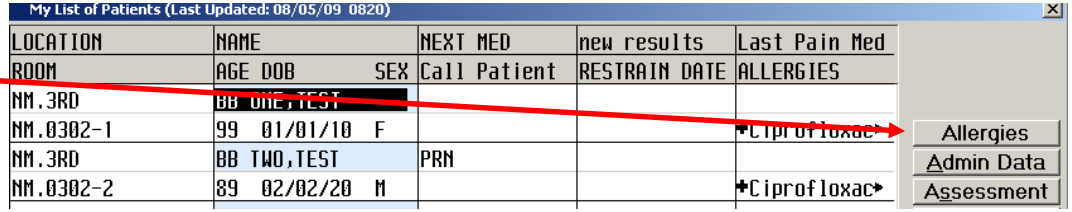
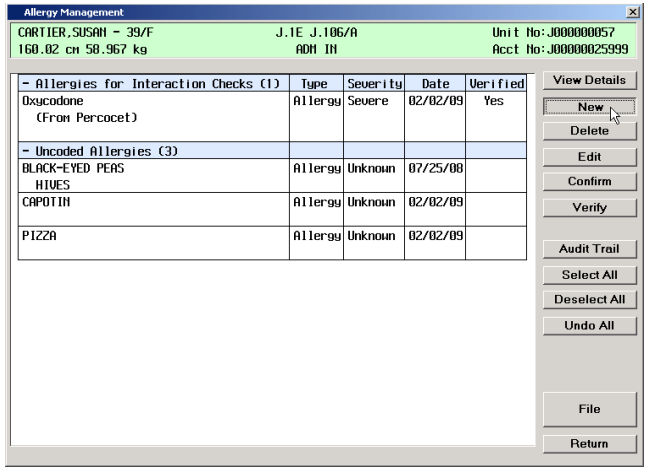
Status Board Icons

Allergies

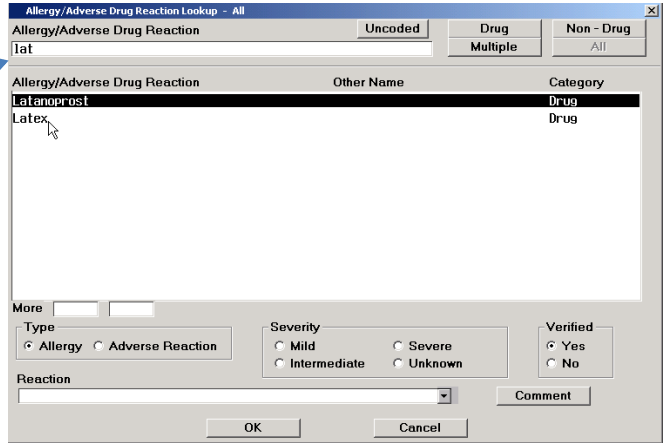
(Click icon with mouse)
To enter, edit, confirm or view allergies

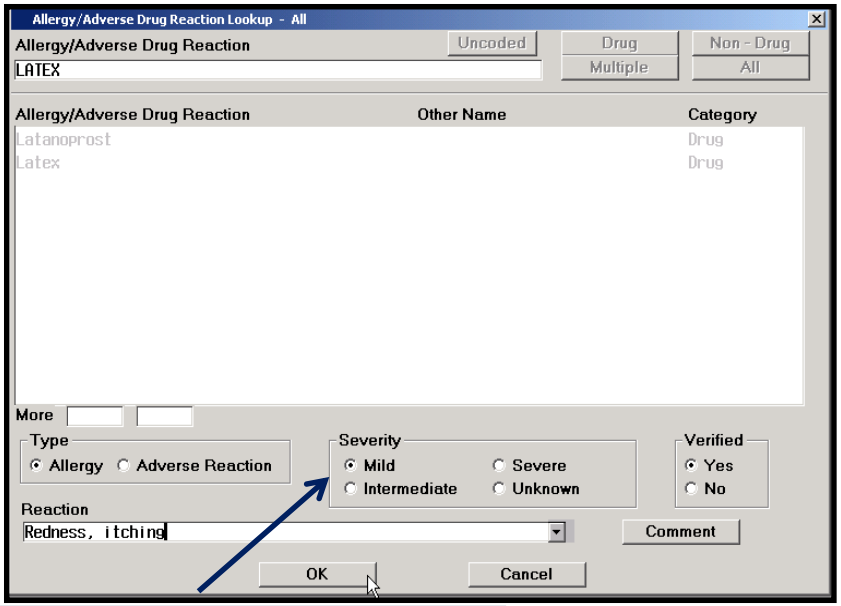




Once on the **Allergy Management screen**, click on the **New** button…

… and **type** in the **first 3 or 4 letters of the allergy**. Using type-ahead functionality, the selection list will narrow down and let you choose the allergy from the list.





