RN Acute Quick Reference Guide MEDITECH 5.67

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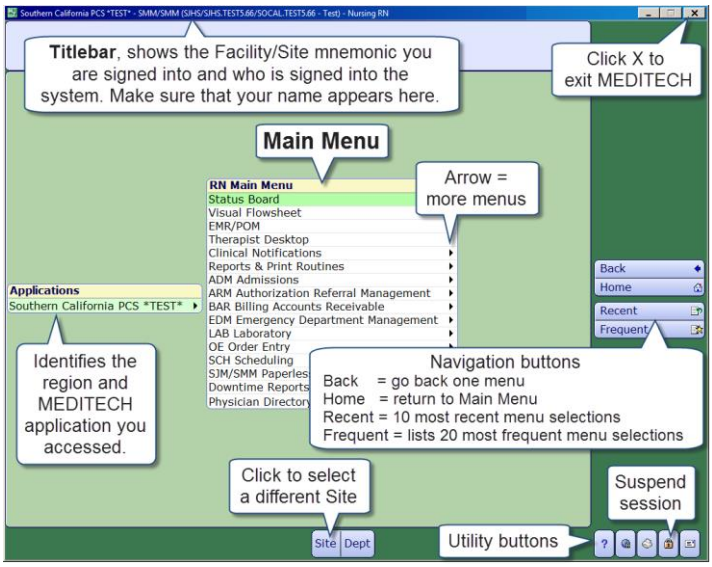
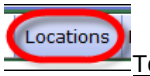
1. Main Menu



2. Find a Patient from the Status Board

1. 

To find a patient by location, click **Locations.** Click on the patient name. This patient highlights in green.
2. 

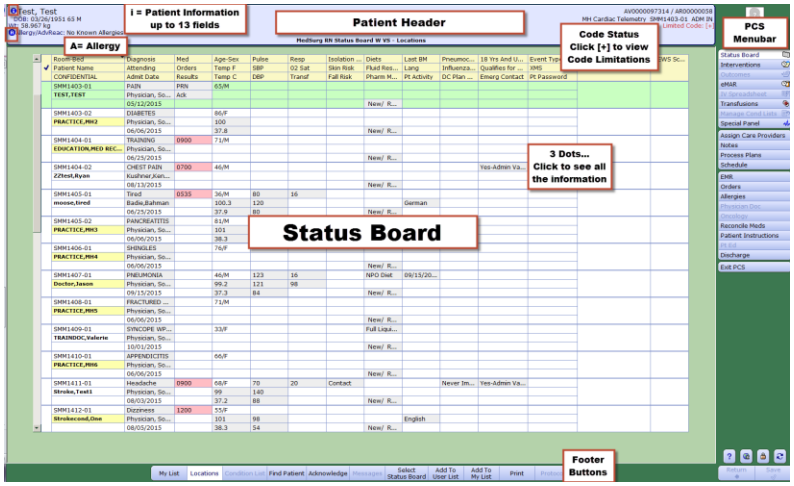
To find the by account number, click **Find Patient**. Type the Account Number. Click **OK.**

   Select the patient that matches the Name, Medical Record # and date of birth.

   Select the visit. Icon with green dot indicates inpatient visit.
3. Visit highlights in green. Patient appears in patient header.

Add the patient to your My List. Highlight the patient on the Status Board. Click the **Add to My List** footer button. Then, click **My List**.

3. Status Board



4. Documenting Allergies

1. Click the **Allergies** menu button.
2. NKA Click **NKA** if patient has no known allergies**.**
3. Unable to Obtain Click **Unable to Obtain** if patient unavailable **.**
4. Enter New 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.*

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

5. POM: Enter non-medication orders

1. Highlight the patient's name on the Status Board.
2. Click **Order**.
3. **Ordering Provider**

   To search for the physician's name, type the appropriate mnemonic in the **Ordering Provider** field. Press **F9**, make a selection and click **OK**.
   - St. Mary's - SYM
   - St. Joseph Orange - SJM
   - St. Jude Fullerton - SFM
   - Mission - SMM
   - CHOC – SCM
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.
   For Imaging orders, type the Imaging mnemonic and the body part, for example, XR wrist.
   For Diet orders, type diet and a few letters of the diet. (Exception is NPO)
7. Click the checkbox next to the order.
8. Click **Edit.**
9. Complete the order details.
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**. Do the orders look okay?
    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. If orders are okay, click **Save.**
14. Choose a File option.
    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. Back on the POM screen, the newly entered orders have moved under their category under **Current order**.

To edit an order, highlight the order and click the **Edit** footer button. Make the edit and click **OK** when finished. Click **Save**. *The **Session Summary** shows the New and Canceled orders for your review.*

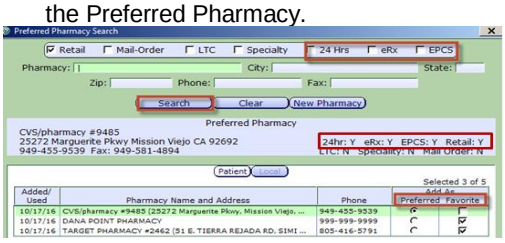
Imaging mnemonics = CT, US, NM, XR, CXR, RAD, MRI, MAM, IR

6. Home Med Rec: Add a Preferred Pharmacy

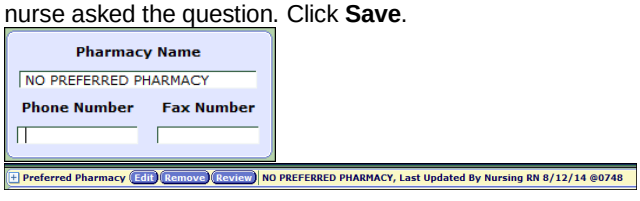
1. Click **Reconcile Med**.
2. At **Preferred Pharmacy** click **Edit.**

3. Enter known information in the Pharmacy, City, and Zip code fields.
4. Click **Search**.
5. From the list, click on the pharmacy name and location to be the Preferred Pharmacy.

