For assistance, contact the Customer Service Center at 3-7272 (PCPC)

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For more training options, visit www.navicenthealth.org Hover over “For Health Care Professionals” and choose “EHR education, Training and Support”. Review the Nursing Staff Folder

### Important Icons:

<table>
<thead>
<tr>
<th>Icon</th>
<th>Definition/Details of Icon’s use</th>
</tr>
</thead>
<tbody>
<tr>
<td>📕</td>
<td>Add Allergy. Click to add an allergy.</td>
</tr>
<tr>
<td>📕</td>
<td>Add Order. Click to add an order.</td>
</tr>
<tr>
<td>🌴</td>
<td>PowerPlan. Indicates a PowerPlan or an order placed as part of a PowerPlan</td>
</tr>
<tr>
<td>☰</td>
<td>Indicates a care set orderable.</td>
</tr>
<tr>
<td>🕰️</td>
<td>Proposed Order, do not act upon until MD signs and Icon disappears</td>
</tr>
<tr>
<td>✅</td>
<td>Active and Inactive Orders. A check mark indicates active.</td>
</tr>
<tr>
<td>🚫</td>
<td>Order Details Not Complete.</td>
</tr>
<tr>
<td>🕵️</td>
<td>Launches the dose calculator</td>
</tr>
<tr>
<td>📲</td>
<td>Nurse Order Review is required</td>
</tr>
<tr>
<td>📜</td>
<td>Denotes that this order is a prescription.</td>
</tr>
<tr>
<td>🢿</td>
<td>Indicates that physician cosign is required.</td>
</tr>
<tr>
<td>🚫</td>
<td>Indicates that the physician refused to cosign.</td>
</tr>
<tr>
<td>🎧</td>
<td>Indicates the order has not been reviewed by a pharmacist.</td>
</tr>
<tr>
<td>🎧</td>
<td>Indicates that a pharmacist has rejected the order.</td>
</tr>
<tr>
<td>🕒</td>
<td>Order has reached its stop date &amp; time.</td>
</tr>
<tr>
<td>📃</td>
<td>Documented Medications by History or Home Meds. NOT orders until converted by MD</td>
</tr>
<tr>
<td>🕒</td>
<td>Active Med orders in PowerChart</td>
</tr>
<tr>
<td>🕒</td>
<td>Hard Stop Renewal - medication has defined stop time.</td>
</tr>
<tr>
<td>💡</td>
<td>Order Modification-- order was modified. May require further research as to what changes were made</td>
</tr>
<tr>
<td>🖥️</td>
<td>Indicates Pharmacy Comment attached to order. Click to view. On CM device, tap &amp; hold med, click “COMMENTS” to review.</td>
</tr>
<tr>
<td>🗨️</td>
<td>Indicates a clinician communication comment is attached Click to view. On CM device, tap &amp; hold med, click “COMMENTS” to review</td>
</tr>
<tr>
<td>🕒</td>
<td>I &amp; O Volume icon (CareMobile), click to change or update volumes PRN</td>
</tr>
</tbody>
</table>

Remember Computer Technology DOES NOT replace Verbal communication!
**PowerChart Basics Patient**

**Access List (PAL)**
- ✔ Used as “To Do” List for the day
- ✔ Click on Patient Access Button at anytime to return to this view

**Patient List View**
- ✔ Click to select patients for your CUSTOM list

**Add Existing Patients to Custom List**
- ✔ Patient List ➔ Highlight patient ➔ Hold down CTRL on keyboard ➔ Click additional pts ➔ Let go of CTRL Button ➔ RIGHT Click BLUE area ➔ Hover over “Add to a Patient List” ➔ Choose your Name ➔ Click OK ➔ Go back to Patient Access List Button ➔ Click “X minutes ago” button

**Manually Add Patient to Custom List**
- ✔ In a “Custom” List Go to Add Patient Icon ➔ Enter FIN # ➔ Double Click encounter in lower box
- ✔ If did not work, is unit list displayed instead of list with your name on it? If so, see “Changing Displayed List on the PAL” below then repeat 1st step

**Remove Patient from Custom List**
- ✔ In Custom List ➔ Highlight patient ➔ Click Remove Patient Icon

**Changing the Displayed List on the PAL**
- ✔ RIGHT click on “Encounter Specific” Banner ➔ Choose “Change Patient List” ➔ Click desired unit list ➔ Click OK (may need to establish relationship)

**SBAR**
- ✔ Use as Adjunct to Patient Handoff Report during shift report

**Patient Name Banner**
- ✔ Viewable inside a Patient Chart
- ✔ If T-20 beside their name identifies a patients who has a personal case manager to reduce visits & readmissions

**Review Orders from PowerOrders Screen**
- ✔ ALWAYS DO this process at beginning of shift!!
- ✔ Enter patient chart ➔ Go to PowerOrders/Orders Menu ➔ click “Orders for Nurse Review” Button (bottom of screen)
- ✔ Non-CPOE orders: compare each order to paper orders, if correct, click Review.
- ✔ CPOE Orders:
  - No written order exists, this is “noting” orders; always use nursing knowledge and skill to evaluate safety of order. Notify pharmacy or MD if ever in question.