Pick patients **allergy by clicking** on it (will highlight)

Determine:

Type: (Allergy/Adverse Reaction)

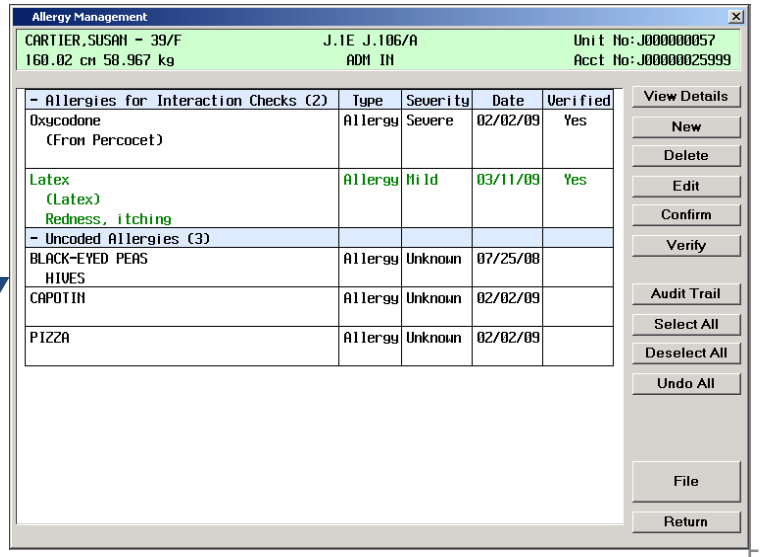
Severity:

Reaction: free text

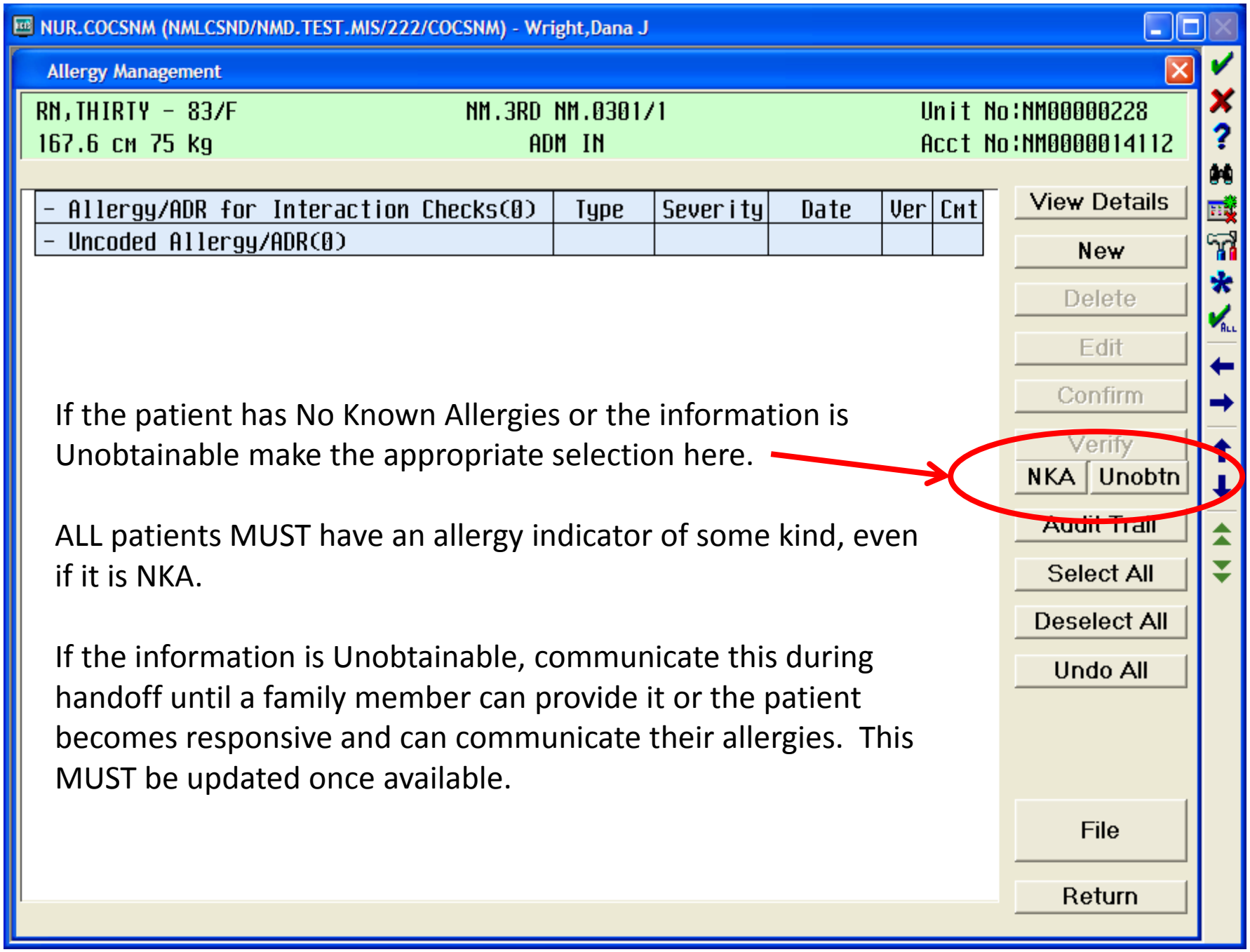
and click **OK to File**.

