THE PATIENT LIST

The Patient List displays a list of all patients on the unit set as your default. However, you may create additional patient lists in order to view other patient lists or a custom list.

TO ADD A PATIENT LIST: (This will allow you to add a patient list tab other than your default list tab.)

- Login to PowerChart.
- Click on List Maintenance wrench located above the default patient list.
- The Modify Patient List window will appear.
- Click on the “New” button in the lower right corner.
- The Patient List Type screen will appear.
- For building a location (unit census list) follow directions below.
  - Click on “Location”, then click the “Next” button.
  - On the Location Patient list screen, click on the “+” next to Sinai Hospital of Baltimore or the Northwest hospital location.
  - Click on the “+” next to SHB or NWHC.
  - Click on desired unit name—the unit census has a nursing cap icon. (not the “+” sign).
  - Click on “finish”.

Patient list

LIST MAINTENANCE WRENCH
• The Department name will appear in the “Available List” section of the Modify Patient List window.
• Click to highlight the department name.
• Click the “blue arrow” button in the middle of the screen.
• The department name will move to the Active List section.
• Click “OK”.
• The selected unit will now appear on your Patient List tab.
HOW TO CREATE YOUR OWN CUSTOM PATIENT LIST TAB:
At the beginning of your shift you will create your custom list specific to your patient assignment. This will require adding patients from the unit list to your custom list and removing patients as your assignment changes.

- Click on List Maintenance **wrench** located on the toolbar.
- The Modify Patient List window will appear.
- Click on the “New” button in the lower right corner.
- The Patient List Type screen will appear.
- Click on “Custom”, then click the “Next” button.

- Enter your name for the list.
- Select “Finish”.

![ Modify Patient List Window ](image1.png)

![ Patient List Type Screen ](image2.png)
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- Click on newly created list from available list column and it will highlight.
- Click Blue Arrow to Activate List.
- Click “OK”.

Your custom list will now display. (Only you will be able to view this new tab.)
TO DELETE A LIST:

- Click on List Maintenance wrench located on the toolbar.
- Right click on the List you wish to delete.
- Click on “Delete Patient List”.

ADDING UNIT PATIENTS (YOUR ASSIGNMENT) TO YOUR CUSTOM PATIENT LIST:

- Go to the Unit Patient List Tab.
- Click to highlight all patients you want to add to your Custom Patient List. (To highlight patients that are not in sequence, hold down the control key as you left click.)
- Right click on highlighted patients and select “Add to a Patient list” and follow arrow over to the list you created as your custom list to view your patient assignment.
- This list needs to be created fresh every day or updated as often as the assignment changes to reflect your patient care assignment.
• Patients will now appear on your Custom List.
• If the patients do not show up on your list you may select the refresh icon to refresh your view to update your list.
SETTING PATIENT LIST TO DISPLAY NON-DISCHARGED PATIENTS:
Discharged patients will automatically fall off your custom list once they have been discharged in Medipac and /or GTE.
- Click on “Patient List”.
- Click on “List Maintenance” on the Menu Bar.
- Select “Properties”.
- Click on “Not Discharged”
- Click “OK”.

DELETING PATIENTS USING TOOL BAR ICONS:
Staff should remove all patients from their Custom List and add their new assignment at the beginning of each shift.

REMOVING PATIENT UTILIZING “REMOVE PATIENT ICON”: 
- Highlight patient you need to remove from your list. (All patients may be selected).
- Click on the “remove patient icon” (Man with the red X)
- Patient will be removed from your list.
SEARCHING FOR PATIENTS NOT ON YOUR PATIENT LIST

Search for patient by name or medical record number. If you type name in first it will populate when the patient search screen opens.

If you prefer you can search pt by medical record number by selecting the arrow down.

- The Patient Search Screen appears.

- You can also just select the binoculars directly to get the search screen to appear to type in the patient information.
OPENING THE PATIENT CHART

**CAUTION:** Both Northwest and Sinai patients are listed in the view screen. To assure you are selecting the correct patient, check the Medical Record number (MRN). Then highlight the patient name and view the Encounter screen. Under the column “Facility”, you should see Sinai or Northwest Hospital listed.
An encounter is defined as a visit to a LifeBridge facility. One patient could have multiple visits/encounters. To be certain you are opening the correct encounter/active encounter, view the encounter screen at the bottom. There should be NO discharge date for an active encounter.

When orders are entered on an incorrect encounter, they will not appear on the current electronic chart. This contributes to a delay in care and billing errors.

To open the chart, select the patient’s name and highlight the correct encounter, then click the “OK” button at the bottom. Chart may also be opened by double clicking the patient name.

**USER TIP:** A relationship must be established with the patient the first time a chart is opened.
The PAL Icon

The PAL is an on-line work list (an electronic version of the report sheet) which serves as a link between physician orders, tasks, and documentation. The PAL is organized two ways. It can display multiple patients and/or can be specific to the clinician’s patient assignment and/or to the unit they are covering. The purpose of the PAL is to:

- Give/receive report.
- Orient the clinician to a new patient.
- Receive immediate electronic notification of changes to the patient’s orders.
- Document care that has been provided throughout the Healthcare providers’ shift.
- Have reminders of when tasks are due.
- Provide a means of communication between the clinician, physician, and administrative associate.

The PAL’s functionality and purpose is specific to the user. The Nurse, PCA (technician & nursing assistant) and Administrative Associate’s (unit clerk’s) PAL display different sections according to job description/role, and the user will utilize the PAL within their scope of practice. (Registered Nurse, Licensed Practical Nurse, Special Assistant, Patient Care Associate 1&2, Technician, Nursing Instructor, Nursing Graduate and Administrative Associate, and Unit clerk will have access to the PAL.) The PAL should be checked at a minimum of every two to four hours depending on the patient’s acuity for new order notification.

ACCESSING THE PAL:
Patient Access List (PAL) is accessed through an icon displayed in the PowerChart Organizer.

- Click the “PAL” icon to display.
- A Time Frame Selection window will appear.
- Select the shift or time frame desired and this selection will create the timeframe on your PAL. Choices can be made from the shift list or you may select a time range.
The PAL allows the clinician to view all patients on a specific unit or view their Custom List.

VIEWING UNIT PATIENT LIST OR CUSTOM PATIENT LIST ON THE PAL:
- Right click on the Green Date/Time Bar.
- Select “Change Patient List”.

![Image of the PAL interface showing patient lists]
• and select “OK”.
• The selected patient list will now appear on the Pal.

**PAL COLUMNS**

**PATIENT NAME COLUMN:**
- Patient’s chart may be opened by double clicking on the patient’s name OR
- Right click on patient’s name to select specific chart sections.
• The PAL may be organized alphabetically by patient name by clicking on “Name” at the top of the Name Column.

PATIENT DEMOGRAPHICS COLUMN:

- **ROOM:** The PAL may also be organized by Room Number by clicking on “Room” at the top of the Room Column. To organize your Room Numbers this way it needs to be done each time you sign on to the PAL.
- **D/C D:** Once a patient is discharged from Medipac or GTE, the discharged date will appear in this column. (If your filter is set for discharged patients to fall off your PAL and Custom list then the patient will fall off and a date will not display in the D/C D column.)
- **ALLERGIES:**
  1. No Known Allergy icon
  2. Allergies Documented icon
  3. No Allergy Information Documented icon

  **USER TIP:** Allergies must be documented within one hour of admission unless an emergency situation is occurring.

- **CODE STATUS:** Full Code or DNR

  **USER TIP:** The electronic chart is equivalent to the paper chart. A code status order must be entered by using the resuscitation status order found in quick orders. If no information displays in the Code Status category it is assumed the patient is a full code, unless otherwise stated.

