Instructions:
Read and familiarize yourself with the contents of this module. Upon completion, print the “Clin Doc Training Pre-test” also available on this site. Bring the completed quiz to your scheduled computer training class at Advocate BroMenn Medical Center. It will serve as your entry ticket for class.
Section 1 – Introduction

Overview: This module includes a brief introduction to the Meditech Patient Care System (PCS), a review of general Meditech functionality, including general navigation principles and key definitions.

Audience: This document is intended for nursing students performing clinical rotations at ABMC.

Key definitions/functionality within PCS:

Auto referral: Meditech can initiate an order or referral based on the answers to an assessment. Example: if the patient requests additional information about Advance Directives and the nurse answers "yes" to the question, Meditech sends a referral to Spiritual Care to request a patient visit.

Demo recall/recall values: The ability to 'pull forward' responses from a previous visit or from a previous assessment. This information must be reviewed to ensure that it is still accurate. Recall reduces the amount of data entry and time needed to complete the assessment, since the care provider is validating and performing data entry only to make changes to the data.

Auto calculation: The system can calculate values automatically, saving time and eliminating errors. For example, Meditech calculates the Fall Risk Score based on the nurses' assessment.

Status Board: A patient list that provides an overview of patient information (e.g. Room/Bed, physicians, allergies, chief complaint, diet, medications due, interventions due, etc.)

Worklist: A patient-specific list of interventions and assessments. When interventions/assessments are assigned a frequency, Meditech will provide a reminder of due and past due items. Assessment and intervention documentation is accessed through the worklist.

Standards of Care: Sets of interventions/assessments that are defined for specific patient populations (e.g. Unit specific minimum care standards, standards specific to patient condition such as Fall Prevention, PICC/Midline catheters, etc.).

Protocols: Resource documents accessible within PCS, associated with interventions/assessments that provide the care provider with additional information or guidance. Protocols are for reference only and do not become part of the patient's medical record.
Section 2 - Policies and Procedures/Expectations

Advocate BroMenn Medical Center's information technology users need to be familiar with and accountable for compliance with all policies and procedures relating to the use of information systems, access and use of patient data, and access and use of organizational data. However, there are key areas which we wish to reinforce and focus on during Information Systems Training. Those areas relate to Security, Confidentiality, Logons/Passwords, Access and Competencies.

Security: All users of information systems are responsible for the security of data. This includes making sure that computer screens are not viewable by the public or by others who do not have a need to see the data being displayed. Users are responsible to ensure that they log off of systems appropriately to make sure that the systems are not open to unauthorized access. Physical security of data also applies to any other media such as paper reports, data on disks/CDs, etc. This data must also be secured and disposed of properly to prevent access by others.

Confidentiality: Users are only authorized to access information on patients in whose care they are involved and only that data required to perform their job function. System audit trails allow for the reporting of document access. These audit trails will be systematically reviewed to monitor compliance with our policy. Information should only be shared with others involved in the patient’s care and only the information that is ‘need to know’. Staff should be cognizant of the environment in which the data is shared to prevent inadvertent disclosure (e.g. be sure that others can not overhear or see the information).

Passwords/logons: Passwords/logons are assigned to an individual. They belong only to that individual. You should not share your password/logon with anyone else. You should never use another’s password/logon. Be sure that prior users are logged off the system before using the system and make sure that all work is done under your own log on. Remember the audit trail and that you are accountable for all activities under your access. In the event that you forget your password, your identity will be verified per policy and then you will be issued a temporary password. You will access the system using your temporary password and then enter a new password on prompting (known ONLY by you). Passwords will change every 60 days. Passwords must be at least 7 characters, should be alphanumeric mix, and should not be easily guessed combinations (e.g. children’s names, anniversary, etc.).

It is the intent that documentation will be real time and performed at the point of care whenever possible. Data entered is available within the Electronic Medical Record (EMR) for review.
Section 3 – The 'Rights' of Clinical Documentation

Online clinical documentation is utilized by the physician and the care team to make decisions regarding patient care. Therefore it is very important that the data within the patient record be timely and accurate. One major consideration is validating that you are documenting the right information on the right patient and within the right encounter for the patient. With each step/screen within the documentation process, the user should be validating accuracy.

Important items on the Document Intervention window

- Correct User (you should be logged in)?
- Correct patient?
- Correct encounter?
- Correct intervention?
- Correct date and time?
Section 4 – Basics of Worklist/Status Board Management

The Status Board is a listing of patients with columns of high level information. This overview assists the care provider in managing work flow and prioritizing care.

Status Board Functions

The Status Board Screen

Overdue activities will be highlighted pink, with the time displayed of the next due Meds/Interventions.

