Meditech Order Entry Manual

10/10/18

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PC Keys and GEMMS Toolbar

GEMMS Toolbar	KEY	DESCRIPTION	NOTES
	F12	**"OK"** ("File", "Save")	
	F11	**"Exit"**	
	F9	**"Lookup**" Displays a list of valid responses to a prompt	
	Enter	**"Enter"** ("Return") Moves the cursor forward one field or question	
	(Right) Ctrl	**"Check mark"** ("Block")	
	↓	**"Down Arrow"** key moves you down one item at a time for a list of items and moves the highlight bar down one item at a time	
	↑	**"Up Arrow"** key moves you up one item at a time for a list of items and moves the highlight bar up one item at a time	
	F10	**"Delete Line"** key deletes an entire line that appears in the field or question (May also use the "Backspace" key to delete one letter at a time)	
	Esc	**"Escape"** key gets you out when "Exit" does not work	
	F6	**"Prev Field"** key moves you back one field or question	
	→ (Right Arrow) ← (Left Arrow)	Used to view patient's record from PCI, navigating in MOX and Patient Notes routine. "Right Arrow" in and "Left Arrow" out. (sometimes you may have to use the "Shift" key with the Arrow key)	
	Page Up	Moves back one page or section	
	Page Down	Moves forward one page or section	

Combination Keys

GEMMS Toolbar	Keys	Description	Notes
	Ctrl/F12	Displays a **Calculator or Calendar**	
	F4/F9	Used for **"Canned Text"** when documenting patient notes (choose from a list of partially typed patient notes)	
	Shift/F12	**Magic Key** Used to get to the **Hot Key Menu** (another main menu) and **Suspend Session** (temporarily locks the computer screen when you have to leave and you do not want to log off)	
	Shift/F8	Displays **Online Documentation** about the field and routine where the cursor is located.	
	Shift/Ctrl	**Select All** and **Deselect All**	

Shortcuts and Miscellaneous Information

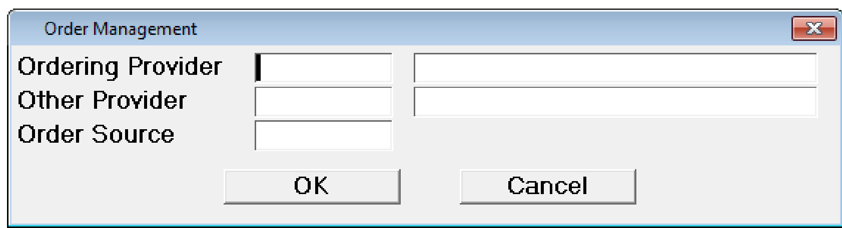
1. **CAPS Lock** – must be on at all times in Meditech (except when logging in)
2. **Date** – For today's date, type T enter and today's date will populate field. Type T+1 for tomorrow or T-1 for yesterday.
3. **Time** – For now, type N enter and current time will drop in.
4. **Capital X** – Type X at any menu and the system will automatically log off.
5. **Spacebar Enter** – pulls up the last patient or printer you were working on
6. **c**Smith,John – A 'c' before the name identifies a confidential patient.
7. *****Smith,Jane – A '*' before the name identifies a VIP patient.
8. To locate providers whose mnemonic is not easily found, type N\ and providers last name.

Tips for Entering Orders

1. It is preferred that providers enter their own orders into the computer. However, there will occasionally be a need for the nurse to enter an order. If entering a telephone or verbal order, it is <u>very important to keep the ordering provider on the phone</u> or next to the computer to answer questions regarding medications.
2. Order Sets are grouped by disease process and are orders that are commonly used together in-patient care i.e. Sepsis/Shock includes medications, IV fluids, nursing care orders, radiology and cardiology. Orders and Meds/Fluids buttons are for individual items ordered when not using an Order Set or that need to be added within a set.
3. POC before an order means 'Point of Care' or that the nurse is completing the test. This is used for Bedside Glucose Sticks, Transcutaneous Bilirubin, and various test in the Emergency Department.
4. All patients should have a diet order even if it is NPO. Each diet order has a primary diet with options of a secondary diet, modifiers, diet restrictions, and diet texture.
5. Consults are used for physician ordered consults. Nurses can request a 'screen' without a physician order. For instance, the physician would order a Lactation Consult but without a physician order, the nurse can order a Lactation Screen.
6. Lab orders can be entered up to 7 days in advance, Respiratory Therapy Orders are valid for 30 days, and all other orders can be entered up to 3 days in advance.
7. MMM or Medication Management Message should be used to contact pharmacy regarding medication needs. For example, Norco is ordered for the patient but needs to be stocked in the Pyxis.
8. Some orders will automatically reflex or add other orders. When ordering an inhaler, respiratory consult is automatically ordered. When ordering a Cardiac Stress Test, the Nuclear Medication portion of the test is automatically ordered.
9. Some test may be listed more than once due to aliases being added to make finding the test easier. Example: Chest X-Ray is listed as Chest X-Ray and CXR.
10. Some orders such as Dialysis, Restraints, TPN, Special Labs, Foley – Renewal Order, and Suicide Precautions continue as paper orders.
11. To look up a physicians' mnemonic when entering an order, type the first 3 letters of the physicians' last name and press F9. This will bring up a list of physicians. Enter the number to the left of the physicians name and press enter. If the physician name is hard to locate, type N\ and then the last name.

Entering Orders

To enter orders, select your patient from the 'Status Board" and click on 'Orders'. This will display the 'Order Summary' with the order buttons located on the right hand side of the screen - 'Order Sets', 'Orders', and 'Meds/Fluids'. Select the type of order needed. Once in the order type, you must enter the physicians pneumonic or type the first 3 letters of the physician's last name and press F9. Select the correct provider and press 'enter'.



'Ordering Provider' is the Physician, Physicians' Assistant, or Nurse Practitioner who gave the order. 'Other Provider' is where you enter the physician with whom the Physicians' Assistant or Nurse Practitioner is associated with so they can co-sign the order. Use the F9 function key to look up the persons pneumonic. 'Order Source' is the type of order received.

<u>C – Plan of Care</u> - Will be used by therapy services at this time. Their plan of care for the patient will queue back to the provider for a signature.

<u>P – Protocol</u> - These orders queue back to the provider for a signature and "Protocol" is used for example when we order Flu and Pneumonia vaccines and/or MRSA swabs on admission.

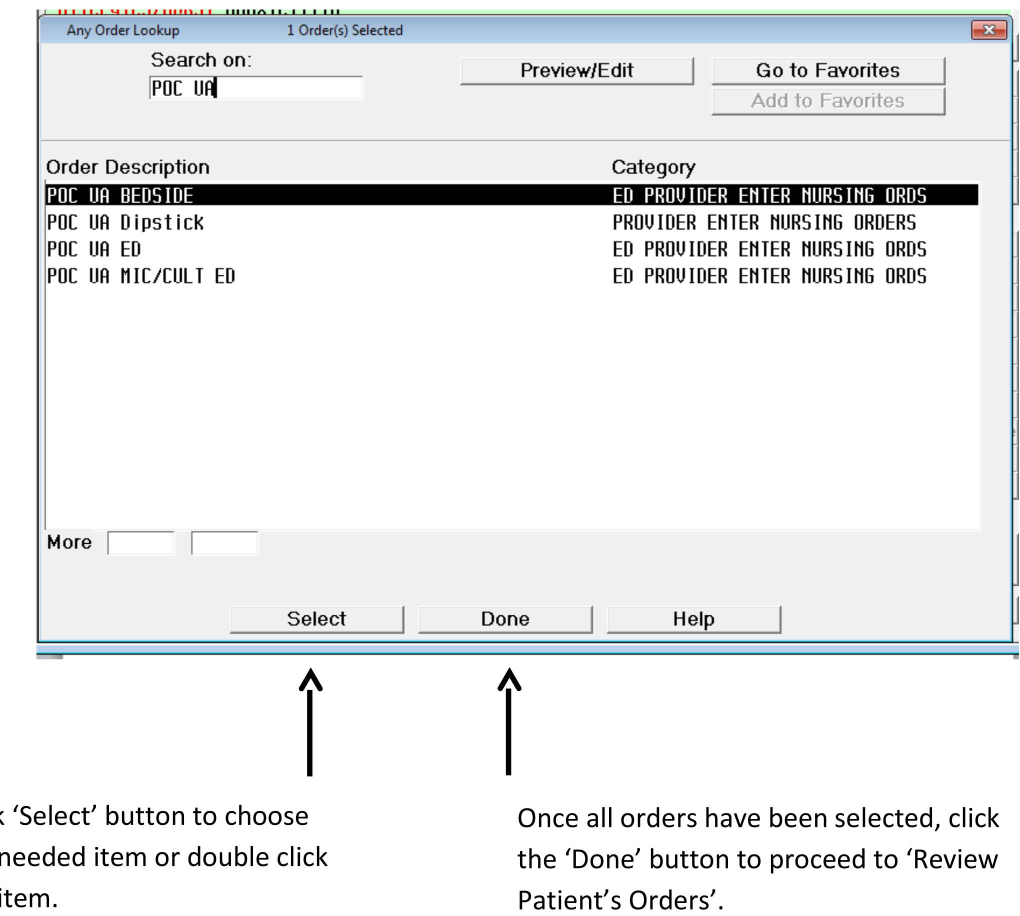
<u>T – Telephone -</u> Order documentation is originated by a clinician authorized to accept telephone orders and includes documentation of ordering provider and clinician.

<u>V – Verbal -</u> Order documentation is originated by clinician authorized to accept verbal orders and includes documentation of ordering provider and clinician. Verbal orders should only be entered by the nurse in emergency situations.

<u>W – Written -</u> : Order documentation is originated by provider and includes the provider's written signature.

<u>Z – Department/Process -</u> Orders sourced as "Z-process" do not queue back to the provider for electronic signature and should only be used when the original order gives titration variables or specific conditions. The original order should be entered by the provider or sourced as Telephone, Verbal or Written. A good example of this is when the provider orders "Transfuse 2 units of packed cells ***<u>if</u>*** the hemoglobin drops less than 8.0". We have the order to transfuse and 2 days after the order was written, the patient's hemoglobin drops. The nurse would order the transfusion and source the order as "Z-process" because we have the original transfusion order that was signed when entered.

Once in Order Entry, begin typing the name of the order needed. When the item is on the screen, use the mouse to highlight the item by clicking on it. Click ‘Select’ at the bottom of the screen or double click order and enter another item if needed using the same process of highlighting the item and clicking ‘Select’. When complete, click ‘Done’ and complete all required fields.



Click ‘Select’ button to choose the needed item or double click the item.

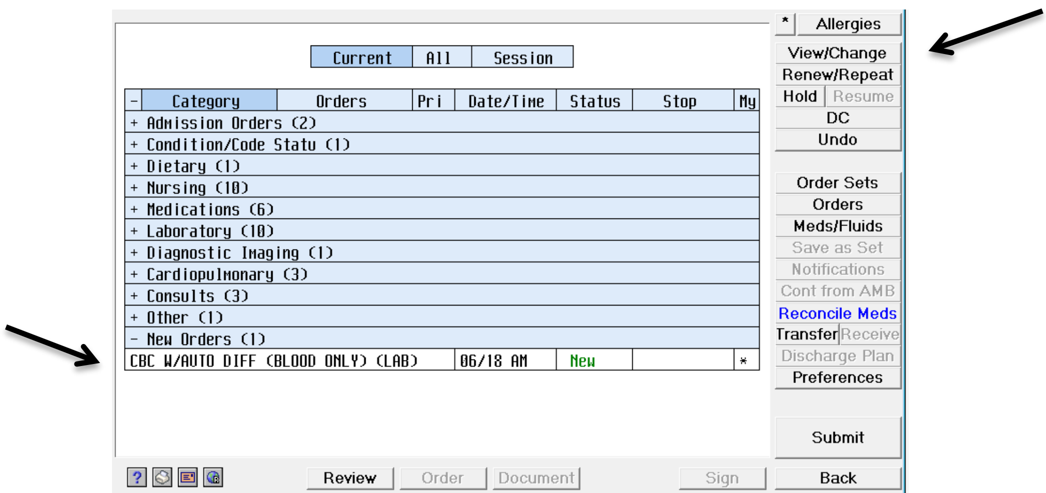
Once all orders have been selected, click the ‘Done’ button to proceed to ‘Review Patient’s Orders’.

Required fields include Priority, Start/Service date and time, Series if needed, and red **“Req”** fields.

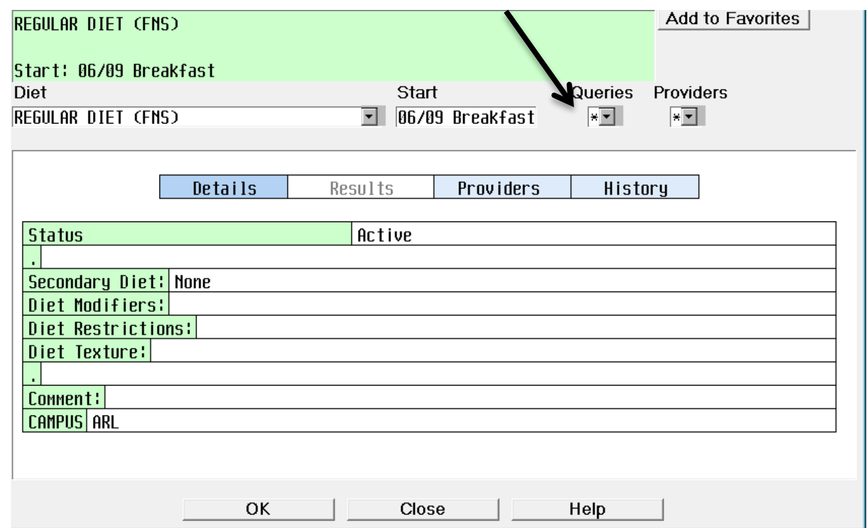
Make sure you click ‘Submit’ to complete the order process.

Editing Orders

Once entered, orders may need to be edited. One example of this would be to update/ change information before the order is submitted. Meditech allows the user several opportunities to review orders before they are submitted. From the review screen, highlight the item that needs to be corrected by clicking the item, click the '**View/Change'** button. This will take you to back to the 'Preview/Edit' screen. Please note that completed orders cannot be edited or discontinued.



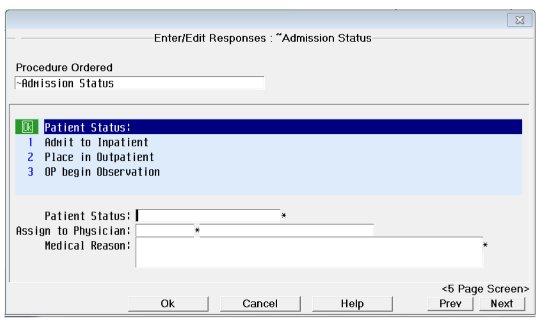
Some orders can be updated after being 'Submitted'. After selecting the patient, click 'Order', locate the order to be updated, highlight it, and click the **'View/Change'** button. If there is an asterisk in the **'Queries'** box, the order can be updated. Click the 'Queries' drop down box and the ordering information will open, and updates can be made. Once updates are completed, click 'OK' and 'Submit' order.