- **NPO:** Displays when patient is ordered to be NPO.
- **IV:** Icon displays when patient has an IV solution order that has been entered into the system by pharmacy.
- **ISOLATION:** Displays isolation type.
- **ATTENDING PHYSICIAN:** populates over from registration system
- **Scheduled Events:** Displays diagnostic tests and surgical procedures already scheduled.

  **USER TIPS:** The width of the Pal’s sections can be adjusted by holding and left clicking the mouse on the borders and dragging at the same time. All sections also have a horizontal scroll at the bottom of the screen.
ORDERS COLUMN:
Notification of orders that are new, STAT, and/or discontinued, and which may require Nurse Review.

Eyeglasses signify there is a new order and nurse review must be performed. If there is a red exclamation point following the eyeglasses, the order has been designated as STAT. The provider should continue to notify the nurse when entering STAT orders.

Nurse Review (eyeglasses) is the process to verify new orders and/or discontinued orders entered by the AA or Providers are correct.

NURSE REVIEW FROM THE PAL:

- Double click the “eyeglass” icon.
- Verify computer order with the written order.
- Ensure that the box to the left of the orders you wish to review contains a check mark (or uncheck the box if you do not wish to review that order at the present time or if the order needs clarification).
- Click the “Apply” and then “Review” button in the lower right corner.
- All staff caring for a patient will receive order notification, however only appropriate staff will be able to review orders. Generally, tasks should not be carried out by the PCA or technician until the order has been reviewed. Exceptions to this would be when vital signs are ordered, or the tasks are delegated verbally to the PCA or technician from the RN.
- The Nurse Review process is a nursing function that is performed whenever new orders are entered. Also, look for new orders whenever you utilize the PAL.
- The Clipboard icon notifies the health care provider of new orders that have been reviewed by the nurse. Double click the “clipboard” icon and then click “apply” to signify you were notified of the new orders.
USER TIPS:

Scenarios where you will see clipboards and eyeglasses:
Orders are entered into the computer for Mrs. Smith. The RN sees eyeglasses on Mrs. Smith’s PAL. The RN completes Nurse Review on the orders for Mrs. Smith. The following nurse’s view will now be a clipboard. Once the second nurse does the second nurse review (selects apply), their clipboard icon will fall off their PAL. Staff are only responsible for reviewing the eyeglasses and clipboards on their assigned patients.

- New orders that need to be reviewed always appear on the Nurse Review Tab. The Nurse Review Tab should be clear when giving shift report or giving/obtaining report on a transfer patient. This is another way to hold your peers accountable. Think of clearing the Nurse Review Tab like the “chart check” that is performed in the paper chart.

- If Nurse Review is performed from the PAL first, the orders will fall off the Nurse Review Tab. If you perform Nurse Review from the Nurse Review Tab first, the orders will still appear on the PAL.

NOTE: More information about the Nurse Review Process is located on page 33 of this manual.

The sticky notes column has been discouraged from use due to non-consistant functionality at this time
TASKS COLUMNS
Allow the user to view tasks that have been ordered, tasks that must be completed and tasks that are overdue. (Tasks are represented by icons.)

- **OVERDUE COLUMN**: Incomplete patient care tasks appear in this column four hours after they are due to be completed.
- **PRN/CONTINUOUS COLUMN**: Task is always present. These are tasks that do not have a frequency.
- **CURRENT COLUMN**: Tasks post into this column the hour that they are due and will remain until they are completed or they move into the overdue column.
- **TIMED COLUMNS**: Time specified columns that are divided into four hour increments.

TASK ICONS

- ![Medication Task icon](image)
  - Medication Task

- ![IV fluid task](image)
  - IV fluid task

- ![Patient Care Task](image)
  - Patient Care Task

- ![Pain response task](image)
  - Pain response task

VIEWING TASKS:
- Double-click icon.
- Detailed information will display in the context menus or dialog boxes (Date, Time, Task, Detail, and Status)
- One icon can represent multiple tasks.

**USER TIP:** If many task icons appear on the PAL, you can be certain you are selecting the correct patient’s icons by single clicking on an icon in the PAL, it will highlight the patient’s name in the demographics section on the left of the screen. When charting a task be sure to check you are in the correct patient’s chart.
CHARTING COMPLETED TASKS:
- Double click on cell containing icons and all tasks associated with that icon will list.
- The task information will display.
- Each task will have a check mark in the box to the left. This check mark indicates that the task is ready to chart.
- Charting Tasks can be performed using two methods: 1. Either Left click on the word “chart” at the bottom right hand corner or 2. right click on the selected task and choosing “chart details. If the option is used to select “chart” make sure the check mark is present only in front of the form wished to be documented on or else all of the items selected will appear one after the other to be charted upon.

User tip: It is not recommended for nurses to use “quick chart.” There will be medication tasks and patient care tasks displayed on the PAL. Only patient care tasks are to be completed by the PAL. Medication tasks are to be completed on the EMAR. Medication tasks are only on the PAL as a reminder. If Quick chart is selected and a medication task with no mandatory details are present it is possible to make a medication error.

Chart Button: If certain tasks were not completed, deselect those tasks by removing the check marks and click the “Chart” button. The associated powerform will display for documentation. Once the form is completed and signed the task will fall off of the PAL.
2. **Chart Details**: Right click on the selected item to chart upon. This is very helpful when have many tasks and even medication tasks present. Choose the option of **“Chart details”** to view powerform.

**USER TIPS:**
Unless a task has an associated PowerForm, additional documentation will still occur on the progress notes or IPOC form. (ex., EKG completion, DARP and SBAR notes)

If a task is charted through Ad Hoc charting, and not the PAL, the icon will not disappear. If you have charted through Ad Hoc, you must open the Icon from the PAL, “right click” on the task and select “**Chart Not Done**” with a reason of “Task Duplication”
MULTI-PATIENT TASK LIST

The Multi-Patient Task List displays tasks of all patients on the provider’s custom list and/or unit list. These are tasks that are to be completed by the clinician. The tasks are sorted into the following tabs: Scheduled Patient Care, Scheduled Medication, All PRN Tasks, and All Scheduled Tasks. The Multi-Patient Task List also displays all PowerForms associated with tasks that require charting. As you recall, tasks can be accessed via the PAL. The Multi-Patient task list provides another method to access information that is also present on the PAL. Depending on the task, the provider is able to chart and/or modify.

SETTING TASK LIST PROPERTIES (Must set for each Tab):

- Click “Options” on the menu bar.
- Select “Task List Properties”.
- The Task List Properties window will appear.
- In the Time Frame tab, click to select “Defined Time”.
- Select a shift (do not click OK at this time).
- Click to select the “Patient List” tab.
- Click in the square field next to Choose a Patient List.
- Select a department or custom list.
- Click the “OK” button.

  From the list, single click on the task and the form will appear. If there is no form associated with the task, a check mark will appear to the left of the task name. The check mark indicates “Task Complete”.

![Multi-Patient task list](image-url)
THE PATIENT CHART

OPENING A PATIENT’S CHART:
- Double click on patient’s name from patient list tab.
- Double click on patient’s name in the name column of the PAL.
- Searching for patient and clicking on the patient’s name to open.

PATIENT’S CHART VIEW

With cerner enhanced view (Lifebridge went live with Enhanced View in March 2009). We maneuver through a patient’s chart using the menu option on the left side of the screen. The display along the top is the yellow banner bar. Always confirm the correct patient name and room number prior to completing any online documentation.
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Enhanced View Quick Reference Guide- Patient Care

What has changed?

