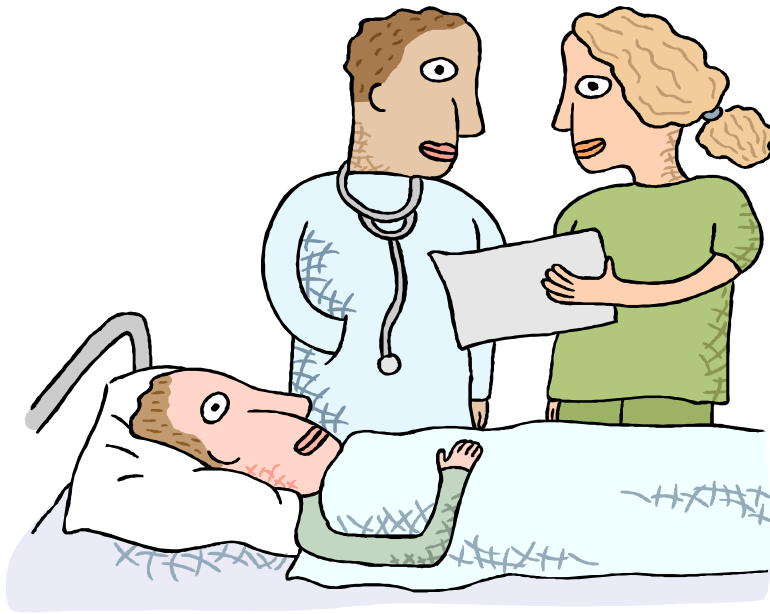


CERNER POWERCHART
NURSING DOCUMENTATION
TRAINING MANUAL



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1. About Documentation Management

Learning Objectives

Upon completion of this training program, participants will be able to

- Understand the PowerChart Organizer Displaying Tabs for Patient List, PAL, Shift Assignment, and Icons to Find Patient, Launch a Web Application, Clinical Calculator, Ad Hoc Charting, Patient Management Conversations, Add Patient, Add/View Sticky Notes, Help
- Use the PAL (Patient Access List) to locate patient Demographics, Allergies, Notification of Results for Labs and Radiology Reports, Tasks, Intake and Output, and Sticky Notes
- Understand the Patient Chart for Demographics, Banner Bar, Visit List, PPR Summary, Allergies, Problem List, Immunizations, Lab Results, Radiology Results, Task List, Clinical Notes, Orders, Medication Profile, Form Browser, Intake and Output, Precautions, Clinical Flowsheets, and Vital Signs
- Use Ad Hoc Charting to Complete and Sign or Save Forms
- Enter Allergies and modify
- Enter Medications by history and modify
- Understand the Task List for In Process and Pending Validation Forms
- View tasks for incomplete forms in the Task Lists
- Understand Clinical Notes to complete a focus note or 24 hour progress note
- Find and modify or unchart forms using the Form Browser
- Understand Intake and Output direct charting flowsheet functionality
- Use Shift Assignment to create a patient assignment and/or view an individual assignment

Course Organization

This class is organized into three main sections: Introduction and Overview of Document Management, Nursing Documentation application training, and Competency Testing

Course Length

The class for nursing is designed for four hours.

Prerequisites

All participants are expected to be competent in the following areas:

Computer Basics and Microsoft Windows Using this Reference Guide

This reference guide was designed to help new users learn how to use the system and other tools to support the process. The information in this guide was designed to supplement a hands-on session.

There are pictures of various screens to familiarize you with information placement. These are only a small sample of the screens you will use. As you move through the manual you may see information repeated more than once. This is intended to assist you in selecting the proper program for the task you are doing without difficulty.

Information Security and Confidentiality

When dealing with computerized health care records, specific confidentiality and security issues must be followed to protect the patient. Also, there are increasing HIPAA and JCAHO regulations that dictate how these records are handled.

- When selecting a password, do not choose anything obvious, such as your birth date, social security number, or spouse and children's names.
- Do not tell anyone your password.
- Your system will require you to change your password at regular intervals.
- When you open a chart you will be asked to identify your relationship to the patient, for example primary RN, consulting physician, and so on.
- The system keeps an audit trail, or record, of who enters each chart and when. It records who reads the chart and who recorded each piece of information in the chart.
- Not every employee will be allowed to see or perform every activity on the computer. For example, a lab technician will be able to see and do more in the lab application than a nurse will.
- Do not leave the computer while still signed on.
- Do not access any charts that do not apply to your current job and caseload. This would be considered a HIPPA violation.
- Each facility has its own specific confidentiality and information security policy. It describes the repercussions of not following these rules.

Terms to Know

The following terms will be used frequently in this manual and in the class sessions.

Click – To tap on a mouse button, pressing it down and then immediately releasing it. The phrase to click on means to select (a screen object) by moving the mouse pointer to the object's position and clicking the left mouse button.

COW – Computer On Wheels

Cursor – The flashing marker that tells you where you are on the screen

Default – Preset information in the system that automatically appears

Double click – Clicking a mouse button twice in rapid succession. The second click must immediately follow the first; otherwise the program will interpret them as two separate clicks rather than one double-click.

Dithered – Icon or menu item that is gray in color, which indicates that it is not available for use or select.

Encounter – A single patient visit or episode of care. The following are examples of encounters:

Patient registered as an inpatient

Patient registered as an outpatient

Left click – To click the left mouse button. When instructions call for a screen object to be “clicked” a left-click is inferred.

Maximize – Located on the menu bar or title bar of the active window. It is used to maximize the window so that it takes up the entire desktop.

Menu – Displays a list of commands. Some of the commands have images next to them so you can quickly associate the command with the image. Menus are located on the menu bar at the top of the PowerChart Office window.

Minimize – Located on the menu bar or title bar of the active window. It is used to minimize the window so that it appears only on the Windows taskbar.

Mouse – A device used to move the cursor around on the screen

Navigator – A panel on the left side of a window that contains categories for which you want subcategories displayed. For example, selecting Assessment in the Navigator causes many types of assessments (admission, discharge, Braden, pediatric, and so on) to be displayed on the right side of the window. You then can select the assessment you want.

PC – A personal computer that is also referred to as a “Desktop”.

Right click – To click the right mouse button. A right-click opens a drop-down menu with a list of options.

Scrollbar – Located on the right and bottom of some screens and is used to adjust the view on screen.

Shortcut Menu – Available when you right-click text, objects, or other items.

Title bar – Located at the top of the each window and is used to identify that window.

Toolbar – A toolbar can contain buttons with images (the same images you see next to corresponding menu commands), menus, or a combination of both.

Documentation Management Basics

Documentation Management is used to record patient information in the chart. For example, vital signs, physical assessment results, and notations indicating that orders were carried out, are all entered into the chart through Documentation Management. Documentation Management has several sections and each is a part of the *PowerChart* solution.








In review, the *PowerChart* solution is the basis of the electronic medical record. Documentation Management is a part of the *PowerChart* solution and is used to enter information about patient status. Orders is also a specific part of the *PowerChart* solution and is used to read and write orders. The Orders functionality will be implemented at a later date.


















Advantages of Using Documentation Management









The *Cerner*® Documentation Management application provides clinical staff with the ability to record patient information with increased ease and organization. For example:

- You will not ever run out of forms as you might with paper copies.
- Forms are automatically attached to the patient's chart and do not get lost.
- The forms contain certain fields that only light up when a previous choice indicates that they apply.
- The only items showing on the Task List are the In Process forms and Pending Validation.
- The tasks are automatically connected to the correct forms, thus saving the time normally required in searching for a form.

Toolbar Icons

Icon	Action
	Find Patient Icon – Opens the encounter search dialog box to enable you to select a patient
	Launch Web Application – Provides a link to Radiology Image “Kodak” web browser and any defaulted web browser sites
	Clinical Calculator – Contains clinical equations
	Ad Hoc Charting - Opens a window with folders to chose a form to complete
	Patient Management Conversations – allows the transfer and/or discharge of patient—including change of service, attending and location
	Add Patient – Allows you to add patients to your lists
	Remove a Patient – Allows you to remove a patient from a list

	Sticky Note – Similar to a post-it note, a means of passing helpful information to other caregivers, can be discarded after it is no longer useful, and is not entered into the patient record (All language is to be professional)
	Help Selection on the Menu Bar – Opens PowerChart help topics
	(PAL) No Allergy Icon – Indicates no allergies listed
	(PAL) NKA Allergy Icon - Indicates No Known Allergies
	(PAL) Allergy Icon _ Indicates listed allergies
	(PAL) New Result Icon – Indicates new Lab and Radiology results are available
	(PAL) Critical New Result Icon – Indicates a result is critical
	(PAL) In Process Forms Icon - Indicates incomplete forms
	(PAL) Pending Verification/ Co-signature Icon - Indicates a form needs a co-signature
	(Form) Required Incomplete Icon – Indicates required documentation is incomplete
	(Form) Complete Icon – Indicates required documentation is complete
	(Form) In Error Icon – Indicates that a form has been uncharted and views as in error
	(Form) Defaulted Answer Icon – Indicates last charted value or default response based on sex/ age
	(Form) Binoculars Icon - Allow you to search for all care providers
	Save Form – Saves your entries and returns you to the previous window. A saved form does not view until signed
	Sign Form - Attaches the nurse's electronic signature to the form and entering document into the permanent medical record. All information on signed forms is viewed in flowsheets, clinical notes and form browse
	(Form) Clear Icon - Clears information from a form allowing you to start over

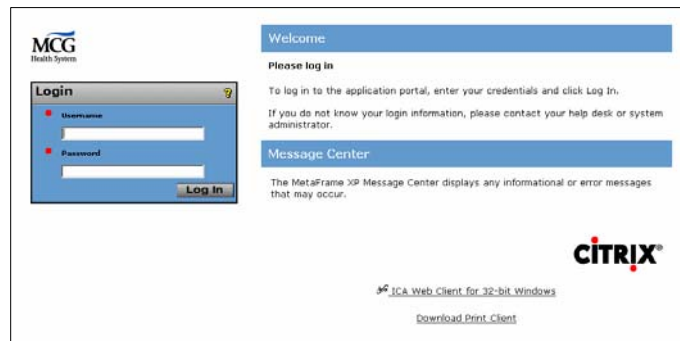
	(Form/ I/O) Cancel Charting - Used to undither time scale clock in I/O tab and cancels the charting session without saving any entered information
	(Shift Assignment) Add Care Providers –Used to pick providers in a shift assignment
	Quick Chart - Future functionality – Not to be used at this time
	(Task List) Unchart – Changes the status of all results associated with a form to “In Error”
	I/O time Scale Clock allows changes to time interval in I/O
	(I/O) Display Hidden Category Icon - Allows you to select hidden categories in I/O
	Power Vision Icon - Allows access to reports
	Chart Details - allows user to modify or add information on a previously signed form

2. Accessing Cerner PowerChart

There are 2 logon steps to PowerChart. The first logon is to **Citrix**. Citrix allows the user to access the application in a secure network. The second logon is to Cerner Millennium **PowerChart**.

To Access Citrix:

1. **Citrix icon on the desktop** – double left click on the Citrix icon or Citrix Portal icon
2. Enter your Citrix user name and password. (Passwords should be at least 6 characters)
3. Click on the Log In button to open the Cerner PowerChart access window



To access PowerChart:

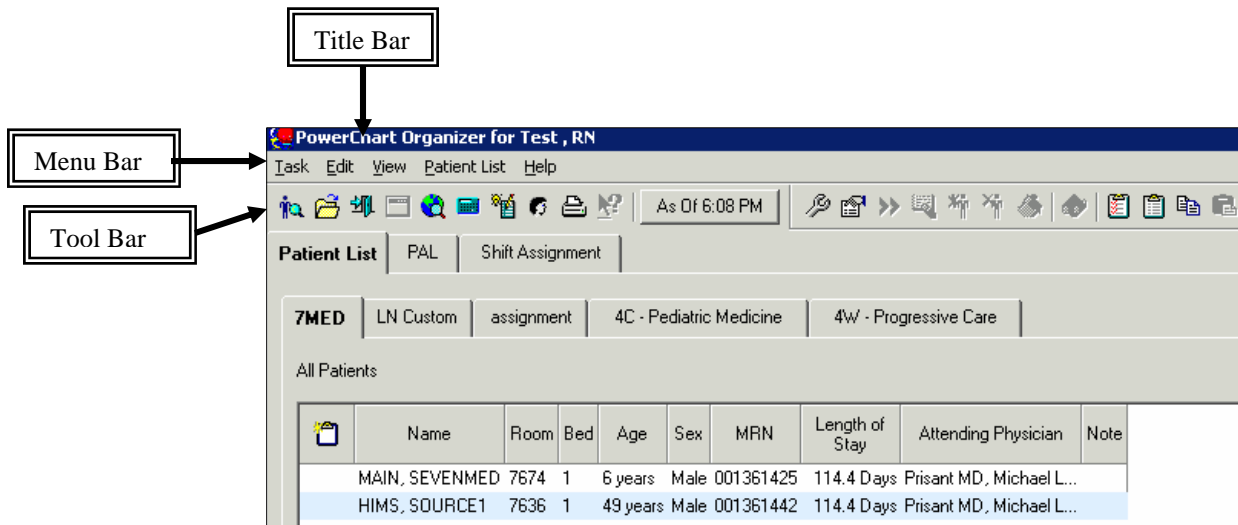
1. Enter your user name on the Cerner Millennium window
2. Enter your password. It must be at least 6 characters and can be the same as Citrix.
3. Click on the OK button. PowerChart will open to your default Organizer view based on your role/position (RN, LPN, Respiratory Therapist, etc.)



3. PowerChart Organizer

The Organizer is the first window that opens when you access PowerChart.

It is arranged with a Title bar to display your name, the Menu bar displays a list of commands, and the Tool bar contains buttons (icons) with images, menus, or a combination of both to perform a function.



Patient List Tab –

Defaults to assigned location for the computer. You may also create customized lists.

