



Allscripts™

Basic Guide to ICU, Telemetry and Medical/Surgical Unit Workflows

Culver City, 2017v.1

How to log in and access the system:



Click on the Citrix XenApp Icon to launch the Citrix Gateway



Enter facility provided username and password in order to log in to the Alta Hospitals server.

Upon initial log-in, by default, the site will bring you to the change password page.

Change Password

Consult your help desk or corporate security policy to learn about your company's password guidelines.

Old password:

New password:

Confirm password:

Password Guidelines:

- User name cannot be a part of password
- At least 8 - 10 characters
- At least 1 uppercase letter
- At least 1 number
- Password CANNOT be previously used in the past

Enter provided default password on the “old password” space and enter new password as per facility password guidelines. Click the “Ok” button, then click on “Save”.

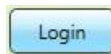


Click on the Sunrise Clinical Manager - LIVE folder to access the SCM gateway.



Double click on the [15-3 SCM Allscripts](#) SCM-Gateway-LIVE icon to launch the Allscripts Gateway Logon screen.

Enter the same User Name and Password used on the Citrix Gateway. Click



****Log in problems or password reset, please call **ITHELPDESK** at (562)293-3276****

Allscripts Gateway Logon

Allscripts Sunrise Enterprise™
Release 6.1

Username/Password

User Name:

Password:

Authorized users ONLY

ALTA HOSPITALS LLC - ALLSCRIPTS GATEWAY

Forgot Info?

Current Workgroups: ALTA_SCM_PROD

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MAIN TOOLBAR

PATIENT INFO BAR

PATIENT CHARTS

LOG OFF /SUSPEND

Allscripts Gateway | My Applications | Acute Care

My Applications ▶ Acute Care ▶ Patient List

File Registration View GoTo Actions Preferences Tools

Previous Next Refresh Find Change Preferences Problems Allergies Outpatient
Patient Screen Patient Location Summary Medication Review Reconciliation Manager Management V-sever Info Log Instructions Document Discharge Send Exch. Enter NOVABAD Add Care
Life Viewer Provider

ZZZTEST-DO NOT USE, PATIENT-DO
ED-01-C
Allergy: TEST TEST TEST, 4 Way Saline, 4...
WT: kg HT: cm BSA: m2 BMI: IW: 61.5 kg AWM: kg ADM: Nov-30-2016 DSC:
Code Status: Fall Risk:

Unreviewed Allergies

999999999 / 111150805 49y (Jan-01-1968) Male Spanish
Test, EDMD

Patient List Orders Results Documents Patient Info Flowsheets Clinical Summary Medical Record Viewer Visit Record Review

ED Status Board

New Visit Modify Delete Delete Current List Visit List New On New Off All Visits Visits Select Save Selected Remove Selected Select Visit Define Save Sort Reset Sort Order

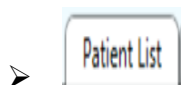
Current List: *test patients 2 Select All Patients 5 Visit(s) Save Selected Patients...

Patient Name	Patient ID / Visit Number	Birthdate	Current Location	Visit Status	Admit Date	Admit Time	Provider	To Sign	Flag New	New Alerts	New Orders	New Results	New Com...	New Docu...
ZZZTEST-DO NOT USE...	999999999/111150805	Jan-01-1...	ED-01-C	ADM	Nov-30-...	09:20	Test, EDMD							
ZZZTEST-DO NOT USE...	999999999/111151003	Jan-01-1...	ED-1	ADM	Nov-17-...	04:36	Test, EDMD							
ZZZTEST-DO NOT USE...	999999999/100005002	Jan-01-1...	FRMC ED-01	ADM	Jan-04-2...	12:21	Test, EDMD							
ZZZTEST-DO NOT USE...	999999999/111151306	Jan-01-1...	FRMC Unit-3 SubAcute...	ADM	Oct-17-2...	07:40	Test, MD	▼						
ZZZTS1-DO NOT USE...	999999999/100000000	Jan-01-1...	Urosterics-UJ26-U	ALUM	Feb-03-2...	12:24	Test, HU		☒					✓

TO USE THIS GUIDE...

The **ICON** images represents the buttons that are found in Allscripts. These buttons will link the user to the different channels where the user can review and/or enter documentations as outlined/described in this booklet.