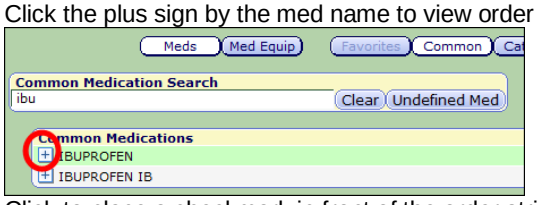
   

6. If the preferred pharmacy is not listed, click the **Not Found** button. Enter the Pharmacy Name and phone number which will update the Preferred Pharmacy field. This information will be available during the discharge process but **Not Found** information is not stored in MEDITECH so it won't be available 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**.

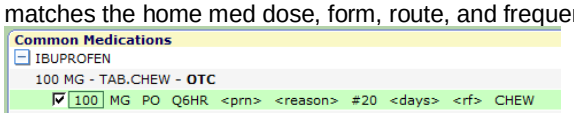
   

7. Home Med Rec: Documenting Home Med with Known Name and Dose Action

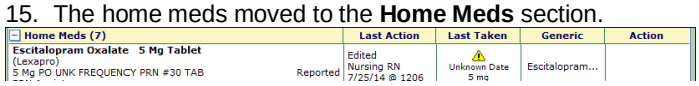
1. From the Status Board highlight the patient.
2. Click **Reconcile Med** menu bar button.
3. Confirm the patient name is in the patient header.
4. Click the **Meds** button.
5. At **Common Medication Search**: Type a few letters of the medication name.
6. Click the plus sign by the med name to view order strings.



7. Click to place a checkmark in front of the order string that matches the home med dose, form, route, and frequency.



8. **Reported** appears in the Action cell. Reported identifies this as a Home Med instead of a prescription to be created.
9. Document **frequency**:
   a. if unknown, click on the **<freq>** cell. Type UN. Select **Unknown**.
   b. is PRN, click on **<prn>** . Select a reason. This list only displays PRN reasons.
   c. is not PRN, enter the purpose of the medication on the Last Taken screen. The <reason> field on the order string is for a PRN reason which is why the list is limited to PRN reasons but for Home Med Rec, the nurse can select a PRN reason or free text a reason which is the same way the nurse would enter the Medication Purpose on the Last Taken screen.
10. Click **Select**.
11. On the **Last Taken** screen:
    a. Enter a **Date/Time** to indicate when the med was last taken. If unknown, click the box for **Unknown Date/Time**.
    b. At **Dose** document the dose taken even if it does not match the STRENGTH of the medication that was prescribed. If **Unknown Dose**, click the box if not already noted on order string.
    c. At **Medication Purpose** – type a reason. Notice that if you entered a Reason on the order string it will appear here.
    d. At **Information Source** click the arrow and document who provided the information.
    e. At **Attention Req** click **Yes** when there is an unknown name, dose, frequency or reason. Ignore the No.
12. Click **Save**. Home med appears under New Orders section.
13. Repeat steps to enter more home meds.
14. When done, choose a File option:
    a. **File and Exit** = files the orders and you return to the Status Board.
    b. **File and Refresh =** files the orders and you return to the Reconcile Meds screen. Choose this option if you want to continue working on the Reconcile Meds screen.
    c. **Return to screen =** nothing is filed and you return to the Reconcile Meds screen. Choose this option if any of the home med information on the screen is incorrect.
15. The home meds moved to the **Home Meds** section.



8. Home Med Rec: Update Route, Frequency, or Reason

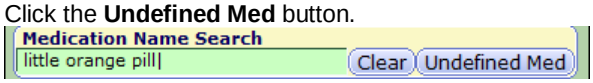
1. From the AOM screen, highlight the medication under the **Home Meds** category. To expand the category, click the +.
1. Click **View/Change**.
2. Click in each field you want to update and edit.
3. When done, click **Keep as Reported**.
4. Click on the **Last Taken** cell.
5. Remove the Attention Required "Yes" if the information was provided to remove the yellow alert triangle.
6. Click **Save**. Click **Save** again to file the change.
7. Choose a file option.

9. Home Med Rec: Document Unknown Name

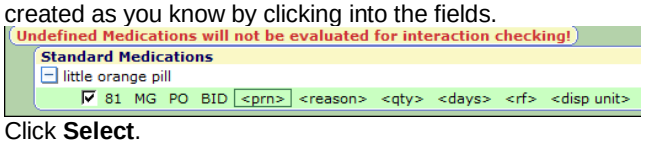
1. Highlight the patient. Click **Reconcile Meds**.
2. Click **Meds.**

If the Name of the Med is Unknown (for example, "little orange pill" daily for blood clotting. 81 mg. Last taken today at 6am.)

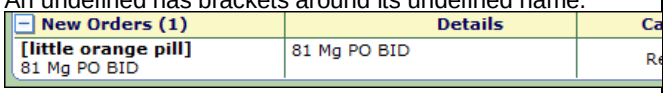
3. At **Medication Name Search**: type a description of the medication as described by the patient. Example: "little orange pill."
4. Click the **Undefined Med** button.



