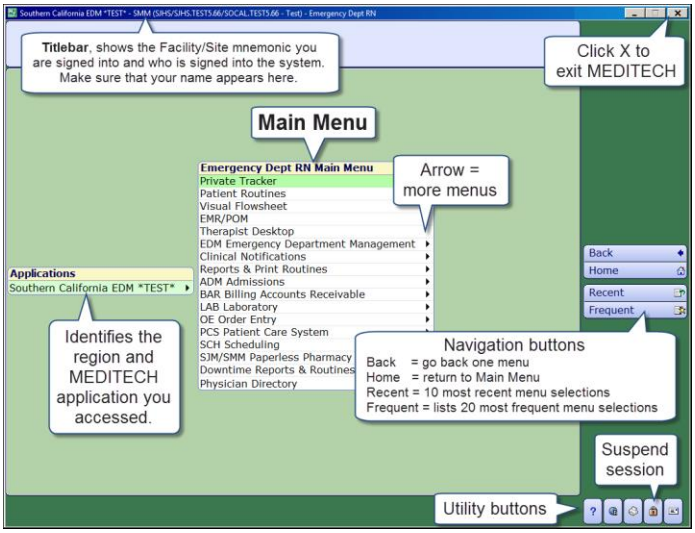
Table of Contents

1. Main Menu



2. Private Tracker

Discuss Private Tracker layout for your ministry, including right-side menu. (HANDOUT)

3. Search for a patient Using Find Patient

1. Click the **Find Patient** button.
2. Type patient's name (LAST,FIRST) or type the account number, for example, AV07613.
3. The system locates the patient on the tracker and highlights them in green. Patient populates on the Patient Header.

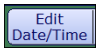
4. Assign a Chief Complaint.

1. Click in the **Chief Complaint** cell.
2. At **New Complaint**: click the down arrow or press **F9**.
3. Make a selection and click **Save**.
4. The mnemonic appears in the Chief Complaint cell on the Tracker.
5. Assessments and Treatments automatically populate the Interventions screen based on the Chief Complaint selected and patient's age.

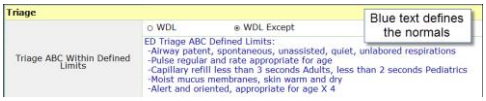
5. Document Triage Assessment

*This assessment has required fields.

1. Highlight the patient's name on the Tracker.
2. Click **Interventions**.
3. Highlight the **ED Adult Intake Triage Assessment**
4. Click **Document**.
5. Edit Date/Time to the actual time the assessment was completed if more than 15 minutes has passed since you did the assessment. Note: Certain assessments should be down to the minute accurate. Triage Intake and Disposition are examples



6. *Document by Exception: WDL and WDL Except.* Blue text descriptor defines the Normals (WDL). If anything is not true, then select **WDL Except** and ONLY document what applies. DO NOT document every question in every assessment.



7. 

Click **Insert Occurrence** to document more than one blood pressure.

8. **Sepsis Screening Section** If the patient is positive for sirs there is a place in this assessment to document who you notified**.**

Sepsis Screening	
Sepsis Screen	Possible Sepsis Risk
If Positive Sepsis Screen- Name Of Individual Notified	Dr. Smith

9. **Triage Comment.** Use the Comment sections for any question not specifically addressed above.
10. Click **Save.**

Reminder: Document the <u>Triage Update Assessment</u> if the patient has not been seen by the physician and is still waiting in the lobby (per ministry protocol).

6. Document Allergies

1. <u>Click the</u> **Allergies** menu button on right-side menu.
2. 

Click **NKA** if patient has No Known Allergies**.**
3. 

Click **Unable to Obtain** if patient unavailable is unable to communicate**.**
4. 

To enter new allergies, click **Enter New**.
5. At **Allergy/Adverse Reaction**: type the first few letters of the allergy name.
6. Make a selection.
7. Complete the Allergies Enter screen.
8. The **Type** field defaults to **Allergies**.
9. Each ministry has their own policy for completing this screen. Students need to check with their preceptor for instructions on how their ministry expects this screen to be completed.
10. At **Reaction**: click the down arrow to lookup choices.
11. At **Comments** (optional): you can type a description of additional reactions.
12. Click **Save**. Click **Done**. Click **Save**. *The allergy displays in green font under **New Allergies** header. Green font indicates it has not been saved.*

<u>To edit or delete an allergy</u>. Highlight the allergy. Choose the Delete or Edit footer button. When done making the change, click **Save** twice. Click **Done**.

<u>Confirm existing allergy/allergies</u>: Highlight the allergy(s). Click the **Confirm** footer button. Current date will now be displayed to show it was confirmed Click **Save**. Click **Done**.

<u>Note</u>: Un-coded allergies cannot be Confirmed

7. Assessments / Treatments

Discuss the layout of the Interventions screen. Discuss Assessments and Treatments. Explain the difference between the two and which user types document each.

