order is used when the patient can be discharged ONLY after specified conditions have been met i.e. waiting for SNF placement, last dose of medications, lab results, or discharge from another physician.

Once the parameter or condition noted within the order has been met, the nurse either:

1. If the physician requested to be notified once condition is met, the nurse notifies the physician and gets an unconditional discharge order
- OR
2. If the physician did not request notification, the nurse enters a Ready for Discharge order.

Discharging Patients from Meditech

The Discharge Routine which discharges the patient from the computer can be done by the nurse or the HUC. From the Status Board, select 'Print Report', then 'Admission Menu', and choose either 'Discharge Patient', 'Discharge Observation Patient' or 'Discharge SCD Patient'. Once the required information is completed and the information is filed, the patient will be discharged from the computer and Environmental Services will be notified to clean the room.

The image shows two screenshots of the 'Discharge Inpatient' form in Meditech.
Page 1: Patient ID: 88000000290, Name: TEST, MARGUERITE, Birthdate: 10/03/87, Age: 31, Sex: F. Physicians listed are CPOEBB1 and CPOE ALLIANCE 1 (MD). Service: ICU INTENSIVE CARE. Unit #: 8800000028, Location: BB.MUE, Room: BB.999, Admit Date: 10/03/17, Admit Time: 1034. Discharge Date: 10/10/18. Discharge Disposition: WALGREENS49971A, Walgreens Drug Store 04692.
Page 2: Shows 'Delay Time:' and a section for 'If delay is over 2 hours, reason for the delay:'. A small 'Page' dialog box is open, showing 'Page 1' selected and a list of options: 1 Discharge Information, 2 Inpatient/Obs Discharge, F *** FILE ***.

Meditech Tracker

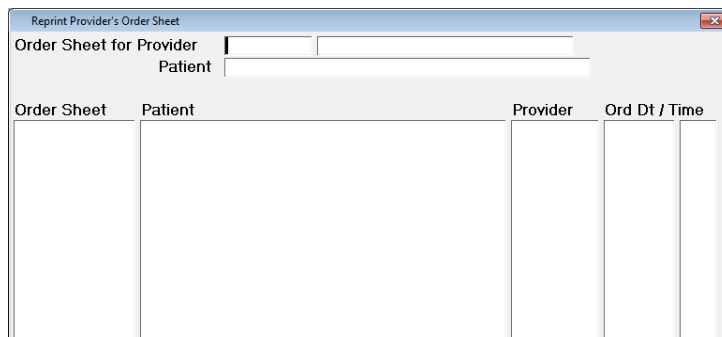
Unit Supervisors and Unit Clerks have access to the Order Entry Tracker. The Tracker can be used to follow orders that have been entered – Discharge Order, Change Attending, Transfer, etc. From the Status Board, click on the 'Print Report' button on right side of screen which will open a larger menu. Click 'Order Tracker'. 'All' is automatically populated into the location field but should be changed to desired viewing location. Type **BB.ADM** into the 'Dept. or Category' field.

The image shows the 'North Florida Division OE (ROAM) Tracker v4.0' interface.
Location(s)/Department(s)/Category(ies): Select Campus: [blank], Select Location(s): ALL, Dept. or Category: BB.ADM.
Shift Information: From Date: [blank], Time: [blank].
Select Only: Priority: [blank], Order Source: [blank].
Exclude: Status: Future Orders [checkbox].
ROAM Tracker Behaviour: Refresh Rate (in seconds): [blank], Secure Name Display? [checkbox], Interactive Session? [checkbox].
Show Proc(s): 200373, ADMS1, CHGATT, CHGSI, OCCOND, OBEOPT, OBREGER, UNCCOND.

Once the location and department fields are completed, a list of order types will populate the 'Show Proc(s)' field and the undesired order types can be deleted. Use the right arrow to view the reports. Once the reports are viewed, you MUST press the Enter key to exit the report.

