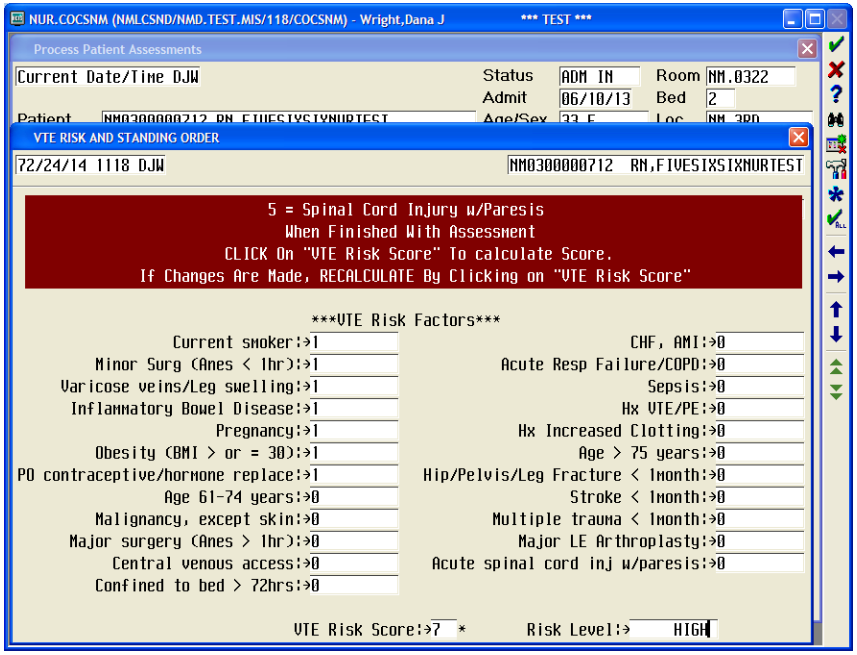
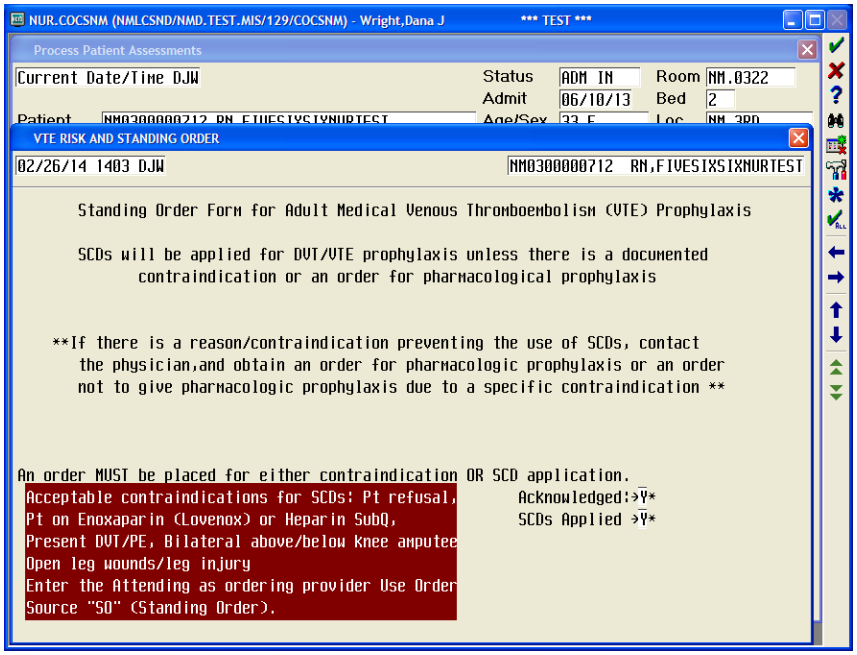
VTE Assessment Documentation