**NOTE:** 1) If error noted, do not immediately review, after items are corrected THEN Review to clear them from the column. 2) Column should be empty at the end of the shift

**Review Orders from PAL**
- ✔ Only use this process after reviewing in PowerOrders at beginning of shift
- ✔ Double-Click eyeglass icon ➔ Review as instructed

**Complete NON-Med Reminder on PAL**
To prevent opening tasks you do not wish to open, DO NOT click “Quick Chart” or “Chart” buttons with all items checked
- ✔ To chart task as done:
  - Double-Click Heart Icon ➔ Find specific task you wish to complete ➔ RIGHT-click ➔ Choose CHART DETAILS ➔ Complete required items ➔ Sign
- ✔ If task is not performed:
  - RIGHT-click ➔ Choose CHART NOT DONE ➔ Enter reason (ex. duplicate, NPO, etc.) ➔ Sign
- ✔ To reschedule a task:
  - RIGHT-click ➔ Choose “RESCHEDULE THIS TASK” ➔ Enter future time ➔ Enter reason for the reschedule ➔ Sign

**NOTE:** complete ALL tasks scheduled on your shift BEFORE end of shift and heart will disappear (unless others left undone tasks)

**Change Displayed Dates on Tabs**
- ✔ Where ever banner displayed, Right-Click Date/Time ➔ Choose Change Search Criteria ➔ Enter desired date or other criteria ➔ Click OK

**Ad Hoc Charting**
- ✔ Inside Patient Chart, click Ad Hoc Icon ➔ Double click desired form ➔ Change performed as necessary ➔ Complete details in EACH section shown on Left side of the form ➔ Sign

**Results Review**
- ✔ Used for reviewing Documented Data such as Nursing Doc, Lab/Rad Results, Transcribed Docs, Blood Cultures, and “other” Flow sheets
- ✔ Click Results Review Section ➔ Click Desired Tab for needed results ➔ Double-click the result to view ALL details of the result.

**History Menu**
- ✔ Used for reviewing previous charts and documents
Using Navigator in Results Review Area
- In Results Review Menu ➔ click desired Flow sheet Tab ➔ Locate Navigator View window ➔ Click Blue “Section” Button to bring desired items into view

Change Filters in Results Review Section
- Click on the Results Review section then desired Flow sheet Tab ➔ Click Table, Group, or List
- **Table Filter:**
  - Date & time across top, item to LEFT (best for one point in time)
- **Group Filter:**
  - Date & time down side, item across top (best for seeing trends)
- **List Filter:**
  - Reads like a book & shows reference ranges for lab values

Print Reports
- In chart, click Task (top LEFT of screen) ➔ Click Reports ➔ Click desired report(s), Enter Printer Name ➔ choose Print

View Orders or Quality Measure Plans
- PowerOrders Menu ➔ Click desired Plan/Order Category in View Window ➔ Orders on right side ➔ Use Filter pull down menu at top of section to sort active vs. D/Cd, completed, etc.

Entering Allergy Data
**NOTE:** Must always address Medication Allergies even if has another type of allergy
- To enter that there are no allergies of any kind, click the NKA button at top of Allergy Section ➔ enter info source ➔ click OK
- To enter that the patient has no Medication allergies but is allergic to another substance, click NKMA button ➔ enter info source ➔ click OK then follow steps below to enter allergy
- To enter any allergy:
  - Select Allergies Menu ➔ Right Click in white box ➔ Choose add new-drug allergy (or add new- other) ➔ Type drug/substance name into Search Field on left ➔ click Search ➔ Double-click substance in lower left window ➔ Verify correct category on right (drug, food, etc.) ➔ On left side, Select reaction type ➔ Type reaction into Search box ➔ Click Search ➔ Double-click reaction in window ➔ Complete other pertinent info ➔ Click OK

MED RECONCILIATION
**IMPORTANT: FOLLOW Step-by-Step:** Data must be correct; MD/Provider will use to write orders and prescriptions. In Non-CPOE Areas print Med Summary- Admission report for MD to review & sign.

