

CliniComp, Intl.

Clinical Computer Systems

CONFIDENTIAL

CLINICAL USER REFERENCE MANUAL

AUGUST 1997

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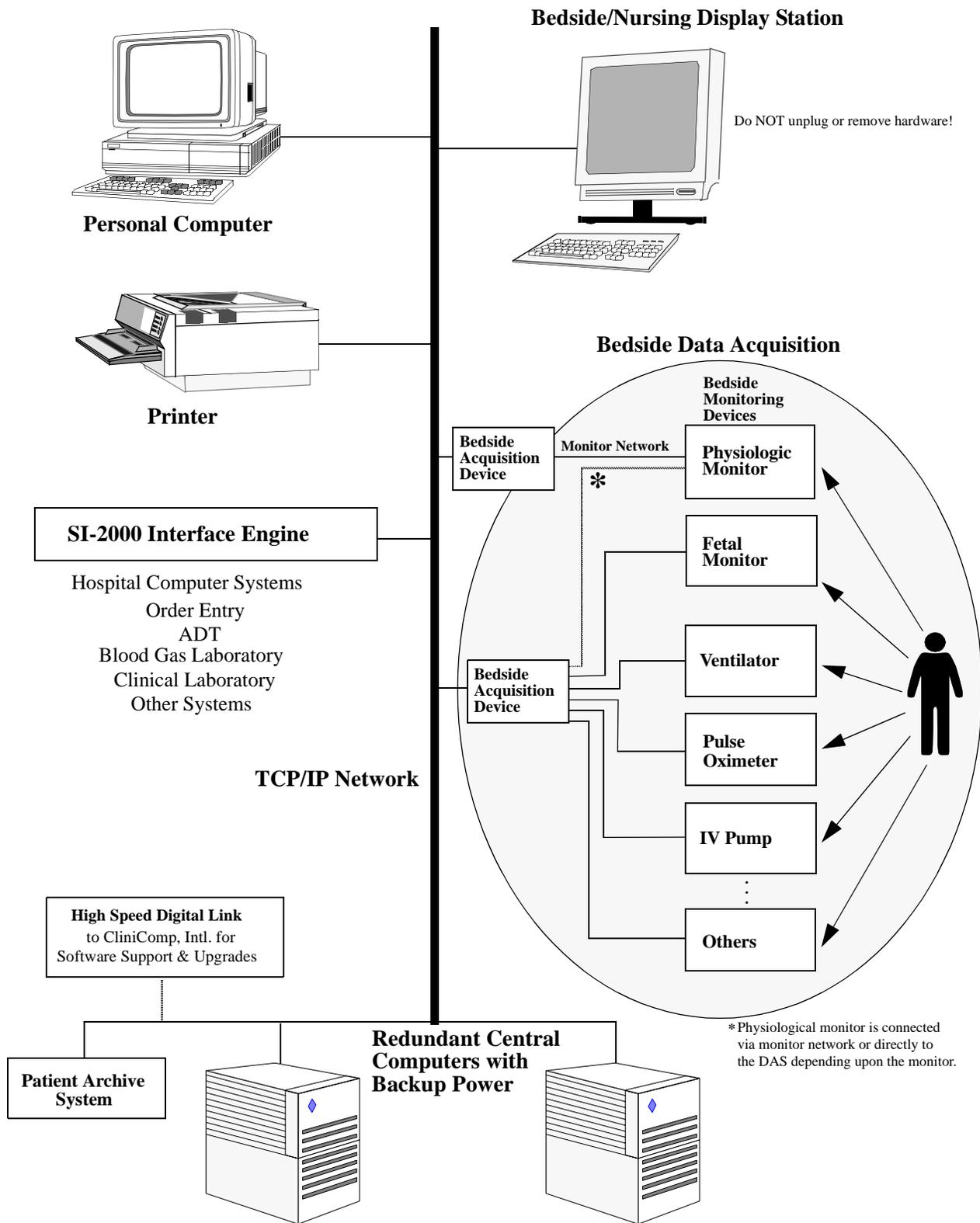
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PREFACE

THE CLINICOMP, INTL. SYSTEM ARCHITECTURE



CLINICAL INFORMATION SYSTEM OVERVIEW

WHAT IS A CLINICAL INFORMATION SYSTEM?

A clinical information system is a hardware and software system that automates clinical charting. CliniComp, Intl.'s Clinical Information System (CIS) is the largest, operational clinical information system in the world since 1985.

WHAT ARE THE BENEFITS OF THE CIS?

- Replaces the handwritten chart
- Allows multiple users to access patient information simultaneously
- Configured to each hospital, environment and patient
- Eliminates redundant charting
- Reads data from bedside devices and other systems (lab, ADT)
- Calculates IV Drips, I&O, etc.
- No downtime architecture
- Data is stored for future retrieval.

WHAT ARE THE COMPONENTS OF THE CIS?

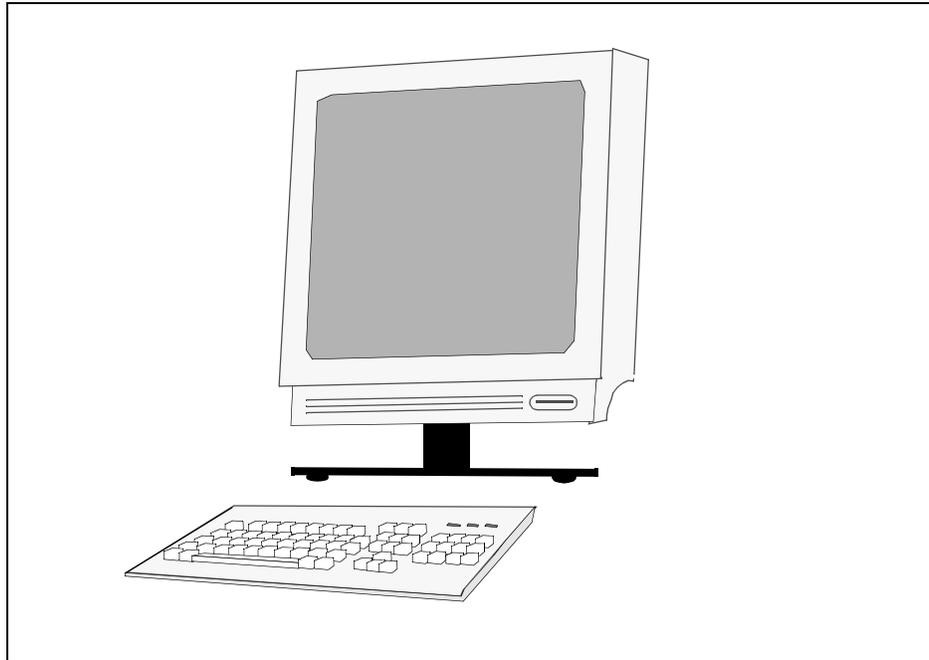
- Display stations
- Laser printers
- Dual central systems
- Interfaces to bedside monitors and other hospital systems.

WHAT CIS COMPONENTS WILL YOU USE?

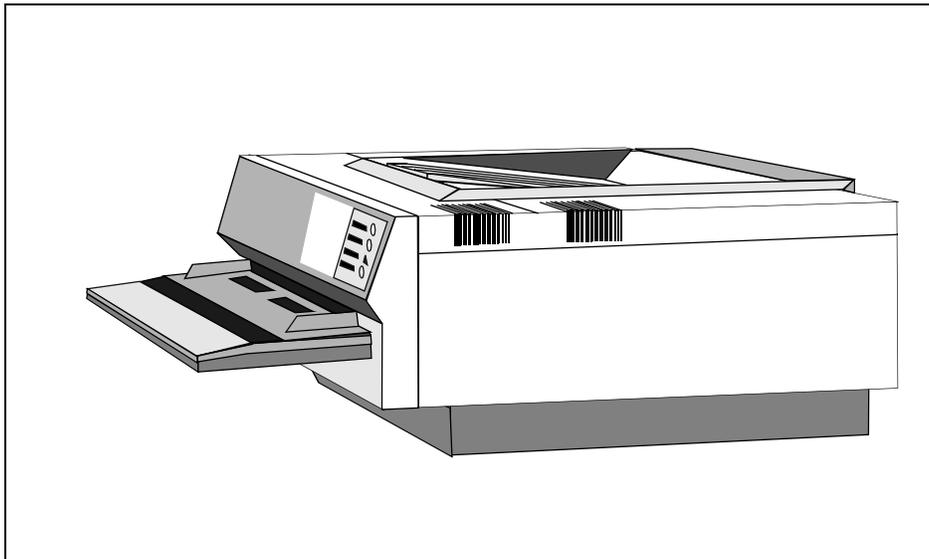


Your hardware components may vary from the following illustrated hardware items.

- **Display Station**



- **Laser Printer**



MANUAL OVERVIEW

OBJECTIVE

This manual has been developed to instruct clinical users and managers in the use of the CliniComp, Intl. CIS. Upon review of this manual, users should be able to use the system to document required patient care information.

MANUAL OUTLINE

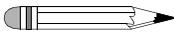
This manual is organized into the following chapters:

- Components of the CIS (Chapter 1.0, CIS INTRO)
- Basic CIS operations (Chapter 2.0, CIS BASICS)
- Charting functions (Chapter 3.0, CIS CHARTING FUNCTIONS)
- Special review capabilities (Chapter 4.0, CIS REVIEW FUNCTIONS)

ADDITIONAL CIS USER DOCUMENTATION

- CIS User Training Booklet
- CIS Physician Training Booklet
- Helpful Hints Booklet
- User Quick Guide

SYMBOLS USED WITHIN THIS MANUAL

	= Hard Keys		= Note
	= Soft Keys		= Warning
	= Other Keys		= Disclaimer
	= Configurable Item		= Caution Before Storing

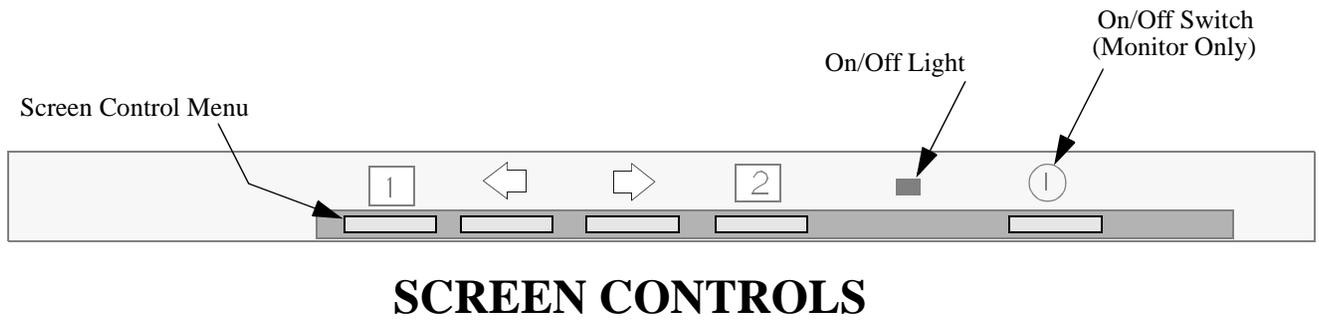
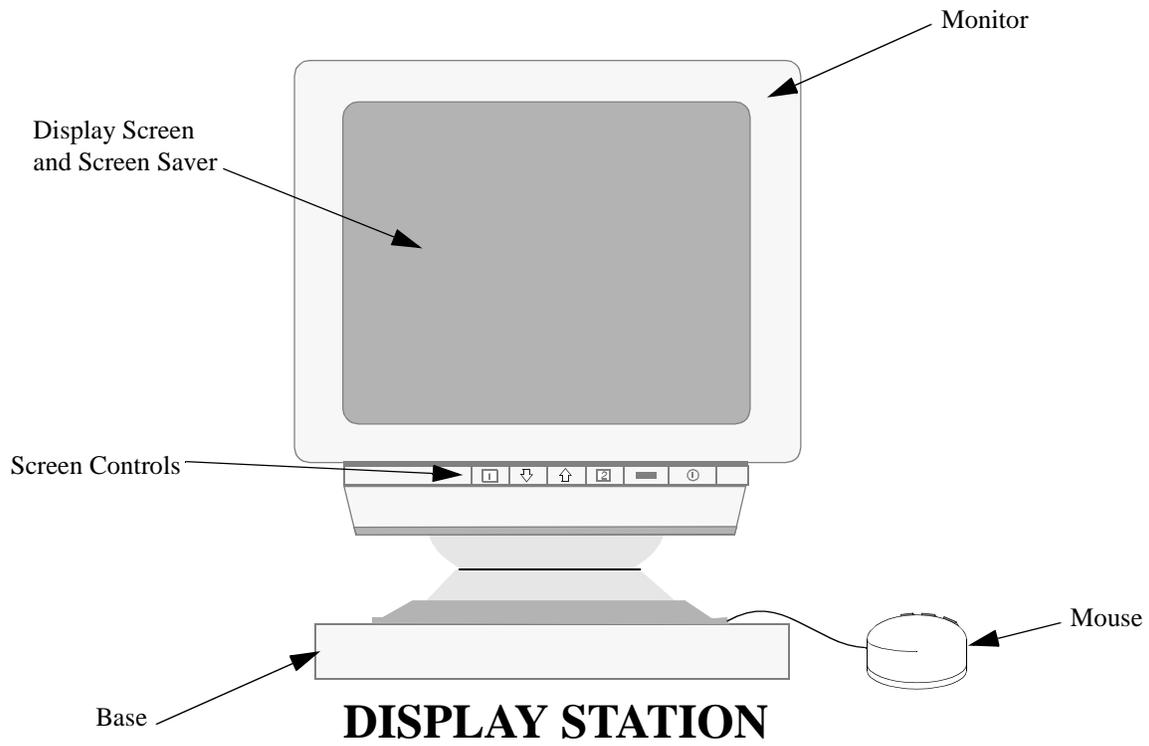
1.0 CIS INTRODUCTION

CHAPTER OBJECTIVES

Upon completion of this chapter, the user will be able to:

- Identify and know the display station components and their functions.
- Identify the differences between the navigation and soft keys.
- Navigate between and within the screen with the navigation and soft keys.
- Familiar with other frequently used keys.

1.1 USING THE DISPLAY STATION



A facilities' display stations may vary from the following illustrated example. However, the functionality of the control functions will be similar.

1.1.1 DISPLAY STATION FUNCTIONS

The CIS display station operates as an interactive window to the CIS. The display station and the monitor consists of a base, monitor and control panel.

1.1.1.1 Display Screen

The display screen is where the system applications appear on the front of the monitor.

1.1.1.1.1 Screen Saver

The display screen will darken after a set time of inactivity. This 'black out' capability provides protection and longevity to the internal imaging mechanics of the monitor. When any key is touched, the Screen Saver is deactivated. (Be aware that the software application related to the key pressed will appear on the screen.)



The Screen Saver will not be activated on the Fetal Monitor Remote Display.

1.1.1.1.2 On/Off Light and Switch

The On/Off light indicates the display station is receiving power. Unless directed by your Clinical Systems Administrator, the display station should remain "ON" at all times.

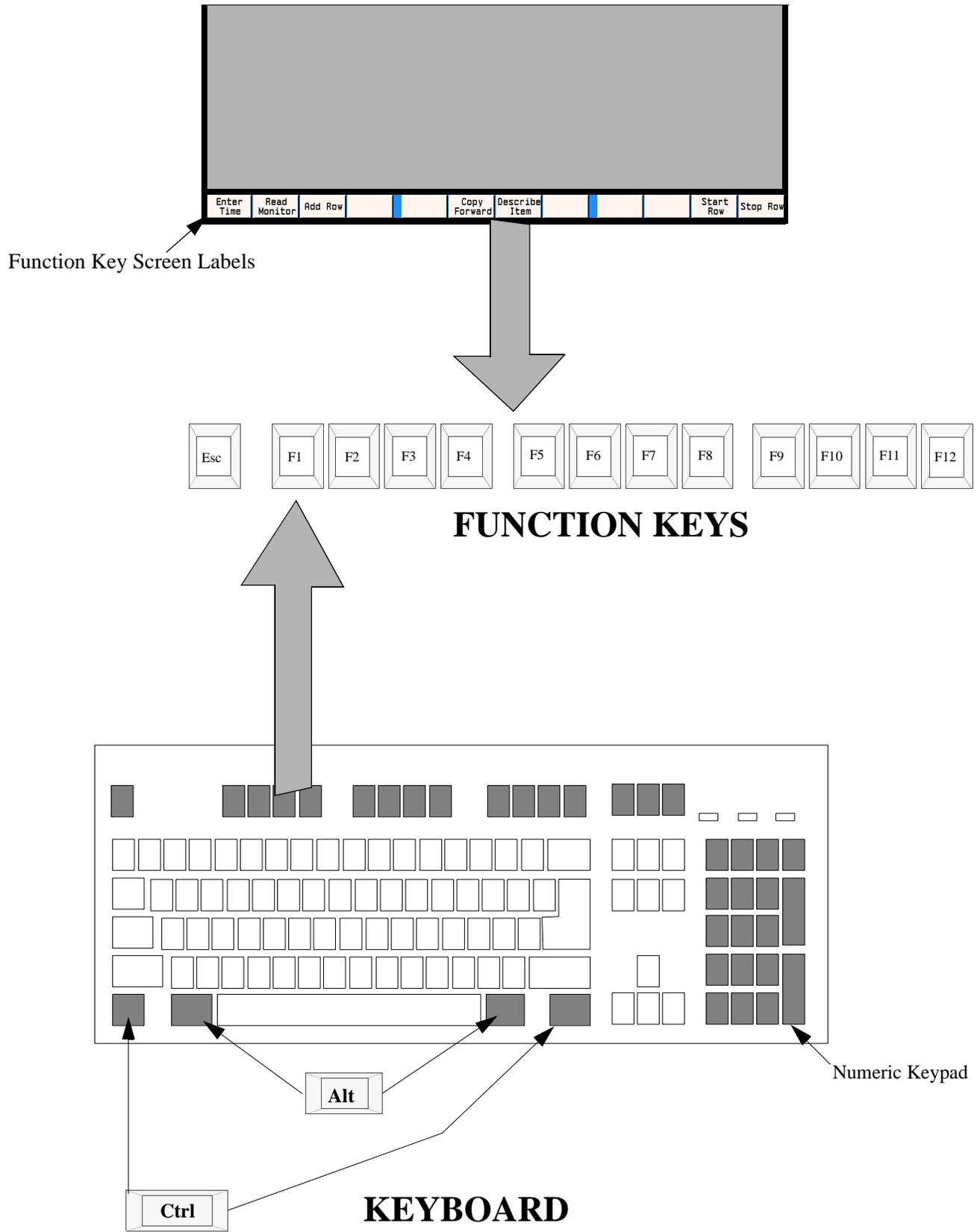
1.1.1.2 Screen Controls

The menu of screen controls for the monitor is located on the front of the monitor. To adjust screen contract, brightness, display size, etc., select the menu by pressing on the button below the "1" on the front of the screen. The Left and Right Arrow buttons will move the cursor through the available menu options and controls. To exit from the menu, press the "1" button again.



In the event of a spill on or around the CliniComp, Intl. system hardware, please notify your Clinical Systems Administrator immediately. Do not attempt to clean up spills on or around system hardware.

1.2 USING THE KEYBOARD



1.2.1 KEYBOARD FUNCTIONS

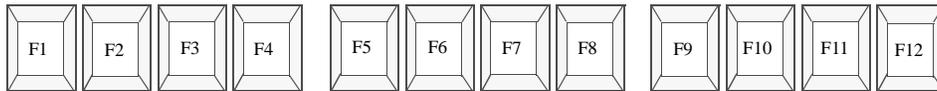
The keyboard allows you to communicate with the CIS.

1.2.1.1 Numeric Keypad

The 10-key keypad is provided for speed in numeric data entry. The 10-key numbers function the same as those numeric keys on the keyboard.

1.2.1.2 Function Keys

The top row of keys on the keyboard marked [F1] through [F12] are called "Function Keys." Each function key can perform more than one function. These different functions are labeled at the bottom of each screen.



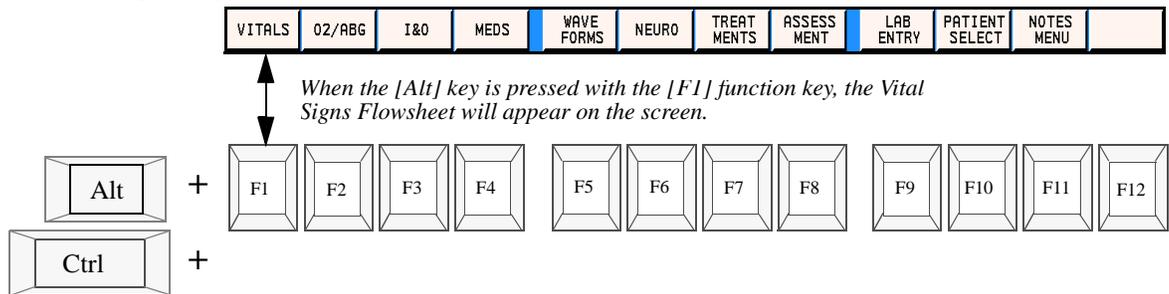
1.2.1.2.1 Function Keys Screen Labels

The function key screen labels are displayed at the bottom of the screen. These labels are arranged in sets of four to correspond to the function keys on the keyboard.



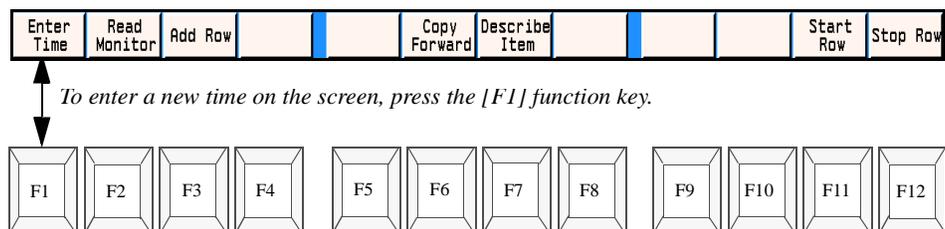
1.2.1.2.2 Navigation Soft Keys (to navigate within system)

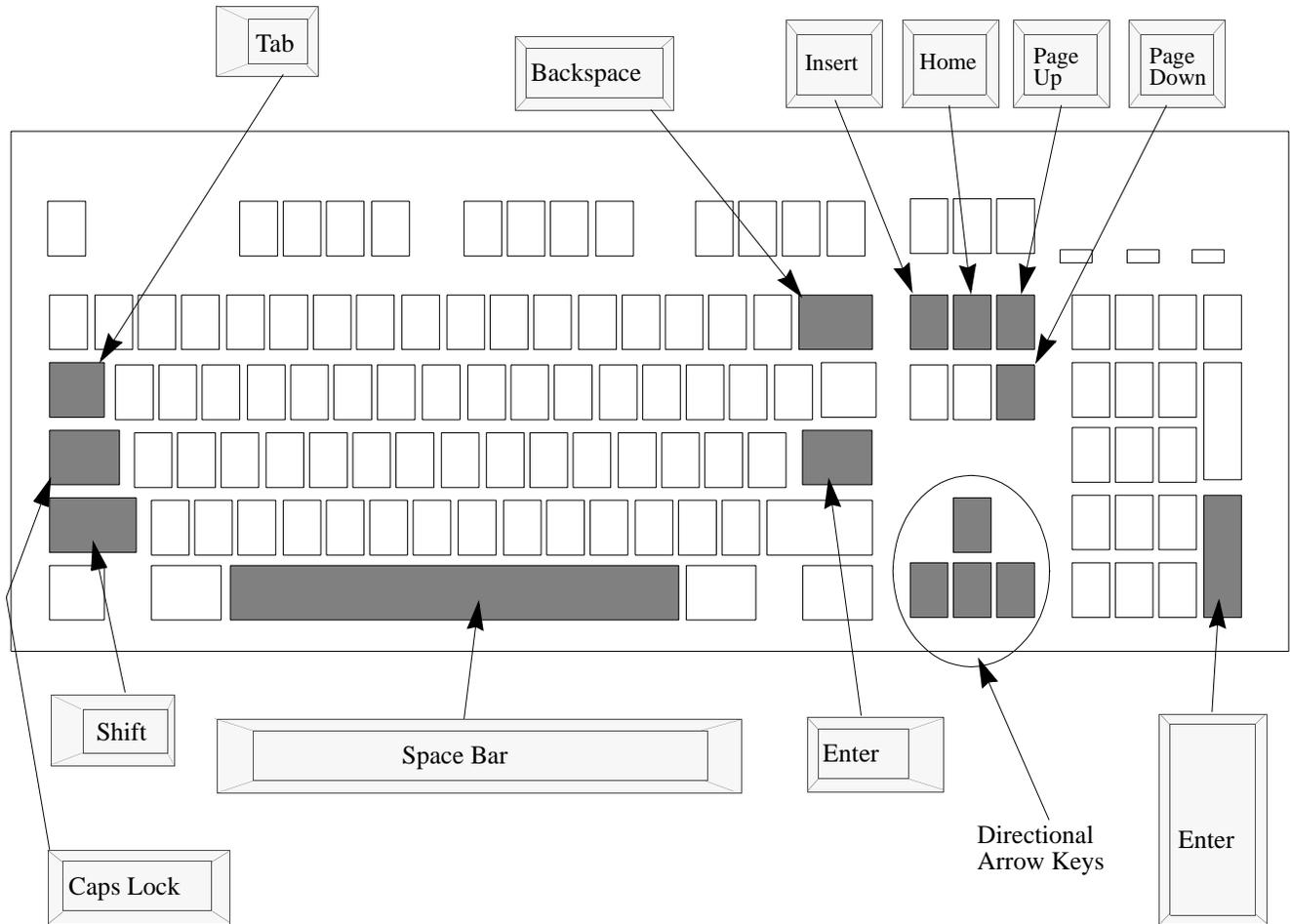
Navigating between system applications (i.e, the clinical flowsheets/screens) is performed via the Navigation keys. These keys are pre-determined and are dependent on the hospital's environment. To access a clinical flowsheet/screen, hold down the [Alt] key or [Ctrl] key and press the function key corresponding to the desired screen labeled on the screen.



1.2.1.2.3 Soft Keys (to access screen functions)

The Soft Keys are dependent on the screen selected. Soft keys are visible on every screen. To perform the desired soft key operation, press the function keys [F1 - F12] on the keyboard corresponding to the label.





KEYBOARD

1.2.1.3 Other Keys

The following is a basic description of the key functionality in the CIS Flowsheet Application. Additional functionality of these keys (i.e., the Notes Application) are addressed in the appropriate section of this manual.



[Backspace] Key

The [Backspace] key moves the cursor backwards one space at a time as it deletes a single character.

Directional [Arrow] Keys

The Directional [Arrow] keys move the cursor between rows and columns on a flowsheet.



[Enter] Key

The [Enter] key must be pressed for the data to be entered into a cell or field. Whenever you enter, edit or delete data, you must press the [Enter] key.



[Home] Key

The [Home] key typically selects the previous time interval such as day.



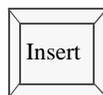
[Page Up] Key

The [Page Up] key typically selects the next time interval such as day on a screen.



[Page Down] Key

The [Page Up] key activates the Find Row function on a flowsheet.



[Insert] Key

When pressed, the [Insert] key will enter an 'X' or checkmark in the data cell.



[Tab] Key

The [Tab] key moves the cursor **forward** to the top of the next flowsheet section.



[Shift][Tab] Key

The [Shift][Tab] key moves the cursor **backward** to the bottom of the previous flowsheet section.

[Space Bar] Key

The [Space Bar] key with the [Enter] key deletes data from a cell on flowsheets.

2.0 CIS BASICS

CHAPTER OBJECTIVES

Upon completion of this chapter, the user will be able to:

- Know fundamental terminology used within the CIS
- Identify the components of the CIS screen.
- Prepare the display station for operation.
- Perform basic clinical charting operations used throughout the CIS.

2.1 SYSTEM DEFINITIONS

Audio-Visual Warning

An audio-visual warning on the CIS is an indication (e.g., audible, reverse video, visual indicator, etc.) that charted or interfaced data is out of a pre-set range.

Charting in The Future

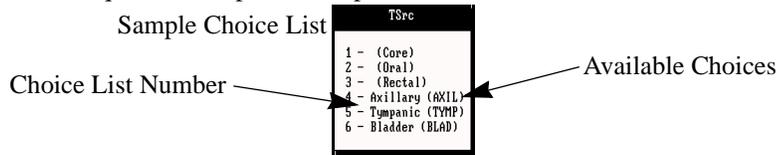
Charting in the future is limited to a configured amount of time past the current time. For example, if charting is restricted to two hours past the current time and the current time is 10:09, then the following prompt will appear when data entry is attempted at any time after 12:09 on the same day.

Time is Too Far in the Future
<Press Any Key To Continue>

These functions are allowed past the restriction time: Enter Time, D/C, New Order, Add Row and Start/Stop Row.

Choice Lists

A choice list is a listing of available entry choices, pre-configured to a specific row or field. A choice list window will appear on the screen when the cursor highlights the configured row or field. Choice lists facilitate quick data input and helps to standardize documentation.



Compound Choice Lists in Orders

Based on the initial choice from an order choice list, a second list of choices may be configured to appear called compound choice lists. Compound choice lists are used when ordering. 'Comment' choice lists can be configured for each new name on the order choice list.

'Name' choice list

Name
 Comment
 Start Time
 D/C Time
 <Tab> - Next Field
 <Shift+Tab> - Previous Field

'Comment' different choice lists

Name
 Comment
 Start Time
 D/C Time
 <Tab> - Next Field
 <Shift+Tab> - Previous Field

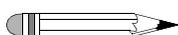
0 - Activity Intolerance 1 - Airway Clearance, Ineffective 2 - Anxiety 3 - Body Temperature, Alt. in 4 - Bowel Elimination, Alt. in: Areflexic 5 - Bowel Elimination, Alt. in: Constipation 6 - Bowel Elimination, Alt. in: Diarrhea 7 - Bowel Elimination, Alt. in: Incontinence 8 - Bowel Elimination, Alt. in: Reflexic 9 - Bowel Elimination, Alt. in: Uninhibited 10 - Breastfeeding, Ineffective	21 - Fluid Volume Excess 22 - Gas Exchange, Impaired 23 - Grieving (PT/Family/S.O.) 24 - Growth and Development, Alt. in 25 - Health Maintenance, Alt. in: 26 - Home Maintenance Management, Impa 27 - Hopelessness 28 - Impaired Memory Deficit (REHAB) 29 - Infection Transmission, Potential 30 - Infection, Potential for 31 - Injury, Potential for
--	--

Name
 Comment
 Start Time
 D/C Time
 <Tab> - Next Field
 <Shift+Tab> - Previous Field

0 - R/T-Food Intolerance 1 - R/T-Increased Peristalsis 2 - R/T-Intestinal Inflammatory Process 3 - R/T-Medication 4 - R/T-Opportunistic Bowel Inf 5 - R/T-Tube Feeding Intoleranc	0 - R/T-Spinal Cord Infarct 1 - R/T-Spinal Cord Injury 2 - R/T-Spinal Cord Tumor
--	--

Configuration

The CIS screens and reports are arranged to best emulate the existing hospital paper flowsheets. The arrangement of the system's rows, choice lists, displayed parameters, sections and reports at the hospital is referred to as a hospital's configuration.



The pencil symbol will indicate those features that are configurable.

Cursor

The cursor is the position indicator for data entry or editing. Depending upon the CIS application, the cursor will appear as one of the following:

	= Box
	= Bar (with reverse video indicates selected data)

Data Cells



A data cell is the intersection of a row and time column on a flowsheet. Patient data is charted in the data cell. If the data cell appears as a gray box, then data has been removed. If the data in the data cell appears in reverse video, then the data has been modified.

INTERVENTIONS (*)					
Circulation Check					N
Restraints			A		
Anti-Embolism Stockings			OFF		
EKG/Chest Xray	E		*	E	
Thermal Device			L		
Specialty Bed					
Orthopedic Appliance					RR

Data has been removed.

Data has been changed.

Default



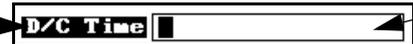
A preset value. The CIS uses default values (e.g., current time) as a convenience. Typically, these preset values are predefined by the hospital and can be manually changed.

Discharge Unit

The CIS 'DISCH' unit is where a patient's chart is transferred when a patient is discharged from the hospital. A patient's chart is automatically sent to this unit when the discharge function is performed. The patient's record will remain in discharge for a hospital defined duration before being archived.

Field

A field is the space in a note or an entry window (e.g., new row window) where patient data is entered. The following is an example of a D/C field.

Field Prompt  Field

Row

A row is the horizontal display of parameters on a flowsheet. A flowsheet row can be pre-configured on the flowsheet or added by the user.

Row Label 

INTERVENTIONS (*)					
Circulation Check					N
Restraints			A		
Anti-Embolism Stockings			OFF		
EKG/Chest Xray	E		*	E	
Thermal Device			L		
Specialty Bed					
Orthopedic Appliance					RR

Message

A message is an automatic system statement generated by a specific user action, which does NOT require user acknowledgment (e.g., warning).

No Bed

'No Bed' is a vacant unit on the CIS. Typically, this unit is used as a "Holding" unit.

Prompt

A prompt is an automatic system question generated from a specific user action, which does require user acknowledgment. For example, if a user fails to enter in their correct user ID code, then the following prompt will appear requesting a response from the user.

```
Sorry, you DO NOT have permission for this operation.
Would you like to try again? (y/n)
```

Refresh the Screen

Refreshing the screen is synonymous with updating the screen. The user selects the same screen again to update the screen to the current time with new data (e.g., plotted parameters).

Reverse Video

Reverse video is white text appearing in a black background.

REVERSE VIDEO

Schedule Markers

Schedule markers appear as outlined data cells on the flowsheets and represent a delivery schedule. Schedule markers may be set from a pre-configured choice list or in free text by day, hour or minutes. The assigned frequency will appear next to the row label.

SCHEDULED MEDICATIONS			00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15
DIGOXIN INJ -IU	0.25MG QAM																	
CARAFATE TAB -GT	1GM Q6																	
>CLAMP 45 MIN AFTER DOSE																		
MYCOSTATIN ORAL SOLN -PO	5CC QID																	
>TO MOUTH																		

Scrolling Indicator

The scrolling indicator visually displays the location of the cursor within a screen, choice list, etc.

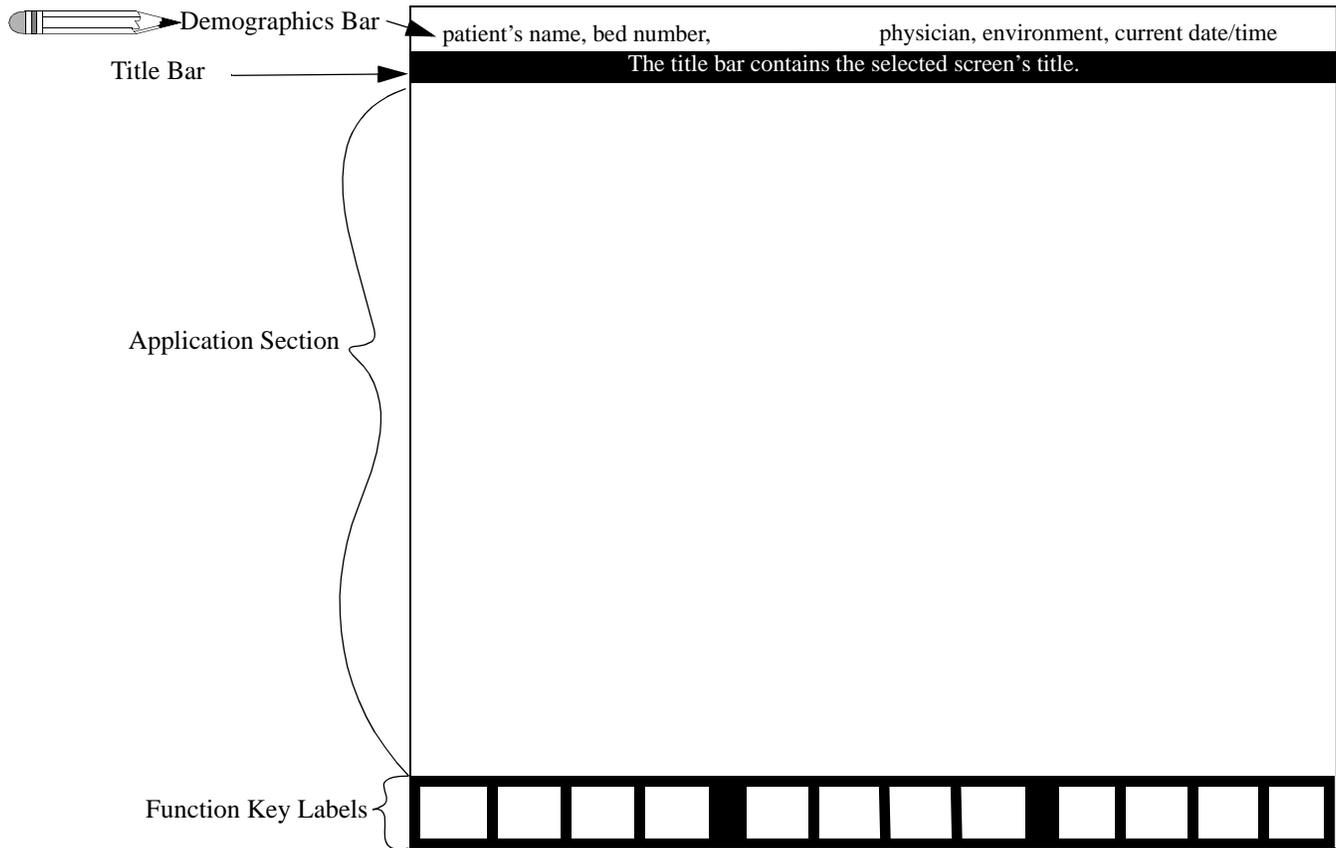
USER-DEFINED TREATMENTS		- MORE -					Time: 1600 23 Jun 93				
		1200	1300	1400	1500	1600					
Check Diet							Check Diet				
With Meals							Vital Signs				
Vital Signs	Q8						Prep Groins				
Prep Groins	X1						NPO Except Meds				
NPO Except Meds	QSHIFT						Consent				
NPO Except Meds ___hr on___							Insure Consent Signed and Witnessed				
Consent	X1						Void Prior to Sending				
Insure Consent Signed and Witnessed							To Cath Lab				
Void Prior to Sending	X1						To Cath Lab on Call				
To Cath Lab							C Chart				
To Cath Lab on Call	X1						Meds as Ordered				
C Chart							On Order Sheet DA				
Meds as Ordered	X1										
On Order Sheet DA											

Indicator

'More' indicates additional rows exist than are shown.

Screen Layout

The data on each CIS screen is arranged into four (4) parts. They are the Demographics Bar, Title Bar, Application Section and Function Key Screen Labels. The following graphic illustrates the location of these parts.



Section

A section on a flowsheet or note differentiates common charting parameters. For example, the Medications Flowsheet sections can be separated by PRN, Scheduled and STAT medication frequencies.

Starred Sections

A star (*) next to a flowsheet section title indicates the section contains charted patient data.

NUTRITION STATUS (*)

DIAGNOSTIC PROCEDURES (NONE)

— indicates there are no row items in that section.

Simultaneous Charting

The system will inform the user when the following CIS cases of simultaneous charting occur:

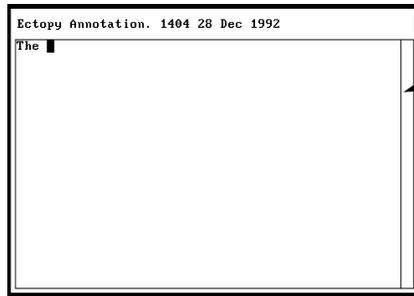
- Reviewing Patient Data - New data stored on by another user at a different CIS display station will automatically appear when changing the time columns.
- Charting Patient Data - New data stored on by another user at a different CIS display station will generate a warning when attempting to change time columns.

```

WARNING: The Patient Database Has Been Modified!
You Must Store Before Proceeding
<Press Any Key To Continue>
    
```

Text Window

A text window is an area where free text is entered.

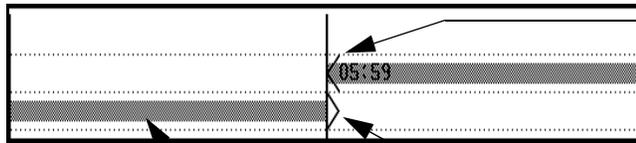


A scrolling indicator will appear for large text entries.

Time Bars



A time bar with an arrowhead indicates start and/or stop times for a flowsheet row. In addition, the arrowhead can be configured to appear in the data cell where the start or D/C time occurred.



A Right Arrow indicates Stop or D/C Time

Time Bar

Left Arrow indicates Start Time



If no data is charted at the same time as the DC time, then only the arrowhead with the DC Time will be displayed.

Time Brackets

Time brackets are enclosure marks indicating the start time or stop time for a flowsheet row.



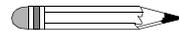
Start Time Bracket

Stop Time Bracket

Time Column

A vertical time column on a flowsheet or summary screen represents a period of time (e.g., minute, hour, day).

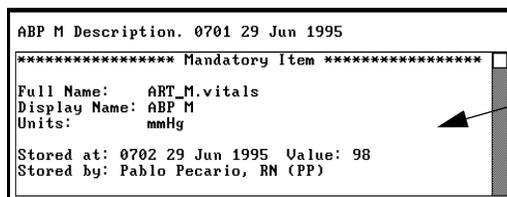
Unstored Data



Data not-yet-stored is referred to as unstored data. Unstored data entered on a flowsheet can be displayed as underlined until stored.

Window

The CIS uses pop-up boxes or windows to display patient information or parameters.



Describe Item Window

2.2 TO BEGIN

THE PATIENT CONTROL SCREEN

When selected, the patient's name will appear.

Cursor Row

Tom Axlerod I-1 Phy: Dr. Brookstone (Env DOD-ICU) 13:55 Apr 17, 98
 PATIENT CONTROL

BED	Name	MRN	Physician
1. I-1	Tom Axlerod	64144677	Dr. Brookstone
2. I-2			
3. I-3			
4. I-4			
5. I-5			

UNITS:
 100.DISCH 101.NOBED 102.DOD-ICU 103.DOD-PICU 104.DOD-NICU 105.DOD-OR 106.DOD-PACU-SDS
 107.DOD-MEDSURG 108.DOD-PSYCH 109.DOD-ED 110.DOD-LND 111.DOD-NB 112.TEST

Select bed/unit: ■ Tom Axlerod selected.

ENVIRONMENT: DOD-ICU

Change Env Admissn Data Find Patient Admit Discharg Transfer Print etc... CQL LOCK

When selected, the patient's name will appear next to the cursor.

The selected unit will be highlighted as reverse video.



The Multiple Stays window will appear on the screen for patients with more than one hospital visit. The cursor will default to the Current Stay.

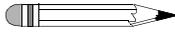
1. CHECK THE DISPLAY STATION

- The display station should be “ON” at all times.



The display station’s brightness and contrast are pre-set and should not require ANY adjustment.

2. VERIFY THE CURRENT PATIENT; OR



- The Patient Control Screen can be configured to default to the unit and bed where the display station is located. However, the patient should be verified BEFORE any charting.

Tom Axlerod I-1 Phy: Dr. Brookstone (Env DOD-ICU) 13:55 Apr 17, 98
 PATIENT CONTROL

BED	Name	MRN	Physician
1. I-1	Tom Axlerod	64144677	Dr. Brookstone
2. I-2			
3. I-3			
4. I-4			
5. I-5			

UNITS:
 100.DISCH 101.NOBED 102.DOD-ICU 103.DOD-PICU 104.DOD-NICU 105.DOD-OR 106.DOD-PACU-SDS
 107.DOD-MEDSURG 108.DOD-PSYCH 109.DOD-ED 110.DOD-LND 111.DOD-NB 112.TEST

Select bed/unit: ■ Tom Axlerod selected.

ENVIRONMENT: DOD-ICU

Change Env	Admissn Data	Find Patient	Admit	Discharg	Transfer	Print etc...	CQL	LOCK
------------	--------------	--------------	-------	----------	----------	--------------	-----	------

3. SELECT A PATIENT

- Move the cursor to highlight the desired unit and patient with the Arrow keys.
- Press the [Enter] key when the correct unit and patient are highlighted.
- OR
- Type in the corresponding number(s) to the desired unit and bed.
- Press the [Enter] key after each entry.

2.3 USING THE BASICS

How to Unlock the Display Station Screen

When the display station lock feature is activated, the following prompt will appear on the screen.



If you Wish to Unlock the Screen Please enter ID code:

1. Enter in your ID code.
2. Press the [Enter] key.
 - The last screen or flowsheet prior to inactivity will reappear.

How to Change Environments

Changing environments allows the user to access the screens for a unit where the patient was previously.

1. Press the “Change Env” soft key <F1>.
 - A window with configured environments will automatically appear.
2. Highlight the desired environment with the [Up Arrow] or [Down Arrow] keys.
3. Press the [Enter] key.

How to Enter Data

1. Select the desired patient and screen.
2. Move the cursor to highlight the desired data cell or field with the Arrow keys.
3. Data can be entered in free text, by a choice list number, by pressing a soft key (e.g., Read Monitor soft key) or by a special key.
4. Press the [Enter] key after each entry of data into a data cell or field.

How to Store Data



For data to become part of the permanent patient record, it must be stored with a user’s ID Code. The “Store” soft key <F8> will appear on every screen when data has been entered or modified.

1. Press the “Store” soft key <F8>.
 - The following prompt will appear.

If you Wish to Save Data For (Patient Name) Please enter ID code:
 - Be sure to check the patient name.
2. Type in your ID Code at the prompt.
 - The screen will not display your password, but will echo your input with asterisks (i.e. “*****”).
3. Press the [Enter] key.

If your ID code is incorrectly entered, the following prompt will appear.

**Sorry, you DO NOT have permission for this operation.
Would you like to try again? (y/n)**

- Type in ‘Y’ for Yes to try again.
- Press the [Enter] key.

How to Use Choice Lists

1. Type in the item's corresponding choice list number.



Only the Plus (+) and Minus (-) signs on the keypad will perform the following functions.

- For multiple choice list entries, the [Keypad Plus] key and the [Keypad Minus] key can be pressed. For example, if you pressed 2 + 3 + 4 -, then the items 2, 3 and 4 on the choice list would be entered automatically, and the cursor would be moved to the next field.

+	= Combines choice list items.
-	= Inserts last choice list item and moves cursor to next field.

- Numeric entries can be combined with free text entries. For example, if you typed 2 + BGL, then item 2 on the choice list and 'BGL' would appear in the data cell or field.
- Press the [Space Bar] key before entering a free text entry that begins with a number on a flowsheet.

2. Press the [Enter] key.

Hiding or Showing a Choice List Window



This function will change dependent upon the soft key selected.

Flowsheet choice lists may cover up certain sections of the flowsheet during data entry.

- The "Hide Choices" soft key <F4> temporarily removes the choice list window from the screen for that flowsheet row.
- The "Show Choices" soft key <F4> shows the choice list window on the screen for that flowsheet row.

How to Cancel an Entry

All data entries can be cancelled prior to pressing the "Store" soft key <F8> by pressing the [Space Bar] key once OR the "Cancel," "Cancel All" or "Delete Row" soft keys, if available.

How to Edit Stored Data

1. Move the cursor to highlight the desired data cell.

Activity		L	B		R		L			1		Activity
R O M			A		A		A					R O M
Suction										ET	ET	Suction
Deep Breathe/IS/R.Tx			D		D		D					Suction
Trach Care												1 - ET tube/mouth (ET)
Peripheral IV												2 - Oropharynx (OP)
Central IV			S		S		T					3 - Nose (N)
Arterial Line												4 - Mouth/nose (MN)
Dressing Check/Change			Ck		Ck		Cg					5 - Stomach (S)
Hygiene		S		S		O				S		

2. Type in the new data.
3. Press the [Enter] key.
 - The Edit prompt will appear.

Are you sure you want to edit this item? Y, N



The edit prompt will only appear for stored data.

4. Type in either 'Y' for Yes or 'N' for No.



*If you type in 'N' for No, your edits will **NOT** be recorded on the permanent patient chart.*

5. Press the [Enter] key.
 - The edited data will appear in reverse video.

How to Remove Stored Data

1. Move the cursor to highlight the desired data cell.
2. Press the [Space Bar] key once.
3. Press the [Enter] key.
 - The Edit prompt will appear.
4. Type in 'Y' for Yes.
 - If you type in 'Y' for Yes, the complete entry will be removed from the field.
5. Press the [Enter] key.
 - The data cell will appear as a gray box.

How to Overwrite the Store Prompt

If unstored data has been charted on a screen, yet you wish to leave the screen without storing, perform the following steps.

1. Select the desired CIS screen key once.
 - Choose a soft key labeled on the bottom of the screen when the [Alt] key or [Ctrl] key is pressed.
 - The Store prompt will appear to indicate screen data has not been stored.
2. Select the same CIS screen a second time.
 - Selecting the CIS screen a second time will 'overwrite' the Store prompt.
 - The selected CIS screen will appear on the screen.



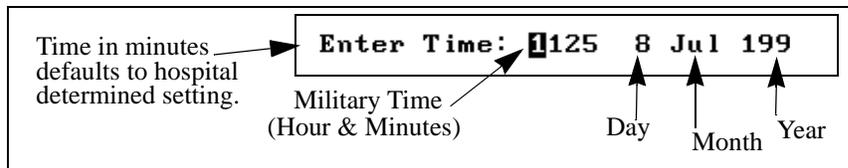
*Should the Store prompt be 'overwritten,' all data **charted but not stored** will be lost.*

How to Enter/Change the Time



The "Enter Time" soft key <F1> is consistent throughout the system.

1. Press the "Enter Time" soft key <F1>.
 - The time defaults to a hospital-specified minute resolution.



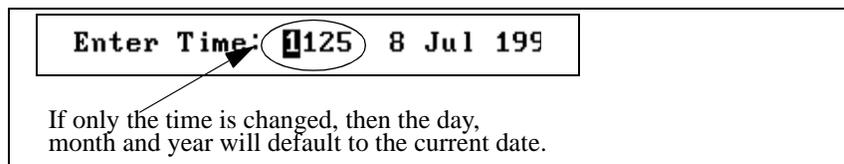
Time may be entered in one minute resolution. Each application may have a default time resolution for presetting time or changing time by that resolution. For example, 1, 5, 15 or 60 minute resolutions may be used.

2. Enter the desired date and time.

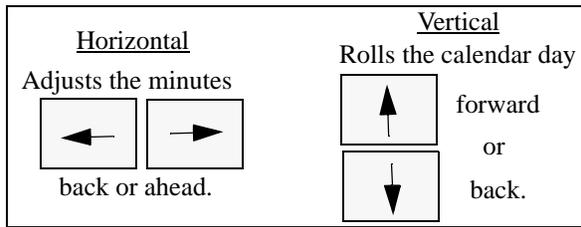


The cursor is in the overwrite mode.

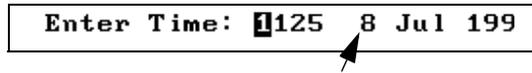
- The time, day, month and year will default to current time, day, month and year unless it is **manually** changed.



- Time and date can be changed using the keypad or the Arrow keys.



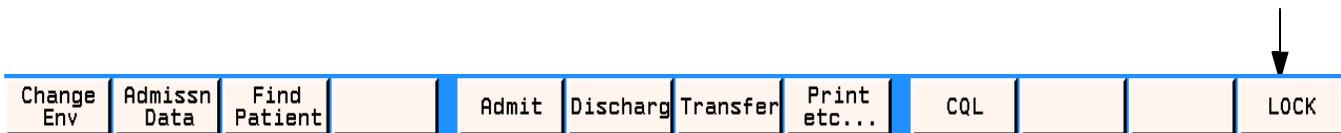
- The [Minus] key at the top of the keyboard can be used to subtract days. For example, if 1125 -5 is entered, 1125 3 Jul 199X will appear.



- The month can be entered numerically (e.g., 8 for August) and the year can be entered in the short year format (e.g., 99 for 1999).

3. Press the [Enter] key once the desired time is entered.

How to Activate the Display Station Lock Out



Access to the CIS can be prevented via a lock-out feature. This feature can be manually activated by the user or configured to automatically lock after a predetermined period of inactivity. Once the lock out feature is activated, the screen will become black and display only the CliniComp, Intl. logo and a window for entering in a user’s ID code.

If the display station is logged-on by a user different than the previous user, then the screen will return to the Patient Control Screen. Any data not stored when the display station was logged-off will be lost. However, if the display station is logged-on by the original user that logged-off the display, the screen will return to the screen selected prior to being logged-off. To activate the lock out feature, perform the following steps.

- Select the Patient Control Screen [Alt] [F10].
- Press the “Lock” soft key <F12>.
 - The CliniComp, Intl. logo will appear on a black background.

How to Unlock a Display Station

To unlock a display station, perform the following steps.

- Type in your ID code.
- Press the [Enter] key.

3.0 CIS CHARTING FUNCTIONS

CHAPTER OBJECTIVE:

Upon completion of this chapter, the user will be provided with sufficient skills to perform the following system functions:

- General Administrative Functions (Section 3.1 - GENERAL ADMINISTRATIVE FUNCTIONS)
 - Admitting, Transferring, Discharging, Printing
- General Order Administration (Section 3.2 - ORDER ADMINISTRATION FUNCTIONS)
 - Entering individual or standing orders
- General Flowsheet Functions (Section 3.3 - GENERAL FLOWSHEET FUNCTIONS)
General features are available on all screens that use the flowsheet format such as Vital Signs, Oxygen Therapy & Arterial Blood Gases, Intake and Output, Medications, Neurological Assessments, Treatment Assessments, Laboratory, Respiratory Therapy, etc.
- Special Flowsheet Functions (Section 3.4 - SPECIAL FLOWSHEET FUNCTIONS)
 - Charting Vital Signs Data
 - Documenting Fluid Balances
 - Documenting Medications
 - Charting Critical Paths
 - Charting on the Procedural Flowsheet
 - Documenting Assessments and Notes



All screen configurations are determined by the hospital and may vary from this manual's screen graphics.



*Charting can be done from any display station, but verify the correct patient is selected **BEFORE** charting.*

3.1 GENERAL ADMINISTRATIVE FUNCTIONS

THE PATIENT CONTROL SCREEN

The demographic bar can be configured per environment to display any database item.



Demographic columns are configurable per unit.