PAL Tab –

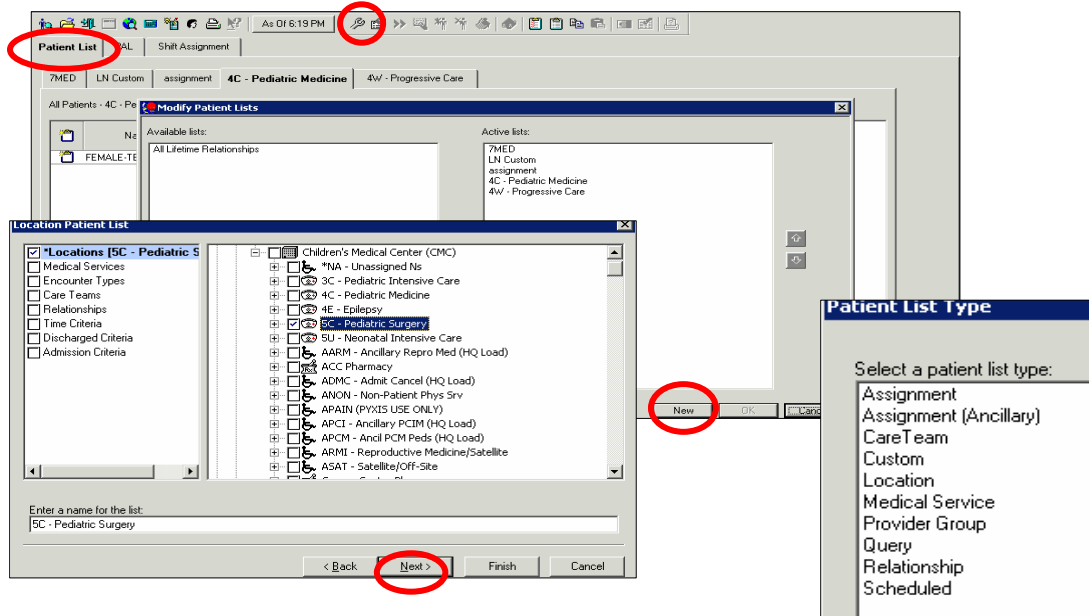
Displays a patient list based on assignment.

Shift Assignment Tab –

Allows authorized individuals to make an assignment and displays the assignment for all other care providers.

Adding a Patient List

There may be times when it is necessary to add patient lists that are not available in the Available Patient List window.



1. Click Patient List tab
2. Click List Maintenance icon on the tool bar
3. Click “New” button at the bottom of the Location Patient List window
4. Select desired Patient List Type

Note: You must have an Assignment list and then you can create additional lists if desired. You can only make one list at a time.

5. Click Next
6. Type in name for list in Enter a name for the list bar
7. Complete requested information in right box
8. Click Finish

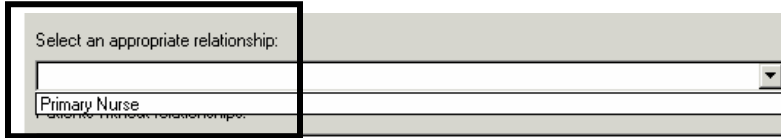
Note: Selecting the Patient List Type of Assignment will pull in any predetermined shift and appropriate assignments created for that provider via the Activity Assignment tool. (See Shift Assignment).

9. List will now view in Available list
10. Click on list
11. Click on right arrow to move to active list
12. Click OK and list will display under Patient list
13. To change the list follow above steps to either create a new list or activate an available list

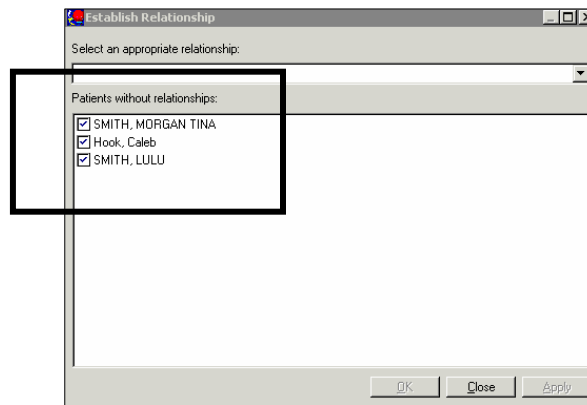
Establishing a Relationship

The first time you use the PAL and as new patients are added, the “Establish Relationship” window is displayed if there are patients assigned to you with whom you do not have a relationship defined. To use the PAL, you must have a relationship established with all the patients you wish to see on your list.

When prompted to establish a relationship with a patient, complete the following steps:
In the “Select an Appropriate Relationship” box, select a relationship type from the list.



In the “Patients Without Relationships” box, names of patients assigned to you with whom you have not established a relationship are displayed. A check box is displayed to the left of each name. A check mark in the box means the patient name is selected. The system defaults to selecting all the patient names on the list. You may deselect a patient name by clicking the check box. Clicking an empty check box selects the patient name. You may select or deselect more than one patient before clicking OK.



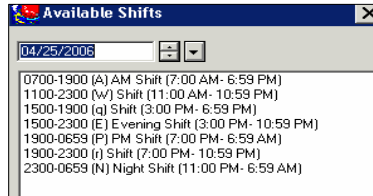
Click OK. The PAL is displayed.

Selecting/Changing the Shift in the PAL

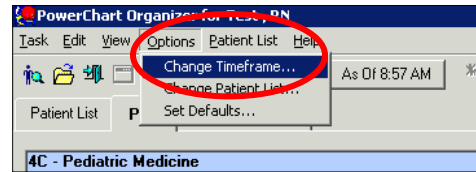
When opening the PAL, you will need to select a predefined time frame. Information for shifts in progress, or shifts that have not yet begun, can be displayed in the PAL.

The Timeframe Selection window will automatically display the first time you click the PAL tab.

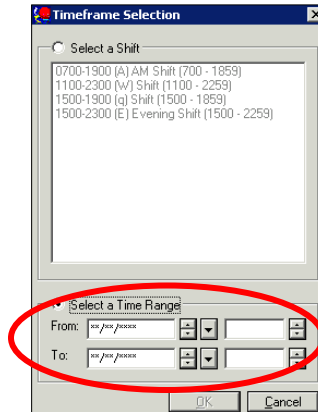
1. Choose the timeframe that is appropriate for your work day by selecting the appropriate one.



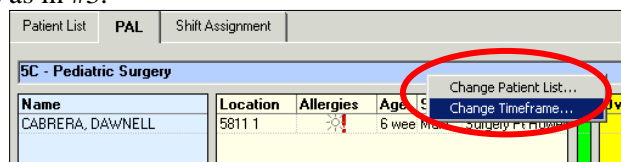
2. Timeframes can be updated by clicking “Options” from the menu bar and select “Change Timeframe”.



3. Click in the radio button, “Select a Tree Range” to change the timeframe at the bottom of the Timeframe Selection window.



4. When selecting a date from the calendar in this view, the first set of arrows determine the year. The second set of arrows determine the month.
5. Another method to change a timeframe is to right-click anywhere in the Information bar, choose “Change Timeframe”..., and follow the same instructions as in #3.



Note: To default a shift, select Set Defaults from the Options menu, and select the appropriate time frame. Shift times are displayed based on the current time.

4. Understanding PAL Sections

Six sections are displayed, each containing a specific category of patient information. Information within each section is displayed in cells, which can be matched easily with the correct patient name.

Sections are identified by the information they contain. Individual columns within these sections are labeled and display notification icons or textual information when appropriate. Each column within a section displays a different type of information such as room location or lab results.

The location of each section and the types of information they contain are determined by your system administrator. The information available to you reflects specific clinical needs defined by your position.

Icons and text are displayed in PAL sections to indicate the presence of patient information. To access this data you can double-click or right-click to display context menus for charting options.

Scroll bars at the bottom of each section and at the right of the window allow you to navigate each section for specific patient information.

Column titles can be sorted by clicking on the column heading for alphabetical or numeric ordering.

Patient List PAL Shift Assignment														
LN Custom											April 24, 2006 12:00 PM - April 24, 2006			
Name	Location	Allergies	Age	Sex	Service	Attending	Lab	Rad	Notes	Overc	PRN	Current	4/24/2006	Wt
CHILDMALE, THREEYEAR			3 years	Male	Surgery	Dr Wang MD								
CHILDMALE, TWOYEAR			2 years	Male	Inpt Intern	Wang MD								
ALLEN, SUE A			68 year	Female	Sports Mec	Valentine I								
TEST, APACHE1	3577 1		41 year	Male	Inpt Intern	Prisant MD							600 / 350	
RADNETCHILD, INPATIENT	4707 1		8 years	Female	Inpt Radiol	Prather MD								
TEST, PEG10			53 year	Female	Epilepsy A	Murro MD								
TEST, CHILD			9 month	Female	Anesthetic	Martin MD								
TEST, MOM			51 year	Female	Dermatolog	Leshner MD								
HESTER, BETTY J			44 year	Female	Unassigne	Leshner MD								
FLOWCAST, DAD			106 year	Male	Dermatolog	Leshner MD								

Names Section

The Names section contains the list of patients whose information can be accessed from the Patient Access List (PAL).

Viewing the Assigned Caregiver


To view the assigned caregiver for a patient, complete the following steps:


1. In the names section, right-click a patient's name.
2. Select Assigned Caregivers.
3. A dialog box showing the caregivers for that patient is displayed.
4. Select Close to return to the PAL.

Opening a Patient Chart from the PAL

To open a patient chart, do one of the following:

1. In the names section, double-click the patient's name. The patient's chart is displayed, defaulted to the patient information tab.
2. Right-click specific information in any section or column.
 - From the menu, select Open Chart
 - Click the tab you want to access.

To return to the PAL window, close the patient's chart by clicking . This button only closes the patient's chart.




Another way to get back to the PAL window click the *PowerChart* Organizer icon  on the taskbar at the top of your screen; however, this option merely switches you from the chart to the organizer and leaves the patient's chart open until you manually close it.

Demographic Section

Demographic information such as location, allergies, age, sex, service and attending physician are displayed as text in the demographic section. To display a patient's demographic information in more detail than is displayed in PAL (predefined or by adding a column), open the patient's chart.

Allergies



Allergy information displays in the demographics section. The icons represented in the allergy section indicate:

- Allergies recorded 
- No Known Allergies (NKA) entered 
- No allergies recorded 

Double-clicking on the icon accesses the Allergy entry window.

Notifications Section

The following icons can be displayed in the notification section:

- New Laboratory and Radiology Results icon 
- Sticky Note icon -  Sticky notes are part of the chart until removed and should be used to communicate vital patient information only and are not automatically deleted (Please use professional language only)

To review notifications details, do the following:

- Double-click the desired icon to display the dialog box containing detailed information for the patient you have selected.

To return to the PAL, close the Results dialog box.

Tasks Section

This section is a patient task list that uses icons as the visual indication that tasks are due. There are multiple columns within this section referencing different types of task identification:

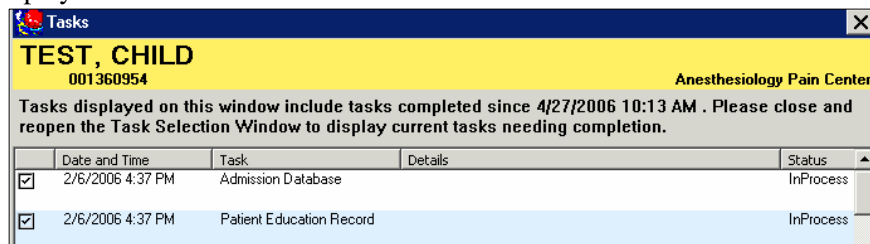
- Overdue Tasks—Future functionality
- PRN/Continuous---Future functionality
- Current Task – In process (incomplete) and pending verification forms (needing co-signature)

Tasks are accessed in the PAL by selecting a “task group” icon. Below are the icons you might encounter:




Charting Tasks

To access tasks for charting, double-click the task group icon in the appropriate column. The Tasks window is displayed.

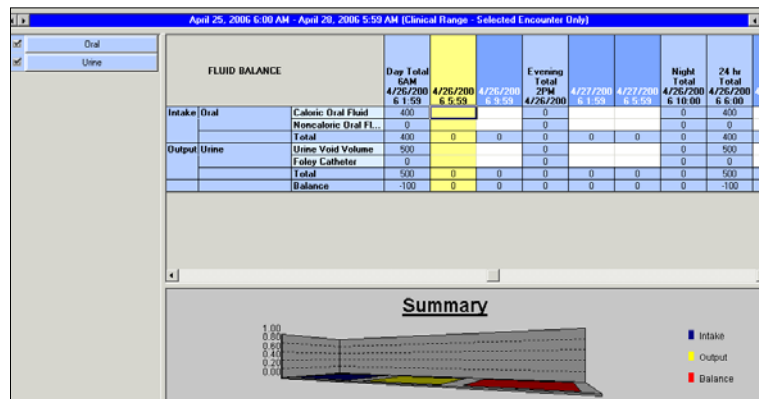


1. All check boxes next to the Date and Time Column will come prechecked. If you do not want to document on all tasks, click on all check boxes of the tasks you do not want to document. If the user does not have authority to chart the task, the check box will be unavailable.
2. Select Chart (Quick Chart is future functionality). The form will open for completion.

If the task is built for detail charting, the associate form is displayed. When the form is signed after completion or co-signature, the task will clear from the Task window. To return to the PAL window, close the patient’s chart by clicking .

Intake and Output

Labeled with current date, displays intake over output in a blood pressure format



Results Section

This section provides a view of the *last* documented result that has been entered on the patient. Weight is the only defaulted result. These data points are predefined by the system administrator or you may right-click and add a column synonymous with the result you want to view.

Critical results are displayed in red text.

To review the result details: Right-click the text displayed in the results section menu and select View Details to view the Results Details window.

Click Close to return to PAL.

Moving the mouse over a result displays the date and time of the result.

The screenshot shows a software interface for Patient Assessment Lists (PAL). At the top, there are tabs for 'Patient List', 'PAL', and 'Shift Assignment'. Below this is an 'Information Bar' displaying 'LN Custom' and a date range 'April 24, 2006 12:00 PM - April 24, 2006'. The main area is a table with columns: Name, Location, Allergies, Age, Sex, Service, Attending, Lab, Rad, Not, Overc, PRN, Current, 4/24/2006, and Wt. The 'Wt' column contains the value '600 / 350'. A callout box points to this value with the text: 'Weight is the only default displayed in Results section.' Other callouts identify sections: 'Name Section' (points to the Name column), 'Demographic Section' (points to Age, Sex, Service), 'Task Section' (points to the 'Overc' column which has red heart icons), 'Intake and Output Section' (points to the '4/24/2006' column), and 'Notification Section' (points to the 'Not' column).

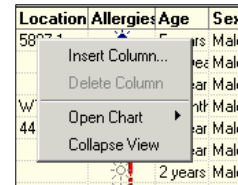
Name	Locatic	Allergies	Age	Sex	Service	Attending	Lab	Rad	Not	Overc	PRN	Current	4/24/2006	Wt
CHILDMALE, THREEYEAR			3 years	Male	Surgery	Dr Wang MD								
CHILDMALE, TWOYEAR			2 years	Male	Inpt Intern	Wang MD								
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RADNETCHILD, INPATIENT	4707	1	8 years	Female	Inpt Radiol	Prather MD								
TEST, PEG10			53 year	Female	Epilepsy	Av Murro MD								
TEST, CHILD			9 month	Female	Anesthetic	Martin MD								
TEST, MOM			51 year	Female	Dermatolog	Leshner MD								
HESTER, BETTY J			44 year	Female	Urologist	Leshner MD								

Working with PAL Sections and Columns

Each column in a PAL section has a heading, which is either a descriptive name, an abbreviation for the information displayed, or a date for the Intake and Output column. Column headings are defined when the PAL is created by the system administrator.

