

# eKiDs PowerChart



## Emergency Nursing CLINICAL DOCUMENTATION

### Training Guide



Presented by the IS Training Department



**eKIDs PowerChart  
CLINICAL DOCUMENTATION**

<b>SECTION I PowerChart® for ED Nurses .....</b>	<b>1</b>
Introduction .....	1
Objectives: .....	1
<b>PowerChart Structure .....</b>	<b>2</b>
PowerChart Organizer .....	2
<b>First Net Updates .....</b>	<b>3</b>
Toolbar Icons .....	3
Columns and Tabs .....	3
Columns.....	4
Toolbar Icons .....	8
<b>SECTION II Introduction to PowerForms.....</b>	<b>9</b>
Introduction .....	9
Features.....	9
<b>Accessing PowerForms .....</b>	<b>10</b>
PowerForms Toolbar .....	10
Form Navigator .....	11
PowerForm Section Field Types .....	12
Label Boxes .....	12
Text Controls .....	12
Alpha Controls .....	12
Provider Controls .....	13
Numeric Controls .....	13
Conversion Controls .....	13
Date Controls.....	13
Grids .....	14
Ultra Grids.....	14
Conditional Fields and Sections .....	14
Required Fields .....	15
Interacting with PowerForm Section Fields .....	15
Grids .....	15
Adding Comments .....	16
Charting Options.....	17
Sign PowerForm.....	17
Cancel.....	17
Performed on : .....	17
Nursing PowerForms.....	18
Form Browser .....	19
Form Browser Basics .....	19
Retrieving PowerForms .....	20
Change the Default time range .....	21
Viewing a Completed PowerForm .....	22
Modifying a PowerForm.....	23
Changing the Date/Time of a Charted Result .....	23
Uncharting a PowerForm.....	24
Viewing Document History .....	25
Documents Tab .....	26
Practice Scenario for PowerForms.....	27
<b>Section III Patient's Chart.....</b>	<b>29</b>
Chart Tabs.....	30
ED Summary Tab .....	33

Customizing the ED Summary Tab .....	34
Viewing Information from Form Browser Tab.....	36
Form Browser Basics .....	36
Form Browser Tab Displays .....	37
Change the Default Time Range .....	38
Viewing a Completed PowerForm .....	39
Viewing Results from the Flowsheet Tab .....	40
Allergies Tab.....	41
Accessing Allergy Tab .....	41
Accessing Allergy Profile Window from the Banner Bar .....	42
Accessing Allergy Profile Window from the Tracking List .....	42
Allergy Icons .....	43
Allergy Interactions .....	43
Allergies Profile Window Components .....	44
Adding Allergies.....	45
Adding NKA (No Known Allergies) from the Allergy Profile .....	47
Cancelling NKA (No Known Allergies) from the Allergy Profile.....	47
Tips and Tricks .....	47
The Power Orders Tab .....	48
Detail Screen Adjustments .....	49
Practice Scenario for Chart Tabs .....	50
<b>Section IV Power Orders .....</b>	<b>51</b>
General Steps for Placing an Order .....	51
Add Order Window .....	52
Ordering Physician Window .....	53
Documenting Medication by History.....	54
Nurse Review .....	56
Entering a PowerPlans .....	57
Right Click Functions for PowerPlans .....	72
Discontinue Selected PowerPlan Orders .....	73
+ Add to Phase .....	73
Adding Preferred Pharmacies .....	74
Practice Scenario for PowerPlans .....	76
<b>SECTION V Task Management .....</b>	<b>78</b>
Introduction.....	78
Features.....	78
Objectives.....	78
<b>Single Patient Task List.....</b>	<b>79</b>
Task Completion Methods.....	79
Accessing the Task Lists.....	79
Single Patient Task List Components .....	80
Information Bar .....	81
Task-at-a-Glance Bar .....	82
Status Indication .....	82
Quick Chart.....	82
Chart Done for Lab “Need to Collect” Task.....	83
Task-at-a-Glance Legend.....	84
Task List Toolbar Buttons.....	85
Options Menu .....	86
Task Display Filter .....	87
Refresh Button.....	88
Tips and Tricks .....	88
<b>Setting Up the Task Lists to Display Tasks.....</b>	<b>89</b>
Filtering Tasks Using the Time Frame Filter .....	89

Task List Right-Click Menu.....	91
Charting Tasks as Done and Done(Date / Time).....	92
Rescheduling Tasks.....	93
To reschedule a task:.....	94
Charting Tasks as Not Done.....	95
Uncharting Tasks.....	96
Viewing Additional Task Information.....	97
Troubleshooting Q & A.....	97
<b>Practice Scenario for TASK LISTS.....</b>	<b>98</b>
<b>SECTION VI Introduction to eMAR.....</b>	<b>99</b>
Introduction.....	99
Features.....	99
Intended Audiences.....	99
Objectives.....	99
Accessing the eMAR.....	100
MAR Chart Tab.....	101
Time Frame.....	101
MAR View Options.....	102
Time View.....	102
Therapeutic Class View.....	102
MAR Sections.....	103
Continuous Infusions.....	107
<b>Charting Activities in the eMAR.....</b>	<b>108</b>
Components of the Medication Charting Window.....	108
Medications that Require a Witness.....	110
Immunization Documentation in the eMAR.....	113
Charting Additional Data Elements.....	114
Rescheduling a Single Medication Dose.....	115
Rescheduling Admin Times.....	115
Message Sender.....	116
Administering Additional Medication Doses.....	117
Modifying a Charted Task.....	119
Uncharting a Medication Task.....	120
Charting a Medication Task as Not Given.....	121
Viewing Order Details in the MAR.....	123
Viewing Admin Details in the MAR.....	124
Creating an Admin Note.....	125
Viewing the Reference Manual from the MAR.....	126
<b>Charting Continuous Infusions.....</b>	<b>127</b>
Components of the IV Charting Form.....	127
IV Charting Options.....	129
Charting Begin Bag Events.....	129
Charting Infuse or Bolus IV.....	131
Considerations.....	132
Charting Rate Change IV Events.....	133
Considerations.....	134
Charting Site Change IV Events.....	135
Modifying IV Events.....	137
Uncharting IV Events.....	137
Viewing History of IV s.....	138
<b>Charting Titratable Drips in eMAR.....</b>	<b>139</b>
Best Practice:.....	139
Titratable Drips/Dosing Weight.....	139

Nursing Workflow .....	139
eMAR IV Drips Process in eKiDs PowerChart .....	140
<b>Infusion Billing .....</b>	<b>143</b>
Steps for completing the Infusion Billing Report: .....	144
MAR Summary Tab .....	146
Time Interval Settings .....	146
MAR Summary Display .....	147
Identifying Icons in the Mar .....	148
Practice Scenario for eMAR .....	149
<b>SECTION VII Introduction to Interactive View (iView) .....</b>	<b>150</b>
Introduction .....	150
Features .....	150
Objectives .....	150
<b>The Interactive View (iView/I&amp;O 2G).....</b>	<b>151</b>
<b>Major Components of iView .....</b>	<b>152</b>
iView Toolbar and Icons .....	154
Forward and Back Browser-Style Buttons .....	154
Reviewing the iView Bands .....	155
Working with iView Bands .....	160
Customizing the iView Bands .....	161
Adding a Section to an iView Band .....	161
Removing a Section within an iView Band .....	162
Setting Time Frames .....	164
Changing Date and Time.....	165
Overdue Tasks .....	168
<b>Documenting Results .....</b>	<b>170</b>
Documenting in a single section:.....	170
Documenting in Multiple sections.....	171
Reference Text .....	172
Types of iView Documentation .....	173
Signing/Cancelling Documentation .....	175
Troubleshooting Unsigned Documentation Messages.....	176
Calculations – Built in Calculations .....	178
Documenting Intake and Output.....	179
I&O Totals.....	181
<b>Interacting with iView (Right Click Functions).....</b>	<b>192</b>
Modifying an iView Result .....	194
Uncharting an iView Result .....	194
Changing the Date and Time of Documentation in iView.....	195
Adding and Viewing Comments at the Results Level .....	196
Flagging a Result.....	197
Viewing Reference text.....	197
<b>Viewing Results.....</b>	<b>198</b>
Viewing Result Details in iView .....	198
Result Indicator Icons .....	202
Troubleshooting Results.....	202
Viewing Critical, High, Low or Abnormal Results .....	203
<b>Complex iView Charting .....</b>	<b>204</b>
iView Titratable IV Drips Process in eKiDs PowerChart .....	204
Documenting a Discontinued Drip.....	207
V Drip Dose/Rate Changes .....	207
Dynamic Groups.....	208

Removing Dynamic Groups.....	210
Conditional Logic .....	212
Activity View Band .....	213
<b>Practice Scenario for iView .....</b>	<b>214</b>
iView Documentation Tips and Practice .....	214
Practice Scenario .....	215
<b>BMDI – Bedside Medical Device Interface .....</b>	<b>216</b>
Device Association Steps .....	217
View Acquired Data .....	219
Tips and Tricks .....	220
Changing the Date/Time of an Association .....	221
Retrieving Data from you BMDI.....	223
Disassociating a Patient from the Monitor.....	225
Viewing Acquired Data .....	226
Steps to Insert Acquired Data .....	227
<b>Section VIII: Nursing Depart Process .....</b>	<b>228</b>
Depart Process Window Components .....	228
Selecting your Patient.....	229
Discharge Actions.....	230
Patient Education .....	230
Building Favorites for Patient Education .....	231
Pt ED Printed.....	232
Task List .....	232
ED Discharge Notes .....	233
Billing .....	234
& Depart.....	237
<b>APPENDIX A – Downtime Procedures .....</b>	<b>238</b>
Eclipsys Downtime .....	238
eKiDs PowerChart Downtime .....	238
Downtime Procedures – Cerner 724 .....	239
<b>APPENDIX B – Nursing Policy for Downtime.....</b>	<b>240</b>
Downtime Process – Emergency Department (E.D.).....	246
<b>APPENDIX C – TRANSFER TO 1-C.....</b>	<b>247</b>
<b>APPENDIX D – Tap &amp; Go .....</b>	<b>248</b>
Steps To Register a Proximity Identification Badge .....	248
Complete Personal Security Questions.....	251
Zero Client - Automatic Lock .....	253
Daily Log In and Grace Period .....	253
Frequently Asked Questions .....	254
Tap & Go / Zero Client Quick Reference Tips.....	255

## SECTION I PowerChart® for ED Nurses

### Introduction

---

PowerChart is a flexible, graphical tool that provides the clinician immediate access to the information in the clinical database.

PowerChart is designed to operate in two main windows: the **Organizer** and the **Patient Chart**. Both windows can be open concurrently. The Organizer serves as the desktop for FirstNet, linking Emergency Department healthcare professionals to vital patient and department information. Certain tabs are always available from the Organizer, including the Emergency Department Tracking List.

The Patient Chart displays several customized views. Access to both the Organizer and Patient Chart makes it easy to navigate between them and quickly obtain desired patient information for the best possible outcomes.



### Objectives:

- Review new FirstNet functionality
- Become familiar with functionality of new and/or revised chart tabs in PowerChart
- Become familiar with additional PowerForms.
- Place orders for and work with PowerPlans
- Work with the Task Lists
- Document in the eMAR
- Document in iView
- Document New Depart Process functions

# PowerChart Structure

PowerChart operates in two main windows: the **First Net Organizer (Tracking List)** and the **Patient Chart**.

## PowerChart Organizer

The PowerChart Organizer opens to your home view. The Emergency Department's home view is the FirstNet Tracking List.

The screenshot displays the 'FirstNet Organizer for TestUser RN, EDNurse' window. The main area shows a 'Tracking List' table with the following data:

Bed	Ni:Ac Name	Age	All Reason For Visit	Call Pre-ATT	RES	RN	VS Lc Tasks	Order Meds Events	Lab	Rad	Reg Even MC	Image Comments	Add'l C
1	Test P			Pre-									
9	5 LLOYD E	8 yrs	Abrasion*	Zubi		4*	+	9	6/0	1/0/0		Testing comments test 1	
10	Little K	6		Pre-									
WR	Diane			Pre-									
WR	3 EDTHREE C	11 yrs	Abdominal pain*	ET		TRN	⊗*	1					
WR	3 Betty Z	3 yrs	Wheezing - Pediatr	Pre-			⊗*	6	3/0	1/0/0			
WR	Scooty Z	6 yrs		ET	BD		+						
WR	5 Bogus Z	12 yrs	Abrasion*	ET		4*	⊗*						
WR	3 MOCKUPGRADE R	12 yrs	Allergic reaction*			⊗*	⊗*			10/10			
WR	5 XZ	4 yrs	Abdominal distentio	DW		4*	+	1	3/0			ad lib	

# First Net Updates

FirstNet includes toolbar icons that will enhance your daily workflow with Electronic Medical Record (EMR) functionality.

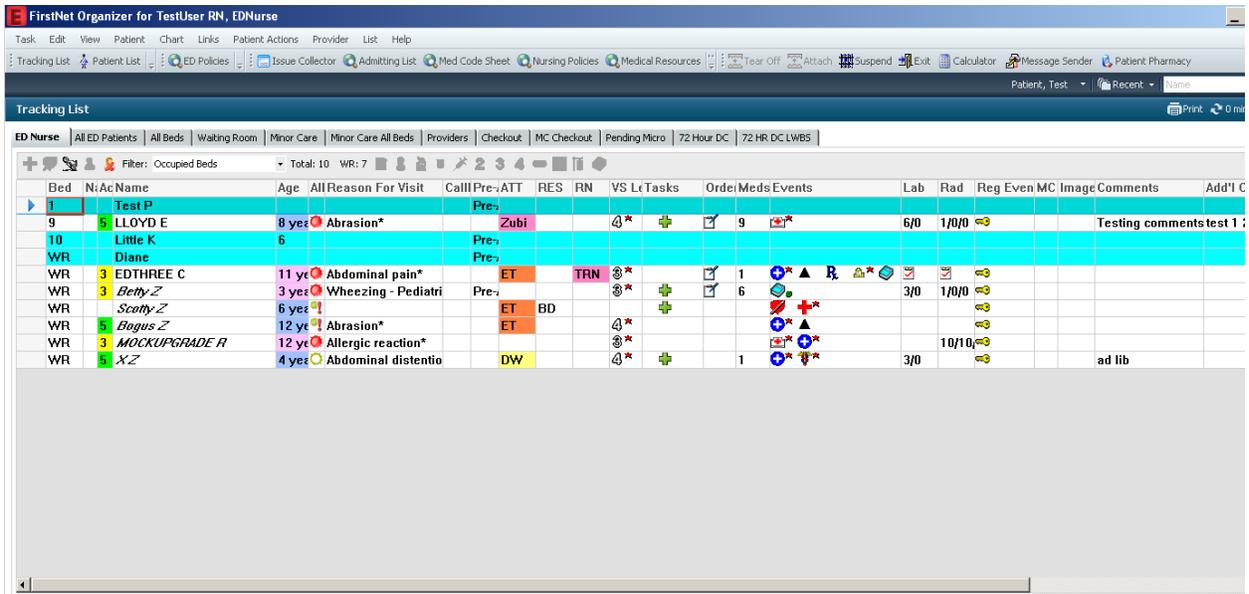
## Toolbar Icons



NAME	DESCRIPTION
Patient Pharmacy	Displays the patient's preferred pharmacy and also provides a location to search for additional pharmacies. This is typically only updated by providers.
Admitting List	Displays a list of all providers that currently have admitting privileges to CHKDHS.
Message Sender	Allows patient related messages to send to the Pharmacy for Medication needs.

## Columns and Tabs

The implementation of Phase V of PowerChart EMR and CPOE provides additional columns to the FirstNet Tracking List.



## Columns

### Orders

Displays a clipboard icon when new orders have been placed that need to be reviewed by nursing.

- Double clicking on this icon takes you to the Actions Requiring Review window. All orders placed for your patient must be reviewed by a Nurse.
- Select all is the default for the new orders. This places a check mark beside the order information.
- To deselect all and select only those orders you currently wish to review uncheck the select all and place a check mark beside those orders.
- When orders are reviewed select the Review button at the bottom of the screen to return you to the FirstNet Tracking List.



Note: When all orders are reviewed the clipboard icon will no longer display unless additional orders are added.

**ZZTest, Betty U - Actions Requiring Review**

ZZTest, Betty U      Age:3 years      Sex:Female      Loc:CHKD-ED  
 DOB:06/17/2010      EMR:00001164      Fin#:000075167      Emergency [06/17/2...  
 Allergies: codeine, sulfa drugs      Clinical(Dosing) Wt:1...

	Action	Action Date/Time	Entered By	Order	Details
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	Communication Order	If O2 sats <93%, initi
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	Pulse Oximetry Continuous	Daily
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	Peak Flows	A5 DIRECTED, Childrei
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	Notify Provider Vital Signs	Children 2-5 yrs HR >
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	prednisoLONE (prednisoLONE base)	32 mg, Liquid, By mout
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	ipratropium	0.5 mg, Soln, Nebulize
<input checked="" type="checkbox"/>	Order	06/24/2013 14:45 EDT	TestUser RN, EDNurse	albuterol	2.5 mg, Inhalant, Nebi
<input checked="" type="checkbox"/>	Order	06/20/2013 10:06 EDT	TestUser MD, EDAttending	CBCA	Collect Priority= Stat,
<input checked="" type="checkbox"/>	Order	06/19/2013 16:19 EDT	TestUser, Resident	Communication Order	If O2 sats <93%, initi
<input checked="" type="checkbox"/>	Order	06/19/2013 16:19 EDT	TestUser, Resident	Pulse Oximetry Continuous	Daily
<input checked="" type="checkbox"/>	Order	06/19/2013 16:19 EDT	TestUser, Resident	Peak Flows	A5 DIRECTED, Childrei
<input checked="" type="checkbox"/>	Order	06/19/2013 16:19 EDT	TestUser, Resident	Notify Provider Vital Signs	Children 2-5 yrs HR >
<input checked="" type="checkbox"/>	Order	06/19/2013 16:19 EDT	TestUser, Resident	ipratropium	0.5 mg, Soln, Nebulize

Select All     Show All Details

ZZTest, Betty U    **Review**    Cancel

## Meds

Displays the current number of Medication orders for your patient. When Med order is completed the number will decrease.

- Hovering over the number in the med column for your patient will display additional details about the medications.
- Double-clicking on the number will launch you to the MAR (Medication Access Record) where med task can be completed. This will be discussed in further detail later in the manual.

Meds
6
3
6

The screenshot shows the 'Tracking List' window with a toolbar at the top and a table of patient data. The table has columns for Bed, Ni:Ac Name, Age, All Reason For Visit, Pre-ATT, RES, RN, VS Lt Tasks, Order Meds Events, Lab, and Rad. A red box highlights the number '6' in the 'Order Meds Events' column for patient Betty Z. Below the table, there are sections for 'IV Medications', 'Scheduled Medications', and 'Unscheduled Medications', each with columns for Name, Time, Order Status, Departmental Status, and User.

## VS Level (Vital Signs Level)

Displays the current acuity level for your patient.

- The Acuity column displays the patient's triaged acuity.
- The VS Level displays the patient's acuity based on your assessment and reassessments.
- If a patient's current acuity differs from the number displayed in the VS Level column it can be updated by selecting the appropriate acuity icon from the toolbar at the top of the window. Selecting the new acuity level will open a Powerform where current vital sign information can be documented.

VS Level
4
3*
4
2*
2*
4*
4*



- Once the new acuity has been entered the column will display the previous acuity as well as the new acuity level .

Acuity	Name	Age	All	Reason For Visit	Call	Pre-ATT	RES	RN	VS Level
2	Trainer, Diane	14 m	☀	shortness of breath			DOC	RN	2* ③

- Double clicking on the acuity number in the VS Acuity column will launch the Quick Flowsheet for your patient. All documentation associated with the selected acuity level will display.
- Clicking on Flowsheet button at the bottom of this window will launch you to iView that will be discussed in further detail later in this manual.

The screenshot shows the 'Flowsheet' application interface. At the top, there is a navigation bar with a home icon and the text 'Flowsheet'. On the right side of this bar, there are icons for 'Print' and '0 minutes ago'. Below the navigation bar is a 'Patient Care' section with tabs for 'Flowsheet', 'Recent Results', 'Lab', and 'Radiology'. The 'Flowsheet' tab is active. Below the tabs, there are two dropdown menus: 'Flowsheet: Emergency Department View' and 'Level: Emergency Department View'. To the right of these are radio buttons for 'Table', 'Group', and 'List'. A date range '23 June 2013 15:48 - 26 June 2013 15:48 (Posting Range)' is displayed. The main content area is divided into a 'Navigator' on the left and a data table on the right. The Navigator has several checked items: Vital Signs, Oxygenation, Pain Assessment, Emergency Dept Documentation, ED Triage Medical History, Measurements, General, and KD ED Pre-Arrival Note. The data table has columns for 'Emergency Department View', '06/25/2013 10:33', and '06/25/2013 10:24'. The table content includes sections for 'ED Triage Medical History', 'Measurements', and 'General'.

Emergency Department View		06/25/2013 10:33	06/25/2013 10:24
<b>ED Triage Medical History</b>			
Isolation Precautions Needed	None		
Medical History ED	Denies		
Mental/Behavioral Health History	Denies		
Feels Like Hurting Self or Others	No		
<b>Measurements</b>			
<input type="checkbox"/> Height, Clinical (Dosing)	78 cm		
<input type="checkbox"/> Weight, Clinical (Dosing)	16 kg		
<input type="checkbox"/> BMI	26.3 kg/m2		
<b>General</b>			
Pregnancy Status	N/A		
Immunizations Current	Yes		
Domestic Concerns	None		
Barriers to Care	None		
Learning Needs Assessed	Yes		
Allergies Assessed	Not verified		
<b>KD ED Pre-Arrival Note</b>			
KD ED Pre-Arrival Note		KD ED Pre-Arrival Note	

## Infusion Billing Column

Infusion Billing Column on the Tracking List displays an IV Bag icon to open and complete the Infusion Billing Form task.

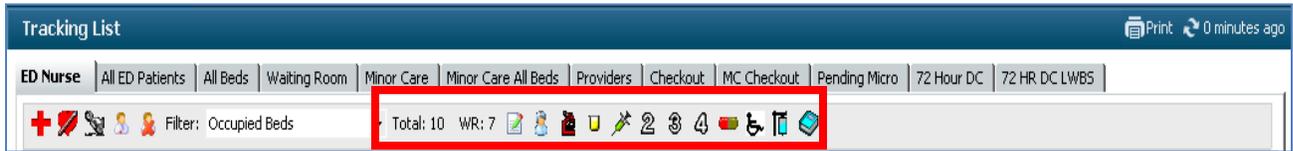
The screenshot shows a 'Tracking List' window with a table of patient data. The table has columns for Bed, N/Ac Name, Age, All Reason For Visit, Orders, Tasks, Med Infusion Billing, Events, Lab, Rad, Reg Even MC, and Comm. The row for patient JENNIFER Z is highlighted, and the 'Med Infusion Billing' column contains an IV Bag icon. An 'IV Stop Times' dialog box is open over this row, displaying patient information and a list of infusion orders.

Bed	N/Ac Name	Age	All Reason For Visit	Orders	Tasks	Med Infusion Billing	Events	Lab	Rad	Reg Even MC	Comm
0001	MOCKUPGRADE R	12 ye	Abrasion*						41/40		
1	Test P										
7	EPICCSGONE C	7 ye	Abrasion*								
9	LLOYD E	8 ye	Abrasion*			9		6/0	1/0/0		Testin
10	Little K	6									
12	Scotty Z	6 ye	Abscess*			2					
15	Jennifer P	2 ye									
WR	Diane G										
WR	JENNIFER Z	4 ye	Abscess*			4		5/0	1/0/0		
WR	Diane										
WR	Betty Z	3 ye	Wheezing - Pediatr			27		6/0	3/0/0		
WR	Bogus Z	12 ye	Abrasion*								
WR	MOCKUPGRADE R	12 ye	Allergic reaction*								
WR	XZ	4 ye	Abdominal distentio			2					

**IV Stop Times**  
 ZZTEST, JENNIFER  
 Age: 4 years Sex: Female Loc: CHD-ED Iso: Contact Pr...  
 DOB: 07/09/2009 EMR: 00001165 Fnr: 000075170 Emergency (07...  
 Allergies: No Known Allergies  
 Select All (1)  
 Dextrose 5% - NaCl 0.45% 1000 mL  
 Soln, IV Continuous, Rate: 10 mL/hr, Infuse over: 100 hr

Buttons: Document, Cancel

## Toolbar Icons



	iView/I&O 2G -- Clicking on this icon launches you into iView within the patient's chart.
	Task List --Opens you to the task list within the patient's chart.
	ED Specimen Collection Details -- Launches a PowerForm where specimen collection details can be entered. This will be completed in conjunction with a task on your task list.
	ED Urine Collection Details -- Launches a PowerForm where urine collection details can be documented.
	ED CSF Collection Details -- Launches a PowerForm where CSF collection details can be documented.
	ED VS Acuity Level 2 -- Launches a PowerForm where the patient's Level 2 acuity information can be documented.
	ED VS Acuity Level 3 -- Launches a PowerForm where the patient's Level 3 acuity information can be documented.
	ED VS Acuity Level 4 -- Launches a PowerForm where the patient's Level 4 acuity information can be documented.
	ED Med Response -- Launches a PowerForm where you can document Medication Response.
	Ed Transfer-Transport Details – Launches a PowerForm to document details for the transport.
	Depart Process – Launches you to the discharge process
	Billing Form – Launches the IV Meds Billing Form for completion

## **SECTION II      Introduction to PowerForms**

### **Introduction**

---

PowerForms is the clinical charting tool that allows staff to record the completion of tasks and enter patient results to be stored as part of the patient's electronic medical record. A healthcare professional may find it necessary or desirable to record results for unscheduled tasks. Ad Hoc Charting enables you to chart unscheduled task results and documents.

Depending on your role within CHKDHS, PowerForms are available to chart directly from the Ad Hoc Icon on the toolbar. However, only those with privileges to perform Ad Hoc Charting will have access to the menu commands and toolbar buttons to open the PowerForms.

### **Features**

---

*Via PowerForms, users can:*

- Access PowerForms from the icons on the ED Tracking List
- View completed forms from the Forms Browser tab in eKiDs PowerChart
- Modify and Unchart forms that were charted in error

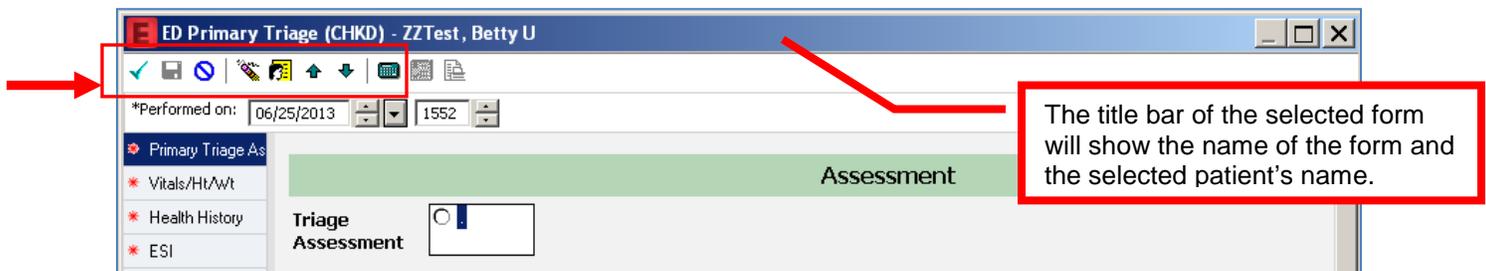
## Accessing PowerForms

When you have successfully logged into your application, you can access charting PowerForms from different areas. Some examples of how forms are accessed include:

- Tracking List Icons in FirstNet
- Single and Patient Task List
- Patient's chart

## PowerForms Toolbar

Components of the PowerForm toolbar vary depending on which PowerForm is open.

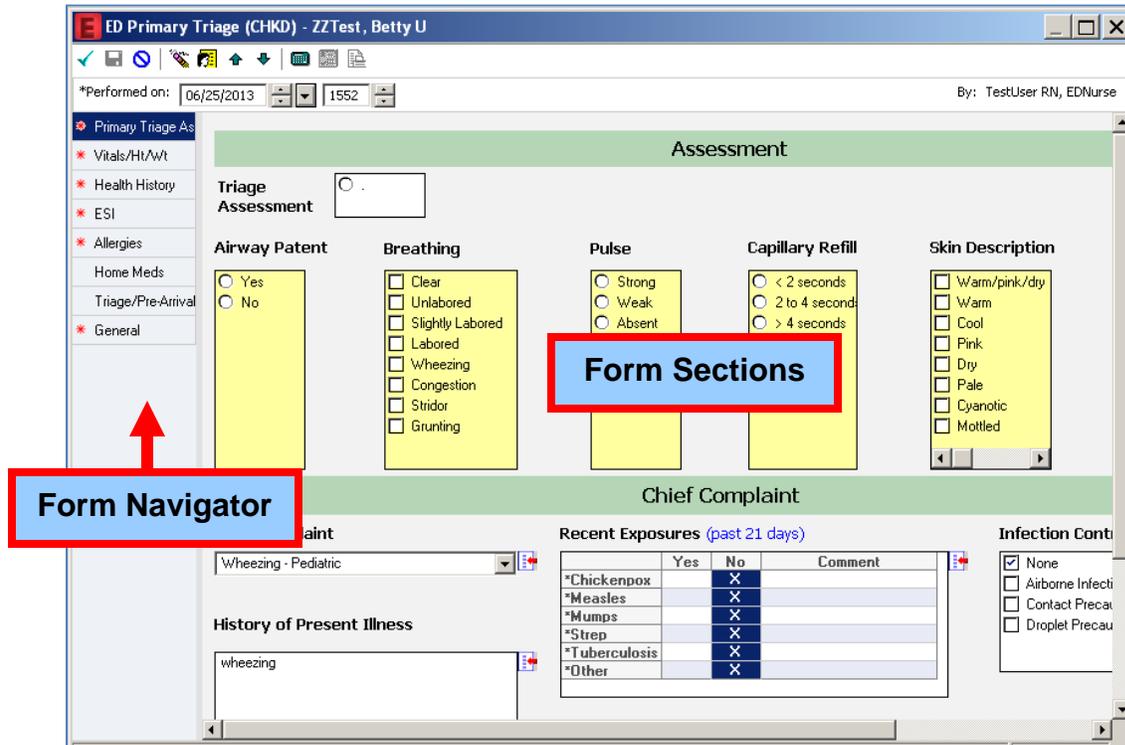


The PowerForms toolbar contains all or some of the following elements:

	<b>Sign PowerForm</b> - Charts the information entered into the PowerForm. The completed PowerForm is accessible from Form Browser when the patient's chart is open. The completed PowerForm information is also displayed in one or more cells of the patient's Flowsheet.
	<b>Cancel</b> - Cancels the charting session without saving any entered information.
	<b>Clear</b> - Clears information from the PowerForm so the user can start over.
	<b>Result Information</b> - Opens the Result Information window so a user can indicate who completed the PowerForm if different from the defaulted ID based upon login. If a user is charting for another provider, they can select the appropriate name or alias.
	<b>Previous</b> - In a PowerForm that was designed in separate sections, this icon opens the previous section. The sections are listed in order in the navigator or left panel of the PowerForm display.
	<b>Next</b> - In a PowerForm that was designed in separate sections, opens the next section. The sections are listed in order in the navigator or left panel of the PowerForm display.
	<b>Clinical Calculator</b> - Opens the Online Clinical Calculator window.
	<b>Charge Details</b> - Opens the Charge Details dialog box where the user can attach diagnosis codes and other related details to any charges generated as a result of documenting the PowerForm.

## Form Navigator

The PowerForms sections display in the Navigator on the left side of the screen. Access the sections by clicking on the section name in the Navigator or using the Previous and Next toolbar buttons.



- PowerForm section names in the Navigator with a light blue background are available and have been accessed, but are not currently open.
- PowerForm section names in the Navigator with a dark blue background are the PowerForm section that is currently open.
- PowerForm section names in the Navigator with a white background are the PowerForms that are available but have not been accessed.
- PowerForm section names in the Navigator with gray background are conditional sections that are inaccessible until activated by an answer from another PowerForm field.

A notification icon within the PowerForm Navigator notifies there is a required field within that PowerForm section.



Required fields must be satisfied prior to charting the PowerForm.

## PowerForm Section Field Types

---

Fields within each PowerForm section element are formatted to accept specific types of data input. In order to ensure the correct data is added to each PowerForm section, it is helpful to understand the formatting of each element section. For example, if an element anticipates numeric data, letters cannot be entered.

### Label Boxes

Label boxes are used to identify and provide instructions for completing a field in the PowerForm section.

**Interpreter Needed**

Yes  
 No

Please refer to the list of medical interpreters on KDnet under Medical Resources. If no interpreters are available, utilize the blue Cyracom phone.

### Text Controls

Free Text fields allow the user to enter up to 255 characters, and Rich text fields allow lengthy blocks of text to be entered or for default information to be pulled in from another PowerForm section element.

**Medical/Treatment Diagnosis**

[Empty text input field]

### Alpha Controls

An alpha control displays a data-entry box with a list of predefined values.

Alpha controls can be displayed as a drop-down menu, or as a single select/multiple select list.

**Treatment Precautions**

<input type="checkbox"/> Apnea	<input type="checkbox"/> Weight bearing precautions
<input type="checkbox"/> Allergies notes (food, latex)	<input type="checkbox"/> NPO
<input type="checkbox"/> Bradycardia	<input type="checkbox"/> Other:
<input type="checkbox"/> Feeding/swallowing precautions	
<input type="checkbox"/> Hearing impairment	
<input type="checkbox"/> Infectious disease precautions: MRSA, RSV, CMV	
<input type="checkbox"/> Judgment/safety concerns	

## Provider Controls

Clicking the binoculars button opens a provider search for selecting the appropriate provider.



A rectangular control box with a light gray background. At the top, the text "Referring Provider" is displayed in bold. Below this is a white text input field. To the right of the input field is a small icon of binoculars.

## Numeric Controls

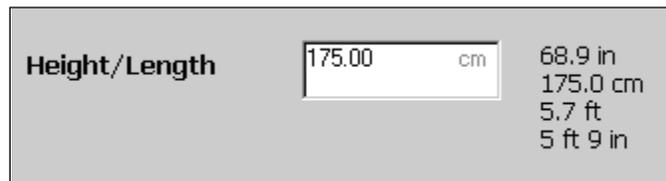
Numeric controls allow the entry for numeric result values. A unit of measure can be associated to the numeric control. Only numerical data can be entered into Numeric Control PowerForm elements.



A rectangular control box with a light gray background. On the left, the text "Evaluation Time" is displayed in bold. To the right is a white text input field containing the value "175.00". To the right of the input field is a small box containing the text "minute(s)".

## Conversion Controls

A units-of-measurement conversion control can be associated with fields on a PowerForm section. This makes it possible for the person entering values during the documentation process to view the converted values in more than one measurement system. In the example below, the height entered in centimeters is converted and displayed in inches, feet and feet/inches.



A rectangular control box with a light gray background. On the left, the text "Height/Length" is displayed in bold. To the right is a white text input field containing the value "175.00". To the right of the input field is a small box containing the text "cm". To the right of the input field and unit box are four lines of converted values: "68.9 in", "175.0 cm", "5.7 ft", and "5 ft 9 in".

## Date Controls

A date/time field is designed specifically for capturing a date and time of day, a date only, or a time only.



A rectangular control box with a light gray background. At the top, the text "Onset Date" is displayed in bold. Below this is a white text input field containing the value "00/00/0000". To the right of the input field are two small buttons: one with a left-pointing arrow and one with a right-pointing arrow.

## Grids

Grids are designed to capture a set of responses for a list of questions. Each answer can be entered into the appropriate cell on the grid.

Previous Surgeries				
Surgery Date	Surgery Description	Surgery Facility	Surgery Complications	Previous Surgeries Comment
	Tonsillectomy			
	<MultiAlpha>			

## Ultra Grids

Ultra grids are setup to prompt the user to select the appropriate response from a list. This list will open into a separate window when you select the cell on the grid display.

Procedure Type	Education Topics	Individuals Taught	Barriers to Learning	Teaching Method	Teaching Evaluation	Education Referral Made To	Comment
	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	
	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	<MultiAlpha>	

**Result Details**

**Education Topics**

- Anesthesia/Sedation
- Family instructions
- Medication instructions
- Pain management
- Plan of care
- Preprocedure diet
- Preprocedure tests/labs
- Respiratory care
- Turn/Cough/Deep breathing
- Tubes/Drains/IV's
- Other:

Comment

OK Cancel

## Conditional Fields and Sections

Conditional fields are dithered (grayed out) and only open when a related selection is made.

In example below, selecting 'No' in the *Blood Work Done* box causes the Reason Blood Work Not Done Comment box to display.

<p><b>Blood Work Done</b></p> <p><input type="radio"/> Yes</p> <p><input checked="" type="radio"/> No</p> <p><input type="radio"/> Sent patient to lab</p> <p><input type="radio"/> N/A</p>	<p><b>Reason Blood Work Not Done</b></p> <div style="background-color: yellow; height: 40px; width: 100%;"></div>
---	---

## Required Fields

A bold-yellow background indicates required fields within each PowerForm section. These required fields must be answered before you can chart the PowerForm.



Very poor  
 Probably inadequate  
 Adequate  
 Excellent

Required fields must be satisfied prior to charting the PowerForm.

## Interacting with PowerForm Section Fields

---

While adding data to each PowerForm field, you can right-click to review additional options available. The available options are dependent on what type of data format the field has (i.e.: label, grid, alpha control etc.).

Comment  
Modifiers  
Reference Text  
View Result Details  
Clear

**Comment:** You can add textual comments within various section fields.

**View Result Details:** If there are result details associated with that section field, you can review these results.

**Clear:** You can clear the inputted data for that specific field without clearing the entire PowerForm section.

## Grids

The available right-click options for grid fields are:

Comment  
Chart Details...  
Modifiers  
Reference Text  
View Result Details  
Clear  
Clear Cell  
Add Row  
Delete Row

**Chart Details:** You can add a comment about a specific detail within the selected cell.

**Clear:** You can clear the current grid, without clearing the entire PowerForm section.

**Clear Cell:** You can clear the information in the current cell within the grid, without clearing the entire grid or PowerForm section.

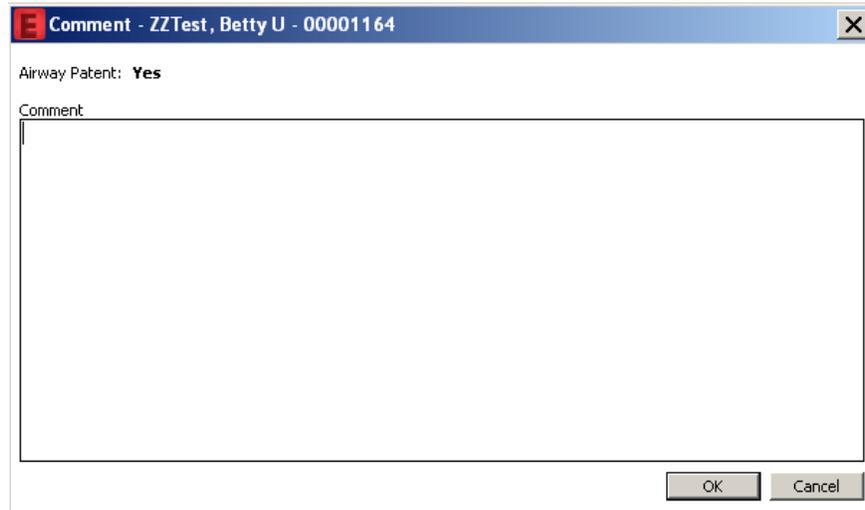
**Add Row:** You can add an additional data row within the selected grid. This option is only available for Ultra Grids.

**Delete Row:** You can delete a data row within the selected grid. This option is only available for Ultra Grids.

## Adding Comments

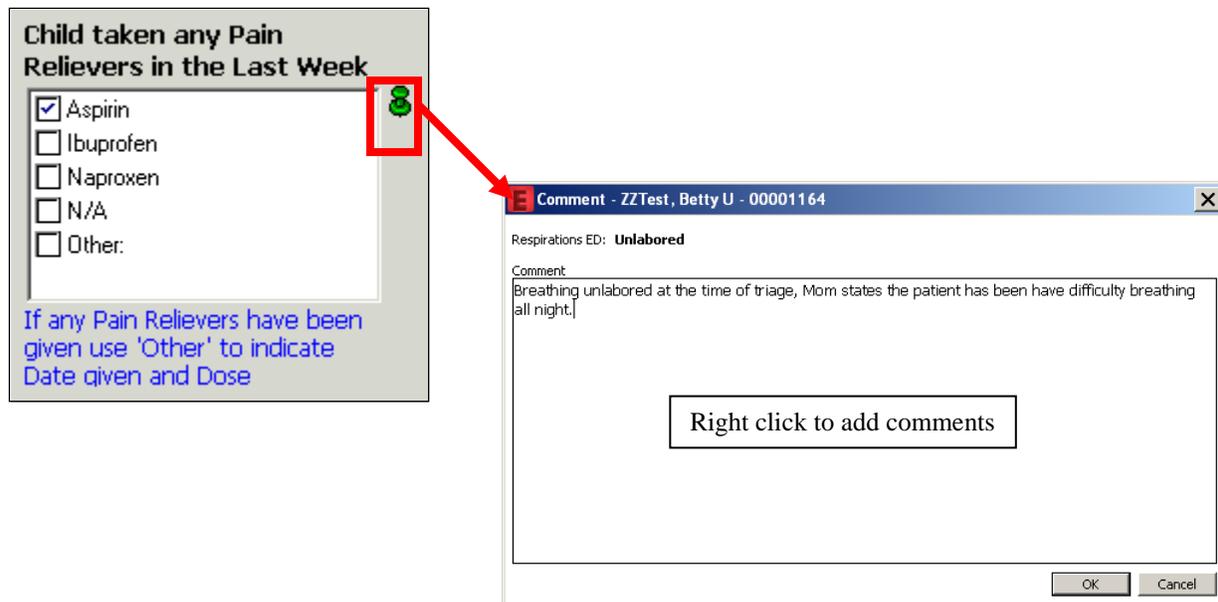
You can add comments to section fields by right-clicking on the field and selecting 'Comment' from the menu option.

The Comments widow will open, and you can type your comments that are relevant to the designated field.



After entering your comment details, select 'OK' to save the information. After you save or chart the PowerForm, any fields that have comments added will display the comment's icon .

To review the comment within the PowerForm, right-click on the push pin comment icon and select 'Comment' from the menu. You will then be able to review the entered comment, modify the comment existing comment, or add an additional comment.

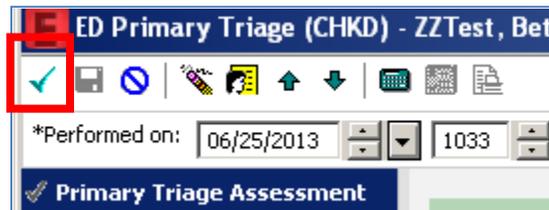


## Charting Options

After accessing the PowerForm and entering your data, you can either sign the PowerForm and chart the data, save the data within the PowerForm to complete later, or you can cancel the PowerForm without charting any changes.

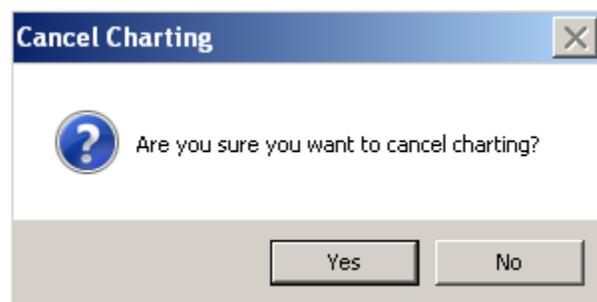
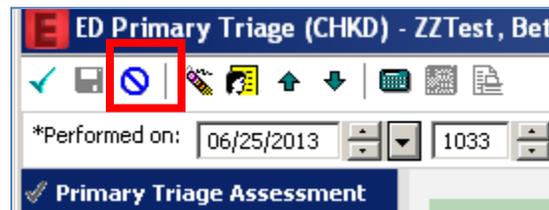
### Sign PowerForm

When the PowerForm is completed and you are ready to chart the PowerForm, select the  'Sign Form' icon to save and chart the data within the PowerForm.



### Cancel

You can cancel charting the PowerForm without saving by selecting the  'Cancel' icon.



Select 'Yes' on the Cancel Charting prompt to cancel current charting, and return to the previous screen.

Select 'No' on the Cancel Charting prompt to return to the current PowerForm.

### Performed on :

Defaults in the current date and time for charting the Powerform and can be changed as needed.

## Nursing PowerForms

This table lists some typical PowerForms used by Nursing in various areas of the hospital that may be included within a previous admission encounter.

Folder - Components	
Powerform	Description
<b>Contact Information Form</b>	<p>This is also a section of the Pediatric Admission History PowerForm and it is also a stand alone form.</p> <p>Use this form to update contact information during patient's stay.</p>
<b>Ht/Wt/Allergies Form</b>	<p>This form will be tasked on admission.</p> <p>A licensed person (RN, LPN) must complete this form, for the weight entered will be the dosing weight.</p> <p>This is also a standalone form.</p>
<b>Med Response Form</b>	<p>Will be tasked after giving a PRN medication.</p>
<b>Nursing Diagnoses/End Note Form</b>	<p>Will be tasked before change of shift (1730 and 0530).</p> <p>This form takes the place of today's end note.</p>
<b>Nursing Note Form</b>	<p>This is a blank form where a nurse can write a narrative note.</p> <p>It can be used for documentation of emergent or unexpected events in which the nurse would like to elaborate on what occurred.</p>
<b>Pediatric Admission History Form</b>	<p>This form is generated from a task on admission.</p> <p>This form was created based on the current paper admission database form.</p>
<b>EMR Quicknotes</b>	<p>This form contains information such as Nickname, Password, Clinical Reminders, Devices and Contact Information. Information documented in this form flows to the Admission History Form and vice versa.</p> <p>This form should be updated as needed and with each 24hr MAR/Chart Check.</p>

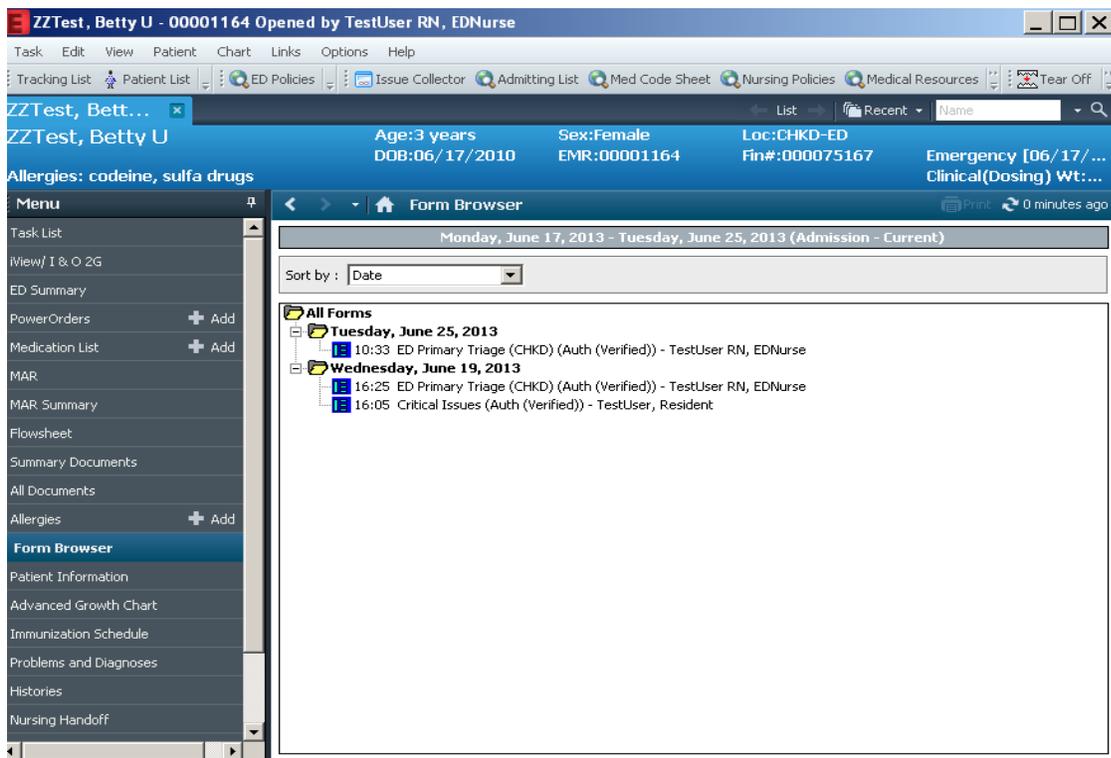
## Form Browser

Information or results entered during the charting process for the patient are available on the patient's chart. The charted results can be viewed within the related Flowsheet, and the charted PowerForm is available in the Documents tab within the patient's chart.

Depending on your role within the organization, charted PowerForms and PowerForms in process of being charted are available within the Form Browser. The Form Browser is a convenient way to view the complete details of any charting that has been completed via PowerForms. The user can see the charted information in its entirety and is better able to view related items.

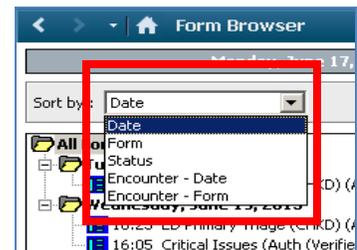
## Form Browser Basics

The Form Browser window displays a directory tree that lists all the charted, in progress, and uncharted PowerForms for the selected patient. Open a PowerForm to view the information. An icon is displayed to the left of an occurrence. A red icon indicates a required field was not completed, and a blue icon indicates that required fields are completed.



You can sort the PowerForms by Date, Form type, Form Status, Encounter Date, or Encounter Form by selecting the Drop-down menu.

If the sort criteria of 'Form' or 'Date' is selected, then the status of the PowerForm (Authenticated, Verified, Modified etc.) also displays.



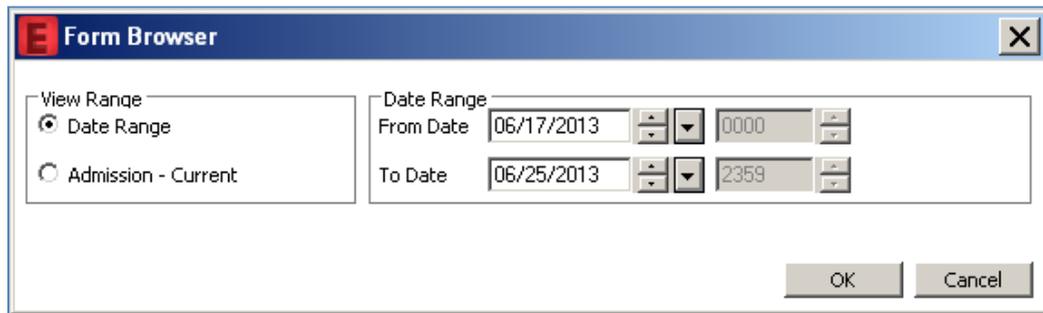
## Retrieving PowerForms

The Form Browser tab displays a default time range. A user can change the time range for the **current** session by completing the following steps:

1. Select the Form Browser tab. Completed PowerForms for the selected patient are retrieved for a defaulted time span.
2. Right-click the information bar (where the time range is displayed) and select 'Search Criteria', or select 'Search Criteria' from the Options menu to open the Form Browser dialog box.



3. To view PowerForms within a specific date range, select Date Range in the View Range group box, and then enter the From and To dates and times. Use the small up and down arrows to increase or decrease the date and time. The large down arrow opens a calendar on which the month and day can be selected.

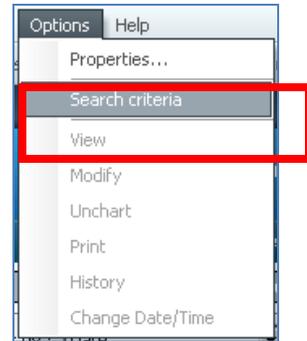


4. To view all PowerForms from admission to the current date, select Admission – Current in the View Range group box.
5. Click OK.

## Change the Default time range

To change the **defaulted** time range for retrieving completed PowerForms, complete the following steps. If these preferences are saved, the new time range is used for PowerForm retrieval the next time the Form Browser is opened.

1. Select the Form Browser tab. Completed PowerForms for the selected patient are retrieved for a defaulted time span.
2. From the Options menu, select Properties to open the Form Browser Properties dialog box.

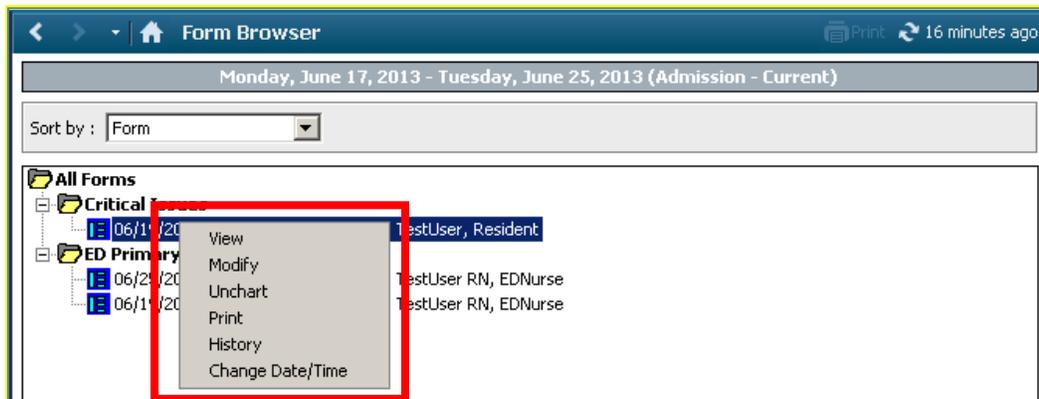


3. In the Sort By box, select the way the PowerForms will sort (by date, form name, status, encounter date, or encounter form).
4. In the Date Range group box, select Date Range to specify how far back or forward the system should search for PowerForms, and the increment value and units of that search (for example, five days).
5. In the Offset group box, change the entries to match you preferences. (Options in this group box are not available if Admission – Current was selected in the Date Range group box.)
  - **Back box:** Enter a number to indicate how far back from now to search for charted PowerForms. Select a unit such as a day or a week in the Units box.
  - **Forward box:** Enter a number to indicate how far forward from now to search for charted PowerForms. Select a unit such as a day or a week in the Units box.
  - **Increment Value box:** Enter the number of units of time measure that are increased or decreased each time the left or right arrow buttons on the information bar are clicked.
  - **Units box:** Click the down arrow and select the unit of time measure (year, month, week, day, hour, or minute) desired.
6. Click OK to save these settings for the current session of Form Browser, or click Save to save your preferences for all sessions. Click Cancel to return to the previous window without saving any entries.

## Viewing a Completed PowerForm

To view information that has been entered for a patient as it was charted on a PowerForm, complete the following steps:

- Select the Form Browser tab. A list of PowerForms completed for this patient during the time range displayed on the information bar is displayed in a tree. The tree may be sorted by date, form, status, encounter date, or encounter form by making a selection from the Sort By box.
- Double-click a folder under the 'All Forms' folder to open and display the available PowerForms.
- Right-click the PowerForm occurrence and select View, or select View from the Options menu to open the PowerForm.



The completed PowerForm is displayed in the form viewer in a read-only format. If the PowerForm is subdivided into sections, a list of their names is displayed in the left panel. The first section is displayed. Use the arrows on the toolbar to navigate among the sections.

- Click  in the upper right corner to return to the previous window.

## Modifying a PowerForm

---

To modify the information on a completed PowerForm, complete the following steps:

1. Select the Form Browser tab. A list of PowerForms completed for this patient during the time range displayed on the information bar is displayed in a tree. The tree may be sorted by date, form, status, encounter date, or encounter form by making a selection from the Sort By box.
2. Double-click a folder to open and display occurrences of the PowerForm.
3. Right click the PowerForm occurrence and select Modify, or select Modify from the Options menu to open the PowerForm in modification mode.

If the PowerForm is subdivided into sections, a list of the section names is displayed in the left panel. The first section is displayed. Use the arrows on the toolbar to navigate among the sections.

4. Enter corrections and additions.
5. Click  to chart the information.

NOTE: If the data you modify within the PowerForms also displays in iView, that modification will be updated with a modify symbol

## Changing the Date/Time of a Charted Result

---

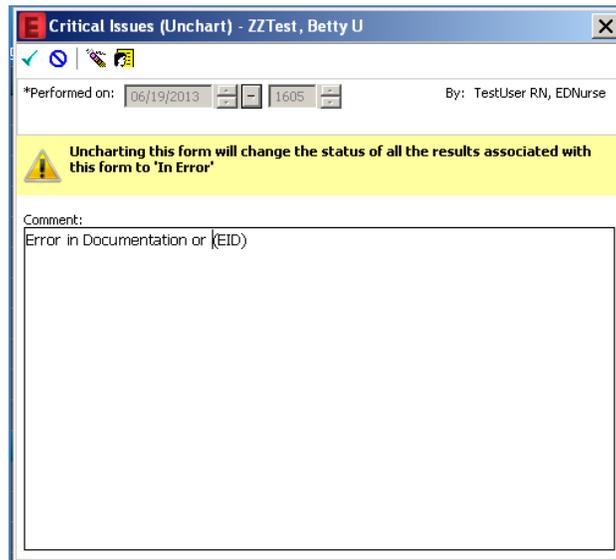
To change the date and time a result was charted, complete the following steps:

1. Open the patient chart to the Form Browser tab.
2. Double-click a folder to display occurrences of the PowerForm.
3. Right-click the PowerForm occurrence and select Change Date/Time from the context menu, or select Change Date/Time from the Options menu.
4. The Adjust Result Date/Time window opens. Enter the correct result date and time, or use the spin boxes to select the date and time.
5. To enter a comment, click in the Comments box to place the cursor, and enter the comment.
6. Click  to Sign your changes and return to the Form Browser tab. To cancel your entries and return to the Form Browser tab, click .

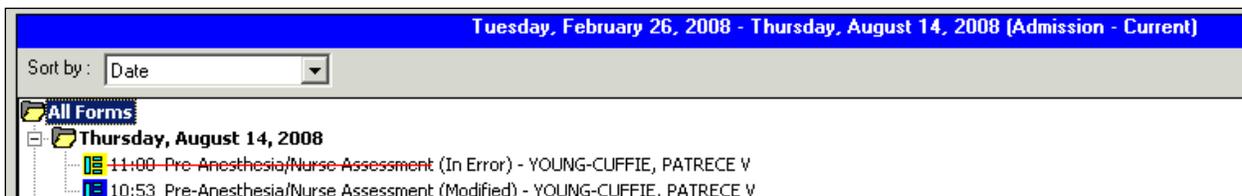
## Uncharting a PowerForm

Results that were entered in error (charted to wrong patient, for example) can be uncharted from the Flowsheet or from the PowerForm that originally captured the data. To unchart results that were entered in error by using the PowerForm, complete the following steps:

1. Open the patient chart to the Form Browser tab.
2. Double-click a folder to display occurrences of the PowerForm.
3. Right-click the PowerForm occurrence and select Unchart to open a comments dialog box.
4. When Uncharting always enter "EID" Error in Documentation.



5. Click  to chart the information. The results displayed on the Flowsheet for this patient now display as In Error and the Form Browser displays the PowerForm with a strike through.

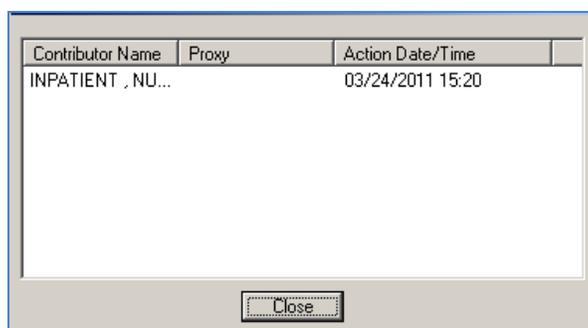


## Viewing Document History

---

To view a PowerForms documentation history, complete the following steps:

1. Open the patient chart to the Form Browser tab.
2. Double-click a folder to display occurrences of the PowerForm.
3. Right-click the PowerForm occurrence and select History from the context menu, or select History from the Options menu.
4. The Action List for <PowerForm name> dialog box opens, listing the name of the contributor, the name of the proxy (if any), and the date and time the action took place.

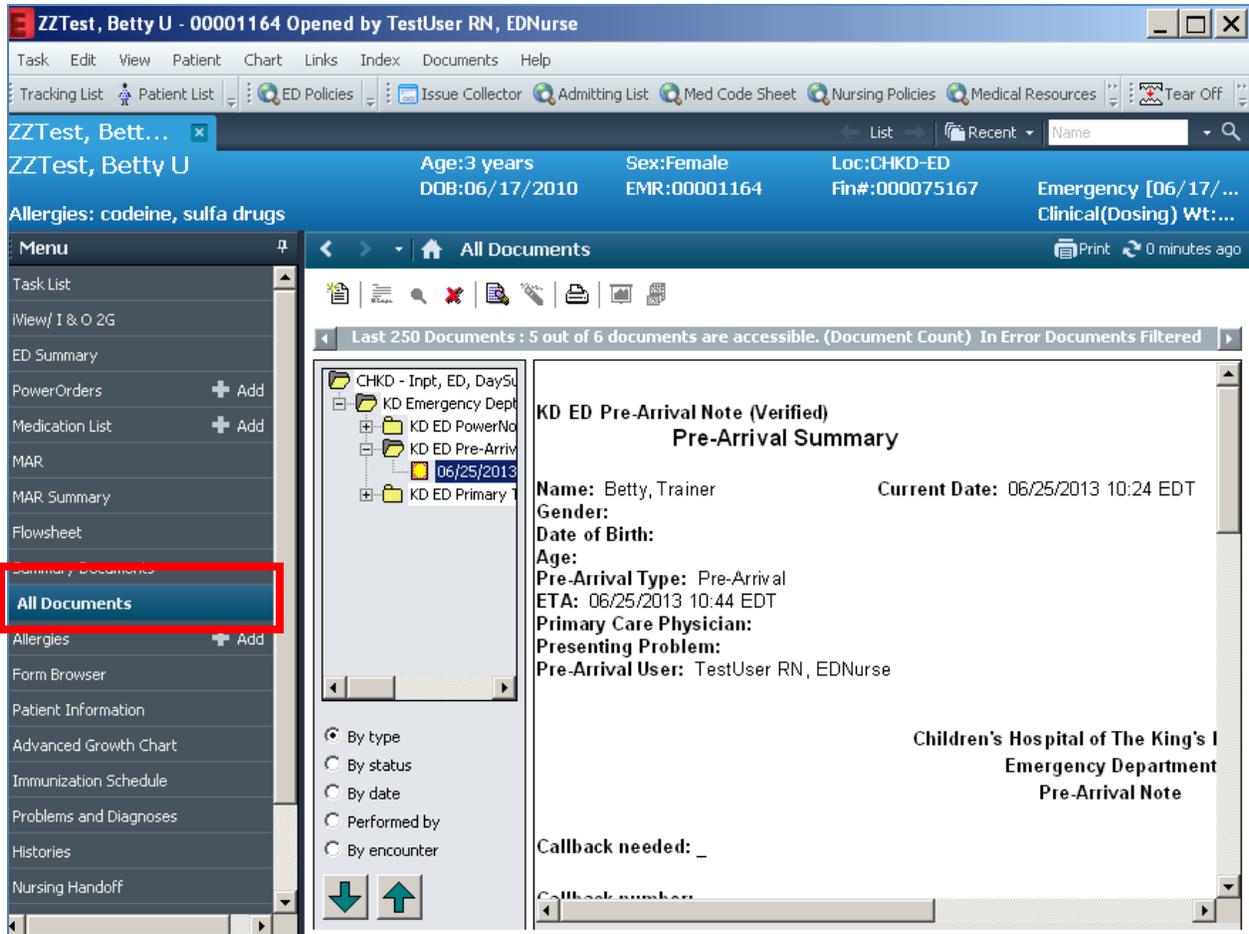


Contributor Name	Proxy	Action Date/Time
INPATIENT , NU...		03/24/2011 15:20

## Documents Tab

Some PowerForms can also be reviewed from the Documents tabs within the patient's chart. **However, none of the Phase 4A PowerForms will be available in the documents tab.**

To view other documents, select a Documents Tab from within the patient's chart. Expand the folder sections and select the desired PowerForm to review in the Documents window.





## Practice Scenario for PowerForms



### Chart the ED Primary Triage Assessment form

Your patient was just admitted to the ED with a chief complaint of wheezing. Complete the Acuity Level Form for your patient.

#### PRACTICE 1:

- 🕒 Triage Assessment
- 🕒 The has a patent airway and they are wheezing with congestion, slight fever
- 🕒 Pulse is strong, capillary refill <2 seconds
- 🕒 Skin description = warm/pink/dry
- 🕒 LOC = Awake and alert
- 🕒 Chief Complaint = wheezing
- 🕒 Recent exposure = no to all
- 🕒 Infection Control = Contact Precautions
- 🕒 History of Present Illness = wheezing x 6 hours, Hx of asthma
- 🕒 Triage Focused Assessment = no acute distress
- 🕒 NPO = today at (2 hours ago)
- 🕒 Vital signs – Oral = 38, Pulse Rate = 75, BP = 110/65 from L arm, RR = 18, SPO2 96, using your clinical Calculator enter Ht = 60 inches, Wt = 78 lbs and weight determined by stand up scale. Pain = Numeric 3 (mild headache)
- 🕒 Health History = Asthma/Mental Behavior Health History=none/Feels like hurting self/others=No
- 🕒 Right-click in the Health History section and add a comment about the patient's behavior.
- 🕒 Recent Illness = Hospitalized for Acute asthma 08/01/2012, responded to therapy and discharged to home after 2 days
- 🕒 ESI level 3 with many resources
- 🕒 No P-BRAT needed
- 🕒 Allergies = Verified with No known allergies
- 🕒 Home Meds = Prednisone (dose unknown), Atrovent Inhaler 2puffs 30 min prior to arrival
- 🕒 Triage Treatments Initiated = Medication per Ed protocol, Ibuprofen 200mg Tab PO (this is practice only)
- 🕒 General = Accompanied by Mother and Father. All immunizations are current with no domestic concerns, no barriers to care and learning needs have been assessed

#### PRACTICE 2:

### Chart the ED VS Acuity Level Form



- 🕒 Patient's acuity level has changed to a Level 4
- 🕒 Chart the appropriate changes on the Acuity Level Form
- 🕒 Notice the change on the Tracking List

**PRACTICE 3:**

- 🕒 Chart an ED Specimen Collection PowerForm from the Tracking List
- 🕒 Access the charted form from FormBrowser and make a modification

**PRACTICE 4:**

- 🕒 Chart a Med Response PowerForm

**PRACTICE 5:**

- 🕒 Chart An ED Transport Details Form
- 🕒 The patient was transported to Dialysis
- 🕒 Complete any additional information needed
- 🕒 Sign your form

**PRACTICE 6:**

- 🕒 You realize the ED Transport Details form was charted on the wrong patient.
- 🕒 Access the charted form in Form Browser and unchart the form due to error in documentation

## Section III Patient's Chart

The Patient Chart consists of a combination of tabs that allow the clinician to access information that is pertinent at that moment.

The screenshot displays the PowerChart software interface for a patient named Betty U. The window title is "ZZTest, Betty U - 00001164 Opened by TestUser RN, EDNurse". The interface includes a menu bar (Task, Edit, View, Patient, Chart, Links, Navigation, Help) and a toolbar with various icons. The main content area is titled "ED Summary" and contains several tabs:

- Critical Issues:** A table with columns "Issue" and "Date Entered". One entry is "Critical Airway" dated "06-19-2013".
- Patient Information:** Fields for "Chief Complaint: Wheezing - Pediatric", "Reason For Visit: No results found", "Primary: No results found", "Physician:", and "Last Visit: No results found".
- Diagnoses:** A section for "Selected visit" with "No results found".
- Problems:** A section for "All Visits" with "No results found".
- Vital Signs:** A table showing vital signs for "Last 2 days for the selected visit".
 

	Today	Previous
Dosing Weight	16 06/25/13 10:33	-- --
Clinical Height	78 06/25/13 10:33	-- --
BP	100/80 06/25/13 10:33	-- --
Temp	38 06/25/13 10:33	-- --
Respiratory	16 06/25/13 10:33	-- --
- Documents (2):** A list of documents for "Last 6 months for all visits".
 

Note Type	Author	Date/Time
KD ED PowerNote	TestUser, Resident	06/24/13 13:47
KD ED PowerNote	TestUser, Resident	06/19/13 16:08

The interface also features a left-hand menu with options like Task List, ED Summary, Medication List, MAR, and Vital Signs. A right-hand sidebar contains sections for "New Order Entry" and "Outstanding Orders".

Like most Windows applications, PowerChart utilizes a menu bar and a toolbar.

The menu bar contains textual options of system actions available based on the particular window that is open.

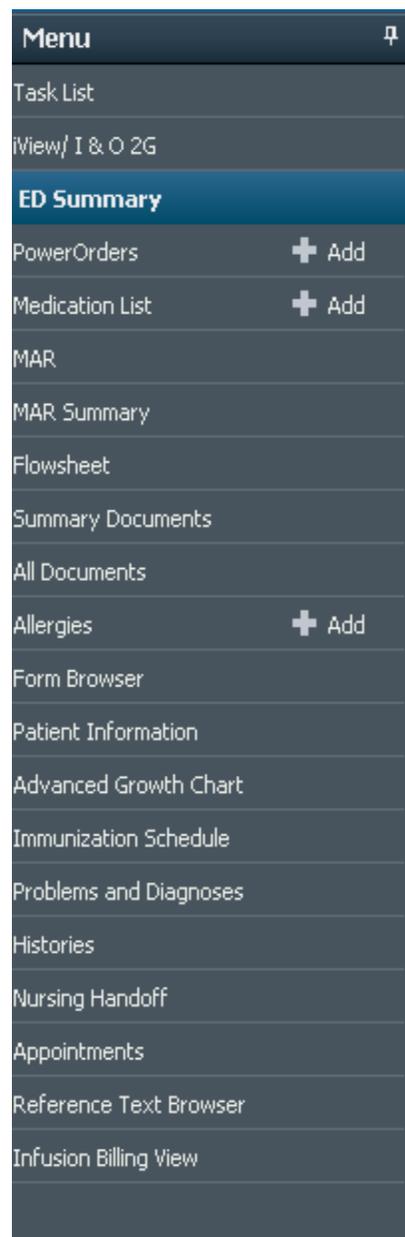
Remember, you must close both the Organizer and the Patient Chart to log completely out of PowerChart.