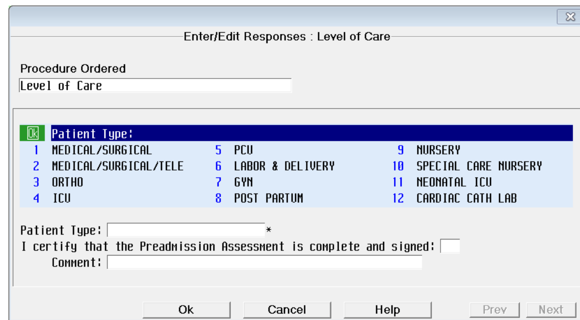


Patient Admission & Level of Care

**** This is very important for billing purposes and needs to be entered as soon as possible.**

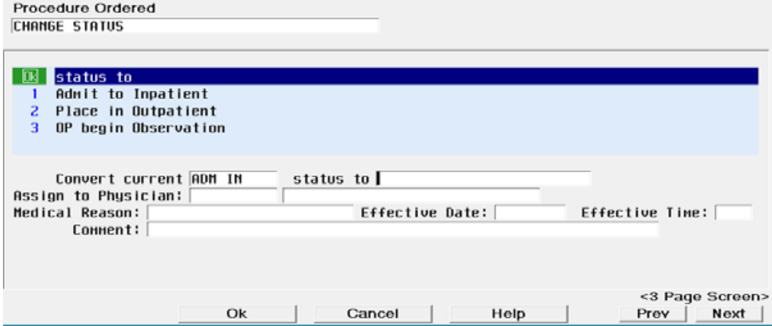
** Complete all fields within the Admission Status & the Level of Care Order. Please note that the Admission Status order has multiple pages.





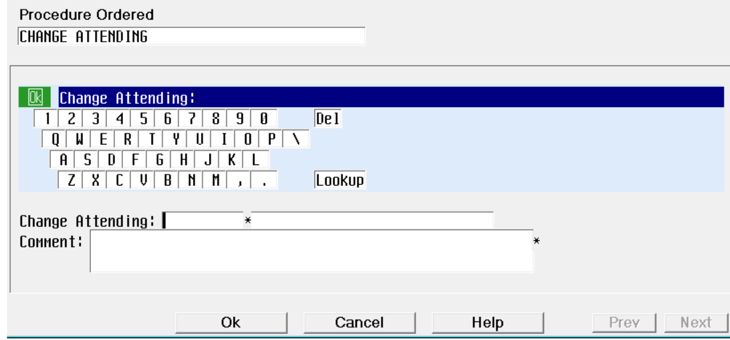
Change Status

Complete the Change Status order when the patients admission status changes. i.e. Outpatient to Inpatient or Observation to Inpatient status. This is very important for Case Management as well as for billing purposes.



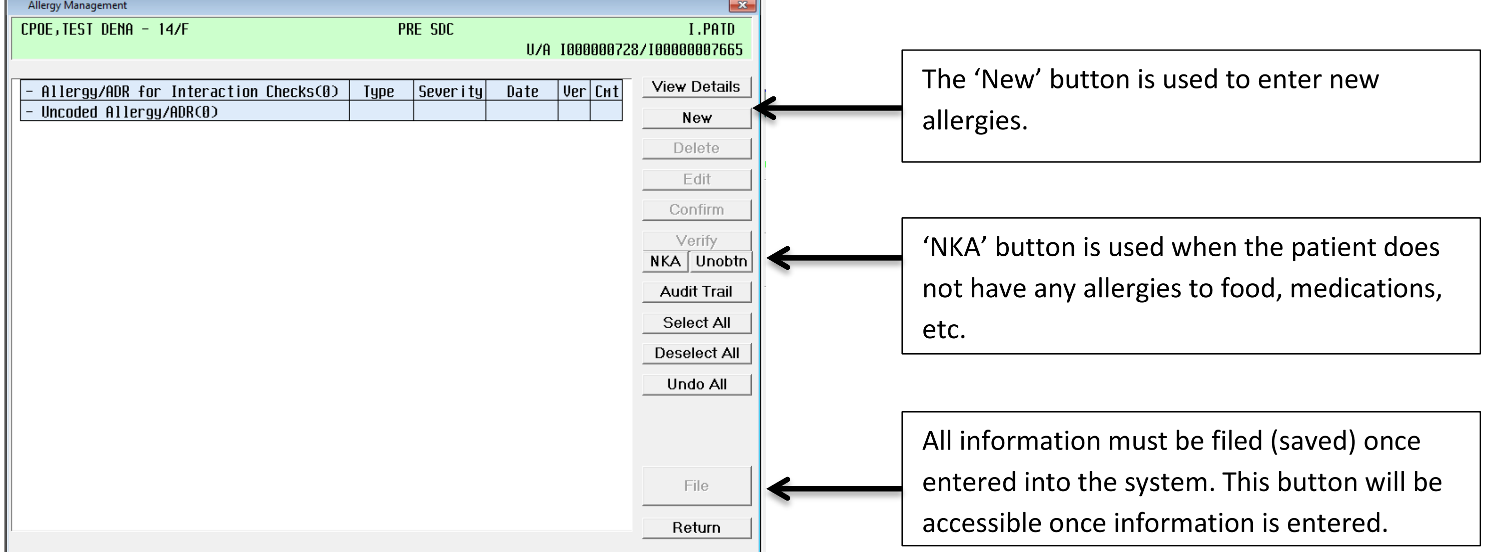
Update Attending

This order is used to change the current listed physician to the patients attending physician.

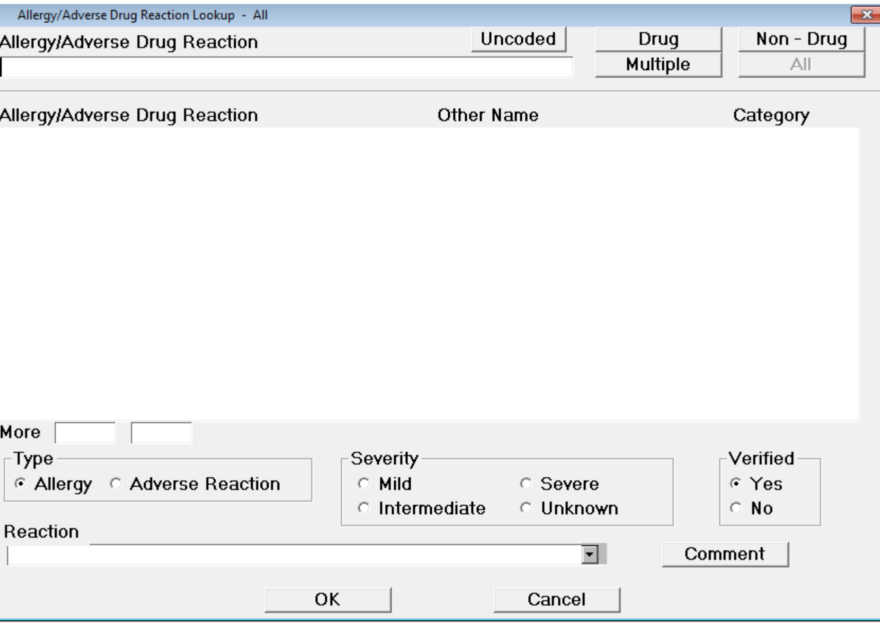


Entering Allergies and Adverse Reactions

Allergy and adverse reaction history must be obtained and entered into Meditech for all new patients in order for the Pharmacy to process medications. Allergies must be spelled correctly in order for the system to cross check allergies with medications.



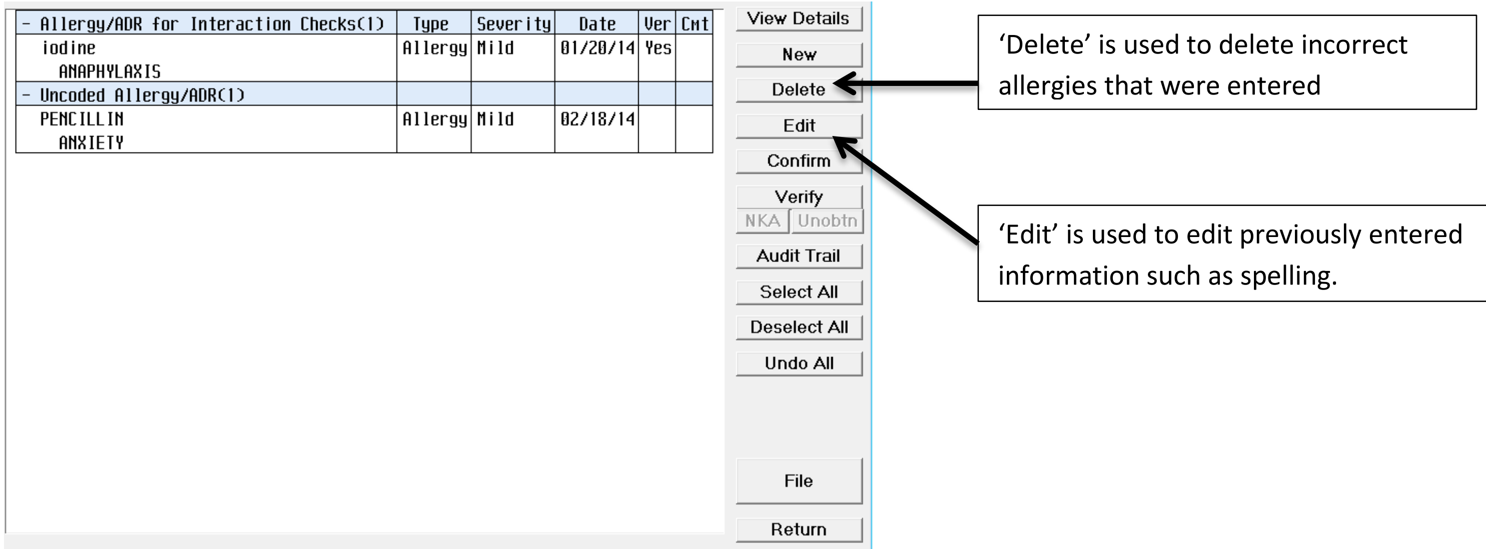
To enter allergies, click the 'New' button and type in the first three letters of the allergen.



All fields must be completed and spelled correctly. Once entered, Meditech should be able to check for medication interactions. Allergies listed in brackets [ ] are not listed in the dictionary and cannot be checked for interactions. If you notice a bracketed allergy, please double check the spelling and correct if needed.

Updating Allergies and Adverse Reactions

Allergies and reactions should be updated as needed. Once in the Allergy screen, use the 'New' button to add new allergies. Previously entered allergies can be updated by using the 'Delete' and the 'Edit' function. To use 'Delete' or 'Edit', first click on the allergy that needs to be changed then click the 'Delete' or 'Edit' function and update the information making sure to spell all information correctly.

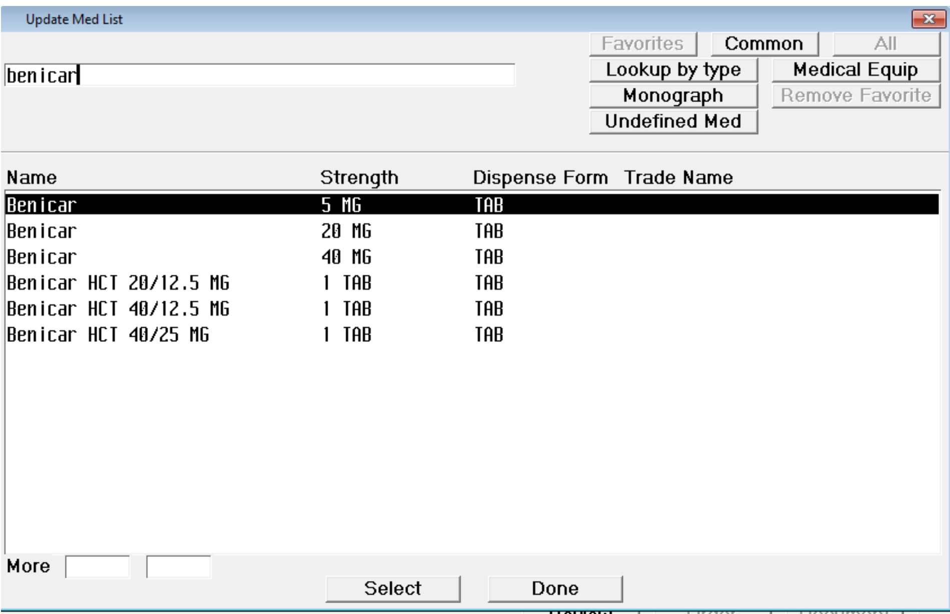


MEDICATION RECONCILIATION

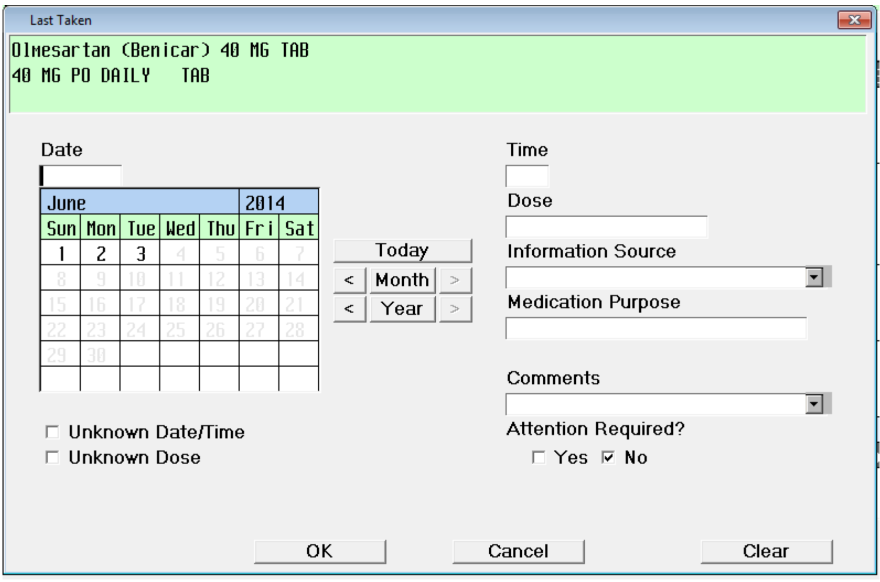
When a patient is admitted, the Medication Reconciliation or Med Rec must be filled out completely and accurately as soon as possible. Entering the patients' allergies before starting the Med Rec will prevent pop-ups during this process. From the Status Board, highlight the patients name and click Reconciliation Rx. Medical City contracts with PAYORENGINE which pulls the patients medication information from community pharmacies. This is an automatic query once the patient is added into the computer system. This information needs to be verified with the patient and added to the Med Rec if applicable with the last date and time completed.

For period 12/04/13 - 06/02/14 (180 days)		Add Disclaimer Update
[Clonidine Tab 0.1MG]	06/02/14	PAYORENGINE
Benicar HCT 40/25 MG TAB 1 TAB	06/02/14	PAYORENGINE
+ [Losartan/Hct Tab 100-25]	05/16/14	PAYORENGINE

To add medications, click Update Med List button located on the right of the screen. Type the name of the medication making sure to spell it correctly and select the appropriate medicationstring. Click ‘Select’ and the computer will have you click the medication string with the correct dose and directions then click ‘Done’.

