RESOURCE AND PATIENT MANAGEMENT SYSTEM

RPMS Electronic Health Record
(EHR)

Inpatient User Guide

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FOREWORD

The Indian Health Service (IHS) Office of Information Technology (OIT) National Electronic Record (EHR) Training and Deployment Program "EHR for Inpatient" workgroup has diligently worked to prepare the necessary deployment and training documents to facilitate the deployment of EHR in the Inpatient setting. We hope that you find these documents helpful.

The Office of Information Technology would like to sincerely thank all the members and guests of this workgroup. They spent long hours preparing these documents and even longer documenting their experience and deserve our appreciation. Without these dedicated workgroup members this would not be possible. A special thanks to Shirley Teter, OIT, for her assistance in formatting and ensuring consistency in our documentation. We would like to give special recognition to Crow Indian Hospital (CIH), Fort Defiance Indian Hospital (FDIH) and Cherokee Indian Hospital Authority (CIHA) for their dedication in both deploying EHR within the Inpatient setting and serving as subject matter experts (SMEs) for this project. Finally, we are indebted to our colleagues in the Indian Health Service for their support, encouragement, and input.

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1.0 Provider

This section provides information about various inpatient activities for the Provider.

1.1 Admission

Providers will not use POV or E&M codes for hospitalization.

Providers will write an H&P and enter orders.

1.1.1 Admit from E.D. or Clinic

Follow these steps:

1. Choose the E.D. or clinic visit that the patient is currently checked in.
2. Add yourself as a provider.
3. Write orders using the Write Delay Orders function. If the patient goes to a different location, you will need to write new delayed orders and d/c the previous delayed orders.

> **NOTE**: Make sure pt isn't already admitted by ADT. If so, orders are written as active inpatient orders instead of delayed.

Figure 1-1: Delayed Orders Function

4. After selecting Delayed Orders, the Release Orders dialog displays.

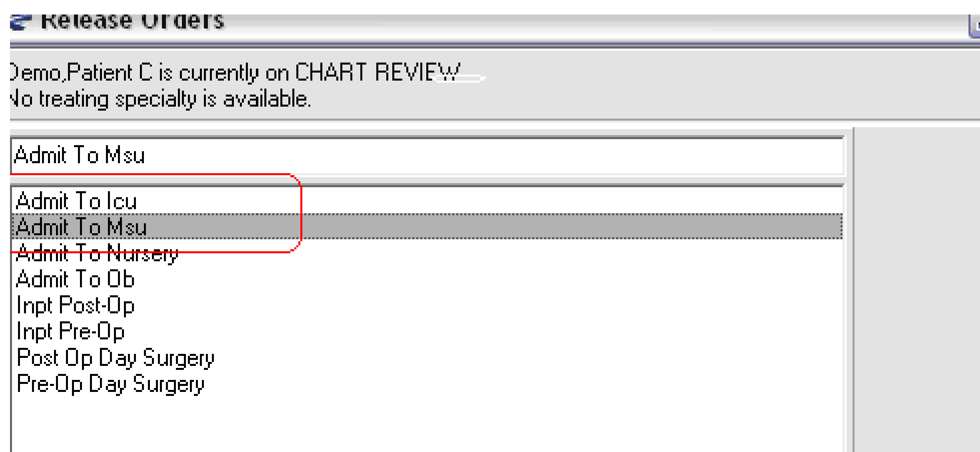


Figure 1-2: Options to Selected

5. Select one of the options, like Admit to MSU, to display the Admit Patient dialog.

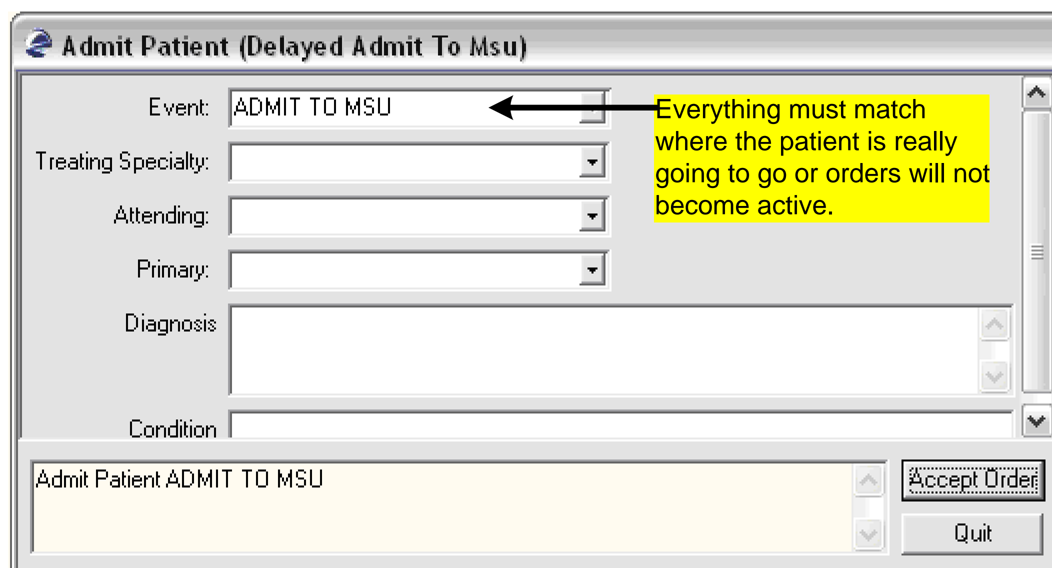


Figure 1-3: Sample Admit Patient Dialog

a. **Treating Specialty**: select the correct admitting specialty.

b. **Attending** and **Primary**: put yourself as both Attending and Primary.

c. **Diagnosis** and **Condition**: type in the admitting diagnosis and condition. For example, Diagnosis = Cellulitis and Condition = Stable.

d. Click **Accept Order**. It will display as a Delayed Order.

Inpatient medication menu --- make sure you DO NOT use outpatient med menu

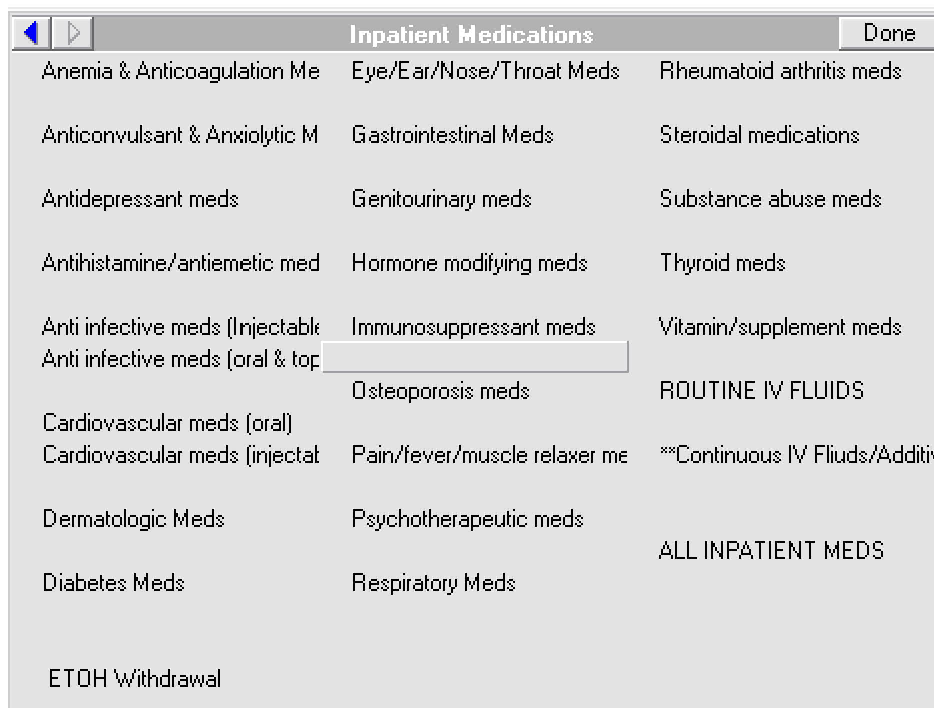


Figure 1-4: Inpatient Medications Selections

Make sure you sign off on the delayed orders……

Event	Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Delayed A	A/D/T	>> Admit Patient Admit to MSU Specialty: GENERAL MEDICINE Attending: TUTT,MICHAEL L Primary: TUTT,MICHAEL L Diagnosis cellulitis Condition: stabe *UNSIGNED*		Nelson,R				unreleased
Delayed A	Nursing	>> Activity: Ad Lib Keep Leg Elevated (left) *UNSIGNED*		Nelson,R				delayed
Delayed A		>> DIET Full Liquid *UNSIGNED*		Nelson,R				delayed
Delayed A		>> Salinelock IV *UNSIGNED*		Nelson,R				delayed

Figure 1-5: Written Orders on Orders Tab

NOTE: Another option to transfer the outpatient meds to inpatient is to go to the medications tab after you have completed picking all the other inpatient orders from the inpatient menu. Highlight the orders you want, select Action → Transfer to Inpatient.

View | Action

Action menu: New Medication... | Change... | Discontinue / Cancel... | Renew... | Copy to New Order... | Transfer to Inpatient... | Refill... | Chronic Medication

Outpatient Medications	Expires	Status	Last Filled	Refills Remaining
N 160MG/5ML SOLUTION Qty: 120 for 30 days 1 AND 1/2 TEASPOONSFUL) BY MOUTH EVERY 6 ED FOR PAIN OR FEVER	31-Oct-2006	Expired	01-Oct-2006	0
0.1% OINTMENT (15GM) Qty: 15 for 10 days L AMOUNT TO AFFECTED AREA TWICE A DAY DISPENSED IN CLINIC FROM OMNICELL.	04-May-2006	Expired	04-Apr-2006	0
REAM Qty: 120 for 30 days Sig: APPLY THIN FILM MOISTURIZING CREAM 120G TO AFFECTED AREA EVERY DAY	04-May-2006	Expired	04-Apr-2006	0
IBUPROFEN 100MG/5ML SUSP Qty: 120 for 10 days Sig: TAKE 6 ML BY MOUTH EVERY 6 HOURS IF NEEDED FOR PAIN - SHAKE WELL; TAKE WITH FOOD OR MILK	04-May-2006	Expired	04-Apr-2006	0
ACETAMINOPHEN 80MG/0.8ML DROPS Qty: 15 for 5 days Sig: TAKE 2 ML BY MOUTH EVERY 4 HOURS IF NEEDED FOR PAIN OR FEVER DO NOT DISPENSE IN PHARMACY!!! MEDICATION DISPENSED IN CLINIC FROM OMNICELL.	04-May-2006	Expired	04-Apr-2006	0
AMOXICILLIN 250MG/5ML SUSP Qty: 150 for 7 days				

Figure 1-6: Transfer to Inpatient Option on Action Menu

<u>You will then again get the pop up of what you want to link this to</u>

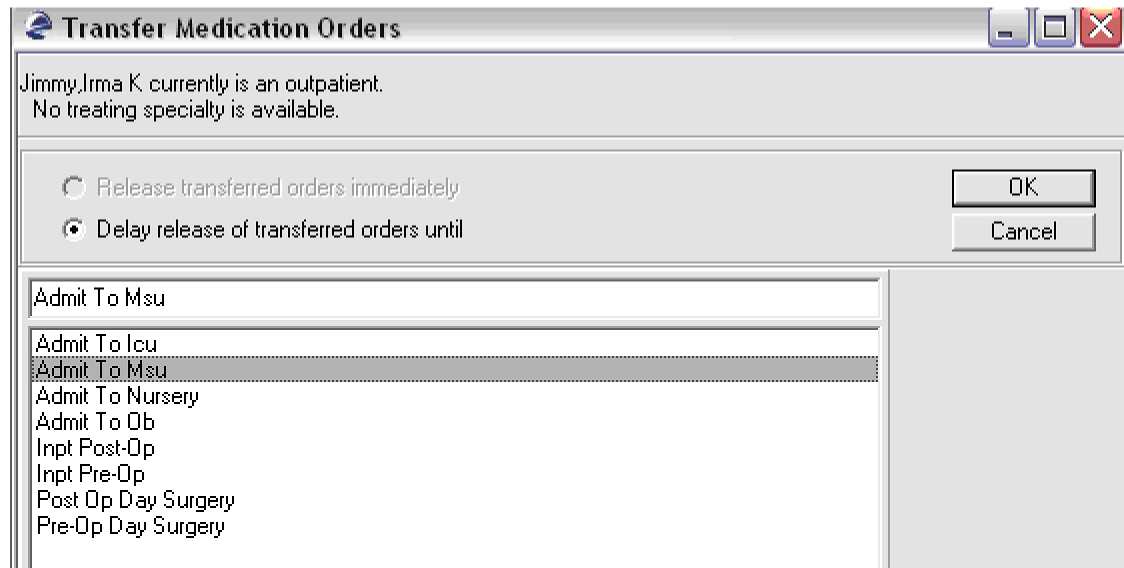


Figure 1-7: Sample Transfer Medication Orders Dailog

If you get an error that a certain drug cannot be ordered from a picklist on an inpatient, discuss with Pharmacist or CAC.

Once you sign the orders they will release & print to the designated admission unit after ADT occurs.

1.1.2 Direct Admit with Chart

1. You can choose the New Visit tab & Chart Review (for the Visit Location) to write a delayed order to admit the patient and leave off all other orders until you see the patient if you want.

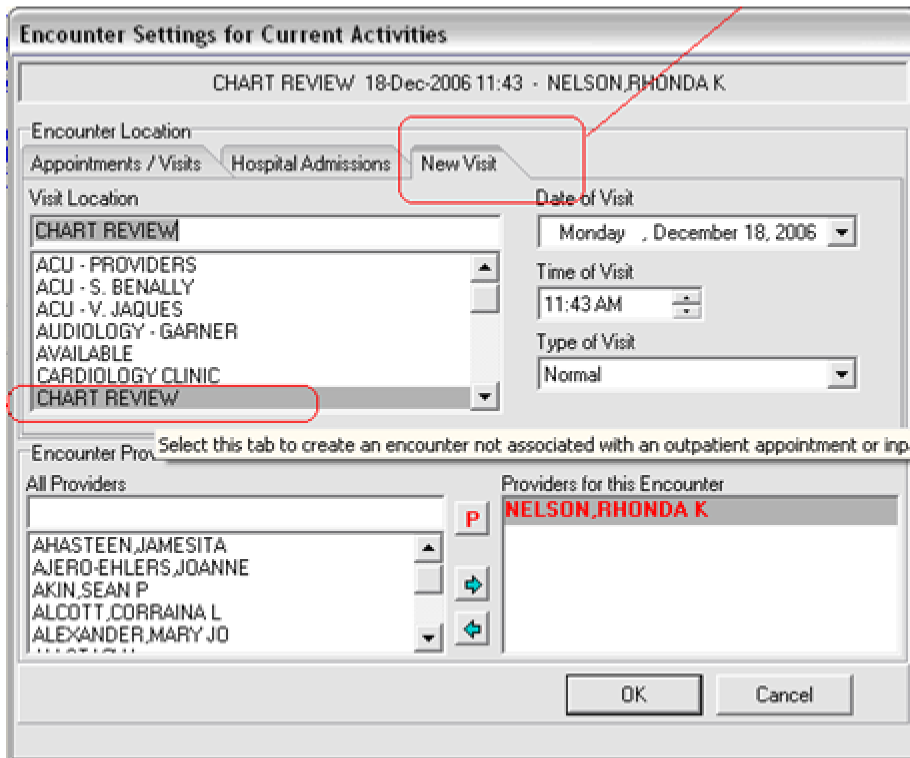


Figure 1-8: Sample Encounter Settings for Current Activities Dialog

2. After the patient has been admitted in ADT, write the H&P and remaining orders using the hospitalization as the visit context.

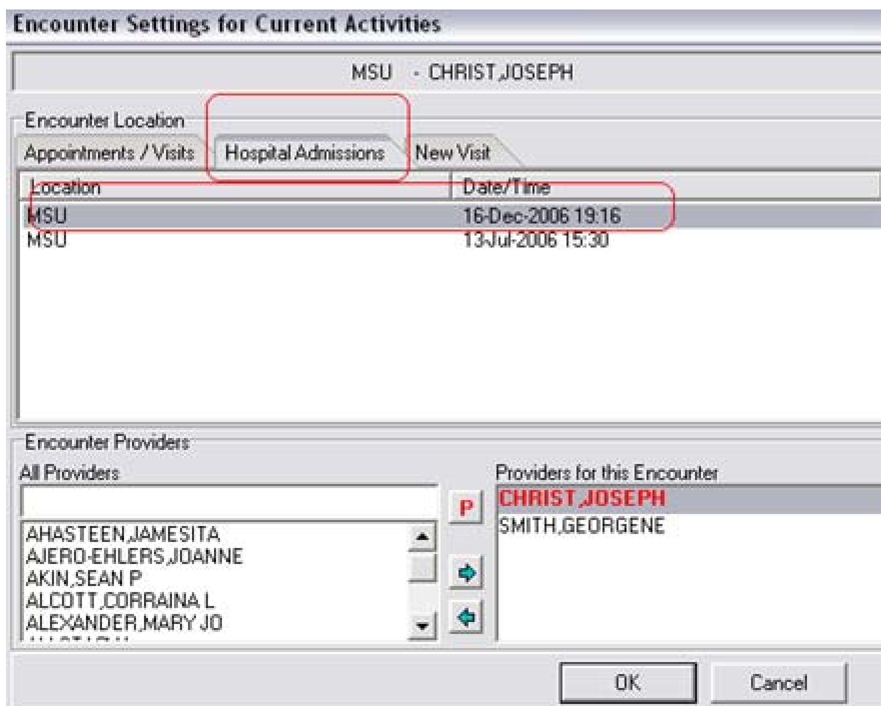


Figure 1-9: Hospital Admissions Tab

1.1.3 Direct Admit with No Chart

1. Notify admission staff immediately of planned transfer to the facility.
2. Give admission staff the following:
    a. Patient name.
    b. Patient date of birth.
    c. Referring facility name, phone #, and a contact.
    d. Instruct referring facility to fax a face sheet to admissions staff.
    e. Give admissions your pager or phone # to call you when pt has been given a chart #. Then you can write the order to admit as a delayed order before pt arrives, using Chart Review as the visit context.
    f. Ward nursing staff will notify admissions immediately upon arrival of the patient to the floor. The admission time is entered as the time the patient arrives on the floor.

1.1.4 Admit From O.R.

1. Choose the patient from the Clinic list of OR-XXX.
2. Write delayed orders the same as in Admit from E.D. or clinic.

    If the patient's hasn't been entered for an appointment, the pt name will not be on the list.

    In this case, choose the New Visit tab and Chart Review as the visit context.

1.2 Ongoing Patient Care

1. Notes

    Choose title of INPT for the specialty progress

    Include information for the pharmacists if meds are changed etc.

    Consults should be answered with the title of Consult your specialty

2. Orders

    These are written as active orders

1.3 Transfer

The Transfer information addresses "To Different Ward" and "To & From OR" situations.

1.3.1 To Different Ward

The Providers WILL want to choose delayed orders for this & do it prior to ADT entry BECAUSE this will copy active orders, which can save a lot of time. The CAC will explain which types of orders will discontinue automatically on transfer.

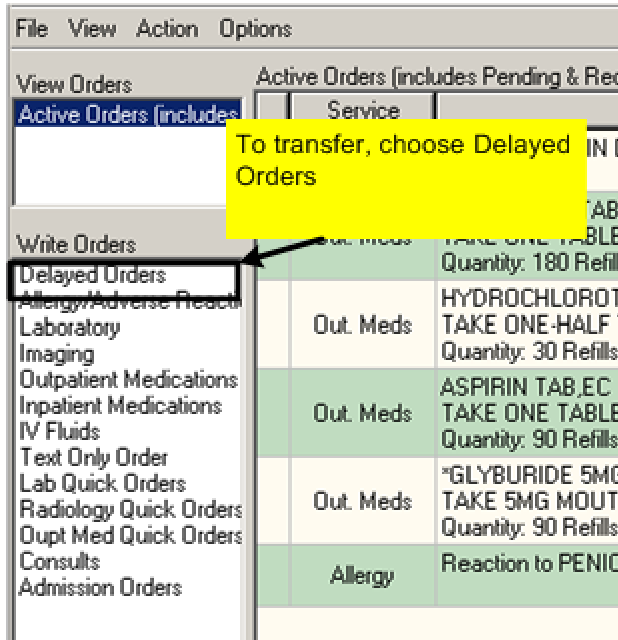


Figure 1-10: Delayed Orders Option in Write Orders

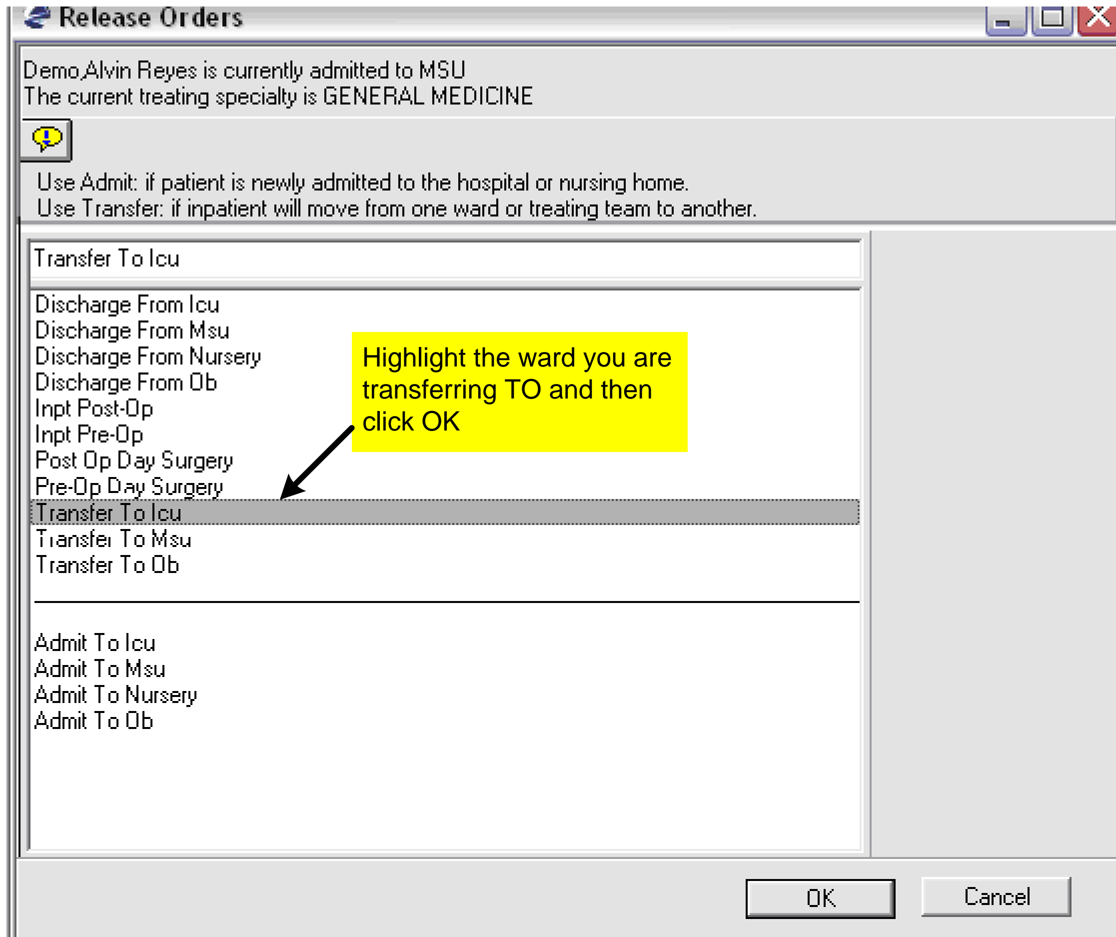


Figure 1-11: Highlighting Ward for Transfer

This now takes you to Transfer Patient dialog. Click the Accept Order button.

Figure 1-12: Transfer Patient Dialog

After accepting the order, you will then get a pop up of all the current active orders which will allow you to select the ones that you wish to continue on the next ward.

With medication orders, the provider will be prompted to edit, if necessary.

> **CAUTION** Check for comments on pharmacy orders to make sure they are appropriate.

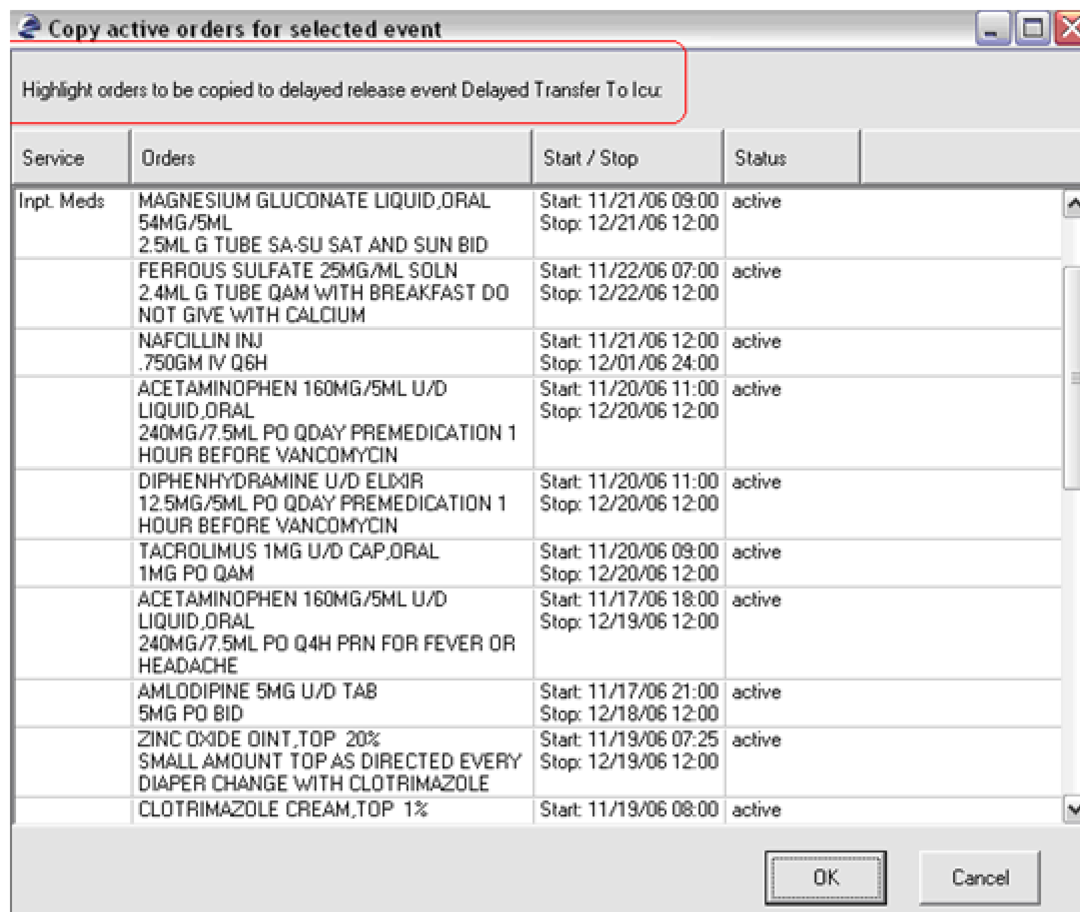


Figure 1-13: Copy Active Orders for Selected Event Dialog

The regular inpatient order menu will pop up after this (if you need to add anything else).

1.3.2 To & From OR

Review site hospital policy regarding d/c orders for patients going to OR.

EG Policy states all orders are to be discontinued when the patient goes to OR→Consideration: Do not discontinue pending Lab & X-ray orders (this is to avoid the cultures & x-rays from being discontinued prior to read), other labs such as BMP, CBC etc. could be cancelled if you really don't want them..

1. Discontinue all floor orders (the RN does this when the patient goes to OR).

2. When doing the post op orders the doctor will choose the hospitalization as the visit context.

3. Highlight the discontinued orders and then right-click.

Figure 1-14: Highlighting Discontinued Orders

Figure 1-15: Selecting Discontinue/Cancel Option

4. Choose Action → Copy to New Order & then enable Release Copied Orders Immediately.

5. Sign the orders.

Figure 1-16: Copy to New Order Option

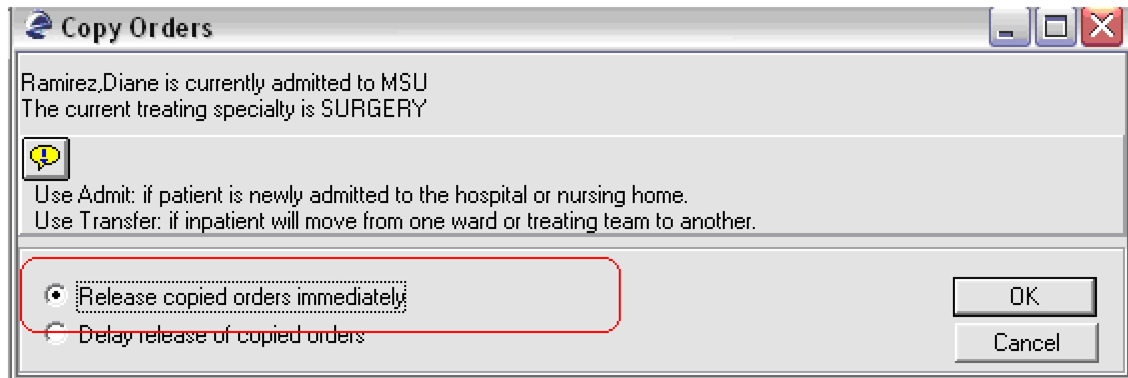


Figure 1-17: Copy Orders Dialog

1.4 Discharge

1. Write a discharge note.
2. Write a discharge summary, according to local policy.
3. Use Inpatient Menus in the Write Orders

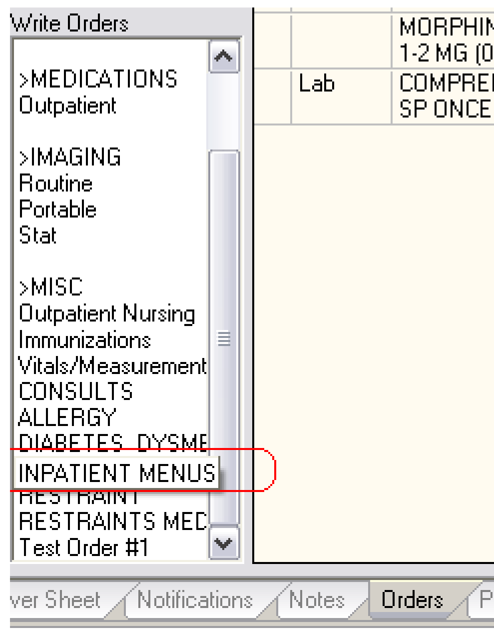


Figure 1-18: Inpatient Menus Option

4. Choose the Discharge Order menu.

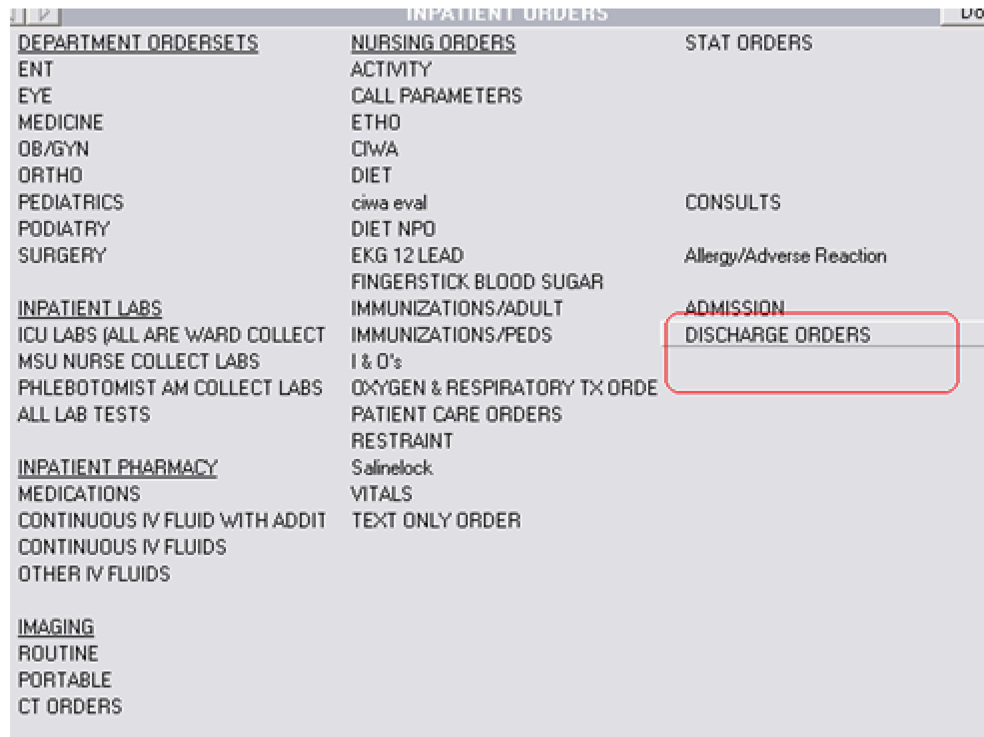


Figure 1-19: Sample Inpatient Orders Options

5. Select all that apply by holding down the Control key & left mouse click.

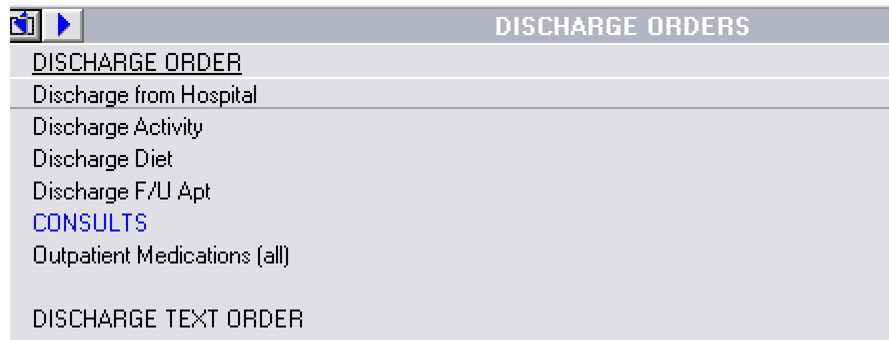


Figure 1-20: Sample Options for Discharge Orders

6. For the medications you can transfer the inpatient ones to outpatient meds by going to the Medications tab.

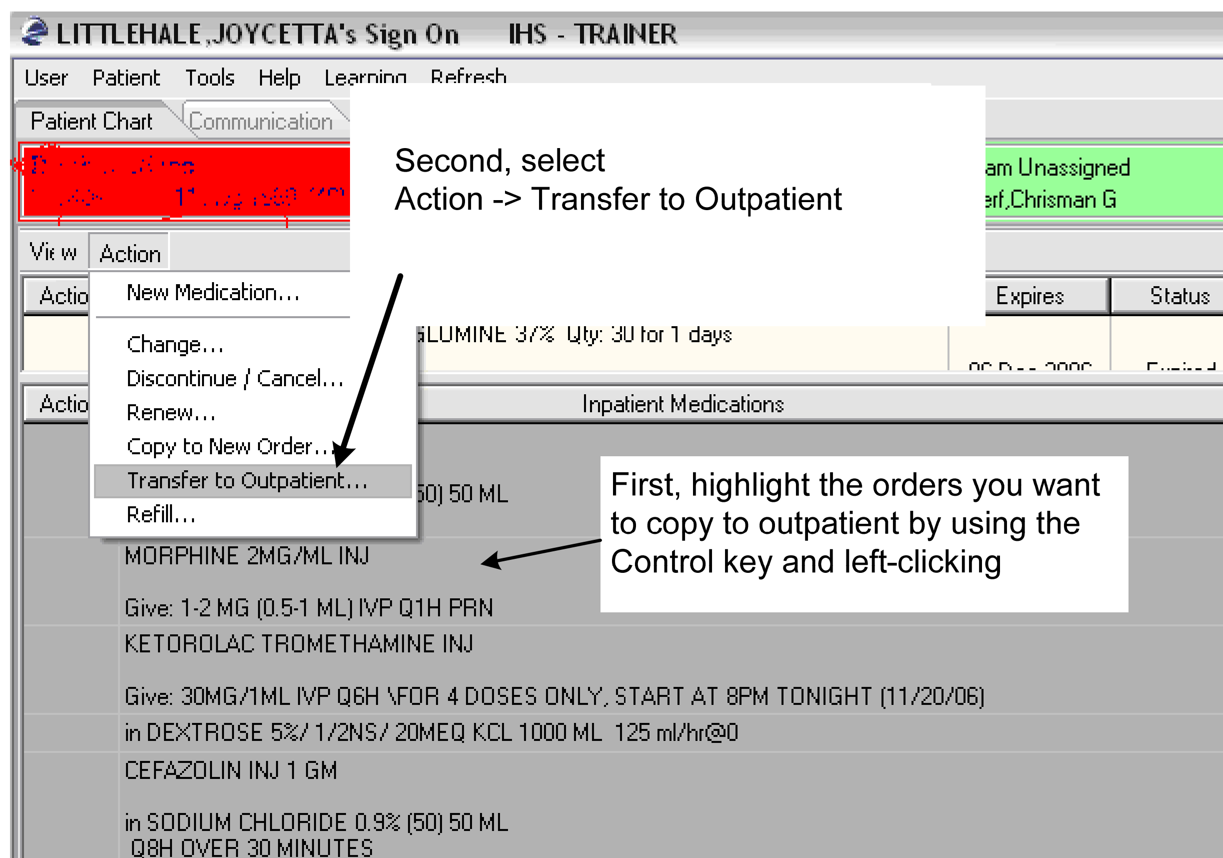


Figure 1-21: Selecting Transfer to Outpatient Option

Be sure you read each order before you accept it & sign it. There are some inpatient medications that cannot be transferred to outpatient medications. In which case, you will need to go to the outpatient menu to select the discharge medications.

NOTE: The following functionality only works if a manual release of the orders is finished; otherwise, the order will sit there until the patient is discharged (i.e., the release event has occurred) and that doesn't fit with the inpatient workflow.

Go to the Orders tab and click on Delayed Orders. The Release Orders dialog displays.

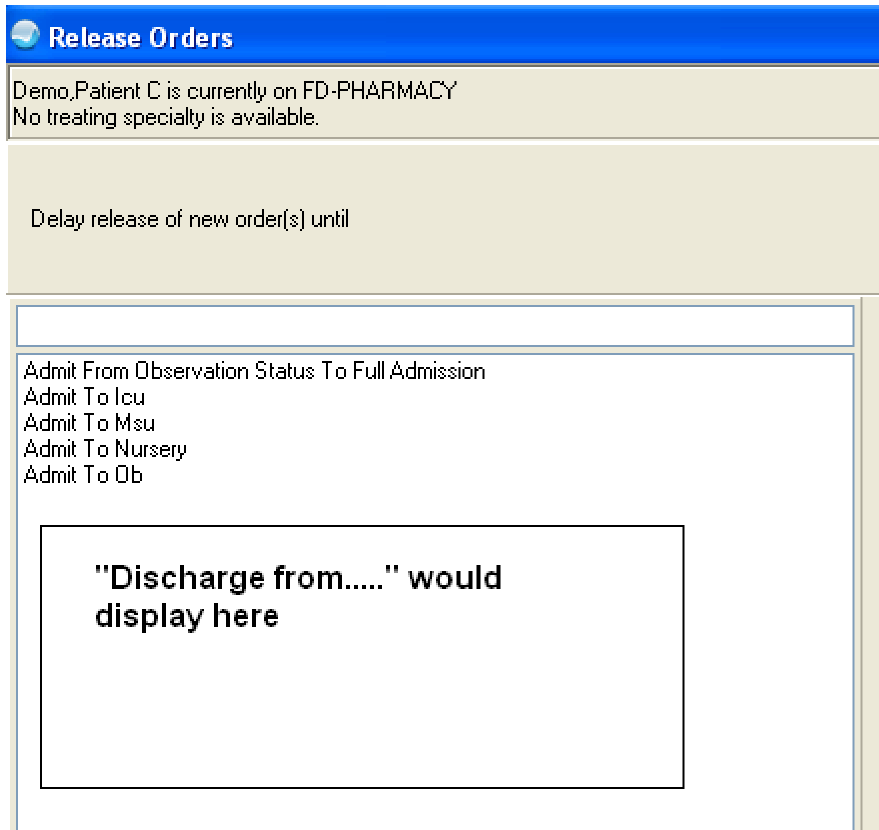


Figure 1-22: Sample Release Orders Dialog

It is also possible to write delayed discharge orders, as shown below.