ADMISSION WORKFLOW



PATIENT LIST TAB *(Create/Modify your patient list)*



New Visit List or Modify Visit List



FLAG NEW ON – *(Flag all your patients)*



ALLERGY SUMMARY – *(Add Allergy, Intolerances)*



OUTPATIENT MEDICATION REVIEW *(aka "HOME MEDS")*



PROBLEM LIST – *(Add/Review Diagnosis and Medical HX)*

- Admitting/Discharge Diagnosis
- Past Medical and Surgical History
- Family and Social History
- Pre/Post-Operative Diagnosis
- Procedure / Surgical Event
- Visit Problem
- Working Diagnosis

▪ *(***Mark POA if present on admission)*



ADMISSION NOTE NURSING *(aka "patient profile")*

▪ RN CO-Sign for LVN



FLOWSHEET *(see add parameter/time column page 17-19)*

▪ **Assessment and Cares** *(For head to toe assessment)*



SEPSIS SCREENING TOOL

- *If diagnosed or manifests septic S/Sx*



BELONGINGS LIST – (Choose Admission)



FLOWSHEET – Add/setup appropriate parameters

- *Vital Signs*
- *Plan of Care*
- *Intake Output*
- *Education Record*



ORDER RECONCILIATION (Choose Admission)

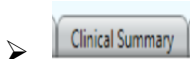


ENTER ORDER *(see sample order on page 20 – 23)*

- **ADMISSION (MED. General Admission) ORDER SET**
 - **or CORE MEASURE order sets** (PNA, CHF, STROKE)



- **MRSA /** **ADD SPECIMEN**
- **ISOLATION** *(If any)*



CLINICAL SUMMARY – (F-up CORE MEASUREs)



NURSING NARRATIVE NOTE *(aka “progress notes”)*

- *save as complete at end of shift*

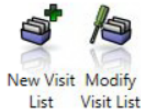


TICKET TO RIDE *(for Radiology orders, OR transport, etc)*

DAILY CHARTING WORKFLOW



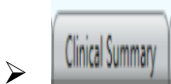
- **PATIENT LIST TAB** *(Create/Modify your patient list)*



New Visit List or Modify Visit List



- **FLAG NEW ON ALL YOUR PATIENTS**



- **CLINICAL SUMMARY TAB** *(Preset or customized)*

- *Give/Receive Bedside Shift Endorsement*



- **CHECK OMR** *(If done and saved complete)*



- **FLOWSHEET** - *Add/setup appropriate parameters*

- ***Vital Signs***
- ***Assessment and Cares***
- ***Plan of Care***
- ***Intake Output***
- ***Education Record***



- **NURSING NARRATIVE NOTE** *(Save as complete at end of shift)*



- **PHYSICIAN CENTRAL LINE DAILY ASSESSMENT INDICATOR** *(Co-Sign MD)*



- **CRITICAL LAB RESULT NOTIFICATION** *(if any)*



- **EVENT NOTE** *(if any)*



- **BELONGINGS LIST - Transfer** *(for room/unit transfers)*



MARK ALL eMAR TASKS (ex: blood transfusion)



▪ **KBMA** (Barcode Scanning)



MARK ALL NURSING TASKS (ex: Turn patient Q2hrs)

- **Most charges are captured by marking the tasks as done**

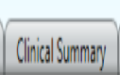


ADD SPECIMEN (if any)



ORDERS

- **TELEPHONE ORDERS**
- **COMMUNICATION ORDER TO NURSES** (mark as complete when done)
- **CHARGES** (Hemodialysis, Blood Transfusion)



COMPLETE THE CORE MEASURES REQUIREMENTS

- **(VTE, CHF, PNA, SEPSIS,MI)**

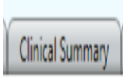


SIGNATURE MANAGER

- **Sign all witnessed documents and/or Orders**

DISCHARGE WORKFLOW

- **TAKE A PHOTO OF WOUND** *(print/scan/fax to chart)*



- **COMPLETE THE CORE MEASURES REQUIREMENTS**
 - (VTE, CHF, PNA, SEPSIS, MI)



OR



- **PRINT EDUCATIONAL MATERIAL(s)**
 - *Exit Care*
 - *Info Button*



- **DISCHARGE INSTRUCTIONS** *(print for patient)*



- **BELONGINGS LIST - Discharge** *(print/sign for chart)*



- **CHECK OMR** *(If done and saved complete)*



- **DISCHARGE ORDERS**

- **MRSA ORDER** *(check your policy)*



- **ORDER RECONCILIATIONS –** *(Choose Discharge /print)*



- **MARK ALL YOUR SHIFT TASKS** *(if any)*



- **CCDA DISCHARGE SUMMARY**



- **RECORD VITAL SIGNS** *(prior discharge)*



- **DISCHARGE NOTE NURSING**





- **DISCHARGE PATIENT FROM PARAGON**

- **DON'T FORGET TO:**





- Return Patient Belongings and Own Medications
- Remove IV access / Telemetry Box

ADDITIONAL WORKFLOWS...