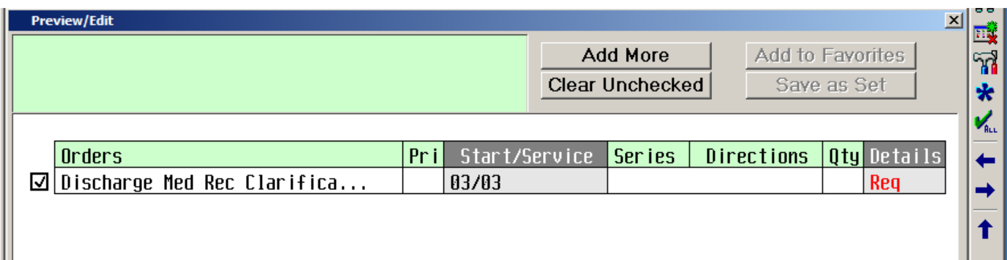


All information on this screen should be completed as accurately and as soon as possible. If unable to obtain the information, the Unknown Date/Time or Unknown Dose queries can be used and attention required should be changed to “ Yes”. This information needs to be completed as soon as possible and the need for information should be passed on in report to the next nurse. Not completing this information can delay the patient’s medications.



- Home Meds (2)	Trade	Last Taken	Review	DC	Cont	Hold
Esomeprazole Mag Trihydrate (NexIUM) 20 MG CAPSULE.D 20 MG PO BID	Reported	Unk DT/TM Unk Dose	○	○	○	
Levalbuterol Tartrate (Xopenex HFA 45 MCG/ACT) 15 GM 1 PUFF INH RTQ4H	Reported	Unk DT/TM Unk Dose	○	○	○	

It is preferred that the physician reviews the Admission and the Discharge Med Rec and makes the decision to Continue, Hold, Discontinue, or Cancel medications; however, the nurse does have the capability to complete the Med Rec based on the physicians order. The Admission Med Rec will prompt for an ordering physician and source. The Discharge Med Rec does not prompt for a physician or source. Therefore, if the nurse completes the Discharge Med Rec, a Discharge Med Rec Clarification order must be entered detailing the changes made to the Med Rec and this order will need to be signed by the physician.



Definitions for Med Rec

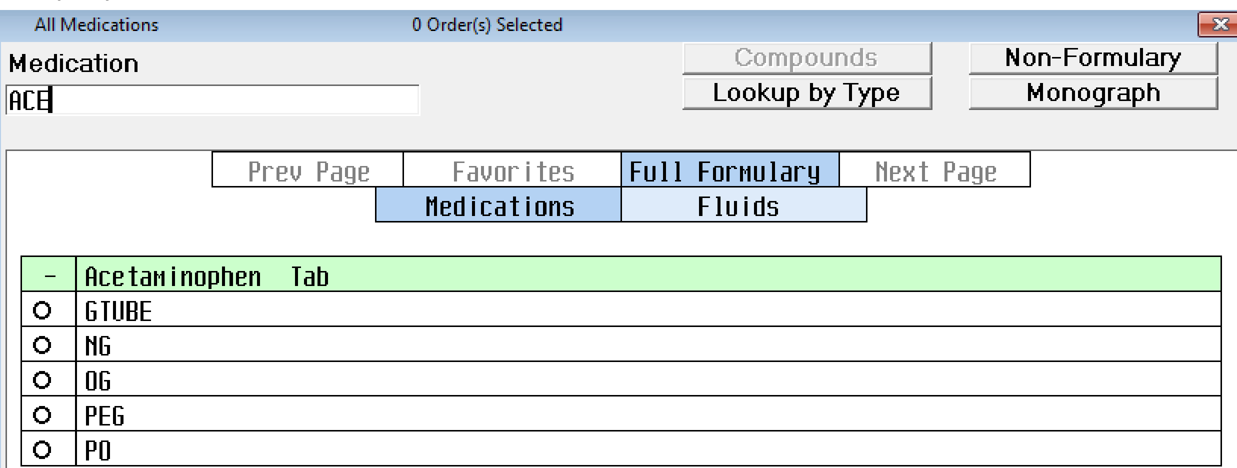
Hold = Provider has indicated to hold this medication.

Cancel = removes the medication from the process med screen. This medication will not appear on the patient's printed home med list.

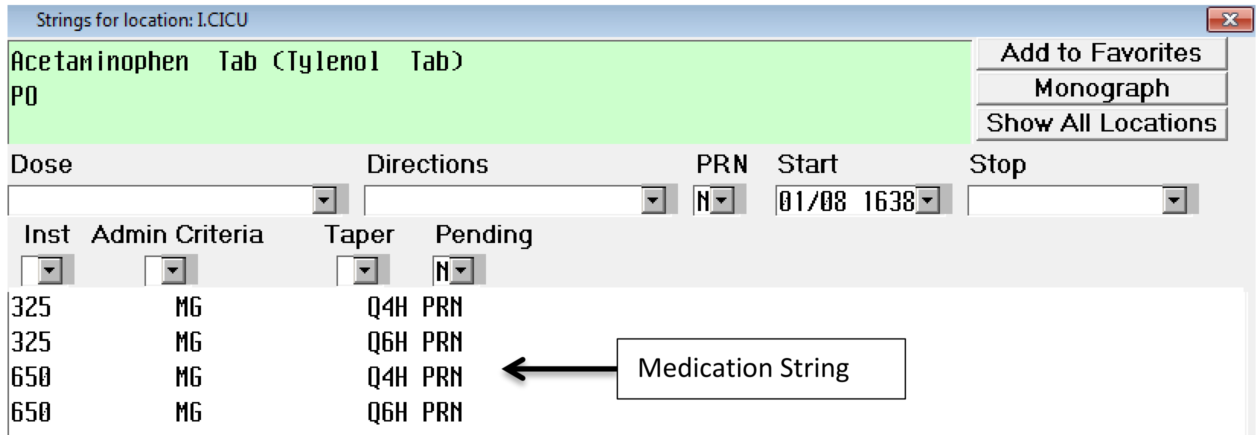
Discontinue = use discontinue if a patient is no longer taking a medication reported in prior visits.

Ordering Medications

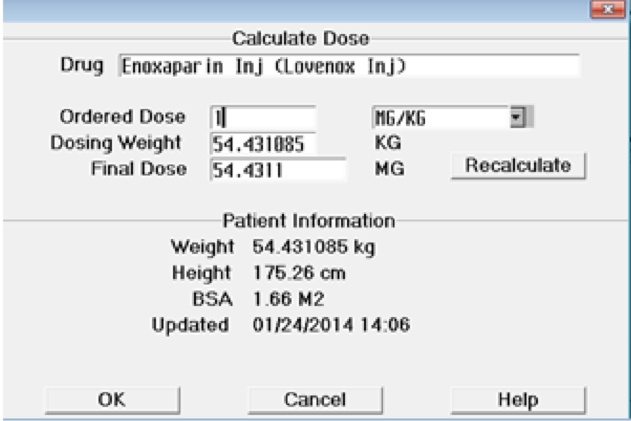
To order medications, chose the 'Meds/Fluids' option. Type the name of the medication which should display on the screen. Click on the medication and select the route.



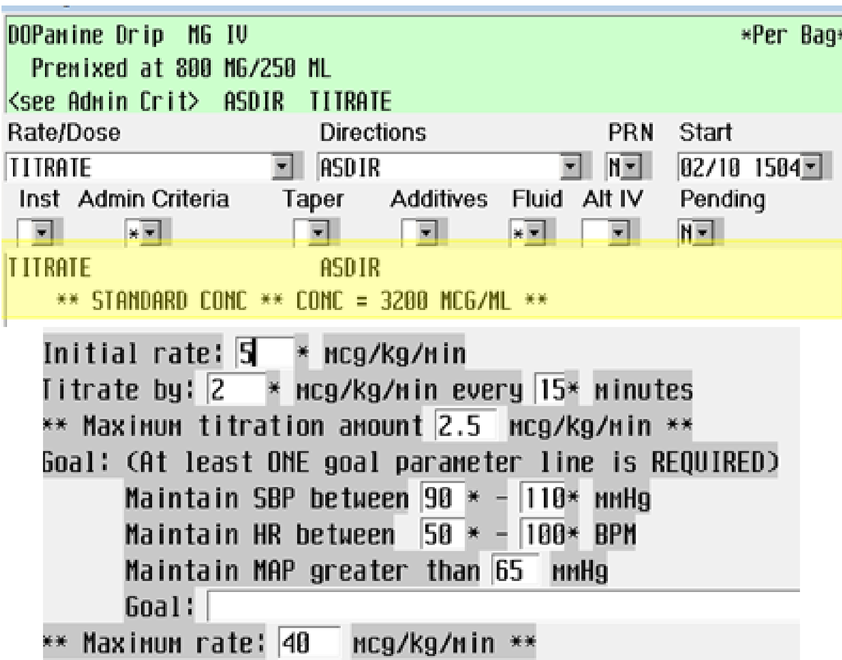
Once the route is selected the common medication doses or 'Strings' will be displayed. Select a string and make adjustments if needed.



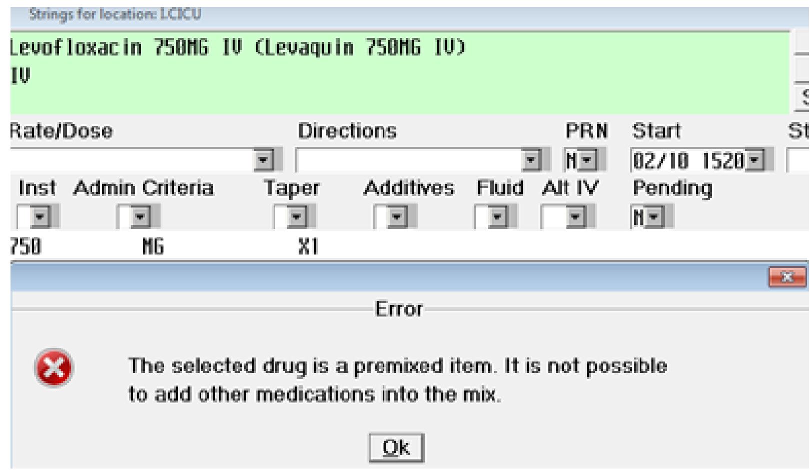
Weight-based Medications - Some medications such as Lovenox are weight based and require the patient's current weight to calculate the medication dose.



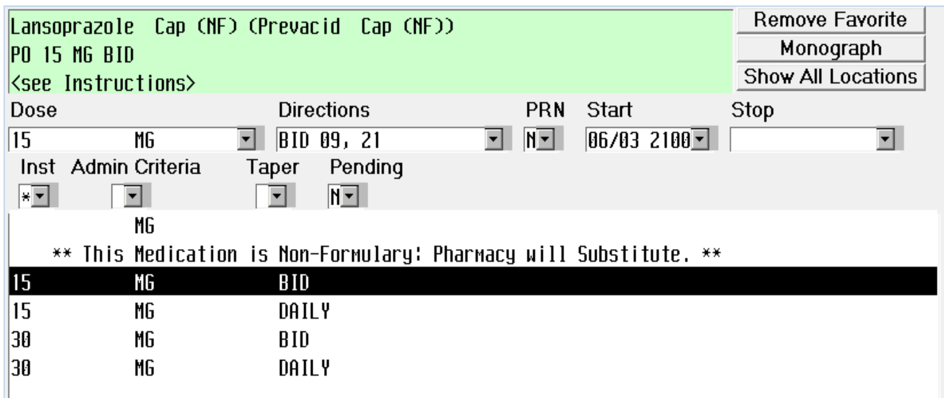
Titration Medications - Medications such as Dopamine require Titration information. The provider needs to set the parameters for this medication and if not entering this order themselves, need to be accessible to the nurse and to answer appropriate questions.



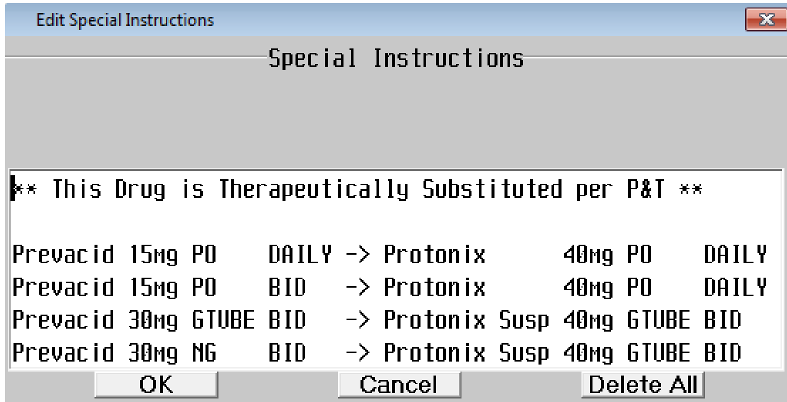
Premixed Medications - Various medications are premixed and the dosages are pre-set and cannot be changed. If you attempt to change the dose an error message will appear as shown below.



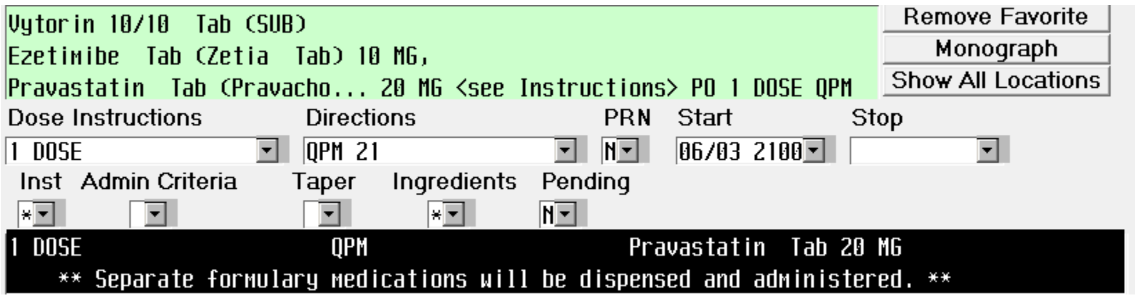
Non-Formulary Medications - If there is an (NF) beside the name of the medication, it means that the medication is not stocked at this facility but will be therapeutically substituted by pharmacy. You can click on 'Inst' or Instruction drop down box to review the substituted medication.



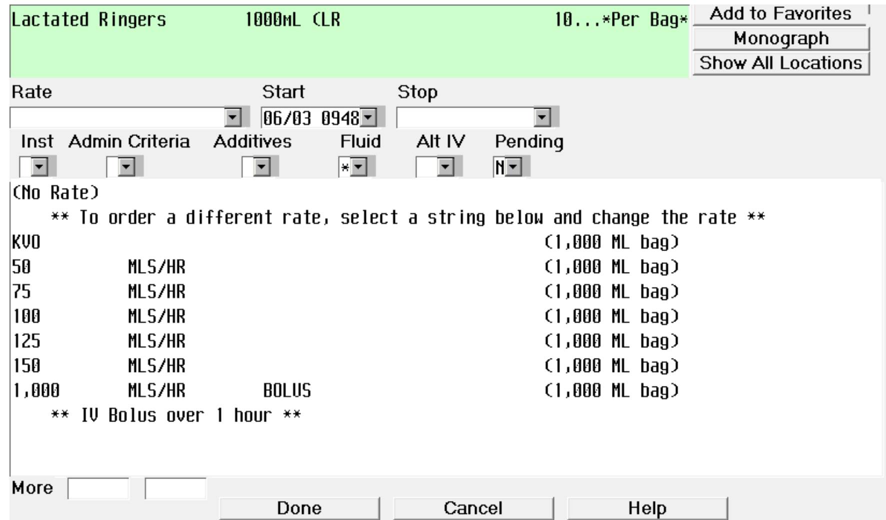
This is an example of the information contained in the 'Inst' drop down box.



