



Electronic Documentation (eDoc)



USER MANUAL

August 2008

Table of Contents

SECTION I. WHAT IS MEDITECH?	1
1.01 EDOC - NURSING AND ALLIED HEALTH DOCUMENTATION	1
1.02 PCI - PATIENT CARE INFORMATION	1
1.03 ACCESS	1
1.04 CONFIDENTIALITY	1
1.05 SIGNING INTO MEDITECH	2
SECTION II. NUI – NEW USER INTERFACE	3
2.01 WHAT’S DIFFERENT ABOUT NUI?	3
2.02 USING THE MOUSE	3
SECTION III. MOVING AROUND WITHIN NUI TOOLBAR	4
SECTION IV. DOCUMENTATION	5
4.01 PURPOSES OF DOCUMENTATION.....	5
4.02 REQUIREMENTS OF DOCUMENTATION.....	5
4.03 KEY COMPONENTS OF DOCUMENTATION	5
4.04 METHODOLOGY.....	5
SECTION V. STATUS BOARD	7
5.01 STATUS BOARD - KEY POINTS	7
5.02 HOW TO USE THE STATUS BOARD	8
5.03 STATUS BOARD HEADERS	8
5.04 STATUS BOARD BUTTONS	9
5.05 LOCATION.....	9
5.06 FIND PATIENT	9
5.07 MANAGE LIST – ADDING PATIENTS AND ROOMS.....	10
5.08 MANAGE LIST – REMOVING PATIENTS/ROOMS.....	11
5.09 STATUS BOARD OPTIONS	12
5.10 STATUS BOARD/PROCESS FLOWSHEET DESKTOP BUTTONS	13
5.11 NAVIGATING ON THE STATUS BOARD - SORTING	14
5.12 VIEWING MORE INFORMATION	15
5.13 PATIENT NAMES.....	16
5.14 PATIENT NAMES – MORE THAN 11 PATIENTS	17
5.15 PATIENT NAMES – MORE COLUMNS TO VIEW	17
5.16 STATUS BOARD RESULT INDICATORS	18
5.17 RESULT INDICATORS - KEY POINTS	18
5.18 DEPARTMENTAL REPORTS - KEY POINTS	19
5.19 ORDER INDICATORS - KEY POINTS	19
5.20 ACKNOWLEDGING ORDERS - KEY POINTS	19
5.21 HOW TO ACKNOWLEDGE ORDERS.....	20
5.22 ORDER COLUMN.....	21
5.23 DOCUMENTING INTERVENTIONS FROM THE STATUS BOARD	21
5.24 HOW TO DOCUMENT FROM THE STATUS BOARD	22
5.25 TIME PERIOD	23
5.26 PROCESS INTERVENTIONS	24
SECTION VI. PLAN OF CARE	24
6.01 ADMISSION INTERVENTION SETS - KEY POINTS	24
6.02 HOW TO ADD ADMISSION INTERVENTION SETS.....	25
6.03 ADMISSION ASSESSMENTS - KEY POINTS	26

6.04	ADDING ASSESSMENT INDICATORS/OUTCOMES - KEY POINTS	26
6.05	HOW TO ADD INDICATORS/OUTCOMES	26
6.06	VIEWING THE CARE PLAN - KEY POINTS	27
6.07	DOCUMENTING INDICATORS/OUTCOMES - KEY POINTS.....	27
6.08	HOW TO DOCUMENT INDICATORS/OUTCOMES	27
SECTION VII. ADMIN DATA SCREEN.....		27
7.01	ADMINISTRATIVE DATA SCREEN – KEY POINTS	27
7.02	HOW TO ENTER DATA IN THE ADMINISTRATIVE DATA SCREEN.....	28
SECTION VIII. PROCESS INTERVENTIONS		29
8.01	PROCESS INTERVENTIONS - KEY POINTS	29
8.02	NAVIGATING THE PROCESS INTERVENTIONS SCREEN.....	30
8.03	VERB STRIP FUNCTIONS	31
8.04	AI: ADD INTERVENTION - KEY POINTS	31
8.05	INTERVENTION DESCRIPTIONS – KEY POINTS.....	32
8.06	HOW TO ADD INTERVENTIONS	33
8.07	USING THE WILDCARD LOOKUP TO SELECT AN INTERVENTION	33
8.08	ADDING INTERVENTION SETS	34
8.09	CD: CHANGE DIRECTIONS - KEY POINTS	35
8.10	HOW TO CHANGE DIRECTIONS.....	35
8.11	FIXED DIRECTIONS	36
8.12	CL: CHANGE LEVEL - KEY POINTS.....	36
8.13	HOW TO CHANGE LEVELS	37
8.14	CS: CHANGE STATUS – KEY POINTS.....	37
8.15	HOW TO CHANGE INTERVENTION STATUS	37
8.16	DI: DOCUMENT INTERVENTIONS – KEY POINTS	38
8.17	HOW TO DOCUMENT INTERVENTIONS	38
8.18	DOCUMENTING MULTIPLE OCCURRENCES OF THE SAME INTERVENTION.....	39
8.19	DOCUMENTING MULTIPLE INTERVENTIONS FOR THE SAME DATE/TIME.....	39
8.20	DN: DOCUMENT NOW - KEY POINTS.....	40
8.21	HOW TO DOCUMENT NOW	40
8.22	EA: EDIT ADMIN DATA - KEY POINTS	40
8.23	HOW TO EDIT ADMIN DATA	41
8.24	EO: ENTER ORDERS - KEY POINTS.....	41
8.25	HOW TO ENTER ORDERS	41
8.26	ET: EDIT TEXT - KEY POINTS.....	41
8.27	HOW TO EDIT TEXT.....	41
8.28	VP: VIEW PROTOCOL - KEY POINTS.....	42
8.29	HOW TO VIEW PROTOCOL	42
8.30	SI: SELECT INTERVENTION - KEY POINTS.....	42
8.31	HOW TO SELECT INTERVENTIONS.....	42
8.32	PROCESS INTERVENTIONS BY LOCATION - KEY POINTS	43
8.33	HOW TO DOCUMENT INTERVENTIONS BY LOCATION.....	43
8.34	WORKLOAD MEASUREMENT – KEY POINTS	43
8.35	HOW TO TEMPORARILY LOCATE	44
SECTION IX. VIEW HISTORY.....		44
9.01	VH: VIEW HISTORY – KEY POINTS.....	44
9.02	E: EDIT DOCUMENTATION – KEY POINTS.....	45
9.03	HOW TO EDIT DOCUMENTATION	45
9.04	U: UNDO – KEY POINTS	45
9.05	HOW TO UNDO DOCUMENTATION	45

SECTION X. PATIENT NOTES	46
10.01 PATIENT NOTE - KEY POINTS	46
10.02 HOW TO ENTER PATIENT NOTES	46
10.03 CANNED TEXT - KEY POINTS	47
10.04 HOW TO USE CANNED TEXT	47
10.05 AMEND EXISTING NOTES - KEY POINTS.....	48
10.06 HOW TO AMEND EXISTING NOTES	48
10.07 UNDO NOTES - KEY POINTS	49
10.08 HOW TO UNDO NOTES	49
10.09 VIEW EXISTING NOTES - KEY POINTS.....	49
10.10 HOW TO VIEW EXISTING NOTES	50
10.11 VIEW UNDONE NOTES	50
SECTION XI. PROCESS FLOWSHEET	51
11.01 SECTIONS - KEY POINTS	51
11.02 HOW TO USE SECTIONS.....	51
11.03 SECTIONS.....	52
11.04 GRAPH.....	52
11.05 TIME PERIOD	53
SECTION XII. PCI	54
12.01 PCI - KEY POINTS	54
SECTION XIII. FLOW OF INFORMATION WITHIN EDOC/PCI	54
SECTION XIV. PRINTING.....	56
SECTION XV. DOWNTIME	56
SECTION XVI. QUESTIONS	57

Section I. WHAT IS MEDITECH?

 **Meditech is the Hospital Information System**


 **Meditech is comprised of different modules that integrate information from one to another – these include:**

- **Documentation (eDoc)**
- **Radiology (RAD)**
- **Lab (LAB)**
- **Pharmacy (PHA)**
- **Admissions (ADM)**
- **Order Entry (OE)**


1.01 eDoc - Nursing and Allied Health Documentation


 “ Enter the Clinical Data Electronically”

1.02 PCI - Patient Care Information


 “ View the Clinical Data “



1.03 Access


 In order to access the information to document and/or view, you need a confidential electronic password



 Your electronic password for documenting in Meditech is **equivalent to your signature**

1.04 Confidentiality


 Access only the information you require for performing your job

-  Do not share your password with anyone else
 -  Do not discuss information you have viewed with anyone else who does not need to be aware of the patient's clinical information

 -  Destroy unnecessary printed information in the appropriate confidential waste areas as per hospital policy

 -  Audit trails are run periodically
 -  Be advised that the Hospital policy for breaching confidentiality will be followed
-


1.05 Signing into MEDITECH

-  You are assigned a user ID and a confidential password to access the MEDITECH system

User ID → Unique permanently assigned code










-  Access is dependent upon your job requirements

Password → Confidential Password (system or user assigned and requires users to change routinely and assign new password based on hospital defined parameters)

-  Letters/numbers are not displayed while you type. They are confidential and a security feature shows only an asterisk to indicate that a keystroke was entered

Section II. NUI – New User Interface

2.01 What's different about NUI?

-  A windows look and feel
-  Enhanced menu options
-  Ability to use a mouse
-  Ability to view graphs
-  A new colour scheme
-  Title bars
-  Colour coding
-  Response Field Changes
-  System Messages




NUI Workstation Icon





2.02 Using the Mouse

The mouse can be used to select items from your computer's desktop and drop down menus. For example: to open the NUI icon on your desktop, use the mouse to double click the icon, NUI will then open.

