# BIG BANG '08 COMPLETE GUIDE

# PHYSICIANS

# Table of Contents

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## REVIEWING ORDERS

### ORDERS TAB

= Suspended Order
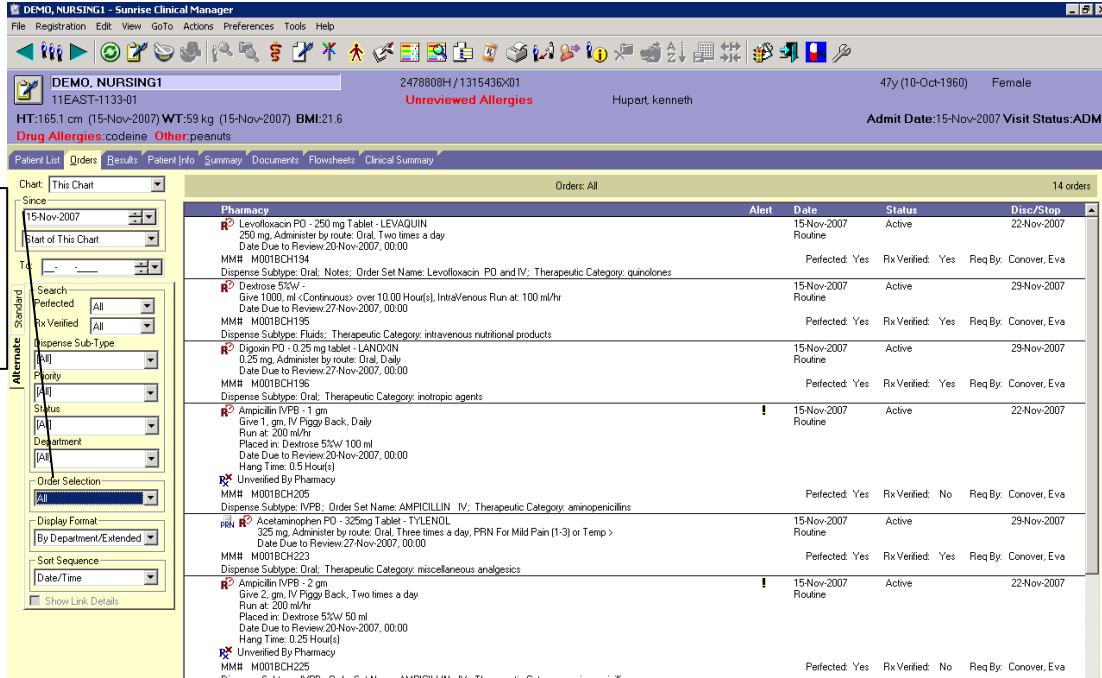
R = A review on the order is required  R = A review on the order is overdue



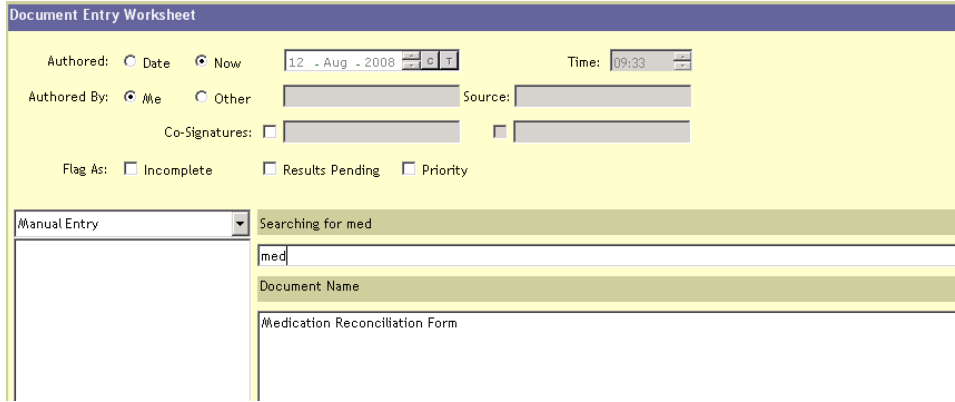Use Department /Extended Filters

## MEDICATION RECONCILIATION

Medication Reconciliation will begin in the ED.  A nurse will start filling out an electronic Medication reconciliation form in SCM

Select the patient and then click on the New Document icon in your toolbar

Type Med in the Searching for field and double click on it.