Grey shading w/arrows indicate that more information is available. Clicking on the arrow will display additional information.
Section 5 – Understanding the Basics of the Patient Worklist

When admitted, a patient is placed on a unit specific Standard of Care (SOC). This SOC is comprised of a group of interventions representing the minimum level of care for patients within the care setting. Through selection of the interventions within the worklist, the nurse can document care provided to the patient.

Interventions are of two types:
- ‘I did it’ interventions where the nurse is simply 'checking off' completion of a task
- Interventions with attached assessment screens that require entry of data relevant to the intervention (e.g. Nursing assessment, ADL assessment, Intake and Output, etc.).

**Important items on the Worklist window**

**Worklist Layout:**

**#1** First Column (no heading) – by clicking within this column, to the left of the individual interventions, you can select one or more interventions in order to document, edit status, etc. A check mark will appear when interventions are selected.

**#2** Intervention – The descriptions of interventions for the selected patient are listed. Clicking on the name of the intervention launches a 'new' assessment or instance of documentation.

**#3** Text/Ord - A conversation icon indicates that there are specific directions/comments relating to the performance of the intervention.
#4 Status – The status of the intervention is displayed. Available statuses and their definitions are listed below.

<table>
<thead>
<tr>
<th>Status</th>
<th>Indicator</th>
<th>Describes interventions that:</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active</td>
<td>A</td>
<td>Are current care delivery responsibilities</td>
<td>Taking vital signs</td>
</tr>
<tr>
<td>Complete</td>
<td>C</td>
<td>Are no longer necessary in the current phase of care, but which appear on the plan to show a true picture of the patient’s progress</td>
<td>Interventions completed in SDS before the patient was transferred to the unit</td>
</tr>
<tr>
<td>Hold</td>
<td>H</td>
<td>Have been temporarily stopped</td>
<td>Interventions while a patient is in the OR</td>
</tr>
<tr>
<td>Inactive</td>
<td>I</td>
<td>May or may not be appropriate for a patient in this phase of care</td>
<td>Teaching the administration of insulin to an already knowledgeable patient</td>
</tr>
</tbody>
</table>

#5 Src (Source) – This column denotes the origination of the intervention.

#6 Frequency – This column displays the frequency designated for the intervention and generates the schedule if appropriate.

#7 History – This column displays the elapsed time since the last documentation filed for this intervention. By clicking within the 'History' column, a listing of all previous episodes of documentation for the intervention are listed. By selecting a specific date/time or instance of documentation, the documentation can be completed/edited/undone as appropriate. If editing or removal of charting is required, you should consult with your instructor or the nurse caring for the patient to assist you with making the needed corrections to the patient’s chart.

#8 Next Scheduled – This column displays the schedule associated with the frequency of the intervention. (See Frequency above.)

#9 Protocol – Indicates whether there is a protocol associated with the intervention. Clicking within the column displays any associated protocol.

#10 Associated Data – Indicates whether there is additional data for the intervention. Clicking within the column displays any data associated as a ‘drill down’ into the EMR. Ex: lab values.
Section 7 - Medication Administration

Medications should be administered as close to their scheduled time as possible. Use of scanning is required for all non-emergent medication administration.

Nursing students should not administer a medication that has not been acknowledged by a RN. If administration of a med is needed and it has not been acknowledged, notify the nurse caring for the patient and he/she can acknowledge the medication.

Section 8 – Basics of the Electronic Medical Record (EMR)

Patient data and documentation entered within PCS is reviewed within the Electronic Medical Record (EMR) via the EMR function on the Status Board toolbar. The EMR provides many options for review of this data.

Note: There are many ways to review data within the EMR. This training will highlight only one view of the data. The Care Activity link provides a comprehensive view of the data just entered, while other options provide only snapshots of specific data elements.

Accessing the EMR

Click on EMR.

The EMR Summary screen is displayed.

Nursing documentation is best reviewed from Care Activity for the complete entry and Notes for any notes entered.
Click on **Care Activity**.

**Care Activity List of Documentation**

A list of documentation entered on the patient appears in spreadsheet format. To view individual documents, click on:

- **Name** – lists documentation by specific intervention name.
- **Recorded by**– Lists documentation by name of individual who documented.

Individual documents are viewed by clicking on the magnifying glass to the right of the listed document.
Click on the “I” next to the desired document.

The documentation is displayed.
Additional documentation can be viewed via the navigation buttons above the documentation section.

(Return) – Takes you back to the full listing of documentation on the Care Activity Screen.

(Earlier) – Takes you back to the next earlier documentation (reverse chronological order).

(Later) – Takes you forward to the next documentation completed (chronological order).

Your overview is finished! Next, print and complete the quiz, and bring it with you to your scheduled training. We look forward to having you at Advocate BroMenn Medical Center!