- Document on "*VTE Risk and Standing Order*" from Assessments

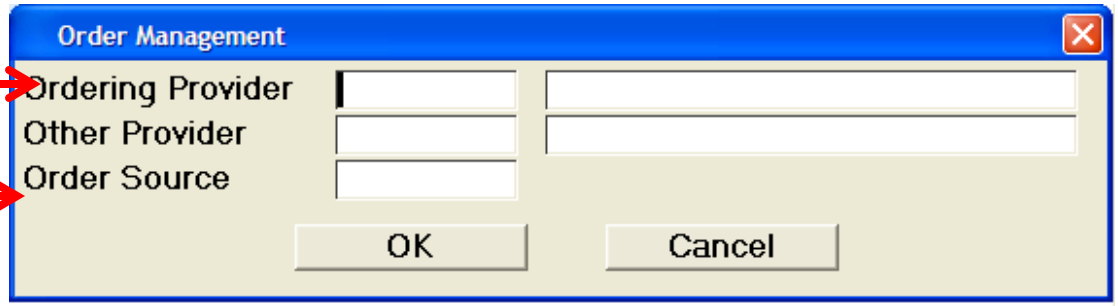
- Complete all fields on Page 1 to obtain score

- Acknowledge that you need to place the order, then indicate Y/N if SCDs were applied to your patient (Acceptable contraindications are listed in the on-screen display box; SCDs MUST be placed if none of these are present). You will be taken to the ordering screen.