## Chart Tabs

From within a patient's chart specific information such as orders, results and documentation are available in the Chart Tabs. The Chart Tabs provide actions based on the window that opens. Depending on your role and security, the availability and order of the tabs may differ.

The new and/or revised chart tabs are listed below:

- **Task List** - The Task List displays the tasks clinicians need to perform for the selected patient.
- **iView I&O/2G** - Interactive View, also known as iView/I&O 2G, is a flowsheet of a wide variety of patient data in a single area. Head to toe assessments, Vital signs and I/O are documented on this tab. In iView you can document, view, modify and unchart results.
- **ED Summary** - The ED Summary tab displays clinical data as staff contributes documented results to the patient's EMR. Some of the information that will populate this tab include: Patient Information, Diagnosis & Problems, Allergies, Vital Signs, Diagnostic Results, Laboratory and Pathology results, etc. Actions such as entering orders, home meds and adding allergies may be completed directly from the ED Summary. Customization and user preferences can be set to enhance your view and workflow.
- **PowerOrders** - The Orders section allows you to view and enter orders. The Document Medication by HX sub-tab allows you to enter a patient's medication history.
- **Medication Lists** - The Medication List tab enables you to view all documented medication therapies for a patient. You can also document the patient's medication history here by clicking on the **Document Medication by History** tab and clicking ADD. Search for the medication and select it from the search window. Enter as many details as you are aware of. If you do not know the details, for example the mother says the patient takes Tylenol at home but does not know any other details, simply select Tylenol without the details. **If there are no home medications "NO KNOWN MEDS" should be documented here.**
- **MAR** - From within the MAR the Nursing Staff can document medication administration, IV Events, and reschedule medication doses if needed.
- **Mar Summary** - The MAR Summary tab displays the patient's medications in a view only mode. This tab will be utilized by providers to view medication administration information. By hovering over a medication, additional information regarding that medication may be viewed.



- **Flowsheet** – The Flowsheet Tab provides a view only flowsheet of all documented result information. Combined results of 48 hours in the past and 24 hours in the future may be viewed as a table, group or list. Be aware that other clinicians may have a different view which lists the sub tabs in Results Review as individual tabs in the menu.
- **Summary Documents** - The Summary Documents tab allows you to view such things as operative reports or H&P's.
- **All Documents** - All Documents tab displays all documents entered into the system.
- **Allergies** - The Allergies tab is used to view and enter allergies for a patient. **If no allergies are noted, "NO KNOWN ALLERGIES" should be documented.**
- **Form Browser** - The Forms Browser tab allows you to see charted information in its entirety that was done for a selected patient via PowerForms.
- **Patient Information** – The Patient Information tab includes information such as the Patient's Demographics, Visit list, and PPR Summary.
- **Advanced Growth Chart** - The Advanced Growth Chart tab provides a graph of a child's growth compared to the national standard. Gender specific Height, Weight and Head Circumference charts are available for ages 0-36 month and Height and Weight charts are available for ages. 2-18 years. Information can be entered by CHKDHS ambulatory sites that have access to clinical documentation. It can be viewed by all inpatient staff with view access to PowerChart. All staff should follow their unit policies concerning viewing and documenting within growth charts.
- **Immunization Schedule** - The Immunization Schedule tab allows you to view past immunizations administrations documented by CHKD staff at sites that have access to clinical documentation. Immunizations that are administered while the patient is an inpatient will be documented in the eMAR and the information will populate in the Immunization Schedule.
- **Problems and Diagnosis** - The Diagnosis and Problems tab provides a view of Diagnosis & Problems that have been entered for a selected patient. Anything that presents a problem to the patient's overall health may be listed in the Problem List. Only designated roles such as Infection Control Nurses and Physicians can enter problems on the Problem List.
- **Histories** - The Histories tab has two sub-tabs and allows you to view and designated staff to document the patient's procedure history and the patient's family history.
  - Procedures: **CHKD Operating Room Staff** will document procedures that take place at any CHKD operating room facility. This information can be viewed by all staff that have security to view information in PowerChart.
  - Family: Any Family History that has been recorded by a CHKDHS site that has access to clinical documentation can be viewed here by staff that have access to view information in PowerChart. Staff with access can also add Family History as appropriate by clicking the ADD button and entering the appropriate health history for the selected family member.

- **Nursing Handoff** – The Nursing Handoff Tab is similar to the ED Summary Tab that displays a consolidated view of clinical data as staff contributes documented results to the patient's EMR. This tab can be used at shift change or when handing off patient care from Nurse to Nurse.
- **Appointments** – The Appointments tab is a view only tab that displays Future appointments and Past appointments that have been scheduled for your patient by CHKDHS outpatient locations who are currently using PowerChart EMR documentation.
- **Reference Text Browser** – The Reference Text Browser tab displays Drug Reference, Education Leaflet and other Reference Material.

## ED Summary Tab

The ED Summary pulls information entered or viewed in different areas of the chart into a single convenient view. The ED Summary contains a quick view of information such as Diagnoses, Problems documented in the Problem List, Allergies, Vital Signs, Triage Information and Patient Education.

The ED Summary M-Page supports interactive workflows. For example, physicians can enter orders, and PowerNotes (documents) directly from ED Summary.

You can “jump” to certain areas of the chart from the Patient Summary by clicking on the hyperlink at the top of the specific section.

You can also hover over sections and view additional information about the documented result.

The screenshot displays the ED Summary interface with the following sections:

- Critical Issues:** Table with columns 'Issue' and 'Date Entered'. Row: Critical Airway, 06-19-2013.
- Patient Information:** Chief Complaint: Wheezing - Pediatric; Reason For Visit: No results found; Primary Physician: No results found; Last Visit: No results found.
- Diagnoses:** Selected visit: No results found.
- Problems:** All Visits: No results found.
- Allergies (2):** codeine (Hives), sulfa drugs (Abdominal pain).
- CDC Growth Chart:** Last 1 years for all visits. No results found.
- Vital Signs:** Last 2 days for the selected visit. Table with columns: Parameter, Today (Date/Time), Previous (Date/Time).
 

Parameter	Today (Date/Time)	Previous (Date/Time)
Dosing Weight	16 (06/25/13 10:33)	--
Clinical Height	78 (06/25/13 10:33)	--
BP	100/80 (06/25/13 10:33)	--
Temp	38 (06/25/13 10:33)	--
Respiratory Rate	16 (06/25/13 10:33)	--
SpO2	98 (06/25/13 10:33)	--
- Documents (2):** Last 6 months for all visits. Table with columns: Note Type, Author, Date/Time.
 

Note Type	Author	Date/Time
KD ED PowerNote	TestUser, Resident	06/24/13 13:47
KD ED PowerNote	TestUser, Resident	06/19/13 16:08
- New Order Entry:** Search New Order, Favorites (Public, Shared), No Favorites Found.
- Outstanding Orders (4):** Selected visit table.
 

Order	Status	Ordered
CBCA	Ordered	06/20/13 10:01
XR Chest 1 View Portable	Ordered	06/19/13

The Vital Signs section will display the ‘Last 2 days for the selected visit’. Both Today’s results and Previous results will display.

Results recorded for Today or Previous may have been recorded during a previous ED visit or a previous PCP visit. Make sure you also look at the date and time the result was documented.

You can hover over a result to display additional information.

The close-up shows the Vital Signs section with a tooltip for the Clinical Height result (78 cm):

- Parameter: Clinical Height
- Today: 78 (06/25/13 10:33)
- Previous: --
- Height: 78 cm
- Date/Time: 06/25/2013 10:33
- Status: Auth (Verified)
- Normal Low: [blank]
- Normal High: [blank]
- Critical Low: [blank]

## Customizing the ED Summary Tab

Inpatient Summary MPage Tab within the patient chart can be customized by you to display the headers based on your individual preferences.

- View Layout – allows you to view the screen in one, two or three columns
- Enable Drag and Drop – allows you to rearrange the order of sections and display sections such as Vital Signs under your patient information section.
- Expand All – expands all the sections within the ED Summary Tab.
- Clear Preference – resets the ED Summary to the default view.

Once you change any of these settings they become your default view for all patients.

\*\*\*\*\*

In order to Customize your screen click the *pull down arrow* in the upper right-hand corner of the Inpatient Summary MPage.

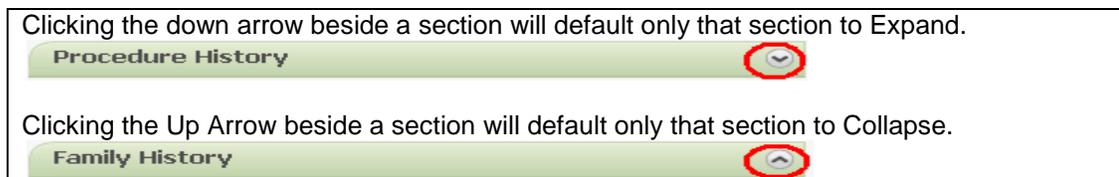


1. Left-click on the Header that you would like to move and drag and drop it to your desired location.

Note some Headers such as Patient Information can be moved but will only be displayed in the original column. Before moving headers be sure to consider the screen resolution for your view and how you would like the information displayed.

2. To default the sections to display as opened or closed click *Expand All* (to display all as open) or *Collapse All* (to display all as closed).

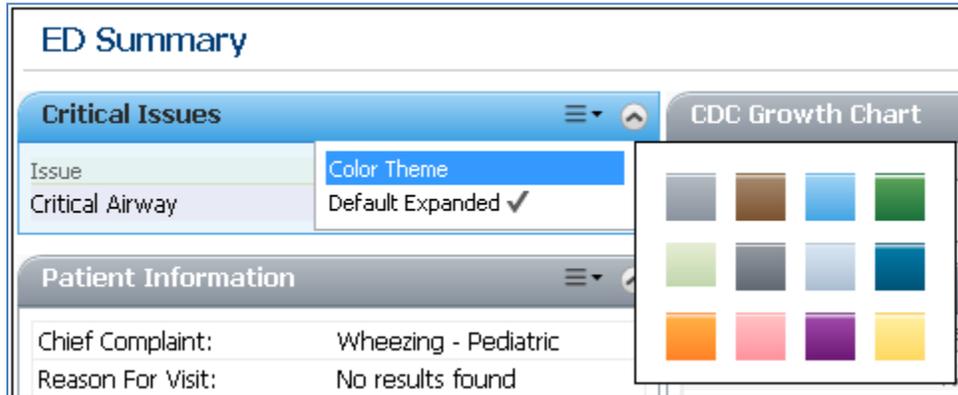
You can also choose to display individual sections open or closed.



3. Once the headers have been moved to your desired location and all defaults are set as desired, click on *Save Preferences* to complete and retain your changes.

If you would like to restore the Inpatient Summary MPage its original view, select *Customize View* again to continue moving the headers or *Clear Preferences* to restore the screen to its original view.

Sections within the ED Summary can also be customized by clicking on the pull down within the section and selecting a color. This can be used to make sections that you frequently visit or sections that you want to stand out be more visable.



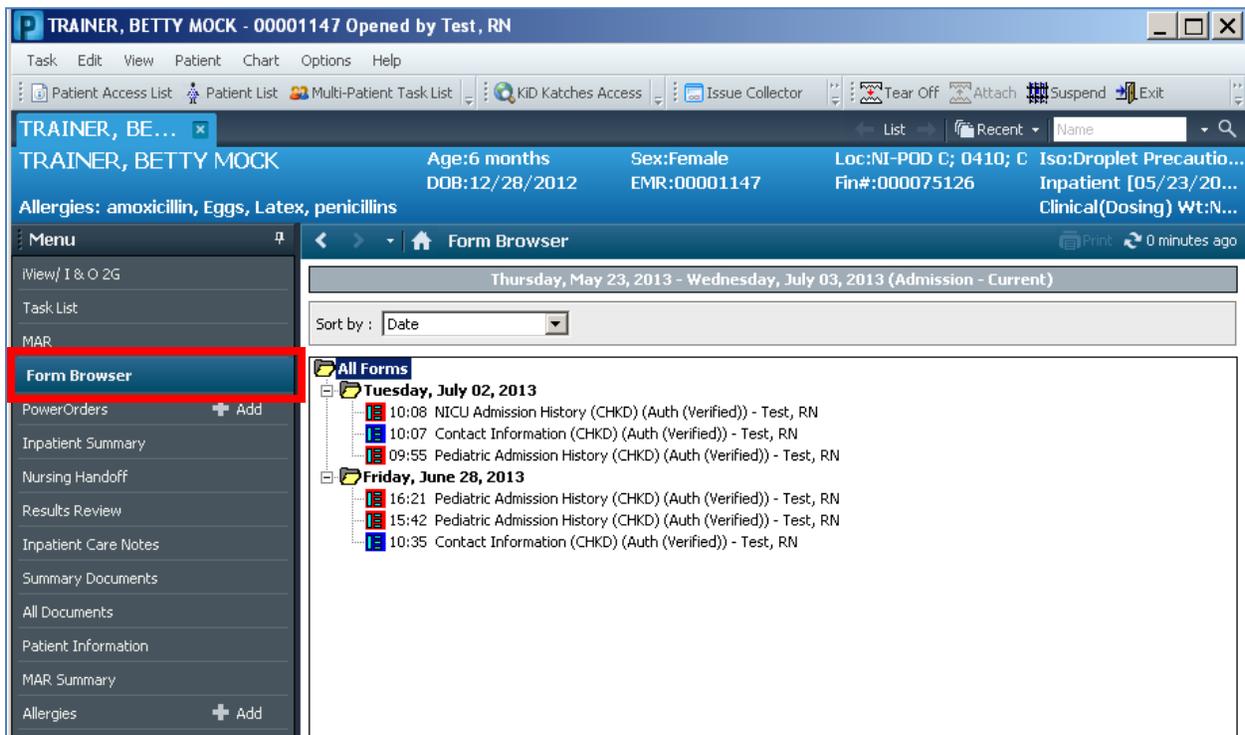
## Viewing Information from Form Browser Tab

Information or results entered during the charting process for the patient are available on the patient's chart. The charted results can be viewed within the related Flowsheet.

Charted PowerForms and PowerForms in process are available within the Form Browser. The Form Browser is a convenient way to view the complete details of any charting that have been completed via PowerForms. The user can see the charted information in its entirety and is better able to view related items.

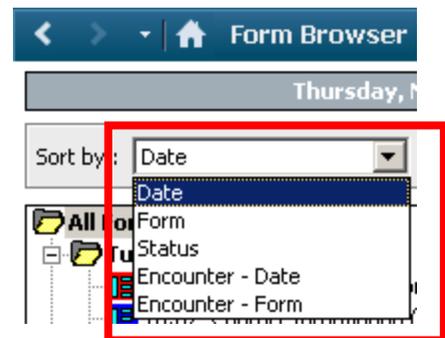
### Form Browser Basics

The Form Browser window displays a directory tree that lists all the charted, in progress, and uncharted PowerForms for the selected patient. Open a PowerForm to view the information. An icon is displayed to the left of an occurrence. A red icon beside the PowerForm indicates a required field was not completed for that form, and a blue icon indicates that required fields are completed.



You can sort the PowerForms by Date, Form type, Form Status, Encounter Date, or Encounter Form by selecting the Drop-down menu.

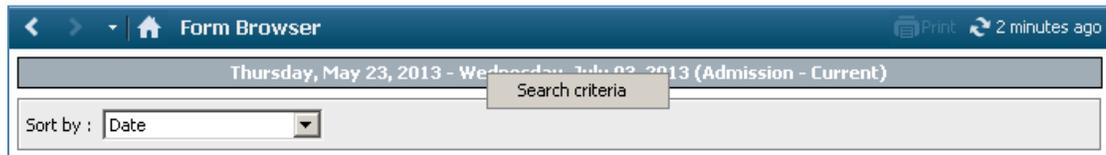
If the sort criteria of 'Form' or 'Date' is selected, then the status of the PowerForm (Authenticated, Verified, Modified etc.) also displays.



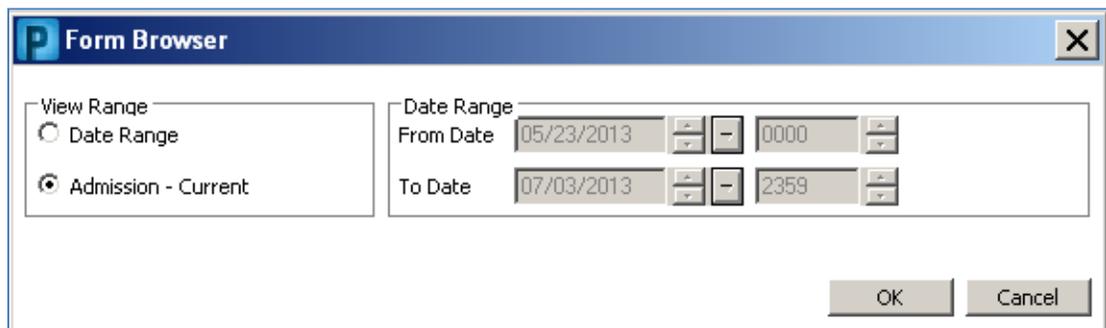
## Form Browser Tab Displays

The Form Browser tab displays a default time range. A user can change the time range for the **current** session by completing the following steps:

6. Select the Form Browser tab. Completed PowerForms for the selected patient are retrieved for a defaulted time span.
7. Right-click the information bar (where the time range is displayed) and select 'Search Criteria', or select 'Search Criteria' from the Options menu to open the Form Browser dialog box.



8. To view PowerForms within a specific date range, select Date Range in the View Range group box, and then enter the From and To dates and times. Use the small up and down arrows to increase or decrease the date and time. The large down arrow opens a calendar on which the month and day can be selected.



9. To view all PowerForms from admission to the current date, select Admission – Current in the View Range group box.
10. Click OK.

**Remember: If the date that the form was charted is not included in the Information Bar, then the PowerForm will not show up in Forms Browser.**

## Change the Default Time Range

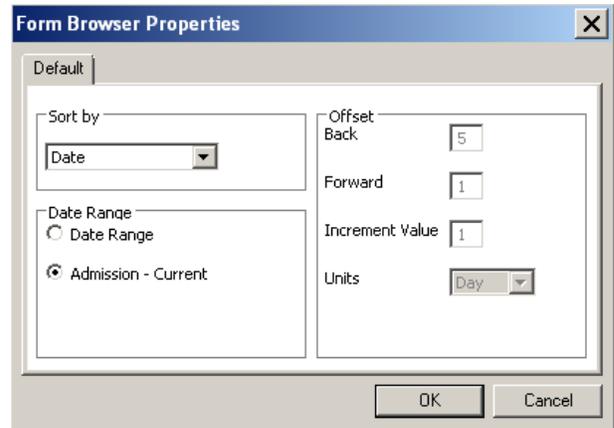
To change the **defaulted** time range for retrieving completed PowerForms, complete the following steps. If these preferences are saved, the new time range is used for PowerForm retrieval the next time the Form Browser is opened.

Select the Form Browser tab. Completed PowerForms for the selected patient are retrieved for a defaulted time span.

From the Options menu, select Properties to open the Form Browser Properties dialog box.

In the Sort By box, select the way the PowerForms will sort (by date, form name, status, encounter date, or encounter form).

In the Date Range group box, select Date Range to specify how far back or forward the system should search for PowerForms, and the increment value and units of that search (for example, five days).



In the Offset group box, change the entries to match your preferences. (Options in this group box are not available if Admission – Current was selected in the Date Range group box.)

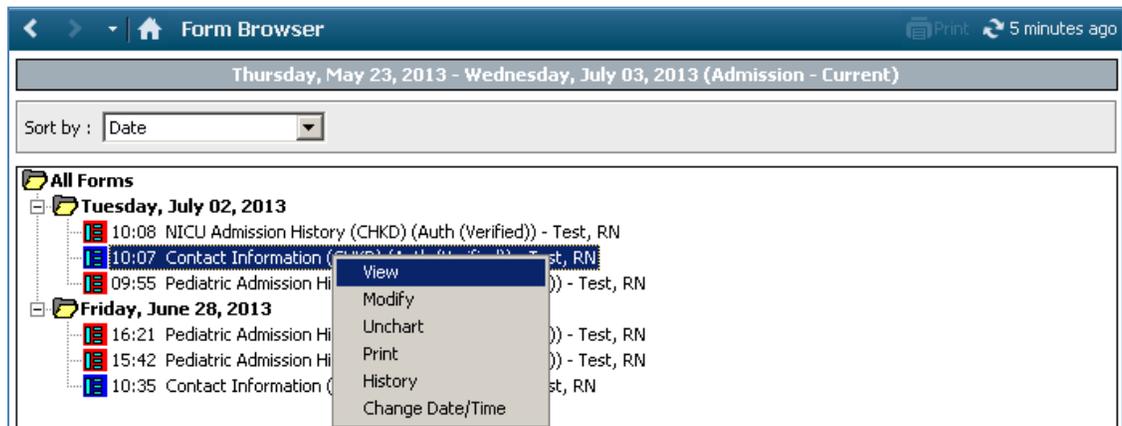
- **Back box:** Enter a number to indicate how far back from now to search for charted PowerForms. Select a unit such as a day or a week in the Units box.
- **Forward box:** Enter a number to indicate how far forward from now to search for charted PowerForms. Select a unit such as a day or a week in the Units box.
- **Increment Value box:** Enter the number of units of time measure that are increased or decreased each time the left or right arrow buttons on the information bar are clicked.
- **Units box:** Click the down arrow and select the unit of time measure (year, month, week, day, hour, or minute) desired.

Click OK to save these settings for the current session of Form Browser, or click Save to save your preferences for all sessions. Click Cancel to return to the previous window without saving any entries.

## Viewing a Completed PowerForm

To view information that has been entered for a patient as it was charted on a PowerForm, complete the following steps:

- Select the Form Browser tab. A list of PowerForms completed for this patient during the time range displayed on the information bar is displayed in a tree. The tree may be sorted by date, form, status, encounter date, or encounter form by making a selection from the Sort By box.
- Double-click a folder under the 'All Forms' folder to open and display the available PowerForms.
- Right-click the PowerForm occurrence and select View, or select View from the Options menu to open the PowerForm.



The completed PowerForm is displayed in the form viewer in a **read-only format**. If the PowerForm is subdivided into sections, a list of their names is displayed in the left panel. The first section is displayed. Use the arrows on the toolbar to navigate among the sections.

- Click  in the upper right corner to return to the previous window.

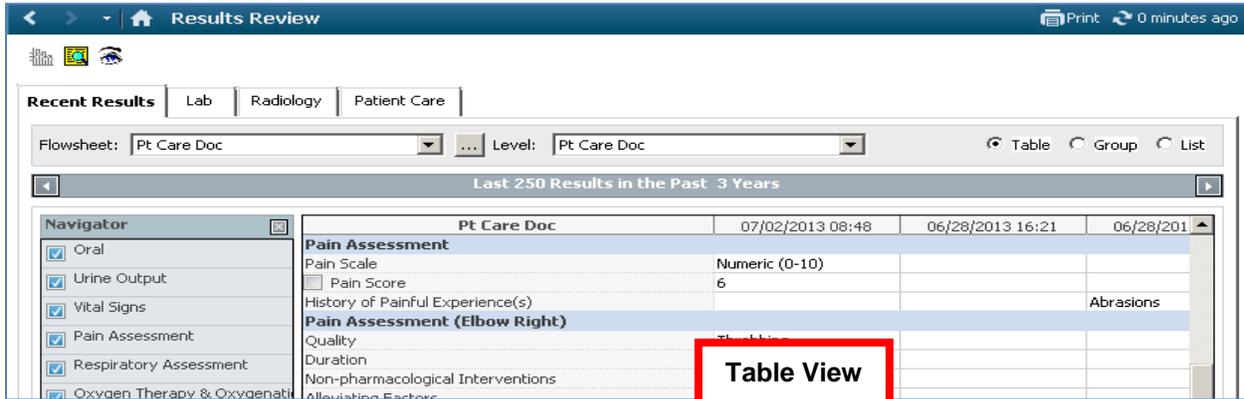
### Tip:

If the date that the form was charted is not included in the Information Bar, then the PowerForm will not show up in Forms Browser.

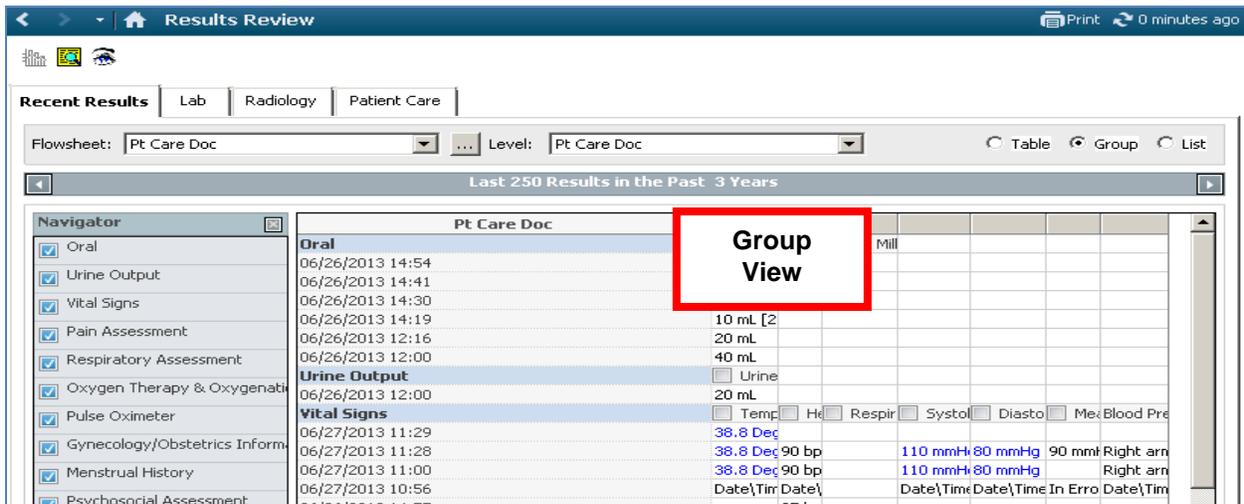
## Viewing Results from the Flowsheet Tab

You can review results and information that have been entered for a patient using the FlowSheet Tab. You can also customize your view to display Table (default), Group, and List views.

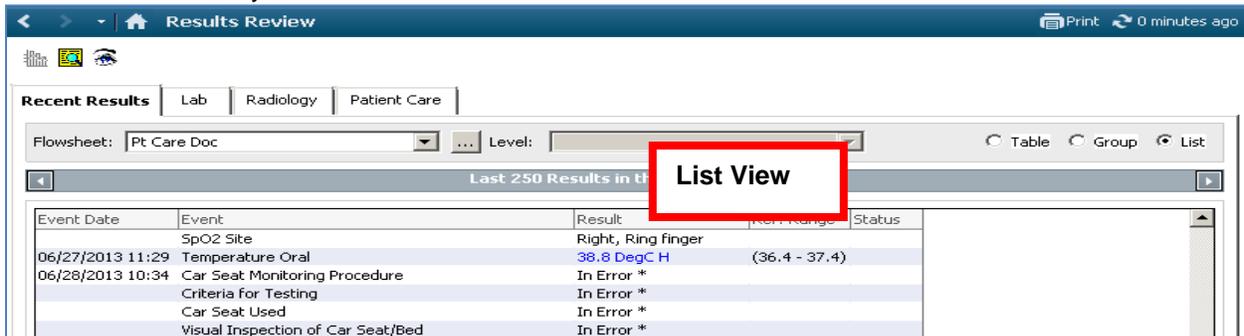
The Table View allows you to view the documented information in a flowsheet format.



The Group view allows you to view the documented information in groups. In the example below you can view a group of all Emergency Department Documentation, Primary Triage Assessment Details, etc.



The List View allows you to view the information documentation for a select date/time in a list format.



## Allergies Tab

Allergies can be accessed and entered from the Allergies Tab or the patient's Banner Bar within the patient's chart. Allergies can also be accessed and entered from the Tracking List within FirstNet. If the patient has any allergies recorded, you can view these allergies by selecting the Allergies Tab within the patient's chart, the Allergies hyperlink within the patient's demographics bar or the Allergies Icon on the FirstNet Tracking List. If "no known allergies" have been recorded this will reflect on the banner bar, the Tracking List Allergy Icon and the allergy profile window. Each recorded allergy will be listed, along with the allergy category, reactions, and severity.

- Double clicking on either the (1) Allergies Tab in the patient's chart, (2) Allergies Hyperlink in the Banner Bar or (3) Allergies Icon on the Tracking List
- Access the allergy profile window.
- Allergy documentation can be added, cancelled or modified if needed from this view.
- Click Refresh to display the most up-to-date information.

## Accessing Allergy Tab

Double-clicking on the Allergies Tab and access the allergy profile window. The patient's Allergy documentation can be added, cancelled or modified if needed from this view. Click Refresh to display the most up-to-date information.

The screenshot shows the 'Allergies' tab interface. On the left is a menu with 'Allergies' selected. The main content area has a 'Mark All as Reviewed' button and several action buttons: '+ Add', 'Modify', 'No Known Allergies', 'No Known Medication Allergies', and 'Reverse Allergy Check'. Below these is a table of allergies.

D.	Substance	Category	Reactions	Seve...	Type	C.	Est. Onset	Reaction S...	Updated By
✓	amoxicillin	Drug	Diarrhea, ...		Allergy			Active	06/28/201...
	Eggs	Drug	Hives		Allergy			Active	07/03/201...
	Latex	Drug	Rash		Allergy			Active	07/03/201...
✓	penicillins	Drug	Rash		Allergy			Active	06/28/201...

## Accessing Allergy Profile Window from the Banner Bar

Double clicking on the Allergies Hyperlink from the patient's banner bar and access the allergy profile window. The allergy documentation can be added, cancelled or modified if needed from this view. Click Refresh to display the most up-to-date information.

**TRAINER, BE...** | List | Recent | Name

**TRAINER, BETTY MOCK** | Age: 6 months | Sex: Female | Loc: NI-POD C; 0410; C | Iso: Droplet Precauti...  
 DOB: 12/28/2012 | EMR: 00001147 | Fin#: 000075126 | Inpatient [05/23/20...  
 Clinical(Dosing) Wt:N...

**Allergies: amoxicillin, Eggs, Latex, penicillins**

**Allergies** | Print | 5 hours 21 minutes ago

Mark All as Reviewed

+ Add | Modify | No Known Allergies | No Known Medication Allergies | Reverse Allergy Check

D.	Substance	Category	Reactions	Seve...	Type	C.	Est. Onset	Reaction S...	Updated By	Source
✓	amoxicillin	Drug	Diarrhea, ...		Allergy			Active	06/28/201...	
	Eggs	Drug	Hives		Allergy			Active	07/03/201...	
	Latex	Drug	Rash		Allergy			Active	07/03/201...	
✓	penicillins	Drug	Rash		Allergy			Active	06/28/201...	

## Accessing Allergy Profile Window from the Tracking List

Double clicking on the Allergies Icon the Tracking List and access the allergy profile window. The allergy documentation can be added, cancelled or modified if needed from this view. Click Refresh to display the most up-to-date information.

**FirstNet Organizer for TestUser RN, EDNurse**

Task Edit View Patient Chart Links Patient Actions Provider List Help

Tracking List | Patient List | ED Policies | Issue Collector | Admitting List | Med Code Sheet | Nursing Policies

Patient, Test | Recent | Name

**Tracking List** | Print | 0 minutes ago

Minor Care All Beds | Providers | Checkout | MC Checkout | Pending Micro | 72 Hour DC | 72 HR DC LWB5

ED Nurse | All ED Patients | All Beds | Waiting Room | Minor Care

Filter: Occupied Beds | Total: 12 | WR: 7

Bed	Ni:Ac	Name	Age	Allergy	Reason For Visit	Call Pre	ATT	RES	RN	VS	Lt	Ord	Tasks
1		Test P					Pre						
9	5	LLOYD E	8 ye		Abrasion*			Zubi		4*			+
10		Little K	6				Pre						
12	2	Scotty Z	6 ye		Abscess*			ET	BD	JP	2*		+
15		Jennifer P	2 ye				Pre						
WR		EPICCSGONE C	7 ye										
WR	2	JENNIFER Z	3 ye		Abscess*				JP	2*			+
WR		Diane					Pre						
WR	3	Betty Z	3 ye		Wheezing - Pediatri		Pre	KH		3*			
WR	5	Bogus Z	12 ye		Abrasion*			ET		4*			
WR	3	MOCKUPGRADE R	12 ye		Allergic reaction*					3*			
WR	5	XZ	4 ye		Abdominal distentio			DW		4*			+

## Allergy Icons

	Indicates that a patient has no known allergies
	Indicates that no allergies have been entered and No Known Allergies have been entered
	Indicates that the patient has allergies documented
	Indicates that the patient has no known medication allergies

### Manipulating the Allergy Profile Columns

The Allergy Profile has several pieces of functionality to allow the clinician to more easily see an overview of the allergies and adjust the sort of the allergies based on a particular data point.

To sort the allergies based on a particular data point, click on the column. The system will adjust the sorting of the columns in either alphabetical or reverse-alphabetical order.

Several icons are also available on the view for ease in seeing information:

	The green check-mark icon will display when a particular codified allergy is recognized by Multum for Drug/Allergy Interactions.
	The paper clip icon will display when additional comments are available on a particular patient.
	See Viewing Allergy Interaction below.

## Allergy Interactions

If a patient is on a medication that may cause an interaction with a known allergy, the Allergy Alert will display when the medication allergy or when the reverse allergy search is done.

If you wish to continue adding the medication in spite of the reaction, enter an override reason and select continue.

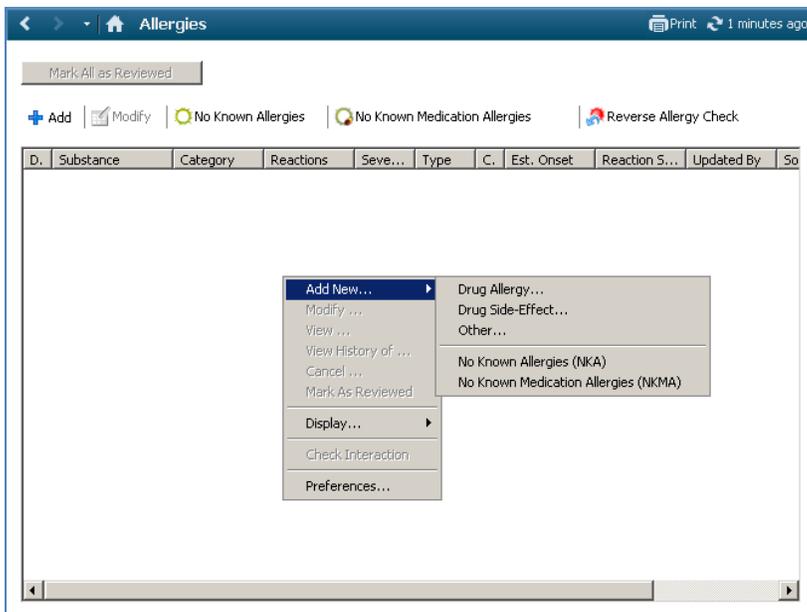
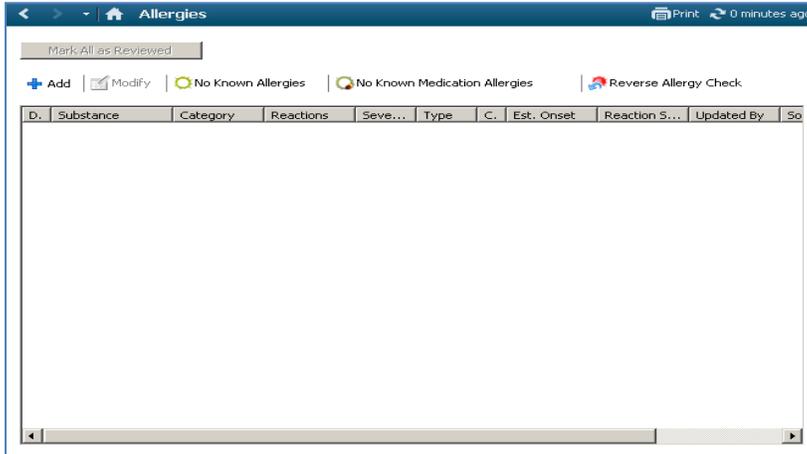
## Allergies Profile Window Components

Column	Description
<b>D/A</b>	A green check in this column indicates that the allergy qualifies for Drug/Allergy interaction checking. No check indicates that no interaction checking is available for the allergy.
<b>Substance</b>	Displays the known allergens for the patient.
<b>Category</b>	Displays the allergen category (i.e. Drug, Food).
<b>Reactions</b>	Displays recorded reactions to the allergen.
<b>Severity</b>	Indicates the severity experienced by the patient to the allergy. <ul style="list-style-type: none"> <li>• <b>MILD:</b> Requires minimal therapeutic intervention, such as discontinuation of drug(s).</li> <li>• <b>MODERATE:</b> Requires active treatment of adverse reaction, or further testing or evaluation to assess extent of non-serious outcome.</li> <li>• <b>SEVERE:</b> Any serious outcome resulting in life- or organ-threatening situation or death, significant or permanent disability, requiring intervention to prevent permanent impairment or damage, or requiring / prolonging hospitalization.</li> </ul>
<b>Type</b>	Displays the type of reaction. <ul style="list-style-type: none"> <li>• <b>Allergy</b> – An adverse reaction of the immune system to the exposure of a substance.</li> <li>• <b>Intolerance</b> - An adverse reaction of the digestive system to the exposure of a substance.</li> <li>• <b>Secondary Effect</b> – An adverse reaction that is the direct result of another reaction (such as an allergy to peanuts that results in a rash that causes the secondary effect of itching.)</li> <li>• <b>Sensitivity</b> – An adverse response to a substance that does not occur in normal situations.</li> <li>• <b>Other</b> – Any reaction type that does not fit into any other category as listed.</li> </ul>
<b>Comments</b>	Displays comments recorded for this patient's allergy.
<b>Est. Onset</b>	Indicates the estimated onset date of the allergy.
<b>Reaction Status</b>	Lists the status of the allergy. <ul style="list-style-type: none"> <li>• <b>Active</b> – The patient currently experiences reactions to this allergen.</li> <li>• <b>Proposed</b> – The allergy has been reported, but not confirmed by a clinician.</li> <li>• <b>Resolved</b> – The patient has experienced an allergic reaction to a substance, but the reaction has not re-occurred.</li> <li>• <b>Canceled</b> – The allergy was entered in error.</li> </ul>
<b>Updated By</b>	Displays who last updated the allergy.
<b>Source</b>	Indicates the source of the information, such as Patient, Family, or Physician.
<b>Reviewed</b>	Displays if and how the listed allergy was reviewed.
<b>Reviewed by</b>	Displays who reviewed the listed allergy information.
<b>Interaction</b>	Indicates the interactions associated with the allergy.

## Adding Allergies

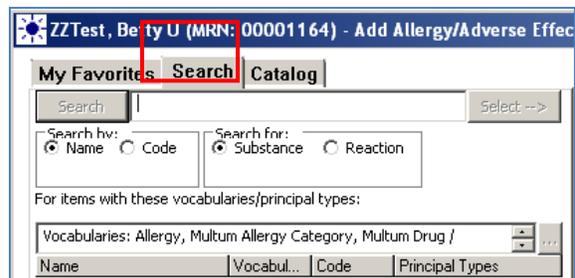
There are several methods for entering allergies into the system. The preferred method is shown below.

1. Select Add New / Drug Allergy from the Allergies window.

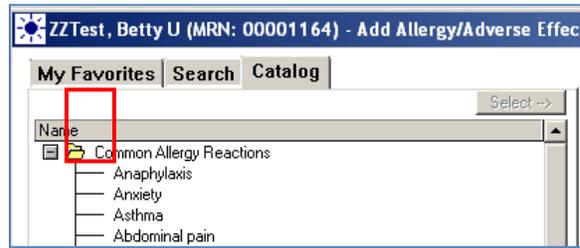


The Add Allergy / Adverse Effect window will open.

2. Click the Catalog tab.

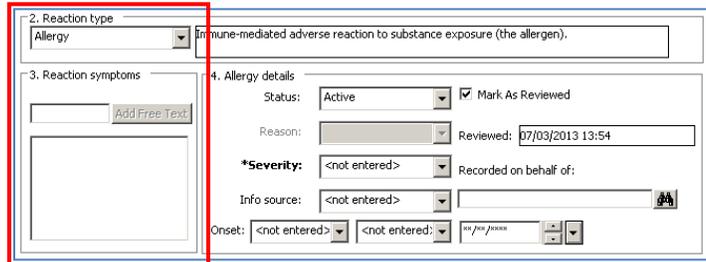


- Indicate if the allergen is a common drug, food, or environmental allergy by expanding the applicable category (click the + sign beside it).



- Double click the desired allergen. The substance tab will populate with the selected allergen.

- Indicate the reaction type from the drop down box. Selection options are Allergy, Intolerance, Secondary Effect, Sensitivity, and Other.

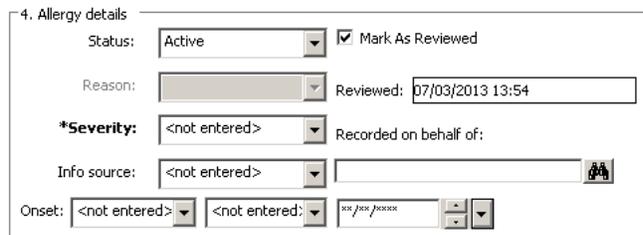


- Expand the Common Allergy Reaction folder (click the + sign beside it).

- Indicate the reactions that the patient experiences by double-clicking. More than one can be selected. These reactions will populate in the Reactions symptoms section of the Add Allergy / Adverse Effect window.



- Indicate Allergy Details such as Status (Active, Proposed, Resolved, and Canceled), Severity (Mild, Moderate, or Severe), Info Source (who provided the information regarding the allergy), and Onset. **Any allergy that is entered in the EMR should be entered as an "active" allergy** (do not use the "proposed" feature).



Add any necessary comments, if applicable.



- Click Apply and OK to save your changes for the patient. The allergy that you added will appear.

## Adding NKA (No Known Allergies) from the Allergy Profile

There may be occasions when “NKA” (No Known Allergies) need to be recorded for a patient and that patient has only drug allergies and in some cases only food or environmental allergies. This information can be documented by clicking on the appropriate icon at the top of the Allergies profile window.

**No Known Allergies** should continue to be used when the patient has no medication, food, environmental or other allergies

**No Known Medication Allergies** should be used when the patient has no allergies that are categorized as medications (drugs), but may have allergies of other categories (including food and environmental.)



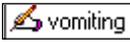
## Cancelling NKA (No Known Allergies) from the Allergy Profile

There may be occasions when “NKA” (No Known Allergies) was recorded for a patient and allergy information to be documented was revealed at a later time.

In the example below the initial documentation was “NKA” (No Known Allergies).

- An allergy for Acetaminophen is then added to the Allergy profile
- The system generates a message as seen below
- Answering Yes, will add the new allergy to the patient’s allergy profile and cancel the NKA (No Known Allergy) that was previously selected
- Then click OK

## Tips and Tricks

- Both PowerChart and PowerForms share the same data area with regard to patient allergies.
- Reactions can also be entered as free-text (manually typed in) in steps 6 & 7. Simply type in the name of the reaction (ie.. ‘Vomiting’) and click Add as Free Text. The entered reaction will appear in the Reaction Symptoms box, but with a handwriting icon  vomiting to indicate that the reaction was manually entered.

## The Power Orders Tab

The PowerOrders tab within the patient's chart is used to place, view, modify, cancel and generally work with various types of orders. There are two main sections of the Orders tab: the Clinical Categories Navigator and the Existing Order Profile.

The screenshot displays the PowerOrders interface for a patient named ZZTest, Betty U. The patient's age is 3 years, sex is Female, and location is CHKD-ED. The interface is divided into several sections:

- Menu:** A vertical list on the left containing options like Task List, iView/ I & O 2G, ED Summary, PowerOrders (highlighted), Medication List, MAR, MAR Summary, Flowsheet, Summary Documents, All Documents, Allergies, Form Browser, Patient Information, Advanced Growth Chart, Immunization Schedule, Problems and Diagnoses, Histories, Nursing Handoff, and Appointments.
- PowerOrders Section:** Contains a 'View' panel with a tree structure of categories: Orders, Diagnostic Tests, Consults, Condition, Activity, IV Solutions (checked), Special, and Laboratory. Below this are 'Vital Signs' and 'Non Categorized' options.
- Orders Profile:** A table displaying a list of orders. The table has columns for Order Name, Status, and Details. The orders listed include:
 

Order Name	Status	Details
Sodium Chloride 0.9% 1000 mL	Ordered	Soln, IV Continuous After NS Bolus com
DSW 1/2NS 1000 mL	Ordered	Soln, IV Continuous
lidocaine (Lidocaine 1%...	Ordered	0.2 mL, Soln, Subcu
albuterol	Ordered	2.5 mg, Inhalant, N
ipratropium	Ordered	0.5 mg, Soln, Nebu
albuterol	Ordered	mg, Inhalant, N
ipratropium	Ordered	mg, Soln, Nebu

### Clinical Categories Navigator Overview

The left side of the Orders tab is the Navigator, which lists clinical categories.

The Navigator allows you to select the categories from which you want results displayed.

When the check mark on the left is selected, the category of orders from the profile section is displayed. When it is unchecked, the category and its orders are hidden.



### Order Profile Overview

The right side of the Orders Tab is the Order Profile. The Order Profile lists patient orders and medications, as well as their statuses and detailed information.

### Tips and Tricks

The Medication List sub-tab on Orders Profile displays medication orders for the patient. Clicking on the Medication List sub-tab or the Medication List tab takes you to the same list.

## Detail Screen Adjustments

The order detail screen can be adjusted up or down. Place your mouse on the Details bar and a double-sided arrow appears. Hold the left mouse button and move the window up or down.

The upside-down triangle on the left corner of the details bar can be clicked to hide this screen.

The order detail can also be expanded left and right. Place your mouse on the side of the clinical categories navigator, and a double-sided arrow appears. Hold the left mouse button and move the window left or right. The upside-down triangle on the right corner of the clinical categories navigator can be clicked to hide this area.

The screenshot displays the PowerOrders interface for patient ZZTest, Betty U. The top bar shows patient demographics: Age: 3 years, Sex: Female, Loc: CHKD-ED, DOB: 06/17/2010, EMR#: 00001164, and Fin#: 000075167. The left sidebar contains a menu with options like Task List, iView/ I & O 2G, ED Summary, PowerOrders (highlighted), Medication List, MAR, MAR Summary, Flowsheet, Summary Documents, All Documents, Allergies, Form Browser, Patient Information, Advanced Growth Chart, Immunization Schedule, Problems and Diagnoses, Histories, Nursing Handoff, and Appointments. The main area shows a list of orders under the 'Medication List' tab. The orders are categorized into IV Solutions, Medications, and Respiratory. A table of orders is visible:

Order Name	Status	Details
Sodium Chloride 0.9% 1000 mL	Ordered	Soln, IV Continuous After NS Bolus com
DSW 1/2NS 1000 mL	Ordered	Soln, IV Continuous
lidocaine (Lidocaine 1%...	Ordered	0.2 mL, Soln, Subcu
albuterol	Ordered	2.5 mg, Inhalant, N Give back to back tr
ipratropium	Ordered	0.5 mg, Soln, Nebu If asthma score >=
albuterol	Ordered	2.5 mg, Inhalant, N Give back to back tr
ipratropium	Ordered	0.5 mg, Soln, Nebu If asthma score >=

At the bottom of the interface, there are buttons for 'Related Results', 'Formulary Details', 'Orders For Nurse Review', and 'Orders For Signature'. A red circle highlights a double-headed arrow on the top bar of the PowerOrders section, indicating that the window can be adjusted vertically.



## Practice Scenario for Chart Tabs

---

### Practice Scenario #1

Enter a Penicillin allergy for your patient.  
Cancel the Sulfa allergy for your patient.

### Practice Scenario #2

Document Medication by History for your patient by accessing this tab and clicking ADD.

Search for the medication Motrin Suspension and select it from the search window.  
Enter as many details as you would expect to get from the parent.

### Practice Scenario #3

Mom also indicates that your patient has an allergy to Peanuts and Latex.  
Add these allergies for your patient.

### Practice Scenario #4

Customize your view of the ED Summary Tab and save the changes.  
Now change the ED Summary Tab back to the default view.

### Practice Scenario #5

Review the information on the Nursing Handoff Tab

## Section IV Power Orders

As a patient's condition warrants, it may be necessary for a health care provider to request orders to facilitate patient care. eKiDs PowerChart is used to process orders.

When placing an order it is important to make sure that you have selected the right patient, provider, test, priority code, date, and time. For most orders, this information will default in, but you may occasionally need to change the order details.

It is in good practice to review the practice and procedure manual for additional mandates in placing orders within your office.

### General Steps for Placing an Order

---

1. Select the patient from the patient list or from the Schedule.
2. Click the Add button on the PowerOrders tab.
3. Locate/Select the order.
4. The provider will populate, based on who the patient was scheduled with (the Attending Provider).
5. Order details will populate, based on pre-built order sentences within the system. However, this information can be changed, as necessary.
6. Review orders and verify accuracy.
7. Sign the order.
8. 'Refresh' to refresh your screen and see the correct status of the orders.

### Searching for Orders

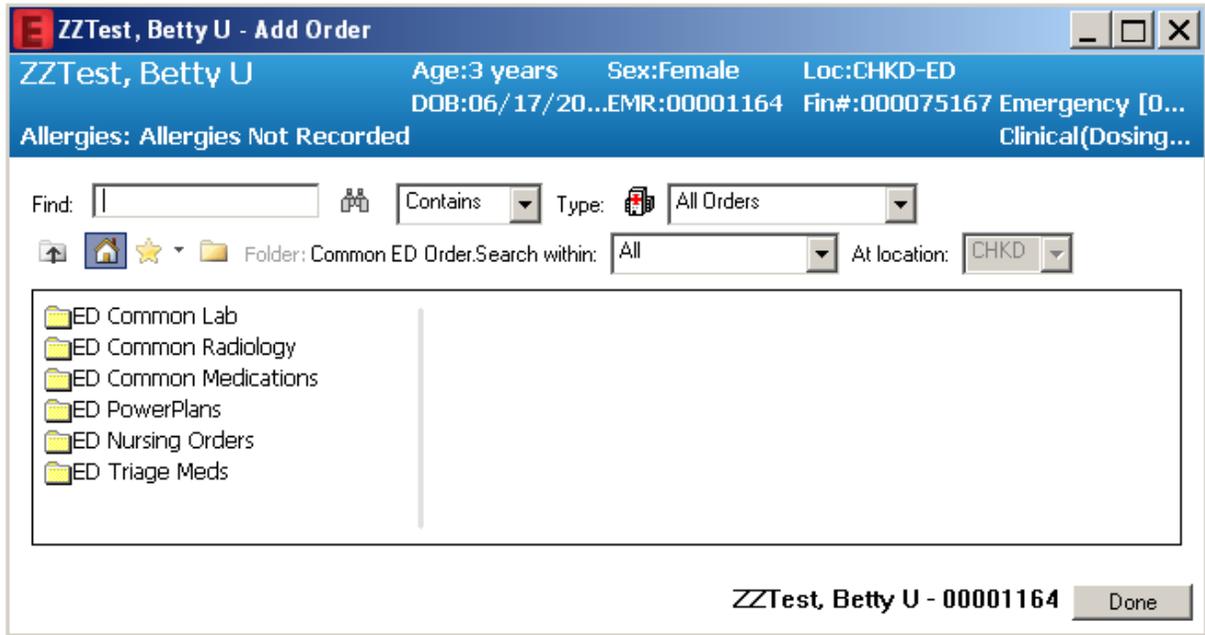


From the Orders tab within the Patient's chart, select the Add Icon to open the Add Order window.

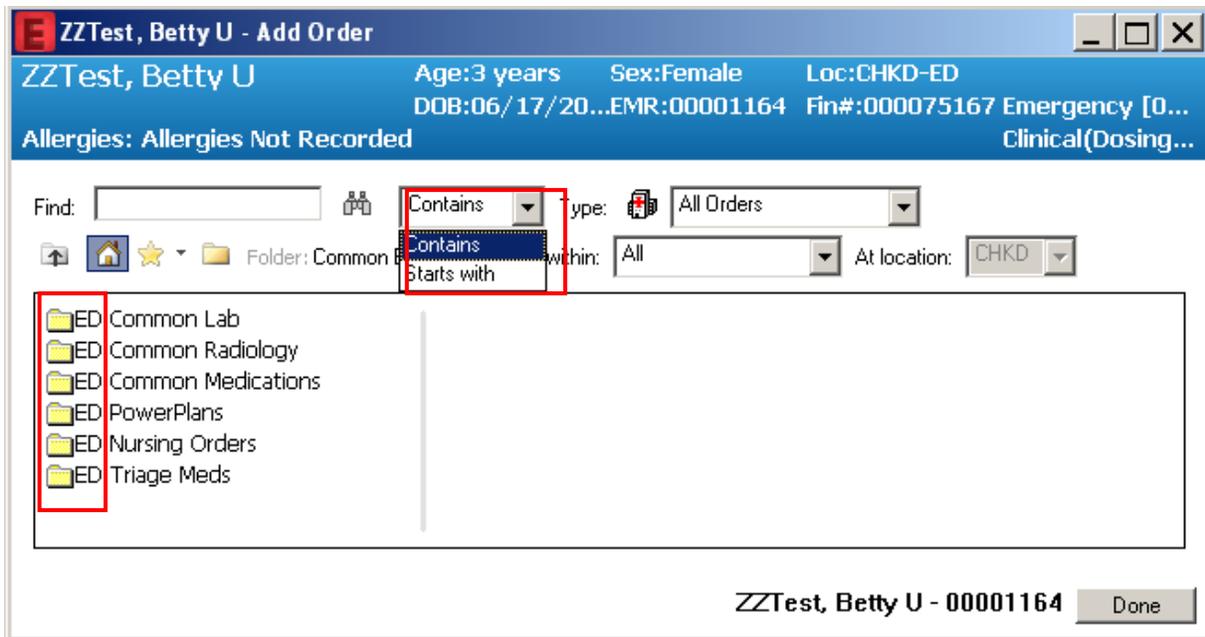
As a shortcut, you can also select ALT+R from your keyboard to open the Add Order window.

## Add Order Window

When the Add Order window is initially opened, the **Quick Folders** displays by default because they are specified as 'Home'. The Quick Folders offer the ability to drill through and find commonly ordered items by a defined category. (The 'Home' location within the Add Order Window can be changed and is discussed later in this manual).



The **Starts With / Contains Drop-down Box** is also located within the Add Order Window. You can direct the system how to locate an orderable using either starts with or contains (i.e. contains the word chest or starts with chest). You only need to type in the first few letters of the order and the system will use completion matching to automatically bring up orders that match what you entered.



- ◆ The Up icon  within the Add Order window will take you up a level when you are in a subfolder.
- ◆ The **Home icon**  within the Add Order window will take you back to the folders that are defined as your Home. By default, these are the Quick Folders unless changed.
- ◆ The **Favorites icon**  will within the Add Order window will take you to your favorites folder. Set-up and maintenance of the Favorites folder is discussed later in this manual.
- ◆ The **Folders icon**  within the Add Order window will return you to your Quick Folders.

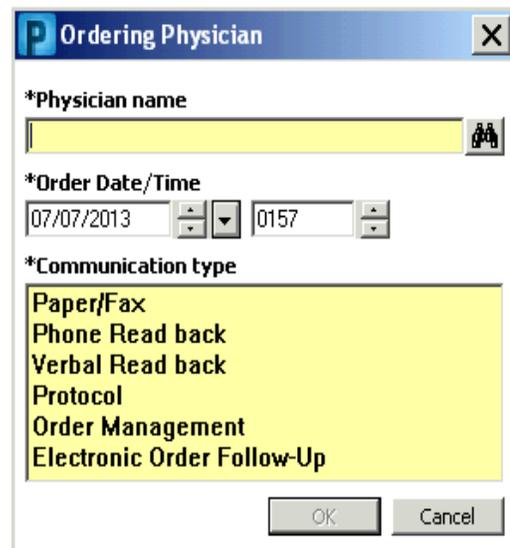
The Type dropdown displays a selection list of types of orders that you can enter.



## Ordering Physician Window

Nursing Services will be required to select the appropriate communication type when adding an order in PowerChart.

- **Paper/Fax** -> used when transcribing a written physician order into the system. This **will NOT** route to provider for signature.
- **Phone Read back** -> used when entering an order received via telephone by provider. This **WILL** route for signature.
- **Verbal Read back** -> used when entering an order received verbally by provider. This **WILL** route for signature.
- **Protocol** -> used when entering protocol orders. This **WILL** route for signature.
- **Order Management** -> used for order profile management. For example, order is for XYZ to occur for 3 times. If this is not a tasked order, this will need to be manually discontinued at appropriate time. This **will NOT** route for signature.
- **Electronic Order Follow-Up** -> used if there is a communication order by provider for lab/rad order entry at specified time or when defined criteria are met. For example, communication order by provider states: 'Obtain XYZ lab with electrolytes supplementation, blood products, or ventilator changes'. 'Electronic Order Follow-Up' would be the communication type used when the lab order is placed by nurse. This **will NOT** route for signature.



## Documenting Medication by History

Documenting medication by history is used to enter medication orders that the parent or guardian has administered to the patient at home **or** for meds that were not completed in PowerChart (prescribed by a different provider).

To document medication by history, complete the following steps:

1. Click Document Medication by HX from the Orders or the Medication List tab.

The Document Medication by Hx window will open.

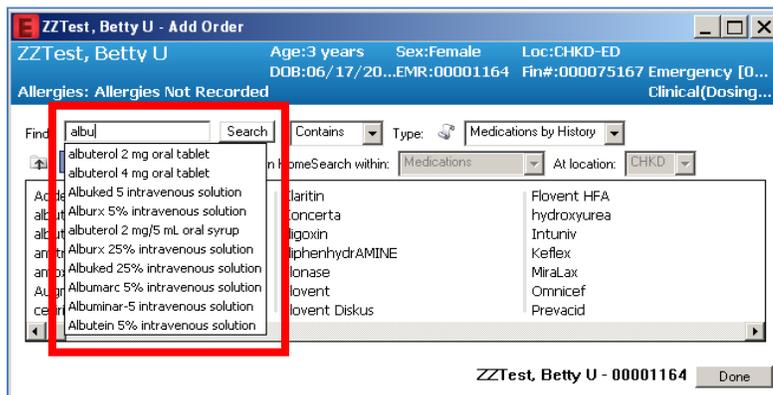


2. Click Add.

The Document Medication by Hx Window will open.



3. Enter the first few letters of the name of the medication in the Find field.



4. When the medication is found, select it by clicking on it.

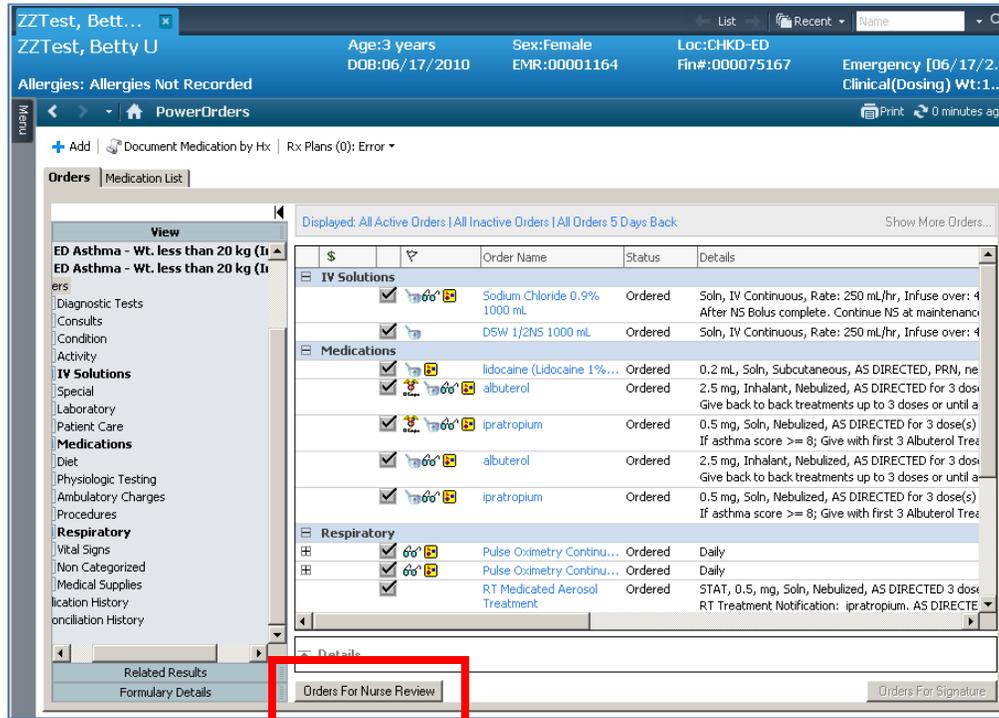
Note: If the medication is not found or if you simply wish to enter the medication with no details click the 'Search' button to display additional choices.

5. The Order Sentences will appear, if applicable. Select the appropriate sentence, or click None.
6. Click OK.
7. Continue looking up and adding additional medications, as necessary.
8. When finished click Done.
9. Make modifications to the details window, as necessary. If details are unknown, click Document History to include the known information

10. When finished (and after you have reviewed the order), click Document History. The Medication that you entered will appear in the Medication List (the tab beside the orders tab) with a status of Documented.

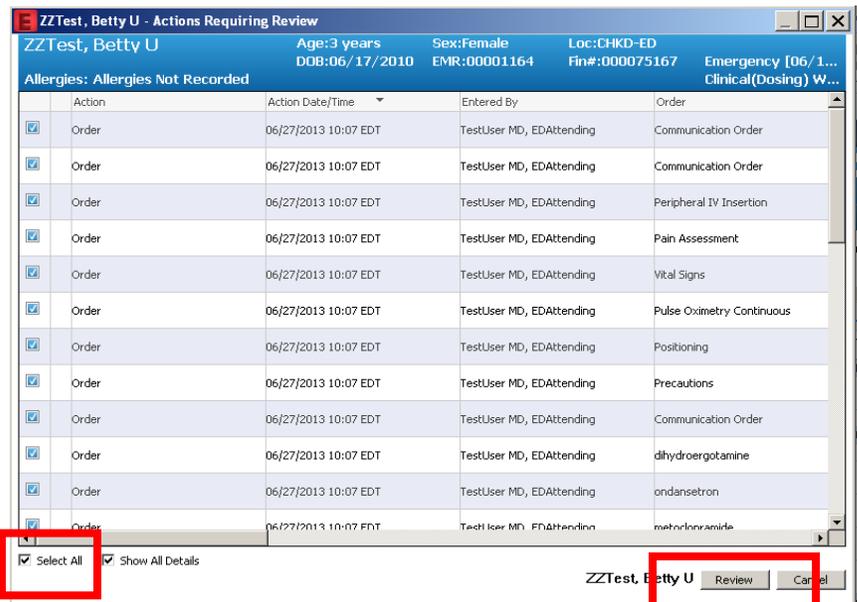
## Nurse Review

The Orders for Nurse Review Button will display at the bottom of the PowerOrders window. The button will only be available to click on if there are orders to be reviewed. If there are no new orders to review the button will be dithered or grayed-out.



Clicking on the Orders for Nurse Review button launches the Actions Requiring Review window. From here all orders are selected.

You can deselect All by un-clicking the Select All in the bottom of the window and placing a check mark beside only those orders you wish to review.



When you have completed your order review select the Review Button at the bottom of the window. Those orders will be removed from this list and noted as reviewed. The eyeglass icon will also be removed from the Notification column within the PowerOrders window.

## Entering a PowerPlans

---

A PowerPlan is a care planning tool that allows you to manage orders as they relate to a pre-defined plan of care. *PowerPlans* define decisions, activities and expectations for a specific problem. The plan serves as the primary catalyst for a number of activities such as orders, diagnostics and medication administration to be executed by the care team. PowerPlans are commonly grouped together for the purpose of completing specific clinical pathways. The PowerPlans in FirstNet are created based on the Existing Clinical Pathways already used at CHKD.

A PowerPlan is accessed from PowerOrders in the same way individual orders or care sets are found.

- Orders placed as a PowerPlan will stay grouped and identified with a PowerPlan Icon.
- Orders can be added to the PowerPlan.
- PowerPlans can be discontinued in two ways:
  - Discontinue the entire Plan
  - Discontinue selected order(s) within the plan

## Notifications in the Orders Profile Window

Icons will display in the Notification column within the order profile window of PowerPlans. Hovering over these icons will display the definition of the icon as noted below:

Notifications:



Mortar and Pestle – This order is yet to be verified by a pharmacist

PowerPlan Icon – This order is part of the plan: (PLAN NAME)

Caduceus – This order is yet to be cosigned by the ordering Physician

Eyeglasses – This order is yet to be reviewed by a nurse



Clipboard – This order is yet to be reviewed by a nurse

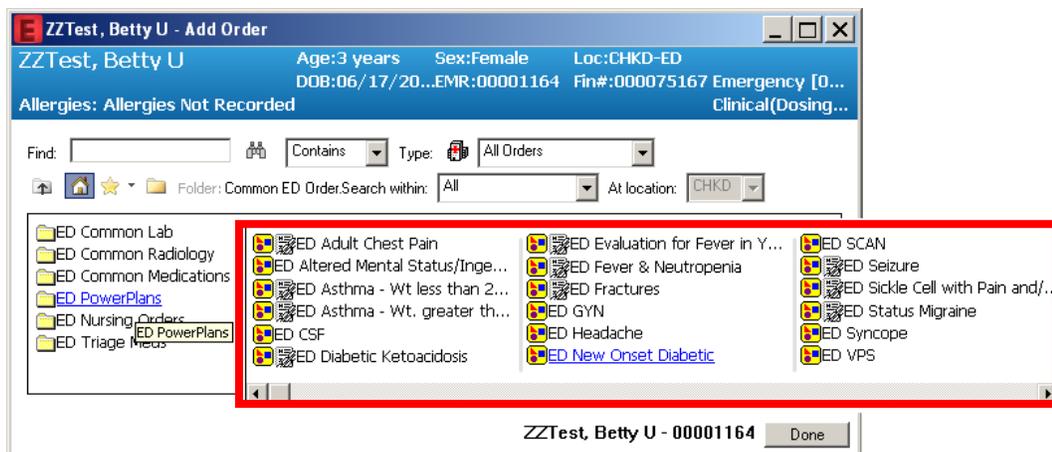
## Searching for a PowerPlan

Steps to Search for a PowerPlan:

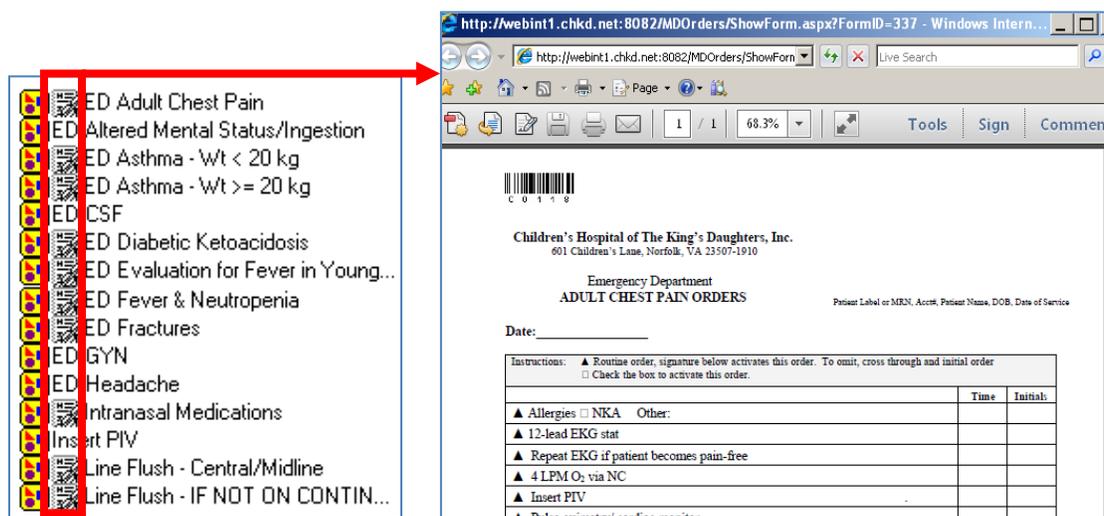
1. Click the Add icon  from the PowerOrders Window.
2. In the Find box, you can search for a plan by typing the title in the search window. This functionality is the same as searching for any orderable.

OR

You can also select the folder at the bottom of the window specified for PowerOrders and select the needed PowerPlan from that folder.