8. Chief Complaint, Additional Assessments, Treatment

All Chief Complaint Assessments (in green) are REQUIRED. Additional Assessments (in black) are available to document as needed.

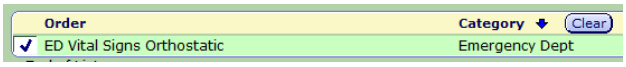
9. Enter Non-Medication Orders

1. Highlight the patient's name on the Tracker.
2. Click the **Order** menu button.
3. **Ordering Physician**. The MD name defaults in this field if the MD has signed up with the patient on the Tracker.

   To search for the physician's name, type the appropriate mnemonic in the **Ordering Physician** field. Press **F9**, make a selection and click **OK**.
4. **Order Source**. Click the down arrow (or press F9) and select. *(ES) Electronic signature:order sent to MD queue*
5. For single non-medication orders, click **Orders.**

6. At **Search**: type a few letters of the order name 

   a. If this is a nursing order, type ED first to narrow the search list. ED nursing orders begin with ED except for12 Lead EKG/ECG
7. Click the checkbox next to the order.



8. Click **Select**
9. An order details screen may appear. Complete. Click **OK** when finished.
10. Complete any reflex order screens that may appear.
11. Repeat the steps to enter more orders.
12. When done ordering, review the **New Orders** list.
    a. To erase an order before Saving, highlight and click **Undo**.
    b. To edit an order before Saving, highlight the order and click **Edit**. Make changes to the Order Details screen.
13. Click **Save** when done**.**
14. Select **File and Refresh**

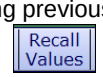
Note:

a. **File and Refresh -** files the orders and returns you to the POM screen.
b. **File and Exit** files the orders and returns you to the Tracker.

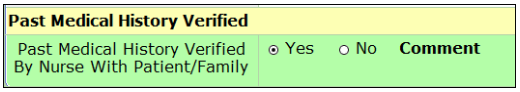
15. The newly entered orders move under their category under **Current order**.

Add on lab test example and screen shot

10. ED Past Medical History Adult

1. Recall Values function will pull past medical history answers gathered during previous visits into this assessment. 

2. *ALWAYS REVIEW* recalled values with the patient to confirm the information is accurate.
3. Document by Exception: As a general rule Yes No Comment queries should only be documented if the answer is Yes. Uncheck any queries answered No without a comment.



11. Home Med Rec: Healthstream eLearning

*Some ministries use non-nurse resources to assist with Med Rec in the ED. Check with your preceptor for ministry-specific process.

Enroll in and complete the following Healthstream Curriculum:

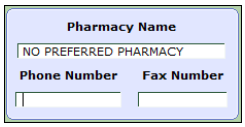
- **MEDITECH_Home Medication Documentation – Nursing_Pharm Tech**

Steps for Entering Preferred Pharmacy:

1. Click **Reconcile Med** button in right-side menu.
2. At **Preferred Pharmacy** click **Edit.**

3. Enter known information in the Pharmacy, City, and Zip code fields.

4. Click **Search**.
5. To select a pharmacy as the **preferred pharmacy**, click the radio button in the Preferred column. To select as a **favorite**, click the radio button in the Favorite column.
6. If the preferred pharmacy is not listed, click the **Not Found** button. Enter the Pharmacy Name and phone number. This will be available during the discharge process but **Not Found** information won't be available for subsequent visits.
7. If the patient does not have a preferred pharmacy, click the **Not Found** button. Type NO PREFERRED PHARMACY in the Pharmacy Name field. This will alert the provider that the nurse asked the question. Click **Save**.



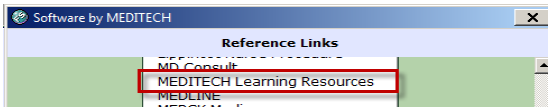
12. Home Med Rec: Home Med Rec Completed Treatment

1. Click Interventions tracker menu button
2. Locate the green (required) ED Med Rec Completed intervention under the Treatment header
3. Click to highlight in green
4. Click the Document footer button
5. Edit the timestamp if needed
6. Click OK

13. Home Med Rec: Accessing the Online Reference Guide

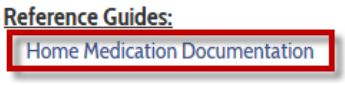
1. Click the Globe icon in the lower right corner.