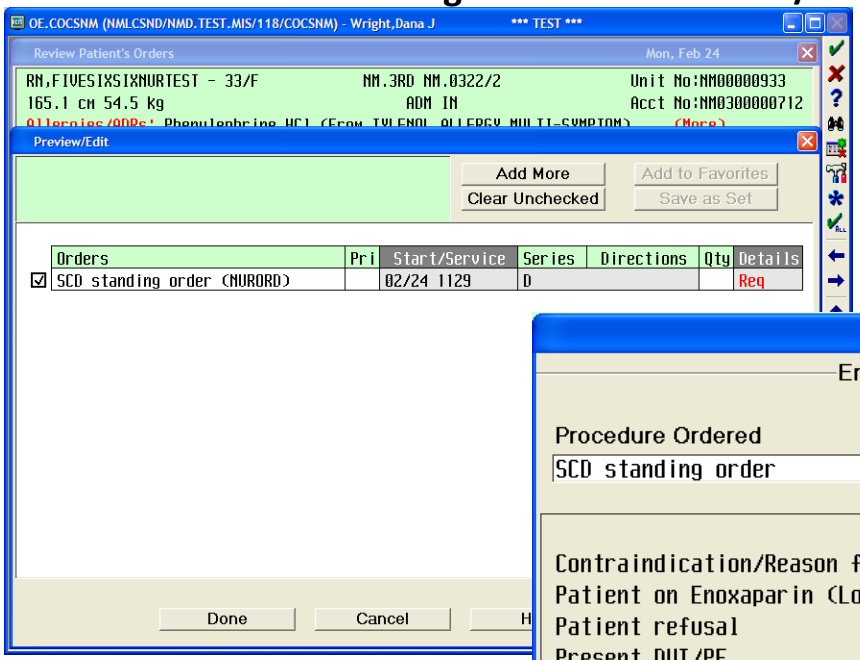


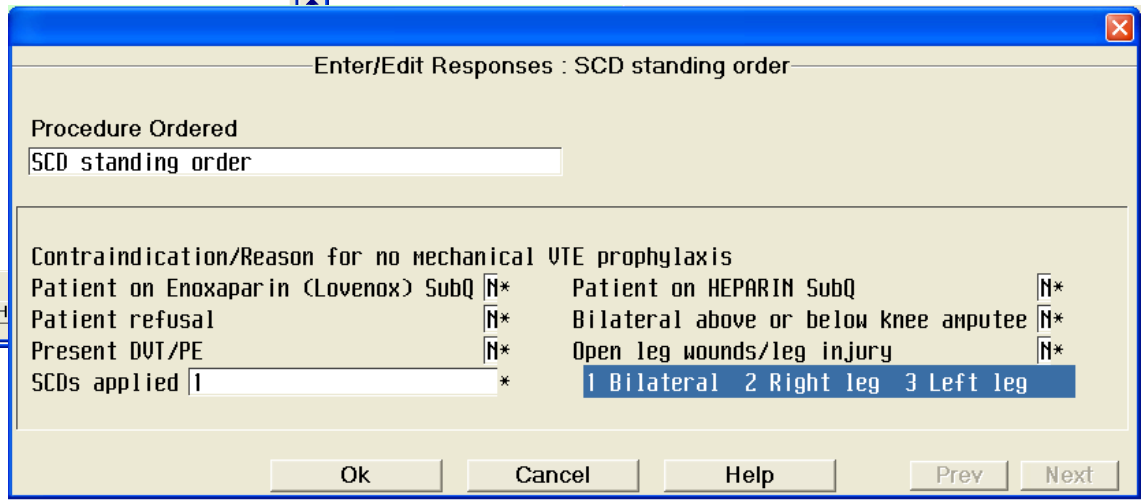


Use the Attending MD as the ordering provider and select **SO (Standing Order)** as the Order Source



Complete the order details appropriately. This documents contraindications and where SCDs were applied (or NA). Once filed the Provider will be able to sign the order from his/her queue





IF PHARMACOLOGIC PROPHYLAXIS IS NEEDED YOU MUST PLACE AN ORDER FOR THE SPECIFIC MEDICATION USING THE USUAL ORDERING METHOD, IN ADDITION TO THE ABOVE

ACKNOWLEDGING ORDERS FROM STATUS BOARD

- **Why is it important?**
- All orders must be acknowledged from the Status Board so that all the appropriate flags appear.
- Acknowledging orders from the Status Board is the **ONLY** way nurses will see new orders that have been entered electronically by the provider
- Flags appear under the **NEW ORDERS** column and will show in order of urgency
  - **STAT** – Stat orders or medications have been ordered.
  - **ACK**nowledge – immediate notification and ability to acknowledge new orders or medications entered by staff or provider.
  - **NEW** – provides opportunity to review orders or medications entered and acknowledged by previous RN.
  - **UNC**ollected – uncollected specimens are ordered and need to be collected.

“ACK” Definitions:

- **Status Board ACK for <u>non medication orders</u>:**

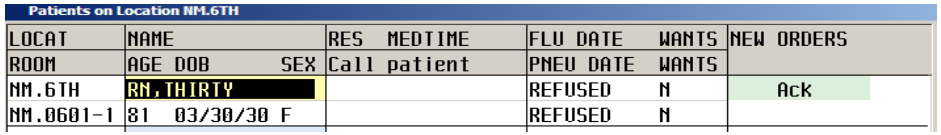
  I, as clinician, am aware of this order.

- **Status Board ACK for <u>medication:</u>**

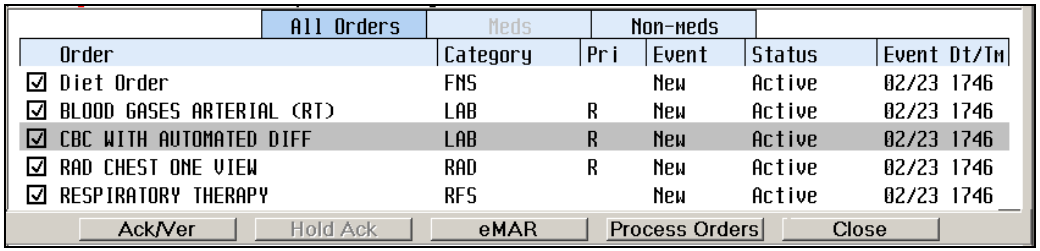
  I, as clinician, am aware of this order and I have reviewed the order for appropriateness for my patient as well as reviewed dose, route, frequency, start/stop dates and all comments/instructions on the order. I agree that the order appears to be appropriate based on my clinical knowledge.

