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.

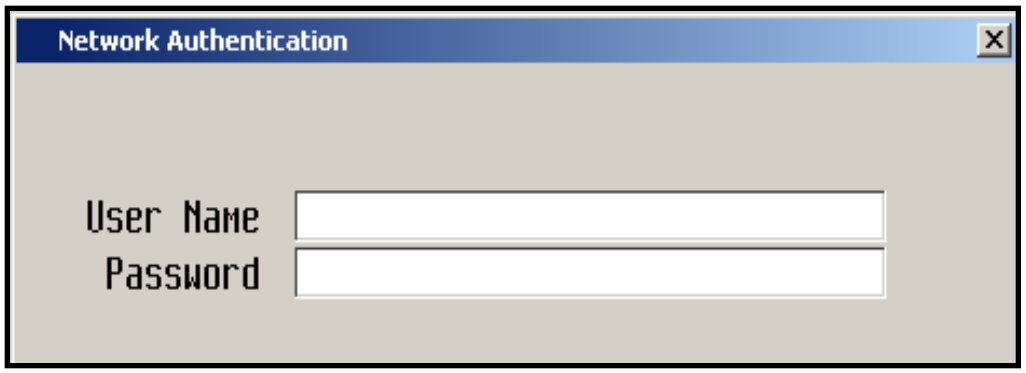
Always exit to “goodbye” when you have finished so that no one can work after you using your log-on.

Function Key/ Quick Strokes Cheat Sheet

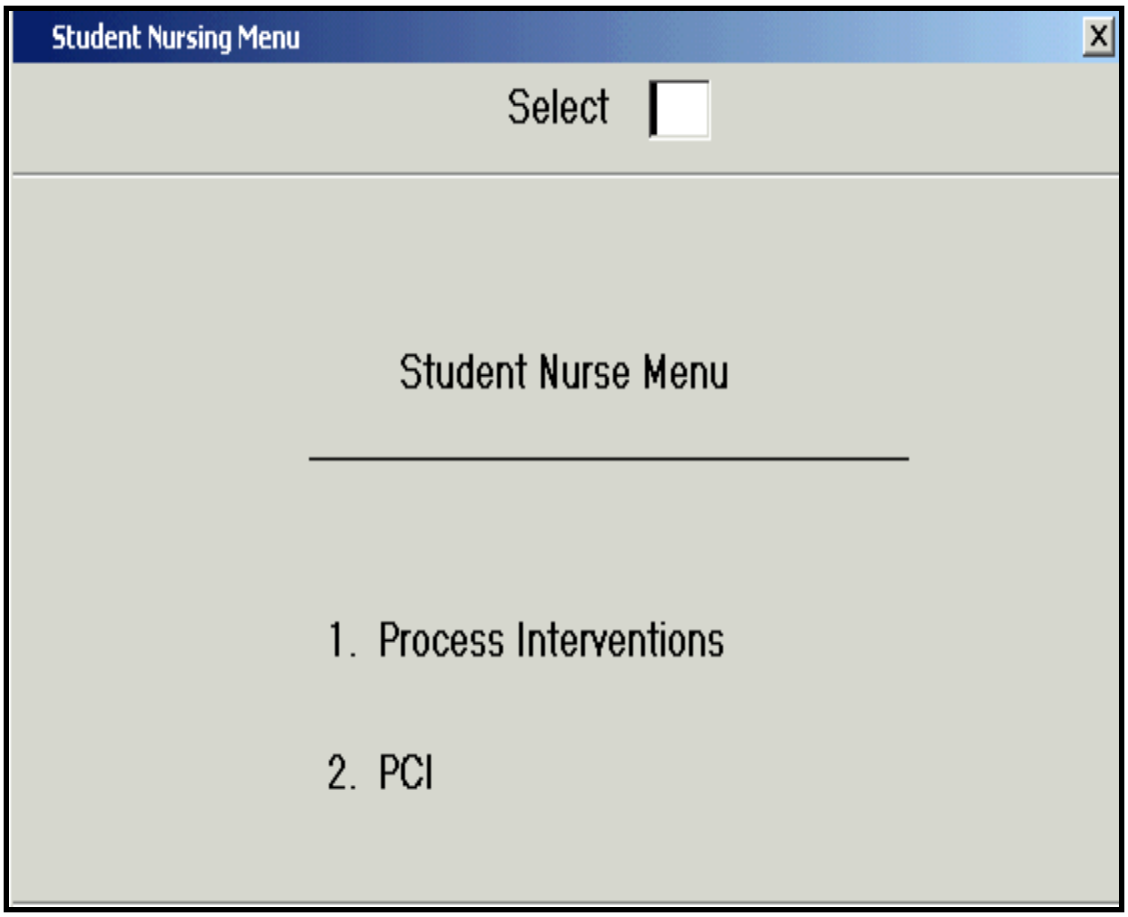
You Want To …	Hit Key or Click Icon
Save Information or send and email	F-12 
Exit without saving	F-11 
Recall last patient accessed	Space bar, enter
Erase the entire line	F-10
Look up list of defined answers	F-9 
Move cursor to end of list	F-8 
Move cursor to beginning of list	F-7 
Move cursor back one field	F-6
Recall last answer (if allowed)	F-5
“Get” i.e. canned text	F-4
Escape out of current window	Esc
Check or uncheck highlighted item	Right Ctrl 
Check or uncheck ALL items	Shift Right Ctrl 
Move cursor to right, left, up, or down	Arrows 
Move further into a function	R arrow or Shift R arrow
Delete the character the cursor is on	Delete
Move the cursor left and remove the character	Backspace
Access additional menu	Shift F-12 
Suspend your session	Shift F-12
Spell Check/Dictionary/Thesaurus in MOX	Shift F-9
Join lines in MOX	Shift F-6
Colors/Italics/Bold/Underline in MOX	F-1 at beginning of characters, F-2 at end of characters
Calendar/Calculator	
Name Look Up	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.