PAIN MEDICATION ADMINISTRATION

-  **PRE PAIN MEDICATION PAIN ASSESSMENT**
-   **SCAN THE PAIN MEDICATION**
-  **POST PAIN MEDICATION PAIN ASSESSMENT**
 - (Note: Both pre/post pain assessments must have a numerical value to indicate the pain level from 0-10)

VTE CORE MEASURE

-  **VTE PROPHYLAXIS ORDERS** (*Meds, SCD, Stockings*)
 - This order is commonly found under all admission order sets (bottom part)
-  **VTE OMISSION ORDERS** (*Pt refused or contraindicated*)
-  **MARK THE TASK FOR SCD & STOCKINGS**
-  **ASSESSMENT AND CARES** – Add and/or Document on all the following parameters that applies:
 - **Under PERIPHERAL VASCULAR parameters**
 - Antiembolic interventions
 - Compression device sequential
 - Antiembolism stockings

AT RISK/PRESENCE OF PRESSURE ULCER OR SKIN BREAKDOWN

(Wound, P. Ulcer, Bruise, Rash, etc) / (bedridden)



ORDERS that may apply

- **Consult – Wound Care**
- **Consult – Social Services** (*For signs of abuse*)
- **Low Air Loss Mattress** (*If bedridden*)
- **Positioning/Turning** (*If bedridden*)
- **Heel Protector** (*If applicable*)
- **Wound Culture** (*as ordered*)



ASSESSMENT AND CARES – Add and/or Document on all the following parameters that applies:

➤ **Under SKIN parameters**

- **skin assessment** (*default*)
- **hygiene** (*default*)
- **specialty bed/surface**
- **skin incontinence protection**
- **pressure ulcer**
- **bruising**
- **rash**
- **burn**

➤ **Under MUSCULOSKELETAL parameters**

- **positioning** (*default*)



MARK WOUND CARE ORDER TASKS

- (*Post wound care/wound meds administration*)



PLAN OF CARE

- **Tissue Integrity Impaired**
- **Skin Integrity Impaired Risk**



PHOTOGRAPH(s) (*print/fax/scan to chart*)

FOR PREOP SURGERY



PROCEDURE



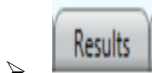
CONSENT

➤ **PAPER**

SIGNED CONSENT(S)



➤ **Check for H&P** (*follow-up with MD if not found*)



➤ **Check for latest lab results** (*seek MD order if not yet done*)



➤ **BLOOD TRANSFUSION (PRN)** (*seek MD order if none*)



➤ **VITAL SIGNS** (*within an hour before sending patient to OR*)



➤ **Check if Admission Height & Weight is recorded**



➤ **ALLERGY** (*if not yet entered*)



➤ **ISOLATION** (*if not yet entered*)



➤ **PREOPERATIVE CHECKLIST** (*done after V/S are recorded*)



➤ **CHANGE LOCATION**

☐ *to Operating Room (before transfer to OR)*

☐ *Clear current temporary location (Once patient returns)*

IF PATIENT SUFFERED A FALL



CALL THE MD AND GET ORDERS

- TYPICAL ORDERS:
 - X-RAY/MRI/CT OF BODY PART AFFECTED
 - NEUROCHECK Q15 X 1HR



ASSESSMENT AND CARES



CALL

NOTIFY FAMILY AND/OR FACILITY



EVENT NOTE



WRITE AN INCIDENT REPORT

IF PATIENT AMA/ELOPED



CALL

POLICE IF NECESSARY *(FOR ELOPEMENT ONLY)*



PAPER

HAVE PATIENT SIGN AMA FORM *(Voluntary)*



EVENT NOTE



DISCHARGE INSTRUCTIONS *(if patient is willing)*



WRITE AN INCIDENT REPORT USING CLARITY












DISCHARGE ORDER *(For coding purposes)*







DISCHARGE PATIENT FROM PARAGON SYSTEM

DEATH/EXPIRATION OF A PATIENT

-  **CALL** **ONE LEGACY**
-  **EVENT NOTE**
-  **OR**  **RRT AND/OR CODE BLUE** *(if it applies)*
-  **DEATH PRONOUNCEMENT** *(MD document)*
-  **DEATH PROCEDURE CHECKLIST**
-  **MARK ALL YOUR TASKS** *(no exceptions)*
-  **WRITE AN INCIDENT REPORT USING CLARITY**
-  **DISCHARGE ORDER** *(For coding purposes)*
- **DISCHARGE PATIENT FROM PARAGON SYSTEM**

BLOOD TRANSFUSION

-  **TRANSFUSION** (CORE, Blood product and Transfusion)
-  **Medications (eMAR) Task**
 - *You must activate order if task is purple*
-  **ADD/DOCUMENT PARAMETER**
 - **UNDER INTAKE – Blood Products**
- **PAPER** **BLOOD BANK TRANSFUSION RECORD FORM**
-  **BLOOD TRANSFUSION/ADMINISTRATION CHRG**
 - *charge only Once per Day of administration*