5. Enter as much information in the order string MEDITECH created as you know by clicking into the fields.



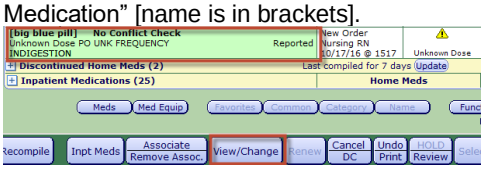
6. Click **Select**.
7. On the **Last Taken** screen:
   a. Enter a **Date/Time** med was last taken. If unknown, click the box for **Unknown Date/Time**.
   b. At **Dose** document the dose taken even if it does not match the prescribed STRENGTH of the med.
   c. At **Information Source** document who provided the information.
   d. At **Medication Purpose** – type a reason. A reason entered using the order string will appear here.
   e. At **Attention Req**: click **Yes** when an unknown name, dose, frequency or reason. So click **Yes**.
8. Click **Save**.
9. The "Undefined" description is saved under **New Orders**. An undefined has brackets around its undefined name.



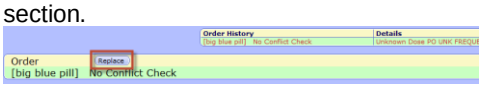
10. Continue documenting home meds.

10. Home Med Rec: Replacing an "Undefined" Home Medication

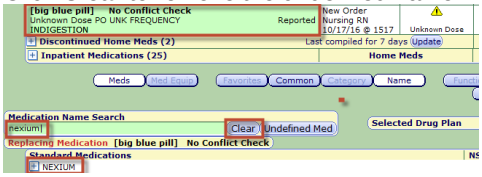
1. Under the **Home Meds** section, highlight the "Undefined Medication" [name is in brackets].



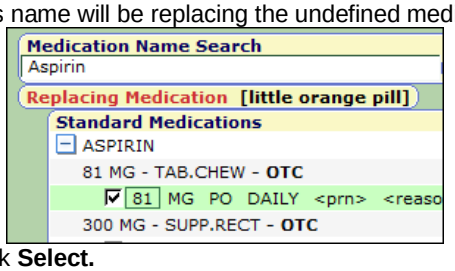
2. Click **View/Change**.
3. Click **Replace** on the order field located in the second section.



4. Click **Clear** to remove the undefined name

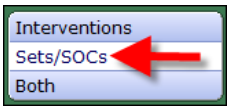


5. At **Medication Name Search**: type the medication name.
6. Click the [+] to show the order strings.
7. This name will be replacing the undefined medication.

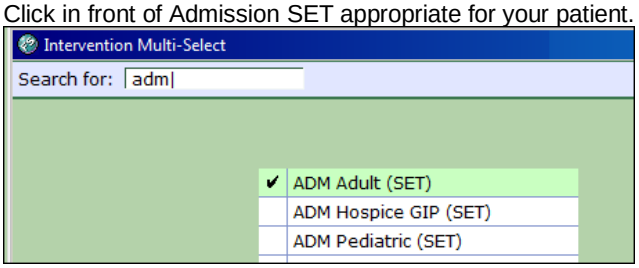


8. Click **Select.**
9. Click on the **Last Taken** cell. Record the **Date/Time** taken, **Dose Taken**, **Information Source**, and **Medication Purpose**.
10. Click **Save**. Select a File option.
11. Back on the AOM screen, the Undefined Med name has replaced the description with the actual med name.

11. Adding the Admission SET

1. Highlight the patient on the Status Board.
2. Click **Interventions.**
3. Click **Add Intervention**.
4. 

Click **Sets/SOCS**
5. At **Search for**: type ADM.
6. Click in front of Admission SET appropriate for your patient.

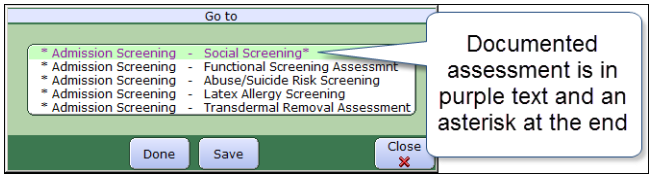


7. Click the **Add and Close** button.
8. Click **Save** to file**.**

12. Go to menu (Admission Screening)

This group assessment uses a **Go to** menu.

1. Highlight **Admission Screenings** assessment.
2. Click **Document.**
3. The **Go to** menu appears.



4. Click on an assessment.
5. 

When done documenting the assessment, click the **Go to** footer button.

13. Past Medical History

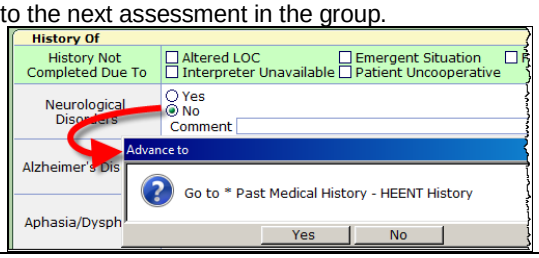
Recall Values. Click Recall Values before you begin documenting each Past Medical History assessment to bring forward EMR data from the last admission.

Caution: Be very cautious about using Recall Values. Do not file unless you have checked with the patient that each answer is true and current. Do not assume "correct" responses have pulled forward. You are signing your name to this information.