Remember the Severity Rules:
Severe = Life threatening
Mild = All others
DO NOT USE INTERMEDIATE

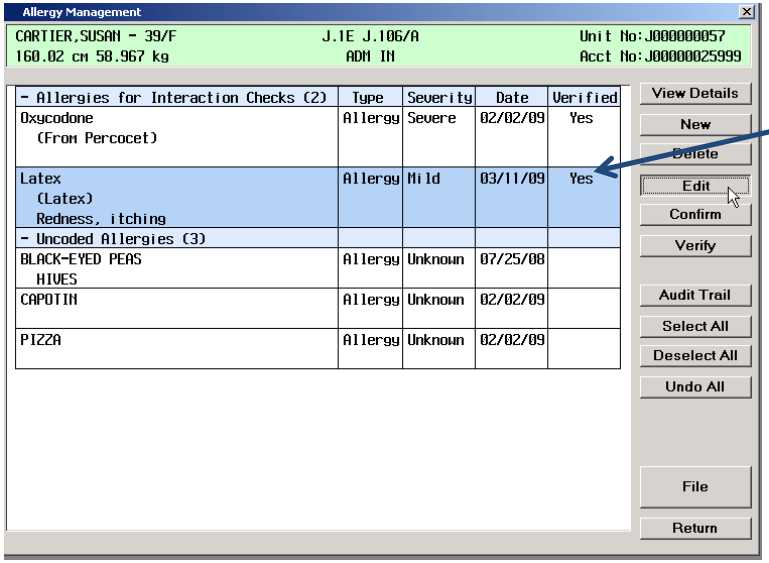
The added Allergy will appears in green text. **Remember to FILE**



Allergies you document from the lookup will appear as "Coded" allergies, meaning they are eligible for allergy checking. ***Uncoded*** *allergies are* ***NOT checked*** *against patients medications.*


NUR.COCSNM (NMLCSND/NMD.TEST.MIS/222/COCSNM) - Wright,Dana J
Allergy Management
RN,THIRTY - 83/F
167.6 cm 75 kg
NM.3RD NM.0301/1
ADM IN
Unit No:NM00000228
Acct No:NM0000014112
- Allergy/ADR for Interaction Checks(0)
Type
Severity
Date
Ver
Cmt
- Uncoded Allergy/ADR(0)
View Details
New
Delete
Edit
Confirm
Verify
NKA
Unobtn
Audit Trail
Select All
Deselect All
Undo All
File
Return
If the patient has No Known Allergies or the information is Unobtainable make the appropriate selection here.
ALL patients MUST have an allergy indicator of some kind, even if it is NKA.
If the information is Unobtainable, communicate this during handoff until a family member can provide it or the patient becomes responsive and can communicate their allergies. This MUST be updated once available.