- Full Medication Reconciliation must be completed on Admission, Transfer to different level of care, and at Discharge.
- In Medication List Menu, if Home Med List has been updated, a green check will display:

  ![Status](Med History 1 Adm, Med Rec 1 Disch, Med Rec)

- If Not, a Blue exclamation will display:

  ![Status](Med History 1 Adm, Med Rec 1 Disch, Med Rec)

**IMPORTANT:** Before starting, please see important notes below:
- **NOTE:** DO ALL steps before doing Admission Assessment

**(STEP 1) Set up Patient Preferred Pharmacy:**
- Click Patient Preferences ➔ If not visible click drop down arrow at end row where “AdHoc” Button is.
- Search screen displays—Preferred Pharmacy is not set up. Verify w/ patient where prescriptions should go.
- Enter city/state where they want to pick up prescriptions ➔ enter pharmacy name ➔ click search
- Right click pharmacy ➔ choose “add”
- Click Patient Preferred Tab, default pharmacy is at top
- If more than one pharmacy listed, to change default pharmacy, right-click ➔ choose “set as default”

**(STEP 2) Checking for Insurance Plans:**
- In PowerOrders Menu, click on [Rx Plans] ➔ Button ➔ Click on [Eligibility Details] ➔ Click OK ➔ refresh screen

**(STEP 3) Import Pharmacy History & Update Home Meds Already Listed:**
- In PowerOrders Menu, click on [External Rx History] ➔ click Import ➔ Click [Content Shared] if this displays.
- Adjust filter on External History ➔ Last 6 Months to desired timeframe
- Left side—Pharmacy history of filled Rx (if their pharmacy subscribes to SureScripts)
- Right side—“Document Medications by Hx” screen.
- Review all data already listed on the right side of the screen
- **Pt still on med & details are unchanged:** right click med ➔ choose “add/modify compliance” ➔ enter compliance info. ALWAYS document last dose DATE and TIME even if estimate.
- **Patient no longer prescribed a med or the details of the RX have changed:** right-click it ➔ choose “Complete”. If this option is not available choose “DC/Cancel” and enter a reason
- **If a mistake was made when entering med:** if not yet signed (drug name displays black) right-click ➔ choose...
“Remove”; if signed (drug name displays blue), right click it→choose “void”

- **Now review Rx Meds on the left side of the screen:**
- Rx with 🏥 were filled but are not listed in the Document Medications by History (on the right),
- Discuss with patient, to add click the scroll icon 📦
- Highlight med under 🛍 Pending Home Medications header (on right) to complete details
- Complete compliance on Compliance tab 📋. ALWAYS document DATE & TIME of last dose even if estimate.
- Click the drop down arrow to return to list

(STEP 4) **Enter New Home Medications not on either side**

- This could include OTC or samples, or meds from a pharmacy not subscribing to SureScripts such as VA or RAFB etc.
- Click 🚀 (top left)→Type drug name in “Search” field
- Choose appropriate med/dosage→choose closest match if order sentences display (any fields can be changed later)
- Don’t enter all details now; that will be done after all med names are chosen. Continue to Search meds until all have been entered (without hitting “DONE” button)
- When all med names are found, then click DONE
- ✗ Highlight first drug with a SINGLE click on the drug
- Update/add info by clicking in the boxes for Dose, Route, Frequency and PRN if applicable
- Click the next med and repeat from ✗ until all medication information data is entered.

**NOTE:** If unable to find medications, use MicroMedex for spelling! If still cannot find, CONTACT Pharmacy at 3-1435. Do not Free Text drug without first contacting pharmacy!!

- If patient does not know name of medication and not in Pharmacy History, type “Misc Medication” into “Search” field
- Click 🎨 Freetext Drug Name 🎨, enter med description (ex. “little blue pill for BP”)
- Enter other available details, when entering compliance, in the first pull down menu choose “Investigating”, enter comment such as “husband to bring pill bottle”
- **ALWAYS enter Compliance Info on all MEDS:**
  - Enter Status, Information Source & last dose date/time, estimate if necessary. Use CTRL key to enter like details: Example-If half of pills taken today at breakfast, hold down CTRL key and click each med taken at breakfast enter today at 8:00am
  
- When finished with History, Uncheck the Leave Med History Incomplete - Finish Later box.
- Click Document History after medication details and compliance are entered on all medications.

**IVIEW DOCUMENTATION**

<table>
<thead>
<tr>
<th>Helps:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Icon Key- in IIVIEW window: click Options→click Show Legend</td>
</tr>
<tr>
<td>If item is Blue, reference material is available, click blue to see</td>
</tr>
</tbody>
</table>

**When do I have to document?**

- At assumption of care document a full assessment
- When patient status changes or new information is available
- Per unit protocol or as ordered by MD
- Per acuity re-assessment Policy using Review of Systems section & any additional Bands necessary to describe changes.
- Once per shift, review every section on the D.O.N.E. Band for required assessments or mandatory documentation

**Insert a performed on time**

- Click insert Date and Time icon, or right click on a time, choose “insert Date and Time”→Enter date/ time→Hit ENTER

**To insert a lot of things**

- Insert the “performed on time” column
- On the Left Menu, click each desired section
- Double-Click on the time at the top of the column
- Enter data; use “Tab” or “Enter” button on to skip items PRN

**Activate a specific section**

- Double-click in the blue section header under time column

**Conditional Logic**

- Look for conditional logic Icons 🕊 which denote prerequisite questions if something seems to be missing

**Customizing the View**

- Items such as Ostomy data may be hidden, Click the 🎨 icon.
- Place a check mark by section or individual item to display
Sign documentation [✓]
- Sign documentation into chart with the checkmark icon.