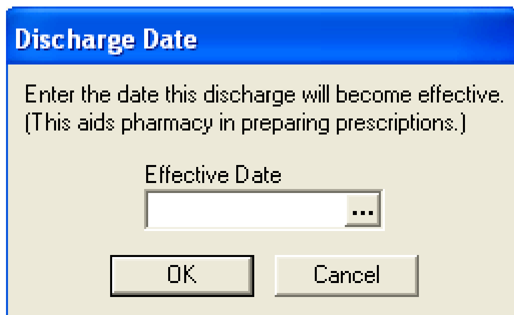


Figure 1-23: Discharge Date Dialog

Usually the Discharge Type is Regular.

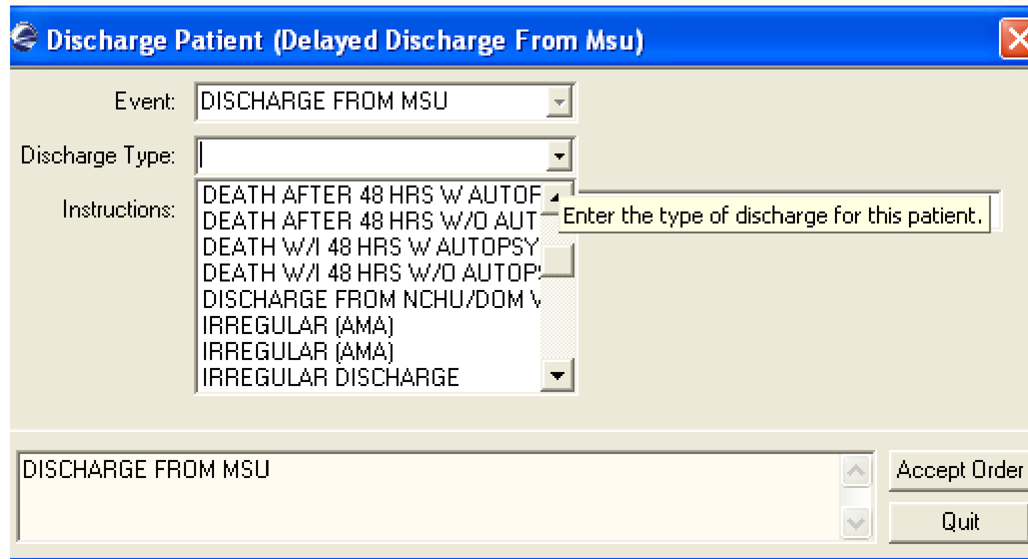


Figure 1-24: Sample Discharge Patient Dialog

It will then take you to the menu where you can select the outpatient meds for the discharge.

When you choose the outpatient meds at this point, EHR will show them as delayed orders.

Delayed Dis	A/D/T	>> Discharge from MSU REGULAR DISCHARGE	Start: 10/30/05 13:32	Nelson,R				active
Delayed Dis	Out. Meds	CORTISPORIN (PODIATRY) SUSP,RTL APPLY 2-3 DROPS TO TOE AFTER SOAKS TWICE A DAY - SHAKE WELL BEFORE USING DO NOT FILL!!! GIVEN IN CLINIC FROM OMNICELL. Quantity: 10 Refills: 0		Nelson,R				pending
Delayed Dis		CLINDAMYCIN CAP,ORAL 150MG TAKE TWO CAPSULES BY MOUTH THREE TIMES A DAY UNTIL ALL TAKEN FOR INFECTION-WITH FULL GLASS OF WATER DO NOT FILL!!! GIVEN IN CLINIC FROM OMNICELL. Quantity: 60 Refills: 0		Nelson,R				pending

Figure 1-25: Written Orders on Orders Tab

If you forget some outpatient meds & want to add more, highlight the delayed orders.

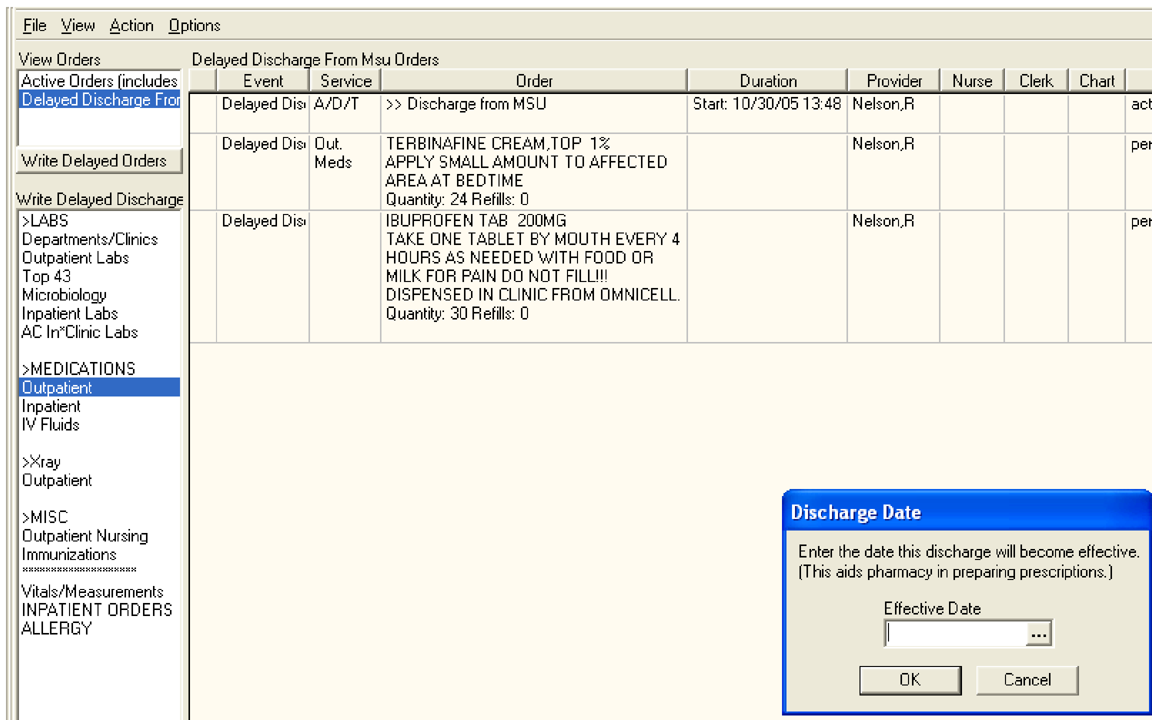


Figure 1-26: Discharge Date Dialog

The EHR will now allow you to add more orders. If you have ACTIVE highlighted it will only show on the medication tab & not on the orders tab… it's still there & pending but rather confusing.

1.5 Orders Help

The following provides information that can help you with Pharmacy, Change Order, Copy to New, Discontinuing Meds, PRN, Lab, Radiology, and Nursing orders.

1.5.1 Pharmacy

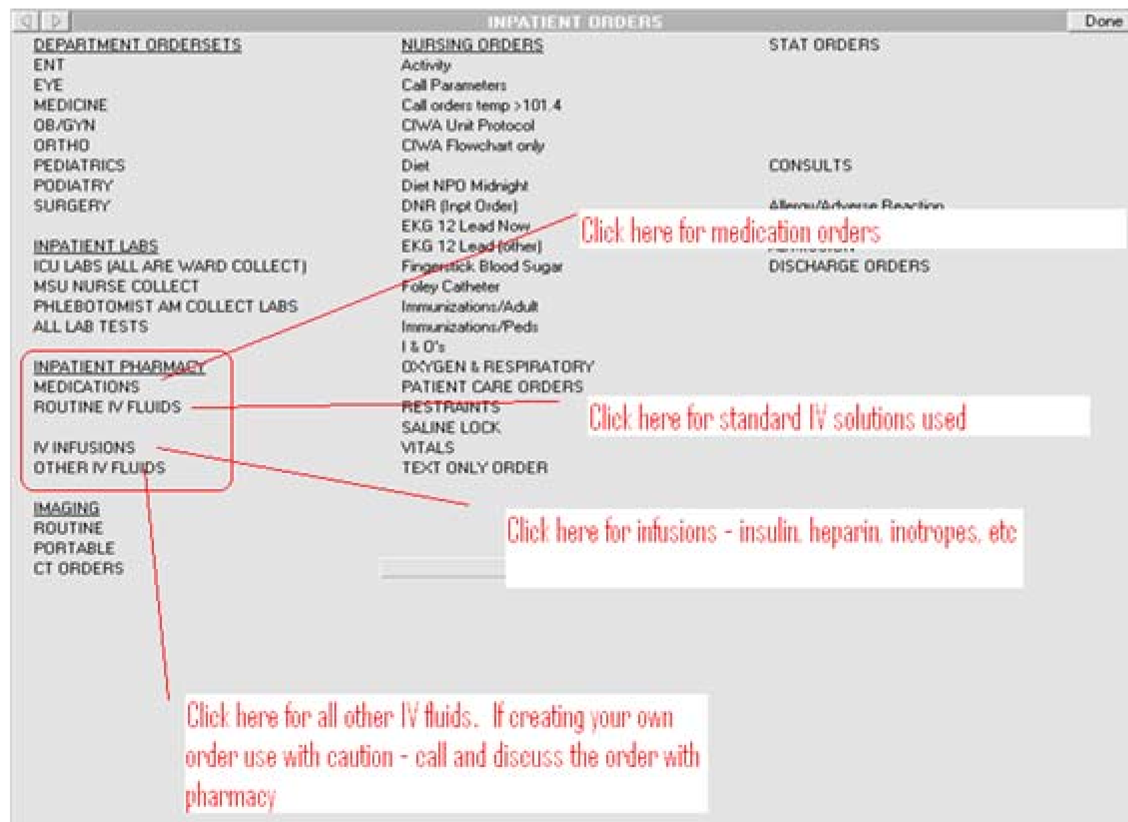


Figure 1-27: Sample of Various Quick Orders

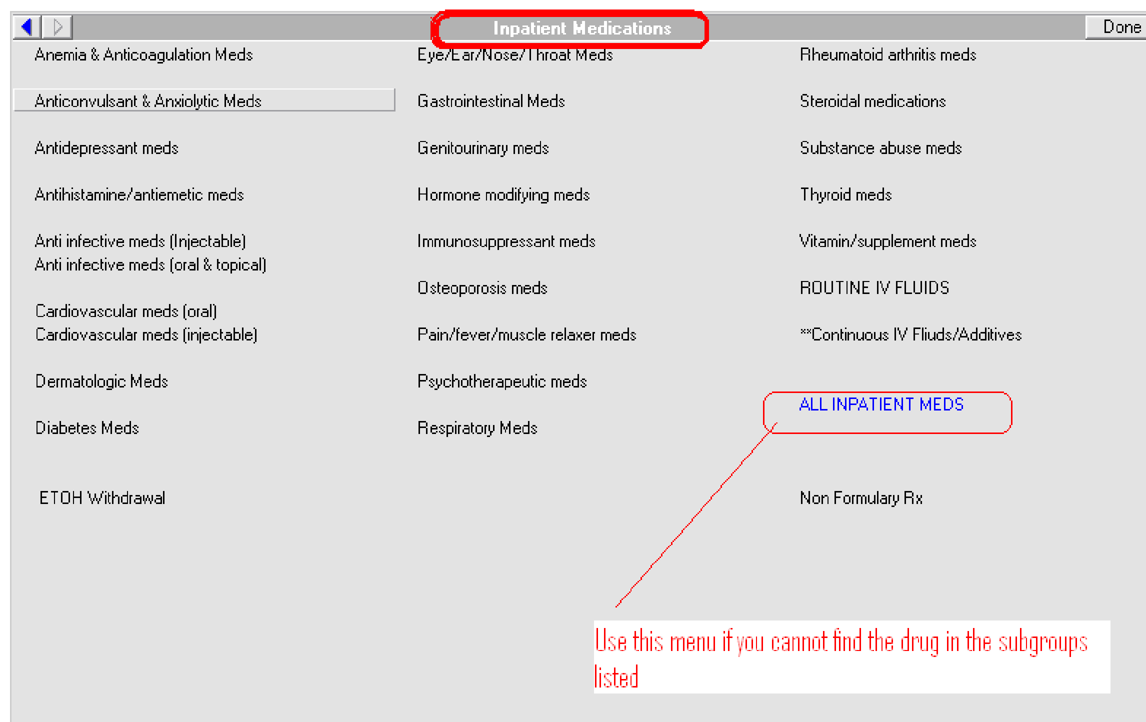


Figure 1-28: Menu to Use

Figure 1-29: Sample Routine IV Fluids Quick Orders

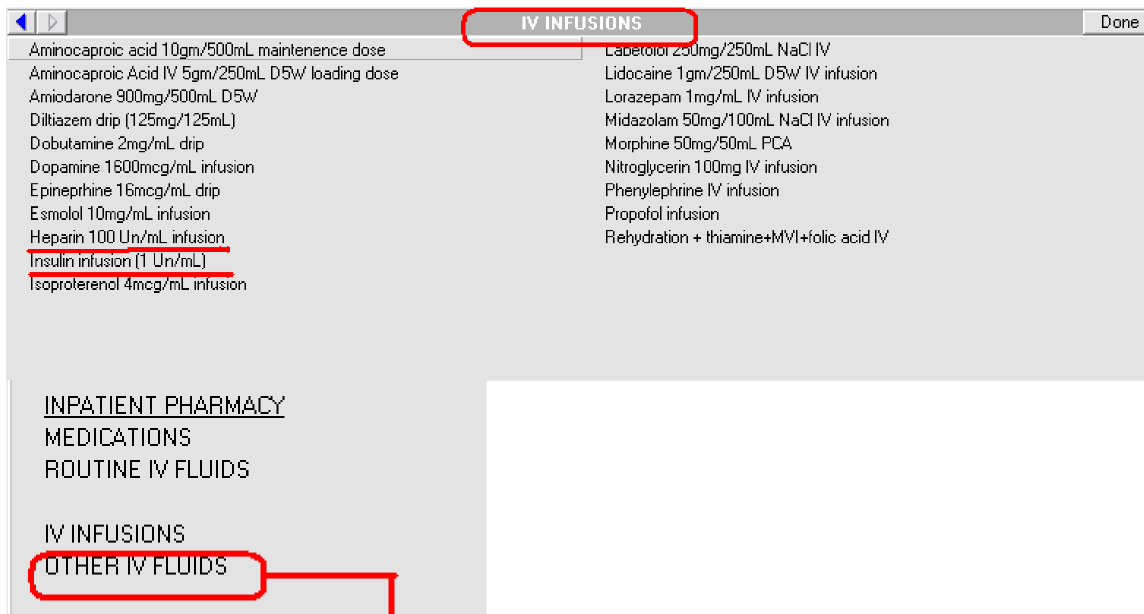


Figure 1-30: Sample IV Infusions Quick Orders

USE THE FOLLOWING WITH CAUTION

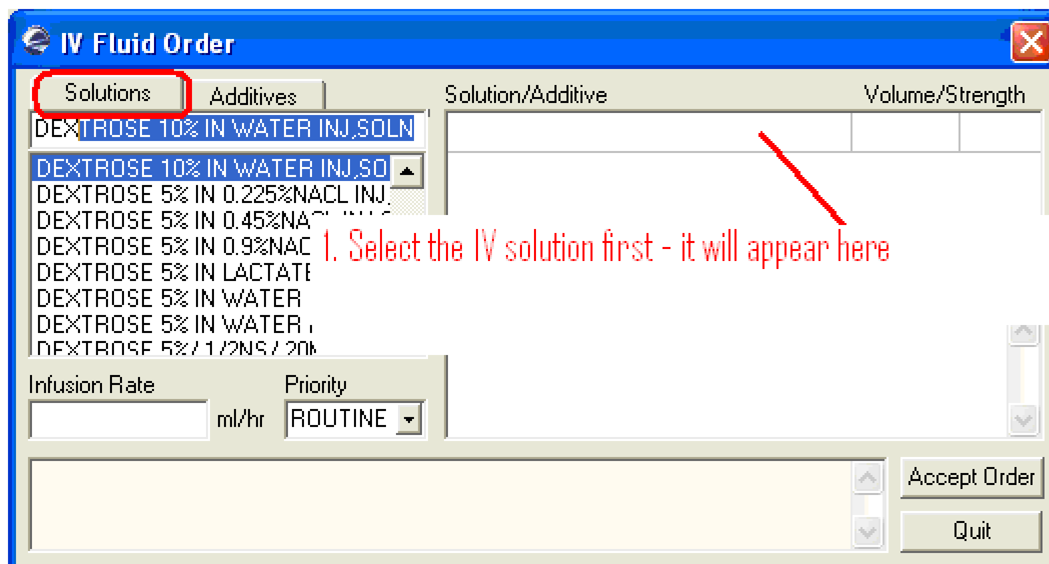


Figure 1-31: Using the Solutions Tab

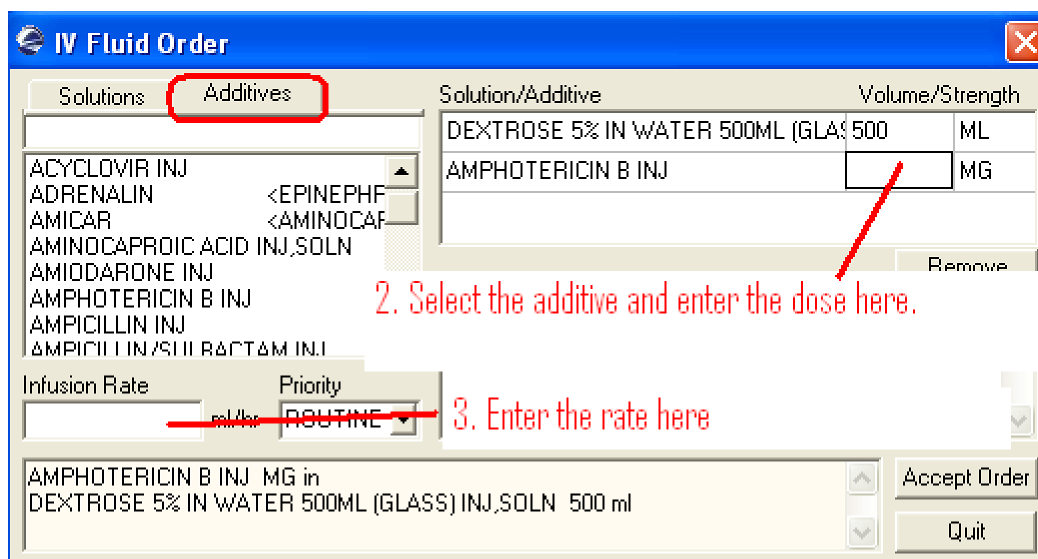


Figure 1-32: Using the Additives Tab

1.5.2 Change Order

Select the medication you want to change and then select Action → Change. The medication order will display.

This works better on inpatient than it does on outpatient. However it does pull the comments with it so double check before you press Accept Order.

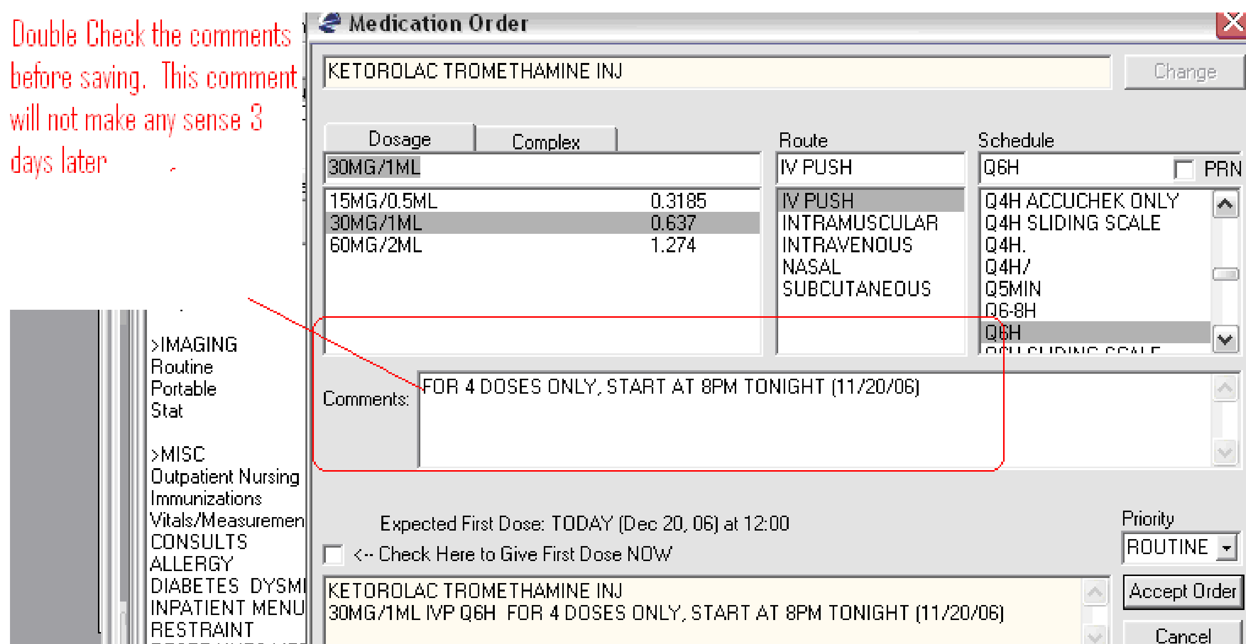


Figure 1-33: Reviewing the Comments on Medication Order

1.5.3 Copy to New Order

Not much need for this except for transferring from OR and back again.

Automatically pops up for delayed orders for other transfers.

1.5.4 Discontinuing Med Orders

Find the original order, highlight it, and choose Discontinue/Cancel on the right-click menu. The Discontinue/Cancel Order dialog will display.

Reason should be Requesting Physician Cancelled.

> **NOTE**: DO NOT EVER write a nursing text order to discontinue a medication.

1.5.5 First Dose Information

Figure 1-34: Reviewing the Next Expected Dose Information

1.5.6 PRN Orders

If you have a medication that is both a PRN & a regular scheduled standing dose, you will need to write two orders.

Example, nebs

One order will be written as q 6 hours

The other order will be written as q 2 hrs PRN.

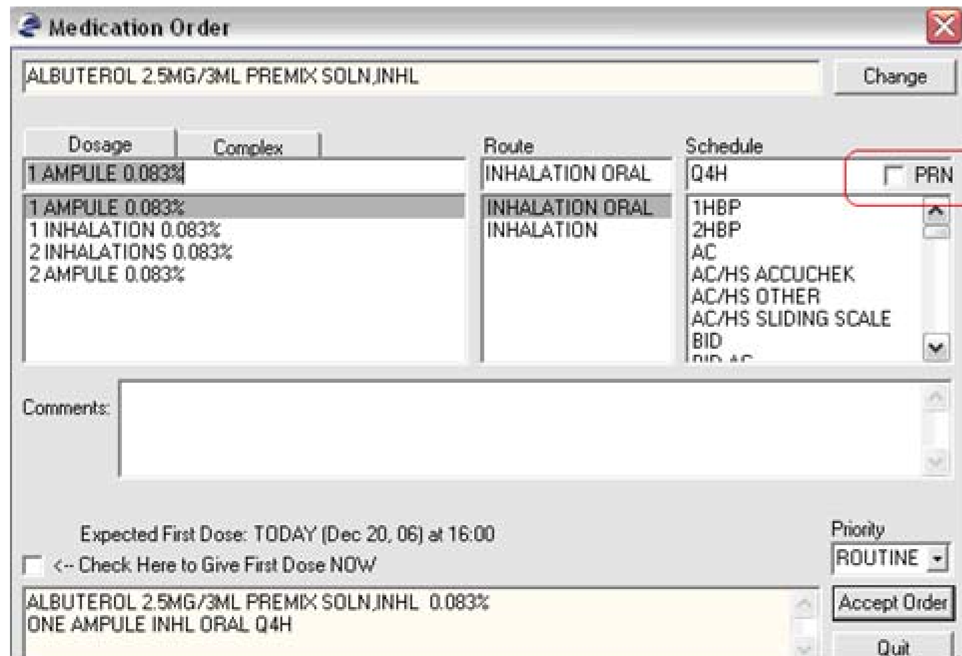


Figure 1-35: Writing Medication Order

1.5.7 Lab

It is important that you choose the correct menu; it matters because it prints in different places depending upon who is drawing the blood & what time.

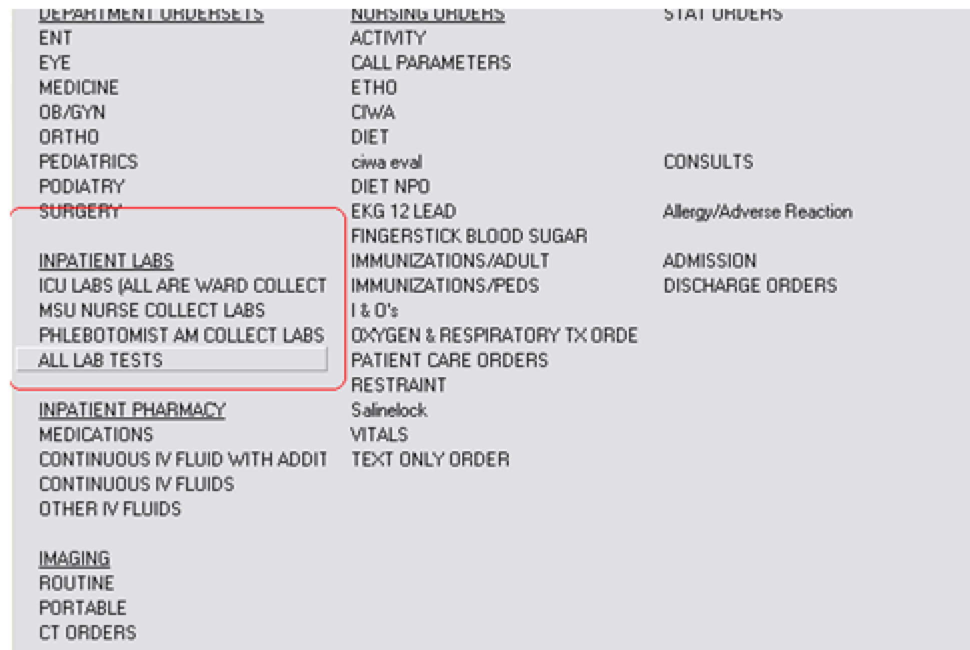


Figure 1-36: Sample Inpatient Labs Quick Orders

Provided your laboratory package has been set up, inpatient labs can be set to repeat.

For labs that start the clock from an event such as an M.I. enzymes, you can use N+6 hrs for ward collect x 3.

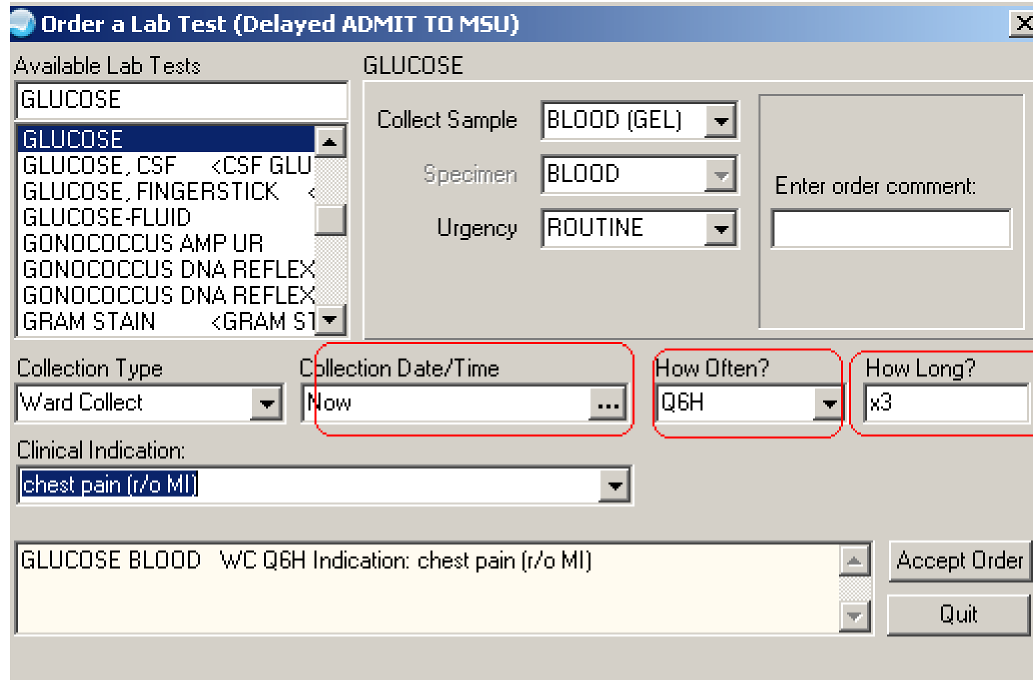


Figure 1-37: Fields to Select for Lab Test Order

Beware that N means the time the order is "released" for a delayed order for admit, that is the time that the patient is admitted in the Admission package. So if writing a delayed order, you may want to write a specific time in & then write q6 hours to ensure they go correctly.

1.5.8 Radiology

System realizes that patient is inpatient & defaults to inpatient. There is no need to use a different menu for outpatient unless you have order sets that include gastroview (need to order the inpatient gastroview order).

1.5.9 Nursing Orders

Again, nursing orders should never be written to start or discontinue a medication, lab, or x-ray order. If further clarification to one of those orders is needed, that is directed to the nurse, then that is acceptable.

Nursing orders need to have a stop date, otherwise they will hang on the system.

If it is something that will continue for quite sometime, example a daily dressing change, you could put a stop date of 30 days. If it is a one time order, you might put a stop date of T+2 (which is 2 days from now).

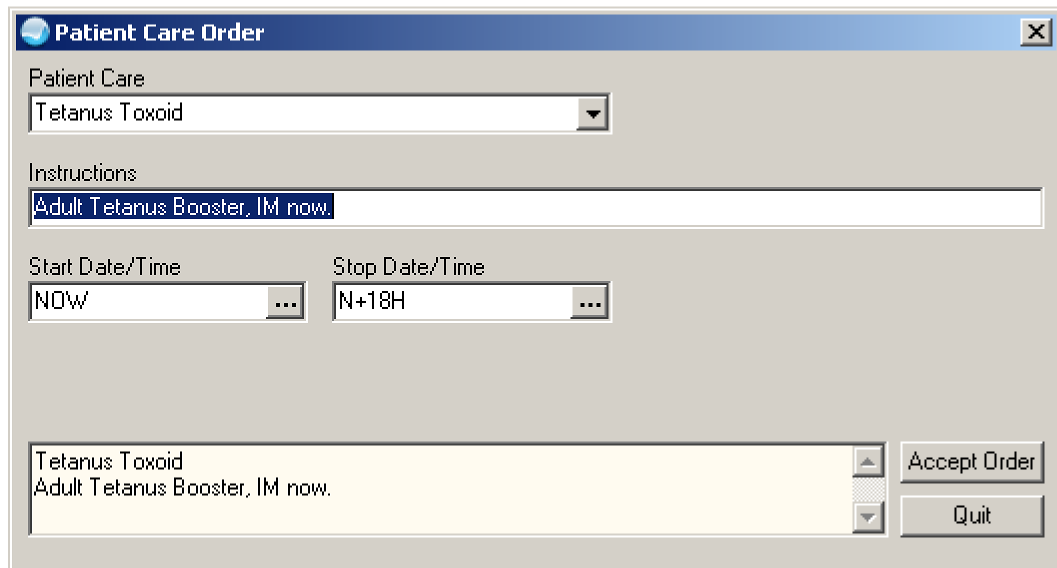


Figure 1-38: Sample Patient Care Order

Notice in above example stop time is N+18H which is Now+18hours.

2.0 Nurses

You must also make certain that your name is displayed in the Visit box whenever you enter anything into the EHR.

2.1 Where to Locate Basic Information

The following provides information about where particular information is located on the EHR window.

2.1.1 Posting WAD

A button located at the upper right corner of the toolbar that might read any of the following: No Postings; Postings WAD; Postings A; Postings CWAD.

Click on this button and a "Patient Postings" dialog opens up. This lists any patient Allergies, Crisis notes, Warning Notes, and Directives.

You can click on this any time you are in the EHR, it does not matter which tab you are viewing.

2.1.2 Cover Sheet Tab

Throughout EHR information is displayed in panes (or windows).

You can change the size of the panes by placing the mouse arrow⇨ on the divider bar.

The mouse arrow will change into this shape. ← II →. Then do a "left click and hold" on the mouse and drag the mouse in the direction you wish to open or widen the window.

Doing this allows you to view information more easily.

The cover sheet has panes with **headings** at the top of each:

- **Problem List** – Lists the active patient problems and date the patient visited the facility.
- **Adverse Reactions** – Lists adverse drug reactions.
- **Alerts** – Lists advance directives, crisis notes, or warnings.
- **Medications** – By clicking on the radio buttons you can sort medications as either All or Active, Inpatient, or Outpatient. The selection "All" will list all medications – active, expired, discontinued, hold, inpatient and outpatient.
- **Reminders –** Lists any clinical reminders.

- **Vital Measurements –** Displays the most recent vital signs and the date taken. A graph can be displayed by clicking on any vital signs. For example, click on BP and the "Vitals" dialogue box opens. The BP is then displayed in graph form. Above the graph is a table which contains all the vital signs and the date recorded.
- **Lab Orders –** Displays lab results. You can click on the results you want to view.
- **Appointments and Visits –**Lists the past and future outpatient visits of the patient.

2.1.3 Notes Tab

This tab has two parts:

- The left side of the window defaults to "All Signed Notes" which determines the types of notes displayed.
- The right window displays the text of the note.

You are able to change the size of these windows as described in the Cover Sheet section.

Throughout the EHR information that is highlighted is what is displayed.

The notes are listed by date, the most recent first, and then goes backward in time.

The most recent note is always highlighted and is displayed on the right side of the screen.

2.1.3.1 Elements of the Notes Listed

Notes are listed in the following way:

Figure 2-1: Elements of Notes Information

2.1.3.2 Note Addendums

Notes can have addendums. You can identify them when the + sign appears beside a note. This means an addendum is attached to the original note.

When you open the original note you will see "Has ADDENDA" in the header section of the original note. The addendum is located at the bottom of the original note.

2.1.3.3 Organizing Notes

Notes can be organized by any the of the following: Date, Location, Title, Author.

To do, select View → Custom View.

Look for Group By field. Select an option from the drop-down list. For example Author. Then click OK.

The notes will now be organized on the left side of the screen by whatever method you chose, arranged in alphabetical order. The + sign means there is more information behind it. Click the + and all the notes will be displayed, the + changes to a –sign. Close the notes by clicking on the – sign.

2.1.4 Wellness Tab

This has two major windows - the right and left sides.

The right side of the screen gives information about immunizations and skin tests.

- **Immunization Forecast** - lists immunization due.
- **Contraindications –** lists any contraindications.
- **Immunization History** – lists immunization given and when.
- **Skin Test History** – list skin tests, date and results.

The left side of the screen has three sections which record GPRA indicators.

- **Health Factors** - records health screening e.g., tobacco use, ETOH consumption, etc.
- **Education –** records the education the patient has been given.
- **Exams** – records screening examinations (e.g., diabetic, rectal, prostate, breast, etc), the date of the exam, and the result.

This is where the domestic violence screen is recorded and it is listed as "Intimate Partner Violence."

2.1.5 Medications Tab

This tab is divided in two halves - Outpatient Medications & Inpatient Medications.

2.1.6 Labs Tab

This tab displays lab results by various methods.

The screen defaults to Most Recent labs, but you can choose other ways to view labs by selecting a type of Lab Results.

- For example, click Cumulative, and the screen changes. Cumulative is a good way to look at lab results for consecutive dates.

2.1.7 Reports Tab

- **Health Summary** (listed on the left side). Click on the + beside health summary.

Click on FT. D. Adult Regular (the title might be different, like Adult Regular) to view the health summary of your patient.

2.2 Wellness

The functionality of the Add, Edit, and Delete buttons is the same for all sections on this tab.

- To add information, click Add.
- To edit information, first select the item and then click Edit.
- To delete information, first select the item and then click Delete.

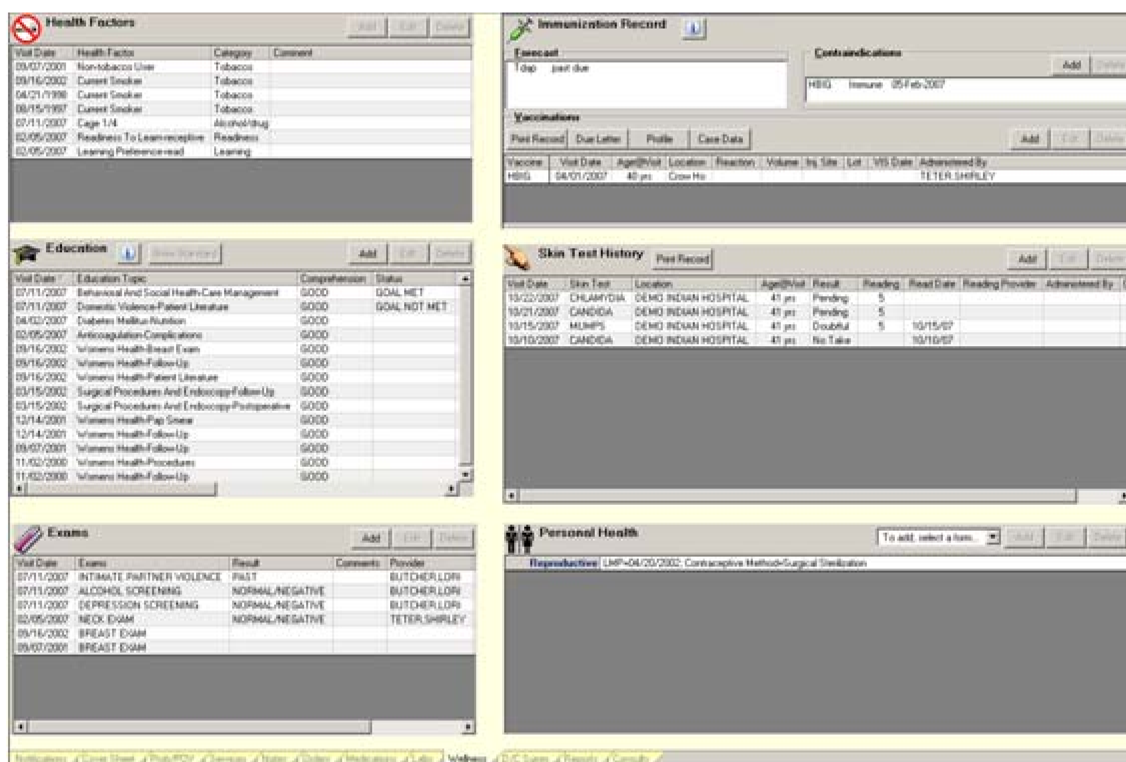


Figure 2-2: Parts of the Wellness Tab

Each wellness topic is entered separately.

- Sign onto EHR
- Select correct patient.
- Note that the Visit defaults to the current inpatient visit.
- Check that your name appears in the Visit box.
- Select Wellness tab.

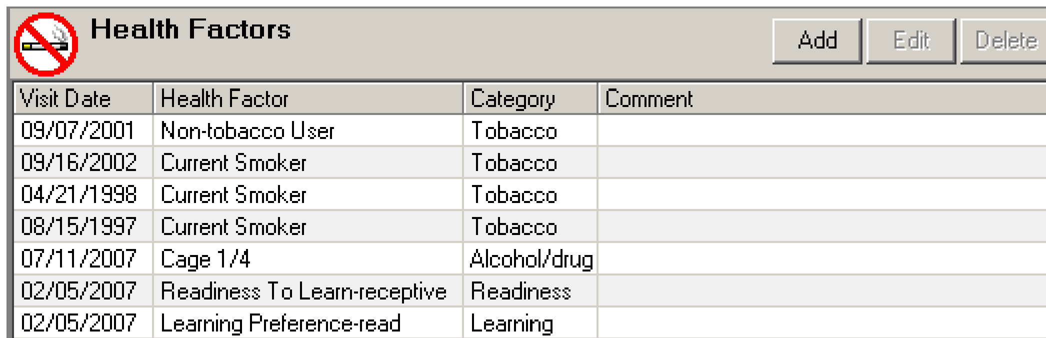
2.2.1 Health Factors

Health factors are health screenings that are done on admission of a patient. Health factors are also referred to as GPRA standards.

Health factors are documented on the Wellness Tab in the Health Factors section.

Document these before initiating a note. Check with your facility which health factors need to be documented by inpatient nursing.

