

# Meditech Training Guide 2013

For Nursing Students and Clinical Instructors



# TRIDENT HEALTH

## **Students:**

This is for your information concerning the clinical documentation system at Trident Health.

- There is no test or affirmation of completion necessary.
- Please feel free to print this handout and use as a reference
- Your instructor will be given your personal logon information and a temporary password.

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# Computer System Confidentiality

Patient information, including names, orders, test results and any other clinical data, is confidential. In caring for patients, you must access only that information which relates to your assignment.

Protecting patient confidentiality is the highest priority.

Every staff member, physician, or person accessing the electronic health system will be given a “Security Agreement” to read and sign BEFORE he or she can obtain a password into the system. The signed agreement will be kept on file for up to 3 years.

Every user sets his/her own personal and confidential password. There are no written records kept of your password. This password functions as your signature and is **NEVER** to be shared with another!

Your name and all activity can be traced with the use of your login & password, and you will be held accountable for all of your activities in the computer. Use of another person’s password is the same as forging someone’s signature to your work. This will result in disciplinary action.

Every job title in the Health System may have a different-looking computer menu, with different functions on that menu. Your menu is created for you, according to the work you do.

Always exit to “goodbye” when you have finished so that no one can work after you using your log-on.

# Function Key/ Quick Strokes Cheat Sheet

## You Want To ...

Save Information or send and email

Exit without saving

Recall last patient accessed

Erase the entire line

Look up list of defined answers

Move cursor to end of list

Move cursor to beginning of list

Move cursor back one field

Recall last answer (if allowed)

“Get” i.e. canned text

Escape out of current window

Check or uncheck highlighted item

Check or uncheck ALL items

Move cursor to right, left, up, or down

Move further into a function

Delete the character the cursor is on

Move the cursor left and remove the character

Access additional menu

Suspend your session

Spell Check/Dictionary/Thesaurus in MOX

Join lines in MOX

Colors/Italics/Bold/Underline in MOX

Calendar/Calculator

Name Look Up

## Hit Key or Click Icon

F-12



F-11



Space bar, enter

F-10

F-9



F-8



F-7



F-6

F-5

F-4

Esc

Right Ctrl



Shift Right Ctrl



Arrows



R arrow or Shift R arrow

Delete

Backspace

Shift F-12



Shift F-12

Shift F-9

Shift F-6

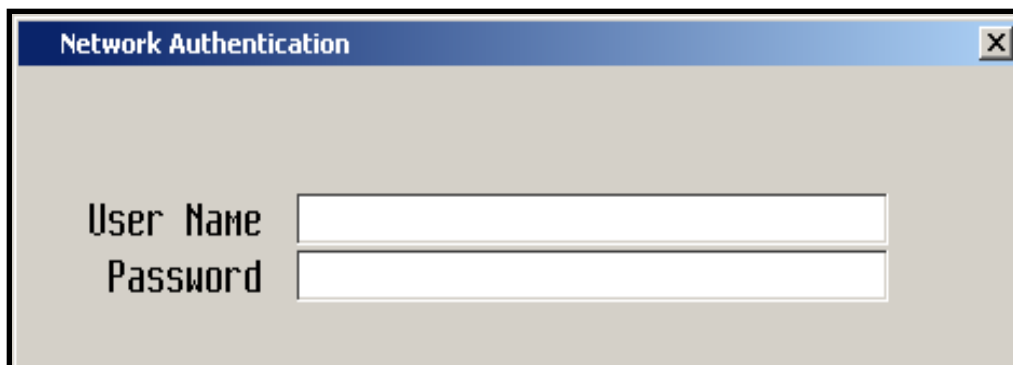
F-1 at beginning of characters,  
F-2 at end of characters