Combination Medications - Combination medications may be provided separately instead of being a compound medication. When pharmacy is supplying separate medications, they are listed in the medication window as shown below.



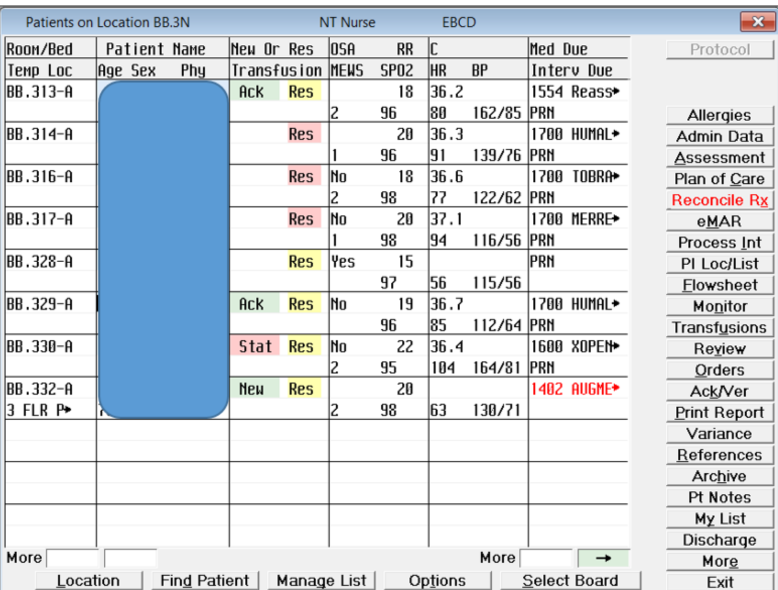
IV Fluids – IV Fluids that contain medications are ordered under the 'Medications' tab. Plain IV Fluids are ordered under the 'Fluids' tab. Bolus' and continuous rates are entered as separate orders even when they are the same fluid.



When entering medications various items are adjustable. Items with a pop-down box can be changed or special instructions can be added in the 'Inst' box.

Status Board

Once orders have been entered, the nurse is notified of the order by a 'Flag' that appears on the Status Board to the right of the patients name.



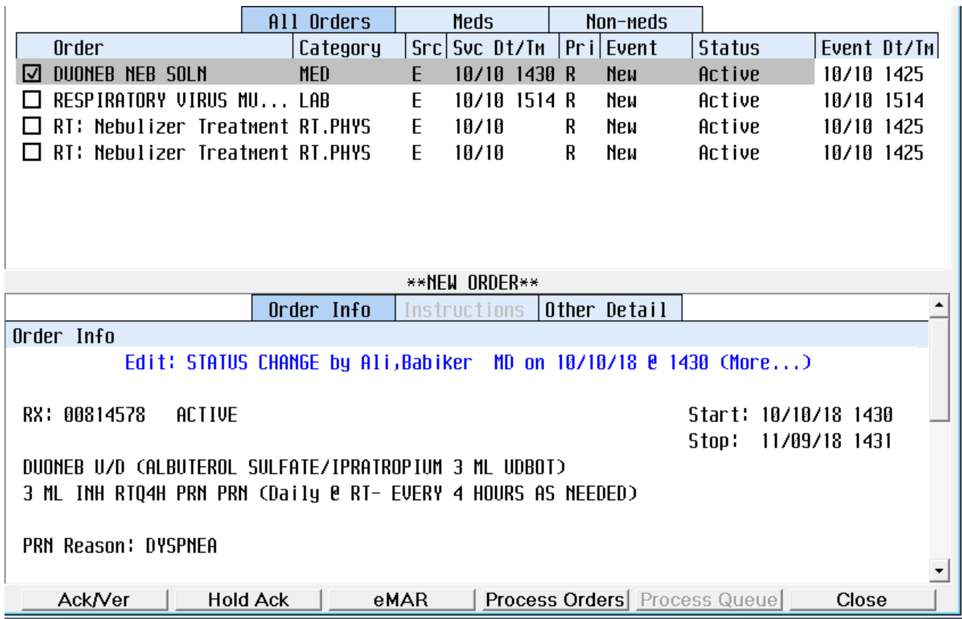
The Order Management Flags follow a hierarchy of importance and flags may be stacked if multiple flags are needed.

Acknowledging and Verifying Orders

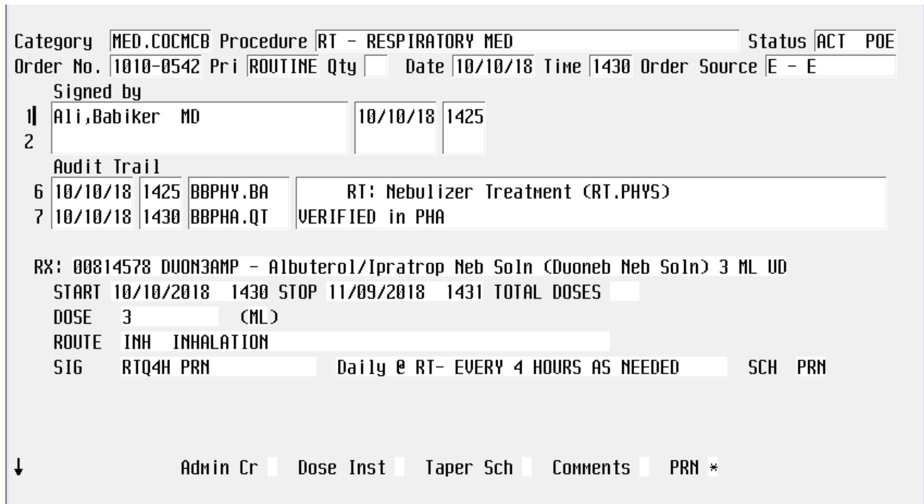
To process a new order, begin by clicking the order flag on Status Board. Then we view the orders that are waiting to be acknowledged. We check the order or orders that we would like to acknowledge, and then we click the Ack/Ver button.

Acknowledging and Verifying Orders

To process a new order, begin by clicking the order flag on Status Board. Then we view the orders that are waiting to be acknowledged. Check the order or orders that need to be acknowledged and click the Ack/Ver button.

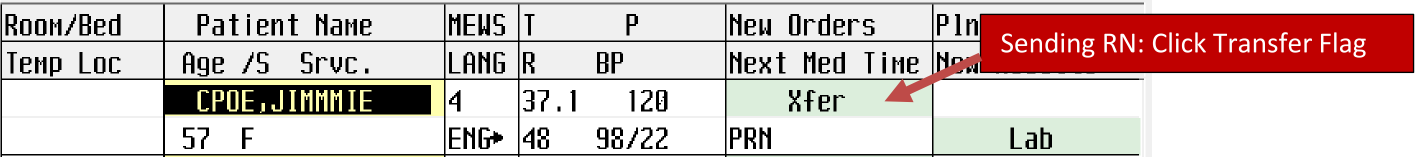


Once we click the Ack/Ver button, we are brought to the Order Record screen where we can view additional details regarding the order. After reviewing the details, press F12 and confirm the order with "yes" or "no". Clicking "yes" completes the acknowledgement process for a non-med order. Medication orders must be verified through pharmacy prior to administration to patient.

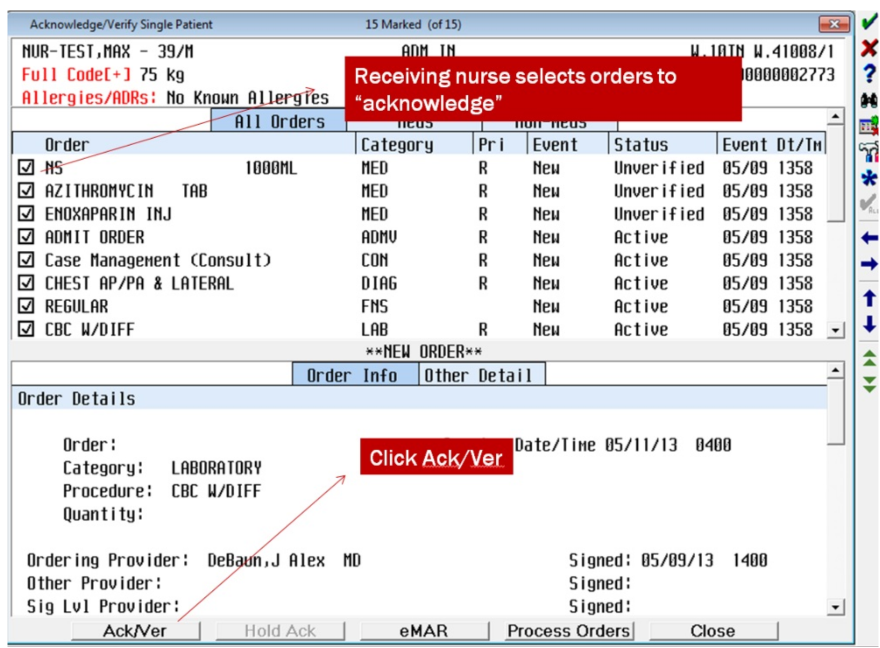


Transfer Process

When a Transfer order has been entered, the 'X-fer' flag will appear on the Status Board. The Transfer process is a two-step process which includes actions for the Sending Nurse and the Receiving Nurse. The Sending Nurse clicks the 'X-fer' flag, clicks 'Bypass Transfer Orders", reviews the details of the transfer order, and follows the acknowledgement process.



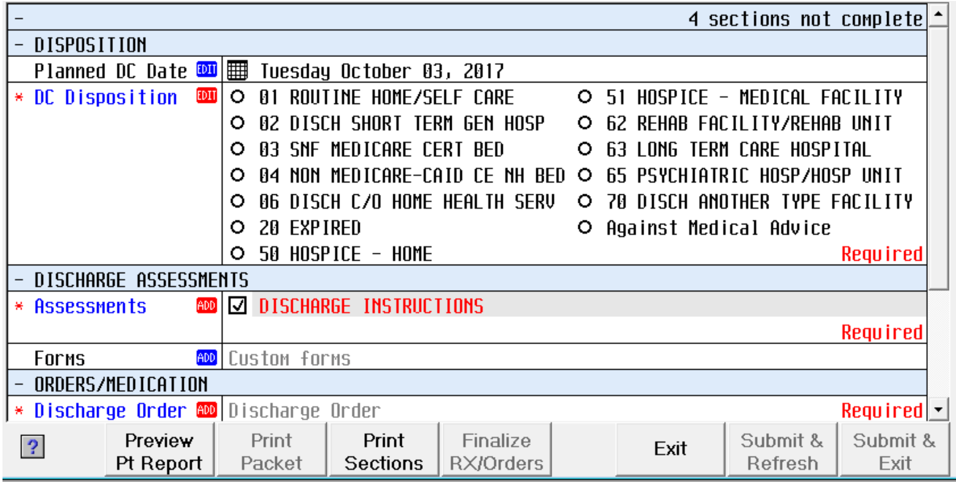
Once report has been received, the Receiving Nurse should click the 'Receive' button. This will release the orders from the 'Transfer' process and allow other departments to process their orders. Example – medications will be sent to Pharmacy and lab orders will print in Lab. The Receiving Nurse can also Acknowledge the orders from the Status Board to release them.



Transfer orders are not activated until the Receiving Nurse either 'Receives' the patient or acknowledges the Transfer Orders. Remember: A delay in receipt of orders will cause a delay in patient medication being available.

Discharge Process

When a patient is being discharged, the 'Discharge' process must be completed. Click the 'Discharge' or 'Discharge Plan' button and complete all fields. You know you have completed all fields when the red fields have turned blue.



The Discharge Order within the 'Discharge Plan' notifies the nurse that the patient needs to be discharged. This is not the order that notifies Registration that the patient has left the building.

Unconditional Discharge – the patient may be discharged as soon as the paperwork is completed. This will appear as a "STAT" order that the nurse will acknowledge. From there, the nurse will proceed with the normal discharge process.

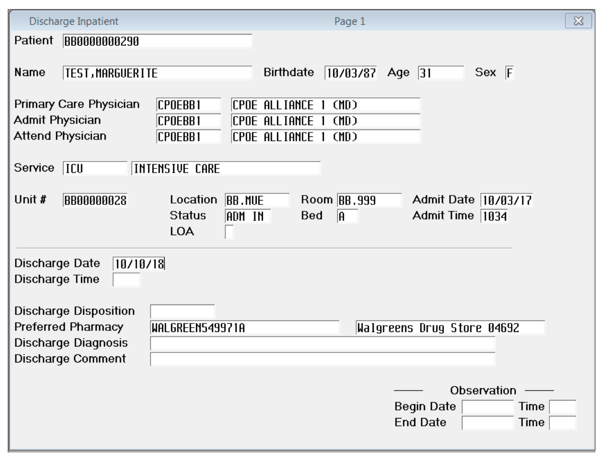
- NOTE: Discharge Orders expire in 24 hours.

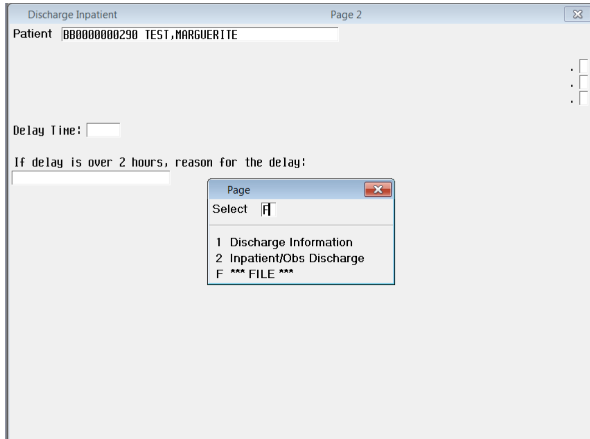
Discharge Order with Parameters - this order is used when the patient can be discharged ONLY after specified conditions have been met i.e. waiting for SNF placement, last dose of medications, lab results, or discharge from another physician.

Once the parameter or condition noted within the order has been met, the nurse either:
1. If the physician requested to be notified once condition is met, the nurse notifies the physician and gets an unconditional discharge order
OR
2. If the physician did not request notification, the nurse enters a Ready for Discharge order.

Discharging Patients from Meditech

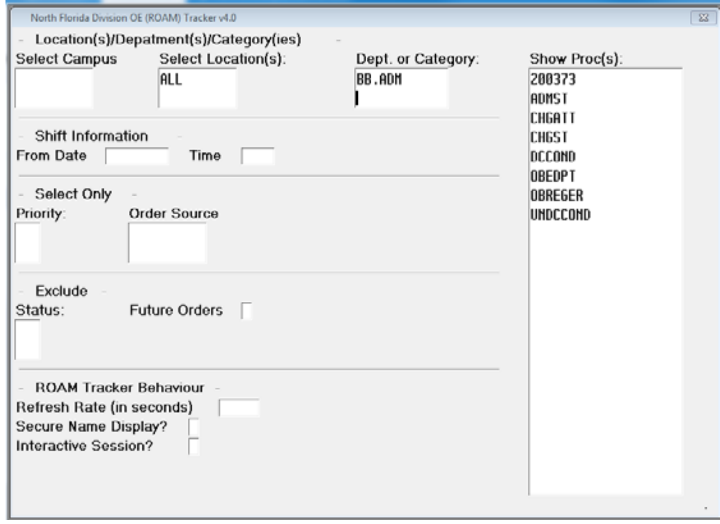
The Discharge Routine which discharges the patient from the computer can be done by the nurse or the HUC. From the Status Board, select ‘Print Report’, then ‘Admission Menu’, and choose either ‘Discharge Patient’, ‘Discharge Observation Patient’ or ‘Discharge SCD Patient’. Once the required information is completed and the information is filed, the patient will be discharged from the computer and Environmental Services will be notified to clean the room.