RESTRAINTS



RESTRAINTS ORDER

- **NON-BEHAVIORAL** *(Renew every 72 Hours)*
- **BEHAVIORAL** *(Renew every 4 hours)*
- *Note: use discontinue/reorder to renew expired order*



PLAN OF CARE – Add and/or Document on all the following parameters that applies:

- **Under SAFETY parameters**
 - Harm to others
 - Harm to self risk
- **Under FUNCTIONAL parameters**
 - Self-care deficit *(use free text)*
- **Under SKIN parameters**
 - Skin Integrity impaired risk *(use free text)*



ASSESSMENT AND CARES – Add and/or Document on all the following parameters that applies:

- **Under SKIN parameters**
 - skin assessment *(default)*
 - hygiene *(default)*
 - specialty bed/surface *(if bedridden)*
 - skin incontinence protection
- **Under MUSCULOSKELETAL parameters**
 - positioning
- **Under SAFETY parameters**
 - safety measures *(default)*
 - precautions *(default)*

- **PAPER - RESTRAINTS FORM** *(continue to use existing paper form)*

HEMODIALYSIS



- **HEMODIALYSIS ORDER** *(1 order per procedure)*

- **Hemodialysis Administration CHRG**

- Done post administration
 - By marking task on worklist manager or
 - By completing order via “right click”



- **INTAKE OUTPUT – Add and/or Document**

- **Under OUTPUT parameters**

- Hemodialysis



- **NURSING NARRATIVE NOTE** *(Document HD nurse report/communication)*

ORAL SUPPLEMENTS



- **ORAL SUPPLEMENT ORDER**



- **INTAKE OUTPUT – Add and/or Document**

- **Under INTAKE parameters**

- ORAL – (NAME OF SUPPLEMENT)
 - Ex. Boost, Benprotein, etc.



- **MARK THE NURSING TASK**

- FOR THE ORAL SUPPLEMENT
 - Ex. Boost, Benprotein, etc.

TUBE FEEDING



TUBE FEEDING ORDER SET



ASSESSMENT AND CARES – Add and/or Document on all the following parameters that applies:

➤ **Under NUTRITION parameters**

- enteral tube feeding

INTAKE AND OUTPUT

➤ **Under INTAKE parameters**

- tube feeding or the formula name

➤ **Under NET parameters**

- residual/refeeding



MARK THE NURSING TASK FOR RESIDUAL CHECK

FLWSHEET

The flowsheet contains the routine documentations performed by the staff. By default, preconfigured parameters already exist. Additional parameters may be added as necessary to complete and comply with documentation standards.



Click on FLOWSHEET MANAGER ICON OR TAB

- 1) Select Section to document (*ex. Vital Signs*)
- 2) Add additional parameter (*as needed*)
- 3) Add a time column (*change time as needed*)
- 4) Document on the time column

FLWSHEETS TAB To Add Parameter and or Time column

To save document

To choose section to document

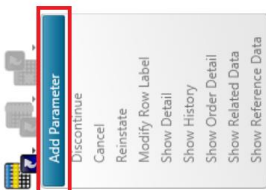
		Jun-19-2017 1054 ADMISSION	Jun-19-2017 1400
Temperature			
Temperature	degrees F	100.1	98.9
	degrees C	37.8	37.3
	Site	oral	
Heart Rate			
Heart Rate	beats/min	80	79
	Method		
	Rhythm		
Respiratory			
Respiratory/Pulse Oximetry			
	Respiration (breaths/min)	20	20
	SpO2 (%)	97	
	Patient On	room air	
	Pulse Oximeter Probe Placement		
Blood Pressures			