Type “Last name” hit enter

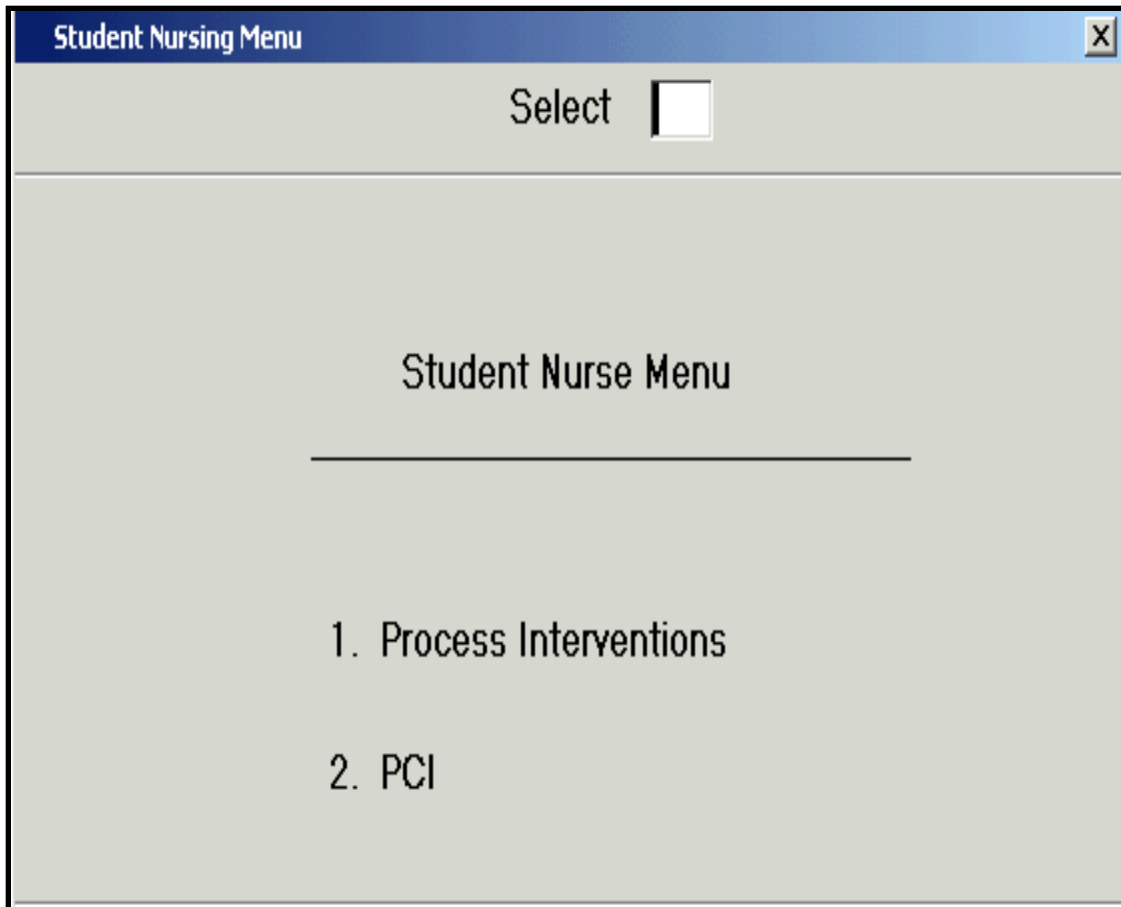
## A few notes about signing on the Meditech system:

1. Terminals & printers are always left ON. Never unplug or move a computer without notifying the Information Services Department. All terminals & PC's have a specific location/address in the system, so if moved, they probably will not work.
2. Most of the Meditech activities are done in capital letters, so make sure the Caps Lock is ON once you get into Meditech.
3. The Numbers Lock must also be ON.
4. The screen on the Monitor may be dark because of a screen saver that protects the quality of the monitor. Hit the <enter> key and the screen will come up.
5. Hit enter again if needed until a screen with "SCA-South Carolina Market" appears. Hit <enter> to continue.
6. The login screen like the one below will appear. This is where you will type in your user name & password. Also, everyone's password will expire 6 months from the date it was set. The system will then prompt you to enter a new password.



The image shows a screenshot of a "Network Authentication" window. The window has a blue title bar with the text "Network Authentication" and a close button (X) in the top right corner. The main area of the window is light gray and contains two input fields. The first field is labeled "User Name" and the second field is labeled "Password". Both fields are empty and have a white background with a thin gray border.

Once you have logged in, you may or may not be given a menu options choice. If you are given a choice, choose the option that starts with “NUR”. This will take you to your student menu as seen below.



The Process Interventions option is where you will do all of your daily documentation. The PCI (or Patient Care Inquiry) option will take you in to view your patient’s electronic medical record via Clinical Review or PCI.

# PI -Process Interventions Screen

Process Interventions

Document Patient Allergy View Process Select  
 Interv's Notes Link History Meds Interv's : 07 of 17

Interv's History Link Meds Notes

Patient 00000022361 BELLE,SOUTHERN Status ADM IN Room D.319  
 Attend Dr PEECH PEERY,CHARLES U Admit 08/28/02 Bed A  
 Start Date 05/19/08 at 0000 End Date 05/19/08 at 2359 Age/Sex 50 F Loc D.T3FL  
 Include A AS,CP,OE 1:99 OWN INT Med Edit Unit# 0000000982  
 Acuity

