Allscripts™

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

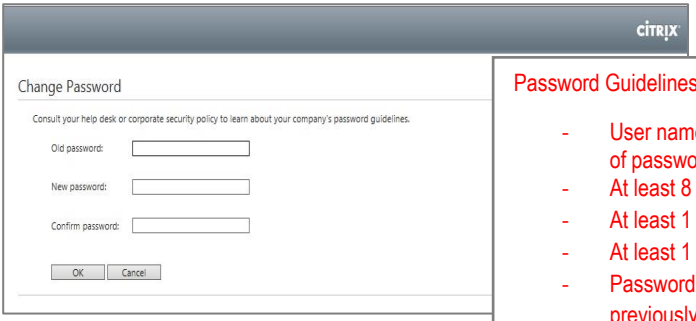
Culver City, 2017v.1

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.



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 

folder to access the SCM gateway.

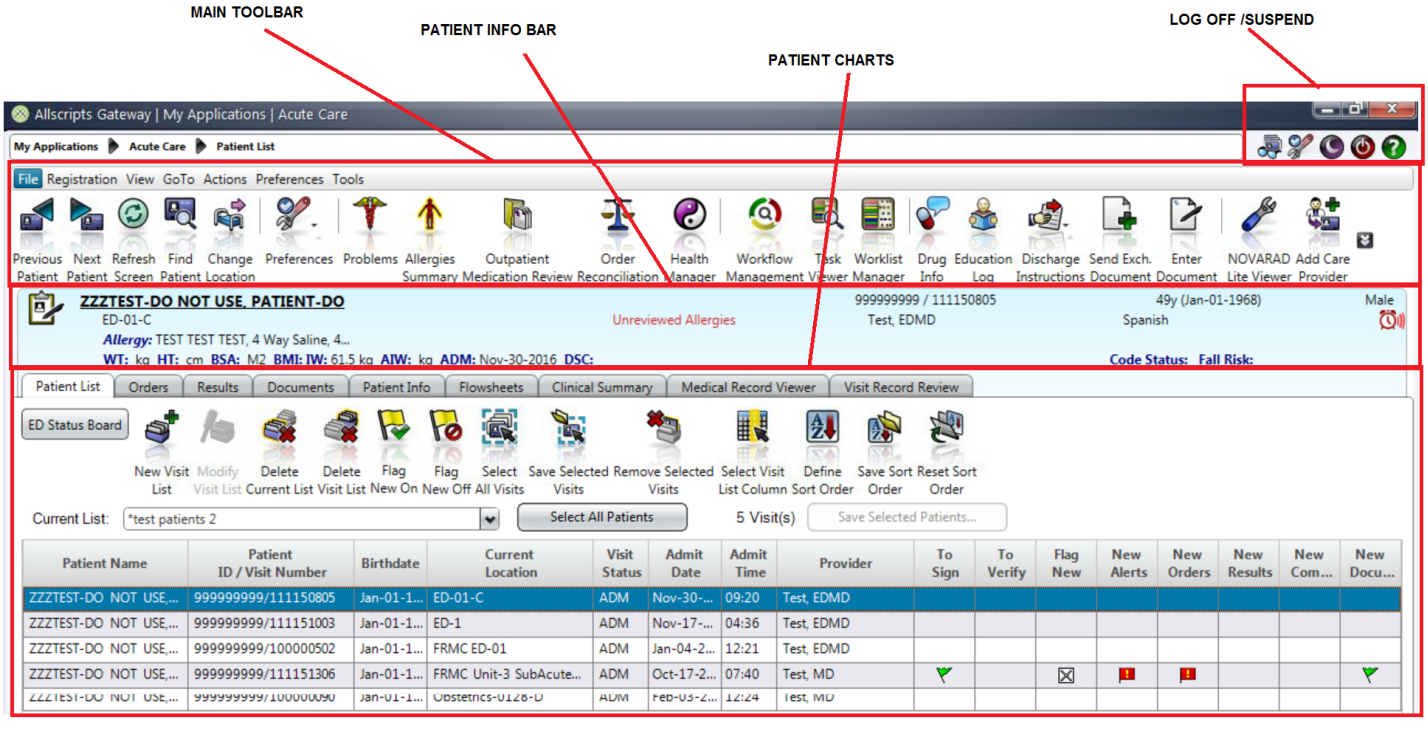
Double click on the 

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****

THE ACUTE CARE PAGE (MAIN SCREEN)



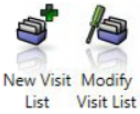
TO USE THIS GUIDE…

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*

    - *(***<u>Mark POA</u> if present on admission)*

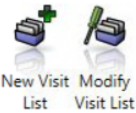
- 
ADMISSION NOTE NURSING *(aka "patient profile")*
  - *RN CO-Sign for LVN*
- 
FLOWSHEET *(see add parameter/time column page 17-19)*
  - ***Assessment and Cares*** *(For head to toe assessment)*

- **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 **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

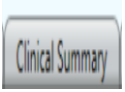
- 

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***

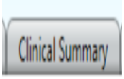
- 
NURSING NARRATIVE NOTE *(Save as complete at end of shift)*

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

- 
CRITICAL LAB RESULT NOTIFICATION *(if any)*

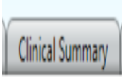
- 
EVENT NOTE *(if any)*

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

-  **MARK ALL <u>eMAR</u> TASKS** *(ex: blood transfusion)*
  -  **KBMA** *(Barcode Scanning)*
-  **MARK ALL <u>NURSING</u> 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 documentsand/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)*