Tom Axlerod		I-1	Phy: Dr. Brookstone	(Env DOD-ICU)	13:55 Apr 17, 98
P A T I E N T C O N T R O L					
BED	Name	MRN	Physician		
1. I-1	Tom Axlerod	64144677	Dr. Brookstone		
2. I-2					
3. I-3					
4. I-4					
5. I-5					

UNITS:
 100.DISCH 101.NOBED **102.DOD-ICU** 103.DOD-PICU 104.DOD-NICU 105.DOD-OR 106.DOD-PACU-SDS
 107.DOD-MEDSURG 108.DOD-PSYCH 109.DOD-ED 110.DOD-LND 111.DOD-NB 112.TEST

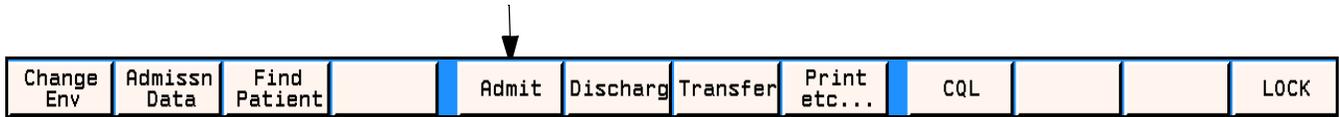
Select bed/unit: Tom Axlerod selected.

ENVIRONMENT: DOD-ICU

Change Env	Admissn Data	Find Patient		Admit	Discharg	Transfer	Print etc...	CQL		LOCK
------------	--------------	--------------	--	-------	----------	----------	--------------	-----	--	------

3.1.1 PATIENT ADMISSION FUNCTIONS

3.1.1.1 Admitting a New Patient on the CIS



To admit a new patient into the CIS, perform the following steps.

1. Select the Patient Control Screen [Alt] [F10].
2. Press the “Admit” soft key <F5>.
 - The Admit prompt will appear above the soft keys.
3. Select the desired unit and empty bed.
4. Press the [Enter] key.
 - The Admission Data window will appear.
5. Type in the requested information.



The system will only allow one current stay per patient identifier number. Therefore, an existing patient with the same patient identifier number must be discharged before being admitted as a new, current stay.

- When entering a patient’s identifier number, the system will automatically check on-line an archived patients for previous stays.
 - If the patient has been previously admitted with the same patient identifier number, the patient’s name will automatically appear on the Admit Screen.
 - If the patient identifier number exists on the system and the patient has been discharged, then a warning message will appear and the patient will be admitted with a stay.

WARNING: This MED. RECORD NUMBER is taken by a discharged patient in DISCH named ISABEL, CAREN
 Creating new stay as the Current Stay!
 <Press Any Key To Continue>

- If the patient identifier number exists on the system and the patient has not been discharged, then an error message will appear and a new stay will not be admitted.

ERROR: This MED. RECORD NUMBER is taken by a patient in NOBED named ISABEL, CAREN
 To Create a new stay for this MED. RECORD NUMBER, the Current Stay must be discharged!
 <Press Any Key To Continue>



The patient identifier number cannot be edited if the new number will be the same number as an active patient (i.e., not in Discharge).

- When the patient identifier number is changed on a current stay, then all previous stays will be transferred automatically to the Discharge Environment with the old patient identifier number. (The most recent previous stay will appear as the current stay in the DISCH environment.)
6. Press the [Enter] key after each entry.
 7. When finished with admitting the patient, press the “Store” soft key <F8>.

THE PATIENT CONTROL SCREEN WITH THE 'MULTIPLE STAYS' WINDOW

A **previous stay** is a patient's past visit to the hospital.

Previous Stay charts are 'Review Only.'

A **current stay** is defined as the stay (or record) with the most recent Admit Time.

BETHANY, FRANCINE (Review) Phy: ARCCROSS (Env ANTE) 10:00 Jul 25, 95
P A T I E N T C O N T R O L

BED	Name	MRM	Physician	Admit Date
1. LD-PREP1	Norris, Annie	20-17-90	Mardex, Mark	09/02/92
2. LD-PREP2	Newman, Tracy	66-78-54	Harrison, Kenneth	06/29/95
3. L&D-BR1				
4. L&D-BR2	Bethany, Francine	44-66-88	Arcross, Robert	08/30/93
5. L&D	Bethany, Francine has multiple active stays. Please select one.			
6. L&D				
7. L&D				
8. L&D	Current Stay : BETHANY, FRANCINE	Env: LDRP	Admit Time: 1201 30 Aug 1993	
9. L&D	Previous Stay: BETHANY, FRANCINE	Env: ANTE	Admit Time: 2047 29 Aug 1993	
10. L&D	Previous Stay: BETHANY, FRANCINE	Env: ANTE	Admit Time: 1538 26 Aug 1993	
11. L&D-BR3	Benn, Diane	12-30-45	Stilman, James	04/28/94
12. L&D-BR10	Benn, Diane	20-34-80	Craig, Dean	04/27/94
13. L&D-BR11				
14. L&D-BR12	Bentley, Martha	20-23-90	Stout, Micheal	01/16/95

UNITS:
 100.DISCH 101.NOBED 102.ED 103.SICU 104.CCU 105.MICU 106.NEURO 107.PRE-WAIT 108.ANESTHESIA
 109.PRE-OP 110.OR 111.PACU 112.STEPDOWN-MED-SURG 113.ORTHO 114.TRIAGE-UC 115.PERINATAL **116.L&D**
 117.NEWBORN-I 118.LDR 119.PSCU 120.WC-OR 121.NEWBORN-II 122.NICU 123.PEDS 124.PICU 125.ANTE
 126.RADIOLOGY 127.TEST

Select bed/unit:
 ENVIRONMENT: ANTE

Change Env	Admissn Data	Find Patient	Sign On	Admit	Discharg	Transfer	Print etc...	CQL			LOCK
------------	--------------	--------------	---------	-------	----------	----------	--------------	-----	--	--	------

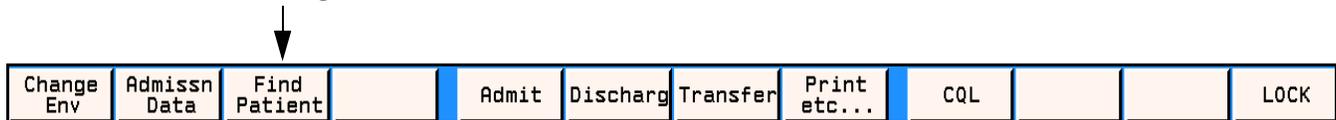
The Multiple Stays window will appear below the selected patient's name.

3.1.1.2 Selecting a Patient’s Chart from a Previous Stay

A **Previous Stay** is a patient’s past visit to the hospital. Previous Stay charts are REVIEW ONLY. A **Current Stay** is defined as the stay (or record) with the most recent Admit Time. A patient may be admitted into the system with the same patient identifier number (e.g., Medical Record Number, History Number, SSN) as a current stay provided all former stays are discharged. When the patient is selected, a listing of multiple stays may be reviewed on the Patient Control Screen [Alt][F10]. To review any one of patient’s multiple stays, perform the following steps.

1. Select the Patient Control Screen [Alt][F10].
2. Select the desired unit and patient.
 - The Multiple Stays window will appear on the screen for patients with multiple stays.
3. Move the cursor to highlight the desired Stay chart.
 - Press any key to remove the window and not select a chart.
4. Press the [Enter] key.
 - If the current stay was selected, the chart is available for charting.
 - If a previous stay was selected, the chart is available for review only.
 - For previous stays, the environment will change to the last unit the patient was in before being discharged. (The ‘NoBed’ environment will appear at the top of the screen if the last unit is unknown.)

3.1.1.3 Searching for a Patient Chart



On-line patient records can be searched and selected for charting of patient data. To locate a patient record, perform the following steps.

1. Press the “Find Patient” soft key <F3>.
 - The Find Patient window will appear.

Name	MRN	Billing Num	Physician	Unit	Bed
Bentley, Martha	20-23-90	546465	Stout, Micheal	L&D	L&D-BR12
Grady, Mark	00-11-33	540323	Wong, Mark	STEPDOWN-MED-SU	S-MED-2
Mandra, James	23-98-01	233927	Myers, Caroline	PEDS	PEDS-5
Marcus, Will	11-23-90	009988	Green, Tom	ORTHO	ORTHO-3
Marks, John	24-56-43	155283	Ross, Mathew	CCU	CCU-2
Newman, Tracy	66-78-54	346543	Harrison, Kenneth	L&D	LD-PREP2
Valentine, Mark	69-10-15	140311	Ruby, John	ED	ER-5
Willis, Samantha	53-56-46	140104	Catter, Nancy	ANTE	ANTE-1

Search Mode: **Name** MRN Billing Num Physician

Enter Search String: ma

2. Highlight the desired search mode with the [Left Arrow], [Right Arrow] or [Tab] keys.
3. Type in the first few characters of the desired patient record.
 - The search string is not case specific (i.e., lower case or upper case).
 - The system will display all available patient records matching the search string.
4. Highlight the desired patient record with the [Up Arrow] and [Down Arrow] keys.
5. Press the [Enter] key.

THE PATIENT CONTROL SCREEN WITH THE FIND PATIENT WINDOW

Indicates an archived chart Discharge Date and Time

Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 09:47 Aug 8, 97

P A T I E N T C O N T R O L

BED	Name	MRN	Physician
1. 300-1	Kingsford, Larry	50357856	Dr. Brookstone
2. 300-2	Tran Ho Li	50340514	Dr. Brookstone
3. 300-3	Smith, Lily	23272721	Jones

Name	MRN	Billing Num	Physician	Unit	Bed
Clark, Mary	47586968	38573	Silverman, Glenn	ED	ED-9
Gray, Mary	44849944	437589	N/A	ARCHIVED	1301 28 Jul
Gray, Mary	44849944	437589	N/A	ARCHIVED	1305 22 Jul
Henry, Mary Ann	64198660	64198660	Dr. Brookstone	LDR	306-1
Rossini, Rosemary	83911880	83911880	Dr. Brookstone	DOD-ED	ED-1

Search Mode: Name MRN Billing Num Physician

Enter Search String:

UNITS:

100.DISCH 101.NOBED **102.SICU** 103.CCU 104.ORTHO 105.PEDS 106.PSYCH 107.ANTE 108.LDR 109.LDRP
 110.NICU 111.NEWBORN 112.SDS/OR 113.PACU 114.ED 115.UCLA 116.OUT-PATIENT 117.SSHC 118.DOD-ICU
 119.DOD-PICU 120.DOD-NICU 121.DOD-MEDSURG 122.DOD-PSYCH 123.DOD-ED 124.DOD-L&D 125.DOD-PP
 126.DOD-NB 127.DOD-OR 128.CPA 129.TEST

Select bed/unit:

ENVIRONMENT: ICU

Cancel
Archive Info

→ To review the selected record's archive information before unarchiving.

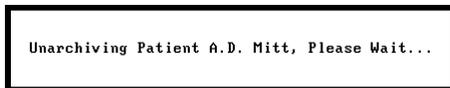
3.1.1.4 Unarchiving a Patient Chart



Change Env	Admissn Data	Find Patient		Admit	Discharg	Transfer	Print etc...	CQL			LOCK
------------	--------------	--------------	--	-------	----------	----------	--------------	-----	--	--	------

On-line patient records can be searched and selected for charting of patient data. To locate a patient record, perform the following steps.

1. Press the “Find Patient” soft key <F3>.
 - The Find Patient window will appear.
2. Highlight the desired search mode with the [Left Arrow], [Right Arrow] or [Tab] keys.
3. Type in the first few characters of the desired patient record.
 - The search string is not case specific (i.e., lower case or upper case).
 - The system will display all available patient records matching the search string.
4. Highlight the desired patient record with the [Up Arrow] and [Down Arrow] keys.
 - Recently archived patients will have “ARCHIVED” within the Unit column in the Find Patient window.
 - To review the selected record’s archive information before unarchiving, press the “Archive Info” soft key <F7>.
5. Press the [Enter] key.
 - The selected patient chart is now selected for review or charting.
 - If the patient is archived, the Unarchive Permission prompt will appear.
6. Type in your ID code.
7. Press the [Enter] key.
 - The Unarchive Status message will appear while the selected record is being unarchived.



- Once the record is unarchived, the Unarchived message will appear.
8. Press the [Enter] key.
 - The unarchived patient chart is selected and replaced in the last unit before the patient was discharged from the system.

THE ADMISSION DATA SCREEN

Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 09:37 Aug 8, 97

Note Time: 0808 6 Jul 1997
Topic:
Mode: Entry

Admission Information

Name: Admit Date:
FMP-SSN: Hospital Register Number:
Sex: Race:
Rank: Occupation:
Religion: Birth Date:
Allergies:

Admitting Physician:
Attending Physician:
Admission Diagnosis:
MEPRS Code: MEPRS Code Description:
ICD9 Code:
Outpatient Record Location:

Command Interest:
Duty Station/Office Phone: Home Phone:
Address:
City: State: Zip: Country:

Next of Kin: Relationship:
Address: Phone:
City: State: Zip: Country:

Emergency Contact: Relationship:
Address: Phone:
City: State: Zip: Country:

APACHE Details			Erase data	Describe Item	Store	Toggle Mode	Edit Topic	Print
-------------------	--	--	---------------	------------------	-------	----------------	---------------	-------

This is an example of a medical record number.

Examples of data entry format are provided.

Do not use the minus sign '-' on the keypad.

Allergies are typed in as free text.

Height and Weight are automatically converted to the desired measurement standard. For example, Metric (cm/kg) is converted to the English equivalent (in/lbs).

THE ADMIT RECORD SCREEN

3.1.1.5 Entering a Patient's Admission Data



Change Env	Admissn Data	Find Patient		Admit	Discharg	Transfer	Print etc...	CQL			LOCK
---------------	-----------------	-----------------	--	-------	----------	----------	-----------------	-----	--	--	------

The patient's admission data screen is configured to contain pertinent patient information. To enter the patient's admission data, perform the following steps.

1. Select the Patient Control Screen [Alt] [F10].
2. Select the desired unit and patient.
3. Press the "Admission Data" soft key <F2>.
 - Type in the requested patient data.
4. Press the [Enter] key after each entry.
 - The patient's height and weight are automatically converted to the desired measurement standard. For example, Metric (cm/kg) is converted to the English equivalent (in/lbs) or visa versa.
5. When finished with the entire screen, press the "Store" soft key <F8>.

THE ADMISSION DATA SCREEN

Jefferson, Darlene 301-1 Phy: Dr. A (Env LDR) 10:00 Aug 08, 97
Admit Screen

Note Time: N/A Type: LDR Admission Topic: N/A Mode: [Entry]
Last Stored By: (Created) Last Store At: N/A

LDR Admission

Admit Number: 375533 Insurance Name: _____
MRN: 76859432 SSN: _____ SHCN: _____
Name: Jefferson, Darlene Maiden Name: Peterson
Admit Date: 07/28/97 Time: 1700
Presented By: Ambulatory From: Home
Reason For Admission: Possible labor, Term
GR: 11 P: 10 T: 10 preT: 0 TAB: 0 SAB: 0 SB: 0 LB: 10
LMP: _____ EDC: 07/29/97 EDC By: _____ Weeks Gestation: 40
ROM Date: 07/28/97 ROM Time: 1630 Fluid Character: CLR
DOB: 09/01/62 Age: 34
Marital Status: Married Race: White Father's Race: White
Language: English Fluency: Fluent English Religion: None
Primary Physician: Dr. A Clinic Affiliation: _____
Consulting/Resident MD: Sarah Lee Pediatrician: _____
Patient Allergies: _____
Current Medications: _____
Height: _____ ft. _____ in. _____ cm.
Weight: _____ lbs. _____ kg BSA _____ m^2 BMI: _____
Fetal Assessment/Diagnostics: _____

Note Exit Another Note Edit Field Hide Choices More Fields Erase Data Describe Item Store Toggle Mode Date/Time Import Data Print

This is an example of a medical record number.

Examples of data entry format are provided.

Do not use the minus sign '-' on the keypad.

ngsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 09:37 Aug 8,

Note Time: 0808 6 Jul 1997
Topic:
Mode: Entry

Admission Information

Name: Admit Date:
FMP-SSN: Hospital Register Number:
Sex: Race:
Rank: Occupation:
Religion: Birth Date:
Allergies:

Admitting Physician:
Attending Physician:
Admission Diagnosis:
MEPRS Code: MEPRS Code Description:
ICD9 Code:
Outpatient Record Location:

Command Interest:
Duty Station/Office Phone: Home Phone:
Address:
City: State: Zip: Country:

Next of Kin: Relationship:
Address: Phone:
City: State: Zip: Country:

Emergency Contact: Relationship:
Address: Phone:
City: State: Zip: Country:

APACHE Details Erase data Describe Item Store Toggle Mode Edit Topic Prin

Allergies are typed in as free text.

Height and Weight are automatically converted to the desired measurement standard. For example, Metric (cm/kg) is converted to the English equivalent (in/lbs).

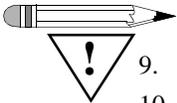
THE ADMIT RECORD SCREEN

3.1.1.6 Importing Admission Data

Note Exit	Another Note	Edit Field	Hide Choices	More Fields	Erase Data	Describe Item	Store	Toggle Mode	Date/ Time	Import Data	Print
--------------	-----------------	---------------	-----------------	----------------	---------------	------------------	-------	----------------	---------------	----------------	-------

Admission data from one chart can be imported automatically into another chart. This is typically used from Mom's record into the Baby's record. To import admission data, perform the following steps.

1. Select the Patient Select Screen [Alt][F10].
2. Select the patient into which data will be imported.
3. Press the "Admission Data" soft key <F2>.
4. Press the "Import Data" soft key <F9>.
 - A Find Patient window will appear with an alphabetical listing of patients from pre-configured units.
5. Highlight the desired search mode with the [Left Arrow], [Right Arrow] or [Tab] keys.
6. Type in the first few characters of the desired patient record.
 - The search string is not case specific (i.e., lower case or upper case).
 - The system will display all available patient records matching the search string.
7. Highlight the desired patient record with the [Up Arrow] and [Down Arrow] keys.
8. Press the [Enter] key.
 - Admission data from pre-configured fields will import automatically into the chart.
9. Verify the data imported is correct.
10. Edit the admission data as needed.
11. Press the [Enter] key after each entry.
12. When finished with the screen, press the "Store" soft key <F8>.



THE PATIENT SELECT SCREEN WITH THE DISCHARGE PROMPT

Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 10:04 Aug 8, 97

P A T I E N T C O N T R O L

BED	Name	MRN	Physician
1. 300-1	Kingsford, Larry	50357856	Dr. Brookstone
2. 300-2	Tran Ho Li	50340514	Dr. Brookstone
3. 300-3	Smith, Lily	2322222J	Jones
4. 300-4	Gray, Marsha	64196646	Dr. Brookstone
5. 300-5	Karen, Karen	234234	jones
6. 300-6	Campbell, Marshall	64197210	Dr. Brookstone
7. 300-7			
8. 300-8			
9. 300-9			
10. 300-10			
11. 300-11			
12. 300-12			
13. 300-13			
14. 300-14			
15. 300-15			
16. 300-16	Sampson, Earl	50358001	Dr. Brookstone

UNITS:

100.DISCH 101.NOBED **102.SICU** 103.CCU 104.ORTHO 105.PEDS 106.PSYCH 107.ANTE 108.LDR 109.LDRP
 110.NICU 111.NEWBORN 112.SDS/OR 113.PACU 114.ED 115.UCLA 116.OUT-PATIENT 117.SSHC 118.DOD-ICU
 119.DOD-PICU 120.DOD-NICU 121.DOD-MEDSURG 122.DOD-PSYCH 123.DOD-ED 124.DOD-L&D 125.DOD-PP
 126.DOD-NB 127.DOD-OR 128.CPA 129.TEST

Select bed/unit:

Discharging Patient Kingsford, Larry; Enter Discharge Permission

Cancel
▶

Discharge Permission prompt

3.1.2 PATIENT DISCHARGE, TRANSFER AND PRINT FUNCTIONS

3.1.2.1 Accessing ADT History Information on a Patient



To determine the user admitted, transferred or discharged a patient’s record, perform the following steps.

1. Select the Patient Control Screen [Alt][F10].
2. Select the desired unit and patient.
3. Press the “Print, etc. . .” soft key <F8>.
4. Press the “Print Chart” soft key <F4>.
5. Press the “ADT History” soft key <F10>.
 - The ADT History window will appear with the name of the person responsible for the admission, transfer or discharge of the selected patient’s record.

UNIT	BED	ENV	FROM	-	TO	STAFF
ER	PRE-OP	ER	1021 16 Oct 1995	-	1226 16 Oct 1995	LARRY E. BENNETT, LPN
OR	OR-A3	OR	1226 16 Oct 1995	-	1343 16 Oct 1995	LARRY E. BENNETT, LPN
SICU	SICU-4	ICU	1343 16 Oct 1995	-	PRESENT	LARRY E. BENNETT, LPN

6. Press the “Cancel” soft key <F4> to return to the Printed Report Dispatcher Screen.

3.1.2.2 Discharging a Patient



When a patient is transferred out of a CIS configured unit or discharged from the hospital, the patient’s record must also be discharged from the system. To discharge a patient record, perform the following steps.



Previous stays will accompany the current, active record upon discharge. (‘DISCH’ will appear next to the environment on the Multiple Stays Window.) The charts from a previous stay can be individually discharged; however, they will not appear in the Discharge Environment.

1. Select the Patient Control Screen [Alt][F10].
 2. Select the desired unit and patient.
 3. Press the “Discharge” soft key <F6>.
 - The Discharge prompt will appear at the bottom of the screen.
- Discharging Patient BETHANY, FRANCINE; Enter Discharge Permission
4. Press the [F8] hard key (an unlabeled soft key to access the Discharge Permission).
 - The discharge permission can be restricted per user and/or display station location.
 5. Enter in your ID code.
 6. Press the [Enter] key.
 - The Print Chart prompt will appear.
 7. Type in ‘Y’ for “Yes” to print a chart set, or ‘N’ for “No” to not print a chart set.
 8. Press the [Enter] key.
 - A Discontinue Orders prompt may be configured to appear. Respond to the prompt as needed.
 - The patient’s record will be placed in the Discharge (DISCH) unit. The patient’s records will remain in Discharge for a hospital-defined duration before being archived.



If a record is placed in DISCHARGE by mistake, it can be transferred back via the TRANSFER function (undischarge) to the proper unit and bed. All archived patient records can be re-accessed from an archived tape.

THE PATIENT SELECT SCREEN WITH THE TRANSFER PROMPT

A 'No Bed' may be configured to appear when the "Transfer" soft key is pressed.

Sadler, Marjorie-OR OR-1 Phy: Dr. Brookstone (Env SURGERY) 10:22 Aug 8, 97
P A T I E N T C O N T R O L

BED	Name	MRN	Physician
1. OR-1	Sadler, Marjorie-OR	83911846	Dr. Brookstone
2. OR-2	Thompson, Gregory	83914972	Dr. Brookstone
3. OR-3	Hartman, Paul-OR	50364030	Dr. Brookstone
4. OR-4	Devers, Jennifer-OR	83911026	Dr. Brookstone
5. OR-5	Hardiman, Jennifer	50369919	Dr. Brookstone
6. OR-HOLD			

UNITS:
100.DISCH 101.NOBED 102.SICU 103.CCU 104.ORTHO 105.PEDS 106.PSYCH 107.ANTE 108.LDR 109.LDRP
110.NICU 111.NEWBORN 112.SDS/OR 113.PACU 114.ED 115.UCLA 116.OUT-PATIENT 117.SSHC 118.DOD-ICU
119.DOD-PICU 120.DOD-NICU 121.DOD-MEDSURG 122.DOD-PSYCH 123.DOD-ED 124.DOD-L&D 125.DOD-PP
126.DOD-NB 127.DOD-OR 128.CPA 129.TEST

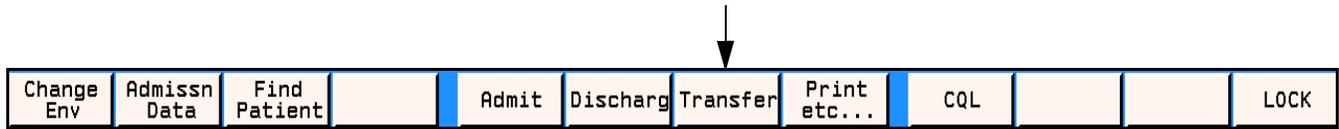
Select empty bed/unit: █

Select Empty Bed For Transferring Patient Sadler, Marjorie-OR

Cancel

Transfer Request prompt

3.1.2.3 Transferring a Patient



When a patient is moved to another CIS configured unit, the patient record must be transferred to that unit and bed. To transfer a patient’s record, perform the following steps.



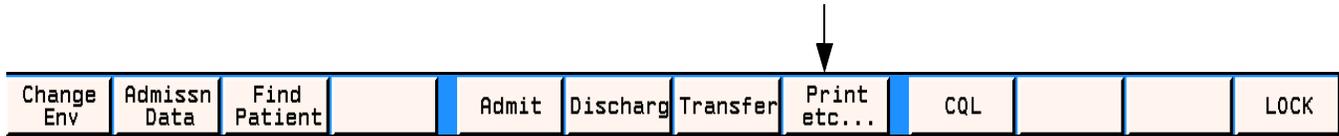
When a current patient’s record is transferred, all previous stays will move with the current stay. The charts from a previous stay cannot be individually transferred.

Not a Current Stay - Cannot be Transferred.
 <Press Any Key To Continue>

1. Select the Patient Select Screen [Alt][F10].
2. Select the desired unit and patient.
3. Press the “Transfer” soft key <F7>.
 - The Transfer prompt will appear.

Select Empty Bed For Transferring Patient BETHANY, FRANCINE
4. Select the destination unit and bed.
 - A ‘No Bed’ may be configured to appear when the “Transfer” soft key is pressed.
5. Press the [Enter] key.
6. Enter in your ID code.
7. Press the [Enter] key.
 - A Discontinue Orders prompt may be configured to appear. Respond to the prompt as needed.
 - The Print Chart prompt will appear.
8. Type in ‘Y’ for “Yes” to print a chart set, or ‘N’ for “No” to not print a chart set.
9. Press the [Enter] key.
 - The patient chart will be placed in the selected unit and bed.

3.1.2.4 Printing Manual Charts



Typically, charts are configured to automatically print on a scheduled basis. However, charts can be selected for manual print. To print an unscheduled report, perform the following steps.

1. Select the Patient Control Screen [Alt] [F10].
2. Select the desired unit and patient.
3. Press the “Print, etc...” soft key <F8>.
 - The status of printers experiencing problems (i.e., paper outage, toner shortage, open cover, etc.) will appear on the screen.
4. Press the “Print Chart” soft key <F4>.
 - To select the charts for a desired environment, press the “Change Env.” soft key <F9>.
 - A window with configured environments will appear on the screen.
 - Highlight the desired environment with the [Up Arrow] and [Down Arrow] keys and press the [Enter] key.
 - The charts configured for the selected environment will appear on the Printed Report Dispatch screen.
 - The duration of a patient’s stay in each CIS unit may be reviewed, and the desired unit can be selected for the display of charts by pressing the “ADT History” soft key <F10>.
 - A window with the patient’s duration in each unit will be displayed.
 - Highlight the desired environment with the [Up Arrow] and [Down Arrow] keys and press the “Change Env.” soft key <F8> or the [Enter] key.
5. Press the “Select Time” soft key <F1> to change the chart date to print, if different from the date displayed.
6. Type in the number corresponding to the desired report.
7. Press the [Enter] key.
 - More than one report can be requested for printing.
 - Selected charts will be highlighted in reverse video on the screen.
8. Press the “Dispatch Charts” soft key <F8>.
9. Enter in your ID code.
10. Press the [Enter] key.
 - The Dispatching Chart message will quickly appear.
 - The screen will return to the Patient Select Screen.



If the print request is cancelled, the Print Cancelled message will appear on the screen.



Automatic daily chart sets can be configured to print at a specific time. (eg. 0600 or 0800)

3.1.2.5 Specifying the Print Range



When printing a report selected on the Print Menu Screen, the user can specify the range of days for the report, the report for the patient's entire stay or the report for a patient's stay in the current unit. To set the range of days when printing the patient charts, perform the following steps.

1. Select the Patient Control Screen [Alt] [F10].
2. Select the desired unit and patient.
3. Press the "Print, etc..." soft key <F8>.
4. Press the "Print Chart" soft key <F4>.
5. Press the appropriate soft key.
 - If specifying the range of days to print a report, press the "Specify Range" soft key <F4> and type in the date when the printing will begin and cease. The range may be edited by selecting the "Specify Range" soft key again.
 - If printing the report for the patient's entire stay, press the "Entire Stay" soft key <F2>. The resulting print set will print a patient's chart set by DAY.
For Example, printing the "ENTIRE STAY" selection will print out all of the Vitals, Fluids, Meds., Treatments, Orders and Notes for Day One of the patient's stay; then, printing for Day Two will start again with the Vitals, Fluids, Meds, Treatments, Orders and Notes; etc.
 - If printing the report for the patient's stay in the current unit, press the "Stay in Unit" soft key <F3>.
 - The print range will appear on the screen.
6. Press the "Dispatch Charts" soft key <F8>.
7. Enter in your ID code and press the [Enter] key.
 - A quick dispatching charts message will appear.

3.1.2.6 Specifying the Sort for Multiple Charts

Charts can be configured per environment to be sorted by day or by report when requesting more than one day's report. To select the sort mode when printing more than one day's report, perform the following steps.

1. Select the Patient Control Screen [Alt] [F10].
2. Select the desired unit and patient.
3. Press the "Print, etc..." soft key <F8>.
4. Press the "Print Chart" soft key <F4>.
 - If configured, the information box will display the current sort mode.
5. Press the "Specify Range" soft key <F4>.
6. Type in the date when the printing will begin.
7. Press the [Enter] key.
8. Type in the date when the printing will cease.
9. Press the [Enter] key.
10. Press the "Sort Select" soft key <F5>.
 - This soft key is only available when the print range is for more than one day.
 - The Sort Selection Window will appear.
11. Select the desired sort mode.
12. Press the [Enter] key.
13. Press the "Dispatch Charts" soft key <F8>.

14. Enter in your ID code and press the [Enter] key.

THE PRINTED REPORT DISPATCHER SCREEN THE LENGTH OF STAY REPORT



3.1.2.7 Length of Stay Printing



Select Time			Specify Range		Cancel	Dispatch Reports	Change Env.	ADT History		LOS Record
-------------	--	--	---------------	--	--------	------------------	-------------	-------------	--	------------

Length-of-stay print function will print an entire patient's chart (one week at a time) across the environments visited during their stay. LOS Chart Set prints out a patient's record by **APPLICATION** versus an Entire Stay Chart set which prints out the patient's record by **DAY**. The sequence of the print set is configured by the hospital.

For example, the Vital Signs Flowsheets for the duration of the patient's stay will be grouped and printed together; then, the Fluids Flowsheets for the duration of the patient's stay will be grouped and printed together; then, the next configured screen/note/flowsheet will be grouped and printed together; etc.

To print a patient's LOS Report, perform the following steps.

1. Select the "Patient Control Screen" [Ctrl][F10].
2. Select the desired patient record.
3. Press the "Print, Etc. . ." soft key <F8>.
4. Press the "Print Chart" soft key <F4>.
5. Press the "LOS Record" soft key <F12>.



The "LOS Record" soft key can be turned on or off per environment.



WARNING: Do not select any item off the Print Menu in conjunction with the LOS Print Set option via the "LOS Record" soft key <F12>. This will result in printing the selected chart for every DAY of the patient's stay AND a LOS Chart Set causing many duplicate prints.

In addition, the LOS Chart set may be on the print menu. It is very important to never select the "ENTIRE STAY" key and then select the LOS Chart set off the menu. This will result in printing a LOS Chart set for every day of the stay. For example if the patient was in the hospital 18 days, you will receive 18 LOS Chart sets.

Furthermore, do not select the "Specify Range" soft key <F4> and the "LOS Record" soft key <F12> together or the resulting print out will be a LOS Chart Set for every Day in the range specified causing many duplicate prints.

- The Print Request prompt will appear for entry of your ID code.
- The LOS Report can be automatically printed to a specified printer upon discharge or transfer of a patient's chart.



If there is not enough disk space in the printer queue, an error message will be displayed and the charts will not print.

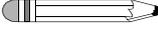
6. Enter in your ID code.
7. Press the [Enter] key.
 - The printed charts will appear in the following order:
 - First by report type (e.g., Vital Signs Report, then Treatments, etc.)
 - Then by Clinical Environments (e.g., SICU, then MICU, etc.).



The environment from the previous unit will be used if the patient was in No Bed or Discharge.

3.2 ORDER ADMINISTRATION FUNCTIONS

THE ORDER ENTRY SCREEN

 Orders are sorted by Approval Level, Category, Order Time, Start Time, Name and then Stop Time.

Column order is configurable per environment.

Cursor Bar

Tom Axlerod I-1 Phy: Dr. Brookstone (Env DOD-ICU) 13:57 Apr 17, 98

ORDER ENTRY

Active Orders: IV Drugs

ENT	APP	Order-Time	Start-Time	Stop-Time	Name	Volume (ml)	Amount	Dose	Site	Comment
MRK	MRK	1300 23 Aug	1300 23 Aug		DSW#EPI/CAL	250	2 (?)	1 (?)		
ENR	ENR	2100 23 Aug	2100 23 Aug		DSW#MORPHINE SULFATE	100	100 (?)	5 (?)		
ENR	ENR	2100 23 Aug	2100 23 Aug		DSW#UECURIUM	100	50 (?)	0 (?)		
LM	LM	0100 24 Aug	0100 24 Aug		DSW#DOPAMINE	250	800 (?)	6 (?)	Right Subclavian	
SD	SD	1100 24 Aug	1100 24 Aug		NS#BUMEX	100	10 (?)	0 (?)		
SD	SD	1100 24 Aug	1100 24 Aug		DSW#ATIUM	280	58 (?)	0 (?)		
HD	HD	0500 25 Aug	0500 25 Aug		NS#FLUSH HEPARIN	500	1000 (?)	3 (?)		

Active Orders: Intake Fluids

ENT	APP	Order-Time	Start-Time	Stop-Time	Name	Volume (ml)	Rate (ml/hr)	Site	Input Category	Comment
AMC	AMC	1300 23 Aug	1300 23 Aug		PRBC's	250			blood	
LM	LM	1300 23 Aug	1300 23 Aug		NS	200			crystal	
SS	SS	1400 23 Aug	1400 23 Aug		LR	1000		RIHGT SUBCLAVIAN	crystal	
MN	MN	1500 23 Aug	1500 23 Aug		DSW (C.O.)	500			crystal	
LM	LM	2000 23 Aug	2000 23 Aug		FFP	200		Subclavian	blood	
LM	LM	2100 23 Aug	2100 23 Aug		PLATELETS	175		Right Subclavian	blood	
SS	SS	1200 24 Aug	1200 24 Aug		ALBUMIN 25% 25GM/100ML	100			colloid	
SS	SS	1400 24 Aug	1400 24 Aug		DSW	1000		Right Subclavian	crystal	
SD	SD	1400 24 Aug	1400 24 Aug		PLASMANATE	250			colloid	
DEM	DEM	0900 26 Sep	0900 26 Sep		WHOLE BLOOD	100	30	Left Arm	blood	test at KUO or sal
DEM	DEM	1600 20 Feb	1600 20 Feb		DSW 1/2 NS	200	50		crystal	
DEM	DEM	1100 26 Feb	1100 26 Feb		NUTRIHEP	450	54		tubef	
DEM	DEM	1100 26 Feb	1100 26 Feb		DSW (C.O.) +20KPO4	10	6	Lower Left Leg	crystal	
DEM	DEM	1100 26 Feb	1100 26 Feb		DSW +20KCL	1000	100	Right Hand	crystal	none
DEM	DEM	1100 26 Feb	1100 26 Feb		DSW +20KCL	1000	125	Right	crystal	stat
DEM	DEM	1100 26 Feb	1100 26 Feb		DSW +20KCL	500	250	Subclavian	crystal	
DEM	DEM	1100 26 Feb	1100 26 Feb		D10W	100		uac	crystal	
DEM	DEM	1500 29 Feb	1500 29 Feb		ALITRAQ	1000	50		tubef	
DEM	DEM	1500 29 Feb	1500 29 Feb		ALITRAQ	1000	50		tubef	
DEM	DEM	1000 12 Apr	1000 12 Apr		Hespan	50	125	Left	colloid	

Active Orders: Output Fluids

ENT	APP	Order-Time	Start-Time	Stop-Time	Name	Comment
MRK	MRK	1300 23 Aug	1300 23 Aug		CHEST TUBE #2 RIGHT	

Active Orders: Medications

ENT	APP	Order-Time	Start-Time	Stop-Time	Name	Dose	Mode	Freq	Comment
SS	SS	1500 23 Aug	1500 23 Aug		CEFAZOLIN 1 GM IVPB	1 GM	IU	Q8-	
SS	SS	1500 23 Aug	1500 23 Aug		LASIX 20MG/2ML INJ	20MG	IU	Q4-6 PRN	ICP > 20MMHG
SS	SS	1500 23 Aug	1500 23 Aug		MANNITOL 25% INJ 12.5GM/50ML VIAL	25 GM	IU	Q3-4 PRN	ICP > 25MM HG
SS	SS	1500 23 Aug	1500 23 Aug		KCL 40MEQ/20ML INJ	10MEQ	IU	PRN	IN 40CC OVER 1'HR FOR K <
SS	SS	1500 23 Aug	1500 23 Aug		LACRI-LUBE S.O.P. OPHTH DINT 3.5 GM TUBE	Dab	OU(B)	Q4-6 PRN	
SS	SS	1500 23 Aug	1500 23 Aug		ARTIFICIAL TEARS OPH SOLN 15ML BTL	Gtts	OU(B)	PRN	
SS	SS	1600 23 Aug	1600 23 Aug		MS 10MG/1ML INJ	2-5MG	IU	Q1-2 PRN	PAIN SHIVERING
SS	SS	1600 23 Aug	1600 23 Aug		DEMEROL 25MG/ML INJ	12.5-25MG	IU	PRN	
SS	SS	1900 23 Aug	1900 23 Aug		FAMOTIDINE INJ 20MG/2ML VIAL	20mg	IU	Q12-	
LM	LM	2100 23 Aug	2100 23 Aug		UECURIUM 20MG VIAL	5-10MG	IU	Q1HR PRN	
JED	JED	2300 23 Aug	2300 23 Aug		CEFOTAN 1GM INJ	1 Gm	IU	Q12-	
DEM	DEM	1700 20 Sep	1700 20 Sep		DECADRON INJ	amps	IU	QPM	

Active Orders: Treatments

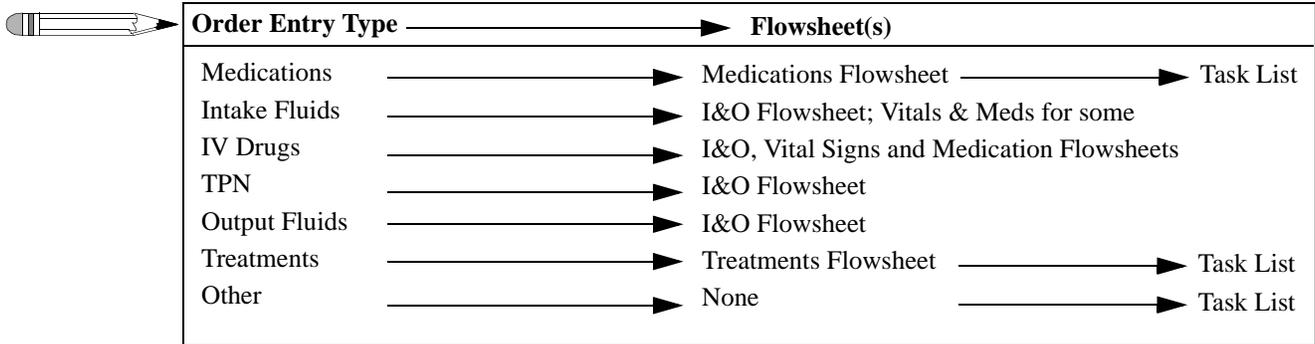
Renew Order	Remove Order	New Order	Edit Order	Approve Order	Describe Order	Store	Display Mode	Standard Orders	Task List
-------------	--------------	-----------	------------	---------------	----------------	-------	--------------	-----------------	-----------

Order types are separated into sections and can be accessed with the [Tab] or Arrow keys.

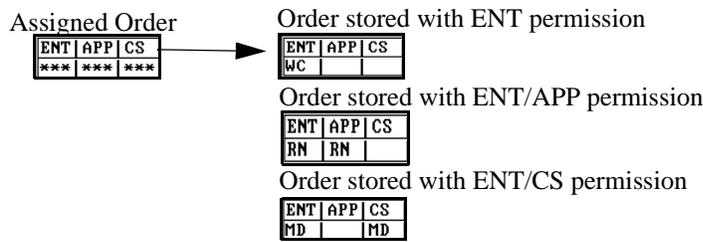
3.2.1 ORDER ENTRY REVIEW

The Order Entry Screen is the CIS Nursing Kardex. Pre-configured standard orders are entered on the Order Entry Screen and then automatically transferred to the applicable flowsheets for charting. Individual orders are entered via the flowsheet or the Order Entry Screen. The order completions charted on the flowsheets will automatically update the Order Entry Screen and Task List.

When assigned on the Order Entry Screen, the following order types will appear on a flowsheet.



When assigning a new order or editing an existing order, asterisks will appear in the Entry, Approval and Counter Sign columns.



[Home] key



The [Home] key moves the cursor to the **first** order within each section.

[End] key



The [End] key moves the cursor to the **last** order within each section.

[Page Up] key



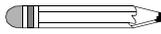
The [Page Up] key scrolls the screen up within each section.

[Page Down] key



The [Page Down] key scrolls the screen down within each section.

THE NEW ORDER SCREEN

 The presence of the site field is configurable by intake fluid category.

 The screen can be configured so that the cursor will default on the Start Time, D/C Time, Order Time or Name field.

Dashed-line box for non-prompting fields.

Diagnosis: COPD Name: STEVENS, ANTHONY Phy: DR. HANSENS 17:07 Jul 26, 95

ORDER ENTRY

NEW IV Drug ORDER

Entry: ***	Approval: ***	Counter:
Category: IV Drugs	Type: IV Drug	Order Time: 1700 26 Jul 1995
Start Time: 1700 26 Jul 1995	D/C Time:	

Carrier: D5W	Site: ARM
Comment:	
Volume: 500 (ml)	Rate: 20 (ml/hr) Infusion Time: 25 (hr)

Drug Name: Heparin	
Amount: 25000 (U)	
Dose: 24000 (U/day)	
Concentration: 50 (U/ml)	

<Tab> - Next Field
 <Shift+Tab> - Previous Field

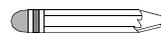
*** DEFAULT ORDER ***

STD CARRIER: D5W+Heparin
 VOLUME: 500 (ml)

DRUG: Heparin
 AMOUNT: 25000 (U)
 DOSE: 24000 (U/day)
 CONC: 50 (U/ml)

Allergies: TETANUS VACCINE, TETRACYCLINE

Assign	Done	Cancel Order			Add IV Drug	Change Category		Cancel All
--------	------	--------------	--	--	-------------	-----------------	--	------------

 If the Arrow keys are configured for cursor movement, they will be disabled for the entry of time.

3.2.2 ORDER ENTRY FUNCTIONS

3.2.2.1 Entering a New Order

To assign a new order from any flowsheet or the Order Entry Screen, perform the following steps.

 *New rows for the Care Path, Text Box and Charting by Exception flowsheet sections will continue to be added via the “New Row” soft function key <F3>.*

1. Move the cursor to the flowsheet section with the desired order type (i.e., Medications, IV-Drug, Treatment) or select the Order Entry Screen [Ctrl][F10].
2. Select the “New Order” soft function key <F3>.

 *New flowsheet data must be stored prior to accessing the New Order function.*

- Depending upon the current flowsheet section type, either the New Orders Screen for that order type or the Order Category window with pre-defined categories will appear on the screen.
 - If applicable, select one of the Order Categories and press the [Enter] key.
 - Selection windows without numbered choices allow for the cursor to move to the desired choice when the first letter of the selection is typed.
3. Enter in the requested information per the order type.
Refer to the following sections for additional information on assigning these order types:
Section 3.2.2.1.1 - Assigning an Intake Fluid
Section 3.2.2.1.2 - Assigning an IV Drug
Section 3.2.2.1.3 - Assigning Multiple IV Drugs
Section 3.2.2.1.4 - Assigning a Medication
 - To enter or clear the Order, Start or D/C Times, press the “Enter Time” (or “Clear Time”) soft function key <F1> and enter the time.
 - To clear all fields on the screen and return to the pre-defined cursor start field, press the “Cancel Order” soft function key <F4>.
 4. Press the [Enter] key after each entry.
 5. Press the “Assign” soft function key <F2>.
 - The assigned order will move to the ‘Assigns:’ field and the cursor will be positioned for the entry of multiple assignments.
 - To select a different order category (even a category differing from the current flowsheet), press the “Change Category” soft function key <F9>.
 - To abort the current, assigned order and return to the current flowsheet, press the “Cancel All” soft function key <F12>.
 6. When finished with entering the new order information, press the “Done” soft function key <F3>.

 *The order must contain Order Time, Start Time and Name for the order to be assigned. For IV Drugs and Medications, the Dose must be entered also.*

7. If entering the new order from the flowsheet, type in your ID code and press the [Enter] key.
 - Depending upon the storing permission level, the order may appear on the applicable flowsheet under the appropriate section or added to the pending orders listing.
 - The screen will return to the flowsheet in which the “New Order” soft function key <F3> was selected.
8. When finished with entering the new order on the Order Entry Screen, press the “Store” soft function key <F8>.

THE NEW IV DRUG ORDER SCREEN

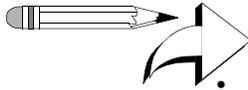
Brown, John		SICU-1	Phy: James, Fred		(Env	SICU)	17:32 Jul 26, 95		
ORDER ENTRY									
NEW IV Drug ORDER									
Entry ***	Approval ***		Counter						
Category: IO Drugs	Type: IO Drug		Order Time: 1700 26 Jul 1995						
Start Time: 1700 26 Jul 1995	D/C Time:								
Carrier: D5W									
Comment:									
Volume: 250 (ml)	Rate: 7.5 (ml/hr)	Infusion Time: 33.33 (hr)							
Drug Name: Epinephrine									
Amount: 2 (mg)									
Dose: 1 (mcg/min)									
Concentration: 8 (mcg/ml)									
<Tab> - Next Field <Shift+Tab> - Previous Field									
*** DEFAULT ORDER ***									
STD CARRIER: D5W+Epinephrine									
VOLUME: 250 (ml)									
DRUG: Epinephrine									
AMOUNT: 2 (mg)									
DOSE: 1 (mcg/min)									
CONC: 8 (mcg/ml)									
TYPE: CARDIOVASCULAR									
Allergies: NKA									
Assign	Done	Cancel Order			Add IV Drug	Change Category		Cancel All	

THE EDIT ORDER SCREEN

Brown, John	SICU-1	Phy: James, Fred	(Env SICU) 10:20 Jul 27, 95
ORDER ENTRY			
EDIT Medication ORDER			
Entry ***	Approval ***	Counter	
Category Medications	Type Medication	Order Time 0600 24 Jun 1995	
Start Time 0600 24 Jun 1995	D/C Time 0000 27 Jul 1995		
Name LOPRESSOR INJ 5MG/5ML AMP			
Dose 5 MG			
Route IU			
Frequency Q 5MINS			
Comment X3 DOSES, HOLD HR<55			
Expires			
<Tab> - Next Field <Shift+Tab> - Previous Field			
Allergies: NKA			
Clear Time	Done	Cancel Edit	

3.2.2.1.4 Assigning a Medication

When entering a medication name in free text, an automatic medication finder will provide possible choices. At a minimum, the medication and dosage fields must be entered for the medication to be assigned



Medication expiration times are configurable per medication.

- Time markers will automatically appear on the flowsheet for pre-set frequency schedules (i.e., BID, TID, QID).
- Time markers will automatically appear on the flowsheet for delayed frequency schedules after the administration of the first dose.

3.2.2.2 Editing an Order



Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
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Once an order has been approved, only the D/C Time can be changed. To edit an unapproved order or to change an order's D/C Time, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Move the cursor to highlight the desired order with the [Up Arrow] and [Down Arrow] keys, if applicable.
3. Press the "Edit Order" soft function key <F4>.
 - If an order has been stored, then the Edit prompt will appear.
4. Type in "Y" for Yes and press the [Enter] key, if applicable.
 - An Edit Order Screen will appear for the selected order type.
5. Enter in the desired changes.
 - The status of the order will determine which parameters of the order may be changed. There are three (3) edit permission levels:
 - If the order has NOT been stored (the asterisks (***) are visible), all parameters can be edited.
 - If the order has been stored, yet not approved, all parameters except for the Order Time can be edited.
 - If the order has expired, the order can be renewed via the Renew Order function.



To edit an approved order, you must have the appropriate Edit Level approval permission.

- Enter in your changes in free text or by typing in the desired choice list number.
- To enter or clear the Order, Start or D/C Times, press the "Enter Time" (or "Clear Time") soft function key <F1> and enter the time.
 - To cancel the edit, press the "Cancel Edit" soft function key <F4>.

6. Press the [Enter] key after each entry.
7. When finished with editing the order, press the "Done" soft function key <F3>.



The order must contain Order Time, D/C Time and Name for the order to be accepted.

- The edited order will appear on the Active Orders Screen.
8. When finished with the entire screen, then press the "Store" soft function key <F8>.
 - Depending upon your user permission level, when the edit is stored any approval or counter sign asterisks will be replaced by your initials.

THE RENEW ORDER SCREEN

Diagnosis: COPD Name: STEVENS, ANTHONY Phy: DR. HANSENS 17:07 Jul 26, 95
 ORDER ENTRY

NEW IV Drug ORDER

Entry ***	Approval ***	Counter
Category: IV Drugs	Type: IV Drug	Order Time: 1700 26 Jul 1995
Start Time: 1700 26 Jul 1995	D/C Time:	
Carrier: D5W		
Site: ARM		
Comment:		
Volume: 500 (ml)	Rate: 20 (ml/hr)	Infusion Time: 25 (hr)
Drug Name: Heparin		
Amount: 25000 (U)		
Dose: 24000 (U/day)		
Concentration: 50 (U/ml)		

<Tab> - Next Field
 <Shift+Tab> - Previous Field

*** DEFAULT ORDER ***

```

STD CARRIER: D5W+Heparin
VOLUME:      500 (ml)

DRUG:        Heparin
AMOUNT:      25000 (U)
DOSE:        24000 (U/day)
CONC:        50 (U/ml)
  
```

Allergies: TETANUS VACCINE, TETRACYCLINE

Assign	Done	Cancel Order				Add IV Drug	Change Category			Cancel All
--------	------	--------------	--	--	--	-------------	-----------------	--	--	------------

3.2.2.3 Renewing an Order



Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders	Task List
-------------	--------------	-----------	------------	---------------	--------------	----------------	-------	--------------	-----------------	-----------

When TPN, one time or STAT orders have expired, the system provides a function to renew the same order. To renew an expired order, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Move the cursor to the desired order.
3. Press the “Renew Order” soft function key <F1>.
 - The following D/C prompt will appear if the D/C time of the original order is after the current hour.

```
Do you wish to D/C the original order at 0859 2 Jul 1993 (Y/N)? █
```

- If the prompt is acknowledged by typing ‘Y’ for Yes, then the original order will be discontinued at one minute before the current hour. If ‘N’ is entered for No, then the original order will not be changed and a new order will be created.



The system will prevent the D/C of an order if there is charting that occurs after the D/C Time. The following warning will appear:

```
WARNING: Could not D/C the original order at 0859 2 Jul 1993:
Bad Stoptime: There is a input_del Stored For This Order at 0900 2 Jul 1993!
<Press Any Key To Continue>
```

- The selected order information will appear on the screen.
4. Modify the information as needed.
 - *The Order and Start Times may be changed when renewing an order.*
 5. Press the [Enter] key after each entry.
 6. When finished with modifying the order, press the “Done” soft function key <F3>.
 - The renewed order will appear on the Active Orders Screen.
 7. When finished with the entire screen, press the “Store” soft function key <F8>.

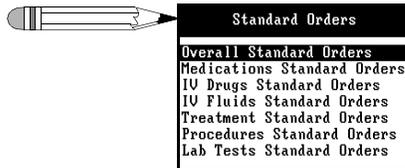
3.2.2.4 Entering Standard Orders



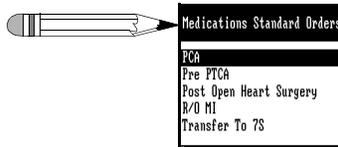
Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
-------------	--------------	-----------	------------	---------------	--------------	----------------	-------	--------------	-----------------	--	-----------

To assign pre-configured standard orders, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Press the “Standard Orders” soft function key <F10>.
 - To abort the standard orders function, press the “Cancel” soft function key <F4>.
 - The Standard Orders window with pre-defined order categories will appear.



3. Select one of the Standard Order Types.
 - Use the [Up Arrow] and [Down Arrow] keys to highlight the desired order.
4. Press the [Enter] key.
 - A window containing subcategories for the selected order category will appear.



5. Select one of the orders sets.
 - Use the [Up Arrow] and [Down Arrow] keys to highlight the desired order.
6. Press the [Enter] key.
 - The Order Entry Screen with the selected standard orders will appear.
7. Acknowledge **each** of the standard orders by pressing one of the following soft function keys.

Copy Order	Delete Order	New Order	Edit Order	Assign Order				Abort All			
------------	--------------	-----------	------------	--------------	--	--	--	-----------	--	--	--

- To accept the order, press the “Assign Order” soft function key <F5>.



The order must contain Order Time, Start Time and Name for the order to be assigned.

- To reject the order, press the “Delete Order” soft function key <F2>.
- To change the order, press the “Edit Order” soft function key <F4>.

8. When all items have been approved or deleted, verify that the assigned orders appear on the Active Orders Screen.
9. When finished with entering orders, then press the “Store” soft function key <F8>.