Interventions	Sts	Frequency	Doc	Src	D	C/N	KI	Prt
~~~~~ ALERTS/PRECAUTIONS ~~~~~								
-Precautions: Falls	A	.VIEW PROTOCOL		CP				
-Precautions: Isolation/Droplets	A	.VIEW PROTOCOL		CP				*
~~~~~ ROUTINE RN/LPN CARE ~~~~~								
-Shift Assessment: Adult +	A	QS	old	CP				
-End of Shift Check Off +	A	QS	old	CP				
-Care Plan Review +	A	QD	old	CP				
-Discharge: Instruction +	A	.UPON DC		CP				
~~~~~ ROUTINE PCT/NURSE CARE ~~~~~								
-Nutrition/ADL/Safety Flowsheet +	A	QS		CP				*
-I&O Monitor +	A	QS		CP				
-VS/Wt/Pulse O <sub>2</sub> +	A	.QS OR PER MD ORDER		CP				
~~~~~ SYSTEM REASSESSMENTS ~~~~~								
-Assess: Musculoskeletal +	A	PRN	old	CP				
~ Assess Strength								
~ Assess Safety								

Interventions represent the plan of action to accomplish the goals. These are the bulk of your daily documentation. The “verb strip” is the group of commands at the top of the Process Intervention screen. These verbs indicate the functions that you may perform within this routine. Simply highlight the desired Intervention, then choose the verb strip option that you want.

- **Document Interventions** - type in DI or simply click on the word This will take you to a documentation screen.
- **Patient Notes** – type PN or click on the words to go to the notes documentation screen.
- **Allergy Link** - Type AL or click on the word to view the patient’s allergy screen.
- **Process Meds** – Allows you to see your Patient’s Medication List.
- **View History** - Type VH or click on the words to view the documentation history. Notice that this routine has its own verb strip options:

View Intervention History							
->View Select Undo Edit <-Exit							
Number	Description			Status	From Frequency		
478	Shift Assessment: Adult +			A	CP	Q5	
Activity	Occurred		Recorded			Old Value → New Value	
Type	Date	Time	by	Date	Time	by	or Comment
Create	09/04/02	0948	RN	09/04/02	0949	RN	
Document	09/04/02	0958	RN	09/04/02	1000	RN	

**View** : To view information regarding the documentation and/or creation of an intervention. Highlight the appropriate date/time and press the <Right Arrow> key or click on the word. This displays the date/time & user that documented an intervention, the terminal ID, and the screen information that was recorded.

**Select**: This allows you to view either all the activity for that intervention (ie. Created, Undone, etc) or only the documentation that occurred. Type in “S” or click on the word. To exit, press the <Left Arrow>.

**Undo**: To undo documentation (ie. User documented on the wrong patient). Highlight the appropriate intervention and type in U or click on the word. A pop up box will ask “Undo the documented Intervention?” Answer “Y”. You will have to give a reason why this is being undone – do an F9 lookup to choose from the list, then F12 to file. The documentation will be undone & a record will be kept.

**Edit**: Allows user to correct previously documented interventions or to add additional documentation. Type in “E” or click on the word. A box will pop up asking for a reason – do an F9 lookup to choose from the list. Then the documentation screen will pop up and allow you to edit the information. (The blue around the screen lets you know this is an editable screen, not just a view only screen) Again, a record will be kept.

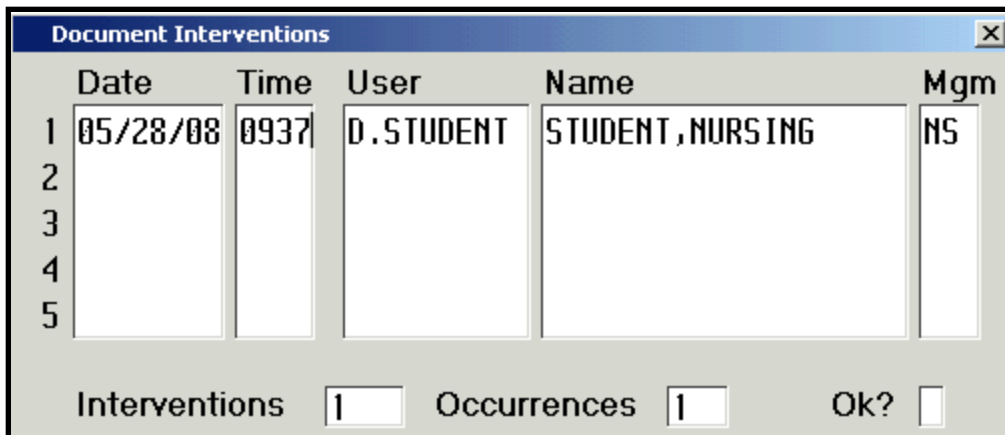


## The Columns on the Process Interventions Screen

- **Interventions** column gives you the full name of the intervention. You usually only have to document those interventions that have + sign.
- **Sts** (Status) column displays the status of the Intervention. (A = Active, C = Complete, H = Hold, I = Inactive, and X = cancelled.)
- **Frequency** column displays the frequency ordered for that particular intervention. (Q Shift, PRN, etc)
- **Doc** (Last Documented) column displays how long ago the intervention was documented on – in minutes, then hours, then days.
- **Src** (Source) column displays the source from which the Intervention originated (OE = Order Entry, CP = Care Plan, AS = Assessment)
- **D** (Duplicate) column displays a “D” if the intervention is a duplicate.
- **C/N & KI** – not used here at Trident
- **Prt** (Protocol) column displays an \* if a protocol is attached to that intervention.