Editing an Allergy

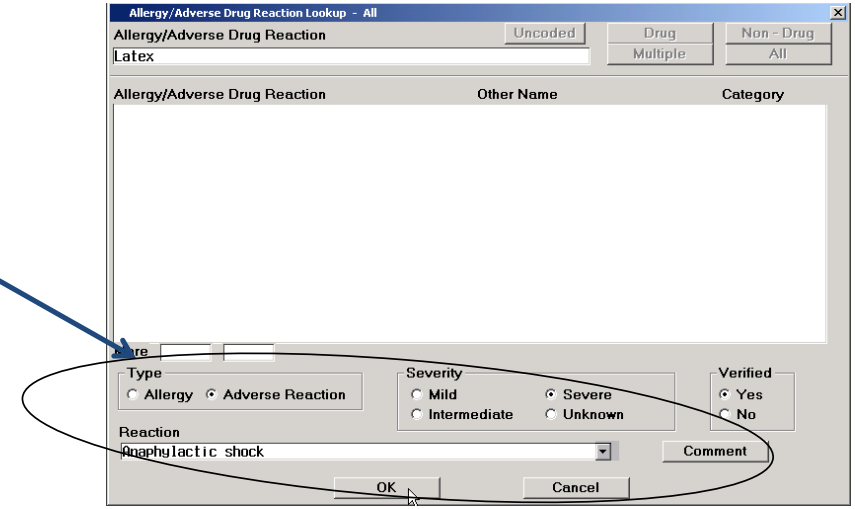


Select an **allergy** by clicking on it (highlights in blue).

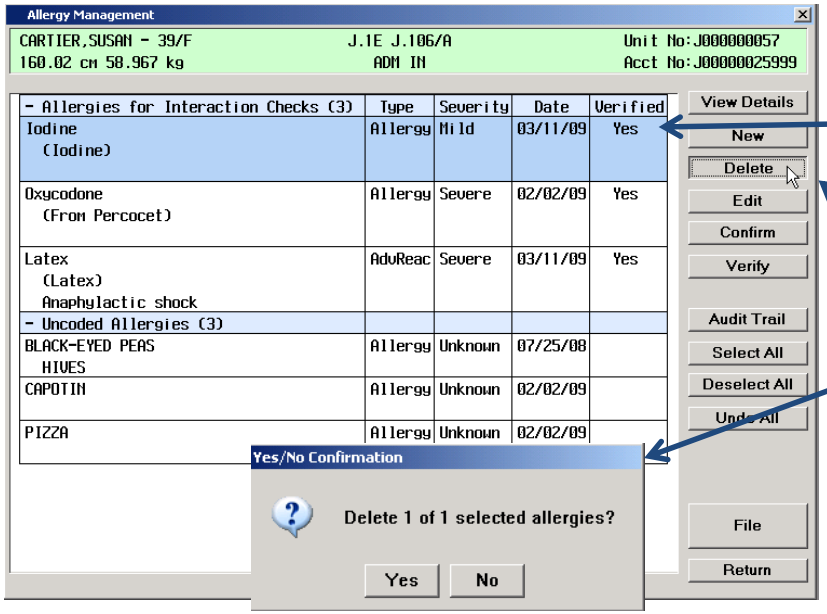
Click the **Edit** button.

Make necessary **edits** (Type, Severity Reaction or Comment)

Click **OK** and **File**



Deleting an Allergy

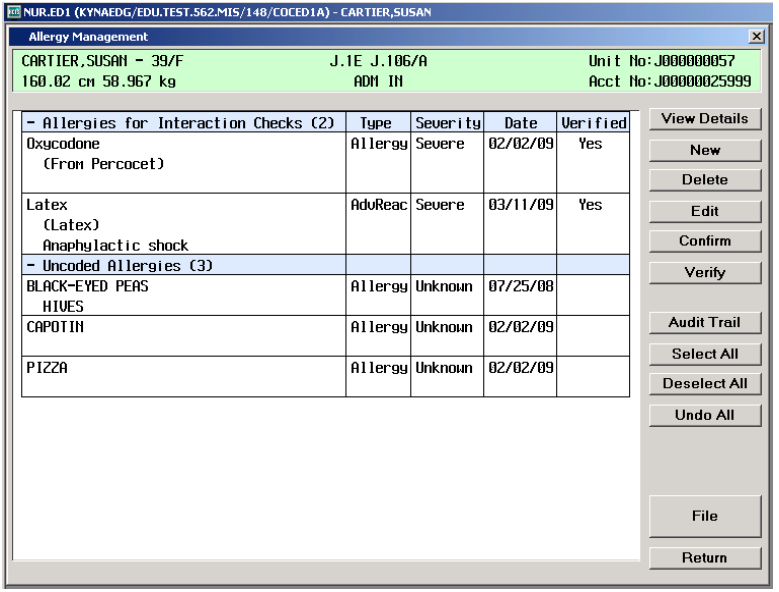


Select an **allergy** by clicking on it (highlights in blue).