What is the process?

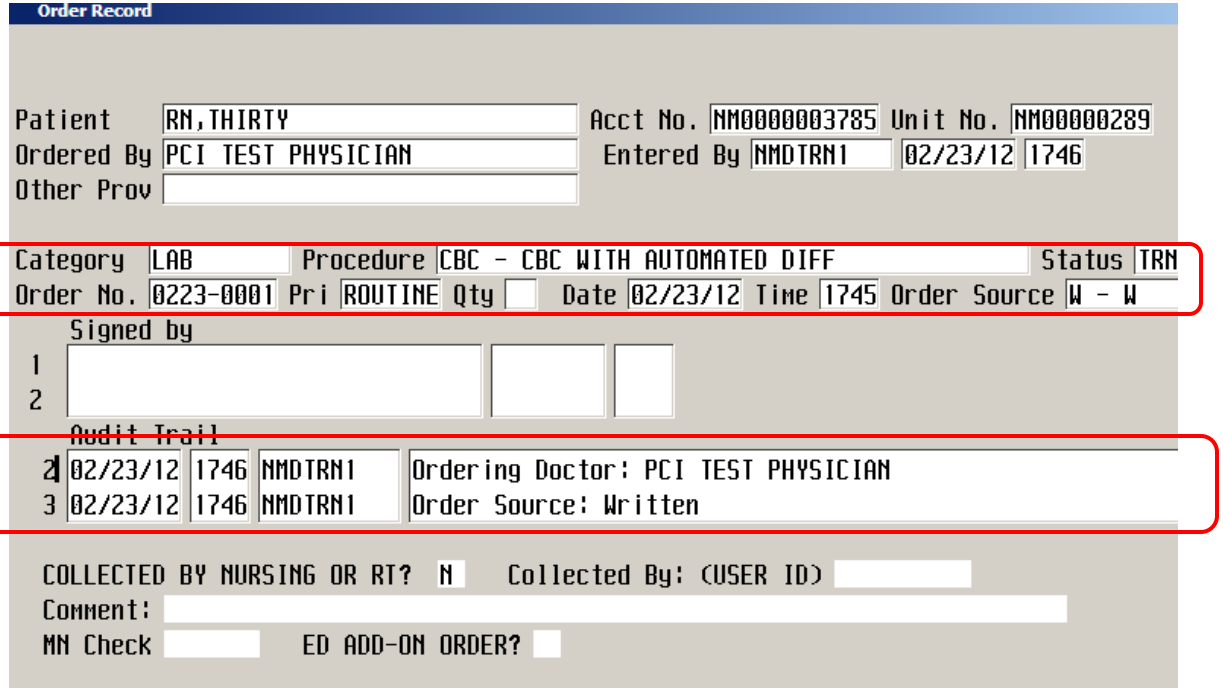
- To acknowledge orders click on the flag in the NEW ORDERS column on the Status Board.



- Place a check mark on ANY order with a box next to it and click the Ack/Ver button at the bottom left of the screen



Review the screen to make sure the order entered matched the physician written order.



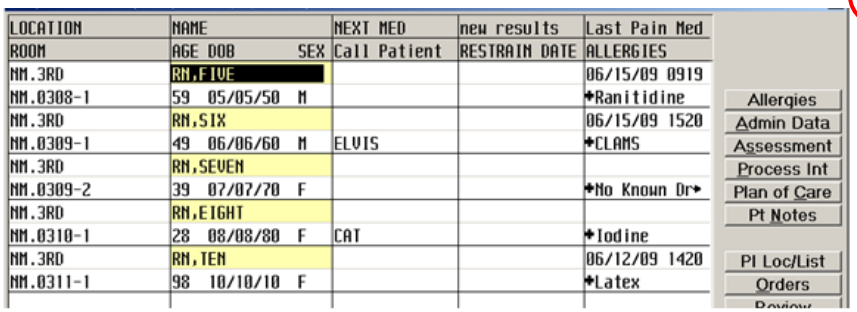
•If there is not a written order found, check the Order Source field. **If the order was submitted electronically by the provider the order source will be POM or EPOM and there will be <u>NO paper copy.</u>**