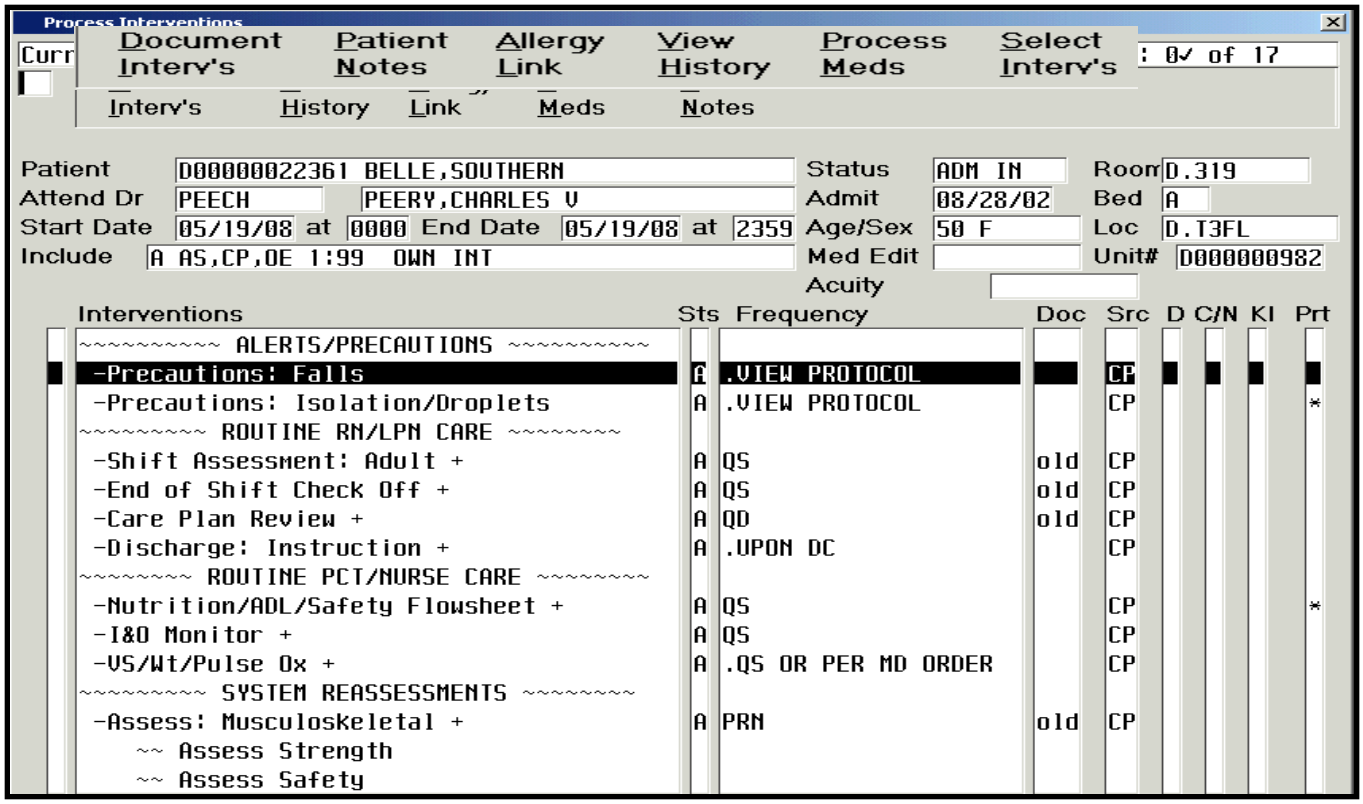


Once you have logged in, you may or may not be given a menu options choice. If you are given a choice, choose the option that starts with “NUR”. This will take you to your student menu as seen below.