## How to Document in Process Interventions

- Identify the Patient – type in the last name of the patient & hit F9. Choose the correct patient by clicking on the Name or typing in the number in front of the name. The system will ask you if this is the one. Click OK.
- Verify that the correct patient has been pulled up on the screen by looking at the name & demographics at the top of the page.
- Interventions are grouped under Intervention Headers indicated by ~~~~~~. To move from header to header, use the page up & page down keys. To move from individual intervention to individual Intervention, use the up/down arrows. Use this method to highlight the particular intervention that you want, or simply point & click on the appropriate intervention.
- Type in DI or click on the verb strip option Document Intervention. A Date/Time Stamp box will pop up like below. This will allow you to set the ACTUAL date & time that the Intervention was done. Once the date & time are correct, answer “Y” to the “OK?” question.

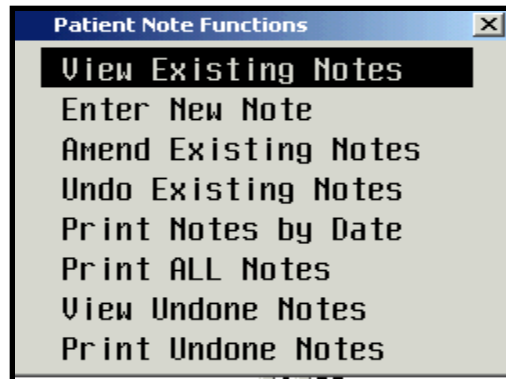


	Date	Time	User	Name	Mgm
1	05/28/08	0937	D.STUDENT	STUDENT,NURSING	NS
2					
3					
4					
5					

Interventions  Occurrences  Ok?

- Once the Documentation screen appears, simply fill in the blanks as appropriate, using the F9 as needed to select the correct responses.

- To enter a Patient Note, type in PN or click on the words of the verb strip. The following pop up box will appear.



- You have the options to Enter, Amend or Undo the Patient Notes. The other options will not be available to you.

**Enter New Note** : Click on or Right Arrow into this option. Choose the Type of Note you want to document, (Students usually use “No Type”) and click on or Right Arrow in. A text box is brought up for you to type in your note. You have the ability to F6 back up to the Date & Time sections of the Note screen in order to make sure it accurately reflects the ACTUAL time the note took place.

**Amend Existing Note** : Use this option when you need to add to or correct a note that you have already written. You will click on or Right Arrow into the option. Then choose the note you want to amend from the list by clicking on it. Click again or Right Arrow in. The original note will show up on the screen, and an empty text box will appear for you to type in your addendum. The system will keep a record that the addendum was made.

**Undo Existing Note**: Use this option when you want to completely remove a note that you have written (either because it's the wrong date/time or the wrong patient). Click on or Right Arrow in and choose the note you want to undo, then click or Right Arrow in again. You will be prompted to give a “Reason for Undo” – do an F9 look-up and choose the appropriate option.

## Documentation Hints for the Intervention Screens

- Dates : Use the format 012304 (no slashes or hyphens), or type “T” for today & today’s date will default in. “T+1” will enter tomorrow’s date, “T-1” will enter yesterday’s date, etc.
- Time: Enter in military format, or type “N” for now.
- Single Response : Single space prompts usually require “Y” for YES or “N” for NO. Sometimes it calls for a number. If you do an F9 look-up, it will let you know if it is looking for “Y”, “N”, or numbers.
- Large Response: Moderate to Long space prompts usually require an F9 look-up in order to choose the appropriate answer from a group response. If it is a free-text box, the F9 will tell you this.
- Comment Fields – This is a free-text field. Type any comment you wish to make on the specific topic associated with that comment field. Larger comment fields that are “scrolling” comment boxes require you to hit the “ESC” key to move on.
- You will not be required to document on *every* Intervention that is listed on the screen. Some of the screens that you *will* want to document on are : Shift Assessment, End of Shift Check off, Nutrition/ADL/Safety, I&O monitor, VS, Selected System Reassessments, Pain Assess/Reassess, and PFE: Patient Family Education. Two of the most frequently used are shown on the next pages.