2.2.1.1 Adding Health Factor



Visit Date	Health Factor	Category	Comment
09/07/2001	Non-tobacco User	Tobacco	
09/16/2002	Current Smoker	Tobacco	
04/21/1998	Current Smoker	Tobacco	
08/15/1997	Current Smoker	Tobacco	
07/11/2007	Cage 1/4	Alcohol/drug	
02/05/2007	Readiness To Learn-receptive	Readiness	
02/05/2007	Learning Preference-read	Learning	

Figure 2-3: Health Factors Component

1. Click Add to display the Add Health Factor dialog.

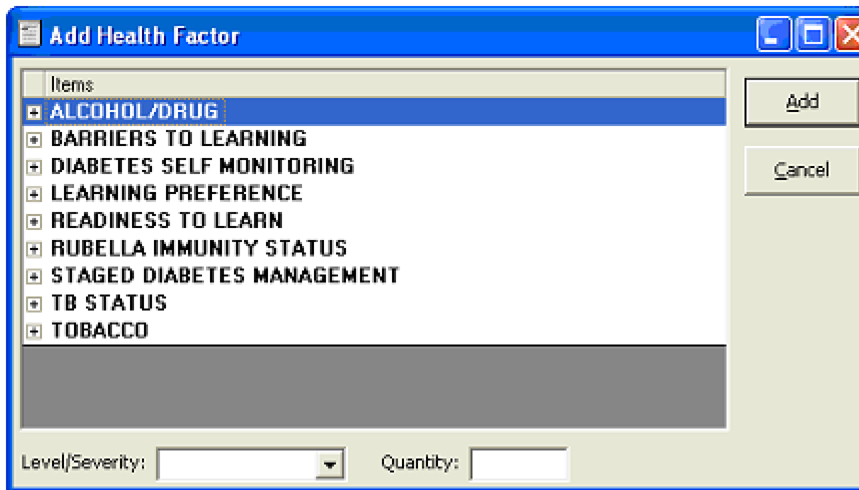


Figure 2-4: Add Health Factor Dialog

Click the + plus sign beside the applicable health factor group - a list will appear.

Click on the relevant health factor, then click the ADD button

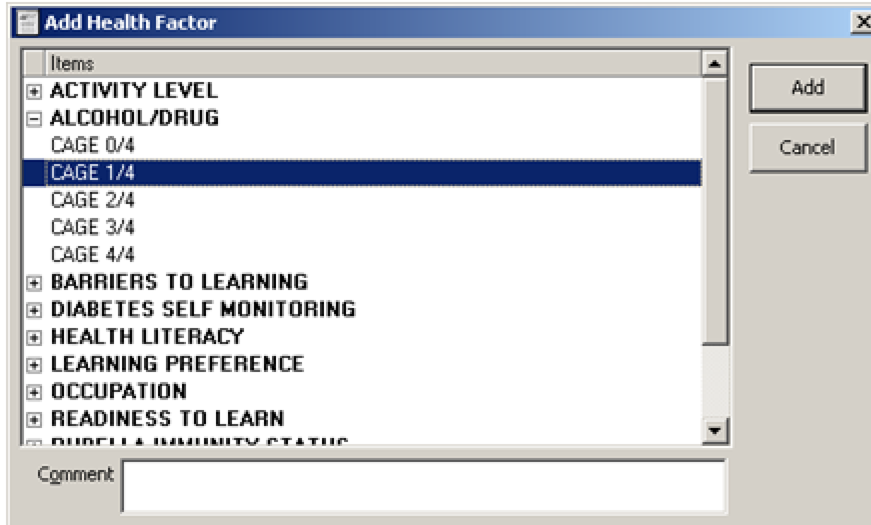


Figure 2-5: Selecting Option on Add Health Factor

3. The health factor is now added to the Wellness tab and appears in blue.

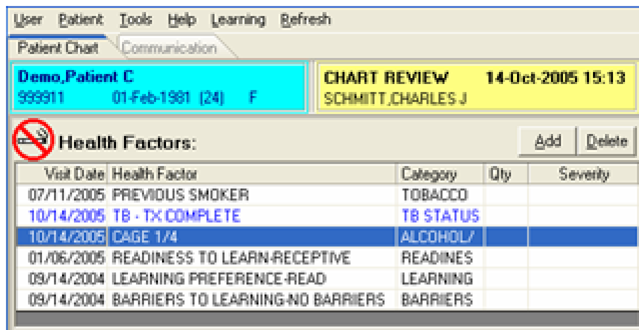
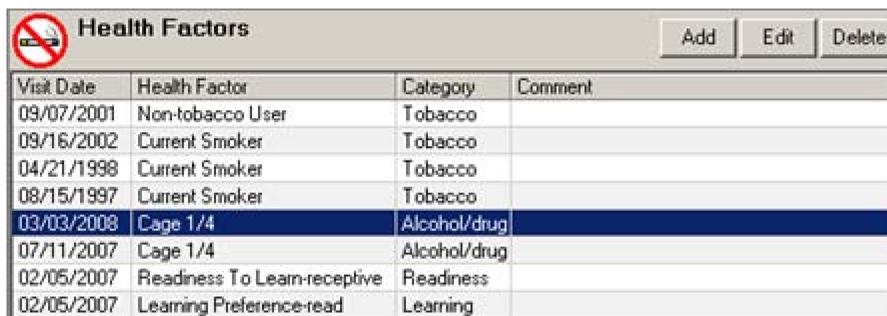


Figure 2-6: New Health Factor Added

2.2.1.2 Deleting Health Factor

1. Click on the health factor you want to delete.



Visit Date	Health Factor	Category	Comment
09/07/2001	Non-tobacco User	Tobacco	
09/16/2002	Current Smoker	Tobacco	
04/21/1998	Current Smoker	Tobacco	
08/15/1997	Current Smoker	Tobacco	
03/03/2008	Cage 1/4	Alcohol/drug	
07/11/2007	Cage 1/4	Alcohol/drug	
02/05/2007	Readiness To Learn-receptive	Readiness	
02/05/2007	Learning Preference-read	Learning	

Figure 2-7: Selecting a Health Factor to Delete

2. Click Delete to display the “Delete Health Factor?” dialog will display.

Figure 2-8: Delete Health Factor Confirmation

Click Yes. The health factor will be removed from the Wellness tab.

2.2.2 Education

Documenting patient education is done on admission of a patient, as relevant throughout hospitalization and on discharge. Patient Education is a GPRA standard.

Education is documented on the Wellness Tab in the Education section.

Check with your facility which education topics need to be documented by inpatient nursing.

2.2.2.1 Adding Education Event

Education | Show Standard | Add | Edit | Delete

Visit Date	Education Topic	Comprehension	Status	Objectives
03/05/2007	Allergies-Nutrition	GOOD		
01/05/2007	Anemia-Disease Process	GOOD		
05/22/2006	Diabetes Mellitus-Disease Process	GOOD		
03/01/2006	Asthma-Exercise	GOOD		
12/16/2004	Hypertension-Medications	GOOD		
03/02/2004	Abdominal Pain-Medications	GOOD		
09/25/2000	Diabetes Mellitus-Exercise	GOOD		
06/20/2000	Laboratory-Tests	GOOD	GOAL MET	

Figure 2-9: Education Component

1. Click Add in the Education grid to display the “Education Topic Selection” dialog.
2. The Category List radio button is the default. The Items list is arranged in alphabetical order.

   Click and drag the scroll bar on the right or click ▼ to find the education topic you want.

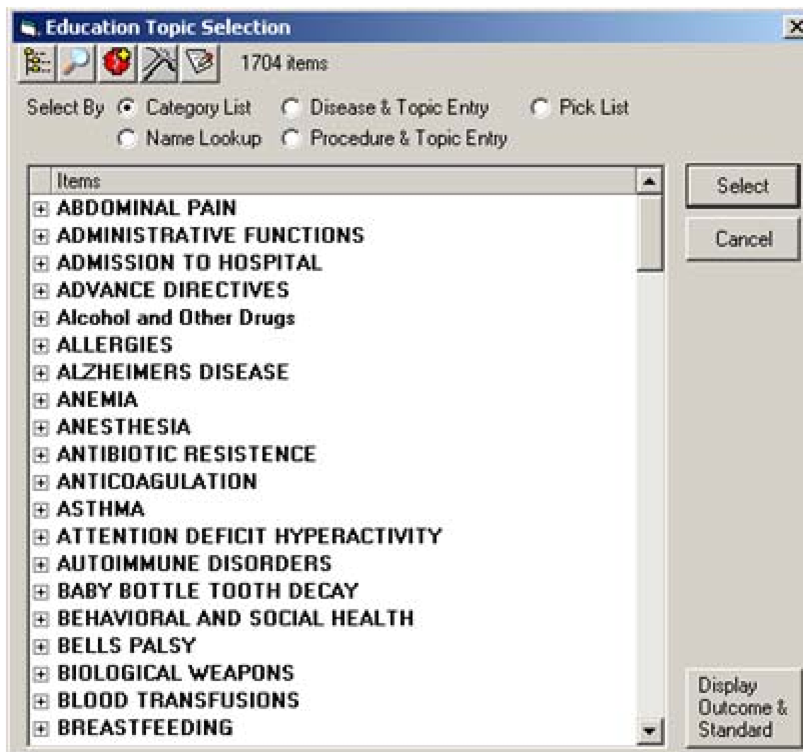


Figure 2-10: Education Topic Selection by Category List

Click the + sign next to an education topic and a subset will appear underneath. (In this example click the + sign by Admission to Hospital and the subset appears underneath).

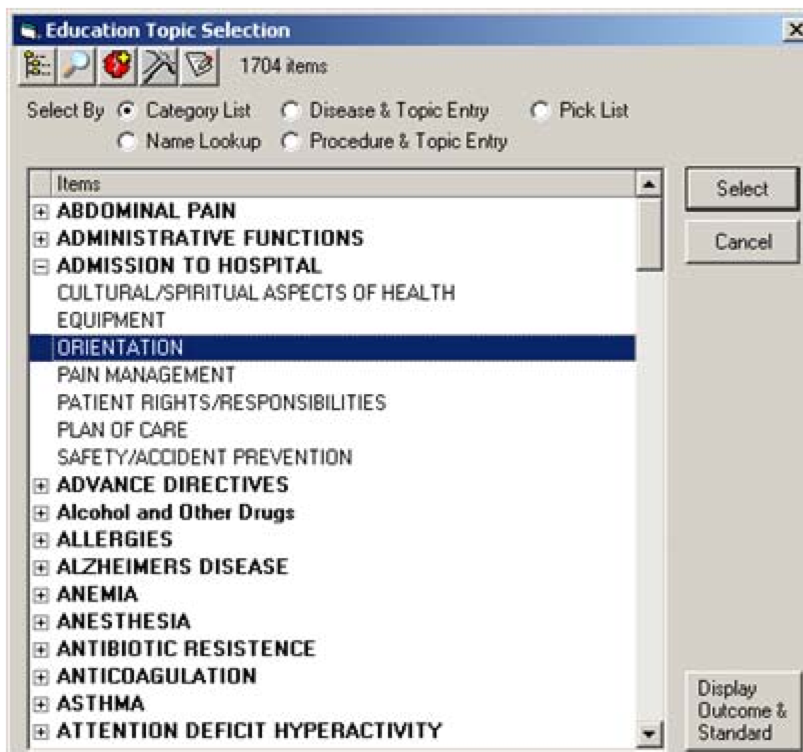


Figure 2-11: Expanding a Category

Highlight the relevant topic. (In this example Orientation was highlighted).

3. Click the “Display Outcome & Standard” button to check the details of a patient education topic.

   It contains the following information: OUTCOME – the desired outcome of your patient’s education. STANDARD – lists the content you teach to your patient.

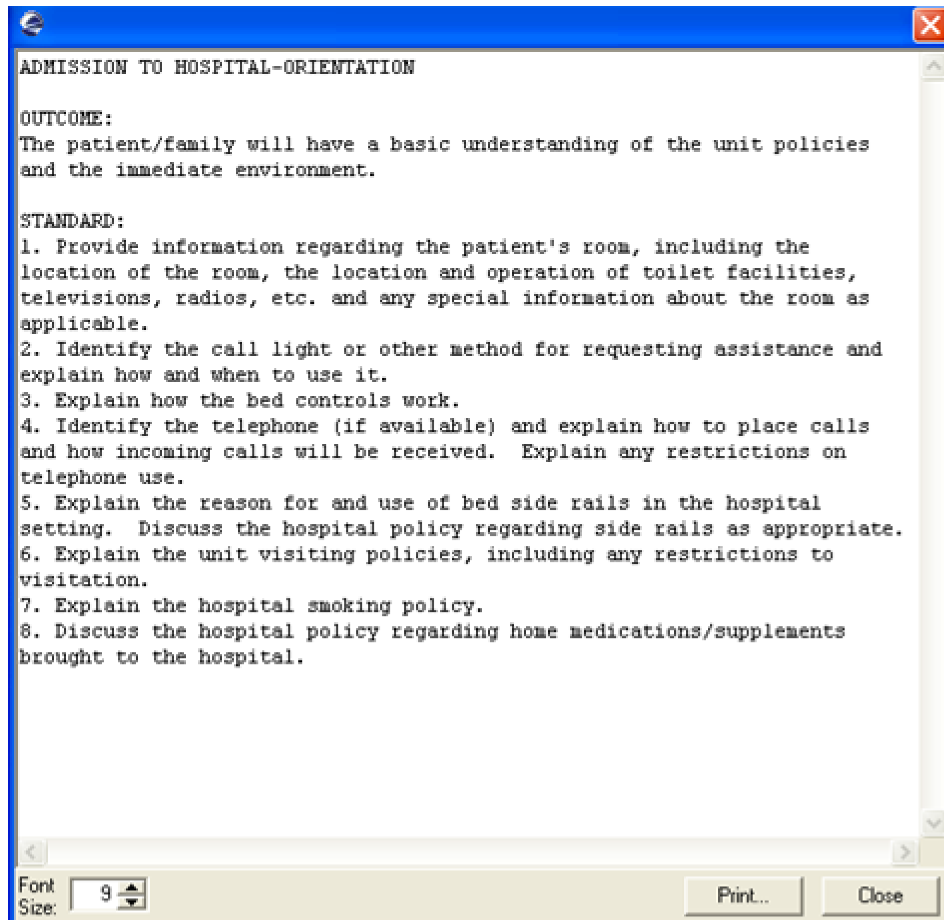


Figure 2-12: Sample Popup

   Click Close to dismiss the pop-up. You return to the Education Topic Selection box.

4. Click Select to continue documenting.

5. The “Add Patient Education Event” will display.

Figure 2-13: Sample Add Patient Education Event Dialog

Type of Training: Defaults to Individual. Accept this.

Comprehension Level: Click ▼ to obtain a drop-down list, and click on the appropriate response. The patient's Comprehension Level (also called Level of Understanding) can be classified as the following:

- Good (examples: verbalizes understanding; able to return demonstration or teach-back correctly)
- Fair (examples: verbalizes need for more education; incomplete return demonstration or teach-back indicates partial understanding)
- Poor (examples: does not verbalize understanding; unable to return demonstration or teach-back)
- Group – No Assessment (examples: education provided in group; unable to evaluate individual response)
- Refused

Length: Type in the minutes teaching your patient.

Comment: Not required but you can add relevant comments. Comments can be used for describing the name of a lesson plan or education material provided to the patient (limited to 100 characters).

Provided By: Defaults to your name.

Status/Outcome: Leave blank.

5. Click ADD. The education topic is entered and appears in blue on the Wellness tab.

2.2.2.2 Deleting Education Event

See Section 2.2.1.2 for deleting.

2.2.2.3 Editing Education Event

Only the person who entered the patient education event can edit on that same topic.

You should update patient education information as applicable.

For example:

- A patient has poor comprehension on a topic, you continue to give education until the patient has good comprehension on the topic - update this information on the wellness tab.
- A patient refuses education on a topic; you continue offering education to the patient and when the patient accepts education update the patient's education accordingly.

If you are unable to edit, you re enter the topic with the current comprehension level.

- Click on the topic you want to edit.
- Click Edit.

  Comprehension level – change the level as indicated.

  Comment box – enter the date, add a relevant comment and the new comprehension level.

2.2.3 Exams

Check with your facility which exams need to be documented by inpatient nursing.

For example, **Intimate Partner Violence** (or domestic violence) is a health screening that is done on admission of a patient. Screening for intimate partner violence is a GPRA standard.

2.2.3.1 To Add

Exams: Add Edit Delete

Visit Date	Exams	Result	Comments	Provider
07/11/2005	INTIMATE PARTNER VIOLENCE	NORMAL/NEGATIVE		PETERSE
01/25/2005	DIABETIC EYE EXAM	NORMAL/NEGATIVE		USER,RN
10/14/2004	RECTAL EXAM	REFUSED		
10/14/2004	PELVIC EXAM	REFUSED		

Figure 2-14: Exams Component

1. Click ADD to display the "Exam Selection" dialog.

Click and drag the scroll bar on the right or click on ▾ to find Intimate Partner Violence.

Click on Intimate Partner Violence.

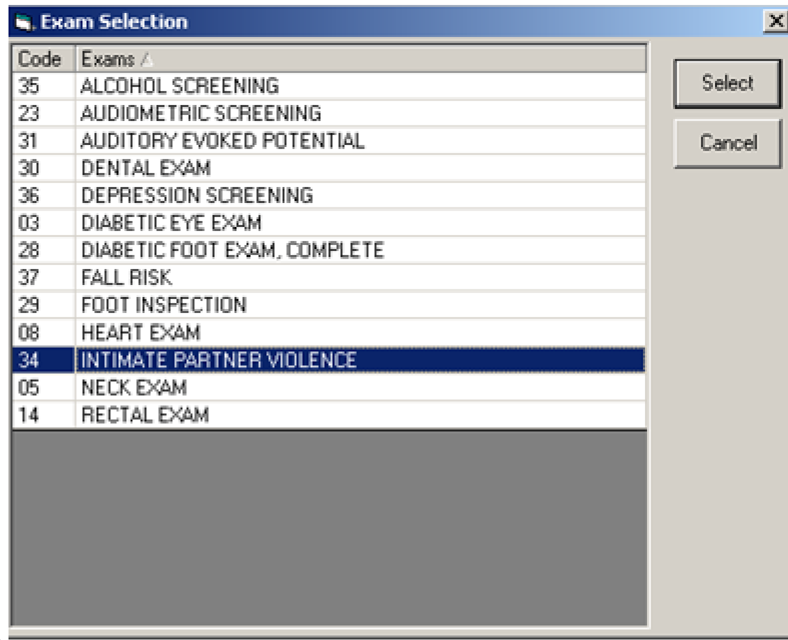


Figure 2-15: Exam Selection Dialog

2. The Document an Exam dialog will display.

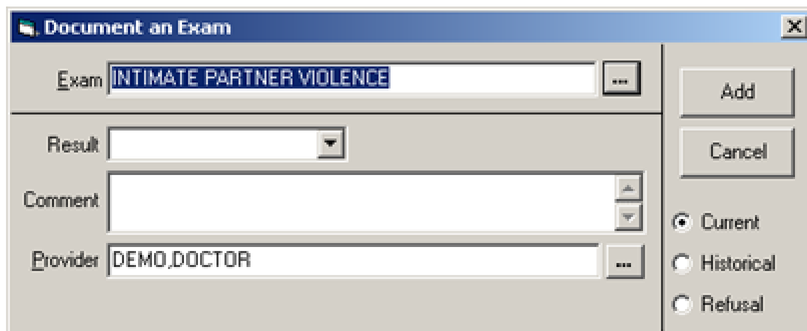


Figure 2-16: Document an Exam Dialog

Exam: Intimate Partner Violence defaults here.

Provider: your name should default here.

Result: select from the drop-down list.

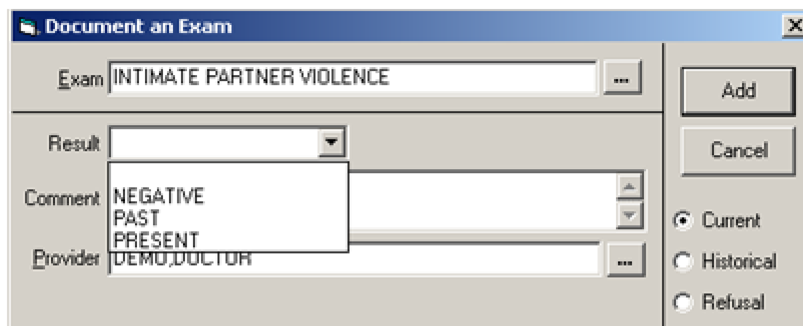


Figure 2-17: Options on Result Field

The table below describes the options for the Result field:

Result	Definition
Negative	The patient denies being a current or past victim of domestic violence.
Past	The patient denies being a current victim, but discloses being a past victim of domestic violence.
Present	The patient admits being a victim of domestic violence.

Comment: type in a comment if applicable. You use this field to note abnormal findings, for example.

4. Click ADD. The intimate partner violence exam screen is entered and appears in blue on the Wellness tab.

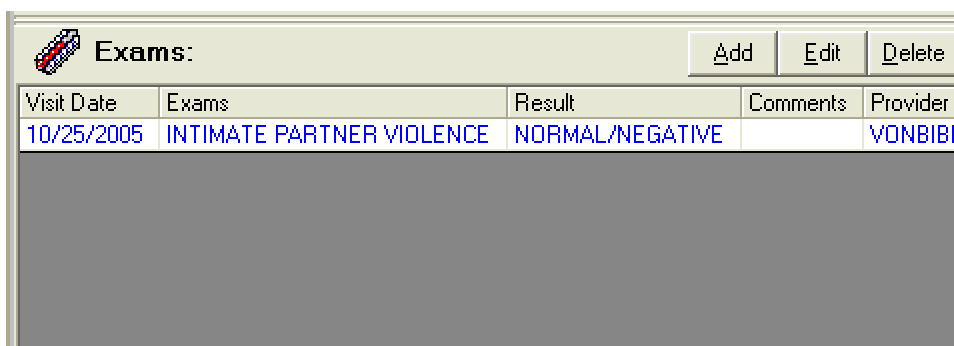


Figure 2-18: New Exam Added to Exams Component

2.2.3.2 Deleting Exam

You would do this if you made an error with entry (e.g. wrong patient).

Only the person who made the entry can delete the entry.

See section 2.2.1.2 for deleting.

2.2.3.3 Editing Exam

You would do this to correct information that was entered or to add more information.

Only the person who made the entry can edit it.

1. Click on the exam you wish to edit.
2. Click Edit.
3. Make corrections or add information.
4. Your name defaults to the provider column.
5. Click Save to save your changes.

2.2.3.4 Refusals

On the Document an Exam dialog, enable the Refusal radio button.

Complete the fields on this dialog. The Provider field defaults to the current user.

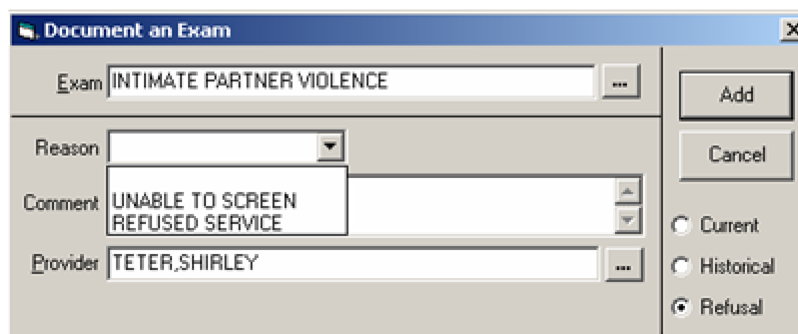


Figure 2-19: Sample Refusal for Exam

The table below describes the options for the Reason field:

Result	Definition
Refused Service	Patient declined exam/screen.
Unable to screen	Unable to screen patient (partner or verbal child present, unable to secure an appropriate interpreter, etc.)

After clicking Add, the record is added to Exam component as well as to the Personal Health component.

2.2.4 Immunizations

Immunizations are documented on the Wellness Tab in the Immunization Record section.

It is important to obtain a thorough immunization history.

If a patient does not have immunization documentation on the chart, do not assume that immunizations are needed. The patient may have been immunized elsewhere. Patients receive immunizations from a variety of sources outside of the clinic, such as other IHS facilities, schools, chapter houses, military service, blood banks, county and state health departments, private providers.

Figure 2-20: Immunizations Component

1. Review the Immunization Forecast. - Are any immunizations due? If so, go to step 3.
2. Immunization History – Is there a pnuemovax or flu vaccine recorded? If no, go to step 3.

   When was it last given?
3. Ask if the patient has received:

- Any of the vaccines listed in the immunization forecast.
- A pnuemovax or flu vaccine.

  If the patient says YES to any of the above questions, ask the patient when and where the immunization was administered. Enter this information as a Historical Immunization.

4. Check the Blue Sheet in the paper chart, depending on local policy.

- Are there vaccines recorded on the Blue Sheet that are not listed in the EHR Immunization History?

  If YES, enter this information as a Historical Immunization.

5. Inform the physician of any immunizations due.
6. Note Contraindications – inform physician if applicable.
7. Follow FDIH Protocols for immunizations.
8. Check the physician order before giving an immunization, depending on local policy.

A pre immunization screen must be completed prior to giving an immunization.

This screen is documented in the Notes tab using the note title “Nursing Inpatient Pre Immunization Screen.”

2.2.4.1 Adding Immunization

1. Click ADD to display the “Vaccine Selection” dialog.

Search Value: The search value can either be the first few letters of an Immunization name, HL7-CVX code, or a Brand name.

(You can also use the scroll bar on the right to find the immunization)

Click Search.

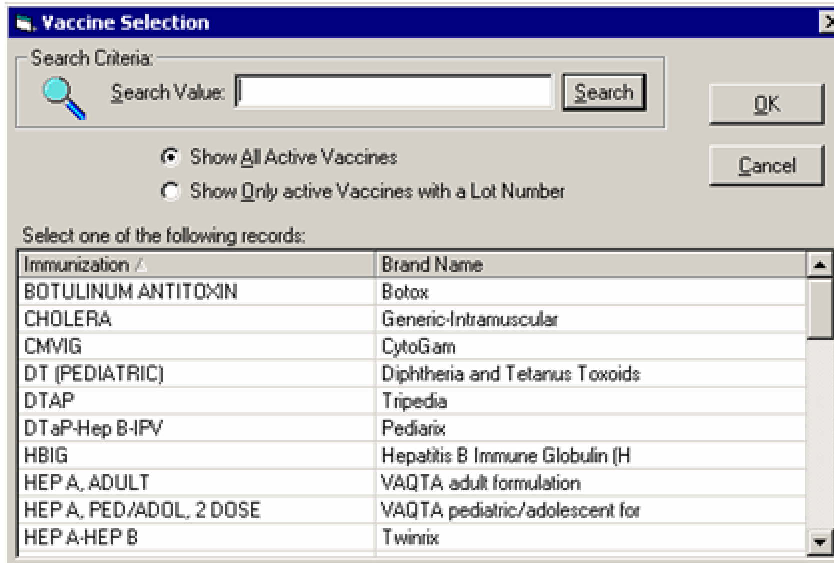


Figure 2-21: Sample Vaccine Selection Dialog

Now a short list of the vaccines is displayed.

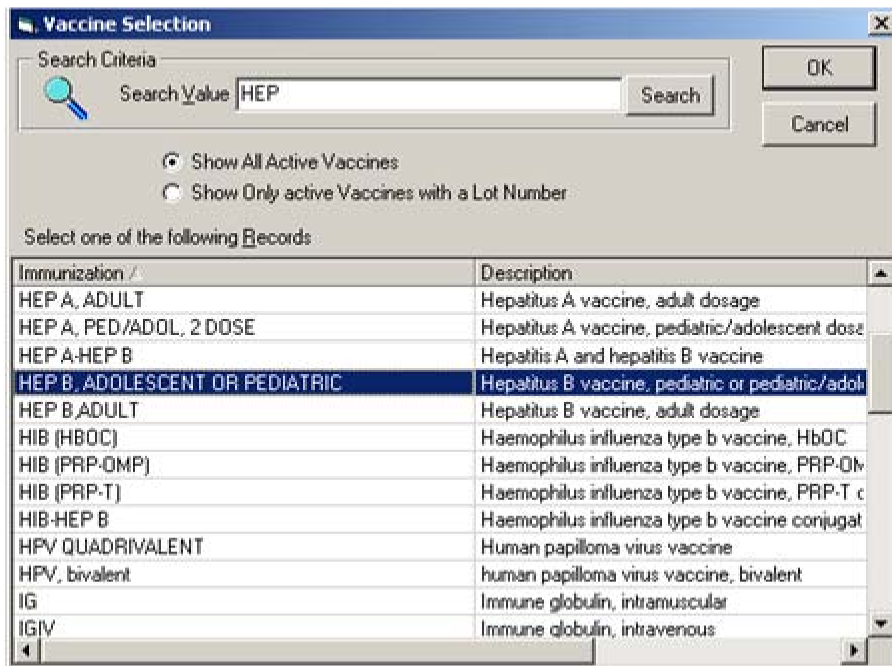


Figure 2-22: Highlighting Vaccine

Click on the correct vaccine.

Click OK.

3. The "Add Immunization" dialog displays.

Figure 2-23: Sample Add Immunization Dialog

Vaccine: Check your selection is correct.

Administered By: Defaults to your name.

Lot: Defaults are set. Select from the drop-down list for a different Lot No.

Injection Site: Select from the drop-down list.

Volume: Defaults to 0.5. Change amount if required.

Vac. Info Sheet No: Default dates are set. (Verify dates match with the VIS sheet given to the patient).

4. Click OK when information completed.

   The immunization is entered and appears in blue on the Wellness tab. If this record is for a patient under 8 years of age, a record is also added to the Patient Education component. This indicates that the physician counseled the patient/family

2.2.4.2 Add Historical Immunization

You can add a historical immunization in one of two methods: (1) by selecting the Historical radio button on the Add Immunization dialog or (2) by not having a visit selected, click Add, and the Add Historical Immunization dialog automatically displays with the Historical radio button selected.

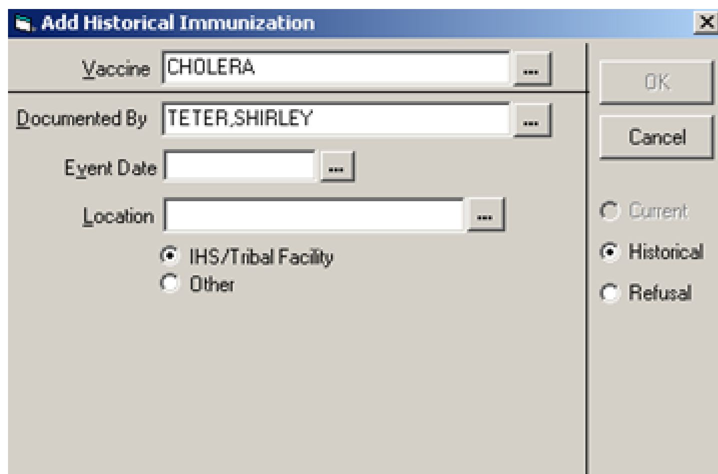
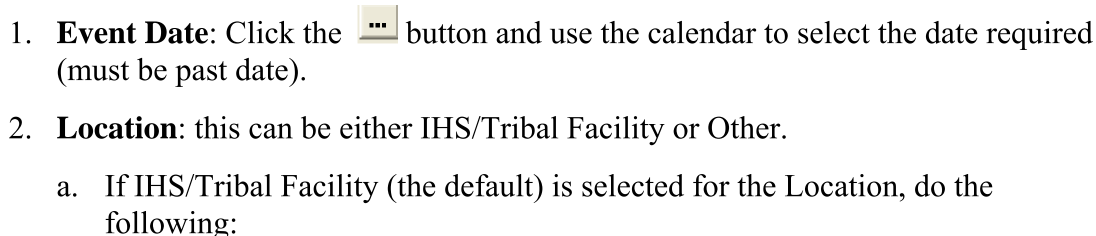
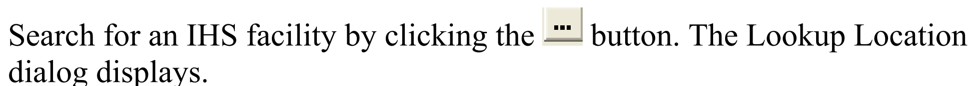


Figure 2-24: Sample Add Historical Immunization Dialog



1. **Event Date**: Click the ... button and use the calendar to select the date required (must be past date).
2. **Location**: this can be either IHS/Tribal Facility or Other.
    a. If IHS/Tribal Facility (the default) is selected for the Location, do the following:

    Search for an IHS facility by clicking the ... button. The Lookup Location dialog displays.

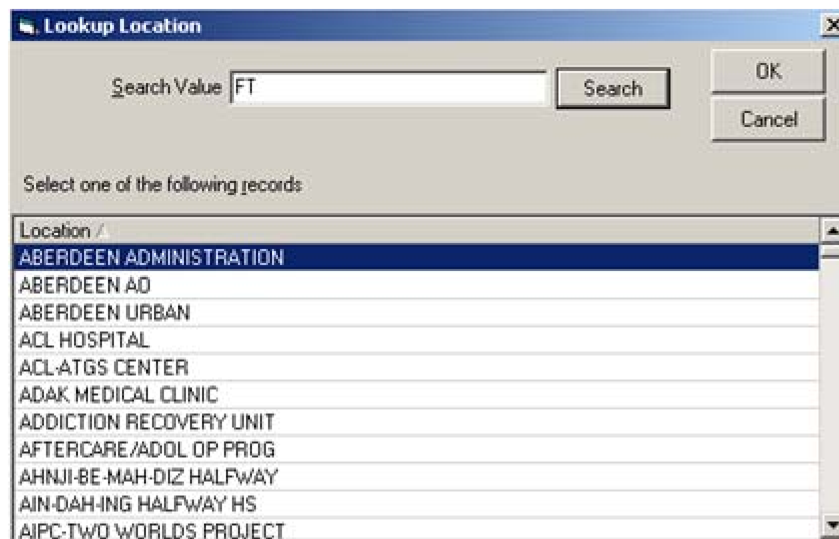


Figure 2-25: Lookup Location Dialog

Search value – type in a few letters of the name of the facility.

Click Search.

Note: Sometimes you will have to experiment with the search value naming convention.

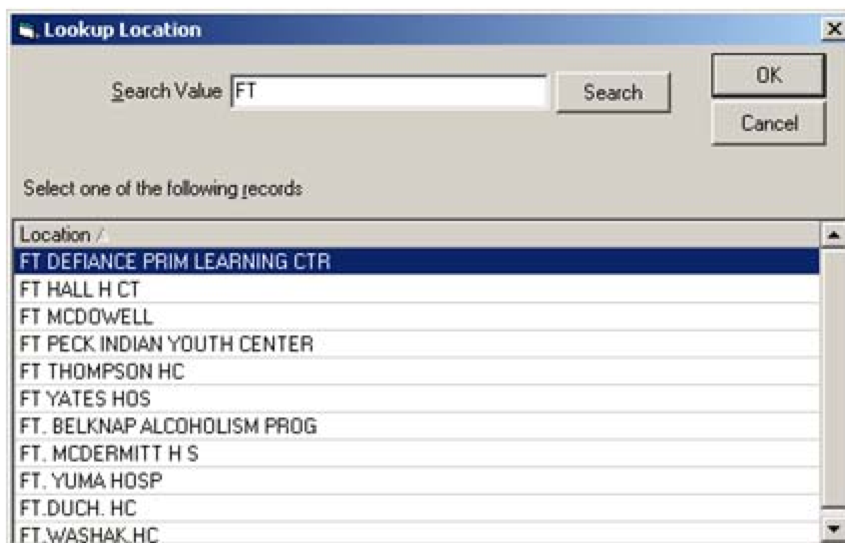


Figure 2-26: Sample Search Criteria

Click on the facility name.

Click OK.

You return to the Add Vaccination dialog.

b. If Other is selected for Location, you type the location in the Location field. If your site has been configured with a default outside location, type OTHER in the Location field. Then when you display the View Visit Detail pop-up, the default outside location will display at the LOC. OF ENCOUNTER field.

3. Click OK on the Add Vaccination dialog. The immunization is now added to the Wellness tab and appears in black. If a compound vaccine was selected, then a separate immunization record will be added for each component of the vaccine.

2.2.4.3 Deleting Immunizations

See section 2.2.1.2 for deleting.

2.2.4.4 Editing Immunizations

1. Click on the immunization you want to edit.
2. Click the Edit button to display the “Edit Vaccination” dialog.
3. Edit the information as relevant.

Figure 2-27: Sample Edit Immunization Dialog

You use the Dose Over-ride field to force a dose valid (if given a day or so early but won't affect school) or invalid (due to expired vaccine, etc.)

This field affects the forecasting; it will ignore invalid doses and count forced valid doses.

You can enter a reaction by selecting from the drop-down list for the Reaction field.

When a entered reaction is 'Anaphylaxis, Convulsions, Lethargy, or Fever >104', then a corresponding contraindication is automatically added.

Otherwise you are asked if it should be added as a contraindication for the patient.

Figure 2-28: Save to Contraindications Confirmation

Click Yes to save the reaction as a contraindication. (Otherwise, click No.)

If you answer yes, a contraindication of 'Other Allergy' is added.

3. Click OK to save.

2.2.4.5 Print Record

1. Select a record and click the Print Record button to display and print the Print Record pop-up. This pop-up shows the immunizations that the patient has received.
2. Click Print and type in the unit printer name.
3. Click OK.

2.2.4.6 Due Letter

Check with the facility about pertinent inpatient usage.

2.2.4.7 Contraindications

The Contraindications field informs the physician of the contraindications that the current patient has.

2.2.4.7.1 Adding Contraindication

1. Click Add in the Contraindications group box.
2. Select the vaccine first.

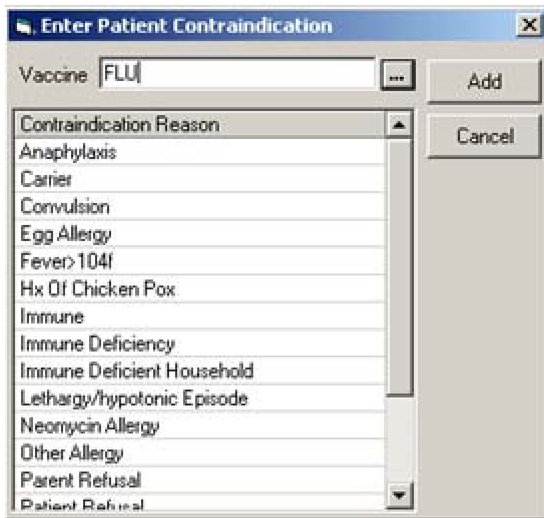


Figure 2-29: Enter Patient Contraindication Dialog

Vaccine: Enter the causative vaccine. Type in the first few letters of the vaccine name then click ... to display the “Vaccine Selection” dialog.

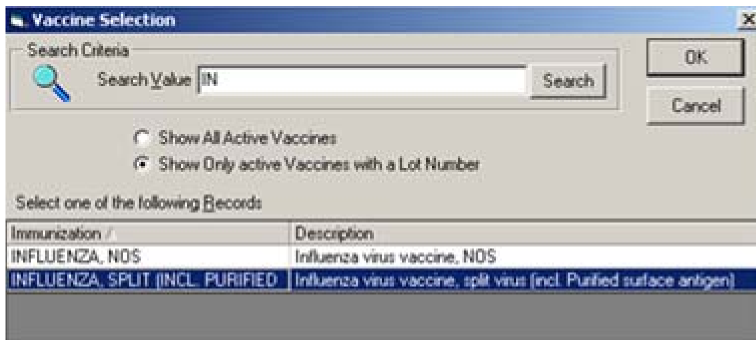


Figure 2-30: Selecting the Correct Vaccine

Click on the correct vaccine.

Click OK.

You return to the Enter Patient Contraindication dialog.

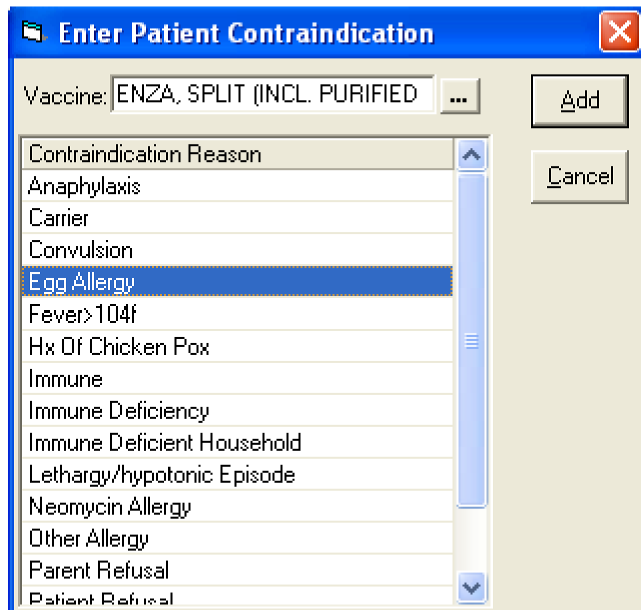


Figure 2-31: Selecting the Contraindication Reason

3. Select the contraindication reason.
4. Click Add.

   The contraindication is now added to the Wellness tab in the contraindication box.