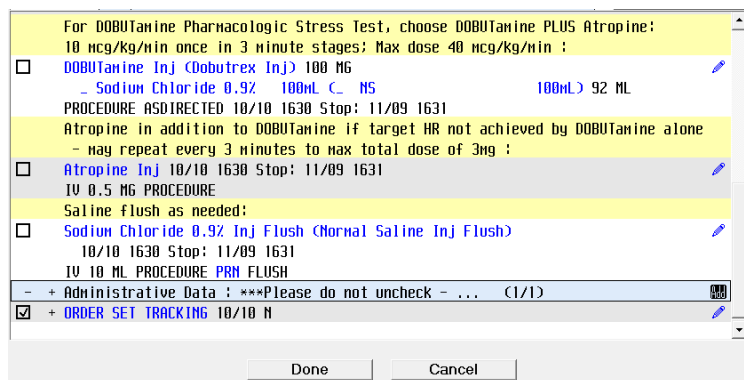
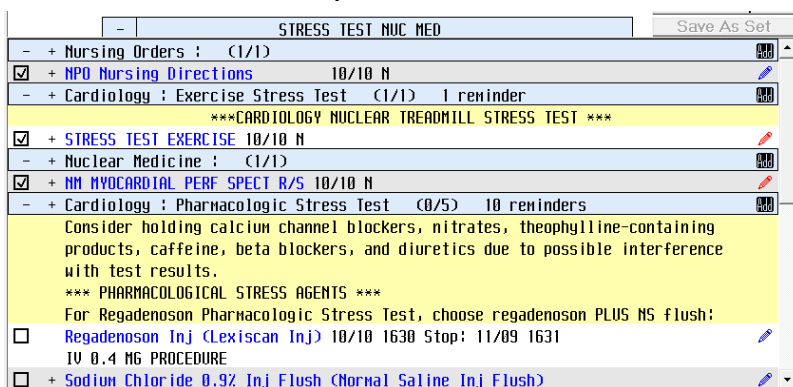
Print OM Order Session

If needed, patient's orders can be printed for viewing. From the Status Board, click the 'Print Order Session Sheets'. The 'Reprint Provider's Order Sheet' screen will open. Locate the patient by typing the patient's name, pressing F9, and select the correct patient. In the 'Order Sheet' field, press the F9 key and the orders will be listed in chronological order. If searching for a specific order, the date and time of entry or the provider's name must be known.



Stress Test

Stress tests are performed by the Nuclear Medicine department and is an order set. To order a stress test, type in 'Stress' and choose the correct order set. Please note the special instructions in the yellow boxes.

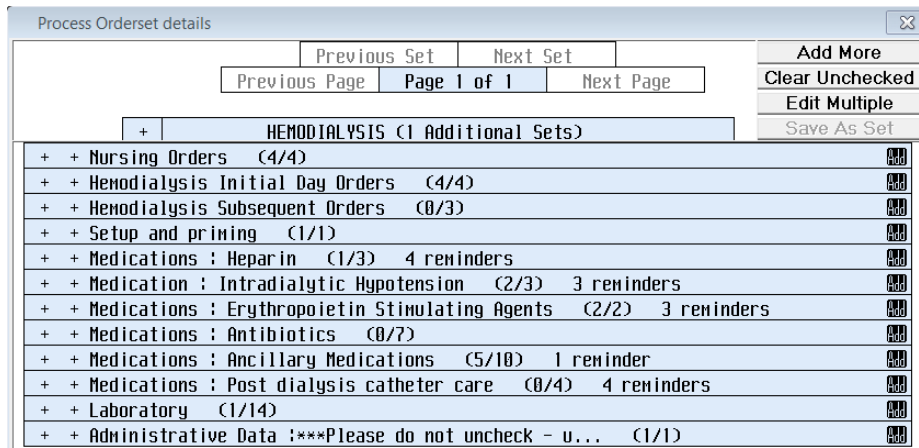


Patient Preparation:

- 1) NPO for at least 8 hrs. prior to test for morning studies and NPO after light breakfast without caffeine for PM studies.
- 2) Physician should specify on the order sheet what meds to hold (usually Beta Blockers).
- 3) Nuclear Med and the Stress Lab need to know the height and weight of the patient beforehand to determine how they will, or whether they can perform the test.

Process for Ordering Dialysis

Dialysis is ordered using the Hemodialysis Order Set. Under 'Order Set' type Hemodialysis and select the hemodialysis order set. Complete required information and 'Submit' the orders.



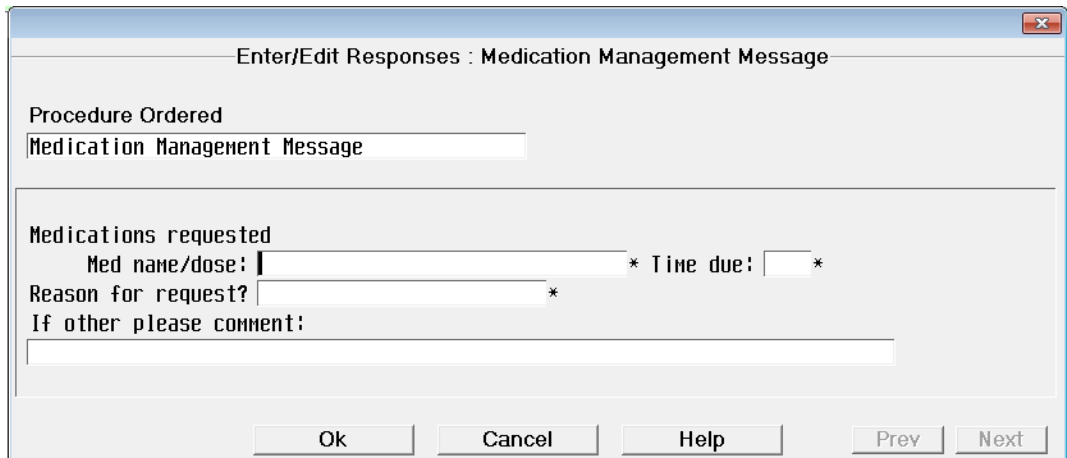
The screenshot shows a window titled "Process Orderset details" with a close button in the top right. Below the title bar are navigation buttons: "Previous Set", "Next Set", "Previous Page", "Page 1 of 1", and "Next Page". To the right of these are buttons: "Add More", "Clear Unchecked", "Edit Multiple", and "Save As Set". Below the navigation is a header row: "+ HEMODIALYSIS (1 Additional Sets)". The main area contains a list of order sets, each with a plus sign, a name, a count in parentheses, and a reminder icon:

Order Set Name	Count	Reminders
Nursing Orders	(4/4)	
Hemodialysis Initial Day Orders	(4/4)	
Hemodialysis Subsequent Orders	(0/3)	
Setup and priming	(1/1)	
Medications : Heparin	(1/3)	4 reminders
Medication : Intradialytic Hypotension	(2/3)	3 reminders
Medications : Erythropoietin Stimulating Agents	(2/2)	3 reminders
Medications : Antibiotics	(0/7)	
Medications : Ancillary Medications	(5/10)	1 reminder
Medications : Post dialysis catheter care	(0/4)	4 reminders
Laboratory	(1/14)	
Administrative Data :***Please do not uncheck - u...	(1/1)	

When you FILE the order, the request will print automatically in the Dialysis Department.

Missing Medication Management

To notify Pharmacy of a missing medication, use the '**Medication Management Message**' order. While you have to list the primary physician to place this order, the physician does not need to sign this order and the ordering source should be 'Department Process'. Complete all required fields and 'Submit'.



The screenshot shows a dialog box titled "Enter/Edit Responses : Medication Management Message". It contains the following fields and buttons:

- Procedure Ordered: Medication Management Message
- Medications requested: Med name/dose: [] * Time due: [] *
- Reason for request? [] *
- If other please comment: []
- Buttons: Ok, Cancel, Help, Prev, Next

Documentation of IV Infusion Stop Times

To document an IV Infusion Stop Time, select the patient and access the patient's EMAR.

1. Select the medication to document the IV Infusion Stop Time
2. Click on the GREY infusion Start time.

A	Start	Medication	Sched Time	Today		
				Tue	Wed	Thu
✓	Stop					
	Status	Route Schedule		06/23	06/24	06/25
A	06/22/15 1700	KC1 20MEQ in D5w/NaCl 0.9% 20... IV 5XD	0600	0600	0600	0600
	07/22/15 1659	D5ns/Pot Ch... (1,000 mls @ 100 mls/hr)	0900	0900	0900	0900
	Active	...	1300	1444	1300	1300
			1700	1700	1700	1700
			2100	2100	2100	2100

Click on a medication that was given by others, then click the "Document" button on the bottom

3. Confirm the medication at the top of the "Edit Undo Document RX" screen.
4. Enter the date and time into the "Infusion Complete" field. (NOTE: If a Complete Date/Time is pre-calculated, the Infusion Complete date / time fields will default that date and time.)
5. Confirm the correct infusion completion date and time has been entered.
6. Click on the "Edit Infusion" button, this will complete the documentation session.

Edit Undo Document Rx # 00000368

KC1 20MEQ in D5w/NaCl 0.9% 20... IV 5XD

Non-Scheduled

Scheduled

06/23/15-1300

Given

Not Given

DOWNTIME

Administration
06/23/15 1444

Volume
1,000

Units
MLS

User
C.NT.PSS

Text

Site
IV

Infusion Complete 06/24/15 0900

Edit Infusion

Undo

Cancel

PCA Documentation

It is mandatory that all PCA Pump totals are documented in the patients EMAR every 12 hours at 0600 and 1800 AND when the caregiver changes i.e. PACU gives report to Med/Surg nurse until the PCA Pump is discontinued. The Controlled Substance Handoff intervention is used to document the PCA. Two nurses must verify the information on the PCA pump and complete the Controlled Substance Handoff intervention documentation in Meditech. Complete all fields in the Controlled Substance Handoff intervention on both pages.