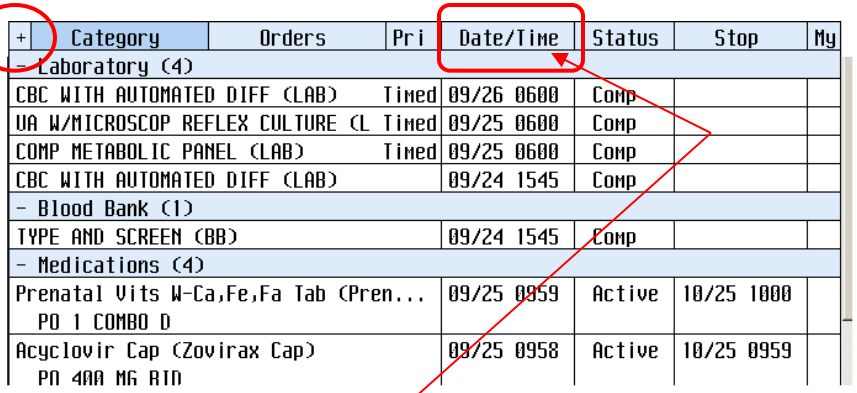
•If order is correct, **F12** to file. You will be prompted to proceed to the next order: Repeat step 1-4 for all orders (if an order is incorrect, continue acknowledging orders. When you have finished, the incorrect order must be cancelled and reordered correctly)

Viewing Orders by Date/Time - Allows RN to view **ALL** procedural and Medications orders entered

Access ORDERS from Status Board.

All orders will appear under collapsed cells. Open cells by clicking the + icon near CATEGORY.

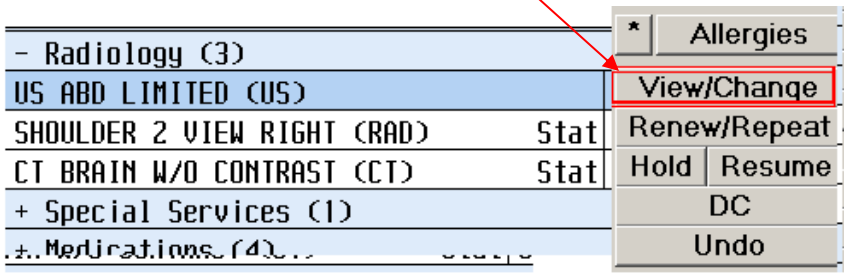




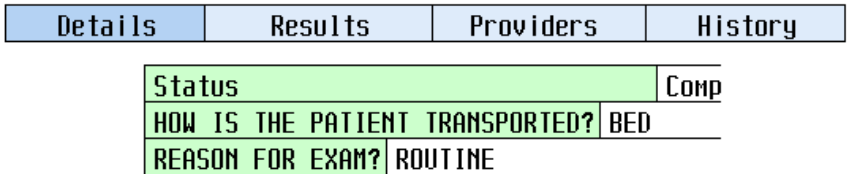
•Click on **DATE/TIME** ***TWICE*** to list orders from newest to oldest

To view details of a specific order:

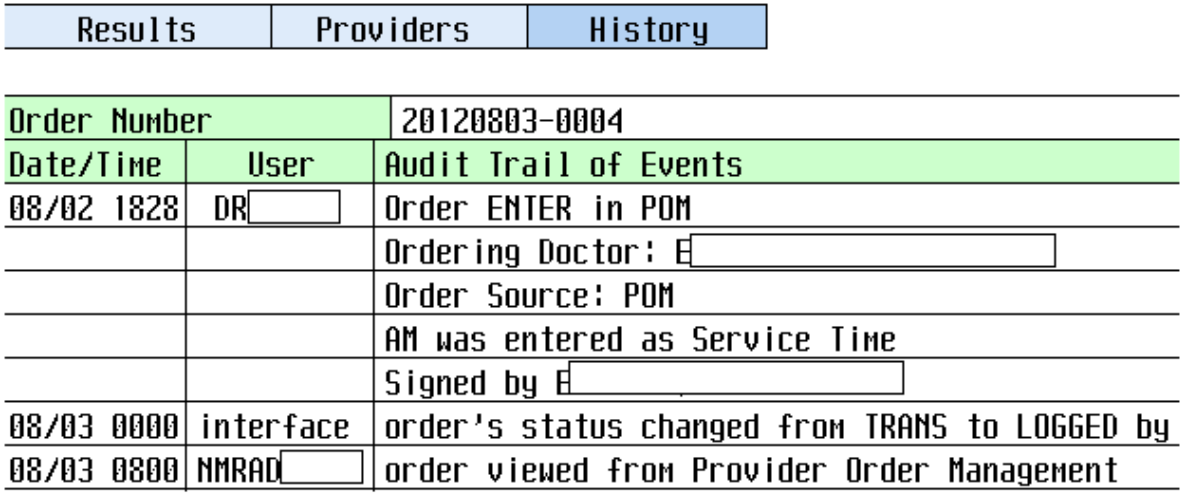
Highlight order by clicking order to view;
Click View/Change button



Screen will default to DETAILS which shows information entered when procedure or medication was ordered.



HISTORY provides audit trail of entire order.



PROCESS INTERVENTIONS

(Click with mouse or type "P")

•Select "**Process Intervention**" from the Status Board. This routine is "multi-functional". You can perform many functions related to patient documentation here. After the patient's Plan of Care is created, it is important to document that the planned care is being carried out. Process intervention is the primary routine for this to be done. From this screen you will be able to:

You may double click on your choice or enter the underlined letters (short keys). The above is called a "Verb Strip".

THE PROCESS INTERVENTION SCREEN

Interventions are grouped under intervention headers. A dash (-) precedes each intervention. Indented under each intervention is its supplementary text. Listed to the right of each intervention are:

(Sts)	Status of the intervention
(Directions)	Directions (Instructions)
(Doc)	Last date of documentation
(Src)	Source of the intervention
(D)	Duplicate (Is this intervention a duplicate?)
(C/N)	Comment (has a comment been entered?)
(Prt)	Protocol – whether protocol text is associated with this intervention

The first 3 items in the list are of primary importance; the subsequent 4 are listed mostly for informational purposes.

Moving around the screen:

Press	To Move
↑ or ↓	from one intervention to the next
<PAGE UP>,<PAGE DOWN>	from one Intervention Header to another. (The highlight bar moves to the first line of an intervention, not to the Header. Located above arrow keys)
F7	to the TOP of all interventions
F8	to the BOTTOM of all intervention

THE VERB STRIP

Document Now

Document Now ("DN")

This routine is used to document interventions that are performed at the present time (within 15 minutes). You can click on the Verb Strip icon "**Document Now**" or type in "**DN**" in order to access this routine.

Document Interv's

Document Interventions ("DI")

This is the routine used to document interventions that are performed. You can click on the Verb Strip icon "**Document Intervention**" or type in "**DI**" in order to access this routine. There are 3 ways to "document":

Highlight a single intervention

Check off Method

Entering Multiple Dates/Times on Date/Time stamp screen

More detail of these three methods will be presented on the pages that follow

Highlight a single intervention

- A screen will appear showing the date, time, and User.
- The number of interventions to be documented along with the number of occurrences is seen at the bottom of the screen. This is called the "date and time stamp".
- The cursor is in the "**OK**?" box.
- Type in "**Y**" if all the information in the box is correct.
- To change the date and/or time, press **F6** (previous field) key. This will take you to the date and time stamp box. Date and time can be changed if needed.
- Hit <**ENTER**> if information is correct. Answer the queries and **F12** to File, when completed.