Parameters Time columns



CLICK

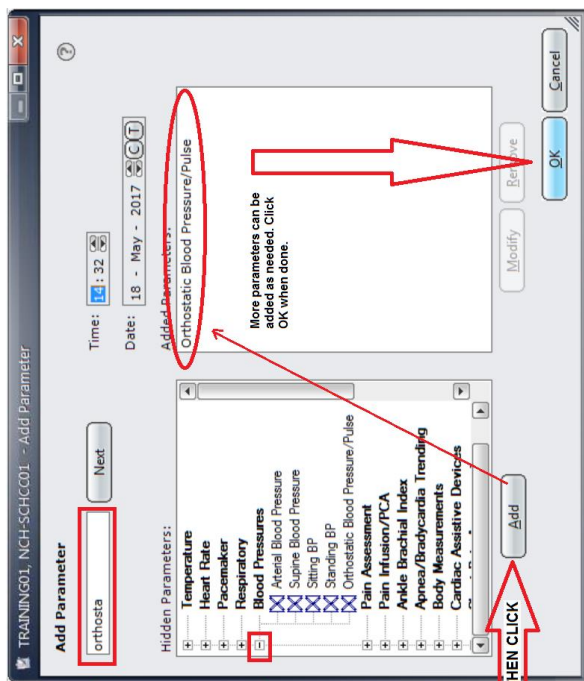
SELECT



SEARCH

OR

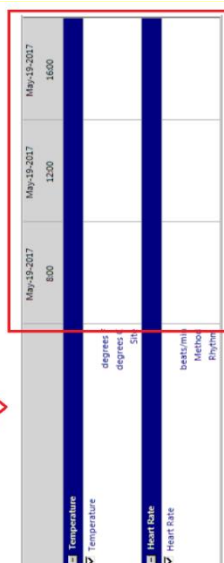
EXPAND




FLWSHEET

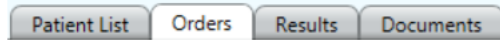
ADDING ADDITIONAL PARAMETERS





PHYSICIAN ORDERS

Orders placed are found under the  **ORDERS TAB.**



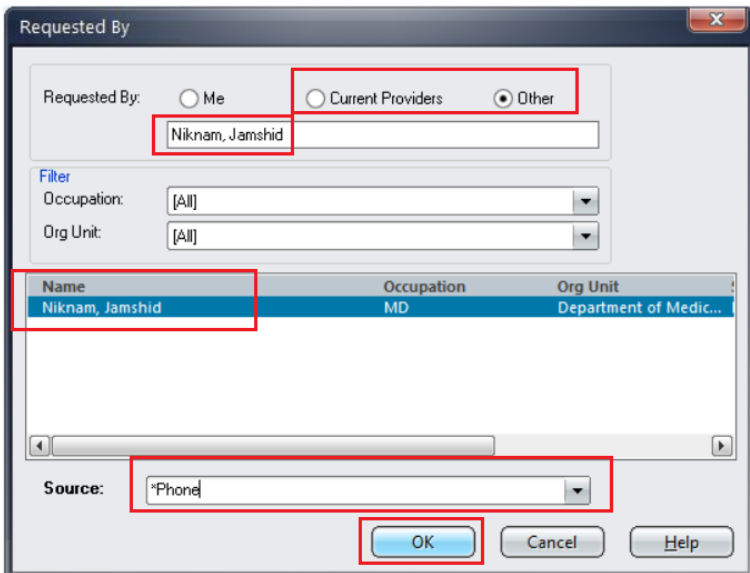
ORDER ENTRY

To enter orders in behalf of the Physician:



Click on **ENTER ORDER**

- 1) Requested by window will appear and select “**Other**” if the prescribing MD name is not listed below.
- 2) Type and search for ***last name of MD***
- 3) ***Select correct MD name*** from the populated list
- 4) Source: “**Phone**”
- 5) Click “**Ok**”.



Requested By

Requested By: ☐ Me ☐ Current Providers ☒ Other

Niknam, Jamshid

Filter

Occupation: [All]

Org Unit: [All]

Name	Occupation	Org Unit
Niknam, Jamshid	MD	Department of Medic...

Source: Phone

OK Cancel Help

- 6) Type the order name to search or look under the start of browse categories

Order Entry Worksheet - TRAINING_505PATIENT17

TRAINING_505PATIENT17 100000088 / 100000... 52y (07-04-1964) Female

SCH-H 2nd Fir Med/S... Unreviewed Allergies

Allergies: No Known Drug Allergies, Fruit (See Desc), Dust, Du...

Requested By: ☐ Me ☒ Other: Niknam, Jamshid Source: *Phone Allergy Details

Date: ./. Time: Session Type: Standard Reason:

Start Of Browse

- Charges
- Consults
- Diagnostic GI and Endoscopy
- Diagnostic Imaging
- ED/UC Order Sets
- EEG/ECG/Echo
- Laboratory
- MD Procedures
- Nutritional Services
- Patient Care
- Pharmacy
- Protocol
- Rehab Services
- Respiratory Care

Type here to enter order name

Type order here to search

OR

Search from Categorized Orders

Order

Add... View... Item Info Message Drug Info Edit... Delete Copy... Add Specimen... Indication... Mark as Done

Submit Order(s) for TRAINING_505PATIENT17... Hide Worksheet Cancel Help

- 7) Select the appropriate order
- 8) Click View

Requested By: ☐ Me ☒ Other: Niknam, Jamshid Source: *Phone Allergy Details

Date: ./. Time: Session Type: Standard Reason:

Manual Entry Searching for ...

O2

O2 (Oxygen Therapy) ...

O2 Sat, Maintain > 92% via Mask (Maintain O2 Sat > 92% via M

O2 Sat, Maintain > 92% via Nasal Cannula (Maintain O2 Sat >

Add... View... Item Info Message Drug Info

- 9) Fill out the order form details and instructions
- 10) Click ADD

RT Oxygen Delivery Requisition - TRAINING_50SPATIENT7

TRAINING_50SPATIENT7 100000088 / 100000132 52y (07-04-1964) Female

SCH-H 2nd Flr Med/Surg-0201-A
Allergies: No Known Drug Allergies; Fruit (See Desc); Dust, D...