To sort within columns, complete the following steps:

1. Click a column heading to sort the column. The names of patients who have information available in that column, along with their data in all PAL sections, will rise to the top in descending order (Z-A) for that column.
2. To display the information in ascending order (A-Z), click the column heading again. All blank columns are displayed before those with information in them because an empty value is before 'A' in ascending order.



Adding a Column to the PAL Section

You have the ability to add your own columns to the PAL. This provides a more detailed view of the patients' information. Right clicking in the column opens a window to select, "Insert Column" or to "Delete Column". The preset columns cannot be removed.

Only three sections currently allow for additional columns:
Demographic Section, Notification Section, and the Results Section.

(1) Demographic Section

1. To add a column, right-click anywhere within the section and select Insert Column
2. Choose demographic field option (no other options are available)
3. Select "Next"
4. Choose column type you would like to add to this section by clicking it
5. Select "Next"
6. Choose "None"
7. Select "Next"
8. Add a title to the column title field and you may change column width if desired.
9. Select "Next"
10. Review data
11. Select "Finish"

(2) Notification Section

1. To add a column, right-click anywhere within the section and select Insert
2. Choose column type
3. Select "Next"
4. Double click "All OCF Event Sets folder"
5. Double click on folders to locate the result type that you wish to be notified
6. Highlight your choice
7. Select "Next"
8. Add a title to the column title field and you may change column width if desired.
12. Select "Next"
13. Review data
14. Select "Finish"

(3) Results Section

1. To add a column, right-click anywhere within the section and select Insert
2. Choose column type
3. Select "Next"
4. Double click "All OCF Event Sets folder"
5. Double click on folders to locate the result that you wish to automatically view. Drill down to the specific result (there cannot be a + sign in front of the folder that you choose)
6. Highlight your choice)
7. Select "Next"
8. Select the time to look back for results

9. Select “Next”
9. Add a title to the column title field and you may change column width if desired.
10. Select “Next”
11. Review data
12. Select “Finish”

Collapsing or Expanding a Section

You can reduce or increase the width of any section to provide more viewing space for information in the other sections and otherwise modify the layout of PAL to best serve your needs.

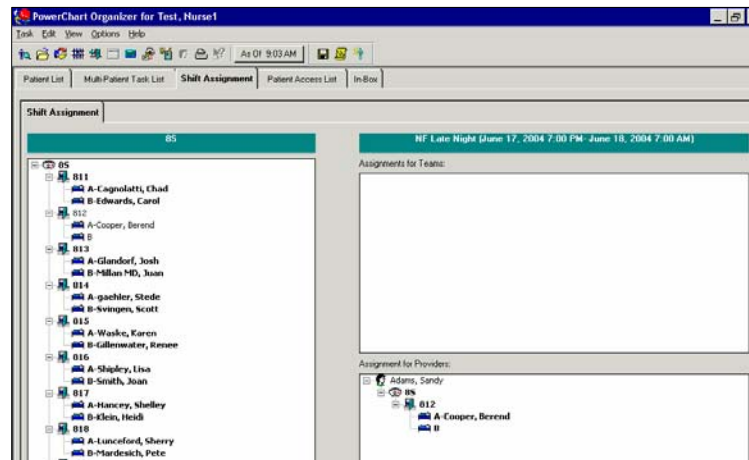
To collapse or expand a section, do one of the following:

1. Right-click anywhere in the section you wish to collapse or expand.
 - Select Collapse View to make the section narrower or
 - Select Expand View to return it to its original size
2. Columns within sections also can be resized with the cursor over the divider line in the header between columns and dragging one side or the other to the desired position.
3. You may also place your cursor over the gray divider, between the sections, wait to receive the pointer and drag the column open or closed as desired.

All changes made to the PAL will remain until removed by the user.

5. Shift Assignment

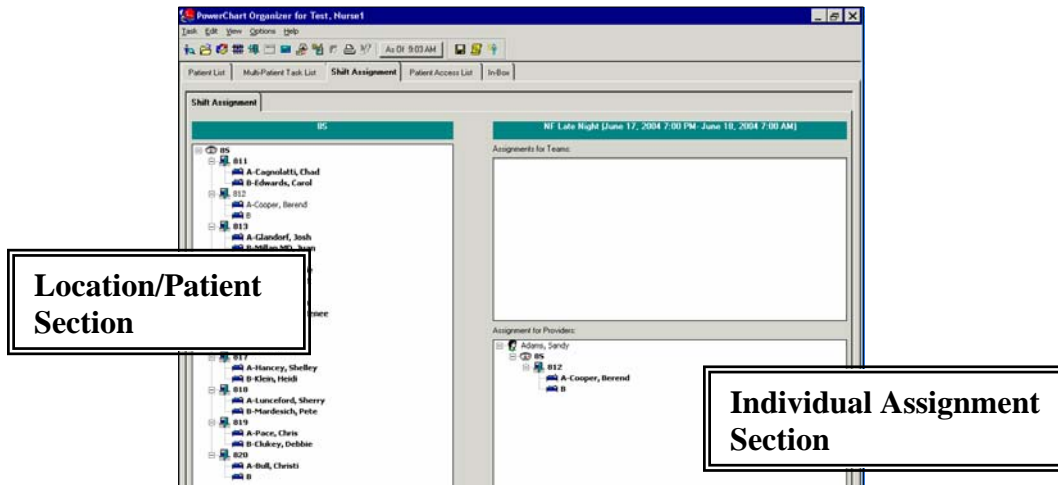
Shift Assignment enables authorized users to assign care providers as an individual assignment. This assignment is the basis of the assignment patient list appearing in the PAL. Shift Assignment is accessed through a tab displayed at the Organizer level within the *PowerChart®* solution.



Assignment options:

- Location/Shift-based assignments current or future
- Assignment viewable from the PAL

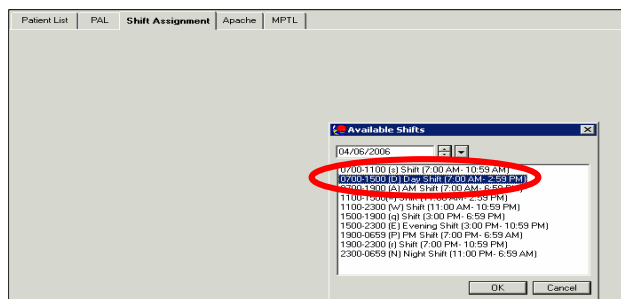
The Shift Assignment window should be similar in appearance to the example below, consisting of the Location/Patient, and Individual Assignment Sections.



Setting Shift Timeframes

Shift Assignments and their corresponding dates are displayed in the Shift Assignment Tab on your Organizer. Verify this date and time are correct before making assignments. This currently defaults to the previous day. The Available Shifts window is displayed with all available time frames.

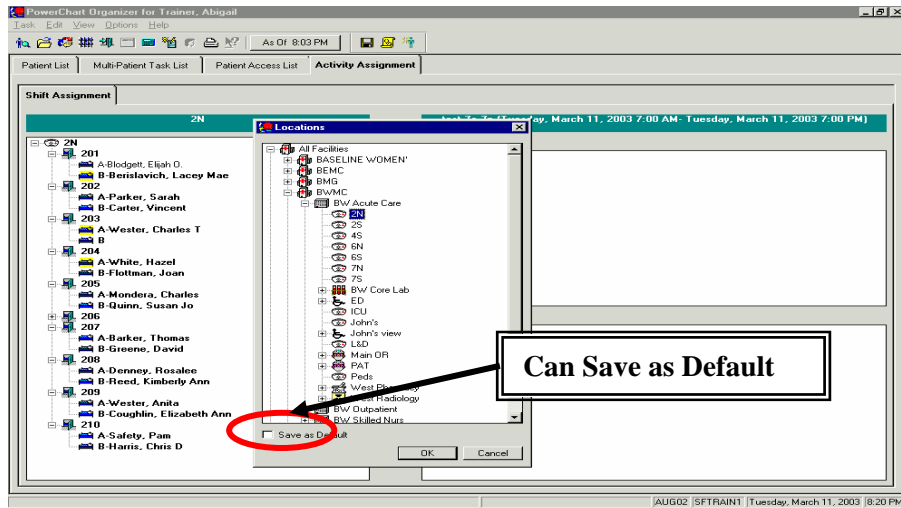
1. Highlight the shift and change the date, if appropriate for this assignment.
2. Click “OK” when finished. The appropriate date and time appears above the Assignments for Teams window.



Assigning a Location

Upon opening the Shift Assignment tab for the first time, a “Locations” window is displayed, requesting a specific unit, room or bed to be chosen, to populate the patient list.

Note: Making a location selection as specific as possible will limit the amount of patients in the Location/Patient window and make it easier to complete assignments. Locations chosen in the dialog box can be defaulted so the user does not have to choose them each time they log into the Shift Assignment.



1. Click the Shift Assignment tab. The location window appears so you can choose a location for the assignments. Click the plus (+) sign beside “All Facilities”.
2. Click the plus (+) next to the facility name. Continue to expand the (+)’s until you find the desired location.
3. If this location is the one you primarily work with, check the box next to “Save as Default” in the left lower corner of the window.
4. Click **OK**. All beds contained in the location are displayed in the Location/Patient window. The current location is displayed in the green bar above the window.

Changing Location

Location assignments can be changed at any time while in the “Shift Assignment” tab. The change can be made two ways.


1. Right-click anywhere in either blue banner on the Shift Assignment tab and ‘Select Location’. The Locations window is displayed at the ‘All Facilities’ level.
2. In the Shift Assignment tab, Select ‘options’ from the menu and choose ‘Select Location’. The Locations window appears at the ‘All Facilities’ level.

When the ‘Locations’ window is displayed, drill down into the facility to find your location. Choose either the plus sign for CMC or MCG Adult. This will take you to the next level. Again, choose CMC or MCG Adult. Click the appropriate location and save as default if desired. Then click OK and the location with a current patient list will display in the Location/Patient section.

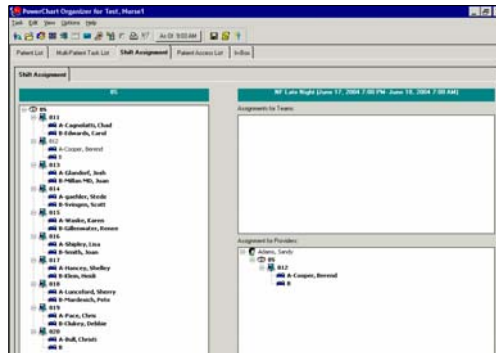
Creating Assignments

Adding Care Providers


Providers must be assigned to the shift before patients can be assigned.

1. On the Shift Assignment tab, click the yellow scroll icon  at the top of the Organizer window or right-click in the blue information bar. The “Add Care Providers” window is displayed showing the list of providers assigned to the location for the designated shift.
2. If providers are present from previous shifts, but should not be for this shift, remove them by dragging the names out of the box and returning them to the personnel group box.
3. Add care providers by entering a portion or the entire name of the provider in the window of “Add Person”, beginning with the last name (Last, First). If an appropriate match is found, the name will default, or you may need to click the “Binocular icons” for assistance. Select the individual from the list and click “OK”
4. The individual’s name appears in the box below “Personnel Group”. Drag and drop the name into the “Individuals” box.
5. Delete the name in the “Add Persons” field. Repeat steps 3, 4, and 5 until all care providers have been added to the “Individuals” list. Click “OK” to return to the Activity Assignment tab.
6. Providers may also be selected from the “Personnel Group” box by selecting the drop down window and then selecting the appropriate unit and/or shift.
7. The providers will appear in the Personnel Group window.
8. All individual’s names in the selected personnel group appear in the box below “Personnel Group”. Drag and drop the name into the “Individuals” box.
9. Click “OK” to return to the Shift Assignment tab.
10. The care provider list appears on the “Assignment for Provider” list.
11. Each patient to be assigned must be assigned to a provider. From the Location/Patient section, drag the bed number, room number, or any patient that should be assigned to a provider. Drag the location on **top** of the provider’s name. (The provider’s name is highlighted in blue when your cursor is directly over the name). Once complete, the location is displayed under the provider’s name.

12. Patients may be assigned to more than one individual. For example a patient assigned to a RN can also be assigned to a PCT.



Note: In the example above, empty beds are also assigned. If a patient is admitted to that bed, the new patient appears on the Provider's Patient Access List.

Once patients have been assigned to their appropriate providers, click the save icon  to **Save The Assignment.** .

Modifying Patient Assignments

You can remove a previously assigned patient:

1. Choose the inappropriate selection in the Individual Assignment window and drag that assignment into the Location/Patient window and drop in the window in any location.
 2. A "Delete Location" dialog box appears. Click "Yes" to delete the assignment.
- OR-
1. Right-click the assignment and select Delete.
 2. Click the Save icon to save the modification.

Modifying Patient Assignments during the Shift

The techniques for adding and deleting patients and providers apply at all times.

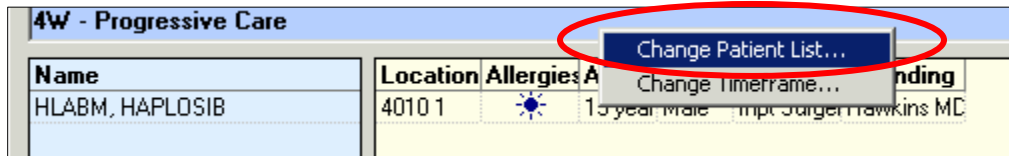
Just remember to click SAVE between each of the following actions:

- Removing a patient from a provider
- Adding a provider
- Adding patients to a provider

Assignment Review from PAL

The clinician's assignment is accessed via the Patient Access List (PAL).

When accessing the PAL, you will need to make sure your view is set to the patient list type of Assignment. If it is not, right-click the information bar and select Change Patient List.



General Shift Assignment Notes

- When making assignments for the next shift or the following day, the previous assignments are displayed for that unit by that position. Assignments are displayed for 48 hours after they are created. The care providers for a previous shift must be removed **BEFORE** making assignments.
- Patients not assigned to a care provider are listed in bold.
- Click the plus (+) sign under each care provider's name to view the assigned patients.
- Assigned patients remain on the nurse's Patient Access List for two hours after the patient's discharge. The patient will **NOT** appear on the Patient List by location. After two hours, the clinician is still able to open the patient's chart by using the search function.
- When a patient is transferred within a nursing unit or from unit to unit, the patient's name is displayed in the new location. The patient's name remains in the old location **ONLY** on the assignment list for two hours. If the nurse is using the PAL list by location, the patient transferred to another unit will not appear on that PAL.