Controlled Substance Handoff 10/11 1128 BB0000745908 CPOE,JIMMMIE

Amount infused ml:

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

Medication:

Device:

Infusion status:

Medication time total:

Medication bolus ml:

Number of PCA/PCEA attempts:

Number of PCA/PCEA injections:

Amount infused ml:

Amount handoff ml:

Cosign:

Password:

(Next Page)

Controlled Substance Handoff 10/11 1128 BB0000745908 CPOE,JIMMMIE

Controlled substance comment:

Enter free text

Sensation level:

Motor strength:

Controlled substance side effects:

Assess pain:

Assess vitals:

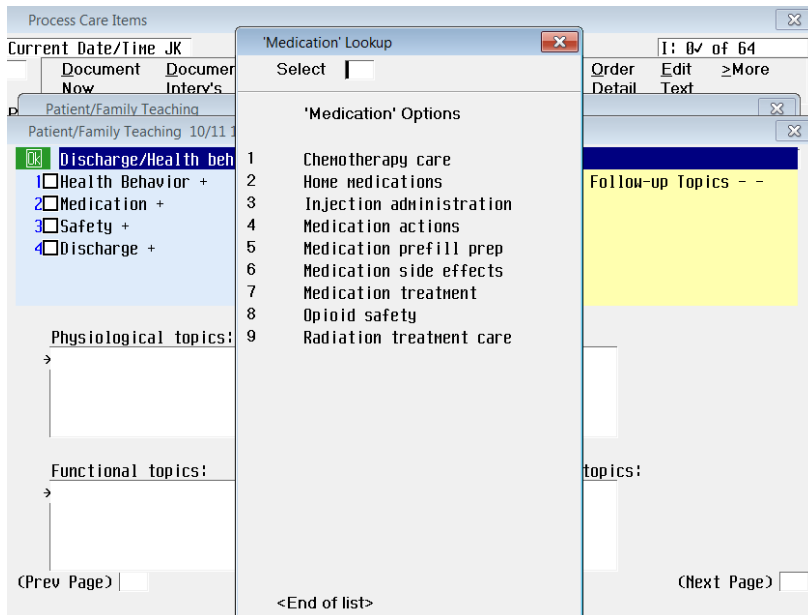
Enter/Edit RASS/Cam:

Controlled substance comment:

(Prev Page)

(End)

Remember to document the PCA Pump education within the Teach/Educate intervention.



CARE PLANS

Care Plans should be updated every shift to reflect the patient's needs. Choose 3-4 problems or goals to work on each shift for your patient. Select your patient from the Status Board and click on Process Interventions. Highlight Plan of Care and click DN (Document Now) or DI (Document Intervention).

Care Items	Sts	Directions	OD	Doc	Src	D	C/N	KI	Prt
Plan of Care									
-Plan of Care +	A				PC				
-Plan of Care +	A				CP				
Health Behavior Problems									
-Fall Risk	A				PS				
PT/OT/ST/Rehab									

Choose the applicable category: Physiological, Psychological, Functional, or Health behavior. Select the sub category. After choosing 3-4 problems, click End. If you are continuing a problem(s) entered by a previous nurse, then click End and update the information on the next screen.

If the problem is new for this patient you will need to complete the expected to field and the target date. If this problem is being continued, update the expected to field and the target date and you will document whether the problem is improving, stabilizing or deteriorating.

If the problem has resolved, then complete the problem has field as either Resolved, Stabilized, or deteriorated.

RESTRAINTS

Two nurses must verify that all alternative measures have been attempted and that the patient would be safer in restraints. Contact the physician and get a restraint order. The Restraint documentation is located within the Safety/Risk/Regulatory intervention. Select Yes next to Assess restraints and enter.

Safety/Risk/Regulatory 10/11 1201 BB0000745908 CPOE,JIMMIE

Assess Broset violence screening:

1 Yes

Isolation status: Contact *

Assess sepsis:

Assess vaccines:

Assess adult skin risk:

Assess pediatric skin risk:

Assess fall risk:

Assess suicide:

Assess restraints: Yes

Assess Broset violence screening:

Assess trauma alcohol screening (CAGE):

Assess stroke depression screening:

(End)

There are 4 pages. Complete all applicable fields.

Restraint Documentation 10/11 1201 BB0000745908 CPOE,JIMMIE

Restraint status:

1 Start

2 Second tier review

3 Face to face

4 Monitor/RN assess

5 Safety/Rights/Dignity

6 Discontinue

Document second tier once per restraint episode.

----- No previous documentation found. -----

Restraint status: *

Clinical justification: *

Alternatives utilized: *

Level of restraint:

Non-violent restraint device:

Violent restraint device:

Date restraints initiated: *

Time restraints initiated: *

(Next Page)

***** Before the 'Application date & time of restraints' can be documented, the '2nd Tier Review' has to be documented by the nurse that verified the need for restraints. *****

***** All restraints are reported to CMS. The Application date & time and the discontinuation date & time MUST be documented *****

Safety/Rights/Dignity maintained verified is to be completed three times per hour if under continuous audio, video or in-person observation (e.g. ICU) or every 15 minutes if not being monitored via audio, video or in ICU. Per current policy (2017), Safety/Rights/ Dignity checks can be charted as one entry at the end of the shift or when restraints are discontinued.