2. Select:



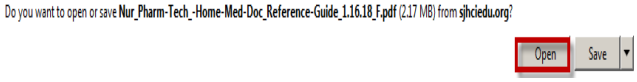
3. Choose:

4. Click on:

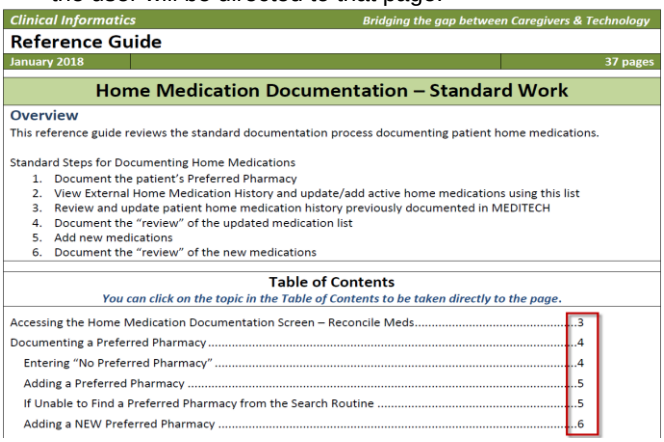


5. Click **here**:

6. Select **Open**:



7. When the page number in the Table of Contents is selected, the user will be directed to that page.



14. Print Triage Summary

1. Highlight the patient on the Tracker.
2. Click the **Summary Rpt** menu button.
3. Select the **Triage Summary Report.**

4. To print the report, click the print icon in the upper left of the screen.
5. To exit the screen, click the X in the upper right corner.

15. Pt Status Event (Cell) Status events are ministry specific. (check with your preceptor)

Patient Status Events appear in a cell called "Pt Status" to communicate the progression of the patient's treatment during their ED visit. These Patient Status events can be advanced/changed manually or may automatically advance, for example, when the patient Triage Assessment is completed.

** - Indicates an auto-advance event

Appears in cell	Name	Indicates
ABC Triage	ABC Triage	Appears when the ABC Triage Assessment has been documented.
ADMIT	Decision to Admit	Confirmation that Patient will be admitted to hospital.
BED READY	Bed is Ready	The requested bed is ready for patient.
CANCEL (not used at SFM)	Cancelled Account	No show or error with account
COMPLETE	Ready for Final Depart	All documentation completed and patient ready to be departed from MEDITECH system. Primarily used in Texas.
CONSULT (not used at SFM)	Consultation	The ED physician requested a consult with another MD.
DEPARTED	Departed	Removes patient from the Tracker (final status event)
DOCUMENT	Document	Used when patient is no longer in ED and final documentation has not yet been completed. At SFM - Patient moves to Document Tracker.
ED HOLD	Patient on hold in ED	"Virtual Bed" - Used when patient is waiting for an available inpatient bed

EDBED (not used at SFM)	Pt Needs ED Bed	Not used at SFM – ministry specific
INCOMING (not used at SFM)	Incoming EMS/Call In	Ambulance/ Call-in. Patient is coming to the hospital.
MD Exam **	MD Exam	When MD signs up it advances to this event.
MDREEVAL	MD Reevaluation	Patient requires the provider to reevaluate before discharge.
QC WAIT	Quick Care Wait	Patient placed in Quick Care Wait Area. [ministry specific]
READY DC	Ready to DC	Potential Discharge Patient. Cell is green.
READY MOVE (not used at SFM)	ED is ready to move.	ED staff have completed orders and assessments and is ready to move the patient.
READYIPMD	Waiting for MD/PCP Hospitalist	Waiting for MD/PCP Hospitalist [ministry specific]
RECEIVED **	Received in the ED	Patient has been electronically added to the system via the reception routine.
ROOM **	Patient in Room	All Patients within ED. Appears when room is assigned.
TRANSFER	Transfer to Other Facility	Patient leaving to go to another facility
TRIAGE **	Triage	All Patients. Triage Assessment completed.
TX DC	DC After Med/Tx	MD identified as ready to go home after meds or treatment
WAIT AREA	Patient in Wait Area	Patient received and waiting for a room.

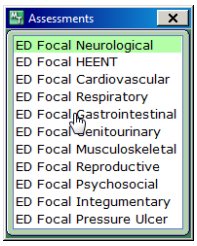
16. My List Tracker

Click **Sign Up** to sign up for the patient. Your name appears in the Nurse cell on the Tracker.

The patient is also added to the **My List** Tracker and will stay there until manually removed by using the **Remove from My List** footer button. Documentation should be completed and the patients should be removed by the end of your shift.

17. Focal Head to Toe Assessment

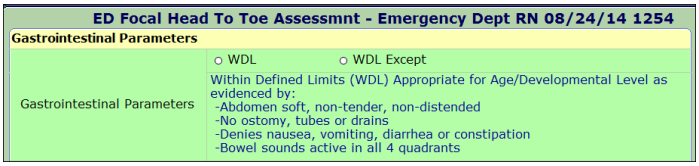
- **Focal Head to Toe** is a "group" assessment.
- To document a group assessment: Click on the **Interventions** right-side menu button. Select ED Focal Head To Toe assessment and click Document.
- Only document on the assessment(s) that relate to the Chief Complaint
- If documenting more than one assessment, click the **Go to** footer button.



WDL - The assessment is built with a WDL format. WDL is Within Defined Limits. A WDL descriptor defines parameters for what is normal. Read the WDL descriptor text and determine if the patient is within these defined limits listed.

If the patient is within the defined limits, select the **WDL** option.