Associate a monitor (if available in your unit):
- Associate screen automatically displays on 1st sign-in to chart. Or to manually launch, click Associate Monitor icon.
- Select the correct unit/room number to assign monitor. Click the Associate button and answer “YES” to warning question.

Disassociate a patient from monitor:
- Manually click Highlight patient’s name ➔ Choose “Disassociate” ➔ answer the warning question YES

Expand and collapse a section:
- Choose the triangles next to the section header ➔ Suction/Cough ➔ Ventilator Settings Subset

Adding Narrative Annotations/Notes
NOTE: Only use narratives if no place exists in IVIEW to document needed data
- Create time column ➔ single click on time ➔ Click Action Icon (top left just below the IVIEW Banner) ➔ Click Add Annotation or Flag Annotation ➔ Name note ➔ add Comment ➔ SIGN

How to read attached comments
- Hover icon or right-click ➔ choose “View Comment”

Document critical values:
NOTE: DO NOT utilize “add comment” function for this purpose.
- QuickView Band ➔ click Critical Result/Other MD Communication Section ➔ complete Critical Results section

Modify documentation
- Right click incorrect item ➔ Choose Modify ➔ enter correct data ➔ sign

Fix errors (wrong patient documentation)
- Highlight and drag across 10-12 incorrect items ➔ Right-click “BLACK” area ➔ Click Un-Chart ➔ enter reason ➔ Sign

Creating Dynamic Group item:
- SINGLE Click the icon ➔ Click in blue header just created ➔ Enter label data, scroll down if necessary ➔ Click OK ➔ Document applicable data ➔ sign

Inactivating a Dynamic Group item:
- Right Click the Labeled name of the item ➔ Choose “inactivate”

Intake & Output
Auto-entered Medication Volumes:
NOTE: IVPB, IVP, NGT/GT/JT, and PO meds the volume will automatically document into I&O

To set a Default I&O Time Frame:
- Click Customize View Icon ➔ click preferences Tab ➔ Select Default Time Scale Pull Down Menu ➔ choose desired timeframe ➔ OK

Activation of a Field to enter totals:
- Double-click the individual white boxes under correct time column to enter total ➔ SIGN

Entering IV Drip Totals (after Begin Bag is done):
NOTE: Document only Primary Infusion totals from the pump
- Clear IV Pump to obtain total ➔ In correct time column on correct drug, double click white box ➔ enter total ➔ SIGN

Entering IV Drip Totals if drip was started in Non-eMAR area (ex. Surgery or Cath Lab):
- Check Pump for total ➔ In correct time column on correct drug, double click white box ➔ BEGIN BAG screen displays, click on “Infuse” at top of screen ➔ Be sure lower right of screen says “Infuse” ➔ Enter amount ➔ Fill in required information ➔ SIGN

Modifying, Un-charting, or Adding additional results
- Right Click item ➔ to Add Additional Result, Modify, Un-chart, or Add Comment ➔ Click SIGN

Departing Home:
- Click Depart Button
- Click Pencil Icons of desired/required sections
  - Follow-up - Use to enter instructions for any appts made for patient or inform when they should make their own appts. Always check the MD Discharge Form/Orders to include all items the MD is requesting. Every patient should have at least one follow-up item
  - Patient Education - Use to enter patient specific education r/t condition/diagnosis. At least 1 is required. Use “More” button for Patient Specific Education Resources
  - Med Leaflet - Use to give medication instructions for any new medications the patient is going home on.
NOTE: Patient MUST have email address to complete this process

☐ Click PM Conversation button ➔ Click IQ Health Registration ➔ Type Medical Center into Facility Name ➔ click ellipses ➔ Choose Medical Center of Central GA (or other as applicable) ➔ Click OK ➔ Enter Patient’s email Address & desired 4 digit PIN ➔ Click OK

CAREMOBILE AND eMAR
NOTE: All Tasks MUST be documented as either done or Not Done/Not Given

CareMobile Device Documentation

To reboot the HANDHELD DEVICE:
☑ Hold the CTRL key & SFT keys down together until screen goes blank ➔ Release both buttons, allow home screen to load