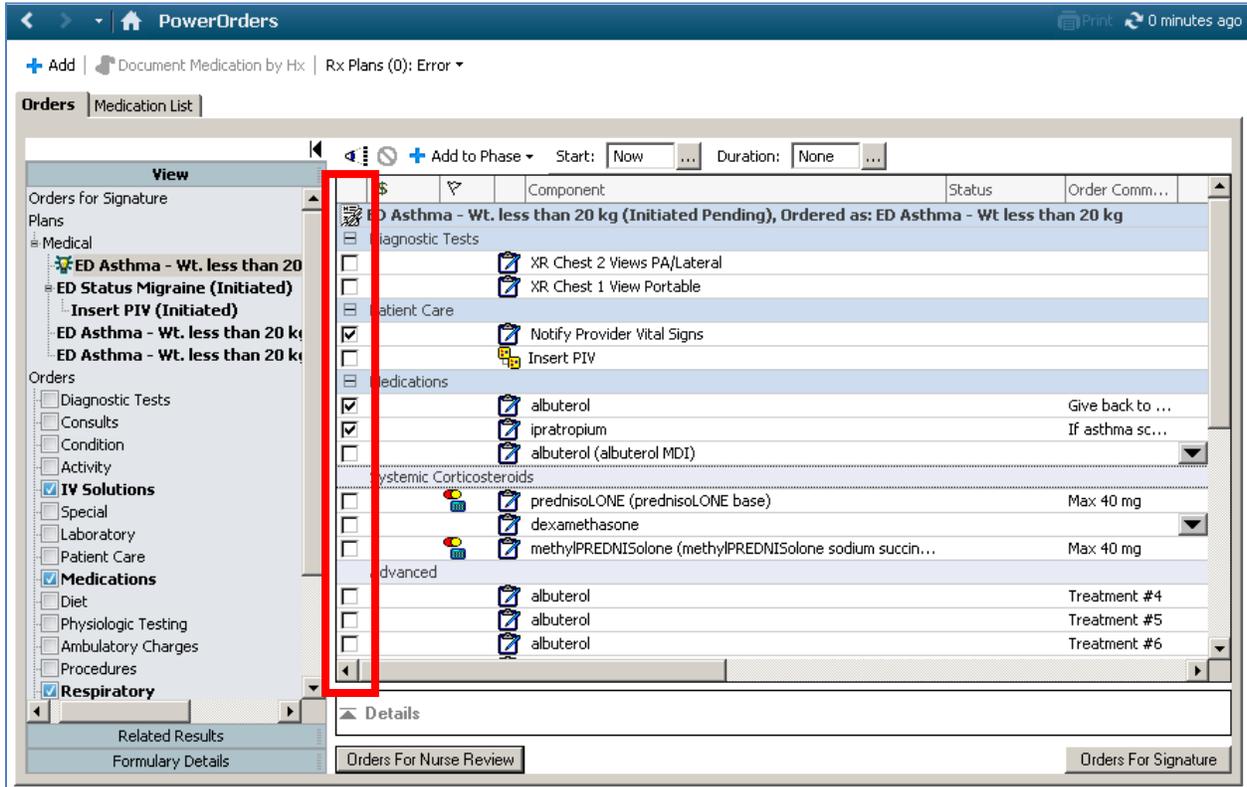


3. The yellow icon  displayed in front of the search results indicates these are power plans. This icon is identical to the care set icon except for the yellow color.
4. Clicking the icon beside the CarePlan  will display existing Clinical Pathways



## Sections of a PowerPlan

The sections to the PowerPlan are laid out in order, similar to a physicians pre-printed paper order sheet. Each section heading is colored blue to help identify the beginning of a new section.



## Preselected Orders

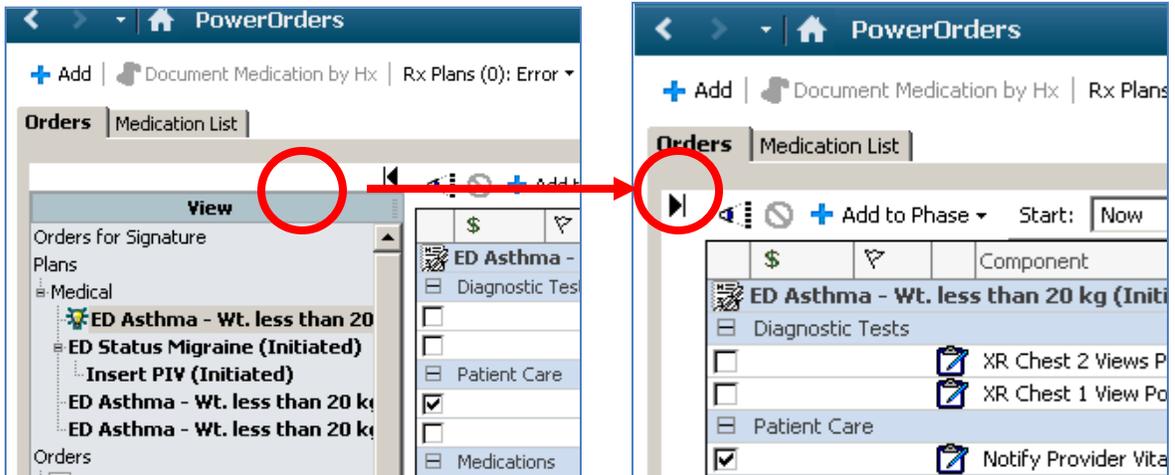
The checkmarks on the left are preselected orders (as seen in the image above) for your PowerPlan. You can select additional orders or deselect by unchecking the preselected orders.

To allow additional viewing space on the right side of the PowerPlan window, you can collapse the Navigator on the left.

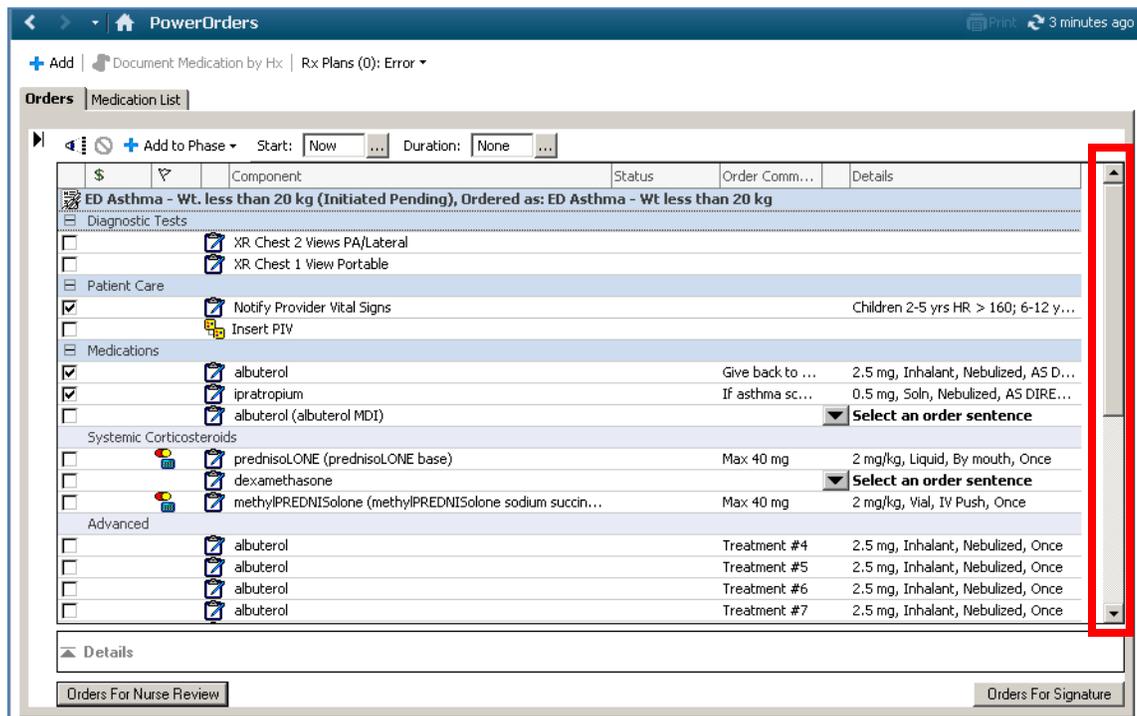
## Navigation through the PowerPlan

There are several ways to navigate down the PowerPlan.

1. One way is to collapse each section after completing it.



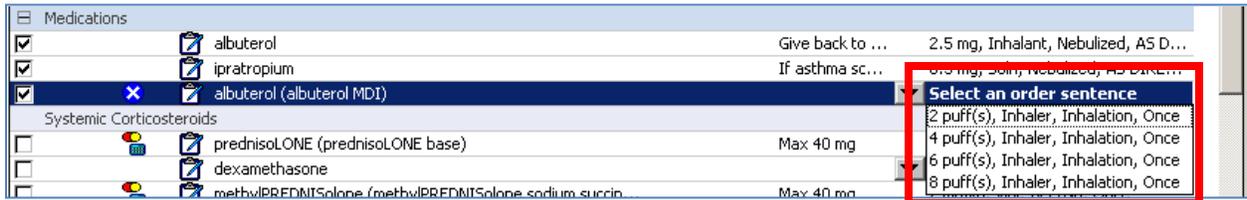
2. Navigate down the PowerPlan by clicking the scroll down bar on the right.



## Medication Section

The medication section of the PowerPlan will display the most commonly used medications for the selected plan. The Order sentences for each medication listed on the right.

A drop down arrow is displayed when there are more commonly used order sentences for that medication.



Select the appropriate order sentence details that is defaulted or use the drop down arrows if needed.

Certain Medications may prompt you to include information in the Ordering Physician Window. If this displays also add the correct communication type for the med order.. Enter the information as you would for any orderable.

## Required Details

Although some of the order details may be listed, the blue circle with white X indicates there are more Required Details that need to be satisfied.

If an **order** has a **required detail**, the detail must be satisfied before signing the order. System required details are noted in several areas:

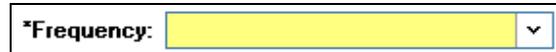
1. Blue Circle with a white 'X' next to the Orderable in the Order Review window.



2. Blue circle with a white 'X' in the Details Tab.



3. Order detail is Bolded with an asterisk and Highlighted Yellow within the Details section.



4. Order detail fields that use radio buttons are Bolded with an asterisk.



5. Notification in bottom of the details window, stating how many required details are missing.



ZZTest, Bett... x

ZZTest, Betty U Age:3 years Sex:Female Loc:CHKD-ED  
DOB:06/17/2010 EMR:00001164 Fin#:000075167 Emergency [06/17/2...  
Allergies: Allergies Not Recorded Clinical(Dosing) Wt:1...

PowerOrders Print 6 minutes ago

+ Add Document Medication by Hx Rx Plans (0): Error

Order Name	Status	Start	Details
CHKD-ED Fin#:000075167 Admit: 06/17/2013 14:40 EDT			
Diagnostic Tests			
*R Chest 2 Views PA/L...	Order	07/03/2013 14:48	Study Priority = Stat, Call Results To ED Attending
*R Chest 1 View Portable	Order	07/03/2013 14:48	Study Priority = Stat, Call Results To ED Attending
Patient Care			
Notify Provider Vital Signs	Order	07/03/2013 14:48	Children 2-5 yrs HR > 160; 6-12 yrs HR > 140; > 12 yrs HR > 120
Communication Order	Order	07/03/2013 14:48	If O2 sats < 93%, initiate O2 therapy to maintain O2 sats >= 93%.
Medications			
albuterol	Order	07/03/2013 14:48	2.5 mg, Inhalant, Nebulized, AS DIRECTED for 3 dose(s) Give back to back treatments up to 3 doses or until asthma score < 8
ipratropium	Order	07/03/2013 14:48	0.5 mg, Soln, Nebulized, AS DIRECTED for 3 dose(s) If asthma score >= 8; Give with first 3 Albuterol Treatments
Respiratory			
Pulse Oximetry Continu...	Order	07/03/2013 14:48	Daily

4 Missing Required Details Orders For Nurse Review Sign

The detail window for your order opens. The Reason for Exam has an asterisk and is bold indicating it is a required field. The field itself is yellow, another indication this field is required. Click the drop down arrow to select the reason for the exam.

**Details for XR Chest 2 Views PA/Lateral**

Details     Order Comments     Offset Details

+               

**\*Requested start date and time:** 07/03/2013 1448    **\*Priority (Obtain Study):** Stat

Wet Reading Interpretation = STAT:  Yes  No    **\*Call Results/Critical Results To:** ED Attending

Frequency:    Duration:

Duration unit:    **\*Reason for Exam:**

Pertinent Medical/Surgical Hx and P...    Special Instructions:

**\*Isolation Code:**

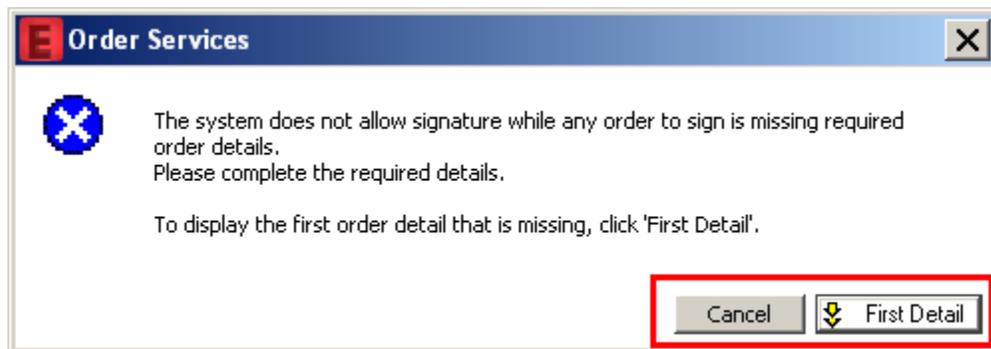
Anesthesia Requested:  Yes  No    Sedation Requested:  Yes  No

4 Missing Required Details    Orders For Nurse Review    Sign

You can complete or change other details to the order, if needed. Once you have finished collecting all order details you can sign the order.

### Missing Detail Notification

If you attempt to sign the order without satisfying the missing system required details, you will get a warning prompt.



From the warning screen, the First Detail button will take you directly to the first missing required detail. The Cancel option will close the warning prompt.

## Offset Details

Allows you to establish different start times for orders within a PowerPlan.

The screenshot shows a software window titled "Details for XR Chest 2 Views PA/Lateral". It has three tabs: "Details", "Order Comments", and "Offset Details", with "Offset Details" being the active tab. The main content area displays "ED Asthma - Wt. less than 20 kg (Initiated Pending)" and "Phase start: 07/03/2013 14:48". Below this is a "Start offset:" field with a dropdown menu and a "Clear" button. The "Actual start date/time:" is shown as "07/03/2013 14:48". At the bottom of the window, there are three buttons: "4 Missing Required Details", "Orders For Nurse Review", and "Sign".

## Ordering Physician window

When completing the PowerPlan the final step is to complete the Ordering Physician. This is the same step as when entering individual orders.

The screenshot shows a dialog box titled "Ordering Physician". It contains the following fields and options: a text field for "\*Physician name" with a search icon; a date and time selector for "\*Order Date/Time" showing "07/03/2013" and "1448"; and a list box for "\*Communication type" with options: "Paper/Fax", "Phone Read back", "Verbal Read back" (which is selected and highlighted in blue), "Protocol/Standing Order", and "Order Management". At the bottom are "OK" and "Cancel" buttons.

Select the appropriate Communication type for your order:

- Paper/Fax – the order is written on paper or faxed for entry
- Phone Read Back – the order was taken over the phone
- Verbal Read Back – the order was a verbal order
- Protocol/Standing Order – The order was entered based on Standing Protocol order
- Order Management –Used to clean up orders that need to be DC'd. For example if the physician orders a urinary cath insertion, a urinary cath care order may be placed too. If the urinary cath insertion order is DC'd the physician may not cancel the cath care order. The nurse could cancel this order using the Order Management Communication Type.

## Decision Support Alerts

Decision Support Alert Window may display if medications ordered for your patient are contraindicated. The example below shows a Duplicate Alert since the same medication has been ordered twice.

The screenshot shows a software window titled "Decision Support: ZZTest, Betty U - 00001164". The main content area displays a message: "The new order has created the following alerts: ipratropium". Below this is a table with the following data:

Severity	Substance	Details	Status	Interaction Information	Reference Information
	ipratropium	0.5 mg, Nebulized, AS DIRECTED	Ordered	<a href="#">ipratropium-ipratropium</a>	
	ipratropium	0.5 mg, Nebulized, AS DIRECTED	Ordered	<a href="#">ipratropium-ipratropium</a>	

At the bottom of the window, there are controls for applying the alert: "Apply to all interactions" (selected) and "Apply only to required interactions", an "Override Reason:" dropdown menu, and "Continue" and "Remove New Order" buttons. The patient ID "ZZTest, Betty U - 00001164" is also visible at the bottom.

To override the alert select the reason from the Override Reason Drop down menu to address each alert separately.

Or

You can select the Override Reason in the bottom right corner to address all the alerts with the same response.

Next, Select the Continue button or Select Remove the New Order button based on clinical judgment.

As always follow Hospital Policies and Procedures when handling these alerts.



**Tip:**

Clicking the hyperlink in the Interaction Information section will display additional information related to the reason for the alert

## Discern Alerts

Discern Alerts are generated for Medication Dose Range Alerts. In the example below the ordered dose is over the suggested dose range for METOCLOPRAMIDE. You can choose to Cancel the Order, Ignore the alert or Modify the order and click OK.

**Discern:**

**Dose Range Alert**

The following violation was found:

The ordered dose (2 mg/kg IV Once) is OVER the suggested dose range for this medication (metoclopramide)

Suggested SINGLE DOSE range: 0.1 - 0.2 mg/kg. (0.7 - 1.4 mg for this patient's Weight, Clinical (Dosing) (7kg) recorded on 06/22/2012 15:53.)

Adjusted variance SINGLE DOSE range: 0.09 - 0.22 mg/kg. (0.63 - 1.54 mg for this patient's Weight, Clinical (Dosing) (7kg) recorded on 06/22/2012 15:53.)

**Alert Action**

Cancel order

Ignore alert

Modify order

Alert History      OK

Choosing Ignore alert will prompt you to enter an override reason. Select the reason for overriding the med alert and select OK to continue and order the me.

**Override Reason Form**

Appropriate for Disease State  
Multiple Routes/Frequencies  
Intolerance, not true allergy  
Conflicting order(s) will be d/c'd  
Invalid or inappropriate alert  
Current/previously tolerated med  
Dose adjusted/mitigating med given  
Other (please specify details)

Additional Freetext Override Reason:

Cancel      OK

As always follow Hospital Policies and Procedures when handling these alerts.

## **PowerPlan Statuses**

### **Initiated:**

Initiated Pending phases move to a status of Initiated when you sign the Initiate action. As the phase moves to a status of Initiated, the orders within it will have a status of Order. All components (orders, outcomes, and interventions) within a phase get their start date and time from the start date and time of the phase. Exceptions are those orderable items previously assigned a start offset, to indicate that they are to start so many minutes, hours, or days after the start of the phase or orders that have a specific start date and time set in the order details.

### **Completed:**

This status denotes a plan, phase, or order whose stop date and time have elapsed, meaning that this plan, or portion of it, has been administered and is finished. A phase will also go to a Completed status when all included components in the phase are in a final status.

### **Discontinued:**

Plans can be discontinued automatically at patient discharge. Phases and plans can also be discontinued manually by taking a Discontinue action on them.

### **Void:**

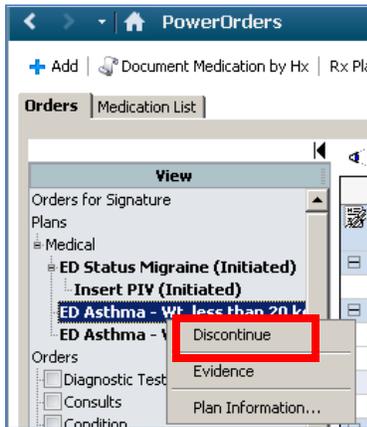
Phases and plans are voided when a Void action is taken against them.

## Removing an Order

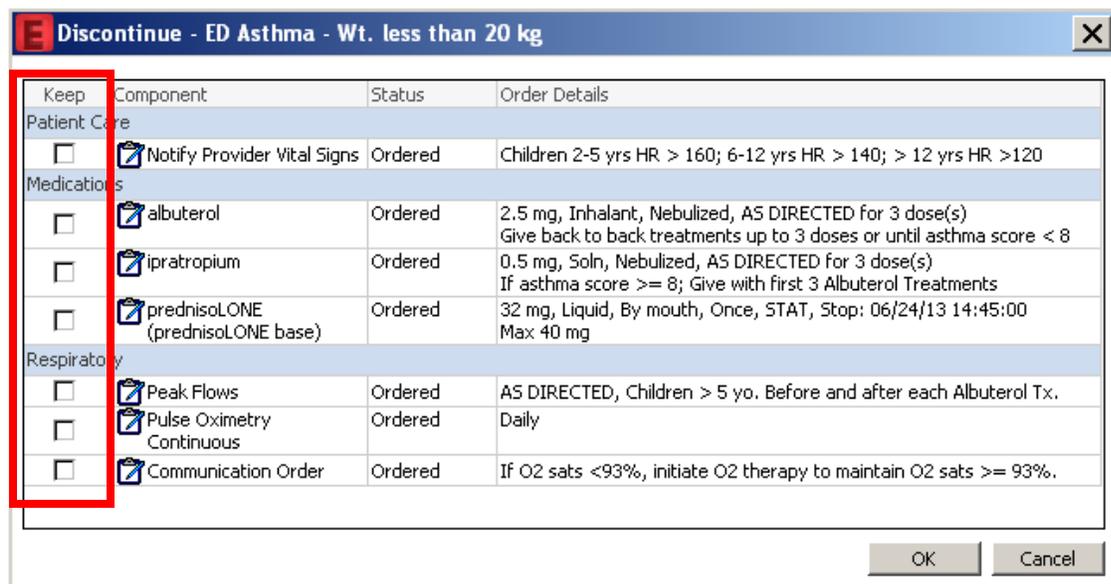
To remove an order prior to signing, highlight the order in the navigator window, right click and select remove. When the order is removed, it no longer appears within the patient record because it was never submitted.

### NOTE:

After a **PowerPlan** has been signed and submitted, it cannot be removed using the Remove option. If the order is no longer needed, right click on the PowerPlan in the Navigator and select Discontinue.



A window will display which will allow you to check any components of the PowerPlan that you want to keep. Otherwise, all the components will be discontinued.



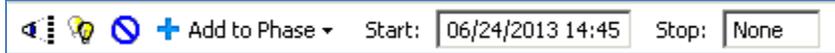
Click OK at the bottom of the screen when you are done to continue the Discontinue process.

## Right-click Functions

Depending on the order you may or may not see all of these functions.

- **Modify** – When available, allows you to modify an existing signed order
- **Copy** - Allows you to copy the existing order and make modifications before signing the new order
- **Cancel Reorder**–used to cancel an order and re-enter the same order with the details modified as needed
- **Complete** - Allows you to complete orders that do not generate a task (example Nursing communication orders (do not use for medication, lab or radiology orders)
- **Discontinue/Cancel** - Allows you to cancel a one-time existing signed order or discontinue a continuing order. Recommended to use Cancel / DC and place new orders when changing a medication's Route or Concentration
- **Void** – Allows you to void orders that should never have been placed, for example orders that were placed on the wrong patient
- **Order Information** - Displays the order information window.
- **Comments** – Allows you to view any comments on the order
- **Results** – Allows you to see any related results associated with the order
- **Reference Information** – Allows you to see reference information in the system related to the order
- **Print** – Allows you to reprint the orders sheet, a requisition for that order or a consent attached to the order
- **Advanced Filters** – Allows you to create and save filters to view subsets of orders
- **Disable Order Information Hyperlink** – Allows you to disable the hyperlink on the Order Name

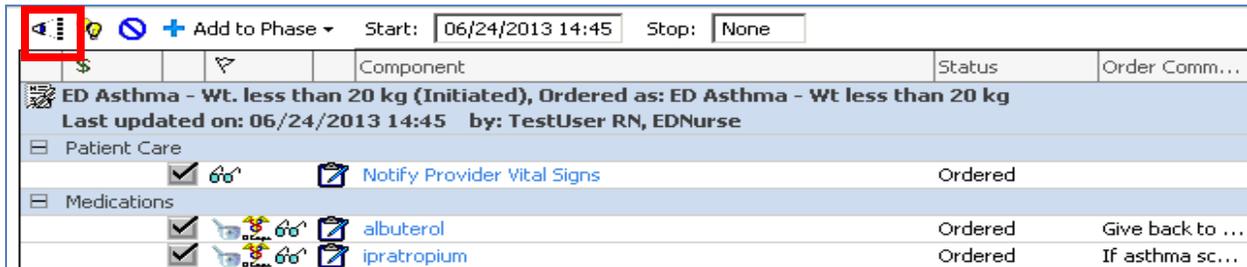
## PowerOrders Profile Toolbar



## Merge View

The Merge View can be used to review active orders adjacent to pending PowerPlan orders.

1. Click on the appropriate PowerPlan from the Navigator window.
2. Click **Merge View** icon .



## View Excluded Components

Allows you to view the components of the PowerPlan that were not originally selected. To select and additional component

1. Click on the appropriate PowerPlan from the Navigator window.
2. Click **View Excluded components**.
3. Click the check box beside the component to add
4. Complete the Ordering Physican window
5. Complete any needed details for the order
6. Click Orders for signature
7. Click Sign.
8. Click the Refresh button



## Discontinue Button

The Discontinue Button opens up the discontinue window where selected components of the PowerPlan can be removed. In the Keep column you can select the items you wish to remain as part of the plan. Deselected items will be discontinued from the Powerplan.

	\$		Component	Status	Order Comm...
<b>ED Asthma - Wt. less than 20 kg (Initiated), Ordered as: ED Asthma - Wt less than 20 kg</b>					
Last updated on: 06/24/2013 14:45 by: TestUser RN, EDNurse					
Patient Care					
<input checked="" type="checkbox"/>			Notify Provider Vital Signs	Ordered	
Medications					
<input checked="" type="checkbox"/>			albuterol	Ordered	Give back to ...
<input checked="" type="checkbox"/>			ipratropium	Ordered	If asthma sc...

1. Click on the Discontinue Button
2. Click on the items in the **Keep** column you wish to keep

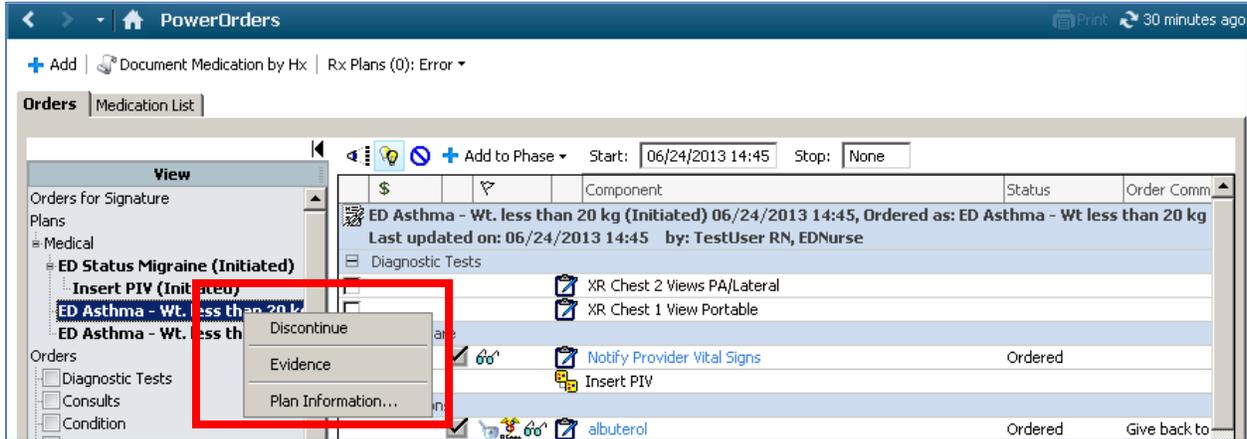
**Note:** Any items not selected will be discontinued from the plan.

Keep	Component	Status	Order Details
<input type="checkbox"/>	Notify Provider Vital Signs	Ordered	Children 2-5 yrs HR > 160; 6-12 yrs HR > 140; > 12 yrs HR >120
<input type="checkbox"/>	albuterol	Ordered	2.5 mg, Inhalant, Nebulized, AS DIRECTED for 3 dose(s) Give back to back treatments up to 3 doses or until asthma score < 8
<input type="checkbox"/>	ipratropium	Ordered	0.5 mg, Soln, Nebulized, AS DIRECTED for 3 dose(s) If asthma score >= 8; Give with first 3 Albuterol Treatments
<input type="checkbox"/>	prednisolONE (prednisolONE base)	Ordered	32 mg, Liquid, By mouth, Once, STAT, Stop: 06/24/13 14:45:00 Max 40 mg
<input type="checkbox"/>	Peak Flows	Ordered	AS DIRECTED, Children > 5 yo. Before and after each Albuterol Tx.
<input type="checkbox"/>	Pulse Oximetry Continuous	Ordered	Daily
<input type="checkbox"/>	Communication Order	Ordered	If O2 sats <93%, initiate O2 therapy to maintain O2 sats >= 93%.

3. Select the OK button
4. Enter the reason for discontinuing the components
5. Complete any needed details for the order
6. Click Orders for Signature
7. Click Sign.
8. Click the Refresh button

## Right Click Functions for PowerPlans

Additional functionality is available for PowerPlans in the Navigator section of PowerOrders. By Right-clicking in on a Powerplan you can access the following functions:



### Discontinue

Performs the same function as the Discontinue button on the toolbar. The Discontinue Button opens up the discontinue window where selected components of the PowerPlan can be removed. In the Keep column you can select the items you wish to remain as part of the plan. Deselected items will be discontinued from the Powerplan.

### Evidence

Opens the CHKD Pathway for selected plan

### Plan Information

Opens to a Plan Information window which displays the progression of the plan.

## Discontinue Selected PowerPlan Orders

1. Click the Power**Orders** tab.
2. Right-click the desired plan found in the Navigator window
3. Select Discontinue
4. Unclick the selected order(s) you wish to continue.
5. Complete the Ordering Physician Window (Enter Physician and Communication Type)
6. Complete required details
7. Click **Orders for Signature**; the discontinued orders display.
8. Click **Sign**.
9. Click **Refresh** .

## + Add to Phase

To add an additional order to a PowerPlan that was not included in the orderset complete the following steps:

1. Click on the appropriate PowerPlan from the Navigator window.
2. Click **Add to Phase** and select **Add Order**.
3. Enter the order name in the **Find** field.
4. Click Search.
5. Double-click the desired order.
6. Click **Done**.
7. Complete order details.
8. Click **Sign**.
9. Click the Refresh button to refresh.

Note: If you select the regular ADD button the order will not become part of the plan. You must use the Add to Phase button to include it as part of the PowerPlan.

## Adding Preferred Pharmacies

In PowerChart, you can specify a preferred pharmacy for patients. A Patient Pharmacy button appears on the toolbar.



By selecting this button, you are able to enter the preferred pharmacy for the patient.

 A screenshot of the "Custom Patient Preferred Pharmacies" window. The patient information at the top includes: ZZTest, Betty U, Age: 3 years, Sex: Female, Loc: CHKD-ED, DOB: 06/17/2010, EMR: 00001164, Fin#: 000075167, and Emergency [06/1... Clinical(Dosing) W... Allergies: Allergies Not Recorded. The window contains a search form on the left and a results table on the right. The search form includes fields for Pharmacy Name (containing "cvs"), Address, City, State (containing "va"), and Zip Code (containing "23228"). There are also radio buttons for Pharmacy Type (Retail, Mail Order) and checkboxes for Filter Results By (Specialty, 24-hour, Long-term Care). A "Search" button and a "Remember search options" checkbox are also present. The results table shows four CVS Pharmacy entries with their respective addresses, cities, states, and zip codes.
 

Pharmacy Name	Address	Cross-Street	City	State	Zip Co
CVS Pharmacy # 1538	9167 STAPLES MILL ROAD		RICHMOND	VA	23228
CVS Pharmacy # 1990	6100 LAKESIDE AVENUE		RICHMOND	VA	23228
CVS Pharmacy # 2307	7590 STAPLES MILL ROAD		RICHMOND	VA	23228
CVS Pharmacy # 2389	9501 WOODMAN RD.		RICHMOND	VA	23228

To add a Preferred Pharmacy, complete the following steps:

1. Click the Patient Pharmacy button from within the patient's chart. The Custom Patient Preferred Pharmacies window will appear.
2. Search for the pharmacy by entering the name, city, state and or zip code. Remember, the more information that you enter, the more the system will narrow the search and return results quicker.
3. Select the Pharmacy Type (if needed)
4. Select to filter results by: Speciality, 24-hour or Long-Term Care.

5. When the desired pharmacy is located, right click and select ADD.

The pharmacy will be added to the Patient Preferred Pharmacy tab.

Note: if multiple Pharmacies are added to the Patient Preferred Pharmacy tab, you can right click on the “set the preferred pharmacy”. You can also Remove a Pharmacy but you cannot Remove one entered from a location other than the ED.



The screenshot shows a window titled "Patient Preferred" with a search bar. Below the search bar is a table with the following columns: Pharmacy Name, Address, City, State, and Zip Code. The table contains two entries. The second entry is highlighted, and a context menu is open over it, showing "Remove" and "Set as Default" options.

Pharmacy Name	Address	City	State	Zip Code
CVS Pharmacy # 2338	700 MERRIMAC TRAIL	WILLIAM...	VA	23185
CVS Pharmacy # 1372	6404 WILLIAM...	WILLIAMSBURG	VA	22207



## Practice Scenario for PowerPlans

---

After CPOE is implemented, physicians should typically enter their requested orders. However, at times nursing will need to enter these orders.

Ask instructor for the correct physician's name to use for all of the following orders.

### Scenario 1:

Dr. \_\_\_\_\_ has asked you to enter a PowerPlan for Oxygen Therapy.  
Include the following orders:

Oxygen Therapy at 2lpm to keep the SpO<sub>2</sub> greater than 96.  
Pulse Oximetry Continuous

Add to Phase an iSTAT ABG to the Oxygen Therapy PowerPlan

### Scenario 2:

Dr. \_\_\_\_\_ has written an order for the ED Status Migraine Plan.  
He is with the patient now and asked you to enter the order.  
Include the following orders:

Vital Signs  
Pain Assessments  
Insert PIV Nursing Assessment  
Precautions  
Positioning  
Pulse Oximetry Continuous  
Oxygen Therapy 1lpm via mask  
Sodium Chloride 0.9% (0.9% Sodium Chloride Bolus)  
Sodium Chloride 0.9% (0.9% Sodium Chloride)  
Sumatriptan 6mg syringe, subcutaneous, once

### Scenario 3:

Dr. \_\_\_\_\_ asked you to enter an order for the ED Asthma PowerPlan for your patient. Keep in mind the patient's weight when entering the plan.  
Include the following orders:

Notify provider of vital signs  
Peak flows  
Pulse Ox continuous  
Albuterol 5mg inhalant  
Dexamethosone 8mg  
XR chest 1 view portable

The patient is also complaining of chest pain and has a history of irregular heart rhythm. Add an order for a cardiac Doppler ultrasound and an iSTAT ABG to the ED Asthma PowerPlan. (Make sure to use the Add to Phase option when adding this order).

**Scenario 4:**

Dr. \_\_\_\_\_ is planning to write prescriptions for the patient upon discharge and asks you to obtain the information for the patient's preferred pharmacy.

The patient's preferred pharmacy is The CVS Pharmacy at 700 Merrimac Trail in Williamsburg

**Scenario 5:**

Dr. \_\_\_\_\_ asked you to enter an order for the ED Adult Chest Pain PowerPlan. Request the following orders in the PowerPlan::

Monitor  
Oxygen Therapy 2L nasal cannula  
Pulse Ox Check  
Aspirin  
Morphine (morphine IV) 5mg  
iSTAT Chem 8 Components  
EKG and repeat as indicated

**Scenario 6:**

Cancel the Albuterol 5mg inhaled and ordered by Dr. \_\_\_\_\_ with the ED Asthma PowerPlan because it was ordered in error. Add to plan an order for Albuterol MDI in its place.

**Scenario 7:**

The ED Adult Chest Pain PowerPlan was entered in error for Dr. \_\_\_\_\_. Discontinue the entire PowerPlan. (Since you signed this PowerPlan you cannot "remove" it.

**Scenario 8:**

Add an ED Seizure PowerPlan for your patient. The physician is Dr. \_\_\_\_\_. Include the following:

Seizure Precautions  
Insert PIV  
Pulse Oximetry Continuous  
Oxygen Therapy  
D5W ½ NS w/KCl 20 mEq in 1000ml  
Carbamazepine 100mg  
CBCA  
Cabam Level, last dose today at 0800  
iSTAT Collection Blood Gases  
EEG Awake/Drowsy w/stem for seizures, no isolation

## **SECTION V    Task Management**

### **Introduction**

---

Task Lists are used to identify tasks that clinicians need to perform and to document those tasks.

In the Emergency Department you will always use the Single Patient Task List that displays within your patient's chart. The Single Patient Task List displays only those tasks for the selected patient.

Tasks in the Emergency Department are generated by orders placed for a patient. Not all orders will generate tasks.

### **Features**

---

- Assigned tasks retrieval
- Ability to modify types of tasks being retrieved
- Filterable views
- Ability to document tasks
- Ability to reschedule tasks
- Ability to view order information

### **Objectives**

---

In this lesson, you will learn how to:

- Retrieve assigned tasks.
- Complete / chart assigned tasks.
- Manage views of task lists.
- Customize task lists.

## Single Patient Task List

The Single-Patient Task List is found by opening a patient's chart and selecting the Task List tab.

It lists all tasks for a specific patient and displays limited additional information, such as the task status, scheduled date and time, and the details of the order associated to the task.

## Task Completion Methods

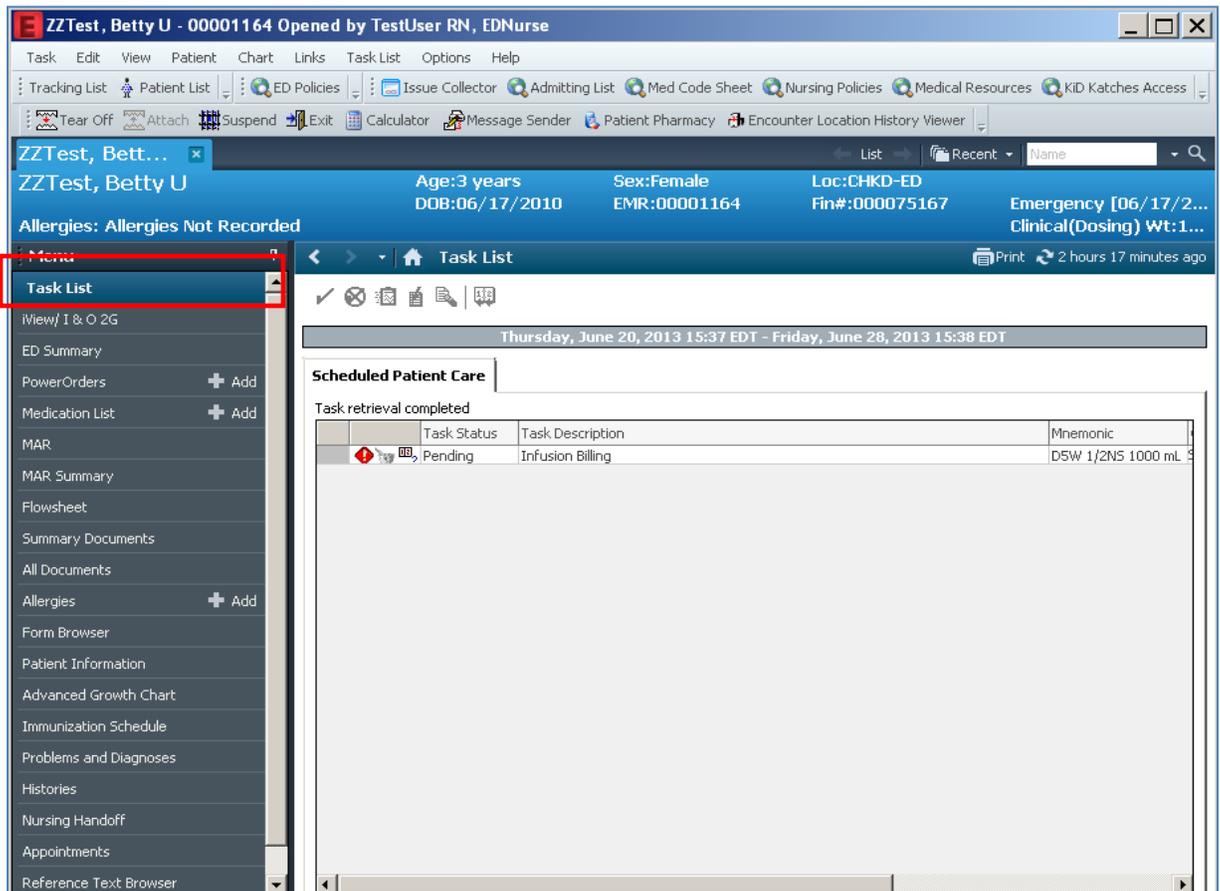
Depending on the type of task, the completion method may differ. Tasks can be completed by any of the following methods:

- Chart Done or Chart Done Date/Time
- PowerForms
- iView (Activity View Windows)

## Accessing the Task Lists

To access the Task List from any location within PowerChart complete the following steps:

1. Open a patient's chart and select the Task List tab.



To access the Task List while on the Tracking List complete the following steps:

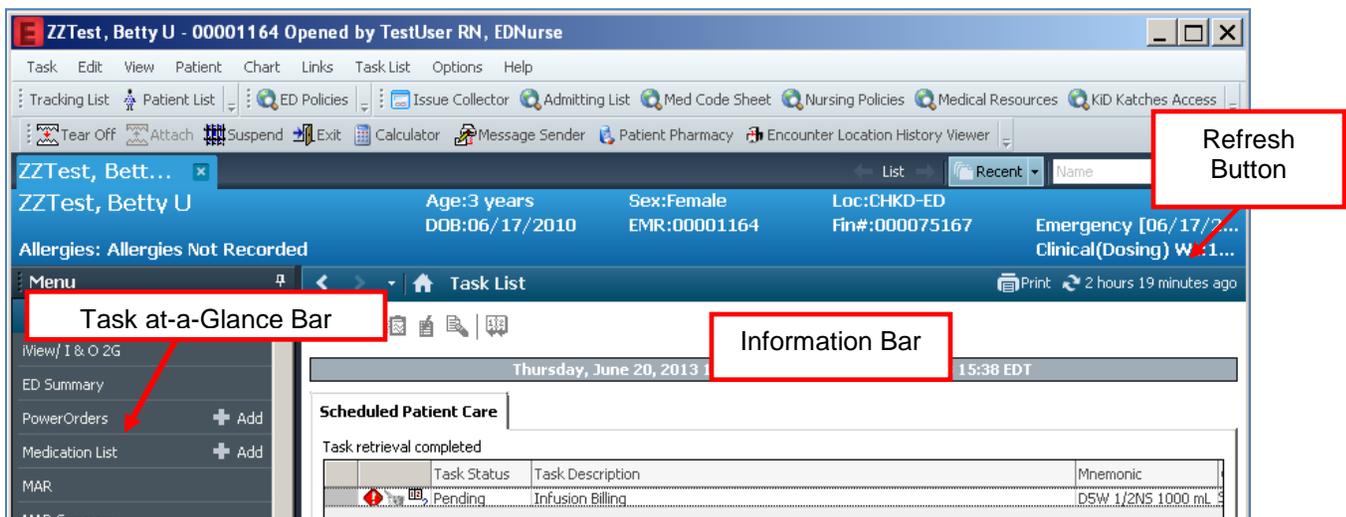
1. Open your patient's Chart from the Tracking List.

or

2. Look up the patient by clicking on the associated  icon.

## Single Patient Task List Components

The SPTL is displayed as a tab on the patient's chart.

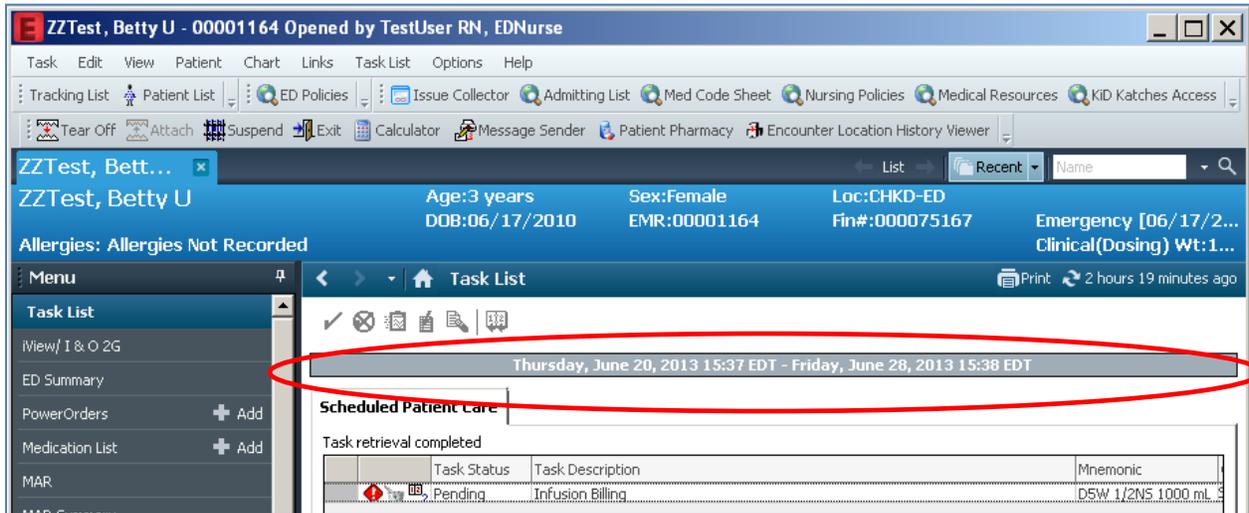


Component	Description
<b>Refresh Button</b>	The Refresh Button displays the time that the data were last refreshed.
<b>Information Bar</b>	The Information Bar in the SPTL located above the Scheduled Patient Care sub-tab displays the selected date range for tasks
<b>Task-at-a-Glance Bar</b>	The TAG (Task-at-a-Glance) bar is the first untitled column in the Single or Multi-Patient Task List.

## Information Bar

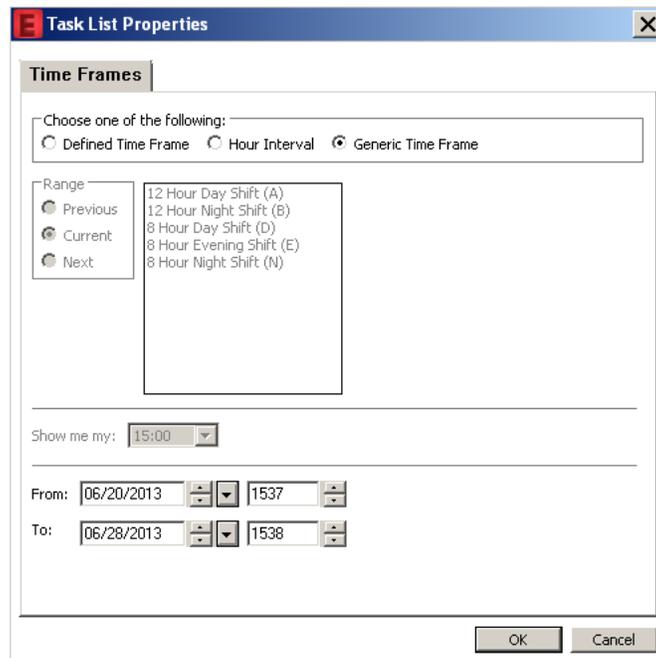
The Information Bar in the SPTL displays the selected date range for tasks.

**The tasks that are displayed on the task list are generated from the date range in the system. If the date is inaccurate, the current tasks may not display.**



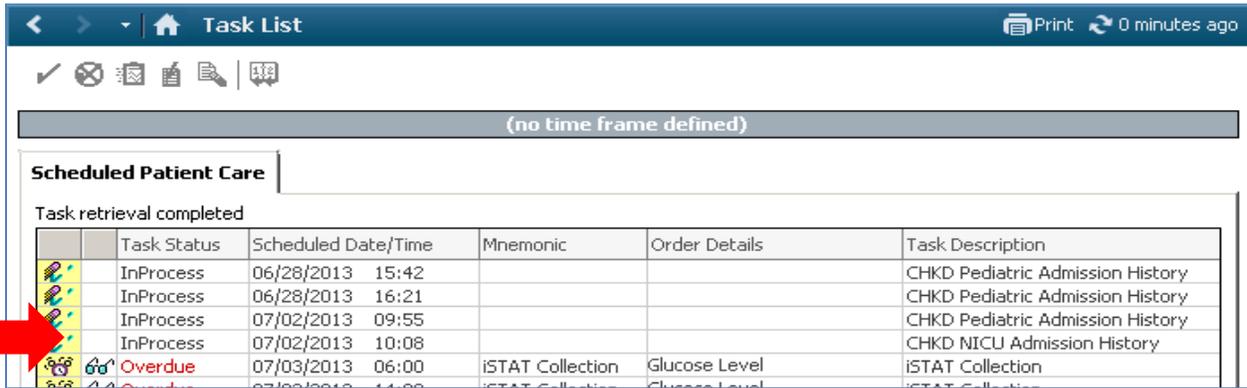
**To change the date range:**

1. Right-click on the date range in the Information Bar and select Change Time Frame Criteria.
2. Enter the date range information you want on the Task List Properties dialog box that opens.



## Task-at-a-Glance Bar

The TAG (Task-at-a-Glance) bar is the first untitled column in the Single Patient Task List. This column displays a color or color/symbol to assist you in identifying the status of each task.



In the screen shot above, two tasks are in an overdue status, indicated by the alarm clock icon in the Task-at-a-Glance-Bar. Overdue tasks will always display on the Task List regardless of the date range.

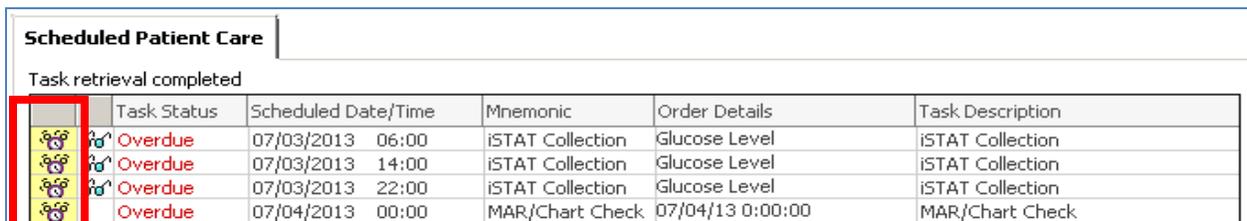
Check the TAG (Task-at-a-Glance) column to determine the status of a task or to open Quick Chart or Chart Done for a selected task.

## Status Indication

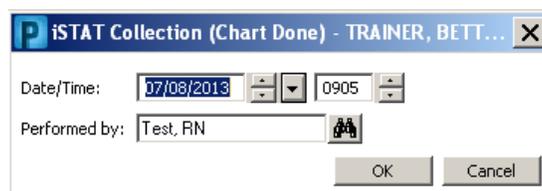
To see the indicator definitions, select *Task-at-a-Glance Legend* from the Options menu.

## Quick Chart

Single-clicking the TAG bar opens the Quick Chart or Chart Done functionality for Pending, Overdue, or Canceled/Discontinued tasks. You can chart some tasks simply by clicking the icon on the task-at-a-glance bar.



Once selected the Charted Done Window displays. Clicking OK will chart the task for the date and time displayed. You can also change the date and time if needed prior to selecting OK.



## Chart Done for Lab “Need to Collect” Task

When a “Need to Collect” lab task is displayed on your patient’s task list you can hover over that task to view the Order Details for the Task.

	Pending	Need to Collect: 1 Blue Volume 1.80 mL, Accession # 1 Volume 2.80 mL, Accession # 12-212-000025 A
--	---------	--

Order Details Grouped by Container

**Bld Anaerobe - Accession #BL-12-0000030 A - Volume 3.00 mL- RT - Pending**  
 C Bld Anaer; Blood Central Venous Line, Routine, RT - Routine, 07/30/12 10:18:00, 07/30/12 10:18:00, Nurse collect, Print label Y/N; Ordered; Dispatched

**Bld Aerobe - Accession #FG-12-0000006 A - Volume 3.00 mL- RT - Pending**  
 C Bld Fun; Blood Central Venous Line, Routine, RT - Routine, 07/30/12 10:18:00, 07/30/12 10:18:00, Nurse collect, Print label Y/N; Ordered; Dispatched

Order View

Single-clicking the TAG bar for the “Need to Collect” task opens the Associated Container Task Window.

Associated Container Tasks - ZZTest, Betty U - 00001164

Please select the containers which should be completed with this action

Red/Gold, Accession #13-189-000133 A, 0.7 mL

07/08/2013 0940

Performed By: TestUser RN, EDNurse

OK Cancel

Once the window opens, you can chart on all of the components to be drawn at that time. Deselect those that will not be drawn by deselecting the check mark by the component. You can also change the date and time at the bottom of the window if needed and then select OK to chart as done.

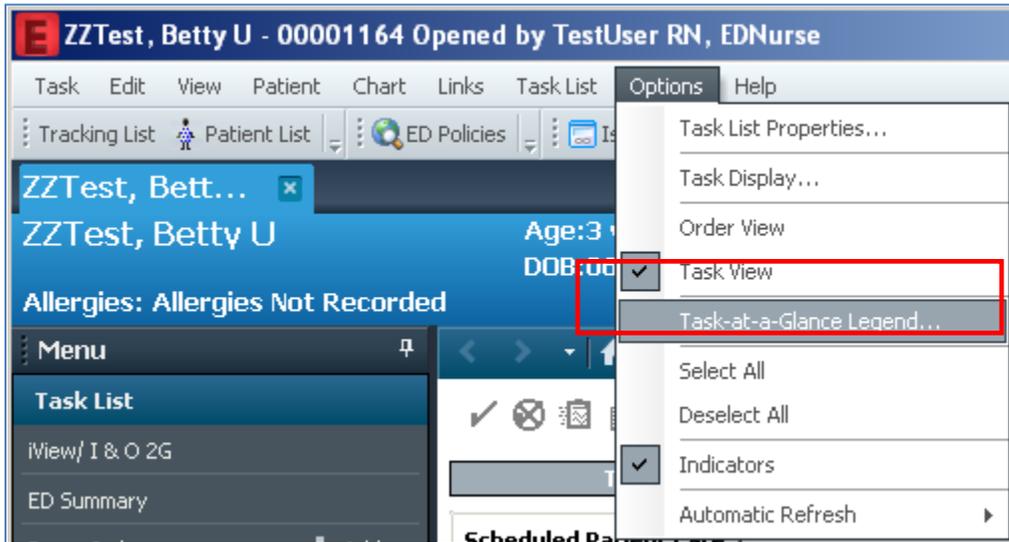
Any components of the task not completed at that same time will generate an additional task for that component(s) on the task list to be completed a later time.

**REMINDER:** You must also go back to the Tracking List to document the procedure collection via the associated PowerForm by clicking the “ED Specimen Details” icon from the toolbar. Another option to complete the procedure collection documentation is to enter this information directly in iView.

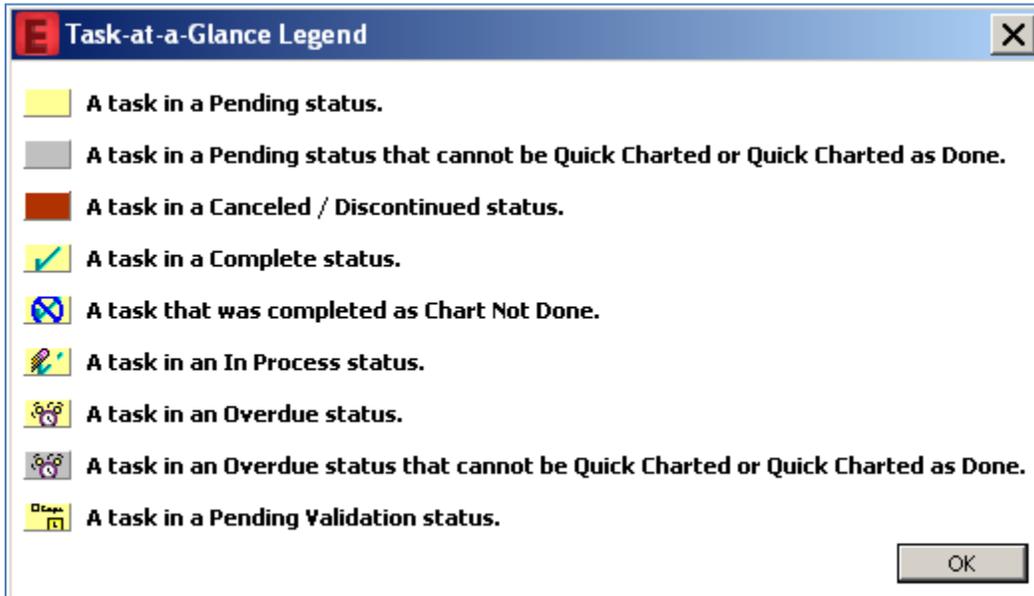
## Task-at-a-Glance Legend

The Task-at-a-Glance Legend provides an explanation of the symbols used on the Task-at-a-Glance Bar. To open the Task-at-a-Glance Legend, complete the following steps:

1. From the *Options* menu, select *Task-at-a-Glance Legend*.



2. Review the *Legend*, and click OK when finished.



## Task List Toolbar Buttons



Definitions of buttons used on the Task List toolbar are shown below:

Button	Action
	<b>Chart Done</b> —Allows you to chart the task as Done. (Results are entered as Done.)
	<b>Not Done</b> —If a task is unable to be performed, click this button. The status of the task then becomes Complete.
	<b>Quick Chart</b> —Same functionality as <b>Chart Done</b> . Allows you to chart the task as Done. Not available in all departments. (Results are entered as Done.)
	<b>Un-chart</b> —If a task was started or completed accidentally, Un-chart reinitializes the task to a Pending status.
	<b>Reschedule This Task</b> —Opens the Reschedule dialog box so a task can be rescheduled.

## Options Menu

The *Options Menu* can be accessed by clicking on *Options* on the menu bar from the Task List.

The *Options* menu contains the following commands:

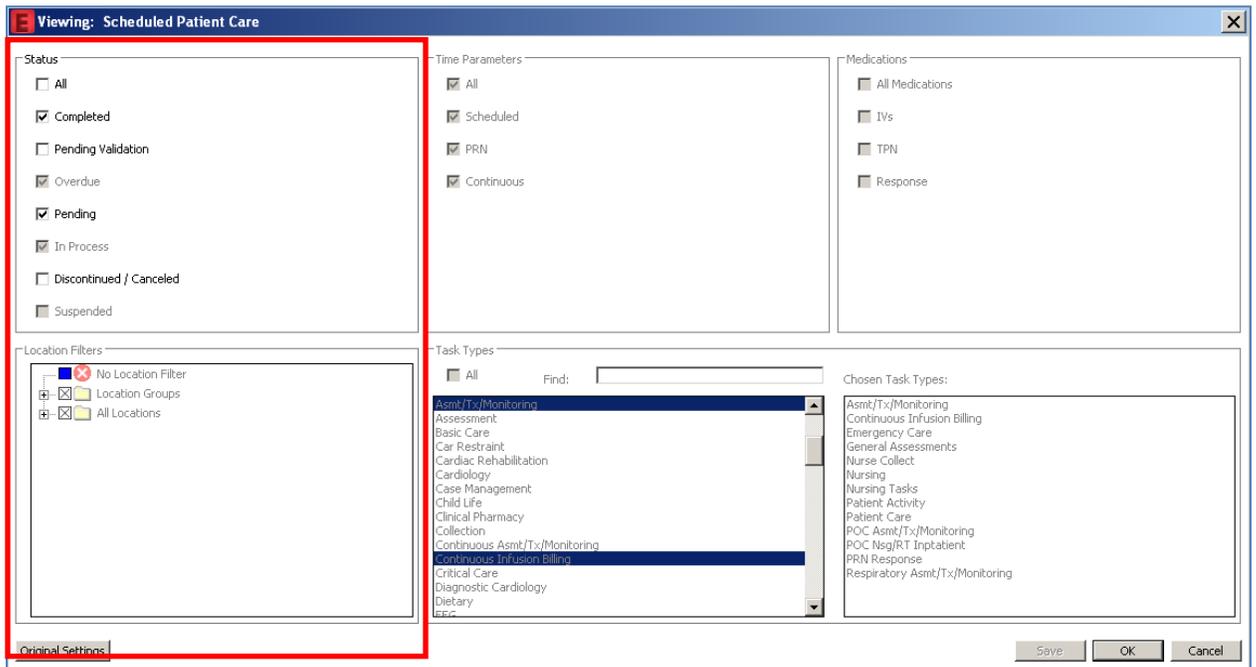
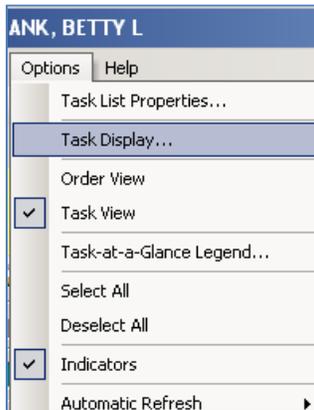
Command	Action
<b>Task List Properties</b>	Opens the Task List Properties dialog box so time frames or patient lists can be selected
<b>Task Display</b>	Displays the Viewing dialog box for the selected task so filters can be viewed or changed. (Ex: Completed orders, Discontinued Orders, All Orders)
<b>Order View</b>	Displays a column (third from the left) with icons that show the task is a single task (icon is a gray square) or that there is a list of tasks that belong to the same order (plus or minus sign). The plus sign displays when only one of the group of tasks related to an order is displayed. The minus sign displays when all tasks associated with an order are displayed. Tasks cannot be sorted in this mode.
<b>Task View</b>	When checked, the Order View column does not display. Tasks are not grouped by order, and they are allowed to be sorted. (This cannot be unchecked.)
<b>Task at-a-glance Legend</b>	Displays the task status icon legend.
<b>Select All</b>	Selects all tasks that are not selected.
<b>Deselect All</b>	Deselects all selected tasks.
<b>Indicators</b>	Toggles on or off the Indicators column. (Example: Nurse review glasses)
<b>Automatic Refresh</b>	Allows you to indicate how often the screen is to be refreshed, every 5, 15, or 30 minutes. You also may turn off this indicator by selecting Off. (It is imperative to refresh your display normally by clicking the Refresh button even if this option is used.)

## Task Display Filter

The Task Display provides a means to filter the tasks by their status. The system always displays tasks in an Overdue status. The default in the Emergency Department is to display all task statuses for the selected patient, Completed and Pending. Filters can be changed if needed.

### Complete the following steps to change the filter:

1. Select Task Display from the Options Menu. The Viewing window appears.



Under Status, select applicable statuses of the tasks that you want displayed on your task list.

Status	Explanation
<b>All</b>	Displays all tasks.
<b>Completed</b>	Displays all tasks with a status of completed. These will default to remain on the task list in the Emergency Department.
<b>Pending Validation</b>	This task status will not be used.
<b>Overdue</b>	Displays all tasks with a status of Overdue. The system automatically displays tasks with this status, and this cannot be deselected.
<b>Pending</b>	Displays all tasks that have not been charted (tasks that are waiting to be completed).
<b>In Process</b>	This task status will not be used.
<b>Discontinued / Cancelled</b>	If the order that triggered a task is discontinued /cancelled, the associated tasks will also become discontinued /cancelled.

3. Click OK. Tasks with any of the selecting statuses are displayed.

## Refresh Button

The Refresh Button tells you the last time the data on display were refreshed. Click the button to perform a manual refresh and to display up-to-date information.



## Tips and Tricks

It is imperative to refresh your display by clicking on the Refresh Button. Otherwise, the data that you are looking at may not be up-to-date.

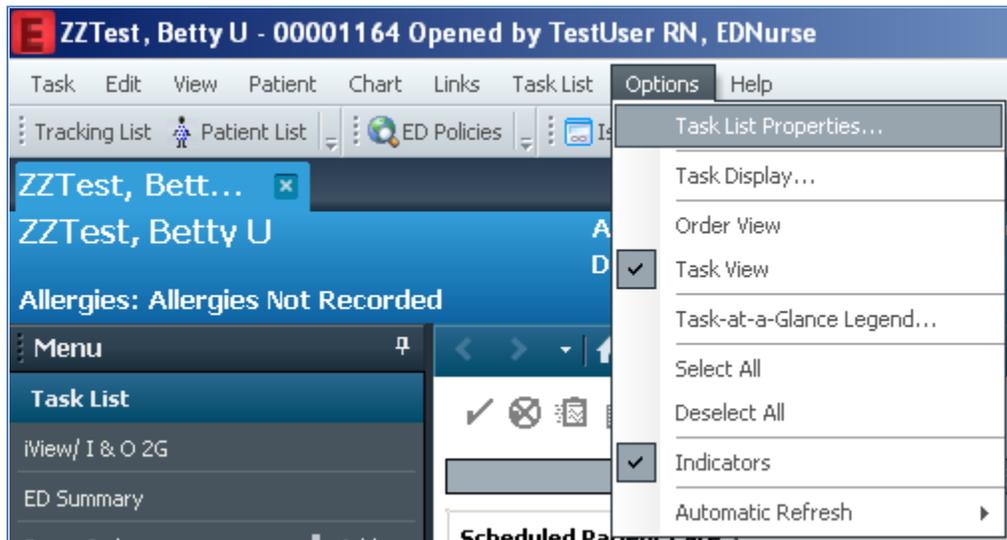
## Setting Up the Task Lists to Display Tasks

Filters provide the ability to limit the tasks that are displayed on the task list, thereby, keeping the task list more manageable. Task lists can be filtered by time (ex. to see tasks for only one day or one shift) and by status (ex. to show only Pending tasks or all tasks).

### Filtering Tasks Using the Time Frame Filter

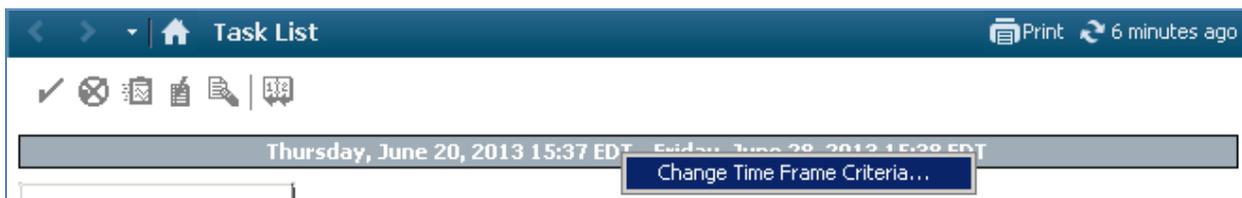
Complete the following steps to change the Time Frame Filter:

1. From the Options menu, select Task List Properties



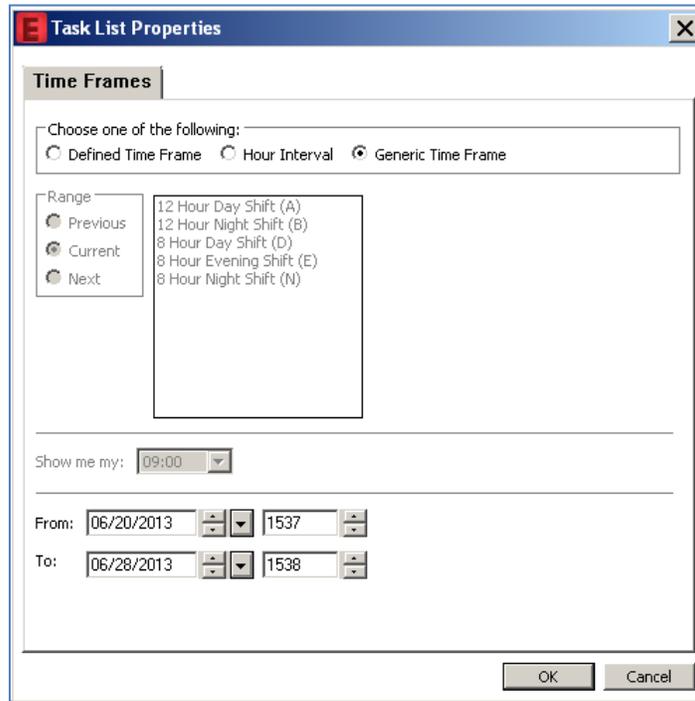
OR

Right-click the Information Bar and select *Change Time Frame Criteria*.



(Both options will open the Task List Properties window.)

2. When the Task List Properties window is displayed, select the appropriate Time Frame Option.



<b>Defined Time Frame</b>	A predefined time frame, such as a shift, that has been built into the database. With the defined time frame option selected, the <i>Range</i> selection becomes active. The <i>Range</i> selection allows you to view tasks for the current shift, the previous shift, or the next shift.
<b>Hour Interval</b>	A filter of only one hour's time for the current day. When this option is selected, the <i>Show Me My</i> portion of the Task List Properties window will become active, allowing you to specify a specific hour's worth of tasks to view.
<b>Generic Time Frame</b>	A time frame to be defined by the user for unique shifts or for past task data retrieval. With the <i>Generic Time Frame</i> option selected, the <i>From / To</i> portion of the Task List Windows becomes active, allowing you to view tasks from the past or the future.

3. Click OK when finished.

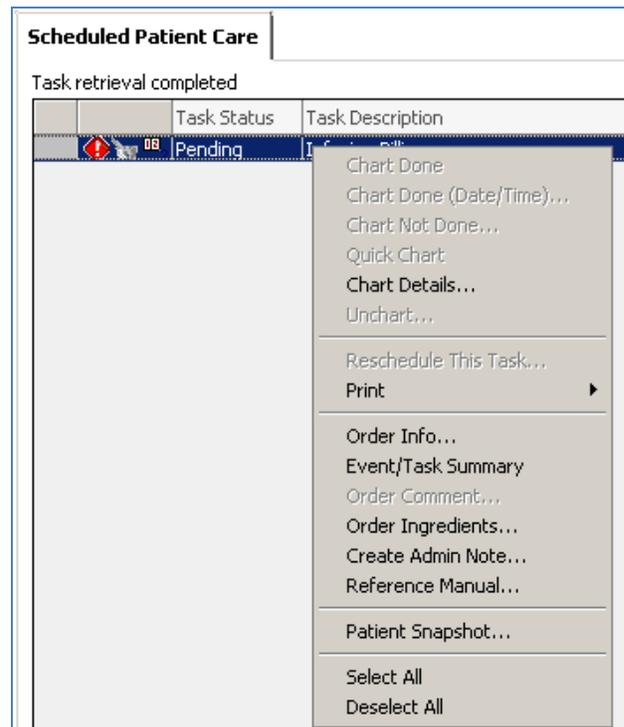
### Considerations

- If you select the day shift of 0700 to 1500, when 1501 arrives the view will be set to 0700 to 1500 for the next day.
- There is a limit of 1,000 tasks that can be retrieved. For this reason, you should not ask the system to retrieve more than three months worth of tasks when using the *Generic Time Frame* option.
- If you work a schedule that is not included in the *Defined Time Frame*, use *Generic Time Frame* and enter the date and time information of your scheduled shift.