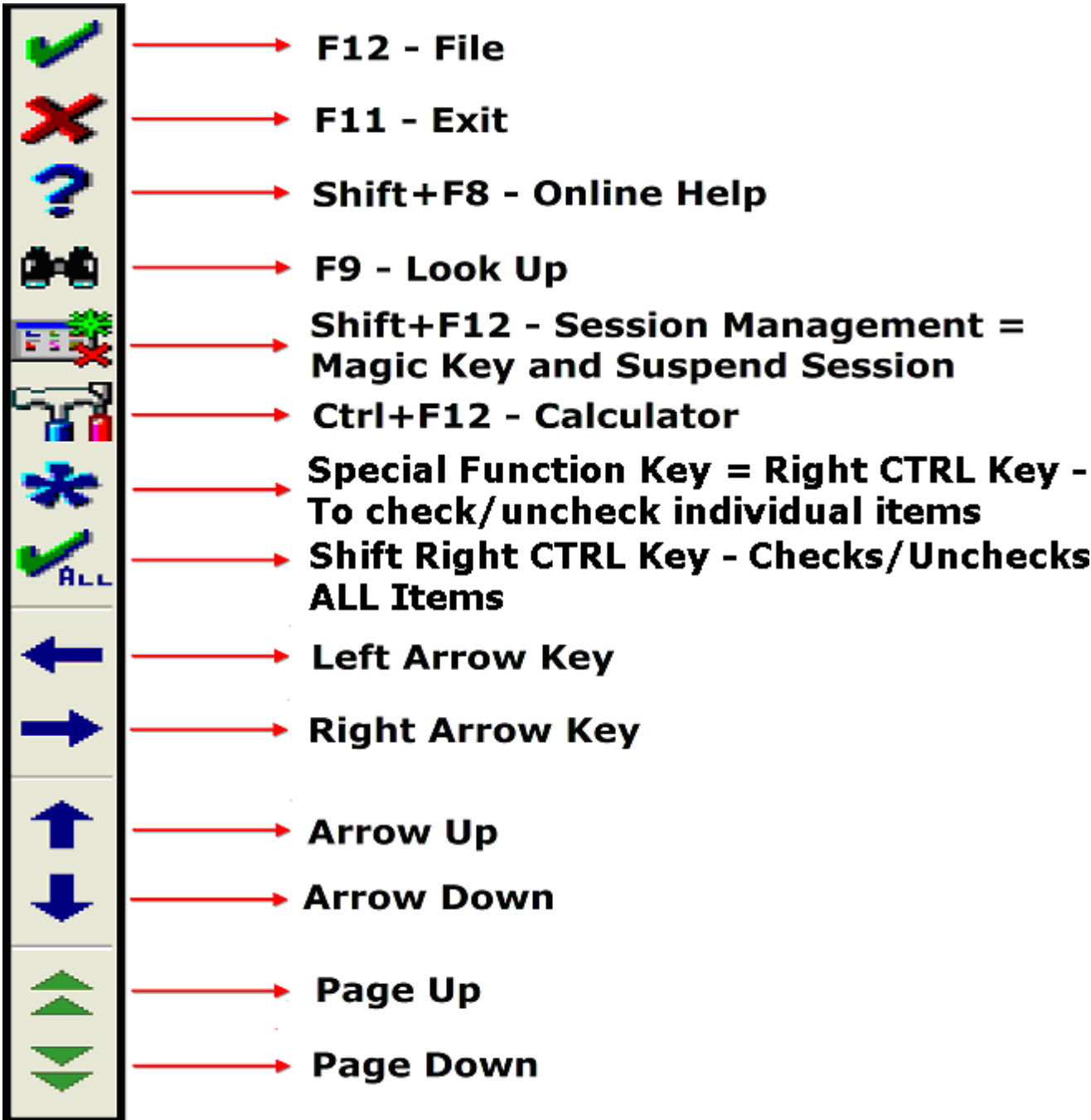
When using a mouse in a Windows environment:

-  Items from a verb strip can be selected by highlighting the option with the mouse and clicking:



-  A single left click highlights an entry
-  A double left click selects an entry
-  Many Meditech functions will only require a single click
-  Clicking on arrows will move the lookup display







Section III. MOVING AROUND WITHIN NUI TOOLBAR









Mouse/Keypad Functionalities in NUI/Magic

Section IV. Documentation






4.01 Purposes of Documentation

-  Accountability
 -  Legislation
 -  Quality Improvement
 -  Research
 -  Funding/ Resource Allocation
 -  ** Communication **
-


4.02 Requirements of Documentation

-  **Document must be:**
 -  Accurate & Timely
 -  Relevant & Useful
 -  Clear & Concise
 -  Tell a Story
 -  Be Retrievable
-

4.03 Key Components of Documentation

-  Admission Profile (database)
 -  Plan of Care:
 - Ongoing Assessments
 - Interventions
 -  Progress Notes
 -  Teaching
 -  Discharge Planning
-

4.04 Methodology

-  **Vision/Mission:**
 - Interdisciplinary electronic documentation; the key to supporting patient centered care.



Guiding Principles/Values:

- Documentation reflects an interdisciplinary and patient focused plan of care.
- Documentation reflects the patient care goals, the care that the patient receives and the outcomes achieved.
- Documentation is easily retrievable and accessible.
- The documentation tools and processes are comprehensive, sustainable, integrated, user friendly, streamlined and reduce duplication.
- The documentation system supports the collection and reporting of workload measurement data.
- The documentation system incorporates best practice initiatives to support the appropriate utilization of resources.



QHC Documentation Methodology Statement:

- QHC interdisciplinary documentation incorporates standards methodologies.



POC (Point-of-Care):

- Document as close to the patient as possible using wireless mobile/handheld devices
- Document as close to the time of the event as possible
- Document the time of the event (occurred time vs recorded time)



Exception Based Charting:

- Patient Care Standards
- Protocols/Best Practice Guidelines
- Assessment Parameters
- Significant Event/Findings - Focus Note (structured narrative note)

Workload Measurement is a by-product of documentation.

Section V. STATUS BOARD

Rm/Bd	Patient Name	Age Sex	Diet	Order	Code Status
Temp-Loc	Attending Physician	Diagnosis	Int Time	Result	Isolation
H101-1	FLOW, SHEET Yee, E.	49 F MI	NOTHING 0730 N →	Ack	NO INTUBAT
H101-6	WORKSHOP, ICU Bates, W.F.	55 F CARDIAC →	CARDIAC 0715 N →	Ack	FULL CODE D Drople →
H102.ERIC →	HT, TEST1 Caccia, Nicolte	20 M	REGULAR 0730 N →	Stat	
H308-1	GROUP, JANET1 Williamson, E.E.	47 F	CALORIE → 0730 N →	Ack Res	
H355-2	HEALTHTECH, TEST PAT → Aaron, Shawn	4Y → M			
H356-2	HT, TEST2 Aaron, Shawn	10 M	DIABETI → 1801 Co →		
H358-1	HT, TEST BBK1 Aaron, Shawn	00M → M			
H358-2	HT, TEST3 Aaron, Shawn	24 M			
H359-2	HT, TEST4 Aaron, Shawn	20 M			
H363-1	GROUP, CAROL1 Bates, R.	69 F			
H409-2	GROUP, GARRY1 Bates, W.F.	70 M		Stat	
			1000 N →		









More



Location Find Patient Manage List Options

More



Allergies
Admin Data
Orders
My List
Process Int
Pt Notes
Flowsheet
PCI
References
Print Report
Regulatory
More
Exit

5.01 Status Board - Key Points

-  Displays all patients on your unit or specific patient assignments or "lists" of patients.
-  Allows you to document in eDoc and view in PCI
-  Status board refreshes (renews data) automatically and the screen will change periodically as information is updated
-  Each clinician is responsible for entering his/her assigned patients at the beginning of the shift and to delete patients from this routine when they are no longer assigned
-  Add patients by account number, name, room number or by location
-  The status board functions as your "home page"
-  You can access any part of your patient's electronic record from this page
-  Provides visual notification of scheduled interventions

-  Provides visual alerts, Result Indicators when new results are available for Lab, Microbiology, Pathology, Blood Bank, Radiology, and Transcribed Reports
-  Provides visual alerts, Order Indicators when new orders have been entered in Order Entry and allows clinicians to view and acknowledge the orders

5.02 How to Use the Status Board

-  Sign into NUR, and choose the status board from the Clinical Documentation Main Menu
-  Across the top of the Status Board, patient information is listed in double rows & columns:
 - Room & Bed, Temporary Location
 - Patient's Name
 - Attending Physician
 - Age/Sex
 - Diagnosis
 - Diets – current diets from Order Entry
 - Intervention time - Scheduled interventions
 - Order Indicators
 - Result Indicators
 - Values from documented queries such as isolation and code status

5.03 Status Board Headers

Nursing

Rm/Bd	Patient Name	Age Sex	Diet	Order	Code Status
Temp-Loc	Attending Physician	Diagnosis	Int Time	Result	Isolation

Allied Health

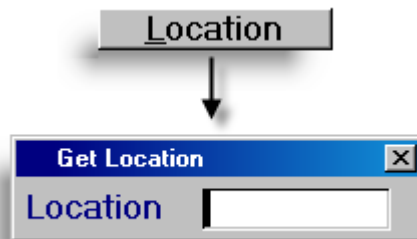
Rm/Bed	Pt.Name	Sex Age	Unit #	Code Status
Temp-Loc	Attend.Phys	Diagnosis	Diet	Isolation


5.04 Status Board Buttons

- Located across the bottom of the status board are 4 buttons or tabs that are Meditech standard buttons.
- To access each function, click on the button or enter the underlined letter on the routine.

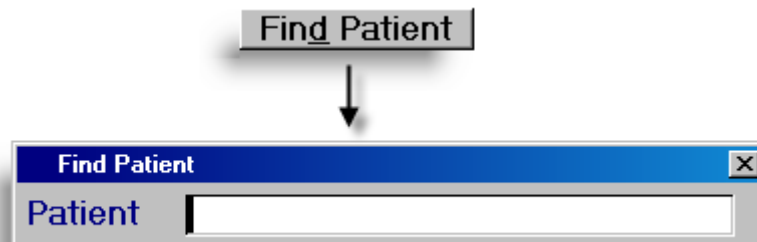


5.05 Location





- One time only view to review and/or document for one patient
- The patient's are not a permanent part of your list and drop off once you exit the status board
- Location** - Type the location mnemonic, press <F9> or click the  button to view a list of all locations. The status board will refresh and add all patients for that location.





5.06 Find Patient











- One time only view to find a patient to review and/or document

-  The patient isn't a permanent part of your list and drops off once you exit the status board
 -  **Find patient** – Type in last name, comma, and first initial, or account number. Ensure the correct visit for the correct patient is selected. Once you have chosen the patient the status board list will display this patient.
-

5.07 Manage List – Adding Patients and Rooms

-  Allows users to add and delete patients from their list to maintain a user specific patient list
-  To add patient(s) to **My List**:
 -  Click on 'Manage List' or enter 'G'
 -  Your Meditech user mnemonic will default in

-  **Add by Patient** – Type in last name, comma, and first initial; account number; or type L (spacebar) and the location mnemonic
-  Use the up/down arrow keys to move up/down the list.
-  Use the right control key or click the  icon to checkmark the patient(s) you wish to add to your list.
-  Press right arrow or click the  button to select.
-  File.

-  **Add by Room** – Enter the room number and bed.

If occupied the current occupant will default, otherwise the room will be on your list as an empty room/bed. Continue to add patients by room/bed one at a time. File.

Managing My List by room will update My List automatically as admissions, discharges or transfers occur and always show the current occupant of the Room/Bed.