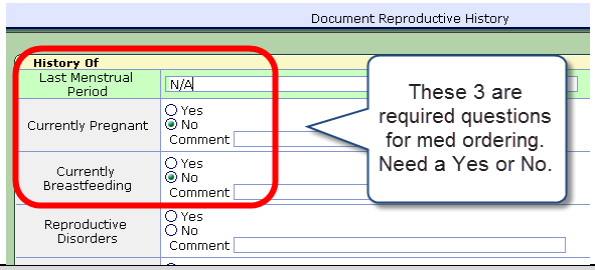
Document by Exception

This means that you only document what is outside the normal, in other words, the exception.

- If Yes, there is a history of the disorder, click Yes in the Disorder field. Then only document a Yes in the specific queries that describe why this is a Yes. Ignore the "No" responses to conditions that do not apply to the patient.
- At the bottom of each assessment is a Comment box to document any history not covered by the queries.
- If No, there is NO history of the disorder, then click No. Clicking No prompts an **Advance to** message which jumps you to the next assessment in the group.

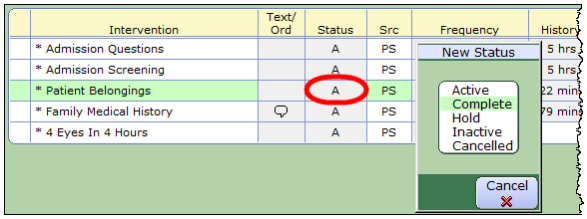


Occasional required Yes or No. On occasion, part of an assessment may have a required Yes or No, usually because the question relates to med ordering. For example, in the Reproductive assessment, the 2nd and 3rd questions are required.



14. Edit Status to Complete

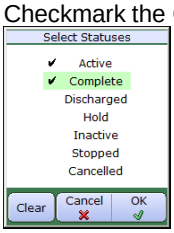
1. Click in the **Status** column of the intervention.
2. Click **Complete.**
3. Click **Save**



How to document an intervention that is in a "Complete" Status.

This would apply to an assessment in Complete Status that only needs to be documented this one time. If a the assessment is needed for continuous documentation, for example, the Telemetry assessment, then change the Status back to Active to keep it on the worklist.

1. Click the **Select Status** footer button.
2. Checkmark the **Complete**. Keep the **Active**. Click **OK**.



3. The intervention reappears on the worklist. Document and Save.
4. Click the Click the **Select Status** footer button again.
5. Uncheck the Complete. Click **OK**.

Never use the "Cancelled" option under Edit Status. If you do, you will need to add the intervention back to the worklist instead of changing the status back to Active.

15. EMR

From the PCS menubar, click on **EMR**. Buttons on the right are called panel buttons

Vital Signs

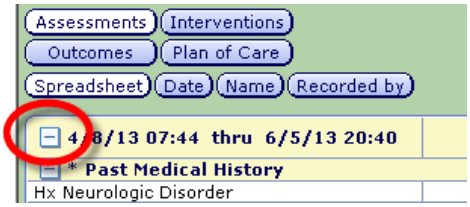
Click **Vital Signs** to see a table of the vital signs taken up until now.

Care Activity

Click the **Care Activity** panel.

The display opens in a Spreadsheet view of the 3 most recently documented Assessments.

- Dates run across the top.
- The Assessment name and queries documented in the assessment appear in the first column.
- An Assessment name has a tan background. Queries are in the rows below.



- You can select other assessments to view by swapping out these 3 for 3 others. Do this by clicking the box with the minus sign in the top left.
- Once collapsed, right-click on the three assessments you want to view. Backgrounds turn green.
- Then click the **Display** footer button. The assessments you selected appear.
- Instead of Spreadsheet view, you can sort assessments by the Date documented, by the Name of the assessment, or by who did the documentation (Recorded by).
- Click into each of those buttons to discover the different views.

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 for details.

Orders

Order Date	Order Time	Service Date	Service Time	Ordered By	Category	Procedure	Status
7/29/14	08:28	7/29/14	08:23	Doc1	PCS	* Pneumonia Vaccine (ONC...	In Process
7/29/14	08:28	7/29/14	08:25	Doc1	PHA	Pneumococcal 23-Vale... 0.5 ML IM ONCE ONE	Active

Click **Audit Trail** to view the progress of the order.
Click **Return** at the top of the EMR menubar to return to the previous window

Laboratory

Click **Laboratory** to see the results of various laboratory tests.

Imaging

Click I**maging** to view a listing of imaging studies that were done and be able to read the reports.

Other Reports

Click **Other Reports** to read ED physician reports and notes.

16. Adding the Standard of Care

1. Click **Process Plans**.
2. Click **Standard of Care** on the menu, or **Enter** footer button
3. At first blank line, press the down arrow.
4. Select the SOC for your unit.
5. Click **Save**.

Telemetry patients. At admission, if the patient requires telemetry then add the **Telemetry SOC.**

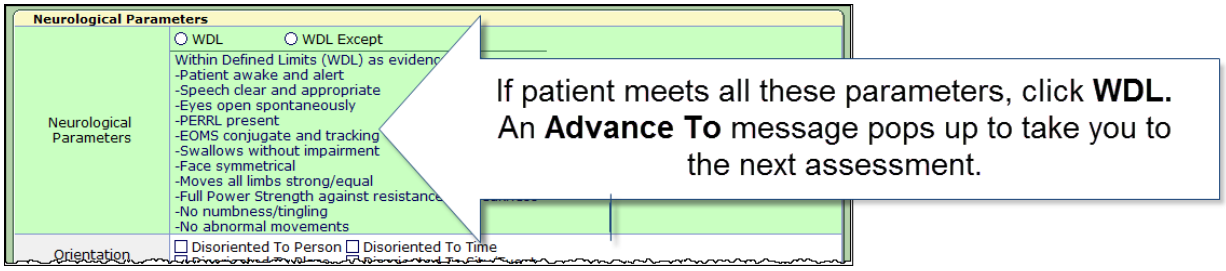
During their stay, if a patient who already has a Med/Surg SOC loaded requires telemetry monitoring, then use the **Add Intervention** footer button to add the needed assessments, for example, the **Telemetry Assessment** and the **Transcutaneous Pacemaker.** Add these assessments individually as needed. It is not necessary to stop the Med/Surg SOC.