## Task List Right-Click Menu

When you right-click a task on the task list, a context menu is displayed. Menu options may vary depending on what task you have right-clicked.

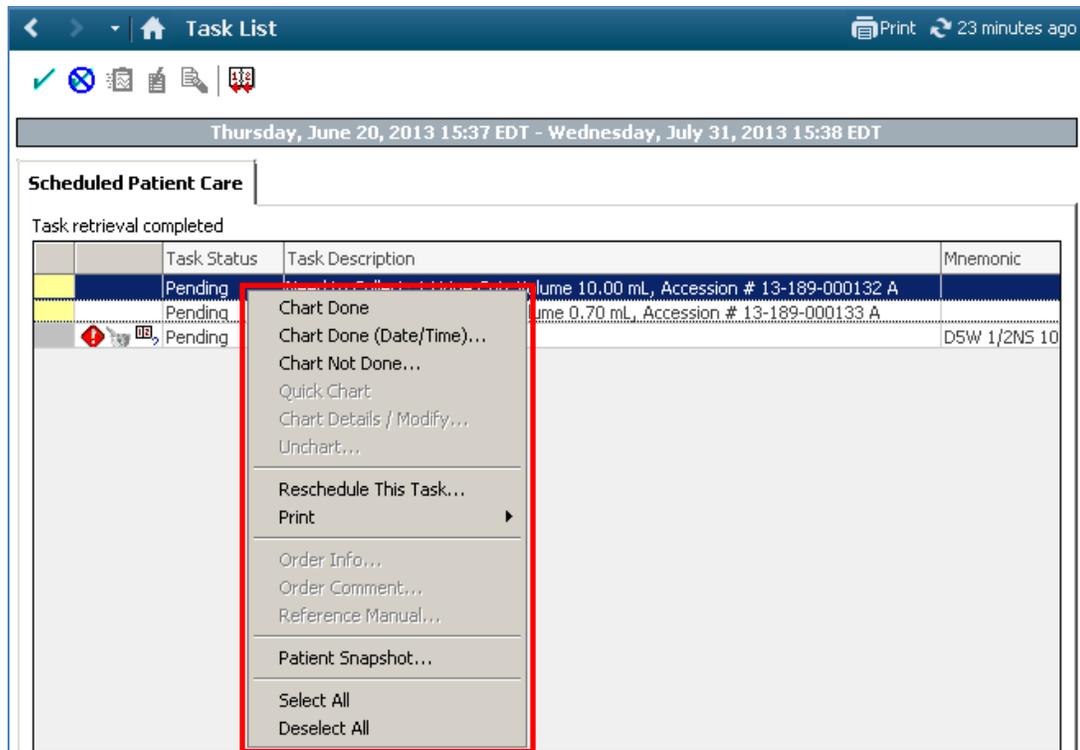
Command	Action
<b>Chart Done</b>	Chart the task as Done. (Results are entered as Done.)
<b>Chart Done (Date / Time)</b>	Chart the task as Done, allowing you to set the date and time to stamp on the results. (Results are entered as Done.) This option also allows you to chart a task for someone else.
<b>Chart Not Done</b>	Indicate selected tasks were not done. Must enter a reason why the task was not done.
<b>Reschedule This Task</b>	Allows you to reschedule tasks that cannot be completed at the current time.
<b>Order Info</b>	Displays who entered the order, who ordered it and when, and the "owner" department
<b>Create Admin Note</b>	Opens the Create Admin Note Dialog box and allows the user to create an admin note.
<b>Reference Manual</b>	Opens Online Reference Information, including Preps, etc. If there is no Reference Information available, nothing appears when this option is selected.
<b>Patient Snapshot</b>	Displays site-defined information such as the patient's diagnosis and allergies.
<b>Select All</b>	Selects all tasks that are not selected.
<b>Deselect All</b>	Deselects all selected tasks.



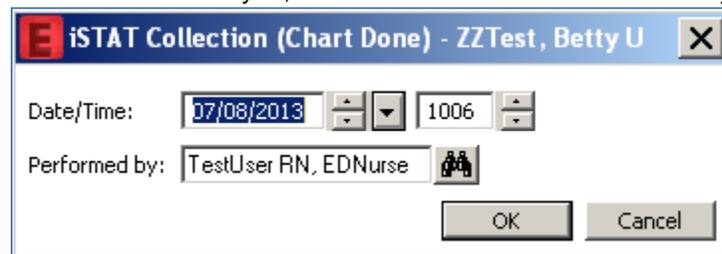
## Charting Tasks as Done and Done(Date / Time)

To chart a task as done (performed / completed) with a date / time stamp, complete the following steps:

1. Select the task from the Task List.
2. Right Click the Task and select Chart Done (Date / Time).



3. In the Chart Done window, enter the date and time that the task was completed. If the task was completed by a clinician other than you, enter their name in the *Performed By* field.



4. When finished, click OK.
5. A checkmark will appear in the Task-at-a-Glance column, indicating that the task was charted as Done. Once the screen is refreshed by clicking on the Refresh Button, the task may disappear from the task list (this may vary, depending on if the task list is filtered to show 'All' or 'Completed' tasks.)

## Rescheduling Tasks

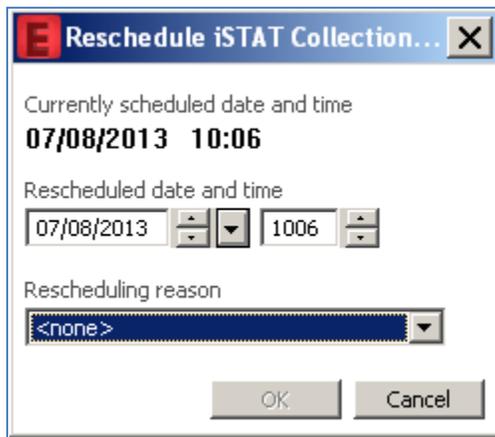
Occasionally a task cannot be completed at the time it was scheduled. Tasks that cannot be completed but can be completed at a later time (example: the patient is unavailable at the scheduled time), should be rescheduled. Rescheduling a task will simply move it from the current schedule to the new schedule.

If you are unable to complete a task at the scheduled date and time, it may be possible to reschedule it. The ability to reschedule a task is a database setting. The standard setting allows the ability to reschedule a task for 72 hours after its scheduled date and time. However, additional rescheduling parameters are listed below:

<b>Department</b>	<b>Overdue</b> (The length of time that a task can remain in a pending status before it is considered Overdue)	<b>Retention Time</b> (The length of time that a charted task will remain on the task list before it is dropped.)	<b>Reschedule Time</b> (The number of hours up to which a task can be rescheduled.)
Peripheral Vascular Lab	24 Hours	30 Days	72 Hours
EEG	24 Hours	30 Days	72 Hours
Hospital School Program	24 Hours	15 Days	72 Hours
Infection Control	24 Hours	15 Days	72 Hours
Nutrition	Screening - 48 hrs Consults – 24 hrs Diets – 4 Hours	1 Week	Screening - 72 hrs Consults – 72 hrs Diets – 24 Hours
PT, OT, and ST	24 Hours	15 Days	72 Hours
Respiratory Therapy	1 Hour	15 Days	24 Hours
Sleep Lab	24 Hours	30 Days	72 Hours
Pulmonary Function	24 Hours	30 Days	72 Hours
Cardiology	24 Hours	30 Days	72 Hours
Social Work	24 Hours	15 Days	72 Hours
Nursing	1 Hour	5 Days	72 Hours

## To reschedule a task:

1. From the Task List, select a Pending task.
2. Right-click the task, and select Reschedule This Task from the menu. The following dialog box appears:



3. Select the Rescheduled date and time and a rescheduling reason.
4. Click OK. The task displays with the new date and time.

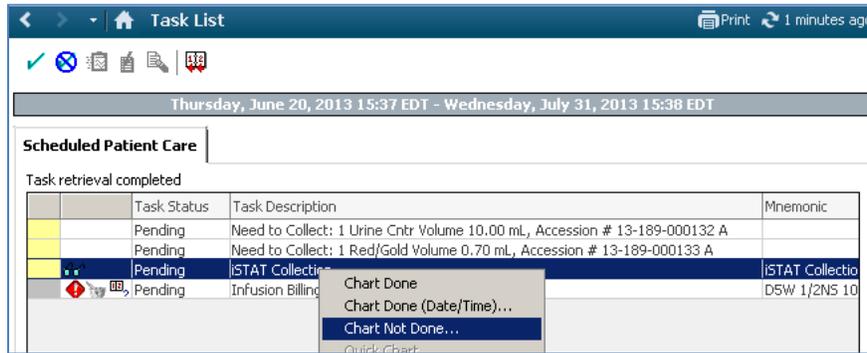
## Tips and Tricks

The OK button remains unavailable unless the rescheduled date and time fall within the defined range. See the Rescheduling Parameters Chart above for more information.

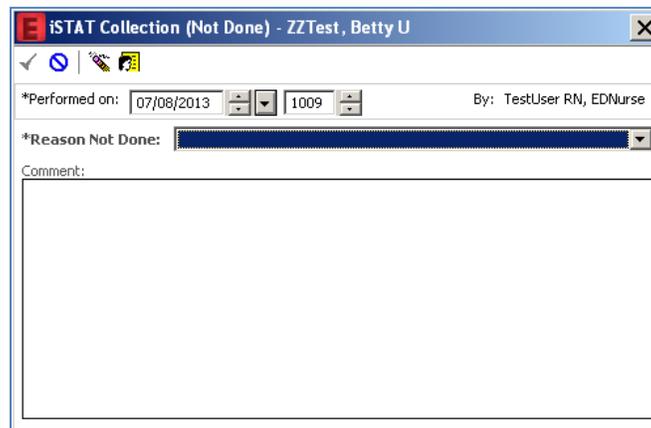
## Charting Tasks as Not Done

To chart a task as Not Done (performed / completed), complete the following steps:

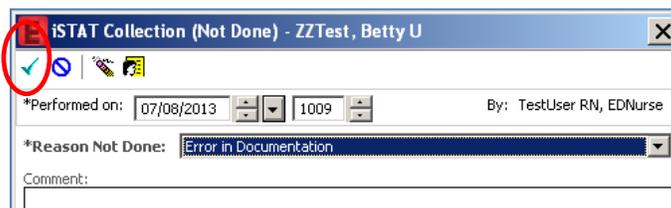
1. Select the task from the Task List.
2. Right Click the Task and select Chart Not Done (or select 'Chart Not Done' from the Task Menu).



3. The Not Done window will appear. Select a reason that the task was not completed from the Drop-Down Menu. Enter any related comments in the Comment field.



4. Once a reason that the task was not performed is selected, the Sign (checkmark) icon will become active, allowing you to sign the task as Not Done.



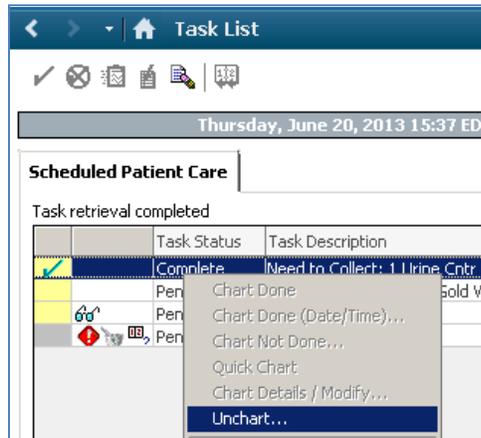
5. The Chart Not Done Icon will appear in the Task-at-a-Glance column, indicating that the task was charted as Not Done. Refresh the screen by clicking on the Refresh Button. The task may disappear from the task list (this may vary, depending on if the task list is filtered to show 'All' tasks, or only Pending and Overdue tasks.)

## Uncharting Tasks

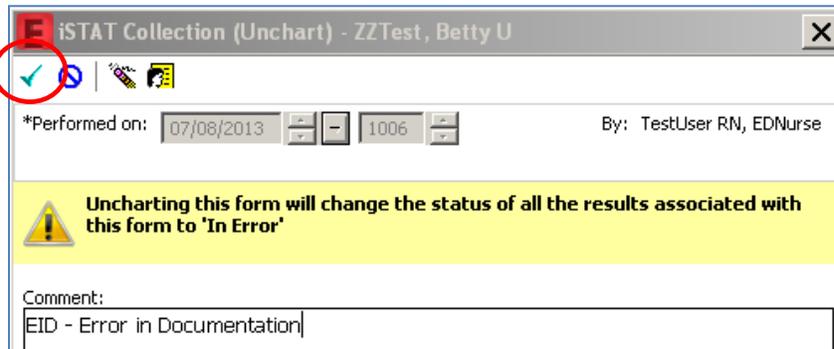
### To unchart a task that was previously charted incorrectly:

Select the task from the Task List. (If the task List is no longer displaying the task, change the Task Display filter so that all tasks are being displayed.)

Right Click the Task and select Unchart (or select Unchart from the Task List Toolbar).



The Unchart window will appear. You must insert a comment regarding why you are uncharting the current task.

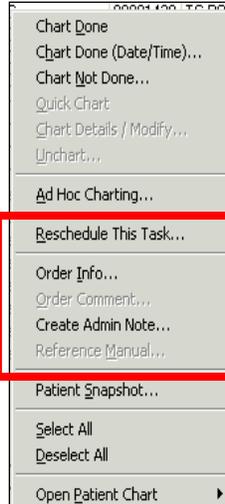


Once Unchart Comments have been entered, the sign (checkmark) icon will become active. Click the checkmark to sign that you are uncharting the task.

The task will return to the Task List with a status of **Pending**. Any associated forms that were completed when you previously charted the task will be marked 'In Error.'

## Viewing Additional Task Information

To view additional information about a task, right click on the task list and select one of the options listed below.



**Order Information:** Displays who entered the order, who ordered it and when, and the "owner" department. Select the appropriate tab to view order details, comments, validation information, additional information, history, and results.

**Create Admin Note:** Use this selection to add an administrative note regarding a task.

**Order Comment:** If there is a comment attached to the order, it is displayed here. Order comments also may be viewed in the Order Details column. If the comment is too long for the space provided, an ellipsis (...) is displayed. Drag the column line to the right of the Order Details column heading name to enlarge the space to show the additional information.

**Reference Manual:** Opens Online Reference Information, including Preps, etc. If there is no Reference Information available, nothing appears.

**Patient Snapshot:** Displays site-defined information such as the patient's diagnosis and allergies.

## Troubleshooting Q & A

**Q: When I multi-select all the tasks on my task list, all of the completion options are grayed out. Why?**

A: If more than one task is selected and they do not have the same method of completion, all of the completion options are grayed out.

**Q: Why does the OK button remain grayed out when I attempt to reschedule a task?**

A: The OK button remains unavailable unless the rescheduled date and time fall within the defined range. See the Rescheduling Parameters Chart for more information.

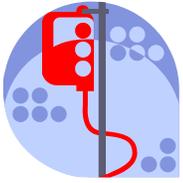
**Q: Why is there an alarm clock on the task list?**

A: If a patient has an overdue task, the alarm clock icon is displayed to the left of the patient's name in the navigator.

## Practice Scenario for TASK LISTS



1. From the Task List, Chart an iSTAT task using the Chart Done Option
2. Unchart the iSTAT task. EID (Error in Documentation) is the reason.
3. Chart a *Need to Collect* task (requiring only one tube) using the Chart Done Option. Return to the Tracking List and click the ED Specimen Collection Details PowerForm icon to open the PowerForm and chart the collection details.
4. Click on the Peripheral IV Insertion Task and note what happens.  
**Do not** complete this task at this time but return to the task list in the patient's chart.
5. Right click on a task and select Order Info. Review the information and close the window.
6. Right click on a task and select Reschedule. Reason was no IV access at this time.
7. Chart a Need to Collect Task requiring multiple tubes. Return to the Tracking List and chart the ED Specimen Collection details regarding the one tube collected. Note another task appears on the Task List for the remaining tube(s) to be collected.
8. Chart the task(s) for the remaining tubes and complete the appropriate PowerForm from the Tracking List.
9. Find your Task-at-a-Glance legend and review the possible task statuses. Review and identify the ones on your patient's Task List.



## SECTION VI

## Introduction to eMAR



---

### Introduction

The eMAR (electronic Medication Administration Record) is used to view and chart all active medications (scheduled, unscheduled, PRN, Continuous infusion and Titratable Drips) and PRN response tasks for a specific patient. The eMAR displays the medication orders, tasks, and documented administrations for the selected time frame and selected order status.

---

### Features

- Provides an easily accessible online comprehensive view of a patient's medication administration record
- Prevents medication records from being lost or misfiled
- Provides information regarding all statuses of medications
- Can chart tasks directly from the eMAR
- Can access patient information from the eMAR
- Can filter information based on needs and preferences

---

### Intended Audiences

All staff that will need to document patient medication administration

---

### Objectives

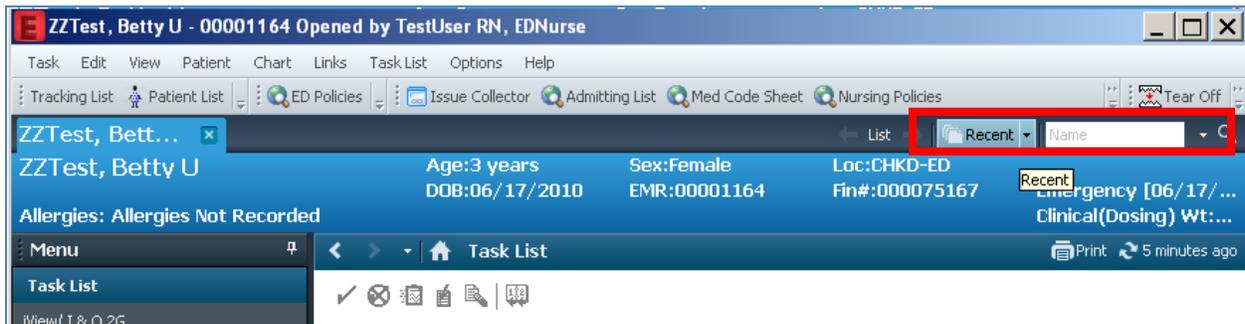
In this lesson, you will learn how to:

- Access the eMAR in eKIDs PowerChart
- Set the correct timeframe
- Navigate in the eMAR
- Chart a medication task
- Unchart a medication task
- Chart a medication task as Not Done
- Modify a medication task
- Reschedule a medication task
- Add an Administrative Note
- View Order Information
- Review the MAR Summary Tab

## Accessing the eMAR

When you have successfully logged into your application, you can access the eMAR from the patient's chart. As a reminder, depending on where you work, you can open a patient's chart from the **Patient Access List** by double clicking on their name, by right clicking on their name and selecting **Open Chart** or by selecting **Chart** from the menu and then selecting the part of the chart you want to open. If you work in the Emergency Department, you can access the patient's chart and eMAR from the FirstNet Tracking List.

You can also search for a specific patient by entering their name or medical record number in the field beside the binoculars, or by clicking on the binoculars on the toolbar to open the search window.



## MAR Chart Tab

The MAR (also referred to as the eMAR) is available as a chart tab within the patient's chart. To open the MAR, simply click on the MAR tab.

Click on the pushpin to collapse your menu and enlarge your MAR view.

Medication	Dose	Frequency	Status
acetaminophen	160 mg, Liquid, By mouth, Once, STAT, Stop: 06/27/13 10:05:00		STAT
acetaminophen			
dihydroergotamine	0.5 mg, Soln, IV Piggyback, Once, STAT, Stop: 06/27/13 10:05:00, Infuse over: 60 minute(s), DHE 0.5mg in NS 100 mL IV Set		STAT
dihydroergotamine			
diphenhydramine	20 mg, Liquid, By mouth, Once, Stop: 06/27/13 11:00:00		20 mg
diphenhydramine			
metoclopramide	5 mg, By mouth, Once, Stop: 06/27/13 11:00:00		5 mg
metoclopramide			
ondansetron	2 mg, Liquid, By mouth, Once, Stop: 06/27/13 11:00:00		2 mg
ondansetron			
prednisolone (prednisolone)	32 mg, Liquid, By mouth, Once, Stop: 06/27/13 11:00:00		

## Time Frame

To indicate a specific time frame for which tasks and results for orders are to be displayed, right-click the information bar and select Change Search Criteria. The Search Criteria dialog box is displayed, and the dates and time can be changed as needed from the default 12 hours back and 12 hours forward.



**Note:** Alternatively, the date can be modified by clicking the left or right arrows on each end of the information bar.

To set the search criteria for active orders to the current 24-hour period, right-click the information bar and select Set to Today.

Use the **overdue icon** next to the date/time bar to have the system automatically adjust the clinical range to include any overdue medications during the *look back* period which is a 48 hour range, 24 hours back and 24 hours forward. This alarm



clock icon only displays if there are overdue medications.

## MAR View Options

### Time View

By default the MAR is sorted by administration status such as Scheduled, Unscheduled, PRN, etc. This is referred to as the **Time View**.

Medications	06/27/2013 10:05	06/27/2013 10:08	06/27/2013 11:00
<b>Scheduled</b>			
<b>acetaminophen</b> 160 mg, Liquid, By mouth, Once, STAT, Stop: 06/27/13 10:05:00	STAT		
acetaminophen			
Pain Scale			
Pain Score, Inpatient			
<b>dihydroergotamine</b> 0.5 mg, Soln, IV Piggyback, Once, STAT, Stop: 06/27/13 10:05:00, Infuse over: 60 minute(s), DHE 0.5mg in NS 100 mL IV Set	STAT		
dihydroergotamine			

### Therapeutic Class View

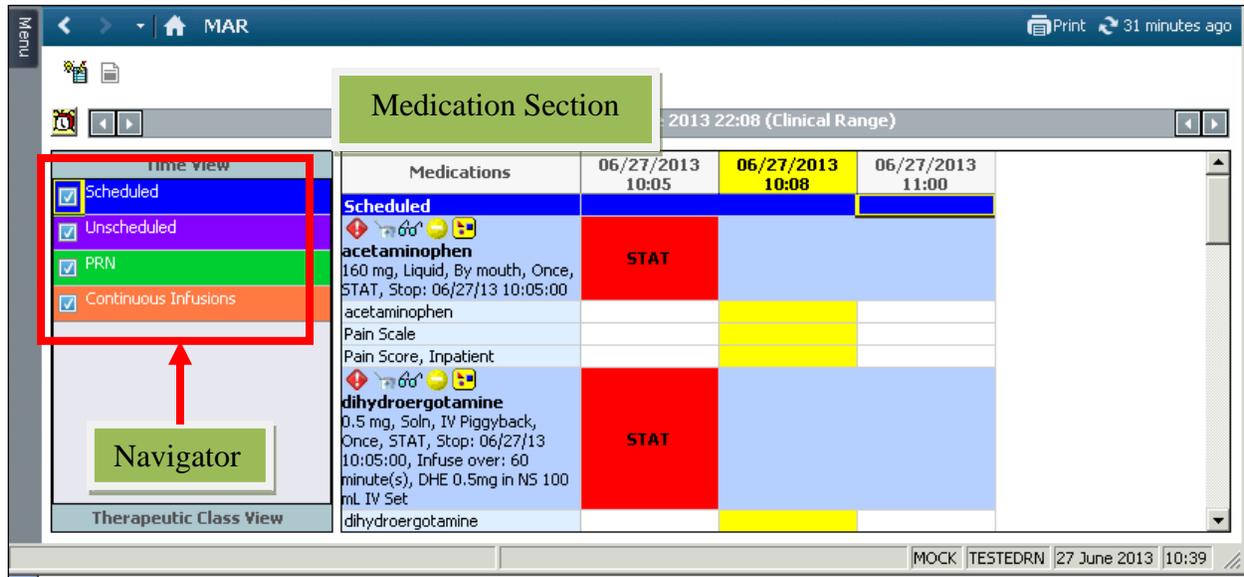
The **Therapeutic Class View**. To switch to this view, simply click on the Therapeutic Class View button on the Navigator. This will sort the MAR by Therapeutic Class groups. **NOT AVAILABLE AT THIS TIME.**

Medications	06/27/2013 10:05	06/27/2013 10:08	06/27/2013 11:00
<b>Scheduled</b>			
<b>acetaminophen</b> 160 mg, Liquid, By mouth, Once, STAT, Stop: 06/27/13 10:05:00	STAT		
acetaminophen			
Pain Scale			
Pain Score, Inpatient			
<b>dihydroergotamine</b> 0.5 mg, Soln, IV Piggyback, Once, STAT, Stop: 06/27/13 10:05:00, Infuse over: 60 minute(s), DHE 0.5mg in NS 100 mL IV Set	STAT		
dihydroergotamine			

In the example above, under the Therapeutic View Class Group of **anti-infectives**, the sub group of **sulfonamides** has been selected and is brought into view on the MAR. To switch back to the default view, simply click on **Time View** on the MAR.

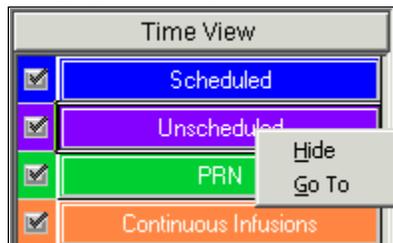
## MAR Sections

The MAR window includes two sections; the Navigator section and the Medication Section.



### Navigator Section

In the Navigator, the medications that are displayed can be controlled by selecting or deselecting the check box next to the medication type (Scheduled, Unscheduled, PRN, Continuous Infusion, etc.) or right-clicking a medication type and selecting Hide or Show. Clicking on a medication type will bring that category to the top of the list if that category is active for the selected patient.



**Scheduled:** Medications scheduled to be given at certain times and/or frequencies

**Unscheduled:** Medications to be given in conjunction with some other event such as “with diaper change” or “with meals”

**PRN:** Medications given as needed

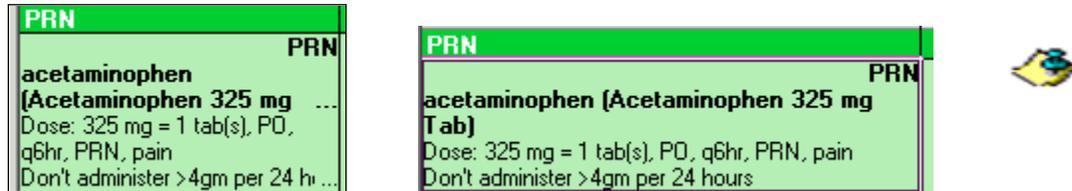
**Continuous Infusions:** Infusions that are given on a continuous basis. IV drips are included in this section.

### Medication Section

The Medications section displays all medications for the patient for the selected filter and time frame. Use the scroll bar to locate medications if necessary. Adjust the dates by clicking on the arrows.



The medication's name, order details, and order comments (if any) are displayed. If an order consists of multiple ingredients, each ingredient and its ordered dose are displayed on a separate line. If any of these lines is too long to fit the space, an ellipsis (...) is displayed. Drag the column line to the right of the Medications column heading name to enlarge the space to show the additional information.



Various icons may be displayed directly above the medication name. For example, this icon indicates that there is a pharmacy comment attached to the order.

Please refer to Appendix A at the back of this manual for a detailed description of icons in use at CHKDHS.

Administration dates and times appear to the right on the same row as the order detail. It is on this row, under the appropriate administration date and time, that charting is performed.

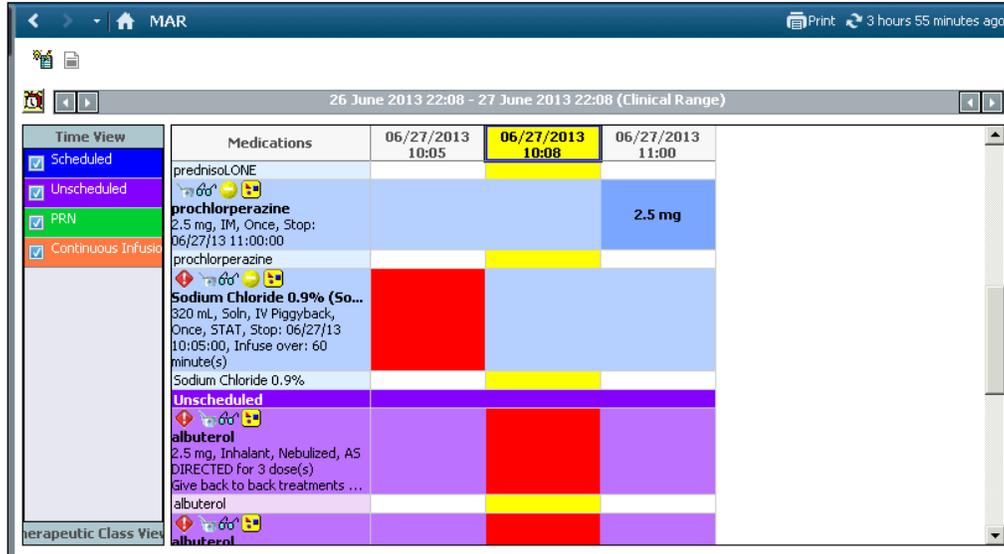
Medications	06/27/2013 10:05	06/27/2013 10:08	06/27/2013 11:00
<b>Scheduled</b>			
acetaminophen 160 mg, Liquid, By mouth, Once, STAT, Stop: 06/27/13 10:05:00	STAT		
acetaminophen Pain Scale, Inpatient			
<b>dihydroergotamine</b> 0.5 mg, Soln, IV Piggyback, Once, STAT, Stop: 06/27/13 10:05:00, Infuse over: 60 minute(s), DHE 0.5mg in NS 100 mL IV Set	STAT		
dihydroergotamine			

**Important Notes**

- The date and time column highlighted in yellow is the current date and time.
- Be sure to click the Refresh button to view the most current and up to date information.

### Overdue Medications

Overdue medication tasks within the set timeframe are displayed with a red background. Click on the alarm clock icon next to the filter window to display overdue medication tasks outside the specified time range. Medications become past due 60 minutes past their due time. For example, if a medication is due at 8:00 it will become overdue at 9:00. STAT meds are also displayed with a red background with STAT in the cell.

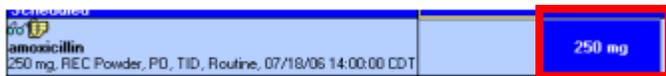


### Discontinued Medications

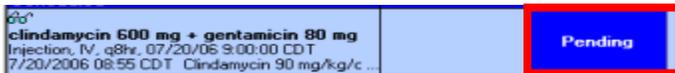
Discontinued meds will display grayed out in their category for 48 hours at which time they will drop off the MAR.

### Scheduled Medications

Scheduled medication tasks are displayed in the appropriate time cell on a blue background. The ordered dose displays in the cell.



Multi-ingredient medications will display as Pending instead of the dose.



For an uncharted task for a new medication, the system displays the notation "Not given within 7 days."



**PRN Medications**

PRN medication tasks are displayed in a separate section of the MAR, under the heading PRN. PRN medications display with a green background. The notation PRN is displayed in the upper right corner of the order.

<b>PRN</b>		
<b>diphenhydrAMINE (DiphenhydrAMINE 12.5 mg/ 5 mL UD Liq)</b>	<b>PRN 12.5</b>	<b>12.5 mg</b> Not previously given
12.5 mg, 5 mL, Liquid, PO, BID, PRN, pruritus, 07/27/10 8:05:00, PI-POD A		
<b>diphenhydrAMINE</b>		

For a charted PRN task, the system displays in the MAR the last date and time a dose was administered. When a PRN medication is charted as administered, the system generates another task for the current time.

If the medication or other task charted has been set up to require the clinician to chart a response to the intervention at a certain interval afterwards, the PRN response task is displayed in the appropriate time cell. For example, if a response should be charted 30 minutes after the administration of a pain medication, the system would display a PRN response task 30 minutes after the time the medication was administered. This PRN response task is displayed on the MAR.

Medications	03/06/2011 11:21	03/06/2011 11:27	03/06/2011 12:00	03/06/2011 12:21	03/06/2011 13:00	03/06/2011 13:01
<b>PRN</b>						
<b>acetaminophen (Acetaminophen 325 mg Tab)</b>		<b>325 mg</b> Last given: 03/06/2011 11:21		<b>KD Med Respon</b>		
Dose: 325 mg = 1 tab(s), PO, q6hr, PRN, pain Don't administer >4gm per 24 hours						

In this example, the administration of Tylenol has triggered a PRN Response task for 60 minutes later. At the designated time, the clinician will click on the PRN Response task and complete the form that is associated with the PRN response task, in this example, the Pain Follow Up form needs to be completed. If the KD Med Response task is not completed within a designated amount of time, it will become overdue and turn red on the MAR.

**Intervention Info:**  
**acetaminophen**  
 Performed by INPATIENT, NURSE 1 on 03/06/2011 11:21  
**acetaminophen,325mg**  
 PO,pain

---

**Pain Follow Up**

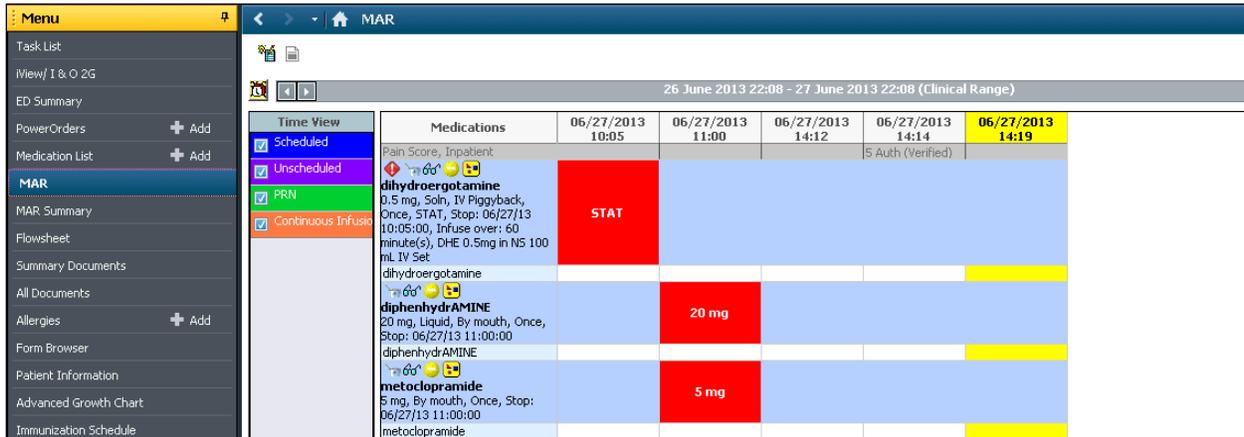
<b>Pain Quality</b> <input type="checkbox"/> Aching <input type="checkbox"/> Burning <input type="checkbox"/> Cramping <input type="checkbox"/> Dull <input type="checkbox"/> Heaviness <input type="checkbox"/> Pressure <input type="checkbox"/> Radiating <input type="checkbox"/> Sharp <input type="checkbox"/> Tightness <input type="checkbox"/> Unable to describe <input type="checkbox"/> Other:	<b>Pain Scale</b> <input type="radio"/> FACES <input type="radio"/> FLACC <input type="radio"/> NRS <input type="radio"/> Numeric (0-10) <input type="radio"/> Oucher <input type="checkbox"/> Not given for pain	<b>Pain Score</b> <input style="width: 50px;" type="text"/>	<b>Patient Response</b> <input type="checkbox"/> Symptom(s) completely relieved <input type="checkbox"/> Symptom(s) improved <input type="checkbox"/> No improvement/change <input type="checkbox"/> Symptom(s) worsened <input type="checkbox"/> Other:	<b>Actions</b> <input type="radio"/> No further care <input type="radio"/> MD/Provider <input type="radio"/> Additional nursing <input type="radio"/> Other:
<b>Provider Notified</b> <input style="width: 100%;" type="text"/>		<b>Notification Comment</b> <input style="width: 100%; height: 40px;" type="text"/>		



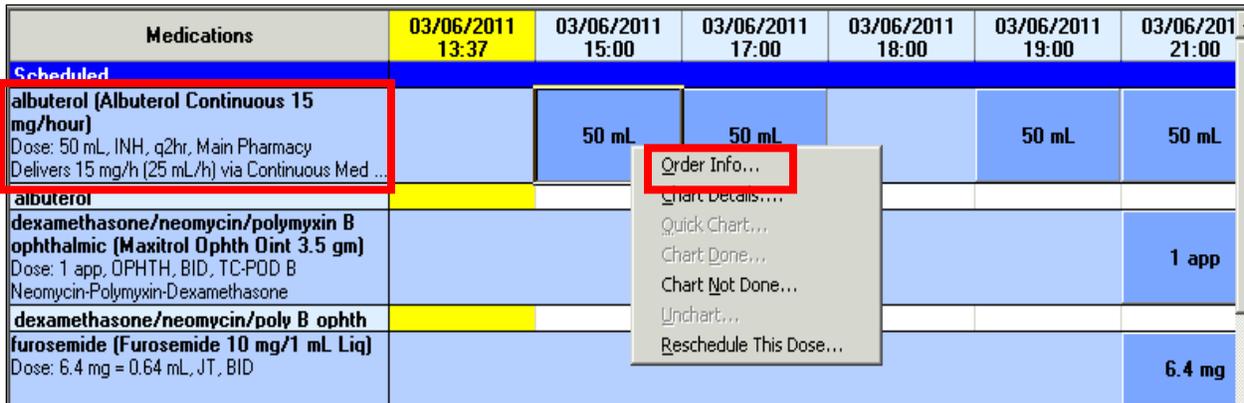
# Charting Activities in the eMAR

## Components of the Medication Charting Window

To chart a medication task, open the patient's chart and select the MAR chart tab.



Click the pending task, or right click and select Chart Details to open the charting window.



Depending on the type of task, the components of the medication charting window will vary. All required sections will be highlighted in yellow.

If a medication is given for pain, indicate the pain scale used and the pain score. If the medication can be given for pain but was given for another reason (EX: inflammation) select "not given for pain" as the Pain Scale indicator.

Complete the fields with the appropriate information and click the green check mark in the upper left hand corner of the window to chart the information.

To clear your entries, click the blue circle with a line through it.



**acetaminophen (Acetaminophen 325 mg Tab)**  
Dose: 325 mg = 1 tab(s), PO, q6hr, PRN, pain  
Don't administer >4gm per 24 hours

\*Performed date / time: 03/06/2011 1416  
\*Performed by: INPATIENT, NURSE 1  
Witnessed by: [ ]

Last Documented Administration: 03/06/2011 11:21 EST by INPATIENT, NURSE 1

Pain Scale: Numeric (0-10) [Trend](#)  
Pain Score, Inpatient: 5 [Trend](#)

\*acetaminophen 325 mg Volume: 0 ml  
Diluent: <none> ml  
\*Route: PO Site: [ ]  
Reason: pain  
Total Volume: 0 Infused Over: 0

03/06/2011	03/06/2011	03/06/2011	03/06/2011	03/06/2011	03/06/2011
1300	1400	1500	1600	1700	03

Not Given  
Reason: [ ]

Performing Information - Use this box to confirm the clinician administering the medication and the date/time that it was done.

## Medications that Require a Witness

A witness to a medication administration can be captured in the performing information section if the order has been defined to require a second signature, which is determined by policy. Enter the witnesses name in the “**Witnessed by**” field or click the binoculars to perform a search.

The screenshot shows a software window titled "morphine: ZZTest, Betty U". Inside, there is a medication order for "morphine" with details: "1.6 mg, Syringe, IV Push, Once, STAT, Stop: 07/08/13 10:32:00, >50 kg, Max 5mg". A "Verify user" dialog box is overlaid on top, featuring the Cerner logo and a background of binary code. The dialog box contains the following fields and buttons:

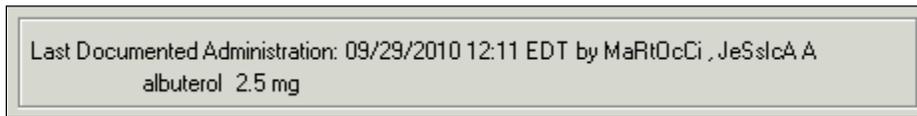
- User Name: TESTRNF
- Password: (empty field)
- Domain: MOCK
- Buttons: OK, Cancel

Below the dialog box, the main form shows a "Pain Score, In" section and a "\*morphine:" section with fields for "Diluent", "\*Route", and "Total Volume". There are also date and time pickers for "07/08/2013 0900" and "07/08/2013 1400". At the bottom, there is a "Not Given" checkbox, a "Reason" dropdown menu, and a "Comment..." button.

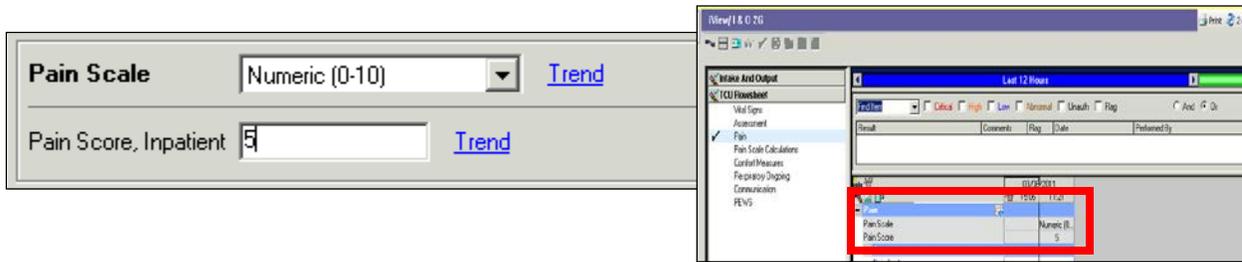
When the witnesses name is entered, click the green check mark to sign. The witness will then be verified by entering their User Name and Password. Click OK to complete charting the medication administration.

Note: It is important to make your eKiDs password and Network password the same for those users accessing PowerChart via Zero Clients.

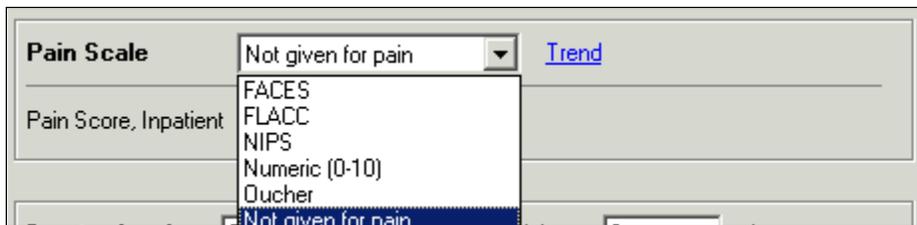
Last Documented Administration - This box is only available on PRN medications and will display the last documented administration of that order.



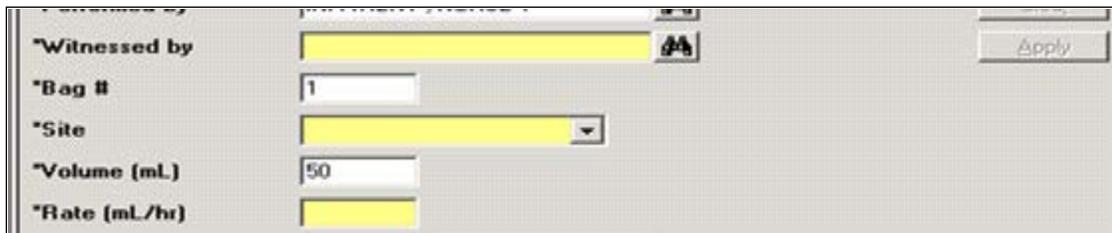
For medications typically given for pain, a Pain Scale is required. This information will flow automatically to the iView Flowsheet.



If given for fever or something other than pain, select... Not given for pain.



Depending on the order, additional information may be required. Any mandatory information will be highlighted in yellow.



**Considerations**

- Some information may default into the medication charting window. Be sure to review the information for accuracy and edit as needed.
- Hospital policy **must be** followed for documenting a witness.
- There is a link to Nursing Policies on the PowerChart toolbar.



## iView/I&O 2G

Any fluid intake given with medication administration will flow to and be recorded in iView I&O. The amount recorded will display in the MAR with the date and time administered.

\*morphine PCA 30 mg Volume: 30 ml  
 Diluent: <none> ml  
 \*Route: IV \*Site: Left Upper Arm  
 Total Volume: 30 Infused Over: 0

03/06/2011 1300	03/06/2011 1400	03/06/2011 1500	03/06/2011 1600	03/06/2011 1700
	30			

It will also automatically display in the I&O section in iView.

05 March 2011 6:00 - 08 March 2011 5:59  
 Today's Intake: 30 Output: 0 Balance: 30 Yesterday's Intake: Output: Balance:

	03/06/2011						
	14:00 - 14:59	13:00 - 13:59	12:00 - 12:59	11:00 - 11:59	10:00 - 10:59	9:00 - 9:59	8:00 - 8:59
<b>- Intake Total</b>	30						
<b>- Continuous Infusions</b>							
D5W-1/2NS w/KCl 20 mEq in 1000 mL 1,000 mL							
D5W-1/3NS w/KCl 20 mEq in 1000 mL 1,000 mL							
<b>- Medications</b>	30						
morphine PCA mL	30						
<b>- Ural</b>							
Oral Intake Type							
Oral Intake mL							
Oral Intake Time minute(s)							

## Immunization Documentation in the eMAR

At times immunizations may be ordered for your patient.

In this example a Hepatitis B Pediatric vaccine was ordered and administered, and should be documented in the eMAR.

As usual, begin documentation by clicking on the task or right clicking and selecting Chart Details to open the charting window. Review the defaulted information for accuracy and complete the required yellow fields.

The information regarding the vaccine, Manufacturer, Lot Number and Expiration Date will be on the label of the vaccine. Enter this information in the designated fields and sign to complete.

The screenshot shows a software window titled "measles/mumps/rubella virus vaccine: ZZTest, Ben". The form contains the following fields and sections:

- Vaccine Information:** measles/mumps/rubella virus vaccine (MMR Vaccine), 0.5 mL, subq, Once, Stop: 07/03/13 9:21:00
- \*Performed date / time:** 07/03/2013 1014
- \*Performed by:** Test, RN
- \*Manufacturer:** (Yellow field)
- \*Lot Number:** (Yellow field)
- \*Expiration Date:** (Yellow field)
- \*Vaccines For Children:** (Yellow field)
- Vaccine Information Statements:**
  - \*Given:** 07/03/2013
  - \*Statements:** Measles, Mumps, Rubella (English)
  - \*Published:** 04/20/2012
- \*measles/mumps/rubella virus vaccine:** 0.5 mL, Volume: ml
- \*Route:** Subcutaneous
- \*Site:** (Yellow field)
- Total Volume:** 0.5, **Infused Over:** 0
- Timeline:** A grid showing dates and times from 07/03/2013 0900 to 1400.
- Not Given:**  Not Given
- Exception:** (Dropdown menu)
- Exception Reason:** (Dropdown menu)
- Comment...** (Text input field)

In the Vaccine Information Sheet **Given On** date, enter the date the patient's parent/guardian was given the information sheet regarding the Vaccine. If a vaccine was given that contains multiple components click the blue cross to open additional fields to document the date the VIS was given for those components.

## Charting Additional Data Elements

Some medications require the charting of additional data elements that will display in the charting window. While these elements may not be required by the system to complete charting, they may be required by hospital policy.

**acetaminophen (Tylenol)**  
160 mg, Liquid, By mouth, Once, Stop: 07/08/13 11:00:00

\*Performed date / time : 07/08/2013 1047  
\*Performed by : TestUser RN, EDNurse  
Witnessed by :

**Pain Scale:** [Dropdown] [Trend](#)

Pain Score, Inpatient: [Text] [Trend](#)

\*acetaminophen: 160 mg Volume : 0 ml  
Diluent : <none> ml  
\*Route : By mouth Site : [Dropdown]  
Total Volume : 0 Infused Over : 0 [Dropdown]

07/08/2013 0900	07/08/2013 1000	07/08/2013 1100	07/08/2013 1200	07/08/2013 1300	07/08/2013 1400
[Chart Area]					

Not Given  
Reason : [Dropdown]  
Comment...

Be sure to consult hospital policy to make sure all required data elements are completed prior to signing in accordance with hospital policy.

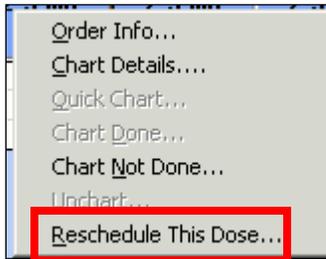
## Rescheduling a Single Medication Dose

---

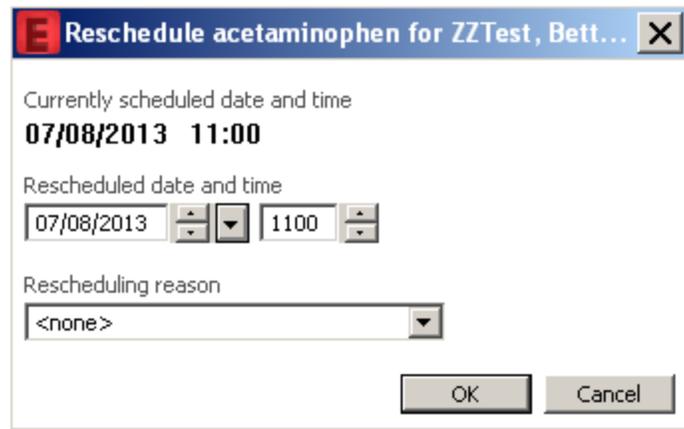
In the event that a single dose of medication cannot be given at the scheduled time, it can be rescheduled. For example, if a patient's medication is due, but they are in radiology at that time, that dose of medication can be rescheduled from the MAR.

### Steps to Reschedule a Medication Dose

1. From the MAR right click on the medication task.
2. Select *Reschedule This Dose* from the drop down menu.



3. Enter the new date and time in the Reschedule window.
4. Enter the Rescheduling Reason, per policy
5. Click OK



### Considerations

- Medications cannot be rescheduled in the past.
- Before rescheduling any medications, check to make sure it is appropriate to do so.
- Always follow polices for rescheduling meds

### Rescheduling Admin Times

---

Rescheduling the Administration times of a medication will reschedule all doses from that point forward. This will **only be done by pharmacy**. However, nursing can stagger doses by individually rescheduling all available doses on the MAR.

## Message Sender

One way to request another dose from the pharmacy is through the Message Sender button on the toolbar. Click the Message Sender button on the toolbar to open a Pharmacy Request Form. Highlight Med Request Form under Templates to default patient information and then click on Pharmacy for the destination.

Templates:	Destinations:
Med Request Form	Pyxis Connect

Message:

**Pharmacy Request Form**

Patient: ZZTest, Betty U  
MRN: 1164  
FIN: 75167  
Loc: CHKD-ED ,  
Request: Need an additional dose of...

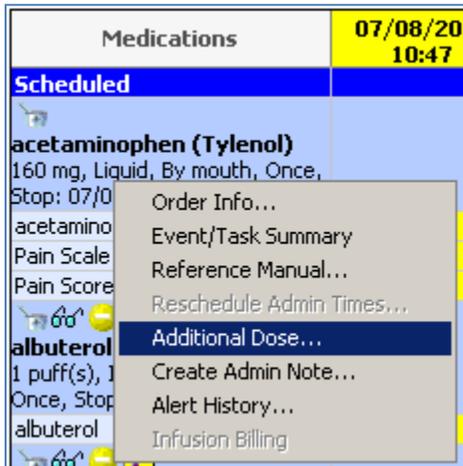
Send Cancel

Enter the request and medication that your are requesting then click the Send button. A requisition will print in the pharmacy.

## Administering Additional Medication Doses

When it is appropriate for the patient, an additional dose of medication can be administered and documented in the eMAR. For example, the patient needs an additional dose of a scheduled medication, the physician has written a new order and you have scanned it to the Pharmacy and then received the new medication. Selecting Additional Dose will generate an additional **task** on the eMAR for you to document the medication administration for this dose.

1. From the MAR right click the medication details.
2. Select *Additional Dose* from the dropdown menu.



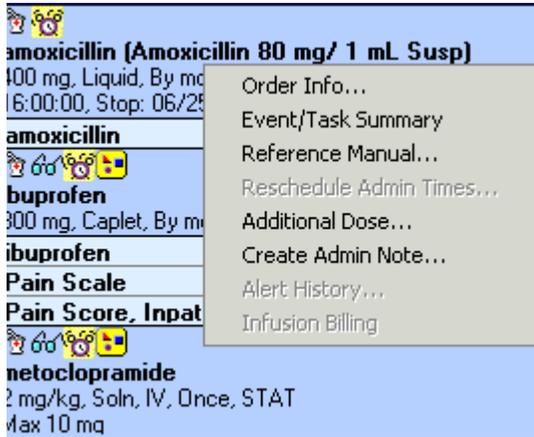
3. Complete the fields in the medication administration screen.

4. Chart the medication .

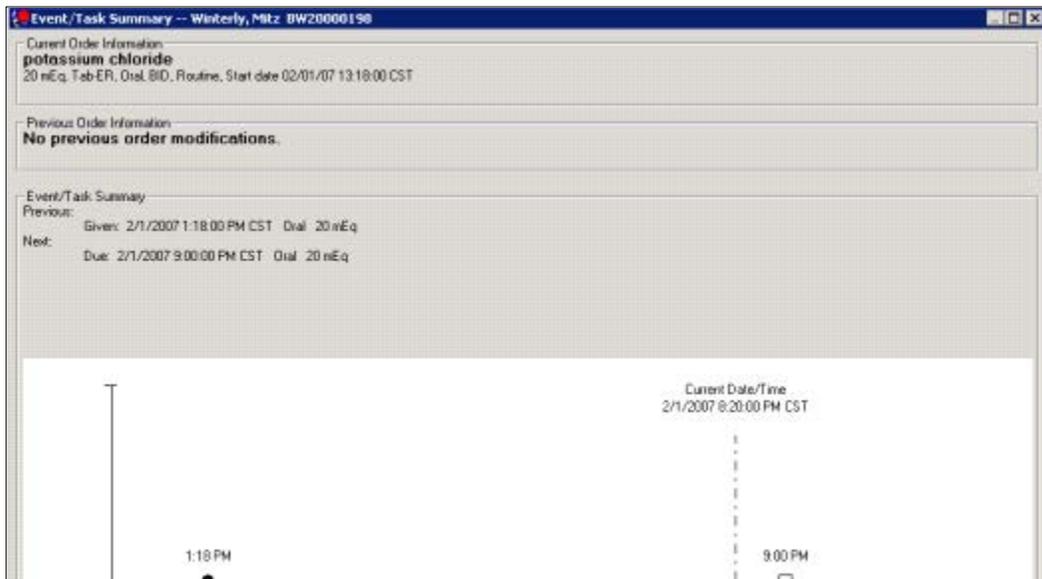
## Viewing Event/Task Summary

### Steps to view a summary of medication events:

1. Right click on the medication and select Event/Task Summary from the dropdown menu.



The Event/Task Summary screen for that medication appears.



## Modifying a Charted Task

Sometimes it may be necessary to modify a charted task.

### Steps to modify a charted task:

1. From the MAR, right click the result to modify and select Modify from the drop down menu.

Dose: 0.5 mg = 2.5 mL, INH, q6hr									
<b>ipratropium</b>									0.5 mg
<b>multivitamin (Multivitamin Drops UD 1 mL)</b>									
Dose: 1 mL, PO, Daily, TC-POD B Mix patient's dose in 3-5ml of breast milk or formu...									
<b>multivitamin</b>									
<b>omeprazole (Omeprazole 2 mg/ 1 mL Susp)</b>									
Dose: 6 mg = 3 mL, PO, BID									

View Details...  
 View Comments...  
 View Order Info...  
 Add Comment...  
**Modify...**  
 Unchart...

2. Enter the modifications on the charting form.

**ipratropium (Ipratropium 0.5 mg/2.5 mL Inh)**  
 Dose: 0.5 mg = 2.5 mL, INH

\*Performed date / time: 03/06/2011 1337  
 \*Performed by: INPATIENT, NURSE 1  
 Witnessed by:

\*ipratropium: 0.5 mg Volume: 2 ml  
 Diluent: <none> ml  
 \*Route: INH Site:

Total Volume: 2 Infused Over: 0

←	03/06/2011 1200	03/06/2011 1300	03/06/2011 1400	03/06/2011 1500	03/06/2011 1600	03
---	--------------------	--------------------	--------------------	--------------------	--------------------	----

Not Given  
 Reason:

3. Click the Sign Form icon  on the toolbar.
4. Enter a comment regarding the modification by clicking the comment button.

### Considerations

- Any date and time changes made will apply to all elements of the charting form.
- Modified results are preceded by a "c" (c) 250 mg Modified
- Some modifications may also trigger a new KD Med Response form.

## Uncharting a Medication Task

Sometimes it may be necessary to unchart a medication task that was charted in error.

### Steps to unchart a charted task:

1. From the MAR right click the result in the appropriate date and time box for the medication
2. Select *Unchart* from the dropdown menu

<b>furosemide</b>			
 <b>ipratropium (Ipratropium 0.5 mg/2.5 mL Inh)</b> Dose: 0.5 mg = 2.5 mL, INH, q6hr			
<b>ipratropium</b>	0.5 mg Auth Iv		
<b>multivitamin (Multivitamin Drops UD 1 mL)</b> Dose: 1 mL, PO, Daily, TC-POD B Mix patient's dose in 3-5ml of breast milk or formu ...			
<b>multivitamin</b>			
<b>omeprazole (Omeprazole 2 mg/ 1 mL Susp)</b> Dose: 6 mg = 3 mL, PO, BID Shake well.			

View Details...

View Comments...

View Order Info...

Add Comment...

Modify...

**Unchart...**

3. Enter a comment in the comment field, EID (error in documentation)






**\*Performed on:** 03/30/2011 1743 **By: INPATIENT , NURSE 1**


**Uncharting this form will change the status of all the results associated with this form to 'In Error'**

Comment:

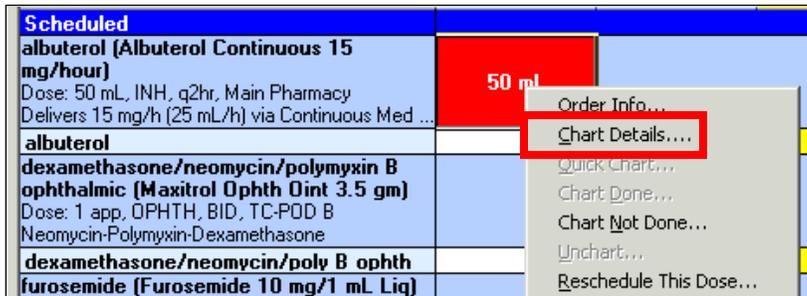
4. Click the sign form  icon on the toolbar.
5. The status of the result and all other results associated with this form are changed to  and the task is returned to a pending status.

## Charting a Medication Task as Not Given

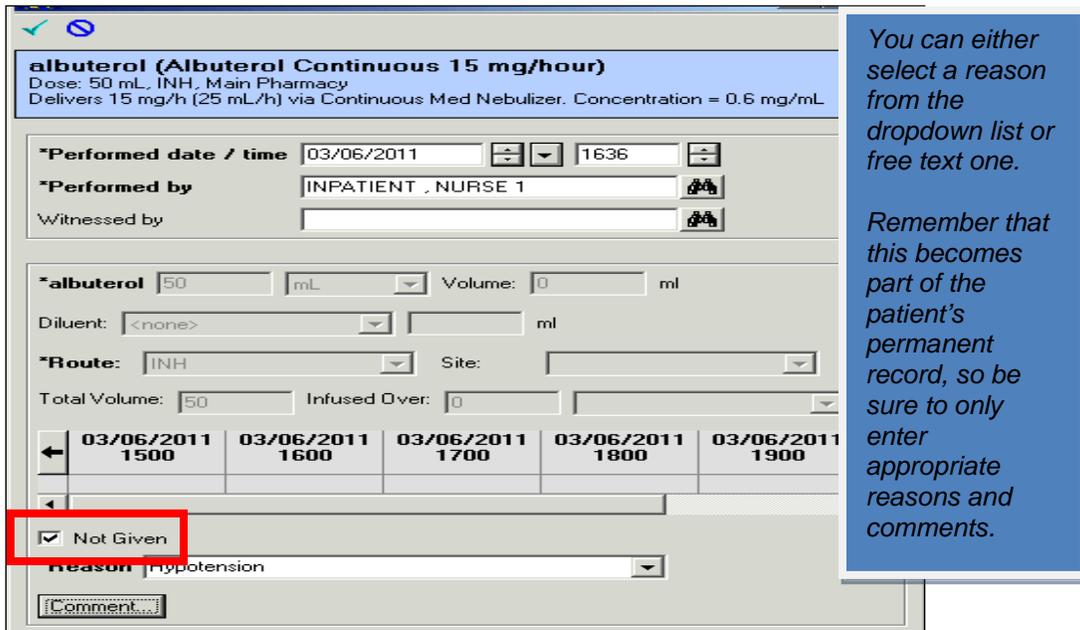
At times it may be necessary to chart a medication task as not given. For example, if it is necessary to document vital signs prior to administering a medication and the vital signs indicate the medication should not be given, the task should be documented as *Not Given*.

### Steps to chart a medication task as Not Given:

1. From the MAR, right click Pending task in the appropriate date and time box for the medication.
2. Double click on the task OR Select *Chart Details* from the dropdown menu.



3. From the charting window, select Not Given and enter a reason from the dropdown menu.



4. Additional comments can be entered by clicking on the Comment button.
5. Click on the Sign Form  icon on the toolbar.
6. Not Given  is displayed in the appropriate date and time box for the medication.

### Tip and Tricks

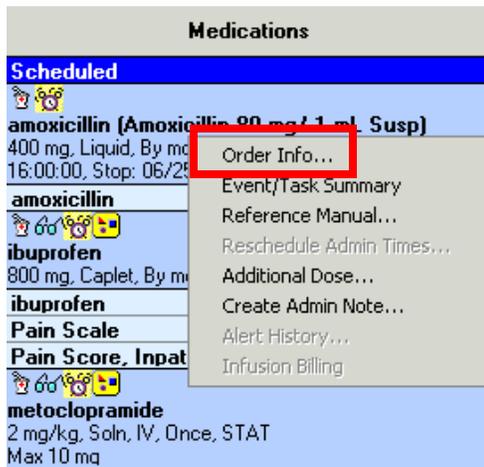
- If the date and time box for the medication does not show “Not Given”, click the  Refresh button to update the system to the most current information.
- If a parent or caretaker gives the meds, document as normal and indicate “parent/caretaker gave meds” in a comment.
- **Chart Not Done** is not used at CHKD at this time and should **never** be selected.

## Viewing Order Details in the MAR

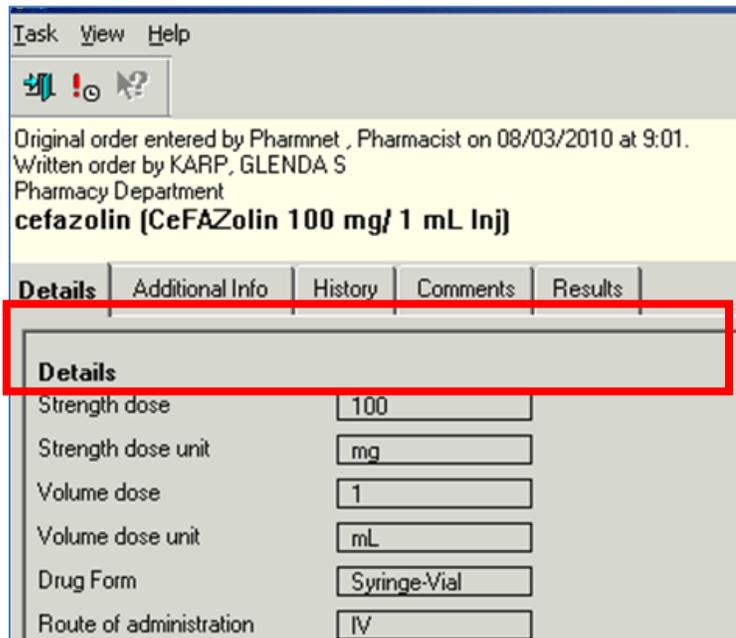
Order details are easily accessible from the MAR.

### Steps to view order details from the MAR:

1. From the MAR, right click on the Order Details box and select *Order Info* from the dropdown menu.



2. Click the appropriate tab from the Order Information window to display the desired information.



3. Close the Order Information window by clicking the X in the upper right hand corner or the Exit icon on the toolbar.

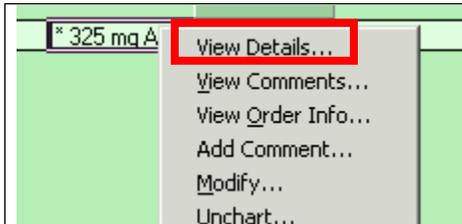


## Viewing Admin Details in the MAR

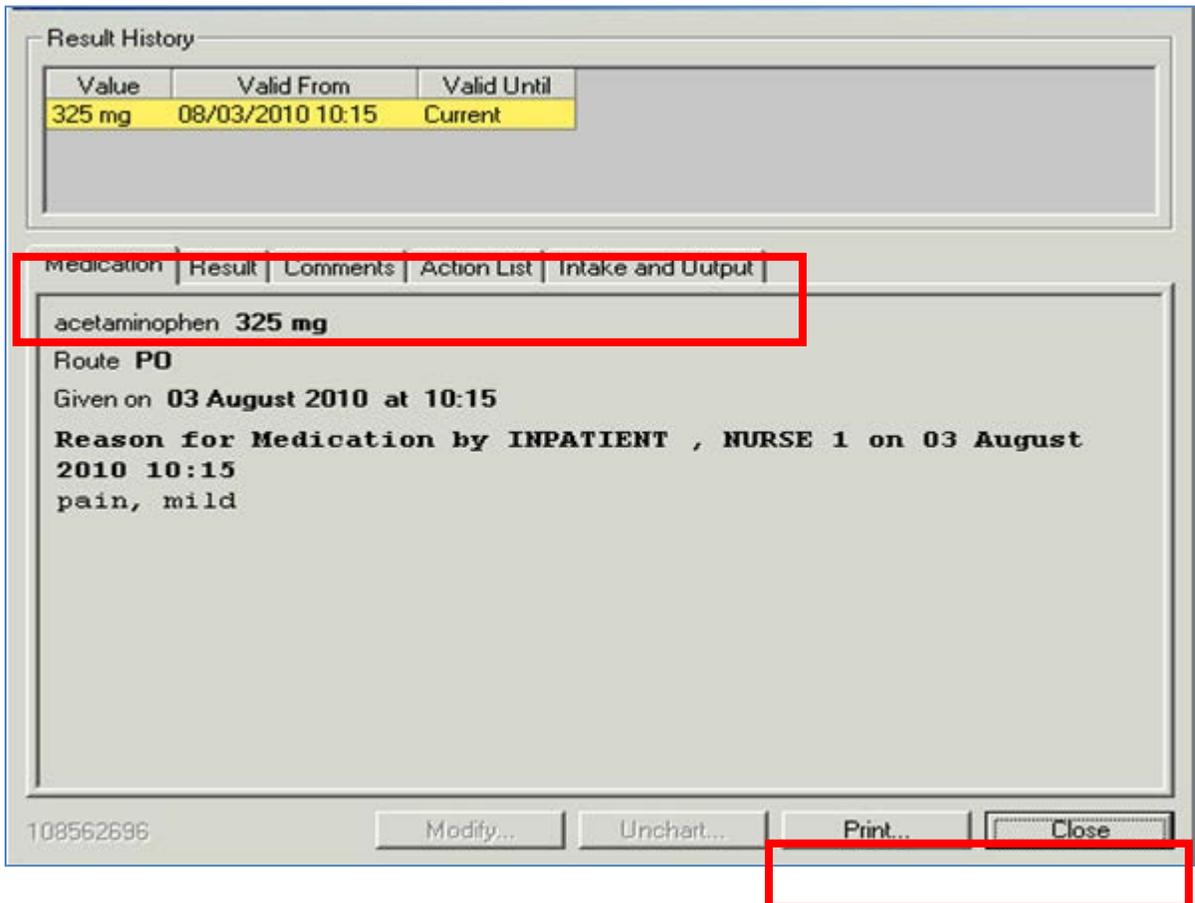
Medication Administration details are easily accessible from the MAR.

### Steps to view Administration Details from the MAR:

1. From the MAR right click the box that contains the Medication Administration results.
2. Select *View Details* from the dropdown menu.



3. Select the appropriate tab(s) to access the desired information.



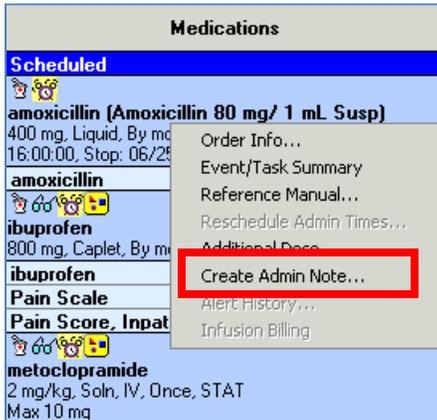
4. To print the result details click the Print button.
5. Click the Close button or the X in the upper right hand corner to close the Result Details window and return to the MAR.