Meditech Tracker

Unit Supervisors and Unit Clerks have access to the Order Entry Tracker. The Tracker can be used to follow orders that have been entered – Discharge Order, Change Attending, Transfer, etc. From the Status Board, click on the **‘Print Report’** button on right side of screen which will open a larger menu. Click ‘**Order Tracker’.** ‘All’ is automatically populated into the location field but should be changed to desired viewing location. Type **BB.ADM** into the ‘Dept. or Category’ field .



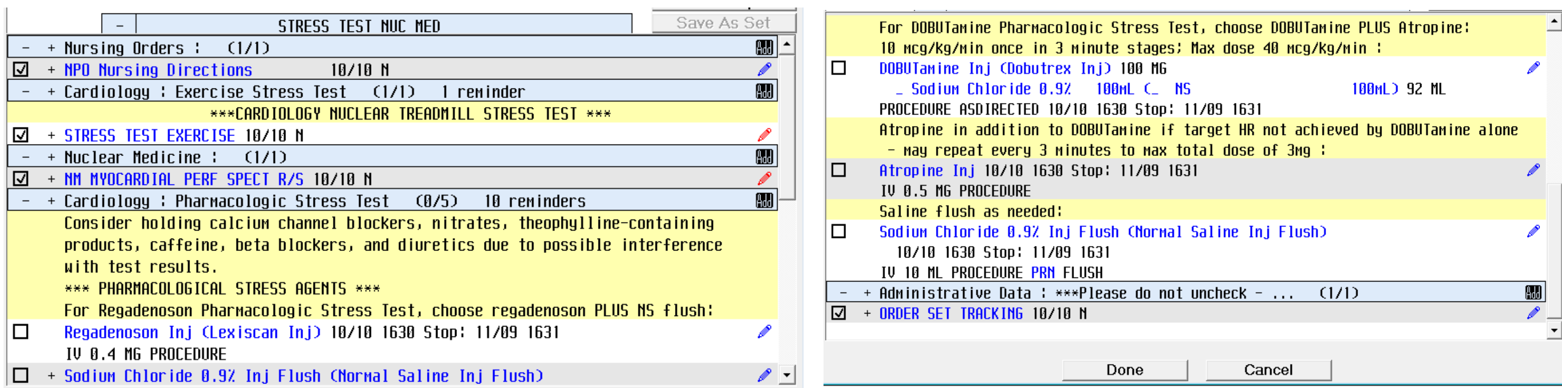
Once the location and department fields are completed, a list of order types will populate the **‘Show Proc(s)’** field and the undesired order types can be deleted. Use the right arrow to view the reports. Once the reports are viewed, you MUST press the Enter key to exit the report.

Print OM Order Session

If needed, patient's orders can be printed for viewing. From the Status Board, click the 'Print Order Session SheetS'. The 'Reprint Provider's Order Sheet' screen will open. Locate the patient by typing the patient's name, pressing F9, and select the correct patient. In the 'Order Sheet' field, press the F9 key and the orders will be listed in chronological order. If searching for a specific order, the date and time of entry or the provider's name must be known.

Stress Test

Stress tests are performed by the Nuclear Medicine department and is an order set. To order a stress test, type in 'Stress' and choose the correct order set. Please note the special instructions in the yellow boxes.

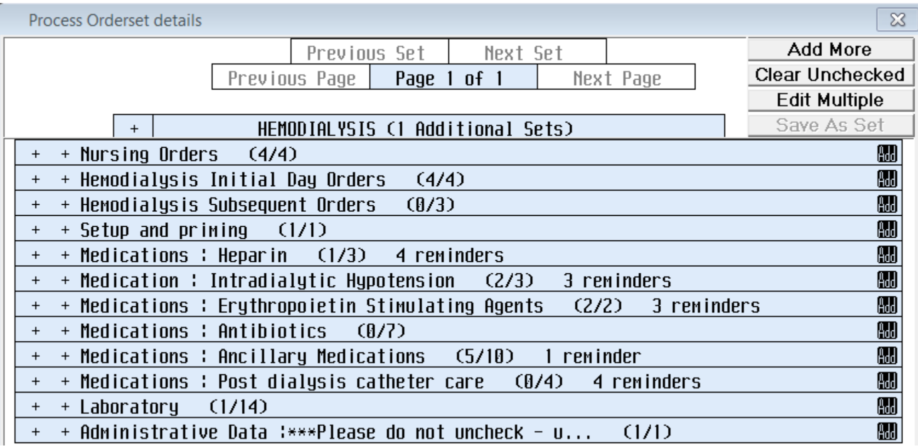


Patient Preparation:

1) NPO for at least 8 hrs. prior to test for morning studies and NPO after light breakfast without caffeine for PM studies.
2) Physician should specify on the order sheet what meds to hold (usually Beta Blockers).
3) Nuclear Med and the Stress Lab need to know the height and weight of the patient beforehand to determine how they will, or whether they can perform the test.

Process for Ordering Dialysis

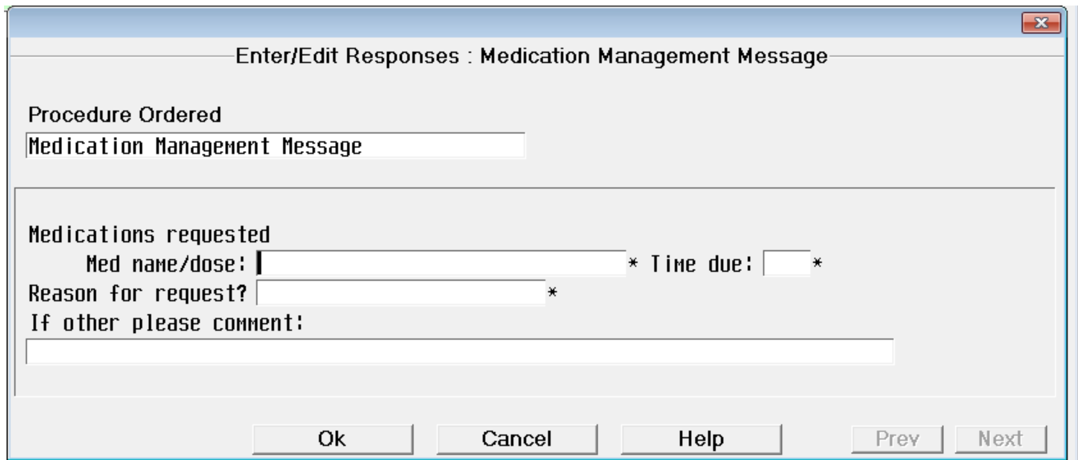
Dialysis is ordered using the Hemodialysis Order Set. Under 'Order Set' type Hemodialysis and select the hemodialysis order set. Complete required information and 'Submit' the orders.



When you FILE the order, the request will print automatically in the Dialysis Department.

Missing Medication Management

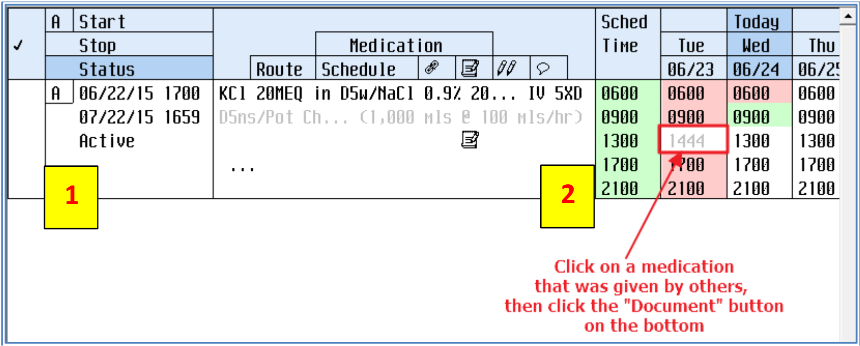
To notify Pharmacy of a missing medication, use the **'Medication Management Message'** order. While you have to list the primary physician to place this order, the physician does not need to sign this order and the ordering source should be 'Department Process'. Complete all required fields and 'Submit'.



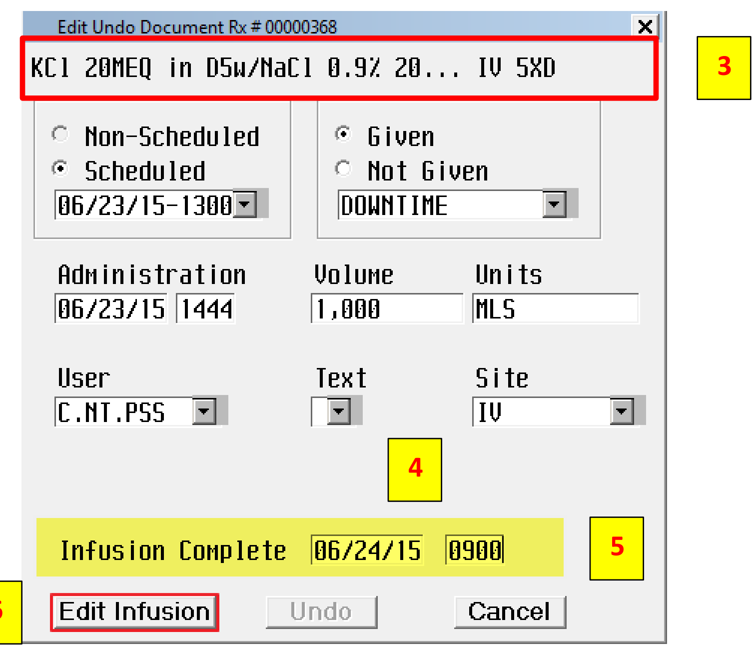
Documentation of IV Infusion Stop Times

To document an IV Infusion Stop Time, select the patient and access the patient's EMAR.

1. Select the medication to document the IV Infusion Stop Time
2. Click on the GREY infusion Start time.

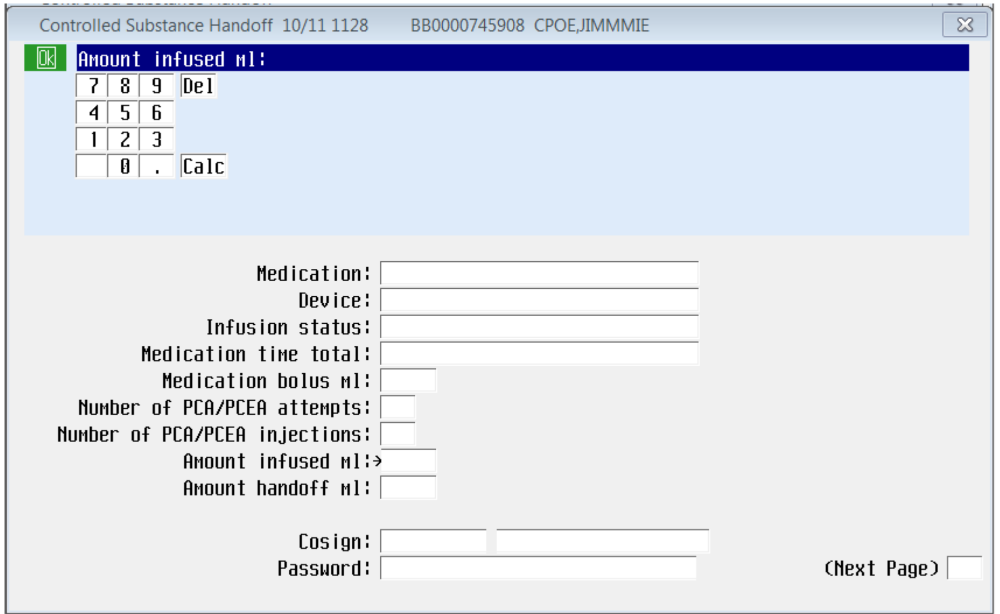


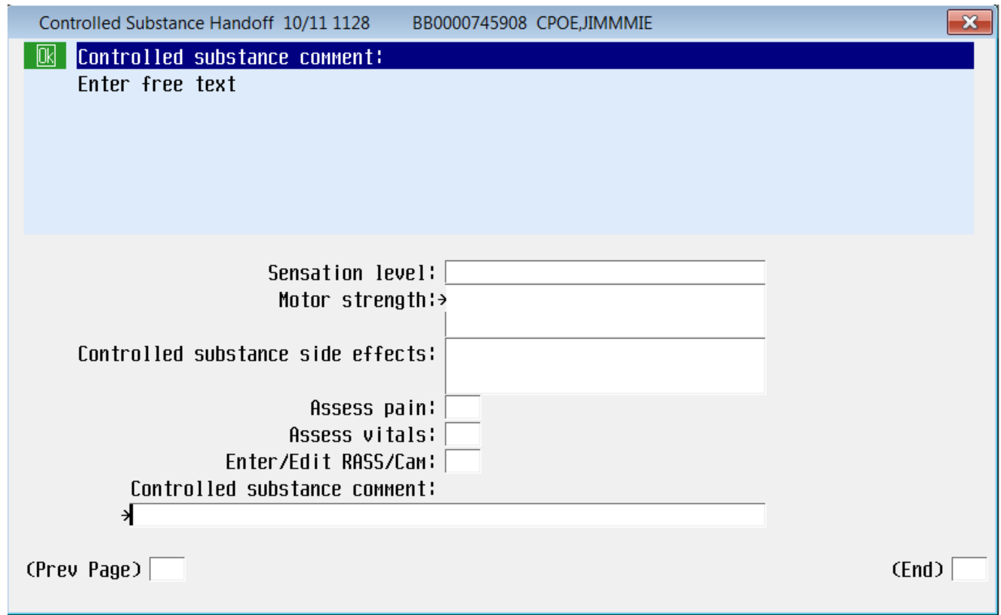
3. Confirm the medication at the top of the "Edit Undo Document RX" screen.
4. Enter the date and time into the "Infusion Complete" field. (NOTE: If a Complete Date/Time is pre-calculated, the Infusion Complete date / time fields will default that date and time.)
5. Confirm the correct infusion completion date and time has been entered.
6. Click on the "Edit Infusion" button, this will complete the documentation session.