THE ORDER ENTRY SCREEN DISPLAYING THE 'NOT COUNTER-SIGNED ORDERS' MODE

HALVERSON, JAMES			CCU-1		Phy: TENG		(Env ICU/CCU)		10:20 Jul 1, 91														
O R D E R E N T R Y																							
Standard Orders: Treatments																							
ENT	APP	CS	Order-Time	Start-Time	Stop-Time	Name	Category	Freq	Comment														
			1000 1 Jul	1000 1 Jul		Take Vital Signs	Treatments	Q2	XZ														
			1000 1 Jul	1000 1 Jul		Take Vital Signs	Treatments	Q4	While on PCA														
			1000 1 Jul	1000 1 Jul		No Additional Pain Meds	Treatments	QSHIFT	While PCA w/o prior approval of APS														
			1000 1 Jul	1000 1 Jul		Naloxone	Treatments	QSHIFT	Have 0.4mg Naloxone at Bedside														
			1000 1 Jul	1000 1 Jul		Maintain Pain Mgmt	Treatments	QSHIFT	Flowsheet														
			1000 1 Jul	1000 1 Jul		Maintain PCA as Primary	Treatments	QSHIFT	Line														
			1000 1 Jul	1000 1 Jul		Lock Out Interval	Treatments	QSHIFT	---- Minutes														
			1000 1 Jul	1000 1 Jul		If RR<8 Call HO	Treatments	PRN	+Anes Pain Svc - Voice 8-0937-551														
			1000 1 Jul	1000 1 Jul		If BP<90 Sys Call HO	Treatments	PRN	+Anes Pain Svc - Voice 8-0937-551														
			1000 1 Jul	1000 1 Jul		If Analgesia still Inad.	Treatments	PRN	Decrease Lockout Interval to __ Min														
			1000 1 Jul	1000 1 Jul		If Analgesia Inadequate	Treatments	PRN	May Increase dose __ml:Max dose __ml														
			1000 1 Jul	1000 1 Jul		Contact Anes Pain Svc/HO	Treatments	PRN	If Naloxone is used														
			1000 1 Jul	1000 1 Jul		Call HO	Treatments	PRN	For Urinary Retension														
			1000 1 Jul	1000 1 Jul		Begin PCA Post-Op	Treatments	X1															
			1000 1 Jul	1000 1 Jul		Basal Rate	Treatments	QSHIFT	IU ____ml/hr														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td>Copy Order</td> <td>Delete Order</td> <td>New Order</td> <td>Edit Order</td> <td>Assign Order</td> <td></td> <td></td> <td></td> <td>Abort All</td> <td></td> <td></td> <td></td> </tr> </table>												Copy Order	Delete Order	New Order	Edit Order	Assign Order				Abort All			
Copy Order	Delete Order	New Order	Edit Order	Assign Order				Abort All															

3.2.2.5 Selecting the Display Mode of Orders

Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
-------------	--------------	-----------	------------	---------------	--------------	----------------	-------	--------------	-----------------	--	-----------

A historical listing of patient's orders may be displayed. Additionally, orders with a particular status such as 'D/Ced Orders,' 'Not Counter-Signed,' 'New Orders,' etc. can also be reviewed. This review function defaults to the "Active Orders" display mode. To select the display mode of orders, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Press the "Display Mode" soft function key <F9>.
 - The Display Mode window will appear.
3. Select the desired mode for review.
 - Use the [Up Arrow] and [Down Arrow] keys to highlight the desired mode.
 - The selected display mode will remain on the screen until it is changed with the "Display Mode" soft function key or the Order Entry Screen is exited.

3.2.2.6 Removing an Unapproved, Pending Order

Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
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Orders that have not been approved can be removed. To render an unapproved order inactive, perform the following steps.



The "Remove Order" soft function key <F2> will delete a new, unstored order, or an order that has been entered but not approved.

1. Select the Order Entry Screen [Ctrl][F10].
2. Highlight the unapproved, pending order with the [Up Arrow] and [Down Arrow] keys.
3. Press the "Remove Order" soft function key <F2>.
 - The removed order will not be displayed on the applicable flowsheet.
 - The removed order may only be viewed via the 'Removed Orders' display mode.

3.2.2.7 Viewing/Restoring Removed Orders

To view or restore an inactive order, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Press the "Display Mode" soft function key <F9>.
3. Highlight the 'Removed Orders' mode with the [Up Arrow] and [Down Arrow] keys.
4. Press the [Enter] key.
 - All removed orders for the selected patient will be displayed.
5. Highlight the order to be restored with the [Up Arrow] and [Down Arrow] keys.
6. Press the "Restore Order" soft function key <F2>.
 - The restored order can now be viewed in the 'Active Orders' display mode.



A removed order must be restored before it can be approved.

THE EDIT ORDER SCREEN

To discontinue an order from the Order Entry Screen, edit the D/C Time.

Brown, John		SICU-1	Phy: James, Fred		(Env	SICU)	10:20 Jul 27, 95	
O R D E R E N T R Y								
EDIT Medication ORDER								
Entry ***	Approval ***	Counter						
Category Medications:	Type Medication:	Order Time: 0600 24 Jun 1995						
Start Time: 0600 24 Jun 1995:	D/C Time:	0000 27 Jul 1995						
Name: LOPRESSOR INJ 5MG/5ML AMP								
Dose: 5 MG								
Route: IU								
Frequency: Q 5MINS								
Comment: X3 DOSES, HOLD HR<55								
Expires:								
<Tab> - Next Field <Shift+Tab> - Previous Field								
Allergies: NKA								
Clear Time	Done	Cancel Edit						

3.2.2.8 Discontinuing an Order

Orders can be discontinued on the appropriate flowsheet or on the Order Entry Screen. The D/C indicator will appear interactively on both screens. To discontinue an approved order, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
 2. Press the “Edit Order” soft function key <F4>.
 3. Type ‘Y’ for Yes at the Edit prompt.
 4. Press the [Enter] key.
 - The cursor will default to the D/C Time field.
 5. Edit the D/C Time.
 6. Press the [Enter] key.
 7. When finished with discontinuing the order and to return to the Order Entry screen, press the “Done” soft function key <F3>.
 8. When finished with the entire screen, then press the “Store” soft function key <F8>.
 - **OR**
1. Select the Order Entry Screen [Ctrl][F10].
 2. Press the “D/C Order” soft function key [Shift][F4].
 - The order will be discontinued at the current hour.
 - The cursor will move to the next order with a Stop Time after the current hour.
 3. When completed with the entire screen, press the “Store” soft function key <F8>.
 - **OR**
1. Select the desired flowsheet for the type of order to be discontinued.
 2. Move the cursor to the desired item to be discontinued.
 3. Press the “D/C” soft function key <F3>.
 - The D/C bar will appear on the screen.
 4. When completed with the entire screen, press the “Store” soft function key <F8>.

3.2.2.9 Approving an Order

Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
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Orders with user initials in the ‘APP’ column have been approved. To approve an order, perform the following steps.

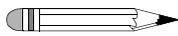
1. Select the Order Entry Screen [Ctrl][F10].
2. Move the cursor to highlight the desired order with the [Up Arrow] and [Down Arrow] keys.
3. Press the “Approve Order” soft function key <F5>.
 - Three (3) asterisks (***) will appear on the Order Entry Screen under the ‘APP’ heading.
4. When finished with the entire screen, then press the “Store” soft function key <F8>.
 - Depending upon your user permission level, when the approval is stored, the asterisks will be replaced with your initials.



As configured by order type (i.e., Medication, Treatment, IV-Drug, etc.), a printed copy will automatically print to the designated printer(s) ONCE when an order is **initially approved OR countersigned**.

3.2.2.10 Counter Signing an Order

Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
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Orders with user initials in the “CS” column have been counter signed. Counter Signatures are used as a second approval level. To counter sign an order, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Move the cursor to highlight the desired order with the [Up Arrow] and [Down Arrow] keys.
3. Press the “Counter Sign” soft function key <F6>.
 - Three (3) asterisks (***) will appear on the Order Entry Screen under the ‘CS’ heading.
4. When finished with the entire screen, then press the “Store” soft function key <F8>.
 - Depending upon your user permission level, when the counter signed is stored, the asterisks will be replaced with your initials.

Prevention Of Simultaneous Order Approvals

The system will prevent the simultaneous approval (or counter-sign) of an order on the Order Entry Screen. Before an order is approved (or counter-signed), the system checks for prior approval (or counter-sign) signature(s) from another terminal.

If attempted simultaneous approvals are detected, the system will notify the user with the following warning.



or ‘Approved’

After pressing any key to continue, the screen will refresh automatically to display the approval initials.

THE TASK LIST SCREEN

Orders must have a valid frequency to appear on the Task List.

Columns are configurable.

Long, William		SICU-2		Phy: Davis, Dan		(Env SICU)		11:47 Jul 27, 95	
O R D E R E N T R Y									
Task List (From:0946 27 Jul 1995 To:0146 28 Jul 1995)									
Time/Date	Req	Name	Dose	Mode	Comment	Start-Time			
1000 Jul 27	Q6	MANNITOL 25% INJ 12.5GM/50ML VIAL	12.5 GM	IV					
1000 Jul 27	BID	Clear Liquids			Clear liquids till stable. Progress to cardiac select.				
1200 Jul 27	Q6	LOPRESSOR INJ 5MG/5ML AMP	5MG	IV	HOLD SBP <120				
1600 Jul 27	Q6	MANNITOL 25% INJ 12.5GM/50ML VIAL	12.5 GM	IV					
1800 Jul 27	Q12	ANCEF 1 GM IUPB	1 GM	IV					
1800 Jul 27	Q6	LOPRESSOR INJ 5MG/5ML AMP	5MG	IV	HOLD SBP <120				
2200 Jul 27	Q6	MANNITOL 25% INJ 12.5GM/50ML VIAL	12.5 GM	IV					
2200 Jul 27	BID	Clear Liquids			Clear liquids till stable. Progress to cardiac select.				
0000 Jul 28	Q6	LOPRESSOR INJ 5MG/5ML AMP	5MG	IV	HOLD SBP <120				
		Cancel			Print				

The Task List will display orders Pending approval and Approved orders.

3.2.2.11 Reviewing the Task List

Renew Order	Remove Order	New Order	Edit Order	Approve Order	Counter Sign	Describe Order	Store	Display Mode	Standard Orders		Task List
----------------	-----------------	--------------	---------------	------------------	-----------------	-------------------	-------	-----------------	--------------------	--	--------------

Orders that still must be charted on the flowsheet are presented chronologically on the Task List. To review the task list, perform the following steps.



This is a review only screen.

1. Select the Order Entry Screen [Ctrl][F10].
2. Press the “Task List” soft function key <F12>.
 - The window of time in which the orders are displayed on the Task List is configured per your institution.
 - Only items with valid frequencies will appear on the Task List.
 - Use the [Up Arrow], [Down Arrow], [Page Up] and [Page Down] keys to scroll through the screen.
3. To return to the Order Entry screen, press the “Cancel” soft function key <F4>.
4. To document the completion of items listed on the Task List go to the appropriate flowsheet.

3.2.2.12 Printing the Task List

			Cancel				Print				
--	--	--	--------	--	--	--	-------	--	--	--	--

To print the task list, perform the following steps.

1. Select the Order Entry Screen [Ctrl][F10].
2. Press the “Task List” soft function key <F12>.
 - Only items with valid frequencies will appear on the Task List.
3. Press the “Print” soft function key <F8>.
 - The Task List will print to the printer configured for that display station.
4. To return to the Order Entry screen, press the “Cancel” soft function key <F4>.

3.3 GENERAL FLOWSHEET FUNCTIONS

SAMPLE VITAL SIGNS FLOWSHEET

Flowsheet Sections

Tom Axlerod		I-1		Phy: Dr. Brookstone		(Env DOD-ICU)		13:59 Apr 17, 98																																																																																																																																																																																																																																																																																																																																																																																																																																																																															
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<td>37.0</td><td>36.9</td><td></td><td>37.0</td><td>36.8</td><td></td><td>36.8</td><td>36.8</td><td>36.7</td><td>36.6</td><td></td><td>36.5</td> <td>TempC (DegC)</td> </tr> <tr> <td>TSrc</td> <td>F</td><td>F</td><td></td><td>F</td><td>F</td><td></td><td>F</td><td>F</td><td>F</td><td>F</td><td></td><td>F</td> <td>TSrc</td> </tr> <tr> <td>SpO2</td> <td>94</td><td></td><td>96</td><td></td><td></td><td>98</td><td></td><td></td><td></td><td></td><td>99</td><td>100</td> <td>SpO2 (%)</td> </tr> <tr> <td>CUP</td> <td>14</td><td>14</td><td></td><td>14</td><td>13</td><td></td><td>48</td><td>50</td><td>51</td><td>53</td><td></td><td>13</td> <td>CUP (mmHg)</td> </tr> <tr> <td>PAS</td> <td>60</td><td>62</td><td></td><td>62</td><td>50</td><td></td><td>24</td><td>25</td><td>25</td><td>26</td><td></td><td>52</td> <td>PAS (mmHg)</td> </tr> <tr> <td>PAD</td> <td>28</td><td>29</td><td></td><td>30</td><td>25</td><td></td><td></td><td></td><td></td><td></td><td></td><td>27</td> <td>PAD (mmHg)</td> </tr> <tr> <td>PAM</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>PAM (mmHg)</td> </tr> <tr> <td>PCW</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>PCW (mmHg)</td> </tr> <tr> <td>CO</td> <td></td><td>12.10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>CO (L/min)</td> </tr> <tr> <td>CI</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>CI (L/min/M2)</td> </tr> <tr> <td>SUR</td> <td></td><td>476</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>SUR (Ds/cm5)</td> </tr> <tr> <td>SURI</td> <td></td><td>893</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>SURI (Ds/cm5/M2)</td> </tr> <tr> <td>PUR</td> <td></td><td>73</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>PUR (Ds/cm5)</td> </tr> <tr> <td>PURI</td> <td></td><td>136</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>PURI (Ds/cm5/M2)</td> </tr> <tr> <td>SvO2</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>SvO2 (%)</td> </tr> <tr> <td>et CO2</td> <td>22</td><td></td><td>26</td><td></td><td></td><td>22</td><td></td><td></td><td></td><td></td><td>21</td><td>19</td> <td>et CO2 (torr)</td> </tr> <tr> <td>LOS</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>LOS</td> </tr> <tr> <td>Pain Rating</td> <td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>Pain Rating</td> </tr> <tr> <td>PURI</td> <td></td><td>136</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>PURI (Ds/cm5/M2)</td> </tr> <tr> <td>SU</td> <td></td><td>100.0</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>SU (ml)</td> </tr> <tr> <td>SI</td> <td></td><td>53.3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>SI (ml/M2)</td> </tr> <tr> <td>LUSWI</td> <td></td><td>41.3</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td> <td>LUSWI (gm-M)</td> </tr> </table>										HR	121	121		124	111		107	105	104	103		93	HR (BPM)	Rhythm													Rhythm	Ectopy													Ectopy	NBP-S													NBP-S (mmHg)	NBP-D													NBP-D (mmHg)	NBP-M													NBP-M (mmHg)	ABP-S	131	130		130	126		121	126	135	142		154	ABP-S (mmHg)	ABP-D	65	66		69	70		67	69	74	78		85	ABP-D (mmHg)	ABP-M	84	86		90	88		86	88	94	100		109	ABP-M (mmHg)	B/P Source	ART	ART		ART	ART		ART	ART	ART	ART		ART	B/P Source	TempF	98.6	98.4		98.6	98.2		98.2	98.2	98.1	97.9		97.7	TempF (DegF)	TempC	37.0	36.9		37.0	36.8		36.8	36.8	36.7	36.6		36.5	TempC (DegC)	TSrc	F	F		F	F		F	F	F	F		F	TSrc	SpO2	94		96			98					99	100	SpO2 (%)	CUP	14	14		14	13		48	50	51	53		13	CUP (mmHg)	PAS	60	62		62	50		24	25	25	26		52	PAS (mmHg)	PAD	28	29		30	25							27	PAD (mmHg)	PAM													PAM (mmHg)	PCW													PCW (mmHg)	CO		12.10											CO (L/min)	CI													CI (L/min/M2)	SUR		476											SUR (Ds/cm5)	SURI		893											SURI (Ds/cm5/M2)	PUR		73											PUR (Ds/cm5)	PURI		136											PURI (Ds/cm5/M2)	SvO2													SvO2 (%)	et CO2	22		26			22					21	19	et CO2 (torr)	LOS													LOS	Pain Rating													Pain Rating	PURI		136											PURI (Ds/cm5/M2)	SU		100.0											SU (ml)	SI		53.3											SI (ml/M2)	LUSWI		41.3											LUSWI (gm-M)
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LUSWI		41.3											LUSWI (gm-M)																																																																																																																																																																																																																																																																																																																																																																																																																																																																										

IV DRUGS (*) - MORE -										
Allergies: NKA										
Enter Time	Read Monitor	Add Row			Copy Forward	Describe Item			Start Row	Stop Row

3.3.1 FLOW SHEET REVIEW

This manual section identifies all the basic system functions necessary to chart on the CIS flowsheets. Some functions discussed may be configurably added to all flowsheets. Special flowsheet operations are discussed in Section 3.3, Special Flowsheet Functions.



All CIS flowsheets are configurable to the requirements of each hospital and each unit within a hospital. The flowsheets at your hospital may not include some of the standard functionalities discussed in this section.

Flowsheet Sections

The CIS flowsheets are designed by the hospital to include one or more of the following section types. The display order of these sections on a flowsheet is configurable.



Some flowsheet configurations are restricted by charting protocol.

- **Pre-Defined Section.** This section type contains pre-determined rows. Pre-determined items may be added individually or in groups and can be started and stopped as needed per patient.
- **User-Defined Section.** This section type consists of rows created by the user. User created rows can be modified using the following functions: Reset Schedule, Set Frequency, Add Row and Delete Row.
- **Plot Section** (see Vital Signs Flowsheet). This section type graphically displays charted patient parameters corresponding to a time column and offers the ability to chart events.
- **IV Rate Section** (see Vital Signs Flowsheet). This section type is used for the charting of IV fluid rates.
- **IV Drug Section** (see Vital Signs Flowsheet). This section type includes a drug calculator for the conversion of drug rate to drug dose. Dose may be manually entered.
- **Fluids Section** (see Intake and Output Flowsheet). This section type is used for the charting of patient fluid intake and output, and calculates fluid balance by hour, shift and day.
- **Medications Section** (see Medications Flowsheet). This section type is used for the charting of medication deliveries.

General Flowsheet Functions

Each flowsheet can be configured with the following basic functions (as shown on the screen in the soft key labels). These functions are discussed within this section as well as the section-specific functions (e.g., Modify Row).

- Read Monitor
- Add Row
- Copy Forward
- D/C
- Describe Item
- Set Frequency
- Reset Schedule
- Annotation

SAMPLE COMPRESSED MEDICATIONS FLOWSHEET

User initials can be configured to appear once the data is stored.

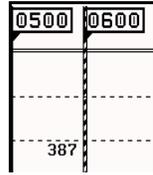
Kingsford, Larry		300-1		Phy: Dr. Brookstone		(Env		ICU)		12:30 Jul 21, 97												
PATIENT MEDICATIONS																						
SCHEDULED MEDICATIONS (*)										Time: 2100 28 Jun 97												
	02	03	04	05	06	07	08	09	10	11	12	13	14	15	15:35	15:37	16	17	18	19	20	21
CEFAZOLIN INJ 1GM VIAL "IU 1GM Q8H X 6 doses; 1st dose in SICU=dose #2									Held #3 MN	DC												
MANNITOL 25% INJ 12.5GM/50ML VIAL 12.5 GM "IU 12.5 GM Q6 HOLD FOR CVP>15			OR							DC												
REGLAN INJ 10MG/2ML VIAL "IU 10 MG Q8									DC													
PEPCID INJ 20MG/2ML VIAL "IU 20 MG Q12									DC													
ANCEF INJ 1GM VIAL "IU 1 GM Q12												DC										
LASIX 100MG INJ "IU 160 MG Q6									MN													
REGLAN INJ 5MG/ML 30ML MD VIAL "IU 5 MG Q8									MN													FB
PEPCID INJ 20MG/2ML VIAL "IU 20 MG Q24									MN													FB
ROCEPHIM 1GM INJ "IU 1 GM Q24																						FB
STAT/ONE TIME MEDS (NONE)																						
PCA (NONE)																						
PRN MEDICATIONS (*)																						
APRESOLINE INJ 20MG/ML 1ML AMP "IU 5-10Mgs Q1H PRN GIVE #3 FOR GOAL SBP< 140																						
KCL 40MEQ/20ML INJ "IUPB 10-20mEq Q1H PRN Maintain K 4.5. Repeat K prn.																						
MAGNESIUM SULFATE INJ 1GM/2ML AMPULE 2 gm "IU 2 gm PRN PRN for Mgt < 2.2																						
TYLENOL 650MG SUPP "PR 650Mgs Q4H PRN Temp > 101.																						
MS 10MG/1ML INJ "IU 2-8 mg Q1H PRN For pain																						
PERCOCET TABLET "PO 1-2 Tabs Q3 PRN PRN pain when taking PO																						
- MORE -																						
IV CONTINUOUS INFUSIONS (*)																						
OTHER MEDICATIONS																						
Allergies: PCN																						
Enter Time	Give Med	New Order	Hold Med	D/C	Describe Item																	

General Display Features

- Upon accessing a flowsheet, the cursor will default to a pre-defined time column.
- Allergies charted on the Admission Data Screen can be configured to appear on the bottom of each flowsheet.

Allergies: , PROPOXYPHENE/ACETAMINOPHEN, HYDROCODONE/APAP

- A thick vertical line on the flowsheet between time columns indicates the beginning of a shift.



- Compressed Flowsheet
 - Flowsheets can be configured to display compressed with additional rows and time column space. The features of a compressed flowsheet include: reduced section, row and data gaps, no section shading and smaller font size.
- Narrow Time Columns
 - The date and time cell at the top of each time column can now be configurably reduced to display only the time. The cell will not grow when the column is enlarged.

MEDICATIONS (*)	- MORE -									
	0416	0425	0446	0453	0455	0500	0504	0515	0525	0555
SOLUMEDROL 40MG VIAL 40 Mgs IV Q8										
EPINEPHRINE 1:1000 INJ-1ML AMP 1 amp IV PRN				1 amp		1 amp				1 amp

- D/C Message
 - When a flowsheet row is discontinued, a message can be configured to appear after the D/C arrow. The D/C arrow will appear to the right of the charted data.

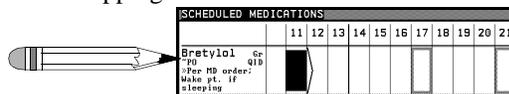


- Order Annotation
 - If an order has an annotation, an asterisk will be displayed next to the flowsheet row name. The contents of the annotation can be accessed via the “Describe Item” soft key <F7>.

D5W*	Q10									
~WRIST	†100									
D5W	Q0									
~JF	†1000									

Row Display Information

- Label Height
 - The label height will increase to accommodate label comments that are long enough to require wrapping.



- Mini Row Labels
 - The row labels on a flowsheet can now be configurably reduced to display only one line of text. Comments, initials and remarks will add an extra line.

MEDICATIONS (*)		
DEHEROL 25MG/ML INJ 12.5-25 MG IV Q2-4 PRN		Heid
BLISTEX OINTMENT Dabs TOP PRN		
VERSED 10ML/2ML INJ 2-5MG IV PRN		Heid
GANCYCLOVIR INJ 500MG VIAL 300MG IV Q12		
ERYTHROMYCIN 1GM IUPB 1.0GM IV Q6	Heid	

A SAMPLE ANESTHESIA RECORD FLOWSHEET WITH QUICK ACCESS TO NOTES

Pizarro, Francisco		TEST-5	Phy: Dr. Brookstone		(Env	TEST)	13:39 Jul 25, 97						
VITALS PLOT (*)		ANESTHESIA RECORD					Time: 1338 25 Jul 97						
		0830	0900	1000	1030	1100	1137	1155	1338				
										Day	Eve	Noc	Tot
		◆ HR (BPM) ▼ NBP-S (mmHg) ▲ NBP-D (mmHg) ■ ABP-S (mmHg) ■ ABP-D (mmHg)											
1338 Jul 25										YESTERDAY TODAY Jul 24 97 Jul 25 97			
HT cm (cm)	165.1									IN	0	0	
WT kg (kg)	76.9									OUT	0	0	
calcWT (kg)	72.0									NET	+0	+0	
RSA (m ²)	1.8									Time	Weight (kg)		
		0300 Jul 2	76.9										
		0500 Jul 1	77.9										
VITAL SIGNS (*)										Note Time: N/A			
SpO2										Topic:			
NBP-M										Mode:	Entry		
TempC													
MEDICATIONS (*)		ANESTHESIA QUESTIONNAIRE											
MS 2MG/ML INJ 1-2MG		Pre-Admit Date	Procedure:										
ESQUAM 2MG/2ML INJ		Date of surgery	Age 62	Sex M	Ht. 11.00	Wt. 180	Kg. 81.50						
PEPCID INJ 20MG/20ML		Allergies , NO KNOWN ALLERGIES											
CORBARONE 200MG TAB		Pre-Admit-Vital Signs	B/P	Pulse	Resp	Temp	SpO2						
LACAL-LURE S.O.P.		Pre-Op Vital Signs	#1 B/P	Pulse	Resp	Temp	SpO2						
TYLENOL 650MG SUPP		NPO after midnight		NPO Since:		Name patient goes by							
TYLENOL 325MG TAB		Do you smoke?	Amount	Do you drink alcohol?	Amount								
ROCEPHIN 1GM INJ 10		FEMALE											
KCL 40MEQ/20ML INJ		CHILD:		Premature									
DIGOXIN 0.25MG/ML		Medications											
CENTANTICIN 80MG/20ML		Medical History Primary Physician											
HEPARIN FLUSH 100U/		<input type="checkbox"/> Cardiac/Pulmonary/Other Special Work-ups:											
MAGNESIUM SULFATE 1		Cardiac											
AMOXICILLIN-PO 125		Pulmonary											
FENICILLIN 6 R-IV		Peripheral-Vascular											
		EKG											
FLUIDS (*)													
DSW 1500 R FEM PRO													
DSW (C.O.) 1500 R													
Dianeal PD 1.5% +B													
IV Meds													
NS 1250 1100 00													
NS 11000 0300													
NS 11000													
PRECO 1250													
ANESTHESIA GASES (NONE)													
IV DRUGS (*)													
DSW+HEPARIN 1250 00													
FOR CUUH CIRCUIT													
VENT SETTINGS (*)		- MORE -											
ARTERIAL BLOOD GASES													
VITAL SIGNS PLOT ITEMS (*)													
Allergies: , NO KNOWN ALLERGIES													
Return				Erase data	Describe Item	Store	Toggle Mode	Edit Topic	Print				

Data Entry



Each row within a pre-defined section can be assigned individual pre-configured choice lists. Each row within a user-defined section can be assigned the same pre-configured choice list.

Flowsheet data can be entered by:

- Typing in the corresponding choice list number; or
- Typing in the flowsheet data in free text; or
- Pressing the [Insert] key to place an “X” as an entry.



Data not-yet-stored can be configured to appear as underlined until stored.



User initials can be configured to appear once the data stored.

- Quick Notes
 - The Notes application can be accessed directly from a pre-configured flowsheet section via the “Add Note” soft key [Shift][F6]. The new notes created via this function can be reviewed from the Notes Screen.

Scrolling Section Key Entry

Within a scrolling section in a flowsheet:

- The [Tab] key moves the cursor forward (down) one page in the section.
- The [Shift][Tab] key moves the cursor backward (up) one page in the section.

Within non-scrolling section in a flowsheet:

- The [Tab] key moves the cursor forward (down) to the top of the next section.
- The [Shift][Tab] key moves the cursor backward (up) to the bottom of the previous section.

Responding To An IV-Drug Dose Warning.



A warning can be configured to appear on the Vital Signs, Intake & Output and Order Entry Flowsheets when an IV-Drug dose entered and/or automatically calculated violates the configured limits. For example, if a rate is entered on the Vital Signs Flowsheet and, when calculated to dose, it exceeds the maximum limit, the warning will appear.

The user then must respond by either accepting or rejecting the entered and/or calculated dose. The configured minimum and/or maximum limits will be visible when assigning the fluid.

Configured limits 

Minimum Dose:	1.00 (U/hr)
Maximum Dose:	100.00 (U/hr)

- To overwrite the warning and chart the new dose, type in ‘Y’ for Yes and press the [Enter] key.
 - The new dose will appear on the flowsheet.
- To change the charted dose to be within the configured limits, type in ‘N’ for No and press the [Enter] key.
 - The new dose will NOT appear on the flowsheet.

A SAMPLE ANESTHESIA RECORD FLOWSHEET WITH ACTIVITY LOG

Thompson, Gregory		OR-2	Phy: Dr. Brookstone		(Env TEST)	14:47 Jul 25, 97																																																					
VITALS PLOT (*)		A N E S T H E S I A R E C O R D						Time: 1446 25 Jul 97																																																			
		1626	1630	2100	2200	0500	0509	0600	1000	1446	Day	Eve	Noc	Tot																																													
		♥ HR (BPM) ▼ NBP-S (mmHg) ▲ NBP-D (mmHg) ◻ ABP-S (mmHg) ◼ ABP-D (mmHg)																																																									
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>1446 Jul 25</td><td></td></tr> <tr><td>HT cm (cm)</td><td>175.3</td></tr> <tr><td>WT kg (kg)</td><td>43.1</td></tr> <tr><td>calcWT (kg)</td><td>43.1</td></tr> <tr><td>BSA (m²)</td><td>1.5</td></tr> <tr><td colspan="2">ADMIT DATA</td></tr> <tr><td>Age</td><td>51</td></tr> </table>		1446 Jul 25		HT cm (cm)	175.3	WT kg (kg)	43.1	calcWT (kg)	43.1	BSA (m ²)	1.5	ADMIT DATA		Age	51											<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="2" style="text-align: center;">YESTERDAY</td><td colspan="2" style="text-align: center;">TODAY</td></tr> <tr><td>Jul 24 97</td><td></td><td>Jul 25 97</td><td></td></tr> <tr><td>IN</td><td>0</td><td>0</td><td></td></tr> <tr><td>OUT</td><td>0</td><td>0</td><td></td></tr> <tr><td>NET</td><td>+0</td><td>+0</td><td></td></tr> <tr><td colspan="2">Time</td><td colspan="2">Weight (kg)</td></tr> <tr><td>0400 Jul 1</td><td></td><td>43.1</td><td></td></tr> <tr><td>0400 Jul 1 calc</td><td></td><td>43.1</td><td></td></tr> </table>		YESTERDAY		TODAY		Jul 24 97		Jul 25 97		IN	0	0		OUT	0	0		NET	+0	+0		Time		Weight (kg)		0400 Jul 1		43.1		0400 Jul 1 calc		43.1	
1446 Jul 25																																																											
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YESTERDAY		TODAY																																																									
Jul 24 97		Jul 25 97																																																									
IN	0	0																																																									
OUT	0	0																																																									
NET	+0	+0																																																									
Time		Weight (kg)																																																									
0400 Jul 1		43.1																																																									
0400 Jul 1 calc		43.1																																																									
VITAL SIGNS (*)																																																											
SpO2												96		SpO2 (%)																																													
NBP-M												81		NBP-M (mmHg)																																													
TempC												36.2		TempC (DegC)																																													
MEDICATIONS (*)																																																											
AMITRIPTYLINE 50 MG PO QHS												50 MG		0700		AMITRIPTYLINE																																											
VANCOMYCIN INJ 1.0GM IV Q12HR														0700		VANCOMYCIN INJ																																											
TYLENOL (ACETAMINOPHEN) 325MG TAB 650 MG PO PRN														0700		TYLENOL (ACETAMINOPHEN) 325MG																																											
SOLU-MEDROL (METHYLPREDNISOLONE) INJ 100 MG IV X1														0700		SOLU-MEDROL (METHYLPREDNISOLONE)																																											
ALLOPURINOL 300 MG PO QHS												300 MG		0700		ALLOPURINOL																																											
AXID (NIZATIDINE) 150MG CAP 150 MG PO X1												150 MG				AXID (NIZATIDINE) 150MG CAP																																											
REGLAN (METOCLOPRAMIDE) 10MG TAB 10 MG PO X1												10 MG				REGLAN (METOCLOPRAMIDE) 10MG TAB																																											
AXID (NIZATIDINE) 150MG CAP 150 MG PO X1												150 MG				AXID (NIZATIDINE) 150MG CAP																																											
MORPHINE SULFATE 1-4MG IV PRN																MORPHINE SULFATE																																											
PEPCID 20MG IV Q12																PEPCID																																											
VANCOMYCIN 1 GRAM IV Q12														0800		VANCOMYCIN																																											
TYLX 1-2 PO PRN																TYLX																																											
KCL REPLACEMENT SLIDING																KCL REPLACEMENT SLIDING SCALE:																																											
KCL REPLACEMENT SLIDING																KCL REPLACEMENT SLIDING SCALE:																																											
MGS04 2 GRAMS IN 100CC																MGS04																																											
CHANGE PRESSURE BAG XX																CHANGE PRESSURE BAG																																											
AUTO TRANSFUSION PROTO																AUTO TRANSFUSION PROTOCOL																																											
TYLENOL 650 MG SUPPOS																TYLENOL																																											
FLUIDS (*)																																																											
DSMS 1250 CORDIS 020												1250		0		0		0		0																																							
IV Meds														0		0		0		0																																							
IUPB 1100												1100		0		0		0		0																																							
MS FOR CARDIAC OUTPUT												1500		0		0		0		0																																							
OR FLUIDS 11000												11000		0		0		0		0																																							
PLASMANATE 1250												1250		0		0		0		0																																							
OR FLUIDS 1500												1500		0		0		0		0																																							
ANESTHESIA GASES (NONE)																																																											
IV DRUGS (*)																																																											
VENT SETTINGS (*)																																																											
ARTERIAL BLOOD GASES (*)																																																											
VITAL SIGNS PLOT ITEMS (*)																																																											
Allergies: DARUON (PROPOXYPHENE)																																																											
Return																																																											

SCHEDULE MARKERS SAMPLE TREATMENTS FLOWSHEET

Coag, Carlton		I-3	Phy: Dr. Brookstone		(Env	D0D-ICU)	13:59 Jul 25, 97
Treatments Flowsheet							
BASIC CARE (*) IV ACCESS (*) RESPIRATORY (NONE) O2 THERAPY/NEBS (NONE) TUBES/DRAINAGE DEVICES (NONE) LABS RADIOLOGY (NONE) OTHER DIAGNOSTICS (NONE) CONSULTS (NONE) BEDSIDE TESTING (NONE) TREATMENTS/INTERVENTIONS (NONE) OTHER TREATMENTS (*)							
							Time: 2300 1 Jul 97
		1 Jul	2 Jul	2 Jul	2 Jul	2 Jul	
		2300	0000	0100	0200	0300	
VITAL SIGNS	Q-SHIFT	█					VITAL SIGNS
BLEEDING HEMATOMA W/ US CHECKS/	Q-SHIFT						CHECK PUNCTURE SITE FOR
CALL H.O FOR PROBLEMS	Q-SHIFT						CALL H.O FOR PROBLEMS
S/P UE VENOGRAM WITH	QSHIF		X				S/P UE VENOGRAM WITH
L ARM 6 FR SHEALTH WITH	Q-SHIFT						L ARM 6 FR SHEALTH WITH
DO NOT DRAW PTT ABOVE	QSHIF		X				DO NOT DRAW PTT ABOVE
ICE TO HIP PRN	QSHIF		X				ICE TO HIP PRN
SGD TO BLE	QSHIF		X				SGD TO BLE
Vital Signs	Q4				X		Vital Signs
Maintain Pain Mgmt	QSHIF		X				Maintain Pain Mgmt
If RR<8 Call HO	PRN						If RR<8 Call HO
If BP<90 Sys Call HO	PRN						If BP<90 Sys Call HO
Call HO	PRN						Call HO
No Additional Pain Med	QSHIF		X				No Additional Pain Med
Maintain PCA	QSHIF		X				Maintain PCA
PCA Injection Dose	PRN						PCA Injection Dose
Basal Rate	QSHIF		X				Basal Rate
Max 1 hour limit	QSHIF		X				Max 1 hour limit
SAFETY/RESTRAINTS (*)							
MORE							
Enter Time	New Order	D/C	Copy Forward	Describe Item	Store	Set Freq.	Reset Schedule

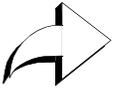
System Schedules

When assigned, the frequency will appear next to the flowsheet row label. For additional schedule information for a flowsheet row, press the “Describe Item” soft key <F7>.



When a row is stopped the schedule markers are discontinued. When the cursor is positioned after the stop time, the row label will not display the frequency or comment.

Schedule markers for a set schedule will be visible only in those time columns existing on the flowsheet. However, should a time column be created at the time interval of the assigned schedule, a marker will appear.

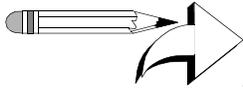


Once charted, the system will automatically discontinue flowsheet rows with Xn or STAT frequency. For these frequencies, a D/C gray bar or Stop Time bracket will automatically appear in the time column where charted.

Limited Schedule

- (Xn = where n is the maximum number of deliveries)
 - X1 = One Time Delivery
 - STAT = Immediately (One Time Delivery)
- Limited schedules will be automatically discontinued after charting the last delivery per the frequency.
- Limited schedules will be automatically displayed on the Order Entry Task List. After the last delivery, the item will drop off Task List.
- The schedule markers for limited schedules can be added or removed via the “Schedule” soft key <F10>.
- Qm Xn = The interval between the deliveries is defined for limited schedules (where m = the interval in hours).

Periodic Schedule (Qn = where n is the interval between deliveries)



Schedule markers for periodic schedules can be configured to be automatically delayed until the first delivery is charted.

- An interval warning will appear if the interval between the deliveries is less than the specified interval (e.g., four hours for Q4). The warning will not prevent the charting of the delivery on the screen.
- Periodic schedules will be automatically displayed on the Order Entry Task List.
- Frequency can be delayed via the “Schedule” soft key <F10> and selecting the ‘Delay’ option. Delayed frequencies will be notated with a Minus symbol next to the frequency in the row label. Delayed schedules will be displayed on the Order Entry Task List with the Minus symbol.
- Free Text Schedules: The system will allow schedules to be entered in free text as follows:
 - Q N X where N = Type in a number greater than zero; X = Type in D for Day, H for Hour or M for Minutes (e.g., Q15M is equivalent to every 15 minutes).
 - The schedule default for the free text entry is Hours.
 - The schedule, when assigned, will round to the nearest hour or day (or portion thereof) depending on the schedule.

Pre-defined, Non-periodic Schedule (QD, BID, TID, QID, Weekly, MWF, etc.)

- Pre-defined, non-periodic schedules can be modified to include limited schedules (i.e., x1, x2, etc.), which will be automatically discontinued after the final delivery.
- Pre-defined, non-periodic schedules are configured by the hospital and will be automatically displayed on the Order Entry Task List.
- The schedule markers for pre-defined, non-periodic frequencies can be added or removed via the “Schedule” soft key <F10>.

PRN = Deliver as needed. PRN frequencies will not be displayed on the Order Entry Task List.

Undefined Schedules

- Undefined frequency schedule markers can be added or removed via the “Schedule” soft key <F10>.

- Undefined schedules will not appear on the Order Entry Task List.

SAMPLE TREATMENT FLOWSHEET WITH THE "FIND ROW" WINDOW

Cursor

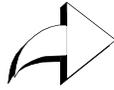
Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 14:16 Jul 25, 97																
Treatments Flowsheet																
															Time: 1400 25 Jul 97	
ACTIVITY	25 Jul	25 Jul														
	0100	0200	0300	0400	0500	0600	0700	0800	0900	1000	1100	1200	1300	1400		
Activity ROM																Activity ROM
RESPIRATORY																
Suction																Suction
Cough/Deep Breathe																Cough/Deep Breathe
Trach Care																Trach Care
NUTRITION																
Diet%																Diet%
Rate/%																Rate/% (cc)
Diet/Nutrition Consult																Diet/Nutrition Consult
LINE TUBES																
Peripheral IV																Peripheral IV
IV Site																IV Site
Central IV																Central IV
Site																Site
Swan Line																Swan Line
Arterial Line																Arterial Line
IABP																IABP (ratio)
ICP Line																ICP Line
Cal&Zero Lines																Cal&Zero Lines
Chest Tube																Chest Tube
NG Placement/Residual																NG Placement/Residual
DIALYSIS CIRCUIT																
Circuit																Circuit
Filter																Filter
PD Exchange																PD Exchange
Placement																Placement
INTEGUMENTARY STATUS																
Dressing Check/Change																Dressing Check/Change
Pulse Check																Pulse Check
Hygiene																Hygiene
Foley																Foley
Skin Care																Skin Care
Peri Care																Peri Care
INTERVENTIONS																
Therapeutic Bed																Therapeutic Bed
Precautions																Precautions
Anti-Embolism Stockings																Anti-Embolism Stockings
PAS Stockings																PAS Stockings
Orthopedic Appliance																Orthopedic Appliance
Hypo/Hyperthermia																Hypo/Hyperthermia
RESTRAINTS																
BEDSIDE TESTING																
SAFETY / ACUITY STATUS																
TREATMENTS (NONE)																
PROCEDURES (NONE)																
LABS (NONE)																
																Cancel

Row	Site	Section
Activity		LINE TUBES
Anti-Embolism Stockings		ACTIVITY
Arterial Line		INTERVENTIONS
Cal&Zero Lines		LINE TUBES
Call Light in Reach		LINE TUBES
Central IV		SAFETY / ACUITY STATUS
Chest Tube		LINE TUBES
Circuit		LINE TUBES
Cough/Deep Breathe		DIALYSIS CIRCUIT
Diet%		RESPIRATORY
Diet/Nutrition Consult		NUTRITION
Dressing Check/Change		INTEGUMENTARY STATUS
EKG/CXR		BEDSIDE TESTING
Elimination Offered		RESTRAINTS
Extremity Check		RESTRAINTS
Filter		DIALYSIS CIRCUIT
FingerStick Glucose		BEDSIDE TESTING
Foley		INTEGUMENTARY STATUS
Gastric pH (x.x)		BEDSIDE TESTING
Hematest		BEDSIDE TESTING
Hygiene		INTEGUMENTARY STATUS
Hypo/Hyperthermia		INTERVENTIONS
IABP		LINE TUBES

Search Mode: Row Section

Enter Search String:

3.3.2 BASIC FUNCTIONS



Verify the time column is appropriate to the charting time required.

3.3.2.1 Finding a Flowsheet Row

To locate a row within a large flowsheet, perform the following steps.

1. Within the large flowsheet, press the [Page Down] key.
 - The Find Row window will appear on the screen.
2. Highlight the desired search mode (i.e., Row, Section) with the [Left Arrow], [Right Arrow] or [Tab] keys.
3. Type in the first few characters of the desired row.
 - The search string is not case specific (i.e., lower case or upper case).
 - The system will display all available flowsheet rows matching the search string.
4. Highlight the desired row with the [Up Arrow] and [Down Arrow] keys.
5. Press the [Enter] key.
 - The cursor will be positioned on the selected row.

3.3.2.2 Entering an Event in a Plot Section

Noted events deemed important to patient care and treatment can be charted in relation to graphically displayed vitals data. To record an event, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to the plot section.
 - The Events choice list will appear.
 - Events choice lists are configurable per flowsheet.
 - Each plot section can be configured to have a unique event choice list.
 - Event choices can now be up to 32 characters in length.
 - The plot section resizes to fit the longest event currently displayed.
 - To hide the choice list, press the “Hide Choices” soft key <F4>.



The naming of the “Plot 24 Hours” soft key label <F5> is configurable on a per flowsheet basis. If the label is not configured, the soft key label will default to the original label of “Plot 24 Hours.”

3. Move the cursor to highlight the desired time column.
4. Enter in the event.
 - Type in the number corresponding to the event desired.

OR

 - Type in the event in free text.
 - The cursor for free text entries is located in the plot section above the time column.
 - There is a space limit of 15 -32 characters depending on how your system was configured.
5. Press the [Enter] key.
 - The entered event will be vertically displayed in the plot section.
6. When finished with the entire screen, press the “Store” soft key <F8>.

3.3.2.3 Importing Monitored Data

All monitored patient data can be automatically captured and recorded on a flowsheet, in addition to obtaining previous parameters. To import monitored data, perform the following steps.

1. Select the desired Flowsheet.
2. If capturing previously monitored data, change the time by pressing the “Enter Time” soft key <F1>, entering in the desired time and pressing the [Enter] key.
3. Press the “Read Monitor” or “Read Rates” soft key <F2>.



If Read Monitor/Read Rates data is entered before the patient was transferred to the current bed, a warning will appear.

- Monitored parameters will automatically appear in the column where the cursor is located.



Monitored parameters will be continuously read as long as the patient is connected to the bedside monitor. However, monitored data will not be transferred to the system until the “Read Monitor” soft key is pressed.



4. Verify the imported information is correct.
 - Change any values desired or press the “Read Monitor” soft key <F2> again for the most current monitored data.
5. Edit or add data as desired.
6. Press the [Enter] key after each entry.
7. When finished with the entire screen, then press the “Store” soft key <F8>.

3.3.2.4 Copying Existing Flowsheet Data



Enter Time		New Order		D/C	Copy Forward	Describe Item		Set Freq.	Reset Schedule		
------------	--	-----------	--	-----	--------------	---------------	--	-----------	----------------	--	--

For speed in data entry, previously charted flowsheet data can be copied into the current time column. The Copy Forward is configured per flowsheet section by the hospital. To copy existing flowsheet data forward, perform the following steps.

1. Select the desired flowsheet.
2. Verify the cursor is in an empty time column to the right side of the time column with data to be copied.
3. Press the “Copy Forward” soft key <F6>.



- Copy forward will bring forward all information from the proceeding time column. This feature can be configured to bring forward alpha only or both alpha and numeric.

4. Edit or add data as desired.
5. Press the [Enter] key after each entry.
6. When finished with the entire screen, press the “Store” soft key <F8>.

SAMPLE TREATMENTS FLOWSHEET

Coag, Carlton		I-3	Phy: Dr. Brookstone		(Env D0D-ICU)	13:59 Jul 25, 97	
Treatments Flowsheet							
BASIC CARE (*) IV ACCESS (*) RESPIRATORY (NONE) O2 THERAPY/NEBS (NONE) TUBES/DRAINAGE DEVICES (NONE) LABS RADIOLOGY (NONE) OTHER DIAGNOSTICS (NONE) CONSULTS (NONE) BEDSIDE TESTING (NONE) TREATMENTS/INTERVENTIONS (NONE) OTHER TREATMENTS (*)							
						Time: 2300 1 Jul 97	
		1 Jul	2 Jul	2 Jul	2 Jul	2 Jul	
		2300	0000	0100	0200	0300	
VITAL SIGNS		Q-SHIFT					VITAL SIGNS
CHECK PUNCTURE SITE FOR BLEEDING HEMATOMA W/ US CHECKS/ CHECK DISTAL PULSES W/ US CHECKS		Q-SHIFT					CHECK PUNCTURE SITE FOR
CALL H.O FOR PROBLEMS PAIN MAEDS PER REFERRING SERVICE		Q-SHIFT					CALL H.O FOR PROBLEMS
S/P UE VENOGRAM WITH THROMBOLIC THERAPY (URKINASE INFUSION)		QSHIFT		X			S/P UE VENOGRAM WITH
L ARM 6 FR SHEALTH WITH HEPARINIZED SALINE (1,000U/500cc NS) to tko		Q-SHIFT					L ARM 6 FR SHEALTH WITH
DO NOT DRAW PTT ABOVE HEPARIN IV (D51/2NS)		QSHIFT		X			DO NOT DRAW PTT ABOVE
ICE TO HIP PRN		QSHIFT		X			ICE TO HIP PRN
SCD TO BLE		QSHIFT		X			SCD TO BLE
Vital Signs While on PCA		Q4				X	Vital Signs
Maintain Pain Mgmt Flowsheet		QSHIFT		X			Maintain Pain Mgmt
If RR<8 Call HO BEEPER #3144		PRN					If RR<8 Call HO
If BP<90 Sys Call HO BEEPER #3144		PRN					If BP<90 Sys Call HO
Call HO (PCA) FOR URINARY RETENTION		PRN					Call HO
No Additional Pain Med While PCA is in use w/o prior approval of Pt's MD		QSHIFT		X			No Additional Pain Med
Maintain PCA as Primary line		QSHIFT		X			Maintain PCA
PCA Injection Dose 2 ML		PRN					PCA Injection Dose
Basal Rate 0 ML/HR		QSHIFT		X			Basal Rate
Max 1 hour limit 15 ML/HR		QSHIFT		X			Max 1 hour limit
SAFETY/RESTRAINTS (*)							
MORE							
Enter Time	New Order	D/C	Copy Forward	Describe Item	Store	Set Freq.	Reset Schedule

3.3.2.5 Discontinuing a Flowsheet Row



Only flowsheet rows that have been ordered (i.e., fluids, labs, treatments) can be discontinued. To discontinue an ordered flowsheet row, perform the following steps.



A row cannot be D/Ced before the hour it was assigned, charted or replenished.

1. Select the desired flowsheet.
2. Move the cursor to highlight the desired row and the time column to be discontinued.
3. Press the “D/C” soft key <F5>.
 - A confirmation prompt may appear.
4. Type ‘N’ for No to abort the discontinuation of the flowsheet row **OR** Type ‘Y’ for Yes to discontinue the flowsheet row.



- If yes is entered, a time bar and arrowhead will appear up to the time column where the cursor was placed. The time bar will appear black until the screen is stored.
- To remove a discontinued error, move the cursor to the desired data cell within the D/Ced row and press the “D/C” soft key <F5> again. A confirmation prompt can be configured to appear.
- To adjust the D/C time forward or back, move the cursor to the desired data cell within the D/Ced row and press the “D/C” soft key <F5> again.



Discontinued rows will not appear on the next day’s flowsheet, nor will you be able to document data after the row is discontinued.

- The D/Ced rows can be configured to drop off the screen as soon as the D/C time leaves the screen or when the shift is over.

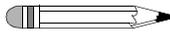
3.3.2.6 Setting or Changing Flowsheet Schedule



A schedule for timed events such as Medications and Treatments can be created or changed. To create or change the schedule for a row with an ordered frequency (i.e, Medications, Treatment), perform the following steps.

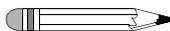
1. Select the desired flowsheet.
 2. Move the cursor to highlight the desired flowsheet row and time column.
 3. Press the “Set Frequency” soft key <F9>.
 4. Type in the number corresponding to the desired schedule.
- OR**
5. The system allows schedules to be entered in free text.
 6. Press the [Enter] key.
 7. Type in a start time if different from the default time.
 8. When finished setting the frequency, press the “Done” soft key <F3>.
 9. When finished with the entire screen, press the “Store” soft key <F8>.

THE 'TOGGLE MARKER' WINDOW SAMPLE TREATMENT FLOWSHEET

 Schedule markers can be delayed until the initial delivery is charted.

Cursor

Daniels, Erin		561		Phy: Dr. Brookstone		(Env ICU)		16:49 Jul 30, 97						
Treatments Flowsheet														
ACTIVITY (*) RESPIRATORY (*) NUTRITION (*) LINE TUBES (*) DIALYSIS CIRCUIT INTEGUMENTARY STATUS INTERVENTIONS (*) RESTRAINTS (*) BEDSIDE TESTING (*)														
- MORE -														
Time: 1400 1 Jul 97														
Hematest	1 Jul 0900	1 Jul 1000	1 Jul 1100	1 Jul 1200	1 Jul 1300	1 Jul 1400	1 Jul 1500	1 Jul 1600	1 Jul 1700	1 Jul 1800	1 Jul 1900	1 Jul 2000	1 Jul 2100	Hematest
FingerStick Glucose						182								FingerStick Glucose
Specific Gravity														Specific Gravity
ERG/CXR														ERG/CXR
SAFETY / ACUITY STATUS (*)														
Side Rails	X4							X4					X4	Side Rails
Call Light in Reach														Call Light in Reach
Isolation														Isolation
Level Of Care	C							T					T	Level Of Care
Instructed on Safety														Instructed on Safety
TREATMENTS (*)														
DAILY WT	QD													DAILY WT
NG TO GRAVITY	QSHIFT	X						X						NG TO GRAVITY
SCD'S BILAT CALF	QSHIFT	X						X					ON	SCD'S BILAT CALF
SOFT RESTRAINTS	QSHIFT	ON						ON					ON	SOFT RESTRAINTS
RESUME PREVENT PT FROM PULLING LINES /ET TUBE														
D-STICK	Q6													
CALL HO FOR >400. COVER W/ SS														
INSULIN FOR GLUCOSE 200-400														
CALL ICU HO & ROD FOR HEMATOMA OR LINE PROBLEM	PRN	X												
TRANSFER TO ICU-WEST S/P L FRONTAL CRANI W/ L MCA ANEURYSM CLIPPING	QSHIFT	X												
CONDITION GUARDED	QSHIFT	X												CONDITION GUARDED
VITAL PER ROUTINE	QSHIFT	X						X						VITAL PER ROUTINE
ALLERGIES NKDA	QSHIFT	X						X						ALLERGIES NKDA
BR W/ HOB @ 20 DEGREES	QSHIFT	X						X						BR W/ HOB @ 20 DEGREES
STRICT I&O'S	QSHIFT	X						X						STRICT I&O'S
FOLEY TO GRAVITY	QSHIFT	X						X						FOLEY TO GRAVITY
NPO	QSHIFT	X						X						NPO
Maintain SBP <160 call HO	QSHIFT	NOTED						DONE					NOTED	Maintain SBP <160
NEUROCHECKS	Q4HRS	X						X						NEUROCHECKS
weaning parameters at 0700 hr .	QSHIFT												DONE	weaning parameters
HOLD FENTANYL GTT	X1													HOLD FENTANYL GTT
ON CALL TO CT SCAN	X1													ON CALL TO CT SCAN
diet: osmolyte @10cc/hr.	QSHIFT													diet: osmolyte @10cc/hr
PROCEDURES														
LABS (*)														
Done														
Toggle Marker														
Cancel														

 The Plus/Minus symbol indicates the scheduled hours have been modified.

3.3.2.7 Resetting a Periodic Flowsheet Schedule



A periodic schedule (e.g., Q2, Q4, Q6) on a flowsheet row (e.g., within a treatment or medication section) can be reset with the time markers automatically adjusting. To reset the schedule markers for a specific row on a flowsheet, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to the desired flowsheet row and time column where the new schedule markers will begin.
3. Press the “Reset Schedule” soft key <F10>.
 - To delay and/or reset schedule markers, press the “Schedule” soft key <F10>. The Schedule window will appear in which schedule options may be selected.
 - A minus (-) symbol will appear next to the frequency label to indicate a delayed schedule.
4. When finished with the flowsheet, press the “Store” soft key <F8>.

 *This function is limited to users with RESCHEDULE permission.*

3.3.2.8 Resetting A Pre-defined, Non-periodic Time Schedule



To reset a pre-defined, non-periodic schedule (QD, BID, TID, QID, etc.), perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to the desired row with the pre-defined, non-periodic schedule (e.g., QD, BID, TID, QID, etc.).
3. Move the cursor to the schedule marker to be changed.