Order: Oxygen Therapy Order ID: 001BBW556

Requested By: Niranjan, Janshid Template Name: Oxygen Therapy ...

Messages:

Start Date: Start Time: Frequency: [Continuous] Verbal Readback: Yes

Delivery Method: Nasal Cannula

☐ Aerosol Mask ☒ Nasal Cannula ☐ Face Tent ☐ Hood

☐ Mist Tent ☐ Non-Rebreather Mask ☐ Simple Mask

☐ T-Piece ☐ Trach Collar ☐ Transtracheal Catheter ☐ Venturi Mask

Specify one of the following parameters:

FIO2: LPM: 4 Maintain SaO2: 95

Instructions:

Repeat View Document Add Close

- 11) Do another order search to add into the queue (if any)
- 12) Click on SUBMIT once all orders are in queue

Another Order search/entry

Manual Entry Searching for ...

cpt

Order

CPT (Chest Physiotherapy)

Oxygen Therapy - Delivery Method: Nasal Cannula; LPM: 4; Frequency: < Continuous>; Maintain O2 Sat: 95	Jun-17-2017	Pending
Chest Physiotherapy		
Chest Physiotherapy - Requested Date: Jun-17-2017 Frequency: every 6 hours	Jun-17-2017	Pending
PD&P Treatment (New Start) - Requested Date: Jun-17-2017 Frequency: ONCE	Jun-17-2017	Pending
PD&P Treatment (Subsequent Tx) - Requested Date: Jun-17-2017 Frequency: every 6 hours	Jun-17-2017	Pending

Submit Order(s) for TRAINING_50SPATIENT7... Hide Worksheet Cancel Help

Submit Button

Order Queue

Go to ORDERS TAB  to view your orders:



Order Summary						Order Date	Status	Stop Date	Entry Date
<input type="checkbox"/>	Respiratory Therapy								0/4
<input type="checkbox"/>	Chest Physiotherapy - Requested Date: Jun-17-2017 Frequency: every 6 hours					Jun-17-2017	Active		Jun-17-2017 12:23
<input type="checkbox"/>	Oxygen Therapy - Delivery Method: Nasal Cannula; LPM: 4 ; Frequency: <Continuous>; Maintain O2 Sat: 95					Jun-17-2017	Active		Jun-17-2017 12:23
<input type="checkbox"/>	PD&P Treatment (New Start) - Requested Date: Jun-17-2017 Frequency: ONCE					Jun-17-2017	Active		Jun-17-2017 12:23
<input type="checkbox"/>	PD&P Treatment (Subsequent Tx) - Requested Date: Jun-17-2017 Frequency: every 6 hours					Jun-17-2017	Active		Jun-17-2017 12:23

Variations of Order entry/modifications

- Repeat order
- Conditional Order
- Suspend/Unsuspend Order
- Discontinue/Cancel
- Discontinue/Reorder

STRUCTURED DOCUMENTS

Structured documents are notes that have templates designed specifically for each discipline/department use. These are available for view/modification under the DOCUMENTS TAB.



DOCUMENT ENTRY



Click on **ENTER DOCUMENT**

- 1) Type the first few letter of the document name
- 2) Select the Document
- 3) Click Open

Document Entry Worksheet - TRAINING, NCH-SCHCCKBM404

Date of Service: Jun - 21 - 2017 Time: 10:06
Authored: ☐ Date ☒ Now Jun - 21 - 2017 Time: 10:06
Authored by: ☒ Me ☐ Other Source:
Co-Signer(s): ☐ ☐
Mark Note As: ☐ Incomplete ☐ Results pending ☐ Priority

Manual Entry Searching for ADM
ADM
Document Name
Admission Note Nursing
Admission Psych Note Nursing

Type Document name (or first few letters)
Select appropriate Document to use

Click to open/start document

Need help? Document Help Open Close

For LVNs tht may need to assign an RN name to co-sign with their documentation

Document Sections

Preview Button

Preview Pane

Acronym Expansion

To save Incomplete or Complete

Structured Notes Entry TRAINING, NCI-SCHOLIMADS - Admission Note Nursing

Date of Service: Jun - 21 - 2017 Time: 10:10:56

Sections: Coping/Stress, Spiritual/Religious/Cultural Va, Risk Screens, TRAVEL RISK SCREEN, VTE Risk Assessment, VTE RISK FACTOR AS, MORSE FALL SCALE, CURRENT FUNCTIONAL LEVEL, PRIOR FUNCTIONAL LEVEL, BRADEN SCALE, NUTRITION SCREEN, DEPRESSION RISK ASSES, SUBSTANCE USE, ABUSE SCREEN, SUICIDE/HOMICIDE RISK, ELOPEMENT RISK INSTRU, ELOPEMENT RISK ASSES, Advance Directives, Family History, Allergy, Intolerance, Adverse E, Vital Signs