6. Patient Chart Level

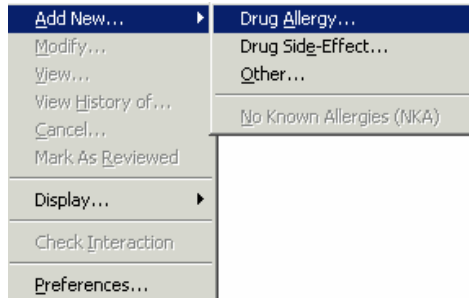
The screenshot shows a web-based patient chart interface. At the top, a blue banner bar contains the text "Banner Bar" in a white box. Below the banner bar, a yellow bar displays patient information: "FEMALE-TEST, DAYS9", "MRN:001361084", "Acct:0085004876013", "Sex:Female", and "** No Known Allergies ** Preadmit". Below the yellow bar, a navigation menu includes tabs for "Clinical Flowsheets", "Vital Signs", "Patient Information", "All Results", "Lab Results", "Radiology Results", "Task List", "Clinical Notes", "Orders", "Medication Profile", "Form Browser", "Intake and Output", and "Precautions". The "Patient Information" tab is selected, showing a sub-menu with "Patient Demographics", "Visit List", "PPR Summary", "Allergies", "Problem List", and "Immunizations". The "Patient Demographics" sub-tab is active, displaying a form with the following fields: Name (FEMALE-TEST, DAYS9), Birth Date (01/29/06), Age (2 months), Race (White), Religion (Baptist), and Risk Code. To the right, an "Addresses" table shows a home address: 123 MAIN STREET, GIBSON, GA 30810.

- **Banner Bar**
 1. Patient demographics
 2. Location (can access visit list displaying encounters – left click on Location)
 3. Patient name (can access patient demographics – left click on pt name)
 4. Allergies (can be reviewed and updated – left click on Allergies)
- **Patient Information tabs**
 1. Patient demographics
 2. Visit list
 3. PPR summary
 4. Allergies (can be reviewed and updated from this tab)
 5. Problem list
 6. Immunizations (can enter immunizations from this tab)
- Lab result tab (Unchanged from current view/ displays all lab results)
- Radiology result tab (Unchanged from current view/ displays all radiology results)
- Task list (See below for detailed information)
- Clinical Notes tab (See below for detailed information)
- Orders tab (Future functionality)
- Medication Profile tab (See below for detailed information)
- Form Browser tab (See below for detailed information)
- Intake and Output tab (See below for detailed information)
- Precautions tab (See below for detailed information)
- Clinical Flowsheets tab (See below for detailed information)
- Vital Signs tab (See below for detailed information)

7. Allergies

Allergy window can be accessed through the PAL, Allergy icons, Banner Bar, Allergy tab and Forms.

Do not change display or click Reverse Allergy Check or click Mark All Shown as Reviewed or click Mark Selected as Reviewed



Adding an Allergy

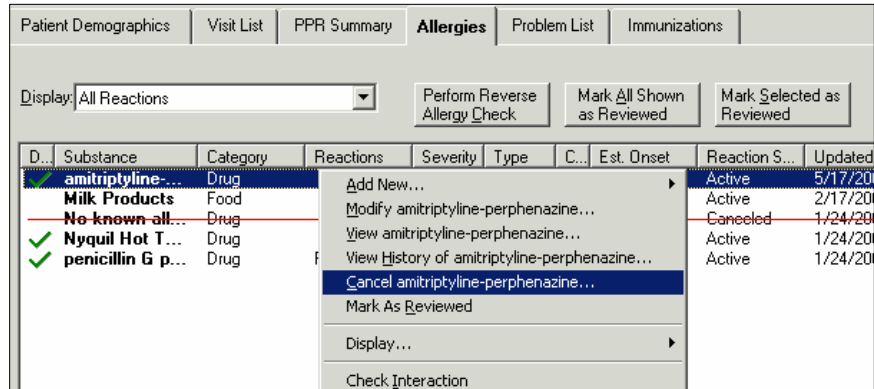
1. Select Add new or No Known Allergies and left-click
2. Select Drug Allergy
3. If other than drug allergy select the category from right side (Food, Environment or Other)
4. Type drug name or other allergy in Search box
5. Click search
6. Double click the appropriate drug or other allergy (Moves allergy to right Substance required)
7. Select Severity drop down menu and click on appropriate choice
8. Click in Reaction symptoms if known (Can refer to enclosed list for codified reaction symptoms)
9. Type in reaction in search box to left
10. Click search
11. Double click the appropriate symptom (Moves symptom to the reaction symptom box with a gold key in front of symptom)
12. Click OK
13. If selecting NKA Allergy box is prefilled, select OK

A screenshot of a software window titled 'TEST, NOK - Add Allergy/Adverse Effect'. The window is divided into several sections. On the left, there is a search area with a search box containing 'zan' and a search button. Below the search box are radio buttons for 'Name', 'Code', 'Substance', and 'Reaction'. There is also a section for 'Vocabularies/principal types' with a dropdown menu. The main area on the right is titled 'Substance' and contains several sections: 1. Substance (required) with a dropdown for 'NKA' and a text box containing 'Zantac 300'. 2. Reaction type with a dropdown for 'Allergy'. 3. Reaction symptoms with a text box and an 'Add Free Text' button. 4. Allergy details with a 'Status' dropdown set to 'Active', a 'Mark As Reviewed' button, a 'Reason' dropdown, a 'Reviewed' date field set to '5/17/2006', a 'Severity' dropdown set to 'Severe', and a 'Recorded on behalf of' field. 5. Comments with an 'Add Comment' button and radio buttons for 'Chronological' and 'Reverse chronological'.

Modify or Cancel an Allergy

1. Click on the allergy to be modified or cancelled
2. Right click and choose modify or cancel
3. If modifying, change information to be modified may choose “add comment” to add a reason for modification and click OK

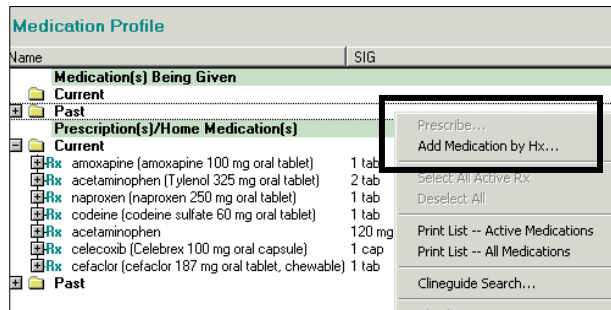
If canceling, may choose “add comment” to add a reason for canceling and click OK. The cancelled allergy substance displays a red line through it.



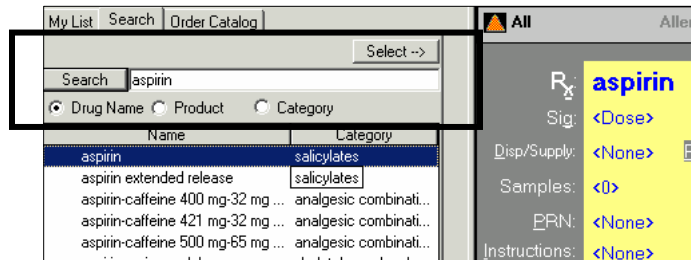
8. Medications

Adding a Medication by History

1. Right click in the blank part of the window
2. Click “Add Medication by Hx”

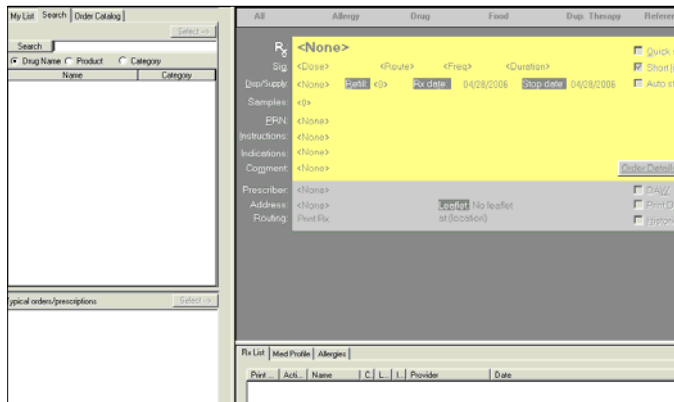
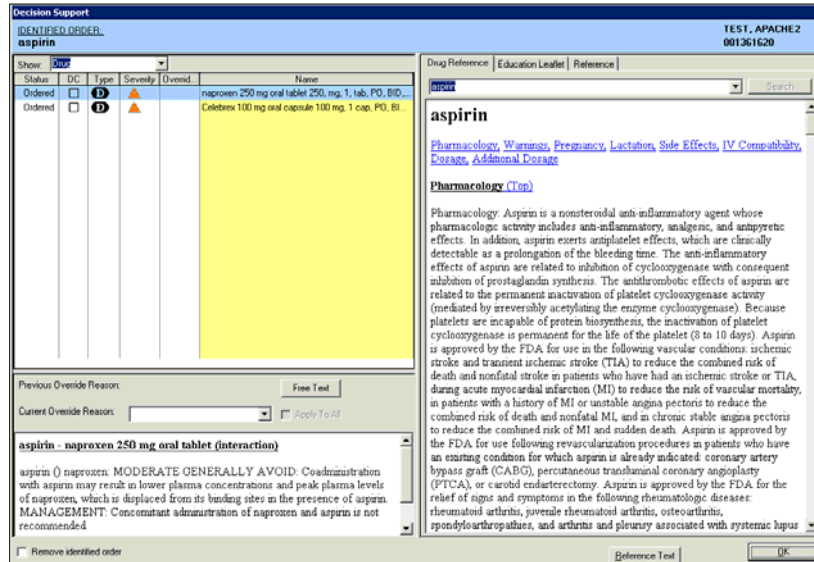


3. Type medication in the “Search” field
4. Click search



5. Double click appropriate medication

- A decision support window may open if there is an allergy or potential interaction with another medication, review and click OK

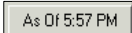


- Medication will appear in the Rx line (Looks like a prescription pad)
- Complete "Dose", "Route", "Freq", and "Duration" if known
- Clicking on any of these will display a dropdown box with the most frequently used responses.
- Comments may be entered as needed by clicking and highlighting the "none" next to Comment.
- Click sign orders
- You will be taken back to the medication profile and the medication will be positioned as pending
- Click the As of button and the medication will move to Prescriptions/ Home Medication

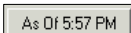
As of 5:57 PM

Modifying a medication by history

- Click the medication you wish to modify

2. Right click and choose modify
3. Update information on the Prescription pad window
4. Sign orders
5. You will be taken back to the medication profile and the medication will be positioned as pending.
6. Click the As of button and the medication will move to Prescriptions/ Home Medication 

Canceling a medication by history

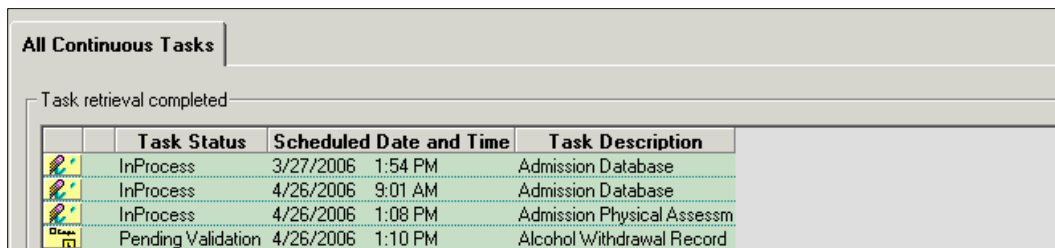
1. Click the medication you wish to cancel.
2. Right click and choose cancel.
3. In the Cancel/DC Order box Click the <> next to comment and enter the reason for cancelling the medication.
4. Sign orders.
5. You will be taken back to the medication profile and the medication will be positioned as pending.
6. Click the As of button  and the medication will move to past.
7. To view cancelled medications, you will need to click the + sign next to past.

Note: Leaflets may be printed by choosing “Print English Leaflet” in the dropdown box





9. Task List

Charting can create a task. If a form is started and saved rather than signed, incomplete (In process) or needs a co-signature (Pending validation) a task is added as a reminder to complete the form.

Single-Patient Task List



The screenshot shows a window titled "All Continuous Tasks" with a sub-header "Task retrieval completed". Below this is a table with the following data:

	Task Status	Scheduled Date and Time	Task Description
	InProcess	3/27/2006 1:54 PM	Admission Database
	InProcess	4/26/2006 9:01 AM	Admission Database
	InProcess	4/26/2006 1:08 PM	Admission Physical Assessm
	Pending Validation	4/26/2006 1:10 PM	Alcohol Withdrawal Record

The Single-Patient Task List can be viewed by opening a patient’s chart to the Task List tab.

Note: You may click a column header to sort by that column.

Working with Tasks

Tasks are completed by Chart Details/Modify and Unchart

Task Status	Scheduled Date and Time	Task Description
InProcess	2/2/2006 1:48 PM	Admission Database
InProcess	2/6/2006 2:02 PM	Admission Database
InProcess	2/6/2006 3:44 PM	Admission Database
InProcess	2/6/2006 3:45 PM	Admission Database

Uncharting Results

Results that were entered in error, such as charted to the wrong patient, can be uncharted from the original form. Uncharting a task changes the form to In Error and removes it from the Task list. To unchart results that were entered in error, complete the following steps:

Select a task list item, such as the Admission Database, from within the task list.



1. Right-click the form, and select Unchart to open a comments dialog box.
2. Review the title bar and validate that you have the correct patient and form.
3. Enter an explanation in the Comment box as to why you are uncharting the form.
4. Click the Sign Form toolbar button  to unchart the information.
5. The uncharted form is displayed in the Form Browser with a red line to signify (In Error) and remove it from the task list.

Chart Details/Modify

Use this selection to record further information about the task that you just completed. These are tasks that are connected to PowerForms. Results entered in error, such as an incorrect answer, may be modified without modifying the entire form, such as an incorrect height. To modify a result in error, complete the following steps:

1. Right-click the task list item, and select Chart Details/Modify.
2. Review the title bar and validate that you have the correct patient and form.
3. Locate the question within the form to be modified and enter the correct information.
4. Click the Sign Form toolbar button  to modify the information.
5. The modified form is displayed in the Form Browser as modified.
6. If all required fields are not completed the form will remain on the task list.

Note: Each user has the ability to Unchart and Chart Details/Modify their own forms. Uncharting and Modifying other users form is defined by role.

Selecting Chart Details/Modify, confirming the information and signing the form, can also remove Pending Validation from the task list. *All forms, which require a co-signature, such as student documentation, will view as Pending Validation.*

Multi-Selecting Tasks

More than one task can be selected and completed at one time. Select the tasks desired. You will see them highlighted in white then follow the steps above to complete.