Starting the new schedule after an uncharted schedule marker may result in extraneous markers.



Changing the schedule will only affect markers from the cursor time forward, including future days. Markers prior to the cursor time will not be affected.

4. Press the “Reset Schedule” soft key <F10>.
 - The Toggle Marker window will appear.
5. Modify the schedule markers on the Toggle Marker window.
 - Move the cursor to the desired hour block with the [Left Arrow] or [Right Arrow] keys.
 - Press the “Toggle Marker” soft key <F10> to either clear or set the schedule marker.
6. When finished modifying the schedule marker(s), press the “Done” soft key <F3>.



The number of markers in the Toggle Marker window is forced by the system to remain the same.

- The Plus/Minus “±” symbol will appear in the row label next to the original frequency indicating the schedule was changed.
 - The new schedule times may be viewed via the Describe Item function.
7. When finished with the entire screen, press the “Store” soft key <F8>.
 - The Orders Task List will be updated to display the schedule change.

3.3.2.9 Adding a Group of Pre-Defined Rows to a Flowsheet



Pre-configured flowsheet rows can be added individually or in groups to the flowsheet on a per patient basis. Once added to the flowsheet, the new row(s) can be either started or stopped as needed. To add a group of pre-defined rows to a flowsheet, perform the following steps.



New parameters will remain a part of the patient's permanent record. The rows will not disappear from the flowsheet until Stop Times are assigned.

1. Select the desired flowsheet.
2. Press the “Add Row” soft key <F3>.
 - The Add Group choice list will appear with hospital-configured row groups.
3. Move the cursor to highlight the desired row group option with the [Arrow] keys.
4. Press the [Enter] key.
 - The selected group of parameters will appear on the flowsheet.
 - The Start Time Indicator (“[”) will automatically appear on the screen for the new rows.
5. Enter in patient data for the new rows.
6. Press the [Enter] key after each entry.
7. When finished with the entire screen, press the “Store” soft key.

3.3.2.10 Adding an Individual, Pre-Defined Row to a Flowsheet



To add an individual, pre-defined row to a flowsheet, perform the following steps.

1. Select the desired flowsheet.
2. Press the “Add Row” soft key <F3>.
 - The Add Group choice list will appear with pre-defined groups.
3. Move the cursor to highlight ‘Optional Rows’ with the [Arrow] keys.
4. Press the [Enter] key.
 - The ‘Optional Rows’ choice list will appear with hospital-configured row labels.
5. Move the cursor to highlight the desired row label with the [Arrow] keys.
6. Press the [Enter] key.
 - The selected row label will appear on the flowsheet.
 - The Start Time Indicator (“[”) will automatically appear on the screen for that row.
7. Enter in patient data for the new row.
8. Press the [Enter] key after each entry.
9. When finished with the entire screen, press the “Store” soft key.

START AND STOP TIME BRACKETS SAMPLE TREATMENTS FLOWSHEET

Start Time Bracket

Stop Time Bracket

Coag, Carlton		I-3	Phy: Dr. Brookstone		(Env DOD-ICU)	17:03 Jul 30, 97			
Treatments Flowsheet									
BASIC CARE (*)						Time: 1200 2 Jul 97			
		2 Jul 0800	2 Jul 0900	2 Jul 1000	2 Jul 1100	2 Jul 1200			
ADL							ADL		
Activity			A				Activity		
Hygiene			SELF				Hygiene		
Diet							Diet		
Diet%			100				Diet%		
Safety Measures							Safety Measures		
Nsg CP Reviewed							Nsg CP Reviewed		
Acuity							Acuity		
Patient Teaching									
Emotional Support									
IV ACCESS (*)									
Peripheral IV			X2						
Heparin/Saline Lock							Lock		
RESPIRATORY (NONE)									
O2 THERAPY/NEBS (NONE)									
TUBES/DRAINAGE DEVICES (NONE)									
LABS									
PTT	X1		0600				PTT		
AT 0600 (1-15) CALL HD IF PTT <60 >80									
PTT @ 1400	X1						PTT @ 1400		
RECHECK PTT	X1						RECHECK PTT		
IN 6HRS THIS 2ND BOLUS									
RADIOLOGY (NONE)									
OTHER DIAGNOSTICS (NONE)									
CONSULTS (NONE)									
BEDSIDE TESTING (NONE)									
TREATMENTS/INTERVENTIONS (*)									
OTHER TREATMENTS (*)									
SAFETY/RESTRAINTS (*)									
Enter Time	Add Row	Hide Choices	Copy Forward	Describe Item	Store	Set Freq.	Reset Schedule	Start Row	Stop Row

- Acuity

 - 0 - Category 0 (0)
 - 1 - Category I (I)
 - 2 - Category II (II)
 - 3 - Category III (III)
 - 4 - Category IV (IV)
 - 5 - Category U (U)
 - 6 - Category VI (VI)

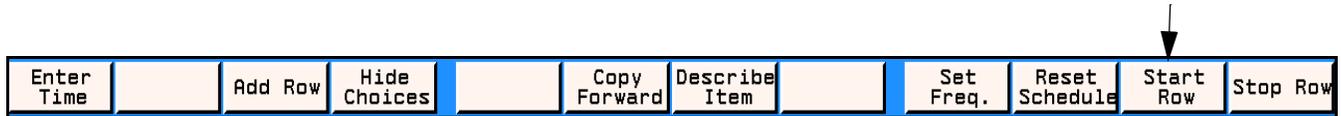
3.3.2.11 Stopping a Pre-Defined Flowsheet Row



A pre-defined row can be stopped and re-started multiple times. This is indicated on the flowsheet with the “[“ and “]” bracket. However, a start time must be followed by a stop time before another start time is initiated. To stop a pre-defined row, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight a row with a start bracket and time column.
3. Press the “Stop Row” soft key <F12>.
 - A Stop Time Indicator “]“ will automatically appear on the screen for that row.
 - The stopped row will disappear from the screen when the Stop Time Indicator is off the screen at the far LEFT.
4. When finished with the entire screen, press the “Store” soft key <F8>.

3.3.2.12 Re-starting a Pre-Defined Flowsheet Row



A pre-defined row can be stopped and re-started multiple times. This is indicated on the flowsheet with the “[“ and “]” brackets. However, a start time must be followed by a stop time before another start time is initiated. To re-start a pre-defined row still visible on the flowsheet, perform the following steps.



If the row is no longer visible on the flowsheet, the row will need to be added back on the flowsheet with the Add Row function.

1. Select the desired flowsheet.
2. Move the cursor to highlight the desired row and time column after the stop bracket.
3. Press the “Start Row” soft key <F11>.
 - The Start Time Indicator “[“ will automatically appear on the screen for that row.



A ‘re-started’ row will not disappear from the flowsheet until a Stop Time is assigned to it.

4. When finished with the entire screen, press the “Store” soft key <F8>.

FLOWSHEET ANNOTATION SAMPLE NEUROLOGICAL ASSESSMENT FLOWSHEET

Row Name Annotation Time and Date

Daniels, Erin		561		Phy: Dr. Brookstone		(Enr)		ICU		17:12 Jul 30, 97			
Treatments Flowsheet													
											Time: 1200 29 Jun 97		
Activity	29 Jun 0900	29 Jun 1000	29 Jun 1100	29 Jun 1200	29 Jun 1300	29 Jun 1400	29 Jun 1500	29 Jun 1600	29 Jun 1700	29 Jun 1800	29 Jun 1900	29 Jun 2000	29 Jun 2045
Activity	BR U B					BR U				BR U			Activity
ROOM	A P					A P				A			ROOM
RESPIRATORY (*)													
Suction		S Tk Y								sx			Suction
Cough/Deep Breathe													Cough/Deep Breathe
Trach Care													Trach Care
NUTRITION (*)													
Diet%	NPO					NPO				NPO			Diet%
Rate/%													Rate/% (cc)
Diet/Nutrition Consult													Diet/Nutrition Consult
LINE TUBES (*)													
Peripheral IV	S X2				N X	N X	S X2			S			Peripheral IV
IU Site													IU Site
Central IV													Central IV
Site													Site
Swan Line													Swan Line
Arterial Line	S												Arterial Line
IABP													IABP (ratio)
ICP Line													ICP Line
Cal&Zero Lines		Yes											Cal&Zero Lines
Chest Tube													Chest Tube
NG Placement/Residual													NG Placement/Residual
DIALYSIS CIRCUIT													
Circuit													Circuit
Filter													Filter
PD Exchange													PD Exchange
Placement													Placement
INTEGUMENTARY STATUS (*)													
Dressing Check/Change													Dressing Check/Change
Pulse Check													Pulse Check
Hygiene													Hygiene
Foley													Foley
Skin Care													Skin Care
Peri Care													Peri Care
INTERVENTIONS (*)													
Therapeutic Bed													Therapeutic Bed
Precautions	F Sz					F Sz				F			Precautions
Anti-Embolism Stockings	S On				S Off	S On				S On			Anti-Embolism Stocking
PAS Stockings													PAS Stockings
Orthopedic Appliance													Orthopedic Appliance
Hypo/Hyperthermia													Hypo/Hyperthermia
RESTRAINTS (*)													
BEDSIDE TESTING (*)													
SAFETY / ACUITY STATUS (*)													
TREATMENTS (*)													
PROCEDURES													
LABS													
		OK		Delete									Cancel

Annotation Peripheral IV. 1200 29 Jun 1997

18G LEFT FOREARM. LEFT AC SITE LEAKING, SITE D/C'D

Cursor

3.3.2.13 Creating a Flowsheet Annotation

Flowsheet data cell may be annotated with free text messages. To add an annotation to data cell, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight the data cell.
3. Type in the Asterisk “*” symbol [Shift][8] or asterisk on numeric key pad.
4. Press the [Enter] key.
 - A text window will appear to enter your annotation.
5. Type in your note in free text.
 - The annotation function includes the following features:
 - Words will automatically wrap to the next line of text.
 - Edits are performed in an insert mode.
 - The [Home], [End], [Page Up], [Page Down] and [Backspace] keys are available.
6. Press the “OK” soft key <F3> to accept the annotation as typed.
 - A star will appear in the selected data cell.



- On the Intake & Output Flowsheet, the star will appear in the upper left corner of the data cell.
7. When finished with the entire screen, press the “Store” soft key <F8>.

3.3.2.14 Editing a Flowsheet Annotation

An Annotation can be edited as needed. A complete edit history of each annotation is available for review via the “Describe Item” soft key <F7>. To edit an existing annotation, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight a data cell with the Star symbol.
3. Type in the Asterisk “*” symbol [Shift][8] or asterisk on numeric key pad.
4. Press the [Enter] key.
 - The Edit prompt will appear.
5. Type in ‘Y’ for Yes and press the [Enter] key.
 - The existing text window will appear with the cursor positioned at the beginning of the text.
6. Type in your changes in free text.
7. Press the “OK” soft key <F3> to accept the edits as typed.
 - An Asterisk will appear on the selected flowsheet cell in reverse video to indicate an edit.
8. When finished with the entire screen, press the “Store” soft key <F8>.

SAMPLE TREATMENTS FLOWSHEET VIEWING AN 'ANNOTATION' WINDOW

The time and date of stored annotation.

Pizarro, Francisco		563		Phy: Dr. Brookstone		(Env ICU)		17:18 Jul 30, 97							
Treatments Flowsheet															
ACTIVITY (*)															
		29 Jun 0000	29 Jun 0100	29 Jun 0200	29 Jun 0300	29 Jun 0400	29 Jun 0500	29 Jun 0600	29 Jun 0700	29 Jun 0800	29 Jun 0900	29 Jun 1000	29 Jun 1100	29 Jun 1200	
Activity		B		B		B		B		RO A/P		RO A/P		RO A/P	Activity
ROM		R		R		R		R							ROM
RESPIRATORY (*)															
Suction		RT		RT		RT		RT		RT		RT		RT	Suction
Cough/Deep Breathe															Cough/Deep Breathe
Trach Care															Trach Care
NUTRITION															
Diet%															Diet%
Rate/%															Rate/% (cc)
Diet/Nutrition Consult															Diet/Nutrition Consult
LINE TUBES (*)															
Peripheral IV															Peripheral IV
IV Site															IV Site
Central IV															Central IV
Site		PICC		PICC		PICC									Site
Swan Line		S		S		S									Swan Line
Arterial Line		S		S		S									Arterial Line
IABP		1:2		1:2											IABP (ratio)
ICP Line															ICP Line
Cal&Zero Lines		Y		Y		Y									Cal&Zero Lines
Chest Tube															Chest Tube
NG Placement/Residual															NG Placement/Residual
DIALYSIS CIRCUIT (*)															
Circuit		S		S		S									Circuit
Filter		F		F		F									Filter
PD Exchange		M/A		M/A		M/A									PD Exchange
Placement		S		S		S									Placement
INTEGUMENTARY STATUS (*)															
Dressing Check/Change		Ck		Ck		Ck									Dressing Check/Change
Pulse Check		X4	X4	X4		X4									Pulse Check
Hygiene							B/O Sv*								Hygiene
Foley		G		G		G		G		G		G		G	Foley
Skin Care		N		N		N		N		N		N		N	Skin Care
Peri Care															Peri Care
INTERVENTIONS (*)															
Therapeutic Bed Precautions		Q2+		Q2+		Q2+		Q2+		Q2+		Q2+		Q2+	Therapeutic Bed Precautions
Anti-Embolism Stockings															Anti-Embolism Stockings
PAS Stockings															PAS Stockings
Orthopedic Appliance															Orthopedic Appliance
Hypo/Hyperthermia															Hypo/Hyperthermia
RESTRAINTS (*)															
BEDSIDE TESTING															
SAFETY / ACUITY STATUS (*)															
TREATMENTS															
PROCEDURES (NONE)															
LABS (NONE)															
		Cancel	Ref	Info	Edit	Hist	Item	Info							

Hygiene Annotation. 0500 29 Jun 1997

AWAKENED FOR BATH, SHAVE AND ORAL CARE. NO CHANGE IN NEURO STATUS. MONDS APPROPRIATELY. INDICATES HE WANTS HIS ET TUBE OUT AND THAT IT IS UNCOMFORTABLE. MEDICATED AGAIN FOR DISCOMFORT AND ANXIETY. ABLE TO ASSIST WITH TURNS.

Created by: Brian Mueller, RN (BM)

The creator and editor of the annotation

3.3.2.15 Deleting a Flowsheet Annotation

To delete an annotation, perform the following steps.

1. Move the cursor to the desired data cell with the annotation.
2. Hold down the [Shift] key and press the [*] key and press the [Enter] key.
 - If deleting a stored annotation, the Edit prompt will appear.
3. Press the “Delete” soft key <F5>.
 - The screen will return to the flowsheet.
 - The annotation asterisk will disappear and a gray box will be displayed to indicate a deleted annotation.
4. When completed with the screen, press the “Store” soft function key <F8>.

3.3.2.16 Reviewing a Flowsheet Annotation

To review a row’s current annotation, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight a data cell with the Asterisk.
3. Press the “Describe Item” soft key <F7>.
 - The CURRENT annotation will appear on the screen.

3.3.2.17 Reviewing a Previous Flowsheet Annotation

To review a row’s previous annotation, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight a data cell with the Asterisk.
3. Press the “Describe Item” soft key <F7>.
4. Press the “Edit Hist” soft key <F6>.



- A complete audit trail on the selected row will appear.
- Annotations surrounded by stars in the Edit History window can be viewed.

Date Stored	Status	Value	Stored by
0544 29 Jun 1997	Curr	** Annotation **	Brian Mueller, RN (BM)
0541 29 Jun 1997	Curr	delivery: B 0 Sv	Brian Mueller, RN (BM)

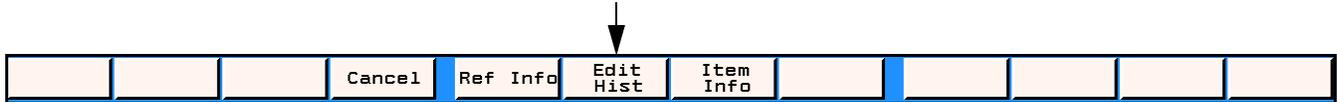
- The status column identifies if the data stored is a current or previously charted value.
5. Move the cursor bar to the desired annotation with the [Up Arrow] and [Down Arrow] keys.
 6. Press the “Show Text” soft key <F7>.
 - A previous annotation will appear in reverse video.
 - Press the “Edit Hist” soft key <F7> to return to the Edit History window.
 7. Press the “Cancel” soft key <F4> to return to the flowsheet.

EDIT HISTORY WINDOW SAMPLE TREATMENTS FLOWSHEET

Pizarro, Francisco 563 Phyl: Dr. Brookstone (Env ICU) 17:36 Jul 30, 97																											
Treatments Flowsheet																											
ACTIVITY (*)													Time: 1000 30 Jun 97														
	30 Jun	0100	30 Jun	0200	30 Jun	0300	30 Jun	0400	30 Jun	0500	30 Jun	0600	30 Jun	0700	30 Jun	0800	30 Jun	0900	30 Jun	1000	30 Jun	1100	30 Jun	1200	30 Jun	1300	
Activity																											Activity
ROM			RO				RO					RO					RO							RO			ROM
RESPIRATORY (*)																											
Suction																											Suction
Cough/Deep Breathe																											Cough/Deep Breathe
Trach Care																											Trach Care
NUTRITION (*)																											
Diet%																											Diet%
Rate/%																											Rate/% (cc)
Diet/Nutrition Consult														Diet/Nutrition Consult													
LINE TUBES (*)																											
Peripheral IU																											Peripheral IU
IU Site																											IU Site
Central IU																											Central IU
Site																											Site
Swan Line																											Swan Line
Arterial Line																											Arterial Line
IABP																											IABP (ratio)
ICP Line																											ICP Line
Cal&Zero Lines																											Cal&Zero Lines
Chest Tube																											Chest Tube
NG Placement/Residual																											NG Placement/Residual
DIALYSIS CIRCUIT (*)																											
Circuit																											Circuit
Filter																											Filter
PD Exchange																											PD Exchange
Placement																											Placement
INTEGUMENTARY STATUS																											
Dressing Check/Change																											Dressing Check/Change
Pulse Check																											Pulse Check
Hygiene																											Hygiene
Foley																											Foley
Skin Care																											Skin Care
Peri Care																											Peri Care
INTERVENTIONS (*)																											
Therapeutic Bed																											Therapeutic Bed
Precautions																											Precautions
Anti-Embolism Stockings																											Anti-Embolism Stockings
PAS Stockings																											PAS Stockings
Orthopedic Appliance																											Orthopedic Appliance
Hypo/Hyperthermia																											Hypo/Hyperthermia
RESTRAINTS (*)																											
BEDSIDE TESTING																											
SAFETY / ACUITY STATUS (*)																											
TREATMENTS (*)																											
PROCEDURES (NONE)																											
LABS (NONE)																											
Cancel																											

The status column identifies if the data stored is current or previously charted.

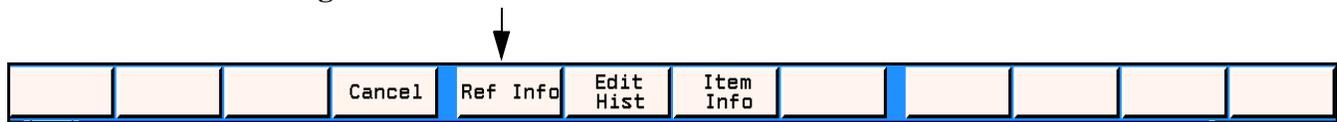
3.3.2.18 Reviewing a Flowsheet Row's Edit History



To review a row's edit history, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight the desired row and time column.
3. Press the "Describe Item" soft key <F7>.
4. Press the "Edit Hist" soft key <F6>.
 - A complete audit trail on the selected row will appear in the Edit History window.
5. Press the "Cancel" soft key <F4> or the [Enter] key to return to the flowsheet.

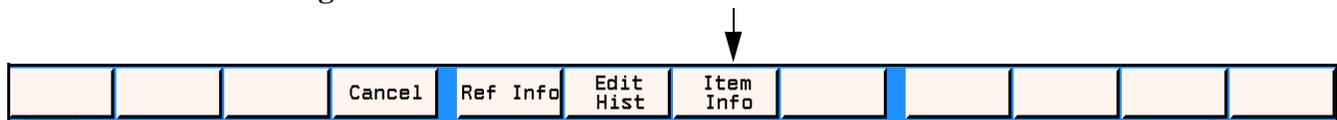
3.3.2.19 Reviewing a Flowsheet Row's Reference Information



The "Ref Info." soft key will only appear if row reference information has been configured by the hospital. To review information on a row (e.g., protocol issues, entry formats, etc.), perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight the desired row and time column.
3. Press the "Describe Item" soft key <F7>.
4. Press the "Ref. Info." soft key <F7>.
 - Pre-configured reference information for the selected row will appear on the screen.
5. Press the "Cancel" soft key <F4> or the [Enter] key to return to the flowsheet.

3.3.2.20 Reviewing Row Information



To review general information on a row, perform the following steps.

1. Select the desired flowsheet.
2. Move the cursor to highlight the desired row and time column.
3. Press the "Describe Item" soft key <F7>.
4. Press the "Item Info." soft key <F7>.
 - Unique information for the selected item will appear on the screen.
5. Press the "Cancel" soft key <F4> or the [Enter] key to return to the flowsheet.

3.4 SPECIAL FLOWSHEET FUNCTIONS



All screen configurations are determined by the hospital and may vary from this manual's screen graphics.

THE VITAL SIGNS FLOWSHEET

Plot Section

Daily Summaries

Kingsford, Larry												300-1		Phy: Dr. Brookstone		(Env ICU)		13:06 Jun 30, 97																																									
Vitals Flowsheet																																																											
VITALS PLOT (*)																		Time: 1306 30 Jun 97																																									
<div style="display: flex; justify-content: space-between;"> <div style="width: 20%;"> <p>1306 Jun 30</p> <p>HT cm (cm) 177.8</p> <p>WT kg (kg) 60.3</p> <p>calcWT (kg) 70.6</p> <p>BSA (m²) 1.9</p> </div> <div style="width: 60%;"> </div> <div style="width: 15%;"> <table border="1" style="font-size: small;"> <thead> <tr> <th colspan="2">YESTERDAY</th> <th colspan="2">TODAY</th> </tr> <tr> <th>Jun 29 97</th> <th>Jun 30 97</th> <th>Jun 29 97</th> <th>Jun 30 97</th> </tr> </thead> <tbody> <tr> <td>IN</td> <td>2179</td> <td></td> <td>0</td> </tr> <tr> <td>OUT</td> <td>2940</td> <td></td> <td>1000</td> </tr> <tr> <td>NET</td> <td>-761</td> <td></td> <td>-1000</td> </tr> <tr> <td colspan="2">Time</td> <td colspan="2">Weight (kg)</td> </tr> <tr> <td>0200</td> <td>Jun 28</td> <td>60.3</td> <td></td> </tr> <tr> <td>0500</td> <td>Jun 27</td> <td>75.6</td> <td></td> </tr> <tr> <td>0500</td> <td>Jun 26</td> <td>74.3</td> <td></td> </tr> <tr> <td>1200</td> <td>Jun 25</td> <td>70.6</td> <td></td> </tr> </tbody> </table> </div> </div>												YESTERDAY		TODAY		Jun 29 97	Jun 30 97	Jun 29 97	Jun 30 97	IN	2179		0	OUT	2940		1000	NET	-761		-1000	Time		Weight (kg)		0200	Jun 28	60.3		0500	Jun 27	75.6		0500	Jun 26	74.3		1200	Jun 25	70.6									
YESTERDAY		TODAY																																																									
Jun 29 97	Jun 30 97	Jun 29 97	Jun 30 97																																																								
IN	2179		0																																																								
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0500	Jun 26	74.3																																																									
1200	Jun 25	70.6																																																									
VITAL SIGNS (*)																																																											
HR			73		84	81		71	80		71	84		78	HR (BPM)																																												
Rhythm															Rhythm																																												
Ectopy															Ectopy																																												
NBP-S															NBP-S (mmHg)																																												
NBP-D															NBP-D (mmHg)																																												
NBP-M															NBP-M (mmHg)																																												
ABP-S															ABP-S (mmHg)																																												
ABP-D			117		103	98		110	105		125	125		122	ABP-D (mmHg)																																												
ABP-M			60		59	58		53	63		55	55		61	ABP-M (mmHg)																																												
B/P Source			DINAM		DINAM	DINAM		DINAM	DINAM		DINAM	DINAM		DINAM	B/P Source																																												
TempF						97.7						98.7			TempF (DegF)																																												
TempC						36.5						37.1			TempC (DegC)																																												
TSrc						0						0			TSrc																																												
Resp			12		28	10		8	8		9	7		8	Resp (RPM)																																												
SpO2		97		98			99			98			97		SpO2 (%)																																												
CUP															CUP (mmHg)																																												
PAS															PAS (mmHg)																																												
PAD															PAD (mmHg)																																												
PAM															PAM (mmHg)																																												
PCW															PCW (mmHg)																																												
CO															CO (L/min)																																												
CI															CI (L/min/M2)																																												
SVR															SVR (Ds/cm5)																																												
SVRI															SVRI (Ds/cm5/M2)																																												
PVR															PVR (Ds/cm5)																																												
SvO2															SvO2 (%)																																												
et CO2															et CO2 (torr)																																												
LOS															LOS																																												
Pain Rating															Pain Rating																																												
IV DRUGS (*)																																																											
Fluid: NS+BUMEX												Volume: 100 (ml)		Rate: 5 (ml/hr)																																													
Drug: BUMEX												Amount: 10 (mg)		Dose: 0.5 (mg/hr)		Conc: 0.1 (mg/ml)																																											
DOPAMINE	2.3														DOPAMINE (mcg/kg/min)																																												
NITROGLYCERIN	0														NITROGLYCERIN (mcg/min)																																												
BUMEX	0.5		1		1	1		1	0.5		0.5	0.5		0.5	D.5	BUMEX (mg/hr)																																											
Allergies: PCN																																																											
Enter Time	Read Rates		Hide IV Info					Describe Item							IV Pump Config																																												

The rate or dose displayed next to the row label is dependent upon the location of the cursor.

3.4.1 VITAL SIGNS FUNCTIONS

3.4.1.1 Recording an IV-Drug Rate/Dose

Patient IV-drug drip rates can be charted every minute if the IV Drug section is configured on the Vital Signs Flowsheet. To record a patient's IV-drug rate, perform the following steps.

1. Select the Vital Signs Flowsheet.
2. Move the cursor to the IV Drug section.
3. Move the cursor to highlight the desired IV-Drug data cell.
 - IV Drug information will automatically appear for the selected IV drug.
 - To hide the IV Drug information window, press the "Hide IV Info" soft key <F4>.
4. Enter the rate of administration in cc/hr.
5. Press the [Enter] key.



When the rate is entered, the CIS will automatically calculate and display the dose.

6. If you prefer to enter the dose of the drug in the data cell, type in the letter <D> and the IV drug dose.
 - The letter "D" may be in upper or lower case.
7. When finished with the entire screen, press the "Store" soft key <F8>.

3.4.1.2 Recording an IV Fluid Rate

To chart a patient's IV fluid rate changes, perform the following steps.



When the IV fluid rate is entered at a specific time (e.g., 1414) on the Vital Signs Flowsheet, the rate will appear in the corresponding time column on the Intake and Output Flowsheet (e.g., 1400).

1. Select the Vital Signs Flowsheet.
2. Move the cursor to the IV Rate section.
3. Move the cursor to highlight the desired IV Drug and time column.
4. Enter the rate of administration in cc/hr.
5. Press the [Enter] key.
6. When finished with the entire screen, press the "Store" soft key <F8>.

THE VITAL SIGNS FLOWSHEET

Lines are configurable

Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 13:06 Jun 30, 97

Vitals Flowsheet

VITALS PLOT (*) Time: 1306 30 Jun 97

1306 Jun 30 HT cm (cm) 177.8 WT kg (kg) 60.3 calcWT (kg) 70.6 BSA (m^2) 1.9		YESTERDAY TODAY Jun 29 97 Jun 30 97 IN 2179 0 OUT 2940 1000 NET -761 -1000 Time Weight (kg) 0200 Jun 28 60.3 0500 Jun 27 75.6 0500 Jun 26 74.3 1200 Jun 25 70.6
---	--	---

VITAL SIGNS (*)

HR			73		84	81		71	80		71	84		78	HR (BPM)
Rhythm															Rhythm
Ectopy															Ectopy
NBP-S															NBP-S (mmHg)
NBP-D															NBP-D (mmHg)
NBP-M															NBP-M (mmHg)
ABP-S			117		103	98		110	105		125	125		122	ABP-S (mmHg)
ABP-D			60		59	58		53	63		55	55		61	ABP-D (mmHg)
ABP-M			79		74	70		72	77		79	79		85	ABP-M (mmHg)
B/P Source			DINAM		DINAM	DINAM		DINAM	DINAM		DINAM	DINAM		DINAM	B/P Source
TempF						97.7						98.7			TempF (DegF)
TempC						36.5						37.1			TempC (DegC)
TSrc						0						0			TSrc
Resp			12		28	10		8	8		9	7		8	Resp (RPM)
SpO2		97		98				99		98			97		SpO2 (%)
CUP															CUP (mmHg)
PAS															PAS (mmHg)
PAD															PAD (mmHg)
PAM															PAM (mmHg)
PCW															PCW (mmHg)
CO															CO (L/min)
CI															CI (L/min/M2)
SVR															SVR (Ds/cm5)
SVRI															SVRI (Ds/cm5/M2)
PUR															PUR (Ds/cm5)
SvO2															SvO2 (%)
et CO2															et CO2 (torr)
LOS															LOS
Pain Rating															Pain Rating

IV DRUGS (*)

Fluid: NS+BUMEX	Volume: 100 (ml)	Rate: 5 (ml/hr)													
Drug: BUMEX	Amount: 10 (mg)	Dose: 0.5 (mg/hr)	Conc: 0.1 (mg/ml)												
DOPAMINE	2.3														DOPAMINE (mcg/kg/min)
NITROGLYCERIN	0														NITROGLYCERIN (mcg/min)
BUMEX	0.5	1	1	1	1	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	BUMEX (mg/hr)

Allergies: PCN

Enter Time	Read Rates	Hide IV Info	Describe Item	IV Pump Config
------------	------------	--------------	---------------	----------------

IV Drug Dose Entry



All screen configurations are determined by the hospital and may vary from this manual's screen graphics.

THE INTAKE AND OUTPUT SCREEN

Admission data

Daily Summaries

Kingsford, Larry		300-1	Phy: Dr. Brookstone		(Env	ICU)	11:17 Jun 30, 97		
Fluid Balance									
INTAKE FLUIDS (*)		Time: 0200 29 Jun 97							
HEIGHT:	177.8 (cm)	0200	0300	0400	0500	0600	0700	0800	0900
BSA:	1.876 (m2)								
ORAL									
CT CONTRAST	0450 1450							1620	
NEPRO	020 1235				169 1240				
D5W	050 11000				10				
									Day Eve Noc Tot
									0 0 0 0
									0 0 0 0
									0 70 169 239
									124 222 10 356
IV DRUGS (*)									
D5W+DOPAMINE	06 1250				49				
D5W+NITROGLYCERIN	00 1250								
NS+BUMEX "Right Arm	020 1100				162 1100				
									71 12 49 132
									6 0 0 6
									0 17 162 179
OUTPUTS (*)									
URINE		100	70	85	90	90	80	90	60
NG									
CHEST_TUBE#2					0				
STOOL									
									690 124 657 1471
									0 0 0 0
									0 0 0 0
									0 0 0 0
TOTALS (*)									
IN	[11505]	0	0	0	390	0	0	0	0
OUT	[2050]	100	70	85	90	90	80	90	60
NET	[-545]	-100	-70	-85	+300	-90	-80	-90	-60
									231 321 390 942
									690 124 657 1471
									-459 +197 -267 -529
WEIGHTS									
WT kg	60.30								
calcWT	70.60								
WEIGHT lbs									
Height ft									
HEIGHT in									
HT cm	177.8								
									WT kg (kg)
									calcWT (kg)
									WEIGHT lbs
									Height ft
									HEIGHT in
									HT cm (cm)
Allergies: PCN									
Enter Time	New Order	Weight History			Describe Item				

Column Totals Shift and Day Totals
(Totals are updated with each entry)

3.4.2 INTAKE AND OUTPUT FUNCTIONS

3.4.2.1 Reviewing the Intake and Output Flowsheet

The Intake and Output Flowsheet can be configured with multiple flowsheet sections. Fluids are grouped and displayed with the following possible sorting criteria: Output, IV Drug, TPN, Meds, Oral, NG, Crystalloid, Colloid, Blood, Urine, NG Output, Chest Tube Output, Blood Outputs, Irrigations.

Intake and Output items can NOT be configured to appear within the same section.
 The far left column will display the following Intake and Output Information.

Name:	Standard Peripheral	05	Rate:
Site:	~RIGHT	↑1250	Volume:
Label Comment:	»See MD Orders for changes		

A double arrow symbol will appear in front of the fluid label comment.

Fluid Arrangement

As fluids are assigned, they are sorted and placed on the Intake and Output Flowsheet using the following criteria.

- By Fluid - Intake or Output; Then
- By Fluid Category; then (If the fluid is an intake, it will be sorted in this sequence: Oral, Tube Feeding, Crystalloids, IV Drugs, Colloids and Blood Products.)
- By Fluid Name in Alphabetical Order; Then
- By Order of Time Assigned (if the same fluid).

Data Entry

The columns on the Intake and Output Flowsheet will automatically grow to accommodate free text comments and fluid volume. Initially, the flowsheet defaults to 12 hour columns before comments and fluid data is charted. The volume entered on the Intake and Output Flowsheet is in 'cc.'

- Volume in tenths can be entered as a decimal.

	Intake Comment		Charted infusion volume	
Intake:	D5W+Nitroglycerin	025	HELD 250	
	~LOWER	↑150	~0 ↑150	
			250	0
Output:	OUTPUT			
	URINE		Clear 50	
	Output Comment		Volume Hung	

Special Keys

Key	Key Name	Keystroke	Function
^	Up Caret	[Shift][6]	To rehang a fluid on the I&O Flowsheet.
@	At	[Shift][2]	Used to identify rates in ml/hr on the I&O Flowsheet.
~	Tilde	[Shift][']	To change the site of a fluid on the I&O Flowsheet.
+	Plus	[Shift][=]/Keypad	To enter an incremental volume infused on the I&O Flowsheet.
Insert	Insert	[Insert]	To enter the intake fluid delivery for the current cell. The system calculates the current delivery by integrating all rates charted since the last delivery. (Note: The cursor must be in an even hour column.)

THE INTAKE AND OUTPUT FLOWSHEET

Charted infusion volumes will appear above the volume hung.

Kingsford, Larry		300-1	Phy: Dr. Brookstone		(Env	ICU)	11:17 Jun 30, 97																																																																				
Fluid Balance																																																																											
INTAKE FLUIDS (*)																																																																											
HEIGHT: 177.8 (cm)		0200	0300	0400	0500	0600	0700	0800	0900																																																																		
BSA: 1.876 (m2)																																																																											
Time: 0200 29 Jun 97																																																																											
<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 10%;"></th> </tr> <tr> <th colspan="2"></th> <th>Day</th> <th>Eve</th> <th>Noc</th> <th colspan="2">Tot</th> <th colspan="3"></th> </tr> </thead> <tbody> <tr> <td colspan="2">ORAL</td> <td>0</td> <td>0</td> <td>0</td> <td colspan="2">0</td> <td colspan="3"></td> </tr> <tr> <td>CT CONTRAST</td> <td>0450 1450</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1620</td> <td colspan="2"></td> </tr> <tr> <td>NEPRO</td> <td>020 1235</td> <td></td> <td></td> <td></td> <td>169 1240</td> <td></td> <td></td> <td>0</td> <td>70 169 239</td> </tr> <tr> <td>D5W</td> <td>050 11000</td> <td></td> <td></td> <td></td> <td>10</td> <td></td> <td></td> <td>124</td> <td>222 10 356</td> </tr> </tbody> </table>																						Day	Eve	Noc	Tot					ORAL		0	0	0	0					CT CONTRAST	0450 1450						1620			NEPRO	020 1235				169 1240			0	70 169 239	D5W	050 11000				10			124	222 10 356						
		Day	Eve	Noc	Tot																																																																						
ORAL		0	0	0	0																																																																						
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D5W	050 11000				10			124	222 10 356																																																																		
IV DRUGS (*)																																																																											
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WEIGHTS																																																																											
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WT kg	60.30									WT kg (kg)																																																																	
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HT cm	177.8									HT cm (cm)																																																																	
Allergies: PCN																																																																											
Enter Time	New Order	Weight History			Describe Item																																																																						

Discontinuing Fluids

Fluids are all discontinued on the Intake and Output Flowsheet including IV fluids that carry over to the Medications Flowsheet. Discontinued IV Drugs will be automatically discontinued on the Vital Signs and Medications Flowsheets.

Intake Delivery Warning

When a delivery exceeds what is in the bag, the following warning will appear.

- WARNING - The Current Delivery (150 ml) Will Cause
The Sum of Deliveries (250 ml) To Exceed the Hang Volume (200 ml)
Do You Wish to Override This Warning (Please answer Y or N)? █

- To override the warning and chart the delivery, at the warning prompt, type in "Y" for Yes and press the [Enter] key.
 - The new delivery will appear regardless of the original hang volume.
- To acknowledge the warning and not chart the delivery, at the warning prompt, type in "N" for No.
 - The new delivery will not appear on the flowsheet.

Assigning a Fluid Order

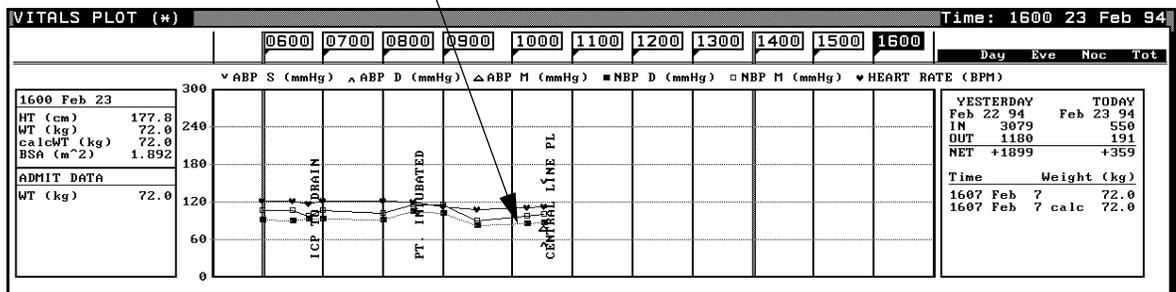
To assign a new fluid order to the Intake and Output Flowsheet, refer to the ORDER ENTRY FUNCTIONS.

Plot Items

This Vitals Plot section can now be configured on the Intake and Output Flowsheet.

The plotted data will be displayed within the time column at the approximate time the data was charted on the Vital Signs Flowsheet.

For example, the data charted at 10:15 will appear a fourth of the way between the column bars.



THE INTAKE AND OUTPUT SCREEN

Oral, Stool and Urine cannot be discontinued.

When entered on the flowsheet, the Up Caret symbol will allow you to 'rehang' another bag.

Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 11:23 Jun 30, 97

F l u i d B a l a n c e

INTAKE FLUIDS (*) Time: 1000 30 Jun 97

HEIGHT: 177.8 (cm)	0400	0500	0600	0700	0800	0900	1000	1100				
BSA: 1.876 (m2)												
ORAL									Day	Eve	Noc	Tot
D5W 050		80							0	0	0	0
↑1000		↑1000							0	0	0	0

IV DRUGS (*)

D5W+DOPAMINE 06		48							0	0	0	0
1250									0	0	0	0
D5W+NITROGLYCERIN 00									0	0	0	0
1250									0	0	0	0
NS+BUMEX 05		80				20	↑100		20	0	0	20
*Right Arm ↑100		↑100										

OUTPUTS (*)

URINE		140	160	140	200	290	310	1000	0	0	1000
NG			50					0	0	0	0
CHEST_TUBE#2			0					0	0	0	0
STOOL								0	0	0	0

TOTALS (*)

IN	[2179]	0	208	0	0	0	20	0	0	20	0	20
OUT	[2940]	140	210	140	200	0	290	0	310	1000	0	1000
NET	[-761]	-140	-2	-140	-200	+0	-270	+0	-310	-980	+0	+0

WEIGHTS

WT kg	60.30								WT kg (kg)
calcWT	70.60								calcWT (kg)
WEIGHT lbs									WEIGHT lbs
Height ft									Height ft
HEIGHT in									HEIGHT in
HT cm	177.8								HT cm (cm)

Allergies: PCN

Enter Time		Weight History	D/C	Describe Item	Store				
------------	--	----------------	-----	---------------	-------	--	--	--	--

A thick vertical gray line indicates either change of shift or start of day. This screen capture shows that change of shift is Q8 hours.

3.4.2.2 Replenishing an Existing Intake Fluid

To replenish an existing fluid on a current order (i.e., “hang another bag”), perform the following steps.

1. Select the Intake & Output Screen.
2. Move the cursor to highlight the desired data cell.
 - To chart multiple hangs within one hour, press the “Enter Time” soft key <F1>, enter the desired time and press the [Enter] key.
3. Type the Up Caret symbol “^” (shift-6) and then the volume amount.
 - For example, to hang another bag of Dopamine at 250 ml, type in ^250.



The numeric volume must accompany the ‘^’ symbol.

4. Press the [Enter] key.
 - When replenishing an existing IV Drug order, the amount corresponding to the new volume hung is computed so as to keep the concentration the same. The resulting Volume, Amount, Concentration, Dose and Rate are presented for acceptance.
 - The [Up Arrow] symbol with the volume hung will appear on the flowsheet.
 - The most recent volume will appear next to the fluid name.
5. When finished with the entire screen, press the “Store” soft key <F8>.

3.4.2.3 Removing a Fluid Re-Hang

To remove a charted fluid rehang, perform the following steps.

1. Move the cursor to the desired data cell.
2. Type in the Caret Symbol “^” followed by a space.



The initial ordered volume cannot be removed.

3. Press the [Enter] key.



The flowsheet will ignore removed rehangs for all calculations. The last charted re-hang will display in the row label.

SELECTING IV PUMPS TO READ RATES

Assignment Time

Ken Peters MICU-2 Phy: Moore (Env ICU) 15:50 Jun 28, 95

F l u i d B a l a n c e

IV Pump Configuration for 1500 28 Jun 1995

Fluid Name	Volume (ml)	Rate (ml/hr)	Start Time	DAS Port	Make	Model	Channel	Mode
D5W .45NS +20KCL	1000	050	1300 27 Jun 1995	Z	IUAC	570	A	Primary
				Z	IUAC	570	A	Secondary

Allergies:

Done Clear Fluid Assign Fluid Cancel

3.4.2.4 Configuring the Fluid to IV Pump

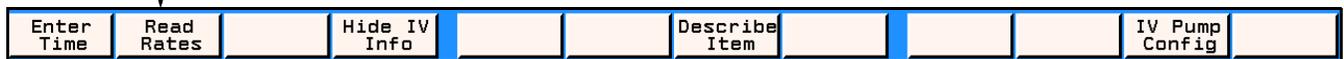


To configure the IV pumps per fluid, perform the following steps.

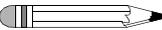
1. Select the Intake & Output Flowsheet or Vital Signs Flowsheet.
 - On the Vital Signs Flowsheet, move the cursor to the IV Drug or IV Drip Section.
2. Press the “IV Pump Config” soft key <F11>.
 - The IV pumps interfaced to the system via the data acquisition boxes will appear on the IV Pump Configuration Screen.
3. Assign the desired fluid to the corresponding IV pump with the “Assign Fluid” soft key <F5>.
 - Highlight the desired fluid with the [Up Arrow] or [Down Arrow] keys.
 - Press the [Enter] key.
 - To clear assigned fluids, press the “Clear Fluid” soft key <F4>.
4. When finished with configuring the IV pumps, press the “Done” soft key <F3>.

 *The IV pumps are configured for the importing of rates on the Vital Signs Flowsheet. The IV pump configuration must be manually changed to reflect all changes to the IV bags/IV pumps.*

3.4.2.5 Importing IV Drug Rate Changes



IV drug rates imported onto the Vital Signs Flowsheet will also appear on the Intake and Output Flowsheet. To import the IV Drug rates changes, perform the following steps.

1. Select the Vital Signs Flowsheet.
-  2. Press the “Read Rates” soft key <F2>.
 - All rate **changes** since the last stored rate change will automatically appear.

 *IV Drug rates will be continuously read as long as the patient is connected to the IV pump. However, monitored data will not be transferred to the system until the “Read Rates” soft key is pressed.*

-  3. Verify the imported information is correct.
4. Edit or add data as desired.
5. Press the [Enter] key after each entry.
6. When finished with the entire screen, then press the “Store” soft key <F8>.

THE INTAKE AND OUTPUT SCREEN

The '~' symbol will be displayed in the cell where the site has been charted.

Kingsford, Larry		300-1	Phy: Dr. Brookstone		(Env	ICU)	12:43 Jun 30, 97						
Fluid Balance													
INTAKE FLUIDS (*)								Time: 2000 28 Jun 97					
HEIGHT:	177.8 (cm)	2000	2100	2200	2300	0000	0100	0200	0300	Day	Eve	Noc	Tot
BSA:	1.876 (m2)									0	0	0	0
ORAL										0	0	0	0
NEPRO	@20 ↑235		70							0	70	169	239
D5W	@50 ↑1000		98							124	222	10	356
D5W (C.O.)	↑500									30	0	0	30
IV DRUGS (*)													
D5W+DOPAMINE	@6 ↑250		12							71	12	49	132
D5W+NITROGLYCERIN	@0 ↑250									6	0	0	6
NS+BUMEX ~Right Arm	↑100		17					↑100		0	17	162	179
OUTPUTS (*)													
URINE		20	30	60	100	27	125	100	70	690	124	657	1471
NG										0	0	0	0
CHEST_TUBE#2										0	0	0	0
STOOL										0	0	0	0
TOTALS (*)													
IN	[1505]	0	197	0	0	0	0	0	0	231	321	390	942
OUT	[2050]	20	30	60	100	27	125	100	70	690	124	657	1471
NET	[-545]	-20	+167	-60	-100	-27	-125	-100	-70	-459	+197	-267	-529
WEIGHTS													
WT kg	60.30									WT kg (kg)			
calcWT	70.60									calcWT (kg)			
WEIGHT lbs										WEIGHT lbs			
Height ft										Height ft			
HEIGHT in										HEIGHT in			
HT cm	177.8									HT cm (cm)			
Allergies: PCN													
Enter Time		New Order	Weight History			Describe Item							

3.4.2.6 Entering and Editing a Fluid Site

An existing site can be viewed in the row label by moving the cursor back to the hour column with the previously charted site. To enter or edit the site of a fluid, perform the following steps.

1. Select the Intake & Output Screen.
2. Move the cursor to highlight the desired intake data cell.
3. Type the Tilde '~' symbol.
 - For an existing fluid site, type the Tilde symbol over the existing one.
4. Press the [Enter] key.
 - The New Site screen will appear.
OR
 - The Edit prompt will appear when modifying an existing fluid site.
 - Type in 'Y' for Yes to change the site.
 - Press the [Enter] key.
5. Type in the choice list number corresponding to the new site.
 - To remove the site, in the 'Name' field, press the [Space Bar] key.
6. Press the [Enter] key.
7. Enter in new time, if applicable.
8. Press the [Enter] key.
9. When finished with editing the fluid site, press the "Done" soft key <F3>.
 - The most recent site will appear next to the fluid name, and the '~' symbol will appear in the time column.
10. When finished with the entire screen, press the "Store" soft key <F8>.

3.4.2.7 Entering and Editing a Fluid Rate

To enter or edit the rate of a fluid, perform the following steps.



The rate symbol '@' can be configured to NOT appear in the time column for IV Drugs only.

1. Select the Intake & Output Screen.
2. Move the cursor to highlight the desired intake data cell.
 - To enter multiple rate changes within an hour, press the “Enter Time” soft key <F1>, enter the desired time and press the [Enter] key.
3. Type in the At '@' symbol and the new rate.
 - For example, @120.



The numeric rate must accompany the '@' symbol.

- For an existing fluid rate, type the @ symbol over the existing one.



Only the rate for the selected time will be removed when multiple rates are charted within an hour.

4. Press the [Enter] key.
 - The Edit prompt will appear when modifying an existing rate.
 - Type in 'Y' for Yes to change the rate.
 - Press the [Enter] key.
 - The most current rate will appear next to the fluid name, and the '@' symbol will appear in the time column if configured to do so.
 - A previous rate can be viewed in the row label by moving the cursor back to the hour column with the previously charted rate.
5. When finished with the entire screen, press the “Store” soft key <F8>.



When the modified rate is stored, it will appear on the Vital Signs Flowsheet.

- Rate information such as multiple rate changes within an hour may be viewed via the “Describe Item” soft key <F7> or on the Vital Signs Flowsheet.

3.4.2.8 Removing a Fluid Rate

To remove charted rates, perform the following steps.

1. Move the cursor to the desired data cell.
2. Type in the @ Symbol followed by a space.
 - The Edit prompt will appear when modifying an existing rate.
 - Type in 'Y' for Yes to change the rate.
 - Press the [Enter] key.



The initial ordered rate cannot be removed.

3. Press the [Enter] key.



The flowsheet will ignore removed rates for all calculations. The last charted rate will display in the row label.

3.4.2.9 Entering a Patient's Weight

A patient's weight, calculation weight, pre-dialysis weight and post-dialysis weight can be configured for addition on the Intake and Output Flowsheet. Fluctuations with a patient's daily weight can be recorded to accurately calculate Intake fluids. To record a patient's weight, perform the following steps.

1. Select the Intake and Output Screen.
2. Move the cursor to highlight the desired data cell where the weight entries should appear.
 - To enter in multiple weights within the hour, press the "Enter Time" soft key <F1> and enter the time in minutes.
3. If the desired weight label is not displayed, press the "Add Row" soft key <F3>.
 - Select the desired weight option and press the [Enter] key.



The weight used for the IV Drug calculator is configurable and may be the patient's current weight.

4. Enter the desired weight.
5. Press the [Enter] key.
6. When finished with charting a patient's weight, press the "Store" soft key <F8>.
 - To review the patient's weight history, move the cursor to the desired data cell and press the "Weight History" soft key <F4>.
 - The last ten weights charted will be displayed with the most recent weight appearing first.



All screen configurations are determined by the hospital and may vary from this manual's screen graphics

THE MEDICATIONS FLOWSHEET

Kingsford, Larry		300-1	Phy: Dr. Brookstone		(Env	ICU)	09:45 Jun 30, 97																			
P A T I E N T M E D I C A T I O N S																										
SCHEDULED MEDICATIONS (*)																		Time: 0000 28 Jun 97								
		00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22		
LASIX 100MG INJ "IU	160 MG Q6			✓	TC					✓	SD						✓	SD							DC	
REGLAN INJ 5MG/ML 30ML HD VIAL "IU	5 MG Q8		✓							✓	SD								✓							
PERCID INJ 20MG/2ML VIAL "IU	20 MG Q24		TC							✓	SD									✓	LJ					
ROCEPHIN 1GM INJ "IU	1 GM Q24													✓	SD									✓	LJ	
SALINE LOCK FLUSH 10ML "VIA PICC (GROSHONG) IF NOT IN USE	10ML Q8H-																								Hold LJ	
STAT/ONE TIME MEDS (*)																										
BUREX INJ 0.25%/ML 10ML VIAL "IU	4MG X1																								Hold LJ DC	
PCA (NONE)																										
PRN MEDICATIONS (*)																										
APRESOLINE INJ 20MG/ML 1ML AMP "IU	5-10Mgs Q1H PRN																									
GIVE #3 FOR GOAL SBP< 140																										
KCL 40MEQ/20ML INJ "IUPB	10-20mEq Q1H PRN																									
Maintain K 4.5. Repeat K prn.																										
MAGNESIUM SULFATE INJ 1GM/2ML AMPULE "IU	2 gm PRN																									
PRN for Mg < 2.2																										
TYLENOL 650MG SUPP "PR	650Mgs Q4H PRN																									
Temp > 101.																										
MS 10MG/1ML INJ "IU	2-8 mg Q1H PRN																								DC	
For pain																										
PERCOCET TABLET "PO	1-2 Tabs Q3 PRN-																									
PRN pain when taking PO																										
INAPSINE 2.5MG/ML INJ "IU	.25-.5 cc Q4 PRN-																									
PRN N/U/agitation																										
DEMEROL 25MG/ML INJ "IU	12.5-25 mg Q1 PRN-																									
PRN severe shivering																										
VERSED 5MG/ML INJ "IU	1-3 mg Q1 PRN																								DC	
PRN agitation																										
IV CONTINUOUS INFUSIONS (*)		- MORE -																								
OTHER MEDICATIONS (NONE)																										
Allergies: PCN																										
Enter Time	Give Med	New Order	Hold Med	D/C		Describe Item																			Reset Schedule	Remarks

THE MEDICATIONS FLOWSHEET

Medication delivery charted in a created time column.

Medication delivery charted on the hour.