## Creating an Admin Note

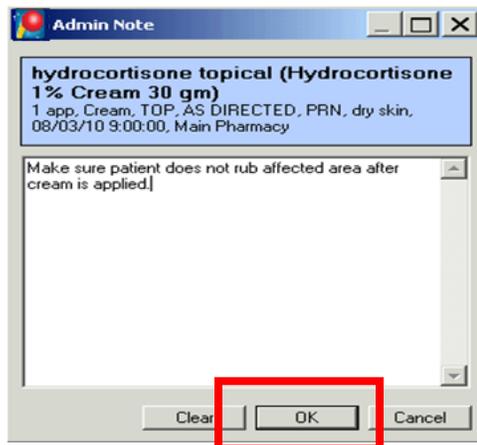
For nurse to nurse communications an administrative note can be created and associated with a medication, for example, “patient likes to take medication with applesauce”.

### Steps to Create an Administrative Note:

1. From the MAR, right click the name of the medication the admin note will be associated with.
2. Select Create Admin Note from the dropdown menu



3. Enter the note in the Admin Note form.



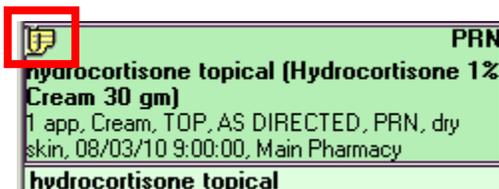
*Only one Admin Note icon will display on the MAR, but multiple entries can be made on the same note.*

*Admin notes become part of the patient's permanent record, so be sure to only enter appropriate information!*

4. Click OK to save the note and return to the MAR.

### Tip and Tricks

When an admin note is created, an icon depicted by a yellow piece of paper is displayed on the MAR above the medication name. Click on the icon to open the note.



*To clear one entry, highlight the text and hit the Delete key.*

*To clear the entire contents of the Admin note, click the Clear key.*

## Viewing the Reference Manual from the MAR

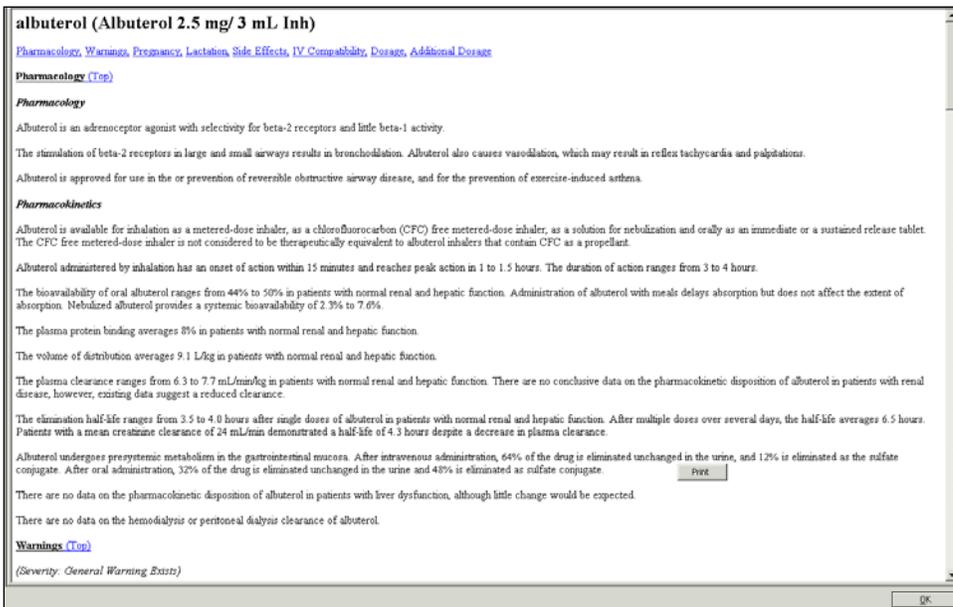
Reference Manual materials can be accessed and viewed from the MAR.

### Steps to view Reference Manual Materials from the MAR:

1. From the MAR, right click on the medication for which you want Reference Manual materials.
2. Select *Reference Manual* from the dropdown menu.



3. Any Reference Manual materials available will display.



To print the materials, right click and select Print.

## Considerations

While these reference materials are available for the user's information, CHKD will continue to use the reference materials and patient education materials that are currently being used.

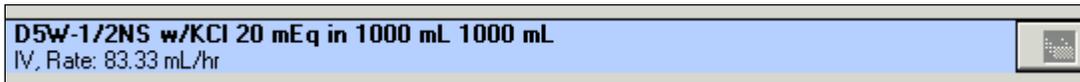
# Charting Continuous Infusions

## Components of the IV Charting Form

The components of the IV charting form consist of the following:

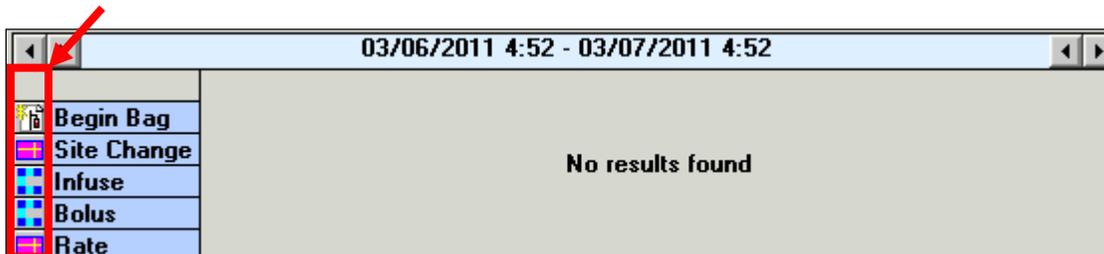
### Order Details Displays

- Any icons associated with the order
- The name of the IV fluid and any additives (**these are in bold face type**)
- IV order details
- Any order comments



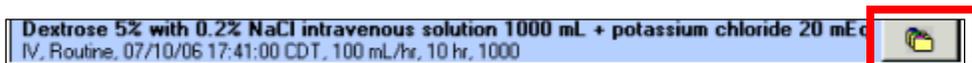
### IV History Displays

- IV events for the given date range
- IV results for the given date range
- Charting event icons (click to chart the event)



### Order History

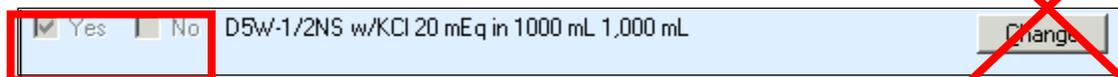
- Displays the versions of the order that is being charted on
- If an order has been modified, the user can select the version to be charted on by clicking the  icon.



### Order Ingredients **NO CHANGES ALLOWED HERE.**



- Displays the IV name and ingredients, if any
- The Yes and No checkboxes indicate whether the ingredients are used in the bag being charted



### IV Detail

- Displays the required information for charting the event
- Details of this section vary depending on the IV event

The screenshot shows a form titled "IV Detail" with the following fields and controls:

- \*Infuse volume (mL): A text input field with a yellow background.
- Bolus: A checkbox.
- \*From: A date and time selector showing 02/23/2011 0859.
- \*To: A date and time selector showing 03/06/2011 1652.
- Infused Over: A text field showing 271 Hours 53 Minutes.
- \*Performed by: A dropdown menu showing INPATIENT , NURSE 1 and a Sign Form icon.
- \*Bag #: A text input field showing 2.
- \*Site: A dropdown menu showing CVL, Subclavian, L, Brown.
- Buttons: Comment..., Clear, and Apply.
- Infuse: A button in the bottom right corner.

### Considerations

1. Click the Clear button to clear information on an uncharted event.
2. Multiple events can be charted in one session by clicking the **Apply** button and clicking the Sign Form icon when charting is complete.
3. Continuous Infusion events flow to iView I&O

### Adding a Comment

4. To add a comment, click the Comment button.
5. If more than one comment is made, comments will be listed in chronological order.
6. More than one clinician can add a comment.
7. Double click inside a comment box to modify.

Once a comment has been added to an event, one of three icons is displayed to the right of the date/time.

	A pushpin indicates that a comment exists for this event.
	A piece of paper with a red X indicates that the event has been modified.
	A piece of paper with a red X and a pushpin indicates that the event has been modified and has a comment.

### Floating Tasks

When a continuous infusion administration event is documented, another task is automatically created for the current time.

## IV Charting Options

### Charting Begin Bag Events

#### Steps to chart a Begin Bag Event:

1. Access the IV task
2. Double click the pending task or right click and select Chart Details to open the charting window.
3. Select Begin Bag from the IV history section (this will default if the bag has not been previously charted)
4. The charting form for the event is displayed.
5. For each new fluid bag, you must chart a **Begin Bag** event.

**E Dextrose 5% - NaCl 0.45% 1,000 mL: ZZTest, Betty U**

✓ | [No] | [Calendar]

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

07/07/2013 23:08 EDT - 07/08/2013 23:08 EDT

**Begin Bag**  
Site Change  
Infuse  
Bolus  
Rate Change

**No results found**

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

Yes  No D5W 1/2NS 1,000 mL

\*Performed date / time: 07/08/2013 11:09  
\*Performed by: TestUser RN, EDNurse  
Witnessed by:  
\*Bag #: 3  
\*Site: PIV, AC, L  
\*Volume (mL): 1000  
\*Rate (mL/hr): 250

~~Comments~~  
Clear  
Apply

**Begin Bag**

In Progress

**Complete the IV detail section:**

1. **erformed Date/Time:** The current date and time defaults. Modify if needed.
2. **Performed By:** Defaults the name of the logged in user. Search for another user by clicking on the binoculars.
3. **Bag #:** Enter the Bag# that is being started.
4. **Site:** Select the IV insertion site from the list.
5. **Volume (mL):** The volume entered on the order is defaulted by the system. If infusing a different amount, enter it here.
6. **Rate (mL/hr):** The rate is defaulted by the system to the rate entered on the order.
7. **Comment:** Click the comment button to open the dialog box. Enter a comment and click OK. If a comment is entered, an asterisk is displayed next to the IV event.

\*Performed date / time : 07/08/2013 1109

\*Performed by : TestUser RN, EDNurse

Witnessed by :

\*Bag # : 3

\*Site : PIV, AC, L

\*Volume (mL) : 1000

\*Rate (mL/hr) : 250

Comment...  
Clear  
Apply

Begin Bag

6. Click *Apply* to save entries. The results are now displayed on the appropriate line in the date and time column for which the IV event was charted.
7. Click the check mark on the toolbar to sign the new or modified results and return to the MAR.
8. To return to the initial window without saving changes, click the *Clear* button.

## Charting Infuse or Bolus IV

### Steps to chart an Infuse or Bolus IV Event:

1. Access the IV task.
2. Double click the Pending task or right click and select Chart Details to open the charting window.
3. Select Infuse or Bolus from the IV history section.
4. The charting form for the event is displayed.

The screenshot shows a software window titled "Dextrose 5% - NaCl 0.45% 1,000 mL: ZZTest, Betty U". The window contains a task list on the left with options: Begin Bag, Site Change, Infuse, Bolus, and Rate Change. The "Infuse" option is selected. The main area displays "D5W 1/2NS 1,000 mL" with "Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr". Below this, there is a section for "D5W 1/2NS 1,000 mL" with a "Yes" checkbox selected. The "Infuse volume (mL)" field is empty, and the "Bolus" checkbox is unchecked. The "From" date is 06/25/2013 and the "To" date is 07/08/2013. The "Performed by" field is "TestUser RN, EDNurse". The "Bag #" is 2 and the "Site" is "PIV, AC, L". The "Infuse" button is highlighted with a red box.

5. If an IV solution that contains ingredients is being initiated, indicate whether the ingredients are included in the bag by selecting the Yes or No check box in the order ingredient section of the form.

6. Complete the IV detail section:

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

Yes  No D5W 1/2NS 1,000 mL

\*Infuse volume (mL):   Bolus Comment...

\*From: 06/25/2013 1127 Clear

\*To: 07/08/2013 1110 Apply

Infused Over : 311 Hours 43 Minutes

\*Performed by : TestUser RN, EDNurse 🔍

\*Bag # : 2

\*Site : PIV, AC, L

**Infuse**

In Progress

**Infuse volume (mL):** Enter the amount being infused/bolused.

8. **From/To Dates/Times:** Modify the defaulted dates and times if needed.  
**Infused Over:** Calculated by the system  
**Performed By:** Defaults the name of the logged in user. Search for another user by clicking on the binoculars.
9. **Bag #:** The # of the bag currently being infused is defaulted.
10. **Site:** Select the IV insertion site from the list.
11. **Comment:** Click the comment button to open the dialog box. Enter a comment and click OK. If a comment is entered, an asterisk is displayed next to the IV event.
12. Click *Apply* to save entries. The results are now are displayed on the appropriate line in the date and time column for which the IV event was charted.
13. Click the check mark on the toolbar to sign the new or modified results and return to the MAR.
14. To return to the initial window without saving changes, click the *Clear* button.

## Considerations

- If an order is placed for a bolus of the same continuous infusion IV fluid, select **Bolus** from the IV Charting Events.
- Continuous infusion events flow to iView I&O.

## Charting Rate Change IV Events

### Steps to chart a Rate Change IV Event:

1. Access the IV task.
2. Double click the Pending task or right click and select Chart Details to open the charting window.
3. Select the Rate Change event.
4. The charting form for the event is displayed at the bottom of the window.

The screenshot shows a software window for an IV task. The title bar reads "Dextrose 5% - NaCl 0.45% 1,000 mL: ZZTest, Betty U". Below the title bar, there are icons for a checkmark, a no icon, and a keyboard icon. The main content area shows a task list on the left with items: "Begin Bag", "Site Change", "Infuse", "Drips", and "Rate Change". The "Rate Change" item is highlighted with a red box. The main area displays "No results found" for the selected event. Below this, there is a form for charting a "Rate Change" event. The form includes a section for "D5W 1/2NS 1,000 mL" with a "Yes" checkbox selected and a "No" checkbox unselected. Below this, there are fields for "\*Performed date / time" (07/08/2013 1116), "\*Performed by" (TestUser RN, EDNurse), "Witnessed by", "\*Bag #" (2), and "\*Rate (mL/hr)" (250). There are buttons for "Comment...", "Clear", and "Apply". The word "Rate Change" is displayed at the bottom right of the form area, and "In Progress" is shown in the bottom right corner of the window.

5. If an IV solution that contains ingredients is being initiated, indicate whether the ingredients are included in the bag by selecting the Yes or No check box in the order ingredient section of the form.

6. Complete the IV detail section:

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

Yes  No D5W 1/2NS 1,000 mL

**\*Performed date / time:** 07/08/2013 1116 Comment...

**\*Performed by:** TestUser RN, EDNurse Clear

Witnessed by: Apply

**\*Bag #:** 2

**\*Rate (mL/hr):** 250

**Rate Change**

In Progress

- **Performed date/time:** Modify the defaulted date and time, if needed.
  - **Performed By:** Defaults the name of the logged in user. Search for another user by clicking on the binoculars.
7. **Bag #:** The # of the bag currently being infused is defaulted.
8. **Rate:** Enter the new rate.
9. **Comment:** Click the comment button to open the dialog box. Enter a comment and click OK. If a comment is entered, an asterisk is displayed next to the IV event.
10. Click *Apply* to save entries. The results are now are displayed on the appropriate line in the date and time column for which the IV event was charted.
11. Click the check mark on the toolbar to sign the new or modified results and return to the MAR.
12. To return to the initial window without saving changes, click the *Clear* button.

**Considerations**

When a continuous infusion IV is DC'd or stopped, change the rate to zero at the appropriate time so the correct amount will flow to I&O.

## Charting Site Change IV Events

### Steps to chart a Site Change IV Event:

Access the IV task.

1. Double click the Pending task or right click and select Chart Details to open the charting window.
2. Select the Site Change event.
3. The charting form for the event is displayed at the bottom of the window.

**E Dextrose 5% - NaCl 0.45% 1,000 mL: ZZTest, Betty U**

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

07/07/2013 23:16 EDT - 07/08/2013 23:16 EDT

Begin Bag  
 **Site Change**  
 Infuse  
 Bolus  
 Rate Change

**No results found**

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

Yes  No D5W 1/2NS 1,000 mL

\*Performed date / time : 07/08/2013 1118

\*Performed by : TestUser RN, EDNurse

\*Bag # : 2

\*Site : PIV, AC, L

**Site Change**

In Progress

4. If an IV solution that contains ingredients is being initiated, indicate whether the ingredients are included in the bag by selecting the Yes or No check box in the order ingredient section of the form.

5. Complete the IV detail section:

**D5W 1/2NS 1,000 mL**  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

Yes  No D5W 1/2NS 1,000 mL

\*Performed date / time : 07/08/2013 1118 Comment...

\*Performed by : TestUser RN, EDNurse Clear

\*Bag # : 2 Apply

\*Site : PIV, AC, L

Site Change

In Progress

- **Performed date/time:** Modify the defaulted date and time, if needed.
  - **Performed By:** Defaults the name of the logged in user. Search for another user by clicking on the binoculars.
6. **Bag #:** The # of the bag currently being infused is defaulted.
  7. **Site:** Enter the new insertion site.
  8. **Comment:** Click the comment button to open the dialog box. Enter a comment and click OK. If a comment is entered, an asterisk is displayed next to the IV event.
  9. Click *Apply* to save entries. The results are now are displayed on the appropriate line in the date and time column for which the IV event was charted.
  10. Click the check mark on the toolbar to sign the new or modified results and return to the MAR.
  11. To return to the initial window without saving changes, click the *Clear* button.

## Modifying IV Events

Sometimes it may be necessary to modify an IV event. Modifications can be done from the MAR.

### Steps to modify an IV Event:

1. From the MAR, right click on the IV event to be modified.
2. Select *Modify* from the dropdown menu.
3. From the charting window, enter the information to be modified.
4. Click Apply.
5. To add a comment, click on the Comment button.
6. Click on the check mark on the tool bar to chart the modified information and return to the MAR.

## Uncharting IV Events

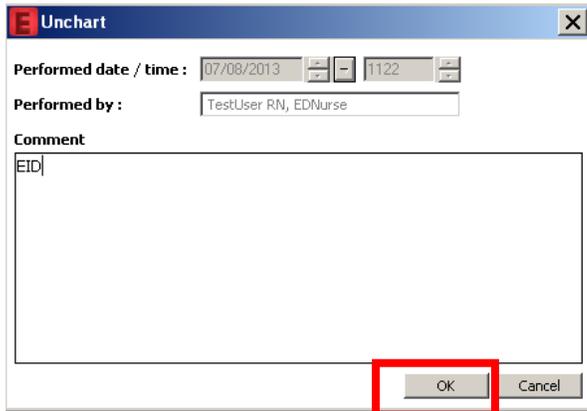
If an IV event is charted in error or if the details are incorrect, it can be uncharted from the MAR.

### Steps to Unchart an IV Event:

1. From the MAR, right click the IV event that was charted in error.
2. Select *Unchart* from the dropdown menu.
3. The charting window will display with the previously entered information.

The screenshot shows a software window titled "Dextrose 5% - NaCl 0.45% 1,000 mL: ZZTest, Betty U". The main content area displays "DSW 1/2NS 1,000 mL" with a sub-note "Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr". Below this is a timeline from 07/07/2013 23:21 EDT to 07/08/2013 23:21 EDT. A list of events includes "Begin Bag" (Bag # 3), "Site Change" (PIV, AC, L), "Infuse", "Bolus", and "Rate Change" (250 mL/hr). The main event details are repeated: "DSW 1/2NS 1,000 mL" and "Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr". There are checkboxes for "Yes" and "No" next to "DSW 1/2NS 1,000 mL". The "Performed date / time" is set to 07/08/2013 11:21. The "Performed by" field contains "TestUser RN, EDNurse". The "Witnessed by" field is empty. Other fields include "Bag #": 3, "Site": PIV, AC, L, "Volume (mL)": 1000, and "Rate (mL/hr)": 250. In the bottom right corner, there are buttons for "Comment", "Unchart..." (highlighted with a red box), and "Apply". At the very bottom, there is a "Begin Bag" button and an "Auth (Verified)" indicator.

4. Click the Unchart button and enter a comment regarding the reason in the comment window and click OK.



5. Click the check mark on the toolbar to sign the modified result and return to the MAR.

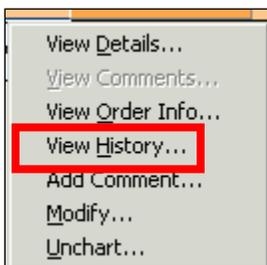
## Viewing History of IV s

---

From the MAR clinicians can view a history of IV s and details regarding the s.

### Steps to View a History of IV s and details:

1. From the MAR right click on the IV event.
2. Click *View History* from the dropdown menu.



3. The charting window displays in a view only mode with charting event details in chronological order.
4. If comments are attached to the event, the Comment button will be available to click on and open the comment.
5. Click the X in the upper right hand corner to close the window and return to the MAR.

## Charting Titratable Drips in eMAR

Titratable IV Drips should always be started in eMAR. Changes can then be charted either in (1) iView in the flowsheet – IV Drips section or in (2) the eMAR.

### Best Practice:

Users have the ability to select where they prefer to document the rate change for IV Drips. However, it is **recommended that the rate change be charted in the IV Drips section of iView for ease of workflow**, unless the user is already in the eMAR when making a rate change.

## Titratable Drips/Dosing Weight

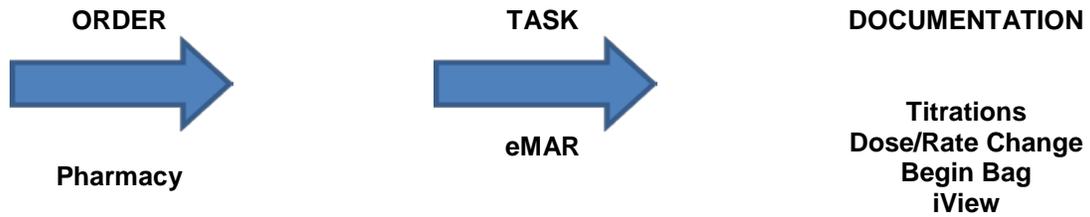
When the physician writes an order for a titratable drip:

- 1) If the physician specifies a certain weight to be used, pharmacy will update the “dosing weight” on the banner bar. This will be the new weight to be used for all drips.
- 2) If the physician does not specify a weight, nursing staff will use the dosing weight that is indicated on the banner bar. They WILL not adjust based on daily weights, etc. (note: if the RN notices a discernable difference they should confer with the MD or Rx). NICU leadership will work to educate staff regarding this practice change.
- 3) Pharmacy staff in the NICU will continue to review weights at least weekly and update the banner bar when appropriate. The NICU pharmacists also state they monitor the weights frequently. If they notice a significant weight change, they will discuss with the physician to determine if the dosing weight on the banner bar needs to be updated sooner.

## Nursing Workflow

1. Pharmacist updates Clinical Weight and enters order in PowerOrders “Review Clinical Weight”.
2. Nurse sees Nurse Review icon (eyeglasses) and New Result icon (clipboard) on PAL.
3. Nurse reviews order.
4. Nurse clicks on New Result icon
  - a. You can see what the Clinical Weight has been changed to.
5. PowerOrders tab (Patient Care section)
6. Task List – this is a done/not done task. Once the task is documented, the order will be completed.
7. This task does not have any info, this is simply a means to let the nurse know that Pharmacy changed the Clinical Weight. The nurse can see the updated Clinical Weight in the Banner Bar, in Results Review, and on the Inpatient Summary MPage.

## eMAR IV Drips Process in eKiDs PowerChart



- a. The order is placed by Pharmacy and displays in PowerOrders

Displayed: All Active Orders | All Active Orders Show More Orders...

\$		Order Name	Status	Start	Details
<b>Diagnostic Tests</b>					
<input checked="" type="checkbox"/>		XR Chest 2 Views PA/L...	Ordered (Exam ...	08/20/2012 16:30	Study Priority = Stat, Call Results To ED Attendin
<input checked="" type="checkbox"/>		XR Chest 1 View Portable	Ordered (Exam ...	08/17/2012 14:56	Study Priority = Stat, Call Results To ED Attendin
<b>Activity</b>					
<input checked="" type="checkbox"/>		Positioning	Ordered	08/17/2012 14:44	Positioning = Elevate Head of Bed, Complete Drc
<b>IV Solutions</b>					
<input checked="" type="checkbox"/>		D5W w/ KCl 20 mEq in ...	Ordered	08/22/2012 10:02	Soln, IV Continuous, Rate: 100 mL/hr, Infuse ovs
<input checked="" type="checkbox"/>		DOPamine 1600 MCG/1...	Ordered	08/22/2012 10:00	1,000 mL, Bag, IV Continuous, AS DIRECTED, F
<input checked="" type="checkbox"/>		D5W-1/2NS w/KCl 20 ...	Ordered	08/22/2012 9:51	Soln, IV Continuous, Rate: 20 mL/hr, Infuse over
<input checked="" type="checkbox"/>		D5W-1/2NS w/KCl 20 ...	Ordered	08/21/2012 8:50	Soln, IV Continuous, Rate: 20 mL/hr, Infuse over
<input checked="" type="checkbox"/>		D5W-1/2NS w/KCl 20 ...	Ordered	08/17/2012 15:32	Soln, IV Continuous, Rate: 1,000 mL/hr, Infuse o
<input checked="" type="checkbox"/>		0.9% Sodium Chloride 1000 mL	Ordered	08/17/2012 14:51	Soln, IV Continuous, Rate: 1,000 mL/hr, Infuse o After NS Bolus complete. Continue NS at mainter
<b>Laboratory</b>					
<input checked="" type="checkbox"/>		CBCA	Ordered (Dispatc...	08/23/2012 14:19	Collect Priority= Stat, Reporting Priority= ST - Stat
<input checked="" type="checkbox"/>		Sed Rate-West	Ordered (Dispatc...	08/20/2012 17:33	Collect Priority= Stat, Reporting Priority= ST - Stat
<input checked="" type="checkbox"/>		WBC w/Diff	Ordered (Dispatc...	08/20/2012 17:30	Collect Priority= Stat, Reporting Priority= ST - Stat
<input checked="" type="checkbox"/>		Albumin Level (Albumin ...	Ordered (Dispatc...	08/20/2012 16:51	Collect Priority= Stat, Reporting Priority= ST - Stat
<input checked="" type="checkbox"/>		C RSV Culture (Culture ...	Ordered (Dispatc...	08/20/2012 16:47	Specimen Source= Nasal Wash, Collect Priority=
<input checked="" type="checkbox"/>		AST (SGOT)	Ordered (Dispatc...	08/17/2012 15:53	Collect Priority= Stat, Reporting Priority= ST - Stat
<input checked="" type="checkbox"/>		Carbam Level (Carbama...	Ordered (Dispatc...	08/17/2012 15:32	Collect Priority= Stat, Report Priority= ST - Stat, 0
<input checked="" type="checkbox"/>		CBCA	Ordered (Dispatc...	08/17/2012 15:32	Collect Priority= Stat, Reporting Priority= ST - Stat

- b. The Drips are then listed under Continuous infusion on the eMAR.

MAR

23 August 2012 3:29 - 24 August 2012 3:29 (Clinical Range)

Time View	Medications	08/23/2012 15:23	08/23/2012 15:29
<input checked="" type="checkbox"/> Scheduled	<b>Continuous Infusions</b>		
<input checked="" type="checkbox"/> Unscheduled	<b>Insulin Reg 1 unit/ 1 mL Inj 25 unit</b> Soln, IV Continuous, 08/22/12 11:15:00 Requires RN double check. See Chart for Rate ...		<b>Pending</b> Last bag started: 08/23/2012 15:23
<input checked="" type="checkbox"/> PRN			

- c. Enter the dose from the physician's order and the rate will automatically calculate.

**Insulin Regular 25 unit: EDHolmes, Russell**

Insulin Reg 1 unit/ 1 mL Inj 25 unit  
Soln, IV Continuous, 08/22/12 11:15:00  
Requires RN double check. See Chart for Rate & Dose.

08/23/2012 3:30 - 08/24/2012 3:30

Begin Bag	Bag #1
Site Change	ART Line, Axilla, L
Infuse	
Bolus	
Rate Change	7.09 mL/hr
Insulin Regular	0.1 unit/kg/hr

Insulin Reg 1 unit/ 1 mL Inj 25 unit  
Soln, IV Continuous, 08/22/12 11:15:00

Yes  No Insulin Reg 1 unit/ 1 mL Inj 25 unit/50 mL

\*Performed date / time: 08/23/2012 15:30  
\*Performed by: TestUser RN, EDNurse  
\*Witnessed by: TestUser RN, EDNurse1  
\*Bag #: 1  
\*Rate (mL/hr): 7.09  
**\*Insulin Regular Dose: 0.1 unit/kg/hr**  
\*Weight: 35.45 kg 08/23/2012 15:18

Rate Change  
In Progress

Documentation for the IV Drip will be available on the iView Flowsheet Band. When selected from the navigator – IV Drips will appear on the working view. We will discuss documenting IV Drips in the Flowsheet Band later in the manual.

ED Flowsheet

- Vital Signs
- Asthma Score
- Neuro Check
- Pain Score
- Pain
- IV Drips**
- ACTIVITIES/SAFETY
- CAREGIVER INTERACTION
- Monitor Alarms
- Communication
- Lab Procedures

Last 12 Hours

Find Item  Critical  High  Low  Abnormal  Unaut

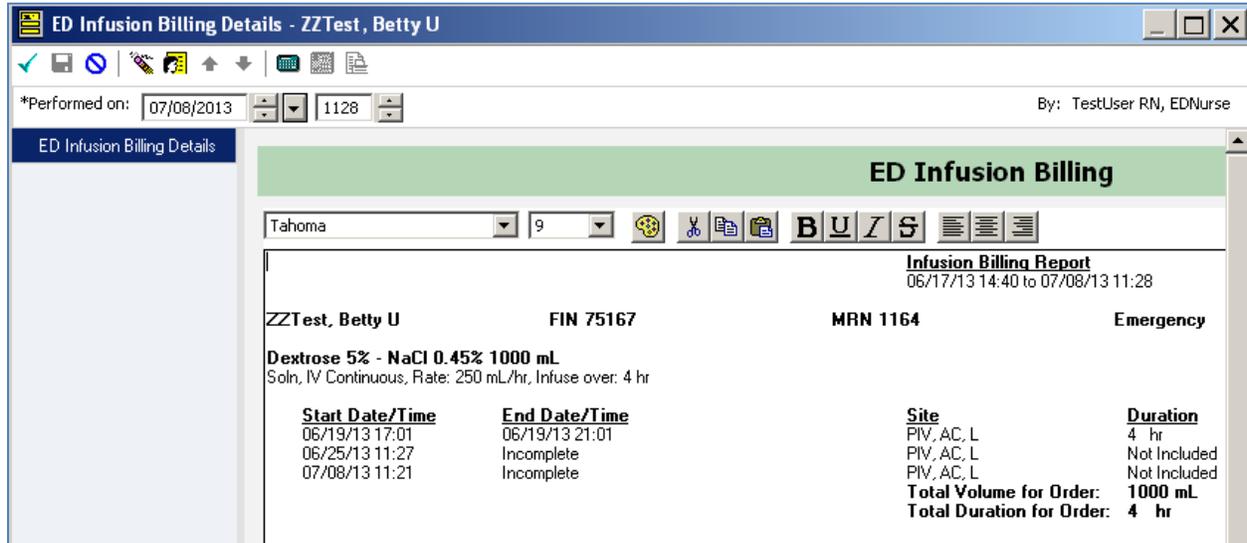
Result	Comments	Flag	Date
			08/23/2012 15:33 15:23
<b>IV Drips</b>			
Insulin Reg 1 unit/ 1 mL Inj 2...	Rate mL/hr		7.09
insulin regular unit/kg/hr		0.1	
<b>ACTIVITIES/SAFETY</b>			
Bed Type			08/23/2012 15:18 35.45 kg
Patient Position			<b>*Witness Required</b>

**Things to Remember:**

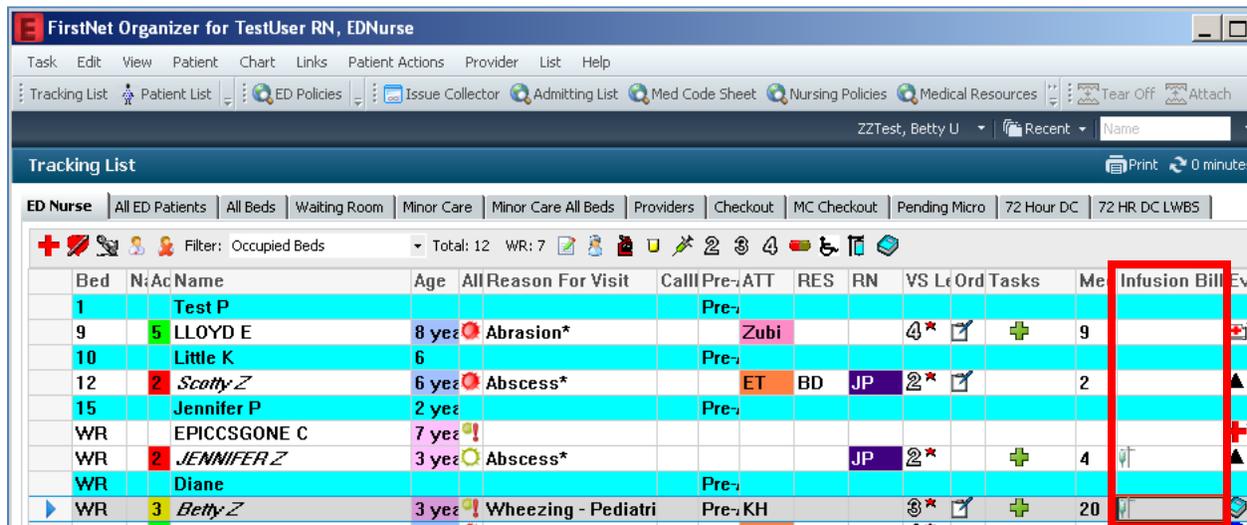
- Do not click to fill in hourly totals in Intake and Output section until the end of the hour.
- If the documented titrations are covered in the order, you do not need to fax a copy of the order to pharmacy when the rate is adjusted.
- If there is a new order, make sure you do not just change the rate in PowerChart. You also need to send the order for the rate change to the Pharmacy so that they can be aware of the changes.
- Only titratable drips will appear in the IV drips section in iView.
- IV fluids and TPN will not show up in this section.
- Reminder: Nursing Informatics ***recommends that dose/rate changes be charted in the IV Drips section of iView for ease of workflow***, unless the user is already in the eMAR when making a dose/rate change.

# Infusion Billing

The Billing Process is completed at the end of each bag administered for your patient. This allows a full report to be created and delivered electronically as part of the patient chart to MRSI at the end of the Patient's Visit. Note: This step is also included in the Depart Process for Nursing.

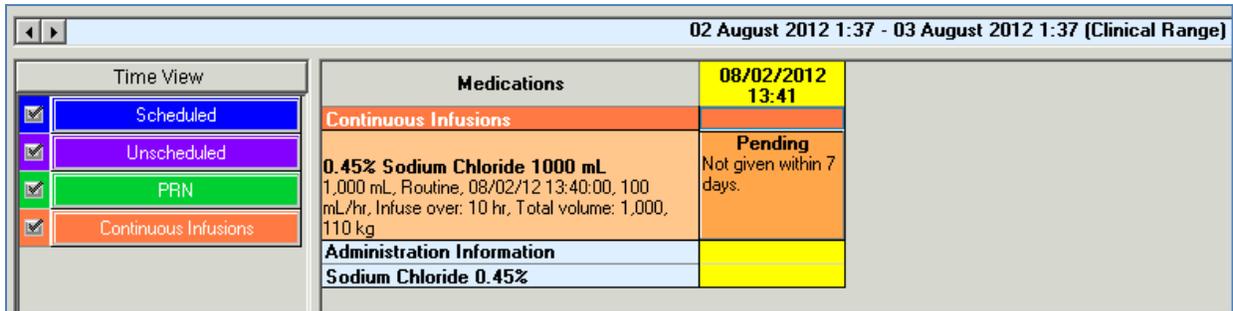


When a continuous infusion is ordered, it will appear on the FirstNet Tracking List under the Infusion Billing column.



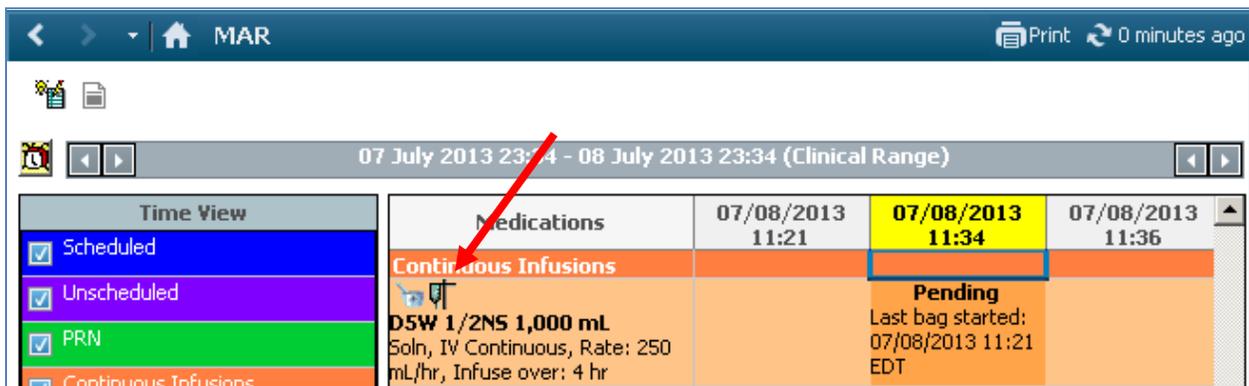
## Steps for completing the Infusion Billing Report:

The IV is then documented in the MAR by clicking on the appropriate task.



After a begin bag has been documented, the IV icon  for Infusion Billing will appear on the MAR.

Note: The  Billing icon will also appear when documenting a bolus as given.



The Billing task will also appear on the Task List within the patient's chart. The Billing task that displays launches the same Stop date/time window as the icon from the MAR.



You can chose to document the Billing task from the MAR or the Task List.

Note: Documenting on the Infusion Billing task from either location will launch the same Billing window as seen below.

Once the Billing window opens, it will default in several values such as the start date and time from when the bag started.

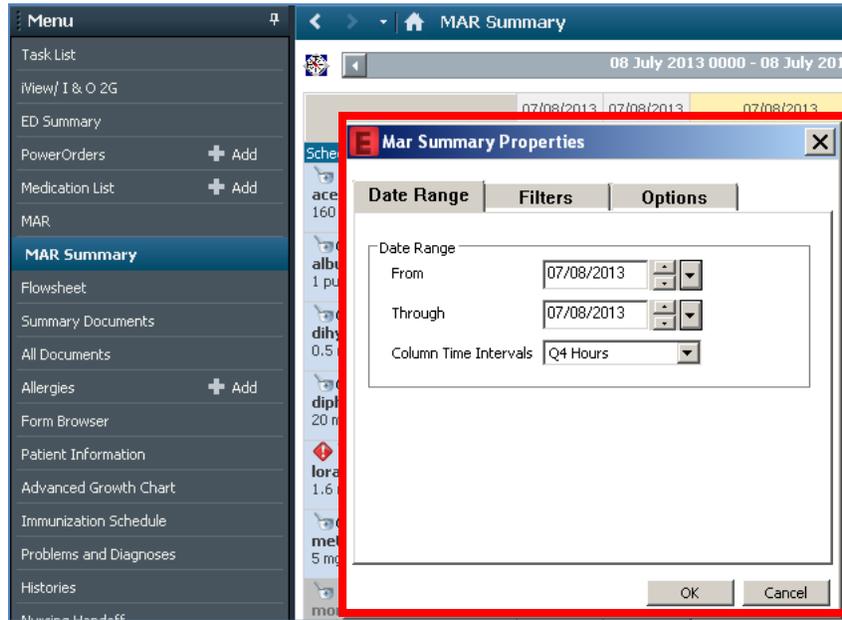
- The end date time will also default in according to the duration.
- The Rate change will also display on the form.

- Note: If this time is too far into the future, the sign button will be dithered or grayed out and you will not be able to sign.
- The dates, times, and Infused Volume can be manually corrected to reflect the actual values.
- Edit the End Date and Time as needed by clicking in the field and making the appropriate adjustments or selecting the up/down arrow beside the field.
- Once the appropriate edits have been included the Sign button becomes available.
- Select sign at the bottom of the window to complete the Billing Task.

## MAR Summary Tab

The MAR Summary tab provides a *view only* condensed display of medication administration information and a high level overview of the medications that are prescribed for the patient. The Summary allows the user to modify the view to accommodate their individual needs.

Right click on the blue bar on the MAR to change the time frame and intervals that you want to display on the MAR Summary.



## Time Interval Settings

Time interval settings can be set per session or as a user default. The following displays the MAR Summary set with a 4 hour time interval.

	07/08/2013 0000 - 0359	07/08/2013 0400 - 0759	07/08/2013 0800 - 1159	07/08/2013 1200 - 1559	07/08/2013 1600 - 1959	07/08/2013 2000 - 2359
Scheduled			@1100			
acetaminophen (Tylenol) 160 mg, Liquid, By mouth, O...						
albuterol (albuterol MDI) 1 puff(s), Inhaler, Inhalation...			@1000			

## MAR Summary Display

### Order/Administration Details

- The drug name will display
- The order entry details will display
- Order comment information **does not** display.
- The column in which the current date and time falls is highlighted in **yellow**.
- Pending administrations display the scheduled admin time highlighted with blue background.

 <b>simethicone</b> 20 mg, Liq, PO, q6hr, Routine, 06/04/06 9:00:00 CDT	@1500
---	-------

- Charted medications display with the dose given and the time administered.

 <b>simethicone</b> 20 mg, Liq, PO, q6hr, Routine, 06/04/06 9:00:00 CDT	20 mg @0900
---	-------------

- “Not Given” or “Not Done” administrations display with an orange border for easier viewing. The Not Given or Not Done reason and the charting time display.
- Discrete results charted with the medications display under the result.

 <b>digoxin (Lanoxin)</b> 0.125 mg, Tab, PO, Daily, Routine, 06/04/06 9:00:00 CDT	Not Given: Bradycardia @0900 ↓ Apical Heart Rate: 52 bpm
---	---

- Overdue Medications display with a red background and the overdue icon.

 <b>simethicone</b> 20 mg, Liq, PO, q6hr, Routine, 06/04/06 9:00:00 CDT	 @0300
---	---

- Discontinued medications display with a gray background and will remain on the MAR Summary for a designated period of time.

 <b>acetaminophen</b> 325 mg, Tab, PO, q4hr, PRN, for fever, Routine, 06/06/06 ...			
--	--	--	--

- Continuous infusion results display include the event charted (e.g. Begin Bag, Bolus, Rate Change) and limited information charted for the event.

 <b>Sodium Chloride 0.45% intravenous solution 1000 mL</b> IV, Routine, 06/04/06 8:13:00 CDT, 100 mL/hr, 10 hr, 1000	1000 Begin Bag: 1,000 mL
--	--------------------------

- Titratable drugs will display the documented ingredient dose rate

## Hover Text/Tool Tips

You can hover your mouse over the medication name to access more complete information regarding the order, scheduled administration or the results charted. You can also access Order Information and the Event Task Summary.

**ZZtest, Maadie** Age: 11 months  
 PRIVACY RESTRICTION: PRIVACY RESTRICTION, PRIVAC... DOB: 10/09/2009  
 Allergies: penicillins

**MAR Summary**

All Active Medications (System) 28

	09/28/2010 0000 - 0359	09/28/2010 0400 - 0759	09/28/2010 0800 - 1159	09/28/2010 1200 - 1559	09/28/2010 1600 - 1959
<b>methylPREDNISolone (MethylPREDNISolone 40 mg/ 1 mL Vial)</b> 40 mg, 1 mL, Vial, IV, BID, 08/03/10 9:00:00, PI-POD A			@0900		
<b>valproic acid (Valproic Acid 50 mg/ 1 mL Liq)</b> 250 mg, 5 mL, Liquid, PO, q6hr, 08/03/10 12:00:00, Main Pharmacy	@0000	@0600		@1200	@1800
<b>PRN</b>					
<b>acetaminophen (Acetaminophen 325 mg Tab)</b> 325 mg, 1 tab(s), Tab, PO, q6hr, 08/03/10 9:00:00, PI-POD A					

**acetaminophen (Acetaminophen 325 mg Tab)**  
 325 mg, 1 tab(s), Tab, PO, q6hr, PRN, pain, mild, 08/03/10 9:00:00, PI-POD A  
 Order Comment: Don't administer >4gm per 24 hours

Event/Task Summary Order Info

## Tips and Tricks

You can also access Order Information, Event Task Summary and Reference Materials by right clicking in the medication cell.

<b>albuterol (Albuterol 2.5 mg/ 3 mL Inh)</b> 2.5 mg, 3 mL, Inhalant, INH, q4hr, PRN, SUB/wheezing, 08/03/10 9:00:00, PI-POD A	Order Info Event/Task Summary Reference Manual...
<b>docosate (Docosate 100 mg C)</b> 100 mg, 1 cap(s), Cap, PO, BID, PRN, 08/03/10 9:00:00, Main Pharmacy	
<b>hydrocortisone topical (Hydrocortisone 1% Cream 30 gm)</b> 1 app, Cream, TOP, AS DIRECTED, PRN, dry skin, 08/03/10 9:00:00, Main Pharmacy	
<b>polyethylene glycol 3350 (Miralax 17 gm Packet)</b> 17 gm, 1 Packet(s), Packet, PO, BID, PRN, constipation, 08/03/10 8:59:00, Main Pharmacy	

## Identifying Icons in the Mar

	Admin Note—Indicates that there is a nurse-to-nurse communication attached to the order, such as "Do not allow patient to walk unassisted". Opens the Admin Note window where the note can be viewed and cleared if desired.
	Pharmacy Comment—Indicates that there is a pharmacy comment attached to the order. Opens the Order Information For <medication name> window with the Comments tab active.

## Practice Scenario for eMAR

---

Since some meds in the ED will go to a DC'd status when given, you may need to right click on the med column and select Additional Dose for practice purposes.



1. Chart a Medication task.
2. Unchart Medication task.
3. Chart a Med as not given.
4. Modify a Med task.
5. Reschedule a Med task.
6. Add an Admin Note.
7. Chart a Begin Bag event
8. Change the dose/rate of a titratable med
9. Chart the Infusion Billing Task.



## **SECTION VII     Introduction to Interactive View (iView)**

### **Introduction**

---

Interactive View or iView is a clinical charting tool that allows staff to record the completion of tasks, and enter patient results to be stored as part of the patient's electronic medical record. Clinicians are able to record results for their patients such as Vital Signs, Assessments and Intake & Output data. iView enables you to chart results throughout the patient's stay displaying these results in a flowsheet format replacing the need for paper flowsheets, kardex and other paper documentation forms.

Depending on your role within CHKDHS, different views or bands are available for iView within the patient's chart. However, your views are based on the location(s) where you work and your individual security.

### **Features**

---

*iView, users can:*

- Document results in flowsheet format.
- Search for selected documentation and view completed documentation from within the iView bands.
- Sign and complete iView documentation results as they are entered.
- Modify results as needed
- Unchart results that were charted in error and add comments to results as needed
- Customize charting sections.

### **Objectives**

---

In this lesson, you will learn how to:

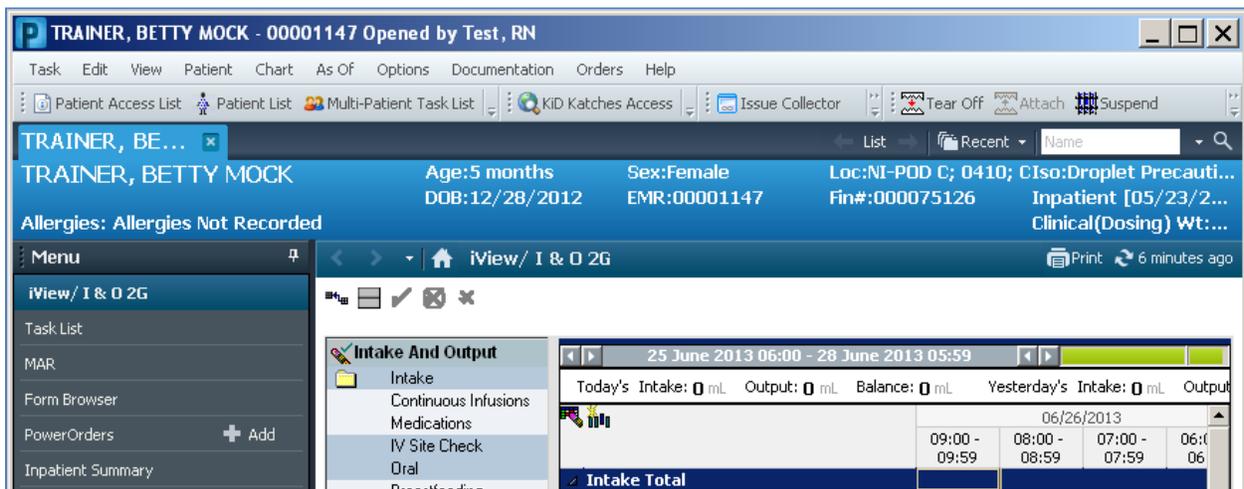
- Complete documentation in iView.
- Access customization tools to add and remove items from the iView sections.
- Select the appropriate bands/section for documentation.
- Modify, edit and update previously charted results.
- View and search for selected results in iView.

## The Interactive View (iView/I&O 2G)

The Interactive View or iView (iView/I&O 2G) can be accessed from within the patient's chart in eKIDs PowerChart.

The Interactive View chart tab is located on the menu bar within the patient's chart. It is a means of viewing a wide variety of patient data in a single area including current and past documentation. You can customize what sections are displayed, what data is included, and how that data is organized. In iView results can be added, modified and uncharted. You can directly chart and view result details from iView. Some of the results recorded in iView are Vital Signs, Assessments, Intake and Output data as well as treatments and procedures. These results are charted throughout the patient's stay and will display in a flowsheet format known as iView.

Once in the patient's chart, click once on the iView/I&O 2G tab to access.



## Major Components of iView

The screenshot displays the iView software interface for patient documentation. The interface is divided into several key components:

- Navigator:** A vertical sidebar on the left containing a list of sections and bands. Sections with a checkmark indicate charted data. Bands are sub-sections within the main sections.
- Sections:** A list of clinical categories such as Vital Signs, N-PASS Sedation Score, Pain, and Nutrition.
- Bands:** Sub-sections within the main sections, such as 'NICU Systems Assessment' and 'Ventilators' under the 'NICU Flowsheet' section.
- Interactive View Area:** The main central area where data is entered and viewed. It shows a table of vital signs and other clinical data for a specific patient (I & O 26) over a 72-hour period.
- Information Date Range Bar:** A bar at the top of the main area that allows users to filter data by date range (e.g., 'Last 72 Hours').

The main data table shows the following information:

Find Item	06/26/2013	06/25/2013	Date and Time Column
Result	Comments	Flag	Date
	09:43	08:00	09:37
<b>Vital Signs</b>			
Temperature Axillary	DegC		
Temperature Oral	DegC	38 ↑	37
Temperature Skin	DegC		
Environment Temperature	DegC		
Incubator Set Temperature			
Radiant Warmer Set Temperature			
Radiant Warmer Heater Output	%		
% Humidification	%		
Heart Rate	bpm	85	90
Respiratory Rate	br/min	60	65 ↑
SBP/DBP Cuff	mmHg	90/70 ↑	100/80 ↑
Mean Arterial Pressure	mmHg	77	87
Mean Arterial Pressure			
Blood Pressure Site		Right arm	Left arm
SBP/DBP Line	mmHg		
Mean Arterial Pressure, Invasive			
SpO2	%	98	97
SpO2 Site		Right, Finger	Right, Index ...
SpO2 Site #2			
SpO2 Site Changed			
SpO2 Probe Changed			
<b>N-PASS Sedation Score</b>			
Crying/Irritability			
Behavior State			
Facial Expression			
Extremities Tone			
N-PASS Vital Signs			
Sedation Score Calculation			

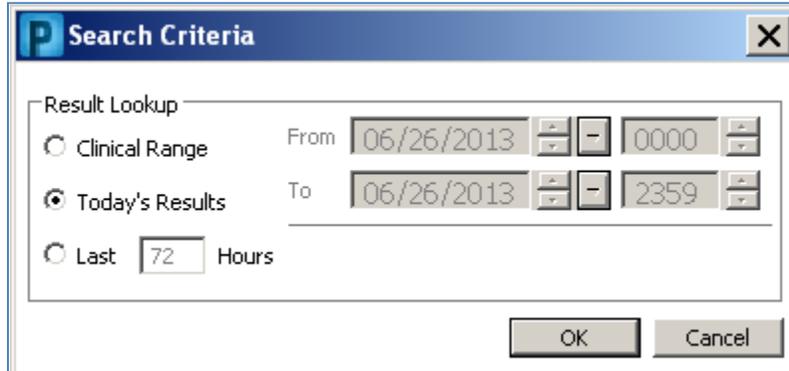
1. **Navigator** - The navigator is a table of contents for the Interactive view and displays the different views available to you. Each view is called a band. The sections with a “checkmark” indicate that data has been charted in that section.
2. **Band** – The view within the navigator that holds related sections.
3. **Interactive View Area or Working View Area** – This is the area where you can document results, view existing results, and modify the information documented.
4. **Section** – Contains related groups of items used for completing the patient’s documentation. These sections can be defaulted in by the system or you can customize what is included in the section as needed for documentation.

5. Date and time columns – The date and time columns will display for each section displaying the date and time of documentation within the selected cells.

Information Date Range Bar – This is the blue bar across the top of the Interactive View Area allowing you to set a range for how you would like to view and display the information in this area.



6. The Search Criteria can be set to display a Clinical Date Range or Today's Results. If the date range exceeds 3 days, the load time will be extended presenting a warning.



7. **Questions** – Items under each section selected for responses or Results for the patient's documentation. Ex: Question -- Heart Rate
8. **Results** – These are your responses to the questions. Ex: Result 48.8

## iView Toolbar and Icons

The iView Toolbar and Icons are located within iView and will provide the needed functionality to complete your documentation.

Icons in the iView toolbar will display based on the action that is being performed.

Example: After you have completed adding results to a cell the  icon will display in the toolbar.



Available icons include:

Icon	Description
	Collapse Navigator – Hides the navigator to increase the view on the screen. Clicking the button again will restore the navigator window to the original view.
	Split Window – Allows two views on the screen. It splits the view to the right of the navigator, allowing multiple interactive views at one time. Select the band to populate the top window. Then click in the bottom half of the split screen window and select the appropriate band to view in that window. Clicking the Split Window button again will remove the split screen
	Show Empty Columns/Rows – Displays columns that contain results. Clicking this icon again will remove the empty columns/rows.
	Review Results – Marks all new results visible in the interactive view sections as reviewed.
	Sign – Allows you to sign and save documented results and is available only after you have initiated documentation.
	Cancel – Allows you to cancel the charting session without saving the changes you entered. This button is only available when documentation has been initiated.

## Forward and Back Browser-Style Buttons



The **Backward** button allows you to access previous tabs within the patient’s chart.

The **Forward** button moves you to where you were in the patient’s chart prior to clicking the back button.

The **Drop-down arrow** allows you to jump to a certain tab within the patient’s chart (i.e. Medication List tab).

The **Home button** takes you to the defined home tab . This cannot be changed.

## Reviewing the iView Bands

The Bands on the iView provide a location where information can be entered directly into fields and saved to the patient's chart. The sections under the bands can be customized to add or remove sections as indicated in order to complete the patient's documentation providing ease of documentation and result review.

Not all users will be able to view all the documentation. While some users may be able to view documentation in selected bands, they may not be able to document in selected sections based on their security.

**Views in iView will vary based on the user's role.** The following are examples of the different bands available based on security. Notice that some users have several bands while others may only have a few. Also, notice that the order of the bands may differ based on your role.

The location of the patient also determines which bands are available for view and documentation. The bands will be discussed in greater detail later in the manual.

### Flowsheet Band

The Flowsheet Band allows you to document for many of the areas currently documented using the front page of a typical paper flowsheet. It contains sections such as the vital signs section and the pain section.

### System Assessment Band

The System Assessment band allows you to chart the patient assessments and replaces the narrative nursing note used today. It contains all the components of a complete head-to-toe assessment with the exception of the Skin Assessment. This section also includes activities such as ADLs and Fall Risk Assessment.

### Skin – Wounds – Tubes – Drains Band

The Skin – Wounds – Tubes – Drains Band provides a location to document general skin assessment, assessment of abnormalities, incisions and wounds. It also includes a section to document any tubes and drains such as gastric tubes and hemovac drains.

### Lines – Devices Band

The Lines – Devices Band provides sections similar to the existing CVL flowsheet where they are currently documented. PIVs that are documented on today's flowsheet in the narrative section will also be documented on the Devices Band. The Lines – Devices Band is also similar to the Infiltration Flowsheet that is used today to document IV infiltration.

The Lines – Devices Band is also where BMDI (Bedside Monitoring Device Interface) will be associated to you patients. The BMDI will be discussed later in the manual.

### Treatment – Procedures Band

The treatment and Procedures Band provides a location to document various treatment and procedures such as chest PT, blood transfusions, and lab procedures such as lab draw and specimen collection.

## **Events Band**

The Events Band provides a location to document events such as seizures, apnea, bradycardia, bronchospasm, desaturation, color change, suction site and the name of a provider notified and RT notified.

The Events Band also provides a location to easily view documentation of Vital Signs. The Vital Signs that are documented in the Flow Sheet Band will auto populate in the Vital signs section on the Events band. Vital signs documented in the Events Band will also flow to the Flowsheet Band.

## **Behavioral Band**

The Behavioral Band provides sections for psychosocial assessments and restraint documentation that is currently documented in the restraint flowsheet.

## **Transfer – Transport - Discharge Band**

The Transfer – Transport – Discharge Band provides a location to document both transfers In-house and outside of the facility.

## **Intake and Output (I&O) Band**

The iView Intake and Output 2G flowsheet is a record of a patient's fluid intake and output for a specified time period, typically one hour increments. However, the hourly increments can be adjusted if required for documentation.

Clinicians can view the individual resulted amounts of each output or input event. Discrete amounts of each event can be viewed, as well as shift totals and daily totals displayed in a spreadsheet format.

The information can also be viewed in a split screen format within iView allowing you to see two individual flowsheets at one time. However, even though you can view the documentation for continuous infusion and medications in iView, documentation for medications and Continuous infusion will be completed in the MAR.

### ***Intake and Output Summary***

Accumulated hourly totals, shift totals, daily totals, subtotals, and fluid balance can also be viewed from the Intake and Output band by clicking on the Date Range Information Bar. Examples of Intake and Output documented in this area would include oral intake, gastric tube intake, urine output, stool output, drain output.

As results are entered into the Intake and Output band in iView, a quick view summary of the information is displayed at the top of the flowsheet. Intake and Output totals for Today's recorded results and Yesterday's results are displayed for quick review. The Today's totals are updated as documentation for the current day is entered.

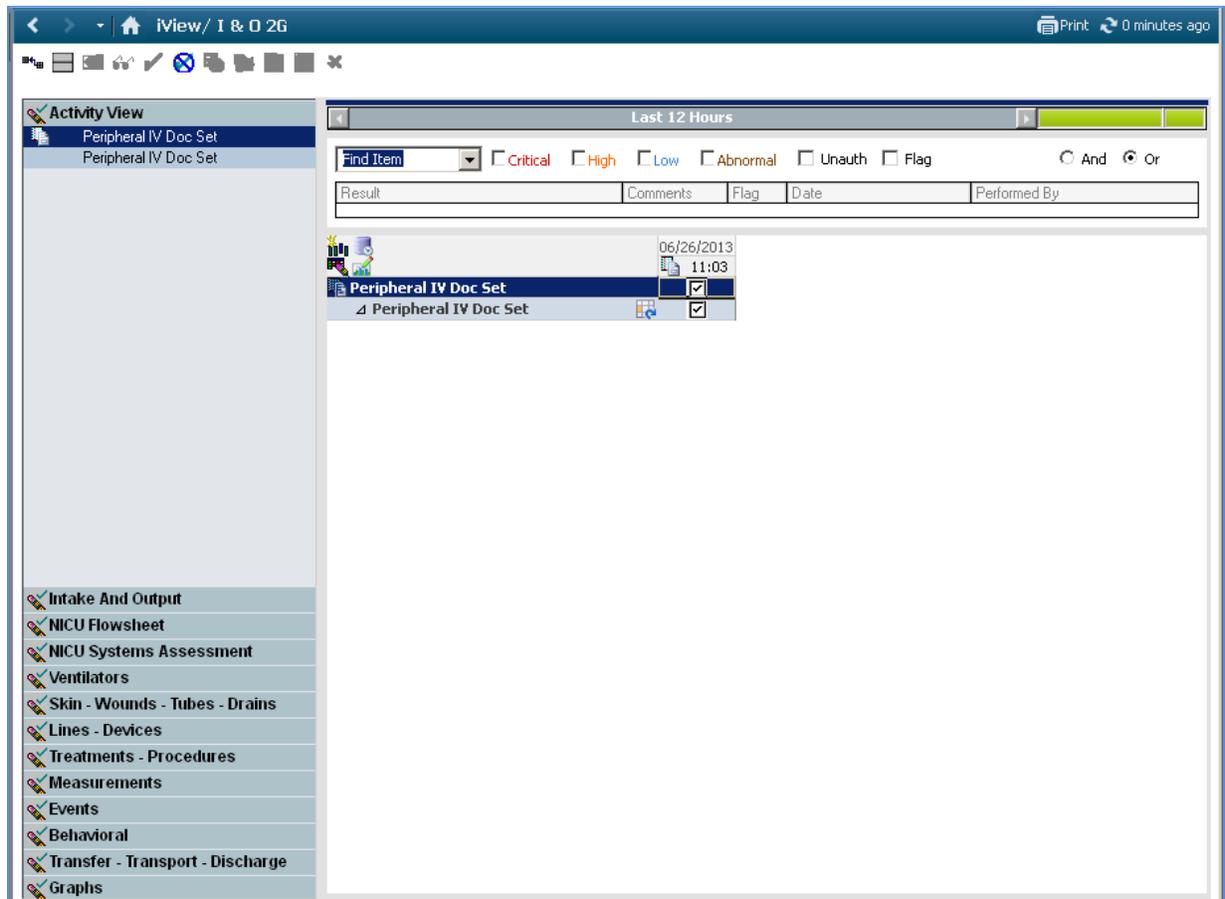
## **Graph Band**

When populated, the Graph Band will display graphs of documentation such as Vital Signs for Temperatures. The example below displays graphed information for three documented Oral Temperatures. This band is available based on your user security and login.

## Activity Bands

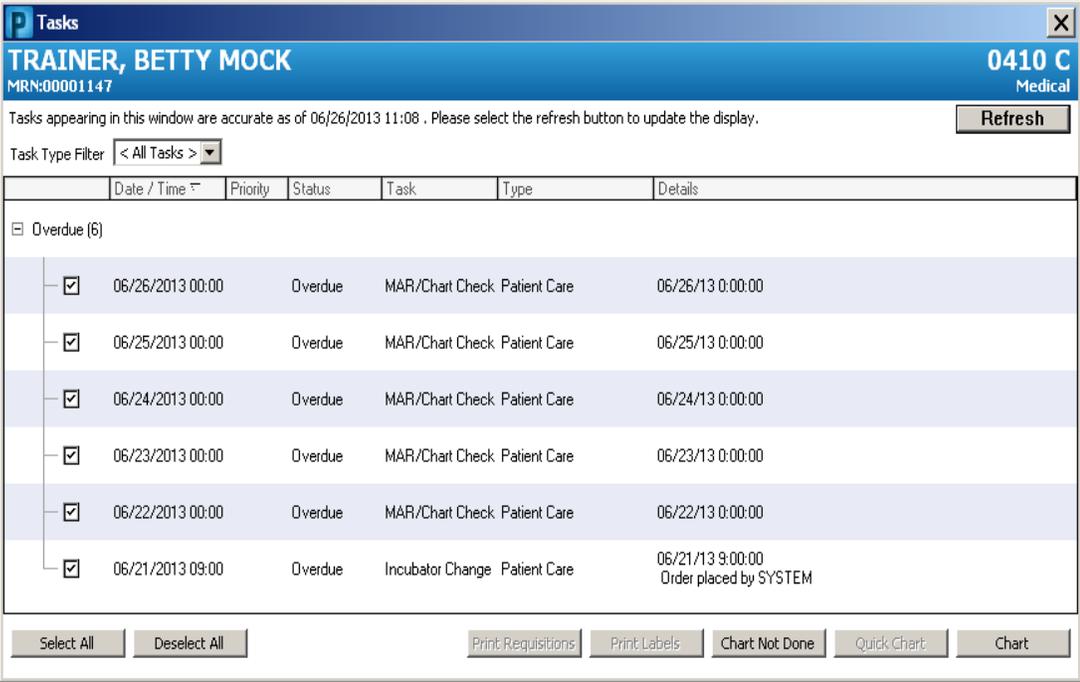
The purpose of the Activity Band is to allow ease of documentation. It provides the clinician with the section(s) to document a task without having to search for the task in iView.

The Activity Band will display at the top of the existing iView Bands. The Activity Band will only be available when orders meeting criteria specified by CHKDHS have been entered. These orders will create tasks within the Task List in the patient's chart. Once documentation is completed via the Activity Band, the Activity Band will drop from the iView until another order and task meeting the specified criteria is generated.

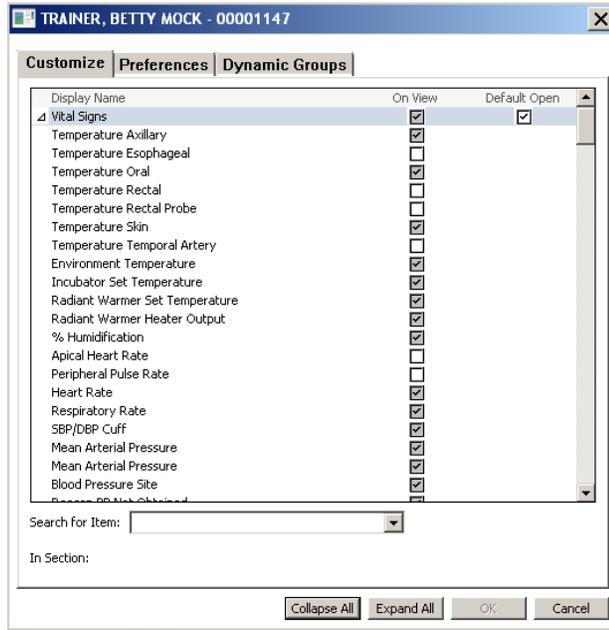


Once documentation is completed via the Activity Band and the chart is closed, the Activity Band will drop from the iView until another order and task meeting the specified criteria is generated. Upon reentering the patient's chart the documentation can then be viewed under the appropriate section. In the example below the Bladder Scan is now viewed in the Treatments – Procedures Band.

## iView Band Icons

	<p>Insert date/Time – Displays your charting in time increments such as Q1 min, Q1 hr, etc. You can also click on Insert Date/Time allowing you to change both the date and time to document a single occurrence.</p>  <p>Double clicking this icon presents a Change Column Date/Time Window where changes can be applied.</p>
	<p>View overdue task -- Displays all task that are overdue for your patient. This icon will only display for your patient if there are overdue task.</p>  <p>Clicking on Task will launch a task window where any overdue task can be charted and completed. Note: If you launch a task for a Medication you will be taken to a MAR task window. Medication documentation will always be completed in the MAR.</p>

Customize View – Remove and add options for a selected section.

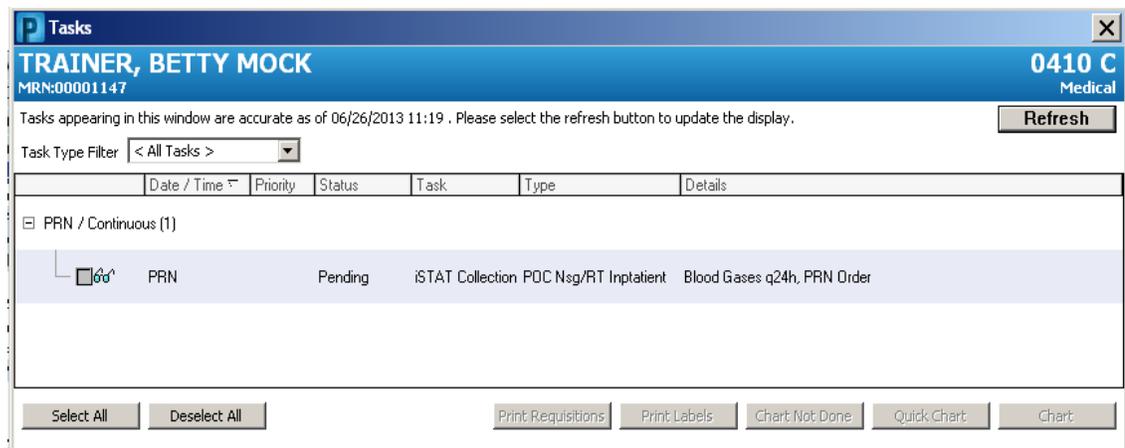


Clicking on this icon will launch a window where you can add and removed sections and questions in order to document needed clinical information for your patient.



Change I/O Total Start Time -- Allows you to change the I/O start time and date from the defaulted time.

Views PRN and Continuous Task. This icon will only appear on the iView Band if PRN and continuous task are ordered for the chart that is currently open.