**Document Entry Worksheet**

Authored:  ○ Date  ● Now      12 - Aug - 2008   c  T        Time: 09:33

Authored By:  ● Me   ○ Other  [          ]   Source: [          ]

Co-Signatures: □ [          ]   □ [          ]

Flag As:  □ Incomplete   □ Results Pending  □ Priority

Manual Entry ▼     Searching for med
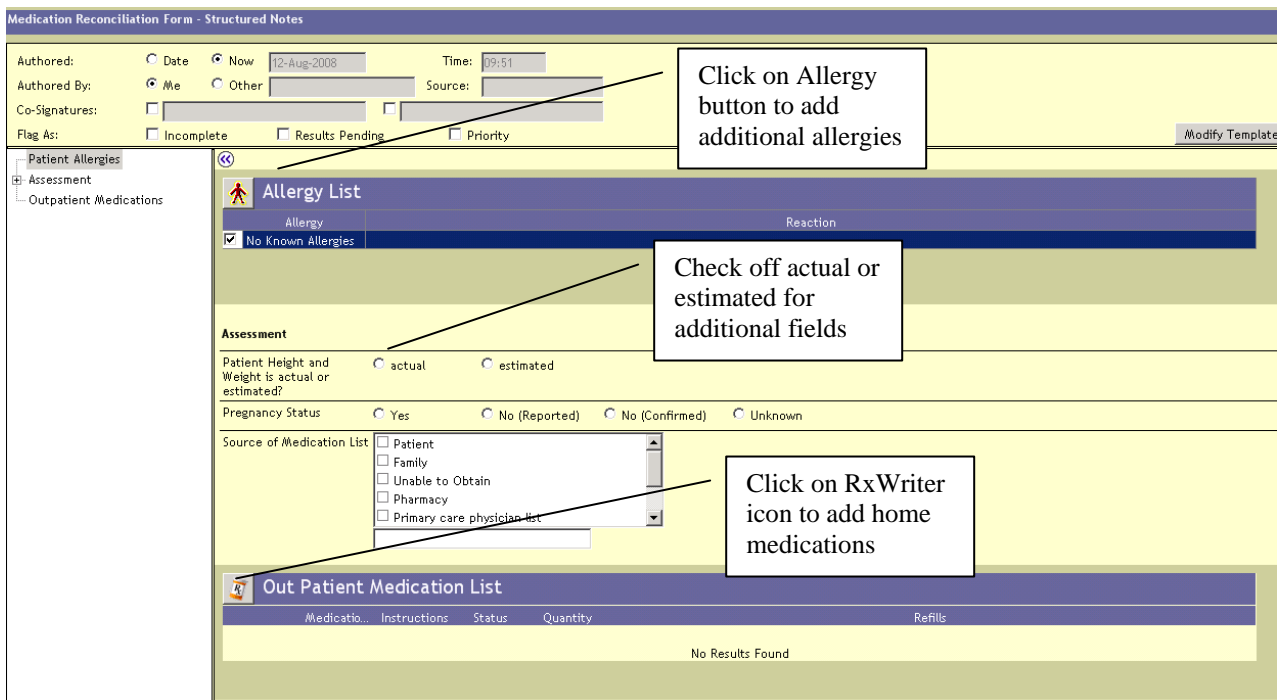
med

Document Name

Medication Reconciliation Form

*Allergies*:  If you need to add additional allergies, click on the Allergy button       (same as the icon in the toolbar)

*Patient HT&WT:* If you fill out **actual** it will populate the patient header.  If you fill out estimated it will document on note but not override header.

*Pregnancy and Lactation*: will only show for females age 10 and over.

*Home Medications (Outpatient Medication List):*      Will be entered in RxWriter by clicking on the Add HX button.  (if patient isn't on any meds choose the check box, patient takes no medications)

**Medication Reconciliation Form - Structured Notes**

Authored:       ○ Date ● Now  12-Aug-2008        Time: 09:51
Authored By:    ● Me  ○ Other [          ]   Source: [          ]
Co-Signatures:  □ [          ]   □ [          ]
Flag As:        □ Incomplete   □ Results Pending   □ Priority                           Modify Template

