Meditech Patient Care System
Clinical Documentation
Nursing Student Overview and Clinical Tips
Section 1 – Introduction

Overview: This module includes a brief introduction to the Meditech Patient Care System (PCS), a review of general Meditech functionality, including general navigation principles and key definitions.

Audience: This document is intended for nursing students performing clinical rotations at SBMC.

Key definitions/functionality within PCS:

Auto referral: Meditech can initiate an order or referral based on the answers to an assessment. Example: if the patient answers “yes” they do not feel safe in their home, Meditech sends a referral to Social Work.

Auto calculation: The system can calculate values automatically, saving time and eliminating errors. For example, Meditech calculates the Fall Risk Score based on the nurses' assessment.

Status Board: A patient list that provides an overview of patient information (e.g. Room/Bed, diet, code status, orders, diagnosis, confidential )

Worklist: A patient list of interventions and assessments. When interventions/assessments are assigned a frequency, Meditech will provide a reminder of due and past due items. Assessment and intervention documentation is accessed through the worklist.

Standards of Care: Sets of interventions/assessments that are defined for specific patient populations. Each specific unit has a set of interventions that are added to a patient’s worklist depending on the area the patient is admitted. (e.g. ICU, OB, Med/Surg).

Protocols: Resource documents accessible within PCS, associated with interventions/assessments that provide the care provider with additional information or guidance. Protocols are for reference only and do not become part of the patient’s medical record.

Section 2 – Policies and Procedures/Expectations

St Bernards Medical Center information technology users need to be familiar with and accountable for compliance with all policies and procedures relating to the use of information systems, access and use of patient data, and access and use of organizational data. However, there are key areas which we wish to reinforce and focus on during Information Systems Training. Those areas relate to Security, confidentiality, Logons/Passwords, Access and Competencies.
**Security:** All users of information systems are responsible for the security of data. This includes making sure that computer screens are not viewable by the public or by others who do not have a need to see the data being displayed. Users are responsible to ensure that they log off of systems appropriately to make sure that the systems are not open to unauthorized access. Physical security of data also applies to any other media such as paper reports, data on disks/CDs, etc. This data must also be secured and disposed of properly to prevent access by others.

**Key Points:**
- Always log off the computers when finished.
- Do not take printed information home with you.
- Dispose of any reports used throughout your clinical day in the shred bin.

**Confidentiality:** Users are only authorized to access information on patients in whose care they are involved and only that data required to perform their job function. System audit trails allow for the reporting of document access. These audit trails will be systematically reviewed to monitor compliance with our policy. Information should only be shared with others involved in the patient’s care and only the information that is ‘need to know’. Students should be cognizant of the environment in which the data is shared to prevent inadvertent disclosure (e.g. be sure that others can not overhear or see the information)

**Key Points:**
- Only access information on patients in whose care you are involved in for the day.
- Do not discuss patients in the hallway, elevators, cafeteria or any other public place.
- What happens in clinical stays in clinical!

**Passwords/logons:** Passwords/logons are assigned to an individual. They belong only to that individual. You should not share your password/logon with anyone else. You should never use another’s password/logon. Be sure that prior users are logged off the system before using the system and make sure that all work is done under your own log on. Remember the audit trail and that you are accountable for all activities under your access. In the event that you forget your password, your identity will be verified per policy and then you will be issued a temporary password. You will access the system using your temporary password and then enter a new password on prompting (known ONLY by you). Passwords will change every 60 days. Passwords must be at least 7 characters, should be alphanumeric mix, and should not be easily guessed combinations (e.g. children’s names, anniversary, etc.).

It is the intent that documentation will be real time and performed at the point of care whenever possible. Data entered is available within the Electronic Medical Record (EMR) for review.

**Key Points**
- Do not share your username and password with anyone.
- Make sure that you are logged in before documenting.
- If you forget your username or password, call the HELP desk- 870-207-HELP
- Document at the bedside in real time when possible.
Section 3 – The ‘Rights’ of Clinical Documentation

Online clinical documentation is utilized by the physician and the care team to make decisions regarding patient care. Therefore it is very important that the data within the patient record be timely and accurate. One major consideration is validating that you are documenting the right information on the right patient and within the right encounter for the patient. With each step/screen within the documentation process, the user should be validating accuracy.