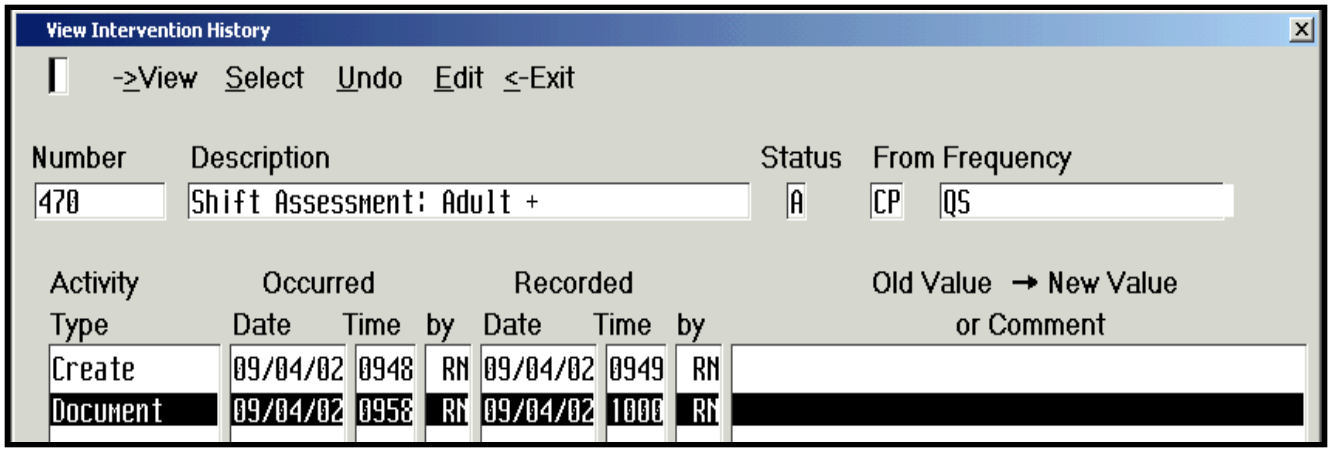
The Process Interventions option is where you will do all of your daily documentation. The PCI (or Patient Care Inquiry) option will take you in to view your patient’s electronic medical record via Clinical Review or PCI.

PI -Process Interventions Screen



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 : 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)

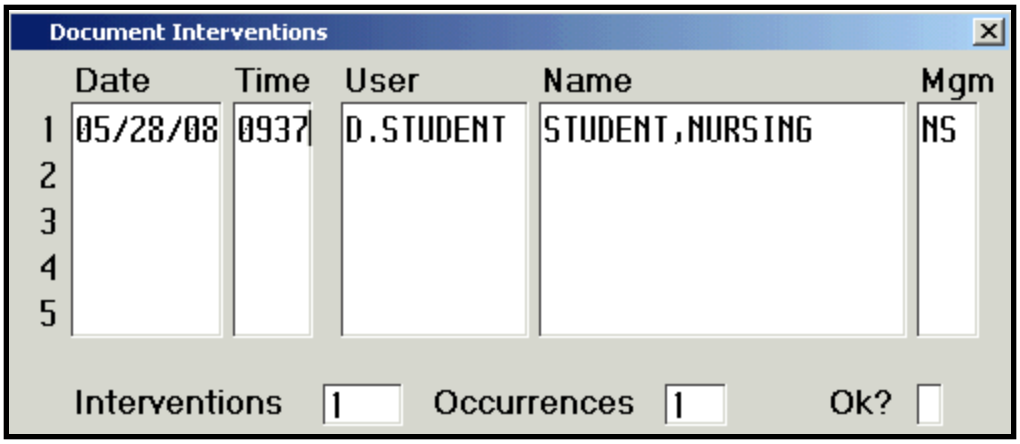
- **D** (Duplicate) column displays a “D” if the intervention is a duplicate.

- **C/N** & **KI** – not used here at Trident

- **Prt** (Protocol) column displays an * if a protocol is attached to that intervention.

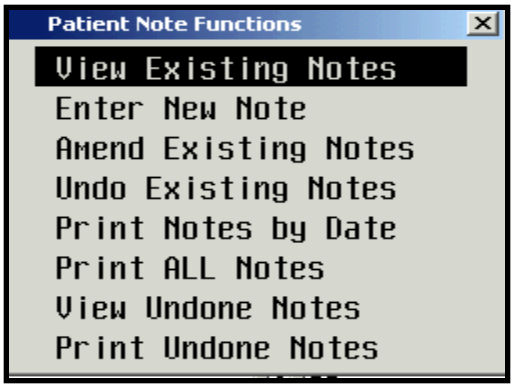
How to Document in Process Interventions

- 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.



- 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.