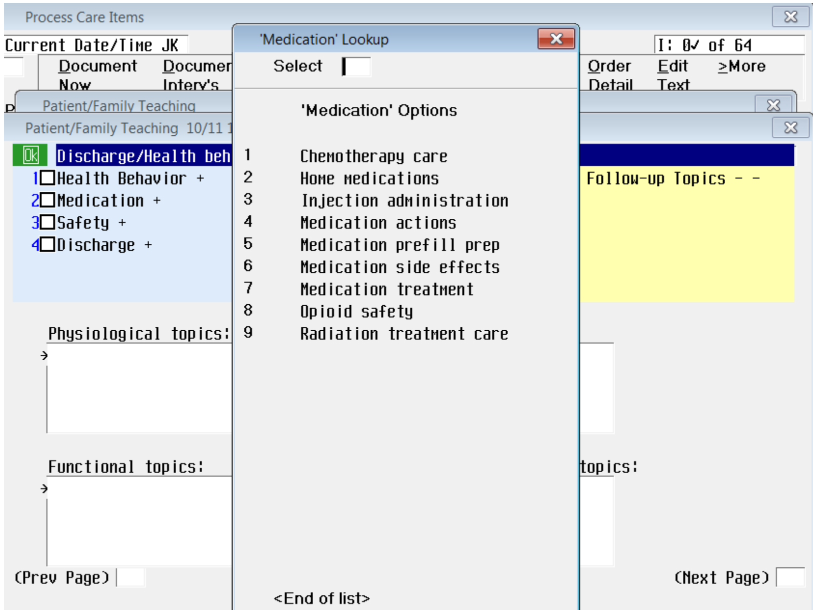
PCA Documentation

It is mandatory that all PCA Pump totals are documented in the patients EMAR every 12 hours at 0600 and 1800 AND when the caregiver changes i.e. PACU gives report to Med/Surg nurse until the PCA Pump is discontinued. The Controlled Substance Handoff intervention is used to document the PCA. Two nurses must verify the information on the PCA pump and complete the Controlled Substance Handoff intervention documentation in Meditech. Complete all fields in the Controlled Substance Handoff intervention on both pages.



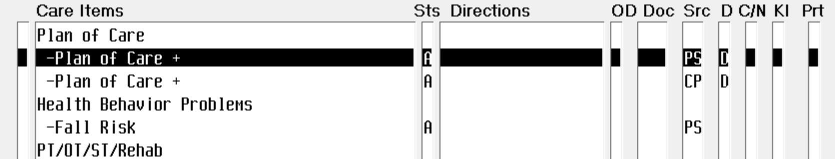


Remember to document the PCA Pump education within the Teach/Educate intervention.

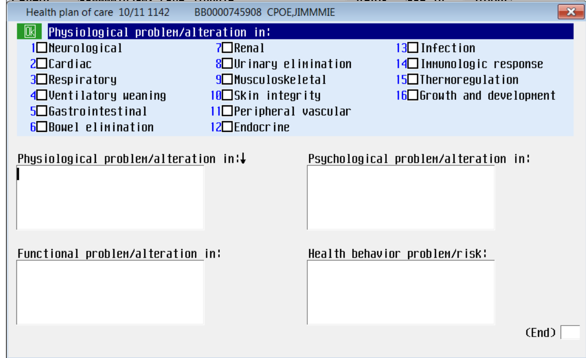


CARE PLANS

Care Plans should be updated every shift to reflect the patient's needs. Choose 3-4 problems or goals to work on each shift for your patient. Select your patient from the Status Board and click on Process Interventions. Highlight Plan of Care and click DN (Document Now) or DI (Document Intervention).

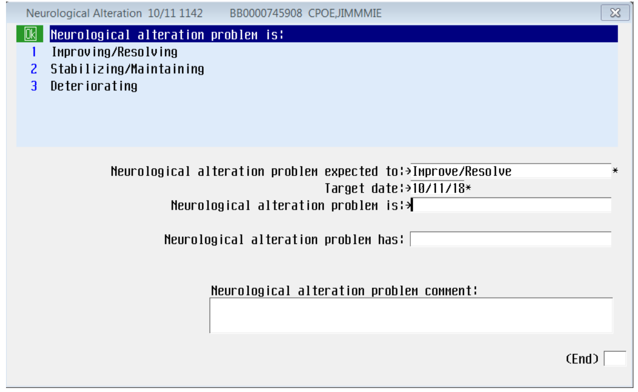


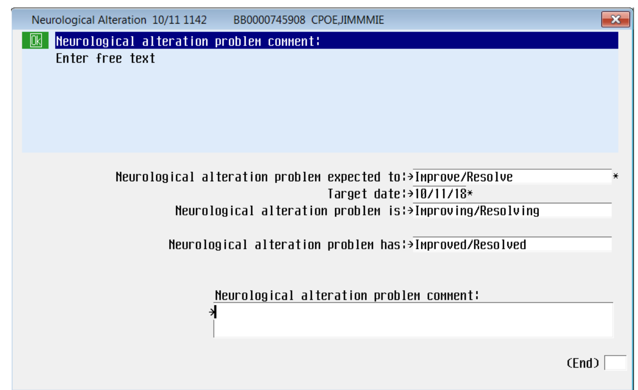
Choose the applicable category: Physiological, Psychological, Funtional, or Health behavior. Select the sub catagory. After choosing 3-4 problems, click End. If you are continueing a problem(s) entered by a previous nurse, then click End and update the information on the next screen.



If the problem is new for this patient you will need to complete the expected to field and the target date. If this problem is being continued, update the expected to field and the target date and you will document whether the problem is improving, stabalizing or deteriorating.

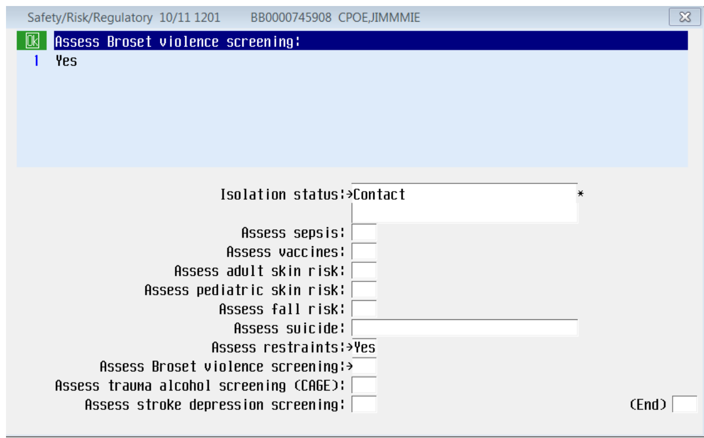
If the problem has resolved, tehn complete the problem has field as either Resolved, Stabalized, or deteriorated.



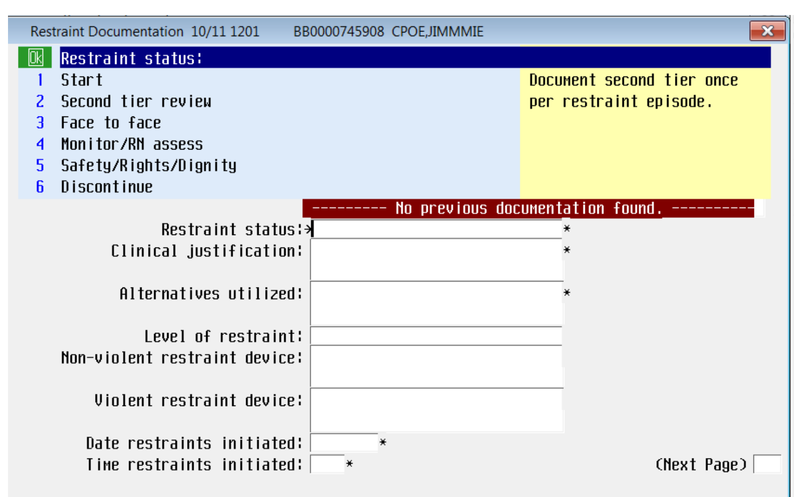


RESTRAINTS

Two nurses must verify that all alternative measures have been attempted and that the patient would be safer in restraints. Contact the physician and get a restraint order. The Restraint documentation is located within the Safety/Risk/Regulatory intervention. Select Yes next to Assess restraints and enter.



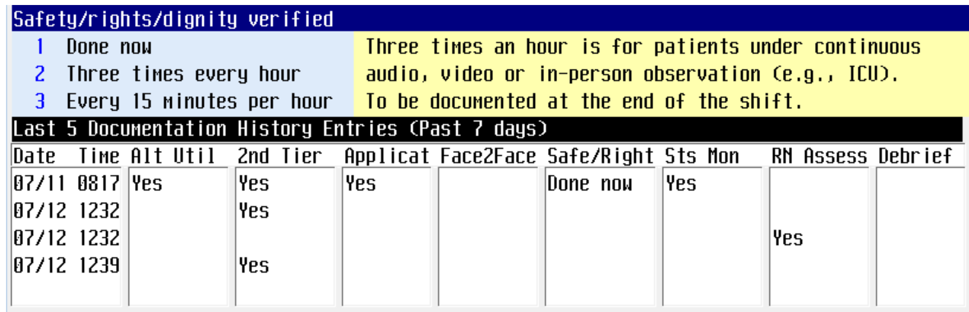
There are 4 pages. Complete all applicable fields.



<u>* Before the 'Application date & time of restraints' can be documented, the '2nd Tier Review' has to be documented by the nurse that verified the need for restraints. ***</u>**

<u>* All restraints are reported to CMS. The Application date & time and the discontinuation date & time MUST be documented ***</u>**

Safety/Rights/Dignity maintained verified is to be completed three times per hour if under continuous audio, video or in-person observation (e.g. ICU) or every 15 minutes if not being monitored via audio, video or in ICU. Per current policy (2017), Safety/Rights/ Dignity checks can be charted as one entry at the end of the shift or when restraints are discontinued.


Safety/rights/dignity verified

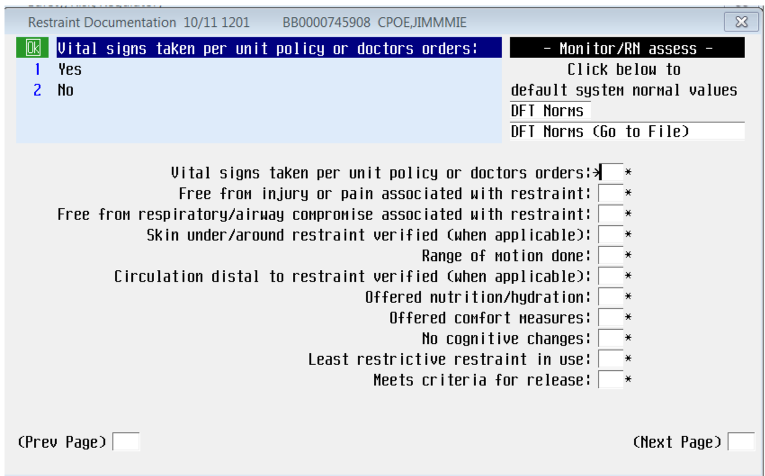
1 Done now
2 Three times every hour
3 Every 15 minutes per hour

Three times an hour is for patients under continuous audio, video or in-person observation (e.g., ICU). To be documented at the end of the shift.

Last 5 Documentation History Entries (Past 7 days)

Date Time	Alt Util	2nd Tier	Applicat	Face2Face	Safe/Right	Sts Mon	RN Assess	Debrief
07/11 0817	Yes	Yes	Yes		Done now	Yes		
07/12 1232		Yes						
07/12 1232							Yes	
07/12 1239		Yes						

Patients in restraints are required to be assessed by a Registered Nurse a minimum of every 2 hours. The nurse will use the 'Document restraints status monitor' to chart their restraint assessment including but not limited to:


Restraint Documentation 10/11 1201 BB0000745908 CPOE,JIMMMIE

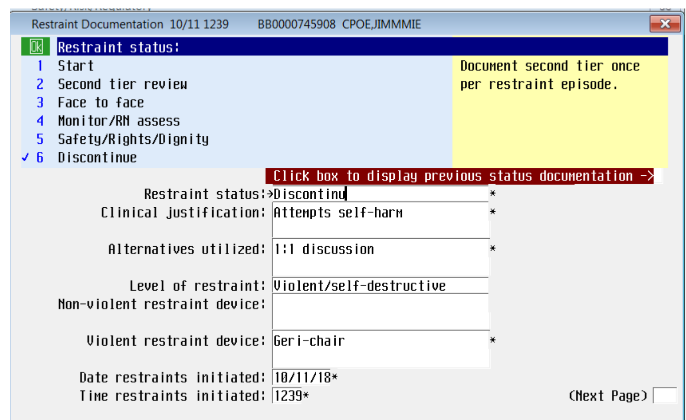
OK Vital signs taken per unit policy or doctors orders:
1 Yes
2 No

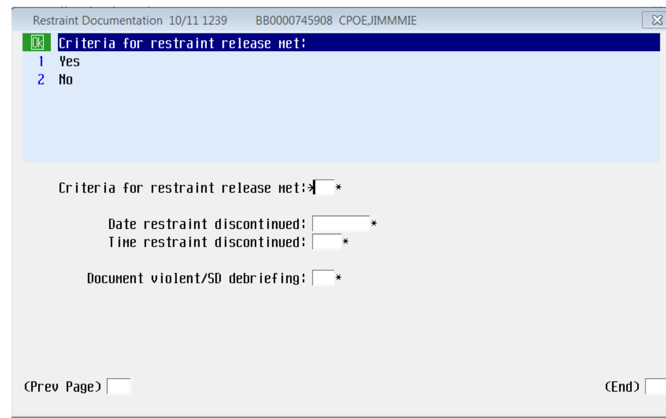
- Monitor/RN assess -
Click below to default system normal values
DFT Norms
DFT Norms (Go to File)

Vital signs taken per unit policy or doctors orders: *
Free from injury or pain associated with restraint: *
Free from respiratory/airway compromise associated with restraint: *
Skin under/around restraint verified (when applicable): *
Range of motion done: *
Circulation distal to restraint verified (when applicable): *
Offered nutrition/hydration: *
Offered comfort measures: *
No cognitive changes: *
Least restrictive restraint in use: *
Meets criteria for release: *

(Prev Page)
(Next Page)

Documant RN assess/discontinue is used when the restraints are being discontinued. Complete all fields especially the disconinuation date and time. .





Violent restraints require a 'Face-to-face' assessment be completed within one hour' by the physician.

Critical Values

When you receive a Critical Value from the lab, the Critical Value, whether or not the Physician was Notification and the outcome of the call must be documented in Meditech. In Process Interventions, highlight Manage/Refer/Contact/Notify intervention.

Manage Refer Contact Notify 10/11 1243 BB0000745908 CPOE,JIMMMIE
Chain of command contact name:
Action: Notified
Reason notified: Critical value
Entity attempted/notified:
Provider attempted/notified: CPOEBB1 CPOE ALLIANCE 1 (MD)
Sepsis notification:
PEDS concerning event:
Family member notified:
Chain of command contact name:

Manage Refer Contact Notify 10/11 1243 BB0000745908 CPOE,JIMMMIE
Value(s) read back and verified by provider:
1 Yes
2 No
Other notification comments:
Critical value(s) received from:
Value(s) read back and verified: Yes*
Critical value(s) called to provider: Yes*
Value(s) read back and verified by provider: Yes*
(Prev Page) (Next Page)

Manage Refer Contact Notify 10/11 1243 BB0000745908 CPOE,JIMMMIE
Critical value(s) comment:
Enter free text
Critical value(s) comment: document the values you reported to the physician
(Prev Page) (End)

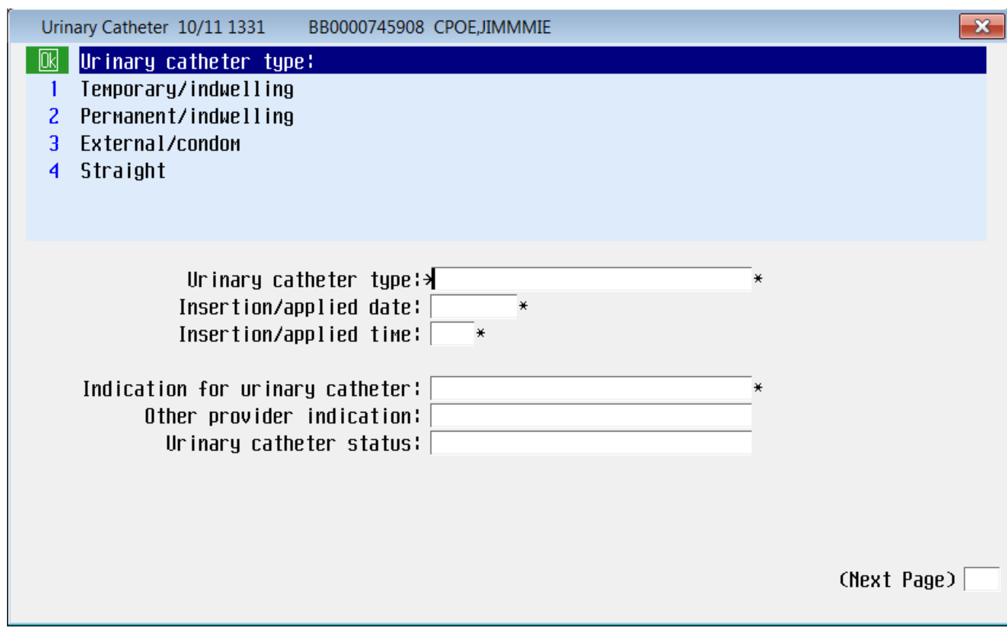
Foley

All catheter orders must be entered in Meditech. When a catheter is ordered, two additional orders will reflex or add to the Foley order. Foley and CAUTI: Prevention are prechecked but Do Not Remove Foley is not checked.