# Shift Assessment

Adult Shift Assessment x

05/28 0800 NS
000000138834 FLINTSTONE, FRED I I

Date: 05/28/08    Assessment Time: 0800    DNR/CODE Status: DNI    Pt. Age: 97.0

Pt. Location: D.TEST

Neurological WDP: \*    **===NEUROLOGICAL===**    Dev. Delay: N

Dev = Developmental

LOC:     Sensation:

Responds To:     Speech:

Oriented To:     Grip Rt:

Behavior:     Grip Lt:

Facial Dev:     Pupil Reaction Rt. Eye:

   Pupil Reaction Lt. Eye:

   Current Seizure Activity:

**Neurological WDP:**

- Eyes Open Spontaneously
- Oriented x 3 (4)
- Follows Commands
- Facial Symmetry
- PERRLA
- Speech Clear
- Glasgow Coma Scale = 15

**=== GLASGOW COMA SCALE ===**

Eye Response:

Verbal Response:

Motor Response:

Total:

Neuro Comment:

The Shift Assessment is one of the main screens that you will document on. It is a system by system assessment of the patient that also includes documentation on DVT Risk, Fall Risk, Skin Risk, Wounds, IV/CVAD's, Pain, Education, and Safety.

- An Asterisk (\*) means it is a required field.
- "WDP" means Within Defined Parameters. These parameters are found in the pop up box on the right side of the screen.
- If you answer "Y", it will take you down to the comment box. If you answer "N", it will take you to each of the fields under that system for you to document on.
- Once the Shift Assessment documentation is complete, F12 to file.

# Pain Assess/Reassess

The Pain screens will be documented on as needed, and one-hour after any intervention for pain.

Pain Assess/Reval x

05/28 1136 NS D00000138834 FLINTSTONE,FRED11

Time of Pain Assess:

If Unable to Verbalize Pain, 1 = Yes Pain Scale Utilized: \*

Vocal Expression w/Movement: <input type="checkbox"/>	Vocal Expression at Rest: <input type="checkbox"/>
Facial Grimace w/Movement: <input type="checkbox"/>	Facial Grimace at Rest: <input type="checkbox"/>
Bracing w/Movement: <input type="checkbox"/>	Bracing at Rest: <input type="checkbox"/>
Restlessness w/Movement: <input type="checkbox"/>	Restlessness at Rest: <input type="checkbox"/>
Rubbing w/Movement: <input type="checkbox"/>	Rubbing at Rest: <input type="checkbox"/>

Pain Scale (0-10):

===NIPS PAIN ASSESSMENT===

Facial Expression: <input type="checkbox"/>	Arms: <input type="checkbox"/>
Cry: <input type="checkbox"/>	Legs: <input type="checkbox"/>
Breathing Patterns: <input type="checkbox"/>	State of Arousal: <input type="checkbox"/>

Total NIPS Score (0 - 7):

Pain Assess/Reval x

05/28 1136 NS D00000138834 FLINTSTONE,FRED11

Is this a Re-Assessment?

Post Pain Intervention Eval: \* Intervention Eval: \*

Pain Unrelieved, MD Notified:

Location: \*

Quality: \*

Onset: \*

Aggravating Factors: \*

Alleviating Factors: \*

Interventions Taken:

Pain Comment:

# The eMAR Desktop

You will have the ability to view your patient's Medication list from your Process Interventions screen, but you can not administer medications from here. You will have to give medications under the Login of your Instructor.

**Patient Header**

**Med Profile Header**

**Med Profile**

**Integrated Desktop Buttons**

**Constant Navigation Buttons**

Status	Route	Medication	Sched Time	Today		
				Thu	Fri	Sat
Active		Glyburide 5 mg PO QD Glyburide DIABETA	0700	0700	0700	
Active		Glucophage 500 mg PO QMALS Metformin HCl ALERT! This medication is contraind...	0730 1200 1700	0730 1200 1700	0730 1200 1700	0730 1200 1700
Active		Novolin R 10 un SQ WBK Insulin Reg Human Rec High Alert Medication - 2 signatures...	0800	0800	0800	0800
Active		Furosenide 40 mg PO QAM Furosenide	0900	0900	0900	0900

### Using eMAR Desktop

<p><b>Scan Med Process</b></p> <ol style="list-style-type: none"> <li>1. Scan patient armband</li> <li>2. Scan bar code on each medication package</li> <li>3. Complete any screen presented</li> <li>4. Click Submit button</li> <li>5. Click Save and Recompile or Save and Exit button</li> </ol>	<p><b>Edit/Undo Administration</b></p> <ol style="list-style-type: none"> <li>1. Click the administration time of medication to edit</li> <li>2. Change information and data in pop-up box</li> <li>3. Click the Edit or Undo buttons</li> <li>4. Click Submit button</li> <li>5. Click Save and Recompile or Save and Exit button</li> </ol>
<p><b>Full Document - Med Given and Armband Not Scanned</b></p> <ol style="list-style-type: none"> <li>1. Click Other button and click Manual Barcode</li> <li>2. Manually enter patient's account number</li> <li>3. Click to select medication</li> <li>4. Click the schedule time; be sure cursor is on correct date</li> <li>5. Document any information in pop-up box</li> <li>6. Click Document button</li> <li>7. Click Submit button</li> <li>8. Click Save and Recompile or Save and Exit button</li> </ol>	<p><b>Full Document - Med Not Given</b></p> <ol style="list-style-type: none"> <li>1. Click Other button and click Manual Barcode</li> <li>2. Manually enter patient's account number</li> <li>3. Click to select medication</li> <li>4. Click the Sched time; be sure cursor is on correct date</li> <li>5. Review information on pop-up box</li> <li>6. Click "Not given"</li> <li>7. Enter Reason Code (required)</li> <li>8. Click Document button</li> <li>9. Click Submit button</li> <li>10. Click Save and Recompile or Save and Exit button</li> </ol>