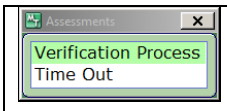
If the patient is NOT within defined limits, select the **WDL Except** option. Then ONLY document the exceptions. Document only on the questions that a pertinent to this patient.



The **Bowel Sounds** Occurrence includes a **Keyed Query** (gold key).


Keyed query - A keyed query response will carry over the next time you open the assessment.

18. ED Universal Protocol

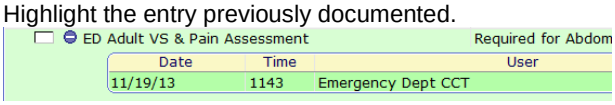


This group assessment is used by an RN or ED CCT when you are assisting with a procedure; typically an invasive procedure we want to verify the correct site/side.

When done documenting, click the **Go to** footer button. The Assessments menu appears. Select **Time Out.** Document. When done, click **Save**. Both assessments are filed.

19. Edit an Assessment

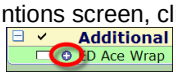
1. From the Interventions screen, click the plus sign next to the assessment name you wish to edit the content.
2. Highlight the entry previously documented.



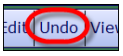
3. Click the **Edit** footer button. The assessment opens. Make your edits. Change the name of the MD who was notified.
4. Click the **Save** button. ***Edited*** *appears in the* ***Status*** *column.*

20. Undo an Assessment Intervention

1. From the Interventions screen, click the plus sign next to the assessment**.**



2. Highlight the documentation session <u>with your name</u> you need to undo.
3. Click the **Undo** footer button.

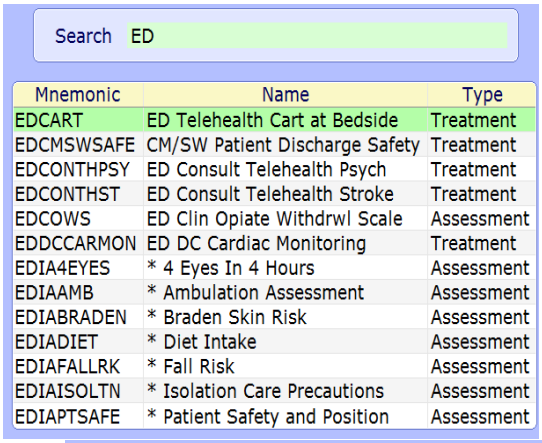


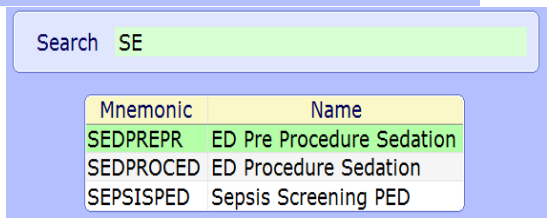
4. Click the drop-down arrow in the ***Undone Documentation Reasons*** *field and select a reason.*
5. Click **Save**. ***Undone*** *appears in the* ***Status*** *column.*

21. Add an Intervention

1. 

From the **Interventions** list, click the **Add** footer button.
2. At **Search**: type ED and a few letters of the assessment name.





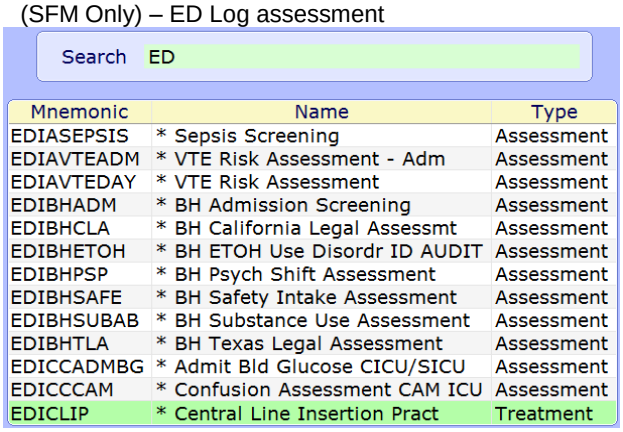
3. Make a selection and click **OK**.

The assessment opens for you to document**..**

Reminder:

- Assessments with an asterisk "*" are to be added when patients are admitted and are in ED Hold for more than 4 hours.
- BH assessments are added to all Psych patients.
- ED Pre Procedure Sedation and ED Procedure Sedation assessments must be added in addition to documenting the ED Universal Protocol assessment.

4. (SFM Only) – ED Log assessment



Additional Assessments-

Review and document through the assessments listed under the Additional Assessment header.

22. ED Cares/Event Assessment

ED Cares/Event section

- Document events, condition changes, critical result calls, handoff, codes, etc. that occurred with this patient during your shift.

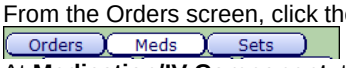
23. Co-Sign Assessment

- **Co-Sign For (Role)**: Select one. If not listed, select Other.
- **Other Co-Sign Role** – only define if Other chosen on previous query.
- **Co-Sign For (Name)** – Type name and title
- **Co-Sign For (Item)** – Select all that apply
- **Other Co-Sign Item** – only define if not listed in the previous query
- **Reason For** Co-Signature – only complete for Titratable Drips
- **Co-Sign Comment** – if needed for additional details

24. Entering Single Medication Orders

Check with your preceptor for the policy at your hospital regarding nurses entering medication orders as single orders or within an order set.