Safety/rights/dignity verified									
1	Done now	Three times an hour is for patients under continuous audio, video or in-person observation (e.g., ICU).							
2	Three times every hour								
3	Every 15 minutes per hour	To be documented at the end of the shift.							
Last 5 Documentation History Entries (Past 7 days)									
Date	Time	Alt Util	2nd Tier	Applicat	Face2Face	Safe/Right	Sts Mon	RN Assess	Debrief
07/11	0817	Yes	Yes	Yes		Done now	Yes		
07/12	1232		Yes						
07/12	1232							Yes	
07/12	1239		Yes						

Patients in restraints are required to be assessed by a Registered Nurse a minimum of every 2 hours. The nurse will use the 'Document restraints status monitor' to chart their restraint assessment including but not limited to:

Restraint Documentation 10/11 1201 BB0000745908 CPOE,JIMMIE

Vital signs taken per unit policy or doctors orders: - Monitor/RN assess -

1 Yes Click below to

2 No default system normal values

DFT Norms

DFT Norms (Go to File)

Vital signs taken per unit policy or doctors orders: *

Free from injury or pain associated with restraint: *

Free from respiratory/airway compromise associated with restraint: *

Skin under/around restraint verified (when applicable): *

Range of motion done: *

Circulation distal to restraint verified (when applicable): *

Offered nutrition/hydration: *

Offered comfort measures: *

No cognitive changes: *

Least restrictive restraint in use: *

Meets criteria for release: *

(Prev Page) (Next Page)

Document RN assess/discontinue is used when the restraints are being discontinued. Complete all fields especially the discontinuation date and time. .

Restraint Documentation 10/11 1239 BB0000745908 CPOEJIMMMIE

Restraint status:

- 1 Start
- 2 Second tier review
- 3 Face to face
- 4 Monitor/RN assess
- 5 Safety/Rights/Dignity
- 6 Discontinue

Document second tier once per restraint episode.

Click box to display previous status documentation ->

Restraint status:>Discontin*

Clinical justification:>Attempts self-harm*

Alternatives utilized:>1:1 discussion*

Level of restraint:>Violent/self-destructive

Non-violent restraint device:

Violent restraint device:>Geri-chair*

Date restraints initiated:>10/11/18*

Time restraints initiated:>1239*

(Next Page)

Restraint Documentation 10/11 1239 BB0000745908 CPOEJIMMMIE

Criteria for restraint release met:

- 1 Yes
- 2 No

Criteria for restraint release met:>*

Date restraint discontinued:>*

Time restraint discontinued:>*

Document violent/SO debriefing:>*

(Prev Page)

(End)

Violent restraints require a 'Face-to-face' assessment be completed within one hour' by the physician.

Critical Values

When you receive a Critical Value from the lab, the Critical Value, whether or not the Physician was Notification and the outcome of the call must be documented in Meditech. In Process Interventions, highlight Manage/Refer/Contact/Notify intervention.

Manage Refer Contact Notify 10/11 1243 BB0000745908 CPOEJIMMMIE

Chain of command contact name:

1 2 3 4 5 6 7 8 9 0 Del

Q W E R T Y U I O P \

A S D F G H J K L

Z X C V B N M , . Lookup

Action:>Notified

Reason notified:>Critical value

Entity attempted/notified:>

Provider attempted/notified:>CPOEBBT CPOE ALLIANCE I CHO

Sepsis notification:

PEIS concerning event:

Family member notified:

Chain of command contact name:>

(Next Pa

Manage Refer Contact Notify 10/11 1243 BB0000745908 CPOEJIMMMIE

Value(s) read back and verified by provider:

- 1 Yes
- 2 No

Other notification comments:

Critical value(s) received from:>*

Value(s) read back and verified:>Yes*

Critical value(s) called to provider:>Yes*

Value(s) read back and verified by provider:>Yes*

(Prev Page)

(Next Page)

Manage Refer Contact Notify 10/11 1243 BB0000745908 CPOEJIMMMIE

Critical value(s) comment:

Enter free text

Critical value(s) comment:>document the values you reported to the physician*

(Prev Page)

(End)

Foley

All catheter orders must be entered in Meditech. When a catheter is ordered, two additional orders will reflex or add to the Foley order. Foley and CAUTI: Prevention are prechecked but Do Not Remove Foley is not checked.