Document Info

CREATE Preview Refer to Note Copy Forward Modify Template Preview Acronym Expansion

DEPRESSION RISK ASSESSMENT

Current Feelings of Depression ☐ yes... ☒ no

History of Depression ☐ yes ☒ no

Depression Risk Comments

SUBSTANCE USE

☒ Smoking Status ☐ current every day smoker... ☐ current some day smoker... ☐ light smoker... ☐ heavy smoker... ☐ smoker, current status unknown... ☐ former smoker... ☐ never smoker ☐ unknown if ever smoked

☐ Caffeine Use Status ☐ caffeine use current... ☐ does not use caffeine

☐ Alcohol Use Status ☐ alcohol current... ☐ alcohol past... ☐ alcohol never used

Street Drug/Inhalant/Medication Use Status ☐ street drug/inhalant/medication abuse current... ☐ street drug/inhalant/medication abuse past... ☐ street drug/inhalant/medication never used

Exposure to Second Hand Smoke ☐ none ☐ infrequent ☐ frequent

Substance Use Comments

ABUSE SCREEN

Comfortable/Feel Safe ☐ yes ☒ no

Need Help? Mark Note as: ☐ Results pending ☐ Priority ☐ Incomplete ☐ Save

Home Medications: HOME MEDICATIONS REVIEW/ADD: * No Current Medications as of May-30-2017 16:48 documented

Problem List:

Past Medical Hx:

- Type 2 diabetes mellitus with stage 2 chronic kidney dis
- Schizophrenia
- Obesity

Family History:

- HT-diabetes mellitus
- Family history of hypertension
- Family history of lung cancer

Electronic Signatures: 502TRAIN, RN33 (RN) (Signed Jun-21-2017 10:16)

Authored: Home Medications, Problem List

Last Updated: Jun-21-2017 10:16 by 502TRAIN, RN33 (RN)

4) Fill out the form. Mandatory fields will have either of the following symbols:

🔴 Mandatory - Document cannot be saved if not addressed

🔵 Significant - Document can only be saved "incomplete" if not addressed

5) Save the document

Once saved, it is found under the DOCUMENTS TAB



For Nursing Units, the following are the most common structured notes available for use:

1. Nursing Narrative Note
2. Admission Note Nursing
3. Sepsis Screening Tool
4. Belongings List
5. Ticket to Ride
6. Transfer Note
7. Preoperative Checklist
8. Critical Lab Result Notification
9. Event Note
10. Discharge Instructions
11. Discharge Note Nursing
12. Death Procedure Checklist
13. Physician Central Line Daily Assessment

Some other notes may be of use depending on the unit workflow

Problem Manager | Add - TRAINING01, NCH-SCHCC01

TRAINING01, NCH-SCHCC01 East Med/Surg-0150-8 Female 57y (04-26-1960) Allergy - No Known Drug Allergies; Environment: Cats; Contact: Later; Intolerance - Food: Beans

Show/Discontinue
 Delete
 Copy
 Quick Copy
 Manual Mapping
 Preferred Mapping
 Filter
 Reset
 Clear All
 Community Filters
 Column Selection
 Grid Options
 Acronym Expansion
 InfoButton

9 Problem(s) shown

TRAINING01, NCH-SCHCC01 Problems: Currently showing - Problem Types (All); Status (Active Only); Entered By (All)

Problem	Code	ICD-9	ICD-10	SNOMED CT	Type	Onset Date	POA	Relationship to Patient (Age at Diagnosis)
- Past Medical Hx (8)								
Major depressive disorder, single episode	F32.9		F32.9		Past Medical Hx	05-10-2017		
New onset of diabetes mellitus in pediatric...	E11.9	250.00	E11.9	405749004	Past Medical Hx	05-10-2017		
Gastrointestinal hemorrhage	K92.2		K92.2		Past Medical Hx	05-10-2017		
Blindness, both eyes	H54.0		H54.0		Past Medical Hx	05-10-2017		
Dysphagia	R13.10		R13.10		Past Medical Hx	05-10-2017		
Unsteadiness on feet	R26.81		R26.81		Past Medical Hx	05-10-2017		
Chronic obstructive pulmonary disease	J44.0		J44.0		Past Medical Hx	05-10-2017		

Add New Problem

Select a Type:

- Admitting Dx
- Discharge Dx
- Family History
- Past Medical Hx
- Past Surgical Hx
- Postoperative Dx
- Preoperative Dx
- Procedure-Other
- Social History
- Surgical Dx
- Surgical Event
- Visit Problem
- Working Dx