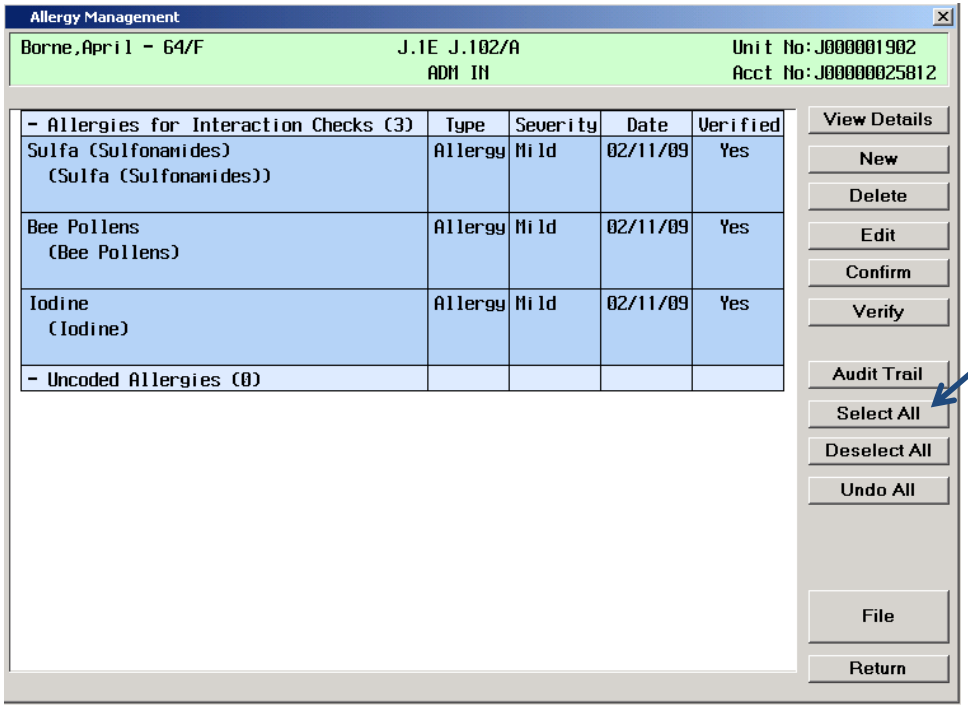
Click the **Delete** button and **answer prompt to confirm** deletion.

Allergy is then deleted and removed from the Allergy Management screen.

Remember to File.