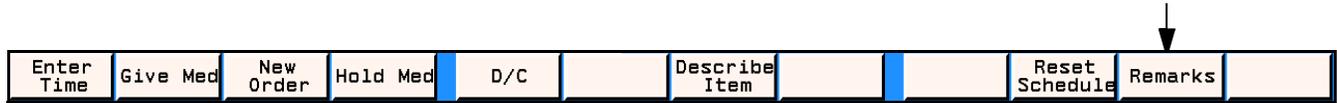
Held Medications

Sampson, Earl		300-16	Phy: Dr. Brookstone		(Env	ICU)	09:51 Jun 30, 97																		
P A T I E N T M E D I C A T I O N S																									
SCHEDULED MEDICATIONS (*)							Time: 0700 29 Jun 97																		
		07	08	09:09:40	10	11	12	13	14	15	16	17	18	19	20	21	22	23	00	01	02	03	04	05	
PEPCID INJ 20MG/2ML VIAL "IU	20 MG Q12		✓												✓										
DILANTIN 100MG/2ML INJ "IU	100MG BID		BS												He	MA									
STAT/ONE TIME MEDS (*)																									
DILANTIN 250MG/5ML INJ "IU	500MG X1												1845	DC											
PCA (NONE)																									
PRN MEDICATIONS (*)																									
MANNITOL 25% INJ 12.5GM/50ML VIAL "IU	25 GM Q4 PRN																								
FOR ICP > 25																									
DROPERIDOL 2.5MG/ML INJ-2ML AMP "IU	0.25 CC Q6 PRN-																								
NAUSEA																									
MORPHINE 10MG/1ML INJ "IU	2-10 MG PRN			4MG *																					
ELEVATED ICP				BS																					
VERSED 10ML/2ML INJ "IU	2-4 MG PRN			2MG																					
ELEVATED ICP				BS																					
LABETALOL INJ 20MG/4ML SYRINGE "IU	5MG Q1-2 PRN																								
FOR SBP >170																									
APRESOLINE INJ 20MG/ML 1ML AMP "IU	5MG Q1-2 PRN																								
FOR SBP >170																									
LASIX 20MG/2ML INJ "IU	20MG Q4 PRN-																								
UO<20CCHR X 2 CONSECUTIVE HRS																									
IV CONTINUOUS INFUSIONS (*)																									
NITROPRUSSIDE "IUB	50 mg							48.6 mg	Add								30.8 mg							16 mg	
in 250cc D5W								BS	MA								MA							CL	
OTHER MEDICATIONS (*)																									
20KCL "IUB															Add									Add	
1000cc NS +20KCL															MA									AT	
Allergies: PENICILLIN.																									
Enter Time	Give Med	New Order	Hold Med	D/C	Describe Item	Reset Schedule	Remarks																		

THE MEDICATIONS FLOWSHEET

Kingsford, Larry		300-1	Phy: Dr. Brookstone		(Env	ICU)	10:16 Jun 30, 97																		
P A T I E N T M E D I C A T I O N S																									
SCHEDULED MEDICATIONS (*)							Time: 2000 25 Jun 97																		
		20	21	22	23	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	15	15:35	15:37		
CEFAZOLIN INJ 1GM VIAL TU 1GM Q8H X 6 doses; 1st dose in SICU=dose #2							OR								Heid #3 MKK	DC									
MANNITOL 25% INJ 12.5GM/50ML VIAL 12.5 GM TU Q6 HOLD FOR CUP>15				MKK					OR							DC									
REGLAN INJ 10MG/2ML VIAL TU 10 MG Q8							OR									DC									
PEPCID INJ 20MG/2ML VIAL TU 20 MG Q12-			MKK													DC									
ANCEF INJ 1GM VIAL TU 1 GM Q12																									
LASIX 100MG INJ TU 160 MG Q6-																									
REGLAN INJ 5MG/ML 30ML MD VIAL TU 5 MG Q8																MN									
PEPCID INJ 20MG/2ML VIAL TU 20 MG Q24																								2100	
ROCEPHIM 1GM INJ TU 1 GM Q24-																									
STAT/ONE TIME MEDS (NONE)																									
PCA (NONE)																									
PRN MEDICATIONS (*)																									
APRESOLINE INJ 20MG/ML 1ML AMP TU 5-10Mgs Q1H PRN GIVE #3 FOR GOAL SBP< 140																									
KCL 40MEQ/20ML INJ TU 10-20meq Q1H PRN Maintain K 4.5. Repeat K prn.																									
MAGNESIUM SULFATE INJ 1GM/2ML AMPULE 2 gm TU PRN PRN for Mgt < 2.2																									
TYLENOL 650MG SUPP PR 650Mgs Q4H PRN Temp > 101.																									
MS 10MG/1ML INJ TU 2-8 mg Q1H PRN For pain								2mg * 0225 OR			2mg 0510 OR			2mg 0615 OR											
PERCOCET TABLET PO 1-2 Tabs Q3 PRN- PRN pain when taking PO																									
IV CONTINUOUS INFUSIONS (*) - MORE -																									
OTHER MEDICATIONS (*)																									
Allergies: PCN																									
Enter Time	Give Med	New Order	Hold Med	D/C		Describe Item									Reset Schedule	Remarks									

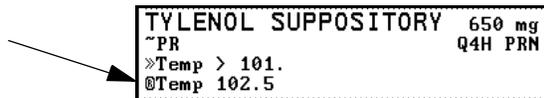
3.4.3.4 Remarking on a Medication Delivery



A medication comment is created at the time of the medication order and is part of the original order. The remark function allows the creation of additional comments after the order has been stored that will appear in the row label. To add a remark to a medication row label, perform the following steps.

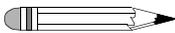
1. Select the Medications Flowsheet.
2. Move the cursor to the desired medication data cell.
3. Press the “Remarks” soft key <F11>.
4. Type in the desired remark in free text.
5. Press the [Enter] key.
6. When finished with entering the remark, press <Enter>. To return to the Medications Flowsheet, press the “Done” soft key <F3>.

- The remark will appear below the label comment and distinguished by the Registered Trademark Symbol (®).



- A remark will be displayed when the cursor is positioned after the start time.
7. When finished with the entire screen, press the “Store” soft key <F8>.

3.4.3.5 Performing a Quick Medication Order



Pre-configured medication orders can be quickly added to a medication flowsheet section via a quick order selection window. To quickly add a medication order, perform the following steps.

1. Move the cursor to the medication section.
 2. Press the “New Order” soft key <F3>.
- The Quick Order window will appear.

Start-Time	Stop-Time	Name	Dose	Mode	Freq
1400	6 Mar	Fentanyl	1mcg	IU	PRN
1400	6 Mar	Midazolam	2.5mg	IU	PRN
1400	6 Mar	Tylenol	2 TABS	PO	PRN
1400	6 Mar	Robinul	0.1mg	IU	PRN
1400	6 Mar	Morphine	1mg	IU	PRN
1400	6 Mar	O2	4 l/min	Inhale	Continuous

3. Highlight the desired medication order.
 4. Press the [Enter] key.
 5. Respond to the Edit prompt.
- The selected medication order will appear in the configured medication section with the start time being the current system time (not cursor time).
 - If needed, the full orders application can be accessed by pressing the “Full Orders” soft key <F3> from the quick medication order function.

THE CRITICAL CARE PATH SCREEN



All screen configurations are determined by the hospital and may vary from this manual's screen graphics.

Critical Care Path			
ACTIVE CAREPATHS (*)		7 Jan 0935	Time: 0935 7 Jan 94 8 Jan 0000
HIP REPLACEMENT		Operative Day	Post-Op Day 1
ACUITY (*)			
PATIENT PROBLEMS (*)			
BOWEL ELIMINATION, ALTERATION IN: CONSTIPATION R/T-Surgery and immobility		Pain controlled on IM/PCA medications. -DEM-	Pain controlled on PO/IM/PCA medications. -DEM-
COMFORT, ALTERATION IN R/T-Muscle spasms and pain pre & post op		-DEM-	Patient verbalizes activity limitations ie. use of walker. -DEM-
KNOWLEDGE DEFICIT R/T-Surgery		-DEM-	-DEM-
MOBILITY, IMPAIRED PHYSICAL R/T-Surgery, medication, pain/discomfort		-DEM-	Able to stand at bedside with maximal assistance. Up in chair. Bed mobility with maximal assistance. -DEM-
SKIN INTEGRITY, IMPAIRED R/T-Surgery and immobility		No evidence of skin breakdown. -DEM-	No evidence of skin breakdown. -DEM-
URINARY ELIMINATION PATTERN, ALTERATION IN: R/T-Surgery and immobility		Voiding per normal pattern. -DEM-	Voiding per normal pattern. -DEM-
ASSESSMENTS MEDICATIONS (*) IV'S (*) CONSULTS (*) TESTS (*) ACTIVITY INSTRUCTIONS (*) ACTIVITY NUTRITION (*) TREATMENTS W/ STANDARDS TREATMENTS (NONE) SPECIAL INSTRUCTIONS / MISC. (*) PROCEDURES (NONE) DISCHARGE PLANNING (*) DISCHARGE PLANNING W/ STANDARDS TEACHING			
Enter Time	New Row	D/C	Describe Item Store
			Edit One Cell Edit All Cells Disch. Outcome

The vertical bar distinguishes the primary text cell from a repeat cell.

The display of user initials in the primary stored cell is configurable.

3.4.4 CRITICAL CARE PATHS FUNCTIONS

3.4.4.1 Reviewing the Critical Care Path Screen

A Care Path is a diagnosis specific, multi-discipline, time-sequenced patient care plan. The Critical Care Path Screen is formed for each patient by adding Care Paths that have been defined by the hospital per existing Standards of Care. The Care Paths can be further tailored to each patient’s needs and expected outcomes.

The patient status can be documented on the Care Path Assessment Flowsheet in accordance with the hospital’s Care Path Assessment protocol and Standards of Care, or using a standard CIS flowsheet.

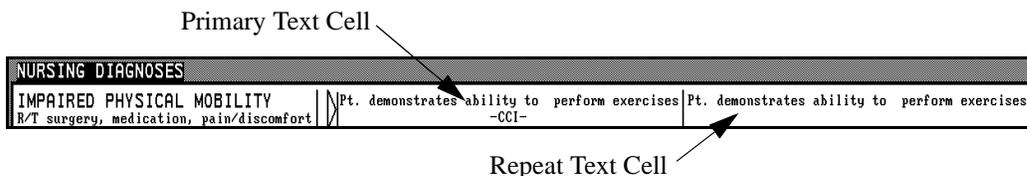
Section Types

The Critical Care Path Screen is organized into the following three (3) section types.

- Active Care Paths
- Text Items
- User-defined Tasks
- **Active Care Path Section**
 Care Paths for surgical diagnoses are configured for pre and post surgery patient care; Care Paths for medical diagnoses are configured for non-surgical patient care. For example, a patient is admitted for a Hip Replacement and is a diabetic. A surgical diagnosis Hip Replacement Care Path and medical diagnosis Diabetes Care Path is assigned. All Care Paths are defined by the hospital per the existing Standards of Care and may include Text and Task sections.
 Based on the medical diagnoses of the patient, the user can select pre-configured Care Paths to appear automatically on the Critical Care Path Screen. The screen can then be tailored by merging several Care Plans to account for different diagnoses and multiple operations.
- **Text Item Sections**
 Based on the selected Care Path, expected outcomes will appear as text in the time columns. The text may be changed on a per cell basis for individualized patient care.
- **User-Defined Task Sections**
 These sections are configured to be interactive with the Care Path Assessment Flowsheet. The scheduling of item frequency on the Critical Care Path Screen will set time markers on the Care Path Assessment Flowsheet.

Definitions

- **Primary Text Cell**
 The initial cell where text is stored is the primary cell. The text from this primary cell will automatically appear in the secondary cells unless manually changed.



- **Repeat Text Cells**
 Repeat text cells are text cells containing duplicate text from the primary text cell. For example, the outcomes for Day 2 may be the same as Day 1. A repeat cell can be modified and stored to become a primary text cell.

THE EXPECTED OUTCOME WINDOW THE CRITICAL CARE PATH SCREEN

Brech, Janet		UR-2	Phy: Howard, James	(Env	TEST)	12:55 Feb 16, 94														
Critical Care Path																				
ACTIVE CAREPATHS (*)			Time: 0000 13 Jan 94																	
		13 Jan	14 Jan																	
		0000	0000																	
HIP REPLACEMENT		Post-Op Day 4	Post-Op Day 5																	
PNEUMONIA _ ATELECTASIS - SECONDARY		Evaluation	Evaluation																	
ACUITY (*)																				
ACUITY		2	-DEM-	2																
FIMI GOALS																				
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="2">FIMI GOALS Expected Outcome</th> </tr> <tr> <td>Bed Mobility</td> <td>6</td> </tr> <tr> <td>Basic Transfers</td> <td>6</td> </tr> <tr> <td>Basic Ambulation</td> <td>6</td> </tr> <tr> <td>Step Ambulation</td> <td>6</td> </tr> <tr> <td>Car Transfer</td> <td>5</td> </tr> <tr> <td>Self Care</td> <td>6</td> </tr> </table>		FIMI GOALS Expected Outcome		Bed Mobility	6	Basic Transfers	6	Basic Ambulation	6	Step Ambulation	6	Car Transfer	5	Self Care	6					
FIMI GOALS Expected Outcome																				
Bed Mobility	6																			
Basic Transfers	6																			
Basic Ambulation	6																			
Step Ambulation	6																			
Car Transfer	5																			
Self Care	6																			
PATIENT PROBL																				
BOWEL ELIMINA		Bowel movement QOD		-DEM-																
»R/T-Surgery and		-DEM-		-DEM-																
COMFORT, ALTE		Pain controlled on PO		Pain controlled on PO																
»R/T-Muscle spasms		medications. -DEM-		medications.																
KNOWLEDGE DEFICIT		Patient recalls 3/3 THA		Patient/family verbalize																
»R/T-Surgery		precautions. -DEM-		understanding of Home Care.																
Knowledge Deficit		-DEM-		Patient recalls 3/3 THA																
»R/T-Disease Process		Discuss pneumonia/		Discuss pneumonia/																
		atelectasis prevention.		atelectasis prevention.																
- MORE -																				
ASSESSMENTS																				
MEDICATIONS (*)																				
IV'S (*)																				
CONSULTS (*)																				
TESTS (*)																				
ACTIVITY INSTRUCTIONS (*)																				
ACTIVITY																				
NUTRITION (*)																				
TREATMENTS W/ STANDARDS																				
TREATMENTS (NONE)																				
SPECIAL INSTRUCTIONS / MISC. (*)																				
PROCEDURES (NONE)																				
DISCHARGE PLANNING (*)																				
DISCHARGE PLANNING W/ STANDARDS																				
TEACHING																				
		OK	Cancel	Clear Text		Delete Cell														

Discontinuing

12 Apr 0900	13 Apr 0600
Post-Operative	←05:59

D/C time is one minute before the time in the next time column

Time column in which the D/C soft function key <F5> was pressed.

- The D/C arrow and bar will appear in the next column. The D/C bar will appear black before stored and then turn gray once the screen is stored.
- The D/C time may be set when assigning a new item.



Discontinued Task items will be discontinued automatically on the Care Path Assessment Flowsheet.

Expected Outcomes

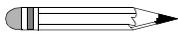
Configured expected outcome will appear when the “Expected Outcome” soft function key <F11> is pressed. The expected outcomes can be entered and modified as needed via this function key.

Comfort, Alt. in Expected Outcome

able to control pain.

Cursor

Describe Information



- The information on each Care Path item will differ per the item type section when “Describe Item” soft function key <F7> is pressed.
 - Active Care Path Section - All values of the assigned Care Path will appear.
 - Text Section - Item information and Comments will appear.
 - Task Section - Edit history, frequencies and deliveries will appear.

THE CARE PATH ASSIGNMENT SCREEN

An example of adding medical diagnosis

JOHNSON, SUSAN	MICU-3	Phy:	(Env ICU/CCU)	03:55 Jan 17, 94
Critical Care Path				
ADD CAREPATH				
Carepath Type: Medical Diagnosis				
Carepath Name: PNEUMONIA - ATELECTASIS - SECONDARY				
Evaluation Time: 0000 17 Jan 1994		Start Stabilization:		
<Tab> - Next Field <Shift+Tab> - Previous Field				
Clear Time	Done	Clear Fields		Cancel All

3.4.4.2 Adding a Care Path



To add a Care Path to the Critical Care Path Screen, perform the following steps.

1. Select the Critical Care Path Screen.
2. Move the cursor to the 'Active Care Paths' Section.
3. Press the "Add Carepath" soft function key <F3>.
 - The Care Path Type window will appear within the Add Care Path screen. The Care Path types are configurable by environment.



4. Highlight the desired type with the [Up Arrow] and [Down Arrow] keys.
5. Press the [Enter] key.
6. Type in the desired Care Path's corresponding choice list number.
7. Press the [Enter] key.
8. Depending upon the Care Path Type, enter in the 'Start Time' or 'Evaluation Time.'
 - The Start Time or Evaluation Time is required to activate the Care Path.
9. Press the [Enter] key.
10. Depending upon the Care Path Type, enter in the 'Post-Op Time' or 'Start Stabilization Time,' if known.



The 'Post-Op Time' or 'Stabilization Time' should only be set when they are known. The times cannot be changed when set. Post-Op Time and Stabilization Time are defined by the hospital for each patient.

11. When finished adding a Care Path, press the "Done" soft function key <F3> to return to the flowsheet.
 - The new Care Path and corresponding Text and Task items will automatically appear in the applicable sections on the Critical Care Path Screen.
 - This is the only opportunity to delete or modify an imported care path, because once the care path is stored, rows cannot be deleted, row labels cannot be modified, and any cell modification will be considered an edit by the system.
 - When merging multiple Care Paths, the new items will be combined with existing items on the Critical Care Path Screen and Care Path Assessment Flowsheet.
 - The text sections will NOT merge and duplicate diagnoses will be displayed alphabetically.
 - Task items will not merge if a frequency is present.
12. When finished with the screen, press the "Store" soft function key <F8>.
 - Once stored, the task items will automatically appear on the Care Path Assessment Flowsheet.



To a remove row from a care path once it has been stored, use the "D/C" soft function key <F5>.

THE CRITICAL CARE PATH SCREEN IN THE PREVIEW MODE

Labels for the time columns are user-configurable.

JOHNSON, SUSAN		MICU-3	Phy:	(Env ICU/CCU)	04:18 Jan 17, 94
Critical Care Path					
ACTIVE CAREPATHS (*)			Time: 0000 9 Jan 94		
		9 Jan 0000		9 Jan 0935	
HIP REPLACEMENT		Post-Op Day 2		Post-Op Day 2	
PNEUMONIA _ ATELECTASIS - SECONDARY		Evaluation		Stabilization	
ACUITY (*)					
PATIENT PROBLEMS (*)					
ASSESSMENTS					
MEDICATIONS (*)					
IV'S (*)					
CONSULTS (*)					
TESTS (*)					
CARDIOVASCULAR					
LAB					Sputum: Gram stain/C&S Blood culture tests which determine microbial antigens in serum/sputum/urine.
LABORATORY		CBC or H&H PT and/or APTT			CBC or H&H PT and/or APTT
		-DEM-			
RADIOLOGY					
RESPIRATORY					Blood gas analysis (if in respiratory distress)
ACTIVITY INSTRUCTIONS (*)					
ACTIVITY					
NUTRITION (*)					
TREATMENTS W/ STANDARDS					
TREATMENTS (NONE)					
SPECIAL INSTRUCTIONS / MISC. (*)					
PROCEDURES (NONE)					
DISCHARGE PLANNING (*)					
DISCHARGE PLANNING W/ STANDARDS					
TEACHING					
Enter Time				Describe Item	End Preview

3.4.4.3 Previewing a Care Path

Enter Time		Add Carepath	Set Post-Op	D/C		Describe Item	Store		Preview Carepath		
------------	--	--------------	-------------	-----	--	---------------	-------	--	------------------	--	--

The user can preview post-operative or stabilization requirements on a per patient basis. For example, the user can examine the second half of a Care Path prior to setting the post-operative or stabilization times. To activate the preview mode, perform the following steps.



The preview mode is not useful if the 'Post-Op' or 'Stabilization' time has been stored, because the entire path is not visible on the screen.

1. Select the Critical Care Path Screen.
2. Move the cursor to highlight the desired Care Path in the 'Active Care Paths' Section.



All patient data on the Critical Care Path Screen must be stored to access the preview mode.

3. Press the "Preview Carepath" soft function key <F10>.
 - The Edit PostOp screen will appear and the cursor will default to the applicable time.
4. Depending upon the Care Path Type, enter in the **anticipated** 'Post-Op Time' or 'Stabilization Time.'



Setting the anticipated Post-Operative or Stabilization Time does not actually set the time. It temporarily sets the time for the care path to be reviewed.

5. Press the [Enter] key.
6. When finished setting the anticipated time, press the "Done" soft function key <F3>.
 - The Post-Operative or Stabilization time columns will appear automatically with the appropriate text and Task sections on the Critical Care Path Screen.
7. When finished with the preview mode, press the "End Preview" soft function key <F8>.



Accessing the Care Path Assessment Flowsheet will automatically end the Preview mode.

3.4.4.4 Setting 'Post-Op Time' or 'Stabilization Time'

Enter Time		Add Carepath	Set Post-Op	D/C		Describe Item	Store		Preview Carepath		
------------	--	--------------	-------------	-----	--	---------------	-------	--	------------------	--	--

The Post-Operation Time or Stabilization Time may be set after assigning the Care Path. The 'Post-Op Time' is assigned to the surgical diagnosis and the 'Stabilization Time' is assigned to the medical diagnosis. To set one of these times, perform the following steps.

1. Select the Critical Care Path Screen.
2. Move the cursor to highlight the desired Care Path in the 'Active Care Paths' Section.
3. Press the "Set Post-Op" or "Set Stab" soft function key <F4>.
 - The Edit PostOp screen will appear and the cursor will default to the applicable time field.
4. Enter in the desired time.
5. Press the [Enter] key.
6. When finished setting the time, press the "Done" soft function key <F3> to return to the flowsheet.
 - All subsequent time columns for that Care Path will appear as either 'Post-Operative Day X' or 'Stabilization.'
7. When finished with the entire screen, press the "Store" soft function key <F8>.



NEW ROW SCREEN CRITICAL CARE PATH SCREEN

The data box is the allowable field length.

Use the [Tab] and [Shift][Tab] keys for field movement.

Riggs, Daniel SICU-1 Phy: Williams, David (Env SICU) 11:56 Feb 16, 94
Critical Care Path

NEW ACTIVITY INSTRUCTIONS ROW

Name

Comment

Start Time D/C Time

<Tab> - Next Field
<Shift+Tab> - Previous Field

Assign Done Clear Fields Cancel All

3.4.4.5 Adding a New Row



Enter Time		New Row		D/C		Describe Item	Store	Edit One Cell	Edit All Cells	Expected Outcome	Modify Row
------------	--	---------	--	-----	--	---------------	-------	---------------	----------------	------------------	------------

To add a new row to the Critical Care Path flowsheet, perform the following steps.

1. Select the Critical Care Path Flowsheet.
2. Move the cursor to the desired data cell.
3. Press the “New Row” soft function key <F3>.
 - The New Row screen for that section type will appear.
4. Enter in the requested information.
5. Press the [Enter] key after each entry.
 - To clear all fields in the window and return to the ‘Name’ field, press the “Clear Fields” soft function key <F4>.
 - To abort the new row mode, press the “Cancel All” soft function key <F12>.
 - To clear the default time when in a time field, press the “Clear Time” soft function key <F1>.
6. Press the “Assign” soft function key <F2>.
 - The cursor will be positioned for the entry of another row.
7. When finished entering new row information, press the “Done” soft function key <F3>.
 - To remove a new row before it has been stored, position the cursor on the appropriate row and press the “Modify Row” soft function key <F12>.
8. When finished adding a new row, press the “Store” soft function key <F8>.



Once a row has been assigned and stored, it cannot be modified or removed.

3.4.4.6 Modifying a New Row



In a text box, care path assessment or user-defined section, only the name, comment, D/C time and/or frequency of an **unstored** row can be modified. To modify the unstored row, perform the following steps.

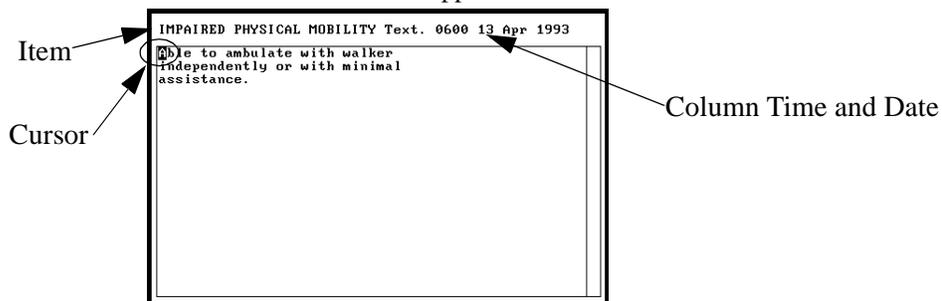
1. On the flowsheet, move the cursor to the **unstored** row.
2. Press the “Modify Row” soft function key <F12>.
 - The Modify Row window will appear.
3. Highlight one of the modify row options with the [Up Arrow] and [Down Arrow] keys.
 - To change the name, comment, D/C time and/or frequency, select the ‘Edit Labels’ option.
 - To remove the unstored row, select the ‘Delete Row’ option.
4. Press the [Enter] key.
 - If the ‘Edit Labels’ option is selected, the Edit Labels screen will appear.
5. When finished editing, press the “Done” soft function <F3>.
6. When finished with the flowsheet, press the “Store” soft function key <F8>.

3.4.4.7 Editing a Text Cell



The text cells may be edited for custom diagnoses on a per patient basis. To edit a text cell, perform the following steps.

1. Select the Critical Care Path Screen.
2. Move the cursor to highlight the desired text cell.
3. Press the desired edit soft function key (“Edit One Cell” <F9> or “Edit All Cells” <F10>).
 - The selected text cell will appear.



4. Type in the desired edits in free text.
 - The text cell has the following features:
 - Words will automatically wrap to the next line of text.
 - Edits are performed in an insert mode.
 - The [Home], [End], [Page Up], [Page Down], [Insert] and [Backspace] keys are available.
 - To remove the text in the box, press the “Clear Text” soft function key <F5>.

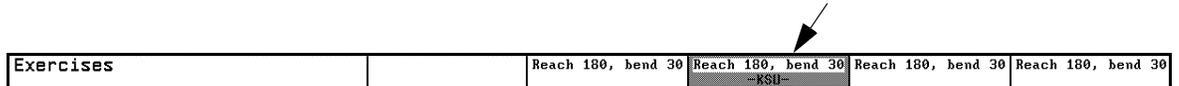
THE CRITICAL CARE PATH SCREEN WITH 'EDIT CELL' WINDOW

Critical Care Path			
ACTIVE CAREPATHS		Time: 0600 21 Apr 93	
	20 Apr 1000	21 Apr 0600	
HIP REPLACEMENT	Post-Operative	Post-Op Day 1	
NURSING DIAGNOSES			
ALTERATION IN BOWEL ELIMINATION R/T Surgery and Immobility			06:00
ALTERATION IN COMFORT R/T Muscle Spasms and Pain pre and post operative	Pain controlled on IM/PCA medication	Pain controlled on PO/IM/PCA medication	
ALTERATION IN URINARY ELIMINATION R/T Surgery and Immobility	Voiding per normal pattern	Voiding per normal pattern	
IMPAIRED PHYSICAL MOBILITY R/T Surgery, medication, pain/discomfort		Able to stand at bedside up in chair	
IMPAIRED SKIN INTEGRITY R/T Surgery and Immobility	No evidence of skin breakdown	No evidence of skin breakdown	
KNOWLEDGE DEFICIT R/T Surgery	IMPAIRED SKIN INTEGRITY Text. 0600 21 Apr 1993 No evidence of skin breakdown and		Pt verbalizes limitations, ie... use of walker
ASSESSMENTS			
Cardiovascular			
Neurological			
Respiratory			
Gastrointestinal			
Genitourinary			
Integumentary			
Musculoskeletal			
Neurovascular			
Incisional/Dressing			
Psych/Social			
Pain			
ACTIVITY			
	OK	Cancel	Clear Text

- **Deleting a Primary Text Cell**

Repeat text cells are text cells containing duplicate text from the primary text cell. For example, the outcomes for Day 2 are the same as Day 1. And a primary text cell can be deleted to become a repeat cell. For example, the cell may be deleted if the data in Today's text cell is different, but should be the same as the previous day's text cell.

A primary text cell is deleted via the "Delete Cell" soft function key <F12> when in the "Edit All Cells" or "Edit One Cell" functions. When deleted, the text cell will appear gray and text from the previous primary cell will carry over.



Exercises	Reach 180, bend 30			
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When accessing the "Edit All Cells" function and pressing the "Delete Cell" soft function key <F12>, **all** following repeat cells will be cleared and the previous primary cell data will be carried over.

5. Press the "OK" soft function key <F3> to accept the edits as typed.



- The edited text will appear underlined until stored.
 - The new text will be visible in the selected cell and/or on all subsequent, identical text cells for that item.
6. When finished with the entire screen, press the "Store" soft function key <F8>.
- To view the edit history for text windows, press the "Describe Item" soft function key <F7>.
 - The edited text may appear in reverse video when stored.



An extended view of an item's text cells

April 11 0600	April 12 0600	April 13 0600	April 14 0600	April 15 0600
No evidence of skin breakdown. Incision healing	No evidence of skin breakdown. Incision healing	No evidence of skin breakdown. Incision healing	No evidence of skin breakdown.	

When the original text in a text cell is edited and stored, the text will appear in reverse video.



If "Edit All Cells" key is selected, the modified text will change in all repeat cells.

THE CARE PATH EVALUATION FLOWSHEET

Checkmark
Exception Star

John Carter ORTHO-10 Phy: Blankenship (Env ORTHO) 10:15 Jun 28, 94										
Care Path Evaluation Flowsheet										
ASSESSMENTS W/ STANDARDS (*)										Time: 1350 3 Dec 94
	3 Dec 0710	3 Dec 0800	3 Dec 0900	3 Dec 1000	3 Dec 1032	3 Dec 1100	3 Dec 1200	3 Dec 1231	3 Dec 1300	3 Dec 1350
NEUROLOGICAL		✓			✓			✓		■
CARDIOVASCULAR					✓					
RESPIRATORY		+			+			+		
GASTROINTESTINAL		✓			✓			✓		
GENITOURINARY		✓			✓			✓		
INTEGUMENTARY		+			+			+		
MUSCULOSKELETAL		+			+			+		
PERIPHERAL VASCULAR		✓			✓			✓		
INCISIONAL										
DRESSING		+			+			+		
PSYCH/SOCIAL		✓			✓			✓		
PAIN		+			+			+		
ACTIVITY (*)										
PT DAILY EVALUATION	OK									OK
HIP AROM: DEGREES FLEXION	56									56
HIP A/AROM: DEGREES FLEXION	62									62
HIP AROM: DEGREES EXTENSION	0									0
HIP AROM: DEGREES ABDUCTION	9									9
HIP A/AROM: DEGREES ABDUCTION	14									14
EXERCISES: REPS/ASSIST	10/MIN									10/MIN
GAIT TRAINING: DISTANCE ___FT.	30									30
GAIT TRAINING: WEIGHT BEARING	PWB									PWB
ASSISTIVE DEVICE	W									W
ACTIVITIES OF DAILY LIVING: 1/4 HR										
GAIT TRAINING: 1/4 HR	1									1
PT EVALUATION: 1/4 HR	1									1
THERAPEUTIC EXERCISE: 1/4 HR	1									1
HOME PROGRAM	1									1
LEVEL OF INDEPENDENCE (*)										
FIMI BED MOBILITY	4 Min									
FIMI BASIC TRANSFERS	4 Min									
FIMI BASIC AMBULATION	4 Min									
FIMI STEP AMBULATION	NT									
- MORE -										
TREATMENTS W/ STANDARDS (*)										
TREATMENTS (*)										
TEACHING										
Enter Time	New Row	D/C	Copy Forward	Describe Item	Set Freq.	Schedule	Expected Outcome			

Continuation Arrow

3.4.5 CARE PATH EVALUATION FUNCTIONS

The Care Path Evaluation Flowsheet can contain Charting By Exception Sections.

3.4.5.1 Reviewing the Charting By Exception Sections

The Charting By Exception (CBE) Section is formatted as a checklist and created from the Task items generated when a Care Path is assigned on the Critical Care Path Screen. Additional flowsheet items may be added interactively from either screen via the 'New Item' function.

The 'Charting By Exception' symbols (i.e., star, arrow, checkmark) are entered on the flowsheet with a single keystroke. These symbols will not appear on the main Critical Care Path Screen. However, all changes to the Care Path Evaluation Flowsheet such as frequency, item addition or deletion and expected outcomes will be reflected automatically on the Critical Care Path Screen.



A flowsheet section with the standard charting functions may be added to the Care Path Evaluation Flowsheet as well.

3.4.5.2 Charting in the Charting By Exception Section

To chart patient care by exception, perform the following steps.

1. Select the Care Path Evaluation Flowsheet.
2. Move the cursor to highlight the desired data cell.
3. Enter in one of the following Charting By Exception symbols.

Symbol	Symbol Name	Keystrokes	Symbol Description
✓	Checkmark	[Insert]	Patient progressing per the Standard of Care
*	Exception	[*]	Exception to the Standard of Care requires an annotation
→	Continuation Arrow	[>]	Previously charted exception continues

- If the patient's status differs from the assigned Standard of Care, then an annotation should be charted.
 - The Continue Arrow symbol should be entered only after an exception has been documented by an annotation.
4. When finished with the entire screen, press the "Store" soft function key <F8>.

THE PROCEDURAL FLOWSHEET

Wright, Chrystal		ED-1		Phy: Dr. Brookstone		(Env ED)		11:38 Apr 29, 97				
Time/Date	ABP-S	ABP-D	B/P Source	HR	SpO2	Resp	TempF	TempC	TSrc	Rhythm	Treatments	Medications
0121 18 Sep				106	96							FLAGYL 500MG IVPB 500 MG IVPB
0110 18 Sep											Foley Catheter Inserted »BY FEMALE RN	
0102 18 Sep												
0058 18 Sep	143	83	NIBP	106	95	20				ST		FORTAZ 1GM UIAL 1GM IVPB TYLENOL 325MG TAB 975MG PO »FOR FEVER
0055 18 Sep												INSULIN REGULAR HUMAN U-100 INJ 10ML MDU 10U SQ
0051 18 Sep												
0029 18 Sep	133	55	NIBP	108	98	20				ST		
0027 18 Sep											BLOOD CULTURE #2 DRAWN.	
0021 18 Sep											ONE TOUCH = 469	
0011 18 Sep	125	71	NIBP	108	98	20				ST	LAB DRAWN »ABCS DRAWN BLOOD CULTURES X2	
0004 18 Sep											12 LEAD EKG DONE.	
0000 18 Sep	135	86	NIBP	107	91	20				ST		
2355 17 Sep												
2353 17 Sep					99							
2346 17 Sep												

TRIAGE ADMISSION

Patient Name: Wright, Chrystal Admit Date: 09/17/1996

Birthdate: 04/09/1940 Age: 57 Sex: F Admit Time: 2350

Billing #: 3900613 MRN #: 39006137 SHC#:

Primary Doctor: _____ Insurance: SELF PAY

Chief Complaint:

Assessment

Allergies: PENICILLIAN											
Enter Time				Fluid Totals	Print Report	Describe Item	Store			Triage Admissn	Discharg

Scrolling Indicator

Double lines separate the charting categories and indicate Tab stops.



All screen configurations are determined by the hospital and may vary from this manual's screen graphics.

3.4.6 PROCEDURAL FLOWSHEET FUNCTIONS

3.4.6.1 Reviewing the Procedural Flowsheet

The Procedural Flowsheet consolidates ICU CIS applications (i.e., Vital Signs, Fluids, Medications, etc.) for quick charting in any environment. Data charted on the Procedural Flowsheet will be automatically transferred to the applicable flowsheets.

The Procedural Flowsheet displays patient data in columns and the time and data is displayed in rows. The most recent time (and entry of patient data) appears at the top of the screen. If a data cell is partially displayed, then the text in the data cell will appear in gray. Multiple items within the same cell will be separated by dotted lines.

3.4.6.2 Charting on the Procedural Flowsheet

Charting categories (i.e., Fluids, Medications, etc.) are separated by dual gray lines and accessible via the [Tab], [Shift][Tab] and Arrow keys. Depending upon the category, data may be entered by one of the following methods:

- in Flowsheet Data Cells
Flowsheet data cells will expand automatically to accommodate the data charted in free text or from a corresponding choice list. Data charted in these cells may be edited and/or removed by pressing the [Space Bar] once.
- in theText Cell
The text cell is used for charting patient notes and provide the following features:
 - Words will automatically wrap to the next line of text.
 - Edits are performed in an insert mode.
 - The [Home], [End], [Page Up], [Page Down] and [Backspace] keys are available.
 - A scrolling indicator will automatically appear when entering large notes.
- via a Fixed Prompt Window
The assignment of medications, treatments, intakes and outputs are all charted via a Fixed Prompt window. Each window includes a scrolling choice list configured to the appropriate section. Delivery of fluids is achieved through a fluids totals fixed prompt window.

3.4.6.3 Using the Scrolling Choice List

The Scrolling Choice List will appear when charting in a fixed prompt. One of the following methods may be used when using the scrolling choice list:

- Type in the first few characters of the item's name. The system will display possible matches, which may be selected from the choice list or entered in free text.
- Press the [Tab] key to access the items listed in the choice list. With the Arrow keys, highlight the desired item.
 - If any key is pressed within the choice list, the system will automatically search and highlight the first item with that same character.
 - Multiple choice list entries may be entered by pressing the [+] key within the choice list.

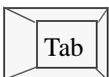
3.4.6.4 Screen Keys

The following keys may be used for cursor movement within the Procedural Flowsheet.



[Shift][Tab] key

The [Shift][Tab] key moves the cursor to the previous section separated by dual lines.



[Tab] key

The [Tab] key moves the cursor to the next section separated by dual lines.

THE PROCEDURAL FLOWSHEET

Time/Date		Fluid Outputs	Fluid Totals	Patient Notes	Labs	Rad	Orders	Pt Status
2249 29 Aug			Total In: 0.00 Total Out: 0.00 Net: +0.00	PT TO FLOOR WITH NURSE AND HCA ON MONITOR. IV INFUSING WELL. ☒ Mary Lamb, RN (ML)				
2218 29 Aug				DR. BROWN IN TO EVALUATE THE PT. REPORT CALLED TO FLOOR IV INFUSING WELL. FAMILY LEFT ED WILL CALL LATER. ☒ Mary Lamb, RN (ML)				
2215 29 Aug				PT TO GO TO 666-1 ☒ Toni Smith, RN (TS)				Bed Assigned
2152 29 Aug								Bed Requested
2141 29 Aug								
2131 29 Aug				PT AA OX 3 SKIN W/D PT UNABLE TO AMB. UNSTEADY TO SIT UP WITH A PULLING BACK MOTION. INCREASE IN PAIN. ☒ Mary Lamb, RN (ML)				Return from XRay
2031 29 Aug								To XRay
1954 29 Aug				pt with family c/o pain to neck and to r shoulder. iv infusing well. ☒ Mary Lamb, RN (ML)				
1950 29 Aug								Return from CT
1859 29 Aug								To CT
1829 29 Aug								
1752 29 Aug		Default Fluid List: - URINE - EMESIS - ORAL - IV Meds - NG - CHEST TUBE LAC		BROUGHT IN BY ALS MEDICS - PT ARRIVES WITH SOFT CERVICAL COLLAR AND AWAKE AND ORIENTED TO NAME AND PLACE ONLY. PT WAS SEEN AT GROSSMONT ER THIS AM FOR HEAD INJURY AND NECK INJURY. PT STATES HE TRIPPED AND FELL ON HIS WAY TO THE BATHROOM THIS AM AT APPROX 2:00AM. PT HAD A CT-SCAN OF HEAD AND NECK A GROSSMONT ER. UPON ARRIVAL TO ER, PT C/O CERVICAL NECK PAIN. DENIES NUMBNESS				Pt in Bed

TRIAGE ADMISSION

Patient Name: Jacobson, Amy Admit Date: 08/29/1996

Birthdate: 06/19/1905 Age: 91 Sex: M Admit Time: 1750

Billing #: 6419243 MRN #: 64192432 SHC#:

Primary Doctor: Insurance: MEDICARE*

Chief Complaint: WEAKNESS

Assessment

Allergies: MORPHINE

Enter Time				Fluid Totals	Print Report	Describe Item	Store	Edit Note	Triage Admissn	Discharg
------------	--	--	--	--------------	--------------	---------------	-------	-----------	----------------	----------

Allergies charted on the Admission Record Screen can appear on the bottom of the screen.

The default note will be displayed after it has been stored.

3.4.6.5 Adding a Pre-Defined Note to the Procedural Flowsheet



Two notes can be configured for access via the soft keys <F11> and <F12> on the Procedural Flowsheet. When the desired note’s soft key is pressed, the notes application will appear on the screen with the selected note. To add a note, perform the following steps.

 *As rows are added to the Procedural Flowsheet, the height of the default note below will shrink. However, the minimum height of the note can be configurably set, which will enable the Procedural Flowsheet to scroll vertically as new rows are added.*

1. Press the desired note’s soft key label <F11> or <F12>.
2. Enter in the desired information.
3. When finished with the note, press the “Store” soft key <F8>.
4. Press the “Return” soft key <F1> to return to the Procedural Flowsheet.

 *The note is displayed in a “Review Only” mode.*

- To review the note, press the [Page Down] key.
- Scroll through the note with the [Up Arrow] and [Down Arrow] keys.

3.4.6.6 Importing Monitored Data

Monitored patient data may be captured and recorded on the Procedural Flowsheet. To import monitored data, perform the following steps.

1. Select the Procedural Flowsheet.
2. If capturing previously monitored data, change the time by pressing the “Enter Time” soft key and entering in the desired time.
3. Press the “Read Monitor” soft key <F2>.
 - Monitored parameters will be imported to the rows that have been mapped to read the data from the monitor.

 *Monitored parameters will be continuously read as long as the patient is connected to the bedside monitor. However, monitored data will not be transferred to the system until the “Read Monitor” soft key <F2> is pressed.*

-  4. Verify the information imported is correct.
- Change any values desired or press the “Read Monitor” soft key again for the most current monitored data.
5. Edit or add data as desired.
 6. Press the [Enter] key after each entry.
 7. When finished with the entire screen, press the “Store” soft key <F8>.

THE PROCEDURAL FLOWSHEET WITH A FIXED PROMPT WINDOW

Scrolling Choice List

Cursor

Fixed Prompt window configurations will vary with the section type.

Jacobson, Amy		ED-7	Phy: Dr. Brookstone	(Env ED)	12:04	08/29/97
Flowsheet						
Time/Date	ns	Fluid Intakes	Fluid Outputs	Fluid Totals	Patient Notes	
2249 29 Aug				Total In: 0.00 Total Out: 0.00 Net: +0.00	PT TO FLOOR WITH NURSE AND HCA ON MONITOR. IV INFUSING WELL. Mary Lamb, RN (ML)	
2218 29 Aug					DR. BROWN IN TO EVALUATE THE PT. REPORT CALLED TO FLOOR/IV INFUSING WELL. FAMILY LEFT ED WILL CALL LATER. RN (ML)	
2215 29 Aug					666-1 RN (TS)	
2152 29 Aug						
2141 29 Aug						
2131 29 Aug					SKIN W/D PT UNABLE TO AMB. SIT UP WITH A PULLING BACK EASE IN PAIN. RN (ML)	
2031 29 Aug						
1954 29 Aug					ly c/o pain to neck and to v infusing well. RN (ML)	
1950 29 Aug						
1859 29 Aug						
1829 29 Aug						
1752 29 Aug		Default Fluid - URINE - EMESIS - ORAL - IV Meds - NG - CHEST TUBE			GROSSMONT ER. UPON ARRIVAL TO ER, PT C/D CERVICAL NECK PAIN. DENIES NUMBNESS ALS MEDICS - PT ARRIVES CRITICAL COLLAR AND AWAKE AND NAME AND PLACE ONLY. PT WAS SMONT ER THIS AM FOR HEAD NECK INJURY. PT STATES HE FELL ON HIS WAY TO THE S AM AT APPROX 2:00AM. PT N OF HEAD AND NECK A	

Enter Output Name:

Enter Fluid Label Comment:

Press <TAB> to select from choice list...

TRIAGE ADMISSION

Patient Name: Jacobson, Amy Admit Date: 08/29/1996

Birthdate: 06/19/1905 Age: 91 Sex: M Admit Time: 1750

Billing #: 6419243 MRN #: 64192432 SHC#:

Primary Doctor: _____ Insurance: MEDICARE*

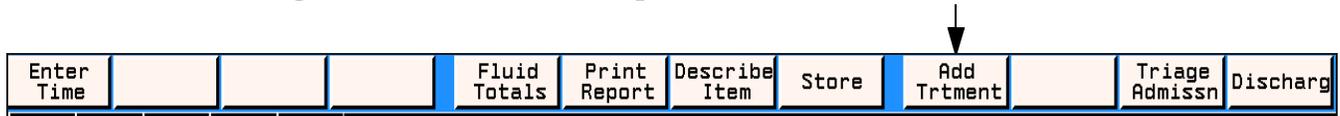
Chief Complaint: WEAKNESS

Assessment

Allergies: MORPHINE

		OK								Cancel
--	--	----	--	--	--	--	--	--	--	--------

3.4.6.7 Charting a Medication, Intake, Output or Treatment



Enter Time				Fluid Totals	Print Report	Describe Item	Store	Add Trtment		Triage Admissn	Discharg
------------	--	--	--	--------------	--------------	---------------	-------	-------------	--	----------------	----------

Medications, treatments and fluids are entered via a fixed prompt window with a pre-configured, scrolling choice list. To document a medication, treatment, intake or output, perform the following steps.

1. Select the Procedural Flowsheet.
2. Move the cursor to the desired time row.
3. Press the [Tab] key or [Right Arrow] key to the desired column (i.e., Medications, Treatments, Fluid Intake, Fluid Output).
4. Begin entering data or press the corresponding soft key for the section (e.g., “Add Med” when in the Medication Section).
 - The Fixed Prompt window will appear on the screen.
5. Enter in the requested information (i.e, Dose, Route, Comments, etc.) in free text or via the scrolling choice list.
 - The system may only accept items listed on the choice list if configured to do so.
6. Press the [Enter] key.
 - All data entered via a fixed prompt window will have a Start Time equal to the time of the current row.
7. When finished charting, then press the “OK” soft key <F3>.
 -  *Once the “OK” soft key <F3> is pressed, patient data cannot be changed.*
8. When finished with the entire screen, press the “Store” soft key <F8>.

THE PROCEDURAL FLOWSHEET WITH A PATIENT NOTE TEXT CELL

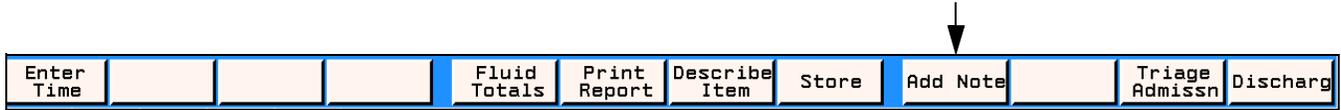
Jacobson, Amy		ED-7	Phy: Dr. Brookstone		(Env	ED)	12:23 Apr 29, 97
Fl o w s h e e t							
Time/Date	ns	Fluid Intakes	Fluid Outputs	Fluid Totals		Patient Notes	
2249 29 Aug				Total In:	0.00	PT TO FLOOR WITH NURSE AND HCA ON MONITOR. IV INFUSING WELL. ☑ Mary Lamb, RN (ML)	
				Total Out:	0.00		
				Net:	+0.00		
2218 29 Aug						DR. BROWN IN TO EVALUATE THE PT. REPORT CALLED TO FLOOR IV INFUSING WELL. FAMILY LEFT ED WILL CALL LATER. ☑ Mary Lamb, RN (ML)	
2215 29 Aug						PT TO GO TO 666-1 ☑ Toni Smith, RN (TS)	
2152 29 Aug							
2141 29 Aug							
2131 29 Aug				ER patient note - 2141 29 Aug. per MD order		PT AA OX 3 SKIN W/D PT UNABLE TO AMB. UNSTEADY TO SIT UP WITH A PULLING BACK MOTION. INCREASE IN PAIN. ☑ Mary Lamb, RN (ML)	
2031 29 Aug							
1954 29 Aug						pt with family c/o pain to neck and to r shoulder. iv infusing well. ☑ Mary Lamb, RN (ML)	
1950 29 Aug							
1859 29 Aug							
1829 29 Aug							
1752 29 Aug		Default Fluid List: - URINE - BHESTIS - URAL - IV Meds - NG - CHEST TUBENS T1000				BROUGHT IN BY ALS MEDICS - PT ARRIVES WITH SOFT CERVICAL COLLAR AND AWAKE AND ORIENTED TO NAME AND PLACE ONLY. PT WAS SEEN AT GROSSMONT ER THIS AM FOR HEAD INJURY AND NECK INJURY. PT STATES HE TRIPPED AND FELL ON HIS WAY TO THE BATHROOM THIS AM AT APPROX 2:00AM. PT HAD A CT-SCAN OF HEAD AND NECK A GROSSMONT ER. UPON ARRIVAL TO ER, PT C/O CERVICAL NECK PAIN. DENIES NUMBNESS	
				F3-OK	F12-Cancel		

TRIAGE ADMISSION			
Patient Name: Jacobson, Amy	Admit Date: 08/29/1996	↑ ↓	
Birthdate: 06/19/1905 Age: 91 Sex: M	Admit Time: 1750		
Billing #: 6419243 MRN #: 64192432 SHC#: <input type="text"/>	Insurance: MEDICARE*		
Primary Doctor: <input type="text"/>	Chief Complaint: WEAKNESS <input type="text"/>		
Assessment			

Allergies: MORPHINE									
	OK								Cancel

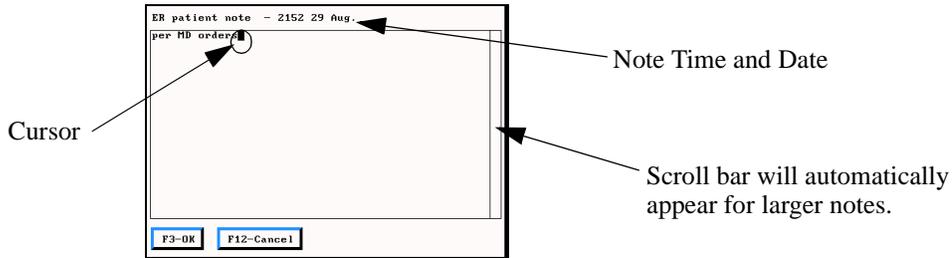
The display of large patient notes will be limited. To review the entire note, press the "Describe Item" soft key <F7>.

3.4.6.8 Entering a Patient Note



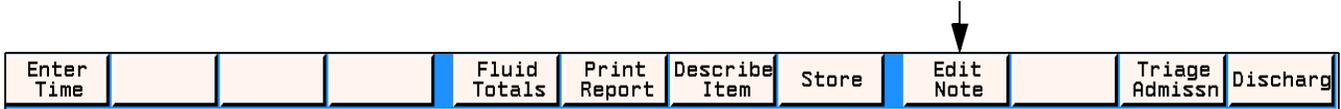
Free text patient notes may be entered and displayed on the screen. To add a patient note, perform the following steps.

1. Select the Procedural Flowsheet.
2. Move the cursor to the desired time row.
3. Press the [Tab] key or [Right Arrow] key to the 'Patient Notes' column.
4. Type in the note in free text or press the "Add Note" soft key <F9>.
 - A text window will appear.



5. Press the "OK" soft key <F3> to accept the note as typed.
6. When finished with the entire screen, press the "Store" soft key <F8>.

3.4.6.9 Editing a Patient Note



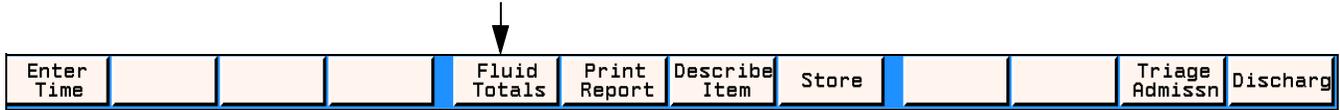
Patient notes on the Procedural Flowsheet can be modified as needed. A complete edit history of each note is available for review via the "Describe Item" soft key <F7>. To edit an existing patient note, perform the following steps.

1. Select the Procedural Flowsheet.
2. Move the cursor to the desired time row.
3. Press the [Tab] key or [Right Arrow] key to the 'Patient Notes' column.
4. Press the "Edit Note" soft key <F9>.
 - The existing note will appear with the cursor positioned at the beginning of the text.
5. Type in your changes in free text.
6. Press the "OK" soft key <F3> to accept the changes.
 - The Edit prompt will appear.
7. Type in 'Y' for Yes.
8. Press the [Enter] key.
9. When finished with the entire screen, press the "Store" soft key <F8>.

THE PROCEDURAL FLOWSHEET WITH THE "FLUID TOTALS" WINDOW

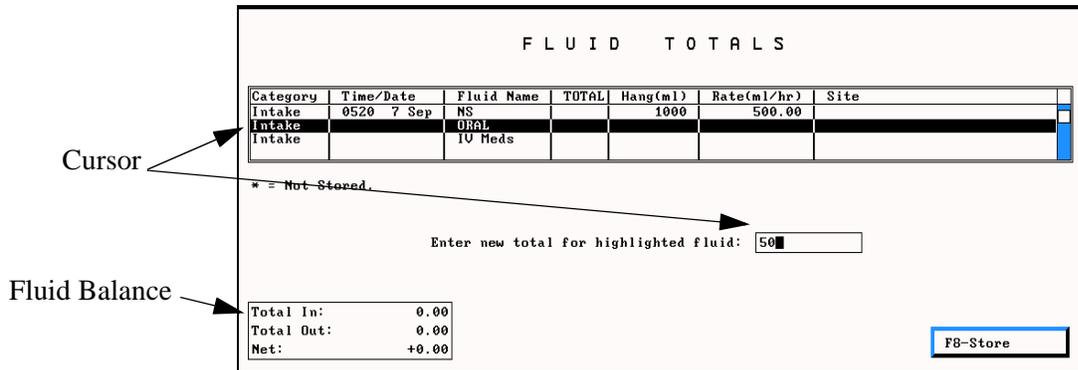
Osborne, Michael		ED-2	Phy: Dr. Brookstone		(Env ED)	12:35 Apr 29, 97																												
Fl o w s h e e t																																		
Time/Date	Fluid Intakes	Fluid Outputs	Fluid Totals		Patient Notes																													
0734 7 Sep			Total In:	0.00	REPORT CALLED TO JEANETTE RN ON 9SOUTH, TRANSPORTED VIA GURNEY IN SATIS CONDITION																													
			Total Out:	0.00	☐ Teri Heller, RN (TH)																													
			Net:	+0.00																														
0725 7 Sep	FLUID TOTALS				DR FURTHER ASKING FOR TIME																													
0706 7 Sep	<table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th>Category</th> <th>Time/Date</th> <th>Fluid Name</th> <th>TOTAL</th> <th>Hang(ml)</th> <th>Rate(ml/hr)</th> <th>Site</th> </tr> </thead> <tbody> <tr> <td>Intake</td> <td>0520 7 Sep</td> <td>NS</td> <td></td> <td>1000</td> <td>500.00</td> <td></td> </tr> <tr> <td>Intake</td> <td></td> <td>ORAL</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td>Intake</td> <td></td> <td>IV Meds</td> <td></td> <td></td> <td></td> <td></td> </tr> </tbody> </table>						Category	Time/Date	Fluid Name	TOTAL	Hang(ml)	Rate(ml/hr)	Site	Intake	0520 7 Sep	NS		1000	500.00		Intake		ORAL					Intake		IV Meds				
Category	Time/Date	Fluid Name	TOTAL	Hang(ml)	Rate(ml/hr)	Site																												
Intake	0520 7 Sep	NS		1000	500.00																													
Intake		ORAL																																
Intake		IV Meds																																
0702 7 Sep																																		
0700 7 Sep	* = Not Stored.																																	
	Enter new total for highlighted fluid: <input style="width: 50px;" type="text"/>																																	
0651 7 Sep	<table border="1" style="width: 100%; border-collapse: collapse;"> <tbody> <tr> <td>Total In:</td> <td>0.00</td> </tr> <tr> <td>Total Out:</td> <td>0.00</td> </tr> <tr> <td>Net:</td> <td>+0.00</td> </tr> </tbody> </table>						Total In:	0.00	Total Out:	0.00	Net:	+0.00																						
Total In:	0.00																																	
Total Out:	0.00																																	
Net:	+0.00																																	
0648 7 Sep	F8-Store																																	
0634 7 Sep																																		
0625 7 Sep	UPRIIGHT. ☐ Bonnie Stevens, RN (BS)																																	
0613 7 Sep	C/D CONTINUED PAIN. ☐ Bonnie Stevens, RN (BS)																																	
0600 7 Sep	STATES FEELS A LITTLE BETTER. CONTINUES TO MOAN AT TIMES. SKINS SLIGHTLY MOIST. ☐ Bonnie Stevens, RN (BS)																																	
0525 7 Sep																																		
TRIAGE ADMISSION																																		
Patient Name: Osborne, Michael			Admit Date: 09/07/1996																															
Birthdate: 11/26/1962		Age: 34	Sex: M	Admit Time: 0508																														
Billing #: 6419366		MRN #: 64193660	SHC#: <input style="width: 50px;" type="text"/>																															
Primary Doctor:			Insurance: SELF PAY																															
Chief Complaint: <input style="width: 100%;" type="text" value="ABDOMINAL PAIN"/>																																		
Assessment																																		
Allergies: NKA																																		
					Store																													

3.4.6.10 Charting Fluid Totals



The total intake and output volume may be charted from any section on the Procedural Flowsheet. The fluid balance is tallied and updated with every entry. To record the intake or output totals, perform the following steps.