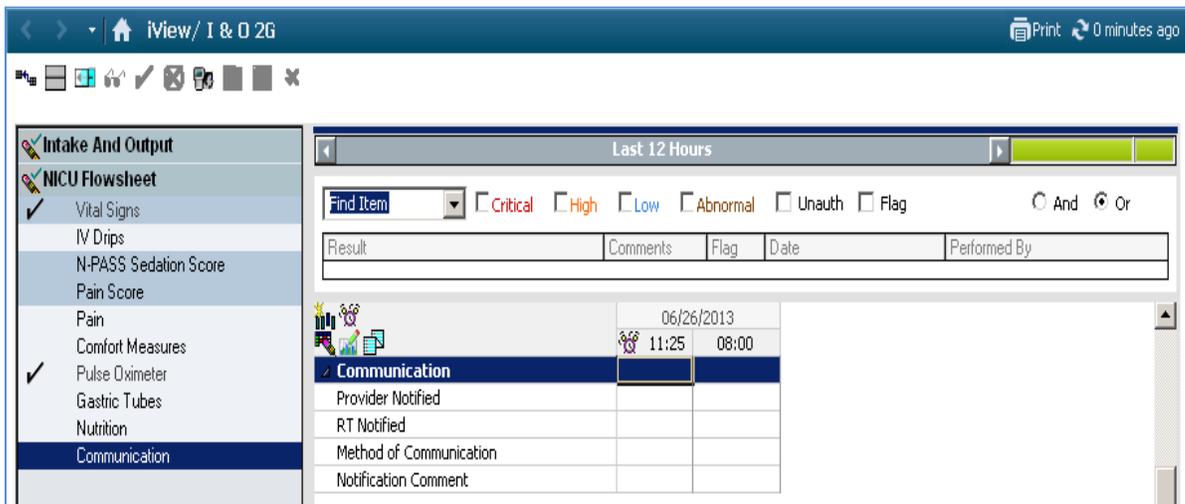


Clicking on Task will launch a task window where any PRN task can be charted and completed.

## Working with iView Bands

Once you have opened the patient's chart and reviewed the information available in iView, you should determine which bands are necessary to complete documentation of results in the patient's chart.

1. Review available bands and determine which bands are necessary for documentation.
2. Click on the Band and the Section tile within the navigator.
3. Once selected, it will be highlighted in yellow within both the Navigator and View area.
4. The sections with ✓ a check mark to the left indicate that these sections already have documentation from a previous time and/or date.



The Vital Signs section is an example of a section that is repeated in different bands for ease of documentation and viewing of results. This allows the clinician to document in one location and it will then automatically populate the documentation on the additional bands.

Example: Vital Signs are in the Flowsheet Band and the information documented will automatically populate in the Vital Signs section of the Events Band.

***At this time, lets enter a Heart Rate in vital signs by right clicking in the field and selecting Add Result. Enter a heart rate and click the green check mark on the toolbar to sign. Click on the Events Band and note that it also appears there.***

Note: Once a section contains documentation it will remain available for future documentation and also viewing previous documentation. However, if results are not entered within 48 hours the fields will collapse from view optimizing your work space. Previous documentation remains available for review by expanding the date and time range to view results.

## Customizing the iView Bands

The bands within each section can be customized to add or remove the sections that are needed to complete a patient's documentation. Items you customize are items specific to your individual patient. These items can be added throughout the patient's stay based on need. Once customized for your patient they will be available in iView when you and other users with charting privileges access the patient's chart to document

## Adding a Section to an iView Band

At times it may be necessary to add an additional section to the patient's chart if that section is not readily available. The sections can be added and removed based on need to ensure all necessary documentation is added.

To add a section:

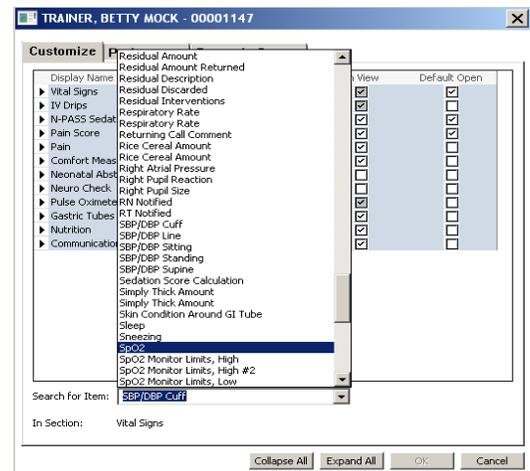
1. Click on the section you wish to customize.
2. Once you click on the desired section it will be highlighted in yellow.
3. Then click on the  Customize View Icon at the top of the spreadsheet.
4. A pop up window will appear displaying options for the selected view. The options with a check mark in the box will display on the flowsheet. The options with no check mark can be selected to display by clicking on the appropriate box.
5. You can also uncheck items in this window and they will not appear on the flowsheet unless there has been prior documentation completed for those item.
6. Searching for an assessment starts within the band. The search function only searches one band at a time. The screen shot below depicts the steps needed to perform a search. Start by reviewing the flowsheet and looking through the sections within a band.

In the example below a search was performed for a Newborn Tone. By typing "tone" in the *Search for Item* window both Tone and Tone Newborn is displayed as an option to select.

7. Clicking on the box  beside the appropriate selection (in this case Tone Newborn) and then clicking OK will populate the flowsheet with Tone Newborn for documentation.

**Tone Newborn**

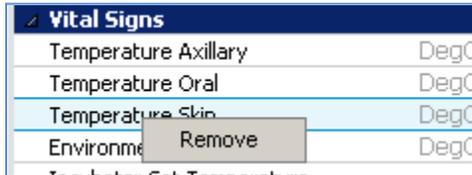
By Clicking in the **"Search for Item"** window you can type the name you are searching for or use the pull down arrow to scroll through a list of items. The Search for Item only searches for the band that is currently open. You may need to check other bands to find the item you need.



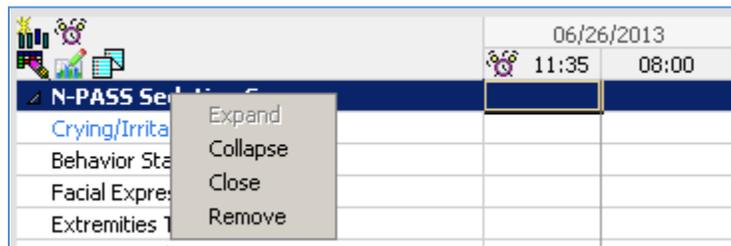
## Removing a Section within an iView Band

If you have added a section in error or discover the section is not needed, following the steps above unclick the section that is no longer needed on the flowsheet and click OK.

For sections that have been added using the Customize Icon, such as the example below, right clicking on the section name or section header will allow you to remove the section. However, the section cannot be removed once it contains documentation.



Removing section name



*At this time let's right click on a section that has not been documented on. Notice Remove is an option. Right click on heart rate in Vital Signs and notice Remove is grayed out.*

## Additional Buttons in the Customize View

The view area of the iView flowsheet contains the sections and questions of the flowsheet. This view can become cluttered and become difficult for viewing information.

The “**Collapse All**” button will allow you to collapse the sections showing only the title of the sections.

Selecting “**Expand All**” button will return the screen to the full view.



You can also collapse sections within the View Area once your items have been selected in order to make it easier to view and less cluttered on your screen.

1. Clicking the “Collapse Navigator” icon  within the tool bar of the flowsheet will collapse the navigator to allow more viewable space on the screen for completing documentation.
2. Clicking it again will expand the view.
3. Clicking on the plus signs beside the sections will temporarily collapse the section.
4. Clicking on the minus again will restore it to the original view.



The collapse function of the sections does not stick. It is a temporary setting and when you refresh the flowsheet it will automatically re-open the sections.

## Setting Time Frames

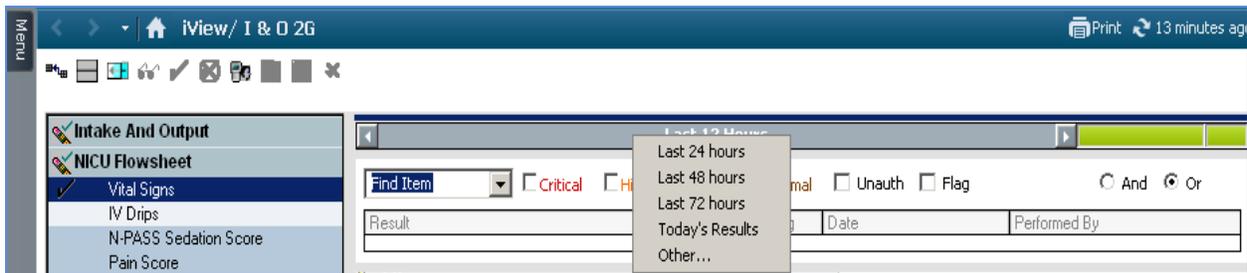
Setting the Time Frames for which you would like to view your documentation is customized by the individual users and saved with your security log in. Time frames typically default to 12 hours but can be changed to range from 24 hours to 72 hours, display today's results, or additional customized options as needed.

To set the Time frames in iView:

1. Right click on the blue banner bar at the top of the iView Window.
2. Choose the selection that best fits your needs. Click once on your selection.
3. This will change the view as you have indicated.

Last 24 hours, Last 48 hours, Last 72 hours Views

In the example below "Last 24 Hours" was selected. This will display the last 24 hours of documentation in your flowsheet for your patient.



By selecting "Today's Results" the results completed for just today's date will be displayed.



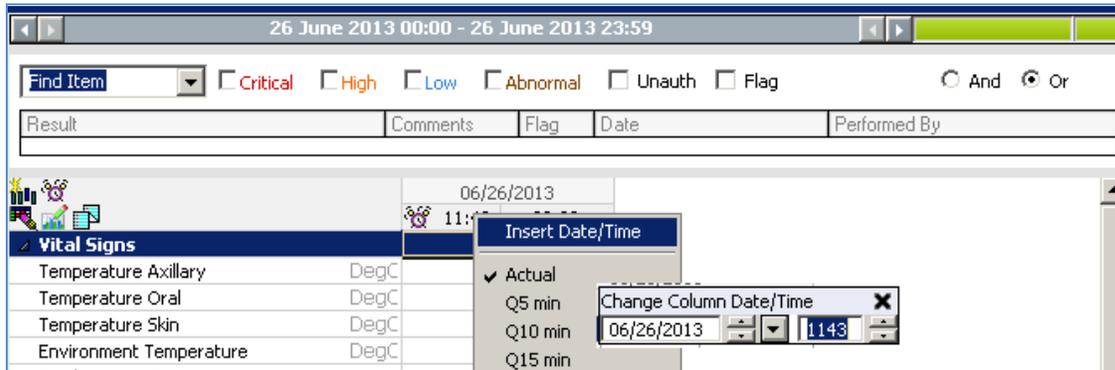
Selecting Other... will allow you to select a Clinical Range, Today's Results or the Last number of hours you wish to view.

1. Select the parameters you wish to view.
2. You can also set the date and time range you wish to view
3. Click OK.



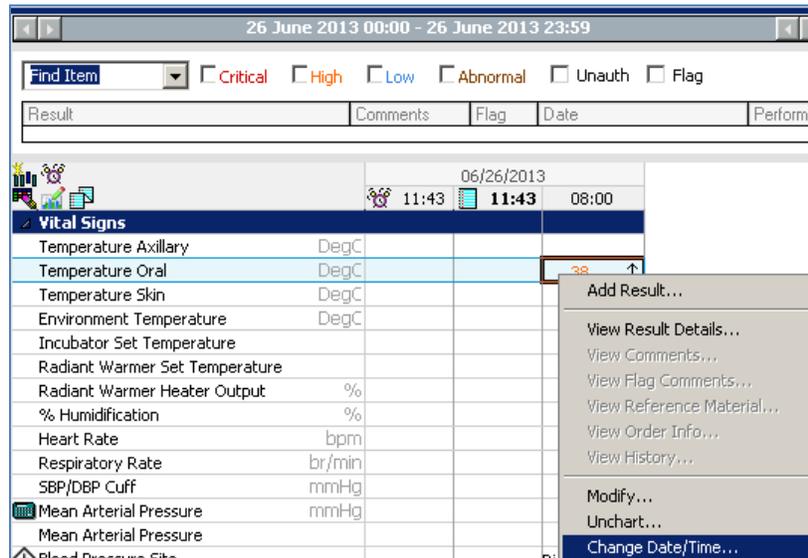
## Changing Date and Time

The charting time will default to the current date and time.



You can change the date and time for the entire column.

- ✓ Right Click on the column to change. Click on the Insert Date/Time. You can now change the date and/or the time for the column in the Change Column Date/Time window.
- ✓ Date and/or Time can also be changed by clicking on the Insert Date/Time Icon.
- ✓ Changing the date and time for an individual cell can be performed by right clicking on the cell and selecting Change Date/Time.



- ✓ A pop up window will display.
- ✓ Enter the appropriate date and/or time and click on sign.

The result entered will then be signed and completed and displayed in the new time slot. The new information will also display in a new column with the new date and/or time indicated.

## Modifying Date and/or Time of Completed Result

There may be occasions where the date and/or the time of a completed result needs to be modified in order to reflect the most accurate time of documentation.

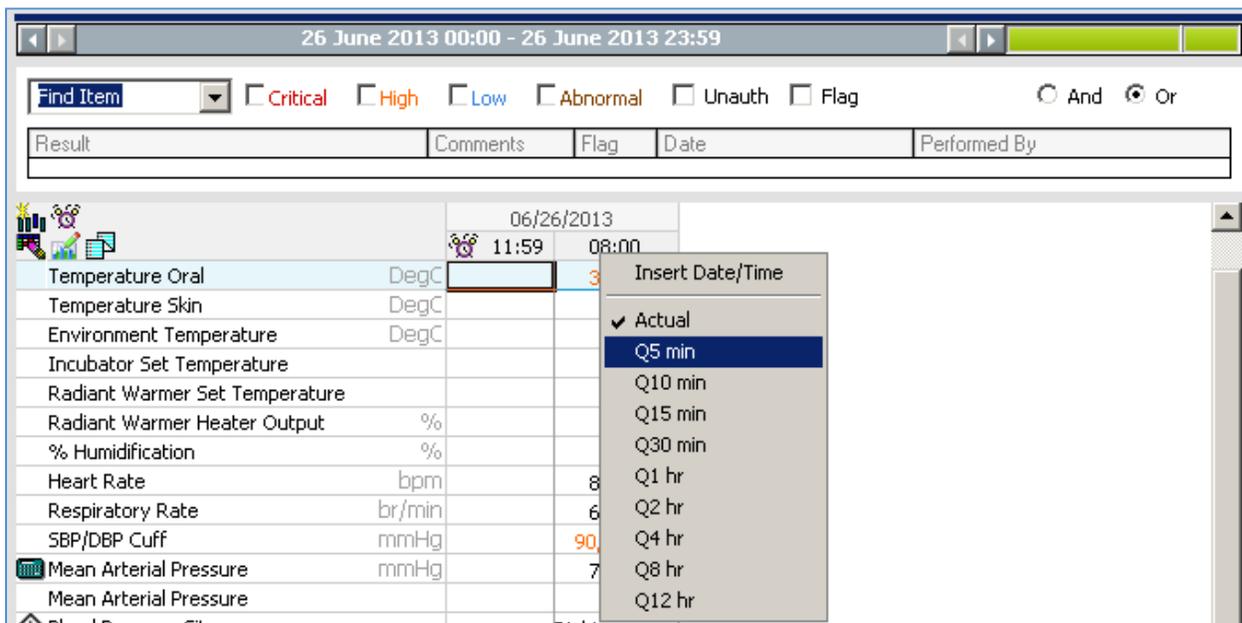
To Modify the Date and/or Time of a completed result:

1. Select the Band in iView where you wish to Change Date/Time.
2. Select the correct date and cell to Change Date/Time.
3. Right click on the cell and select Change Date/Time.
4. The Change Result Date/Time window will open.
5. Select the correct Date and/or time you wish to change by either keying the information in or clicking on the arrow keys located to the right of each individual field.
6. A comment can be added if indicated
7. Click  to sign and complete.
8. A new column will display on the spreadsheet indicating the new date and/or time that was indicated.

## Establishing Charting Times

Charting times can be reset and established to accommodate the frequency of when procedures are performed. The clinician can change the documentation time by right clicking on the date/time cell. A pop up will then display and you can select to display your charting time increments such as Q15 min, Q1 hr, etc.

As a reminder, clicking on **Insert Date/Time** allows the change of both the date and time



Select the time frame that is needed for the section you are documenting.

The following is an example of a populated flow sheet when Q2 hr has been selected.

		06/26/2013										
		12:00	11:45	11:30	11:15	11:00	10:45	10:30	10:15	10:00	09:45	09:30
Temperature Oral	DegC											
Temperature Skin	DegC											
Environment Temperature	DegC											



This will change your ongoing charting frequency for the selected time frame. To change the time frame to display current time, right click in the time cell and select actual.

## Overdue Tasks

Clicking on the View Overdue task icon  on the flowsheet toolbar displays tasks that are currently overdue. Depending on the task, results can be entered into the flowsheet, an Adhoc form or in the MAR.

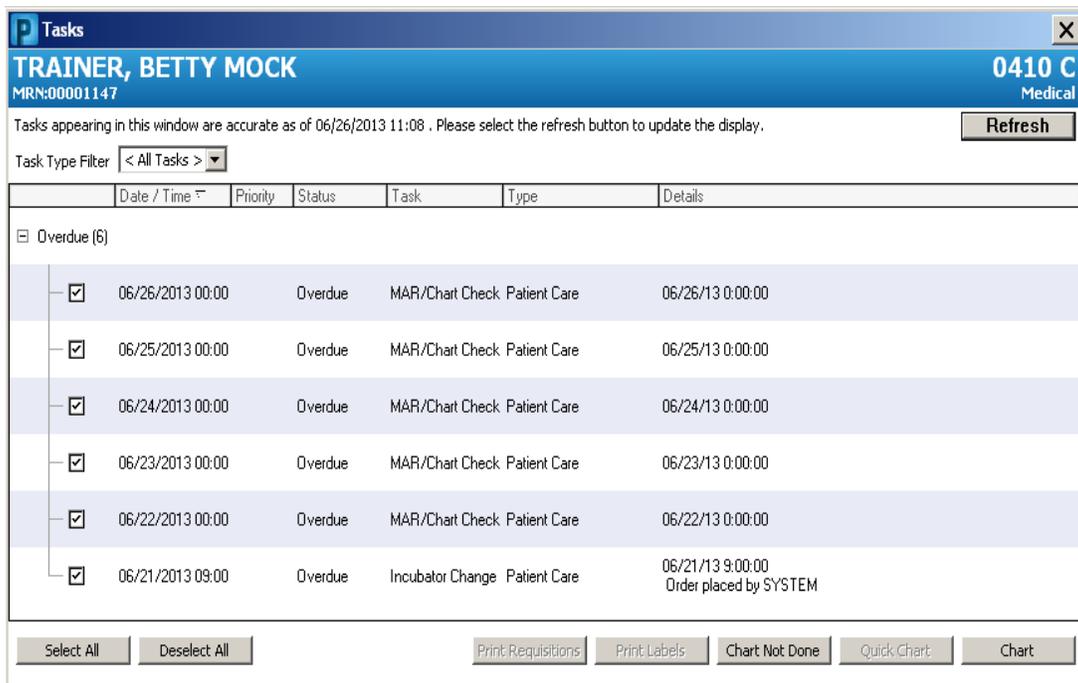


Result	Comments
	12:00
<b>Vital Signs</b>	
Temperature Axillary	DegC
Temperature Oral	DegC

The following is an example of an Overdue task. You can select to chart on one or all of the tasks by clicking or unchecking in the checked box to the left. By default, all tasks are selected.

Using the Select All and Deselect All will toggle the check mark off and on.

Once the task to be documented has been selected using the buttons at the bottom of the screen charting can begin.



	Date / Time	Priority	Status	Task	Type	Details
<input checked="" type="checkbox"/>	06/26/2013 00:00	Overdue		MAR/Chart Check	Patient Care	06/26/13 0:00:00
<input checked="" type="checkbox"/>	06/25/2013 00:00	Overdue		MAR/Chart Check	Patient Care	06/25/13 0:00:00
<input checked="" type="checkbox"/>	06/24/2013 00:00	Overdue		MAR/Chart Check	Patient Care	06/24/13 0:00:00
<input checked="" type="checkbox"/>	06/23/2013 00:00	Overdue		MAR/Chart Check	Patient Care	06/23/13 0:00:00
<input checked="" type="checkbox"/>	06/22/2013 00:00	Overdue		MAR/Chart Check	Patient Care	06/22/13 0:00:00
<input checked="" type="checkbox"/>	06/21/2013 09:00	Overdue		Incubator Change	Patient Care	06/21/13 9:00:00 Order placed by SYSTEM



The Chart Meds Button should not be used. All Medication documentation should be completed from the eMar.

If the overdue task is a medication, after selecting the task and clicking on Chart you will be taken directly to a MAR screen to complete documentation. This will be discussed further with the MAR documentation training.

**P** albuterol: TRAINER, BETTY MOCK
✕

✓
🚫

albuterol (albuterol (conc))  
 5 mg, Inhalant, Nebulized

**\*Performed date / time :**

**\*Performed by :**

Witnessed by :

**\*albuterol:**

Diluent :

**\*Route :**

Total Volume :  Infused Over :

	06/26/2013 1100	06/26/2013 1200	06/26/2013 1300	06/26/2013 1400	06/26/2013 1500	06/26/2013 1600
←						

Not Given  
 Reason :

Introduction to Clinical Documentation for Emergency Department Nursing

169

## Documenting Results

Now that you have established the correct time to begin your documentation, be aware that there can be several system generated tasks that will be created by a rule in the system. Once the task is accessed via the PAL by double clicking on the appropriate icon, the system will display the appropriate iView location or Adhoc form where documentation can be completed.

Some of the system generated tasks that will be documented in iView or on a PowerForm include:

Height/Weight/Allergies on Admission  
Pediatric Admission Assessment

Additional orders that will create tasks to be documented in iView include:

CVL Injection Cap Change  
Bladder Scan  
Enema  
Gastric Lavage  
Wound Care  
Burn Care  
Nsg/RT POC iStat  
Weight  
Head Circumference  
Height/Length  
Abdominal Girth  
Trach Change  
Trach Tie Change  
Car Seat Trial – on a PowerForm

### Documenting in a single section:

If it is necessary to only document a single section use the following steps:

1. Double click in the section header to activate all the cells within that section.
2. A  will be present on the header bar.
3. Continue to click in the cells in that section and document as needed.
4. You can also right click on a single cell and click on Add Results to enter documentation in a single cell. (This is like we did for the Heart Rate)

		06/26/2013	
		12:16	08:00
<input checked="" type="checkbox"/> Vital Signs		<input checked="" type="checkbox"/>	
Temperature Oral	DegC		38 ↑
Environment Temperature	DegC		
Heart Rate	bpm		85 ▲
Respiratory Rate	br/min		60 ▲
SBP/DBP Cuff	mmHg		90/70 ▲
Mean Arterial Pressure	mmHg		77 ▲
Blood Pressure Site			Right arm
SBP/DBP Line	mmHg		
Mean Arterial Pressure, Invasive			
SpO2	%		98
SpO2 Site			Right, Finger
SpO2 Site #2			
SpO2 Site Changed			
SpO2 Probe Changed			

Not all fields in a section need to be completed. Follow policy regarding documentation!

## Documenting in Multiple sections

If more than one result or a group of results needs to be entered in a single time frame, the entire column can be activated.

To activate the entire column complete the following steps:

1. Double click in time cell under the date to activate all the available cells within that section.
2. A  will be present on the header bar of each section and the first chartable field will be selected.
3. Continue to click in the appropriate cells in the sections and document as needed.

The example below displays the Vital Signs and Pain sections checked and all available for documentation.

		06/26/2013	
		13:23	08:00
<b>NEUROLOGICAL</b>		<input checked="" type="checkbox"/>	
Neurological System			
Level of Consciousness			
Affect/Behavior			
Cry Description			
Tone Newborn			
Anterior Fontanel Description			
Movement Newborn			
Neurological Comment			
<b>RESPIRATORY</b>		<input checked="" type="checkbox"/>	
<b>Breath Sounds Assessment</b>		<input checked="" type="checkbox"/>	
Breath Sounds Auscultated			
All Lobes Breath Sounds			
Lung Sounds Left			
Lung Sounds Right			
<b>Oxygen Therapy</b>		<input checked="" type="checkbox"/>	
Oxygen Therapy			
Oxygen Flow Rate	liters/min		
FiO2	%		
SpO2	%		98
<b>CARDIOVASCULAR</b>		<input checked="" type="checkbox"/>	
Cardiovascular System			
Cardiovascular Symptoms			
Capillary Refill Upper Extremities			
Capillary Refill Lower Extremities			
Precordial Activity			
Cardiovascular Comment			
<b>GASTROINTESTINAL</b>		<input checked="" type="checkbox"/>	
Gastrointestinal System			

Documented results will display in purple text until signed. Additional functionality of adding comments to a cell will be discussed in the section titled Interacting with iView.

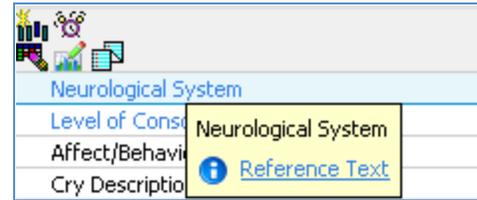


Documentation in iView should be completed by documenting based on the Hospital Policy of “Charting by Exception”. In other words, if you are documenting and the result you document is “meets acceptable parameters” you do not need to populate the other items unless necessary to provide the additional appropriate information in the chart.

		06/26/2013	
		13:23	08:00
<b>NEUROLOGICAL</b>		<input checked="" type="checkbox"/>	
Neurological System	Neurological System		
Level of Consciousness	Meets acceptable parameters		
Affect/Behavior	Exception to normal parameters		
Cry Description	Same as previous assessment		
Tone Newborn	Not assessed		

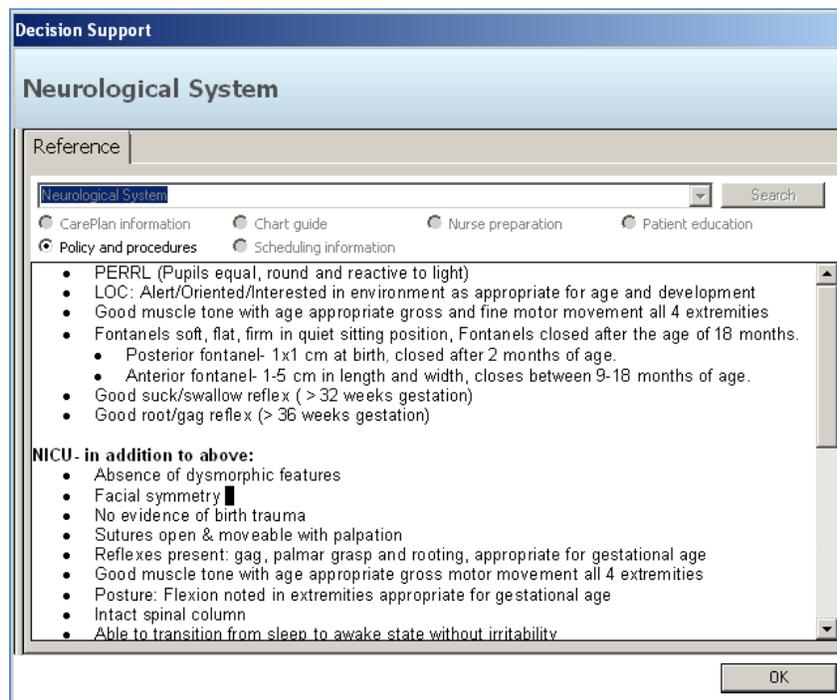
## Reference Text

Reference Text is the Decision Support Reference information providing the clinician with useful information related to the selected cell. This information can be beneficial to the clinician when completing documentation. (Click on System Assessment, Genitourinary)



Reference Text can be identified as a section title that is underlined and highlighted in blue also known as a Reference Text hyperlink. A single click on the hyperlink in the section will provide access to the information related to that section.

Double clicking on the Hyperlink will move you directly to the Decision Support Reference Text. In the example below WDL information for the Genitourinary System is provided.



## Tips and Tricks

Based on your security and available bands you will be able to add textural, numeric and free text documentation in the selected cells.

You can also add comments to any cell as needed when documenting.

## Types of iView Documentation

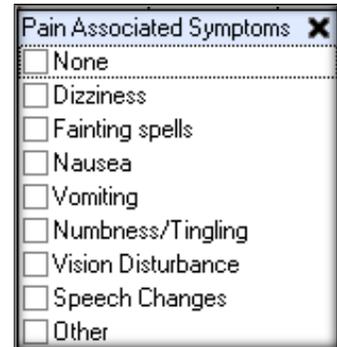
Based on your security and available bands you will be able to add textural, numeric and free text documentation in the selected cells.

You can also add comments to any cell as needed when documenting.

### Multi Select

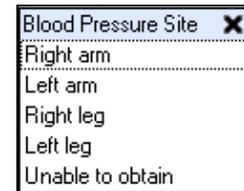
A multi select window will appear on the spreadsheet for certain documentation allowing you to select one or more items when charting. This type of list can be recognized by the open box  beside each item.

Simply click in the box beside one or more of the options to complete your documentation. Selecting other will allow you to enter a free text entry. Make sure to use the available options when possible.  
Examples: SPO2 Site, Pain Associated Symptoms



### Alpha Select

An alpha select option will allow you to select one item for documentation. Click once on the item you choose to document in the selected cell.



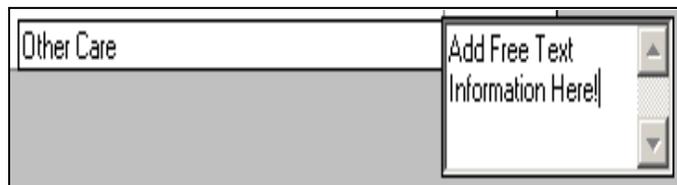
### Numeric

A numeric field allows you to place a number or value in the selected field. IE: Temperature, SpO2 or Blood Pressure.



### Free Text

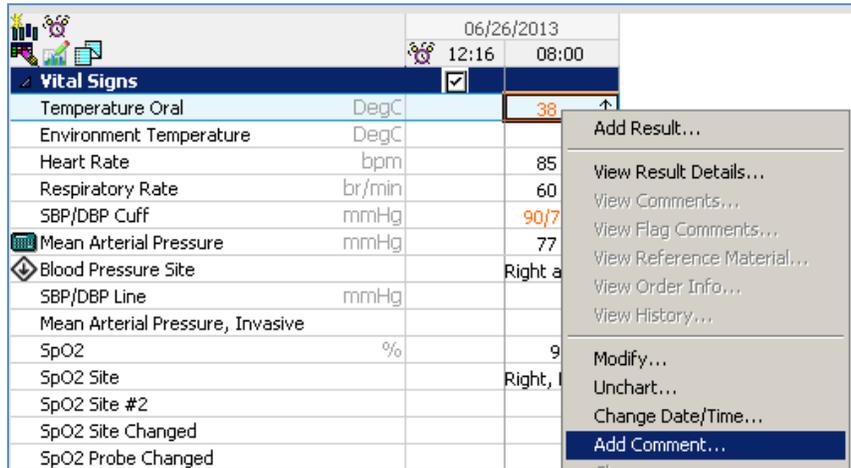
This is an Alfa-numeric field that allows you to type anything related to the question to be answered in the selected cell. The information entered can be viewed by right clicking on the cell and clicking on View Results Details or simply hovering over the cell to display the information entered.



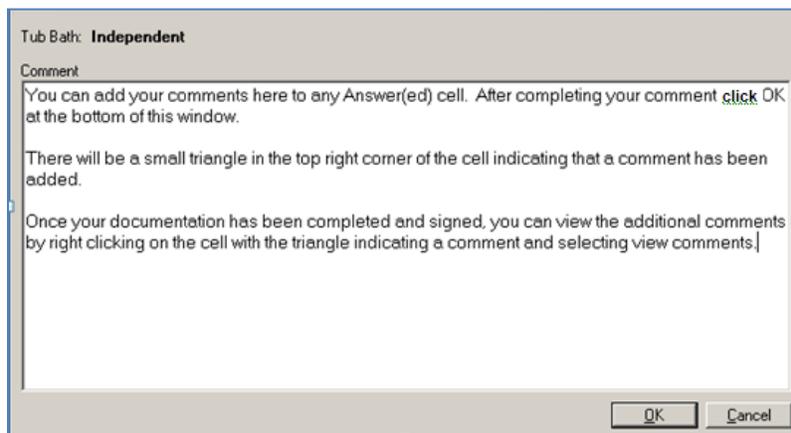
**Example: Flowsheet/Nutrition...Oral Intake type**

## Comments

Comments can also be added to any type of field by right clicking on the Resulted(ed) field and selecting Add Comment.



A window will pop up allowing you to add additional information to any field that you have Resulted.



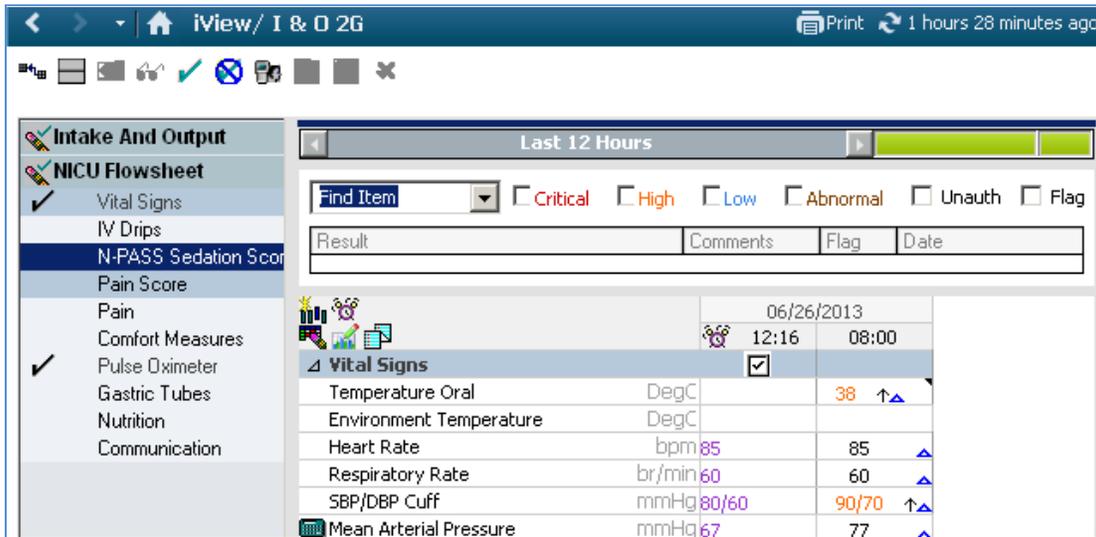
The following is an example of a cell containing a comment --



## Signing/Cancelling Documentation

Completed documentation needs to be signed upon completion in order to save the information as part of the patient's electronic medical record.

Once you have completed your documentation you can sign that documentation by clicking the check mark  on the iView toolbar.



Last 12 Hours			
Find Item	Critical	High	Low
Result	Comments	Flag	Date
06/26/2013			
12:16 08:00			
Vital Signs			
Temperature Oral	DegC	38	↑
Environment Temperature	DegC		
Heart Rate	bpm	85	↑
Respiratory Rate	br/min	60	↑
SBP/DBP Cuff	mmHg	80/60	↑
Mean Arterial Pressure	mmHg	67	↑

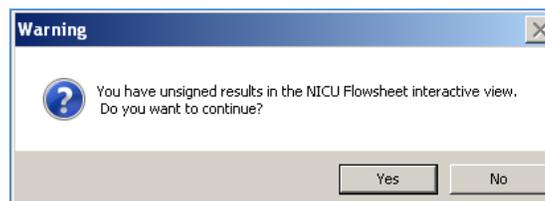
The Cancel button  is also now available if you wish to cancel the document Results without signing. Selecting Cancel will remove any unsigned documentation that you have entered.

### *Tips and Tricks for Signing Documentation*

Selecting the Refresh button **prior to** signing documentation will **remove** any unsigned documentation that you have entered. Also, any customized items added to the section that have not been previously documented on will be removed.



The following message will display as a warning. If you answer yes, all documentation entered during this charting session will be lost.



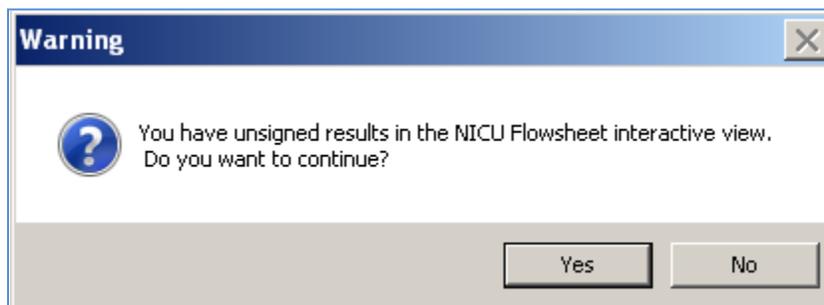
## Troubleshooting Unsigned Documentation Messages

When documenting in iView any unsigned documentation will display in purple as seen below.

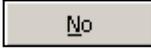
		06/26
		12:16
<b>Vital Signs</b>		<input checked="" type="checkbox"/>
Temperature Oral	DegC	
Environment Temperature	DegC	
Heart Rate	bpm	85
Respiratory Rate	br/min	60
SBP/DBP Cuff	mmHg	80/60
Mean Arterial Pressure	mmHg	67
<b>Blood Pressure Site</b>		
SBP/DBP Line	mmHg	
Mean Arterial Pressure, Invasive		
SpO2	%	98
SpO2 Site		
SpO2 Site #2		
SpO2 Site Changed		
SpO2 Probe Changed		

### Troubleshooting Tip #1

In the event that you attempt to close the patients chart prior to signing your documentation the following warning will be displayed.



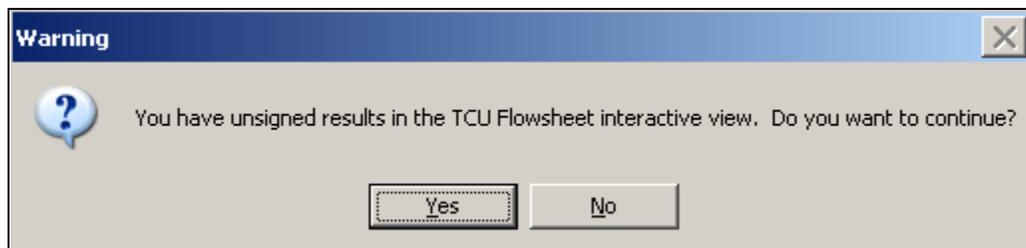
Clicking  will exit the patient's chart and your documentation will not be saved.

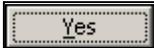
Clicking  will return you to the flowsheet to complete and sign your documentation.

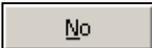
## Troubleshooting Tip #2

In the event that you leave iView and select a different section of the chart from the menu bar, such as MAR prior to signing your documentation, the results you entered will remain in purple until they are signed. You can then go back to iView and complete and sign the documentation.

If you were to close the patient's chart from the MAR prior to signing the following message would display.



Selecting  would allow you to exit the patient's chart and **remove** any unsigned documentation.

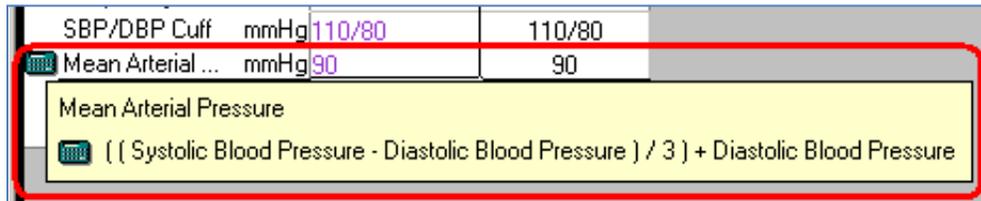
Selecting  will allow you to go back to iView and complete and sign your documentation.

Click 

## Calculations – Built in Calculations

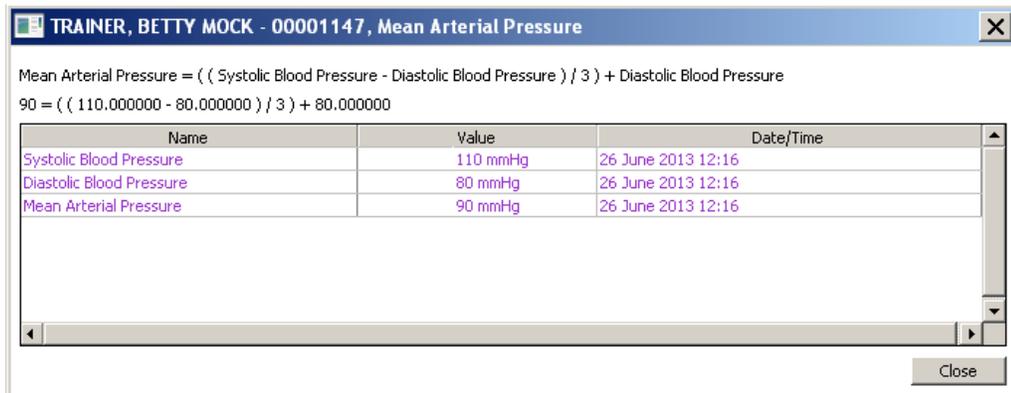
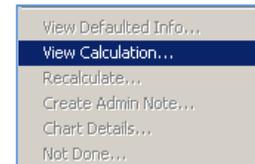
Calculations are present throughout the iView Band indicated by a small calculator icon shown to the left of the section name. The system will automatically calculate fields that have been designated with a calculation icon once the cell has been selected. Depending on the setup of the equation, the system may display a value when other values are documented or create a running total in the field.

Hovering over the calculator will display the formula used to populate the field.



To view complete calculation information:

1. Right click in the field and select, View Calculations. The calculation, value and date/time entered will display.



The box includes:

- Equation – the calculation used.
  - Equation using actual values – the value(s) that contributed to the equation is displayed in the equation.
  - Name column – the name of the result that contributed to the calculation. In the example above is blood pressure.
  - Value column – the result for each item that contributed to the calculation.
  - Date and Time Column – the date and time the contributing results were documented.
2. Click Close to return to iView.

## Documenting Intake and Output

The iView Intake and Output 2G flowsheet is a record of a patient's fluid intake and output for one hour increments. Clinicians can view and record the individual resulted amounts of each output or input event. Accumulated hourly totals, shift totals, daily totals, subtotals, and fluid balance can also be viewed from the Intake and Output Band by clicking on the Date Range Information Bar.

Intake and output values documented in like sections on other bands will flow into the Intake and Output bands displaying those values. Examples of values documented on other bands are Nutrition information for input, Gastric Tubes input, Blood Transfusions input.

25 June 2013 06:00 - 26 June 2013 05:59							
Today's Intake: 0 mL Output: 0 mL Balance: 0 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL							
06/26/2013							
	12:00 - 12:59	11:00 - 11:59	10:00 - 10:59	09:00 - 09:59	08:00 - 08:59	07:00 - 07:59	
<b>Intake Total</b>							
IV Site Check							
Line Site Check							
Oral							
Oral Intake							mL
Oral Intake Type							
<b>Output Total</b>							
Urine Output							
Urine Voided							mL
Urine Catheter							mL
Urine Count							
Urine Weighed Diapers							mL
12 Hr Weight Based Urine Output							mL/kg/hr
24 Hr Weight Based Urine Output							mL/kg/hr
Stool Output							
Stool Count							
Balance							

### Defaulting Volumes from IV Rate:

When clicking on the hourly cell to document Continuous infusion the flowsheet will default the volume into the cell. The volume displayed in the cell is based on the documented rates from the Rate and "Begin Bag" events.

If no (Begin Bag) previous documentation has occurred on the continuous infusion, the system will not default a volume into the cell. The initial documentation or Begin Bag documentation should occur in the eMAR.



**Training**

Knowledge  
useful abilities  
backbone of co  
quired for a tr  
today

**It is recommended that all documentation for Continuous IVs and medications be completed in the eMAR for consistency.**

**Continuous IVs that have previously been documented in the eMAR can be documented in the hourly cells within iView.**

**Functions of I & O Totals include:**

- I&O Totals Display on Interactive View from the eMAR documentation and can be included in sections of iView that contain other relevant data.
- I&O Totals can be used in selected calculations on the iView.

**Types of I&O Totals/Calculations include:**

Rolling Totals – Documentation that will be continuing for a period of time. Example: Urine totals for the last 24 hours.

Shift (Interval) Totals – Documentation for certain periods of time. Example: 12 hour shift total, 24 hour total.

CHKDHS defined totals – Calculations defined by the organization to enhance documentation workflow.

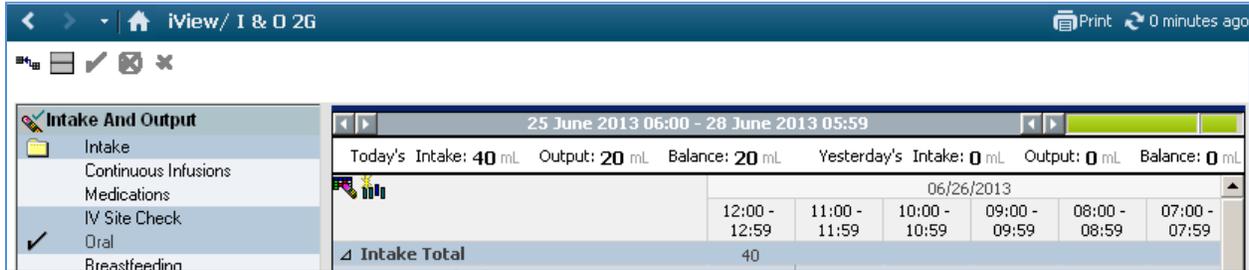
Weight based calculations – Calculations based from the patient's weight. Example: Urine Output mL/kg/hr.

Recalculation logic- when volumes are changed or added on I&O 2G that affect the totals used on the iView, totals can be recalculated to keep them in sync.

## I&O Totals

In the I&O 2G flowsheets, there are several components that will count toward the I&O Totals displayed at the top of the flowsheet. These items are labeled Today's Intake: and Yesterday's Intake:

- The balance for Today's Intake will display for the current calendar date.
- The balance for Yesterday's Intake will display the balance for the previous day's calendar date.



### Components that count toward the I&O Totals

The following are the INPUT Items that are resulted in the Intake and Output sections.

- Results for the items with YES will display in the Today's & Yesterday's Intake & Output totals.
- Results for the items with NO will NOT Display in the Today's & Yesterday's Intake & Output totals.

INTAKE			
DESCRIPTION	TOTALS INCLUDED	DESCRIPTION	TOTALS INCLUDED
<b>Intake</b>		<b>Intake</b>	
Continuous infusion	YES	<b>Transfusions</b>	
Medications	YES	blood volume infused	YES
<b>IV site check</b>		<b>Dialysis intake</b>	
line site check	NO	hemodialysis net intake	YES
<b>Oral</b>		CAPD net solution intake	YES
oral intake type	NO	<b>Other intake sources</b>	
oral intake	YES	Other intake	YES
oral intake time	NO	oral contrast	YES
<b>Breastfeeding</b>		bladder irrigation	YES
breastfeeding time	NO	maintenance fluid	YES
<b>Gastric tubes intake</b>			
gastric tube intake	YES		
gastric tube amount of irrigant	YES		

OUTPUT			
<i>DESCRIPTION</i>	<b>INCLUDED IN TOTALS</b>		<b>INCLUDED IN TOTALS</b>
<b>OUTPUT</b>			
<b>Urine Output</b>	YES		
urine voided	YES		YES
urine output initial	YES		
urine catheter	NO		YES
urine count	NO		YES
urine weighed diapers	YES		YES
urine diaper count	NO		
weight based urine output	YES		YES
<b>Urostomy</b>			
Urostomy output	YES		YES
<b>Emesis output</b>			
emesis	YES		YES
emesis count	NO		
<b>Gastric tube outputs</b>	YES		
Gastric tube output-initial	YES		
gastric tube output	YES		
<b>Stool output</b>	YES		
stool count	NO		
stool volume	YES		
stool color	NO		
stool description	NO		
emesis description	NO		
combine weighed diapers	YES		
combined diaper count	NO		

### Documenting a Continuous IV in iView with no previous documentation:

1. From the patient's chart, access the Intake and Output band.
2. Right click on the cell beside the Continuous infusions.
3. The charting window will display from the eMAR to complete your documentation if nothing has been previously documented for the .
4. Complete the required fields in the charting window
5. Select Apply
6. Sign the charting by clicking the Sign (green checkmark) button.
7. The information documented will flow to the I&O flowsheet.

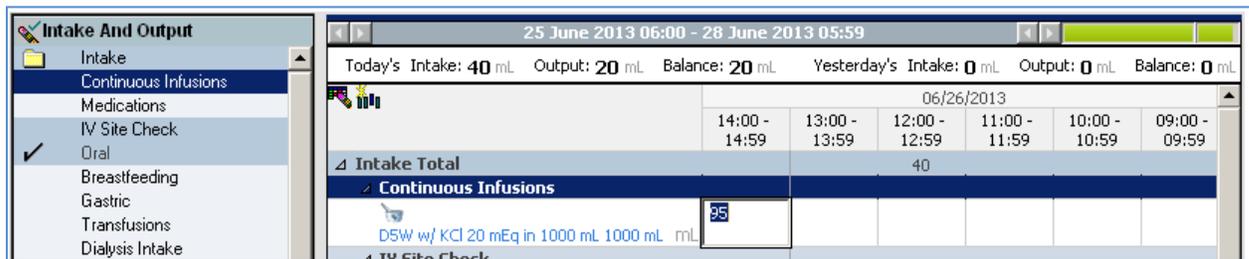
The screenshot displays the iView software interface for documenting a continuous IV infusion. On the left, a table shows the 'Continuous Infusions' section with a checkmark in the adjacent cell. The main window shows the following details:

- Medication:** D5W-1/2NS w/KCl 20 mEq in 1000 mL. 1000 mL
- IV Rate:** 83.33 mL/hr
- Duration:** 02/23/2011 09:59 to 02/25/2011 11:08
- Infused Over:** 49 Hours 9 Minutes
- Performed by:** TestUser, Nurse Full
- Bag #:** 1
- Site:** CVL, Subclavian, L, Blue

The 'Infuse volume (mL)' field is highlighted in yellow, and the 'Bolus' checkbox is checked. The 'In Progress' button is visible at the bottom right.

## Documenting a Continuous Infusion in iView with previous documentation

1. From the patient's chart, access the Intake and Output band.
2. Right click on the appropriate hourly cell for the Continuous infusion as seen below.
3. The amount infused during the hour will automatically be populated in the cell based on the infused volume that was previously entered. (Note: If the Continuous Infusion was stopped during the hour and the rate changed to zero, the value populated will reflect that total.)
4. Sign the charting by clicking the Sign (green checkmark) button. 



NOTE: If you are documenting at a later time and need to document in several hourly cells, always populate the result for the cell with the earliest time first. This will ensure that the totals are calculating accurately.

Example: As seen above, if the last continuous infusion was documented in the 1500-1559 cell and it is now 1800. Documentation should be completed in the 1600-1659 cell first, then the 1700-1759 cell next.

### Adding Multiple Results in a Single Hourly Cell

Multiple results can be added in a single hourly cell based on the documentation needs of the patient. An example of documentation that might be added to a single cell in the I&O is Combined Diaper Count.

To add a result:

1. From the patient's chart, access the Intake and Output band.
  2. Right click on the section above on the appropriate hourly cell.
  3. Select the cell(s) to document.
  4. Enter the result and press Enter or Tab.
  5. Sign the charting by clicking the Sign (green checkmark) button. 
- (If additional results need to be entered later in the hour repeat the above steps.)

Note: You can also add an additional input or output "source" by clicking the Customize View button.  This will be discussed in detail later in the manual.

## Documenting Oral Intake

Oral Intake for your patient such as Formula, Juice or ice chips should be documented in the Flowsheet band under Nutrition. This allows you to document the Oral Intake Type and Oral Intake amount in the same time cell. The results will then also be displayed in the Intake and Output band allowing you to view all the results and totals given within a selected hour.

Multiple results can be added in a single hourly cell based on the documentation needs of the patient.

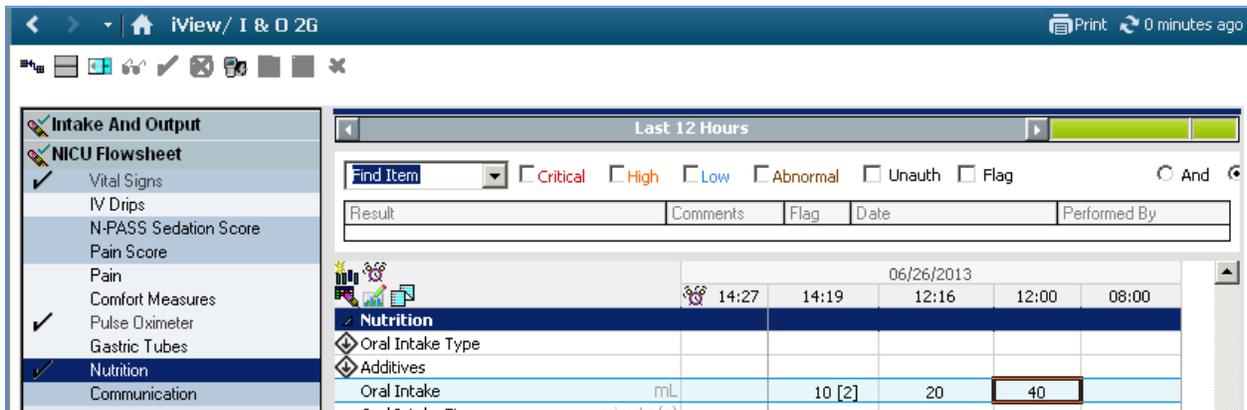
To add a result:

1. From the patient's chart, access the Intake and Output band.
2. Right click on the section above on the appropriate hourly cell.
3. Select the cell(s) to document.
4. Enter the result and press ENTER OR TAB.
5. Sign the charting by clicking the Sign (green checkmark) button. ✓

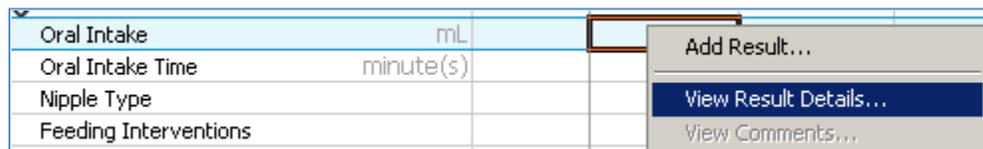
(If additional results need to be entered later in the hour repeat the above steps.)

Note: You can also add an additional input or output "source" by clicking the Customize View button.  This will be discussed in detail later in the manual.

In the example below you will see multiple Oral intake items added to the 1500-1559 timeframe. This is noted by the (4) in parenthesis in the cell below.

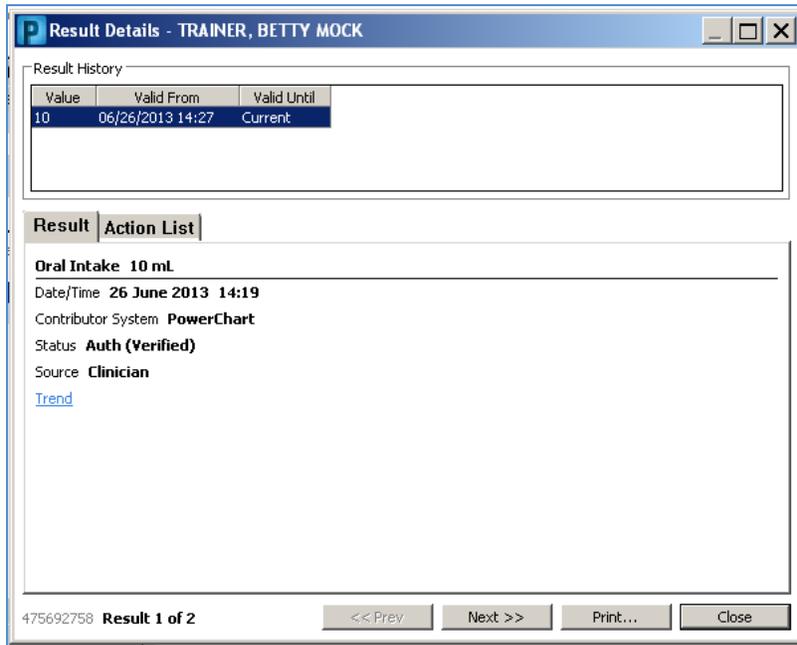


When all results were entered and signed right click on the number beside the result, in this example (4) and select "View Results Details" to view the additional items entered.





The Results Details window will display. Notice “Results 1 of 4” denotes the result that you are currently viewing. Selecting “Next” will allow you to view the additional items that were entered in the hourly cell.



## Documenting Intake with Witness Required

In response to policy, documentation of Breast Milk for Oral Intake requires a witness to the documentation in iView. The witnesses' electronic signature allows the entry for Breast Milk to be electronically verified, completed and signed.

Take the following steps when entering Breast Milk for Oral Intake:

1. Select Breast Milk as a result for Oral Intake Type, the Breast Milk Double Check window opens. Select 'Yes'

Nutrition		<input checked="" type="checkbox"/>
Oral Intake Type	Breast milk	
<b>*Breast Milk Double Checked</b>	<b>*Breast Milk Double Checked</b>	<b>X</b>
Breast Milk Concentration	Kcal/oz	Yes
Additives	<b>*Witness Required</b>	
Oral Intake	mL	10 [2] 20

2. The "Witnessed By" box opens. Click in this box to search for the appropriate witness.

**P** Witness Required - TRAINER, BETTY MOCK - 00001147

Please enter a witness for the following results:

Item	Date/Time	Result	*Witnessed By
Breast Milk Double Checked	06/26/2013 14:30	Yes	<input type="text" value=""/>

When the search window opens, search for the person that is the Witness in the Witness By field. (Do not enter the same person entering the documentation.)

**Provider Selection**

Last Name:  First Name:  Suffix:

Title:  Alias:  Alias Type:

Limit by group  No data filtering  
 Limit by organization  No data filtering  
 Limit by position  No data filtering  
 Limit by relationship  No data filtering

View physicians only

Name	Organizations	Services	Aliases	Positions

1. The witness name is now in the Witnessed By box. Click OK

**P Witness Required - TRAINER, BETTY MOCK - 00001147**

Please enter a witness for the following results:

Item	Date/Time	Result	*Witnessed By
Breast Milk Double Checked	06/26/2013 14:30	Yes	EUBANK, BETTY L

OK Cancel

2. Select Witness Sign.

**P Witness Signature - TRAINER, BETTY MOCK - 00001147**

Results for witness EUBANK, BETTY L

Item	Date/Time	Result
Breast Milk Double Checked	06/26/2013 14:30	Yes

Witness Sign Cancel

3. The Witness must enter their Password into the prompt.

**HNAM Authorizing Signature - THOMPSJA**

Cerner  
Cerner Millennium®

User Name :

Password :

Domain :

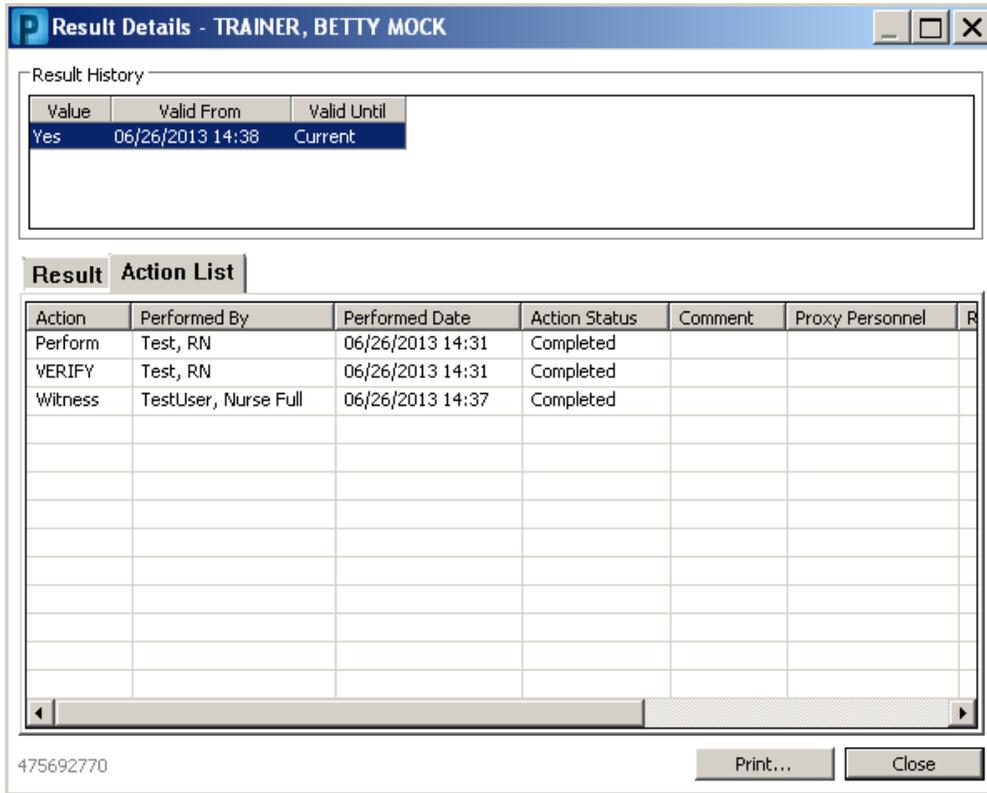
OK Cancel

© 2011 Cerner Corporation. All rights reserved.

4. The results then become verified.

	14:36	14:30
<b>Nutrition</b>		
Oral Intake Type		Breast milk
Breast Milk Double Checked		Yes
Breast Milk Concentration	Kcal/oz	
<b>Additives</b>		
Oral Intake	mL	20
Oral Intake Time	minute(s)	

5. If you right-click on the result and select view result details, you can view the history and see the witness by information.



### Modifying Intake and Output

To modify Intake and Output results:

(Modifying results will be discussed in more detail later in the manual.)

1. From the patient’s chart, access the Intake and Output band.
2. Right click the result you want to modify and select Modify.
3. Change the result amount and press Enter.
4. Complete and Sign  your documentation.

## I&O Totals/Calculations

As documentation is entered in the Intake and Output section many of the results entered will apply to the calculations displayed. (Note: additional information related to the result types that apply to the calculations is located in the Appendix in the back of this manual.)

Rolling Totals – Documentation that will be continuing for a period of time. Example: Urine totals for the last 24 hours.
Shift (Interval) Totals – Documentation for certain periods of time. Example: 12 hour shift total, 24 hour total.
CHKDHS defined totals – Calculations defined by the organization to enhance documentation workflow.
Weight based calculations – Calculations based from the patient's weight. Example: Urine Output mL/kg/hr.
Recalculation logic- when volumes are changed or added on I&O 2G that affect the totals used on the iView, totals can be recalculated to keep them in synch.

Below you can see the the calculations for:

- Today's Intake – displaying the daily Intake and Output totals for the patient
- Intake Total – displaying the Intake Totals for each hourly cell.
- Output totals – displaying Output Totals for each hourly cell.
- Balance - displaying the balance for the intake and output results entered.

25 June 2013 06:00 - 28 June 2013 05:59		06/26/2013							
Today's Intake: 225 mL Output: 20 mL Balance: 205 mL Yesterday's Intake: 0 mL Output: 0 mL Balance: 0 mL		14:00 - 14:59	13:00 - 13:59	12:00 - 12:59	11:00 - 11:59	10:00 - 10:59	09:00 - 09:59	08:00 - 08:59	
<b>Intake Total</b>		165		60					
Continuous Infusions		95							
D5W w/ KCl 20 mEq in 1000 mL 1000 mL	mL	95							
IV Site Check									
Line Site Check									
Oral		70		60					
Oral Intake	mL	70		60					
Oral Intake Type									
Breast Milk Double Checked									
Breast Milk									
Yes									
<b>Output Total</b>				20					
Urine Output				20					
Urine Voided	mL			20					
Urine Catheter	mL								
Urine Count									
Urine Weighed Diapers	mL								
12 Hr Weight Based Urine Output	mL/kg/hr								
24 Hr Weight Based Urine Output	mL/kg/hr								
Stool Output									
Stool Count									
Balance		165 mL		40 mL					

- Shift totals displaying 24 Hour Total, Night Shift Total and Day Shift Total are also displayed.

06/27/2013		07:00 - 07:59	06:00 - 06:59	24 Hour Total	Night Shift Total	05:00 - 05:59	Day Shift Total
<b>Intake Total</b>				225			225
Continuous Infusions				95			95

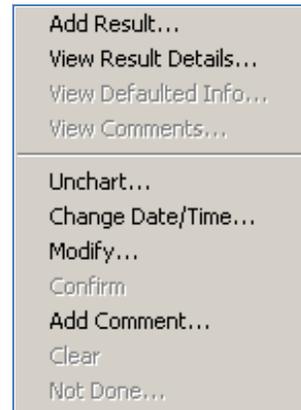
## Interacting with iView (Right Click Functions)

We have already learned that you can right click in a cell that contains documentation results and enter a comment. In many of the cells you can also right click and add an Answer or result.

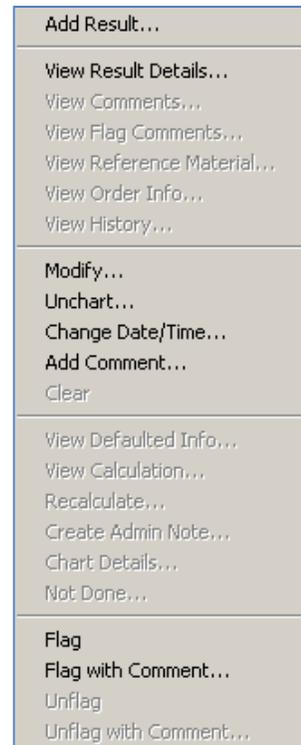


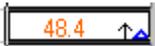
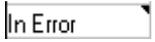
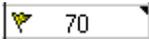
By Right Clicking on the Results in the cell you can also perform a variety of functions when those options are available. Dithered options (options that are not highlighted) are not available. Available options will be indicated by the dark print as seen in the examples below.

Right Click Options in the Intake and Output section include:



Right Click Options available in other bands include:



Add Results – Adds results to the selected cell.	Clear -- for a selected cell.
View Results Details – Allows you to view all results entered into selected cell.	View Defaulted Info – Views defaulted information in a selected cell.
View Comments – Allows you to view all the comments entered in a selected cell.	View Calculation – Allows you to view a calculation in a selected cell when available.
View Flag Comments - Allows you to view the flagged comments in a selected cell.	Recalculate – Allows you to recalculate a value in a selected cell when available.
View Reference Material – Allows you to view reference material when available in a selected cell.	Create Admin Note – Creates an Admin Note for the selected cell.
View Order Info -- Allows you to view order information when available in a selected cell.	Chart Details – Allows specific detail or comments to be charted for a selected cell.
View History -- Allows you to view history when available for a selected cell.	Not Done – Allows you to select the Result as not done for a selected cell.
Modify – Allows you to modify a selected cell. Note that a modified cell will display a blue triangle showing the item in the cell has been modified. 	Flag -- Allows you to create a flag for a selected cell. 
Unchart -- Allows you to unchart a selected cell. The uncharted cell will display an “in Error” value and can be viewed by selecting View Results Details or View Comments. 	Flag with Comments – Allows you to create flag with a comment for a selected cell. The additional of a comment will display a triangle in the top corner. 
Change Date/Time – Allows you to change the date/time for a selected cell.	Unflag – Allows you to unflag when a flag is available for the selected cell.
Add Comment -- Allows you to add a comment for a selected cell.	Unflag with Comment – Allows you to unflag with a comment for the selected cell.

## Modifying an iView Result

---

To modify the information in a signed cell in iView, complete the following steps:

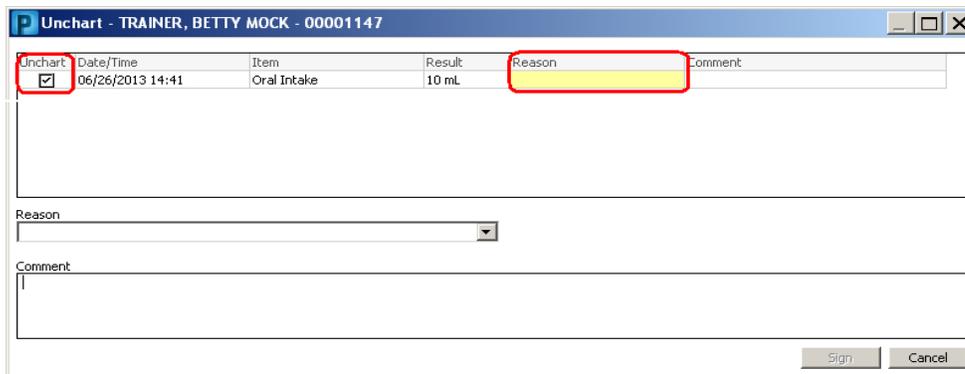
1. Select the Band in iView you wish to modify.
2. Select the correct date and cell to modify.
3. Right click on the cell and select modify.
4. Edit the information displayed by either unchecking, or changing the Result to your new Result.
5. Click  to chart the information.

## Uncharting an iView Result

---

To Unchart a Result in iView, complete the following steps:

1. Select the Band in iView you wish to Unchart.
2. Select the correct date and cell to Unchart.
3. Right click on the cell and select Unchart.
4. A window will appear with a check mark beside the selected item to Unchart.



Unchart	Date/Time	Item	Result	Reason	Comment
<input checked="" type="checkbox"/>	06/26/2013 14:41	Oral Intake	10 mL		

Reason  
▼

Comment  
|

Sign Cancel

5. A Reason for Uncharting must be entered following hospital policy.
6. Select the pull down window to enter a reason for Uncharting.
7. Click  to sign the reason for Uncharting.
8. "In Error" will display in the field indicating that it was uncharted.