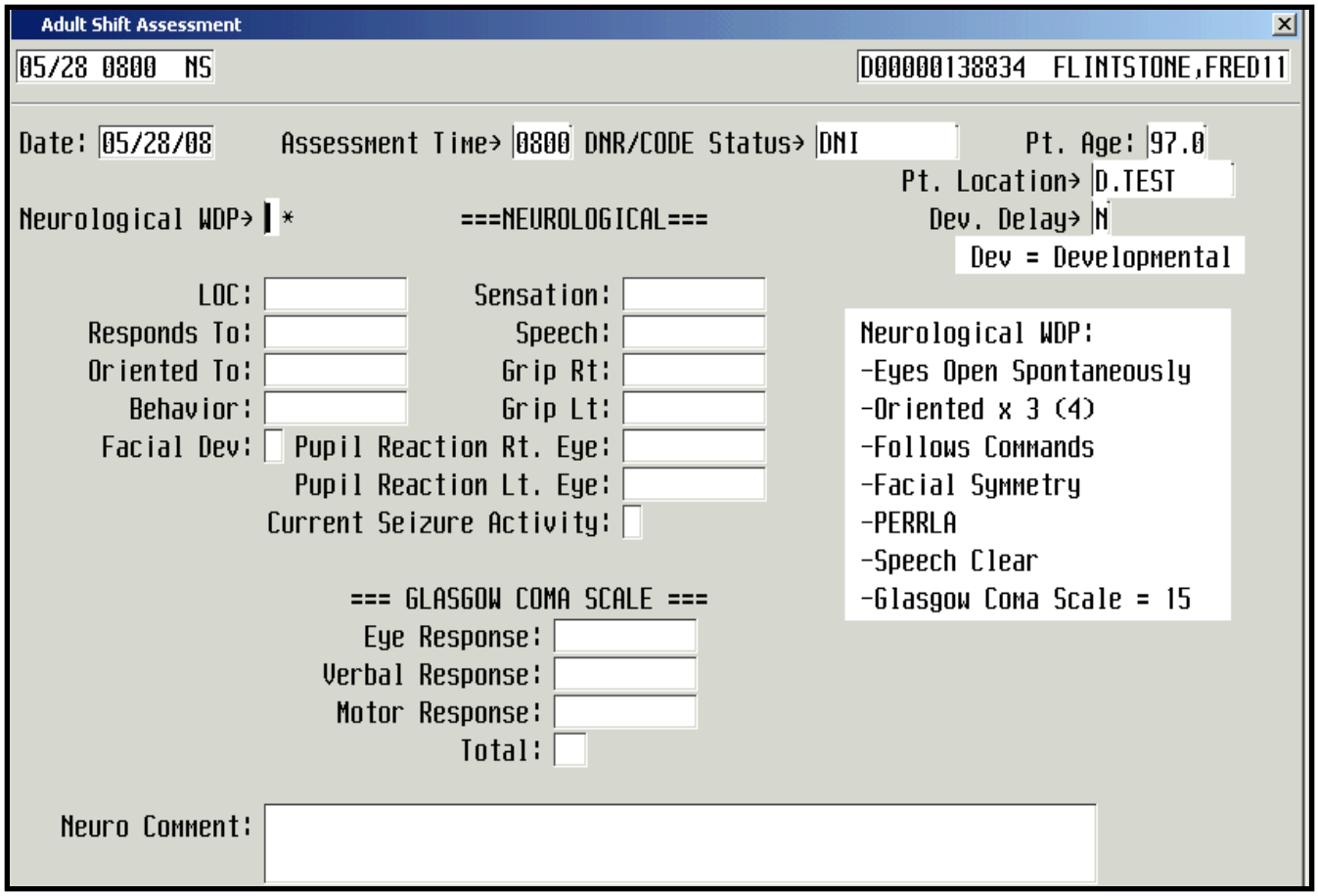
- Single Response : Single space prompts usually require “Y” for YES or “N” for NO. Sometimes it calls for a number. If you do an F9 look-up, it will let you know if it is looking for “Y”, “N”, or numbers.