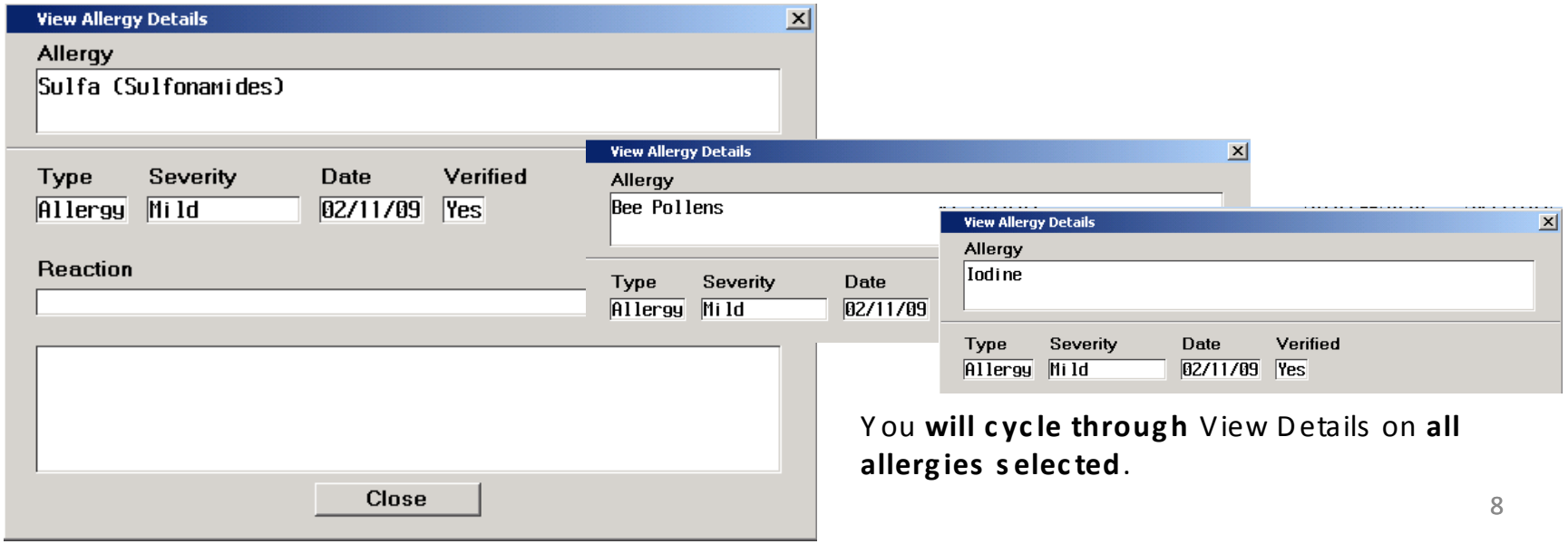


Confirming Existing Coded Allergies

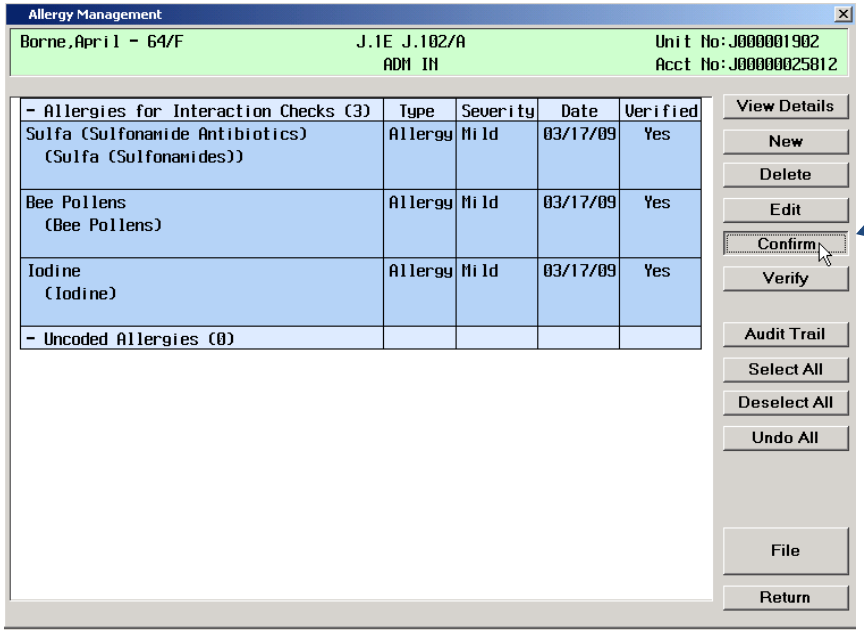


Select all allergies by **clicking** on **Select All** (turns all allergies blue, *but only Coded allergies will be confirmed)*

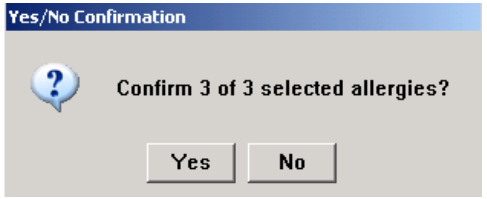
Click **View Details** button to review allergy, reaction and comments and make any necessary edits.

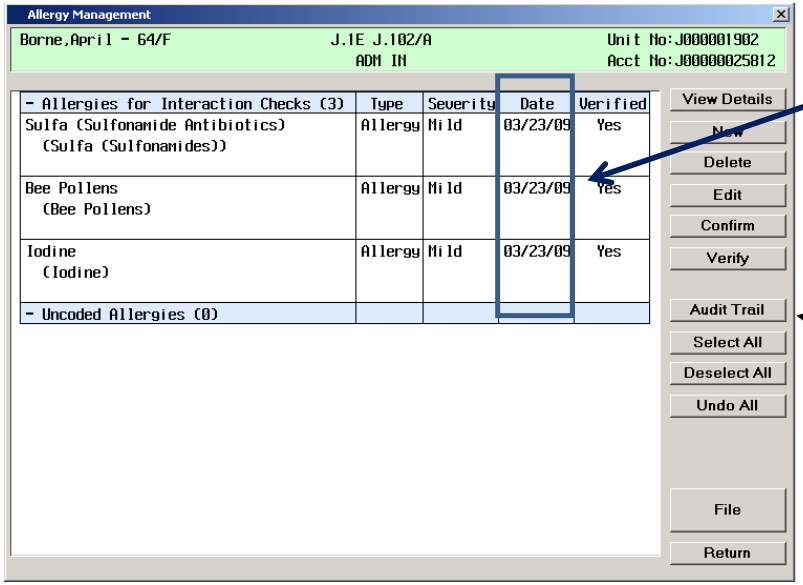


You **will cycle through** View Details on **all allergies selected**.