1. From the Orders screen, click the **Meds** button.



2. At **Medication/IV Component**: type a few letters of the med name.
3. Place a checkmark to the left of the medication name
4. Click the **Select** button.
5. Select the checkbox next to the order string that matches the order.
6. Click **Select** again.
7. The order details screen opens. Complete as needed.
8. *Repeat steps to enter more medications.*
9. When finished selecting orders, click the **Save** button. Review the orders.
10. Click **File and Refresh**.

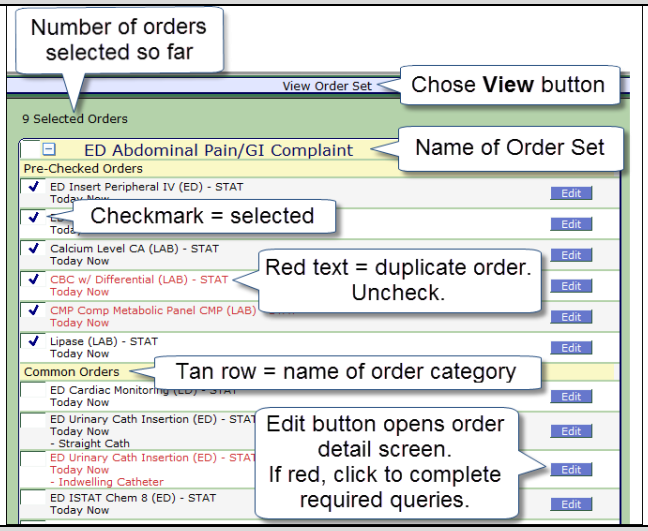
25. Using an Order Set

Check with your preceptor for the policy at your hospital regarding nurses entering medication orders as single orders or within an order set.

1. Click the **Sets** button.

2. Click the **Emergency Dept** box.
3. Select an Order Set. The system places a check mark and the selection turns green.
4. 

Click the **View** footer button. ALWAYS select View. View allows you to view all the orders in the set. View allows you to select the orders and fill out the order detail screens. Do not click Select or Edit. Select will only choose the pre-checked orders in the set. Edit requires the user to view each of the order detail screens even if the responses are already completed.
5. When the order is complete. Click **OK**. Order detail screens will pop up if any required questions are incomplete.

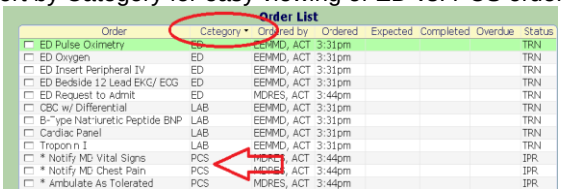


26. Review Order List

1. Click the **Order List** button.

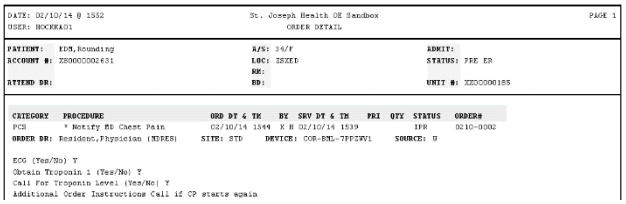
2. Select the order to be viewed.

TIP: Sort by Category for easy viewing of ED vs. PCS orders.



3. 

Click the **View Order** footer button.

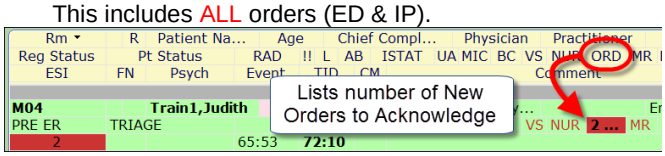


4. *The **Order Details** screen appears.*

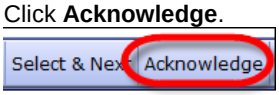
REMINDER: All orders must be acknowledged.

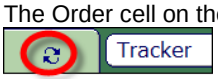
27. Acknowledge Orders from Tracker

1. The number of new orders appears in the **ORD** cell. This includes ALL orders (ED & IP).



1. Click the patient's **ORD** cell. The Acknowledge Orders screen opens. Details for the highlighted order appears below. Orders can be filtered by All, Meds, or Non-Meds.
2. Review the details of each order by placing a checkmark in the box to the left of the order name, or click the **Select & Next** button.
3. Repeat the steps until all the orders have been reviewed
4. Click **Acknowledge**.



5. The Order cell on the Tracker should now appear blank
6. 

(Tip: you may need to click the Refresh icon to hurry MEDITECH along.)