Check off Method

- Check off the interventions to be documented.
- Use the **RIGHT <CONTROL**> key. <**SHIFT> RIGHT <CONTROL**> key will check off ALL interventions)
- Type in "**DI**". Follow instructions above regarding changing time/date, etc. if needed.
- If more than one intervention is checked off, the screens will be brought up consecutively to document on. ***Note: in the upper right hand corner of the screen, the number of interventions checked off is noted. It is a good idea to always look at this prior to documenting.***
- A box appears at the end of the documenting stating "2 out of 2 done", "1 out of 2 done", etc.

Entering Multiple Dates/Times on Date/Time stamp screen

- Enter multiple times and dates. Example: documentation of frequent vital signs:

- 8/21 @ 0700
- 8/21 @ 0800
- 8/21 @ 1415
- 8/21 @ 1500
- When the screen is **FILED** after documenting a set of vitals for a specific time, a blank screen will appear for the next set time stamp. A new screen will appear for each time stamp entered.
- Be cautious when using this function to document; ensure the correct data is entered for the correct time.

CHANGE STATUS – ("CS")

This routine is used when an intervention has been completed, a duplicate intervention exists, or for some other reason the intervention status needs to be changed. **ARROW** down to highlight the intervention you want to change the status. You can also select more than one intervention using the **RIGHT <CONTROL>** key to check off the interventions you want. This will allow you to change the status for more than one intervention, at the same time. (e.g. to COMPLETE 5 interventions) At the Verb Strip, type in **"CS"** and press <**ENTER**> (or click on the Change Status box). A screen will appear with the cursor flashing in the Status box. Enter the letter **"C"** for complete. Then **F12** to FILE and select **"Y**" to file your change in status. To verify this was completed, look under the "Sts" column in the Process Intervention Screen and it should reflect the change.

Status choices are:

A = Active	In use and waiting to be documented on.
C = Complete	Documentation is completed for the patient's entire stay.

You will never use any of the status options listed below!!!!!!!!!!

H = Hold	Active but on hold, e.g. when the patient is off the unit.
I = Inactive	WE DO NOT USE THIS STATUS.
X = Canceled	Reserved for interventions that have been added to the patient's plan of care in error. Once canceled, cannot be reactivated. Must be added again.
D = Discharged	System generated when the patient is discharged from the system.

VIEW HISTORY – ("VH")

This function is an on-line method of looking at the history of a particular Intervention. You can view all changes, edits, and comments made to a particular intervention, here. This function will also allow you to "edit" or "undo" information that you have recorded. At the verb strip type in "**VH**" (or click on **View History**) A screen appears with a list of verbs at the top of it:

The Intervention number and description shows up along with the status and the source of the Intervention. Under the heading "activity", it shows when the intervention was created and by whom.

View: **RIGHT ARROW (→)** at the intervention to see results of the documentation.

Undo: Type "**U**" and you will be prompted with the question, "Undo this documentation?" Answer "**Y" or "N**". If "Y", it will show up with the date, time, and your monogram. (You will be prompted to enter a comment why Undoing documentation). Use **UNDO** if you document on the wrong patient. ***YOU CAN NOT UNDO SOMEONE ELSE'S DOCUMENTATION.***

Edit: Type "**E**" to enter form highlighted. (You will be prompted to enter a comment why editing the documentation). Edits can be made here. **Hit F12 FILE** and you will be prompted to "File changes?" enter "**Y**" to file? You'll see the activity "edited results" appear in the activity column directly below the original documentation. You cannot "edit" an Intervention that does not have a screen attached, you can only "undo" the documentation. ***YOU CANNOT EDIT SOMEONE ELSE'S DOCUMENTATION.***

NOTE: You must enter a comment whenever you edit or undo an Intervention.

Select: Type in "S" and you will see a screen appear giving you a choice of looking at all the activity on the Intervention vs. documented activity only. Choose the appropriate one ("all" will show up edits, comments, variances, etc.)