# Clinical Review (CR) & Patient Care Inquiry (PCI) - View Patient's Record

## Common Questions :

1. What is Clinical Review / PCI?

Clinical Review & Patient Care Inquiry (PCI) is the ultimate resting place of all our electronic, computer-generated data entry.

2. What can I find there?

Most diagnostic results (labs, radiology, MRI, CT, etc), medications, physician-dictated H&P, all patient care entries such as nursing or other assessments, clinical notes, VS, I&O...almost any data entered into the Meditech system.

3. Can I print from CR / PCI?

No. Only the staff have access to print from PCI.

4. Who looks at CR / PCI?

All who have the security access to that particular patient: Physicians, Nurses, therapists, dieticians, respiratory therapists...all care givers for that patient. In addition, the Physician office staff can look into PCI for their own patient's records.

5. Where can CR / PCI be accessed?

From wherever the individual logs on. However, students are restricted by location, so you can only access PCI for a patient from a computer on the particular floor where that patient is located.

6. Once I access CR / PCI, how do I move around?

You can use the mouse to click on the item that you want to access further, or use the arrows keys to go into and out of the option & information screens.

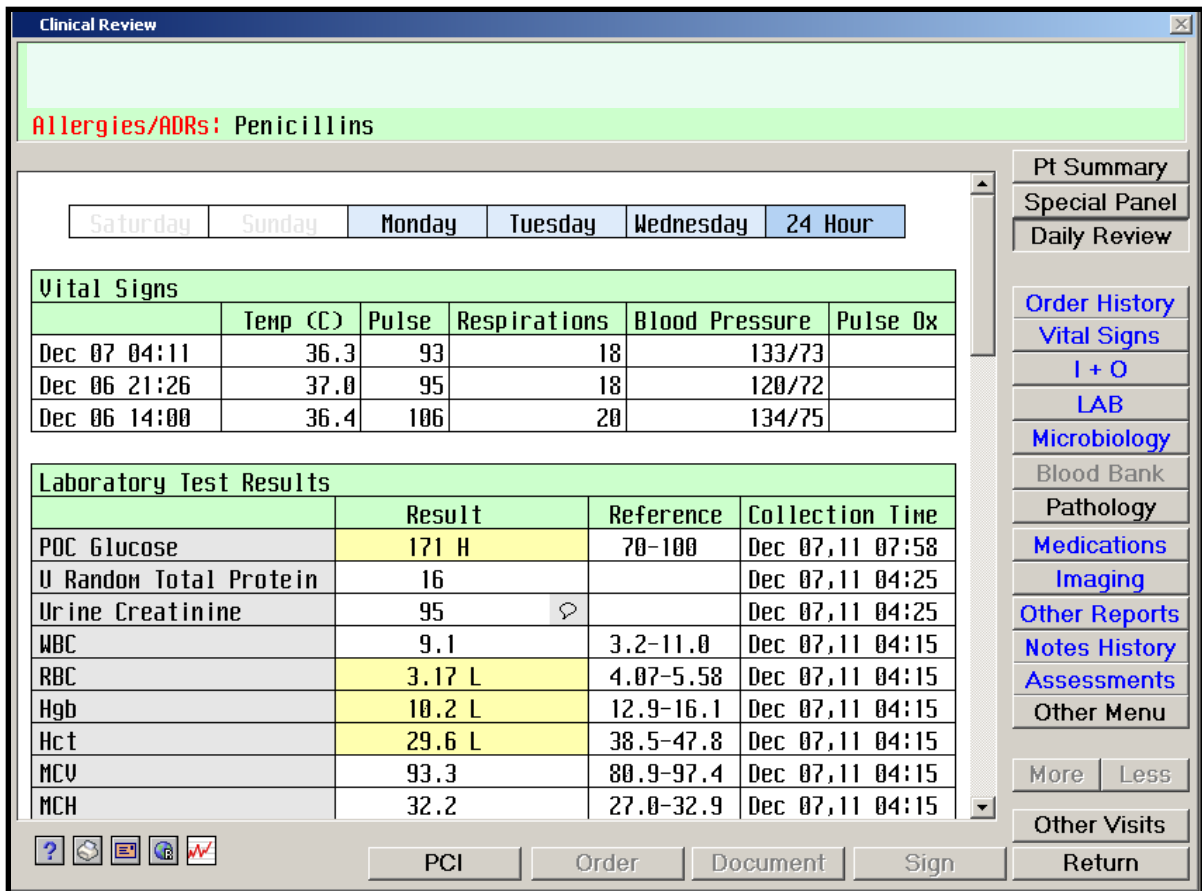


# Accessing Clinical Review & PCI -

Choose the Patient – type in their Last name & do an F9 look up.