Manage List

↓

Enter/Edit User's List of Patients

User:

HH Format:

Enter User Name Here

Patient	Age/Sex	Room	Bed	Attending	Handheld Format
1 HA000095/05 HEALTHTECH, TEST PATIENT	4Y 11M M	H355	2	Aaron, Shawn	
2 HA000030/05 MATERNITY, MBU	02M 13D F	HN700	1	Dempsey, G.P	
3 HA000088/05 HOLLAND, PAED	8 M	H7TR	1	Bates, R.	
4 HA000108/05 HT, TEST1	20 M	H102.	1	Caccia, Nic	
5 HA000109/05 HT, TEST2	10 M	H356	2	Aaron, Shawn	
6 HA000110/05 HT, TEST3	24 M	H358	2	Aaron, Shawn	
7 HA000111/05 HT, TEST4	20 M	H359	2	Aaron, Shawn	
8 HP000006/05 HT, TEST5	40 M			Aaron, Shawn	
9 HP000007/05 HT, TEST5	40 M			Aaron, Shawn	
10 Add New Patient Here					

User's Existing List






Room	Bed	Current Occupant	Age/Sex	Attending
1 H352	1	HC000001/05 CCC, ONE	83 M	Bates, R.
2 H102. ERICU	6			
3				
4				
5				
6				
7				
8				
9				
10				

Patient name will show when bed is assigned

Add Room + Bed Number




*Note-The user name will now default into the top of this screen.



5.08 Manage List – Removing Patients/Rooms

-  To remove patient(s) from **My List**
 -  Click on manage list or enter G
 -  Position cursor beside the patient you want to remove
 -  Press F10 to delete patient
 -  File

5.09 Status Board Options







-  Overdue (Past) and future hours for both Medications (future) and Interventions to appear on the Status Board may be changed via the Options button
-  Times default based on user group settings
-  **4 hours past and 8 hours future**



-  Status Board format may be chosen from the formats assigned based on your user group
-  Settings are session specific and return to the default settings upon exiting the status board


5.10 Status Board/Process Flowsheet Desktop Buttons


Down the right hand side of the Status Board and Process Flowsheet are buttons or tabs that allow access to other screens/routines with one keystroke or click. To access, click on the button or enter the underlined letter on the button. The buttons, underlined letter and order of display on the status board are defined based on access group.


Allergies		Pharmacy allergies and ADR (Adverse Drug Reactions) appear in the patient header
		Drug, food and other allergies appear as they have been documented in eDoc and/or OE Administrative data, and the date/time last updated
		Click detail and view allergies as displayed in PCI


Admin Data		Enter/Update/View Administrative Data
-------------------	---	---------------------------------------


My List		Displays user specific list of patients
		Top left of screen shows My List and the date/time the list was last updated

Orders		Review orders routine for Nursing and Process Orders routine for Allied Health
---------------	---	--

Process Int		Process Interventions routine
--------------------	---	-------------------------------

Pt Notes		Patient Notes routine
-----------------	---	-----------------------

Flowsheet		Defaults a generic default flowsheet format
------------------	---	---

PCI		PCI / Review
------------	---	--------------

*Note-The PCI button is now known as Review

Regulatory		MDS and RAI MH routines
References		Link to Internet websites defined for the access group
Print Report		Reports that can be printed i.e. CMARs, Electronic Kardex
More (Standard)		If the user has more than one desktop assigned clicking on More will display a list to choose a different format
		After choosing the new desktop, the buttons/order of buttons will change
Exit (Standard)		To leave the status board or flowsheet routines

5.11 Navigating on the Status Board - Sorting

- The default sort order is ascending for each field
- Click any of the fields across the top of the screen and the field sort changes to descending.

ex	Diet	Order ↓	Code Status
osis	Int Time	Result	Isolation
		Ack	
	1530 *Z>		
	+REGULAR	Stat	

Note the down arrow

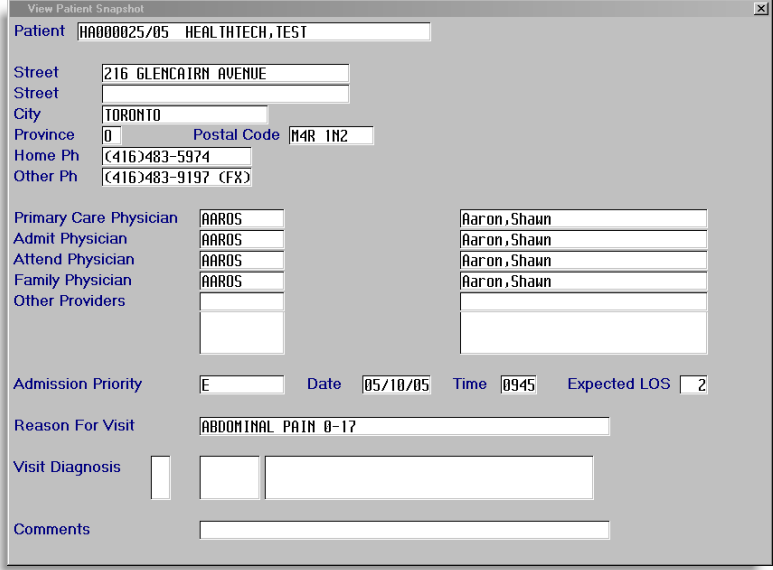
- Click on the field again, the sort changes to ascending.

ex	Diet	Order ↑	Code Status
osis	Int Time	Result	Isolation
		Ack	
	1530 *Z>		
	+REGULAR	Stat	

Note the up arrow


5.12 Viewing more information

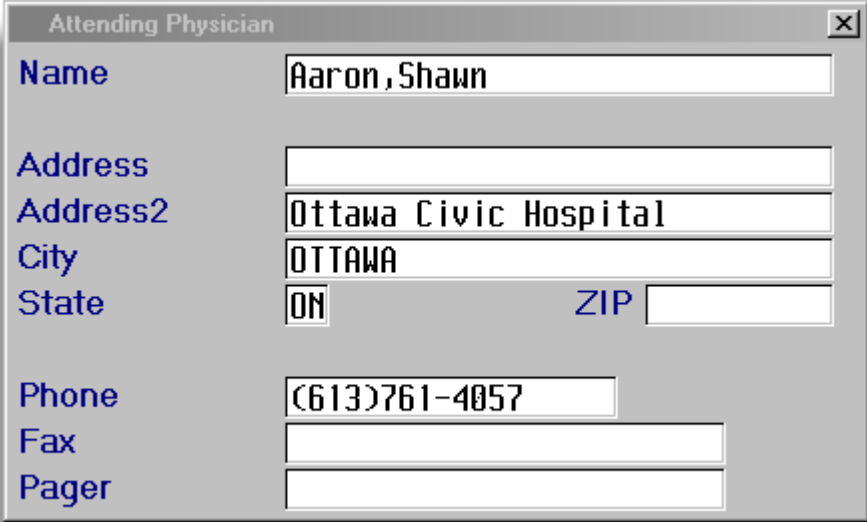
 Click on patient name to view demographic patient snapshot



The screenshot shows a window titled "View Patient Snapshot" with the following fields:


- Patient: HA000025/05 HEALTHTECH, TEST
- Street: 216 GLENCAIRN AVENUE
- City: TORONTO
- Province: ON Postal Code: M4R 1N2
- Home Ph: (416)483-5974
- Other Ph: (416)483-9197 (FX)
- Primary Care Physician: AAROS Aaron, Shawn
- Admit Physician: AAROS Aaron, Shawn
- Attend Physician: AAROS Aaron, Shawn
- Family Physician: AAROS Aaron, Shawn
- Other Providers: (empty)
- Admission Priority: E Date: 05/10/05 Time: 0945 Expected LOS: 2
- Reason For Visit: ABDOMINAL PAIN 0-17
- Visit Diagnosis: (empty)
- Comments: (empty)

 Click on physician name to view physician demographic snapshot




The screenshot shows a window titled "Attending Physician" with the following fields:

- Name: Aaron, Shawn
- Address: (empty)
- Address2: Ottawa Civic Hospital
- City: OTTAWA
- State: ON ZIP: (empty)
- Phone: (613)761-4057
- Fax: (empty)
- Pager: (empty)

-  A black arrow at the end of the data indicates the information has truncated, click the field to view the complete detail

Bates, R.		
HEALTHTECH, TEST RES	M	
Aaron, Shawn		
HT, TEST 1	M	




-  A "+" sign in front of data indicates there is more than one documented result or value to view. Click the field to view the complete details.

M	20	
+REGULAR		Stat
M	10	
DIABETIC STANDAR		Stat
M	24	Bbk
M	20	

"+" Appears for the following:

- o Allergies
- o Diets
- o Other Physicians
- o Responses to a Multiple type query, such as Isolation

5.13 Patient Names

-  Patient names display with blue shading
-  Last names that are the same or sound the same display with yellow shading
-  Selecting a patient changes the shaded colour to black

Selected Name - Black Highlight

Unique Names - Blue Background

Same/Similar Names - Yellow Background

Emp-Loc	Attending Physician	Diagnosis
53-2	HEALTHTECH, TEST	M
53-2	Aaron, Shawn	FUO
53-2	HEALTHTECH, TEST PAT	M
53-2	Aaron, Shawn	M
57R-1	HOLLAND, PAED	M
584-1	Bates, R.	F
584-1	HT, PATIENT ONE	M
582.ERIC	Macdonald, W.	M
56-2	HT, TEST1	M
56-2	Caccia, Nicolte	M
56-2	HT, TEST2	M

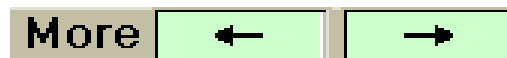
Status Board Patient Name Display

5.14 Patient Names – More than 11 Patients



- When greater than 11 patients are included on a list, up and down green shaded arrow keys will display to indicate where you are on the list
- Click on the up or down arrow and the list will move up or down

5.15 Patient Names – More Columns to View



- If there are more columns than the screen width of 72 characters, right and left green shaded arrows will display to indicate there is additional information to view. We are currently not using any additional columns.
- Click on the right or left arrows to change the column display as applicable

5.16 Status Board Result Indicators

Critically Abnormal Lab Result(s)

Normal Path Result(s)

Normal Mic Result(s)

Abnormal - Multiple Result Types

Normal - Multiple Result Types

Normal Bbk Result(s)

5.17 Result Indicators - Key Points

- Result indicators display the department the results are from or if results are from more than one department, **Res** displays.
- Result backgrounds are coloured dependent on the results.