Calibrate the HANDHELD DEVICE
☑ Tap Calibrate ➔ Tap Align Screen ➔ Tap in center of + sign as it moves until Align Screen returns ➔ Tap OK in upper right

To pick organization (Not necessary very often):
☐ Sign In ➔ Choose Tasks Menu ➔ Choose Pick Organization ➔ Scroll to Medical Center of Central Georgia ➔ Click “Select”

To Set Location on the Handheld device:
☑ Choose Tasks Menu ➔ Choose List Maintenance ➔ Tap “edit” in upper box ➔ Click the “M” on the Hard Keys until the first MCCG is highlighted blue ➔ Click the “M” one more time, allow to load (may take a minute) ➔ Type first Letter of the Unit you are adding (ex: M for M4) ➔ Click small minus sign in box beside the unit name ➔ Scroll to find unit name and click on it with the stylus ➔ Choose SELECT button ➔ Hit OK, then hit OK again

To display your Custom List:
☑ Choose the Task Menu ➔ Choose List Maintenance ➔ Tap on “edit” in lower box ➔ Place a check by your name, click OK, then OK again ➔ From the unit list screen, click Mobile Location button ➔ Check your name ➔ Click OK

To document Pain/Temp responses:
☐ On Handheld: Go to the Scheduled patient care folder ➔ Select the Pain Response Task ➔ Scan patient armband ➔ Complete appropriate fields ➔ sign

To get additional information on any drug:
☐ Tap and hold the drug and choose Order Info

IQ HEALTH PATIENT PORTAL:

- Discharge Instructions: Use to enter patient care items such as diet, bathing, driving, CHF, update Home Med List, etc. be sure all instructions desired by MD are included.
- Skip Discharge to another Facility
- Nursing Doc Discharge Disposition: Used to enter final nursing narrative note as well as any required items at discharge such as POLST.
  ☑ Click that the Patient Understands instructions
  ☑ If patient requests electronic discharge instructions you MUST do the PM Conversation (see next section).
  ☑ Select Print to print the first ½ of the D/C instructions
  ☑ Click Save/Close
  ☑ Click Tasks ➔ Reports
  ☑ Select these to print the other ½ of the instructions always print 2 copies of DC Meds, one for Pt, one for hard Chart
    ☑ Discharge Patient Medications
    ☑ Inpatient Discharge Instructions
  ☑ Before taking to patient, verify Pt. Name and FIN number on each sheet to avoid wrong patient receiving data
  ☑ Have patient sign the Signature sheets, keep & place in the hard chart with copy of the Discharge Pt Meds report. Go over verbally and give all instructions to patient.

DEPARTING TO ANOTHER FACILITY:
☑ Click Depart Button
☑ Click Pencil Icon on Depart to Another Facility Section. The first 4 sections are not needed
☑ In special instructions, do not remove any information in the field that was entered by another clinician unless information is inappropriate to D/C situation. Add details of any non-assessment or non-medication information that the facility might need to know (include follow up appts they need to make).
☑ Complete all other applicable fields ➔ Sign
☑ Complete Nursing Doc Discharge Disposition ➔ Used to enter final nursing narrative note as well as any required items at discharge such as POLST.
☑ Click Save/Close
☑ Click Tasks ➔ Reports
☑ Select these 3 reports, print 2 copies (one for chart and one to go with patient).
  ☑ 24 Hr Medication Administration Summary
  ☑ Discharge Patient Medications
  ☑ Discharge to Another Facility
☑ A Chart copy is still required, HIM can print unless middle of night when MR/Unit Sec. must print
☑ Send POLST with patient (RED clear folder in the hard chart)
To go back to Pt List after selecting a patient:
☑ Tap Patient List Icon in the upper Right corner of screen

To Mark medications as GIVEN
NOTE: DO NOT just bypass alerts. Read all carefully.
☑ Click Patients Name→Choose pull down arrow and tap correct folder→Pull meds listed and take to patient’s room→Scan Patient Armband→Scan each med barcode and complete details of mandatory fields (highlighted pink)→Complete I&O information if necessary using +/- icon→SAVE→Administer Med→Go to the “To Be Signed” folder→Sign

To mark as NOT GIVEN
☑ Tap to open Med (bypass scan alert)→select NOT GIVEN→Enter Reason & appropriate Comment→SAVE→Sign

To remove an unsigned med after scanning:
☑ Go to the To BE Signed folder→Tap and HOLD the drug→Choose the Remove option

To change I & O totals:
☑ Click icon→Change the volumes in the “lower” I&O Flow Sheet columns

To add diluents volume:
☑ Click on the icon→Pick the drug used in the “diluents” field→In the volumes field document the amount used to dilute drug→SAVE→Continue documenting Med