- 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

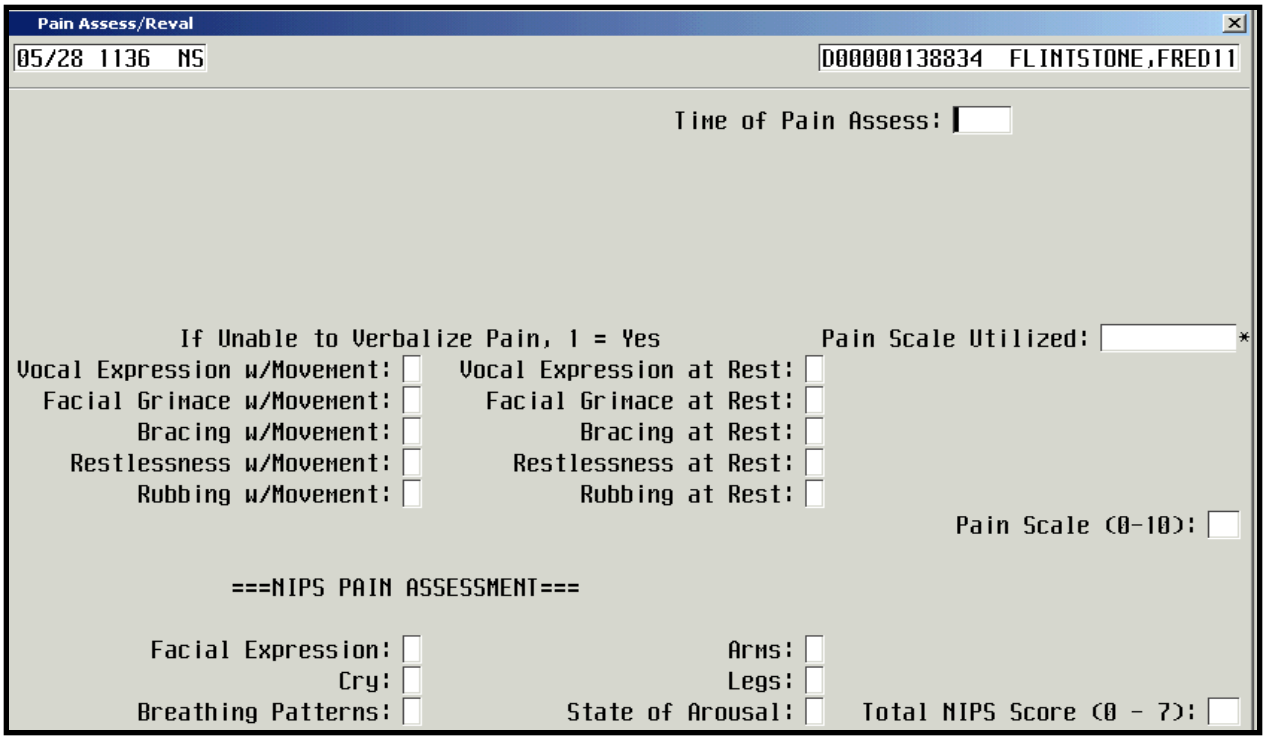


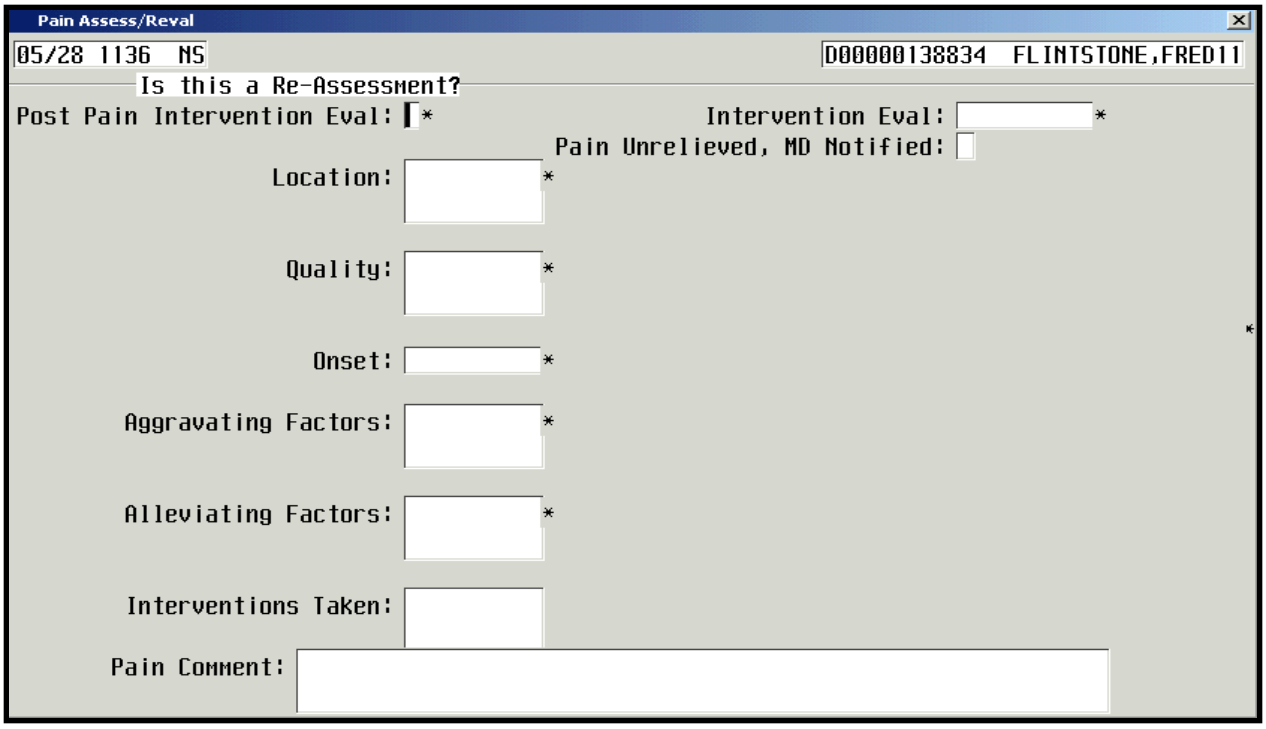
The Shift Assessment is one of the main screens that you will document on. It is a system by system assessment of the patient that also includes documentation on DVT Risk, Fall Risk, Skin Risk, Wounds, IV/CVAD's, Pain, Education, and Safety.

- 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

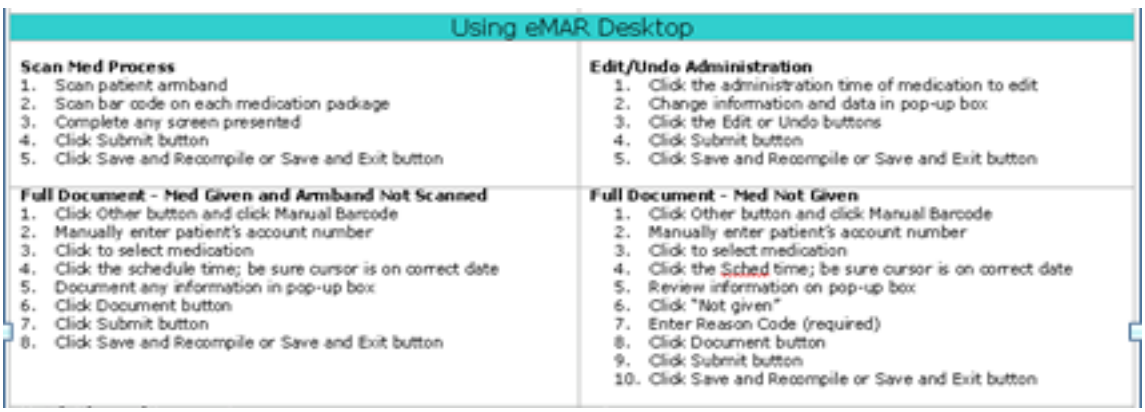
The Pain screens will be documented on as needed, and one-hour after any intervention for pain.