28. ED Tracker MED Cell

Alerts the user that that the patient has medications ordered.
Colors in the MED column indicate the following status:

- M... Red - Med is ordered and needs to be acknowledged and administered
- M... Blue - Reassessment is Due on at least one medication.
- M... Yellow - Patient has active PRN medications
- M... Green- All meds ordered have been documented.

29. eMAR: Acknowledging Medications

1. Highlight the patient on the Tracker. Click **eMAR**.
2. Click the **ACK** cell.
3. Review the order details and ask yourself: Is this the correct patient? Is the drug/dose/route correct and appropriate for the patient?
4. If all details are correct and make sense, click **Acknowledge** footer button.

5. Click **Save**.

30. eMAR: Document a Medication Administration (with barcode scanner)

1. **Scan the patient's account # on their armband**. Verify Name and DOB.
2. **Scan the medication** barcode.
3. If a Warning appears, review it and decide if you are going to continue to administer the medication.
4. If an assessment displays, document it.
5. Click **Save**.

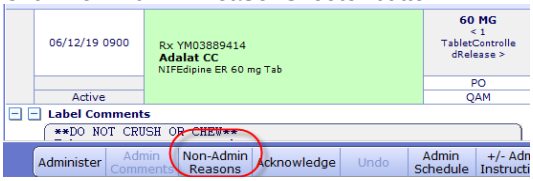
Note: a checkmark appears in front of the med name, barcode scan sign displays, and below the med is a magenta Administered time stamp indicating "not yet filed." Look at the Next Schedule cell. You are automatically documenting against the current med schedule which displays as the top date and time in that cell.

31. eMAR: Document a Medication Administration (manual entry process)

1. Highlight the **med** on the eMAR.
2. Click **Administer**.
3. A warning box may appear if you are outside the parameter for early or late documentation.
4. If the medication has not been acknowledged the Acknowledge screen will appear.
5. Document any assessments that appear. Then click **Return**.
6. Click **Save**.

32. eMAR: Document a Non-Administration

1. Highlight the medication on the eMAR.
2. Click **Non-Admin Reasons** footer button.



3. Select a reason. Click **OK**.
4. If a reason is not listed here, select **Other**. Document the reason using the **Notes** menu button.
5. Click **Save.**

*TIP: Click **Next** to move through the alphabetical list.*

33. eMAR: Edit Documentation

1. Click into the **History** cell of the medication.
2. You can edit the following information in a gray cell. Click on the gray cell to edit:
   a. **Admin Comment** of a previously filed admin/non-admin
   b. **Assessment** of a previously filed admin/non-admin
   c. **Non-Admin Reason** of a previously filed non-admin
3. You cannot edit the Administration Date/Time. You would need to UNDO the documentation and re-document
4. Click **OK**.
5. Click **Return**.
6. Click **Save**.

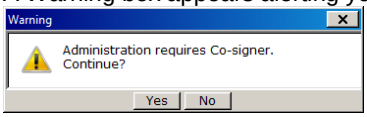
34. eMAR: Undo Documentation

1. Click into the **History** cell of the medication.
2. Highlight the activity line to be undone.
3. Click **Undo**.
4. Click **Return**.
5. Click **Save**.

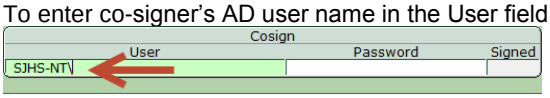
35. eMAR: Co-sign a medication

(Example: Insulin)

1. Provide education and confirm the patient will take the medication.
2. Highlight the Humulin R on the eMAR. Read the Label Comments.
3. Click **Administer.**
4. Document the Document Blood Glucose Assessment. Click **Return**.
5. A Warning box appears alerting you that a co-signer is required. Assuming a co-signer is available, click **Yes**.



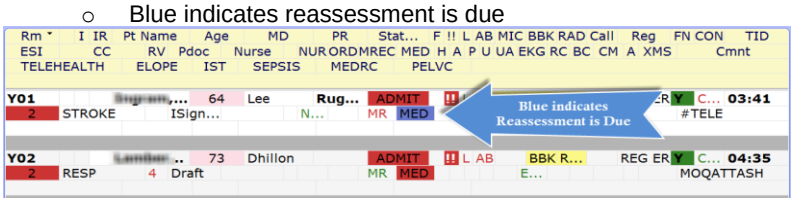
6. *The Electronic Signature box appears. The administering nurse's name populates the User field.*
7. Enter your AD password in the Password field and press **Enter.**
8. Follow the Independent double-check process; the co-signer must verify the medication and dose before signing.
9. To enter co-signer's AD user name in the User field press the right arrow key on the keyboard.