Indicator	Criteria
Lab	If ALL the results are from Laboratory
Mic	If ALL the results are from Microbiology
BBK	If ALL the results are from Blood Bank
PTH	If ALL the results are from Pathology
RAD	If ALL the results are from Radiology
Res	If the results are from more than one department

- Normal results have a shaded green background with black text
- Abnormal results have a yellow shaded background with black text
- Critically abnormal results have a red shaded background
- Like PCI abnormal results include critical high/low results outside of the normal test results range or high/low results which are abnormal for the patient but within the normal range
- Viewing new results:
 - Click on the shaded indicator
 - Right arrow and view the report
 - Once viewed the indicator disappears, for each user

5.18 Departmental Reports - Key Points

- Reports associated with orders that have been entered and filed will display on the status board to alert the user that there is a new report available to be viewed
- The report mnemonic displays in the Result Indicator cell or if there are multiple results then Res displays
- Click on the indicator and view the Recent Results screen from PCI
- Right arrow and view the report
- Once viewed, the indicator disappears, for each user

5.19 Order Indicators - Key Points

- When new orders are entered in Order Entry, the orders are flagged on the status board and users can verify or acknowledge the orders as applicable.
- All indicators are black text with a green shaded background.
- Ack** - Verified orders entered in OE display an Acknowledge flag
- Stat** - Stat orders entered in OE display a Stat flag with a red background

Acknowledged/Verified Order(s)

Stat Order(s)

Diet	Order	Code	Int Time	Result	Is
DIABETI	Ack				
1500 *N	Stat				
2000 ZT					

5.20 Acknowledging Orders - Key Points

- Order Indicators** - Orders entered in Order Entry can be set to flag users of new orders on the Status Board.
- Verified Orders – only the 'Acknowledge' and 'Details' buttons will be available, the process orders button will be greyed out as not applicable.

5.21 How to Acknowledge Orders

- Click the Ack/Stat indicator to acknowledge a specific patient's orders.
- Only one clinician can view the order indicator and after acknowledging, the indicator disappears from the status board for all users.

HT,TEST1 - 20/M H.ER.IN H102.ERICU/1 Unit No:H0000136
ADM.IN Acct No:H0000108/05
Allergies/ADRs:

Order	Pri	Qty	Event	Status	Event Dt & Th
FLUID FULL (DIET)			New	Unverified	12/11 1755
REGULAR (DIET)			New	Unverified	12/11 1755
REGULAR (DIET)			New	Unverified	12/11 1755
REGULAR (DIET)			New	Unverified	12/11 1755
ELECTROLYTES (LAB)		R	New	Active	26/11 1640
GLUCOSE *RANDOM/TIMED* (LAB)		R	New	Unverified	12/11 2057

More **NEW ORDER**

Order originated from OE.
Service Date/Time: 16/11/2005 B

Add to Existing Diet? N
Enter N if this is first diet ordered
Texture *DOCUM*: FULL FLUIDS
e Ordering site: B6H

4. Select order to be acknowledged


5. Click 'Acknowledge' to acknowledge selected order

Selected order details are displayed here


Acknowledge Details Process Orders Exit

- Select the order to be acknowledged, order will be highlighted
- Click 'Acknowledge' button

Yes/No Confirmation

 Acknowledge Order(s)?

Message




 1 procedure(s) verified/acknowledged as requested

5.22 Order Column

Once the order has been acknowledged the indicator disappears and the order cell is empty unless a new order has been entered in the interim.

Attending Physician	Diet	Order	Wkload	Isolation
HT, TEST1	M 20		2239	
Aaron, Shawn	REGULAR			
HEALTHTECH, TEST	M 01M 23D		2100	
Aaron, Shawn	DIABETIC 10000 ▶	Unv	0.04	A Airborne
HEALTHTECH, TEST PAT▶	M 4Y 10M			
Aaron, Shawn		Ack	0	
HT, TEST2	M 10		0800	
Aaron, Shawn	DIABETIC STAND▶	Stat		

5.23 Documenting Interventions from the Status Board

-  Intervention times display in red text which have exceeded the directions time and have not been documented.
-  The default setting is
 - **4 hours in the past and 8 hrs in the future.**
-  These settings can be changed; see Options on the Status board or Time Period from the intervention indicator but will revert back to the default settings once you exit the status board.

My List of Patients (Last Updated: 11/17/05) **Current Time = 1109**

Rm/Bd	Patient Name	Age	Sex	Diet	Order	Code	Status
Temp-Loc	Attending Physician	Diagnosis	Int Time	Result	Isolation		
H101-1	FLOW, SHEET	49	F	NOTHING	Ack		NO INTUBAT
	Yee, E.		MI	0730 N			
H101-6	WORKSHAOP, ICU	55	F	CARDIAC	Ack		FULL CODE
	Bates, W.F.		CARDIAC	0715 N			D Drople
H102.ERIC	HT, TEST1	20	M	REGULAR	Stat		
	Caccia, Nicoltte			0730 N			

Scheduled Interventions: 0700 - 1900

WORKSHAOP, ICU - 55/F H. ICU H101/6 Unit No: H0000129
 162.560000cm 74.160000kg ADM IN Acct No: HA000101/05

Allergies/ADRs:

Time	Interventions
1100	N-Vital Signs +
1100	N-Intake & Output +
1100	N-Glucometer +
1100	N-Ventilator/BIPAP Monitorin
1100	N-Inf: Epidural/Thoracic Mon
1100	N-Inf: Blood/Blood Products
1115	N-Inf: Epidural/Thoracic Mon
1130	N-Inf: Epidural/Thoracic Mon
1145	N-Inf: Epidural/Thoracic Mon
1200	N-Vital Signs +








Status Board Display Options

Intervention

Overdue	Future
<input type="radio"/> 0 Hours	<input type="radio"/> 0 Hours
<input type="radio"/> 1 Hours	<input type="radio"/> 1 Hours
<input type="radio"/> 2 Hours	<input type="radio"/> 2 Hours
<input checked="" type="radio"/> 4 Hours	<input type="radio"/> 4 Hours
<input type="radio"/> 8 Hours	<input checked="" type="radio"/> 8 Hours
<input type="radio"/> 12 Hours	<input type="radio"/> 12 Hours

Buttons: Process Int, Document, Time Period, Exit

5.24 How to Document From the Status Board

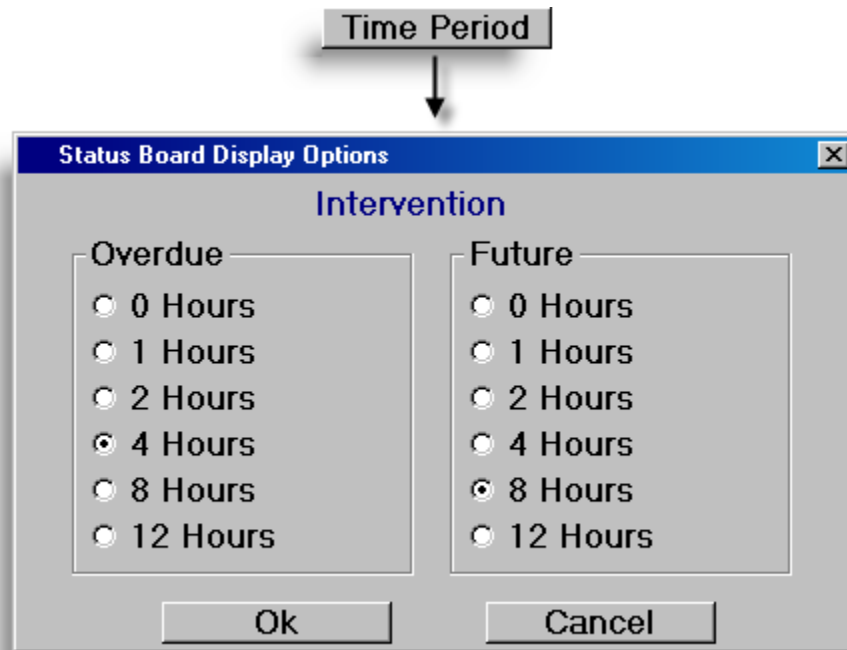
-  Click the Intervention Time cell on the status board to select the patient to document.
-  A list of interventions that fall within the specified documentation time range displays.
-  Highlight the intervention to be documented.
-  Click the document button.
-  Change the time to the time that the event occurred.
-  Document.
-  File.

Although there may be multiple occurrences of the same intervention each intervention has a different time. Whichever intervention is selected, the time displayed on the board does not reflect the time that the

intervention was done. The time must be changed to reflect the actual time.

- Once the interventions have been documented they may not be removed or drop off your status board immediately, and the time remains red. This is dependent on the settings in the background that determine the time range for documented interventions. If you are documenting an intervention for a time within the time range then it should drop off your list. If you are documenting for a time outside of the time range it will not drop off your list until the limits have been reached.





5.25 Time Period



- To change the time period, click on the applicable time(s) for overdue (past) and future and click OK
- Status board will refresh and display interventions based on new time range
- Once you exit the status board the settings return to the default setting
- Can also be changed from the options button located on the bottom row of the Status board