   Check the information entered is correct.

> **NOTE**: This contraindication (egg allergy) might need to be entered in "Adverse Reactions" on the Cover Sheet.

2.2.4.7.2 Deleting Contraindications

See section 2.2.4.3 for deleting.

Check the correct contraindication has been removed.

> **NOTE**: A contraindication may also need to be removed from Allergies on the Cover Sheet – contact pharmacy.

2.2.5 Skin Test

Skin Tests are documented on the Wellness Tab in the Skin Test History section.

Inpatient nursing staff is to record when a PPD skin test is placed and when it is read.

The entry will always be associated with the Visit date, which is the date the patient was admitted to hospital. This date appears in the Visit Box on the patients EHR chart.

2.2.5.1 When a PPD is placed

1. Click Add on the Skin Test History panel.

Skin Test History: Print Record Add Edit Delete

Visit Date	Skin Test	Location	Age@Visit	Result	Reading	Read Date	Reading Provider
05/05/1955	PPD	Chicago	9 yrs		6	09/29/04	[illegible]
11/11/1995	PPD	Phoenix Indian Medic	49 yrs				
11/11/1995	PPD	Phoenix Indian Medic	49 yrs			10/22/04	[illegible]
12/08/2003	PPD	Fort Defiance Ihs; Negative 5 Mm	57 yrs				
12/28/2004	PPD	Ft.Defiance	58 yrs	Positive	13	12/30/04	[illegible]

Figure 2-32: Skin Test Component

The "Add Skin Test" dialog displays.

Add Skin Test
Skin Test: PPD
Administered By: DEMO,DOCTOR
Results: PENDING
Save
Cancel
Current
Historical
Refusal

Figure 2-33: Sample Add Skin Test Dialog

Skin Test: Click on PPD.

Administered By: Defaults to your name.

2. Click SAVE. The PPD is entered on the Wellness tab and appears in blue.

2.2.5.2 When a PPD is read

1. Click on the correct skin test and inpatient visit date.
2. Click Edit.

Skin Test History: Print Record Add Edit Delet

Visit Date	Skin Test	Location	Age@Visit	Result	Reading	Read Date	Reading Provic
05/05/1955	PPD	Chicago	9 yrs		6	09/29/04	[illegible]
11/11/1995	PPD	Phoenix Indian Medic	49 yrs				
11/11/1995	PPD	Phoenix Indian Medic	49 yrs			10/22/04	[illegible]
12/08/2003	PPD	Fort Defiance Ihs; Negative 5 Mm	57 yrs				
[illegible]	[illegible]	Ft.Defiance	58 yrs	Positive	13	12/30/04	
10/13/2005	PPD	Ft.Defiance	59 yrs				

Figure 2-34: Skin Test Component

3. The "Edit Skin Test" dialog displays.

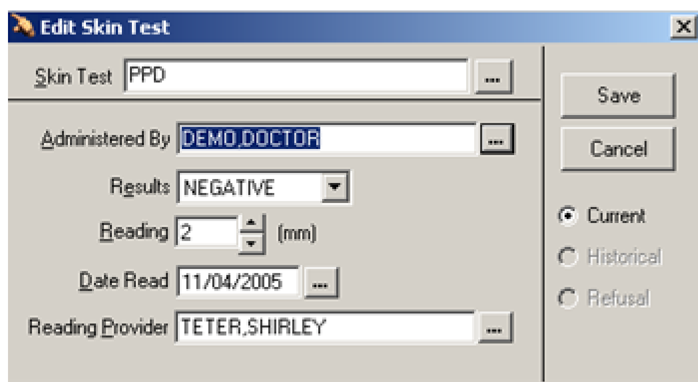


Figure 2-35: Sample Edit Skin Test

Skin Test: defaults to the skin test selected.

Administered By: Defaults to person who placed the skin test.

Results; Click ▼ to obtain a list of results. Click on the appropriate result. **If anything but Pending is selected, the remaining fields display**.

Reading: Enter the numeric value.

Date Read: Defaults to current date once the reading is entered.

Reading Provider: Defaults to your name.

4. Click Save. The skin test is now entered on the Wellness tab with the reading result associated with the correct visit.

Skin Test History: Print Record Add

Visit Date	Skin Test	Location	Age@Visit	Result	Reading	Read Date	Reading Provider	Administered By
05/05/1955	PPD	Chicago	9 yrs		6	09/29/04		
11/11/1995	PPD	Phoenix Indian Medic	49 yrs					
11/11/1995	PPD	Phoenix Indian Medic	49 yrs			10/22/04		
12/08/2003	PPD	Fort Defiance Ihs; Negative 5 Mm	57 yrs					
12/28/2004	PPD	Ft.Defiance	58 yrs	Positive	13	12/30/04		
10/13/2005	PPD	Ft.Defiance	59 yrs	Negative	2	11/04/05	VONBIBRA,LYNDA E	VONBIBRA,LYNDA E

Figure 2-36: New Skin Test Record on Component

2.2.5.3 Adding Historic Skin Test

You can add a historical skin test in one of two methods: (1) by selecting the Historical radio button on the Add Skin Test dialog or (2) by not having a visit selected, click Add, and the Add Historical Skin Test dialog automatically displays with the Historical radio button selected.

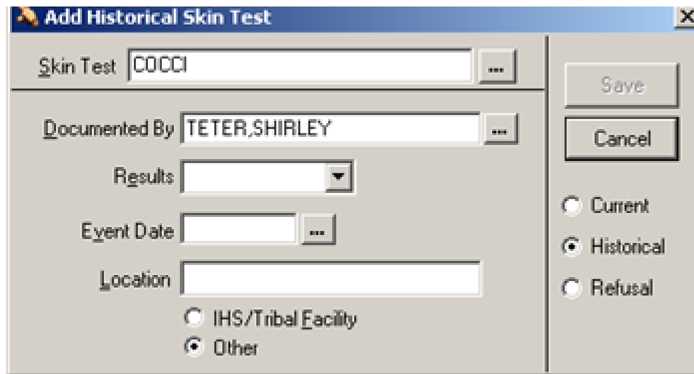


Figure 2-37: Add Historical Skin Test Dialog

See section 2.2.5.2 for more information about the fields above the Location field.

See section 2.2.4.2 for more information about the Location field.

- Click OK.

  The skin test is now added to the Wellness tab and appears in black.

2.2.5.4 Deleting Skin Test

Refer to section 2.2.4.3 for deleting.

2.2.5.5 Adding Refusal

See section 2.2.3.4 for general information about refusals.

2.3 Creating Your Electronic Signature

> **Note**: If you cannot remember your RPMS/EHR access/verify code contact your CAC or IT.

1. Click the Communications tab at the top of the EHR.
2. Click RPMS
3. <site> login: type rpms (use lower case), then press enter twice.

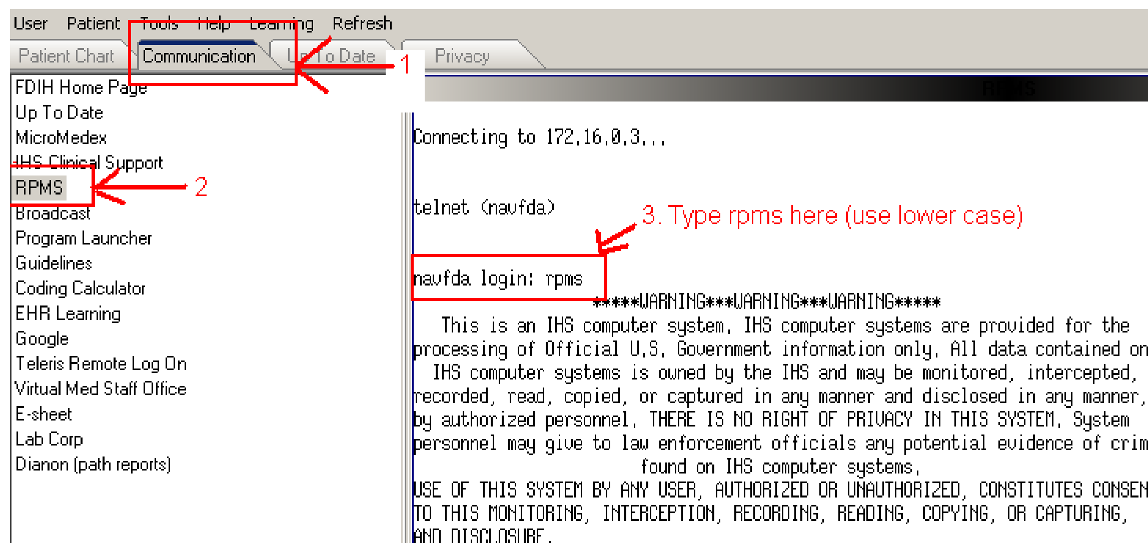


Figure 2-38: Communication Tab Options

4. Access code: type you're EHR/RPMS access code, then press Enter.

5. Verify Code: type you're EHR/RPMS verify code, then press Enter.

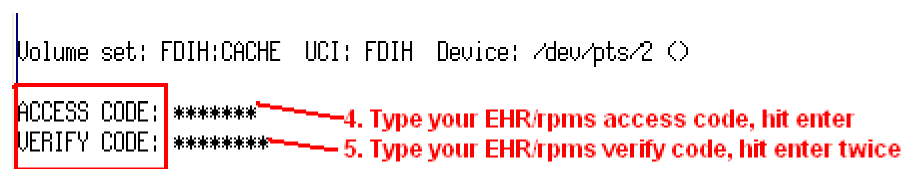
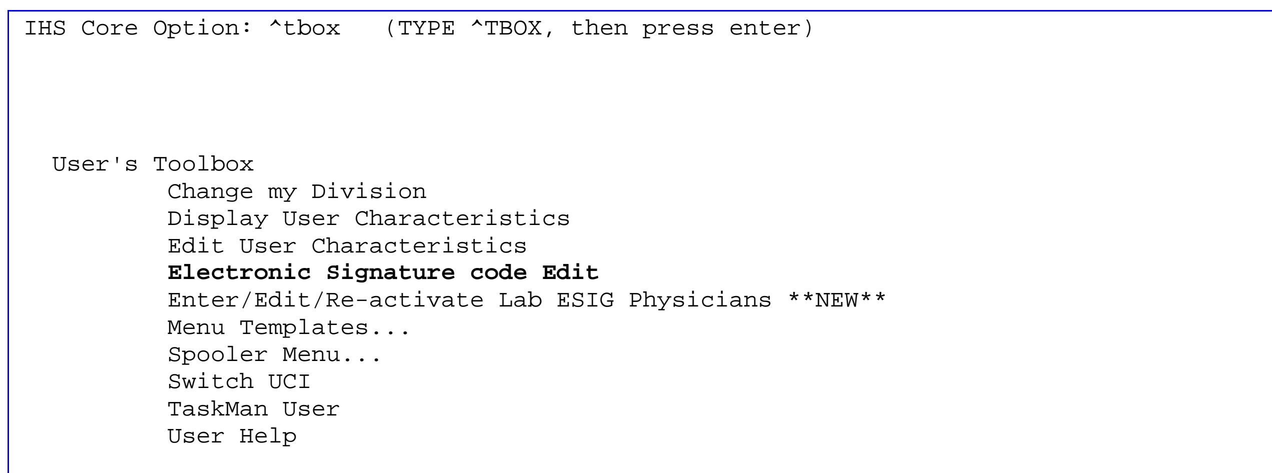


Figure 2-39: Entering Access and Verify Codes

6. IHS Core Option: type TBOX and then press enter until you reach the prompt ELECTRONIC SIGNATURE CODE EDIT



```
IHS Core Option: ^tbox   (TYPE ^TBOX, then press enter)



  User's Toolbox
          Change my Division
          Display User Characteristics
          Edit User Characteristics
          Electronic Signature code Edit
          Enter/Edit/Re-activate Lab ESIG Physicians **NEW**
          Menu Templates...
          Spooler Menu...
          Switch UCI
          TaskMan User
          User Help
```

You use the bolded option

7. Select User's Toolbox Option: Electronic Signature Code Edit

This is where you enter your new Electronic Signature Code or change the existing one.

You enter (or can change) your Initials, Signature Block Information, Office Phone number, Voice and Digital Pagers numbers.

```
INITIAL: rkn//    ←press Enter
SIGNATURE BLOCK PRINTED NAME: RHONDA K NELSON, DPM       ←press Enter
           Replace
SIGNATURE BLOCK TITLE:   //          ←press Enter
OFFICE PHONE: 928-729-8819//         ←press Enter
VOICE PAGER: 435//                   ←press Enter
DIGITAL PAGER:                       ←press Enter

Enter your Current Signature Code: ←this is where you type your e sig.
                                    CAPS LOCK ON. 6-20 characters.
                                    You will not see your typing. Press Enter
    Reenter your signature coded : ←you will not see your typing. Press Enter
```

NOTE: If you cannot remember the signature code entered already call your CAC or IT.

If an electronic signature has never been set, it should say: *enter a new code***.**

2.4 Templates

Templates standardize documentation. The size of templates will vary; generally the more information to be documented the larger the template.

Templates are usually attached to a note title.

Nursing templates contain topic headers to break the template into sections. The topic name reflects the subject of documentation.

Templates can also contain instructions.

2.4.1 Activating Templates

Template note has to be activated before you can document.

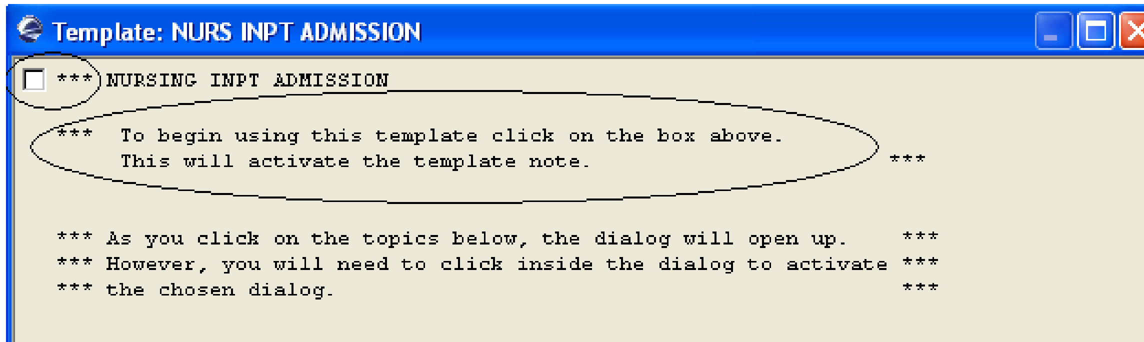


Figure 2-40: Activating Template

- Click on the checkbox next to note titles or section headings to activate the dialog.

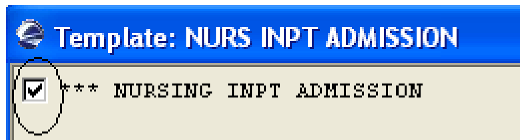


Figure 2-41: Checkbox to Check

The topic headings will appear, each has *** before it.

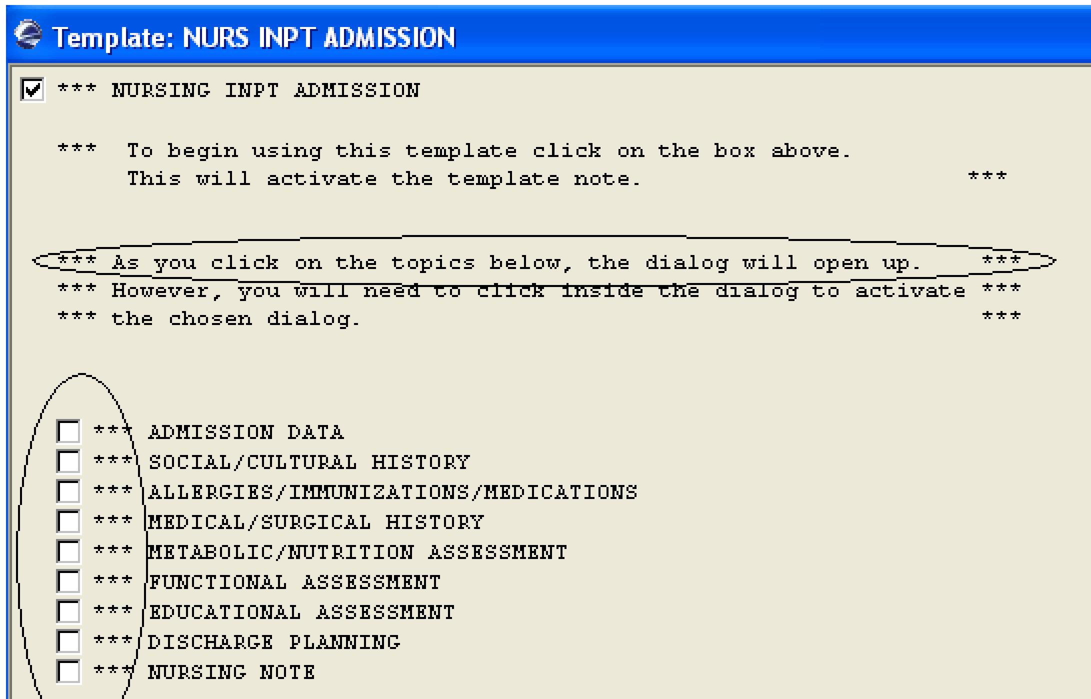


Figure 2-42: Checkboxes to Consider

The checkbox next to each topic must be activated to open the dialog, e.g., click on the checkbox. For example click ADMISSION DATA to open the Admission Data dialog.

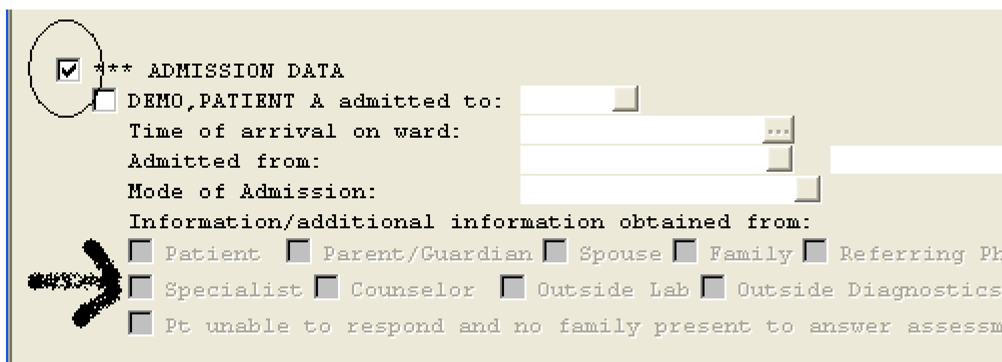


Figure 2-43: Display After Checking the Checkbox

At this point you cannot document – notice the typing opposite the black arrow is grayed out.

Remember the instructions

*** You will need to click inside the dialog to activate the chosen dialog. ***

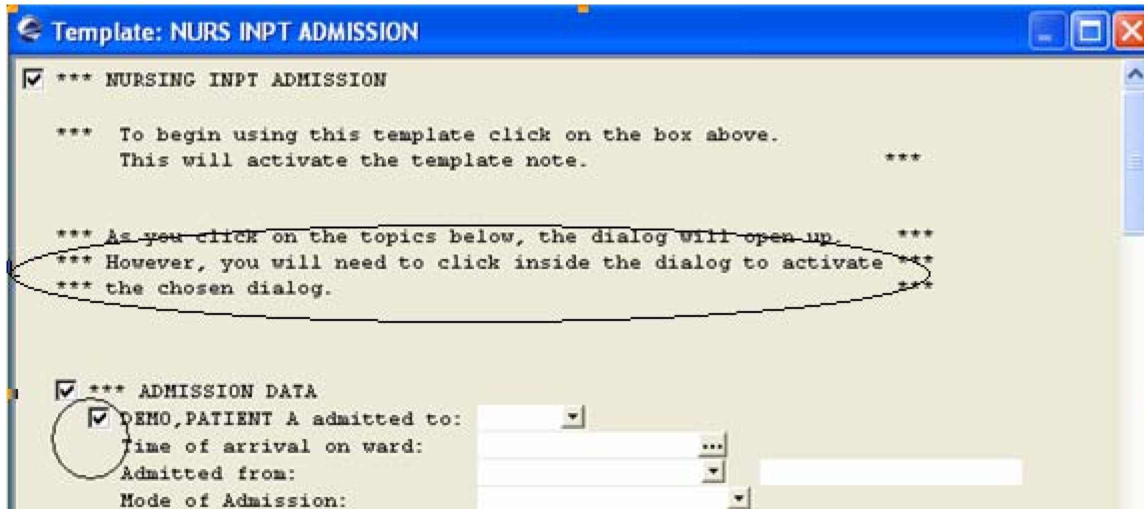


Figure 2-44: Activating the Dialog

- Click the box next to Demo Patient A to activate the dialog.

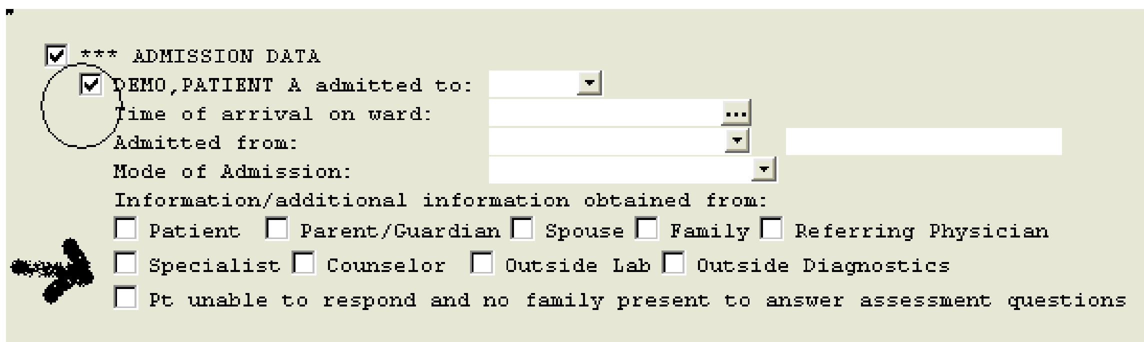


Figure 2-45: Completing the Dialog

Notice the typing is now black - the dialog has been activated.

2.4.2 How Templates Work

Most of your documentation is done by clicking in template fields. You can also type in free text.

Below is a template explaining how different template fields work.

Template: Template Fields	
There are different types of template fields: Edit box: (character limited field. Max 240) What are template fields? Radio button: (can only choose one) Do you know what template fields are? Yes No Combo Box: (Saves space - can only select one) What template field do you like best? Button: (Each time you click, it changes - good if user usually answers one way - but needs options) You have Met your goals. Check Boxes: (can select as many as desired, comma put between each selection. Also used when you want to give the choice whether to include something in a note - if user doesn't click in check box, nothing will show) Other: Specify by name, relationship to patient When does this training end? Today Tomorrow Yesterday Never Date: When did you meet your goal? ... Hyperlink You can get more information at IHS FTP Site Word Processing: Can designate how many lines viewable, but user can keep typing) Explain the template creation process: Text - can exclude from note Please answer all	Edit box – type in the box. 2 L/min Radio button. YES NO Combo box - click the for a list of possible answers, then click on your answer. nasal cannula simple mask non-rebreather blow-by nasal cannula Button – the answer changes as you click on the button. Yes No Leave it at your selection. Check boxes – select as many answers as appropriate. NG Tube: None Salem Dobhoff Peg tube Drainage Suction Clamped off Date – click on the ellipsis button for the calendar to open Word processing box – pt complains of itching skin, red rash 2x2" o

2.4.3 Other Tips

Information can also be "pulled" from other RPMS packages into the template note so the order in which you document is important.

For example:

- Enter immunizations given on the Wellness Tab first. Do the Pre Immunization template next so that the immunizations will "pulled" into your template note.
- Enter admission vital signs before starting your admission note.

Other information is also pulled into notes, e.g., patient's name, current IHS medications, allergies, immunizations due.

2.4.4 How to Document

You document in each section what is applicable to your patient.

In the example below the patient has no NG tubes and no ostomy, therefore no further documentation is required in those fields - you do not activate the sub sections that allow for more detailed charting.

This is how the note looks as you document.

Figure 2-46: Sample Template Information

To look at your note click Preview (at the bottom right of the screen)

Figure 2-47: Previewing the Template

This is how your finished note will look – check for accuracy.

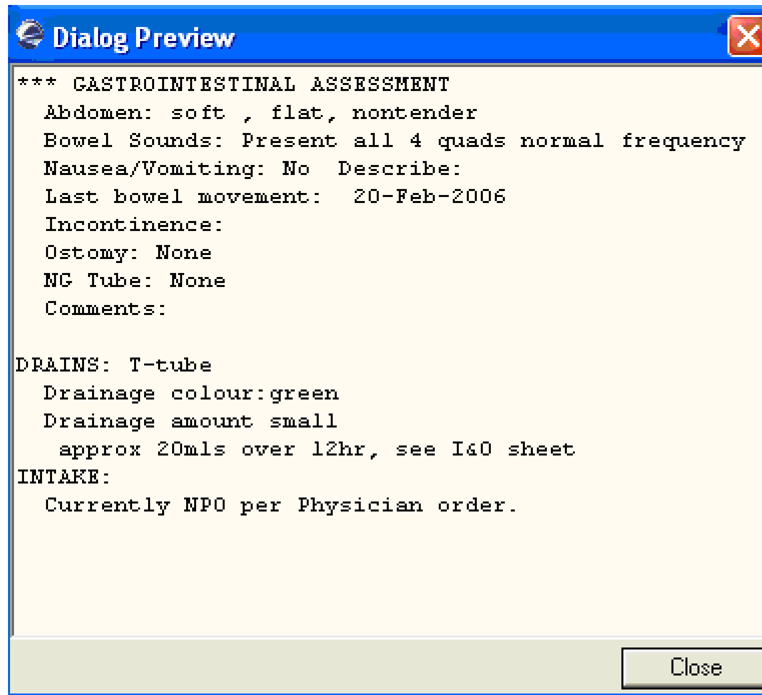


Figure 2-48: Sample Dialog Preview

- Click Close when you want to return to the template note.

Once the template is competed, click OK at the bottom of the screen.

Figure 2-49: Completing the Template

The template will show on right side of the screen.

Recheck your note for accuracy.

- Sign your note when completed.

> **Note**: If you click cancel, the template is cancelled. You have to start documentation from the beginning.

2.5 Adding Default Note Titles to Your Personal List

You can organize the note titles used most frequently as defaults in the Note Properties box. Every time you click New Notes your list shows, you then click on the note title you want and save time with documentation. This is important when entering a progress note.

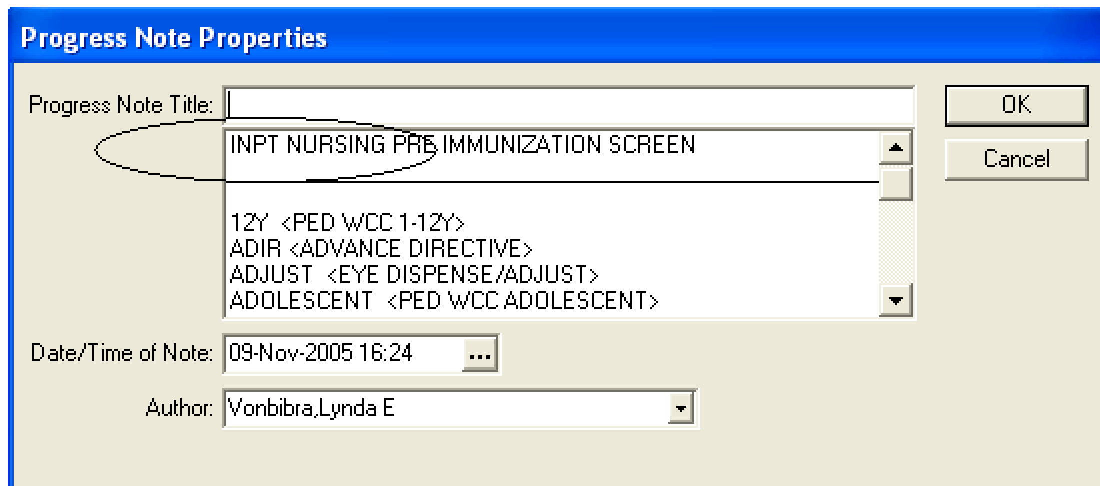


Figure 2-50: Progress Note Properties Dialog

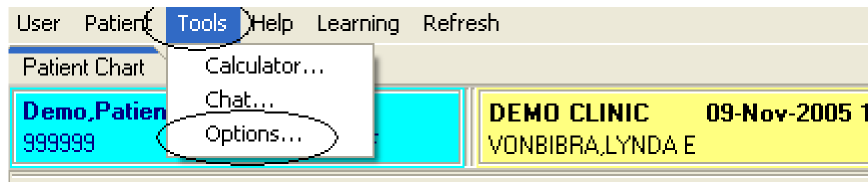


Figure 2-51: Selecting the Options Selection

1. On the EHR toolbar, select Tools → Options.
2. The "Options" dialog displays.

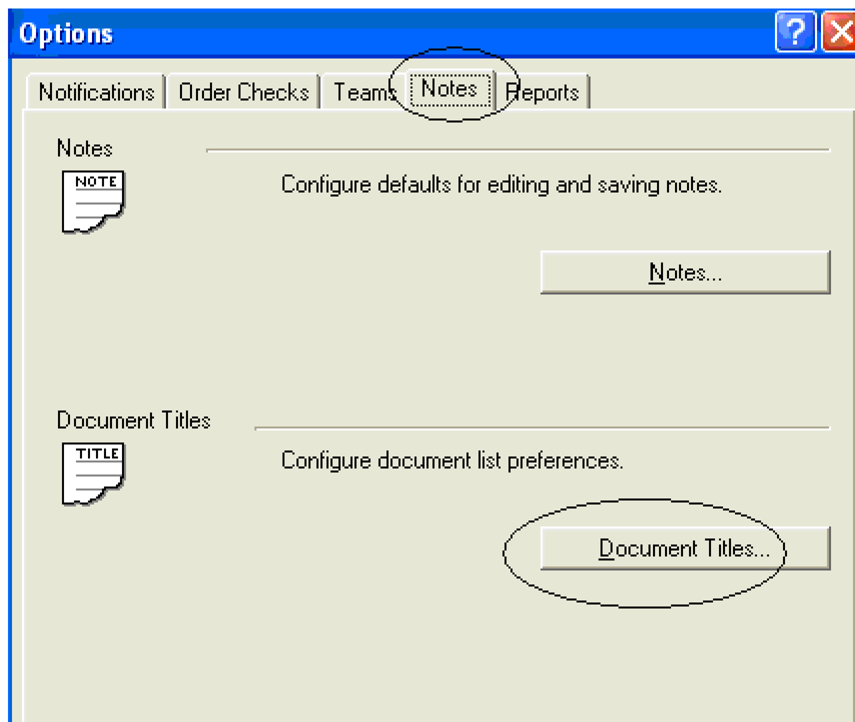


Figure 2-52: Selecting the Notes Tab

3. Select the Notes tab.

4. Click the Document Titles button.

5. The "Document Titles" dialog displays

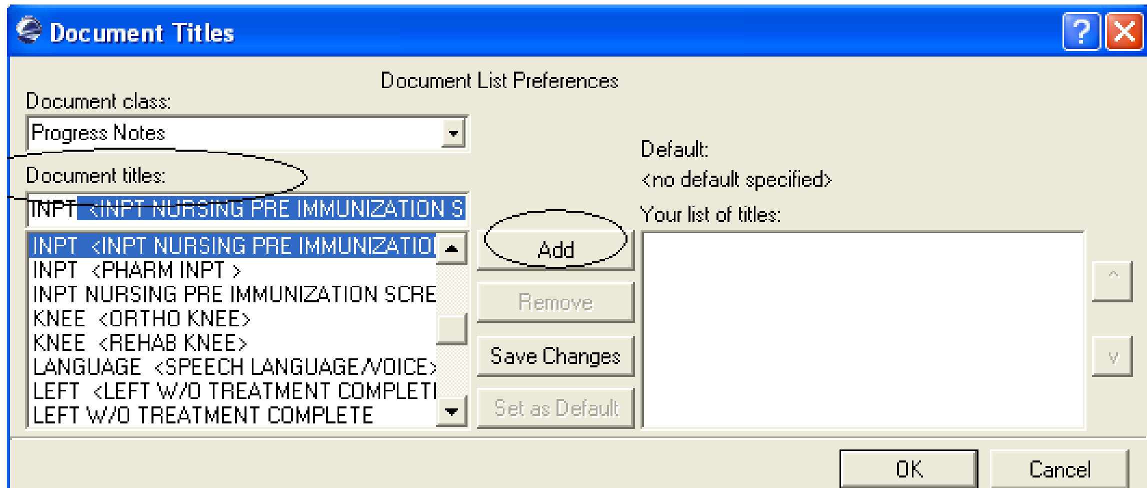


Figure 2-53: Document Titles Dialog

Document Titles – type in a few letters of the note title and allow for the list to default.

Click on the note title you want.

Click the Add button. The note title will listed on the right under "Your List of Titles".

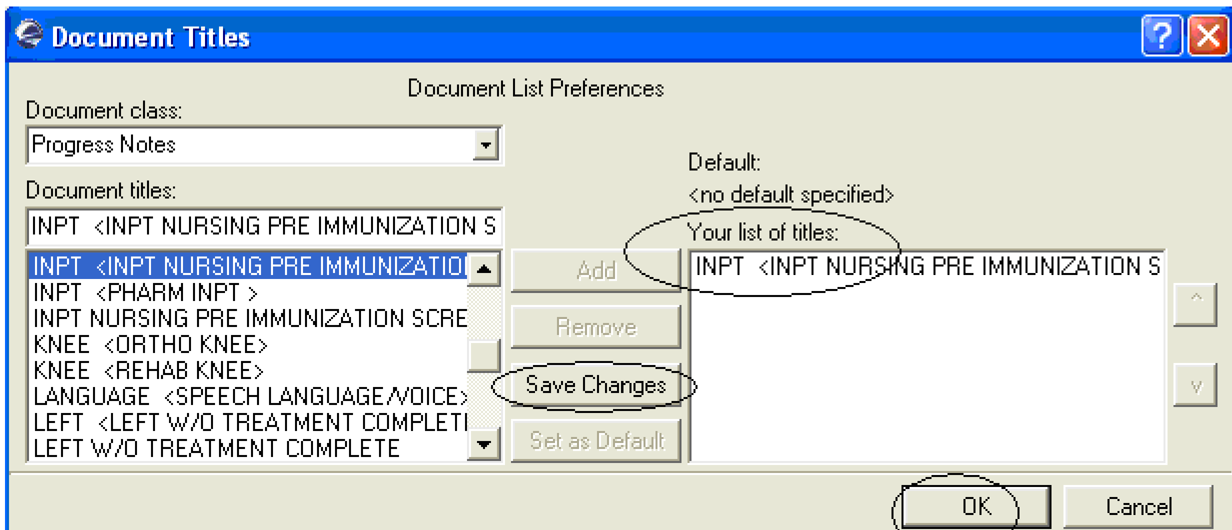


Figure 2-54: Completing the Document Titles Dialog

Repeat the above steps as needed.

Click the Save Changes button.

Click OK to close the dialogs.

6. Click the New Notes button.

7. Your list of note titles defaults to the top of the Note Properties box.

2.6 Entering a Progress Note

Progress notes are documented in the Notes tab.

Note titles are organized in groups and reflect the event being documented, e.g., Nursing Admission Assessment.

Note titles usually have a template attached; when a note title is selected the template opens. Templates standardize documentation and are efficient to use. After a template is completed, it is also possible to type more information below the template before signing the note. All notes are signed by using an electronic signature.

- **INPT** is the prefix that will be used to distinguish inpatient progress notes from outpatient notes.
- **INPT NURSING** is how inpatient nursing note titles will be listed.

The title is further defined by function

- INPT NURSING ADMISSION ASSESSEMENT
- INPT NURSING SHIFT NOTE
- INPT NURSING DISCHARGE NOTE
- INPT NURSING PRE IMMUNIZATION SCREEN.

2.6.1 To Enter a Note

1. Sign onto EHR
2. Select correct patient.
3. Note that the Visit defaults to the current inpatient visit.
4. Check that your name appears in the Visit box.
5. Select Notes tab.

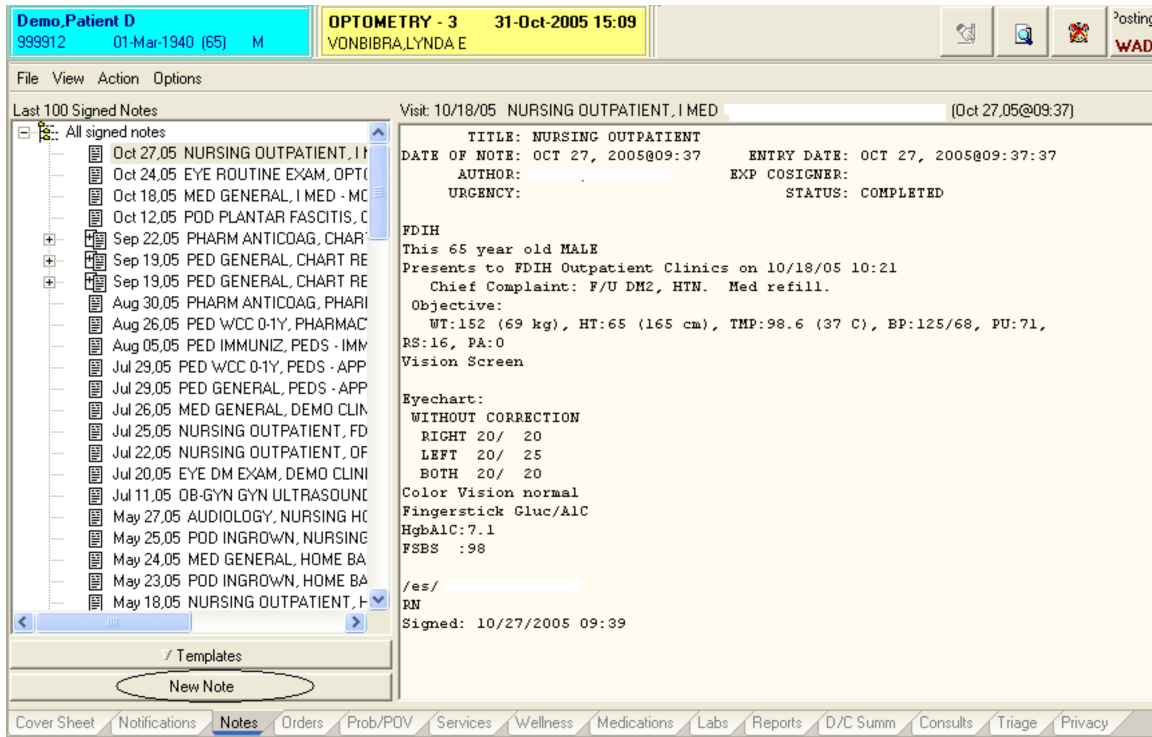


Figure 2-55: Selecting New Note Button

6. Click New Note. The “Progress Note Properties” dialog will display.

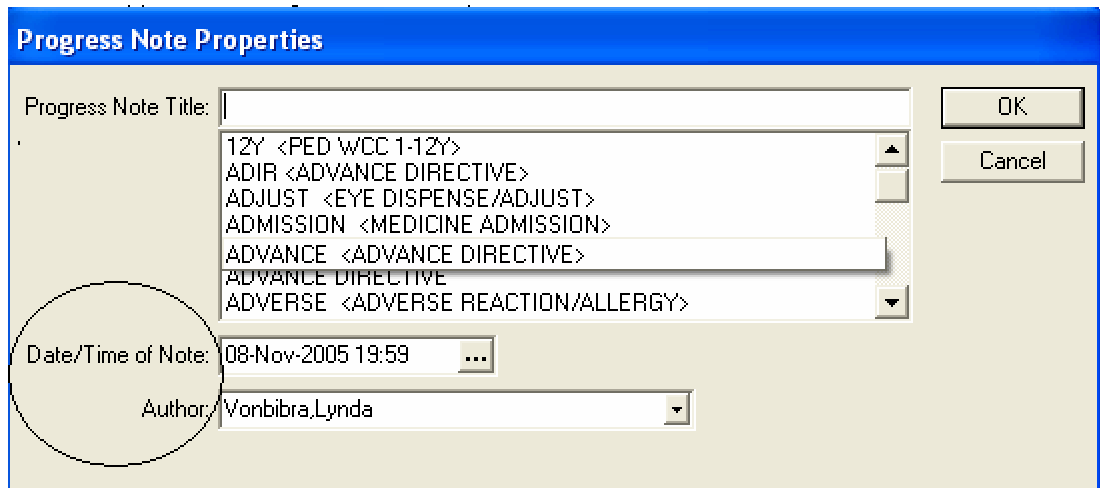


Figure 2-56: Progress Note Properties Dialog

Date/Time of Note: defaults to real time.