**Quick Patient Search**- Enter MRN or name and hit enter to search

**Patient Search Window**- Click the binoculars to access the full Patient Search Window

**Recently Viewed Charts**- Menu will display up to the last 5 patient charts opened. Click on the down triangle to open the list

**Refresh Button**- replaces the “As of…” button with a Microsoft Windows refresh symbol and indicates how many minutes since last refresh

**Menu**- tabs that were previously across the top of the patient chart are now listed along the left side alphabetically in a table of contents

Hide or show table of contents of Menu by clicking push pin

April 2009
Table of contents/Menu

1. Clinical consults and clinical notes

To view a specific consult Left double click on the note to view note or consult.
To view clinical notes pin the menu closed and choose the note from the left hand side wished to be viewed and then left double click to open note. These notes will appear in summary format.

2. Form Browser

Allows the user to view, modify, and erase data that has been documented.
- Blue icon indicates required fields have been completed.
- Red icon indicates required fields have not been completed.
- Form Browser posts forms in order by date.
- User may right click on Blue Date/Time bar and change Date range historically.

... The most recent form completed is at the top. We can also change the sort at the top to view by form in alphabetical order.

UNCHARTING the Data if Completed on the Wrong Patient

- Click on the **Form Browser** from menu
- Select a form that you need to unchart
- Right click
- Select **Modify**
- **Click on Clear** (eraser) icon to delete the data then sign the form.
VIEWING DOCUMENTED POWERFORMS:
This function only allows you to view the form.
- Double Click on selected form OR
- Single click to highlight selected form.
- Right click.
- Select “View”.

MODIFYING FORMS:
This function is used to document information on a form that has already been started or to correct wrong information.
- Single click to highlight selected form.
- Right click.
- Select “Modify”.
- Modify and sign form.

STUDENTS DOCUMENTATION and New Grad/LPN (assessment) CO-SIGNING PROCESS
- Students are able to document and modify a form.
- Once the form is signed by a student it will have a status unauthorized.
- To check if the form was co-signed already or not, go to Form Browser and look at the status of the form:
  - Unauthorized = form was not co-signed by RN
  - Authorized = form was created by or co-signed by RN
- RN will need to co-sign the student’s form in Form Browser:
  - Select the Form to be co-signed
  - Right click
  - Select Modify
  - Review student’s documentation
  - Sign the form
  - Once the form is co-signed by RN, the status of the form will change to authorized.
3. Handoff

Summarizes key handoff information about the patient on one tab. Available as view only it is used to supplement/enhance current report/handoff processes for report between units and shifts to ensure accurate communication.

4. Intake and output

- The Intake and Output flow sheet default view displays results for 24 hours beginning at 0000 hour. The time frame can be changed by clicking on the arrows or by right clicking to change the search criteria. A navigator bar displays I&O types.
- The current date and time row is highlighted in yellow.
For more information regarding I+O’s please refer to EMAR and I+O manual in cerner help guides.

5. IVIEW

For Nurses Only:

IVIEW Documentation

IVIEW allows the nurse to document directly onto the flowsheet

To change the time, complete these steps:

- Right click on the date/time
- Click on Insert Date/Time

- The new column will be displayed
- Right click on the Date/Time in the new column
- Select Change Date/Time
- Date and Time fields will open
- Change the time in the Time field
- Click Enter
Data Entry in IVIEW

1. Double Click on the Section Title (for documentation on the entire section)
   - Check mark will appear in the box
   - The first field will open
   - Enter data
   - The next field will automatically open (for single choice selections)
   - In multiple selections fields, click Enter after each entry
   - Sign IVIEW by clicking on the checkmark on the top

To fix errors in IVIEW:

Modify Data
   - Right click on the field to be modified
   - Select Modify
   - Change information
   - Sign
   - Updated information will appear in the field with the small blue triangle on the right lower corner (delta sign)

Unchart Data
   - Right click in the field
   - Select Unchart
   - Select “other” in the reason field
   - Type “Error” in the Comment field
Note: In addition to uncharting data in IVIEW, “Uncharted Results IVIEW” powerform has to be completed if the entire assessment was done in error:

- Click on Ad Hoc icon
- Select Uncharted Results IVIEW form
- Enter information

5. MAR
The default view is 24 hours-12 hours prior to current time and 12 hours following current time. It may be customized by either:

- clicking the arrows at either end of the information bar
- by right clicking and changing search criteria.

**NAVIGATOR BAR**

- Active in color
- Inactive in gray

The Scheduled medications section is where the patient's current medications are available.

<table>
<thead>
<tr>
<th>Medications</th>
<th>02/09/06 09:00</th>
<th>02/09/06 10:00</th>
<th>02/09/06 11:00</th>
<th>02/09/06 14:00</th>
<th>02/09/06 16:00</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dis contributed</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.125 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apical Heart Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Penilecure Rate</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Second Nurse Verify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diphenhydramine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.125 mg</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Apical Heart Rate</td>
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<td>Penilecure Rate</td>
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<tr>
<td>Second Nurse Verify</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acepromazine</td>
<td>40 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.5 mg</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Medication administration is documented from the task box displayed under the time the medication is due. Medication administered posts on the administration line below the time it was administered.

For more information regarding The electronic MAR please refer to EMAR and I+O manual in cerner help guides.
6. Medication List

Inpatient orders, documented home medications and prescriptions will appear on this tab grouped together when the default view for the Medication List is customized. Here is how to customize this tab.

Customize View screen for the Medication List Tab

Change “Group Orders by” to “Venue”

Medication orders are grouped by 1. Inpatient Orders, 2. Prescriptions (from EVisits), 3. Documented Home Medications.
Providers can review the med list to see medications that the patient is on during inpatient visit, home medications, and prescriptions given to the pt from the ED or upon discharge. 

**Note:** If the patient is to be transferred to another facility either the AA/Unit clerk or nurse can print off this list and handwrite in the last dose of medication received in the hospital prior to discharge so the next facility has this information for their medication reconciliation. To print this list select the task option from the menu bar and choose the dropdown “print”.

### 7. Meds given

Medication dosage posts under the time the medication was given.
8. Nurse review

TO DO NURSE REVIEW:
- Single click to highlight the orders you want to Review.
- Click on “Review” in the lower right hand corner of the screen.

NOTES ON NURSE REVIEW:
- Orders can be reviewed from the PAL and/or from the Nurse Review Tab.
- The only way the eyeglass icon disappears from the PAL is to open the icon and review the orders.
- When opening the eyeglass icon from the PAL there may be orders that don’t have eyeglasses next to them. See following screen shot.
When orders are reviewed from the Nurse Review Tab order notification still goes to the PAL, however there are no eyeglasses next to the orders because the orders have already been reviewed. After entering orders on a patient, immediately go to the Nurse Review Tab and review the orders. This will prevent other health care providers receiving eyeglasses on their PALs. Instead they will receive clipboards.

- New orders that need to be reviewed always appear on the Nurse Review Tab. The Nurse Review Tab should be clear when giving shift report or giving/obtaining report on a transfer patient. This is another way to hold your peers accountable. Think of clearing the Nurse Review Tab like the “chart check” that is performed in the paper chart.

- If Nurse Review is performed from the PAL first, the orders will fall off the Nurse Review Tab. If you perform Nurse Review from the Nurse Review Tab first, the orders will still appear on the PAL.

  Note: If an order is not appropriate for the patient—DO NOT REVIEW/APPLY the order. Follow up should occur with the physician to make sure appropriate care is given.

9. ORDERS

Orders are categorized by Clinical Category to facilitate search. The Clinical categories are listed on the left side of the screen in the “View” field. To move to a specific category, click on the category on the left side of the screen to navigate to that section.