1. Select the Procedural Flowsheet.
2. Move the cursor to the Fluid Totals column or press the “Fluid Totals” soft key <F5>.
 - The Fluid Totals window will appear displaying the total intake and total output for the most recent time.



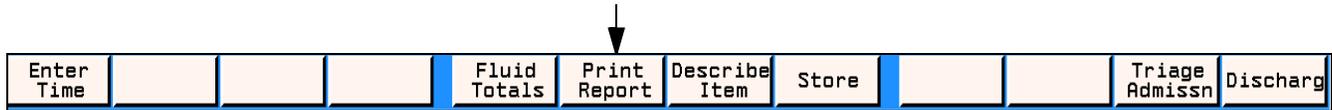
3. Highlight the desired intake or output with the [Up Arrow] and [Down Arrow] keys.
4. Type in the fluid total.
 - To add to an existing fluid total, type in ‘+’ followed by the additional amount. The system will automatically add the two totals and display the sum amount.
5. Press the [Enter] key.
6. When finished with fluid totals, press the “Store” soft key <F8>.
7. To exit from the Fluid Totals window.

OR
8. Press the “Done” soft key <F12>.

THE PROCEDURAL FLOWSHEET WITH "DISPATCH REPORT" PROMPT

Times, Christopher		ED-3		Phy: Dr. Brookstone				(Env ED)		12:48 Apr 29, 97		
Fl o w s h e e t												
Time/Date	ABP-S	ABP-D	B/P Source	HR	SpO2	Resp	TempF	TempC	TSrc	Rhythm	Treatments	Medications
1248 29 Apr												
1359 8 Oct	95	60	NIBP	87	96	18				SR		
1325 8 Oct												
1245 8 Oct												
1145 8 Oct												ALTERNAGEL 600MG/5ML-12OZ. BOTTLE 30M PO
1100 8 Oct												
1050 8 Oct												
1029 8 Oct												ROCEPHIN 1GM IVPB 1gm IVPB
1015 8 Oct	106	63	NIBP	88	96	16				NSR		
0948 8 Oct											Lab Drawn	
0942 8 Oct	93	63	NIBP	103	95	20				ST		PRILLOSEC (CR) 20MG CAP 20MG PO
<div style="border: 2px solid black; padding: 5px; width: fit-content; margin: 0 auto;"> Report Dispatched to Printer COMPROOM Press any key to continue... </div>												
0932 8 Oct												
<div style="border: 2px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <p style="text-align: center; margin: 0;">TRIAGE ADMISSION</p> <p>Patient Name: Times, Christopher Admit Date: 10/08/1996</p> <p>Birthdate: 09/26/1926 Age: 70 Sex: M Admit Time: 0856</p> <p>Billing #: 6419797 MRN #: 64197978 SHC#: <input type="text"/></p> <p>Primary Doctor: Insurance: SELF PAY</p> <p>Chief Complaint: <input type="text" value="SHORTNESS OF BREATH"/></p> <p style="text-align: center; margin-top: 5px;">Assessment</p> </div>												
Allergies: CODEINE												

3.4.6.11 Printing the Report



To print the Procedural Flowsheet, perform the following steps.

1. Select the Procedural Flowsheet.
2. Press the “Print Report” soft key <F6>.
 - If data has been entered and not stored, the following warning will appear. Acknowledge the

WARNING: There is unstored data which will not appear on the report. Print anyway (Y/N)? █

- prompt with ‘Y’ for Yes or ‘N’ for No.
 - If data has been stored, the Dispatch prompt will appear.
3. Press any key to continue.
 - The report will print to the printer configured for that display station.



The Procedural Flowsheet Report can be configured to print in ascending and descending chronological order.

3.5 NOTES APPLICATION FUNCTIONS

NOTES APPLICATION THE NOTES MENU SCREEN

Acidosis, Andy
I-1
Phy: Dr. Brookstone (Env DOD-ICU)
11:07 Jul 18, 97

Notes Menu Screen

Care Plan (Active Problem):

Topic	Assigned (Days Ago)	Last Update (Days Ago)
15 Co. Pac. De	1929 4 Mar 1997 (135)	0912 13 Mar 1997 (126)
22 Coping	0237 10 Mar 1997 (130)	0237 10 Mar 1997 (130)
21 Comfort	0115 11 Mar 1997 (129)	0115 11 Mar 1997 (129)

Notes for 17 Jul 1997:

Note time	Type	Topic	Stored At	Last Stored By	Status
N/A	Admission History (3888)		1901 5 Mar 1997	Alice Holliday, RN	(Edited)
N/A	CC Multidisciplinary PT ED	COUNADIN NOTE	1412 5 Mar 1997	Nefario Salamanca, RN	(Created)
N/A	Advance Directives		0033 5 Mar 1997	James Little, RN	(Created)
N/A	Admission Data Screen		0937 20 Jun 1997	Demo User	(Created)
N/A	Admit ICU		1556 13 Mar 1997	Arty B Goode, RN	(Edited)

New Note
Review Note
Edit Note
Scan Notes
Show All
Prev Day
Next Day
Specify Day
Category List
Copy Note
Sort By
CarePlan Mode

CARE PLAN SECTION
NOTES SECTION

Note time as entered by the user.

Menu Display Date

The selected note will appear in reverse video.

When pressed, all patient notes will be listed of defined type.

When pressed, the previous day's timed notes will be displayed.

When pressed, a particular day can be selected.

When pressed, the next day's timed notes will be displayed.

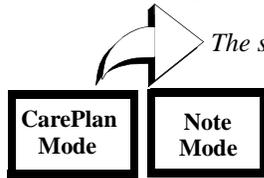


All screen configurations are determined by the hospital and may vary from this manual's screen graphics.

3.5.1 NOTES FUNCTIONS

3.5.1.1 Reviewing the Notes Application

The color of the screen display is configurable by facility. Upon selecting Notes, the Notes Menu Screen will appear. This screen is divided into two related sections: Care Plan and Notes.



The screen will default to display the current day's Care Plan, Notes and Admit Notes.

“CarePlan Mode” / “Note Mode” Soft Key <F12>
When the <F12> soft key is selected, depending upon the cursor location, the cursor will move to the top of either the Notes Section or Care Plan Section. The [Tab] key can also be used.

CARE PLANS SECTION

Care plans document the nursing process by incorporating nursing objectives and guidelines for a specific patient problem or collection of problems. Each problem may contain related clinical notes that have been updated and/or created based on the patient's status.

Active problems will be displayed by default and include the date and time each problem was assigned and last updated. As the problems are resolved, then the resolution date and time will be listed.



“Show Status” Soft Key <F3> (or the [Enter] key)
When selected, the latest care plan update will be displayed for review. To return to the Notes Menu Screen, press either the “Notes Menu” soft key <F1> or the [Enter] key.

NOTES SECTION



The display date will default to current date. Admit notes or one-time notes will display at all times.

The Notes Section lists the patient's daily notes and updated care plans notes. The columns in the Notes Section lists per note the following: the creation time, the note name (type), the note topic, the store date and time, the storing user and the status of the note.

Note Time Column

The default time to create a note is the current time; however, the user can change the time manually within the time range allowed.

The configured note types can be grouped into categories as defined by the hospital. For example, the ‘Discharge’ category could contain all notes needed when discharging a patient such as the Discharge Instruction Note, Follow-up Note, etc. Categories can be viewed via the “Categories List” soft key <F9>.

Default categories can be configured per environment. For example, if the SICU unit is configured to only display the “Assessment” category, then only the Assessment Notes will be displayed when selecting the Notes Menu Screen. The user will have to manually select the other categories to see other notes.

Note Type Column

The note type is actually the note name. The note types available for selection are configured by your hospital to best reflect your patient care protocols.

Note Topic Column

A note topic can be created for each note. The topic is a ‘keyword’ defined by the user, which may be used as a note's subject line, as the keyword for future queries of the note, to refer to a specific care plan problem, etc.



If a Care Plan is created, the assigned problem will become the topic.

NOTES APPLICATION A CONDITIONAL PROMPT EXAMPLE

Kemper, Anna Note Time: 1110 15 Jan 1996 Type: Critical Care Assessment Topic: N/A Mode: [Entry] 5 Oct 02, 96

Rhythm: Ectopy:

Heart Sounds: Pulses:

IV Access: #1 Site: Appearance:

Infusing:

Hemodynamic Monitoring:

IABP:

Pacer:

Pacer Settings: Rate: MA: Sens: Mode:

Gastrointestinal

Abdomen: Tubes:

Stoma:

Enteral Feedings:

Genourinary

Urine Characteristic:

Dialysis:

Integumentary

Skin: Edema:

Drains:

Wounds:

Note Menu Edit Field More Fields Describe Item Store Toggle Mode Erase Data Edit Topic Print

Check Box Prompt

Dependant Prompts

A grayed soft key indicates the function is not applicable.

DEFINITIONS

Check Box Prompts

If an “X” is entered by the user in a pre-defined check box conditional prompt, then the dependent prompts or pre-configured text will appear automatically on the screen. For example, if ‘Yes’ is selected in the following example, field prompts for medications will appear,

Mutually Exclusive Prompts

Field prompts can be configured so that a user can respond to only one of the available choices. For example, with the following prompt, the ‘Yes,’ ‘No,’ and ‘Unknown’ check boxes are mutually exclusive and the system will only accept one selection.

Yes	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient taking medications?			
Medications			

Multiple Choice List Prompts

The choice list for the primary prompt can be configured with multiple choices separated by the pipe (|) symbol. Upon selecting the choice list item, the multiple choices will automatically appear in the subsequent prompts.

Name	Dose	Freq	Route	Comment
#1 LEVODOPA	1 TAB	PRN	ORAL	For vomiting
↓				
All 1 - AMIODARONE	1 TAB	PRN	ORAL	
2 - CEFTIN	2 TAB	TID	ORAL	Call me in the morning
3 - LACTINEX	2 TAB	BID	ORAL	
4 - LEVODOPA	1 TAB	PRN	ORAL	For vomiting

The multiple choices will not appear in the respective fields if any of the prompts already have data.

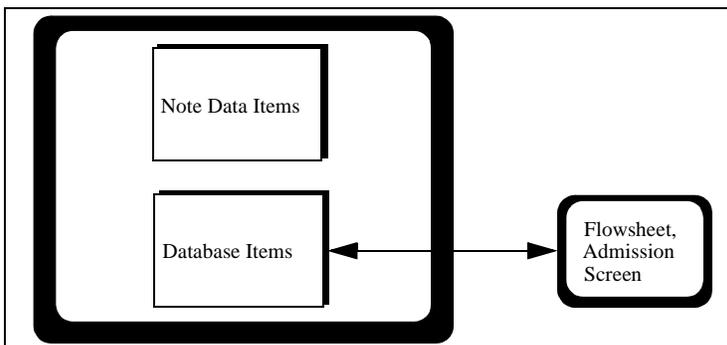
Enforced Choice Lists

An enforced choice list is one that has been configured to allow the user to only select one item displayed in the list. No other item can be appended once an item has been selected.

Database Items

Prompts identified as database items differ from regular note prompts.

- A database item can be shared with different screens.
Database items stored on a flowsheet can be shared for viewing and editing on another screen or Notes.



- The database item is retrieved each time the note is accessed.
Each time a Note with database items is accessed (i.e., shift assessment may need to import in the most recent lab values), the system will retrieve the database item values (i.e., lab values) closest to the time of the note, if it is configured to do so.
- The database item can be edited via other flowsheets and by any user.

There are three possible types of database items:

- Admit - (Read/Write) - the value charted at Admit Time.
- Latest - (Read Only) - the most recent value prior to the Note Time.
- Current - (Read/Write) - the value at the Note Time.



Database item edit history can be viewed via the “Describe Item” soft key <F7>.

THE NOTES MENU SCREEN DISPLAYING ALL NOTES AND ANNOTATIONS FOR A PATIENT

To scroll in the Notes Menu Screen, use the [Page Down] and [Page Up] keys or click and drag with the mouse.

Martin, Sarah 560 Phy: Dr. Brookstone (Env ICU) 11:52 Jul 18, 97

Notes Menu Screen

Care Plan (Active Problems):

Topic	Assigned (Days Ago)	Last Update (Days Ago)
Cardiac Output	2347 28 Nov 1996 (231)	0027 1 Dec 1996 (229)
Anxiety	2352 28 Nov 1996 (231)	0026 1 Dec 1996 (229)
Gas Exchange	0200 29 Nov 1996 (231)	0023 1 Dec 1996 (229)
Hyper/Hypoglycemia	0000 1 Dec 1996 (229)	0000 1 Dec 1996 (229)

Notes for Entire Stay:

Note Time	Type	Topic	Stored At	Last Stored By	Status
N/A	Admission Assessment Note		1658 9 Jul 1997	Demo User	(Created)
0704 1 Dec 1996	Assessment		0706 1 Dec 1996	Tom Campbell, RN	(Created)
0530 1 Dec 1996	Nursing Note	TCI	0711 1 Dec 1996	Tom Campbell, RN	(Created)
0530 1 Dec 1996	Nursing Note	DR. ADAMSON	0709 1 Dec 1996	Tom Campbell, RN	(Created)
0515 1 Dec 1996	Nursing Note		0536 1 Dec 1996	Teri Heller, RN	(Created)
0445 1 Dec 1996	Nursing Note	Hyper/Hypoglycemia	0535 1 Dec 1996	Teri Heller, RN	(Created)
0430 1 Dec 1996	Nursing Note	Cardiac Output	0459 1 Dec 1996	Teri Heller, RN	(Created)
0417 1 Dec 1996	Annotation	NS+INSULIN-HUMULIN	0429 1 Dec 1996	Teri Heller, RN	(Created)
0300 1 Dec 1996	Nursing Note	Gas Exchange	0435 1 Dec 1996	Teri Heller, RN	(Created)
0200 1 Dec 1996	Nursing Note	Gas Exchange	0217 1 Dec 1996	Teri Heller, RN	(Created)
0100 1 Dec 1996	Nursing Note	Cardiac Output	0215 1 Dec 1996	Teri Heller, RN	(Created)
0027 1 Dec 1996	CarePlan Note	Cardiac Output	0028 1 Dec 1996	Teri Heller, RN	(Created)
0026 1 Dec 1996	CarePlan Note	Anxiety	0027 1 Dec 1996	Teri Heller, RN	(Created)
0023 1 Dec 1996	CarePlan Note	Gas Exchange	0026 1 Dec 1996	Teri Heller, RN	(Created)
0000 1 Dec 1996	CarePlan Note	Hyper/Hypoglycemia	0046 1 Dec 1996	Teri Heller, RN	(Created)
0000 1 Dec 1996	Nursing Note	Hyper/Hypoglycemia	0047 1 Dec 1996	Teri Heller, RN	(Created)
2345 30 Nov 1996	Nursing Note	Gas Exchange	0021 1 Dec 1996	Teri Heller, RN	(Created)
2325 30 Nov 1996	Nursing Note	Gas Exchange	2337 30 Nov 1996	Teri Heller, RN	(Created)
2300 30 Nov 1996	Nursing Note	Cardiac output/Gas exchange	2324 30 Nov 1996	Teri Heller, RN	(Created)
2230 30 Nov 1996	Nursing Note	Cardiac output/Gas exchange	2321 30 Nov 1996	Teri Heller, RN	(Created)
2223 30 Nov 1996	Annotation	NS+INSULIN-HUMULIN	2227 30 Nov 1996	Teri Heller, RN	(Created)
2209 30 Nov 1996	Assessment		0224 1 Dec 1996	Teri Heller, RN	(Edited)
2201 30 Nov 1996	Annotation	SpO2	2215 30 Nov 1996	Charlie Muldoon, RN	(Created)
2145 30 Nov 1996	Nursing Note	Gas Exchange	2223 30 Nov 1996	Teri Heller, RN	(Created)
2130 30 Nov 1996	Nursing Note		2218 30 Nov 1996	Teri Heller, RN	(Created)
2100 30 Nov 1996	Nursing Note	DR. ADAMSON	2130 30 Nov 1996	Tom Campbell, RN	(Created)
2010 30 Nov 1996	Nursing Note	PH CARE	2130 30 Nov 1996	Tom Campbell, RN	(Created)
1620 30 Nov 1996	Nursing Note	DR. ADAMSON	1704 30 Nov 1996	Tom Campbell, RN	(Created)
1150 30 Nov 1996	Nursing Note	TCI SPECIALIST NURSE	1141 30 Nov 1996	Tom Campbell, RN	(Created)
1142 30 Nov 1996	Nursing Note	Cardiac Output	1148 30 Nov 1996	Tom Campbell, RN	(Created)
1142 30 Nov 1996	Nursing Note	Anxiety	1147 30 Nov 1996	Tom Campbell, RN	(Created)
1142 30 Nov 1996	Nursing Note	Gas Exchange	1147 30 Nov 1996	Tom Campbell, RN	(Created)
0850 30 Nov 1996	Annotation	Ejection Duration	1103 30 Nov 1996	Tom Campbell, RN	(Created)
0759 30 Nov 1996	Annotation	Mode	0802 30 Nov 1996	Shirley B Wrightmann, RN	(Created)
0700 30 Nov 1996	Annotation	Suction	0701 30 Nov 1996	Shirley B Wrightmann, RN	(Created)
0619 30 Nov 1996	Annotation	Pressure Support	0621 30 Nov 1996	Shirley B Wrightmann, RN	(Created)
0600 30 Nov 1996	Assessment		0724 30 Nov 1996	Tom Campbell, RN	(Created)
0530 30 Nov 1996	Nursing Note	DR. ADAMSON	0647 30 Nov 1996	Tom Campbell, RN	(Created)
0521 30 Nov 1996	Annotation	Pressure Support	0525 30 Nov 1996	Shirley B Wrightmann, RN	(Created)
0448 30 Nov 1996	Nursing Note	End of shift	0501 30 Nov 1996	Michelle Hallton, RN	(Created)
0447 30 Nov 1996	Annotation	Suction	0448 30 Nov 1996	Shirley B Wrightmann, RN	(Created)
0423 30 Nov 1996	Annotation	Mode	0426 30 Nov 1996	Shirley B Wrightmann, RN	(Created)
0423 30 Nov 1996	RCP Assess/Tx Note		0455 30 Nov 1996	Shirley B Wrightmann, RN	(Edited)

New Note
Review Note
Edit Note
Scan Notes
Show 1 Day
Category List
Copy Note
Sort By
CarePlan Mode

To move the cursor between notes, use the [Up Arrow] and [Down Arrow] keys or click with the mouse.

NAVIGATION KEYS

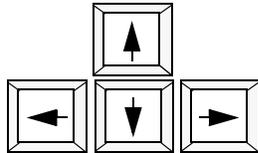
The following keys may be used for cursor movement within the Notes Application.



[Enter] Key

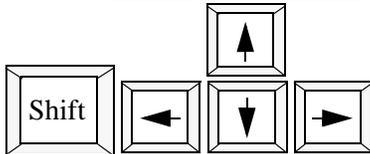
The [Enter] key will move the cursor to the next field. Additionally, the user can exit from reviewing a note and return to the Notes Menu Screen by pressing the [Enter] key. That is, if reviewing a note (via the “Review Note,” “Scan Note” or Care Plan’s “Show Status” soft keys), the [Enter] key will now hide the note and display the Notes Menu Screen. The user can then select another note for review.

Also, if the user presses the [Enter] key when in the Edit Topic window, the highlighted topic will be selected and inserted into the topic selector field. If the [Enter] key is pressed again, the topic will updated the note’s topic.



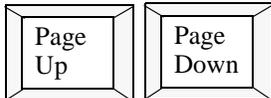
Directional Arrow Keys

The Arrow keys move the cursor to select the choice or within a prompt when in edit mode.



[Shift][Directional Arrow Keys]

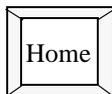
The [Shift] key with any of the directional arrow keys move the cursor to the next closest field.



[Page Up] and [Page Down] Keys

The [Page Up] and [Page Down] keys scroll the note.

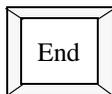
Also, the [Page Up] key will move the cursor to the **beginning** of the field and the [Page Down] key will move the cursor to the **end** of the field when editing a field via the “Edit Field” soft key.



[Home] Key

The [Home] key moves the cursor to the **first prompt** in a note. If the [Home] key is selected again, the cursor will move to the top of the note.

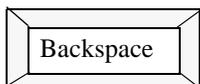
Also, the [Home] key will move the cursor to the **beginning** of the field when editing a field via the “Edit Field” soft key.



[End] Key

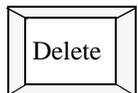
The [End] key moves the cursor to the **last prompt** in a note. If the [End] key is selected again, the cursor will move to the end of the note.

Also, the [End] key will move the cursor to the **end** of the field when editing a field via the “Edit Field” soft key.



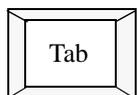
[Backspace] Key

The [Backspace] key moves the cursor backwards one space at a time as it deletes a single character within the field.



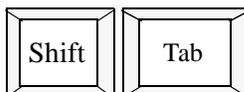
[Delete] Key

The [Delete] key will only remove the single character to the right of the cursor.



[Tab] key

The [Tab] key moves the cursor to the next Tab-configured section.



[Shift][Tab] key

The [Shift][Tab] key moves the cursor to the previous Tab-configured section.

NOTES APPLICATION AN 'EDIT MODE' EXAMPLE

In the edit mode, the Arrow keys move the cursor within the field.

Martin, Sarah 560 Phy: Dr. Brookstone (Env ICU) 12:08 Jul 18, 97

Notes Menu Screen

Care Plan (Active) Topic Cardiac Output Anxiety Gas Exchange Hyper/Hypoglycemia Notes for Entire S... Note Time 2209 30 Nov 1996 2201 30 Nov 1996 2145 30 Nov 1996 2130 30 Nov 1996 2100 30 Nov 1996 2010 30 Nov 1996 1620 30 Nov 1996 1150 30 Nov 1996 1142 30 Nov 1996 1142 30 Nov 1996 1142 30 Nov 1996 0850 30 Nov 1996 0759 30 Nov 1996 0700 30 Nov 1996 0613 30 Nov 1996 0600 30 Nov 1996 0530 30 Nov 1996 0521 30 Nov 1996 0448 30 Nov 1996 0447 30 Nov 1996 0423 30 Nov 1996 0423 30 Nov 1996 0330 30 Nov 1996 0323 30 Nov 1996 0300 30 Nov 1996 0200 30 Nov 1996 2345 29 Nov 1996 2341 29 Nov 1996 2341 29 Nov 1996 2230 29 Nov 1996 2138 29 Nov 1996 2138 29 Nov 1996 2015 29 Nov 1996 1915 29 Nov 1996 1833 29 Nov 1996 1745 29 Nov 1996 1730 29 Nov 1996 1725 29 Nov 1996 1706 29 Nov 1996 1701 29 Nov 1996 1600 29 Nov 1996 1532 29 Nov 1996	<table border="1" style="width: 100%;"> <tr> <td style="width: 20%;">Note Time: 1730 29 Nov 1996</td> <td style="width: 20%;">Type: Assessment</td> <td style="width: 20%;">Topic: N/A</td> <td style="width: 40%;">Mode: [Entry]</td> </tr> <tr> <td colspan="4"> <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pacer Settings: All Extremities Warm and Dry Yes All Peripheral Pulses Strong and Equal RADIALS 2+, PEDALS 1+ <input type="checkbox"/> LUE <input type="checkbox"/> LLE <input type="checkbox"/> RUE <input type="checkbox"/> RLE Edema Mild JVD: Unable To Assess Mediastinal Chest Tube <input type="text"/> </td> </tr> <tr> <td colspan="4" style="text-align: center;">GI/GU</td> </tr> <tr> <td colspan="4"> Abdomen SOFT AND NONTENDER, NOT ABLE TO AUSCULTATE BOWEL SOUNDS DUE TO LVAD NOISE <input checked="" type="checkbox"/> Tubes #1 Nasogastric Location Nasal LEFT Draining To Low Intermittent Suction Draining Small Amount Brown Irrigation Saline Tube Feeding Type <input type="text"/> </td> </tr> <tr> <td colspan="4"> <input type="checkbox"/> Stoma GU Foley Draining to Gravity Date/Time Foley Inserted 10/5 </td> </tr> <tr> <td colspan="4" style="text-align: center;">DIALYSIS</td> </tr> <tr> <td colspan="4"> Dialysis Type <input type="checkbox"/> CAUH <input type="checkbox"/> CUUH <input type="checkbox"/> Prefilter Replacement Fluid <input type="checkbox"/> </td> </tr> </table>	Note Time: 1730 29 Nov 1996	Type: Assessment	Topic: N/A	Mode: [Entry]	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Pacer Settings: All Extremities Warm and Dry Yes All Peripheral Pulses Strong and Equal RADIALS 2+, PEDALS 1+ <input type="checkbox"/> LUE <input type="checkbox"/> LLE <input type="checkbox"/> RUE <input type="checkbox"/> RLE Edema Mild JVD: Unable To Assess Mediastinal Chest Tube <input type="text"/>				GI/GU				Abdomen SOFT AND NONTENDER, NOT ABLE TO AUSCULTATE BOWEL SOUNDS DUE TO LVAD NOISE <input checked="" type="checkbox"/> Tubes #1 Nasogastric Location Nasal LEFT Draining To Low Intermittent Suction Draining Small Amount Brown Irrigation Saline Tube Feeding Type <input type="text"/>				<input type="checkbox"/> Stoma GU Foley Draining to Gravity Date/Time Foley Inserted 10/5				DIALYSIS				Dialysis Type <input type="checkbox"/> CAUH <input type="checkbox"/> CUUH <input type="checkbox"/> Prefilter Replacement Fluid <input type="checkbox"/>			
Note Time: 1730 29 Nov 1996	Type: Assessment	Topic: N/A	Mode: [Entry]																										
<input type="checkbox"/> Pacemaker <input type="checkbox"/> Pacer Settings: All Extremities Warm and Dry Yes All Peripheral Pulses Strong and Equal RADIALS 2+, PEDALS 1+ <input type="checkbox"/> LUE <input type="checkbox"/> LLE <input type="checkbox"/> RUE <input type="checkbox"/> RLE Edema Mild JVD: Unable To Assess Mediastinal Chest Tube <input type="text"/>																													
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Abdomen SOFT AND NONTENDER, NOT ABLE TO AUSCULTATE BOWEL SOUNDS DUE TO LVAD NOISE <input checked="" type="checkbox"/> Tubes #1 Nasogastric Location Nasal LEFT Draining To Low Intermittent Suction Draining Small Amount Brown Irrigation Saline Tube Feeding Type <input type="text"/>																													
<input type="checkbox"/> Stoma GU Foley Draining to Gravity Date/Time Foley Inserted 10/5																													
DIALYSIS																													
Dialysis Type <input type="checkbox"/> CAUH <input type="checkbox"/> CUUH <input type="checkbox"/> Prefilter Replacement Fluid <input type="checkbox"/>																													

Soft Keys on the Notes Menu Screen

The following soft keys are singular function keys on the Notes Menu screen.



The soft keys will appear gray on the screen if the function is not appropriate.

**Show
All**

“Show All” Soft Key <F5>

To display on the Notes Menu Screen the patient’s notes for the entire stay, press the “Show All” soft key <F5>. To display only one day of the patient’s note (the default is typically the current day), press the “Show 1 Day” soft key <F5>.

**Previous
Day**

**Next
Day**

“Previous Day” Soft Key <F6> and “Next Day” Soft Key <F7>

To display on the Notes Menu Screen only the patient’s notes from the previous day, press the “Previous Day” soft key <F6>. To display on the Notes Menu Screen the patient’s notes from the next day, press the “Next Day” soft key <F6>.

Soft Keys when a Note is Accessed

The following soft keys are singular function keys within a note.

**Edit
Field**

“Edit Field” Soft Key <F3>

To change the cursor into the edit mode within a field, press the “Edit Field” <F3> soft key. This allows the cursor to be moved via the Arrow keys for editing as needed.

**Exit
Edit**

“Exit Edit” Soft Key <F3>

To cancel the cursor in the edit mode, press the “Exit Edit” <F3> soft key.

**Hide
Choices**

“Hide Choices” Soft Key <F4>

To temporarily remove a choice list from the screen and access the free text mode, press the “Hide Choices” soft key <F4> or the “Edit Field” soft key <F3>. To display the choice list once it has been hidden, press the “Show Choices” soft key <F4>.

**More
Fields**

“More Fields” Soft Key <F5>

Fields within the Notes Application that display the soft key “More Fields” (<F5>) indicate duplicate fields may be added. When selected, the “More Fields” soft key will add another field type identical to the one currently being used such as another text field for the entry of another medication. Once the duplicate fields are added, they cannot be removed.

**Toggle
Mode**

“Toggle Mode” Soft Key <F9>

The cursor mode can be switched between ‘Review’ or ‘Entry’ (i.e., allowing edits) with the “Toggle Mode” soft key <F9>. The ‘Entry’ mode allows the user to enter data with the above entry options. The ‘Review’ mode suspends the cursor from entering data. The screen can be reviewed in the ‘Review’ mode with the [Up Arrow] and [Down Arrow] keys or the [Page Up] and [Page Down].

**Erase
Data**

“Erase Data” Soft Key <F6>

To clear a field of data, press the “Erase Data” soft key <F6>.

**Current
Time**

“Current Time” Soft Key <F10>

To input the current time and date in a field, press the “Current Time” soft key <F10>.



The field must be configured to use the Current Time function.

NOTES APPLICATION A SCROLLING CHOICE LIST EXAMPLE

Scroll within the note window with the [Page Up] and [Page Down] keys or click on the scroll bar and drag with the mouse.

The screenshot shows a medical notes application window for patient Anna Kemper. The window title bar includes the patient name, note time (1608 26 Sep 1996), type (History and Physical), topic (N/A), mode (Entry), and date (2 Sep 26, 96). The main form contains fields for Patient Name, Age, Sex (Male/Female), Patient MRN, Historian, and Chief Complaint. A scrolling choice list is open over the Chief Complaint field, listing 18 options: 1 Heart Disease, 2 Murmur, 3 AS, 4 AR, 5 MS, 6 MR, 7 MUP, 8 PS, 9 PR, 10 TS, 11 TR, 12 CHF, 13 Cardiomegaly, 14 Hypertension, 15 A. fib., 16 Syncope, 17 Thoracic Aortic Aneurysm, and 18 High Cholesterol. Below the choice list are sections for Childhood Diseases, Past Medical Problems (checked), and various organ system categories: General, Cardiovascular Disease, Lung Diseases, Gastrointestinal, Hepatic, Renal GU Disease, Musculo-Skeletal and Rheumatologic Disease, and Malignancy (Solid tumors). A toolbar at the bottom contains buttons for Note Menu, Edit Field, Hide Choices, More Fields, Describe Item, Store, Toggle Mode, Erase Data, Edit Topic, and Print.

Scroll between choices with the [Up Arrow] and [Down Arrow] keys or type in free text to search for a match in the choices.

DATA ENTRY

Data can be entered into a note by choosing from the choice list or entering free text:

- **Selecting an item from a choice list; or**
- Type in the corresponding choice list number and press the [Enter] key.



The keypad is recommended when entering choice list items for improved entry speed.

OR

- Type in the first few characters of the choice list item and the system will display possible matches.
- OR*
- Highlight the desired choice with the [Up Arrow] and [Down Arrow] keys or by clicking with the mouse.

OR

- Link choice list items with free text (e.g, item 2+3+free text)
 - After entering the choice list items' numbers, press the "Edit Field" soft key <F3>and start typing.
 - [Delete] key deletes only the character to the right of the cursor.
 - [Backspace] key moves backwards one space at a time as it deletes a single character within the field.



The '+' key on the keypad can be used to append choices if the prompt is configured for more than one choice.

- **Typing in the note data in free text; or**

When entering notes, the CIS operates similar to most word processing applications. For instance, the CIS provides the following word processing characteristics.

 - Words are automatically wrapped to the next line of text.
 - Configured fields are expandable to allow for additional data as needed.
 - Edits are performed in an edit mode. Refer to the Keys Section for the "Edit Field" soft key description.
- **When in a 'Check Box' field, press the [Insert] key to enter an "X" in the box or click on the field with the mouse and move the cursor to the next field; or**
 - To place an "X" in a check box without moving the cursor to the next field, press the [Space Bar] key.
 - To remove the "X" in the checkbox and subsequent fields, press the [Space Bar].
- **Cutting the data from one field and pasting it into another field.**
- The data in a field can be copied and pasted with the mouse into a new field within the same note.
 - Highlight the text to be copied with the left mouse button by clicking and dragging and then release the mouse button.
 - Move to the new field where the data will be pasted.
 - Click in the new field with the left mouse button to place the cursor.
 - Paste the copied text into the new field by clicking once on the middle mouse button.

NOTES APPLICATION A NEW NOTE EXAMPLE

Kemper, Anna
Note Time: 1508 20 Dec 1996 Type: Discharge Planning Note Topic: N/A Mode: [Entry] Dec 20, 96

PRE-ADMIT DISCHARGE PLANNING NOTE

CURRENT FUNCTIONAL ASSESSMENT

Mobility:

Activities Of Daily Living:

Physical Limitations:

Nutritional Status:

Elimination Problems:

Sleeping Patterns:

DISCHARGE CONSIDERATIONS

Occupation/Last Job:

Living Situation:

Living Arrangements:

What Do You Expect During This Hospitalization:

Do You Have Any Additional Concerns/Stressors:

Is There Any Other Information The Nurse Should Know In Order To Better Plan Your Care:

Plan After Discharge:

Discharge Needs Identified On Initial Assessment:

Anticipate Equipment Needed:

Referrals/Consults Made To:

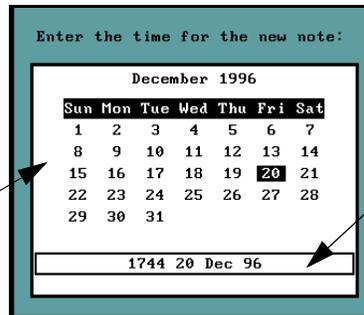
Name of Local Contact/NOK:

1		
2	None Stated	<input type="text" value=""/>
3	Constipation	<input type="text" value=""/>
4	Diarrhea	<input type="text" value=""/>
5	Frequent Urination	<input type="text" value=""/>
6	Unable to Empty Bladder Completely	<input type="text" value=""/>
7	Related to Medical Diagnosis	<input type="text" value=""/>

Note Menu		Edit Field	Hide Choices	More Fields	Erase Data	Describe Item	Store	Toggle Mode	Current Time	Edit Topic	Print
-----------	--	------------	--------------	-------------	------------	---------------	-------	-------------	--------------	------------	-------

CALENDAR

A graphic calendar will display for the selection of the time and date of the note. The [Tab] key allows for the toggling between the calendar and the clock. The selected mode will be highlighted with a box.



The time can be typed in manually or the [Left Arrow] and [Right Arrow] keys adjust the time in minutes. The [Up Arrow] and [Down Arrow] key adjust the hour.

While in the calendar, the [Page Up] and [Page Down] keys will move to previous/next month. The Arrows keys will navigate between the different days of the month. The time range can be configured to restrain the user from selecting outside of the range of time. (If the user selects the time outside the range, an audible beep will sound.) The lower and upper time range can be determined by the user by pressing the [Home] and [End] keys.

3.5.1.2

Creating a New Note



To create a note, perform the following steps.

1. Select the Notes Menu Screen.
2. Press the “New Note” soft key <F1>.
 - The Note Types window will appear listing all available notes for charting in the environment.
3. Select the desired note type from the listing.
 - The title of a new note can be searched via a free text search string field.
4. Press the [Enter] key.
 - The Enter Time prompt will appear if configured for that note type.
5. Select the desired date and time, if applicable.
 - The selected note will appear.
6. Enter in the desired information into the note.
 - Refer to the previous Data Entry Section.
7. When finished with creating the note, press the “Store” soft key <F8>.
8. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

3.5.1.3 Scanning a Patient's Notes



New Note	Review Note	Edit Note	Scan Notes	Show All	Prev Day	Next Day	Specify Day	Category List	Copy Note	Sort By	CarePlan Mode
----------	-------------	-----------	------------	----------	----------	----------	-------------	---------------	-----------	---------	---------------

All patient notes are available to review for the entire length of their stay. Upon selecting the Notes Application, only the current day's notes will be displayed on the Notes Menu Screen. To scan a patient's notes, perform the following steps.

1. Select the Notes Menu Screen.
2. Highlight the desired note type.
3. Press the "Scan Note" soft key <F4>.
 - When "Scan Note" is selected, the note will appear on the screen in 'REVIEW' Mode.
 - To scan the next note, press the "Next Note" soft key <F3>.
 - To scan the previous note, press the "Previous Note" soft key <F2>.
4. Press the "Note Menu" soft key <F1> to return to the Notes Menu Screen.

3.5.1.4 Reviewing a Note



New Note	Review Note	Edit Note	Scan Notes	Show All	Prev Day	Next Day	Specify Day	Category List	Copy Note	Sort By	CarePlan Mode
----------	-------------	-----------	------------	----------	----------	----------	-------------	---------------	-----------	---------	---------------

To review a patient's note, perform the following steps.

1. Select the Notes Menu Screen.
2. Highlight the desired note type.
3. Press the [Enter] key to review one note.
OR
4. Press the "Review Note" soft key <F2>.
 - When "Review Note" is selected, the note will appear on the screen in 'REVIEW' Mode.
 - To scroll through the note, press the [Up Arrow] and [Down Arrow] or [Page Up] and [Page Down] keys.
 - To return to the Notes Menu Screen, press the "Note Menu" soft key <F1>.
 - To print a note that has been configured to print, press the "Print" soft key <F12>.
5. Press the "Note Menu" soft key <F1> to return to the Notes Menu Screen.

NOTES APPLICATION

THE "SORT BY" WINDOW

Kemper, Anna Marie MICU-1
Phy: Dr. Brookstone (Env ICU)
15:28 Dec 20, 96

Notes Menu Screen

Care Plan (Active Problems):

Topic	Assigned (Days Ago)	Last Update (Days Ago)

Notes for Entire Stay:

Note Time	Type	Topic	Stored At	Last Stored By
N/A	Triage Admission	Test topics	1433 19 Dec 1996	Debbie Werner
N/A	MBHW Triage Admission		1204 15 Jan 1996	Frank Burnham, RN
N/A	Discharge		1620 15 Jan 1996	John E. Dunn, RN
N/A	Peds Discharge Instructions		1440 19 Dec 1996	Debbie Werner
N/A	SMH Delivery Summary		1035 19 Dec 1996	FLAGG, ken
N/A	Admit		1557 26 Sep 1996	KAREN FRIEDRICHS
N/A	Provider Application		1344 11 Oct 1996	JEFFREY WANG
N/A	Triage Admission		1508 26 Aug 1996	DEMO USER
N/A	Case Report		1206 11 Nov 1996	JEFFREY WANG
N/A	Discharge		1813 3 Jul 1996	CliniComp, Intl. Staff
N/A	sample of copy	1036 21 Aug 1996	DEMO USER	
N/A	sample of copy	1734 9 Sep 1996	DEMO USER	
N/A	Provider Application	1243 16 Oct 1996	JEFFREY WANG	
1516 20 Dec 1996	Arthroscopic Intra-Up Doc	1517 20 Dec 1996	KAREN FRIEDRICHS	
1508 20 Dec 1996	Discharge Planning Note	1515 20 Dec 1996	KAREN FRIEDRICHS	
1654 19 Dec 1996	Clinical Note	1654 19 Dec 1996	Debbie Werner	
1622 19 Dec 1996	Clinical Note	1623 19 Dec 1996	JEFFREY WANG	
1446 19 Dec 1996	Clinical Note	1448 19 Dec 1996	Debbie Werner	
1434 19 Dec 1996	Judi's Test Note	1435 19 Dec 1996	Debbie Werner	
1117 18 Dec 1996	Judi's Test Note	1119 18 Dec 1996	Debbie Werner	
1115 18 Dec 1996	Judi's Test Note	1116 18 Dec 1996	Debbie Werner	
1603 1 Nov 1996	Nursing Note	1604 1 Nov 1996	JEFFREY WANG	
1155 14 Oct 1996	CarePlan Note	1155 14 Oct 1996	Dan J. Renaghan	
1153 14 Oct 1996	CarePlan Note	1154 14 Oct 1996	Dan J. Renaghan	
1143 14 Oct 1996	CarePlan Note	1143 14 Oct 1996	Dan J. Renaghan	
1743 11 Oct 1996	Nursing Note	1743 11 Oct 1996	JEFFREY WANG	
1025 8 Oct 1996	Clinical Note	1026 8 Oct 1996	FLAGG, ken	
1600 26 Sep 1996	Annotation	HEPLOCK FLUSH 10U/ML 10ML MDU	1644 26 Sep 1996	KAREN FRIEDRICHS
1100 25 Sep 1996	Nan's Test Note	2104 25 Sep 1996	FLAGG, ken	
1055 25 Sep 1996	CCI TPN Worksheet	1056 25 Sep 1996	FLAGG, ken	
1040 21 Aug 1996	Patient Self Assessment	1043 21 Aug 1996	DEMO USER	
1255 9 Aug 1996	CarePlan Note	1256 9 Aug 1996	DEMO USER	
1111 9 Aug 1996	CarePlan Note	1114 9 Aug 1996	Carol U.	
1729 7 Aug 1996	CCI Engineering Change Suggestion	CCI Engineering Change Suggestion	1729 7 Aug 1996	DEMO USER
1727 7 Aug 1996	CCI Configuration Change Request	CCI Configuration Change Request	1727 7 Aug 1996	DEMO USER
1648 18 Jun 1996	CCI Communication	CCI Communication	1505 26 Aug 1996	DEMO USER
1659 20 Feb 1996	{?? Unknown ??}	Gas Exchange	1705 20 Feb 1996	Marcel Aliopare, RN
1530 20 Feb 1996	Nursing Note	REPORT	1633 20 Feb 1996	Marcel Aliopare, RN
1530 20 Feb 1996	Nursing Note		1550 20 Feb 1996	James I. Dandy, RN
1530 20 Feb 1996	Assessment		1626 20 Feb 1996	Marcel Aliopare, RN
1510 20 Feb 1996	{?? Unknown ??}		1545 20 Feb 1996	Frank Burnham, RN
1500 20 Feb 1996	{?? Unknown ??}	Family Process	1513 20 Feb 1996	James I. Dandy, RN
1500 20 Feb 1996	CarePlan Note	Cardiac Output	1512 20 Feb 1996	James I. Dandy, RN
1500 20 Feb 1996	{?? Unknown ??}	Gas Exchange	1515 20 Feb 1996	James I. Dandy, RN
1400 20 Feb 1996	Nursing Note	hello there	1025 17 May 1996	CliniComp, Intl. Staff
1400 20 Feb 1996	Nursing Note	Cardiac Output	1457 20 Feb 1996	James I. Dandy, RN

Select the column to be sorted by:

Note Time	F3-OK
Type	F12-Cancel
Topic	
Stored At	
Last Stored By	
Status	

OK
Cancel

3.5.1.5 Sorting Notes on the Notes Menu Screen



All the notes listed on the Notes Menu Screen can be sorted in ascending alpha-numeric order by Note Time, Type, Topic, Stored At, Last Stored By and Status (the columns shown on the Note Menu Screen). To sort a patient's notes, perform the following steps.

1. Select the Notes Menu Screen.
2. Press the "Sort By" soft key <F11>
 - The Sort By Column window will appear.
3. Select the column to sort the notes on the Notes Menu Screen.
4. Press the "OK" soft key <F3> or the [Enter] key.
 - The patient's notes will be sorted by the selected column on the Notes Menu Screen.

3.5.1.6 Selecting a Note Category



The Notes Menu Screen can be configured to only display user-defined default categories. To filter notes within one or more categories, perform the following steps.

1. Select the Notes Menu Screen.
2. Press the "Category List" soft key <F9>.
 - Category List window will appear.
3. Highlight the desired one or more categories.
 - To select all categories listed, press the "Select All" soft function key <F1>.
 - To clear all selected categories, press the "Clear All" soft function key <F2>.
 - To select or clear individual categories, press the [Enter] key.
4. When completed with selecting the desired categories, press the "OK" soft key <F3>.
 - Only the notes from the selected categories will be listed on the screen.



The notes in the selected categories will appear in reverse video on the New Note Directory window.

NOTES APPLICATION EDITING A NOTE



When field capacity is reached, an audible beep will sound. However, some fields are configured as 'expandable' without a character limit.

Title Bar Entry Mode

Martin, Sarah 560 Phy: Dr. Brookstone (Env ICU) 12:36 Jul 18, 97

Notes Menu Screen

<p>Care Plan (Active)</p> <p>Topic</p> <p>Cardiac Output</p> <p>Anxiety</p> <p>Gas Exchange</p> <p>Hyper/Hypoglycemia</p> <p>Notes for 18 Jul 19</p> <p>Note Time</p> <p>N/A Adult</p>	<p>Note Time: N/A Type: Admission Assessment Note Topic: N/A Mode: Entry</p> <p>CARDIAC #1 <input type="text"/></p> <p>CIRCULATORY #1 <input type="text"/></p> <p>RESPIRATORY #1 <input type="text"/></p> <p>ENDOCRINE #1 <input type="text"/></p> <p>GASTROINTESTINAL #1 <input type="text"/></p> <p style="margin-left: 20px;">Laxative Use <input type="checkbox"/></p> <p>GENITOURINARY #1 <input type="text"/></p> <p>REPRODUCTIVE/GENITAL #1 <input type="text"/></p> <p style="margin-left: 20px;">Monthly Breast/Testicular <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p style="margin-left: 20px;">Last PAP Smear/Prostate Exam: <input type="text"/> LMP: <input type="text"/></p> <p>NEURO/SENSORY #1 <input type="text"/></p> <p style="margin-left: 20px;">Pain <input type="text"/></p> <p style="margin-left: 20px;">Hearing <input type="text"/></p> <p style="margin-left: 20px;">Eyes <input type="text"/></p> <p>INTEGUMENTARY #1 <input type="text"/></p> <p style="margin-left: 20px;">Skin Color <input type="text"/></p> <p>MUSCULAR/SKELETAL</p> <p style="margin-left: 20px;">General <input type="text"/></p> <p style="margin-left: 20px;">Balance & Gait <input type="text"/></p> <p style="margin-left: 20px;">Needs Assistance with <input type="text"/></p> <p style="margin-left: 20px;">Mobility <input type="text"/></p>
---	---

Note Menu Another Note Edit Field Hide Choices More Fields Erase Data Describe Item Store Toggle Mode Date/Time Edit Topic Print

Additional fields may be added when the "More Fields" soft key <F5> is displayed.

3.5.1.7 Editing a Note



Patient notes can be modified as needed. To modify a patient's note, perform the following steps.



More than one user can access the same note and both users' changes will be stored.

1. Select the Notes Menu Screen.
2. Highlight the desired note.
3. Press the "Edit Note" soft key <F3>.



The Edit prompt will appear once and at the time the user is accessing the note to be edited.

4. Enter your ID code and press the [Enter] key.
 - The selected note will appear on the screen in 'ENTRY' Mode in the Note Title Bar.
5. Edit or add data.



A note being edited can also be printed; however, unstored changes will not appear when printed.

6. When finished with editing the note, press the "Store" soft key <F8>.
7. Press the "Note Menu" soft key <F1> to return to the Notes Menu Screen.

3.5.1.8 Copying a Note



Previous notes can be copied to the current time and edited to reflect patient status. To copy an existing note, perform the following steps.

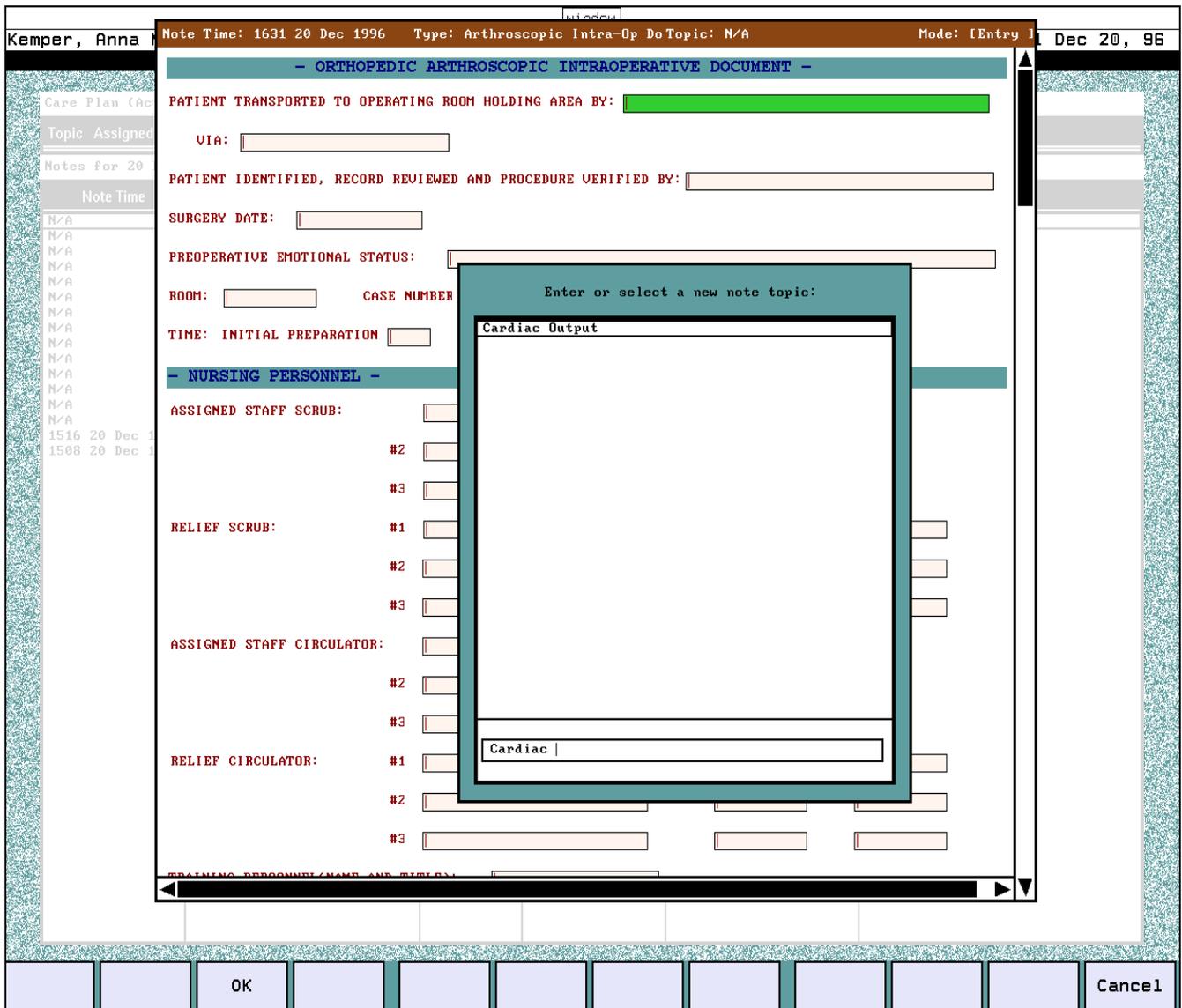
1. Select the Notes Menu Screen.



An admit note cannot be copied.

2. Highlight the desired note.
3. Press the "Copy Note" soft key <F10>.
4. Enter in the desired date and time.
5. Press the [Enter] key.
 - A copy of the selected note will appear for editing.
6. Edit or add data as necessary.
7. When finished with editing the note, press the "Store" soft key <F8>.
8. Press the "Note Menu" soft key <F1> to return to the Notes Menu Screen.
 - A new note has now been created.

NOTES APPLICATION WITH THE "EDIT TOPIC" WINDOW



3.5.1.9 Editing a Note Topic



Notes can be assigned a topic. Topics may be used as keywords for an assessment note, the subject for a progress note, the reference to a care plan problem, etc. To modify a notes topic, perform the following steps.

1. Select the Notes Menu Screen.
2. Highlight the desired note.
3. Press the “Edit Note” soft key <F3>.
4. Enter your ID code and press the [Enter] key.
5. Press the “Edit Topic” soft key <F11>.
 - The Edit Topic Entry window will appear on the screen.
 - Highlight the desired note topic and press the [Enter] key
 - The highlighted topic will be selected and inserted into the topic selector field. If the [Enter] key is pressed again, the topic will updated the note’s topic.