5.26 Process Interventions

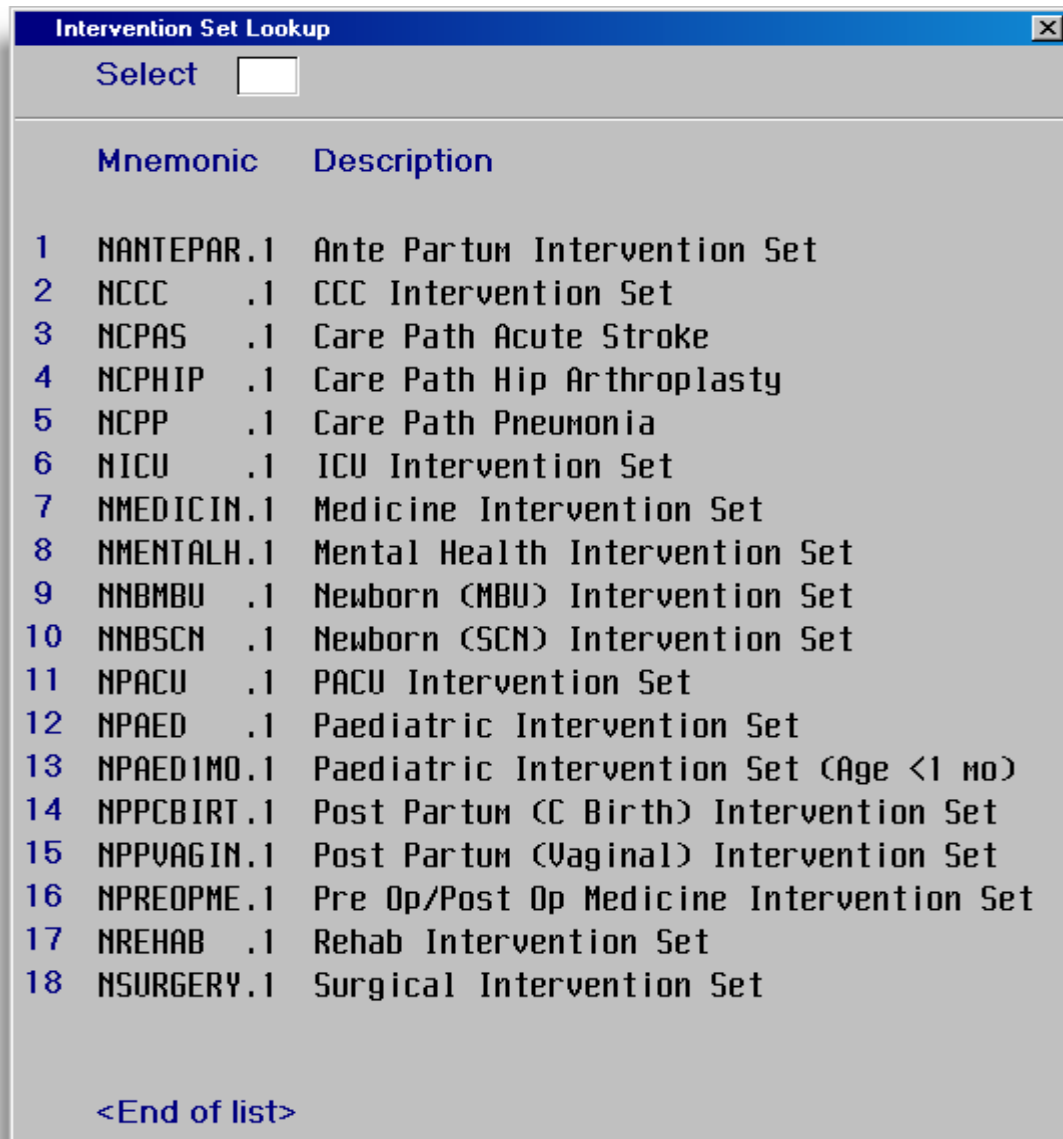
Process Int

-  Document other interventions
-  Change level
-  Change directions
-  Change text

Section VI. Plan of Care





6.01 Admission Intervention Sets - Key Points

-  Initial admission intervention sets have been developed **for nursing units** to include the minimum expectation for care of all patients in that area.
-  **Allied Health has a few intervention sets. Otherwise, they will add their interventions individually or the interventions will be part of the initial admission intervention set.**
-  The intervention sets have been standardized with core interventions. These core interventions are applicable across the corporation. Specialty areas have additional interventions included that relate to the care of that particular patient population type.
-  The Intervention Set is to be added, by the primary nurse, when the patient is admitted to the nursing unit.
-  The set of interventions initiates the plan of care for your patient.
-  The plan of care is comprised of interventions some of which are assessments and some of which are related to activities of daily living, safety, care planning, etc.
-  **Patient care plans are designed using the 80/20 rule. If 80% of patients in the specific population will use the intervention it is included in the set.**
-  Other interventions can be added as needed.
-  All interventions are at an **active** status when added.
-  The care plan travels with the patient and is revised as needed.




Admission Intervention Sets



6.02 How to Add Admission Intervention Sets

-  From the status board, single click on the Process Intervention button, or enter "I".
-  In the box where the cursor is flashing, enter AI (Add Interventions).
-  Enter forward slash (/), <F9> lookup and choose appropriate set.
-  File.

6.03 Admission Assessments - Key Points

-  Clinicians are responsible for completing an admission assessment for the patient, within the **defined hospital timeframe** of the patient's admission.
-





6.04 Adding Assessment Indicators/Outcomes - Key Points

-  Supplements to the patient's Care Plan are added in the form of "Indicators/Outcomes".
-  Based on responses in the patient assessments, "Indicators" will be triggered.


Indicator	Outcome
Breast Feeding	Latch Score >7 for 2 consecutive feeds
Continence	No bladder or bowel concerns
Falls	Maintain patient safety from falls
Functional Status	ADL's managed in a discharge setting
Nausea	Effective management of nausea
Pain	Pain scale 3 or less
Safety	Patient safety will be maintained
Skin Integrity	Maintain or improve skin integrity
Shortness of Breath	Effective management of shortness of breath

QHC Indicators and Outcomes





6.05 How to Add Indicators/Outcomes

-  When you have filed the patient assessment(s), an indicator/outcome intervention will appear based on responses to specific queries in the assessments.
 -  You will be asked if you want to accept these indicator/outcome(s). You should always answer yes, and you will then be taken to the enter/edit plan of care screen.
 -  Press the enter key once, and ensure that the indicators/outcome(s) are listed in the middle of the screen.
 -  File.
-





6.06 Viewing the Care Plan - Key Points

-  The PI screen will allow you to see the complete plan of care for your patient including the interventions that are part of the admission set, additional interventions that you have added (discussed later in this manual) and the indicator/outcome(s) that have been added to the care plan.
-

6.07 Documenting Indicators/Outcomes - Key Points

-  A screen is attached to the indicator to document patient progress.
 -  Patient notes are used to elaborate on progress towards the outcome and you can link directly to patient notes from this screen.
 -  **Nursing is required to review and document on the patients outcomes q shift.**
 -  **Allied Health should document on outcomes as applicable.**
-



6.08 How to Document Indicators/Outcomes

-  Choose the indicator/outcome from the PI screen.
-  Enter DN (Document Now).
-  An outcome screen will appear. The focus and outcome will default. Do not edit the indicator or outcome.
-  <F9> lookup at "Outcome met".



Section VII. ADMIN DATA SCREEN

7.01 Administrative Data Screen – Key Points






Admin Data






-  **The Admin Data Screen is the electronic Kardex**
-  Allergies, Height/Weight, Primary Diagnosis and Secondary Diagnosis will default to the Admin Data screen, if filed in clinical documentation. They can also be entered and filed in

the Admin Data screen. Daily weights can be documented in screens and will update in the Admin Data screen.







-  The Admin data screen is where patients are placed in or removed from a **Temporary Location**. This allows other areas access to the patient record when the patient is away from their primary location i.e. x-ray, and also ensure that workload is captured in appropriate areas i.e. an inpatient patient is in the PACU.
 -  Admin Data can also be accessed and edited while in the Process Interventions screen using the verb strip function Edit Admin Data (EA).
-

7.02 How to Enter Data in the Administrative Data Screen

-  Select patient.
-  Single Click on Admin Data button/tab on the Status Board, enter A (the underlined letter on the Edit Admin Data button) or enter EA from the Process Intervention screen.
-  Temporary locate patient if required by entering the mnemonic of the location and filing.
-  Remove the temporary location by deleting (<F10> the location, leaving it blank and file.
-  If Allergies, Primary Diagnosis and Secondary Diagnosis were answered on the admission assessment, they will default to the EA however, the screen must be viewed in order for the allergies and diagnoses to appear.

Column	Functionality
	 Hold  Discharged
Directions	Frequency that the intervention is to be done
SRC - Source	How the intervention is added to the Plan of Care:  PS - Process Interventions  CP – Enter/Edit Plan of Care
Doc	Displays amount of time since last documented:  Days, Hrs. and Min.
D - Duplicate	D displays in this column when two or more of the same interventions exist on the care plan
C/N – Comment/Note	C or N displays in column if using comments or note link to interventions – Not applicable at QHC
KI – Key Indicators	An asterisk * displays in column if using critical paths Not applicable at QHC
Prt - Protocol	An asterisk * displays in column when a protocol is attached

8.02 Navigating the Process Interventions Screen

ICON/Function Keys	Function
 or Up Arrow	Move up one intervention
 or Down Arrow	Move down one intervention
 or Page Down	Move down the screen from one intervention header/category to the next
 or Page Up	Move up the screen from one intervention header/category to the next
<F7>	Move to the top of the Process Intervention screen
<F8>	Move to the bottom of the Process Intervention screen
 or Right <CTRL>	Checkmark one intervention or remove one checkmark
 or <Shift> & Right <Ctrl>	Checkmark all interventions or remove checkmarks from all

8.03 Verb Strip Functions

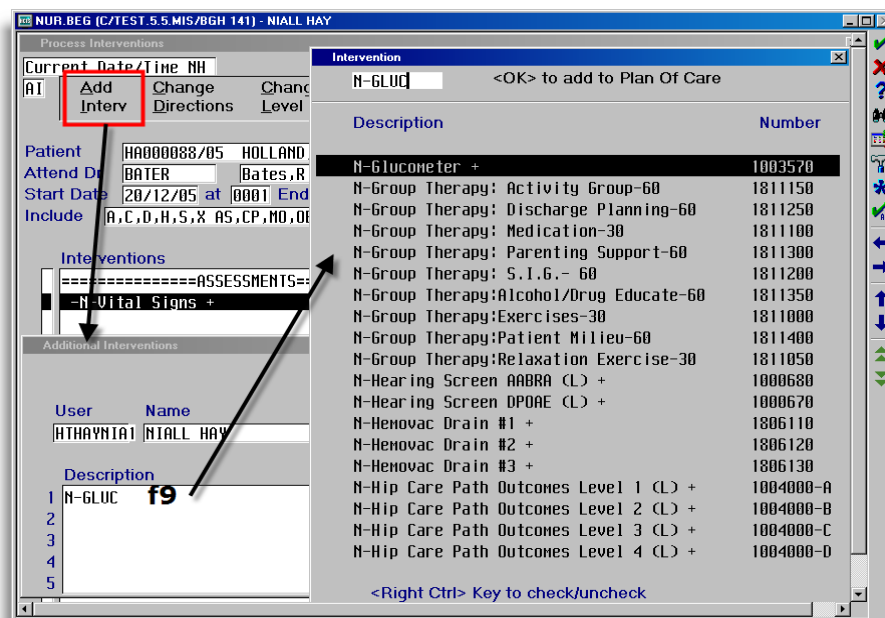
- The Verb Strip is a list of commands or functions. This is located at the top of the screen where the cursor is flashing
- Enter the mnemonic (Underlined Letters) to command the system to perform the associated function.

Document >Document Add Change Change Edit View >More
 Now Interv's Interv Level Directions Text History

- >More:** To go to Page 2 of the verb strip, use the '>' key or the '<' key to return to previous page.

<More Patient Enter Edit Change View Select
 Notes Orders Admin Data Status Protocol Interv's

8.04 AI: Add Intervention - Key Points



- Additional interventions can be added to the care plan
- <F9>lookup displays all interventions that can be added
- These interventions may have screens attached that are unique to that population
- Ensure that you choose correct interventions for your patient

NB – this is a pre-determined list; interventions cannot be created

8.05 Intervention Descriptions – Key Points

- ☐ All interventions are prefaced with a discipline specific prefix (i.e. **N**-for Nursing, **PT**-for Physiotherapy etc.). Disciplines chart on discipline specific interventions only.
- ☐ Interventions which have more than one level are designated by (L) in the Intervention description line (i.e. < 5 mins, > 5 mins).
- ☐ Interventions which have a screen attached, in order to record specific documentation, are designated with a + sign in the Intervention description line.