**Important items on the Document Intervention window**

- Correct Patient Name/Account Number
- Your Login
- Correct Intervention

![Image of Document Intervention window]

**Have you validated:**

- Correct User (you should be logged in)?
- Correct patient?
- Correct encounter?
- Correct intervention?
- Correct date and time?

Section 4 – Basics of Worklist/Status Board Management

The Status Board is a listing of patients with columns of high level of information. This overview assists the care provider in managing work flow and prioritizing care.
Section 5 – Understanding the Basics of the Patient Worklist

When admitted, a patient is placed on a unit specific Standard of Care (SOC). This SOC is comprised of a group of interventions representing the minimum level of care for patients within the care setting. Through selection of the interventions within the worklist, the nurse can document care provided to the patient.

Interventions are two types:

- ‘I did it’ interventions where the nurse is simply ‘checking off’ completion of a task
- Interventions with attached assessment screens that require entry of data relevant to the intervention (e.g. Shift assessment, ADL assessment, Intake and Output, etc.).
Worklist Layout:

#1 Column (no heading)- A is for an ASSESSMENT type intervention, Ao is for an ordered Assessment, I is for an INTERVENTION, Io is for ordered Intervention, O is for OUTCOMES, RX is for MEDICATIONS

#2 Column- Care Item – Interventions to be completed for the patient.

#3 Column- Frequency – This column displays the frequency designated for the intervention and generates the schedule if appropriate.

#4- ? column- To view what the letters in this column mean click on the “?” . A means associated data, P means view protocol, I means to edit or view info, O means edit or view order information.

#5 Column- Last Done- shows time frame the care item was last documented on. Click in this column on the last done time to Undo and Save / Edit your own assessment documentation. For example if documented in error on wrong chart.

#6 Column- Status/Due – Length of time until A or I is due again. Items in RED are past due.

#7 clocks- Care items are assigned frequencies which produce a clock on the worklist with the time the task is due.

NURSING STUDENTS ARE TO DOCUMENT IN THE “NOW” COLUMN SO THE CLOCKS STAY ON THE WORKLIST FOR THE PATIENTS PRIMARY NURSE/PCT.

Section 6 – Medication Administration

Medications should be administered as close to their scheduled time as possible. Use of scanning is required for all non-emergent medication administration.

Nursing students should not administer a medication that has not been acknowledged by a RN. If administration of a med is needed and it has not been acknowledged, notify the nurse caring for the patient and he/she can acknowledge the medication.

Section 7 – Basics of the Electronic Medical Record (EMR)

Patient data and documentation entered within PCS is reviewed within the Electronic Medical Record (EMR). It begins with the Summary tab to the refresh tab. Information can only be viewed from these tabs except for the Summary tab. All documentation related to the care of the patient can be viewed under “Patient Care” tab. The word turns red if there is new information to be viewed. Example laboratory—if new labs come back that have not been viewed the work “laboratory” will be red.
Section 8- Helpful Tips for Clinical

Assessments you should chart (only in the NOW column; DO NOT chart on the clocks!):

- Activities of Daily Living
- Vital Signs Assessment
- Shift Assessment
- IV Site Assessment
- Braden Skin Risk
- Fall Risk Assessment
- Pain Assessment
- Wound/Incision Assessment (if there is one)
- Education Record
- Intake and Output Collect and Record
- Feedings NG, DHT, PEG

Notes you should chart:

Hello narrative: For example—“Received report from primary nurse, Jane, introduced self to patient. Patient resting quietly in bed, no s/s of acute distress. VS stable at this time. Patient states no pain and does not need to use the restroom. Patient states no other needs at the present time. Call light within reach. Patient instructed to call for assistance. Will continue to monitor.”