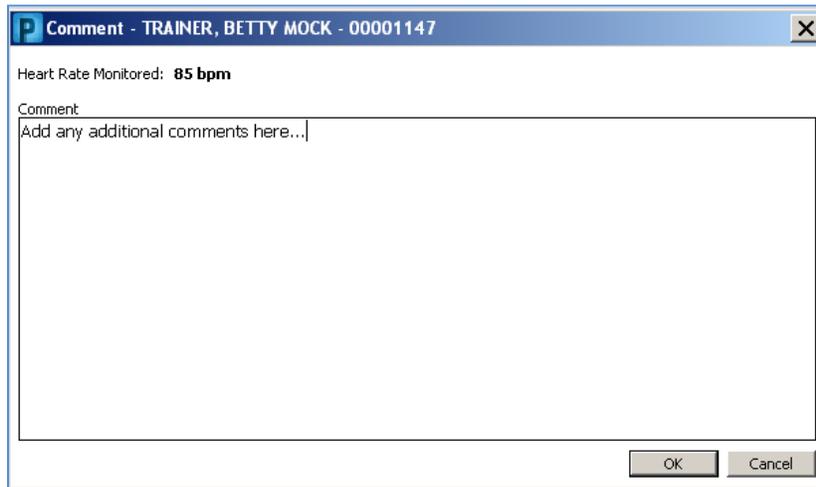
## Adding and Viewing Comments at the Results Level

---

Comments should be included with the result when modifying or uncharting documentation to explain why the result has been changed. If a result has been documented in error and Uncharting is the option selected, always enter EID (error in documentation)

To add a comment to the information in a signed or unsigned cell in iView, complete the following steps:

1. Select the Band in iView where you wish to add a comment.
2. Select the correct date and cell to modify.
3. Right click on the cell and select Add Comment.
4. Enter comments you wish to add to the cell.
5. Click  to add the comment to the cell.



### To View Comments:

1. Right-click on the result and select “View Comments” or select the “View Comments” option from the “Options” menu.
2. The “Result Detail” window will display with the comment tab showing



Note: You cannot add a comment to a cell that does not contain a result or value.

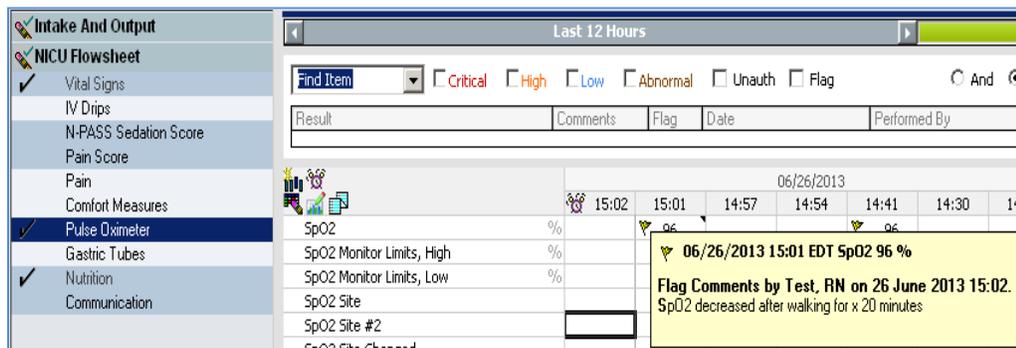
## Flagging a Result

To Flag a documented result indicating the result is significant, complete the following steps:

1. Select result that has been a signed. (Holding down the CTRL key will allow you to select several results at one time.)
2. Right click on the cell(s) and select Flag from the list of functions.
3. The cell(s) will then appear with a small flag in the left corner.



4. Results can also be flagged with a Comment by selecting Flag With Comment from the functions list, entering your comment and clicking okay.
5. The comments can be viewed by right clicking on the cell with the comment and selecting View Flag Comment or simply hovering over the cell(s) with the mouse and the comment will display.



## Viewing Reference text

Reference text is commonly used to remind users of policies or procedures associated with their documentation. Items with reference text display in blue font and are underlined. This is a hyperlink to the reference information when available.

- You can single click on the item to launch the reference text or hover over the item to display the reference text icon.
- By clicking on the icon or on the words "Reference Text" the reference text window will be launched. [Reference Text](#)
- The Reference Material can also be viewed by Right clicking on the cell where documentation is completed and selected View Reference Material.

Or

- Right clicking on the hyperlink and selecting View Reference Material.

# Viewing Results

## Viewing Result Details in iView

You can view results in various different ways within iView. Details about the results, comments associated with the result, a view of the history of the result, and a view of order information can be seen from iView.

Sections within the iView bands that contain results will display a check mark beside them indicating that results are present.

### Viewing a Specific Item:

Clicking on the Find Item pull down will help in filtering and searching for a specific item.

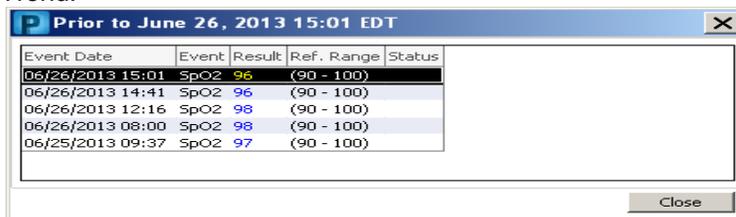
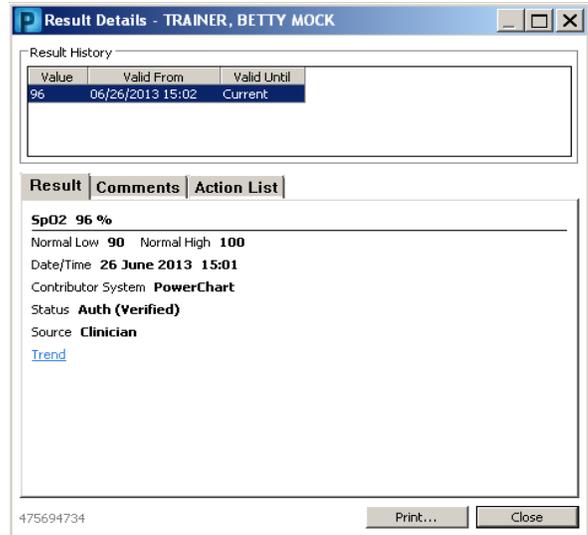
1. Select the item that you are looking for from the drop-down box.
2. Once selected the results display in the white box below the drop down box.



### Viewing Results and Result Details within the bands:

To View documentation results/Results in iView, complete the following steps:

1. Select the Band in iView you wish where you wish to view a result.
2. Select the result to view.
3. Right click on the cell and select View Result Details. The result details will display.
4. Print these results by clicking on Print.
5. In the example below the option to trend the results is available. This is a hyperlink that will allow you to view additional information. Click on Trend.

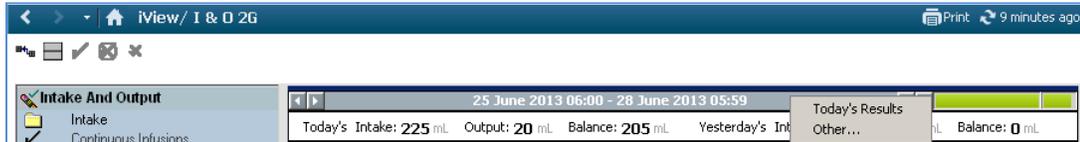


6. The screen that displays will show trended data for any information entered prior to the result you are entering.

### Viewing Results in the Intake and Output Band

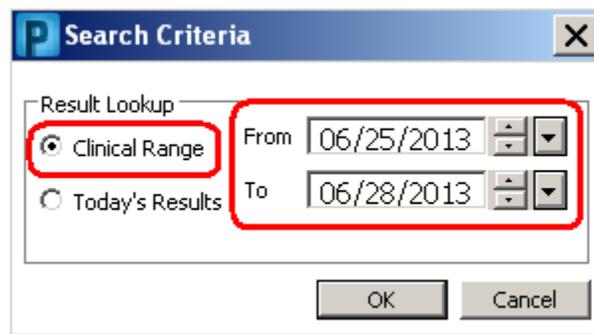
To View documentation results/Results in the iView Intake and Output band, complete the following steps:

1. Select the Intake and Output band in iView. The system will default to today's date and results.
2. Right click on the blue Information Date Range Bar and it will allow you to select to view Today's Results or Other.



3. Selecting *Other* gives the option to choose from Today's Results or Clinical Range.
4. Choosing Clinical Range activates the *From and To* date range fields where you can indicate the dates to view.

It is recommended to only view 3 days at a time in order to allow the results to load timely.



5. Click OK. 
6. Use the scroll bar along the bottom and side of the window to view all results within the selected range.

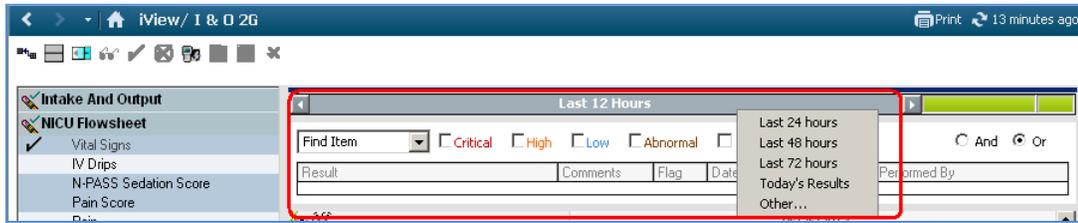
Note: If a date range exceeding 4 days is entered you will receive the following warning. Selecting OK will continue to load the information but may take an extended amount of time.



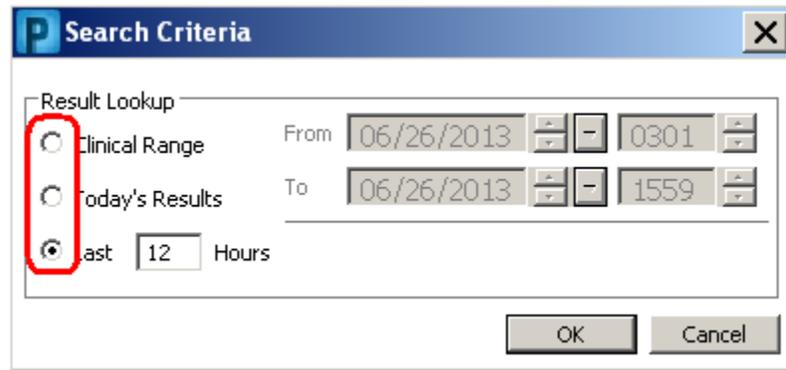
### Viewing Results in other iView Bands

To View documentation results/Results in using other iView bands such as the Flowsheet band, the Systems Assessment band and others as seen below, complete the following steps:

1. Click the band in to view. The system will default to the Last 12 Hours to display results.
2. Right click on the blue Information Date Range Bar and it will allow you to select to view *Today's Results*, results from the *Last 24 – 72 hours* or *Other*.



3. You will be prompted to select one of the following
  - a. Clinical Range – this will activate the *From and To* date range fields where you can indicate the dates to view.  
  
Note: If a date range exceeding 4 days is entered you will receive the following warning.
  - b. Today's Results – this will display results for today's date.
  - c. Last \_\_\_ Hours – this field will allow you to enter the number of hours in the past for which you would like to view results.



4. Click OK.
5. Use the scroll bar along the bottom and side of the window to view all results within the selected range.

### Viewing Critical, High, Low or Abnormal Results

A critical, high, low, abnormal or flagged result can be searched and found using the filter at the top of iView window. By clicking in the check mark beside one of these values any result falling within the selected range will populate in the Result view window below the filter.

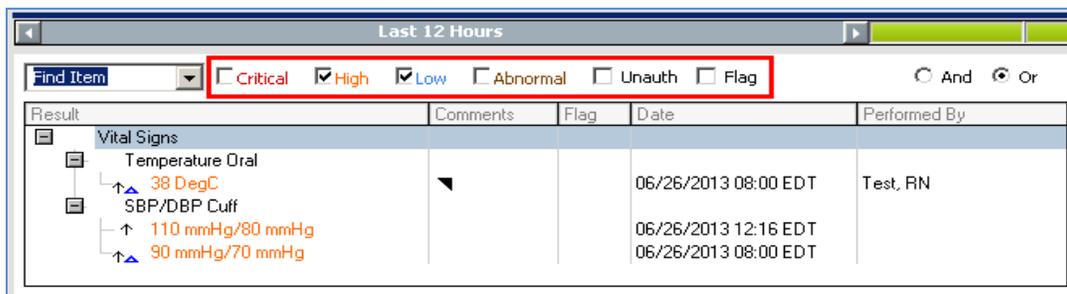
#### Descriptions:

Critical result – Any critical result in the view will display in red text with an exclamation point to its immediate right.

High result – Any high result in the view will display in orange text with an up arrow to its immediate right.

Low result – Any low result in the view will display in blue text with a down arrow to its immediate right.

Abnormal result – Any abnormal result in the view will display in brown text with a lightning bolt icon to its immediate right. Unsigned

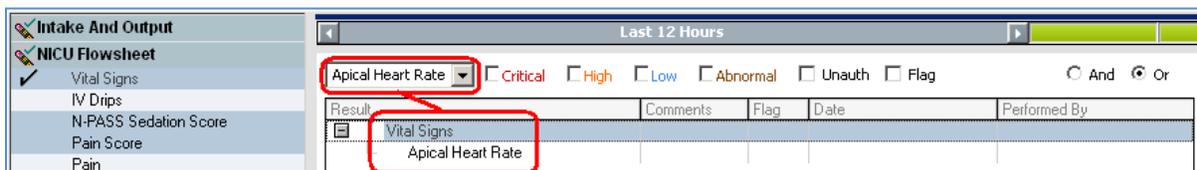


### Viewing Specific Results within a Band

This search window can also be used to search for results for a specific item within the band you are viewing. Type the item description in the Find Item window. A list of item names will appear in the drop down for you to select from.



In the example below SpO2 is entered in the Find Item window and the results display in the window below.

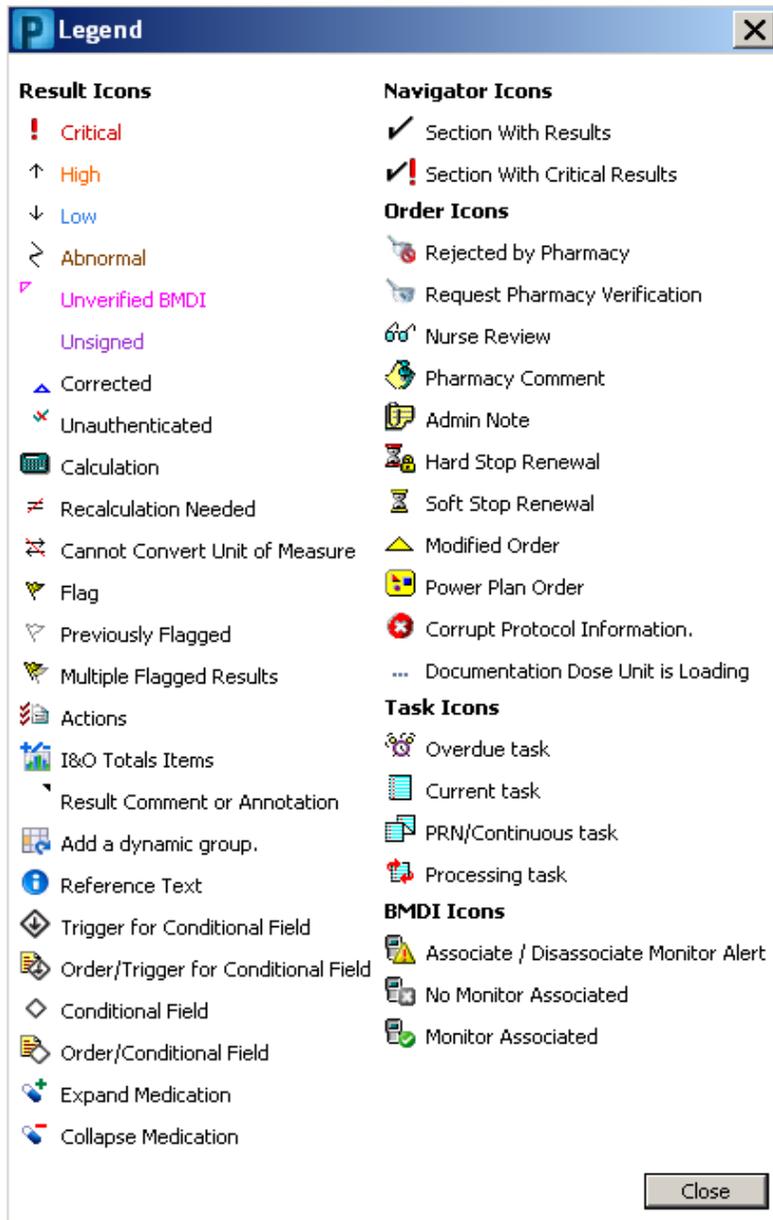
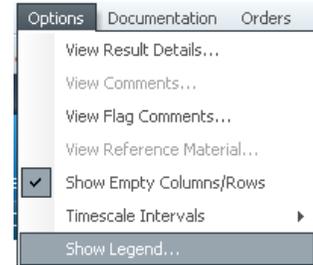


## Result Indicator Icons

The Results Indicator Icons will be displays beside the results in the individual cell to when an applicable action is resulted. A quick reference to the indicator legend can be viewed at any time by clicking Options in the Organizer Toolbar and then Show Legend.

To access these icons

1. Click on **Options** on the eKIDs task bar.
2. Click on **Show Legend**.
3. The Legend will display the icons indicators and their purpose:



## Troubleshooting Results

When viewing results or looking for entries previously posted remember these troubleshooting tips:

Check the Timeframe Bar at the top of the screen to ensure the date and time you are expecting correctly displayed in the Timeframe Bar.

Make sure you “Refresh” iView so that the most up to date information is displayed.

If you still can't find the results you are looking for, check the forms browser to see if they may have been charted on a Powerform.

## Viewing Critical, High, Low or Abnormal Results

A critical, high, low, abnormal or flagged result can be searched and found using the filter at the top of iView window. By clicking in the check mark beside one of these values any result falling within the selected range will populate in the Result view window below the filter.

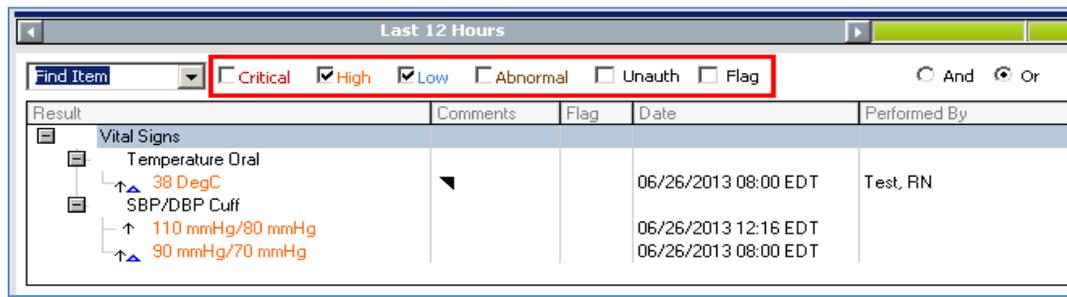
### Descriptions:

Critical result – Any critical result in the view will display in red text with an exclamation point to its immediate right.

High result – Any high result in the view will display in orange text with an up arrow to its immediate right.

Low result – Any low result in the view will display in blue text with a down arrow to its immediate right.

Abnormal result – Any abnormal result in the view will display in brown text with a lightning bolt icon to its immediate right. Unsigned



### Viewing Specific Results within a Band

This search window can also be used to search for results for a specific item within the band you are viewing. Type the item description in the Find Item window. A list of item names will appear in the drop down for you to select from.



You can also search and filter an item by using the look up window. Search for an item by using the drop down arrow or start typing the name of the item in the “Find Item” field. Note: when typing in the name it must be exactly as it appears in the flow sheet.

In the example below the search was for “Apical Heart Rate”. In the results areas you can see that “Apical Heart Rate” can be found under “Vital Signs” in the customized view.



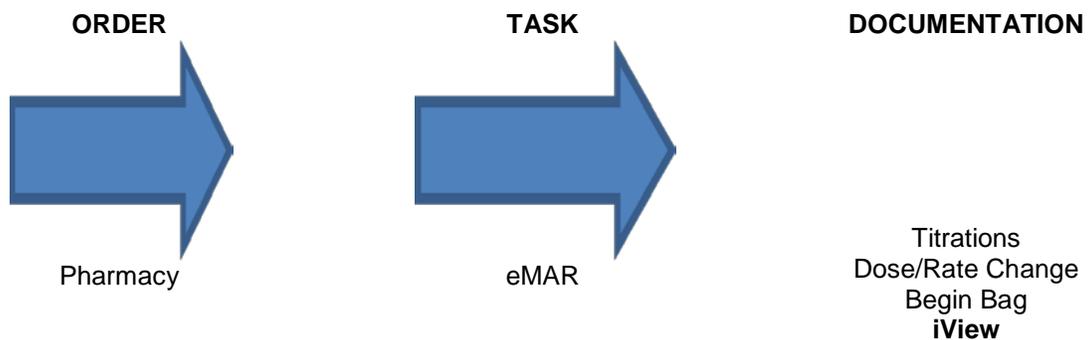
## Complex iView Charting

In addition to routine flowsheet documentation there are additional features available that will assist in documentation ease and functionality. These include:

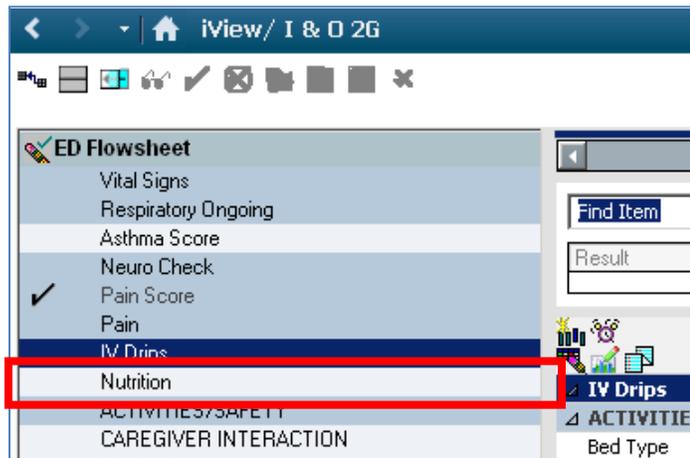
- Titratable Drips
- Dynamic Groups
- Conditional Logic
- Activity View Functionality

### iView Titratable IV Drips Process in eKIDs PowerChart

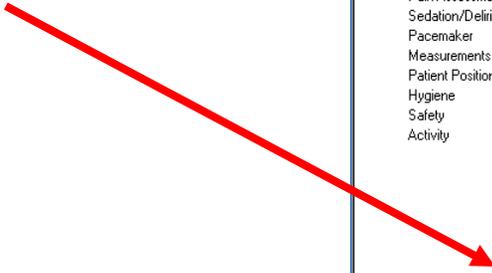
As we discussed previously in the eMAR section of this manual, the IV Drip documentation should always begin in the eMAR where the Begin Bag is charted. Documentation for the IV Drip will then be available on the iView NICU Flowsheet Band. When selected from the navigator – IV Drips will appear on the working view.



The IV Drips are available on the iView in the NICU Flowsheet band. When selected from the navigator the IV Drips will appear on the working view.

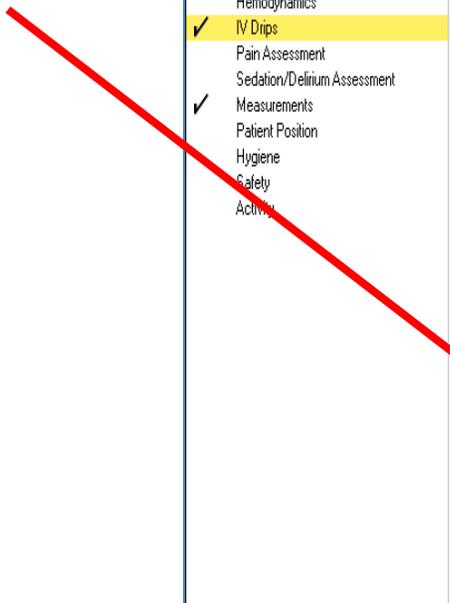


The drips will display in alphabetical order. All of the inactive drips will appear grey and be listed at the bottom of the screen.



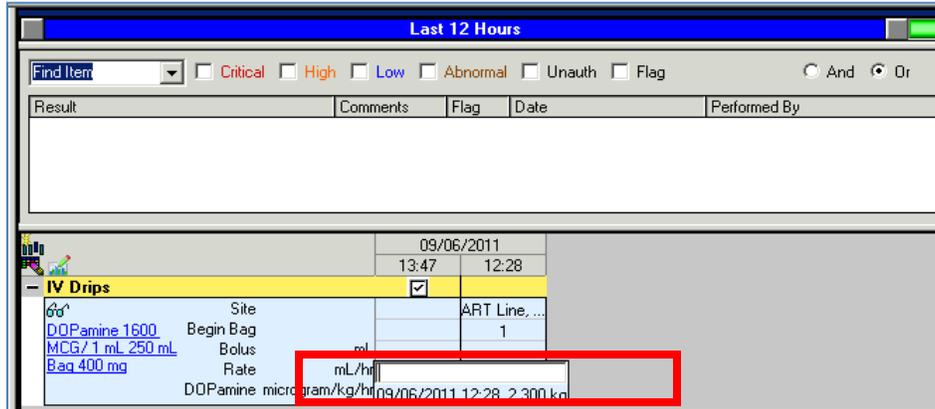
Find Item	Critical	High	Low	Abnormal
Result				
Comments				
4/14/2011 15:11				
<b>IV Drips</b>				
Dopamine 400mg Drip std* NEW 400 mg + Dextrose 5% Premix Diluent 250 mL Rate DDPamine				
DOPamine 400mg/D5W Drip std* 400 mg Rate DDPamine				
DOPamine additive 400 mg + Dextrose 5% Premix Diluent 250 mL Rate DDPamine				
DOPamine additive 400 mg [2 mcg/kg/min] + Dextrose 5% Premix ... Rate DDPamine				
Heparin 25,000 units Drip/premix std* 250 mL Rate hePARIN				
Heparin 25,000 units Drip/premix std* 250 mL Rate hePARIN				

Once the begin bag has started the rate and dose appears in iView.

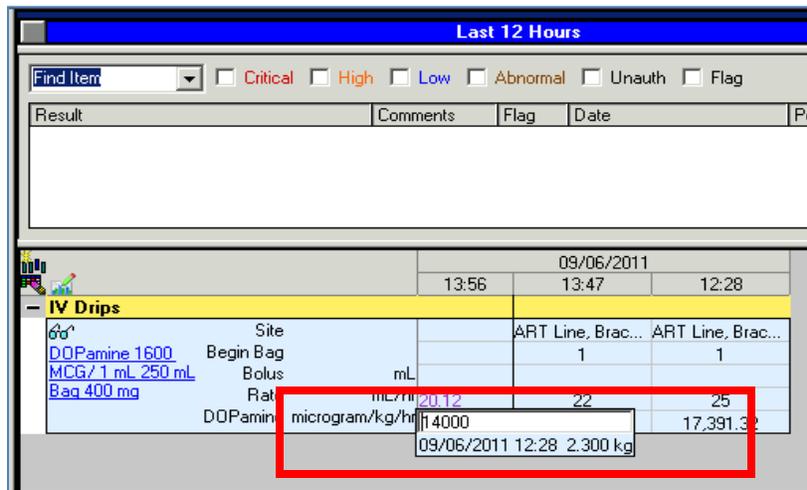


Find Item	Critical	High	Low	Abnormal
Result				
Comments				
Flag				
Date				
4/14/2011 15:26 15:18				
<b>Vital Signs</b>				
SBP / DBP mmHg				
Mean BP				
BP Site				
SBP / DBP Arterial -/-				
MAP Arterial				
RTF				
Heart Rate bpm				
Cardiac Rhythms				
Temp (C)				
Temp Source				
Resp Rate (Spont) br/min				
SPO2 %				
EtCO2 mm/Hg				
SiO2 %				
VS Observation & Intervent				
<b>IV Drips</b>				
DOPamine additive 400 mg [2 mcg/kg/min] + De... Rate mL/hr 5.09				
DOPamine mcg/kg/min 2				

Charting can be activated which in turn opens the rate field for adjustments and documentation.



Adjustments to the dose will automatically calculate the rate.



## Documenting a Discontinued Drip

It may be necessary to document on IV drips that have already been discontinued in PowerChart. In order to document on a discontinued drip, simply activate charting by clicking on the IV drips band or right clicking in the rate cell and adding results. Then proceed to enter the documentation.

IV drips that have been discontinued will stay on your iView until the order discontinued date falls outside of the timeframe bar.

		4/19/2011		
		13:53	13:51	11:30
<b>Vital Signs</b>				
SBP / DBP	mmHg			
Mean BP				
BP Site				
SBP / DBP Arterial	-/-			
MAP Arterial				
RTF				
Heart Rate	bpm			
Cardiac Rhythms				
Temp (C)				
Temp Source				
Resp Rate (Spont)	br/min			
SP02	%			
EtCO2	mm/Hg			
StO2	%			
VS Observation & Intervent				
<b>IV Drips</b> <input checked="" type="checkbox"/>				
DOPamine additive	Begin Bag		1	1
400 mg [2 mcg/kg/...	Rate mL/hr	3	11	6.99
	DOPamine mcg/kg/min	2.29	3.15	2

## V Drip Dose/Rate Changes

Dose/Rate changes can be charted directly from iView by activating charting and entering the dose in the appropriate cell. This will automatically update the rate.

VS Observation & Intervent				
<b>IV Drips</b> <input checked="" type="checkbox"/>		2	1	1
DOPamine additive	Begin Bag			
400 mg [2 mcg/kg/...	Rate mL/hr	5	4	4
	DOPamine mcg/kg/min	04/14/2011 15:17:00 67.800 kg 1.57		
<b>IV Drips</b> <input checked="" type="checkbox"/>				
DOPamine additive	Begin Bag	2	1	1
400 mg [2 mcg/kg/...	Rate mL/hr	4	4	4
	DOPamine mcg/kg/min	1.97	1.57	1.57

### Things to Remember:

- Do not click to fill in hourly totals in Intake and Output section until after the end of the hour so that the correct amount calculates properly for the entire hour. Example: Rate changed to 0 stopping continuous infusion and then restarted.
- IV fluids and TPN will not show up in this section.
- Reminder: Nursing Informatics **recommends that dose/rate changes be charted in the IV Drips section of iView for ease of workflow**, unless the user is already in the eMAR when making a rate change.

Always chart from the earliest hour to the most current. Example: 7am, 8am, 9am and then 10am.

## Dynamic Groups

---

Dynamic Groups are used to create multiple instances within a section for the same types of documentation within iView and I&O 2G flowsheet allowing the clinician to setup and create multiple charting sections for the same types of patient care documentation.

Throughout the flowsheet there are many dynamic group options. The dynamic group icon  is displayed to the right of the section title. Only those bands that can have the same types of documentation contain the dynamic group icon. As many sections as necessary can be created to define each instance needed for results.

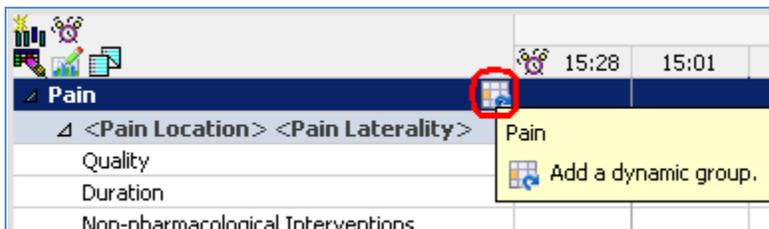
Examples of documentation using Dynamic Groups are:

- Multiple Wounds
- Multiple Central Lines
- Multiple Drains and Tubes
- Patient Education for multiple events or actions
- Pain Assessment of multiple areas
- Caregiver Interaction

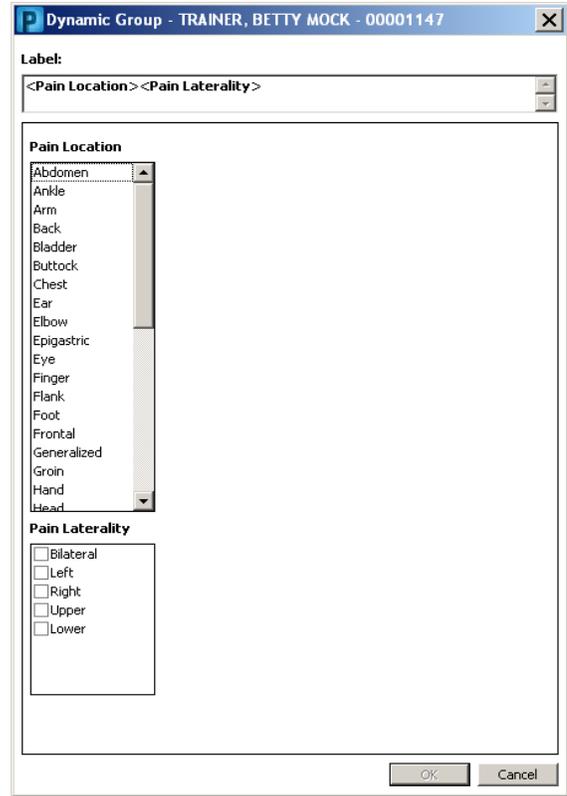
To create the dynamic group:

1. Select the Band in iView where the dynamic group is to be created. In the example below we are adding a Dynamic Group to the Pain Assessment. The new dynamic group will display at the end of the list for this section.

Click on the icon .



2. Double click on the blue bar under the time.
3. A pop up box will open and allow you to label the group. Using the available options, you can add descriptions within the label. This allows results to be added and then reviewed easier while ensuring documentation is completed in the correct section.



4. Select the appropriate labels within the window and click OK .

The labels you have selected will populate on the flowsheet.

5. Now you are ready to complete the documentation and sign.
6. To add a second Dynamic Group, click on the icon and follow the steps above.



When documenting on an existing dynamic group examine the title to ensure it is the label that corresponds to the data you wish to document.

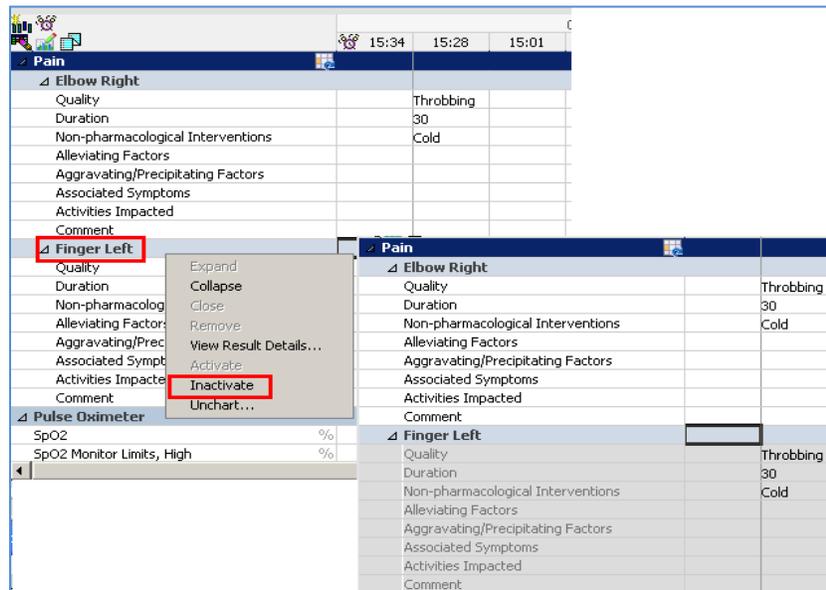
		02/22/2011	
		13:26	10:52
+ None Right			
- <Elbow Right>			
	Pain Scale		
	Pain Score		
	Pain Quality		
	Pain Duration		
	Pain Interventions		
	Pain Alleviating Factors		
	Pain Aggravating/Precipitating Fact...		
	Pain Associated Symptoms		
	Pain Activities Impacted		
- <Elbow Left>			
	Pain Scale		
	Pain Score		
	Pain Quality		
	Pain Duration		
	Pain Interventions		
	Pain Alleviating Factors		
	Pain Aggravating/Precipitating Fact...		
	Pain Associated Symptoms		
	Pain Activities Impacted		
- Comfort Measures			

## Removing Dynamic Groups

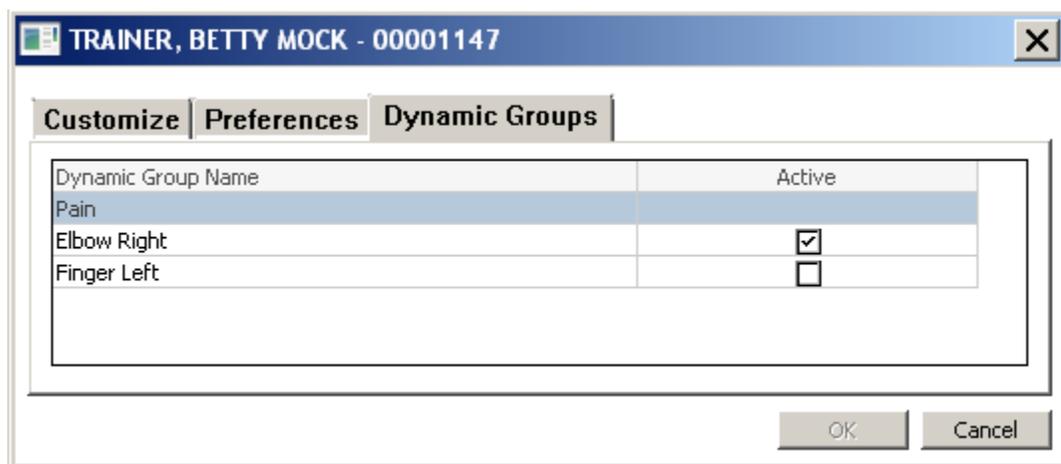
If a Dynamic Group has been created or is no longer necessary it may be deactivated so that no additional charting can be added to that group.

There are four available methods for removing or deactivating the Dynamic Groups in the event it was added in error or the group is no longer needed for documentation. This will make the group unavailable for charting.

1. If the group was added prior to documentation results being signed, it can be removed by:
  - a. Clicking the refresh button.
  - b. Be aware that clicking on refresh will not only remove the Dynamic Group but it will remove any unsigned documentation.
  
2. If the group was added and **labels were NOT** assigned **prior** to your result documentation being signed, the group will be removed from view.
  - a. Sign and finish your results.
  - b. If no labels or results are contained within the unwanted Dynamic Group it will be removed from view.
  
3. If the group was added and **labels** were assigned **prior** to your result documentation being signed, the group will remain in view.
  - a. Sign and finish your results.
  - b. Deactivate the group by right clicking on the section name added in error.
  - c. Click on Inactivate.
  - d. The Dynamic Group will turn grey and remain in view for 72 hours but the result cells will be inactive.



4. Completing the following steps will also deactivate the Dynamic Groups.
  - a. On the Tool Bar click Options.
  - b. Click on Customize View.
  - c. Click on the Dynamic Groups Tab.
  - d. Unchecking the group to be deactivated but the result cells will be inactive.
  - e. Click OK.



A Dynamic Group can also be Inactivated if it were deactivated in error or needs to be available for additional documentation purposes.

## Conditional Logic

Conditional Logic Icons  are located within various sections in iView. When documenting the results in the cells associated with the Conditional Logic icon, there are *certain* results that will automatically generate (conditional logic) additional questions to be resulted.

The example below shows conditional logic for PIC Activity.

RESPIRATORY	
Respiratory System	
 Respiratory Symptoms	
Chest Motion	
Aeration	
Respiratory Comment	

In this example, When the result "Discontinue" is selected, two additional questions appear for documentation.

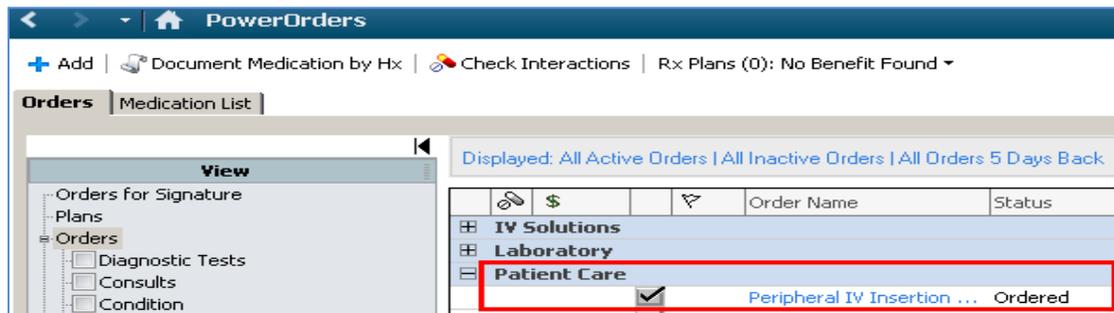
 <span style="float: right;"> 15:42</span>	
RESPIRATORY <input checked="" type="checkbox"/>	
Respiratory System	
 Respiratory Symptoms	Retracting
 Retraction Location	
 Retraction Severity	

As with all documentation in iView, if results are not entered within 72 hours the fields will collapse from view allow for optimization of your work space.

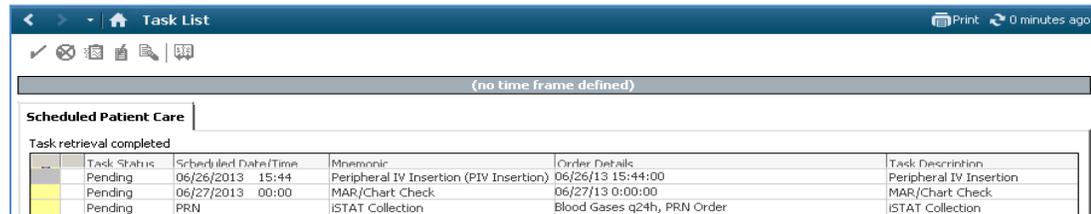
## Activity View Band

The purpose of the Activity View Band is to allow ease of documentation while providing a direct and concise approach to adding results. It is a specific list of questions for an ordered task that pulls the appropriate fields together so that the results can be entered quickly and completely. It provides the clinician with the section(s) to document a task without having to search for the task in iView.

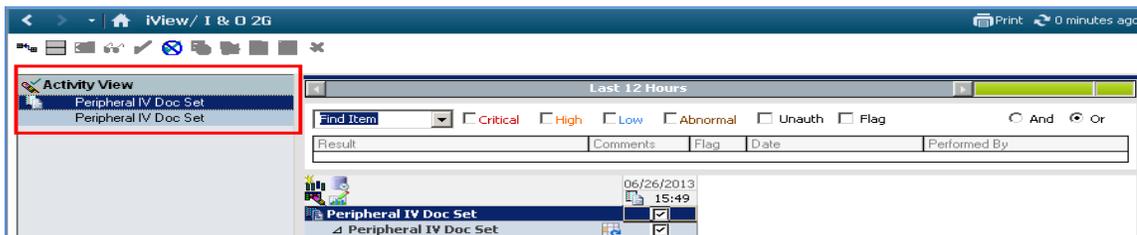
- The Activity Band will display at the top of the iView Bands.
  - The Activity Band will only be available when orders meeting criteria specified by CHKDHS have been entered.
  - These orders will create task within the Task List in the patients chart. Examples include: Bladder Scan, Daily Weight, Circumcision.
  - Once documentation is completed via the Activity Band, the Activity Band will drop from the iView until another order and task meeting the specified criteria is generated.
1. The order is entered.



2. The task is appears on the Patient's Task List.



3. Double clicking on the above task will bring you to the Activity View Band to complete your documentation.



Once the documentation has been signed and completed, refresh your view. The documentation will no longer reside in the Activity Band. It will reside in the appropriate location within iView for future review or documentation.

## Practice Scenario for iView

### iView Documentation Tips and Practice

#### Flowsheet – Communication



- The purpose of this section is to document communication between staff.
- Nurses can document communication with physicians, other nurses, or RTs.
- Clins can document communication with nurses (ie. "Notified nurse of temp. of 38.7").
- RTs will also have access to this section to document their communication with other staff members.

A screenshot of the iView software interface. The window title is "iView/ I & O 2G". On the left is a navigation pane with "Activity View" and "ED Flowsheet" sections. Under "ED Flowsheet", "Communication" is highlighted in yellow. The main area shows a "Last 12 Hours" view with a search bar and filters for "Critical", "High", and "Low". Below this is a table with columns for "Result" and "Comments". A date and time stamp "08/15/2012 10:49" is visible. The "Communication" section is expanded, showing a list of communication events: "Provider Notified", "RT Notified", "RN Notified", "Method of Communication", "Notification Comment", "Returning Call Comment", and "Provider Returning Call". Each event has a corresponding empty input field for documentation.

From iView chart the following information on your patient:

1. Chart Vital Signs including oral temp, HR, RR, BP and O2 sats
2. Chart a Pain Score of 6 and add a dynamic group for left leg and right leg
3. Document that the provider (Dr \_\_\_\_\_) was notified of pain
4. Chart a Neuro and Respiratory Assessment
5. Chart Skin Condition
6. Chart Height and Weight Measurements
7. Document Intake of Juice and Milk in the nutrition section
8. Document Urine Output during current time period
9. Document an Apnea event

## Practice Scenario

---

Please be aware that because you are working in the practice environment you will be entering all of the orders for your practice patient.

<b>Background</b>	5 yo Patient arrives in the ED with complaints of pain in left leg, fell off monkey bars.
<b>Step 1</b>	The patient arrives in triage. Obtain and document the patient's vital signs.
<b>Step 2</b>	Patient gets moved into an ED Room. The Fracture PowerPlan is initiated. Check the tracking board to view new orders.
<b>Step 3</b>	Start the PIV as ordered. Document this from the task list. (If your patient does not already have the order, you will have to enter the order for the task to fire)
<b>Step 4</b>	The physician has ordered a CBC and BMP. Document the collection of the lab on the task list. Document the lab draw in the Lab Procedures section in iView (This can also be documented by clicking on the microscope quick link on the tracking board to complete the PowerForm.)
<b>Step 5</b>	The patient vomits. Document the emesis in the Intake and Output band. In addition, document that you notified the physician in the Communication section.
<b>Step 6</b>	The doctor asks you to assist with the splint application. Document that you assisted in the Treatments-Procedures band.

## **BMDI – Bedside Medical Device Interface**

The Bedside Medical Device Interface also known as BMDI, allows the system to default in information to the clinical documentation in iView in the appropriate section based on the monitor attached. The data from the monitor is downloaded based on specifications predetermined by CHKD. Monitors will typically download data every 60 seconds.

### **BMDI Features:**

- Captures designated patient data every minute
- Monitors will typically download data every 60 seconds
- You can Edit captured data if applicable
- Allows you to change the date and time if needed
- You can view and select acquired data from the past 4 hours
- You can disassociate a monitor when it is no longer needed

BMDIs are set up in groups with IDs that are unique to the monitor and monitor groups. For example, NICU Monitor 123 may be set up in a group for just NICU monitors. Once the patient has been associated with a particular monitor the data will also be associated with that patient. This will allow you to accept the results from the monitor such as heart rate, blood pressure and SPO2 “based on your clinical judgement” and the appropriate patient information will then default into iView. If data from the monitor is not accepted and authenticated by you it will be purged after a predetermined amount of time.

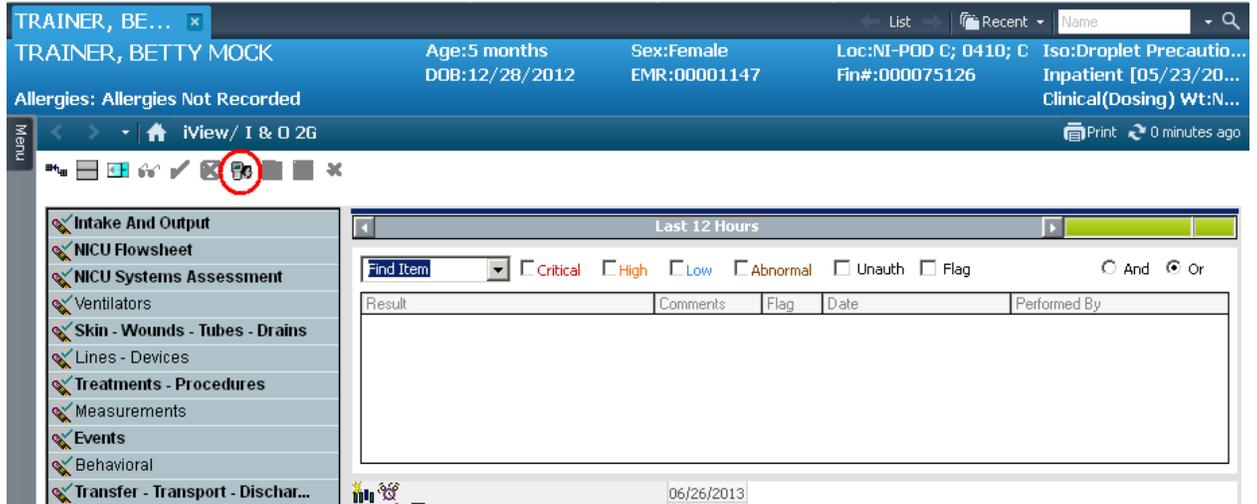
In this phase of the implementation data that can be retrieved from your monitors include:

- ▶ SpO2
- ▶ Peripheral Pulse Rate
- ▶ Heart Rate Monitored
- ▶ Respiratory Rate
- ▶ Systolic Blood Pressure
- ▶ Diastolic Blood Pressure
- ▶ Mean Arterial Pressure
- ▶ Systolic Blood Pressure – invasive
- ▶ Diastolic Blood Pressure – invasive
- ▶ Mean Arterial Pressure – invasive

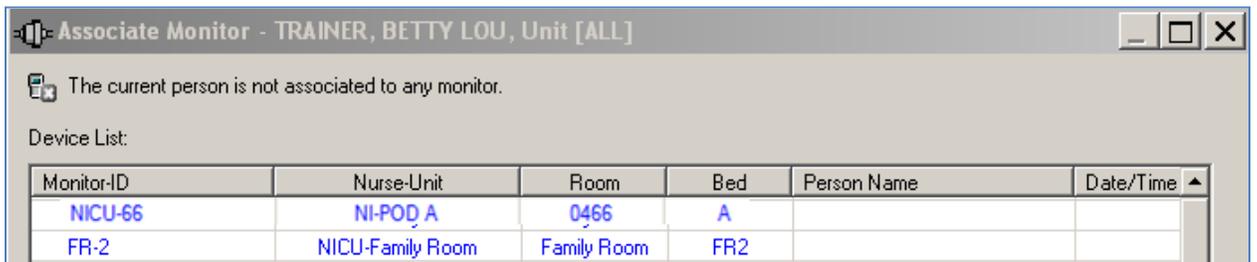
## Device Association Steps

1. Access iView/I & O 2G. If the patient you are accessing does not have any monitors already associated the Associated Monitor screen will automatically launch.

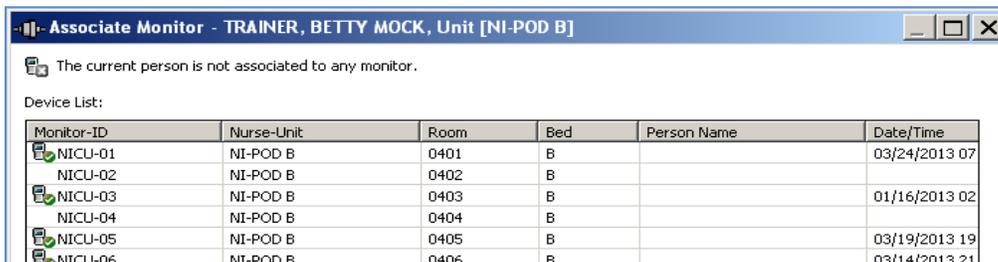
(Note: the Associate Monitor Icon is NOT available when accessing the Intake and Output band.)



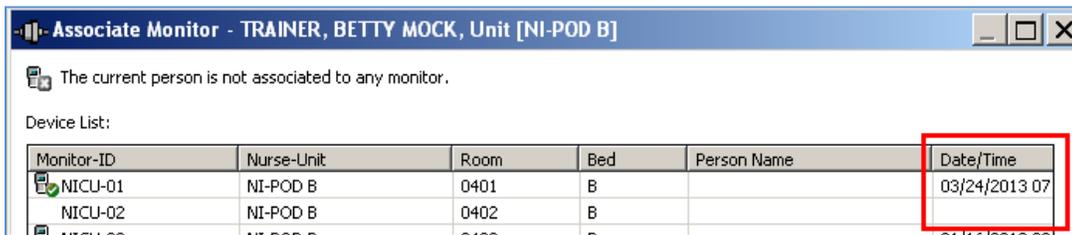
To manually display the Associate Monitor window, select any of the bands starting with the flowsheet band and the Associate Monitor Icon will become active and available to select.



2. To launch the Associate Monitor window, click on the Associate Monitor icon  on the toolbar.
3. In the Monitor-ID column select the Monitor ID number that you would like to associate with your patient.

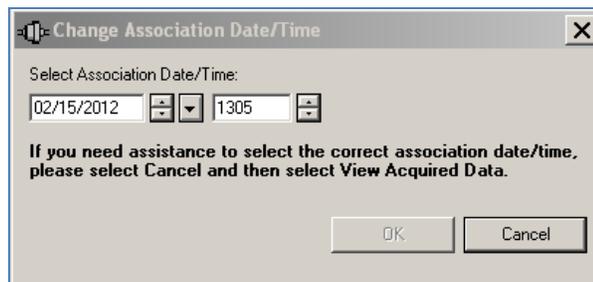


4. Verify that the monitor ID, Nursing Unit, Room and Bed are correct.
  - Top Window – Patient Name is always displayed in the blue bar
  - Monitor ID: shows the Cerner monitor name.
  - Nurse-Unit: Displays the NICU POD of the monitor.
  - Room: room number
  - Bed: bed number
5. To associate a patient, click on the appropriate monitor (line will highlight in blue).
6. Double-Click in the Date/Time cell if you wish to change the date and time you are associating the monitor to the patient to the actual time you placed the patient on the Bedside Monitor.



A window will appear allowing you to change the Date/Time.

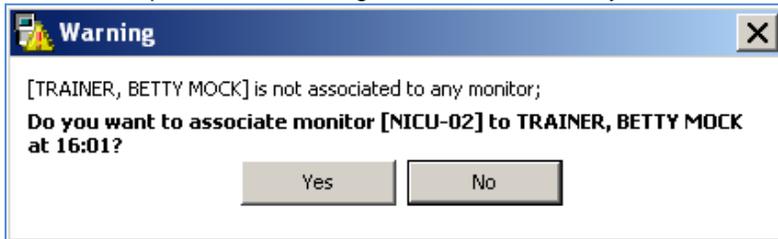
If no date time change is needed, you can proceed to step 8 to associate your patient.



7. Click the Associate button and the patient's name is displayed in the Patient Name column.

Once you have associated your patient a warning will appear as displayed below. This is a final check to ensure the patient is associated to the correct monitor.

Click Yes to proceed or No to go back and make any needed correction.

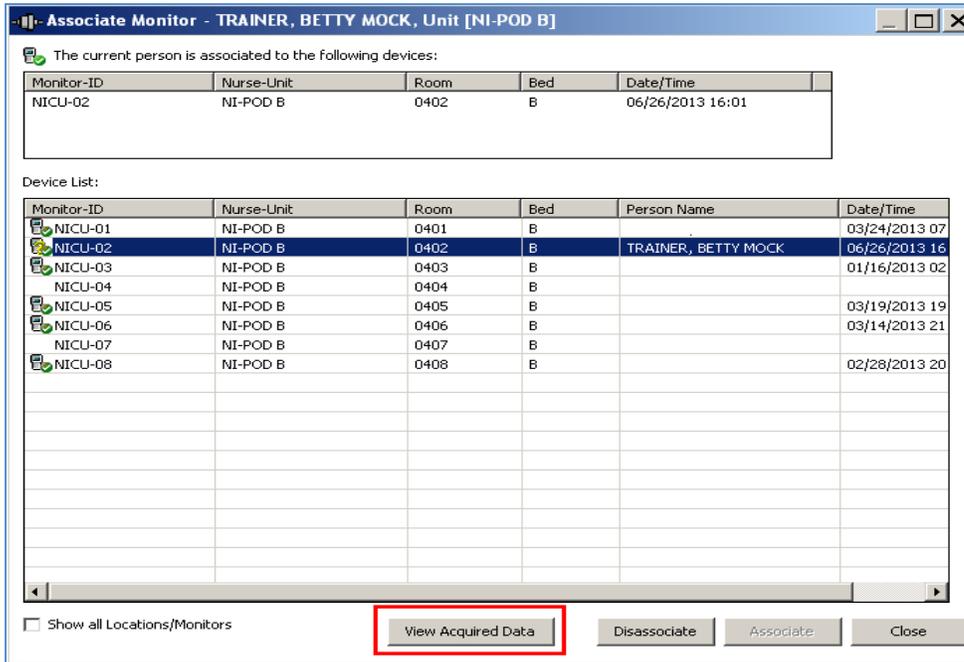


NOTE: Default look-forward time is 5 minutes and default look-back time is 30 minutes. For example, if the time column chosen is 13:00, then only data from the chosen monitor will be retrieved from between 12:30 and 13:05. Your patient will remain on the monitor until they are disassociated.

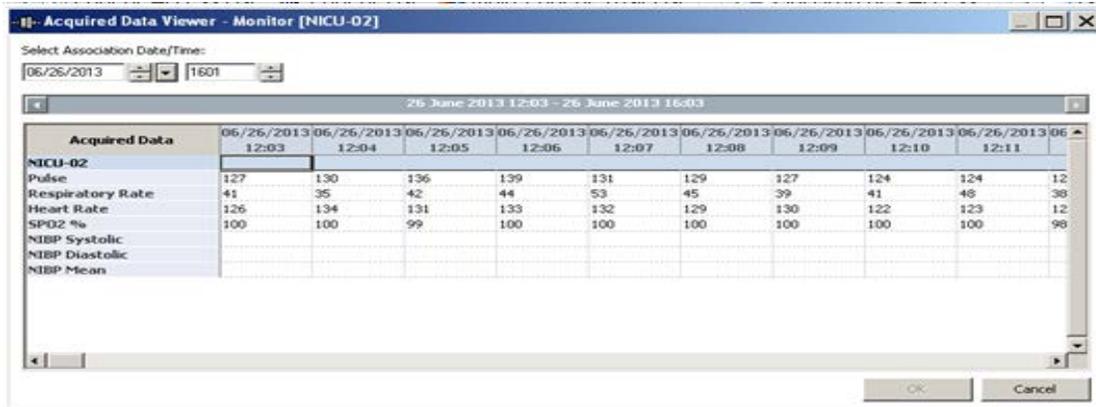
## View Acquired Data

Data acquired by the monitor can be viewed by clicking the 'View Acquired Data' button at the bottom the window.

- Click on the 'Associate Monitor' icon to access the 'Associate Monitor' window
- Highlight your patient's name



- Click on View 'Acquired Data' button



Data can be viewed in one minute intervals. If you identify data you would like to include in your documentation:

1. go to iView and insert date and time of the data
2. double click on the time field and the results will populate
3. sign-off on the results by clicking the green checkmark.

## Tips and Tricks

---

The default is for you to only see those monitors associated with your patient's location. In the event that you need to see monitors for locations outside of the one where your patient resides, simply click the "Show all locations" check box located in the bottom left of the Associate Monitor Window.

- A snapshot of data is captured every **minute**.
- Captured patient data is available for viewing for 4 hours
- The data may have a slight delay in appearing as it must come from the device – to the gateway – to the server then to eKIDs PowerChart; this may cause a delay of about **one** minute.

## Changing the Date/Time of an Association

The date/time can be changed at any time either before associating a monitor to your patient or after the monitor has been associated.

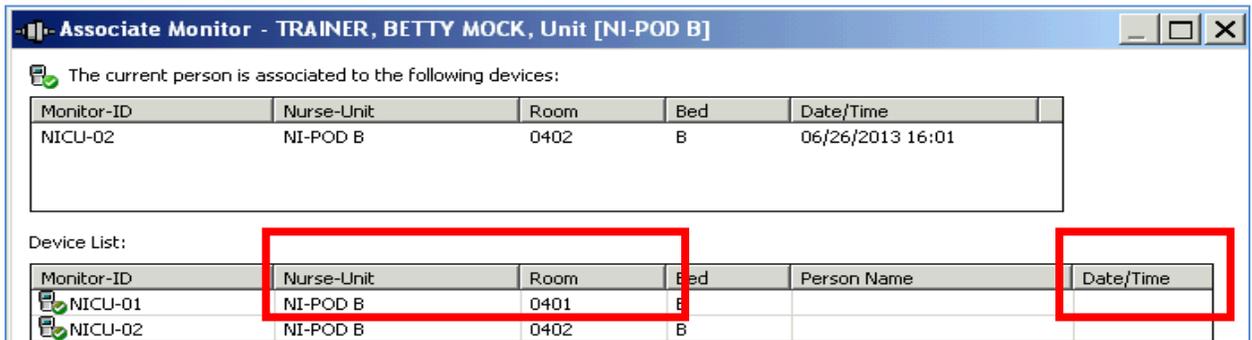
### Before a Patient is Associated with the Monitor

If changing the date/time before the monitor has been associated simply follow the steps for Associating the patient.

1. Access iView/I & O 2G and Click on a band below the I&O Band
2. Launch the Associate Monitor window click on the Associated Monitor icon  on the toolbar. Remember, If the patient you are accessing does not have any monitors already associated the Associated Monitor screen will automatically launch.

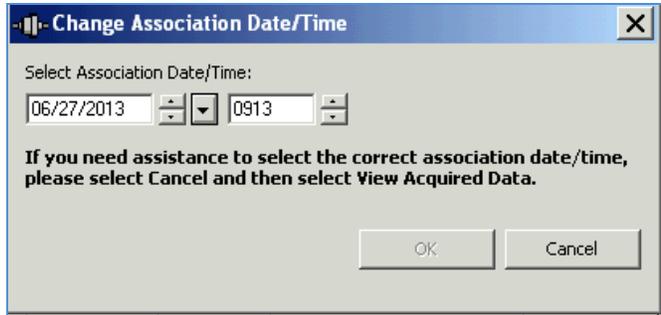
In the Monitor-ID column select the Monitor ID number that you would like to associate with your patient.

3. Verify that the monitor ID, Nursing Unit, Room and Bed are correct.
4. Click on the appropriate monitor.

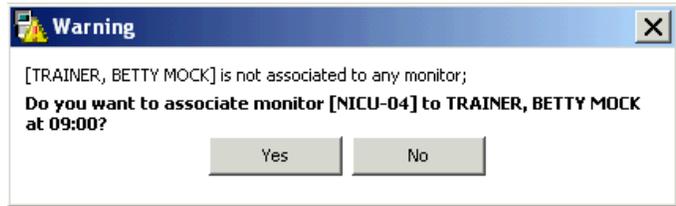


5. Prior to selecting the Associate button you can click the date/time box on the device row.
6. The Change Association Date/Time window is displayed.

7. Change the date/time as needed.



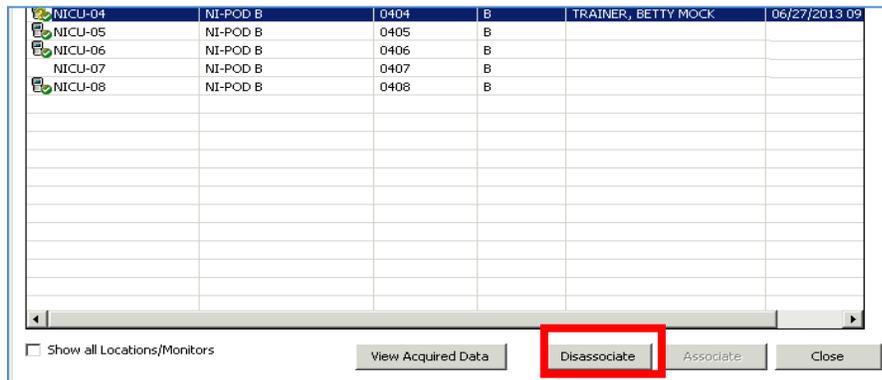
8. Click the Associate button and the patient's name is displayed in the Patient Name column.
9. Once you have associated your patient a warning will appear as a final check.



### After a Patient is Associated with the Monitor

If needed, you can change the date and time the BMDI device was associated. IF the device has already been associated to a patient and actively capturing data for a period of time, this function will allow you to obtain the data needed prior to the associated time

1. To change the date/time of an association, you must first disassociate the patient with the monitor by highlighting the monitor and selecting Disassociate.



2. Then double click on the date/time box of the associated monitor. This allows you to change the time of the association. Click OK.

3. Enter the new date/time in the window and select okay.

The date/time you entered is displayed in the Date/Time field on the monitor device row.

2. Click Associate to re-associate the BMDI device to your patient at the specified date and time and select Close to close the window.

A warning will appear. This is a final check to ensure the patient is associated to the correct monitor. Click Yes to proceed or No to go back and make a correction.

## Retrieving Data from you BMDI

Now that the BMDI device has been associated with the appropriate patient and monitor you can retrieve data from the monitor in iVlew.

To Retrieve Data from your BMDI complete the following steps:

1. Double click the blue band to retrieve data for the appropriate time column to open the cells. (You can right click to add Date and Time to insert a specific time column.)

The screenshot shows the iVlew software interface for patient TRAINER, BETTY MOCK. The patient's age is 5 months, sex is Female, and DOB is 12/28/2012. The interface includes a navigation menu on the left with options like Intake And Output, NICU Flowsheet, and Vital Signs. The main window displays a table of vital signs data for the last 12 hours, with a search bar and filters for Critical, High, and Low values.

Last 12 Hours		
Find Item		
Result		Comments
		06/27/2013 09:26
<b>Vital Signs</b>		
Temperature Oral	DegC	
Environment Temperature	DegC	
Heart Rate	bpm	
Respiratory Rate	br/min	
SBP/DBP Cuff	mmHg	
Mean Arterial Pressure	mmHg	
Blood Pressure Site		
SBP/DBP Line	mmHg	
Mean Arterial Pressure, Invasive		
SpO2	%	
SpO2 Site		
SpO2 Site #2		
SpO2 Site Changed		
SpO2 Probe Changed		

2. Data for the selected time frame will automatically populate in the defined cells.
3. Using your clinical judgement, review and Sign the entry or make needed edits if applicable prior to signing.

In addition to other vital signs, the BMDI also pulls in the invasive blood pressure monitoring and mean arterial pressure (MAP), invasive. Specific to NICU, the Vital Signs section of the NICU Flowsheet band have been setup to default open the following DTA's:

- **SBP/DBP Cuff** – this is composed of the following 2 DTA's:
  - Systolic Blood Pressure
  - Diastolic Blood Pressure
- **Mean Arterial Pressure** – this is the MAP from the monitor
- **SBP/DBP Line** - this is composed of the following 2 DTA's:
  - Systolic Blood Pressure, Invasive
  - Diastolic Blood Pressure, Invasive
- **Mean Arterial Pressure, Invasive** – this is the MAP from the monitor

As long as the patient is associated to a monitor and the nurse double clicks on the section to activate charting the system will pull in the results (cuff or line) into the correct fields.

There are also two Mean Arterial Pressure fields; one that the monitor calculates and one is a calculated field within iView. The system will pull in the Mean Arterial Pressure that is calculated by the monitor.

Below is an example of the data that will default into iView when selected.

- Vital Signs							
Temperature Axillary	DegC		37.1		37.1	37.0	36.9
Temperature Skin	DegC		37.1		37.1	37.3	36.6
Environment Temperature	DegC		28.2		28.6	28.5	28.6
Incubator Set Temperature			28.3		28.5	28.5	28.5
% Humidification	%						
Heart Rate	bpm		156	165	180	168	159
Respiratory Rate	br/min		54	43	44	34	53
SBP/DBP Cuff	mmHg				62/26 ↓		70/60 ↓
Mean Arterial Pressure					39		64
Blood Pressure Site							Right leg
SBP/DBP Line	mmHg						
Mean Arterial Pressure, Invasive							

## **Disassociating a Patient from the Monitor**

---

It is important that clinical staff disassociates the patient from the monitor in iView when the device is no longer needed. This helps to ensure that the correct results from YOUR patient are populating in iView as expected.

You should always Disassociate your patient from the monitor in iView if:

- The patient is being placed on a different monitor – they need to be disassociated from the first monitor before placing them on a new or different monitor.
- The patient is being transferred to a different bed space – transferred to a new bed or location.
- The patient has been discharged – the monitor must be disassociated so that new patients admitted to that bed space can be associated to that monitor
- The date/time of the monitor association needs to be changed.
- If the monitor is no longer needed.

### **To disassociate a patient with a monitor:**

1. Open the patient's chart and go to Iview/I&O2g and access an appropriate band
2. Click on the associate monitor icon on the toolbar.
3. Highlight the monitor/person name for the monitor you want to disassociate.

Click **Disassociate** at the bottom of the screen and the patient's name is removed from the Patient name column and the patient is no longer associated with that monitor.

4. The patients name is now removed from the monitor in the Associate Monitor Window

**NOTE:** If you are moving a patient to a different monitor you must first disassociate the patient from one monitor and associate that same patient to another monitor. When doing this a warning is displayed stating the patient is already associated to a previous monitor. Click Yes to disassociate the patient from the previous monitor and associate the patient to the new monitor you have selected.

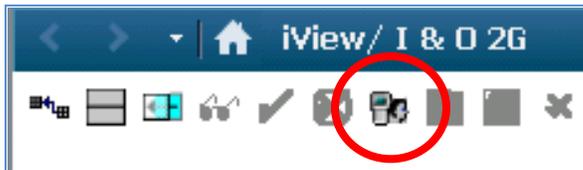
## Viewing Acquired Data

Viewing Acquired Data is a convenient way to view results being recorded for the selected patient at CHKDHS. The data is captured every 60 seconds and the data is available to be pulled in as acquired data.