To sign off of HANDHELD DEVICE:
☑ Touch word “Workflow”→Choose EXIT

eMAR View on the PC

Mark medications as GIVEN
☑ MAR Menu→Select the red, blue or green boxes under correct time column→Complete all mandatory fields (pink areas). Validate dosages, volumes and administration times→SIGN with checkmark in upper Left corner

To Mark medications as NOT GIVEN
☑ MAR Menu→Open med, Place check in Not Given box→Enter reason & Comment if needed
☑ ALWAYS comment if choose N/A or Nurse Judgment→SIGN

To clean up undocumented tasks due to downtime
☑ Right click red or blue task box under correct time column→Choose “Chart not Done”→Choose “Task Clean Up”, enter Downtime see paper MAR as a comment→Sign

To document Pain/Temp responses:
☑ On PAL, open Hearts→Locate Pain/Temp Task→Right Click→Choose Chart Details→Complete Form→Sign
☑ In eMAR→Open PAIN/TEMP task box→Complete form→Sign

To Un-chart/Modify or Add Comments to items:
☑ Locate charted item→Right-Click→Select desired action→If pull down menu is present, choose appropriate response→Add Comments as appropriate→SIGN

To reschedule 1-2 tasks only:
NOTE: DOES NOT adjust timing of all additional doses so should only safely adjust tasks to times viewable on MAR
☑ Right click red, blue task boxes→Choose Reschedule this task→Enter new due time→Enter reason→Click OK

To reschedule all current & future tasks:
☑ INTRANET→FORMS and Ordersets→All FORMS List→M→Medication Action Request, print form
☑ Place patient sticker in lower Right→Enter Med name→Indicate new schedule & starting dose time→Scan to pharmacy→Verify request completed

To document a dose of a drug previously documented as not given:
☑ Right Click drug name→click Additional Dose→Document information→Add comment as appropriate→SIGN

To document Infusion Volume Op & Med Obs:
☑ Click IV Pole Icon→check box of Med→Enter Start Date/Time→Enter Stop Date/Time→Enter volume infused→SIGN

ORDER ENTRY:

Important DO & DO NOT’s
☑ DO STAY ON Phone with Provider while entering TO’s, ALERTS will fire & they must be addressed by provider
☑ DO use correct FIN Encounter for patient
☑ DO enter/review Dosing Weights before ANY Medication order is placed
☑ DO use the Dosing Calculator for Weight Based meds
☑ Do Not Use any field labeled “Special Instructions” for Med orders. Pharmacists DO NOT see it! Use Order Comments Tab
☑ NEVER adjust a pre-programmed 1x dose medication order to multiple doses. Doing so will place a stop time of TODAY & NOW resulting in patient NOT receiving the ordered med.
Clinical Decision Support Alerts
- Read Alerts carefully. “Decision Support” Screens provide Important Alerts/Warnings R/T Allergy Interaction or Dangerous Drug Interaction
- When Entering Override reasons change the filter in the Lower Right of the Screen to “Apply only to required interactions” so you do not apply this reason to lesser alerts that are hidden from view

CPOE Pharmacy Verification
- Unverified drugs show above Icon. Every order should be verified by a pharmacist before 1st dose is given. If deemed urgent or emergent, system will allow drug to be documented.

CPOE MD Co-Sign & Communication Type
- TO/VO entered electronically on behalf of a Provider must be co-signed electronically. Do not count for Meaningful Use (MU)
- Signed Paper Order used when a paper order is written and signed by the Provider. Does not count for MU
- Protocol Order used for MEC approved Protocols. Use only if dependent clinician can initiate without any Provider input whatsoever. Electronically co-signed. Does not count for MU
- Electronically Written used for initiating PowerPlans planed by Provider or when referencing a previous CPOE order such as repeat INR for heparin drips if original CPOE order specifies when to collect. Not co-signed & doesn’t count for MU
- Paper TO/VO is used if clinician took order but cannot enter electronically. Cosigned on paper. Does not count for MU

Place Individual (one-off) Order
- PowerOrders Menu→Click →Add→Type key word in Search Field→Choose from top 15 (or hit ENTER to see all)→Select order with no icons beside it (if prompted, click sentence then OK)→Click Done→Verify Details of order (If missing data a blue X will display)→If necessary Add Comments in Comments Tab →Click Sign

Place Active Orders Using a PowerPlan
- “PowerOrders”/”Orders” Menu→Click →Add→Type key word in “Search” Field→Single-Click desired PowerPlan/Order with beside it→Click “Done” to see order entry screens & details.
- Yellow Sticky Notes are informational & cannot be changed). Evidence based links display this icon
- Uncheck pre-checked order if NOT desired

Place Planned Orders Using a PowerPlan
- Note: These steps only work if Plan has Button Should be done by Provider only if orders are not to be carried out immediately
- Complete steps as if placing active PowerPlan but stop at
- Complete all incomplete details →Click SIGN
- In the View Window, Plan will be in planned status.