	Orders	Pri	Start/Service	Series	Directions	Qty	Details
☑	Foley ...		07/17 Now				Req
☑	CAUTI: Prevention Protocol ...		07/17 Now				Avail
☐	Do Not Remove Foley:Call Pr...		07/17 Now				

Click the REQ and complete the information.

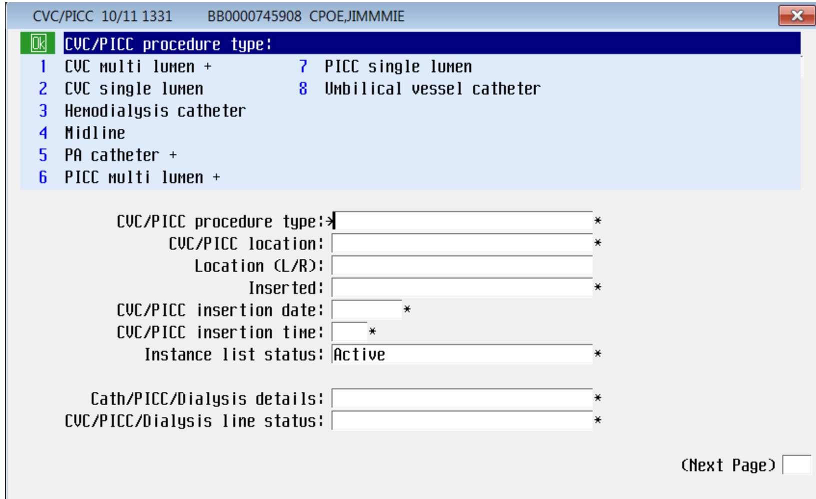
Catheters insertion, Daily Care and Removal must be charted in Meditech using the Lines/Drains/Airways Intervention. Select Drains, select the type of drain, and complete the fields.



Complete all information within the screen that applies to the process performed. When the insertion date and time are charted, Meditech will calculate the number of days the patient has had the catheter. Unless you have a DO NOT REMOVE order, an indwelling catheter should be removed per unit protocol and as soon as possible.

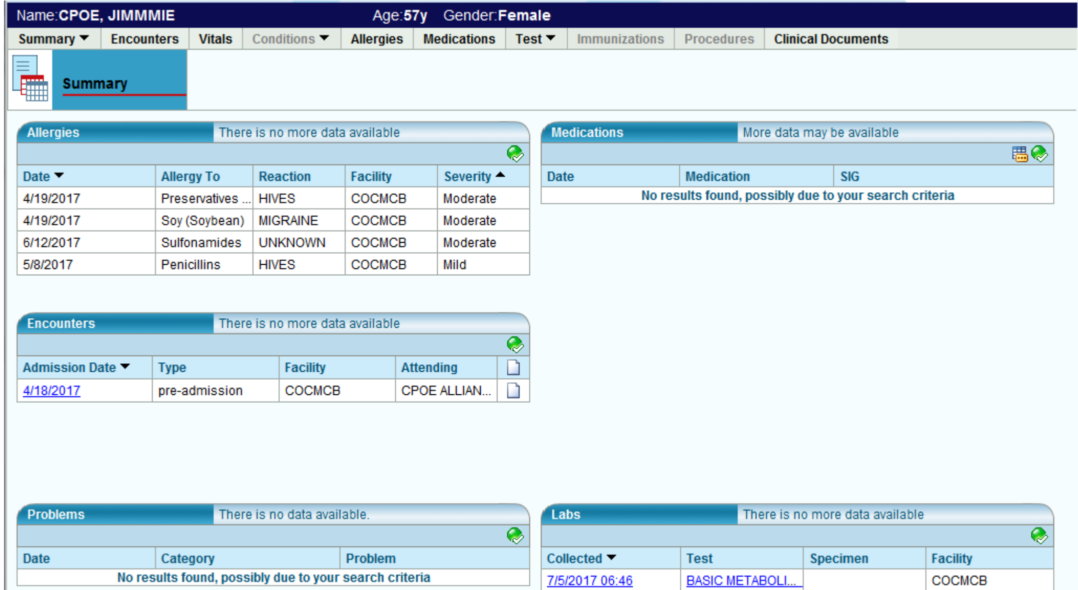
CVC

Documentation for a CVC line is completed using the Lines/Drains/Airway intervention. Select Lines and the choose the type of Line to document. Complete all fields.



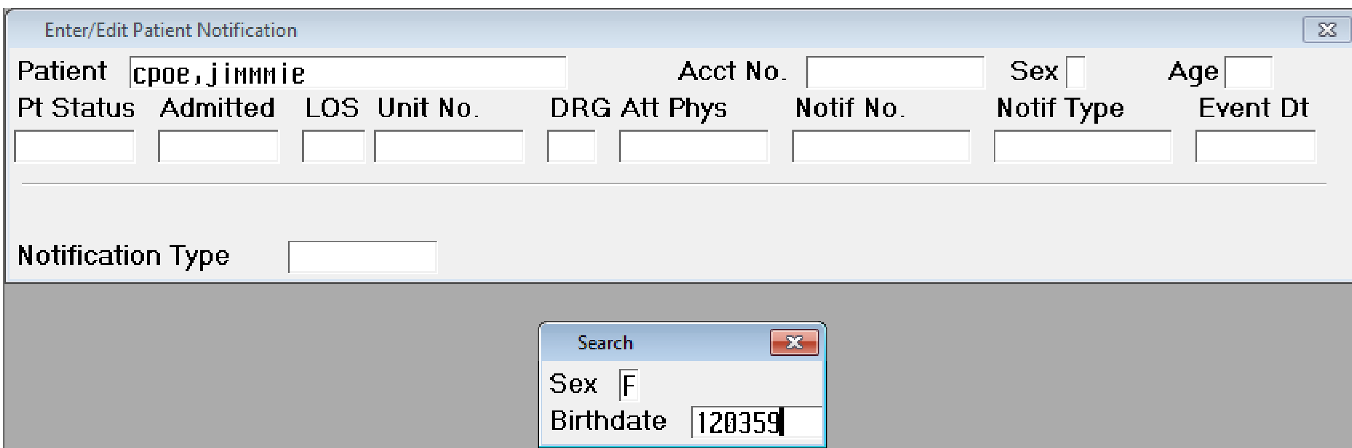
HIE

HIE or Health Information Management allows the user to access a patient’s medical records from all other HCA facilities. Select the patient from the Status Board and click the Magic Key icon and select Magic Key Meu. HIE Clinical Viewer is #18.

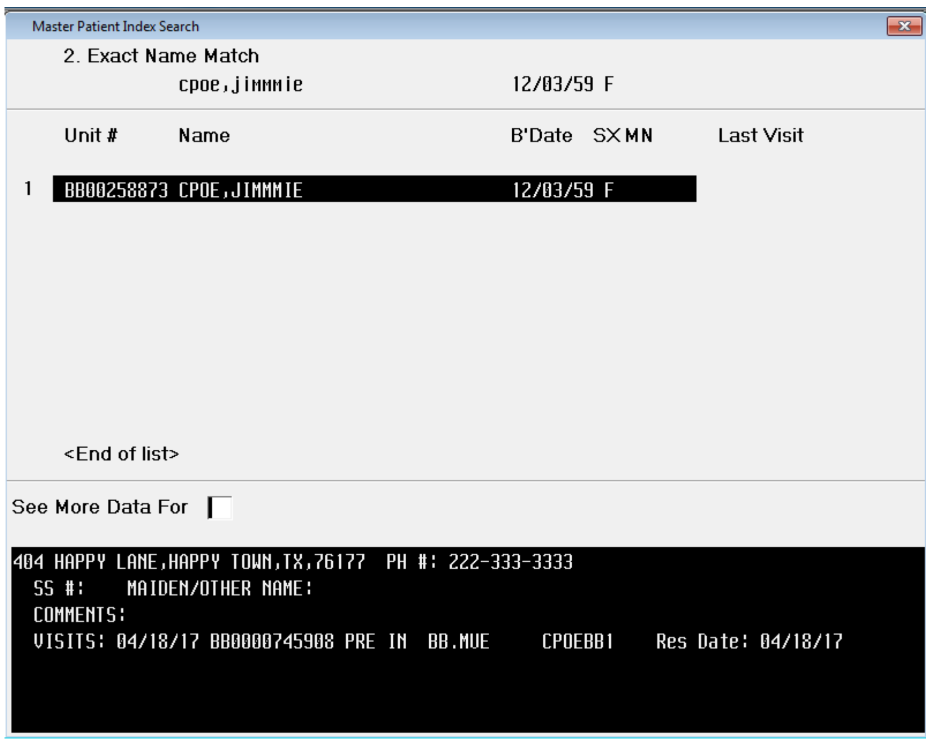


OCCURENCE REPORTS

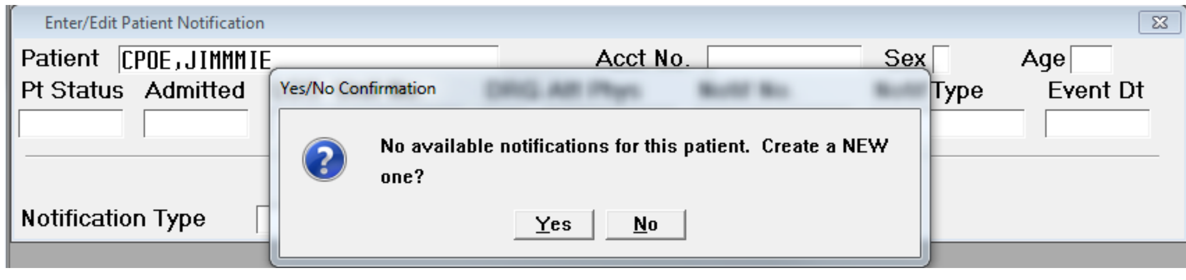
To enter an Occurrence Report, you will need to access the MOX Module instead of the Nursing Module. Occurrence Report is #60. There are 3 options: Employee Occurrence, Patient Occurrence Reports, and Non-Patient Occurrence Reports. Enter the number for the appropriate report and then sue 11. Enter/Edit. You will need the patient's name, gender, and DOB.

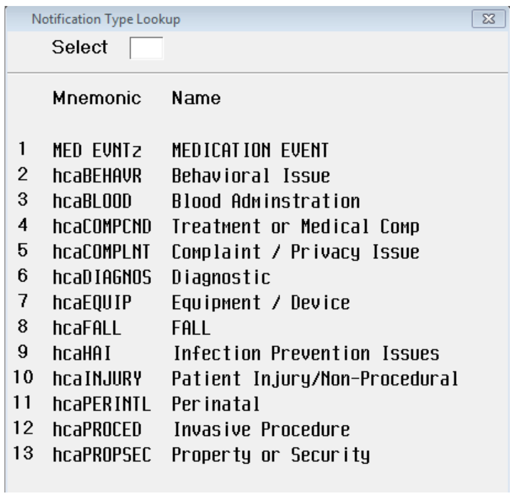


The Occurrence Report module uses right and left arrows in many places instead of using the Enter key. After verifying the patient's information, right arrow.



If you want to enter a new occurrence report, click Yes and select the Notification type from the list provided.



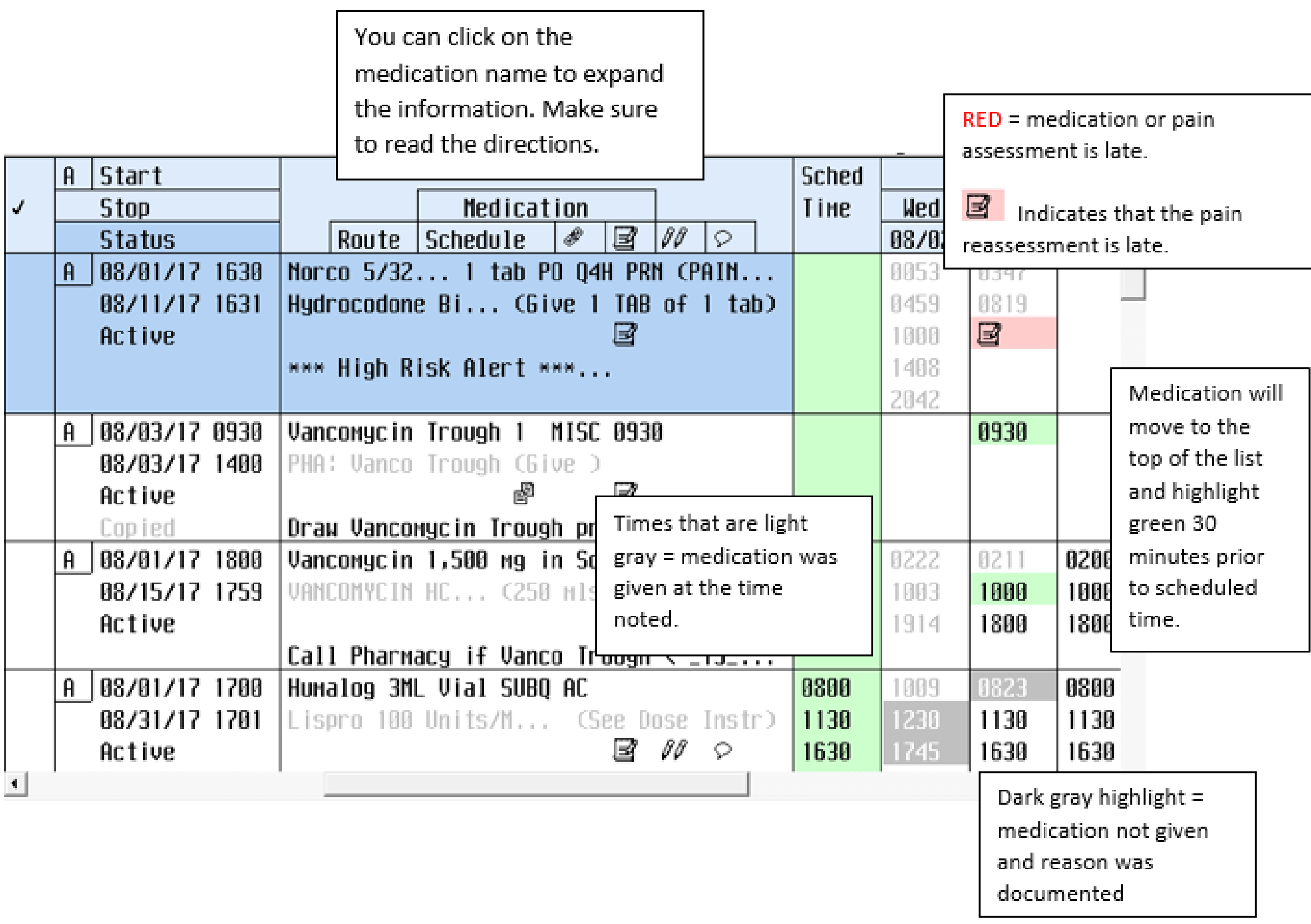


Complete the information on all screens, making sure you add your manager and director to the notification list at the end. Once complete F12 or File. Reminder: F9 is the Lookup key.