Favorites Browse Full Catalog Search ICD-10

Cancel Hide All Code Linkages Add to Favorites Add Non-Coded Issue

Close Help

PROBLEM LIST





OUTPATIENT MEDICATION REVIEW

COMMONLY KNOWN AS HOME MEDICATIONS

28

Outpatient Medication Review

TRAINING01_NCH-SCHIC01
1000002087 / 100000215
571 (04-26-1960)
Female

Unreviewed Allergies
Allergies: No Known Drug Allergies, Cats, Latex/Intolerance: Bakers

Med Status: Patient Currently Takes Medications
Preferred Pharmacy: cHemo2

Options Panel
Filters
Status:
☒ Unsubmitted
☐ Active
☐ Not Being Taken
☐ Inactive
(All)

Multitask Item Class:
☒ By Prescription Only
☒ Over the Counter (OTC)
☒ Free Text (non-Multitask)

Display Styles
Group/Sort Medication by:
Drug and Status

Show:
☒ Instructions
☒ Health Issues
☒ Discharge
☒ Discharge
☒ Pharmacy
☐ Comments
☐ More Details
☐ Renew

Home Medications Review Status for Reconciliation: Not Done
Discharge Reconciliation Status: Not Done
Some patient medication may not be shown. Showing All Needs to be reviewed for this visit.
Display Format: Review Active Medications (Medication)

Group/Sort By: Drug and Status

Items: 6

aspirin 81 mg oral tablet (1 item)
1 tablet orally once a day
Entered By: SCOTTSMAN, RNT(RN)
Status: Active
Last Dose Taken Date Time: 0
Entry Type: Rx Refill: 450
Follow up Reason: 0

Dexamethasone 80 mg oral tablet (1 item)
1 tablet orally once a day
Entered By: SCOTTSMAN, RNT(RN)
Status: Active
Last Dose Taken Date Time: 0
Entry Type: Rx Refill: 449
Follow up Reason: 0

Ginkgo Biloba oral capsule
1 capsule orally once a day
Entered By: SCOTTSMAN, RNT(RN)
Status: Active
Last Dose Taken Date Time: 0
Entry Type: Rx Refill: 607
Follow up Reason: 0

Levetiracetam 1500 mg oral capsule (1 item)
1 capsule orally once a day
Entered By: SCOTTSMAN, RNT(RN)
Status: Active
Last Dose Taken Date Time: 0
Entry Type: Rx Refill: 602
Follow up Reason: 0

Levetiracetam 1500 mg oral capsule (1 item)
1 capsule orally once a day
Entered By: SCOTTSMAN, RNT(RN)
Status: Active
Last Dose Taken Date Time: 0
Entry Type: Rx Refill: 602
Follow up Reason: 0

Levetiracetam 1500 mg oral capsule (1 item)
1 capsule orally once a day
Entered By: SCOTTSMAN, RNT(RN)
Status: Active
Last Dose Taken Date Time: 0
Entry Type: Rx Refill: 598
Follow up Reason: 0

Need Help?

Save Complete Save Incomplete Cancel

Worklist Manager - TRAINING, 508KBMAS

File Edit View Actions Help

Close

Nursing - Selected Patient

Modify...

Scheduling

Status

From

May-21-2017

to

May-21-2017

by

Task (Actual)

intervals

Update

Task Description	Task Start	Task Stop	May 2017																				
			6:00	8:00	10:00	12:00	14:00	16:00	18:00	20:00	22:00	0:00	2:00	4:00	6:00	8:00	10:00	12:00	14:00	16:00	18:00	19:00	
TRAINING - 508KBMAS (06-02-1960); 100000095/100000126;																							
Consults																							
• Consult Social Services	May-10-2017 10:23																						
Nursing																							
• • IV Insert																							
• Priority/Time: Routine	May-10-2017 10:53																						
• Frequency: ONCE																							
• Turn Side to Side every 2 hours	May-10-2017 10:53																						
DVT Prophylaxis																							
• Sequential Compression Device (SCD) Routine Bilateral	May-10-2017 11:01																						
Nutrition																							
• Diet Order: NPO	May-10-2017 10:53																						
• Diet Order: NPO	May-10-2017 14:06																						

Ready

508TRAIN, RNLI (RN)



WORKLIST MANAGER NURSING TASKS

NOTES -

1. ALL users are responsible to call **ITHELPDESK** if they encounter a problem with their username or password.



ITHelpdesk

email: ITHelpdesk@Altacorp.com

(562)293-3276



Alta Hospitals System LLC



FOOTHILL REGIONAL MEDICAL CENTER



PROSPECT MEDICAL
HOLDINGS, INC.