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.



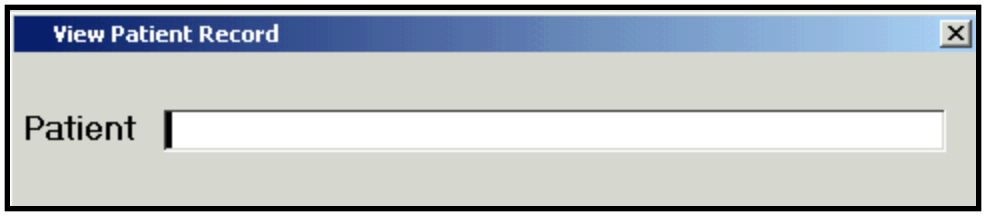
Clinical Review (CR) & Patient Care Inquiry (PCI) - View Patient's Record

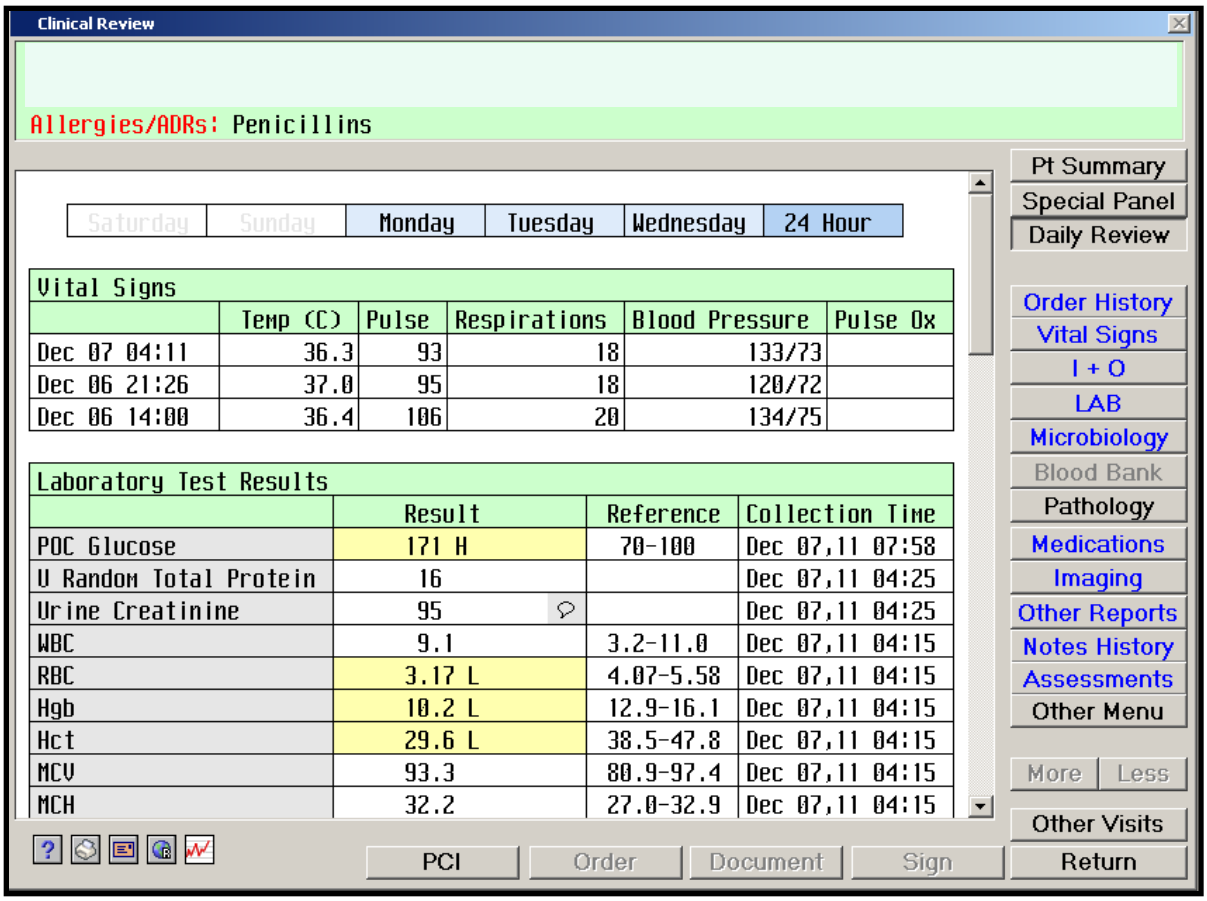
Common Questions :