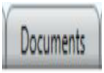
- **ASSESSMENT AND CARES** – Add and/or Document on all the following parameters that applies:
  - ***Under SKIN parameters***
    - **skin assessment** *(default)*
    - **hygiene** *(default)*
    - **specialty bed/surface**
    - **skin incontinence protection**
    - **pressure ulcer**
    - **bruising**
    - **rash**
    - **burn**
  - ***Under MUSCULOSKELETAL parameters***
    - **positioning** *(default)*

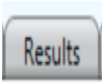
- **MARK WOUND CARE ORDER TASKS**
  - (*Post wound care/wound meds administration*)

- **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**

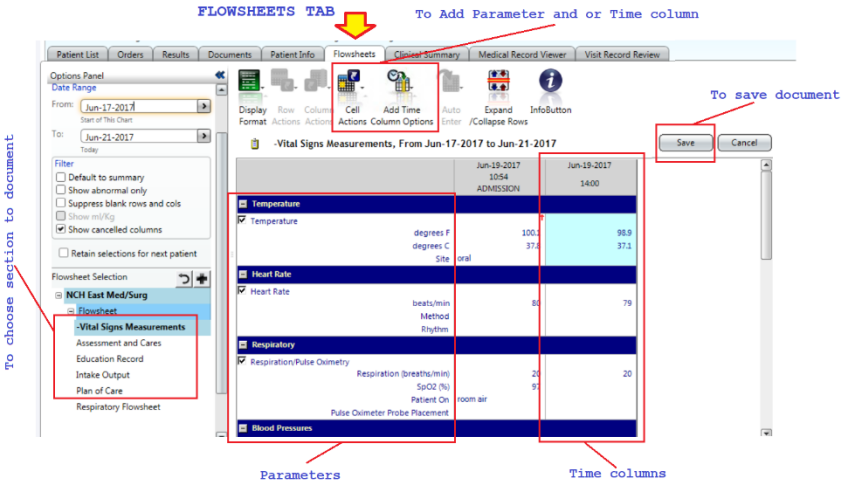
    INTAKE AND OUTPUT
  - ***Under INTAKE parameters***
    - **tube feeding or the formula name**
  - ***Under NET parameters***
    - **residual/refeeding**
-  **MARK THE NURSING TASK FOR RESIDUAL CHECK**