All Continuous Tasks			
Task retrieval completed			
	Task Status	Scheduled Date and Time	Task Description
	InProcess	2/6/2006 2:02 PM	Admission Database
	InProcess	2/6/2006 3:44 PM	Admission Database
	InProcess	2/6/2006 3:45 PM	Admission Database
	InProcess	2/7/2006 12:50 PM	Physical Assessment
	InProcess	2/9/2006 12:16 PM	Admission Database
	InProcess	2/9/2006 12:27 PM	Admission Database
	InProcess	2/10/2006 11:22 AM	Admission Database
	InProcess	2/10/2006 12:24 PM	Patient Education Record
	InProcess	2/23/2006 9:58 AM	Fall Risk Assessment

10. Clinical Notes Tab

The clinical notes tab displays all validated patient information except for Intake and Output. You can search in clinical notes by Date Range, Document Count, Admission-Current, and All Documents by right-clicking on the green information bar. The Document tree can be arranged By Type, By Status, By Date, Performed By, and By Encounter, below the document tree window.

To view the form within the document window double-click the desired form in the document tree window.

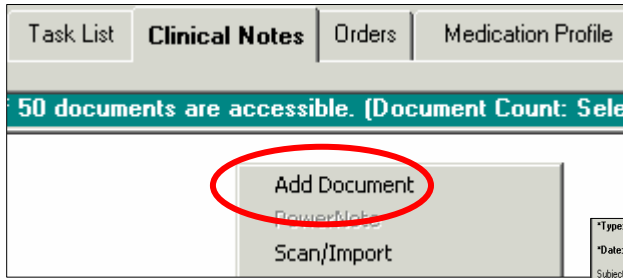
The screenshot shows a software window titled "TEST, NOK - 001361240 Opened by Test, RN". The patient information bar includes: TEST, NOK; DOB: 1/1/1950; MRN: 001361240; Age: 56 years; Acct: 0085006606005; Sex: Male; Loc: 4I, 4421; 2. The "Clinical Notes" tab is selected. The document tree on the left shows a folder structure with "Progress Note Nurse-System Report" selected. The main window displays the following details:

- Type: Progress Note Nurse-System Report
- Date: April 27, 2006 3:27 PM
- Status: Modified
- Title: Pain Management
- Performed By: Build, Nurse 2 on April 27, 2006 3:31 PM
- Verified By: Build, Nurse 2 on April 27, 2006 3:31 PM
- Account Info: 0085006606005, MCG ADULT, Emergency, 1/5/2006 -

Below the details, it states: **Document Contains Addendum** and **Focus Note:**

Focus and 24 Hour Progress Notes

To add a Focus Note right-click in the document view window and click “Add Document”.

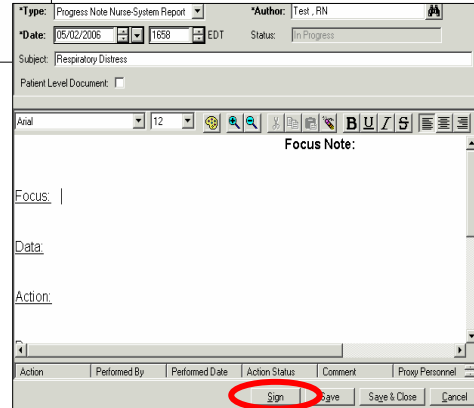


OR



Click on the “Add Document” icon on the toolbar.

The window will default to a Focus Note.

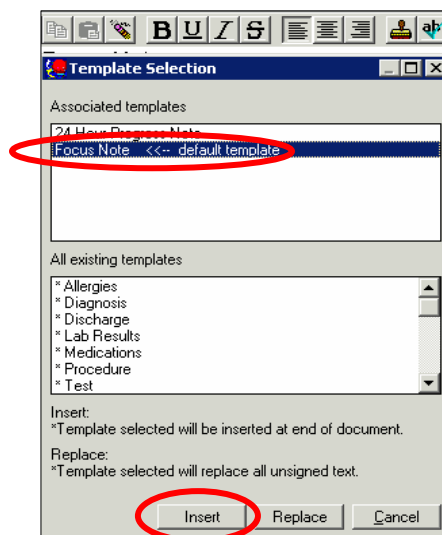


Enter the title of the note in the Subject box, such as respiratory distress. Then complete the note according to the provided template and click sign. All documentation in the documentation window will require verification of password.


To add additional focus notes, maximize the focus note screen, and select “Insert Template” icon on the toolbar.

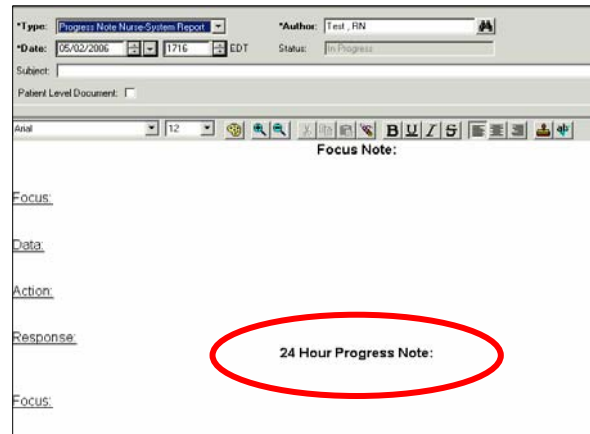
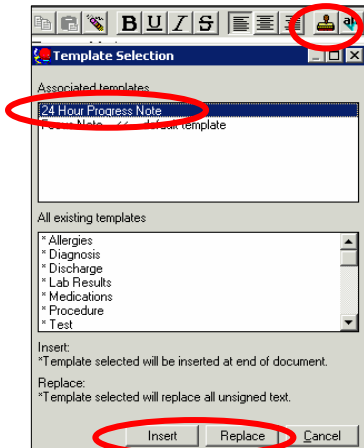


You now select “Focus Note” and click “Insert”. This may be repeated for multiple focus notes.



Addendums may be added to previously signed focus notes. Open the desired document by double clicking on the document. You then right click within the document window and select modify, scroll to the bottom of the note and enter additional data below “Insert Addendum Here”. You may also insert additional focus notes from this location.

To add a 24 Hour Progress Note - Maximize the “Focus Note” screen and click the “Insert Template” icon  and select the 24 Hour Progress note and select Insert or Replace.



Insert will insert a 24 Hour Progress Note template below the Focus note template. Complete information and click sign.

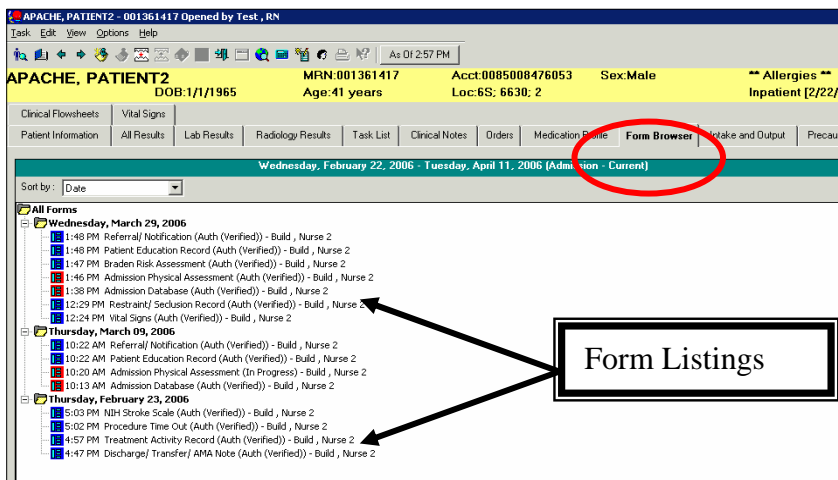
Replace will replace the Focus note template with a 24 Hour Progress Note template. Complete information and click sign.

Addendums may be added to previously signed 24 Hour Progress notes. Open the desired document by double clicking on the document. You then right click within the document window and select modify, scroll to the bottom of the note enter additional data below “Insert Addendum Here”. You may also insert additional Focus notes or 24 Hour Progress notes from this location.

11. Form Browser

Working With the Form Browser

Forms may be viewed, modified, or uncharted from within the Form Browser. The options available to you will vary according to your position. All roles can modify forms for which they have access.

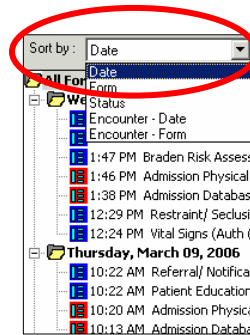


Sorting Forms

When a patient has multiple forms in their Form Browser, it is often helpful to arrange the list in different ways. For example, you can sort them by date or form type.

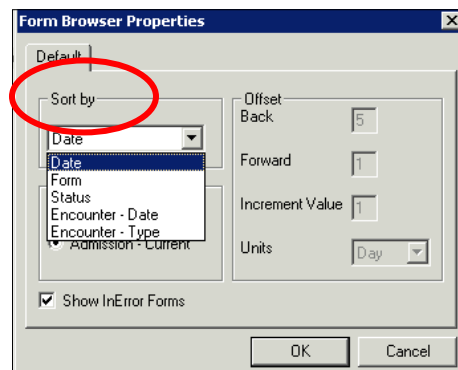
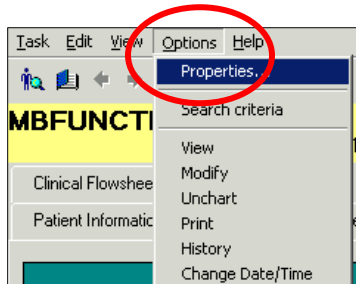
To Sort by Date in the Form Browser tab:

1. Click the “Sort by list”
2. Select the desired option, and notice how the information displayed below changes as you modify the sort criteria



To sort from the Menu bar:

1. Click on “Options”
2. Select “Properties”
3. Window opens to “Sort By”.
4. Select the method.
5. Click “OK”

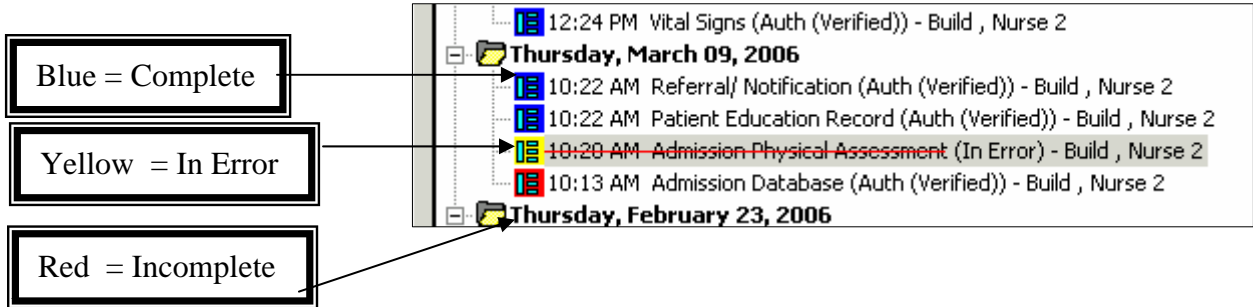


Form Icons

Icon color is used to indicate whether all of the required fields have been completed on a form.

A blue icon indicates that all **required** documentation is complete, and a red icon indicates that all **required** documentation is not completed.

A yellow icon indicates that a form has been uncharted and views as in error.



(Auth(Verified)) means the form is complete and signed by an authorized position.

(Unauth) means the form was signed by an unauthorized position, such as a student, and requires a co-signature.

(Modified) means the documentation has been changed after it has been signed.

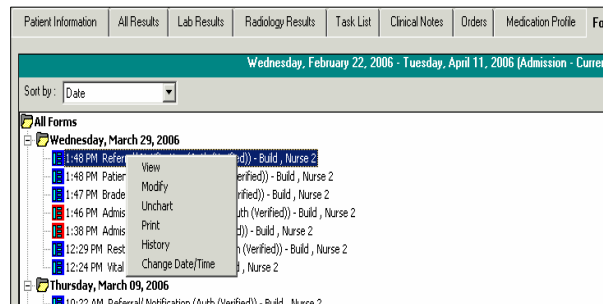
(In Progress) means the form has been saved and not signed.

(In Error) means all documentation on the form has been charted in error and cancelled

Opening Forms from the Form Browser Tab

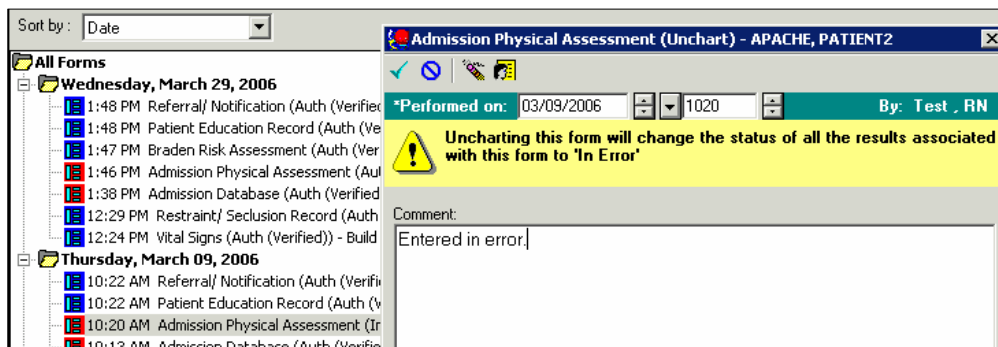
The Form Browser is a tab within a patient's chart that lists all the forms started or completed for that patient. They are displayed in a tree format.

You may double click on the desired form to open and view.




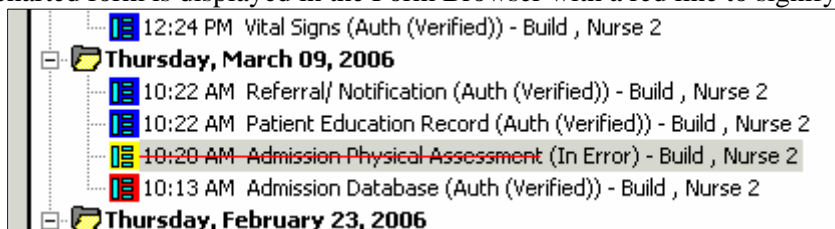
Uncharting Results

Results that were entered in error, such as charted to the wrong patient, can be uncharted from the original form. To unchart results that were entered in error, complete the following steps:




Select a form, such as the Admission Physical Assessment, from within the Form Browser.

1. Right-click the form, and select Unchart to open a comments dialog box
2. Review the title bar and validate that you have the correct patient and form.
3. Enter an explanation in the Comment box as to why you are uncharting the form.
4. Click the Sign Form toolbar button  to complete the uncharting process.
5. The uncharted form is displayed in the Form Browser with a red line to signify (In Error).