10. If you accidentally delete the SJHS-NT, click on the administering RN's password field for it to repopulate.
11. The co-signer enters their AD password in the Password field.
12. Click **OK**. *The medication is documented.*

36. eMAR: Document Reassessment

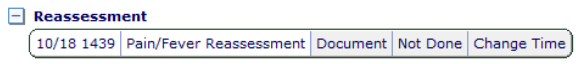
- There are 2 types of reassessments: Pain/Fever and IV Stop Time
  - Blue indicates reassessment is due



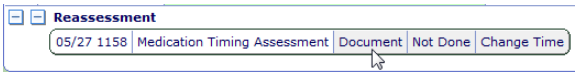
- Stop Time reassessments are required on all IVs, IVPBs, and Bolus infusions.
  - IV fluid Reassessment **"PINKS UP"** in **60 min.** IVPB and IV bolus **"PINKS UP"** in **25 min**.
  - Only document the Stop Time reassessment when infusion is complete.
  - If documenting the IV Intake on the reassessment, do not document again on the Infusion Assessment

1. Underneath the medication click the plus sign next to **Reassessment**. Then, click **Document.**
2. Enter the **Medication Stop Date** and **Medication Stop Time**.
3. Click **Return**. Click **Save**.
4. *"Reassessed" with the date and time appears below in purple font.*

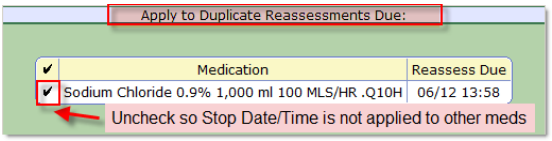
Pain/Fever Reassessment:



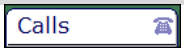
IV Stop Time/Med Timing Reassessment:



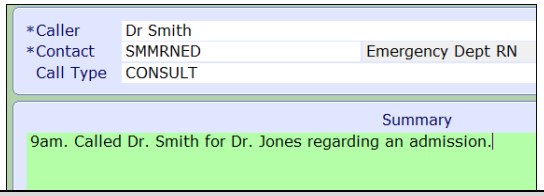
If there are **multiple reassessments due on multiple meds at the same time** you will get a pop-up asking if you want to apply your reassessment to the others that are due. **Uncheck all of the IV meds** and only document **one at a time** to ensure the correct stop date/time.



37. Documenting Calls

1. Highlight the patient. Click **Calls**. 

2. Click the **New Call** footer button.
3. At **Caller**: type the name of the **other person on the phone.**
4. Press **Enter** or Tab or click in the **Contact** field.
5. *Your user name defaults.*
6. Press Tab again or click in the **Call Type** field.
7. At **Call Type**: click the down arrow. Make a selection.
8. In the **Summary** field type the time of the call and call details.
9. Click **Save**.



38. Patient Handoff

The Patient Handoff Report. Includes ~~all~~ information documented in MEDITECH.
At the end of each shift the expectation for the patient hand-off is for both caregivers to review together the following information at the patient bedside:

- **Order History**
- **eMAR**

Document on the **ED Cares/Event Assessment**.

39. Depart / Disposition

- Information from the physician's documentation is pulled into the routine.
  - Impression, Disposition, Condition, and Prescriptions
- Documents to be sent with the patient based on the Disposition:
  - Discharge (home): Patient packet and prescriptions
  - Transfer to Outside Facility: Transfer paperwork, ED Summary Report, Physician Report

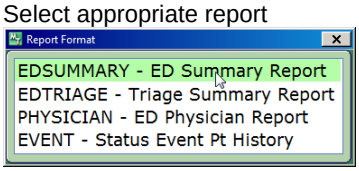
1. Prior to departing the patient, make sure:
   a. The patient is in a Reg Status Event of REG ER
   b. The FN cell shows Y
2. Click the **Interventions** button.
3. Complete the **ED Disposition Assessment** on the Interventions list
   a. Enter the patient's vital signs. If taken within the last hour, use Recall Values.
   b. Pain Presence (if applicable)
   c. Disposition
4. Click **Save** when finished.
5. Verify that there are no required (green text) Assessments remaining on the **Interventions** work list.

If unable to complete documentation prior to patient's departure, advance their Patient Status Event to **Document**. This places the patient on the **Document** Tracker. Once documentation is completed, advance the Patient Status Event to **Complete**.

d. Document the appropriate section based on patient's disposition:
   i. Discharge
   ii. Admission
   iii. Transfer Outside Facility
   iv. AMA
   v. Expired

40. Print ED Reports

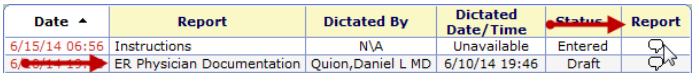
1. From the Tracker, click the **Summary Rpt**.
2. Select appropriate report



3. Click the Printer icon in the Task bar.

41. Printing Physician Documentation for Transfer

1. Highlight the patient's name on the Tracker.
2. Click **EMR**.
3. Click **Other Reports**.
4. Click the bubble in the Report column of the Physician Documentation row.



Date	Report	Dictated By	Dictated Date/Time	Status	Report
6/15/14 06:56	Instructions	N\A	Unavailable	Entered	
6/10/14 19:46	ER Physician Documentation	Quion,Daniel L MD	6/10/14 19:46	Draft	

5. Click **Print**.
6. Select the appropriate printer and click **Print**.
7. Click the ✕ in the upper right-hand corner when finished.