A dialog box titled "View Patient Record" with a close button (X) in the top right corner. It contains a text input field labeled "Patient" with a cursor inside, ready for text entry.



The "Clinical Review" screen displays patient information and various data tables. At the top, it shows "Allergies/ADRs: Penicillins". Below this is a navigation bar with buttons for "Saturday", "Sunday", "Monday", "Tuesday", "Wednesday", and "24 Hour". The main content area is divided into two sections: "Vital Signs" and "Laboratory Test Results".

**Vital Signs**

	Temp (C)	Pulse	Respirations	Blood Pressure	Pulse Ox
Dec 07 04:11	36.3	93	18	133/73	
Dec 06 21:26	37.0	95	18	120/72	
Dec 06 14:00	36.4	106	20	134/75	

**Laboratory Test Results**

	Result	Reference	Collection Time
POC Glucose	171 H	70-100	Dec 07,11 07:58
U Random Total Protein	16		Dec 07,11 04:25
Urine Creatinine	95		Dec 07,11 04:25
WBC	9.1	3.2-11.0	Dec 07,11 04:15
RBC	3.17 L	4.07-5.58	Dec 07,11 04:15
Hgb	10.2 L	12.9-16.1	Dec 07,11 04:15
Hct	29.6 L	38.5-47.8	Dec 07,11 04:15
MCV	93.3	80.9-97.4	Dec 07,11 04:15
MCH	32.2	27.0-32.9	Dec 07,11 04:15

On the right side of the screen is a vertical menu of buttons: "Pt Summary", "Special Panel", "Daily Review", "Order History", "Vital Signs", "I + O", "LAB", "Microbiology", "Blood Bank", "Pathology", "Medications", "Imaging", "Other Reports", "Notes History", "Assessments", "Other Menu", "More", "Less", "Other Visits", and "Return". At the bottom of the screen are buttons for "PCI", "Order", "Document", "Sign", and "Return".

When the Clinical Review screen comes up, use the buttons on the right side to access the information that you want to see. Blue buttons mean there is new data to see, black buttons means it contains older data. A grayed out button means there is no data available. Gray fields allow you to dial in for further information. The PCI button at the bottom will take you to the PCI screen.

# This is the Table of Contents ( or **Data Source**) Window

The screenshot shows a software window titled "Data Sources" with a subtitle "8 Days". At the top, there are input fields for patient information: "Pt FLINTSTONE, FRED11", "Unit # 0000000005", "Age/Sex 97 M", and "User D.STUDENT". Below this, another field shows "Rm 0.TEST 0.9999 66 (Adm: 05/19/08)".

Below the patient information, there are several checkboxes: "Time", "Mail", "Select(111)", "Allergies\*", and "Highlight".

The main area of the window is a list of data sources. The first item, "Admissions Demographic Data", is highlighted in black. To its right, the text "<Bulletin Board Data is NOT Displayed>" is visible. The list of data sources includes:

- Admissions Demographic Data
- Visit History
- Vital Signs
- Orders
- Medication Orders History
- Laboratory Data
- Microbiology Data
- Radiology Reports
- Intake and Output Summary
- Assessment Forms
- Plans of Care
- Patient Care Notes
- MICROMEDEX
- Psychiatric Nursing Queries
- Admission Assessment Queries
- Vital Signs Queries
- Intake and Output Queries
- Neurologic Queries
- Cardiology Queries
- Respiratory Queries

On the right side of the window, there is a vertical toolbar with various icons, including a question mark, a magnifying glass, a printer, a star, a checkmark with "ACL", and several arrows (left, right, up, down, and a double down arrow).

Use the up/down arrows or the mouse to point & click in order to highlight the topic that you want to enter

When you right arrow into (or double click on) the selected topic, you reach the **Summary Window**. (For some topics, you may have to make a few more choices before you reach this point.) The Summary Window lets you see a summary of all the information available on a selected topic.

The screenshot shows a window titled 'CHEMISTRY Summary' with a date and time of 'Wed - May 28 (13:11)'. The patient information is as follows:

Pt **FLINSTONE, FRED11** Unit # **D000000005** Age/Sex **97 M**  
 Rn **D.TEST D.9999 GG (Adm: 05/19/08)**

Below the patient info is a control bar with the following options:  Split, Mail, Time, Highlights, Jump (Assmts).