Modifying Results

Results entered in error, such as an incorrect answer may be modified without making the entire form “in error”. To modify a result in error, complete the following steps:

7. Right-click the form, and select Modify.
8. Review the title bar and validate that you have the correct patient and form.
9. Locate the question within the form to be modified and enter the correct information.
10. Click the Sign Form toolbar button  to modify the information.
11. The modified form is displayed in the Form Browser as modified.

Note: Each user has the ability to Unchart and Modify their own forms. Uncharting and Modifying other users forms is defined by role.

12. Intake and Output

At this time I & O is the only Direct Charting available

Results can be entered directly into the Intake and Output flowsheet.

Patient Information
 All Results
 Lab Results
 Radiology Results
 Task List
 Clinical Notes
 Orders
 Medication Profile
 Form Browser
 Intake and Output
 Precautions

April 25, 2006 6:00 AM - April 28, 2006 5:59 AM (Clinical Range - Selected Encounter Only)

FLUID BALANCE			Day Total 6AM 4/26/200 6 1:59	4/26/200 6 5:59	4/26/200 6 9:59	Evening Total 2PM 4/26/200	4/27/200 6 1:59	4/27/200 6 5:59	Night Total 4/26/200 6 10:00	24 hr Total 4/26/200 6 6:00	4/27/200 6 6:00
Intake	Oral	Caloric Oral Fluid	400			0			0	400	
		Noncaloric Oral FL...	0			0			0	0	
		Total	400	0	0	0	0	0	0	400	
Output	Urine	Urine Void Volume	500			0			0	500	
		Foley Catheter	0			0			0	0	
		Total	500	0	0	0	0	0	0	500	
Balance			-100	0	0	0	0	0	0	-100	

Summary

Intake and Output (I&O) is a record of a patient's fluid intake and output for a specified time period. The window is divided into three sections: the Navigator, Flowsheet, and a Graph.

- The Navigator works the same way as the Flowsheet and the Task List. Selecting a category brings that category to the top. A checked category indicates it is displayed in the navigator and flowsheet, and an unchecked category is hidden in the flowsheet only
- The main section of the I&O tab is set up like a spreadsheet. It contains details as well as the following totals.

The last column on the right displays the current 24-hour Total for each row. The intersection of the 24-hour intake total and the 24-hour output total represents the fluid balance for those 24 hours. The bottom row is a balance row representing the Output subtracted from the Input for each column for that time period.

Prior to changing properties, such as Time Scale or other properties options, you must either Document or Sign or click the Cancel Charting icon.

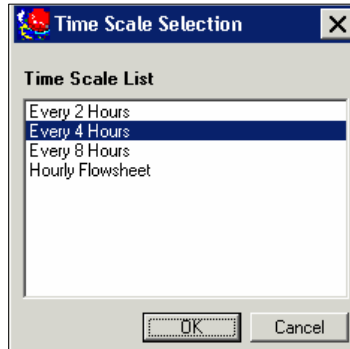
I&O Time Scale Overview

The system provides the ability to group Intake and Output together to be viewed in increments of time, such as the defaulted 4-hour view. The increments of time are Every 2 Hours, Every 4 Hours, Every 8 Hours, and Hourly flowsheet.

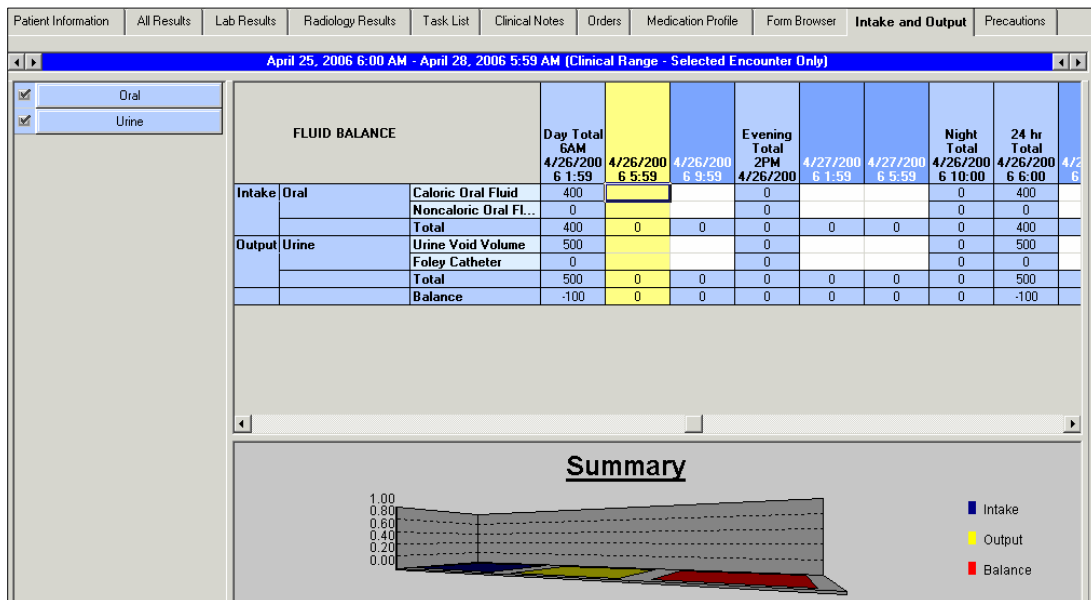
To change the view to display grouped Intake and Output, complete the following steps.

From the Intake and Output tab, click the Select Time Scale button , or select that option from the Options menu.

Select an option listed in the Time Scale Selection box and click OK. Your I&O tab is now grouped in the time increments you just defined.



Combined data for the defined time period is displayed in one column with the date and end time of that defined time increment. Then a total is displayed for each column. In addition there is a day, evening, night and 24-hour total column. These display with the date, beginning and end times of the column.



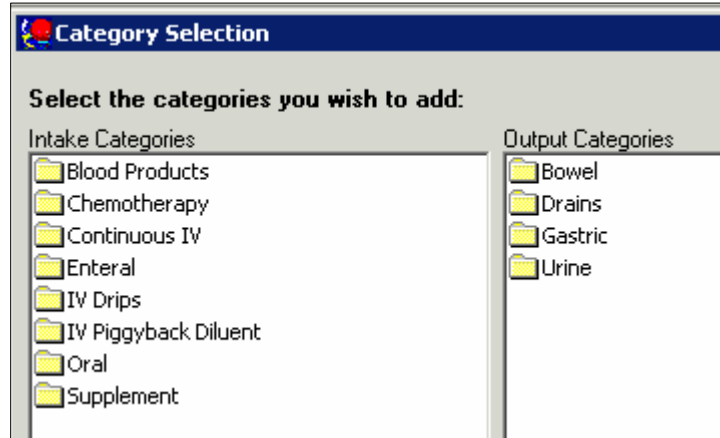
Direct Charting

The intake and output flowsheet has some defaults. Intake defaults to Oral displaying Caloric Oral Fluid and Noncaloric Oral Fluid. Output defaults to Urine displaying Urine Void Volume. These defaults cannot be removed.

You may select other Intake or Output categories by clicking on the Display Hidden Categories icon on the toolbar

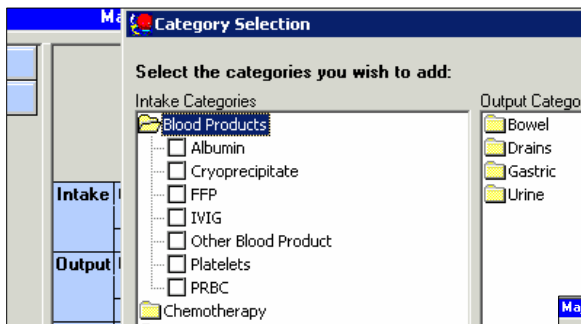


This will display all available Intake and Output categories.




Double click on the desired category and select the appropriate item. You may select multiple items in multiple categories if needed. Click "OK". Selected items will appear on the Intake and Output flowsheet for documentation. Once an item is listed it will remain on the Intake and Output flowsheet until removed.


If you are unable to find a specific item within a category, select "Other" within that category. Items not defaulted may be removed if there has never been any documentation on that item.



The current time defaults to the yellow column and totals default to the blue columns.

		May 17, 2006 6:00 AM - May 18, 2006 5:59 AM (Clinical Range - Selected Encounter Only)				
		FLUID BALANCE				Day Total
				5/17/2006	5/17/2006	5/17/2006
				6 5:59	6 5:59	6 9:59
Intake	Continuous IV	TPN			0	
		Other IV #1			0	
	IV Drips	Dopamine Drip			0	
	Blood Products	Albumin			0	
	Oral	Caloric Oral Fluid			0	
		Noncaloric Oral Fl...			0	

To chart, click in the correct category, date and time box and type the numeric value. These values will automatically be calculated in the Balance and Total columns. Once data is entered click Sign Charting icon. 

You need to click on the “Start Charting” icon  to add any additional data. Charted data will automatically graph below the flowsheet.

Modifying Intake and Output

5/3/2006 9:59 AM	5/3/2006 1:59 PM	5/3/2006 1:59...	5/3/2006 5:59 PM
2			
2			0

View Details...

View Comments...

Add Comment...

Modify...

Unchart...

Change Date/Time...

Add Additional Result...

Right click on the data you wish to modify and click modify. The Result modifications box will open. Now you may modify your results and add a comment as to why the modification was made. Click OK.

Uncharting Intake and Output

You will need to right click on the data you wish to modify and click unchart. The Result Uncharting box will open. Now add a comment as to why you want to unchart the data. Click OK. The amount changes to *0 indicating a change was made.

Change Date/Time

Right click on the data you wish to modify and click Change Date/Time. The Change Result Date/Time box will open. Now you may change the date and/or time with a comment. Click OK. The data will move to the correct date and/or time. The original cell will display *0.

Add Additional Result

You will need to right click on the data you wish to add additional results. The Result Details box will open. Now add the additional result and comment if necessary. Click OK. The new amount will display.

Adding Comments

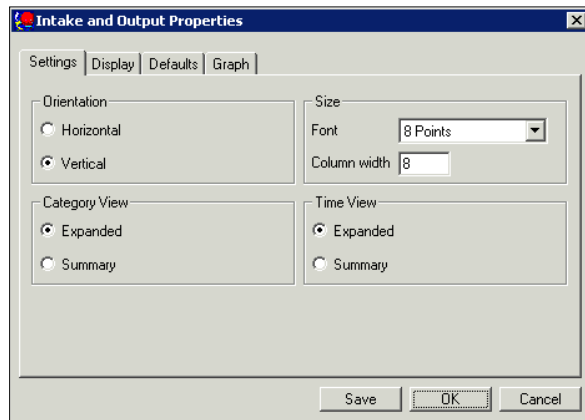
You will need to right click on the data you wish to add a comment. The Result Comments box will open. Now add a comment. Click OK. The comment will show as an *before the amount.

Notes To view changes or comments as noted by an * right click on the numeric value and select the appropriate view.

Intake & Output Properties

The system provides several customization opportunities within the Intake and Output Properties window. The Intake and Output Properties window includes four tabs with a variety of options under each tab. If the user makes any changes within this window and saves, they will automatically default to this view in the future unless changed to another view.

To open the Properties dialog box, select Properties from the Options menu or right-clicking within the graph box and selecting graph properties



Settings

The following pages explain the different options on each of the tabs shown above.

Horizontal Orientation

FLUID BALANCE			5/3/2006 9:59 AM	5/3/2006 1:59 PM	Day Total 6AM 5/3/2006 1:59...	5/3/2006 5:59 PM	5/3/2006 9:59 PM
Intake	Continuous IV	TPN	2		2		
		Other IV #1			0		
	IV Drips	Dopamine Drip			0		
	Oral	Caloric Oral Fluid			0		
		Noncaloric Oral FL...			0		
	Total		2	0	2	0	0
Output	Urine	Urine Void Volume			0		
		Foley Catheter			0		
	Bowel	Stool Ostomy			0		
	Drains	Jackson-Pratt 1			0		
		Chest Tube Draina...			0		
	Total		0	0	0	0	0
	Balance		2	0	2	0	0

In the Horizontal view, the type of Intake and Output is listed on a horizontal line with the corresponding amounts.

Vertical Orientation

FLUID BALANCE	Intake					
	Continuo...	Other IV #1	IV Drips	Oral		Total
	TPN		Dopamine Drip	Caloric Oral Fluid	Noncaloric Oral FL...	
5/3/2006 9:59 AM	2					2
5/3/2006 1:59 PM						0
Day Total 6AM 5/3/2006 1:59 PM	2	0	0	0	0	2
5/3/2006 5:59 PM						0
5/3/2006 9:59 PM						0
Evening Total 2PM 5/3/2006 9:59 PM	0	0	0	0	0	0
5/4/2006 1:59 AM						0
5/4/2006 5:59 AM						0
Night Total 5/3/2006 10:00 PM - 5/4/2006 5:59 AM	0	0	0	0	0	0
24 hr Total 5/3/2006 6:00 AM - 5/4/2006 5:59 AM	2	0	0	0	0	2

In the vertical view, the type of Intake and Output is listed in a vertical column with the corresponding amounts.

Expanded Category View

FLUID BALANCE			5/3/2006 9:59 AM	5/3/2006 1:59 PM	Day Total 6AM 5/3/2006 1:59...	5/3/2006 5:59 PM	5/3/2006 9:59 PM
Intake	Continuous IV	TPN	2		2		
		Other IV #1			0		
	IV Drips	Dopamine Drip			0		
		Caloric Oral Fluid			0		
	Oral	Noncaloric Oral FL...			0		
		Total	2	0	2	0	0
Output	Urine	Urine Void Volume			0		
		Foley Catheter			0		
	Bowel	Stool Ostomy			0		
		Jackson-Pratt 1			0		
	Drains	Chest Tube Draina...			0		
		Total	0	0	0	0	0
Balance		2	0	2	0	0	

In the expanded category view, the details of the different types of Intake and Output are listed.