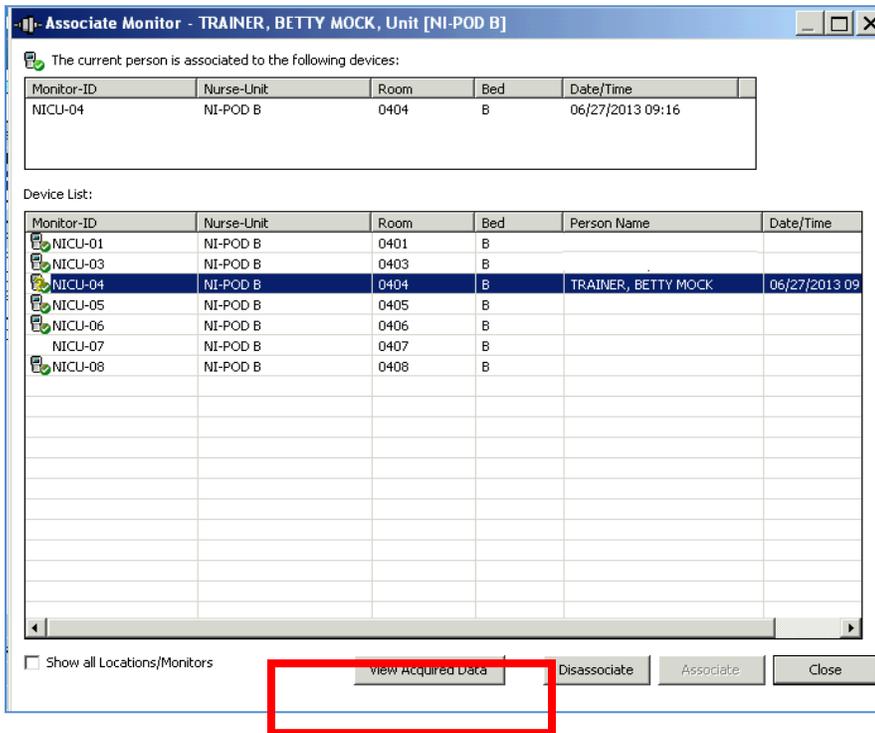
Data that has been acquired by the monitor is available for viewing for 4 hours and can be pulled into your iView flowsheet in the appropriate cells and columns. When retrieving acquired data, there may be a slight delay before it appears on your iView flowsheet as it must come from the device – to the gateway – to the server then to eKIDs PowerChart. This may cause a delay of about **one** minute.

To view the Acquired Data that was collected since the time the patient was associated to a monitor complete the following steps:

1. Open the patient's chart and go to iView/I&O2g and access an appropriate band.
2. Click on the associate monitor icon on the toolbar.



3. Select the "View Acquired Data" button at the bottom of the Associate Monitor Window.



4. The Acquired Data Viewer Window will then open for your monitor.

## Steps to Insert Acquired Data

Once you have viewed and selected the data you wish to insert in iView, note the appropriate date/time of the data and complete the following steps:

Select Association Date/Time:  
 03/24/2013 0732

27 June 2013 05:36 - 27 June 2013 09:36

Acquired Data	06/27/2013 05:37	06/27/2013 05:38	06/27/2013 05:39	06/27/2013 05:40	06/27/2013 05:41	06/27/2013 05:42	06/27/2013 05:43	06/27/2013 05:44	06/27/2013 05:45	06/27/2013 05:46
NICU-01										
Pulse	159	160	159	131	161	160	154	159	160	15
Heart Rate	159	160	158	138	161	160	154	159	159	15
SPO2 %	88	89	89	88	88	89	85	87	88	89
NIBP Systolic										
NIBP Diastolic										
NIBP Mean										

1. Insert a new Date/Time column in iView
2. Enter the Date/Time indicated for the result you wish to document from the Acquired Data.
3. Double Click on the yellow band of the section for the Date/Time where you wish to insert results.
4. Review the results for accuracy and sign as appropriate.

## Section VIII: Nursing Depart Process

The Depart Process dialog box allows you to efficiently manage the activities associated with the process of documenting and departing a patient in FirstNet. The window serves as a launch pad for depart-related solutions, PowerForms, registration conversations, and tracking events. The Patient Demographics Banner is displayed at the top of the window to provide you with pertinent information about the selected patient.

### Depart Process Window Components

The **Demographics Banner** displays general information of the patient you are departing.

**Demographics Banner**

ZZTest, Betty U      Age: 3 years      Sex: Female      Loc: CHKD-ED  
 DOB: 06/17/2010      EMR: 00001164      Fin#: 000075167      Emergency [06/17/20...  
 Allergies: Allergies Not Recorded      Clinical(Dosing) Wt: 16 ...

Templates: Patient\_Summary\_PROD\_092012

Depart Actions:

- Patient Education
- Pt ED Printed
- Task List
- ED Discharge Notes
- IV Stop Times
- Dextrose 5% - NaCl 0.45% 1000 mL
- ED Infusion Billing details
- &Depart

**Pt Ed Summary**      **Clinical**

**The Clinical tab** displays the Visit Summary information for the patient.

**The Pt Ed Summary tab** displays the Education material listed for the patient.

**Depart Actions** display the actions that need to be completed before the patient can be departed.

Primary Care Provider:  
 Name:  
 Phone:

*Visit Information*

Chief Complaint:  
 Date and Time Signed In: 6/17/2013 2:40 PM

*Discharge Information*

ZZTest, Betty U has been given the following follow-up instructions:

Follow-up Instructions:  
 Medication List:  
 New Medications:  
 Printed Prescriptions:  
 amoxicillin-clavulanate (Augmentin ES-600 oral liquid) 45 mg/kg, By mouth, Twice daily, 10 day  
 Refills: 0  
 Medications to Continue Taking That Have Changed

Print      Save      Close

The Depart Process window is where you will complete the Depart Actions before the patient is to be discharged or admitted to the hospital or admitted to the Surgery department.

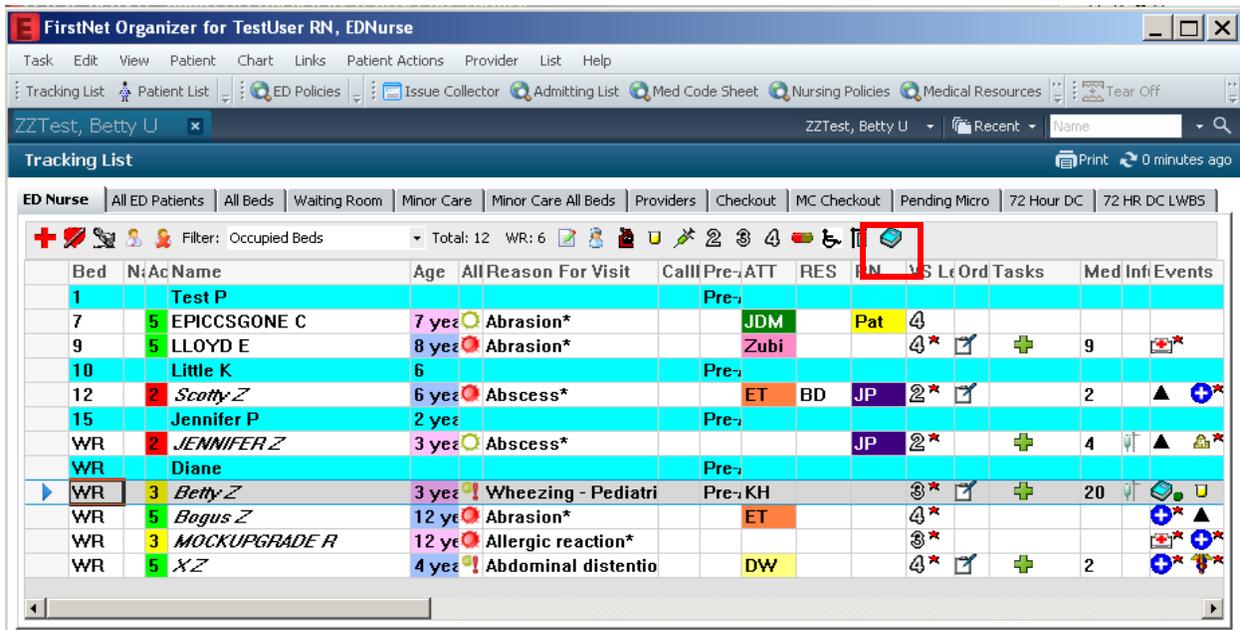
The following are the Depart Actions for completion:

- **Patient Education** – In this section you can review and edit patient education as needed.
  - **Pt ED Printed** -- Indicates that the Patient education information has been printed.
  - **Task List** – Launches you to the Task List where task are verified as completed or completed prior to the patient’s discharge.
  - **ED Discharge Notes** – Launches the ED Discharge Notes Powerform for completion.
  - **Billing** – Displays the Billing Details Report
  - **&Depart** – Will depart the patient from the Emergency Department.
- \*\*Note: Completion of this section is done by RNs, techs, and secretaries.

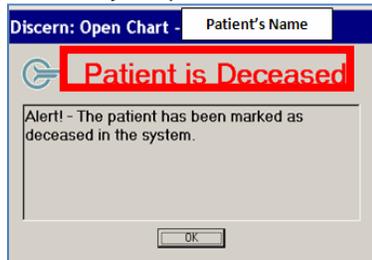
## Selecting your Patient

Prior to departing the patient you will need to select the correct patient from the Tracking List.

- Select the patient you wish to depart by clicking on the patient’s name from the tracking list.
- Once the patient’s name is highlighted as seen below, select the Depart Process Icon on the tool bar.
- This will launch you to the Depart Process window.



**Note:** If your patient is deceased, you will receive the following message upon selecting your patient.



This message will only display once the **Deceased** field has been set to “Yes” in a patient’s record. Click **OK** to move on to the patient’s record.

You will be able to view this information in the Patient Information tab also.

## Discharge Actions

### Patient Education

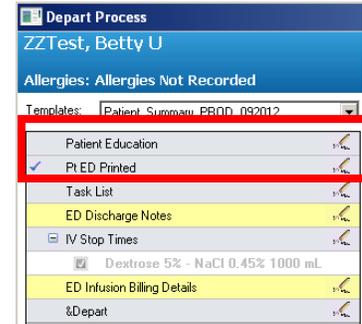
The Patient Education Section Launches the Patient Education Window. Information relative to the patients discharge needs can be selected at this time.

To complete the Patient Education section, complete the following steps

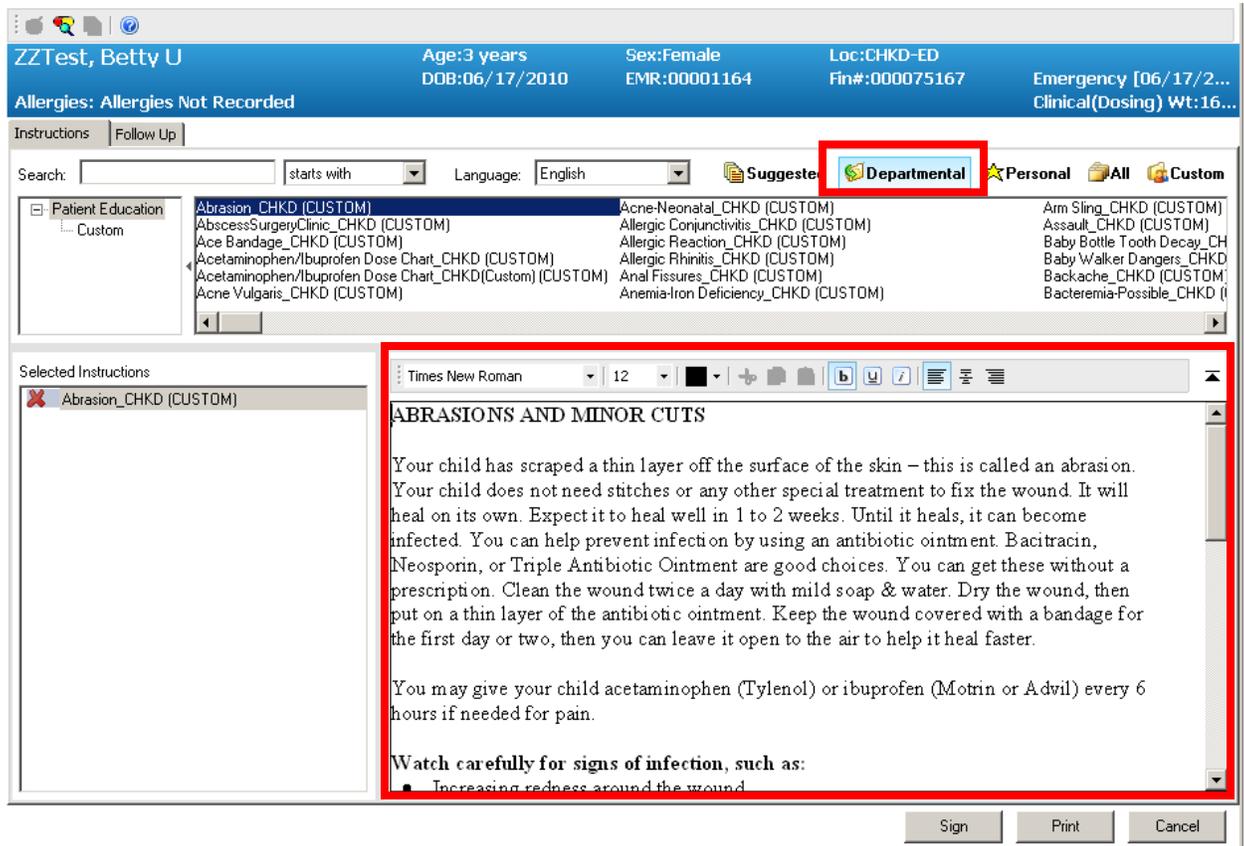
- Select the icon next to Patient Education.

This will open the Patient Education window.

The diagnoses that match your diagnosis will appear in the Suggested folder.



- Select from the available options. The Patient Education will populate once a diagnosis is selected.



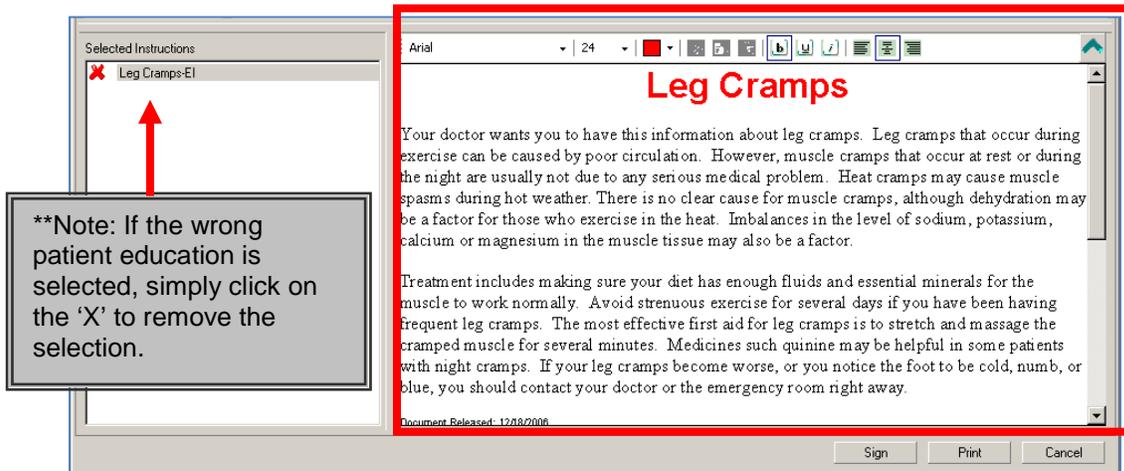
**\*\*Note:** If no patient education is suggested or if a Free Text diagnosis was entered, you will have to search for it by typing the diagnosis in the Search box provided.

If needed, you can edit information in the Patient Education document before printing out for the patient. This will help to personalize the document to the patient's diagnosis.

To edit the information, simply type the information you would like to add in the document.

- Once complete, select Print if you would like to print the information.
- If complete, select Sign.

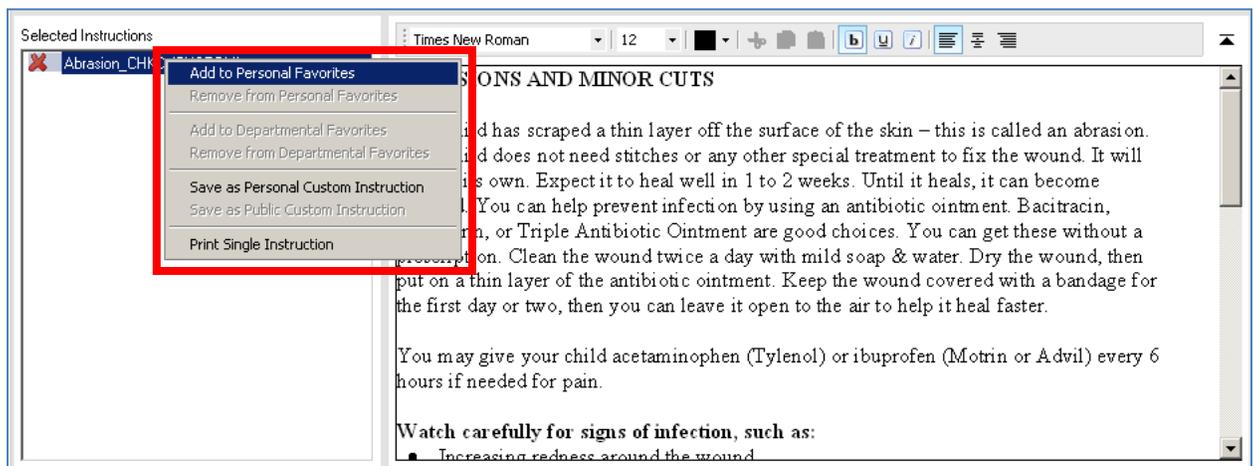
When the Patient Education is signed, the document is automatically saved to the Documents tab within the patient's chart. If the document is signed multiple times, it overwrites the existing document instead of making a new one.



## Building Favorites for Patient Education

By right clicking on the selected patient education in the Selected Instructions window, you are able to add frequently used instructions to the following folders:

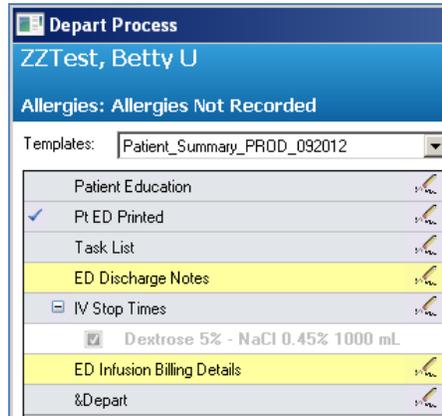
- **Add to Personal Favorites** – Adds patient education to your Personal folder.
- **Add to Departmental Favorites** – Adds patient education to your Department Folder.
- **Save as Personal Custom Instruction** – Adds your custom diagnosis to the patient education selection list.



Once you add a patient education to one of the folders, simply click on that folder and the added patient education will be available for selection.

## Pt ED Printed

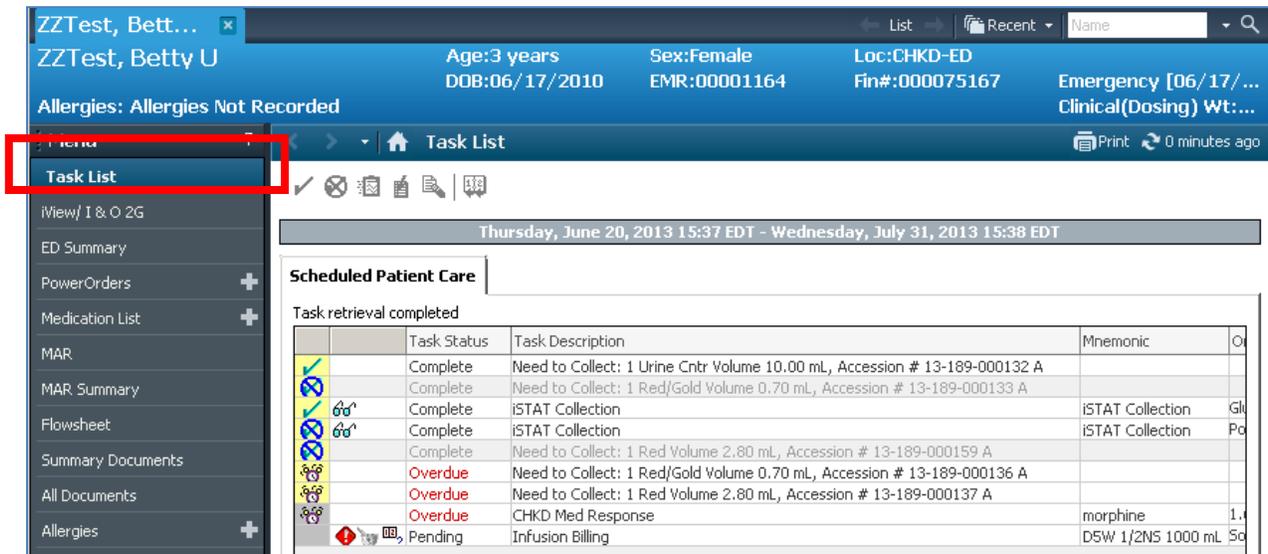
Displays verification that ED Educational/Discharge materials have been printed which is indicated by the check mark beside Pt ED Printed.



## Task List

The Task List section launches to the patients Task list.

The expectation is for users to make sure that all tasks have been completed and that this list is clear prior to discharging the patient from the ED.



## ED Discharge Notes

ED Discharge Notes are REQUIRED documentation. This section launches the ED Discharge Notes PowerForm where notes are completed for discharge.

The screenshot shows the 'ED Discharge Notes' PowerForm. At the top, it indicates the patient name 'ZZTest, Betty U' and the user 'TestUser RN, EDNurse'. The form is divided into several sections:

- Outstanding Tasks:** A list of medications including albuterol, ipratropium, prednisone, Sodium Chloride, prochlorperazine, diphenhydramine, and metoclopramide, each with a date and time.
- IV Removal Documented:** A radio button for 'Yes'.
- Tolerated PO:** A radio button for 'Yes'.
- VS/Pain Documented Per Policy:** A radio button for 'Yes'.
- LOC (Level of Consciousness):** A list of checkboxes for 'Awake and alert', 'Frequently drowsy, easy to arouse', 'Normal sleep, easy to arouse', 'Somnolent, difficult to arouse', 'Awake and irritable', 'Lethargic', 'Obtunded', 'Stuporous', 'Comatose', 'Jittery', 'Unresponsive', and 'Baseline WNL for Patient'.
- Respirations:** A list of checkboxes for 'Clear', 'Unlabored', 'Slightly Labored', 'Labored', 'Wheezing', 'Congestion', 'Stridor', and 'Grunting'.
- Pulses:** A list of radio buttons for 'Strong', 'Weak', and 'Absent'.
- Skin Description:** A list of checkboxes for 'Warm/pink/dry', 'Warm', 'Cool', 'Pink', 'Dry', 'Pale', 'Cyanotic', 'Mottled', and 'Diaphoretic'.
- D/C Give:** A list of checkboxes for 'Meds', 'Falls', 'Legal', and 'Other'.

- If a user tries to continue the depart process without signing the ED Discharge Note PowerForm they will receive the following prompt:

The 'Depart Process Gap Checking' dialog box displays the following instructions: "Instructions: The following request elements are incomplete. Select a reason to override the requirement." Below the instructions is a table:

Actions	Reasons
ED Discharge Notes	

At the bottom of the dialog are 'OK' and 'Cancel' buttons.

- However, they are able to select an override reason from the dropdown if appropriate

The 'Reasons' dropdown menu is open, showing the following options:

- Medication only
- Patient expired
- Patient left AMA
- Patient left prior to Dr exam
- Suture removal only

## Billing

The Billing Process is completed prior to discharging your patient from the Emergency Department. The full Billing Report is created to be sent to MRSI at the end of the patient's visit as per your Department's Policy.

NOTE: If the Patient has had IV's during their stay in the ED, the Billing Form will need to be completed for all patients upon discharge from the ED to surgery, any inpatient floor, home , etc.

The Infusion Billing Process should be completed when the patient is moved to 1C or when all IV fluids have finished for discharged patients.

During the Depart Process, the user will need to sign off on the billing for MRSI (billing purposes).

If previously completed a check mark will appear next to ED Billing.

If the Billing Process was not completed prior to discharge, it will display highlighted yellow as a required item to complete.

## IV Stop Times

Clicking the pencil icon beside the IV Stop Times will display infusion that have been completed and any outstanding Infusions that need to be stopped.

Infusion Billing: ZZTest, Betty U - 000075167

D5W 1/2NS 1,000 mL  
Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr

Show Previous Infusions

Current Infusions						
Event Date/Time	Bag#	Start	End	Duration	Infuse Volume	
<input checked="" type="checkbox"/> 06/25/2013 11:27 EDT	2	06/25/2013 11:27	06/25/2013 15:27	4 Hours, 0 Minutes	1,000 mL	
<input type="checkbox"/> 07/08/2013 11:21 EDT	3	NA	NA	Not included		

Total Volume For Order: 2,000 mL  
Total Infusion Duration For Order: 8 Hours, 0 Minutes

Sign Cancel

## ED Infusion Billing Details

Infusion Billing Clicking the pencil icon beside the Billing Section of the Depart Process Window will launch the Billing Form.

Start Date/Time	End Date/Time	Site	Duration	Infuse Volume	Personnel
06/19/13 17:01	06/19/13 21:01	PW, AC, L	4 hr	1000 mL	TestUser RN, EDNurse
06/25/13 11:27	06/25/13 15:27	PW, AC, L	4 hr	1000 mL	TestUser RN, EDNurse
07/08/13 11:21	07/08/13 15:21	PW, AC, L	4 hr	1000 mL	TestUser RN, EDNurse
<b>Total Volume for Order:</b>			<b>3000 mL</b>		
<b>Total Duration for Order:</b>			<b>12 hr</b>		

## Completing the Infusion Billing Form

In the event the Billing Process needs to be completed you can complete it either from the Task List, the task icon on the MAR or the icon available from the tracking list. See documentation in the MAR section of this manual for the complete process.

## Correcting the Billing Form.

In the event a correction needs to be made to the Billing Form complete the following steps:

1. Go to the MAR in your patient's chart.
2. Right Click on the medication section for the infusion that needs to be corrected.
3. Select ' Infusion Billing' from the drop down menu.

Time View	Medications	07/08/2013 11:21	07/08/2013 11:36	07/08/2013 15:16
<input checked="" type="checkbox"/> Scheduled	<b>Continuous Infusions</b>			
<input checked="" type="checkbox"/> PRN	<b>DSW 1/2NS 1,000 mL</b>			<b>Pending</b>
<input checked="" type="checkbox"/> Continuous Infusions	Soln, IV Continuo mL/hr, Infuse ov			Last bag started: 07/08/2013 11:21 EDT
	<b>Administration</b>			<b>STAT</b>
	Dextrose 5% w/			Not given within 7 days.
	<b>Administration</b>			
	Soln, IV Continuo mL/hr, Infuse ov			
	After NS Bolus co			
	<b>Administration</b>			
	Sodium Chloride			

4. Click on Modify

The screenshot shows a window titled "Infusion Billing: ZZTest, Betty U - 000075167". The main area displays "D5W 1/2NS 1,000 mL" and "Soln, IV Continuous, Rate: 250 mL/hr, Infuse over: 4 hr". Below this is a section titled "Previous Infusions" with a "Modify" button. A table lists three previous infusions:

Start	End	Duration	Infuse Volume
06/19/2013 17:01 EDT	06/19/2013 21:01 EDT	4 Hours, 0 Minutes	1,000 mL
06/25/2013 11:27 EDT	06/25/2013 15:27 EDT	4 Hours, 0 Minutes	1,000 mL
07/08/2013 11:21 EDT	07/08/2013 15:21 EDT	4 Hours, 0 Minutes	1,000 mL

At the bottom right, it states: "Total Volume for Order: 3,000 mL" and "Total Infusion Duration for Order: 12 Hours, 0 Minutes". There are "Sign" and "Cancel" buttons.

5. Make any applicable adjustments

The screenshot shows the same window as above, but with the "Modify Previous Infusions" section active. It contains a table with columns for "Event Date/Time", "Bag#", "Start", "End", "Duration", and "Infuse Volume". Each row has a checkbox and dropdown menus for editing the start and end times.

Event Date/Time	Bag#	Start	End	Duration	Infuse Volume
<input checked="" type="checkbox"/> 06/19/2013 17:01 EDT	1	06/19/2013 1701	06/19/2013 2101	4 Hours, 0 Minutes	1,000 mL
<input checked="" type="checkbox"/> 06/25/2013 11:27 EDT	2	06/25/2013 1127	06/25/2013 1527	4 Hours, 0 Minutes	1,000 mL
<input checked="" type="checkbox"/> 07/08/2013 11:21 EDT	3	07/08/2013 1121	07/08/2013 1521	4 Hours, 0 Minutes	1,000 mL

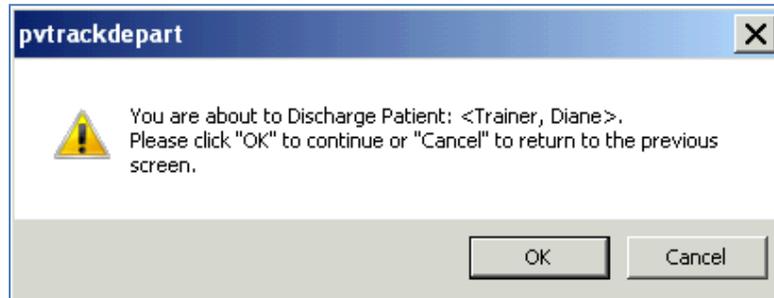
At the bottom right, it states: "Total Volume for Order: 3,000 mL" and "Total Infusion Duration for Order: 12 Hours, 0 Minutes". There are "Sign" and "Cancel" buttons.

6. Click Sign

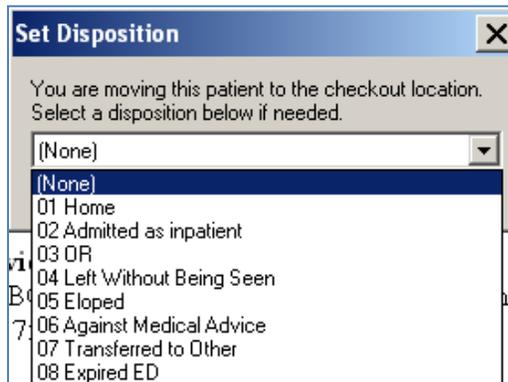
7. If a correction was made **AFTER** you have signed off on the infusion in the Billing section, in the Depart Process or on the Tracking List toolbar, you will need to repeat the process to create the Billing Report (as discuss in the MAR section of this manual) to reflect those corrections.

## & Depart

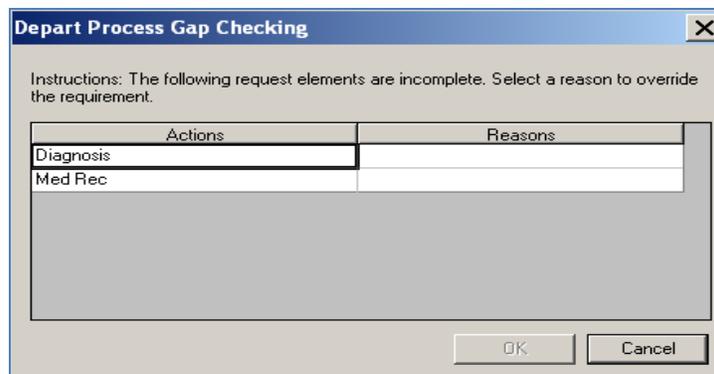
When you are ready to discharge the patient select the “& Depart” section of the Depart Process. A window will display warning that you are about to Discharge the Patient. Clicking OK will begin the Discharge Process. Clicking Cancel will return you to the previous screen.



- The Set Disposition Window displays the disposition options.



- If trying to discharge without completion of required actions the following message will pop up requiring you to select a reasons for the missing actions. Once completed the Set disposition Window will display.
- Clicking in the Reasons window will display a listing of reasons to select from.





## APPENDIX A – Downtime Procedures

Scheduled Downtime will be necessary at times for both Eclipsys and PowerChart. During the times when the system is not operational, you must use Downtime procedures.

Please make sure to check with **your Management Team** to familiarize yourself with your Department's Downtime procedures and their location. These procedures may be specific to your area.

### Eclipsys Downtime

When Eclipsys is down, but eKiDs PowerChart is up you may continue to process orders on all currently Registered or Admitted patients. If the patient you need document on is not in PowerChart, then you must follow the Nursing Downtime Procedure.

### eKiDs PowerChart Downtime

If PowerChart is down, it will be necessary to following the Nursing Downtime Procedure.

### Monthly Downtime

System	Monthly Downtime
eKiDs PowerChart	2 <sup>nd</sup> Wednesday from 0001-0300
<b>ECLIPSYS</b>	2 <sup>nd</sup> Wednesday from 0001-0300

- Unscheduled downtime will be announced through the overhead paging system.
- To report an issue, error or malfunction of the computer equipment, or with an application, call the I.S. Help Desk at 8-7075.
- If you have questions about your username/password or system/application security, call the I.S. Help Desk at 8-7075.
- Refer to Downtime Procedures Policy and manual in your department for complete downtime procedures. Also refer to Kdnet for the most up-to-date EMR downtime policies.

## Downtime Procedures – Cerner 724

### How to Access the 724 Application

Cerner 724 is a read-only display of Cerner modules (PowerChart, SurgiNet, FirstNet, RadNet, and PathNet) to view information during downtime.

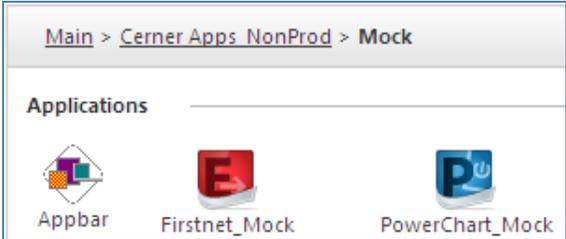
Cerner 724 enables users **read only** access to view information that was available in the applications prior to Cerner going into downtime. During a scheduled downtime, Cerner 724 becomes available immediately to users. Conversely, for an **unscheduled downtime availability may be delayed by approximately 15 – 30 minutes** while the switch over process is completed.

To open **724**, from KDnet login to Citrix Web Access and do the following steps:

1. Click on the **724 Folder** icon.



2. Click the Cerner Application icon you want to access as shown below.



3. Log in using your Domain User Name and Password . You will see a red screen displaying: Cerner Millennium **\*\*DOWNTIME READ-ONLY\*\***



Once you are logged into the application the information will look somewhat the same. Much of the information will be grayed out. The buttons you usually select to add or edit information will not be accessible.

When the user selects the VMware client, the window will display the option to select the “724Cern” environment, which will provide **READ- ONLY** access to the Cerner modules.

Remember, whether you use Citrix or VMware to access the application, you will be able to **READ-ONLY**, no charting can take place in the application.

For more information, you may view the Gazette Newsflash on KDnet.



## APPENDIX B – Nursing Policy for Downtime

For the most up-to-date copy of the Downtime Procedure for entering Patient Assessment and Medication Administration Data into the Electronic Medical Record (EMR) go to:

<http://kdnet.chkd.net/policies/nursing/ND/ND.04.1.doc>



Policy No.: 105-04-ND.04.1

Effective Date: 07/22/11

Previous Revision: New

**Individuals Reviewing Policy:**

Marti Bevan, RN

Director, Nursing Informatics

H. Brent Loftis, RN MSCIT

Director, IS Applications

Shelly Gilson, RN

Chairperson

Deborah Hardway, BSN, RN

Patient Care Services Director

Jo-Ann Burke, MBA, BSN, RN

Vice President, Patient Care Services

---

**SUBJECT:** **DOWNTIME, PROCEDURE FOR ENTERING PATIENT ASSESSMENT AND MEDICATION ADMINISTRATION DATA INTO THE ELECTRONIC MEDICAL RECORD (EMR)**

**POLICY:** A structured manual process is used by nursing and respiratory therapy staff for charting assessment data and medication administration during scheduled maintenance downtime or unexpected computer system downtimes. When computer systems return to operational status nursing and respiratory therapy staff are responsible for ensuring that appropriate data is entered into the computer system in a timely manner.

**DEFINITIONS:** Downtime is defined as any period of time, scheduled or unscheduled, during which the Cerner PowerChart System is unavailable for use by nursing staff.

**Downtime Level Definitions:**

**Level One:** Downtime that lasts less than 4 hours

**Level Two:** Downtime that lasts 4 hours or more

**PROCEDURE:**

**Types of Downtime:**

A. Scheduled Downtime

1. In the event of a scheduled downtime of the PowerChart System the Information Systems (I.S.) Department notifies all system users of the planned date, time and estimated level of the downtime (see definitions above). This information is communicated to all users via e-mail communication at least two weeks before the scheduled downtime is to occur.
2. A follow-up communication to remind staff of the scheduled downtime occurs one week prior to and the day of the scheduled downtime. This information is communicated to all users via e-mail communication.
3. I.S. makes every attempt to schedule downtime during off-peak business hours (i.e. weekends, overnight hours).

B. Unscheduled Downtime

1. In the event of an unscheduled downtime of the PowerChart System the I.S. Department communicates the downtime information to Nursing and Respiratory Therapy Staff via an overhead announcement in the Main Hospital which states the estimated level of the downtime if currently known (see definitions above) and e-mail communication if available. Off-site locations are notified of the unscheduled downtime via phone call or text-page to Nursing Management at that location.
2. Updates are provided if the downtime level is increased as soon as that information becomes available. These updates are provided via overhead announcement in the Main Hospital and by calling or paging nursing management at off-site locations.
3. When the system becomes accessible once again an overhead announcement is made in the Main Hospital and e-mail communication is sent to all nursing and respiratory therapy staff members. The operator announces "Level \_\_\_ downtime is now resolved. The Cerner PowerChart system is fully operational."

**Nursing Responsibilities:**

1. Nursing and respiratory therapy staff are notified of downtime (scheduled or unscheduled) by I.S. The unit charge nurse and charge respiratory therapist on duty obtain the "*Downtime Documentation Packets*" available on the unit. This packet contains up-to-date paper documentation forms that the unit nurse and respiratory therapists need immediately to ensure there is no interruption to the provision of care. On most units this consists of the appropriate unit Flow Sheet and Supplemental Nursing Notes Sheets for nurses and Respiratory Flow Sheets for respiratory therapy staff. Those forms that are unit specific are also available on an as needed basis.

2. The charge nurse and charge respiratory therapist distribute a packet of paper documentation forms to each nurse and respiratory therapist on the unit. These paper documentation sets include the following forms per unit (listed in **bold** for nursing):

<b>TCU</b>	<b>TCU Nursing Flow Sheet, Supplemental Nursing Notes Sheets</b>
<b>NICU</b>	<b>NICU Flow Sheet, Supplemental Nursing Notes Sheets</b>
<b>NSDU/7D</b>	<b>NICU Flow Sheet, Supplemental Nursing Notes Sheets</b>
<b>PICU</b>	<b>Pediatric Critical Care Flow Sheet, Supplemental Nursing Notes Sheets</b>
<b>7B</b>	<b>Inpatient Rehabilitation Nursing Flow Sheet, Supplemental Nursing Notes Sheets</b>  Also available: Inpatient Rehabilitation Unit Guidelines of Care, Nursing Goal Status Sheet (Progress)- Rehabilitation Goals, Weekly Team Rounds Nursing Progress Report
<b>7C</b>	<b>General Care Flow Sheet, Supplemental Nursing Notes Sheets</b>  Also available: Evening Shift Nursing Burn Care Note
<b>7H</b>	<b>Outpatient Flow Sheet, Supplemental Nursing Notes Sheets</b>
<b>8B</b>	<b>General Care Flow Sheet, Supplemental Nursing Notes Sheets, CVL Flow Sheet</b>
<b>8C</b>	<b>General Care Flow Sheet, Supplemental Nursing Notes Sheets</b>
<b>CCBDC</b>	<b>CCBDC Flow Sheet, CCBDC Additional Notes/Doctors' Orders Sheets.</b> Also available: Bleeding Disorders Center Nursing Documentation Sheet
<b>Kidney Center</b>	<b>Hemodialysis Flowsheet, Hemodialysis Supplemental Flowsheet, Prisma/Prismaflex Flowsheet (pgs. 1 and 2)</b>  Also available: Manual Peritoneal Dialysis Flow Sheet,
<b>ED</b>	<b>ED Flow Sheet, ED Supplemental Flow Sheet</b>  Also available: P-BRAT Tool, ED Asthma Therapy Flow Sheet, ED Adult Chest Pain Orders, ED Pre-Op/Procedure Nursing Plan of Care
<b>PACU/Day Surgery</b>	<u>Pre-Op</u> : <b>Surgical Services/Cardiac Cath Lab Checklist, Pre-Anesthesia Evaluation Form</b>  <u>Post-Op</u> : <b>PACU Flowsheet, Peri-Anesthesia</b>

	<b>Medication Administration Record, Outpatient Medication Reconciliation Form</b>
<b>Respiratory Therapy</b>	<b>Respiratory Flow Sheet</b>
<b>Supplemental Forms (Available on Units on an as Needed Basis)</b>	<ul style="list-style-type: none"> <li>• Bereavement Checklist</li> <li>• Bronchiolitis Flow Sheet</li> <li>• Calorie Count Flow Sheet</li> <li>• CVL Flow Sheet</li> <li>• Child/Infant Neuro Flow Sheet</li> <li>• Diabetic Flow Sheet</li> <li>• Diabetic Ketoacidosis Flow Sheet</li> <li>• Interdisciplinary Admission Database</li> <li>• IV Infiltration/Extravasations Flow Sheet</li> <li>• Laboratory Downtime Forms</li> <li>• Neonatal Interdisciplinary Admission Database</li> <li>• Neurology Flow Sheet</li> <li>• Neurovascular Assessment Flow Sheet</li> <li>• Nursing Orders for Screening</li> <li>• Nursing/Pharmacy Communication Form</li> <li>• Respiratory Flow Sheet</li> <li>• Respiratory Flow Sheet- Asthma Pathway</li> <li>• Restraint Flow Sheet</li> <li>• Seizure Flow Sheet</li> <li>• Skin Breakdown Flow Sheet</li> <li>• Suicide Precautions/Close Watch Flow Sheet</li> </ul>

3. Supplemental documentation forms (see list above) are also available as appropriate for each unit. Staff nurses and respiratory therapists on each unit are responsible for obtaining the additional supplemental documentation forms as needed on a per patient basis.
4. Information Services is responsible for printing active Medication Administration Records (MAR), Last Dose Medication Lists (24 hours) and up-to-date order lists for all patients. These paper MARs, Last Dose Medication Lists (24 hours) and Current Order lists are then delivered to the charge nurse on the appropriate units by the staff in the 6<sup>th</sup> floor Data Center and I.S. staff. The charge nurse is responsible for distribution of the MARs, Last Dose Medication Lists (24 hours) and order lists to unit staff nurses.
5. Nursing staff are responsible for adding a downtime notation to the orders section of the patient's paper chart. **The notation states that a downtime began at a particular time and date and is signed by the nurse assigned to the patient.** This notation reminds nursing staff to enter orders into the system when the Electronic Medical Record returns to operational status
6. All new medication orders that are written during the downtime are transcribed onto the paper MAR provided to staff nurses by I.S. Staff. These entries are written in the same format as the printed medication orders already on the form.

7. Nursing staff and respiratory therapy staff use paper documentation forms to record all necessary patient care information until the Electronic Medical Record returns to operational status. Paper forms are accurately completed and become a permanent part of the patient's medical record. All new orders received during the downtime are transcribed onto the paper order lists provided by I.S. This ensures that all order lists remain current and up-to-date and serves as a tool for order entry when the system is restored to operational status. Any orders previously recorded in the patient's chart that were not entered into the PowerChart system prior to the downtime are noted in order to provide an easy reference for order entry when the system again becomes operational. These orders also are transcribed onto the paper order list provided by I.S.
8. When the Electronic Medical Record functionality is restored I.S. communicates this information to nursing staff and respiratory therapy staff as stated above. Upon resolution of the downtime nursing staff are responsible for entering specific patient information into the Cerner PowerChart system according to the Level of downtime experienced. Once this information is entered the staff nurse reviews all of the information entered into the PowerChart system and verifies its accuracy with the paper documentation.

- a. **Level One:** Nursing Staff enters all information collected during the downtime (i.e. assessment data, vital signs recorded, medications given, interdisciplinary admission database, new orders received, etc.) into the PowerChart system for each patient assigned to them. All assigned nursing tasks completed during the downtime are documented with the actual time of completion.

Respiratory Therapy Staff are responsible for entering all information collected during the downtime (i.e. medications given, treatments performed) into the PowerChart system for each patient assigned to them. All assigned respiratory therapy tasks completed during the downtime are documented with the actual time of completion.

- b. **Level Two:**

Nursing Staff enters the following information obtained during downtime for each assigned patient:

- last set of vital signs
- any new height or weight measurements
- any new allergy information
- any new ongoing orders
- any new medication orders (orders must be scanned to pharmacy)
- interdisciplinary admission database/neonatal interdisciplinary admission database form (for patients who were admitted during downtime)
- all medications given during the downtime period on the MAR.

Respiratory Therapy Staff enters the following information obtained during downtime for each assigned patient:

- any new ongoing orders

- any new medication orders (orders must be scanned to pharmacy)
- all medications given during the downtime period on the MAR.

**NOTES:**

- **Nurses and respiratory therapists must be mindful to change the current system default time of medication administration and tasks listed in the Power Chart system to document the actual time the medication was given or the task was completed.**
- **One time only non-medication orders are not entered into the PowerChart system if the orders were obtained and completed during the downtime.**
  9. Nursing staff must write a note in each patient's chart in the "Inpatient Care Notes" section noting that a downtime occurred and the length of the downtime (i.e. *System downtime occurred from 2400-0400*).
  10. All paper documentation used during the downtime is sent to Medical Records for inclusion in the patient's permanent medical record. The paper order list provided by I.S. is the only document that is not sent to Medical Records- it is a reference tool for the staff nurse and respiratory therapist only, and not a permanent part of the patient's medical record.
  11. Nursing staff and respiratory therapy staff resume documentation within the Cerner PowerChart Electronic Medical Record immediately upon resolution of downtime. Paper documentation is discontinued when the PowerChart system is available.

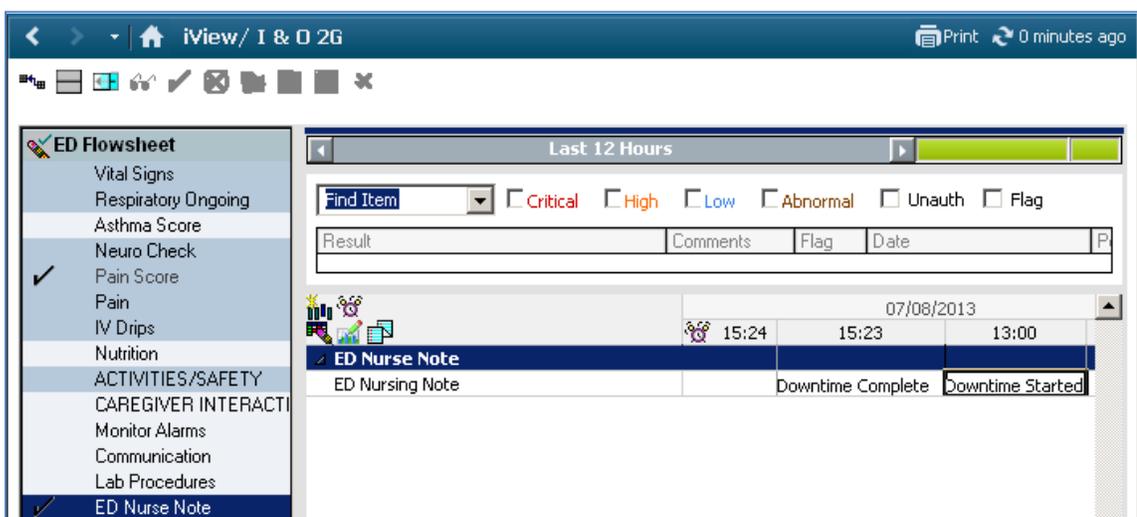
**Special Circumstance:** Downtime occurs during a shift change:

- The nursing staff and respiratory therapy staff who relinquish patient care are responsible for ensuring that all paper documentation is completed the end of their shift.
- The nursing staff and respiratory therapy staff who assume patient care are responsible for documenting certain data collected by the nursing staff and respiratory therapy staff from the previous shift when the Cerner PowerChart system is once again operational. This documentation includes:
  1. Any new height, weight or allergy information obtained during the downtime. (Nursing)
  2. All medications given during the downtime. (Nursing and Respiratory)
  3. An Interdisciplinary Admission Database or Neonatal Interdisciplinary Admission Database for any patients admitted during the downtime. (Nursing)
- The nursing staff and respiratory therapy staff who assume care of the patient ensure the EMR reflects the correct time for data collection. Entries on the MAR must be corrected for the time that the medication was actually given and for the staff nurse or respiratory therapy staff who administered the medication (corrected within the "Performed By" section of the administration record).

## Downtime Process – Emergency Department (E.D.)

Note: For new patient arrivals, the emergency room staff will agree on a set time prior to the planned downtime to start the paper process (i.e. for a planned downtime at midnight, staff will agree to initiate paper documentation for any new patients arriving after 2330). This will allow support staff the opportunity to print the appropriate reports for existing patients.

- Pertinent patient information will be printed and distributed prior to downtime (outstanding orders, tasks, meds)
- During downtime
  - RN staff will utilize normal paper process for documentation of care, meds, etc.
  - Any new orders prescribed during downtime will be written on paper
  - **All patient care documentation related to orders written on paper (or electronic orders not completed prior to the downtime) will be documented on paper (see additional information below for medication documentation)**
- Upon completion of the downtime (for patients still present in the E.D.)
  - All paper documentation will be scanned in to the medical record (will be available in forms browser)
  - Nursing will enter an ED Nurse Note to signify when the downtime started and when downtime was complete (this is necessary so caregivers know to look in forms browser for any pertinent documentation occurring during the downtime)
  - Any new orders will be entered in the EMR
  - RN staff will resume documentation electronically
  - **Pharmacy will back enter medication orders written during downtime and nurses will need to document in the EMR to satisfy the med tasks**



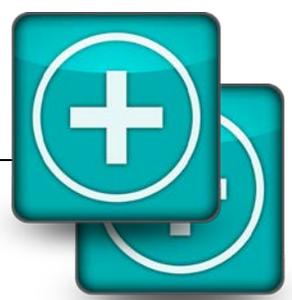


## APPENDIX C – TRANSFER TO 1-C

In the event a patient is admitted and transferred to 1-C there will be an indicator on the tracking board that the patient is being admitted.

- Once a patient goes to 1-C **ALL** documentation will be done using the paper chart. This includes all assessments, medications (MAR) and IV fluids, etc.
- Upon arriving in 1-C the patient's status changes to the 1-C location. Clinicians will continue to have access to the EMR but should only document information relative to the patient's care delivered while in the ED.
- All ED documentation **MUST** be completed before a patient is transferred from 1-C to any other unit in house. If not completed prior to that time, the bands for the ED documentation will no longer be available.

It is imperative that you enter the correct date/time that the task was performed while the patient was in the ED if you are charting after the fact.



## APPENDIX D – Tap & Go

Tap & Go Authentication leverages Proximity Cards for advanced authentication. This technology provides quick access to caregivers to allow you to log on by entering your username and password once at the beginning of your shift. After your initial log in for the day, you can use your proximity card to tap into any Zero Client in your work area to instantly gain access to the clinical patient information needed. Tap & Go Authentication is also referred to as Instant Access or Single Sign On (SSO).

To start using Tap & Go, you must register your Proximity Card (employee identification badge). Once the card is registered, you can use it to tap into a Zero Client in your work area and access patient information without needing to re-enter your password each time. When you have finished, simply tap the card again on the badge reader to disconnect from the Zero Client.



### Steps To Register a Proximity Identification Badge

1. Tap your ID badge on the Card Reader

Children's Hospital  
of The King's Daughters

User name:

Password:

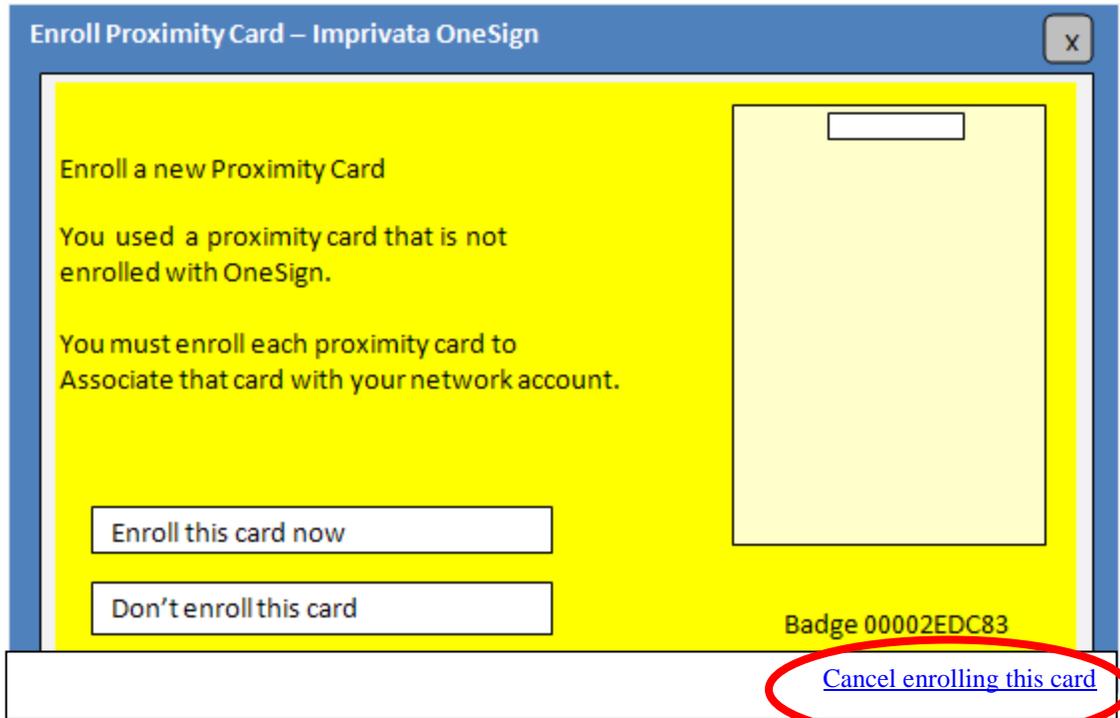
Log on to:

OK Cancel

OneSign Logon

Password  Prox Card

2. Select the option to **Enroll this card now**



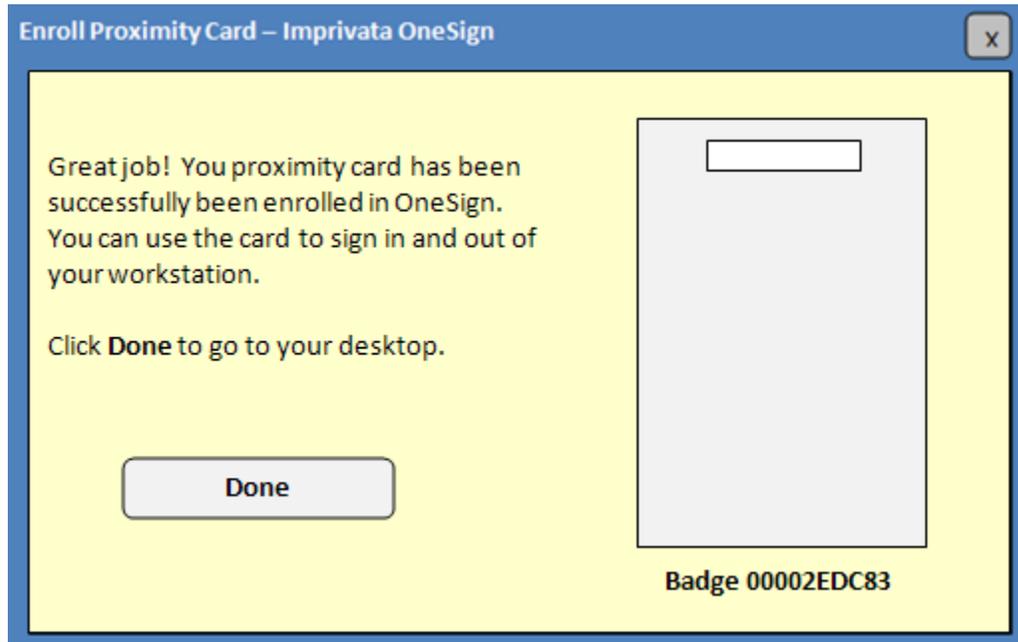
- You can cancel the enrollment of the card by clicking on the hyperlink (circled) in the lower right corner of the screen.

3. Enter your network **username** and **password**:

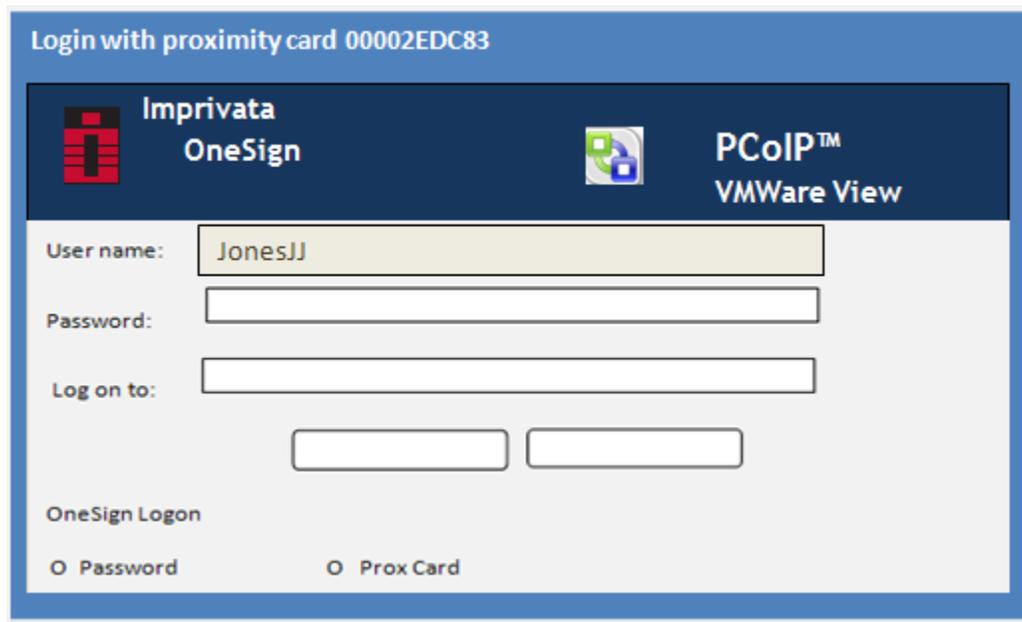


**Note:** This is the same password you use to log into API or your email.

4. Click **Next**
5. Enter **your password** to proceed with logging in. The user name field will be dithered (grayed) out with your user name displayed. Once your password is entered, you will be able to access the

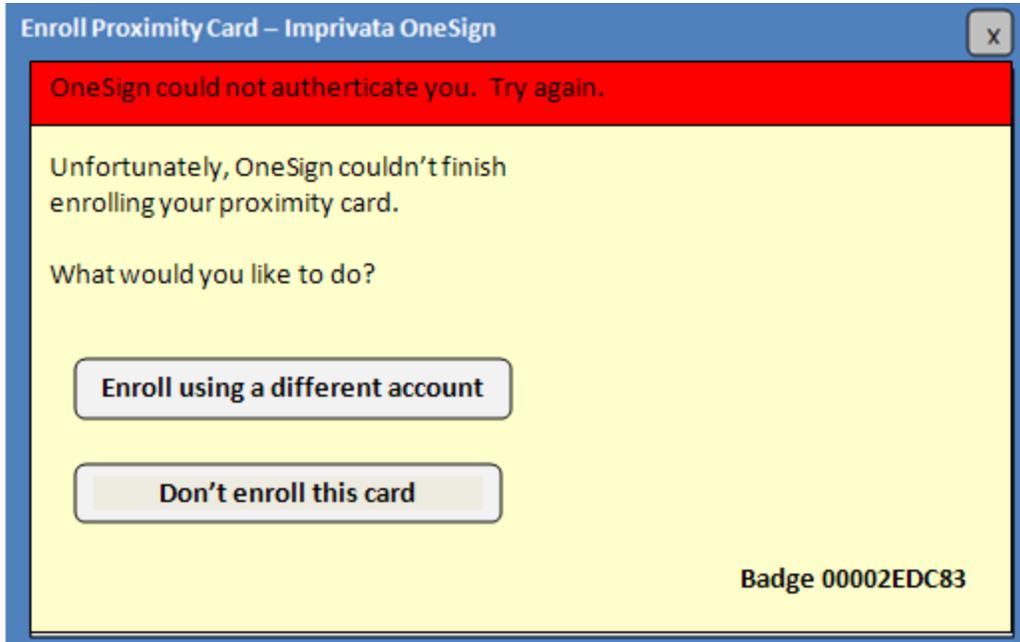


system as usual.



**Important Note:**

The follow message will display if the enrollment process cannot be completed:  
You can select the option to “Enroll using a different account”; this action will restart the process.



---

### Complete Personal Security Questions

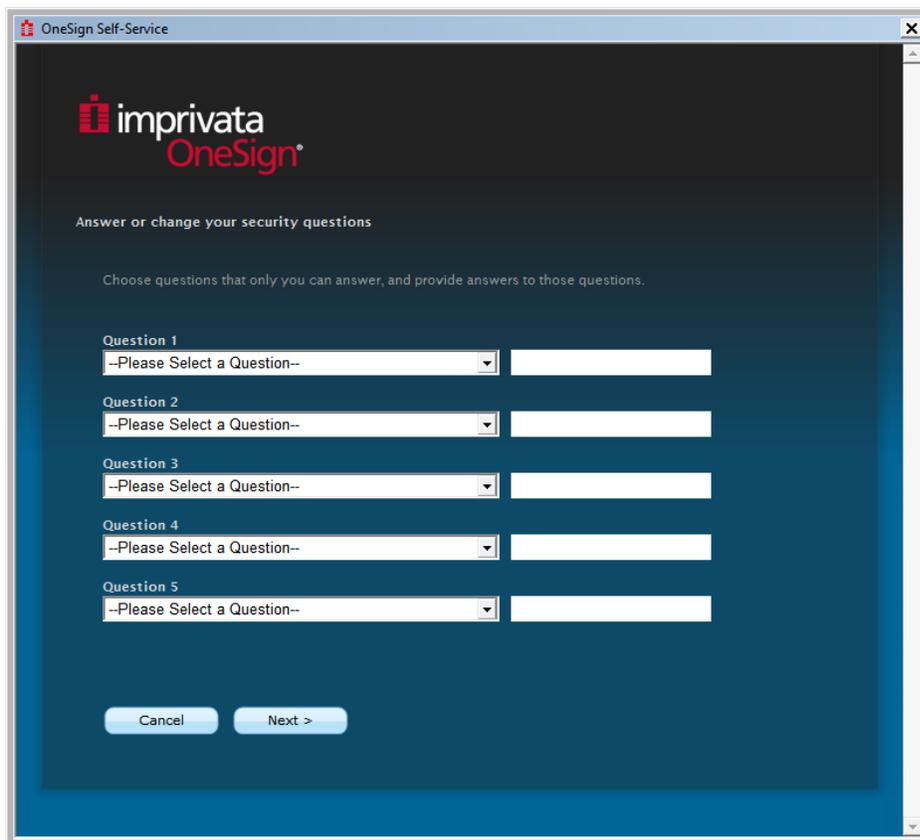
---

1. When you access the Zero Client desktop, you will be prompted to set up personal security questions. To proceed with this step, click the **Set up questions now** button. **If you select the option "ask me again later"; you will be prompted each time you log in until this step is completed.**



2. Select and **answer Personal Security Questions:**

You can choose from a list of questions by clicking on the down arrow; type your response in the space available to the right of each question.



The screenshot shows a window titled "OneSign Self-Service" with the Imprivata OneSign logo. Below the logo, the text reads "Answer or change your security questions" and "Choose questions that only you can answer, and provide answers to those questions." There are five rows, each labeled "Question 1" through "Question 5". Each row contains a dropdown menu with "--Please Select a Question--" and an adjacent text input field. At the bottom of the window, there are two buttons: "Cancel" and "Next >".

3. Click **Next** to complete registering your personal security questions.



The screenshot shows the same "OneSign Self-Service" window. The top section with the logo and instructions is visible. Below that, a large green checkmark icon is displayed next to the text "Your security questions and answers have been saved." At the bottom of the window, there is a link that says "Close or choose another operation".

4. Click **Close** to complete the process.

## Zero Client - Automatic Lock

---

Tap & Go is configured so that the Zero Client will automatically lock if it has been sitting idle for **15 minutes** or more without any activity. When this happens; the screen will display the steps to “unlock” the computer as well as the name of the person that was logged on when the computer automatically locked.

To log back into the Zero client, you must first press **CTRL + ALT + DELETE** to unlock the computer; you can then use your proximity card to log back in. If you are different user; you will be required to restart the computer. **Any unsaved data by the “logged in user” will be lost.**

Sample message:

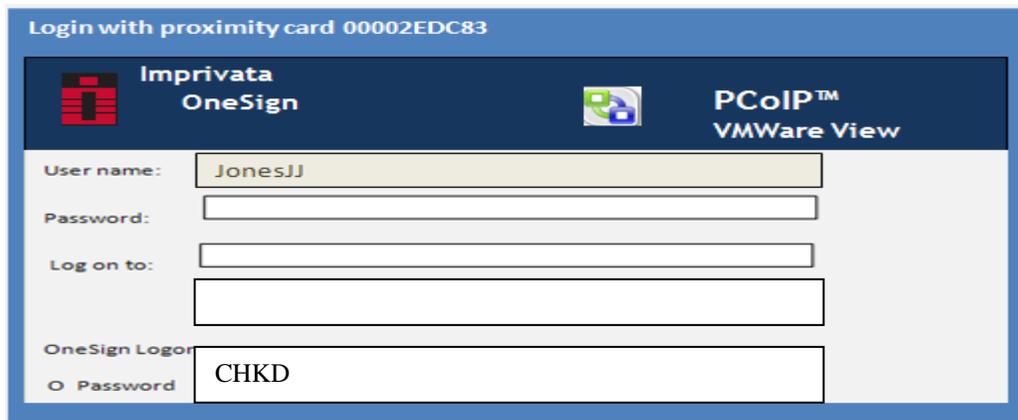
*Press CTRL + ALT + DELETE to unlock this computer  
Jones, Jessie (CHKD) is logged on*

## Daily Log In and Grace Period

---

With Tap & Go, you can use your CHKD ID badge for identification and then enter a password to log in. Once authenticated, a "grace period" is established during which the caregiver can subsequently log on to the Zero Client or any other Zero Client simply by tapping a badge on the card reader.

**The first time you “tap in” each day, you will need to enter your password if it has been more than eight hours since you last authenticated by entering your log in credentials.** Once your log in credentials (username and password) is entered, the system provides you an 8-hour grace period. The grace period represents the time period where you will be able to use instant access to tap in and out of the Zero Client without re-entering your password.



The screenshot shows a login window titled "Login with proximity card 00002EDC83". The interface includes the Imprivata OneSign logo and the PCoIP™ VMWare View logo. The login fields are as follows:

User name:	JonesJJ
Password:	<input type="password"/>
Log on to:	<input type="text"/>
OneSign Logon	<input type="text"/>
<input type="radio"/> Password	CHKD

Once you reach the expiration of the grace period, you simply need to re-enter your password to initiate a new grace period.

**Remember, the duration of the grace period set at CHKDHS is 8 hours.**

## Frequently Asked Questions

---

**1. Is Tap & Go set up to work on PC's too?**

**No**, at this time it is only set up to work on Zero Clients.

**2. With Tap & Go, do I ever need to enter my password after I register my proximity card?**

**Yes**, the first time you log into the system each day, you will need to enter your password. Once you tap in, the log in screen will appear with your username dithered (grayed) out. Click in the password field to authenticate to the server and begin accessing the system.

**3. What is a "Grace Period" and how does it work?**

At CHKDHS, the "Grace Period" is the length of time that the user can be logged into the computer and not have to enter their password. Remember, the "Grace" period is **8 hours**.

**4. What should I do if I have lost my proximity badge?**

It must be reported as soon as possible to the **Information Services Help Desk** to prevent unauthorized access to the system.

**5. Can I still log in without my proximity badge?**

**Yes**; you will need to enter your log in credentials in the username and password fields.

**6. What if I come up to a workstation and the username is dithered with another user's name displayed, what should I do?**

To use the workstation, you must first **click Cancel** to request a new desktop before you are able to access the workstation using Instant Access. Once you click Cancel, you can tap your proximity badge on the card reader to proceed to log in.

**7. What if I don't answer the personal security questions?**

**You will continue to be prompted** to answer them each time you log into the Zero Client. Once the questions are answered, you will not be prompted again.

**8. How long does it take before the Zero Client automatically locks from inactivity?**

Fifteen **(15) minutes**.

## Tap & Go / Zero Client Quick Reference Tips

---

If you...	Then...
Need to register a new proximity badge	Tap the un-registered badge on the card reader and follow the screen prompts (steps 1-5 in this guide).
Lost your proximity badge	Report it immediately to the IS Help Desk
Need to walk away from the workstation	Tap your badge on the card reader to disconnect or press the <F4> key; you can also click on the disconnect icon on the desktop.
Are asked to re-register your proximity badge after completing the process	Call the IS Help Desk and report the badge number displayed on the screen.
Need to log into a workstation that does not have a badge reader to use PowerChart	Enter your login credentials for the application

### Confirm Zero Client Configurations:

- Click on Options in the upper left corner of the screen
- Select Information menu option; ensure firmware version is 3.5.1
- Select the Configuration menu option; select the Session tab

### Important Reminder:

If for any reason a user cannot use their Proximity Card to log in/out; **staff can still sign in manually by entering their UserName and Password on the log in screen.**

**Configure the Session tab – *To Connection to a Peer Device***

**Connection Type:** View Connection Server + Imprivata OneSign™

**Bootstrap URL:** <https://onesignprod1.chkd.net>