Author: your name appears here.

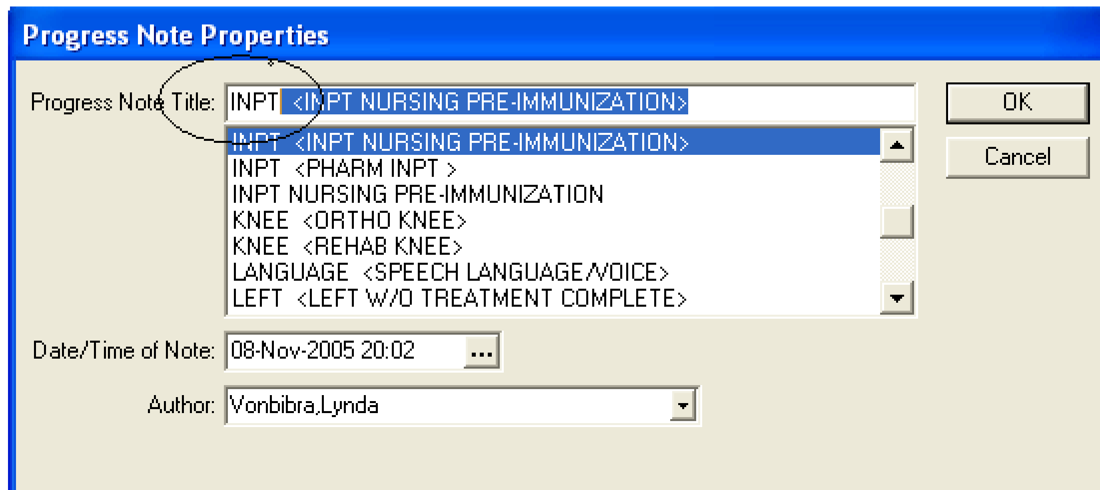


Figure 2-57: Selecting a Note Title

6. Progress Note Title: Type in INPT.

   The screen defaults to INPT and note titles starting with INPT are listed alphabetically.

   Use the scroll bar to find the note title you want and click on the title.

7. Click OK.

   The left side of the screen lists “New Note in Progress” and the note tile underneath.

   The note tile is listed on the top of the screen.

   The template attached to the note title is open.

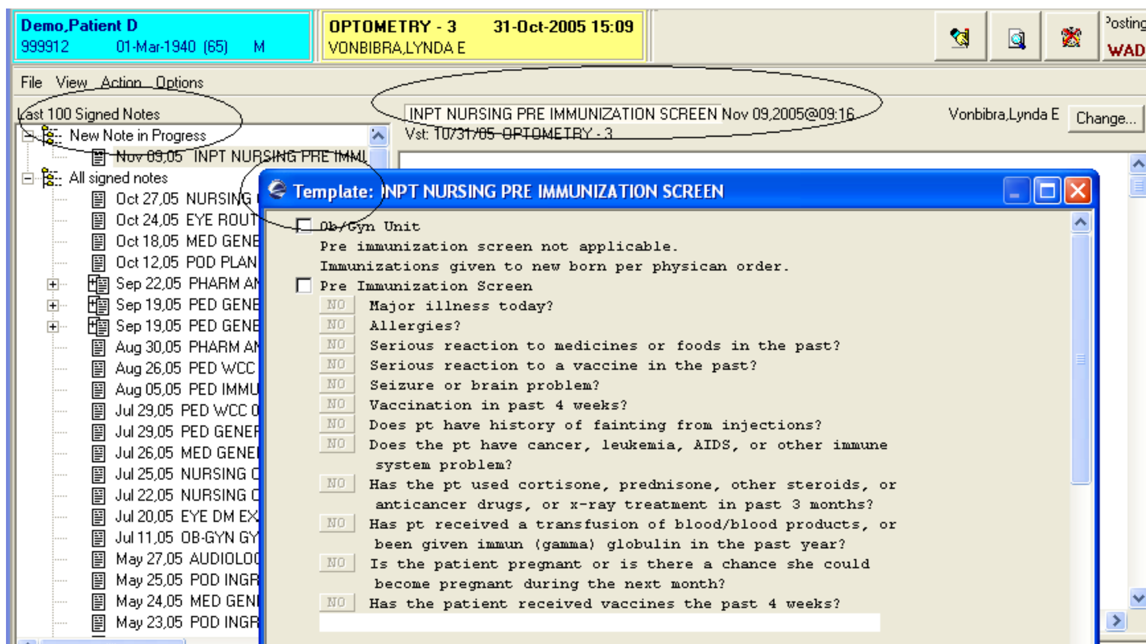
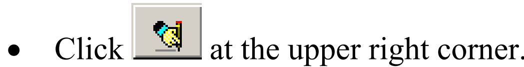


Figure 2-58: Template Attached to the Note Title

- Complete the template. (Refer to Templates section.)
- Sign your note.

2.6.2 Signing a Note

Until a note is signed no other provider can read the note. Sign your notes once completed because other providers need to know the information contained in your note. More information can be added to a note after it is signed as an addendum.

- Click  at the upper right corner.

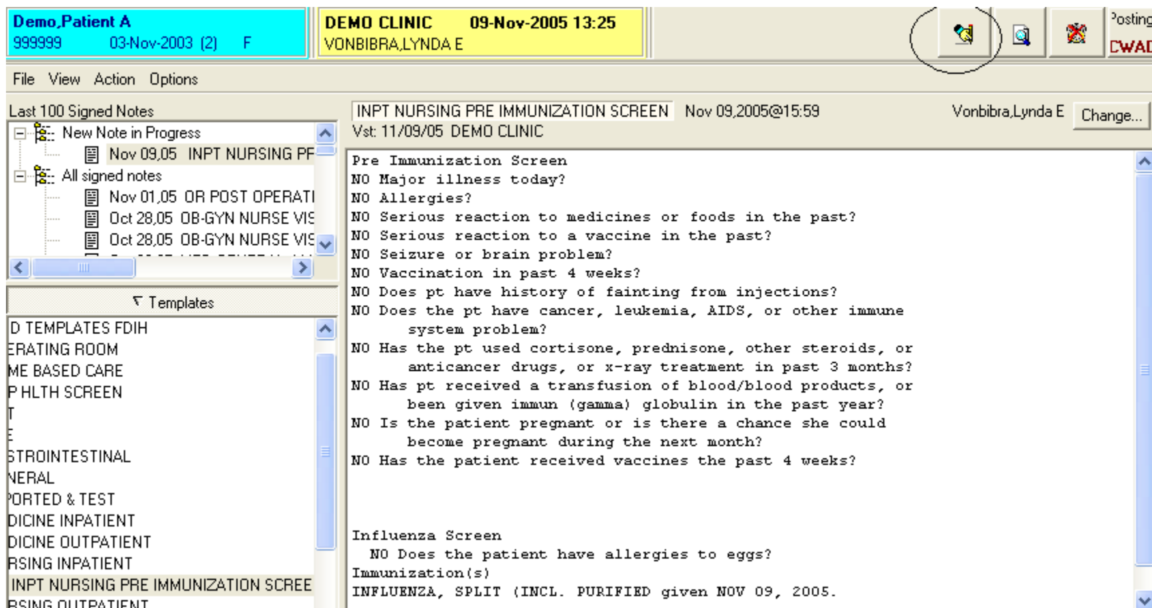


Figure 2-59: Selecting the Button in Toolbar

The "Review/Sign Changes" dialog will display.

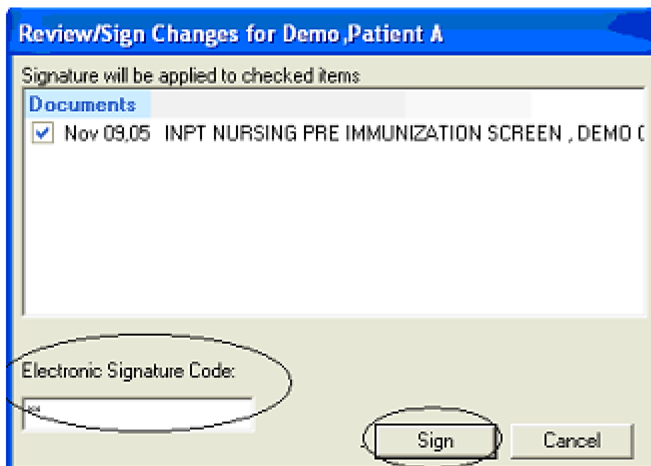


Figure 2-60: Review/Sign Changes Dialog

- Enter your electronic signature

- Click Sign. The note is now listed under All Signed Notes.

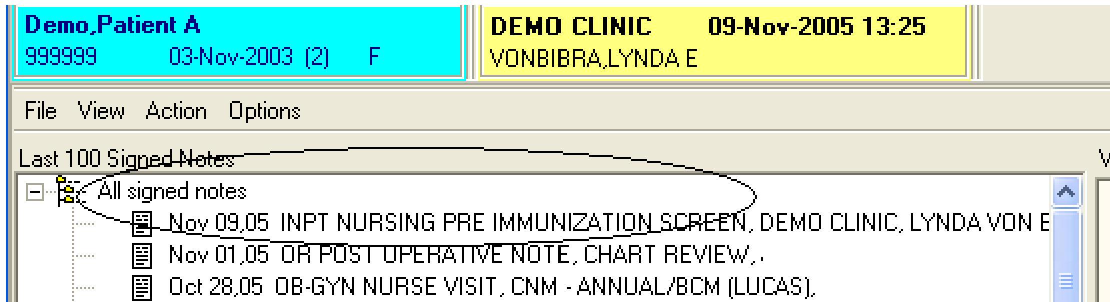


Figure 2-61: Note in All Signed Notes Area

2.6.3 Dragging a Note

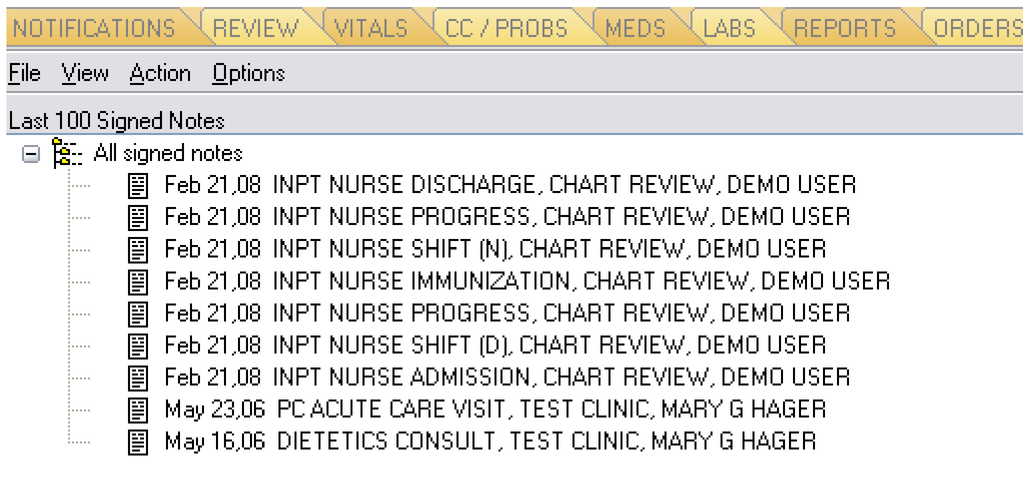


Figure 2-62: List of Note Titles

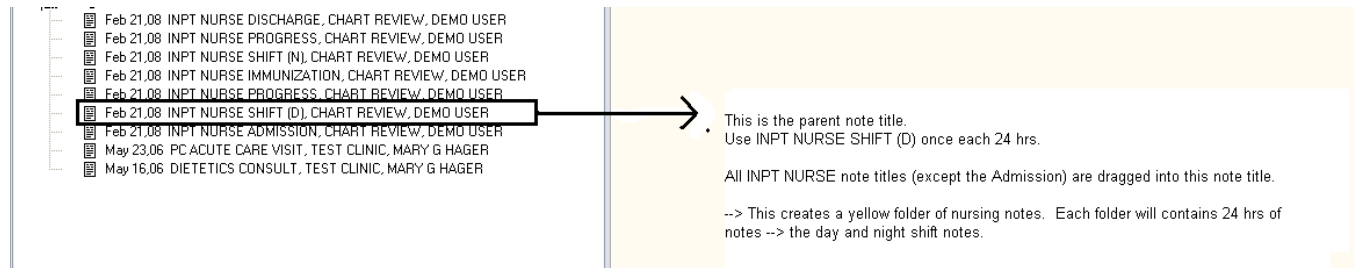


Figure 2-63: Dragging the Note

- Highlight the note title
- Right-click on this note title and hold the click → drag the mouse cursor down onto INPT NURSE SHIFT (D) and then release the click.
- Answer Yes to the Confirm Attachment Message

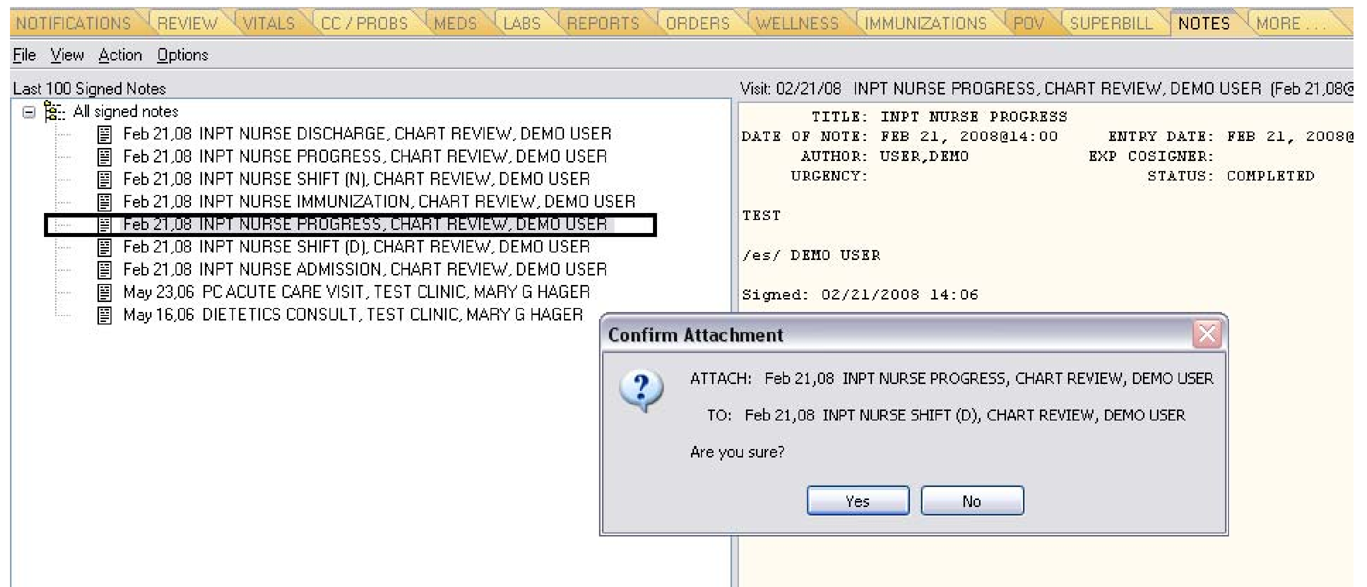


Figure 2-64: Confirm Attachment Confirmation

The folder now "appears"

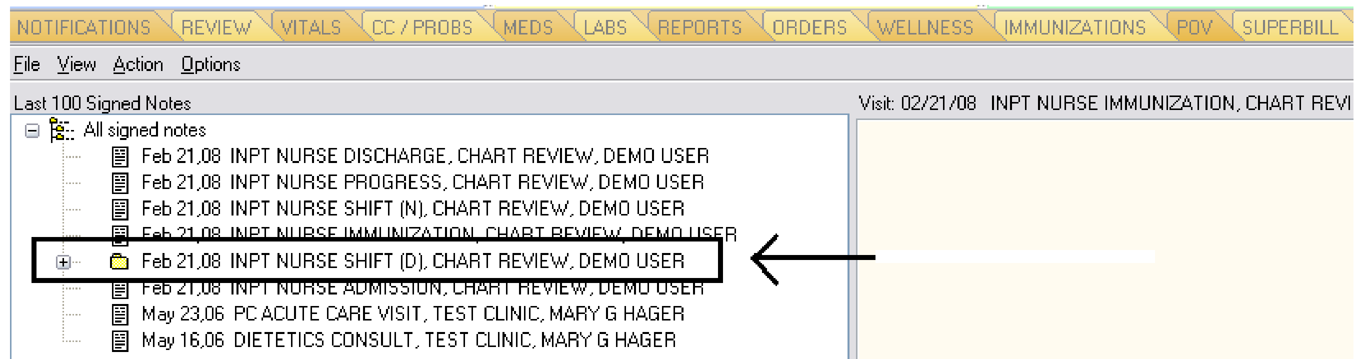


Figure 2-65: New Folder

In the example below look at how the screen changed after all the notes titles for 24 hrs have been dragged into the folder.

The INPT NURSE ADMISSION note cannot be dragged into the folder; it stands alone.

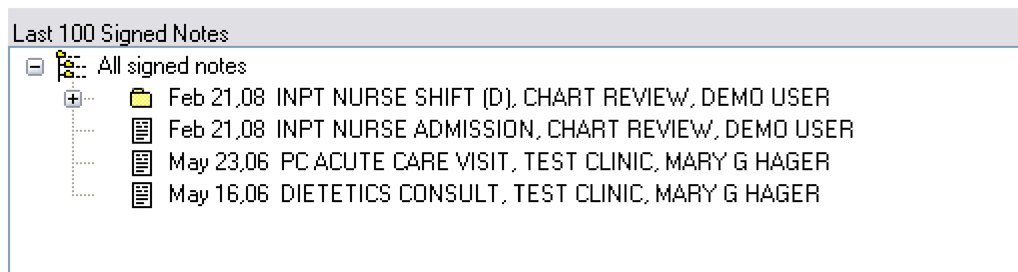


Figure 2-66: Notes in Folder

To view the notes in the folder click on the + sign

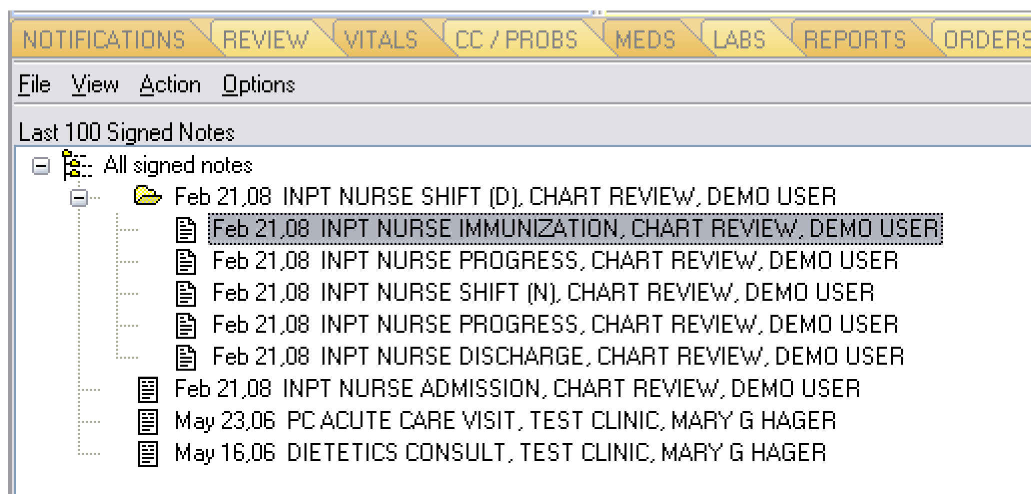


Figure 2-67: View Notes in Folder

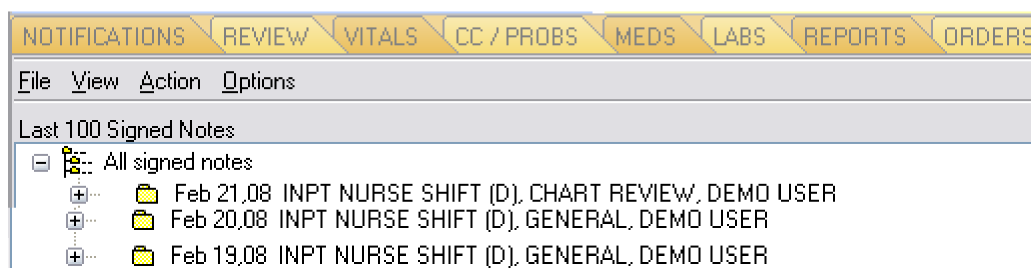


Figure 2-68: Folder in Signed Notes

2.6.4 Addendums

Information can be added to a note after it is signed. You add an addendum to the original note. (You do not have to create a new note).

1. Click on the note title that will have the addendum attached to it.

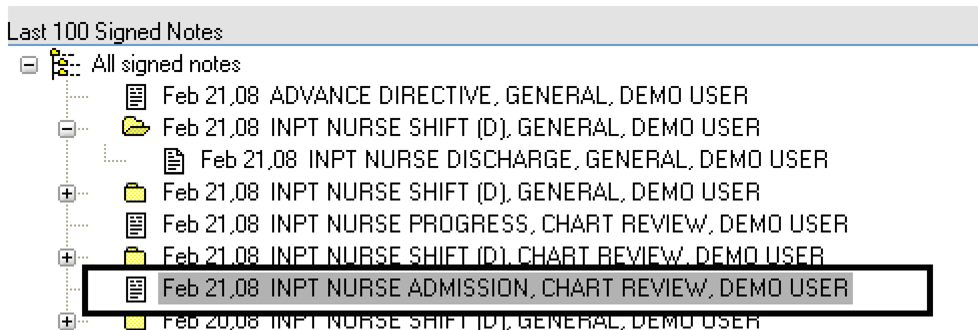


Figure 2-69: Note to Select

2. Select Action → Make Addendum.

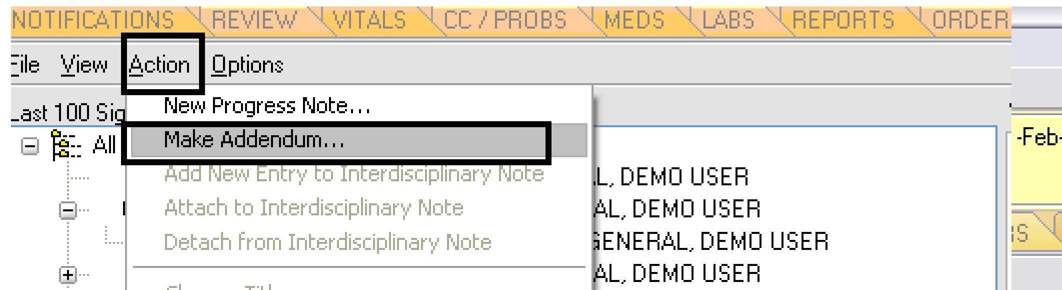


Figure 2-70: Selecting the Make Addendum Option

3. Type the addendum → Sign the Addendum

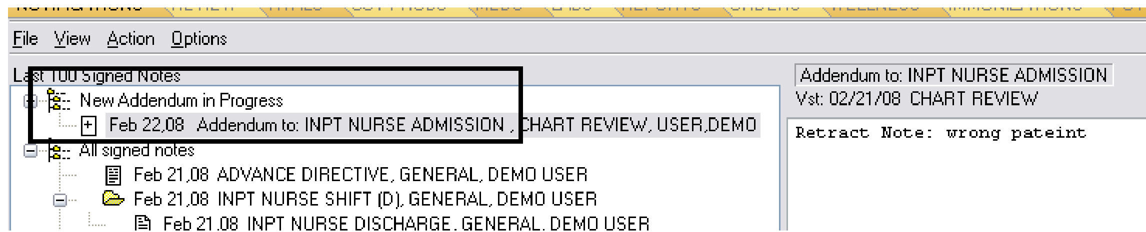


Figure 2-71: New Addendum

4. The Addendum displays with a + sign next to it.

   Click on the + sign to read the addendum.

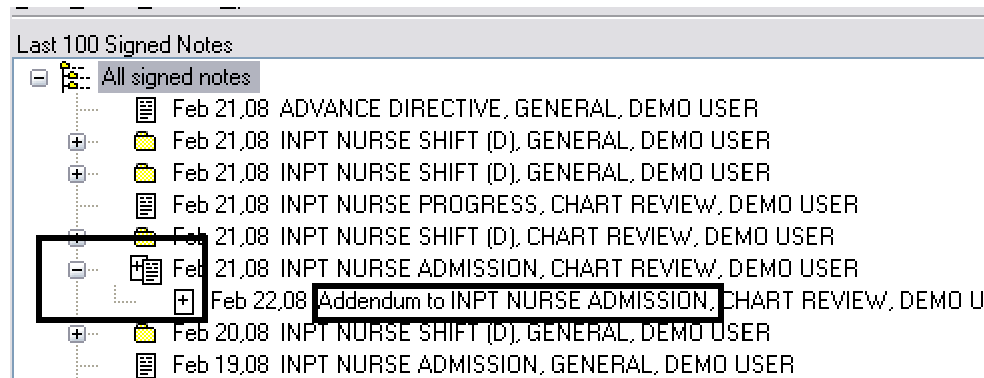


Figure 2-72: Addendum Location

2.6.5 Late Notes

This section addresses how to enter a late entry note.

1. Do this first:

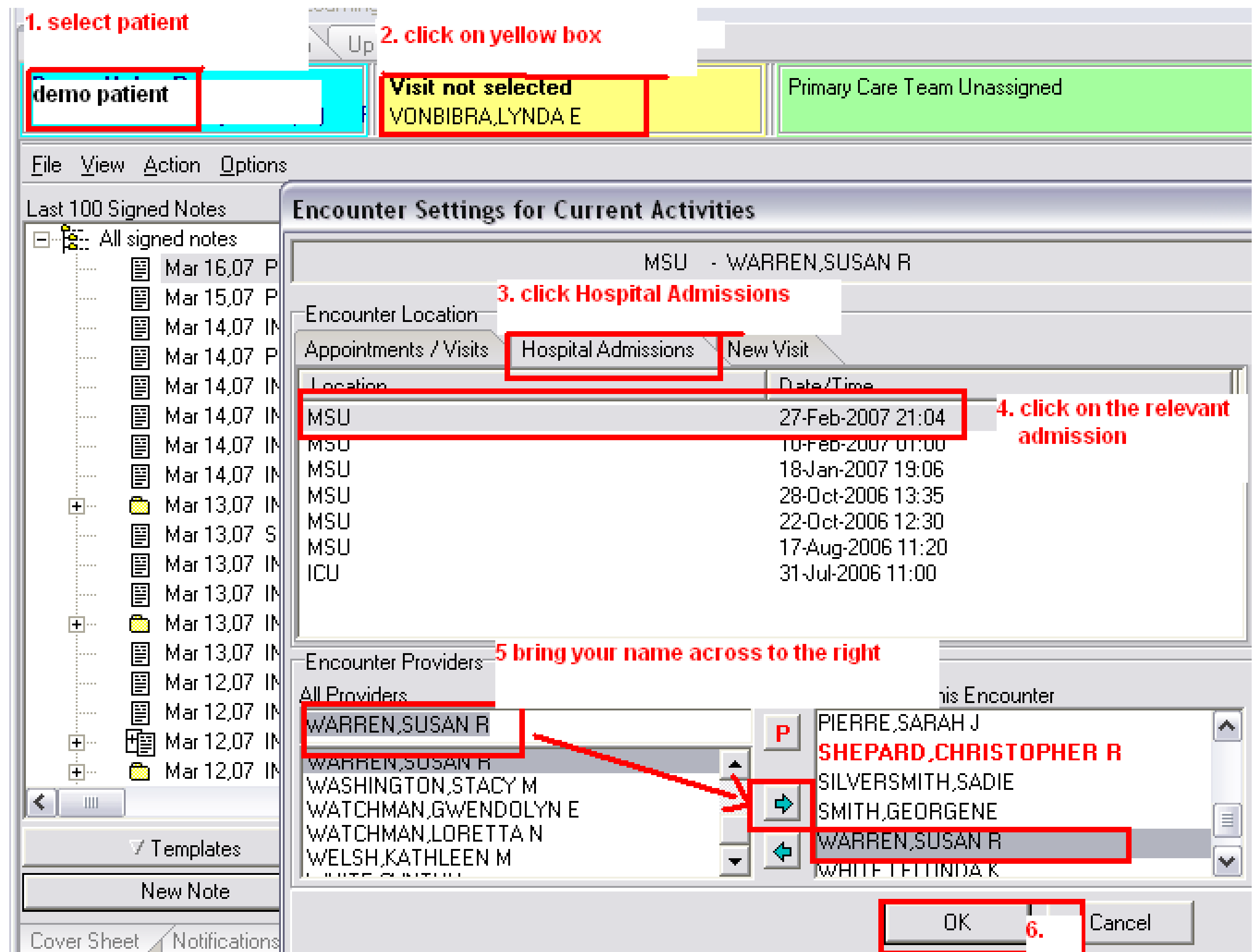


Figure 2-73: Entering a Late Note

2. Do this next:

File View Action Options

Last 100 Signed Notes

All signed notes

Mar 13,07
Mar 07,07
Mar 07,07
Mar 06,07
Feb 23,07
Feb 23,07
Feb 14,07
Feb 09,07
Feb 09,07
Feb 07,07
Jan 22,07
Jan 08,07
Dec 19,0
Dec 07,0
Nov 16,06 OB C
Nov 12,06 PHAF
Nov 07,06 OB-G
Nov 07,06 MED

Progress Note Properties

Progress Note Title:

DIETARY
INPT DIETARY

2.

Date/Time of Note: 16-Mar-2007 13:45

Click here to change the date of your note from today to whatever date you want. Select a time too.

Author: Warren, Susan

OK

Cancel

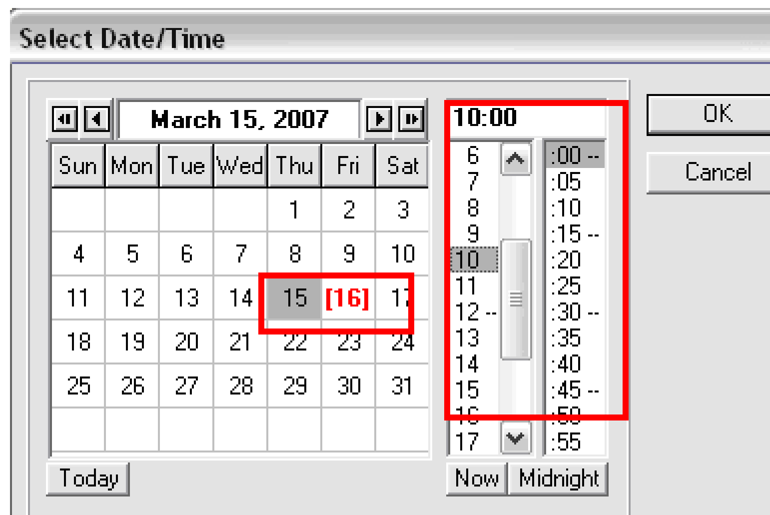
Templates

New Note

1. Click New Note

Cover Sheet | Notifications | Notes | Orders | Prob/POV | Services | Wellness | Medications | Labs | Reports | D/C Summ

Figure 2-74: Entering a New Note



The date will always default to today's date (in red) and real time.

For your note - Click on the date you want and the time you want.

Then click OK

Figure 2-75: Selecting the Date and Time

3. Now do your note:

- Click on the note title INPT DIETARY and complete your template. Click OK.
- Then place the curse at the top left of the note and press Enter three times.
- Reposition the cursor at the top of the page and type LATE ENTRY
- Sign your note.

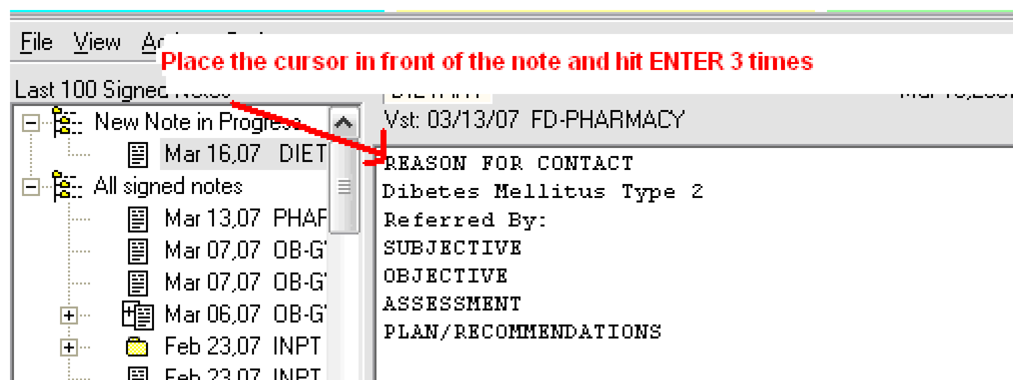


Figure 2-76: Where to Place Cursor

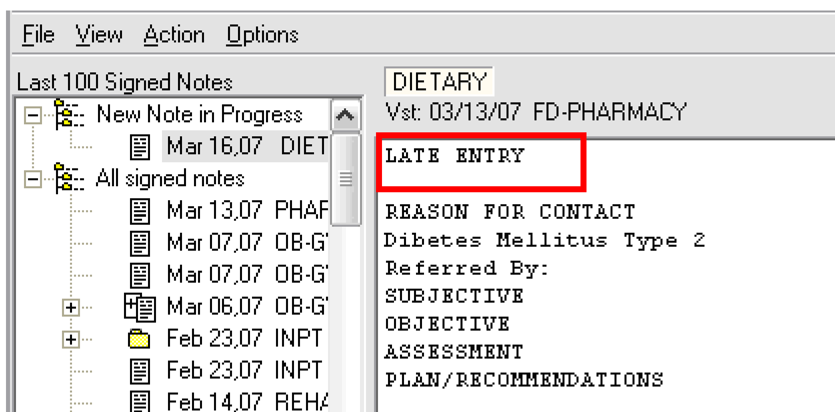


Figure 2-77: Entering the LATE ENTRY Text Line

2.6.6 Retracting a Note

To retract a note, an addendum must be done on the Note to be retracted. Retraction is done because the wrong the patient was documented on or incorrect information was entered in a patient note. Partial retraction cannot be done. Therefore, the whole note has to be retracted. Notify Chief MIS to retract a note.

2.6.7 Changing a Note Title

Sometimes the wrong note title is selected. If the note is unsigned, the user can change the note title by using the Change button located at the upper, right side of the window. If the note has been signed, notify either CAC or Chief of MIS to change the note title.

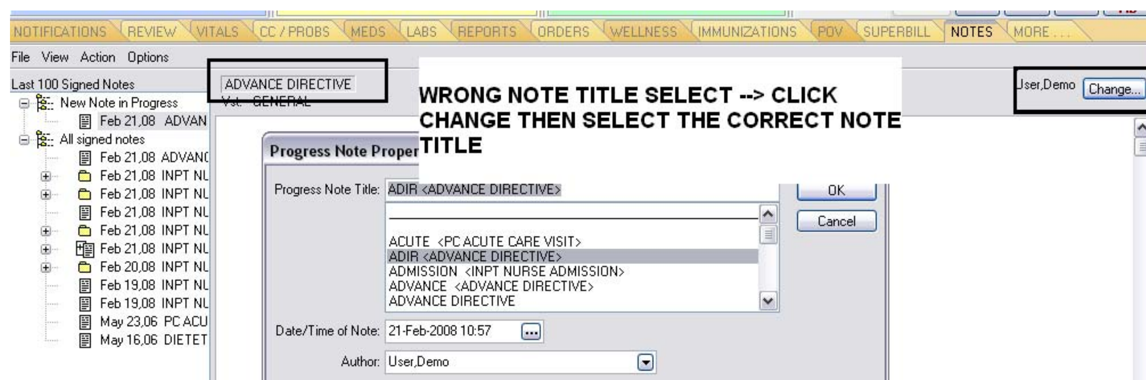


Figure 2-78: Clicking Change Button

2.7 Vital Signs

When you select the "Enter Vitals" option, the Vital Measurement Entry dialog opens. The current date/time column will appear on the dialog.

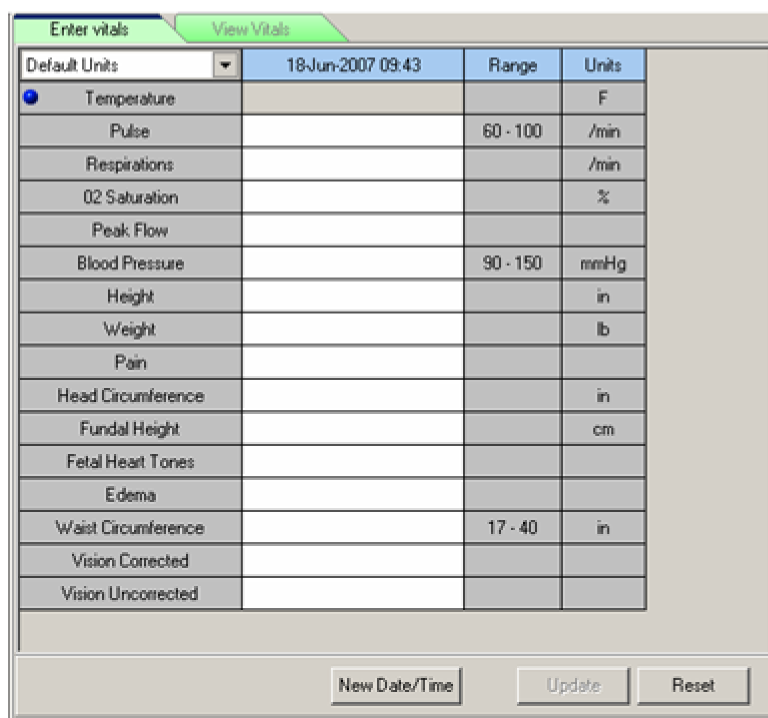


Figure 2-79: Enter Vitals Tab

- Enter data in the appropriate fields.
- When vital sign entry is finished, click Update.

2.8 Allergies and Adverse Reactions

Your site can be configured (in RPMS) such that a user can enter adverse reactions. This user can select the appropriate option on the right-click menu of the Adverse Reactions panel (on the Cover Sheet) to enter adverse reactions.

Figure 2-80: Right-Click Menu Options

The new adverse reaction data will not display on the Orders window, however. In this case, we recommend that your site be configured such that adverse reactions cannot be entered on the Orders window (to lessen any confusion).

2.8.1 New Adverse Reaction

You use the "New Adverse Reaction" option on the right-click menu to enter a new adverse reaction for the current patient.

1. After selecting the New Adverse Reaction option, the Look up Causative Agent dialog displays.

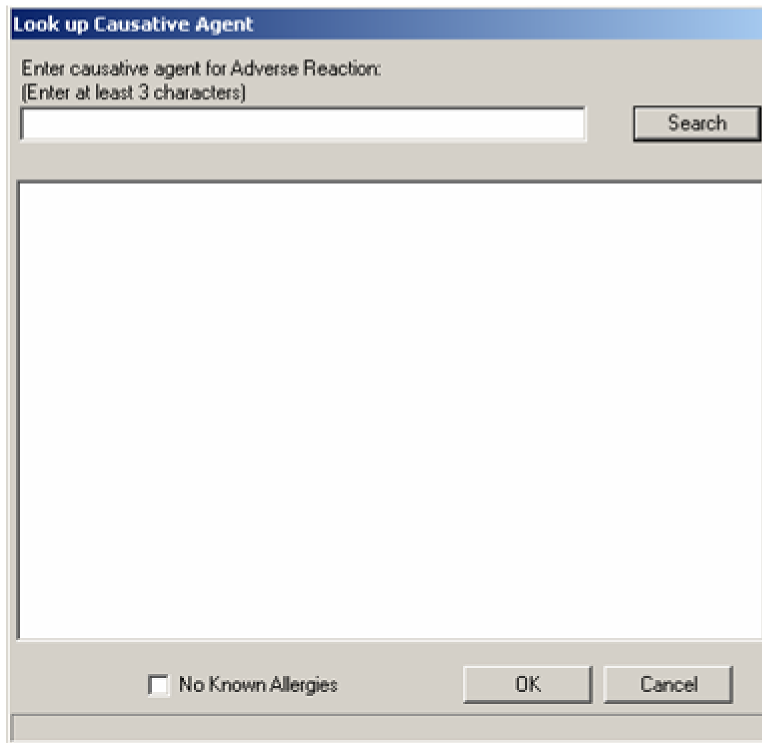


Figure 2-81:Look Up Dialog

The "No Known Allergies" checkbox does not appear on this dialog if the current patient has active allergies.