Summary Category View

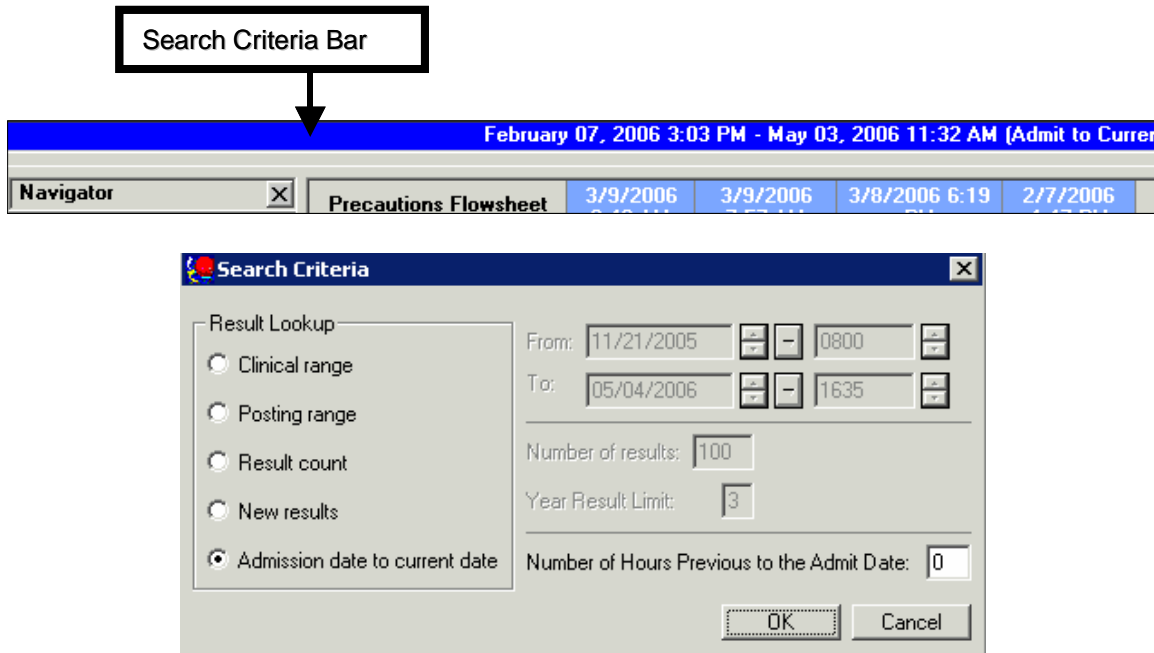
FLUID BALANCE			Day Total 6AM 5/3/2006 1:59...	Evening Total 2PM 5/3/2006 9:59 PM	Night Total 5/3/2006 10:00 PM	24 hr Total 5/3/2006 6:00 AM -
Intake	Continuous IV	TPN	2	0	0	2
		Other IV #1	0	0	0	0
	IV Drips	Dopamine Drip	0	0	0	0
		Caloric Oral Fluid	0	0	0	0
	Oral	Noncaloric Oral FL...	0	0	0	0
		Total	2	0	0	2
Output	Urine	Urine Void Volume	0	0	0	0
		Foley Catheter	0	0	0	0
	Bowel	Stool Ostomy	0	0	0	0
		Jackson-Pratt 1	0	0	0	0
	Drains	Chest Tube Draina...	0	0	0	0
		Total	0	0	0	0
Balance		2	0	0	2	

In the summary category view, all types of intake are combined into totals. All types of output are also combined into totals.

13. Precautions

You may view Pregnancy Status, Diabetic Status, Isolation Precautions, Safety Precautions, Code Status, and Fall Risk Category from this tab. All information is automatically defaulted from the last charted entry within the forms. This information is view only and may only be altered from the forms.

To change the search criteria by Clinical range, Posting range, and Admission date to Current date, right-click in the search criteria bar (time/date bar). The only categories that will view are those with documented information.



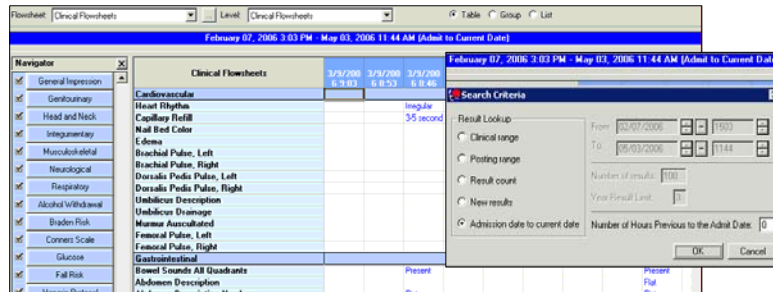
Information with an asterisk * indicates a comment. You may right click to view this information.

May 16, 2006 8:00 AM - May 17, 2006 4:54 PM (Admit to Current Date)										
Navigator	Precautions Flowsheet	5/17/20 06 1:58	5/17/20 06 1:43	5/17/20 06 9:31	5/17/20 06 9:02	5/17/20 06 8:57	5/16/20 06 2:24	5/16/20 06 2:14	5/16/20 06 12:37	5/16/20 06 12:08
	Precautions Flowsheet									
	Code Status		* (c) DNR							
	Pregnancy Status	N/A	N/A		* In Error		N/A		Full code	N/A N/A
	Diabetic Status		Diabetic							
	Isolation Precautions	Standard, C	Standard, C			Standard, C		Standard		
	Safety Precautions	Alcohol with	Alcohol with			Fall precaut		Fall precaut		
	Fall Risk Category		High							

14. Clinical Flowsheets

You may view assessment and monitoring data through the Clinical Flowsheet tab. This information is displayed in a flowsheet view allowing the viewer to compare information over time.

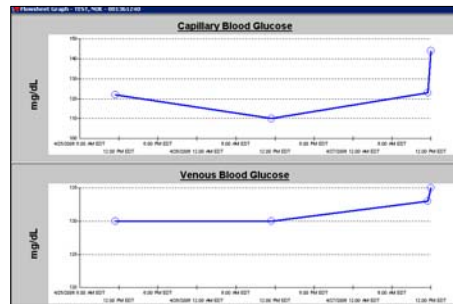
The information may be viewed in Clinical Flowsheet format. This displays all flowsheets. The Physical Assessments view displays by system, such as respiratory or cardiovascular. The Monitoring Record view displays specialized flowsheets, such as Alcohol Withdrawal and Restraints. The displays are view only and defaults to the last charted entry. The only flowsheets that will view are those with documented data and are listed alphabetically in the navigator bar. You may click on the desired flowsheet to bring it to the top of the flowsheet window. You may right-click in the Search Criteria Bar (time/date bar) to change the search criteria by Clinical range, Posting range, Result count, New result, and Admission date to current date.



A gray box in the label precedes all numeric information.

Clinical Flowsheets				
Glucose	Blood Glucose T	<input checked="" type="checkbox"/> Capillary Blood	<input checked="" type="checkbox"/> Venous Blood	Inter
4/27/2006 11:58 AM	Routine	144 mg/dL	135 mg/dL	Notif
4/27/2006 11:29 AM	Routine	123 mg/dL	133 mg/dL	Notif
4/26/2006 11:29 AM	Symptoms of hyp	110 mg/dL	130 mg/dL	None

You may check the gray box and then the Graph icon to automatically graph numeric information over time. Also, you may combine graphs by clicking the Combine button at the bottom of the window. The information will view in the Flowsheet graph box.




Information may view in different colors or have an * or (c). You may right-click this information and view details: red equals critical value, an asterisk indicates a comment, and (c) indicates a change to the original documented result.

Vital Signs	Pain Score	Pain Scale	Temperature	Peripheral P _u	Apical Heart	Respiratory F _r	Systolic Blood	Diastol
4/27/2006 11:29 AM	4	FACES	(c) 38.0 DegC	90 bpm		14 br/min	121 mmHg	65 mmHg
4/26/2006 11:29 AM	6	FACES	39.0 DegC	120 bpm	* 110 bpm	22 br/min	* (c) 144 mmHg	90 mmHg
4/25/2006 11:29 AM	5, 4	FACES, FACES	37.4 DegC	100 bpm		16 br/min	125 mmHg	67 mmHg
Vital Signs	Mean Arterial	Oxygen Satu	Oxygen Therapy	Oxygen Flow	FI O ₂	Height	Weight	
4/27/2006 11:29 AM	102 mmHg	97 %	None, None					
4/26/2006 11:29 AM	126 mmHg	94 %	None, None					
4/25/2006 11:29 AM	106 mmHg	99 %	None, Nasal car	2.00 L/min	67 %	155.00 cm	60.000 kg	
3/29/2006 10:41 AM							99.000 kg	

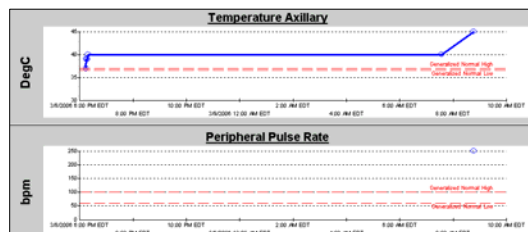
15. Vital Signs Flowsheet

You may view documented Vital Signs from this tab. This information is displayed in a flowsheet view to compare information over time. All information is automatically defaulted from the last charted entry within the forms. This information is view only and may only be altered from the forms. You may right-click in the Search Criteria Bar to change the search criteria by Clinical range, Posting range, Result count, New result, or Admission date to current date. The only categories that will view are those with documented information

A gray box in the label precedes all numeric information. You may check the gray box and then the Graph icon  on the toolbar to automatically graph numeric information over time.

January 13, 2006 12:45 PM - May 03, 2006 1:24 PM (Admit to Current Date)									
Clinical Flowsheets	3/9/2006 6:9:03	3/9/2006 6:8:46	3/9/2006 7:20	3/9/2006 6:7:34	3/8/2006 6:6:19	3/8/2006 6:6:18	3/8/2006 6:6:15	3/8/2006 6:6:14	
Vital Signs									
<input checked="" type="checkbox"/> Temperature Oral				34.0 DegC					
<input checked="" type="checkbox"/> Temperature Axillary		45.0 DegC		40.0 DegC	40.0 DegC	39.0 DegC	(c) 39.0 De	37.0 DegC	
<input checked="" type="checkbox"/> Peripheral Pulse Rate		250 bpm							
<input checked="" type="checkbox"/> Respiratory Rate		44 br/min							
<input checked="" type="checkbox"/> Systolic Blood Pressure		250 mmHg							

The information will view in the Flowsheet graph box. Information displayed in the cells reflect:



Also, you may combine graphs by clicking the Combine button at the bottom of the window.

Right-click in the cell displaying results to open the Result Details window.

Select "View Details", as it may be outside of normal or have a comment attached.

Result Details - FEMALE-TEST, DAYS9			
Result History			
Value	Valid From	Valid Until	
39.0	3/8/2006 6:15 PM	Current	
36.0	3/8/2006 6:15 PM	3/8/2006 6:15 PM	
Result Action List			
Temperature Axillary 39.0 DegC (-HHI)			
Normal Low	36.6	Normal High	37.0
Critical Low	36.5	Critical High	38.0
Date/Time	March 08, 2006 6:15 PM		
Contributor System	PowerChart		
Status	Modified		

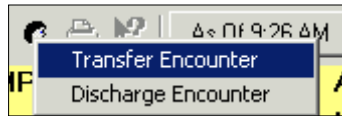
16. Patient Management Conversations

Cerner PowerChart allows the transfer and discharge of patients; however, IDX remains the primary application. IDX receives information through Cerner; therefore, patient management conversations are updated in IDX.

You may transfer a patient, (either location, service or attending), cancel a transfer, and discharge.

- **Transfer Encounter:**

1. Click the Patient Management Conversations icon.

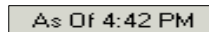


2. Select transfer encounter
3. Verify correct patient in all dithered (gray) boxes in the Copy of Bed Transfer page
4. All yellow cells are required. To view yellow cells, right-click and select “Highlight Required Fields”.

Name	SEX	Female	Isolation	Birth Date	04/17/2006	Age	2W
Medical Record Number	Financial Number	007500217	0085014976122				
Current Information:							
Patient Type	Attending Physician	Medical Service	Nurse Unit	Room			
Inpatient	Sethi MD, Kapil D	Inpt Neurology	3NSC	3018			
Bed	1						
New Medical Service Data:							
Requested Medical Service	Attending Physician						
Inpt Neurology	Sethi MD, Kapil D						
New Location Data:							
Facility	Building	Nurse/Ambulatory	Room				
MCG Hospitals and Cl...	MCG Adult	3NSC	3018	LocInfo Separator			
Bed	Requested Accommodation	Requested Accommodation Reason					
1	Neuro Intensive						
Transfer Information:							
Transfer Reason	Transfer Date	Transfer Time	User ID				
	06/04/2006	09:38	BUILDING				

5. Verify and update each cell as needed to complete the transfer.
6. To select a new room number or bed select the Loc Info Separator and choose the correct room and bed.
7. A transfer reason is required.
8. Click OK.
9. The Closed Encounter box will appear. Verify all information and click yes if correct or no if a change is needed.
10. You will return to the previous screen.

Click the “As of” button to update the patients electronic chart



- **Cancel Transfer Encounter**
- **Discharge Encounter**

17. Documenting With Forms


PowerForms are electronic documents that are used to record information about patient status. Some examples include Admission Database and Physical Assessments.

Ad Hoc Charting

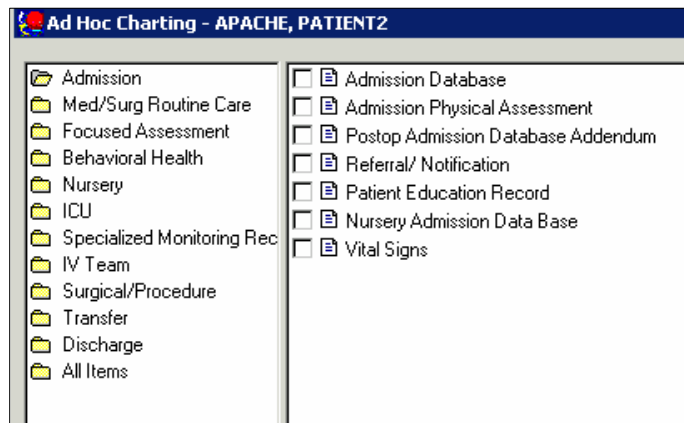
- Ad Hoc charting window
 1. Folders display in the left pane of the window. The specific folders and their contents vary by the role of the caregiver. *Do not select the “All Items” folder.*
 2. Forms within the selected folder display in the right pane of the window.

Opening Blank Forms

Ad Hoc Charting allows you to open any form, any time. Essentially, it is a file cabinet of blank forms. The window can be opened from either the Organizer or the Chart.

From the Organizer, highlight your patient and click on the “Ad Hoc” toolbar icon .

From the Patient’s chart, click on the “Ad Hoc” toolbar icon.



The folders are designed to follow patient care processes or to group forms used by a particular specialty area.

You may select one or more forms within each folder. If multiple forms are chosen, documentation will automatically flow from one form to another once a form is signed.