Orders	Pri	Start/Service	Series	Directions	Qty	Details
<input checked="" type="checkbox"/> Foley ...		07/17 Now				Req
<input checked="" type="checkbox"/> CAUTI: Prevention Protocol ...		07/17 Now				Avail
<input type="checkbox"/> Do Not Remove Foley:Call Pr...		07/17 Now				

Click the **REQ** and complete the information.

Catheters insertion, Daily Care and Removal must be charted in Meditech using the Lines/Drains/Airways Intervention. Select Drains, select the type of drain, and complete the fields.

Urinary Catheter 10/11 1331 BB0000745908 CPOE,JIMMIE

Urinary catheter type:

- 1 Temporary/indwelling
- 2 Permanent/indwelling
- 3 External/condom
- 4 Straight

Urinary catheter type: *

Insertion/applied date: *

Insertion/applied time: *

Indication for urinary catheter: *

Other provider indication:

Urinary catheter status:

(Next Page)

Complete all information within the screen that applies to the process performed. When the insertion date and time are charted, Meditech will calculate the number of days the patient has had the catheter. Unless you have a DO NOT REMOVE order, an indwelling catheter should be removed per unit protocol and as soon as possible.

CVC

Documentation for a CVC line is completed using the Lines/Drains/Airway intervention. Select Lines and then choose the type of Line to document. Complete all fields.

HIE

HIE or Health Information Management allows the user to access a patient's medical records from all other HCA facilities. Select the patient from the Status Board and click the Magic Key icon and select Magic Key Meu. HIE Clinical Viewer is #18.

Date	Allergy To	Reaction	Facility	Severity
4/19/2017	Preservatives ...	HIVES	COCMCB	Moderate
4/19/2017	Soy (Soybean)	MIGRAINE	COCMCB	Moderate
6/12/2017	Sulfonamides	UNKNOWN	COCMCB	Moderate
5/8/2017	Penicillins	HIVES	COCMCB	Mild

Admission Date	Type	Facility	Attending
4/18/2017	pre-admission	COCMCB	CPOE ALLIAN...

Collected	Test	Specimen	Facility
7/5/2017 06:46	BASIC METABOL...		COCMCB

OCURRENCE REPORTS

To enter an Occurrence Report, you will need to access the MOX Module instead of the Nursing Module. Occurrence Report is #60. There are 3 options: Employee Occurrence, Patient Occurrence Reports, and Non-Patient Occurrence Reports. Enter the number for the appropriate report and then sue 11. Enter/Edit. You will need the patient's name, gender, and DOB.

Enter/Edit Patient Notification

Patient CPOE, JIMMIE Acct No. Sex Age

Pt Status Admitted LOS Unit No. DRG Att Phys Notif No. Notif Type Event Dt

Notification Type

Search

Sex F Birthdate 120359

The Occurrence Report module uses right and left arrows in many places instead of using the Enter key. After verifying the patient's information, right arrow.

Master Patient Index Search

2. Exact Name Match
CPOE, JIMMIE 12/03/59 F

Unit #	Name	B'Date	SXMN	Last Visit
1	BB00258873 CPOE, JIMMIE	12/03/59	F	

<End of list>

See More Data For

404 HAPPY LANE, HAPPY TOWN, TX, 76177 PH #: 222-333-3333
SS #: MAIDEN/OTHER NAME:
COMMENTS:
VISITS: 04/18/17 BB0000745908 PRE IN BB.MUE CPOEBB1 Res Date: 04/18/17

If you want to enter a new occurrence report, click Yes and select the Notification type from the list provided.


Enter/Edit Patient Notification

Patient Acct No. Sex Age

Pt Status Yes/No Confirmation

Notification Type

Event Dt

 No available notifications for this patient. Create a NEW one?

Notification Type Lookup

Select

	Mnemonic	Name
1	MED EVNTz	MEDICATION EVENT
2	hcaBEHAUR	Behavioral Issue
3	hcaBLOOD	Blood Administration
4	hcaCOMPCND	Treatment or Medical Comp
5	hcaCOMPLNT	Complaint / Privacy Issue
6	hcaDIAGNOS	Diagnostic
7	hcaEQUIP	Equipment / Device
8	hcaFALL	FALL
9	hcaHAI	Infection Prevention Issues
10	hcaINJURY	Patient Injury/Non-Procedural
11	hcaPERINTL	Perinatal
12	hcaPROCED	Invasive Procedure
13	hcaPROPSEC	Property or Security

Complete the information on all screens, making sure you add your manager and director to the notification list at the end. Once complete F12 or File. Reminder: F9 is the Lookup key.

SCANNING MEDICATIONS

All medications should be scanned into Meditech prior to administering. The medication should be scanned and given at the patient's bedside. . Once the pharmacy has verified the medication order, the medication will be listed on the patient's EMAR.

After logging into Meditech and selecting your patient from the Status Board, click the eMAR button. The patient's medication profile will display.