Orders are also viewed by Clinical Category on the scratch pad. Categories are written in blue with orders listed underneath.
Types of Orders

- **Individual Orders** – each order is entered separately into the system.
- **Order Sets** – grouping of orders that allow ease of order entry based upon a patient’s diagnosis or specialty area. For example, a patient with a pneumonia diagnosis can easily have orders entered by choosing an order set for that diagnosis.
- **Protocol Orders** – a group of orders approved by MEC that may be ordered without notifying the physician (i.e. vaccines and consults based on risk assessment tools, IV line flushes).
  - Protocol orders may be entered by the RN for approved LifeBridge Health protocols.
  - Orders are entered using the **Protocol, Protocol** name as the prescriber, and ensuring that **Protocol** is highlighted in the Ordering Physician box (Communication Type) prior to clicking OK.
  - These orders will NOT route to the MD for co-signature as protocols have been approved by MEC throughout LifeBridge Health.

**NOTE:** Protocols are entered in computer by RN; they are initiated by RN. Protocols do not contain medication orders. Order sets are entered by MD; Order sets are more comprehensive than protocols. Order sets contain medication orders.

Orders placed with protocol or an order set will display in their individual clinical category and will not be displayed under the “Order Set” category. The name of the ordered protocol or order set will be displayed under Admit/Diagnosis clinical category.

**PLACING ORDERS:**

**ORDERS CAN BE PLACED USING DIFFERENT SEARCH METHODS:**

- **Global Search** (just typing order in order entry window)
- **Search within specific order profiles** (Similar to an All Items and Orderable Search combination in the old system.)
- **Search by Unit Folder Hierarchy**
- **Favorites**

**GLOBAL SEARCH:**

Allows you to search the entire database of orders.

- Single click the “Add order icon” (Blue plus sign +) to enter new orders.

![Image of order entry window]
Once the order is selected order sentences appear. **Some orders will have default order sentences pre-built for added efficiency and convenience.**

- Select the correct/closest order sentence. Order sentences can be modified once selected or “None” can be selected to add the order details manually.
- RT=routine, ST=stat, T;N=today and now, T+1=tomorrow.
If no order sentences are selected these orders will post with a “X” indicating mandatory fields must be selected before orders can be signed. Once the order is highlighted the order details at the bottom is displayed so the details may be changed.

ORDER ENTRY

Most orders take these steps to complete:
- Search for the order
- Select the order
- Complete the order details
- Review the order
- Sign the order
- View the completed order on the Order Matrix

Adding the Order
- Open patient chart
- Click on the Orders tab
- Click on the Quick Orders
- Single click the “Add” icon to enter new orders (displays as + Add)
NOTE: You are able to search according to “start with” details or “contains” details.

- The order conversation window will appear
- From here, the appropriate orderable can be searched and the order details are entered
- Click in the “Find” field to activate
- Type in order name. The system will search for the order
- Select the order(s) and click the “Done” button in the lower right corner once you have selected ALL required orders. The order details will be displayed in the top half of the screen (in the Scratch Pad)

User Tips: Multiple orders from the same clinical category can be added to the scratch pad and modified or signed at the same time by clicking on the orders while depressing the control key.

Order Modification.
Methods to Modify order details:

1. Order Sentence
   Some orders will have default order sentences pre-built for added efficiency and convenience. Order sentences contain the pre-set order details and are used to streamline order entry.
   - The order sentence window will appear when the order is selected
   - Select the correct/closest order sentence.
   - Order sentences can be modified once selected or “None” can be selected to add the order details manually

2. Order Details Screen
   If there are no order sentences for the order or if you prefer to add the order details manually, modify the order using the order details screen at the bottom.
   - Single click to select the order to be modified prior to signing
   - The Order Details screen will appear
   - This window may have to be re-sized to be able to view all order details. Resizing may be accomplished by clicking on the arrow in the upper left corner of the window or by clicking and dragging the border
   - To modify orders manually, click once on each of the order details to enter the detail values on the right side of the screen.

NOTE: Any order which has required fields for completion will have a blue “X” on the left side of the order. Yellow Fields are required fields and bolded fields with bracketed values are default values.
   - The order details will be displayed in the top half of the screen (on the Scratch Pad)
Finish the Ordering Process:
- Review the order on the scratch pad before signing it
- When no further modifications are needed, click the “Sign Now” button in the bottom right corner to sign the order
- The order will be displayed in the appropriate clinical category
- Click the “As Of <blue refresh icon>” to refresh the Order Display Matrix

*User Tips: Orders cannot be signed until all required fields have been completed. If you attempt to exit the system without signing orders, an alert screen will fire.*

**Favorites** allow for the creation of a customized list of the prescriber’s most commonly ordered items.

**Saving in Favorites with order details**
- When placing the order, add all details such as frequency, duration, etc.
- Prior to signing, right click once on the order from the scratch pad
- Select “Add to Favorites”
- Create and name new folder – could be the prescriber’s name or could be name for the clinical category (i.e. labs)
- Click “OK”

### ORDER ACTIONS

**Remove Order**
Orders may be removed from the scratch pad before they are signed (if selected in error).

*NOTE: If the order you are trying to remove is a required order in an order set, when you remove it, ALL orders in the order set are removed (after a warning message).*

To remove the order:
- Right click once on the order name located on the scratch pad
- Left click to select Remove

**Cancel/DC Order**

To cancel/discontinue an active order:
- Locate the order under the specific Clinical Category
- Right click on the order to select Cancel/D/C or uncheck the gray check box next to the orderable
- Enter Cancel Reason (required only for certain orders, such as laboratory and radiology)
- Sign the order

**Reset Order (restore before signing)**
*Reset* means that the order can be “restored” after it was canceled, discontinued, or voided in error.

*NOTE: Reset can only be used if the order was not yet signed.*

To reset the order if it was canceled or voided in error:
- Right click on the order to highlight and select Reset
- The order will become active again

**Cancel/Reorder**

This feature may be used to quickly cancel a current order and reorder with new detail information. (E.g. change in frequency, date, etc.).

To Cancel/Reorder:
- Right click on the order to be canceled/reordered
- Left click to select Cancel/Reorder
- Modify order details
- Sign the order

*Note: Cancel/Reorder action is used for holding Heparin (provider will change required date/time, infusion rate, and type in the order comments: “Hold for __ hours”)
ORDER SETS
All of the ordersets are kept in the folder “Ordersets”. To locate the “Ordersets” folder:
- Click on the Quick Orders tab
- Click on the Add(with blue +) then Add Order icon
- Click on “SHB” folder at SHB or “NW” folder at NW
- Click on “Ordersets” folder
- Click on the specific orderset sub-folder (e.g., Acute Care Ordersets)
- Search for the appropriate orderset
- All the components of the orderset are displayed
- A check mark in the box indicates that component will be ordered. A gray (dithered) component with a check mark means it is required for that order set
- Additional orders are also available for selection
- To select - click on the order to check
- To modify the details of a checked order, highlight the order and select appropriate order details located from the details window at the bottom of the screen

User Tips: Do not click “OK” until all desired orders from the orderset have been selected.
- Click “OK” and all checked orders of the Order Set will be ordered

NOTE: Orders placed with an orderset will display in their individual clinical category on the orders tab and will not be displayed under the “Order Set “category.

Radiology Orders
- When entering an order for a Radiology test, you must search for the order by typing the radiology modality: CT- Cat Scan, IR- Interventional Radiology, XR- Diagnostic Radiology MAMM - Mammography, MRI- Magnetic Resonance, NM- Nuclear Medicine, US – Ultrasound, CP- Cardio Pulmonary (NW only).

Medications
- Standard medications default to Standardized medication administration times. Always confirm the start date and time is the time you want the medication to be started. If the next dose is not within a reasonable period of time the order priority may be changed to “now” in the order details to produce a NOW dose task on the EMAR.