- Patient Allergies
- Assessment
- Outpatient Medications

**Allergy List**

| Allergy | Reaction |
|---|---|
| ☑ No Known Allergies | |

> Click on Allergy button to add additional allergies

**Assessment**

Patient Height and Weight is actual or estimated?    ○ actual      ○ estimated

Pregnancy Status    ○ Yes       ○ No (Reported)   ○ No (Confirmed)   ○ Unknown

> Check off actual or estimated for additional fields

Source of Medication List  □ Patient
□ Family
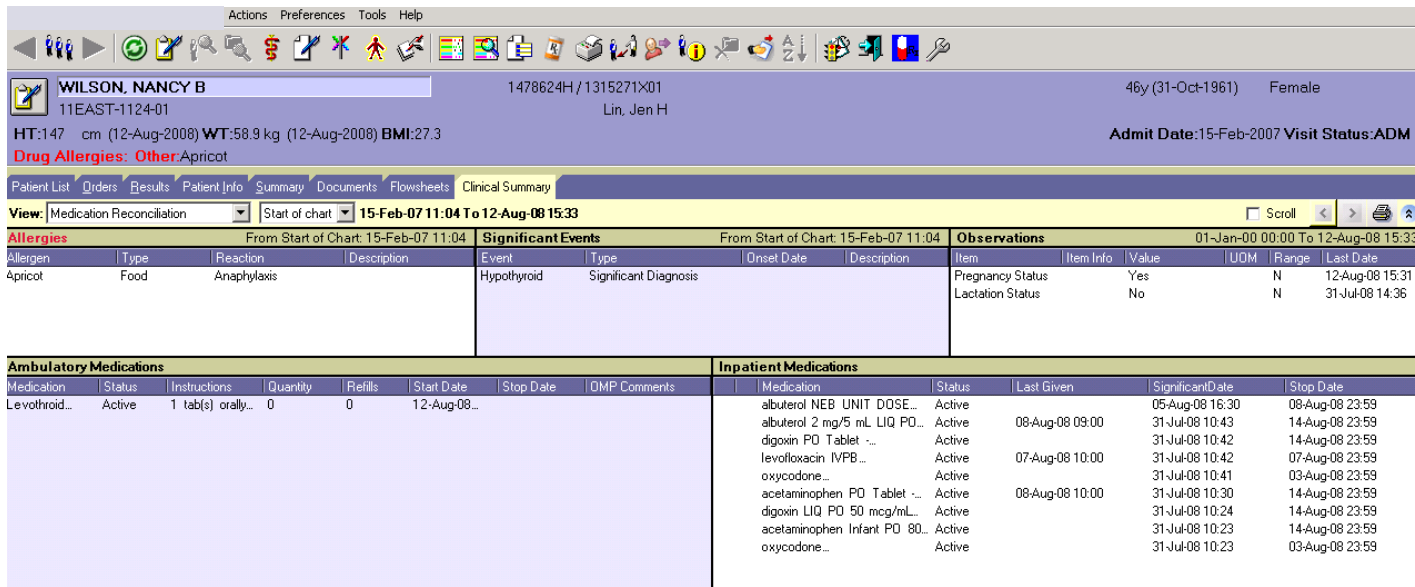□ Unable to Obtain
□ Pharmacy
□ Primary care physician list

> Click on RxWriter icon to add home medications

**Out Patient Medication List**

| Medicatio... | Instructions | Status | Quantity | Refills |
|---|---|---|---|---|
| | | No Results Found | | |

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Everything the nurse enters on the Medication Reconciliation note, will populate on the Clinical Summary Tab—Medication Reconciliation View (may need to refresh screen )

**Clinical Summary tab**- choose view Medication Reconciliation



**Documents Tab-**Double-click on the form to view

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Physicians will should review home meds tile and begin ordering inpatient meds. You will no longer have to circle, continue or stop.

Placing an order for the medication is understood that you are continuing medication upon admission.

When reconciliation is complete physician will add a significant event to document medication reconciliation. Right click in the Significant Event box (in the clinical summary tab) to do this.
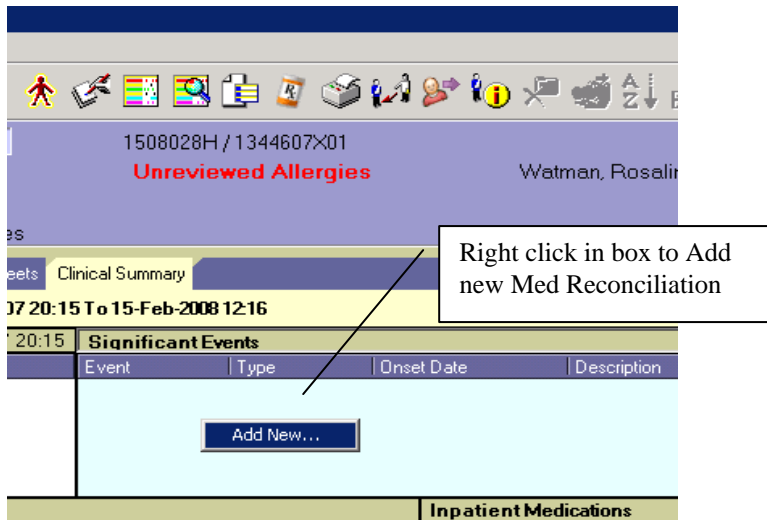


Select Type: Medical Reconciliation, Choose Event (Admission) and fill in necessary fields.
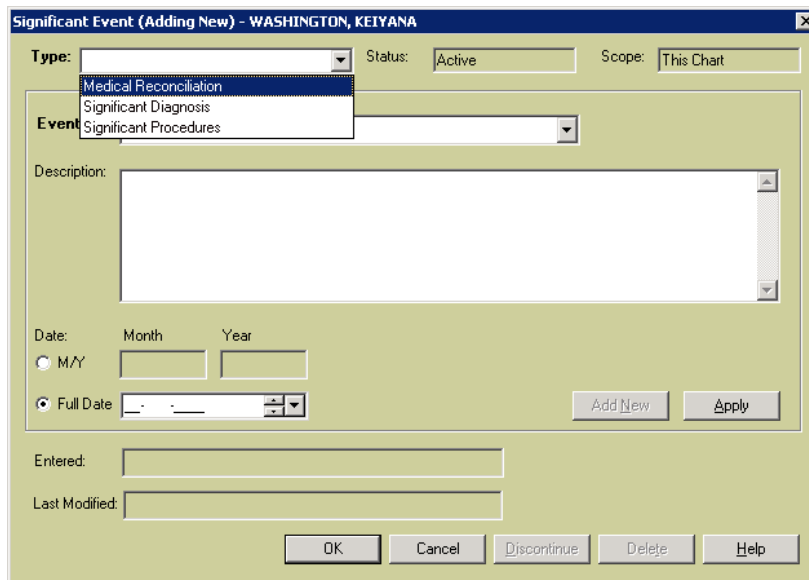
**To Edit an Significant Event** go to the Patient info tab, double click on the Event you wish to edit and choose Discontinue.