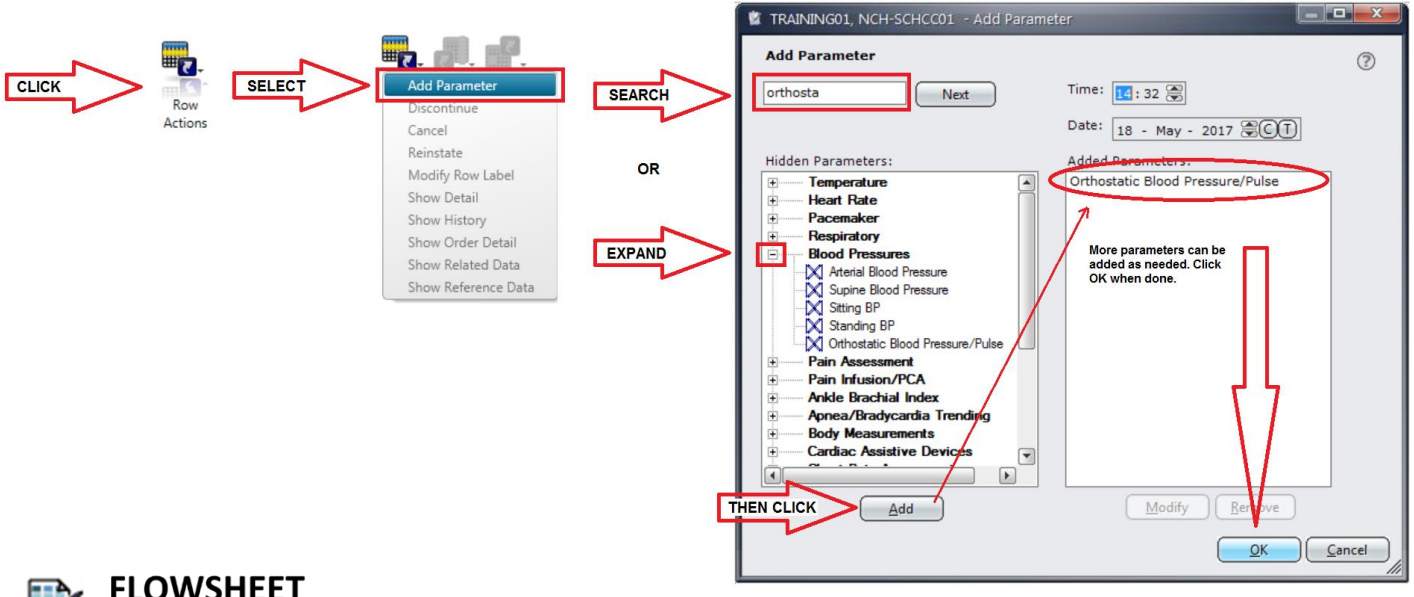
FLOWSHEET

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

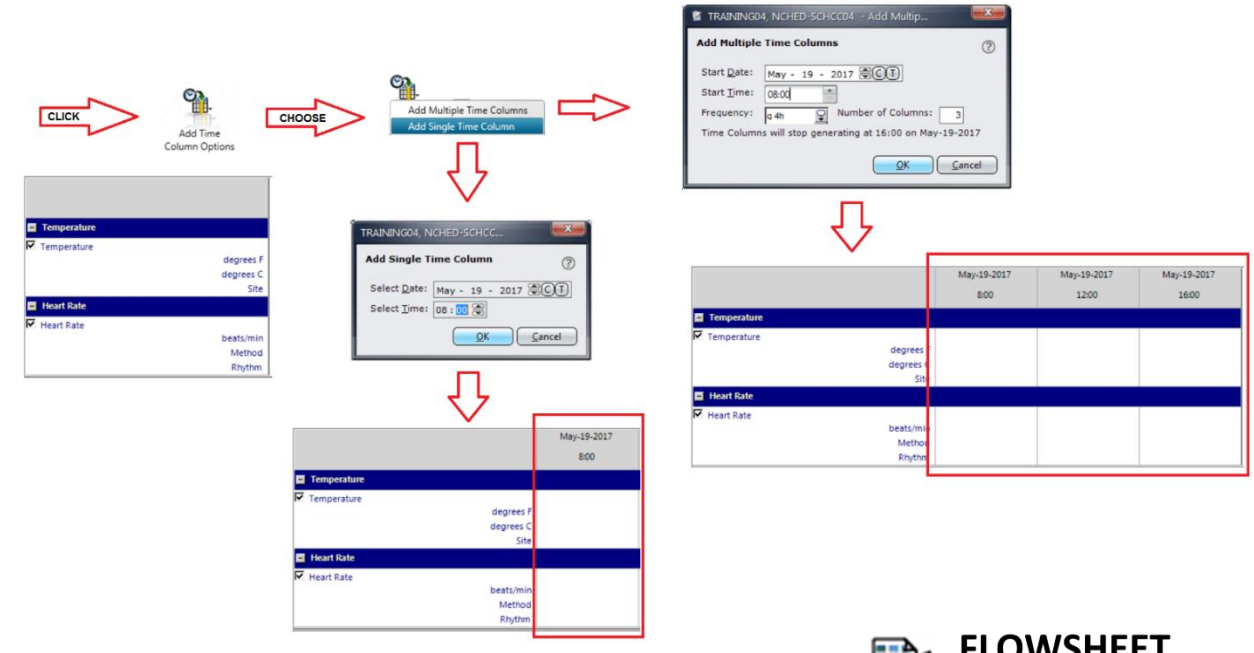
1) Select Section to document *(ex. Vital Signs)*
2) Add additional parameter (*as needed)*
3) Add a time column *(change time as needed)*
4) Document on the time column





FLOWSHEET

ADDING ADDITIONAL PARAMETERS



FLOWSHEET

ADDING TIME COLUMNS

PHYSICIAN ORDERS

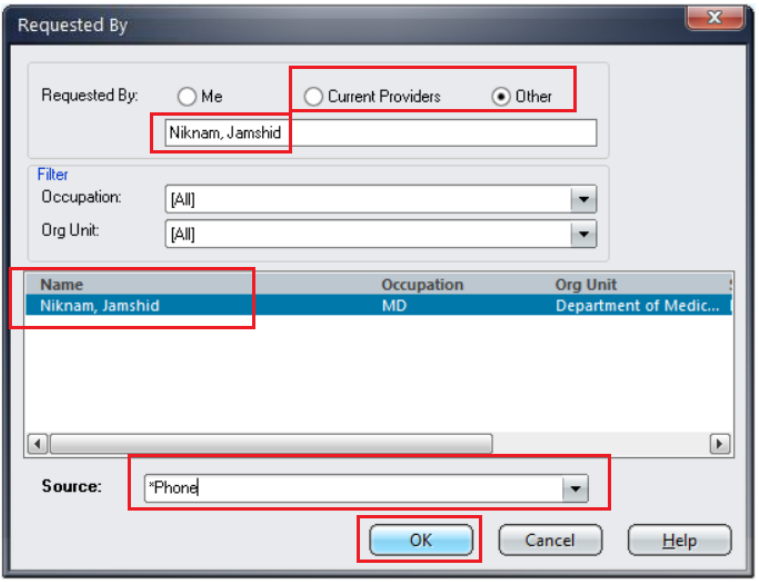
Orders placed are found under the **ORDERS TAB.**

ORDER ENTRY

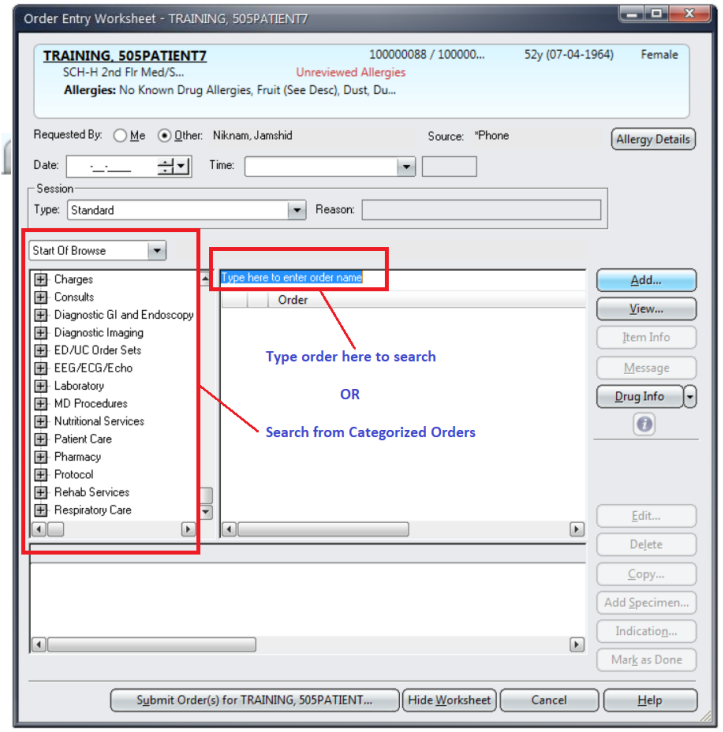
To enter orders in behalf of the Physician:

Click on **ENTER ORDER**

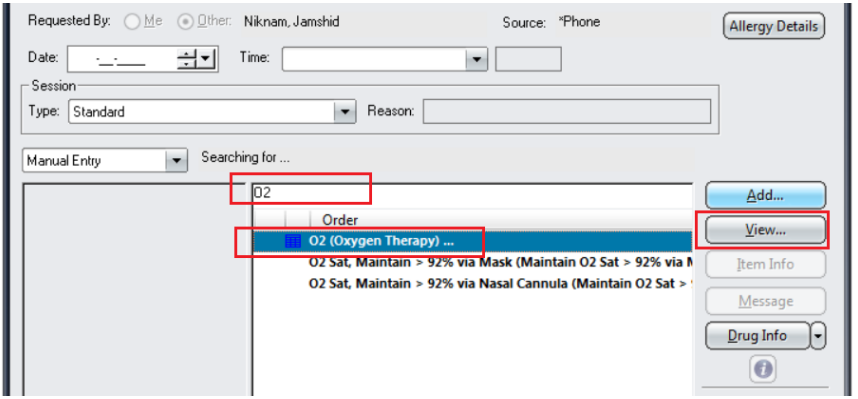
1) Requested by window will appear and select "**Other**" if the prescribing MD name is not listed below.
2) Type and search for ***last name of MD***
3) ***Select correct MD name*** from the populated list
4) Source: "**Phone"**
5) Click "**Ok**".



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

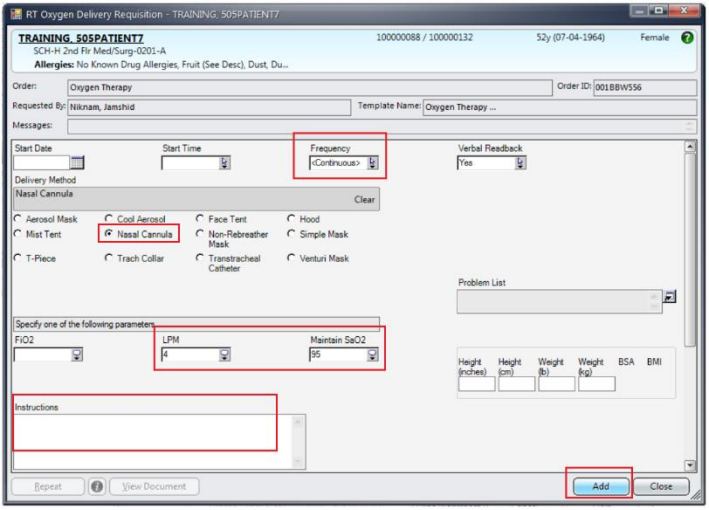


7) Select the appropriate order
8) Click View



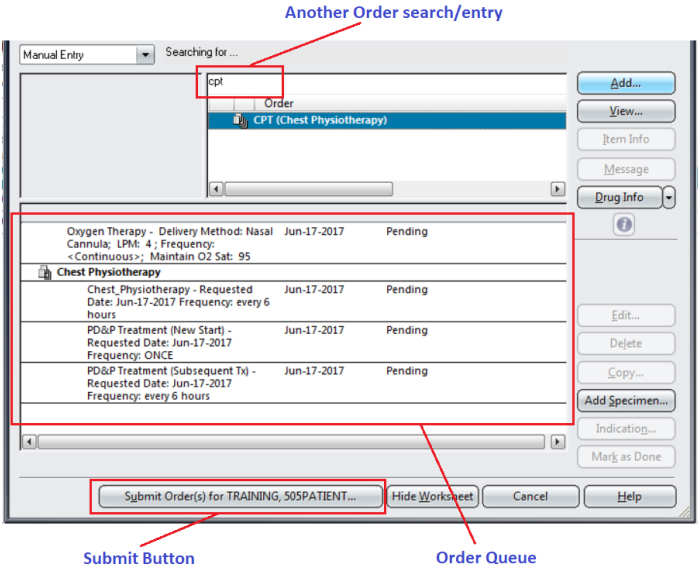
9) Fill out the order form details and instructions

10) Click ADD

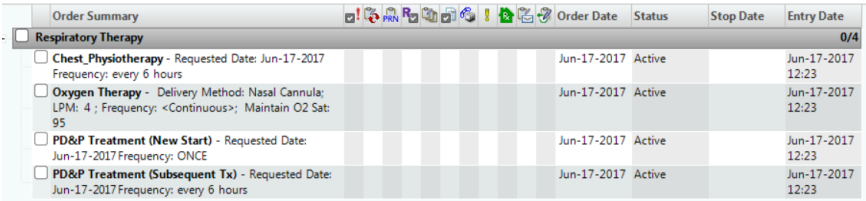


11) Do another order search to add into the queue (if any)