10. Overview
Over view is a view only area to see more information about a pt. The clinician can clear the date and time stamp to only see new information since the last time the chart was viewed. Other tabs also display pt information data available in a few chart tabs.
11. Patient information

Information can be retrieved through the separate sub tabs below.

1. Pt demographics gives home address and telephone number
2. Visit history displays the different encounters/pt visits. All results are not encounter specific—thus there is rarely a need to open old encounters however, orders are encounter specific. As long as a chart is opened from the unit census—it will always open to the current encounter.

3. The provider tab displays the name of anyone that has ever opened up the patients chart. To find a providers phone number you may right click on the providers name and choose more info to display address and phone number.

4. Allergies displays allergy info which is also viewable from the yellow banner bar below the patients name.

5. The immunizations tab would display any immunizations that the patient may have received at Lifebridge that has been signed off on the EMAR.(this will not capture immunizations given elsewhere.)
12. Reference text

User Tip: 1. In this screen, you can search for any drug reference information: just delete the original medication name in the search field, type in the new drug, and click search tab.
2. Click on Education Leaflet tab, to view educational materials for patient/family.
3. To print this information, right click anywhere on the white space and select print.

13. Results review
14. Rounds Report

Offers a quick view of what is going on with the patient. Certain information on the left comes over from orders. Data is available as a “snapshot” of recent vitals, weights, labs and medications.
15. Transcribed documents

Provider notes are displayed from here. To open a note Left double click and note can be read.

User tip: To get back to the patient list (unit census or PAL) from inside a patients chart just select the icon from the top left corner. If there are tasks on the PAL-complete the task from there. If there are no tasks on the PAL for documentation—we will stay in the patients chart and pull up the form from the ad hoc charting icon. Continue on to page 45 of this manual.
TOOLS/POWERFORMS

Computerized Clinical Documentation PowerForms gives us the ability to document clinical data electronically into PowerChart.

The Advantages to documenting in the computer are:

- Provides real time information.
- Historical data will remain in the electronic chart.
- Data entered on the ER triage form will pre-populate the Admission Database.
- Consistent information across the continuum of care promotes patient safety.
- Less duplication of questions to patients to obtain data will promote patient and provider satisfaction.

- Double click on patient name to open desired patient chart. Click “Ad Hoc Charting Icon”.

Ad hoc charting icon.
Some forms are available as soon as you open up this window. As more forms and areas are going up with clinical documentation separate folders on the left house more forms for different areas.

**EXAMPLE**—For inpatient nursing staff:

- **Click on** Inpatient **folder on the left**
- **3 new folders appear:**
  - Assessments (nursing)
  - Treatments (nursing)
  - PCA/TECH (treatments)
- **PowerForms will appear on the right:**
  - Select appropriate PowerForm.
  - Select “Chart”.
  - The PowerForm will open.

If a form has sections, they will be listed on the navigator bar on the left side of the form.

- A Blue X beside the title of the section indicates a required field has not been completed.
- A Blue Check Mark besides the title of the section indicates a required field has been completed.
- Enter data into cells.
Yellow fields = Required fields. Form will appear red on the form browser if mandatory fields have not been completed prior to signing.

White fields = Not required fields.

Some fields will cause additional documentation forms to open for the purpose of documenting required/additional information.

Circles ○ indicate only one option can be selected.

Squares indicate more than one option can be selected.

Click “Sign Form” icon when data entry is complete. This is an icon that looks like a green check mark.

REMEMBER TO SIGN YOUR FORMS PRIOR TO CLOSING, OR YOUR DATA WILL NOT BE RECORDED!!

PRINTING FORMS:
Forms are printed when a patient is discharged to a Nursing Home/Rehab or another facility.

- Open patient’s Chart.
- Single click on “Task” in the menu bar.
- Select print
- Click “Publish Medical Record”.

- In the Print What section on the left, select “PowerForms”.
- In the Purpose section on the right, select “For Paper Medical Record”.
- In the bottom right corner, select printer number (Printers in CAPS) for MRP printing.
• Dates may be filtered by selecting “Specific Date Range Filter” found at the bottom of the center column. Enter appropriate “From and To” date ranges.
• Select “OK” and selected documented forms will print.

**USER TIPS:**
Tracking will be maintained in the HIM department as to what items were printed and by whom to comply with HIPPA privacy regulations. Printed forms should be considered part of the Legal Medical Record.
Check the administrative policy regarding printing of patient’s medical record.

Because of the volume of data contained in the MRP reports, it may take the system up to 60 minutes to queue the report into the printer. The larger the patient’s record, the more time the system needs to gather the data and send to the printer. Please be patient with MRP reports.

**ADMISSION DATABASE FORM**

The Nursing Admission Database is used to document patient history and provide consistency in documentation. Information will pull forward from forms previously documented that contain the same data. Such as information documented on the ED Triage form or from prior hospital admissions.

Persons trained and authorized to use this form include, but are not limited to: Registered Nurses, Licensed Practical Nurses, Special Assistants, Nursing Instructor, Student Nurse, and Nursing Graduate.

The Electronic Database is to be completed within 24 hours of admission, as is current practice with the paper database. However, Allergies, Medications from home, height and weight are to be documented within one hour of admission If you are unable to complete the Database on your shift, be sure to pass this information on in report to ensure completion.
USER TIPS:
Opening a section requires clicking on the section in the navigator bar. If a section is grayed out, it is a conditional field and requires you to answer a related question before opening up.
Complete all sections before signing the form. If you are unable to complete a form, remember to sign the form by clicking on the check mark in the upper left-hand corner before closing out of the form or your data will not be recorded. When you are able, open the form through Form Browser and select modify to finish adding information. Again, remember to sign the form before closing.

If “Unable to Obtain” is initially documented on a question in the Admission Database, and the nurse is still unable to document 24 hours later, this is to be noted daily in the interdisciplinary notes. Once the nurse is able to obtain the information, the Admission Database should be modified with the appropriate information.

ADMISSION DATABASE SECTIONS:
- **GENERAL INFORMATION:** MD name will pre-populate from the ED; if this field is blank, begin typing MD name and click on binoculars to choose appropriate physician.
- **PAST MEDICAL HISTORY**: Pulls forward from previous hospitalizations and from the ED, but must be validated with each new admission.

- **OTHER PATIENT HISTORY**: Previous illnesses and past surgical history will not pull forward from the ED, but will from previous hospitalizations. When entering surgical history, select only one surgery per line so that the appropriate date may be added (dates may be approximate); additional lines may be added by right clicking and selecting “add row”.

- **ANESTHESIA/TRANSFUSION**: Also includes pre-op education for PASS and documentation of prior transfusion reaction.

- **ADULT INFECTIOUS DISEASE**: This form will pop up when the adult option is selected and assesses for TB, MRSA, VRE, and SARS risk.

- **PEDIATRIC INFECTIOUS DISEASE**: Information is documented on patients under the age of 18 – you must do the screen for either the adult or the pediatric patient.

- **NUTRITIONAL SCREEN**: Upon selecting yes in the “Adult or Pediatric Nutritional Risk Factors” section will trigger an automatic nutritional consult;

- **ENVIRONMENTAL/FUNCTIONAL**: Includes the patient’s living situation and sensory deficits.

- **SOCIAL HABITS**: Entries can be made by selecting in each category. Even if they deny use, “none” should be selected from the multi-select box.

- **PSYCHOSOCIAL**: Stressors and concerns are addressed in this section. In the future, selecting yes in the “Psychosocial” section will trigger an automatic Social work consult;

- **CULTURAL/SPIRITUAL**: Addresses the patient’s religious needs.

- **ADVANCE DIRECTIVES**: Sections are dependent on choices selected in each section; if the patient has a durable power of attorney, the gray box becomes white and allows the name of that person to be entered.