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 -

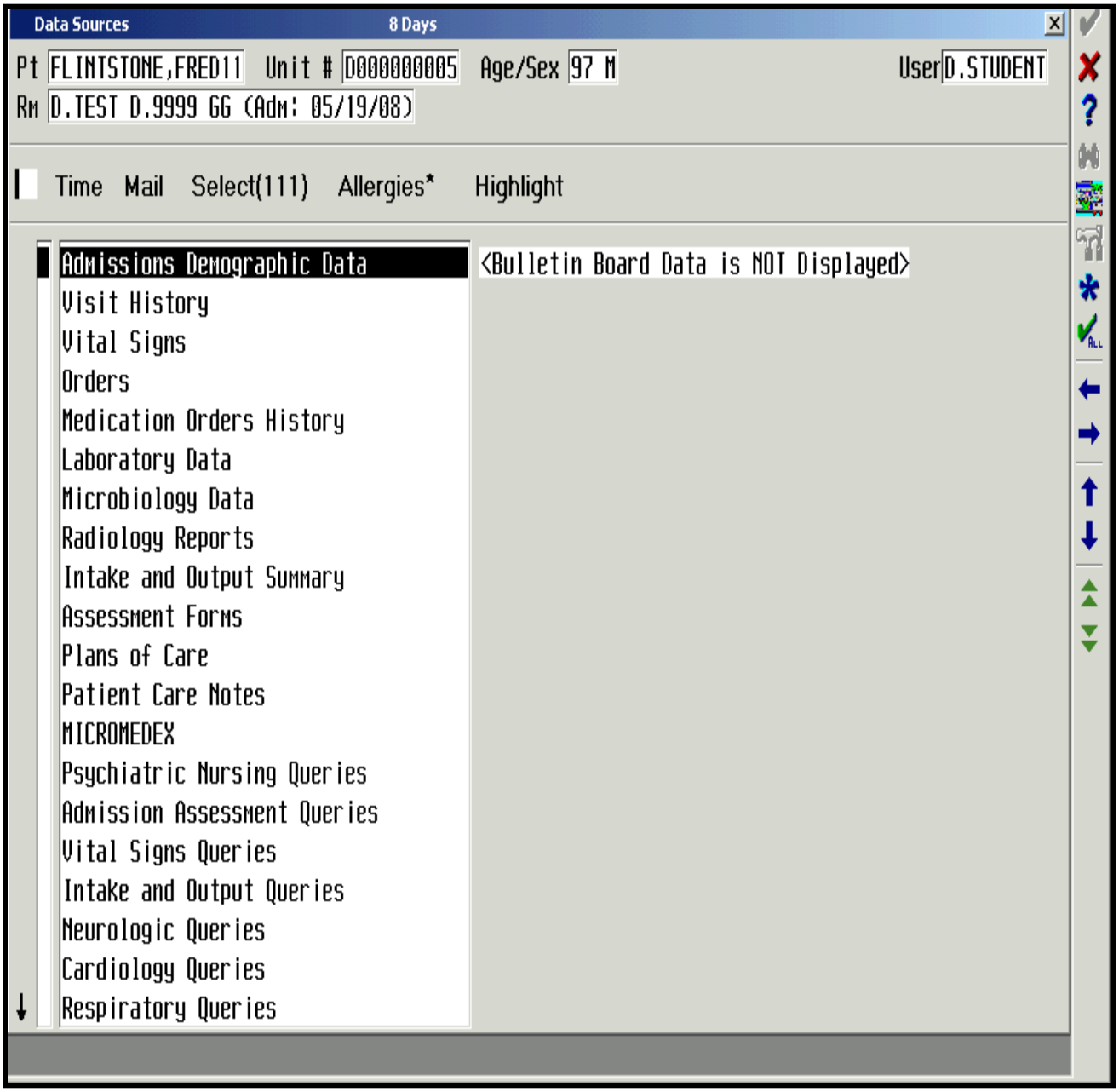
Choose the Patient – type in their Last name & do an F9 look up.