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## TRANSFERS

Physician places a Transfer Service Request order.  This notifies patient access that the patient needs a transfer in Eagle.

Once the patient is in the new location the accepting Attending will:

1. Place a SATC order (updates Service, Attending, and Team)
2. Review Clinical Summary Tab (medication reconciliation view)
   a. Look at home meds and inpatient meds
3. Discontinue/Cancel any active orders or Discontinue/Recorder active orders
4. From the Clinical Summary tab add a significant event- Medication Reconciliation upon transfer

Please note:  Nurse will continue using Transfer paperwork.

### SATC Order:



### Significant Event – Medication Reconciliation – Transfer

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Please add the column TEAM to your patient list so you can view all patients based on team assigned.

*(CAN ALSO VIEW TEAM IN PATIENT INFO TAB UNDER COMMENTS)*



## DISCHARGE

1. 24 hour Discharge Order which will notify patient access and case management to begin preparing for discharge- placed by physician. (this will appear on Nurses Tasklist)

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2. Discharge Summary- Electronic will replace the paper version and is all free text



*Note: Medical Records will run a Discharge Summary Report that will pull in all of the remaining information that is currently filled out on paper (lab results, Meds, Diet, activity).*

**3.** Discharge paperwork- replaces the physician discharge order sheet and replaces nursing Interdisciplinary patient education sheet.

*Every observation section must be completed.  Click Submit at the bottom of the screen when finished.*

Submit
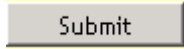


Nurse completes the final section on the bottom of the discharge paperwork.  When ready for Discharge, nurse will go over education with patient and print report to give to patient.

Must all be completed

Diagnosis specific. Must be completed if treated for any of these three.

*Revised 2/26/08 DAs*                    10

## EDIT OR APPEND A DOCUMENT

Go to the Documents Tab, click on the note and then right click and choose Edit Document or Append Document.



## MEDICATION RECONCILIATION AT DISCHARGE:

In the new discharge paperwork, the MD should update RxWriter with new meds for home. *Note*: Discontinue any meds you want the patient to stop taking.

## ENTERING MEDICATION ORDERS

### PLEASE NOTE:

The orders placed by the care provider will be automatically populated in the nurses' work list to be documented. Task schedules are defined by the type of frequency selected by the prescriber. Medication schedule times are set in the system according to NUMC's Medication Administration Policy, i.e. every six hours equals 12 am, 6 am, 12 pm, 6 pm, daily equals 10 am.

For typical orders with fixed schedule, select the appropriate frequency such as every six hours, daily, two times a day etc.

Please pay attention to these frequency types:

**Multiple** – allows user to order items with multiple frequencies in the same order. For example, vitals signs every 15 minutes X 1 hour, then every 30 minutes X 4 hours, then every 4 hours X 8 hours etc.

**User schedule**- allows user to place an order to be done at particular times instead of the system defaulted times. For example, Librium 5mg PO at 8 am, 12 pm, 4 pm, 8 pm.

**Standing order-** Used for one time standing orders that do not require a frequency, For example, bed rest, activity as tolerated etc.

For PRN orders without a frequency, such as "suction PRN", select **continuous** as frequency **AND** check off the PRN box which will allow the nurse to document against the task as many times as needed.

### How to:
You enter medication orders the same as you would any order.  You can find medication orders either through the Start of Browse, under Pharmacy, Pharmacy ED or manually type in the name of the medication.

In the Order Browse, medication orders are located under Pharmacy and are categorized according to therapeutic class.

**Start of Browse**
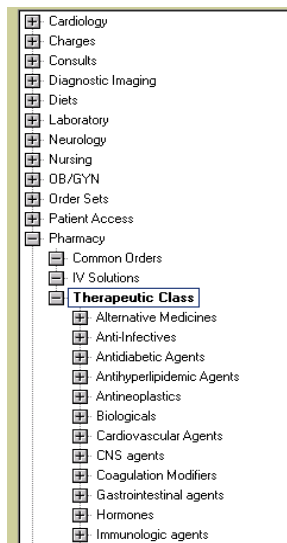


Or Manual Entry type the name of the medication you wish to order.

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## IV fluids example



## Additive to an IV Fluid

- After selecting the solution click on the box for the additive.  Start typing in the additive to pull up a list.
- Select the additive and add it to enter the dose.  Click Ok and then enter the Rate.