For Example:

N-Assist with Procedures < 10 min (L) +
PT-Assessment: Mobility 10 min (L) +



Description	Number
N-Accompany Pt In Hospital <15 mins(L)+	1804300-A
N-Accompany Pt in Hospital 16-25mins(L)+	1804300-B
N-Accompany Pt in Hospital 26-35mins(L)+	1804300-C
N-Accompany Pt in Hospital 36-45mins(L)+	1804300-D
N-Accompany Pt in Hospital >45 mins (L)+	1804300-E
N-Accompany Pt Other Instit < 2 hrs(L)+	1804400-A
N-Accompany Pt Other Instit 2-4 hrs (L)+	1804400-B
N-Accompany Pt Other Instit 5-7 hrs (L)+	1804400-C
N-Accompany Pt Other Instit 8-10 hrs(L)+	1804400-D
N-Accompany Pt Other Instit >10 hrs (L)+	1804400-E
N-Acute Stroke OC Level 4 Palliative(L)+	1004100-A
N-Acute Stroke OC Level 4 Rehab (L) +	1004100-D
N-Acute Stroke Pt Outcomes Level 1 (L) +	1004100-A
N-Acute Stroke Pt Outcomes Level 2 (L) +	1004100-B
N-Acute Stroke Pt Outcomes Level 3 (L) +	1004100-C
N-Additional Help Required < 5 mins(L)	1804700-A
N-Additional Help Required 6-15 mins(L)	1804700-B
N-Additional Help Required 16-25 mins(L)	1804700-C
N-Additional Help Required 26-35 mins(L)	1804700-D

Description	Number
PT-6 Minute Walk Test 20 min (L) +	1101600-A
PT-6 Minute Walk Test 21-30 min (L) +	1101600-B
PT-6 Minute Walk Test 31-40 min (L) +	1101600-C
PT-6 Minute Walk Test 41-50 min (L) +	1101600-D
PT-Admission Database 20 min (L) +	1100100-A
PT-Admission Database 21-30 min (L) +	1100100-B
PT-Admission Database 31-40 min (L) +	1100100-C
PT-Admission Database > 40 min (L) +	1100100-D
PT-Assessment: Cardio Resp 10 min (L) +	1100200-A
PT-Assessment: Cardio Resp 11-20 min(L)+	1100200-B
PT-Assessment: Cardio Resp 21-30 min(L)+	1100200-C
PT-Assessment: Cardio Resp 31-40 min(L)+	1100200-D
PT-Assessment: Cardio Resp > 40 min (L)+	1100200-E
PT-Assessment: Mobility 10 min (L) +	1100300-A
PT-Assessment: Mobility 11-20 min (L) +	1100300-B
PT-Assessment: Mobility 21-30 min (L) +	1100300-C
PT-Assessment: Mobility 31-40 min (L) +	1100300-D
PT-Assessment: Mobility 41-50 min (L) +	1100300-E
PT-Assessment: Mobility 51-60 min (L) +	1100300-F

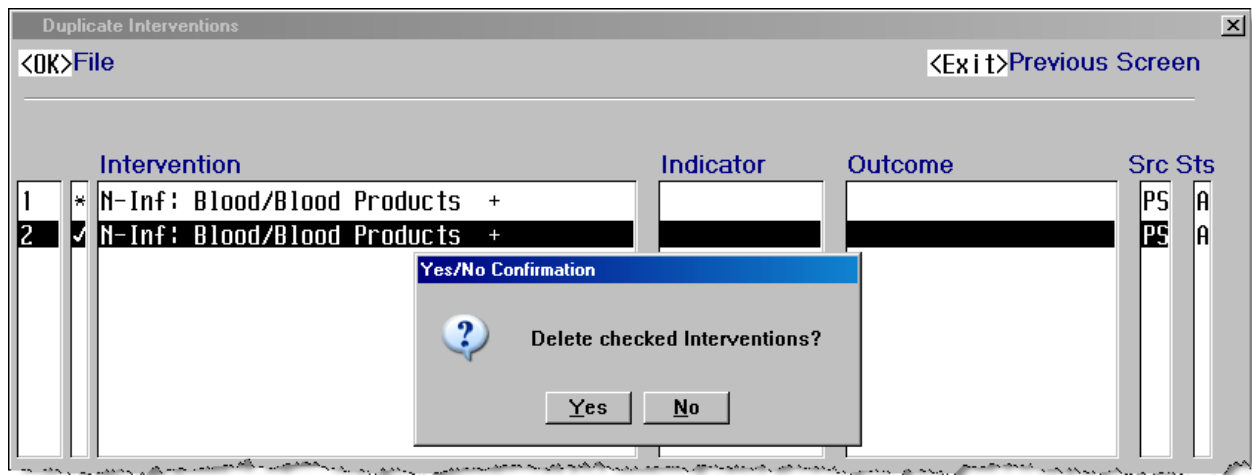
8.06 How to Add Interventions






-  Select the patient.
 -  At verb strip enter AI or click 'Add Intervention' on verb strip
 -  Press <F9> or click  to display all interventions listed in alphabetical order OR to display a shortened list, type the first three letters of the first word in the intervention description and press <F9> or click  to display interventions starting with the intervention you want to add. i.e. IV, Vital Signs, Intake/Output
 -  Use the arrow keys to move down the page one intervention at a time or <Page Up>/<Page Dn> to move to the next page or back to a previous page to locate the intervention.
 -  Use Rt <Ctrl> to checkmark the intervention(s) you need; or highlight with one mouse click, check with a second click; or highlight and click 
 -  File.
-

8.07 Using the Wildcard lookup to select an Intervention









-  A "wildcard" method is available to locate an intervention:
 - At the intervention prompt, enter an asterisk (*) and then a key word of the intervention description (i.e. pass)
 - Press the <F9> lookup key or click  and a list of all interventions that include the word "pass" displays
 - Select the intervention you want from the list.
 - File.

Note: If a screen displays called 'Duplicate Interventions', the system is advising that the intervention you have newly added is already an active intervention on the care plan. DO NOT add duplicate interventions.









-  The Duplicate Interventions screen will present the Active intervention with an * beside the name, and the intervention you are trying to add with no asterisk. Use the Rt<Ctrl> to place a checkmark beside the duplicate (under the *) and file.
-  The next prompt is "Delete Checked Interventions", choose yes.
-  Only the interventions that are not duplicated will be added.
-  You will be flagged for Duplicate interventions most often when the patient moves between locations i.e. to or from PACU
-  If you have added an inappropriate intervention or duplicate, highlight it, enter CS for change status at the verb strip, backspace out the "A" for active, and change to "C" for complete.

8.08 Adding Intervention Sets

-  Select patient.
-  At the verb strip option, enter AI or click Add Intervention on the verb strip.
-  Enter forward slash </>.
-  Press <F9> or click  to display intervention sets listed in alphabetical order OR to display a shortened list, type the first three letters of the first word in the description and press <F9> or click  to display intervention sets
-  Select the applicable intervention set
-  File.








8.09 CD: Change Directions - Key Points

-  Directions indicate when an intervention is to be performed.
-  **Directions that default with the intervention(s) at the time they are added to the care plan represent the minimum expectation.**
-  The user has the ability to change or add a direction for an intervention, based on Physician' orders and/or patients' condition.
-  Any direction you require should be listed in the lookup.
-  Directions in the lookup are specific to eDoc.
-  Directions impact the appearance of interventions on the Status Board.

N.B. Allied Health users do not have directions associated with interventions.

N.B. Directions that are minimum standards (default in as part of care plan) should not be adjusted to a lesser frequency unless ordered by a physician.

8.10 How to Change Directions

-  Highlight the intervention.
-  At the verb strip, enter CD or click Change Directions on the verb strip
-  A box displays indicating current date/time and directions.
-  To change the directions enter past the current directions to the next blank line, enter today's date and the now time, (or if the directions were to start earlier enter the actual time they were to start) then press <F9> lookup or click  to choose directions.
-  Select the applicable directions from the lookup by choosing the number or click the entry.
-  File.

Change Intervention Directions

User: HTHAYNIA1 Name: NIALL HAY Mgm: NH


Patient: HA000108/05 HT,TEST1

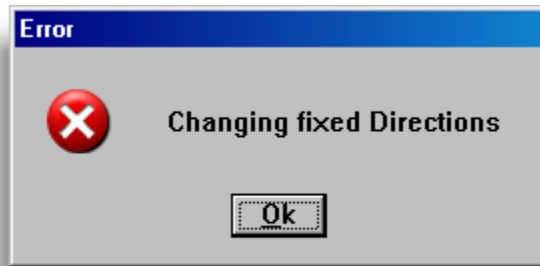
Intervention: N-Glucometer +

	Date	Time	Directions
1	04/12/05	2214	3XD
2			
3			
4			
5			


S

8.11 Fixed Directions






-  Some interventions have fixed directions that should NOT be changed. You will be flagged that you are “Changing Fixed Directions”



8.12 CL: Change Level - Key Points


-  The level determines the amount of care provided, which in turn **may generate the workload**. Examples: Amount of time or number of trips taken.
-

8.13 How to Change Levels




-  Highlight the appropriate intervention.
-  At verb strip enter CL or click Change Level on the verb strip
-  On the "Change Level Screen" the cursor will be flashing at new, use the <F9> lookup or click  to choose the correct level by number and press enter.
-  The cursor will be located at 'Edit', enter 'Y' if you wish to enter/edit how the Supplementary Text will appear under the intervention.

NB: Indenting your text 3 spaces will allow it to stand out.





Refer to Edit Text instructions.

-  File. The PI screen will display the new level.

8.14 CS: Change Status – Key Points

-  The status of an intervention should be changed according to the patient's needs, and/or Physicians' orders. The status of each intervention is displayed in the Process Interventions screen in the status column (STS).
-  Interventions statuses should be changed to reflect the current care.
-  Interventions that are no longer applicable should be completed. If these interventions become applicable again then the status should be changed to active rather than adding a new intervention and creating duplicate interventions.




8.15 How to Change Intervention Status

-  Highlight the intervention(s).
-  At verb strip enter CS or click Change Status on the verb strip.
-  Delete the current status, and add the new status.
-  File.






Status	Description
A – Active	Identifies the current care on the care plan (process intervention screen). Added interventions automatically default to A.
C – Complete	Status is changed to “C” for complete when the intervention is no longer required (i.e. after completing admission assessment), or the desired Outcome is met.
H – Hold	Status changed to “H” for hold when the intervention is temporarily not used or on hold because the patient is out on pass.
D – Discharge	When active interventions remain on the care plan after discharge – the system automatically changes the status to “D” as soon as the patient has been discharged from the system which identifies that the patient has been discharged. NOTE: You can still document on interventions that are at a “D” status for past dates (T-3) .