42. Admit as Inpatient

The following actions are completed prior to admitting a patient: *Check with your preceptor for specific actions at your ministry.*

1. ED Physician places an **ED Request to Admit** order.
2. Registration puts the patient into a virtual bed with one of the following statuses. Patient must be in one of these status' before they leave the ED.
   a. ADM – IN – Inpatient
   b. ADM – OBS – Observation
   c. ADM – SDC – Same Day Care
3. The ED physician advances the patient's status to **ADMIT**.
4. At this point, the Admitting Physician can start placing admission orders on patient.
   *a. This action triggers the **ORD** cell to turn red indicating new orders.*
5. After the bed is requested, the ED nurse or ED CCT can advance the Patient Event Status according to ministry-specific process.

REMINDER: Inpatient documentation is available for patients holding in the ED. Assessments can be added as needed via the Add Intervention functionality. Follow ministry-specific process.

EDIA4EYE	* 4 Eyes In 4 Hours	Assessment
EDIAAMB	* Ambulation Assessment	Assessment
EDIABRADEN	* Braden Skin Risk	Assessment
EDIADIET	* Diet Intake	Assessment
EDIAISOLTN	* Isolation Care Precautions	Assessment
EDIAPTSAFE	* Patient Safety and Position	Assessment
EDIASEPSIS	* Sepsis Screening	Assessment

6. Once the bed is available, the ED Nurse or ED CCT will:
   a. Advance Patient Status Event to **BED READY**.
   b. Complete all required assessments/treatments, including the **Disposition Assessment**.
7. Give report using the **Patient Handoff Report**.

43. Depart Process

1. Return to the Tracker and click the **Depart** menu button.
   a. Information from the physician's documentation is pulled into the routine.
      i. Impression, Disposition, Condition, and Prescriptions
2. Select Patient Language
3. Select Patient Instructions – recommended instructions auto-populate based on Primary Impression
4. Complete remaining fields if applicable
5. Click **Save**. *The **Depart Patient** footer button becomes active.*

The **Depart Patient** button will remain lowlit if:

6. Click **Depart Patient**.
7. Enter the actual **Date/Time** the patient left the ED. The time the Disposition is filed is considered the Depart Time.
8. MEDITECH automatically updates the Patient Status Event to Departed.
9. Review the departure packet with the patient. Make sure the **proper packet is going home with the patient**. IMPORTANT. Complete a 2 person-check of EVERY PAGE of the discharge instructions and any prescriptions for patient identification.
10. The patient name is removed from all Trackers except the My List Tracker. Patients must be manually removed from the My List Tracker.

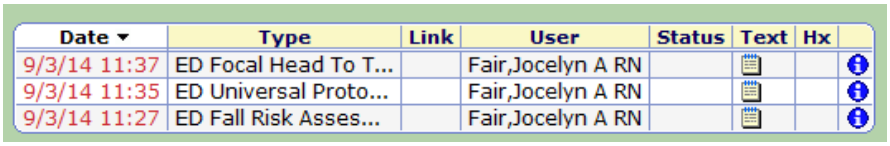
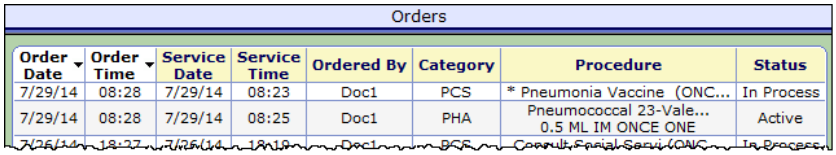
- if the patient has not been registered (still in PRE ER Reg Status)
- if Impression, Disposition, or Condition have not been documented yet.

Important: The patient should be departed before you leave your shift

44. Reprinting Armbands, Labels, and Facesheets

1. From the Main Menu, click Reports & Print Routines.
2. Click **Admission Reports**
3. Click **Reprint Facesheets/Armbands**
4. Click your site's **Reprint Facesheets/Armbands/Labels** option.
5. Search for and select the appropriate Patient.
6. Click **OK** when finished.

45. EMR

	From the Tracker, click on **EMR**.
Vital Signs	Click **Vital Signs** to see a table of the vitals documented up until now.
Notes	Click the **Notes** button to view a list of all the documented assessments and notes.  Click the blue circle with the white "i" you can view the contents of the individual assessment.
History	Click **History** to view Past Medical History**.**
Order History	Click **Order History** to view the orders that were entered in POM. Click on an order date for details.  Click **Audit Trail** to view additional details of the order. Click X at the top right corner to close the report Click **Back** to return to the list of orders
Laboratory	Click **Laboratory** to see the results of various laboratory tests.
Imaging	Click I**maging** to view a list of imaging studies that were done.
Other Reports	Click **Other Reports** to read ED physician reports and notes.