Note: When you open Ad Hoc charting, the folders that you will see are determined by your role

Completing Forms

The screenshot shows a 'General Information' form with a sidebar on the left containing categories like Allergy, Medications, Substance Use, Nutrition, and Functional Assessment. The main form area includes fields for Preferred Name, Height/Length, Weight, Birth Weight, Head Circumference, Admitted From (with radio buttons for L/D, ACC, ASU/OR/PACU, Critical transport team, Direct admit, ED, Home, PAS), Mode of Arrival (with radio buttons for Ambulatory, Bassinet, Bed, Carried, Stretcher, Wheelchair), Accompanied By (with checkboxes for No one accompanied pt, Parent, Spouse, Significant other, Son, Daughter, Sibling, Family member, Other), Chief Complaint, Information Given By (with checkboxes for Unable to obtain, Patient, Son, Daughter), and Reason Information (with checkboxes for Nonverbal, Language barrier).

The following is a list of common fields. Most forms share general guidelines for completing them.

Tabbing within the form is imperative.
Tabbing will automatically guide the user to all available questions.

Single Select Answer Box

Only one selection is allowed by left clicking on the response in the options circle. You may unselect any answer by clicking on the response again.

This close-up shows the 'Admitted From' section with the following options: L/D, ACC, ASU/OR/PACU (selected), Critical transport team, Direct admit, ED, Home, and PAS.

Multi Select Answer Box

This close-up shows the 'Accompanied By' section with the following options: Friend, Relative, Significant other, Spouse, and Other.

All options that apply may be selected by left clicking on the response in the options boxes. You may unselect any answer by clicking on the response again.

This close-up shows the 'Accompanied By' section with the following options: No one accompanied pt, Parent (selected), Spouse, Significant other (selected), Son, Daughter, Sibling, Family member, and Other.

Multi First Single Select Answer Boxes

If the first answer is chosen, you cannot choose any other answer or you may choose multiple responses from the options box. You may select a response by left clicking on the response in the options box. You may unselect any answer by clicking on the response again.

Accompanied By	<input type="checkbox"/> No one accompanied pt	<input type="checkbox"/> Sibling
	<input type="checkbox"/> Parent	<input type="checkbox"/> Family member
	<input checked="" type="checkbox"/> Spouse	<input type="checkbox"/> Other:
	<input checked="" type="checkbox"/> Significant other	
	<input type="checkbox"/> Son	
	<input type="checkbox"/> Daughter	

When “Other” is selected the comment box will open and allow free text to be entered.



The screenshot shows a window titled "Other Accompanied By" with a text area containing the text "Neighbor accompanied the patient." Below the text area are "OK" and "Cancel" buttons. In the background, a form is visible with the "Accompanied By" section where "Other:" is selected.

Patient Specific Responses

Some responses vary according to the patient’s age and sex, i.e., Pregnancy Status
Example shows a male response:

Pregnancy Status	<input type="radio"/> N/A
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Default/Last Charted Values

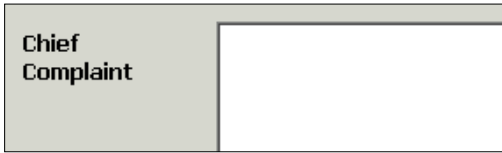
Some responses may be prefilled, such as Standard in the Isolation Precautions question since all patients must be on standard precautions. Other responses are prefilled with the only logical response. For example, Pregnancy Status for a male comes prefilled as N/A. Some historical values will automatically prefill, such as Previous Hospitalizations/ Surgeries and Restraint Initiation Date. The Icon denotes a prefilled field. The user may change this data if appropriate.

Pregnancy Status	<input checked="" type="radio"/> N/A	
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Free Text/Rich Text

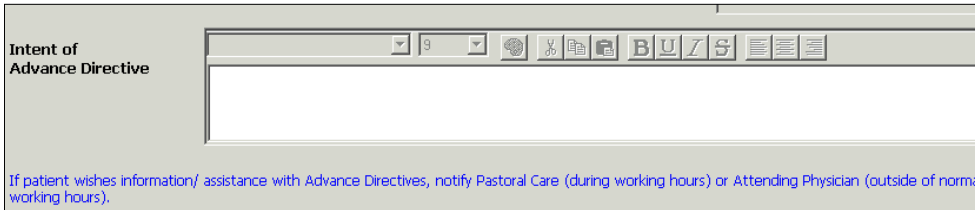
Some responses may be entered by typing the answer in the free text or rich text box. These boxes will accept alpha and numeric entries to the defined limits.

Free text allows 255 characters.



A form with a label 'Chief Complaint' on the left and a large empty text box on the right for entering the patient's chief complaint.

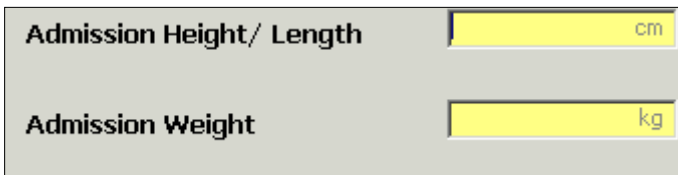
Rich text allows unlimited characters.



A form with a label 'Intent of Advance Directive' on the left and a rich text editor on the right. The rich text editor includes a toolbar with icons for bold, italic, underline, strikethrough, bulleted list, numbered list, link, unlink, and text color. Below the text box is a note: 'If patient wishes information/ assistance with Advance Directives, notify Pastoral Care (during working hours) or Attending Physician (outside of normal working hours).'

Numeric

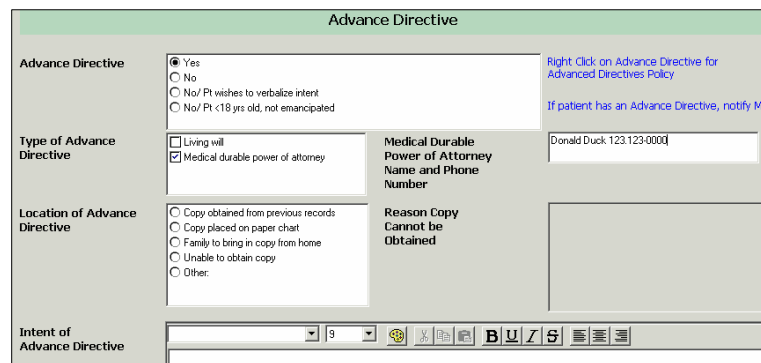
Some responses, such as weight, will only allow numeric entry. There may be feasible parameters for numeric entry and will not allow entries outside of the range. A warning will display when signing the form if the value is outside the feasible range. Most numeric boxes will show the unit of measure that is to be entered. Some, such as weight, will automatically show a conversion to the right of the numeric box.



Two numeric input fields. The first is labeled 'Admission Height/ Length' and has a yellow input box with 'cm' to its right. The second is labeled 'Admission Weight' and has a yellow input box with 'kg' to its right.

Conditional Questions/Triggered Sections

Conditional questions and triggered section labels are dithered (grayed out) and will only open when a related question is answered with a specific response. The question/section cannot be answered if it remains dithered. A warning box will appear if you change a triggering response to a conditional question. For example, the Medical Durable Power of Attorney triggering response opens the name and phone number question. If you attempt to change your answer after entering a name and phone number, a warning box will appear.



A screenshot of the 'Advance Directive' form. It contains several sections: 'Advance Directive' with radio buttons for 'Yes', 'No', 'No/ Pt wishes to verbalize intent', and 'No/ Pt <18 yrs old, not emancipated'; 'Type of Advance Directive' with checkboxes for 'Living will' and 'Medical durable power of attorney'; 'Location of Advance Directive' with radio buttons for 'Copy obtained from previous records', 'Copy placed on paper chart', 'Family to bring in copy from home', 'Unable to obtain copy', and 'Other'; 'Medical Durable Power of Attorney Name and Phone Number' with a text box containing 'Donald Duck 123 123-0000'; and 'Reason Copy Cannot be Obtained' with a text box. A note at the top right says 'Right Click on Advance Directive for Advanced Directives Policy' and 'If patient has an Advance Directive, notify MD.'

Required Questions

Required questions are indicated by a yellow background. Once the question is answered the background turns white. Any section of a form with required questions will show as a blue circle with a white X in the navigator bar. Once all required questions are answered in that section, the icon changes to a blue check on the navigator bar.

Very poor

Probably inadequate

Adequate

Excellent

Types of Available Grids

Discrete Grid

Gastrointestinal

	Present	Hyperactive	Hypoactive	Absent	Unable to assess	Comment
LIQ		X				
RUQ					X	
LLQ				X		
RLQ						

In the discrete grid above, selecting a cell adds an X in that column. Selecting the same cell again clears the X.

Ultra Grid

Ultra grids allow you to enter data into the cell. If the cell says <MultiAlpha>, a results box opens that allows multiple responses. <Alpha> allows single responses. Empty fields allow either numeric or free text responses as appropriate.

Neurological Detailed Assessment

<p>Swallowing Difficulty</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Liquids, thick</p> <p><input type="checkbox"/> Liquids, thin</p> <p><input type="checkbox"/> Pills</p> <p><input type="checkbox"/> Saliva</p> <p><input type="checkbox"/> Solids</p> <p><input type="checkbox"/> Other:</p>	<p>Pupil Assessment</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 20%;"></th> <th style="width: 20%;">Description</th> <th style="width: 20%;">Reaction</th> <th style="width: 10%;">Size (mm)</th> <th style="width: 30%;">Comment</th> </tr> </thead> <tbody> <tr> <td>Pupil, Left</td> <td><MultiAlpha></td> <td><Alpha></td> <td></td> <td></td> </tr> <tr> <td>Pupil, Right</td> <td><MultiAlpha></td> <td><Alpha></td> <td></td> <td></td> </tr> </tbody> </table>		Description	Reaction	Size (mm)	Comment	Pupil, Left	<MultiAlpha>	<Alpha>			Pupil, Right	<MultiAlpha>	<Alpha>		
	Description	Reaction	Size (mm)	Comment												
Pupil, Left	<MultiAlpha>	<Alpha>														
Pupil, Right	<MultiAlpha>	<Alpha>														

Power Grid

Power Grids data is entered in the same manner as Ultra grids. They allow you to add additional rows for complete assessments. To add a row right click in the grid field then click “Add Row”.

The screenshot shows a 'Musculoskeletal Assessment' form. It includes sections for 'Special Orthopedic Devices' (with checkboxes for Nons, Brace, Cast, Immobilizer, Prosthesis, Splint, and Other) and a 'Joint Abnormality' section. Below these is a 'Joint Assessment' table with columns for Location, Assessment, and Range of Motion. A context menu is open over the table, listing options like Comment, Chart Details..., Modifiers, Reference Text, View Result Details, Clear, Clear Cell, Add Row, and Delete Row. The 'Add Row' option is highlighted in blue.

Calculated Scores

Some questions are associated with numeric scores. For example, in the Substance Use section of the Admission Database is the **CAGE** score. Once all questions are answered the score will automatically calculate and be viewable only. Calculated scores cannot be altered manually.

The screenshot shows the CAGE score calculation interface. It includes four questions with radio button options for Yes and No:

- Have you ever felt you should cut down on your drinking? (Yes selected)
- Have people annoyed you by criticizing your drinking? (Yes selected)
- Have you ever felt bad or guilty about your drinking? (Yes selected)
- Have you ever taken a drink first thing in the morning to steady your nerves or get rid of a hangover? (Eye-opener) (Yes selected)

 The CAGE Score is displayed as 4. A note below the score states: "Score >/= 2 is positive, Notify MD".

Reference Text

Reference text allows the user to access policy and procedures, guidelines, and the patient education website. You will be guided by blue text instructions. For example, in the Neurological Detailed section of the Admission Physical Assessment, you will see the blue text “[Right Click on CSF Drain...](#)” You will right-click in the answer box and select “Reference Text”. A Decisions Support window will open and click on the blue text within the box. This will take you to the appropriate website. When finished close the website and click “OK” in the Decision Support window. You will automatically be taken back to the original question. Some questions may have more than one reference text attached. A single reference text is attached to each undithered circle in the decision support box.


The screenshot shows a 'CSF Drain Type' form with radio button options for EVD and Lumbar. A context menu is open over the 'Reference Text' option, which is circled in red. The menu also includes options for Comment, Modifiers, View Result Details, and Clear.

The screenshot shows a 'Decision Support' window for 'CSF Drain Type'. It features a 'Reference' section with a link: "For CSF drain policy infant and children". This link is circled in red. Below the link are several tabs: CSF Drain Type, CSF drain information, Chart guide, Nurse preparation, Patient education, and Policy and procedures.

Provider Selection Box

This tool provides the names of users in PowerChart. A Provider Selection box is identified with Binoculars. Enter the first few letters of the last name.

Click the binocular button. Choose the correct name and it will populate the cell.

Witnessed by [Build,Nurse] «Multiple Matches» 

If there is a common name, be sure to select the correct Licensed Staff name to witness or notify within forms.

Provider Selection

Last Name: [build] First Name: [nurse] Suffix: [] Search

Title: [] Alias: [] Alias Type: [] New Provider

Preview Clear

Limit by group No data filtering

Limit by organization Filtered: MCG Hospitals and Clinics

Limit by position No data filtering

Limit by relationship No data filtering

If the provider name is within a grid, such as Referral Notification form, enter part or all of the name and click the tab key. The search window will open if the provider is not recognized. If the provider's name is not available, documentation of the name should be done in the "Comment" field.

Date/ Time

Date/ time may be entered in three ways. Enter "T" for today's date and "N" is for current time or the user may choose the drop down calendar and choose a different date/time. The user may also directly enter a numeric date/time. Entered dates/times do not alter the electronic chart time (Time actually entered into the computer).

Referral/ Notification

	Provider Name	Date/ Time	Reason for Notification/ Referral
Physician			
Social Services			
Case Management		05/04/2006 10:23	
Pastoral Care			Comment
Clinical Nutrition			
Enterostomal Therapist			

Pastoral Care 721-2929

Case Management 721-8150

Add Result Comment

Date/ Time

05/08/2006

2006

May

Su	Mo	Tu	We	Th	Fr	Sa
30	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31	1	2	3
4	5	6	7	8	9	10

OK Cancel


Uncharting Documentation within a Form

By choosing either of these options no documentation will be saved.


Clearing a Single Entry within a Form

You may click the original answer to deselect that answer.

Clearing Multiple Entries


You may click on the Clear Icon  This will clear all documentation within a section, but leaves the section of the form open to allow correct documentation.

Cancel Charting within a Form

You may click on the Cancel Icon.  This will cancel all documentation and close the form


You may close the form by clicking the X in the top right hand corner. This will cancel all documentation and close the form.

Saving a Form

- You may Click the Save Icon. 

This will allow you to save a form and complete it at a later time. Saving a form without signing it changes it to an **In Progress** status on the Form Browser and **In Process** on the Task List, and the results do not show on the flowsheet or in clinical notes. Only the results of signed forms are displayed on the flowsheets or clinical notes.

Signing a Form

- You may click the Sign Form Icon. 
- This will sign your document with an electronic signature and will allow others to view your documentation in flowsheets or clinical notes.
- Signing a form does not signify all required documentation has been completed.