12) Click on SUBMIT once all orders are in queue



Go to ORDERS TAB to view your orders:



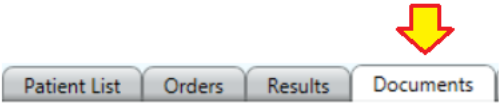
Order Summary	Order Date	Status	Stop Date	Entry Date
Respiratory Therapy				0/4
Chest_Physiotherapy - Requested Date: Jun-17-2017 Frequency: every 6 hours	Jun-17-2017	Active		Jun-17-2017 12:23
Oxygen Therapy - Delivery Method: Nasal Cannula; LPM: 4 ; Frequency: <Continuous>; Maintain O2 Sat: 95	Jun-17-2017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

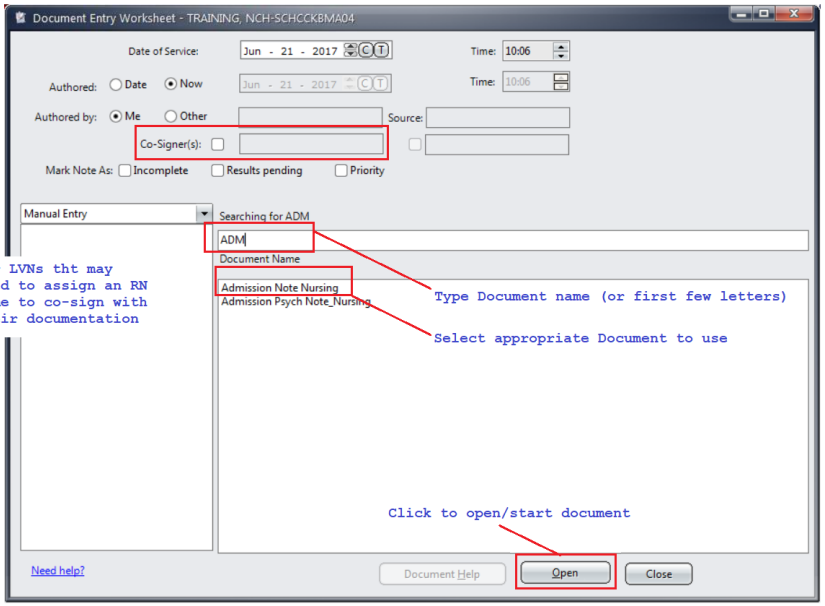
Structured documents are notes that have templates designed specifically for each discipline/department use. These are available for view/modification under the DOCUMENTS TAB.