You can click on the medication name to expand the information. Make sure to read the directions.

RED = medication or pain assessment is late.
 Indicates that the pain reassessment is late.

Medication will move to the top of the list and highlight green 30 minutes prior to scheduled time.

Times that are light gray = medication was given at the time noted.

Dark gray highlight = medication not given and reason was documented

Start	Stop	Status	Route	Medication	Sched Time	Wed
08/01/17 1630	08/11/17 1631	Active		Norco 5/32... 1 tab PO Q4H PRN (PAIN... Hydrocodone Bi... (Give 1 TAB of 1 tab) *** High Risk Alert ***...	0853 0459 1000 1408 2042	0819
08/03/17 0930	08/03/17 1400	Active		Vancomycin Trough 1 MISC 0930 PHA: Vanco Trough (Give) Draw Vancomycin Trough pr		0930
08/01/17 1800	08/15/17 1759	Active		Vancomycin 1,500 mg in Sc VANCOMYCIN HC... (250 mL) Call Pharmacy if Vanco Trough < -15...	0222 1003 1914	0211 1000 1800
08/01/17 1700	08/31/17 1701	Active		Humalog 3ML Vial SUBQ AC Lispro 100 Units/H... (See Dose Instr)	0800 1130 1630	1009 1230 1630

Always verify the 5 Medication Rights – right medication, right patient, right time, right route, & right dose. At the patient's bedside, scan the patient's armband and then scan the barcode on the medication package prior to giving the medication. Once you have verified the 5 rights and the computer has confirmed the information, you can educate the patient about the medication and correctly administer the medication to the patient.

Blood Administration

Verify that you have an order for blood products and there is a medical reason for the patient to receive blood. BCTA or Barcoded Transfusion Administration is our method of documentation for blood transfusions. The Blood Transfusion must be started within 30 minutes of getting it from the Blood Bank so you should have all supplies ready to start the transfusion before getting the blood. Before going to the Blood Bank to pick up the blood, complete the BCTA Pre-Issue Checklist. The checklist will be under Process Intervention.

The screenshot shows a software window titled "BCTA Pre-issue checklist 10/11 1344" with a patient ID "BB0000745908" and user "CPOE,JIMMIE". A dropdown menu is open, showing three options: "1 Yes", "2 No", and "3 Ord verif'd/med necessity". Below the menu, there are several input fields for the checklist items: "Physician order verified/patient consent signed:", "Armband(s) on patient verified:", "Previous history of transfusion reactions reviewed:", "Pre-meds verified and available:", "Pre-transfusion vital signs reviewed:", "IV patency and gauge appropriate:", and "Blood transfusion equipment available:". Each field has a corresponding input box. At the bottom right, there is an "(End)" button.

A 'Ready' indicator will appear on the Status Board when blood is ready to be dispensed. After completing the BCTA Pre-Issue Checklist, take a patient label to the Blood Bank to pick up the blood. The Blood Bank will have you verify the patient information before dispensing blood.


*****DO NOT REMOVE THE UNIT HANG TAG. IT MUST REMAIN ON THE BLOOD UNTIL THE TRANSFUSION IS COMPLETED *****

Once the blood has been issued, the transfusion must start within 30 minutes. Once at the bedside, two nurses must verify the blood, complete and sign the hangtag. The Transfusion button will be used for documentation pertaining to the transfusion. Once the blood has been verified by 2 nurses, click the Transfusions button on the the Status Board. A new screen will appear and if the patient had prior transfusions that information will appear. Please note the 30 clock that started at the time of the blood was issued.

ORIENTATION, ONE Blood Type: A POSITIVE
 DOB: 01/01/80
 Patient Markers:

Lot # Cosign Begin User
 Instr Assoc Data * React End User
 Last VS Next VS

Product	Unit #	Expiration	Unit Type	Status
Packed Cells LR	W200215187072	10/09/15 2359	A P05	Issued



More


Special Instr	Assoc Data	View Checklist	Document	Reactions
Verify	Begin	End	Hold	Resume

Document vital signs prior to the transfusion. Click the Document button at the bottom of the screen. Click the Verify button to record the verification of the blood. To verify, scan each item in order and a check mark will appear next to the item.