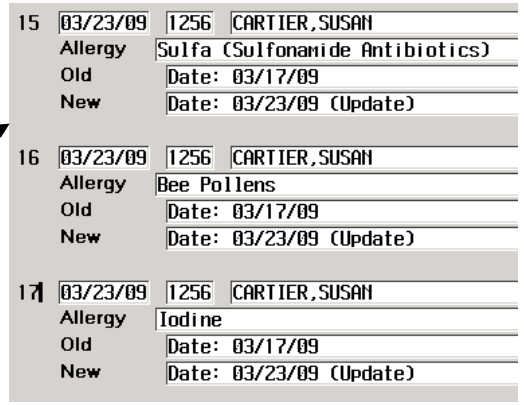
Once allergies have been **reviewed**, **click** on the **Confirm** button and **click Yes** to confirm the selected allergies





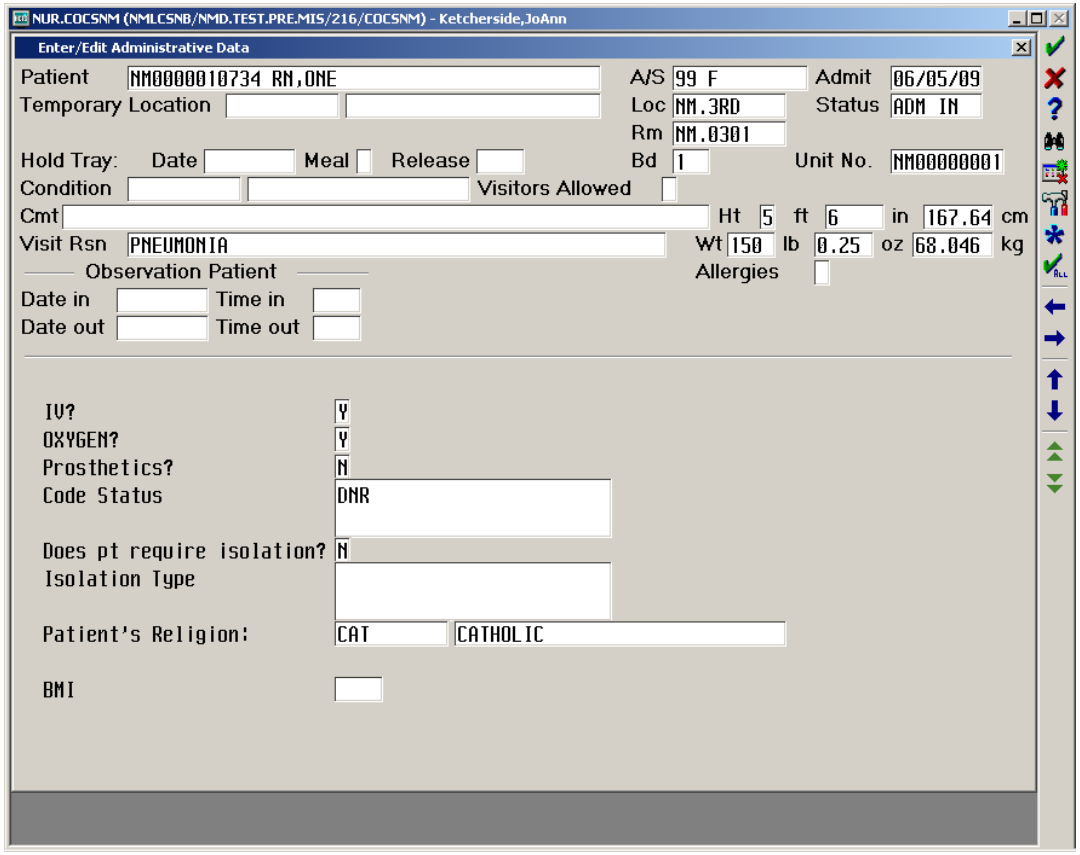
The date column will be updated to the current date. Click **OK** and **File**

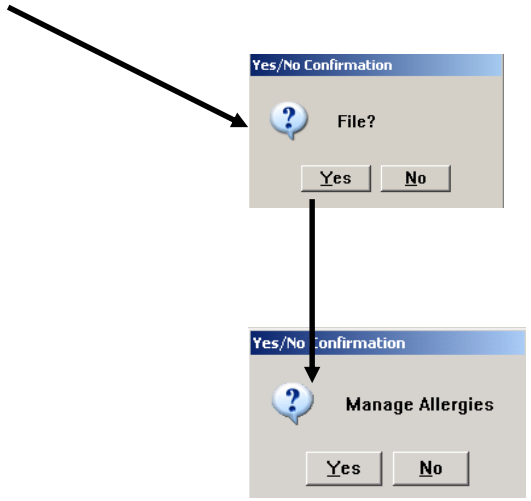
The confirmation appears on the audit trail.