Initiating Orders-Planned Status
- PowerOrders Menu→in View window click on the plan→Click Check Alerts to determine if any alerts are not verified by Provider, then look for incomplete orders
- if either found, notify provider for instructions→choose Initiate→choose Orders for signature→SIGN

Ordering SubPhases within PowerPlans
- A subphase is a grouping of orders in a PowerPlan identified by double yellow icon
- Place a check in the box and it will expand the subphase
- To go back to the original Plan, click:
  - button at the bottom of the orders
  - Or - On Left “View Window” Click original plan name

IV Fluid Order Differences
- IMPORTANT: Do Not Use any field labeled “Special Instructions. Pharmacists will not see data entered there!
- Details of the IV Fluid order may need to be entered.
- Yellow Fields are Mandatory
- Any Comments or parameters you wish to communicate, should be entered on ‘Order Comments’ Tab
- To modify IV drip rates→right click→choose Modify→enter new rate→Sign

Entering a CareSet
- Select the +Add button on the PowerOrders Section→Type Order to be entered in Search
field to Single Click Order Set with this icon

- Click/unclick boxes as per MD's
- Complete order details as in "entering orders" section above
- click OK
- Click Done
- SIGN

Favorites Folder

- PowerOrders/Orders Menu
- Click +Add
- Search desired order
- enter all order details you want
- saved
- Right click order name beside
- icon
- choose "add to Favorites"

- To make Sub Folders within Favorites, click [New Folder...]
- name folder (example below):
  - Medications
  - Labs
  - Radiology

- To Access Favorites
- PowerOrders/Orders
- click +Add
- click Yellow Star
- click folder name

Per Kilogram Meds and Dosing Calculator

- Auto fires whenever a per kilo med sentence is selected
- A Weight is required before a weight-based med order is placed.
- "Missing data" warning is related to missing Actual Weight, or missing Serum Creatinine, these must be entered to continue
- Other Missing data can be bypassed if necessary by clicking Apply Dose or Apply Standard Dose were applicable

Modifications & Correction of Errors

- If order is not yet signed, right click and remove or modify details
- If order is in "Completed" or "In-Process" Status, NO corrections or modifications should occur

Completing an Order

**Note:** Do this if part of a serial order is been completed already (ex. EKG x 3, 1 is complete & 2 are outstanding, MD writes to DC's)

- RIGHT-click the order you wish to complete
- Select Complete from the menu
- Click Orders for Signature Button
- SIGN

Cancelling Orders

**Note:** Do this if no part of the order has been started/perform

- Click the Quick Discontinue Check Box beside order
- Enter MD name
- Enter Date, Time and Type of communication
- Choose OK
- If prompted, select cancel reason
- Click additional checkboxes if other orders are also being DC’d
- Click Orders for Signature Button
- SIGN

Modify an Order

- Do NOT Modify Orders, Right click
- choose Cancel/Reorder

Entering Details on Multiple Items

- Any time the same details need to be entered on multiple items, hold down CTRL key on keyboard, click all items
- enter detail

Printing Requisitions

- Click on PowerOrders Section
- RIGHT Click on Item
- scroll down to Print
- Click Reprint
- Requisition
- Verify printer name
- choose Print

**Problems:**

**NOTE:** Medical Problems entered using PMHx Grid on admission. Do not Rank or alter "Medical" (System, System) Problems

- Use the lower "Problems" Box only
- click +ADD
- type problem into Search Field hit <enter>
- Double click desired problem
- Rank for today & set onset date
- Be sure RN or LPN is chosen correctly
- Click OK
- To Inactivate a Chronic Problem
- TO right click
- choose Modify
- change Status Field to Inactive
- To Resolve a onetime problem
- TO right click
- choose Modify
- change Status Field to Resolved
- Prioritize top 3 problems each shift and leave others unranked
- Clean up problems on Admission and on Discharge

**VTE Quality Measure:**

- Every Inpatient should have the VTE Quality Measure Initiated!!
- PowerOrders Menu
- Locate VIEW window
- Look for "Suggested Plans"
- expand (click +)
- Click VTE Quality Measure
- Click Accept
- Click Orders for Signature
- SIGN
- Documentation of the SCD is done in IVIEW in DONE band, be sure to document as soon as placed since this is a timed measure

**SCIP Quality Measure:**

- PowerOrders Menu
- Locate VIEW window
- Locate Quality Measures section under Plans header
- If SCIP Measure is "planned", click it
- "Initiate"
- Click Orders For Signature
- SIGN
- If measure is not displayed added it
- Click +Add on PowerOrders
- Type "Quality" into the Find field
- Appears as PowerPlan (DO NOT use any labeled Subphase in this step), use only these items:
  - [SCIP Quality Measures]
  - Highlight SCIP Measure so it turns Blue
Default ▶ Adding Sticky Note to PAL
☑ While in the PAL, RIGHT-Click on New Orders
   → Select Insert Column... → Select Sticky Note Indicator
   → Select Next ▷ Select Sticky Notes Medication Column → Type SN in header field → Select Next ▷ Click Finish (icon may take a few minutes to display)