If the "No Known Allergies" checkbox does display and you want to record that the patient has no known allergies, check the checkbox. Upon exiting the application, you will be asked for your electronic signature.

2. If you want to enter a known allergy, enter at least three characters of the causative agent's name in the "Enter causative agent for Adverse Reaction" field.

   Click Search and the application displays a list of possible matches in the lower group box of the Look up Causative Agent dialog.

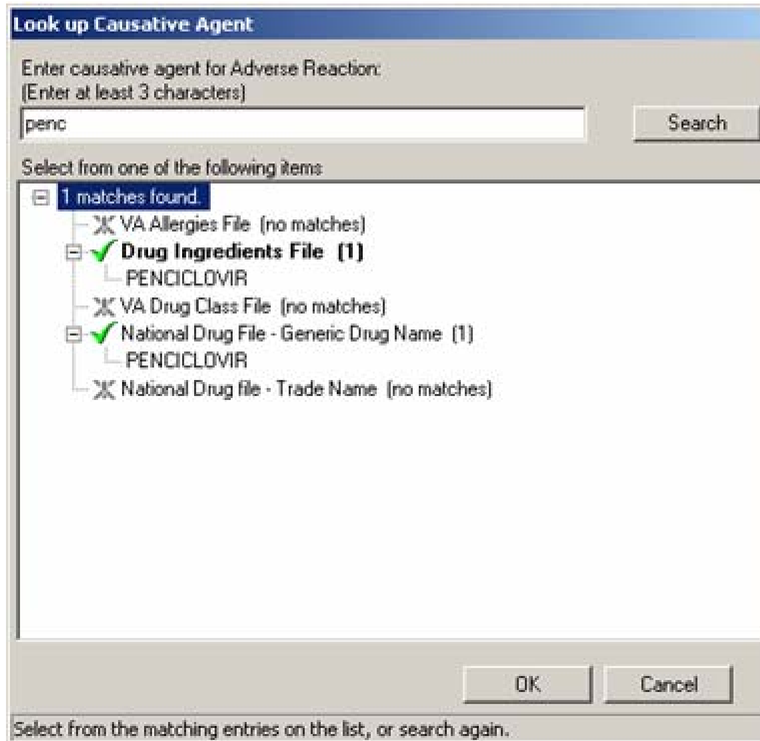


Figure 2-82: Selecting the Causative Agent

   You can do one of the two things: (1) enter a new search or (2) select from the matching entries in the lower group box.

   If no causative agent can be found in the search, you can create a new. See 2.8.2 Creating New Causative Agent for more information.

3. After you select from the matching entries in the lower group box, the Create Adverse Reaction dialog displays.

Figure 2-83: Create Adverse Reaction Dialog

4. You can select those options that you want in the record by selecting from the various group boxes. But you might want to know the current allergies that the patient has. Click the Current button to display the Current Allergies pop-up.

Figure 2-84: Current Allergies Pop-up

You can change the font size of the text displayed in this pop-up by adjusting the size in the Font Size field (enter manually or use the up and down arrows). Note that this does not change the size of the text on the output (when you print).

Click Print to choose a printer and to output the (entire) contents of this pop-up to the specified printer.

The detail pop-up has a right-click menu where you can copy selected text and paste it into any free-text field within the EHR or into another application (like MS Word).

Click Close to dismiss the pop-up.

5. If you check the Observed checkbox, the fields in the Observed group box become active. You can change any data in the following fields:

   Observer: this is the name of the person who was the observer when the reaction occurred. You can change the Observer by selecting from the drop-down list.

   Reaction Date/Time: this is the date and time when the reaction was observed. This can be a historical date.

   Severity: this is the severity of the reaction, which can be Mild, Moderate, or Severe.

6. You can change the Causative agent field by clicking the ellipsis button to go to the Look up Caustic Agent dialog.

7. Select from the drop-down list for the Nature of Reaction field, if needed. The default is Drug.

8. The Signs/Symptoms group box allows you to select one or more signs/symptoms and move them to the Selected field.

   To move a sign/symptom from the Available field to the Selected field, highlight it and then click the right-pointing arrow.

   To move a sign/symptom from the Selected field to the Available field, highlight it and then click the left-pointing arrow.

   To move all of the sign/symptoms from the Selected field to the Available field, click the left-pointing double arrow (no selection is necessary).

9. You can enter any comments about the adverse reaction in the Comments field.

10. Click OK to save your data (otherwise, click Cancel).

    After clicking OK, the new adverse reaction record will display in the Adverse Reaction panel, showing the Agent (Causative Agent) and Reaction (Nature of Reaction). The record also appears on the Patient Postings pop-up. The Status will be UNSIGNED.

> **NOTE**: The new adverse reaction must be signed to be available for display throughout RPMS-EHR. See "Signing Adverse Reaction" on page 14 for more information.

2.8.2 Creating New Causative Agent for Adverse Reactions

You can create a new causative agent for adverse reactions if your search for the agent fails to find any matches.

Figure 2-85: Confirm Confirmation Dialog

1. Click Yes on the Confirm information message to proceed with the adverse reaction process. (Otherwise, click No to exit the process).
2. Click OK on the Look up Causative Agent dialog to process with the adverse reaction entry. (Otherwise, click Cancel to dismiss the dialog).
3. The Create Adverse Reaction dialog displays, with the "new" causative agent in the field.

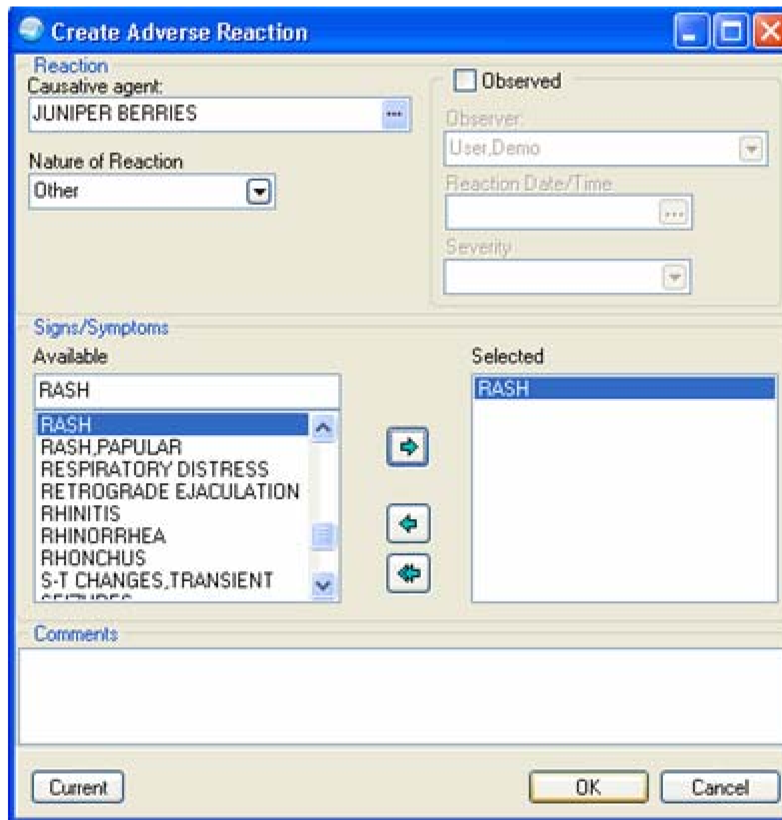


Figure 2-86: Create Adverse Reaction Dialog

4. Complete the Create Adverse Reaction like you would when adding a new adverse reaction. See the section "New Adverse Reaction" on page 10 for more information.

5. Click OK to create the adverse reaction and to have the "new" caustic agent display on the Adverse Reactions component (otherwise, click Cancel).

Adverse Reactions

Agent	Reaction
IBUPROFEN	CONFUSION
JUNIPER BERRIES	RASH
PENICILLIN	ANAPHYLAXIS
PENICILLINS	
TEST DRUG	ANEMIA

Figure 2-87: Adverse Reactions Component

2.8.3 Signing Adverse Reaction

You can sign an unsigned adverse reaction record by right-clicking on the record and then selecting the "Sign Adverse Reaction" option. The Electronic Signature dialog displays.

Figure 2-88: Electronic Signature Dialog

Type your electronic signature in the text box and then click OK. (Otherwise, click Cancel to not sign the selected adverse reaction record.) Signing the adverse reaction record might verify the adverse reaction. See "Verifying Adverse Reactions" for more information.

2.8.4 Verifying Adverse Reactions

Your site can be configured (in RPMS) such that a user can be authorized to verify adverse reaction information. The examples below show how this feature works.

In the following example, provider Carolyn has permission to ENTER and VERIFY adverse reactions. When she signs it, it also verifies the adverse reaction

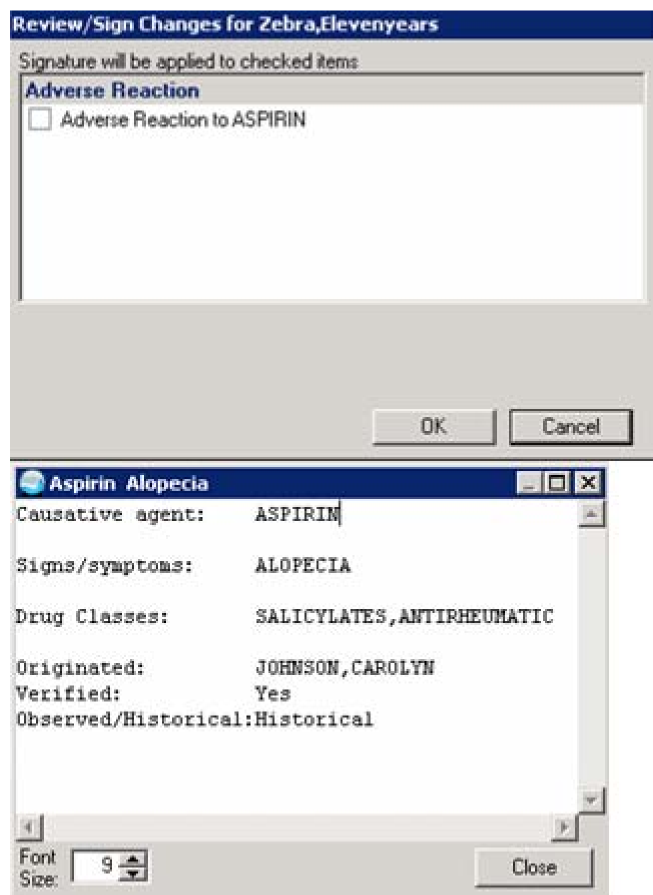


Figure 2-89: Person Can ENTER and VERIFY Adverse Reactions

The same provider will be prompted to verify allergies entered by other providers because the system recognizes that she is a verifier, and the patient has unverified allergies. Notice the prompt is different-it prompts to verify.

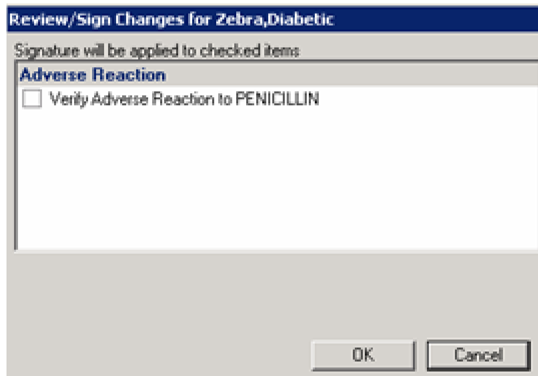


Figure 2-90: Review/Sign Changes Dialog

Provider Tom has permission to enter allergies, but not verify. When he enters an allergy, he gets the following:

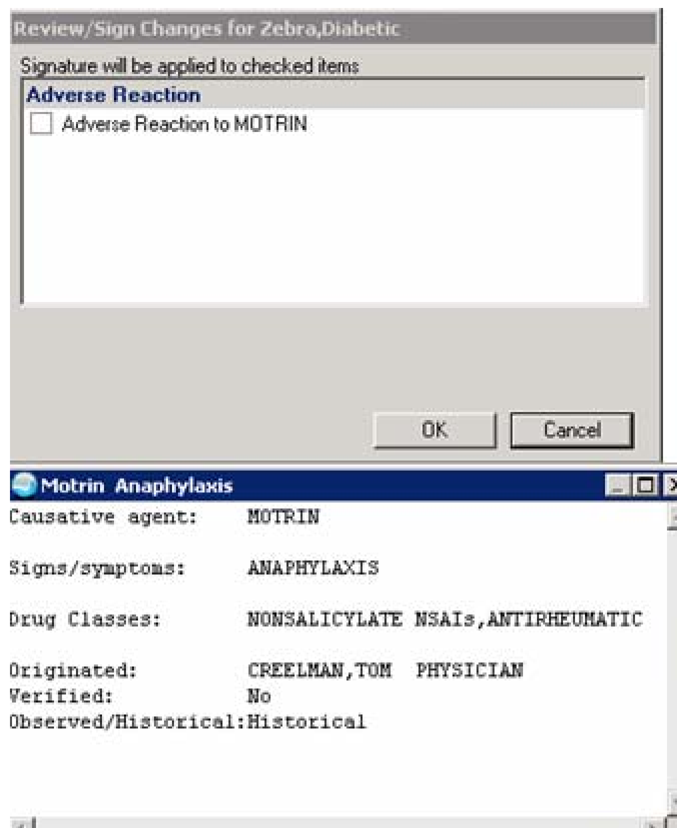


Figure 2-91: Person Can ENTER but not VERIFY Allergies

2.9 Orders

This section provides information on Telephone Orders, Discontinue/Cancel Orders, Release Delayed Orders, and Modify Medication Orders.

2.9.1 Telephone Orders

There are 3 steps to entering a telephone order.

1. Put the ordering doctors name in the Visit box and enter the order
2. Release the order
3. Verify the order.

2.9.1.1 Enter the Order

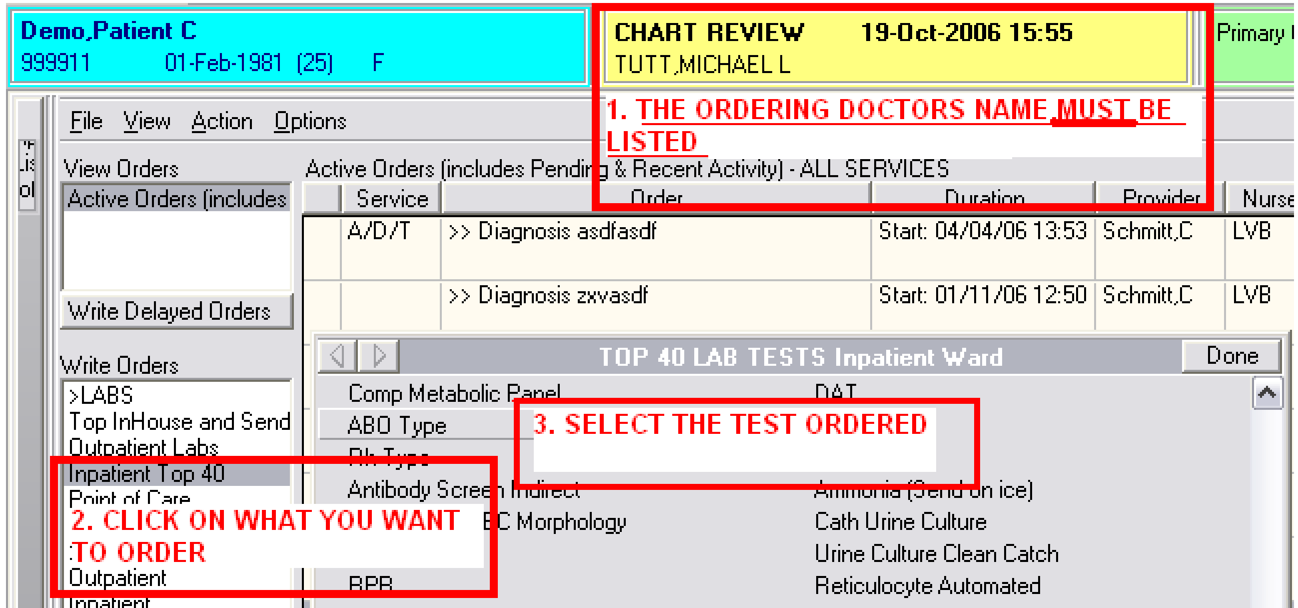


Figure 2-92: Entering the Order

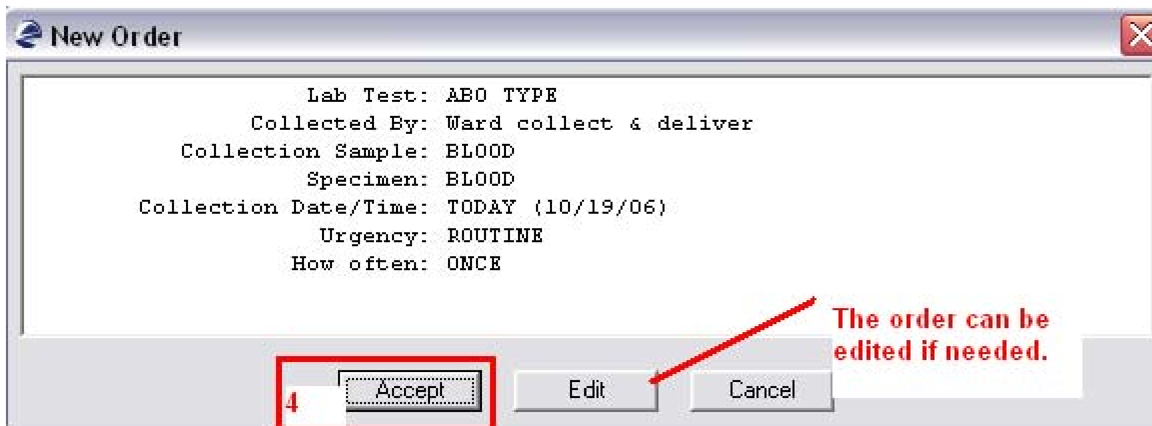


Figure 2-93: New Order Dialog

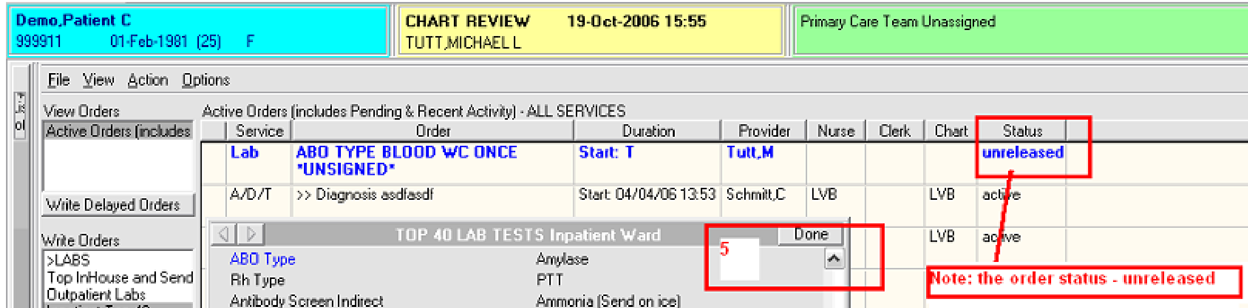


Figure 2-94: New Order Status

2.9.1.2 Release the Order

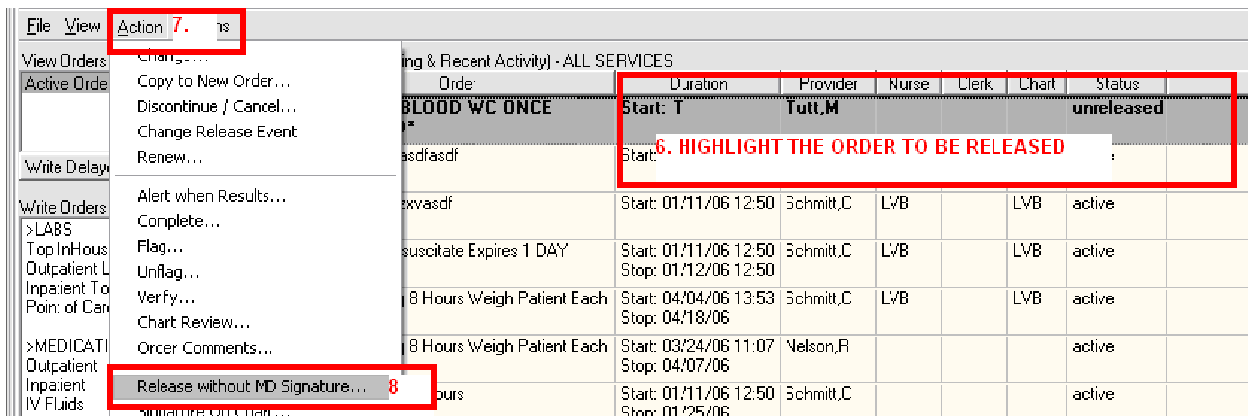


Figure 2-95: Release the Order

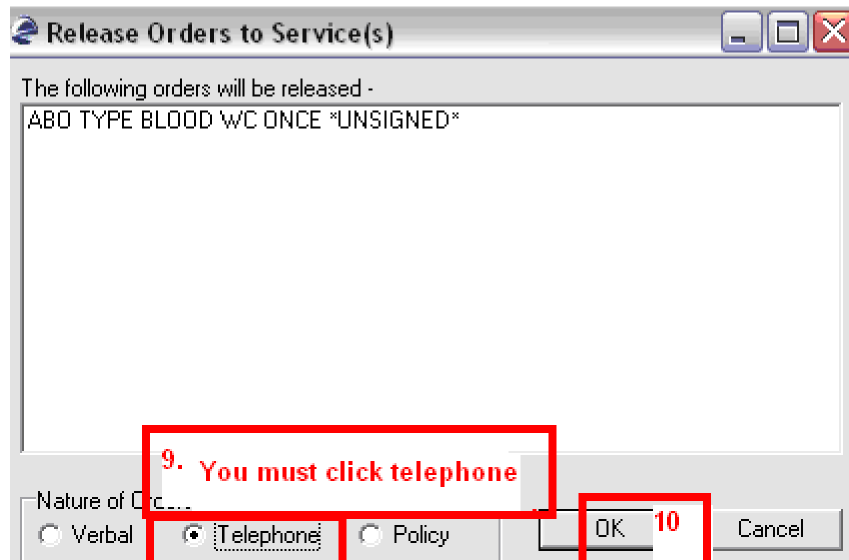


Figure 2-96: Selecting the Nature of the Release

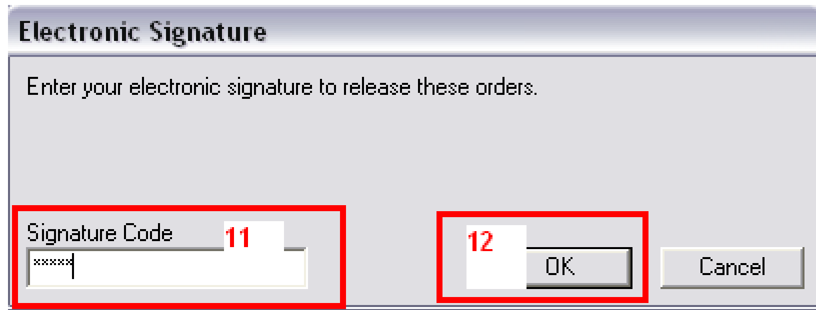


Figure 2-97: Entering Electronic Signature

Active Orders (includes Pending & Recent Activity) - ALL SERVICES

Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
Lab	ABO TYPE BLOOD WC ONCE LB #396866 *UNSIGNED*	Start: 10/19/06	Tutt,M				pending
	1HR GLUCOLA BLOOD SP ONCE LB #390768	Start: 09/26/06	Jones,H				
	HELICOBACTER PYLORI IGA BLOOD SP ONCE LB #388437	Start: 09/18/06	Bilagody,A				
	TSH 3RD GENERATION BLOOD SP	Start: 09/22/06	Spinks,D				pending

Note: the order status is pending. It will remain pending until the results are entered into the lab pakage. Then the status will change to completed.

Figure 2-98: Status Change for Order

2.9.1.3 Verify the Order

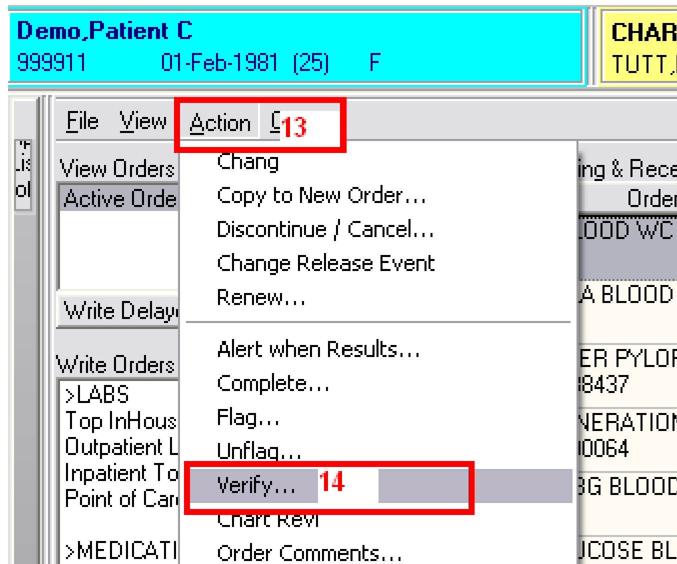


Figure 2-99: Verify Option on Active Menu

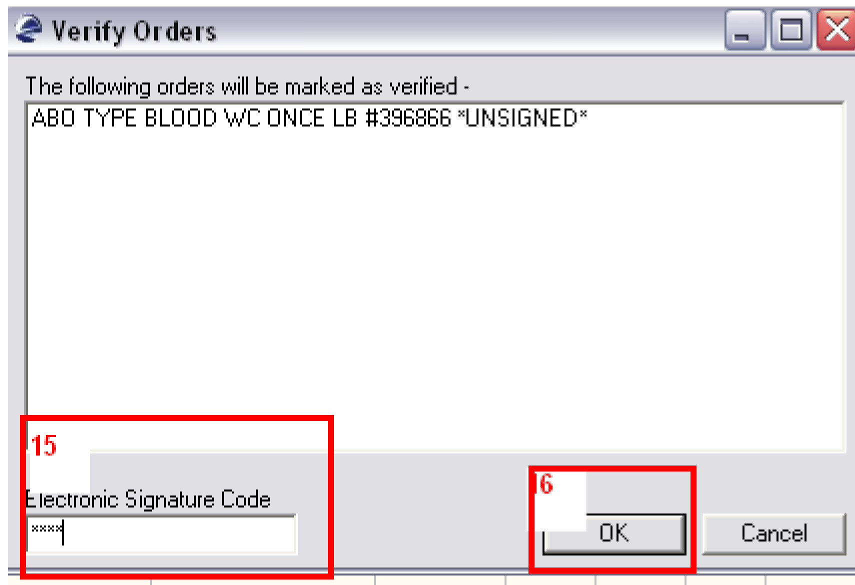


Figure 2-100: Entering Electronic Signature Code

Active Orders (includes Pending & Recent Activity) - ALL SERVICES

Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
	WARFARIN TAB 2MG TAKE ONE AND ONE-HALF BY MOUTH DAILY TO PREVENT BLOOD CLOTS Quantity: 30 Refills: 0	Start: 08/10/05 Stop: 09/09/05	Feldman,L				renewed
Lab	ABO TYPE BLOOD WC ONCE LB #396866 *UNSIGNED*	Start: 10/19/06	Tutt,M	LVB			pending
	1HR GLUCOLA BLOOD SP ONCE LB #390768	Start: 09/26/06	Jones,H				pending

17. THE ORDER IS NOW VERIFIED

Figure 2-101: Order on Orders Tab

2.9.2 24 Hour Chart Check

Active Orders (includes Pending & Recent Activity) - ALL SERVICES

Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
A/D/T	>> Diagnosis asdfasdf	Start: 04/04/06 13:53	Schmitt,C	LVB			active
	>> Diagnosis zxvasdf						
	>> Do Not Resuscitate Expires 1 DAY FROM NOW	Start: 01/11/06 12:50 Stop: 01/12/06 12:50	Schmitt,C	LVB			active
Vitals	>> TPR B/P q 8 Hours Weigh Patient Each Day Please	Start: 04/04/06 13:53 Stop: 04/18/06	Schmitt,C	LVB			active

1. HIGHLIGHT THE ORDERS FOR THE 24 HR CHART CHECK

Figure 2-102: Highlighting Orders

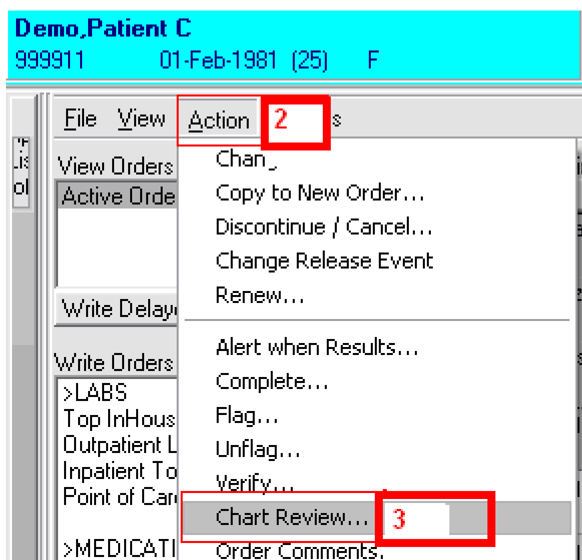


Figure 2-103: Selecting Chart Review Option on Active Menu

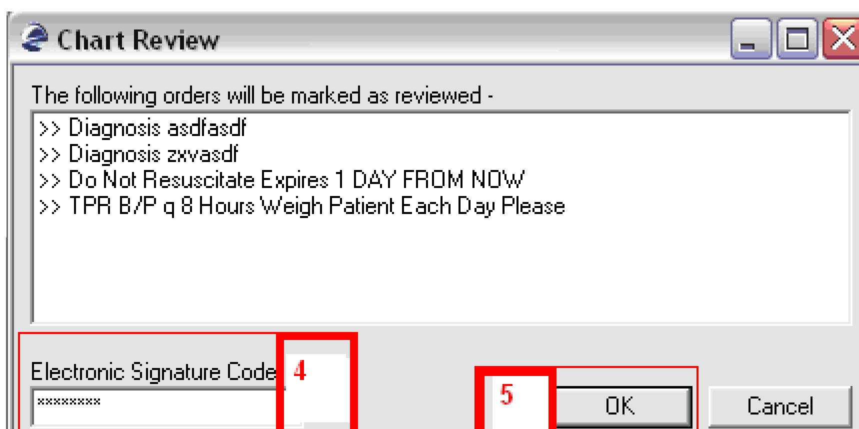


Figure 2-104: Entering Electronic Signature Code

Active Orders (includes Pending & Recent Activity) - ALL SERVICES

Service	Order	Duration	Provider	Nurse	Clerk	Chart	Status
A/D/T	>> Diagnosis asdfasdf	Start: 04/04/06 13:53	Schmitt,C	LVB		LVB	active
	>> Diagnosis zxvasdf	Start: 01/11/06 12:50	Schmitt,C	LVB		LVB	ac
	>> Do Not Resuscitate Expires 1 DAY FROM NOW	Start: 01/11/06 12:50 Stop: 01/12/06 12:50	Schmitt,C	LVB		LVB	ac
Vitals	>> TPR B/P q 8 Hours Weigh Patient Each Day Please	Start: 04/04/06 13:53 Stop: 04/18/06	Schmitt,C	LVB		LVB	active

6. THE ORDERS NOW HAVE THE 24 HR CC DONE.

Figure 2-105: Order on Orders Tab

2.9.3 Discontinue/Cancel Orders

When discontinuing orders the nurse must indicate the reason.

- Obsolete Order: The nurse sending a patient to OR discontinues all the current orders. Per Hospital Policy orders are cancelled when a patient goes to the OR - the orders become “obsolete” - and new post op orders must be written - or

entered in the EHR by the Doctor. (The doctor will usually do Delayed Inpt Post-Op orders to be released when the patient returns from OR).

- Requesting Physician Cancelled: Use when a doctor gives a telephone order to cancel an order.
- Duplicate Order and Entered in Error: – use if applicable.

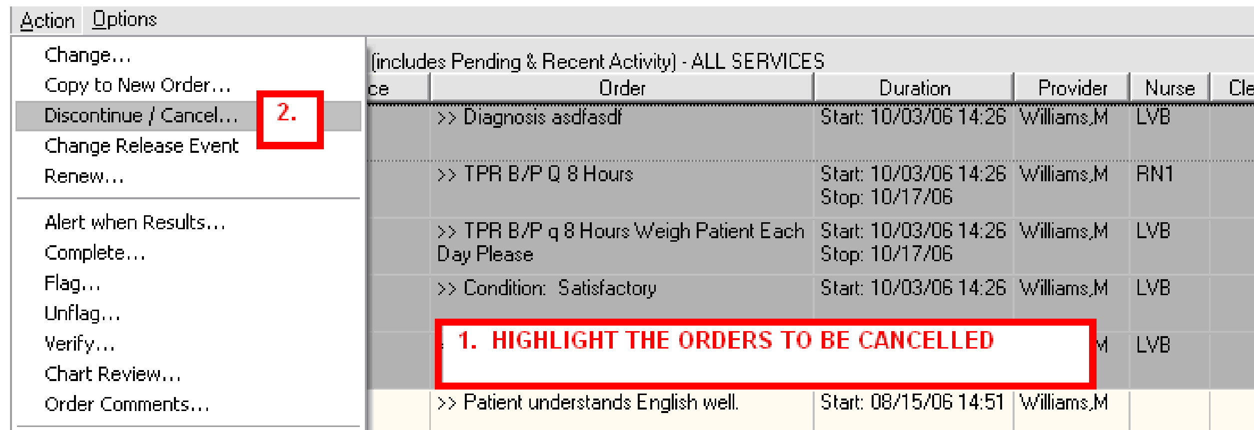


Figure 2-106: Highlighting Orders to Cancel

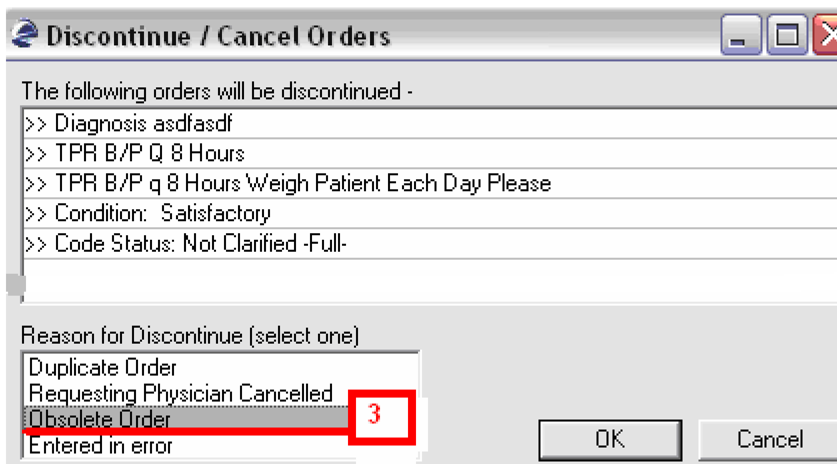


Figure 2-107: Discontinue/Cancel Orders Dialog

2.9.4 Release Delayed Orders

Figure 2-108: Delayed Transfer Orders

Figure 2-109: Delayed Orders Listing

Figure 2-110: Highlighting the Orders to be Released

2.9.5 Modifying Medication Orders

Telephone orders

1. The ORDERING DOCTORS NAME MUST be in the Visit box.
2. Enter the order
3. Release without MD signature
4. Verify the orders
5. Chart Review if working ND.

Use of CHANGE

"Change" is used when changing a medication dose, frequency, or route.

They can also use it to change an IV Fluid.

Read your orders carefully

- If a nurse is trying to "double guess" what an order means - it may be a system error that needs correcting.
- If a nurse has any questions or does not understand the order please do one or all of the following. Do not guess, assume or try to figure it out for yourself – this leads to errors. Do one or all of the following:

1. Talk to the doctor for clarification.
2. Talk to the pharmacist

The process is:

- Select the medication order.
- Right-click and select Change.
- Type in the changes you want to make.
- Here is what the "changed" order will look like:

IV Fluids	Change DEXTROSE 5%/0.45%NS/ 40MEQ KCL (1000ML) INJ,SOLN 1000 ml 125ml/hr@0 to DEXTROSE 5%/0.45%NS/ 40MEQ KCL (1000ML) INJ,SOLN 1000 ml 100ml/hr@0	Start: 01/29/07 15:30 Stop: 02/01/07 24:00	Shankel,W				active	

Figure 2-111: Changed Order on List

2.10 Printing a Medication Administration Record (MAR) from RPMS

```
Select IHS Core Option:
    1    24 Hour MAR
    2    7 Day MAR

24 Hour MAR
Select the MAR forms: 3//   Print both Blank and Non-Blank MARs
   (?? to display what MAR form can be printed)


Enter START DATE/TIME for 24 hour MAR: T@0700  (FEB 22, 2008@07:00)  ←Site decision

Select by WARD GROUP (G), WARD (W), or PATIENT (P): pATIENT

Select PATIENT:
  DEMO,MOTHER R                          <AD>   F 09-02-1957 332445454  SOUC 3423

Select another PATIENT:
```

```
Enter medication type(s): 2//  ←Type ?? to display what medication types can be
printed

Select PRINT DEVICE:  ←Enter the print device name here
```

7 Day MAR

```
Select the MAR forms: 3//   Print both Blank and Non-Blank MARs

Select TYPE OF SHEETS TO PRINT: BOTH//

Enter START DATE/TIME for 7 day MAR: T@0700  (FEB 22, 2008@07:00:00)

Select by WARD GROUP (G), WARD (W), or PATIENT (P): WARD

Select WARD: ??  ← Site specific

   Choose from:
   GENERAL
   ICU
   NURSERY
   OB WARD
   PEDS WARD

Select WARD: GENERAL


Do you want to sort by Administration Team (Y/N)? NO// NO

Do you wish to sort by Room-Bed (R), Patient (P): R// Room-Bed


Enter medication type(s): 2//

Select PRINT DEVICE:  ← Enter the print device name here
```

2.11 Printing MAR Labels from EHR

For new medication orders or changes in medication order print MAR labels from EHR and place these in the patient MAR.

Do not print label until after the medication order has been processed by Inpatient Pharmacy and the order status is Active.

Order tab → highlight the medications orders you want

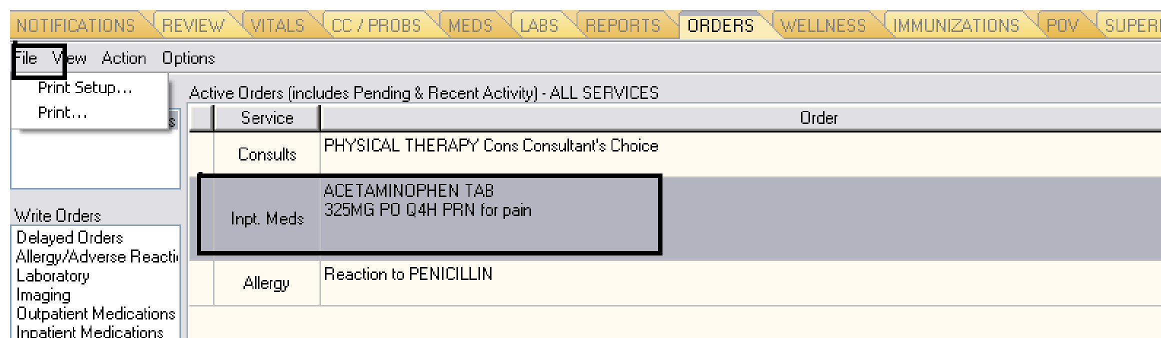


Figure 2-112: Highlighting the Medication Orders

- Select File → Print
  Check Labels check box

  The Print device can be set to a default printer

  (If no device printer contact the CAC to set up this).