ORIENTATION, ONE Blood Type: A POSITIVE
 DOB: 01/01/80
 Patient Markers:

Lot # Cosign Begin User
 Instr Assoc Data * React End User
 Last VS Next VS

Product	Unit #	Expiration	Unit Type	Status
Packed Cells LR	W200215187072	10/09/15 2359	A P05	Issued



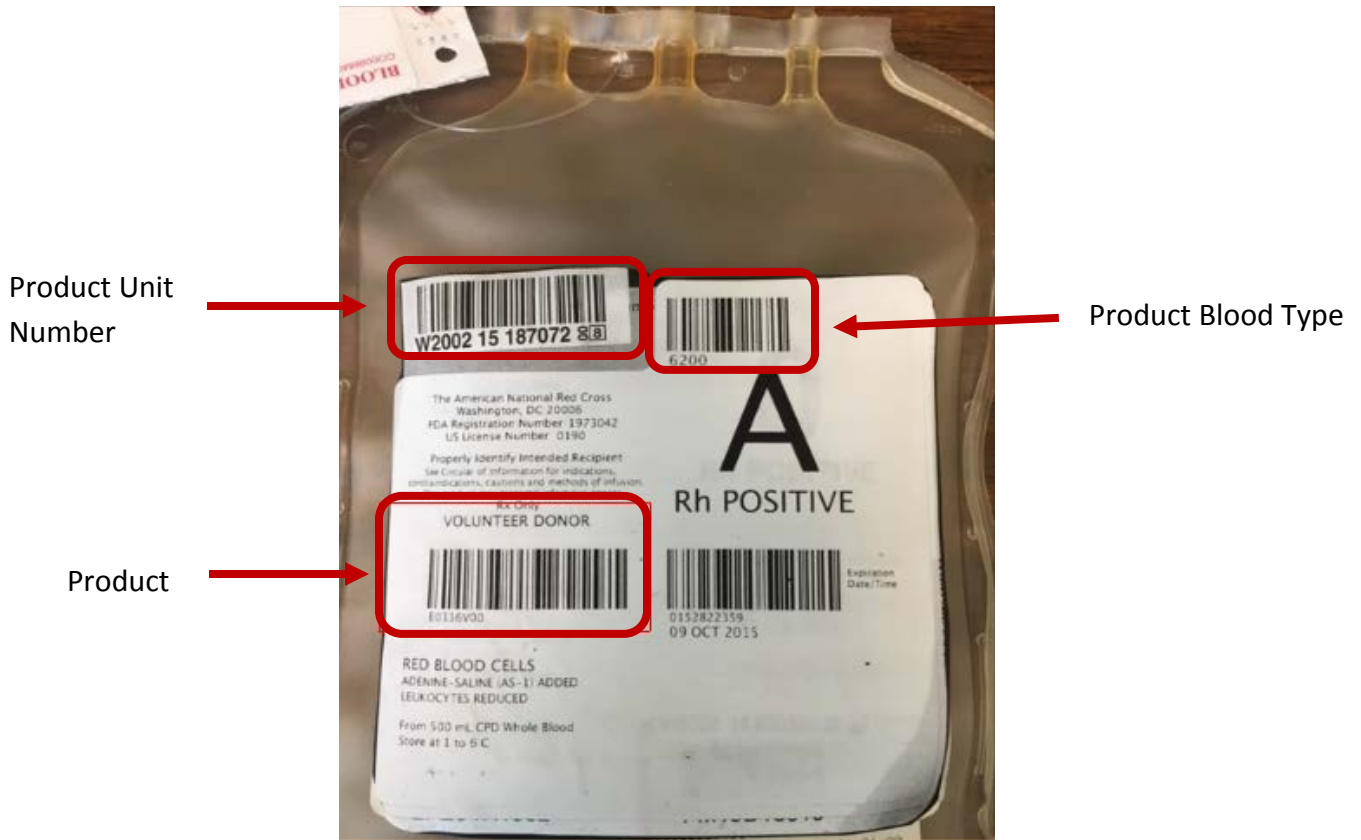
More

Special Instr	Assoc Data	View Checklist	Document	Reactions
Verify	Begin	End	Hold	Resume

Scan Bar Codes (1 of 6)

- Patient Wristband
- Blood Bank Wristband
- Product Unit Number
- Product
- Source Registration Number
- Product Blood Type

Scan Patient Wristband Now



Once the blood is verified, the transfusion can begin. Use the Begin button to document the start date and time that the transfusion is started. Note that the status of the blood has changed from Issued to Transfusing.

ORIENTATION, ONE Blood Type: A POSITIVE
DOB: 01/01/80
Patient Markers:

Lot # Cosign Begin 09/18 1235 User MILLER, DEBRA
Instr Assoc Data React End User
Last VS Next VS

Product	Unit #	Expiration	Unit Type	Status
Packed Cells LR	W200215187072	10/09/15 2359	A POS	Transfusing

More

Special Instr Assoc Data View Checklist Document Reactions
Verify Begin End Hold Resume

Once the transfusion has begun, other documentation key are active at the bottom of the screen. Make sure to “End” the transfusion when it is complete. Remove the hangtag from the blood bag. Complete the hangtag, place the top copy in the patient’s chart and return the bottom copy to the Blood Bank.

Thank you