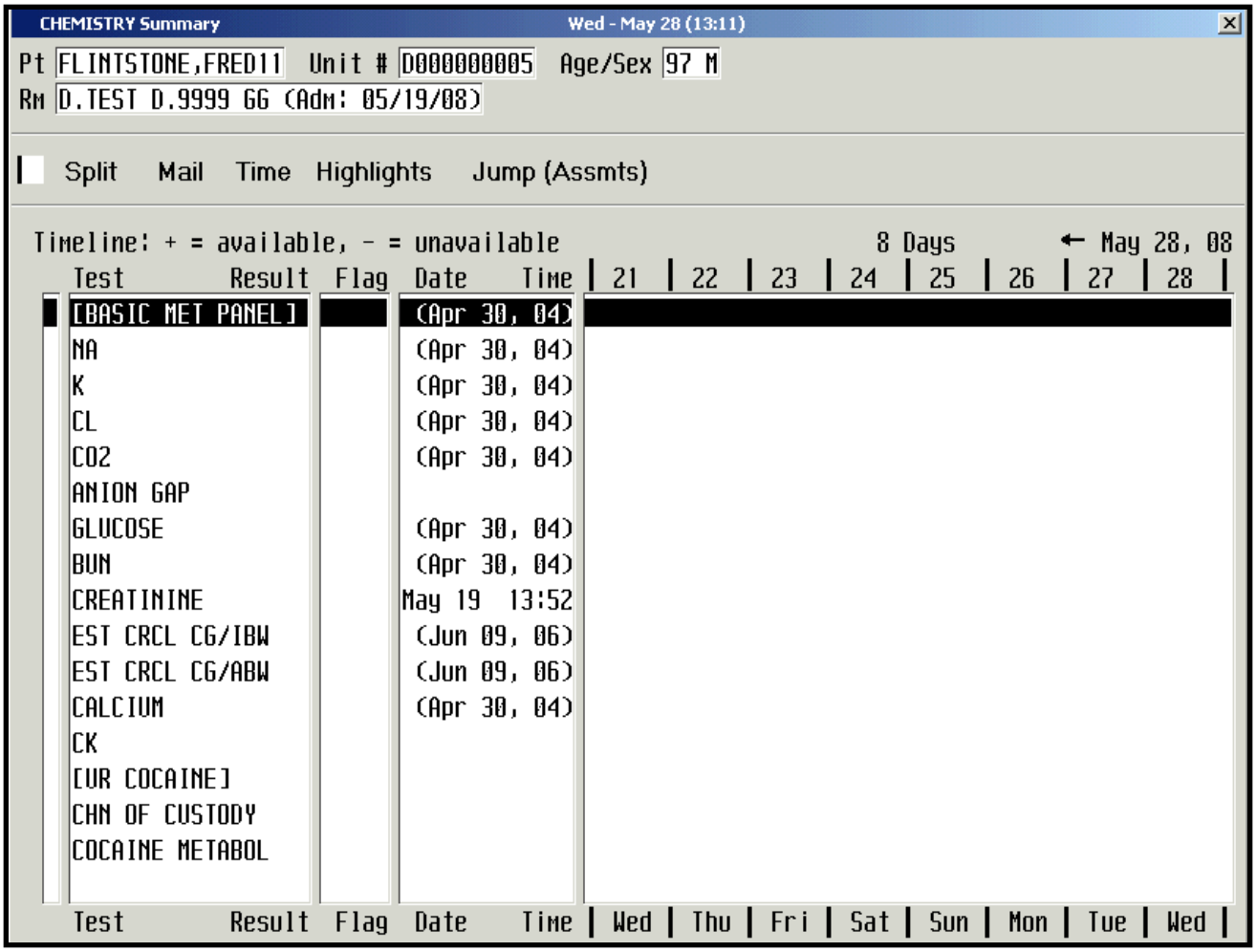
When the Clinical Review screen comes up, use the buttons on the right side to access the information that you want to see. Blue buttons mean there is new data to see, black buttons means it contains older data. A grayed out button means there is no data available. Gray fields allow you to dial in for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



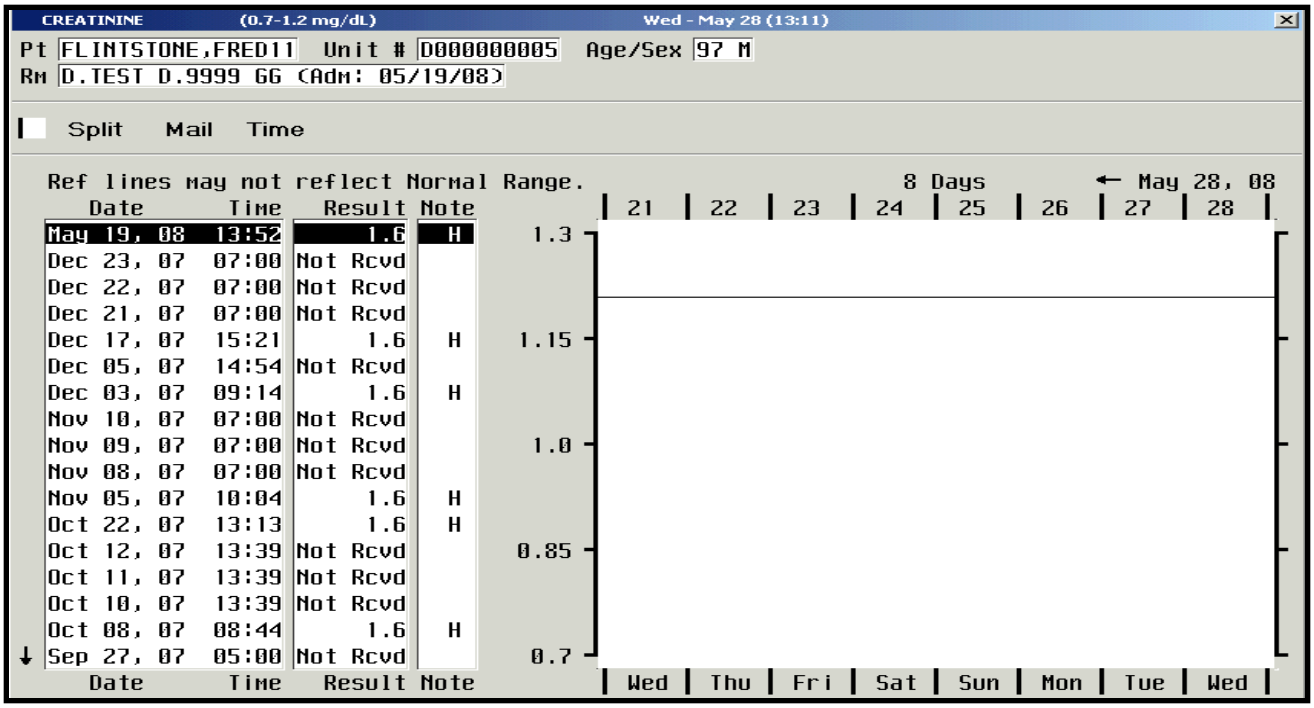
Use the up/down arrows or the mouse to point & click in order to highlight the topic that you want to enter

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.



- 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.