- **EDUCATIONAL NEEDS**: A broad assessment of future educational needs based on information gathered from the database and patient assessment.

- **PEDIATRIC SCREEN**: Utilized for patients under the age of 18 and assesses vaccinations and developmental needs.

- **HEALTH SCREENING**: Assesses health maintenance issues and vaccine information and is the first step in completing the influenza and pneumovax screening.

- **ABUSE AND NEGLECT**: Pulls forward from the ED, but will need to be completed on direct admissions. Use the current process for referral.

- **REHAB**: This section is for NW hospital only at this time.
MEDICATION HISTORY & ALLERGY HISTORY
Should be completed within one hour of room arrival or from ED or Pre-op if patient enters hospital from that area.

DOCUMENTING ALLERGIES:

It is the responsibility of the primary care Nurse to enter patient allergy information within 1 hour of arrival. If unable to enter allergy information due to downtime, fax to Pharmacy. This information is required before Pharmacy can begin dispensing medication.

1. Left click on the allergy information hyperlink on the yellow Banner Bar.

To Add an allergy select add. If the patient has no known allergies..select No Known Allergies. If Add is selected choose the catalog tab at the top.
To add allergy

- Left click on the catalog tab
- Search for the Drug Name, or food/environmental allergies, or allergies by class.
- Select the Allergy to highlight it
- Click the Select button.
- The medication will be displayed in the section 1 “Substance (required)

- Click the Catalog tab on the left side to add the reaction symptoms.
- Allergy Reactions folder is displayed.
- Click on the “+” sign next to the folder.
- The allergy reaction list will display.
- Select the reaction
- Once this is completed, Select the OK at the bottom to save this information to be displayed on the yellow banner bar.
It is very important with CPOE (computerized provider order entry) to complete what the allergy reaction is so when medications are ordered the provider knows what reaction is produced which may have an effect on the medication being ordered.

For Physicians only:

*To change the allergy to an adverse reaction or side effect...move on to section number 2. Left click on the Reaction type
Then select OK at the bottom.*

Nurses do not change allergy info to side effect or adverse effect.

**CANCELLING ALLERGIES**

- Open patient chart.
- Click **Allergy hyperlink** in the yellow banner/demographics bar.
- Select the allergy.
- Right click the mouse on the allergy to cancel.
- Select **Cancel**.
- Click “OK “ button.

**ENTERING ENVIRONMENTAL OR FOOD ALLERGY NOT LISTED IN THE CATALOG:**

- Right click the mouse on the **allergy screen**.
- Select “Add New”.
- Select “Other”.
- Single click to select the **Catalog tab**.
- Click on the “+” sign next to Food or Environmental.
- Select “Other Food” or “Other Environmental”.
- Click the “Select” button.
- In the section marked “5. Comments”, click the “Add Comment” button.
- Type allergy name in the **comment field**.
- Click the “OK” button.
- Click the “Apply” button.
- Click the “OK” button.
RE-ACTIVATING AN ALLERGY:
• Right click the mouse on the allergy screen.
• Right click the mouse on the allergy to reactivate.
• Select “Modify”.
• Click the “Status” drop down arrow in section 4. “Allergy details”.
• Select “Active”.
• Click “Apply”.
• Click “OK” button.

PATIENT ALLERGY DRUG ALERT SCREEN:
• Will appear if the patient is ordered to receive a drug that they are allergic to.
• Notify the prescriber immediately.
• If drug is to be given, enter a comment in the allergy screen.
• If drug is to be discontinued, fax orders to pharmacy.

TO INDICATE ALLERGIES HAVE BEEN REVIEWED WITH THE PATIENT:
If the patient has had a previous encounter with LifeBridge Health, then the allergy information should already be documented. To indicate that you have reviewed the allergy information with the patient and it is correct:
• Right click on the allergy screen.
• Select “Mark as Reviewed”.
• Notice the date in the “Updated” column changed to the present date.
Medication History

Upon the patient’s presentation to the hospital/office, a list of home medications must be obtained and entered into CERNER by the RN.

*(All paper lists must be entered into CERNER)*

During the completion of the Nursing Admission Database by the unit RN, the home medication list must be reviewed with the patient and the family and corrections entered into CERNER.

*(All paper lists must be entered into CERNER)*

**Nursing, Respiratory Therapy, Pharmacy, Radiology**

Anytime additional home medications are identified during the hospitalization, the person making the discovery must enter the new information into CERNER.
DOCUMENTING HOME MEDICATIONS

TO VIEW CURRENT HOME MEDICATIONS

➢ Click on Document Medication by Hx from the Orders tab

TO ADD A HOME MEDICATION:

➢ Enter the medication name in the search window. Select the appropriate medication and strength (if known). Select from the available order sentences if appropriate or select "None".

➢ If the medication strength is not known. The medication name can be selected without the strength.
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- **COMPLIANCE, INFORMATION SOURCE AND LAST DOSE ARE ENTERED FOR EACH HOME MEDICATION:**
  - Click the Compliance tab.
  - Window will default to a Status "Still taking as prescribed" and Information Source "Patient".

- **NO KNOWN HOME MEDICATIONS OR UNABLE TO OBTAIN INFORMATION:**
  - Click the appropriate box in the Document Medication by Hx window.

- **HOME MEDICATIONS THAT PATIENT IS NO LONGER TAKING:**
  - Right click on the medication and select Cancel/DC.
PRESCRIPTIONS (FROM ED VISITS) THAT THE PATIENT IS NO LONGER TAKING:

- Right click on the medication and select Add/Modify Compliance.

- Change the Status to "Not Taking".

ADDING COMPLIANCE AND LAST DOSE TAKEN TO CURRENT HOME MEDICATION LIST:

- Right click on the medication and select Add/Modify Compliance.

Remember to update med history by documenting med compliance (including last dose taken) of the medications that were entered during the past hospital visits. If the medication dose or frequency was changed since the last time, then this medication needs to be discontinued and re-entered with the new med details.
DOCUMENTING AN UNKNOWN OR MISCELLANEOUS MEDICATION:

- Search for "unknown medication" or misc. medication

- From the Detail tab, highlight the dose, route and frequency fields and enter the information under the detail values.

COMPLETING HOME MED DOCUMENTATION

- Click the Document History button.
WITH THE ADMIT ORDER AN ORDER FOR MEDICATION HISTORY FOLLOW-UP WILL AUTOMATICALLY BE PLACED BY THE SYSTEM AND A TASK WILL APPEAR ON THE PAL.

- The task is completed when the nurse has selected “chart” to signify she has completed the medication history information.

THE MEDICATION HISTORY FOLLOW-UP ORDER CAN ALSO BE ENTERED BY THE NURSE WHEN ADDITIONAL INFORMATION IS NEEDED AFTER THE MEDICATION HISTORY WAS BELIEVED TO BE COMPLETE: (Or just leave the task on the PAL if this information is not complete).
CHARTING HEIGHTS, WEIGHTS, AND MEASUREMENTS

HEIGHT AND WEIGHT (STANDARD UNIT OF MEASURE)
All Patients are measured weight in kilograms (kg), and height and weight in centimeters (cm).

HEIGHT /WEIGHT DOCUMENTATION AND/OR CONVERSION:
• Open the PowerForm from the PAL, Task List, or Ad Hoc as appropriate.
• Click the “Clinical Calculator icon” on the toolbar.
• Select “formula pounds to kilograms and/or inches to centimeters”.
• Enter data into the “white fields”.
• Write down the data that appears in the gray fields.
• Close the “Clinical Calculator screen”.
• Chart obtained values and select method of measurement (Estimated, measured, or stated). When measured weight is obtained-select the scale used.
• Click on the “Head Circumference section” in the navigator bar if documenting Head Circumference.
• Chart obtained values.
• Click on the “Abdominal girth section” in the navigator bar if documenting Abdominal girths
• Complete charting by clicking on the “check mark icon” in the left upper corner.