Lunch narrative: For example—“Reported off to primary nurse, Jane, for lunch break. Patient sitting up in chair in no acute distress. Patient states no pain and no other needs at this time. Call light within reach. Patient instructed to call for assistance.”

Goodbye Narrative: For example—“Patient sleeping in bed at this time. No s/s of acute distress. Family at bedside states no needs at this time. Call light in reach. Family instructed to call for assistance if needed. Reported off to primary nurse, Jane.”

Any change or occurrence during the shift should also prompt you to write a note in the chart.
**Section 9- Where to find information in the Electronic Medical Record**

Diet, allergies, attending physician, admitting diagnosis, fall score, etc. can be found on your status board prior to opening the patient’s chart.

H&P, x-ray and other radiology reports, surgery reports, EKG, ER physician documentation: in your patient’s open chart, click reports on the right hand side of the screen. Click the clipboard to view the report. For EKG ONLY, click the camera beside the name of the report.

Labs: Click the lab tab within your patient’s open chart. To view labs from previous days, click < or << and be sure to scroll down. If a lab is listed, it has been drawn during this hospitalization. Be sure to click the < or << button enough to find it if it is pertinent to your patient’s condition. Click all tabs at the top to view all labs (Hematology, Chemistry, Toxicology, Urine, etc.).

To see the reference range for a given lab, click the value of the result (click on the number). A pop-up will appear that will give you the reference range (normal range).

Culture results: click the microbiology tab with your patient’s open chart.

Vital Signs: to view vitals from the entire admission, click the vital signs tab.

I&O: to view I&O from the entire admission, click the I&O tab. This is a good place to find last BM if the patient doesn’t remember or can’t tell you.

To view other people’s notes: In your patient’s open chart, click patient care on the right hand side. Click sort by provider type (Physical therapy, speech therapy, RN, LPN, PCT, etc.). You will choose which type of provider’s notes you want to view. Then click the note to read it. This is helpful if you want to know what a therapist said about a patient’s progress or treatment options.

<table>
<thead>
<tr>
<th>IV size/color of cathlon:</th>
<th>Common IV fluids:</th>
</tr>
</thead>
<tbody>
<tr>
<td>18gauge: green</td>
<td>NS-normal saline, 0.9% sodium chloride</td>
</tr>
<tr>
<td>20gauge: pink</td>
<td>½ NS-half normal saline, 0.45% sodium chloride</td>
</tr>
<tr>
<td>22gauge: blue</td>
<td>LR-Lactated Ringers</td>
</tr>
<tr>
<td>24gauge: yellow</td>
<td>D5W-5% dextrose in water</td>
</tr>
<tr>
<td></td>
<td>D5NS-5% dextrose in normal saline</td>
</tr>
<tr>
<td></td>
<td>D5 ½ NS-5% dextrose in half normal saline</td>
</tr>
<tr>
<td></td>
<td>½ NS20KCL-half normal saline with 20meq of potassium chloride</td>
</tr>
<tr>
<td></td>
<td>D5 ½ NS 20KCL-5% dextrose in half normal saline with 20 meq of potassium chloride</td>
</tr>
</tbody>
</table>
Medication information: Click MAR on the right hand side in the patient’s open chart. Find the medication you want more information on. Click them M just below the name of the medication. This will pull up information about the medication. You can click print at the bottom if you want to give your patient a handout about a new medication (or an old one).

To view more information about an order (for instance a dressing change): click the P, I, or O button that is right beside the order on your worklist.

To determine if a physician entered a medication order, click orders, then click medications. Click on the specific medication order you are wondering about. If the ordering USER and the ordering PROVIDER are the same, the physician entered his/her own order.

To view past records: If your patient was admitted only for surgery, or if you simply wonder what their H&H was the last time they were admitted because they were just admitted last night, you can click select visits from the right hand side in the patient’s open chart. For patient’s admitted for surgery, select the visit (place a checkmark in the box) that says PAT. This stands for pre-admission testing. For other patients place a checkmark in the box beside the most recent hospitalization (it will say DIS or DISCH for discharge and a floor number). Then simply click the tab that contains the information you want (labs, reports, etc.).