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## IV Piggy back example



## Dosing options

- Sequential Dosing- Used for orders such as tapering medications which uses same frequency but different dose and different duration.
  For example, Prednisone 20 mg PO daily X 3 days; 10 mg PO daily X 2 days; 5 mg PO daily X 1 day.
- Concurrent Dosing- Used for orders with different doses and different frequencies.
  For example, Risperidone 1 mg PO every morning; 2 mg PO every evening.
- Stat & Then- Must be placed as two separate orders. Place the STAT order first, then place a second order with priority as Time Critical and enter time that is a safe interval from the STAT dose.

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## Sliding Scale

- Click on the variable dose button to the right of the box for variable dose
- Standard sliding scale ranges are defaulted.  Adjust ranges as necessary.  Type in units.
- If you have extra lines when finished you MUST delete the blank lines before clicking OK
- Dose low Dose high fields- enter dosing information for anything outside the sliding scale.  Both have defaulted text but can be edited.



## TPN Order

- The form will calculate calories (forwards not backwards)
- Once you put in the total volume, it will calculate the IV Rate
- If you enter one field or the other it will populate either field
- Go to TPN ingredients to enter the electrolyte doses.  You can select only what you need.

## Titrating Drips

- Enter the starting rate, auto calculates the rate of administration
- Enter yes/no for titration
- You must then free text the titration instructions for the nurse



## PRN Order (Pain Scale)

- Click on the Variable Dose to enter the dosing information. The standard pain scale is defaulted.
- Always check off the PRN check box and enter the PRN Reason

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- Enter the Frequency



## OTHER ANCILLARY ORDERS:

## ADMIT ORDER

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## CALCULATED DOSE

If you want to calculate the dose amount based on height, weight, or BSA you would select this option in the order form.

Selecting the Per Dose requirement will take the total daily amount requested and divide it by the frequency. Selecting the Daily dose requirement will calculate the dose and multiply by the frequency.

You must fill out the Requested amount per dose, the UOM, and the "per" field to get newly calculated ordered amount.

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## NEW SYSTEM ALERTS

Alert messages may warn you of possible problems, or notify you of new information. For example, Drug to Drug Interaction, Drug to Food Interaction and Duplicate orders. MAKE SURE YOU READ ALL ALERT MESSAGES!

You must click proceed to continue with the order.  If there is more than one alert, you must click next to proceed.



MAKE SURE YOU ACKNOWLEDGE ALL MESSAGES BEFORE PROCEEDING!

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## *Additional ancillary orders:*

## RESPIRATORY THERAPY

Select the order which will then open the order form.  Each order has specific fields to complete.

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Select your patient and then click on the Taskviewer button in the toolbar of SCM
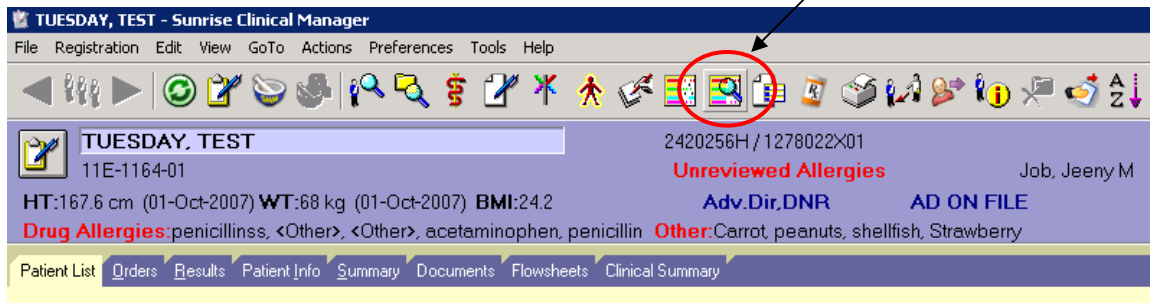


## Tasklist layout

The worklist is called All Tasks and it is separated by department.  You can see tasks for EMAR, Nursing interventions, Respiratory etc.

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**Task Icon definitions:**

1. Marked as done- chart ✔ drug administered/task completed

2. Marked as not done- ✖ drug not administered/task not completed

## VIEWING FLOWSHEETS

*Flowsheets available are*: Nursing Daily Assessment, Pain, Vital Signs, I/O, Critical Care, Interdisciplinary Progress Note, and Respiratory Care Evaluation Form.
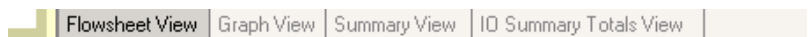
Click on the Flowsheets Tab
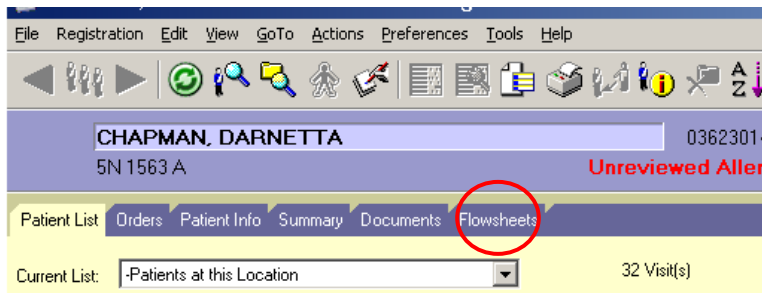