Heights and weights should also be entered within one hour of room arrival. Medications may not be ordered by pharmacy until weight information is entered. If there is not a task on the pal go into the patients chart and select the ad hoc charting icon to retrieve this form.
The Pain Assessment Form has been developed to assist health care providers to consistently and accurately chart pain assessments throughout LifeBridge.

Persons trained and authorized to use this form include but are not limited to: Physician, Registered Nurse, Licensed Practical Nurse, Nursing Instructor, Student Nurse, and Nursing Graduate.

**DOCUMENTING PAIN:**
The healthcare provider must select a pain scale to indicate the method as to how they evaluated the patient’s pain, even if the patient does not have any pain.

**Verbal Scale:** Charting is done according to the standard accepted by LifeBridge using PQRRSTT.

*USER TIP:* The regions are organized in head to toe order and certain selections will open conditional fields such as quadrant, laterality, or radiation.

- The window for multiple pain sites opens by clicking on “question for multiple pain Yes/No”. After selecting yes, the multiple pain sites window will open. Continue to chart on multiple pains according to the PQRRSTT evaluation. Clicking on a cell will open up a window that corresponds to the choices on the verbal pain assessment scale. If more space is needed to document multiple pain sites, right click in a cell and select “Add Row” to add additional rows.
- A “Blue Circle” in the upper left-hand column is utilized to sign the completed pain assessment scale and return to the prior form.
- Complete charting by clicking on the “check mark” in the upper left corner.
**FLACC Scale:** A behavioral pain scale used when patient is unable to verbally communicate.

**Face Scale:** Used in pediatrics and with patients who have communication barriers.

**PIPP Scale:** Used for Neonates in the NICU

**REASSESSMENT OF PAIN:**
When pain occurs, reassessment is expected within one hour of intervention. All interventions, either medication or comfort, require reassessment. The reassessment includes:

- An indication of the scale used.
- A pain score.

*Note: When prn pain meds are given a pain response task will post on the pal and the emar. This task can be completed from either location and assists with compliance of documentation.*
VITAL SIGNS POWERFORM

The Vital Signs PowerForm allows documentation of a patient’s vital signs, including orthostatic vitals and incubator temperatures for the neonatal population.

Persons trained and authorized to use form to include but not be limited to: Physician, Registered Nurse, Licensed Practical Nurse, Special Assistant, Patient Care Associate 1&2, Nursing Instructor, Student Nurse, and Nursing Graduate.
USER TIPS: Values are grouped by categories (e.g. temperature, cardiovascular, and respiratory).

- Warmer/incubator temperature is for pediatric patients as identified by unit policy or practice.
- There are four temperature fields, which indicate the route from which the temperature was obtained (oral, rectal, tympanic, or axillary).
- Mean arterial pressures will be manually entered from the dimamapp.
- Documentation of the extremity and the method the Blood Pressure was obtained are separate fields.
- There is a field to document the mode of oxygen delivery.
- Temperature is to be documented in Celsius.
- To convert Fahrenheit temperature to Celsius, use the formula Fahrenheit to Celsius in the Clinical Calculator.
- Remember to utilize the PAL first for documenting vital signs created by an order with a specific time and open a new form when documenting new vitals. Only use Ad Hoc charting Icon if documenting vitals not ordered on your PAL or Task List.

Assessments:

A full assessment must be completed with each new admission using the assessment powerform. After an assessment is completed by the form every other assessment may be completed by the IVIEW functionality if preferred.

ACCESSING the Forms:

To open an Assessment form, complete these steps:

- Open Patient Chart
- Click “Ad Hoc Charting” icon
• **Ad Hoc** window will appear
• Click on **Inpatient Documentation** folder on the left
• 3 new folders will appear:
  o **Assessments** (nursing)
  o **Treatments** (nursing)
  o **PCA/TECH** (PCA/techs treatments and procedures)
• Click on **Assessment folder**
• All of the **Assessments forms** will display on the right

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**Assessment Forms**

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**Adult Assessment Form**

**Note:**

- Nurses need to use Adult Assessment **PowerForm** to document the initial (admission) assessment.
- Nurses can use either Adult Assessment PowerForm or IVIEW to document all further systems reassessments.

- All patients must have at least one Adult Assessment Form completed.
- This Form was created to make it easy to chart a full, head-to-toe initial assessments, or short, simple focused assessments/reassessments and may be used by nurses at any time, on any patient.
- The Adult Assessment Form is a single-nurse / single-use form. It should not be modified by another nurse and should only be modified by the same nurse to correct an error in the original documentation. It should always be timed for the date/time the assessment actually took place and should be back-timed if charting is delayed. If a patient’s assessment is interrupted and then...
completed more than 15 minutes later, the two partial assessments should be charted in two separate forms with correct times showing the delay.

♦ Yellow fields must to be completed (required fields)
♦ The sections on this form are accessed by selecting them on the navigator bar to the left.
♦ Some fields are conditional – can make choice selections in them on them if previous documentation was done in the related field (e.g., gray filed “emesis description” will open (light up) if “emesis” was selected.

**Tasks**

Tasks will go to the PAL for assessment of:

♦ Skin - q 12 hours
♦ Fall - q 12 hours
♦ Pain - per vital sign order and q 4 hours in Critical Care

**Treatment/Procedures and Education Forms**

♦ Nurses can document on all of the listed below forms.
♦ PCAs (Techs) can document on the selected treatment and procedures forms (identified below as PCAs/Techs).
♦ PCAs (Techs) can’t document on Education forms.

♦ Activity /Hygiene/Nutrition Safety Form (PCAs/Techs)
♦ Bladder Scan Form
♦ Bronchial Hygiene Form
♦ Cardioversion/Pacemaker Procedures Form
♦ Chest Tube Procedures Form
♦ Comfort Measures Form (PCAs/Techs)
♦ Education, Adult Form
 Treatment and Procedures Forms (RNs or PCAs/CCTs/Techs)

- **Treatment and Procedures forms are provided to document completed treatments and procedures.**
- These forms can be completed by PCA/CCTs/Techs or RNs, however, any assessment questions on the forms can only be charted by the RN. Most sections on this form have a field called “Documented By.” When RN is selected in this field, the assessment fields open so the RN is able to chart in them.
- These Forms are single-documenter / single-use form. They should not be modified unless there is an error in the original documentation.
- These forms should always be timed for the date/time the treatment/procedure actually took place and should be back-timed if charting is delayed.
- The sections on the forms are accessed by selecting them on the navigator bar to the left.
Patient Education Form (RNs only)

♦ The Patient Education Form is provided for documentation of patient education done on the inpatient unit (PCAs/CCTs/Techs can not chart on this form.) If a PCA/CCT/Tech, under the direction of an RN, assists with patient teaching, the RN must document the session.

♦ Regulatory agencies require that we assess learning styles, barriers, etc., whenever patient education takes place so all of the fields at the top of the form must be completed.

**IVIEW**

The results charted in electronic forms will appear on specialty flowsheets (All Results, Assessment, and Clinical Notes tabs). In addition, the results from **Adult Assessment**, **Invasive Monitoring**, **Activity/Hygiene/Nutrition/Safety**, **Bronchial Hygiene**, **Tracheostomy Care**, and **VS’**s, will appear on the IVIEW Flowsheet found on the IVIEW tab. IVIEW also allows the nurse to document directly onto the flowsheet.