Intervention Statuses








8.16 DI: Document Interventions – Key Points

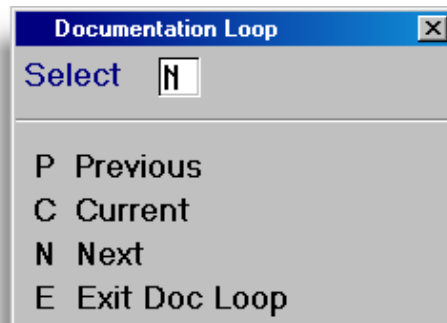
-  **IMPORTANT:** The time of documentation will default to a date of “Today” and a time of “Now”. If charting must be completed retrospectively, ensure that the time is changed to reflect when the intervention was completed. If the date and time both need to be changed use the following format: *T (today’s date), T-1, T-2 or T-3.*
-  Use this function to document interventions and document as close as possible to the time the intervention was completed.
-  Only document multiple interventions if they occurred at the same time or document a single intervention with multiple occurrences.



8.17 How to Document Interventions

-  Highlight the intervention you want to document
-  At verb strip enter DI or click ‘Document Interv’s’ on the verb strip
-  At OK?, enter Y
-  Complete the documentation.
-  File.







8.18 Documenting Multiple Occurrences of the Same Intervention





-  Highlight the intervention to be documented
-  At verb strip enter DI or click 'Document Interv's' on the verb strip
-  Enter additional dates/times on line 2, line 3 etc. as applicable
-  At OK?, enter Y
-  Complete documentation for first occurrence
-  A documentation loop screen appears, N defaults for next, press enter
-  Continue to document for all occurrences



-  While documenting, enter:
 - **P** - to return to a previous occurrence
 - **C** - to return to current occurrence
 - **E** - to exit without finishing occurrences
-  File. Message displays that "x" occurrences have been filed for 1 intervention

8.19 Documenting Multiple Interventions for the Same Date/Time



-  Highlight the first intervention to document, press the Rt Ctrl key or click  to place a checkmark in the left column.
-  Highlight the next intervention and press the Rt <Ctrl> key or click  to place a checkmark in the left column.
-  Continue to checkmark all interventions that occurred at the same date/time.
-  Note the top right hand screen indicates the number of interventions that are checked.

-  At the verb strip enter DI or click 'Document Interv's', document.
-  File.
-  Once filed, remove the checkmarks by pressing <Shift> + Rt <Ctrl> or click  to remove all checkmarks.





Note – The checkmark is powerful and always wins regardless of the intervention that is highlighted!

Remember to remove the checkmarks after documenting multiple interventions before continuing.



8.20 DN: Document Now - Key Points

-  Document Now - DN will bypass the date and time screen.
 -  To be utilized only when you are documenting for the current date and time.
-




8.21 How to Document Now

-  Highlight the intervention you wish to document.
 -  At the verb strip enter DN or click 'Document Now' on the verb strip
 -  Document.
 -  File.
-



8.22 EA: Edit Admin Data - Key Points

-  This function allows you to enter/edit the patient's Administrative Data, as needed. This should be updated regularly, as this screen is a "feeder" to many other screens, including the Order Entry Module, and is also the Electronic Kardex.
 -  Can also be edited from the status board by clicking Admin Data or entering "A"
-




8.23 How to Edit Admin Data

-  At verb strip enter EA or click 'Edit Admin Data' on the verb strip.
 -  Edit admin data screen as applicable
 -  File.
-





8.24 EO: Enter Orders - Key Points

-  Allows you to enter orders on your current patient, without leaving the Process Intervention screen.
 -  You cannot review orders through this option.
-




8.25 How to Enter Orders

-  At the verb strip enter EO or click 'Enter Orders' on the verb strip.
 -  Enter orders.
 -  File.
-

8.26 ET: Edit Text - Key Points


-  Edit Text (Same as Supplemental Text) enables you to add additional information regarding the intervention when you are not changing levels or there are no levels.
 -  Edit Text & Supplemental Text associated with interventions is not permanent, more like 'sticky notes' for reminders.
 -  Anything significant should be documented in an assessment and/or a patient note.
 -  The last Edit Text on a Care Plan is archived on the permanent chart.
-

8.27 How to Edit Text



-  Highlight the intervention.
-  At the verb strip enter ET or click 'Edit Text' on verb strip.
-  A pop up box appears, indent **3** spaces and type in information

 File.




The filed text will be seen each time the Process Interventions screen is viewed.

 To remove previously filed text, enter ET and use the backspace or <F10> (delete line) to delete, and file.



8.28 VP: View Protocol - Key Points

-  Interventions can have a definition, protocol, or care standards attached and these are viewable from the Process Interventions screen using the verb option VP - View Protocol.
 -  An asterisk (*) will display in the PRT column if there is a protocol attached.
-


8.29 How to View Protocol






-  Highlight the intervention.
 -  At the verb strip enter VP or click 'View Protocol' on verb strip.
 -  To exit the pop up box, use the enter key.
-

8.30 SI: Select Intervention - Key Points


-  Use this function to access any Inactive or Completed interventions to include them temporarily on the process screen. Once on the process screen, change the status to Active to retain it on the process screen.
 -  Exit from the routine and the additional Inactive and Completed interventions will be removed from the Process Intervention screen.
-

8.31 How to Select Interventions






-  At the verb strip enter SI or click 'Select Interventions' on the verb strip.

-  Sort – defaults according to user's access (INT – Intervention Headers or DGI – Diagnosis/Goals/Intervention).
 -  Include Status – defaults statuses viewable on the Process Interventions screen according to access.
 -  Go to the end of the list to a blank line, add the wanted status, (i.e. C – Completed) OR remove the unwanted status (i.e. I – Inactive).
 -  File. The PI screen displays with the updated statuses.
 -  Save for Next Time – if left blank or enter "N" for one time use only. To save these options for the next access of this patient then enter "Y".
-




8.32 Process Interventions by Location - Key Points



-  This functionality is used to 'mass' document an intervention that is applicable to a large number of patients. Example: Multidisciplinary Conference once a week applies to all patients on the unit.
-

8.33 How to document Interventions by Location





-  Enter the location (i.e. H.MED)
 -  Enter the intervention (i.e. Multidisciplinary Conference)
 -  Apply a checkmark beside the intervention for the appropriate patients.
 -  Document either using DN or DI.
 -  File.
-

8.34 Workload Measurement – Key Points

-  Workload Measurement is a by-product of documentation.
-  The GRASP Methodology is used to determine workload calculations; however, the Dataworks software will no longer be used to record workload.
-  Documenting in Meditech eDoc will not only record the care given but also calculate the workload measurement.








-  **Non Inpatient Nursing Units** (i.e. Recovery Room) will use the temporary locate feature to record the documentation and thus the workload.
 -  Temporary Location is managed from the Admin Data Screen.
-

8.35 How to Temporarily Locate

-  At the verb strip enter EA or click 'Edit Admin Data' on the verb strip.
-  The cursor will stop at the Temporary Location prompt.
-  Enter in the temporary location (i.e. H.PACU.D) or you can also do an <F9> lookup.
-  File.

Section IX. VIEW HISTORY


9.01 VH: View History – Key Points

-  This function allows you to view all activity that has occurred on a particular intervention.
-  This function also allows Edit or Undo of information recorded via the Document Intervention function.
 -  To edit previously filed documentation.
 -  To undo/delete any filed documentation.
 -  Edit/undo information is possible for a period **of T (today) and past days up to T-3**
-  Once data is edited, the edited version only will appear in PCI.
-  Both versions are in the permanent audit format of the online chart.






Users are responsible to chart the care provided as close to the time of the activity as possible. Using wireless technology/laptops or Point of Care devices at the bedside assists documentation in a timely manner.

However, there are instances when documentation must be edited. Refer to hospital policy for editing/undoing documentation.

9.02 E: Edit Documentation – Key Points

-  Edit queries previously filed or add to documentation if filed before completing.
-

9.03 How to Edit Documentation


-  Highlight the intervention to be edited.
-  At the verb strip enter VH or click 'View History' on the verb strip.
-  At View History, highlight correct date and time of the documentation to be edited (the type is Document).
-  Enter 'E' to edit and make the changes required.
-  File.

"Edit Results" will appear under the Activity Type on the VH screen with the new date and time of the edited intervention.






The time of a previously filed intervention cannot be edited. To do this – use the Undo function the intervention and re-enter with the appropriate date stamp using DI.

Note: Edited interventions do not generate workload measurement

9.04 U: Undo – Key Points

-  Undo or negate all queries on previously filed documentation.
-

9.05 How to Undo Documentation

-  Highlight the intervention that is to be undone.
-  Enter VH or click 'View History' on verb strip.
-  In the type column, choose the correct documentation to be undone, the type will be Document.
-  Enter "U" for undone.
-  File.







"Undo" will appear under the Activity Type on the VH screen with the new date and time the intervention was undone.

This undone documentation will always be viewed in the View History, and on the patient audit report but it will not appear in PCI.

N.B. You can only Undo your own documentation.



Section X. PATIENT NOTES





10.01 Patient Note - Key Points

-  Patient Notes are Interdisciplinary notes
-  A note is usually required:
 - On admission, transfer, and discharge.
 - For changes in patient status.
 - Significant events for the patient.
 - Exceptions to existing patient norms (including improvements and deterioration or additional data regarding the problem/focus.
-  A problem/focus is a description that defines a patient problem, strength, or significant finding that care will be focused on.
-  The "Focus" of the note should be identified on the 1st line
-  Patient note functions include:
 - **E** - Enter
 - **A** - Amend
 - **V** - View
-  Notes can also be viewed in PCI

Patient notes cannot be deleted once filed, however they can be amended to allow the user to clarify an entry. (i.e. mistaken entry)

10.02 How to Enter Patient Notes

-  Enter note, either via an intervention, or at the PN (patient note) on the PI screen or through a "Y" response to "Enter Patient Note" on select screens.
-  At the patient note functions box, highlight 'Enter Note' and press the right arrow.



-  At the note type, highlight No Type and press right arrow.
-  At the note category, press right arrow and your designation will appear. Press right arrow.
-  Verify that the date and time are correct, if not press <F6> previous field key to go back and edit date and/or time.
-  Enter the note using the FAIO note format.

F = Focus


A = Assessment

I = Implementation/Intervention







O = Outcome




-  File the completed note.
-  Spell check is available for notes by pressing Shift <F9> and highlight "Spell check".

10.03 Canned Text - Key Points



-  Canned text is used to assist in entering patient notes by providing templates and reducing the amount of free text typing.

10.04 How to Use Canned Text















-  In the patient note screen, to Get Canned Text press the <F4> (Get Key).
-  Press <F9> or click  to look up the list.
-  Choose the appropriate entry, press or click the up/down arrow keys to scroll and select the appropriate note.
-  The cursor will stop after the description – you can add more detail if needed. Within canned text there are [] brackets that have been created to help move your cursor to the correct place to document. Information may default in as you move through the screen if it has been previously entered or documented.
-  Enter the text of the note then move from bracket to bracket with the enter key.