Select the appropriate Flowsheet from the bottom of the control panel.  Use Filter on left to change date range.  Check off the box Suppress Blank Row and Cols to see only valued cells.  Click Apply to update the view
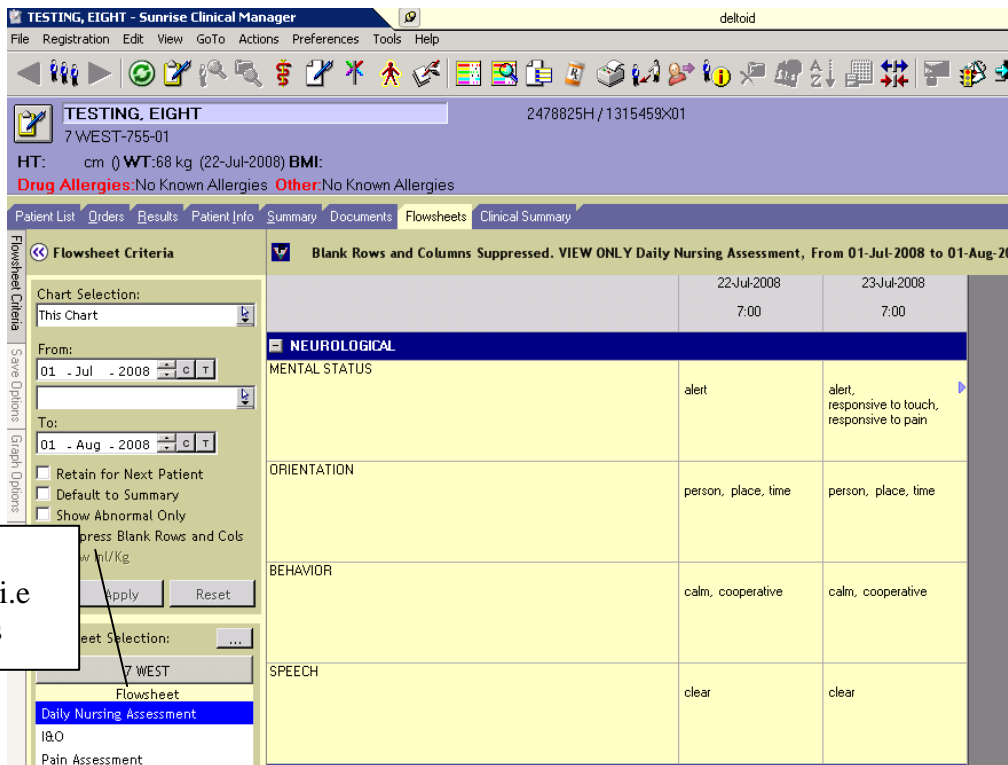


Select Flowsheet i.e Vital Signs

Alternate tab views at the bottom of the screen.

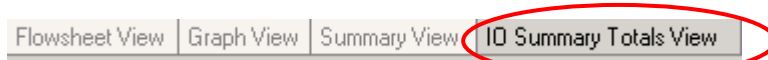ECLIPSYS®
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You can click on the tabs at the bottom to see this data in a different view. *Please note in order to see the data plotted in the other tabs you must put a check next to the observation.*

If you want to see the graphical representation, check off the boxes and click on graph view at the bottom of the screen. Graph View



Check off boxes to see graphical representation
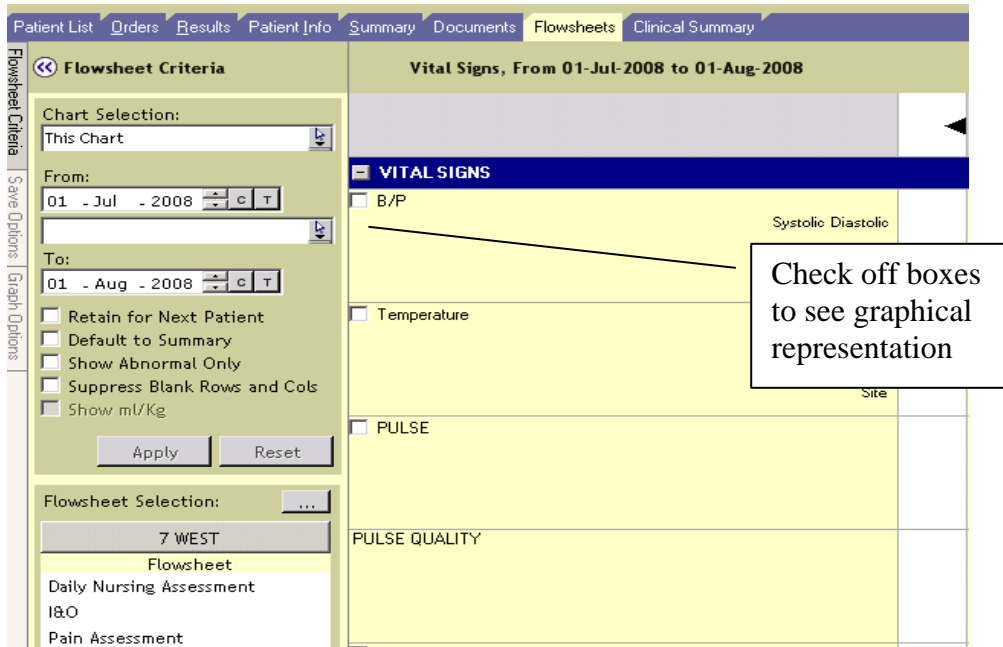
## I/O Flowsheet Summary View

Click on the I/O Summary totals View when in the I/O flowsheet to see totals.