17. WDL and Documenting by Exception (Physical Assessment)

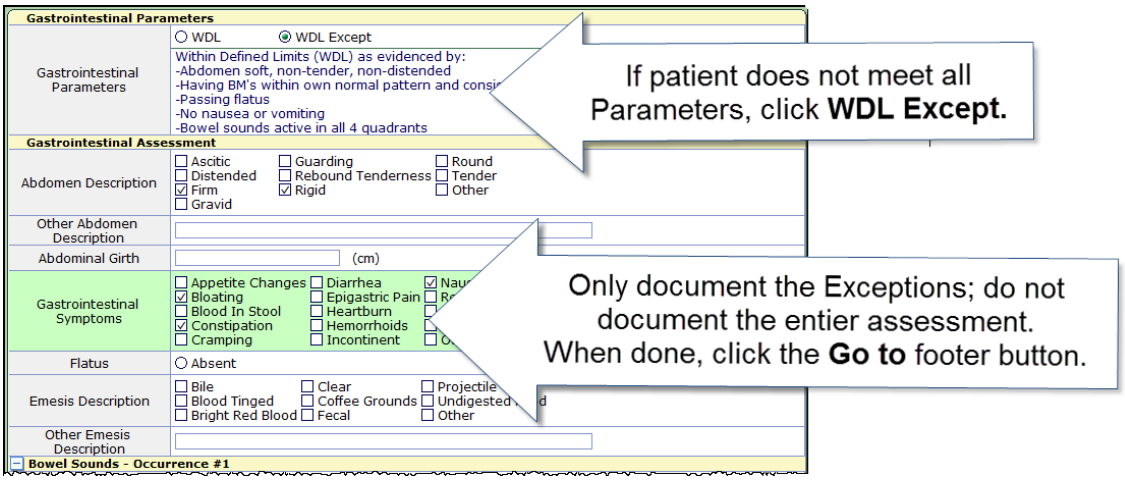
Document by Exception - The assessments in the Physical Assessment are designed for you to "document by exception."

a) Read the WDL Parameters and determine if the patient is within the defined limits described.

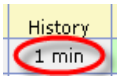
b) **WDL**



c) **WDL Except**

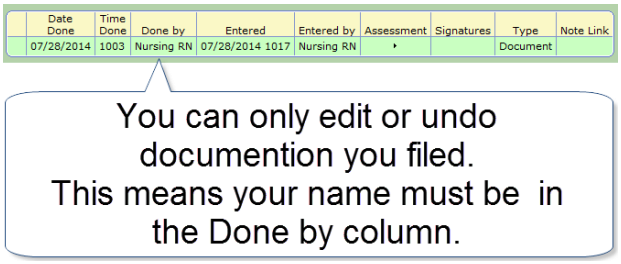


18. Edit or Undo Filed Documentation



To Edit or Undo documentation, from the Interventions worklist, click into the **History cell** of the intervention you want to edit or undo.

Just remember what you UNDO is always UNDONE. Only use Undo if the entire assessment is documented in error because all your documentation sessions will be removed.

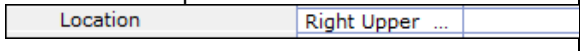


19. Document Spreadsheet

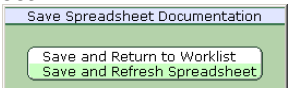
Choose **Document** the first time you document an assessment. After that you can choose **Document Spreadsheet**.

To add a response to a cell you can either:

1. Click in the cell. Possible responses display. Make your selection.
2. "Click and drag" a response from the previous column and paste onto the new column.
3. Click and drag" the whole column by clicking on the header of the column and drag to new column header. Warning: be sure to check EVERY copied response to confirm it is still the same.
4. "Warning: if a cell has 3 dots indicating hidden responses do not copy the cell unless you have reviewed the responses.



5. To keep the spreadsheet open to do continuous documentation choose **Save and Refresh Spreadsheet**.



20. Shift Event Assessment

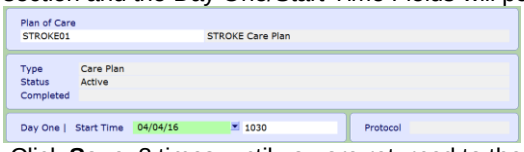
- If you do a bedside procedure you need to document this assessment in the **Shift Event** section as well as document on the **Universal Protocol** intervention.

21. Add an Initial Care Plan

1. Click **Process Plans** on the PCS menu bar.
2. Click **Enter** footer button
3. Click **Care Plan.**
4. At **Plan of Care** search box type a **? and the first part of the CP** (the CP you choose need to be based on the admitting diagnosis), then click the down arrow for a list of all Care Plans.
5. If you can't find an appropriate CP, the **General Medical**, **Cardiac or Surgical** can be used.
6. Select a Care Plan.

Note: Do Not Add 2 Care Plans!!