  Click Print All Checked Items

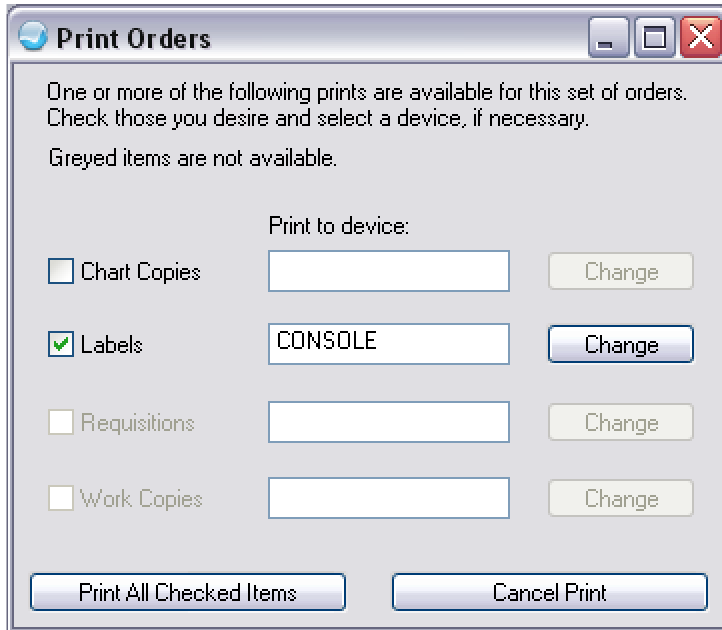


Figure 2-113: Print Orders Dialog

NOTE: Cancel Print only dismisses the Print Orders dialog. This button does not cancel any printing.

3.0 Clerks

This section describes various topics for Clerks.

3.1 Patient Selection

You can select a patient in one of two ways:

a. Select Patient → Select.

Figure 3-1: Selecting the Select Option on Patient Menu

b Single click on the Patient Name component.

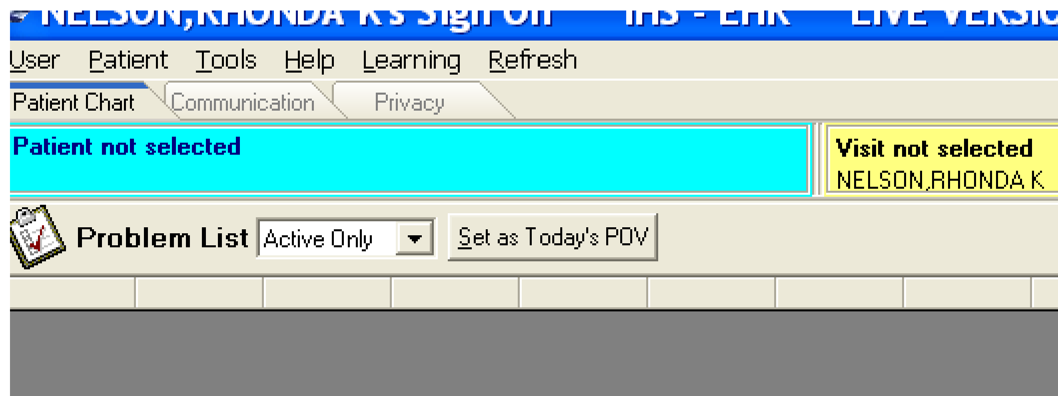


Figure 3-2: Clicking the Patient Name

In either case, the Patient Selection dialog displays.

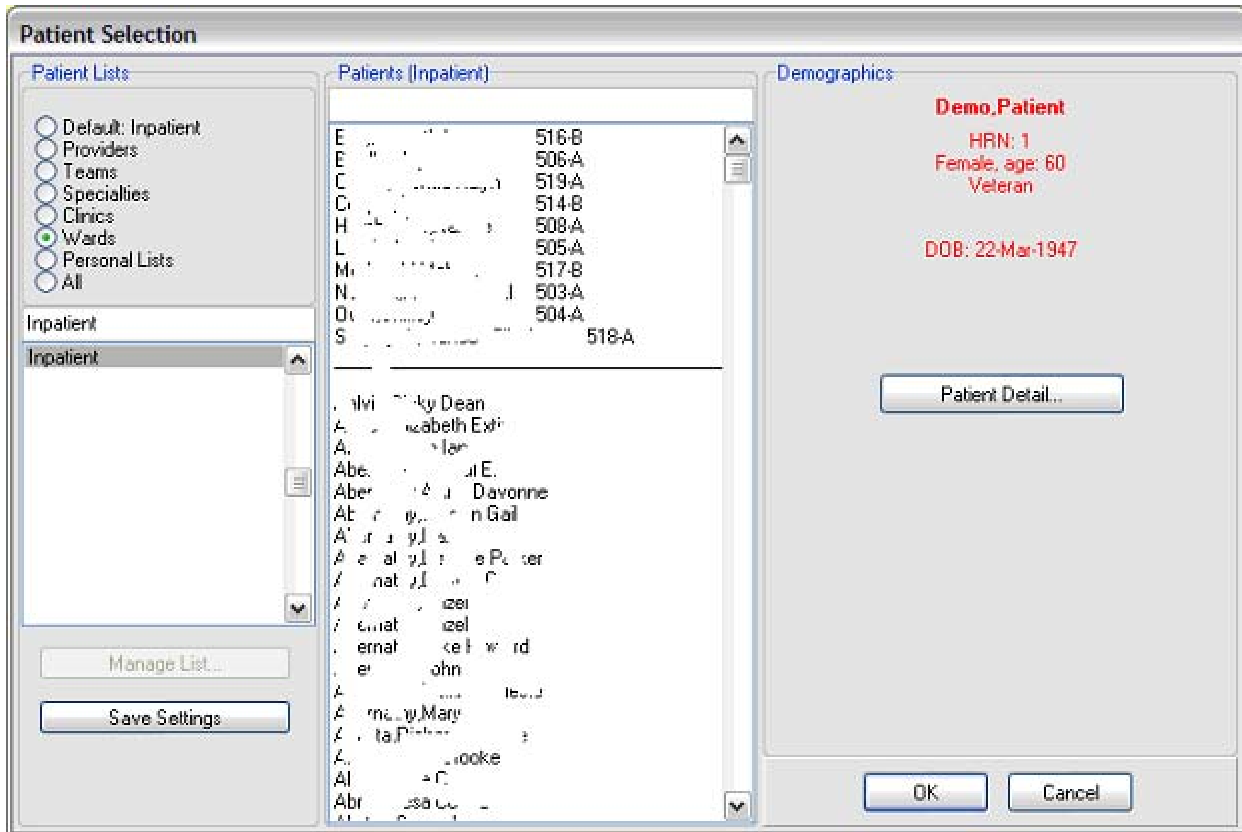


Figure 3-3: Sample Patient Selection Dialog

The following might be the easiest way to find the patient that is already admitted through ADT.

a. By LastName, FirstName

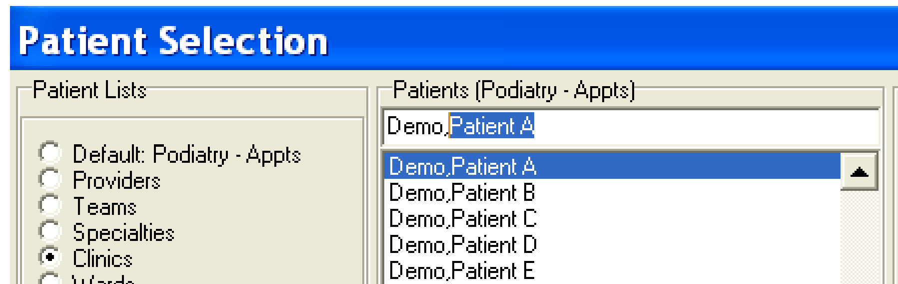


Figure 3-4: Finding Patient by Name

b. By Birth Date

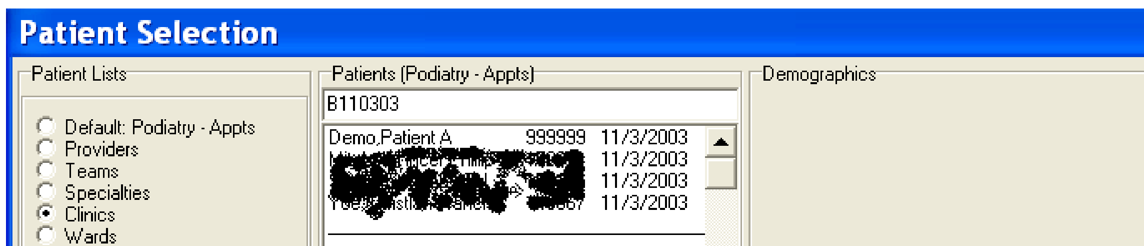


Figure 3-5: Finding Patient by Birth Date

c. By Chart Number

Figure 3-6: Finding Patient by Chart Number

3.2 Visit Selection

The visit will default to the patient's current inpatient location, if admitted through ADT.

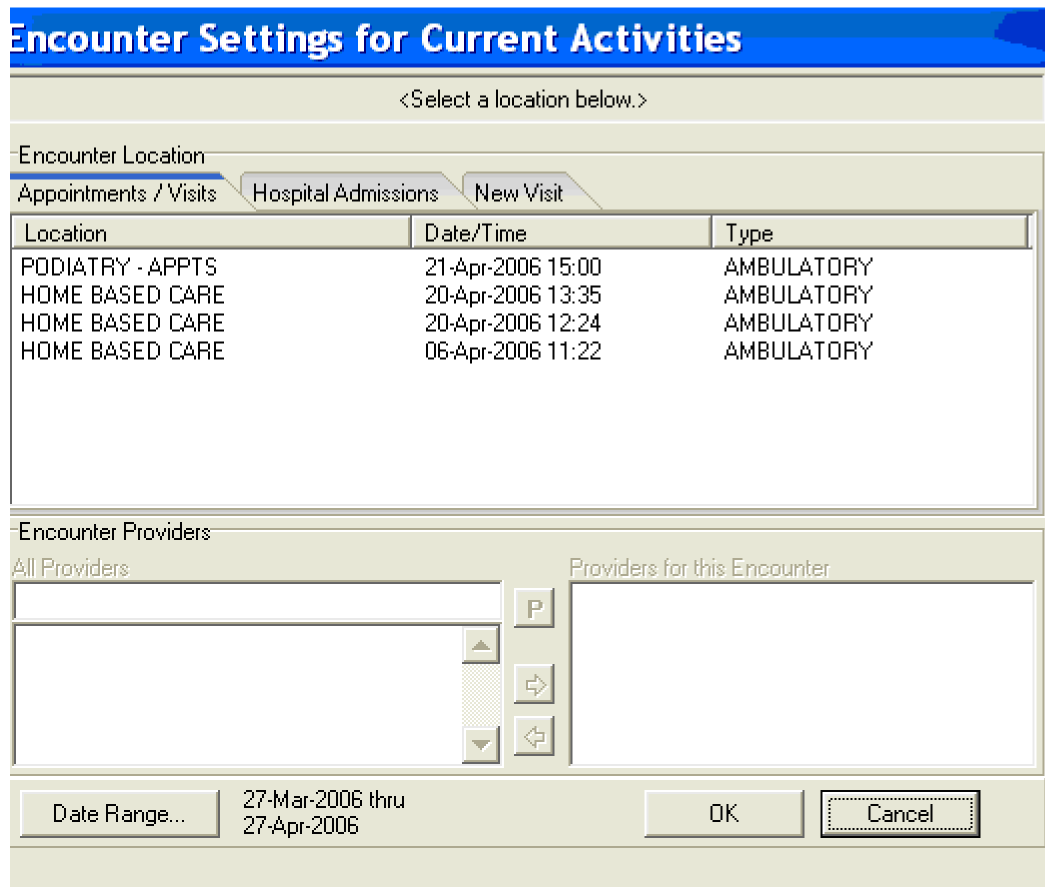


Figure 3-7: Selecting a Visit

In certain situations, you might have to use the Hospital Admissions tab to view the visit.

3.3 How to View Notes

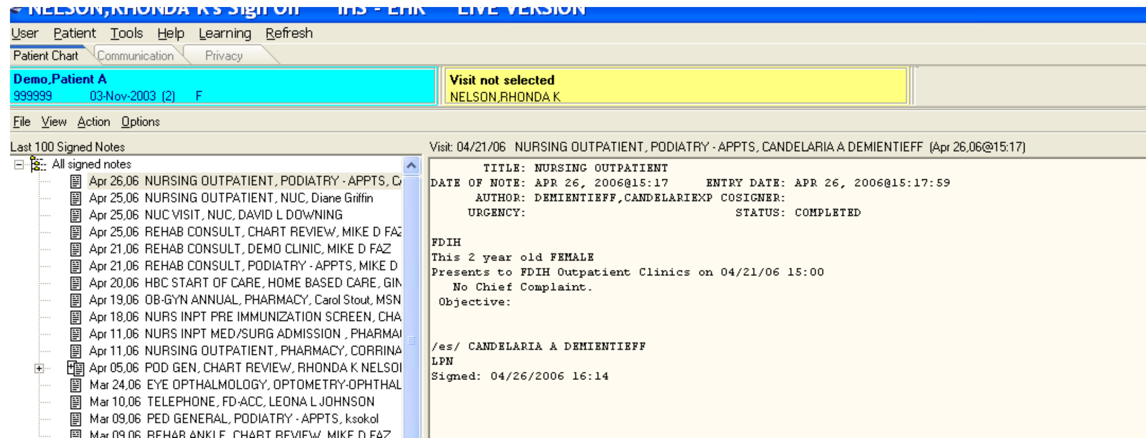


Figure 3-8: Viewing Notes List on Notes Tab

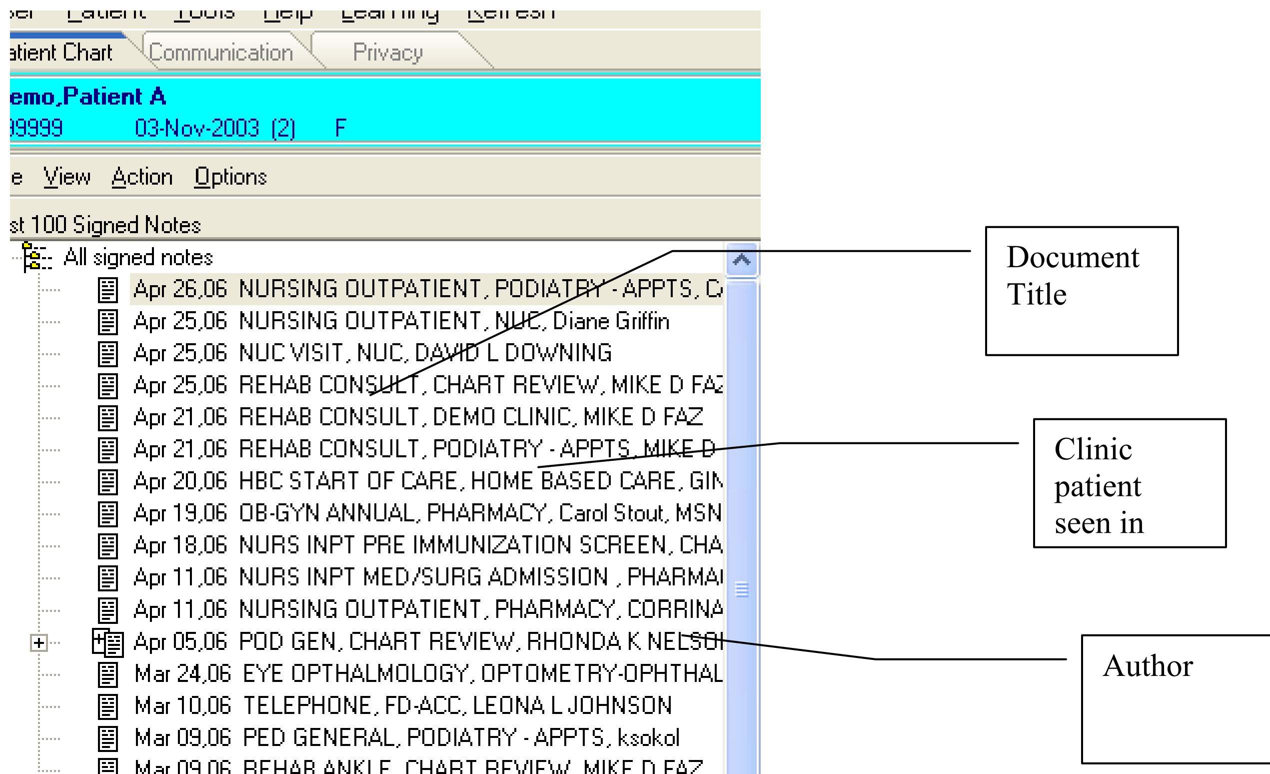


Figure 3-9: Parts of the Notes Information

3.4 View Discharge Summaries

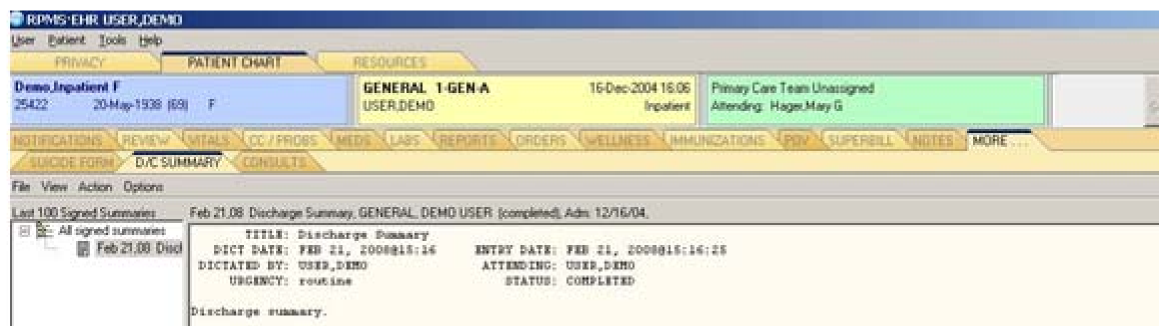


Figure 3-10: Viewing the Discharge Summaries for Patient

3.5 Cover Sheet

The Appointments and Visits panel on the Cover Sheet shows the appointment history.

Appointments and Visits

Appointment/Visit	Date	Status
01GENERAL	16-Feb-2005 11:47	AMBULATORY
01GENERAL	18-Jan-2005 13:01	AMBULATORY
01GENERAL	14-Jan-2005 13:51	AMBULATORY
01GENERAL	25-Aug-2004 10:14	AMBULATORY
01GENERAL	13-Aug-2004 14:40	AMBULATORY
01GENERAL	08-Jul-2004 16:24	AMBULATORY
01GENERAL	21-May-2004 14:37	AMBULATORY
39 PHARMACY	28-Apr-2004 12:00	AMBULATORY
01GENERAL	19-Apr-2004 11:26	AMBULATORY
39 PHARMACY	15-Apr-2004 12:00	AMBULATORY
01GENERAL	14-Apr-2004 13:28	AMBULATORY
05 DERMATOLOGY	14-Apr-2004 10:04	AMBULATORY
39 PHARMACY	14-Apr-2004 10:04	AMBULATORY
05 DERMATOLOGY	06-Apr-2004 10:10	AMBULATORY
01GENERAL	02-Apr-2004 10:21	AMBULATORY
39 PHARMACY	24-Mar-2004 08:35	CHART REVIEW
39 PHARMACY	24-Mar-2004 08:29	AMBULATORY

Figure 3-11: Appointments and Visit Component on Cover Sheet

3.6 Printing from EHR

You print a note using the options on the File menu.

3.6.1 Printer Setup

This might NOT be necessary if the printer has been setup before.

1. To setup the printer, select File → Print Setup.
2. The Printer Selection dialog displays.

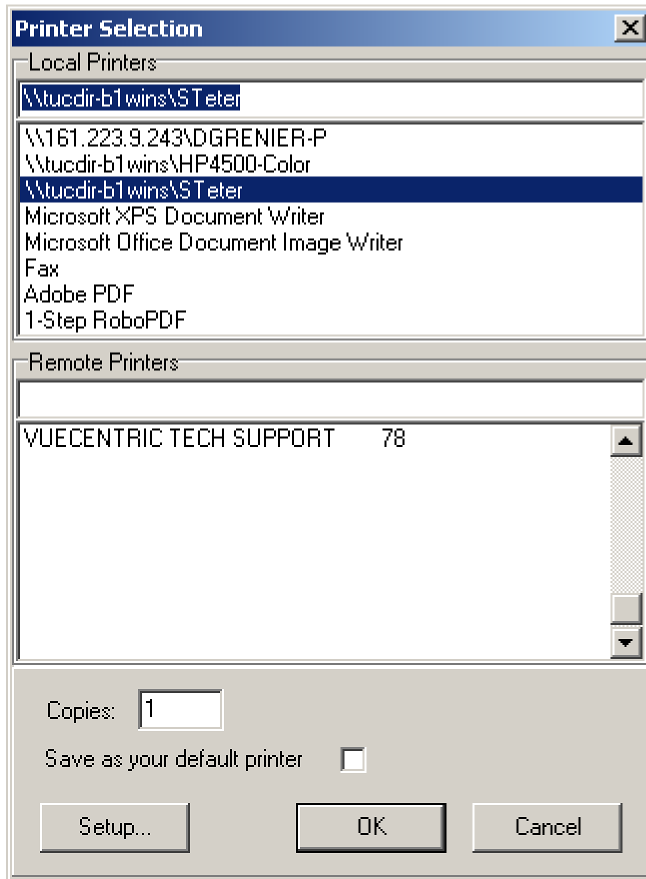


Figure 3-12: Sample Printer Selection Dialog

Highlight the printer to output the note.

3. Click OK.

3.6.2 Print Note

1. Highlight the note to print.
2. Select File → Print to display the Print dialog.

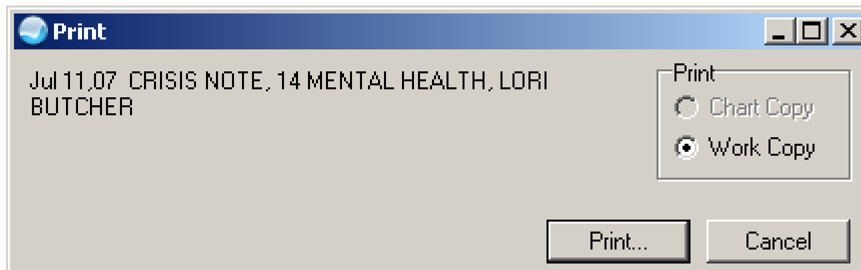


Figure 3-13: Print Dialog

3. Make sure the correct note is shown on the dialog.
4. Click Print to output the contents of the note.

3.7 Dragging a Note

Notes can be moved into folders. The folders organize the notes that belong together.

- Highlight the note title
- Left-click on this note title and hold the click → drag the mouse cursor down onto INPT NURSE SHIFT (D) and then release the click.
- Answer Yes to the Confirm Attachment Message

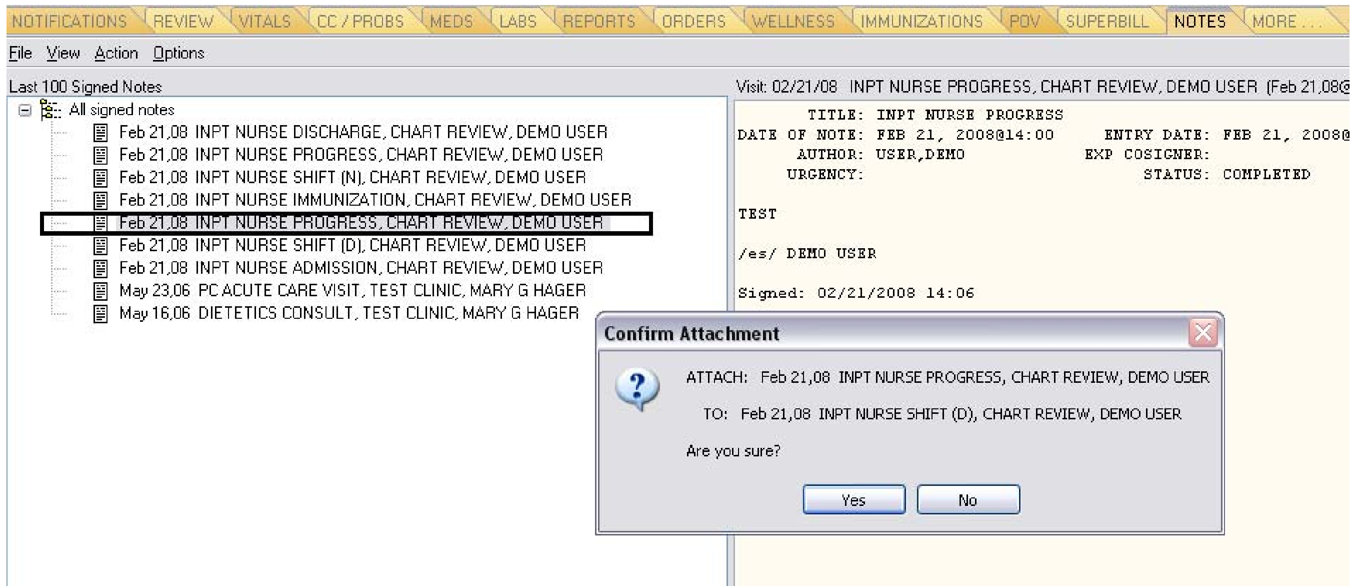


Figure 3-14: Confirm Attachment Confirmation

The folder now "appears"

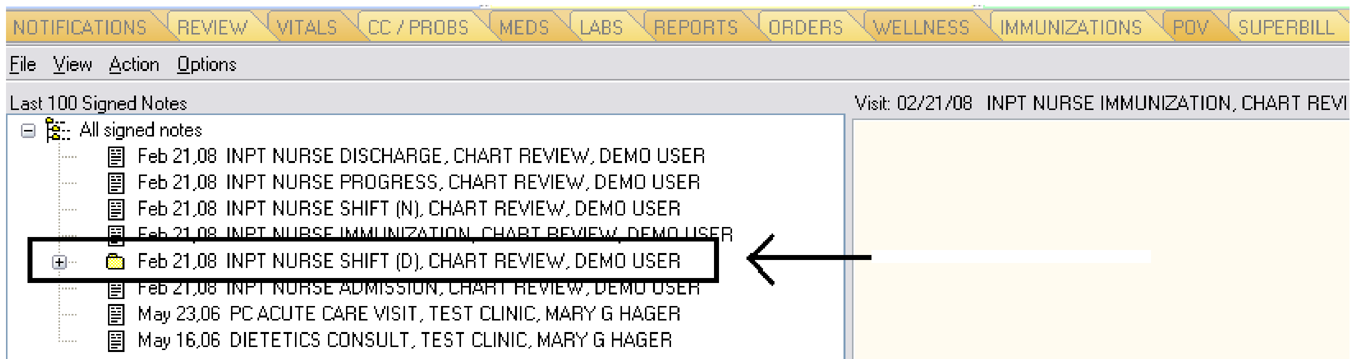


Figure 3-15: New Folder

In the example below look at how the screen changed after all the notes titles for 24 hrs have been dragged into the folder.

The INPT NURSE ADMISSION note cannot be dragged into the folder; it stands alone.

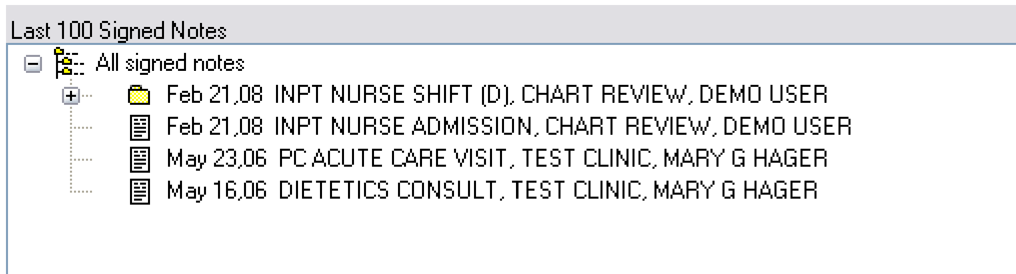


Figure 3-16: Folder with Notes

To view the notes in the folder click on the + sign.

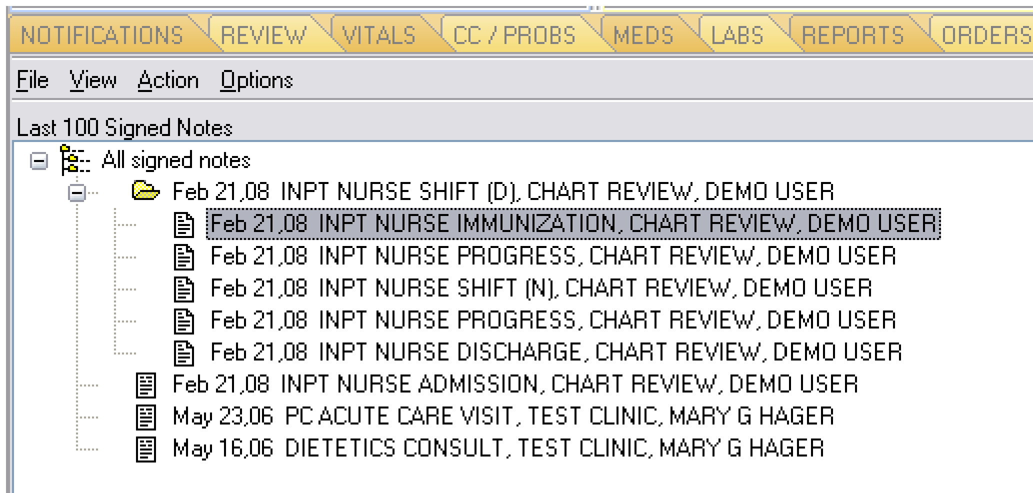


Figure 3-17: Notes in Folder

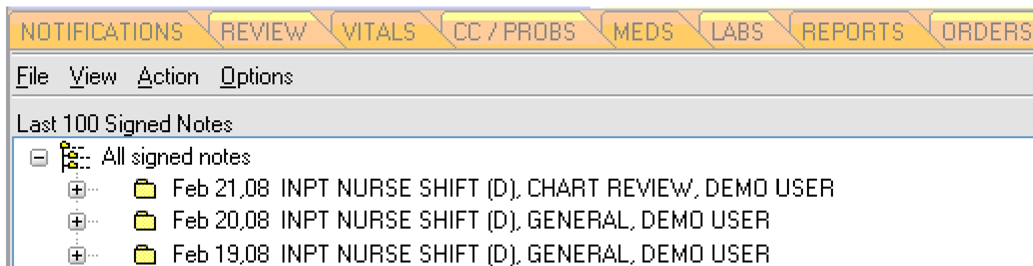


Figure 3-18: Collapsing the Folder

3.8 Attaching a Note

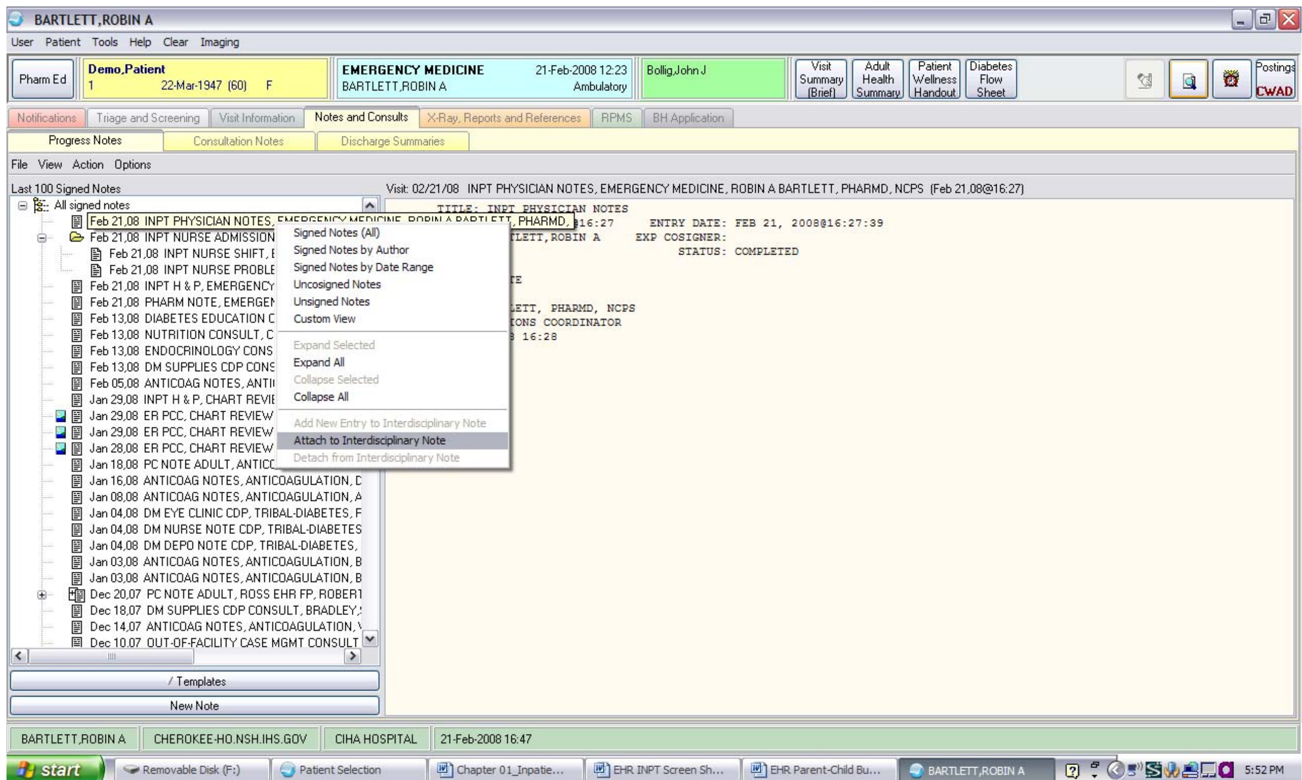


Figure 3-19: Attach Note Option

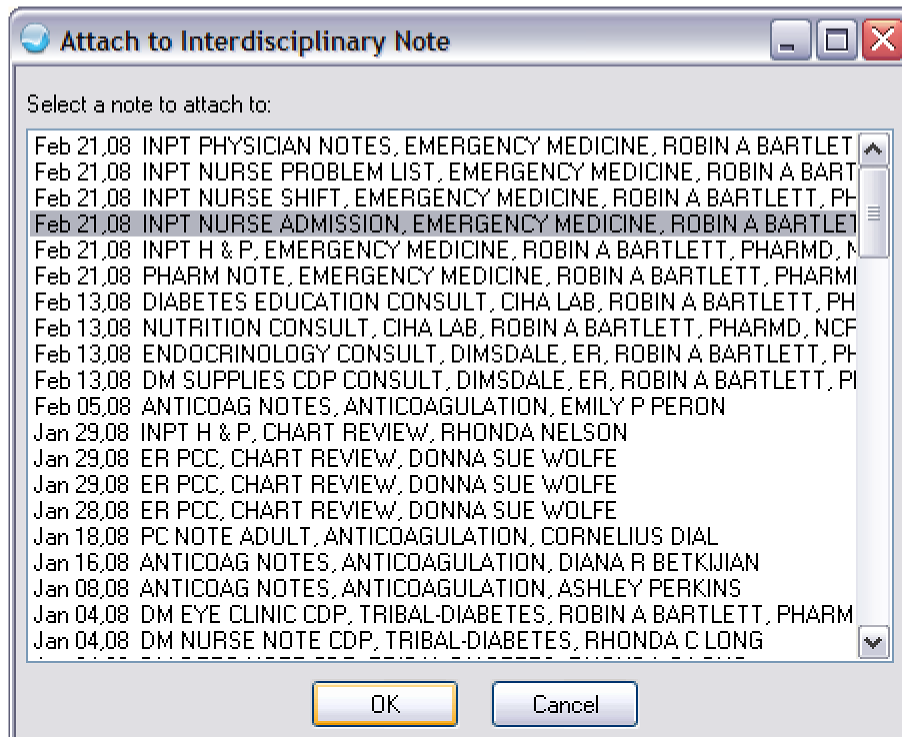


Figure 3-20: Attach to Interdisciplinary Notes Dialog

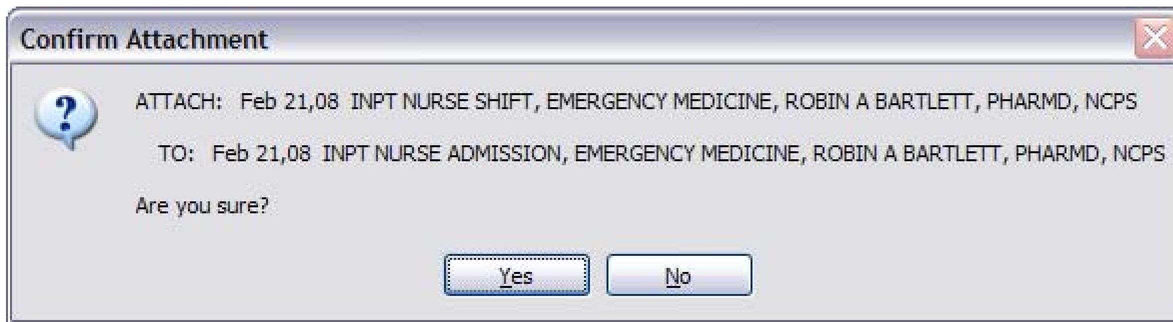


Figure 3-21: Confirm Attachment Confirmation

3.9 Printing Interdisciplinary Notes

To print an individual note that is in a folder, it first must be detached from the folder.