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*You will need to Sign off on Verbal Readback orders as well as documents such as H&Ps, Discharge Summary etc.*

***Please note***: *You will need to add the To sign column to your patient list.  Click View in the Menu bar, column selection, select "To sign", click add and then OK.*

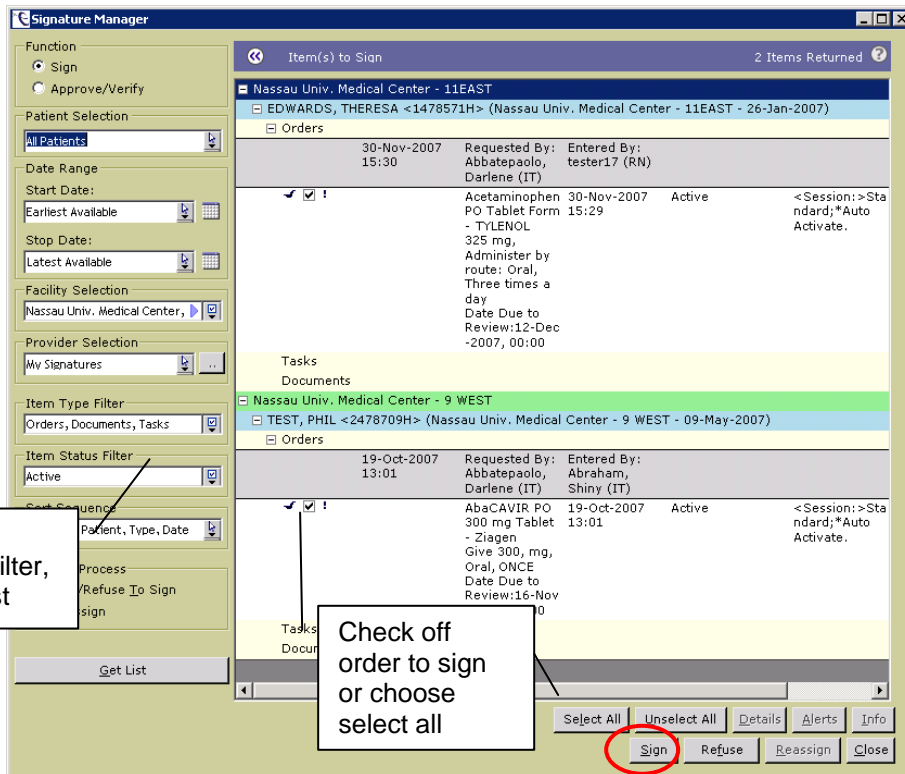| TO ACCESS THE SIGNATURE MANAGER |
|---|
| **TOOLBAR:**<br>The SIGNATURE MANAGER ICON  will display items that require your signature |
| **PATIENT LIST COLUMN:** TO SIGN Column<br><br>**GREEN FLAG-** list of all items that requires a signature<br>**RED FLAG-** requires your signature |

**Signature Manager Screen**

You can also use the Signature Manger icon in the toolbar.

You can use the **provider selection** filter to narrow to orders that require your signature.  If you use filters you must check the Get List button at the bottom of the filtering section.

You can select the orders to sign by checking off each one or choosing the select all option.  Click the Sign button at the bottom of the screen to complete.



Provider Selection Filter, click Get List

Check off order to sign or choose select all

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**Check mark definitions**

| | |
|---|---|
| ✔ | Black check mark indicate the items assigned to you. |
| ✔ | Blue check mark indicate items you can sign for. |
| ✔ | Red check mark indicate items you have processed. The check marks stay red until you click Get List to refresh the display of items in Signature Manager. |

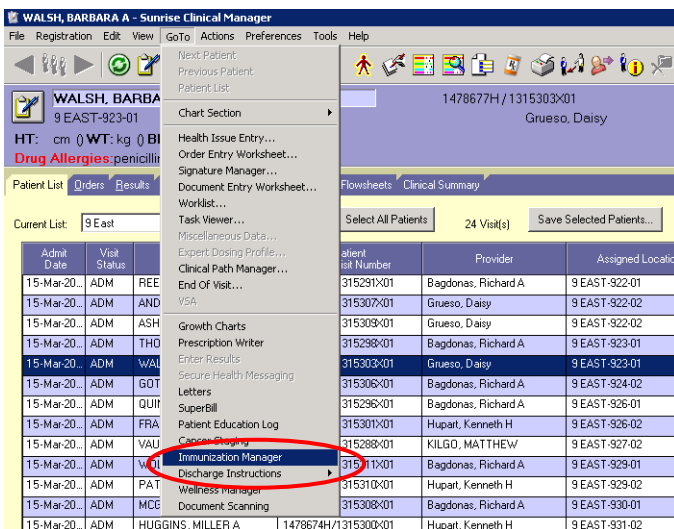Once you have clicked Sign button you will be required to put in your password.