Admin Data (Click with mouse or Type "A")

- Document Ht, Wt, Allergies, Code Status, Isolation status, Religion and lists equipment being used by patient (IV, O2 etc).
- The Admin Data routine must be completed upon every admission as answers will flow from Nursing to Order Entry. When filed you will be prompted to Manage Allergies - yes or no.





To Manage Allergies, follow procedure on previous pages

(Click icon with mouse)

- Allows documentation of one intervention on several patients at one time

(Click on or Type "M")

- Allows documentation of Medications. See eMAR Manual for details

(Click on or Type "R")

- Where all Printing options are located

[CLINICAL REVIEW] (Click on or Type "I")

- View a patient's record, examine details such as:
  - (a) Orders
  - (b) Medications (current and past)
  - (c) Administrative Data
  - (d) Laboratory Data
  - (e) Radiology & other dictated reports
  - (f) Assessments
  - (g) Patient's Notes
  - (h) Patient Care Documentation Profile (Blood glucose trending, education documentation, pain management)
  - (g) Old records can be reviewed

(Click on or Type "O")

- Enter orders for nursing interventions, tests, diets, consults and treatments.

Assessment (Click with mouse or type "S")

- **1. Quick Start**
- The Quick Start screen is a short screen that can be documented on by the Unit Secretary, PCT (if working as a secretary), or the Nurse. **This is the first thing to do when a patient is admitted.**
- From **Status Board** click on the **Assessment** Icon
- Click **Enter Form**, this allows you to go forward and enter the document.
- "**ADMISSION QUICK START**" is on the first line. **Double click** on it or **Rt arrow**.
- Choose the "**type of patient**" you are caring for.
- Choose "**Age of Patient**" choose the developmental age of the patient.
- **If patient's admission diagnosis is for a Total Hip or Total Knee surgery, put a Y next to the appropriate question**. File, F12,or
- After you File, a box will appear and ask you if you want to "**Add Checked Problems to the Plan of Care?**" Always enter a "**Y**" and press ENTER.
- You are now in the **ENTER/EDIT PLAN OF CARE ROUTINE**.
- Press **ENTER** a second time until the problems are added to the Problem section in the center of the screen
- **Press F12 or** ✔ and "**File Plan of Care**" This will file the Standard of Care and Age Guidelines.
- When the screen is filed, the Standards of Care and the Age Development Guidelines will be loaded into the care plan. Included within the Standards of Care are all the interventions that are needed to document on a continual basis, i.e., the department specific Standards of Practice, Vital Signs, Intake, Output, Shift Assessment, etc.

- **2. <u>Admission Assessment /Admission History</u>**
- **Assessment/History Forms**: From Status Board, make sure that your patient is highlighted and click on the **Assessment** Icon. **Double click** or **Rt Arrow on Enter Form** and select **Admission Assessment or Admission History** to fill out. If Assessments or History have been done on this patient a (→) arrow will appear next to the assessment along with the date and time under Last documented. This does not guarantee that the form was completed. Incomplete forms are corrected in another routine. If the user is unsure as to which type of response is required, press the F9 (or cl on binoculars) LOOKUP key. All fields that the cursor lands on are required to be answered. If the cursor skips a field, it may be due to the previous answer and it does not require an answer. In the assessment routine, you can pass a required answer BUT you cannot file the document until all required answers are done. DO NOT CLICK PAST FIELDS. Enter an answer in each field and press the <Enter> key to continue. In other routines, required answers will make you answer them immediately press the **F12** (file) key (or click on the green mark) and answer "Y" to the box that appears. The letter "**F**" will automatically default in the box, hit ENTER to file. Do not change your options, leave at 'F' to File. **You must "File" or your information will be lost.**

- On the last page of **Admission Assessment** user will determine Care Plan Problems based on your assessment. User is encouraged to keep the Care Plan SIMPLE. Pick problems based on the patients admission diagnosis, pain, and safety. Upon filing a screen a questions will appear asking if the user wants to add "**Checked Problems to the Plan of Care**?" if satisfied with list, answer '**Y' – Yes and [ENTER].**

- **<u>Care plans must be evaluated and updated every shift for every patient; this is done in Process Interventions. Part A must be completed at the start of shift and Part B at the end of shift.</u>**