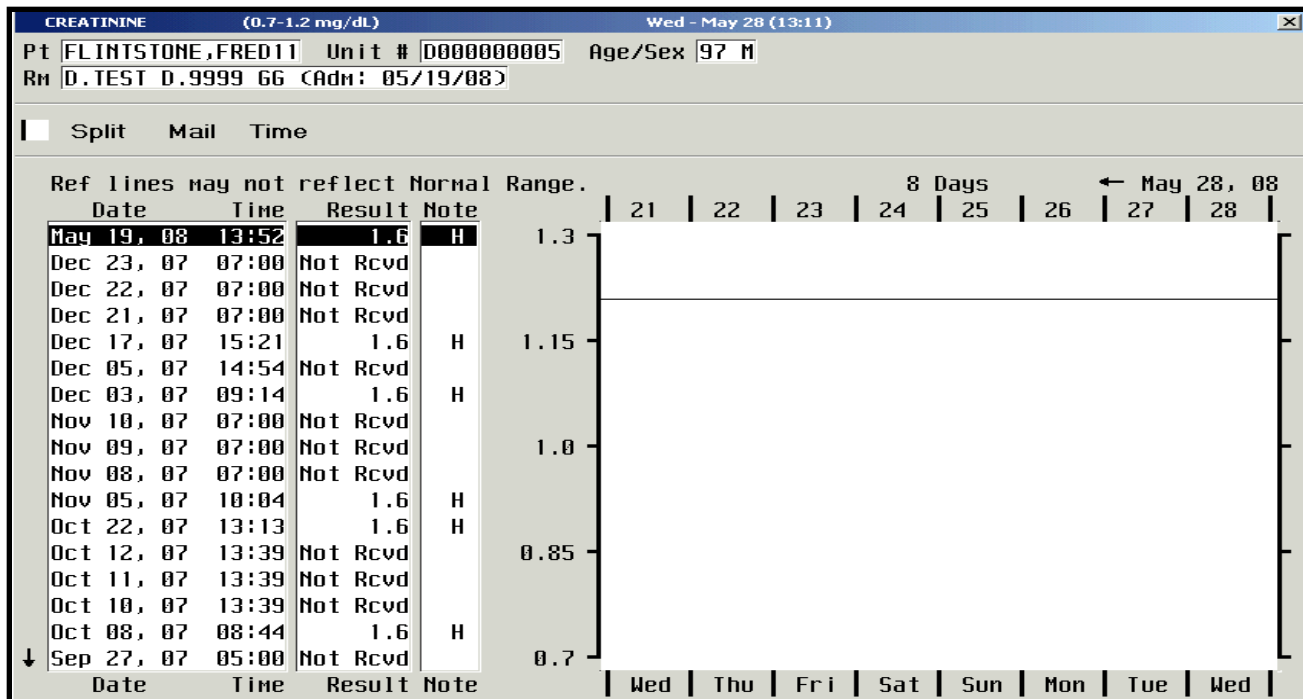
The main area is a 'Timeline' showing test results. The header indicates '+ = available, - = unavailable' and shows a view of '8 Days' ending on 'May 28, 08'. The timeline columns are labeled 21 through 28. The 'Test' column lists various tests, and the 'Date' column shows when each test was performed.

Test	Result	Flag	Date	Time	21	22	23	24	25	26	27	28
[BASIC MET PANEL]			(Apr 30, 04)									
NA			(Apr 30, 04)									
K			(Apr 30, 04)									
CL			(Apr 30, 04)									
CO2			(Apr 30, 04)									
ANION GAP												
GLUCOSE			(Apr 30, 04)									
BUN			(Apr 30, 04)									
CREATININE			May 19	13:52								
EST CRCL CG/IBW			(Jun 09, 06)									
EST CRCL CG/ABW			(Jun 09, 06)									
CALCIUM			(Apr 30, 04)									
CK												
[UR COCAINE]												
CHN OF CUSTODY												
COCAINE METABOL												

At the bottom of the window, there is a navigation bar with labels: Test, Result, Flag, Date, Time, Wed, Thu, Fri, Sat, Sun, Mon, Tue, Wed.

- Small white arrows on the far left of the screen let you know there are more lines to look at by scrolling up & down the list using the Up/Down arrows.
- The verb strip at the top tells you which functions you may perform at this level.
- To go to the next level, highlight the desired test or topic and either Click or Right Arrow in.

This is the **History Window**. It gives a history of all the tests/data In the particular category that was selected. Use the Up/Down Arrows or point and click to highlight the desired item, then click Again or Right Arrow in.



This **Detail Window** is as far as the Right Arrow will take you. It gives you The final details of the one particular item that was selected.