OR

 - Type in free text a note topic.
6. Press the “OK” soft key <F3> or press the [Enter] key.
7. Press the “Store” soft key <F8>.
8. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

3.5.1.10 Printing a Note



The information on a note that can be printed as configured by the hospital and can include the complete note or portions of a note. To print a note, perform the following steps.

1. Select the Notes Menu Screen.
2. Select the desired note.
3. To access the note, press either the “Review Note” soft key <F2> or “Edit Note” soft key <F3>.
4. Press the “Print” soft key <F12>.
 - The selected note will print to the printer configured for that display station.
5. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

NOTES APPLICATION WITH THE "ASSIGN PROBLEM" WINDOW

Martin, Sarah 560 Phy: Dr. Brookstone (Env ICU) 12:46 Jul 18, 97

Notes Menu Screen

Care Plan (Active Problems):

Topic	Assigned (Days Ago)	Last Update (Days Ago)
Cardiac Output	2347 28 Nov 1996 (231)	0027 1 Dec 1996 (229)
Anxiety	2352 28 Nov 1996 (231)	0026 1 Dec 1996 (229)
Gas Exchange	0200 29 Nov 1996 (231)	0023 1 Dec 1996 (229)
Hyper/Hypoglycemia	0000 1 Dec 1996 (229)	0000 1 Dec 1996 (229)

Notes For 18 Jul 1997:

Note Time	Type	Topic	Stored At	Last Stored By	Status
N/A	Admission Assessment Note		1658 9 Jul 1997	Demo User	(Created)

Select the problem that you wish to assign:

- Activity/Exercise
- Anxiety
- Cardiac Output
- Cerebral Perfusion
- Coagulation
- Constipation/Ileus
- Coping
- Denervated Heart
- Diarrhea-CP
- Electrolytes
- Family Process
- Gas Exchange

F3-OK
F12-Cancel

OK Cancel

3.5.2 CARE PLAN FUNCTIONS

3.5.2.1 Assigning a Problem



Pre-configured nursing guidelines for a specific patient problem can be selected and tailored per patient. To select and assign a problem, perform the following steps.

1. Select the Notes Menu Screen.
2. Move the cursor to the Care Plans Section by pressing the “CarePlan Mode” soft key <F12>.
3. Press the “Assign Problem” soft key <F1>.
 - The New Problem Types window will appear listing all available problems or care plans for that environment.
4. Highlight the desired problem with the [Up Arrow] and [Down Arrow] keys.
5. Press the [Enter] key or the “OK” soft key <F3>.
 - The Time window will appear.
6. Enter in the desired date and time.
7. Press the [Enter] key or the “OK” soft key <F3>.
 - A hospital configured care plan will appear for editing.
8. Edit the default care plan associated with the chosen problem.
9. When finished with editing the care plan, press the “Store” soft key <F8>.
 - Once a care plan is stored, it cannot be modified; however, updates to the care plan may be created via the “Update Problem” soft key <F2>.
10. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

NOTES APPLICATION CARE PLAN EXAMPLE

Kemper, Anna Note Time: 1739 26 Sep 1996 Type: CarePlan Note Topic: Anxiety Mode: [Entry] 3 Sep 26, 96

Anxiety

Nursing Diagnosis: Anxiety R/T depersonalization, dependent state, isolation, new heart, body image changes, fear of , insufficient preparation for .

Expected Outcomes: Patient will demonstrate reduced anxiety manifested by:
1. Expression of concerns and fears.
2. Ability to rest at intervals.
3. Absence of physical signs and symptoms of anxiety. |

Multidisciplinary Plan of Care: |

Care Plan (Ad
Topic
Activity/Exer
Antepartum
Notes for 26
Note Time
N/A Adm
N/A Tri
N/A SMH
N/A Tri
N/A sam
N/A sam

Note Menu Edit Field Hide Choices More Fields Describe Item Store Toggle Mode Erase Data Edit Topic Print

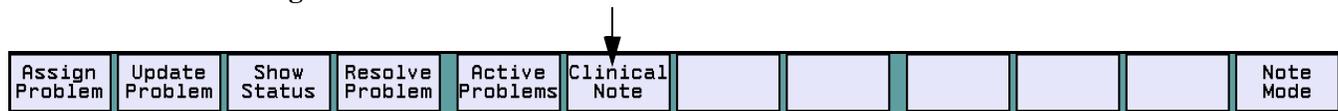
3.5.2.2 Updating a Problem



Existing problems can be copied to the current time and edited to reflect patient status. To update an existing problem, perform the following steps.

1. Select the Notes Menu Screen.
2. Move the cursor to the Care Plan Section by pressing the “CarePlan Mode” soft function key <F12>.
3. Highlight the desired problem.
4. Press the “Update Problem” soft key <F2>.
5. Enter your ID Code and press the [Enter] key.
6. Enter in the desired date and time.
7. Press the “OK” soft key <F3> or press the [Enter] key.
 - A copy of the selected problem will appear for editing.
8. Edit or add data as necessary.
9. When finished with editing the problem, press the “Store” soft key <F8>.
10. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

3.5.2.3 Creating a Clinical Note



Progress notes may be created to update the status of a specific care plan. The assigned problem will automatically become the topic of the progress note. To create a note, perform the following steps.

1. Select the Notes Menu Screen.
2. Move the cursor to the Care Plan Section by pressing the “CarePlan Mode” soft key <F12>.
3. Highlight the desired problem for the topic of the note.
4. Press the “Clinical Note” soft key <F6>.
 - The Time window will appear if configured for that note type.
5. Enter in the desired date and time.
6. Press the “OK” soft key <F3> or press the [Enter] key.
 - A clinical note type will appear with the assigned problem as the topic.
7. Enter in the desired information.
 - To create multiple notes at the same time related to different, separate problems, press the “Another Note” soft key <F2> and follow Steps 3 to 7.
 - The Note Topic Entry window will appear.
 - Highlight the desired note type with the [Up Arrow] and [Down Arrow] keys.
 - Press the “OK” soft key <F3> or press the [Enter] key.
8. When finished with entering the note, press the “Store” soft key <F8>.
9. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

NOTES APPLICATION STATUS OF A CARE PLAN

The screenshot displays a software window titled 'Kemper, Anna' with a status bar showing 'Note Time: 1500 20 Feb 1996', 'Type: CarePlan Note', 'Topic: Cardiac Output', 'Mode: [Review]', and '5 Dec 20, 96'. The main content area is titled 'Cardiac Output' and contains the following text:

Nursing Diagnosis: Alteration in cardiac output R/T: Sepsis, ARDS ,MULTIPLE PNEUMOTHORAX

Expected Outcomes: Patient will demonstrate adequate cardiac output as evidenced by:

1. Maintenance of cardiovascular parameters sufficient to sustain:
 - a. Heart rate 80-120
 - b. B.P. MAP 70-100
 - c. CO >4.0
 - d. CI >2.2
 - e. Urine output > 30 cc/hr
 - f. Pulses: Pedal strong
Radial strong
 - g. Warm and perfused skin
2. Controlled cardiac rhythm

Multidisciplinary Plan of Care:

1. DOPAMINE may be restarted to keep bp>85
2. CHECK CO QS AND PRN
3. SERIAL K LEVEL WITH ALLOQUOTS TO MAINTAIN K>4.0.
4. HYPERTENSION AND TACHYCARDIA USUALLY INDICATE TOO LITTLE SEDATION IF ACCOMPANIED BY DESATURATION, SUSPECT EQUIPMENT PROBLEM (LIKE SUCTION INEFFECTIVE ON CHEST TUBES, or new pneumothorax)

The interface includes a left sidebar with a 'Notes for 20' section and a bottom toolbar with buttons for 'Notes Menu', 'Prev Update', 'Next Update', and 'Print'.

3.5.2.4 Showing the Status of a Problem



To view the status of a problem, perform the following steps.

1. Select the Notes Menu Screen.
2. Move the cursor to the Care Plan Section or press the “CarePlan Mode” soft key <F12>.
3. Highlight the desired problem.
4. Press the “Show Status” soft key <F3>.
 - The selected problem will appear for review.
 - To review the previous update to the care plan, press the “Prev Update” soft key <F2>.
 - To review the next update, press the “Next Update” soft key <F3>.
 - To print the care plan to the designated printer, press the “Print” soft key <F12>.
5. Press the “Note Menu” soft key <F1> to return to the Notes Menu Screen.

3.5.2.5 Resolving a Problem



When the expected outcome for a patient’s problem has been met, the assigned problem is recorded as resolved. Resolved care plans will not appear as active in the Care Plan Section. To resolve a problem, perform the following steps.

1. Select the Notes Menu Screen.
2. Move the cursor to the Care Plan Section or press the “CarePlan Mode” soft key <F12>.
3. Highlight the desired ‘unresolved’ problem.
4. Press the “Resolve Problem” soft key <F4>.
5. Enter in the desired date and time.
6. Press the “OK” soft key <F3> or press the [Enter] key.
 - *Once a care plan is resolved, it cannot be updated.*
7. Enter in your ID code and press the [Enter] key.
 - The resolved problems can now only be seen by pressing the “All Problem” soft key <F5> from the Note Menu Screen.
 - The resolution date and time of the selected problem will appear next to the problem.



A new care plan can be created with the same problem, but with the start time later than the previous problem.

4.0 CIS REVIEW FUNCTIONS

CHAPTER OBJECTIVE:

Upon completion of this chapter, the user will be competent with performing the following review functions.

- Review current and previous patient summary data
- Review of patient cardiac output values
- Plot data items over time or on an XY axis
- Review reference information



All screen configurations are determined by the hospital and may vary from this manual's screen graphics.



*Charting can be done from any terminal, but verify the correct patient is selected **BEFORE** charting.*

4.1 DATA PRESENTATION FUNCTIONS

SAMPLE CLINICAL SUMMARY SCREEN

Time Bar moves by using the Arrow Keys.

Tom Axlerod I-1 Phy: Dr. Brookstone (Env DOD-ICU) 14:33 Apr 19, 96

CLINICAL SUMMARY

Electrolytes	1242 23 Aug	1243 23 Aug	1316 23 Aug	1543 23 Aug	2239 23 Aug
Na			151	143	
K	5.8	5.8	3.4	4.1	3.7
Cl			124	116	
Bun			16	21	
Creat			1.6	2.2	
Gluc			263	204	233

Misc. Labs	1053 23 Aug	1149 23 Aug	1423 23 Aug	1543 23 Aug	2243 23 Aug
PT	31.0	27.0	19.5		14.0
PTT			85		34
CPK					
LDH			1066		

Blood Gases	0 23 Aug	1453 23 Aug	1835 23 Aug	1848 23 Aug	2315 23 Aug
pHa	7	7.23	7.29	7.27	7.40
PaO2		51	434	486	153
PaCO2		27	24	26	21
HCO3		11.9	11.7	12.2	13.0
SaO2		93.7	99.9	99.1	99.6
BE		-14.3	-12.8	-12.5	-9.5

CBC	1118 23 Aug	1256 23 Aug	1409 23 Aug	1740 23 Aug	2225 23 Aug
Hgb	15.0	8.6	12.7	13.7	10.0
Hct	44.3	25.4	38.6	40.4	29.7
WBC	8.5	5.0	7.0	8.1	7.7
PLTS	108	113	87	121	133

Nutrition	00-24 23 Aug	00-24 24 Aug
N (g)	0	0
Carb (g)	44.8	86.3
Prot (g)	0	0
Fat (g)	0	0
Calories	152	293

Intakes	00-24 23 Aug	00-24 24 Aug
Oral		0
NG		
Crystalloid	4213	5283
Colloid		700
Blood	2325	1400
Irrigation		
TOTAL INTAKE	6538	7383

Outputs	0-24 23 Aug	00-24 24 Aug
Urine	83	1225
NG out	0	1020
Chest	40	450
Blood		
Outputs, Other	345	620
TOTAL OUTPUT	648	3315

Totals	00-24 23 Aug	00-24 24 Aug
TOTAL INTAKE	6538	7383
TOTAL OUTPUT	2648	3315
NET	3890	4068

2020 23 Aug 1995	
HR	120
RESP	25
TempC	37.0
ART S	67
ART D	47
PAS	24
PAD	16
LA	
PCW	
CUP	17
ICP	9
CO	2.50
CI	
LUSWI	5.4
SvO2	
avDO2	

Cardiac Index	
CI	FP (mmHg)
6	40
5	30
4	20
3	10
2	5
1	0
0	0

0000 23 Aug			2020 23 Aug
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ART D	ART S	PAD	PAS
300	300	80	80
200	200	53	53
100	100	27	27
0	0	0	0
47	67	16	24

0000 23 Aug			2020 23 Aug
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CUP	PCW	RESP	HR
30	30	30	300
20	20	10	100
10	10	0	0
0	0	25	120

0000 23 Aug			2020 23 Aug
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U.D.	U.D.	U.D.	U.D.
100	100	100	100
50	50	50	50
0	0	0	0

0000 23 Aug			2020 23 Aug
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0000 24 Aug			2020 24 Aug
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Enter	Set Time	Print	Load
End Time	Interval	Screen	Screen

CLINICAL	PULMO	RENAL	LAB
SUMMARY	NARY	FUNC	REVIEW

If the table does not contain data for the selected time, then the time column's divider will be highlighted.

The initial end time per screen configuration can be rounded up or down to the nearest hour, shift or day.

All screen configurations are determined by the hospital and may vary from this manual's screen graphics.

4 - 4 (07/15/99)

Clinical User Reference Manual

4.1.1 SUMMARY SCREEN

Charted patient data can be configured to display on a Summary Screen with interval options and configurable sections. The Summary Screen is a "Review Only" screen.



The Summary Screen can be accessed via the "Clinical Summary" combination soft key or via the soft key <F5> on the Vital Signs Flowsheet in the Plot Section.

4.1.1.1 Section Types

The Summary Screen provides three types of configurable display sections - Table, Plot and Specific-Time Sections. In addition, more support is available to distinguish and separate different fluids and medications.

4.1.1.1.1 Table Section

Data can be presented in tables with timed columns or rows. Time Row Tables may be configured to display the most recent time row and data at the top of the table, or it can also be configured to display the oldest data at the top of the table.

a.) Time Columns

Partially displayed data will appear in gray.

Electro	1000 21 Aug	1600 21 Aug	2230 21 Aug	0343 22 Aug
Na (mEq/L)	142	144	143	133
K (mEq/L)	3.10	3.10	3.30	3.30
Cl (mEq/L)	108	106	136	138
BUN (mg/dl)	91	27	22	19
Creat (mg/dl)	0.700	0.700	0.700	0.704
Gluc (mg/dl)	213	229	217	189
0600 21 Aug				

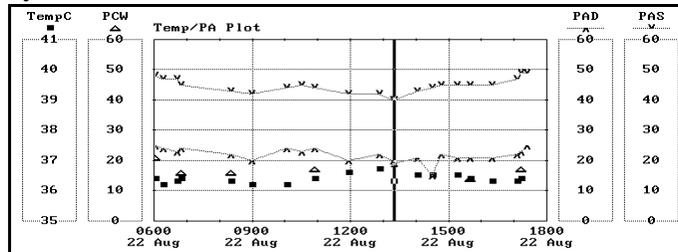
b.) Time Rows

CBC	Hgb	Hct	WBC	PLTS
2225 23 Aug	10.0	29.7	7.7	133
1740 23 Aug	13.7	40.4	8.1	121
1409 23 Aug	12.7	38.6	7.0	87
1256 23 Aug	8.6	25.4	5.0	113
1118 23 Aug	15.0	44.3	8.5	108

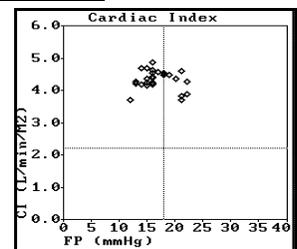
4.1.1.1.2 Plot Section

There are four plot types that can be used when configuring the Summary Screen. An example of each type is provided.

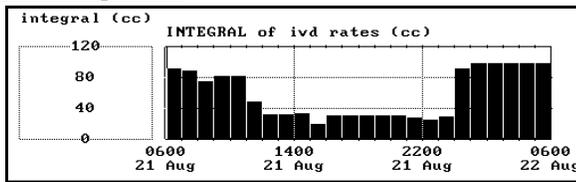
a.) Symbol Plot



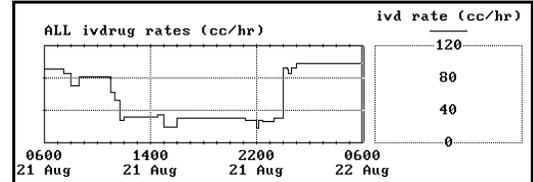
c.) XY Plot



b.) Bar Graph Plot



d.) Plateau Plot



4.1.1.1.3 Specific-Time Table Section

A Specific-Time Table section will display the configured data items for the cursor time (as displayed at the top of the box). The time will change as the cursor is moved through the summary screen.

IV Drugs 1500 17 May 1994	
hr ivdvol (cc)	
ivd rate (cc/hr)	38.00
integral (cc)	38.00

Data items are configurable

SAMPLE SUMMARY SCREEN FIVE DAY RESPIRATORY ANALYSIS SCREEN



The Summary Screen font size adjusts to the number of sections on the screen.

Kingsford, Larry 300-1 Phy: Dr. Brookstone (Env ICU) 15:38 Jun 26, 97

5 DAY RESPIRATORY ANALYSIS

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%;">Resp Acid</td> <td style="width: 50%;">Meta Alk</td> </tr> <tr> <td>Comp</td> <td>Norm</td> </tr> <tr> <td>Meta Acid</td> <td>Resp Alk</td> </tr> </table> <p style="font-size: x-small; margin-top: 5px;">7.250 7.288 7.325 7.363 7.400 7.438 7.475 7.513 7.550 pH Blood</p>	Resp Acid	Meta Alk	Comp	Norm	Meta Acid	Resp Alk	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">NUTRITION</th> </tr> <tr> <td style="font-size: x-small;">5-06 3 Jun</td> <td style="font-size: x-small;">06-06 10 Jun</td> <td style="font-size: x-small;">06-06 14 Jun</td> </tr> <tr> <td>CAL</td> <td>98</td> <td>567</td> </tr> <tr> <td>N gm</td> <td></td> <td>2.68 2.30</td> </tr> <tr> <td>PROT gm</td> <td></td> <td>16.7 14.3</td> </tr> <tr> <td>CHO gm</td> <td>3.3</td> <td>26.2 17.3</td> </tr> <tr> <td>FAT gm</td> <td></td> <td>22.8 19.6</td> </tr> </table>	NUTRITION			5-06 3 Jun	06-06 10 Jun	06-06 14 Jun	CAL	98	567	N gm		2.68 2.30	PROT gm		16.7 14.3	CHO gm	3.3	26.2 17.3	FAT gm		22.8 19.6	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <th colspan="3">Diffusion</th> </tr> <tr> <td style="font-size: x-small;">0600 7 Jun</td> <td style="font-size: x-small;">2200 8 Jun</td> <td style="font-size: x-small;">1400 10 Jun</td> <td style="font-size: x-small;">0600 12 Jun</td> </tr> <tr> <td>PaO2</td> <td>300</td> <td>225</td> <td>150</td> </tr> <tr> <td>PaO2</td> <td>700</td> <td>550</td> <td>400</td> </tr> </table>	Diffusion			0600 7 Jun	2200 8 Jun	1400 10 Jun	0600 12 Jun	PaO2	300	225	150	PaO2	700	550	400																																																																																																																				
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This scroll bar displays the current cursor position and the time that the Summary Screen is displaying.

The solid line in the scroll bar represents the start of day.

The start and stop times are displayed at the end of the screen scroll bar.



[Page Up] Key

The [Page Up] key will display the next time interval applicable for each section type.

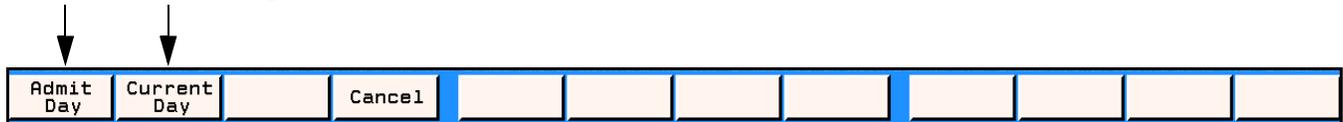


[Page Down] Key

The [Page Down] key will display the previous time interval for each section type.

To scroll through time, click to the left or right of the scrolling time cursor with the pointing device or use the [Left Arrow] or [Right Arrow] keys.

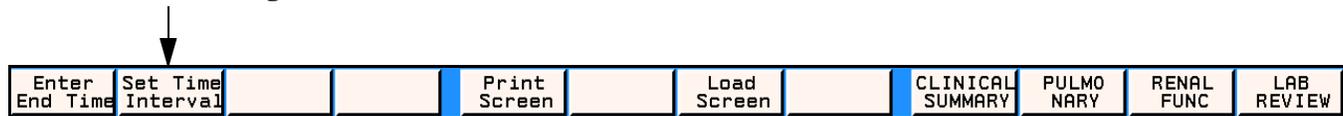
4.1.1.2 Selecting the End Time



The end time of the Summary Screen can be selected manually in free text or by soft key. To set the end time, perform the following steps.

1. Press the “Enter End Time” soft function key <F1>.
 - The Enter End Time prompt will appear.
2. Enter the desired End Time.
 - Type in the date and time in free text or with the Arrow keys.
 - To set the end time to the admission day, press the “Admit Day” soft key <F1>.
 - To set the end time to the start of day, press the “Current Day” soft key <F2>.
3. Press the [Enter] key.
 - The data presented for the selected end time will appear on the Summary Screen.

4.1.1.3 Selecting the Time Interval



To change the default time interval, perform the following steps.

1. Press the “Set Time Interval” soft key <F2>.
 - The Set Time Interval prompt will appear.
- Enter time window in hours (or use ↑ and ↓): 24
- ↙ Cursor
2. Type in free text (or change with the Arrow keys) the desired time interval in hours.
 - The default time interval will need to be removed by pressing the [Backspace] key.
 3. Press the [Enter] key.
 - The data presented for the selected time interval will appear on the screen.

SAMPLE SUMMARY SCREEN RENAL FUNCTION SCREEN

Tom Axlerod		300-1		Phy: Dr. Brookstone		(Env ICU)		10:51 Oct 2, 95	
Renal Function									
Blood Chemistry			1125	1242	1243	1316	1543	2239	
			23 Aug	23 Aug	23 Aug	23 Aug	23 Aug	23 Aug	
Na						151	143		
K	3.8	5.8	5.8	3.4	4.1	3.7			
Chloride						124	116		
CO2						16	15		
BUN						16	21		
CREAT						1.6	2.2		
Osmo									
Panel			1543	1816	2239				
			23 Aug	23 Aug	23 Aug				
Ca				7.9					
PO4				2.7					
Mg					1.9	2.4			
Tot. Prot.									
Albumin				1.9					
Hgb & Hct			9943	1019	1118	1256	1409	1740	2225
			23 Aug	23 Aug	23 Aug	23 Aug	23 Aug	23 Aug	23 Aug
Hgb	9.6	8.3	15.0	8.6	12.7	13.7	10.0		
Hct	28.1	25.3	44.3	25.4	38.6	40.4	29.7		
Weight							851		
							23 Aug		
PreDialysis									
PostDialysis									
Daily Wt.							70.50		
Blood Gases			1222	1310	1453	1835	1848	2315	
			23 Aug	23 Aug	23 Aug	23 Aug	23 Aug	23 Aug	
pH	7.22	7.17	7.23	7.29	7.27	7.40			
PCO2									
PaO2	39	79	51	434	486	153			
HCO3	22.3	16.9	11.9	11.7	12.2	13.0			
BE	-4.9	-11.5	-14.3	-12.8	-12.5	-9.5			
SaO2	82.2	81.5	93.7	99.9	99.1	99.6			
Intakes			00-24	00-24					
			23 Aug	24 Aug					
PLATELETS			175						
FFP			400	400					
D5W (C.O.)			120	120					
D5W/20MEQ KC			1118	1952					
D5.45NS			400						
LR			1000	200					
D5W+DOBUTAMI			0	56					
D5W+DOPAMINE			203						
D5W+EPI/CAL			172	658					
PRBC's			1500	500					
PRBC's			250	500					
NS			200	300					
LR			1000	1000					
Outputs			00-24	00-24					
			23 Aug	24 Aug					
CHEST TUBE #	1345	620							
NG	80	1020							
CHEST TUBE	940	450							
URINE	283	1225							
Net			00-24	00-24					
			23 Aug	24 Aug					
Net			3890	4068					

Urine Volume

Renal Perfusion

Urinalysis		Urine Chemistry	
Color		24h Creat Cl.	
Clarity		Na	
Sp Gravity		K	
pH		Chloride	
Glucose		Osmo	
Acetone		UUN	
Protein		CREAT	
Sediment			

0000
22 Aug

1800
23 Aug

0000
24 Aug

Enter End Time	Set Time Interval	Hide Bar	Done	Print Screen	Load Screen	CLINICAL SUMMARY	PULMO NARY	RENAL FUNC	LAB REVIEW
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4.1.1.4 Printing a Summary Screen



Enter End Time	Set Time Interval			Print Screen		Load Screen		CLINICAL SUMMARY	PULMO NARY	RENAL FUNC	LAB REVIEW
-------------------	----------------------	--	--	-----------------	--	----------------	--	---------------------	---------------	---------------	---------------

A Summary Screen can be printed manually as needed with a single keystroke. To print a screen, perform the following steps.

1. Perform the steps to set the End Time and Time Interval for the desired screen to print.
2. Press the “Print Screen” soft key <F5>.
3. Enter in your ID Code and press the [Enter] key.
 - The screen will print to the printer configured for that display station.

4.1.1.5 Reviewing Other Summary Screens



Enter End Time	Set Time Interval			Print Screen		Load Screen		CLINICAL SUMMARY	PULMO NARY	RENAL FUNC	LAB REVIEW
-------------------	----------------------	--	--	-----------------	--	----------------	--	---------------------	---------------	---------------	---------------

The data items and display formats presented are completely configurable by hospital. For example, the Friedman Curve can be selected for review by the users in the Labor & Delivery Environment. To view additional screens, perform the following steps.

1. Press the “Load Screen” soft key <F7>.
 - The Load Screen window will appear with pre-configured screens.
2. Select one of the pre-defined screens for review.
 - Use the [Up Arrow] and [Down Arrow] keys to highlight the desired screen.
3. Press the [Enter] key.
 - The desired screen will appear on the screen.

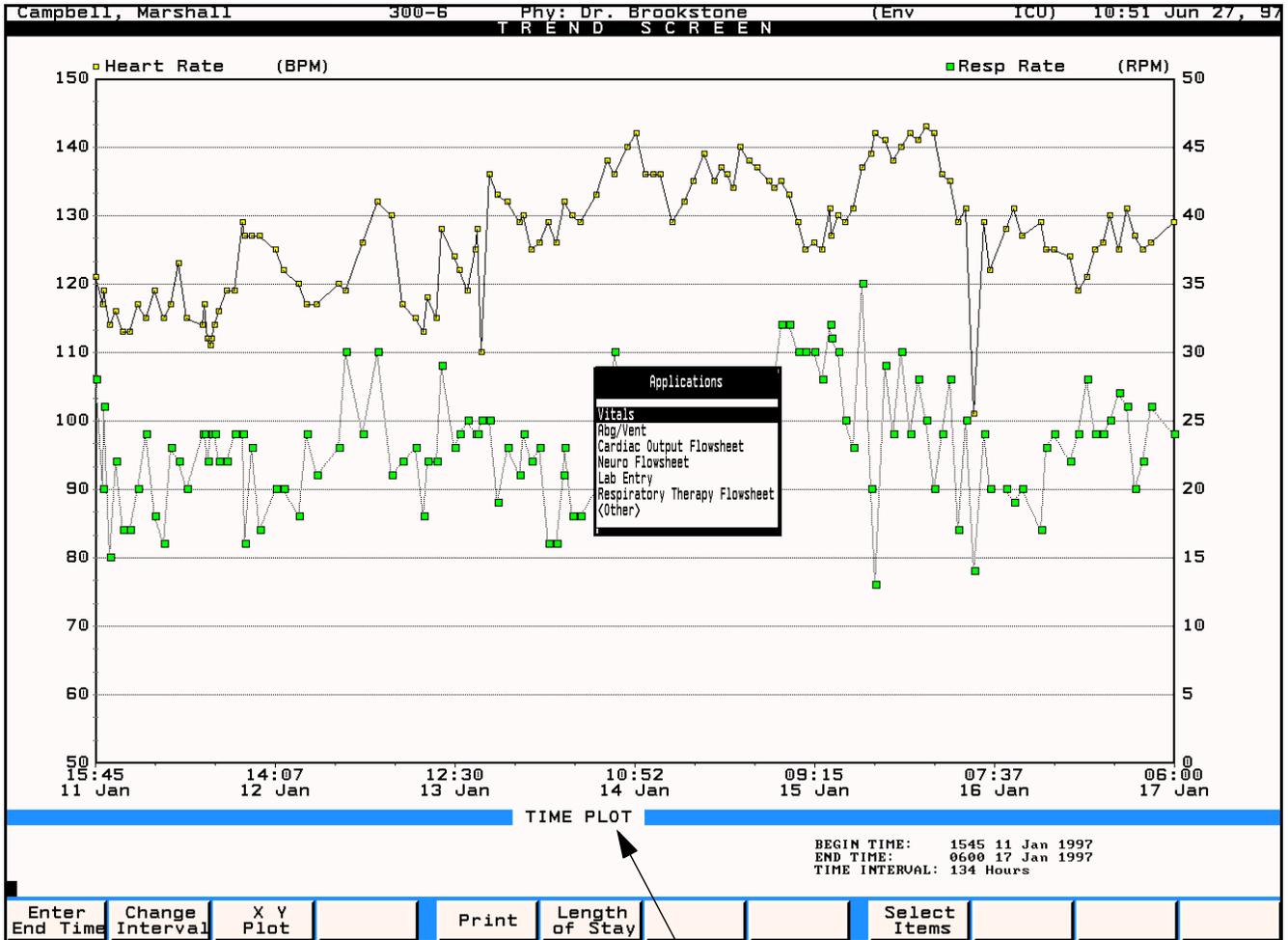
OR

- Select the desired Summary Screen configured as a Secondary Summary Screen.
 - Secondary Summary Screens are configured on soft keys <F9 - F12> and [Shift][F1 - 12].

4.2 SPECIAL REVIEW SCREENS

THE TREND PLOT SCREEN DISPLAYED OVER TIME WITH 'APPLICATIONS' WINDOW

The Trend Plot Screen defaults to the Time Plot.



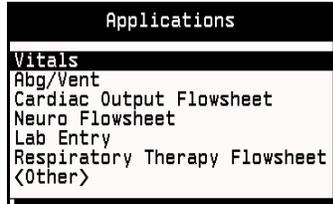
The plot type is indicated

4.2.1 TREND PLOT FUNCTIONS

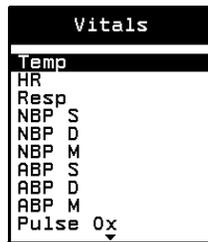
4.2.1.1 Selecting Data Parameters to Trend or Plot

Any data parameter defined in the CIS database can be plotted over time or against another parameter. To select the data items to be plotted, perform the following steps.

1. Select the Trend Plot Screen.
 - The Applications choice list window will appear.



2. Select the desired flowsheet application for the first item to be plotted.
 - Move the cursor with the [Up and Down Arrow] keys to highlight the desired application.
 - Press the [Enter] key.
3. Select the desired parameter to plot.
 - The Parameters choice list window will appear.

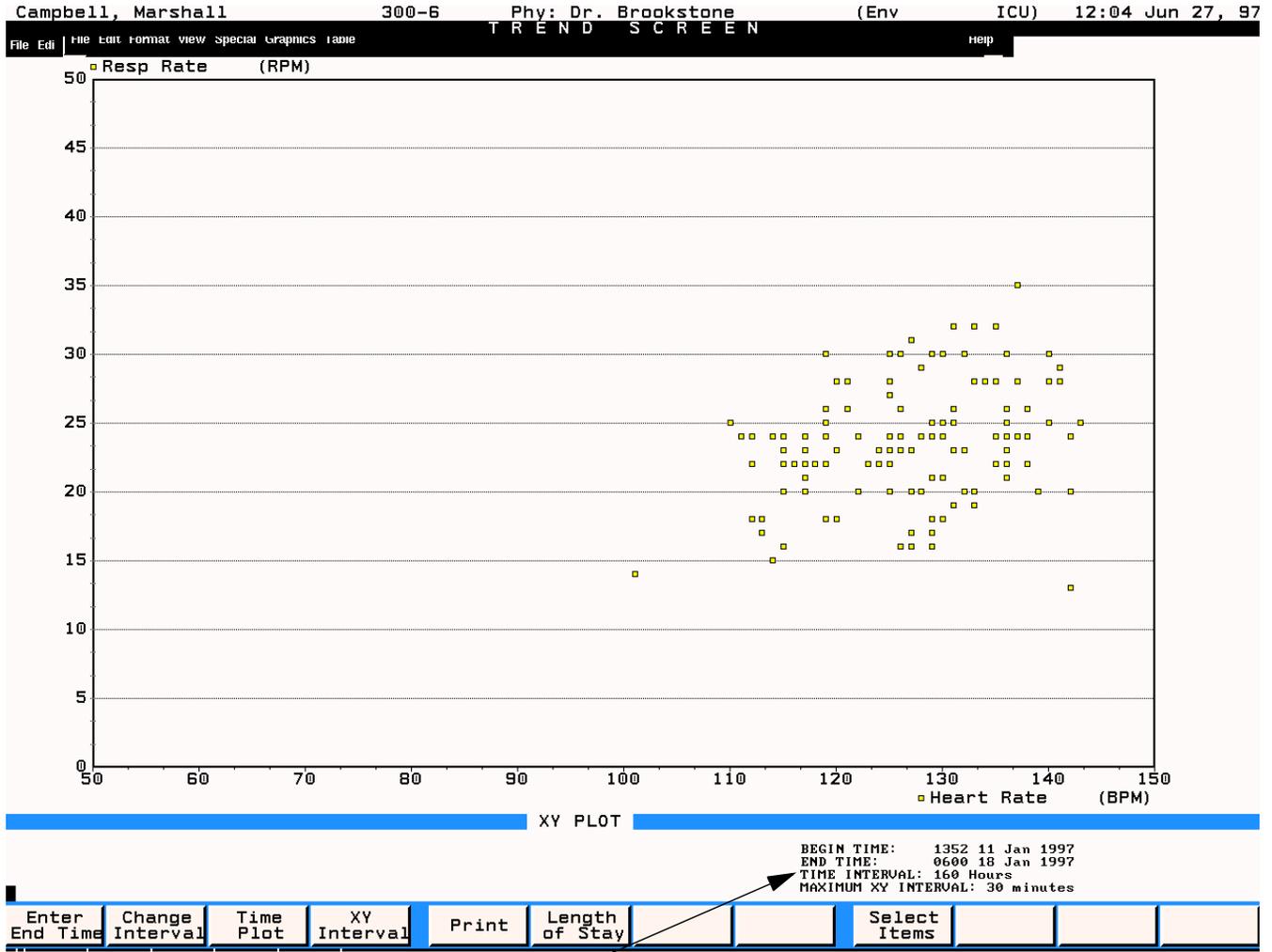


- Move the cursor with the [Up and Down Arrow] keys to highlight the desired parameter.
- Press the [Enter] key

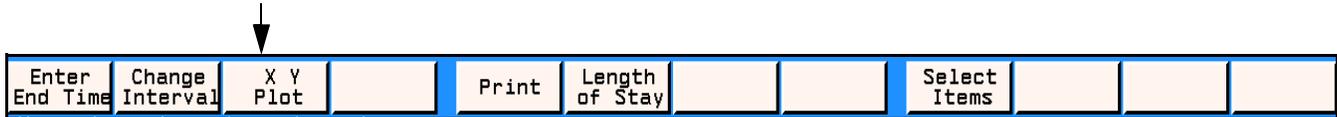
OR

4. Enter in the parameter in free text using a proper database name.
 - Move the cursor with the [Up and Down Arrow] keys to highlight the <Other> option in the application list window.
 - Press the [Enter] key.
 - Type in the first few letters of the item name and press the “Complete” soft key <F1>.
 - A list of possible items will be displayed.
 - Finish typing in the item name as spelled on the screen.
 - Press the [Enter] key.
5. Repeat Steps 2 and 3 or 4 to select the second item to be plotted.
 - The selected parameters will appear trended on the screen.

TREND PLOT SCREEN DISPLAYED ON AN 'XY' AXIS



4.2.1.2 Plotting Trend Data Using the XY Axis



Any data parameter defined in the CIS database can be plotted over time or against another parameter. To trend a data item on an XY axis, perform the following steps.

1. Select the Trend Plot Screen.
2. Perform the steps in the section titled, "Selecting Data Parameters to Trend."
3. Press the "XY Plot" soft key <F3>.
 - The selected parameters will appear trended against each other.
4. Press the "Time Plot" soft key <F3> to return to the screen trending the parameters against time.

4.2.1.3 Changing the Trend End Time



To change the end time displayed on the screen, perform the following steps.

1. Select the Trend Plot Screen.
2. Perform the steps in the section titled, "Selecting Data Parameters to Trend."
3. Press the "Enter End Time" soft key <F1>.
4. Enter in the desired end time.
 - The data parameters will appear trended to the new end time.
5. Press the [Enter] key.

4.2.1.4 Changing a Trend Parameter



One or both of the trend parameters can be changed and a new trend plot will automatically appear. To change one or both of the trend parameters, perform the following steps.

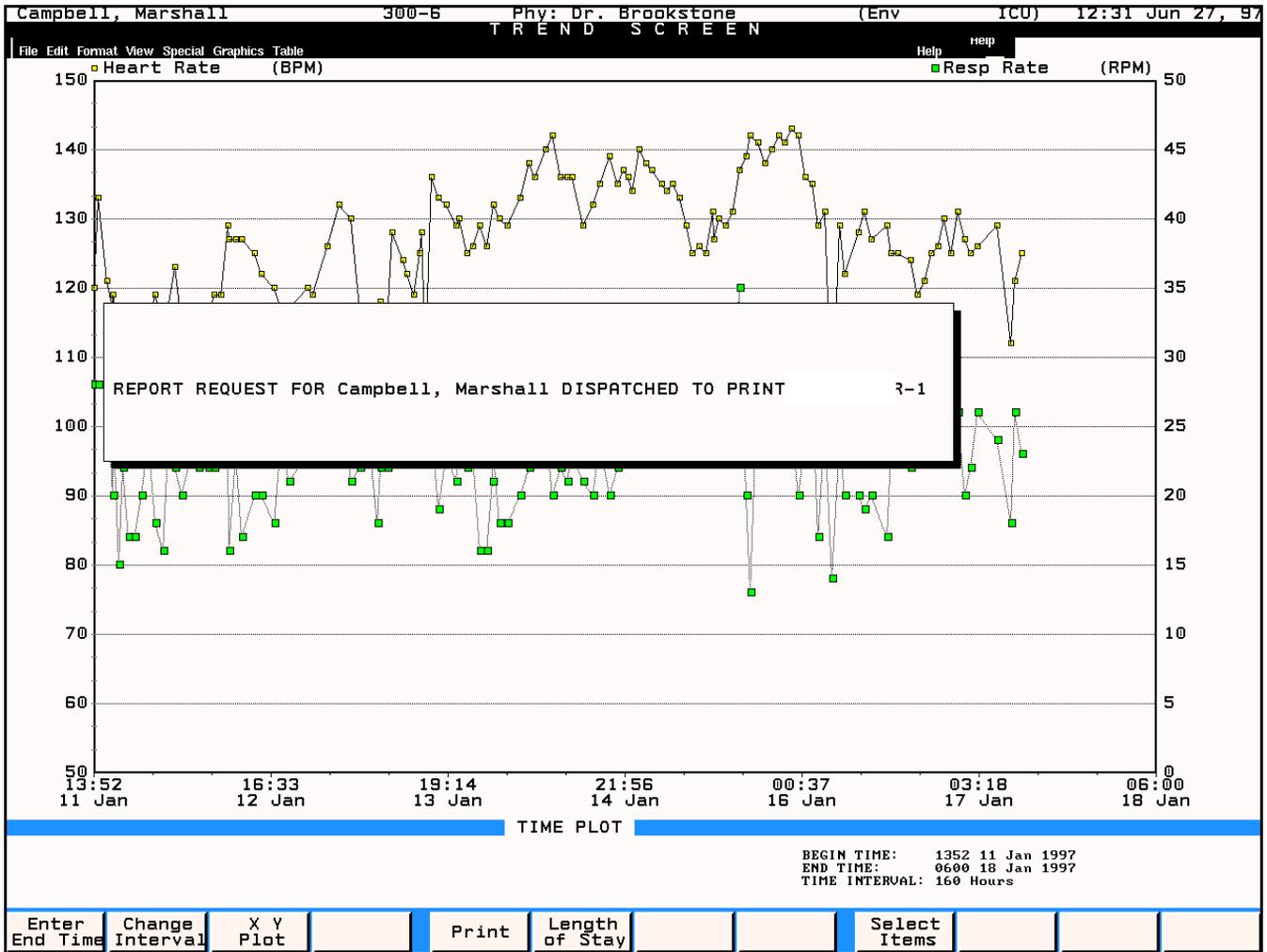
1. Select the Trend Plot Screen.
2. Perform the steps in the section titled, "Selecting Data Parameters to Trend."
 - The selected parameters will appear trended on the screen.
3. Press the "Select Items" soft key <F9>.
 - The Applications choice list window will appear to select the desired application.
 - Perform the steps in the section titled, "Selecting Data Parameters to Trend" to select a new parameter.



The parameters will be changed in the order in which they were selected.

4. The new parameters will be trended.

TREND PLOT SCREEN WITH 'PRINT STATUS' WINDOW



4.2.1.5 Changing the Default Time Interval

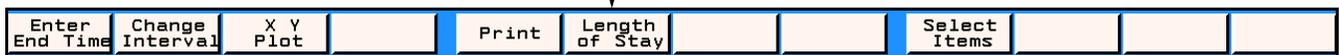


To change the default time interval, perform the following steps.

1. Select the Trend Plot Screen.
2. Perform the steps in the section titled, “Selecting Data Parameters to Trend.”
3. Press the “Change Interval” soft key <F2>.
 - The following prompt will appear:

Interval (enter number of hours): █
4. Enter in the desired time interval in hours.
 - For example, if four (4) is entered, then the two data items will be plotted over four (4) hours.
5. Press the [Enter] key.
 - The trend screen will automatically readjust to the new time interval.

4.2.1.6 Reviewing Trend Data for the Patient’s Entire Length of Stay



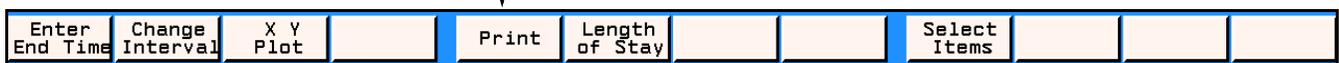
To view patient data trended over their entire stay, perform the following steps.

1. Select the Trend Plot Screen.
2. Perform the steps in the section titled, “Selecting Data Parameters to Trend.”
3. Press the “Length of Stay” soft key <F6>.
 - Patient data trended over their stay at the hospital will appear on the screen.



If the time interval is changed when in the Length of Stay mode, the Begin Time will automatically adjust to the new time interval. The End Time will remain constant.

4.2.1.7 Printing Trend Data



To print a report of the data items trended over time or against each other, perform the following steps.

1. Select the Trend Plot Screen.
2. Perform the steps in the section titled, “Selecting Data Parameters to Trend.”
3. Press the “Print” soft key <F5>.
4. Enter in your ID Code.
 - A printed report of the trend screen will be sent to the printer.

REFERENCE LIBRARY SCREEN

Reference Index Window

The screenshot shows a terminal window with a header bar containing patient information: "Campbell, Marshall", "300-6", "Phy: Dr. Brookstone", "(Env ICU)", and "14:10 Jun 27,". The main content area is divided into two sections. On the left is the "Reference Index:" which lists a hierarchy of topics: "Population Based Standards»Acute Respiratory Failure", "Population Based Standards: Acute Respiratory Failure Assessment", "Monitoring/Interventions", "Patient/ Family Teaching" (highlighted), "Outcomes", and "References". Below this is the text "ADMISSION ORDERS FOR PATIENTS WITH ACUTE RESIPATORY FAILURE". On the right is the "Search Results:" section, which is currently empty. Below these sections is a larger text window titled "Patient/ Family Teaching" containing a numbered list of instructions: "1. Teach about disease process, therapeutic modalities, expected outcomes.", "2. Provide explanations about interventions.", and "3. Teach patient/ family suctioning procedure as appropriate." Below this list is an "Outcomes" section with a numbered list: "1. Absence of subjective feelings of dyspnea.", "2. Respiratory rate WNL for the patient.", "3. ABGs WNL for the patient", "4. O2 Sats > 90%", "5. Lungs clear", "6. No use of accessory muscles", "7. US stable", "8. Clear CXR", and "9. Peak airway pressures WNL for the patient." At the bottom of the screen is a control bar with buttons: "Back 1 Level", "Goto Text", "FullScrn Text", "Select", a vertical bar, and "Search".

Text window displaying data

When pressed, the cursor will move to the Search Results Window

When pressed, the cursor will move to the Reference Index Window

4.2.2 REFERENCE LIBRARY FUNCTIONS

Hospital reference information can now be selected for review on the Reference Library Screen from an indexed listing of libraries and books or via a search feature. The selected or searched information will then appear on the lower half of the screen for review.



To add reference information created with the Reference Library Configuration Tool, please contact your CliniComp, Intl. Configuration Specialist.

4.2.2.1 Reference Information Index

Information on the Reference Library Screen is presented in four hierarchical levels: 1.) Reference Library Listings 2.) Reference Books 3.) Table of Contents 4.) Data.

4.2.2.1.1 Reference Library Listing Level

The Reference Library Listing Level displays the reference information headings available to the user for selection. For example, the following reference libraries currently available include:

- CliniComp System Documentation (Clinical User Reference Manual)
- CliniComp New Features (Clipboards)
- Clinical Reference (Hospital Specific Information such as Standards of Care)

Upon selecting the Reference Library, the screen will display the Reference Library Listing in the Reference Index window.

4.2.2.1.2 Reference Book Level

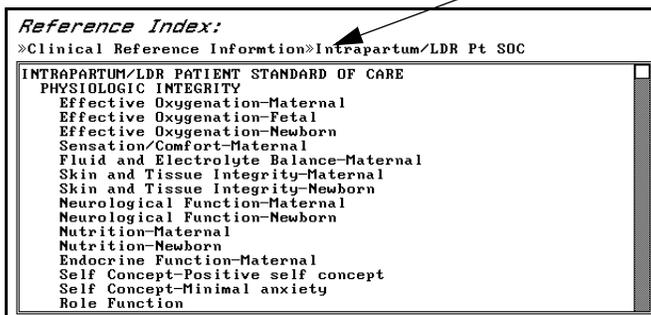
The Reference Book Level lists those topics configured per environment related to the selected library. For example, while in the Labor & Delivery environment, under the clinical reference library heading, Prenatal Assessment Risks will appear as a reference book.

4.2.2.1.3 Table of Contents Level

The Table of Contents Level displays an outline of data related to the selected book. For example, if the Prenatal Assessment Risks book heading is selected, then the table of contents will appear in the Reference Index window and the reference data will appear in the Text window for review. The reference data displayed can be configured per environment.

The reference library and book selection path will be displayed above the Referencing Index Window. The table of contents will be displayed in the main portion of the Reference Index window.

>>Reference Library Listing Level >> Reference Book Level



4.2.2.1.4 Data Level

The Data Level displays the detail of the reference information.

REFERENCE LIBRARY SCREEN

Cursor movement is performed with the Arrow keys.

The screenshot displays a terminal window with a header bar containing patient information: "Campbell, Marshall", "300-B", "Phy: Dr. Brookstone", "(Env ICU)", and "14:10 Jun 27, 97". The main content area is divided into two sections: "Reference Index:" and "Search Results:". The "Reference Index:" section contains a table of contents with the following items: "Population Based Standards: Acute Respiratory Failure", "Assessment", "Monitoring/Interventions", "Patient/ Family Teaching" (highlighted with a thick black bar), "Outcomes", and "References". Below the table of contents is the text "ADMISSION ORDERS FOR PATIENTS WITH ACUTE RESIPATORY FAILURE". The "Search Results:" section is currently empty. Below the main content area is a detailed view of the "Patient/ Family Teaching" section, which lists three numbered items: "1. Teach about disease process, therapeutic modalities, expected outcomes.", "2. Provide explanations about interventions.", and "3. Teach patient/ family suctioning procedure as appropriate.". Below this is the "Outcomes" section, which lists nine numbered items: "1. Absence of subjective feelings of dyspnea.", "2. Respiratory rate WNL for the patient.", "3. ABGs WNL for the patient", "4. O2 Sats > 90%", "5. Lungs clear", "6. No use of accessory muscles", "7. VS stable", "8. Clear CXR", and "9. Peak airway pressures WNL for the patient.". At the bottom of the screen is a navigation bar with buttons: "Back 1 Level", "Goto Text", "FullScrn Text", "Select", a series of empty buttons, and "Search".

The selected item from the table of contents will be displayed at the top of the Text window.

4.2.2.2 Selecting Reference Information

To select the desired reference data from the Reference Index Window, perform the following steps.

1. Select the Reference Library Screen.
2. Move the cursor to the desired reference library in the Reference Index Window.
3. Press the “Select” soft key <F4> or press the [Enter] key.
 - To return to the reference library listing, press the “Back 1 Level” soft key <F1>.
4. Move the cursor to the desired book in the Reference Index Window.
5. Press the “Select” soft key <F4> or press the [Enter] key.
6. Move the cursor through the table of contents in the Reference Index Window and stop on the desired reference data.
7. Press the “Select” soft key <F4> or press the [Enter] key.
 - To scroll within the text window with the Arrow keys, press the “Goto Text” soft key <F2>.
 - To display and review a full page of the data, press the “FullScrn Text” soft key <F3>.
 - To move the cursor back to the table of contents level, press the “Return” soft key <F1>.

REFERENCE LIBRARY SCREEN WITH SEARCH WINDOW

Campbell, Marshall 300-6 Phy: Dr. Brookstone (Env ICU) 14:21 Jun 27, 97

Reference Index:

»Population Based Standards»Acute Respiratory Failure

Population Based Standards: Acute Respiratory Failure
Assessment
Monitoring/Interventions
Patient/ Family Teaching
Outcomes
References
ADMISSION ORDERS FOR PATIENTS WITH ACUTE RESIPATORY FAILURE

Search Results:

Enter Search String:

Case Sensitive

Global Search

Population Based

Assessment

1. Assess for possible etiologies of acute respiratory failure
(including but not limited to):
 - airway obstruction (edema, bleeding, altered LOC)
 - pneumonia
 - aspiration
 - ARDS
 - pneumothorax
 - atelectasis
 - pain
 - neuromuscular compromise
 - pulmonary edema

2. Assess for signs/symptoms of ARF

- O2cs: PaO2 < 50 mmHg, PaCO2 > 50 mmHg on room air on

OK Cancel Toggle CaseSens Toggle Global

4.2.2.3 Searching for Reference Information

To search the reference files for a particular data string, perform the following steps.



When searching from the Reference Library Listing Level, all libraries will be searched.

When searching from the Reference Book Level, all books in that library will be searched.

When searching from the Table of Contents Level, only the selected book will be searched.

1. Select the Reference Library Screen.
2. Press the “Search” soft key <F11>.
 - The Search window will appear.

```
Enter Search String:
prenatal
 Case Sensitive
 Global Search
```

3. Type in the first few characters of the search string.
 - To search all reference libraries in the system while in a book, press the “Toggle Global” soft key <F6>.
 - For the search to be sensitive to upper and lower case characters, press the “Toggle CaseSens” soft key <F5>.
4. Press the “OK” soft key <F3> or the [Enter] key to activate the search.
 - All available matches to the data string will be displayed in the Search Results window until another search is activated.
 - The first match to the data string will be displayed in the Text window and the cursor will automatically highlight the first match in the Search Results window.
 - To view other matches, move the cursor to the desired match in the Search Results window and press the [Enter] key.
5. When done searching, press the “Index Mode” soft key <F12> to return to the library and exit from the search mode.
 - The cursor will appear in the Reference Index window.

4.3 WAVEFORM ACQUISITION

THE WAVEFORM SCREEN WITH 'REQUEST' WINDOW

DANIELS, BETTY MICU-2 Phy: DR. SIMTH (Env ICU/CCU) 12:40 Oct 27, 93

W A V E F O R M S

Lead II for ECG (mV) 0812 14 Sep 1993

Arterial Blood Pressure (mmHg) 0812 14 Sep 1993

Central Venous Pressure (mmHg) 0812 14 Sep 1993

1124	13	Sep	1993:	II	ABP	CVP
1943	13	Sep	1993:	II	ABP	CVP NOTE
0812	14	Sep	1993:	II	ABP	CVP NOTE
2248	14	Sep	1993:	II	ABP	CVP
0039	15	Sep	1993:	II	ABP	CVP NOTE
1055	15	Sep	1993:	II	ABP	CVP NOTE

MONITOR AFIB WITHOUT ECTOPY. NEXT WAVEFORM= GOOD ALINE WAVEFORM, CORRELATES WITH CUFF BP. NEXT WAVEFORM= GOOD CVP WAVEFORM.

Use ↑ and ↓ keys to select. Use <Enter> to choose.

Read Waves
Request Waves
Note
X1.5
X1.0
Scale
Store
Cancel
Delete Item

4.3.1 WAVEFORM SCREEN FUNCTIONS



The Waveform Screen provides a reasonable facsimile of the waveforms produced at the bedside. The Waveforms on the Waveform Screen are **not to scale**, and therefore are not identical to the bedside physiologic monitor's waveforms. All clinical judgement must be made from the bedside monitor only.



The Waveform Screen is not to scale, but the printed report is an exact reproduction of millimeter paper.

4.3.1.1 Importing the Waveform(s)



	Read Waves	Request Waves	Note	X1.5	X1.0	Scale	Store	List Waves			Delete Item
--	------------	---------------	------	------	------	-------	-------	------------	--	--	-------------

Monitored parameters can be automatically imported into the system. To import the monitored waveform(s), perform the following steps.

1. Select the Waveform Screen.
2. Press the "Read Wave" soft key <F2>.
 - A message showing the remaining seconds until the data is imported may appear on the screen.

Seconds 9. Press any key to exit



3. Verify imported data is correct.
4. When finished with the entire screen, then press the "Store" soft key <F8> to store the waveforms on the patient record.