-  Originally the canned text is pink. The text will turn black when the end of the note is reached. The arrow keys can then be used to move up through the text to edit, add, or spell check the note.
 -  File.
 -  Once filed the note is immediately available to be viewed in eDoc and PCI.
-


10.05 Amend Existing Notes - Key Points

-  Attaches (or adds) a note to one already entered.
 -  This includes making a correction or addition to an existing note.
-

10.06 How to Amend Existing Notes

-  At the verb strip enter PN or click 'Patient Note' on the verb strip.
 -  At the patient note functions, highlight Amend Existing Notes and press the right arrow or click .
 -  At the type of note, highlight All Types, and press the right arrow or click .
 -  At the Amend Note, identify the note by date/time and highlight the note to be amended.
 -  Press the right arrow or click .
 -  When the note has been viewed on screen press the escape, exit, or enter keys to amend. The cursor will move to the bottom of the screen where the new note can be entered.
 -  Enter the updated note.
 -  File.
 -  The new note text will display below the existing note text when printed and/or viewed, preceded by an Addendum notation indicating the author and date/time of the amended note.
 -  A filed note CANNOT BE DELETED.
 -  *NOTE:* When viewing notes an * asterisk will display beside the note after an edit or amendment has been filed.
-

10.07 Undo Notes - Key Points


 Allows clinical staff to undo patient notes. Reasons for undo are:



- Incorrect Patient
- Incorrect Pt Visit/Account
- Incorrect Documentation
- Duplicate Documentation



 Undone notes are not visible in PCI and in “View Existing Notes”.


 Undone notes can be viewed in eDoc in “View Undone Notes”.

10.08 How to Undo Notes


 At the verb strip enter PN or click ‘Patient Note’ on the verb strip.

 At the patient note functions, highlight Undo Existing Notes and press the right arrow or click 


 At the type of note, highlight All Types, and press the right arrow or click 


 At the Undo Note, identify the note by date/time and highlight the note to be undone.


 Press the right arrow or click , press enter.

 Reason For Undo, enter free text or choose from lookup, Undo this Note? Enter Y.




10.09 View Existing Notes - Key Points

 Notes will appear in chronological order, and by note type.


 The first line of the note will always be the focus using the FAIO methodology.

 All notes can be viewed under Patient Notes via the status board and process intervention screen. They can also be viewed in PCI under the header Patient Care Notes.

10.10 How to View Existing Notes


-  Highlight the note to be read.
 -  Continue to press the right arrow until you are able to read the note.
 -  To exit use the left arrow or the <F11> exit key.
-

10.11 View Undone Notes

-  View all undone notes for all note types for all days of stay
-

10.12 Print Notes by Date







Note- Printing should be done through the Print Patient Profile option on the Main Menu. Please do not use the Print Note features found on the Patient Note mini menu.

-  The buttons that are greyed out are unable to be used in the FLOWSHEET. To use the other choices, you must enter the underlined letter of choice, or click on the button.

The buttons across the bottom of the status board are standard to the Flowsheet.

11.03 Sections

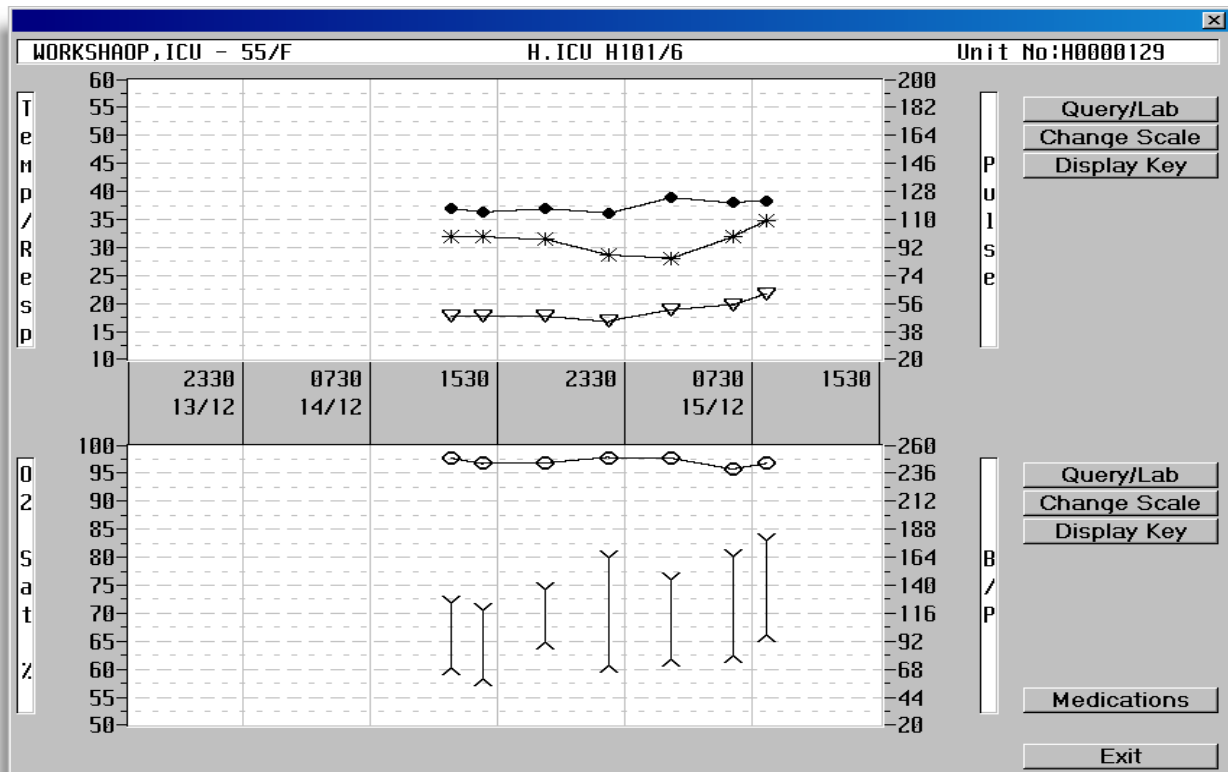
Sections

-  Will display the following
 - o Vital Signs, Intake/Output, CBI, Glucose Results, Weight, ABG/Ventilator
-  Only one section at a time can be viewed.
-  Choose a section by clicking on the selection or using the up/down arrow keys – wait for Flowsheet to refresh.
-  Subsections can be collapsed or expanded by clicking on the subsection.
-  '+' sign indicates there is data available under that subsection.
-  '-' sign indicates there is no data.

11.04 Graph

Graph









-  View numerical data in a graph format



Vital Signs Graph

11.05 Time Period







Time Period

-  Standard Flowsheet defaults 48 hrs.
-  Can only view a range of 4 days.
-  May go to past dates to view data as well, but may still only view 96 hours of data.
-  To view another time range, click on Time Period.
-  Cursor stops at new format.
-  Press <F10> to delete the default date and time and enter numerically or use "T & N" or click and use the mouse on the calendar.
-  New Time Period, press <F10> to delete the default period or click to choose a time period from 12 - 96 hrs.
-  File


Flowsheet View can also be changed from Time Period if users have more than one view defined.

Section XII. PCI

12.01 PCI - Key Points

-  All clinical documentation from eDoc may be viewed in PCI.
-  Information from other modules is also available in PCI (i.e. Pharmacy, Admissions, Order Entry).
-  This is a 'view only' application.
-  There are audits that are done to ensure that you are only viewing appropriate patient data necessary to provide care.
-  eDoc clinical information can be displayed in PCI under Data Sources on the Table of Contents.
-  This data source will allow you to scroll to the left and right to view more data use the "+" and "-" keys to scroll.

Section XIII. FLOW OF INFORMATION WITHIN eDoc/PCI

-  Within eDoc there are various places to document clinically significant information. Based on the key components of documentation the following table outlines where information is documented within eDoc and where it can be viewed in PCI.





Patient Information (Documented and viewable in eDoc)	PCI Data Source (View only)	Flowsheet Section (View only)
Intake and Output	Intake and Output Summary	Intake and Out
Vital Signs	Vital Signs Queries	Vital Signs
Weights	Assessment Forms Care Area Administrative Data Weights Queries	Weight
ADL's – Nutrition, Hygiene, Elimination, Mobilization, Sleep	Activities of Daily Living (ADL)	
Admission History, Physical Assessment, etc.	Assessment Forms	
Drains, Tubes, Catheters, Respiratory Treatments, Nausea & Vomiting Management,	Treatments & Procedures	

Patient Information (Documented and viewable in eDoc)	PCI Data Source (View only)	Flowsheet Section (View only)
Bowel & Stoma Care, Compress & Ice Pack, Assistive Devices, CPM, Deep Tendon Reflex, Breast Pump		
Safety, Wandering Patient, Restraint Care/Monitor, MH Control/Restraint, MH Constant Care, Infection Control	Safety / Environment	
Croup Score, Braden Scale, PPS, ESAS, Paediatric Coma Scale, Pain Scale- Adult/Paediatrics, Retraction Score, Gait Speed, 6 Minute Walk Test, Berg Balance Scale, CB&M Scale, COVS Mobility Scale, Elderly Mobility Scale, TUG, STREAM	Scales/Scores	
Vent/BIPAP, Cardiac Telemetry, Temporary Pacemaker, Vaginal Exam, Enteral Feeding, Tracheostomy Care	Nursing Specialty Procedures	ABG/Ventilator
Glucometer, Bilimeter, Blood Collection, Urine Dip/ Amniocator, POC Testing-NH, Specimen Collection	Specimen Collection	Glucose Results (Glucometer)
Breast Feeding, Continence, Falls, Functional Status, Nausea, Pain, Skin Integrity, Shortness of Breath, Safety	MOH Indicators/Outcomes	
Hip Care Path, Acute Stroke Path, Pneumonia	Care Path/Outcomes	

Patient Information (Documented and viewable in eDoc)	PCI Data Source (View only)	Flowsheet Section (View only)
Recommendations for consideration by Physicians or other clinicians	Recommendations	
Intervention Sets & Additional Interventions	Plans of Care	
Patient Notes	Patient Care Notes	

Section XIV. PRINTING

Printing - Key Points

-  Printed information should be maintained in a confidential manner.
-  Printing information that is not necessary increases your risk of breaching patient confidentiality.
-  Only print when absolutely necessary following the corporation's printing policies.
-  **Refer to 'Patient Records – Printing-Electronic Record Policy' for specific information**

Section XV. DOWNTIME

Downtime - Key Points

-  **Refer to 'Documentation – Electronic Downtime' for specific information**

Section XVI. QUESTIONS



Please write down your questions for the end of the sessions.