7. The name of the Care Plan will populate the Plan of Care section and the Day One/Start Time Fields will populate.



8. Click **Save**, 3 times, until you are returned to the main process plans screen.
9. Displaying on the process plans screen will be the admitting care plan, along with the interventions added to the patient's plan of care.
    a. There are 2 active interventions the nursing care plan and the additional problems intervention.
    b. Along with the nursing care plan interventions, initiating a care plan also adds the ancillary care plans to the patient's plan of care
10. **Multiple diagnosis/conditions**: Choose the CP for the primary reason for admission or the highest acuity diagnosis/condition. Then add additional problems to address other conditions if they are not already on the CP
11. **Co-Morbidities**: Choose the admission diagnosis/condition CP, then add additional problems related to the co-morbidities ONLY if the comorbidity is ustable.
12. When the admitting care plan is entered, multiple interventions are added to the patient's Plan of Care
    - 2 active interventions
        - o Care Plan for admitting diagnosis/condition
        - o Care Plan Problems Additional
    - Inactive Interventions that may need to be activated when needed:
        - o Restraints documentation
        - o *VAP assessments
        - o *Measure & Photo Wound, Pressure Ulcer
    - Additional Interventions based on the care plan (i.e. Stroke will have the NIH Scale)
13. When the Standard of Care is added it will also bring "risk" care plan interventions:
    - 1 for Skin, Adult or Pediatric specific

Care Plan Prob Neonatal Skin Cond Score
Care Plan Problem Braden Skin Risk

    - 1 for Falls, Adult or Pediatric specific

Care Plan Problem Fall Risk Morse
Care Plan Problem fall Rsk Humpty Dumpty

22. Changing the Admit Care Plan

Due to MEDITECH functionality, if it is necessary to change the admitting care plan, **nursing will NOT return to the Process Plans screen.**

- The care plan intervention will be completed on the intervention list and the new care plan will be added from the intervention list" **Add Intervention**" footer button
- If a care plan is completed on the Process Plans screen, then ancillary team documentation will be interrupted.

Changing the admitting care plan is done when a patient is admitted with one disease/condition, but then another becomes the focus of care.

Follow the steps below to change the admitting Care Plan:

1. Locate the current admitting care plan on the intervention worklist, and then click in the status cell of the care plan.
2. Click Complete in the New Status box that displays.
3. Click Add Intervention, to add the new care plan
4. In the search for box, type Care Plan and use the scroll bar to locate the appropriate care plan.
5. Click in the box to the left of the care plan you want to add to place a checkmark
6. Click Add and Close
7. Click Save to complete the old care plan and add the new one.

Note: If you need to add problems for concerns related to the completed admitting care plan that aren't addressed on the new admitting care plan, you would use the **Additional Problems intervention.**

23. Restraints

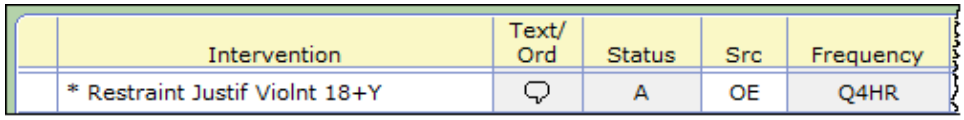
POLICY. Violent restraint orders require a frequency default specific to the age to meet regulatory requirements. The frequency of documentation is based on the type of restraint and age.

INITIAL RESTRAINT ORDER

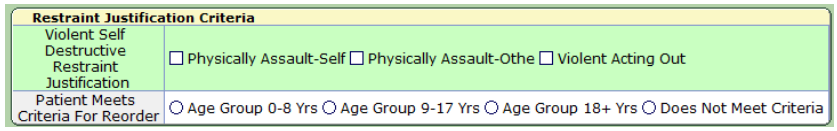
1. Patient meets criteria for Non-Violent or Violent restraints.
2. MD selects the **Restraint Justification** order in POM that is specific to age OR the nurse receives a telephone order and selects an Order Source of TO.
3. Complete the order details.
4. Click **Save**.
5. Result: Order will add a ***Restraint Justification** intervention to the nurses worklist. Documentation frequency is based on the type of restraint and patient age. Turns pink as a reminder for restraint renewal.
6. Nurse acknowledges the order from the Status Board.
7. Nurse activates the **Care Plan Problem restraint Non Violent or Violent** on the Intervention worklist
8. Nurse documents on the Care Plan Restraints assessment

RENEWING THE ORDER FOR RESTRAINTS

1. Based on frequency, the nurse documents on the **Restraints Justification** order whether the **Patient Meets Criteria For Reorder**. If restraints are justified, this will launch POM to enter the renewal order. (Order Source = Telephone or Verbal)



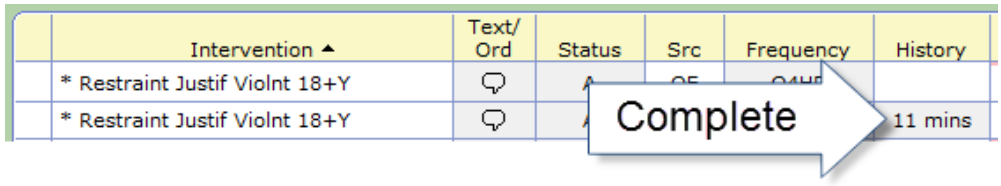
	Intervention	Text/ Ord	Status	Src	Frequency
	* Restraint Justif Violnt 18+Y	🗨	A	OE	Q4HR



Restraint Justification Criteria	
Violent Self Destructive Restraint Justification	☐ Physically Assault-Self ☐ Physically Assault-Othe ☐ Violent Acting Out
Patient Meets Criteria For Reorder	○ Age Group 0-8 Yrs ○ Age Group 9-17 Yrs ○ Age Group 18+ Yrs ○ Does Not Meet Criteria

2. The RN completes the older **Restraint Justification** intervention leaving only the new one on the worklist.

   Older intervention displays minutes in the History cell.