4.3.1.2 Requesting the Waveform(s)



	Read Waves	Request Waves	Note	X1.5	X1.0	Scale	Store	List Waves			Delete Item
--	------------	---------------	------	------	------	-------	-------	------------	--	--	-------------

Specific waveforms that were monitored at an earlier time can be selected to import into the system. To import selected monitored waveform(s), perform the following steps.

1. Select the Waveform Screen.
2. Press the "Request Wave" soft key <F3>.
 - The request choice list window containing available monitored waveforms will appear.
3. Using the [Up and Down Arrow] keys, Move the cursor to highlight the desired waveform(s).
 - To select more than one waveform, press the "+" key on the keypad, move the cursor to the next desired waveform and press the "+" key. Repeat this for as many waveforms as needed and available.
4. Press the [Enter] key.

Seconds 19. Press any key to exit



- A message showing the remaining seconds until the data is imported may appear on the screen.
5. Verify imported data is correct.
 6. When finished with the entire screen, then press the "Store" soft key <F8>.

THE WAVEFORM SCREEN WITH THE 'DELETE' WINDOW

DANIELS, BETTY MICU-2 Phy: DR. SIMTH (Env ICU/CCU) 12:44 Oct 27, 93

W A V E F O R M S

0812 14 Sep 1993

Lead II for ECG (mV)

0812 14 Sep 1993

Arterial Blood Pressure (mmHg)

0812 14 Sep 1993

Central Venous Pressure (mmHg)

0812 14 Sep 1993

II (Lead II for ECG)
ABP (Arterial Blood Pressure)
CVP (Central Venous Pressure)
NOTE (Waveform Annotation)

MONITOR AFIB WITHOUT ECTOPY. NEXT WAVEFORM= GOOD ALINE WAVEFORM, CORRELATES WITH CUFF BP. NEXT WAVEFORM= GOOD CVP WAVEFORM.

Use f and ↓ keys to select. Use <Enter> to choose.

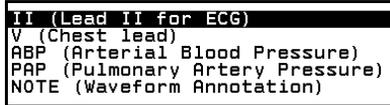
Read Waves	Request Waves	Note	X1.5	X1.0	Scale	Store	List Waves	Cancel
------------	---------------	------	------	------	-------	-------	------------	--------

4.3.1.3 Deleting the Waveform(s)



One or all of the imported waveforms can be removed from the system before they have been saved. To remove the monitored waveform(s), perform the following steps.

1. Select the Waveform Screen.
2. Generate a waveform by either selecting the “Read Wave” soft key <F2> or “Request Wave” soft key <F3>.
3. Press the “Delete” soft key <F12>.
 - The delete choice list window will appear listing the waveforms.



4. Select the waveform to be deleted by using the [Up and Down Arrow] keys.
 - The selected waveform will appear as reverse video.
5. Press the [Enter] key.
6. When finished with the entire screen, then press the “Store” soft key <F8>.



The “Delete Item” soft key <F12> does not delete previously stored waveforms from the chart.

4.3.1.4 Reviewing the Waveform(s)



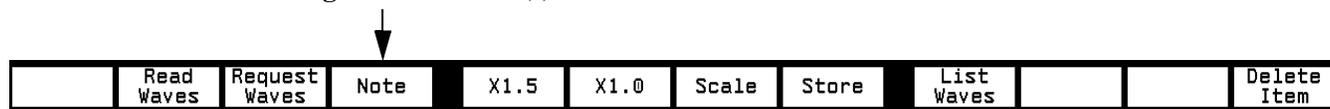
Previously stored waveforms can be reviewed. To review stored waveforms, perform the following steps.

1. Select the Waveform Screen.
2. Press the “List Wave” soft key <F9>.
3. Select the desired waveform by using the [Up and Down Arrow] keys.
 - The selected waveform will appear as reverse video.
4. Press the [Enter] key.
 - The requested waveforms will appear on the screen.

THE WAVEFORM SCREEN WITH 'NOTE' WINDOW



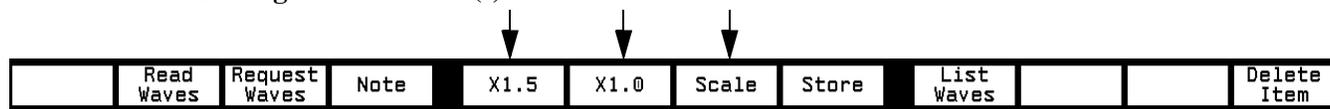
4.3.1.5 Annotating the Waveform(s)



Pertinent information and events related to the waveform(s) can be noted. To record a note, perform the following steps.

1. Select the Waveform Screen.
2. Generate a waveform by either selecting the “Read Wave” soft key <F2> or “Request Wave” soft key <F3> or “List Waves” soft key <F9>.
3. Press the “Note” soft key <F4>.
 - A note window will appear with the cursor positioned for the entry of free text at the bottom of the screen.
4. Press the “End Note” soft key <F4> when completed with entering the note.
 - The note will appear in a window at the bottom of the screen.
 - Additional notes may be added via the “Note” soft key and will be appended to the existing note.
5. When finished with the entire screen, then press the “Store” soft key <F8>.

4.3.1.6 Scaling the Waveform(s)



The imported waveforms can be rescaled for viewing clarity. The soft keys <F5>, <F6> and/or <F7> can be configured as reduction or expansion keys with configurable text (e.g., 200%, X1.5). To scale the monitored waveform(s), perform the following steps.

1. Select the Waveform Screen.
2. Generate a waveform by either selecting the “Read Wave” soft key <F2> or “Request Wave” soft key <F3> or “List Waves” soft key <F9>.
3. Select the appropriate soft key to either expand or reduce the waveform.
 - A window with configured scale options (e.g., 200%, X1.5) may appear.
 - Highlight the desired scale option with the [Up Arrow] and [Down Arrow] keys.
 - Press the [Enter] key.
 - Use the [Up Arrow] and [Down Arrow] keys to access the expanded waveforms NOT displayed on the screen.
4. Select the appropriate soft key to return the waveform(s) to original size.

THE CARDIO-RESPIROGRAM (CRG) SCREEN WITH THE ENTER GRAPH LENGTH PROMPT

The duration of the CRG Screen defaults to one (1) hour.

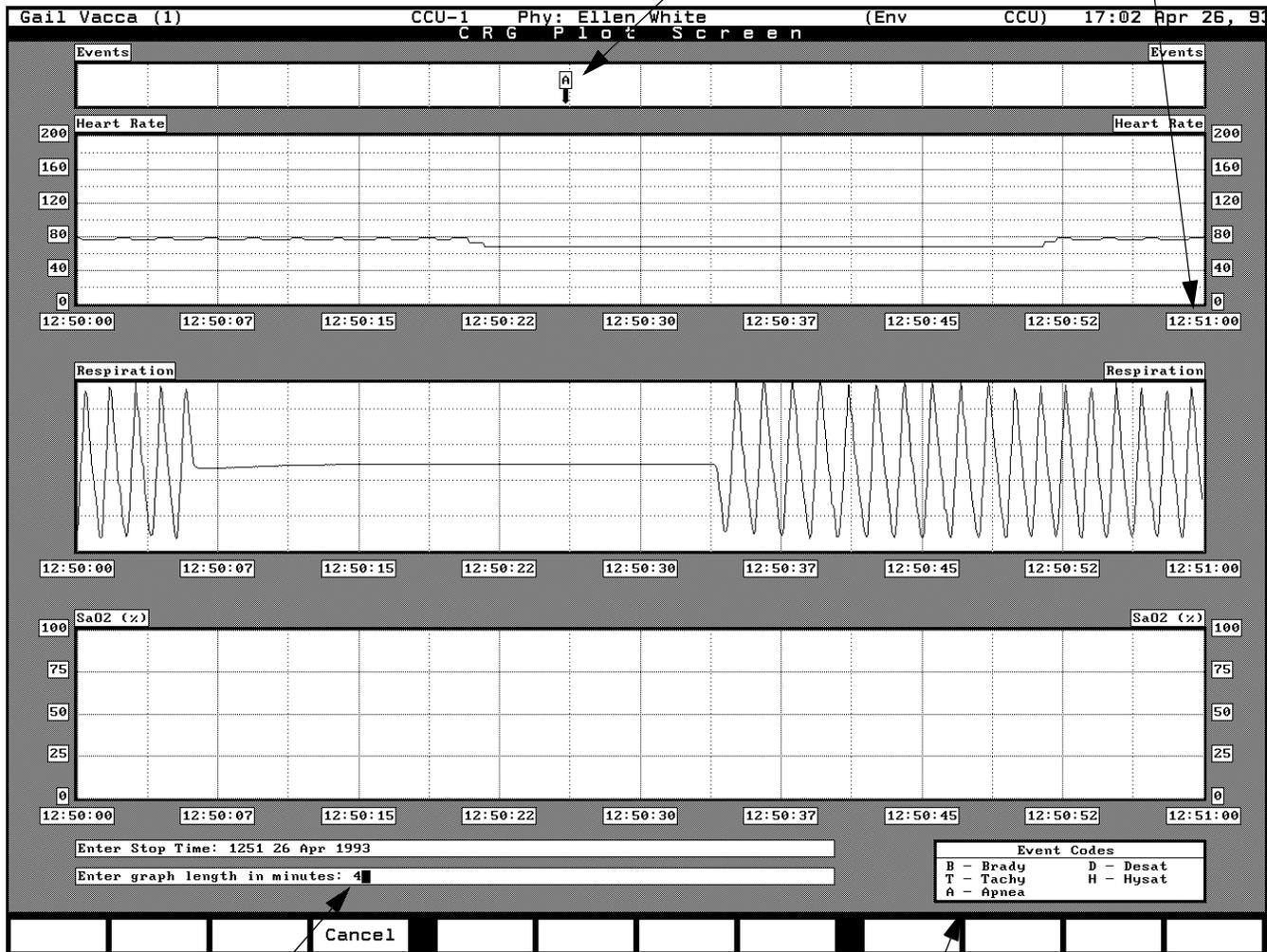


Chart Length Prompt

Event Codes

4.3.2 CARDIO-RESPIROGRAM (CRG) FUNCTIONS

4.3.2.1 Changing the Graph Stop Time

The end time of the CRG waveforms can be changed to review previous CRGs. To set the stop time of the graph, perform the following steps.

1. Select the CRG Screen.
2. Type in the desired time.

Enter Stop Time: 1235 8 Apr 1993
3. Press the [Enter] key.
 - The new CRGs will appear with the set end time.

4.3.2.2 Adjusting the Duration of the Graph



Prev Screen	Next Screen	Current Time	Graph Length	Resp ZoomOut	Resp ZoomIn	Resp Default		Select Graphs			Update Screen
----------------	----------------	-----------------	-----------------	-----------------	----------------	-----------------	--	------------------	--	--	------------------

The length of the CRG graph can be changed to expand or compress the waveforms. To adjust the CRG duration, perform the following steps.

1. Select the CRG Screen.
2. Press the “Graph Length” soft key <F4>.
 - The following prompt will appear below the ‘Enter Stop Time:’ prompt at the bottom of the screen.

Enter graph length in minutes: 30
3. Type in the desired time in minutes.
 - To enter the graph length less than one minute, type a colon followed by the number of seconds desired (e.g., 60 minutes).
4. Press the [Enter] key.
 - The length of the CRG waveforms will automatically adjust, and the correct time will appear below each waveform.

4.3.2.3 Changing the Graph to Current Time



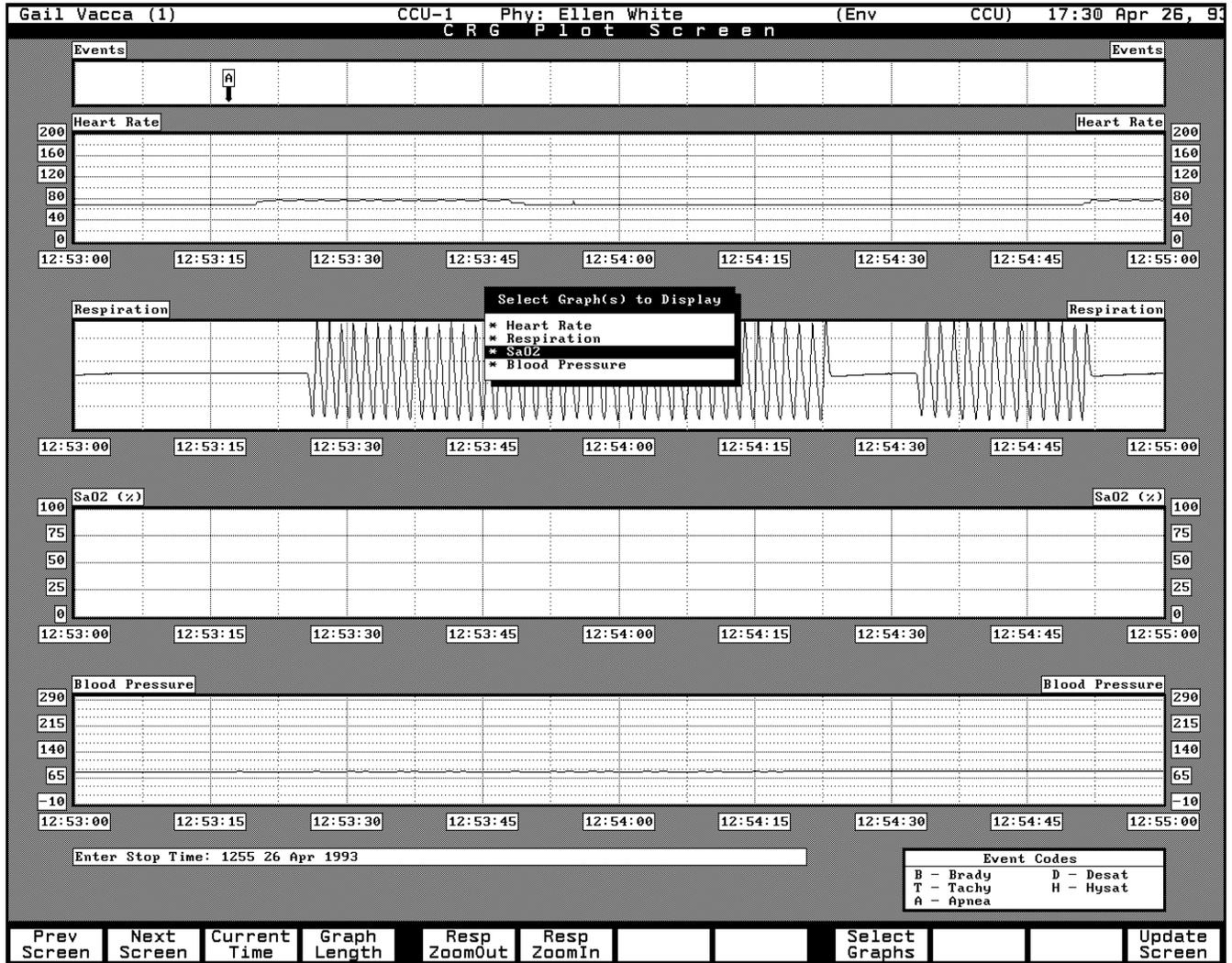
Prev Screen	Next Screen	Current Time	Graph Length	Resp ZoomOut	Resp ZoomIn	Resp Default		Select Graphs			Update Screen
----------------	----------------	-----------------	-----------------	-----------------	----------------	-----------------	--	------------------	--	--	------------------

To return the CRG waveforms to current time while in the CRG screen, press the “Current Time” soft key <F4>.

- The end time of the CRG waveforms will automatically adjust to the current time.

THE CRG SCREEN WITH THE GRAPH SELECTION WINDOW

Window of Observation Time



4.3.2.4 Updating the Screen

Prev Screen	Next Screen	Current Time	Graph Length	Resp ZoomOut	Resp ZoomIn	Resp Default		Select Graphs			Update Screen
-------------	-------------	--------------	--------------	--------------	-------------	--------------	--	---------------	--	--	---------------



Updates to the CRG waveforms are automatically transferred to the system in sets. The screen can be refreshed to include this data for observation purposes. To update the CRG waveforms while in the CRG screen, press the “Update Screen” soft key <F12>.

- The CRG waveforms will automatically reappear with new data, if applicable.

4.3.2.5 Requesting the Graph(s)

Prev Screen	Next Screen	Current Time	Graph Length	Resp ZoomOut	Resp ZoomIn	Resp Default		Select Graphs			Update Screen
-------------	-------------	--------------	--------------	--------------	-------------	--------------	--	---------------	--	--	---------------



Specific graphs can be viewed at one time on the screen. To select the desired CRG graph(s), perform the following steps.

1. Select the CRG Screen.
2. Press the “Select Graphs” soft key <F9>.
 - The following Select Graph(s) to Display window will appear.

Select Graph(s) to Display
* Heart Rate
* Respiration
SaO2
Blood Pressure

3. Select the desired graph(s) by using the [Up Arrow] and [Down Arrow] keys.
 - The selected graph will appear in reverse video.
 - To select more than one graph at a time, press the [+] key on the keypad.
 - An asterisk will appear next to the selected graph name.
 - To de-select a graph (remove the asterisk), press the [+] key on the keyboard.



The graph highlighted in reverse video will be selected when the [Enter] key is pressed.

4. Press the [Enter] key.
 - The selected graph(s) will appear on the screen.

4.3.2.6 Printing the Graph(s)

To print the desired CRG graph(s), perform the following steps.

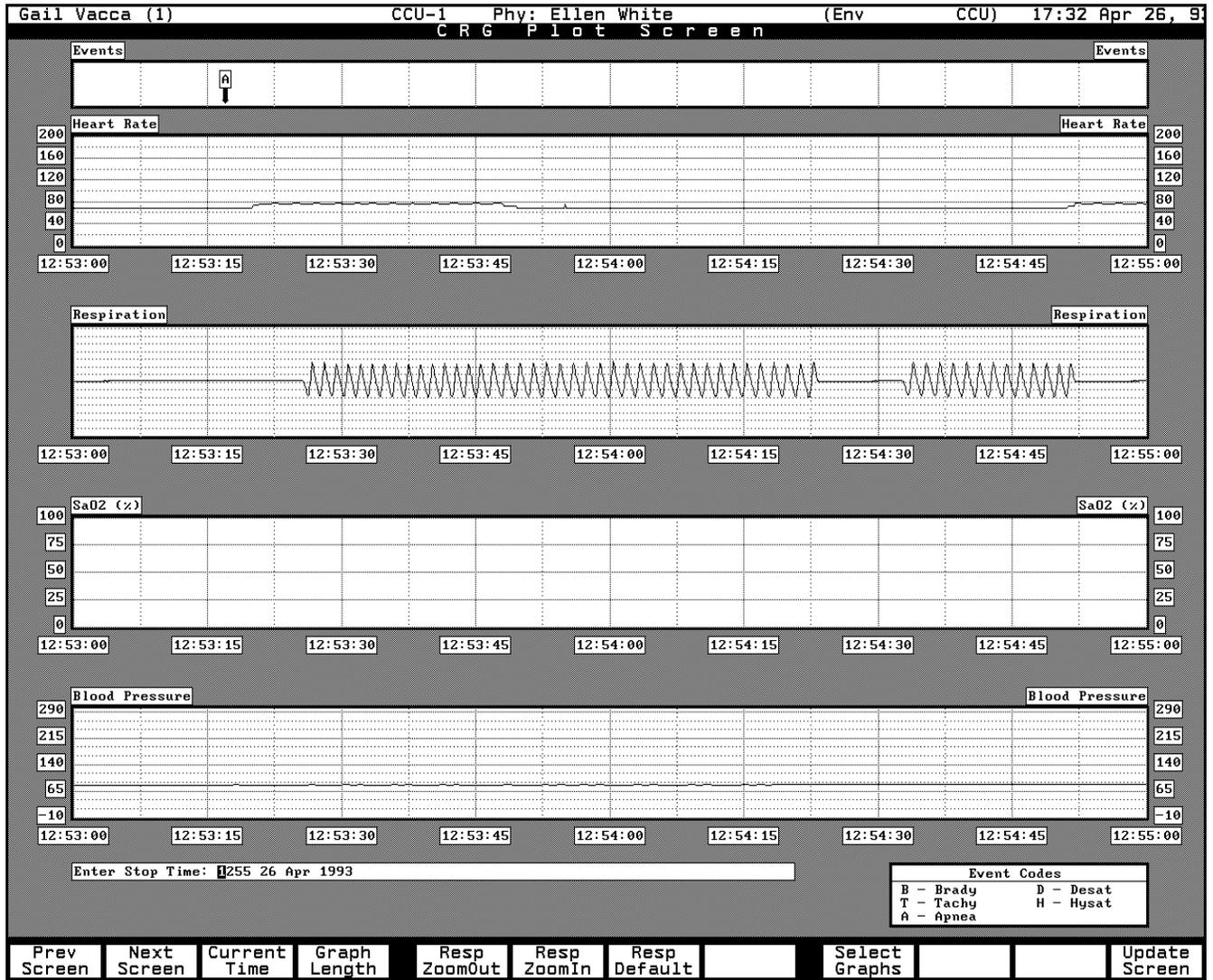
1. Select the Patient Control Screen.
2. Press the “Print, etc...” soft key <F8>.
3. Press the “Print Chart” soft key <F4>.



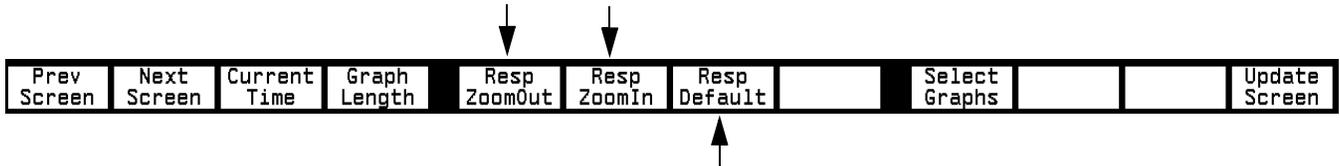
The CRG Screen must be configured on the print menu to be selected for printing.

4. Type in the number corresponding to the graph from the menu.
5. Press the “Dispatch Reports” soft key <F8>.

THE CRG SCREEN IN THE ZOOM OUT FUNCTION



4.3.2.7 Enlarging or Reducing the Respiration Graph



To enlarge or reduce the height of the graph, perform the following steps.

1. Select the CRG Screen.
2. Modify the size of the Respiration Graph.
 - To expand the size of the Graph, press the “Resp ZoomOut” soft key <F5>.
 - To reduce the size of the Graph, press the “Resp ZoomIn” soft key <F6>.
 - To return the height of the Graph to the pre-configured size, press the “Resp Default” soft key <F7>.

4.3.2.8 Reviewing the Previous Graph



The window of observation time on the chart can be changed to the previous CRG waveforms without changing the graph length. To review the previous CRG waveforms, perform the following steps.

1. Select the CRG Screen.
2. Press the “Prev Screen” soft key <F1>.
 - The previous CRG waveforms will automatically appear on the screen.

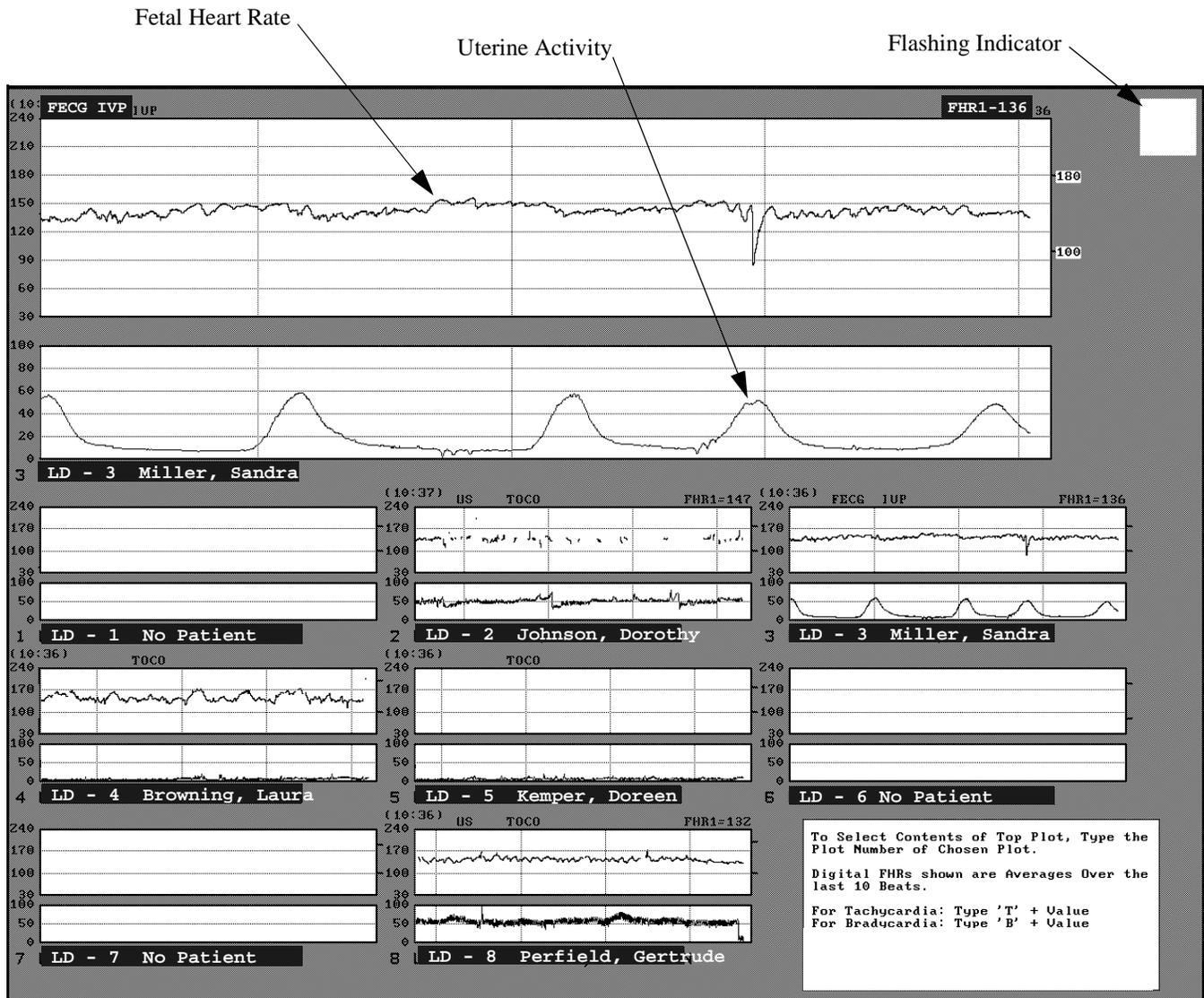
4.3.2.9 Reviewing the Next Graph



The window of observation time on the chart can be changed to the next CRG waveforms without changing the graph length. To review the next CRG waveforms, perform the following steps.

1. Select the CRG Screen.
2. Press the “Next Screen” soft key <F2>.
 - The next CRG waveforms will automatically appear on the screen.

THE FETAL MONITOR REMOTE DISPLAY



4.3.3 FETAL MONITOR REMOTE DISPLAY FUNCTIONS



The Fetal Monitor Remote Display provides a reasonable facsimile of the fetal trace produced at the bedside. The traces on the Fetal Monitor Remote Display are scaled, and therefore are not identical to the bedside trace. All clinical judgements must be made only from the bedside fetal monitor attached to the patient.

The Fetal Plot Screen will display the fetal heart rates for twins. The Fetal Heart Rate 1 will be displayed by a thin line and the Fetal Heart Rate 2 will be displayed by a thick line.

4.3.3.1 Reviewing the Fetal Monitor Remote Display



Fetal heart rate numbers displayed at the top right of each plot represent the average fetal heart rate over the last ten beats.

Flashing Indicator

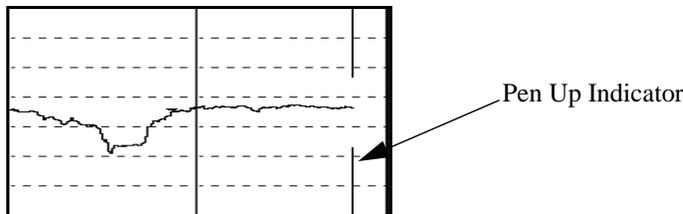
A square blinking box in the upper right corner of the screen indicates system operation. If the flashing indicator should stop, then it would indicate the display has become frozen and the data on the display is no longer accurate.

Reverse Video

When communication between the Data Acquisition device and the Fetal Monitor Remote Display is severed, the applicable trace on the Fetal Monitor Remote Display will appear in reverse video.

Pen Up Indicator

A pen up marker indicates the patient is not connected to the Fetal Monitor, and no data is being transmitted to the CIS Fetal Monitor Remote Display.



Out of Range Alarms for Tachycardia and Bradycardia

Audible alarms and visual indicator marks will appear on the Fetal Monitor Remote Display when a fetal heart rate average (average of the last ten consecutive beats) goes above or below the range set by the hospital or user.

4.3.3.2 Setting the Indicators for Violation of Tachycardia and Bradycardia Limits

An indicator will sound when the FHR violates user-set or default parameters. The indicators for Tachycardia and Bradycardia can be set on each individual patient on the Fetal Monitor Remote Display. To set these indicators for Tachycardia and Bradycardia on the Fetal Monitor Remote Display, perform the following steps.



If the Fetal Monitor Remote Display experiences any power failures, the limits for the Tachycardia and Bradycardia are reset to the hospital defined defaults.

1. Select the desired patient by typing in the corresponding plot number.
2. Press the [Enter] key.
 - The desired plot will be displayed in the top “Zoom” plot.
3. Type in either “T” for Tachycardia or “B” for Bradycardia and the desired numeric indicator limit.
 - For example, ‘B80.’
4. Press the [Enter] key.
 - The trace parameters will reflect the new indicator limit.



The default Tachycardia and Bradycardia limits should be reset after the patient is transferred or discharged.

4.3.3.3 Fetal System Alarms

FMRD Not Responding

- This System Alarm checks each Fetal Monitor Remote Display (performed twice per 10-minute period) to determine that the display responds to both network-level requests and graphics-level Requests. If a display doesn’t respond, the following System Alarm is displayed in the Alarm Area at the bottom of all Fetal Displays:

WARNING - The following Fetal Central Stations are not responding: LDR1

DAS Box Not Responding

- This System Alarm checks each fetal trace that is currently active, to determine if it is regularly receiving new heart beats (performed every 30 seconds). Note: Heart beats are received from a DAS box, either directly or via the system’s data redundancy mechanism. If the system doesn’t receive new heart beats for a trace, the following System Alarm is displayed above that trace:

DAS Box NOT RESPONDING

Data Integrity Problem

- This System Alarm checks that each minute of heart beats is received in one minute’s time, (performed every 4 seconds). If a trace is not updating at the appropriate pace, the following System Alarm is displayed above that trace:

DATA INTEGRITY PROBLEM

- This System Alarm also checks that each twelve minutes of heart beats is received in twelve minutes’ time, (performed every 4 seconds). If a trace is not updating at the appropriate pace, the following System Alarm is displayed above that trace:

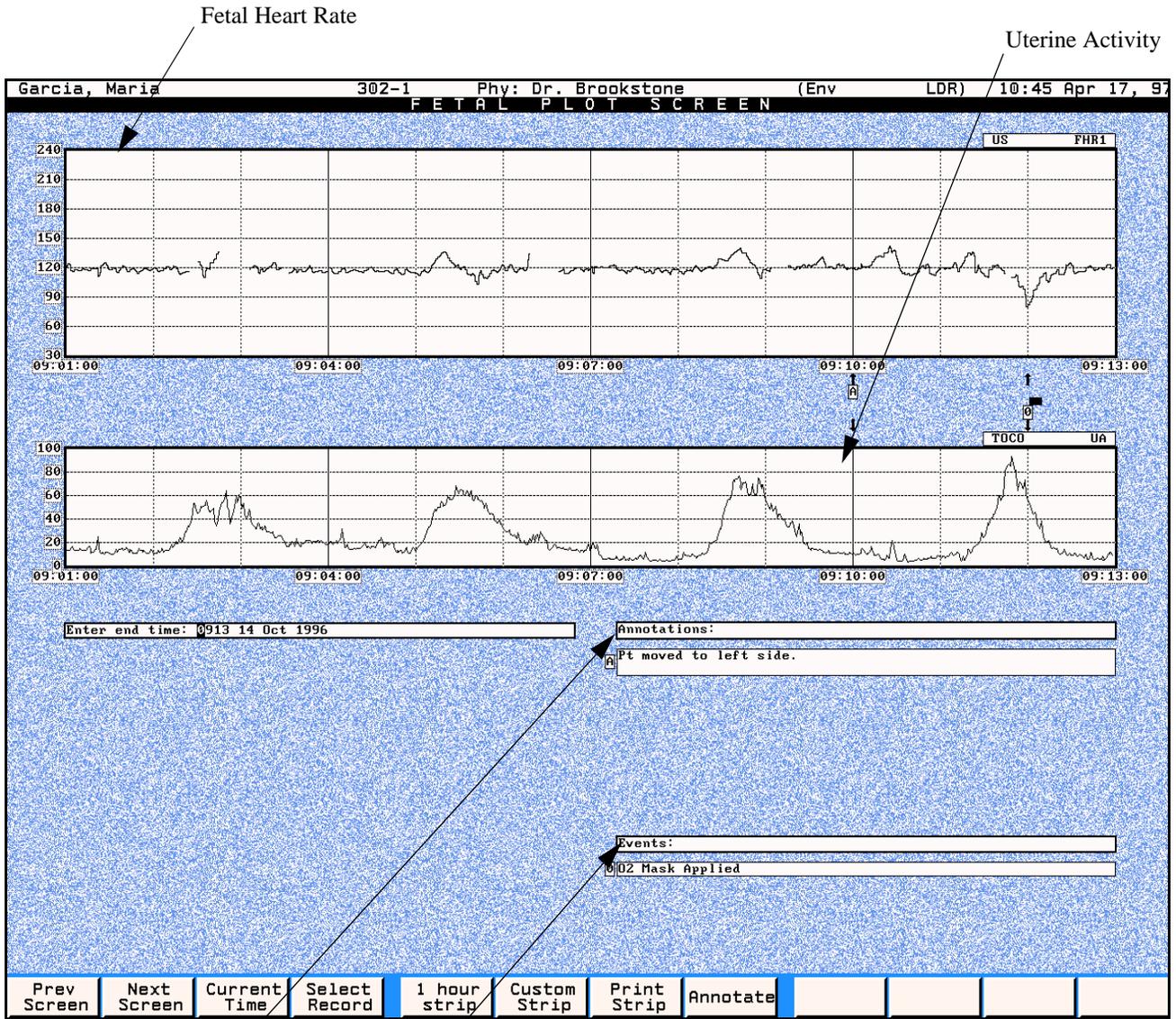
DATA INTEGRITY PROBLEM

4.3.3.4 Features of the Fetal System Alarms:

- All system alarms are continuous. They are constantly displayed and an audible beep is generated at least once per second until the problem is resolved.
- Alarms will only stop when the symptom causing the alarm is resolved.

4.4 MATERNAL CHARTING

THE FETAL PLOT SCREEN



Events are designated by numbers and entered on the Vital Signs Flowsheet.
Annotations are designated by letters and are entered via the "Annotate" soft key.

4.4.1 FETAL PLOT FUNCTIONS



The Fetal Plot Screen provides a reasonable facsimile of the fetal trace produced at the bedside. The traces on the Fetal Plot Screen are scaled, and therefore are not identical to the bedside trace. All clinical judgements must be made from the bedside fetal monitor attached to the patient monitor only.

The Fetal Plot Screen will display the fetal heart rates for twins.



On the CIS Fetal Plot Screen and Fetal Monitor Remote Display (FMRD), the fetal heart rate for baby #1 is displayed as a thin line and the fetal heart rate for baby #2 is displayed as a thick line. On some bedside fetal monitors, the fetal heart rate for baby #1 is displayed as a thick line and the fetal heart rate for baby #2 is displayed as a thin line. Please check with your fetal monitor vendor to determine how twins are displayed on your bedside fetal monitors.

When the Fetal Plot Screen is displaying real-time data, the fetal strip labels will flash every second in reverse video. When any key is pressed, the real-time display mode will cease thereby stopping the flashing of the labels.

Once the Fetal Plot Screen is selected, the current fetal trace will appear on the screen.



Changing the end time will allow you to view other than current strips.

4.4.1.1 Selecting another Fetal Record



Another fetal record can be selected for review. To select another record, perform the following steps.

1. Press the “Select Record” soft key <F4>.
 - A choice list window listing previous fetal records will appear.
2. Select the desired record with the [Up Arrow] and [Down Arrow] keys.
 - The selected record will appear in reverse video.
3. Press the [Enter] key.
 - The desired record will appear on the screen with the correct beginning and ending times.

4.4.1.2 Returning to the Current Fetal Plot Data



Monitored fetal parameters are automatically imported and stored once the patient is admitted. The fetal record will cease once a patient is transferred out of the CIS area or discharged.

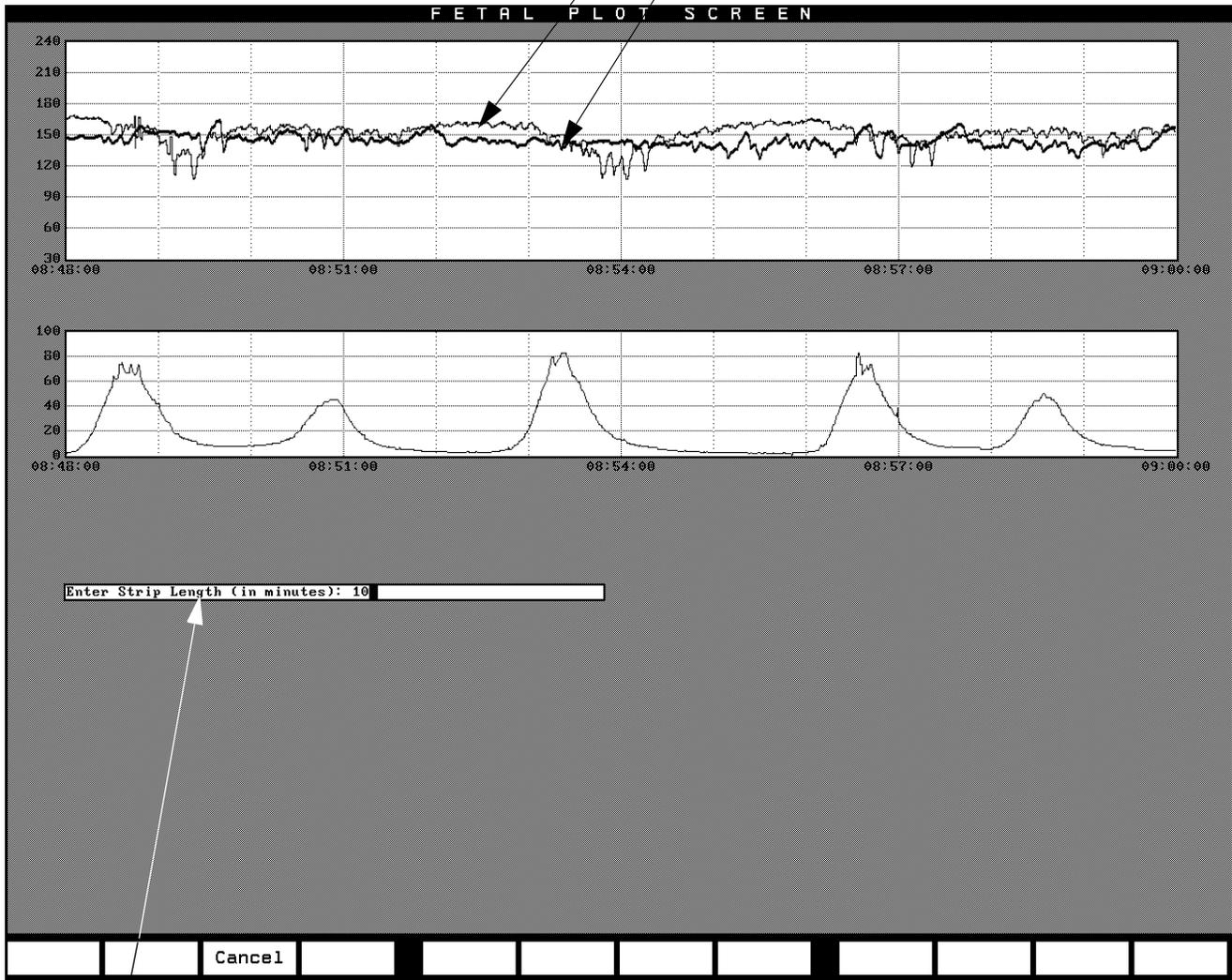
When reviewing the previous time of a fetal strip, the current time can be selected. To return to the most current fetal trace, press the “Current Time” soft key <F3>.



If a patient is disconnected from the fetal monitor, the fetal trace will automatically pick up once the patient has been re-connected.

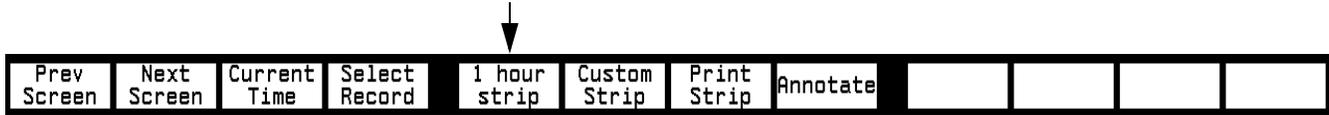
THE FETAL PLOT SCREEN

For Twin Strips:
Baby #1 (Thinner Line)
Baby #2 (Thicker Line)



Strip Length Window for a custom strip

4.4.1.3 Changing the Fetal Plot Time Interval



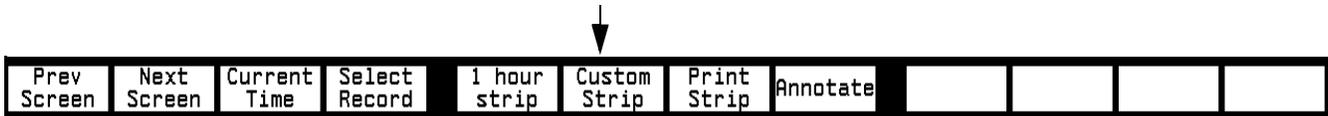
 *Monitored fetal parameters are automatically imported and stored once the patient is admitted. The fetal record will cease once a patient is transferred out of the CIS area or discharged.*

The fetal strip can be manipulated for review between 1 hour or 12 minute time intervals. To change the fetal strip time interval, perform the following steps.

1. Select the Fetal Plot Screen.
 - The Fetal Plot defaults to 12 minute strips.
 - The end time will remain constant when the time interval is changed.
2. Press the “1 Hour Strip” soft key <F5>.
 - The trace time length will be 1 hour.
 - A warning will appear to indicate a non-standard strip length.
3. Press the “12 min strip” soft key <F5> to return to a 12 minute trace.

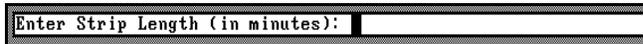
 *If a patient is disconnected from the fetal monitor, the fetal trace will pick up automatically once the patient has been re-connected*

4.4.1.4 Customizing the Fetal Plot Time Interval



The duration of the fetal strip can be customized for review. To customize the monitored fetal plot time strip, perform the following steps.

1. Select the Fetal Plot Screen.
2. Press the “Custom Strip” soft key <F6>.
 - The following window will appear requesting the new time interval in minutes.



3. Enter in the desired strip length in minutes.
 - The end time will remain constant when the time interval is changed.
4. Press the [Enter] key.
 - The following warning will appear for strips with customized time intervals.



THE FETAL PLOT SCREEN WITH ANNOTATIONS

McRossmond, Stephanie 401-1 Phy: Dr. Brookstone (Env LDRP) 17:38 Apr 2, 97

FETAL PLOT SCREEN

US FHR1

240
210
180
150
120
90
60
30

21:57:00 22:00:00 22:03:00 22:06:00 22:09:00

IUP UA

100
80
60
40
20
0

21:57:00 22:00:00 22:03:00 22:06:00 22:09:00

Annotation time: 2200 19 Sep 1996

Enter first line of text:

0 - Vaginal Exam by MD	7 - Heavy Meconium Stained Fluid	14 - Knee Chest Position	21 - Prostin Gel
1 - Vaginal Exam by RN	8 - External Monitors	15 - Trendelenberg Position	22 - Prostin Suppository
2 - SROM	9 - Fetal Scalp Electrodes	16 - Scalp Stimulation	23 - Bicitra
3 - AROM	10 - IUPC	17 - Terbutaline 0.25mg SQ	24 - MgSO4 Bolus
4 - Clear Fluid	11 - Amnio-Infusion	18 - Pitocin Induction	25 - MgSO4 Therapy
5 - Light Meconium Stained Fluid	12 - RLD	19 - Pitocin Augmentation	26 - Ritodrine Therapy
6 - Moderate Meconium Stained Fluid	13 - LLD	20 - D/C Pitocin	27 - Increase IV Fluids

Cancel
Store

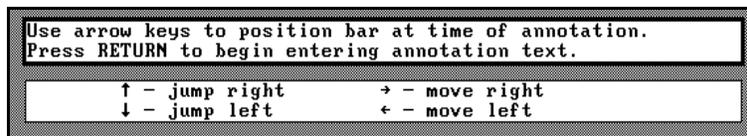
4.4.1.5 Annotating the Fetal Strip



Monitored fetal parameters are automatically imported and stored once the patient is admitted. The fetal record will cease once a patient is transferred out of the CIS area or discharged.

The Fetal Strips can display both annotations and Vital Signs events. Events entered in the Vital Signs Plot Section are designated by numbers on the strip. Annotations are designated by letters and are entered via the “Annotate” soft key. To record an annotation, perform the following steps.

1. Select the Fetal Plot Screen.
2. Press the “Annotate” soft key <F8>.
 - The following instructions will appear below the annotation time.



3. Move the cursor bar to the desired time on the strip.
 - The Arrow keys will move the cursor right or left on the screen.
 - The [Home] key moves the cursor a page to the left, and the [Page Up] key moves the cursor a page to the right.
 4. Press the [Enter] key.
 - Fetal Strip annotations can be entered from a pre-configured choice list or manually in free text.
 - Type in free text.
 - Press the [Enter] key to expand the note box for additional text lines.
- OR
5. When finished with your note, then press the “Store” soft key <F8>.
 - The note will appear on the right hand side of the fetal screen with a letter indicator marking the annotation time on the fetal strip.



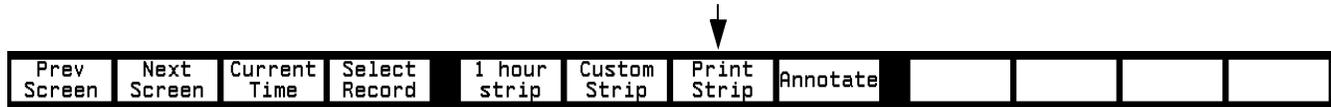
If a patient is disconnected from the fetal monitor, the fetal trace will automatically pick up once the patient has been re-connected.

THE FETAL PLOT SCREEN WITH PRINT TIMES



Print Time Range Windows

4.4.1.6 Printing the Fetal Strip



Monitored fetal parameters are automatically imported and stored once the patient is admitted. The fetal record will cease once a patient is transferred out of the CIS area or discharged.

To print portions of the fetal strip displayed on the Fetal Plot Screen, perform the following steps.

1. Select the Fetal Plot Screen.
2. Press the “Print Strip” soft key <F7>.
 - The Start Time and End Time will default to the Fetal Strip portion currently displayed on the screen.
 - The Start Time prompt will appear.
3. Enter in the desired Start Time.
4. Press the [Enter] key.
 - The End Time prompt will appear.
5. Enter in the desired End Time.
6. Press the [Enter] key.
 - The Fetal Strip Report will be dispatched to the display station’s configured printer.

THE STATUS BOARD SCREEN

Columns and status information displayed are configurable by hospital.

Mutter, Hillary 301-1 Phy: Dr. Brookstone (Env LDR) 18:08 Apr 02, 97

Tracking Screen

Bed Number	Nur Name	Age	G	T	P	A	L	D11	Eff	St	ROM	Anes	GA	Comments	Staff/PNC	
301-1	Mutter, Hillary		1	0	0		0	10.0	100.0	2	R	12	DEL	40	hard of hearing	molly post RN
302-1	Garcia, Maria		3	1	2			10.0	80.0	1	R		DEL	40	Spanish-spkg	
304-1	Godzic, Andrea		1	0	0		0	2.0	70.0	0	I					rita walsh, RN
305-1	Madre, Gisela		3	1	1		1	10.0	100.0	2	R	B		37+2	Mother for support	
306-1	Henry, Mary Ann		1	0	0		0	10.0	100.0	3	R		DEL	39+4		

Highlighted input cell

4.4.2 MATERNAL CHARTING REVIEW FUNCTIONS

The Status Board can be configured to compute and display a patient's age at the current time. For example, a baby's age will be displayed in months and days.

Upon access to the Status Board Screen, pre-configured status information charted on applicable flowsheets will be displayed on the screen.



The information displayed comes from the patient charts.

4.4.2.1 Entering data into the Status Board Screen

To enter free text data into a cell on the new Status Board, perform the following steps.

1. Select a pre-defined, free text input cell on the Status Board.
 - Cells may be selected via the mouse or by the keyboard (i.e., Enter, Tab, etc.).
2. Enter data into the pre-defined input cell.
 - Type in patient data into a single cell.
 - The data within a cell can be removed via the "Clear Data" soft key <F5>.
 - Any modifications to a cell can be reverted via the "Undo" soft key <F6>.
 - To move the cursor BETWEEN editable cells, use the [Shift][Arrow] key sequence.
 - Press the [Enter] key or [Tab] key to move to another cell.
3. Press the "Store" soft key <F8>.
 - Prompt for your user ID code will appear to store the data in the single cell.
4. Enter your user ID code.
5. Press the [Enter] key.



The Status Board can be configured to allow multiple cells to be edited and then stored at one time. If the screen is left idle for a pre-set time, then the cells will revert to the previously stored data.

4.4.2.2 Accessing the Friedman Curve Screen



The Friedman Curve is a "view only" screen.

Upon access to the Friedman Curve Screen, parameters charted on the applicable flowsheets will be displayed on the screen.

Symbols

- “1 Hour Strip” 4 - 49
 - “12 min strip” 4 - 49
 - “Add Carepath” 3 - 109
 - “Add Row” 3 - 69
 - “Admission Data” 3 - 13
 - “Admit Day” 4 - 7
 - “Admit Record” 3 - 11
 - “Admit” 3 - 5
 - “Annotate” 4 - 51
 - “Approve Order” 3 - 43
 - “Assign Order” 3 - 37
 - “Assign Problem” 3 - 155
 - “Assign” 3 - 113
 - “Back 1 Level” 4 - 23
 - “Cancel All” 3 - 113
 - “CarePlan Mode” 3 - 135, 3 - 155
 - “Category List” 3 - 149
 - “Change Interval” 4 - 17
 - “Clear Fields” 3 - 113
 - “Clear Text” 3 - 115
 - “Clinical Note” 3 - 157
 - “Complete” 4 - 13
 - “Copy Forward” 3 - 63
 - “Copy Note” 3 - 151
 - “Counter Sign” 3 - 43
 - “Current Day” 4 - 7
 - “Current Time” 3 - 141, 4 - 35, 4 - 47
 - “Custom Strip” 4 - 49
 - “D/C” 3 - 41, 3 - 65
 - “Delete Order” 3 - 37
 - “Delete” 4 - 31
 - “Describe Item” 3 - 75
 - “Discharge” 3 - 15
 - “Dispatch Reports” 3 - 19
 - “Display Mode” 3 - 39
 - “Done” 3 - 113
 - “Edit Cell” 3 - 115
 - “Edit Field” 3 - 141
 - “Edit Hist” 3 - 75
 - “Edit Note” 3 - 127, 3 - 151
 - “Edit Order” 3 - 33, 3 - 37, 3 - 41
 - “Edit Topic” 3 - 153
 - “End Note” 4 - 33
 - “End Preview” 3 - 111
 - “Enter Time” 3 - 63, 4 - 7
 - “Erase Data” 3 - 141
 - “Find Patient” 3 - 7, 3 - 9
 - “Fluid Totals” 3 - 129
 - “FullScrn Text” 4 - 23
 - “Give Med” 3 - 101
 - “Graph Length” 4 - 35
 - “Hide Choices” 3 - 141
 - “Hide IV Info” 3 - 81
 - “Hold Med” 3 - 101
 - “Import Data” 3 - 13
 - “Item Info.” 3 - 77
 - “List Notes” 3 - 145, 3 - 151
 - “List Wave” 4 - 31
 - “Load Screen” 4 - 9
 - “Lock” 2 - 16
 - “Modify Row” 3 - 113, 3 - 115
 - “More Fields” 3 - 141
 - “New Note” 3 - 145
 - “New Order” 3 - 29
 - “Next Day” 3 - 141
 - “Next Screen” 4 - 39
 - “Note Mode” 3 - 135
 - “Note” 4 - 33
 - “OK” 3 - 73
 - “Prev Screen” 4 - 39
 - “Preview Carepath” 3 - 111
 - “Previous Day” 3 - 141
 - “Print Chart” 3 - 19, 3 - 21
 - “Print Report” 3 - 131
 - “Print Screen” 4 - 9
 - “Print Strip” 4 - 53
 - “Print, etc...” 3 - 19, 3 - 21
 - “Print” 4 - 15, 4 - 17
 - “Read Monitor” 3 - 63
 - “Read Wave” 4 - 29
 - “Ref. Info.” 3 - 77
 - “Remove Order” 3 - 39
 - “Renew Order” 3 - 35
 - “Request Wave” 4 - 29
 - “Reset Schedule” 3 - 67
 - “Resolve Problem” 3 - 159
 - “Resp Default” 4 - 39
 - “Resp ZoomIn” 4 - 39
 - “Resp ZoomOut” 4 - 39
 - “Restore Order” 3 - 39
 - “Review Note” 3 - 147
 - “Scan Note” 3 - 147
 - “Search” 4 - 25
 - “Select Graphs” 4 - 37
 - “Select Record” 4 - 47
 - “Select Time” 3 - 19
 - “Select” 4 - 23
 - “Set Post-Op” 3 - 111
 - “Set Schedule” 3 - 65
 - “Set Stab” 3 - 111
 - “Set Time Interval” 4 - 7
 - “Show All” 3 - 141
 - “Show Annot” 3 - 75
 - “Show Status” 3 - 135, 3 - 159
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 - “Standard Orders” 3 - 37
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 - “Toggle Mode” 3 - 141
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