Default ▶ Customize PowerOrders
☑ Click PowerOrders Section → Be Sure filter is set to All Active Orders, EXCEPT Quick Med or EC employees will choose All orders 5 days back → Click Customize view → Highlight all items in the LEFT column → Click ADD> button → In RIGHT column move by highlighting item then click ▷ or ▷ to move up or down use the following order:
   - Quick Discontinue → Stop
   - Type → Details
   - Notifications → Order Comment
   - Order Name → Ordering Physician
   - Status → Last Updated
   - Start → Last Updated By

☑ Change the “Then By” Menu to Encounter → Change the “Sort Orders By” Menu to Order Name → Click “Ascending” checked and click OK

Default ▶ Customize Medication List
☑ Click Medication List Section → Click Customize view → Move all items in Left Window to the Right window → In RIGHT column move by highlighting item then click ▷ or ▷ to move up or down use the following order:
   - Quick Discontinue → Stop
   - Type → Details
   - Notifications → Order Comment
   - Order Name → Ordering Physician
   - Status → Last Updated
   - Start → Last Updated By

☑ Select Sort Orders by “Order Name”, Click Ascending button → Group Orders by “Venue”, Then by “Encounter” → Choose “OK”

Default ▶ MAR Summary
☑ Click MAR Summary Menu → RIGHT Click Clinical Range Bar → Choose Change Defaults → Change Column Time to q12hr and change Each day begins to whatever time your shift begins → Click OK, then YES → Note yellow column contains the current date and time

☑ RIGHT Click Clinical Range Bar → Choose Change Properties → Click OPTIONS Tab → Change “no pending doses” to “all pending doses” → Select all boxes and choose OK/Apply then YES

Default ▶ Setting Default Shift
☑ From the PAL Click the OPTIONS Menu at top of screen while in the Patient Access List view (PAL) → Choose SET DEFAULTS → Select appropriate shift → Click APPLY then OK.
   NOTE: prevents having to choose your shift every time

Default ▶ Create Custom List on PAL
☑ From the Patient Access List (PAL) RIGHT Click Unit Name List
   - ADM → Choose “Change Patient List” → Choose NEW at the bottom of the pop up screen → Choose CUSTOM then NEXT → Type the name of your list (ex. Jane’s Custom List) → Choose FINISH
   NOTE: You only have to create ONE list for yourself it will always be there for you in the future

Default ▶ Expand Tool Bars
☑ LEFT Click & hold the small light gray “dots” icon at the top of the screen directly to the LEFT of Add/Hide button → Drag DOWN and to the LEFT Margin → There should now be 2/3 rows of Buttons and the Add/Hide button should be visible on the lower set toward the right.
   NOTE: this will now be the default view

Default ▶ Other Quality Measures (CAP, CP/AMI, Stroke, CHF):
☑ PowerOrders Menu → Locate the VIEW window → Locate Quality Measures section under Plans header → If Measure is “planned”, click it → Click “Initiate” button → Click Orders For Signature → Sign → If measure is not displayed add it → Click +Add on PowerOrders → Type the Measure so it turns Blue → Click Orders for Signature → Click Sign → Click Minutes ago button to refresh

☑ Locate Quality Measures section under Plans header → Create Custom List on PAL
   - ADM → Choose “Change Patient List” → Choose NEW at the bottom of the pop up screen → Choose CUSTOM then NEXT → Type the name of your list (ex. Jane’s Custom List) → Choose FINISH
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☑ Other Quality Measures (CAP, CP/AMI, Stroke, CHF):
   - Stroke Quality Measures v4.1
   - Pneumonia Quality Measures v4.1
   - Heart Failure Quality Measures v4.1
   - Chest Pain, Acute Myocardial Infarction Quality Measures

☑ Highlight desired Measure so it turns Blue → Click Done → Click “Initiate” Button → Click Orders for Signature → Click Sign → Click Minutes ago button to refresh

Default ▶ Default Quality Measures
☑ MUST click subphase HERE then click
   - Return to SCIP Quality Measures
☑ Click “Initiate” Button → Click Orders for Signature → Sign → Click Minutes ago button to refresh

Default ▶ Default to Sign
☑ While in the PAL, RIGHT-Click on New Orders
   → Select Insert Column... → Select Sticky Note Indicator
   → Select Next ▷ Select Sticky Notes Medication Column → Type SN in header field → Select Next ▷ Click Finish (icon may take a few minutes to display)

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