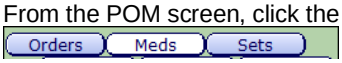


3. When the restraints are no longer justified, the RN will obtain a **DC Restraints** order and complete the Care Plan Outcomes and the last Restraint Justification intervention on the worklist.

24. POM: 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 POM screen, click the **Meds** button.



2. At **Medication/IV Component**: type a few letters of the med name.
3. Select the checkbox next to the med to place a checkmark.
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**.

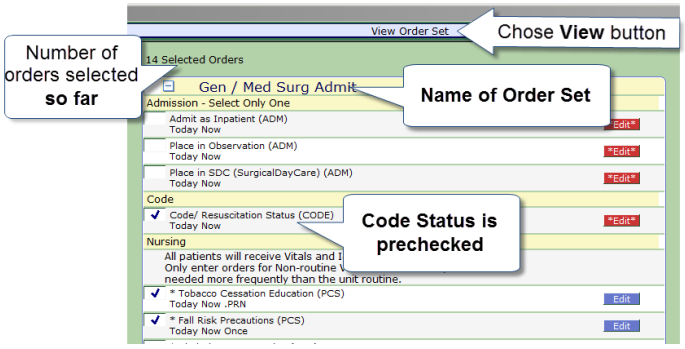
25. POM: Using an Order Set

1 *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 on a category.
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. eMAR: Acknowledging Medications

1. Highlight the patient on the Tracker.
2. Click **eMAR**.
3. Click the **ACK** cell.
4. Review the order details and ask yourself: Is this the correct patient? Is the drug/dose/route correct and appropriate for the patient?
5. If all details are correct and make sense, click **Acknowledge**.
6. If the order details are incorrect, click **Reject**. In the **Enter Reject Comment** box enter the reason for rejection along with details about dose, route, or rate.
7. Click **Save**.

27. eMAR: Document a Non-Administration

1. Highlight the medication on the eMAR.(no scanning)
2. Click **Non-Admin Reasons** footer button.
3. Select a reason. Click **OK**.
   *TIP: Click **Next** to move through the alphabetical list.*
4. If a reason is not listed here, select **Other**. Document the reason using the **Notes** menu button.
5. Click **Save.**

27. eMAR: Document a Scheduled Medication Administration

IMPORTANT: LET THE SCANNER FIND THE MEDICATION NAME AND ADMINISTER.
Remember, the scanner is clicking the Administer button for you.

1. Provide education. Confirm the patient will take the meds.
2. You are automatically documenting against the current med schedule which displays as the top date and time in the **Next Sched** cell. Make sure you chose the correct scheduled dose before scanning.
3. Scan the patient's account # on their armband.
4. Scan the medication barcode
5. If a Warning appears, read and decide if you are documenting against the correct schedule (correct date and time).
6. Result: The scanning highlighted the med on the eMAR and automatically documented the Administration (replaces clicking the Administer button.)
7. If an assessment displays, document it.
8. To add a comment, click **Admin Comments**.
9. Result: a checkmark appears in front of the med name and below the med is a magenta Administered time stamp indicating "not yet filed."
10. Click **Save** or document other administrations and then click **Save**.

28. 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**.

29. eMAR: Undo Documentation

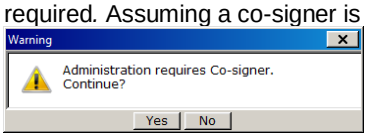
1. Click into the **History** cell of the medication.
2. Highlight the activity line to be undone.
3. Click **Undo**.
4. Click **Return**. Click **Save**.

30. Unscheduled Adminstration

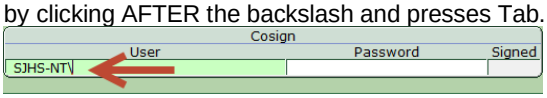
1. Click into the **Next Sched** cell of the medication.
2. Click the **Unscheduled Administration** footer button.
3. A new entry titled **Unscheduled** appears. Click **OK.**
4. Scan the armband and scan the medication.
5. Click **Admin Comment** and enter a reason.
6. Click **OK**. Click **Return**. Click **Save**.

31. eMAR: Documenting an Insulin Administration

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. The co-signer enters their AD user name in the User field by clicking AFTER the backslash and presses Tab.

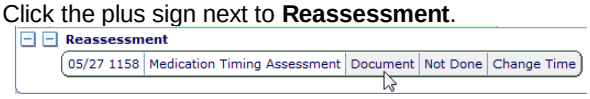


10. If you accidentally delete the SJHS-NT, click the dark green field to get it back.
11. The co-signer enters their AD password in the Password field.
12. Click **OK**. *The medication is documented.*

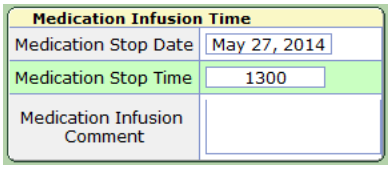
32. eMAR: Document an IV Stop Time Reassessment

Stop Time reassessments are required on all IVs, IVPBs, and Bolus infusions ONLY for OBS patients.
IMPORTANT Nothing in the system flags the nurse to document the IV Stop Time Assessment but it still must be completed.