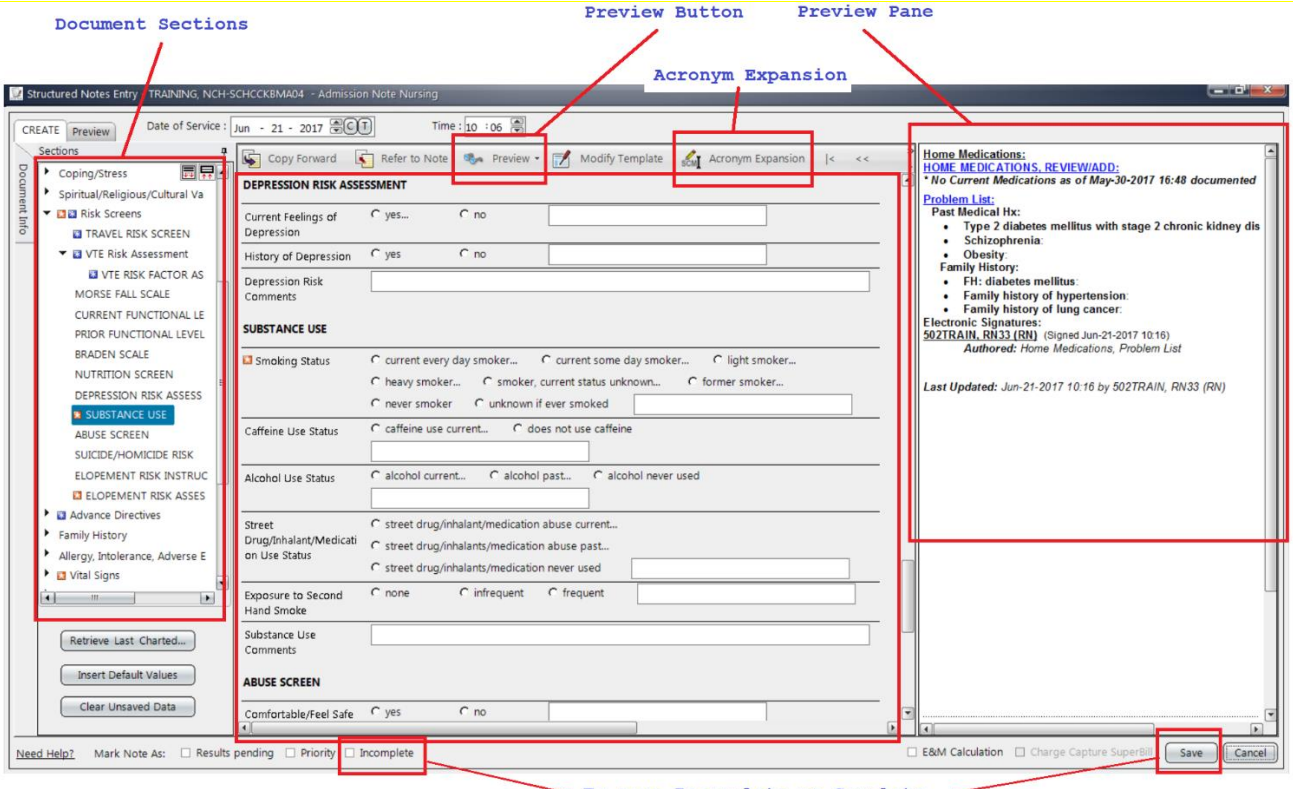


DOCUMENT ENTRY

Click on **ENTER DOCUMENT**

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




Document Sections
Preview Button
Preview Pane
Acronym Expansion
Structured Notes Entry TRAINING, NCH-SCHCCKBMA04 - Admission Note Nursing
CREATE
Preview
Date of Service : Jun - 21 - 2017
Time : 10 : 06
Sections
Document Info
Coping/Stress
Spiritual/Religious/Cultural Va
Risk Screens
TRAVEL RISK SCREEN
VTE Risk Assessment
VTE RISK FACTOR AS
MORSE FALL SCALE
CURRENT FUNCTIONAL LE
PRIOR FUNCTIONAL LEVEL
BRADEN SCALE
NUTRITION SCREEN
DEPRESSION RISK ASSESS
SUBSTANCE USE
ABUSE SCREEN
SUICIDE/HOMICIDE RISK
ELOPEMENT RISK INSTRUC
ELOPEMENT RISK ASSES
Advance Directives
Family History
Allergy, Intolerance, Adverse E
Vital Signs
Retrieve Last Charted...
Insert Default Values
Clear Unsaved Data
Copy Forward
Refer to Note
Preview
Modify Template
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/inhalants/medication abuse past...
street drug/inhalants/medication never used
Exposure to Second Hand Smoke
none infrequent frequent
Substance Use Comments
ABUSE SCREEN
Comfortable/Feel Safe
yes no
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:
FH: 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)
Need Help?
Mark Note As:
Results pending
Priority
Incomplete
E&M Calculation
Charge Capture SuperBill
Save
Cancel
To save Incomplete or Complete

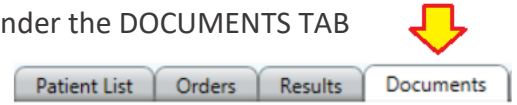
4) Fill out the form. Mandatory fields will have either of the following symbols:

Mandatory - Document cannot be saved if not addressed

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

5) Save the document

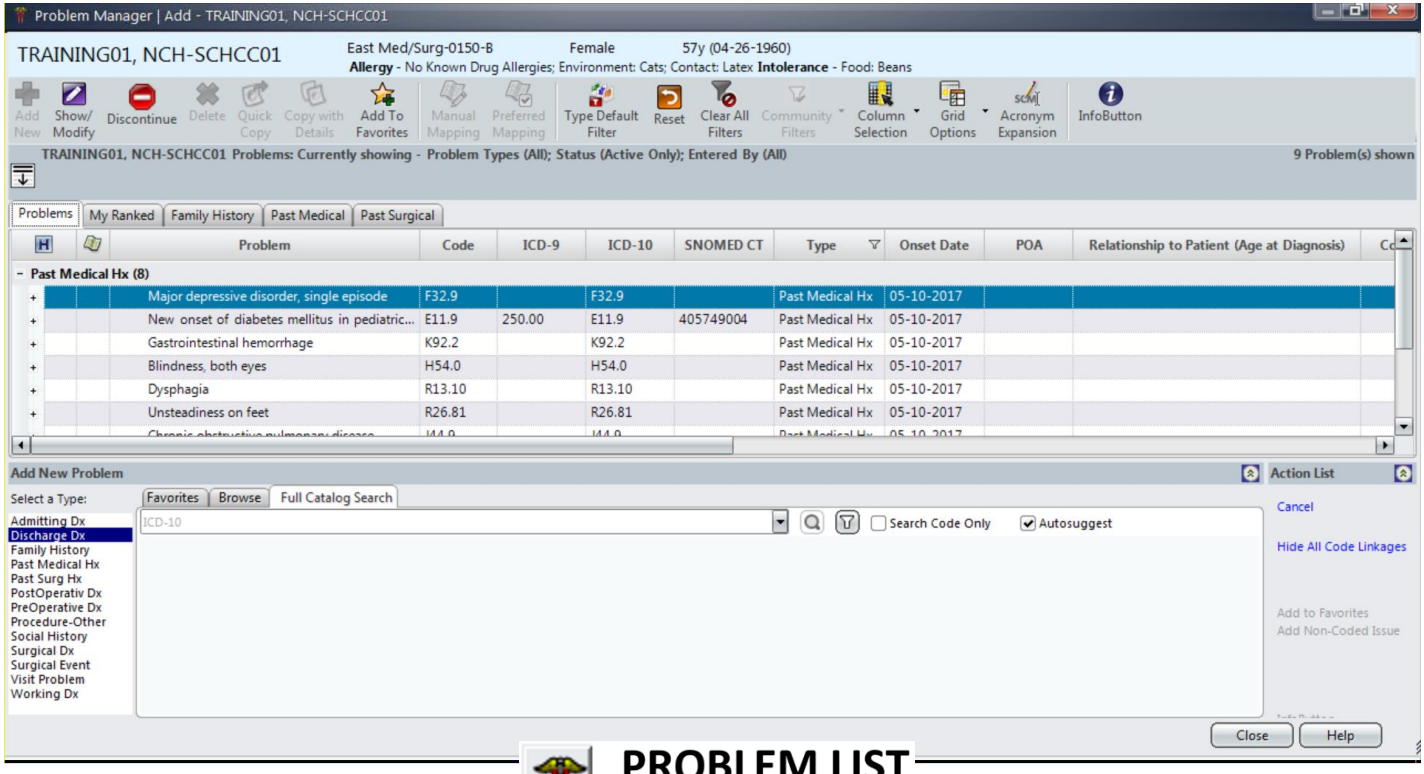
Once saved, it is found under the DOCUMENTS TAB