**IVIEW Structure**

When you first time login in IVEW, you will see 4 different bands there: ED Assessment, Adult Assessment, Inpt Treatments and Procedures, Vitals and Measurements.

To avoid in error documentation on ED Assessment, the ED Assessment band needs to be removed:
• Click on View on the menu bar
• Select Layout → Navigator Bands

Navigator Documents screen will display
• In the Current Document section, click on ED Assessment on the right
• Click on the arrow in the middle
• ED Assessment will be moved

Time Change in IVIEW

◆ The new column is auto-generated by a system with the current time
◆ Change the time to reflect the actual time the assessment was completed

To change the time, complete these steps:
◆ Right click on the date/time
◆ Click on Insert Date/Time
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- The new column will be displayed
- Right click on the Date/Time in the new column
- Select Change Date/Time
- Date and Time fields will open
- Change the time in the Time field
- Click Enter

**Data Entry in IVIEW**

There are 2 ways to enter information:

2. **Double Click on the Section Title (for documentation on the entire section)**
   - Double left click on the section title
     - Check mark will appear in the box
     - The first field will open
     - Enter data
     - The next field will automatically open (for single choice selections)
     - In multiple selections fields, click Enter after each entry
     - Sign IVIEW by clicking on the checkmark on the top

1. **Right Click on the Field (for documentation on the selected field)**
   - Right click on any field
   - Click on **Add Results**
• Enter data
• Sign IVIEW

Modify Data in IVIEW
• Right click on the field to be modified
• Select Modify
• Change information
• Sign
• Updated information will appear in the field with the small blue triangle on the right lower corner (delta sign)

Unchart Data in IVIEW
• Right click in the field
• Select Unchart
• Select “other” in the reason field
• Type “Error” in the Comment field

Note: In addition to uncharting data in IVIEW, “Uncharted Results IVIEW” powerform has to be completed:
• Click on Ad Hoc icon
• Select Uncharted Results IVIEW form
• Enter information

• Sign the form

Note: Acute and Subacute Care Nurses will be able to enter VSs directly on IVIEW. ICU will remain on paper.
Remember: If use IVIEW for reassessments, the nurse must also go to Ad Hoc Charting to complete Skin, Fall, and Pain powerforms that are not available in IVIEW (they are required for assessment documentation.)

2.4 Required Forms
One Form that should be found for every patient is an Adult Assessment form.

♦ Acute Care Restraints Flowsheet (RNs only)
All patients who are placed in acute care restraints must have Acute Care Restraints Form completed.

Nurses
To document restraints initiation or discontinuation, always use Restraints PowerForm. To document ongoing monitoring, you can use either Restraints PowerForm or Restraints IVEW.

To open Restraints PowerForm, complete these steps:
• Open Patient’s chart
• Click on Ad Hoc Charting Icon
• Click on Inpatient Documentation folder on the left
• Click on Treatments/Procedures
• Select Acute or Behavioral Restraints Form
• The selected form will open

**Ongoing Monitoring** The ongoing monitoring can be documented via the 1) PowerForm or in 2) IVIEW:
1) Restraints Ongoing Monitoring – section of the Acute Restraints Form
PCAs/Techs can document the basic care provided for the restrained patient in the Activity/Hygiene/Safety Form. (section - Tech/PCA Restraint Monitoring).

To document activity, nutrition, and hygiene provided to the restrained patient, complete these steps:

- Open Patient’s chart
- Click on Ad Hoc Charting Icon
- Click on Inpatient Documentation folder on the left
- Click on Techs/PCAs
- Select Activity/Hygiene/Safety Form
- Click Chart
- The selected form will open
- Click on Tech/PCA Restraint Monitoring section on the left
- Complete documentation and sign the form
Skin (Integumentary) assessments:

Are to be documented daily either from within the assessment flow sheet—or if the assessment was completed in IVIEW The task on the PAL may be used or the form can be found in Ad Hoc.

If the patient has an incision or pressure area that is covered and is NOT due for a dressing change, document this under the Wound Assessment portion of the form. This is accessible by clicking on “Non-intact or Stage 1 pressure ulcer.” This will pop up the following screen: For a dressing NOT CHANGED select the last column multialpha in treatment section as “dressing intact not changed” and give the location of the dressing.
Please enter data in the following areas when appropriate:
Location
Location details
Drainage
Drainage amount
Surrounding Tissue
Treatment

On the day that a dressing is changed, please complete the Integumentary Assessment and Wound Assessment forms completely.
Select appropriate box based upon patient status. The form will open when the top box is selected.

Based upon the selections, the total risk score will be calculated. There are now different...
### Fall Prevention Interventions - LifeBridge Health

**Basic Safety Interventions (Low fall risk: 0-5 points)**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Safety Counts: bedtone. give to patient hand.</td>
<td>Yes</td>
</tr>
<tr>
<td>Remove excess equipment</td>
<td>Yes</td>
</tr>
<tr>
<td>Keep floor clutter / obstacle free</td>
<td>Yes</td>
</tr>
<tr>
<td>Assure adequate lighting, especially at night</td>
<td>Yes</td>
</tr>
<tr>
<td>Offensive furniture in bed area</td>
<td>No</td>
</tr>
<tr>
<td>Split patient to surrounding, use of bed, and call bell</td>
<td>Yes</td>
</tr>
<tr>
<td>Keep bed in lowest position</td>
<td>Yes</td>
</tr>
<tr>
<td>Keep top 2 side rails up</td>
<td>Yes</td>
</tr>
<tr>
<td>Secure locks on beds, stretchers, and wheelchair</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Moderate fall risk (6-12 points)**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select pertinent interventions from low risk category</td>
<td>Yes</td>
</tr>
<tr>
<td>Institute flagging system: magnet outside door, sticker on medical record; blue fall safety bracelet/lanyet</td>
<td>Yes</td>
</tr>
<tr>
<td>Supervise and assist with bedside sitting, personal hygiene, and toileting as appropriate</td>
<td>Yes</td>
</tr>
<tr>
<td>Prevent confused patients as necessary</td>
<td>Yes</td>
</tr>
<tr>
<td>Initiate elimination schedule, including use of bedside commode if necessary</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**High fall risk (13 or greater points)**

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Select pertinent interventions from low and moderate risk categories</td>
<td>Yes</td>
</tr>
<tr>
<td>Institute flagging system: magnet outside door, sticker on medical record; blue fall safety bracelet/lanyet</td>
<td>Yes</td>
</tr>
<tr>
<td>Personalize patient while toileting</td>
<td>Yes</td>
</tr>
<tr>
<td>Observe patient every hour</td>
<td>Yes</td>
</tr>
<tr>
<td>When necessary transport throughout hospital with assistance of staff or trained caregiver. Consider bedside procedures. Notify receiving areas of high fall risk.</td>
<td>Yes</td>
</tr>
<tr>
<td>Move patient to room with best visual access to nursing station</td>
<td>Yes</td>
</tr>
<tr>
<td>Initiate bed / chair alarm</td>
<td>Yes</td>
</tr>
<tr>
<td>Specify prevention bed (low bed)</td>
<td>Yes</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
<tr>
<td>___</td>
<td>___</td>
</tr>
</tbody>
</table>

**Note:** Basic safety measures are PRE-SELECTED. Moderate Risk is now separate from High Risk. The nurse is to select individualized, appropriate interventions based upon patient history and nursing judgment.
Fall Prevention Education Tool

This Fall Prevention Education form REPLACES the blue FAIR note sticker at SHB.

Note how the education targets the different risk levels of patients:

1. Standard and Mobility Safety Interventions
2. High Fall Risk, Special Conditions & Injury Factors
3. Additional High Risk for Patients Unable to Participate
4. Discharge Planning
For more information please review the other manuals and brochures available from the cerner help guides.