1. Click the plus sign next to **Reassessment**.



2. Click **Document.**
3. Enter the **Medication Stop Date** and **Medication Stop Time**.



4. Document other assessments that popup.
5. Click **Return**.
6. Click **Save**.
7. *"Reassessed" with the date and time appears below in purple font.*

33. Shift Handoff

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:

- The Nursing Handoff Tool. Includes all information documented in MEDITECH.
- Order History
- eMAR
- Lab and Radiology results
- Document on the **Handoff Communication Report** assessment

To print the Nursing Handoff /SBAP Tool: From the RN Main Menu click select **Reports & Print Routines.** Select **Handoff Communication Reports or SBAP (select the unit).**

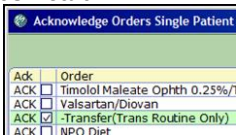
34. Transport Handoff

1. From the RN Main Menu select **Reports & Print Routines**.
2. Select **Handoff Communications Reports**.
3. Select **Ticket To Ride.**
4. Type the patient's name and click **OK**. Be sure to select the correct patient and the correct account.
5. The report defaults to **Preview.** Click **OK.**
6. Confirm the clinical data that appears on the report is up to date.
7. To print a paper copy of the **Ticket to Ride** report: Click the print icon in the top left of the screen.

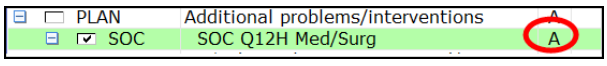
8. Select the proper printer and click **OK.**
9. On the **Ticket to Ride** printed report circle the **O2 Delivery** method information.

35. Patient Transfer to another facility

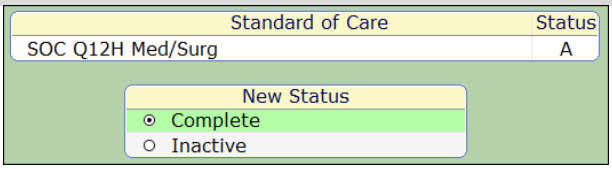
1. Sending nurse: On the Interventions worklist, make sure interventions with a **Src** of OE (physician ordered interventions) for the patient are documented.
   - **TIP**: Click the **Src** column header to group all the orders together (**Src = OE**).
   - Change the Status to Complete unless the receiving unit will need that intervention.
2. Receiving or sending nurse (ministry specific, check with preceptor): If the MD used the MEDITECH Transfer order, the nurse must acknowledge the transfer order from the Status Board.



3. If the orders come across as DC'd, click the Audit Trail button to see if the MD DC'd the orders in POM.
4. Sending nurse: Complete the SOC. The receiving unit will be adding the SOC for that unit. *Follow these steps to complete the SOC:*
   1) From the Status Board, highlight the patient.
   2) Click **Process Plans** from the PCS menubar.
   3) Scroll down to find the **SOC.** Status is A (Active.)
   4) Click on the title of the SOC to highlight it and put a checkmark in the box.



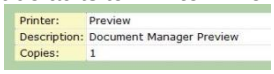
   5) Click the **EDIT** footer button.
   6) Select **Edit Status.**
   7) The **COMPLETE** status is the default selection. Click **Save.**



   8) Result: The Status of the SOC changed to C (Complete) as well as all the interventions in the SOC.
   9) Click **Close** to return to the Status Board.

   NOTE: To reactivate a SOC that is in the Complete status, you have to select every intervention in the SOC that you want reactivated by clicking the box to leave a checkmark. Then click the Edit footer button, select Edit Status. Choose Active and Save.
5. Sending nurse: Preview or print the **Nursing Handoff or SBAP Tool** report. The report appears on your screen. Confirm the clinical data on the report is up to date.

   To print:
   1) From the RN Main Menu select **Reports & Print Routines**.
   2) Select **Handoff Communications Reports**.
   3) Select the **Nursing Handoff or SBAP (sending unit) Tool**. At Mission, select the **SBAP** instead.
   4) Type the patient's name and click **OK**. Be sure to select the correct patient and the correct account.
   5) The report defaults to **Printer: Preview.**



   6) Click **OK.**
6. Sending nurse: Document the **Handoff Communication** intervention
7. Receiving nurse: The receiving unit will add the SOC for their unit.

36. Patient Instructions Krames

1. Click **Patient Instructions.** 

2. Click the **Add/Remove Instructions** footer button.
3. At **Search**: type a few letters of the disease or condition or education topic. For example, vac for vaccination.
4. Highlight the instructions you want (green background)
5. Click the **View** footer button to preview the health sheet.
6. When done viewing, click the X in the upper corner of the screen to exit.
7. If these are the instructions you want, click **OK**.
8. Result: The instructions are added to the list of Patient Instructions to be given to the patient now or at discharge.
9. Repeat to add other patient instructions.
10. To print a copy now click the Print footer button.
11. Click **Save** to file the instructions so they stay on the list.
12. Click **Cancel** to return to the Interventions Worklist.

37. Reprinting Armbands, Labels, and Facesheets

1. From the Main Menu, click Reports & Print Routines.
2. Click **Admission Reports** from the **Reports & Print Routines** submenu.
3. Click **Reprint Facesheets/Armbands** from the **Admission Reports** submenu.
4. Click your site's **Reprint Facesheets/Armbands/Labels** option.
5. Select the appropriate document to print.
6. Search for and select the appropriate Patient.
7. Verify the correct network printer. Change if needed.
8. Note: **DO NOT** select a **LOCAL** printer.
9. Click **OK** when finished.