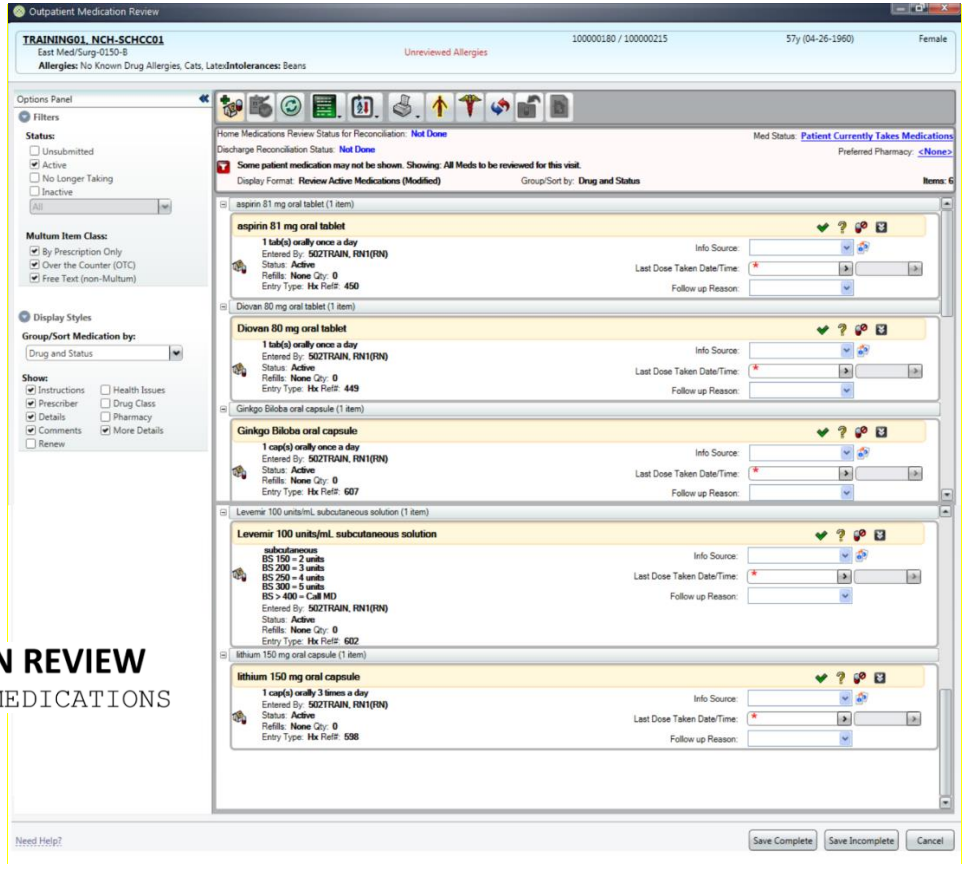
For Nursing Units, the following are the most common structured notes available for use:

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

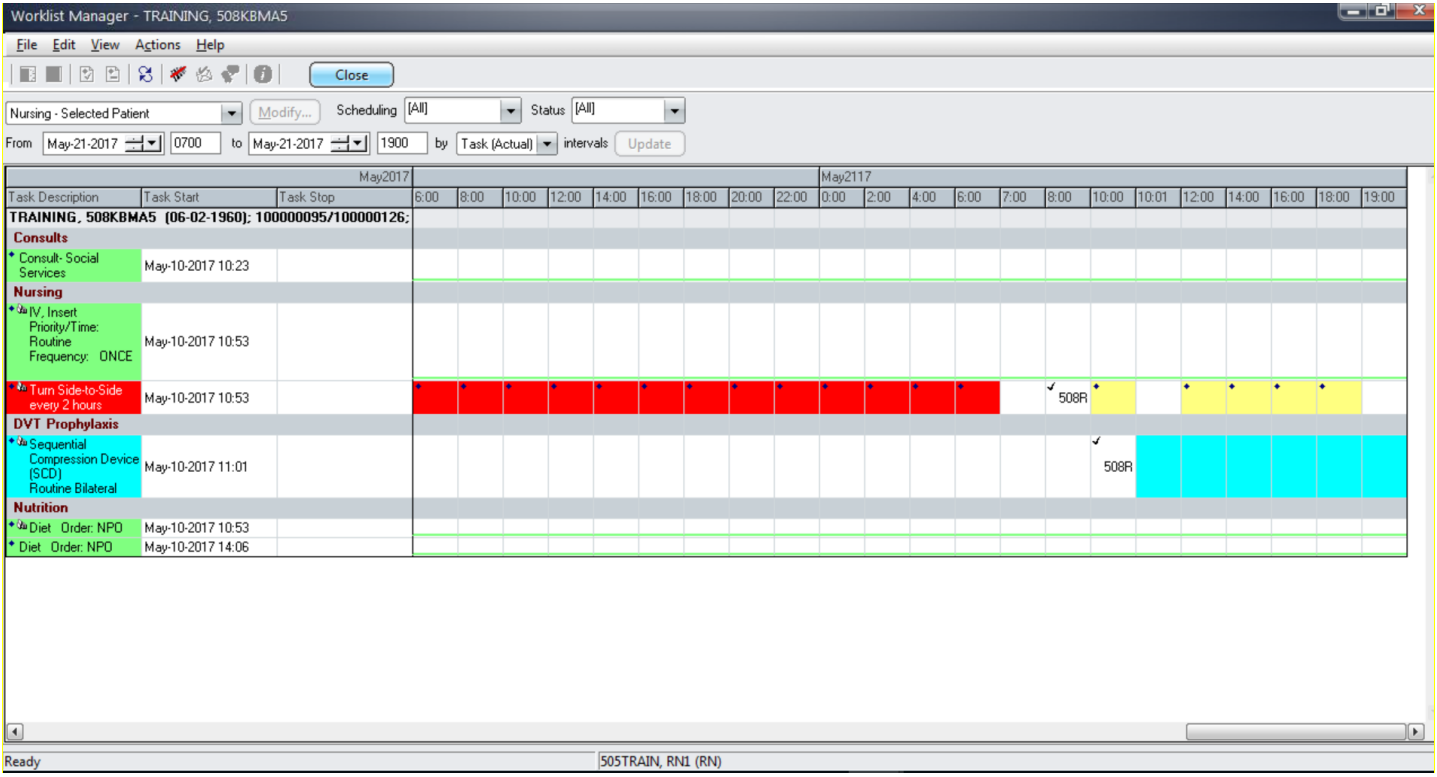


PROBLEM LIST

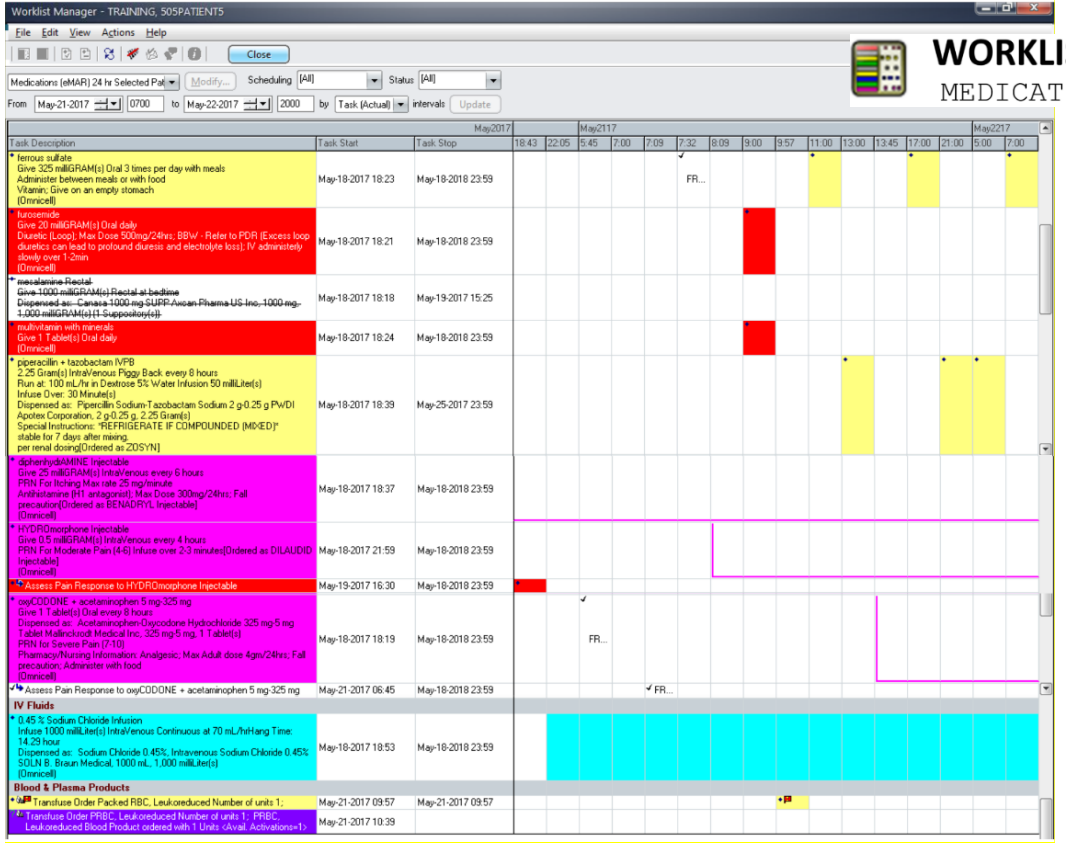


OUTPATIENT MEDICATION REVIEW

COMMONLY KNOWN AS HOME MEDICATIONS



WORKLIST MANAGER
NURSING TASKS



WORKLIST MANAGER

MEDICATIONS (eMAR)

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

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