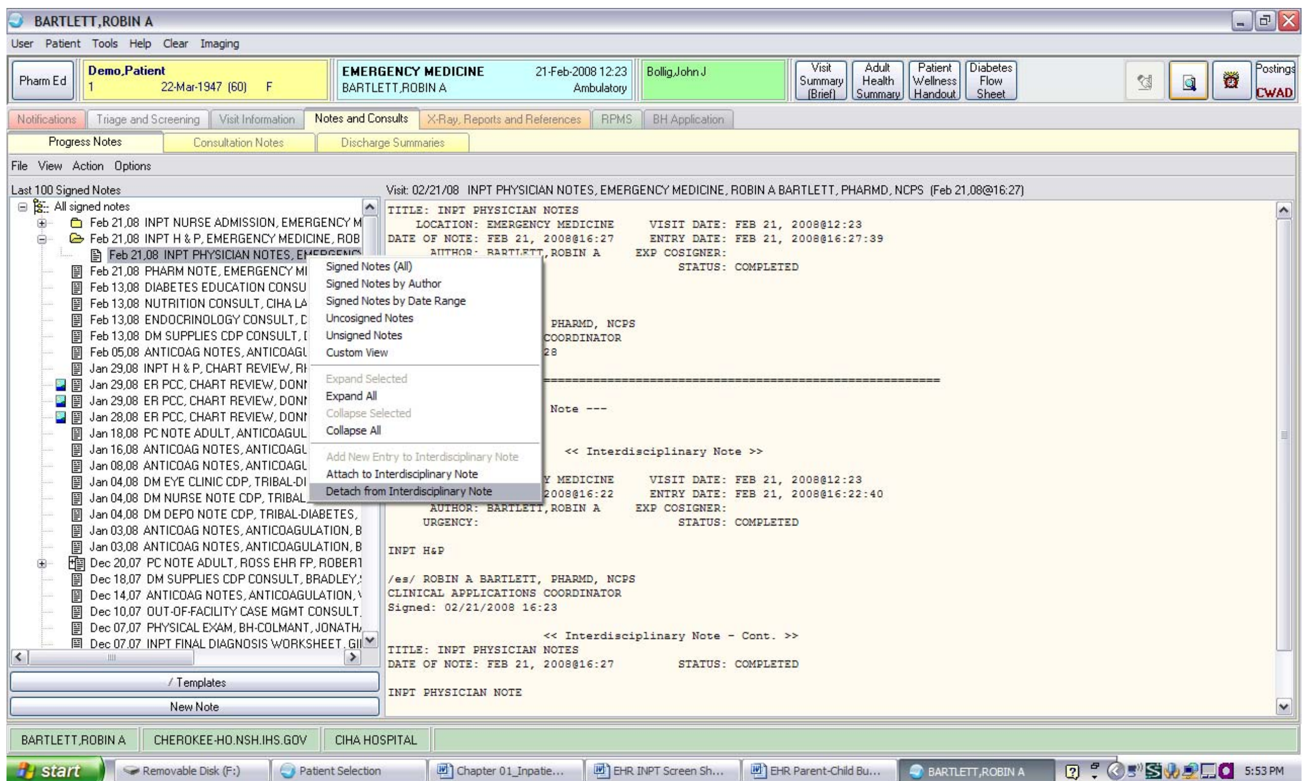


Figure 3-22: Detach from Interdisciplinary Note Option

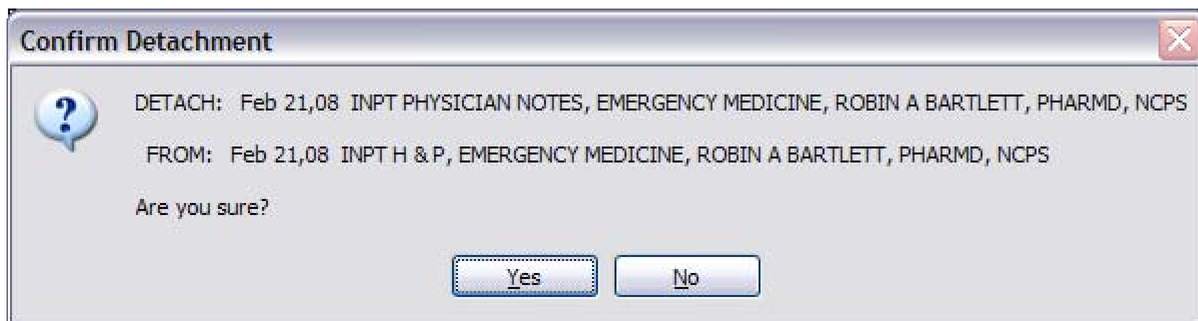


Figure 3-23: Confirm Detachment Confirmaton

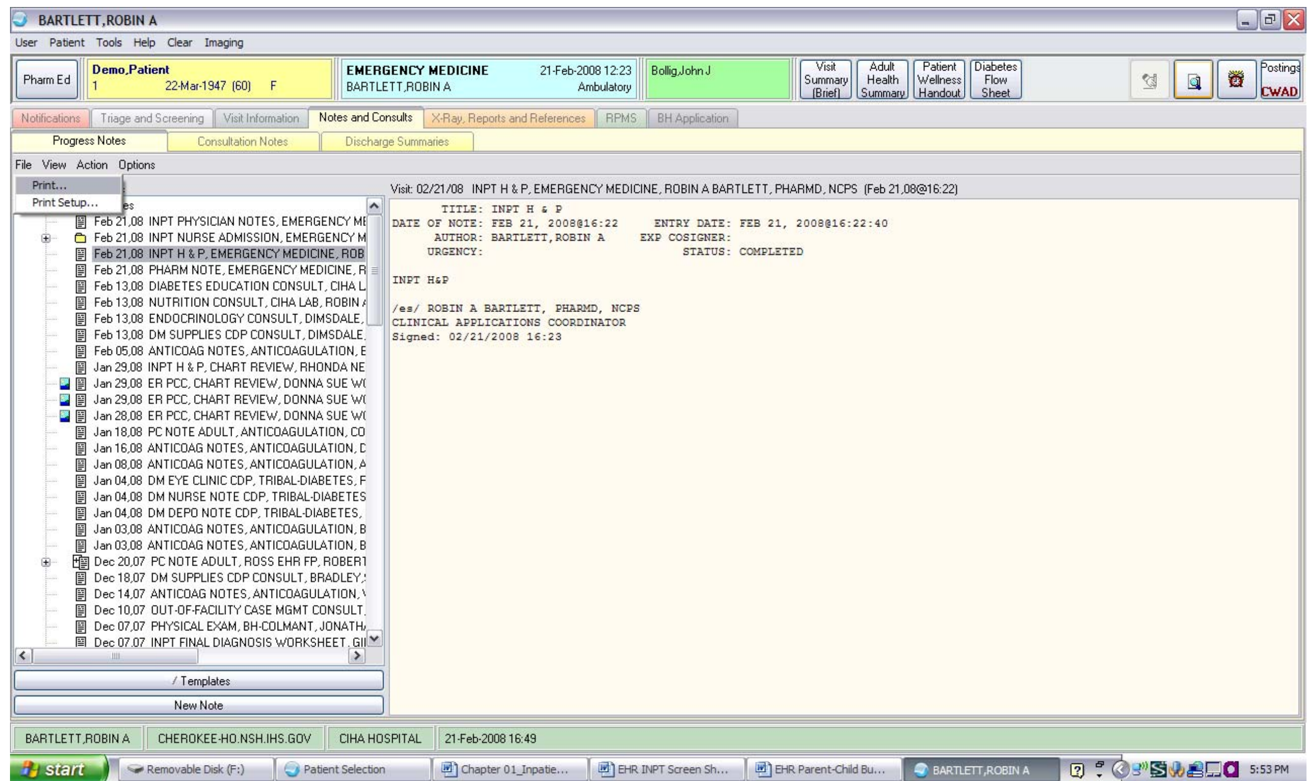


Figure 3-24: Selecting the Print Command on File Menu

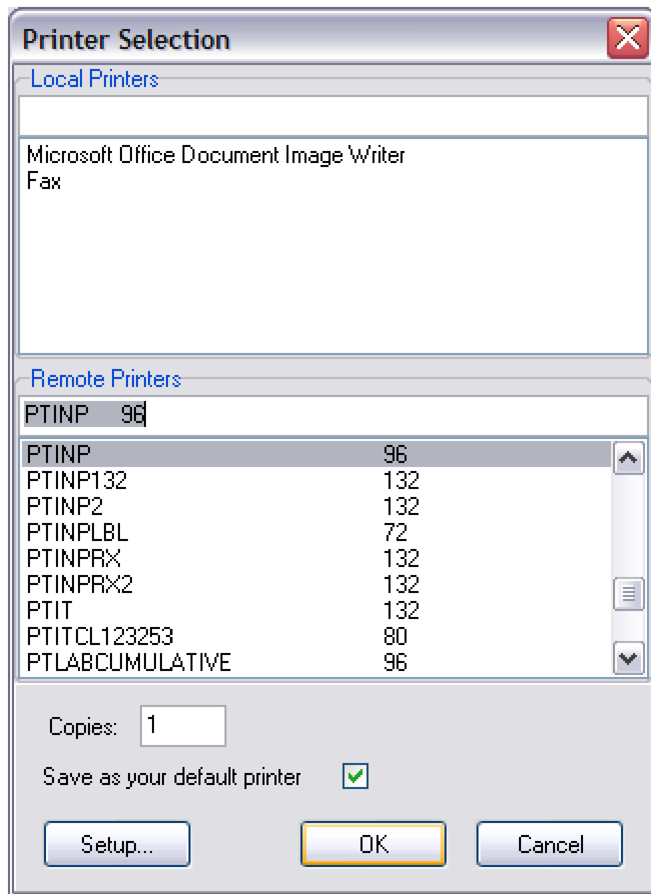


Figure 3-25: Printer Selection Dialog

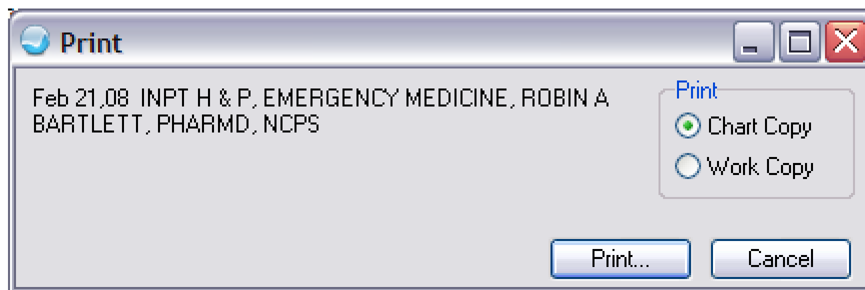


Figure 3-26: Print Dialog

3.10 ADT Considerations

EBC (Extended Bed Control) is used to make corrections to admissions.

Do not use ADM (Admission Bed Control) to change the admission or it will delete delayed orders.

Use switch bed in order to move patients within same ward.

4.0 Appendix A

This section describes competency documentation, General Information and User Acknowledgement Form, Prompts Only Documents, Scavenger Hunt for Providers, Pocket Guide, Daily Check List, and EHR Audit Form.

4.1 Competency Documentation

This section shows several types of competency forms.

4.1.1 Nursing Location Competency Form

The entire competence form appears on the next page.

EHR COMPETENCY – LOCATING INFORMATION IN EHR

STAFF NAME: ___________________________________ POSITION & UNIT: _____________________

Instructor/Evaluator: DATE: ________________________________

Self Evaluation	How Competency/Skill is Evaluated	Experience Level
1. Have not experienced before. 2. Know principle, but haven't actually performed. 3. Have performed but not recently, need review. 4. Fee comfortable and competent in activity/skill.	Competency will be validated by:: • Direct observation (D), • Simulation (S), • Return demonstration (RD) • Test (T) • Class (C) Use the appropriate letter in the column How Evaluated	1. Acquired some experience (may require practice, assistance). 2. Competent and/or can perform independently. 3. Competent, performs independently, and is able to teach and/or assess the competency of others.

Self Evaluation	Skills Competency – Locate Information in EHR Goal: Staff member gave successful return demonstration and this person is competent to locate information in EHR. Reference per Guides to Documenting in EHR.	How Evaluated	Experience Level
	Posting WAD - Identify location and states information contained here.		
	Cover Sheet - Identify components on this tab		
	Notifications - States understanding that notifications relevant to the EHR user are listed here.		
	Notes - Demonstrates how to view notes by <u>author</u> and <u>note title</u> (custom view) - States understanding of a + sign (addendum) and use of.		
	Orders - States understanding that doctors and nursing orders are here.		
	Medication - Identifies inpatient and outpatient medications.		
	Wellness - Identifies components: immunizations due, contraindication, immunization history, skin history, health factors (GPRA indicators), education, exams.		
	PROB/POV - States understanding this tab contains patient's purpose of visit. (Inpt nursing does not enter information here).		
	Services - States understanding this tab contains services patient received. (Inpt nursing does not enter information here).		
	LAB - Demonstrates viewing cumulative labs & printing labs. - Demonstrates selecting a specific lab type (e.g., microbiology). - Demonstrates using the "Date Range".		
	Reports - Demonstrates viewing patient Health Summary/FT.D Adult Regular.		
	D/C Summary - Doctor's discharge summaries go here.		
	Consult - Consultation notes go here.		
	Triage - Vital signs and chief complaints entered here (primarily outpt use).		
	Successful return demonstration of the above was given by staff member and this person is competent to perform these entries in EHR. **Staff Signature:** **Trainer Signature:**		

4.1.2 Nursing Note Competency Form

The entire competence form appears on the next page.

E H R C O M P E T E N C Y - NOTES

STAFF NAME: ______________________________ POSITION: ________________

DATE: __________

Instructor/Evaluator:

Self Evaluation	How Competency/Skill Is Evaluated	Experience Level
1. Have not experienced before. 2. Know principle, but haven't actually performed. 3. Have performed but not recently, need review. 4. Feel comfortable and competent in activity/skill.	Competency will be validated by: Direct observation (D), Simulation (S), Return demonstration (RD) Test (T) Class (C) Use the appropriate letter in the column How Evaluated.	1. Acquired some experience (may require practice, assistance). 2. Competent and/or can perform independently. 3. Competent, performs independently, and is able to teach and/or assess the competency of others.

Self Evaluation	Skills Competency – Document nursing notes Goal: Staff member gave successful return demonstration and this person is competent to document nursing notes on the Notes tab in EHR. (Reference per Guides to Documenting in EHR.)	How Evaluated	Experience Level
	Demonstrates selecting a nursing note title		
	Demonstrates selecting a template to use with a nursing note title in My Templates.		
	Demonstrates saving a note as "unsigned note". Demonstrates editing and deleting an unsigned note.		
	Demonstrates signing a note.		
	Demonstrates adding an addendum to a signed note.		
	States understanding the following: Unsigned notes can be deleted. Signed notes cannot be deleted. Signed notes that are incorrect can be retracted.		
	Note retraction: Demonstrates adding an addendum to a note which states the reason for retraction. States understanding that the Supervisor of Medical Records has to be notified to retract the note. (use email) State: author's name, date/time of note, note title, state an addendum explaining the reason for retraction has been attached to the note.		
	INPATIENT ONLY • States understanding the INPT NURS SHIFT (D) is the note title that all other inpatient nursing notes are dragged into. Doing this will create a folder with 24 hrs of nursing notes from 0700hr - 0659 hr the next day. (a day and a night shift) • Demonstrates dragging notes into the Inpt Shift (d) title. • The exception is the admission note that stands alone.		
	Successful return demonstration of the above was given by staff member and this person is competent to perform these entries in EHR. Staff Signature: Trainer Signature:		

4.1.3 Nursing Immunization Competency Form

The entire competence form appears on the next page.

RPMS Immunization Package

Staff Name: ______________________________
Date: ___________________________________

RN able to:	Proficient (Yes/No)	Trainers Comments
1. Sign onto RPMS.		
2. Select Immunization Package (IMM).		
3. Select Patient Menu (PAT).		
4. Select Single Patient Record (SGL).		
5. Complete entering data in the following fields of the Single Patient Record.		
A – Add immunization		
S – Sink Test Add		
E – Edit Visit		
D – Delete Visit		
I – Imm Serve Profile		
H – Health Summary		
P – Patient Edit		
C – Contraindication		
L - Letter Print		
RN understands:		
1. The use of "??".		
2. The use of PCC Category "Inpatient" vs "Historical" vs "Ambulatory".		
The need for accuracy when inputting the vaccine given.		

Staff comment:
____
____
Does the RN require further training or supervision? (Yes/No) __________________
(If yes, refer back to Nursing CAC).

Trainer's Name & Signature: ______________________________
RN Signature: ____

4.1.4 Nursing Vitals and Allergies Competency Form

The entire competence form appears on the next page.

Nursing Vitals and Allergies Competency Form

STAFF: ______________________ Position & Unit: ______________________

INSTRUCTOR/EVALUATOR: ______________________ Date: ______________________

Self Evaluation	How Competency/Skill Is Evaluated	Experience Level
1. Have not experienced before. 2. Know principle, but haven't actually performed. 3. Have performed but not recently, need review. 4. Feel comfortable and competent in activity/skill.	Competency will be validated by: Direct observation (D), Simulation (S), Return demonstration (RD) Test (T) Class (C) Use the appropriate letter in the column How Evaluated.	1. Acquired some experience (may require practice, assistance). 2. Competent and/or can perform independently. 3. Competent, performs independently, and is able to teach and/or assess the competency of others.

Self Evaluation	Skills Competency – Documenting Vital Signs & ADR/Allergies Goal: Staff member gave successful return demonstration and this person is competent to document vital signs, ADR/Allergies. (Problems on triage - outpatient clinics). Reference per Guides to Documenting in EHR.	How Evaluated	Experience Level
	Vital Signs		
	Demonstrates entering vital signs on the Cover Sheet.		
	Demonstrates editing incorrect date & time.		
	Demonstrates editing incorrect vital sign.		
	Demonstrates deleting a vital sign.		
	Demonstrates entering a Problem on the triage tab.		
	Allergies/ADR		
	Demonstrates checking if a patient has allergy/allergies assessment completed.		
	Demonstrates entry "No known allergies".		
	Demonstrates entering an allergy.		
	States required action if an allergy information is incorrect or incomplete.		
	Successful return demonstration of the above was given by staff member and this person is competent to perform these entries in EHR. Staff Signature: Trainer Signature:		

4.1.5 Nursing Orders Competency Form

The entire competence form appears on the next page.

EHR Competency - ORDERS

STAFF NAME: ______________________________ UNIT / POSITION: ________________

DATE: __________ Instructor/Evaluator:

Self Evaluation	How Competency/Skill Is Evaluated	Experience Level
1. Have not experienced before. 2. Know principle, but haven't actually performed. 3. Have performed but not recently, need review. 4. Feel comfortable and competent in activity/skill.	Competency will be validated by: Direct observation (D), Simulation (S), Return demonstration (RD) Test (T) Class (C) Use the appropriate letter in the column How Evaluated.	1. Acquired some experience (may require practice, assistance). 2. Competent and/or can perform independently. 3. Competent, performs independently, and is able to teach and/or assess the competency of others.

Self Evaluation	Skills Competency – ORDERS Vital Signs & ADR/Allergies Goal: Successful return demonstration by staff member of performing these entries into EHR and is competent to perform these entries in EHR.	How Evaluated	Experience Level
	States the difference between: - Verbal order - Telephone order - Policy order		
	Service Column: States understanding 1. Services are listed here. ADT, Nursing, Activity, IV Fluids, Inpt Meds, Outpt Meds, Lab, Radiology, Consults (in that order from top to bottom of screen). Become familiar with the listing sequence to navigate the orders. 2. All orders relating to a service will be grouped together. 3. In each Service group the most recent order by date & time is listed first, then the orders run chronologically backward in time		
	Status Column: States understanding 1. The status of an order displays here - the status determines how the order works and what you see in EHR. 2. All orders will have a pending status until some type of action is taken on the order from within its own RPMS package. 3. An electronic signature has to be applied to any order to change the status from "unreleased" to pending.		
	Nursing Orders: States understanding 1. Nursing orders can be completed by a nurse if it is indicated. e.g., insert Foley catheter now. Once done, the order is "complete". 2. Demonstrates completing a nursing order. 3. Nursing can Discontinue/Cancel Nursing/Activity orders if Dr order given.		

	Medication and IV Fluid Orders: States understanding 1. The status of Medication and IV fluid orders are made “Active”, “Completed”, and “Expired” from the pharmacy package. 2. Nursing cannot do any of these actions only the pharmacist. 3. Orders cannot be verified until the status is “Active”. 4. Order verification - check all fields are processed to satisfy BCMA. 5. Nursing can Discontinue/Cancel med and IV fluid orders if Dr order given.		
	Radiology Orders: States understanding 1. Radiology orders are made “Active”, “Scheduled”, “Completed”, and “Expired” by the radiology package. 2. Nursing cannot do any of these actions only the radiologist. 3. Nursing can discontinue/cancel radiology orders if Dr order given.		
	Lab Orders: States understanding 1. Lab orders are made “Active”, “Completed”, and, “Expired” by the laboratory package. 2. Nursing cannot do any of these actions only the lab personnel. 3. Nursing can discontinue/cancel lab orders if Dr order given.		
	Consult Orders: States understanding 1. Consult orders status of “Completed” occurs when the doctor enters a note that is linked to the Consult in the EHR. 2. Nursing cannot do any of these actions only the person doing the consult. 3. Nursing can discontinue/cancel consult orders if Dr order given.		
	Telephone Orders: Demonstrates - entering a laboratory test, radiology test, medication order. - selects the ordering doctor’s name first, check it is listed in the Visit Encounter box. - enters the order - selects “Release to Service” and “Telephone” as the type of Order - “Verify” the orders (verify = I have noted these orders) - Order will have “unsigned” listed in order display until the Dr signs the order.		
	Discontinue or Cancel an order: Demonstrates - selects the ordering doctor’s name, check it is listed in the Visit Encounter box. - highlights the order to be cancelled - selects reason		
	Complete a 24hr chart check - Demonstrates (Night shift - Inpatient only)		
	Successful return demonstration was given by staff member and this person is competent to perform these entries in EHR. **Staff Signature:** **Trainer Signature:**		

4.2 General Information and User Acknowledgement Form

The entire competence form appears on the next page.

GENERAL INFORMATION ON EHR

Obtain computer codes

- AD codes – to sign onto the hospital computer Active Directory network. This is done first.
- RPMS Access-Verify Code **–** the same code is used to sign onto the **EHR.** BCMA & RPMS.
- If you have problems with your codes contact the Helpdesk.

Electronic Signature

- An electronic signature is required to sign notes and orders
- The Clinical Application Coordinator (CAC) will assist you with this

General information

Several principles apply throughout the EHR. Also in EHR there is usually 2 or 3 ways to achieve the same end result. Below are listed the more common principles.

Information is displayed in panes (or windows).

- Change the size of the panes by placing the mouse arrow ⇨ on the divider bar
- The mouse arrow will change into this shape. **← II →**.
- Do a "left click and hold" then move the mouse in the directed needed to widen or narrow a window → enables easier viewing of information

What is highlighted is displayed.

- To read something – click on what you want to read or
  - click on the **+** sign to expand a list
- Cover Sheet – click on something here → a dialog with more information opens. This dialog must be closed (click the **X**) before anything else can be done in the EHR.
- Notes Tab – note titles are listed at the left of the screen. Click on the title you want to read
- Lab Tab – Click on the lab you want to display
  Click on the date range you want – today, one week, two weeks, etc.

A + sign means more information attached.

- To expand a list - click on the **+**
- This will change the **+** it to a **–** sign with the attached list or information displayed below it
- Close the list by clicking on the **–** sign
- Notes Tab: **+** means an addendum is attached to the original note
- Reports Tab: click **+** and a list of reports opens. Click on the report name you want → it displays on the right side of the screen
- Wellness Tab: click on **+** to expand lists, then click on the item you want

What you see is what you get.

Pt information is contained in both EHR and the paper chart. If you cannot find something in EHR, then look in the paper chart. Please ask question when you are uncertain or if you know some information is located in EHR but you are unable to see it.

To enter data into the EHR there are the 4 RIGHTS

- Right patient
- Right visit
- Right date
- Right provider.

To select a patient - click on the box at the top left hand corner of the screen.

Patient not selected

Select a patient by using:

1. Medical record number – a minimum of 4 numbers is required
   - If MR number is 3 or less numbers use leading zeros e.g. 0967
2. Patient's name – lastname,firstname. E.g. Brown,Mary (No space after the comma)
3. Birth date – B03151964 e.g. the birth date is March 15, 1964.
   B (capital) is typed first, then month, day, and year. No spaces, commas, or slashes.

The Visit - is displayed in the Visit box next to the patient name.

Visit not selected
VONBIBRA,LYNDA E

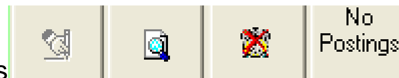
Default name – person who signed onto EHR

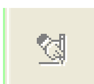
Inpatient stays - unit, bed number and admission date automatically default when a patient is selected.

TABS

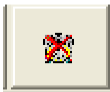
Tabs are located at the bottom of the screen. To change tabs – click on the tab you want.

COVER SHEET – At the upper right corner you see these icons

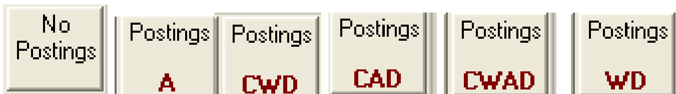



Click this to sign notes, orders etc.

Face Sheet.


Clinical Reminders – none due

Clinical Reminders - due



The postings icon indicates what is listed: Allergies (A), Crisis Notes(C), Warning Notes (W) and Directives (D)

- No postings usually means there are no allergies, advance directives etc. You must check No Postings for "No Allergy Assessment" → this means either NKA or know allergies has to be entered into EHR.
- The Cover Sheet has 8 panes (windows) with information contained below the **headings:** Problems – Adverse Reactions – Alerts – Medications – Reminders – Vital Measurements – Lab Orders – Appointments and Visits.

NOTES TAB

A note title is selected first. The note content is formed by using Templates containing "pre canned" text and selecting response from lists (some examples below); free text typing is also used.

Check boxes: used for multiple selections

Yes No N/A

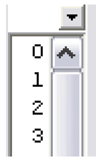
Radio button: one answer

free text

Word processing boxes

18-Apr-2007 07:00 ...

Ellipsis button - usually a calendar



Drop down boxes – select your response.

I have read and understand this information sheet which lists basic computer concepts/functionalities of FDIH E.H.R.

Staff name: _______________ **Signature:** _____________________ **Date:** ____________________

4.3 Prompts Only Documents

This section describes various topics using words only (no screen captures).

4.3.1 Notes for Nurses

Sign onto EHR etc.

New Note – click this button.

The "Progress Note Properties" dialog displays.

- Type in NURS - the screen defaults to NURSING
- Use the scroll bar to find the note title you want.
- Click on it.
- Click OK.

The note title is now listed on the top of the screen.

The left side of the screen lists "New Note In Progress" and the note title underneath.

If there is a template:

The template attached to the note title will open.

The template has a title, usually the same as the note title.

- Complete the template.
- Click Preview to review the template (as the text will appear in the note) and check the accuracy of the information.
- Click OK if satisfied with the content.

The template now appears under the note title on the screen.

If you wish to add any further comment, place the curso at the end of the template, click once, and the type your note.

Click OK when completed.

4.3.1.1 To Sign A Note

Until a note is signed no other provider can read the note in progress. It is important to remember this, because other providers may need to know what your note says. Sign your notes once completed; do not wait until the end of shift. More information can be added to a note after it is signed. (See Addendums)

Click the Integrated Signature Tool button at the upper right corner of the toolbar.

The Review/Sign Changes dialog display.

Type your electronic signature.

The note is now listed under All Signed Notes.

4.3.1.2 Addendums

Information can be added to a note after it is signed – you add an addendum to the original note. (You do not have to create a new note).

4.3.1.3 Default Note Titles to Your Personal List

You can organize the note titles used most frequently to default to the top of the Note Properties box.

This will save time when documenting notes.

Go to the upper left corner of the screen and select Tools → Options → Notes (tab) → Document Titles.

Click on the note title you want.

ADD – click

The note title is listed on the right under "Your List of Titles".

Repeat the above steps as needed.

Save Changes – click.

OK – Click.

Close the dialogs.

Click on New Notes.

Your list of note titles defaults to the top of the Progress Note Properties dialog.

4.3.1.4 Guide to Using Templates

Templates standardize documentation and are easy to use. The size of templates will vary. The more information to be documented, the larger the template will be. These templates will be listed in subsections. This will allow staff to identify various sections of the template. If a nurse is unable to complete a whole template before end of shift, for example an Admission Assessment, the oncoming shift is told the template has been completed up to Section XXX. The next shift nurse know at what Section to start to complete the template.

To open fields click the box

There are various methods used to for entering information.

Click on any of the following:

☐ A heading is beside this and indicates what the topic of documentation is about.

Clicking on the box ☑opens the field of information to be completed. Do not click on the box if a note is not required on this topic.

○ Click on this for answering questions. It will change to ⊙.

⮟ Click on this for a drop-down list of responses. Click on the response you want.

Some buttons you click on until you find the answer you want. The label on the button change with each click. For example: Yes – No – Maybe – Unknown.

There are many variations of the response combinations used.

There are also blank boxes that either require you type a response or allow for a comment.

Information can also be "pulled" from other RPMS packages, so the order information is entered into the EHR can be important.

For example – FIRST enter an immunization given into the Wellness tab and when the Pre Immunization template is completed this information will pulled into your template note.

4.3.1.5 Prompts

Sign onto EHR etc.

New Note – click this button.

The "Progress Note Properties" dialog displays.

Type in NURS - the screen defaults to NURSING

Use the scroll bar to find the note title you want.

Click on it.

Click OK.

The note title is now listed on the top of the screen.

The left side of the screen lists "New Note In Progress" and the note title underneath.

If a template is attached:

The template attached to the note title will open.

The template has a title, usually the same as the note title.

Complete the template.

Click Preview to review the template and check the accuracy of the information.

Click OK if satisfied with the content.

The template now appears under the note title on the screen.

If you ant to add any further comment, place the cursor at the end of the template, click once, and the type your note.

Click OK when completed.

4.3.2 Orders

- The doctor will enter all orders in the EHR on the Orders tab. (COE)
- When orders are entered they print automatically to a dedicated orders printer.
- The unit clerk or charge nurse will place the printed orders in the patient hard copy chart so that nurses know there are new orders.
- The nurse will verify the orders in the EHR on the Orders tab. In EHR "Verify" = "Noted".
- Telephone orders can be entered by a nurse when the doctor is not present in the hospital (e.g. on night duty), or when in the OR. **The ordering doctor's name MUST be listed in the encounter box.**
- When a patient goes to the OR the doctor must:

  Copy current orders to Delayed Inpt Post-op orders

  Cancel all current orders on the Orders tab.
- When a patient returns from the OR the doctor must:

  Manually release the orders on the Orders tab. (Delayed Inpt Post-Op)
- When a patient is discharged the nurse must:

  Verify all orders asap. Inpatient orders are automatically discontinued on discharge.
- When a patient is transferred to another unit the nurse must:

  Notify Patient Registration of the transfer when the patient leaves the unit.

  The doctor enters delayed orders for the transfer unit. The current orders auto-d/c on transfer. When the transfer is entered into ADT the orders print to the dedicated orders printer in the unit the patient is transferred to.

- Orders will have a Status assigned:

  Unreleased - Active - Pending – Completed – Scheduled – Expired.

  Discontinued/Cancelled – will be noted under the order itself, not in the status column.

- Nursing orders may be completed if applicable.

  E.G. You can complete an order “Insert Foley”.

  E.G. You would not complete an order “Ambulate TID” as this order should remain active.

- Pharmacy, labs and imaging orders are completed within each of those packages.

  Labs will remain pending until the lab results are entered into the lab package. (Pending → Complete)

  Imaging will remain pending until the results are entered into the radiology package. (Pending → Complete)

  Medication status is changed in the pharmacy package. (Pending → Active)

- Reports Tab – You can read all the orders entered under “Orders Summary for a Date Range”.

4.4 Scavenger Hunt for Providers

INPATIENT PHYSICIAN

ADMISSIONS

1. Choose a new visit chart review or attach to an existing visit.
2. Select the Notes tab.
   - Choose note title of Admit H & P
   - Sign it
   - Choose delayed orders.
   - Choose Admit to MSU
   - Choose Admitting Provider and Attending Provider

   Admitting Provider– Person writing the order

   Attending Provider – Person following the patient (This provider receives all lab notifications on the patient.) Admitting and Attending providers might be the same person.

   - Put in admitting diagnosis and condition. Check OK.

   (You will now get the inpatient menus.)
3. Write admission orders for patient using the Peds Dept. list or use the Admit orders listed to the right and nursing orders listed in the middle. Put in all the admit orders you normally use.

4. Go to the Medications tab
    - Highlight outpatient med orders.
    - Choose Action →Transfer medications to inpatient
5. Go back to the Orders tab
    - Sign all orders.

If you forget an order:

6. Highlight delayed orders.
7. Go to Inpatient Meds Menu

    For meds order: K-riders x 3 to start on the floor

    Order warfarin to be given upon arrival to the floor and then begin regular daily dose

    Order IV fluid with K+

    Order one time dose of heparin

    Order cardiac enzymes for 6hours from now (hint don't use n+6.. put in actual time)

    Order gentamycin trough

    Order a nursing text order to change dressing daily on the left foot

    Order a diet

    Order IV fluid for # of days

    Order a fluid bolus and then continuous IV

    Order a PPD and instruct to read on date
8. Go to Services tab – choose E&M code for initial hospitalization @ appropriate level
9. Notify admission clerk to admit patient (This releases delayed orders)

ONGOING DAILY CARE

Your orders show as active orders.

1. To discontinue one of the med order:
    - Find that med order
    - Highlight
    - Choose Action → Discontinue
    - State reason requesting discontinue

- Choose physician cancelled **ALWAYS** select physician cancelled otherwise it doesn't print to the nurses & they won't have any idea it's been cancelled until they do 24 hr chart checks!

CHANGING ORDERS

1. To change orders:
    - Change dressing order to BID
    - Highlight order. Select change.
2. Write a new med order for T#3. Give one immediately and QID. Notice the time the next medications is to be administered to avoid administering double dosage.
3. Write an order for liquid Tylenol
    - Write the number of CC's under the dosage box instead of comments.
4. Order a lab.
    - Order one as ward collect
    - Order one as phlebotomist collect
    - Notice the difference in timing and who collects. Note: This is very important, because the lab collects (phlebotomist) prints in the lab and shown on the morning collection list.
5. Do a progress note.
    - Choose INPT PEDS PROGRESS as the note title.
    - Sign the progress note.
6. Do an E&M code for subsequent hospital stay
    - Go to Services tab choose subsequent hospital stay appropriate level
    - Edit the narrative & put today's date in parenthesis – helps keep track of the date for billing
    - If you do critical care – choose the critical care codes from the pick list for MSU

FLAGGING & UNFLAGGING ORDERS
Highlight an order, then go to Action → Flag.

DISCHARGE

1. Go to Inpatient Menu
2. Choose the discharge menu
3. Write an order to discharge the patient
4. Order from the discharge menu
    - Follow up appointment
    - Nursing text order

5. Go to Medications tab.
   - Highlight the inpatient meds you want to patient to go home with.
6. Select Action → Transfer to Outpatient.
7. Go to Orders tab.
   - Sign all orders.

Note:

(a) The outpatient meds will disappear once signed. You will need to change your view to "current" instead of "active" in order to view them. IN THE INPATIENT SETTING "Active" medication orders equal ONLY inpatient medication orders. "Current" medication orders equal BOTH inpatient and outpatient medication orders.

(b) The order automatically defaults to a 30 day supply. Make sure you change the order to the appropriate number of days.

8. Go to Services tab
   - Choose Discharge E&M code
9. Check over the diagnosis on the E-sheet to make sure everything is there, communicate with coder if you have questions RE diagnosis codes

4.5 Pocket Guide

The packet guide appears on the next page. It might be printed and laminated for use within your facility.

Cover Sheet
- Vital signs, allergies, height, weight, pain

Wellness

1. Health Factors
- Smoking - yearly, from age 7
- Drinking - yearly, from age 5
- Readiness to learn - yearly
- Learning preference - yearly
- Barriers to learning - yearly

2. Education
- Admission - do all topics on admission
- Fall Prevention - if fall risk pt. (once only)
- Restraints - if in restraints (once only)
- Discharge - what is applicable on d/c
- Each shift document any other education done

3. Exams
- Depression screen - yearly, from age 18
- Intimate Partner Violence - yearly, female From age 18

4. Immunizations

If any due, notify MD.
Do immunization screen
Enter imm. on Wellness tab/imm history
Do an Inpt Nurs Immunization Screen note
Nurse can initiate adult flu or pneunovax per Hospital policy.

Communication
Click on Broadcast

Orders Tab
- All orders - verify here
  - 24 hr CC here (nights)
  - Nursing orders - Complete if applicable

Telephone Orders - new orders

1) *Ordering MD name in Visit Box
2) Check on Inpatient Menus
3) Make your selections
   - Med orders - click on MEDICATIONS
   - IV fluids - click on ROUTINE IV FLUIDS
   - Labs - click your unit name listed under Inpatient Labs
   - Radiology - click as appl. under Imaging
   - Nursing Orders - click as appl. under Nursing
4) Highlight orders → Release with MD Sig
5) Highlight orders → verify orders

Telephone Orders - Discontinue or Cancel

1) *Ordering MD name in Visit Box
2) Highlight order - Action → Discontinue/Cancel → Select reason.
3) Highlight orders → Release with MD Sig
4) Highlight orders → verify orders

4.6 Daily Check List

These might be useful for audit form. There are two lists: one for day and one for evening. Then will appear on separate different pages.

EHR CHECK LIST – DAY SHIFT

	MR #	MR #	MR #	MR #
EACH DAY SHIFT - THIS IS DONE				
1. Check allergies (Posting Wad @ upper R corner of screen)				
2. Notes - INPT SHIFT (D)				
3. Notes - INPT PROGRESS				
4. Notes – drag your notes into the INPT SHIFT (D) immediately after signing it.				
5. Orders - Verify orders				
6. Orders - Complete nursing orders as applicable.				
IMMUNIZATIONS – DO THIS				
1. Do an immunization screen per Inpt Nurs Immunization Screen Note (do not sign your note)				
2. VIS - Give pt a Vaccination Immunization Sheet (VIS) if applicable. Answer all pt questions and obtain consent, give the shot.				
3. Wellness tab – document immunization under Immunization History				
4. Notes – INPT NURS IMMUNIZATION SCREEN Check these boxes in the template ➢ General Screen ➢ Immunization specific screen ➢ VIS ➢ Consent ➢ Immunizations				
5. Notes – drag imm. note into the INPT SHIFT (D) immediately after signing it.				
ADMISSIONS – DO THIS				
1. Check Allergies. Enter allergies if indicated (Cover Sheet)				
2. Wellness Tab - health factors, education, exams as applicable. i. - Check Immunizations due – obtain order if applic.				
3. Notes – INPT NURS ADMISSION 4. This note stands alone – cannot be dragged into Shift (D)				
5. Notes – INPT NURS SHIFT (D)				
6. Notes – IINPT NURS PROGRESS				
7. Notes – drag your Progress note into the INPT SHIFT (D) immediately after signing it.				
8. Orders - Verify orders				
9. Orders - Complete nursing orders as applicable.				
DISCHARGES – DO THIS				
1. Notes – INPT NURS DISCHARGE				
2. Notes – drag Discharge note into the INPT SHIFT (D) immediately after signing it.				
3. Orders – verify all orders before patient is discharged by Pt Reg.				

4. Orders – complete all nursing orders as applicable before pt is discharged by Pt Reg.				
PATIENT TRANSFERRED OUT OF THE UNIT – DO THIS				
1. Notes – INPT NURS TRANSFER OUT OF UNIT				
2. Notes – drag Discharge note into the INPT SHIFT (D) immediately after signing it.				
3. Orders – verify all orders before patient is transferred by Pt Reg.				
4. Orders – complete all nursing orders as applicable before pt is transferred by Pt Reg.				

EHR CHECK LIST – NIGHT SHIFT

	MR #	MR #	MR #	MR #
EACH NIGHT SHIFT – THIS IS DONE				
1. Check Allergies (Posting Wad @ upper R corner of screen)				
2. Notes - INPT NURS SHIFT (N)				
3. Notes - INPT NURS PROGRESS				
4. Notes – drag all your notes into the INPT SHIFT (D) immediately after signing it.				
5. Orders **-** 24 hour chart check on orders				
- if you take new orders do verify & 24h CC				
6. Orders - Complete nursing orders as applicable.				
ADMISSIONS – DO THIS				
1. Check Allergies**.** Enter allergies if indicated (Orders tab)				
2. Wellness Tab – health factors, education, exams as applicable Check Immunizations due – if applic. obtain order for day staff				
3. Notes - INPT NURS ADMISSION This note stands alone – cannot be dragged into Shift (D)				
4. Notes - INPT NURS SHIFT (N)				
5. Notes - INPT NURS PROGRESS				
6. Notes – for night duty admissions all notes stand alone as there is no INPT SHIFT (D) note title to drag notes into.				
7. Orders - Verify orders when the pt is admitted on your shift				
8. Orders **-** 24 hour chart check on orders				
9. Orders - Complete nursing orders as applicable				
DISCHARGES – DO THIS				
1. Notes – INPT NURS DISCHARGE				
2. Notes – drag Discharge note into the INPT SHIFT (D) immediately after signing it.				
3. Orders – verify all orders before the patient is discharged by Pt Registration				
4. Orders – complete all nursing orders as applicable before the pt is discharged by Pt Reg.				
PATEINT IS TRANSFERRED OUT OF YOUR UNIT – DO THIS				
1. Notes – INPT NURS TRANSFER OUT OF UNIT				

2. Notes – drag Discharge note into the INPT SHIFT (D) immediately after signing it.				
3. Orders – verify all orders <u>before</u> patient is transferred by Pt Registration				
4. Orders – complete all nursing orders as applicable <u>before</u> the pt is transferred by Pt Reg.				

4.7 EHR Audit Form

The audit form appears on the following page.

EHR AUDIT FORM

Nursing staff are required to complete 2 chart audits per month.
One form per chart audit - Enter MR no.
- Check either yes/no/na for each section.
- List admitting RN/LPN and NA.
- List discharge RN/LPN.

Comments if part of documentation has not been completed.
(E.g. learning barriers completed but not preference or readiness)

Audit done by: ____________________________

Date: ______________________

	Cover Sheet		Wellness Tab					
Medical Record	Vitals Include: Ht., Wt, Head Circum	Allergies updated	Immunz. Forecast Enter Historical immune or f/u with MD.	Tobacco Screen q 12 mth.	Etoh/drug Screen q 12 mth.	Learning Barriers Preference Readiness Each admission	Education - Admission to Hospital False (if applic.) Restraints (if applic.)	Exams - IVP Depression Screen q 12 mth.
Yes								
No								
N/A								
Admitting RN/LPN N/A								
Comment								

	Notes					**POV Tab**		
	Admission note done	If pt. transferred to your unit - does shift assess state from: Which unit Arrival time	Look at meds section - "Yes pt takes alternative meds"	Notes dragged into a shift assess (D) note to make a 24 hr folder.	Circle one - Discharge Or Transfer Note done	"Takes alternative meds" Entered as an active problem		
Discharge RN/LPN								
Yes								
No								
N/A								
Comments								

5.0 Contact Information

If you have any questions or comments regarding this distribution, please contact the OIT Help Desk by:

Phone: (505) 248-4371 (local) or

(888) 830-7280 (toll free)

Fax: (505) 248-4297

Web: http://www.ihs.gov/GeneralWeb/HelpCenter/Helpdesk/index.cfm

Email: support@ihs.gov