SCANNING MEDICATIONS

All medications should be scanned into Meditech prior to administering. The medication should be scanned and given at the patient's bedside. . Once the pharmacy has verified the medication order, the medication will be listed on the patient's EMAR.

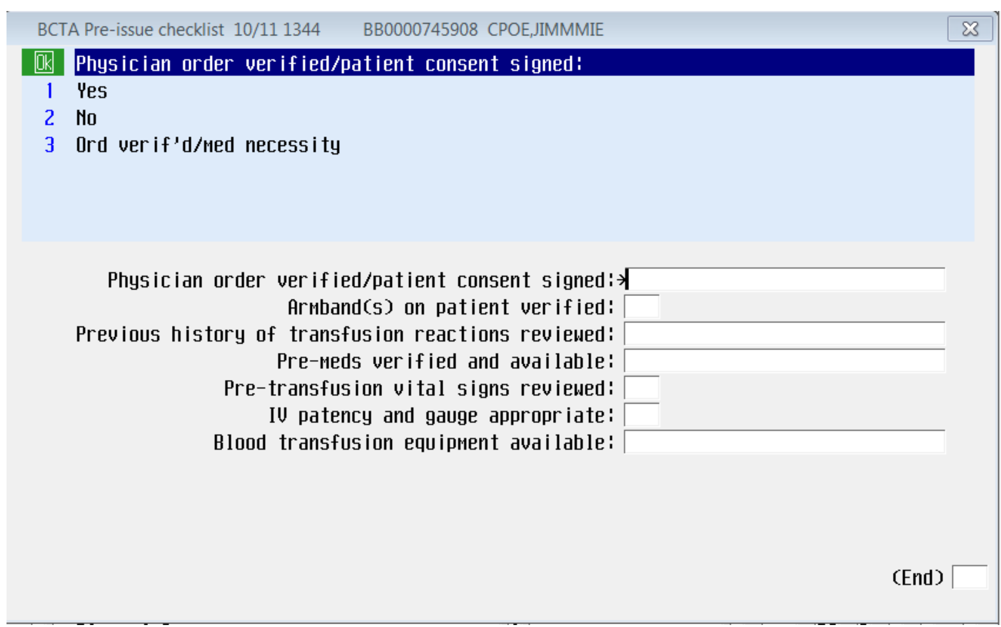
After logging into Meditech and selecting your patient from the Status Board, click the eMAR button. The patient's medication profile will display.



Always verify the 5 Medication Rights – right medication, right patient, right time, right route, & right dose. At the patient's bedside, scan the patient's armband and then scan the barcode on the medication package prior to giving the medication. Once you have verified the 5 rights and the computer has confirmed the information, you can educate the patient about the medication and correctly administer the medication to the patient.

Blood Administration

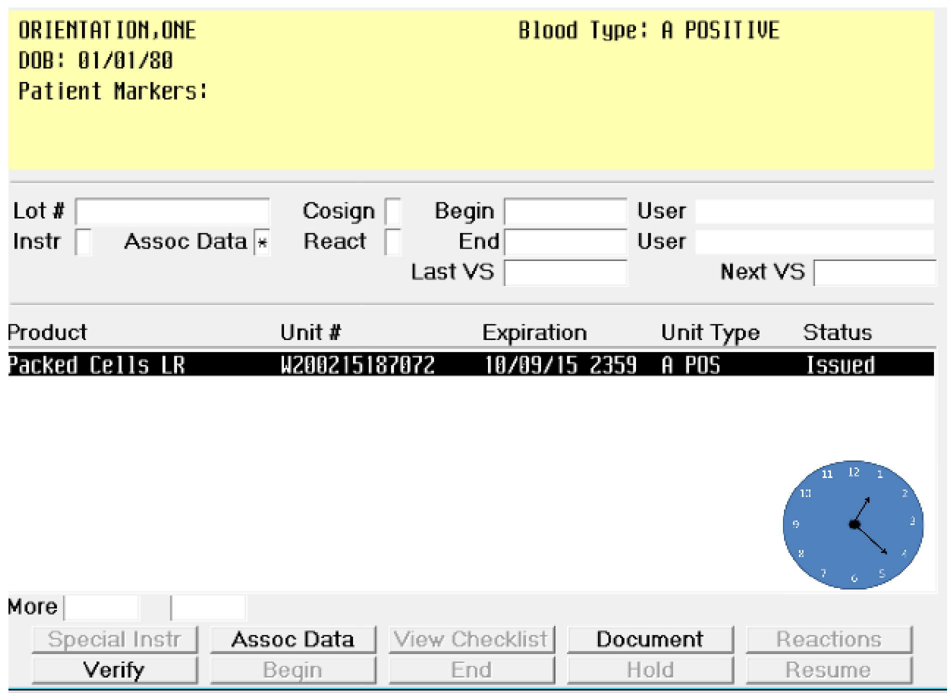
Verify that you have an order for blood products and there is a medical reason for the patient to receive blood. BCTA or Barcoded Transfusion Administration is our method of documentation for blood transfusions. The Blood Transfusion must be started within 30 minutes of getting it from the Blood Bank so you should have all supplies ready to start the transfusion before getting the blood. Before going to the Blood Bank to pick up the blood, complete the BCTA Pre-Issue Checklist. The checklist will be under Process Intervention.



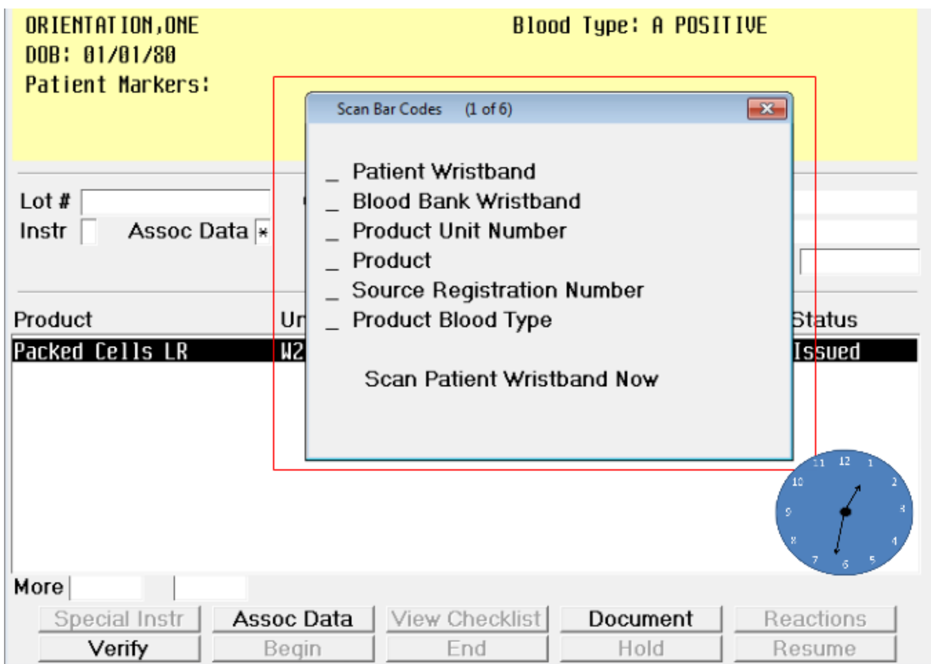
A 'Ready" indicator will appear on the Status Board when blood is ready to be dispensed. After completing the BCTA Pre-Issue Checklist, take a patient label to the Blood Bank to pick up the blood. The Blood Bank will have you verify the patient information before dispensing blood.

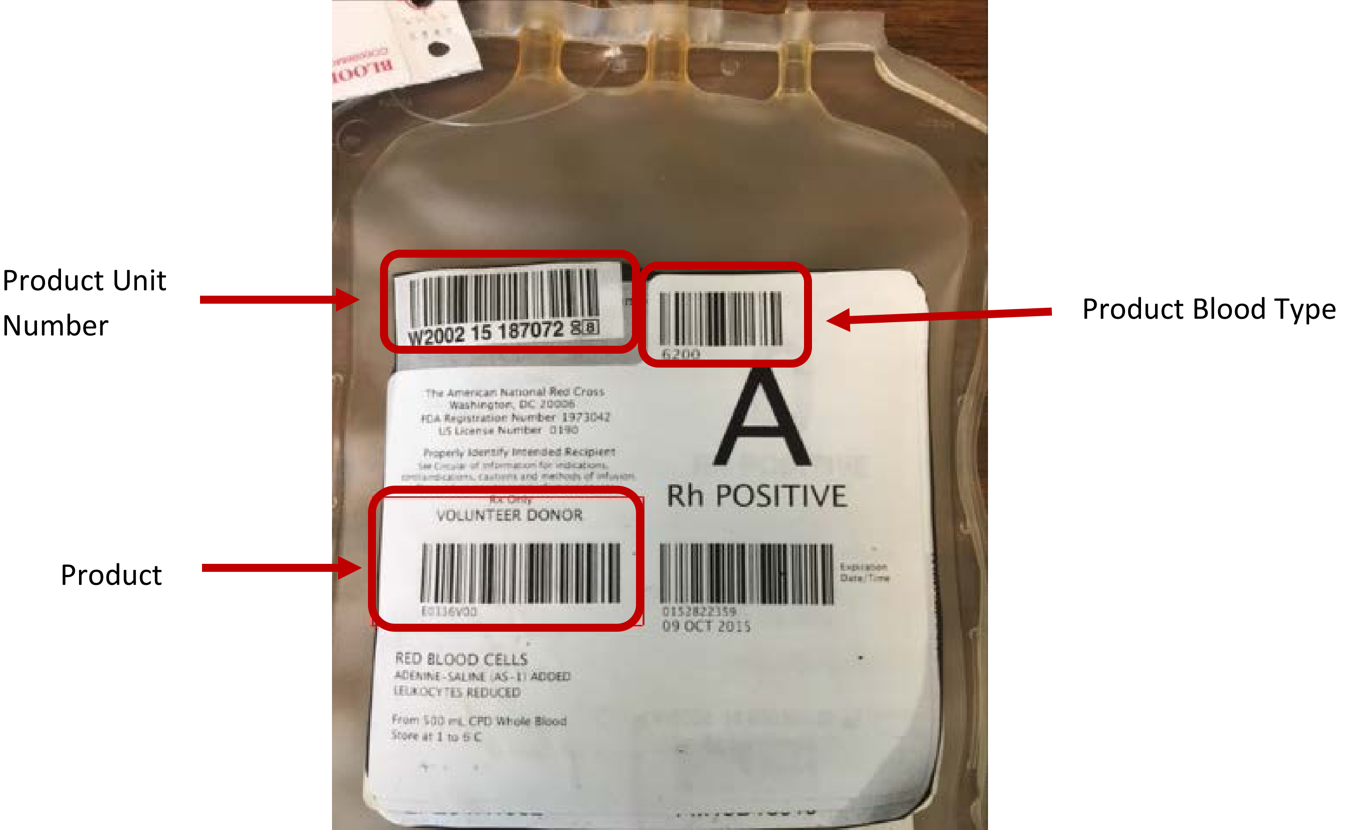
***DO NOT REMOVE THE UNIT HANG TAG. IT MUST REMAIN ON THE BLOOD UNTIL THE TRANSFUSION IS COMPLETED ***

Once the blood has been issued, the transfusion must start within 30 minutes. Once at the bedside, two nurses must verify the blood, complete and sign the hangtag. The Transfusion button will be used for documentation pertaining to the transfusion. Once the blood has been verified by 2 nurses, click the Transfusions button on the the Status Board. A new screen will appear and if the patient had prior transfusions that information will appear. Please note the 30 clock that started at the time of the blood was issued.

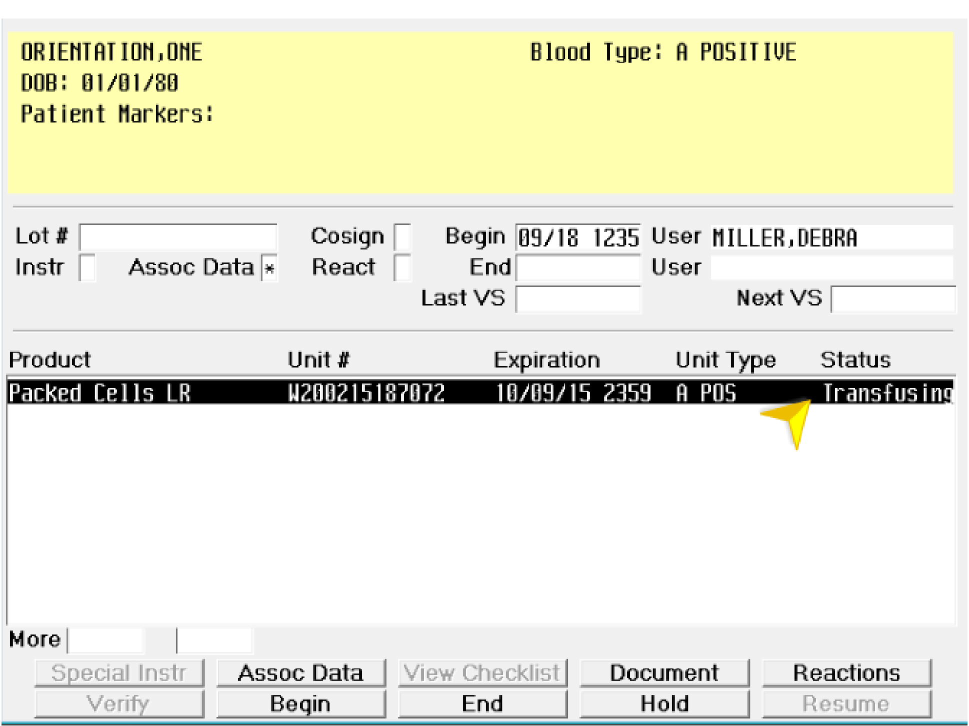


Document vital signs prior to the transfusion. Click the Document button at the bottom of the screen. Click the Verify button to record the verification of the blood. To verify, scan each item in order and a check mark will appear next to the item.





Once the blood is verified, the transfusion can begin. Use the Begin button to document the start date and time that the transfusion is started. Note that the status of the blood has changed from Issued to Transfusing.



Once the transfusion has begun, other documentation key are active at the bottom of the screen. Make sure to “End” the transfusion when it is complete. Remove the hangtag from the blood bag. Complete the hangtag, place the top copy in the patient’s chart and return the bottom copy to the Blood Bank.

Thank you