The check mark next to the order will then change to processed.

Then click close.

## IMMUNIZATION MANAGER

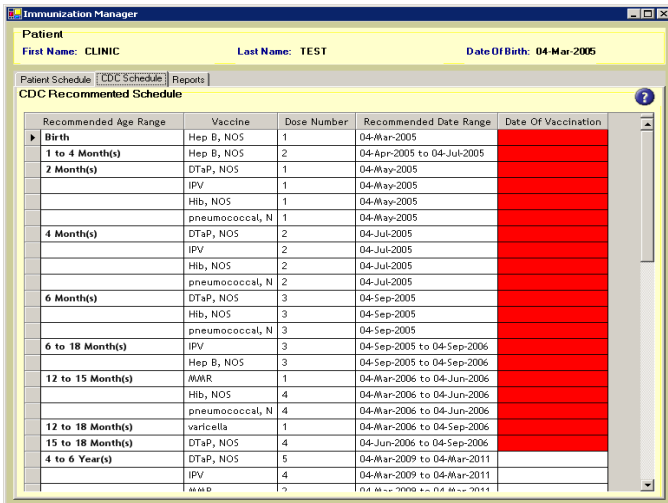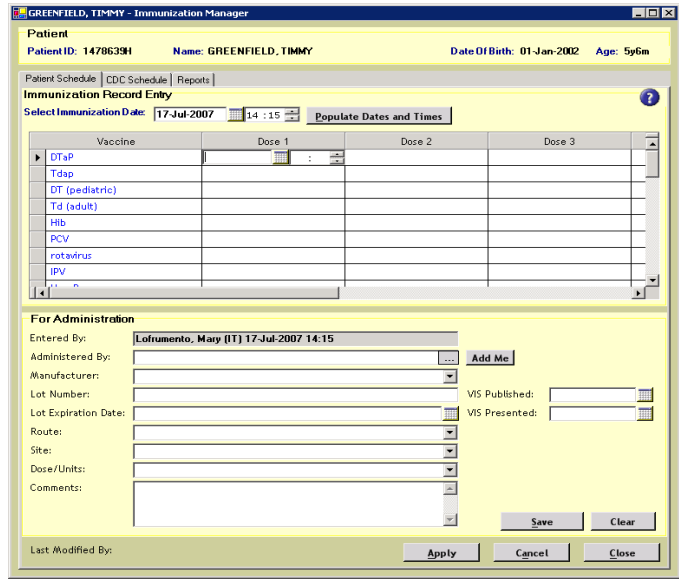Click on Go To in the menu bar and select the **Immunization Manager**.



Here you can view the CDC Schedule or a report of the immunizations. Click on either the CDC Schedule tab or the Reports tab.
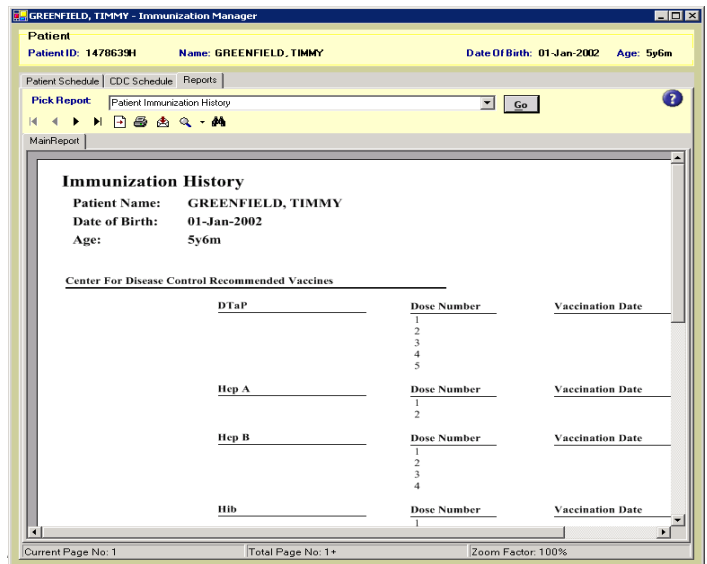
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**Patient Schedule Tab:** This shows all vaccines documented



**CDC Schedule:**  THIS IS FOR PEDIATRICS ONLY

CDC recommended vaccines and date range based on the patients age.  **Red= Vaccinations are overdue!**



**Reports:**  There are several reports that clinicians can view.  These can also be printed. Patient Immunization History shows all documented vaccines.

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